

Obzornik zdravstvene nege

Slovenian Nursing Review

REVIJA ZBORNICE ZDRAVSTVENE IN BABIŠKE NEGE SLOVENIJE -
ZVEZE STROKOVNIH DRUŠTEV MEDICINSKIH SESTER, BABIC IN ZDRAVSTVENIH TEHNIKOV SLOVENIJE

REVIEW OF THE NURSES AND MIDWIVES ASSOCIATION OF SLOVENIA



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OBZORNIK ZDRAVSTVENE NEGE

NAMEN IN CILJI

Obzornik zdravstvene nege (Obzor Zdrav Neg) objavlja izvirne in pregledne znanstvene članke na področjih zdravstvene in babiške nege ter interdisciplinarnih tem v zdravstvenih vedah. Cilj revije je, da članki v svojih znanstvenih, teoretičnih in filozofskih izhodiščih kot eksperimentalne, neeksperimentalne in kvalitativne raziskave ter pregledi literature prispevajo k razvoju znanstvene discipline, ustvarjanju novega znanja ter redefiniciji obstoječega znanja. Revija sprejema članke, ki so znotraj omenjenih strokovnih področij usmerjeni v ključne dimenzije razvoja, kot so teoretični koncepti in modeli, etika, filozofija, klinično delo, krepitev zdravja, razvoj prakse in zahtevnejših oblik dela, izobraževanje, raziskovanje, na dokazih podprto delo, medpoklicno sodelovanje, menedžment, kakovost in varnost v zdravstvu, zdravstvena politika idr.

Revija pomembno prispeva k profesionalizaciji zdravstvene nege in babištva ter drugih zdravstvenih ved v Sloveniji in mednarodnem okviru, zlasti v državah Balkana ter širše centralne in vzhodnoevropske regije, ki jih povezujejo skupne značilnosti razvoja zdravstvene in babiške nege v postsocialističnih državah.

Revija ima vzpostavljene mednarodne standarde na področju publiciranja, mednarodni uredniški odbor, širok nabor recenzentov in je prosto dostopna v e-obliki. Članki v Obzorniku zdravstvene nege so recenzirani s tremi zunanjimi anonimnimi recenzijami. Revija objavlja članke v slovenščini in angleščini in izhaja štirikrat letno.

Zgodovina revije kaže na njeno pomembnost za razvoj zdravstvene in babiške nege na področju Balkana, saj izhaja od leta 1967, ko je izšla prva številka Zdravstvenega obzornika (ISSN 0350-9516), strokovnega glasila medicinskih sester in zdravstvenih tehnikov, ki se je leta 1994 preimenovalo v Obzornik zdravstvene nege. Kot predhodnica Zdravstvenega obzornika je od leta 1954 do 1961 izhajalo strokovno-informacijsko glasilo Medicinska sestra na terenu (ISSN 2232-5654) v izdaji Centralnega higienskega zavoda v Ljubljani.

Obzornik zdravstvene nege indeksirajo: CINAHL (Cumulative Index to Nursing and Allied Health Literature), ProQuest (ProQuest Online Information Service), Crossref (Digital Object Identifier (DOI) Registration Agency), COBIB.SI (Vzajemna bibliografsko-kataložna baza podatkov), Biomedicina Slovenica, dLib.si (Digitalna knjižnica Slovenije), ERIH PLUS (European Reference Index for the Humanities and the Social Sciences), DOAJ (Directory of Open Access Journals), J-GATE, Index Copernicus International.

SLOVENIAN NURSING REVIEW

AIMS AND SCOPE

Published in the Slovenian Nursing Review (Slov Nurs Rev) are the original and review scientific and professional articles in the field of nursing, midwifery and other interdisciplinary health sciences. The articles published aim to explore the developmental paradigms of the relevant fields in accordance with their scientific, theoretical and philosophical bases, which are reflected in the experimental and non-experimental research, qualitative studies and reviews. These publications contribute to the development of the scientific discipline, create new knowledge and redefine the current knowledge bases. The review publishes the articles which focus on key developmental dimensions of the above disciplines, such as theoretical concepts, models, ethics and philosophy, clinical practice, health promotion, the development of practice and more demanding modes of health care delivery, education, research, evidence-based practice, interdisciplinary cooperation, management, quality and safety, health policy and others.

The Slovenian Nursing Review significantly contributes towards the professional development of nursing, midwifery and other health sciences in Slovenia and worldwide, especially in the Balkans and the countries of the Central and Eastern Europe, which share common characteristics of nursing and midwifery development of post-socialist countries.

The Slovenian Nursing Review follows the international standards in the field of publishing and is managed by the international editorial board and a critical selection of reviewers. All published articles are available also in the electronic form. Before publication, the articles in this quarterly periodical are triple-blind peer reviewed. Some original scientific articles are published in the English language.

The history of the magazine clearly demonstrates its impact on the development of nursing and midwifery in the Balkan area. In 1967 the first issue of the professional periodical of the nurses and nursing technicians Health Review (Slovenian title: Zdravstveni obzornik, ISSN 0350-9516) was published. From 1994 it bears the title The Slovenian Nursing Review. As a precursor to Zdravstveni obzornik, professional-informational periodical entitled a Community Nurse (Slovenian title: Medicinska sestra na terenu, ISSN 2232-5654) was published by the Central Institute of Hygiene in Ljubljana, in the years 1954 to 1961.

The Slovenian Nursing Review is indexed in CINAHL (Cumulative Index to Nursing and Allied Health Literature), ProQuest (ProQuest Online Information Service), Crossref (Digital Object Identifier (DOI) Registration Agency), COBIB.SI (Slovenian union bibliographic/catalogue database), Biomedicina Slovenica, dLib.si (The Digital Library of Slovenia), ERIH PLUS (European Reference Index for the Humanities and the Social Sciences), DOAJ (Directory of Open Access Journals), J-GATE, Index Copernicus International.

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Editorial/Uvodnik

Nurses' voice as the key to change

Glas medicinskih sester je ključnega pomena za spremembe

Paul De Raeve^{1, *}

For the last two years, nurses have been more than ever before in a very complex and challenging timing. COVID-19 has disrupted society in its entirety. But, of all the different sectors, one that remained working day and night, with incredible shifts and no breaks or holiday, were the nurses, who through their relentless commitment, expertise, professionalism, bravery, care for our most vulnerable, have and continue preserving millions of lives daily and providing comfort and dignified care at end of life. This pandemic has for sure demonstrated the added value of the nursing workforce to the European healthcare ecosystems: working at the frontline of care, at the bedside with the patients, and providing the evidence that nurses' competencies are central to the functioning of healthcare systems in the EU.

In the last few months, another reality hit us all hard with the war in Ukraine, and again brought very difficult timings for a whole population - a humanitarian crisis that has been threatening our nurse colleagues and their families, and world peace. More than ever, international cooperation and solidarity have been vital to support nurses, midwives and healthcare professionals at the frontlines. In these difficult times, the European Federation of Nurses Associations (EFN) has been collaborating very closely with international organisations, as the International Council of Nurses (ICN), and with EFN National Nurses Associations from Poland, Slovenia, Hungary and Romania, as well as Moldova, to bring its support to the nurses' colleagues from Ukraine, refugees or still in the country, and to those at the neighbouring countries borders trying to help as much as they can the refugees flying the country, which for some of them are also nurses and midwives. The EFN is also in close contact with other key EU stakeholders and with the European Commission to collectively support the efforts to support and protect nurses, midwives, health

professionals and ensure access to healthcare and promote peace through a unified nursing response.

More than ever, nurses have witnessed the devastating suffering of individuals and their families with an enormous impact on their mental and physical health. The COVID-19 pandemic reaffirmed the value of well prepared and educated nurses which leads to lower mortality rates and better patient outcomes. Nurses play an essential role in the provision of safe and quality healthcare. Despite the ongoing challenges they are facing and the difficult and stressful working conditions, nurses continue to tackle the situations with incredible strength and dedication to ensure the smooth functioning of the healthcare systems and the well-being of their patients. From the European Commission perspective, it is acknowledged that a stronger Europe-wide coordination is required in relation to health, with more investment to build the foundations for a more resilient health system and better preparation for possible future health crises. As such, people and their well-being are at the heart of the European Pillar of Social Rights Action Plan (European Commission, 2021) that sets out the common agenda to reinforce social Europe.

As the single largest occupational group in healthcare, nurses have a crucial and unique role to play in the efforts to develop effective and efficient health systems able to respond to the challenges they face. This depends to a considerable extent on having a high-quality health workforce of sufficient capacity and with the right skills. The way forward could be simple as we do not need to make things more complicated than they already are. With the very good steps already achieved, we need for sure to build further on all the work done and the outcomes reached so far at national and EU level, building on partnerships with the EU leaders and policymakers, and knowing that a lot is happening at EU level, namely on Digitalisation, Workforce

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and Education. The nurses' voice is key to change for the better, to make sure that the EU includes health in all policies to tackle the EU, European and global challenges, and enhance nurses' ability to shape and deliver effective and efficient EU policies that impact positively on the EU citizens.

A resilient future-proof health ecosystem is urgently needed with the agreement of EU institutions and Member States on the use of the EU Recovery & Resilient Funds. This is necessary to respond to the major healthcare challenges that COVID-19 put boldly on the political table: the resilient health and care workforce, the care left undone, the digitalisation of the healthcare services, planetary health, and last but not least citizens' value recognition to build the future of Europe. Still today, nurses have to face shortage, lack of protection, heavy workload, and low wages. It is time to take real EU actions, to address in a systematic way the recruitment and retention of frontline nurses. Nurses through their relentless commitment, expertise, professionalism, bravery, and heroic actions have saved countless numbers of lives. Despite ongoing challenges they are facing and the difficult and stressful working conditions, nurses continue to tackle the situations with incredible strength and dedication to ensure the smooth functioning of the healthcare systems and the well-being of their patients.

The new European Semester Spring Package 2022 (European Commission, 2022, May 23) can be a good tool to look at, next to the implementation of the national recovery and resilience plans (European Commission, 2020) which sets out a coherent package of reforms and public investment projects. In these difficult times, creating resilient healthcare systems is a fundamental starting point to support nurses and healthcare professionals at the frontline. It is time for the EU governments and health systems to invest in nursing education and in a resilient Nursing Workforce to address the growing nursing shortage. Nursing workforce is the backbone of the healthcare ecosystem and the most trusted healthcare professional closer to patients. As such, nurses are the solution to address the world's growing health care needs.

Nurses are natural healthcare innovators being at the frontline of care, ready to upscale new digital health tools for the benefit of patients, and as such contribute to address three key elements of the current transformation of health ecosystems: building trust, promoting user-centre innovation and ensuring an appropriate use of data to enable technology. EFN, representing 3 million nurses in the EU and 6 million in Europe, supports the boosts of the digitalisation process and in particular the engagement of nurses in co-creation. The EFN believes that it is necessary to create the right digital instruments which can facilitate and support nurses' daily operational activities/services. Therefore, it is urgent to create

digital tools that can really help and facilitate nurses and other healthcare professionals' working life. But this is possible only by engaging nurses in co-creation! Nurses really know what the healthcare eco-system needs are and where digitalisation could be helpful and essential for achieving better health and care outcomes.

In this context in which digitalisation is more and more essential in the health systems, the European Health Data Space (EHDS) (European Commission, 2022) plays a key role. Recently launched by the European Commission, it represents a great opportunity for nurses and for all the healthcare professionals to have an easy access to the health data of patients, ensuring protection and high-quality care. For EFN, the central issues in the weeks, months and years ahead will be about public trust and keeping the citizen/patient in the centre of proceedings. The EFN placed and will be placing a lot of focus on the health data space, as demonstrated by the 2 EU projects almost coming to an end in the Health Data Space context: Smart4Health (EFN, 2019) and InteropEHRate (EFN, 2020).

Challenges for the healthcare systems all over Europe cannot be underestimated, namely in these very difficult times. The EFN and its Members are committed and determined to ensure that EFN EU policy agenda priorities on education, workforce, quality and safety, remain high on national and EU political agendas, and continue lobbying the national governments and the EU institutions to make sure the nurses' voice is heard and taken into account in any of the key health developments.

More than ever, it is crucial for nurses and midwives to engage and proactively influence EU policies that impact on quality and safety of healthcare and contribute to the population's health throughout Europe. Therefore, it is essential to support, to listen, and to encourage each other. It is not about prestige, it is not about who is the best, it is about our collective interests, views, actions, concerns and challenges. As we all know, we cannot change the world on our own. But we can focus and work together, in synergy, on specific actions that can make the difference for the nurses and the citizens of Europe.

Slovenian translation/Prevod v slovenščino

V zadnjih dveh letih so se medicinske sestre znašle v nadvse kompleksnem in težavnem položaju. Medtem ko je pandemija COVIDA-19 za družbo pomenila popoln prelom z utečenimi praksami, so bile med vsemi storitvenimi sektorji so ravno medicinske sestre tiste, ki so se odpovalde odmorom in počitnicam in ohranile celodnevni delovnik z garaškimi izmenami. Njihova trdna zavezanost, znanje in strokovnost, pogum in skrb za najšibkeje člane družbe so reševali

in še naprej dnevno rešujejo na milijone življenj ter pacientom zagotavljajo olajšanje, skrbno nego in dostojnost tudi ob koncu življenja. Pandemija je evropskim zdravstvenim ekosistemom jasno pokazala dodano vrednost delovne sile v zdravstveni negi: delo na prvi liniji nege, ob posteljah pacientov, je dokaz, da so kompetence medicinskih sester osrednjega pomena za delovanje zdravstvenih sistemov v EU.

V preteklih mesecih je javnost pretresel izbruh vojne v Ukrajini. Ta grožnja svetovnemu miru in populaciji pomeni humanitarno krizo, ki ogroža tako naše kolege na področju zdravstvene nege kot tudi njihove družine. Sedaj je še posebej pomembno mednarodno sodelovanje in solidarnost v podporo medicinskim sestram, babicam in drugemu zdravstvenemu osebju v prvih bojnih linijah. V teh težavnih časih Evropska federacija združenj medicinskih sester (European Federation of Nurses Associations [EFN]) nudi podporo ukrajinskim zdravstvenim delavcem (tako beguncem kot tistim, ki so ostali v državi, ter tistim iz sosednjih držav, ki nudijo pomoč beguncem, med katerimi so tudi medicinske sestre in babice), pri čemer tesno sodeluje z mednarodnimi organizacijami, kot so Mednarodni svet medicinskih sester (ICN) in nacionalna združenja medicinskih sester znotraj EFN iz Poljske, Slovenije, Madžarske, Romunije in Moldavije. EFN se v okviru enotnega odziva zdravstvene stroke zavzema za mir in zagotavljanje dostopa do zdravstvene nege ter v tesnem sodelovanju z ostalimi ključnimi evropskimi deležniki in Evropsko komisijo nudi podporo in zaščito medicinskim sestram, babicam in drugemu zdravstvenemu osebju.

Medicinske sestre so bolj kot kdajkoli prej priča neizmernemu trpljenju posameznikov in njihovih družin, kar močno vpliva na njihovo duševno in fizično zdravje. Pandemija COVIDA-19 je poudarila pomen razpoložljivosti dobro pripravljenih in strokovno podkovanih medicinskih sester, saj ta pripomore k nižji smrtnosti in boljšim rezultatom zdravljenja. Medicinske sestre igrajo ključno vlogo v procesu zagotavljanja varne in kvalitetne zdravstvene nege. Kljub neprestanim izzivom, s katerimi se soočajo, ter težkim in stresnim delovnim pogojem, se medicinske sestre s kriznimi situacijami spopadajo z neverjetno močjo in predanostjo, s čimer omogočajo nemoteno delovanje zdravstvenih sistemov v dobrobit svojih pacientov. Evropska komisija prepoznava potrebo po močnejši vseevropski koordinaciji na področju zdravstva ter naložbah v izgraditev temeljev odpornejšega zdravstvenega sistema in boljše pripravljenosti za primer morebitnih prihodnjih kriznih situacij. Evropski steber socialnih pravic (European Commission, 2021) tako predstavlja skupno strategijo za okrepitev socialne Evrope, v kateri so ljudje in njihova dobrobit v središču pozornosti.

Medicinske sestre imajo kot največja poklicna skupina v zdravstvu ključno in edinstveno vlogo v prizadevanjih po razvoju učinkovitih zdravstvenih

sistemov, ki se bodo sposobni odzvati na tekoče izzive. To je seveda v veliki meri odvisno od razpoložljivosti zadostnega števila kvalitetnega in ustrezno strokovno podkovanega zdravstvenega osebja. Pravzaprav je pot naprej lahko preprosta. Na podlagi že doseženih premikov, opravljenega dela ter dosedanjih rezultatov na nacionalni in evropski ravni je vsekakor potrebno še naprej graditi na partnerstvih z voditelji in oblikovalci politik EU, obenem pa ohraniti zavedanje, da se na ravni EU že odvijajo ključne spremembe na področju digitalizacije, razvoja delovne sile in izobraževanja. Vendar pa je za potrebne spremembe in vključitev zdravstva v vse politike spoprijemanja z evropskimi in globalnimi izzivi ključnega pomena glas medicinskih sester. Prav tako je nujno potrebno povečati možnosti medicinskih sester po sooblikovanju in uresničevanju učinkovitih in za prebivalstvo pozitivnih evropskih politik.

Izgraditi je potrebno odporen zdravstveni ekosistem, ki bo temeljil na sporazumu med institucijami EU in državami članicami o uporabi sredstev Mehanizma EU za okrevanje in odpornost. Na podlagi tega se je potrebno odzvati na ključne zdravstvene izzive, ki jih je pandemija pogumno postavila na politično prizorišče in ki vključujejo potrebo po odporni delovni sili v zdravstvu, neopravljeno zdravstveno nego, digitalizacijo zdravstvenih storitev, planetarno zdravje in nenazadnje tudi pomen gradnje prihodnosti EU s strani njenih prebivalcev. Danes se medicinske sestre še vedno soočajo s pomanjkanjem delovne sile in varnosti, preveliko delovno obremenitvijo ter nizkimi plačami. Čas je, da v EU pride do konkretnih ukrepov, ki bodo sistematično naslovili zaposlovanje in obdržanje medicinskih sester na prvih linijah nege. S svojo neomajno predanostjo, znanjem in strokovnostjo, pogumom in herojskimi dejanji so medicinske sestre rešile že nešteto življenj. Kljub nenehnim izzivom ter težavnim in stresnim delovnim pogojem se s situacijami spopadajo z neverjetno močjo in predanostjo, s čimer zagotavljajo nemoteno delovanje zdravstvenih sistemov in dobrobit svojih pacientov.

Pri uvajanju potrebnih sprememb se lahko opiramo na novi spomladanski sveženj evropskega semestra za leto 2022 (European Commission, 2022, May 23), obenem pa tudi na nacionalne načrte za okrevanje in odpornost (European Commission, 2020), ki vsebujejo priporočila za reforme in projekte javnih naložb. V teh težavnih časih predstavlja oblikovanje prožnih zdravstvenih sistemov temeljno izhodišče za podporo medicinskim sestram in zdravstvenim delavcem na prvi liniji. Da bi rešili problem pomanjkanja medicinskih sester, morajo vlade in zdravstveni sistemi EU sedaj vlagati v izobraževanje na področju zdravstvene nege in s tem v zagotavljanje odporne delovne sile v zdravstveni negi. Medicinske sestre so kot najbolj zaupanja vreden zdravstveni delavci najbližje pacientom in zato predstavljajo ne le hrbtnico zdravstvenega ekosistema, ampak tudi odgovor na naraščajoče svetovne potrebe po zdravstveni oskrbi.

Medicinske sestre so naravne inovatorke na področju zdravstvenega varstva in so v korist pacientov pripravljene nadgraditi digitalna zdravstvena orodja ter s tem prispevati k naslavljanju treh ključnih elementov preobrazbe zdravstvenih ekosistemov: krepitev zaupanja, spodbujanje inovacij v korist uporabnika in zagotavljanje ustrezne rabe podatkov v podporo tehnološkim rešitvam. EFN, ki zastopa 3 milijone medicinskih sester v EU in 6 milijonov v Evropi, spodbuja pospeševanje digitalizacije in zlasti vključevanje medicinskih sester v njeno soustvarjanje. EFN namreč zagovarja stališče, da je potrebno razviti ustrezna digitalna orodja, ki bodo olajšala in podprla dnevne operativne naloge medicinskih sester. Zato je nujno potrebno razviti digitalna orodja, ki lahko resnično pomagajo in olajšajo poklicno življenje medicinskih sester in drugih zdravstvenih delavcev. Vendar pa je to mogoče le z vključevanjem medicinskih sester v njihov razvoj! Medicinske sestre so dobro seznanjene tako s potrebami zdravstvenega ekosistema kot tudi s koristjo in uporabnostjo digitalizacije za doseganje boljšega zdravja in boljših rezultatov zdravstvene nege.

V kontekstu vse večjega pomena digitalizacije v zdravstvenih sistemih ima Evropski zdravstveni podatkovni prostor, ki ga je pred kratkim uvedla European Commission (2022), ključno vlogo. Evropski zdravstveni podatkovni prostor medicinskim sestram in vsem zdravstvenim delavcem omogoča enostaven dostop do zdravstvenih podatkov pacientov, kar pacientu zagotavlja zaščito in kakovostno oskrbo. V prihodnjih tednih, mesecih in letih bosta za EFN osrednjega pomena predvsem vprašani javnega zaupanja in ohranjanja državljana/pacienta v središču procesov. Da je za EFN zdravstveni podatkovni prostor bistvenega pomena, dokazujeta tudi dva skoraj zaključena projekta EU v kontekstu zdravstvenega podatkovnega prostora: Smart4Health (EFN, 2019) in InteropEHRate (EFN, 2020).

V teh težavnih časih resnično ni mogoče podcenjevati izzivov, s katerimi se soočajo zdravstveni sistemi po vsej Evropi. EFN in njeni člani so zato trdno zavezani ohranjanju prednostnih nalog politike EFN EU o izobraževanju, delovni sili, kakovosti in varnosti visoko na nacionalnih in političnih agendah EU. Še naprej bodo intenzivno lobirali pri nacionalnih vladah in institucijah EU in s tem poskrbeli, da se glas medicinskih sester sliši in upošteva pri ključnih premikih na področju zdravstvenega varstva.

Zdaj sta bolj kot kdajkoli prej nujno potrebna vključitev in proaktivno delovanje medicinskih sester in babic pri oblikovanju evropskih politik, ki uravnavajo kakovost in varnost zdravstvene nege in prispevajo k zdravju populacije vse Evrope. V teh prizadevanjih je zelo pomembno, da si nudimo podporo, si prisluhnemo in se medsebojno bodrimo. Ne gre za prestiž ali tekmovanje, gre za naše kolektivne interese, poglede, dejanja, skrbi in izzive. Povsem jasno je, da sami ne moremo spremeniti sveta. Lahko pa se osredotočimo na skupni cilj in skozi skladno sodelovanje izboljšamo položaj medicinskih sester in prebivalcev Evrope.

Conflict of interest/Nasprotje interesov

The author holds a position of General Secretary of the EFN./Avtor opravlja funkcijo glavnega sekretarja EFN.

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Primary healthcare nurses' perceptions about their ability to utilise electronic health records

Samoocena sposobnosti medicinskih sester za uporabo elektronskih zdravstvenih kartotek v primarni zdravstveni dejavnosti

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Key words: electronic health records; nurses' perceived skill levels; primary healthcare

Ključne besede: elektronske zdravstvene kartoteke; medicinske sestre; samoocena sposobnosti; primarno zdravstveno varstvo

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ABSTRACT

Introduction: The implementation, adoption and use of electronic health records remains a global challenge despite the numerous advantages associated with their use. This paper explores primary healthcare nurses' perceptions regarding their skill levels in using EHRs.

Methods: Data were collected using a self-administered questionnaire from a sample of 71 nurses (63% response rate) in selected primary health care (PHC) facilities of the Northern-Tygerberg substructure, Cape Town.

Results: The overall results show that 59 respondents (83%) believed that they were skilled in using EHRs in PHC. Nearly two thirds of all nurses (46 or 64.8%) reported using EHRs for nursing documentation, 45 nurses (63%) reported using EHRs to store, retrieve and transfer data, 44 (62%) reported being able to design a flow chart, 38 (53.5%) reported being able to access databases and 38 (52.1%) reported being able to convert electronic files for various applications. However, 33 nurses (46.5%) were unsure of their computer skills in creating multimedia files. This varied from service department to service department, with 62 respondents (87.3%) in pediatric care and 59 respondents (83.1%) in family planning, adult nursing and HIV management reporting having EHR skills. Enrolled nurses rated their EHR skills significantly lower (58%) than registered nurses (92%) ($p = 0.028$).

Discussion and conclusion: Although most respondents in this study reported being skilled in using EHRs in PHC, better computer accessibility and continuous training are important ongoing requirements. Further qualitative research is needed to better understand some of the problems and barriers which affect nurses' ability to use EHRs in PHC settings.

IZVLEČEK

Uvod: Uvedba in uporaba elektronskih zdravstvenih kartotek (EZK) predstavlja globalen izziv kljub številnim prednostim, povezanim z njihovo uporabo. Namen raziskave je bil raziskati sposobnosti uporabe EZK medicinskih sester v primarni zdravstveni dejavnosti.

Metode: Za zbiranje podatkov smo uporabili lasten vprašalnik na vzorcu 71 medicinskih sester (63-odstotna stopnja odziva) v izbranih ustanovah primarnega zdravstvenega varstva v podstrukturi Northern-Tygerberg, v mestu Cape Town.

Rezultati: Rezultati raziskave kažejo, da 59 anketirancev (83 %) ocenjuje, da so večji uporabe EZK v primarni zdravstveni dejavnosti. Skoraj dve tretjini medicinskih sester (46 oz. 4,8 %) uporablja EZK za potrebe zdravstvene dokumentacije, 45 (63 %) medicinskih sester uporablja EZK za shranjevanje, pridobivanje in prenos podatkov, 44 (62 %) medicinskih sester je sposobnih oblikovati diagram poteka, 38 (53,5 %) medicinskih sester zna dostopati do baz podatkov in 38 (52,1 %) medicinskih sester zna pretvarjati elektronske datoteke za rabo z različnimi aplikacijami. Vendar pa kar 33 (46,5 %) medicinskih sester ni bilo prepričanih o svojih računalniških spretnostih za ustvarjanje večpredstavnostnih datotek. Rezultati se razlikujejo po posameznih oddelkih zdravstvene nege. Kar 62 (87,3 %) anketirancev v pediatrični oskrbi in 59 (83,1 %) anketirancev na področju reproduktivnega zdravja, oskrbi odraslih in na področju obvladovanja virusa HIV izkazuje večšine za uporabo EZK. Srednje medicinske sestre svoje spretnosti uporabe EZK ocenjujejo bistveno nižje (58 %) kot diplomirane medicinske sestre (92 %) ($p = 0,028$).

Diskusija in zaključek: Čeprav večina anketirancev v raziskavi meni, da je večša uporabe EZK v primarni zdravstveni dejavnosti, je potrebno zagotoviti boljšo dostopnost do računalnikov in stalno usposabljanje osebja. Potrebne so nadaljnje kvalitativne raziskave, ki bi osvetlile težave in ovire, ki vplivajo na večšine medicinskih sester za uporabo EZK v zdravstvenih ustanovah.



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Introduction

The implementation, adoption and use of electronic health records (EHRs) is a global challenge despite their numerous advantages for improving health care services. The use of EHRs (O'Mahony, Wright, Yogeswaran, & Govere, 2014; Murua, Carrasco, Agirre, Susperregi, & Gómez, 2017) helps prevent data loss, reduces room for error, enhances the work of nurses, and reduces patient waiting time in the hospital. EHRs can help get more work done efficiently, streamline work processes, and provide point-of-care decision support (Noah & Thomas 2017). Moreover, the use of EHR systems can significantly improve connectivity within the healthcare system, encourage continuous education of healthcare professionals, and allow remote access to patient data, as well as improve patient follow-up (Thomas, 2016).

Nevertheless, the use of EHRs is not without problems. The EHR challenges reported include lack of computer skills, poor infrastructure, and poor implementation strategies (Ajiboye, Adekoya, Alawiye, & Oyedipe, 2014; Odekunle, Odekunle, & Shankar, 2017). Although healthcare systems around the globe are geared towards using EHRs to enhance healthcare delivery, Mugomeri, Chatanga, Maibvise, & Masitha (2016) highlight that this is only possible if healthcare workers possess the fundamental computer skills. According to Alwan, Awoke, & Tilahun (2015), the current skill level of healthcare professionals is one of the most common obstacles to the adoption of EHR systems in health care. Holden & Karsh (2010) argue that the success or failure of EHR systems depends on nurses as they play a pivotal role in the healthcare team. If they do not possess the necessary computer skills, their engagement in the functions of the EHR system would be very challenging (Tubaishat, 2017). However, the EHR system could reduce disparities in the quality of care by enabling people in remote areas to access the services and expertise that would otherwise not be available to them (World Health Organization [WHO], 2008).

In South Africa, the eHealth strategy was introduced in 2002. It represented an initiative to move from a paper-based health record system to an EHR system in primary health care (PHC) facilities. However, there is little evidence in the literature which would indicate that PHC nurses possess the necessary skills to implement an EHR system (Thomas, 2016).

Access to computers and lack of computer skills among nurses is a challenge in developing countries, including South Africa, and it impacts on the use of EHR systems (Furst et al., 2013). This has affected both productivity and workflow, with productivity measured by the number of patients healthcare staff treat per hour (Masselink & Erikson, 2016). Due to the extensive documentation and complexity of the EHR software, healthcare staff find it very time-consuming.

In addition, Frogner, Wu, Ku, Pittman, & Masselink (2017) report that nurses lack the skills of using EHR systems, which in turn affects the implementation of EHR and therefore negatively impacts nurse productivity in primary health centres.

Aims and objectives

Understanding the current perceived skills of PHC nurses in EHR use could help the Department of Health (DoH) and all relevant stakeholders to develop better strategies to equip PHC nurses with the necessary skills and support so as to improve the implementation of EHR systems in PHC facilities. The purpose and objective of this study was to investigate the perceived skill levels of primary care nurses regarding their use of EHRs at PHC level.

Method

The study was carried out using a quantitative research approach. This allowed the researcher to draw conclusions based on numerical data, which were quantified and examined using mathematical procedures (Houser, 2016). According to Alwan et al. (2015), surveys are the most commonly used method of assessing perceived skill levels as they provide respondents ample time to reflect on a given topic while maintaining privacy and confidentiality. This approach also ensures that researchers cannot influence the responses as they are measured using a Likert scale.

Oliver's (2000) ICT skills benchmarking system was used to assess whether respondents felt they possessed lower or higher skill levels, where a score of 0 meant the respondent possessed no skills, and where all 18 questions answered correctly meant the respondent had maximum skills. Those who scored 75% and above were considered having higher skill levels, while those who scored below 75% were considered having lower skill levels.

Description of the research instrument

A descriptive survey design with a self-administered questionnaire was used to investigate PHC nurses' perceived skill levels in using EHRs in selected PHC facilities. The questionnaire consisted of two sections: Section A consisted of closed-ended questions on demographic data (age, gender, race, marital status, work experience, highest professional qualification, and areas of experience). In contrast, Section B consisted of 18 questions developed by Jiang, Chen, & Chen (2004). These questions tested respondents' skills in using computers, applications and software. Similar studies were conducted by Cheng, Meng-Hsiang, & Chen-Wei (2014) and Asah (2020). The questions in Section B were rated using a Likert scale ranging from

"Agree" to "Disagree". The Cronbach's alpha test of the questionnaire was 0,96, indicating that the internal consistency of the instrument was reliable.

Description of the sample

Data collection was carried out from ten purposively selected PHC facilities in the Northern-Tygerberg substructure in Cape Town (Northern & Western: Bloekombos, Brackenfell, Brighton, Durbanville, Wallacedene Clinics and Tygerberg/Klipfontein: Delft South, Dirkie Uys, Elsie's River, Parow Clinics, Kasselsvlei Community Health Centre. Self-administered questionnaires were distributed to all nurses who were willing to take part in the study (112 PHC nurses). A total of 71 PHC nurses returned completed questionnaires, yielding a response rate of 63%. The information obtained from the questionnaire and during data analysis was secured with codes to avoid disclosure of information that could cause harm to the respondent.

Description of the research procedure and data analysis

Data were collected from September to October 2018 and analysed using the Statistical Package for Social Services (SPSS) version 25.0. Descriptive analysis was conducted to determine frequencies and percentages (numerical values were assigned to a three-point Likert scale, namely Disagree – 1, Uncertain – 2, Agree – 3). A Chi-square test was performed and a bivariate analysis was used to test the relationship between two variables, with a cross-tabulation test to determine the association between sociodemographic characteristics (age, gender, years of work experience, level of qualification), and nurses' perceived skill levels in using EHRs in health care. The threshold for statistical significance was fixed at $p < 0.05$.

Results

About 39 percent of nurses were between 40 and 50 years of age, followed by 26 nurses (36.6%) between 30 and 40 years of age. There were 9 nurses (12.7 %) above 50 years of age and 8 nurses (11.3%) between 20 and 30 years of age. In terms of work experience, 28 nurses (39.4%) had more than 15 years of work experience in the nursing profession, and 23 (32.4%) had 5–10 years of work experience, followed by 14 (19.7%) and 6 (8.4 %) of those with 1–5 and 10–15 years of work experience respectively. More than half, i.e., 26 nurses (36%) held a Bachelor's degree in nursing, followed by 23 nurses (32.4%) with an advanced nursing qualification. In comparison, 12 nurses (16.9%) had an additional qualification or were pursuing a qualification in nursing and 10 (14.1%) had a diploma in nursing.

Results show that a larger proportion of nurses had work experience in more than one clinical setting. The majority, 62 nurses (87.3%), had worked in paediatric care and adult care. A total of 59 nurses (83.1%) had worked in family planning, HIV treatment and management and adult consulting. Others ($n = 58$, 81.7%) had experience in tuberculosis (TB) management and 54 (76.1%) in trauma or emergency departments, while 52 (73.2%) had experience in antenatal care. Forty nurses (56.3%) had experience in the delivery room, 36 (50.7%) had experience in neonatal care, and 35 (49.3%) had worked in psychiatric service areas.

Perceived level of skill in EHRs

As can be seen in Table 1, about 46 nurses (64.8%) were able to use EHRs to conduct nursing work (nursing records), while 45 (63.0%) reported using EHRs to store/retrieve and transfer data, such as patient and drug information. Privacy maintenance when using nursing information systems (EHRs) was reported by 44 nurses (62.0%), flowchart design by 44 (62.0%) nurses and database software use to access patient files by 38 nurses (53.5%). On the other hand, being unsure of their computer skills for creating multimedia files was reported by 33 nurses (46.5%), for statistical data use by 32 nurses (45.1%), for resolving common computer errors by 30 (42.3%) and for assembling essential computer components by 29 nurses (40.8%).

As for the use of online libraries and databases, 53 nurses (74.6%) reported being able to use a library retrieval system such as Medline to search for information. Fifty-eight nurses (81.7%) reported being able to use the World Wide Web to search for information. The majority of nurses, i.e. 52 (73.2%), were able to use computerised self-learning equipment. Some nurses were uncertain about their ability to create multimedia files when recording patient information (46.5%), to use statistical software for analysing research data when necessary ($n = 34$, 45.1%), to resolve common computer errors ($n = 30$, 42.3%) and assemble essential components of the computer ($n = 29$, 40.8%).

Except for professional qualification, there were no significant variations between demographic information and perceived competence in the use of EHRs (Table 2). Nurses with a Bachelor's degree in nursing ($n = 24$, 92.0%) and nurses with an advanced nursing diploma ($n = 21$, 91.0%) reported having significantly higher skills than enrolled/auxiliary nurses ($n = 7.58%$) in EHRs ($p = 0.028$).

Those with 15 years of work experience and more ($n = 23$, 82 %), and those with 5–10 years of work experience ($n = 18$, 78 %) reported having higher skill levels in the use of EHRs compared to those who had 1–5 years, and 10–15 years of work experience.

Table 1: Perceived skill levels in the use of EHRs in PHC**Tabela 1:** Samoocena sposobnosti medicinskih sester za uporabo EZK v PZD

Statements/ Izjave	Agree/ Strinjam n (%)	Uncertain/ Neodločen n (%)	Disagree/ Se ne strinjam n (%)
Being able to send/receive mails regarding patient care as part of EHRs	65 (91.5)	3 (4.2)	3 (4.2)
Being able to use the World Wide Web (www) to search for treatment guidelines and protocols	58 (81.7)	12 (16.9)	1 (1.4)
Being able to use word processing software to record patient health information (EHRs)	55 (77.5)	13 (18.3)	3 (4.2)
Being able to use computers as self-learning tools to gain knowledge on diseases and management protocols	55 (77.5)	15 (21.1)	1 (1.4)
Being able to use a library information retrieval system for research on diseases and management protocols	53 (74.6)	13 (18.3)	5 (7.0)
Being able to use computerised equipment for recording patient information (EHRs)	52 (73.2)	17 (23.9)	2 (2.8)
Being able to use Microsoft (MS) software when recording patient information (EHRs)	50 (70.4)	19 (26.8)	2 (2.8)
Being able to use nursing information systems for EHRs	46 (64.8)	23 (32.4)	2 (2.8)
Being able to use EHRs to do nursing work	46 (64.8)	23 (32.4)	2 (2.8)
Being able to store/retrieve EHRs of patients from a nursing information system	45 (63.0)	24 (33.8)	2 (2.8)
Being able to maintain privacy when using nursing information systems for EHRs	44 (62.0)	25 (35.2)	2 (2.8)
Being able to design and use a flowchart when recording patient health information (EHRs)	44 (62)	22 (31)	5 (7.0)
Being able to use database software to access patient file for electronic health recording	38 (53.5)	28 (39.4)	5 (7.0)
Being able to convert files for different applications when recording patient information (EHRs).	37 (52.1)	29 (40.8)	5 (7.0)
Being able to use statistical software to analysed research data when necessary	34 (47.9)	32 (45.1)	5 (7.0)
Being able to create multimedia files when recording patient information	32 (45.1)	33 (46.5)	6 (8.5)
Being able to resolve common computer errors when recording patient information (EHRs)	22 (31.0)	30 (42.3)	19 (26.8)
Being able to assemble basic components of the computer	22 (31.0)	29 (40.8)	20 (28.2)

Legend/Legenda: n – number/število; % – percentage/odstotek

Table 2: Association between demographic information and perceived skills in the use of EHRs in PHC**Tabela 2:** Povezava med demografskimi podatki in zaznanimi veščinami pri uporabi EZK v PZD

Demographic data/ Demografski podatki	Perceived skills, n (%) of the total score/ Zaznane veščine, n (%)				p
	Lower skill levels/ Nižja stopnja veščin n (%)		Higher skill levels/ Višja stopnja veščin n (%)		
Age group (years)	30–40	4	15.4	22	0.102
	40–50	8	28.6	20	
	50+	0	0.0	9	
	20–30	0	00.0	8	
Highest professional qualification	Bachelor of Science in nursing	2	7.7	24	0.028
	Advanced nursing	2	8.7	21	
	Diploma in nursing science	3	30	7	
	Enrolled/Auxiliary nurses	5	41.7	7	
Years of experience	15+	5	17.9	23	0.221
	5–10	5	21.7	18	
	1–5	0	0.0	14	
	10–15	2	33.3	4	

Legend/Legenda: n – number/število; % – percentage/odstotek; p – statistical significance/statistična značilnost

Table 3: Areas of work experience and perceived skill levels in the use of HER**Tabela 3:** Področje dela in zaznana stopnja EZK

<i>Areas of experience/ Področje dela</i>	<i>Lower skill levels/ Nižja stopnja veščin n (%)</i>	<i>Higher skill levels/ Višja stopnja veščin n (%)</i>	<i>p</i>
Paediatric rooms	7 (11.3)	55 (88.7)	0.001
TB rooms	8 (13.8)	50 (86.2)	0.140
HIV rooms	9 (15.3)	50 (84.7)	0.412
Adult consulting rooms	11 (18.6)	48 (81.4)	0.385
Family-planning rooms	11 (18.6)	48 (81.4)	0.385
Antenatal rooms	8 (15.4)	44 (84.6)	0.573
Emergency/trauma rooms	11 (20.4)	43 (79.6)	0.165
Labour/delivery rooms	5 (12.5)	35 (87.5)	0.261
Neonatal rooms	3 (8.3)	33 (91.7)	0.051
Psychiatric rooms	4 (11.4)	31 (88.6)	0.225

Nurses with higher skill levels in using EHRs (55 or 88.7%) had worked in paediatric departments. Statistical significance was found between working in paediatrics and the perceived level of skills in EHR use ($p = 0.001$). These findings show that the perceived skill levels of the 50 respondents (86.2%) who had experience working in tuberculosis care and the 50 respondents (84.7%) who had worked in HIV management of HIV or the HIV consulting rooms were significantly higher.

Similar results were observed in more than two-thirds of the nurses ($n = 48, 81.4\%$) who had experience in adult consulting rooms and in those working in family-planning ($n = 48, 81.4\%$), as their perceived skill levels in the use of EHRs were significantly higher

Discussion

The study revealed that the majority of the participating nurses felt that they were skilled in the use of EHRs even though very few computers were available in their health facilities. Nurses working in paediatrics, as well as those working in TB and HIV management, had more opportunities to work with computers and EHR systems. In contrast, Mugomeri et al. (2016) reported that the majority of nurses in Lesotho were found to have inadequate computer skills. This was attributed to the many years that had passed since the nurses obtained their latest qualification and the lack of accessibility to computers in their work environment. Furthermore, most of the nurses participating in our study reported that they were able to use the World Wide Web (www) to access library database systems such as Medline to search for evidence-based practices relating to patient care, treatment and management protocols. In contrast to this study, Sadoughi, Azadi, & Azadi (2017) reported that nurses had insufficient skills to

search the internet for evidence-based practices or to search online databases for information. The authors also point out that computer skills are essential for storing and retrieving patient health information and treating patients based on best evidence-based practice (Sadoughi et al., 2017).

Respondents had some level of experience using computers as they were able to send and receive emails regarding patient care as part of EHRs. The majority of respondents were able to use word processing software to record patient health information, use presentation-editing software, design and use flowcharts, or convert files for different applications when recording patient health information. Similarly, Kahouei, Zadeh, & Roghani (2015) noted that the use of EHRs in PHC facilities should not be a problem as most of the respondents in the study had the essential skills or some degree of experience in information literacy and computer use in health care (Kahouei et al., 2015).

Some nurses were unsure of their ability to create multimedia files, use statistical software to analyse study data, troubleshoot typical computer errors, and assemble a computer. This supports the findings of a Delphi survey in which nurses from Indonesia reported that these skills were irrelevant to their daily work activities (Rachmani et al., 2020). The study identified no significant association between age and skills in EHR use and between years of work experience and EHR use. In contrast, Mugomeri et al. (2016) identified a significant relationship between nurses' age and inadequate computer skills and between their years of work experience and inadequate computer skills. With regard to educational attainment, there was a significant relationship between nurses' highest professional qualification attained and their skill levels in EHR use. This could be due to the fact that most nurses had a Bachelor's degree or an advanced diploma in nursing. The same categories of nurses were also

in managerial positions or worked in specialty areas such as TB/HIV, and they had access to computers for electronic recording of patient information or calculating statistics for the Department of Health.

We found a statistically significant relationship between work area and skills in using the EHR system. We found that work areas are essential in developing nurses' computer skills and EHR skills in PHC. This was evident from the fact that nurses who worked in paediatric care had more exposure to computers and electronic health information recording than nurses working in other areas. Kim et al. (2017) note that the adoption of EHRs improves the efficiency and quality of childhood immunisation through EHR-based clinical alert systems and results in higher immunisation rates in paediatrics. Nurses working in such settings were therefore exposed to computers on a daily basis. Although the majority of respondents reported higher perceived skill levels, a small percentage reported lower perceived skill levels, which is concerning as these skills are essential for an effective use of any EHR system. Management should therefore develop programmes for health professionals to learn using EHR systems as part of their continuous professional development so as to increase the use of EHRs by nurses. Increasing computer accessibility in all PHC facilities and providing regular computer skills training will help them enhance their computer skills and use the EHR system in their work environment. This study only covered PHC facilities in the Western Cape that are part of the Tygerberg-Northern substructure, which limits its representativeness to the broader population of all Cape Town nurses. Moreover, the small sample size means that the results cannot be generalised to other nursing populations or significantly affect nursing legislation, thus highlighting the need for similar research with a larger sample size. Nurses who were less interested in EHRs or less comfortable with computers may not have participated in the study, which might have led to reporting bias.

A larger-scale study is therefore recommended in order to inform decision-making and policy development regarding the use of EHRs in health care. In addition, further qualitative research is needed to better understand some of the issues and barriers which affect nurses' perceived skills in the use of EHRs in PHC settings. A study of nurses' ICT competences in South Africa is needed, as is an exploration of the framework for incorporating nursing ICT into the new nursing curriculum.

Conclusion

The findings of this study demonstrate that the majority of respondents have perceived skills in the use of EHRs. However, the perceived skill levels vary by nursing department, with nurses working in paediatrics, TB and HIV departments reporting higher skill levels than those working in other departments. Nevertheless, this is an encouraging initiative for more

nurses to be able to use computers for EHRs. Better accessibility of computers in all PHC facilities and continuous training in computer skills could improve nurses' skills in using computers and EHR systems in PHC facilities. Accessibility of computers for nurses is critical for the successful implementation and use of the EHR system in primary health facilities.

Conflict of interest/Nasprotje interesov

The authors declare that no conflict of interest exists./Avtorja izjavljata, da ni nasprotja interesov.

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Ethical approval/Etika raziskovanja

The study received ethical approval from Biomedical Science Research Ethics Committee of the University of the Western Cape. It approved the scientific methodology and ethics of the above mentioned research project (Ethics Reference Number: BM18/3/4)./Raziskavo je odobril Odbor za etiko raziskav biomedicinskih znanosti Univerze Western Cape. Potrdil je znanstveno metodologijo in etiko omenjenega raziskovalnega projekta (Referenčna številka: BM18/3/4).

Author contributions/Prispevek avtorjev

The first author conceptualised the study, reviewed the literature, collected and analysed the data, compiled the article and submitted the manuscript. The second author assisted in conceptualising the study, analysing the data, and writing the manuscript./Prva avtorica je zasnovala raziskavo, pregledala literaturo, zbrala in analizirala podatke in sestavila članek. Drugi avtor je pomagal pri konceptualizaciji raziskave, analizi podatkov in pri pisanju prispevka.

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Izvirni znanstveni članek/Original scientific article

Prepričanja in implementacija na dokazih podprte prakse med visokošolsko izobraženimi diplomiranimi medicinskimi sestrami in zdravstveniki v Sloveniji (1. del): psihometrična analiza instrumentov

Evidence-based practice beliefs and implementation among nurses with a higher education degree in Slovenia (1. Part): A psychometric analysis of instruments

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Ključne besede: znanje; spremembe; raziskave; izboljšave; klinična ekspertiza; pacient; zdravstvena nega

Key words: knowledge; change; research; improvements; clinical expertise; patient; nursing

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IZVLEČEK

Uvod: Za načrtovanje strategije uvajanja na dokazih podprte prakse v slovenski zdravstveni negi je pomembna ocena znanj, prepričanj in različnih vidikov uporabe na dokazih podprte prakse pri izvajalcih zdravstvene nege. Ocena mora biti zanesljiva, veljavna in reprezentativna, da lahko koristi načrtovanju nacionalnih strategij na tem področju. Namen raziskave je prikaz psihometrične analize uporabljenega in mednarodno uveljavljenega instrumenta.

Metode: Sodelovalo je 1014 visokošolsko izobraženih medicinskih sester in zdravstvenikov z vseh treh nivojev zdravstvenega varstva. V raziskavi sta bili uporabljeni dve lestvici, in sicer »Evidence-Based Practice Beliefs Scale« in »Evidence-Based Practice Implementation Scale«. Lestvici sta bili psihometrično analizirani s testi zanesljivosti in veljavnosti.

Rezultati: Povprečna vrednost prepričanj na dokazih podprte prakse je 3,47 ($s = 0,54$). Zanesljivost lestvice je znašala 0,909, varianca je bila pojasnjena v 63,71 % s tremi faktorji (prepričanja v znanje, prepričanja v uporabnost, težavnost uporabe in časovna potratnost). Povprečna vrednost implementacije je 2,23 ($s = 0,89$). Zanesljivost lestvice je znašala 0,969, varianca je bila pojasnjena v 68,52 % z dvema faktorjema (uporaba znanj, uporaba korakov).

Diskusija in zaključek: Testirana instrumenta se pokažeta kot zanesljiva in veljavna. Raziskava zelo poudari primanjkljaj znanj za razvoj na dokazih podprte prakse in znanj, ki so del vsakodnevnih razvojnih aktivnosti v delokrogu visokošolsko izobražene medicinske sestre. Zahtevajo se aktivnosti za izboljšanje stanja na ravni visokošolskih in zdravstvenih zavodov, kot na ravni nacionalnih združenj v zdravstveni negi.

ABSTRACT

Introduction: Planning the strategy of evidence-based care implementation in Slovenian nursing calls for an assessment of knowledge, beliefs, and various aspects of evidence-based care implementation among nursing care providers. The assessment should be reliable, valid and representative in order to be used for the planning of national strategies in this field. The aim of the article is to present the psychometric analysis results of the internationally-renowned instrument used.

Methods: A total of 1,014 nurses with a higher education degree from all three levels of health care participated in the research. Two established scales were used in the research: *Evidence-Based Practice Beliefs Scale* and *Evidence-Based Practice Implementation Scale*. A psychometric analysis of the data was conducted using reliable, valid tests.

Results: The mean value for evidence-based practice beliefs was 3.47 ($s = 0.54$). Reliability of the scale was 0.909, the variance was explained in 63.71% with three factors (beliefs in knowledge; beliefs in usefulness; difficulty of implementation and time efficiency). The mean value for implementation was 2.23 ($s = 0.89$). Reliability of the scale was 0.969, the variance was explained in 68.52% with two factors (application of knowledge; application of implementation steps).

Discussion and conclusion: The tested instruments have proven to be reliable and valid. Research results clearly demonstrate insufficient knowledge for the development of evidence-based practice and knowledge that is required for daily development activities implemented by nurses with a higher education degree. Steps should be taken to improve the situation in higher education institutions, healthcare institutions, and at the level of national nursing associations.



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Uvod

Na dokazih podprta praksa omogoča, da si zdravstveni delavci pri svojem delu postavljajo ustrezna klinična vprašanja in za iskanje odgovorov na njih uporabljajo kakovostne znanstvene raziskave različnih nivojev dokazov in da znajo te povezati z lastno klinično ekspertizo, potrebami in pričakovanji pacientov (Melnyk & Fineout-Overholt, 2019; Skela-Savič et al., 2020). Raziskave kažejo, da uporaba na dokazih podprte prakse rezultira v številnih pozitivnih izidih zdravstvene obravnave, kot so povečanje varnosti pacientov in kakovosti zdravstvene obravnave, izboljšanje izidov za paciente z manj zapleti in neželenimi dogodki. Pomembno je tudi zmanjšanje stroškov (Melnyk & Fineout-Overholt, 2019; Titler, LoBiondo-Wood, & Haber, 2019). Na dokazih podprta praksa je postala prioritarno področje izobraževanja v zdravstveni negi in standard dodiplomskega znanja za vse, ki sodelujejo v kliničnem okolju (Skela-Savič et al., 2020). Dandanes se od zdravstvenih delavcev pričakuje, da imajo znanja o dokazih podprti zdravstveni obravnavi in ta postanejo del obveznih vsebin kontinuiranega profesionalnega izobraževanja (Skela-Savič et al., 2020; Skela-Savič & Lobe, 2020).

Za razvoj na dokazih podprte prakse v zdravstveni negi je pomembno, da izvedemo samooceno stanja na tem področju in pri tem uporabimo zanesljiv in veljaven instrument zbiranja podatkov. Raziskave, ki natančno opišejo dokaze o merskih lastnostih uporabljenih instrumentov, omogočajo presojo veljavnosti in zanesljivosti uporabljenih instrumentov na različnih skupinah prebivalstva in tako pomagajo raziskovalcem izbrati najboljša orodja za zajem podatkov in primerjavo spoznanj v mednarodnem prostoru. Kakovost zbranih informacij in podatkov je namreč soodvisna od njihovih psihometričnih lastnosti (de Souza, Costa Alexandre, & Britto Guirardello, 2017). V literaturi se kot glavna dejavnika kakovosti uporabljenih instrumentov za zajem podatkov v kvantitativni raziskavi pojavljata zanesljivost (ang. *reliability*) in veljavnost (ang. *validity*), ki pojasnita psihometrične značilnosti načinov merjenja, s katerima lahko raziskovalec oziroma raziskovalka zagotavlja uporabnost raziskave (Bhattacharjee, 2012) in sta osnovna pogoja zagotavljanja objektivnejšega raziskovanja, na kar opozorijo tudi slovenski metodologi (Ferligoj, Leskošek, & Kogovšek, 1995), zlasti v neeksperimentalnem raziskovanju v družboslovju, v katerem pogosto najdemo različne izsledke merjenja istih konceptov.

Namen in cilji

Za načrtovanje strategije uvajanja na dokazih podprte prakse v slovenski zdravstveni negi je pomembna ocena znanj, prepričanj in različnih vidikov uporabe na dokazih podprte prakse pri izvajalcih zdravstvene

nege. Da je lahko ocena uporabna za načrtovanje nacionalnih strategij na tem področju, mora biti zanesljiva. Namen raziskave je prikaz psihometrične analize dveh uporabljenih mednarodno uveljavljenih lestvic »*Evidence-Based Practice (EBP) Beliefs Scale*« in »*Evidence-Based Practice (EBP) Implementation Scale*« (Melnyk, Feneout-Overholt, & Mays, 2008) za oceno prepričanj in implementacije na dokazih podprte prakse med diplomiranimi medicinskimi sestrami, ki delujejo na vseh treh ravneh zdravstvenega varstva. Cilj raziskave je predstavitev prevoda instrumentov prepričanja in implementacije na dokazih podprte prakse v slovenskem izvirniku in prikaz zanesljivosti in veljavnosti obeh instrumentov in s tem omogočiti njegovo uporabo v slovenskem jeziku.

Metode

Podatke smo zbirali s presečno raziskavo. Pri oceni psihometrične ustreznosti uporabljenih instrumentov smo preverili zanesljivosti in veljavnost. Zanesljivost se nanaša na ponovljivost ugotovitev in s tem stabilnost uporabljenega instrumenta. Zanesljivost ni stalna, je v funkciji instrumenta, povezana je z značilnostmi skupine, pri kateri uporabljamo instrument in s tem povezane okoliščine (Keszei et al., 2010). Veljavnost se nanaša to, ali instrument meri tisto, kar je bil namen (Rattray & Jones, 2007). Osredinja se na vsebino, pomen merjenega in interpretacijo dobljenih rezultatov. Usmerja nas k zaključkom, ki so rezultat danih odgovorov določene skupine vključenih v raziskavo na postavljena stališča v instrumentu (Keszeia, Novaka, & Streiner, 2010).

Opis instrumentov in kulturna adaptacija

Za oceno prepričanj in implementacije na dokazih podprte prakse smo uporabili »*EBP Beliefs Scale*« in »*EBP Implementation Scale*« (Melnyk et al., 2008). Gre za instrument, ki je bil uporabljen že v več raziskavah in se je pokazal kot veljaven in zanesljiv tudi pri prevodu v različne jezike (Wang et al., 2012; Zelenikova et al., 2016; Yoo, Kim, Kim, Kim, & Ki, 2019; Kerwien-Jacquier, Verloo, Pereira, & Peter, 2020). Lestvica prepričanj o na dokazih podprti praksi ali »*EBP Beliefs Scale*« vsebuje šestnajst zaprtih prepričanj, na katere so anketiranci odgovarjali na petstopenjski Likertovi lestvici (1 – Sploh se ne strinjam, 2 – Se ne strinjam, 3 – Delno se ne strinjam, delno se strinjam, 4 – Se strinjam, 5 – Popolnoma se strinjam).

Lestvica implementacije na dokazih podprte prakse ali »*EBP Implementation Scale*« vsebuje devetnajst zaprtih trditev o implementaciji različnih nalog na področju na dokazih podprte prakse, na katere anketiranci odgovarjajo s petimi možnimi frekvencami pogostosti uporabe ključnih elementov na dokazih podprte prakse v zadnjih osmih tednih (1 – Nikoli v osmih tednih, 2 – Od enkrat do trikrat v osmih tednih,

3 – Od štirikrat do šestkrat v osmih tednih, 4 – Od sedemkrat do osemkrat v osmih tednih, 5 – Več kot osemkrat v osmih tednih).

Prevod obeh lestvic v slovenski jezik in prevod nazaj v angleški jezik so izvedli profesionalni prevajalci za angleški jezik. Vzratni prevod v angleški jezik je bil lektoriran in se je uporabljal pri mednarodnih objavah (Skela-Savič, Pesjak., & Lobe, 2016; Skela-Savič, Hvalič-Touzery, & Pesjak, 2017; Skela-Savič & Lobe, 2020). Pri prevodu so sodelovali raziskovalci zdravstvene nege za pojasnitev pojmov in ustrezno rabo terminologije. V okviru prevoda v slovenski jezik smo naredili nekaj vsebinskih prilagoditev, saj smo ocenili preveliko kompleksnost nekaterih vprašanj glede na to, da večina vključenih v raziskavo ni imela znanj o na dokazih podprti praksi v okviru izobraževanja za poklic. Besedo dokazi (ang. *evidence*) smo razširjeno prevedli kot dokazi raziskav (ang. *research evidence*), saj smo želeli doseči razumevanje besede dokazi. V lestvici implementacije smo trditev 11 »*Read and critically appraised a clinical research study*«, razdelili v dve trditvi, da smo razlikovali branje člankov kot samostojno dejavnost in kritično oceno metodološke izvedbe raziskave samostojno dejavnost (trditev 11 in 12, Tabela 2), saj smo ocenili, da za kritično oceno raziskav potrebujemo naprednejše kompetence, kot jih za branje raziskav. Trditev »*Accessed the Cochrane database of systematic reviews*« smo posplošili v »*Uporabim zbirke sistematičnih pregledov raziskav na podatkovnih bazah*« (trditev 13), saj smo ocenili, da poznavanje podatkovne baze Cochrane med anketiranci ni dobro in ni treba, da se usmerimo le v eno bazo. Trditev 14 »*Accessed the National Guidelines Clearinghouse*« smo prav tako posplošili v uporabo nacionalnih smernic (trditev 14, Tabela 2). Prevod ni bil pilotno testiran.

Opis vzorca

V raziskavo so bile povabljeni vse slovenske javne bolnišnice ($n = 27$) in vsi zdravstveni domovi ($n = 67$). Sodelovanje je potrdilo dvajset bolnišnic in 29 zdravstvenih domov. Ciljna populacija so bile medicinske sestre in zdravstveniki z visokošolsko izobrazbo. Po metodi cenzusa smo razdelili 1650 vprašalnikov med visokošolsko izobražene medicinske sestre v bolnišnicah in 1123 v zdravstvenih domovih, skupno 2773. Stopnja odgovora v raziskavi je bila 36,57 % ($n = 1014$). Največ izpolnjenih vprašalnikov smo prejeli iz zdravstvenih domov ($n = 329$, 32,4 %), sledita oba klinična centra ($n = 245$, 22,2 %), splošne bolnišnice ($n = 202$, 19,9 %) in specializirane bolnišnice ($n = 199$, 19,6 %). 39 vprašalnikov (5,1 %) ni vključevalo podatka o zdravstveni ustanovi. Glede na spol je v raziskavi sodelovalo 887 (89,5 %) žensk in 104 (10,5 %) moški. Povprečna delovna doba dela v zdravstveni negi je bila 17,10 let ($sD = 10,1$). Glede na stopnjo izobrazbe je v raziskavi sodelovalo 90 višjih medicinskih sester (9 %),

809 diplomiranih medicinskih sester (80,80 %) in 102 anketiranca z magisterijem zdravstvene nege ali drugih smeri (10,2 %).

Zbiranje in obdelava podatkov

Podatki v vključenih bolnišnicah so bili zbrani med majem 2015 in januarjem 2016, v zdravstvenih domovih je zbiranje podatkov potekalo od septembra 2017 do marca 2018. Pridobili smo dovoljenje za uporabo obeh lestvic od avtorjev (Melnik et al., 2008). Vsak vključen zdravstveni zavod je o sodelovanju v raziskavi odločal na svoji organih odločanja in podal pisno soglasje za izvedbo raziskave. Vsak vključen posameznik v raziskavo je z anketnim vprašalnikom prejel pisne informacije o raziskavi in njenem pomenu za razumevanje profesionalizacije v zdravstveni negi. Vključene smo pisno informirali o njihovi pravici do prostovoljne vključenosti, da lahko kadar koli izstopijo iz raziskave in da jim zagotavljamo anonimnost izvedbe raziskave. Pisnega soglasja za sodelovanje pri raziskavi nismo uporabili. Pri izvedbi raziskave smo upoštevali etične smernice *Social Research Ethics Guidance* (Social Research Association, 2021).

Delitev vprašalnikov so izvedli koordinatorji raziskave v bolnišnicah, medtem ko je zbiranje podatkov v zdravstvenih domovih potekalo na daljavo, vprašalnik je bil anketirancem ponujen v okolju Enka (1KA, 2017). Povabilo k raziskavi in povezavo do vprašalnika je vsem diplomiranim medicinskim sestram v posameznem zdravstvenem domu poslala glavna medicinska sestra.

Podatke smo obdelali s programom SPSS 22.0. Uporabili smo opisno statistiko in faktorsko analizo (analiza glavnih komponent in metodo glavnih osi s poševnokotno rotacijo Oblimin s Keiserjevo normalizacijo). Izračunali smo Barlettov test sferičnosti ($p < 0,05$) in KMO test ($> 0,6$), ki kaže, da je vzorec primerne velikosti (Pallant, 2010). Meja statistične značilnosti je bila postavljena na $p < 0,05$.

Rezultati

Zanesljivost in veljavnost prepričanj o na dokazih podprti praksi

Povprečna vrednost prepričanj o na dokazih podprti praksi je 3,47 ($s = 0,54$). Zanesljivost lestvice je znašala 0,909. Zanimala so nas notranja razmerja med uporabljenimi stališči prepričanj in možnosti vsebinskega združevanja uporabljenega konstrukta stališč. Za ta namen smo preverjanje veljavnosti in iskanje možnih vsebinskih konstrukтов znotraj lestvice izvedli faktorsko analizo. Po izvedeni analizi osnovnih komponent smo uporabili metodo glavnih osi s poševnokotno rotacijo Oblimin s Kaiserjevo normalizacijo in s tremi faktorji pojasnili varianco v 63,71 % (KMO = 0,925, Barlett $p < 0,001$). V prvi

Tabela 1: Opisni rezultati prevoda prepričanj o na dokazih podprti praksi (Melnyk et al., 2008) in rezultati faktorjske analize
Table 1: Descriptive results of translation of »EBP Beliefs Scale« (Melnyk et al., 2008) and results of factor analysis

<i>Trditev/Statement</i>	<i>n</i>	\bar{x}	<i>s</i>	<i>%</i>	<i>F1</i>	<i>F2</i>	<i>F3</i>
1. Menim, da uporaba na dokazih podprte prakse (DPP) vodi do najboljših oskrbe pacientov.	987	4,09	0,80	79,0	0,01	-0,71	-0,01
2. Dobro poznam korake uporabe DPP.	982	3,26	0,99	40,6	0,64	-0,13	0,00
3. Prepričan/-a sem, da lahko implementiram DPP.	975	3,38	0,90	45,5	0,55	-0,28	-0,06
4. Menim, da je kritična presoja dokazov obstoječih raziskav pomemben korak v procesu DPP.	974	3,79	0,84	67,7	0,11	-0,69	0,01
5. Prepričan/-a sem, da na dokazih temelječe smernice lahko izboljšajo delo v kliničnih okoljih.	983	4,01	0,78	77,7	-0,09	-0,96	0,03
6. Menim, da lahko hitro in učinkovito poiščem najboljše dokaze za odgovore na klinična vprašanja.	980	3,50	0,83	49,5	0,68	-0,09	-0,05
7. Menim, da lahko premagam ovire pri implementaciji DPP.	978	3,39	0,82	42,7	0,79	0,01	-0,06
8. Prepričan/-a sem, da lahko hitro in učinkovito implementiram DPP.	975	3,25	0,84	34,9	0,87	0,06	-0,09
9. Prepričan/-a sem, da bo uporaba DPP izboljšala moje delo s pacienti.	976	3,73	0,84	63,6	0,29	-0,59	-0,04
10. Vem, kako meriti rezultate kliničnega dela.	975	3,34	0,93	43,8	0,69	-0,01	0,01
11. Menim, da DPP vzame preveč časa.	962	3,19	0,87	32,2	0,02	0,04	0,64
12. Prepričan/-a sem, da lahko pridobim najboljše virov, da lahko implementiram DPP.	960	3,19	0,83	30,7	0,74	0,08	0,12
13. Menim, da je uporaba na DPP težavna.	968	3,27	0,86	36,5	-0,00	-0,07	0,66
14. Zadosti dobro vem, kako implementirati DPP, da dosežem spremembe v praksi.	970	3,12	0,87	30,0	0,80	0,12	0,13
15. Vem, da zmorem implementirati DPP v svoje delo.	973	3,35	0,83	41,3	0,68	-0,09	-0,00
16. Verjamem, da je moje delo na dokazih temelječe.	754	3,54	0,84	52,0	0,45	-0,22	0,08

Legenda/Legend: n – število /number; \bar{x} – povprečje/average; s – standard odklon/standard deviation; % – odstotek/percentage; F1 – Prepričanja v znanje/Belief in knowledge; F2 – Prepričanja v uporabnost/Beliefs in the usefulness; F3 – Težavnost uporabe in časovna potratnost/Difficulty of use and time efficiency; DPP – Na dokazih podprta praksa/Evidence based practice

Tabela 2: Opisni rezultati implementacije na dokazih podprti praksi in rezultati faktorске analize
Table 2: Descriptive results of »EBP Implementation Scale« and factor analysis results

<i>Trditev/Statement</i>	<i>n</i>	\bar{x}	<i>s</i>	%	<i>F1</i>	<i>F2</i>
1. Uporabim dokaz raziskave za spremembo svoje klinične prakse.	940	1,99	1,02	9,1	0,87	-0,09
2. Kritično ocenim dokaze izvedenih raziskav.	939	2,06	1,05	10,1	0,90	-0,06
3. Oblikujem PICO-vprašanje o lastni klinični praksi.	888	1,82	1,01	7,7	0,95	-0,14
4. Neformalno razpravljam o dokazih raziskav s sodelavci.	928	2,34	1,13	16,0	0,65	0,15
5. Zberem podatke o pacientovih težavah.	935	2,93	1,34	34	0,18	0,40
6. Delim dokaze raziskav v obliki poročila ali predstavitev z več kot dvema sodelavcema.	926	2,05	1,14	12,6	0,81	0,03
7. Vrednotim izide uvedenih sprememb v praksi.	927	2,20	1,15	14,6	0,62	0,18
8. Delim smernice za DPP s sodelavci.	931	2,16	1,12	13,7	0,69	0,20
9. Delim dokaze raziskav s pacientom/družinskimi člani.	919	1,99	1,11	9,0	0,70	0,13
10. Delim dokaze raziskav s člani multidisciplinarnega tima.	928	2,18	1,11	13,2	0,71	0,19
11. Preberem znanstveni članek.	939	2,50	1,12	21,5	0,34	0,41
12. Ko preberem znanstveni članek, kritično ocenim izvedeno raziskavo.	933	2,46	1,15	17,1	0,41	0,41
13. Uporabim zbirke sistematičnih pregledov raziskav na podatkovnih bazah.	928	2,12	1,14	12,7	0,56	0,30
14. Uporabim izdelane nacionalne smernice.	935	2,45	1,26	24,7	0,19	0,58
15. Uporabim DPP smernice ali pregledne raziskave za spremembo dela v klinični praksi, kjer delam.	920	2,20	1,14	15,3	0,34	0,57
16. Vrednotim delovanje v zdravstveni negi z zbiranjem izidov zdravstvene obravnave pacientov.	930	2,35	1,20	18,5	-0,06	0,95
17. Dobljene rezultate/podatke delim s sodelavci.	933	2,35	1,20	18,8	0,05	0,83
18. Sprememim svoje delovanje glede na rezultate pri delu s pacienti.	936	2,48	1,20	20,5	-0,10	0,99
19. Promoviram uporabo DPP sodelavcem.	937	2,12	1,18	14,0	0,25	0,49

Legenda/Legend: n – število / number; \bar{x} – povprečje/average; s – standard odklon/standard deviation; % – odstotek/percentage; F1 – Uporaba znanj/Use of knowledge; F2 – Uporaba korakov/Use of steps; DPP – Na dokazih podprta praksa/Evidence based practice

faktor se je uvrstilo deset trditvev, poimenovali smo ga »Prepričanja v znanje« o na dokazih podprti praksi v 45,52 % ($n = 10$, $Cronbach \alpha = 0,918$). Njegova povprečna vrednost znaša 3,0 ($s = 0,58$), kar kaže na nezanesljivost v prisotnost oziroma neprisotnost znanja o na dokazih podprti praksi. Drugi faktor oblikujejo štiri trditve, faktor ima negativne uteži, poimenovali smo ga »prepričanja v uporabnost« na dokazih podprte prakse in varianco pojasni v 10,76 % ($n = 4$, $Cronbach \alpha = 0,877$). Faktor ima povprečno vrednost 3,91 ($s = 0,69$). V tretji faktor sta se uvrstili dve trditvi, ki varianco pojasnita v 7,43 % ($n = 2$, $Cronbach \alpha = 0,664$). Poimenovali smo ga »Težavnost uporabe in časovna potratnost« in kaže neodločenost v stališču, da je na dokazih podprta praksa težavna in časovno obremenjujoča ($\bar{x} = 3,23$, $s = 0,75$). V našem primeru trditvi 11 in 13, ki sta se uvrstili v tretji faktor, nismo negativno kodirali, kot so to storili avtorji instrumenta (Melnik et al., 2008). Rezultati so prikazani v Tabeli 1.

Rezultati implementacije na dokazih podprte prakse in psihometrična analiza instrumenta

Povprečna vrednost implementacije je nizka ($\bar{x} = 2,23$, $s = 0,89$). Nizka je realizacija aktivnosti zbiranja podatkov o pacientovih težav, ki je vsakodnevna delovna obveza vključenih v raziskavo ($\bar{x} = 2,93$, $s = 1,34$), in vrednotenje izidov uvedenih sprememb v praksi ($\bar{x} = 2,20$, $s = 1,15$). Rezultati pogostost branja znanstvenih člankov ($\bar{x} = 2,50$, $s = 1,12$), stopnja uporabe znanj o dokazih ($\bar{x} = 2,06$, $s = 0,91$) in uporaba različnih virov o dokazih podprti praksi in usmerjenosti k izidom ($\bar{x} = 2,43$, $s = 0,94$) so prav tako nizki.

Zanesljivost lestvice implementacije na dokazih podprte prakse je znašala 0,969. Zanimala so nas notranja razmerja med uporabljenimi stališči o implementaciji na dokazih podprte prakse in možnosti vsebinskega združevanja uporabljenega konstrukta stališč. V ta namen smo za preverjanje, ali merjene spremenljivke veljavno merijo vsebinski konstrukt znotraj lestvice uporabili metodo glavnih komponent s poševnokotno rotacijo in Kaiserjevo normalizacijo. Pojasnili smo 68,52 % skupne variance z dvema faktorjema ($KMO = 0,952$ in $Barlett p < 0,001$). V prvi faktor, ki varianco pojasni v 62,93 %, se je uvrstilo deset trditvev, poimenovali smo ga »Uporaba znanj« ($n = 10$, $Cronbach \alpha = 0,954$). Njegova povprečna vrednost znaša 2,06 ($s = 0,91$). V drugi faktor se je uvrstilo devet trditvev, poimenovali smo ga »Uporaba korakov«, varianco pojasni v 5,59 % ($Cronbach \alpha = 0,917$). Faktor opisuje korake v procesu uporabe na dokazih podprte prakse, povprečna vrednost doseganja je 2,43 ($s = 0,94$). Rezultate faktorjske analize prikazuje Tabela 2.

Razprava

Članek prikazuje psihometrično analizo vprašalnika za zajem podatkov o prepričanjih in implementaciji na

dokazih podprte prakse avtorjev Melnyk et al. (2008). Gre za prvo objavo prevoda instrumenta v slovenskem jeziku.

Raziskava pokaže, da je povprečje prepričan anketiranih o dokazih podprti praksi nekoliko nad ravno neodločenosti, opazen je skromen premik strinjanja. Večje strinjanje je doseženo le pri dveh trditvah v oblikovanem konstrukt prepričanja, in sicer da uporaba na dokazih podprte prakse vodi do najboljših oskrb pacientov (trditve 1) in da na dokazih temelječe smernice lahko izboljšajo delo v kliničnih okoljih (trditve 5). Vse ostale trditve ne dosežejo povprečja strinjanja in so na ravni neodločenosti. Rezultat ne preseneča, saj smo pri raziskavi vrednot med visokošolsko izobraženimi medicinskimi sestrami slovenskih bolnišnic ugotovili, da strokovno delo usmerjajo vrednote negovanja, zaupanja in pravičnosti in pomembno manj vrednote aktivizma in profesionalizma za razvoj stroke (Skela-Savič et al., 2017). Doseženi rezultati na področju prepričanj o na dokazih podprti praksi so primerljivi z drugimi avtorji (Melnik et al., 2008; Hauck, Winsett, & Kuric, 2012; Zelenikova et al., 2016; Kerwien-Jacquier et al., 2020). Dve tretjini anketiranih se strinjata, da je kritična presoja dokazov pomembna (trditve 4) in uporaba na dokazih podprte prakse izboljša delo s pacienti. Kar polovica anketiranih se strinja, da je njihovo delo na dokazih temelječe (trditve 16), kar se ne ujema z rezultati implementacije na dokazih podprte prakse in kaže na nerazumevanje procesa in ključnih aktivnosti na dokazih podprte prakse. V primerjavi z vzorcem čeških in slovaških medicinskih sester (Zelenikova et al., 2016) opazimo razliko v oceni težavnosti na dokazih podprte prakse, saj so medicinske sestre v našem vzorcu ocenile večjo težavnost, vendar je ta primerljiva z dosežki raziskave v nemškem prevodu instrumenta (Kerwien-Jacquier et al., 2020), medtem ko je ocena težavnosti še večja v raziskavi avtoric instrumenta (Melnik et al., 2008), saj se s težavnostjo strinja polovica anketiranih. Z vidika dosežkov na področju prepričanj so rezultati izvedene raziskave mednarodno primerljivi.

Dosegli smo visoko zanesljivost instrumenta prepričanj (0,91), kar je primerljivo z dosežki Hauck et al. (2012) in je višja, kot so bili dosežki v tem članku uporabljenih primerjav. Dosežena zanesljivost pri Melnyk et al. (2008) je bila 0,85, Zelenikova et al. (2016) 0,85, Kerwien-Jacquier et al. (2020) 0,85, vendar je bil vzorec naše raziskave in vzorec raziskave Hauck et al. (2012) pomembno večji. Sklenemo lahko, da se je zanesljivost uporabljenega instrumenta prepričanj pokazala kot zelo dobra, uporabljen prevod je stabilen, notranjo konsistenten in doseže visoko notranjo konsistentnost v slovenskem prevodu. Tudi veljavnost instrumenta se je pokazala kot zelo dobra. Izvedena analiza osnovnih komponent in iz nje izhajajoča analiza glavnih osi nam podata tri vsebinske konstrukte in 64 % pojasnitev variance. Primerljivo pojasnitev variance so dosegli

tudi drugi avtorji, vendar se pojavi razlika v številu dobljenih vsebinskih konstruktov. Tako Melnyk et al. (2008) in Zelenikova et al. (2016) sprejmejo odločitev za en vsebinski konstrukt, medtem ko Kerwien-Jacquier et al. (2020) sprejmejo odločitev za štiri vsebinske konstrukte. S pridobljenimi vsebinskimi konstrukti prispevamo k boljšemu razumevanju in interpretaciji dimenzij prepričanj o dokazih podprti praksi. Naša raziskava namreč prepričanja vsebinsko razdeli na prepričanja o znanju v zvezi z dokazi podprto prakso, ki doseže največjo pojasnitev variance. Anketiranci so svoje znanje opredelili na ravni neodločenosti, torej ne moremo sklepati, da imajo dobro znanje o dokazih podprti praksi in njeni implementaciji. Drugi faktor opredeli prepričanja o uporabnosti na dokazih podprte prakse in spoznamo, da se anketiranci v povprečju strinjajo z uporabnostjo. Tretji faktor govori o težavnosti na dokazih podprte prakse, ki ji anketiranci ne pritrdijo, ostanejo na ravni neopredeljenosti.

Raziskava pokaže, da je povprečje implementacije na dokazih podprte prakse izjemno nizko, saj se opisane aktivnosti implementacije izvajajo v povprečju od enkrat do trikrat v osmih tednih. Nobeno stališče ni doseglo povprečne vrednosti nad tri, kar pomeni, da bi se opisane aktivnosti implementacije izvajale od štirikrat do šestkrat v osmih tednih. To preseneča pri tistih aktivnostih, ki niso značilne samo za proces implementacije na dokazih podprte prakse, temveč se tičejo samega procesa zdravstvene nege kot temeljnega orodja delovanja medicinskih sester. Sem spadajo zbiranje podatkov o pacientovih težavah, vrednotenje izidov uvedenih sprememb v praksi, vrednotenje zdravstvene nege na osnovi zbiranja izidov zdravstvene obravnave, delitev rezultatov dela in podatkov med sodelavci, spremembe v lastnem delovanju glede na rezultate in branje znanstvenih člankov. Ta rezultat lahko povežemo z rezultati raziskave o kompetencah visokošolsko izobraženih medicinskih sestrah v slovenskih bolnišnicah. Med njimi smo namreč prepoznali pomembno več strinjanja s kompetencami, ki jih pričakuje standardno delovno okolje, in pomembno manj kompetenc aktivizma in razvoja stroke (Skela-Savič et al., 2017).

Dosežki na področju implementacije so povezani s stanjem razvoja zdravstvene nege v državi. Raziskava avtorjev instrumenta Melnyk et al. (2008) pokaže na primeren rezultat pri aktivnostih, ki se izvajajo pri več kot 30 % anketiranih, to so kritična ocena rezultatov raziskav, zbiranje podatkov o pacientih, branje znanstvenih člankov in neformalno razpravljanje o dokazih s sodelavci. Dosežek je star vsaj trinajst let. Trideset in več odstotkov implementacije smo v naši raziskavi ugotovili le pri zbiranju podatkov o pacientih. Raziskava med nemško govorečimi medicinskimi sestrami pokaže še nižje povprečne ocene implementacije (Kerwien-Jacquier et al., 2020), kot je v naši raziskavi.

Zanesljivost instrumenta implementacije na dokazih podprtega dela je bila visoka (0,97), kar je primerljivo z dosežki primerljivih raziskav (Melnyk et al., 2008; Hauck et al., 2012; Zelenikova et al., 2016; Kerwien-Jacquier et al., 2020). Uporabljen prevod je stabilen, notranjo konsistenten in doseže visoko notranjo konsistentnost v slovenskem prevodu. Tudi veljavnost instrumenta se je pokazala kot zelo dobra. Izvedena analiza glavnih komponent in iz nje izhajajoča analiza glavnih osi poudarita dva vsebinska konstrukta in 68,5 % pojasnjene skupne variance. Primerljivo pojasnitev variance so dosegli tudi v nemškem prevodu (Kerwien-Jacquier et al., 2020), vendar se pojavi razlika v številu dobljenih vsebinskih konstruktov. Tako Melnyk et al. (2008) in Zelenikova et al. (2016) sprejmejo odločitev za en vsebinski konstrukt, medtem ko Kerwien-Jacquier et al. (2020) prikažejo pet vsebinskih konstruktov. S pridobljenimi vsebinskimi konstrukti v naši raziskavi prispevamo k boljšemu razumevanju in interpretaciji dimenzij implementacije na dokazih podprte prakse, saj smo implementacijo vsebinsko razdelili na uporabo znanj, ki se pokaže kot nizka, in to ne samo pri tistih neposredno povezanih z dokazi podprto prakso, temveč temeljnih znanj v delovnem procesu medicinske sestre in uporabo osnovnih orodij za delo. Že pri prepričanjih ugotovimo pomanjkanje znanj, zato je dosežek pri implementaciji logičen, znanja se malo uporabljajo, saj jih anketiranci nimajo dovolj, da bi lahko izvedli implementacijo po postopkih sistematičnega načina.

Rezultati pokažejo, da sta oba instrumenta dosegla odlično zanesljivost, medtem ko se pri veljavnosti instrumenta kažejo manjše razlike od izvirnika, kar je posledica značilnosti anketiranih in okolja, v katerem delujejo, na kar so že opozorili drugi avtorji (Stokke, Olsen, Espehaug, & Nortvedt, 2014; Thorsteinsson, 2012; Zelenikova et al., 2016; Verlo, Desmedt, & Morin, 2017; Kerwien-Jacquier et al., 2020). Tudi pridobljeni vsebinski konstrukti obeh instrumentov vplivajo na boljše razumevanje prepričanj in implementacije na dokazih podprte prakse.

V naši raziskavi se pokaže, da imata obe uporabljeni lestvici (Melnyk et al., 2008) dobro teoretično podlago in lahko to teorijo opredelimo z več spremenljivkami, ki smo jih dobili v analizi veljavnosti obeh prevedenih lestvic. Pomembna za psihometrično analizo je tudi velikost vzorca, ki smo jo dosegli, in tudi pokritost vseh treh nivojev zdravstva, kar nam je omogočilo dobre pogoje za oceno zanesljivosti in veljavnosti zbranih podatkov.

Omejitve izvedene raziskave in psihometrične analize so v neenakih skupinah glede na stopnjo izobrazbe, spol, zastopanost anketiranih iz zdravstvenih zavodov glede na raven zdravstvene obravnave. Dejavnika, kot sta spol in stopnja izobrazbe, sta realni dejstvi, ki ju ne moremo spremeniti. Omejitev raziskave je tudi slaba odzivnost, zlasti med vključenimi v raziskavi v bolnišnicah. Uporaba cenzusa vedno ne zagotavlja,

da bomo dosegli reprezentativnost vseh značilnosti populacije, zato bi bilo ustrežnejše naključno vzorčenje, vendar smo močno presegle minimalna priporočila, da na vsako trditev v lestvici dosežemo vsaj dvajset odgovorov (Clark & Watson, 1995). V članku se nismo osredotočili na povezave demografskih značilnosti in dosežkov pri prepričanjih in implementaciji. Temu se bomo posvetili v drugem delu prikaza rezultatov raziskave. Udeležba je bila anonimna in prostovoljna, vendar ne moremo izključiti, da so k raziskavi pristopili tisti, ki so bolj naklonjeni razvoju zdravstvene nege, ali tisti, ki tega razvoja ne podpirajo. Oba instrumenta gradita na samooceni, kar pomeni, da je to pogled posameznika oziroma posameznice in je pri interpretaciji treba biti previden.

Zaključek

Predstavljena analiza prevoda instrumentov za zajem podatkov o prepričanjih in implementaciji na dokazih podprte prakse nam omogoča nadaljnje raziskave na tem področju in nadaljnji razvoj instrumentov v slovenskem jeziku. Raziskava predvsem poudari manko znanj tako za razvoj na dokazih podprte prakse kot tudi znanj, ki so del vsakodnevnih razvojnih aktivnosti v delokrogu visokošolsko izobražene medicinske sestre. Rezultati raziskave ponudijo priložnosti za razmislek in izboljšanje stanja tako na ravni visokošolskih in zdravstvenih zavodov kot na ravni nacionalnih združenj v zdravstveni negi. Z dokazi podprta praksa mora skupaj z dodiplomskim izobraževanjem postati tudi del kontinuiranega profesionalnega izobraževanja za pridobitev licence. K temu so ameriške medicinske sestre pristopile že pred sedemnajstimi leti. Nekatere od naših izvedenih raziskav že predlagajo nujno potrebne izboljšave na tem področju.

Nasprotje interesov/Conflict of interest

Avtorji izjavljajo, da ni nasprotja interesov./The authors declare that no conflicts of interest exist.

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Etika raziskovanja/Ethical approval

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Prispevek avtorjev/Author contributions

Vsi avtorji so sodelovali pri zasnovi in oblikovanju dela, pridobivanju dela in analizi, kritičnem pregledu dela, dokončni odobritvi različice objavljenega članka. Prva in zadnja avtorica sta sodelovali pri interpretaciji podatkov./All authors participated in the conception and design of the paper, acquisition of the work and analysis, the critical review of the work, the final approval of the version of the published article. The first and last authors participated in the interpretation of the data.

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Izvirni znanstveni članek/Original scientific article

Vpliv multimodalne analgezije na samostojnost otročnic pri osebni higieni, skrbi za novorojenčka in dojenja po carskem rezu: retrospektivna kohortna raziskava

Influence of multimodal analgesia on maternal independent personal hygiene, newborn care and breastfeeding after cesarean delivery: A retrospective cohort study

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Ključne besede: bolečina; porod; negovalne intervencije; analgezija; dojenje

Key words: pain; childbirth; nursing interventions; analgesia; breastfeeding

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Članek je nastal v okviru raziskave »Primerjava quadratus lumborum bloka in infiltracije operativne rane z lokalnim anestetikom za analgezijo po carskem rezu: randomizirana raziskava«, ki je bila izvedena v Univerzitetnem kliničnem centru Ljubljana, na Ginekološki kliniki, Kliničnem oddelku za perinatologijo.

IZVLEČEK

Uvod: Namen raziskave je bil ugotoviti, ali lahko z uvedbo multimodalne analgezije po carskem rezu zmanjšamo odmerke opioidov in pospešimo pooperativno okrevanje.

Metode: V retrospektivni kohortni raziskavi sta bili primerjani dve skupini: eksperimentalna (po uvedbi novega analgetičnega režima) in kontrolna skupina (pred uvedbo novega analgetičnega režima). Opazovana je bila sposobnost samostojne osebne higiene porodnice, skrb za novorojenčka po carskem rezu in čas od operacije do prvega podoja. Pri statistični analizi je bil uporabljen test hi-kvadrat in Mann-Whitneyjev U-test.

Rezultati: V skupino z quadratus lumborum blokom in v kontrolno skupino smo vključili po 58 otročnic. Po uvedbi multimodalnega analgetičnega režima je večji delež otročnic samostojno skrbel za osebno higieno po šestih urah po carskem rezu (44 (76 %) otročnic v skupini quadratus lumborum blok in nobena v skupini opioidne analgezije). Po dvanajstih urah se je delež pri skrbi za osebno higieno v skupini, v kateri smo lajšali bolečino z opioidno analgezijo, nekoliko popravil 55 (95 %) v prvi skupini in v drugi skupini 28 (48 %, $p < 0,001$). Prvi podoj po carskem rezu je bil v prvi uri po operaciji pogostejši pri kontrolni skupini (19 otročnic pri quadratus lumborum bloku (33 %) in 32 otročnic z opioidno analgezijo (55 %, $p = 0,02$), po dveh urah razlik ga niso zaznali.

Diskusija in zaključek: Z multimodalnim analgetičnim načinom pripomoremo k hitrejšemu samostojnemu izvajanju negovalnih aktivnosti otročnice, ki ji omogočajo hitrejšo prilagoditev na novo življenjsko vlogo.

ABSTRACT

Introduction: The objective of the study was to evaluate whether introducing multimodal analgesics after caesarean delivery can reduce doses of opioids and speed up post-operative recovery.

Methods: We performed a retrospective cohort study comparing two groups: experimental (after introducing a new analgesics regime) and control group (before introducing a new analgesics regime) We observed patients' ability to independently care for personal hygiene, care for the newborn after cesarean delivery and time from the operation to the first attempt to breastfeed. Chi-square test and Mann-Whitney U test were used as part of the statistical methods for comparison.

Results: Quadratus lumborum block group included 58 patients. After the introduction of the multimodal analgesic regimen, a higher proportion of patients took care of their personal hygiene after 6 hours after cesarean section (44 (76%) patients in the group of quadratus lumborum block and 0 in the group of opioid analgesia). After 12 hours, the share of personal hygiene care in the group where pain was relieved with opioid analgesia slightly improved (55 (95%) in the first group and 28 in the control group (48%, $p < 0.001$). The first attempt to breastfeed after cesarean section was more frequent in the first hour after surgery in the control group (19 patients in group of quadratus lumborum block (33%) and 32 patients in group with opioid analgesia (55%, $p = 0.02$). After two hours no differences were detected.

Discussion and conclusion: Multimodal analgesic approach after caesarean delivery allows women to start independently caring for themselves and their newborns quicker, which can help them to adapt to their new role faster.



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Uvod

Delež carskih rezov v svetu in v Sloveniji narašča. Pri nas trenutno znaša 21 % (Abdulkhalikova, Trojner, Bregar, & Premru Sršen, 2016; European Perinatal Health Report, 2021). Obvladovanje poporodne bolečine je pomembno za kakovostno zdravstveno obravnavo, saj omogoča nemoteno povezovanje med otročnico in novorojenčkom in spodbuja dojenje (ACOG Committee Opinion, 2018; Wen, Yu, Kong, Liu, & Wei, 2020). Neustrezna analgezija po carskem rezu je lahko pomemben dejavnik tveganja za razvoj kronične bolečine, ki je povezana s poporodno depresijo in drugimi psihičnimi težavami (Eisenach et al., 2009; Holland et al., 2019; Bornstein et al., 2021). Večina analgetičnih režimov po carskem rezu vključuje opioidne analgetike. Z njimi sicer dosežemo ustrezno obvladovanje bolečine, vendar lahko njihovi stranski učinki (npr. slabost in bruhanje) negativno vplivajo na povezovanje med otročnico in novorojenčkom po porodu (Food and drug administration, 2017; ACOG Committee Opinion, 2018; Smith, Young, Blosser, & Poole, 2019). Prav tako opioidi prehajajo v materino mleko in lahko v nekaterih primerih povzročajo sedacijo novorojenčka. Prekomerna uporaba teh analgetikov tudi poveča tveganje za dolgotrajno odvisnost od opioidov, ki je vse večja javnozdravstvena težava tudi v Sloveniji (Kostnapfel & Hočevar, 2019).

Koncept multimodalne analgezije vključuje načrtno kombiniranje področnih tehnik lajšanja bolečine s sistemskimi analgetiki, različne farmakodinamične in farmakokinetične lastnosti z namenom doseganja sinergističnih analgetičnih učinkov (Holland et al., 2019; Smith, Young, Blosser, & Poole, 2019; Bornstein et al., 2021). Z multimodalnimi režimi analgezije lahko po carskem rezu pomembno zmanjšamo uporabo opioidnih analgetikov, ob tem pa še vedno zagotovimo ustrezno obvladovanje bolečine (Stopar-Pintarič et al., 2021; Višić, Stopar Pintarič, Albreht, Blajić, & Lučovnik, 2021).

Namen in cilji

Namen raziskave je bil preučiti vpliv uvedbe multimodalnega analgetičnega režima na čim hitrejše okrevanje otročnic po carskem rezu. Cilj raziskave je bil ugotoviti, ali uvedba multimodalnega analgetičnega režima po carskem rezu vpliva na delež otročnic, ki so po šestih, dvanajstih in štiriindvajsetih urah sposobne samostojne osebne higijene ter skrbeti za novorojenčka. Prav tako je bil cilj ugotoviti, ali uvedba multimodalnega analgetičnega režima vpliva na dojenje po eni, dveh in štirih urah po carskem rezu. V skladu s cilji so bile zastavljene tudi naslednje hipoteze:

H1: Koncept multimodalne analgezije pospeši samostojno izvajanje osebne higijene otročnice po carskem rezu.

H2: Otročnice so sposobne samostojno skrbeti za novorojenca.

H3: Pri otročnicah z multimodalnim konceptom lajšanja bolečine po carskem rezu nemoteno spodbujamo dojenje.

Metode

Uporabili smo kvantitativno metodo dela, pri čemer je bil v retrospektivni kohortni raziskavi za pridobivanje podatkov izveden eksperiment.

Opis instrumenta

Uvajanje multimodalnega analgetičnega režima je potekalo v sestavnem delu randomizirane raziskave z naslovom »Primerjava *quadratus lumborum* bloka in infiltracije operativne rane z lokalnim anestetikom za analgezijo po carskem rezu: randomizirana raziskava« (ClinicalTrials: NCT04000308), vključujoč strokovnjake s področja ginekologije, anesteziologije in zdravstvene nege. Opažanja in ocene smo sprotno zapisovali v zasnovano preglednico za zbiranje podatkov. Prvi del je vseboval osnovne demografske podatke, podatke o eventualni dodatni aplikaciji opioida, opažanja o srbečici, slabosti in sedaciji ter vpisovanje vrednosti vitalnih znakov. Drugi del je vseboval oceno bolečine po VAS (vizualno-analogni skali) v mirovanju in v gibanju ter samostojno izvedbo vnaprej določenih aktivnosti zdravstvene nege. Opazovane negovalne intervencije so bile:

- izvedba osebne higijene pri otročnici – ocenjevali smo čas in samostojnost (pomoč pri vstajanju, mobilnosti, osebni higieni) šest, dvanajst in štiriindvajset ur po porodu;
- samostojna skrb za novorojenca – ocenjevali smo čas in samostojnost (dvigovanje, pristavljanje za dojenje) šest, dvanajst in štiriindvajset ur po porodu;
- skrb za vzpostavitev dojenja – ocenjevali smo čas (prvi podoj) in samostojnost eno, dve in štiri ure po porodu.

S predhodno določenimi negovalnimi problemi smo definirali intervencije zdravstvene nege, ki jih prikazuje Tabela 1.

Opis vzorca

V raziskavo smo vključili otročnice z oceno ASA (*American Society of Anesthesiologists*) 2 ali 3 po načrtovanem carskem rezu v spinalni anesteziji in po dopolnjenem 37. tednu nosečnosti. Izključitveni kriteriji so bili: prirojene ali pridobljene motnje strjevanja krvi, indeks telesne mase > 40 kg/m², znana alergija na katero koli zdravilo v prej opisanih analgetičnih režimih, preeklampsija in znana zloraba opioidov v preteklosti. V raziskavo smo vključili 116 otročnic ($n = 116$); 58 v (eksperimentalno) skupino pred novim analgetičnim režimom in 58 v

Tabela 1: *Negovalne diagnoze in intervencije povzete po M. Gordon – NANDA (Herdman et al., 2019)***Table 1:** *Nursing diagnosis and interventions according to M. Gordon – NANDA (Herdman et al., 2019)*

<i>Domena/ Domain</i>	<i>Negovalna diagnoza/ Nursing diagnosis</i>	<i>Diagnostični kazalci/ Diagnostic indicators</i>	<i>Negovalne intervencije/ Nursing interventions</i>
Aktivnost	primanjkljaj v samooskrbi pri izvajanju osebne higiene porodnice	oslabljena zmožnost samostojne izvedbe aktivnosti osebne higiene	asistenca pri izvajanju negovalne intervencije, spodbujanje k samostojnemu izvajanju osebne higiene
Vloge v medosebnih odnosih	pripravljenost za doseganje višje ravni starševstva	pomanjkljiva skrb za novorojenca; primanjkljaj ljubkovanja, kožnega stika; nezmožnost zadovoljevanja otrokovih potreb; verbalizacija frustracije	spodbujanje interakcije med otročnico in novorojencem; spodbujanje kožnega stika; povezovanja, vzpostavitev poskusa dojenja; spodbujanje sobivanja
	pripravljenost za izboljššan proces dojenja	ustrezen vzorec laktacije; vnema novorojenca za dojenje; komunikacija med otročnico in novorojencem; vzdrževanje dojenja;	spodbujanje vzpostavitve dojenja; skrb za higieno dojk; znanje o pomenu pristavljanja za dojenje

(kontrolno) skupino po uvedbi novega analgetičnega režima. Izvajalci zdravstvene nege smo opredelili potrebe otročnice in novorojenčka po carskem rezu v zgodnjem poporodnem obdobju in ocenjevali čas in samostojnost izvedbe negovalnih intervencij, ki jih otročnice želijo najprej izvajati samostojno.

Opis poteka raziskave in obdelave podatkov

Sodelujoče v raziskavi so bile pred sodelovanjem k raziskavi seznanjene s potekom raziskave in njenim namenom, imele so možnost odklonitve sodelovanja, prav tako smo sodelujočim zagotovili anonimnost. V retrospektivni kohortni raziskavi smo ocenjevali čas in samostojnost pri izvajanju treh življenjskih aktivnosti (skrb za osebno higieno, skrb za novorojenčka in dojenje) pred in po uvedbi novega, multimodalnega režima analgezije po carskem rezu. Pred uvedbo novega analgetičnega režima (premultimodalni analgetični režim) so otročnice za lajšanje poporodne bolečine v prvem dnevu po carskem rezu na kliničnem oddelku rutinsko prejemale intravenozno tramadol 100 mg in metoklopramid 10 mg na osem

ur, paracetamol 1 g vsakih 8 ur, metamizol 2,5 g na dvanajst ur in piritramid 3 mg pri intenziteti bolečine VAS > 3. Multimodalni, analgetični režim je vključeval tehniko področne analgezije (quadratus lumborum blok), ki so ga otročnice prejele v operacijski dvorani neposredno po carskem rezu, paracetamol 1 g na šest ur, metamizol 2,5 g na dvanajst ur, kombinacijo diklofenaka in orfenadrina (Neodolpasse® 250 ml) na dvanajst ur in piritramid 3 mg ob VAS > 3.

Delež otročnic v obeh skupinah (pred in po uvedbi novega analgetičnega režima), ki so lahko samostojno skrbele za osebno higieno in novorojenčka in so dojele v določenih časovnih obdobjih po carskem rezu, smo primerjali z Mann-Whitneyjevim U-testom (zvezne spremenljivke). Vrednost $p < 0,05$ je pomenila za statistično pomembno. Statistično analizo smo izvedli s programom SPSS (IBM, SPSS Inc., Chicago, IL, ZDA).

Rezultati

Preučevani skupini (skupina otročnic pred in skupina otročnic po uvedbi novega analgetičnega režima) sta bili primerljivi glede osnovnih demografskih

Tabela 2: *Značilnosti testne in kontrolne skupine (n = 58)***Table 2:** *Characteristics of the test and control group (n = 58)*

<i>Značilnosti/ Characteristics</i>	<i>Pred uvedbo novega analgetičnega režima/ Before introduction of a new analgesic regimen</i>	<i>Po uvedbi novega analgetičnega režima/ After introduction of a new analgesic regimen</i>	<i>P</i>
Starost otročnice (leta)	33 (30–35)	31 (29–36)	0,35
Indeks telesne mase ob porodu ($\frac{cm}{kg}$)	30 (27–32)	28 (25–31)	0,38
Prvesnice	15 (26 %)	19 (33 %)	0,38
Porodna teža novorojenčka (g)	3575 (3218–3763)	3370 (3073–3615)	0,10
Ocenjena izguba krvi ob carskem rezu (ml)	500 (500–500)	500 (500–500)	0,47

Legenda/Legend: n – število/number; cm – centimeter/centimeter; kg – kilogram/kilogram; g – gram/gram; mL – mililiter/milliliter; % – odstotek/percentage; p – statistična značilnost/statistical significance

Tabela 3: Rezultati opazovanj aktivnosti zdravstvene nege pri otročnicah ($n = 58$)**Table 3:** Results of observations in nursing activities in patients ($n = 58$)

Intervencije/ Intervention	Časovni okvir po carskem rezu (h)/ Time frame after caesarean section (h)	Pred uvedbo novega analgetičnega režima n (%)/ Before introduction of a new analgesic regimen n (%)	Po uvedbi novega analgetičnega režima n (%)/ After introduction of a new analgesic regimen n (%)	P
Osebna higiena otročnice	6	0 (0)	44 (76)	< 0,001
	12	28 (48)	55 (95)	< 0,001
	24	58 (100)	58 (100)	/
Skrb za novorojenca	6	1 (2)	0 (0)	0,32
	12	28 (48)	36 (62)	0,11
	24	58 (100)	58 (100)	/
Poskus prvega podoja/ dojenje	1	32 (55)	19 (33)	0,02
	2	56 (97)	53 (91)	0,39
	4	56 (97)	58 (100)	0,16

Legenda/Legend : h – ura/hour; n – število/number; p – statistična značilnost/statistical significance; % – odstotek/percentage

in kliničnih značilnosti. V Tabeli 2 smo ugotavljali srednje vrednosti pri starosti otročnic, indeksu telesne mase, porodni teži novorojenčkov in ocenjeni izgubi krvi po opravljenem carskem rezu. Med njimi ni statistično pomembnih razlik.

Tabela 3 prikazuje rezultate opazovanj negovalnih težav. Po uvedbi multimodalnega analgetičnega režima je večji delež otročnic lahko samostojno izvajal osebno higieno po šestih in dvanajstih urah po carskem rezu. Razlik med skupinama štiriindvajset ur po carskem rezu ni bilo. Prav tako nismo opazili razlik pri samostojni skrbi za novorojenčka šest, dvanajst in štiriindvajset ur po carskem rezu. Več otročnic je dojilo v prvi uri pred uvedbo novega analgetičnega režima, vendar razlike po dveh urah niso bile več značilne. V povprečju je bila ocena bolečine po VAS pri otročnicah po carskem rezu ocenjena približno s 3, kar pomeni ustrezno obvladovanje bolečine po carskem rezu. Po uvedbi novega analgetičnega režima so štiri ure po carskem rezu dojile vse otročnice, predtem pa 97 %.

Diskusija

Multimodalni način k obvladovanju bolečine po carskem rezu omogoča otročnicam, da po operaciji prej samostojneje izvajajo osebno higieno. Na sposobnost samostojne skrbi za novorojenčka uvedba novega analgetičnega režima ni bistveno vplivala. Delež dojenih novorojenčkov je bil višji v premultimodalni skupini po eni uri, medtem ko po dveh urah ni bilo več pomembne razlike med skupinama. Pri tem verjetno niso pomembna samo zdravila in način lajšanja pooperativne bolečine, temveč tudi psihosocialni način. Osebnost zdravstvene in babiške nege ima ključno vlogo, saj pomembno vključuje zdravstvenovzgojno delo, uči otročnico, kako rokovati z novorojencem in spodbuja navezovanje stika med otročnico in novorojencem (Brady, Bulpitt, & Chiarelli, 2014; Huang, 2015; Balatero, Spilker, & McNiesh, 2019).

Naša raziskava potrjuje, da je za optimalno analgezijo nujno sodelovanje vseh udeležencev v procesu rehabilitacije. Za obvladovanje pooperativne bolečine je nujen multidisciplinaren način, pri katerem ima vsak od udeležencev pomembno vlogo; operater z izbiro operativne tehnike, anesteziolog s področno anestezijo in analgezijo v kombinaciji s sistemskimi analgetiki in osebje zdravstvene in babiške nege z apliciranjem predpisanih zdravil glede na oceno poporodne bolečine otročnice.

Vzpostavljane in spodbujanje dojenja ter kožni stik med drugim izboljšata interakcijo med otročnico in novorojencem (Jin, 2012). Zato je bistvenega pomena razumevanje dejavnikov, ki vplivajo na dojenje - tudi po carskem rezu. Wen et al. (2020) so v svoji raziskavi, v katero so vključili več kot 5546 porodov, ugotovili, da so otročnice po carskem rezu v 86 % začele dojiti pozneje kot tiste po vaginalnem porodu. S klasifikacijo potreb in aktivnosti pri otročnicah lažje opredelimo zahteve in intervencije zdravstvene in babiške nege, ki omogočijo lažji prehod v zgodnje poporodno obdobje. Izvedba intervencij zdravstvene nege in edukacija o zdravstvenovzgojnih vsebinah vplivata na izid in zadovoljstvo z hospitalno obravnavo ter prehod v domače okolje. Izzivi za dojenje po carskem rezu so najpogostejše fizično nelagodje, primanjkljaj znanja in spretnosti pri dojenju ter nezadostna laktacija (Schoenwald, Windsor, Gosden, & Douglas, 2018; Wang et al., 2018; Wen, 2020). V naši raziskavi je pomembo več otročnic dojilo v prvi uri po carskem rezu pred uvedbo multimodalnega analgetičnega režima. Upoštevajoč ostale rezultate je zelo malo verjetno, da je bil poglaviti vzrok za to, neustrezno obvladovanje bolečine. Vendar je to pomemben podatek, ki vsekakor zahteva nadaljnje raziskovanje. Zgodnji začetek dojenja (v t. i. »zlato oz. posvečeni uri« po porodu) je namreč zelo pomemben za nadaljnjo laktacijo in dojenje, za celoten proces povezovanja med otročnico in novorojenčkom, pa tudi za preprečevanje poporodne krvavitve, ki je po carskem rezu pogostejša (Pavel, 2016).

Raziskava ima tudi nekatere pomanjkljivosti, ki jih je treba upoštevati ob interpretaciji rezultatov. Poglavitna pomanjkljivost je opazovalna raziskovalna metodologija, ki ne omogoča nedvoumnih sklepov o vzročnih povezavah. Prav tako so medicinske sestre in babice, ki so ocenjevale vnaprej določene izide, vedele, da bodo njihova opažanja vključena v analizo. To bi lahko predstavljalo vir pristranosti. V raziskavi tudi nismo neposredno ocenjevali zadovoljstva otročnic s poporodno oskrbo. Na kliničnem oddelku rutinsko kontinuirano spremljamo zadovoljstvo otročnic z oskrbo s pomočjo anonimnih vprašalnikov. V času raziskave nismo opazili niti ene pritožbe zaradi nezadostnega ali neustreznega lajšanja bolečine po carskem rezu.

Zaključek

Obvladovanje bolečine po carskem rezu je pomemben del kakovostne multidisciplinarnе obravnave otročnic. Z multimodalnim režimom analgezije lahko ob nižjih odmerkih opioidnih analgetikov zagotovimo ustrezno obvladovanje bolečine in pripomoremo k hitrejšemu okrevanju po operaciji, skrajšamo čas hospitalizacije in stroškovno učinkovitost. Z vidika zdravstvene nege pa pomeni, da pravočasno prepoznavanje in ustrezno ukrepanje ob pristotnosti bolečine vpliva na povezovanje med otročnico in novorojencem in pripomore k lažjemu vzpostavljanju involucijskih procesov po carskem rezu.

Nasprotje interesov/Conflict of interest

Avtorji izjavljajo, da ni nasprotja interesov./The authors declare that no conflicts of interest exist.

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Prispevek avtorjev/Author contributions

Vsi avtorji so sodelovali pri idejnem načrtovanju, pisanju in pregledu uvoda, metodologije, rezultatov, interpretacije, diskusije in zaključka raziskave. Prvi avtor je izvedel pregled literature in zbral podatke, drugi avtor je opravil statistično analizo./All authors participated in the conceptual planning and in writing and reviewing the introduction, methodology, results, interpretation, discussion and conclusion of the research. The first author reviewed the literature and collected data, the second author conducted the statistical analysis.

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Izvirni znanstveni članek/Original scientific article

Izkušnje medicinskih sester z albansko govorečimi pacienti: kvalitativna raziskava Nurses' experience with Albanian-speaking patients: A qualitative study

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Ključne besede: komunikacija; kultura; ovire; zdravstveni delavci; kompetence

Key words: communication; culture; barriers; healthcare professionals; competences

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IZVLEČEK

Uvod: Medicinske sestre se pri svojem delu pogosto soočajo z jezikovnimi in kulturnimi izzivi, ki jih prinaša stik z albansko govorečimi pacienti. Namen raziskave je bil preučiti doživljanja medicinskih sester in njihove izkušnje z albansko govorečimi pacienti, raziskati morebitne težave in predlagati rešitve.

Metode: Uporabljena je bila kvalitativna raziskovalna metodologija. V namenski kvotni vzorec je bilo vključenih 12 medicinskih sester, zaposlenih na primarnem in sekundarnem nivoju zdravstvene dejavnosti. Delno strukturirani intervjuji so bili opravljeni novembra 2021. Za analizo podatkov je bila uporabljena metoda vsebinske analize besedila.

Rezultati: Identificirane so bile štiri tematske skupine, ki opisujejo preučevani fenomen: (1) prvi stik z albansko govorečimi pacienti, (2) značilnosti obravnave albansko govorečih pacientov, (3) načini reševanja jezikovnih preprek, (4) predlogi za razreševanje ovir pri zdravstveni obravnavi.

Diskusija in zaključek: V Sloveniji je problematika albansko govorečih pacientov opazna že nekaj let, a do občutnega urejanja tega področja ne prihaja. Ugotovitve nakazujejo, da trenutno reševanje jezikovnih in kulturnih ovir po večini temelji na improvizaciji zdravstvenih delavcev, kar lahko vodi v številne napake. Nadaljnje raziskovanje bi moralo vključevati vidik albansko govorečih pacientov.

ABSTRACT

Introduction: Nurses often face linguistic and cultural challenges when dealing with Albanian-speaking patients. The aim of the study was to investigate nurses' experiences with Albanian-speaking patients, to identify potential challenges and propose solutions.

Methods: A qualitative research method was used. A purposeful quota sample of 12 nurses working in primary and secondary levels of healthcare was interviewed in November 2021 using semi-structured questionnaires. The data collected were subjected to text analysis.

Results: Four thematic groups that describe the studied phenomena were identified: (1) the first encounter with Albanian-speaking patients, (2) characteristics of dealing with Albanian-speaking patients, (3) ways to overcome language barriers, (4) suggestions to overcome barriers in medical treatment.

Discussion and conclusion: The challenges concerning Albanian-speaking patients have been known in Slovenia for a few years, but this problem has not been significantly dealt with. The results show that overcoming language and cultural barriers currently depends on the improvisation of healthcare professionals, which may result in oversights. Further research should include the aspect of Albanian-speaking patients.



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Uvod

V zadnjih letih se Slovenija srečuje s povečanjem prisotnosti tujcev. Od priseljencev, ki so se v letu 2019 priselili v Slovenijo, jih kar 78,5 % prihaja iz držav na Balkanu; mednje uvrščamo tudi prebivalce Albanije (Statistični urad Republike Slovenije, 2020). Ne glede na spol, narodnost, raso, etnično pripadnost ali drugo osebno okoliščino pa imajo vsi pravico do enake zdravstvene obravnave in oskrbe (Zakon o pacientovih pravicah [ZPacP]), kar za zdravstvene delavce pomeni potrebo po razumevanju različnih kultur pri dojemanju zdravja, boleznih, bolečine, oskrbe in zdravljenja, saj se le tako lahko izognemo nesporazumom med zdravstvenimi delavci, uporabniki in njihovimi svojci (Bofulin et al., 2016; Lipovec-Čebtron, Bombač, Kocijančič-Pokorn, & Lučovnik, 2019). Kocijančič-Pokorn & Lipovec-Čebtron (2019) v raziskavi na primer ugotavljata, da je 94 % anketiranih zdravstvenih delavcev poročalo o stikih s pacienti, ki ne govorijo slovenskega jezika.

O neenakosti in ranljivosti na področju zdravja sta bili v Sloveniji narejeni dve kvalitativni raziskavi: prva leta 2014 v okviru projekta *Skupaj za zdravje*, druga pa leta 2019 v okviru projekta *MoST*. Obe sta kot najranljivejšo populacijo v zdravstvu označili priseljence, saj se ti soočajo z mnogimi jezikovnimi in kulturnimi ovirami, ki povzročajo neenakosti v zdravstveni obravnavi. V omenjenih raziskavah so albanščino izpostavili za najbolj problematičen jezik, saj ustvarja največ ovir v komunikaciji (Huber, Lipovec-Čebtron, & Pistotnik, 2020; Kocijančič-Pokorn & Lipovec Čebtron, 2019). Kljub temu slovenske zdravstvene ustanove nimajo vpeljanega sistemskega reševanja otežene komunikacije, kakršno opažamo v Italiji, Nemčiji in Švici (Kocijančič-Pokorn & Lipovec-Čebtron, 2019; Lipovec-Čebtron et al., 2019). Kocijančič-Pokorn & Lipovec-Čebtron (2019) navajata, da so v zvezi s tem organizirana zgolj usposabljanja za zdravstvene delavce, v uporabi pa je tudi *Večjezični priročnik za lažje sporazumevanje v zdravstvu*. V prihodnje kot najprimernejše načine premagovanja jezikovnih ovir predlagajo izobraževanje profesionalnih tolmačev in medkulturnih mediatorjev, učenje tujih jezikov, ki predstavljajo zdravstvenim delavcem največji izziv, ter vključitev tem s področja kulturnih kompetenc v izobraževalne programe medicinskih in zdravstvenih fakultet. Podobne rešitve so predlagale tudi anketirane migrantke v sklopu projekta INTEGRA (Bogataj, Prosen, Karnjuš, Rebec, & Ličen, 2019).

Zdravstveni delavci ugotavljajo, da jezikovne ovire prinašajo številne nesporazume in neenakosti v zdravstveni obravnavi, v skrajnem primeru tudi travmatične izkušnje. Posledično se kakovost zdravstvenega varstva poslabšuje, saj priseljenci odlašajo z zdravstvenimi pregledi ali se zanje sploh ne odločajo. Zaradi nerazumevanja jezika je pacientom lahko odvzeta pravica do samostojnega odločanja o zdravstveni obravnavi, aplikaciji terapije in drugih medicinskih

posegih. Prav tako se ne udeležujejo raznih preventivnih programov, delavnic, šol za starše ipd. (Lipovec-Čebtron et al., 2019; Huber et al., 2020; Al Shamsi, Almutairi, Al Mashrafi, & Al Kalbani, 2020). Ob jezikovnih ovirah se zdravstveni delavci soočajo s časovnimi stiskami, čustvenimi težavami in strokovnimi dilemami, saj prihaja do komunikacijskih ovir tako med samim pregledom kot tudi pri sporočanju diagnoze in pri predpisovanju ustrezne terapije (Huber et al., 2020; Škraban & Lipovec-Čebtron, 2021). Poleg že omenjenih jezikovnih ovir se zaposleni v zdravstvu srečujejo tudi s kulturnimi ovirami tujgovorečih pacientov, zlasti z drugačnimi kulturnimi navadami (prehrana, higiena, odnos do telesa in zdravja, medosebni odnosi) in prisotnostjo svojcev pri zdravstveni obravnavi obolelega člana družine (Huber et al., 2020). Soočanje s tujgovorečimi pacienti zdravstvenim delavcem povzroča strah in stiske, saj ne vedo, kako naj pristopijo do njih in pridobijo podatke, pomembne za zdravstveno obravnavo (Štante, Mlinar Reljič, & Donik, 2018).

Namen in cilji

Ker se zaposleni v slovenskem zdravstvenem sistemu pogosto srečujejo s tujejezičnimi posamezniki, med drugim tudi z albansko govorečo skupnostjo, je bil namen raziskave preučiti, kako se medicinske sestre v praksi soočajo z albansko govorečimi pacienti, predstaviti njihove izkušnje, morebitne težave in predlagane rešitve. Cilj je bil raziskati in predstaviti izkušnje medicinskih sester z albansko govorečimi pacienti in ugotoviti, s kakšnimi posebnostmi so se medicinske sestre soočale pri njihovi zdravstveni obravnavi. Želeli smo ugotoviti tudi njihovo perspektivo za izboljšanje zdravstvene obravnave albansko govorečih pacientov. V raziskavi smo postavili naslednji raziskovalni vprašanji:

- Kakšne so izkušnje zaposlenih v zdravstveni negi z albansko govorečimi pacienti?
- S katerimi izzivi se srečujejo zaposleni v zdravstveni negi pri obravnavi albansko govorečih pacientov?

Metode

Uporabljena je bila kvalitativna metoda raziskovanja, saj zaradi narave preučevanega fenomena omogoča boljši vpogled v razmišljanje, razumevanje in vedenje posameznika (Kaae & Traulsen, 2015). V okviru kvalitativne metodologije smo uporabili deskriptivno interpretativno metodo, ki je opisana kot kombinacija, sestavljena iz tehnike zbiranja, analiziranja, obdelave in interpretacije pridobljenih podatkov ter njihove predstavitve (Sandelowski, 2000; Polit & Beck, 2020).

Opis instrumenta

Podatke smo pridobili z izvedbo delno strukturiranih intervjujev. Pri tej obliki raziskovalec pred intervjujem

pripravi glavna vprašanja, ki jih zastavlja vsakemu intervjuvancu posebej. Če so potrebna podvprašanja, jih raziskovalec oblikuje in postavlja med intervjujem (DiCicco-Bloom & Crabtree, 2006). Na podlagi pregleda literature smo pripravili 12 izhodiščnih vprašanj, ki so bila uvodoma splošna, da so intervjuvanci razvili občutek pripovedi, med intervjujem pa so se vprašanja, povezana z izkušnjami medicinskih sester z albansko govorečimi pacienti, poglobljala. Primeri nekaterih vprašanj: Kako doživljate obravnavo albansko govorečih pacientov? S kakšnimi izzivi se srečujete pri obravnavi albansko govorečih posameznikov? Kakšne so običajne prakse zdravstvenih delavcev na vašem področju pri obravnavi

albansko govorečih pacientov? Kakšne predloge imate za dolgoročne in sistemske rešitve teh ovir? Na koncu so bili intervjuvanci naprošeni, da podajo še nekaj osnovnih demografskih podatkov (starost, dosežena izobrazba, delovna doba, delovna doba na trenutnem področju, nivo zdravstvene dejavnosti, področje zaposlitve).

Opis vzorca

V raziskavi je bil uporabljen namenski kvotni vzorec dvanajstih izvajalcev zdravstvene nege z različnih ravni zdravstvene dejavnosti in vsaj tremi leti delovne dobe, ki so bili pri svojem delu že v stiku z albansko

Tabela 1: Demografski in drugi podatki intervjuvancev

Table 1: Demographic and other data of interviewees

Šifra/ Code	Starost/ Age	Dosežena izobrazba/ Education attained	Delovna doba/ Years of service	Delovna doba na trenutnem področju/ Years of service in current field	Nivo zdravstvene dejavnosti/ Level of health system	Področje zaposlitve/ Field of employment	Pogostost srečevanja z albansko govorečimi pacienti/ Frequency of meeting Albanian speaking patients
Ž59SN	59 let	srednja medicinska sestra	40 let	37 let	sekundarna raven	oddelek za porodništvo	tedensko srečevanje
M30SN	30 let	magister zdravstvene nege	6 let	2 leti	sekundarna raven	odsek za anestezijo in reanimacijo	mesečno srečevanje
Ž48PN	48 let	srednja medicinska sestra	28 let	12 let	primarna raven	specialistična parodontološka ambulanta in odrasla splošna zobna ambulanta	tedensko srečevanje
Ž61SN	61 let	diplomirana medicinska sestra	40 let	2 leti	sekundarna raven	oddelek za pediatrijo	tedensko srečevanje
Ž40SN	40 let	diplomirana medicinska sestra	14 let	12 let	sekundarna raven	oddelek za porodništvo	mesečno srečevanje
Ž24SN	24 let	srednja medicinska sestra	3 leta	3 leta	sekundarna raven	oddelek za kirurgijo	mesečno srečevanje
Ž55SN	55 let	diplomirana medicinska sestra	32 let	17 let	sekundarna raven	oddelek za ginekologijo in porodništvo, oddelek za pediatrijo	dnevno srečevanje
M30PN	30 let	diplomiran zdravstvenik	8 let	5 mesecev	primarna raven	nujna medicinska pomoč	dnevno srečevanje
Ž26PN	26 let	diplomirana medicinska sestra	3 leta	3 leta	primarna raven	ambulanta družinske medicine, referenčna ambulanta	dnevno srečevanje
Ž40PN	40 let	srednja medicinska sestra	20 let	11 let	primarna raven	dispanzer za otroke in šolarje	dnevno srečevanje
Ž35PN	35 let	diplomirana medicinska sestra	10 let	10 let	primarna raven	dispanzer za otroke in šolarje	dnevno srečevanje
Ž38PN	38 let	diplomirana medicinska sestra	19 let	5 let	primarna raven	patronažna služba	tedensko srečevanje

govorečimi pacienti (Tabela 1). Imena intervjuvancev smo nadomestili s posebno šifro. Prva črka šifre označuje spol, drugi dve številki starost v letih, zadnji dve črki pa nivo zdravstvenega varstva.

Glede na izbran raziskovalni dizajn je bila velikost vzorca ustrezna (Steen & Roberts, 2011), vendar smo pri opredelitvi velikosti upoštevali tudi kriterij nasičenosti (Fusch & Ness, 2015). Najmlajši intervjuvanec je bil star 24 let, najstarejši pa 61 let. Povprečna starost intervjuvancev je bila 40,5 leta. Šest intervjuvancev je bilo zaposlenih v primarni zdravstveni dejavnosti, šest pa v sekundarni zdravstveni dejavnosti. Najnižje število let delovne dobe je bilo 3 leta, najvišje pa 40 let. Povprečna delovna doba intervjuvancev je bila 18,58 let.

Opis poteka raziskave in obdelave podatkov

Potencialno sodelujoče smo k sodelovanju povabili osebno. Razložili smo jim namen, cilj in način raziskovanja ter se glede na njihovo dosegljivost dogovorili za predviden termin in kraj intervjuja. Intervjuji so potekali novembra 2021 v prostorih, kjer so bili intervjuvanci zaposleni. Zaradi upoštevanja etičnih vidikov raziskovanja so vsi sodelujoči pred pričetkom intervjuja podpisali t. i. informirano soglasje, v katerem so bili ponovno seznanjeni z namenom, cilji, potekom raziskave, tveganji, koristmi, varovanjem zaupnosti podatkov in anonimnostjo, predvidenim trajanjem intervjuja, možnostmi prekinitve intervjuja oziroma zavrnitve odgovarjanja na določena vprašanja ter možnostjo povratnih informacij o rezultatih.

Intervjuji so bili zvočno snemani in nato takoj prepisani. Nasičenost podatkov, ko med povedanim ni bilo zaznani nobenih novih dejstev (Fusch & Ness, 2015), se je nakazovala že pri desetem intervjuju, vendar so avtorji zaradi nekaterih novih dejstev med intervjuji sklep o prenehanju zbiranja podatkov sprejeli

pri dvanajstem opravljenem intervjuju. Podatki so bili analizirani in sintetizirani z metodo analize vsebine. To je analiza pripovednih podatkov, ki pomaga med vsebino prepoznati teme in vzorce. Podatke razčleni v manjše enote, sledi kodiranje ter poimenovanje enot glede na vsebino, ki jo predstavljajo. Nazadnje se kodirno gradivo združi na podlagi skupnih konceptov (Polit & Beck, 2012).

Rezultati

Rezultati kažejo, da imajo medicinske sestre pogosto težave pri obravnavi albansko govorečih pacientov, a vseeno poskušajo svojo vlogo opraviti profesionalno in nuditi pacientom kar se da kompetentno zdravstveno nego. Slednje je predvsem zaradi jezikovnih ovir velik izziv. Vse omenjeno se izpostavlja tudi v analizi, v kateri so bile identificirane štiri teme: (1) prvi stik z albansko govorečimi pacienti; (2) značilnosti obravnave albansko govorečih pacientov; (3) načini reševanja jezikovnih preprek; (4) predlogi za razreševanje ovir pri zdravstveni obravnavi (Tabela 2).

Prvi stik z albansko govorečimi pacienti

Intervjuvane medicinske sestre so izpostavile pogosto srečevanje z albansko govorečimi pacienti, pet izmed njih se z njimi srečuje tudi vsakodnevno. Večina jih prvi stik povezuje z neprijetnimi občutki, predvsem zaradi občutka nemoči ob izrazito oteženi komunikaciji. Stisko najpogosteje izražajo z besedno zvezo »težko je«.

Obravnava albansko govorečih pacientov je zelo težka in stresna, ker jim težko pomagaš, saj ne znajo povedati ničesar. (Ž40SN)

Le eden izmed intervjuvancev je izrazil nevtralne občutke, saj je tudi sam del albanske kulture, kar predstavlja veliko prednost pri soočanju z albansko govorečimi pacienti.

Tabela 2: Shematični prikaz razvoja tem in podtem

Table 2: A schematic view of the development of themes and sub-themes

Tema/Theme	Podtema/Sub-theme
Prvi stik z albansko govorečimi pacienti	Občutja ob srečanju
	Prepoznani razlogi za neprijetne občutke
Značilnosti obravnave albansko govorečih pacientov	Izkušnje medicinskih sester
	Ovire in posebnosti pri obravnavi žensk
	Ovire in posebnosti pri obravnavi moških
	Jezikovne ovire in posebnosti moških in žensk
Načini razreševanja jezikovnih preprek	Nejezikovne ovire in posebnosti moških in žensk
	Verbalna komunikacija
Predlogi za razreševanje ovir pri zdravstveni obravnavi	Neverbalna komunikacija
	Albansko govoreči pacienti
	Sistemska ureditev problematike albansko govorečih pacientov

Značilnosti obravnave albansko govorečih pacientov

Po izkušnjah intervjuvanih medicinskih sester so obravnave daljše in zahtevnejše predvsem zaradi nezmožnosti predaje kompleksnejših informacij in dvoma o zanesljivosti prevoda.

Saj nekako se sporazumemo, [...] da morajo iti na stranišče, pod tuš, to jim lahko tudi pokažemo, samo česa podrobnega, na primer o dojenju ali zdravstvenem stanju, jim ne moremo razložiti. (Ž59SN)

Večina intervjuvancev je kot posebnost pri obravnavi albansko govorečih pacientk izpostavila njihovo nepripravljenost na prilagoditev slovenskemu okolju in kulturi ter neizobraženost, ki se kaže predvsem v neustreznem ukrepanju ob pojavu zdravstvenih težav. Ena izmed intervjuvank je pri nekaterih pacientkah opazila tudi nepismenost.

Včasih si pomagam s priročnikom (Večjezični priročnik za lažje sporazumevanje v zdravstvu, op. a.) in vidim, da nekatere mame ne znajo brati. Ko jim s pomočjo priročnika postavim vprašanje, na katerega bi morale odgovoriti s številko, le prikimajo. Tako vidiš, da ne znajo niti brati, kaj šele da bi vprašanje razumele. (Ž38PN)

Iz zapisov intervjujev je razvidno, da albansko govoreče pacientke pri zdravstveni obravnavi najpogosteje spremljajo partnerji, drugi družinski člani ali prijatelji. Spremljevalci v tem primeru nadomestijo tolmača, kar z vidika prevajanja pozitivno vpliva na obravnavo. Po drugi strani pa nekatere medicinske sestre opozarjajo na pravico do zasebnosti, ki je pacientkam s tem odvzeta in lahko vpliva na okrnjeno količino podanih informacij. Intervjuvanci poleg tega izpostavljajo tudi podrejenost partnerju, ki je pogosto povezana prav z neznanjem slovenskega ali drugega skupnega jezika.

Pacientke nikoli ne pridejo same, vedno jih nekdo pripelje. Zdi se mi, kot da mora biti vedno nekdo zraven, da ne bi kaj drugače videle ali se naučile. [...] Med obravnavo pacientke odgovarjajo le partnerju, nič ne povedo same, [...] ponižne žene so to. (Ž48PN)

Posebnost obravnave albansko govorečih pacientov je, da je v primerjavi z albansko govorečimi pacientkami komunikacija z njimi lažja, saj jezikovne prepreke niso prisotne v tolikšni meri. Največkrat izpostavljena značilnost med obravnavo albanskih pacientov je njihovo neupoštevanje pravil in dogovorjenih terminov obravnave. Ena izmed intervjuvank razlog za to vidi v slabih delovnih pogojih, saj jim po njenem mnenju delodajalec pogosto ne omogoča dostopa do zdravnika med delovnim časom.

Moški se navadno ne držijo ure, ki je določena za obiske na oddelku, zanje ni pravil. [...] Na obisk pridejo tudi ob 21. uri. Sedaj, ko obiskov zaradi covida ni, izsiljujejo obisk na oddelku, češ da jim je zdravnik to dovolil, kar pa ne drži. (Ž59SN)

Intervjuvanci so v pripoved vključevali tudi jezikovne ovire in posebnosti obravnave. Vsi so večkrat

izpostavili problem nerazumevanja slovenskega jezika in odsotnost *lingue france*, saj albansko govoreči pacienti le redko govorijo katerega izmed tujih jezikov, na primer angleščino ali italijanščino.

Pacientki je težko kaj razložiti ali povedati, [...] med razlaganjem te samo gleda s široko odprtimi očmi. [...] Jo vprašaš, kako ji je ime, in ti ne ve povedati, jo vprašaš, kdaj je rojena, in ti ne ve povedati, če jo kaj boli, ti ne ve povedati, nič ti ne ve povedati. (Ž40SN)

Nejezikovne ovire in posebnosti albansko govorečih pacientov so povezane predvsem z navadami in običaji, ki izvirajo iz njihove kulture in tradicije. Intervjuvanci so navajali drugačne prehranjevalne navade, ohranjanje tradicije in tudi to, da so med medsebojnim komuniciranjem ali med izražanjem bolečine veliko glasnejši. Tri sodelujoče intervjuvanke so izpostavile, da je prehrana albansko govorečih pacientov pogosto neuravnotežena in da vsebuje veliko maščob. Navadno ne uživajo svinjskega mesa, zaradi strahu pred vsebnostjo svinjine v jedeh zavračajo bolnišnično hrano.

Zelo nezdravo se prehranjujejo, in če je le mogoče, jim partnerji prinesejo sokove, slane prigrizke, burek. Bolnišnično hrano pogosto zavračajo. [...] Vidimo, da se ne prehranjujejo pravilno. Svinjine ne jejo, a to razumem, to je njihova kultura. (Ž55SN)

Večina intervjuvancev je izpostavila, da je albansko govorečim pacientom izjemno pomembna družina in da so z njo tesno povezani. Po besedah ene izmed intervjuvank se povezanost z družino občuti tudi po porodu, ko za novorojenčka skrbijo stari starši, otročnica lahko počiva. Izpostavili so tudi druge tradicije albanske kulture, kot je na primer nošnja amuletov.

Nekateri novorojenčkov odpadli popek shranijo, a mi nikoli niso hoteli ali znali povedati, zakaj to počnejo. Enkrat sem nevede popek zavrgla in smo ga potem iskali po smeteh. (Ž38PN)

Načini razreševanja jezikovnih preprek

Intervjuvane osebe so izrazile nezadovoljstvo s trenutnim načinom razreševanja jezikovnih preprek, saj večinoma temelji zgolj na improvizaciji in tako pušča veliko prostora za napake. Opisovali so različne načine reševanja jezikovnih ovir. Najpogosteje so v okviru verbalne komunikacije omenjali neformalne tolmače. To so navadno partnerji, drugi sorodniki, prijatelji ali albansko govoreči zdravstveni delavci in sodelavci. Intervjuvanci dvomijo o zanesljivosti takšnega prevoda, saj ne morejo z gotovostjo trditi, da tovrstni tolmači v zadostni meri obvladajo oba jezika. Osem intervjuvancev je imelo izkušnjo, ko je bil v vlogo prevajalca postavljen otrok, ob čemer so izražali neprijetne občutke.

Najbolj elegantna rešitev so neformalni prevajalci, a se velikokrat zgodi, da niti oni ne govorijo dobro slovensko. [...] Včasih pridejo zraven otroci ali pa po

telefonu pokličejo prijatelja, ki zna malo bolje slovensko, [...] pač improvizacija. [...] Najbolj nevhvaležno je, ko prosiš otroka, da ti prevaja kdaj je imela njegova mama zadnjo menstruacijo in podobno. (M30PN)

V intervjujih sta kot druga dva načina reševanja jezikovnih preprek omenjena poznavanje skupnega jezika (italijanščina in angleščina) in uporaba Večjezičnega priročnika za lažje sporazumevanje v zdravstvu, ki je edini pripomoček v kliničnem okolju, imajo pa ga le na določenih deloviščih. Ena izmed intervjuvank je izpostavila, da njegova uporaba včasih ni mogoča.

Pomagam si s priročnikom. Pokažem na vprašanje v njem in potem pacienti nanj odgovorijo. [...] Sicer se ga redko poslužujem, ker pacienti govorijo različna narečja in včasih ne razumejo vprašanja. (Ž38PN)

Glede uporabe spletnega prevajalnika so bila mnenja deljena. Nekateri intervjuvanci ga pri razreševanju jezikovnih ovir uporabljajo vedno, spet drugi se ga ne poslužujejo, saj po njihovem mnenju njegova uporaba ni zanesljiva.

Aplikacije Google Translate si ne upam uporabljati, ker so ljudje lahko zelo občutljivi. Ko hočem pacientki nekaj povedati, ji prevajalnik prevede čisto nekaj tretjega. [...] Ne gre, lahko izpade še veliko slabše. (Ž40SN)

Poleg verbalne komunikacije je pri zdravstveni obravnavi albansko govorečih pacientov pomembna tudi neverbalna komunikacija, ki je po mnenju intervjuvancev včasih edini možni način komuniciranja. Z opazovanjem mimike in gestike lahko zdravstveni delavci pridejo do pomembnih informacij za zdravstveno obravnavo.

Opazujem pacientkin obraz, ali je razumela razlago in navodila ali ne. (Ž24SN)

Predlogi za razreševanje ovir pri zdravstveni obravnavi

Zadnji tematski sklop govori o predlogih medicinskih sester za dolgoročno in sistemsko razreševanje kulturnih in jezikovnih ovir, ki jih prinaša obravnavo albansko govorečih pacientov. Čeprav na to nimajo vpliva, je večina intervjuvanih izrazila željo po pripravljenosti albansko govorečih pacientov za učenje slovenskega jezika. Tako bi se lažje prilagodili slovenskemu zdravstvenemu sistemu in se akulturirali. Nekaj medicinskih sester je pri nekaterih pacientih že zaznalo proces prilagajanja na slovensko kulturo in jezik, pri drugih pa predlagajo vsaj osnovno znanje slovenskega jezika, saj so v nasprotnem primeru ogroženi, ker jih zdravstveno osebje težko razume in sta pomoč ter obravnavo oteženi. Dve intervjuvanki predlagata obvezno znanje osnov slovenščine že ob vstopu v državo.

Pošteno bi bilo, da se albansko govoreči pacienti naučijo vsaj osnovnih stvari, če že pridejo v tujo državo. [...] Z naše strani bomo težko karkoli naredili, ker je

albanski jezik drugačen od slovenskega in se mi ne zdi smiselno, da bi se ga učili. (M30PN)

Kot sistemsko rešitev problematike intervjuvani največkrat vidijo profesionalno tolmačenje, ki bi povečalo zanesljivost in varnost zdravstvene obravnave. Tolmači bi predstavljali posrednika med pacienti in zdravstvenimi delavci na najbolj objektivni možen način.

Menim, da bi morala imeti vsaka ustanova skupino uradnih prevajalcev, ki so dosegljivi 24 ur na dan. Če bi jih morali pacienti plačati sami, bi se veliko prej naučili slovenskega jezika. (Ž55SN)

Nekateri zdravstveni delavci rešitev vidijo v pridobivanju medkulturnih kompetenc, ki bi po njihovem mnenju olajšale obravnavo. Eden izmed intervjuvancev meni, da bi morali biti zdravstveni delavci do albansko govorečih pacientov potrpežljivi, razumevajoči in jim nuditi čim bolj enakovredno zdravstveno oskrbo. Opisuje tudi, da se morajo zdravstveni delavci učiti tujih jezikov ter tako tujcem omogočiti obravnavo v njihovem jeziku, drugi intervjuvanci pa poročajo, da to ni njihova dolžnost. Edino rešitev vidijo v tem, da se pacienti sami prilagodijo in naučijo slovenskega jezika.

Menim, da ima vsak pacient pravico, da dobi razlago zdravstvenega stanja in navodila v jeziku, ki ga razume. [...] Seveda se morajo tudi pacienti potruditi, da se naučijo in razumejo slovenski jezik, ampak vseeno mislim, da je pravica pacienta, da je seznanjen s svojim zdravstvenim stanjem in zdravljenjem. (M30SN)

Diskusija

Z raziskavo smo želeli ugotoviti, kakšne so izkušnje zaposlenih v zdravstveni negi z albansko govorečimi pacienti in s kakšnimi izzivi se srečujejo pri njihovi zdravstveni obravnavi. Ugotovitve raziskave potrjujejo, da se medicinske sestre pogosto srečujejo s tujegovorečimi pacienti, med katerimi prevladujejo albansko govoreči pacienti, ki hkrati povzročajo največ izzivov. Tudi avtorici Kocjančič-Pokorn & Lipovec-Čebren (2019) sta v sklopu anketne raziskave, ki je preučevala srečevanje zdravstvenih delavcev z uporabniki zdravstvenih storitev, ki ne govorijo slovenskega jezika (najpogosteje Hrvati, Srbi, Bošnjaki, Črnogorci in angleško govoreči pacienti), ugotovili, da imajo zdravstveni delavci največ komunikacijskih težav ravno z albansko govorečimi pacienti. Tako kot Huber et al. (2020) ter Štante et al. (2018) smo tudi mi ugotovili, da jih večina pri prvem stiku z albansko govorečimi pacienti občuti stisko, saj so zaradi otežene komunikacije izpostavljeni nezmožnosti nujenja ustrezne zdravstvene oskrbe in pomoči. Štante et al. (2018) so tako kot mi med razlogi navedli še nepoznavanje jezika in nerazumevanje pacienta, v sklopu možnosti nujenja pomoči pa so zaznali neznanje o tem, kako pristopiti k pacientu in navezati stik z njim. V raziskavi z naslovom *Analiza*

ranljivosti in neenakosti v zdravju v lokalnih skupnostih so intervjuvanci izpostavili, da jim obravnave albansko govorečih pacientov vzamejo več časa (Huber et al., 2020). To se je pokazalo tudi v rezultatih naše raziskave, saj so intervjuvanci izpostavili tako zahtevnejše kot tudi daljše obravnave.

Med izzivi, s katerimi se medicinske sestre srečujejo pri obravnavi albansko govorečih pacientov, so intervjuvanci navajali različne kulturne in jezikovne ovire. Izpostavili so podrejenost pacientk v odnosu do njihovih partnerjev, ki se kaže predvsem v partnerjevem prevzemanju vodilne vloge v pogovoru. Še do nedavnega je bila namreč za Albanijo značilna patriarhalna družbena ureditev, zato je spolna segregacija v kulturi še zelo ukoreninjena (D'Avanzo & Geissler, 2008). Tudi Ricci & Scrimin (2019) ugotavljata, da nekatere ženske albanske narodnosti pri odločanju o posegih čakajo na partnerjevo privolitev. Včasih največ povedo, ko so same, brez svojcev, zato jim morajo zdravstveni delavci vselej omogočiti tudi individualne pogovore. Sodelujoči intervjuvanci v projektu MoST so izpostavili, da so Albanke družbeno izolirane in nemotivirane ter se ne želijo vključiti v družbo (Huber et al., 2020). Iste avtorice poročajo tudi o ugotovitvah tujih raziskovalcev, ki pravijo, da sta v zahodnih državah posameznikova individualnost in avtonomija visoko cenjeni, kar pa ne velja za vsa kulturna okolja. Slednje je treba spoštovati. Sodelujoči v naši raziskavi posledice podrejenosti vidijo tudi v počasni akulturaciji albansko govorečih pacientk, ki veliko večino časa preživijo kot del albanske skupnosti in tako nimajo možnosti stika s slovensko kulturo in jezikom. Poleg naštetega so intervjuvanci v naši raziskavi izpostavili tudi neizobraženost albanskih pacientk. Ricci & Scrimin (2019) ugotavljata, da imajo v Albaniji deklice manj možnosti za srednješolsko izobraževanje kot dečki, kar se lahko odraža v splošni izobraženosti priseljenk.

V naši raziskavi so intervjuvanci izpostavili tudi druge kulturne značilnosti albansko govorečih pacientov, kot je močna povezanost z družino. Pogosto so opisovali pomembnost prisotnosti družinskih članov pri obravnavi tako z vidika prevajanja kot tudi spremljanja in podpore. Tudi D'Avanzo & Geissler (2008) opisujeta, da v albanski kulturi družina igra pomembno vlogo v skrbi za bolne in onemogle. Od družinskih članov se pogosto pričakuje, da poskrbijo za bolno osebo in ji nudijo potrebno podporo, kar je v povezavi s skrbjo za otročnico omenila tudi ena izmed naših intervjuvank. Sodelujoči v naši raziskavi so kot zadnjo posebnost v obravnavi albansko govorečih pacientov opisali glasno izražanje bolečine, kar je v nasprotju z ugotovitvami D'Avanza & Geisslerja (2008), ki poročata, da glasnejše izražanje ni značilno za albansko kulturo.

V intervjujih je pogosto prepoznana logika asimilacije, ko se od pacientov pričakuje, da kar se da hitro opustijo svoje prakse in se čim hitreje

povsem prilagodijo ustaljenim navadam večinskega prebivalstva. Vseeno pa velja poudariti, da posamezni intervjuvanci kažejo določeno mero odprtosti do navad, ki niso del slovenske kulture.

Intervjuvanci v naši raziskavi so kot skupne jezikovne ovire med albansko govorečimi pacienti zaznali pogosto odsotnost skupnega jezika (*lingua franca*), saj večinoma ne govorijo angleškega jezika (Lipovec-Čebren et al., 2019). Prav tako predstavlja veliko oviro njihovo nerazumevanje slovenščine. To potrjujeta tudi De Moissac & Bowen (2018), ki ugotavljata, da nerazumevanje jezika, v katerem poteka zdravstvena obravnava, pomembno prispeva k slabši kakovosti oskrbe pacientov. Najpogostejša oblika premoščanja jezikovnih ovir je uporaba neformalnih tolmačev. Kot Štante et al. (2018) ugotavljamo, da se zaposleni pri premagovanju jezikovnih ovir velikokrat poslužujejo tudi t. i. notranjih virov, kot so drugi zdravstveni delavci in sodelavci, zaposleni v zdravstveni ustanovi, ki prihajajo iz albanske skupnosti in so seznanjeni s kulturnimi navadami, običaji ter tekoče govorijo albanski jezik. Štante et al. (2018) navajajo tudi, da se zaposleni v zdravstveni negi v primeru odsotnosti notranjih virov pomoči zanašajo na pomoč zunanjih virov, kot so prevajalske službe. Tovrstna rešitev jezikovnih preprek se pri nas ni pojavila, so pa intervjuvanci izpostavili, da jezikovne ovire razrešujejo s pomočjo večjezičnega priročnika in spletnega prevajalnika. Al Shamsi et al. (2020) so ugotovili, da lahko uporaba spletnega prevajalnika izboljša kakovost zdravstvenega varstva in raven zadovoljstva med pacienti in zdravstvenimi delavci, medtem ko Guo (2016) in Patil & Davies (2014) temu nasprotujejo – uporaba spletnega prevajalnika se jim zdi primerna le v redkih situacijah in nikakor ne more nadomestiti profesionalnega tolmača. Tudi De Moissac & Bowen (2018) menita, da je uporaba omenjenega orodja neprimerna za podajanje zdravstvenih informacij.

Kot dolgoročne in sistemske ureditve problematike albansko govorečih pacientov intervjuvanci predlagajo razvijanje medkulturnih kompetenc pri zdravstvenih delavcih in vzpostavitev sistema profesionalnih tolmačev, ki po mnenju Al Shamsi et al. (2020) prinaša velike prednosti z vidika zadovoljstva pacientov in kakovosti zdravstvene obravnave. Dodajajo tudi, da se s prisotnostjo tolmača pri zdravstveni obravnavi poveča število obiskov tujegovorečih pacientov v preventivnih programih. Sistem tolmačenja pa ima tudi določene omejitve, kot sta vprašljiva stalna razpoložljivost tolmačev in pacientovo zaupanje (Ali & Watson, 2018).

Ugotovitve naše raziskave jasno kažejo, da je na področju obravnave albansko govorečih pacientov še veliko prostora za napredek, saj trenutna ureditev povzroča stiske pri zaposlenih v zdravstveni negi. Strinjamo se s predlogom intervjuvancev, vezanim na sistemsko reševanje, ki rešitev vidijo v organiziranem sistemu tolmačenja. V primerih, ko oviro predstavlja le

nerazumevanje slovenskega jezika, odgovor vidimo v vzpostavitvi tolmačenja na daljavo (videokonferenca), v primeru potrebe po razreševanju kompleksnejših, kulturno pogojenih ovir pa bi medkulturni mediator prišel v klinično okolje.

Kot omejitev raziskave bi izpostavili dejstvo, da je bila ta izvedena le na enem geografskem območju, kjer se lahko demografska struktura pacientov in s tem pogostost srečevanja razlikujeta v primerjavi z ostalimi deli države; prav tako se glede na geografsko območje lahko razlikuje tudi stopnja integriranosti albansko govorečih pacientov. Ena izmed omejitev je dejstvo, da je interpretacija podatkov odvisna tudi od raziskovalcev. Raziskovanje bi bilo smiselno nadaljevati s kvalitativno in kvantitativno raziskovalno paradigmo ter vanjo vključiti tudi doživljanja in izkušnje obravnave z vidika albansko govorečih pacientov.

Zaključek

Medicinske sestre se pri zdravstveni obravnavi pogosto soočajo z albansko govorečimi pacienti, kar jim predstavlja izzive, vezane na njihove kulturne navade in komunikacijske težave. Ustrezna usposobljenost medicinskih sester in razvoj njihovih medkulturnih kompetenc ter sistemsko reševanje z vzpostavitvijo profesionalnih tolmačev so ključni pri zagotavljanju lažjega sodelovanja medicinskih sester z albansko govorečimi pacienti. Vseeno se moramo zavedati, da čeprav predstavljene jezikovne ovire zelo otežujejo delo zdravstvenih delavcev, najtežje posledice teh ovir nosijo pacienti, ki so posledično deležni manj kakovostne zdravstvene oskrbe in so soočeni s slabo dostopnimi ali nedostopnimi zdravstvenimi programi.

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in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014).

Prispevek avtorjev/Author contributions

Avtorji so raziskavo konceptualno zastavili skupaj. Prvi trije avtorji so sodelovali pri zbiranju, analizi in interpretaciji podatkov. Četrty in peti avtor sta sodelovala pri metodološki zasnovi raziskave, opravila kritični pregled osnutka in dopolnila končno različico članka. Avtorji so prebrali in odobrili končni prispevek./The authors jointly conceptualised the study design. The first three authors have collected all data, contributed to the analysis and interpretation of the gathered data. The fourth and fifth authors contributed to drafting the methodological concept of the research, prepared a critical review of the article and completed the final version of the article. The authors read and approved the final version of the paper.

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Review article/Pregledni znanstveni članek

Comparison of community health nurses' preventive home visits to older adults in Sweden and Slovenia: A literature review

Primerjava preventivnih obravnav starejših odraslih v patronažnem varstvu med Švedsko in Slovenijo: pregled literature

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Ključne besede: oskrba; preventiva; domače okolje; zdravstvena nega

Key words: care; prevention; home environment; nursing

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ABSTRACT

Introduction: Community health nurses contribute significantly to better health, well-being and independence of older adults. The aim of the study is to compare preventive services for older adults in community health care between Sweden and Slovenia.

Methods: Literature review and document analysis were used to conduct a qualitative comparative analysis. Literature was retrieved from the MEDLINE, CINAHL and COBIB databases. An analysis of documents such as sectoral legal bases, guidelines and expert recommendations in Slovenia and Sweden was also conducted. The analysis included sources related to preventive services for older adults living at home published between January 2000 and December 2020 in Slovene, English or Swedish.

Results: Twenty units of literature were included in the review. Four comparative factors were identified: system and legal basis, organisation and scope, providers, and content. In Slovenia, all older adults are entitled to the same range of preventive services. Compared to Sweden, the organisation of community health care in Slovenia is more centralised, all older adults are entitled to the same scope of preventive health visits, while the level of education and scope of competences of healthcare providers are lower. In both countries, the content of preventive home visits to older adults is similar.

Discussion and conclusion: In Slovenia, community health nurses with additional knowledge could prescribe medical devices and medications form a limited list, as well as coordinate care. This would allow them to act more independently in patients' home environment. Further development of more personalised preventive services for older adults depends on research, resource provision and consideration of the organisational culture.

IZVLEČEK

Uvod: Preventivne obravnave v patronažnem varstvu pomembno prispevajo k samostojnosti, boljšemu zdravju in dobremu počutju starejših odraslih. Namen raziskave je primerjati preventivne obravnave starejših odraslih v patronažnem varstvu med Švedsko in Slovenijo.

Metode: Na osnovi pregleda literature in analize dokumentov je bila narejena kvalitativna primerjalna analiza. Vključena je bila literatura iz podatkovnih bazah MEDLINE, CINAHL in COBIB. Narejena je bila tudi analiza dokumentov, kot so področne pravne podlage, smernice ter strokovna priporočila v Sloveniji in na Švedskem. Vključeni so bili viri objavljeni med januarjem 2000 in decembrom 2020, so se nanašali na preventivne obravnave starejših odraslih, ki živijo doma in so bili napisani v slovenščini, angleščini ali švedščini.

Rezultati: V analizo smo vključili 20 enot literature. Opredeljeni so bili štirje faktorji primerjave: sistem in pravne podlage, organiziranost in obseg, izvajalci ter vsebina. V Sloveniji so vsi starejši odrasli upravičeni do enakega obsega preventivnih obravnav. V primerjavi s Švedsko je v Sloveniji bolj centralizirana organizacija patronažnega varstva, vsi starejši odrasli imajo enak obseg preventivnih obiskov, izobrazba in obseg kompetenc izvajalcev pa je v Sloveniji nižja. Vsebinske preventivnih patronažnih obiskov starejših odraslih je v obeh državah podobna.

Diskusija in zaključek: V Sloveniji bi lahko medicinske sestre v patronažnem varstvu z dodatnimi znanji pridobile tudi kompetence na področju predpisovanja z omejene liste zdravil in medicinskih pripomočkov ter koordinacije oskrbe. Tako bi lahko bolj samostojno delovale v domačem okolju pacientov. Za nadaljnji razvoj bolj personaliziranih preventivnih obravnav za starejše odrasle je pomembno raziskovanje, zagotavljanje virov in skrb za organizacijsko kulturo.



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Introduction

The silvering of the developed world also includes Slovenia and Sweden, with both countries facing all the challenges of an ageing society. According to Eurostat (2020), the proportion of people aged over 65 in Slovenia has increased over the past decade from 16.4% in 2009 to 19.8% in 2019, while Sweden has recorded an increase from 17.8% to 19.9% over the same period (Table 1). Although this proportion is somewhat lower than the European average in both countries, these trends point to a more intense ageing of the population in the future.

Available Eurostat data show that the trend in population ageing is faster in Slovenia compared to Sweden. According to demographic projections, Slovenia will be the European Union (EU) country with the largest proportion of older adults by 2050 (He, Goodkind, & Kowal, 2016). Slovenia and Sweden have almost the same life expectancy at age 65 (21.80 vs. 21.60) (Organisation for Economic Co-operation and Development [OECD], 2021a). Slovenia is affected by a relatively low health expectancy for people aged 65 (only 7.4 years), while Sweden (with 15.7 years) ranks first in the EU (Statistični urad Republike Slovenije [SURS], 2020; OECD, 2021a; Statistiska centralbyrån, 2021). According to 2010 data, Slovenia and Sweden spent 8.3% and 8.5% of their gross domestic product (GDP) on health care per year respectively, with Sweden increasing its health expenditure over the last decade to reach 10.9% of GDP in 2018, while health expenditure in Slovenia remained at 8.3% of GDP (OECD, 2021b).

Trends of an ageing population in Slovenia are expected to lead to an increase in the need for health and social care services (Howdon & Rice, 2018). Our contemporary society is characterised by an extremely rapid development of societies and thus also of health care. At the same time, the morbidity of the ageing population is changing towards increasing comorbidity and multimorbidity, which is accompanied by constant changes in treatment approaches and economic issues in health care. As people grow older, their physical and mental abilities gradually decline and complex health problems increase (Cohen-Mansfield et al., 2013). Multimorbidity is present in up to 97% of older adults in developed societies (Prados-Torres, Calderón-Larrañaga, Hanco-Saavedra, Poblador-

Plou, & Van Den Akker, 2014; Nguyen et al., 2019). Health and well-being, also in old age, are the key factors for independence and good quality of life. Therefore, it is very important for older adults to be supported by healthcare and other systems. To protect the health of older adults, it is also important to ensure continuous health monitoring, preventive measurements, and timely action. Monaro, White, & West (2015) emphasise that it is essential to maintain a continuum of care between the hospital and the home. Vertical integration between healthcare providers is also becoming increasingly important as healthcare delivery to patients in the community becomes more intensive, calling for a cross-system approach that focuses on integration and coordination of services (Bryce et al., 2014).

Nurses working in patients' homes or in community services therefore face major challenges (Krajnc, 2013) in providing continuous and integrated care with an emphasis on preventive activities and the active role of patients. An important task for nurses, including those working in patients' homes, is to focus on four basic tasks: promoting health, preventing illness, restoring health, and alleviating patients' suffering, so as to help manage diseases and support rehabilitation (International Council of Nurses, 2012; World Health Organisation [WHO], 2017). Furthermore, nurses working in such a demanding and dynamic environment need to be available to provide continuous support to carers, ensuring quality care for people through education, training and leadership (Bryce et al., 2014).

Community health nursing is a specific form of health care that provides active health and social care to individuals, families, and communities (WHO, 2017). Nurses working in communities and patients' homes support a healthy lifestyle and help identify risk factors also among older adults (Krajnc, 2016; Dravec et al., 2017; WHO, 2017). In Slovenia, nursing activities are the responsibility of registered nurses, while nursing assistants and nursing aids may also be involved in the delivery of curative activities and care (Kadivec et al., 2011; Železnik, Horvat, Panikvar Žlahtič, Filej, & Vidmar, 2011). Community health nursing is characterised by the field concept of working in a specific geographical area (WHO, 2017).

Most developed countries support older adults to delay their move into nursing homes and to help

Table 1: Proportion of the population aged 65 and over (Eurostat, 2020)

Tabela 1: Delež populacije nad 65 let (Eurostat, 2020)

Country, year / Država, leto	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
European Union	17.3	17.5	17.6	17.9	18.2	18.5	18.9	19.2	19.5	19.7	20.0
Slovenia	16.4	16.5	16.5	16.8	17.1	17.5	17.9	18.4	18.9	19.4	19.8
Sweden	17.8	18.1	18.5	18.8	19.1	19.4	19.6	19.8	19.8	19.8	19.9

them continue living in their own homes for as long as possible. As a result, the importance of preventive home visits (PHVs) has increased in recent decades. According to Bannenberg et al. (2021), PHVs have an impact on reducing institutionalisation of care in Norway. PHVs have also been found to have an impact on reducing mortality, hospital admissions and improving health status in the population over 80 years of age. Through their interventions, community health nurses encourage older adults to take an active role and responsibility for their health and well-being, thereby improving their quality of life (Maček, Skela-Savič, & Zurc, 2011).

Aims and objectives

The aim of the literature review and document analysis conducted in this study is to compare the Slovene and Swedish systems of PHVs provision by community health nurses to older adults living at home. We formulated the following research question: According to the analysis of preventive health services for older adults in Sweden, how could PHVs to older adults living at home be improved in Slovenia?

Methods

Review methods

The literature review and document analysis relied on a qualitative comparative analysis, which focused on the macro level (community health nursing) as suggested by Esser & Vliegenthart (2017). This approach provides a clearer understanding, description and analysis of complex community health nursing (Healy, Tang, Patcharanarumol, & Annear, 2018). We reviewed the literature on community health nursing for older adults between Slovenia and Sweden with a focus on PHVs to older adults. We searched for relevant full-text articles in the MEDLINE and CINAHL bibliographic databases and the COBIB database through the EBSCOhost information service. We compiled the search terms in text form using the Boolean logical operators, and the following keywords: "starostnik", "patronaža", "elderly care", "primary health care", "preventive home visits", "community nurse", "district nurse", "health care system", "Sweden", "Slovenia". We also focused on Slovene and Swedish legal sources, guidelines and recommendations, which form the basis for conducting PHVs to older adults living at home.

The following primary inclusion criteria were used: availability of articles in full text published in Slovene, English or Swedish between January 2000 and December 2020, and population aged 65 years and over. If the record was relevant, we also included literature from older publications. Secondary inclusion criteria were preventive services, home-based approach and nursing profession. Our exclusion

criteria included curative treatment of older adults or younger population, treatment in an institution, and diploma or master's thesis.

Results of the review

By searching electronic databases based on our inclusion and exclusion criteria, we identified 558 records and narrowed down the number of sources to be included in the final analysis. We also searched websites of public health institutions and nursing association for additional sources, and included guidelines and recommendations. We also included legislation on the preventive services provided by nurses in the home setting. A total of 20 records were included in the final review. Figure 1 shows the systematic nature of the literature review process using the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) diagram (Page et al., 2021).

Results

We identified differences in the provision of PHVs to older adults between the Slovene and Swedish healthcare systems. The defined factors for comparison were system and legal basis, organisation and scope, providers, and content of PHVs (Table 2).

The following section provides a more detailed comparison of the implementation of PHVs to older adults between Slovenia and Sweden based on our literature review by individual factors.

System and legal basis for preventive home visits

In Slovenia, the health care system is organised at tertiary, secondary and primary level (Ministrstvo za zdravje, n.d.). Primary health care is provided mostly by community health centres, which are owned and managed by municipalities, while other healthcare providers are privately managed and operate on the basis granted concessions, which ensure inclusion into the network of publicly financed health care (Pravila obveznega zdravstvenega zavarovanja, 2003; Zakon o zdravstveni dejavnosti [ZZDej], 2005). In 2019, there were almost 729 registered nurses, 105 nursing assistants and some other employees working in 212 municipalities in community health nursing (Renar & Zavrl Džananović, 2020). PHVs are part of primary health care and are fully covered by compulsory health insurance. For persons who are not covered by compulsory health insurance, treatment costs are covered from other sources (Pravilnik za izvajanje preventivnega zdravstvenega varstva na primarni ravni, 1998; Pravila obveznega zdravstvenega zavarovanja, 2003). Ensuring the rights and implementation of preventive screening programmes and early detection of risk factors for chronic non-communicable diseases, including screening tests, and health promotion services,

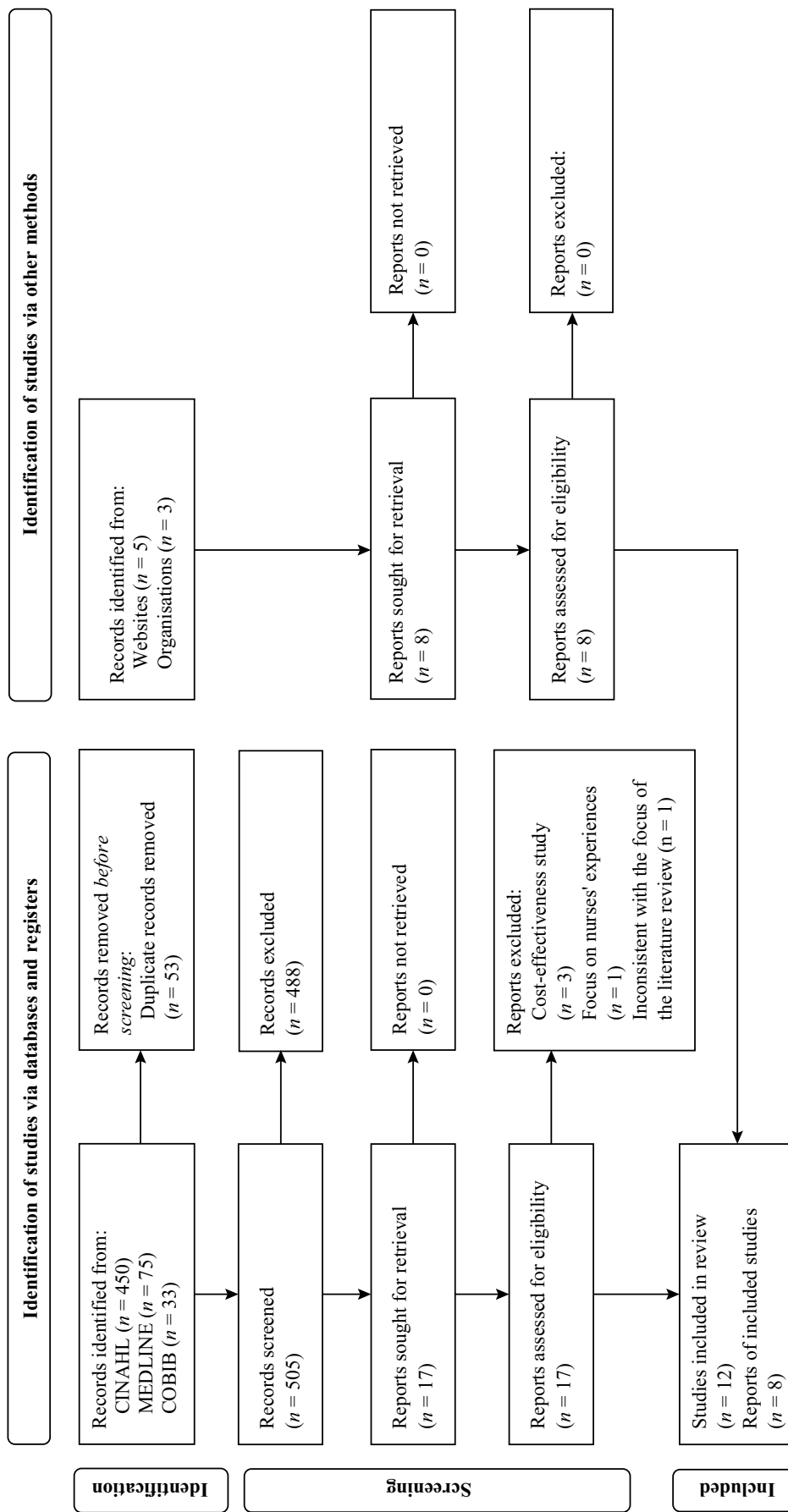


Figure 1: PRISMA flow diagram of literature review
Slika 1: PRISMA diagram pregleda literature

Table 2: Differences between the two countries in conducting preventive home visits to older adults by selected factors**Tabela 2:** Razlike med državama pri izvedbi preventivnih obravnav starejših odraslih v patronažnem varstvu po nekaterih izbranih faktorjih

Factor of comparison/ Faktorji primerjave	Slovenia/Slovenija	Sweden/Švedska
System and legal basis	Mostly centralised approach and financed, but municipally managed.	Decentralised approach, council/municipality managed and financed.
Organisation and scope	Nurses are employed by community health centres or self-employed (concession). Equal scope for the entire country. 2 PHVs per year to people aged 65 years and over.	Nurses are mainly employed by health centres but also by municipalities. Age (usually 75+ or older) and frequency (1 to 5 per year or rarer) of PHVs differ among municipalities.
Providers	Registered nurses (at least higher education – 3 years). Some nurses have a specialisation in community health nursing.	Registered nurses (higher education – 3 years), 8 weeks of pharmacology course, specialisation in primary care – 75 ECTS.
Content	Physical examination Physical, social, and economic assessment Health education Medication utilisation Ensuring continuity and coordination of care Prevention of violence Infection prevention Family support Collaboration with different professionals.	Information, counselling/guidance on: – home exercise – incontinence – pharmacological counselling – home care services – adapting the home environment – smoke detectors, checking – municipality services and activities – legislation and assistance – public transportation Fall risk assessment and advice Driving capacity assessment Advice and support for family members/carers.

Legend/Legenda: ECTS – European Credit Transfer and Accumulation System/Evropski sistem prenašanja in zbiranja kreditnih točk; PHV – preventive home visits/preventivne obravnave v patronažnem varstvu

together with guidelines for their implementation, are established by the Minister of Health on the proposal of the Health Council (Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju, 2006).

According to the current legislation, older adults can be included in preventive services provided by community health nursing if they are over 65 years of age, lonely and socially disadvantaged, or if they are patients with chronic diseases and over 25 years of age. Community health nurses also visits people who do not respond to invitations to participate in national prevention programmes (ZORA, DORA, Svit) (Pravilnik za izvajanje preventivnega zdravstvenega varstva na primarni ravni 1998, 2002, 2007; Pravila obveznega zdravstvenega zavarovanja, 2003; Berčan & Krajnc, 2016).

The Swedish healthcare system is organised at three levels: national, regional, and local. At the regional level, 17 district councils and nine regional bodies are responsible for financing and providing healthcare services to citizens. At the local level, 290 municipalities are responsible for the care of older adults and people with disabilities (Anell, Glengård, & Merkur, 2012). There is no hierarchy between individual municipalities, district councils and regions, as they have self-governing local authorities responsible for various activities in their area, including health care (Marczewska, 2011). The local and regional authorities

are represented by the Swedish Association of Local Authorities and Regions (SALAR) (Anell et al., 2012).

Within the Swedish healthcare system, different district councils have different forms of health care provision. Each district council decides for itself on the organisation of primary health care, including the implementation of PHVs performed by nurses. One of the main changes in recent years has been that the responsibility for the care of older adults has been transferred from district councils to municipalities. According to this, municipalities have to care for older adults and support them in maintaining their health. In Sweden, if a person needs help to maintain a decent standard of living, they are entitled to support, regardless of the level of dependency (Anell et al., 2012).

Organisation and scope of preventive home visits to older adults

Community health nurses in Slovenia work in the field, at the homes of individuals and families, and in the local community. Community health nursing is provided throughout the country, with each nurse covering an area of 2200–2500 inhabitants (Šušteršič, Horvat, Cibic, Peternelj, & Brložnik, 2006). Community nursing services are provided by nurses who are employed by primary health care centres or self-employed on the basis of a granted

concession (ZZDej, 2005; Albreht et al., 2016). The rules on compulsory health insurance (Pravila obveznega zdravstvenega zavarovanja, 2003, Article 26) in Slovenia guarantee the right of insured persons to access basic healthcare services, which include community health care and the right to PHVs (Article 27) from the nearest community health service (Article 160). The rules on the implementation of preventive healthcare services at the primary level stipulate that in-depth individual and family treatment is required, especially for vulnerable groups, including older adults and people with chronic diseases. Based on these rules, community health nurses may visit older adults who are lonely or socially vulnerable or persons with chronic diseases twice a year to help them maintain their health and provide support to the persons and their families for the best possible quality of life in the home environment (Pravilnik za izvajanje preventivnega zdravstvenega varstva na primarni ravni, 1998). The aim of nurses' activities in PHVs to older adults is to maintain well-being, promote self-care, provide information about various forms of assistance and services available in their home environment, identify health risk factors, reduce the consequences of illness, and implement therapeutic programmes as directed by the physician (Berčan & Krajnc, 2016).

In Sweden, the primary healthcare system is organised by district councils and municipalities. Each district council, together with the municipality, can decide how to provide medical and nursing care (Sherman, 2012). Most municipalities provide PHVs to older adults who live at home and do not need additional care. Nurses usually visit persons over the age of 75 (this varies from municipality to municipality), as well as younger people in need. The number of visits and the duration of the visit also vary from municipality to municipality, with one to five visits usually conducted over a period of one year or more (Socialstyrelsen, 2019). There are municipalities that have restricted eligibility for PHVs in terms of age. In Stockholm, for example, the age limit for PHVs is 75 years (Sherman, 2012), while in Härryda, a small municipality in the southwestern region of Sweden, the age limit is 81 years (Härryda Kommun, n.d.).

Providers of preventive home visits

The provider of nursing activities in Slovenia is a person who has completed at least higher education in nursing (Skela-Savič, 2015; Ažman & Prestor, 2019). The nursing profession is regulated and, in accordance with European Union directives, during their studies students acquire profession-specific competences for independent planning and delivery of nursing care in accordance with the nursing process (Železnik et al., 2011; Skela-Savič, 2015; Ažman & Prestor, 2019). The

undergraduate nursing degree programme in Slovenia lasts three years. After graduation, newly graduated nurses can perform nursing activities independently, including in community health care. Nurses can also call in nursing assistants when curative services are needed (Šušteršič et al., 2006; Ažman & Prestor, 2019).

In Sweden, nurses must have a higher education degree. To work in community health care, they must also complete a specialisation in primary care. As part of this requirement, they must complete 50 weeks of specialist training, earning 75 credits (European Credit Transfer and Accumulation System [ECTS]). Since 1994, community health nurses working with older adults have been able to prescribe medications from a limited list. To be able to do so, they must first successfully complete an eight-week pharmacology course which is integrated into the specialisation year. This provides them with a license to prescribe certain medications and medical devices (Mardby, Jakobsson, & Hedenrud, 2014).

Content of preventive home visits of older adults

The aim of preventive home visits is to improve the quality of life in older people. The tasks of community health nurses in Slovenia are described as follows (Pravilnik za izvajanje preventivnega zdravstvenega varstva na primarni ravni, 1998; Berčan & Krajnc, 2016):

- Preparing for field work (family documentation, health education materials, nursing aids),
- Conducting physical examination of older adults (weight, height, mobility, health status, mental state) and checking their vital functions, pain assessment,
- Performing health education activities with families and older adults (nutrition, care, independence, possibility of arranging meals through a service provider, health insurance rights, protection of older adults, arranging nursing home admission or household assistance, support to improve the quality of life, education about diseases, referrals for regular check-ups, familiarisation with associations and non-governmental organisations, health education for the family and older adults with a view to strengthen and maintain health and prevent illness, support for early disease detection, coordination of nursing of care at home),
- Ensuring continuity of care,
- Reviewing knowledge and awareness of the use of prescribed therapy and other medications and dietary supplements,
- Assessing the immediate and wider environment: architectural arrangement, hygienic condition,
- Assessing the threats of domestic violence,
- Implementing infection prevention measures,
- Assessing the individual's social and economic situation and supporting them in resolving troubled

situations,

- Supporting family relationships,
- Providing information about other services and coordinating care,
- Informing the physician and other agencies as necessary.

Providers of PHVs to older adults in Sweden must follow a protocol consisting of 12 elements (Behm, Ivanoff, & Zidén, 2013):

- Providing information, advice, and guidance on a basic (balance) workout programme including exercises,
- Performing fall risk assessments, providing prevention checklists and information and advice on how to identify fall risks and how to stay active and safe,
- Providing information and advice on technical aids and housing changes, and, if necessary, information on where and to whom to turn for help,
- Providing information and advice about the use of smoke detectors, and, if needed checking the smoke alarm,
- Providing information on the help and support services available in the municipality (volunteers, churches, missions, health centres etc.), and on who to contact for help in case of health problems and illnesses, as well as opening hours and contact information,
- Providing information on the possibility of making an appointment with a pharmacist to check and advise on the patient's medication,
- Providing information and advice on incontinence,
- Presenting and delivering a brochure with information on Swedish legislation and the possibilities of professional counselling and assessment of driving capacity,
- Providing information and advice on what the municipality can offer in the form of local meeting places, activities run by local associations, such as physical exercise for older adults and various workshops, different types of help and support provided by volunteers or professionals,
- Offering participation in activities, group visits to local meeting places, courses in digital technology, clubs for seniors, gyms for seniors, Nordic walking groups, etc.,
- Providing information on public transport, including busses adapted for (older) people with disabilities,
- Providing information on the Social Services Act, and who to contact in the municipality to apply for home care services.

In Sweden, community health nurses provide advice and support to patients, families, and other carers individually or in groups (Sherman, 2012). They also provide information on how older adults can contact the appropriate institutions in case of other problems (Dahlin-Ivanoff et al., 2010).

Discussion

The comparison of PHV provision between Sweden and Slovenia based on our literature review and document analysis shows that Slovenia may have a better legal basis for a more comprehensive and earlier implementation of PHVs, as these are offered to people who are ten years or more younger than in Sweden, which also means better maintenance of well-being and earlier detection and prevention of problems and diseases in older adults. In Slovenia, older adults are entitled to two PHVs from the age of 65 onwards. In Sweden, PHVs are generally promoted from the age of 75 onwards; however, the entry age and the number of PHVs depend on the person's region of residence and are based on a decision by the district council together with the municipality. With the expansion of prevention programmes in Slovenia in 2021 (Horvat, Mihevc Ponikvar, & Krajnc, 2021), PHVs to older adults are available to all people aged 65 and over regardless of their social status or presence of disease. Community health nurses identify risk factors and provide more PHVs if needed.

Sweden has a different organisation of PHVs and more experience in researching, providing, and adapting PHVs to older adults and might therefore be more successful, as is indicated by its population's longer life expectancy and healthy life years. Sweden could be more aware of the importance of PHVs and seems to provide timely preventive services at home, at least in some municipalities. Through the municipality-based organisation of preventive services, they can adapt interventions to meet people's needs, there is perhaps more democracy and opportunities for personalisation of PHVs. In Slovenia, primary health care is the responsibility of municipalities, but they have not been actively involved in the provision of PHVs (Albreht et al., 2016). It would therefore be sensible to encourage them to take a more active role in assessing the needs related to health and well-being of all citizens, including older adults.

Activities of Slovene community health nurses are primarily focused on prevention. However, it is difficult to determine the amount and successfulness of the preventive services provided from the available data. In practice, preventive and curative services are interwoven (Krajnc, 2016), and the preventive part of services cannot always be properly documented (Hrovatin, Govc-Eržen, Medved, Milavec Kapun, & Horvat, 2015). Statistical data for Slovenia (Petrović & Zavrl Džananović, 2021) show that in 2019 PHVs accounted for only 14.9% of all community health nursing services in Slovenia (of which the share of PHVs to older adults accounted for only 1.7%). In the last decade, there has been a considerable decline in PHVs to older adults (by 71%). Other healthcare services are characterised by a focus on and rapid development of curative services, and therefore also by

the provision of better technical and financial support.

In terms of content, PHVs in Slovenia and Sweden are very similar in that their focus is on health education of older adults and their families through the provision of information about other services, activities, and organisations. The content of health education is not specified in detail. This could depend on individual providers or established doctrine. In Slovenia, the content of PHVs focuses more on physiological health (e.g., physical examinations, nutrition). In Sweden, a slightly more pronounced promotion of social health and active living was observed, which is also evident from the established protocols (Löfqvist, Eriksson, Svensson, & Iwarsson, 2012). The new upgrade of PHVs in Slovenia seems to focus more on social health (Horvat et al., 2021). According to a study conducted in Norway, this focus may be correct, as poorly perceived health was associated with health-related risks among older adults at home, suggesting that preventive health programmes need to focus on social and lifestyle factors (Fjell et al., 2018). Health promotion, risk prevention and better social participation need to be addressed during PHVs (Nivestam, Westergren, Petersson, & Haak, 2020, 2021). Based on the results of a study conducted in Sweden (Sherman, Söderhielm-Blid, Forsberg, Karp, & Törnkvist, 2016), it would be useful to examine the effects of improved PHVs to older adults and to dynamically adjust the scope and content of PHVs in Slovenia as well.

The new instructions for community health nurses in Slovenia highlight the role of different preventive services for patients, families and/or significant others, which include different tests and assessments (Horvat et al., 2021). According to the conclusions of a Swedish study (Lannering, Lannering, Ernsth Bravell, & Johansson, 2017), a structured preventive process only partially facilitates different healthcare providers (including nurses) to improve the quality of care. The assessment tools were not considered to be close to reality. Based on these findings, it would be beneficial to investigate the usefulness of the newly included assessment tools in PHVs to older adults in Slovenia.

In Sweden, although community health nurses play a significant role in ensuring safe medication management for older adults, this role is not sufficiently recognised (Lagerin, Törnkvist, Nilsson, Johnell, & Fastbom, 2020). In Slovenia, this is part of PHVs in relation to adherence to the medication plan but not in relation to dealing with polypharmacy and inappropriate medication use. Due to the increasing multimorbidity and the resulting higher number of prescribed medications also in Slovenia, this aspect should be included more in PHVs to older adults.

The educational level of Swedish community health nurses is higher than that of Slovene community health nurses. As a rule, they must complete a one-year specialisation for district nurses (primary health care specialisation), during which they acquire additional knowledge, including that needed to prescribe

medications and medical devices (Jangland et al., 2014), which is also the case in 11 EU countries and the United Kingdom (Maier, 2019). In Slovenia, there is a noticeable lack of specialisation for community health nursing, as there are only nine nurses with this specialisation (Zavrl Džananović, 2018). Thus, there is a clear need to reintroduce it and to determine the content and areas of urgently needed specialised knowledge and competences for these nurses. Following the example of Sweden and other EU countries, Slovene community health nursing could also include competences for prescribing medical devices and medications from a limited list. Therefore, Swedish community health nurses are independent and competent providers and have the highest competence level among professional home care providers (Josefsson & Peltonen, 2015). In Slovenia, the transfer of competences from physicians to community health nurses would decrease the burden on physicians, improve the adaptation of interventions to older adults at home and thus reduce the burden on the health system.

According to Slovene documents (Železnik et al., 2011), community health nurses are coordinators of all forms of care and assistance for patients at home. They can identify patients' needs for different services, make assessments and give advice on finding relevant providers. In practice however, they do not have the authority to coordinate the work of different providers. The importance of integrated and coordinated services at home are recognised by the newly adopted Long-Term Care Act (Zakon o dolgotrajni oskrbi, 2021), and now community health nurses have the possibility to take the position of coordinators.

A Swedish study (Brobeck, Odenrants, Bergh, & Hildingh, 2013) shows that while community health nurses would like to conduct PHVs, especially with older adults with or without symptoms of illness, they feel that those who are already ill need more of their time. For better quality of care, it is necessary to identify barriers, facilitators and dilemmas in order to improve the training of PHV providers and promote the development of this field (Lagerin, Törnkvist, & Hylander, 2016).

In both countries, there is a general awareness of the importance and benefits of PHVs for older adults. In Sweden, PHVs have been evaluated as a very cost-effective approach (Sahlen, Löfgren, Mari Hellner, & Lindholm, 2008) that promotes health and quality of life in old age, as well as patients' feelings of safety and being well informed (Gleason, 2017; Nivestam et al., 2020). Nurses are recognised as suitable professionals for health promotion (Kemppainen, Tossavainen, & Turunen, 2013), but there is a need to ensure an appropriate organisational culture in nursing as an important factor for a successful implementation of health education and health promotion. Therefore, more time and resources are required to develop successful health-promotion initiatives.

PHVs to older adults have a wide range of positive effects on patients and their families, which go beyond reducing societal costs (Zingmark, Norström, Lindholm, Dahlin-Ivanoff, & Gustafsson 2019), although some studies (Brettschneider et al., 2015; Liimatta, Lampela, Kautiainen, Laitinen-Parkkonen, & Pitkala, 2020) argue against their cost-utility. According to a Finnish study, PHVs provided by a multidisciplinary team have a positive effect only on health-related quality of life in older adults (Liimatta et al., 2020). For more successful PHVs, comprehensive geriatric assessment, follow-up visits, and a focus on the younger population are important (Tourigny et al., 2015). When developing preventive community/home-based nursing interventions, aspects such as programme duration, frequency of visits, providers and age of the target group should be considered.

Sweden has one of the best healthcare systems in the world, and the longest life expectancy and healthy life years in Europe (Eurostat, 2021). In 2019, Slovenes rated their health significantly worse than their Swedish peers (OECD, 2021a). Regardless of community health nurses' efforts to improve the health of older adults, a culture of health and well-being across the lifespan needs to develop among Slovene citizens. There are many factors that influence a person's health and well-being. In Slovenia as well, the sole activity of community health nurses might have only a limited impact on the health of older adults.

This qualitative comparative analysis provides an opportunity to explore new and diverse possibilities for mutual learning through examples of appropriate and effective PHVs to older adults. It provides an opportunity to reflect on the transformation of existing approaches. Through timely preventive services, we can repay older adults for their contribution to a better society during the active phase of their lives.

The results of this study should be interpreted with caution. Nevertheless, the comparison increases the explanatory power for inductive conclusions: Would preventive services for older adults in Sweden also work in Slovenia? This also increases the power of a deductive explanation: What are the exceptions to the generalisation? It would be particularly useful to modify the Swedish examples of good practice before successfully transferring them to the Slovene context.

Conclusion

Our literature review shows that there are several levels of differences between the two countries. There are significant differences in eligibility requirements for PHVs between the countries compared, and clear differences between community health nurses who in Sweden have higher educational levels and a broader range of competences. We see room for improvement in Slovene community health nurses' specialisation and acquisition of knowledge and competences that

would allow for their greater independence in working and prescribing medical devices and medications from a limited list. There are several opportunities for further research in Slovenia, including research on the impact of PHVs on older adults, the implementation of evidence-based prevention interventions, and the examination of community health nurses' attitudes towards preventive healthcare services.

Conflict of interest/Nasprotje interesov

The authors declare that no conflicts of interest exist./Avtorice izjavljajo, da ni nasprotja interesov.

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Ethical approval/Etika raziskovanja

No approval by the National Medical Ethics Committee was necessary to conduct the study due to the selected research methodology./Za izvedbo raziskave glede na izbrano metodologijo raziskovanja dovoljenje ali soglasje Komisije za medicinsko etiko ni bilo potrebno.

Author contributions/Prispevek avtorjev

MMK – introduction, methods, results, discussion, and conclusions/uvod, metode, rezultati, diskusija in zaključki

NM – research conceptualization, paper review and final approval/konceptualizacija raziskave, pregled prispevka in končna odobritev

SH – introduction, methods, results, discussion/uvod, metode, rezultati, diskusija

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NAVODILA AVTORJEM

Splošna navodila

Članek naj bo napisan v slovenskem ali angleškem jeziku, razumljivo in jedrnato. Revija sprejema izvirne znanstvene in pregledne znanstvene članke. Izvirni znanstveni članek, naj bo dolg največ 5000 besed in pregledni znanstveni članek največ 6000 besed, vključno z referencami. Avtorji naj uporabijo Microsoft Wordovi predlogi, ki sta dostopni na spletni strani uredništva (Naslovna stran in Predloga za izvirni znanstveni/pregledni članek). Vsi članki, ki so uvrščeni v uredniški postopek, so recenzirani s tremi anonimnimi recenzijami. Revija objavlja le izvirna, še neobjavljena znanstvena dela. Za trditve v članku odgovarja avtor oziroma avtorji, če jih je več (v nadaljevanju avtor), zato morajo biti podpisani s celotnim imenom in priimkom. Navesti je potrebno korespondenčnega avtor (s polnim naslovom, telefonsko številko in elektronskim naslovom), ki bo skrbel za komunikacijo z uredništvom in ostalimi avtorji. Avtor mora pri oddaji članka dosledno upoštevati navodila glede standardizirane znanstvene opreme, videza in tipologije dokumentov ter navodila v zvezi z oddajo članka. Članek bo uvrščen v nadaljnjo obravnavo, ko bo pripravljen v skladu z navodili uredništva.

Če članek objavlja raziskavo na ljudeh, naj bo v podpoglavju metod *Opis poteka raziskave in obdelave podatkov* razvidno, da je bila raziskava opravljena skladno z načeli Helsinško-Tokijske deklaracije, opisan naj bo postopek pridobivanja dovoljenj za izvedbo raziskave. Eksperimentalne raziskave, opravljene na ljudeh, morajo imeti soglasje komisije za etiko bodisi na ravni ustanove ali več ustanov, kjer se raziskava izvaja, bodisi na nacionalni ravni.

Naslov članka, izvleček, ključne besede, tabele (opisni naslov in legenda) ter slike (opisni naslov oziroma podpis in legenda) morajo biti v slovenščini in angleščini, leto velja tudi za angleško pisane članke, le da so v tem primeru našteje notne navedene najprej v angleščini in nato v slovenščini. Skupno število slik in tabel naj bo največ pet. Tabele in slike naj bodo v besedilu članka na ustreznem mestu. Za prikaz rezultatov v tabelah, slikah in besedilu je treba uporabljati statistične simbole, ki jih avtor najde na spletni strani revije, poglavje Navodila. Na vsako tabelo in sliko se mora avtor v besedilu sklicevati. Uporaba sprotnih opomb pod črto ni dovoljena.

Etična načela

Če uredništvo ugotovi, da rokopis krši avtorske pravice, se rokopis takoj izloči iz uredniškega postopka. Plagiatorstvo ugotavljamo s *Detektorjem podobnih vsebin* (DPV) in *CrossCheck Plagiarism Detection System*. Avtorji ob oddaji članka podpišejo *Izjavo o avtorstvu* in z njo potrdijo, da noben del prispevka do sedaj ni bil objavljen ali sprejet v objavo kjer koli drugje in v katerem koli jeziku.

V primeru etičnih kršitev se sproži postopek pregleda in razsojanja, ki ga vodi uredniški odbor revije. Na drugi stopnji etičnega presojanja razsodi Častno razsodišče Zbornice Zveze.

Opredelitev tipologije

Uredništvo razvrsti posamezni članek po veljavni tipologiji za vodenje bibliografij v sistemu COBISS (Kooperativni online bibliografski sistem in servisi) (dostopno na: http://home.izum.si/COBISS/bibliografije/Tipologija_slv.pdf). Tipologijo lahko predlagata avtor in recenzent, končno odločitev sprejme glavni in odgovorni urednik.

Metodološka struktura članka

Naslov, izvleček in ključne besede naj bodo v slovenščini in angleščini. Naslov naj bo skladen z vsebino članka in dolg največ 120 znakov. Oblikovan naj bo tako, da je iz njega razviden uporabljeni raziskovalni dizajn. Če naslovu sledi podnaslov, naj bosta ločena s podpičjem. Navedenih naj bo od tri do šest ključnih besed, ki natančneje opredeljujejo vsebino članka in ne nastopajo v naslovu. Izvleček naj bo strukturiran, vsebuje naj 150–220 besed. Napisan naj bo v tretji osebi. V izvlečku se ne citira.

Strukturirani izvleček naj vsebuje naslednje strukturne dele:

Uvod (Introduction): Navesti je treba ključna spoznanja dosedanjih raziskav, opis raziskovalnega problema, namen raziskave, v katerem so opredeljene ključne spremenljivke raziskave.

Metode (Methods): Navesti je treba uporabljeni raziskovalni dizajn, opisati glavne značilnosti vzorca, instrument raziskave, zanesljivost instrumenta, kje, kako in kdaj so se zbirali podatki in s katerimi metodami so bili obdelani in analizirani.

Rezultati (Results): Opisati je treba najpomembnejše rezultate raziskave, ki odgovarjajo na raziskovalni problem in namen raziskave. Pri kvantitativnih raziskavah je treba navesti vrednost rezultata in raven statistične značilnosti.

Diskusija in zaključek (Discussion and conclusion): Razpravljati je treba o ugotovitvah raziskave, navesti se smejo le zaključki, ki izhajajo iz podatkov, pridobljenih pri raziskavi. Navesti je treba tudi uporabnost ugotovitev in izpostaviti pomen nadaljnjih raziskav za boljše razumevanje raziskovalnega problema. Enakovredno je treba navesti tako pozitivne kot tudi negativne ugotovitve.

Struktura izvirnega znanstvenega članka (1.01)

Izvirni znanstveni članek je samo prva objava originalnih raziskovalnih rezultatov v takšni obliki, da se raziskava lahko ponovi ter ugotovitve preverijo.

Revija objavlja znanstvene raziskave, za katere zbrani podatki niso starejši od pet let ob objavi članka v reviji.

Uvod: V uvodu opredelimo raziskovalni problem, in sicer v kontekstu znanja in znanstvenih dokazov, v katerem smo ga razvili. Pregled obstoječe znanstvene literature mora utemeljiti potrebo po naši raziskavi in je osnova za oblikovanje namena in ciljev raziskave, raziskovalnih vprašanj oziroma hipotez in izbranega dizajna raziskave. Uporabimo znanstvena spoznanja in koncepte aktualnih mednarodnih in domačih raziskav, ki so objavljena kot primarni vir in niso starejša od deset oziroma pet let. Obvezno je citiranje in povzemanje spoznanj raziskav in ne mnenj avtorjev. Na koncu opredelimo namen in cilje raziskave. Priporočamo zapis raziskovalnih vprašanj (kvalitativna raziskava) oziroma hipotez (kvantitativna raziskava).

Metode: V uvodu metod navedemo izbrano raziskovalno paradigmo (kvantitativna, kvalitativna) in uporabljeni dizajn izbrane paradigme. Podpoglavja metod so: *opis instrumenta*, *opis vzorca*, *opis poteka raziskave in obdelave podatkov*.

Pri *opisu instrumenta* navedemo: opis sestave instrumenta, kako smo oblikovali instrument, spremenljivke v instrumentu, merske značilnosti (veljavnost, zanesljivost, objektivnost, občutljivost). Navedemo avtorje, po katerih smo instrument povzeli, ali navedemo literaturo, po kateri smo ga razvili. Pri kvalitativni raziskavi opišemo tehniko zbiranja podatkov, izhodiščna vprašanja, morebitno strukturo poteka zbiranja podatkov, kriterije veljavnosti in zanesljivosti tehnike zbiranja podatkov.

Pri *opisu vzorca* navedemo: opis populacije, iz katere smo oblikovali vzorec, vrsto vzorca, kolikšen je bil odziv vključenih v raziskavo, opis vzorca po demografskih podatkih (spol, izobrazba, delovna doba, delovno mesto ipd.). Pri kvalitativni raziskavi opredelimo še možnosti vključitve in izbrani način vključitve v raziskavo, vrsto vzorca, velikost vzorca in pojasnimo zasičenost vzorca.

Pri *opisu poteka raziskave in obdelave podatkov* navedemo etična dovoljenja za izvedbo raziskave, dovoljenja za izvedbo raziskave v organizaciji, predstavimo potek izvedbe raziskave, zagotovila za anonimnost vključenih ter prostovoljnost pri vključitvi v raziskavo, navedeno obdobje, kraj in način zbiranja podatkov, uporabljene metode analize podatkov, pri slednjem natančno navedemo statistične metode, program in verzijo programa statistične obdelave, meje statistične značilnosti. Pri kvalitativni raziskavi natančno opišemo celoten potek raziskave, način zapisovanja, zbiranja podatkov, število izvedb (opazovanj, intervjujev ipd.), trajanje izvedb, sekvence, transkripcijo podatkov, korake analize obdelave, tehnike obdelave in interpretacije podatkov ter receptivnost raziskovalca.

Rezultati: Rezultate prikažemo besedno oziroma v tabelah in slikah ter pazimo, da izberemo le en prikaz

za posamezen rezultat in da se vsebina ne podvaja. V razlagi rezultatov se osredotočamo na statistično značilne rezultate in tiste, ki so nas presenetili. Rezultate prikazujemo glede na stopnjo zahtevnosti statistične obdelave. Pri prikazu rezultatov v tabelah in slikah je za vse uporabljene kratice potrebna pojasnitev v legendi pod tabelo ali sliko. Rezultate prikažemo po postavljenih spremenljivkah, odgovorimo na raziskovalna vprašanja oz. hipoteze. Pri kvalitativnih raziskavah prikažemo potek oblikovanja kod in kategorij, za vsako kodo predstavimo eno do dve reprezentativni izjavi vključenih v raziskavo, ki najbolje predstavita oblikovano kodo. Naredimo shematični prikaz dobljenih kod in iz njih razvitih kategorij ter sodbo.

Diskusija: V diskusiji ugotovitve raziskave navajamo na besedni način (številčnih rezultatov ne navajamo).

Nizamo jih po posameznih spremenljivkah in z vidika postavljenih raziskovalnih vprašanj oz. hipotez, ki jih ne ponavljamo, temveč nanje besedno odgovarjamo. Rezultate v razpravi pojasnimo z vidika razumevanja, kaj lahko iz njih razberemo, razumemo in kako je to primerljivo z rezultati drugih raziskav in kaj to pomeni za uporabnost naše raziskave. Pri tem smo odgovorni in etični ter rezultate pojasnjujemo z vidika spoznanj naše raziskave in z vidika spoznanj, ki so preverljiva, splošno znana in primerljiva z vidika drugih raziskav. Pazimo na posploševanje rezultatov in se pri tem zavedamo omejitev raziskave z vidika instrumenta, vzorca in poteka raziskave. Upoštevamo načelo preverljivosti in primerljivosti. Oblikujemo rdečo nit razprave kot smiselne celote, komentiramo pričakovana in nepričakovana spoznanja raziskave. Na koncu razprave navedemo priporočila, ki so plod naše raziskave, in področja, ki jih nismo raziskali, pa bi jih bilo treba, ali pa smo jih, vendar naši rezultati ne dajejo ustreznih pojasnil. Navedemo omejitve raziskave.

Zaključek: Na kratko povzamemo ključne ugotovitve izvedene raziskave, povzamemo predloge za prakso, predlagamo možnosti nadaljnjega raziskovanja obravnavanega problema. V zaključku ne citiramo ali povzemamo.

Članek naj se zaključi s seznamom literature, ki je bila citirana ali povzeta v članku.

Struktura preglednega znanstvenega članka (1.02)

V kategorijo preglednih znanstvenih raziskav sodijo: sistematični pregled literature, pregled literature, analiza koncepta, razpravni članek (v nadaljevanju pregledni znanstveni članek). Revija objavlja pregledne znanstvene raziskave, za katere je bilo zbiranje podatkov končano največ tri leta pred objavo članka v reviji.

Pregledni znanstveni članek je pregled najnovejših raziskav o določenem predmetnem področju z namenom povzemanja, analiziranja, evalviranja ali

sintetizirati informacije, ki so že bile publicirane. V preglednem znanstvenem članku znanstvena spoznanja niso le navedena, ampak tudi razložena, interpretirana, analizirana, kritično ovrednotena in predstavljena na znanstvenoraziskovalen način. Na osnovi kvantitativne obdelave podatkov predhodnih raziskav (metaanaliza) ali kvalitativne sinteze (metasinteza) rezultatov predhodnih raziskav prinaša nova spoznanja in koncepte za nadaljnje raziskovalno delo. Struktura preglednega znanstvenega članka je enaka kot pri izvornem znanstvenem članku.

V **uvodu** predstavimo znanstveno, konceptualno ali teoretično izhodišče kot vodilo pregleda literature. Končamo z utemeljitvijo, zakaj je pregled potreben, zapišemo namen, cilje in raziskovalno vprašanje.

V **metodah** natančno opišemo uporabljeni raziskovalni dizajn pregleda literature. Podpoglavja metod so: *metode pregleda, rezultati pregleda, ocena kakovosti pregleda in opis obdelave podatkov. Metode pregleda* vključujejo razvoj, testiranje in izbor iskalne strategije, vključitvene in izključitvene kriterije za uvrstitev v pregled, raziskane podatkovne baze, časovno obdobje iskanja objav, vrste objav z vidika hierarhije dokazov, ključne besede, jezik pregledanih objav. *Rezultati pregleda* vključujejo število dobljenih zadetkov, število pregledanih raziskav, število vključenih raziskav in število izključenih raziskav. Uporabimo diagram poteka raziskave skozi faze pregleda, pri izdelavi si pomagamo z mednarodnimi standardi za prikaz rezultatov pregleda literature (npr. PRISMA-Preferred Reporting Items for Systematic Review and Meta-Analysis). *Ocena kakovosti pregleda in opis obdelave podatkov* vključuje oceno uporabljene iskalne strategije in kriterijev za dokončni nabor uporabljenih zadetkov, kakovost vključenih raziskav z vidika hierarhije dokazov ter način obdelave podatkov.

Rezultate prikažemo tabelarično kot analizo kakovosti vključenih raziskav. Tabela naj vključuje avtorje raziskave, leto objave raziskave, državo, kjer je bila raziskava izvedena, namen raziskave, raziskovalni dizajn, proučevane spremenljivke, instrument, velikost vzorca, ključne ugotovitve idr. Jasno naj bo razvidno, katere vrste raziskav glede na hierarhijo dokazov so vključene v pregled literature. Rezultate prikažemo besedno, v tabelah in slikah, navedemo ključna spoznanja glede na raziskovalni dizajn. Pri kvalitativni sintezi uporabimo kode in kategorije kot rezultat pregleda kvalitativne sinteze. Pri kvantitativni analizi opišemo uporabljene statistične metode obdelave podatkov iz vključenih znanstvenih del.

V **diskusiji** v prvem delu odgovorimo na raziskovalno vprašanje, nato komentiramo ugotovitve pregleda literature, kakovost vključenih raziskav, svoje ugotovitve primerjamo z rezultati drugih primerljivih raziskav, razvijemo nova spoznanja, ki jih je doprinesel pregled literature, njihovo teoretično, znanstveno in praktično uporabnost, navedemo omejitve raziskave, uporabnost v praksi in priložnosti za nadaljnje raziskovanje.

V **zaključku** poudarimo doprinos izvedenega pregleda, opozorimo na morebitne pomanjkljivosti v splošno uveljavljenem znanju in razumevanju, izpostavimo pomen bodočih raziskav, uporabnost pridobljenih spoznanj in priporočila za prakso, raziskovanje, izobraževanje, menedžment, pri čemer upoštevamo omejitve raziskave. Izpostavimo teoretični koncept, ki bi lahko usmerjal raziskovalce v prihodnosti. V zaključku ne citiramo ali povzemamo.

Navajanje literature

Vsako trditev, teorijo, uporabljeno metodologijo, koncept je treba potrditi s citiranjem. Avtorji naj uporabljajo *APA 6 - American Psychological (APA Style, 2021)* za navajanje avtorjev v besedilu in seznamu literature na koncu članka. Za navajanje avtorjev v **besedilu** uporabljamo npr.: (Pahor, 2006) ali Pahor (2006), kadar priimek vključimo v poved. Ko avtorje v besedilu navajamo prvič zapišemo do 5 avtorjev s priimki (zadnja dva priimka ločimo z »&«: (Stare & Pahor, 2010; Sharp, Novak, Aarons, Wittenberg, & Gittens, 2007). Če je avtorjev več kot 5 navedemo le prvega in dopišemo »et al.«: (Chen et al., 2007). V nadaljnjem tekstu pišemo kadar so 3 ali več avtorjev priimek prvega avtorja in »et al.« (več o uporabi najdete na strani <https://blog.apastyle.org/apastyle/2011/11/the-proper-use-of-et-al-in-apa-style.html>). Če navajamo več citiranih del, jih ločimo s podpičji in jih navedemo po kronološkem zaporedju, od najstarejšega do najnovejšega, če je med njimi v istem letu več citiranih del, jih razvrstimo po abecednem vrstnem redu: (Bratuž, 2012; Pajntar, 2013; Wong et al., 2014). Kadar citiramo več del istega avtorja, izdanih v istem letu, je treba za letnico dodati malo črko po abecednem redu: (Baker, 2002a, 2002b).

Kadar navajamo sekundarne vire, uporabimo »cited in«: (Lukič, 2000 cited in Korošec, 2014). Če pisec članka ni bil imenovan oz. je delo anonimno, v besedilu navedemo *naslov*, v oklepaju pa zapišemo »Anon.« ter letnico objave: *The past is the past* (Anon., 2008). Kadar je avtor organizacija oz. gre za korporativnega avtorja, zapišemo ime korporacije (Royal College of Nursing, 2010). Če ni leta objave, to označimo z »n. d.« (ang. no date): (Smith, n. d.). Pri objavi fotografij navedemo avtorja (Foto: Marn, 2009; vir: Cramer, 2012). Za objavo fotografij, kjer je prepoznavna identiteta posameznika, moramo pridobiti dovoljenje te osebe ali staršev, če gre za otroka.

V **seznamu literature** na koncu članka navedemo bibliografske podatke/reference za *vsa v besedilu citirana ali povzeta dela* (in samo ta!), in sicer po abecednem redu avtorjev. Sklicujemo se le na objavljena dela. Kadar je avtorjev do vključno sedem, moramo navesti vse avtorje. Pred zadnjim avtorjem damo znak &. V primeru, da je avtorjev 8 ali več, navedemo prvih šest avtorjev, dodamo tri pike in zadnjega avtorja. V primeru, da imamo med viri dva avtorja z istim priimkom in enakimi prvimi črkami imena, moramo avtorjevo polno ime napisati v oglatih oklepajih za začetnico imena.

Za oblikovanje seznama literature velja velikost črk 12 točk, enojni razmik, leva poravnava ter 12 točk prostora za referencami (razmik med odstavki, ang. paragraph spacing).

Pri citiranju, tj. dobesednem navajanju, citirane strani zapišemo tako v navedbi citirane publikacije v besedilu: (Ploč, 2013, p. 56); kot tudi pri ustrezni referenci v seznamu (glej primere v nadaljevanju). Če citiramo več strani iz istega dela, strani navajamo ločene z vejico (npr.: pp. 15–23, 29, 33, 84–86). Če je citirani prispevek dostopen na spletu, na koncu bibliografskega zapisa navedemo »Retrieved from« in datum dostopa ter zapišemo URL- ali URN-naslov (glej primere).

Avtorjem priporočamo, da pregledajo objavljene članke na temo svojega rokopisa v predhodnih številkah naše revije (za obdobje zadnjih pet let).

Ostali primeri citiranja so avtorjem na voljo na <https://apastyle.apa.org/>.

Primeri navajanja literature v seznamu

Citiranje knjige:

Nemac, D., & Mlakar-Mastnak, D. (2019). *Priporočila za telesno dejavnost onkoloških bolnikov*. Ljubljana: Onkološki inštitut.

Ricci Scott, S. (2020). *Essentials of maternity, newborn and women's health nursing* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Citiranje poglavja oz. prispevka iz knjige, ki jo je uredilo več urednikov:

Kanič, V. (2007). Možganski dogodki in srčno-žilne bolezni. In E. Tetičkovič & B. Žvan (Eds.), *Možganska kap: do kdaj* (pp. 33–42). Maribor: Kapital.

Longman, L., & Heap, P. (2010). Sedation. In R. S. Ireland (Ed.), *Advanced dental nursing* (2nd ed., pp. 159–224). Hoboken: Blackwell Publishing.
<https://doi.org/10.1002/9781118786659.ch4>

Citiranje knjige, ki jo je uredil en ali več urednikov:

Farkaš-Lainščak, J., & Sedlar, N. (Eds.). (2019). *Ocena potreb, znanja in veščin bolnikov s srčnim popuščanjem in obremenitev njihovih neformalnih oskrbovalcev: znanstvena monografija*. Murska Sobota: Splošna bolnišnica.

Citiranje člankov iz revij:

East-Telling, C., Kingston, P., Taylor, L., & Emmerson, L. (2021). Ageing simulation in health and social care education: A mixed methods systematic review. *Journal of Advanced Nursing*, 77(1), 23–46.
<https://doi.org/10.1111/jan.14577>

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Oh, H.-K., & Cho, S.-H. (2020). Effects of nurses' shiftwork characteristics and aspects of private life on work-life conflict. *PLoS ONE*, 15(12), Article e0242379.
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Marion, T., Reese, V., & Wagner, R. F. (2018). Dermatologic features in good film characters who turn evil: The transformation. *Dermatology Online Journal*, 24(9), Article 4. Retrieved December 4, 2019 from <https://escholarship.org/uc/item/1666h4z5>

Sundaram, V., Shah, P., Karvellas, C., Asrani, S., Wong, R., & Jalan, R. (2020). Share MELD-35 does not fully address the high waiting list mortality of patients with acute on chronic liver failure grade 3. *Journal of Hepatology*, 73(Suppl. 1), S8–S9.
[https://doi.org/10.1016/S0168-8278\(20\)30578-X](https://doi.org/10.1016/S0168-8278(20)30578-X)

Livingstone-Banks, J., Ordóñez-Mena, J. M., & Hartmann-Boyce, J. (2019). Print-based self-help interventions for smoking cessation. *Cochrane Database of Systematic Reviews*.
<https://doi.org/10.1002/14651858.CD001118.pub4>

Anonymous. (2010). Food safety shake-up needed in the USA. *The Lancet*, 375(9732), 2122.
[https://doi.org/10.1016/S0140-6736\(10\)60979-8](https://doi.org/10.1016/S0140-6736(10)60979-8)

Citiranje prispevka iz zbornika referatov:

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NAVODILA ZA PREDLOŽITEV ČLANKA

Članek je treba oddati v e-obliki preko spletne strani revije. Revija uporablja *Open Journal System* (OJS), dostopno na: <http://obzornik.zbornica-zveza.si>. Avtor mora natančno slediti navodilom za oddajo članka in izpolniti vse zahtevane rubrike.

V primeru oddaje članka, ki ni skladen z navodili, si uredništvo pridružuje pravico do zavrnitve članka. Spreminjanje vrstnega reda avtorjev ali korespondenčnega avtorja tekom postopka objave članka ni dovoljeno, zato naprošamo avtorje, da skrbno pregledajo v dokumentu Naslovna stran vrstni red avtorjev.

Pred oddajo članka naj avtor članek pripravi v naslednjih treh ločenih dokumentih.

1. NASLOVNA STRAN, ki vključuje:

- naslov članka;
- avtorje v vrstnem redu, kot morajo biti navedeni v članku;
- popolne podatke o vseh avtorjih (ime, priimek, dosežena stopnja izobrazbe, habilitacijski naziv, zaposlitev, e-naslov, ORCID, Twitter) in podatek o tem, kdo je korespondenčni avtor; če je članek napisan v angleščini, morajo biti tako zapisani tudi vsi podatki o avtorjih; podpisi avtorjev; v sistem je vključena e-izjava o avtorstvu;
- informacijo, ali članek vključuje del rezultatov večje raziskave oz. ali je nastal v okviru diplomskega, magistrskega ali doktorskega dela (v tem primeru je prvi avtor vedno študent);
- izjave (statements): avtorji morajo ob oddaji rokopisa podati sledeče izjave (pri slovensko pisanem članku so vse izjave tako v slovenščini kot tudi v angleščini), ki bodo po zaključenem recenzentskem postopku in odločitvi za sprejem članka v objavo prikazane na koncu članka pred poglavjem *Literatura*.

Zahvala/Acknowledgements

Avtorji se lahko zahvalijo posameznikom, skupinam ali sodelujočim v raziskavi za sodelovanje v raziskavi (izbirno).

Nasprotje interesov/Conflict of interest

Avtorji so dolžni predstaviti kakršnokoli nasprotje interesov pri oddaji članka. V kolikor avtorji nimajo nobenih nasprotujočih interesov naj zapišejo naslednjo izjavo: »Avtorji izjavljajo, da ni nasprotja interesov.«

Financiranje/Funding

Avtorji so dolžni opredeliti kakršnokoli finančno pomoč pri nastajanju članka. Ta informacija je lahko podana z imenom organizacije, ki je financirala ali sofinancirala raziskavo, ter v primeru projekta z imenom in številko projekta. V kolikor ni bilo nobenega financiranja, naj avtorji zapišejo naslednjo izjavo: »Raziskava ni bila finančno podprta.«

Etika raziskovanja/Ethical approval

Avtorji so dolžni podati informacije o etičnih vidikih raziskave. V primeru odobritve raziskave s strani komisije za etiko zapišejo ime komisije za etiko in številko odločbe. V kolikor raziskava ni potrebovala posebnega dovoljenja komisije za etiko, so avtorji to dolžni pojasniti. Glede na posamezen tip raziskave lahko avtorji na primer zapišejo tudi naslednjo izjavo: »Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (ali) Kodeksom etike za babice

Slovenije (2014),« v skladu s katero je treba v seznamu literature navajati oba vira.

Prispevek avtorjev/Author contributions

V primeru članka dveh ali več avtorjev so avtorji dolžni opredeliti prispevek posameznega avtorja pri nastanku članka, kot to določajo priporočila International Committee of Medical Journal Editors (ICMJE), dostopno na: <http://www.icmje.org/recommendations>. Vsak soavtor članka mora sodelovati v najmanj dveh strukturnih delih članka (Uvod/Introduction, Metode/Methods, Rezultati/Results, Diskusija in zaključek/Discussion and conclusion). Za vsakega avtorja je treba napisati, v katerih delih priprave članka je sodeloval in kaj je bil njegov prispevek v posameznem delu.

2. IZJAVA O AVTORSTVU

Izjavo o avtorstvu in strinjanju z objavo prispevka, s podpisami avtorjev in razčlenitvijo delov pri katerih so sodelovali na podlagi ICMJE smernic h katerim je revija zavezana.

3. GLAVNI DOKUMENT, ki je anonimiziran in vključuje naslov članka (obvezno brez avtorjev in kontaktnih podatkov), izvleček, ključne besede, besedilo članka v predpisani strukturi, tabele, slike in literaturo. Avtorji lahko v članku uporabijo največ 5 tabel oziroma slik.

Obseg članka: članek naj vsebuje največ 5000 besed za kvantitativno in do 6000 besed za kvalitativno zasnovane raziskave. V ta obseg je vključen izvleček, tabele, slike in seznam literature. Število besed članka je treba navesti v dokumentu »Naslovna stran«.

Za **oblikovanje besedila članka** naj velja naslednje: velikost strani A4, dvojni razmik med vrsticami, pisava Times New Roman, velikost črk 12 točk in širina robov 25 mm. Obvezna je uporaba oblikovne predloge za članek (Word), dostopne na spletni strani Obzornika zdravstvene nege.

Tabele naj bodo označene z arabskimi zaporednimi števkami. Imeti morajo vsaj dva stolpca ter opisni naslov (nad tabelo), naslovno vrstico, morebitni zbirni stolpec in zbirno vrstico ter legendo uporabljenih znakov. V tabeli morajo biti izpolnjena vsa polja, obsegajo lahko največ 57 vrstic. Za njihovo oblikovanje naj velja naslednje: velikost črk 11 točk, pisava Times New Roman, enojni razmik, pred in za vrstico 0,5 točke prostora, v prvem stolpcu in vseh stolpcih z besedilom leva poravnava, v stolpcih s statističnimi podatki leva poravnava, vmesne pokončne črte pri prikazu neizpisane. Uredništvo si pridružuje pravico, da preobsežne tabele, v sodelovanju z avtorjem, preoblikuje.

Slike naj bodo oštevilčene z arabskimi zaporednimi števkami. Podpisi k slikam (pod sliko) in legende naj bodo v slovenščini in angleščini, pisava Times

New Roman, velikost 11 točk. Izraz slika uporabimo za grafe, sheme in fotografije. Uporabimo le dvodimenzionalne grafične črno-bele prikaze (lahko tudi šrafure) ter resolucijo vsaj 300 dpi (dot per inch). Če so slike v dvorazsežnem koordinatnem sistemu, morata obe osi (x in y) vsebovati označbe, katere enote / mere vsebujeta.

Članki niso honorirani. Besedil in slikovnega gradiva ne vračamo, kontaktni avtor prejme objavljeni članek v formatu PDF (Portable Document Format).

Predložitev članka s strani urednikov ali članov uredniškega odbora

Spodbudno je, da uredniki in člani uredniškega odbora Obzornika zdravstvene nege objavljajo v reviji. V izogib vsakršnemu konfliktu interesov, člani uredniškega odbora ne vodijo uredniškega postopka za svoj članek. Če eden izmed urednikov predloži članek v uredništvo, potem drugi urednik sprejema odločitve vezane na članek. Uredniki ali člani uredniškega odbora ne opravljajo recenzije ali vodijo uredniškega postopka sodelavcev iz institucije v kateri so zaposleni, pri čemer morajo paziti na nastanek potencialnih konfliktov interesov. Od vseh članov uredniškega odbora kot tudi urednikov se pričakuje, da bodo spoštovali zasebnost, sledili načelu pravičnosti in sporočali morebitne konflikte interesov, ki jih imajo do avtorjev oddanih člankov.

Sodelovanje avtorjev z uredništvom

Članek mora biti pripravljen v skladu z navodili in oddan prek spletne strani revije na <http://obzornik.zbornica-zveza.si>, to je pogoj, da se članek uvrsti v uredniški postopek. Če uredništvo presodi, da članek izpolnjuje kriterije za objavo v Obzorniku zdravstvene nege, bo poslan v zunanjo strokovno (anonimno) recenzijo. Recenzenti prejmejo besedilo članka brez avtorjevih osebnih podatkov, članek pregledajo glede na postavljene kazalnike in predlagajo izboljšave. Avtor je dolžan izboljšave pregledati in jih v največji meri upoštevati ter članek dopolniti v roku, ki ga določi uredništvo. Uredništvo predlaga avtorju, da popravke/spremembe v članku označi z rumeno barvo. V kolikor avtor članka ne vrne v roku, se članek zavrne. V kolikor avtor katere od predlaganih izboljšav ne upošteva, mora to pisno pojasniti. Po zaključenem recenzijem postopku uredništvo članek vrne avtorju, da popravke odobri, jih upošteva in pripravi čistopis. Čistopis uredništvo pošlje v jezikovni pregled.

Avtor prejme prvi natis v korekturo s prošnjo, da na njem označi vse morebitne tiskovne napake, ki jih označi v PDF-ju prvega natisa. Spreminjanje besedila v tej fazi ni sprejemljivo. Korekture je treba vrniti v treh delovnih dneh, v nasprotnem uredništvo meni, da se avtor s prvim natisom strinja.

NAVODILA ZA DELO RECENZENTOV

Recenzentovo delo je odgovorno in zahtevno. S svojimi predlogi in ocenami recenzenti prispevajo k večji kakovosti člankov, objavljenih v Obzorniku zdravstvene nege. Od recenzenta, ki ga uredništvo neodvisno izbere, se pričakuje, da bo odgovoril na vprašanja, ki so postavljena v obrazcu OJS, in ugotovil, ali so trditve in mnenja, zapisani v članku, verodostojni in ali je avtor upošteval navodila za objavljanje. Recenzent mora poleg znanstvenosti, strokovnosti in primernosti vsebine za objavo v Obzorniku zdravstvene nege članek oceniti metodološko ter uredništvo opozoriti na pomanjkljivosti. Ni treba, da se recenzent ukvarja z lektoriranjem, vendar lahko opozori tudi na jezikovne pomanjkljivosti. Pozoren naj bo na pravilno rabo strokovne terminologije. Posebej mora biti recenzent pozoren, ali je naslov članka jasen, ali ustreza vsebini; ali izvleček povzema bistvo članka; ali avtor citira (naj)novjšo literaturo in ali citira znanstvene raziskave avtorjev, ki so pisali o isti temi v domačih revijah; ali se avtor izogiba avtorjem, ki zagovarjajo drugačna mnenja, kot so njegova; ali navaja tuje misli brez citiranja; ali je citiranje literature ustrezno, ali se v besedilu navedena literatura ujema s seznamom literature na koncu članka. Dostopno literaturo je treba preveriti. Oceniti je treba ustreznost slik ter tabel, preveriti, če se v njih ne ponavlja tisto, kar je v besedilu že navedeno. Recenzentova dolžnost je opozoriti na morebitne nerazvezane kratice. Recenzent mora biti še posebej pozoren na morebitno plagiatstvo in krajo intelektualne lastnine.

S sprejetjem recenzije se recenzent zaveže, da jo bo oddal v predpisanem roku. Če to ni mogoče, mora takoj obvestiti uredništvo. Recenzent se obveže, da vsebine članka ne bo nedovoljeno razmnoževal ali drugače zlorabil. Recenzije so anonimne: recenzent je avtorju neznan in obratno. Recenzent bo v pregled prek sistema OJS prejel le vsebino članka brez imena avtorja. V sistemu OJS recenzent poda svoje strokovno

mnenje v recenzijskem obrazcu. Če ima recenzent večje pripombe, jih kot utemeljitev za sprejem ali morebitno zavrnitev članka na kratko opiše oz. avtorju predlaga nadaljnje delo, pri čemer upošteva njegovo integriteto. Zaradi večje preglednosti in lažjih dopolnitev s strani avtorja lahko recenzent svoje pripombe in morebitne predloge vnese v besedilo članka, pri tem uporabi možnost, ki jo ponuja Microsoft Word – sledi spremembam (Track changes). Recenzent mora biti pozoren, da pred uporabo omenjene možnosti prikrije svojo identiteto (slediti spremembam, spremeni ime/Track changes, change user name). Recenzentsko verzijo besedila članka z vključenimi anonimiziranimi predlogi nato recenzent naloži v sistem OJS in omogoči avtorju, da predloge dopolnitev vidi. Končno odločitev o objavi članka sprejme uredniški odbor.

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GUIDE FOR AUTHORS

General guidelines

The manuscript should be written clearly and succinctly in standard Slovene or English and should conform to acceptable language usage. The journal accepts original and review scientific articles. Original scientific article should be up to 5000 words long, review scientific article should be up to 6000 words, including the references. The authors should use the Microsoft Word templates accessible on the website of the editorial board (Title Page and Template for Original Scientific Article/Review Article). All articles considered for publication in the Slovenian Nursing Review will be subjected to external, triple-blind peer review. Manuscripts are accepted for consideration by the journal with the understanding that they represent original material, have not been previously published and are not being considered for publication elsewhere. Individual authors bear full responsibility for the content and accuracy of their submissions and should therefore state their full name(s) when submitting the article. The submission should also include the name of the designated corresponding author (with their complete home and e-mail address, and telephone number) responsible for communicating with the editorial board and other authors. In submitting a manuscript, the authors must observe the standard scientific research paper structure, format and typology, and submission guidelines. The manuscript will be submitted to the review process once it is submitted in accordance with the guidelines of the editorial office.

If the article reports on research involving human subjects, it should be evident from the methodology section that the study was conducted in accordance with the Declaration of Helsinki and Tokyo. All human subject research including patients or vulnerable groups, health professionals and students requires review and approval by the ethical committee on the institutional or national level prior to subject recruitment and data collection.

The title of the article, abstract and key words, tables (descriptive title and legend) and figures (descriptive title, notes and legend) must be submitted in Slovene as well as in English. The same applies to articles written in English, in which these elements must be presented first in the English language, followed by their translation into Slovene. A manuscript can include a total of five tables and/or figures. Tables and figures should be placed next to the relevant text. The results presented in the tables and figures should use symbols as required by the Author Guidelines, available on the journal website. The authors should refer to each table/figure in the text. The use of footnotes or endnotes is not allowed.

Ethical principles

Should the editorial board find that the manuscript infringes any copyright, it will be immediately excluded from the editorial process. In order to detect plagiarism, a detector of similar contents *Detektor podobnih vsebin* (DPV) and the *CrossCheck Plagiarism Detection System* are used. The authors sign the Authorship Statement confirming that no part of the paper has been published or accepted for publication elsewhere and in any other language.

In case of ethical violations, a resolution and adjudication process is initiated, led by the editorial board of the journal. The second stage of the resolution process is conducted by an honorary review panel of the Slovenian Nursing Review.

Article typology

The editors reserve the right to re-classify any article under a topic category that may be more suitable than that it was originally submitted under. The classification follows the adopted typology of documents/works for bibliography management in COBISS (Cooperative Online Bibliographic System and Services) accessible at: http://home.izum.si/COBISS/bibliografije/Tipologija_slv.pdf). While such reclassification may be suggested by the author or the reviewer, the final decision rests with the editor-in-chief and the executive editor.

Methodological structure of an article

The title, abstract and key words should be written in Slovene and English. A concise but informative title should convey the nature, content and research design of the paper. It must not exceed 120 characters. If the title is followed by a subtitle, a semicolon should be placed in between. Up to six key words separated by a semicolon and not included in the title should define the content of the article and reflect its core topic or message. All articles should be accompanied by an abstract of no more than 150–220 words written in the third person. Abstracts accompanying articles should be structured and should not include references.

A **structured abstract** is an abstract which has individually outlined and labelled sections for quick reference. It is structured under the following headings:

Introduction: This section indicated the main question to be answered, and states the exact objective of the paper and the major variables of the study.

Methods: This section provides an overview of the research or experimental design, the research instrument, the reliability of the instrument, the place, methods and time of data collection, and methods of data analysis.

Results: This section briefly summarises and discusses the major findings. The information presented in this

section should be directly connected to the research question and purpose of the study. Quantitative studies should include the statement of statistical validity and statistical significance of the results.

Discussion and conclusion: This section states the conclusions and discusses the research findings drawn from the results obtained. Presented in this section are also limitations of the study and the implications of the results for practice and relevant further research. Both positive and negative research findings should be adequately presented.

Structure of an Original Scientific Article (1.01)

An original scientific article is the first-time publication of original research results in a way which allows the research to be repeated and the findings checked. The research should be based on primary sources no older than five years at the time of the publication of the article.

Introduction: In the introductory part, the research problem is defined in the context of theoretical knowledge and scientific evidence. The review of scholarly literature on the topic provides the rationale behind the study and identifies the gap in the literature related to the problem. It justifies the purpose and aims of the study, research questions or hypotheses, as well as the method of investigation (research design, sample size and characteristics of the proposed sample, data collection and data analysis procedures). The research should be based on primary sources of recent national and international research no older than ten or five years respectively if the topic has been widely researched. Citation of sources and references to previous research findings should be included while the authors' personal views should not. Finally, the aims and objectives of the study should be specified. We recommend formulating research questions (qualitative research) or hypotheses (quantitative research).

Method: This section states the chosen paradigm (qualitative, quantitative) and outlines the research design. It typically includes sections on the research instrument; sample size and characteristics of the proposed sample; description of the research procedure; and data collection and data analysis procedures.

The *description of the research instrument* includes information about the structure of the instrument, the mode of instrument development, instrument variables and measurement properties (validity, reliability, objectivity, sensitivity). Appropriate citations of the literature used in research development should be included. In qualitative research, the data collection method should be stated along with the preliminary research questions, a possible format or structure of data collection and processing, the criteria of validity and reliability of data collection.

The *description of the sample* defines the population from which the sample was selected, the type of the sample, the response rate of the participants, the respondents' demographics (gender, level of educational attainment, length of work experience, post currently held, etc.). In qualitative research, the categories of the sampling procedure and inclusion criteria are also defined and the sample size and saturation is explained.

The *description of the research procedure and data analysis* includes ethical approvals to conduct the research, permission to conduct the research within the confines of an institution, description of the research procedure, guarantee of anonymity and voluntary participation of the research participants, the period and place of data collection, method of data collection and analysis, including statistical methods, statistical analysis software and programme version, limits of statistical significance. Qualitative research should include a detailed description of the methods of data collection and recording, number and duration of observations, interviews and surveys, sequences, transcription of data, steps in data analysis and interpretation, and receptiveness of the researcher.

Results: This section presents the research results descriptively or in numbers and figures. A table is included only if it presents new information. Each finding is presented only once so as to avoid repetition and duplication of the content. Explanation of the results should be focused on statistically significant or unexpected findings. Results are presented according to the level of statistical complexity. All abbreviations used in figures and tables should be accompanied with explanatory captions in the legend below the table or figure. Results are presented according to the variables, and should answer all research questions or hypotheses. In qualitative research, the development of codes and categories should also be presented, including one or two representative statements of respondents. A schematic presentation of the codes and ensuing categories should be provided.

Discussion: The discussion section analyses the data descriptively (numerical data should be avoided) in relation to specific variables from the study. Results are analysed and evaluated in relation to the original research questions or hypotheses. The discussion part integrates and explains the results obtained and relates them to those of previous studies in order to determine their significance and applicative value. Ethical interpretation and communication of research results is essential to ensure the validity, comparability and accessibility of new knowledge. The validity of generalisations from results is often questioned due to the limitations of qualitative research (sample representativeness, research instrument, research proceedings). The principles of reliability and comparability should be observed. The discussion includes comments on the expected and unexpected

findings and the areas requiring further or in-depth research as indicated by the results of the study. The limitations of the research should be clearly stated.

Conclusion: Summarised in this section are the author's principal points and transfer of new findings into practice. The section may conclude with specific suggestions for further research building on the topic, conclusions and contributions of the study, taking into account its limitations. Citations of quotes, paraphrases or abbreviations should not be included in the conclusion. The article concludes with a list of all the published works cited or referred to in the text of the paper.

Structure of a Review Article (1.02)

Included in the category of review scientific research are: literature review, concept analyses, discussion-based articles (also referred to as a review article). The Slovenian Nursing Review publishes review scientific research, the data collection of which has been concluded a maximum of three years before article publication.

A review article represents an overview of the latest publications in a specific subject area, the studies of an individual researcher or group of researchers with the purpose of summarising, analysing, evaluating or synthesising previously published information. Research findings are not only described but explained, interpreted, analysed, critically evaluated and presented in a scholarly manner. A review article presents either qualitative data processing of previous research findings (meta-analyses) or qualitative syntheses of previous research findings (meta-syntheses) and thus provides new knowledge and concepts for further research. The organisational pattern of a review article is similar to that of the original scientific article.

The **introduction** section defines the scientific, conceptual or theoretical basis for the literature review. It also states the necessity for the review along with the aims, objectives and research question(s).

The **method** section accurately defines the research methods by which the literature search was conducted. It is further subdivided into: review methods, results of the review, quality assessment of the review and description of data processing.

Review methods include the development, testing and search strategy, predetermined criteria for the inclusion in the review, the searched databases, limited time period of published literature, types of publications according to hierarchy of evidence, key words and the language of reviewed publications.

The *results of the review* include the number of hits, the number of reviewed research studies, the number of included and excluded sources consulted. The **results** are presented in the form of a diagram of all the research stages of the review. International

standards for the presentation of the literature review results may be used for this purpose (e.g. PRISMA - Preferred Reporting Items for Systematic Review and Meta-Analysis).

Quality assessment of the review and description of data processing includes the assessment of the research approach and data obtained as well as the quality of included research studies according to the hierarchy of evidence, and the data processing method.

The results should be presented in the form of a table and should include a quality analysis of the sources consulted. The table should include the author(s) of each study, the year of publication, the country where the research was conducted, the research purpose and design, the variables studied, the research instrument, sample size, the key findings, etc.

It should be evident which studies are included in the review according to the hierarchy of evidence. The results should be presented verbally and visually (tables and figures), the main findings concerning the research design should also be included. In qualitative synthesis, the codes and categories should be used as a result of the qualitative synthesis review. In quantitative analysis, the statistical methods of data processing of the used scientific works should be described.

The first section of the **discussion** answers the research question which is followed by the author's observations on literature review findings and the quality of the research studies included. The author evaluates the review findings in relation to the results from other comparable studies. The discussion section identifies new perspectives and contributions of the literature review, and their theoretical, scientific and practical application. It also defines research limitations and indicates the potential applicability of the review findings and suggests further research.

The **conclusion** section emphasises the contribution of the literature review conducted, sheds light on any gaps in previous research, identifies the significance of further research, the translation of new knowledge and recommendations into practice, research, education, management by also taking into consideration its limitations. It also pinpoints the theoretical concepts which may guide or direct further research. Citation of quotes, paraphrases or abbreviations should not be included in the conclusion.

References

In academic writing, authors are required to acknowledge the sources from which they draw their information, including all statements, theories or methodologies applied. Authors should follow the *APA 6 - American Psychological Association* (APA Style, 2021) for in-text citations and in the list of references at the end of the paper. **In-text citations** or parenthetical citations are identified by the authors' surname and the publication year placed within parentheses immediately

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Secondary sources should be referenced by 'cited in' (Lukič, 2000 cited in Korošec, 2014). In citing a piece of work which does not have an obvious author or the author is unknown, the in-text citation includes the title followed by 'Anon.' in parentheses, and the year of publication: *The past is the past* (Anon., 2008). In citing a piece of work whose authorship is an organisation or corporate author, the name of the organisation should be given, followed by the year of publication (Royal College of Nursing, 2010). If no date of publication is given, the abbreviation 'n. d.' (no date) should be used: (Smith, n. d.). An in-text citation and a full reference should be provided for any images, illustrations, photographs, diagrams, tables or figures reproduced in the paper as with any other type of work: (Photo: Marn, 2009; source: Cramer, 2012). If a subject in the photo is recognisable, a prior informed consent for publication should be gained from the subject or, in the case of a minor, from their parent or guardian.

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Authors are advised to consult articles on the topic of their manuscript which have been published in previous volumes of our journal (over the past five-year period). Other examples of citations and references are available at <https://apastyle.apa.org/>.

Reference examples by type of reference

Book references:

Nemac, D., & Mlakar-Mastnak, D. (2019). *Priporočila za telesno dejavnost onkoloških bolnikov*. Ljubljana: Onkološki inštitut.

Ricci Scott, S. (2020). *Essentials of maternity, newborn and women's health nursing* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

References for chapter/essay in a book edited by multiple editors:

Longman, L., & Heap, P. (2010). Sedation. In R. S. Ireland (Ed.), *Advanced dental nursing* (2nd ed., pp. 159–224). Hoboken: Blackwell Publishing.
<https://doi.org/10.1002/9781118786659.ch4>

Kanič, V. (2007). Možganski dogodki in srčno-žilne bolezni. In E. Tetičkovič & B. Žvan (Eds.), *Možganska kap: do kdaj* (pp. 33–42). Maribor: Kapital.

References for books edited by one or multiple authors:

Farkaš-Lainščak, J., & Sedlar, N. (Eds.). (2019). *Ocena potreb, znanja in veščin bolnikov s srčnim popuščanjem in obremenitev njihovih neformalnih oskrbovalcev: znanstvena monografija*. Murska Sobota: Splošna bolnišnica.

Journal article references:

Eost-Telling, C., Kingston, P., Taylor, L., & Emmerson, L. (2021). Ageing simulation in health and social care education: A mixed methods systematic review. *Journal of Advanced Nursing*, 77(1), 23–46.
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References

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