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Development of nursing professionalization elements in Slovenia: the group interview technique

Razvoj elementov profesionalizacije v slovenski zdravstveni negi: tehnika skupinskih intervjujev

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ABSTRACT

Introduction: An occupation becomes a profession once it uses a systematic approach to generate new knowledge and transfer it directly into professional work. The aim of this paper is to show the attitudes of nursing care professionals towards the professionalization of nursing care and make a contribution by means of identifying the factors that are important for the development of the professionalization of nursing in Slovenia.

Methods: The group interview technique was used with two rounds. Participants responded to 15 open premises/questions. Purposive sampling was used and groups were comprised of professionals from all levels of clinical environments, secondary and higher education teachers and master's and doctoral degree students (n = 48).

Results: The results of the first round produced 3 themes, while the second round generated findings related to 4 themes. The synthesis of the findings from both rounds resulted in two overarching themes. The first is "*National responsibility*" which includes the responsibility of the nursing care management and the management of higher education institutions as well as the responsibility of the Nurses and Midwives Association of Slovenia for developing nursing care as a scientific discipline. The second theme is "*National indicators for the realization of national responsibility*" which includes (1) Classification of jobs in nursing care to reflect the 4 levels of nursing care competencies, (2) research and development as work tools in nursing care, and (3) the national institute for nursing care research.

Discussion and conclusion: The responsibility for the development of professionalization lies with several sectors. A clear and ambitious vision, and a strategy for the development of nursing care that should include responsibility for setting a new paradigm for the development of nursing care as a response to the needs of the society, occupation and science, are needed. The strategy should be supported by means of a planned distribution of means to facilitate its realisation.

IZVLEČEK

Uvod: Stroka postane profesija, kadar s sistematičnim pristopom ustvarja novo znanje in ga prenaša v neposredno delo. Namen raziskave je bil preveriti stališča in razumevanje nekaterih elementov profesionalizacije med strokovnjaki ter prispevati k prepoznavanju dejavnikov pomembnih za razvoj profesionalizacije zdravstvene nege v Sloveniji.

Metode: Uporabljena je bila tehnika skupinskega intervjuja. V dveh sekvencah so bili izvedeni štirje skupinski intervjuji, oblikovanih je bilo 15 odprtih izhodišč/vprašanj. Uporabljen je bil sistematični namenski vzorec, skupine so sestavljali strokovnjaki iz kliničnih okolij vseh ravni, učitelji srednješolskega in visokošolskega izobraževanja in študenti magistrskega in doktorskega študija (n = 48).

Rezultati: Rezultati prve sekvence dajo tri tematske ugotovitve, rezultati druge sekvence nadaljnje štiri. Sinteza spoznanj obeh sekvenc je podala dve nadtemi. Prva je *nacionalna odgovornost*, le-ta vključuje odgovornost menedžmenta zdravstvene nege, visokošolskih zavodov in Zbornice – Zveze za razvoj zdravstvene nege kot znanstvene discipline. Druga nadtema so *nacionalni kazalniki uresničevanja nacionalne odgovornosti*, le-ti vključujejo (1) sistematizacijo delovnih mest za štiri ravni kompetenc, (2) raziskovanje in razvoj kot orodje dela in (3) nacionalni inštitut za raziskave v zdravstveni negi.

Diskusija in zaključek: Odgovornosti za razvoj profesionalizacije so medsektorske. Potrebni sta jasna in ambiciozna vizija ter strategija razvoja zdravstvene nege, ki naj vključuje odgovornost za postavitev nove paradigme razvoja zdravstvene nege, ki bo odziv na potrebe družbe, stroke in znanosti. Strategija naj bo podprta z načrtno razdelitvijo sredstev za njeno uresničevanje.

The article is partially based on the results of a research project *Nursing as a scientific discipline in Slovenia: an internationally comparable secondary and tertiary education system in nursing care as the foundation of research and scientific contribution to the sustainable development of society./* Članek je nastal na podlagi dela rezultatov raziskovalnega projekta *Zdravstvena nega kot znanstvena disciplina v Sloveniji: mednarodno primerljiv sistem sekundarnega in terciarnega izobraževanja v zdravstveni negi kot temelj raziskav in prispevka znanosti k trajnostnemu družbenemu razvoju*.

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Introduction

Many of those in Slovenia who are involved in the research and development of nursing feel that the professionalization of nursing has been developing too slowly. Therefore, the issue is how well do we understand the concepts related to professionalization and the related factors? Carvalho (2014) states that nursing is often referred to as a 'half profession' or a 'virtual' profession in the discourse related to the professionalization of healthcare occupations.

Definitions

The concept of professionalization is an issue in many occupational groups and has a long history and social context. Consequently, several interpretations and definitions of this concept developed related to different use and needs (Demirkasimoğlu, 2010). An often-cited definition of professionalization states that professionalization is a social process that involves an institutionalised manner of preparing individuals for conducting professional tasks. During the process of professionalization, norms and qualifications for the representatives of the profession are established, and there is also responsibility for obtaining and transferring knowledge, certifying competencies, looking after relations among the members of the profession on the inside and on the outside (Wilensky & Harold, 1994). The Slovenian author Svetlik (1999) thinks that the process of professionalization of a certain occupation depends on several factors such as the area of work, the reasons for work, the resources that an occupation has available, as well as self-awareness and self-regulation of the occupation. That is why professionalization of various professions also differs amongst each other themselves.

Defining professionalization and professionalism in nursing

Many researchers have studied the professionalism of nursing through the years, so there are many definitions and descriptions of characteristics (Adams & Mikker, 2001; Manojlovich & Ketefian, 2002) and researchers use different methods and tools for evaluating it (Ghadirian, et al., 2014).

Professionalization is a multi-dimensional concept that ensures nurses develop personally and professionally. This process requires knowledge, skills, development of the characteristics of a professional identity related to a particular profession and internationalization of the values and norms of the professional group (Alidina, 2013). Professionalism is assessed according to individual characteristics and behaviour, relations with other individuals and the context of operation, as well as social dimensions such as social responsibility, morals, and political and economic responsibility. In addition, professionalism also includes following standards and competencies (Keeling & Templeman, 2013; Fantahun, et al., 2014). The concept of professionalism itself demonstrates dedication to the profession, so nurses are expected to educate themselves, publish their research, improve the practical and theoretical concepts of nursing and work independently (Çelik & Hisar, 2012). Their own professional perception and understanding of the concept of nursing, as well as their implementation in the social context, are of the utmost importance. Both their own professional perception and the understanding of the significance of nursing, affect the development and growth of nursing as a scientific discipline (Viitanen, 2007).

Watkins (2011) describes professionalism as a concept by means of three variables. The first one is *the formation of profession,* that involves a professional group, defined knowledge of the area of operation, established self-regulation and a continuing development of professional knowledge and skills for continuous improvement of the quality of work. The second variable of professionalism is *recognition of profession,* that includes core components such as knowledge, independence, responsibility of a professional judgement and their joined effect on the effectiveness of clinical work. The third variable is *success of the profession,* that can only be achieved by means of formal education and must include knowledge obtained by systematic research and professional review that is formed through critical thinking and decisions based on evidence. Watkins (2011) states that education on the master's level is a key element that uses the findings of research studies on professionalization in order to reach it. The reason for this is that research increases trust in graduates' own work, so that it is meaningful: the abilities of graduates to make decisions and their other cognitive abilities contribute to the implementation of evidence-based practice, thus achieving professionalism. Carvalho (2014) has found that professions in healthcare differ the most in terms of research-obtained knowledge. However, some nurses understand new knowledge as moving away from nursing care and support the local context of knowledge in practice.

Researching professionalization in Slovenia

Professionalization of nursing has been researched by Slovenian authors in original scientific works such as a dissertation, scientific or professional monograph or original scientific article (Pahor, 1998; Cvetek, 1999; Starc; Starc, 2009, 2016). An important contribution to understanding the professionalization of nursing in Slovenia is the scientific monograph *Medicinske sestre in univerza* (Pahor, 2006) ('Nurses and the University' transl.) in which the author summarises and reflects on the development of nursing education since 1990, thus demonstrating an important part of

professionalization that, according to Watkins (2011), belongs to *forming the profession*. An important contribution to understanding the professionalization is a monograph by Starc (2014) that finds three main characteristics of nursing professionalization in Slovenia, which are knowledge, power and ethics. In a quantitative analysis, Starc defines the concept of professionalization as nursing independence, which participants understand as knowledge, education, training, competencies and life-long learning.

The research conducted by Skela-Savič and colleagues (2016a; 2017a) focuses on professionalization from the aspect of professional values, competencies and evidence-based practice. The research has shown that the established values in nursing can only be understood as (1) values of nursing care, trust and fairness, and (2) values of development, professionalism and activism. The research has shown that the values of development, professionalism and activism are less important, which explains the success of the implementation of evidence-based practice. Nurses with a higher education degree in Slovenian hospitals understand competencies as "expected competencies for practical work" and as "competencies of development and professionalism". Knowledge and beliefs of evidence-based practice are present, but those included in the study are not convinced that they know evidence-based work well enough to incorporate it in practice. That is why evidence-based practice is rarely conducted . The causal non-experimental model shows that the beliefs and implementation of evidence-based practice may be explained by (1) values of development, professionalism and activism, (2) competencies of development and professionalism, (3) knowledge of research work, (4) knowledge of evidence-based practice, (5) education or training on evidence-based practice and (6) access to databases.

Aims and objectives

The purpose of the study was to verify the attitudes and understanding of certain elements of professionalization among experts of nursing in Slovenia. The aim of the study was to make a contribution towards recognising the factors that are important for the development of the professionalization of nursing care and that can contribute to the strategic planning of its development.

The research question:

– Which strategic factors are necessary in order to develop elements of professionalization in nursing in Slovenia, in the areas of education, professional competencies, and research related to the development of the occupation and nursing science?

Methods

A quantitative research paradigm was used and data was collected using a group interview technique and processed using a thematic analysis method, which is one of the approaches of analysing the content of a text (Gomm, 2008). A group interview is used when we wish to obtain data for strategic planning, whereby we are interested in opinions and answers to pre-prepared open questions. The group interview might be more successful if the participants know each other as the interaction between them and the host improves. The discussion is managed by the host who knows the topic of the discussion well (Kumar, 2011). Since the participants of the group interview also know the topic, Green and Thorogood (2004) refer to such a group as a natural group – a researcher can detect cultural dynamics on topics of interest and responses from practice, which forms the course of the group interviews and data processing.

Description of the research instrument

A group interview was conducted in two rounds. The first one, entitled "Development of a competence model for all levels of education in nursing", was conducted in October 2016, while the second round, entitled "The national model of development and consolidating nursing as a scientific discipline", was conducted in March 2017. Seven days before both meetings, the participants were sent questions/premises. The first round contained 5, while the second round was composed of 10 open questions/premises.

A sample of open questions from the first round:

– What is your attitude towards accepting the competence model in nursing for Slovenia?
– What kind of changes do you propose with reference to updating the standard of secondary education in nursing?
– What is your opinion about the aim of achieving a high level of organisation across all levels of nursing education, to enhance the sustainability of the healthcare system?

An example of open questions from the second round:

– What do you see as the key problem that should be solved, so that nursing could develop as a scientific discipline?
– What kind of knowledge do you miss at your work or the lack of what kind of knowledge hinders you in the development of the occupation that you are involved in?
– Generally, higher education teachers also work in clinical settings, which means that such a teacher has two jobs within full-time 100% employment. What would a healthcare institution gain from such cooperation and vice versa, what would the faculty gain?

On the day of the study the participants were placed in two groups in order to secure better conditions for active participation. We ensured that each group was equally comprised of the different professional groups

attending. The discussion was held simultaneously in separate rooms, according to the schedule, for five hours with two breaks, alongside an introductory presentation of the starting points for the discussion, that were related to findings of previous parts of the research project (Skela-Savič, et al., 2017b) whose part is also formed by this study. Before starting, we notified all the participants about the anonymity of the data processing and the voluntary participation in the study. The participants gave a written consent alongside the recording of the discussion. The groups of the first and second round were hosted by higher education teachers that are involved in the scientific research of nursing care in Slovenia. They had a uniform previously designed protocol of managing an interview with defined open questions. The discussion in both rounds was conducted according to the same protocol.

Description of the research sample

Kumar (2011) states that the selection of the sample in a group interview is the researcher's responsibility and that they should follow the purpose, which is addressing strategic themes. It is important that the professionals who are involved know the field and cover a wide spectrum of content that is related to the field of the discussion. In order to satisfy the conditions, we used a systematic purposeful sample of professionals (n = 48) that Green and Thorogood (2004) define as a prerequisite for obtaining representative data. The systematic feature of the sample was understood to mean ensuring an appropriate involvement of various sectors and other participants in the development of professionalization of nursing care. We included professionals from the following fields: secondary education (n = 8) and higher education in nursing (n = 15), healthcare institutions on all three levels of healthcare and other institutions (n = 17), students of master's and doctoral studies programmes that work in nursing (n = 3), and members of various professional bodies on the national level (n = 5). Those invited had operated at various levels of responsibility, from a professional leader of a certain area to a leader on the highest level of organisational management. 42 women and 6 men participated and all the participants had at least a higher education professional study degree; 9 (19 %) participants cooperated in both rounds of the study.

Description of the research procedure and data analysis

In data analysis we followed the thematic text analysis approach according to Gomm (2008), and Green and Thorogood (2004), which means that the researcher searches for common characteristics in the entire set of interview data and forms themes based on a comparison between similarities and differences in the respondents' responses in the interviews. A researcher decides what will count as evidence in order to design themes. The final themes may also be inspired by the ideas of the researcher; most often originating from the previous research of the research problem in question. In doing so, a researcher should be capable of reflection.

Based on the described guidelines we excluded the content that was unclear and could not be understood. We put all the forms in the female grammatical gender form as there were more women in both groups. We deleted all place names, names of institutions, bodies and communication fillers. In this way we secured anonymity of the respondent. The unit of coding was an uttered thought or opinion of a respondent about a specific topic. If a speaker talked about several themes, the uttered items were coded in several individual themes. In coding, the Thematic coding technique was used (Gomm, 2008), so we formed the codes with several words in order to describe the gist of what was said, which is called open descriptive coding. This enabled us to design categories such as hypernyms of the codes also in terms of content and to therefore come up with key findings based on the interviews that we presented in the form of themes. We conducted a secondary analysis of results and added some content and terminology in accordance with the research report by Skela-Savič and colleagues (2017b). In the data analysis we followed the processing guidelines according to Green (2004), as we wished to understand the connections between the attitude, behaviour and experience of the respondents in the field of the discussed themes. We also wished to understand the phenomenon of some elements of professionalization which the respondents used in their descriptions and, as a result of the study, we aimed at forming new ideas and a theoretical construct of findings for future research. The synthesis of findings from both rounds gave us the opportunity to better define the responsibility for the development of professionalism in nursing on a strategic level, which is also the purpose of the group interview technique.

Results

Round 1: Development of the competence model for all levels of education in healthcare

As part of the analysis we formed 49 codes that were supported by 150 quotations by the respondents. Each quotation was used only once. From 47 codes we developed 14 hypernymic categories that form 3 final themes (Table 1), while two codes were not listed under any category. A few examples of the development of codes are presented below. The development of all codes is shown in the research report with reference to the project *Nursing as a scientific discipline* (Skela-Savič, et al., 2017b).

As an example, the code "It is necessary to define the competencies depending on the level of education" was developed with three quotations:

Quotation 14: *I think that it is time that we agree on things, that this applies to the whole of Slovenia; that we do not ask ourselves who does what and what they should not be doing; that it is clear what the competencies of those with completed secondary school education are and of those who have completed the higher education programme.*

Quotations 15: */…/ that it has been clarified what the master's study entails. And of course, the first students have now enrolled in doctorate studies. I think that all of this has not yet been clarified or defined. And now that we are here, we have the chance to talk about these things.*

Quotation 16: *I think that we have now reached the point when we need to precisely define the competencies of individual contractors. Otherwise, I feel that the levels have been well designed, so I don't see any issues here.*

As another example, the code "An awareness of exceeding competencies of healthcare assistants is present" was developed considering four quotations.

Quotation 117: *We educate at level V, but what happens at the employers' is no longer our concern.*

Quotation 118: *When secondary school students attend work placement, they tell us what they have done and we worry because work placement seems not to be well designed. /.../ I'm not saying that we never learnt about this. I think this is where the difference is, namely what students learn at level V and what is then happening at work when these students start it.*

Quotation 119: *Employees with secondary school qualifications exceed their competencies, which is a matter for the employer.*

Table 1: *Results of the discussion on education and competencies in nursing care (Round 1)*
Tabela 1: *Rezultati razprave o izobraževanju in kompetencah v zdravstveni negi (sekvenca 1)*

Codes/Kode	***Categories/Kategorije***	***Themes/Teme***
Better involvement in the discussion on education and competencies is necessary.	There are differences in opinion between representatives of secondary and higher education regarding education.	Social responsibility of higher education to organise education on all levels and for the argumentation of the development of nursing as a scientific discipline.
Agreement between those actively involved in education and their users is necessary.		
Fear of competencies being taken away is present.		
There are ongoing opposing views regarding the education in nursing care.		
Levels of education are badly connected on the system level.		
Education is not systematically organised.		
The occupation is not uniform, neither systematically nor historically.		
Secondary education is training to work in the profession, not to study.	A dilemma exists whether the vertical system in education for the development of science should include secondary education.	
Most students come from secondary school for healthcare.		
A continuous vertical transition of secondary school students is expected.		
Training to work in the occupation should start in secondary school.		
Secondary schools promote the entire vertical system.		
The European directive assist in solving the issues in education.	The occupation of a nurse regulated by the European Union requires at least a higher professional study qualification.	
The university study programme of nursing is needed.		
The term nurse requires a higher education qualification.		
Study programmes should be comparable developments in the European Union.	European comparability safeguards the development of nursing care.	
Interference of other occupations in the autonomy of education in nursing care must be stopped.		
Higher professional education programmes must be changed to university programmes.	Sound general knowledge is needed to study nursing care.	
To enter higher education study programmes, sound general knowledge is needed.		
The higher education sector should respond to the lack of knowledge.		

Continues/Se nadaljuje

Codes/Kode	*Categories/Kategorije*	*Themes/Teme*
The title of healthcare assistant is not acceptable.	It is expected that a healthcare assistant works independently.	*Systemic responsibility of the nursing management and national professional association to stop exceeding the competencies of healthcare assistants and to ensure placement of the required levels of competences in nursing into the healthcare system.*
Healthcare assistant is an independent worker in health care, and is more than an assistant.		
Nurses with a higher education degree have to do too much administrative work.	A nurse with a higher education degree is not accepted as a responsible healthcare worker.	
Delegation and management performed by a nurse is not accepted.		
Awareness exists that the competencies of healthcare assistants are often exceeded.	All the involved parties are aware of the fact that competencies of healthcare assistants are being exceeded in clinical environments.	
There is no exceeding of competencies in secondary schools.		
Clinical environments the competencies of healthcare assistants to be exceeded.		
Exceeding of competencies is a professional self-approval for healthcare assistants.		
Exceeding the competencies of healthcare assistants is a complex problem.		
The informing of employees is insufficient.	Nursing management has a significant responsibility for classifying the levels of competencies and stop exceeding the competencies of healthcare assistants.	
Competencies should be determined based on the level of education.		
Changes of the collective agreement, systematisation and levels of competence are needed.		
A uniform understanding of the role of a master of healthcare is necessary.		
Interests of the profession should be balanced with the interests of employers.		
Exceeding the competencies of healthcare assistants is a serious problem.		
Responsibility of the management for exceeding the competencies of healthcare assistants.		
Vertical terms caregiver.	The professional term 'caregiver' does not have good social standing.	*Defining a healthcare assistant as a co-worker on the team of nursing care on all levels of healthcare system and as a key performer in healthcare and social care in the community and long-term care.*
The term 'nurse' is traditional.		
Cooperation of several stakeholders is necessary for the development of a professional standard.	The design of secondary school programmes is poorly understood.	
Unawareness of real professional titles through the course of changes in education is present.		
No distinction between professional titles and names for the level of qualification is also present.		
The name of the occupation does not include care and welfare.	The identity of the occupation of a healthcare assistant is lacking in terms of the competencies of social care.	
The needs for social competencies of healthcare assistants are expressed.		
The open curriculum must be unified.	Secondary schools do not show that they are ready for changes in the curriculum.	
Changes on the open curriculum are not enough.		
Assistive workers should be part of the vertical system.	There is a danger of overlapping competencies of a healthcare assistant and an assistive healthcare worker.	
There is a danger of overlapping the competencies of an assistive healthcare worker and healthcare assistant.		

Round 2: The national model of development and consolidating nursing as a scientific discipline

As part of text analysis we designed 20 codes that are justified with 101 quotations by respondents. Every quotation is used only once. We developed 7 hypernym categories that form 4 completed themes (Table 2). Below we present a few examples of code development, which is shown in great detail in the research report of the project *Nursing as a scientific discipline* (Skela-Savič, et al., 2017b).

As a further example, we developed the code "The interest in research skills is questionable" in reference to four quotations:

Quotation 25: *There is 30 min allocated to nurses with a higher education degree intended for reading just like doctors.*

Table 2: *Results of the discussion on the development and consolidation of healthcare as a scientific discipline (round 2)*
Tabela 2: *Rezultati razprave o razvoju in krepitvi zdravstvene nege kot znanstvene discipline (sekvenca 2)*

Codes/Kode	***Categories/Kategorije***	***Themes/Teme***
The management must be considerate of the employees' professional qualifications.	Management of healthcare institutions is responsible for the development of nursing as a scientific discipline.	*The responsibility of nursing management and management of faculties for the development of a scientific discipline at the level of each institution.*
Research and development must be supported by a systemization of job positions.		
With institutionalised organisation of research and development there are several issues.		
Movement of employees between a higher education and healthcare institution as part of 100 % employment is necessary.		
Management does not take on sufficient responsibility for research and development.		
Cooperation between the higher education and healthcare institutions is necessary.	Research groups should be organised between healthcare and higher education institutions.	
A research entity should be established between the higher education and healthcare institutions.		
Professional work and research must be connected.	The point of research is the development of the occupation and benefits for the patient.	*Research and development of the field as a work commitment of nurses with higher education qualifications.*
The centre of the research and development work should be the patient.		
Interest in knowledge of research is questionable.	Research is seen as optional and not as a priority of nurses.	
Understanding of research and development as leisure time activities conducted by nurses.		
Nurses are not willing to do research.		
To build a scientific discipline, knowledge is necessary.	Disagree on the scope and type of knowledge for development of occupation and science.	*Implementation of Europian comparable knowledge and competencies for the development of the occupation and scientific discipline in Slovenia.*
There is not enough training for research and development in the workplace.		
Opinions vary on the scope of training in research and development which is necessary for the profession of a nurse.		
An opinion that knowledge of research might be necessary in quality control was expressed.		
A national research institute is necessary.	The responsibility for the national research and development institute should be taken by the National Nurses and Midwives Association.	*The National Research Institute as a formal connecting form for the development and research in nursing care in Slovenia.*
The National Research Institute should be under the auspices of the national professional association.		
The National research institute should have other development tasks.		
An influence on the policy makers should be exerted through a National Research Institute.	The National Research Institute should influence the policy makers.	

Quotation 26: *It is up to an individual how much they will then educate themselves about a certain topic and whether they will look out for additional knowledge.*

Quotation 29: *I think the main problem is that we do not know about the opportunity or wish for additional knowledge.*

Quotation 79: *The management will decide, but she also has to venerate and be aware of the knowledge that she needs.*

The code "Nurses are not prepared to conduct research" was developed with five quotations:

Quotation 3: *A lot of knowledge, experience, but they don't know how to put this into words and write it down, which is a problem.*

Quotation 8: *Because of all that, the majority of those who enrol in nursing are people who are practical and who like working with people etc.*

Quotation 30: *And if you come with that idea to a clinical environment you get beaten.*

Quotation 119: *The problem lies in us as a professional group in the first place and then in our colleagues, especially doctors who won't allow us to develop. But, my personal opinion is that the problem is in our professional group, in our heads and our way of thinking. We say: "We are independent, we are autonomous," but if we take a look around at what goes on....subordination of nursing is...*

Quotation 120: *I strongly agree with my colleague and I think that the key problem is in us and in the fact that we underestimate intellectual work. That we should really identify what is necessary.*

Table 3, which shows a synthesis of content of the seven themes obtained in both rounds, points

Table 3: *Synthesis of rounds 1 and 2*
Tabela 3: *Sinteza tem sekvenc 1 in 2*

Themes/Teme	***Themes synthesis/Sinteza tem***
The responsibility of the nursing management and the management of faculties for the development of a scientific discipline on the level of each institution.	*NATIONAL RESPONSIBILITY – responsible for the implementation of a competence model in practice and for the development of nursing as a scientific discipline:* *(1) nursing management,* *(2) management of higher education and* *(3) the national association of nursing*
Social responsibility of higher education for organisation of education on all levels and for argumentation of the development of nursing as a scientific discipline.	
Implementation of European comparable knowledge and competencies for the development of the occupation and scientific discipline in Slovenia.	
Research and development of the occupation as a work commitment of nurses with a higher education degree.	*INDICATORS OF IMPLEMENTATION OF NATIONAL RESPONSIBILITY:* *(1) systematization of job position on four levels of competences in nursing,* *(2) research and development as a tool for working in nursing,* *(3) establishment of a national institute for research in nursing*
Systemic responsibility of the nursing management and the national professional association to end the exceeding competencies of healthcare assistants and introduction of levels of competences in nursing into the healthcare system.	
Defining a healthcare assistant as a co-worker on the team of nursing care on all levels of healthcare system and as a key performer in healthcare and social care in the community and long-term care.	
The National Research Institute as a formal connection for the development and research of nursing care in Slovenia.	

at factors that have, in the study, been found as important in constructing a national approach to the development of nursing as a scientific discipline in Slovenia. We have found two main themes that refer to national responsibility. The first one focuses on those responsible for the implementation of a competence model in practice and for the implementation of the development of nursing as a scientific discipline, while the second one refers to the indicators which we will use to follow the development of nursing as a scientific discipline.

Discussion

The results of group interviews conducted in two rounds bring our attention to the seven themes and two umbrella themes. The responsibility of healthcare management and higher education institutions and the professional association that is the Nurses and Midwives Association of Slovenia is of major importance for the development of nursing as a scientific discipline. These responsibilities have been defined on the level of national responsibility for the development of professionalization of nursing in Slovenia. We have also defined three national indicators of the implementation of this national responsibility: systematization of job positions on four levels of competencies in nursing, research and development as a tool for working in nursing and the establishment of the national institute for research in nursing.

The study has shown that we will only be able to talk about the real development of nursing care as a profession and scientific discipline when the key holders of responsibility, especially the nursing management in healthcare institutions, begin with systematization of job positions for four levels of competencies in nursing care and follow the internationally comparable conditions of qualifications for implementing competencies at a certain level. Two previous studies conducted by Skela-Savič and colleagues (2016b, 2016c) have shown that experts agree on the achieved adjustments of competencies as recommended by the European Federation of Nurses Associations – EFN, however, realistically speaking, there is no model outlining the competencies and activities of nursing care for the four levels of providers of nursing care despite the fact that a professional master's degree has been offered for ten years.

This study has shown that content and terminological implementation of the categories of providers of nursing care according to the EFN model (EFN Workforce Committee, 2014) into our education system, the system of national competencies and activities of nursing care is sensible, and its transfer into descriptions and systematization of job positions. Under the auspices of the project *Nursing as a scientific discipline*, matrix of the levels of competencies in nursing according to the model EFN (Skela-Savič, et al., 2017b) with the use of a quantitative and qualitative approach was verified. For the purposes of the article this matrix has been terminologically upgraded and conditions of qualifications were set and comparisons with the frameworks of qualifications have been made. The proposed model for Slovenia will be explained in detail in the future publications relating to this project.

The proposed competence model of the level of providers of nursing care in Slovenia:

– Level 1: an employee on the nursing team and the healthcare team – healthcare assistant (*'tehnik/tehnica zdravstvene nege'*), education – secondary vocational school for nursing (5th level of the Slovenian framework of qualifications or 4th level of the European framework of qualifications);

– Level 2: provider of nursing care on the team of nursing or healthcare team – general care nurse (*'diplomirani zdravstvenik/diplomirana medicinska sestra'; dipl. zn./dipl. m. s.*), education – higher education professional study programme nursing cycle 1 of the Bologna study programme that has been harmonised with the current European directive for regulated professions (Level 7 of the Slovenian framework of qualifications and Level 6 of the European framework of qualifications);
– Level 3: a specialist of a certain field in nursing – specialist nurse (*'diplomirani zdravstvenik/diplomirana medicinska sestra specialist/-ka'; dipl. zn. spec./dipl. m. s. spec.*), education – postgraduate specialist education or postgraduate education 2nd cycle Bologna study programme (Level 7–8 of the Slovenian framework of qualifications and Level 6–7 of the European framework of qualifications);
– Level 4: an expert for advanced forms of work in nursing and healthcare proceedings – Master of Nursing (*'magister/magistrica zdravstvene nege'; mag. zdr. nege*), Doctor of Nursing or Healthcare Sciences – Advance Nurse Practitioner, education – postgraduate education of 2nd and 3rd cycle of the Bologna study programme (Level 8–10 of the Slovenian framework of qualifications and level 7–8 of the European framework of qualifications).

In reference to the proposal of the presented competence model it should be emphasised that Level 3 and 4 cannot be reached if Level 2 has not been reached, while Level 1 is not a pre-condition to achieve Level 2, which is in accordance with the conditions to enter the education programme for a regulated profession (Directive 2013/55/EU of the European Parliament and of the Council, 2013).

The next significant step is to include all levels of competence into national human resource norms and into appropriate salary brackets. The study brings attention to the fact that developmental and research work in nursing is a tool for reaching evidence-based work. The respondents think that the implementation of research work in nursing may only eventuate through a national institute for research in nursing care whose founder is the Nurses and Midwives Association of Slovenia. The institute should be funded from membership fees and applications to tenders. The author of the article believes that waiting for other institutions to support nursing care considering the general current state of the healthcare policies in Slovenia is not sensible, but that rather the Nurses and Midwives Association of Slovenia should invest. Namely, the study has shown that a national research institute should implement an effect on healthcare policies. The following finding is that studies conducted by the new institute should be directed especially towards the needs of the patients. In this way, researchers of nursing care would contribute to forming new policies on the state level and broader, and would be more successful in obtaining research funding, which was mentioned by Büscher and colleagues (2009) in one of the studies.

A thorough analysis of the research results shows an important emphasis on higher education management from the perspective of social responsibility for the argumentation of the development of nursing as a scientific discipline and organisation of education on all levels. This is a logical expectation as accumulation of knowledge from research is the highest at faculties since research work must be conducted in order for the faculty to offer and further develop high quality programmes, which is possible only if there is research on the occupation for which the faculty educates and, if it is connected with the occupation, also in direct contact work with the patients. It is highly significant to also involve the clinical setting into research work, which the study has confirmed by the obtained codes such as "Higher education and healthcare institutions must cooperate", "There should exist a common research entity between the higher education and healthcare institution" and "Professional and research work must be connected". More emphasis on these themes is recommended in nursing study programmes to provide better integration of research culture and paradigms of conducting research in clinical settings (Kelly, et al., 2013; Loke, et al., 2014). Our study has brought attention to the above-mentioned, especially from the perspective that in Slovenia building a research culture is challenging, as the respondents are indecisive about the type and scope of knowledge for the development of the professional field and science. There is also an issue referring to the fact that research does not belong to standard work commitments of nurses and that nurses themselves do not see it as a big enough priority.

The present state that has been found in this study will improve when the nursing management support the development of knowledge of research and knowledge of evidence-based work with their employees (Skela-Savič, et al., 2016a). In this way, despite the present belief that research and development are not compulsory nor are they a priority; motivation for developmental work will increase – the study has shown a low awareness of the needs of developmental work; interest in obtaining knowledge to conduct research and development will increase and awareness on the relevance of research for high quality work will increase. Kelly and colleagues (2013) and Loke and colleagues (2014) state that research is simply not yet a part of the professional identity of nurses, so it often happens that nurses do not apply research findings in their everyday practical work, which has also been shown by this and other studies conducted in Slovenia (Skela-Savič, et al., 2016a; Skela-Savič, et al. 2017a). The established present situation also supports the established concept of values and competencies that would support the development of nursing as the value system of the nurses' work in Slovenian hospitals

is directed especially at completing daily professional tasks rather than developmental tasks (Skela-Savič, et al., 2017). The latter can also be confirmed with an existing study when we define the issue of exceeding the level of professional competence by healthcare assistants and thus bring attention to the lack of systematised job positions for nurses with a higher education study degree who are the only ones to carry the responsibility for development tasks in nursing and that are listed as competence level 4. The International Council of Nurses (2008) states that to perform development tasks a master's degree in nursing is a requirement, however, in Slovenia these job positions have not yet been systematized. That is why the defined responsibility of nursing management in this and previous research is justified.

A review of competencies written in the European Directive (Directive 2013/EU of the European Parliament and of the Council, 2013) clearly shows that *the competence ability to analyse the quality of nursing care and consequently improvement of the professional work of nurses for general healthcare* (listed under group H in the Directive) cannot be realised if the provider does not possess the basic knowledge on research and development and if they do not work according to the evidence-based concept. The fact that research and development should be included in the regular workload of nurses with a higher education study programme degree is logically a condition for realising the listed competences and consolidates the topic "implementation of knowledge and competencies for the development of the profession and science in Slovenia comparable to the European Union". Here it should be continuously explained that levels of competence should be implemented as our research has shown that there is indecisiveness present among the participants regarding the scope and levels of education, which means that the professional public does not yet understand the levels of education well and has difficulties trying to transfer them to a real clinical setting. It is also important to be aware of the fact that in developmental work in nursing we can come across many problems such as the time intended for research, a lack of research skills, insufficient support from the management and doctors, work processes and organisational culture that do not support research (Kelly, et al., 2013; Loke, et al., 2014; Yoder, et al., 2014). As regards nurses with a higher education study programme degree in Slovenian hospitals, it can be unfortunately said that there is a lack of knowledge and education and poor accessibility to professional and scientific literature (Skela-Savič, et al., 2016a, 2017a). All these findings make us consider the compulsory training courses to obtain a licence for work and whether this content is up to date in terms of knowledge necessary for the development of nursing in Slovenia and the qualifications of the nursing management, whose research has shown to be one of the key factors of the development of professionalization.

The research also draws attention to the discrepancies between secondary and higher education, as the expectations of secondary education, in the sense of uninterrupted vertical promotion for pupils of secondary schools for healthcare without the general school-leaving exam 'Matura', hinder ambitions of faculties to develop university study programmes of nursing. In this way the expected vertical schooling system in nursing in secondary school might be an obstacle for university education of nursing, which is also the starting point of the academic studies of nursing as this is how the majority of the providers for the professionalization of nursing obtain their professionalization.

The finding that competencies of healthcare assistants in clinical settingss are regularly being exceeded on a conscious level, which formally means that clinical setting disregards the fact that education for the occupation of a healthcare assistant in the education system does not compare with the competencies of nurses with a higher education degree. Namely, on a conscious level, healthcare assistants are expected to exceed their level of competencies. Similarly, participants of the secondary sector are bothered by a nurse who delegates and controls the work of a healthcare assistant because healthcare assistants are expected to be independent, which is the next obstacle in the professionalization of nursing in Slovenia. The established exceeding of competencies draws attention to the fact that employment of nurses should increase and that those healthcare assistants whose work interferes with the competencies of nurses with a higher education degree should be given an opportunity to train further. The nursing management is responsible for exceeding the levels of competencies of healthcare assistants because they fail to employ enough staff with a higher education degree. This is irresponsible towards patients and the occupation of nursing as it was also established by a study completed this year in Belgium, England, Spain and Finland by Linde Aiken (2017). The findings of this research state very clearly that if, in the nursing team who looks after 25 surgery patients and is composed of four nurses with a higher education degree and two caregivers with lower qualifications, we replace one nurse with a caregiver with lower qualifications, the probability for a patients' death increase by as much as 21 %. Melnyk and colleagues (2012) state that research studies enable practice which is evidence-based. These studies increase the quality and reliability of healthcare treatment, improve the outcomes of the treatment and decrease the variations in the treatment and costs. That is why in Slovenia systematic research in relation to the connections between the level of education and the number of healthcare employees and the outcomes of the treatment of patients is needed on a national level.

We can conclude that in nursing professionalization there are issues also in naming the occupation in

Slovenia, as the research has shown that "Professional name of a caregiver" is generally not very respected in the society and is considered as less valued or an inappropriate name for providers of nursing care. In addition, recognising new areas of operation of healthcare assistants such as social and care competencies by the representatives of the secondary school sector has not been accepted, which puts forward challenges for nursing as an occupation and scientific discipline.

The limitations of the research relate to the selection of the paradigm as high quality research in the field of validity and reliability has several restrictions. Validity and reliability was ensured with the method of a hermeneutic circle (Mesec, 1998), as the data was obtained based on broadening the findings of previous research and sequential research was conducted. The respondents of the study were always informed with previous findings on which our questions for the group interviews were based. Therefore, in the first round the respondents were sent a report on the conducted quantitative research among secondary school students, students, healthcare employees, secondary and higher education on the competence model in nursing and the attitude towards research and development in nursing (Skela-Savič, et al., 2016b, 2016d). These results were presented orally before the beginning of the first round. In the second round the respondents were sent and orally presented the results of the first round (Skela-Savič, et al., 2016c). Our research and the developed open questions are based on a research project that was previously conducted in Slovenian hospitals on a large sample (Skela-Savič, et al., 2016a; Skela-Savič, et al., 2017b), which might be understood as legitimising the research, that is evidenced by long-term observation, triangulation of various research methods for researching nursing professionalization in Slovenia and by informing the respondents about previous findings of our research on this topic. As a final step in legitimising the validity of the conducted research we conducted a "scientific café" in 2017 to which we invited experts in nursing, higher education and research. At the meeting we presented the obtained themes of the research and discussed them with the invited guests from a strategic point of view and also from the point of view of planning the necessary changes. Green and Thorogood (2004) name this a consensual conference. It should also be noted that the author of this article is an advocate for the need for accelerated development of nursing professionalization in Slovenia and that she is also a higher education lecturer of research methods, evidence-based work and healthcare management, which may be reflected in the interpretation of the results that the author managed with a reflective stance and by informing the participants of the research with previous findings of research (Mesec, 1998) that formed the course of the group interview. For the purposes of the article, the author reviewed the obtained results for the second time with the secondary analysis technique with an aim to achieve clarity, transparency and precision.

An inductive approach to research was used to identify some responsibilities for the development of the elements of nursing professionalization in Slovenia, which could be a challenge for researchers to verify the findings using a deductive approach to research. The research offers the basis for planning strategic guidelines for the development of nursing professionalization in the future, which was also the purpose of this study.

Conclusion

Research with a qualitative approach brings attention to the factors that will play an important role in the development of nursing professionalization in Slovenia and its breakthrough in scientific research and placement of the level of competencies in clinical work. An occupation becomes a profession once it creates its own knowledge with a systematic approach and transfers it directly into professional work and when experts generate research problems that they resolve together with those who have the competencies for thorough scientific work. The tools of operation include systematic research, professional judgement, development of critical thinking and decision-making on the basis of evidence. That is why nurses with a higher education degree in Slovenia must be given access to knowledge for the development of values of activism and development, research skills and evidence-based work, as in this way they will have a significant influence on the development of professionalization and nursing as a scientific discipline. Healthcare managers in key positions in various sectors must be trained to understand professionalization and for their responsibility in this area. A clear and ambitious vision is needed, as well as a development strategy for nursing that should include national guidelines for life-long professional training for healthcare institutions, professional sections, regional professional associations and management at all levels of nursing. The national professional association should assume the responsibility for the presentation of the new paradigm of the development of nursing that will be a response to the needs of the society, occupation and science, and to conduct a precise allocation of financial means in order to realise it.

Slovenian translation/Prevod v slovenščino

Uvod

V Sloveniji imajo mnogi, ki se ukvarjajo z raziskovanjem in razvojem zdravstvene nege, občutek, da se profesionalizacija zdravstvene nege razvija prepočasi. Upravičeno se postavlja vprašanje, kako

dobro razumemo pojme, povezane s profesionalizacijo, in dejavnike, ki so z njo povezani? Carvalho (2014) navaja, da se zdravstvena nega v razpravah o profesionalizaciji zdravstvenih poklicev pogosto navaja kot »polprofesija« ali »navidezna« profesija.

Opredelitev pojmov

Koncept profesionalizacije se pojasnjuje v številnih poklicnih skupinah in ima dolgo zgodovino ter družbeno-socialni kontekst. Posledično so za različno rabo in različne potrebe nastale številne interpretacije in definicije tega koncepta (Demirkasimoğlu, 2010). Zelo pogosto citirana definicija profesionalizacije pravi, da je profesionalizacija družbeni proces, ki poteka kot institucionaliziran način priprave posameznikov na opravljanje poklicno usmerjenih nalog. V procesu profesionalizacije se vzpostavljajo norme in kvalifikacije za predstavnike profesije, skrbi se za vzpostavljanje in prenašanje znanj, potrjevanje sposobnosti, urejanje odnosov med člani profesije in le-teh navzven (Wilensky & Harold, 1994). Slovenski avtor Svetlik (1999) meni, da je proces profesionalizacije določenega poklica odvisen od številnih dejavnikov, kot so področje delovanja, potrebnosti delovanja, virov, s katerimi poklic upravlja, pomembna sta tudi samozavedanje in samoregulacija poklica. Tako se poti profesionalizacije različnih profesij med seboj razlikujejo.

Opredelitev profesionalizacije oz. profesionalizma v zdravstveni negi

Skozi leta je profesionalizacijo v zdravstveni negi raziskovalo veliko raziskovalcev, nastalo je veliko definicij in opisov značilnosti (Adams & Mikker, 2001; Manojlovich & Ketefian, 2002), raziskovalci uporabljajo različne metode in orodja za oceno in evalvacijo le-te (Ghadirian, et al., 2014).

Profesionalizem je večdimenzionalni koncept, ki medicinskim sestram zagotavlja priložnosti za osebnostno in profesionalno rast. Ta proces zahteva znanje, veščine, razvoj značilnosti poklicne identitete profesije in internacionalizacijo vrednot in norm profesionalne skupine (Alidina, 2013). Profesionalizem se ocenjuje po individualnih značilnostih in obnašanju, odnosih z drugimi posamezniki in konteksti delovanja ter po socialnih dimenzijah, kot so družbena odgovornost, morala, politična in ekonomska odgovornost, profesionalizem vključuje tudi spoštovanje standardov in kompetenc (Keeling & Templeman, 2013; Fantahun, et al., 2014). Koncept profesionalizma sam po sebi pokaže na pripadnost profesiji, tako se od medicinskih sester pričakuje, da se izobražujejo, publicirajo svoje raziskave, izboljšujejo prakso in teorije zdravstvene nege ter da delujejo avtonomno (Çelik & Hisar, 2012). Pri tem je izjemnega pomena lastna poklicna percepcija in razumevanje pomena zdravstvene nege ter umestitev obojega v socialni kontekst. Oboje, lastna poklicna percepcija in razumevanje pomena zdravstvene nege, vpliva na razvoj in rast zdravstvene nege kot znanstvene discipline (Viitanen, 2007).

Watkins (2011) profesionalizem kot koncept opiše v obliki treh spremenljivk. Prva je *oblikovanje profesije*, ki vključuje poklicno skupino, definirana znanja na področju delovanja, vzpostavljeno samoregulacijo ter kontinuiran razvoj profesionalnega znanja in veščin za nenehno izboljševanje kakovosti dela. Druga spremenljivka profesionalizma je *priznavanje profesije*, ki vključuje temeljne komponente, kot so znanje, avtonomija, odgovornost za profesionalno presojo in njihov skupni učinek na učinkovitost kliničnega dela. Tretja spremenljivka je *uspešnost profesije*, ki je lahko dosežena samo s formalnim izobraževanjem, ki mora vključevati znanje, pridobljeno s sistematičnim raziskovanjem, in strokovno presojo, ki se oblikuje z razvojem kritičnega razmišljanja in odločanja na osnovi dokazov. Watkins (2011) definira, da je izobraževanje na magistrski ravni ključni element, ki spoznanja raziskav o profesionalizaciji postavi v kontekst akcije za doseganje le-te. Pri diplomantih namreč poveča zaupanje v lastno delo, tako da le-to dobi smisel; sposobnosti diplomantov za odločanje in njihove druge kognitivne sposobnosti pa pripomorejo k uresničevanju na dokazih podprte prakse in s tem k doseganju profesionalizma. Carvalho (2014) ugotavlja, da profesije v zdravstvu med seboj najbolj loči prav znanje, pridobljeno z raziskovalnim delom. Toda nekatere medicinske sestre to novo znanje zaznavajo kot odmik od negovanja in podpirajo lokalni kontekst znanja v praksi.

Raziskovanje profesionalizacije v Sloveniji

Profesionalizacijo v zdravstveni negi so na ravni izvirnega znanstvenega dela, tj. z izdelavo disertacije, objavo znanstvene ali strokovne monografije ali izvirnega znanstvenega članka, raziskovali tudi slovenski avtorji (Pahor, 1998; Cvetek, 1999; Starc, 2009, 2016). Pomemben prispevek k razumevanju profesionalizacije zdravstvene nege v Sloveniji predstavlja znanstvena monografija Medicinske sestre in univerza (Pahor, 2006), v kateri avtorica povzema in reflektira razvoj izobraževanja v zdravstveni negi od leta 1990 naprej ter tako prikaže pomemben segment profesionalizacije, ki po Watkins (2011) sodi v *oblikovanje profesije*. Naslednji pomembni prispevek k razumevanju profesionalizacije je monografija avtorja Starca (2014), ki ugotovi tri temeljne značilnosti profesionalizacije zdravstvene nege v Sloveniji, to so znanje, moč in etika. Koncept profesionalizacije Starc v kvalitativni analizi opredeli kot samostojnost zdravstvene nege, ki jo udeleženci raziskave razumejo kot znanje, izobrazbo, izobraževanje, kompetence in vseživljenjsko učenje.

Raziskava Skele-Savič in sodelavcev (2016a, 2017a) se osredotoča na profesionalizacijo z vidika profesionalnih vrednot, kompetenc in na dokazih podprtega dela. Raziskava pokaže, da je ugotovljene vrednote v zdravstveni negi mogoče razumeti kot (1) vrednote negovanja, zaupanja in pravičnosti ter kot (2) vrednote razvoja, profesionalizma in aktivizma. Raziskava je pokazala, da se vrednote razvoja, profesionalizma in aktivizma izkažejo kot manj pomembne, kar pomembno pojasni uspešnost implementacije na dokazih podprtega dela v praksi. Visokošolsko izobražene medicinske sestre v slovenskih bolnišnicah kompetence dojemajo kot »pričakovane kompetence za delo v praksi« in kot »kompetence razvoja in profesionalizma«. Znanja in prepričanja o na dokazih podprtem delu so prisotna, vendar vključeni v raziskavo niso prepričani, da na dokazih podprto delo poznajo dovolj dobro, da bi ga implementirali v svoje delo. Tako je implementacija na dokazih podprtega dela izjemno majhna in se izvaja le izjemoma. Vzročni neeksperimentalni model pokaže, da je prepričanja in implementacijo na dokazih podprtega dela mogoče pojasniti (1) z vrednotami razvoja, profesionalizma in aktivizma, (2) s kompetencami razvoja in profesionalizma, (3) z znanjem o raziskovanju (4) z znanjem o na dokazih podprtem delu, (5) z izobraževanjem oz. usposabljanjem o na dokazih podprtem delu in (6) z dostopom do podatkovnih baz.

Namen in cilji

Namen raziskave je bil preveriti stališča in razumevanje nekaterih elementov profesionalizacije med strokovnjaki zdravstvene nege v Sloveniji. Cilj raziskave je bil prispevati k prepoznavanju dejavnikov, ki so pomembni za razvoj profesionalizacije zdravstvene nege in ki lahko pripomorejo pri strateškem načrtovanju njenega razvoja.

Raziskovalno vprašanje:

– Kateri so strateški dejavniki za razvoj elementov profesionalizacije v zdravstveni negi v Sloveniji na področju izobraževanja oz. kompetenc za poklic ter na področju raziskovanja za razvoj stroke in znanosti zdravstvene nege?

Metode

Uporabili smo kvalitativno raziskovalno paradigmo, podatke smo zbirali s tehniko skupinskega intervjuja in jih obdelali po metodi tematske analize, ki je eden od pristopov analize vsebine besedila (Gomm, 2008). Skupinski intervju uporabimo, ko želimo pridobiti podatke za strateško načrtovanje; pri tem nas zanimajo mnenja in odgovori na že vnaprej pripravljena izhodiščna vprašanja. K uspešnosti skupinskega intervjuja pripomore, če se udeleženci med seboj poznajo, saj se tako poveča interakcija med njimi in moderatorjem. Razpravo vodi moderator, ki temo razprave dobro pozna (Kumar, 2011). Ker temo poznajo tudi udeleženci skupinskega intervjuja – tako skupino Green in Thorogood (2004) poimenujeta naravna skupina – raziskovalec lahko zazna kulturno dinamiko o obravnavanih temah in odzive iz prakse, kar oblikuje tudi potek skupinskega intervjuja in obdelavo podatkov.

Opis instrumenta in poteka raziskave

Skupinski intervju je potekal v dveh sekvencah, prva z naslovom »Razvoj kompetenčnega modela za vse ravni izobraževanja v zdravstveni negi« je bila izvedena oktobra 2016, druga sekvenca »Nacionalni model razvoja in krepitve zdravstvene nege kot znanstvene discipline« marca 2017. Sedem dni pred obema srečanjema smo udeležencem poslali izhodiščna vprašanja oz. stališča. Za prvo sekvenco smo pripravili 5 in za drugo 10 odprtih izhodiščnih vprašanj oz. stališč.

Primer izhodiščnih vprašanj v prvi sekvenci:

– Kakšno je vaše stališče do sprejema kompetenčnega modela v zdravstveni negi za Slovenijo?
– Kakšne spremembe predlagate v okviru prenove poklicnega standarda srednješolskega izobraževanja v zdravstveni negi?
– Kakšno je vaše stališče do doseganja urejenosti vseh posameznih ravni izobraževanja v zdravstveni negi za pozitiven vpliv na vzdržnost zdravstvenega sistema?

Primer izhodiščnih vprašanj v drugi sekvenci:

– Kaj ocenjujete kot ključni problem, ki ga je treba rešiti, da bi se zdravstvena nega lahko razvila kot znanstvena disciplina?
– Katera znanja pogrešate pri svojem delu in vas njihov primanjkljaj ovira pri uveljavljanju stroke, ki jo vodite ali kjer delujete?
– Praksa fakultet v tujini je, da visokošolski učitelji delajo tudi v kliničnih okoljih, to pomeni, da ima tak učitelj dve zaposlitvi v okviru 100 % zaposlitve. Kaj bi zdravstveni zavod v Sloveniji pridobil od takega sodelovanja in obratno, kaj bi pridobila fakulteta?

Na dan raziskave smo udeležence zaradi omogočanja boljših pogojev za aktivno sodelovanje razvrstili v dve skupini, pri čemer smo v vsaki skupini zagotovili enakomerno zastopanost vseh področij, na katerih delujejo povabljeni strokovnjaki. Razprava je potekala po skupinah prostorsko ločeno in sočasno po načrtovanem urniku, pet polnih ur z dvema odmoroma in uvodno predstavitvijo izhodišč za razpravo, ki so bila povezana s spoznanji predhodnih delov raziskovalnega projekta (Skela-Savič, et al., 2017b), katerega del je tudi ta raziskava. Pred pričetkom dela smo sodelujoče seznanili z anonimnostjo pri obdelavi podatkov in prostovoljno vključenostjo v raziskavo. Sodelujoči so podali pisno strinjanje s snemanjem razprave. Skupine prve in druge sekvence so moderirali

visokošolski učitelji, ki se znanstveno ukvarjajo z razvojem zdravstvene nege v Sloveniji. Imeli so enoten predhodno izdelan protokol vodenja intervjuja z opredeljenimi izhodiščnimi vprašanji. Razprava je v obeh sekvencah potekala po enakem protokolu.

Opis vzorca

Kumar (2011) pravi, da je izbor vzorca pri skupinskem intervjuju odgovornost raziskovalca, ki naj sledi namenu, to je obravnava strateških tem. Pomembno je, da vključeni strokovnjaki področje poznajo in da pokrivajo širok spekter vsebin, ki so s področjem razprave povezane. Da bi tem pogojem zadostili, smo uporabili sistematični namenski vzorec strokovnjakov ($n = 48$), ki ga Green in Thorogood (2004) utemeljujeta kot pogoj za pridobivanje reprezentativnih podatkov. Sistematičnost vzorca smo razumeli predvsem z ustrezno zastopanostjo različnih sektorjev in drugih akterjev pri razvoju profesionalizacije v zdravstveni negi. Vključili smo predstavnike z naslednjih področij: srednješolsko izobraževanje ($n = 8$) in visokošolsko izobraževanje v zdravstveni negi ($n = 15$), zdravstveni zavodi na vseh treh nivojih zdravstva in drugi zavodi ($n = 17$), študenti magistrskega in doktorskega študija, ki delajo v zdravstveni negi ($n = 3$), ter člani različnih strokovnih teles na nacionalni ravni ($n = 5$). Povabljeni so delovali na različnih nivojih odgovornosti, od strokovnega vodje določenega področja do vodje na najvišjem nivoju menedžmenta v organizaciji. Sodelovalo je 42 žensk in 6 moških, vsi udeleženci so imeli najmanj visokošolsko strokovno izobrazbo; 9 (19 %) udeležencev je sodelovalo v obeh sekvencah raziskave.

Opis obdelave podatkov

Pri obdelavi podatkov smo sledili pristopu tematske analize besedila po avtorjih Gomm (2008) ter Green in Thorogood (2004). Pri tem pristopu obdelave raziskovalec išče skupne vsebine v celotnem setu podatkov intervjujev in teme oblikuje na osnovi primerjav in nasprotij v povedanem s strani intervjuvancev. Raziskovalec se odloči, kaj bo štelo kot dokaz za oblikovanje tem. Končne teme so lahko inspirirane tudi z idejami raziskovalca, ki najpogosteje izhajajo iz predhodnega raziskovalnega dela obravnavanega raziskovalnega problema. Pri tem je potrebna reflektivna drža raziskovalca.

Na osnovi opisanih usmeritev smo pri prepisovanju posnetega intervjuja izločili vsebinsko nerazumljivo izrečeno besedilo. Zapis smo poenotili v žensko slovnično obliko, ker je bilo razmerje spolov v obeh skupinah v korist žensk. Izbrisali smo vse navedbe krajev in ustanov, različnih organov, za posameznikov govor značilna mašila ipd. S tem smo zagotovili anonimnost pri neposredni rabi izrečenega. Enota kodiranja je bila izrečena misel ali izrečeno stališče posameznega govorca na določeno temo. Če je govorec govoril o več temah, smo izrečeno kodirali pri več posameznih temah. Pri kodiranju smo uporabili tehniko tematskega kodiranja (Gomm, 2008), zato smo kode oblikovali večbesedno, s ciljem opisa ključne vsebine povedanega, kar imenujemo odprto opisno kodiranje. Le-to nam je omogočilo, da smo lahko kategorije, kot nadpomenke kod, ravno tako oblikovali na vsebinski ravni in iz njih razvili ključne ugotovitve intervjujev, ki smo jih podali v obliki tem. Pri pripravi članka smo izvedli sekundarno analizo dobljenih rezultatov in naredili nekaj vsebinskih in terminoloških dopolnitev glede na analizo v raziskovalnem poročilu Skela-Savič in sodelavci (2017b). Pri analizi podatkov smo sledili usmeritvam obdelave po avtorici Green (2004), saj smo želeli razumeti povezave med odnosom, vedenji in izkušnjami intervjuvancev na področju obravnavanih tem, prav tako smo želeli razumeti fenomen nekaterih elementov profesionalizacije, s katerimi so jo opisali intervjuvanci, kot rezultat raziskave pa smo želeli izoblikovati nove ideje in teoretični konstrukt spoznanj za nadaljnje raziskave. Sinteza spoznanj tem obeh sekvenc nam je dala možnost boljše opredelitve odgovornosti za razvoj profesionalizacije zdravstvene nege na strateški ravni, kar je tudi namen uporabe tehnike skupinskih intervjujev.

Rezultati

Sekvenca 1: Razvoj kompetenčnega modela za vse ravni izobraževanja v zdravstveni negi

V okviru analize besedila smo oblikovali 49 kod, ki so utemeljene s 150 citati udeležencev. Vsak citat je uporabljen samo enkrat. Iz 47 kod smo razvili 14 nadpomenskih kategorij, ki tvorijo 3 zaključene teme (Tabela 1), dve kodi se nista uvrstili v nobeno kategorijo. V nadaljevanju predstavljamo nekaj primerov razvoja kod. Razvoj vseh kod je natančno prikazan v raziskovalnem poročilu projekta Zdravstvena nega kot znanstvena disciplina (Skela-Savič, et al., 2017b).

Primer razvoja kode »Treba je določiti kompetence glede na ravni izobraževanja«, ki smo jo razvili s tremi citati:

Citat 14: *Jaz mislim, da je čas, da dogovorimo stvari, da jeto enotno za celotno Slovenijo; da se ne sprašujemo, kaj kdo dela in kaj naj ne bi delali; da se točno ve, kakšne so kompetence tistih, ki končajo srednješolsko izobraževanje, ter kakšne so kompetence tistih, ki končajo visokostrokovni program.*

Citat 15: */…/ da so razčiščene stvari, kako je na magistrskem študiju. In seveda, zdaj že imamo tudi vpise na doktorat. Jaz mislim, da te stvari res niso razčiščene in dorečene. In zdaj imamo možnost, ko smo tukaj skupaj, da se o teh stvareh pogovorimo.*

Citat 16: *Mislim, da smo zdaj prišli do tiste točke, da moramo samo opredeliti natančno, kaj so kompetence*

Tabela 1: *Rezultati razprave o izobraževanju in kompetencah v zdravstveni negi (sekvenca 1)*
Table 1: *Results of the discussion on education and competencies in nursing care (Round 1)*

Kode/Codes	***Kategorije/Categories***	***Teme/Themes***
Potrebna je širša vključenost v razpravo o izobraževanju in kompetencah.	Med srednjim in visokim šolstvom so razhajanja in nezaupanje glede izobraževanja.	Družbena odgovornost visokega šolstva za ureditev izobraževanja na vseh nivojih in za argumentacijo razvoja zdravstvene nege kot znanstvene discipline
Potrebna je uskladitev med akterji izobraževanja in le-teh z njihovimi uporabniki.		
Prisoten je strah pred odvzemom kompetenc.		
Glede izobraževanja v zdravstveni negi obstajajo stalna nasprotja.		
Nivoji izobraževanja so sistemsko slabo povezani.		
Izobraževanje ni sistemsko urejeno.		
Stroka je neenotna, tako sistemsko kot tudi zgodovinsko.		
Srednjestrokovno izobraževanje je usposabljanje za poklic in ne za študij.	Obstaja dilema, ali naj vertikala v izobraževanju za razvoj znanosti vključuje srednjestrokovno izobraževanje.	
Večina študentov je iz srednjih zdravstvenih šol.		
Pričakuje se neprekinjena vertikalna prehodnost dijakov srednjih zdravstvenih šol.		
Izobraževanje za poklic naj se začne na srednji strokovni stopnji.		
Srednje šole delajo promocijo za celotno vertikalo.		
Evropska direktiva pomaga reševati probleme izobraževanja.	Evropsko reguliran poklic medicinska sestra zahteva najmanj visokostrokovno izobrazbo.	
Potreben je univerzitetni študij zdravstvene nege.		
Poimenovanje medicinska sestra je pogojeno z visokošolsko izobrazbo.		
Študijski programi naj bodo primerljivi razvoju v Evropski uniji.	Evropska primerljivost varuje razvoj zdravstvene nege.	
Poseganje drugih poklicev v avtonomijo izobraževanja v zdravstveni negi je treba preseči.		
Visokostrokovne programe je treba preoblikovati v univerzitetne.	Za visokošolski študij zdravstvene nege je potrebno dobro splošno znanje.	
Za vstop v visokošolsko izobraževanje je potrebno dobro splošno znanje.		
Na primanjkljaj znanj naj se odziva visokošolski sektor.		
Naziv zdravstveni asistent ni sprejemljiv.	Pričakovana je samostojna vloga poklica TZN.	*Sistemska odgovornost menedžmenta zdravstvene nege in nacionalnega strokovnega združenja za ustavitev preseganja kompetenc TZN in umestitev ravni kompetenc v zdravstveni negi v sistem zdravstvenega varstva*
TZN je samostojni izvajalec zdravstvene nege, je več kot asistent.		
Diplomirane medicinske sestre opravljajo preveč administrativnega dela.	Diplomirana medicinska sestra/ zdravstvenik ni sprejet kot odgovorna nosilka zdravstvene nege.	
Delegiranje in nadzor diplomirane medicinske sestre se ne sprejema.		
Prisotno je zavedanje o preseganju kompetenc TZN.	Preseganja kompetenc TZN v kliničnih okoljih se zavedajo vsi akterji.	
Prekoračitve kompetenc v srednjih šolah ni.		
Klinična okolja dopuščajo prekoračitev kompetenc TZN.		
Preseganje kompetenc je za TZN poklicna samopotrditev.		
Preseganje kompetenc TZN je kompleksen problem.		
Informiranje zaposlenih je pomanjkljivo.	Veliko odgovornost za razmejevanje kompetenc in ustavitev preseganja kompetenc TZN nosi menedžmentu zdravstvene nege.	
Treba je določiti kompetence glede na ravni izobraževanja.		
Potrebne so spremembe kolektivne pogodbe, sistemizacije in nivojev kompetenc.		
Potrebno je enotno razumevanje vloge magistra zdravstvene nege.		
Uravnotežiti je treba interese stroke in interese delodajalcev.		
Preseganje kompetenc TZN je kompleksen problem.		
Odgovornost menedžmenta za preseganje kompetenc TZN.		

Se nadaljuje/Continues

Kode/Codes	*Kategorije/Categories*	*Teme/Themes*
Vertikalno poimenovanje negovalec, negovalka.	Poklicno poimenovanje »negovalec, negovalka« nima družbenega ugleda.	*Definiranje TZN kot sodelavca v timu zdravstvene nege na vseh nivojih zdravstva in kot ključnega izvajalca zdravstveno-socialne obravnave v skupnosti in v dolgotrajni oskrbi*
Poimenovanja »sestra« ima tradicijo.		
Za razvoj poklicnega standarda je potrebno sodelovanje različnih deležnikov.	Nastajanje srednješolskih programov je slabo razumljeno.	
Prisotno je nepoznavanje dejanskih strokovnih naslovov skozi spremembe izobraževanja.		
Prisotno je neločevanje med strokovnimi nazivi in poimenovanji stopnje dosežene izobrazbe.		
Oskrbe in sociale ime poklica ne zajame.	Identiteta poklica TZN je v dimenziji socialno oskrbovalnih kompetenc pomanjkljiva.	
Izražene se potrebe po socialnih kompetencah TZN.		
Odprti kurikulum je treba poenotiti.	Srednje šole ne kažejo pripravljenosti za spremembe v kurikulumu.	
Spremembe v odprtem kurikulumu ne zadostujejo.		
Bolničar naj bo del vertikale.	Obstaja nevarnost prekrivanja kompetenc TZN in bolničarja.	
Kaže se nevarnost prekrivanja kompetenc bolničarja in TZN.		

Legenda/Legend: TZN – tehnik/tehnica zdravstvene nege/healthcare assistant

posameznih izvajalcev. Drugače pa se mi zdi, da nivoje imamo kar dobro že začrtane, se mi zdi, da večjih težav tu ne vidim.

Primer razvoja kode »Prisotno je zavedanje o preseganju kompetenc tehnika zdravstvene nege (TZN)«, ki smo jo razvili s štirimi citati:

Citat 117: *Mi izobražujemo na peti stopnji, tisto, kar pa se dogaja pri delodajalcih, ni več naša zadeva.*

Citat 118: *Ko dijaki hodijo na praktično usposabljanje z delom (PUD), povedo, kaj so delali. Nas je kar malo strah, da ta PUD nekako ni dobro zasnovan. /…/ Ne rečem, da mi tega nismo nikoli učili. Mislim, da je tu ta razlika, kaj se uči na 5. stopnji in kaj se potem dogaja, ko dijaki po 5. stopnji gredo v službo.*

Citat 119: *Srednješolsko izobražen kader posega, prevzema kompetence, kar je stvar delodajalca.*

Sekvenca 2: Nacionalni model razvoja in krepitve zdravstvene nege kot znanstvene discipline

V okviru analize besedila smo oblikovali 20 kod, ki so utemeljene s 101 citatom udeležencev. Vsak citat je uporabljen samo enkrat. Razvili smo 7 nadpomenskih kategorij, ki tvorijo 4 zaključene teme (Tabela 2). V nadaljevanju predstavljamo nekaj primerov razvoja kod. Razvoj kod je natančno prikazan v raziskovalnem poročilu projekta Zdravstvena nega kot znanstvena disciplina (Skela-Savič, et al., 2017b).

Primer razvoja kode »Interes za znanje o raziskovanju je vprašljiv«, ki smo jo razvili s štirimi citati:

Citat 25: *Mi imamo v kolektivni pogodbi pol ure za diplomirane medicinske sestre, da je namenjeno branju, tako kot imajo zdravniki.*

Citat 26: *To je potem na strani posameznika, koliko se bodo sami o neki stvari izobrazili in pač neko dodatno znanje iskali.*

Citat 29: *Jaz vidim ključni problem v tem, da mi ne poznamo priložnosti oziroma želje po dodatnih znanjih.*

Citat 79: *Menedžment se bo odločal, pa tudi ona mora generirati, se zavedati tega znanja, ki ga potrebuje.*

Primer razvoja kode »Pri medicinskih sestrah ni pripravljenosti za raziskovanje«, ki smo jo razvili s petimi citati:

Citat 3: *Veliko znanja, izkušenj, ne znajo pa to potem ubesediti in zapisati, to je problem.*

Citat 8: *Zaradi tega, ker vsi, ki se, velika večina/tistih/, ki se vpisuje/jo/ v zdravstveno nego, so to eni ljudje, ki so praktiki, radi imajo delo z ljudmi itd.*

Citat 30: *In potem prideš s tisto idejo v klinično okolje in te povozijo.*

Citat 119: *Problem je v nas, v poklicni skupini, v prvi vrsti; pa drugi naši sodelavci, predvsem zdravniki nas ne pustijo k razvoju. Ampak moje osebno mnenje, problem je v naši poklicni skupini, v naših glavah, v našem razmišljanju. Govorimo: »Smo samostojni, smo avtonomni«, ampak če gledaš okoli, kaj se dogaja, … podrejenost zdravstvene nege je ...*

Citat 120: *Jaz se močno strinjam s kolegico in se mi zdi, da je ključni problem v nas samih, podcenjevanje dela z glavo. To, da bi mi sami zares prepoznali, da je sploh potrebno.*

V Tabeli 3 prikazana vsebinska sinteza sedmih tem, dobljenih v obeh sekvencah, pokaže na dejavnike, ki so v raziskavi ugotovljeni kot pomembni pri izgradnji nacionalnega pristopa razvoja zdravstvene nege kot znanstvene discipline za slovenski prostor. Ugotovili smo dve krovni temi, ki govorita o nacionalni odgovornosti. Prva govori o odgovornih za uveljavitev kompetenčnega modela v praksi in za uveljavitev razvoja zdravstvene nege kot znanstvene discipline, druga pa o kazalnikih, s katerimi bomo spremljali uresničevanje razvoja zdravstvene nege kot znanstvene discipline.

Tabela 2: *Rezultati razprave o razvoju in krepitvi zdravstvene nege kot znanstvene discipline (sekvenca 2)*
Table 2: *Results of the discussion on the development and consolidation of healthcare as a scientific discipline (round 2)*

Kode/Codes	***Kategorije/Categories***	***Teme/Themes***
Menedžment mora biti orientiran v strokovno usposobljenost kadra.	Za razvoj zdravstvene nege kot znanstvene discipline je odgovoren menedžment zdravstvenih zavodov.	*Odgovornost menedžmenta zdravstvene nege in menedžmenta fakultet za razvoj znanstvene discipline na ravni posameznega zavoda*
Raziskovanje in razvoj je treba podpreti s sistematizacijo delovnih mest.		
Pri institucionalnem organiziranju raziskovanja in razvoja prihaja do težav.		
Potrebno je prehajanje zaposlenih med visokošolskim in zdravstvenim zavodom, in sicer v okviru 100-% zaposlitve.		
Menedžment ne prevzema zadostne odgovornosti za raziskovanje in razvoj.		
Nujno je sodelovanje med visokošolskim in zdravstvenim zavodom.	Na ravni med zdravstvenim in visokošolskim zavodom je treba zasnovati raziskovalna jedra.	
Med visokošolskim in zdravstvenim zavodom naj se vzpostavi skupna raziskovalna entiteta.		
Strokovno delo in raziskovanje morata biti povezana.	Smisel raziskovanja je razvoj stroke za koristi pacienta.	*Raziskovanje in razvoj stroke kot delovna obveza visokošolsko izobraženih medicinskih sester*
Središče razvojno-raziskovalnega dela naj bo pacient.		
Interes za znanje o raziskovanju je vprašljiv.	Raziskovanje je videno kot neobvezna, in ne kot prioritetna aktivnost medicinskih sester.	
Prisotno je razumevanje raziskovanja in razvoja kot prostočasnih aktivnosti medicinskih sester.		
Pri medicinskih sestrah ni pripravljenosti za raziskovanje.		
Za izgradnjo znanstvene discipline je potrebno znanje.	Glede obsega in vrste znanj za razvoj stroke in znanosti njeni pripadniki niso enotno odločeni.	*Uveljavitev evropsko primerljivih znanj in kompetenc za razvoj stroke in znanosti v Sloveniji*
Izobraževanja za raziskovanje in razvoj na delovnem mestu je premalo.		
Mnenja o tem, kakšen obseg izobraževanja o raziskovanju in razvoju je potreben za poklic medicinske sestre, so različna.		
Izraženo je stališče, da je znanje o raziskovanju morda potrebno pri spremljanju kakovosti.		
Potreben je nacionalni raziskovalni inštitut.	Odgovornost za nacionalni raziskovalni in razvojni inštitut naj prevzeme Zbornica – Zveza.	*Nacionalni raziskovalni inštitut kot formalna povezovalna oblika za razvoj in raziskovanje v zdravstveni negi v Sloveniji*
Nacionalni raziskovalni inštitut naj bo pod okriljem Zbornice – Zveze.		
Nacionalni raziskovalni inštitut naj ima tudi druge razvojne naloge.		
Preko nacionalnega raziskovalnega inštituta naj se izvaja vpliv na politiko.	Nacionalni raziskovalni inštitut naj izvaja tudi vpliv na politiko.	

Tabela 3: *Sinteza tem sekvenc 1 in 2*
Table 3: *Synthesis of rounds 1 and 2*

Teme/Themes	***Sinteza tem/Themes synthesis***
Odgovornost menedžmenta zdravstvene nege in menedžmenta fakultet za razvoj znanstvene discipline na ravni posameznega zavoda	*NACIONALNA ODGOVORNOST – odgovorni za uveljavitev kompetenčnega modela v praksi in za uveljavitev razvoja zdravstvene nege kot znanstvene discipline:* *(1) menedžment zdravstvene nege,* *(2) menedžment visokega šolstva v zdravstveni negi in* *(3) nacionalno združenje v zdravstveni negi*
Družbena odgovornost visokega šolstva za ureditev izobraževanja na vseh nivojih in za argumentacijo razvoja zdravstvene nege kot znanstvene discipline	
Uveljavitev evropsko primerljivih znanj in kompetenc za razvoj stroke in znanosti v Sloveniji	
Raziskovanje in razvoj stroke kot delovna obveza visokošolsko izobraženih medicinskih sester	*KAZALNIKI URESNIČEVANJA NACIONALNE ODGOVORNOSTI:* *(1) sistematizacija delovnih mest za 4 ravni kompetenc v zdravstveni negi,* *(2) raziskovanje in razvoj kot orodje dela v zdravstveni negi,* *(3) ustanovitev nacionalnega inštituta za raziskave v zdravstveni negi*
Sistemska odgovornost menedžmenta zdravstvene nege in nacionalnega strokovnega združenja za ustavitev preseganja kompetenc TZN in umestitev ravni kompetenc v zdravstveni negi v sistem zdravstvenega varstva	
Definiranje TZN kot sodelavca v timu zdravstvene nege na vseh nivojih zdravstva in kot ključnega izvajalca zdravstveno-socialne obravnave v skupnosti in v dolgotrajni oskrbi	
Nacionalni raziskovalni inštitut kot formalna povezovalna oblika za razvoj in raziskovanje v zdravstveni negi v Sloveniji	

Legenda: TZN – tehnik/tehnica zdravstvene nege/healthcare assistant

Diskusija

Rezultati skupinskih intervjujev, izvedenih v dveh sekvencah, nas opozorijo na sedem vsebinskih tem in dve krovni temi. Ključnega pomena za razvoj zdravstvene nege kot znanstvene discipline se izkaže odgovornost menedžmenta zdravstvene nege in visokošolskih zavodov ter strokovnega združenja Zbornice – Zveze, le-te smo tako opredelili na ravni nacionalne odgovornosti za razvoj profesionalizacije v zdravstveni negi v Sloveniji. Opredelili smo tudi tri nacionalne kazalnike uresničevanja te nacionalne odgovornosti, le-ti so: sistemizacija delovnih mest za štiri ravni kompetenc v zdravstveni negi, raziskovanje in razvoj kot orodje dela v zdravstveni negi in ustanovitev nacionalnega inštituta za raziskave v zdravstveni negi.

Raziskava pokaže, da bomo o uresničevanju razvoja zdravstvene nege kot profesije in znanstvene discipline lahko govorili šele takrat, ko bodo ključni nosilci odgovornosti, zlasti menedžment zdravstvene nege v zdravstvenih zavodih, pričeli s sistematizacijo delovnih mest za štiri ravni kompetenc v zdravstveni negi in upoštevali mednarodno primerljive pogoje usposobljenosti za izvajanje kompetenc določene ravni. Dve predhodni raziskavi Skele-Savič in sodelavcev (2016b, 2016c) namreč pokažeta, da je med strokovnjaki doseženo strinjanje s prilagoditvami kompetenc, ki jih je priporočila Evropska federacija združenj medicinskih sester (European Federation of Nurses Associations – EFN) (EFN, 2014), vendar realno gledano, v Sloveniji modela kompetenc ali aktivnosti zdravstvene nege za štiri ravni izvajalcev zdravstvene nege še nimamo, in sicer ob dejstvu, da na ravni strokovnega magisterija izobražujemo že deset let.

Pričujoča raziskava pokaže, da so smiselni vsebinska in terminološka implementacija kategorij izvajalcev zdravstvene nege po modelu EFN (EFN Workforce Committee, 2014) v naš izobraževalni sistem, sistem nacionalnih kompetenc in aktivnosti zdravstvene nege in prevedba le-tega v opise in sistematizacijo delovnih mest. V okviru projekta Zdravstvena nega kot znanstvena disciplina je bila z uporabo kvantitativnega in kvalitativnega pristopa preverjena matrika ravni kompetenc v zdravstveni negi po modelu EFN (Skela-Savič, et al., 2017b), ki smo jo za namen tega članka terminološko dopolnili, oblikovali pogoje usposobljenosti in naredili primerjave z ogrodji kvalifikacij. Predlagani model za Slovenijo bo vsebinsko natančneje pojasnjen v naslednjih objavah omenjenega projekta.

Predlagani kompetenčni model ravni izvajalcev v zdravstveni negi v Sloveniji:

– Raven 1: sodelavec/sodelavka v timu zdravstvene nege in zdravstvenem timu – tehnik/tehnica zdravstvene nege (TZN) (ang. healthcare assistant), izobrazba – srednješolsko strokovno izobraževanje smeri zdravstvena nega (5. raven slovenskega ogrodja kvalifikacij (SOK) ali 4. raven evropskega ogrodja kvalifikacij (EOK));
– Raven 2: nosilec/nosilka zdravstvene nege v timu zdravstvene nege in zdravstvenem timu – diplomirani zdravstvenik/medicinska sestra (dipl. zn./dipl. m. s.) (ang. general care nurse), izobrazba – visokošolsko strokovno izobraževanje smeri zdravstvena nega 1. bolonjske stopnje, ki je usklajeno z aktualno veljavno evropsko direktivo za regulirane poklice (7. raven SOK ali 6. raven EOK);
– Raven 3: specialist/specialistka določenega področja v zdravstveni negi – diplomirani zdravstvenik/medicinska sestra specialist/-ka (dipl. zn. spec./dipl. m. s. spec.). (ang. specialist nurse), izobrazba – podiplomsko specialistično izobraževanje ali podiplomsko izobraževanje 2. bolonjske stopnje (7.–8. raven SOK ali 6.–7. raven EOK);
– Raven 4: strokovnjak/strokovnjakinja za napredne oblike dela v zdravstveni negi in zdravstveni obravnavi – magister/magistrica zdravstvene nege (mag. zdr. nege), doktor/doktorica zdravstvene nege ali zdravstvenih ved (ang. advance nurse practitioner), izobrazba – podiplomsko izobraževanje 2. in 3. bolonjske stopnje (8.–10. raven SOK ali 7.–8. raven EOK).

Pri predlogu prikazanega kompetenčnega modela je treba poudariti, da ravni 3 in 4 ni mogoče doseči, če ni dosežena raven 2, medtem ko raven 1 ni pogoj za doseganje ravni 2, kar je skladno s pogoji za vstop v izobraževanje za reguliran poklic (Directive 2013/55/EU of the European Parliament and of the Council , 2013).

Naslednji pomemben korak je vključitev vseh ravni kompetenc v nacionalne kadrovske normative in na plačni ravni v ustrezne tarifne skupine. Raziskava opozori, da naj bo razvojno delo in raziskovanje v zdravstveni negi orodje za uresničevanje na dokazih podprtega dela. Intervjuvanci menijo, da se prizadevanja in uveljavljanje raziskovalnega dela v zdravstveni negi lahko uresniči skozi nacionalni inštitut za raziskave v zdravstveni negi, katerega ustanoviteljica naj bo Zbornica – Zveza. Inštitut naj se financira iz članarin članov in iz prijav na razpise. Avtorica članka meni, da čakanje, da bi zdravstveno nego pri tem podprle druge institucije, glede na trenutno stanje zdravstvene politike v Sloveniji ni smiselno. Potrebna je investicija virov Zbornice – Zveze. Raziskava namreč pokaže, da je vpliv na zdravstveno politiko možno pričakovati preko nacionalnega raziskovalnega inštituta. Naslednja ugotovitev je, da morajo biti raziskave novega inštituta usmerjene predvsem v potrebe pacientov. Na ta način bi raziskovalke zdravstvene nege prispevale k oblikovanju politik na nivoju države in širše in bi bile bolj uspešne pri pridobivanju raziskovalnih sredstev, na kar v eni od raziskav opozori tudi Büscher s sodelavci (2009).

Poglobljena analiza rezultatov raziskave pokaže pomemben poudarek na visokošolskem menedžmentu z vidika družbene odgovornosti visokega šolstva za argumentacijo razvoja zdravstvene nege kot znanstvene discipline in ureditev izobraževanja na

vseh nivojih. Le-to je logično pričakovanje, saj je akumulacija znanja o raziskovanju na fakultetah največja, tam mora biti prisotno raziskovalno delo, saj fakulteta lahko kakovostno izvaja in posodablja študijske programe le, če stroko, o kateri izobražuje, raziskuje in če je s stroko povezana pri neposrednem delu s pacienti. Pomembno je vključevanje kliničnega okolja v raziskovalno delo, kar v raziskavi potrdimo tudi z dobljenimi kodami, kot so »Nujno je sodelovanje med visokošolskim in zdravstvenim zavodom«, »Med visokošolskim in zdravstvenim zavodom naj se vzpostavi skupna raziskovalna entiteta«, »Strokovno delo in raziskovanje morata biti povezana«. Za večjo integracijo raziskovalne kulture ter paradigem raziskovanja v kliničnih okoljih se priporoča večja pozornost na teh vsebinah v študijskih programih zdravstvene nege (Kelly, et al., 2013; Loke, et al., 2014). Na slednje opozori tudi naša raziskava, predvsem z vidika, da je v Sloveniji izgradnja raziskovalne kulture zahtevna, saj intervjuvanci izražajo neodločenost glede vrste in obsega znanja za razvoj stroke in znanosti, prav tako se izkaže problem, da raziskovanje ne sodi v delovno obvezo medicinskih sester in da mu same medicinske sestre ne pripisujejo dovolj velike prioritete.

V tej raziskavi ugotovljeno stanje se bo izboljšalo, ko bo menedžment zdravstvene nege pri zaposlenih podprl razvoj znanj iz raziskovanja in znanj iz na dokazih podprtega dela (Skela-Savič, et al., 2016a). S tem se bo presegla ugotovljena miselnost, da sta raziskovanje in razvoj zgolj neobvezni, in ne prioritetni aktivnosti medicinskih sester; povečala se bo motivacija za razvojno delo – v tej raziskavi se namreč kaže nizko lastno zavedanje o potrebah po razvojnem delu; povečal se bo interes za pridobivanje znanj za vzpostavitev raziskovanja in razvoja ter nenazadnje, vzpostavilo se bo zavedanje o pomenu raziskav za kakovostno delo. Kelly in sodelavci (2013) ter Loke in sodelavci (2014) opozarjajo, da raziskovanje preprosto še ni del profesionalne identitete medicinskih sester, zato se pogosto zgodi, da medicinske sestre tudi ne aplicirajo raziskovalnih izsledkov v vsakdanje praktično delo, kar pokaže tudi ta raziskava in druge v slovenskem prostoru že izvedene raziskave (Skela-Savič et al., 2016a, Skela-Savič, et al., 2017a). Ugotovljeno stanje podpira tudi ugotovljeni koncept vrednot in kompetenc, ki bi podpirale razvoj zdravstvene nege, saj je vrednostni sistem delovanja diplomirane medicinske sestre v slovenskih bolnišnicah usmerjen predvsem v uresničevanje dnevnih strokovnih nalog in ne razvojnih nalog (Skela-Savič, et al., 2017). Slednje potrdimo tudi z obstoječo raziskavo, ko opredelimo problematiko preseganja poklicnih kompetenc na strani TZN in s tem posledično opozorimo na pomanjkanje sistematiziranih delovnih mest za visokošolsko izobražene medicinske sestre, ki so edine lahko nosilke razvojnih nalog v zdravstveni negi, ki sodijo na četrto raven kompetenc. Mednarodni svet medicinskih sester (International Council of Nurses, 2008) opredeli, da je za razvojne naloge treba imeti izobrazbo magistra zdravstvene nege, v Sloveniji pa teh delovnih mest še niti nismo sistematizirali. Zato je opredeljena odgovornost menedžmenta zdravstvene nege v tej in predhodnih raziskavah utemeljena.

Že samo vpogled v kompetence, zapisane v direktivi za regulirane poklice Evropske unije (Directive 2013/55/EU of the European Parliament and of the Council, 2013), jasno kaže, da kompetence *sposobnost za analizo kakovosti zdravstvene nege in posledično izboljševanje lastnega strokovnega dela medicinskih sester za splošno zdravstveno nego* (v direktivi zapisano v skupini H) ni mogoče uresničiti, če izvajalec nima bazičnih znanj o raziskovanju in razvoju in če v praksi ne uporablja na dokazih podprtega koncepta dela. Dejstvo, da morata raziskovanje in razvoj postati del delovne obremenitve diplomiranih medicinskih sester, se logično postavi kot pogoj za uresničevanje navedene kompetence in utrdi v raziskavi dobljeno temo »uveljavitev evropsko primerljivih znanj in kompetenc za razvoj stroke in znanosti v Sloveniji«. Ob tem je treba nenehno pojasnjevati, zakaj je treba uvesti ravni kompetenc, saj naša raziskava pokaže, da je med udeleženci prisotna neodločenost o obsegu in ravneh izobraževanja, kar pomeni, da strokovna javnost ravni izobraževanj še ne razume najbolje ali jih težko preslika na realno klinično okolje. V mislih je treba imeti tudi spoznanja, da lahko pri razvojnem delu v zdravstveni negi naletimo na številne težave, kot so čas namenjen raziskovanju, pomanjkljivo znanje za izvajanje raziskovanja, nezadostna podpora s strani vodilnih in zdravnikov, procesi dela in organizacijska kultura, ki ne podpirajo raziskovanja (Kelly, et al., 2013; Loke, et al., 2014; Yoder, et al., 2014). Za diplomirane medicinske sestre v slovenskih bolnišnicah žal namreč lahko potrdimo tudi pomanjkljivo znanje in izobraževanje ter slabo dostopnost do strokovne in znanstvene literature (Skela-Savič, et al., 2016a; 2017a). Vsa ta spoznanja nas vodijo v premislek, kaj so obvezne vsebine izobraževanj za pridobitev licenc za delo in ali so te vsebine aktualizirane glede na znanja, potrebna za razvoj zdravstvene nege v Sloveniji, in kakšna je usposobljenost menedžmenta zdravstvene nege, katerega raziskava pokaže kot enega ključnih dejavnikov razvoja profesionalizacije.

Raziskava opozori tudi na razhajanja med srednjim in visokim šolstvom, saj pričakovanja srednjega šolstva v smislu neprekinjene vertikalne prehodnosti za dijake zdravstvenih šol brez splošne mature ovirajo ambicije fakultet za razvoj univerzitetnega študija zdravstvene nege. Tako se lahko pričakovana vertikala v zdravstveni negi na strani srednjih zdravstvenih šol izkaže kot ovira za univerzitetno izobraževanje v zdravstveni negi, s katerim se tudi začne akademizacija zdravstvene nege, saj z njo dosežemo večinsko usposobljenost izvajalcev za profesionalizacijo zdravstvene nege.

Poseben problem predstavlja ugotovitev, da je preseganje

kompetenc TZN v kliničnih okoljih na zavedni ravni, kar pomeni, da po formalni plati izobraževanje za poklic TZN v izobraževalnem programu ne daje kompetenc diplomiranih medicinskih sester, vendar tega klinično okolje ne upošteva. Na zavedni ravni od TZN namreč pričakujejo preseganje kompetenc. Prav tako je za udeležence iz srednješolskega sektorja moteče delegiranje in nadzor diplomirane medicinske sestre nad delom TZN, pričakujejo namreč samostojno vlogo poklica TZN v zdravstvenem sistemu, kar je naslednja ovira v profesionalizaciji zdravstvene nege v Sloveniji. Ugotovljeno preseganje kompetenc opozarja na dejstvo, da je potrebno povečano zaposlovanje diplomiranih medicinskih sester in omogočanje šolanja tistim TZN, katerih delo posega v kompetence diplomiranih medicinskih sester. Za preseganje kompetenc TZN je odgovoren menedžment zdravstvene nege, ki ne zaposli dovolj visokošolsko izobraženega kadra. To je neodgovorno ravnanje do pacientov in stroke, na kar je opozorila tudi v Belgiji, Angliji, Španiji, Švici in na Finskem letos zaključena raziskava Linde Aiken (2017), ki zelo jasno pove, da če v timu zdravstvene nege, ki skrbi za 25 kirurških pacientov in ga sestavljajo štiri diplomirane medicinske sestre in dva nižje izobražena izvajalca zdravstvene nege, nadomestimo eno diplomirano medicinsko sestro z nižje izobraženim izvajalcem zdravstvene nege, povečamo verjetnost za smrtnost pacientov za kar 21 %. Melnyk in sodelavci (2012) pravijo, da so raziskave tiste, ki omogočajo izvajanje na dokazih podprte prakse. Le-te povečujejo kakovost in zanesljivost zdravstvene obravnave, izboljšujejo izide zdravstvene obravnave in zmanjšujejo variiranje v zdravstveni obravnavi in stroških. Zato je v slovenskem prostoru treba na nacionalni ravni pristopiti k sistematičnim raziskavam o povezavah med stopnjo izobrazbe in številom zaposlenih v zdravstveni negi ter izidi zdravstvene obravnave pri pacientih.

Zaključimo lahko, da imamo pri profesionalizaciji zdravstvene nege v Sloveniji težave tudi s poimenovanjem poklica, saj raziskava pokaže, da »Poklicno poimenovanje »negovalec, negovalka« nima družbenega ugleda« in se ga šteje kot manj vredno in neprimerno poimenovanje za izvajalce zdravstvene nege. Tudi prepoznavanje novih področij delovanja TZN, kot so socialno-oskrbovalne kompetence, s strani predstavnikov srednješolskega sektorja ni sprejeto, kar zdravstveni negi kot stroki in znanosti nalaga izzive, kako v prihodnosti razumeti in odgovoriti na nove potrebe družbe.

Omejitve raziskave so v izboru paradigme, saj ima kvalitativno raziskovanje na področju veljavnosti in zanesljivosti več omejitev. Veljavnost in zanesljivost smo zagotavljali z metodo hermenevtičnega kroga (Mesec, 1998), saj smo podatke pridobivali na osnovi širitve spoznanj predhodnih raziskav in izvedli sekvenčno raziskovanje. Udeležence raziskave smo vedno seznanili s predhodnimi spoznanji, na katerih so temeljila naša izhodiščna vprašanja za skupinski intervju. Tako smo v prvi sekvenci intervjuvancem poslali pisno poročilo o izvedeni kvantitativni raziskavi med dijaki, študenti in zaposlenimi v zdravstvu, srednjem in visokem šolstvu o kompetenčnem modelu v zdravstveni negi in odnosu do raziskovanja in razvoja v zdravstveni negi (Skela-Savič, et al., 2016b, 2016d). Te rezultate smo pred začetkom prve sekvence tudi ustno predstavili. V drugi sekvenci smo intervjuvancem poslali in ustno predstavili rezultate prve sekvence (Skela-Savič, et al., 2016c). Naše raziskovanje in razvita izhodiščna vprašanja temeljijo na raziskovalnem projektu, predhodno izvedenem v slovenskih bolnišnicah na velikem vzorcu (Skela-Savič, et al., 2016a; Skela-Savič et al., 2017b), kar lahko razumemo kot utemeljevanje veljavnosti raziskovanja, ki se kaže z dolgotrajnimi opazovanji, s triangulacijo različnih raziskovalnih metod za raziskovanje profesionalizacije zdravstvene nege v Sloveniji in s seznanjanjem udeležencev s predhodnimi spoznanji našega raziskovanja te tematike. Kot zaključni korak pri utemeljevanju veljavnosti izvedene raziskave smo septembra 2017 izvedli »znanstveno kavarno«, na katero smo povabili strokovnjake v zdravstveni negi, vodilne v zdravstveni negi, v visokem šolstvu in na področju raziskovanja. Na tem srečanju smo predstavili dobljene teme raziskave in o njih s povabljenimi razpravljali s strateškega vidika in z vidika načrtovanja potrebnih sprememb. Green in Thorogood (2004) to poimenujeta konsenzualna konferenca. Pomembno je tudi povedati, da je avtorica članka zagovornica potreb po pospešenem razvoju profesionalizacije zdravstvene nege v Sloveniji in da je visokošolska učiteljica raziskovalnih metod, na dokazih podprtega dela in zdravstvenega menedžmenta, kar se lahko odraža v interpretaciji rezultatov, ki jo je avtorica obvladovala z reflektivno držo in seznanjanjem udeležencev raziskave s predhodnimi spoznanji raziskav (Mesec, 1998), ki so oblikovala tok skupinskega intervjuja. Avtorica je za potrebe objave članka ponovno preverila dobljene rezultate s tehniko sekundarne analize s ciljem razumljivosti, transparentnosti in natančnosti.

Z induktivnim raziskovalnim pristopom smo prepoznali nekatere odgovornosti za razvoj elementov profesionalizacije v zdravstveni negi v Sloveniji, ki so lahko izziv raziskovalcem, da spoznanja preverijo po deduktivni poti raziskovanja. Raziskava daje izhodišča za načrtovanje strateških usmeritev razvoja profesionalizacije zdravstvene nege v prihodnosti, kar je bil tudi cilj naše raziskave.

Zaključek

Raziskava s pomočjo kvalitativnega pristopa opozori na dejavnike, ki bodo odigrali pomembno vlogo pri razvoju profesionalizacije zdravstvene nege v Sloveniji in pri njenem preboju na področju

znanstvenoraziskovalnega dela in umeščanja ravni kompetenc v klinično delo. Stroka postane profesija takrat, kadar s sistematičnim pristopom ustvarja svoje lastno znanje in ga prenaša v neposredno strokovno delo in ko strokovnjaki generirajo raziskovalne probleme, ki jih rešujejo skupaj s tistimi, ki imajo kompetence za temeljno raziskovalno delo. Orodje delovanja so sistematično raziskovanje, strokovna presoja, razvoj kritičnega razmišljanja in odločanje na osnovi dokazov. Zato je visokošolsko izobražene medicinske sestre v Sloveniji treba opolnomočiti z znanji za razvoj vrednot aktivizma in razvoja, z znanji o raziskovanju in o na dokazih podprtem delu, saj bodo s tem pomembno vplivale na razvoj profesionalizacije in razvoj zdravstvene nege kot znanosti. Menedžerji na ključnih položajih zdravstvene nege v vseh sektorjih delovanja morajo biti usposobljeni za razumevanje profesionalizacije in za svojo odgovornost na tem področju. Potrebni sta jasna in ambiciozna vizija ter strategija razvoja zdravstvene nege, ki naj vključuje nacionalne usmeritve za vseživljenjsko profesionalno izobraževanje za zdravstvene zavode, strokovne sekcije, regijska strokovna društva in menedžment na vseh nivojih zdravstvene nege. Nacionalno strokovno združenje mora prevzeti odgovornost za predstavitev nove paradigme razvoja zdravstvene nege, ki bo odziv na potrebe družbe, stroke in znanosti ter izvesti načrtno razdelitev sredstev za uresničevanje le-te.

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Conflict of interest/Nasprotje interesov

The author declares that no conflicts of interest exist./Avtorica izjavlja, da ni nasprotja interesov.

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Ethical approval/Etika raziskovanja

Permission to conduct the research was obtained from the Committee for research and development of the Angela Boškin Faculty of Health Care. The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014)./Dovoljenje za izvedbo raziskave smo pridobili na Komisiji za znanstveno raziskovalno in razvojno dejavnost Fakultete za zdravstvo Angele Boškin. Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2016) in v skladu s Kodeksom etike v zdravstveni negi Slovenije (2014).

Author contributions/Prispevek avtorjev

The author was the head of the project. She designed the research plan and the research instrument as well as the research sample. She participated in managing the group interview to collect data in both rounds, performed data processing of the final transcribed interview (codes, categories, themes) and secondary analysis of data for the purposes of the article, described results, conducted a synthesis of the obtained themes of the four interviews, discussed the obtained results and designed recommendations for further research and developmental work./Avtorica je bila vodja projekta. Naredila je načrt raziskave, oblikovala instrument in vzorec raziskave, v obeh sekvencah sodelovala pri vodenju skupinskega intervjuja za zajem podatkov, naredila obdelavo podatkov prečiščenega besedila prepisa posnetega intervjuja (kode, kategorije, teme) in sekundarno analizo podatkov za potrebe članka, opisala rezultate, naredila sintezo dobljenih tem štirih intervjujev, razpravljala o dobljenih rezultatih in oblikovala priporočila za nadaljnje raziskovanje in razvojno delo.

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