FAKULTETA ZA ZDRAVSTVENE VEDE V CELJU

CENTER ZA VSEŽIVLJENJSKO IZOBRAŽEVANJE IN KARIERNO SVETOVANJE

ZAGOTAVLJANJE IN IZBOLJŠEVANJE KAKOVOSTNE IN VARNE ZDRAVSTVENE OBRAVNAVE – REALNOST ALI ILUZIJA?

Ensuring and improving quality and safe healthcare treatment – illusion or reality?

Zbornik povzetkov

Fakulteta za zdravstvene vede v Celju

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Zagotavljanje in izboljševanje kakovostne in varne zdravstvene obravnave – realnost ali iluzija?
Zbornik povzetkov

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KAZALO

KEY FINDINGS OF THE RANCARE PROJECT: EVIDENCE FOR FURTHER DEVELOPMENT OF NURSING CARE

KLJUČNE UGOTOVITVE PROJEKTA RANCARE: DOKAZI ZA NADALJNJI RAZVOJ ZDRAVSTVENE NEGE

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Key words: nursing care, care, missed care, delayed care

The aim of this presentation is to discuss the issue of missed nursing care by reporting on the key findings of the RANCARE project. The RANCARE project (www.rancare-action.eu) under the European Cooperation in Science and Technology Association was carried on during 2016-2021. The overall aim of this action was to facilitate discussion about rationing of nursing care based on a cross-national comparative approach with implications for practice and professional development. During the project different deliverables were developed with the impact on nurse education, practice, research, leadership, and management. Those deliverables include scientific articles, book chapters, policy brief, a short video for the society, training manuals for nurse managers and other things.
The issue of missed or delayed care was broadly addressed. Missed or rationed nursing care is care which is necessary, but which is not provided due to constrained resources, and therefore has been termed an error of omission within the missed nursing care model. Nursing care can be missed or rationed when resources are unavailable, with resultant compromises in patient safety and possible adverse outcomes for patients and staff. Nurses' knowledge, perceptions and attitudes, professional and personal values are important, along with leadership and collaborative teamwork are influential in how they adhere to patient safety guidelines. Patient safety education can link all these factors together and empower nurses to intervene or give voice to their concerns. Minimising levels of missed nursing care across health systems should be a priority for all those concerned with patient safety.

Kjlučne besede: zdravstvena nega, skrb, neizvedena zdravstvena nega, zamujena zdravstvena nega

Namen predstavitve je obravnava problematike neizvedene zdravstvene nege s poročanjem o ključnih ugotovitvah projekta RANCARE. Projekt RANCARE (www.rancare-action.eu) izveden v okviru Evropskega združenja za sodelovanje v

znanosti in tehnologiji je potekal v letih 2016-2021. Splošni cilj projekta je bil omogočiti razpravo o racionalizaciji zdravstvene nege na podlagi mednacionalnega primerjalnega pristopa s posledicami za prakso in strokovni razvoj. Med projektom so bili razviti različni rezultati z vplivom na izobraževanje, prakso, raziskave, vodenje in organizacijo dela medicinskih sester. Ti rezultati vključujejo znanstvene članke, poglavja v knjigah, povzetek politike, kratek videoposnetek za družbo, priročnike za usposabljanje vodij medicinskih sester in drugo.

Vprašanje neizvedene ali zapoznele zdravstvene nege je bilo široko obravnavano. Neizvedena ali racionalizirana zdravstvena nega je oskrba, ki je nujna, vendar ni zagotovljena zaradi omejenih sredstev, zato se v modelu izpuščene zdravstvene nege imenuje napaka opustitve. Zdravstvena nega je lahko neizvedena ali racionalizirana, če viri niso na voljo, s posledično ogroženostjo varnosti pacientov in možnimi neželenimi izidi za paciente in zaposlene. Znanje, dojemanje in odnos medicinskih sester, poklicne in osebne vrednote so pomembni, skupaj z vodenjem in timskim sodelovanjem pa vplivajo na to, kako se držijo smernic za varnost pacientov. Izobraževanje o varnosti pacientov lahko poveže vse te dejavnike in omogoči medicinskim sestram, da posredujejo ali izrazijo svoje skrbi. Zmanjšanje ravni neizvedene zdravstvene nege v zdravstvenih sistemih bi moralo biti prednostna naloga za vse tiste, ki skrbijo za varnost pacientov.

PREDSTAVITEV AVTORICE

Prof. Olga Riklikiene is a nurse and a nursing professor at Lithuanian University of Health sciences, Nursing department. She delivers lectures for students at all three levels of nursing education. Her topics are: research methodology, mentorship in nursing, quality of nursing care. Olga Riklikiene also actively participates in the research projects, nationally and internationally. Her recent scientific interests relate to the spiritual needs of different groups of ill and healthy people and spiritual care, women's mental health and birth related trauma, patient safety and missed care. Prof. Riklikiene published several book chapters and numerous research articles on her study results.

Prof. Olga Riklikiene je medicinska sestra in profesorica zdravstvene nege na Lithuanian University of Health sciences, na oddelku za zdravstveno nego. Vključena je v študijski proces na vseh treh stopnjah izobraževanja v zdravstveni negi. Njena raziskovalna področja so: raziskovalna metodologija, mentorstvo v zdravstveni negi, kakovost zdravstvene nege. Olga Riklikiene aktivno sodeluje v raziskovalnih projektih, doma in v tujini. Njena zadnja znanstveno raziskovlana dela se nanašajo na duhovne potrebe različnih skupin bolnih in zdravih ljudi ter duhovno oskrbo; duševno zdravje žensk in porodne travme; varnost pacientov in neizvedeno zdravstveno oskrbo. Prof. Riklikiene je o svojih študijskih rezultatih objavila več poglavij v knjigah in številne raziskovalne članke.

NEIZVEDENA ZDRAVSTVENA NEGA: PRESEČNA ŠTUDIJA

MISSED NURSING CARE: A CROSS-SECTIONAL STUDY

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Ključne besede: neizvajanje aktivnosti zdravstvene nege, medicinska sestra, tehnik zdravstvene nege, delovne izkušnje, vzroki

Teoretična izhodišča: V zadnjih letih je neizvedena zdravstvena nega postala pereč globalni problem svetovnega zdravstva in vse pogosteje se z neizvedeno zdravstveno nego srečujejo tudi medicinske sestre v Sloveniji. Neizvedena zdravstvena nega je koncept, ki obsega zavedno ali nezavedno popolno opustitev izvedbe določenih aktivnosti zdravstvene nege, časovno preložitev izvedbe ali le delno izvedbo določene aktivnosti. Z raziskavo smo želeli ugotoviti, katere so najpogostejše aktivnosti zdravstvene nege, ki jih medicinske sestre in tehniki zdravstvene nege ne izvedejo v zdravstvenih in socialno varstvenih zavodih, kakšna je povezanost njihovih delovnih izkušenj na sedanjem delovnem mestu z neizvajanjem zdravstvene nege ter kateri so najpogostejši vzroki za neizvedeno zdravstveno nego.

Metoda: Presečna študija je temeljila na kvantitativnem raziskovalnem pristopu, metodi deskripcije, kompilacije in sinteze. Za zbiranje podatkov smo z dovoljenjem avtorice uporabili revidiran vprašalnik »The MISSCARE Survey«. Podatke smo zbrali s spletno anketo 1KA, v kateri je sodelovalo 180 izvajalcev zdravstvene nege, od tega 81 diplomiranih medicinskih sester, 26 zdravstvenih tehnikov in 73 izvajalcev zdravstvene nege na drugih delovnih mestih (vodja tima zdravstvene nege, vodja enote, oddelka, ambulante), ki imajo v povprečju več kot 10 let delovnih izkušenj na sedanjem delovnem mestu.

Rezultati: Ugotovili smo, da medicinske sestre najpogosteje ne izvedejo naslednjih nalog: dokumentiranje vseh zahtevanih podatkov (M = 1,86, SD = 1,21), čustvena podpora pacientu in/ali svojcem (M = 2,05, SD = 1,11) ter poučevanje pacienta v povezavi z boleznijo, preiskavami in diagnostičnimi rezultati (M = 2,12, SD = 1,22). Tudi zdravstveni tehniki najpogosteje ne dokumentiranjo vseh zahtevanih podatkov (M = 1,69, SD = 1,29), ne oskrbijo rane in ne negujejo poškodovane kože (M = 1,73, SD = 1,04) ter prav tako ne nudijo čustvene podpore pacientu in/ali svojcem (M = 1,88, SD = 0,99). Ugotavljamo tudi povezanost delovnih izkušenj na sedanjem delovnem mestu z

neizvajanjem zdravstvene nege pri naslednjih nalogah: merjenje vitalnih znakov po naročilu, merjenje ravni sladkorja v krvi, kot je naročeno, ter odziv na svetlobni in zvočni signal ali pacientovo trkanje na vrata ambulante v roku pet minut. Več kot imajo izvajalci zdravstvene nege delovnih izkušenj, redkeje ne izvedejo aktivnosti zdravstvene nege in nasprotno, manj kot imajo delovnih izkušenj, pogosteje ne izvedejo aktivnosti zdravstvene nege. Sodelujoči v raziskavi so kot najpomembnejši vzrok za neizvedeno zdravstveno nego navedli neustrezno število kadra (M = 1,59, SD = 0,96), nujno stanje pacienta (npr. poslabšanje) (M = 1,88, SD = 1,17) in nepričakovano povečanje števila pacientov v enoti/oddelku/ambulanti (M = 1,79, SD = 1,07).

Razprava: Neizvajanje zdravstvene nege lahko negativno vpliva na izide pacientovega zdravja ter lahko povzroči neželene dogodke in zaplete. Je pomemben indikator kakovosti in varnosti obravnave pacientov. Neizvedena zdravstvena nega je lahko rezultat različnih strukturnih in procesnih dejavnikov v zdravstvenih, socialno varstvenih in drugih zavodih. Vsekakor pa je treba zagotoviti ustrezno število kadra, ki je pogoj za zmanjšanje neizvajanja aktivnosti zdravstvene nege in za razbremenitev izvajalcev zdravstvene nege, da bodo lahko izboljšali kakovost obravnave pacientov, zagotovili njihovo varnost, dosegli boljše zdravstvene izide pri pacientih in s tem tudi njihovo večje zadovoljstvo z zdravstveno nego.

Key words: missed nursing care activities, nurse, nursing care technician, work experience, causes

Theoretical background: In recent years, missed nursing care has become a pressing global problem in global healthcare, which is increasingly encountered also by nurses in Slovenia. Missed nursing care is a concept which includes the witting or unwitting complete abandonment of the performance of certain nursing care activities, postponement of the performance, or only partial performance of a certain activity. With our research, we tried to establish which are the most common nursing care activities that nurses and nursing technicians allow to go missed in healthcare and social care institutions, what is the connection between their work experience at their current workplace and missed nursing care, and what are the most common causes of missed nursing care.

Method: The cross-sectional study was based on a quantitative research approach, the descriptive research method, compilation and synthesis. With the permission of the author, we used the revised questionnaire "The MISSCARE Survey", in order to collect the data. We collected the data through an online survey 1KA, which included 180 nursing care providers, 81 of which were registered nurses, 26 were healthcare technicians, and 73 were nursing care providers in other positions (nursing team leader, head of unit, department, clinic), who have had an average of more than 10 years of work experience in their current position.

Results: We have established that nurses most often miss the following tasks: documenting of all the required data (M=1.86, SD=1.21), providing emotional support to the patient and/or

relatives (M=2.05, SD=1, 11) and informing the patient in connection with the disease, medical examinations and diagnostic results (M=2.12, SD=1.22). Also, healthcare technicians most often do not document all the required data (M=1.69, SD=1.29), do not perform wound care or care for the damaged skin (M=1.73, SD=1.04), and also do not provide emotional support to the patient and/or relatives (M=1.88, SD=0.99). We also tried to establish the association of work experience in the current workplace with missed nursing care performing the following tasks: measuring vital signs as directed, measuring blood sugar levels as directed, and responding to a light and sound signal or answering the patient's knocking on the clinic door within five minutes. We established that the more work experience that the nursing care providers have, the less often they miss nursing care activities, and vice versa, the less work experience that they have, the more often they miss nursing care activities. The respondents in the research have stated inadequate number of staff (M=1.59, SD=0.96), medical emergencies (e.g. deterioration of patient's condition) (M=1.88, SD=1.17), and an unexpected increase in the number of patients in the unit/ward/outpatient clinic (M=1.79, SD=1.07), as the most important causes of missed nursing care.

Discussion: Missed nursing care can adversely affect the patient's healthcare outcomes, can cause adverse events and complications. It is an important indicator of the quality and safety of patient care. Missed nursing care can be the result of various structural and procedural factors in healthcare, social care and other institutions. In any case, it is necessary to provide an adequate number of healthcare personnel, which is a prerequisite for reducing the scope of missed nursing care activities, for relieving the burden on nursing care providers, so that they can improve the quality of patient care, ensure their safety, achieve better healthcare outcomes in patients and thereby their greater satisfaction with nursing care.

PREDSTAVITEV VODILNE AVTORICE

Dr. Bojana Filej je izredna profesorica za področje zdravstvene nege in je vključena v pedagoški proces na Fakulteti za zdravstvene vede v Celju na 2. stopnji in na Univerzi v Novem mestu na Fakulteti za zdravstvene vede na 2. in 3. stopnji.

Svojo strokovno pot je začela kot višja medicinska sestra v patronažni dejavnosti ter nadaljevala kot predstojnica enote pomoči na domu, kot vodja službe zdravstvene nege pacinenta na domu in kot pomočnica direktorja za zdravstveno nego v Zdravstvenem domu dr. Adolfa Drolca Maribor. Po 27 letih dela v zdravstvenem domu se je zaposlila v izobraževalni dejavnosti kot visokošolska učiteljica, opravljala pa je tudi naloge prodekanice za izobraževalno dejavnost in dekanice fakultete. Bila je tudi vodja Kolaborativnega centra SZO za primarno zdravstveno nego in predsednica Zbornice zdravstvene nege Slovenije.

Sodelovala je v več raziskovalnih projektih Svetovne zdravstvene organizacije, v bilateralnih projektih, v Tempus in Erasmus projektih (Potrebe ljudi po zdravstveni negi, LEMON, Telenursing, TelenurseID, NICE, ODIN, Quality and Quantity in Nursing Care, MICE-ICU, CompRU, QualMent). Trenutno kot članica raziskovalne skupine Visoke zdravstvene šole v Celju sodeluje v mednarodnem projektu DEN. Njena bibliografija obsega okoli 600 enot.

Imenovana je za strokovnjakinjo Nacionalne agencije Republike Slovenije za kakovost v visokem šolstvu (NAKVIS). Je glavna in odgovorna urednica Revije za zdravstvene vede. Za svoje delo je prejela naslednja priznanja: Zlati znak Zbornice-Zveze, Srebrno plaketo Univerze v Mariboru, Zahvalo Združenja medicinskih sester in babic Republike Makedonije ter priznanje International League of Humanists.

NEIZVEDENA ZDRAVSTVENA OBRAVNAVA ZARADI NAPAK IN KRŠITEV OPUSTITVE

MISSED HEALTHCARE TREATMENT DUE TO ERRORS AND VIOLATIONS OF OMISSION

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Ključne besede: varnost pacientov, napaka opustitve, kršitev, preprečljivi škodljivi dogodki

Teoretična izhodišča: Glavni cilj zdravstvenega sistema je zagotavljanje dobrih izidov velikemu številu ljudi za razumno ceno in brez preprečljivih škodljivih dogodkov. Občutek varnosti je ena od bistvenih potreb pacientov in je temeljna človekova pravica. Stik vsakega pacienta z zdravstvom predstavlja tveganje. Izziv za zdravstvene sisteme in za vse, ki izvajajo zdravstveno varstvo, je skrb za varnost pacientov z odkrivanjem in analizo napak in kršitev. Gre za retrogradni pristop, ki je predmet Varnosti-I. To je sistem, ki je opredeljen kot odstotnost nesprejemljive škode ali zmanjševanje škode na minimum. V tem sistemu se ljudje pogosto štejejo za krivca za napake. Naložbe v učenje iz napak in standardizacija so običajen odziv (Reason, 1997). Še en nedavno priznan sistem je Varnost-II, pristop, pri katerem poteka čim več postopkov brez napak. Varnost-II se osredotoča na vsakodnevne prilagodljive dejavnosti, ki prispevajo k varnosti (Hollnagel, 2014). Ljudi razumemo kot prilagodljive, ko naj bi prožno delovali v kompleksnih situacijah. Delovne organizacije preučujejo učinkovitost postopkov, širijo dobre prakse ter vlagajo v zmogljivosti in kompetence. V mnogih delih sveta se *osebni pristop* in Varnost-I osredotočata na predpostavko, da se napake dogajajo zaradi dejanj posameznika in njegovih prepričanj, kar vodi v "sramotenje in kulturo krivde". Na ta način se močno zavira učenje iz napak in preprečevanje škodljivih dogodkov, ki bi se jim dalo v prihodnje izogniti. *Sistemski pristop*, nasprotno, prikazuje napake kot pričakovane dogodke, ker smo ljudje zmotljivi. Iz tega sledi, da je treba sisteme zasnovati tako, da vključujejo zaščitne ukrepe, ki preprečijo, da bi napaka dosegla pacienta. Za izboljšanje varnosti pacientov je treba sprejeti sistemski pristop (Robida, 2013). Škodljivi dogodki pri zdravstveni obravnavi lahko nastanejo zaradi napak, kršitev, komplikacij in naklepnih dejanj. Veliko skupino predstavljajo preprečljivi škodljivi dogodki, katerih vzroki so napake in nekatere kršitve. Napake in kršitve lahko nastanejo zaradi dejanja storitve in dejanja opustitve. Neizvedena zdravstvena obravnava pomeni napako ali kršitev opustitve. Pomeni, da nečesa ne naredimo ali pa naredimo prepozno, kar škoduje ali bi lahko škodovalo zdravstvenemu stanju pacienta (Robida, 2013, Svetovna zdravstvena

organizacija, 2010). Nikakor niso opustitve »privilegij« samo ene poklicne skupine v zdravstvu in tudi ne samo posameznika, ampak zajemajo celoten sistem zdravstva in tudi sisteme izven njega (Reason, 1997). Skoraj vedno je pri nas krivec za napako tista oseba, ki dela v prvi liniji in opusti nekaj, kar lahko škoduje pacientu. Neurejenosti sistema, ki je pripeljal do napake ali kršitve, pa praktično nikoli ne preučimo. O tem je prepričano sodstvo, ki ima podlago v pacientom škodljivem kazenskem zakoniku; javnost, ker se v Sloveniji prav vsi spoznamo na napake, in seveda mediji, ki podpihujejo predvsem krivdo medicinske sestre ali zdravnika (Robida, 2012). Poleg tega imamo tudi krivdno odškodnino, kar pomeni, da je treba krivdo dokazati posamezniku. Ne vem, ali pravosodje in upravljalci zdravstvenega sistema morda vedo, kaj je to znanost o varnosti pacientov in kako se napake in nekatere kršitve lahko prepreči. Rahle izboljšave v prepričanju o krivdi posameznika so z leti nastale v medicinski stroki, stroki zdravstvene nege in morda še kje (AACI, 2019). V Sloveniji poimenovanja strokovnih pojmov jemljemo z lahkoto in si od časa do časa izmišljujemo nova poimenovanja iste stvari (evfemizme), da bi se bolje slišala. Pravega s konsenzom uveljavljenega ali na raziskavi temelječega poimenovanja ne uporabljamo, čeprav imamo na tem področju nakaj temeljnih dokumentov (Svetovna zdravstvena organizacija, 2010; Robida, 2013, 2019).

Metoda: Opustitve zdravstvene obravnave se dogajajo na več ravneh: na ravni posameznika, tima, zdravstvene organizacije, regulatorja in drugih upravljavcev zdravstvenega sistema, plačnika, edukatorja in pravosodja. Eden izmed najboljših načinov razlage napak zaradi opustitve in zaradi kršitev je prikaz zgodb. Raziskav o razsežnosti problema nimamo. Tudi že načrtovane raziskave so bile, potem ko je bila pilotna raziskava že opravljena, preprečene. Opisani so posamezni primeri[1] na ravni regulatorja, pravosodja, plačnika, zdravstvene organizacije, zdravstvenega tima in posameznika. Nekateri primeri so bili javno objavljeni, drugi so bili prikriti in zanje ve le malo ljudi. Čeprav nimamo statističnih podatkov, so dovolj zgovorne posamezne tragedije.

Rezultati: Opustitve regulatorja. Opustitev zakonodaje s področja kakovosti in varnosti privede do tega, da varnost pacientov ni urejena tako, da bi se lahko izognili preprečljivim škodljivim dogodkom. Opustitev ustanovitve neodvisne javne institucije za kakovost in varnost pacientov in za neodvisno analizo preprečljivih škodljivih dogodkov pomeni, da se napake in škodljivi dogodki izredno redko sporočajo in analizirajo in zato ni ustreznih rešitev, učenja in širjenja dobrih praks (institucija je bila prvič načrtovana leta 2003). Sistem izrednega nadzora, ki ga predpisuje Zakon o zdravstveni dejavnosti, pa je večkrat pristranski in se ne izvaja po sodobnih načelih. Čakalne dobe pomenijo nedostopnost do zdravstvene obravnave, kar se lahko konča s preprečljivo smrtjo

[1] *Primeri niso objavljeni in so izmišljeni, morda pa so se tudi res zgodili.*

pacienta. Primer: »*Starejši pacient s srčno boleznijo je čakal na ultrazvočni pregled srca več mesecev. Ko so ga iz specialistične ambulante poklicali na pregled, so svojci sporočili, da je umrl zaradi popuščanja srca.*« **Opustitev pravosodja.** *Kazenski zakonik:* s kaznovanjem posameznika za človeško napako napak ne bo več. Pa je to res? Zaradi takega zunanjega pritiska se napake skrivajo, pripisujejo komplikacijam, izvaja se defenzivna medicina in se celo opušča postopke, ki so razmeroma enostavni. Tako se pacientu škoduje. Edini, ki ima korist od teh postopkov, je odvetnik. *Krivdna odškodnina:* krivdo je treba dokazati posamezniku, sicer škoda, ki jo je doživel pacient, ni zaradi napake ali kršitev. Postopki so dragi, dolgotrajni, velikokrat za pacienta neuspešni, za obtoženega krivde zaradi človeške napake pa škodljivi za njegova psihično zdravje in ugled. Govorimo o drugi žrtvi (Wu, 2000). *Sodna praksa:* Otrok, okužen z virusom, je umrl. Kako so »dokazali« krivdo zdravnice in ali je bilo že vnaprej dogovorjeno, kako se bo sojenje končalo? Bravure odvetnika so bile odločujoče, saj je očital trem našim profesorjem, da se med seboj poznajo in so zato pristranski. Tuji izvedenec, ki sploh ni bil strokovnjak s področja okužb, pa je zmagovito dokazal, da zdravnica ni upoštevala enajst znakov dehidracije, o katerih je prebral v zadnjem članku. Zdravnico so obsodili na zaporno kazen. Pri nas so z raziskavo ugotovili, da približno polovica pediatrov upošteva tri znake dehidracije, druga polovica pa dva. Sodbo je potrdilo vrhovno sodišče in tako v imenu ljudstva odločilo, da sedaj napak ne bo več, saj bodo verjetno vsi pediatri doma in v tujini upoštevali vseh enajst znakov dehidracije. S sistemskimi problemi se ni ukvarjal nihče. **Opustitev plačnika.** *Plačevanje posledic preprečljivih škodljivih dogodkov (never events).* Zavarovalnica plača vsak postopek ne glede na to, ali je bila vzrok škodljivemu dogodku napaka ali kršitev. Plača tudi zdravljenje, ki je potrebno za ublažitev posledic preprečljivega škodljivega dogodka (Rožman, 2012). Zanimanja za tak sistem do sedaj zavarovalnica ni pokazala. Tudi za zmanjševanje preprečljivih dogodkov zaradi napak ni nobene spodbude. Po podatkih OECD, bolnišnice v povprečju porabijo 15 % proračuna za popravo ali ublažitev škodljivih dogodkov, kar znaša za slovenske bolnišnice okrog 240 milijonov na leto, preračunano za leto 2016 (Slawomirski idr., 2017). **Opustitev izobraževalcev.** Kurikuluma o varnosti pacientov ni na nobeni medicinski fakulteti, na zdravstvenih univerzah in šolah pa tudi ni enotnega in sodobnega kurikuluma (Robida idr., 2016). **Opustitve v zdravstvenih organizacijah.** Glede na rezultate akreditaciskih presoj večinoma ni strategije in akcijskih načrtov za varnost pacientov, letnih ciljev za varnost pacientov, sodobnega sistemskega pristopa k analizi napak in ravnanja s kliničnimi tveganji. Zelo pomanjkljiv je razvoj kompetence za varnost pacientov, vključno s specifično izgradnjo timov za varnost pacientov ter sporočanjem opozorilnih nevarnih dogodkov ter drugih napak, ki so ali bi lahko škodile pacientom. **Opustitve v zdravstvenih timih.** Preobremenitev medicinskih sester in več kot dvourna zakasnitev terapije. Ali medicinska sestra lahko spregovori, če opazi, da se morda dogaja napaka ali kršitev? Ali se uporablja orodje dvojnega izziva? **Posameznik** *Kršitev z razlogom:* Nova diplomirana medicinska sestra, zaposlena tri mesece, je v popoldanski izmeni. V opomniku ima razpored dajanja zdravil. Ob 17:55 gre v bolniško sobo, kjer sta dve

pacientki. Inzulin za pacientko A je pripravila v prostoru za pripravo zdravil. Potrka, vstopi v sobo in pozdravi pacientki. Preveri identiteto pacientke A in druge zahteve sistema P. Opazi, da pacientka B, 82-letna gospa, vstaja iz postelje. Gospa ima rumeno zapestnico, kar pomeni, da je pri njej tveganje za padec visoko. Medicinska sestra pomaga pacientki B v toaletne prostore in tudi nazaj v posteljo. Ura je 18:30. Pacientki A vbrizga inzulin in na terapevtski list zapiše tudi čas. Na timskem sestanku zdravstvene nege glavna sestra pred vsemi pove, da se tako ne dela – če piše, da mora pacient inzulin dobiti ob 18:00, se mora to tudi zgoditi. Pove še, da bodo ob ponovitvi nepravega časa dajanja zdravil, ki zahtevajo odmerek takrat, ko je predpisan, za kršitelja uvedli ustrezne posledice. Kaj mislite, da je bilo sporočilo medicinski sestri? Kako bo ravnala v prihodnje? *Heroji:* Nekateri zdravstveni strokovnjaki se obnašajo herojsko in iščejo korist zase pred koristijo pacienta. *Lijakasti prsni koš – estetski poseg***.** Med operacijo prsnega koša zaradi perforacije srca umre 14-letna deklica. Kirurg, ki je operiral, je opravil malo tovrstnih posegov. Če bi mu uspelo, bi si pri kolegih pridobil ugled. Šlo je za sistemsko napako opustitve standardov glede na volumen posameznih operacij. *Koristi zase:* Tujemu kirurgu se je mudilo na letalo. Dokončanje operacije srca je prepustil mlajšemu, manj kompetentnemu kirurgu, čeprav je otrok krvavel. Kasneje je otrok umrl. Šlo je za lahkomiselno dejanje, ki ga ni nihče raziskal. Če bi ostal do konca operacije, bi zamudil let domov.

Razprava: Zgodb je še veliko, preveč, a stori se zelo malo, da bi se varnost pacientov in zaposlenih izboljšala. Gre za ignoranco? Mislimo, da so lahko ljudje vedno pazljivi? Mislimo, da tisti, ki imajo moč, vedo vse? Je vzrok še kje drugje? Strategija varnosti pacientov je pripravljena, največjo odgovornost za njeno izvedbo pa imajo država in vsi drugi deležniki v zdravstvu.

Zaključek: Strategija varnosti pacientov in akcijski načrti so pripravljeni, a še niso vpeljani v vsakdanjo zdravstveno prakso. Preprečljive škodljive dogodke, vključno z opustitvami, bomo lahko preprečili, če bomo resnično vzpostavili celoten izčrpen sistem varnosti pacientov z upoštevanjem znanosti o varnosti pacientov in s pridobitvijo preverjenih kompetenc. Nikakor pa ne bomo uspeli, kadar se bo uporabljala **moč nad** nekom namesto **moč z** nekom in se tako znastvenih dognanj zaradi **moči nad** ne bo upoštevalo.

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Keywords: patient safety, error of omission, violation, preventable adverse events

Theoretical background: The primary goal of the health care system is to provide good outcomes to large numbers of people at a reasonable cost and without preventable adverse events. Feeling safe is one of the essential needs of patients and is a fundamental human right. Every patient's contact with healthcare system represents a risk. The challenge for healthcare systems and for everyone who provides healthcare is to ensure patient safety by detecting and analysing errors and violations**.** This is a retrograde approach that is subject to Safety-I. This is a system defined as a percentage of unacceptable damage or minimizing the damage. In this system, people are often found responsible for the mistakes. Investments in learning from mistakes and standardization are a common response (Reason, 1997). Another recently still recognized system is Safety-II, an approach where as many things as possible go without fail. Safety-II focuses on daily adaptive activities that contribute to safety (Hollnagel, 2014). We understand people as adaptive when they are supposed to act flexibly in complex situations. Work organizations examine what is going right and spread good practices and invest in capabilities and competencies. In many parts of the world, the personal approach and Safety-I focus on the assumption that mistakes happen because of individual's actions and their beliefs, leading to a "shame and guilt culture". In this way, learning from mistakes and the prevention of adverse events that could be avoided

in the future are strongly inhibited. The *Systemic approach*, on the contrary, shows errors as expected events since we humans are fallible. It follows that systems must be designed to include safeguards to prevent the error from reaching the patient. A systemic approach should be adopted to improve patient safety (Robida, 2013). Adverse events in healthcare treatment can occur due to errors, violations, complications and intentional acts. A large group consists of preventable adverse events caused by errors and certain violations. Errors and violations can arise from an act or from omission. Failure to provide healthcare treatment constitutes an error or breach of omission. It means not doing something or doing it too late, which harms or could harm the patient's health (Robida, 2013, World Health Organization, 2010). By no means are the omissions "privileges" of only one professional group in healthcare nor of an individual, but they encompass the entire healthcare system as well as systems outside of it (Reason, 1997). Almost always, the person who is responsible for the error is the person who works in the front line and omits something that can harm the patient. We practically never look at the disorganisation of the system that led to the error or violation. Convinced of this is the judiciary, as it has its basis in the criminal code harmful to patients; the public, because in Slovenia we all know about mistakes and, of course, the media, which mainly incites the nurse's or doctor's guilt (Robida, 2012). In addition, we also have culpable damages, which means that the fault must be proven to the individual. I don't know if the justice system and the managers of the healthcare system know what a science of patient safety is and how errors and some violations can be prevented. Slight improvements in the belief about individual culpability have occurred over the years in the medical and nursing care professions, and perhaps elsewhere (AACI, 2019). In Slovenia, we take the naming of professional concepts lightly and from time to time we invent new names for the same thing (euphemisms) to make it sound better. We do not use the correct nomenclature based on consensus or research, although we have several fundamental documents in this area (World Health Organization, 2010; Robida, 2013, 2019).

Method: Omissions of healthcare treatment occur at several levels: at the level of the individual, the team, the health organization, the regulator and other managers of the healthcare system, the payer, the educator and the judiciary. One of the best ways to explain errors of omission and violations is through the display of stories. We have no research on the size of the problem, and even the already planned research, after the pilot research was already done, were prevented. Separate cases[2] are described at the level of the regulator, the judiciary, the payer, the healthcare organization, the healthcare team and the individual. Some cases have been made public, others have been hidden and few people know about them. Although we do not have statistical data, individual tragedies are telling enough.

[2] *The cases are not published, they are fictional, but they may even have really happened.*

Results: Omissions of the regulator. The omission of legislation in the field of quality and safety leads to the fact that patient safety is not regulated in such a way that preventable adverse events could be avoided. Failure to establish an independent public institution for the quality and safety of patients and for the independent analysis of preventable adverse events means that errors and adverse events are extremely rarely reported, analysed, and therefore there are no adequate solutions, learning and expansion of good practices (the institution was first planned in 2003). The system of extraordinary control prescribed by the Act on Health Care is often biased and is not implemented according to modern principles. Waiting periods mean inaccessibility to healthcare treatment, which can end in the preventable death of the patient. Example: "An elderly patient with heart disease has been waiting for a heart ultrasound for several months. When he was called from the specialist clinic for an examination, his relatives informed them that he had died of heart failure." **Omission of legislation:** Penal Code: by punishing an individual for human error, will there be no more mistakes? Or really? Due to such external pressure, mistakes are hidden, attributed to complications, defensive medicine is practiced and even things that are relatively simple are abandoned, thus harming the patient. The only one who benefits from these procedures is the lawyer. *Culpable damages*: guilt must be proven to the individual, otherwise the damage experienced by the patient is not due to a mistake or violation? The procedures are expensive, time-consuming, often unsuccessful for the patient, and harmful to the mental health and reputation of the accused due to human error. We are talking about the second victim (Wu, 2000). *Case law*: A child infected with the virus died. How did they "prove" the doctor's guilt and was it already agreed in advance how the trial would end? The bravado of the lawyer was decisive, as he accused three of our professors of knowing each other and therefore being biased. A foreign expert, who was not at all an expert in the field of infections, triumphantly proved that the doctor did not take into account the eleven signs of dehydration that he had read in the last article. The doctor was sentenced to prison. Our research found that about half of paediatricians look at three signs of dehydration, and the other half look at two. The verdict was confirmed by the Supreme Court and thus decided on behalf of the people that now there will be no more mistakes, because probably all paediatricians at home and abroad will be looking at all eleven signs of dehydration. No one looked at system problems. **Omission of payment.** *Paying for the consequences of preventable adverse events (never events). The insurance company pays for each procedure, regardless of whether the cause of the adverse event was an error or violation. It also pays for treatment that is necessary to mitigate the consequences of a preventable adverse event (Rožman, 2012). So far, the insurance company has not shown any interest in such a system. There is also no incentive to reduce preventable error events. According to OECD data, hospitals spend an average of 15% of their budget to correct or mitigate adverse events, which amounts to around 240 million per year for* Slovenian hospitals, calculated for 2016 (Slawomirski et al., 2017). **Omission of educators:** There is no curriculum on patient safety in any medical faculty,

and there is no unified and modern curriculum in healthcare universities and schools either (Robida et al., 2016). **Omission in health organisations**. According to the results of accreditation assessments, there are mostly no patient safety strategies and action plans, no annual patient safety goals, no modern systemic approach to error analysis and clinical risk management. Very poor development of patient safety competence, including specific building of patient safety teams and reporting of warning dangerous events and other errors that have or could harm patients. **Omissions in health care teams.** Overworking of nurses and more than 2-hour delay in administration of therapy. Can the nurse speak up if she notices that an error or violation may be occurring? Is the double challenge tool being used?

Individual. *Violation with reason: A new registered nurse who has been employed for 3 months is on the afternoon shift. On the reminder, she has a medication administration schedule that must be given at a certain time. At 17:55 he goes to the hospital room where there are two female patients. She prepared insulin for patient A in the medicine preparation room. She knocks and enters the room and greets the patients. She checks the identity of patient A and other requirements of system P. Now she notices that patient B, an 82-year-old lady is getting out of bed. The lady has a yellow wristband, which means she is at high risk of falling. She goes to help patient B to the toilets and also helps her back to bed. The time is 18:30. She injects insulin to patient A and also writes down the time on the therapy sheet. At the nursing care team meeting, the head nurse says in front of everyone that this is not how it is done, if it says that insulin is given at 6 p.m., it must be given at that time. She also states that in the event of repeated incorrect timing of medication that requires a dose at the time prescribed, there will be appropriate consequences for the offender. What do you think the message was to the nurse? How will she act in the future? Heroes: Some medical professionals behave heroically and seek self-benefit before patient benefit; Funnel chest – an aesthetic procedure. A 14-year-old girl died of heart perforation during chest surgery. The surgeon who performed the operation had few such operations. If he succeeded, he would gain a reputation among his colleagues. It was a systemic error of abandoning the standards regarding the volume of individual operations. Benefits for himself: The foreign surgeon was in a hurry to get on the plane. He left the completion of the heart surgery to a younger, less competent surgeon, even though the child was bleeding. Later the child died. It was a reckless act that no one investigated. If he had stayed until the end of the operation, he would have missed his flight home.*

Discussion: There are still many stories, too many of them, but very little is done to improve the safety of patients and employees. Because of ignorance? Because people are thought to be constantly alert? Because those with power know everything? For what else? The patient safety strategy is ready and the state and all other participants in healthcare have the ultimate responsibility for its implementation.

Conclusion: The patient safety strategy and action plans have been prepared, but have not yet been implemented in everyday healthcare practice. Preventable adverse events,

including omissions, can be prevented if we truly establish a complete comprehensive patient safety system by following patient safety science and acquiring proven competencies. However, there is no way that we could succeed when **power over** someone is used instead of **power with** someone, and thus scientific findings due to **power over** will not be taken into account.

PREDSTAVITEV AVTORJA

Dr. Andrej Robida, dr. med., FACC, GBLSS, izredni profesor pediatrije in javnega zdravja je upokojeni pediatrični kardiolog (Univerzitetni klinični center Ljubljana in Splošna bolnišnica Hamad Doha, Katar). Od leta 2001 se strokovno ukvarja s kakovostjo zdravstvene obravnave in varnostjo pacientov. Za varnost pacientov se je izobraževal v ZDA, za sistem izboljševanja kakovosti pa na Lean Six Sigma v Indiji. Imel je več vodilnih funkcij, med drugim na ministrstvu za zdravje, so-predsedoval je delovni skupini Evropske komisije za varnost pacientov. Kakovost in varnost v zdravstvu je poučeval na medicinski fakulteti v Mariboru in na mnogih zdravstvenih fakultetah in šolah. Je TAIEX strokovnjak za varnost pacientov in kakovost v zdravstvu ter strokovnjak NTT DATA, kjer je prispeval k strategiji varnosti pacientov in ravnanja s kliničnim tveganjem za ministrstvo za zdravje. Je tudi klinični presojevalec pri American Accreditation Commission International (AACI). Je avtor in soavtor nacionalnih dokumentov o kakovosti in varnosti pacientov (politika, strategija, varnostni dogodki, priročnik za akreditacijo bolnišnic ...) ter več znanstvenih in strokovnih člankov o kakovosti in varnosti pacientov v tujih in domačih revijah. Napisal je učbenik otroške kardiologije ter mnogo strokovnih in znanstvenih člankov s področja otroške kardiologije. Je tudi avtor knjige s področja kakovosti *Pot do odlične zdravstvene prakse* in s področja analize napak v zdravstvu *Napake pri zdravstveni obravnavi pacientov – sistematična analiza globljih vzrokov za napake in njihovo preprečevanje*. Leta 2019 je izšla obsežna knjiga o menedžmentu zdravstvene prakse, v katero je vključil poglavje o kakovosti in varnosti v zdravstvu. Je ustanovitelj Centra za izboljševanje kakovosti in varnosti zdravstvene obravnave – Prosunt (https://www. prosunt.si), v sklopu katerega najdemo mnogo koristnih vsebin za vsakogar, ki dela v zdravstvu.

INADEQUATE HEALTH CARE AS A KEY DETERMINANT OF THE QUALITY OF HEALTH CARE

NEZADOSTNA ZDRAVSTVENA OSKRBA KOT KLJUČNA DETERMINANTA KAKOVOSTI ZDRAVSTVENE OSKRBE

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Key words: inadequate health care, treatment outcomes, quality of health care, education

The health care system, in which nursing care is the core activity of nurses, is making great efforts to provide patients / service users with safe and quality health care. Quality of health care refers to the full provision of safe interventions related to health care.

The rationalization of health care is linked to the economic and ethical dimension. The topic of insufficient health care is not yet widely known in nursing, and thereby in the health system of the Republic of Croatia, as well as in the wider European region. The outcomes of treatment are largely related to the quality of health care, which is directly related to: the number of nurses, the work environment and financial capabilities.

Inadequate health care often goes unrecognized (invisible), but can manifest itself and become visible when delayed, incomplete, or absent, ultimately resulting in negative treatment outcomes. This is becoming one of the leading challenges arising from insufficient number of healthcare personnel, which endangers patient safety, and has a strong impact on the quality of service provision of an institution.

The first step is to become aware of the existence of inadequate health care in practice, it is necessary to become aware that something has not been done for the patient in the shift, that something was skipped, delayed, interrupted such as e.g. feeding. EU Member States encourage education aimed at raising awareness of the presence of inadequate nursing care in everyday practice. The quality of health care provided is closely related to the provision of nursing services, which will certainly affect the level of quality of health care provided to the patient.

Ključne besede: neustrezna zdravstvena oskrba, rezultati zdravljenja, kakovost zdravstvene oskrbe, izobraževanje

Zdravstveni sistem, v katerem je zdravstvena nega temeljna dejavnost medicinskih sester, si zelo prizadeva zagotoviti pacientom/uporabnikom storitev varno in kakovostno zdravstveno oskrbo. Kakovost zdravstvene oskrbe se nanaša na popolno zagotavljanje varnih posegov, povezanih z zdravstveno oskrbo.

Racionalizacija zdravstva je povezana z ekonomsko in etično dimenzijo. Tematika nezadostne zdravstvene oskrbe je v zdravstveni negi in s tem v zdravstvenem sistemu Republike Hrvaške, pa tudi v širši Evropski regiji, še premalo poznana. Rezultati zdravljenja so v veliki meri povezani s kakovostjo zdravstvene oskrbe, ki je neposredno povezana s številom medicinskih sester, delovnim okoljem in finančnimi resursi.

Neustrezna zdravstvena oskrba pogosto ostane neprepoznana (nevidna), vendar se lahko manifestira in je vidna, če je odložena, nepopolna ali odsotna, kar ima na koncu negativne rezultate zdravljenja. Postaja eden vodilnih izzivov, ki izhajajo iz pomanjkanja kadra, kar ogroža varnost pacientov in močno vpliva na kakovost izvajanja storitev zavoda.

Prvi koraki so zavedanje obstoja nezadostne zdravstvene oskrbe v praksi, potrebno je ozavestiti, da se pacientu v izmeni nekaj ni naredilo, da je bilo nekaj preskočeno, da se je zamujalo, da je bilo prekinjeno, kot je recimo hranjenje. Države članice EU spodbujajo izobraževanje, namenjeno ozaveščanju o prisotnosti neustrezne zdravstvene nege v vsakodnevni praksi. Kakovost zdravstvene oskrbe je tesno povezana z izvajanjem storitev zdravstvene nege, kar bo zagotovo vplivalo na raven kakovosti zdravstvene oskrbe pacienta.

PREDSTAVITEV VODILNE AVTORICE

Brankica Rimac lives in the city of Zagreb and works at the Clinical Hospital Center Zagreb/KBC Zagreb as the head nurse of the Joint affairs Department. She started her career as a nurse at the Department of Rheumatic Diseases and Rehabilitation, also she was a head nurse of KBC Zagreb. She finished the graduate study of nursing at the Faculty of Medicine in Zagreb where she is teaching. Now she is preparing a PhD dissertation at the Croatian Catholic University in Zagreb in Sociology. The topic of the dissertation is: Spirituality and life satisfaction of patients with chronic diseases. It seeks to connect the social sciences and humanities. She actively participated in the work of civil society in the Croatian Nurses Association, on the position of President and Vice President of the European Federation of Nursing Associations. She was an external member of the Gender Equality Committee in the Croatian Parliament. She received awards and recognition for her work: 2016 The honorable member of the Nurses and Midwives Association of Slovenia, Nurses and Midwives Association of Slovenia, Slovenia, 2010 Honorary Fellowship, Royal College of Nursing, United Kingdom, 2009 International Human Rights and Nursing Award, University of Surrey, Great Britain.

Brankica Rimac živi v mestu Zagreb in dela v Kliničkem bolničkem centru u Zagrebu (KBC Zagreb) kot glavna medicinska sestra Oddelka za skupne zadeve. Svojo poklicno pot je začela kot medicinska sestra na Oddelku za revmatološke bolezni in rehabilitacijo, bila je tudi glavna medicinska sestra KBC Zagreb. Končala je podiplomski študij zdravstvene nege na Medicinski fakulteti v Zagrebu, kjer tudi poučuje. Zdaj pripravlja doktorsko disertacijo na Hrvaški katoliški univerzi v Zagrebu s področja sociologije. Tema disertacije je: Duhovnost in življenjsko zadovoljstvo pacientov s kroničnimi boleznimi. Prizadeva si za povezovanje družboslovja in humanistike. Aktivno je sodelovala pri delu civilne družbe v Hrvaškem združenju medicinskih sester, na mestu predsednice in podpredsednice Evropskega združenja medicinskih sester. Bila je zunanja članica odbora za enakost spolov v Hrvaškem saboru. Za svoje delo je prejela nagrade in priznanja: 2016 Častna članica Zveze društev medicinskih sester in babic Slovenije, Zveze društev medicinskih sester in babic Slovenije, Slovenija, 2010 Častna štipendija, Royal College of Nursing, Velika Britanija, 2009 Mednarodna nagrada za človekove pravice in zdravstveno nego, Univerza Surrey, Velika Britanija.

ZDRAVSTVENA OBRAVNAVA PRED EPIDEMIJO IN V ČASU EPIDEMIJE: KAJ NAS ČAKA V PRIHODNOSTI?

MEDICAL TREATMENT BEFORE AND DURING AN EPIDEMIC: WHAT AWAITS US IN THE FUTURE?

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Ključne besede: covid-19, epidemija, organizacija

Epidemija virusa SARS-CoV-2 je slovenski zdravstveni sistem postavila pred preizkušnjo, na katero nikakor ni bilo pripravljeno, a se je kljub temu odzvalo hitro in učinkovito. V vseh valovih, ki so bili med seboj precej različni, smo uspeli zagotoviti vzdržnost sistema, ki je vsem pacientkam in pacientom s covidom-19 zagotovil potrebno dostopnost. Seveda pa smo na osnovi izkušenj organizacijo tudi prilagajali. Posebej velja izpostaviti pomen javnega zdravstva in koordinacijo slovenskih bolnišnic, ki so delovale zelo enotno in solidarno. Z učinkovitimi ukrepi so bila zagotovljena tudi finančna sredstva, ki so omogočala finančno vzdržnost celotnega sistema. Kljub novim potrebam smo zagotavljali tudi zdravstvene storitve, ki so bile opredeljene kot tiste, katerih opustitev bi lahko povzročila dolgoročne posledice za zdravje posameznikov in celotne družbe. Seveda pa se vsi zelo dobro zavedamo, da so nastali zaostanki, ki jih bo treba odpraviti, in tu bo nujno sodelovanje vseh deležnikov. V letu 2022 je treba pregledati zaostanke, posebno skrb nameniti ureditvi čakalnih seznamov in takoj pristopiti k organizaciji dela, ki bo realizacijo vrnila na raven iz leta 2019 in zagotovila odpravo zaostankov, ocenjenih kot posebej tveganih za javno zdravje.

Keywords: covid-19, epidemic, organization

The epidemic of the SARS-CoV-2 virus put the Slovenian healthcare system in front of a test for which it was in no way prepared, but it nevertheless responded quickly and efficiently. In all the waves, which were quite different from each other, we managed to ensure the sustainability of the system, which ensured the necessary accessibility for all patients with covid-19. Of course, based on experience, we also adjusted the organization. The importance of public health and the coordination of Slovenian hospitals, which worked in a very unified and solidary manner, should be highlighted. Financial resources were also secured through effective measures, which ensured the financial sustainability of the entire system. Despite the new needs, we also provided health services, which were defined as those whose omission could cause long-term

consequences for the health of individuals and society as a whole. Of course, we are all aware that there are backlogs that will have to be eliminated, and this will require the cooperation of all stakeholders. In 2022, it is necessary to review the backlog, pay special attention to the arrangement of waiting lists and immediately address the organization of work, which will return the implementation to the level of 2019 and ensure the elimination of backlogs assessed as particularly risky for public health.

PREDSTAVITEV AVTORJA

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Po opravljenem specialističnem izpitu iz splošne kirurgije leta 2001 je bil zaposlen v SB Celje, najprej na Otroškem oddelku kirurških strok in od leta 2007 na Travmatološkem oddelku. Od leta 2008 do leta 2011 je bil predstojnik Oddelka za skupne potrebe kirurgije. Leta 2011 je nastopil funkcijo strokovnega direktorja SB Celje. Vključeval se je v projekte v okviru ministrstva za zdravje in Združenja zdravstvenih zavodov Slovenije. Od marca 2021 do sredine maja 2022 je opravljal funkcijo državnega sekretarja na ministrstvu za zdravje, kjer je bila ena od njegovih osnovnih nalog koordinacija dela ob obvladovanju epidemije covida-19.

VPLIV EPIDEMIJE NA (NE)IZVAJANJE STORITEV V BOLNIŠNIČNEM OKOLJU

THE IMPACT OF THE EPIDEMIC ON THE (NON)PROVISION OF SERVICES IN THE HOSPITAL ENVIRONMENT

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Ključne besede: epidemija, bolnišnica, zaposleni, organizacija dela

Teoretična izhodišča: Epidemija covida-19 je močno vplivala na celoten zdravstveni sistem, saj ga je bilo treba v zelo kratkem času reorganizirati. Bolnišnice, ki smo sprejemale bolnike, okužene z virusom covid-19, smo se morale čez noč prestrukturirati v »covid oddelke«. V bolnišnicah je bilo treba začrtati posebno klinično pot, da ne bi prišlo do kontaminacije v »čistem delu bolnišnice«. Bolnišnice so se soočale z ogromno zahtevo po povečanju bolnišničnih zmogljivosti za akutno dihalno stisko kot akutno dihalno odpovedjo s potrebo po umetnem predihavanju pljuč. Še posebej slednja je zahtevala ogromno bolnišničnih kadrovskih virov, žal na račun elektivnih zdravstvenih programov, ki smo jih bili v bolnišnicah prisiljeni ukinjati oziroma omejevati.

Metoda: Namen raziskovalnega prispevka je bil ugotoviti vpliv na (ne)izvajanje storitev v bolnišničnem okolju v SB Novo mesto. Postavili smo si tri raziskovalna vprašanja:
RV1: Kako je epidemija vplivala na organizacijo dela v bolnišnici?
RV2: Kako je epidemija vplivala na zaposlene v bolnišnici?
RV3: Kako je epidemija vplivala na realizacijo pogodbenega programa z ZZZS?
Za pridobitev rezultatov je bila uporabljena kvalitativna metoda nestrukturiranega intervjuja. Sestavljen je bil iz treh ključnih raziskovalnih vprašanj. Vzorec intervjuvanih je bil namenski, izveden s štirimi člani Uprave bolnišnice, in sicer z direktorico bolnišnice, s strokovnim direktorjem, pomočnico direktorice za zdravstveno nego ter pomočnico direktorice za pravno in splošno področje. Izpeljali smo ga 31. 3. na kolegiju Uprave. Rezultati odgovorov so bili medsebojno primerjani in tabelirani.

Rezultati: Vsi štirje intervjuvanci so se strinjali, da je epidemija drastično vplivala na organizacijo dela v bolnišnici. Bolnišnica ni bila pripravljena na izbruh epidemije v nobenem pogledu, niti prostorsko niti kadrovsko. Direktorica je izpostavila izjemno zahtevno odločitev za prekinitev vseh ne nujnih zdravstvenih storitev. Intervjuvanci so se strinjali, da je med zaposlenimi vladal strah tako pred okužbami kot pred neznanim virusom. Pomočnica direktorice za pravne in splošne zadeve je izpostavila spopadanje s pomanjkanjem osebne varovalne opreme, direktorica pa velik psihični pritisk za vse

zaposlene. Strokovni direktor je poudaril zmedo pri zaposlenih zaradi nenehnih novih navodil in ukrepov v zvezi z obvladovanjem epidemije. Pomočnica direktorice za zdravstveno nego je poudarila veliko odsotnost negovalnega kadra, zlasti v prvih dveh valih epidemije, ko je bila država praktično zaprta, zaradi varstva otrok. Kar zadeva realizacije pogodbenega programa z ZZZS, ta ni bil izveden pri rednih elektivnih programih, je pa bil dosežen z upoštevanjem zdravljenja covidnih bolnikov.

Razprava: Epidemija covida-19 je že sicer ranljivemu zdravstvenemu sistemu postavila številne nove izzive.

RV1: Kako je epidemija vplivala na organizacijo dela v bolnišnici? Že v normalnih razmerah so se bolnišnice soočale s pomanjkanjem kadrovskih in tudi prostorskih virov. Epidemija je zahtevala takojšnjo reorganizacijo bolnišnic na praktično dve ločeni bolnišnici: za covidne in za ostale paciente. Z Odlokom o začasnih ukrepih na področju zdravstvene dejavnosti je bilo treba prekiniti z izvajanjem vseh ne nujnih zdravstvenih storitev ter kadrovske in prostorske kapacitete nameniti za zdravljenje covidnih bolnikov, nujnih zdravstvenih stanj, porodnic in onkoloških bolnikov. V bolnišnici so se vzpostavile tako imenovane rdeče, sive in bele cone. Uvedene so bile nove klinične poti za vse imenovane cone, nova navodila za delo z bolniki. Vzpostavile so se triaže tako na vhodu bolnišnice kot v Urgentnem centru, kamor so se ljudje ob zmanjšani dostopnosti do zdravstvenih storitev še posebej veliko zatekali. Zato so bili urgentni centri prava bojišča, ki pa so morala delati tudi pod posebnimi varnostnimi ukrepi. Veliko napora je bilo v prvem valu namenjenega zagotavljanju zaščitne oziroma varovalne opreme tako za zaposlene kot bolnike ter določene opreme, kot so npr. ventilatorji za intenzivne covid oddelke. Ves čas epidemije je bilo potrebno dnevno prilagajanje potrebam po sprejemu in zdravljenju covidnih pacientov. Vseskozi je potekalo intenzivno sodelovanje in komuniciranje z zunanjimi deležniki, še posebej ministrstvom za zdravje, kjer so bili strokovni sestanki v najhujšem valu tudi dnevni. Usklajevali so se kapacitete in viri za covidne bolnike na državni ravni in se skladno z zmožnostmi posameznih covid bolnišnic sproti premeščali, uvajali in ukinjali.

RV2: Kako je epidemija vplivala na zaposlene v bolnišnici? Dejstvo je, da je bil nad zaposlenimi v zdravstvu v času epidemije vršen večji psihološki pritisk. Število okuženih je nenehno naraščalo, prisotno je bilo pomanjkanje kakršnega koli posebnega zdravila, kasneje so se soočali z nezaupanjem javnosti v cepivo, visoko medijsko informiranostjo javnosti, veliko delovno obremenitvijo, pomanjkanjem osebne zaščitne opreme, občutki neustrezne podpore in še bi lahko naštevali. V delovno okolje so vsak dan prihajala nove informacije in navodila glede organizacije oddelkov, razporeditve kadra, spreminjanja urnika dela itd. Delo v takšnih situacijah privede do tveganja za različne psihične in duševne bolezni ter fizične in čustvene stiske (Vizeh et al, 2020). Pri tem se postavlja vprašanje, kako se zoperstaviti stresorjem in se lotiti motiviranja zaposlenih v tako težki

situaciji. Direktorica meni, da imajo pri tem glavno vlogo vodje. Vodje so tisti, ki so znali in zmogli pomiriti sodelavce, jih motivirati, jim svetovati, prisluhniti, vlivati upanje in zaupanje v delo s covidnimi bolniki. V vsem sproti nastajajočem kaosu sta bila pomembna komunikacija in soočanje z nenehnimi spremembami. Pomočnica za zdravstveno nego doda, da je prihajalo tudi do konfliktnih situacij, zaradi stresa, naporov in napetosti med sodelavci, vendar se je vse reševalo s pogovori in primerno komunikacijo. Pomembne so bile tudi pohvale in vzpodbude javnosti ter prepoznavanje majhnih in velikih zmag skozi epidemijo. Kot doda intervjuvanka, pa je epidemija kljub teži in negotovosti prinesla tudi nekaj pozitivnih izzivov. Zaradi epidemije so se začeli intenzivnejše delo od doma (seveda tam, kjer je delovni proces to omogočal), virtualno učenje in virtualni sestanki. Zdravstveni delavci so s premagovanjem krize nadgrajevali tudi svoje sposobnosti in se hitreje prilagajali spremembam, vse to pa je pomagalo pri krepitvi njihove samozavesti.

RV3: Kako je epidemija vplivala na realizacijo pogodbenega programa z ZZZS? Intervjuvanka – direktorica pove, da je izvajanje načrtovanega programa dela v bolnišnici v letu 2021 zaznamovala epidemija koronavirusa, kar je imelo za posledico 12-odstotni izpad rednega programa na račun zdravljenja 1.115 covidnih pacientov. Zdravljenje covidnih bolnikov je zaradi dela v posebnih kriznih razmerah celotno zdravstveno oskrbo zelo podražilo in, kar je še huje – drastično se je zmanjšala dostopnost do zdravstvene oskrbe. Strokovni direktor doda, da je, če je bilo pred epidemijo težko priti do zdravnika specialista, sedaj težko priti celo do osebnega zdravnika. Intervjujanci poudarijo, da bo to gotovo vplivalo na slabše zdravstveno stanje državljanov, saj se bodo določene bolezni kasneje odkrile in zdravile.

Key words: epidemic, hospital, employees, work organization

Theoretical background: The covid-19 epidemic has had a strong impact on the entire healthcare system, which needed to be reorganized in a very short time. Hospitals that received patients infected with the covid-19 virus had to restructure into "covid wards" overnight. A special clinical pathway was needed within hospitals to avoid contamination of the “clean part of the hospital”. Hospitals were faced with a huge demand to increase their capacities for patients with acute respiratory distress such as acute respiratory failure with the need for artificial lung ventilation. The latter in particular required a huge amount of hospital personnel, unfortunately at the expense of elective healthcare programs, which we were forced to abolish or limit in hospitals.

Method: The purpose of our research paper was to determine the effect on the (non)provision of services in the hospital environment, more precisely, in General Hospital Novo mesto. We asked ourselves three research questions:
RQ1: How has the epidemic affected the organization of work in the hospital?

RQ2: How has the epidemic affected hospital personnel?
RQ3: How has the epidemic affected the implementation of the contractual program with the Health Insurance Institute of Slovenia (ZZZS)? A qualitative method of unstructured interview was used to obtain the results. The interview contained the three key research questions mentioned above. The sample was purposive, and included four members of the Hospital Management Board, that is: General Manager, Professional Director, Assistant Manager for Nursing Care, and Assistant Manager for Legal and General affairs. The research was conducted on March 31, at the College Meeting of the Management. The results of the responses were compared with each other and recorded in a tabular form.

Results: All four respondents agreed that the epidemic had drastically affected the organization of work in the hospital. The hospital was not prepared for the outbreak of the epidemic in any way, neither spatially nor in terms of personnel. General Manager pointed out the extremely difficult decision to suspend all non-emergency health services. The respondents agreed that there existed fear among the employees of both infection and of an unknown virus. The Assistant Manager for Legal and General Affairs highlighted the struggle due to the lack of personal protective equipment, and the General Manager pointed out high pressure exerted on all the employees. The Professional Director highlighted the confusion among employees due to the constant new instructions and measures related to the management of the epidemic. The Assistant Manager for Nursing Care pointed out the severe shortage of nursing personnel, especially in the first two waves of the epidemic, when the country was virtually closed, for child protection reasons. As far as the realization of the contractual program with the Health Insurance Institute of Slovenia (ZZZS) is concerned, it was not implemented in regular elective programs, but it was achieved by taking into account the treatment of covid patients.

Discussion: The covid-19 epidemic has posed a number of new challenges to the already vulnerable health system.

RQ1: How did the epidemic affect the organization of work in the hospital? Already under normal circumstances, hospitals faced a shortage of human and spatial resources. The epidemic required the immediate reorganization of hospitals into virtually two separate hospitals: for covid and non-covid patients. With the Ordinance on Interim Measures in the Field of Health Care, it was necessary to suspend the provision of all non-emergency health services and to allocate human and spatial capacities for the treatment of covid patients, medical emergencies, birthing mothers and oncology patients. The so-called red, gray and white zones have been established in the hospital. New clinical pathways were introduced for all the named zones, and new instructions for working with patients were given. Triage was established both at the entrance of

the hospital and in the Emergency Center, to which people resorted to in especially large numbers due to the reduced access to health services. Therefore, the emergency centers turned into real battlefields, which also had to work under special security measures. In the first wave, a lot of effort was devoted to providing protective equipment for employees and patients, as well as to providing specialized equipment, such as ventilators for intensive care covid wards. Throughout the epidemic, daily adaptation to the needs of admission and treatment of covid patients was required. Throughout these times, there was an intensive cooperation and communication with external stakeholders, especially with the Ministry of Health, where expert meetings in the most severe wave of epidemics took place even as frequently as daily. Capacities and resources for covid patients at the state level were coordinated and relocated, introduced and discontinued in accordance with the capabilities of individual covid hospitals.

RQ.2: How has the epidemic affected hospital staff? Without doubt, there was higher psychological pressure on healthcare workers at the time of the epidemic. The number of infected people was constantly growing, there was a lack of any special medication, later public vaccine distrust, high media awareness of the public, heavy workload, lack of personal protective equipment, feelings of inadequate support etc. New information and instructions about the organization of departments, staffing, changing the work schedule, etc. poured into the work environment daily. Working in such conditions leads to the risk of various mental and emotional illnesses as well as to physical and emotional distress. (Vizeh et al, 2020). This poses the question of how to counteract stress factors and motivate employees in such a difficult situation? The General Manager believes that managers play a key role in this. Managers are those who knew and were able to reassure co-workers, motivate them, advise them, listen to them, instill hope and confidence in work with covid patients. In all the ongoing chaos, communication and confrontation with constant change was important. The Assistant Manager for Nursing Care added that there also existed conflict situations due to stress, excessive efforts and tensions between co-workers, but everything was resolved through conversation and appropriate communication. Public praise and encouragement were also important, as well as the recognition of small and big victories through the epidemic. The respondent adds that the epidemic, despite its weight and uncertainty, also brought on some positive challenges. The epidemic started more widespread working from home (where the work process allowed), virtual learning, virtual meetings. By overcoming the crisis, health professionals have also improved their abilities, adapted more quickly to change, and all of this has helped boost their self-confidence.

RQ3: How did the epidemic affect the implementation of the contractual program with the Health Insurance Institute of Slovenia (ZZZS)? The respondent - the General Manager states that the implementation of the planned work program in the hospital in 2021 was

marked by an epidemic of coronavirus, which resulted in a 12 percent drop in the regular program at the expense of treating 1,115 covid patients. Due to the work in special crisis situations, the treatment of covid patients has made the entire healthcare much more expensive and, what is even worse, the availability of medical care has drastically decreased. The Professional Director adds that if before the epidemic it was difficult to get access to a specialist doctor, it is now difficult to get even a GP. The respondents emphasize that this will certainly have an adverse effect on the health of the citizens, as certain medical conditions will be discovered and treated later.

PREDSTAVITEV VODILNE AVTORICE

Doc. dr. Milena Kramar Zupan je diplomirala, magistrirala in doktorirala na Ekonomski fakulteti v Ljubljani. V raziskavah povezuje aktualna teoretična spoznanja na področju vodenja in menedžmenta s svojimi več desetletnimi izkušnjami na različnih vodilnih delovnih mestih (deset let je bila glavna direktorica tekstilne tovarne Novoteks iz Novega mesta, dva mandata direktorica Poslovne enote Telekom Slovenije, Novo mesto, petletni mandat direktorica Sektorja prodaje na Telekomu Slovenije, dva mandata – osem let direktorica Zdravstvenega doma Novo mesto in od leta 2016 direktorica Splošne bolnišnice Novo mesto). Aktivno sodeluje v domačih strokovnih in znanstvenih združenjih Slovenske akademije za menedžment, Dolenjske akademske pobude, Uredniškega odbora spletne revije Izzivi managementa in drugih. Je predsednica UO Združenja zdravstvenih zavodov Slovenije, je bila in je članica nadzornih svetov, svetov javnih zavodov, različnih organov v lokalnih skupnostih in znanstvenih združenj. Je avtorica člankov s področja menedžmenta in vodenja, monografije Menedžment vs. Vodenje in učbenika Menedžment. Je predavateljica na Fakulteti za poslovne in upravne vede ter in na Fakulteti za zdravstvene vede Univerze v Novem mestu.

IZKUŠNJE ZASTOPNICE PACIENTOVIH PRAVIC O DOSTOPNOSTI DO ZDRAVSTVENE OBRAVNAVE Z VIDIKA PACIENTA

THE EXPERIENCE OF A PATIENT'S RIGHTS ADVOCATE ON THE ACCESS TO HEALTHCARE TREATMENT FROM THE PATIENT'S PERSPECTIVE

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Ključne besede: pacientove pravice, zastopnik pacientovih pravic, izbran osebni zdravnik, čakalne dobe, dolžnosti

Zakon o pacientovih pravicah je bil v Republiki Sloveniji sprejet na pobudo Evropske Unije leta 2008, v letih 2017 in 2020 pa posodobljen z namenom omogočiti enakopravno, primerno, kakovostno in varno zdravstveno oskrbo, ki temelji na zaupanju in spoštovanju med pacientom in zdravstvenim delavcem ter zdravstvenim sodelavcem. Obstoječi sistem zdravstvenega varstva dela bolj kakovosten in pacienta kot šibkejši člen v procesu zdravstvene oskrbe postavlja v ugodnejši položaj nasproti izvajalcem zdravstvenih storitev v javnem in zasebnem sektorju. Pri uresničevanju pravic pacientov po Zakonu o pacientovih pravicah se upošteva zlasti spoštovanje pacientovega dostojanstva, ki izhaja iz temeljne človekove pravice do dostojanstva posameznika, kot je zapisano v 21. členu Ustave Republike Slovenije. Pacientove pravice se pri vseh izvajalcih zdravstvenih storitev uveljavljajo v okviru sodobne medicinske doktrine, strokovnih standardov in normativov ter razvitosti zdravstvenega sistema v Republiki Sloveniji. Zakon je torej namenjen zaščiti pacienta in ureja njegov položaj do izvajalcev zdravstvenih storitev. Zakon o pacientovih pravicah ureja 14 pacientovih pravic, postopke in poti, kako te pravice uveljavljati v primeru, če so le te kršene. Uvaja tudi pacientove dolžnosti in inštitut zastopnika pacientovih pravic. Vse pravice so v zakonu nazorno opisane, podrobno so predstavljene poti, kako te pravice uveljavljati. Žal pa so danes za mnoge paciente nekatere pravice le želja na papirju in jih le težko uresničujejo ali sploh ne. Tako so nekatere pravice pacientov postale zgodbice, žal nerealne. Čas od leta 2020, ko se je začel širiti koronavirus in so bile po svetu razglašene izredne razmere, je bil nekaj posebnega. Čez noč se je spremenila dostopnost izbranih osebnih zdravnikov, ukinjene so bile referenčne ambulante, kontrola pacientov s kronično boleznijo se je zmanjšala, osebje iz Centrov za krepitev zdravja je bilo prestavljeno na točke za testiranje za okužbo s koronavirusom, preventivno delovanje pa je za dve leti zamrlo. Težko je bilo priti do specialističnih pregledov, operacije so bile prestavljene ali celo odpovedane, posamezni bolniški oddelki so se ukinjali in spreminjali v covidne oddelke. Domovi za starejše in Centri za usposabljanje, delo in varstvo so se zaprli za

zunanje obiskovalce in stanovalci so osamljeni preživljali obdobje epidemije. Posebna zgodba so bili umirajoči, ki so bili brez svojih bližnjih v zadnjih trenutkih življenja. Ukrepi, ki so bili uvedeni za omejitev epidemije covida-19, so povsem spremenili življenje. Nastalo situacijo je večina pacientov sprejemala razumevajoče in strpno. Izbrane osebne zdravnike so obiskovali samo v nujnih primerih. Velikokrat se za obisk zdravnika sploh niso odločili, saj so se bali, da ga bodo po nepotrebnem obremenili ali pa da se bodo v ambulanti okužili z virusom. Prepuščanje odločitve pacientom o tem, ali zdravnika potrebujejo ali ne, bo imelo in že ima za posledico poslabšanje zdravstvenega stanja pri posameznih pacientih. Za nekatere je bilo dolgo razmišljanje, ali naj zdravnika obiščejo ali ne, celo usodno. Epidemija je bila preklicana, razmere v zdravstvu pa se niso bistveno izboljšale. V Zakonu o pacientovih pravicah je v Pravici do proste izbire zdravnika in izvajalca zdravstvenih storitev jasno zapisano, da ima vsak pacient pravico, da si prosto izbere osebnega zdravnika, osebnega zobozdravnika, ženske osebnega ginekologa in osebe, mlajše od 19 let, osebnega pediatra. Izbor zdravnika je pomemben dejavnik v procesu zdravljenja in ima veliko vlogo pri gradnji medsebojnega zaupanja in spoštovanja. Pomembno je, da med pacientom in zdravnikom vlada zaupanje, saj je le to ključnega pomena za kakovostno zdravljenje, za dobro komunikacijo in za sodelovanje. Pravica do proste izbire zdravnika ni absolutna, saj jo omejujejo zmogljivost in normativi javne zdravstvene mreže. Da v Sloveniji primanjkuje osebnih zdravnikov, je znano že dlje časa. Čas epidemije covida-19 pa je stvari še poslabšal. Danes je v Sloveniji brez osebnega zdravnika več kot 132.000 ljudi in v državi skoraj ni zdravnika, ki bi sprejemal nove paciente. Poleg tega se pacienti pritožujejo nad neodzivnostjo osebnih zdravnikov in nad tem, da še vedno težko pridejo na pregled v ambulanto. Na pregled se je treba naročiti in nanj čakati tudi več dni, pacienti pa imajo težave že v času naročanja. Pritožujejo se, da se diagnosticira in predpisuje zdravila kar po telefonu ali e-pošti, kar je še posebej moteče za starejše paciente, ki elektronske pošte ne obvladajo in bolj zaupajo osebnemu stiku. Pacienti se počutijo odrinjeni. Najpogosteje se pritožujejo nad kršitvami Pravice do primerne, kakovostne in varne zdravstvene oskrbe, ki je ena od glavnih pravic in je osnova za vse druge pacientove pravice. Pacienti zdravstveno oskrbo ocenjujejo po dobrem sodelovanju in zaupanju med njimi in zdravstvenim osebjem. Pričakujejo prijazen odnos, spoštljivo ravnanje, skrb za zasebnost, dostopnost do zdravstvenih storitev, razumljivo razlago o zdravstvenem stanju, razvoju bolezni, poteku zdravljenja, morebitnih stranskih učinkih zdravil in možnostih zdravljenja. Žal ta pričakovanja niso vedno izpolnjena in pacienti pravijo, da jim zdravniki ne naklonijo dovolj časa in da dobijo veliko premalo razumljivih informacij. Skrbijo jih nepremišljeni varčevalni ukrepi, ki predstavljajo nevarnost za njihovo zdravje. Nerazumno dolge čakalne vrste predstavljajo kršitev Pravice do spoštovanja pacientovega časa, žal pogosto kršene pravice. Čakalne dobe so se v času epidemije covida-19 močno podaljšale in po preklicu epidemije ni nič bolje. Odpovedi terminov se vrstijo, novih terminov pa ne dobijo vedno. Pacienti čakajo na posamezne preglede po več mesecev in celo let. Težko si predstavljamo, kakšno stisko doživljajo ljudje, ki jim je

postavljen sum za nevarno bolezen, pa ne pridejo do specialista, do postavitve diagnoze, do pričetka zdravljenja. Predolgo čakajo na izvide in odpustna pisma. Da ni dovolj zdravstvenega kadra, primerno usposobljenih zdravnikov, da zavarovalnica plača le določeno število storitev – to ni stvar pacienta, temveč je stvar zdravstvene ustanove in predvsem zdravstvene politike. Če pacienti ne pridejo do ustreznega strokovnjaka, poiščejo pomoč na urgenci, pri zasebnikih in celo v tujini. A žal to ni dostopno vsem in pacienti se upravičeno pritožujejo, da so neprimerno in nepravočasno obravnavani. Posebej je treba izpostaviti področje zobozdravstva, kjer po dolgi čakalni dobi pacientu samo pregledajo zobe, potem pa več mesecev ali celo let čaka na potrebno storitev. Veliko težavo predstavlja pomanjkanje ortodontov. Mladostniki, ki niso pravi čas vpisani za pregled pri ortodontu, do obravnave sploh niso upravičeni, čakalne dobe pa se merijo v letih. Pacienti se redko pritožujejo nad samim procesom zdravljenja, pogosteje se pritožujejo nad neprimernim odnosom zdravstvenega osebja. Temeljni vzrok za pogosto nezadovoljstvo pacientov je pomanjkljivo komuniciranje med zdravniki in drugim medicinskim osebjem ter svojci. Pacienti se pritožujejo nad odnosom medicinskih sester pri družinskih zdravnikih, nad telefonsko neodzivnostjo posameznih ambulant, hitro in površno zdravstveno obravnavo, nepopolno pojasnilno dolžnostjo. Večino nesoglasij rešijo pacienti sami ali s pomočjo svojcev. Kadar nesporazuma ne morejo rešiti sami, poiščejo pomoč pri zastopnikih pacientovih pravic. Zastopniki pacientom nudijo konkretno pomoč pri doseganju pravic po Zakonu o pacientovih pravicah, ki jih sami niso uspeli doseči ali so jim bile kršene v procesu zdravljenja. Pacientom svetujejo tudi na področju zdravstvenega varstva, zdravstvenega zavarovanja in izvajanja zdravstvene dejavnosti. Zastopnik lahko na izvajalce zdravstvenih storitev kadarkoli naslovi predloge, mnenja, kritike ali priporočila, ki so jih ti dolžni obravnavati in nanje odgovoriti v roku, ki ga določi zastopnik. Izvajalec zdravstvenih storitev mora zastopniku omogočiti dostop do vseh podatkov, ki so potrebni za njegovo delo v zvezi z obravnavo, najpozneje v petih dneh od prejema zahteve. Zastopnik se lahko seznani z zdravstveno dokumentacijo pacienta na podlagi njegove pisne privolitve. Zastopnik lahko na osnovi pooblastila pacienta izvajalcu zdravstvenih storitev predlaga način, s katerim naj se ugotovljena nepravilnost odpravi. Zastopniki so pogosto neke vrste mediatorji med zdravstvenimi delavci in pacienti pa tudi med zdravstvenim sistemom in pacienti. V Sloveniji je 13 zastopnikov pacientovih pravic, ki jih je imenovala vlada Republike Slovenije. Delujejo v skladu z Zakonom o pacientovih pravicah, delo opravljajo nepoklicno 12 ur na teden. Delo je zaupno, njihova pomoč je brezplačna, paciente zastopajo na osnovi pooblastil, zastopanje je obveza. Prizadevajo si, da se vsa nesoglasja, ki so nastala na področju zdravstva, tam tudi uredijo – kar se v zdravstvu zgodi, se tam tudi uredi. V času epidemije so poleg pacientov pri njih iskali pomoč tudi zdravstveni delavci. Tudi pacienti imajo svoje dolžnosti, in sicer so za doseganje kakovostne in varne zdravstvene oskrbe dolžni dejavno sodelovati pri varovanju, krepitvi in povrnitvi lastnega zdravja, podajati resnične informacije o svojem zdravju, biti spoštljivi in obzirni do drugih pacientov in zdravstvenih delavcev, spoštovati

hišni red in objavljene urnike, pravočasno obvestiti izvajalca o morebitnem izostanku od pregleda ali zdravljenja. Zdravje postaja vse večja vrednota. Spreminja se odnos med zdravnikom in pacientom. Ni več dovolj samo zaupanje, pojavljajo se vprašanja in dvomi. Pacienti želijo biti o svojem zdravju, preiskavah in posegih obveščeni. Pričakujejo, da so zdravstveni delavci do njih spoštljivi, da jim na njim razumljiv način razložijo vse o njihovi bolezni, postopkih zdravljenja in morebitnih negativnih posledicah bolezni. Zdravniki tudi zaradi preobremenjenosti pogosto spregledajo krhkost, ranljivost in prestrašenost pacienta. Primanjkuje jim časa za komunikacijo in prijazen odnos, in to je v večini primerov glavni razlog za nastanek nesporazumov. Kot je zapisal Šime Ivanjko: »Odsotnost prijaznosti izniči pomen poklicnega znanja, njena prisotnost pa strokovnemu znanju doda posebno človeško žlahtnost, ki jo še kako pogrešamo v srečanju z ljudmi, ki so poklicani, da nam pomagajo.« Zavedati se moramo, da smo za varno zdravstveno oskrbo odgovorni vsi udeleženci v zdravstvenem procesu, tako pacienti kot zdravstveni delavci. Samo zaupljiv partnerski odnos med zdravstvenimi delavci in pacienti, v okviru katerega bodo vsi spoštovali pravice drug drugega in se zavedali svojih dolžnosti, bo omogočil primerno, kakovostno in varno zdravstveno oskrbo, ki bo privedla do skupnega cilja: premagovanja bolezni in ohranjanja zdravja.

Literatura:

- Zakon o pacientovih pravicah (Uradni list RS, št. 15/2008, 55/2017, 177/20)

Keywords: patient's rights, patient's rights advocate, selected general practitioner, waiting times, duties

The Patient's Rights Act was adopted in the Republic of Slovenia at the initiative of the European Union in 2008 and updated in 2017 and 2020 with the aim of enabling equal, appropriate, high-quality and safe health care, based on trust and respect between the patient and the health worker and the health worker. It adds quality to the existing health care system and puts the patient, as the weaker participant, in a more favourable position in the health care process towards healthcare service providers in the public and private sectors. When exercising the rights of patients according to the Act on Patient Rights, respect for the patient's dignity, which derives from the fundamental human right to individual dignity as stated in Article 21 of the Constitution of the Republic of Slovenia, is taken into account. The patient's rights are enforced by all healthcare providers within the framework of modern medical doctrine, professional standards and norms, and the development of the healthcare system in the Republic of Slovenia. The law is therefore intended to protect the patient and regulates his position vis-à-vis healthcare providers. The Act on Patient Rights regulates 14 patient rights, procedures and ways to enforce these rights in the event that they are violated. It also introduces the patient's duties and the institute of the patient's rights advocate. All rights are clearly described in the Act, and the ways to exercise these rights are

presented in detail. Unfortunately, for many patients today, certain rights are just a wish on paper and they are difficult to realize or not at all. Thus, some patients' rights have become stories, unfortunately only fictional. The time since 2020, when the corona virus began to spread and a state of emergency was declared around the world, has been something special. Access to selected general practitioners changed overnight, referral clinics were closed, the monitoring of patients with chronic diseases was reduced, employees from Health Promotion Centres were moved to testing points for corona virus infection, and preventive healthcare has died down for two years. It was difficult to get specialist examinations, operations were postponed or even cancelled, individual patient wards were closed and turned into covid wards. Homes for the elderly and Centres for training, work and care were closed to outside visitors and residents spent the period of the epidemic in isolation. A special story were the dying who were without their loved ones in their last moments of life. The measures introduced to limit the covid-19 epidemic have completely changed people's lives. Most of the patients accepted the situation with understanding and tolerance. Selected general practitioners were visited only in emergency cases. Frequently people even decided not to visit the doctor, because they were afraid that they would burden him unnecessarily or that they would get infected with the virus in the clinic. Leaving it up to patients to decide whether they need a doctor or not will have and already has the effect of deteriorating the health of some patients. For some, the long deliberation of whether to see a doctor or not was even fatal. The epidemic was cancelled, but the healthcare situation did not significantly improve. In the Act on Patient Rights, the Right to Free Choice of a Doctor and Health Service Provider clearly states that every patient has the right to freely choose a general practitioner, a personal dentist, a personal gynaecologist and a personal paediatrician for persons under the age of 19. The choice of a doctor is an important factor in the treatment process and plays a big role in building mutual trust and respect. It is important that there is trust between the patient and the doctor, because this is crucial for quality treatment, for good communication and for cooperation. The right to freely choose a doctor is not absolute, as it is limited by the capacity and norms of the public healthcare network. It has been known for a long time that there is a shortage of general practitioners in Slovenia. The time of the covid-19 epidemic, however, made things even worse. Today, there are more than 132,000 people without a general practitioner in Slovenia, and there are almost no doctors in Slovenia who accept new patients. In addition, patients complain about the unresponsiveness of general practitioners and that it is still difficult for them to get an examination at the doctor's office. It is necessary to make an appointment for an examination and wait several days for it while patients already have problems at the time of making the appointment. Patients complain that diagnoses and prescriptions are made over the phone or by e-mail, which is especially disturbing for older patients who do not know how to use e-mail and trust personal contact more. Patients feel left out. They most often complain about violations of the Right to appropriate, quality and safe medical care, which is one of the main rights and

is the basis for all other patient rights. Patients rate medical care based on good cooperation and trust between them and the healthcare staff. They expect a friendly attitude, respectful treatment, concern for privacy, accessibility to health services, an understandable explanation of the health condition, the development of the disease, the course of treatment, possible side effects of drugs, treatment options. Unfortunately, these expectations are not always met, and patients say that doctors do not give them enough time and that they receive a lot of poorly understood information. They are worried about reckless austerity measures that pose a danger to their health. Unreasonably long waiting times represent a violation of the Right to respect the patient's time, a right that is unfortunately often violated. Waiting times have increased significantly during the covid-19 epidemic and this has not improved after the cancellation of the epidemic. Cancellations of appointments keep coming, but new appointments are not always given. Patients wait for individual examinations for several months and even years. It is hard to imagine the hardship experienced by people who are suspected of having a serious health condition, but do not get to a specialist, get a diagnosis, or start treatment. They are waiting too long for doctor's reports, letters of discharge. That there are not enough medical personnel, suitably qualified doctors, that the insurance company only pays for a certain number of services is not a matter for the patient, but for the medical institution and above all for the healthcare policy. If patients cannot find a suitable specialist, they seek help at the emergency room, from private doctors and even abroad. Unfortunately, this solution is not accessible to everyone, and patients rightly complain that they are treated inappropriately and untimely. It is especially necessary to point out the field of dentistry, where after a long waiting period the patient only gets a dental examination and then waits for the desired service for several months or even years. A big problem is the lack of orthodontists. Adolescents who are not registered at the right time for an examination by an orthodontist are not entitled to treatment at all, and waiting times are measured in years. Patients rarely complain about the treatment process itself, more often they complain about the inappropriate attitude of the healthcare staff. The fundamental cause of frequent patient dissatisfaction is poor communication between doctors and other healthcare professionals and relatives. Patients complain about the attitude of nurses at family doctors, the unresponsiveness of individual doctor's offices, quick and superficial medical treatment, incomplete explanatory duty. Most disagreements are resolved by patients themselves or with the help of relatives. When they cannot resolve the misunderstanding on their own, they seek help from patient's rights advocates. The advocates give concrete help to the patients in achieving the rights according to the Patient's Rights Act, which they themselves failed to achieve or which were violated during the treatment process. They also advise patients in the field of health care, health insurance and the implementation of healthcare activities. At any time, the advocate may address proposals, opinions, criticisms or recommendations to health service providers, which they are obliged to consider and respond to within the time limit set

by the advocate. The health care provider must provide the advocate with access to all data necessary for his work in relation to the treatment, no later than five days after receiving the request. The advocate can familiarize himself with the patient's medical documentation based on his written consent. On the basis of the patient's authorization, the advocate can propose to the health care provider a method by which the identified irregularity should be eliminated. Advocates often serve as a kind of mediator between health professionals and patients, as well as between the healthcare system and patients. There are 13 patient's rights advocates in Slovenia, appointed by the government of the Republic of Slovenia. They work in accordance with the Act on Patient Rights, they work informally twelve hours a week, their work is confidential, their help is free of charge, they represent patients on the basis of authorisation, and representation is an obligation. They strive to resolve all disagreements that have arisen in the field of healthcare - what happens in healthcare, is resolved there. During the epidemic, in addition to patients, healthcare professionals also sought help from them. Patients also have their duties, namely, in order to achieve high-quality and safe health care, they are obliged to actively participate in the protection, strengthening and recovery of their own health, to provide truthful information about their health, to be respectful and considerate of other patients and healthcare professionals, to respect house rules and published schedules, inform the provider in time about possible absences from examination or treatment. Health is becoming an increasingly important value. The relationship between doctor and patient is changing. Trust alone is no longer enough; questions and doubts arise. Patients want to be informed about their health, examinations, medical procedures. Patients expect healthcare professionals to treat them with respect, to explain everything about their disease, treatment procedures, and possible negative consequences of the disease in an understandable way. Doctors, also due to being overwhelmed, often overlook the fragility, vulnerability and fear of the patient. They lack time for communication, a friendly attitude, and this is in most cases the main reason for misunderstandings. As Šime Ivanjko wrote: "The absence of kindness negates the importance of professional knowledge, while its presence adds a special human nobility to professional knowledge, which we strongly missed in meeting people who are called to help us." We must be aware that safe healthcare is the responsibility of all participants in the healthcare process, both patients and healthcare professionals. Only a trusting partnership between healthcare professionals and patients, where everyone respects each other's rights and is aware of their duties, will enable appropriate, high-quality and safe health care, which will lead to a common goal: overcoming disease and maintaining health.

PREDSTAVITEV AVTORICE

Cvetka Jurak je po gimnaziji v Celju študij nadaljevala na Univerzi v Ljubljani, na Višji šoli za zdravstvene delavce, smer fizioterapija. Po opravljeni diplomi se je zaposlila v Thermani, d. d., takrat Zavodu za medicinsko rehabilitacijo Zdravilišče Laško, in študij nadaljevala na Univerzi v Mariboru, na Fakulteti za organizacijske vede. V Thermani, d. d., je opravljala različna dela: bila je višja fizioterapevtka, vodja terapije, vršilka dolžnosti direktorja, vodja hotela, vodja profitnega centra Zdravilišče Laško, vodja programa hotelirstvo in vodja programa medicina. Ves čas je tudi nadomeščala direktorja družbe v času njegove odsotnosti. Po odhodu v pokoj je svoje znanje in energijo usmerila v delo z ljudmi, ki menijo, da so jim bile kratene pravice na področju izvajanja zdravstvene dejavnosti in preventivinih storitev. Vlada Republike Slovenije jo je leta 2014 imenovala za Zastopnico pacientovih pravic za področje celjske regije. Temu delu je tako predana že osmo leto.

IZZIVI FINANCIRANJA ZDRAVSTVENE OSKRBE V SLOVENIJI V ČASU EPIDEMIJE COVIDA-19

CHALLENGES OF FINANCING HEALTHCARE IN SLOVENIA DURING THE COVID-19 EPIDEMIC

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Ključne besede: zdravstveni sistem, financiranje zdravstva, zdravstveni izdatki, izzivi zdravstvenih sistemov, slovenski zdravstveni sistem.

Pred epidemijo covida-19 so bili osnovni razvojni izzivi pri financiranju zdravstvene (in tudi dolgotrajne) oskrbe povezani z dolgoživostjo slovenske družbe oziroma z njenim hitrim staranjem. Projekcije za Slovenijo so nakazovale številna tveganja pri financiranju oziroma možnost rastočega razkoraka med prihodki in odhodki Zavoda za zdravstveno zavarovanje Slovenije (v nadaljevanju ZZZS) oziroma sistema obveznega zdravstvenega zavarovanja (v nadaljevanju OZZ). ZZZS se je zato skladno s svojim Strateškim razvojnim programom za obdobje 2020–2025 zavzel za določene sistemske spremembe, ki naj bi te možne vrzeli v financiranju blažile ali zmanjševale. Gre za ukrepe na prihodkovni in odhodkovni strani sistema OZZ, ki naj bi (1) preprečili dovzetnost finančnih virov sistema OZZ za nihanja v gospodarstvu oz. zaposlovanju, (2) povečali delež proračunskih virov za zdravstvo, (3) bolj pravično porazdelili bremena plačevanja prispevkov za OZZ, (4) krepili strateške nakupe zdravstvenih programov, (5) spodbujali učinkovitost in kakovost izvajanja programov z izbranimi obračunskimi modeli in (6) krepili nadzorne aktivnosti oz. preprečevali razsipavanje javnih sredstev OZZ.

Na teh osnovah je ZZZS skupaj s partnerji v zdravstvu že dlje časa izvajal določene organizacijske in finančne ukrepe za boljše obvladovanje izzivov, ki izhajajo iz staranja prebivalstva, spremenjenih potreb pacientov, vse večjega števila kroničnih bolezni, multimorbidnih stanj in drugih sodobnih bolezni. Na primarni ravni smo npr. krepili promocijo zdravja in preventivne programe, uvajali in širili referenčne ambulante za obravnavo pacientov s kronično boleznijo, centre za duševno zdravje in nekatere druge nove programe. Na sekundarni in terciarni ravni zdravstvene dejavnosti pa so se uveljavljale učinkovite kratke akutne bolnišnične in dnevne obravnave ter ambulantni posegi namesto daljših bolnišničnih obravnav.

Kljub temu pa so se v letih pred epidemijo že stopnjevale določene težave pri zadovoljevanju potreb prebivalstva in dostopu do storitev, povezane predvsem s pritiski

na rast izdatkov za zdravstvo. To je bila posledica povečanega povpraševanja po storitvah zaradi hitrega staranja prebivalstva. Zaznani strukturni problemi bi terjali nujne institucionalne spremembe oz. reformo, do katere pa kljub nekaterim poskusom (npr. v letih 2016 in 2019) ni prišlo. Zato smo v epidemijo vstopili v finančno, organizacijsko in kadrovsko relativno neoptimalnem stanju. Slovenija je npr. v letu 2019 za zdravstvo namenila 2.186 PPP evrov na prebivalca in 8,3 % BDP, kar je pomenilo 85 % povprečja EU 27. Javni izdatki za dolgotrajno oskrbo (400 evrov na prebivalca oz. 0,9 % BDP) pa so npr. dosegli le 50 % povprečja EU 27.

Opisane strukturne težave, predvsem pomanjkljivi kadrovski viri na določenih področjih, in pa dolge čakalne dobe, so izbruh in širjenje epidemije covida-19 v letih 2020 in 2021 zgolj še izpostavile in zaostrile. Epidemija je npr. razgalila zlasti pomanjkanje zdravnikov na primarni ravni, pomanjkanje specializiranih medicinskih sester na zahtevnejših oddelkih oz. enotah za intenzivno terapijo ali nego in pomanjkanje negovalnih kadrov v domovih za starejše. Gre za področja, ki so bila že pred epidemijo zaradi povečanih in spremenjenih zdravstvenih potreb starejše populacije zelo izpostavljena. Posledično je bila dostopnost do zdravstvenih storitev zelo otežena.

V letu 2020 so se storitve večinoma izvajale v omejenem obsegu, tako v ambulantni dejavnosti kot v bolnišnicah. Na primarni ravni se je število obiskov osebnih zdravnikov zaradi izvajanja protiepidemijskih ukrepov v primerjavi s predhodnim letom zmanjšalo. Vsaj deloma se je omejen dostop »kompenziral« z izvajanjem (digitalnih) posvetov na daljavo. Še zlasti se je zmanjšalo oziroma ponekod celo zastalo število preventivnih obravnav. Število obiskov pri zdravnikih je najbolj upadlo pri starejših od 65 let in mlajših od 19 let. Veliko bolj kot na primarni ravni se je zmanjšalo število obravnav v specialističnih ambulantah (za 20 %), čeprav so se tudi te deloma izvajale na daljavo. Predvideni program v specialističnih ambulantah v večini dejavnosti ni bil realiziran. Izjema je bil program radioterapije za zdravljenje onkoloških bolnikov. Tudi v bolnišnicah se je zmanjšalo število bolnišničnih obravnav, na letni ravni za 15 %. Zaščitni ukrepi, sprejeti zaradi epidemije covida-19, so močno vplivali na dostopnost do storitev tudi v letu 2021. Zaradi dodatnih aktivnosti izvajalcev, povezanih s testiranjem in cepljenjem proti covidu-19, velikega števila obolelih in ob upoštevanju varnostnih ukrepov je bila dostopnost do zdravstvenih storitev na primarni ravni kljub povečanem številu obiskov slabša. Posamezne storitve (npr. preventiva) se niso izvajale oziroma so se izvajale v omejenem obsegu. Veliko število covidnih bolnikov in izvajanje zaščitnih ukrepov sta povzročila, da se je zmanjšalo število obravnav ostalih bolnikov tudi v specialistični ambulantni in bolnišnični dejavnosti, kar se je odrazilo v povečanju števila čakajočih nad dopustno čakalno dobo. Zaradi visoke precepljenosti pa so bile razmere bistveno boljše kot v letu 2020 v domovih za starejše oz. socialnovarstvenih zavodih.
Za financiranje zdravstvene oskrbe v času covida-19 je bil v obeh letih zelo pomemben prispevek državnega proračuna. V letu 2020 je ZZZS poslovno leto zaključil sicer s

presežkom odhodkov nad prihodki, v višini 87 milijonov evrov. Primanjkljaj je bil rezultat tako manjših prihodkov od načrtovanih kot posledice porasta brezposelnosti zaradi krize v letu 2020Tudi odhodki so bili višji zaradi aktivnosti za obvladovanje epidemije covida-19. Poleg rednih virov za sistem OZZ je ZZZS v letu 2020 iz naslova začasnih interventnih ukrepov prejel za 61,9 milijona evrov transfernih prihodkov iz državnega proračuna, kot povračilo za interventne oprostitve plačila prispevkov. Zato je bil primanjkljaj ZZZS manjši od načrtovanega in ga je lahko pokril iz lastnega vira sredstev (iz rezervnega in splošnega sklada). Leto 2021 pa je ZZZS zaključil s presežkom prihodkov nad odhodki v višini 120,3 milijona evrov in ponovno oblikoval rezerve v višini 40,1 milijona evrov. V tem letu je imel namreč večje prihodke od prispevkov, kar je bila posledica ugodnejših gospodarskih razmer in finančnih spodbud države gospodarstvu v času epidemije. ZZZS pa je tudi v preteklem letu prejel transfer iz državnega proračuna za delno kritje v zvezi z epidemijo nastalih stroškov zdravstvenih storitev in povračila nadomestil plač za čas zadržanosti od dela iz naslova izolacije. Obveznosti ZZZS iz naslova covida-19 na letni ravni so znašale skupaj 277,8 milijona evrov, in sicer 179,9 milijona evrov za opravljene zdravstvene storitve v letu 2021 in 97,9 milijona evrov za izplačana nadomestila iz razloga izolacije v letu 2021.

Poleg sredstev OZZ pa so izvajalci zdravstvenih storitev v času epidemije covida-19 iz državnega proračuna od ZZZS prejeli tudi določena izplačila zaradi izpada dejavnosti, od ministrstva za zdravje pa neposredno še sredstva za izplačila dodatkov vsem zdravstvenim delavcem za posebne obremenitve v času epidemije ter medicinsko in varovalno opremo in sredstva za povečanje kapacitet.

Opisane značilnosti financiranja zdravstvene oskrbe v času epidemije covida-19 izkazujejo, da je krizne razmere v zdravstvu mogoče obvladovati, če se zdravstvo opredeli in z njim upravlja kot s prioriteto na nacionalni ravni. Osnovne zdravstvene posledice epidemije, kot so povečana umrljivost, sorazmerno velik delež obolelega prebivalstva, specifičen potek bolezni in posledice oz. t. i. »dolgotrajen covid«, omejena dostopnost do zdravstvene oskrbe za ostale skupine bolnikov in druge značilnosti, bodo nedvomno vplivale na počasno urejanje razmer v zdravstvu po epidemiji. Odpravljanje zastojev v dostopnosti in normalizacija zdravstvenega sistema se tako zdita nujen cilj sanacije razmer po epidemiji covida-19 v neposredni prihodnosti. Za bolj trajno ureditev zdravstvenega sistema pa bo potrebna celovita strukturna reforma, kjer bodo v ospredju poleg izboljšanja zdravstvenih zmogljivosti na ključnih področjih predvsem vzpostavitev dolgoročnih pogojev za večjo finančno vzdržnost sistema in sodobnejši pristopi organiziranja dela pri izvajalcih zdravstvenih storitev in ostalih subjektih znotraj sistema zdravstvenega varstva.

Literatura:

- Letno poročilo ZZZS za leto 2021

Key words: healthcare system, financing of healthcare, healthcare expenditures, challenges of healthcare systems, Slovene healthcare system.

Before the covid-19 epidemic, the basic development challenges in financing healthcare (and also long-term) treatment were related to the longevity of Slovenian society or its rapid aging. The projections for Slovenia indicated a number of financing risks, or the possibility of a growing gap between the income and expenses of the Health Insurance Institute of Slovenia (hereafter ZZZS) or the compulsory health insurance system (hereafter OZZ). Therefore, in accordance with its Strategic Development Program for the period 2020-2025, ZZZS advocated for certain systemic changes that should mitigate or reduce these possible funding gaps. These are measures on the revenue and expenditure side of the OZZ system, which are supposed to (1) prevent the vulnerability of the financial resources of the OZZ system to fluctuations in the economy or employment, (2) increase the share of budgetary resources for healthcare, (3) more fairly distribute the burden of paying contributions for OZZ, (4) strengthen strategic purchases of healthcare programs, (5) promote the efficiency and quality of program implementation with selected billing models and (6) strengthen supervisory activities or prevent the wastage of public funds of OZZ.

On these bases, ZZZS, together with its partners in healthcare, has been implementing certain organizational and financial measures for some time to better manage the challenges arising from the aging of the population, the changed needs of patients, the increasing number of chronic diseases, multimorbid conditions and other modern diseases. At the primary level we have, for example, strengthened health promotion and prevention programs, introduced and expanded referral clinics for the treatment of patients with chronic diseases, mental health centres and some other new programs. At the secondary and tertiary level of health care, effective short acute hospital and day treatments and outpatient procedures were implemented instead of longer hospital treatments.

However, despite this, in the years before the epidemic, certain problems in meeting the needs of the population and access to services had already escalated, mainly related to pressures on the growth of healthcare expenditures, as a result of the increased demand for services due to the rapid aging of the population. Perceived structural problems would require urgent institutional changes or reform, which, despite some attempts (e.g., in 2016 and 2019), did not take place. Therefore, we entered the epidemic with a relatively suboptimal financial, organizational and personnel situation. Slovenia has, for example, in 2019 allocated 2,186 PPP euros per capita and 8.3% of GDP for healthcare, which was 85% of the EU 27 average. Public expenditures for long-term care (400 euros per capita or 0.9% of GDP) have, for example, reached only 50% of the EU 27 average.

The described structural problems, especially insufficient personnel resources in certain areas and long waiting times, were only highlighted and exacerbated by the outbreak and spread of the covid-19 epidemic in 2020 and 2021. The epidemic has, for example, revealed in particular the lack of doctors at the primary level, the lack of specialized nurses in more demanding departments or units for intensive therapy or care and the lack of nursing personnel in homes for the elderly. These are areas that were already exposed before the epidemic due to the increased and changed health needs of the elderly population. As a result, access to healthcare services was made very difficult.

In 2020, services were mostly provided on a limited scale, both in doctor's offices and in hospitals. At the primary level, the number of visits to general practitioners decreased compared to the previous year due to the implementation of anti-epidemic measures. At least in part, the limited access was "compensated" by conducting (digital) consultations at a distance. In particular, the number of preventive treatments decreased or even stopped in some places. The number of visits to doctors declined the most among those over 65 years and those under 19 years. The number of treatments in specialist outpatient clinics decreased much more than at the primary level (by 20%), although these were also partly carried out remotely. The planned program in specialist clinics was mostly not realized. An exception was the radiotherapy program for the treatment of oncology patients. The number of hospitalizations also decreased in hospitals, by 15% on an annual basis. The protective measures taken due to the covid-19 epidemic had a strong impact on the accessibility of services also in 2021. Due to the additional activities of providers related to testing and vaccination against covid-19, a large number of patients and taking into account security measures, accessibility to health services at the primary level was worse despite the increased number of visits. Certain services (e.g. prevention) were not provided or were provided to a limited extent. The large number of covid patients and the implementation of protective measures resulted in a decrease in the number of treatments for other patients also in specialist outpatient and hospital activities, which was reflected in an increase in the number of people waiting beyond the permissible waiting period. Due to the high level of vaccination, conditions in homes for the elderly or social welfare institutions were significantly better than in 2020.

In both years, the contribution of the state budget was very important for the financing of health care during covid-19. In 2020, ZZZS ended the financial year with an excess of expenses over revenues, in the amount of 87 million euros. The deficit was the result of both lower-than-planned revenues as a result of the increase in unemployment due to the crisis in 2020, as well as higher expenses due to activities to control the covid-19 epidemic. In addition to the regular resources for the OZZ system, in 2020, the ZZZS received 61.9 million euros in transfer revenues from the state budget as compensation for intervention exemptions from the payment of contributions due to temporary

intervention measures. Therefore, the deficit of ZZZS was smaller than planned and they were able to cover it from their own funds (from the reserve and general fund). The ZZZS closed the year 2021 with a surplus of revenues over expenses in the amount of 120.3 million euros and again created reserves in the amount of 40.1 million euros. In this year, they had higher income from contributions, which was the result of more favourable economic conditions and financial incentives from the state to the economy during the epidemic. In the past year, ZZZS also received a transfer from the state budget for partial coverage of the costs of medical services incurred in connection with the epidemic and reimbursement of salary compensation for the period of absence from work due to isolation. The liabilities of ZZZS related to covid-19 at the annual level totalled 277.8 million euros, namely 179.9 million euros for medical services provided in 2021 and 97.9 million euros for benefits paid due to isolation in 2021.

In addition to the funds of the OZZ, healthcare service providers during the covid-19 epidemic also received certain payments from the state budget through ZZZS due to the interruption of activities, and funds directly from the Ministry of Health for the payment of supplements to all health care workers for special burdens during the epidemic and medical and protective equipment and means to increase capacities.

The described characteristics of health care financing during the covid-19 epidemic show that crisis situations in health care can be managed, as long as health care is defined and managed as a priority at the national level. The basic health consequences of the epidemic, such as increased mortality, a relatively large proportion of the affected population, the specific course of the disease and its consequences, or the so-called "prolonged covid", limited access to health care for other groups of patients and other characteristics will undoubtedly affect the slow regulation of the situation in health care after the epidemic. Eliminating accessibility difficulties and normalizing the health system thus seem to be a necessary goal of rehabilitating the situation after the covid-19 epidemic in the immediate future. For a more permanent regulation of the healthcare system, a comprehensive structural reform will be necessary, where, in addition to the improvement of healthcare capabilities in key areas, the priority will be the establishment of long-term conditions for greater financial sustainability of the system and more modern approaches to organizing the work of health care providers and other entities within the healthcare system.

PREDSTAVITEV VODILNE AVTORICE

Doc. dr. Tatjana Mlakar je doktorica znanosti s področja poslovnih ved. Od 39 delovnih let je bila prvih 11 let zaposlena v gospodarskih sistemih. Pridobljeno znanje s področja realnega sektorja s pridom uporablja pri upravljanju negospodarskega sektorja. Njeno raziskovalno delo je vezano na sistem zdravstvenega varstva, ki ga skoraj tri desetletja združuje z rednimi delovnimi obveznostmi na Zavodu za zdravstveno zavarovanje Slovenije (ZZZS), trenutno v vlogi generalne direktorice ZZZS. Osnova njenih znanstvenih raziskav je proučevanje različnih teorij sistemov, s katerimi je oblikovala nov model – kontrolno teorijo sistemov s preveritveno aplikacijo na sistem zdravstvenega varstva kot pripomočka za upravljanje in vodenje zdravstvenih sistemov.

SMO PAMETNEJŠI IN MOČNEJŠI, ČE DELAMO SKUPAJ?

ARE WE SMARTER AND STRONGER IF WE WORK TOGETHER?

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Ključne besede: skill mix, timski pristop v zdravstvu, zdravstvena nega

Teoretična izhodišča: Timski pristop v zdravstveni oskrbi temelji na delitvi odgovornosti in dela med strokovnjaki znotraj tima, ki skupaj delujejo za zagotavljanje učinkovite, v pacienta in njegovo družino usmerjene oskrbe. V takem timu se mora združiti kombinacija različnih znanj in spretnosti večkomponentne konstrukcije, ki zajema problemu prilagojeno potrebno število, izkušnje in izobrazbo različnih strokovnjakov znotraj zdravstvenih ustanov. Predvsem na področju kompetenc posameznih strokovnjakov v timu se danes v svetu govori o spremembi kombinacije znanja in veščin z izboljšanjem in razširitvijo kompetenc medicinskih sester; zamenjavo kompetenc, kjer farmacevti s svojim znanjem obravnavajo paciente na področju jemanja terapije, delegiranjem nalog zdravnika specialista na zdravnika specializanta pod nadzorom; in končno inovacije, kot recimo pri fizioterapevtih, ki vodijo obravnavo pacienta z mišično-skeletnimi težavami. V raziskavi smo si zastavili raziskovalno vprašanje: Kakšni so izkušnje in razmišljanje raziskovalcev na področju »skill mix« pristopov v okviru zdravstvene obravnave pacienta?

Metoda: Izvedli smo pregled literature, za katerega smo uporabili metodo Prizma diagrama. Pregledali smo dva spletna brskalnika (Google Scholar in PubMed). Prvi iskalni niz smo izvedli na ključno besedo »skill mix«, ki smo ji dodali »healthcare« z Boolovima operaterjema »in« ter »and«. Ključni vključitveni kriteriji za pregled literature so bili starost objavljenega vira ne več kot pet let, angleški jezik, članki, objavljeni v relevantnih virih, ter prosta dostopnost članka v celoti.

Rezultati: V prvem iskalnem nizu smo na spletnem brskalniku Google Scholar našli 2.480 zadetkov, na spletnih straneh PubMed pa 93 zadetkov. Z uporabo vključitvenih kriterijev smo pregledali 25 člankov. Tematika »skill mix« pristopov obravnave pacienta v zdravstvu se dotika vseh ravni zdravstvenega varstva. V primarnem zdravstvenem varstvu ključne usmeritve za »skill mix« pristop temeljijo na multidisciplinarnih in interdisciplinarnih pristopih ter na razširitvi kompetenc na druge zdravstvene kadre. V

bolnišničnem okolju se razporejanje kompetenc poudarja znotraj posameznih poklicnih skupin, kar pomeni predvsem za zdravstveno nego nujni dvig izobrazbene strukture medicinskih sester.

Razprava: Timska obravnava z uporabo »skill mix« pristopov je lahko velik doprinos v razvoju zdravstvenih sistemov ter reševanju trenutnih težav v zdravstvenem sistemu. Tovrstni pristop v zdravstveni sistem vpelje racionalizacijo časa, kadrov in denarja. Potrebna sta samo politična volja in pogled, usmerjen v potrebe pacienta in njegove družine. Glede na kopičenje težav in zapletov ob reševanju zdravstvenega sistema je morda smiselno v vseh poklicnih skupinah v zdravstvenem sistemu razmisliti o elementih »skill mix« pristopov.

Key words: skill mix, team approach in healthcare, nursing care

Theoretical background:
The team approach in healthcare is based on the division of responsibilities and work among professionals within the team, who work together to provide effective, patient- and family-centered care. In such a team, a combination of different knowledge and skills of a multi-component, to the problem adapted, structure must be combined, which includes the necessary number, experience and education of different healthcare professionals within medical institutions. Especially in the field of competencies of individual experts in the team, today the world is talking about changing the combination of knowledge and skills by improving and expanding the competencies of nurses; replacement of competencies, where pharmacists treat patients with their knowledge in the field of taking therapy, by delegating the tasks of a specialised doctor to a junior doctor under supervision; and finally innovations such as, for example, physiotherapists who lead the treatment of patients with musculoskeletal problems. In our research, we asked ourselves a research question: What are the experiences and the way of reasoning of the researchers in the field of "skill mix" approaches in the frame of healthcare treatment of the patient?

Method: We conducted a literature review for which we used the Prisma flow diagram method. We reviewed two internet browsers (Google Scholar and PubMed). We performed the first search string on the keyword "skill mix", to which we added "healthcare" with the Boolean operators "in" and "and". The key inclusion criteria for the literature review were the age of the published source of no more than five years, the English language, articles published in relevant sources, and the free availability of the entire article.

Results: In the first search string, we found 2480 hits on the Google Scholar internet browser, and 93 hits on the PubMed internet pages. Using the inclusion criteria, we

reviewed 25 articles. The topic of "skill mix" approaches to patient treatment in health care extends to all levels of health care. In primary health care, the key directions for the "skill mix" approach are based on multidisciplinary and interdisciplinary approaches and on the extension of competences to other health care personnel. In the hospital environment, the allocation of competences is emphasized within individual professional groups, which means, primarily for the field of nursing care, the pressing need to raise the educational structure of nurses.

Discussion: Team approach using "skill mix" approaches can represent a great contribution to the development of healthcare systems and resolving current problems in the healthcare system. This kind of approach brings rationalization of time, personnel and money to the healthcare system. All that is needed is political will and a focus on the needs of the patient and his family. Given the accumulation of problems and complications in solving the healthcare system, it may make sense, in all professional groups in the healthcare system, to consider elements of "skill mix" approaches.

PREDSTAVITEV VODILNE AVTORICE

Doc. dr. Tamara Štemberger Kolnik je zaposlena na Fakulteti za zdravstvene vede v Celju. Z Ministrstvom za zdravje sodeluje pri projektu Dvig zdravstvene pismenosti v Sloveniji, imenovana je bila v skupino M POHL, ki deluje pri WHO, in v Nacionalni svet za bralno pismenost na področju zdravja. Ima več kot 30 let delovnih izkušenj v kliničnem okolju na primarni zdravstveni ravni, pretežno v patronažnem zdravstvenem varstvu in v zdravstveno vzgojnem centru. Delovne izkušnje je nabirala tudi na področju vodenja zdravstvenih in socialnih zavodov kot pomočnica direktorja za zdravstveno nego in kot direktorica zdravstvenega doma. Od leta 2008 do danes je bila vključena v več raziskovalnih projektov, in sicer kot članica raziskovalne skupine ali kot koordinatorka projekta (ministrstvo za zdravje: ZaPiS – Dvig zdravstvene pismenosti v Sloveniji, MoST - Krepitev zdravja za vse; Nacionalni inštitut za javno zdravje: Skupaj za zdravje; Interreg Alpine Space: CONSENSo – skupnostna medicinska sestra, ki podpira starejše v spreminjajoči se družbi; projekt Erasmus+: HLAW – Zdrav življenjski slog za dobro staranje, DEN – Digitalno izobraževanje v zdravstveni negi).

MEDPOKLICNO SODELOVANJE V LUČI V PACIENTA USMERJENIH ZDRAVSTVENIH OBRAVNAV: VIDIK ZBORNICE ZDRAVSTVENE IN BABIŠKE NEGE SLOVENIJE

INTERPROFESSIONAL COOPERATION IN THE LIGHT OF PATIENT-CENTERED HEALTHCARE TREATMENT: THE ASPECT OF NURSES AND MIDWIVES ASSOCIATION OF SLOVENIA

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Ključne besede: zdravstvena nega, specializacije, napredna znanja, timsko delo

Zdravstveni sistemi v Evropi se v svoji togosti in tradicionalnosti ob vse večjih potrebah dolgožive družbe srečujejo z vse večjimi kadrovskimi, organizacijskimi in strokovnimi izzivi. Reševanje teh težav pa ne poteka sistemsko, ampak parcialno in le za posamezne poklicne skupine. Tako se v slovenski zdravstveni negi srečujemo s pojavnostjo zapuščanja poklica, predvsem zaradi neustreznih delovnih pogojev, delovnih obremenitev, neustreznega plačila in onemogočenega kariernega razvoja, vse skupaj pa je odraz neustrezne nacionalne kadrovske strategije v zadnjih desetletjih. Zaradi spremenjene strukture prebivalstva in njegovih potreb po zdravstvenih storitvah pa se pojavljajo nove priložnosti tudi za zdravstveno nego (Rod, 2009), ki pa jih ne znamo izkoristiti. Razvoj podiplomskih specialističnih znanj na področju zdravstvene nege se je začel že v 60. in 70. letih prejšnjega stoletja kot odraz pomanjkanja zdravnikov, dolgožive družbe s kroničnimi nenalezljivimi boleznimi, večjih potreb prebivalstva po dostopnih zdravstvenih storitvah in nenehnega višanja stroškov v zdravstvu. V državah, kjer so specializacije v zdravstveni negi že stalnica, strokovnjaki dokazujejo, da specialistična znanja pomembno in pozitivno vplivajo na razvoj zdravstvene nege in zdravstvenega varstva v celoti ter prispevajo h kakovostnejši, varnejši in k pacientu usmerjeni zdravstveni obravnavi (Delamaire & Lafortune, 2010) ter učinkovitosti diplomiranih medicinskih sester v klinični praksi (Pulcini, Jelic, Gul & Loke et al., 2010). Pri pacientih, ki pridejo v neposreden stik z diplomirano medicinsko sestro s specialističnimi znanji, je manjša možnost sprejema v bolnišnico in je bolj verjetno, da bodo deležni zdravljenja, ki temelji na podlagi kliničnih smernic in dokazov (Grothier, 2012). Prav tako so izidi primerljivi s tisto skupino pacientov, ki je v obravnavi pri zdravniku, pacienti pa odražajo večjo stopnjo zadovoljstva pri zdravstveni obravnavi z medicinskimi sestrami. Tudi slovenske raziskave podpirajo dognanja drugih avtorjev in, kot trdita Pajnkihar & Jakl (2013), nastaja prostor med drugim tudi za razvoj specializacij v slovenski zdravstveni negi. A zakaj tega v letu 2022 še nismo dosegli? Skela-Savič (2020) trdi, da velik problem predstavljata majhno število diplomiranih medicinskih

sester na 1000 prebivalcev ter dolgoletno onemogočanje njihovega razvoja na ravni kliničnih specializacij in naprednih oblik dela. Čeprav smo prepoznali potrebe po podiplomskem izobraževanju na ožjih strokovnih področjih (predvsem preventiva in ambulante družinske medicine, skupnostna psihiatrija, urgentna stanja), le te ob uporabi priporočil ICN (2020) opredelimo v treh nivojih: kot specializirana znanja (specialna znanja), klinično specializacijo v zdravstveni negi ter napredno zdravstveno nego in obravnavo. V Sloveniji se najbolj poslužujemo specialnih znanj, kar pa seveda v bodočnosti ne bo zadoščalo pri v pacienta usmerjeni zdravstveni obravnavi. Razvoja kliničnih specializacij in kliničnih specialistk, kot jih poznamo v evropskih državah, v takem obsegu nimamo. Po definiciji je klinična specializacija prepoznana kot napredna zdravstvena nega na ožjem strokovnem področju, ki sodi najmanj na sedmo raven Evropskega kvalifikacijskega okvira (stopnja strokovni magisterij, European Specialist Nurses Organisations, 2015). Več držav Evropske unije (Poljska, Ciper, Irska, Češka) meni, da bi razvoj specialističnih znanj v zdravstveni negi služil tudi kot eden izmed podpornih dejavnikov za medicinske sestre za nadaljnje podiplomsko izobraževanje. S tako možnostjo kariernega razvoja bi jih lažje zadržali v državi in tako onemogočili odliv delovne sile v države z boljšimi pogoji dela in kariernim razvojem (Aiken & Cheung, 2008). Pomembnost razvoja specializacij se je še posebej pomembno pokazala na področju, kjer se prepletata zdravstvena nega in medicina. Kot trdita Sever in Bregar (2015), se morajo specializacije razvijati vzporedno s spremenjenimi nacionalnimi potrebami. Žal je Slovenijo študija OECD razvrstila med države, ki ima najmanj razvita napredna znanja (Maier, Aiken & Busse, 2017). Kaj so glavni zaviralci takega razvoja zdravstvene nege? Snovalci strategije razvoja zdravstvene nege in babištva 2022–2030 bodo te ovire morali prepoznati in jih predstaviti odločevalcem kot ključne za vzdržen in trajnostni zdravstveni sistem. Obenem ne gre zanemariti vidika tradicionalnih vlog članov zdravstvenega tima, pogosto tudi slabega medpoklicnega sodelovanja. Avtorji medpoklicno sodelovanje opredeljujejo kot nadgradnjo tradicionalnega timskega načina zdravstvene obravnave pacientov, ki vključuje sodelovanje dveh ali več strokovnjakov z različnih področij (Kendall-Gallagher, Reeves, Alexanian & Kitto, 2017). Njihov cilj je doseganje najboljših izidov zdravljenja (Serrano-Gemes & Rich-Ruiz, 2017). Seveda so v času epidemije dodatne obremenitve, neurejena delovna okolja, pogosta premeščanja, siljenje medicinskih sester v preseganje kompetenc in podplačanost ter tudi nasilje pacientov in svojcev pustili svoj pečat tudi na odnosih v timih. Kot trdi Poplas-Susič (2017), je za uspešen razvoj in nadgradnjo medpoklicnega sodelovanja pomembno, da je zdravstveni sistem urejen in zdravstveni poklici znotraj sistema regulirani. V zdravstvenem timu je zdravnik kot nosilec zdravstvene dejavnosti odgovoren za zdravstveni izid pacientov in kot vodja prevzema odgovornost tudi za opravljeno delo. V skladu z Zakonom o zdravstveni dejavnosti Republike Slovenije pa vsak član za svoje delo prevzema etično, strokovno, kazensko in materialno odgovornost. Vsak član tima ima znanja in veščine, v skladu z zaključenim izobraževalnim procesom, ki so potrebni pri obravnavi pacientov, ne glede na to, kje se zdravstvena obravnava izvaja (Greene,

Hibbard & Overton, 2014). V kvantitativni raziskavi o medpoklicnem sodelovanju avtorjev Šavc in Prosen (2022) so ugotovili, da so v povprečju z medpoklicnim sodelovanjem najbolj zadovoljni zdravniki, najmanj pa medicinske sestre. Tradicionalni hierarhični odnosi še naprej zaznamujejo sodelovanje med obema poklicnima skupinama in imajo za posledico slabo komunikacijo in nerešene konflikte znotraj poklicnih skupin (Foth, Block, Stamer & Schmacke, 2015). Čeprav so zdravniki najvišje na hierarhični lestvici, je za uspešno sodelovaje znotraj tima treba graditi poklicno identiteto prav vseh članov tima (Romijn, Teunissen, de Bruijne, Wagner & de Groot, 2016).

Ključno bi bilo uvesti interdisciplinarni učni program, v katerega bi bilo treba vključiti vse profile zdravstvenih smeri – prav zaradi zgodnjega dobrega medsebojnega sodelovanja bi bili odnosi in sodelovanje znotraj timov v kliničnih okoljih boljši ob spoštovanju poklicne raznolikosti.

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Key words: nursing care, specializations, advanced knowledge, teamwork

In their rigidity and traditionality, healthcare systems in Europe are facing increasing personnel, organizational and professional challenges in addition to the growing needs of a long-lived society. Solving these problems does not take place systematically, but partially and only for individual professional groups. Thus, in Slovenian nursing, we encounter the incidence of leaving the profession, mainly due to inadequate working conditions, workload, inadequate pay and prevented career development, all of which is a reflection of the inadequate national HR strategy in recent decades. Due to the changed structure of the population and its needs for health services, new opportunities also appear for healthcare (Rod, 2009), but we do not know how to take advantage of them. The development of postgraduate specialist knowledge in the field of nursing care began in the 60s and 70s of the last century, as a reflection of the shortage of doctors, the long-lived society with chronic non-communicable diseases, the greater needs of the population for accessible health services and the constant increase in costs

in health care. In countries where specializations in nursing care are already permanent practice, experts prove that specialized knowledge has a significant and positive impact on the development of nursing care and healthcare as a whole, and contributes to higher quality, safer and patient-centered healthcare (Delamaire & Lafortune, 2010), and the effectiveness of registered nurses in clinical practice (Pulcini, Jelic, Gul & Loke et al., 2010). Patients who come into direct contact with a registered nurse with specialist knowledge are less likely to be admitted to hospital and more likely to receive treatment based on clinical guidelines and evidence (Grothier, 2012), and the outcomes are comparable to the group of patients who are treated by a doctor, whereby patients reflect a higher level of satisfaction with medical treatment by nurses. Slovenian research also supports the findings of other authors and, as Pajnkihar & Jakl (2013) claim, a space is being created, among other things, also for the development of specializations in Slovenian nursing. But why haven't we already achieved this in 2022? Skela – Savič (2020) claims that the small number of registered nurses per 1,000 inhabitants and the long-term impossibility of their development at the level of clinical specializations and advanced forms of work represent a major problem. Although we have recognized the need for postgraduate education in narrower professional areas (mainly prevention and family medicine clinics, community psychiatry, emergency situations), these are, according to the recommendations of the ICN (2020) defined in three levels: as specialized knowledge (special knowledge), clinical specialization in nursing care and advanced nursing care and treatment. In Slovenia, we mostly use specialized knowledge, which of course will not be enough in the future for patient-centered healthcare treatment. We do not have the development of clinical specializations and female clinical specialists, as we know them in European countries, on such a scale. By definition, clinical specialization is recognized as advanced nursing in a narrower professional field, which belongs to at least the seventh level of the European Qualification Framework (professional master's degree (European Specialist Nurses Organisations, 2015)). Several European Union countries (Poland, Cyprus, Ireland, Czech Republic) believe that the development of specialist knowledge in nursing would also serve as one of the supporting factors for nurses in their further postgraduate education. With such an opportunity for career development, it would be easier to keep them in the country and thus prevent the outflow of labor to countries with better working conditions and career development (Aiken & Cheung, 2008). The importance of the development of specializations has become particularly important in the area where nursing and medicine are intertwined. As Sever and Bregar (2015) claim, specializations must develop in parallel with changed national needs. Unfortunately, the OECD study classified Slovenia among the countries with the least developed advanced skills (Maier, Aiken & Busse, 2017). What are the main inhibitors of such development in nursing? The drafters of the nursing and midwifery development strategy 2022-2030 will have to recognize these obstacles and present them to decision-makers as key to a sustainable healthcare system. At the same time, the aspect of the traditional roles of

members of the healthcare team and often poor interprofessional cooperation, should not be neglected. The authors define interprofessional collaboration as an upgrade of the traditional team method of healthcare treatment of patients, which includes the collaboration of two or more specialists from different fields (Kendall-Gallagher, Reeves, Alexanian & Kitto, 2017). Their goal is to achieve the best treatment outcomes (Serrano-Gemes & Rich-Ruiz, 2017). Of course, during the epidemic, additional workload, messy work environments, frequent transfers, forcing nurses to exceed their competence and underpayment, as well as violence by patients and relatives, also left their mark on the relationships in the teams. As Poplas - Susič (2017) claims, for the successful development and upgrade of interprofessional cooperation, it is important that the healthcare system and the healthcare professions within the system are regulated. In the medical team, the doctor, as the carrier of the medical activity, is responsible for the medical outcome of the patients and, as the manager, also assumes responsibility for the work performed. In accordance with the Act on Healthcare Activities of the Republic of Slovenia, each member assumes ethical, professional, criminal and material responsibility for their work. Each member of the team has the knowledge and skills, according to the completed educational process, that are necessary in the treatment of patients, regardless of where the medical treatment is performed (Greene, Hibbard & Overton, 2014). In a quantitative study on interprofessional cooperation by the authors Šavc and Prosen (2022), they established that, on average, doctors are the most satisfied with interprofessional cooperation, and nurses the least. Traditional hierarchical relationships continue to characterize collaboration between the two professional groups, and result in poor communication and unresolved conflicts within professional groups (Foth, Block, Stamer & Schmacke, 2015). Although doctors are at the top of the hierarchy, for successful cooperation within the team, it is necessary to build the professional identity of all team members (Romijn, Teunissen, de Bruijne, Wagner & de Groot, 2016).

The key would be to introduce an interdisciplinary learning program in which all profiles of healthcare professionals should be included - precisely because of early good mutual cooperation, the relationships and cooperation within teams in clinical settings would be better, while respecting professional diversity.

PREDSTAVITEV VODILNEGA AVTORJA

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»Poklic medicinske sestre je poslanstvo«, pravi Monika Ažman, po izobrazbi diplomirana medicinska sestra. Ima več kot 30 let zelo različnih delovnih izkušenj v tem plemenitem poklicu. 20 let je delala v kliničnem okolju Splošne bolnišnice Jesenice, nato pa od leta 1993 do 2001 za delo v zdravstveni negi navduševala dijake srednje zdravstvene šole kot učiteljica zdravstvene nege in praktičnega pouka. Ker ima rada izzive, je leta 2008 sprejela mesto izvršne direktorice Zbornice zdravstvene in babiške nege – Zveze društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije, 2016 pa so jo kolegice in kolegi izvolili za predsednico svoje strokovne organizacije, ki jo zavzeto vodi že drugi mandat. Njeno vodilo, kot predsednica strokovne organizacije, ki zastopa največjo poklicno skupino v zdravstvu je: «Če bo dobro za medicinske sestre in babice, bo dobro tudi za paciente«.

K PACIENTU USMERJENA OBRAVNAVA – PREIDIMO OD BESED K DEJANJEM

PATIENT-CENTERED HEALTHCARE – LET'S MOVE FROM WORDS TO ACTION

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Ključne besede: holistična obravnava, celostna obravnava, zdravstveni strokovnjaki, oskrba, medicinska sestra

Teoretična izhodišča: K pacientu usmerjena obravnava je zelo širok, multidimenzionalni koncept, ki je usmerjen v spoštovanje pacientovih vrednot, v upoštevanje njegovih prednosti in izraženih potreb. Prvi, ki se je začel ukvarjati s proučevanjem navedenega koncepta, je bil Harvey Picker, ameriški izumitelj in filantropist. Poudarjal je, da se pri obravnavi pacienta mora upoštevati biopsihosocialni vidik in ne le biomedicinski, saj je človek bio-psiho-socialno in duhovno bitje. Dejavniki, ki tvorijo njegovo celoto, so med seboj tesno povezani, kar pomeni tudi njihovo medsebojno vplivanje. Zadovoljevanje pacientovih fizičnih, psihičnih, socialnih in duhovnih potreb pomeni zagotavljanje celostne obravnave, ki je del holistične. Holistična obravnava poudarja tudi pomen spoštovanja pacientovih vrednot in prepričanj, upoštevanje procesa zdravljenja ter upoštevanje integrativnih pristopov v obravnavi.

Koncept holizma poudarja pomen upoštevanja in povezovanja telesa, uma, emocij, duše in okolja v celovito osebo, je gibanje v smeri pridobivanja občutka za celoto in popolnost. Prva, ki sta začela razvijati holistično misel že pred našim štetjem, sta bila Hipokrat, oče znanstvene medicine, in Sokrat, ustanovitelj zahodne filozofije. Holizem je filozofija, da mora biti obravnava pacienta osredotočena na posameznika in njegovo dobro počutje ter na medsebojne odnose med ljudmi, dogodke in okolje. V holizmu so simptomi odraz »modrosti telesa«, ki reagira na zdravljenje neravnovesja ali bolezni. Ameriško združenje holističnih medicinskih sester je leta 2007 sprejelo, da je holistična zdravstvena nega specialno znanje v zdravstveni negi, za kar si morajo medicinske sestre pridobiti dodatna znanja. Njihova vizija in strategija sta, da bi bili vsi pacienti enakopravno, holistično obravnavani, kar pomeni tudi zagotavljanje zadovoljstva pacientov.

Picker je postavil osem načel k pacientu usmerjene obravnave: dostop do oskrbe, kontinuiteta in premestitev, vključenost družine in prijateljev, emocionalna podpora, fizično udobje, informiranje, komunikacija in izobraževanje, koordinacija in integracija

oskrbe ter spoštovanje pacientovih vrednot. K pacientu usmerjena oskrba se lahko izvaja pri vseh pacientih, ne glede na njihovo starost in v vseh zdravstvenih institucijah. K pacientu usmerjena obravnava poudarja humanistični in holistični pristop pri obravnavi pacienta, ki temelji na vzajemnem partnerstvu med zdravstvenimi strokovnjaki, pacienti in njihovimi svojci ali za pacienta pomembnimi drugimi osebami. Danes se torej pojavlja ključno vprašanje: Kakšna je dostopnost pacientov do zdravstvene oskrbe kot temeljnega kriterija k pacientu usmerjene obravnave oz. ali je vsem pacientom zagotovljena enakopravnost v dostopanju do obravnave? Če bomo odgovorili pritrdilno, potem smo na dobri poti za zagotavljanje k pacientu usmerjene obravnave.

Key words: holistic care, integrated care, healthcare professionals, healthcare treatment, nurse

Theoretical background: Patient-centered healthcare is a very broad, multidimensional concept, which is aimed at respecting the patient's values, taking into consideration his strengths and expressed needs. The first to study this concept was Harvey Picker, an American inventor and philanthropist. He emphasized that the biopsychosocial aspect, and not only the biomedical aspect should be taken into consideration when treating the patient, since a person is a bio-psycho-social and spiritual being. The factors that make up the patient's whole are closely related to each other, which also means their mutual influence. Meeting the patient's physical, psychological, social and spiritual needs means providing an integrated treatment, which is part of a holistic treatment. Holistic treatment also emphasizes the importance of respecting the patient's values and beliefs, taking into consideration the process of treatment and integrative approaches to treatment.

The concept of holism emphasizes the importance of considering and connecting the body, mind, emotions, soul and environment into a whole personality, it is a movement in the direction of gaining a sense of wholeness and perfection. The first two personalities to develop holistic thought in BC were Hippocrates, the father of scientific medicine, and Socrates, the founder of Western philosophy. Holism is the philosophy that the treatment of the patient is focused on the individual and his well-being, as well as on the mutual relations between people, on events and the environment. In holism, symptoms reflect the "wisdom of the body" that responds to the treatment of an imbalance in the body, i.e. the disease. In 2007, the American Holistic Nurses Association accepted the notion that holistic nursing is a nursing specialty for which nurses must acquire additional knowledge. Their vision and strategy is for all patients to be treated equally, holistically, which also means ensuring patient satisfaction.

Picker established eight principles of patient-centered healthcare: access to care, continuity of care and transfer, involvement of family and friends, emotional support, physical comfort, providing information, communication and education, coordination and integration of care, and respect for the patient's values. Patient-centered care can be provided to all patients, regardless of their age, and in all health care institutions.

Patient-centered healthcare emphasizes a humanistic and holistic approach to patient care, based on a mutual partnership between healthcare professionals, patients and their relatives or significant others.

Today, therefore, a key question arises: What is the accessibility of patients to healthcare, as a fundamental criterion of patient-centered care, and are all patients guaranteed equality in accessing treatment? If we can answer with "yes", then we are well on our way to providing patient-centered healthcare.

PREDSTAVITEV AVTORICE

Dr. Bojana Filej je izredna profesorica za področje zdravstvene nege in vključena v pedagoški proces na Fakulteti za zdravstvene vede v Celju na 2. stopnji ter na Univerzi v Novem mestu na Fakulteti za zdravstvene vede na 2. in 3. stopnji.

Svojo strokovno pot je začela kot višja medicinska sestra v patronažni dejavnosti, nadaljevala pa kot predstojnica enote pomoči na domu, kot vodja službe zdravstvene nege pacienta na domu in kot pomočnica direktorja za zdravstveno nego v Zdravstvenem domu dr. Adolfa Drolca Maribor. Po 27 letih dela v zdravstvenem domu se je zaposlila v izobraževalni dejavnosti kot visokošolska učiteljica, opravljala pa je tudi naloge prodekanice za izobraževalno dejavnost in dekanice fakultete. Bila je tudi vodja Kolaborativnega centra SZO za primarno zdravstveno nego in predsednica Zbornice zdravstvene nege Slovenije.

Sodelovala je v več raziskovalnih projektih Svetovne zdravstvene organizacije, v bilateralnih projektih ter v Tempus in Erasmus projektih (Potrebe ljudi po zdravstveni negi, LEMON, Telenursing, TelenurseID, NICE, ODIN, Quality and quantity in nursing care, MICE-ICU, CompRU, QualMent). Trenutno sodeluje kot članica raziskovalne skupine Fakultete za zdravstvene vede v Celju v mednarodnem projektu DEN. Njena osebna bibliografija obsega okoli 600 enot.

Imenovana je za strokovnjakinjo Nacionalne agencije Republike Slovenije za kakovost v visokem šolstvu (NAKVIS). Je glavna in odgovorna urednica Revije za zdravstvene vede. Za svoje delo je prejela naslednja priznanja: Zlati znak Zbornice – Zveze, Srebrno plaketo Univerze v Mariboru, Zahvalo Združenja medicinskih sester in babic Republike Makedonije ter priznanje International League of Humanists.