CODEN: OZNEF5 UDK 614.253.5(061.1) = 863 = 20 ISSN 1318-2951

Obzornik zdravstvene nege

Slovenian Nursing Review

53(1)
Ljubljana 2019

OBZORNIK ZDRAVSTVENE NEGE
ISSN 1318-2951 (tiskana izdaja), e-ISSN 2350-4595 (spletna izdaja)
UDK 614.253.5(061.1)=863=20, CODEN: OZNEF5

Ustanovitelj in izdajatelj:
Zbornica zdravstvene in babiške nege Slovenije – Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije

Naslov uredništva: Ob železnici 30 A, SI-1000 Ljubljana, Slovenija
E-naslov: obzornik@zbornica-zveza.si
Spletna stran: http://www.obzornikzdravstvenenege.si
Letna naročnina za tiskan izvod (2017): 10 EUR za dijake, študente in upokojence; 25 EUR za posameznike - fizične osebe; 70 EUR za pravne osebe.
Naklada: 640 izvodov
Tisk in prelom: Tiskarna knjigoveznica Radovljica
Tiskano na brezkislinskem papirju.
Matična številka: 513849, ID za DDV: SI64578119, TRR: SI56 0203 1001 6512 314
Ministrstvo za izobraževanje, znanost, kulturo in šport: razvid medijev - zaporedna številka 862.
Izdajo sofinancira Javna agencija za raziskovalno dejavnost Republike Slovenije.

CODEN: OZNEF5 UDK 614.253.5(061.1) = 863 = 20 ISSN 1318-2951

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

REVIEW OF THE NURSES AND MIDWIVES ASSOCIATION OF SLOVENIA

Ljubljana 2019 Letnik 53 Številka 1
Ljubljana 2019 Volume 53 Number 1

OBZORNIK ZDRAVSTVENE NEGE

NAMEN IN CILJI

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

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

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

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

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

SLOVENIAN NURSING REVIEW

AIMS AND SCOPE

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

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

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

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

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

KAZALO / CONTENTS

UVODNIK / LEADING ARTICLE

IZVIRNI ZNANSTVENI ČLANEK / ORIGINAL SCIENTIFIC ARTICLE

PREGLEDNI ZNANSTVENI ČLANEK / REVIEW ARTICLE

Leading article / Uvodnik

The need for understanding
Potreba po razumevanju

Elisabeth Lindahl

Whenever I meet nurses, registered nurses, in conferences and in other contexts it seems that doing a good job for the patient and being a good nurse is a general concern all over the world. It also seems that this concern, this ambition, is not easy to fulfill. The ambition can even lead to frustation, when understanding for the work and the work situation is lacking among e.g. colleagues, managers and significant others (Lindahl, et al., 2010; Jangland, et al., 2017).

Both van Manen (1997) and Dahlberg and colleagues (2008) developed research on lived experience and lifeworld. They opened up for gaining an understanding of a phenomenon as it is experienced by persons, and shared through their narratives. The lifeworld is only mine and cannot be experienced by anyone else. We can share experiences but not the lifeworld, and it is only through narratives we can get access to someone's lifeworld. Furthermore, we can only learn what they tell. Hence, the lifeworld can be described but also understood. Husserl provides an epistemological perspective on the lifeworld, a foundation for descriptive phenomenology. Heidegger provides an ontological perspective, opening up for an understanding of a phenomonon, hermeneutic phenomenology (van Manen, 1997; Dahlberg, et al., 2008).

In order to provide good care we need to understand patients' and relatives' experiences as well as nurses' experiences. We need to learn about their lifeworlds in order to be able to create caring encounters. How can we ever grasp fears, predjudices, perceptions or false expectations if we do not ask patiens and relatives to tell about their thoughts and experiences. How can we ever support nurses in their challenging work if we do not ask them about their experiences and reflections.

There is a growing body of research on patients' and relatives' lived experiences to learn from, and to consider in daily work. The meaning of living with malodorous excuding ulcers can be understood as being trapped in a debilitating process that slowly strikes one down. There is a longing for life to improve, a longing for wholeness and purity. Nurses cannot make ulcers and malodour disappear but they can provide consolation and hence contribute significantly to improve patients' lives (Lindahl, et al., 2007). According to West and colleagues (2012) the impact of chronic pain on the family is extensive. Understanding the physical, social and emotional changes opens opportunities for nurses to develop and implement strategies to better support partners/families, and strategies to involve families in e.g. assessment, education and treatment processes. A review by Larsen and Uhrenfeldt (2013) aiming to identify patients' lived experiences of having reduced intake of food and drink during illness report high satisfaction with hospital food. However, due to physical changes because of illness, experiences of reduced intake seems to be related to negative feelings during meals, such as anxiety and shame. The review points to the need for more professional assisstance during meals as well as the need for guidance on how to handle specific nutritional problems. Living with arterial or mixed leg ulcers can be interpreted as "life in hell" (Lernevall, et al., 2017). Living with constant pain, between hope and despair, in an eternal battle against the ulcer means that the ulcer controls life. The findings call for individualistic holistic care where not only the ulcer is treated. Lingehall and colleagues (2015) interviewed older people diagnosed with postoperative delirium about their experiences of undergoing cardiac surgery, a one year follow-up. Their experiences were interpreted as feeling drained of viability, feeling trapped in a weird world, being met with disrespect and feeling safe. Hence, health care personnel need deeper knowledge in order to prevent, detect and treat delirium to avoid and relieve suffering

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Received / Prejeto: 15. 2. 2019
Accepted / Sprejeto: 22. 2. 2019

https://doi.org/10.14528/snr.2019.53.1.2965

that might be caused of patients' experiences. This sample of studies, there are of course more to be found, focus on patients' and relatives' experiences. The findings provide significant insights and knowledge for nurses who are responsible for nursing care.

Research on nurses' lived experiences is equally important to consider and to learn from. Blondal and Halldorsdottir (2009) report that caring for patients in pain is a "challenging journey" for the nurse. Reading the patient, dealing with inner conflict of moral dilemmas, dealing with gatekeepers and organisational hindrances were challenges the nurse could face. Coleman and Angosta (2016) interviewed acute care nurses about their lived experiences of caring for patients and their families with limited English proficiency in the United States of America. The nurses desire to connect, to provide care and to provide cultural respect and understanding. These findings point to the need for nurses to share their experiences and ideas for solutions, and to the need for identifying e.g. barriers and resources for communication. Identifying concerns of the bedside nurses is equally important. District nurses shared their lived experiences of meeting significant others in the home when providing advanced home care to patients (Pusa, et al., 2015). Interpretations of the findings were formulated as themes; feeling close, mediating strength and being emotionally influenced. Creating and maintaining a trustful relationship with significant others in order to illuminate and respond to their needs and desires was found to be the meaning of the meetings. It is emotionally demanding as well as emotionally rewarding being a district nurse in advanced home care. Egede-Nissen and colleagues (2017) performed interviews with minority health care providers in a dementia unit within a Norwegian nursing home aiming to examine challenges in care. Findings show that experienced challenges were related to an ethical striving for understanding the patient. Minority healthcare providers share almost the same challenges as ethnic norwegians but their work includes an extra dimension due to their cultural and linguistic experiences from their home country. The findings open up for the need of sharing experiences and supporting each other. This sample of studies focus on nurses' experiences. The findings provide significant insights and knowledge for nurses but also for managers responsible for organising work and providing education and support.

To sum up, phenomenological research provides advantages for nursing as the findings or interpretations reveal meanings of health and illness. It also guides nurses' understanding of emotional needs/desires and impact of illness, e.g. dying, caring, comfort. Furthermore, self- understanding is included and constitutes the cornerstone to understanding. Phenomenological research is used internationally, in various contexts. The siginificance for nursing is that phenomenological research reveals depth and diversity of nursing knowledge. It explicates tacit knowledge inbedded in caring and provides a foundation for caring science. Finally phenomenological research advances our knowledge and practice. When extending our knowledge and understanding creating caring encounters becomes possible and hence good nursing care can be provided.

Slovenian translation / Prevod v slovenščino

Ko na konferencah in drugje srečujem zaposlene v zdravstveni negi, se mi zdi, da sta povsod po svetu bistvena skrb za paciente in kakovostno opravljeno delo. Gre za cilja, ki ju ni lahko doseči. Kadar pa pri tem ni razumevanja med sodelavci, vodji in pomembnimi drugimi, lahko pride do frustracij (Lindahl, et al., 2010; Jangland, et al., 2017).

Van Manen (1997) ter Dahlberg in sodelavci (2008) so razvili raziskave o življenjskih izkušnjah in osebnem doživljanju sveta. S tem so omogočili, da določen pojav razumemo bolje – tako kot ga razumejo posamezne osebe in ga delijo z drugimi s pripovedovanjem svoje zgodbe. Kljub temu je osebno izkustvo sveta le moje in ga ne more izkusiti nihče drug. Lahko si sicer delimo izkušnje, a ne lastnega sveta. Čeprav skozi pripovedovanje zgodbe dostopamo do sveta nekoga drugega, lahko izvemo le tisto, kar nam nekdo pove. Svet pa je mogoče opisati in ga tako tudi razumeti. Husserl je podal epistemološko videnje sveta, ki je osnova za deskriptivno fenomenologijo, Heidegger pa ontološko perspektivo, ki omogoča razumevanje nekega pojava in s tem hermenevtično fenomenologijo (van Manen, 1997; Dahlberg, et al., 2008).

Da bi lahko nudili kakovostno zdravstveno nego, moramo razumeti izkušnje pacientov in njihovih sorodnikov ter tudi izkušnje zaposlenih v zdravstveni negi. Da bi zagotovili srečanja, ki izražajo skrb, moramo spoznati njihove svetove. Kako razumemo strahove, predsodke, zaznavanja ali napačna pričakovanja, če pacientov in sorodnikov ne povprašamo o njihovem razmišljanju in izkušnjah? Kako lahko podpiramo zaposlene v zdravstveni negi pri njihovem težavnem delu, če jih ne povprašamo po njihovih izkušnjah in doživljanju?

Vse več raziskav se ukvarja z osebnimi življenjskimi izkušnjami pacientov in njihovih sorodnikov, iz česar se lahko učimo in vedenje uporabimo pri svojem delu. Tako je na primer življenje z razjedo, zaradi katere pacient oddaja neprijeten vonj, mogoče razumeti, kot da je pacient ujet v situaciji, ki mu počasi jemlje moči in opravilnost. Želi si izboljšanja življenja, celostnega pristopa in čistosti. Čeprav zaposleni v zdravstveni negi razjede in slabega vonja ne morejo odpraviti, mu lahko nudijo oporo in tolažbo ter tako znatno pripomorejo k izboljšanju njegovega življenja (Lindahl, et al., 2007). West in sodelavci (2012) menijo, da ima kronična bolečina

velik vpliv na pacientovo družino. Razumevanje fizičnih, družbenih in čustvenih sprememb pomeni, da zaposleni v zdravstveni negi dobijo priložnosti za razvijanje in uporabo strategij, ki jim omogočajo, da pacientovim partnerjem zagotavljajo učinkovitejšo podporo. Tako jih na primer vključijo v procese ocenjevanja, izobraževanja in zdravljenja. Raziskava Larsena in Uhrenfeldta (2013) izpostavlja, da so pacienti, ki imajo zaradi bolezni zmanjšan vnos hrane in pijače, bolj zadovoljni s hrano v bolnišnici. Zaradi fizičnih sprememb, ki so posledica bolezni, pa je zmanjšan vnos hrane in pijače povezan z negativnimi občutji med obroki, kot sta tesnoba in sramota. Zato se kaže potreba po večji strokovni pomoči in smernicah za soočanje s specifičnimi prehranskimi težavami. Življenje z arterijskimi ali mešanimi razjedami na nogah se pogosto interpretira kot »življenje v peklu« (Lernevall, et al., 2017). Živeti s kronično bolečino, med upanjem in obupom, v večni bitki proti razjedam pomeni, da bolezen upravlja pacientovo življenje. Ugotovitve kažejo na potrebo po individualni celostni oskrbi, pri kateri se ne zdravi le razjed. Lingehall in sodelavci (2015) so intervjuvali starejše paciente z diagnozo pooperativnega delirija o njihovih izkušnjah operacije srca in enoletnega spremljanja. Izrazili so jih kot občutek, da so jim bile odvzete sposobnosti za normalno življenje, da so ujeti v čuden svet, da se srečujejo z nespoštovanjem in da se počutijo varne. Da bi lahko preprečili, zaznali in zdravili delirij ter tako pacientom odvzeli ali olajšali trpljenje, ki ga izkušajo, morajo zaposleni v zdravstveni negi razviti globlje razumevanje. Obstaja več raziskav, omenjene se osredotočajo na izkušnje pacientov in njihovih sorodnikov. Ugotovitve predstavljajo pomemben vpogled in zaposlenim v zdravstveni negi nudijo novo znanje.

Vir znanja pa predstavljajo tudi raziskave o osebnih izkušnjah zaposlenih v zdravstveni negi. Blondal in Halldorsdottir (2009) poročata, da je za zaposlene v zdravstveni negi skrb za paciente z bolečinami zahteven izziv. Spoznati pacienta, soočiti se z notranjimi konflikti in moralnimi dilemami, z zaprtimi vrati in organizacijskimi preprekami so samo nekateri od izzivov, s katerimi se srečujejo. Coleman in Angosta (2016) sta v Združenih državah Amerike intervjuvala zaposlene v akutni zdravstveni negi o njihovih osebnih izkušnjah pri oskrbi pacientov in njihovih družin, ki imajo omejeno znanje angleškega jezika. Želja zaposlenih je, da se povežejo ter nudijo oskrbo ob razumevanju in spoštovanju različnih kultur. Ugotovitve kažejo na njihovo potrebo, da delijo svoje izkušnje, ideje in rešitve ter prepoznavajo tudi ovire in različne vire komunikacije. Prepoznavanje potreb zaposlenih v zdravstveni negi je torej enako pomembno kot prepoznavanje potreb pacientov. Zaposleni v patronažni zdravstveni negi so delili svoje izkušnje o srečanju s pomembnimi drugimi na domu, ko so izvajali napredno oskrbo pacientov na domu (Pusa, et al., 2015). Interpretacije ugotovitev izpostavljajo: občutek bližine, posredovanje moči in vpliv na čustvovanje. Izkazalo se je, da je bil pomen teh obiskov v ustvarjanju in obnavljanju pristnih odnosov, kar pomaga osvetlili potrebe in želje ter se odzvati nanje. Poklic patronažne medicinske sestre je čustveno zahteven, a hkrati prinaša tudi čustveno zadovoljstvo. Egede-Nissen in sodelavci (2017) so z namenom preučiti izzive v zdravstveni negi intervjuvali zaposlene v zdravstveni negi, ki so predstavniki manjšin in nudijo oskrbo na oddelku za demenco v norveškem domu za ostarele. Ugotovitve kažejo, da so bili izzivi, s katerimi so se zaposleni srečevali, vezani na etično željo razumeti pacienta. Zaposleni v zdravstveni negi, ki so predstavniki manjšin, imajo skoraj enake izzive kot Norvežani, vendar jih pri delu zaznamujejo tudi njihove kulturne in jezikovne izkušnje iz domovine. Ugotovitve kažejo na potrebo po deljenju izkušenj in medsebojni podpori.

Omenjene raziskave se osredotočajo na izkušnje zaposlenih v zdravstveni negi. Ugotovitve omogočajo pomemben vpogled v delo v zdravstveni negi in oskrbi ter predstavljajo vir znanja za zaposlene v zdravstveni negi, pa tudi za menedžerje, ki so odgovorni za organiziranje dela ter zagotavljanje izobraževanja in podpore.

Povzamemo lahko, da so fenomenološke raziskave za zdravstveno nego koristne, saj njihove ugotovitve in interpretacije pripomorejo k razumevanju pomena stanja zdravja in bolezni. Poleg tega pomagajo razumeti čustvene potrebe in želje zaposlenih v zdravstveni negi ter vpliv bolezni, na primer umiranja, skrbi in tolažbe. Pomemben del razumevanja predstavlja tudi razumevanje samega sebe. Fenomenološke raziskave uporabljajo po vsem svetu v različnih kontekstih. Za zdravstveno nego so pomembne, ker odkrivajo globino in raznolikost znanja. Predstavljajo pa tudi »tiho znanje«, ki je vključeno v skrb in je temelj znanosti o zdravstveni negi. Hkrati prispevajo k napredku na področju znanja in praktičnega dela. Proces razširjanja znanja in razumevanja omogoča nova spoznanja, kar pripomore k zagotavljanju kakovostne zdravstvene nege.

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Cite as / Citirajte kot:
Lindahl, E., 2018. The need for understanding. *Obzornik zdravstvene nege*, 53(1), pp. 4–7.
https://doi.org/10.14528/snr.2019.53.1.2965

Original scientific article / Izvirni znanstveni članek

Understanding and applying the matrix on the four levels of competences and categories of the nursing care providers: a descriptive research

Razumevanje in umeščanje matrike štirih ravni kompetenc in kategorij izvajalcev v zagotavljanje zdravstvene nege: opisna raziskava

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Key words: education; European Directive; health care assistant; registered nurse; specialization; scientific discipline

Ključne besede: izobraževanje; evropska direktiva; zdravstveni asistent; diplomirana medicinska sestra; specializacija; znanstvena disciplina

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ABSTRACT

Introduction: The complexity of patients' needs in today's health care calls for a revision and extension of nursing professions to ensure optimal health care outcomes. The aim of the research was to assess the understanding of the four categories of the nursing care continuum and, accordingly, four categories of nursing care providers.

Methods: A descriptive, quantitative research design was employed. Participants included 365 nursing educators and nurses working in the clinical setting. The structured questionnaire used was based on the four categories of the nursing care continuum.

Results: Secondary school teachers expressed significantly lower agreement with the terming of health care assistant ($p < 0.001$), and with the general ($p < 0.001$) and specific ($p < 0.001$) competencies of this profession, contrary to management workers ($p < 0.001$) and those trained in research ($p = 0.030$) and evidence-based care ($p = 0.004$) who expressed higher agreement with the competencies of health care assistants.

Discussion and conclusion: The research draws attention to the issue of understanding and applying the competencies of health care assistants. In order to implement the workforce matrix of competences, the European Directive on regulated professions should be supplemented with minimum requirements for specialist knowledge and advanced practice in nursing. In addition, the competencies and minimum educational requirements for health care assistants should be defined.

IZVLEČEK

Uvod: Trenutna kompleksnost pacientovih potreb zahteva revizijo in razširitev kompetenc poklicev v zdravstveni negi, ki bo zagotovila optimalne zdravstvene izide. Cilj raziskave je bil preveriti razumevanje štirih ravni kompetenc pri zagotavljanju zdravstvene nege in s tem povezanih štirih kategorij izvajalcev zdravstvene nege.

Metode: Uporabljena je bila opisna kvantitativna metoda. V raziskavi je sodelovalo 365 oseb s področja izobraževanja in kliničnega dela v zdravstveni negi. Uporabljen je bil strukturirani vprašalnik, ki je temeljil na štirih ravneh kompetenc in kategorij izvajalcev v zdravstveni negi.

Rezultati: Učitelji srednjih šol se manj strinjajo s poimenovanjem poklica zdravstveni asistent ($p < 0{,}001$) ter splošnimi ($p < 0{,}001$) in specifičnimi kompetencami za ta poklic ($p < 0{,}001$). Nasprotno menedžment ($p < 0{,}001$) in tisti, ki so se izobraževali iz raziskovanja ($p = 0{,}030$) in na dokazih podprtega dela ($p = 0{,}004$), kompetence za zdravstvenega asistenta značilno bolj podpirajo.

Diskusija in zaključek: Raziskava kaže na problem razumevanja in ustreznega umeščanja kompetenc zdravstvenega asistenta. Za implementacijo matrike kompetenc je potrebno Evropsko direktivo za regulirane poklice dopolniti z minimalnimi zahtevami za specialistična znanja in napredne oblike dela v zdravstveni negi ter zapisati kompetence in minimalne pogoje šolanja za zdravstvenega asistenta.

Received / Prejeto: 24. 4. 2018
Accepted / Sprejeto: 16. 2. 2019

https://doi.org/10.14528/snr.2019.53.1.267

Introduction

At the European Union (EU) level, the minimum requirements for the training of registered nurses (RN) and their professional competences are governed by two European Parliament and Council Directives (Directive 2013/55/EU of the European Parliament of the Council, 2013; Directive 2005/36/EC on the recognition of professional qualifications: 22–142, 2005). The guidelines of various international associations further explain the requirements set out by these directives. They also advocate for an increase in the knowledge and education levels in nursing, and position it as a profession and a scientific discipline that contributes to meeting the health care needs of the society, thereby justifying the need for a variety of training for nurses to increase their knowledge and competences in patient work (World Health Organization [WHO], 2016, 2011; European Federation of Nurses Associations [EFN] 2015; International Council of Nurses [ICN], 2015). National education and competence development standards and guidelines contribute to improving the quality of education and development of professional competences in nursing care (Nursing & Midwifery Council [NMC], 2010; American Nurses Association [ANA], 2013; Skela-Savič, 2015, 2017).

It has become evident that the complexity of current patient needs results in the necessity for a revision and expansion of nursing competence standards in order to ensure optimal health care outcomes. Therefore, competences are no longer seen as static, but what is needed is the evaluation of competence development across all nursing care educational levels and the ability to perform them effectively in practice (Garside & Nhemachena, 2013; Dury, et al., 2014; McKenna, et al., 2014; Numminen, et al., 2014; Kroezen, et al., 2018). Nursing competences and their assessment are topical issues in current nursing education and practice, contributing to the safety and quality of nursing care (Numminen, et al., 2014).

With the ability to acquire and use modern scientific findings and evidence-based clinical practice (EBP) in everyday work, nursing care requires interdisciplinary skills that support the development of competences and transferrable skills (Blažun, et al., 2015). A comparison of nursing care education within the EU revealed differences in educational programs across countries (Palese, et al., 2014). The most significant differences and the lack of regulation were found in educational levels for the "Nursing Support Worker" and "Enrolled, Registered or Licensed Practical Nurse" categories, a fact confirmed by two European projects analyzing this situation. Differences were found in the ages of students enrolling in the educational program, duration of the program, relationship between practical and theoretical training, competences, etc. (Braeseke, et al., 2013; Schäfer, et al., 2016). In both projects mentioned, the term used for this category was Health Care Assistant (HCA). It is becoming increasingly important to regulate the education of HCAs and define their role in health care provision—clear boundaries and competences must be defined for their patient work (Cassier-Woidasky, 2013). European Member States differ in terms of the knowledge, skills and competences which health care assistants are expected to achieve as learning outcomes, and the CC4HCA study shows that there is presumably a common, core set of learning outcomes which almost all HCAs across Europe possess (Kroezen, et al., 2018).

Currie and Carr-Hill (2013) recommended that standards be specified in terms of what different categories of nurses actually do, and their responsibilities and the role within that scope in practice. The European Federation of Nurses Associations (EFN, 2014) defined four categories of nursing care providers in its "EFN Matrix on the Four Categories of the Nursing Care Continuum" document (EFN Matrix): Health Care Assistant (HCA), General Care Nurse (GCN), Specialist Nurse (SN) and Advanced Nurse Practitioner (ANP), defining GCN as a professional educated in compliance with Art. 31, modernized Directive 2005/36/EC. In its Nursing Care Continuum and Competences document, the International Council of Nurses (2008) similarly used five nursing care provider categories: Support or Assistive Worker; Enrolled Nurse/Registered Nurse Assistant/Licensed Practical Nurse; Registered/Licensed Nurse; Specialist Nurse; Advanced Practice Nurse.

Aims and objectives

Slovenia has 8.6 nurses per 1,000 people, of which only 2.5 are RNs or holders of a Nursing BSc, qualifications compliant with EU directives (2013/55/EU, 2005/36/E); the rest are Health Care Technicians (HCT) or Practical Nurses (PN) with completed secondary education, placing Slovenia at the bottom of European countries. The aim of the research was to determine the level of understanding of nursing care continuum provider category descriptions and their competences according to the EFN Matrix; this will serve as an important starting point for planning nursing care education and employment changes and working requirements in nursing in Slovenia.

Methods

A descriptive quantitative research method was employed.

Description of the research instrument

A structured questionnaire with two sections was employed. The first, demographic section contained

22 questions. We gathered basic demographic data, information on employment position, participation in training over the past five years, database access, and other parameters. Participants replied with dichotomous responses (Yes/No). Respondents self-evaluated their knowledge of research, evidence-based work, the English language proficiency and assessed their satisfaction with professional work on a five-point scale (1 – Insufficient; 2 – Sufficient; 3 – Good; 4 – Very good; 5 – Excellent). Respondents also indicated their agreement with the Slovenian translations of English names for the four nursing care provider categories defined by the EFN Matrix.

The second questionnaire section inquired into the understanding of the EFN Matrix. Respondents rated 37 statements on a five-point scale (1 – Strongly disagree; 2 – Disagree; 3 – Neither agree nor disagree; 4 – Agree; 5 – Strongly agree). Participants responded to general descriptions of individual provider categories and specific competences. Provider categories, descriptions, and specific competences were translated from English into Slovenian by a professional translator. Reliability and validity evaluations were used for all sets of statements where data were shown to be useful for future analysis. The general descriptions of four nursing care provider categories through the four statements proved to have good reliability (Cronbach alpha = 0.807).

The instrument's ability to measure:

- the "specific HCA competences" phenomenon through eight statements turned out to be very reliable (Cronbach alpha = 0.901). Factor analysis explained 55.43 % of the variance (KMO = 0.878, Bartlett $p < 0.001$). The result is a single factor (FA1 – Specific HCA competences) in which all statements have a factor loading of less than 0.63;
- the "specific GCN competences" phenomenon through eight statements has turned out to be very reliable (Cronbach alpha = 0.958). Factor analysis explained 75.31 % of the variance (KMO = 0.932, Bartlett $p < 0.001$). The result is a single factor (FA2 – Specific GCN competences) in which all statements have a factor loading of less than 0.77;
- the "specific SN competences" phenomenon through eight statements turned out to be very reliable (Cronbach alpha = 0.966). Factor analysis explained 77.19 % of the variance (KMO = 0.954, Bartlett $p < 0.001$). The result is a single factor (FA3 – Specific SN competences) in which all statements have a factor loading of less than 0.76;
- the "specific ANP competences" phenomenon through eight statements turned out to be very reliable (Cronbach alpha = 0.933). Factor analysis explained 79.15 % of the variance (KMO = 0.885, Bartlett $p < 0.001$) with two factors. The first factor explained 68.18% of the variance (Cronbach alpha = 0.939) and the second 10.97 % of the variance (Cronbach alpha = 0.910). The first factor describes collaborative, educational, and development tasks (collectively: FA4 – Collaboration and development), while the second covers responsibility for treatment, clinical decisions, and patient referrals (collectively: FA5 – Responsibility for treatment).

The results of factor analysis (Principal Axis Factoring) are shown in Tables 2 and 3.

Description of the research sample

Purposive sampling was used. In total, 785 people were invited; 569 (72.48 %) agreed to receive the questionnaire and 365 respondents returned the questionnaire, making the response rate 64.15 %. The sample included nursing care teachers and management from secondary health care schools (n = 31), nursing care lecturers and management from health care science colleges and faculties (n = 30), GCNs who are clinical mentors and educators in health care institutions (n = 274), and members of national nursing bodies in Slovenia (Nurses and Midwives Association of Slovenia, Ministry of Health) (n = 30). In terms of gender representation, 315 (86.3 %) respondents were female. On average, the respondents were 43.4 years old (s = 9.4). In terms of educational achievement, participants ranged from GCNs (n = 310) to masters in nursing (n = 55). The average length of employment in nursing was 15.17 years (s = 10.66).

Description of the research procedure and data analysis

The research took place between April and June 2016. Reliability analysis was calculated using Cronbach's alpha coefficient of internal consistency (< 0.70) (Pallant, 2010). Consistency analysis was validated using exploratory factor analysis (Principal Axis Factoring approach, the Oblimin with Kaiser Normalization rotation method), the Bartlett sphericity test was performed ($p < 0.05$), and the KMO measure used was (> 0.6) (Pallant, 2010). If a factor has four or more factor loadings exceeding 0.6, the result is reliable regardless of the sample size (Pallant, 2010). In addition, descriptive statistics, paired t-test, variance analysis (ANOVA with post-hoc tests), and correlation analysis were used to process data. Statistical significance was set at $p < 0.05$. The program SPSS ver. 22 was used to process data.

Results

In terms of training and educational activities, respondents indicated that over the previous five years (2010–2015), only half had received education and training in nursing research (n = 182), followed by evidence-based practice (EBP) in nursing (n = 173). A total of 157 (43 %) reported on having access to information databases (e.g. Cinahl, Web of Science,

ProQuest) at their workplace. When asked to rate their knowledge, skills, and job satisfaction on a 5 – point scale, the mean value obtained for research skills was 3.14 (s = 0.94), EBP knowledge 3.20 (s = 0.97), and English language proficiency 2.93 (s = 1.05). Job satisfaction was rated with a mean value of 3.99 (s = 0.77). A total of 62.7 % of respondents actively participated in working and professional nursing bodies outside their workplace; 43.3 % held a management position and 78.9 % acted as mentors to nursing students.

When it came to naming nursing care provider categories, the HCA translation proposal had the lowest level of agreement ($\bar{x}$ = 3.29, s = 1.34) or revealed ambivalence about naming appropriateness in all areas of respondent employment (F = 17.170, df = 294, $p < 0.001$). A secondary school nursing teacher had significantly lower agreement with the naming of HCA ($\bar{x}$ = 1.54, s = 0.86) than a faculty nursing teacher ($\bar{x}$ = 3.26, s = 1.10) and GCNs from clinical area ($\bar{x}$ = 3.38, s = 1.31), while high agreement ($\bar{x} <$ 4) was achieved with the other three proposals (GCN, SN and ANP) from all respondents.

The general description of HCA showed the lowest level of agreement (Table 1). Secondary school nursing teachers ($\bar{x}$ = 2.27, s = 1.40, F = 14.151, df = 298, $p < 0.001$) had significantly lower agreement rates with the general description of HCA than faculty nursing teachers ($\bar{x}$ = 4.00, s = 1.00), and GCNs ($\bar{x}$ = 3.70, s = 1.10), from the clinical area. Respondents in management positions had higher agreement rates with a general description of HCA ($\bar{x}$ = 3.88, s = 1.05, t = 2.787, p = 0.006) than other respondents. The same applies to mentors who had higher agreement rates ($\bar{x}$ = 3.73, s = 1.33, t = 2.213, p = 0.028) than other respondents. Respondents who had received training in EBP over the past five years had higher agreement rates with the general description of HCA ($\bar{x}$ = 3.79, s = 1.18, t = 2.038, p = 0.042) than other respondents.

Specific competences for individual nursing care continuum provider categories

1. *Health Care Assistant*

The average value of responses on specific HCA competences was 4.1 (s = 0.69). For individual statements, the lowest levels of agreement and response dispersion were identified for the response describing the delegation of tasks by GCNs. The research found that respondents from secondary health care schools have lower agreement levels ($\bar{x}$ = 3.60, s = 0.57) with HCA competences (F = 5.494, df = 2.96, p = 0.001), while respondents working in management have higher agreement levels (t = 4.362, $p < 0.001$) than other respondents. Higher levels of agreement were reported by those who had received training in research in the last five years (t = 2.174, p = 0.030), who had received training in EBP (t = 2.899, p = 0.004) and who have database access (t = 2.194, p = 0.029). As the years of mentoring students (r = 0.241, $p < 0.001$) and job satisfaction levels (r = 0.171, p = 0.002) increase, so does the agreement level with HCA competences. Descriptive results with factorial analysis are shown in Table 2.

2. *General Care Nurse*

The average value for responses on specific competences was acquired using the "GCN competences" derived variable; its value was 4.55 (s = 0.58). Higher levels of agreement were recorded among

Table 1: *Results for respondents' agreement with the general descriptions of individual EFN Matrix nursing care continuum provider categories*
Tabela 1: *Rezultati odgovorov strinjanja s splošnimi opisi štirih kategorij izvajalcev v zagotavljanju zdravstvene nege Evropskega združenja medicinskih sester*

Descriptions of the cathegories / Opisi kategorij	$\bar{x}$	***s***
Health Care Assistant (HCA): An auxiliary that assists the nurse directly in nursing care in institutional or community settings under the standards and the direct or indirect supervision of the general care nurse.	3.67	1.18
General Care Nurse (GCN): A self-regulated health care professional who works autonomously and in collaboration with others and who has completed a nursing education program and is qualified and authorized in his/her country to practice as a general care nurse. Has successfully completed a program of education approved by the nursing board/council; has passed the required assessments established by the nursing board/council for entry into the profession; continues to meet the standards of the nursing board/council (ref. art 31, modernized Directive 2005/36/EC).	4.23	0.80
Specialist Nurse (SN): A nurse prepared at an advance level and authorized to practice as a specialist with specific expertise in a branch of the nursing field.	4.27	0.79
Advanced Nurse Practitioner (ANP): A general care nurse who has advanced knowledge base, complex decision-making skills and clinical competencies for expanded clinical practice on advanced level; the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice.	4.19	0.88

Legend / Legenda: $\bar{x}$ – average / povprečje; s –standard deviation / standardni odklon

Table 2: *Results for respondents' agreement with the specific competences for HCA and GCN*
Tabela 2: *Rezultati odgovorov strinjanja s specifičnimi kompetencami zdravstvenega asistenta in diplomirane medicinske sestre za splošno zdravstveno nego*

Health Care Assistant (HCA) / Zdravstveni asistent	$\bar{x}$	***s***	***FA1***
To work under the delegation and supervision of nurses to support nursing care and administration.	3.74	1.12	0.64
To support nurses with the preparation and delivery of diagnostic and treatment interventions.	4.12	0.80	0.72
To monitor basic patient vital and other signs and progress as indicated by the nurse and report to her/him as appropriate.	4.02	1.03	0.75
To support patients and citizens with activities of daily living, including hygiene, comfort, and mobilization and feeding needs.	4.28	0.77	0.75
To convey routine information to patients/citizens and relatives.	3.98	0.92	0.62
To communicate promptly and accurately with nurses and other health professionals in ensuring the delivery of quality and safe patient care.	4.30	0.78	0.81
To work together with nurses and other health professionals in supporting the delivery of basic patient care.	4.21	0.83	0.77
To identify what is normal concerning patient and citizen well-being through experience and instruction, and report that which is out with normal to nurses.	4.20	0.81	0.82
General Care Nurse (GCN) / Diplomirana medicinska sestra; Diplomirani zdravstvenik	$\bar{x}$	***s***	***FA2***
To independently diagnose the nursing care required using current theoretical and clinical knowledge and to plan, organize and implement nursing care when treating patients on the basis of the knowledge and skills acquired in order to improve professional practice.	4.48	0.64	0.85
To work together effectively with other actors in the health sector, including participation in the practical training of health personnel on the basis of the knowledge and skills acquired.	4.54	0.60	0.88
To empower individuals, families and groups towards healthy lifestyles and self-care on the basis of the knowledge and skills acquired.	4.52	0.61	0.93
To independently initiative life-preserving measures and to carry out measures in crises and disaster situations.	4.40	0.73	0.76
To independently give advice to, instruct and support persons needing care and their attachment figures.	4.40	0.70	0.77
To independently assure quality and evaluation of nursing care.	4.50	0.64	0.92
To comprehensively communicate professionally and to cooperate with members of other professions in the health sector.	4.53	0.63	0.91
To analyze the care quality to improve the own professional practice as a general care nurse.	4.50	0.65	0.88

Legend / Legenda: $\bar{x}$ – average / povprečje; s –standard deviation / standardni odklon; FA1 – factor analysis 1 / faktorska analiza 1; FA2 – factor analysis 2 / faktorska analiza 2

the respondents in management positions ($t = 3.088$, $p = 0.002$), members of working and professional bodies ($t = 2.704$, $p = 0.007$), student mentors ($t = 1.975$, $p = 0.049$), and those who had received training in research ($t = 2.175$, $p = 0.030$) or EBP ($t = 3.235$, $p = 0.001$) over the past five years. The results are shown in Table 2.

3. *Specialist Nurse*

The average value for responses on specific competences was acquired using the "SN competences" derived variable; its value was 4.48 ($s = 0.59$), revealing agreement with competences. Higher levels of agreement were recorded among the respondents in management positions ($t = 2.951$, $p = 0.003$), members of working and professional bodies ($t = 2.062$, $p = 0.040$), and those who had received training in research ($t = 3.248$, $p = 0.001$) or EBP ($t = 3.724$, $p < 0.001$) over the past five years. As the years of mentoring students ($r = 0.241$, $p < 0.001$) and job satisfaction levels ($r = 0.171$, $p = 0.002$) increase, so does the level of agreement. The results are shown in Table 3.

4. *Advanced Nurse Practitioner*

The lowest level of agreement was recorded for the statement related to independent prescription of medication and independent treatment. The mean value for responses on specific competences was obtained using the derived variable "ANP competences" with a value of 4.24 ($s = 0.76$). The level of agreement increases with the level of education ($F = 3.061$, $p = 0.028$), among management workers ($t = 2.696$, $p = 0.007$), and persons who had received training in research ($t = 2.990$, $p = 0.003$) or EBP ($t = 3.216$, $p = 0.001$). Correlation analysis revealed a weak correlation between opinions and years of mentoring students ($r = 0.115$, $p = 0.046$).

A significant difference in mean values was found to exist between the two factors: the "Collaboration and development" statements have a mean value of 4.39

Table 3: *Results for respondents' agreement with the specific competences for SN and ANP*
Tabela 3: *Rezultati odgovorov strinjanja s specifičnimi kompetencami diplomirane medicinske sestre specialistke in magistrice zdravstvene nege*

Specialist Nurse (SN) / Diplomirana medicinska sestra, specialistka, Diplomirani zdravstvenik specialist	$\bar{x}$	***s***	***FA3***	
To analyze complex clinical problems with the use of relevant knowledge, diagnose, initiate and evaluate treatment for patients in a multi-professional arena, within the field of specialization following agreed protocols.	4.44	0.65	0.88	
To operate within an extended practice role in order to carry out advanced treatment, diagnostic and invasive interventions as related to the field of specialization.	4.44	0.67	0.82	
To identify health promotion and education needs for patients within the field of specialization and develop and implement strategies as appropriate.	4.49	0.64	0.93	
To keep abreast of technological developments and educate nurses, other health professionals and patient groups about advancements in the field of specialization.	4.54	0.61	0.90	
To further develop the communicative skills and be able to formulate and communicate complex clinical issues to patients, relatives and other health professionals,	4.50	0.64	0.87	
To identify health, health-related and nursing needs of patients and develop appropriate care and treatment plans in a multi-professional arena.	4.49	0.67	0.89	
To lead and coordinate the treatment of patients in the field of specialization to ensure continuity and fullness of care.	4.51	0.64	0.91	
To evaluate and undertake audit of the field of specialization to ensure the delivery of quality and safe nursing care.	4.49	0.67	0.90	
To think critically and contribute to the continuous development of the field of specialization and research-based practice through participation in professional development and research programs.	4.43	0.76	0.75	
Advanced Nurse Practitioner (ANP) / Magistrica zdravstvene nege; Magister zdravstvene nege.	$\bar{x}$	***s***	**FA4**	**FA5**
To autonomously examine, diagnose and prescribe evidence-based therapeutic interventions, including prescribing medication and actively monitoring the effectiveness of treatment for patients.	3.88	1.20	–0.07	1.00
To be accountable and responsible for clinical decision-making at advanced practice level through caseload management for individual patients, families and communities.	4.14	0.93	0.34	0.58
To identify risk prevention and health promotion priorities in order to develop and implement relevant strategies within a wider public health agenda.	4.39	0.75	0.83	0.06
To guide, counsel and educate other health professionals about latest practice innovations, act as a mentor and role model, and actively engage in knowledge transfer with patient communities.	4.49	0.71	1.01	–0.17
To communicate assertively and contribute equally to decision-making at clinical, management and policy levels, including the allocation of health funds.	4.36	0.82	0.75	0.16
To autonomously perform comprehensive health assessment and use professional judgement to refer patients requiring specialist attention to other health professionals and agencies as appropriate.	3.99	1.11	0.08	0.84
To initiate and lead on changes in health care service in response to patient need and service demand in order to ensure the continuous quality improvement of the service.	4.31	0.83	0.63	0.30
To identify research priorities, and to lead, conduct and disseminate research findings that shape and advance nursing practice, education and policy.	4.40	0.78	0.88	0.02

Legend / Legenda: $\bar{x}$ – average / povprečje; s –standard deviation / standardni odklon; FA3 – factor analysis 3 / faktorska analiza 3; FA4 – factor analysis 4 / faktorska analiza 4; FA5 – factor analysis 5 / faktorska analiza 5

(s = 0.71), while "Responsibility for treatment statements" scored with 4.01 (s = 1.01) (t = 9.817, p < 0.001).

Discussion

We aimed to research the understanding of nomenclature, descriptions, and competences for various categories of nursing providers based on the EFN Matrix among different groups of professionals.

Low levels of agreement were identified with the category naming and general description of HCA among health care teachers in secondary schools. Respondents in management positions, those participating in professional bodies outside their workplace, those who received training in research

or EBP, who have database access, and those who are mentoring students and expressed job satisfaction reported greater agreement with the HCA naming and general and specific HCA competences. The importance of postgraduate education in research or EBP and database access for understanding development activities in nursing has also been stressed by other researchers (Stokke, et al., 2014; Yoder, et al., 2014; Wilson, et al., 2015; Skela-Savič, et al., 2016, 2017).

High levels of agreement have been recorded for descriptions and specific competences of other provider categories apart from GCN, which had significantly lower agreement levels among secondary school health care teachers, who dislike having GCNs delegate work to HCAs. This points to the specific situation in Slovenia, where the secondary education sector wants to establish HCT/PNs as fully independent from GCNs and disagrees with a reduced scope of their education and employment in health care institutions, in which they are supported by physician associations.

In addition to Associate Professional Nurses (Assistant Nurse, Enrolled Nurse, Practical Nurse), Eurostat lists another category: Practicing Caring Personnel (Nursing Aide - clinic or hospital, Patient Care Assistant, etc.) (Eurostat, n.d.). This raises the question of whether the description in Nursing Care Continuum and Competences (ICN, 2008) with five categories is not more appropriate. This division is particularly important for post-socialist countries, where the number of HCT/PNs is still high in relation to GCNs. The HCT/PNs educational program in Slovenia is a four-year professional secondary educational program, while a three-year secondary educational program is designed for Health Care Assistive Workers. In Slovenia, the HCA general description in the EFN Matrix is closer to Health Care Assistive Workers, while the specific competences are passed between HCT/PNs and Health Care Assistive Workers. Since the respondents were not offered a competence set that would describe HCT/PNs specifically, it can be concluded that this is the cause for their low levels of agreement. Meretoja and Koponen (2012) found that department heads often entrust more responsibility with the providers than they would have the courage to take on themselves, which was also observed in Slovenia where HCT/PNs are instructed by the management to perform competences of GCNs which they were not educated or trained for (Skela-Savič, 2017). Skela-Savič (2017) also explained that education for HCAs is not a pre-condition for education for GCNs, which is in accordance with the conditions to enter the education program for a regulated profession (Directive 2013/55/EU of the European Parliament and of the Council, 2013). Education of HCAs has been recognized as a European problem, which needs to be solved because there is a lack of GNCs and the importance of HCAs in modern health care systems is expected to grow (Kroezen, et al., 2018).

Our research shows how important post-graduate education, training, and job satisfaction are for the understanding and agreeing with nursing care provider categories. The importance of post-graduate education in research or EBP has been shown to contribute significantly to the development of nursing care in extant international and Slovenian research (Palese, et al., 2014, Stokke, et al., 2014; Yoder, et al., 2014; Wilson, et al., 2015; Sibandze & Scafide, 2017; Skela-Savič, et al., 2016, 2017), which is why it is important for nursing care management and national nursing associations to strive to increase the number of GCNs through specialization and master's and doctoral degrees and to end the practice of having Associate Professional Nurses take on the tasks of GCNs in clinical settings. More, Skela-Savič (2017) added that the implementation of research work in nursing may only eventuate through a national institute for research in nursing care whose founder is the Nurses and Midwives Association of Slovenia. Slovenian nursing care education is not integrated enough and there is insufficient collaboration between schools and clinical settings, resulting in the described discrepancies confirmed by qualitative research (Skela-Savič, 2017) which was conducted as a continuation of the results in this article.

We found that general category descriptions and specific competences for HCAs, GCNs, and SNs in the EFN Matrix show a unified measurement construct with good reliability, while ANP shows two content constructs with high reliability and consistency: "Collaboration and development" and "Responsibility for treatment". This result reflects the situation in Slovenia, where the ANP role has not been developed in practice and has no systematized position, which makes prescribing medications a taboo topic. Purposive sampling is a limitation of our research; however, we wanted to include respondents who actually work with professional competences. A higher response rate would also be desired. Another limitation was poor responsiveness from secondary and tertiary education institutions. Because the EFN Matrix was translated into Slovenian prior to validation, there is a possibility of slight differences in the local terminology compared to the original instruments. It is possible that the respondents were overly positive or negative, so a generalization cannot be made based on this. Finally, the accuracy of self-reporting survey techniques may be limited.

Conclusion

The results provide a significant insight into understanding the EFN Matrix at the level of a single EU country. The research provides significant

international insight into the understanding, reliability, and consistency of the EFN Matrix. Furthermore, the research reveals the importance of clearer definitions for nursing care provider categories in the first EFN Matrix category (HCA). It is particularly important to define the role and education at the Support or Assistive Worker and Registered Nurse Assistant levels. This would prevent unqualified nursing providers from performing RN/GCN competences. There is an increasing need to amend the EU Directive for regulated professions with the minimum requirements for specialized nurse training and ANP education. In addition, the competencies and minimum educational requirements for health care assistants have to be defined. This would support the mechanisms for developing nursing care as a profession and as a scientific discipline.

Conflict of Interest / Nasprotje interesov

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

Funding / Financiranje

This publication arises from the project ARRS CRP V5-1507 (2015-2017) Nursing as a Scientific Discipline in Slovenia. An internationally comparable secondary and tertiary education system in nursing care as the foundation of research and scientific contribution to the sustainable development of society. / Ta prispevek je nastal v okviru projekta ARRS CRP V5-1507 (2015-2017) Zdravstvena nega kot znanstvena disciplina v Sloveniji. Mednarodno primerljiv sistem sekundarnega in terciarnega izobraževanja v zdravstveni negi kot temelj raziskav in prispevka znanosti k trajnostnemu družbenemu razvoju.

Ethical approval / Etika raziskovanja

No ethical approval was needed for this type of research. / Raziskava ni potrebovala posebnega dovoljenja etične komisije.

Author contributions / Prispevek avtorjev

Authors contributed equally to the development of the article. / Avtorji so enakovredno prispevali k nastanku članka.

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Cite as / Citirajte kot:
Skela-Savič, B., Pivač, S., Čuk, V. & Gabrovec, B., 2019. Understanding and applying the matrix on the four levels of competences and categories of the nursing care providers: a descriptive research. *Obzornik zdravstvene nege*, 53(1), pp. 8–17. https://doi.org/10.14528/snr.2019.53.1.267

Original scientific article / Izvirni znanstveni članek

The Heyman Survey of nursing employees' attitudes towards mechanical restraints in Slovenia

Heymanova lestvica odnosa zaposlenih v zdravstveni negi do posebnih varovalnih ukrepov v Sloveniji

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Key words: nursing; nurses; coercive measures; psychiatry; violence

Ključne besede: zdravstvena nega; medicinske sestre; prisilni ukrepi; psihiatrija; nasilje

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ABSTRACT

Introduction: Attitudes of nursing employees towards mechanical restraint are directly connected to their incidence. The purpose of this research was to examine the attitudes of psychiatric nursing staff towards the use and administration of mechanical restraints.

Methods: The cross-sectional descriptive study was conducted using a structured Heyman-type survey. All the Slovenian nursing staff in psychiatric hospitals participated on a given day (n = 367).

Results: Differences were observed in the average duration of administered mechanical restraint between individual hospitals (χ^2 = 43.770, p < 0.001). Staff most often stated that patients felt angry when subjected to mechanical restraint (n = 328, 89.4 %). Nonetheless, the majority of respondents believe that mechanical restraints can be an effective therapeutic tool (n = 343, 91.6 %). Females (U = 11450.50, p = 0.025) and with higher education (U = 9527.00, p = 0.002) experience statistically significantly more negative emotions and are less inclined to use mechanical restraints.

Discussion and conclusion: It is evident that in addition to the factors we researched some other factors are more influential when the incidences of coercive measures are closely studied. Due to some variation between hospitals it would be advisable to review the current clinical practices in this field. The management of health institutions should be considered an essential factor in the efforts to decrease mechanical restraint use.

IZVLEČEK

Uvod: Odnos zaposlenih v zdravstveni negi do posebnih varovalnih ukrepov je povezan z njihovo pojavnostjo. Namen raziskave je bil raziskati odnos zaposlenih v zdravstveni negi do posebnih varovalnih ukrepov.

Metode: Izvedena je bila presečna raziskava z uporabo Heymanove lestvice o odnosu do posebnih varovalnih ukrepov med vsemi zaposlenimi v zdravstveni negi (n = 367) v psihiatričnih bolnišnicah v Sloveniji.

Rezultati: Med slovenskimi psihiatričnimi bolnišnicami so ugotovljene razlike v trajanju posebnih varovalnih ukrepov (χ^2 = 43,770, p < 0,001). Zaposleni se najpogosteje strinjajo, da pacient med posebnim varovalnim ukrepom čuti jezo (n = 328, 89,4 %). Kljub temu večina anketirancev verjame, da so posebni varovalni ukrepi lahko učinkovito terapevtsko orodje (n = 343, 91,6 %). Ženske (U = 11450,50, p = 0,025) in višje izobraženi zaposleni (U = 9527,00, p = 0,002) izražajo statistično bolj negativna čustva in manj odobravajo posebne varovalne ukrepe.

Diskusija in zaključek: Ob raziskovanju pojavnosti prisilnih ukrepov je jasno, da poleg dejavnikov, raziskovanih v naši študiji, obstajajo tudi drugi, bolj vplivni dejavniki. Zaradi razlik med bolnišnicami bi bilo treba pregledati obstoječo klinično prakso. Predvideva se, da je management zdravstvenih inštitucij pomemben dejavnik pri zmanjšanju pojavnosti posebnih varovalnih ukrepov.

The article is based on the research as part of the doctoral thesis by Branko Bregar *A model of factors that explain the psychiatric nursing employees' attitudes to using mechanical restraints.*

Received / Prejeto: 3. 5. 2018
Accepted / Sprejeto: 26. 1. 2019

https://doi.org/10.14528/snr.2019.53.1.275

Introduction

Coercive measures in psychiatric treatment consist of seclusion (seclusion room), restraint (physical or mechanical restraint), and chemical (pharmacological) restraint. The lawful forms of coercive measure use differ in individual countries, and their practical incidence also frequently varies within the same country (Raboch, et al., 2010; Janssen, et al., 2011). In most cases, coercive measure application is governed by mental health legislation. While various forms of coercive measures are primarily used to ensure the safe treatment of patients who are considered at risk for auto- and hetero-aggression, and for the protection of health care employees, such measures also entail the hazard of unexpected adverse events. Since these events may be as severe as patient death, the use of coercive measures alone already has an indirect effect on stress of conscience, and the general well-being and satisfaction of psychiatric health care patients and staff (Stewart, et al., 2010; Strout, 2010; Gates, et al., 2011; Hollins & Stubbs, 2011; Berzlanovich, et al., 2012; Van der Merwe, et al., 2013; Whitecross, et al., 2013). The professionals in the health sector and interested publics have, accordingly, been investing considerable efforts into decreasing the incidence of coercive measure use, especially as recent research has revealed that the incidence of such use primarily depends on the nurses' attitude towards applying the measures in the first place (Happell, et al., 2012). The profession is thus experiencing gradual changes in the attitude of psychiatric nursing staff towards the use of coercive measures although these changes are most often the result of organizational measures implemented by individual institutions (Espinosa, et al., 2015). However, change appears to be occurring slowly. The proportion of psychiatric nursing staff condoning the use of coercive measures remains very high (Gelkopf, et al., 2009).

Due to conflicting guidelines and recommendations, medical institutions are experiencing disagreements when it comes to addressing this issue, which consequently impedes the systemic examination of incidence rates and problems related to the use of coercive measures, not only on the international level, but even on the level of individual countries (Bowers, et al., 2004; Knutzen, et al., 2013; Soininen, et al., 2014). Scientific treatment is further hindered by the fact that researchers are employing a wide range of different quantitative and qualitative research methods that are often incompatible from the methodological standpoint (Gelkopf, et al., 2009; Bergk, et al., 2010; 2011; Happell & Koehn, 2010; Happell, et al., 2012; Van der Merwe, et al., 2013; Steinert, et al., 2013; Ejneborn Looi, et al., 2015).

In spite of the hurdles, certain significant conclusions have been reached in this context in the past several years. Research thus shows, for example, that nursing staff with completed higher levels of education believe that coercive measures can be a therapeutic tool suitable for the specific treatment of aggressive patients, while those with lower levels of education consider them to be an essential means of subduing patients who are restless, disturb the medical personnel or interfere with other patients. Although less educated staff understand that the use of coercive measures incites feelings of humiliation and undue punishment in affected patients, they nonetheless harbour a less negative stance towards coercive measures overall compared to their higher educated colleagues, and are more inclined to use them (Gelkopf, et al., 2009). This has led some researchers to conclude that the practical incidence of coercive measure use is primarily dependant on the training and education of the nursing staff (Morgan, 2011; Moylan & Cullinan, 2011). Further research has revealed that female nursing staff perceive coercive measures as less therapeutic and more punitive in nature, compared to male nursing staff, and are on average less inclined to administer them (Gelkopf, et al., 2009). Nursing staff who work in closed psychiatric wards and have a more direct experience with aggressive patients are in general inclined to believe that coercive measures may be used as a therapeutic means, but do not view them as a legitimate punitive measure (Gelkopf, et al., 2009; Van der Merwe, et al., 2013). Existing studies thus clearly indicate that the key factors affecting the incidence rates of coercive measure use in psychiatric health care practice are mainly the sex of the nursing staff, their workplace (open/closed ward), and their level of education.

Aims and objectives

Our research aimed to assess the attitude of Slovene psychiatric nursing professionals towards the use of mechanical restraint. The purpose of this research is to establish whether the attitude of Slovenian nursing staff is affected by the same factors and learn whether certain local special characteristics or deviations can be observed in comparison to the conclusions of the research conducted abroad.

Methods

A descriptive and exploratory non-experimental method of empirical research was used in all psychiatric hospitals in Slovenia.

Description of the research instrument

The questionnaire consisted of two segments. The first one was concerned with demographical data. The second one was represented by a survey modelled after the Heyman survey of nurses' attitudes to seclusion (SNASS) (Heyman, 1987; Bowers, et al., 2004; Happell,

et al., 2012). From the range of coercive measures, which include physical restraint, mechanical restraint (strapping to a bed), seclusion (the seclusion room) and pharmacological restraint, the conducted survey explored the attitude of nursing staff specifically regarding the use of mechanical constraint. The survey consisted of five items: 1) reasons for using mechanical restraints and their justification, 2) sentiments of staff regarding mechanical restraint use, 3) respondents' opinion about the patients' reaction to mechanical restraints and the corresponding impact on the patients' overall mood, 4) respondents' opinion on the effectiveness of mechanical restraints, and 5) changes that the respondents would propose when it comes to mechanical restraint use. Each of the items was addressed separately in the analysis. The survey consisted of three-point and four-point Likert scales. The reliability test – retest of previously executed research ranges between 0.62–0.79 (Happell & Koehn, 2010). Since the survey was used in Slovenia for the first time, it has been translated to Slovene for the purposes of the research. This was conducted by three independent translators and included a back translation. The survey was then test-completed by 10 nursing employees and found to be clear and consistent. Cronbach Alpha was between 0.64 and 0.80.

Description of the research sample

The sample included psychiatric nursing staff from all six psychiatric hospitals in Slovenia. As of 2013, these six hospitals employed 464 psychiatric nursing staff, of which 118 were registered nurses and 346 were health care assistants. The response rate was 79.0 % or 367 respondents of whom 33.9 % (n = 125) were male and 66.1 % (n = 242) were female. The majority of the respondents, which is 71.8 % (n = 264), had secondary school-level nursing education (health care assistant, HCA), while the remainder had a bachelor's degree in nursing (registered nurse, RN) or a post-graduate degree. Most (n = 255, 69.6 %) respondents had already worked in a closed psychiatric ward.

Description of the research procedure and data analysis

Participation in the survey was voluntary and the questionnaire was anonymous. Research was conducted in 2013/2014 in all psychiatric hospitals in Slovenia after we had received their consent. Mechanical restraint and seclusion are the only allowed coercion measures in Slovenian psychiatric hospitals (Mental Health Act, 2008), however, mechanical restraint has been the only coercive measure used in Slovenian psychiatric hospitals so far. The terms "mechanical restraint" and "coercive measure" are therefore used interchangeably in the article. In the Introduction "coercive measures" is used since a general review of literature on coercive measures is given. Elsewhere in the article, we used the term "mechanical restraint" because the content of the article is based on Slovenian circumstances.

Analysis was conducted using SPSS ver. 20 (IBM, SPSS Inc., Chicago, IL, USA). The results were considered statistically significant at $p < 0.05$. In addition to the basic descriptive statistics, a Mann-Whitney U test was used to compare statistically significant differences between two samples, and a Kruskal-Wallis test was used to compare statistically significant differences between more than two samples. Within the framework of the correlational method, the Spearman correlation coefficient ρ was used to assess the correlation between two ordinal variables, or between an ordinal and an interval variable. The Pearson χ^2 test was used to verify the independence of two variables in the contingency table.

Results

The decision to use mechanical restraints is most often made by doctors, 273 (75.2 %), followed by health care assistants, 56 (15.4 %) and finally, registered nurses, 33 (9.2 %). The majority of respondents, 123 (56 %) assessed that the average duration of a mechanical restraint used on a patient is up to 4 hours; 46 (13.4 %) respondents assessed that the average duration of a mechanical restraint is up to 6 hours; and 105 (30.6 %) assessed that the average duration of a mechanical restraint is more than 8 hours. The results show statistically significant differences in the assessment of mechanical restraint duration between the individual hospitals ($\chi^{2(2)}$ = 43.770, p < 0.001). Males statistically significantly decide to use a mechanical restraint for a longer time duration (U = 11184.50, p = 0.012). The age of the worker (ρ = -0.071, p = 0.187), their education level (ρ = −0.016, p = 0.775) and work position (U = 11296.50, p = 0.193) have not been found to be significantly connected to the average length of mechanical restraint use.

When asked to assess the optimal duration of mechanical restraint use, 79 (23.5 %) respondents stated that they believed that a mechanical restraint should last more than 4 hours. 119 (35.4 %) respondents stated that a mechanical restraint should last less than 4 hours. 13 (3.86 %) respondents stated that they did not approve of mechanical restraint use at all. The greatest share of respondents, namely 126 (37.2 %), were unable to choose an appropriate answer. Females statistically significantly more often believe that the duration of a mechanical restraint should be longer (U = 11057.00, p = 0.024) compared to males. The age of the staff (ρ = 0.022, p = 0.694), their level of education (ρ = 0.021, p = 0.662) and work position (U = 11446.50, p = 0.737) are not significantly connected to the perceived optimal duration of the mechanical

Table 1: *Reasons for the use of mechanical restraints*
Tabela 1:*Vzroki za uporabo mehaničnega oviranja*

Reasons / Razlogi	***Never / Nikoli n (%)***	***Sometimes / Včasih n (%)***	***Often / Pogosto n (%)***	***Sex / Spol U (p)***	***Ward / Oddelek U (p)***	***Education / Izobrazba U (p)***	***Hospital / Bolnišnica $\chi^{2(2}$ (p)***
The patient is being excited and out of control.	28 (7.63)	203 (55.31)	107(29.16)	10712.00 (0.002)	10611.50 (0.046)	10783.50 (0.167)	4.172 (0.525)
The patient is hitting another patient.	12 (3.27)	157 (42.78)	168 (45.78)	11428.00 (0.085)	10438.00 (0.032)	11483.50 (0.750)	6.868 (0.231)
The patient is yelling and making too much noise.	141 (38.42)	165 (44.96	33 (8.99)	11786.50 (0.122)	11821.00 (0.656)	11476.00 (0.651)	16.222 (0.006)
The patient is hitting a staff member.	16 (4.36)	142 (38.69)	178 (48.50)	10554.50 (0.005)	10303.50 (0.019)	11317.50 (0.563)	3.565 (0.614)
The patient wants to sleep.	296 (80.65)	40 (10.90)	4 (1.09)	12859.00 (0.798)	11739.50 (0.336)	11621.50 (0.520)	3.949 (0.557)
The patient is exhibiting inappropriate sexual behaviour.	157 (42.78)	161 (43.87)	22 (5.99)	12602.50 (0.526)	11449.50 (0.309)	11048.00 (0.268)	12.749 (0.026)
The patient is annoying or interrupting other people.	193 (52.59)	123 (33.51)	20 (5.45)	11776.50 (0.165)	11595.50 (0.573)	11205.50 (0.654)	16.472 (0.006)
The patient is trying to break something like a chair or window.	8 (2.18)	151 (41.14)	178 (48.50)	12201.50 (0.335)	10624.50 (0.041)	11532.00 (0.749)	10.211 (0.069)
The patient is cursing or swearing at other people.	190 (51.77)	125 (34.06)	22 (5.99)	12194.50 (0.337)	11526.00 (0.468)	11346.00 (0.679)	8.496 (0.131)
The patient is trying to hurt him/ herself.	11 (3.00)	124 (33.79)	202 (55.04)	11196.50 (0.026)	11755.00 (0.744)	10745.50 (0.198)	16.079 (0.007)
The patient will not take his/her medication.	225 (61.31)	82 (22.34)	29 (7.90)	10986.00 (0.012)	11430.00 (0.402)	10227.00 (0.032)	20.298 (0.001)
The patient is waking other patients at night.	122 (33.42)	188 (51.23)	31 (8.45)	12409.50 (0.368)	10398.00 (0.012)	9791.50 (0.003)	39.030 (0.001)
The patient is asking to be restrained.	87 (23.71)	212 (57.77)	43 (11.72)	12000.00 (0.122)	12021.50 (0.762)	11332.50 (0.330)	32.792 (< 0.001)

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restraint use. The results have shown statistically significant differences in the respondents' perceived optimal duration of mechanical restraint use between the individual hospitals ($\chi^{2(2)} = 17.525$, $p = 0.004$).

Reasons for the use of mechanical restraints

Regarding the reasons for mechanical restraint use, respondents most often stated these to be damaging hospital inventory ($n = 329$, 89.64 %), auto-aggressive behaviour ($n = 326$, 88.6 %), aggressive behaviour towards other patients ($n = 325$, 88.56 %), and aggression towards hospital personnel ($n = 320$, 87.19 %). Certain statistically significantly differences appear in this context according to the sex, work position (closed / open ward), level of education and hospitals (Table 1).

Justification for the use of mechanical restraints

From the behaviours listed in the survey in Table 1, respondents had to decide for the reason which is most justified for implementing mechanical restraints. They considered auto-aggressive behaviour to be the most highly justified reason for the use of mechanical restraints 326 (88.6 %), followed by damaging of hospital inventory ($n = 322$, 87.7 %), aggressive behaviour towards other patients ($n = 314$, 85.5 %), aggression towards hospital personnel ($n = 310$, 84.4 %), and finally, patient being excited and out of control ($n = 287$, 78.2 %).

Mood of patients during the administering of mechanical restraints

Most respondents believe that patients who are subjected to a mechanical restraint feel angry ($n = 328$, 89.4 %), controlled ($n = 292$, 79.6 %), powerless ($n = 288$, 78.5 %), scared ($n = 267$, 72.8 %), helpless ($n = 266$, 72.5 %), frightened ($n = 231$, 62.9 %), appalled ($n = 213$, 58 %), confused ($n = 210$, 57.2 %), punished ($n = 188$, 51.2 %), or safe ($n = 145$, 39.5 %). Compared to females, males more often perceive mechanical restraints to be punitive in nature ($U = 10829.00$; $p = 0.003$) and consider that they are happy during mechanical restraints ($U = 11657.00$, $p = 0.048$). Staff working in closed wards rate the mood of patients as less satisfied ($U = 10511.50$, $p = 0.014$) and those with lower education qualifications consider patients to be more powerless ($U = 11009.00$, $p = 0.034$) when subjected to mechanical restraints compared to staff working in open wards. The individual hospitals results showed statistically significant differences in several areas: that patients feel relieved ($\chi^{2(2)} = 15.003$, $p = 0.010$), feel safe ($\chi^{2(2)} = 20.137$, $p = 0.001$), feel disgusted ($\chi^{2(2)} = 13.512$, $p = 0.019$), feel punished ($\chi^{2(2)} = 11.200$, $p = 0.048$) and feel out of control ($\chi^{2(2)} = 12.358$, $p = 0.030$).

Sentiments of nursing staff following the use of mechanical restraints

Psychiatric nursing staff are confronted with different sentiments after having administered mechanical restraints (Table 2). Females feel less satisfaction in helping patients ($U = 11221.50$, $p = 0.010$), are less relieved ($U = 10699.50$, $p = 0.001$), are less satisfied with everything running smoothly ($U = 9580.00$, $p < 0.001$), feel less disempowered ($U = 11450.50$, $p < 0.025$), feel less in control of the situation ($U = 10234.50$, $p < 0.001$) and feel less fed up ($U = 11722.50$, $p = 0.018$). According to the type of ward, open-ward nurses feel that they have more control over the situation ($U = 9802.00$, $p = 0.003$). Respondents with a higher level of education feel less satisfaction in helping patients ($U = 9527.00$, $p = 0.002$), feel less powerful ($U = 11300.00$, $p = 0.004$) and have a sense of being disempowered after having administered a mechanical restraint on a patient ($U = 10131.00$, $p < 0.009$). Differences in the respondents' answers according to the hospitals are stated in Table 2.

Effect of mechanical restraints on patients

Most respondents ($n = 343$, 91.6 %) believe that mechanical restraints are successful in calming the patients. Compared to males, females statistically significantly more often believe that mechanical restraints are successful in calming the patients ($U = 12299.00$, $p = 0.050$), improve their current behaviour ($U = 11498.00$, $p = 0.016$), make patients feel like staff is worried about them ($U = 1165.00$, $p = 0.010$), or do not help the patients in any way ($U = 10685.50$, $p = 0.003$). Those working in closed wards statistically significantly more often believe that mechanical restraints make them frustrated ($U = 10712.00$, $p = 0.025$) and make patients angry at the staff ($U = 10.455$, $p = 0.011$). With regard to education levels there are not any significant differences. Regarding different hospitals, please see Table 3.

Proposed changes to mechanical restraint administration

Respondents believe certain suggestions would improve the administration of mechanical restraints (Table 4). Females more often than males agree that patients undergoing mechanical restraints should have the possibility of listening to music if they want to ($U = 10358.00$, $p < 0.001$), that the room where mechanical restraints are being administered should be comfortable, unlocked and at the disposal of patients should they want to be restrained themselves ($U = 10344.50$, $p = 0.001$), that mechanical restraints should not be used at all ($U = 9257.50$, $p < 0.001$), that the room where mechanical restraints are administered

Table 2: *Nurses' emotional responses to placing patients in mechanical restraint*
Tabela 2: *Čustva medicinskih sester pri uvedbi mehaničnega oviranja*

Emotional responses / Čustveni odziv	***Never / Nikoli n (%)***	***Sometimes / Včasih n (%)***	***Often / Pogosto n (%)***	***Sex / Spol U (p)***	***Ward / Oddelek U (p)***	***Education / Izobrazba U (p)***	***Hospital / Bolnišnica $\chi^{2(2)}$ (p)***
Satisfaction in helping a patient	67 (18.26)	187 (50.14)	90 (24.52)	11221.50 (0.010)	11999.00 (0.872)	10907.50 (0.179)	21.064 (0.001)
Annoyed	68 (18.53)	200 (54.50)	75 (20.44)	12599.00 (0.289)	11423.50 (0.209)	11866.50 (0.701)	16.091 (0.007)
Relieved	27 (7.36)	84 (22.89)	130 (35.42)	10699.50 (0.001)	11342.50 (0.336)	11197.00 (0.331)	2.866 (0.721)
Satisfied that the ward is running smoothly	61 (16.62)	167 (45.50)	112 (30.52)	9580.00 (< 0.001)	10726.50 (0.111)	9527.00 (0.002)	25.567 (< 0.001)
Guilt or misgivings	134 (36.51)	188 (51.23)	16 (4.36)	12103.50 (0.274)	10753.50 (0.091)	10988.00 (0.325)	18.374 (0.003)
Regretful	87 (23.71)	202 (855.04)	56 (15.26)	13523.00 (0.981)	12050.50 (0.521)	11846.00 (0.586)	16.037 (0.007)
Powerful	326 (88.83)	19 (5.18)	0 (0.00)	13265.00 (0.516)	12174.50 (0.389)	11300.00 (0.004)	3.113 (0.683)
Angry – it was a mistake	245 (66.76)	97 (26.43)	0 (0.00)	12897.50 (0.544)	11768.00 (0.537)	11991.00 (0.867)	18.152 (0.003)
Like a failure	156 (42.51)	182 (49.59)	4 (1.09)	12244.00 (0.159)	11744.50 (0.557)	11171.50 (0.234)	15.610 (0.008)
Disempowered	139 (37.87)	189 (51.50)	12 (3.27)	11450.00 (0.025)	11744.50 (0.557)	10131.00 (0.009)	13.729 (0.170)
In control of the situation	116 (31.61)	177 (48.23)	48 (13.08)	10234.50 (0.001)	9802.00 (0.003)	11083.50 (0.231)	12.871 (0.025)
Fed up	259 (70.57)	77 (20.98)	5 (1.36)	11722.50 (0.018)	11560.00 (0.425)	11026.00 (0.120)	7.278 (0.201)
Angry – don't agree	240 (65.40)	95 (25.89)	6 (1.63)	13085.00 (0.811)	120.79 (0.950)	11603.00 (0.566)	17.487 (0.004)

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Table 3: *Effect of mechanical restraints on patients*
Tabela 3: *Vpliv mehaničnega oviranja na paciente*

Effects / Učinki	***Never / Nikoli n (%)***	***Sometimes / Včasih n (%)***	***Often / Pogosto n (%)***	***Unsure / Ne vem n (%)***	***Sex / Spol U (p)***	***Ward / Oddelek U (p)***	***Education / Izobrazba U (p)***	***Hospital / Bolnišnica $\chi^{2(2)}$ (p)***
Calm them down	3 (0.80)	92 (25.10)	244 (66.50)	8 (2.20)	12299.00 (0.054)	11387.00 (0.054)	11948.50 (0.551)	8.134 (0.149)
Makes them frustrated	9 (2.50)	245 (66.80)	66 (18.00)	18 (4.90)	11550.00 (0.080)	10712.00 (0.025)	11512.00 (0.781)	4.309 (0.506)
Makes them behave better	33 (9.00)	132 (36.00)	139 (37.90)	41 (11.20)	11498.00 (0.016)	12147.00 (0.690)	11930.50 (0.753)	4.708 (0.453)
Decreases frustrating social interactions	15 (4.10)	147 (40.10)	143 (39.00)	36 (9.80)	13012.50 (0.814)	11347.50 (0.272)	11004.00 (0.199)	7.860 (0.164)
Makes them feel angry	23 (6.30)	196 (53.40)	103 (28.10)	21 (5.70)	12399.00 (0.189)	10455.00 (0.011)	11059.50 (0.167)	9.263 (0.099)
Allows them to express anger	24 (6.50)	161 (43.90)	80 (21.80)	75 (20.40)	12612.00 (0.467)	11286.50 (0.354)	11387.50 (0.539)	4.721 (0.451)
Makes them feel like staff care about them	108 (29.40)	119 (32.40)	23 (6.30)	92 (25.10)	1165.00 (0.010)	10767.50 (0.077)	10630.00 (0.092)	10.956 (0.052)
Changes the way they feel	48 (13.10)	168 (45.80)	52 (14.20)	7 (19.90)	12462.50 (0.359)	11059.50 (0.170)	10707.00 (0.098)	3.857 (0.570)
Changes the way the behave	6 (1.60)	183 (49.90)	121 (33.00)	34 (9.30)	12788.50 (0.342)	11998.00 (0.541)	11486.50 (0.312)	9.154 (0.103)
Does not help them at all	107 (29.20)	136 (37.10)	17 (4.60)	77 (21.00)	10685.50 (0.003)	11386.50 (0.453)	11830.50 (0.622)	13.485 (0.019)
Disempowers them	18 (4.90)	99 (27.00)	192 (52.30)	30 (8.20)	12836.50 (0.800)	11543.50 (0.460)	11776.50 (0.887)	8.156 (0.148)
Controls their behaviour	10 (2.70)	117 (31.90)	192 (52.30)	24 (6.50)	12524.00 (0.275)	11823.50 (0.530)	11111.00 (0.190)	7.661 (0.176)
Frightens them	12 (3.30)	205 (55.90)	85 (23.20)	40 (10.90)	13184.00 (0.869)	11379.00 (0.279)	12017.00 (0.987)	5.483 (0.362)

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Table 4: *Proposed changes to mechanical restraint administration*
Tabela 4: *Predlagane spremembe pri organiziranju prisilnih ukrepov*

Proposed changes / Predlagane spremembe	***Strongly agree / Močno se strinjam n (%)***	***Agree / Strinjam se n (%)***	***Disagree / Ne strinjam se n (%)***	***Strongly disagree / Močno se ne strinjam n (%)***	***Sex / Spol U (p)***	***Ward / Oddelek U (p)***	***Education / Izobrazba U (p)***	***Hospital / Bolnišnica $\chi^{2(2)}$ (p)***
A staff member remains with the patient.	182 (49.6)	132 (36.0)	29 (7.9)	1 (0.3)	13244.00 (0.762)	10097.00 (0.001)	9382.00 (< 0.001)	40.179 (< 0.001)
Patient should be able to listen to their music.	43 (11.7)	188 (51.2)	91 (24.8)	23 (6.3)	10358.00 (< 0.001)	10533.50 (0.009)	9594.00 (0.001)	14.083 (0.015)
The room should be comfortable and unlocked.	24 (6.5)	113 (30.8)	136 (37.1)	64 (17.4)	10344.50 (0.001)	11748.50 (0.966)	10132.00 (0.039)	23.294 (< 0.001)
Mechanical restraints should not be used.	4 (1.1)	11 (3)	141 (38.4)	183 (49.9)	9257.50 (< 0.001)	9242.50 (0.001)	10411.00 (0.052)	16.623 (0.005)
The room should be comfortable and furnished.	63 (17.2)	204 (55.6)	65 (17.7)	11 (3.0)	12722.00 (0.437)	10751.50 (0.037)	10194.50 (0.010)	4.309 (0.506)
The room should be painted in a way that has a calming effect.	75 (20.4)	197 (53.7)	61 (16.6)	10 (2.7)	11527.50 (0.015)	10466.00 (0.010)	10065.00 (0.007)	7.773 (0.169)
No changes are needed.	12 (3.3)	74 (20.2)	165 (45.0)	82 (22.3)	11792.50 (0.205)	11356.00 (0.645)	10515.00 (0.051)	8.111 (0.150)
Reading material should be provided.	15 (4.1)	104 (28.3)	165 (45.0)	54 (14.7)	11448.50 (0.041)	10702.00 (0.113)	10353.00 (0.061)	4.064 (0.540)

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should be painted in relaxing colours (U = 11527.50, p = 0.015), and that patients should have books and magazines for reading at their disposal (U = 11448.50, p = 0.041). Compared to staff with completed secondary-level education, higher educated staff more often agree that a staff member should always remain with a patient who is being restrained (U = 9382.00, p < 0.001), that patients should be allowed to listen to music if they wish to (U = 9594.00, p = 0.001), that the room where restraint is being administered should be comfortable, unlocked and at the disposal of patients should they want to be restrained themselves (U = 10132.00, p = 0.039), that the bed where mechanical restraint is being administered should be more comfortable (U = 10194.50, p = 0.010), and the room painted in relaxing colours (U = 10065.00, p = 0.007). Compared to those working in open wards, staff working in closed wards more often agree that a staff member should always remain with a patient who is being restrained (U = 10097.00, p = 0.001), that patients should be allowed to listen to music if they want to (U = 10533.00, p = 0.009), that mechanical restraints should not be used at all (U = 9242.50, p < 0.001), that beds should be more comfortable (U = 10751.50, p = 0.037) and that the room where restraint is being administered should be painted in relaxing colours (U = 10466.00, p = 0.010). According to the different hospitals see Table 4.

Discussion

Research results reveal certain significant differences in the attitude towards the use of mechanical restraints among the nursing staff in individual psychiatric institutions, and differences depending on the sex, education and work position of the psychiatric nursing staff. In Slovenia, the decision to use mechanical restraints is most often made by doctors. Only in roughly one quarter of cases is the decision to use mechanical restraints made by the nursing staff. In this context, some researchers reached diametrically opposite results in their own research, as in their region, over three quarters of decisions to use mechanical restraints are made by nursing staff instead (Happell & Koehn, 2010; Happell, et al., 2012). Due to these differences in conditions on the national level, it is difficult to compare the willingness of nursing staff to administer mechanical restraints between these two cases of research. The aforementioned differences can be attributed to the differences in the mental health care legislation of an individual country. Circumstances in Slovenia are the result of the current Slovenian Mental Health Act (2008), which prescribes that every final decision to administer a mechanical restraint must be made by a doctor. Only in cases where that is considered impossible, other health care workers can make this decision independently, and a doctor must then check on the patient's condition as soon as possible and decide on further measures. In this context, the literature suggests that it is possible to ascertain that the field of mechanical restraints in examined regions has been regulated with new the legislation, which fundamentally decreased the incidence of mechanical restraint use and increased the overall safety of treating mentally ill patients. Regardless of the fact that in Slovenia the law puts full responsibility regarding the use of mechanical restraints on doctors, it should be noted that nursing staff are those that propose the use of a mechanical restraint in the first place, or are the ones forced to implement a measure when this is absolutely necessary, before a doctor is able to arrive on site (Bregar & Možgan, 2012).

The average duration of an administered mechanical restraint differs across countries. Nearly half of Slovene respondents are inclined to believe that a mechanical restraint should be used for more than 4 hours at a time, as opposed to foreign research, where nursing staff was observed to prefer a shorter time. Furthermore, compared to the research (Happell & Koehn, 2010; Happell, et al., 2012), the ratio of Slovene nursing staff who think mechanical restraints should not be used in clinical practice at all is less than half of that observed in foreign findings. Most indicators thus point at the conclusion that Slovene nursing staff are relatively highly inclined to the use of mechanical restraints at this time.

Another point of note was that, considering Slovenia has a highly restrictive legislation governing the use of mechanical restraints in psychiatry, and strict guidelines concerning their application, justification and duration, the research has surprisingly shown considerable statistically significant deviations in the average duration of an administered mechanical restraint and attitudes of the nursing staff between separate domestic institutions. This leads us to conclude that significant differences exist in the professional approach of specific clinical environments in spite of a uniform legislation. Similar to our own research, foreign research was also mostly focused on micro-factors related to the characteristics of the employees, the micro-environment and the attitude of personnel towards administering mechanical restraints (Gelkopf, et al., 2009; Happell & Koehn, 2010; Muir-Cochrane, et al., 2015). Although these factors have already been researched to a considerable degree, we are yet to see notable changes in clinical practice on the level of a single country, which is also exemplified by our own research on the sizeable differences mentioned above between individual hospitals in Slovenia, which, in theory, should not be occurring given the legislative and expert framework. This is why the results of our research and others (Bregar, et al., 2018) mentioned before lead us to believe other essential factors affecting the incidence of mechanical restraint use in practice must exist and that they have been insufficiently treated and explored

or were even left out of existing research. Therefore, the management sphere of individual hospitals is one particular factor that should be examined closely. Also, when comparing the incidence of coercive measures between hospitals on an international level, the differences in hospital characteristics (e.g. staffing, ward characteristics etc.) should be carefully taken into consideration.

Auto- and hetero-aggression, and states of high agitation were shown to be the most frequent justification for the use of mechanical restraints, similar to indications of foreign research (Migon, et al., 2008; Gelkopf, et al., 2009). Our respondents, on the other hand, justified the use of mechanical restraints outside the auto or hetero-aggressive behaviour (the patient is becoming excited and out of control, the patient is yelling and making noise, the patient wants to sleep, the patient is annoying or interrupting other people, refuses to take medications, is waking up other patients at night, or asks for a mechanical restraint to be used on him/herself) comparatively more often in relation to foreign studies (Gelkopf, et al., 2009; Happell & Koehn, 2010). This again leads us to believe that mechanical restraints are administered relatively often to Slovene patients as respondents also more often assessed a range of non-aggressive behaviours as proper justification for using mechanical restraints on patients compared to Happell and colleagues (2012).

Compared to foreign research (Gelkopf, et al., 2009; Roberts, et al., 2009; Happell & Koehn, 2010; Happell, et al., 2012; Van der Merwe, 2013), Slovene respondents less frequently perceive patients' emotions to be negative during the administering of mechanical restraints, as well as stating that they believe their patients to be more satisfied and less threatened by the use of mechanical restraints on average. Staff describe experiencing various kinds of sentiments after having administered a mechanical restraint. Domestic respondents less often report regretting the use of a mechanical restraint and in general appear to be more inclined to use these measures compared to the conclusions of foreign research (Happell & Koehn, 2010). Respondents in general believe that mechanical restraints have a calming effect on the patients, that they allow patients to release their anger in a safer and more controlled manner, and that these measures make patients reconsider and change their behaviour. All in all, it can be concluded that psychiatric nursing staff in general make erroneous assumptions that the administration of mechanical restraints can have a certain therapeutic effect (Gelkopf, et al., 2009; Happell & Koehn, 2010; Van Der Merwe, et al., 2013). In spite of the generally favourable opinion of Slovene nursing staff with regard to the use of mechanical restraints, our respondents statistically significantly more often stated that certain changes were necessary in the clinical practice of mechanical restraint administration compared to the other study (Happell & Koehn, 2010).

The cross-comparison of results of survey assertions with factors such as sex, education level and work position (open/closed ward), points to some characteristics that were already established by other researchers (Gelkopf, et al., 2009; Happell & Koehn, 2010). Male respondents in our research use mechanical restraints more often than females when patients are excited, aggressive, or refuse to take their medication. Males are also more likely to believe that inappropriate sexual behaviour justifies the use of mechanical restraints. Females might be more lenient towards the early signs of aggression and other unwanted behaviour, have a tendency to respond in softer ways, or decide to ask male nursing staff to intervene when improper behaviour begins to escalate. Females more often perceive patients who feel humiliated or unduly punished when they are subjected to mechanical restraints. Our male respondents statistically significantly more often expressed feelings of satisfaction, relief, power, but also regret when it comes to administering a mechanical restraint.

Compared to more educated nursing staff, nursing staff with a completed secondary school more often resort to using mechanical restraints when patients refuse to take their medication or when they wake up other patients at night. These conclusions are in line with several cases of foreign research (Gelkopf, et al., 2009; Happel & Koehn, 2010; McCabe, et al., 2011; Fariña-López, et al., 2014). A possible explanation for the staff's attitude towards mechanical restraints can be that the staff had not been suitably educated or is the result of the fact that staff who are lower educated more often work in night shifts, when fewer staff are present in the ward in general to assist in controlling situations. Since staff are spread thin during the night, they are likely to see restraint as the safest and easiest solution to any issues affecting patient behaviour. Highly educated staff less often believe that inappropriate sexual behaviour, waking up other patients at night, and the necessity to go to sleep are good reasons to administer mechanical restraints. It is possible that less educated staff decide to restrain the patient in aforementioned cases due to the lack of capacity or time to deal with the patient in other ways, or due to a specific attitude towards mechanical restraints in general. Compared to their more educated colleagues, staff with lower education more often experience satisfaction and feelings of power and control when administering mechanical restraints, while more highly educated staff often experience feelings of disempowerment. In this context, we should note that staff with lower education qualifications most often carry out instructions and have a smaller degree of responsibility. Perhaps those rare opportunities where they are the ones making the decision to use mechanical restraints bring them feelings of control and satisfaction that they might not experience when performing tasks ordered by superior

staff. Across the board, positive sensations (satisfaction, relief, power) and a more favourable attitude towards using mechanical restraints appear statistically significantly more often in lower educated staff, which corroborates the findings of foreign research in this context as well (Gelkopf, et al., 2009).

Nursing staff respondents (those who are higher educated, females and those working in closed wards) in our research expressed a desire for changes to be made to the implementation of mechanical restraints, which indicates that they are concerned about the well-being of their patients. It should be emphasised that although our research corroborates the relevance of certain factors of psychiatric nursing staff's attitude in this area, as concerns their mentality regarding mechanical restraint use and its correlation with the practical incidence of the use, our results also clearly show that not enough focus has been placed on the broader context of the hospital environment, especially the management of individual hospitals, which we assert to be the key factor for more effective changes in the future.

The research was based on a non-random, accessible sample, and respondents were not selected according to a balanced ratio of sexes, education levels or work positions. The Heyman-type survey that was used cannot provide a simple assessment of the general attitude of nursing staff towards the use mechanical restraints. Quite a few respondents did not answer all the questions of the survey. Since excluding such respondents would considerably decrease the number of respondents, we decided not to exclude them. This is also the reason why the number of respondents varies throughout the survey.

Conclusion

Our research concludes that psychiatric nursing staff in Slovene hospitals is, overall, relatively more inclined towards using mechanical restraints compared to most instances of foreign research. Furthermore, male staff, nursing staff with a lower level of education and those working in open wards are more inclined to use mechanical restraints compared to their counterparts. Our key finding is that considerable differences appear in the average duration of an administered mechanical restraint and attitudes of nurses towards the mechanical restraints between individual Slovene psychiatric hospitals. This leads us to believe that patients are subjected to different practices of mechanical restraint use in individual establishments, although Slovene legislation is unified and prescriptive. An essential factor affecting mechanical restraint use in practice thus appears to be the policy, guidelines and attitude of the hospital's management, a subject that warrants further investigation domestically as well as abroad. Future research in this context should focus on the most appropriate legal framework and the study of hospital management policy in relation to coercive measures used internally, as these both seem to affect incidence rates to a considerable degree.

Acknowledgements / Zahvala

The authors would like to acknowledge the support of nursing directors, Professional Group of Nurses and Health Technicians in Psychiatry and all respondents in psychiatric hospitals in Slovenia who participated in the research. / Avtorji se želijo zahvaliti pomočnikom direktorjev za zdravstveno nego, Sekciji medicinskih sester in zdravstvenih tehnikov v psihiatriji ter vsem sodelujočim v psihiatričnih bolnišnicah v Sloveniji, ki so sodelovali v raziskavi.

Conflict of interest / Nasprotje interesov

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

Funding / Financiranje

The study received no funding. / Raziskava ni bila finančno podprta.

Ethical approval / Etika raziskovanja

The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014). The research received consent from the Republic of Slovenia National Medical Ethics Committee, decision nr. 37/0315. / Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014). Raziskava je dobila soglasje Komisije Republike Slovenije za medicinsko etiko, odločba št. 37/0315.

Author contributions / Prispevek avtorjev

Branko Bregar conceptualized and designed the study, conducted the study, statistical analysis and interpretation of the results. Brigita Skela Savič conceptualized and designed the study, interpreted the data, and she is the author's second supervisor and consultant. Karmen Kajdiž participated in statistical analysis and interpretation of the results. Blanka Kores Plesničar conceptualized and designed the study, revised the manuscript, and she is the author's first supervisor and consultant. All co-authors contributed to the writing process, and had full access to the data, read, and approved the final manuscript. / Branko Bregar je zasnoval in oblikoval raziskavo, izvedel raziskavo, statistično analizo in interpretacijo rezultatov. Brigita Skela Savič je zasnovala in oblikovala raziskavo, interpretirala podatke in je avtorjeva somentorica in

svetovalka. Karmen Kajdiž je sodelovala pri statistični analizi in interpretaciji rezultatov. Blanka Kores Plesničar je zasnovala in oblikovala raziskavo, pregledala rokopis in je glavna mentorica in svetovalka. Vsi soavtorji so prispevali k procesu pisanja, imeli so popoln dostop do podatkov, prebrali in odobrili so končni rokopis.

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Cite as / Citirajte kot:
Bregar, B., Skela-Savič, B., Kajdiž, K. & Kores Plesničar, B., 2018. The Heyman Survey of nursing employees' attitudes towards mechanical restraints in Slovenia. *Obzornik zdravstvene nege*, 53(1), pp. 18–30.
https://doi.org/10.14528/snr.2019.53.1.275

Original scientific article / Izvirni znanstveni članek

Attitudes towards spirituality and spiritual care among nursing employees in hospitals

Stališča do duhovnosti in duhovne oskrbe med zaposlenimi v zdravstveni negi v bolnišnicah

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Key words: spirituality; spiritual care; attitudes; beliefs; nurses

Ključne besede: spiritualnost; spiritualna oskrba; stališča; prepričanja; medicinske sestre

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The article is based on the master thesis of Tanja Montarič Starc *Nurse's knowledge, beliefs and attitudes towards sprituality and spiritual care* (2017). / Članek je nastal na osnovi magistrskega dela Tanje Montanič Starc *Znanje, prepričanja in stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe pacientov* (2017).

Received / Prejeto: 25. 5. 2018
Accepted / Sprejeto: 20. 11. 2018

ABSTRACT

Introduction: Understanding spirituality and spiritual care is a prerequisite for holistic care. The research goal was to describe nurses' attitudes towards spirituality and spiritual care.

Methods: The study was carried out between 2015 and 2016 using a quantitative non-experimental method. The *Spirituality and Spiritual Care Rating Scale Questionnaire* was given to a sample of 182 nursing care employees, mostly women (n = 153, 88.4 %), with completed higher (n = 93, 53.8 %) or secondary (n = 75, 43.4 %) education, from four Slovenian hospitals. The questionnaire had adequate internal consistency (Cronbach alpha = 0.83).

Results: The highest agreement ($\bar{x}$ = 4.27, s = 0.82) was reached on the statement which describes spiritual care as respecting patient's privacy, dignity, cultural and religious beliefs. Participants also agreed with the statement that they provide spiritual care by demonstrating kindness, care, and cheerfulness ($\bar{x}$ = 4.2, s = 0.76), but they expressed uncertainty about the statement that spirituality and spiritual care are fundamental aspects of nursing care ($\bar{x}$ = 2.88, s = 1.08).

Discussion and conclusion: Participants connect spirituality with an understanding of themselves and the world, rather than only with religion and sacral objects. The research has confirmed the findings of previous Slovenian studies that nurses give priority to meeting patients' physical needs before spiritual ones probably also as a result of a lack of knowledge and professional guidance on spiritual care.

IZVLEČEK

Uvod: Razumevanje duhovnosti in duhovne oskrbe je pogoj nudenja celostne oskrbe pacienta. Cilj raziskave je bil opisati stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe.

Metode: Raziskava je bila izvedena v letih 2015 in 2016, z uporabo kvantitativne neeksperimentalne metode. Na vzorcu 182 zaposlenih v zdravstveni negi iz štirih slovenskih bolnišnic, v katerem so prevladovale ženske (n = 153, 88,4 %) s končano visokošolsko (n = 93, 53,8 %) ali srednješolsko izobrazbo (n = 75, 43,4 %), je bil uporabljen vprašalnik *Spirituality and Spiritual Care Rating Scale*. Vprašalnik je imel ustrezno notranjo konsistentnost (Cronbach alfa = 0,83).

Rezultati: Najvišje strinjanje ($\bar{x}$ = 4,27, s = 0,82) so anketiranci podali za trditev, ki opisuje duhovno oskrbo z vidika spoštovanja zasebnosti, dostojanstva ter spoštovanja kulturnih in verskih prepričanj pacienta. Prav tako se strinjajo, da zagotavljajo duhovno oskrbo pacientov z izkazovanjem prijaznosti, skrbi in vedrine ($\bar{x}$ = 4,2, s = 0,76). Anketiranci so bili negotovi glede trditve, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege ($\bar{x}$ = 2,88, s = 1,08).

Diskusija in zaključek: Anketiranci duhovnost povezujejo predvsem z razumevanjem samega sebe in sveta, najmanj pa z religijo ter s sakralnimi objekti. Raziskava potrjuje ugotovitve predhodnih slovenskih raziskav, da dajejo zaposleni v zdravstveni negi pred duhovnimi potrebami prednost oskrbi fizičnih potreb, verjetno tudi zaradi pomanjkanja znanja o tem področju in ustreznih smernic.

https://doi.org/10.14528/snr.2019.53.1.313

Introduction

Nowadays, spirituality and spiritual care are important elements of holistic, bio- and psychosocial treatment of individuals (Caldeira, et al., 2014) since the time in one's life characterised by injuries, illnesses and especially dying is a time of uncertainty and distress that is beyond a person's bodily functions (Babnik & Karnjuš, 2014) and triggers questions of sense, hope, meaning, forgiveness and higher forces. Spirituality is a concept that brings together religion, religious rituals, transcendency, reciprocity, connection, peace, energy, meaning, purpose, beliefs, values, hope, motivation and love (Hsiao, et al., 2011). In nursing literature, there is no single definition of spirituality (Pike, 2011). In an attempt to define it, some authors have described it as an intra-mental dimension that includes existential principles and beliefs and guides an individual in their search of meaning and purpose in life as well as in creating positive relationships with others (Molzahn & Sheilds, 2008; Ellis & Narayanasamy, 2009). Slovenian author Skoberne (2002) writes about spirituality in a similar way. She published an article on spirituality and spiritual care in nursing care in Slovenia at a time when the field of spirituality in nursing care was only beginning to develop more intensely.

Also from a psychological point of view, spirituality is understood especially as a dynamic, motivational concept or an internal source (van Dierendonck & Mohan, 2006) that drives individuals in their search for meaning and strength. Paley (2008, 2010) states that the reason why there are often issues with the definitions related to spirituality in nursing is because the concept is relatively new and changes according to an individual's beliefs, especially their cultural and religious background and in accordance with the society that surrounds them. Gall and colleagues (2011) warn that definitions of spirituality are often unclear and complicated and generally reflect how researchers understand the concept and less frequently how individuals, that is respondents in studies, experience spirituality. One of the more frequent research subjects related to spirituality is the relationship between religion and spirituality or an explanation whether religion and spirituality are synonymous and whether patients who are not religious also have spiritual needs (Pike, 2011, p. 746). An answer to this question has been provided in the nursing literature by McSherry in Cash (2004) with their taxonomy of spirituality in health care. The taxonomy is a continuum of the meaning of spiritually and consists of spirituality defined exclusively on religious and theistic ideals at one end of the continuum, and spirituality based on secular, humanistic and existential elements, on the other end of the continuum. The explanation of spirituality in nursing is based primarily on the understanding of spirituality as a component of an individual's being, which includes the dimensions of immanence and transcendence, and that it can (or not) include religious beliefs and religious practice (Babnik & Karnjuš, 2014, p. 13).

In addition to spirituality, the concept of "spiritual needs" is also used extensively in nursing, although an appropriate definition of spiritual needs is difficult to find in the literature. Buck and McMillan (2012), and Nizon and colleagues (2013) provide a relevant definition by defining spiritual needs as something that a person wants or needs to find the purpose and meaning. Galek and colleagues (2005) list seven domains of spiritual needs: belonging, meaning, hope, morality, beauty and acceptance of death. Sharma and colleagues (2012) emphasise three categories of spiritual needs: psycho-social, spiritual and religious. Psychosocial spiritual needs are described as the needs for support and help from others; spiritual as related to transcendental questions (meaning, hope, forgiveness, peace), while religious spiritual needs comprise the needs for actively practising religion by reading religious texts, participating in religious rituals and talking to a priest or other religious leader (Sharma, et al., 2012).

Spiritual care of patients should lead to a patient's spiritual well-being in the worst moments of their life when because of an illness or injury, life may lose its purpose and meaning (Cook, et al., 2012). The literature does not give a unified answer to what spiritual care is. In professional literature, the distinction between spiritual care as a broader concept and religious care as its subcategory has been established, mainly because of the demands of the society for the equal treatment of patients, regardless of their religiosity (Gedrih & Pahor, 2009). The purpose of spiritual care is to help patients to achieve balance and a holistic understanding of their health condition, to help them in overcoming feelings of hopelessness and uselessness, and to give them support in finding meanings and purpose (Štrancar, 2009). One of the roles of implementing holistic nursing care is the identification of patient's spiritual needs, and planning and carrying out nursing care interventions, for example: help of a priest, ensuring privacy and a peaceful environment, providing the possibility of conversation, listening to a radio programme, music, and considering requests of spiritual and religious nature (special diet, performing religious rituals) (Skoberne, 2002; Karnjuš, et al., 2014). Health care employees are not synonymous in who is responsible for the spiritual care of patients (Babnik & Karnjuš, 2014), but it is probably nursing care employees who are the most suitable professionals to offer spiritual care due to the nature of their work, which requires an on-going contact with patients (Nixon, et al., 2013). Nursing care employees represent the link between the patient and other health care workers and encourage spiritual care in which all the persons who are important to the patient are included (Zakšek, 2010).

Nowadays, nursing care does not deal with the concept of spirituality and spiritual care only during palliative care and alleviation of suffering, but on all the areas of patient care. An example of such approach to spirituality is evident in Great Britain, which after 2010 (McSherry & Jamieson, 2011, 2013) began conducting intense research on the integration of spirituality and spiritual care in nursing care in general, regardless of the field of work and patients that nursing care employees care for. Based on research conducted on a small sample of nursing care employees in Slovenia, Babnik in Karnjuš (2014) have found that the respondents understand spiritual needs of patients and spiritual care as a part of their job since this role is also included in the *The code of Ethics* (Nurses and Midwives Association of Slovenia, 2014). The importance of spiritual care and consideration of the general spiritual dimension of an individual's actions have also been confirmed by the North American Nursing Diagnosis Association International [NANDA-I], which lists various aspects of an individual's well-being amongst the domain of "Life Principles". In this way, nursing diagnoses "Readiness for enhanced spiritual well-being" (p. 361), "Spiritual distress" (p. 372) and "Risk for spiritual distress" (p. 374) refer directly to recognising the spiritual dimension of one's actions on a person's well-being and their quality of life (Herdman & Kamitsuru, 2014). The concepts of spirituality and spiritual care are regularly found in contemporary textbooks on nursing as with theoreticians Betty Neuman, Margaret Newman, Rosemary Parse in Jean Watson (MacKinlay, 2002; Tanyi, 2002).

Aims and objectives

Spirituality and spiritual care in the field of nursing and health care are not well-researched in Slovenia nor abroad. The purpose of the research was to study the understanding of the concept of spirituality and spiritual care among the employees in nursing in Slovenia. Attitudes are also reflections of understanding a particular subject or a phenomenon, which is why the aim of our research was to study the beliefs and opinions of nursing employees regarding spirituality and spiritual care. Our focus were nursing employees in hospitals where the attention is mainly on treatment and rehabilitation. Such an environment features not only dying patients and terminally ill patients, but also people who have been hospitalised for a shorter or longer period of time. The following research questions were set:

- How do nursing employees understand the concept of spirituality and spiritual care?
- What are the attitudes of the nursing employees in hospitals regarding the need for training in the field of spirituality and spiritual care?
- Which organisations/institutions should offer appropriate support to nursing employees in offering spiritual care according to nursing employees?

Methods

A quantitative descriptive research method with a structured questionnaire was used.

Description of the research instrument

The Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry, et al., 2002) was used as the instrument for collecting data. The questionnaire is composed of three parts: i) the first one establishes how the respondents understand the concepts "spirituality" and "spiritual care" and what their attitudes towards these concepts are (17 statements); ii) the second part identifies the necessary measures in offering spiritual care to patients, especially in terms of the role of educational institutions and regulatory bodies in ensuring spiritual care to patients and the types of measures that would need to be implemented when offering spiritual care to patients (6 statements); iii) the purpose of the third part is to gather demographic data. The first and second parts of the questionnaire contain statements to which respondents responded (expressed their level of agreement) with a Likert type five-point scale (1 – strongly agree; 2 – agree; 3 – neutral; 4 – disagree; 5 – strongly disagree). The second part of the statements form part of the original scale as sent to us by the author (McSherry, et al., 2002). For the purposes of adjusting the questionnaire to the Slovene population, bodies that are used in regulating health care and nursing care in the Republic of Slovenia have been included in the formulation of the statements.

Seventeen statements from the first part of the SSCRS questionnaire measure four dimensions of attitudes towards spirituality and spiritual care (McSherry et al., 2002): i) spirituality, ii) spiritual care, iii) religiousness and iv) individualised personal care. In previous studies the first part of SSCRS showed appropriate and consistent level of reliability with values of Cronbach alpha for SSCRS dimensions between 0.64 (McSherry, 1998) and 0.84 (Khoshknab, et al., 2010). Internal scale consistency was calculated (Cronbach alpha) for the first part of the SSCRS questionnaire that is adequate and amounts to 0.83. Internal consistency of the scale (Cronbach alpha) that amounts to 0.38 was also calculated for the second part. The low internal consistency of the second part of the questionnaire was expected, since the second part is not based on statements intended to consistently describe the superior construct (this consistency would be reflected in high internal consistency or Cronbach alpha coefficient), but the statements are mainly specific beliefs regarding the possible approaches and conditions for the implementation of spiritual care.

Description of the research sample

A convenience sample was used, composed of nursing care employees in four Slovene hospitals. From the

total of 250 returned questionnaires, 173 were valid (70.7 % sample realisation). 153 women (88.4 %) and 20 men (11.6 %) participated in the study. Most respondents had a college or higher-education degree (n = 93, 53.8 %), followed by completed secondary education (n = 75, 43.4 %), five respondents (2.8 %) had a university degree or a master's degree or higher. 114 (65.9 %) of respondents classified themselves as religious and 59 (34.1 %) as non-religious. From the respondents that classified themselves as religious, 64 (56.1 %) practises their religion, while the other 50 (43.9 %) did not. As depicted in Table 1, the majority of the respondents were aged between 30 and 39 (n = 56, 32.4 %). The majority of the respondents have 11 or more years work experience (n = 103, 63.1 %). With regard to the field of work, employees at the department of surgery were the most responsive to the questionnaire (n = 125, 72.3 %).

Table 1: *Demographic data of the study participants*
Tabela 1: *Demografski podatki anketirancev*

Demographic data / Demografski podatki	***n***	***%***
Age group		
21 to 29 years	43	24.9
30 to 39 years	56	32.4
40 to 49 years	46	26.6
50 to 59 years	25	14.5
60 years or more	3	1.7
Total	173	100
Years of service		
Less than 1 year	8	4.6
1 to 5 years	31	17.9
6 to 10 years	25	14.5
11 to 25 years	66	38.2
25 years or more	43	24.9
Total	173	100
Field of work		
Surgery	125	72.3
Internal medicine	32	18.5
Paediatrics	7	4.0
Gynaecology	5	2.9
Anaesthesia	4	2.3
Total	173	100

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

Description of the research procedure and data analysis

Before conducting the research, we obtained an official consent from the author of the research works (McSherry, et al., 2002) on spirituality in nursing in Great Britain to use the above-mentioned instrument. We translated the questionnaire into Slovene, so that with statements that could be unclear the research authors translated the original statements into the Slovene language and then back-translated them to English. A review of both translations was performed by a translator. The statements in the second part ("I believe that Ministry of Health should provide clear guidance and support for nurses to deal with spiritual and religious issues", "I believe that Nurses and Midwives Association of Slovenia should provide clear guidance and support for nurses to deal with spiritual and religious issues.") we made adjustments according to the regulatory institutions for health care and nursing care in Slovenia. The survey was performed after obtaining consent from each institution – the hospital. Questionnaires were distributed in cooperation with the hospitals that approved the research. Every research participant had the possibility to withdraw from participation in the research if they wished and the respondents were assured anonymity in conducting the research and research reports.

The anonymity of the participants was assured by gathering a certain number of demographic variables, so only those that are necessary for a suitable description of the sample and were in previous studies (Kaddourah, et al., 2018; Kavosi, et al., 2018) identified as possible influencing factors on attitudes towards spirituality and spiritual care. We calculated descriptive statistics (frequency, mean value, standard deviation) and used statistical tests (ANOVA, t-test). Before conducting the tests, we calculated the mean value for the first part of SSCRS (attitudes towards spirituality and spiritual care) for each participant, thus designing a variable of composite value of attitudes towards spirituality and spiritual care. Levene's test was used to confirm the hypothesis on the homogeneity of variances and normality of the distribution of mean values in the first part of SSCRS (Kolmogorov-Smirnov Test), so we continued by conducting statistical inference tests (t-test, ANOVA). Statistical analyses were conducted by using the SPSS, ver. 23 statistical programme (SPSS Inc., Chicago, Illinois, ZDA). Values $p < 0.05$ were considered statistically significant.

The first step in data analyses was checking the reliability and construct validity (factor analysis) of the part of the instrument that refers to the attitudes of nursing care employees towards spirituality and spiritual care (the first part of SSCRS). Reliability and construct validity of the Slovene version of the SSCRS scale was checked with an analysis of the dimensional structure and with an analysis of the reliability of the entire scale and its dimensions (reliability as internal consistency – Cronbach alpha). Factor analysis was conducted on seventeen statements of the SSCRS scale. The accuracy of the correlation matrix of SSCRS statements for factor analysis was checked with a Bartlett's test of sphericity and with the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) (Field, 2009) measure. Bartlett's test

of sphericity ($\chi^2 = 924.557, p < 0.01$) and measure KMO = 0.821 confirmed the accuracy of the correlation matrix for studying the dimensional structure. Factor analysis (main component method, varimax rotation) excluded 3 factors with eigenvalue value more than 1 that together explain the 51.7 % variance in the respondents' answers. In accordance with the McSherry and colleagues (2002) instrument validation procedure, the cut-off value of factor weights for determining the factor structure was determined with the value ≥ +/- 0.35. Factor matrix is depicted in Table 2. Dimensional structure of the SSCRS scale deviates from the four dimensions of attitudes towards spirituality and spiritual care identified by McSherry and colleagues (2002), especially from the

Table 2: *Factor matrix with descriptive statistics for the first part of SSCRS*
Tabela 2: *Faktorska matrika in deskriptivne statistike trditev prvega sklopa SSCRS*

Statements in the first part of SSCRS / Trditve prvega sklopa SSCRS	***n***	$\bar{x}$	***s***	***Factors / Faktorji***		
				Definition of spirituality / Opredelitev duhovnosti	***Spiritual care / Duhovna oskrba***	***Religion and spirituality / Religija in duhovnost***
I believe spirituality is a unifying force which enables one to be at peace with oneself and the world	172	4.08	0.74	0.85	0.04	0.13
I believe spirituality is about having a sense of hope in life	169	3.87	0.88	0.79	0.25	−0.09
I believe spirituality is to do with the way one conducts one's life here and now	171	3.68	0.97	0.78	0.17	−0.05
I believe spirituality involves personal friendships and relationships	171	3.43	1.03	0.61	−0.02	0.21
I believe nurses can provide spiritual care by having respect for the privacy, dignity and religious and cultural beliefs of a patient	171	4.27	0.82	0.57	0.21	0.23
I believe spirituality includes peoples' morals	171	3.79	1.04	0.49	0.28	0.17
I believe spirituality is about finding meaning in the good and bad events of life	173	3.75	0.97	0.46	0.36	0.15
I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	172	3.01	1.16	0.44	0.28	−0.45
I believe spirituality is concerned with a need to forgive and a need to be forgiven	170	3.72	1.06	0.39	0.61	−0.12
I believe nurses can provide spiritual care by spending time with a patient, giving support and reassurance especially in times of need	173	3.99	0.87	0.21	0.75	0.18
I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care	172	4.20	0.76	0.08	0.72	0.20
I believe nurses can provide spiritual care by arranging a visit by the hospital chaplain or the patient's own religious leader if requested	172	4.08	1.00	0.08	0.66	−0.05
I believe nurses can provide spiritual care by listening to patients and giving them time to discuss and explore their fears, anxieties and troubles	172	3.83	0.90	0.51	0.38	−0.02
I believe spirituality only involves going to church/place of worship	173	1.73	0.97	0.05	0.15	0.80
I believe spirituality is not concerned with a belief and faith in God or a Supreme being	173	1.88	1.00	0.00	0.10	0.78
I believe spirituality does not include areas such as art, creativity and self-expression	173	2.33	1.13	0.11	0.01	0.59
I believe spirituality does not apply to Atheists or Agnostics	173	2.03	0.98	0.38	0.05	0.57
Percentage of explained variance	/	/	/	30.10	13.15	8.41
Coefficient of internal consistency Cronbach alpha (α)	/	/	/	0.82	0.66	0.69

Legenda / Legend: n – število / number; $\bar{x}$ – povprečje / average; s – standardni odklon / standard deviation

perspective of the fourth factor that these authors named "individualised personal care". This factor as an independent dimension has not been confirmed in our research. The internal consistency of each factor with the exception of the first is also lower and questionable (Gliem & Gliem, 2003). Due to a satisfactory level of internal consistency of the entire scale (Cronbach alpha = 0.83) we treated 17 statements as a one-dimensional measure of attitudes towards spirituality and spiritual care.

Results

In the first part of SSCRS the respondents expressed their understanding of the concepts of spirituality and spiritual care and their attitudes towards these concepts. Table 2 shows factors with corresponding statements of the first part of SSCRS, mean value ($\bar{x}$) and standard deviation (s) of the specific statements in the first part of SSCRS. As seen from Table 2, respondents agreed most with statements that define spiritual care of patients and their spirituality. The respondents agreed most ($\bar{x}$ = 4.27, s = 0.82) with the statement, "I believe nurses can provide spiritual care by having respect for the privacy, dignity and religious and cultural beliefs of a patient. "Respondents also agree that they provide spiritual care by means of their attitude towards their patients: "by showing kindness, concern and cheerfulness" ($\bar{x}$ = 4.2, s = 0.76). The respondents expressed the lowest level of agreement with statements that refer to defining spirituality only from the religious perspective: "I believe spirituality only involves going to church/place of worship" ($\bar{x}$ = 1.73, s = 0.97); "I believe spirituality is not concerned with a belief and faith in God or a Supreme being" ($\bar{x}$ = 1.88, s = 1.00); "I believe spirituality does not apply to Atheists or Agnostics" ($\bar{x}$ = 2.03, s = 0.98).

We were also interested in statistically significant differences between the average score in the first part of SSCRS and demographic data: (i) self-evaluation of respondents, whether they are religious or not (dichotomous variable); (ii) gender (dichotomous variable); (iii) age (age groups). Analysis showed statistically significant differences in the mean score in the first part of SSCRS for self-evaluation of respondents, whether (i) they are religious and (iii) whether they practice religion or not. The mean score in the first part of SSCRS for respondents who answered the question "Are you religious?" with "Yes." (n = 114, $\bar{x}$ = 3.48, s = 0.41) is statistically different from the mean score of the respondents who answered to this question with "No." (n = 58, $\bar{x}$ = 3.23, s = 0.41) as t = 3.76 and is significant on the level, $p < 0.001$. Among the respondents who answered the question "Do you practice religion?" with "Yes." (n = 64, $\bar{x}$ = 3.48, s = 0.39) and those who answered "No." (n = 102, $\bar{x}$ = 3.33, s = 0.43), there is a statistically significant difference in the evaluation of the statements on the scale (t = 2.32, p = 0.02). For demographic variables of sex and age no statistically significant differences were found for the mean score in the first part of SSCRS: sex (t = 0.13, p = 0.89) and age groups (F = 0.51, p = 0.73).

The second part of SSCRS was aimed at finding which measures should be introduced in relation to offering spiritual care to patients according to nurses. The part contained six statements that the respondents evaluated with a five-point Likert scale. The results are shown in Table 3.

As seen in Table 3, respondents show the highest agreement with the statement that during training they do not obtain enough education and training to provide spiritual care to patients ($\bar{x}$ = 3.50, s =1.06),

Table 3: *Descriptive statistics for the second part of SSCRS*
Tabela 3: *Deskriptivne statistike za trditve drugega sklopa SSCRS*

Statement in the second part of SSCRS / Trditve drugega sklopa SSCRS	***n***	***1 (n / %)***	***2 (n / %)***	***3 (n / %)***	***4 (n / %)***	***5 (n / %)***	$\bar{x}$	***s***
I believe that spirituality and spiritual care are fundamental aspects of nursing	170	21/ 12.4	42/ 24.7	52/ 30.6	48/ 28.2	7/ 4.0	2.88	1.08
I believe that nurses do not receive sufficient education and training in order to provide quality spiritual care to the patient	171	6/ 3.5	29/ 16.8	37/ 21.6	72/ 42.2	27/ 15.6	3.50	1.06
I believe that spirituality and spiritual care should not be addressed within programmes of nurse education	171	33/ 19.1	52/ 30.4	45/ 26.3	29/ 16.8	12/ 6.9	2.62	1.18
I believe that Ministry of Health should provide clear guidance and support for nurses to deal with spiritual and religious issues	171	10/ 5.8	19/ 11.1	56/ 32.7	57/ 33.5	29/ 16.8	3.46	1.08
I believe that Nurses and Midwives Association of Slovenia should provide clear guidance and support for nurses to deal with spiritual and religious issues	172	11/ 6.4	20/ 11.6	46/ 26.7	68/ 39.3	28/ 16.2	3.48	1.09
I believe that spiritual care should be an integral part of nursing lifelong education and mandatory content for the renewal of licenses	171	26/ 15	38/ 22.2	44/ 25.7	44/ 26.0	19/ 11.0	2.96	1.24

Legend / Legenda: n – number / število; $\bar{x}$ – average / povprečje; s – standard deviation / standardni odklon; 1 – strongly disagree / sploh se ne strinjam; 2 – disagree / se ne strinjam; 3 – uncertain / negotov; 4 – agree / se strinjam; 5 – strongly agree / zelo se strinjam

and also with the statements referring to the Nurses and Midwives Association of Slovenia ($\overline{x}$ = 3.48, s = 1.09) and the Ministry of Health of the Republic of Slovenia ($\overline{x}$ = 3.46, s =1.08) as those institutions that should set clear guidelines and offer suitable support to nursing care employees in dealing with spiritual and religious issues of patients. With regard to the statement that spirituality and spiritual care represent basic principles in nursing care, the majority (n = 53, 30.6 %) of respondents were undecided ($\overline{x}$ = 2.88, s = 1.08).

Discussion

The results of the study have shown that nursing care employees included in the study understand spirituality especially in connection to understanding oneself and the attitude a person has towards themselves and the outside world, with the ability to live one's life in every moment, and the least with religion, belief in God or another celestial being and visiting religious institutions. The study conducted by McSherry and Jamieson (2013) among nurses in Great Britain gave similar results. Our research has confirmed that the nursing care employees included in the study have a broad, eclectic and inclusive way of understanding the concept of spirituality, which means that they do not only connect spirituality with belief in God or some other celestial being, but understand it primarily as a motivational construct that guides an individual in their search for peace, hope, other human beings, sense and forgiveness. These are the key concepts that define spirituality (Hsiao, et al., 2011) and may, or may not include religion, religious rituals and objects (Pike, 2011). For some individuals spirituality is a recognition of the existence of a divinity or personal relationship with God, while for others spirituality is a reflection of the most honest Self or the internal being (Mayers & Johnston, 2008).

The mean scores of the first part of SSCRS have shown that the respondents do not understand the concept of spirituality as being the same as the concept of religion and do not strictly differentiate between the concepts of spirituality and religion, but connect them both in a common concept of spirituality. Excluding religion from the concept of spirituality in nursing care in Europe is, above all, a consequence of secularisation (Timmins & McSherry, 2012). Some authors tend to criticise such an approach to understanding the relationship between religion and spirituality (Pesut, 2008; Pike, 2011). By emphasising the separation of spirituality and religion, the literature in nursing wishes to bring attention to the fact that an individual spiritual dimension and spiritual needs should also be recognised with patients who do not define themselves as religious (Pesut, 2008; Gedrih & Pahor, 2009). Strict separation of the two concepts may bring about a belief that an individual is a "non-material being" (Pesut, 2008, p. 170), with a pronounced emotional dimension, without the behavioural dimension or without rituals, practices and spiritual objects that are most often associated with the concept of religion as an institutionalised and tangible spirituality. In this sense, religion may be understood as one of the forms of demonstrating an individual's spirituality, which should be taken into account in the holistic care of patients (Timmins & McSherry, 2012). The results of this research have also demonstrated the same understanding of the concept by the nursing care employees included in the study.

In a study carried out in one of the Slovenian general hospitals, Šolar and Mihelič Zajec (2007, p. 144) identifies the "shared opinions" of nursing staff about "that satisfying spiritual needs is a priority or that their implementation is only possible after performed other activities, which, according to respondents, are an advantage". Despite the fact that our research based on the evaluations of the statements of the first part of SSCRS has shown a broad understanding of the concept of spirituality, average evaluations of the statements of the second part of SSCRS show similar opinions of the interviewed nursing care employees as given by Šolar and Mihelič Zajec (2007), and Babnik and Karnjuš (2014). Regarding the statement that spirituality and spiritual care are the basic aspects of nursing care, the majority of the respondents were undecided, while about the same percentage disagreed or strongly disagreed with the statement. This means that spiritual care, according to the interviewed nursing care employees, is not one of the priority areas in nursing care. The fact that the majority of the respondents work in surgery hospital departments may have had an impact on the results. Their experience of providing spiritual care is restricted to clinical settings where patients after an operation do not stay in the hospital or the surgery department for a long time. The concepts of spirituality and spiritual care originate from the biopsychosocial model of health and illness (Borrell-Carrió, et al., 2004) and an upgrade of the latter with the biopsychosocial-spiritual model of care (Sulmasy, 2002). Some recent research (Babnik, et al., 2017) has shown that a holistic care of patients is not a generally accepted model of care in nursing. Spiritual care as the main component of the holistic care has not been given enough attention in practice (Battey, 2012), especially beyond palliative care, since spirituality is not only restricted to the time of dying (McSherry & Jamieson, 2011). The significance of spiritual care may have been diminished also due to the fact that the process of spiritual care has not been entirely defined. Some guidelines of practising spiritual care have been given in the literature after the evaluation of patients' spiritual care and spiritual needs (Elliott, 2011; Daly & Fahey-McCarthy, 2014), but there is a lack of clear guidelines for practising

interventions and their evaluations. The answers by the nursing care employees included in the study regarding the first part of SSCRS have shown an understanding of spiritual care in nursing especially as being kind, caring, spending more time with an individual patient, being supportive and respecting the patient's privacy, their dignity, and religious and cultural beliefs. Other research conducted by means of the SSCRS questionnaire in various cultural and religious environments has also shown that the nursing staff generally consider that the attitude towards patients (care, optimism, support) and therapeutic communication were the key elements of spiritual care in nursing (Kostak & Celikkalp, 2016; Kaddourah, et al., 2018) and in other health care fields such as occupational therapy (Mthembu, et al., 2016).

Half of the interviewed nursing care employees were undecided regarding the need for including spiritual care in nursing care training programmes. Similar results had been found by Babnik and Karnjuš (2014). Generally, the interviewed nursing care employees were quite in agreement that they had not obtained enough knowledge with respect to spiritual care as part of nursing care. Findings of other research (McSherry & Jamieson, 2011, 2013; Kostak, & Celikkalp, 2016; Murray & Dunn, 2017) have also shown that nursing care employees lack the knowledge on spirituality and meeting spiritual needs. Therefore, the need to introduce subjects that would deal with spirituality and spiritual care exists. Before taking this step, a clear definition of the process of implementation of spiritual care as part of nursing care is needed (Ramezani, et al., 2014), which the respondents confirmed by expressing the opinion that clear guidelines and instructions for offering suitable and high quality care of patients should be prepared.

The conducted research also has limitations, which refer especially to the psychometric characteristics of the used questionnaire and the size of the sample. The research did not confirm the dimensional structure of the first part of the SSCRS questionnaire. The factor analysis has shown that the statements of the dimension "individualised personal care" of the original questionnaire (McSherry, et al., 2002) connect in a broader superior concept of spiritual care and not in an independent dimension of spiritual care as it is true for the original questionnaire. The reasons for such deviation may be found especially in the way spirituality and spiritual care is understood among the respondents, which can be a consequence of a somewhat specific professional and/or broader cultural environment. Similar findings have been reported by Martins and colleagues (2015) who confirmed the reliability of the first part of the SSCRS questionnaire but not its dimensional structure. Two research works that described the psychometric characteristics of the SSCRS questionnaire do not report on the dimensional structure of this questionnaire (Khoshknab, et al., 2010; van Leeuwen & Schep-Akkerman, 2015). Confirmation of the dimensional structure of the first part of the SSCRS questionnaire requires additional, also intercultural, research. The other limitation refers to sample size. The research only included a small number of nursing care employees, so a national research should be conducted, which could provide a clearer view on the existing current knowledge and opinions of nursing care employees regarding spirituality and spiritual care. The obtained results could then influence the setting of clear guidelines and preparing instructions that would help nursing care employees in holistic care for their patients.

Conclusion

We have shown how a sample of nursing care employees understand the concept of spirituality and spiritual care and their role in recognising the spiritual needs of patients and providing adequate patient care. Results have shown that the respondents associate spirituality especially with understanding themselves and the attitude that they have towards themselves and the outside world, however they disagree that spirituality and religion may be regarded as the same. Understanding the concept of spiritual care is connected especially to respecting an individual person in all respects and by being kind and caring. The respondents are aware of the importance of spiritual care in a clinical environment, but are at the same time undecided whether spirituality and spiritual care are key aspects of nursing care. The latter shows that there is a lack of understanding of the concept of spirituality and spiritual care among the respondents. The reasons may be lack of knowledge; therefore the study programme syllabi of undergraduate and postgraduate courses should be upgraded by providing subjects that are related to spirituality and spiritual care.

Slovenian translation / Prevod v slovenščino

Uvod

Duhovnost in duhovna oskrba sta danes pomembna elementa celostne, bio- in psihosocialne obravnave posameznika (Caldeira, et al., 2014). Čas poškodb, bolezni, posebej umiranja, je namreč čas negotovosti in stisk, ki presežejo zgolj telesni vidik delovanja posameznika (Babnik & Karnjuš, 2014) in v njem sprožijo vprašanja smisla, upanja, pomena, odpuščanja, višje sile. Duhovnost je koncept, ki združuje številne pomene: religijo, verske rituale, transcendenco, vzajemnost, povezanost, mir, energijo, pomen, namen, prepričanja, vrednote, upanje, motivacijo, ljubezen (Hsiao, et al., 2011). V literaturi zdravstvene nege ni enotne definicije duhovnosti (Pike, 2011). Nekateri avtorji jo v poskusu opredelitve

označujejo kot intrapsihično dimenzijo, ki vključuje eksistencialna načela in prepričanja ter posameznika vodi v iskanju pomena in namena v življenju ter ustvarjanju pozitivnih odnosov z drugimi (Molzahn & Sheilds, 2008; Ellis & Narayanasamy, 2009). Podobno opiše duhovnost tudi slovenska avtorica Skoberne (2002), ki je objavila članek na temo duhovnosti in duhovne oskrbe v zdravstveni negi v Sloveniji v času, ko se je v tujini področje duhovnosti v zdravstveni negi šele pričelo intenzivneje razvijati. Tudi s psihološkega vidika duhovnost razumemo predvsem kot dinamični, motivacijski koncept ali notranji vir (van Dierendonck & Mohan, 2006), ki vodi posameznike v iskanju pomena in moči, še posebno v kriznih situacijah, kamor sodi tudi bolezen. Paley (2008, 2010) navaja, da so v zdravstveni negi težave pri opredelitvi duhovnosti predvsem, ker je ta koncept relativno mlad in se spreminja glede na prepričanja posameznika, zlasti glede na njegovo kulturno ali versko ozadje in v skladu z družbo, ki ga obkroža. Gall in sodelavci (2011) opozarjajo, da so definicije duhovnosti pogosto nejasne in zapletene in pretežno odražajo, kako raziskovalci razumejo ta koncept, redkeje pa to, kako posamezniki, anketiranci raziskav, doživljajo duhovnost. Ena od pogostejših tem proučevanja duhovnosti v zdravstveni negi je pojasnitev odnosa med religioznostjo in duhovnostjo oziroma pojasnitev, »ali sta religija in duhovnost sinonima in ali imajo pacienti, ki niso religiozni, tudi duhovne potrebe« (Pike, 2011, p. 746). Enega od odgovorov na vprašanje odnosa med duhovnostjo in religioznostjo sta v literaturi zdravstvene nege že leta 2004 ponudila McSherry in Cash (2004) s taksonomijo duhovnosti v zdravstvu. Taksonomija predstavlja kontinuum pomenov duhovnosti in seže od duhovnosti, opredeljene izključno na verskih in teističnih idealih, do duhovnosti, ki temelji na sekularnih, humanističnih in eksistencialnih elementih. Razlaga duhovnosti v zdravstveni negi temelji na prevladujočem razumevanju duhovnosti kot komponente posameznikove biti, ki vključuje dimenziji »imanence (neločljivosti) in transcendence (presežnosti, nadizkustvenosti), ter lahko (ali pa tudi ne) vključuje religiozna prepričanja in prakse« (Babnik & Karnjuš, 2014, p. 13).

Poleg pojma duhovnosti je na področju zdravstvene nege uveljavljen tudi pojem duhovnih potreb. V literaturi težko najdemo ustrezno definicijo duhovnih potreb. Usklajeno jih definirajo Buck in McMillan (2012) ter Nixon in sodelavci (2013): duhovne potrebe opredelijo kot nekaj, kar oseba želi ali potrebuje, da bi našla namen in pomen življenja. Galek in sodelavci (2005) izpostavljajo sedem domen duhovnih potreb, in sicer pripadnost, smisel, upanje, sveto, moralnost, lepoto in sprejetje umiranja. Sharma in sodelavci (2012) izpostavljajo tri kategorije duhovnih potreb: psihosocialne, spiritualne in religiozne. Psihosocialne duhovne potrebe opisujejo kot potrebe po podpori in pomoči drugih; spiritualne kot tiste, ki se nanašajo na transcendentna vprašanja (pomen, upanje, odpuščanje, mir); med religiozne duhovne potrebe pa uvrščajo potrebe po aktivnem izvajanju veroizpovedi z branjem verskih besedil, opravljanjem verskih obredov ali pogovorom z duhovnikom oziroma verskim voditeljem (Sharma, et al., 2012).

Duhovna oskrba pacientov naj bi vodila k duhovnemu blagostanju pacienta v najhujših trenutkih njegovega življenja, ko zaradi bolezni ali poškodbe izgubi smisel, pomen in namen življenja (Cook, et al., 2012). O tem, kaj je duhovna oskrba, v literaturi ne najdemo soglasja. V strokovni literaturi se je uveljavilo razlikovanje med duhovno oskrbo kot širšim pojmom ter versko oskrbo kot njeno podkategorijo predvsem zaradi zahtev družbe po enakovredni obravnavi vseh, tudi ateistov (Gedrih & Pahor, 2009). Namen duhovne oskrbe je pomoč pacientom, da dosežejo ravnovesje in celovitost pri razumevanju lastnega stanja; je pomoč pri premagovanju občutkov nesmiselnosti in nekoristnosti; je podpora pri iskanju pomenov in smisla (Štrancar, 2009). Ena od aktivnosti izvajanja celostne zdravstvene nege je tudi identifikacija duhovnih potreb pacienta ter načrtovanje in izvajanje intervencij, med katere sodijo na primer: pomoč duhovnika, zagotavljanje zasebnosti in mirnega okolja, možnosti pogovora, poslušanje radijskega programa, glasbe, upoštevanje želja duhovne in verske narave (dietni predpisi, izvajanje verskih obredov) idr. (Skoberne, 2002; Karnjuš, et al., 2014). Zdravstveni delavci nimajo enotnega mnenja o tem, kdo je odgovoren za duhovno oskrbo pacientov (Babnik & Karnjuš, 2014). Verjetno pa so zaposleni v zdravstveni negi tisti, ki so zaradi narave svojega odnosa in stalnega stika s pacientom najprimernejši strokovni profil za duhovno oskrbo (Nixon, et al., 2013). Zaposleni v zdravstveni negi so vez med pacientom in ostalimi zdravstvenimi profili ter spodbujajo duhovno oskrbo, v katero se vključujejo vse pacientu pomembne osebe (Zakšek, 2010).

Sodobna zdravstvena nega se s konceptom duhovnosti in duhovne oskrbe ne ukvarja le v povezavi s paliativno oskrbo in lajšanjem trpljenja, temveč je razširila ta koncept na vsa področja obravnave pacienta. Primer takega pristopa je viden v Veliki Britaniji, ki je v obdobju po letu 2010 (McSherry & Jamieson, 2011, 2013) intenzivno pristopila k proučevanju vpetosti duhovnosti in duhovne oskrbe v zdravstveno nego na splošno, ne glede na področje dela in paciente, ki jih zaposleni v zdravstveni negi oskrbujejo. Na podlagi raziskave, opravljene na manjšem vzorcu zaposlenih v zdravstveni negi v Sloveniji, Babnik in Karnjuš (2014) ugotavljata, da anketiranci prepoznavajo duhovne potrebe pacientov in duhovno oskrbo kot del svojega dela, saj je ta vloga zapisana tudi v Kodeksu etike v zdravstveni negi in oskrbi Slovenije (Zbornica zdravstvene in babiške nege Slovenije, 2014). Pomen duhovne oskrbe in upoštevanja duhovne dimenzije posameznikovega delovanja potrjuje tudi Severnoameriško združenje

za negovalne diagnoze (North American Nursing Diagnosis Association International [NANDA-I]), ki v domeni »Življenjska načela« vključuje različne vidike duhovnega blagostanja posameznika. Tako se na primer negovalne diagnoze »Pripravljenost za doseganje višje ravni duhovnega blagostanja« (p. 361), »Duhovna stiska« (p. 372) ter »Nevarnost za duhovno stisko« (p. 374) neposredno nanašajo na prepoznavanje pomena duhovne dimenzije individualnega delovanja za posameznikovo blagostanje in kakovost življenja (Herdman & Kamitsuru, 2014). Duhovnost in duhovna oskrba sta redno prisotni v sodobnih učbenikih zdravstvene nege (Pesut, 2008), vključeni pa sta tudi v temeljne teorije in modele zdravstvene nege, kot beremo pri teoretičarkah Betty Neuman, Margaret Newman, Rosemary Parse in Jean Watson (MacKinlay, 2002; Tanyi, 2002).

Namen in cilji

Duhovnost in duhovna oskrba sta na področju zdravstvene nege in zdravstva v tujini in pri nas še vedno slabše raziskani. Namen raziskave je bil proučiti razumevanje koncepta duhovnosti in duhovne oskrbe med zaposlenimi v zdravstveni negi v slovenskem prostoru. Stališča so eden od odrazov razumevanja določene teme ali fenomena, zato smo si kot cilj raziskave zadali proučiti prepričanja in stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe. Pri tem smo se usmerili na zaposlene v zdravstveni negi v bolnišničnem okolju, kjer je zdravstvena nega usmerjena tako v kurativo kakor tudi v preventivo in rehabilitacijo. V takem okolju niso le umirajoči pacienti ali pacienti z neozdravljivo boleznijo, ampak tudi osebe, ki morajo biti zaradi zdravstvenega stanja hospitalizirane za krajše ali daljše časovno obdobje. Zastavili smo si naslednji raziskovalni vprašanji:

– Kako zaposleni v zdravstveni negi razumejo koncept duhovnosti in duhovne oskrbe?
– Kakšno je stališče zaposlenih v zdravstveni negi v bolnišničnem okolju do potreb po izobraževanju na področju duhovnosti in duhovne oskrbe?
– Katere organizacije / institucije bi po njihovem mnenju morale zaposlenim v zdravstveni negi pri izvajanju duhovne oskrbe nuditi ustrezno podporo?

Metode

Uporabljena je bila kvantitativna opisna metoda raziskovanja z uporabo strukturiranega vprašalnika.

Opis instrumenta

Kot instrument zbiranja podatkov smo uporabili »Vprašalnik za oceno duhovnosti in duhovne oskrbe« (*Spirituality and Spiritual Care Rating Scale* [SSCRS]) (McSherry, et al., 2002). Vprašalnik je sestavljen iz treh sklopov: i) prvi ugotavlja, kako ankentiranci razumevajo pojma »duhovnosti« in »duhovne oskrbe« ter kakšno stališče vzpostavljajo do njiju (17 trditev); ii) drugi sklop meri zaznavanje potrebnih ukrepov na področju nudenja duhovne oskrbe pacientov, predvsem v smeri vloge izobraževalnih ustanov in regulatornih organov pri zagotavljanju duhovne oskrbe pacientov in vrste ukrepov, ki bi jih bilo treba uvesti na področju nudenja duhovne oskrbe (6 trditev); iii) tretji sklop je namenjen pridobivanju demografskih podatkov. Prvi in drugi sklop vprašalnika vsebujeta trditve, na katere so anketiranci odgovarjali (izražali stopnjo strinjanja) s petstopenjsko Likertovo lestvico (1 – sploh se ne strinjam; 2 – se ne strinjam; 3 – sem negotov; 4 – se strinjam; 5 – se zelo strinjam). Drugi sklop trditev je sestavni del izvorne lestvice, kot nam jo je posredoval avtor (McSherry, et al., 2002). Za namene prilagoditve vprašalnika slovenski populaciji smo v formulacijo trditev vključili telesa, ki jih ima za namene reguliranja zdravstvene oskrbe in zdravstvene nege Republika Slovenija (RS).

Sedemnajst trditev prvega sklopa vprašalnika SSCRS meri štiri dimenzije stališč do duhovnosti in duhovne oskrbe (McSherry et al., 2002): i) duhovnost, ii) duhovno oskrbo, iii) religioznost in iv) individualizirano duhovno oskrbo. V dosedanjih raziskavah je prvi sklop SSCRS pokazal ustrezno in konsistentno raven zanesljivosti z vrednostmi dimenzij Cronbach alfa od 0,64 (McSherry, 1998) do 0,84 (Khoshknab, et al., 2010). Za prvi sklop vprašalnika SSCRS smo izračunali notranjo konsistentnost lestvice (Cronbach alfa), ki je ustrezna in znaša 0,83. Tudi za drugi sklop SSCRS smo izračunali notranjo konsistentnost lestvice (Cronbach alfa), ki znaša 0,38. Nizka notranja konsistentnost sklopa je pričakovana, saj drugi sklop ne temelji na trditvah, katerih namen bi bil konsistentno opisati nadredni konstrukt (ta skladnost pa bi se odražala v visoki notranji konsistentnosti oziroma Cronbach alfa koeficientu), temveč so trditve zgolj posamična prepričanja o možnih pristopih in pogojih k implementaciji duhovne oskrbe v prakso.

Opis vzorca

Uporabljen je bil priložnostni vzorec, sestavljen iz zaposlenih v zdravstveni negi v štirih slovenskih bolnišnicah. Od skupno 250 posredovanih vprašalnikov smo prejeli 173 veljavnih vprašalnikov (70,7 % realizacija vzorca). V raziskavi je sodelovalo 153 žensk (88,4 %) in 20 moških (11,6 %). Večina anketirancev je imela končano višjo oziroma visokošolsko izobrazbo (n = 93, 53,8 %), sledila je srednješolska izobrazba (n = 75, 43,4 %), pet anketirancev (2,8 %) je imelo univerzitetno izobrazbo oziroma strokovni magisterij ali več. Med anketiranci se jih je 114 (65,9 %) opredelilo za verne in 59 (34,1 %) za neverne. Od anketirancev, ki so se opredelili za verne, 64 (56,1 %) prakticira

svojo veroizpoved, ostalih 50 (43,9 %) pa ne. Kot je razvidno iz Tabele 1, je bilo največ anketirancev iz starostne skupine med 30 in 39 let (*n* = 56, 32,4 %). V skladu s starostno strukturo ima največ anketirancev 11 in več let delovnih izkušenj (*n* = 103, 63,1 %). Glede na področje dela so se na povabilo k anketiranju v največji meri odzvali zaposleni na oddelku kirurgije (*n* = 125, 72,3 %).

Tabela 1: *Demografski podatki anketirancev*
Table 1: *Demographic data of the study participants*

Demografski podatki / Demographic data	***n***	***%***
Starostna skupina		
21 do 29 let	43	24,9
30 do 39 let	56	32,4
40 do 49 let	46	26,6
50 do 59 let	25	14,5
60 let in več	3	1,7
Skupaj	173	100
Delovna doba		
Manj kot 1 leto	8	4,6
1 do 5 let	31	17,9
6 do 10 let	25	14,5
11 do 25 let	66	38,2
25 let in več	43	24,9
Skupaj	173	100
Področje dela		
Kirurgija	125	72,3
Interna	32	18,5
Pediatrija	7	4,0
Ginekologija	5	2,9
Anestezija	4	2,3
Skupaj	173	100

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

Opis poteka raziskave in obdelave podatkov

Pred začetkom raziskave smo za uporabo omenjenega instrumenta pridobili uradno soglasje avtorja raziskav (McSherry, et al., 2002) o duhovnosti v zdravstveni negi v Veliki Britaniji. Vprašalnik smo prevedli v slovenski jezik tako, da so avtorji raziskave pri tistih trditvah, ki bi bile lahko manj jasne, prevedli izvorne angleške trditve v slovenski jezik in nazaj v angleški jezik. Pregled obeh prevodov je opravil prevajalec. Trditve drugega sklopa SSCR vprašalnika (»Ministrstvo za zdravje RS bi moralo zagotoviti jasne smernice glede nudenja duhovne oskrbe pacientov, ki bi bile v pomoč medicinskim sestram pri obravnavi duhovnih in verskih vprašanj«; »Zbornica zdravstvene in babiške nege Slovenije bi morala postaviti jasne smernice in zagotoviti ustrezno podporo medicinskim sestram pri obravnavi duhovnih in verskih vprašanj pacientov«) smo prilagodili glede na regulatorne institucije za zdravstveno nego in zdravstveno oskrbo v Sloveniji. Anketiranje smo izvedli po pridobitvi soglasja s strani posamezne ustanove – bolnišnice. Razdelitev vprašalnikov smo izvedli v sodelovanju z bolnišnicami, ki so odobrile izvedbo raziskave. Vsak sodelujoči v raziskavi je lahko od te odstopil, če je to želel, prav tako pa je bila anketirancem zagotovljena anonimnost pri izvedbi raziskave in poročanju o njej.

Anonimnost udeležencev smo zagotovili z zbiranjem omejenega števila demografskih spremenljivk, torej le tistih, ki so potrebne za zadosten opis vzorca in preverjanje njihove vloge v stališčih do duhovnosti in duhovne oskrbe znotraj nekaterih sodobnejših raziskav (Kaddourah, et al., 2018; Kavosi, et al., 2018). Izračunali smo opisne statistike (frekvenca, povprečna vrednost, standardni odklon) in uporabili statistične teste (ANOVA, t-test). Pred izvedbo testov smo izračunali povprečno oceno za prvi sklop SSCRS (stališča do duhovnosti in duhovne oskrbe) za posameznega udeleženca in s tem oblikovali spremenljivko kompozitna ocena stališč do duhovnosti in duhovne oskrbe. Z Levenovim testom smo potrdili predpostavko o homogenosti varianc ter normalnost distribucije povprečnih dosežkov v prvem sklopu SSCRS (Kolmogorov-Smirnov test), zato smo v nadaljevanju izvedli inferenčne statistične teste (t-test, ANOVA). Statistične analize smo izvedli s pomočjo statističnega programa SPSS, verzija 23 (SPSS Inc., Chicago, Illinois, ZDA). Vrednosti $p < 0,05$ so veljale za statistično značilne.

Prvi korak v analizi podatkov je bilo preverjanje zanesljivosti in konstruktne veljavnosti (faktorska analiza) dela instrumenta, ki se nanaša na stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe ter na njuno razumevanje (prvi sklop SSCRS). Zanesljivost in konstruktno veljavnost slovenske verzije lestvice SSCRS smo preverili z analizo dimenzionalne strukture ter z analizo zanesljivosti celotne lestvice in njenih dimenzij (zanesljivost kot notranja skladnost – Cronbach alfa). Na sedemnajstih trditvah lestvice SSCRS smo izvedli faktorsko analizo. Ustreznost korelacijske matrike trditev SSCRS za faktorsko analizo smo preverjali z Bartlettovim testom sferičnosti in z mero Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) (Field, 2009). Bartlettov test sferičnosti ($\chi^2 = 924,557$, $p < 0,01$) in mera KMO = 0,821 sta potrdili ustreznost korelacijske matrike za proučevanje dimenzionalne strukture. Faktorska analiza (metoda glavnih komponent, varimax rotacija) je izločila 3 faktorje z lastno vrednostjo več kot 1, ki skupaj pojasnijo 51,7 % variance v odgovorih anketirancev. Kot presečno vrednost faktorskih uteži za določitev faktorske strukture smo, v skladu s postopkom validacije instrumenta po McSherryiju in sodelavcih (2002), določili vrednost ≥+/- 0,35. Faktorsko matriko prikazujemo v Tabeli 2. Dimenzionalna struktura lestvice SSCRS odstopa

od štirih dimenzij stališč do duhovnosti in duhovne oskrbe, ki so jih identificirali McSherry in sodelavci (2002), predvsem z vidika četrtega faktorja, ki so ga ti avtorji poimenovali »individualizirana osebna oskrba«. Ta faktor v naši raziskavi kot samostojna dimenzija ni bil potrjen. Tudi notranji konsistentnosti posameznega faktorja, z izjemo prvega, sta nižji in vprašljivi (Gliem & Gliem, 2003). Zaradi manj zadovoljive stopnje notranje konsistentnosti dveh od treh izločenih dimenzij lestvice SSCRS in zaradi dobre notranje konsistentnosti celotne lestvice (Cronbach α = 0,83) smo v nadaljnjih analizah 17 trditev obravnavali kot enodimenzionalno mero stališč do duhovnosti in duhovne oskrbe.

Tabela 2: *Faktorska matrika in deskriptivne statistike trditev prvega sklopa SSCRS*
Table 2: *Factor matrix with descriptive statistics for the first part of SSCRS*

Trditve prvega sklopa SSCRS / Items of the first part of SSCRS	***n***	$\bar{x}$	***s***	***Faktorji/Factors***		
				Opredelitev duhovnosti / Definition of spirituality	***Duhovna oskrba / Spiritual care***	***Religija in duhovnost / Religion and spirituality***
Duhovnost je povezovalna sila, ki omogoča posamezniku iskanje miru pri samem sebi in v povezavi z zunanjim svetom.	172	4,08	0,74	0,85	0,04	0,13
Duhovnost je imeti občutek upanja v življenju.	169	3,87	0,88	0,79	0,25	−0,09
Duhovnost je povezana s sposobnostjo živeti v sedanjosti, tukaj in sedaj.	171	3,68	0,97	0,78	0,17	−0,05
Duhovnost vključuje osebna prijateljstva in ljubezenska razmerja.	171	3,43	1,03	0,61	−0,02	0,21
Medicinske sestre lahko zagotavljajo duhovno oskrbo, tako da spoštujejo pravico do zasebnosti, dostojanstva ter da spoštujejo kulturna in verska prepričanja pacienta.	171	4,27	0,82	0,57	0,21	0,23
Duhovnost vključuje človeško moralo.	171	3,79	1,04	0,49	0,28	0,17
Duhovnost je iskanje smisla v vsem, kar nam prinaša življenje, dobro in slabo.	173	3,75	0,97	0,46	0,36	0,15
Medicinske sestre lahko zagotavljajo duhovno oskrbo tako, da pomagajo pacientu najti smisel njegove bolezni.	172	3,01	1,16	0,44	0,28	−0,45
Duhovnost vključuje potrebo, da ti je odpuščeno in da odpuščaš.	170	3,72	1,06	0,39	0,61	−0,12
Medicinske sestre lahko zagotavljajo duhovnost s tem, da pacientu posvetijo čas in nudijo podporo, ko jo pacient potrebuje.	173	3,99	0,87	0,21	0,75	0,18
Medicinske sestre v času obravnave lahko zagotavljajo duhovno oskrbo pacientu z izkazovanjem prijaznosti, skrbi in vedrine.	172	4,20	0,76	0,08	0,72	0,20
Medicinske sestre lahko zagotavljajo duhovno oskrbo pacientu tako, da organizirajo obisk duhovnika oziroma duhovnega vodje drugih veroizpovedi, če pacient za to zaprosi.	172	4,08	1,00	0,08	0,66	−0,05
Medicinske sestre lahko zagotavljajo duhovno oskrbo s poslušanjem pacienta in z omogočanjem, da razpravlja o svojih strahovih, bojaznih in težavah ter jih raziskuje.	172	3,83	0,90	0,51	0,38	−0,02
Duhovnost vključuje le obiskovanje cerkev oziroma drugih sakralnih objektov.	173	1,73	0,97	0,05	0,15	0,80
Duhovnost je omejena le na prepričanje oziroma vero v Boga ali drugo višje bitje.	173	1,88	1,00	0,00	0,10	0,78
Umetnost, ustvarjalnost in samoizražanje niso del duhovnosti.	173	2,33	1,13	0,11	0,01	0,59
Ateisti in agnostiki se ne srečujejo z duhovnostjo.	173	2,03	0,98	0,38	0,05	0,57
Odstotek pojasnjene variance	/	/	/	30,10	13,15	8,41
Koeficient notranje konsistentnosti Cronbach alfa (α)	/	/	/	0,82	0,66	0,69

Legenda / Legend: n – število / number; $\bar{x}$ – povprečje / average; s – standardni odklon / standard deviation

Rezultati

V prvem sklopu SSCRS so anketiranci odgovarjali na trditve o tem, kakšno je njihovo razumevanje pojmov duhovnost in duhovna oskrba ter kakšna so njihova stališča do njiju. Tabela 2 prikazuje faktorje s pripadajočimi trditvami prvega sklopa SSCRS, povprečno vrednost ($\bar{x}$) in standardni odklon (s) ocen posamezne trditve prvega sklopa SSCRS. Kot je razvidno iz Tabele 2, so anketiranci izrazili najvišjo stopnjo strinjanja pri trditvah, ki se nanašajo na opredelitev duhovne oskrbe pacienta in njegove duhovnosti. Anketiranci so ocenili najvišje povprečno strinjanje ($\bar{x}$ = 4,27, s = 0,82) s trditvijo »Medicinske sestre lahko zagotavljajo duhovno oskrbo, tako da spoštujejo pravico do zasebnosti, dostojanstva ter da spoštujejo kulturna in verska prepričanja pacienta«. Prav tako se anketiranci strinjajo s trditvijo »Medicinske sestre v času obravnave lahko zagotavljajo duhovno oskrbo pacientu z izkazovanjem prijaznosti, skrbi in vedrin« ($\bar{x}$ = 4,2, s = 0,76). Najnižjo stopnjo strinjanja so anketiranci izrazili za trditve, ki se nanašajo na opredelitev duhovnosti zgolj z vidika religioznosti: »Duhovnost vključuje le obiskovanje cerkev oz. drugih sakralnih objektov« ($\bar{x}$ = 1,73, s = 0,97); »Duhovnost je omejena le na prepričanje oz. vero v Boga ali drugo višje bitje« ($\bar{x}$ = 1,88, s = 1,00); »Ateisti in agnostiki se ne srečujejo z duhovnostjo« ($\bar{x}$ = 2,03, s = 0,98).

V nadaljevanju so nas zanimale statistično pomembne razlike med dosežkom v prvem sklopu trditev SSCRS in demografskimi podatki: (i) samoocena anketirancev, ali so verni/religiozni ali ne (dihotomna spremenljivka); (ii) spol (dihotomna spremenljivka); (iii) starost (starostne kategorije). Analiza je pokazala statistično pomembne razlike v povprečnem dosežku v prvem sklopu SSCRS za samooceno anketirancev, ali (i) so verni/religiozni in ali (ii) prakticirajo veroizpoved ali ne. Povprečni dosežek v prvem sklopu SSCRS za anketirance, ki so na vprašanje »Ali ste verni / religiozni?« odgovorili »Da« (n = 114, $\bar{x}$ = 3,48, s = 0,41), se statistično pomembno razlikuje od povprečnega dosežka anketirancev, ki so na to vprašanje odgovorili »Ne« (n = 58, $\bar{x}$ = 3,23, s = 0,41), saj znaša t = 3,76 in je pomemben na ravni tveganja, p < 0,001. Med anketiranci, ki so na vprašanje »Ali prakticirate veroizpoved?« odgovorili »Da« (n = 64, $\bar{x}$ = 3,48, s = 0,39), in tistimi, ki so odgovorili »Ne« (n = 102, $\bar{x}$ = 3,33, s = 0,43), obstaja statistično pomembna razlika v ocenjevanju trditev lestvice (t = 2,32, p = 0,02). Za demografski spremenljivki spol in starost nismo ugotovili statistično pomembnih razlik v povprečnem dosežku v prvem sklopu SSCRS: spol (t = 0,13, p = 0,89) in starostne kategorije (F = 0,51, p = 0,73).

Drugi sklop SSCRS je ugotavljal, katere ukrepe bi bilo treba po mnenju zaposlenih v zdravstveni negi uvesti na področju nudenja duhovne oskrbe pacientov. Sklop je vseboval 6 trditev, ki so jih anketiranci ocenjevali s pomočjo petstopenjske Likertove lestvice. Rezultati so prikazani v Tabeli 3.

Kot je razvidno iz Tabele 3, se anketiranci najbolj strinjajo s trditvijo, da med izobraževanjem ne pridobijo dovolj znanja za nudenje duhovne oskrbe ($\bar{x}$ = 3,50, s = 1,06), ter tudi s trditvami, v sklopu katerih sta Zbornica zdravstvene in babiške nege Slovenije ($\bar{x}$ = 3,48, s =1,09) in Ministrstvo za zdravje RS ($\bar{x}$ = 3,46, s =1,08) tisti instituciji, ki bi morali postaviti smernice in zagotoviti ustrezno podporo zaposlenim v zdravstveni negi pri

Tabela 3: *Deskriptivne statistike za trditve drugega sklopa SSCRS*
Table 3: *Descriptive statistics for the second part of SSCRS*

Trditve drugega sklopa SSCRS / Items of the second part of SSCRS	***n***	***1 (n / %)***	***2 (n / %)***	***3 (n / %)***	***4 (n / %)***	***5 (n / %)***	$\bar{x}$	***s***
Duhovnost in duhovna oskrba sta temeljna vidika zdravstvene nege.	170	21/ 12,4	42/ 24,7	52/ 30,6	48/ 28,2	7/ 4,0	2,88	1,08
Medicinske sestre med študijem ne pridobijo dovolj znanja in niso dovolj usposobljene, da bi lahko nudile kakovostno duhovno oskrbo pacientu.	171	6/ 3,5	29/ 16,8	37/ 21,6	72/ 42,2	27/ 15,6	3,50	1,06
Duhovnosti in duhovne oskrbe pacienta ni treba obravnavati v okviru programa izobraževanja medicinskih sester.	171	33/ 19,1	52/ 30,4	45/ 26,3	29/ 16,8	12/ 6,9	2,62	1,18
Ministrstvo za zdravje RS bi moralo zagotoviti jasne smernice glede nudenja duhovne oskrbe pacientov, ki bi bile v pomoč medicinskim sestram pri obravnavi duhovnih in verskih vprašanj.	171	10/ 5,8	19/ 11,1	56/ 32,7	57/ 33,5	29/ 16,8	3,46	1,08
Zbornica zdravstvene in babiške nege Slovenije bi morala postaviti jasne smernice in zagotoviti ustrezno podporo medicinskim sestram pri obravnavi duhovnih in verskih vprašanj pacientov.	172	11/ 6,4	20/ 11,6	46/ 26,7	68/ 39,3	28/ 16,2	3,48	1,09
Izobraževanja s področja duhovne oskrbe bi morala biti nujen sestavni del izobraževanj za podelitev licenčnih točk.	171	26/ 15	38/ 22,2	44/ 25,7	44/ 26,0	19/ 11,0	2,96	1,24

Legenda / Legend: n – število / number; $\bar{x}$ – povprečje / average; s – standardni odklon / standard deviation; 1 – sploh se ne strinjam / strongly disagree; 2 – se ne strinjam / disagree; 3 – negotov / uncertain; 4 – se strinjam / agree; 5 – zelo se strinjam / strongly agree

obravnavi duhovnih in verskih vprašanj pacientov. V zvezi s trditvijo, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege, je bilo največ (n = 53, 30,6 %) anketirancev negotovih ($\bar{x}$ = 2,88, s = 1,08).

Diskusija

Rezultati raziskave so pokazali, da anketirani zaposleni v zdravstveni negi povezujejo duhovnost predvsem z razumevanjem samega sebe in odnosom do sebe ter zunanjega sveta, s sposobnostjo živeti življenje v vsakem trenutku, najmanj pa z religijo, z vero v Boga ali drugo višje bitje ter z obiskom sakralnih objektov. Podobne rezultate je pokazala raziskava, ki sta jo izvedla McSherry in Jamieson (2013) med medicinskimi sestrami v Veliki Britaniji. Naša raziskava potrjuje, da imajo anketirani zaposleni v zdravstveni negi širok, eklektičen in inkluzivni način dojemanja koncepta duhovnosti, kar pomeni, da duhovnosti ne povezujejo izključno z vero v Boga ali drugo višjo silo, temveč jo pojmujejo predvsem kot motivacijski konstrukt, ki posameznika vodi in usmerja pri iskanju miru, upanja, bližine drugega, smisla, odpuščanja. To so ključni pojmi, ki opredeljuje duhovnost (Hsiao, et al., 2011) in lahko, ali pa tudi ne, vključujejo religijo, verske rituale in objekte (Pike, 2011). Za nekatere posameznike pomeni duhovnost priznanje obstoja božanstva ali osebnega odnosa z Bogom, za druge pa je duhovnost izraz najbolj iskrenega sebstva ali notranjega bitja (Mayers & Johnston, 2008).

Iz povprečnih ocen prvega sklopa SSCRS je razvidno, da anketirani ne enačijo pojma duhovnosti s pojmom religije, kot tudi ne ločujejo strogo pojma duhovnosti in religije, temveč ju povezujejo v enoten koncept duhovnosti. Ločevanje ali izvzemanje religije iz koncepta duhovnosti je prisotno v zdravstveni negi v evropskem prostoru predvsem kot posledica sekularizacije (Timmins & McSherry, 2012). Nekateri avtorji tak pristop k razumevanju odnosa med religijo in duhovnostjo kritizirajo (Pesut, 2008; Pike, 2011). S poudarjenim ločevanjem duhovnosti in religije se želi v literaturi zdravstvene nege poudariti, da je treba tudi pri pacientih, ki se ne opredelijo kot verni oziroma religiozni, prepoznavati individualno duhovno dimenzijo in duhovne potrebe (Pesut, 2008; Gedrih & Pahor, 2009). Strogo ločevanje obeh konceptov lahko uveljavi predstavo o posamezniku kot »nematerialnem bitju« (Pesut, 2008, p. 170), s poudarjeno čustveno dimenzijo, brez vedenjske dimenzije delovanja oziroma brez ritualov, praks in duhovnih objektov, ki se najpogosteje povezujejo s konceptom religije kot institucionalizirane in opredmetene duhovnosti. V tem pogledu lahko religijo razumemo kot eno od oblik izkazovanja posameznikove duhovnosti, ki jo pri izvajanju celostne oskrbe pacienta moramo upoštevati (Timmins & McSherry, 2012). Tako razumevanje med anketiranimi zaposlenimi v zdravstveni negi nakazujejo tudi rezultati naše raziskave.

V raziskavi, opravljeni v eni od slovenskih splošnih bolnišnic, Šolar in Mihelič Zajec (2007, p. 144) ugotavljata »deljena mnenja« zaposlenih v zdravstveni negi o tem, »da je zadovoljevanje duhovnih potreb prioriteta oziroma da se njihovo izvajanje omogoči šele po opravljenih ostalih aktivnostih, ki imajo po mnenju anketirancev prednost«. Kljub temu da naša raziskava na podlagi ocen trditev prvega sklopa SSCRS nakazuje široko razumevanje koncepta duhovnosti, povprečne ocene trditev drugega sklopa vprašalnika nakazujejo podobna stališča anketiranih zaposlenih v zdravstveni negi, kot jih navajata Šolar in Mihelič Zajec (2007), pa tudi Babnik in Karnjuš (2014). Glede trditve, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege, je bilo največ anketiranih negotovih, približno enak delež pa se jih s to trditvijo ni strinjalo oziroma sploh ni strinjalo. To pomeni, da duhovna oskrba po prepričanju anketiranih zaposlenih v zdravstveni negi ni eno od prednostnih področij zdravstvene nege. K takim rezultatom verjetno prispeva tudi dejstvo, da je največ anketiranih zaposlenih na kirurških oddelkih bolnišnic. Njihove izkušnje iz kliničnega okolja z obravnavo duhovnih potreb pacientov so predvsem vezane na paciente, ki so po operativnem posegu zelo kratek čas v bolnišnici oziroma na oddelku. Koncepta duhovnosti in duhovne oskrbe izhajata iz bio- in psihosocialnega modela zdravja in bolezni (Borrell-Carrió, et al., 2004) ter nadgradnje tega z bio- in psihosocialno-duhovnim modelom (Sulmasy, 2002). Nekatere dosedanje raziskave (Babnik, et al., 2017) nakazujejo, da celostna obravnava posameznika še ni povsem uveljavljena v predstavi o zdravstveni negi. Duhovni oskrbi kot sestavnemu delu celostne obravnave je v praksi namenjeno premalo pozornosti (Battey, 2012), še posebno izven paliativne oskrbe, saj se pomen duhovnosti ne izraža zgolj v času umiranja (McSherry & Jamieson, 2011). K dajanju manjšega pomena duhovni oskrbi verjetno prispeva tudi dejstvo, da proces duhovne oskrbe v zdravstveni negi še ni v celoti opredeljen. Nekatere konkretne usmeritve izvajanja duhovne oskrbe so v literaturi podane za fazo ocene duhovnega stanja in duhovnih potreb pri pacientih (Elliott, 2011; Daly & Fahey-McCarthy, 2014), primanjkuje pa jasnih usmeritev za izvajanje intervencij in njihove evalvacije. Odgovori anketiranih zaposlenih v zdravstveni negi na prvi sklop SSCRS kažejo razumevanje duhovne oskrbe v zdravstveni negi predvsem kot izražanje prijaznosti, skrbi, posvečanje časa pacientu, podpore ter spoštovanja zasebnosti pacientov, njihovega dostojanstva ter verskih in kulturnih prepričanj. Tudi druge raziskave, opravljene v različnih kulturnih in verskih okoljih z vprašalnikom SSCRS, kažejo prevladujoče prepričanje zaposlenih v zdravstveni negi, da sta odnos do pacienta (skrb, izražanje pozitivnih čustev, podpora) in terapevtska komunikacija ključna elementa duhovne

oskrbe v zdravstveni negi (Kostak & Celikkalp, 2016; Kaddourah, et al., 2018), pa tudi v drugih zdravstvenih strokah, na primer v delovni terapiji (Mthembu, et al., 2016).

Polovica anketiranih zaposlenih v zdravstveni negi je bila negotovih v zvezi s potrebo po vključevanju duhovne oskrbe v izobraževanje v zdravstveni negi. Podobno ugotavljata tudi Babnik in Karnjuš (2014). Anketirani zaposleni v zdravstveni negi so imeli bolj izraženo mnenje glede tega, da med študijem ne pridobijo dovolj znanja za nudenje duhovne oskrbe. Tudi ugotovitve drugih raziskav (McSherry & Jamieson, 2011, 2013; Kostak, & Celikkalp, 2016; Murray & Dunn, 2017) kažejo, da zaposleni v zdravstveni negi nimajo dovolj znanja o duhovnosti in zadovoljevanju duhovnih potreb. To nakazuje na potrebo po uvedbi predmetov, ki bi v času formalnega izobraževanja obravnavali pojem duhovnosti in duhovne oskrbe. Pred tem korakom je potrebna jasna opredelitev procesa izvajanja duhovne oskrbe v sklopu zdravstvene nege (Ramezani, et al., 2014), kar anketirani v raziskavi potrjujejo s stališčem, da bi bilo treba pripraviti jasne smernice in navodila za nudenje ustrezne in kakovostne duhovne oskrbe pacientov.

Predstavljena raziskava ima tudi svoje omejitve, ki se nanašajo predvsem na psihometrične značilnosti uporabljenega vprašalnika in na velikost vzorca. V raziskavi ni bila potrjena dimenzionalna struktura prvega sklopa vprašalnika SSCRS. V raziskavi opravljena faktorska analiza je pokazala, da se trditve dimenzije »individualizirana osebna oskrba« izvornega vprašalnika (McSherry, et al., 2002) združujejo v širši nadrejeni koncept duhovne oskrbe in ne v samostojno dimenzijo duhovne oskrbe, kot to velja za izvorni vprašalnik. Razloge za tako odstopanje lahko iščemo predvsem v pojmovanju duhovnosti in duhovne oskrbe med anketiranimi, kar je lahko posledica nekoliko specifičnega poklicnega in / ali širšega družbenega kulturnega okolja. Podobno ugotavljajo tudi Martins in sodelavci (2015), ki so sicer potrdili zanesljivost prvega sklopa vprašalnika SSCRS, ne pa tudi njegove dimenzionalne strukture. Dve raziskavi, ki sta opisovali psihometrične značilnosti vprašalnika SSCRS, o dimenzionalni strukturi tega vprašalnika ne poročata (Khoshknab, et al., 2010; van Leeuwen & Schep-Akkerman, 2015). Potrditev dimenzionalne strukture prvega sklopa vprašalnika SSCRS zahteva dodatne, tudi medkulturne, raziskave. Druga omejitev zaključevanja se nanaša na velikost vzorca. V raziskavo smo zajeli le majhen vzorec zaposlenih v zdravstveni negi. Smiselno bi bilo narediti raziskavo na nacionalni ravni, s pomočjo katere bi lahko pridobili jasnejši pogled na trenutno znanje in stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe. S pomočjo dobljenih rezultatov bi lahko vplivali na postavitev jasnih smernic in navodil, ki bi bile zaposlenim v zdravstveni negi v pomoč pri izvajanju celostne oskrbe pacienta.

Zaključek

Predstavili smo, kako vzorec zaposlenih v zdravstveni negi razume koncept duhovnosti in duhovne oskrbe ter kakšna je njihova vloga pri prepoznavanju duhovnih potreb pacientov ter nudenju ustrezne duhovne oskrbe. Rezultati so pokazali, da anketirani pojem duhovnosti povezujejo predvsem z razumevanjem samega sebe in odnosom, ki ga imajo do sebe in zunanjega sveta, ne strinjajo pa se, da lahko duhovnost in religijo / vero enačimo. Razumevanje koncepta duhovne oskrbe povezujejo predvsem s spoštovanjem posameznika v vseh pogledih ter z izkazovanjem prijaznosti in skrbi. Anketirani v raziskavi se zavedajo pomena duhovne oskrbe pacientov v kliničnem okolju, hkrati pa izražajo negotovost glede tega, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege. Slednje nakazuje pomanjkanje razumevanja koncepta duhovnosti in duhovne oskrbe med anketiranci. Vzroke je mogoče iskati v pomanjkanju znanja, torej primanjkljaju na področju izobraževanja, zato bi bilo treba v študijske programe na dodiplomskem in podiplomskem študiju uvesti vsebine, ki obravnavajo duhovnost in duhovno oskrbo.

Conflict of interest / Nasprotje interesov

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

Funding / Financiranje

The study received no funding. / Raziskava ni bila finančno podprta.

Ethical approval / Etika raziskovanja

The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014). / Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014).

Author contributions / Prispevek avtorjev

All three authors planned the survey. The second and the third author translated and adapted the instrument used for the Slovene population. The first author collected data. The second and the third authors participated in the data analysis. All three authors contributed to the preparation of the article: Introduction, Method, Results, Discussion and Conclusion. / Vsi trije avtorji so načrtovali raziskavo, drugi in tretji avtor sta prevedla in priredila za slovensko populacijo uporabljen instrument. Prva

avtorica je zbirala podatke, drugi in tretji avtor pa sodelovala v analizi podatkov. Vsi trije avtorji so prispevali k pripravi vsebine in zapisa delov članka: Uvod, Metoda, Rezultati, Diskusija in Zaključek.

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Cite as / Citirajte kot:
Montanič Starc, T., Karnjuš, I. & Babnik, K., 2019. Attitudes towards spirituality and spiritual care among nursing employees in hospitals. *Obzornik zdravstvene nege*, 53(1), pp. 31–48.
https://doi.org/10.14528/snr.2019.53.1.313

Izvirni znanstveni članek / Original scientific article

Zdravstvena pismenost in sladkorna bolezen: študija primera na skupini pacientov v specialistični ambulanti za zdravljenje sladkorne bolezni

Health literacy and diabetes: a case study on a group of patients in specialist outpatient clinic for diabetes

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Ključne besede: funkcionalna pismenost; zdravje; zdravstvena vzgoja; sladkorna bolezen

Key words: functional literacy; health; health education; diabetes

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IZVLEČEK

Uvod: Sladkorna bolezen zahteva od pacienta učinkovito samooskrbo, h kateri pripomore tudi zdravstvena pismenost. V skladu s tem je bil cilj raziskave na vzorcu pacientov s sladkorno boleznijo ugotoviti, kakšna je stopnja splošne in specifične zdravstvene pismenosti.

Metode: Izvedena je bila študija primera, v katero je bilo vključenih 36 pacientov s sladkorno boleznijo. Instrumenta za zbiranje podatkov sta bila vprašalnik za oceno splošne zdravstvene pismenosti ter vprašalnik za oceno specifične zdravstvene pismenosti. Zbrani podatki so bili analizirani s pomočjo deskriptivne statistike (frekvence, aritmetične sredine, standardne deviacije). Za vprašalnik splošne zdravstvene pismenosti smo izračunali zanesljivost (Cronbach alpha = 0,94) in analizirali dimenzionalno strukturo (faktorska analiza).

Rezultati: Na področju splošne zdravstvene pismenosti so udeleženci dosegli najnižji rezultat pri preprečevanju bolezni ($\bar{x}$ = 2,89, s = 0,85), najvišji pa pri promociji zdravja ($\bar{x}$ = 3,13, s = 0,79). Osebe, ki so sodelovale v raziskavi, izkazujejo visoko specifično zdravstveno pismenost, saj so bili njihovi odgovori na večino vprašanj vprašalnika o specifični zdravstveni pismenosti pacientov s sladkorno boleznijo v povprečju 82 % pravilni.

Diskusija in zaključek: Rezultati raziskave potrjujejo ustrezno stopnjo specifične zdravstvene pismenosti na področju sladkorne bolezni pri skupini pacientov, zajetih v raziskavo. Nekoliko slabša je njihova splošna zdravstvena pismenost na področju preprečevanja bolezni in zagotavljanja zdravega življenjskega sloga.

ABSTRACT

Introduction: Diabetes requires effective self-care from patients and in this respect, health literacy is a great contributor to effective disease self-management. Accordingly, the aim of the study was to determine the level of general and specific health literacy on a sample of patients with diabetes.

Methods: A case study involving 36 patients with diabetes was conducted. The data collection instrument included two questionnaires for evaluating general and specific health literacy. The collected data were analysed using descriptive statistics (frequency, arithmetic mean, standard deviation). The reliability (Cronbach alpha = 0,94) and the dimensional structure (factor analysis) were analysed for the general health literacy questionnaire.

Results: With regard to general health literacy, the participants achieved the lowest result in the area of disease prevention ($\bar{x}$ = 2.89, s = 0.85), and the highest in the area of health promotion ($\bar{x}$ = 3.13, s = 0.79). Patients who participated in the study demonstrated high specific health literacy as their answers to most questions regarding specific health literacy were 82 % accurate, on average.

Discussion and conclusion: The results of the survey have confirmed the appropriate level of specific diabetes health literacy in a small group of patients included in the study. Their general health literacy is somewhat lower in the area of disease prevention and healthy lifestyle.

Članek je nastal na osnovi diplomskega dela Ines Skok *Zdravstvena pismenost pacienta s sladkorno boleznijo* (2015).

Prejeto / Received: 11. 3. 2018
Sprejeto / Accepted: 2. 2. 2019

https://doi.org/10.14528/snr.2019.53.1.233

Uvod

Pismenost predstavlja za posameznika pomemben dejavnik kakovosti življenja (Boyle, et al., 2013). Gre za zmožnost, ki se razvija vse življenje v različnih okoliščinah, področjih in vključuje osnove branja, pisanja, razumevanja in računanja (Hozjan, et al., 2014). Pismenost je pomembna determinanta zdravja in dobrega počutja skozi celotno življenje, še posebej v starosti, ko je posameznik pogosto postavljen pred pomembne zdravstvene odločitve (Ownby, et al., 2012; Boyle, et al., 2013).

V sodobni družbi se klasična pismenost že leta nadgrajuje z informacijsko, matematično, naravoslovno, kulturno pismenostjo, zadnja leta tudi s konceptom zdravstvene pismenosti (Babnik, et al., 2013). Sørensen in sodelavci (2012) definirajo zdravstveno pismenost kot posameznikovo znanje, motivacijo ter sposobnost: i) za dostop do zdravstvenih informacij in njihovo razumevanje; ii) oceniti in uporabljati zdravstvene informacije; iii) o zdravstvenih informacijah znati presojati in sprejemati odločitve v vsakodnevnem življenju v povezavi s promocijo zdravja, ohranjanjem ali izboljšanjem zdravja v vseh življenjskih obdobjih. Nutbeam (2009) opredeljuje kot zdravstveno pismenega posameznika tisto osebo, ki zna poiskati osnovne zdravstvene informacije, jih razume ter jih je sposobna ovrednotiti in uporabiti pri odločanju glede svojega zdravja. Čeprav so nekatere splošne veščine in sposobnosti, ki jih imenujemo temeljne, generične ali pričakovane kompetence (bralna in številčna pismenost, socialne kompetence, uporaba informacijsko-komunikacijske tehnologije itd.) (Kohont, 2011), prenosljive po različnih kontekstih bolezni in zdravja, so za uspešno obvladovanje in vodenje specifičnih bolezni in stanj potrebne tudi za bolezen ali zdravstveno stanje specifične veščine, znanja in kompetence (Yamashita & Kart, 2011). Med specifične zdravstvene pismenosti sodi tudi zdravstvena pismenost pacientov s sladkorno boleznijo. Specifična zdravstvena pismenost pacientov s sladkorno boleznijo se proučuje kot samostojen koncept, povezan s splošno zdravstveno pismenostjo kot mero generičnih kompetenc na področju zdravja, od splošne pismenosti pa se razlikuje po: (i) operacionalizaciji koncepta in (ii) uporabljenih instrumentih (vprašalnikih) (Yamashita & Kart, 2011).

Sladkorna bolezen kot kronično obolenje je ena od bolezni, ki predstavljajo »svetovno pandemijo« (Hjelm, et al., 2003), hkrati pa je to bolezen, ki zahteva veliko mero samodiscipline in samonadzora s strani samega pacienta (Mori Lukančič, et al., 2011). Samostojno obvladovanje sladkorne bolezni je pogojeno z ustrezno zdravstveno vzgojo, ki mora biti stalen, individualiziran, večplasten proces podpore pacientom, da bi z izboljšanjem znanja in veščin vključili obvladovanje bolezni v svoje vsakdanje življenje (Riemenschneider, et al., 2018). Veščine in znanja za samostojno obvladovanje bolezni združujemo pod pojmom specifična zdravstvena pismenost oseb s sladkorno boleznijo (Yamashita & Kart, 2011). Merila uspešnosti samostojnega obvladovanja sladkorne bolezni, ki so v študijah odnosa med zdravstveno pismenostjo oseb s sladkorno boleznijo pogosto obravnavana kot odvisne spremenljivke, so (Egbujie, et al., 2018): krvni sladkor (najpogosteje glikirani hemoglobin), koncentracije lipidov v krvi, krvni tlak, indeks telesne mase, telesna dejavnost, spoštovanje navodil za jemanje terapije (adherenca), število obiskov klinike, vnos sadja in / ali zelenjave oziroma kombinacija navedenih meril.

Raziskave, ki proučujejo odnos med zdravstveno pismenostjo oseb s sladkorno boleznijo in vrednostjo glikiranega hemoglobina, ne dajejo konsistentnih odgovorov oziroma nekatere tega odnosa ne potrjujejo (Morris, et al., 2006; Mancuso, 2010; Yamashita & Kart, 2010), druge pa (Schillinger, et al., 2002; Ying Ho, et al., 2008). Bolj konsistentno raziskave (Rothman, et al., 2004; Ying Ho, et al., 2008) potrjujejo pomen izvajanja zdravstvene vzgoje za doseganje višje ravni samostojnega obvladovanja sladkorne bolezni med pacienti s sladkorno boleznijo, ki imajo nizko stopnjo zdravstvene pismenosti. Pacienti z ustrezno stopnjo zdravstvene pismenosti bolje razumejo navodila in razlago simptomov sladkorne bolezni ter pogosteje iščejo zdravstveno pomoč, ko je ta res potrebna (Coffman, et al., 2012). Long in Gambling (2011) sta dokazala, da z zdravstvenovzgojnimi programi s področja obvladovanja sladkorne bolezni povečamo stopnjo zdravstvene pismenosti pacientov s sladkorno boleznijo, stopnjo zaupanja do zdravstvenega osebja in kompetentnost na področju prenosa pridobljenega znanja v vsakdanje življenje. Stopnja zdravstvene pismenosti pacientov s sladkorno boleznijo odraža stopnjo znanja o sladkorni bolezni (Cavanaugh, 2011) ter je pozitivno povezana z vedenjem, ki pripomore k samostojnemu obvladovanju bolezni (Yamashita & Kart, 2010; Cavanaugh, 2011; Chen, et al., 2014; Xu et al., 2014).

Namen in cilji

Glede na dobro oblikovano oskrbo pacientov s sladkorno boleznijo v slovenskem zdravstvenem sistemu in umeščenost vanj smo se odločili, da izvedemo raziskavo z namenom ugotoviti: (i) stopnjo splošne zdravstvene pismenosti in (ii) specifične zdravstvene pismenosti na manjšem vzorcu pacientov s sladkorno boleznijo, ki so vodeni v eni od slovenskih specialističnih ambulant za zdravljenje sladkorne bolezni.

Kot vodilo pri izvedbi raziskave smo si zastavili dve raziskovalni vprašanji:

- Kakšna je stopnja splošne zdravstvene pismenosti pri pacientih s sladkorno boleznijo?
- V kolikšni meri pacienti s sladkorno boleznijo poznajo svojo bolezen in imajo znanje za njeno samostojno vodenje?

Metode

Pilotna raziskava zdravstvene pismenosti in specifične zdravstvene pismenosti pacientov s sladkorno boleznijo je bila izvedena kot eksploratorna študija primera. Temeljila je na kvantitativni neeksperimentalni metodologiji z anketo kot tehniko zbiranja podatkov. Študija primera namreč pomeni znanstveno preučevanje določenega pojava v resničnem življenju in v lastnem okolju (Ridder, 2017), pri čemer je primer (angl. *case*) lahko »posameznik, skupina, organizacija, dogodek, problem ali določena anomalija« (Ridder, 2017, p. 282), ki ga proučujemo s pomočjo kvalitativnih ali kvantitativnih metod. Kot še ugotavlja avtor, je ena od oblik študij primera tudi eksploratorna študija primera, ki je pilotne narave in daje izhodišča za nadaljnje bolj poglobljene ali bolj obsežne raziskave.

Opis instrumenta

Uporabljeni instrument je bil sestavljen iz treh delov:

(I) Demografski podatki udeležencev: spol, starost, izobrazba, kako in koliko časa se zdravi sladkorna bolezen.

(II) Splošna zdravstvena pismenost: Drugi del vprašalnika predstavlja prevod in priredbo vprašalnika *European Health Literacy Survey Questionnaire* (HLS-EU-Q) avtorjev Sørensena in sodelavcev (2015). Prevod in priredbo vprašalnika za slovensko populacijo je pripravil Zavod VIVA (2013; Kojić, 2013). Za uporabo navedenega vprašalnika smo pridobili dovoljenje direktorice Zavoda VIVA, ki je vprašalnik prevedel v slovenščino. V raziskavi smo uporabili 25 trditev vprašalnika. Trditve so udeleženci ocenjevali na štiristopenjski lestvici, pri čemer pomeni ocena 1 »zelo težko«, ocena 4 »zelo enostavno«. Raziskava, opravljena v Sloveniji (Kojić, 2013; Zavod VIVA, 2013), in raziskava mednarodnega projekta (Sørensen, et al., 2015) sta potrdili tridimenzionalno strukturo vprašalnika, ki vključuje dimenzije »Zdravstvena pismenost na področju zdravstvene oskrbe«, »Zdravstvena pismenost na področju preprečevanja bolezni« in »Zdravstvena pismenost na področju promocije zdravja«. Analizirali smo zanesljivost vprašalnika in dimenzionalno strukturo, saj je bila v raziskavi Zavoda VIVA (2013; Kojić, 2013) validacija vprašalnika opravljena na splošni populaciji in ne na specifični kot v primeru te raziskave (pacienti s sladkorno boleznijo). Zanesljivost, izražena kot notranja konsistentnost vprašalnika, je dobra, saj znaša Cronbach alpha 0,94.

Faktorska analiza (metoda glavnih komponent, varimax rotacija) je izločila 3 faktorje z lastno vrednostjo več kot 1, ki skupaj pojasnijo 63,93 % variance v odgovorih udeležencev. Dimenzionalno strukturo vprašalnika prikazujemo v Tabeli 1. Prvi faktor smo poimenovali »Zdravstvena pismenost na področju zdravstvene oskrbe«, saj vključuje trditve, ki označujejo pridobivanje, razumevanje, oceno in uporabo informacij v procesu in med deležniki zdravstvene oskrbe. Zanesljivost dimenzije je ustrezna (Cronbach alpha = 0,94). Drugi faktor – »Zdravstvena pismenost na področju preprečevanja bolezni« – vključuje trditve, ki se nanašajo predvsem na iskanje oziroma pridobivanje informacij, nujno potrebnih za preprečevanje in obvladovanje bolezni, in prav tako kaže ustrezno notranjo konsistentnost (Cronbach alpha = 0,90). Tretji faktor smo poimenovali »Zdravstvena pismenost na področju promocije zdravja«, saj vključuje trditve, ki se nanašajo predvsem na obdelavo informacij glede aktivnosti preprečevanja bolezni. Tudi zadnji faktor ima zadovoljivo notranjo konsistentnost (Cronbach alpha = 0,70). Vsebinsko strukturo vprašalnika o splošni zdravstveni pismenosti je tako potrdila tudi naša raziskava, čeprav je zaradi majhnega vzorca dobljena struktura manj zanesljiva in ne omogoča zaključevanja vsebinske veljavnosti vprašalnika za slovensko populacijo.

(III) Specifična zdravstvena pismenost pacientov s sladkorno boleznijo: Vprašalnik smo povzeli po različnih vprašalnikih za merjenje specifične zdravstvene pismenosti pacientov s sladkorno boleznijo (Toobert, et al., 2000; Nath, et al., 2001), in po vprašalniku avtorjev Huizinga in sodelavcev (2008) *Diabetes Numeracy Test* (DNT). Prilagoditev vprašalnika našemu vzorcu je temeljila na prilagoditvi specifičnemu vzorcu v študiji –pacientom s sladkorno boleznijo, ki različno obvladujejo svojo bolezen in med katerimi nimajo vsi inzulinske terapije.

Opis vzorca

V raziskavo smo zajeli paciente ambulante za zdravljenje sladkorne bolezni, ki so v času poteka raziskave prišli na kontrolni pregled k zdravniku diabetologu. Vzorec je bil namenski. Razdeljenih je bilo 40 vprašalnikov pacientom, ki so v določenem časovnem obdobju obiskali specifično ambulanto. Veljavnih in v celoti izpolnjenih je bilo 36 vprašalnikov.

Vprašalnik je izpolnilo 10 moških in 26 žensk. Največ sodelujočih pacientov (n = 11) je bilo starih od 51 do 65 let; sledili so pacienti v starosti od 20 do 35 let (n = 10) in starejši od 66 let (n = 9). Najmanj udeležencev je bilo iz starostne skupine od 36 do 50 let. Največ udeležencev je imelo srednješolsko izobrazbo (n = 19), sledili so tisti z univerzitetno izobrazbo (n = 9), poklicno izobrazbo (n = 5) in (ne)dokončano osnovno šolo (n = 3). 9 udeležencem za obvladovanje sladkorne bolezni zadostuje zdrav življenjski slog, 16 udeležencev poleg tega potrebuje inzulinsko terapijo, 10 udeležencev pa poleg zdravega življenjskega sloga potrebuje še tablete za zdravljenje sladkorne bolezni. 31 udeležencev meni, da so svojo bolezen sprejeli in uredili. Anketirani imajo postavljeno diagnozo sladkorna bolezen od treh tednov (en udeleženec) do 37 let (en udeleženec).

Tabela1: *Dimenzionalna struktura in deskriptivne statistike za vprašalnik splošne zdravstvene pismenosti*
Table 1: *Dimensional structure and descriptive statistics for general health literacy questionnaire*

			Faktorji/ Factors		
Trditve / Items	$\bar{x}$	***s***	***Zdravstvena oskrba / Health care***	***Preprečevanje bolezni / Disease prevention***	***Promocija zdravja / Health Promotion***
Razumeti zdravnika, ko vam govori o vašem stanju in različnih možnostih zdravljenja.	3,48	0,79	0,88	/	/
Sodelovati v pogovoru z zdravnikom in mu postavljati vprašanja.	3,39	0,72	0,81	/	/
Razumeti navodila za uporabo, ki jih dobite ob zdravilu.	3,48	0,73	0,74	/	/
Razumeti navodila zdravnika ali farmacevta glede jemanja predpisanih zdravil oziroma ustrezne terapije.	3,61	0,58	0,76	/	/
Presoditi prednosti in slabosti različnih možnosti zdravljenja.	3,13	0,81	0,86	/	/
Presoditi, kdaj potrebujete drugo mnenje, ki ga dobite pri drugem zdravniku.	3,17	0,83	0,84	/	/
Presoditi, katerega specialista potrebujete ob določeni zdravstveni težavi.	3,09	0,90	0,84	/	/
Presoditi, če so informacije o bolezni, ki jih dobite v medijih, zanesljive.	2,48	1,04	0,63	/	/
Najti podatke o tem, kako se lotiti nezdravih navad, kot so kajenje, premajhna telesna dejavnost in pretirano pitje alkohola.	3,30	0,70	0,45	/	/
Odločiti se, kako se lahko zavarujete pred boleznimi, na podlagi informacij v medijih.	2,83	0,89	0,76	/	/
Izbrati in najti aktivnosti, ki so dobre za vaše psihično blagostanje.	3,17	0,58	0,61	/	/
Razumeti informacije na deklaracijah prehranskih izdelkov.	2,48	0,85	0,48	/	/
Najti podatke o znakih in zdravljenju vaše bolezni.	3,13	0,76	/	0,67	/
Vedeti, kaj morate storiti v primeru, ko potrebujete nujno medicinsko pomoč.	3,30	0,82	/	0,77	/
Najti podatke o tem, kako se spopadati s psihičnimi težavami, kot sta stres in depresija.	2,65	0,98	/	0,74	/
Najti podatke o tem, kako preprečevati dejavnike tveganja, kot so prevelika telesna teža, visok krvni tlak in visok holesterol.	3,17	0,89	/	0,81	/
Razumeti, zakaj se morate udeleževati preventivnih presejalnih programov.	3,17	0,94	/	0,75	/
Najti informacije o tem, kako ohraniti zdravje na delovnem mestu.	2,96	0,82	/	0,69	/
Zamenjati izbranega zdravnika oz. specialista.	2,52	1,04	/	0,59	/
Prejeti informacije o zdravstvenem stanju vašega svojca, ki je bil sprejet v bolnišnico.	2,52	0,95	/	0,65	/
Razumeti, zakaj potrebujete cepljenje, denimo proti gripi.	3,30	0,88	/	/	0,78
Presoditi, kdaj morate obiskati zdravnika.	3,57	0,66	/	/	0,66
Presoditi, kako vaši življenjski pogoji vplivajo na vaše zdravje.	3,09	0,85	/	/	0,62
Sprejemati odločitve, ko gre za vaše zdravje.	2,91	0,85	/	/	0,55
Ugotoviti, kdo nadomešča vašega izbranega zdravnika oziroma specialista, kadar je ta odsoten.	3,09	0,79	/	/	0,45
Delež pojasnjene variance faktorja	/	/	44,04	11,11	8,82
Koeficient Cronbach alpha faktorja	/	/	0,94	0,90	0,70
$\bar{x}$ faktorja	/	/	3,08	2,89	3,13
s faktorja	/	/	0,79	0,85	0,79

Legenda / Legend: $\bar{x}$ – povprečje / average; s – standardni odklon / standard deviation

Opis poteka raziskave in obdelave podatkov

Za izvedbo raziskave smo pridobili dovoljenje vodstva zdravstvenega zavoda, v katerem je bila raziskava izvedena. Pred anketiranjem smo pridobili individualno ustno soglasje posameznikov, ki so pristopili k anketiranju. Vprašalnike smo razdelili pacientom v čakalnici specialistične ambulante za zdravljenje sladkorne bolezni. Izbrali smo si en dan v tednu (torek) in v mesecu dni vsak torek razdelili deset vprašalnikov. Vsak anketiranec je prejel v izpolnjevanje vprašalnik in pisemsko ovojnico. Izpolnjen vprašalnik so udeleženci vstavili v pripravljeno pisemsko ovojnico. Zbrani podatki so bili analizirani s pomočjo deskriptivne statistike (frekvence, aritmetične sredine, standardne deviacije), za vprašalnik splošne zdravstvene pismenosti smo izračunali zanesljivost (Cronbach alpha) in analizirali dimenzionalno strukturo (faktorska analiza) (Tabela 1). Analizo podatkov smo izvedli s pomočjo statističnega paketa SPSS, verzija 20 (SPSS Inc., Chicago, IL, USA).

Rezultati

V Tabeli 1 predstavljamo trditve vprašalnika za merjenje splošne zdravstvene pismenosti, deskriptivne statistike posameznih trditev ter faktorsko strukturo vprašalnika. Iz tabele je razvidno, da je udeležencem raziskave najtežje »Presoditi, če so informacije o bolezni, ki jih dobite v medijih, zanesljive« ($\bar{x}$ = 2,48, s = 1,04), »Razumeti informacije na deklaracijah prehranskih izdelkov« ($\bar{x}$ = 2,48, s = 0,85), »Zamenjati izbranega zdravnika oziroma specialista« ($\bar{x}$ = 2,52, s = 1,04), »Prejeti informacije o zdravstvenem stanju vašega svojca, ki je bil sprejet v bolnišnico« ($\bar{x}$ = 2,52, s = 0,95), »Najti podatke o tem, kako se spopadati s psihičnimi težavami, kot sta stres in depresija« ($\bar{x}$ = 2,65, s = 0,98) in »Odločiti se, kako se lahko zavarujete pred boleznimi, na podlagi informacij v medijih« ($\bar{x}$ = 2,83, s = 0,89). Kot najlažje pa udeleženci ocenjujejo naslednje oblike ravnanja z zdravstvenimi informacijami: »Razumeti navodila zdravnika ali farmacevta glede jemanja predpisanih zdravil oziroma ustrezne terapije« ($\bar{x}$ = 3,61, s = 0,58), »Presoditi, kdaj morate obiskati zdravnika« ($\bar{x}$ = 3,57, s = 0,66), »Razumeti zdravnika, ko vam govori o vašem stanju in različnih možnostih zdravljenja« ($\bar{x}$ = 3,48, s = 0,79), »Razumeti navodila za uporabo, ki jih dobite ob zdravilu« ($\bar{x}$ = 3,48, s = 0,73). Vse tri najvišje ocenjene trditve se razvrščajo v dimenzijo »Zdravstvena pismenost s področja zdravstvene oskrbe«, ki je v povprečju ocenjena z oceno 3,08 (s = 0,79). Med vsemi tremi dimenzijami so udeleženci najnižje ocenjevali dimenzijo »Zdravstvena pismenost s področja preprečevanja bolezni« ($\bar{x}$ = 2,89, s = 0,85), najvišje pa dimenzijo »Zdravstvena pismenost s področja promocije zdravja« ($\bar{x}$ = 3,13, s = 0,79).

V nadaljevanju predstavljamo rezultate za vprašalnik o specifični zdravstveni pismenosti pacientov s sladkorno boleznijo. Kot je razvidno iz zastavljenih vprašanj, se od pacientov s sladkorno boleznijo zahteva visoka stopnja numerične (matematične) pismenosti. V Tabeli 2 predstavljamo rezultate, iz katerih je razvidno, da pacienti s sladkorno boleznijo večinoma znajo poskrbeti za pravilen, pravočasen in dosleden vnos zdravil. Najnižje znanje so udeleženci pokazali

Tabela 2: *Deskriptivne statistike za vprašalnik o specifični zdravstveni pismenosti pacientov s sladkorno boleznijo*
Table 2: *Descriptive statistics of the specific health literacy for patients with diabetes questionnaire*

Vprašanja/ Questions	***Pravilni odgovori/ Correct answers***		***Napačni odgovori/ Incorrect answers***	
	n	***%***	***n***	***%***
Vprašanja, povezana z aplikacijo inzulina, določenega glede na višino krvnega sladkorja	36	100	0	0
Jemanje predpisane terapije glede na navodila na škatlici	35	97	1	3
Kako razporedijo aplikacijo inzulina glede na število obrokov na dan	34	95	2	5
Izračun, koliko dni imajo predpisana zdravila glede na količino tablet v škatlici in navodila zdravnika	33	92	3	8
Označitev ciljne vrednosti inzulina na podlagi podanih podatkov	32	89	4	11
Izračun, koliko se zniža krvni sladkor glede na enote apliciranega inzulina	29	81	7	19
Izračun, koliko lističev za merjenje krvnega sladkorja potrebujejo za določeno časovno obdobje	25	69	11	31
Izračun: priprava potrebnega materiala za obvladovanje obolenja, glede na število dni odsotnosti – dopusta	24	67	12	33
Izračun, koliko inzulina potrebujejo na navedeno količino ogljikovih hidratov, opredeljeno v gramih	16	44	20	56
Skupaj	26,3	82	6,7	18

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

na področju usklajevanja zaužitih enot ogljikovih hidratov in aplikacije ustreznega števila enot inzulina (44 % pravilnih odgovorov).

Diskusija

Namen naše študije je bil opisati (i) stopnjo splošne zdravstvene pismenosti in (ii) specifične zdravstvene pismenosti na manjšem vzorcu pacientov s sladkorno boleznijo, ki so vodeni v eni od slovenskih specialističnih ambulant za zdravljenje sladkorne bolezni. V študiji ugotavljamo, da ima majhen vzorec udeleženih pacientov s sladkorno boleznijo relativno ustrezno splošno zdravstveno pismenost, saj se povprečne vrednosti odgovorov na vseh faktorjih gibljejo okoli ocene tri. Najnižja povprečna ocena je bila dosežena pri trditvi »Presoditi, če so informacije o bolezni, ki jih dobite v medijih, zanesljive« in pri trditvi »Razumeti informacije na deklaracijah prehranskih izdelkov« ter na splošno pri faktorju »Zdravstvena pismenost s področja preprečevanja bolezni«. Slednje nakazuje, da je splošna zdravstvena pismenost med udeleženci najmanjša prav na področju preventivnih aktivnosti, preden bolezen nastopi in ko se pojavijo prvi znaki z zdravjem povezanih težav.

Čeprav smo v študijo vključili paciente, ki so v obravnavi v specialistični ambulanti za sladkorno bolezen in so zaradi tega vodeni s strani zdravstvenega osebja, ti ocenjujejo kot najbolj težavno presojo ustreznosti zdravstvenih informacij, pridobljenih v medijih, ter razumevanje prehranskih deklaracij. Slednje je še posebej za paciente s sladkorno boleznijo pomemben vidik obvladovanja bolezni in zagotavljanja življenjskega sloga, prilagojenega bolezni.

Odnos med mediji in vedenjem, povezanim z zdravjem, pa je vprašanje, ki se v zadnjem času nanaša predvsem na svetovno medmrežje. Hogue in sodelavci (2012) ugotavljajo, da se osebe najprej odzovejo na novice o zdravstvenem stanju ali zdravljenju s pogovori z zaupanja vrednimi viri, kot so njihovi zdravniki ali drugi zdravstveni delavci. Tako pridobljeni podatki so osnova za njihova nadaljnja samostojna raziskovanja predvsem po svetovnem medmrežju, kjer je kakovost informacij variabilna in promocija zdravil ter drugih oblik nepreverjene terapije vedno bolj razširjena (Hogue, et al., 2012). Lau in sodelavci (2012) so z obširnim pregledom objav na *YouTube* kanalu ugotovili, da se socialni mediji na svetovnem medmrežju uporabljajo za podpihovanje javnih zdravstvenih sporočil, ki ustvarjajo negativne predstave v zvezi s sporočili javnega zdravstva ter z namenom izkrivljanja politike in programov financiranja zdravstvenih raziskav. Čeprav naša raziskava ne omogoča posploševanja ugotovitev, nakazuje na pomen povečevanja nadzora nad socialnimi mediji in drugimi oblikami javnega sporočanja, ki za osebe s kronično boleznijo niso vedno zaupanja vredni vir informacij.

Preverili smo specifično zdravstveno pismenost na področju poznavanja in obvladovanja sladkorne bolezni, v sklopu katere je v ospredju poleg splošne pismenosti in zdravstvene pismenosti pacientov tudi računska pismenost, saj vprašalnik Huizinga in sodelavcev (2008) zajema veliko računskih nalog v povezavi z obvladovanjem sladkorne bolezni. Osebe, ki so sodelovale v naši raziskavi, izkazujejo visoko specifično zdravstveno pismenost, saj so njihovi odgovori na večino vprašanj v povprečju pravilni 82 %. Vprašanje, pri katerih je bil odstotek pravilnih odgovorov najmanjši, je od udeležencev zahtevalo izračun, koliko inzulina potrebujejo na določeno količino ogljikovih hidratov (le 44 % pravilnih odgovorov). Zuagg in sodelavci (2014) so ugotovili, da 56 % pacientov s sladkorno boleznijo ne zna pravilno prebrati ogljikovih hidratov na nalepki prehranskih izdelkov in 59 % pacientov s sladkorno boleznijo ne bi znalo prilagoditi svojega odmerka inzulina, ki temelji na branju deklaracij na živilih. Isti avtorji ugotavljajo tudi, da pacienti s sladkorno boleznijo, ki redno obiskujejo diabetologa, dosegajo višje povprečne rezultate računskih tipov nalog v primerjavi s pacienti, ki diabetologa ne obiskujejo redno.

Večje neznanje na tem področju lahko na našem vzorcu pacientov pripišemo tudi dejstvu, da vsi udeleženci ne potrebujejo inzulina za obvladovanje svoje bolezni in se tako s potrebo po izračunavanju potrebnih enot še niso srečevali. To je tudi ena od ključnih omejitev te študije. Vzorec udeležencev pilotne študije ni homogen po pristopu k obvladovanju bolezni oziroma prejeti terapiji, po starosti in po letih zdravljenja z boleznijo, čeprav vse našteto sodi med pomembne dejavnike, ki poleg drugih demografskih spremenljivk vplivajo na različna merila uspešnosti samostojnega obvladovanja sladkorne bolezni (Schillinger, et al., 2002; Morris, et al., 2006). Nehomogenost in majhnost vzorca sta ključni omejitvi predstavljene študije, ki zato ne omogoča posploševanja na populacijo pacientov s sladkorno boleznijo v Sloveniji. Študija je eksploratorne narave in predstavlja preizkus vprašalnika o specifični zdravstveni pismenosti med pacienti s sladkorno boleznijo v Sloveniji, zato daje usmeritve predvsem za nadaljnje bolj poglobljene in obsežne raziskave.

Zaključek

Zdravstvena pismenost je osnova za načrtovanje in izvajanje zdravstvene vzgoje na vseh ravneh zdravstvene dejavnosti. Medicinski sestri poda celostni vidik razumevanja zdravstvenih podatkov s strani pacienta, kar omogoči individualiziran pristop k spodbujanju samooskrbe pacienta ne glede na njegovo obolenje ali poškodbo. Pri osebah s sladkorno boleznijo bi bilo zanimivo izvesti študijo, v kateri bi longitudinalno – od diagnosticiranja bolezni dalje – spremljali in ugotavljali povezanost med splošno in specifično zdravstveno pismenostjo pacientov s sladkorno boleznijo in vrednostjo glikiranega hemoglobina v specialističnih ambulantah za zdravljenje sladkorne bolezni.

Nasprotje interesov / Conflict of interest

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

Financiranje / Funding

Raziskava ni bila finančno podprta. / The study received no funding.

Etika raziskovanja / Ethical approval

Raziskava je pripravljena v skladu z načeli Helsinško-tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014). / The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014).

Prispevek avtorjev / Author contributions

Prva in druga avtorica sta načrtovali raziskavo in sodelovali pri pripravi vseh delov članka. Tretja avtorica je prav tako sodelovala pri pripravi delov članka: Uvoda, Metod, Rezultatov, Diskusije in Zaključka. / The first author and the second author designed the study and participated in the writing of the all article sections. The third author participated in the writing of the following sections: Introduction, Methods, Results, Discussion and Conclusion.

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Citirajte kot / Cite as:
Skok, I., Štemberger Kolnik, T. & Babnik, K. 2019. Zdravstvena pismenost in sladkorna bolezen: študija primera na skupini pacientov v specialistični ambulanti za zdravljenje sladkorne bolezni. *Obzornik zdravstvene nege*, 53(1), 49–56.
https://doi.org/10.14528/snr.2019.53.1.233

Pregledni znanstveni članek / Review article

Vloga medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena: pregled literature

The advanced nurse practitioner's role in health care of adolescents with non-suicidal self-injury behavior: literature review

Tilen Tej Krnel

Ključne besede: visoko tvegana vedenja; adolescenca; napredna zdravstvena nega; duševno zdravje; presejanje

Key words: high-risk behaviors; adolescence; advanced nursing; mental health; screening

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IZVLEČEK

Uvod: Duševno zdravje je pri mladostnikih lahko okrnjeno zaradi samopoškodovalnega vedenja v različnih oblikah. Namen raziskave je bil identificirati specifične vloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena.

Metode: Uporabljeni sta bili metoda pregleda literature in metoda tematske analize izbranih virov z oblikovanjem kod, kategorij ter tematskih področij. Po elektronskih podatkovnih bazah CINAHL, MEDLINE in ERIC je iskanje potekalo s pomočjo ključnih besed »samopoškodovanje«, »adolescenca« in »napredna zdravstvena nega« v angleškem prevodu. Glavna vključitvena kriterija sta bila osredotočanje na intervencije zdravstvene nege pri samopoškodovalnem vedenju ter obdobje adolescence. Tematska analiza je potekala na način odprtega kodiranja, kjer so enoto kodiranja predstavljale ključne ugotovitve izbranih virov.

Rezultati: Predlagane vloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnika s samopoškodovalnim vedenjem brez samomorilnega namena so: specializirana klinična ocenjevalka, izvajalka presejalnih programov, promotorka duševnega zdravja, začetnica specializirane obravnave, izvajalka specifičnih intervencij, preprečevanje samopoškodovalnega vedenja, sodelovanje v interdisciplinarnem timu ter izvajanje izobraževanj.

Diskusija in zaključek: Treba bo razviti klinično pot obravnave mladostnika s samopoškodovalnim vedenjem brez samomorilnega namena in intervencije zdravstvene nege, podprte z dokazi. Prav medicinske sestre so pri tem v edinstvenem položaju, saj jih mladostniki pogosto izberejo raje kot ostale strokovnjake, kar predstavlja izreden potencial za razvoj vloge medicinske sestre z naprednimi znanji na področju duševnega zdravja mladostnikov.

ABSTRACT

Introduction: Mental health in adolescents can be compromised by self-injury behaviors in different forms. The purpose of the research was to identify the specific roles of advanced nurse practitioners in the nursing treatment of non-suicidal self-injury behaviors in adolescents.

Methods: Literature review and topic analysis method of selected sources with the development of codes, categories and topic areas were used. The search was performed in the electronic databases of CINAHL, MEDLINE and ERIC with the following search words: self-injury, adolescents and advanced nursing. The two main inclusion criteria were the focus on nursing interventions in self-injury behaviors and the period of adolescence. The topic analysis was conducted in a way of inductive coding, where the coding unit was the main findings from selected sources.

Results: The proposed roles of the advanced nurse practitioner in addressing non-suicidal self-injury behavior in adolescents are: specialized clinical assessor, screening program practitioner, promotor of mental health, initial specialized treatment practitioner, specific interventions practitioner, non-suicidal self-injury prevention practitioner, participant in an interdisciplinary team and training.

Discussion and conclusion: There is a need for the development of the evidence-based clinical pathway for the management of non-suicidal self-injury behavior in adolescents and for evidence-based nursing interventions. Nurses have a unique position here as adolescents often prefer them to other professionals, which might be of great potential for the development of the advanced practitioner role in addressing adolescents' mental health.

Članek je nastal v okviru izbirnega predmeta *Duševno zdravje* na podiplomskem študijskem programu druge stopnje Zdravstvena nega na Fakulteti za zdravstvo Angele Boškin, pod mentorstvom prof. dr. Mojce Zvezdane Dernovšek.

Prejeto / Received: 31. 1. 2018
Sprejeto / Accepted: 2. 2. 2019

https://doi.org/10.14528/snr.2019.53.1.220

Uvod

Razvojno obdobje mladostništva zajema čas od začetka pubertete do dvaindvajsetega oziroma štiriindvajsetega leta (Bürger Lazar & Kodrič, 2014). Pri tem s pojmom puberteta mislimo na fizične spremembe rasti organizma in spolno dozorevanje. Cooper in sodelavci (2009) mladostništvo opredeljujejo kot obdobje prehoda med otroštvom in odraslostjo, ki traja od enajstega do enaindvajsetega leta. Na drugi strani avtorji Ball in sodelavci (2017) to obdobje zaključujejo že pri osemnajstih letih. Večina avtorjev (Cooper, et al., 2009; Golobič, 2009; Bürger Lazar & Kodrič, 2014; Ball, et al., 2017) se strinja, da gre za izredno turbulentno prehodno obdobje med otroštvom in odraslostjo. Glavna naloga tega razvojnega obdobja je oblikovanje posameznikove identitete (Cooper, et al., 2009; Golobič, 2009), pri čemer je v ospredju oblikovanje spolne identitete. Pogosta so razpoloženjska nihanja (Bürger Lazar & Kodrič, 2014). Gledano s fiziološkega vidika se v obdobju mladostništva zaključuje tudi mielinizacija osrednjega živčevja. Hkrati poteka pospešena reorganizacija osrednjih nevronskih povezav, posledice česar so impulzivno vedenje, slabši čustveni nadzor in manjša zmožnost uravnavanja stresa (Tomašević & Drobnič Radobuljac, 2017). Razpoloženjska nihanja pomembno vplivajo na kakovost duševnega zdravja mladostnikov. Skupaj z nizkim samospoštovanjem, težavami v prepoznavanju čustev ter disfunkcionalnostjo družine lahko pripomorejo k udejstvovanju mladostnika v visoko tveganih vedenjih, kamor uvrščamo tudi samopoškodovalno vedenje brez samomorilnega namena (angl. *non-suicidal self-injury*) (Cooper, et al., 2009). Samopoškodovalno vedenje obsega različne načine poškodovanja lastnega telesa: rezanje, praskanje, ugašanje cigaretnih ogorkov na sebi, povzročanje vbodnih ran, udarjanje z glavo in drugimi deli telesa v trde predmete itd., da bi si povzročili bolečino in s tem prekinili neznosne občutke nelagodja, praznine in napetosti. Opisano samopoškodovalno vedenje je pogosto med mladostniki s čustvenimi motnjami (Dernovšek, 2013, pp. 135–136). Samopoškodovalno vedenje se med mladostniki povečuje in je tako postalo javnozdravstveni problem (Davies & Terry, 2017). V Sloveniji se je brez namena umreti kadarkoli do devetnajstega leta samopoškodovalo 24 % deklet in 11,6 % fantov (Drobnič Radobuljac, et al., 2009). Za mladostništvo so značilna posebno tvegana vedenja, kar nam potrjuje podatek, da v Evropi večina mladih umre zaradi zunanjih vzrokov, kot so prometne nesreče in namerne samopoškodbe s samomorom (Musil, 2011, p. 309). Cooper in sodelavci (2009) opozarjajo, da v nasprotju z ostalimi starostnimi skupinami smrtnost v zadnjih petdesetih letih med mladimi ni bistveno upadla. Slovenija je glede stopenj smrtnosti prebivalstva zaradi namernih samopoškodb nad povprečjem evropskih držav (Musil, 2011). Pomembno je, da razlikujemo med samopoškodovalnim vedenjem brez samomorilnega namena ter poskusom samomora, saj je akutna samomorilna ogroženost nujno psihiatrično stanje (Brecelj-Kobe & Drobnič Radobuljac, 2012; Drobnič Radobuljac, 2017; Tomašević & Drobnič Radobuljac, 2017). Neustrezno preprečevanje (samo)poškodb mladih, tudi samopoškodovalnega vedenja brez samomorilnega namena, povečuje možnost dolgotrajnih neugodnih posledic na njihovo zdravje (Cooper, et al., 2009). Kot opozarjajo Davies in sodelavci (2017), lahko samopoškodovalno vedenje razlagamo kot kontinuum, samomor pa kot impulzivno, agresivno in končno dejanje tega kontinuuma. Poleg tega lahko samopoškodovalno vedenje po mehanizmih ojačevanja zavzame značilnosti bolezni odvisnosti (Drobnič Radobuljac, 2017).

Za uspešno zdravstveno obravnavo – za preprečevanje kot tudi zdravljenje težav v duševnem zdravju – izpostavljene populacije mladostnikov je potreben interdisciplinarni tim, pri čemer igrajo pomembno vlogo medicinske sestre (Terry & Davies, 2017). Klinične kompetence medicinske sestre za delo na tem področju sodijo med napredna znanja. Medicinska sestra z naprednimi znanji (angl. *advanced nurse practitioner*) je po definiciji Evropske federacije združenj medicinskih sester (European Federation of Nurses Associations [EFN]) diplomirana medicinska sestra, ki ima dodatna, napredna znanja, kompleksne sposobnosti odločanja ter klinične kompetence za razširjeno klinično prakso na višjem nivoju. Ker omenjeni dokument še ni dokončen, naj bi posamezne karakteristike medicinskih sester z naprednimi znanji dodatno določal kontekst oziroma država, v kateri opravljajo svojo prakso (EFN Workforce Committee, 2014). Delovno mesto medicinskih sester z naprednimi znanji še ni popolnoma natančno definirano, opredeljeno in sprejeto, v slovenskem prostoru pa ni niti uradno sistematizirano, kljub temu da zanje izobraževanje na podiplomskem nivoju že poteka. Tudi Barton in sodelavci (2017) ugotavljajo, da razvoj vloge medicinske sestre z naprednimi znanji še ni zaključen, ima kompleksno zgodovino ter je kontroverzen koncept, saj se standardi prakse in kompetence napredne zdravstvene nege precej razlikujejo.

Namen in cilji

Namen pregleda literature je bil identificirati specifične naloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov, ki se samopoškodujejo. Cilj pregleda je bil ugotoviti specifične vloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov, ki se samopoškodujejo brez samomorilnega namena. Zato smo si zastavili raziskovalno vprašanje:

– Katere so specifične vloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena?

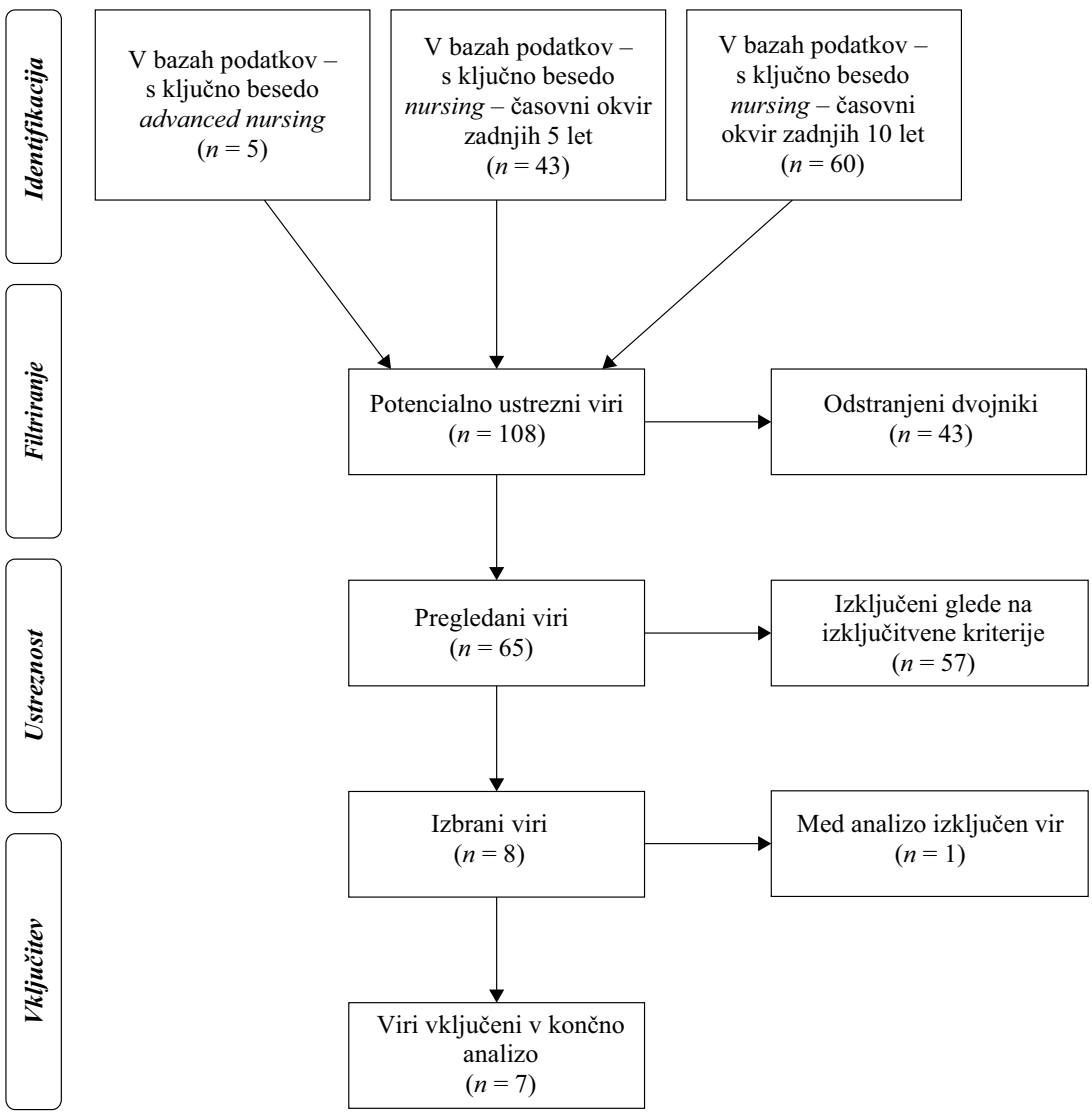
Metode

Uporabljena je bila metoda pregleda literature.

Metoda pregleda

Literaturo smo iskali po elektronskih podatkovnih bazah CINAHL, MEDLINE in ERIC. Iskanje je potekalo novembra 2017, in sicer v dveh korakih. Uporabljene ključne besede so bile »samopoškodovanje«, »adolescenca« in »napredna zdravstvena nega« v angleškem jeziku, skupaj s sopomenkami ter Boolovimi operatorji: *self harm* OR (ALI) *self injury* OR (ALI) *self mutilation* AND (IN) *adolescents* OR (ALI) *adolescence* AND (IN) *advanced nursing*. Zaradi majhnega števila zadetkov smo iskanje v drugem koraku ponovili zgolj s ključno besedo *nursing* (namesto ključnih besed *advanced nursing*) v angleškem jeziku. Prvega iskanja zaradi relativno novega pojma napredne zdravstvene nege časovno nismo omejili, drugo iskanje pa smo časovno omejili na zadnjih deset let.

Izbor virov smo opravili glede na vključitvene in izključitvene kriterije. Glavna vključitvena kriterija sta bila osredotočanje na (samostojne) intervencije zdravstvene nege pri samopoškodovalnem vedenju ter razvojno obdobje adolescence. Pri tem se zaradi majhnega števila zadetkov nismo omejevali na različne vrste kvantitativnih študij, temveč smo v izbor vključili vse najdene vire, ki so ustrezali kriterijem. Izbor tako



Slika 1: *PRISMA diagram poteka raziskave skozi faze sistematičnega pregleda literature*
Figure 1: *Literature review process PRISMA flowchart*

temelji na preglednih in strokovnih člankih (vključno s strokovno kolumno). Izključitveni kriteriji so bili naslednji:
– osredotočanje na patologijo samopoškodovalnega vedenja, torej klinične manifestacije in klinično sliko, etiologijo, epidemiologijo, diagnostiko in zdravljenje samopoškodovalnega vedenja ter komorbidnost;
– osredotočanje na otroško ali odraslo populacijo;
– študija primera kot uporabljena metoda;
– osredotočanje na odnos z vidika stališč in stereotipov oziroma izkušnje pacientov in / ali zdravstvenih delavcev, saj ti niso v specifični neposredni povezavi z naprednimi znanji v zdravstveni negi.

Rezultati pregleda

Iskalna kombinacija s ključnima besedama *advanced nursing* je dala zgolj pet zadetkov (s ključno besedo *adolescents* tri zadetke, s ključno besedo *adolescence* še dodatna dva zadetka), izmed katerih smo štiri vključili v nadaljnjo analizo. Zaradi izredno majhnega števila zadetkov smo iskanje ponovili zgolj s ključnima besedama »zdravstvena nega«, v angleščini *nursing*. Sprva smo rezultate časovno omejili na zadnjih pet let; dobili smo 41 zadetkov z odstranjenimi dvojniki. Glede na izključitvene kriterije smo v nadaljnjo analizo lahko uvrstili le tri vire, zato smo iskanje ponovili z daljšim časovnim okvirjem (zadnjih deset let). Zadnje iskanje je vrnilo še 19 dodatnih zadetkov z odstranjenimi dvojniki, izmed katerih smo enega uvrstili v nadaljnjo analizo. Skupaj smo tako v nadaljnjo analizo uvrstili osem virov, naknadno pa iz nje izločili en vir, saj je podrobnejše branje pokazalo, da se ne osredotoča na samopoškodovalno vedenje. Tako je za končno analizo ostalo sedem virov (Slika 1).

Ocena kakovosti pregleda in opis obdelave podatkov

Vsi viri so recenzirani prispevki v znanstvenih revijah. Kakovost izbranih virov smo ocenili glede na hierarhijo dokazov, ki jo opisujeta Polit in Beck (2018). Večina virov ($n = 4$) je strokovnih člankov, dva vira sta bila pregleda literature, en presečna raziskava (Tabela 1). Glede na hierarhijo dokazov ugotavljamo, da sodi večina virov med dokaze najnižjega ranga. Tudi oba vključena pregledna članka sta nesistematične narave, zato ju ne moremo uvrstiti med dokaze višjega reda. Izjema je presečna raziskava, ki jo po hierarhiji dokazov lahko uvrstimo nekoliko višje.

Proces sistematičnega pregleda literature smo izvedli po smernicah, ki jih opisujeta Polit in Beck (2018). Dobljeni podatki so bili obdelani po metodi tematske analize z oblikovanjem kod in kategorij ter tematskih področij po smernicah, ki jih opisuje Vogrinc (2008). Uporabili smo t. i. odprto oziroma induktivno kodiranje. Enoto kodiranja so predstavljale bistvene ugotovitve izbranih virov, ki smo jih oblikovali v kode. Z metodo združevanja kod smo nato zmanjšali njihovo število, s čimer smo omogočili boljšo preglednost in lažje razumevanje. V zadnjem koraku smo pomensko podobne kode združevali v širše kategorije, ki predstavljajo predlagane vloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena. Za namen tega prispevka smo vsebinsko podobne kategorije združili še v tri vsebinsko zaključena tematska področja.

Rezultati

V končni analizi smo zajeli sedem virov, ki so podrobneje predstavljeni v Tabeli 1.

Bistvene ugotovitve tematske analize člankov smo oblikovali v 94 kod, skladno z vključitvenimi ter izključitvenimi kriteriji. Kode smo v nadaljevanju tematske analize združevali v kategorije, ki so prikazane v Tabeli 2. Oblikovali smo osem kategorij, ki predstavljajo tudi predlagane specifične vloge medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena. Nekaterih kod nismo mogli uvrstiti v nobeno izmed kategorij, zato jih v končni analizi nismo upoštevali, saj ne bi bistveno pripomogle k pojasnitvi namena raziskave. Z metodo združevanja smo vsebinsko enake kode nato združili v eno samo; tako je za končni izbor ostalo še 60 kod, ki so naštete v Tabeli 2.

S pomočjo tematske analize izbranih virov smo identificirali osem specifičnih vlog medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena. Te so v nadaljevanju predstavljene v okviru treh tematskih področij, ki smo jih oblikovali z nadaljnjim združevanjem tematsko podobnih kategorij: (1) javnozdravstvenega delovanja medicinske sestre z naprednimi znanji; (2) kliničnega delovanja medicinske sestre z naprednimi znanji ter (3) razvojnega delovanja medicinske sestre z naprednimi znanji.

Tema 1: Javnozdravstveno delovanje medicinske sestre z naprednimi znanji

Pod to tematsko področje smo združili kategorije: izvajanje presejalnega programa mladostnikov za samopoškodovalno vedenje brez samomorilnega namena; promocija duševnega zdravja mladostnikov ter delo z mladostniki na področju preprečevanja samopoškodovalnega vedenja. Tuji avtorji (Tusaie, et al., 2009) poudarjajo predvsem pomen preprečevanja samopoškodovalnega vedenja brez samomorilnega namena, kar lahko dosežemo z namenskim presejanjem. To poveča identifikacijo mladostnikov, ki se samopoškodujejo. Catledge in sodelavci (2012) omenjajo presejanje za »čustveni distres«, saj so zgodnja

Tabela 1: *Temeljne ugotovitve analiziranih virov, oblikovane v kode*
Table 1: *Key findings from analysed sources put into codes*

Avtor, leto / Author, year	***Tipologija raziskave / Research typology***	***Namen raziskave / Research objective***	***Vzorec / Sample***	***Temeljne ugotovitve / Key findings***
Burton, 2014	Strokovni članek	Razložiti, kako lahko medicinske sestre v praksi prepoznajo in odgovorijo na samopoško-dovalno vedenje pri mladostnikih.	/	Medicinske sestre morajo biti pozorne na prepoznavanje samopoškodovalnega vedenja.
				Samopoškodovanje je način komunikacije.
				Nalogi zdravstvenih delavcev sta interpretacija in razumevanje.
				Pomembno je interdisciplinarno sodelovanje.
				Mladostniki pogosto raje izberejo medicinsko sestro namesto svetovalca/terapevta.
				Pomembno je natančno ocenjevanje »notranjega sveta« mladostnika in njegovo razumevanje.
				Učinkovito ukrepanje je priložnost za zmanjševanje ponavljanja samopoškodovalnega vedenja.
				Specialistično ocenjevanje naj bi se izvedlo znotraj 48 ur po sprejemu.
				V središče obravnave moramo postaviti mladostnika.
				Pri obravnavi uporabimo sistemski pristop.
				Najpomembnejše je sprejemanje in spoštovanje mladostnika kot posameznika.
				Uporabimo model, ki ustreza mladostniku, ne obratno.
				Intervencije zdravstvene obravnave morajo biti podprte z dokazi.
				Številne intervencije zdravstvene obravnave – čeprav uspešne – niso podprte z raziskavami.
				Priporočena standardna intervencija je kognitivno-vedenjska terapija.
				Ustrezen pretok informacij med zdravstvenim osebjem omogoča zgodnjo pomoč in varnost.
				Odločitve naj temeljijo na posameznem primeru, posvetujemo se z mladostnikom.
				Zdravstveni delavci naj ne delajo ločeno drug od drugega in naj bodo podprti s supervizijo.
Catledge, et al., 2012	Strokovni članek	Z uporabo dokazov poudariti nekaj smernic za boljše razumevanje osnovnih komponent ocenjevanja, ki lahko poveča prepoznavo namernega samopoško-dovanja.	/	Ocenjevanje samopoškodovalnega vedenja lahko vpliva na preprečevanje in ponovitve.
				Presejanje za čustvene motnje bi moralo postati standard pri obravnavi mladostnikov.
				Bistvena je vzpostavitev terapevtskega odnosa.
				Ocenjevanje kože mladostnikov naj bi potekalo v rednih časovnih intervalih.
				Potrebno je dokumentiranje.
				Celostna ocena tveganja za samopoškodovanje vodi k primerni oskrbi in spremljanju.
				Dogovor o nesamopoškodovanju večinoma ni učinkovit.
				Potrebno je spremljanje sprožilcev samopoškodovalnega vedenja.
				Specifične potrebe morda zahtevajo ustreznega specialista.
				Razvita so različna orodja za ocenjevanje samopoškodovalnega vedenja.
				Potrebno je zavedanje o globljih vzrokih samopoškodovalnega vedenja.
				Pri posredovanju informacij moramo upoštevati načelo zaupnosti, razen kadar bi to ogrozilo varnost.
				Zagotavljati bi morali oskrbo in spremljanje, podprta z dokazi.

Se nadaljuje / Continues

Avtor, leto / Author, year	*Tipologija raziskave / Research typology*	*Namen raziskave / Research objective*	*Vzorec / Sample*	*Temeljne ugotovitve / Key findings*
				Primerne so psihosocialne intervencije.
				Opolnomočenje zdravstvenih delavcev izboljša učinkovitost, poveča presejanje in izboljša svetovanje.
				Potrebno je izobraževanje vseh zdravstvenih delavcev kot tudi študentov zdravstvenih smeri.
Chiu, et al., 2010	Strokovna kolumna	Povečati zavedanje o namernem samopoško-dovanju.	/	MSNZ so na ključnem položaju za presejanje za samopoškodovalno vedenje.
				Obstajajo številna orodja za presejanje, ki pa se ne uporabljajo rutinsko.
				Razvoj standardiziranega orodja je v začetni fazi.
				MSNZ bi morale privzeti bolj proaktiven pristop k identifikaciji samopoškodovalnega vedenja.
Hvala, et al., 2012	Pregledni znanstveni članek	Predstaviti najpogostejše oblike in funkcije samopoško-dovalnega vedenja mladostnikov in poiskati možnosti za preventivno zdravstvenovzgojno delovanje.	Pregled prispevkov v bazah CINAHL, MEDLINE, Google učenjak, COBIB. SI ter PSYCINFO.	Zdravstvena vzgoja je osnova preprečevanja samopoškodovalnega vedenja.
				Pomembno je ukvarjanje s pozitivnim duševnim zdravjem.
				Šola je edinstven prostor za programe zdravstvene vzgoje in promocije zdravja.
				Primarna preventiva naj se osredotoča na prepoznavanje in izražanje lastnih čustev mladostnika.
				Primerne so metode in oblike dela brez teoretičnih razlag in prepričevanja – delavnice.
				Spodbuja naj se mladostnikove močne točke.
				Treba je razvijati komunikacijske in socialne spretnosti.
				Treba je nuditi možnost individualnega pogovora.
				Po potrebi mladostnike usmerjamo k drugim strokovnjakom.
				Pomembne so različne strategije za obvladovanje stresa.
				Sekundarna preventiva naj vključuje vse ljudi, ki jim mladi zaupajo.
				V praksi pozornost usmerjamo v prepoznavanje samopoškodovalnega vedenja.
				Treba je zagotavljati varno okolje.
				Vzpostavljamo empatičen in neobsojajoč odnos brez podcenjevanja.
				Predlagan je model PER-komunikacije: podpora, empatija in resnica.
Shapiro, 2008	Pregledni članek	Definirati samopoško-dovalno vedenje; raziskati trenutno literaturo o tovrstnem vedenju in predstaviti na dokazih temelječ interdiscipli-narni protokol obravnave mladostnikov, ki se samopoško-dujejo.	/	Medicinske sestre naj bodo pozorne na znake samopoškodovalnega vedenja pri mladostnikih.
				Terapevtski odnos se lahko vzpostavi z začetnim intervjujem.
				Pristop k mladostniku naj bo umirjen in neobsojajoč.
				Zastavljamo ciljna vprašanja brez negativnega prizvoka in obsojanja.
				Treba je ločevati med samopoškodovalnim in samomorilnim vedenjem.
				Fizično ocenimo samopoškodbo, po potrebi nudimo prvo pomoč.
				Nadaljnje ocenjevanje nadaljujemo po smernicah.
				Promoviramo strategije za obvladovanje stresa.
				Učimo strategije za obvladovanje jeze.
				Pomembna je medosebna komunikacija z zagovorništvom.
				Treba je identificirati ogrožene mladostnike.

Se nadaljuje / Continues

Avtor, leto / Author, year	*Tipologija raziskave / Research typology*	*Namen raziskave / Research objective*	*Vzorec / Sample*	*Temeljne ugotovitve / Key findings*
				Skupinske aktivnosti lahko pomagajo pri izogibanju samopoškodovalnemu vedenju.
				Treba je razvijati mladostnikovo samozaupanje.
				Mladostnike učimo ustreznega prepoznavanja in izražanja čustev.
				Pomembno je razumeti potrebo po zgodnji oskrbi in zdravljenju.
				Spodbuja naj se učinkovito interdisciplinarno sodelovanje.
				Primer razvoja klinične poti za obravnavo mladostnika s samopoškodovalnim vedenjem.
				Treba je razviti smernice oskrbe mladostnikov, ki se samopoškodujejo.
				Pozornost potrebujejo tudi starši mladostnika, ki se samopoškoduje.
Tusaie, et al., 2009	Presečna raziskava	Opisati prakso MSNZ na področju presejanja in obravnave samopoško-dovalnega vedenja mladostnikov.	97 MSNZ	MSNZ igra pomembno vlogo v zdravstveni oskrbi mladostnikov.
				Večina MSNZ se srečuje z mladostniki s samopoškodovalnim vedenjem.
				Identifikacija samopoškodovalnega vedenja je večja pri namenskem presejanju.
				MSNZ navajajo deficit znanja glede samopoškodovalnega vedenja mladostnikov.
				Treba je razviti standardizirano in učinkovito presejalno metodo.
				Potrebno je dodatno izobraževanje MSNZ.
Whotton, 2002	strokovni članek	Kritično raziskati potrebe mladostnika, ki se samopoško-duje, in družine v sklopu nujne medicinske pomoči.	/	Komunikacija bo učinkovita samo, če bodo vsi vpleteni verjeli, da bodo slišani.
				Stigma samopoškodovanja negativno vpliva na iskanje zdravstvene oskrbe.
				Zdravstveni delavci morajo vzpostavljati neobsojajoče odnose.
				Medicinska sestra mora aktivno poslušati mladostnika in njegovo družino.
				Medicinska sestra mora oceniti krizno situacijo, v kateri se je mladostnik znašel.
				Problematično je nepriznavanje mladostnikov kot samostojne in specifične skupine.
				Izražena je potreba po vlogi medicinske sestre s specialnimi znanji za obravnavo mladostnikov.
				Potrebno je specifično znanje o razvojnih spremembah in značilnostih adolescence.
				Razvite so smernice ravnanja in ocenjevanja samopoškodovalnega vedenja.
				Vsi mladostniki, ki se samopoškodujejo, bi morali biti pregledani in psihosomatsko ocenjeni.
				Ustrezno izobražene in usposobljene medicinske sestre bi lahko izvajale ocenjevanje.
				Treba je razviti specifična orodja ocenjevanja za uporabo pri mladostnikih.
				Zdravstvena infrastruktura bi morala biti prilagojena mladostnikom.
				Potrebne so zgodnje intervencije.
				Stigmo morda lahko zmanjšujemo s pomočjo medijev.

Legenda / Legend: MSNZ – medicinska sestra z naprednimi znanji / advanced nurse practitioner

Tabela 2: *Prikaz kod po kategorijah*
Table 2: *Codes and categories*

Kategorija / Category	***Kode/ Codes***
MSNZ kot specializirana klinična ocenjevalka	V praksi pozornost usmerjamo v prepoznavanje samopoškodovalnega vedenja in spremljanje sprožilcev.
	Pomembno je natančno ocenjevanje »notranjega sveta« mladostnika in njegovo razumevanje, saj to lahko vpliva na preprečevanje ponovitev.
	Celostna ocena tveganja za samopoškodovanje vodi k primerni oskrbi in spremljanju.
	Razvita so različna orodja za ocenjevanje samopoškodovalnega vedenja.
	Zastavljamo ciljana vprašanja brez negativnega prizvoka in obsojanja.
	Fizično ocenimo samopoškodbo, po potrebi nudimo prvo pomoč.
	Nadaljnje ocenjevanje nadaljujemo po smernicah.
	Medicinska sestra mora oceniti krizno situacijo, v kateri se je mladostnik znašel.
	Vsi mladostniki, ki se samopoškodujejo, bi morali biti pregledani in psihiatrično ocenjeni.
	Ustrezno izobražene in usposobljene medicinske sestre bi lahko izvajale ocenjevanje.
	Treba je razviti specifična orodja ocenjevanja za uporabo pri mladostnikih.
MSNZ kot izvajalka presejalnega programa	Presejanje za čustvene motnje bi moralo postati standard obravnave mladostnikov.
	MSNZ so na ključnem položaju za presejanje za samopoškodovalno vedenje.
	Obstajajo številna orodja za presejanje, ki pa se ne uporabljajo rutinsko.
	Identifikacija samopoškodovalnega vedenja je večja pri namenskem presejanju.
	Treba je razviti standardizirano in učinkovito presejalno metodo.
	MSNZ bi morale privzeti bolj proaktiven pristop k identifikaciji samopoškodovalnega vedenja in ogroženih mladostnikov.
MSNZ kot promotorka duševnega zdravja	Zdravstvena vzgoja je osnova preprečevanja samopoškodovalnega vedenja.
	Pomembno je ukvarjanje s pozitivnim duševnim zdravjem.
	Šola je edinstven prostor za programe zdravstvene vzgoje in promocije zdravja.
	Primarna preventiva naj se osredotoča na prepoznavanje in izražanje lastnih čustev mladostnika.
	Primerne so metode in oblike dela brez teoretičnih razlag in prepričevanja.
	Stigmo morda lahko zmanjšujemo s pomočjo medijev.
MSNZ kot začetnica specializirane obravnave	Mladostniki pogosto raje izberejo medicinsko sestro namesto svetovalca/terapevta.
	Treba je nuditi možnost individualnega pogovora.
	Najpomembnejše je sprejemanje in spoštovanje mladostnika kot posameznika.
	Večina MSNZ se srečuje z mladostniki s samopoškodovalnim vedenjem.
	Terapevtski odnos se lahko vzpostavi z začetnim intervjujem.
	Pristop k mladostniku naj bo umirjen in neobsojajoč.
	Pomembno je razumeti potrebo po zgodnji oskrbi in zdravljenju.
	Treba je zagotavljati varno okolje.
	Treba je ločevati med samopoškodovalnim in samomorilnim vedenjem.
MSNZ kot izvajalka specifičnih intervencij	V središče obravnave moramo postaviti mladostnika.
	Pri obravnavi uporabimo sistemski pristop.
	Priporočena standardna intervencija je kognitivno-vedenjska terapija.
	Bistvena je vzpostavitev neobsojajočega in empatičnega terapevtskega odnosa.
	Dogovor o nesamopoškodovanju večinoma ni učinkovit.
	Zagotavljati bi morali oskrbo, (psihosocialne) intervencije in spremljanje, podprte z dokazi.
	Izražena je potreba po vlogi medicinske sestre, specialistke za adolescenco.
	Naloga zdravstvenih delavcev je aktivno poslušanje, interpretacija in razumevanje brez podcenjevanja.
	Potrebno je zavedanje o globljih vzrokih samopoškodovalnega vedenja.
	Pomembna je medosebna komunikacija z zagovorništvom.

Se nadaljuje / Continues

Kategorija / Category	***Kode/ Codes***
MSNZ dela na področju preprečevanja	Treba je spodbujati mladostnikove močne točke.
	Treba je razvijati komunikacijske in socialne spretnosti.
	Promoviramo različne strategije za obvladovanje stresa in jeze.
	Skupinske aktivnosti lahko pomagajo pri izogibanju samopoškodovalnemu vedenju.
	Treba je razvijati mladostnikovo samozaupanje.
	Mladostnike učimo ustreznega prepoznavanja in izražanja čustev.
MSNZ kot del interdisciplinarnega tima	Pomembno je interdisciplinarno sodelovanje.
	Ustrezen pretok informacij omogoča zgodnjo pomoč in varnost.
	Zdravstveni delavci naj ne delajo ločeno drug od drugega in naj bodo podprti s supervizijo.
	Spodbujati je treba učinkovito interdisciplinarno sodelovanje.
	Po potrebi mladostnike usmerjamo k drugim strokovnjakom.
	Specifične potrebe morda zahtevajo ustreznega specialista.
	MSNZ igra pomembno vlogo v zdravstveni oskrbi mladostnikov.
MSNZ kot izvajalka izobraževanj	Opolnomočenje zdravstvenih delavcev izboljša učinkovitost, poveča presejanje in izboljša svetovanje.
	Potrebno je izobraževanje vseh zdravstvenih delavcev kot tudi študentov zdravstvenih smeri.
	MSNZ navajajo deficit znanja glede samopoškodovalnega vedenja pri mladostnikih.
	Potrebno je dodatno izobraževanje MSNZ.
	Potrebno je specifično znanje razvojnih sprememb in značilnosti.

Legenda / Legend: MSNZ – medicinska sestra z naprednimi znanji / advanced nurse practitioner

najstniška leta pomembno življenjsko obdobje za preventivo in zgodnjo prepoznavo samopoškodovalnega vedenja. Tudi Chiu in sodelavci (2010) poudarjajo pomen presejanja za samopoškodovalno vedenje brez samomorilnega namena, pri čemer vidijo na ključnem položaju prav medicinske sestre z naprednimi znanji, še posebej psihiatrične ter pediatrične. Slovenski avtorji (Hvala, et al., 2012) pa razpravljajo o zdravstveni vzgoji kot temeljni metodi preprečevanja, pri čemer omenjajo tudi promocijo zdravja, ki je področje javnega zdravja.

Tema 2: Klinično delovanje medicinske sestre z naprednimi znanji

Pod to tematsko področje spadajo kategorije: specializirano klinično ocenjevanje mladostnika, ki se samopoškoduje brez samomorilnega namena; začetna specializirana obravnava mladostnika, ki se je samopoškodoval, in nadaljnje izvajanje specifičnih intervencij njegove zdravstvene oskrbe. Specializirano klinično ocenjevanje zajema tudi ocenjevanje morebitnih pridruženih (duševnih) težav, bolezni in nevarnosti. Catledge in sodelavci (2012) poglobljeno opisujejo priporočila za fizično, psihosocialno in psihološko ocenjevanje mladostnika, ki se je samopoškodoval brez samomorilnega namena, ter poudarjajo pomen vzpostavitve terapevtskega odnosa in prakse, podprte z dokazi. Vzpostavljanje terapevtskega odnosa s pomočjo ustrezne komunikacije poudarjajo tudi Hvala in sodelavci (2012). Shapiro (2008) razpravlja o pomembni vlogi šolske medicinske sestre, ki lahko prva začne intervju, s katerim vzpostavi terapevtski odnos z mladostnikom. Whotton (2002) opozarja, da mora medicinska sestra pri tem zavzeti aktivno vlogo ter oceniti celotno krizno situacijo, v kateri se je znašel mladostnik. Začetna specializirana obravnava predstavlja prvi stik z mladostnikom, ki se je samopoškodoval in potrebuje poleg ustrezne prve pomoči tudi nadaljnje specifične intervencije čustvene razbremenitve in psihološke podpore. Idealno naj bi se taka začetna specializirana obravnava izvajala tam, kjer se mladostnik nahaja v trenutku samopoškodovanja (npr. v šoli). Medicinska sestra z naprednimi znanji na področju samopoškodovalnega vedenja mladostnikov bi lahko na tak način po začetni specializirani obravnavi takoj nadaljevala tudi izvajanje specifičnih intervencij, podprtih z dokazi, oziroma postopala v skladu z razvito klinično potjo zdravstvene obravnave mladostnika, ki se je samopoškodoval brez samomorilnega namena. Taka priporočena intervencija je npr. kognitivno-vedenjska terapija, pri čemer je v središče obravnave treba postaviti mladostnika (Burton, 2014). Hvala in sodelavci (2012) opisujejo nekaj intervencij, ki jih lahko uporabi medicinska sestra: spodbujanje primernih navad, učenje strategij spoprijemanja s trpljenjem in stresom, učenje prepoznavanja in izražanja lastnih čustev, spodbujanje sposobnosti vživljanja v čustvene odzive drugih, spodbujanje mladostnikovih močnih točk, razvijanje komunikacijskih in socialnih spretnosti, učenje novih načinov reševanja problemov. Na tak način bi se skrajšalo časovno okno med nudenjem prve pomoči (npr. v sklopu urgentnega oddelka) ter nadaljnjo specialistično obravnavo.

Tema 3: Razvojno delovanje medicinske sestre z naprednimi znanji

Pod to tematsko področje smo združili kategoriji: sodelovanje v interdisciplinarnem timu ter izvajanje izobraževanj za druge zdravstvene delavce v zvezi s samopoškodovalnim vedenjem pri mladostnikih. O pomenu izobraževanja podrobno pišejo Catledge in sodelavci (2012). Burton (2014) opozarja tudi na pomen supervizije oziroma skupinske podpore med strokovnjaki znotraj interdisciplinarnega tima.

Diskusija

Vloga medicinske sestre z naprednimi znanji na področju samopoškodovalnega vedenja mladostnikov še ni jasno razvita in definirana, saj je specifičnih virov na to temo izredno malo, njihova kakovost pa sodi glede na hierarhijo dokazov na začetek razvoja, saj gre večinoma za dokaze najnižjega reda. Sicer pa viri, ki jih je mogoče najti, večinoma govorijo o patologiji samopoškodovalnega vedenja, etiologiji, epidemiologiji in so v povezavi predvsem s pridruženimi (duševnimi) težavami in boleznimi. Na tem področju je raziskav zelo malo (Tusaie, et al., 2009). S pomočjo tematske analize izbranih virov smo identificirali tri ključna področja delovanja medicinske sestre z naprednimi znanji na področju zdravstvene obravnave mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena: javnozdravstveno, klinično ter razvojno delovanje.

Terry in Davies (2017) večkrat poudarita pomen zgodnjega odkrivanja težav v duševnem zdravju mladostnikov in razpravljata o vlogi, ki jo pri tem lahko imajo medicinske sestre. Na eni strani gre za vlogo medicinske sestre v procesu zdravstvene vzgoje mladostnika s samopoškodovalnim vedenjem brez samomorilnega namena, pri kateri je glavni cilj sprememba vedenja oziroma sprememba načina življenja, s čimer naj bi mladostnik dosegel optimalno zdravstveno stanje (Pintar Babič, et al., 2017). Na drugi strani pa imamo, kot razlagamo zgoraj, vlogo medicinske sestre pri namenskem presejanju in preventivnem delovanju. Na voljo so namreč znanstveni dokazi o učinkovitosti promocije duševnega zdravja in preventive duševnih motenj (Klemenčič, 2017).

Namen večine mladostnikov, ki se samopoškodujejo, je pomiritev, sprostitev in nadzor lastnega čustvenega stanja (Drobnič Radobuljac & Pintar Babič, 2017) oziroma zmanjšanje čustvenega distresa (Shapiro, 2008). Medicinske sestre morajo razumeti posebne razvojne vidike (Whotton, 2002) in specifične zdravstvene vidike (Terry & Davies, 2017) te ranljive populacije. Zgodnja prepoznava težav v duševnem zdravju in takojšnje intervencije lahko preprečijo, da bi mladostnikove težave postale kompleksnejše (Terry & Davies, 2017). Strokovnjaki iz prakse (Burton, 2014; Drobnič Radobuljac, 2017) navajajo kognitivno-vedenjsko terapijo kot učinkovito intervencijo. Drobnič Radobuljac (2017, p. 89) hkrati ugotavlja, da je »vse več dokazov o učinkovitosti psihoterapevtske obravnave« mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena.

Veliko uporabnih intervencij, ki jih lahko medicinska sestra izvaja pri zdravstveni obravnavi mladostnika s samopoškodovalnim vedenjem brez samomorilnega namena, je psihoterapevtskih oziroma psiholoških. Zdravstveno obravnavo te ranljive populacije lahko torej učinkovito izvajamo zgolj znotraj interdisciplinarnega tima (Terry & Davies, 2017). Jasno postane, da mora medicinska sestra na tem področju za uspešno zdravstveno obravnavo pridobiti dodatna znanja, kar je mogoče s specialističnim in podiplomskim izobraževanjem. Izobraževanje o samopoškodovalnem vedenju je namreč osnova za ustrezen pristop k mladostniku ter podlaga za učinkovito ukrepanje (Kvas Kučič, et al., 2012). Tudi tuji avtorji (Barton, et al., 2017) ugotavljajo, da kompetence medicinske sestre z naprednimi znanji temeljijo na spretnostih (po)svetovanja, presejanja, fizičnega pregleda, klinične obravnave in edukacije, kar zahteva podiplomsko magistrsko izobraženo medicinsko sestro.

Razvitih je nekaj orodij ocenjevanja in presejanja, vendar nobeno (še) ni standardizirano (Chiu, et al., 2010). Treba bo razviti z dokazi podprte smernice oskrbe (Shapiro, 2008; Catledge, et al., 2012) in intervencije (Burton, 2014). Za zdaj kaže, da so z dokazi najbolj podprte tiste intervencije, ki temeljijo na kognitivno-vedenjskih in podobnih pristopih. Prav medicinske sestre so (lahko pri tem) v edinstvenem položaju, saj jih, kot navaja Burton (2014), mladostniki pogosto izberejo raje kot ostale terapevte, kar vidimo kot izreden potencial za razvoj vloge medicinske sestre z naprednimi znanji na področju duševnega zdravja mladostnikov. Najpomembnejši je ustrezen pristop k mladostniku, ki se je samopoškodoval: umirjen, razumevajoč. Z uporabo ustreznega modela (Burton, 2014) naj se ustvari terapevtski odnos neobsojanja (Shapiro, 2008; Brecelj-Kobe & Drobnič Radobuljac, 2012; Catledge, et al., 2012; Hvala, et al., 2012) in globokega spoštovanja. Izredno problematično je nepriznavanje mladostnikov kot samostojne in posebne starostne in razvojne skupine, kar posledično pomeni, da se jih obravnava skupaj s pediatrično populacijo ali z odraslimi, kar pa z vidika celostne, v pacienta usmerjene obravnave nikakor ni primerno (Whotton, 2002; Cooper, et al., 2009). Mladostniki imajo drugačne psihosocialne in razvojne potrebe kot otroci in odrasli. Neustrezen premik mladostnikov k odraslim znotraj zdravstvenega sistema poveča nevarnost nekompliance oziroma nesodelovanja ter neupoštevanja zdravstvene ureditve v prihodnosti, posledično pa neugodne zdravstvene izide (Cooper,

et al., 2009). K temu dodatno prispeva še stigma samopoškodovanja (Whotton, 2002). Veliko je mogoče narediti na področju preprečevanja samopoškodovalnega vedenja: mladostnike je treba naučiti ustreznega prepoznavanja in izražanja čustev ter konstruktivnega soočanja s stresom (Shapiro, 2008; Hvala, et al., 2012).

Za dosego ciljev izboljšanja duševnega zdravja mladostnikov pa bo vsekakor potrebno dodatno ustrezno (podiplomsko) izobraževanje vseh zdravstvenih delavcev (Tusaie, et al., 2009; Catledge, et al., 2012). Tega ni mogoče doseči brez raziskovalnega dela, ki bo moralo postati sestavni del dela medicinskih sester z naprednimi znanji. Duševno zdravje mladostnikov je namreč »poseben izziv sodobne družbe« in ga uvrščamo med prednostne naloge (Klemenčič, 2017).

Raziskava vključuje izredno malo virov, katerih kakovost se precej razlikuje. To razlagamo z dejstvom, da smo iskali vire, ki se nanašajo na specifične intervencije zdravstvene nege v zvezi z obravnavano tematiko, ter z relativno novostjo pojma napredne zdravstvene nege. Iz pregleda smo namenoma izključili vire, ki obravnavajo medicinski vidik obravnavanega pojava. Večina virov prihaja iz drugačnega kulturnega okolja, zato je njihova aplikacija v evropski, natančneje slovenski prostor lahko problematična. Viri (z izjemo enega) niso raziskovalne narave in temeljijo na kliničnih izkušnjah avtorjev. Sicer je že sam koncept napredne zdravstvene nege slabo razumljen, saj v slovenskem prostoru še vedno prevladuje t. i. multidisciplinarni timski pristop (v nasprotju z interdisciplinarnim pristopom, ki ga omenjamo), ki pri zdravstveni obravnavi predvideva enega nosilca odgovornosti, ki jo hkrati tudi delegira, ostali člani zdravstvenega tima pa so mu neposredno podrejeni. To predstavlja ključno prepreko za aplikacijo modela napredne zdravstvene nege in s tem za razumevanje predlaganih vlog medicinske sestre z naprednimi znanji na področju samopoškodovalnega vedenja brez samomorilnega namena ter tudi na splošno.

Zaključek

Primarna preventiva s presejanjem ter promocija duševnega zdravja sta najboljši sredstvi, ki ju imamo na razpolago za dvig kakovosti duševnega zdravja tako mladostnikov kot celotne populacije. Zato ju je treba začeti izvajati že zgodaj, vsaj v osnovni šoli. Medicinske sestre z naprednimi znanji lahko pri tem igrajo ključno vlogo, saj imajo veliko znanja iz metodike zdravstvene vzgoje, promocije zdravja ter patologije in salutogeneze. Poleg tega lahko prevzamejo tudi druge naloge: npr. poglobljeno specialistično ocenjevanje, izvajanje zgodnjih, začetnih intervencij, pa tudi nadaljnjih specifičnih intervencij znotraj interdisciplinarnega tima, ne zgolj pri obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena, temveč tudi pri mladostnikih z drugimi težavami v duševnem zdravju. Tako bi se lahko v prihodnosti razbremenilo sekundarno in terciarno raven zdravstvenega varstva, s tem pa pomembno zmanjšalo stroške dolgotrajne obravnave naraščajočega problema slabega duševnega zdravja populacije in vseh posledic, ki jih ima na širšo družbo kot celoto. Dobro duševno zdravje v obdobju mladostništva je namreč podlaga za dobro duševno zdravje tudi v kasnejših življenjskih obdobjih.

Nasprotje interesov / Conflict of interest

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

Financiranje / Funding

Raziskava ni bila finančno podprta. / The study received no funding.

Etika raziskovanja / Ethical approval

Raziskava ni potrebovala odobritve etične komisije. / The study needed no ethical approval.

Prispevek avtorja / Author contributions

Avtor je zasnoval raziskavo, definiral namen in metodologijo, izvedel iskanje in sistematični pregled literature, opravil izbor vključenih virov, izvedel analizo podatkov ter napisal diskusijo in zaključek. / The author conceived the study, defined research aims and methodology, searched and reviewed the literature, selected the sources, conducted the analysis of included data and wrote Discussion and Conclusion.

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Citirajte kot / Cite as:
Krnel, T.T., 2019. Vloga medicinske sestre z naprednimi znanji pri zdravstveni obravnavi mladostnikov s samopoškodovalnim vedenjem brez samomorilnega namena: pregled literature. *Obzornik zdravstvene nege*, 53(1), pp. 57–69.
https://doi.org/10.14528/snr.2019.53.1.220

Pregledni znanstveni članek / Review article

Samoobvladovanje kronične bolečine: strategija stimulacije

Self-regulation of chronic pain: stimulation strategy

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Ključne besede: koncept; kronična bolečina; stimulacija; zdravstvena nega

Key words: concept; chronic pain; stimulation; health care

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IZVLEČEK

Uvod: Strategija stimulacije, namenjena pacientom s kronično bolečino, je aktivnost samoobvladovanja bolečine, pri čemer se posameznik nauči najti ravnotežje med časom za fizične aktivnosti in časom za počitek. Cilj strategije stimulacije je ohraniti kakovost življenja in zmanjšati simptome kronične bolečine. Za strategijo še ni razvite enotne definicije, prav tako še ni aplicirana v prakso.

Metode: Uporabili smo opisno metodo dela, metodo analize in sinteze literature ter smernice PRISMA. Izmed skupno identificiranih 789 zadetkov smo v končno analizo vključili 19 zadetkov. Tako smo izvedli pregled relevantne znanstvene literature ter analizo koncepta stimulacije, ki v slovenskem prostoru še ni bila izvedena in poteka v devetih korakih.

Rezultati: Strategijo obvladovanja kronične bolečine je najbolj smiselno deliti v tri skupine: (1) predhodniki: bolečina in neznanje; (2) atributi: aktivnost, čas, ravnovesje, učenje in samonadzor in (3) posledice koncepta: zdravljenje bolečine in povečana učinkovitost pri aktivnostih.

Diskusija in zaključek: Pred aplikacijo v prakso je treba opraviti testiranje strategije v kliničnem okolju ter ponovno oceniti prednosti in pomanjkljivosti uporabe koncepta. Mnenja o aplikaciji koncepta v prakso so različna: nekateri menijo, da koncept lahko privede do negativnih posledic, drugi, da uspešno prispeva k zdravljenju kronične bolečine. Strategija bi bila uporabna pri pacientih, ki imajo diagnosticirano kronično bolečino (kronične bolečine po poškodbah, degenerativnih spremembah, kronične bolečine v hrbtu, kronični glavobol, fibromialgija, nevropatska bolečina itd.), ki ni posledica onkološkega obolenja.

ABSTRACT

Introduction: Strategy of stimulation intended for patients with chronic pain is an active strategy of pain self-regulation where an individual learns to find the balance between the time used for an activity and the time for resting. The aim is to maintain the quality of life and reduce the symptoms of chronic pain. No unified definition for the concept has been developed yet nor has it been applied in practice.

Methods: The descriptive method, the method of analysis, the synthesis of the literature and the PRISMA guidelines were used. Out of a total of 789 results, 19 were included in the final analysis. We performed an overview of the relevant scientific literature and an analysis of the concept stimulation, which has not yet been carried out in Slovenia and includes nine steps.

Results: The strategy for chronic pain management can be divided into three groups: (1) forerunners: pain and ignorance, (2) attributes: activity, time, balance, learning and self-control and (3) consequences of the concept: pain treatment and increased effectiveness at activities.

Discussion and conclusion: Before applying it in practice, the strategy should be tested in a clinical environment and a re-evaluation of the advantages and disadvantages of the use of the concept should be performed. Views on applying the concept in practice differ; some think this would lead to negative consequences, while others think that it would contribute to the healing of chronic pain. The strategy would be useful in programs for patients with a diagnosed chronic pain (chronic pain after injury, degenerative changes, chronic back pains, chronic headaches, fibromyalgia, neuropathic pain etc.) that is not a consequence of oncological illness.

Prejeto / Received: 5. 2. 2018
Sprejeto / Accepted: 26. 2. 2019

https://doi.org/10.14528/snr.2019.53.1.221

Uvod

Vzrokov za kronično bolečino ni mogoče vedno medicinsko pojasniti, zato je paciente treba naučiti strategij za samoobvladovanje kronične bolečine in jih spodbujati k njihovi uporabi s (Antcliff, et al., 2016). Jamieson-Lega in sodelavci (2013) so koncept analizirali in pri tem navedli, da je potrebna podrobnejša analiza, saj je strategija še vedno nejasna, nezanesljiva ter vsebuje premalo kliničnih dokazov za uporabo v praksi – enake ugotovitve navajajo tudi drugi avtorji (Andrews, et al., 2012; Goudsmit, et al., 2012; Antcliff, et al., 2013; Nielson, et al., 2013; Antclif, et al., 2016).

Strategija stimulacije (angl. *pacing*) za samoobvladovanje kronične bolečine je slabo definirana, zato jo raziskovalci različno razlagajo (Gill & Brown, 2009; Jamieson-Lega, et al., 2013). Številni (Andrews, et al., 2012; Antcliff, et al., 2013; Jamieson-Lega, et al., 2013; Murphy & Kratz, 2014) dvomijo o uporabi navedene strategije v praksi, saj menijo, da zaradi netočnih ali preveč poenostavljenih nasvetov, ki jih ponuja, lahko pride do različnih negativnih posledic (pojav pogostejših, močnejših bolečin zaradi različne razlage in nerazumevanja strategije) za pacienta.

Strategija v praksi zdravstvene nege še ni bila uporabljena, zato avtorji (Andrews, et al., 2012; Antcliff, et al., 2013; Jamieson-Lega, et al., 2013; Murphy & Kratz, 2014) menijo, da bi bilo treba uskladiti mnenja in strategijo bolj jasno predstaviti. Jamieson-Lega in sodelavci (2013) na podlagi poročil pacientov navajajo, da bi bila strategija stimulacije uspešna pri pacientih, ki trpijo za kronično bolečino – predvsem za bolečino v križu, fibromialgijo in za sindromom kronične utrujenosti (Karsdorp & Vlaeyen, 2009; Goudsmit, et al., 2012; Antcliff, et al., 2013), pri kateri so prisotni nestabilni simptomi bolečine (Griffin, et al., 2011). Glavna značilnost strategije je spodbujanje pacientov, da se naučijo obvladovati bolečino in ohranijo kakovost življenja z aktivnostmi, ki vključujejo počitke (White, et al., 2011). Strategija stimulacije bi izboljšala delovanje posameznika, zmanjšala simptome in zagone bolečine ter invalidnost (Nijs, et al., 2008). Drugi avtorji (Kindermans, et al., 2011; Andrews, et al., 2012) trdijo, da bi bila strategija povezana s poslabšanjem simptomov –na primer s povečano bolečino.

Pri pregledu strokovne literature smo ugotovili, da v Sloveniji še ni bilo opravljene analize koncepta. Prav tako nismo zasledili aplikacije ali splošnega razumevanja strategije stimulacije v praksi zdravstvene nege. To nam predstavlja strokovni izziv za predstavitev in analizo strategije stimulacije.

Namen in cilji

Namen je bil s pomočjo pregleda literature prikazati, kako s strategijo stimulacije doseči samoobvladovanje kronične bolečine. Cilji raziskave so bili: (1) analizirati znanstveno literaturo s področja stimulacije; (2) ugotoviti, kaj strategija stimulacije pomeni za prakso zdravstvene nege; (3) določiti atribute, predhodnike in posledice strategije ter (4) identificirati empirične kazalnike strategije.

Metode

Uporabili smo opisno metodo dela, metodo analize in sinteze literature ter smernice PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (PRISMA, 2016).

Metode pregleda

Uporabljeni sta bili deskriptivna ali opisna metoda dela ter metoda analize in sinteze literature v angleškem in slovenskem jeziku. Literaturo smo poiskali v podatkovnih bazah PubMed, Cochrane Library, Health Advance, ScienceDirect, MEDLINE in CINAHL. Zbiranje in analiziranje literature je potekalo v novembru 2016. Iskanje literature je bilo omejeno na obdobje od januarja 2001 do novembra 2016. Potekalo je s pomočjo ključnih besed v angleškem jeziku: *activity pacing*, *pain management*, *pain* in *nursing* ter njihovih sopomenk. Ključne besede smo povezali s pomočjo Boolovih operaterjev OR (ALI) ter AND (IN). Končni iskalni niz besed je: *(activity pacing OR pace OR pacing) AND (pain coping OR pain management OR pain treatment) AND (pain OR chronic pain OR prolonged pain OR long term pain) AND (nursing OR nurs* OR care)*. Vključitveni kriteriji so bili kvalitativne raziskave, kvantitativne raziskave, raziskave mešanih metod in strokovne ter znanstvene monografije, ki se nanašajo na temo »Samoobvladovanje kronične bolečine: strategija stimulacije« in na populacijo pacientov s kronično bolečino. Izjemoma smo uporabili dva starejša vira: knjigo iz leta 1976 in članek iz leta 1995, ki smo ju pridobili z dodatnim iskanjem po drugih virih. Izključitveni kriteriji so literatura in članki, ki ne vključujejo tematike »Samoobvladovanje kronične bolečine: strategija stimulacije«, literatura in viri, starejši od leta 2001, ter literatura, ki ni dostopna v slovenskem ali angleškem jeziku. V Tabeli 1 so prikazani vključitveni in izključitveni kriteriji.

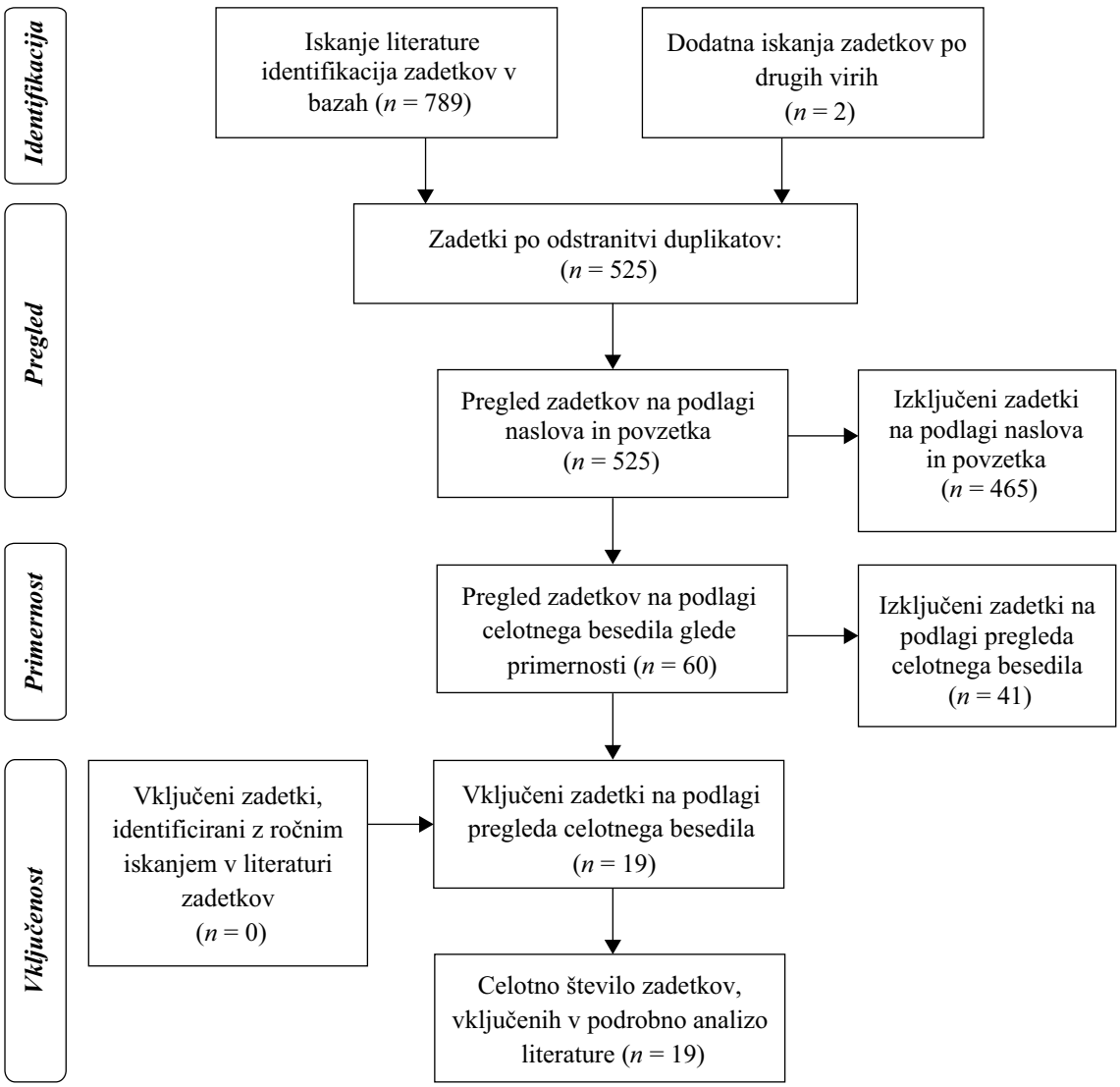
Rezultati pregleda

V podatkovnih bazah smo pridobili naslednje število zadetkov: PubMed 43 zadetkov; Cochrane Library 66 zadetkov; Health Advance 17 zadetkov; ScienceDirect 601 zadetek; MEDLINE 50 zadetkov in CINAHL 12 zadetkov. Dodatno smo vključili dva zadetka, ki smo ju uporabili za razlago termina »strategija stimulacije«.

Izmed skupno identificiranih 789 zadetkov smo najprej izločili 264 dvojnikov ter pregledali naslove in povzetke 525 zadetkov. Zaradi neustreznosti tematike oziroma neskladnosti z raziskovano tematiko smo glede na naslov in povzetek izključili 465 zadetkov. Na podlagi primernosti smo pregledali celotno besedilo 60 zadetkov in dodatno izključili 41 zadetkov, saj v vsebini ni bilo

Tabela 1: *Vključitveni in izključitveni kriteriji*
Table 1: *Inclusion and exclusion criteria*

Vključitveni kriteriji / Inclusion criteria	***Izključitveni kriteriji / Exclusion criteria***
Objava v slovenskem in / ali angleškem jeziku	Objava v drugih tujih jezikih
Dostopnost besedila v celoti v e-obliki ali vsaj v treh univerzitetnih knjižnicah	Dostopen le povzetek oziroma le bibliografski podatki o članku – gradivo ni dostopno v knjižnicah
Leto objave od januarja 2001 do novembra 2016	Leto objave pred januarjem 2001
Tematska ustreznost glede na področje proučevanja	Ne proučuje področja samoobvladovanja kronične bolečine, gre zgolj za omembo
Iskanje: kvalitativne, kvantitativne raziskave, raziskave mešanih metod, strokovne in znanstvene monografije	Poljudni članki in viri, metodologija ni jasno predstavljena
Obravnavana tematika: samoobvladovanja kronične bolečine	Področje raziskave ni samoobvladovanje konične bolečine



Slika 1: *Diagram poteka vključevanja literature*
Figure 1: *Flow chart of study selection*

podane ustrezne definicije / opisa strategije stimulacije. V končno analizo smo vključili 19 zadetkov, ki so ustrezali vključitvenim kriterijem. Potek iskanja prikazuje Slika 1.

Ocena kakovosti pregleda in opis obdelave podatkov

Prvi vključitveni kriterij, ki smo ga postavili, je bila ustrezna vsebina člankov. V analizo smo vključili 19 člankov, ki so izpolnjevali vključitvene kriterije. Vse raziskave, primerne za oceno ustreznosti oziroma kakovosti, spadajo v nivo hierarhije od 1 do 5 ter se nanašajo na temo stimulacijske strategije za samoobvladovanje kronične bolečine in na populacijo pacientov s kronično bolečino.

Rezultati

Do končnih ugotovitev smo prišli s pregledom relevantne znanstvene literature ter analizo koncepta v devetih korakih, kot predlagata Cutcliffe in McKenna (2005). Gre za proces identificiranja sestavnih delov koncepta glede na več kriterijev (Walker & Avant, 2011). Za analizo koncepta smo se odločili, ker ta analiza v slovenskem prostoru še ni bila izvedena. Predstavili smo prva koraka analize koncepta, ki ju opisujeta Cutcliffe in McKenna (2005): (1) izbor koncepta in (2) razjasnitev, zakaj je analiza koncepta primerna. Analizo izbranega koncepta od tretjega do devetega koraka smo po metodi, ki jo predlagata Cutcliffe in McKenna (2005), opisali v podpoglavjih: (3) identifikacija uporabe koncepta, (4) določitev definiranih atributov, (5) identifikacija primere modela, (6) identifikacija alternativnih primerov, (7) identifikacija predhodnika in posledic, (8) upoštevanje vsebine in vrednot in (9) identifikacija empiričnih kazalnikov.

Tretji korak analize koncepta: identifikacija uporabe koncepta

Prvi vir identifikacije uporabe koncepta je slovar, drugi viri so leposlovje, fotografije, literatura itd. (Cutcliffe & McKenna, 2005), kar smo prikazali v Tabeli 3. Stimulacija (angl. *pacing*) je definirana kot aktivna strategija samoobvladovanja bolečine, pri čemer se posameznik nauči najti ravnotežje med časom za aktivnost in časom za počitek, katerega namen je povečano delovanje in sodelovanje v koristnih dejavnostih (Jamieson-Lega, et al., 2013). Definicije so zapisane v Tabeli 3, v kateri je razvidno razvijanje definicije skozi čas.

Četrti korak analize koncepta: določitev definiranih atributov

Za določitev definiranih atributov je značilno, da se prepoznajo samo tiste lastnosti, ki so za koncept značilne (Cutcliffe & McKenna, 2005). Definirani atributi so nam v pomoč pri pojasnitvi pomena koncepta (Walker & Avant, 2011). Številni avtorji Birkholtz, et al., 2004; Molton, et al., 2008; Nijs, et al., 2008; Gill & Brown, 2009; Jamieson-Lega, et al., 2013) navajajo, da ima stimulacija opredeljene naslednje atribute:

- aktivnost – posameznik se mora aktivno vključevati v proces stimulacije;
- čas – gre za dolgotrajen proces, ki zahteva pozornost in čas;
- ravnovesje – pomembno je ravnotežje med aktivnostjo in počitkom, pri čemer ne gre nujno za pravično porazdelitev med aktivnostjo in počitkom;
- učenje – posameznikovo prizadevanje za pridobitev znanja in spretnosti, ki so pomembne za obvladovanje bolečine;
- samonadzor – neodvisno vodenje sebe skozi proces stimulacije.

Peti korak analize koncepta: identifikacija modela primera

Cutcliffe in McKenna (2005) navajata, da je model primera kratka zgodba, v kateri so jasno opredeljeni vsi atributi – lahko je zgrajena hipotetično ali kot resnični dogodek. Model primera daje natančen odsev koncepta (Walker & Avant, 2011).

Tabela 3: *Definicije na temo »Samoobvladovanje kronične bolečine: strategija stimulacije«*
Table 3: *Definitions on the topic 'Self-regulation of chronic pain: stimulation strategy'*

Avtor / Author	***Definicija / Definition***
Fordyce (1976)	Aktivnost stimulacije je sinonim za dejavnost kolesarjenja, za katerega je značilno obdobje zmerne aktivnosti in pogostih kratkih počitkov.
Kavanagh cited in Birkholtz, et al. (2004)	Stimulacija vključuje samostojno oblikovanje dejavnosti, s ciljem dosegati večjo učinkovitost pri aktivnosti, pri čemer je treba prilagoditi vmesne počitke.
Friedberg & Jason (2001)	Stimulacija je večplasten konstrukt.
Birkholtz, et al. (2004)	Stimulacija pomeni postopno povečanje aktivnosti iz dneva v dan.
Friedberg & Jason (2001); Nijs, et al. (2008); Griffin, et al. (2012)	Stimulacija vključuje zmanjšanje aktivnosti ob napornih dnevih in povečanje aktivnosti ob dnevih, ko je bolečina obvladljiva – z namenom preprečevanja poslabšanja simptomov in doseganja večje učinkovitosti.
Jamieson-Lega, et al. (2013)	Stimulacija je aktivna strategija samoobvladovanja bolečine, pri čemer se posameznik nauči najti ravnotežje med časom za aktivnost in časom za počitek, katerega namen je povečano delovanje in sodelovanje v koristni dejavnosti.

Primer: Gospod S. je upokojeni voznik avtobusa, ki so mu diagnosticirali bolečino v hrbtu. Pred pol leta je zapustil službo, saj zaradi bolečin ni mogel opravljati dela. Gospod S. v dnevih, ko je njegova bolečina obvladljiva, poskuša opraviti čim več nalog (skrb za dom, priprava hrane, sesanje, nakupovanje itd.). Posledica preobremenitve v naslednjih dneh so neobvladljive bolečine in nezmožnost opravljanja osnovnih aktivnosti. Gospod S. se počuti nemočno in razočarano, saj ne more opravljati aktivnosti, zato je pričel obiskovati skupino za samopomoč oziroma samoobvladovanje kronične bolečine. Naučil se je obvladovati bolečino, tako da ustrezno razporedi čas za počitek ter čas za aktivnost. Gospod S. učinkoviteje nadzoruje bolečino v hrbtu. Sposoben je načrtovati aktivnost in počitek ter ponovno opravlja vsakodnevne aktivnosti z manj bolečin (Jamieson-Lega, et al., 2013).

V primeru je prikazana strategija stimulacije, ko pacient uporabi vse atribute koncepta. Model ponazarja, da pacient razume in nadzoruje problem prekomerne aktivnosti ter problem premajhne aktivnosti. Prav tako je prikazano, da je pacient sposoben obvladovati bolečino pri vsakodnevnih aktivnostih. Potrebno je časovno ravnovesje med aktivnostjo in počitkom, s čimer doseže tudi samonadzor nad bolečino (Jamieson-Lega, et al., 2013).

Šesti korak analize koncepta: identifikacija alternativnih primerov

Alternativni primeri pomagajo pri boljšem razumevanju koncepta in njegovi uporabi (Cutcliffe & McKenna, 2005). Poznamo več vrst alternativnih primerov: mejni primer, povezan primer in nasprotni primer. V nadaljevanju sta opisana mejni (angl. *borderline*) ter nasprotni (angl. *countrary*) primer koncepta.

Za mejni (angl. *borderline*) primer je značilno, da vanj niso vključeni vsi definirani atributi (Cutcliffe & McKenna, 2005).

Primer: Gospe M. so diagnosticirali kronični glavobol. Pričela je obiskovati delavnice za obvladovanje bolečine, da bi se glavobol naučila nadzorovati. Na delavnicah so udeležence spodbudili k razmišljanju o aktivnostih, ki jih zaradi bolečin ne morejo izvajati. Svetovali so, da aktivnosti, ki jim povzročajo težave, izvajajo vsakodnevno in podaljšujejo čas izvajanja aktivnosti za pet minut z namenom, da jim aktivnost ne bo povzročala težav. Gospa M. je ugotovila, da aktivnosti, ki jih prej zaradi bolečin ni mogla opravljati, lahko opravlja, vendar potrebuje vmesne počitke (Jamieson-Lega, et al., 2013).

Čeprav so rezultati celotnega procesa pozitivni, pacient more opravljati aktivnosti v primeru, ko niso uporabljeni vsi atributi. V opisanem primeru pacient uporabi atribute: aktivnost, čas, učenje in samonadzor. Atribut, ki ga v primeru ne zasledimo, je ravnovesje (Friedberg & Jason, 2001; Jamieson-Lega, et al., 2013).

V nadaljevanju je še opisan nasprotni (angl. *contrary*) primer, za katerega je značilno, da je nepravilen, predstavlja napačno uporabo koncepta, v njem ni uporabljen noben izmed definiranih atributov;gre za primer slabe prakse (Cutcliffe & McKenna, 2005).

Primer: Gospa C. ima dlje časa trajajoče bolečine v vratu in rami, ki jo pogosto ovirajo pri vsakodnevnih opravilih ter ji onemogočajo vsakodnevne aktivnosti. Ob izvajanju osnovnih aktivnosti se bolečine v ramenih in vratu povečajo, zato jo skrbi, da bi lahko prišlo do dodatnih poškodb. Posledično je gospa C. večino časa nedejavna in gleda televizijo. Kadar so bolečine šibkejše, želi opraviti čim več opravil v stanovanju, zato je več ur aktivna ter se ukvarja s čiščenjem in pospravljanjem stanovanja. Zaradi preobremenitve se ponovno pojavijo bolečine, ki zahtevajo počitek in okrevanje. Gospa C. naslednjih nekaj dni počiva in ni aktivna (Jamieson-Lega, et al., 2013).

Primer nakazuje, da niso uporabljeni atributi – ravnotežje med aktivnostjo in počitkom ne obstaja, oseba se ni naučila spretnosti, ne izvaja samoobvladovanja, aktivnosti ne posveča časa (Birkholtz, et al., 2004; Griffin, et al., 2012; Jamieson-Lega, et al., 2013).

Sedmi korak analize koncepta: identifikacija predhodnika in posledic

Cutcliffe in McKenna (2005), navajata, da je predhodnik dogodek, ki se je zgodil, preden je koncept zasedel svoje mesto, posledice pa so izidi koncepta. Na podlagi analize in sinteze literature smo zbrali predhodnike in posledice koncepta, ki temeljijo na izkušnjah pacientov (Jamieson-Lega, et al., 2013).

Predhodniki stimulacije so:
- motnje aktivnosti zaradi bolečine (Jamieson-Lega, et al., 2013),
- neravnovesje med aktivnostjo in počitkom (Jamieson-Lega, et al., 2013),
- pomanjkanje znanja pacienta (Jamieson-Lega, et al., 2013),
- neobvladljiva kronična bolečina (Antcliff, et al., 2013),
- izogibanje dejavnostim (Andrews, et al., 2012).

Nekateri avtorji Karsdorp & Vlaeyen 2009; Jamieson-Lega, et al., 2013; Antcliff, et al., 2015) so ugotovili, da po uporabi strategije stimulacije oziroma po vključitvi atributov v strategijo stimulacije v daljšem časovnem obdobju prihaja do naslednjih posledic:
- večje učinkovitosti pri aktivnostih (Jamieson-Lega, et al., 2013),
- učinkovitega samonadzora nad bolečino (Jamieson-Lega, et al., 2013),
- poznavanja situacij, ki povzročajo pojav bolečine, in izogibanja le-tem (Jamieson-Lega, et al., 2013),
- ravnotežja med aktivnostjo in počitkom (Jamieson-Lega, et al., 2013),
- funkcionalne učinkovitosti (Jamieson-Lega, et al., 2013),

– večje izobraženosti (Jamieson-Lega, et al., 2013),
– zmanjšanih simptomov bolečine (Antcliff, et al., 2015),
– sprostitve (Karsdorp & Vlaeyen, 2009).

Osmi korak analize koncepta: upoštevanje vsebine in vrednot

Dojemanje fenomena in koncepta se spreminja skupaj s kontekstom, vrednotami ter prepričanji, saj imajo koncepti drugačne pomene za različne ljudi in stvari (Cutcliffe & McKenna, 2005). Mnenja o strategiji so deljenja, avtorji navajajo negativne ter pozitivne posledice. Andrews in sodelavci (2012), Jamieson-Lega in sodelavci (2013) ter Molton in sodelavci (2008) navajajo, da ima nejasnost pri definiranih atributih negativne posledice za prakso zdravstvene nege. Nasprotno pa Nijs in sodelavci (2008) trdijo, da bi bila strategija pomembna pri pacientih s kronično bolečino, saj bi pomembno pripomogla k zmanjševanju simptomov in zagonov bolečine ter k zmanjševanju invalidnosti.

Avtorji strategijo stimulacije različno opisujejo, in sicer kot:
– spodbudo, prilagoditev kronični bolečini (Antcliff, et al., 2013),
– spremembo vedenja za izboljšanje in omilitev simptomov (Antcliff, et al., 2015),
– varčevanje z energijo (Nielson, et al., 2013),
– uporabo aktivnosti in počitka (Nielson, et al., 2013),
– postopno povečevanje aktivnosti (Birkholtz, et al. 2004),
– vztrajanje kljub bolečini, sprostitev, pozitivno mišljenje (Molton, et al., 2008),
– varovanje zdravja, obvladovanje dejavnosti (Karsdorp & Vlaeyen, 2009).

Antcliff in sodelavci (2016) so raziskali mnenje uporabnikov stimulacije. Pacienti o stimulaciji navajajo, da: (1) bolje opravljajo vsakodnevne dejavnosti, saj so se naučili enakomerno porazdeliti dejavnosti skozi ves dan, rezultat tega pa je zmanjšana in obvladljiva bolečina; (2) po daljšem časovnem obdobju je stimulacija vsakodnevna rutina, ki dobro vpliva na bolečino; (3) se s stimulacijo ugotovi, kaj omili in kaj poslabša simptome bolečine; (4) gre za postopno povečanje dejavnosti skozi daljše časovne obdobje; (5) je stalna raven dejavnosti za doseganje več dobrih dni; (6) postopnega povečanja dejavnosti ne morejo vedno doseči zaradi starosti in poslabšanja simptomov (starejši pacienti); (7) se izvajanje stimulacije spreminja s starostjo, čustveno stabilnostjo in s komorbidnostjo.

Deveti korak analize koncepta: identifikacija empiričnih kazalnikov

Empirični kazalniki so kriteriji oziroma dokazi, da se koncept pojavlja oziroma se bo pojavil, ter ga lahko izmerimo. Poznamo torej razrede ali kategorije fenomena, ki prikazujejo prisotnost koncepta (Walker & Avant, 2011). Jamieson-Lega in sodelavci (2013) navajajo, da empirični kazalniki za stimulacijo (angl. *pacing*) vključujejo neposredno opazovanje stimulacije v kliničnem okolju, neposredno opazovanje pacientov ter njihov odziv na stimulacijo, pacientova poročila ter dokaze, s katerimi potrdimo njeno uspešnost (npr. ravnovesje med počitkom in aktivnostjo je bilo doseženo). Antcliff in sodelavci (2013) navajajo, da zaradi pomanjkljive definicije o stimulaciji primanjkuje empiričnih kazalnikov in dodajajo, da so številni avtorji že poskusili razviti lestvici za stimulacijo pri kronični bolečini – *The Cronic Pain Coping Inventory* (CPCI) in *The Pain and Activity Relations Questionnaire* (PARQ) (Antcliff, et al., 2016) –, vendar sta uporabni za revmatizem in kronično utrujenost in ne pri kronični bolečini. Navedeni lestvici se osredotočata na preprečevanje oziroma zmanjšanje aktivnosti, kar ni značilnost stimulacije (Antcliff, et al., 2013).

Za ocenjevanje strategije stimulacije še ni pripravljenih orodij, vendar so Antcliff in sodelavci (2016) razvili vprašalnik o aktivnosti stimulacije oziroma *Activity Pacing Questionnaire* (APQ), s katerim so želeli pridobiti mnenje pacientov. Vprašalnik je bil testiran na namenskem vzorcu pacientov, ki so obiskovali fizioterapijo in imajo diagnosticirano kronično bolečino v hrbtu, kronično razširjeno bolečino, fibromialgijo ali kronično utrujenost ter so starejši od 18 let. Zbiranje podatkov s pomočjo vprašalnika se je izvajalo v obliki telefonskega intervjuja.

Diskusija

Stimulacija je večplasten konstrukt (Friedberg & Jason, 2001). Definicija, ki jo navajajo Jamieson-Lega in sodelavci (2013), edina zajema vse atribute strategije stimulacije za obvladovanje kronične bolečine. Opišejo, da je stimulacija aktivna strategija samoobvladovanja bolečine, pri čemer se posameznik nauči najti ravnotežje med časom za aktivnost in časom za počitek. Slednjega uporabi za povečano delovanje in sodelovanje v koristni dejavnosti. Ravnovesje med počitkom in aktivnostjo ni vedno enakomerno porazdeljeno. Izmed vseh definicij, ki so jih napisali drugi avtorji (Friedberg & Jason, 2001; Nijs, et al., 2008; Griffin, et al., 2012), lahko povzamemo, da počitek ni namenjen odlašanju aktivnosti, temveč preprečevanju poslabšanja simptomov bolečine in doseganju večje učinkovitosti. Počitek se torej uporablja ob napornih dnevih, ko bolečina ni obvladljiva.

Koncept še ni apliciran v praksi, saj nekateri raziskovalci (Andrews, et al., 2012; Antcliff, et al., 2013; Jamieson-Lega, et al., 2013; Murphy & Kratz, 2014) menijo, da bi privedel do negativnih posledic, drugi avtorji pa navajajo, da bi uspešno prispeval k zdravljenju kronične bolečine, večji funkcionalni

učinkovitosti, izobraženosti, boljšim spretnostim (Jamieson-Lega, et al., 2013), zmanjševanju simptomov bolečine (Antcliff, et al., 2015) in sprostitvi (Karsdorp & Vlaeyen, 2009). Jamieson-Lega in sodelavci (2013) menijo, da bi zaradi nejasne definicije strategije stimulacije pri aplikaciji koncepta v prakso lahko prišlo do morebitnega izogibanja izvajanju aktivnosti s strani uporabnikov strategije. Z neenotno definicijo strategije stimulacije bi bilo poučevanje pacientov težko in zapleteno, saj bi si lahko zdravstveni delavci, ki bi obravnavali takšne paciente, strategijo različno razlagali. Različne, nenatančne in neenotne definicije ter uporaba strategije v praksi bi lahko predstavljale ovire pri obvladovanju kronične bolečine in zdravljenju pacientov. Za varno uporabo bi bilo treba natančno in razumljivo opredeliti koncept, ki bi bil razumljiv širši javnosti, nato pa dopolniti strategijo obvladovanja kronične bolečine. Strategijo bi nato pilotno vnesli v prakso ter jo testirali na populaciji pacientov. Tako bi lahko z empiričnim raziskovanjem potrdili koncept in vpeljali v prakso učinkovito metodo obvladovanja kronične bolečine, ki zahteva vključenost pacienta. Z uporabo v praksi bi se lahko redefinirala definicija ter podala vnovična ocena atributov koncepta (Jamieson-Lega, et al., 2013). Strategijo bi bilo smotrno aplicirati v prakso, saj bi pomembno prispevala k lajšanju bolečine na nefarmakološki način (Antcliff, et al., 2016).

Zaključek

Menimo, da bi bilo smiselno ponovno razmisliti o aplikaciji strategije v prakso zdravstvene nege, vendar mora biti pred tem ponovno testirana in nadalje razvita s pomočjo kvalitativne analize. Pri tem je raziskovalce treba spodbuditi k enotni rabi izraza stimulacija. Menimo, da bi podrobnejše raziskave in razvoj strategije lahko tako za uporabnika kot za okolje pripomogli k višji stopnji samoobvladovanja kronične bolečine ter zmanjšanju uporabe farmakoloških sredstev za zdravljenje bolečine. Strategija bi se lahko uporabljala v praksi zdravstvene nege, in sicer v protibolečinskih ambulantah, pri pacientih, pri katerih so prisotne dalj časa trajajoče bolečine kot posledica bolezni, pri pacientih z diagnosticirano kronično bolečino po poškodbah oziroma degenerativnih spremembah ter pri pacientih, pri katerih so ostali načini zdravljenja bolečine neučinkoviti.

Nasprotje interesov / Conflict of interest

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

Financiranje / Funding

Raziskava ni bila finančno podprta. / The study received no funding.

Etika raziskovanja / Ethical approval

Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014). / The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014).

Prispevek avtorjev / Author contributions

Soavtorji so z nasveti in pojasnili sodelovali pri vseh strukturnih delih članka. / The co-authors contributed to manuscript preparation of all the structural parts of the article written by the author with guidance and advice.

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Citirajte kot / Cite as:
Nemec, U., Pajnkihar, M., Šostar Turk, S., Klanjšek, P. & Košič, A., 2019. Samoobvladovanje kronične bolečine: strategija stimulacije. *Obzornik zdravstvene nege*, 53(1), pp. 70–77. https://doi.org/10.14528/snr.2019.53.1.221

NAVODILA AVTORJEM

Splošna navodila

Članek naj bo napisan v slovenskem ali angleškem knjižnem jeziku, razumljivo in jedrnato, dolg naj bo največ 5000 besed za kvantitativno in do 6000 besed za kvalitativno zasnovane raziskave. Število besed se nanaša na besedilo članka in ne vključuje naslova, izvlečka, tabel, slik in seznama literature. Avtorji naj uporabijo Microsoft Wordovo predlogo, ki je dostopna na spletni strani uredništva. Vsi članki, ki so uvrščeni v uredniški postopek, so recenzirani s tremi anonimnimi recenzijami. Revija objavlja le izvirna, še neobjavljena znanstvena dela. Za trditve v članku odgovarja avtor oziroma avtorji, če jih je več (v nadaljevanju avtor), zato mora le-ta biti podpisan s celotnim imenom in priimkom, treba je navesti strokovne naslove, akademske nazive avtorja in izvolitev v pedagoški ali raziskovalni naziv, v kolikor ga avtor ima. Če je članek napisan v angleškem jeziku, morajo biti v angleškem jeziku zapisani tudi strokovni naslovi, akademski nazivi in izvolitev v pedagoški ali raziskovalni naziv. Avtor mora pri oddaji članka dosledno upoštevati navodila glede standardizirane znanstvene opreme, videza in tipologije dokumentov ter navodila v zvezi z oddajo članka. Članek bo uvrščen v nadaljnjo obravnavo, ko bo pripravljen v skladu z navodili uredništva.

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

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

Opredelitev tipologije

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

Metodološka struktura članka

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

Strukturirani izvleček naj vsebuje naslednje strukturne dele:

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

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

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

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

Struktura izvirnega znanstvenega članka (1.01)

Izvirni znanstveni članek je samo prva objava originalnih raziskovalnih rezultatov v takšni obliki, da se raziskava lahko ponovi ter ugotovitve preverijo. Revija objavlja znanstvene raziskave, za katere zbrani podatki niso starejši od pet let ob objavi članka v reviji.

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

oz. hipotez (kvantitativna raziskava).

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

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

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

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

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

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

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

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

Struktura preglednega znanstvenega članka (1.02)

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

Pregledni znanstveni članek je pregled najnovejših raziskav o določenem predmetnem področju z namenom povzemati, analizirati, evalvirati ali sintetizirati informacije, ki so že bile publicirane. V preglednem znanstvenem članku znanstvena spoznanja niso le navedena, ampak tudi razložena, interpretirana, analizirana, kritično ovrednotena in predstavljena na znanstvenoraziskovalen način. Na osnovi kvantitativne obdelave podatkov predhodnih raziskav (metaanaliza) ali kvalitativne sinteze (metasinteza) rezultatov predhodnih raziskav prinaša nova spoznanja in koncepte za nadaljnje raziskovalno delo. Struktura preglednega znanstvenega članka je enaka kot pri izvirnem znanstvenem članku.

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

V **metodah** natančno opišemo uporabljeni raziskovalni dizajn pregleda literature. Podpoglavja metod so: *metode*

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

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

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

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

Navajanje literature

Vsako trditev, teorijo, uporabljeno metodologijo, koncept je treba potrditi s citiranjem. Avtorji naj uporabljajo *harvardski sistem (npr. Anglia 2008)* za navajanje avtorjev v besedilu in seznamu literature na koncu članka. Za navajanje avtorjev **v besedilu** uporabljamo npr.: (Pahor, 2006) ali Pahor (2006), kadar priimek vključimo v poved. Če gre za dva soavtorja, priimka ločimo z »&«: (Stare & Pahor, 2010). V besedilu navajamo *do dva avtorja*, če je avtorjev *več* navedemo le prvega in dopišemo »et al.«: (Chen, et al., 2007). Če navajamo več citiranih del, jih ločimo s podpičji in jih navedemo po kronološkem zaporedju, od najstarejšega do najnovejšega, če je med njimi v istem letu več citiranih del, jih razvrstimo po abecednem vrstnem redu: (Bratuž, 2012; Pajntar, 2013; Wong, et al., 2014). Kadar citiramo več del istega avtorja, izdanih v istem letu, je treba za letnico dodati malo črko po abecednem redu: (Baker, 2002a, 2002b).

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

V **seznamu literature** na koncu članka navedemo bibliografske podatke/reference za *vsa v besedilu citirana ali povzeta dela)* (in samo ta!), in sicer po abecednem redu avtorjev. Sklicujemo se le na objavljena dela. Kadar je avtorjev več in smo v besedilu navedli le prvega ter pripisali »et al.«, v seznamu navedemo prvih šest avtorjev in pripišemo »et al.«, če je avtorjev več kot šest. Za oblikovanje seznama literature velja velikost črk 12 točk, enojni razmik, leva poravnava ter 12 točk prostora za referencami (razmik med odstavki, angl. paragraph spacing).

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

Primeri navajanja literature v seznamu

Citiranje knjige:

Hoffmann Wold, G., 2012. *Basic geriatric nursing*. 5th ed. St. Louis: Elsevier/Mosby, pp. 350–356.

Pahor, M., 2006. *Medicinske sestre in univerza*. Domžale: Izolit, pp. 73–80.

Ricci Scott, S., 2007. *Essentials of maternity, newborn and women's health nursing*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins, pp. 32–36.

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

Berryman, J., 2010. Statewide nursing simulation program. In: W.M. Nehring & F.R. Lashley, eds. *High-fidelity patient simulation in nursing education*. Sadbury (Massachusetts): Jones and Bartlett, pp. 115–131.

Girard, N.J., 2004. Preoperative care. In: S.M. Lewis, et al., eds. *Medical-surgical nursing: assessment and management of clinical problems*. 6th ed. St. Louis: Mosby, pp. 360–375.

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

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

Borko, E., Takač, I., But, I., Gorišek, B. & Kralj, B. eds., 2006. *Ginekologija*. 2. dopolnjena izd. Maribor: Visoka zdravstvena šola, pp. 269–276.

Robida, A. ed., 2006. *Nacionalne usmeritve za razvoj kakovosti v zdravstvu*. Ljubljana: Ministrstvo za zdravje, pp. 10–72.

Citiranje članka iz revij (v drugem primeru dostopnega tudi na spletu):

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., et al., 2007. Quality and safety education for nurses. *Nursing Outlook*, 55(3), pp. 122–131.

Papke, K. & Plock, P., 2004. The role of fundal pressure. *Perinatal Newsletters*, 20(1), pp. 1–2. Available at: http://www.idph.state.ia.us/hpcdp/common/pdf/perinatal_newsletters/progeny_may2004.pdf [5. 12. 2012].

Pillay, R., 2010. Towards a competency-based framework for nursing management education. *International Journal of Nursing Practice,* 16(6), pp. 545–554.

Snow, T., 2008. Is nursing research catching up with other disciplines? *Nursing Standard*, 22(19), pp. 12–13.

Citiranje anonimnega dela (avtor ni naveden):

Anon., 2008. The past is the past: wasting competent, experienced nurses based on fear. *Journal of Emergency Nursing*, 34(1), pp. 6–7.

Citiranje dela korporativnega avtorja:

United Nations, 2011. *Competencies for the future*. New York: United Nations, p. 6.

Citiranje članka iz suplementa revije oz. suplementa številke revije:

Hu, A., Shewokis, P.A., Ting, K. & Fung, K., 2016. Motivation in computer-assisted instruction. *Laryngoscope*, 126(Suppl 6), pp. S5-S13.

Regehr, G. & Mylopoulos, M., 2008. Maintaining competence in the field: learning about practice, through practice, in practice. *The Journal of Continuing Education in the Health Professions*, 28(Suppl 1), pp. S19–S23.

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Skela-Savič B., 2008. Teorija, raziskovanje in praksa v zdravstveni negi – vidik odgovornosti menedžmenta v zdravstvu in menedžmenta v visokem šolstvu. In: B. Skela-Savič, et al., eds. *Teorija, raziskovanje in praksa – trije stebri, na katerih temelji sodobna zdravstvena nega: zbornik predavanj z recenzijo. 1. mednarodna znanstvena konferenca, Bled 25. in 26. september 2008*. Jesenice: Visoka šola za zdravstveno nego, pp. 38–46.

Štemberger Kolnik, T. & Babnik, K., 2012. Oblikovanje instrumenta zdravstvene pismenosti za slovensko populacijo: rezultati pilotske raziskave. In: D. Železnik, et al., eds. *Inovativnost v koraku s časom in primeri dobrih praks: zbornik predavanj z recenzijo. 2. znanstvena konferenca z mednarodno udeležbo s področja zdravstvenih ved, 18. september 2012*. Slovenj Gradec: Visoka šola za zdravstvene vede, pp. 248–255.

Wagner, M., 2007. Evolucija k žensko osrediščeni obporodni skrbi. In: Z. Drglin, ed. *Rojstna mašinerija: sodobne obporodne vednosti in prakse na Slovenskem*. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče, Založba Annales, Zgodovinsko društvo za južno Primorsko, pp. 17–30.

Citiranje diplomskega, magistrskega dela, doktorske disertacije:

Ajlec, A., 2010. *Komunikacija in zadovoljstvo na delovnem mestu kot del kakovostne zdravstvene nege: diplomsko delo univerzitetnega študija*. Kranj: Univerza v Mariboru, Fakulteta za organizacijske vede, pp. 15–20.

Rebec, D., 2011. *Samoocenjevanje študentov zdravstvene nege s pomočjo video posnetkov pri poučevanju negovalnih intervencij v specialni učilnici: magistrsko delo.* Maribor: Univerza v Mariboru, Fakulteta za zdravstvene vede, pp. 77–79.

Kolenc, L., 2010. *Vpliv sodobne tehnologije na profesionalizacijo poklica medicinske sestre: doktorska disertacija*. Ljubljana: Univerza v Ljubljani, Fakulteta za družbene vede, pp. 250–258.

Citiranje zakonov, kodeksov, pravilnikov:

Zakon o pacientovih pravicah (ZPacP), 2008. Uradni list Republike Slovenije št. 15.

Zakon o preprečevanju nasilja v družini (ZPND), 2008a. Uradni list Republike Slovenije št. 16.

Zakon o varstvu osebnih podatkov (uradno prečiščeno besedilo) (ZVOP-1-UPB1), 2007. Uradni list Republike Slovenije št. 94.

Kodeks etike medicinskih sester in zdravstvenih tehnikov Slovenije, 2010. Uradni list Republike Slovenije št. 40.

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Citiranje zgoščenk (CD-ROM):

International Council of Nurses, 2005. *ICNP version 1.0: International classification for nursing practice*. [CD-ROM]. Geneva: International Council of Nurses.

Sima, Đ. & Požun, P., 2013. *Zakonodaja s področja zdravstva.* [CD-ROM]. Ljubljana: Društvo medicinskih sester, babic in zdravstvenih tehnikov.

NAVODILA ZA PREDLOŽITEV ČLANKA

Članek je treba oddati v e-obliki preko spletne strani revije. Revija uporablja Open Journal System (OJS), dostopno na: http://obzornik.zbornica-zveza.si. Avtor mora natančno slediti navodilom za oddajo članka in izpolniti vse zahtevane rubrike. Pred oddajo članka naj avtor članek pripravi v naslednjih dveh ločenih dokumentih.

1. **Naslovna stran**, ki vključuje:

- naslov članka;
- avtorje v vrstnem redu, kot morajo biti navedeni v članku;
- popolne podatke o vseh avtorjih (ime, priimek, dosežena stopnja izobrazbe, habilitacijski naziv, zaposlitev, e-naslov) in podatek o tem, kdo je korespondenčni avtor; če je članek napisan v angleščini, morajo biti tako zapisani tudi vsi podatki o avtorjih; v sistem je vključena e-izjava o avtorstvu;
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Zahvala/Acknowledgements

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

Nasprotje interesov/Conflict of interest

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

Financiranje/Funding

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

Etika raziskovanja/Ethical approval

Avtorji so dolžni podati informacije o etičnih vidikih raziskave. V primeru odobritve raziskave s strani komisije za etiko zapišejo ime komisije za etiko in številko odločbe. V kolikor raziskava ni potrebovala posebnega dovoljenja komisije za etiko, so avtorji to dolžni pojasniti. Glede na posamezen tip raziskave lahko avtorji na primer zapišejo tudi naslednjo izjavo: »Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (ali) Kodeksom etike za babice Slovenije (2014),« v skladu s katero je treba v seznamu literature navajati oba vira.

Prispevek avtorjev/Author contributions

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

2. **Glavni dokument**, ki je anonimiziran in vključuje naslov članka (obvezno brez avtorjev in kontaktnih podatkov), izvleček, ključne besede, besedilo članka v predpisani strukturi, tabele, slike in literaturo. Avtorji lahko v članku uporabijo največ 5 tabel/slik.

Obseg članka: članek naj vsebuje največ 5000 besed za kvantitativno in do 6000 besed za kvalitativno

zasnovane raziskave. V ta obseg se ne štejejo izvleček, tabele, slike in seznam literature. Število besed članka je treba navesti v dokumentu »Naslovna stran«.

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

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

Slike naj bodo oštevilčene z arabskimi zaporednimi številkami. Podpisi k slikam (pod sliko) in legende naj bodo v slovenščini in angleščini, pisava Times New Roman, velikost 11 točk. Izraz slika uporabimo za grafe, sheme in fotografije. Uporabimo le dvodimenzionalne grafične črno-bele prikaze (lahko tudi šrafure) ter resolucijo vsaj 300 dpi (dot per inch). Če so slike v dvorazsežnem koordinatnem sistemu, morata obe osi (x in y) vsebovati označbe, katere enote/mere vsebujeta.

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

Sodelovanje avtorjev z uredništvom

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

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

NAVODILA ZA DELO RECENZENTOV

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

S sprejetjem recenzije se recenzent zaveže, da jo bo oddal v predpisanem roku. Če to ni mogoče, mora takoj obvestiti uredništvo. Recenzent se obveže, da vsebine članka ne bo nedovoljeno razmnoževal ali drugače zlorabil. Recenzije so anonimne: recenzent je avtorju neznan in obratno. Recenzent bo v pregled prek sistema OJS prejel le vsebino članka brez imena avtorja. V sistemu OJS recenzent poda svoje strokovno mnenje v recenzijskem obrazcu. Če ima recenzent večje pripombe, jih kot utemeljitev za sprejem ali morebitno zavrnitev članka na kratko opiše oz. avtorju predlaga nadaljnje delo, pri čemer upošteva njegovo integriteto. Zaradi večje preglednosti in lažjih dopolnitev s strani avtorja lahko recenzent svoje pripombe in morebitne predloge vnese v besedilo članka, pri tem uporabi možnost, ki jo ponuja Microsoft Word – sledi spremembam (Track changes). Recenzent mora biti pozoren, da pred uporabo omenjene možnosti prikrije svojo identiteto (sledi spremembam, spremeni ime/Track changes, change user name). Recenzentsko verzijo besedila članka z vključenimi anonimiziranimi predlogi nato recenzent naloži v sistem OJS in omogoči avtorju, da predloge dopolnitev vidi. Končno odločitev o objavi članka sprejme uredniški odbor.

Literatura

World Medical Association, 2013. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *Journal of the American Medical Association,* 310(20), pp. 2191–2194. Available at: http://www.wma.net/en/20activities/10ethics/10helsinki/DoH-Oct2013-JAMA.pdf [1. 9. 2016].

Kodeks etike v zdravstveni negi in oskrbi Slovenije in Kodeks etike za babice Slovenije, 2014. Ljubljana: Zbornica zdravstvene in babiške nege Slovenije – Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije.

Posodobljeno: 21. 11. 2016

Citirajte kot:
Obzornik zdravstvene nege: navodila avtorjem in recenzentom, 2016. *Obzornik zdravstvene nege*. Available at: http://www.obzornikzdravstvenenege.si/Navodila.aspx [23.12.2016].

MANUSCRIPT SUBMISSION GUIDELINES

General policies

The manuscript should be written clearly and succinctly in a standard Slovene or English language and conform to acceptable language usage. Its length must not exceed 5000 words for quantitative and 6000 for qualitative research articles, excluding the title, abstract, tables, pictures and literature. The authors should use the Microsoft Word template, accessible at the editorial website. All articles considered for publication in the Slovenian Nursing Review will have been subjected to an external, triple-blind peer review. Manuscripts are accepted for consideration by the journal with the understanding that they represent original material, have not been published previously and are not being considered for publication elsewhere. Individual authors bear full responsibility for the content and accuracy of their submissions. The statement of responsibility and publication approval must be signed by the authors' full name. The author's (or authors') professional, academic titles and possible appointments to pedagogical or research title must be included. If the article is written in English, all the titles must be translated into the English language. In submitting a manuscript, the authors must observe the standard scientific research paper components, the format and typology of documents, and submission guidelines. The manuscript must be accompanied by the authorship statement, a copy of which is available on the journal website. The statement must be undersigned by the author and all co-authors in the order in which each is listed in the authorship of the article. The manuscript will not be submitted to editing process before the statement has been received by the editorial office. The latter should also be notified of the designated corresponding author (with their complete home and e-mailing address, telephone number), who is responsible for communicating with the editorial office and other authors about revisions and final approval of the proofs. The title page should include the manuscript title and the full names of the authors, their highest earned academic degrees, and their institutional affiliations and status. The manuscript is eligible for editorial and reviewing process if it is prepared according to the uniform requirements set forth by the editorial committee of the Slovenian Nursing Review.

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

The title of the article, abstract and key words, tables (descriptive subtitle and legend), illustrations (descriptive subtitle or signature and legend) must be submitted in Slovene and English. The same applies to the articles written in English, where the above units must be given first in the English language, followed by the Slovene translation. The total of five data supplements per manuscript is allowed.

Tables and other data supplements should adequately accompany the text. The results presented in tables and other data supplements should be presented in symbols as required by the journal, available at the journal website, chapter Guidelines. The authors should refer to each of these supplements in the text. The use of footnotes and endnotes is not allowed.

Typology of articles

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

Methodological structure of an article

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

A structured abstract is an abstract with distinct, labelled sections for rapid comprehension. It is structured under the following headings:

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

Methods: This section provides an overview of the research or experimental design, the research instrument, the reliability of the instrument, methods of data collection, and analysis indicating where, how and when the data were collected.

Results: This section briefly summarizes and discusses the major findings. The information indicated in this section should be directly connected to the research question and purpose of the study. In

quantitative studies it is necessary to state the statistical validity and statistical significance of the results.

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

Structure of an Original Scientific Article (1.01)

An original scientific article is only the first-time publication of original research results in a way that allows the research to be repeated, and the findings checked. The research should be based on the primary sources which are not older than five years at the time of the publication of the article.

Introduction: In the introductory part the research problem is defined within the context of knowledge and scientific evidence it was developed. The review of scientific literature on the topic provides a rationale behind the work and identifies a problem highlighted by the gap in the literature. It frames a purpose and aims for a study, research questions or hypotheses as well as the method of investigation (a research design, sample size and characteristics of the proposed sample, data collection and data analysis procedures). The research should be based on the primary sources of the recent national and international research which are not older than ten or five years respectively, if the topic has been widely researched. Citation of sources and references to previous research findings is obligatory, while the authors' personal views are not given. Finally, the research intentions and purposes are stated. Recommended is also the framing of research questions (qualitative research) and hypotheses (qualitative research) to investigate or guide the study.

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

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

The *description of a sample* defines the population from which the sample has been drawn, the type of the sample, the response rate of the participants, the respondents' demographics (gender, educational level, length of work experience, post currently held, and the like). In qualitative research, the category of sampling technique and the inclusion criteria are also defined and the sample size saturation is explained.

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

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

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

Conclusion: Summarised in this section are the author's principal points and transfer of new findings into practice. The section may conclude with specific further research proposals grounded on the substantive content, conclusions and contributions of the study, albeit limitations cited. Citations of quotes, paraphrases or abridgements should not be included in the conclusion.

The article concludes with a list of all the published works cited or referred to in the text of the paper.

Structure of a Review Article (1.02)

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

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

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

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

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

The *results of the review* include the number of hits, the number of reviewed research works, the number of included and excluded sources consulted. The **results** are presented in the form of a diagram of all the research stages of the review. The international standards for the presentation of the literature review results may be used for this purpose (e.g. PRISMA - Preferred Reporting Items for Systematic Review and Meta-Analysis.

The quality assessment of the review and the description of data processing include the assessment of the research approach and the data obtained as well as the quality of included research works according to the hierarchy of evidence, and the data processing method.

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

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

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

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

Literature Citation

In academic writing the authors are required to acknowledge the sources from which they draw their information, including all statements, theories or methodologies applied. The authors should follow the *Harvard referencing system (Anglia 2008)* for in-text citations and in the reference list at the end of the paper. **In-text citations** or parenthetical citations are identified by the authors' surname and the publication year positioned within parenthesis immediately after the relevant word and before the punctuation mark: (Pahor, 2006). If a citation functions as a sentence element, the author's surname is followed by the year

of publication within parenthesis: Pahor (2006). In case of two authors, their surnames are separated by a "&": (Stare & Pahor, 2010). If there are *more than two authors*, only the first author's last name is noted followed by "et al.": (Chen, et al., 2007). Several references are listed in the chronological sequence of publication, from the most recent to the oldest. If several references were published in the same year, they are listed in alphabetical order: (Bratuž, 2012; Pajntar, 2013; Wong, et al., 2014).

In citing works by the same author published in the same year, a lower case letter after the date must be used to differentiate between the works: (Baker, 2002a, 2002b).

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

All in-text citations should be listed in the **reference list** at the end of the document. Only the citations used are listed in the reference list, which is arranged in the alphabetical order according to authors' last name. In-text citations should not refer to unpublished sources. If there are several authors, the in-text citation includes only the last name of the first author followed by the phrase et al. and the publication date. When authors number more than six, the reference list includes the first six authors' names followed by et al. The list of references should be in alphabetical order according to the first author's last name, character size 12pt with single spaced lines, aligned left and with 12pt spacing after references (paragraph spacing).

Cited pages are included in the in-text citation if the original segment of the text is cited (Ploč, 2013, p. 56) and in the reference list (see examples). If several pages are cited from the same source, the pages are separated by a comma (e.g. pp. 15–23, 29, 33, 84–86). If a source cited is accessible also on the World Wide Web, the bibliographic information concludes with "Available at", followed by URL- or URN-address and a date of access in square brackets (See examples).

Citation Examples by Type of Reference

Citing books:

Hoffmann Wold, G., 2012. *Basic geriatric nursing*. 5th ed. St. Louis: Elsevier/Mosby, pp. 350–356.

Pahor, M., 2006. *Medicinske sestre in univerza*. Domžale: Izolit, pp. 73–80.

Ricci Scott, S., 2007. *Essentials of maternity, newborn and women's health nursing*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins, pp. 32–36.

Citing a chapter/essay in a book edited by multiple authors:

Berryman, J., 2010. Statewide nursing simulation program. In: W.M. Nehring & F.R. Lashley, eds. *High-fidelity patient simulation in nursing education*. Sadbury (Massachusetts): Jones and Bartlett, pp. 115–131.

Girard, N.J., 2004. Preoperative care. In: S.M. Lewis, et al., eds. *Medical – surgical nursing: assessment and management of clinical problems*. 6th ed. St. Louis: Mosby, pp. 360–375.

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

Citing a book edited by one or multiple authors:

Borko, E., Takač, I., But, I., Gorišek, B. & Kralj, B. eds., 2006. *Ginekologija*. 2. dopolnjena izd. Maribor: Visoka zdravstvena šola, pp. 269–276.

Robida, A. ed., 2006. *Nacionalne usmeritve za razvoj kakovosti v zdravstvu*. Ljubljana: Ministrstvo za zdravje, pp. 10–72.

Citing a journal article (the second example refers to citing from the source available online):

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., et al., 2007. Quality and safety education for nurses. *Nursing Outlook*, 55(3), pp. 122–131.

Papke, K. & Plock, P., 2004. The role of fundal pressure. *Perinatal Newsletters*, 20(1), pp. 1–2. Available at: http://www.idph.state.ia.us/hpcdp/common/pdf/perinatal_newsletters/progeny_may2004.pdf [5. 12. 2012].

Pillay, R., 2010. Towards a competency-based framework for nursing management education. *International Journal of Nursing Practice,* 16(6), pp. 545–554.

Snow, T., 2008. Is nursing research catching up with other disciplines? *Nursing Standard*, 22(19), pp. 12–13.

Citing anonymous works (author is not given):

Anon., 2008. The past is the past: wasting competent, experienced nurses based on fear. *Journal of Emergency Nursing*, 34(1), pp. 6–7.

Citing works with society, association, or institution as author and publisher:

United Nations, 2011. *Competencies for the future*. New York: United Nations, p. 6.

Citing an article from a journal supplement or issue supplement:

Hu, A., Shewokis, P.A., Ting, K. & Fung, K., 2016. Motivation in computer-assisted instruction. *Laryngoscope*, 126(Suppl 6), pp. S5-S13.

Regehr, G. & Mylopoulos, M., 2008. Maintaining competence in the field: learning about practice, through practice, in practice. *The Journal of Continuing Education in the Health Professions*, 28(Suppl 1), pp. S19–S23.

Rudel, D., 2007. Informacijsko-komunikacijske tehnologije za oskrbo bolnika na daljavo. *Rehabilitacija*, 6(Suppl 1), pp. 94–100.

Citing from published conference proceedings:

Skela-Savič B., 2008. Teorija, raziskovanje in praksa v zdravstveni negi – vidik odgovornosti menedžmenta v zdravstvu in menedžmenta v visokem šolstvu. In: B. Skela-Savič, et al., eds. *Teorija, raziskovanje in praksa – trije stebri, na katerih temelji sodobna zdravstvena nega: zbornik predavanj z recenzijo. 1. mednarodna znanstvena konferenca, Bled 25. in 26. september 2008*. Jesenice: Visoka šola za zdravstveno nego, pp. 38–46.

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Wagner, M., 2007. Evolucija k žensko osredišèeni obporodni skrbi. In: Z. Drglin, ed. *Rojstna mašinerija: sodobne obporodne vednosti in prakse na Slovenskem*. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče, Založba Annales, Zgodovinsko društvo za južno Primorsko, pp. 17–30.

Citing diploma theses or master's theses and doctoral dissertations:

Ajlec, A., 2010. *Komunikacija in zadovoljstvo na delovnem mestu kot del kakovostne zdravstvene nege: diplomsko delo univerzitetnega študija*. Kranj: Univerza v Mariboru, Fakulteta za organizacijske vede, pp. 15–20.

Rebec, D., 2011. *Samoocenjevanje študentov zdravstvene nege s pomočjo video posnetkov pri poučevanju negovalnih intervencij v specialni učilnici: magistrsko delo.* Maribor: Univerza v Mariboru, Fakulteta za zdravstvene vede, pp. 77–79.

Kolenc, L., 2010. *Vpliv sodobne tehnologije na profesionalizacijo poklica medicinske sestre: doktorska disertacija*. Ljubljana: Univerza v Ljubljani, Fakulteta za družbene vede, pp. 250–258.

Citing laws, codes and regulations:

Zakon o pacientovih pravicah (ZPacP), 2008. Uradni list Republike Slovenije št. 15.

Zakon o preprečevanju nasilja v družini (ZPND), 2008a. Uradni list Republike Slovenije št. 16.

Zakon o varstvu osebnih podatkov (uradno prečiščeno besedilo) (ZVOP-1-UPB1), 2007. Uradni list Republike Slovenije št. 94.

Kodeks etike medicinskih sester in zdravstvenih tehnikov Slovenije, 2010. Uradni list Republike Slovenije št. 40.

Pravilnik o licencah izvajalcev v dejavnosti zdravstvene in babiške nege Slovenije, 2007. Uradni list Republike Slovenije št. 24.

Citing compact disk material (CD-ROM):

International Council of Nurses, 2005. *ICNP version 1.0: International classification for nursing practice*. [CD-ROM]. Geneva: International Council of Nurses.

Sima, Đ. & Požun, P., 2013. *Zakonodaja s področja zdravstva.* [CD-ROM]. Ljubljana: Društvo medicinskih sester, babic in zdravstvenih tehnikov.

ARTICLE SUBMISSION GUIDELINES

The corresponding author must submit the manuscript electronically using the Open Journal System (OJS) available at: http://obzornik.zbornica-zveza.si/. The authors should adhere to the accepted guidelines and fill in all the sections given. Prior to submission the authors should prepare the manuscript in the following separate documents.

1. **The title page** includes:
- the title of the article;
- the full names of the author/s in the sequence as that in the article;
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Acknowledgements

All contributors who do not meet the criteria for authorship and provided purely technical help or general support in the research (non-author contributors) can be listed in the acknowledgments.

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Funding

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Updated on November 21, 2016

Cite as:
Slovenian Nursing Review: author/reviewer guidelines, manuscript submisson guidelines, 2016. *Obzornik zdravstvene nege*. Available at: http://www.obzornikzdravstvenenege.si/Navodila.aspx [23.12.2016].

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SLOVENIAN NURSING REVIEW
ISSN 1318-2951 (print edition), e-ISSN 2350-4595 (online edition)
UDC 614.253.5(061.1)=863=20, CODEN: OZNEF5

Founded and published by:
The Nurses and Midwives Association of Slovenia

Editorial office address: Ob železnici 30 A, SI-1000 Ljubljana, Slovenia
E-mail: obzornik@zbornica-zveza.si
Offical web page: http://www.obzornikzdravstvenenege.si/eng/
Annual subscription fee (2017): 10 EUR for students and the retired; 25 EUR for individuals; 70 EUR for institutions.
Print run: 640 copies
Designed and printed by: Tiskarna knjigoveznica Radovljica
Printed on acid-free paper.
Matična številka: 513849, ID za DDV: SI64578119, TRR: SI56 0203 1001 6512 314
The Ministry of Education, Science, Culture and Sports: no. 862.
The journal is published with the financial support of Slovenian Research Agency.

Kazalo / Contents