Leading article/Uvodnik

The family medicine reference clinic: an example of interprofessional collaboration within a healthcare team

Referenčne ambulante družinske medicine: primer medpoklicnega sodelovanja v zdravstvenem timu

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Since being introduced in 2011, family medicine reference clinics (FMRCs) have created several advantages in the treatment of patients, but have also drawn attention to areas where improvements could be made (Poplas Susič, et al., 2013). Consistent with competencies and experts, each chronic patient care protocol as well as the prevention protocol strictly follows guidelines or recommendations that define diagnostic and treatment as well as education pathways for patient care in a family medicine practice. They are harmonised and agreed with experts at different levels of healthcare (primary, secondary and tertiary) (Vodopivec Jamšek, 2013).

The division of labour among team members in line with the competencies of individual professions and their mutual collaboration (Poplas Susič, et al., 2013; Martínez-González, et al., 2014) are two key elements of patient treatment in FMRCs.

Work undertaken by registered nurses in FMRCs requires specific knowledge and skills. Initially, the Nurses and Midwives Association of Slovenia wanted such work to be carried out systematically and under supervision. This represented an innovation upon implementation since registered nurses in primary care did not receive additional training when starting to work in paediatric, school health or gynaecology clinics. Yet this method has proven to be extremely useful: the wealth of new experience, many new skills and professional sovereignty contribute to comprehensive patient treatment (Bender, 2017), which has naturally yielded positive benefits.

Following the asthma and chronic obstructive pulmonary disease (COPD) modules (Poplas-Susič, et al., 2015), training was expanded to include the arterial hypertension, coronary disease, diabetes (Petek & Mlakar, 2016), osteoporosis and prevention modules (Petek Šter & Šter, 2015; Petek & Mlakar, 2016). Again something unexpected happened: the modules could no longer be included for implementation in good time for several reasons: the large number of registered nurses entering the system at the point of implementing the new FMRCs, time limitations and the temporal and spatial coordination of lecturers. It was proposed that until training in module form is introduced, registered nurses would be provided with induction by way of mentoring. In other words, an experienced registered nurse from an FMRC should help in the induction process of a new registered nurse in the FMRC until the latter starts an organised education path, which was also the case elsewhere (Lea & Cruickshank, 2017; Spiva, et al., 2017).

All work involving patients increasingly reveals a need for full-time education or the regular acquisition of skills (De Los Santos, et al., 2014), which also applies to work undertaken in FMRCs. This is probably best ensured already during a professional master programme so that a family medicine practice obtains a team member who masters a wide range of skills needed in work with patients. This knowledge cannot be fragmented in such a way that one nurse is trained for the needs of diabetic patients, the second for patients suffering from COPD/asthma and the third for arterial hypertension patients. Family medicine is characterised by the comprehensive treatment of patients, meaning that a single patient can be treated for several conditions simultaneously, which in turn requires the entire team's comprehensive knowledge and above all their collaboration (Klemenc-Ketiš, et al., 2014). Registered nurses in FMRCs thus require a broad set of skills to meet the needs of all patients with multimorbidity and to also continue cooperating with a physician. In-depth knowledge is of course needed when a patient is treated at secondary/tertiary level and requires diagnostic and therapeutic procedures as well as health education measures, which cannot be offered by primary care.

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Received/Prejeto: 13. 5. 2017
Accepted/Sprejeto: 23. 5. 2017

https://doi.org/10.14528/snr.2017.51.2.179

The large number of chronic patients and prevention, which should already start at an early age, show the need for a registered nurse's assistance over a full, 8-hour working day. In addition, naturally it is necessary that such labour standards be established that standardise the number of services now being reported by registered nurses and which differ by the way of the numbers involved. Moreover, the recording of services should be simplified to include the procedures of prevention, treatment and the monitoring of risk factors.

Research in family medicine is important (Bowman, et al., 2016). Similar to research undertaken by physicians, far less research is conducted by registered nurses working in FMRCs. Although a few research papers have been written by healthcare faculty graduates in health centres, no important publications can be found (Pečelin & Sočan, 2016). The reason for this is not currently clear, yet it is possible that a work method calling for direct contact with patients throughout the entire working time eliminates the desire to pursue research in one's free time. This represents an additional workload for employees and is thus less attractive.

Family medicine is the only clinical speciality among other clinical professions which lacks a defined tertiary level, thus preventing research as part of the work process. With the support of two faculties covering the area of nursing, a step in this direction was taken with the idea of setting up the Clinical Institute of Family Medicine, thereby enabling development based on its own research projects defining, directing and developing work within FMRCs' multi-disciplinary teams so as to add those aspects of work and team members that would direct patients towards a healthy lifestyle and, in the event of a medical condition, offer support where they need it and in the form they want (Fortin, et al., 2013). Only in this way can the FMRC stand shoulder to shoulder with other advanced clinical areas of patient treatment.

In order to ensure the successful further development and upgrading of interprofessional collaboration in FMRCs, it is important that the system is governed and regulated in at least two areas. One is certainly good team management. Physicians as healthcare service operators are responsible for the medical outcomes of the patients they treat and also assume responsibility for the good (or bad) work of the team as leaders, even though in line with competence models each decision made by both registered nurses and junior nurses forms the basis for their own responsibility. It is important that each team member receives optimal training and also has good command of the knowledge and skills required for treating the patients (Greene, et al., 2014) coming to an FMRC, making a structured educational programme within a professional master programme appear like a good solution.

Another area is research and development: experts, in this case a family medicine practitioner, a registered nurse and a junior nurse making up the team in an FMRC (following completion of the project, only the term family medicine clinic is to be used) must be able to pursue their own research, publish and continuously follow the latest findings of the profession. This cannot be achieved solely through projects, which however can be one of the options; the profession needs its own institutional organisation in the form of tertiary activity in order to fulfil its mission regarding patients also by trying to offer new contents, new insights and new methods by way of their own research activity. Here responsible entities/development experts in the field face a huge challenge, but at the same time decision makers in politics are also confronted with a challenge because sooner or later they will have to take an appropriate decision in this direction (deGruy, et al., 2015).

Slovenian translation/Prevod v slovenščino

Referenčne ambulante družinske medicine (RADM) so od svoje uvedbe leta 2011 pa do sedaj potrdile svoje številne prednosti pri obravnavi pacientov pa tudi osvetlile področja, kjer so možne izboljšave (Poplas Susič, et al., 2013). Vsak protokol (protokoli obravnave kroničnega pacienta in protokoli za izvajanje preventive), usklajen s kompetencami in stroko, strogo sledi smernicam oz. priporočilom, ki definirajo diagnostično-terapevtske in edukacijske poti obravnave pacientov v ambulanti zdravnika družinske medicine in ki so usklajeni in dogovorjeni med strokovnjaki z različnih ravni zdravstvenega varstva (primarni, sekundarni in terciarni nivo) (Vodopivec Jamšek, 2013). Bistvena elementa pri obravnavi pacientov v RADM sta razdelitev dela med člani tima v skladu s kompetencami posamezne stroke in njihovo medsebojno sodelovanje (Poplas Susič, et al., 2013; Martínez-González, et al., 2014).

Delo diplomirane medicinske sestre v RADM zahteva določena znanja in spretnosti, za katera je Zbornica zdravstvene in babiške nege Slovenije - Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije ob uvedbi RADM želela, da jih medicinske sester pridobijo načrtno in nadzorovano. To načelo je bilo novo, saj se za področje osnovnega zdravstva nobena diplomirana medicinska sestra, ko je pričela z delom v pediatričnih, šolskih ali ginekoloških ambulantah, ni dodatno izobraževala. Novi način se je izkazal kot zelo tehten. Veliko novih izkušenj, veliko novih znanj in strokovna suverenost pripomorejo k celoviti obravnavi pacientov (Bender, 2017), kar se je seveda izkazalo kot pozitivno.

Za modulom za astmo in kronično obstruktivno pljučno boleznijo (KOPB) (Poplas-Susič, et al., 2015) se je izobraževanje širilo še na modul za arterijsko

hipertenzijo, koronarno bolezen, sladkorno bolezen (Petek & Mlakar, 2016), osteoporozo ter področje preventive (Petek Šter & Šter, 2015; Petek & Mlakar, 2016). Toda zgodilo se je nekaj nepričakovanega – zaradi več razlogov moduli niso mogli biti več pravočasno izvedeni. Ob implementaciji novih RADM je v sistem namreč vstopalo veliko število diplomiranih medicinskih sester, težave so povzročale časovne omejitve in usklajevanje predavateljev glede terminov pa tudi glede prostora. Predlagano je bilo, naj se diplomirane medicinske sestre do začetka izobraževanja v modulih uvajajo s pomočjo mentoriranja, kar pomeni, da izkušena diplomirana medicinska sestra iz RADM pomaga uvajati novo diplomirano medicinsko sestro v RADM, dokler slednja ne vstopi v organiziran način izobraževanja, kar so prakticirali tudi v tujini (Lea & Cruickshank, 2017; Spiva, et al., 2017).

Vsako delo s pacienti vedno bolj kaže potrebo po rednem izobraževanju oz. regularni pridobitvi znanj (De Los Santos, et al., 2014), kar velja tudi delo v RADM. Potrebna znanja bi bilo verjetno najbolje zagotoviti že v sklopu strokovnega magistrskega študija, tako da bi v ambulanto zdravnika družinske medicine vstopil(a) član(ica) tima, ki bi obvladal(a) široko paleto veščin, potrebnih za delo s pacienti. Ta znanja ne morejo biti drobljena tako, da bi izobraževali ene diplomirane medicinske sestre za potrebe pacientov s sladkorno boleznijo, druge za delo s pacienti z KOPB ali astmo in tretje za obravnavo pacientov z arterijsko hipertenzijo. V družinski medicini obravnava pacientov poteka celostno. To pomeni, da se pri pacientu lahko obravnava več različnih bolezenskih stanj hkrati, kar zahteva celostno znanje celotnega tima in predvsem njihovo sodelovanje (Klemenc-Ketiš, et al., 2014). Diplomirana medicinska sestra v RADM potrebuje torej široko paleto znanja, da lahko zadosti potrebam vseh multimorbidnih pacientov in da lahko usklajeno sodeluje tudi z zdravnikom. Poglobljeno znanje je seveda potrebno, ko pacient pride v obravnavo na sekundarnem ali terciarnem nivoju in potrebuje diagnostično-terapevtske postopke in zdravstvenovzgojne ukrepe, ki mu jih primarni zdravstveni nivo ne more nuditi.

Veliko število kroničnih pacientov in izvajanje preventive, začenši že v mlajšem življenjskem obdobju, kažeta potrebo po zaposlitvi diplomirane medicinske sestre s polnim, osemurnim delovnikom. Ob tem je seveda nujno, da se vzpostavijo standardi dela, ki bodo poenotili število storitev, o katerih sedaj poročajo diplomirane medicinske sestre in ki se razlikujejo v večkratnikih, in da se beleženje storitev poenostavi na preventivni postopek, kurativni postopek in postopek spremljanja dejavnikov tveganja.

Raziskovanje v družinski medicini je pomembno (Bowman, et al., 2016). Podobno kot na področju raziskovanja zdravnikov je opazno manj raziskav tudi s strani diplomiranih medicinskih sester, ki delajo v RADM. Poleg nekaj raziskovalnih projektov, ki so jih opravljale diplomantke zdravstvenih fakultet po zdravstvenih domovih (Pečelin & Sočan, 2016), pomembnejših objav ni zaslediti. Razlog trenutno ni jasen. Možno je, da način dela, ki zahteva neposredni stik s pacientom cel delovni čas, odmakne možnosti za raziskovanje v prosti čas, taka dodatna časovna obremenitev zaposlenih pa je manj privlačna. Drugi možen razlog je, da diplomirane medicinske sestre v referenčnih ambulantah trenutno nimajo zadostnega znanja za raziskovalno delo.

Področje družinske medicine je edina klinična stroka, ki nima definiranega terciarnega nivoja, kar onemogoča, da bi raziskave lahko bile del delovnega procesa. Korak v to smer, narejen tudi s podporo dveh fakultet, ki pokrivata področje zdravstvene nege, je bil predlog za ustanovitev kliničnega inštituta za družinsko medicino, ki bi omogočil razvoj na podlagi lastnih raziskovalnih projektov. Ti projekti bi definirali, usmerili in razvijali delo multidisciplinarnega tima v RADM in mu dodali tiste vidike dela in tiste člane tima, ki bi pacienta usmerjali v zdrav način življenja in mu v primeru bolezenskih stanj nudili oporo tam, kjer bi jo rabil, in tako, kot bi jo želel (Fortin, et al., 2013). Le na tak način se lahko RADM postavijo ob bok drugim naprednim kliničnim vejam zdravstvene obravnave pacientov.

Za uspešen nadaljnji razvoj in nadgradnjo medpoklicnega sodelovanja v RADM je pomembno, da je sistem urejen in reguliran vsaj na dveh področjih. Eno je zagotovo dobro vodenje tima. Zdravnik kot nosilec zdravstvene dejavnosti je odgovoren za zdravstveni izhod pacientov, ki jih obravnava, in kot vodja prevzema odgovornost tudi za dobro (ali slabo) delo tima ne glede na to, da je podlaga za vsako odločitev diplomirane medicinske sestre, ki je v skladu z njenim kompetenčnim modelom, njena lastna odgovornost. Pomembno je, da je vsak član tima optimalno izobražen in da dobro obvlada znanja in spretnosti, potrebne pri obravnavi pacientov (Greene, et al., 2014), ki se oglašajo v RADM. Tako se zdi strukturirano izobraževanje diplomiranih medicinskih sester v okviru strokovnega magisterija dobra rešitev.

Drugo področje je področje raziskav in razvoja. Stroki, v tem primeru zdravniku družinske medicine in diplomirani medicinski sestri, mora biti zagotovljena možnost lastnih raziskav, publiciranja in stalnega permanentnega sledenja najnovejšim dognanjem stroke. Tega ni mogoče zagotavljati le s projekti, ki sicer lahko pomenijo eno izmed možnosti. Stroka potrebuje lastno institucijsko organiziranost v obliki terciarne dejavnosti, da svoje poslanstvo lahko uresničuje tudi tako, da pacientom poskuša nuditi nove vsebine, nova spoznanja in nove metode dela, temelječe na lastni raziskovalni dejavnosti. Tukaj so strokovnjaki kot nosilci razvoja tega področja pred velikim izzivom. Enak izziv pa stoji tudi pred odločevalci v politiki, ki bodo morali slej ko prej sprejeti ustrezno odločitev v tej smeri (deGruy, et al., 2015).

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Cite as/Citirajte kot:
Poplas Susič, T., 2017. The family medicine reference clinic: an example of interprofessional collaboration within a healthcare team. *Obzornik zdravstvene nege*, 51(2), pp. 112–115. https://doi.org/10.14528/snr.2017.51.2.179