Editorial / Uvodnik

It is time for clinical specialisations and advanced nursing practice: marking the International Year of the Nurse and the Midwife

Čas je za klinične specializacije in napredno zdravstveno nego: ob mednarodnem letu medicinskih sester in babic

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In 2019 we celebrated the 100th anniversary of the beginning of Angela Boškin's career as the first professionally trained nurse, and the 120th anniversary of the International Nursing Council. We have now entered the year 2020, which has been declared by the World Health Organization (WHO) to be the International Year of the Nurse and the Midwife and which also commemorates the 200th birthday of Florence Nightingale. Such a wealth of memories and opportunities to evaluate what has been accomplished and plan for the future! Many of the events taking place locally and globally in commemoration of the International Year of the Nurse and the Midwife are part of the three-year Nursing Now campaign, which was launched in 2018 and will continue throughout 2020.

The campaign highlights five key areas: 1) nurses and midwives must be given a more prominent voice in health policy making; 2) greater investment in human resources in nursing and midwifery is required; 3) nurses and midwives should hold leadership positions in health care on an equal footing with other profiles; 4) encouraging research aimed at identifying the direct contribution of nursing and midwifery care to disease prevention and treatment in society; 5) health systems should follow the best practices in nursing and midwifery care and implement them with the aim of achieving effective and accessible health care (All-Party Parliamentary Group [APPG] on Global Health, 2016).

The multifaceted objectives of these three-year efforts directed towards emphasising the prominent role of nurses and midwives in the healthcare system and society are grounded in scientific research. They aim to alert national officials to the fact that nurses and midwives play a vital role in ensuring access, efficiency and quality of care (International Center on Nurse Migration [ICNM], 2018), as the WHO has made it clear that universal health coverage cannot be achieved without an active role played by nurses and midwives (World Health Organization [WHO], 2015). Raising awareness of this fact and promoting the measures to adequately change the role and status of both professional groups in society has received special support by WHO Director-General Dr. Tedros Adhanom Ghebreyesus (Anon., 2020). Thus, in 2019, the WHO launched a data-collection project with the aim of issuing a report on the global state of the nursing workforce, entitled The State of the World's Nursing Report, which is to be presented on the International Health Day, i.e., on 7 April 2020. Data is also being collected for midwifery personnel. The report aims to influence governments and their officials to invest in the development of the nursing practice and personnel. In 2019, a report was published on the recruitment of nursing personnel and the effects thereof on patient safety and work safety for health professionals (Saudi Patient Safety Center & International Council of Nurses [SPSC & ICN], 2019). Recommendations were presented in terms of the registered nurse-to-patient staffing ratio by respective fields of practice. Here are some practical examples: intensive care 1 RN : 1 patient; post anaesthesia recovery 1:2; paediatrics unit 1:4; emergency room 1:2; medical surgical unit 1:4; oncology 1:3. The aim of such recommendations on safety standards and risks posed by "malnourished" staffing policies is to urge healthcare officials and healthcare funders to revise the existing staffing standards. In this context, Aiken and colleagues (2018) point out that at least 80 % of all nursing personnel should hold a bachelor's degree. These guidelines were first adopted by the United States, and later also by other countries, e.g. Ireland, the United Kingdom, etc.

Traditional healthcare systems in Europe have

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struggled to meet the increasing demands for health services resulting from a long-lived society. These policies are predominantly aimed at solving the problems pertaining to doctors, but fail to pay adequate attention to other professional profiles. For years, such has been the attitude of the Slovene health policy, with Slovene nurses and midwives experiencing increasing workloads, poor pay for demanding work, poor working conditions and strained relationships at the workplace, in addition to not having their contribution to patient outcomes recognised. Some of these shortcomings are highlighted in a doctoral dissertation by Mojca Dobnik (Dobnik, et al., 2018). Furthermore, the low number of registered nurses (RNs, i.e., nurses with a bachelor's degree) per 1000 people, coupled with hindering their professional development at the level of clinical specialisations and advanced nursing practices, presents a serious problem. In Slovenia, the practice which has been gaining ground is that of RNs completing postgraduate training for certain professional roles through non-accredited educational programmes designed within narrow circles and aimed primarily towards relieving doctors of their workload. Such training equips students with the ability to perform the tasks and duties of physicians. Upon completion of such a training programme, students at the Nurses and Midwives Association of Slovenia hold specialised skills. This setup has formed the basis for the establishment of reference outpatient clinics**,** family medicine clinics, and community psychiatry clinics, which are currently being established at the primary level. It is interesting to note that these registered nurses are not encouraged to complete a formal postgraduate clinical specialisation and thereby raise their educational attainment, salary, autonomy and professional status. This is the actual state of affairs within the country, while outwardly – in various reports and research articles – these healthcare practitioners are portrayed as clinical nurse specialists within a particular field of practice or as providers of advanced nursing care, which is not in accordance with their actual status in Slovenia.

Durey and colleagues (2014) describe the diverse pathways towards the acquisition of specialised and specialist knowledge in Europe, in both undergraduate and postgraduate education. A clear distinction must be made between the provision of nursing within a specialised field on one hand and specialised nursing practice on the other, as the latter requires clinical specialisation. A clinical nurse specialist is able to perform clinical audits, makes independent clinical decisions, performs clinical supervision, is responsible for the development of research-based practice, provides professional support to employees, trains them and is involved in specialised training (Nursing and Midwifery Council [NMC], 2001). Clinical specialisation is now recognised as advanced nursing practice within a clinical specialty, and requires the completion of training of at least level 7 of the European Qualifications Framework, which is equivalent to at least a professional master's degree (European Specialist Nurses Organisations [ESNO], 2016).

Thus, in 2020, in light of these briefly outlined issues pertaining to competency-based post-graduate training in Slovenia, the new guidelines for advanced nursing practice prepared by the International Council of Nurses (ICN) (2020) will certainly make a significant impact. These guidelines make a clear distinction between: 1) specialised knowledge within nursing (in Slovenia we refer to this as *specialna znanja,* i.e. special skills or special knowledge), 2) clinical specialisation in nursing, and 3) advanced nursing practice and care. As it clearly defines the levels of postgraduate nursing education, this document will be of central importance to the developers of the Slovenian nursing development strategy for the period from 2020 to 2030 period. The following section summarises what we can expect in the new guidelines for advanced nursing practice (ICN, 2020) and existing recommendations for clinical specialisations (ESNO, 2015) and advanced nursing practice (Bryant-Lukosius & Martin-Misener, 2016).

Specialised or special knowledge

Postgraduate education in specialised nursing requires the deepening of knowledge in a particular field of nursing practice and is not related to advanced healthcare proceedings of clinical problems. In fact, in making clinical decisions pertaining to the patient, a registered nurse with specialised skills is also dependent on the physician who monitors and validates their clinical decisions. This is the rationale behind performance algorithms. Entry into such educational training requires considerable professional experience. Training is provided in the form of specialised clinical modules at the workplace or beyond. While there are no international recommendations in this field, such training should not be a substitute for ensuring clinical specialisation in the country (ESNO, 2015; ICN, 2020).

Clinical specialisation

The minimum educational standard for the attainment of clinical specialisation (i.e., Clinical Nurse Specialist) is a professional master's degree obtained through a study programme with clearly defined specialised clinical content and extensive clinical training. The study programme must be accredited within the nursing departments of colleges/schools which are recognised as suitable for the delivery of such educational training. The clinical nurse specialist's field of practice is primarily

secondary and tertiary health care. The recognised clinical areas are defined according to the population group (paediatrics, geriatrics, women's health), environment of practice (emergency states, intensive care), subspecialties (oncology, diabetes), type of disease treatment (psychiatry, rehabilitation), or type of disease problems (pain, wounds, incontinence). Clinical training also includes health promotion, risk factors assessment, symptom management, and addressing functional problems associated with the medical conditions covered by a clinical specialist. The clinical nurse specialist provides direct specialist health care which involves the provision of patient-centred care with regard to the clinical problem, clinical audit, independent clinical decision making, and the search for health resources and deficits. Such nursing care must be evidence-based. Clinical nurse specialists must monitor their own work, be responsible for the development of the clinical field, organising and monitoring it, and engage in research within their specialised field of clinical practice. They must be able to act independently within multidisciplinary teams, which enable consultation and collaboration between clinical specialists in nursing and medicine (NMC, 2001; ESNO, 2015; ICN, 2020).

Advanced practice nursing

Educational training in advanced practice nursing focuses primarily on the problems of the primary level of care. The minimum prerequisite for autonomous work is a master's degree in advanced nursing at the primary level, while in the US, a professional doctoral degree is required. The study programme must be accredited within nursing departments of colleges/schools which are recognised as suitable for the delivery of education. Holders of a master's degree in advanced practice nursing (i.e., advanced practice nurses) are trained to take a holistic approach to patient care at the primary level, which in some countries includes, in addition to diagnosing and taking responsibility for treating disease conditions (both acute and chronic), also prescribing medications. In the context of the European area, i.e., in England, Ireland, Scotland, Wales, Finland, the Netherlands, etc., advanced practice nurses have the ability to also prescribe medications (Maier & Aiken, 2016). They address various medical conditions on the basis of evidence-based guidelines, which incorporate a holistic approach to the treatment of medical conditions. Advanced practice nurses also play an important role in the field of disease prevention and the efficiency of the health system. It is of paramount importance that the study programme includes guided clinical training within a clinical setting. There is also a prescribed minimum number of hours of training, which should be undertaken under the mentorship of an experienced medical doctor or holder of a master's degree in nursing. The countries with an established practice in this field require a minimum of 500 hours of such clinical training (ESNO, 2015; Bryant-Lukosius & Martin-Misener, 2016; ICN, 2020). Advanced practice nurses most often work at the primary level of care in family medicine, care of children and adolescents, elderly care, and acute care. They thus provide care to a complex population with a diverse array of health problems. They act independently, assume responsibility for patient health and their own work, cooperate with other health professionals, perform advanced holistic health assessments, plan investigation tests, provide direct clinical care to patients with un-diagnosed conditions, prescribe medications, monitor and evaluate the activities performed. They also have the authority to refer and admit patients. Advance practice nurses provide evidence-based care. They also monitor their own work and engage in clinical research work in their field of practice. They act independently within multidisciplinary teams which enable them to benefit from consultations and collaboration between advanced practice nurses and clinical medical specialists in their field of practice.

The difference between a clinical nurse specialist and an advanced practice nurse is that the former works as an expert within a limited field of practice, is less often confronted with systemic perspectives of health care delivery, but is instead provided more indirect support for quality clinical work (education, publishing, professional guidance, research), while the latter targets the needs of the healthy and unhealthy population groups alike, most often within primary care, and provides care in both acute and chronic treatment of medical conditions, while also engaging in preventive health care within a highly diverse clinical setting. Compared to a clinical nursing specialist, an advanced practice nurse is hence much more involved in independent clinical work and assumes systemic responsibility for the outcomes of medical treatment.

How to proceed?

The OECD study (Maier, et al., 2017) places Slovenia in the group of countries with the least developed advanced practice skills. Researchers assign the existing training programmes the status of advanced skills and advanced roles within the healthcare team and do not recognise them as advanced training. The interventions are conducted under the supervision of a medical doctor; they are performed by registered nurses listed according to their field of practice ("reference nurses", "health promotion nurse", "family nurse").

In Slovenia, the pathways to clinical specialisation and advanced nursing practice are long, as the accredited master's programmes do not offer the aforementioned clinical content or guided clinical training. In most developed countries, a professional master's degree

takes one year, while a bachelor's degree takes four years to complete. Therefore, bachelor's degree programmes in nursing should be redesigned to the level of a four-year academic bachelor's degree programme in Slovenia, which will allow for the adequate implementation of the competences prescribed in the European Directive (2013/55/EU), such as, for example, evidence-based practice. It will also enable a deepening of professional and specialised knowledge in the field of public health problems of contemporary society. With this change, nursing graduates (registered nurses) will have received a broad educational training conducive to their further development within the clinical setting of their field of practice. Most countries have extended their study programmes in nursing to four years, as the RN4CAST survey clearly showed that treatment outcomes were better in patients treated by nurses with academic bachelor's degrees rather than those with professional bachelor's degrees (Aiken, 2014, 2018). Upon the transition to four-year programmes, the master's degree will be reduced to one year. Master's degree programmes must target different fields of clinical practice, which should be defined at the national level as clinical specialisations and master's degrees in advanced practice care at the primary level. This transition requires professional, multidisciplinary as well as political agreement. Application of specialised knowledge in the implementation of clinical specialisation or advanced nursing competences is professionally unacceptable, as the required level of training to obtain specialised knowledge cannot be compared to the competences acquired through a master's degree programme. Therefore, the professional association and faculties must firmly reject all attempts at the implementation of advanced nursing practice at the primary level and specialist nursing practice at the secondary and tertiary levels.

Slovenian translation / Prevod v slovenščino

Za nami je leto 2019, ko smo praznovali 100-letnico začetka poklicnega dela prve šolane skrbstvene sestre Angele Boškin in 120-letnico ustanovitve Mednarodnega sveta medicinskih sester. Vstopili smo v leto 2020, ki ga je Svetovna zdravstvena organizacija (SZO) razglasila za mednarodno leto medicinskih sester in babic in je posvečeno spominu na 200 let rojstva Florence Nightingale. Kako velika koncentracija spominov in priložnosti za vrednotenje doseženega in snovanje načrtov za prihodnost! Številni dogodki, ki doma in v svetu potekajo ob mednarodnem letu medicinskih sester in babic, so del triletne kampanje »Nursing now« ali »Medicinske sestre in babice zdaj«, ki se je pričela v letu 2018 in se zaključuje konec leta 2020.

Kampanja opozarja na pet ključnih področij: 1) medicinske sestre in babice morajo imeti pomembnejši glas pri oblikovanju zdravstvene politike; 2) potrebno je večje vlaganje v kadrovske vire v zdravstveni in babiški negi; 3) medicinske sestre in babice naj enakovredno z drugimi profili zasedajo vodstvene položaje v zdravstvu; 4) omogočijo naj se raziskave, ki opredelijo neposreden prispevek zdravstvene in babiške nege k preprečevanju in zdravljenju bolezni v družbi; 5) zdravstveni sistemi naj se zgledujejo po najboljših praksah v zdravstveni in babiški negi ter jih implementirajo v korist učinkovitega in dostopnega zdravstva (All-Party Parliamentary Group [APPG] on Global Health, 2016).

Cilji triletnega opozarjanja na vlogo medicinskih sester in babic v zdravstvenem sistemu in družbi so večplastni, izhajajo iz spoznanj številnih raziskav in opozarjajo politike na državni ravni, da so medicinske sestre in babice izjemno pomemben člen pri zagotavljanju dostopnosti, učinkovitosti in kakovosti zdravstvene obravnave (International Centre on Nurse Migration [ICNM], 2018), saj SZO jasno opredeli, da dostopnega zdravja za vse (Universal Health Coverage) ne moremo doseči brez aktivne vloge medicinskih sester in babic (World Health Organization [WHO], 2015). Poseben pečat in podporo širitvi tega zavedanja in spodbujanja ukrepov, ki bi spremenili vlogo in status obeh poklicnih skupin v družbi, daje generalni direktor SZO dr. Tedros Adhanom Ghebreyesus (Anon., 2020). SZO je tako v letu 2019 zbirala podatke za izdelavo svetovnega poročila o stanju kadra v zdravstveni negi v svetu z naslovom *The State of the World's Nursing Report*, ki bo predstavljeno 7. aprila 2020 ob mednarodnem dnevu zdravja. Prav tako se podatki zbirajo za babice. SZO želi s poročilom vplivati na države in njihove politike, da investirajo v razvoj zdravstvene nege in medicinskih sester. V letu 2019 je bilo objavljeno tudi poročilo o zaposlovanju kadra v zdravstveni negi in njegovi povezanosti z varnostjo pacientov ter varnostjo dela za zdravstvene delavce (Saudi Patient Safety Center & International Council of Nurses [SPSC & ICN], 2019). Predstavljena so bila priporočila za razmerje med diplomirano medicinsko sestro (dipl. m. s., ang. RN) in največjim številom pacientov po strokovnih področjih. Naj navedemo nekaj primerov iz prakse: intenzivna terapija 1 dipl. m. s. / 1 pacient, prebujanje po anesteziji 1 / 2, pediatrični oddelek 1 / 4, urgentni oddelek 1 / 2, internistični ali kirurški oddelek 1 / 4, onkološki oddelek 1/3. Priporočila o varnih normativih in nevarnostih, ki so posledica »podhranjene« kadrovske politike, usmerjajo odgovorne v zdravstvu in financerje v zdravstvu, da prenovijo obstoječe kadrovske normative. Tako Aiken in sodelavci (2018) opozorijo, da je v zdravstveni negi treba zagotavljati vsaj 80 % visokošolsko izobraženih medicinskih sester. Temu sledijo najprej ZDA, pa tudi Irska, Velika Britanija idr.

Tradicionalne zdravstvene politike v Evropi imajo ob vse večjem povpraševanju po zdravstvenih storitvah, ki so posledica dolgožive družbe, vedno

večje težave. Usmerjene so predvsem v reševanje problemov zdravnikov, ostalim poklicnim skupinam ne dajejo ustrezne pozornosti. Takšen odnos zdravstvene politike že leta spremlja slovenske medicinske sestre in babice, ki se srečujejo z vedno večjimi delovnimi obremenitvami, slabim plačilom za zahtevno delo, slabimi pogoji dela in odnosi na delovnem mestu, nepriznavanjem njihovega prispevka k izidom zdravstvene obravnave idr. Na nekatere od naštetih pomanjkljivosti opozori doktorska disertacija Mojce Dobnik (Dobnik, et al., 2018). Velik problem predstavljata majhno število diplomiranih medicinskih sester na 1000 prebivalcev ter onemogočanje njihovega razvoja na ravni kliničnih specializacij in naprednih oblik dela. V Sloveniji se uveljavlja praksa, da se diplomirane medicinske sestre podiplomsko izobrazijo za določene delovne naloge na neakreditiranih izobraževalnih programih, ki so pripravljeni v ozkih krogih in usmerjeni predvsem v razbremenitev zdravnikov. Gre za izobraževanja, ki slušatelje usposobijo, da izvedejo dela in naloge zdravnikov. Po končani izvedbi programa slušatelji na Zbornici - Zvezi pridobijo specialna znanja. Tako so nastale referenčne ambulante, danes ambulante družinske medicine, trenutno se vzpostavljajo še ambulante skupnostne psihiatrije na primarni ravni. Zanimivo je, da se teh diplomiranih medicinskih sester ne spodbudi, da bi zaključile formalno podiplomsko klinično specializacijo, si s tem dvignile raven izobrazbe, plačo, avtonomijo in poklicni status. Tako je znotraj države, navzven pa jih v raznih poročilih in znanstvenih člankih prikazujemo kot klinične specialistke določenega področja ali kot izvajalke napredne zdravstvene nege, kar ni skladno z njihovim dejanskim statusom v Sloveniji.

Durey in sodelavci (2014) opisujejo raznolikost pridobivanja specialnih in specialističnih znanj v Evropi, ki je vezana tako na dodiplomski študij kot na podiplomsko izobraževanje. Jasno je treba ločiti med izvajanjem zdravstvene nege na specialnem področju in izvajanjem specialistične zdravstvene nege, za katero je potrebna klinična specializacija. Klinični specialist izvaja klinično presojo, samostojno sprejema klinične odločitve, izvaja klinični nadzor, odgovarja za razvoj prakse na osnovi raziskav, daje strokovno podporo zaposlenim, jih uči in se vključuje v usposabljanje specialistov (Nursing and Midwifery Council [NMC], 2001). Klinična specializacija je danes prepoznana kot napredna zdravstvena nega na ožjem strokovnem področju; izobraževanje zanjo sodi najmanj na sedmo raven Evropskega kvalifikacijskega okvira, kar ustreza stopnji strokovni magisterij (European Specialist Nurses Organistaions [ESNO], 2015).

V letu 2020 bodo tako – ob delčku opisane slovenske problematike izobraževanja za prevzem kompetenc po zaključenem dodiplomskem študiju – zagotovo imele pomembno težo nove smernice za napredno zdravstveno nego, ki jih pripravlja Mednarodni svet medicinskih sester (International Council of Nurses [ICN], 2020). Te jasno ločijo med: 1) specializiranimi znanji v zdravstveni negi (v našem prostoru jih poimenujemo specialna znanja), 2) klinično specializacijo v zdravstveni negi ter 3) napredno zdravstveno nego in obravnavo. Dokument bo ključnega pomena za pripravljavce strategije razvoja zdravstvene nege v obdobju med 2020 in 2030, saj jasno opredeli nivoje podiplomskega izobraževanja v zdravstveni negi. V nadaljevanju povzemamo, kaj lahko pričakujemo v novih smernicah za napredno zdravstveno nego (ICN, 2020) in že objavljenih priporočilih za klinične specializacije (ESNO, 2015) in napredno zdravstveno nego (Bryant-Lukosius & Martin-Misener, 2016).

Specializirana ali specialna znanja

Podiplomsko izobraževanje za specialna znanja v zdravstveni negi *(Specialised Nurse)* zahteva poglabljanje znanja na določenem strokovnem področju zdravstvene nege in ni povezano z napredno zdravstveno obravnavo kliničnih problemov. Dejstvo je, da je diplomirana medicinska sestra s specialnimi znanji pri sprejemanju kliničnih odločitev, povezanih s pacientom, soodvisna od zdravnika, ki njene odločitve spremlja in potrdi. Zato so izdelani algoritmi delovanja. Za vključitev v tovrstno izobraževanje so potrebne daljše strokovne izkušnje. Izobraževanje poteka v obliki specializiranih kliničnih modulov na delovnem mestu ali izven njega. Mednarodnih priporočil na tem področju ni, vendar tovrstno izobraževanje ne sme biti nadomestilo za zagotavljanje kliničnih specializacij v državi (ICN, 2020).

Klinična specializacija

Minimalni standard izobraževanja za pridobitev klinične specializacije (Clinical Nurse Specialist) je strokovni magisterij z jasnimi specializiranimi kliničnimi vsebinami v študijskem programu in obsežnim delom kliničnega usposabljanja. Študijski program mora biti akreditiran v okviru oddelkov za zdravstveno nego fakultet / šol, ki so prepoznane kot ustrezne za izvajanje predvidenega izobraževanja. Področje delovanje kliničnega specialista je predvsem na sekundarni in terciarni zdravstveni obravnavi. Prepoznana klinična področja so definirana glede na populacijo (pediatrija, geriatrija, zdravje žensk), okolje delovanja (urgentna stanja, intenzivna terapija), subspecialnosti (onkologija, diabetes), vrsto zdravstvene obravnave (psihiatrija, rehabilitacija) ali vrste zdravstvenih problemov (bolečina, rane, inkontinenca). Klinično usposabljanje vključuje tudi promocijo zdravja, dejavnike tveganja, management simptomov in funkcijskih problemov, povezanih z bolezenskimi stanji, ki jih pokriva klinični specialist. Klinični specialist v zdravstveni negi zagotavlja

neposredno specialistično zdravstveno obravnavo, ki vključuje na posameznika osredotočeno obravnavo kliničnega problema, klinično presojo, samostojno sprejemanje kliničnih odločitev, iskanje resursov in deficitov v zdravju. Izvajana obravnava mora biti podprta z dokazi. Klinični specialist mora spremljati lastno delo, odgovarjati za razvoj kliničnega področja, ga organizirati, spremljati in se vključevati v raziskovalno delo na specializiranem kliničnem področju. V medpoklicnem timu, ki mu omogoča konzultacije ter sodelovalno delo med kliničnimi specialisti v zdravstveni negi in medicini, deluje samostojno (NMC, 2001; ESNO, 2015; ICN, 2020).

Napredna zdravstvena nega in obravnava

Izobraževanje za napredno zdravstveno nego je usmerjeno predvsem na probleme primarne ravni. Minimalni pogoj za samostojno delo je zaključen strokovni magisterij napredne zdravstvene nege in zdravstvene obravnave na primarni ravni, medtem ko v ZDA že zahtevajo izobrazbo na ravni strokovnega doktorata, ki ga v Evropi ne izvajamo. Študijski program mora biti akreditiran v okviru oddelkov za zdravstveno nego fakultet / šol, ki so prepoznane kot ustrezne za izvajanje izobraževanja. Magister napredne zdravstvene nege je usposobljen za celostni pristop k pacientu na primarni ravni, kar v nekaterih državah vključuje poleg postavitve diagnoze in prevzemanja odgovornosti za zdravljenje bolezenskih stanj, tako na področju akutnih kot kroničnih stanj, tudi predpisovanje zdravil. Če pogledamo samo evropski prostor, magistri napredne zdravstvene nege predpisovanje zdravil izvajajo v Angliji, Irski, Škotski, Walesu, Finski, Nizozemski idr. (Maier & Aiken, 2016). Različna bolezenska stanja so obravnavana na osnovi smernic, podprtih z dokazi, ki vključujejo celostni pristop pri obravnavi bolezenskega stanja. Magister napredne zdravstvene nege ima pomembno vlogo tudi na področju preprečevanja bolezni in učinkovitosti zdravstvenega sistema. Izjemnega pomena je, da izobraževanje vključuje vodeno klinično usposabljanje v kliničnem okolju. Predpisane so tudi minimalne ure usposabljanja pod mentorstvom izkušenega zdravnika ali magistra zdravstvene nege. Države, ki imajo že razvito prakso na tem področju, zahtevajo minimalno 500 ur opisanega kliničnega usposabljanja (ESNO, 2015; Bryant-Lukosius & Martin-Misener, 2016; ICN, 2020). Magister napredne zdravstvene nege najpogosteje deluje na primarni ravni v družinski obravnavi, zdravstveni obravnavi otrok in mladostnikov, obravnavi starejših in akutni zdravstveni obravnavi. Obravnava torej kompleksno populacijo z raznolikimi zdravstvenimi problemi. Deluje samostojno, prevzema odgovornost za zdravje obravnavanih in svoje delo ter deluje sodelovalno z drugimi zdravstvenimi strokovnjaki, izvaja napredno celostno zdravstveno oceno zdravstvenega stanja, načrtuje diagnostične preiskave, postavi diagnozo zdravstvenega stanja, predpiše terapijo, spremlja in evalvira izvedene aktivnosti. Poleg tega ima pooblastila za napotitev in sprejem pacienta. Obravnava, ki jo izvaja, je podprta z dokazi. Izvaja tudi spremljanje lastnega dela in se vključuje v raziskovalno delo na kliničnem področju delovanja. Deluje samostojno v med-poklicnem timu, ki omogoča konzultacije in sodelovalno delo med magistri napredne zdravstvene nege in kliničnimi specialisti medicine na področju kjer deluje.

Razlika med kliničnim specialistom v zdravstveni negi in magistrom napredne zdravstvene nege je predvsem v tem, da prvi deluje kot strokovnjak na omejenem področju, manj se sooča s sistemskimi perspektivami za zagotavljanje zdravstvene oskrbe, več pa s posredno podporo za kakovostno klinično delo (izobraževanjem, publiciranjem, strokovnim vodenjem, raziskovanjem), medtem ko se drugi usmerja v potrebe zdrave in bolne populacije, najpogosteje na primarni ravni, in vključuje tako akutno kot kronično obravnavo bolezenskih stanj ter preventivo v zelo raznolikem kliničnem okolju. Zato je magister napredne zdravstvene nege v primerjavi s kliničnim specialistom zdravstvene nege mnogo bolj vključen v samostojno klinično delo in prevzema sistemsko odgovornost za izide zdravstvene obravnave.

Kako naprej?

Študija OECD (Maier, et al., 2017) je Slovenijo umestila v skupino držav, ki ima najmanj razvita napredna znanja. Raziskovalci so obstoječim izobraževalnim programom dodelili status razširjenih znanj in razširjene vloge v zdravstvenem timu ter jih ne priznavajo kot napredno izobraževanje. Intervencije, ki jih izvajajo, potekajo pod nadzorom zdravnika; izvajajo jih diplomirane medicinske sestre, ki jih v dokumentu poimenujejo glede na področje delovanja (»reference nurses«, »health promotion nurse«, »family nurse«).

Pot do kliničnih specializacij in napredne zdravstvene nege je v Sloveniji še dolga, saj akreditirani magistrski programi še ne ponujajo dovolj zgoraj opisanih kliničnih vsebin in vodenega kliničnega usposabljanja. V večini razvitih držav strokovni magisterij traja eno leto, dodiplomski študij pa štiri leta. Zato je v Sloveniji treba študij zdravstvene nege na dodiplomski ravni preoblikovati na raven štiriletnega univerzitetnega programa, kar bo omogočilo zadostno implementacijo kompetenc, ki so predpisane v evropski direktivi (Directive, 2013), kot je na primer delovanje, podprto z dokazi. Možna bo tudi poglobitev strokovnih in specialističnih znanj s področja javnozdravstvenih problemov sodobne družbe. S to spremembo bo diplomant zdravstvene nege dobil široko izobrazbo za nadaljnji razvoj v kliničnem okolju, kjer bo deloval. Večina držav je študij podaljšala na štiri leta, saj

je raziskava RN4CAST jasno pokazala, da so izidi zdravstvene obravnave boljši pri pacientih, če so jih obravnavale univerzitetno izobražene medicinske sestre v primerjavi z visokostrokovno izobraženimi (Aiken, 2014, 2018). Ob prehodu v štiriletne programe se bo magistrski študij skrajšal na eno leto. Magisteriji morajo biti usmerjeni v različna klinična področja, ki morajo biti opredeljena na ravni države kot klinične specializacije in magisterij za napredno zdravstveno obravnavo na primarni ravni. Za ta prehod je potreben strokovni, medpoklicni in politični dogovor. Uporaba specialnih znanj za izvajanje kompetenc klinične specializacije ali napredne zdravstvene nege je strokovno nedopustna, saj je zahtevani obseg izobraževanja za specialna znanja neprimerljiv z magistrsko ravnjo kompetenc. Zato morajo strokovno združenje in fakultete ostro zavrniti vse poskuse, da se s specialnimi znanji izvaja napredna zdravstvena nega na primarni ravni ter specialistična zdravstvena nega na sekundarni in terciarni ravni.

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