The Changing Role of a Nurse in Lithuania Related to Integrated Team-Based Home Care Pilot Projects

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Key Words: *role of the nurse; transformation of the nursing role; integrated care; home care; multidisciplinary team.*

Summary. *Although the legal acts of the Lithuanian Ministry of Health emphasize the autonomous role of the nurse in the health care system, the understanding of the nurse as an assistant of a physician still prevails in primary health care. Many countries acknowledge nursing as an autonomous profession, where a nurse is entitled to independent decisions in cooperation with (not subordination to) a physician. The aim of the article was to describe the findings of a qualitative case study analyzing the nurses' roles as they were shaped by the innovative integrated home care pilot projects in Lithuania and the diverse spectrum of challenges met by nurses.*

Methods. The data were collected via group interaction in 4 focus groups with 5 nurses in each group (20 nurses from 20 municipalities). Inductive and deductive data analyses were used ensuring reliability and validity of findings through researchers' triangulation.

Results. The roles of the nurses corresponded to the roles of advanced nurses: consulting and cooperating with family members by integrating the formal and informal nursing service at home with social services, consulting the nursing person and managing the nurse assistant teams, and mediating between the family doctor, hospital, and emergency aid and the patient. The degree of autonomy varied in different pilot municipalities, although the descriptions of nurses' activities had the same legal basis.

Conclusions. Attained autonomy in the integrated team-based home care pilot projects facilitated the change of the nurse role. The challenges to the role change were connected to the interaction with primary health care practitioners, posttotalitarian experience, lack of a person-centered approach, and change through innovation.

Introduction

The transformation of services toward more integrated care is seen as a means to health system strengthening (1). The integration of service delivery aims to remove gaps in care that affect care experiences and ultimately health outcomes (2, 3). The "integrating initiatives" aim to overcome the challenges of fragmentation and to ensure comprehensive and continuous response to care needs, especially the growing needs of care of people with chronic conditions (4). Nurses are seen as the main resource in transforming the health care system workforce (5) as they are the best-prepared practitioners to care for people with multiple chronic conditions, and nursing is the largest health care profession with scientific knowledge and adaptive capacity (5, 6). In order to achieve the change, there is a need for transformation of nurses' roles and responsibilities as well as reconceptualization of nurses' functions in health coaching, chronic disease management, and transitional care. The full range of services interfaces with varied settings of care from primary, secondary, and specialist care to the broader setting of social and home care services (7). Multidisciplinary teams delivering community-based services are able to respond to a broader range of the cared person's needs and enable better chronic disease management and stronger prevention that allow lessening reliance on hospitals and doctors (8). One of the most important professionals of multidisciplinary teams is the nurse. In many countries, the role of the nurse as a representative of a separate profession – nursing – has been already established (9, 10): the nurse as an expert of nursing collaborates with (not obeys to) the physician who is an expert of treatment. Meanwhile in Lithuania, the model of the nurse as

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the assistant of the physician that has been evolving through many years dominates. However, there are also some changes. According to the norms issued by the Ministry of Health (11), the general practice nurse has to perform assignments of the physician; the community nurse (12) can perform certain functions independently. In reality, there is little room for independency and self-direction as the infrastructure of home care is not developed in Lithuania because of the low funding rates for home nursing.

One of the acknowledged ways for finding and adapting new solutions is the implementation of pilot projects. In 2012, in response to the call of the Lithuanian Ministry of Social Security and Labour, 21 municipalities (out of 60) (13) started pilot projects financed by EU structural funds. The pilot projects introduced an integrated team-based home care model of multidisciplinary teams combining nursing and social care services for dependent persons with chronic illnesses. In this article, the findings of the pilot projects are described. The aim of this article was to present and analyze the nurses' roles that were shaped by the innovative pilot projects and the transformation of the nurse's role in the process of integrated team-based home care, as well as to analyze a diverse spectrum of challenges met by nurses.

Methods

A design of a constructivist case study (14) was applied to answer the following research questions: 1) what challenges does a community nurse face working in an interdisciplinary mobile team of innovative integrated care (IC) pilot projects? and 2) what roles do nurses shape in the process of overcoming these challenges? The presumption was made that, despite the multiple perspectives of nursing practice in home surroundings, nurses collectively represent nurse roles constructed by the case of the innovative IC pilot projects. A purposeful sample was employed that consisted of nurses from 21 pilot municipalities (13). The data were collected in 4 focus groups with 5 nurses in each group (one nurse was not able to participate). Focus group interviews and especially group interaction provided an opportunity for nurses from different municipalities and mobile teams to share their experiences, opinions, and insights. The data produced via group interaction are deeper and richer (15, 16). All the nurses had the qualification of a general practice nurse and 19 nurses had the specialization of a community nurse.

Data Collection and Analysis. The meetings lasted 120 min each. All the focus groups were conducted in the service provider's premises. The focus groups were recorded with the participants' consent, later transcribed and analyzed. Agreement on the main categories was reached in the group of the authors after a thorough discussion. Researcher triangulation – working as a team on data analysis – ensured reliability and validity of research findings (15).

Context of IC Projects. The IC teams consisted of social workers and their assistants, nurses and their assistants, and a physiotherapist/or masseuse, in contact with a family doctor. In 20 municipalities, the team-based integrated home care services were initiated and implemented by the departments of social care; in one, by a polyclinic (5). There were 2 to 10 teams (mean, 3) in a municipality, providing care for 56 patients a month on average (SD, 29; range, 25–141). One team cared for about 16 patients. On average, 1 nurse (mode, 1; range, 0.5–4), 11 nursing assistants (range, 4–30), and a physiotherapist or a masseuse (mean, 1.2; range, 0.25–4) were employed per IC pilot project.

Results

In providing home care service, the nurses performed 4 key roles: a **practitioner** assessing, planning, and implementing the nursing of the patient; a **co-producer of care** educating and engaging the family in the care of the patient; a **leader and a counselor** of nursing assistants' subteam in cooperation with a social care coordinator; and a **mediator** with health care infrastructures ensuring continuity of health care and advocating for the patient.

1. Nurse as a Home Care Practitioner

The activities of the nurse in the IC teams corresponded to the description of community nurse activities in the Lithuanian Medicine Norm (12). A nurse independently organized nursing services in the territory served by the IC team, planned the schedules of visits, assessed, planned the nursing outcomes and implemented them for every patient, and documented the health condition and changes of health during visits in self-designed forms. When the patient's condition was stable, the nurse performed secondary prevention: monitoring of the patient's condition in order to avoid worsening of an illness. Nursing assistants in the IC projects were responsible for the care of patient's personal hygiene and ensured the basic needs of the patient (in some municipalities, this role was shared together with an assistant social worker). The frequency and duration of nurse visits increased when the patient's condition became acute and needed constant observation and intense nursing.

"... When you have to go with drips, when you need to do some procedures, then you can stay [with the patient] even for several hours. Lately, I had a patient who was prescribed a drip [...]. The veins were very bad ... You go on your knees around the bed, looking for a vein. Three hours pass very honestly".

In different municipalities, the approach to the role of the nurse in the IC projects and the scope of nursing activities differed. In some municipalities, nurses performed all the orders and prescriptions of primary care physicians (i.e., medical tests, intravenous injections, etc.). In other municipalities, there was a strict attitude that a home care nurse could not duplicate the job of a general practice nurse (working together with a physician in the primary health care center). Therefore, the IC nurses would take over injections and drips after the limits of these nursing procedures from the health care center were exceeded. In the third group of municipalities, the IC nurse was seen as lifting the burden of care for the family through providing nursing together with an assistant nurse. This group of nurses did not perform any interventions or intravenous injections.

The nurses providing direct care to the patient faced certain challenges about how and whether to perform a certain procedure, e.g., how to deal with the situation of high blood pressure. The expertise in direct contact with the patient was sufficient to judge that giving certain medication would help to normalize the condition of the patient; however, such an activity would cross the boundary of the profession regulated by law.

"[The physicians say,] you are there in the place, [you decide]. We do have a lot of practice, – I have been working for many years. If it were my family member, you would give a pill and that's it. But when we work, we [...] have to behave according to the job description: only the doctor prescribes the medicine."

The role of the IC nurse practitioner varied depending on whether the patient had caregivers or was single. Although the pilot projects were focused on expanding the possibilities to harmonize the family and work commitments, part of the patients in the projects did not have close relatives that could take care of them when the need for constant specialized nursing care was identified. The number of such patients was not very small.

"Out of 17, I have only 3 people who sleep overnight with somebody at home. The rest stay alone at night. There are really single [patients] without children, when you close the doors on Friday, and the specialists come on Monday."

Our data revealed that all the nurses from the IC pilot projects executed the role of the nurse practitioner providing direct nursing services to patients. The role required case management including assessment, planning, and implementing the nursing of patients in a self-directed manner. The nurses had to perform complicated nursing procedures and at the same time remain sensitive in providing information to patients about their health condition, react empathically to patients' complaints, brighten up their mood, and even provide hope. Finally, they had to empower patients and engage them into coping with the illness.

2. Co-producer of Patient's Care Together With the Family

When a person gets severely chronically ill, family members have to undertake an unexpected burden, for which they are neither physically nor emotionally prepared. Sometimes, family members cannot overcome their disgust in helping the ill person to ensure everyday hygiene.

"The daughter lives in the same apartment. She comes to the mom to change the diaper. But the neighbor tells, she [the daughter] comes with a mask, because she cannot stand it physically and psychologically... It happens that we leave [the mother on one day] and on the next day we find her with the same diaper."

Very often it is difficult for the family to reorganize the existing structure and the rhythm of life so that the activities of family members accommodate the care of a seriously ill person. No wonder that some family members are hostile to the advice and suggestions given by the nurses.

"... the old lady is all stiff, lies on an armchair bed that is not extended, her legs hang. I say, one should lay her comfortably. The daughter objects: "I will not clutter my house. And in general, I took the holidays not for looking for my mother. Of course, these are single cases..."

Family members often try to avoid taking care of a sick person when they start to receive formal professional help. "With us, when the services start, family members distance themselves from care." However, sometimes nurses do not recognize that their status as professionals and their attitude and relationship to nursing family members also affect the relation. When family members do not completely assume any responsibility for their sick family member and leave all the responsibility to health care providers, the nurses of IC try to remind the duties of children to their parents.

"When we start to provide the services, we talk a lot with family members that it is not only our duty, but also their duty. We say, there is such a family code, and it is written there that children are responsible for their parents [in old age]."

In IC, the role of the nurse to involve family members into care according to their possibilities was evident. The nurses encouraged and taught, using visual aids and integrating knowledge with practice acquired at the patient's bed.

"... [I say to the patient:] If you do not know, I can counsel anytime and provide you with knowledge. We prepare folders for family members and leave them with the person. With pictures, how bed-

sores look like. I teach them that it is very difficult to cure bedsores when they appear."

Family members are tired of constant care about a seriously ill person. Sometimes, family members perceive the words that nurses say without much thinking as a reproach and react with an extra sensitivity.

"Recently we got an old lady with Parkinson's disease. The relatives asked for [IC] services. We come in the morning the whole team. I, with my 24 years of experience, tell immediately – not to the daughter, but to the girls [nursing assistants]: "bedsore of the fourth degree – the bone is sticking out". The daughter opened immediately: "Who came here out of the street and states that there is a bedsore of the fourth degree! Who gave you the right to state that?! I refuse the services of a nurse, and that she would not dare put a finger close to my mother! That's all with the work. And I would gladly give advice, after all the experience that I have. And there are different kinds of means, not necessarily only plaster, cross sealed. But... came here out of the street..."

All the research participants claimed that the relationship with family members was one of the most complicated things. Teaching and counseling them request a lot of empathy, patience, and strength. The role of the nurse as a counselor and teacher of family members requires not only medical and nursing abilities, but also a lot of tact and psychosocial competences.

3. Leader and Counselor of Nursing Assistants' Subteam

It is important to admit that constant everyday nursing and ensuring personal hygiene is done by nursing assistants or by family members, and not by the nurse. Nursing assistants are unqualified personnel who undergo 360-hour training and their competence increases with gaining experience and in constant counseling with the nurse in a team. The leader and counselor of nursing assistants' subteams is another key role of the nurse performed in IC pilot projects.

"In practice, we arrange more or less in advance: if there is some problem that can be solved without urgency, if it is possible to delay until tomorrow, we agree with the assistant that she would go alone. Meanwhile, another assistant has already come with her own transportation to her patient and waits for me. This way I go a circle around."

When problems or unexpected situations arise, nursing assistants contact the nurse and ask for her advice or solution.

"You never know where you will be when you are in the nurse's role, because [assistants] called – it is bad [somewhere]; and you drop your plans and hurry there, because there is trouble there. So I drive alone over."

The biggest part of counseling was tele-counseling by phone. However, at any time it could turn out that direct counseling was needed, which usually meant changes in the planned schedule for the nurse.

"I plan in advance who to visit. However, it does not always come true. One calls, another calls, a nursing assistant calls because of some trouble and worsening, because patients are with such complicated diagnoses..."

The role of the leader of a nursing assistants' subteam requests certain competences related to management. The nurse as a manager pays attention to the feelings of nursing assistants, to their encouragement, their motivation, and interest in the work.

"At the beginning [of the project], there were no nursing assistants, and social workers were getting prepared [for that role, they] finished a course. And of course, a lot of work was performed by the nurses, because we visit patients. And we try to analyze, to clarify what is needed, how to help, that a new nursing assistant would not get stressed, because not all have completed studies in medicine. We, nurses, had to do a lot of work."

The nurse in this role provides tele-care: i.e., keeps constant contact with nursing assistants and coordinates their work.

"I drive and I have my phone in the hand. After assessing the information that I get from assistants, I go to the place where I am mostly needed."

The nurse also educates nursing assistants to assess situations, describe them to the leader, give feedback, and share experience among themselves.

"At the beginning, we tried to visit as much as possible per day, but later on I understood that I have to make order with organizing, because there are also assistants, and I do a lot of work that assistants could understand and assess the situation. We also work a lot that assistants could give exact feedback to the nurse. If patients get worse, I get a lot of phone calls."

Organizing in the subteam of nursing assistants is part of the work that needs management competence, time, and energy. It is more than visiting patients at home and performing necessary procedures.

In the IC projects, the leader's role is interconnected with co-leading the patient's care in consulting with the coordinator of the project, who is usually a social worker. The nurse in this role sees not only her work with patients, but also evaluates the progress of the project. She notices obstacles and challenges that the project meets and analyzes possible reasons of problems.

"We have a lack of qualified workers, nursing assistants, and general practice nurses alike. It is very difficult, and I see that nobody wants to do this job.

Because of a low salary. I worked in hospitals and polyclinics myself, and I know that everyone likes to come, to do the [nursing] job and that's it – but we have a lot of papers and reports to do. It is a responsible job. Responsible to family members, to patients themselves, and to the agency. Therefore, everything has to be described, of course the more, the better, in order to also protect yourself."

It is interesting to note that some of the nurses in the project also had an education and a qualification of a social worker. Therefore, they more easily understood both social and medical aspects of help. In the co-leader's role, the aspect of integration of social and medical help is evident.

4. Mediator With Health Care Infrastructures

The mediator's role of the nurse is related to advocating for the patient when the gaps of the health care system are faced, mediating between the patient/family and the family physician and ensuring continuity of care, mediating between the patient/family and the emergency service, and curating in the context of nursing hospitals.

4.1. Advocate of the Patient and Family in Dealing With Gaps in Health Care System

The IC project brought nursing and care to the transition from being provided by family members alone to being co-produced with social and health care institutions. The health care system has a wide infrastructure, and enough specialists of high qualification. However, sometimes the system is so fragmented and lacking the patient-centered approach that the patient and family appear to be aside of the system without getting the services that they need. In such cases, the IC nurse has to take a certain role of an advocate for the patient and/or his/her family.

"And constantly if you need other things – something against bedsores or plasters to cure them, it goes like in a magical circle: [the physician asks,] "Do you know how much it costs?" "I know, – I tell." "And you know that the Health Insurance Fund hits me on my head because you prescribe so much of them?" And what should I do? I need these means, I need to work. If it is compensated, then family members of the sick person [say]: it is compensated, we have to get it. So what is to be done? It is expensive to buy, and doctors do not prescribe it. Quotas [with emotion]. The Health Insurance Fund... I demand and obtain. I say: "Doctor, please sign that you do not prescribe, so that I have something to show to family members". And then he prescribes..."

The nurse is a certain mediator between the family physician and the patient and/or his/her family. For the family, the nurse is the representative of the health care system, and for the physician she often represents the patient and/or his/her family. The role of the mediator is very important so that health care workers see the situation from the patient's side. If the situation is seen only from the side of a physician or another health care practitioner, the result of providing help can be preposterous.

"[The patient] is coughing up to choking, to suffocating. Somehow we managed with the daughter [of the patient] that the doctor comes [to the phone], and not her nurse. The doctor: 'Oh, [I have] so many patients!' [So] she wrote a referral to the hospital without arranging with the hospital: 'Call an ambulance, bring her to the hospital, but do not tell them that it is just bringing her over, tell that you feel really bad.' We do feel very bad. The woman weighs 120 kg. We go to look for an illness in the lungs and end up in Vilnius to do computed tomography of the intestines, because they decided that there was a tumor in the intestines. They brought her to the [tertiary level] clinic. Nobody hospitalized her. The daughter calls me at 8:30 PM: 'What should I do? Nobody hospitalizes us. And how should I bring home a lying woman that weighs 120 kg?' The family doctor did not even come and look. Everyone with the phone: send her, bring her, go... The ambulance somehow brought her back from Vilnius, the woman found herself in a district hospital at 2:30 AM. [They tell her:] 'But we are not going to hospitalize you, your condition is too severe.' And they brought her back home. Here it is your own responsibility. So I say, what is next? The woman was brought around, collected alms through half of Lithuania, and now she lies at home in such a condition. With the inflammation of the lungs. But if a nurse says, she [the patient] needs a doctor – [physicians] do not go. They do not come – they do not have time..."

The role of the advocate is a very challenging one as it means confrontation with physicians and the nurse from polyclinics requesting that they do their job. The advocate's role of the nurse is related to giving feedback about the gaps of the health care system to those who are able to change the situation. It is important to understand that this role should not result in fighting, but should encourage improvement and development of services in implementing the patient-centered model.

4.2. Mediator Between the Patient and/or Family and the Family Physician

Another aspect of the mediator's role is assurance of continuity of care and constant contact with the family physician. The nurse accomplishes this role by providing information about the patient to the family physician. The information of a family member differs from the information of the nurse who constantly watches the condition of the patient and combines it with nursing expertise and competences.

"You can see that a bedsore can form there – and not everyone can [tell the physician] this information. If a family member comes, he/she only tells when the bedsore is already there, when there is a big hole. Meanwhile, the nurse can perform prophylaxis of bedsores through providing information. I think it is really a big input of IC nurses, when they communicate with family doctors."

Physicians very often lack real information about patients at home because they do not see patients. If not for the IC nurse, such information would not reach physicians.

"I called the doctor [about the bedsore]. The doctor got surprised: 'I did not see a bedsore with her!' Well, first, you need to look. If the patient is lying and does not say anything, really not many doctors would take the diaper off and would look what is there."

The nurse brings a concentrated professional message about the patient's health condition and the physician gets a better chance to respond with an adequately planned medical intervention.

"People get a really big help. We [nurses] go to the family doctor knowing what to ask and what to tell the doctor about the condition of the patient. Medications are not prescribed automatically anymore. A social worker used to come to a doctor and get prescriptions for the medicine that the patient used up. And even if the medicine was not effective for the patient, nobody told the doctor about it."

Not all family physicians in primary health care centers recognize and accept the nurse in the role of the mediator. In some health care units, nurses have the same status as patients: for prescription of medications for the patient, they have to wait in the queue with everybody, instead of having a specially appointed time for that.

"Our head of the department was applying to every polyclinic. When she got an answer, she informed us that we could [come to the family doctor without waiting in the common queue]. So we can come in after showing our [employee's] certificate. However, this is still not functioning. In some polyclinics – yes. You can even call, and [the physician] tells: 'Come, I will sign [the prescriptions].' But in other ones, it is very difficult."

At the beginning of the IC service delivery, the functions of nurses were not very clear for family physicians, because general nurses in polyclinics should also provide services to people with a constant need for nursing at home, although it does not always happen in reality. Some physicians and nurses from polyclinics were ignoring the services of IC and treated them as competitors.

"... you can still hear from the doctors: 'They [the patients] are yours, so it is your duty to do something' <...> I say, they are as much ours as yours. There should be one aim – the well-being of the patient. Of course, most [physicians] understand that we are not their competitors. And that we only alleviate their job."

Clarifying the role with family physicians, presenting yourself and creating collaborative relationships with family physicians are other aspects of mediation.

The nurse with her medical competence is a key person connecting social care providers and health care providers (family physicians) to focus on person's needs. The nurse brings a concentrated professional message about the patient's health condition and the physician gets a better chance to correspond with more adequately planned medical intervention. The challenge for the IC nurse is to overcome the role of an outsider, to which she is pushed in the interaction with the family physician.

4.3. Mediator Between the Patient and/or his/her Family and the Emergency Staff

When the condition of the patient worsens suddenly, the IC nurse has to evaluate the risks of further deterioration. This requests that she assesses the risk and makes fast decisions: not to call an ambulance when there is a possibility that one can easily control the condition of the patient, or to call the ambulance when there is a high risk of complications.

"First, we come to the patient and see whether it is necessary to call an ambulance or you can do something yourself. If I see that the condition of the person got worse, I call [an ambulance]. But we try to get the [family] doctor to assess the condition. If there is high blood pressure or diabetes, the family doctor would not come immediately. In such cases, we call a doctor of an ambulance. We practice to call an ambulance when something extra changes."

Sometimes, the nurse has to make a distant decision based on the information provided on the phone by the nursing assistant. When the health condition of the patient worsens, the nurse assesses the risks and makes accountable autonomous decisions about the necessity of other medical interventions. This is the most challenging role of the IC nurse, which has a cost reductive effect to the health care service delivery system in reducing unnecessary emergency calls.

4.4. Curator of the Patient in the Context of Hospitalization

While patients in IC have advanced multimorbidities, the risk of hospitalization is always there. The nurse in the curator's role has to deal with the challenge of poor nursing quality of overcrowded and understaffed nursing hospitals.

"We had a patient with Parkinson's disease. He spent 1 month in the nursing hospital. After discharge, he came home with 3 bedsores. After 1 week

with our care at home, his face started to become bright again. The bedsores were not recorded on the discharge list. They [the hospital staff] do not even think that it is a problem. After that we started to keep the patients from hospitalization. It became very rare, only in the cases when patients asked for it."

The bedsores as an outcome of care at nursing hospitals were repeatedly mentioned by the nurses from different municipalities. A few nurses continued to work with their patients even during their temporary stay in a nursing hospital, as otherwise it would mean hard work for the whole team to cure bedsores after the stay.

The capability of the nurse to cure bedsores in home care conditions shows a higher quality nursing in IC projects compared with a nursing hospital. If the quality of services in nursing hospitals does not improve, hospitalization will lose its sense. The IC nurse deals with this challenge on the personal level taking the role of the patient's curator.

Discussion

The study revealed that the IC nurses performed the roles that were very close to the home care nurse multiple roles described in the literature. Case manager, autonomous self-directed leader and multidimensional care practitioner, educator, and advocate (17) are the key roles in home care. Like in our research, it was found that in order to perform these roles the nurse had to develop skills of advanced assessment and evaluation, effective communication and documentation, sound judgment when to proceed or to stop in questionable and even unsafe situations for both the patient and the nurse (17). Dealing with acute episodes in monitoring the patient's chronic condition was also described as the most challenging part of the nurse's role – professional autonomous decisions that are assigned to competences of the advanced nurse practitioner (18, 19).

However, while performing the above mentioned roles, the IC nurses met the challenges related to the context of posttotalitarian experience, the lack of a patient- and person-centered approach as the organizing principle of service delivery (20, 21), and the specifics of the IC model as innovation.

The relicts of posttotalitarian experience were manifold: 1) people in totalitarian societies do not accept reality, but implement instructions that come in the form of law; 2) the situation is publicly portrayed as it "should be" and the real situation is concealed; and 3) laws come into force first, and only then their consequences are considered (22–24). Achievement of the co-productive role grounded on reciprocal relationships (25) was difficult because of the usual power fight interactions with family or personnel of health care structures, instead of listening to each other or sharing responsibility (26). Another issue that will need to be understood is the structure of the team. The nurse in the subteam leader's role in collaborative leadership with the social worker as a coordinator of integrated care is a good start to develop the concept of co-leadership (27) in integrated team-based home care service departments.

The third group of challenges was related to change through innovation. It is important to note that IC pilot projects facilitated the implementation of the autonomous role of the community nurse. The analysis of the roles of the IC nurse in the context of Lithuania gives evidence that the reality for transformation of the nursing role emerges. The changes in the nurse role could happen as the nurse had the ability to construct a new role in an altered context – the field of social care; transformation of the role was less obvious in the context of a medical facility. Contradicting reality of a constant need for advanced decisions and legal regulations supporting autonomous activities of the nurse and at the same time forbidding prescribing medication require changes in regulation of community nurse's activities. The experiences of the community nurse in IC project care could be taken in consideration as "first step" empirics toward practicing the role of self-directed, autonomous advanced practice nursing, as the legitimization is under the process (28). The management of changes through innovation of pilot projects, which are widely known around the world (29), still remains underestimated. The recognition of roles performed by community nurses in providing integrated home care in pilot projects would lead to reconsideration of functions and activities of other primary health care professionals.

Strengths, Limitations, and Implications for Practice and Future Research

The novelty of this study is the participatory approach as the researchers together with the nurses were participating in the development of innovation: discussed the challenges and looked for new solutions as well as new descriptions of their professional role in IC teams. The findings have practical implications and are significant for all health/social science disciplines of a multidisciplinary team. The critical incidents revealed in the study could be used in the teaching process (e.g., included in designed problems for the problem-based learning method). The limitations of the study are that the data are still not validated in a group discussion with research participants and that comparison of the roles of community nurses in sites without a team-based pilot project was not conducted. In the future, a comparative design study in sites with and without a team-based pilot project would be necessary to employ. Further research to look at the role of the nurse and IC team-based home care from the perspective

of physicians and polyclinic nurses would be very important, as well.

Conclusions

The role of the community nurse is changing with nurses slowly attaining more autonomy in the area of nursing in the sites of IC team-based home care pilot projects. The IC projects, through multidisciplinary teams of nursing and social work specialists, created conditions for implementing real autonomy of nurses, with the nurses taking new roles and facing various challenges. There was a variety in the degree of autonomy in different pilot municipalities, although the descriptions of nurses' activities had the same legal basis. Besides direct nursing, nurses providing IC services at home, performed the role of the co-producer of care together with the family of the patient. Moreover, they performed the roles of the leader and the counselor of a nursing assistants' subteam; as well as that of the mediator with the health care infrastructures ensuring continuity of health care and advocating for the patient. The challenges to the role change toward greater autonomy that the nurses met in contact with other agencies of primary health care were related to the change through innovation (difficulty for other specialists, like physicians or nurses in polyclinics, to critically assess and change their roles, rethink the boundaries of the activities in the context of a new service); to the posttotalitarian context (lack of the touch with reality, pretending everything is well, believing that the legislation is able to deal with the complexities of real life, e.g., the nurses had to fight for getting prescriptions for plasters curing bedsores, because the Health Insurance Fund set limits for them); and to the lack of the patient-centered model (physicians not coming to visit patients even when it is necessary, or overcrowded and understaffed nursing hospitals).

Statement of Conflict of Interest

The authors state no conflict of interest.

Slaugytojo vaidmens kaita Lietuvoje vykdant bandomuosius integraliosios pagalbos plėtros projektus

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Raktažodžiai: slaugytojo vaidmuo, slaugytojo vaidmens kaita, integralioji pagalba, slauga namuose, daugiadalykė komanda.

Santrauka. Nors strateginiuose Sveikatos apsaugos ministerijos dokumentuose vis daugiau dėmesio skiriama slaugos srityje savarankiškai dirbančio slaugytojo vaidmeniui įtvirtinti, pirminės sveikatos priežiūros grandyje vis dar dominuoja slaugytojo, kaip gydytojo padėjėjo, samprata. Užsienio šalyse priimtinesnis slaugytojo kaip atskiros (slaugos) profesijos atstovo vaidmuo. Remiantis šiuo požiūriu, slaugytojas atlieka savarankiškai sprendimus priimančio slaugos specialisto vaidmenį ir dirba laikydamasis bendradarbiavimo (o ne pavaldumo) santykio su gydytoju. Lietuvoje toks slaugytojo vaidmuo dar yra socialinė inovacija.

Tyrimo tikslas – pateikti kokybinio atvejo tyrimo rezultatus apie naują slaugytojo vaidmenį Lietuvoje, iššūkius, su kuriais susiduriama kintant slaugytojo vaidmeniui, ir šių iššūkių įveikos galimybes.

Metodika. Straipsnyje pateikiama kokybinio konstruktyviojo atvejo tyrimo metodika: pusiau struktūruotas interviu su slaugytojų grupėmis, kurios dirbo 20-ies savivaldybių integraliosios pagalbos bandomosiose daugiadalykėse komandose.

Rezultatai. Duomenys atskleidė slaugytojo vaidmens kaitos aspektus per tris santykio su šeimos gydytoju modelius: teikiant slaugos paslaugas pacientams namuose; konsultuojant pacientų šeimos narius ir bendradarbiaujant su jais, derinant formalią ir neformalią paciento slaugą namuose teikiant socialines paslaugas; konsultuojant ir vadovaujant slaugytojų padėjėjų komandų grupėms bei tarpininkaujant tarp paciento ir šeimos gydytojo, greitosios medicinos pagalbos ir slaugos ligoninės.

Išvados. Bandomuosiuose savivaldybių integraliosios pagalbos projektuose slaugytojo vaidmuo pamažu kinta, nes čia slaugytojas, kaip integraliosios pagalbos komandos narys, kaip slaugos specialistas, turi galimybę savarankiškai priimti sprendimus. Tačiau atlikdamas šį vaidmenį jis susiduria su iššūkiais, kurie ryškiausiai atsiskleidžia sąveikaujant su kitomis pirminės sveikatos priežiūros sistemos grandimis ir yra susiję su pototalitarine visuomene, su į asmenį orientuoto požiūrio trūkumu ir su pokyčiu kaip inovacija. Neaiškios ribos su bendrosios praktikos slaugytojų atliekamomis funkcijomis, neapibrėžtumas reikalauja aiškesnio, realybėje įgyvendinamo slaugytojo savarankiškumo įteisinimo.

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