From the District Nurse to the Community Nurse: the Development of a New Professional Role of the Community Nurse in Primary Health Care Teams of Lithuania

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Key Words: *community nurse; primary health care; general practitioner; Lithuania.*

Summary. *The aim of the study was to identify the issues related to the development of a new professional role of community nurses (CNs) within the context of teamwork in primary health care (PHC) by studying daily experiences of collaboration between CNs and general practitioners (GPs).*

Material and Methods. A qualitative study was performed. Six focus group discussions were held involving 29 GPs and 27 CNs (totally 56 participants) from PHC centers of Kaunas region. All the discussions were recorded. The data were obtained from verbatim transcripts of the discussions. A thematic analysis was then performed to analyze the data.

Results. Our study revealed certain circumstances that affected the development of the new CNs role in a PHC team. Five key themes were identified: a lack of understanding of the CNs' scope of work; a lack of clarity in the formal framework of the CNs' activities; cooperation in a team while the duties of CNs are obscure; protection of implicit professional boundaries; and the need for explicit differentiation between professional boundaries in a PHC team.

Conclusions. The study indicated that there was a lack of explicitness of the CNs' scope of work, which might hinder the establishment of a more autonomous role of CNs. CNs struggle for a more effective collaboration in a PHC team. The development of an explicit job description for CNs should be based on a relevant legal framework and eventually introduced into practice together with educational courses on the role of CNs in PHC teams. Such changes might be instrumental in further consolidation of the role of CNs in primary health care.

Introduction

The nursing profession has been changing at a different speed in different countries. Innovations in nursing as part of health care practices are becoming increasingly important, as medical approaches are developing and procedures and technologies are evolving and expanding (1).

Changes have become more rapid since the adoption of the Alma-Ata declaration (2), in which a special emphasis was placed on the importance of primary health care (PHC) in health care systems. Higher expectations from PHC have resulted in a greater workload for general practitioners (GPs) and, consequently, a progressively growing involvement of nurses in the provision of PHC services (3). The shifting of tasks from physicians to nurses has implied a more efficient usage of health care resources and an attempt to improve the quality of health care (4).

A widened scope of professional activities and a higher number of responsibilities for community nurses (CNs) have resulted in the enhancement of the nurse's independency and a growing significance of the nurse's role in PHC (5, 6). The advanced practice of nursing was introduced in the 1960s in the United States of America and in the 1980s in the United Kingdom (7). From being just a helper to a doctor, the nurse became a relatively independent worker, i.e., a nurse practitioner (NP) with a lot of additional responsibilities and duties in patient care. As suggested by Laurant et al. (8, 9), NPs who provide a specific set of services are not substitutes for, yet supplements to GPs.

In the former Soviet Union, the nurses' role was a lot different from the one of nurses in the western countries. Their role was designed to serve other specialists, and they were working more as technical assistants to physicians rather than professional nurses responding to patient needs (10, 11). Changes in the nursing profession began in 1991 with the collapse of the USSR, after which the Semashko model (12) was given up, and the new approach to medicine was chosen by adopting the National Health Concept (13).

In Lithuania, the reorganization of PHC, as part of the whole health care system, is a relatively new process. The new health concept has pointed to

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the importance of nursing for better health care outcomes in patient care. Previously, there were no job descriptions in Lithuania, and the formal organization of the role of the district nurse in health care was lacking (14). A wider range of activities and a more autonomous role of nurses in PHC were the main differences of a newly established specialization of a community nurse from the former practice of a district nurse. The community nurse was supposed to be as a transitional stage of the nurses' profession in their role development from the district nurse to the NP. Unfortunately, the basic responsibilities in the work of CNs remained unchanged, and the nurse was still viewed as a helper to the GP, and not as an advanced practice CN. The CN's job description released in 1996 and updated in 2011 lacks precision and clarity and is not fully acknowledged in practice.

The World Health Organization document on "Primary Health Care 21: Everybody's Business" has pointed to the importance of nursing in PHC and emphasized the role of nurses as the cornerstone in PHC (15). An insufficient input of nurses in policy making and inadequate education and training of nurses were listed among the main barriers of the better use of the potential of nurses in health care (15). The studies on PHC conducted in Lithuania have demonstrated the need for a better integration of nursing in PHC, where nursing should be centered on patient needs, and showed that the role of CNs in PHC should be more significant (16, 17).

The development of the new professional identity of CNs and their pursuit of the professional autonomy (18) strongly depend on the context of PHC. PHC teams consisting of GPs and CNs are in the initial phase of evolution in Lithuanian PHC (19). Research indicates that individuals in efficient teams have task-specific competencies and specialized work rules; they are open to communication and information sharing, but first at all, they have to have an explicit understanding of each other's professional role (20, 21). Studies performed in Lithuania, however, indicate a lack of a clear understanding of the scope of work of each PHC team member in general (19) and a lack of formal delineation of the roles and the responsibilities of CNs in particular (22). Thus, the context of PHC with evolving teamwork could have an important impact on the development of the professional identity of CNs. By studying daily experiences of collaboration between the CNs and the GPs, we aimed at identifying the issues related to the development of the new professional role of CNs within the context of teamwork in PHC.

Material and Methods

This study is a qualitative component of a larger project, which aims to assess teamwork possibilities at Lithuanian PHC centers in solving health care problems in families at social risk. This is a 2-year project (2012–2013) called "Intersectorial Collaboration in Solving Healthcare Problems in Social Risk Families," financed by the Research Council of Lithuania.

Part of this project is related to the investigation of teamwork experiences of GPs and CNs at PHC centers. In the present study, the data were obtained from the focus groups of the GPs and the CNs in Kaunas city area in order to reveal the current problems of CNs in their search for a new professional identity. Kaunas was chosen because of its central position, dense urban population, and because its population accounts for almost 15% of the population in Lithuania. The economic situation in this area conforms to the average economic level in the whole country.

In the autumn of 2011 in Kaunas area, there were 49 PHC centers that worked under contract with the National Health Insurance Fund and provided free PHC services to insured patients. In total, 25 public and private small-to-large PHC establishments were selected in Kaunas area, and invitations were sent to them asking to participate in the study. There were 7 private and 4 public PHC centers that responded positively to the request. The information about the possibility to attend the focus group discussions was distributed among the CNs and the GPs of 11 (3 large, 3 medium, and 5 small) PHC institutions. Only the GPs and the CNs who fell under the legal description of professionals of a PHC team in Lithuania (23) were selected. Focus group discussions were given preference over individual interviews in order to achieve more comprehensive and profound discussions (24), and it was noted that the participants were genuinely eager to discuss their individual experiences.

Participants. The study was conducted by organizing 6 focus group discussions at which 29 GPs and 27 CNs participated (totally 56 participants). All the participants were encouraged to express their opinions freely and to share their experience. The groups consisted of 8 to 12 participants. The participants were divided into 3 groups of the CNs and 3 groups of the GPs. The discussions were held separately in the anticipation of more open and relaxed communication among the participants, considering the background of health provider's hierarchy in Lithuanian health care settings.

Data Collection. Each discussion was moderated by 2 female GPs (moderator and note taker) specially trained in qualitative research methodology and

Table. Topic Guide for Focus Group Discussions

How would you describe a PHC team?
How do GPs and CNs collaborate in practice? Could you tell us from your experience how you engage in teamwork on a daily basis?
What negatively affects collaboration between GPs and CNs?
What favorably affects collaboration between GPs and CNs?
How do you see your role in an effective PHC team?
Any other comments?

CN, community nurse; GP, general practitioner; PHC, primary health care.

data analysis. The discussions lasted for about 1.5 to 2 hours and were audiotaped with the permission of all the participants.

The focus group discussions were followed by a topic guide, which included 5 open-ended questions regarding PHC teamwork in general, everyday experiences in collaboration between the GPs and the CNs, and their ideas about positive and negative factors affecting teamwork (Table).

Data Analysis. The data were collected between April and July 2012. Each audiotaped discussion was transcribed verbatim, and a thematic analysis (25) of the data was initiated after all 6 discussions had been completed. The entire data set was viewed and encoded line by line by 2 independent researchers in a systematic manner. The discrepancies between the codes were discussed and established on the basis of a consensus. Similar codes were grouped into thematic categories, which were later formed into the main final themes.

An ellipsis ... is used to mark a reflective pause. An elipsis in parentheses (...) indicates the ommission of words. In order to clarify some thoughts of the participants, the parentheses, e.g., (CN), are added to reflect the researchers' interpretation. At the end of each quotation, a focus group indicator, meaning a GP or a CN, and the number of the focus group (e.g., GP1, the first group of GPs) are provided.

Ethical Considerations. This qualitative study was approved by the Bioethics Committee of the Lithuanian University of Health Sciences in 2012. The required approvals were obtained from the participating PHC centers. Participation in the study was voluntary. Confidentiality was guaranteed, and the purpose of the study and the usage of the data collected during the study were explained to the participants who signed informed consent forms.

Results

Our study revealed certain circumstances that hindered the realization of CNs' professional activities in a primary health care team. Five key themes were identified: a lack of an understanding of the CNs' scope of work; a lack of clarity in the formal framework for the CNs' activities; cooperation in a team while the duties of CNs are obscure; protection of implicit professional boundaries; and the need for an explicit differentiation between professional boundaries in a PHC team. Each theme is outlined below.

Lack of Understanding of Community Nurses' Scope of Work. Three main categories formed this theme, which included a lack of familiarity of the roles and the responsibilities of the CN, the confusion of district and community nurses' functions, and the importance of GPs in determining the role of CNs.

Both the GPs and the CNs admitted that the duties of the community nurse in a PHC team were not well understood.

"I really have no idea what the nurse should do. I really have no idea ..." (FG1GP)

This confusion is likely to be related with the shift of the professional profile of nurses from the district nurse to the CN. The participants of the study revealed that the actual content of the CNs' scope of work was not well known; however, both the GPs and the CNs agreed on the activities that had traditionally been assigned to the district nurse, i.e., taking blood samples, vaccination, acting as a secretary to the GP, managing patient flow, etc.

"We actually don't know what duties are theirs. For this day, I actually don't know what their duties are." (FG2GP)

It seems that GPs remain the main authority to determine the role of the CN ("Well, the doctor should tell ... what he wants [FG1CN]), the responsibilities of the CN ("When she [CN] doesn't feel responsible for anything [...] [FG3GP]), and even the professional identity in a PHC team.

"It gets worse when she (CN) works for the doctor and not for the team. It gets worse when she doesn't feel responsible for anything (...)." (FG3GP)

Lack of Clarity in the Formal Framework for the Community Nurses' Activities. This theme was formed by 3 categories, which included insufficient explicitness in the formalization of CNs' functions, formal overlap of the functions of GPs and CNs, and insufficient knowledge of formal CNs' functions.

The study participants noticed that the job descriptions of CNs both at the national and institutional levels were mostly of a declarative nature and lacked clarity concerning different duties and responsibilities of the CN.

"They (job descriptions) exist ... they really exist (...) in every institution (...) these days for sure. But (...) they are non-specific or they are too abstract ..." (FG2GP)

The GPs admitted that the job descriptions of CNs and GPs covered a fairly large amount of identical primary care aspects (i.e., assessment and promotion of healthy lifestyle, home care, and patient

education). However, discussions revealed a lack of explicitness about particular actions for which one or another primary health care professional was responsible. According to the study participants, the formal overlap in the functions of GPs and CNs hindered an efficient practical implementation of PHC activities, i.e., some activities were duplicated by CNs and GPs, while others were not addressed at all. On the other hand, the GPs expressed their doubts as to whether CNs were knowledgeable about the existing formal documents describing the role and the responsibilities of the CN.

"Have they read those job descriptions at all?"

"They do keep them on the windowsill." (FG-2GP)

Cooperation in Team While Community Nurses' Duties Are Obscure. This theme was formed by 2 categories, which included cooperation patterns and conflicting expectations of GPs and CNs in collaboration.

While lacking an explicit vision of the work scope and the responsibilities of the CN in a PHC team, CNs either assume a traditional passive role or become proactive members in a PHC team.

A large number of PHC teams seem to remain attached to the traditional cooperation pattern dominated by GPs where CNs play a passive role. Under these circumstances, CNs do not feel to possess a sufficient professional autonomy and do not perform independently ("I can't just do it on my own initiative, but just if [GP] would tell: "well, this or that needs to be [done]" [FG1CN]) and at the same time they feel frustrated about "serving doctors." (FG2CN)

Largely depending on the GP's commands, the CN adopts a defensive attitude toward the new professional role.

"Most (of the CNs) ... I don' know ... Well, they are (working) according to the same old model ... this and that is my job ... and nothing more ... (...), no, that is not part of my job ..." (FG2GP)

Activities refused or neglected by CNs are usually performed by GPs: "The doctor won't stand long and will do it himself" (FG1GP); on the other hand, the idea that GPs all by themselves could provide health services brings to CNs the feeling of being unnecessary at work.

"Well, you're looking for work to be done, simply looking around for somebody to tell you (to do) something somewhere, or maybe I can go now?" (FG1CN)

The passivity of CNs in PHC teams also becomes a source of dissatisfaction for GPs who anticipate a more independent behavior on the part of CNs.

"If told – done ... if not told, well, it is not part of her job (to be performed by CNs)."

"So, where is her (CN's) own specialization, work, and mind?" (FG2GP)

On the other hand, part of CNs seem to be most proactive in PHC teams and perform a lot of activities. As there is a lack of distinct boundaries between the areas of expertise of GPs and CNs, often the duties that are considered to be an exclusive responsibility of the GP (i.e., writing prescriptions, prescription of tests, etc.) are performed by the CN.

"We are trying to work so that we could survive and we don't count those functions ... you just work if there's a need and you work as whoever is needed (...) sometimes the nurse does more of the doctor's work, sometimes the doctor does more of the nurse's work (...)." (FG3GP)

Although professional self-esteem of proactive nurses seems to be higher, confusion of GPs' and CNs' tasks, leading to the overlap of some activities and potential neglect of others, could also become a source of dissatisfaction for other members of a PHC team.

"Maybe they (CNs) do our part of the job, but they don't do their own part." (FG2GP)

Protection of Implicit Professional Boundaries. This theme was formed by the following categories: the existence of implicit professional boundaries, a lack of formal "warnings" to trespass the implicit professional boundaries, and consequences/sanctions for trespassing these boundaries.

Having revealed the lack of clarity in distinguishing between some professional activities of GPs and CNs, the discussions also revealed the existence of implicit professional boundaries between the roles and the responsibilities of GPs and CNs. Advancing beyond inexplicit boundaries may cause some difficulties in the relations between GPs and CNs in certain situations. The discussions with the study participants revealed that GPs adopted a negative and criticizing attitude toward CNs who "intrude" into their professional area. On the other hand, CNs express the feeling of injustice and grievance when their striving to be more proactive (prescription of tests and commenting on them, drug prescription, etc.) is met with a critical response.

"I was so scalded (...) I just told my opinion and was so scalded! ... it was reported even to (chief's name) – (and was criticized) how come I had ventured to interfere and tell my opinion! (...) And how could you dare, when the doctor talks to the patient, insert your? (...)" (FG1GP)

As there is a lack of formal "warnings" to help avoid the potential infringement of professional boundaries, proactive CNs risk to be criticized,

which may lead to their dissatisfaction, decrease in motivation, or even alienation.

"When you get scalded, you disassociate (yourself from your job)." (FG1CN)

Need for Explicit Differentiation Between Professional Boundaries in a Primary Health Care Team. This theme was formed by 3 main categories that included the pursuit to delineate the professional boundaries, the potential outcomes of explicit delineation of the roles and the responsibilities in a team, and the ways to establish more precise professional delineation.

Both the GPs and the CNs expressed the need for a more explicit demarcation in their professional expertise. Firstly, they believed that a clear distinction of the roles and the responsibilities would be helpful for a more efficient cooperation in a team.

"I would say that teamwork begins when both sides understand what each side has to do and what their share is and what your share is." (FG1GP)

Secondly, they noted that an explicit description of the professional activities and the responsibilities of the CN would eliminate the possibility of ungrounded expectations on behalf of the other members of a PHC team and eventually reduce mutual dissatisfaction and the number of conflicts. Thirdly, they admitted that this could be instrumental for CNs in gaining more professional autonomy and help avoid the feeling of being exploited by GPs. However, the ways to achieve higher explicitness in the professional expertise were seen differently by the GPs and the CNs. The GPs counted more on legislative and administrative measures for the establishment of explicit boundaries of the CNs expertise.

"I think it should be delineated as to what they should do and it would be clear for everyone because we will not get far with goodwill."

"To know exactly what nurses have to do ..." (FG2GP)

"In the opinion of the CNs, communication with GPs would help establish the boundaries."

"Doctors need to be asked because it's always wrong, nurses never work anything. (...) it needs to be said specifically, what you want from that nurse." (FG1CN)

Discussion

The results of our study revealed the problems encountered by CNs on their way to a more independent professional role development within the context of evolving team practice in Lithuanian PHC. The final themes centered on a lack of the understanding of the CNs' scope of work; a lack of clarity in the formal framework for the CNs' activities; cooperation in a team while the CNs' duties are obscure; protection of implicit professional boundaries; and the need for explicit differentiation between professional boundaries in a PHC team.

The findings of the study showed that the CN's scope of work was not well known to either the CNs or the GPs. Our research demonstrated that the GPs and the CNs worked in a team even though the duties of CNs were obscure. It also showed that in their work the CNs still sometimes turned to GPs for directions. In view of the lack of clarity in the description of the CN's duties, team members lacked understanding of what the functions of the CN and the ways of effective cooperation as a team were. The study also revealed that both the GPs and the CNs were interested in a better perception of the CN's role in a team. According to the results, it seems that more attention should be paid to the clarification of the CN's professional responsibility and scope of work in the PHC practice. Some researchers demonstrated that the professional clarity of the NPs' role in health care was an important strategy to enhance their position (26). It might be assumed that in Lithuania, CNs lack understanding of their own input in PHC, which might result from inadequately defined regulations and failure to implement regulations in practice.

Our findings suggest that formally indistinct boundaries of GPs' and CNs' professional activities have an effect on professional practice. While lacking a formal distinction, professional boundaries are delineated by PHC team members themselves, mostly by GPs, who have more power in a team. The Australian study showed similar results about the self-defined understanding of the NP's role in practice by GPs (27). This study demonstrated that traditional hierarchical relationships were still existent despite new approaches to health care (27). Our study also revealed that the unclear boundaries of the competency and the responsibilities of CNs and GPs hindered more effective work in a team and impeded the development of professional autonomy of CNs. The study mentioned above also pointed to the importance of the awareness of the CN's possibilities at work, which helps build better collaborative practice (27).

The experience from Canada demonstrates (28) that controlling acts and clear legislation are important for a better implementation of the nurses' role in PHC settings. Although some authors raise hesitations about the need for strict boundaries in the responsibilities of a PHC team (29, 30), studies and reviews have demonstrated that a formal background and a well-developed legal basis of competency and responsibilities are essential for good outcomes of teamwork (31–33) and especially important in the initial stage on collaborative practices (19, 34).

The results of the study revealed that both the GPs and the CNs agreed that overlapping and confusion of tasks sometimes created conflicting situations, which might lead to demotivation and mutual dissatisfaction at work. A Polish study has also demonstrated that clearly-stated duties are important at work (33). A study carried out in New Zealand has demonstrated that good collaboration between primary health care members is essential for efficient patient treatment outcomes and better fulfills patient needs (35).

The findings of the study strongly suggest that the formal framework should be created on an appropriate legal basis and then introduced in PHC along with educational programs. Canada and New Zealand adopted a new approach to nurses when they introduced NPs in their PHC centers. According to the study results, they make PHC centers more efficient and reduce the costs of patient care; they also have a wider range of qualifications and responsibilities (3, 5, 9, 36). Although the process of integration was not easy, researchers from Canada (37) have shown that special education is needed in the course of integration of NPs into practice. This might also apply to Lithuania, as our system was modified without taking any educational effort after the collapse of the Soviet Union, when the PHC system underwent essential changes. Educational programs focused on the scope of CNs' work, and their competency might be helpful in order to better understand their functions and responsibilities and might facilitate the integration of CNs in PHC centers. Special recommendations on collaboration with CNs should also be provided for GPs (27).

Some studies have reported the importance of boundary work as it helps fulfill the scope of health care and makes interprofessional teamwork more efficient (32). The examples from Canada have shown good results in applying special education while integrating new team member roles in a PHC team (37, 38). Similar measures should be taken in Lithuania.

Limitations. The study included only GPs and CNs from urbanized Kaunas city area and their views and experiences cannot be generalized to represent all the PHC community. Further research should focus more on the experiences of GPs and CNs who work in rural areas and smaller towns. The men's perspective on PHC teamwork could also be lacking as the majority of the study participants were women, which reflects the situation in Lithuanian PHC centers where the majority of GPs (85%) and CNs (100%) are women.

The study addressed the development of the professional CN's role only in the context of evolving teamwork in PHC. This approach might have greatly reduced the variety of participants' experiences related to the development of the new professional identity of the CN in general. Our study is among the first attempts to analyze the development of the professional identity of CNs, and future research is needed to explore this issue more in depth.

Conclusions

One of the major problems encountered by the community nurses in their development of the new professional role in the context of evolving primary health care teamwork is that their scope of work is not clear in Lithuanian primary health care centers. An explicit formal framework of the community nurse's scope of work in primary health care should be created on an appropriate legal basis and then commonly introduced in primary health care centers. Educational programs on the role of the community nurse in primary health care might be instrumental in strengthening the professional autonomy of community nurses.

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Statement of Conflict of Interest

The authors state no conflict of interest.

Nuo apylinkės iki bendruomenės slaugytojo: naujas slaugytojo profesinis vaidmuo Lietuvos pirminės sveikatos priežiūros komandose

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Raktažodžiai: *bendruomenės slaugytojai, pirminė sveikatos priežiūra, bendrosios praktikos gydytojai, Lietuva.*

Santrauka. *Tyrimo tikslas. Tirdami bendruomenės slaugytojų kasdienį bendradarbiavimą su bendrosios praktikos gydytojais, siekėme nustatyti esamas problemas, susijusias su bendruomenės slaugytojo naujo profesi-*

nio vaidmens didėjimu pirminės sveikatos priežiūros bendradarbiavimo kontekste.

Tyrimo medžiaga ir metodai. Atliktas kokybinis tyrimas. Visos diskusijos buvo įrašomos į diktofoną. Duomenys surinkti iš pažodžiui perrašytų diskusijų įrašų. Vėliau atlikta teminė duomenų analizė. Diskusijos buvo sudarytos iš šešių grupinių interviu, kuriuose dalyvavo 29 bendrosios praktikos gydytojai ir 27 bendruomenės slaugytojos (iš viso 56 dalyviai). Tyrimo dalyviai dirba Kauno miesto pirminės sveikatos priežiūros centruose.

Rezultatai. Tyrimas atskleidė aplinkybes, kurios daro įtaką naujų bendruomenės slaugytojų funkcijų svarbai pirminės sveikatos priežiūros centruose. Išskirtos penkios pagrindinės temos: nepakankamai aiškios bendruomenės slaugytojų darbo ribos; aiškumo trūkumas oficialiajame slaugytojų veiklos aprašyme; bendradarbiavimas komandoje, kai slaugytojų funkcijos yra neaiškios; numanomų profesinių ribų išsaugojimas ir tikslių profesinių ribų diferenciacijos poreikis pirminės sveikatos priežiūros komandoje.

Išvados. Atlikus tyrimą, paaiškėjo, kad yra slaugytojo darbo apimties aiškumo trūkumas, kuris gali trukdyti įtvirtinti savarankiškesnį bendruomenės slaugytojo vaidmenį. Taip pat paaiškėjo, kad slaugytojai siekia efektyvesnio bendradarbiavimo pirminėje sveikatos priežiūros komandoje. Tikslūs bendruomenės slaugytojo darbo aprašymai turėtų būti parengti pagal atitinkamus teisinius pagrindus ir taikomi pirminės sveikatos priežiūros centruose kartu su atitinkamais mokymais apie bendruomenės slaugytojo vaidmenį pirminės sveikatos priežiūros komandose. Tokie pokyčiai gali būti vieni esminių aspektų siekiant įtvirtinti savarankiškesnį bendruomenės slaugytojo vaidmenį pirminėje sveikatos priežiūroje.

References

1. International Council of Nurses. Delivering quality, serving communities: nurses leading care innovations. In: International Nurses Day. Geneva; 2009. p. 25-7.
2. World Health Organization. Primary health care: report of the International Conference on Primary Health Care. In: International Conference on Primary Health Care. Alma-Ata; 1978. p. 6-12.
3. Whitecross L. Collaboration between GPs and nurse practitioners. The overseas experience and lessons for Australia. Aust Fam Physician 1999;28:349-53.
4. Jenkins-Clarke S, Carr-Hill R, Dixon P. Teams and seams: skill mix in primary care. J Adv Nurs 1998;28:1120-6.
5. Gardner G, Carryer J, Gardner A, Dunn S. Nurse Practitioner competency standards: findings from collaborative Australian and New Zealand research. Int J Nurs Stud 2006;43:691-10.
6. Wright W, Romboli J, DiTulio M, Wogen J, Belletti DA. Hypertension treatment and control within an independent nurse practitioner setting. Am J Manag Care 2011;17: 58-64.
7. Harris A, Redshaw M. Professional issues facing nurse practitioners and nursing. Br J Nurs 1999;22:1381-5.
8. Laurant M, Hermens R, Braspenning J, Sibbald B, Grol RP. Impact of nurse practitioners on workload of general practitioners: randomized controlled trial. BMJ 2004;328:927.
9. Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. Cochrane Database of Syst Rev 2005;CD001271.
10. Poghosyan L, Poghosyan H, Berlin K, Truzyan N, Danielyan L, Khourshudyan K. Nursing practice in a post-Soviet country from the perspectives of Armenian nurses: a qualitative exploratory study. J Clin Nurs 2012;21:2599-608.
11. Arnold L, Bakhtarina I, Brooks A, Coulter S, Hurt L, Lewis C, et al. Nursing in the newly independent states of the former Soviet Union: an international partnership for nursing development. J Obstet Gynecol Neonatal Nurs 1998;27: 203-8.
12. Sheiman I. Rocky road from the Semashko to a new health model. Bull World Health Organ 2013;91:320-1.
13. Supreme council of Lithuania. Lithuanian National Concept of Health. Vilnius; 1991. Decree No I-1939.
14. Murray E. Russian nurses: from the Tsarist Sister of Mercy to the Soviet comrade nurse: a case study of absence of migration of nursing knowledge and skills. Nurs Inq 2004; 11:130-7.
15. World Health Organisation. Primary health care 21: "Everybody's business". In: An international meeting to celebrate 20 years after Alma-Ata. Almaty; 1998. p. 27-28.
16. Margelienė D. Šeimos/bendruomenės slaugytojų paslaugų poreikio nustatymo bendruomenėje sociologinė apklausa. (Sociological interrogatory on family/community nurses' services' needs' establishment in the community.) Sveikatos mokslai 2002;4:5-8.
17. Čiočienė A. Bendruomenės slauga pirminėje sveikatos priežiūroje. (Community nursing in primary health care.) Sveikatos mokslai 2002;4:2-5.
18. Jankauskienė Ž, Kubilienė E, Juozulynas A, Stukas R. Veiksnių, formuojančių slaugytojų profesinę elgseną, analizė. (Analysis of factors conditioning professional behavior of nurses.) Medicinos teorija ir praktika 2009;15:372-81.
19. Jaruseviciene L, Liseckiene I, Valius L, Kontrimiene A, Jarusevicius G, Lapão L. Teamwork in primary care: perspectives of general practitioners and community nurses in Lithuania. BMC Fam Pract 2013;14:118.
20. Xyrichis A, Ream E. Teamwork: a concept analysis. J Adv Nurs 2008;61:232-41.
21. Manser T. Teamwork and patient safety in dynamic domains of healthcare: a review of the literature. Acta Anaesthesiol Scand 2009;53:143-51.
22. Kontrimiene A, Andriuskeviciute L, Radzeviciute S, Liseckiene I, Bumblyte I, Valius L, et al. Community nurses' roles in primary health care: the view point of community nurses and family doctors. Lietuvos bendrosios praktikos gydytojas 2013;17:218-24.
23. Decree of Minister of Health. Adoption of the concept of the development of primary health care. Adopted 5 September 2007, No V-717; Vilnius, Lithuania.
24. Thomas L, Mac Millan J, McColl E, Hale C, Bond S. Comparison of focus group and individual interview methodology in examining patient satisfaction with nursing care. Social Sciences in Health 1995;1:206-19.
25. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3:77-101.
26. Lowe G, Plummer V, Paul O'Brien A, Boyd L. Time to clarify – the value of advanced practice nursing roles in health care. J Adv Nurs 2012;68:677-85.
27. Bailey P, Jones L, Way D. Family physician/nurse practitioner: stories of collaboration. J Adv Nurs 2006;53:381-91.
28. Canada, Toronto, ON. Health Professions Regulatory Advisory Council, 2008. [cited March 15, 2013]. Available from: URL: http://www.hprac.org/en/projects/resources/HPRACExtendedClassNurseReportENGMar08.pdf
29. Carryer J, Gardner G, Dunn S, Gardner A. The capability of

nurse practitioners may be diminished by controlling protocols. Aust Health Rev 2007;31:108-15.
30. Woolf S, Grol R, Hutchinson A, Eccles M, Grimshaw J. Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines. BMJ 1999;318:527-30.
31. Denis JL, Lamothe L, Langley A. www.palgrave.com. [cited March 15, 2013]. Available from: URL: http://www.palgrave.com/pdfs/1403947481.pdf
32. Kilpatrick K, Lavoie-Tremblay M, Ritchie JA, Lamothe L, Doran D. Boundary work and the introduction of acute care nurse practitioners in healthcare teams. J Adv Nurs 2012;68:1504-15.
33. Rogala-Pawelczyk G. Conditioning of community nurse duties towards the patient treated by family doctor – the opinion of family doctor staff members. Wiad Lek 2002;55: 870-6.
34. Boon H, Verhoef M, O'Hara D, Findlay B. From parallel practice to integrative health care: a conceptual framework. BMC Health Serv Res 2004;4:15.
35. Finlayson M, Raymont A. Teamwork – general practitioners and practice nurses working together in New Zealand. J Prim Health Care 2012;4:150-5.
36. Mundinger M, Kane R, Lenz E, Totten A, Tsai W, Cleary PD, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. JAMA 2000;283:59-68.
37. Sullivan-Bentz M, Humbert J, Cragg B, Legault F, Laflamme C, Bailey P, et al. Supporting primary health care nurse practitioners' transition to practice. Can Fam Physician 2010;56:1176-82.
38. The conference board of Canada. www.caslpa.ca. Toronto; 2006. [cited March 15, 2013]. Available from: URL: http://www.caslpa.ca/PDF/EICP_Principles_and_Framework_final.pdf

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