SOCIAL WORK IN HOSPITALS IN SLOVAKIA: CURRENT WORKING CONDITIONS AND DIFFICULTIES IN THE VIEW OF THE PROFESSIONALS

Miriam SLANÁ [*]
Patricia DOBRÍKOVÁ [**]
Michaela HROMKOVÁ [***]
Katarína LETOVANCOVÁ [****]

Abstract

This is one of the first attempts to describe the situation of social workers in hospitals in Slovakia. Social work in health care is an area which had a long tradition and was developed further again in Slovakia from 1989 on but is to a high degree still not sufficiently established. The aim of the study is to identify the key factors considered as most crucial for the work performance and work satisfaction of social workers in hospitals. 18 out of 31 social workers at university hopitals have participated in our study. In our findings, four key factors emerged that significantly determine their work situation: a lack of statuatory rules which give only little orientation to social workers, organizational structures which are not prepared to fully acknowledge social work as important part of healing processes, organizational cultures which are not able to support interprofessional team work, and diffculties with the coordination of patients discharge and the organisation of post hospital care. These circumstances make social work in hospitals more difficult and are forcing social worker to continuously advocate their own position and competences.

Keywords: social work in hospital; social workers and hospital setting; interprofessional social work; organizational structure, organisational culture and social work; social work an job satisfaction.

Résumé

Il s'agit d'une des premières tentatives de description de la situation des travailleurs sociaux dans les hôpitaux en Slovaquie. Le travail social est depuis longtemps implanté

[*] Associate Professor, PhD., Department of Social Work, Faculty of Health Sciences and Social Work, Trnava University, Univerzitné námestie 1, 918 43 Trnava;
e-mail: miriam.slana@truni.sk; tel. 004215939430.

[**] Associate Professor, PhD., MSc., Department of Social Work, Faculty of Health Sciences and Social Work, Trnava University, Univerzitné námestie 1, 918 43 Trnava;
e-mail: patricia.dobrikova@truni.sk; tel. 004215939408.

[***] PhD., MSc., Department of Social Work, Faculty of Health Sciences and Social Work, Trnava University, Univerzitné námestie 1, 918 43 Trnava;
e-mail: michaela.hromkova@truni.sk; tel. 004215939430.

[****] MSc., Department of Social Work, Faculty of Health Sciences and Social Work, Trnava University, Univerzitné námestie 1, 918 43 Trnava;
e-mail: katarina.letovancova@tvu.sk; tel. 004215939426.

dans le domaine de la santé en Slovaquie. Il s'est encore développé à compter de 1989 mais n'est pas encore parvenu à nos jours à un niveau d'excellence. Le but de cette étude est d'identifier les facteurs clé considérés comme cruciaux par les travailleurs sociaux dans le cadre de la performance et de la satisfaction au travail.

18 des 31 travailleurs sociaux du secteur hospitalier universitaire ont participé à notre étude. 4 points essentiels émergent de nos constatations, déterminant leur situation professionnelle : un manque de règles officielles qui ne donnent qu'une orientation parcellaire aux travailleurs sociaux, des structures organisationnelles qui ne sont pas préparées à reconnaître pleinement le travail social comme étant une part importante du travail de guérison, des cultures organisationnelles qui ne sont pas en capacité de soutenir le travail d'équipe interprofessionnelle et des difficultés dans la coordination des patients sortant d'hospitalisation et leur suivi post hospitalier. Ces conditions de travail rendent le travail social en hôpital plus difficile et forcent le travailleur social à défendre perpétuellement sa position et ses compétences.

Mots-clés: travail social en milieu hospitalier, travailleurs sociaux et milieu hospitalier, travail social interprofessionnel, structure organisationnelle, culture organisationnelle et travail social, travail social et satisfaction professionn.

Rezumat

Aceasta este una dintre primele încercări de a descrie situația asistenților sociali în spitalele din Slovacia. Asistența socială în domeniul îngrijirii sănătății este un domeniu cu tradiție, care a cunoscut o dezvoltare mai accentuată, în Slovacia, după 1989. Scopul acestui studiului este de a identifica factorii cheie importanți pentru a performa și a crește satisfacția în muncă a asistenților sociali din spitale. La studiul nostru au participat 18 din 31 asistenți sociali din cadrul spitalelor universitare. În concluziile noastre, patru factori cheie determină în mod semnificativ situația lor de muncă: lipsa unor norme legale, structuri organizatorice care nu sunt pregătite să recunoască pe deplin munca socială, ca parte importantă a proceselor de vindecare, culturi organizaționale care nu sunt în măsură să sprijine munca în echipa interprofesională și dificultățile cu coordonarea pacienților descărcarea de gestiune și organizarea asistenței medicale spitalicești. Toate aceste circumstanțe fac munca socială în spitale mai dificile și obligă asistentul social să-și susțină în mod continuu propria poziție și propriile competențe.

Cuvinte cheie: asistență socială în spital, asistenți sociali din spital, asistență socială interprofesională, cultura organizațională și satisfacție profesională.

1. Introduction

In Slovakia, the rise of social work in hospitals as professional activities was closely linked to the establishment of schools of social work in the early 20th century. In 1919, the first social schools were established, which began to prepare professionals in the field of socio-health care (Majchráková *et al*. 1990). The target groups for their actions were mothers with children, war invalids and people suffering from infectious diseases. However, this trend was stopped after the communist takeover and has led to a situation where social work was performed by nurses.

Democratizing changes in 1989 reopened a new discussion about the increasing need to redefine the position of social workers at hospitals. The only existing legal document was the Act of Ministry of Health SR in 2008 that started discussion about status of social workers at hospitals.

At present the tasks of social workers in hospitals is described as follows:

> “(...) if an institutional healthcare facility provide healthcare in departments of paediatrics, geriatrics, after-treatment, psychiatry, drug addiction medicine, gynaecology and obstetrics, or long-term illness, there must be a social worker employed to support the reduction or elimination of the social consequences of the health situation of the patient in connection with hospitalization and discharge.” (Act of Ministry of Health of Slovak Republic no. 60/2012, p. 284)

Currently, in Slovakia 117 hospitals are in existence. These hospitals are divided into three groups (I, II, III. type) depending on how large areas they cover and the number of units. Most of the hospital social workers operate in hospitals of the third type: these are the biggest and very much oriented on education of healthcare workers and scientific research. 19 of the hospitals are university and teaching hospitals with 47 hospital social workers (from this amount 14 are specialized for particular units like pediatry, geriatry, psychiatry and 31 social workers operate in all units of the hospital). The remaining 98 hospitals have only 9 hospital social workers.

Most of the hospital social workers have to operate in all hospital units. They participate in ensuring comprehensive curative and preventive care for patients. The most important part of the work of their work is to plan and organize processes of discharge or to help to find other forms of institutional care (Judd and Sheffield 2010, Peterson 2012, Linton *et al*. 2015). According to a systemic and ecological understanding social workers have to involve patients as well as family members in this process (Dobríková, 2010, Dobríková *et al*. 2015). In addition, their other activities include the assesment of social, psychological and financial resources of patient and family; crisis intervention; social therapy with patients (Carranza 2012); counseling services (Cowles and Lefcowitz 1995); monitoring, creating and building comunity resources (Cowles and Lefcowitz 1992); creating links between patients and resources (Guo and Company 2007); cooperation with medical staff (Green and Kulper 1990, Albrithen and Yalli 2015); documentation of what was done and has been done for the patient and his/her family (NASW 2005).

2. Research question

At this moment we don't have very detailed knowledge about the situation of social workers in hospital. We especially don't know how they are integrated into a field where a lot of different professions with different status have to work together for the sake of the patients. And we don't know if they are satisfied with their job, their working environment, etc.

There are no comprehensive studies on social work in hospital setting in Slovakia at all. In 2014, only a pilot study was realized (Kovalčíková *et al*. 2014), which aim was to investigate how social workers at hospitals perceive their professional identity. The results of this research study showed a high degree of social workers´ identification with their profession. Social workers presented their own profession as a unique, important for society as well as different from other professions existing in health care. They emphasize the need for constant, continual learning and acquiring new information in their field as means of increasing their own professionalism.

Therefore our group decided to conduct a research that would deal in more detail with the working conditions of social workers in hospitals. The aim of our research investigation was to identify, *which factors are considered as crucial by social workers at hospitals for their work performance and job satisfaction.* Especially we wanted to find out more about the role of social worker in the team, about what they think is important for their work and which are the circumstances wich are affecting their job satisfaction positively or negatively.

3. Research Methodology

The basis of our investigation was a mixed methods research with qualitative strategy as a priority. Qualitative research strategy using in-depth semi-structured interview gives our participants sufficient space to express their views. At the same time, it allowed us to get detailed information about our investigational phenomenon (Strauss and Corbin 1998). Quantitative strategy was used as an embellish, because we wanted to seek information from different perspectives and our respondents answered questios at the beginning of the interview. The first part of questions included relevant demographic items such as age, level and type of education, gender, and practice in the a position of social worker. The second part included items that describe issues regarding satisfaction with the organizational structure, acceptance of the healthcare team, cooperation, organization of post hospital care and pride in the own profession. A five-point Likert scale was used (1 absolutely not, 5 absolutely yes).

The research was conducted at the turn of 2014/2015 and the research participants were 18 from the total of 31 social workers working in university and teaching hospitals in Slovakia, doing work in all the departments of the hospitals. Social workers specialized only in working with psychiatric and geriatric patients or chidren were excluded. Participants in our the study were aged between 37 and 60 years. Seventeen were female and only one was man, which relatively reflects gender balance of the social worker´s profession in Slovakia. One was with higher professional study of social work, six held bachelor level degrees, while seven held master's degrees, two doctor´s degrees and one of them Ph.D. degree. All of them had majored in social work and all the interviewees were currently employed as

hospital social workers, all of them in permanent employment. Each interview took approximately one and half hours.

Before we started with the interviews each of the participants was informed about the aim as well as about the content and intention of the research project. We also asked each participant to give an informed consent with the execution, processing of the interview and the use of the interview data. All interviews with were recorded and transcribed into texts and analysed. For data analysis, the inductive method of creating categories was used. Quantitative data were statistically analyzed via descriptive statistic and Spearman´s correlations.

4. Research Results

The main result of our findings is that social workers in hospitals are of the opinion that there are especially four key factors which have deep (negative) impacts on their work situation und work satisfaction: the *lack of statuatory rules which give only little orientation for daily work (1), organizational structures which are not prepared to include social workers (2) organizational cultures which are not used to work interpressionally (3), and diffculties to identify and get access to enough community resources (4).* This makes social work in hospitals difficult and forces social worker to continuously advocate their own position and competences against other professions.

In the following sections, these factors are described more in detail:

(1) Social workers in hospitals and statuatory rules

The area of legislation was defined by the participants as first and key factor that has the greatest impact on their work performance and, overall, for the recognition of social work as a health – related discipline. The findings of our research point to several shortcomings in the legislation and the consequences associated with them. Even if *the requirements for staffing in health facilities* is more or lesse clearly described in the Act of Ministry of Health SR no. 60/2012, p. 284) the meaning of these recommendations is not very clear. The research participants in particular feel that nobody fully knows how to implement these rules: there is nothing mentioned about the basic conditions for the employment of social workers, nor how many social workers should be employed at the hospital and what should be the scope of their professional activities. Hospitals usually determine the amount of working hours, whether it will be a full-time or part-time job, in their opinion. This situation creates insecurity for social workers who feel dependent on the decision of the hospital management. The testimonies of our participants are clear:

P 15: “Especially in the context that it is not written anywhere that we have to be there...it is an arbitrary choice whether they (the hospital management) want us or not...”

P 2: “It is entirely up to the hospitals whether they want to have a social worker or not. It is each hospital’s arbitrary choice what kind of job a social worker will have (part-time full-time)...”

According to the participants, this problem is directly related to a second problem – the need for a defined social worker – client's ratio. In some hospitals in Slovakia the social worker is in charge for all units and thus for all patients:

P 1: "We would certainly appreciate if there would be more of us... Before, when we were four we went to large ward rounds (with physicians), yet we should also have our own rounds as social workers. Now we are two and there is no more time to do it."

P 18: "no one speaks about standards which should be met (...) that means the insufficient number of social workers. There are two of us, and plus one is, in line with the concept, at the psychiatry department. I can tell you that when one is on holiday for two weeks, the other one can go mad."

Social workers also pointed out that the spectrum of patients is much larger and their patients are not only from units defined by law of 2012. The research participants consistently argued that one of the main groups of patients requiring intervention from social workers are patients of the unit of neurology and traumatology. These are mainly patients who were perfectly healthy and suddenly need help because they had a stroke or remain disabled after a serious accident. In such cases it is necessary to provide help not only to the patients but also to their relatives which have to cope with psycho-social and economical problems.

P 7: "(...) I do not know who was preparing the law, but I can tell you, in practice it does not meet the requirements at all, as we are mostly at neurology, traumatology, surgery and oncology, these are our fundamental pillars, where we are all the time, and it was not included there..."

All 18 social workers also point out the fact that these legislative ambiguities and uncertainties are due to the fact that they are usually not involved in the formulation of laws or commenting. They see a possible solution in an umbrella institution that would be a partner in communicating with the ministry, as is the case with other professions (the Medical Chamber, Chamber of Nurses and Midwives, Chamber of Psychologists etc.):

P 10: "This is still missing that chamber. We have no information. If a chamber would exists it would be possibe to have somebody to fight for us. .. And be involved into the legislation making process."

P 3: "We are waiting if the ice would move... Status would be increased (...) and we are waiting that we will have a professional organization behind us that would be an umbrella..."

Our findings show the fact that social work in hospitals is in a very specific position. The social workers see the solution of this topic in an agreement between ministries, which, however currently does not exist in Slovakia. It is necessary that social work in health care should be covered by one law agreed by both ministries. The area of law is not just a formal issue, but has a direct impact on the performance of the work of social workers in hospital setting. More authors point

out that the Slovakia still faces challenges in the legislative area (Pavelek and Dobríková 2015).

(2) Social workers in hospital and organizational structures

Social work in a hospital implies working directly with the patient, his family, collaborating with other professionals at the hospital and building a bridge between the hospital setting and community services (Carranza 2012). Social work practice must be underpinned by socially inclusive, empowering approaches. Social workers must frame their practice around one of the key element: working interprofessionally (Pockett and Beddoe 2015).

Quality performance depends on an *interdisciplinary cooperation*, which is based on a holistic approach, in which the central figure is “the client in the environment” (Germain and Gitterman 1980; Rock 2002). Researches point to the fact that the position of social workers in interdisciplinary teams varies from a position of leaders (Wagner 2000; Findley 2014) up to a situation where a social workers lacks organizational patronage (Silverman 2008). There are also differences in role expectations of the individual professionals cooperating with the social workers at the hospital. While social workers define their roles as a wide range of activities that include counselling, psychotherapy, provision of services, evaluation, administrative activities, case management, representation of clients, etc., other professionals consider the activities related to the care for the patient after he is released for home treatment to be the most important (Cowles and Lefcowitz 1992, 1995; Craig and Muskat 2013).

In addition to the positives, interdisciplinary cooperation also has its weaknesses, based on the unequal status of team members, the lack of organizational support, the unclear position of team leader or short cooperation (Schofield and Amodeo 1999). The common reasons are differences in values, attitudes, theoretical perspectives of individual departments, reluctance to share knowledge and little effort to teamwork (Reese and Sontag 2001).

Social workers at hospitals interdisciplinarily cooperate with physicians, nurses, psychologists, physiotherapists or clerics and others (Emilsson 2013; McLaughlin 2015; NASW 2011). Several studies also show that social workers have equal status in the mentioned teams and participate in decision – making processes of managed care (Kelly 1998). Authors Guo and Company (2007) highlight the benefits of a case management model in hospitals and observe that the work of an interdisciplinary team, compared to individual work of social workers standing outside the interdisciplinary team, brings several benefits both for the patient and for the hospital in connection with improving the quality of patient care and making the process of care more efficient.

However, from our research, it is obvious that social workers feel standing outside interdisciplinary teams. From the quantitative indicators, we found that social workers do not feel accepted as a full team member (mean 2,0). We also

found that when social worker has a longer practical experience in this field, he feels more accepted as a team member among the health care professionals (R=0,774**, sig.=0,000). The same is true of professional pride and team acceptance (R=0,812**, sig. = 0,000). On the contrary, significant negative correlation was demonstrated for higher education and a feeling of acceptance as as an equal member of the healthcare team (R= -0,872**, sig. = 0,000).

Some of these results are also expressed in the testimonies of the participants:

P 6: "A worker should be part of a team of health professionals, but it is absolutely not the case. We are as if we were solitaires."

P 13: "I do not feel as a member at all, I feel as a solitaire.' It's difficult to cooperate because there is rapid movement (on the units). I come to them and inform them but sometimes I feel that I am there in addition. They want me to arrange something quickly but they do not want me to be involved. Arrange, but do it simply and quickly. "

Very similar results introduced Albrithen and Yalli (2016) whose participants also felt that they have limited partnerships with their medical services colleagues in the hospital, who tend to view social workers as the 'enemy' or as unimportant to patient care and also referred to organisational pressures and the busy nature of work in the hospital. Participants from their research perceive positive cooperation between social workers and medical care professionals as crucial for the effective execution of their duties and they draw attention to complaint about their limited involvement with health care team.

Taking into consideration their performance of work and level of education, social workers should be included in the category of so-called "other medical staff" with speech therapists, psychologists, therapeutic pedagogues, physicists and laboratory diagnosticians. However, part of our participants is included in the category of TAS (technical-administrative staff) and part in the category of nurses. This is also evident from the status of social nurses in the historical point of view, because during the communist period they were regarded as paramedical staff and their education was only secondary. Unfortunately, some health professionals still have this awareness.

These irregularities were also reflected in the very name of the job of social workers at the hospital. Our participants reported that they're called "social nurse", "nurse for social services", etc. Such an employee rating means for social workers working at hospitals not only professional, but also financial undervaluation. The participants say:

P 14: "We are categorized in a very strange way, because it's inconsistent. Every hospital has it otherwise. We are both included among medical workers. They gave us a choice to be classified as a nurse or as TAS (technical-administrative staff)."

In the case of an ambiguous inclusion of social workers in the hospital's organizational structure many restrictions arise, that are not just a formal issue, but

also affect the actual performance of their job. In the Slovak Republic, social workers at hospitals are included in the nursing section. However, this is only a formal inclusion, which does not provide the possibility of staff development in terms of planning and organization of further education, trainings and skills development, providing supervision.

From the results of our quantitative survey is also clear that social workers are not satisfied with the inclusion into the section falling under the competence of the Deputy for nursing (mean 1,83) while satisfaction significantly decreases with increasing education (R= -0,741**, sig.=0,000).

P 6: “We are part of the department of nursing. In fact our superior is a nurse. But we have to solve psychosocial problems, not health problems. Sometimes we have to consult new legislation. In that case we are asking our colleagues from other hospitals. This is the problem...we'd like to have somebody as a supervisor or consultant.”

P 8: “Social workers from other hospitals sometimes asked us for advice. They contacted us and aksed what they should do, how they should do, etc. (...) Therefore, if we have a problem and do not know anything, we also call social worker from another hospital. So we everybody is helping each other.”

P 2: “We'd need a social work department like nurses or doctors have. There is nobody to encourage us. If you are not part of structure your possibilities to promote ideas or programs are limited. We also miss a provision by the hospital of advanced learning. We should attend the conferences, training, etc. But tTaking part in a conference e.g. is my private affair, it´s up to me.”

All these activities are based on the personal motivation of social workers, and therefore not covered by the organization. It is thus a further restriction in the work of social workers at hospitals, who, however, seek opportunities for further professional development in their own informal networks. They often turn to their colleagues from other hospitals who assist them as expert consultants or supervisors.

P 22: “If there is something, we let know each other, we ourselves have to follow everything, and it is not provided on the side of the hospital.”

P 11: “Nobody has given us any methodical direction, that you should do it in this way orin an other way.”

The participants are expressing dissatisfaction with existing organizational and professional management and perceive their work as “silent acitivity” that nobody wants to talk about as long as it works well.

(3) Social workers in hospital and organizational culture

An organizational culture is a system of abstract ideas on desired actions, according to which peopleare orienting their behaviour in their mutual interactions in the organization. It includes ideas on desired values, objectives and interests of

people in the organization, the concept of the desired as well as real characteristics of participants in activities. Organizational culture is complemented by rules according to which people in a certain position have to act in the interaction with people in another position (Martin 1992; Musil 2011).

Most of our participants identified the organizational culture as "a set of expected attitudes, relationships, communication methods, characteristics of staff with whom they work."

In their work in the hospital, social workers intervene in several departments. The participants of our research indicated that there are differences in the attitudes of individual departments for their work. According to them, the attitudes of departments are largely a manifestation of their internal organizational culture. The departments, with which social workers have close cooperation, intensive communication and which show a greater recognition and understanding of their work, were designated as departments with a good organizational culture. The key to creating an organizational culture is the head of a department. If the cooperation of the social worker with the head of department is good, it will be automatically adopted also by other colleagues:

P 5: "...In regard to the departments, it cannot be put in pigeon-holes, much depends on the personality of the head physician... It´s up to people. It takes a long time to build relationship with people in different units. It´s easier to cooperate with those we know several years."

It is a typical example of culture based on a so-called top – down approach. People working in a particular section of an organization will take over the opinions or behaviour of their chief, in our case it is mostly the head physicians or senior consultants. The top–down approach can also be seen in relation with social workers. Of course, this behaviour can not be generalized and, according to one of the participants, not the collective but rather the individual assuming of this culture is important (it will not be assumed by everyone):

P 8: "It's about people. It depends on the personality of head physician. Some will not accept you and some on the contrary, it shows you that he appreciates your job. Then you know how they honor you on that department. It can not be generalized, it depends on the personality of a particular person. There are doctors that when we come on the department, they will discuss with you totally normal, they will tell you all about the patient, they are waiting for our findings, they write it, document ... other physicians whom we write, that do not put it to the final report that we try to solve this patient – like the social worker is nobody."

Other partcipants had similar state:

P 9: "My experience is that head of unit may influence the cooperation very much. He creates organizational culture. I knew very open mind and cooperative ones... It is important for beginning young medicine doctors. They follow patterns of behavior of senior doctors."

Our participants consistently report that their position in the teamwork:

"... is not determined by prestige of social work profession, but the very intense long-term efforts of us. We have to build our position in the eyes of other members of the team. It takes long time to share the same professional language."

Research findings show the perceptions of the position of social workers as a secondary profession, which "does not save lives", and therefore has to make more efforts to defend its position in the hospital. Most participants commented that the collaboration with physicians and other health professionals:

"... is often exhausting and challenging, but after showing our professional competence and capability we are able to defend our position and relationships are changing for the better."

All these reports were also confirmed by quantitative indicators, while cooperating with other health care professionals was assessed only as an average (mean 2.94). Significantly positive correlation was confirmed in terms of better cooperation with longer practice of social worker (R=0,681**, sig.0,000), better cooperation significantly positively correlated also with professional pride (R=0,858**, sig.=0,000) and the better set the social worker cooperation, thus he felt more accepted as an equal member of the healthcare team (R=0,810**, sig.=0,000).

This fact was supported particularly by the participants with many years of experience, who emphasized that such cooperation within the organizational culture had been built up over several years and also university education in social work began only in 1992 in Slovakia. This implies that it must fit into the consciousness of other health professionals that social workers are independent and competent experts in their field.

(4) Social workers in hospitals and the coordination of patient discharge as well as the organisation of post hospital care

In Slovakia there is a growing need for the intervention of social workers in the process of releasing patients from hospital to home setting, or to another care (Linton *et al*. 2015). This process is often viewed through the optics of a biomedical or diagnostic approach, where the main criterion is only the medical condition of the patient. The bio-psycho-social approach is largely neglected and systematically undervalued, which greatly complicates the work of social workers.

Moreover the hospital social workers cooperate with external resources trying to cope with the requirements related to the reduction of economic costs of hospitals, shortening the duration of hospitalization and ensuring the fastest possible transfer from the hospital (Rock 2002; Farley 1994). It is necessary for them to know how organizations work, whether they are public, profit or non-profit, what is the range of services, what are the funding rules, how social workers work in these facilities (Kelly 1998; Cowles 2003). In addition to the availability of services, also the condition of their interconnectivity is important. Integrated services thus meet the conditions of complexity, comprehensiveness and coordination (Waldfogel 1997).

Social workers establish, complete and maintain relationships that are pre-requisites for cooperation and exchange of information between various sources in the community (Hardcastle *et al*. 2004). Their aim is not only to utilize existing resources, but also to identify those that are the source of innovation. It is about networking with the formal and informal links, in which people from different backgrounds cooperate and are bearers of different cultural traditions (Payne 2006). While formal relations are officially established, regulated and have clear rules, the informal are based on personal contacts, mutual trust and personal experience and motivation of the participants.

According to the participants it would by heplful to be involved into the process of treatment of patients from the reception until to the discharge. This requires that health professionals should immediately inform social workers about all social problems of the patient during their whole stay in the hospital (Voráček and Dubnová 2014).

Social workers evaluated whether it is easy to organize post hospital care in Slovakia and their answers shows that it is not very easy (mean 2,55). Post hospital care is less demanding for social workers who have longer experience in the position of social worker (R=0,869**, sig.=0,000). It is also less demanding for those who reports better cooperation with healthcare workers (R=0,648, sig.=0,004) and those who feels higher acceptance as an equal team member (R=0,718**, sig.=0,001).

P 12: "To arrange all things to the well-being of the client and to my own satisfaction is very difficult. It´s all about communication, cooperation with institutions, courts. According to act we have statutory deadline 7 days but we are able to do it in 24 hours thanks to good relationships. For example pediatry – when they call us that they have child in difficult situation, they want to place this child somewhere. And thanks to our extraordinary relationships with curatorship, we immediately write e – mails, pick up the phone and call to them – they are able to find free places in crisis centers or foster care homes. Curatorship gives application to court, and we have to solve this case immediately. Our colleagues on court are very kind, they inniciate the process of interim measure. And after this there is a paper waiting for judge´s signature. I am waiting for feedback that tommorow I will have this paper. And in two days I really have it."

The participants also highlighted the increasing trend in the number of clients of the integrated health and social services.

P 16: "There is a big problem with patients in so-called vigil coma, both health and social problem. There is only a few institutions for them. Also the number of elderly is still growing. They will need this kind of services as well. It is a challenge for me to find suitable institution now not even in future."

P 17: "Another big problem is, for example, the diagnosis of coma vigilae, or patients having tracheostomy, we do not have any facilities for them. This is a huge problem. This is yet another big problem, perhaps even bigger than the first one. We have no corresponding institutions to place them."

P1: “Family members ask us for help, they have no experience with this, and they think we have the key to solve their problem. They call us and ask. We have to help them, they are totally lost.”

Creating informal networks is essential in work of hospital social workers. Social workers use informal networks in order to provide the continuity of care for the patients as well as accelerate the process of discharge planning. According to the participants their networking is based on the:

P 13: We are still building hospital´s relationship with the community resources and local authorities. Our contributions to patients´ quality of life is needed and heavily interchangeable. In my opinion social workers have to have skills to manage care for patient including communication skills, creating of partnership, and knowledge on community planning and so on.”
“We have to be very flexible. Only thanks to our connenctions we are able to react on client’s needs in short time.”

P 2: “But when a patient comes to us, e.g. after an amputation of feet or after a severe stroke, he's totally in bed and the family can not take him, care facilities would take him, but without decisions they'll not take him, and you have to wait a month ... but they will not wait a month at the department ... and the officials they do not understand, they think that to have the patient in hospital the second month is normal, let him wait… hospital becomes unprofitable, insurance companies reimbursed only until such time as it is for the acute treatment, but when the goes into a chronic patient can be treated at home and that's the everlasting fight for the, because we have good cooperation and sometimes we are able to do the decision at half time, but in general from the law it is very long time that month.”

P 12: “... if there are not complications the patient is stable and can move ... and now the problem is -where? Because social networking is such as it is, everything is bound to the Social Services Act, there it is in a two-stage, first report, which takes 30 days... well, with the best will that can be done in two weeks if it is a good cooperation ... but in general that is not possible just wait like this, it's an awful long time, 30 days is impossible for the hospital to wait for the decision ...”

Social workers, despite of the limitations, try to meet clients' needs and provide an adequate care for them after discharge into home setting or in the event of failure to provide care at home, to another facility (medical or social service facility). The existing community services thus sometimes become difficult to access for clients. The problem is usually the number of facilities in the establishing competence of the self-governing region or municipality, where the patient comes from. The participants consistently stated that the only way to ensure the availability of services for clients was personal involvement and good, though informal, relationships which had been built up over the years of practice and were based on mutual trust and a strong personal involvement of both sides.

5. Conclusion

The study shows that at present in Slovakia social workers' performance in hospitals is limited by four key aspects:

1. Legisation

The unclear legislation, which is reflected in the organizational structure of hospitals and incoherent health and social services, leading to the need for a continuous advocacy of own position and competence on the part of social workers.

Social workers consider legislation that would clearly define their place, the competence and scope of activities for the basic framework for carrying out their work. Although the law explicitly appoints departments, which are entitled to employ a social worker at the hospital, they actually intervene wherever necessary (Craig and Muskat 2013). So, if they are to carry out their work professionally and fulfill all the expected roles in full extent, it is important to define what is the capacity, in terms of number of patients, for their performance. The study has shown that the small number of social workers in hospitals actually reduce their performance, and they thus become "fire-fighters" of the incurred adverse social situation of the patient. Instead of creating a plan for the work with a client, social workers are forced to reduce their activities to crisis intervention. The interviews have shown that this way of working participants considered unsatisfactory in relation to themselves and also to the client.

Our findings confirm that the field of activity of social workers should not be just at micro and mezzo levels, but it is necessary that their activities interfered to the macro level, in order to participate in the legislative process and other decision – making processes that affect the lower levels (DiNitto and McNeece 2008). According to participants one of the possible ways of improving position is an umbrella organization which would also assist in discussions with the ministries.

2. Organisational structure

The legislative framework is also reflected in another factor which is the organizational structure. According to the participants, the noninclusion in the so-called "other medical staff" in the hospital organizational structure is weakening their position and limitingt any enforcement of their requirements. They feel alone, without the support and professional guidance (leadership). One of the reasons is the fact that hospitals lack a position as e.g. a "social work director", who could communicate with both internal and external (community resources) environments. The unclear inclusion in the nursing section or TAS (technical-administrative staff) is affecting their position in the team as well and makes the promotion of the values and knowledge of social work impossible (Globerman *et al*.2002). Another problem is the lack of staff development. This study suggests, in line with the study

of Gutiérrez *et al.* (1995), that administration and organizational development is one of the most important aspects of professional knowledge and skills development as well as interdisciplinatory cooperation and peersupervision.

3. Organisational culture

Next factor which affects work of social workers, but is not significantly affected by legislation, is organizational culture. It is a separate factor that can very positively influence the work of social workers at the hospital. Organizational culture is understood as a set of assumptions and beliefs that employees consider to be accurate ways of perceiving and experiencing difficulties in adapting to external conditions and internal cohesion (Martin 1992; Musil 2011). In Slovak hospitals, creating, building and cultivating organizational culture of departments is heavily influenced by a leader, in this case the head of department. It is also part of knowledge and values transfer from the leader towards other employees. The study confirms that collaboration, communication, and also the professional acceptance of social workers at the individual departments depends very much on the quality of the relationship between the head of department and a social worker. Despite the fact that the legislation implies uncertainties regarding competencies, jobs and status of social workers, it is the individual head of department whose approach can have a very positive effect on the perception of social worker’s position and his irreplaceability in the process of comprehensive patient care. The social workers themselves consider organizational culture a factor, which, although not directly affected by legislation, can be a key for their performance.

4. Process of discharge and post hospital care

A strong impact of legislative shortcomings is evident in the provision of community resources for patients who are released from hospital, but can not lead an independent life and need services, whether outreach or outpatient, or even a complete institutional care. The results of this research showed that in providing the aftercare, which is usually entrusted to a social worker, his strong commitment and personal involvement in the collaboration with community resources is essential. The social worker is a case manager who connects patients with the community resources. For the performance of his work, on the one hand, detailed knowledge of the community, an active cooperation with resources, building formal and informal professional networks, an active participation in the creation of community development plan, is important. On the other hand, he has to know about the patient's setting, possibilities and limitations, and also their needs and wishes. In our research we have identified certain constraints which hinder the exercise of social workers in the hospital, especially in the process of transporting the client from hospital and providing subsequent services in the community. In particular, the shortage of medical-social services, and also the lengthy bureaucratic process of assessing the client's claim to the particular services.

Legislation that would result from mutual agreement between the two ministries for social welfare and health care is regarded as essential by the participants.

The overall question remains, how social workers face the above limitations, as they are constantly under pressure to reduce patient's stay in the hospital and to seek new possibilities. The research showed that well-functioning informal networks, which had been built over several years, were essential for the successful work of social workers.

The research shows that it's time now to strengthen the position of social workers in hospitals and to change the existing structural and cultural conditions in order to make social work able to fully play its autonomous part in an integrated care system which helps clients to succesfully cope with the challenges and problems connected with a stay in hospital.

Acknowledgment
This work was supported by the [Slovak Research and Development Agency] under Grant [number APVV - 0524 - 12].

References

1. Albrithen, A., and Yalli, N. (2016). Social workers: Peer interaction and hospital integration. *International Social Work*, **59**(1), 129-140.
2. Albrithen, A., and Yalli, N. (2015). Medical Social Workers' Perceptions Related to Interprofessional Teamwork at Hospitals. *Journal of Social Service Research,* **41**(5).
3. Act of Ministry of Health of Slovak Socialistic Republic no. 13-14 (1984).
4. Act of Ministry of Health of Slovak Republic no. 44 (2008).
5. Act of Ministry of Health of Slovak Republic no. 60 (2012).
6. Carranza, C.M.G. (2012). *Social Work in the Hospital Setting Interventions*. Trafford Publishing, United States of America.
7. Cowles, L.A. and Lefcowitz, M.J. (1992). Interdisciplinary expectations of the medical social worker in the hospital setting. *Health & Social Work*, **17**(1), 57-65.
8. Cowles, L.A. and Lefcowitz, M.J. (1995). Interdisciplinary expectations of the medical social worker in the hospital setting: Part 2. *Health & Social Work*, **20**(4), 57-65.
9. Cowles, L.A. (2003). *Social Work in the health field (2nd ed.)*. Haworth Press, Binghamton, New York.
10. Craig, S.L. and Muskat, B. (2013). Bouncers, Brokers, and Glue: The Self-described Roles of Social Workers in Urban Hospitals. *Health & Social Work*, **38**(1), 7-16.
11. DiNitto, M.D. and McNeece, A.C. (2008). *Social Work Issues and Opportunities in a Challenging Profession*. Lyceum Books, Chicago.
12. Dobríková, P. (2010). Quality of Life in Incurable Patients. *Studia Psychologica*, **52**(2), 155-163.
13. Dobríková P., Pčolková, D., AlTurabi LT, and West, D.J. (2015). The Effect of Social Support and Meaning of Life on the Quality-of-Life Care for Terminally Ill Patients. *American Journal of Hospice and Palliative Care,* **32**(5).

14. Emilsson, U.M. (2013). The Role of Social Work in Cross-Professional Teamwork: Examples from an Older People's Team in England. *The British Journal of Social Work*, **43**(1), 116-134.
15. Farley, J.E. (1994). Traditions in Psychiatric Inpatient Clinical Social Work. *Social Work – Journal of the National Association of Social Workers*, **39**(2), 207-212.
16. Findley, P.A. (2014). Social work practice in the chronic care model: Chronic illness and disability care. *Journal of Social Work*, **14**(1), 83-95.
17. Germain, C. and Gitterman, A. (1980). *The life model of social work practice*. Columbia University Press, New York.
18. Globerman, J., White, J. and McDonald, G. (2002). Social Work in Restructuring Hospitals: Program Management Five Years Later. *Health & Social Work*, **27**(4), 274-284.
19. Greene, G.J. and Kulper, T.K. (1990). Autonomy and Professional Activities of Sociaql Workers in Hospital and Primary Health Settings. *Health and Social Work*, **15**(1), 38.
20. Guo, K.L. and Company, J.D. (2007). Leaders in hospital-based social work: the roles and functions of directors of social work in the case management model. *Leadership in Health Services*, **20**(2), 124-133.
21. Gutiérrez, L., GlenMaye, L., and DeLois, K. (1995). The Organizational Context of Empowerment Practice: Implications for Social Work Administration. *Social Work*, **40**(2), 249-258.
22. Hardcastle, D.A., Powers, P.R. and Wenocur, S. (2004). *Community Practice. Theories and Skills for Social Workers*. Oxford University Press, New York.
23. Judd, R.G. and Sheffield, S. (2010). Hospital Social Work: Contemporary Roles and Professional Activities. *Social Work in Health Care*, **49**(9), 859-871.
24. Kelly, J.M. (1998). Social Workers and the Tradition of Charity in the Changing Health Care System. *Health & Social Work*, **23**(3), 236-240.
25. Kovalčíková, N., Pavelek, L., Slaná, M. and Žáková, M. (2014). Professional Identity Perception of Hospital Social Workers in Slovakia. *ERIS Web Jounal*, **5**(2), 15-24.
26. Linton, F.K., Ing, M.M., Vento, M.A. and Nakagawa, K. (2015). From Discharge Planner to "Concierge": Recommendations for Hospital Social Work by Clients with Intracerebral Hemorrhage. *Social Work in Public Health*, **30**(6), 486-495.
27. Martin, J. (1992). *Cultures in Organizations, Three Perspectives*. Oxford University Press, New York.
28. Majchráková, H. (ed.) (1990). *Sociálna služba a zdravotnosociálna starostlivosť o populáciu*. Osveta, Martin.
29. McLaughlin, J. (2015). Social work in acute hospital settings in Northern Ireland: The views of service users, carers and multi-disciplinary professionals. *Journal of Social Work*, **16**(2), 135-154.
30. Musil, L. (2011). Constancy of Concepts of Desirable Social Workers Actions and Experiencing their Dissimilarity in an Organisation. *Czech and Slovak Social Work*, **11**(5), 17-26.
31. NASW (2005). *NASW Standards for Social Work Practice in Health Care Settings.* Available online [08.09. 2015] at: http://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf.
32. NASW (2011). *Social Workers in Hospitals & Medical Centers*. Washington, NASW. Available online [08.09.2015] at: http://workforce.socialworkers.org/studies/profiles/Hospitals.pdf.

33. Payne, M. (2006). *What is Professional Social Work?*. BASW, Bristol.
34. Pavelek, L. and Dobríková, P. (2015). Sociological Concepts of Identity and Social Capital: the State of Civil Society in Slovak Republic. *The Social Sciences*, **10**(4), 527-531.
35. Peterson, K.J. (2012). Shared decision making in health care settings: a role for social work. *Social Work in Health Care*, **51**(10), 894-908.
36. Pockett, R. and Beddoe, L. (2015). Social work in Health Care: An International Perspective, *International Social Work.*
37. Reese, D.J. and Sontag, M. (2001). Successful Interprofessional Collaboration on the Hospice Team. *Health & Social Work*, **26**(3), 167-173.
38. Rock, D.B. (2002). Social Work in Health Care for the 21st Century: The Biopsycho-social Model. In Roberts, A.R. and Greene, G.I. (Eds). *Social workers desk reference*. Oxford University Press, New York, 10-15.
39. Schofield, R. and Amodeo, M. (1999). Interdisciplinary Teams in Health Care and Human Service Settings: Are they effective?. *Health and Social Work*, **24**(3), 210-219.
40. Silverman, E. (2008). From Ideological to Competency-Based: The Rebranding and Maintaining of Medical Social Work's Identity. *Social Work*, **53**(1), 89-91.
41. Strauss, A. and Corbin, M.J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. SAGE Publications, London.
42. Voráček, J. and Dubnová, M. (2014). System Dynamics Modelling the Role of Social Workers in the Process of Discharges Planning Patients. In Truhlářová, Z., Levická, J., and Smutek, M. *Social Work in The Context of Human Rights*. Gaudeamus, Hradec Králové, 208-218.
43. Wagner, E.H. (2000). The Role of Patient Care Teams in Chronic Disease Management. *British Medical Journal*, **320**(7234), 569-572.
44. Waldfogel, J. (1997). The New Wave of Service Integration. *Social Security Review*, **71**(3), 462-484.