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**POSITION
STATEMENTS**

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INTRODUCTION

These position statements have been developed to guide nurses in practice and nurses acting as spokesperson for the nursing profession.

To ensure a democratic process in the development of these positions, all the drafts were circulated to/ or discussed with the nurses of the country. If you have any additional suggestions, please do not hesitate to let us know.

For easy reference, each position starts with a summary of the DENOSA position, followed by a detailed version. All positions will be updated periodically as the need arises.

We trust that you will find this document useful.

DENOSA

The Democratic Nursing Organisation of South Africa

PO Box 1280

Pretoria, 0001

Tel (012) 343-2315

Fax (012) 344-0750

E-mail : denosahq@mweb.co.za



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**NURSING ROLES
IN
HEALTH CARE**

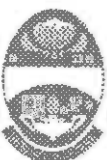


TERMINATION OF PREGNANCY

DENOSA BELIEVES THAT:

1. the pregnant woman's right to choose should be respected;
2. the nurse/midwife/accoucheur's right to freedom of conscience should be respected;
3. the midwife/accoucheur who does not wish to participate in direct termination of pregnancy, should make her/his viewpoint known in good time;
4. the nurse/midwife/accoucheur has a responsibility to nurse the patient before and after the procedure;
5. the employer has a responsibility to provide facilities for debriefing and counselling;
6. the S A Nursing Council has a responsibility to ensure that:
 - 6.1 the scope of practice of the midwife/accoucheur makes provision for performing termination of pregnancy;
 - 6.2 the public is protected from nurses and midwives/accoucheurs not trained to perform termination of pregnancy.

August, 1998



TERMINATION OF PREGNANCY

1. LEGAL POSITION

1.1 *Act on the Choice of Termination of Pregnancy*

The Choice of Termination of Pregnancy Act, No. 92 of 1996, was promulgated on 22 November 1996 in Government Gazette No 17602.

1.2 *RSA Constitution*

The rights of the nurse/midwife/accoucheur and the pregnant woman with regard to the choice of termination of pregnancy, are entrenched in chapter 2 of the Constitution of the country:

Section 9

Everyone is equal before the law and has the right to equal protection and benefit of the law. No person may be unfairly discriminated against directly or indirectly on any or more grounds, including amongst other things religion, conscience and belief.

Section 12 (2)(a)

Everyone has the right to bodily and psychological integrity which includes the right to make decisions regarding productivity.

Section 15(1)

Everyone has the right to freedom of conscience, religion, thought, belief and opinion.

2. THE POSITION OF DENOSA:

2.1 *With regard to the pregnant woman, DENOSA believes that:*

2.1.1 the woman has the right to information to make an informed decision;

2.1.2 nurses/midwives/accoucheurs have to respect the pregnant woman's right to freedom of choice, i.e. not judge the woman in terms of her choice to terminate the pregnancy, and not to unduly influence her to change her mind;

2.1.3 the woman has a right to be referred to an applicable institution;

2.1.4 nurses/midwives/accoucheurs must respect the woman and maintain her dignity;

2.1.5 the woman should have access to supportive/neutral counselling before and after termination of pregnancy.



2.2 *With regard to the rights of the nurse, midwife/accoucheur, student and student midwife/accoucheur, DENOSA believes that:*

- 2.2.1 the registered midwives/accoucheurs have a right to freedom of conscience, i.e. they may not be denied employment, they may not be dismissed or victimised for either the choice to participate or not to participate in termination of pregnancy. Such action constitutes unfair labour practice;
- 2.2.2 the registered nurse and midwife/accoucheur may not be coerced to participate in direct termination of pregnancy, i.e. the theatre nurse, putting up an intravenous infusion to induce the termination, executing the prescription of a medical practitioner for either oral or intravenous medication, or to do the actual termination;
- 2.2.3 only the registered midwife/accoucheur who has undergone the prescribed training for midwives, may be involved in the direct actions of the termination of pregnancy;
- 2.2.4 a midwife/accoucheur who makes herself/himself available for training, implies she/he is available to participate in the termination of pregnancy;
- 2.2.5 the nurse and/or midwife/accoucheur has the right to insist that all the conditions stipulated in the choice on Termination of Pregnancy Act are adhered to before termination of pregnancy can be performed.

2.3 *DENOSA believes that the nurse/midwife/accoucheur has the following responsibilities:*

- 2.3.1 where the registered midwife/accoucheur does not wish to participate in direct termination of pregnancy in terms of her/his constitutional rights, she/he should make her/his viewpoint known in good time, preferably when employment is accepted, so that substitute staff can be arranged (DENOSA has developed a form in this regard);
- 2.3.2 all nurses and midwives/accoucheurs have a professional and ethical obligation, according to the Nursing Act and its related regulations, to nurse the patient before and after the procedure in spite of conscientious objection to the termination of pregnancy;
- 2.3.3 the nurse/midwife/accoucheur acts as an advocate for the patient and therefore has an obligation to refer the woman requesting termination of pregnancy, to an applicable institution(s) for termination of pregnancy;
- 2.3.4 the registered nurse and midwife/accoucheur should recognise the need for counselling and, should she/he not have the necessary skills, she/he should refer the woman to the relevant facilities;



2.3.4 where medical or surgical treatment of a female patient may lead to termination of pregnancy, all reasonable measures must be taken to diagnose pregnancy.

2.4 *DENOSA believes that the employer has the following responsibilities:*

2.4.1 state whether it is licensed to do abortions when advertising posts, particularly related to midwifery, theatre and emergency care units;

2.4.2 provide facilities for debriefing and counselling;

2.4.3 provide on the job training, including value clarification;

2.4.4 ensure that the nurse and midwife know the provisions of the Act.

2.5 *DENOSA believes that the SA Nursing Council has the following responsibilities:*

2.5.1 protect the nurse and midwife/accoucheur by extending the scope of practice;

2.5.2 protect the midwife/accoucheur who has been authorised to do termination of pregnancy;

2.5.3 be directly involved in setting up and approving a training course for midwives/ accoucheurs and approval of training schools;

2.5.4 protect the public from nurses and midwives/accoucheurs not trained to perform termination of pregnancies;

2.5.5 ensure that termination of pregnancy training does not become part of student training.

RESOURCES

1. CONSULTATION with nursing and midwifery profession 1997/1998.
2. SOUTH AFRICA (Republic), 1996: *Choice of Termination of Pregnancy Act (Act No. 92 of 1996)*. Pretoria: Government Printer.
3. SOUTH AFRICA (Republic), 1996: *Constitution of Republic of South Africa Act. (Act No. 108 of 1996)*. Pretoria: Government Printer.

August, 1998



Annexure A

To assist those who object, DENOSA proposes the following wording in a letter to the employer:

I, Sister/Nurse have a conscientious objection
to termination of pregnancies. I, therefore, place my employer on notice that:

- * I will not participate in termination of pregnancy, neither directly
nor indirectly.
- * I will not be available to undergo any training for terminations of
pregnancy.

Signature _____ Date _____



HIV/AIDS

DENOSA BELIEVES THAT:

1. All individuals have a responsibility to understand and prevent HIV/AIDS;
2. All opportunities should be utilised to provide health education and promote behavioural change;
3. The nurse/midwife/accoucheur has a responsibility to care for the person living with HIV/AIDS;
4. All persons living with HIV/AIDS have the right to be cared for and not to be discriminated against;
5. The employer has a responsibility to provide a supportive and safe working environment;
6. Staff organisations have a responsibility to safeguard the interest of their members.

June, 1998



HIV/AIDS

1. PREAMBLE

AIDS is a condition resulting from the human immunodeficiency virus (HIV) attacking the immune system which then results in various secondary infections/diseases. The mode of transmission is through contact with blood and blood products, body fluids and transfer from an infected mother to her child.

DENOSA believes that there are different rights and responsibilities for the various role players that should be upheld at all times.

2. RESPONSIBILITIES

2.1 *The Individual and the community*

- 2.1.1 The individual has a responsibility to understand and prevent transmission of HIV/AIDS.
- 2.1.2 The individual/community/family has a responsibility to educate the youth regarding HIV/AIDS.

2.2 *The Nurse/Midwife/Accoucheur as clinician*

In addition to the charter* on nursing, the nurse/midwife as a clinician has a specific responsibility to:

- 2.2.1 respect the person's right to confidentiality. Should it become imperative to divulge a person's HIV status, the nurse/midwife/accoucheur must do so with the greatest circumspection, with the person's consent and in collaboration with the person's medical practitioner in order to render appropriate, compassionate and comprehensive care.
- 2.2.2 have an understanding of HIV/AIDS, keep him/herself informed and competent at all times with the latest developments such as research, legal position and treatment.
- 2.2.3 care for the patient. Refusal to care for a client who has HIV or AIDS is contrary to the ethical codes of the health care professions. If a nurse/midwife/accoucheur refuses to attend to a client living with HIV/AIDS, such conduct may be a breach of professional conduct. In addition, for the nurse who is employed, such action may also constitute a breach of contract. The employer could take disciplinary action which could culminate in dismissal. In addition the SA Nursing Council may also be involved in taking disciplinary action in terms of the Regulations relating to the Scope of Practice and/or The Acts and Omissions which may indicate professional misconduct.
- 2.2.4 recognise people at potential risk, to ensure that persons receive adequate pre- and post-counselling and to refer them to appropriate services.



- 2.2.5 ensure that universal blood precautions and infection control principles are adhered to in all daily interactions with all the clients under her care and fellow health care workers.
- 2.2.6 bring the non-availability of the necessary supplies and/or equipment to enforce the above precautions to the attention of the employing body without delay.

NOTE: It is vitally important that the nurse/midwife/accoucheur should discuss with another registered practitioner (preferably her/his direct supervisor) any personal, moral and/or ethical dilemmas which may interfere with her/his ability to give competent care to the client as the clients' rights may be compromised by her/his concerns to participate in the care of the client living with HIV/AIDS.

2.3 *The Nurse/Midwife/Accoucheur as an Educator*

In the absence of any known cure, the most powerful tool for reducing both occupational and lifestyle risk of HIV infection, is health education and behavioural change.

- 2.3.1 Nurses and midwives/accoucheurs must use every opportunity to provide information to the public, the patient and the co-health care worker about HIV infection and its prevention.
- 2.3.2. Educators must include the entire spectrum of ethical, legal, psychosocial practice and health care issues specific to HIV/AIDS in the curricula for the education and training of the nurse and the midwife/accoucheur.

2.4 *The Practising Nurse/Midwife/Accoucheur who is living with HIV/AIDS*

- 2.4.1 The nurse/midwife/accoucheur living with HIV/AIDS must take all the necessary precautions to avoid infecting others. Failure to do this could lead to the possibility of a civil claim for damages in the event of a person being infected. The liability of the nurse/midwife/ accoucheur will depend upon proof of causation and legal fault.
- 2.4.2 If HIV positive, the following should be adhered to:
 - a) regular medical follow-up.
 - b) seeking advice from an appropriate professional source on the extent to which professional practice may have to be limited.
 - c) although there is no obligation to do so, it may be advisable to inform the employer of his/her HIV status so that the necessary support can be given with regard to any work related matters.
- 2.4.3 She/he has the responsibility to understand that the sequelae of HIV/AIDS may lead to impaired judgement and work performance.



2.5 The Employer

- 2.5.1 The responsibility of the employer is to take all reasonable steps to ensure a supportive work environment and the safety of both the health care workers and the patients cared for in that particular health care facility. This should include:
- * education,
 - * information,
 - * policies and procedures,
 - * standards and guidelines,
 - * equipment and supplies to ensure the safety of health care workers.

The employer can be held liable if it can be proved that infection has been caused by the employer's negligence.

- 2.5.2 The employer should encourage nurses/midwives/accoucheurs to discuss their moral and personal concerns with their supervisors and/or other counsellors.
- 2.5.3 Flexible work allocation should be provided for the HIV positive nurse/midwife/ accoucheur depending on her/his condition and job demands in order to ensure continuity of their employment as long as possible. The nurse/midwife/accoucheur should be protected from other infections such as tuberculosis.
- 2.5.4 The employer cannot refuse to employ or terminate the employee's service purely on the basis of being HIV positive.
- 2.5.5 The employer has a responsibility to develop a policy and procedure guidelines for the management of accidental injury or exposure to blood or body fluids. This policy should include the following:
- a) the reporting of accidental injury/exposure to blood or body fluids.
 - b) the responsibilities of the medical practitioner in the immediate care of an injured/ exposed employee.
 - c) the documentation, post-exposure, pre- and post-test counselling and follow-up treatment required.
 - d) the obtaining of blood specimens from the source patient if his/her HIV status is unknown.
 - e) the action to be taken in the event of the source person/patient being positive.
 - f) the procedure with regard to the blood specimens referred to above.
 - g) reporting the incident to the Commissioner of Occupational Injuries and Diseases.



2.6 Medical practitioner/Occupational Health nurse

The medical practitioner/occupational health nurse has the responsibility to obtain a blood specimen from the injured/exposed health care worker.

2.7 DENOSA

DENOSA has the responsibility to:

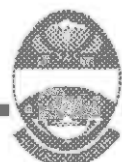
- 2.7.1 protect the benefits and continued employment opportunities for members living with HIV/AIDS;
- 2.7.2 negotiate on an ongoing basis for employer-financed health care and disability insurance for HIV/AIDS sustained through work related incidents;
- 2.7.3 lobby for compensation benefits;
- 2.7.4 negotiate for job retraining opportunities for nursing/midwifery personnel whose physical ability may be compromised and investigate the possibility to make such opportunities available;
- 2.7.5 convince employers, managers and insurance agencies not to discriminate against personnel living with HIV/AIDS;
- 2.7.6 provide support, legal assistance, referrals of members to services and to foster networking with other health workers living with HIV/AIDS;
- 2.7.7 advise members about continued practice and disclosure of HIV status;
- 2.7.8 provide up-to-date and accurate information about compensation benefits, occupational risks and follow up care;
- 2.7.9 lobby for introducing or changing existing legislation and regulations to ensure that people living with HIV/AIDS are treated like any other group with a health problem;
- 2.7.10 network at national and international level in sharing experiences and disseminating information regarding HIV/AIDS.

3. RIGHTS

3.1 Patient's particular rights

The HIV positive patient has a right to:

- 3.1.1 be offered information/education about HIV/AIDS;



- 3.1.2 be afforded counselling on 'living with HIV/AIDS';
- 3.1.3 informed consent, including to be informed of the intention to divulging his/her HIV status;
- 3.1.4 competent care;
- 3.1.5 not to be discriminated against;
- 3.1.6 be given dignity and respect (as always);
- 3.1.7 good infection control and information to protect himself against opportunistic disease;
- 3.1.8 privacy;
- 3.1.9 confidentiality;
- 3.1.10 psycho social safety.

3.2 *Rights of the Nurse/Midwife/Accoucheur*

As far as HIV/AIDS is concerned, the nurse/midwife/accoucheur has the right to:

- 3.2.1. expect the employer to have a policy regarding HIV/AIDS, including accidental exposure to blood and body fluids.
- 3.2.2. expect the employer to provide free preventative treatment immediately following accidental exposure to bodily fluids and blood of a HIV positive person.
- 3.2.3. continuing in service education on HIV/AIDS and universal blood precautions
- 3.2.4. be provided with equipment and supplies and personal protective equipment in line with universal precautions for blood/blood products, organs and body fluids.
- 3.2.5. be granted the opportunity and guidance to develop counselling skills.
- 3.2.6. be allowed to maintain confidentiality.
- 3.2.7. counselling and support facilities

3.3 *The Practising Nurse/Midwife/Accoucheur who is HIV Positive.*

The nurse/midwife/accoucheur living with HIV/AIDS has the right to:

- 3.3.1 not be discriminated against;
- 3.3.2 be compensated for contracting disability arising out of HIV as a result of a work related injury/accident;
- 3.3.3 protection of privacy.



RESOURCES

1. CONSULTATION with the nursing and midwifery professions during 1997.
2. CONSULTATION with other professional bodies during 1997 and 1998.
3. INTERNATIONAL COUNCIL OF NURSES (ICN) 1996: *Guidelines on Reducing the Impact of HIV/AIDS on Nursing/Midwifery Personnel*. Geneva: ICN.
4. INTERNATIONAL COUNCIL OF NURSES 1992: *ICN Position Statements: Acquired-immundeficiency Syndrome (AIDS)*. Geneva: ICN
5. SOUTH AFRICA, Republic 1996: *Constitution of the Republic of South Africa Act (Act No 101 of 1996)*. Pretoria: Government Printer.
6. SA LAW COMMISSION, 1997: *Discussion Documents on Aspects of Law Relating to AIDS*. Pretoria: Government Printer.

June 1998



MIDWIFERY



THE PROFESSIONAL NURSE AND MIDWIFE/ ACCOUCHEUR IN PRIVATE PRACTICE

The professional nurse/midwife/accoucheur is a qualified, legally accountable professional practitioner and has the right to practice her/his profession as a private practitioner within the framework of the Nursing Act.

DENOSA believes that:

1. Professional competence is a pre-requisite for the registered nurse/midwife/accoucheur who wishes to enter into private practice and it is recommended that a period of at least two years post-qualification experience is obtained before attempting to do so in the specific clinical area in which she/he is going to function.
2. It is the responsibility of private nurse practitioners to ensure that they keep abreast of developments in the medical, technological and social fields, and to update their knowledge and practice their skills constantly so that they can render high-quality nursing and midwifery care to their patients.
3. The individual, the family and the community are co-responsible for the promotion and maintenance of good health, and may consult nursing and midwifery services, whether provided by the State or by the private nurse/midwife/accoucheur practitioner.

May 1999



THE PROFESSIONAL NURSE AND MIDWIFE/ ACCOUCHEUR IN PRIVATE PRACTICE

1. INTRODUCTION

A healthy nation is a vital resource and therefore a prime goal and responsibility of the nation. The aim of health legislation in the Republic of South Africa is the rendering of a comprehensive health service (by multi-disciplinary teams) to all sectors of the community. At the same time, it is assumed that the individual, the family and the community are co-responsible for their own health and for the promotion of health in general, and that they may consult nursing and midwifery services.

2. THE PROFESSIONAL NURSE AND MIDWIFE/ACCOUCHEUR

The professional nurse and midwife/accoucheur are registered with the South African Nursing Council in terms of section 16 (1) of the Nursing Act, 1978 (Act 50 of 1978). The nurse/midwife/accoucheur undergoes professional training that must meet the minimum requirements laid down by the Council and which includes instruction in the basic physical, biological and social sciences and in the systems approach to nursing.

She/he practices as a professional nurse and midwife/accoucheur, whether as an employee or as a private practitioner, within the framework of the country's laws in general and of the Nursing Act in particular.

Of specific reference is:

- 2.1 the scope of practice of the registered professional nurse/midwife/accoucheur as determined by the Council under the powers vested in it by section 45(1)(q) of the Nursing Act and;
- 2.2 the regulations relating to the acts and omissions in respect of which the Council may take disciplinary steps.

3. DEFINITION OF PRIVATE PRACTICE

Private practice signifies a situation where the practitioner is self-employed, renders a nursing/midwifery service in the private sector, charges a fee for the service rendered and the income thus generated is for the practitioner's own account. In some countries these practitioners are referred to as nurse entrepreneurs.

4. ADDITIONAL RESPONSIBILITIES OF THE PRIVATE NURSE/MIDWIFE/ ACCOUCHEUR PRACTITIONER.

- 4.1 Professional competence is a pre-requisite for the registered nurse/midwife/accoucheur who wishes to enter into private practice and it is recommended that a period of at least two years post-qualification experience is obtained before attempting to do so in the specific clinical area in which she/he is going to function.
- 4.2 It is the responsibility of private nurse practitioners to ensure that they keep abreast of developments in the medical, technological and social fields, and to update their knowledge and practice their skills constantly so that they can render high-quality nursing and midwifery care to their patients.



- 4.3 If private nurse/midwifery practitioners use medical equipment or apparatus for individual clients/patients, they must ensure that it is safe and effective. Proper health education should be provided to ensure effective use of the equipment. The person left to care for the patient should be knowledgeable and competent to do so.

5. DENOSA POSITION

DENOSA believes that:

- 5.1 the private sector has a responsibility in the provision of health services to the community.
- 5.2 private nurse/midwife/accoucheur practitioners play an important role in a comprehensive health service in the Republic of South Africa and should therefore be authorised to prescribe and licensed to dispense medication where the situation requires it.
- 5.3 the individual, the family and the community are co-responsible for the promotion and maintenance of good health, and may consult nursing and midwifery services, whether provided by the State or by the private nurse/midwife/accoucheur practitioner.
- 5.4 the professional nurse/midwife/accoucheur is a qualified, legally accountable professional practitioner and has the right to practice her/his profession as a private practitioner within the framework of the Nursing Act.
- 5.5 private nurse/midwife/accoucheur practitioners have the right to be remunerated for services rendered by the relevant bodies in the same manner as other health care professionals are remunerated.
- 5.6 DENOSA should assist with negotiations with the relevant bodies for appropriate remuneration for private nurse practitioners.

6. CONCLUSION

DENOSA believes that the nurse/midwife/accoucheur in private practice can make a significant contribution to the delivery of health care in South Africa and the promotion of health in general.

RESOURCES

1. CONSULTATION with the nursing and midwifery professions 1998.
2. CONSULTATION with the Society for Private Nurse Practitioners 1998.
3. DENOSA 1997: *A practical Guide for Private Nurse Practice*. Pretoria: DENOSA.
4. DEPARTMENT OF HEALTH 1996: *Restructuring the National Health System for Universal Primary Health Care*. Pretoria: Department of Health.
5. DEPARTMENT OF HEALTH 1997: *White Paper for the Transformation of the Health System in South Africa*. Pretoria: Department of Health.
6. INTERNATIONAL COUNCIL OF NURSES (ICN) 1992: *Health Care and Quality of Life*. Position Statements. Geneva: ICN.
7. SOUTH AFRICA, Republic 1978: *The Nursing Act (Act No.50 of 1978)*. Pretoria: Government Printer.

May 1999



PRIMARY HEALTH CARE



GROUP PRACTICE

DENOSA supports the principle of group practice in the health services.

THEREFORE:

1. DENOSA believes that health professionals should be legally enabled to establish group practices with all other health professionals.
2. DENOSA believes that professional competence is a prerequisite for the registered nurse/ midwife/ accoucheur who wishes to enter into a group practice and that a period of at least two years post-qualification experience in clinical area/s of intended practice is advisable before participation in a group practice.
3. DENOSA supports the principle of equal remuneration for all team members who perform the same procedures.
4. DENOSA maintains that group practice in the South African Health Services should be marketed in a way which will ensure that the contribution of every member of the multi-professional team should be made known to the public.

April 1999



GROUP PRACTICE

1. INTRODUCTION

The largest component of the health force in South Africa consists of nurses/midwives/accoucheurs who make a significant contribution to the rendering of health services in this country. The training programme designed for registered nurses and midwives/accoucheurs makes provision for comprehensive training which conforms to the health policy of the Republic of South Africa. In addition, provision has been made, by way of diploma and degree courses, for specialisation up to doctoral level.

2. DEFINITION OF GROUP PRACTICE

Group Practice is defined as a formal arrangement, other than a contract of employment, between multi-disciplinary and/or multi-speciality registered professionals in the health and allied fields specially established for the purpose of providing cost effective health care of quality for the benefit of the patient, client and community.

3. PRESENT SITUATION

Presently all acts governing the practice of health professionals, prohibits group practice by stating in regulations that practitioners may only go into a group practice with a practitioner registered under the same act. Nurses, medical practitioners and pharmacists may therefore not establish a group practice. The ethical rules of the Health Professions (previously the Medical, Dental and Supplementary Health Professions) Act specifically prohibits the sharing of consulting or waiting rooms, or having an entrance through, or with a nameplate at the entrance of such premises with a person not registered in terms of the same act.

4. DENOSA POSITION

DENOSA supports the principle of group practice in the health services and is convinced that the registered nurse/midwife/accoucheur can make a valuable contribution in this regard. **DENOSA** therefore:

- 4.1 believes that health professionals should legally be enabled to establish group practices with all other health professionals according to the principles contained in annexure 1.
- 4.2 believes that the registered nurse/midwife/accoucheur has a choice with regard to whether or not to practice in a group practice and that group practice in the health services should be equally accessible to him/her.
- 4.3 believes that professional competence is a prerequisite for the registered nurse/midwife/accoucheur who wishes to enter into group practice and that a period of at least two years post-qualification experience in clinical area/s of intended practice is advisable before participation in a group practice.



- 4.4 believes that the registered nurses/midwives/accoucheurs involved in group practice have a duty in respect of informing the members of the multi-professional team regarding the scope of their independent practice within which they are accountable for their own acts and omissions.
- 4.5 believes that independent practitioners ought to make the necessary provision for indemnity coverage.
- 4.6 believes that the registered nurse/midwife/accoucheur involved in group practice should maintain high professional ethical standards and should give priority to the patient's interests.
- 4.7 supports the principle of equal remuneration for all team members who perform the same procedures.
- 4.8 maintains that group practice in the South African Health Services should be marketed in a way which will ensure that the contribution of every member of the multi-professional team should be made known to the public.

5. CONCLUSION

DENOSA supports the principle of group practice and believes that the nursing/midwifery profession can make a significant contribution to the provision of health care in a group practice.

RESOURCES

1. CONSULTATION with the nursing and midwifery professions 1998.
2. CONSULTATION with the Society of Private Nurse Practitioners 1998/1999.
3. DENOSA 1997: *A practical guide to Private Nurse Practice*. Pretoria: DENOSA.
4. DEPARTMENT OF HEALTH 1996: *Restructuring the National Health System for Universal Primary Health Care*. Pretoria: Department of Health.
5. GEYER, N 1998: *Ethics and Law Column*. Nursing News. 22(8): p.31.
6. INTERNATIONAL COUNCIL OF NURSES (ICN) 1992: *Health Care and Quality of Life*. Position Statements. Geneva: ICN.
7. MEDICAL ASSOCIATION OF SOUTH AFRICA (MASA) 1992: *Minutes: Group Practice Forum*, 4 February Unpublished. Pretoria: MASA.
8. MEDICAL ASSOCIATION OF SOUTH AFRICA (MASA) 1996: *Minutes of the Therapeutic Alliance Steering Group*. Unpublished. Pretoria: MASA.
9. SEARLE, C PERA SA 1998: *Professional Practice: A Southern African Nursing Perspective*. Third edition. Sandton: Heineman.
10. SOUTH AFRICA, Republic 1974: *The Health Professions Act (No 56 of 1974)*. Pretoria: Government Printer.
11. SOUTH AFRICA, Republic 1978 : *The Nursing Act (No 50 of 1978)*. Pretoria: Government Printer.

April 1999



Annexure A

Principles for acceptable group practice

Professional accountability

Health and allied professionals will be personally accountable for compliance with all ethical rules, policies, standards, codes of conduct and legislation which regulate their respective professional activities.

Professional independence

Professional independence is to be ensured so as to support the principle of professional accountability.

Professional reproducibility

Professional practitioners shall only assume responsibilities within their scope of professional competence and accountability.

Peer review and practice parameters

Peer review and good practice parameters are to be encouraged within the group practice. These do not absolve the professional from the principle of accountability and independence. The principles of peer review and good practice parameters exist to promote efficient, effective and safe practice.

Equal norms and requirements

Policies, ethical rules and codes of conduct should be applied consistently in all health care delivery systems (including *solus* practitioners)

Patient interests

All group practice activities should be for the benefit of the patient. The patient should be protected from all forms of exploitation and loss.

Freedom of referral

Appropriate and necessary referrals should be unrestricted.



CONSCIOUS SEDATION

DENOSA believes that:

1. the nurse/midwife/accoucheur has a responsibility to ensure that a conscious sedation patient questionnaire has been completed to identify possible risk factors that should be taken into account for conscious sedation.
2. A designated health care professional (medical practitioner or registered nurse), whose sole purpose is the care of the patient, should be specifically assigned for this purpose.
3. Clinical monitoring must be continued until recovery is completed.
4. In the majority of procedures, the sedationist is also likely to be the operator and as such carries the ultimate responsibility for the safety of both the conscious sedation technique and the procedure itself.
5. The patient's condition cannot be adequately monitored by the operator-sedationist while performing a procedure and a designated person should therefore be available during procedures to provide clinical monitoring of sedated patients (this may be the nurse/midwife/accoucheur).
6. The head of the unit (department or practice) where the procedures are performed, is responsible for ensuring that facilities are adequate and in working order and that the unit is appropriately staffed.
7. The nurse/midwife/accoucheur should receive in service/continuing education to empower her/him to provide safe and competent care to the patient undergoing a procedure under conscious sedation.
8. The nurse/midwife/accoucheur has the right to expect the employer to provide adequate facilities and equipment, staffing, drugs and oxygen to enable safe and competent care of the patient.

March 1999



CONSCIOUS SEDATION

1. PREAMBLE

Conscious sedation is a technique that uses parenteral or inhaled drug(s) to produce a state of altered consciousness, thereby enabling treatment to be carried out within optimal levels of achievable patient comfort. During the period of conscious sedation, communication is maintained so that the patient will respond to commands. The clinical endpoints for sedation are anxiolysis and patient comfort and not ptosis and hypnosis.

Conscious sedation is increasingly being used for diagnostic and increasingly complex therapeutic procedures, including termination of pregnancy, where the nurse/midwife/ accoucheur may also be involved.

DENOSA believes that the nurse/midwife/accoucheur involved in the care of a patient receiving conscious sedation, has certain rights and responsibilities that should be adhered to.

2. RESPONSIBILITIES OF THE NURSE/MIDWIFE/ACCOUCHEUR

2.1 *Safety and emergency measures*

The drugs and techniques used for conscious sedation should carry a margin of safety wide enough to render unintended loss of consciousness or loss of protective reflexes unlikely.

Any technique that exceeds the above definitions of sedation and margin of safety must be regarded as general anaesthesia with all its attendant consequences and responsibilities.

- 2.1.1 All patients undergoing conscious sedation should have a reliable open intravenous line for continuous access throughout the procedure. The intravenous line should remain in place until the end of the procedure.
- 2.1.2 The nurse/midwife/accoucheur has a responsibility to ensure that emergency measures will be immediately available, that will either protect the patient from the effect of unintended over-sedation or allow for rapid reversal of such over-sedation.
- 2.1.3 The nurse/midwife/accoucheur must be able to institute resuscitation measures where indicated.
- 2.1.4 Administration of antagonists does not alter the requirement to maintain vital functions where depression of these have occurred. Monitoring of oxygen saturation and other vital functions should be carried out until recovery is complete. The effect of opioid and benzodiazepine antagonists is not instantaneous and often of shorter duration than that of their antidote, so repeated injections of the antagonists may be necessary to prevent resedation from occurring.



- 2.1.5 The specific antagonists for benzodiazepines (flumazenil) and opioids (naloxone) must be available for immediate use. The availability of specific antagonists should not encourage sedationists to adopt a lax approach to titrating the drug dose against the response of the patient.
- 2.1.6 Discharge of the patient should only take place if he is fully orientated and conscious, has suitable vital signs, is able to walk without support, tolerate fluids and void urine. The patient should be accompanied by a responsible adult.

2.2. Risk Management

- 2.2.1 Appropriate assessment of risk factors may highlight the need to modify drug dosage and the availability of equipment, particularly when the procedures are carried out on an unscheduled basis.
- a) the nurse/midwife/accoucheur has a responsibility to ensure that a conscious sedation patient questionnaire has been completed before booking to identify possible risk factors that should be taken into account for conscious sedation.
- b) a pre-procedural questionnaire should be completed by the nurse/midwife/accoucheur to provide a readily scanned list of potential risk factors for the sedation procedure (see attached list in annexure A).
- 2.2.2 Where risk assessment suggests that the premises and facilities are unsuitable for the intended procedure, alternative arrangements should be made.
- 2.2.3 A risk management plan should be developed and implemented for each patient. At the end of the procedure, the care plan must be evaluated to determine whether all needs have been adequately met.

2.3 Clinical monitoring

- 2.3.1 It is recommended that a designated health care professional (medical practitioner or nurse), whose sole responsibility is the care of the patient, be specifically assigned for this purpose.
- 2.3.2 This person's responsibility is to monitor the patient's safety and maintain communication with him/her to prevent apnoea or hypoventilation. Slurred speech or drooped eyelids are signs that sedation is too deep.
- 2.3.3 Clinical observation of the early signs of respiratory depression is known to be unreliable and additional monitoring techniques must be employed, e.g. such as pulse oximetry and cardiac monitoring. Restless behaviour may signify hypoxia or deep



sedation rather than light sedation. The use of supplemental oxygen is recommended throughout the procedure.

- 2.3.4 Clinical monitoring must be continued until recovery is complete. The sedationist is responsible for prescribing the level of monitoring/observations required to the recovery or ward staff.

3. RESPONSIBILITIES OF OTHER ROLE PLAYERS

3.1 Sedationist

In the majority of procedures the sedationist is also likely to be the operator and as such carries the ultimate responsibility for the safety of both the conscious sedation technique and the procedure itself. The sedationist remains responsible for risk assessment, planning and evaluation and it cannot be devolved or assumed to lie with the referring practitioner. Therefore a procedure should be carried out under the direct supervision of a suitably trained sedationist.

3.2 Assistants

The patient's condition cannot be adequately monitored by the operator-sedationist while performing a procedure. At least one other suitably trained health professional must be present and responsible for the clinical monitoring of sedated patients. A designated person should be available during major procedures to provide clinical monitoring of sedated patients (this may be the nurse/midwife/accoucheur).

3.3 Head of Unit

The head of the unit (department or practice) where the procedures are performed, is responsible for ensuring that facilities are adequate and in working order and that the unit is appropriately staffed.

4 RIGHTS OF THE NURSE/MIDWIFE/ACCOUCHEUR

The nurse/midwife/accoucheur has a right to expect the employer to provide for the following:

4.1 Facilities

Adequate recovery facilities which are suitably staffed and equipped must be available for recovery of patients after conscious sedation. These should include all monitoring and resuscitation equipment, drugs and the facility to obtain appropriate help to cope with a medical emergency.

4.2 Staffing

Appropriately trained staff in sufficient numbers should be available so that patients are not left unattended at any time until recovery is complete. Staffing should be consistent with staffing norms for a recovery room or intensive care unit.

4.3 Staff and training

Staff of all disciplines involved in caring for sedated patients including consultant staff, should be familiar with resuscitation methods and undergo periodic retraining and competency assessment. Regular practice in simulated emergencies is recommended.



4.4 Equipment

A suitable delivery system for the use of inhalational agents must be available, calibrated to deliver the correct gas mixture and a fail-safe device that cuts off inhalation agents in the event of oxygen failure. Resuscitation equipment available in the treatment area and the recovery area (if separate) should include a source of oxygen and suction together with the equipment necessary for the maintenance of airway, breathing and circulation.

4.5 Drugs

The sedatives used for conscious sedation may produce anaesthesia if excessive doses are used. Specific antidotes must therefore be available for immediate use. Appropriate drugs to allow for the adequate treatment of all common medical emergencies involving the cardiovascular and respiratory systems, including anaphylaxis and life-threatening haemorrhage, must be available. Inhalational conscious sedation must be used in a well-ventilated environment to minimise risk to all health care workers.

4.6 Availability of oxygen

Oxygen supply and equipment with compatible fittings for its delivery to the patient must be available in any area where conscious sedation is undertaken.

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March 1999



Annexure A

Classification of physical status

Class I

The patient has no organic, physiological, biochemical or psychiatric disturbances. The pathological process for which surgery is to be performed is localised and does not entail a systemic disturbance.

Examples : a fit patient with an inguinal hernia, a fibroid uterus in an otherwise healthy woman.

Class II

Mild-to-moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes.

Examples : non- or only slightly limiting organic heart disease, mild diabetes, essential hypertension or anaemia. The extremes of age may be included here, even though no discernible systemic disease is present. Extreme obesity and chronic bronchitis may be included here.

Class III

Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality.

Examples : severely limiting organic heart disease, severe diabetes with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris or healed myocardial infarction.

Class IV

Severe systemic disorders that are already life-threatening, not always correctable by operation.

Examples : organic heart disease with marked signs of cardiac insufficiency, persistent angina, or active myocarditis, advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

Class V

The moribund patient who has little chance of survival but is submitted to operation in desperation.

Examples : the burst abdominal aneurysm with profound shock, major cerebral trauma with rapidly increasing pressure, massive pulmonary embolus. Most of these patients require operation as a resuscitative measure with little if any anaesthesia.



MENTAL HEALTH AND MENTAL HEALTH NURSING

Mental health problems are expected to increase due to social problems such as unemployment, crime, poverty, racial intolerance and substance abuse which people are exposed to.

DENOSA believes that:

1. health care institutions should promote the development of appropriate basic, specialist and continuing education programmes for nurses/midwives/ accoucheurs involved in mental health care.
2. health care institutions should support the development and implementation of standards of education and practice to ensure quality in the care of people living with mental health problems.
3. understanding should be promoted to reduce/remove the stigma attached to mental health problems.
4. the role of the generic nurse is to improve the general health of individuals and communities through health education.
5. the role of the comprehensively trained nurse and midwife should further include the knowledge and skills to be able to respond to people's general and mental health needs and skills for early detection and referral of patients.
6. responsibilities of the psychiatric nurse should also include the implementation of appropriate therapies, to liaise with members of the health care team during the care of mentally ill clients and to accurately diagnose and effectively treat mental health problems.
7. the psychiatric nurse should be involved in the development of policy for mental health services at all levels of health care.

April 2000



MENTAL HEALTH AND MENTAL HEALTH NURSING

1. INTRODUCTION:

South African people are at risk of mental health problems which may be the result of a stressful lifestyle, dysfunctional interactive patterns, societal problems, physical illness, infection or trauma and organic brain disorders. Mental health problems are expected to increase due to social problems such as unemployment, crime, poverty, racial intolerance and substance abuse which people are exposed to.

2. DEFINITIONS:

2.1 *Mental Health*

Mental Health is a state of emotional well being in which a person is able to function comfortably within his society and in which personal achievements and characteristics are satisfactory to him. It is a state of mind in which a person who is healthy is able to cope with and adjust to the recurrent stresses of every day living.

2.2 *Mental health nursing*

Psychiatric/mental health Nursing is a specialised field of nursing practice concerned with the prevention and cure of mental disorders and their sequelae.

2.3 *Mental health nurse*

A qualified nurse specialised in the study of care of patients with a mental disorder and of maintaining mental health.

3. THE POSITION OF DENOSA

3.1 *DENOSA believes that:*

- 3.1.1 health care institutions should promote the development of appropriate basic, specialist and continuing education programmes for nurses involved in mental health care.
- 3.1.2 health care institutions should support the development and implementation of standards of education and practice to ensure quality in the nursing care of people with mental health problems.
- 3.1.3 all role players should promote and disseminate research in the field of mental health.
- 3.1.4 understanding should be promoted to reduce/remove the stigma attached to mental health problems which affect not only clients but also their families and mental health professionals.

3.2 *DENOSA believes that the responsibilities of the generic nurse are:*

- 1.2.1 to improve the general health, both physical and psychological of individuals and communities through health education.
- 1.2.2 early detection and referral of mental health problems.
- 1.2.3 to give emotional support and re-assurance to families during times of crisis such as bereavement, loss and illness.



3.3 *DENOSA believes that the responsibilities of the comprehensively trained nurse and midwife/accoucheur should include, in addition to the abovementioned:*

- 3.3.1 to provide effective pre-natal care to detect any conditions in the mother which could affect the health of the foetus.
- 3.3.2 early referral to and/or provision of genetic counselling and pre natal diagnostic facilities particularly for those couples who are at "at risk" (where there is a family history of congenital defects).
- 3.3.3 efforts directed towards the prevention of brain damage and asphyxia during delivery. to encourage the complete immunisation of all children.
- 3.3.4 to encourage the complete immunisation of all children.
- 3.3.5 the knowledge and skills to be able to respond to people's mental health needs.
- 3.3.6 to administer prescribed medication and evaluate the effect thereof.
- 3.3.7 to encourage frequent visits by family and friends of the hospitalised client with mental illness.
- 3.3.8 to provide a physical safe and psychologically healthy working environment and take reasonable steps to remove occupational health hazards.

3.4 *DENOSA believes that the responsibilities of the psychiatric nurse should also include:*

- 3.4.1 to accurately diagnoses and effectively treat mental health problems.
- 3.4.2 to implement appropriate therapies, i.e. they should be skilful in the specialised use of communication, counselling, psychopharmacology, psychotherapeutic and psycho-social techniques as well as to deal with co-existing disorders such as medical illnesses and substance abuse.
- 3.4.3 to liaise with psychiatrists, psychologists, social workers and other members of the health care team during the care of mentally ill clients.
- 3.4.4 involvement in the development of policy for mental health services at all levels of health care.



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April 2000



THE ROLE OF THE NURSE/MIDWIFE/ ACCOUCHEUR IN THE PREVENTION, EARLY DETECTION, TREATMENT AND PALLIATIVE CARE OF CANCER

The health problems encountered in South Africa represent the whole spectrum of diseases of a developing country as well as a developed country and industrialised society.

DENOSA supports the National Cancer Control Programme (NCCP).

DENOSA believes that:

1. nurses/midwives/accoucheurs should promote, support and be actively involved in the implementation of the National Cancer Control Programme (NCCP) at all levels of care.
2. nurses/midwives/accoucheurs should ensure that they are educationally equipped and aware of their potential to contribute to the primary prevention of cancer.
3. specialised nurses should be adequately prepared by an additional educational programme on the modalities of cancer treatment.
4. the employer should provide nurses/midwives/accoucheurs with access to support, stress management, prevention of burnout and counselling programmes.

April 2000



THE ROLE OF THE NURSE/MIDWIFE/ ACCOUCHEUR IN THE PREVENTION, EARLY DETECTION, TREATMENT AND PALLIATIVE CARE OF CANCER

1. INTRODUCTION

South Africa is a developing country with a large and diverse nation and multicultural population. The health problems encountered in South Africa represent the whole spectrum of diseases of a developing country as well as a developed country and industrialised society. In developing countries, one third of all cancers are preventable, one third, if diagnosed early enough, are potentially curable, while appropriate palliative care is needed for the remainder. Cancer is one of the top three causes of deaths in South Africa with fifty thousand new cases reported in 1999. It is estimated that by the year 2015, fifteen million new cases of cancer will have been diagnosed (National Cancer Registry 1998).

2. DEFINITION OF TERMS

2.1 *Cancer*

Cancer is neoplasm characterised by the uncontrolled growth of anaplastic cells that tend to invade surrounding tissue and to metastasize to distant body sites.

2.2 *Palliative care*

Palliative care is the active total care of patients whose disease is not responsive to curative treatment.

3. THE POSITION OF DENOSA

3.1 *DENOSA believes that nurses and midwives/accoucheurs should:*

- 3.1.1 Ensure that they are educationally equipped and aware of their potential to contribute to the primary prevention of cancer through facilitating healthy choices by providing information, encouraging and educating individuals to adopt healthy living habits and reducing exposure to risk factors.
- 3.1.2 Ensure that they are educationally equipped for and involved in:
 - (a) secondary prevention and early detection aimed at detecting and curing cancer or its precursors at an early stage;
 - (b) preventing spread through providing information, counseling and screening programmes and facilities; and
 - (c) encouraging high risk individuals and families to participate in screening activities, particularly at primary health care level.
- 3.1.3 Ensure that new knowledge and technology about cancer prevention and early detection are included in basic, post basic and continuing education programmes for nurses/midwives/accoucheurs.
- 3.1.4 Improve care giving by more effective communication and teamwork, improved cultural sensitivity and collaboration with other health care providers including traditional healers.



- 3.1.5 Promote and facilitate participation of nurses/midwives/accoucheurs in the National Oncology Nursing Society and national and international activities on cancer prevention, early detection, treatment, care and research.
- 3.1.6 Promote and support the implementation of the National Cancer Control Programme (NCCP) according to the national priorities and at all levels of care.
- 3.1.7 Initiate and participate in research and cancer research priorities that address the potential improvement in the approaches and strategies of cancer prevention, early detection, treatment, palliative care and support.
- 3.1.8 Support and become involved in programmes aimed at risk reduction, cancer prevention and early detection.
- 3.1.9 Make the community aware of the signs and symptoms of cancer and the importance of early detection, treatment and intervention.
- 3.1.10 Be actively involved in health promotion priorities for cancers such as esophagus, skin, breast and prostate and cancers identified in the NCCP, namely:
 - 3.1.10.1 Tobacco related cancer by:
 - a] introducing and implementing workplace smoking policies;
 - b] supporting all levels of Government in the implementation of policies and legislation with regard to smoking in public buildings and transport according to the relevant Tobacco Legislation and Regulations.
 - 3.1.10.2 Diet related cancer by making the community aware of good dietary habits and avoidance of diet related risk factors.
 - 3.1.10.3 Cervical cancer by:
 - a] support of the Department of Health's cervical cancer policy and its implementation by clinics and hospitals;
 - b] raising awareness amongst women and encouraging them to undergo appropriate screening; and
 - c] promoting risk reducing behaviour and safe sex practices.
- 3.2 DENOSA believes that specialised nurses should be adequately prepared by an additional educational programme on the modalities of cancer treatment.
- 3.3 DENOSA believes that the employer should provide nurses/midwives/accoucheurs with access to support, stress management, prevention of burnout and counselling programmes.



4. CONCLUSION

The nursing and midwifery professions have an important role to play in the prevention, early detection, treatment and care of cancer and are well positioned to promote the National Cancer Control Programme.

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April 2000



PALLIATIVE CARE



CARE OF THE OLDER PERSON

With regard to the nursing care of the older person DENOSA:

1. believes that the Constitutional rights, legislative framework and Patient's Charter are equally applicable to all persons, irrespective of their age.
2. acknowledges that the older person undergoes physical, social, mental and spiritual changes which should be accommodated in the care of the older person.
3. believes that nurses should support the rights and responsibilities of older persons, including the maintenance of their well being through the promotion of active, health lifestyles, participation of all aspect of society, and participation in decision making.

April 2000



CARE OF THE OLDER PERSON

1. INTRODUCTION

Nursing and midwifery exist as professions to serve the health needs of a society. These needs are dictated, in part, by the age distribution of the population. Age is a variable that influences an individual's needs, not only for health care but also for housing, transportation, education, employment and recreation. In recognising that each age group has specific needs, older persons are as unique as those of any age cohort in our society.

2. DEFINITION OF TERMS

2.1 *Older persons:*

The South African Declaration on the Status of Older Persons states: "The aged person is formally defined as of a specific age, but we believe that older age is indicated not in years, but through the mental and physical capabilities of the individual"

The formal definition is derived from the legislation establishing the age at which older persons qualify for state sponsored financial assistance, and is not a physiological measure.

2.2 *Gerontological Nursing*

This is defined as a specialised branch of nursing care where nurses specialise in the care of older persons.

2.3 *Geriatrics*

Geriatrics is defined as the provision of health care in response to diseases affecting older persons.

2.4 *Gerontology*

This is defined as the study of all aspects of aging, including individuals and societies.

3. THE POSITION OF DENOSA

DENOSA believes that the following principles should be adhered to in the care of the older person:

- 3.1 *Acknowledgement that the older person undergoes physical, social, mental and spiritual changes which should be accommodated in the care of the older person.*
- 3.2 *Nurses should be knowledgeable about the older person and his/her needs to provide quality care for the older person in an appropriate, sensitive manner.*
- 3.3 *The Constitutional rights, legislative framework and Patient's Charter are equally applicable to all persons, irrespective of their age.*



- 3.4 *Inter-disciplinary teamwork is essential to ensure holistic care of the older person.*
- 3.5 *Nurses support the rights and responsibilities of older persons, including the maintenance of their well being through the promotion of active, health lifestyles, participation of all aspect of society, and participation in decision making.*
- 3.6 *Nurses have a responsibility in advocating for the safety, security and rights of the older person.*
- 3.7 *Exploitation and abuse is a violation of individual rights, and the nurse has a moral and legal obligation to report any suspected or evident abuse.*
- 3.8 *Nurses have an obligation to optimally promote and utilise all community resources to the benefit of older persons.*
- 3.9 *Nurses have a distinctive role in providing support and empowering family member and carers to care for older persons.*
- 3.10 *Caregivers in frail care centres and community settings provide an integral service and should have access to the nursing profession for support and supervision to ensure the well being of older persons.*

4. CONCLUSION

DENOSA believes that the nurse has an important role to play in the promotion of quality of life and health care of older persons.

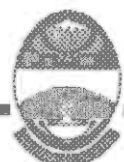
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April 2000



CARE OF PRISONERS AND DETAINEES



2

NURSING PROFESSION



AUTONOMOUS REGULATION OF THE NURSING PROFESSION

DENOSA believes:

1. That autonomous regulation by nurses/midwives/accoucheurs who understand the dynamics and complexities of nursing/midwifery, is essential to ensure quality nursing/midwifery care which is the right of the health consumer. This belief is endorsed by the International Council of Nurses (ICN).
2. That the nursing and midwifery professions form the largest group within the health sector and must therefore have their own Act and Professional Council in order to adequately address the development of nursing/midwifery needs of the country.
3. That the need for professions to co-operate and collaborate more fully with each other should be recognised, both at statutory level as well as at the functional level of health care delivery.

October 1996

Updated April 2000



AUTONOMOUS REGULATION OF THE NURSING PROFESSION

1. STATUS OF NURSING AND MIDWIFERY AS A PROFESSION

The nursing/midwifery profession is an autonomous profession which has obtained recognised professional status by a Nursing Act on 8 November 1944.

2. INTERNATIONAL VIEWPOINT

The International Council of Nurses (ICN) supports the principle of autonomous regulation: "Professional regulation is the means by which order, consistency and control are brought to a profession and its practice" (ICN 1986:7).

3. AUTONOMOUS REGULATION

Autonomous regulation implies the following:

A Nursing Act that governs the nursing/midwifery profession and authorises the profession to:

- 3.1 regulate the practice of nursing and midwifery to ensure the quality of care;
- 3.2 regulate nursing and midwifery education to ensure highly skilled nurses and midwives/ accoucheurs for the health needs of the country;
- 3.3 regulate standards and ethical practice by means of open and transparent peer group review.

4. DENOSA BELIEVES:

- 4.1 The community deserves quality nursing and midwifery care which can only be developed and sustained by nurses and midwives/accoucheurs who understands the dynamics and complexities of nursing and midwifery. As the health care needs of society become more demanding, the practitioners need to become more specialised as more complex ways of meeting the needs become necessary. The regulatory body therefore requires an extensive knowledge of the legal and ethical dimensions and the methods of nursing and midwifery professional practice.
- 4.2 The nursing/midwifery profession is the largest group within the health sector comprising of members compared to significantly less of all other health professionals (see table) and must therefore have its own act and professional council in order to adequately address the development of nursing and midwifery so that the nursing and midwifery needs of the country can be met. The changing nature of health and nursing and midwifery in this country are making many demands which require urgent and full attention and a regulatory body for nursing and midwifery is therefore necessary to address all health related issues and their implications for nursing and midwifery.
- 4.3 The nursing/midwifery profession has regulated its own affairs for 56 years.



THE DISTRIBUTION OF MAJOR HEALTH PERSONNEL CATEGORIES
(Public and Private) BY PROVINCE

PROVINCE (Population)	NURSES	MEDICAL PRACTITIONERS	PHARMACISTS	DENTISTS
Western Cape (4 118 000)	25 195	6 200	1 686	994
Eastern Cape (5 865 000)	22 427	1 959	865	228
Northern Cape (746 000)	3 471	370	110	52
Free State (2 470 000)	12 226	1 521	466	168
KwaZulu-Natal (7 672 000)	33 345	4 689	2 565	547
Gauteng (7 171 000)	46 183	10 162	4 271	1 854
Mpumalanga (2 646 000)	7 550	980	405	160
North West (3 043 000)	11 939	842	473	144
Northern Province (4 128 000)	11 311	781	288	110
Other	56	1 676	55	178
TOTAL	173 703	29 180	10 184	4 435

- 4.4 In the case of one health professions council, there is significant risk that nursing and midwifery matters will not receive the due consideration necessary by the Council members.
- 4.5 There is a significant risk with one health professions council that nursing and midwifery will be dominated by the medical profession as is apparent in all health structures in this country throughout history and internationally.
- 4.6 There is significant financial implications for the nursing/midwifery profession. With such a large profession there is a significant possibility that the nursing/midwifery profession will be subsidising the activities of other health professional boards. Due to the numbers in the nursing/midwifery profession, the Nursing Council has been financially independent with licensing fees lower than that of other professions. Due to the envisaged structuring of one, single health professions council with professional boards, there will be a definite negative financial impact on the nurses and midwives.



- 4.7 Recognition of the need for professions to co-operate and collaborate more fully with each other both at statutory level as well as the functional level of health care delivery.

5. DENOSA POSITION

DENOSA believes in the continuation of autonomous regulation of the nursing and midwifery professions with the Nursing Council and a Nursing Act.

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October 1996

Updated April 2000



REGULATION IN NURSING

DENOSA BELIEVES:

1. The primary purpose of nursing and midwifery is for the public to have access to safe, competent basic care.
2. Nurses and midwives/accoucheurs must be able to practice their profession within ethical and legal boundaries.

THEREFORE DENOSA is of the opinion that:

1. nurses and midwives/accoucheurs should be governing nurses/midwives and nursing/midwifery in the public interest.
2. it is in the public interest that the nursing/midwifery profession adopts a flexible approach to scope of practice to accommodate the overlap between professional roles and to support a dynamic approach to changing and new health needs.
3. the scope of practice should be defined in broad terms which indicate
 - 3.1 the focus of nursing/midwifery, and
 - 3.2 accountability of the practitioner.Conditions should be set on how extend the scope of practice.
4. legal provision should be made for nurses/midwives/accoucheurs to provide comprehensive care to the public.
5. nurses/midwives/accoucheurs should be provided the opportunity to develop the necessary competencies to provide comprehensive care to the public and be recognised to have the authority to do so.

November 1998



REGULATION IN NURSING

1. INTRODUCTION

Professional regulation is the means by which order, consistency and control are brought to a profession and its practice (ICN, 1986 p.7). There is a “social contract” between society and the professions which grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their own affairs. In return the profession is expected to act responsibly, always mindful of public trust. Self-regulation to assure quality in performance is at the heart of the relationship - it is the authentic hallmark of a mature profession (Donabedian 1976, p. xiii; quoted in ICN 1993 p.iii). Regulation provides nurses/midwives/accoucheurs with a critical framework which binds them in a coherent profession. The essential components of such a framework includes:

- 1.1 educational, practice and ethical standards to which nurses/midwives/accoucheurs ascribe;
- 1.2 the processes by which nurses/midwives/accoucheurs are held accountable to society and one another;
- 1.3 the titles and definitions which identify nurses/midwives/accoucheurs professionally;
- 1.4 the nature and scope of general and specialised practice.

2. POLICY OBJECTIVES OF REGULATION

DENOSA supports the twelve ICN policy principles of nursing/midwifery regulation and believes the following which are based on the ICN principles (ICN 1997: 18 - 33):

- 2.1 *Principle of purpose fullness: Regulation should be directed towards an explicit purpose, namely that of service to and protection of the public.*
- 2.2 *Principle of relevance: Regulation should be designed to achieve this stated purpose by:*
 - 2.2.1 individual practitioners recognising the importance and accept the responsibility of maintaining and improving their competence throughout professional life and using all opportunities to improve the quality and standard of nursing/midwifery care.
 - 2.2.2 providing practice settings supportive of practitioners which allow practice to develop and flourish.
- 2.3 *Principle of definition: Regulatory standards should be based upon clear definitions of professional scope and accountability.*
- 2.4 *Principle of professional ultimacy: Regulatory definitions and standards should promote the fullest development of the profession commensurate with its potential social contribution. Therefore:*
 - 2.4.1 educational programmes should encourage the development of nursing/midwifery's potential through liberal, social, scientific and technical education.
 - 2.4.2 nursing/midwifery service standards should reflect both changing needs and enhanced professional capacities.
 - 2.4.3 the role of nursing/midwifery research should be valued and reinforced.



2.5 Principle of multiple interests and responsibilities:

Regulatory systems should recognise and incorporate the legitimate roles and responsibilities of interested parties (public, profession and its members, government, employers and other professions) in various aspects of standard-setting and administration. Such roles and responsibilities consist of:

2.5.1 Public:

- 2.5.1.1 to interpret and represent the public's needs and wishes.
- 2.5.1.2 to collaborate with others in monitoring the content, application and consistency of standards and procedures forming part of the regulatory system.

2.5.2 The Profession:

- 2.5.2.1 must promote self-regulation by nurses/midwives/accoucheurs which involves responsibility for developing their own capacities; participating in their own governance; and fulfilling their personal obligations to the people, practice, society, co-workers and the profession.
- 2.5.2.2 must be vigilant in monitoring the operating effectiveness of existing regulatory arrangements and their sensitivity to the "public interest".
- 2.5.2.3 should take the leading role in its professional governance with sensitivity to and respect for the public interest. All this must be underpinned by an enhanced understanding among nurses/midwives/accoucheurs of the purpose, processes and value of professional regulation.
- 2.5.2.4 establishing and recommending the standards in the form of definitions, ethical codes, education and service requirements and a range of related issues.
- 2.5.2.5 bear the primary responsibility for development of the knowledge and skill base for all nursing/midwifery and for advanced nursing/midwifery practice.
- 2.5.2.6 through its culture and ethic and its regulatory mechanisms, must promote the personal growth of its individual members.
- 2.5.2.7 has to protect the practitioner's right to title, practice and compensation.

2.5.3 The Government:

- 2.5.3.1 to establish legislation which makes provision for self-regulation by the nursing/midwifery profession.
- 2.5.3.2 to establish appropriate legislation which promotes nursing/midwifery's ability to respond to the societal needs and support nursing/midwifery's role in primary health care services and in meeting the *Health for All* objectives.
- 2.5.3.3 to guarantee nursing/midwifery's access to policy development commensurate with its potential to contribute to health care.

2.5.4 Related Professions:

Related professions have the right to participate in nursing/midwifery's external governance processes to promote the complementarity of the professions in the public interest. In this capacity their major roles are to provide liaison and technical advice. The nursing/midwifery profession should expect reciprocal arrangements to exist. Moreover, all of the health professions have a right and responsibility to participate collaboratively in the formulation of health policies and priorities.



2.5.5 The Employer :

- 2.5.5.1 to monitor the standards for the profession for which, in the majority of cases, they provide the practice setting.
- 2.5.5.2 to, with an awareness of the standards proposed and promoted by the profession, articulate their own institutional standards and nursing/midwifery's part in meeting those standards.
- 2.5.5.3 to provide an optimum milieu for achieving the maximum potential of nurse employees, an atmosphere in which they can fulfil their responsibility to comply with ethical and practice standards, and take appropriate action when they observe contravention of these standards.
- 2.5.5.4 to recognise the benefits that stem from individual professional registration or licensure as it provides the confirmation that a practitioner possessing a current licence has, in an initial and continuing sense, satisfied the requirements for such licensure and is accountable to the regulatory body that granted that license.
- 2.5.5.5 health care institutions and community based services, like the professions, must submit to external review and public scrutiny, to ascertain that they are safe environments dedicated to the public interest and that professional practice standards are observed and supported.
- 2.5.5.6 nurses/midwives/accoucheurs who are self-employed or working in independent practice in partnership with professional colleagues have a responsibility to ensure that their working environment (for example, policies, physical resources, means of updating knowledge and skill) is adequate to support compliance with professional and service standards.

2.6 *Principle of representational balance: The design of the regulatory system should acknowledge and appropriately balance interdependent interests. Satisfactory health outcomes for the public will depend on good co-operation between the different health professions in regulation and practice.*

2.7 *Principle of professional optimacy: Regulatory systems should provide and be limited to those controls and restrictions necessary to achieve their objectives. The purpose of statutory regulation is to:*

- 2.7.1 ensure that competent and accessible care is available from truly accountable practitioners. This should be done using efficient, effective and economic processes with a focus on controlling basic education. The screening of practitioners only on the first entry to practice is inadequate to ensure continuing competence.
- 2.7.2 to ensure enabling regulation. Over-regulation is contrary to the public interest, particularly where it limits opportunities for innovations in practice, imposes inappropriate scope of practice restrictions or fails to recognise the logic of overlapping scopes of practice between professions.
- 2.7.3 offer remedial or rehabilitation opportunities during the exercise of its powers of discipline.



2.7.4 ensure supervision of enrolled nurses/midwives/accoucheurs and nursing auxiliaries by registered nurses/midwives/accoucheurs. Titles, roles and responsibilities should be clarified.

2.7.5 provide for the development of post-basic specialists in particular areas of nursing/midwifery.

An optimum system is, therefore, likely to incorporate the following procedures:

- a) approved and, thereafter, periodic accreditation of schools which prepare nurses/midwives/accoucheurs for licensure.
- b) initial credentialing and, thereafter, periodic licensure (subject to certain criteria being satisfied) for individual practitioners.
- c) supplementary entries in addition to those of basic licensure to indicate areas of specialist status and advanced practice.
- d) standards, criteria and related support and monitoring systems for health service settings.
- e) appropriate disciplinary procedures and sanctions for practitioners and practice settings.

2.8 Principle of flexibility: Standards and processes of regulation should be sufficiently broad and flexible to achieve their objective and at the same time permit freedom for innovation, growth and change. Therefore:

2.8.1 Scope of practice definitions and associated educational standards should give broad guidance to practitioners and employers through general statements of nursing/midwifery function.

2.8.2 Broad guidance to educational institutions on required subjects areas, faculty specifications and learning resource requirements is preferred over detailed prescription of procedures and curriculum content. To maintain relevance as practice changes and achieve ultimacy as the profession seeks to reach its potential, flexibility is essential in supporting the development and exercise of professional judgement skills and the search for creative solutions to practice situations.

2.9 Principle of efficiency and congruence: Regulatory systems should operate in the most efficient manner, ensuring coherence and co-ordination among their parts (namely levels of government, categories of personnel, related professions and education and practice, should be co-ordinated to accomplish the purpose of regulation in a uniform streamlined fashion).

2.10 Principle of universality: Regulatory systems should promote universal standards of performance and foster professional identity and mobility to the fullest extent compatible with local needs and circumstances. Although some adaptation to local circumstances is desirable, and accepting the need to be sensitive to cultural differences in developing regulatory procedures, it should be recognised that wide divergence may lead to instability in the work force and variable standards of care. International trade agreements and globalization movements creates a need for international credentials with world wide acceptance.



2.11 Principle of fairness: Regulatory processes should provide honest and just treatment for those parties regulated.

- 2.11.1 The features of an honest and just system of regulation, whether it deals with practitioners, educational institutions, or service agencies are:
- 2.11.1.1 Relevant standards and procedures;
 - 2.11.1.2 Provision of full information regarding criteria and processes;
 - 2.11.1.3 Encouragement of open discussion and comprehensive policy debate involving all those who will be affected;
 - 2.11.1.4 Use of objective measurement and review;
 - 2.11.1.5 Ample opportunity to appeal decisions; and
 - 2.11.1.6 Fair treatment for complainants including reasonable access and the right of appeal against decisions.

These features should be incorporated in the design of the regulatory system and should lead to greater satisfaction of all parties involved. However, they must not jeopardise the public interest, which is the prime purpose of regulation.

- 2.11.2 Application of the principle of fairness will also mean that practitioners honouring their obligations as stated in their national code and acting out of conviction, can expose actions or omissions (whether on the part of individuals or institutions) that are against the public interest, without fear of recrimination.
- 2.11.3 During periods of transition for the profession, when standards are being raised or augmented, practising nurses/midwives/accoucheurs should be provided protection of their credentials and/or opportunity for improving their qualifications.
- 2.11.4 The introduction of more uniform standards and procedures, based on a dynamic standard setting approach and applied research, and shared across national boundaries has the potential to facilitate the mobility of nurses/midwives/accoucheurs, provided that national regulatory laws are not unnecessarily restrictive.

2.12 Principle of inter-professional equality and compatibility: In standards and processes, regulatory systems should recognise the equality and interdependence of professions offering essential services.

For professions to develop and to work collaboratively on the public behalf, education and practice standards need to be comparable and regulatory processes complementary. Nursing/midwifery as the professions who spend the greatest amount of time in direct contact with the patient, should accept the responsibility to take the lead in monitoring existing regulatory arrangement; in generating ideas and promoting debate leading to positive change; and introducing improvements in regulatory standards.



- 2.12.1 For professions to develop and to work collaboratively on the public behalf, education and practice standards need to be comparable and regulatory processes complementary. Nursing/midwifery must be central to the professional mainstream and should position itself at the heart of debates and policy making with respect to these matters.
- 2.12.2 In order to participate as a full and responsible partner in the health care team, nursing/midwifery should closely associate with, and be on par with, other professions. This means that they should be dealt with similarly in regulatory policies and practices, i.e. education for nursing/midwifery should occur in the same setting at the approximate level and with similar autonomy as for other professions. Statutory regulation for nurses/midwives/accoucheurs should parallel that of other professions.
- 2.12.3 Nursing and midwifery must accept the responsibility to take the lead in monitoring existing regulatory arrangements, in generating ideas and promoting debate leading to positive change in those arrangements and in introducing improvements in regulatory standards and processes. These are ways of demonstrating the profession's awareness of the primacy of the public interest and total commitment to serving that interest.

3. DENOSA POSITION

Therefore DENOSA believes:

- A. The primary purpose of nursing/midwifery is for the public to have access to safe, competent basic care.
- B. Nurses/midwives/accoucheurs must be able to practice within legal boundaries. Nurses/midwives/accoucheurs must never be forced to act outside their legal boundaries.

Therefore DENOSA is of the opinion that :

- 1. nurses/midwives/accoucheurs should be governing nurses/midwives/accoucheurs and nursing/midwifery in the public interest.
- 2. it is in the public interest that the nursing/midwifery profession adopt a flexible approach to scope of practice in order to :
 - 2.1 accommodate overlap between professional roles which includes a range of shared competencies, and
 - 2.2 to support a dynamic approach to changing and new health needs in our country.
- 3. The scope of practice should for this reason be defined in broad terms which indicate :
 - 3.1 the focus of nursing/midwifery, and
 - 3.2 accountability of the practitioner.

To accommodate the new and changing health needs of the country, conditions and guidelines should be set on how to extend the scope of practice. A two step approach is recommended :



- (a) delegation of certain competencies to nurses/midwives/accoucheurs. The regulatory body should develop guidelines and set standards on how duties not usually performed by nurses/midwives/accoucheurs can be delegated. Delegation should never become the easy way out or routine.
 - (b) a role of nurses/midwives/accoucheurs with those particular competencies should in the meantime be developed and established, i.e. developing a course for nurses/midwives/accoucheurs and certification by the Nursing Council.
4. Legal provision should be made for nurses/midwives/accoucheurs to provide comprehensive care to the public. The employer should be enabled to create solutions for needs that occur in their institutions and these guidelines should enable them to train nurses/midwives/accoucheurs to perform the competencies and to delegate these competencies to nurses/midwives/accoucheurs. Such an arrangement must never result in the exploitation of any category of health care worker. Delegation of additional tasks must be accompanied by appropriate compensation.
5. Nurses/midwives/accoucheurs should be provided the opportunity to develop the necessary competencies to provide comprehensive care to the public and be recognised to have the authority to do so.

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November, 1998



ETHICAL STANDARDS FOR NURSE RESEARCHERS

DENOSA believes that the following standard should be adhered to:

1. Nursing research is planned and executed in a way which will foster justice, beneficence and exclude harm/exploitation of participants in accordance with certain criteria.
2. The right to self-determination by the participant(s) in the research project is ensured by the researcher in accordance with certain criteria.
3. Confidentiality and anonymity is ensured in accordance with certain criteria.
4. Quality research is ensured in accordance with certain criteria.

August, 1998



ETHICAL STANDARDS FOR NURSE RESEARCHERS

1. INTRODUCTION

The ethical standards for nurse researchers serve as a framework for nurses conducting and participating in research. The standards also serve as criteria against which nurses, as advocates for their patients, can judge proposed research in which their patients will be study subjects, as well as to evaluate and account for the ethical standards in nursing research.

These standards refer primarily to clinical research, but apply equally to all nursing research and include the rights and responsibilities of all the role players in research.

2. ETHICAL STANDARDS

2.1. *Nursing research is planned and executed in a way which will foster justice, beneficence and exclude harm/exploitation of participants in accordance with the following criteria:*

- 2.1.1 Assessment of possible physical or psychological discomfort/harm is conducted by the researcher prior to the commencement of the research project.
- 2.1.2 Any possible identified discomfort/harm for the participant (s) is explained during the process of obtaining informed consent.
- 2.1.3 Any possible identified discomfort/harm shall not exceed that which could be encountered in daily life experience by the participant.
- 2.1.4 Any possible identified discomfort/harm shall cease with the termination of the research project.
- 2.1.5 The negative effects of unavoidable discomfort/distress experienced by the participant after completion of the participation, are only acceptable if the benefits outweigh these negative/unavoidable effects and with informed consent of the participant.
- 2.1.6 Fair and equal treatment of participants during a clinical trial is ensured by equalisation of advantages after completion of the clinical trial.
- 2.1.7 There is no victimisation of a participant that refuses to participate in the research, or has withdrawn during the participation.
- 2.1.8 Approval is obtained from the relevant Research Ethics Committee(s).
- 2.1.9 A contact person is made available to participants for questions regarding the research project.



2.2. The right to self-determination by the participant(s) in the research project is ensured by the researcher in accordance with the following criteria:

- 2.2.1 Informed consent is obtained by the researcher.
- 2.2.2 Informed consent is obtained from the relevant authority.
- 2.2.3 Informed consent is obtained from the relevant participant(s).
- 2.2.4 The legal requirements in terms minors/ participant unable to give informed consent, are adhered to.
- 2.2.5 Informed consent is obtained from captive group(s) involved in a dependent relationship with the researcher, by way of procedures approved by the peer group.
- 2.2.6 Informed consent is obtained from the field workers/collectors of data.
- 2.2.7 Research without patient consent is only executed during observational research totally without risk, or innocuous research involving comprehension.
- 2.2.8 The true purpose of the research without patient consent is declared to the patients as soon as possible.
- 2.2.9 Transparency is upheld in terms of the objectives of the research, type of data to be collected, method of data-collection and possible benefit(s) to the authority and participant(s).
- 2.2.10 Any financial liability (by both the researcher, participant and funder) is adhered to according to an agreement.

2.3. Confidentiality and anonymity is ensured in accordance with the following criteria:

- 2.3.1 Protection of the participant's(s') identity.
- 2.3.2 The researcher ensures privacy, worth and dignity of the participant(s).
- 2.3.3 The researcher ensures that no linking between the individual identity of the participant(s) or organisation(s) to the research data can be made.

2.4. Quality research is ensured in accordance with the following criteria:

- 2.4.1 The researcher(s) has the ability (knowledge, skills and attitude) to execute the research process (a researcher includes the supervisor/mentor).
- 2.4.2 The researcher(s) adheres to the standards of planning, implementation, evaluation and reporting of research.
- 2.4.3 The researcher conforms to the principles of sampling in a rigid and trustworthy manner.
- 2.4.3 The researcher demonstrates integrity (honesty, to act in good faith, adherence to pre-determined agreements) throughout the process.
- 2.4.4 The researcher ensures that the process and results are trustworthy/valid.



- 2.4.5 Thorough and complete documentation of the research process and results to enable a trustworthy audit trail (retrospective auditing).
- 2.4.6 The researcher(s) accepts and demonstrates accountability for the research process and results.
- 2.4.7 The researcher is accountable for the appropriate dissemination of the results and recommendations.
- 2.4.8 Research is meaningful and contributes to the improvement of nursing practice (clinical, educational, ethical and managerial).

3. DENOSA POSITION

DENOSA is of the opinion that these four ethical standards should be adhered to in all research projects in order to ensure that all rights and responsibilities of the various role players are upheld.

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August, 1998



NURSING EDUCATION



THE IMPACT OF THE USE OF HIGH TECHNOLOGY EQUIPMENT IN NURSING AND MIDWIFERY CARE

The introduction of technological equipment and its use is increasing in the world and in the health care setting.

DENOSA believes that:

1. nurses/midwives/accoucheurs should nurse the patient as a totality bearing in mind the spiritual, psychological, emotional, physical and sociological aspects of care.
2. the high technology environment is confusing and the nurse/midwife/ accoucheur is the point where the patient and family can feel cared for.
3. the nurse/midwife/accoucheur is in a unique position to humanise the high technology environment.
4. nurses/midwives/accoucheurs have a responsibility to ensure that they are equipped to use high technology equipment.
5. the employer has a responsibility to provide and maintain equipment to ensure safety of equipment and a safe environment.

April 2000



THE IMPACT OF THE USE OF HIGH TECHNOLOGY EQUIPMENT IN NURSING AND MIDWIFERY CARE

1. INTRODUCTION

The introduction of technological equipment and its use is increasing in the world and in the health care setting. Traditionally in the delivery of health care, nurses and midwives/ accoucheurs have been the liaison between the client and the health care system. In a technologically advanced environment they fulfill this function in new ways which creates a challenge to the profession. In a technological advanced environment nurses and midwives/accoucheurs will be expected to perform at a higher level with more complex activities which cannot be programmed. They will be held accountable and responsible for patients and their families, for continual review and examination of nursing and midwifery practice, for applying basic research for innovative solutions to patient care problems and for devising creative new models for the delivery of nursing and midwifery care.

The considerable expenses involved in the information needed for the use of technology, highlights some of the hidden dangers to both care givers and users of health care and requires continuous education and updating of information if it is to be effective.

The caring ethos and therapeutic milieu must never be lost - high-technology does not equal low care.

2. OPERATIONAL DEFINITION OF TECHNOLOGY

Technology in the health care environment will include body invasive, diagnostic and life supporting equipment and procedures.

3. THE POSITION OF DENOSA

DENOSA believes that:

- 3.1. nurses/midwives/accoucheurs should nurse the patient as a totality bearing in mind the spiritual, psychological, emotional, physical and sociological aspects of care.
- 3.2. the high technology environment is confusing and the nurse/midwife/ accoucheur is the point where the patient and family can feel cared for.
- 3.3. the existence and efficient work of high technology requires competent participation by the nurse/ midwife/accoucheur.
- 3.4. nurse/midwife/accoucheur should have the knowledge, skills and attitude to manage and cope with high technology equipment.
- 3.5. the nurse/midwife/accoucheur should liaise with other interested groups and develop guidelines which relate to the procurement and use of high technology equipment.
- 3.6. health care institutions should promote nursing/midwifery research to improve the nursing/midwifery care in the departments with high technology equipment and to facilitate changes in the nursing care and management of patients.



- 3.7 health care institutions should share the results of such studies and experiences related to high technology equipment with other health care institutions.
- 3.8 nurses/midwives/accoucheurs should nurse the patient as a totality bearing in mind the spiritual, psychological, emotional, physical and sociological aspects of care.
- 3.9 nurses/midwives/accoucheurs should look into and take a stand on the advocacy and/or problems that might arise in the legal, ethical and moral fields related to respect of human rights, dignity and the right to have a peaceful death.
- 3.10 the employer has a responsibility to provide and maintain equipment to ensure safety of equipment and a safe environment, both for the patient and the health care personnel.

4. CONCLUSION

DENOSA believes that the nurse/midwife/accoucheur is in a unique position to create a caring and humane environment for the patient in a high technology environment.

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April 2000



3

**SOCIAL AND
ECONOMIC
WELFARE OF
NURSES**



OCCUPATIONAL HEALTH AND SAFETY FOR NURSES/MIDWIVES AND ACCOUCHEURS

The workplace is considered a part of the overall society, reflecting the problems of all employees. There will often be a need for some adaptation of the workplace to compensate for physical, physiological and psychosensorial limitations or hazards.

DENOSA believes that:

1. All employers should make provision for an occupational health service to promote the health and safety of employees.
2. Employers should have occupational health and safety programmes and health and safety policies in place to manage health and safety risks in the workplace.
3. The nurse/midwife/accoucheur has a responsibility to contribute to the creation of a healthy and safe working environment by adhering to the policies of the workplace.

July 1999



OCCUPATIONAL HEALTH AND SAFETY FOR NURSES/MIDWIVES AND ACCOUCHEURS

1. INTRODUCTION

The workplace must now be considered as part of the overall society, reflecting the problems of all employees. There will often be a need for some adaptation of the workplace to compensate for physical, physiological and psycho-sensorial limitations or hazards.

A number of work-related diseases and injuries are likely to appear among employees in the later stages of life, as a result of adverse working conditions many years previously.

There has been a moral obligation to provide education in occupational health and safety for the working population since all workers, both professional and allied, have the right to be adequately informed about occupational health risks they face, and to know what protective measures should be adopted. DENOSA believes the concern for occupational health and safety should be expressed with more clarity and greater frequency.

2. DEFINITION OF OCCUPATIONAL HEALTH AND SAFETY

2.1 *Occupational safety*

Occupational safety is defined as the absence/elimination of potentially dangerous conditions in the working environment which may lead to accidents, disease and disability, accidents being

4. ROLE OF THE EMPLOYER

DENOSA believes that each employer of nurses/midwives and accoucheurs should:

4.1 *Implement a formal occupational health and safety programme in compliance with the requirements of the Occupational Health and Safety Act (Act No. 85 of 1993) which would provide for at least the following:*

- 4.1.1 A written occupational health and safety policy for nurses/midwives/accoucheurs which should contribute to the establishment and maintenance of the highest possible degree of physical and mental well-being of employees.
- 4.1.2 Establishment of a workplace safety committee with full representation by nurses/ midwives/ accoucheurs with knowledge and training in occupational health and safety.
- 4.1.3 Inclusion of union representatives on the Committee.
- 4.1.4 Basic health education and in-service occupational health and safety training.

4.2 *Control health risks by:*

- 4.2.1 Providing nurses with information about harmful or potentially harmful situations which they may encounter in their environment.
- 4.2.2 Introducing a system of consultation with nurses/midwives/accoucheurs about their health and safety needs in their working environment.
- 4.2.3 Providing the infrastructure required for the identification of health hazards and eliminating or reducing these to a minimum.
- 4.2.4 Providing appropriate and immediate medical intervention and treatment where nurses/ midwives/accoucheurs and other health care workers have been exposed to blood borne diseases and other high risk conditions.
- 4.2.5 The recording and evaluation of accurate epidemiological data of all accidents, incidents and sick leave taken by nurses/midwives/accoucheurs.
- 4.2.6 Establishing and maintaining a safe, healthy working environment which will facilitate optimal physical and mental health in relation to work.
- 4.2.7 Reallocation of work to the capabilities of a worker in the light of his/her state of physical and mental health: subject to medical reassessment as required by the circumstances.
- 4.2.8 Providing safety equipment and mechanical aids where necessary to enable nurses/ midwives/accoucheurs to protect themselves.
- 4.2.9 Providing periodic medical examination and screening programmes based on special needs and in accordance with specific health hazards according to the Basic Conditions of Employment Act (Act no. 75 of 1997).



- 4.2.10 Seriously considering immunisation and chemo-prophylactic treatment in accordance with the latest research findings for nurses/midwives/accoucheurs who are exposed to diseases in their practice.
- 4.2.11 Ensure that multi-disciplinary rehabilitation programmes exist for nurses/midwives/accoucheurs who suffer from the consequences of occupational diseases or accidents.
- 4.2.12 Primary financing of occupational health care for employees post exposure to occupational health hazards.

5. THE RESPONSIBILITIES OF THE EMPLOYEE:

DENOSA believes that the nurse/midwife/accoucheur has the following responsibilities:

- 5.1 to investigate and document attendance of safety training and health education programmes.
- 5.2 to acquaint themselves with the health and safety conditions and regulations of the workplace.
- 5.3 to comply with the health and safety regulations of the workplace.
- 5.4 to perform all duties in a way that will ensure the maintenance of health and safety.
- 5.5 to actively contribute towards creating a safe and healthy work environment.
- 5.6 to report all accidents, incidents and sick leave episodes.

6 CONCLUSION

There are obligations and responsibilities that the nurse/midwife /accoucheur as well as the employer should adhere to.

RESOURCES

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July 1999



LATEX ALLERGY

Latex allergy or hypersensitivity is on the rise among health care workers and patients and could affect as much as 10% of hospital personnel

DENOSA believes that:

1. Employers should provide a health care environment which is safe for both health care workers and the patient in terms of the Occupational Health and Safety Act (Act No 85 of 1993).
2. A multi-disciplinary, interdepartmental committee should be developed in all health care facilities to draft a policy regarding latex. The Committee must ensure that all possible cases of latex allergy are identified, diagnosed and followed up.
3. Employers should develop a policy concerning the use of gloves by health personnel in their institutions.
4. A policy for latex sensitive staff should be developed.
5. Manufacturers should be encouraged to label products that have latex content.
6. Standards for desirable extractable protein levels on gloves should be specified by the South African Bureau of Standards. A central monitoring faculty should be established to ensure that the specifications for safe gloves are strictly adhered to by manufacturers.
7. The Commissioner for occupational diseases should be notified of staff members who become allergic.

August 1999



LATEX ALLERGY

1. INTRODUCTION

Latex allergy or hypersensitivity is on the rise among health care workers and patients. According to reports, latex allergy is now recognised as a life threatening health problem and occupational risk for health care workers which could affect as much as 10% of hospital personnel (Potter, 1998: 15).

Factors influencing the severity of a latex allergy response are the individual's susceptibility, the route, duration, frequency of exposure and the type and amount of allergen present during the exposure. The product most often associated with latex allergy is latex gloves.

DENOSA believes that health care workers should be aware of the signs and symptoms of latex allergy, of health care products containing latex and the preventive measures.

2. TERMINOLOGY

2.1 *Latex*

Latex is the product of the milky sap of the commercial rubber tree called *Hevea Brasiliensis*. The liquid is rich in proteins, some of which are potential allergens.

2.2 *Processing of Latex*

During the processing of latex, chemicals known as accelerators are added to it which add strength and elasticity to the final product. During the end phase of glove production, a washing process removes some of the additional chemicals. The residual level of chemicals in latex depends on the number of washes performed.

2.3 *Latex Allergy*

Reaction to latex allergy are of three main types:

2.3.1 Type I allergy - Immediate hypersensitivity

Primarily a reaction to the extractable natural protein residue found in latex. The response (urticaria, oedema, wheezing, coughing, rarely anaphylactic shock) is almost immediate and symptoms subside rapidly once the latex is removed from the individual.

2.3.2 Type IV - allergy - Delayed sensitivity

Primarily an allergic response to the residues of accelerating agents such as thiurams, mercaptobenzothiazoles and dithiocarbonates found on the surface of the gloves. Symptoms are delayed up to eight hours after contact. Reaction includes a red pruritic dermatitis and itching. Repeated exposure may produce symptoms beyond the area of contact.

2.3.3 Irritant contact dermatitis

This is a reversible non-allergic condition which can also be caused by soaps, jewelry, corn starch glove powder and other agents. The skin becomes dry peeling and itchy. Symptoms resolve with removal of the irritant unless the area is affected over a long period which can lead to chronic dermatitis which is often non-reversible.



2.4 *Other products*

Patients who are allergic to latex may also be allergic to avocados, bananas, raw potatoes, kiwi fruit, chestnuts and melons due to cross reacting elements in these fruits.

Rubber gloves may also contain other contaminants in addition to latex proteins which people may be allergic to e.g. ethylene oxide, lasein and certain preservatives in starch. The starch transfers allergenic proteins into the atmosphere which may be inhaled by health care workers.

3. **PRODUCTS CONTAINING NATURAL RUBBER LATEX**

A list of products is attached as Annexure A.

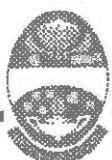
4. **SYMPTOMS OF LATEX ALLERGY**

Symptoms of allergy and high risk candidates are attached as Annexure B.

5. **POSITION OF DENOSA:**

DENOSA believes that:

- 5.1 A multi-disciplinary interdepartmental committee should be established in all health care facilities to draft a policy regarding latex. The Committee must ensure that all possible cases of latex allergy are identified, diagnosed and followed up.
- 5.2 A policy should include the following:
 - 5.2.1 Policy on health care personnel education regarding:
 - 5.2.1.1 the existence, relevance and management of latex allergy.
 - 5.2.1.2 the encouragement of staff to seek guidance from the occupational health department if suspected latex allergy occurs to ensure correct diagnosis and management.
 - 5.2.1.3 education of health care providers about occupational allergy risks.
 - 5.2.1.4 the identification of population at risk for latex allergy, signs and symptoms, diagnosis and management of latex allergy.
 - 5.2.2 the use of gloves by health care personnel including the following:
 - 5.2.2.1 after removing gloves health care personnel should wash glove powder from their hands to minimise skin exposure and to prevent the latex from sensitising mucous membrane.
 - 5.2.2.2 wearing masks while handling products containing latex may help protect health care personnel from direct contact with latex and from air-way exposure to airborne latex particles.
 - 5.2.2.3 avoid touching eyes, nose and mouth while wearing gloves.
 - 5.2.2.4 consideration of the appropriateness of glove use to prevent unnecessary and indiscriminate use.
 - 5.2.2.5 at first sign of latex allergy in a staff member, non latex gloves should be made available.



- 5.3 An employer should:
- 5.3.1 provide a health care environment which is safe for both health care workers and the patient in terms of the Occupational Health and Safety Act (Act No 85 of 1993).
 - 5.3.2 prevent latex allergy by adopting a powder free glove policy.
 - 5.3.3 identify each area of the hospital and list all common sources of latex in each setting.
 - 5.3.4 ensure proper documentation in medical records and labeling of patients as being allergic to latex or at high risk for latex sensitization.
 - 5.3.5 develop a policy for latex sensitive staff which should include:
 - 5.3.5.1 a powder free glove policy.
 - 5.3.5.2 wearing a medic alert.
 - 5.3.5.3 carrying self injectable adrenaline and anti-histamines.
 - 5.3.5.4 provision of non-latex gloves (e.g. neoprene, neotech) for sterile procedures and vinyl or nitrile gloves for non-sterile procedures.
- 5.4 Manufacturers should be encouraged to label products that have latex content.
- 5.5 Standards for desirable extractable protein levels on gloves should be specified by the South African Bureau of Standards. A central monitoring faculty should be established to ensure that the specifications for safe gloves are strictly adhered to by manufacturers.
- 5.6 Commissioner for occupational diseases should be notified of staff members who become allergic.

6 CONCLUSION

The nursing and midwifery professions have a responsibility to be aware of the signs and symptoms and the management of latex allergy.

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August, 1999



Annexure A

Some products containing latex

Anaesthetic apparatus

Baby nipples

Balloons

Bandages

Belts

Brassieres

Buretrols

Cardiac catheters

Carpet backing

Chewing gum

Clothing

Condoms

Corsets

Dental cofferdams

Drip sets

Erasers

Examination gloves

Face masks

Face pillows

Garden hoses

Gloves

Golf grips

Headsets

Injection vials

Latex cuffs

Milking machines

Ostomy bags

Paint

Pacifiers

Rubber bands

Rubber cement

Shoewear

Suspenders

Surgical gloves

Syringes

Tennis grips

Teething rings



Annexure B

B1 Symptoms of allergy

1. IgE mediated latex allergy

Clinical manifestations

Contact urticaria

Generalised urticaria

Conjunctivitis

Rhinitis

Bronchospasm

Anaphylaxis

2. Reported causes of latex associated anaphylaxis

Powered examination gloves

Surgeon's gloves

Barium enema catheters

Condoms

IV catheters

Urological catheters

Balloons

B2 High risk groups

Theatre staff

Patients with repeated surgical procedures

Dentists

Rubber industry workers

Paramedics



4

HEALTH CARE SYSTEMS



RENDERING OF HEALTH CARE SERVICES IN SOUTH AFRICA

A healthy nation is a vital resource and therefore a prime goal and responsibility of the nation.

In terms of the delivery of health care services, DENOSA believes that:

1. The nursing and midwifery profession is equipped to deliver a comprehensive health service to the community.
2. A national development plan is an essential part of the improvement of the health status of communities and should be planned and developed complementary to health services, in consultation with the role players.
3. Health legislation should provide the authorising framework for the effective and integrated rendering of health services.
4. The community as such should also be involved in the planning and implementation of health services.
5. Every individual should be primarily responsible for his own health and specific education programmes should be developed with a view to equipping individuals with the necessary knowledge to ensure a healthy life-style and self-care.
6. Staffing ratios for nursing and midwifery should be agreed upon by role players to maintain high standards of patient care and competence.

In terms of the role of the nurse/midwife/accoucheur DENOSA believes:

1. Nursing and midwifery training should be adapted to the health needs of the community and the country and basic training should be comprehensive and integrated, with the emphasis on the rendering of primary health care.
2. Advanced courses should prepare the nurse/midwife/accoucheurs for the rendering of specialised services not only in primary health care but also in the secondary and tertiary health services.
3. The nurse/midwife is a professionally capable and legally accountable practitioner and as such has the right to practise her profession privately within the framework of the Nursing Act and other health care related acts.
4. Where nurses/midwives are made responsible for the rendering of health care, provision should be made for the necessary legislation and delegating of authority.
5. Nurses/midwives/accoucheurs should make a contribution in respect of the planning, organisation and control of health services on the management and service-rendering levels.

May 1999



RENDERING OF HEALTH CARE SERVICES IN SOUTH AFRICA

INTRODUCTION

A healthy nation is a vital resource and therefore a prime goal and responsibility of the nation. DENOSA represents the largest number of the health personnel involved in the direct rendering of health services to the community and therefore has a responsibility as well as an important contribution to make in respect of changing and improving the rendering of health services to the inhabitants of the RSA. DENOSA's position in this regard is as follows:

1. RENDERING OF HEALTH SERVICES

- 1.1 The rendering of health care should be equitable, affordable, accessible, available and acceptable to all the inhabitants of the RSA.
- 1.2 A national development plan is an essential part of the improvement of the health status of communities and should be planned and developed complementary to health services, in consultation with the role players.
- 1.3 The emphasis should be placed on the rendering of comprehensive (promotive, preventive, curative and rehabilitative) health care on the primary level. Health services on the secondary and tertiary levels should also be available to support primary health care.
- 1.4 The impact of and between primary versus secondary and tertiary health care should be considered and accommodated. Better primary health care services will have the effect of identifying problems which would not have been identified resulting in an increased patient load in secondary and tertiary health care services.
- 1.5 Comprehensive health services are rendered in an inter-sectoral and inter-disciplinary team context.
- 1.6 The nursing profession is the largest health profession and therefore forms the backbone of the health services of the RSA. Specific provision should therefore be made for nurses at all managerial levels to ensure that high standards of nursing care are maintained.
- 1.7 On the basis of the key role of the nurse in the rendering of health services and the unique nature of the profession, the nurse should be involved in policy-making, as well as in the planning, organisation, development and management of health services.
- 1.8 An integrated and participating balance should be developed between the public and the private sectors in respect of the rendering of health care (including expertise, facilities and equipment) and the training of health personnel.
- 1.9 Health legislation should provide the authorising framework for the effective and integrated rendering of health services.



- 1.10 The direct rendering of health services should be brought as close as possible to the specific community and should take into consideration their particular health needs, the cost-effective utilisation of human resources, facilities, equipment and supplies.
- 1.11 The nature, scope, quality and results of health services should be measured and managed scientifically.
- 1.12 An integrated health information system is essential for the scientific planning and evaluation of the health services.
- 1.13 Practical, scientifically justified technology must be applied in the rendering of health care, provided that it is acceptable to the community, affordable and utilised cost effectively.
- 1.14 The community as such should also be involved in the planning and implementation of health services.
- 1.15 Every individual should be primarily responsible for his own health and specific education programmes should be developed with a view to equipping individuals with the necessary knowledge to ensure a healthy life-style and self-care.
- 1.16 Innovative methods for the generation of additional funds for health services should be examined and/or developed. These funds should remain with health services and not be channelled to a general state fund.
- 1.17 Staffing ratios for nursing and midwifery should be agreed upon by role players to maintain high standards of patient care and competence.

2. THE ROLE OF THE NURSE AND MIDWIFE/ACCOUCHEUR IN THE RENDERING OF HEALTH CARE

- 2.1 Nursing and midwifery training should be adapted to the health needs of the community and the country.
- 2.2 Basic training should be comprehensive and integrated, with the emphasis on the rendering of primary health care as the nurse is the community's first contact with the health services.
- 2.3 Advanced courses should prepare the nurse/midwife/accoucheurs for the rendering of specialised services not only in primary health care but also in the secondary and tertiary health services.
- 2.4 The nurse/midwife is a professionally capable and legally accountable practitioner and as such has the right to practise her profession privately within the framework of the Nursing Act and other health care related acts.
- 2.5 Where nurses/midwives are made responsible for the rendering of health care, provision should be made for the necessary legislation and delegating of authority.



- 2.6 Nurses/midwives/accoucheurs should make a contribution in respect of the planning, organisation and control of health services on the management and service-rendering levels. Nurses and midwives, therefore, should be offered educational opportunities to gain knowledge of economic principles, budgeting and resource use, cost-effectiveness in health, leadership and management development.
- 2.7 The nurse/midwife/accoucheur is a unique and essential member of the health team and frequently acts as the initiator, co-ordinator and/or facilitator of the team. Based on this unique and diverse role of the nurse, DENOSA's position is that this role needs to be acknowledged with market related remuneration.

RESOURCES:

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May 1999



5

SOCIAL ISSUES



SMOKING AND HEALTH



