Table of contents

List of tables

List of figures

List of annexures

Foreword by the Minister of Health

The Ministry of Health recognises the essential role of the nurses in achieving: "*A long and a healthy life for all South Africans".* Our country faces a quadruple burden of disease consisting of HIV and AIDS; communicable diseases; non-communicable diseases; and violence and injuries with consequent high levels of morbidity and mortality. The Medium Term Strategic Framework (MTSF) for 2009 – 2014 has as one of its focus areas the improvement of the health profile of all South Africans.

Cognizant of the magnitude of the nursing challenges, in April 2011, the Department of Health called together all the nurses of South Africa and other key stakeholders to the National Nursing Summit with the aim to *reconstruct and revitalise the Nursing Profession for a Long and Health Life for All South Africans.*

Major challenges facing the nursing profession, identified by the Summit, are categorised into the following categories:

i. Nursing education and training;
ii. Resources in nursing;
iii. Professional ethos and ethics;
iv. Governance, leadership, legislation and policy;
v. Positive practice environments;
vi. Compensation, benefits and conditions of employment; and
vii. Nursing human resources for health.

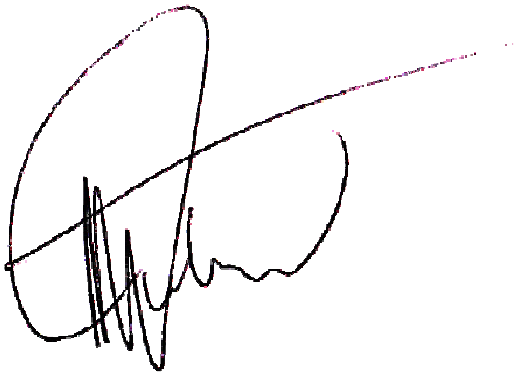
The National Nursing Summit culminated in the Nursing Compact, which represents a summary of collective decisions taken at the event. Against this background, I appointed a special Task Team to develop a plan of action to address nurse education, training and practice by developing a Strategy for Nurse Education, Training and Practice with an Implementation Plan.

I am pleased that the Ministerial Task Team has focused on the problems highlighted in the Nursing Compact.

Through this nurse education, training and practice strategic plan, the reconstruction and revitalisation of the nursing profession in South Africa will be strengthened. The strategy will ensure that our country has nurses of high calibre who can contribute to addressing the healthcare needs of all South Africans.

I thank the special Ministerial Task Team for producing this Strategy for Nurse Education, Training and Practice.

Working in collaboration with the nine Provincial MECs for Health, I commit myself to provide leadership and the necessary resources required to ensure the successful implementation of this Strategic Plan for Nurse Education, Training and Practice.



DR PA MOTSOALEDI, MP
MINISTER OF HEALTH
DATE:

Acknowledgement by the Director-General of Health

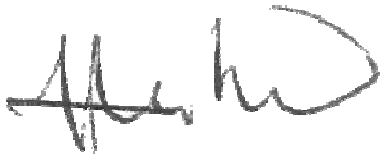
The Department of Health is deeply grateful to all participants of the country's first national Nursing Summit in April 2011 whose contributions provided the foundation for this strategic plan. This document is the product of hours of work by the special Ministerial Task Team (MTT) appointed by the Honourable Minister of Health, Dr AaronMotsoaledi following the Summit. I would like to thank the task team members who represent a cross-section of nursing stakeholders in South Africa: Ms Daisy Mafubelu (Chairperson); Professor Judy Bruce, Ms Nelouise Geyer, Ms ThembekaGwagwa, Mrs Catherine Makwakwa, Dr SiphoMkhize, Professor Laetitia Rispel and Ms Maureen Sithole.

Special thanks also go to Dr Brigid Strachan with the Department of Health who assisted the MTT with the Human Resources planning component of the Strategy.

The MTT was ably supported by the following staff members of the Department who served as Secretariat: Ms KhanyisaNevhutalu, Ms RheinettMohlabi, Ms Masala Silinda and Ms Lindi Mhlanga.

Thank you all for your dedication and commitment to developing, reconstructing and revitalising the nursing profession in South Africa.

The Department is indebted to *The Atlantic Philanthropies*, whose sustained and generous endowment provided the impetus and support to galvanize nursing in South Africa into improving the health status of South Africans, health service delivery and the nursing profession in particular.



MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE:

Executive Summary

South Africa's healthcare system, which is predominantly nurse-based, requires nurses to have the competence and expertise to manage the country's burden of disease and to meet South Africa's healthcare needs. Globally the shortage of human resources for health (HRH) undermines the ability of countries to improve health outcomes and the performance of health systems. This is exacerbated in South Africa where we have a quadruple burden of disease. The high prevalence of HIV which impacts on human resources in the health sector, poor health outcomes for the budget spent on health and shortages of healthcare professionals are among the challenges highlighted in the HRH Strategy for the Health Sector: 2012/13 – 2016/17.

Recognising the depth of the challenges facing nursing, the Department of Health convened the National Nursing Summit, which was held from 5 to 7 April 2011 at the Sandton Convention Centre in Johannesburg. The aim of the Summit was to: *reconstruct and revitalise the Nursing Profession for a Long and Healthy Life for All South Africans*.

The problems were highlighted under seven themes:

1. Nursing education and training;
2. Resources in nursing;
3. Professional ethos and ethics;
4. Governance, leadership, legislation and policy;
5. Positive practice environments;
6. Compensation, benefits and conditions of employment; and
7. Nursing human resources for health.

This consultative Summit culminated in a Nursing Compact providing a summary of the collective decisions taken at the event. The Minister of Health appointed a Task Team on Nurse Education and Training to refine the recommendations contained in the Nursing Compact and to develop a plan of action to address both education and practice issues relating to the profession. The Task Team commenced its work in October 2011.

The MTT on Nurse Education and Training worked with reference groups consisting of members of the profession with relevant expertise and experience in the different themes, supported by contributions from the broader profession. The outcome is a proposed programme of action with recommendations for each of the seven thematic areas which were presented at provincial workshops to disseminate information and raise awareness of the Strategy.

One of the strongest and most urgent recommendations is the need for nursing colleges to be declared higher education institutions in compliance with the provisions of the Higher Education Act (as amended in 2008). Failure to do so will mean public nursing colleges, the primary training platform for nurses, will be unable to continue training after 30 June 2013, the deadline for the interim registration of qualifications, with dire implications for the current nursing shortage. The MTT recommends that Nurse Education and Training be regarded as a national competence accounting to the Director General of Health. This will help to address provincial inequalities, norms and standards, quality, decrease fragmentation, eliminate 'fly by night' Nursing Education Institutions (NEIs), improve clinical training and enhance social accountability. The South African Nursing Council (SANC) should develop and finalise an accreditation framework for NEIs, their programmes and clinical training facilities according to SANC criteria and those of the Council for Higher Education (CHE).

Nursing students should have the status of full student (rather than employee) while undergoing their training. They should receive funding support for tuition, books and study materials, living costs, medical aid and indemnity insurance which should be paid monthly, while tuition fees should be paid directly to NEIs. Accommodation, uniforms and transport for training should be provided. Students should undergo a rigorous selection process by NEIs to attract suitable candidates to the profession. In order to promote the quality of practical hands-on training, students are to be placed in a variety of health establishments linked to all NEIs for their clinical training. The MTT recommends that clinical education and training be strengthened by re-establishing clinical teaching departments at all NEIs or hospitals, supported by a co-ordinated system of clinical preceptors and clinical supervisors. This must be accompanied by the requisite resources from the relevant authorities.

Professionalism and ethics that emphasise caring should be core, compulsory modules at all levels of nursing and midwifery training in order to address the image of nurses and nursing. A Continuing Professional Development (CPD) system for all nurses and midwives, linked to licensing and professional progression, must be introduced urgently and should include professionalism and ethics as a compulsory component. The SANC must prioritise the revision and finalisation of a national framework for education and training of nurse educators and managers and the standards for their CPD.

The MTT recommends that the uniform allowance should be phased out over a three year period and be replaced with the direct provision of contemporary white uniforms provided by employers.

It is recommended that an office of the Chief Nursing Officer (CNO) be established and a permanent appointment be made as a matter of urgency.

The office of the CNO, in consultation with relevant stakeholders, is urged to facilitate a national core curriculum for nursing and to develop a national framework for the efficient and equitable financing model for nursing education and clinical training. The MTT recommends that there should be clearly defined leadership and management nursing structures at all levels of government health services.

Positive Practice Environments (PPE), already partially incorporated in the national core standards, are essential for both nursing education, as well as nursing and midwifery practice. The MTT recommends that PPE should also include: orientation and induction programmes for new staff; formal education opportunities; provision and utilisation of appropriate and effective information, communication technology (ICT) for clinical practice and education.

National nursing norms and guidelines are essential for healthcare planning and safe patient care. This should strike a balance between ideal staffing, what is a safe guideline and what is affordable. The MTT recommends that a combination of the World Health Organization’s (WHO) population-based norms and activity based workload approach be used to determine safe staffing norms for nursing in South Africa.

Summary of recommendations

Strategic Plan: Nursing Education, Training & Practice 2012/13 – 20/1617
Nursing Education & Training 1. There should be a national nursing education policy in place positioning nursing education in higher education. 2. A dedicated structure should be in place to implement the proposed clinical education and training model for nurses and midwives. 3. There should be a national policy in place on student status and a funding model for students in nursing programmes.
Resources in nursing 1. There should be dedicated nursing structures at national, provincial and local government levels, including the appointment of a dedicated person within the national CNO portfolio to provide leadership and stewardship for nursing education. 2. A national framework on nurse educator development with dedicated resources should be in place. 3. A clear support and development framework for nurse managers should be in place.
Professional Ethos 1. A comprehensive programme to restore ethics and respect in nursing should be in place and implemented by stakeholders. 2. A comprehensive programme should be in place to promote the nursing profession at school level to attract a good cadre of nurses. 3. Ethics should be mainstreamed in all basic and post basic nursing programmes as well as in-service training. 4. Promote collaborative partnerships on an ongoing basis to unify nurses and midwives.
Governance, Leadership, Legislation and Policy 1. Ensure the effectiveness of SANC in the execution of its mandate on an ongoing basis. 2. There should be regulations to govern the nursing agencies 3. There should be a mechanism to regulate community health workers. 4. Promote institutional governance and leadership on an ongoing basis
Positive Practice Environments (PPE) 1. There should be a structured roll out and monitoring plan on PPE, developed in conjunction with the proposed Office of Standards Compliance. 2. There should be a framework to recognise post graduate qualifications in nursing and midwifery. 3. There should be a CPD system for nurses and midwives ready for implementation. 4. Improve the use of Information Communication Technology (ICT) in nursing and midwifery care provision on an ongoing basis.
Compensation, benefits and conditions of service

1. An agreement on an improved OSD for nurses should be in place.
2. Improve incentives to promote retention and recruitment of nursing staff on an ongoing basis.
3. All employers should provide nurses and midwives with white contemporary uniforms.

Human resources for health

1. Develop a model which provides information on the future supply of nurses for the public and private sectors, for hospitals, PHC and NGOs (including the new staff nurse category).
2. SANC should have improved data quality on nurses and ensure a database which details qualifications, location of employment, country of employment, employer, and other relevant details.
3. There should be a SANC database developed which details nursing education institutions and their output, production and employment of nurses by district and province for the public and private sectors
4. A project to develop safe nurse staffing guidelines based on the draft guidelines for hospitals and PHC developed by the MTT should be implemented; and the nurse staffing gap by category and the training implications based on safe nurse staffing guidelines determined.
5. The financial implications of nurse training and nurse employment to meet the PHC policy requirements and safe staffing guidelines for hospitals in the public sector should be determined.
6. Develop strategies to increase the return of nurses who have left the profession.

Abbreviations

ANSA	Academy for Nursing of South Africa
CBO	Community-based organisations
CHBH	Chris Hani Baragwanath Hospital
CHE	Council for Higher Education
CNO	Chief Nursing Officer
CPAS	College Principals and Academic Staff
CPD	Continuous Professional Development
DENOSA	Democratic Nursing Organisation of South Africa
DHET	Department of Higher Education and Training
EN	Enrolled Nurses
ENA	Enrolled Nursing Auxiliary
FBO	Faith-based organisations
FTE	Full time equivalent
HCT	HIV Counselling and Testing Campaign
HEI	Higher Education Institutions
HEQC	Higher Education Quality Council
HPPD	Hours per patient day
HRH	Human Resources for Health
HWSETA	Health and Welfare Sector Education and Training Authority
ICN	International Council of Nurses
ICT	Information communication technology
IPC	Infection and prevention control
MEPI	Medical Education Partnership Initiative
MDG	Millennium Development Goals
MDR	Multi-drug resistant

MTT	Ministerial Task Team on Nursing Education and Training
MTSF	Medium Term Strategic Framework
NDoH	National Department of Health
NEI	Nursing Education Institution
NHI	National Health Insurance
NIM-ART	Nurse Initiated Management of Antiretroviral Treatment
NSDA	Negotiated Service Delivery Agreement
NQF	National Qualifications Framework
OHS	Occupational Health and Safety
OSD	Occupation Specific Dispensation
PEPFAR	President's Emergency Plan for AIDS Relief
PHEPSA	Private Health Education Providers in South Africa
PERSAL	Personnel Salary System
PHC	Primary Healthcare
PMDS	Performance Management and Development System
PPE	Positive Practice Environment
SANC	South African Nursing Council
SAPS	South African Police Services
SAQA	South African Qualifications Authority
WHO	World Health Organization
XDR	Extreme Drug Resistance

1. Introduction and background

South Africa's predominantly nurse-based healthcare system requires nurses to have the competence and expertise to manage the country's burden of disease and to meet South Africa's healthcare needs. Globally there is recognition of a health workforce crisis, characterised by critical shortages, imbalanced skills mix, migration and uneven geographical distribution of health professionals, sub-optimal population health outcomes, insufficient progress on the Millennium Development Goals (MDGs), and millions of people without access to health services. The global shortage of HRH undermines health systems effectiveness and the delivery of healthcare services to those most in need. Given that nurses make up the largest single group of healthcare providers in any country, including South Africa, the HRH crisis can also be characterised as a nursing crisis.

South Africa has a quadruple burden of disease consisting of HIV, AIDS and tuberculosis (TB); high maternal and child mortality; non-communicable diseases; and violence and injuries which exacerbates the shortage of HRH. Health status indicators in South Africa are poor relative to the country's economic development and healthcare expenditure.

The Nursing Act No. 33 of 2005 created the legislative framework for the review of scopes of practice for different categories of nurses to ensure that nursing and midwifery practice in South Africa is aligned to the needs of the healthcare system. Subsequently, the new qualifications framework and the revised scopes of practice were developed. A Nursing Strategy for South Africa was launched in 2008 to articulate how nursing education and training, practice, resources, social positioning, regulation and leadership would dovetail to support the nation's health system.

In 2010, the Minister of Health signed the Negotiated Service Delivery Agreement (NSDA) with the President which highlights the government's programme of action for 2010-2014. The Health NSDA has four output areas: increasing life expectancy, decreasing maternal and child mortality; combating HIV and AIDS and decreasing the burden of diseases from TB; and strengthening health system effectiveness. This latter category includes outputs on improving patient care and satisfaction levels of

healthcare users; accrediting health establishments to meet core standards, revitalising primary health care (PHC) and improving quality of care. This put the health sector on a new path towards greater health equity, access and acceptability and necessitated a revision of the 2008 Nursing Strategy.

1.1 2011 Nursing Summit

In October 2010, the Director-General of the National Department of Health (NDoH) appointed an organising committee to oversee preparations for a National Nursing Summit and to ensure that the summit addressed the reported nursing challenges in the country. The theme of the summit was: *Reconstructing and Revitalising the Nursing Profession for a Long and Healthy Life for All South Africans*.

The objectives of the summit were to:

1.1 Reflect critically and discuss key issues affecting nurses and the nursing profession, within the context of South Africa's disease burden, as well as national and international health sector developments.
1.2 Examine how nurse education and training can be improved to ensure alignment to patient and community needs.
1.3 Discuss the role of nurses in major health policies and transformation initiatives, such as revitalising primary health care (PHC); National Health Insurance (NHI); millennium development goals (MDGs); and the Negotiated Service Delivery Agreement (NSDA).
1.4 Identify, showcase and learn from successful models and best practices in nursing education, research and service.
1.5 Examine critically and discuss the draft nursing scopes of practice.
1.6 Discuss how nursing research can contribute to evidence-based knowledge and tools to improve health outcomes and health system effectiveness.
1.7 Reflect critically on how the conference recommendations could inform the revision of the National Nursing Strategy in order to represent the aspirations of all nurses in South Africa and to meet the health needs of communities.

The National Nursing Summit was held from 5 to 7 April 2011 in Johannesburg. The aim of the Summit was to highlight issues of central concern to the future of the

profession and to underscore the importance and centrality of nurses in achieving the health outcomes and thus contribute to the success of the Government's health reform agenda and vision of *"A long and Healthy Life for all South Africans".* Around 1800 nurses, and diverse, stakeholder organisations, representing all districts and provinces in South Africa attended this historic event.

The three-day National Nursing Summit concluded with the adoption of the Nursing Compact representing a collective call for greater attention, investment and integrated action to develop, reconstruct and revitalize the nursing profession.

1.2 From Compact to Strategy

The Minister of Health appointed an eight person task team who was mandated to consult with the profession to develop and finalise a detailed strategic plan for nurse education and training reform. The MTT was also asked to address the concerns and recommendations articulated in the Nursing Compact and to elaborate on nursing reforms needed, specifically on nursing education and training as well as planning the development of the nursing workforce.

The MTT commenced its work in October 2011 by analysing the compact and the decisions of the Nursing Summit. The MTT's approach to the terms of reference consisted of the following strands:

1.2.1 Regular meetings of the MTT: The MTT met between October 2011 and May 2012 to discuss the various work-stream outputs and recommendations emanating from each group.

1.2.2 Each work-stream had a smaller reference group representing different stakeholder groups, to provide inputs.

1.2.3 Invitations to give input were extended to the broader nursing profession through correspondence circulated widely to constituencies, through the Department of Health's website and through social networks.

1.2.4 Analysing and synthesising relevant literature and policies; outputs of meetings or workshops; surveys and discussion groups; and consultation with various stakeholders, including provincial road shows before finalising the Strategy.

2. Purpose of the Strategy

The purpose of the Nursing Education, Training and Practice Strategy is to develop, reconstruct and revitalise the profession to ensure that nursing and midwifery practitioners are equipped to address the disease burden and population health needs within a revitalised healthcare system in South Africa.

3. Objectives of the Strategy

The objectives are to:

3.1 Promote and maintain a high standard and quality of nursing and midwifery education and training;

3.2 Enhance and maintain professionalism and professional ethos amongst members of the nursing and midwifery professions;

3.3 Promote and maintain an enabling, well-resourced and positive practice environment for nursing, midwifery and patients/clients throughout the lifespan;

3.4 Enable strong leadership at all levels of nursing and midwifery practice;

3.5 Guide the production of sufficient numbers and the appropriate categories of nurses required to deliver healthcare services within the policy framework for the healthcare system.

4. Situation Analysis

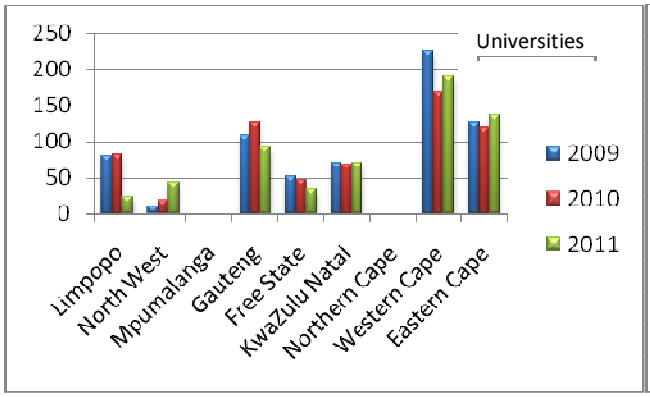
In light of the major healthcare reforms in South Africa, nursing and midwifery education is critical to enable nurses and midwives to provide competent patient care, meet the health needs of South Africans, engage in policy debates and provide leadership for change. An improved nursing education system is necessary to ensure that the current and future generations of nurses and midwives are able to provide safe, quality, patient-centred care across PHC and hospital settings.

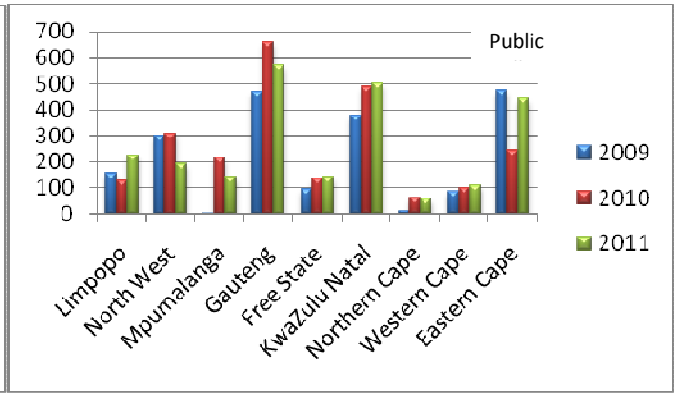
4.1 Nursing education and training

4.1.1 Existing production outputs

The existing outputs of NEIs as indicated in Figures 1 - 5 do not match the health and service demands for nurses and midwives. There is a shortage of nurses and

midwives across all healthcare services, in particular specialised services, with declining production over the lastfew years (Figure 6). Re-engineering of the primary healthcare system to strengthen the District Health System (DHS) has increased the demand for specialist nurses, particularly school health nurses (a speciality generally underutilised for about 20 years), advanced midwives and primary healthcare nurses. Uniform norms and standards are required to assess the real shortage and quantity of nurses for each category. Meeting the demand for more, differently skilled nurses is the responsibility and challenge of NEIs and nursing educators who are essential for revitalising the profession.

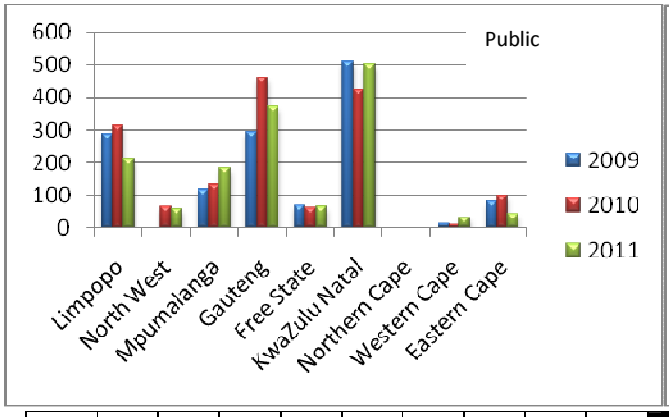


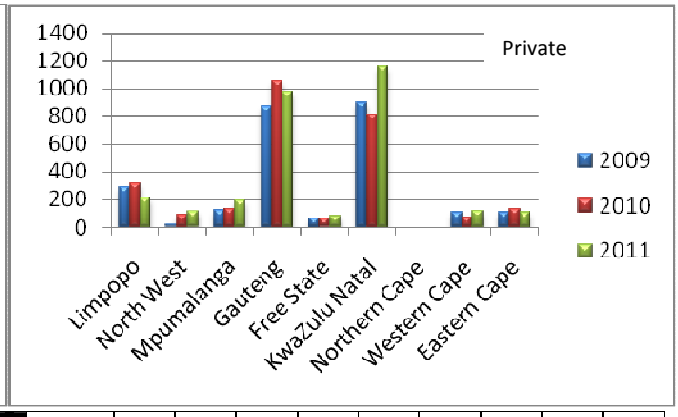


	LIM	NW	MP	GP	FS	KZN	NC	WC	EC
2009	80	10	0	108	51	70	0	225	127
2010	81	18	0	127	47	69	0	168	119
2011	24	44	0	92	33	70	0	191	136

	LIM	NW	MP	GP	FS	KZN	NC	WC	EC
2009	154	299	1	469	95	378	14	85	472
2010	126	309	216	657	135	486	62	101	245
2011	224	190	140	571	141	500	56	110	444

Figure 1: Production of nurses: 4-year programme at Universities and Public Nursing Colleges (SANC statistics)
NB: Mpumalanga (MP) and Northern Cape (NC) have no universities





	LIM	NW	MP	GP	FS	KZN	NC	WC	EC
2009	288	0	115	293	68	509	0	12	81
2010	313	65	132	460	60	425	0	10	98
2011	209	59	184	372	66	500	0	31	44

	LIM	NW	MP	GP	FS	KZN	NC	WC	EC
2009	289	21	121	868	68	894	0	108	106
2010	315	88	132	1050	60	807	0	72	131
2011	209	112	196	977	81	1162	0	120	108

Figure 2: Bridging programme: Public Colleges and Schools & Private Colleges and Schools (SANC statistics)

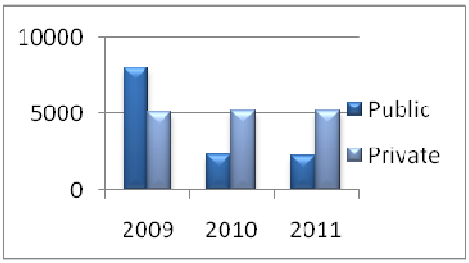


Figure 3: Production of nurses: Enrolled nurse programme 2009 – 2011(SANC statistics)

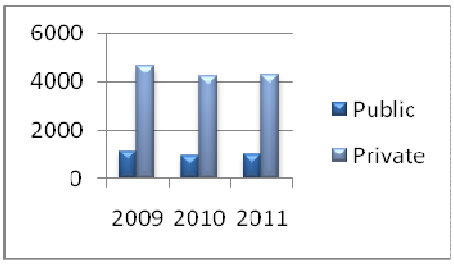


Figure 4: Production of nurses: Auxiliary nurse programme 2009-2011 (SANC statistics)

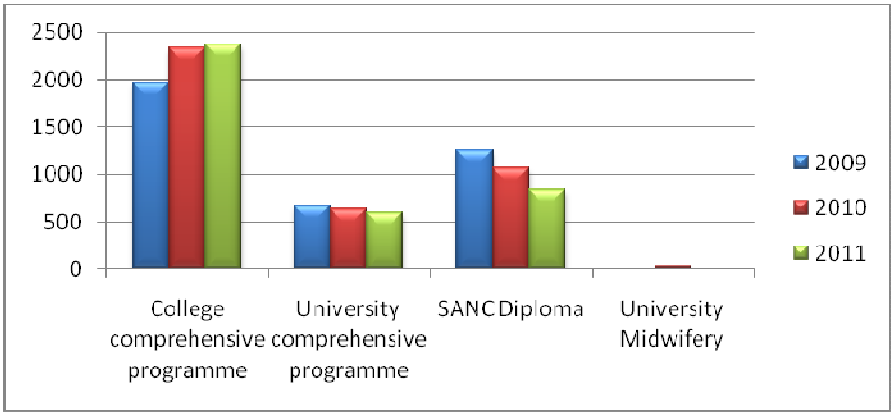
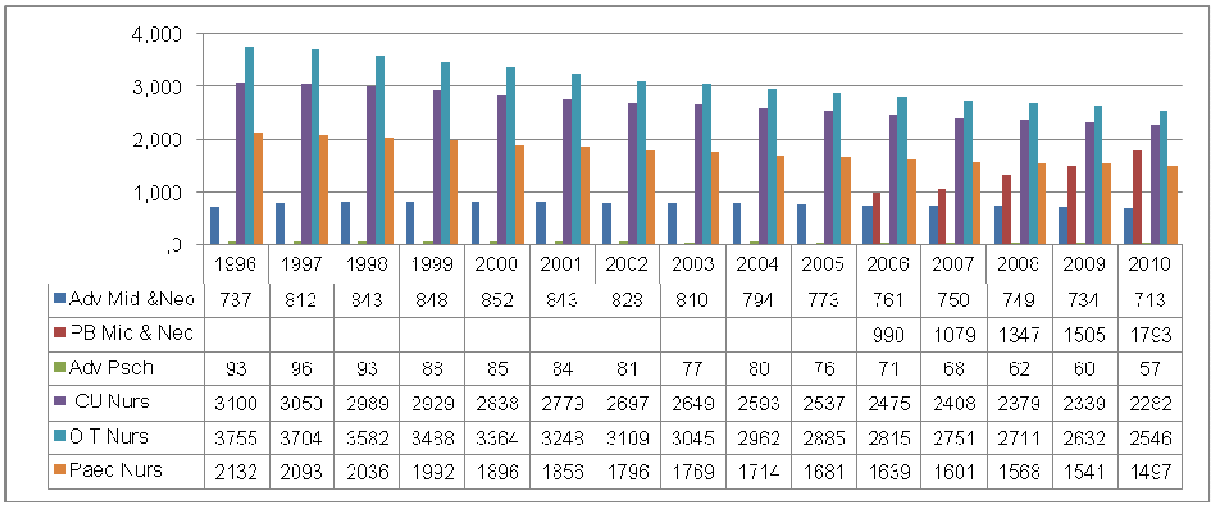


Figure 5: Production of midwives 2009 – 2011 (SANC statistics)

Of particular concern is the decrease in the production of nurses with specialist qualifications, particularly clinical specialisations. The new policies, in particular the re-engineered primary healthcare system, will drastically increase the need nurses with specialist qualifications [for example advanced midwives, child care nurses and family practice nurses (clinical assessment diagnosis, treatment and care skills)]



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Adv Mid &Neo	737	812	843	848	852	843	828	810	794	773	761	750	749	734	713
PB Mic & Nec											990	1079	1347	1505	1783
Adv Psch	93	96	93	83	85	84	81	77	80	76	71	68	62	60	57
CU Nurs	3100	3050	2989	2929	2838	2773	2697	2649	2593	2537	2475	2408	2379	2339	2282
O T Nurs	3755	3704	3582	3438	3364	3248	3109	3045	2962	2885	2815	2751	2711	2632	2546
Paec Nurs	2132	2093	2036	1992	1896	1853	1796	1769	1714	1681	1639	1601	1568	1541	1487

Figure 6: Nursing specialist qualifications1996 - 2010 (Source: SANC statistics)

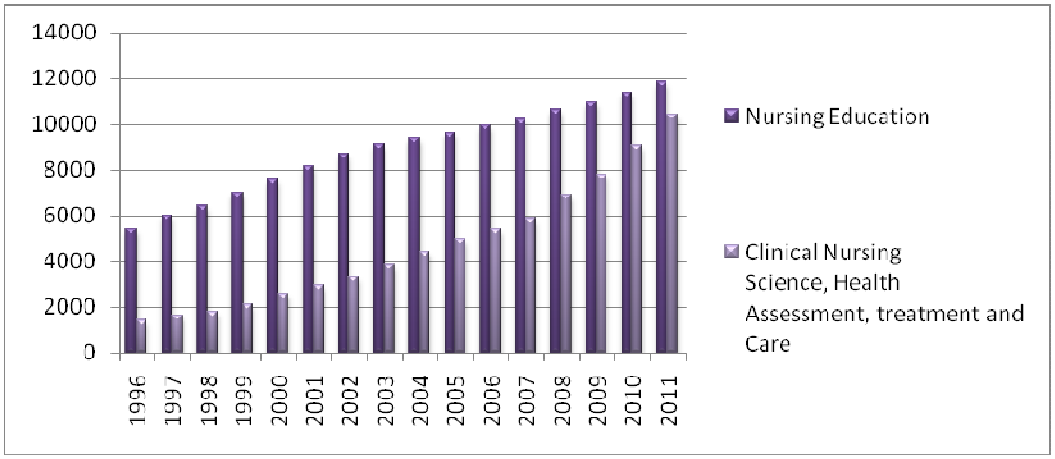


Figure 7: Growth of Nursing Education and Clinical Nursing Science, Health Assessment, Treatment and Care qualifications

4.1.2 Legislative framework

(i) The Constitution of the RSA Act, 1996 (Act No. 108 of 1996).

(ii) The National Health Act, 2003 (Act No. 63 of 2003) which provides for guidelines for service delivery in South Africa and allows for the Department of Health to publish regulations on education and training of health workers after consultation with the Minister of Education.

(iii) The Nursing Act, 2005 (Act No. 33 of 2005) and its related regulations which allows for the review of the scopes of practice for different categories and related education and training programmes.

(iv) Other health service related legislation, for example the Medicines and Related Substances Act (Act 101 of 1965); Mental Healthcare Act (Act 17 of 2002); Occupational Health and Safety Act (Act 85 of 1993); Births and Deaths Registration Act (Act 51 of 1992) and others.

(v) Education legislation, including the National Qualifications Act, 2008 (Act 67 of 2008); Higher Education Act, 1997 (Act 101 of 1997), and the Higher Education Amendment Act (Act 39 of 2008) which defines higher education as a national competence of the Department of Higher Education and Training (DHET) and NEIs have to be declared as Higher Education Learning Institutions based on compliance with the higher education criteria for registration.

(vi) Promotion of Equality and Prevention of Discrimination Act (Act 4 of 2000); Choice of Termination of Pregnancy Act (Act 92 of 1996); Children's Act (Act 38 of 2005) and others.

The National Qualifications Framework (NQF) Act, 2008 and the Higher Education Amendment Act, 2008 pose a potential challenge in nursing production as all nursing programmes are now pegged at levels in the Higher Education Band of the NQF. Therefore reading the Nursing Act (2005) in conjunction with the NQF Act (2008) and the Higher Education Amendment Act (2008),the qualifications for entry into the nursing and midwifery professions will in future be on the following levels (Table1):

(a) Certificate: Nursing Auxiliary at Level 5 replaces the Certificate in Enrolled Nursing Auxiliary at Level 3.

(b) National Diploma: Staff at Level 6 Nurse replaces the Certificate in Enrolled Nursing at Level 4.

(c) Professional Nursing Degree at Level 8 replaces the Comprehensive Diploma in Nursing (General, Psychiatry and Community) and Midwife at level 6.

Table 1: Nursing Education programmes and NQF levels

SANC Category	Qualification	NQF level	Duration
Registered Auxiliary Nurse	Higher Certificate	5	1 year
Registered Staff Nurse	Diploma	6	3 years
Registered Midwife	Advanced Diploma	7	1 year
Registered Professional Nurse & Midwife	Professional Degree	8	4 years
Specialist nurse	Post Graduate Diploma	8	1 year
Advanced Specialist Nurse	Master's Degree	9	1 year
Doctorate in Nursing	PhD	10	3 years

According to the Higher Education Act (Act 101 of 1997), higher education institutions can only be declared HEIs in terms of this Act. Currently public and private nursing colleges that are not HEIs have agreements with Universities to provide oversight and mentoring on the quality and standards of education and training at their institutions. These agreements will no longer be sufficient for the accreditation requirements for nursing institutions and their programmes after June 2013 when the current (legacy)[1] qualifications terminate.

4.1.3 Clinical education and training

Anecdotal evidence suggests that many nurses are not sufficiently competent in a number of different areas e.g. primary healthcare and midwifery. Clinical training departments are no longer in existence in the majority of health service institutions; there is insufficient supervision and management of students; and a general lack of good

[1]Legacy qualifications refer to nursing education programmes approved by SANC prior to the promulgation of the National Qualifications Act, 2008 and which will be terminated in June 2015.

clinical role models. There is disjuncture between the skills and competencies of nurse educators and those of nurses in clinical practice. This is exacerbated by the lack of communication between nursing education and practice. Research on the ability of newly qualified nurses to practice independently in different settings has found that students are dissatisfied with their clinical facilitation and accompaniment; they lack positive role models; do not apply certain theory in clinical situations; suffer high stress levels; and do not feel prepared to fulfil their roles.

4.1.4 Student status

Different funding models are currently used to fund students which impact on the status of students in nursing programmes. These range from receiving a salary (with all the benefits of employment), a bursary, a stipend, a learnership or being on study leave. Students who receive a salary are regarded as 'employees' protected by labour law. This leads to several challenges: difficulty to terminate their training when they do not meet the academic standards; overreliance of the employing institutions on their services; and potential abuse of privileges by the incumbent and failure of the employer to create learning opportunities and meet students' learning needs. On the other hand, students with supernumerary status enter the workplace to 'observe' nursing care in the clinical situation which also does not provide sufficient preparation for students to take up their role as qualified professional nurses on completion of training.

4.1.5 The National Audit of Public Nursing Colleges and Schools: A quantitative overview (June 2010)

In 2009, the national Department of Health commissioned an audit of all public nursing colleges and schools to inform human resource planning and financial investments required to improve infrastructure. The audit found that nurse education and training in South Africa is poorly coordinated and integrated; is characterised by considerable inequity regarding human resources as well as the physical plant (environment, buildings, etc); and programme outputs fall short of the required number of nurses per annum, a situation compounded by the increase in the attrition rate of nurses retiring, or leaving the health services or the country. At the time of the audit there were a number of 223 nursing colleges with sub-campuses and schools, the majority (56%) of which were public.

Delivery challenges identified by the audit include infrastructure and resource shortages; inaccessibility of clinical facilities due to distances between education and training sites and clinical facilities for practica and lack of transport; inadequate number of educators to accompany students; shortage of nurse accommodation and demonstration rooms.

The average age of nursing educators is high with 77% of nurses on the SANC register older than 40 years of which 17% of individuals were of retirement age in 2011. An educator resource plan and a comprehensive recruitment and retention strategy are required for nurse educators. The audit found that infrastructure ranged from state of the art structures to makeshift rooms unfit for purpose. Of these, 22% of the infrastructure required replacing, 8% required critical repairs, 24% required serious repairs whilst 46% required marginal repairs. There is an urgent need to develop building norms and standards for public nursing schools and colleges; torefurbish and regularly maintain infrastructure; to provide infrastructure according to a master plan, and to undertake an extensive audit of available infrastructure, linked to an assessment of the viability of institutions.

4.2 Resources in nursing

4.2.1 Nurse educators

Nurse educators face several challenges: there are insufficient numbers, particularly in rural or under-served areas; they face large work-loads in the face of increasing student numbers; there is inadequate continuing professional development which influences the quality of teaching and clinical accompaniment and supervision of students; lack of orientation or induction programmes for nurse educators, insufficient up-skilling in new technologies, lack of a structured strategy for nursing educators to acquire new knowledge and skills; and an exodus of nurse educators due to occupation specific dispensation (OSD) and rural allowance.

4.2.2 Nursing managers

Nursing managers are in a critical position to lead the implementation of many proposed health care reforms. However, nursing managers face several challenges, including numerous competing demands, lack of formal authority and control over resources, lack of or outdated job descriptions, lack of support from superiors, problematic relationships with doctors, and staff absenteeism, amongst others.

4.2.3 International benchmark

The need to scale up educational programmes to produce more doctors, nurses, midwives and other health professionals is recognised internationally, juxtaposed with the clear challenges facing health professional education which include weak stewardship and leadership to improve health system performance, poor coordination between the health and education ministries, funding constraints, and insufficient prioritisation to investing in health professional education.

4.3 Professional Ethos

4.3.1 Declining status of nursing

Anecdotal evidence, supported by some research studies, suggests that the standards of nursing have dropped and that the image and status of the profession have declined. This was extensively discussed by nurses at the National Summit. The majority of nurses continue to work in the public sector, which is challenged by staff shortages, inconsistent staff patient ratios, lack of equipment, shortages in medication and other supplies and workplace violence, which impacts on the quality of service delivery and nursing morale. Media reports describe conditions at public hospitals as ‘appalling’ and ‘shocking’, with healthcare professionals working in harsh conditions. Reports also highlight lack of professionalism and unethical conduct, with nurse-patient relationships characterised by poor communication, and incidents of violence and abuse.

4.3.2 Nursing ethics

There has been a progressive move from responsibilities to rights despite efforts to link the two concepts and there is often a tension (and at times conflict) between the rights of the nurse and the rights of the patient. Nurses report feeling maligned and under-valued and are resentful of community views that their ‘attitudes’ are ‘bad.’ While nurses recognise unsatisfactory ethical behaviour, and although ethics is values-based and intrinsic, their psycho-social working environment is overwhelmingly negative, making it virtually impossible for nurses to resolve the problems on their own. Stakeholders need to engage in large scale efforts to restore pride in the profession and improve ethical behaviour of nurses with the support of others.

4.3.3 Moral distress

Moral distress is a real problem amongst nurses which is seldom discussed. Nurses are involved in morally significant relationship with their patients, but have limited power to respond to what appears to be 'wrong'. When they cannot do what they think is right or their personal or professional values are violated, they experience moral distress that leaves a moral residue which can influence their personal and professional lives. One consequence of moral distress is that nurses may avoid patients or be over attentive to them because they feel guilty about is happening.

4.3.4 SANC Professional Conduct cases

The SANC statistics reveal that complaints against nurses have increased three hundred fold since 1996. In the majority of cases there is an indication of a negative attitude of the nurse practitioner that eventually led to an act or an omission which constitutes misconduct. These transgressions include cases of rape and other human rights violations. From the SANC's reported professional misconduct cases from 2003 to 2008 (Table 2), it is clear that the rights of both patients and nurses were violated.

Table 2 SANC Professional Conduct Cases 2003-2008

	Number of Persons						
Type of Offence	2003	2004	2005	2006	2007	2008	TOTAL
Education related	-	3	6	5	-	5	19
Fraud/forgery	-	11	3	7	12	3	36
Maternity related	5	28	34	26	33	9	135
Medication related	4	54	39	13	24	9	143
Physical assault of colleague	-	3	2	6	1	3	15
Physical assault of patient	-	8	5	2	3	1	19
Poor basic nursing care	28	142	90	40	72	22	394
Section 36 (see note)	-	15	5	7	13	7	47
Sexual abuse of patient	-	4	15	7	3	2	31
Theft	-	2	-	-	2	-	4
TOTAL	37	270	199	113	163	61	843

4.4 Governance, leadership, regulation and policy

In the pre-summit workshops held throughout the provinces in 2011, several recurring themes emerged which could be addressed by improved governance, policy, legislation and leadership. Failure to do so would worsen the nursing shortage and further jeopardise the delivery of safe patient care.

4.4.1 Governance and regulation of the profession

South Africa was the first country in the world to achieve state registration for nurses, and the establishment of the SANC in 1944 was a significant milestone in the governance and regulation of the nursing profession. Professional governance is vital to protect the public by ensuring quality nursing education through appropriate legislation

and regulations; ensuring quality nursing practice through defined scope of practice and through legislation; setting standards to meet population health and care needs; and ensuring continuing professional development of all nurses.

The MTT is concerned about the Council's governance, notably its sub-optimal leadership and stewardship which has impacted on its professional governance role. The type and quality of the data on the SANC database is inadequate to assist with HRH planning. Council inefficiencies have impacted negatively on the finalisation of regulations on nursing education and training and the scopes of practice, the accreditation of new nursing education institutions/practice settings and programmes, and the re-accreditation of existing nursing education institutions and programmes. Delays in conducting regular quality assurance inspections in nursing education and training and in the registration of all categories of nurses are further concerns.

4.4.2 Regulatory developments

The development of regulations to the Nursing Act, 2005 has been slow and development needs to be speeded up. In particular the lack of regulations to govern the nursing agency sector and healthcare workers is a concern. The regulation of nursing agencies now resort under the National Health Act, 2003 and therefore no regulation exists at this stage while no regulation exists to govern healthcare workers.

4.4.3 Leadership and management capacity

There has been a steady decline in formal, dedicated nursing leadership positions at national and provincial healthcare service organisations in South Africa with a growth in non-nurse practitioners in leadership and management positions. This management approach has inadvertently led to the loss of direction and declining morale of nurses and midwives.

Lack of management capacity has been identified as a key stumbling block to health delivery in South Africa. The loss of experienced nurses through voluntary severance packages in the late 1990s and the migration of nurses and midwives either internationally or out of the health services have decreased the expertise at front line clinical as well as at management levels. Middle management is an important source of support, mentorship and role modelling of excellence in nursing care for new entrants

into the profession. This has created a continuous spiral of loss of nursing and midwifery skills and expertise in the clinical area.

Despite nursing managers being central to overcoming the challenges facing delivery, there is insufficient research that analyses which competencies are important for nursing management and whether managers possess these skills.

4.5 Positive Practice Environments

In South Africa nursing shortages, unrealistic workloads, poorly equipped facilities, unsafe working conditions and perceived unfair compensation are among some of the factors affecting the work life and performance of nurses and midwives and other healthcare professionals and healthcare workers. This not only jeopardises quality patient care, but also the quality of practical training and exposure of nurses, midwives and all other healthcare professionals. **Positive Practice Environments (PPE)**are cost-effective healthcare settings that support nursing excellence as well as decent work, have the power to attract and retain staff and to improve patient satisfaction, safety and outcomes. Characteristically such settings:

- ensure the health, safety and well-being of staff;
- support quality patient care;
- improve the motivation, productivity and performance of individuals and organisations.

4.5.1 Positive working environments

Poor quality workplaces in health systems weaken the ability of employers to meet the organisation's performance targets, quality healthcare outcomes and make it more difficult to attract, motivate and retain staff. There are key elements in the workplace that strengthen and support the workforce and in turn have a positive impact on patient outcomes and organisational cost-effectiveness. These factors, when in place and supported by appropriate resources (both financial and human), go a long way in ensuring quality healthcare, the establishment and maintenance of an effective healthcare professional workforce and ultimately the overall quality of health systems.

4.5.2 Nurses' workload and non-nursing responsibilities

Since 2003, the SANC received several letters of complaints from nursing professionals describing their working conditions as 'unbearable' and stating that nurses can no longer

'cope' with the workload. The complaints highlighted the multitude of tasks expected of nurses: to change bulbs, open blocked drains, clean, dispense and operate as ambulance drivers and undertakers using their own cars. Reasons cited by nurses for leaving the country were that they were not valued by their managers, the communities they serve and the system as a whole.

4.5.3 Lack of compulsory Continuous Professional Development (CPD) System

There has been little progress in finalising the CPD system – one of the concerns about the SANC's governance role. CPD is an essential component to ensure a positive practice environment which will promote staff development that will contribute to improved competence, and skills development, better staff morale and motivated workforce.

4.6 Compensation, benefits and conditions of service

Nursing and midwifery are known as the caring professions which are dependent on expert knowledge and skills. As employees, nurses are required to be competent to deliver services to patients, and are entitled to appropriate compensation, benefits and the right to work in an environment where they can deliver quality health services. The situation particularly in the public health sector has not been supportive of quality service delivery; but both in public and private sectors, abuse and bullying has led to low morale and a high turnover amongst clinical nursing staff. Research has found that salaries are not the main influence affecting motivation of nurses. Lack of trust was identified as de-motivating and linked to uncaring behaviour towards patients. The lack of management skills and the delay in implementing CPD further exacerbate these challenges.

4.6.1 Occupation Specific Dispensation (OSD)

Nurses eagerly anticipated the introduction of OSD which it was thought, would attract back those nurses that had left the health services and would recruit young adults into the nursing profession, and retain those who were still in the public sector. In many instances, OSD resulted in nurses' salary improvements and facilitated the ability of public sector to attract nurses with specialised skills. However, the OSD implementation was characterised by inadequate planning, weak managerial practices and uneven and inconsistent interpretation of the agreement, which resulted in many disgruntled and de-motivated nurses in the public sector.

4.6.2 Contemporary white uniform

Contemporary uniforms create a professional image, make practitioners identifiable, instil confidence amongst patients and communities and create a sense of belonging and identity for practitioners. Currently nurses either wear multi coloured and multi styled uniforms or adorn their uniforms and appearance inappropriately, which do not contribute to this identity. While such uniforms must enable nurses and midwives to perform their physical duties during patient care, it must also portray a professional image.

Traditionally nurses wore white uniforms but this practice has changed over time particularly when nurses started buying their own uniforms. The Nursing Summit Compact includes a recommendation from the delegates that nurses should revert back to wearing white uniforms.

4.7 Nursing human resources for health (HRH)

4.7.1 Nurse staffing norms

Guidelines for the number of nurses who should be employed in a healthcare institution and in the community are essential for safe patient care and healthcare planning. Traditionally population-based norms were used to determine this. However, WHO now recognises that activity-based norms may be a more effective method of determining staffing needs for health, as they account for numbers of patients, types and location of services which determines the number of nurses and the skills mix required. The 'nurse to patient' ratio ultimately determines the nurse's workload, job satisfaction and the effectiveness of care, and correlates with mortality rates in hospitals and other nurse sensitive indicators. The MTT proposes that South Africa adopts a combination of population-based norms and the WHO activity based workload approach to determine safe staffing norms.

4.7.2 The shortage of nurses

Vacancies are regularly used as an indicator of the shortage of health professionals, including nurses. However, perceived nursing 'shortage' and matched high vacancy rates are not a reliable basis for nurse workforce planning. The data are not based on accurate staffing requirements derived from realistic assessments of workload, productivity and the staffing requirements given the new staff nurse category and the

implications for skills mix. The MTT proposes that norms be determined which will inform the staffing gap, and on that basis will provide informed guidelines for vacancies that should be filled.

There is a gap between number of nurses who successfully completed their educational programmes each year and those register with the SANC. The attrition rate of nurses who complete their training but do not register the following year is estimated at 40%. Throughput (the number of nurses that enter training and actually qualify) is informally estimated at about 50% but requires investigation. An estimated 18% of nurses on the SANC register are not actively working. Table 3 shows the estimated 10-year future supply of nurses based on these assumptions regarding attrition and numbers actively working.

Table 3: Future supply of nurses 2009 – 2020

	2009	2010	2012	2015	2018	2020
Projected output of all categories of nurses	15,910	16,674	18,313	21,078	24,262	26,647
60% who register in the NEXT year	9,546	10,004	10,988	12,647	14,557	15,988
Total registered & enrolled with the SANC	221,817	231,363	251,852	286,422	326,214	356,026
18% not actively working in SA	39,927	41,645	45,333	51,556	58,718	64,085
Total nurses actively working in SA	**181,890**	**189,718**	**206,518**	**234,866**	**267,495**	**291,942**
Nurses per 100000pop	369	383	413	462	519	560

Source: ECONEX Reform Note 9, 2010

While the number of nurses per 100 000 population seems favourable, the mix of nursing categories is skewed, with a significant decrease in the proportion of Registered Nurses (RNs) in recent years. RNs comprise only 16% of new nurses registering, and are estimated to decline from 50% in 2009 to 37% in 2020. RNs are older than the other categories with 43.7% being over 50 years old and retiring at a rate of 3000 per year for the next 10 – 15 years. Training and retaining RNs needs urgent attention given the need to improve skills and improve healthcare access with the introduction of NHI and the re-engineering of PHC. International trends are to train all nurses at degree level. In South Africa, approximately 20% of professional registered nurses are trained at universities and 80% at nursing colleges.

4.7.3 Supply of nurseswith specialised qualifications

There is a gradual decline in the number of nurses with specialised qualifications, for examplecritical care nursing, child care nursing, operating theatre nursing,advanced midwifery and advanced psychiatry. Surgeons in public sector hospitals report that operating theatre time is constrained by the lack of available specialist nurses, while the private sector has raised the need to recruit internationally for nurses with specialised qualificationsand to train operating theatre assistants to fill the gap of operating theatre nurses.

4.7.4 The implications of changes to nursing categories

According to the Nursing Act (33 of 2005) the existing categories of nurses will change as indicated in table 1 presented earlier. These changes are significant, placing all nursing qualifications in the HEQF (NQF 5 and higher), highlighting the need for better skills and meeting the demand, in particular the development of specialist nurses and recognition of their qualifications. New modelling of future supply is required to determine the planned demand, coupled with detailed education forecasts to produce the appropriate numbers and categories. The activity based safe staff nursing norms approach will help to address this.

4.7.5 Implications of new staff nurse category and PHC re-engineering

Districts comprise three main types of health facilities: district hospitals, community health centres and clinics. Each clinic will have up to three PHC outreach teams working within the community and at the clinic. Each community outreach team will be responsible for around 1500 households, approximately 6000 people.The team will include a professional nurse (who is also a competent midwife), a staff nurse (to provide basic care to persons with stable and uncomplicated general health problems in a PHC setting), an enrolled nursing assistant (ENA) (to perform routine observations, weighing and measurements, basic support and care), a part-time doctor, and a part-time primary health care nurse practitioner (PHCN) who will handle complex cases and be responsible for the clinic management and the supervision of support staff. The staff quota and teams for the re-engineered PHC model should provide impetus to address current shortages and poor output, but a strong training and staff planning strategy is required. The involvement of up-skilled nurses to manage the implementation of changes is essential.

4.8 Policy framework

Against this background, the Ministry of Health has committed itself to a substantial overhaul of the public health sector to respond to the health needs of all the people of South Africa. Nurses and midwives are critical to the achievement of the new policy initiatives which include:

4.8.1 a national HIV testing and counselling campaign for every South African to know their status. Every clinic or health service is required to offer this service to their clients;

4.8.2 task shifting to enable nurses and midwives to initiate and manage patients on antiretroviral treatment who were previously excluded from this highly technical task;

4.8.3 the re-engineering of PHC to focus the bulk of healthcare at the this level, including the institution of municipal ward-based primary healthcare agents; school-based PHC services and District Clinical Specialist Support Teams in 560 districts in the country;

4.8.4 revision of the HRH Strategy to address the numbers of practitioners of different categories to be trained to meet the country's needs; and

4.8.5 the initiation and implementation of a NHI system over the next 14 years.

5. Strategic Priorities

The following strategic thrusts have been identified as priorities to address the challenges facing nursing:

5.1 Nursing Education and Training

5.2 Resources in nursing

5.3 Professional Ethos

5.4 Governance, Leadership, Legislation and Policy

5.5 Positive Practice Environments

5.6 Compensation, benefits and conditions of service

5.7 Nursing Human Resources for Health.

5.1 Framework: Strategic Plan for Nursing Education, Training and Practice 2012/13 – 2016/17

The Strategic Plan for Nursing Education, Training and Practice 2012/13 – 2016/17 is based on the following framework. Given the complexity of the nursing education and training in South Africa's health system, the themes are complementary rather than exclusionary, and the framework should be taken as an integrated rather than a silo approach.

Priority	Strategic Plan: Nursing Education, Training & Practice 2012/13 – 20/1617
Strategic Priority1	**Nursing Education & Training**
Strategic objective 1.1	4. By 2013, there should be a national nursing education policy in place positioning nursing education in higher education.
Strategic objective 1.2	5. By 2014, dedicated structure should be in place to implement the proposed clinical education and training model for nurses and midwives.
Strategic objective 1.3	6. By 2013, there should be a national policy in place on student status and a funding model for students in nursing programmes.
Strategic Priority2	**Resources in nursing**
Strategic objective 2.1	4. By 2014, there should be dedicated nursing structures at national, provincial and local government levels, including the appointment of a dedicated person within the national CNO portfolio to provide leadership and stewardship for nursing education.
Strategic objective 2.2	5. By 2015, a national framework on nurse educator development with dedicated resources should be in place.
Strategic objective 2.3	6. By 2015, a clear support and development framework for nurse managers should be in place.
Strategic Priority3	**Professional Ethos**
Strategic objective 3.1	5. By 2014, a comprehensive programme to restore ethics and respect in nursing should be in place and being implemented by stakeholders.
Strategic objective 3.2	6. By 2014, a comprehensive programme should be in place to promote the nursing profession at school level to attract a good cadre of nurses.
Strategic objective 3.3	7. By 2014, ethics should be mainstreamed in all basic and post basic nursing programmes as well as in-service training.
Strategic objective 3.4	8. Promote collaborative partnerships on an ongoing basis to unify nurses and midwives.
Strategic Priority4	**Governance, Leadership, Legislation and Policy**
Strategic objective 4.1	5. Ensure the effectiveness of SANC in the execution of its mandate on an ongoing basis.
Strategic objective 4.2	6. By 2014, there should be regulations to govern the nursing agencies
Strategic objective 4.3	7. By 2017, there should be a mechanism to regulate community health workers.
Strategic objective 4.4	8. Promote institutional governance and leadership on an ongoing basis
Strategic Priority 5	**Positive Practice Environments (PPE)**
Strategic objective 5.1	5. By 2014, there should be a structured roll out and monitoring plan on PPE, developed in conjunction with the proposed Office of Standards Compliance.

Strategic objective 5.2	6. By 2014, there should be a framework to recognise post graduate qualifications in nursing and midwifery.
Strategic objective 5.3	7. By 2014, there should be CPD system for nurses and midwives ready for implementation.
Strategic objective 5.4	8. Improve the use of Information Communication Technology (ICT) in nursing and midwifery care provision on an ongoing basis.
Strategic Priority6	**Compensation, benefits and conditions of service**
Strategic objective 6.1	4. By 2014, an agreement on an improved OSD for nurses should be in place.
Strategic objective 6.2	5. To improve incentives to promote retention and recruitment of nursing staff on an ongoing basis. **6.** By 2014, all employers should provide nurses and midwives with white contemporary uniforms.
Strategic Priority7	**Human resources for health**
Strategic objective 7.1	7. By 2014, develop a model which provides information on the future supply of nurses for the public and private sectors, for hospitals, PHC and NGOs (including the new staff nurse category).
Strategic objective 7.2	8. By 2015, SANC should have improved data quality on nurses and ensure a database which details qualifications, location of employment, country of employment, employer, and other relevant details in consultation with nursing stakeholders.
Strategic objective 7.3	9. By 2015, there should be a SANC database developed which details education institutions and their output, production and employment of nurses by district and province for the public and private sectors
Strategic objective 7.4	10. By 2015, the project to develop safe nurse staffing guidelines based on draft guidelines for hospitals and PHC developed by the MTT should be implemented; and the nurse staffing gap by category and the training implications based on safe nurse staffing guidelines determined.
Strategic objective 7.5	11. By 2015, the financial implications of nurse training and nurse employment to meet the PHC policy requirements and safe staffing guidelines for hospitals in the public sector should be determined.
Strategic objective 7.6	12. Develop strategies to increase the return of nurses who have left the profession.

5.2 High level business plan

There is agreement on the proposals.A business plan and a budget must be made available for the activities listed in the strategic plan. The CNO will be appointed to drive the implementation of this strategy.

Strategic Priority 1 Education and Training

The primary aim of nursing education and training is to provide adequate numbers of competent, caring nurses to meet the health needs of the country. Nursing education and training programmes should be harmonised with health service delivery needs while ensuring that qualifications obtained are commensurate with the scopes of practice and relevant legislation. Nursing education reforms must involve strong collaboration between the higher education and health sectors and other relevant stakeholders to ensure success. Nursing education and training should be a national competence accounting to the Director-General of Health. Nursing education reform must address the following:

- Quantity of different categories of nurses produced in the country.
- Quality and relevance of nursing graduates in order to achieve improvements in population health outcomes.
- Health system needs to ensure that qualifications are commensurate with scopes of practice;
- Challenges of teaching platform (quality of health facilities and of supervision/management) capacity and quality of NEIs.

1.1 Develop a national nursing education policy

The execution of such a national strategy will requirenecessary resources and a comprehensivepolicy which clarifies the roles of all stakeholders.

1.2 Status of public colleges

The nursing departments/schools within universities can neither absorb nor produce the numbers currently being trained at nursing colleges. The way forward for public nursing colleges has to be decided urgently to ensure that production of nurses continue, since public colleges are responsible for producing the largest number of nurses and will not be able to train and educate nurses after June 2015 if they are not accredited by the CHE.

1.3 New Model for Clinical Nursing Education and Training

Newly qualified nurses experience significant challenges when entering clinical practice. A model which better correlates theory and practice has been developed for

implementation. Clinical education and training must be strengthened by re-establishing clinical teaching departments/units at all NEIs or hospitals, supported by a co-ordinated system of clinical preceptors and clinical supervisors and funding to support the endeavours.

1.4 National policy on student status and funding model for nursing students

Funding of students requires a nationally acceptable model that facilitates the production of clinically competent practitioners, and which emphasises student status over employee status which prioritises learning and the attainment of learning objectives.

1.	Strategic objectives
1.1	Develop a national nursing education policy
1.2	Position all NEIs in higher education as higher education institutions
1.3	Implement a new Model for Clinical Education and Training
1.4	Establish a national, uniform policy for student status and funding support

Recommendations for Education and Training

1.1 Develop a national nursing education policy

Position nursing education and training as a national competence accounting to the Director General of Health to address provincial inequalities, the development of norms and standards, quality, clinical training, student status and fragmentation between NEIs and provinces. The office of CNO is instrumental in facilitating the task to develop a national policy for nursing education and training.

1.2 Status of public colleges

- Urgent engagement between the national Department of Health and the Department of Higher Education and Training to facilitate the process of incorporation of public nursing colleges and their programmes into the higher education sector, so that the production of nurses is not affected. Office of the CNO should establish a task team to draft a Public Nursing Colleges Act.
- Finalise an accreditation framework for NEIs and their clinical training facilities using SANC and CHE criteria and the national core standards.

1.3 New Model for Clinical Nursing Education and Training

- Implement the Model for Clinical Education and Training with structural support and resources as indicated in the implementation plan.
- Appoint a Working Group to champion the implementation of this model consisting of the nursing education stakeholder (NES) group and two Human Resources representatives from the national and provincial Departments of Health.
- The new SANC regulations must incorporate the recommendations of the Model for Clinical Education and Training accepted at the 2011 Nursing Summit.
- Re-establish clinical teaching departments/units at all NEIs or hospitals supported by a coordinated system of clinical preceptors and clinical supervisors.

1.4 National policy for student status and funding support

- Award full student status[2] to students in nursing programmes.
- Develop a national funding model for nursing students which includes student accommodation and uniforms.
- The Department of Health should develop a national funding model for nursing students which include uniforms and student accommodation in consultation with relevant stakeholders. Foreign students from countries must be funded by their respective countries. Funding should be available for the minimum prescribed period for the programme that students are enrolled for plus, one additional year which allow for one year extension of the study programme. Allocate continued funding based on academic as well as clinical performance and completion of clinical requirements.
- Compel students with a contract to work for the state for same period as they were funded for, inclusive of the community service year, to retain the skills for the public health sector.

[2] Nursing students must have the status of full student (rather than employee) while undergoing their training. They must receive funding support for tuition, books and study materials, living costs, inclusive of medical aid and indemnity insurance, paid monthly, while tuition fees are paid directly to NEIs. Accommodation, uniforms and transport for training must be provided. Clinical exposure for learning skills and roles is compulsory and must ensure competence on conclusion of the basic training programme. Therefore, students must work full shifts at different times of the week and day to ensure adequate exposure in preparation to take up their role as clinical practitioners.

Strategic Priority 2 Resources in nursing

Resources in nursing education represent a core element of achieving the reconstruction and revitalisation of the nursing profession

2.1 Nursing portfolio

The appointment of a Chief Nursing Officer and relevant nursing at all levels of government are essential to facilitate the finalisation of the revised nursing strategy and in order to move forward. Executing the strategy effectively requires determined leadership, pragmatic implementation plans and ongoing monitoring and evaluation.

2.2 Nurse educator development

There have been many positive developments in nursing education in South Africa in the last decade. To meet the needs of nursing education, a national nurse educator development framework is essential to ensure sufficient numbers of appropriately qualified nurse educators in both clinical and theoretical spheres of nursing.

2.3 Nurse manager development

Leadership and management are fundamental for good health outcomes, and depend on adequate numbers of managers, adequate competencies of managers, functional support systems and enabling work environments. These management competencies should be specified for different levels of the health system and programmes/courses should be multi- and interdisciplinary.

2.4 Nurses with specialised qualifications

In light of the decrease in the training of nurses with specialised qualifications (figures 6 and 7), there is a need for increasing training in specialist care, in particular advanced midwifery, child care nursing and primary healthcare in order to address maternal and child mortality in South Africa and to fulfil the requirements of the re-engineered primary healthcare system.

2.4 Direct entry midwifery programmes

Within the current South African context where there is a shortage of nurses and midwives and in the absence of a separate regulatory framework, the MTT does not recommend direct entry midwifery training. The MTT is of the view that South Africa

cannot afford nurses who have very specific training and who are unable to address the quadruple burden of disease, and the needs of a complex health care system. Rather, the country requires comprehensive, multi-skilled practitioners with the skills to recognise and manage a broad range of conditions, and work independently in different health care settings

2.	**Strategic objectives**
2.1	Develop a national nursing portfolio
2.2	Develop and re-orient nurse educators to ensure sufficient numbers of well-trained educators to meet the requirements of the revised strategy
2.3	Develop and re-orient nurse managers with the requisite management competencies
2.4	Increase the number of specialist nurses

Recommendations for Resources in Nursing

For Nurse Educators:

2.1 Structural arrangements

- A permanent chief nursing officer should be appointed in the national Department of Health
- A dedicated person should be appointed within the NDoH to provide leadership and stewardship for the nursing education portfolio.
- This person should report to the Chief Nursing Officer.
- The person should develop a National Plan to update all nurse educators to meet the requirements of the various nursing education reforms once finalised (qualifications framework & requirements of higher education).

2.2 Revision of SANC requirements for registration as nurse educator

- The SANC requirements must be revised to take into account the science and art of teaching and graduating nursing students.
- The core competencies required for prospective nurse educators must be stipulated, and should include inter alia: competencies in interpersonal relationships (including conflict resolution), clinical speciality or area of instruction, teaching and learning

methodologies, supervision of theoretical learning and clinical practice, research methods, knowledge of technology in education, ability to teach/mentor in a clinical environment (not just clinical competence), assessment methods; involvement in policy development and implementation; and leadership.

- The practical component should be commensurate with the attainment of competent education practice and all nurse educators must ensure ongoing clinical competence.
- SANC should prioritise CPD for nurse educators.

2.3 Dedicated earmarked funding

Dedicated ear-marked funding should be available for a nurse educator framework (similar to the Clinical Training Grant provided by the Department of Education to universities):

- Each NEI should be allocated at least 0.5% of their personnel budget to nurse educator development.
- The NDOH should commence with the allocation of seed money of R3 million per province in 2013/14 financial year, expanding over the MTEF period, to start innovative programmes that target nurse educators.
- Provincial and private sector bursaries should target nurse educators specifically.
- Funding is also required for scholarly activities (ongoing educational programmes, study leave, CPD); sabbatical leave – the principle is supported and it is motivated that funding be available to ensure replacement of educator (locum) whilst on sabbatical leave; research support (seed money for studies, statistical and methodological support/supervision).

2.4 Increase number of residential universities that offer postgraduate qualifications in Nursing Education

- The majority of nurse educators obtain their qualifications through distance learning. Although advantageous, this approach also presents challenges with the preparation of educators in practical training and clinical exposure. Hence, there should be an increase in the number of resident universities that offer postgraduate qualifications in Nursing Education.
- There should be an integrated approach to the education of the nurse educators, with education, service and nursing experts involved in delivering the curriculum, including

the teaching and learning experiences.

2.5 Develop a specific recruitment and retention strategy for nurse educators

Tthe career path of nurse educators as well appropriate as remuneration (for example OSD) should be reviewed. There should be recognition that retention is difficult in current small NEIs where academic advancement is often constrained by the number of posts available at different levels. This is also a problem with the status of nursing in faculties of health sciences and should also be addressed. Joint posts, similar to their medical counterparts or academic and clinical posts with equal status, should be investigated.

For Nurse Managers:

2.6 Recognition for different levels

There should be recognition that there are different levels of nursing competencies, depending on whether it is an executive nursing manager, an area nursing manager or a hospital unit or PHC facility nursing manager.

2.7 Review of the content of nursing management courses and teaching methods

Competencies for different levels of nursing management should be defined, and should include inter alia, competencies in financial and human resources, care management, quality, and managing the implementation of complex healthcare reforms

2.8 Merit-based promotion

Implement an open and transparent merit - based promotion system for nursing management positions.

2.9 Mentoring Programme

Emerging managers should be identified and allocated mentors from experienced nurses of a senior rank who are respected and keen to teach and assist.

2.10 Managers' forums

Managers' forums should be set up at district or sub-provincial level where managers from both public and private sectors can share successes and challenges and learn from each other. These forums should be allocated resources and formally recognised.

For nurses with specialised qualifications:

2.11 Increase access to education and training

Access to education and training programmes for clinical specialisation must be made available to enable practitioners to enrol and complete programmes. This includes the provision of study leave and financial support.

2.12 Clinical career paths

To retain nurseswith specialised qualifications in clinical practice, career paths commensurate with post graduate qualifications must be created to ensure that practitioners have equal opportunity to remain in clinical practice. This requires the negotiation for specific positions at healthcare establishments and regulated recognition by the SANC.

Strategic Priority 3 Professional Ethos

While nursing is recognised in South Africa as an essential component of the healthcare delivery system, it is faced with a number of challenges. Some of these challenges are what have given rise to diminished staff morale brought about by the unhealthy environments in which nurses work. Previous research on the nursing profession in South Africa substantiates anecdotal evidence that the standards of nursing have dropped and that the image and status of the profession have declined.

3.1 Comprehensive programme

As the nature of nursing is closely linked and intertwined with the society it serves, there is a need to re-establish the noble and caring nature of nursing, taking into account the socio-political milieu which impacts on nursing. This necessitates intervention in the form of a comprehensive programme to reinstate the professional ethos in the profession, to market the profession in a positive way to the public and as a career of choice to potential nursing recruits.

3.2 Promote nursing as a career of choice

The nursing shortage presents a big challenge to service delivery in the country. Inconsistencies in nursing education with the closing and the subsequent merger of

nursing colleges have caused a decline in the number of comprehensively trained professional nurses. In addition, private nursing schools are also producing a large quantity of a lower category of nurses who are mostly suited for urban areas and are ill prepared for PHC. There is a need to improve the image of nursing and to promote nursing as a career of choice.

3.3 Mainstream ethics in nursing training

The MTT proposed mainstreaming of an ethics programme specifically aimed at rebuilding the professional ethics, nobility and image of the nursing profession.

3.4 Promote collaborative partnerships to unify the profession

Given the multifaceted nature of challenges within nursing, it is essential that relevant stakeholders within the profession work cohesively in finding ways to address these challenges in an attempt to restore the nobility of the nursing profession. These include nurses themselves, the communities they serve, nurse educators, nurse managers as well as nurse researchers. It is therefore imperative that the proposed programme aimed at improving the image of nursing be developed to complement the current developments in the healthcare system of the country.

3.	Strategic objectives
3.1	Implement a comprehensive programme to restore ethics and respect in nursing
3.2	Promote the nursing profession at school level to attract a good cadre of nurses
3.3	Mainstream ethics in basic and post basic nursing training
3.4	Promote collaborative partnerships to unify nurses

Recommendations for Professional Ethos

3.1 Comprehensive programme

- Implement a comprehensive programme to reinstate the professional ethos in the profession, to market the profession positively as a career of choice to potential recruits for nursing programmes.
- Focus the proposed programme on nursing and midwifery practice, nursing education and training, the national nursing association and other professional organisations and the regulatory body.

3.2 Promote nursing as a career of choice

- Focus the implementation of the proposed programme on both current nurses and prospective nurses or recruits into nursing.
- Ensure that recruitment of nursing students is in line with the established values and ethos of nursing. This implies that the selection of students is the responsibility of the nursing fraternity.

3.3 Mainstream ethics in nursing education and training

- Include professional and work ethics as compulsory components of in-service education and CPD programmes for all levels of education and training and practice of nursing and midwifery.
- Include ethics, innovative teaching, group studies and electronic media in the development and reorientation of educators.

3.4 Promote collaborative partnerships to unify the profession

- Strengthen links between societies, organisations and NGOs for human caring to strengthen their work. This could be done by a structure such as the DENOSA Professional Development Institute (DPI).
- Profile the role of professional organisations and employers in assisting nurses to work together.
- Revive and coordinate the professional associations which give the professional a sense of belonging and enhance motivation and professionalism.

Strategic Priority 4 Governance, Leadership, Regulation and Policy

Governance, leadership, legislation and policy constitute the core of the nursing profession which provides direction and guidance for professionalism.

4.1 Promoting SANC's effectiveness

The SA Nursing Council (SANC) is the custodian of the nursing and midwifery profession as it provides oversight over nursing practice and nursing education in line with the Nursing Act of 2005. The Summit resolved that the SANC needed to accelerate its execution of this role following numerous concerns during pre-Summit provincial consultations and at the Summit in 2011 about the SANC's ability to provide the necessary services with existing resources. The current Council's term expires July 2013, and proactive steps must be taken to ensure continuity of services between the outgoing and new Council.

4.1 Regulating nursing agencies

In view of the shortage of nurses, nursing agencies have an important role to play to ensure the continuity of service delivery. Therefore the development and implementation of regulations for nursing agencies require urgent attention to ensure ethically and legally compliant service delivery.

4.2 Promoting the regulation of community health workers

Community health workers are an important component of the South African healthcare system who should be accredited and undergo training in line with the NDoH plan. Regulation of this category of health worker is also necessary.

4.4 Promoting institutional governance and leadership

The Nursing Compact contains a resolution on the need for a Chief Nursing Officer (CNO) at Deputy Director-General (DDG) level with nursing expertise. An acting CNO was appointed at the national Department of Health in October 2011. A nursing leadership structure (figure 7) should now be established to give nurses at national and provincial levels executive authority over nursing and midwifery services, and be responsible for dealing with the bulk of challenges in the profession.

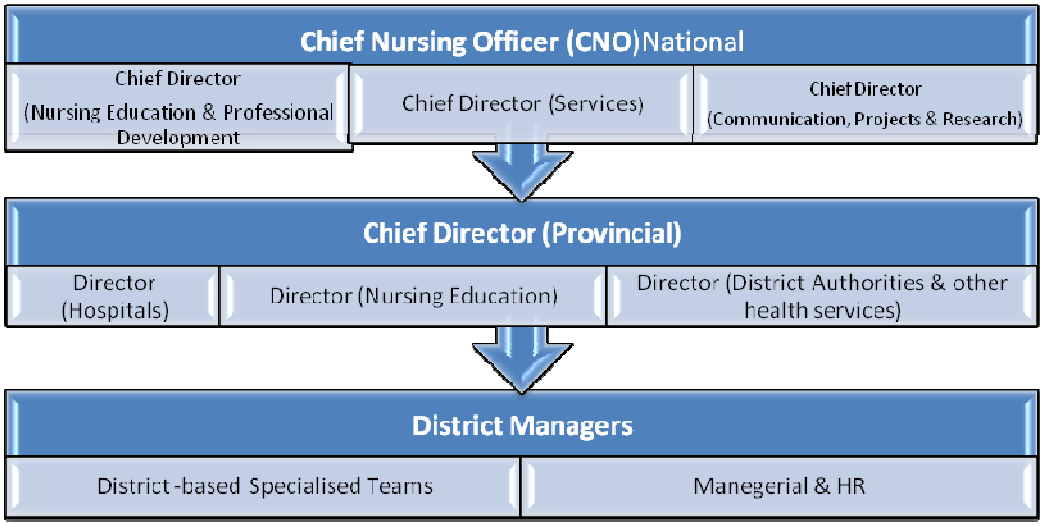


Figure 7: Proposed CNO cluster for South Africa

4.	**Strategic objectives**
4.1	Ensure the effectiveness of SANC
4.2	Develop and promulgate regulations for nursing agencies
4.3	Promote regulation of community health workers
4.4	Promote institutional governance and leadership

Recommendations for Leadership and Governance

4.1 Ensure SANC's effectiveness

- Conduct an audit of Council's operations by persons appointed by the Minister of Health.
- Fast track the development, promulgation and implementation of regulations to give full effect to the 2005 Nursing Act.
- Initiate the process for appointing a new Council which should include the national Chief Nursing Officer, a representative from both a professional nursing organisation and the Council on Higher Education as well as more clinical practitioners or representatives from health services

4.2 Nursing agencies

- The development and implementation of regulations to govern nursing agenciesrequire urgent attention to ensure ethically and legally compliant service delivery. The CNO must take the lead in ensuring that the accountability of nursing agencies is addressed as a matter of urgency.

4.3 Community health worker (CHW) regulation

- Accredit and regulate CHWs based on provincially determined needs.
- Align training of CHWs with the NDoH plan.

4.4 Promoting institutional governance and leadership

- Comply with the National Core Standards in terms of leadership and governance.
- Implement the proposed CNO executive structures. The exact financial implications will be determined by the proposed structure which would need agreement and approval at strategic levels.
- Fill leadership positions with nurse leaders selected on merit who strive to build DOH's ability to meet health service delivery demands.
- Institute annual performance contracts for every nurse manager.
- Implement effective Performance Management Systems for all categories of staff and set norms for all categories and clinical areas based on best care practices/staff satisfaction/quality of services.
- Address nurses' concerns as a matter of priority to ensure the protection of patients and continuation of essential health services before they go on strike. Implement the recommendation of the Nursing Summit Compact 2011, namely that a minimum service level agreement is signed to prevent nurses' participation in future strikes leaving patients unattended.
- Capacitate nurse leaders through appropriate management programmes to equip nurse leaders to compete equitably with other disciplines at all levels of management.
- Implement communication strategies to facilitate open channels of communication with all levels.

Strategic Priority 5 Positive Practice Environments (PPE)

A key overarching strategy used successfully around the world to address numerous challenges in healthcare services is creating positive practice environments (PPE). These encompass among others innovative recruitment and retention policies, strategies for continuing education, adequate employee compensation, recognition programmes, safe, clean working environments, inspirational nursing leadership, collaboration and quality of care. In light of this, it is therefore proposed that a combination of the National Core Standards of the Department of Health, International Council of Nurses (ICN), World Health Organization (WHO) and the World Health Professional Alliance (WHPA), American Association of Critical Care Nurses (AACN) and Registered Nurses of Ontario (RNAO)'s guidelines on PPE be implemented in South Africa**.**

5.1 Develop and implement a structured roll out and monitoring of PPE

Key workplace elements that strengthen and support the workforce and in turn have a positive impact on patient outcomes and organisational cost-effectiveness will help to ensure quality healthcare, the establishment and maintenance of an effective healthcare professional workforce and ultimately the overall quality of health systems. A combination of local and international guidelines on PPE is required to ensure an integrated quality nursing service within a value-based culture in line with Medium Term Strategic Framework 2009 - 2014 "A long and Healthy Life for all SA" and for the successful roll out of the NHI in South Africa**.**

5.2 Develop a framework to recognise post graduate qualifications

A framework for the recognition of post-graduate nursing qualifications, specialities and sub-specialities and implementation over a five-year period needs to be developed.

5.3 Improve the use of ICT in nursing and midwifery care provision

In education and training ICT access to students is essential to assist them with their learning. In clinical practice there is an increasing need to have access to ICT to enhance nursing practice needs. The electronic tools available have contributed to the improved ability of nurses and midwives to effectively and accurately assess and treat patients. It is essential that information systems are accurate and work effectively.

5. Strategic objectives

5.1 Develop and implement a structured roll out and monitoring of PPE

5.2 Develop a CPD system for nurses and midwives

5.3 Develop a framework to recognise post graduate qualifications

5.4 Improve the use of Information Communication Technology in nursing and midwifery care provision

Recommendations for Positive Practice Environments (PPE)

5.1 Develop and implement a structured roll out and monitoring of PPE

- Establish an Advisory Committee comprising of education, public and private healthcare stakeholders through the national CNO's office to assist with developing guidelines to implement and monitor PPE.
- Include nurses, midwives in the initial planning and design of health facilities to ensure best practices and incorporate PPE standards into the National Core Standards project managed by the Office of Health Standards Compliance.
- Recognise improvements within and between institutions and consider developing a recognition system for South Africa similar to the magnet service recognition system[3] used in other countries which refers to facilities able to attract and retain well qualified nurses and to consistently provide quality care.
- Track performance over time to determine the causal link between implementing improvement initiatives and achieving improved results.
- Implement a benchmarking facility to enable sharing of best practices.
- Ensure flexible shifts to suit practitioner and nursing unit needs.
- Explore the current staffing norms and skill mix to identify challenged areas and align clinical practice and pace of work to patient care requirements and needs.
- Develop policies on staffing ratios, occupational health and safety including violence prevention.
- Re-establishment Wellness Centres/Employee Assistance programmes (EAP) for nursing/midwifery and other personnel.

[3]The magnet model refers to institutions able to attract and retain the best nursing practitioners based on transformational leadership (quality of nursing leadership and management style); structural empowerment (organisational structure, personnel policies and programmes, community, image of nursing and professional development); exemplary professional practice (professional models of care, consultation and resources, autonomy, nurses involved in teaching, interdisciplinary relationships); new knowledge, innovation and improvement (quality improvement) and quality results (quality of care).

5.2 Develop a framework to recognise post graduate qualifications

- Develop a framework for the recognition of post-graduate qualifications, specialities and sub-specialities and implementation over a five-year period.
- Develop career paths for advanced practitioner's (Master's and PhD prepared nurses) in the clinical practice setting.

5.3 Implement CPD for nurses and midwives

- Make induction and Continuous Professional Development (CPD) programmes compulsory for all categories of nurses and midwives.
- Institute CPD as matter of urgency and link with licensing and professional progression.

5.4 Information, Communication and Technology (ICT) for nurses and midwives

- Revitalise the SANC database to create a useful tool to strengthen the National Health Information System and inform planning of nursing and midwifery resources and services.
- Incorporate ICT competencies into curricula to improve the competency level of nurses and midwives.
- Improve access and provision of ICT systems in the workplace to capacitate all employees.

Strategic Priority 6 Compensation, benefits and conditions of service

Good evidence exists that financial and other incentives such as better working environments, reasonable workloads and better quality education and training coupled with more accessible facilities are important in motivating health professionals.

6.1 Compensation, OSD, benefits and conditions of service

The National Department of Health has introduced a number of incentives over the past five years to attract and retain health professionals in the public sector and in the country. Most of these were financial incentives, including the OSD and scarce skills and rural allowances. More recent non-financial incentives include revitalisation of the hospitals, nurses' colleges and the nurses' homes. OSD should be revised to eliminate inequalities and also accommodate career pathing to retain advanced practitioners in clinical settings.

6.2 Improve incentives to promote retention and recruitment of nursing staff

Allowances for nurses must receive attention. Currently only nurses working in psychiatric hospitals get *danger allowance*, and consideration should be given to nurses working in high risk areas such as MDR/XDR TB hospitals. *Rural allowances* were introduced to attract and retain health professionals in remote areas, but were perceived to be awarded in a differentiated and discriminatory manner as the percentage allocated is not uniform among healthcare professionals, and non-professional nurses are excluded. The definition of 'rural' also varies between provinces. The issue of *night shift allowances* which are paid to employees working in facilities which offer 24-hour service and do not receive a personal shift allowance, has been on review for over ten years.

6.3. Popularise and propose the use of white uniforms

Nurses envisaged using uniforms as a way of improving the image of nurses in South Africa both on duty and in the public. In the past, nurses were issued with a white uniform but gradually moved to buying their own when the quality deteriorated. In 2005, the government introduced a uniform allowance which resulted in nurses dressing in different colours and styles. Other government departments such as the South African Police Service and the SA Navy have a strict dress code.

6. Strategic objectives

6.1	Revise OSD for nurses to ensure equity
6.2	Improve incentives to promote retention and recruitment of nursing staff
6.3	Popularise and implement the wearing of white uniforms

Recommendations for compensation, benefits and conditions of service

6.1 Occupation Specific Dispensation (OSD)

- Make OSD compatible with Performance Management and Development System (PMDS) tool to be developed to eliminate the current disputes arising out of the Generic PMDS tool.
- Link PMDS with Continuous Professional Development (CPD) to enhance career pathing which is an objective of OSD.
- Install systems which facilitate the smooth implementation of OSD.

6.2 Improve incentives to promote retention and recruitment of nursing staff

- Review financial incentives of nurses, including the different allowances paid to nurses such as rural, night duty, rural and danger allowance. .
- Align nurses' salaries to that of other health professionals.

6.3 Popularise and propose the wearing of contemporary white uniforms

- Popularise the decision of the Summit for high quality and durable white uniforms through communication campaigns and meetings.
- Present the issue to bargaining councils debating the modalities to transition from the allowance to issuing of the uniform for all nurses and midwives.
- Uniform allowances should be phased out over three years.
- Consider centralising procurement and vouchers for uniform acquisition provided for by employers. Proposals have been made to include the employer logo on the uniforms.

Strategic Priority 7 Nursing Human Resources for Health(HRH)

Planning for HRH requires a refined understanding of needs at service level, the gap between ideal and actual staffing, ensuring supply through training through education, training and development of appropriate categories of nurses, and costing the implications for training and employment.

7.Strategic Priorities

7.1 Develop a model which provides information on the future supply of nurses for the public and private sectors, for hospitals, PHC and NGOs (including the new staff nurse category).

7.2 Improved data quality on nurses and ensure a SANC database which details qualifications, location of employment, country of employment, employer, and other relevant details determined in consultation with nursing stakeholders.

7.3 Develop a database which details education institutions and their output, production and employment of nurses by district and province for the public and private sectors.

7.4 Develop a project on safe nurse staffing guidelines based on draft guidelines for hospitals and PHC developed by the MTT.

7.5 Determine the financial implications of nurse training and nurse employment to meet PHC policy requirements and safe staffing guidelines for hospitals in the public sector.

7.6 Develop strategies to increase the return of nurses who left the profession.

7.7 Develop strategies for the appropriate utilisation of retired nurses.

Recommendations for Nursing HRH

7.1 By 2014, develop a model which provides information on the future supply of and demand for nurses in South Africa

A model to determine and monitor nurse staffing needs will be developed**.** Two staffing projection scenarios were modelled by the MTT to take into account the new scope of practice of the staff nurse and the other uses the scope and practice of the current enrolled nurse. These projections result in significantly different staffing requirements

especially with regard to the numbers of professional nurses in relation to staff nurse and enrolled nurse requirements. In the short term, more professional nurses are going to have to be produced while the new model becomes operational and staff nurses are trained. Further modelling is required to develop detailed scenarios and the practical implications and plans for implementation of the new staff nurse category, and ensure increased professional nurses.

7.2 By 2015, SANC should have improved data quality on nurses and ensure a database which details qualifications, location of employment, country of employment, employer, time worked daily, and other relevant details determined with nursing stakeholders.

The current SANC database does not record whether nurses are actually employed in South Africa, where they are employed and all of their qualifications. By negotiating with SANC to improve the data fields they collect when nurses reregister annually, there will be a considerable improvement in the quality of data available on nurses. This data can then for the basis of a database and modelling tools.

7.3. By 2015, there should be a database developed which details education institutions and their output, production and employment of nurses by district and province for the public and private sectors

A SANC database will be developed which details education institutions and their output, and employment data, for the public and private sectors.

7.4. By 2015, the project to develop safe nurse staffing guidelines based on draft guidelines for hospitals and PHC developed by the MTT which should be implemented; and based on safe nurse staffing guidelines determine the nurse staffing gap by category with the training implications.

Nursing norm guidelines for the number of nurses who should be employed in a healthcare institution and in the community are essential for healthcare planning and to ensure safety of safe patient care. Population based norms do not allow for planning of safe patient care as the numbers of patients, types of services and location of the services differ, impacting on the nursing needs. An iterative process is required to ensure a balance between ideal staffing, what is a safe guideline and what is affordable. The WHO activity based workload approach to determine norms is proposed for the development of safe nurse staffing norms for South African nursing. The MTT develop draft guideline norms for all health care units (see Annexure report Reference group 9

Developing Safe Nurse Staffing Norms). These norms need to be tested and reconciled with available nurses by category and affordability.

7.5 By 2015, the financial implications of nurse training and nurse employment to meet PHC policy requirements and safe staffing guidelines for hospitals in the public sector should be determined.

Several key variables affect the future supply of nurses for South Africa which include the new Staff Nurse category and the refined scope of practice of Enrolled Nurses; the re-engineering of PHC, and the need for hospital staffing levels for all Nurses. This will impact on nursing education and training. Table 4 indicates the total number of vacancies to be filled by professional nurses (PNs or RNs). The financial and employment implications and safe nurse staffing norms and new policies need to be modelled and integrated into realistic provincial plans.

Table 4: Professional nurses, HRH goals 2011-2026

	2011	2015	2020	2026
Existing gap in public sector (vacancies)	45682	46603	47780	49231
PHC team vacancies[1]	9293	9480	9720	10015
Additional workers to fill vacancies[2]	-4092	-9027	-16652	-28506
Total vacancies (goal to be reached)	50884	47056	40847	30741

1. Assuming staff nurse model, includes numbers for PHCNs 2. Adjusted for new staff nurse model and after losses to private sector. Source: Econex calculations for NDoH HRH Draft Strategy June 2011

7.6 To facilitate the return of nurses who left the profession

South Africa has seen an exodus of nurses over the past decade, both abroad and outside of nursing locally. Policies should be initiated and implemented to enable the recruitment and appointment of nurses returning to South Africa from abroad, nurses who have left the profession for other positions, and nurses who have taken voluntary severance packages.

7.7 To facilitate the utilisation of the expertise of retired nurses

Policies should be initiated and implemented to enable the utilisation ofretired nurses in a coaching and mentoring role.

6. Implementation

This is a National Nursing Strategy applicable to all sectors.

6.1 Role payers

The Department of Health as the custodian of this strategy will implement the strategy through the office of the CNO. The role players include national and provincial health departments, Department of Higher Education, CHE, all areas of service delivery, the professions, South African Nursing Council, CBOs and FBOs and other organisations and employers of nurses and midwives, NEIs, nursing and midwifery professional organisations/associations, nurses and midwives (inclusive of students) at all levels, including nurse educators and nurse managers, and will all be involved in the implementation of this strategy.

6.2Awareness and communication of the Strategy

All role players will be involved in creating awareness of the strategy. The national Department of Health is responsible for communicating the Nursing Education, Training and Practice Strategy to all role players.

6.3 Administration

The Department of Health is the principal custodian, responsible for its the implementation of the National Strategy for Nursing Education, Training and Practice 2012/13 – 2017/18. The national Department of Health as the custodian of the will be responsible for the administration of the Strategy.

7. Monitoring and evaluation of the Strategy

The national Department of Health is responsible for the monitoring and evaluation of the implementation of the Strategy which is necessary to prevent unintended consequences or possible difficulties in implementation. The strategy development process has been underway for over a year and an interim review would ascertain progress made so far; establish elements that promote successes; assess challenges; and ascertain its relevance in view of new policy developments.

7.1 Recommended steps

The office of the CNO must take responsibility and oversight for the implementation of the strategy over the next five years with an implementation plan drawn up. The findings of the interim review should be used to revise the strategy accordingly. A monitoring team should be established to provide quarterly progress reports. Clear indicators of success are needed, followed by an evaluation of the end of the implementation period by an independent body.

7.2 Oversight of the implementation of the Strategy

The implementation would be the responsibility of the Provincial Directors of Nursing and they would report directly to the Chief Nursing Officer (CNO). The CNO would in turn, be responsible for overall monitoring and evaluation of the outcomes. The success of the Nursing Education, Training and Practice Strategy is subject to regular communication and extensive consultation with relevant nursing bodies. An appropriate budget for the implementation, monitoring and evaluation of the Nursing Education, Training and Practice Strategy is required.

7.3 Levels of evaluation

The research centre of the national Department of Health should be the custodian of the monitoring and evaluation processes of the Nursing Education, Training and Practice Strategy. At the institutional level the Nurse Educator/ Nursing Manager to be responsible for the monitoring and evaluation of the strategic implementation.

8. Signing off of the Strategy

The Strategy will be signed off by the Minister of Health.

9. Implementation Plan

The implementation plan is contained in the following table.

Table 5 Implementation Plan

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
Strategic Pillar 1: Education and Training								
Implement a national nursing education policy		• Implement a comprehensive policy, including role clarification of all stakeholders • Implement Recognition of Prior Learning (RPL) policy • Identify international nursing education partners • Facilitate international nursing education platform	Policies with uniform approach to nurse training including clinical education and training	NDoH, PDoH, Universities, Nursing colleges, Professional organisations		X	X	
Position nursing education institutions in higher education	1	• Submit proposal to Minister of Education • Minister of Health to engage with Minister of Education to facilitate a political decision to declare nursing colleges as HEIs •	• Decision taken to influence policy direction on position of nursing colleges • Public NEIs prepare to function as HEIs	MoH, Office of the CNO with support of legal advisors	X			
	2	• Facilitate the establishment and support the functioning of a Technical Committee to provide the two ministers with informed decisions • Draft a national public colleges act	• Established Technical Committee • Functional Technical Committee • Ministers announce informed plans on Nursing Education	NDoH, PDoH, CHE, DHET, SANC, Office of the CNO with support of legal advisors Universities, Nursing colleges, Professional organisations	X	X		
	3	Transitional and interim measures developed and implemented	Transitional and interim measures in place to prevent stoppage of nurse training	Technical Task Team: NDoH, PDoH, CHE, DHET, SANC, Universities, Nursing colleges, Professional organisations	X			

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
	4	Support NEIs to meet criteria stipulated by the Technical Committee	• Support provided to NEIs • Advise provided to NEIs	Office of the CNO, PDoH, Nursing colleges, Professional organisations	X			
	5	Establish and support the functioning of a National Nursing Education Coordinating structure	• Established structure • Functional structure	Office of the CNO	X			
	6	Develop National Core curriculum with specific provincial addenda to curriculum	Core curriculum developed	NEIs and provinces	X			
	7	• Expedite and support the process to revitalise public NEIs • Monitor	Revitalised public NEIs	MoH, DHET, Dept of Public Works, NEIs,	X	X	X	
Establish a uniform policy for student funding support in nursing programmes	1	Develop a uniform policy on nursing student funding based on MTT recommendations	Funding policy for funding of nursing students	Office of the CNO, NDoH, Nursing Education Stakeholders	X			
	2	Implement policy on student funding	National implementation of funding policy in equitable manner	NDoH, PDoH		X		
Implement a model for clinical education and training of nurses	1	Establish DNS; create post for Clinical Placement Coordinator (CTC)	Clinical Placement Coordinators (CTC) appointed	Provincial DoH, Stakeholders: National and Provincial DoHs; NES	X			
	2	Establish dedicated Clinical Training Departments/Units (CTDs/CTUs) for preceptors	Dedicated units established	Clinical facilities Stakeholders: Provincial DoH/DNS, NEIs and clinical facilities	X			
	3	Create posts for CPCs	Funded posts created	Provincial DoH; Stakeholders:Provincia	X			

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
				l DoH/DNS and clinical facilities				
	4	Prepare focussed short course for clinical preceptors	Short course developed	NEI/HEI Stakeholders: NEI/HEI & clinical facilities	X			
	5	Develop physical infrastructure for preceptors and CPC	Supportive infrastructure in place	Clinical facilities Stakeholders: Provincial DoH/DNS, NEIs and clinical facilities	X			
	6	Recruit and appoint CPC		Clinical facilities Stakeholders: Provincial DoH/DNS, NEIs and clinical facilities		X		
	7	Identify PPEs for clinical placement	Application of PPE criteria and PPEs identified clinical placement	CPC Stakeholders: Clinical Placement Coordinator/DNS, NEIs and clinical facilities		X		
	8	Set electronic system for student placement	Electronic system developed and implemented	CPC Stakeholders: Provincial DoH/DNS; NEI/HEI; CPC		X		
	9	Create positions for preceptors	Funded posts created	Clinical facilities Stakeholders: Clinical facilities management; CPC		X		
	10	Recruit and appoint preceptors	Preceptors appointed	CPC, Stakeholders: CPC and NEI/HEI		X		

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
	11	Re-orientate all RNs to clinical supervisor role	Reorientation of RNs	CPC, Stakeholders: CPC and NEI/HEI and clinical facilities management		X		
	12	Training of preceptors and current clinical supervisors	Training programmes developed and implemented	NEI/HEI nurse educators Stakeholders: NEI/HEI and CPC		X		
	13	Prepare and sign MOAs	Agreements signed	DNS Stakeholders: DNS; NEI/HEI and clinical facilities				
	14	Honorary appointment of clinical preceptors and clinical supervisors in terms of MOA	Appointments finalised	NEI/HEI management Stakeholders: NEI /HEI and clinical facilities		X		
	15	Quality Assurance (QA) system for clinical education and training	QA system developed and implemented	NEI/HEI management Stakeholders: DNS; NEI/HEI and clinical facilities QA structures				
	16	Prepare clinical facilities for new system	Clinical facilities revitalised	NEI/HEI and clinical facilities Stakeholders: DNS, NEI /HEI and clinical facilities		X		
	17	Prepare NEIs/HEIs for new system	NEIs/HEIs revitalised	NEI/HEI and clinical facilities Stakeholders: DNS, NEI /HEI and clinical facilities				

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
	18	New approach to approval of clinical facilities put into regulations	Regulation promulgated	SANC Stakeholders: DNS, NEI /HEI and clinical facilities		X		
	19	Test and evaluate implementation of the model using 1 Private NEI and 1 Public NEI	Pilot test completed	NES and Task Team Stakeholders:				
	20	Research on clinical training model	Research the Model for Clinical Education and training	NEI Stakeholders: NEI/HEI and clinical facilities			X	X
Promote continuous professional development	1	CNO to liaise with SANC re the development of CPD	Develop CPD model for South African nursing profession	CNO Advisory Committee & SANC	X			
	2	Implement CPD model	All stakeholders in healthcare participate in CPD model	SANC and employers		X		
	3	Public and private sector employers to ensure relevant skills development for their staff	Implementation of CPD	All employers	X	X	X	X
Strategic pillar 2: Resources for nursing								
Establish a national nursing portfolio	1	Chief Nursing Officer appointed	Appointment confirmed	NDoH	X			
	2	Office and systems set up	Location identified and office set up	NDoH	X			
	3	Finalisation of organogram	Final organogram	CNO, NDoH and Advisory Committee	X			
	4	Finalisation of revised nursing strategy	Nursing Strategy 2012 - 2017	MTT & CNO	X			
	5	Establish nursing reform advisory committee	Advisory Committee established and TOR identified	CNO & Stakeholders in the profession	X			
	6	Meetings of advisory committee	Meetings scheduled and	CNO and advisory	X	X	X	X

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
			agenda determined	Committee				
	7	Nursing educator & management focal persons appointed/ designated in provinces	Focal persons appointed	CNO and NDoH		X		
Develop and re-orientate nurse educators	1	Revision of SANC requirementsfor registration as a nurse educator	SANC regulations reflect revised requirements	SANC & stakeholders in profession	X			
	2	Dedicated ear-marked funding for nurse educator framework (similar to Clinical Training Grant provided by DoE to universities)	Dedicated ear-marked funding available	NEIs, NDoH& DoE		X		
	3	Increase number of resident universities that offer the Advanced Diploma in nursing education	Increased access to educator preparation at universities	Universities and DoE	X			
	4	Dedicate/ear-mark funding for nurse educators similar to Clinical Training Grant By DoE to universities • 0.5% of personnel budget for educator development • Seed funding of R3m per province expanding over MTEF period for innovative programmes • Bursaries for nurse educators • Funding for scholarly activities	Promote development of nurse educators and increase number of qualified of nurse educators on the SANC register	NDoH and employers, funding stakeholders		X	X	X
	5	Develop a specific recruitment and retention strategy for nurse educators	Recruitment and retention strategies in place	Management & HR of all employers		X		
Develop and re-orientate nurse managers	1	Review of the content of nursing management courses and the teaching methods	Content review and revised	SANC & stakeholders in profession	X			
	2	Implement open and transparent merit - based promotion system to any nursing management position	Merit-based promotion system agreed and implemented	Management & HR of all employers		X		
	3	Establish Mentoring Programme for nurse	Mentoring programme	Management & HR of all NEIs		X		

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
		managers	implemented					
	4	Establish managers forums at district/ sub-provincial level	Forums established at relevant levels	Nursing Service Managers	X			
Increase the number of specialist qualified nurses	1	Increase access to post basic specialist education and training programmes	Increased opportunities for study leave and study funding support	Management, finance & HR of all employers		X		
	2	Make provision for positions for specialist nurses and advanced specialists in healthcare facilities to attract and retain specialist nurses	New positions created for specialist and advanced specialist nurses	Management, finance & HR of all employers, Unions, practitioners		X		
	3	Create a clinical career path for specialist nurses	Retention of specialist nurses in the clinical area	NDoH, PDoH, HR, professional groups, unions		X	X	X
Strategic pillar 3: Professional Ethos: comprehensive programme								
Nursing Practice:								
Ensure that confidentiality of patients is maintained at all times during nursing care	1	Provide sufficient information to permit informed consent and the right to choose or refuse treatment	Patient Rights Charter: Patient and family orientation programme	NDoH, PDoH, Private providers	X	X	X	X
	2	Use recording and information systems that ensure confidentiality and privacy	Accurate patients records: safekeeping of records.	NDoH, PDoH, Private Providers	X	X	X	X
	3	Provide continuing education and support in ethical decision making in the workplace	In-service trainingx4 yearly	Hosp Management: Nursing Associations	X	X	X	X
Foster a working environment that	1	Provision of cultural congruent care that respects human/patients' rights and sensitive to the values, customs and traditions of the communities being served	In service trainingx4 yearly	Hosp management& Nursing associations; NEI; NGO	X	X	X	X
	2	Establish standards of care and setting that respects and promote patients' rights	Hospital Ethics Committee; National Core Standards	DOH Office of Standards	X	X		
	3	Embrace UBUNTU and Humanism as	Modules; patient	NEI; NGO;	X	X	X	X

Strategic Plan for Nursing Education, Training and Practice 2012/13 – 2016/17

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
observe the rights of both patients and nurses		fundamental Philosophies in nursing	questionnaires	Community				
	4	Develop mechanisms to safeguard the individual, family or community when their health care is endangered (Minimum Service Levels)	Complaints register	DOH ; Media		X		
	5	• Establish systems for professional appraisal that also test nurses attitudes towards patients • Patient satisfaction questionnaire should be part of the patient orientation on admission	Patient satisfaction Questionnaires; checklists (ward sister)	DOH & Private providers	X	X	X	X
	6	• Introduction of peer review systems to acknowledge/reward good attitude behaviour towards patients • Continuous performance evaluation of nursing staff attitude and conduct towards patient/public (survey unannounced; anonymous) • Continuous feedback on performance and attitude and conduct to peer groups and relevant stake holders.	Peer Review	DOH & Private providers; families & community organizations (NGOs)	X	X	X	X
	7	Spiritual team building session before shifts to foster team building among nurses	Team building Sessions	Ward sister; Educators; Clinical preceptor	X	X	X	X
	8	Display of Ethics material in all units at the point of service to remind nurses/patients of their responsibilities	Posters; Patient Rights' Charter	DOH; private providers	X	X	X	X
Ensure nurses expertise is relevant to the context in which nursing care is provided	1	Set standards for Nursing Ethics in the workplace	Team building Sessions	DOH; Private Providers.	X	X	X	X
	2	Create awareness of specific and overlapping functions and the potential for interdisciplinary tensions, Promote inter-professional	Posters; Patients Rights' Charter	DOH; Private providers; SANC; Nursing Associations; HPCSA	X	X	X	X

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
		collaboration						
	3	Develop workplace systems that support common professional ethical values and behaviour	Hospital Ethics Committee (multidisciplinary	DOH; Private providers	X	X	X	X
	4	CPD points system for Ethics to ensure compliance according to SANC requirements	Policies; procedures	SANC; CPD accredited provider;	X	X	X	X
Nursing Education:								
To market the nursing profession in basic school to attract good cadre for nursing profession	1	• Develop a marketing strategy for the nursing profession • Interdisciplinary collaboration on wellness day • International nurses day celebrations • Community engagement on various platforms	Marketing and Communication Strategy	NEIs; Nursing Associations; DOH; Private Providers	X	X	X	X
	2	• Provide career guidance sessions at schools to attract potential candidates into nursing • NEI open days • DENOSA exhibitions at career fares • Career fares • Re-introduce a volunteer service by prospective nursing students during school holidays • Scouts	Career Guidance x2 yearly	NEIs; Nursing Associations; DOH; Private providers; DENOSA; NGO; local high schools	X	X	X	X
	3	Develop a database indicating Nursing Institutions training nursing programs and criteria for entry	Database	SANC	X	X	X	X
	4	Develop cultural competence as a core and basic value for nursing	module	NEI; NGO; communities; associations & societies	X			
		Develop a two week Ethics and etiquette access	Induction Program	SANC; NEIs		X		

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
	5	induction program to initiate new recruits into nursing (pre-nurse training)						
To mainstream Nursing Ethics in basic and post basic nursing training	1	Include issues of human rights, equity, justice and solidarity as part of the nursing curriculum	Curriculum; Clinical Accompaniment	SANC; SAQA; NEIs		X		
	2	Introduce in the curriculum concepts of privacy and confidentiality	Curriculum; Clinical accompaniment	SANC; NEIs; Clinical Accompaniment	X			
	3	Sensitize learners to the importance of patient advocacy to safeguard patients' rights	Curriculum; Clinical accompaniment	Ward Sister; NEIs; Clinical preceptor	X			
	4	Ensure presentation modules on Ethical decision making and Ethical conflicts resolutions	Clinical Accompaniment	SANC; NEIs; Nursing Associations	X			
	5	Develop modules on value clarification specific to community being served	Modules of curriculum	SANC; NEIs; Nursing Associations		X		
Nursing Associations and Regulatory Body:								
To advocate for patient's rights during healthcare delivery	1	Develop position statements and guidelines that support human rights and ethical standards	Position Statements	GovDepts; SANC; Nursing Associations;	X			
	2	• Advocate for safe and healthy environments for all • Ensure timeous attention and referral to the next level of care to meet patient needs	National Core Standards	Government Depts; Nursing Associations; SANC; HPCSA; office of standards	X			
	3	Re-emphasize issues of confidentiality and privacy into a national Code of Ethics for nurses	Code of Ethics	SANC; Nursing Associations	X	X	X	X
	4	Establish associations and societies for human caring in the communities. Advancement and development of special interest groups for professional growth of nurses	Nursing associations; Community Societies	DENOSA; Retired Nurses; all nurses; Community Interest groups	X	X X	X	X
	5	Develop awareness of ethical issues of other professions	Campaigns; newsletters; Conferences	All Health Disciplines	X	X	X	X
Establish collaborative partnerships in		Collaborate with others to set standards for	Campaigns; newsletters;	NEIs; DOH; CNO,	X	X	X	X

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
order to unify nurses	1	nursing education, practice, research and management	Conferences	Private providers				
	2	Stimulate co-operation with other related disciplines	Campaigns; workshops; Conferences	DOH; Private providers; NEIs	X	X	X	X
	3	• Establish forums for communities to discuss issues where their care is endangered by healthcare personnel • Awareness of the existence of a complaint process for poor and substandard care	Campaigns; Workshops; Conferences(multidisciplinary)	Government; Community; SANC;	X	X	X	X
Strategic pillar 4: Leadership and Governance								
Promote the effectiveness of SANC	1	Audit of SANC execution of its mandate	Audit performed	NDoH	X			
	2	Fast track the development, promulgation and implementation of regulations to the Nursing Act	Regulations to the Nursing Act promulgated – E&T regulations	SANC, NDoH, stakeholder responses	X			
	3	Revitalise the SANC database to create a useful tool to inform planning of nursing and midwifery resources for health services	Improved and cleaned up database	SANC	X			
	4	Explore best practice for the regulation of professions	Report on best practices for professional regulation	SANC and professional organisations				
Regulate nursing agencies	1	Develop and consult regulations for nursing agencies under the National Health Act	Draft regulations for nursing agencies	DoH, private employers, Nursing professional, agencies	X			
	2	Promulgate and implement regulations for nursing agencies	Promulgated regulations for nursing agencies	DoH, private employers, Nursing professional, agencies	X			
Promote regulation of community health workers	1	Develop and implement a system for regulating community healthcare workers	Regulatory structure for health workers	NDoH, NGO, SANC		X		

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
Promote institutional governance	1	Provide for leadership and management development, including financial management training and business administration	Managers have undergone training and are performance managed	All employers,	X	X	X	X
	2	Succession planning	Succession planning at all institutions	All employers, nursing organisations	X	X	X	X
	3	Implement performance contracts for senior management and ensure that performance is managed accordingly	Performance managed effectively and consistently	All employers, nursing organisations	X	X	X	X
	4	Include nurses, midwives in the initial planning and design of health facilities to ensure best practices and best work environment	Planning teams at all levels include nurses and/or midwives	NDoH, PDoH, nursing organisations, NEIs	X	X	X	X
Strategic pillar 5: Positive Practice Environment								
Develop and implement a structured and focused approach to roll out and monitor PPE standards	1	Collaborate with the office of Standards Compliance to develop and roll out PPE	Meeting with Office of Standards compliance	NDoH, CNO, PDoH, nursing organisations	X			
	2	Develop a magnet-type service recognition system	Recognition system developed and implemented	NDoH, nursing organisations		X		
	3	Do research study on the operational, management and educational services to identify all challenges	Research study done and recommendations used to inform revitalisation of nursing	NDoH, nursing organisations		X		
	4	Employers to implement induction and orientation programmes	Programmes developed and offered by all employers	All employers	X			
Develop a framework for the recognition of post graduate qualifications	1	Develop proposed framework for recognition of post graduate qualifications	Framework for recognition of post graduate qualifications	ANSA,			X	
		Nurses and midwives to improve their skills with	Improved skills with	All practitioners	X			

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
improve the use of ICT in nursing and midwifery care provision	1	electronic media	electronic media					
	2	Employers must recognise and improve the access and provision of effective ICT in the workplace and ensure that all staff can use it correctly	Policy development to improve use of effective ICT	NDoH, PDoH, private sector, nursing organisations		X		
	3	Employers to encourage paperless record keeping	Policy development to improve use of effective ICT	NDoH, PDoH, private sector, nursing organisations	X	X	X	X
Strategic pillar 6: Compensation, benefits and conditions of service								
improve OSD for nurses	1	OSD compatible with PMDS	PMDS compatible with OSD – all mangers trained to implement	NDoH, PDoH, nursing organisations, CNO, Bargaining chambers,		X		
	2	PMDS linked to CPD	PMDS include CPD requirements of practitioners	NDoH, PDoH, nursing organisations		X		
Improve incentives to promote retention and recruitment of nursing staff	1	Review the allowances for nurses and midwives and ensure equitable calculation and allocation of allowances to staff	Revised allowance policy	NDoH, PDoH, nursing organisations, CNO, Bargaining chambers,		X		
	2	Ensure that pay and grade progression are implemented in an equitable manner	Equitable implementation of pay and grade progression	NDoH, Office of the CNO, PDoH, nursing organisations,	X			
Simple, white uniform	1	Popularise the Summit decision	Communication at meetings and in publications	NDoH, PDoH, Office of the CNO, nursing organisations, NEIs	X	X	X	
	2	Take decision to bargaining council for implementation over 3 years	Proposal for revised uniform agreed and funded	NDoH, PDoH, CNO, nursing organisations	X			
	3	Centralise procurement	Central provided identified and appointed	NDoH, PDoH, private service providers	X			

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
	4	DoH to meeting with SAPS and SA Navy	Meetings conducted	NDoH, Office of the CNO	X			
To develop a career path for advanced practitioners in the clinical setting	1	Develop the current OSD provision for this category of worker	Provision in OSD to create a career path in clinical setting to retain practitioners	NDoH, PDoH, CNO, nursing organisations		X		
Strategic focus area: Human resources for health								
To model the future supply of nurses for the public and private sectors, for hospitals, PHC and NGOs (including the new staff nurse category)	1	Collect and analyse data on supply of nurses for the future for all sectors	• Report on nurse supply in South Africa to 2030 • Live database on nurse supply including output of all nurse education institutions	NDoH, CNO	X			
To consult SANC to improve data quality on nurses	1	Discussion with SANC of collection of nurse data	New improved reporting from SANC on the nursing register	NDoH, Office of the CNO and SANC	X			
To develop a database in production and employment of nurses	1	Develop database on nurses in education and nurses in employment	- Report on nurse production and nurse supply - Database on nurse production and employment	NDoH, Office of the CNO				
To implement a project to develop safe nurse staffing guidelines based on draft guidelines for hospitals and PHC	1	Audit all nurses in hospitals and PHC, and compare with draft guideline and develop national guideline	A. Report on safe nurse staffing guidelines for South Africa B. Data on nurses in employment, set of guidelines, and a process of implementation of safe	NDoH, Office of the CNO		X		

Strategic objectives	Number	Activities	Output indicators	Responsible	<1 year	Short term < 2years	Mid term 2-5 years	Long term >10 years
			nurse staffing					
To determine the nurse staff gap by category and the training implications	1	Analyse data from the audit in 9.4 to determine training needs	• Report on the training implications to meet nurse staff needs based on new policy for PHC and safe staffing guideline for hospitals • Data on training needs	NDoH, Office of the CNO	X			
To analyse and report on the financial implications of nurse training and nurse employment to meet PHC policy requirements and safe staffing guidelines for hospitals in the public sector	1	Analyse training costs for all nurses in the public sector and private sectors, and employment costs for all nurses in the public sector	• Report of financial implications of training and employing nurses for the future • Financial information on the training and employment of nurses	NDoH, Office of the CNO	X			

Table 6 Summary of potential costs

	Strategic priority	Cost			Notes
1	**Nursing Education & Training**				
	Education policy development				CNO Stakeholder Task Team to develop policy
	Clinical Education & Training Model: Staffing model: Gauteng province Staffing model: National Set up cost of 1 Training unit (once off) Annual running cost of 1 unit	**2012/13** R108 593 481.25 R173 671 057.68 R321 500.00 R300 000.00	**2013/14** R113 178 842.81 R181 369 225.81	**2014/15** R117 993 472.47 R189 452 294.72	Some provinces already have the staff included in this staffing model
	Student funding per student per year: Tuition fees (if same as university) Study materials Living cost Uniform Accommodation Transport **TOTAL PER STUDENT**	 R22 000.00 R 3 000.00 R 3 500.00/mth R 2 236.00 R 1 200.00 R 1 000.00 **R78 436.00**	10 000 students **R784 360 000.00**	20 000 students **R1 568 720 000.00**	 Tuition fees paid to NEI To be arranged how this is paid To student on monthly basis Issued as for other nurses and midwives This amount would be variable based on residence
2	**Resources in nursing**				
	National nursing portfolio (CNO)/annum Provincial per unit/per annum	 R4 419 960.00 R3 624 483.00			
	Dedicated resources for educator development	0,5% of payroll budgeted for development			
	Development and re-orientation for	0,5% of payroll budgeted for			

	nursing service managers	development			
	Revision of nurse educator and manager competencies and programmes	In progress			SANC function
	Increased production of specialist nurses Tuition fee Books Salary	R22 500.00 R 3 500.00 ****	100 practitioners R2 600 000.00 over and above salary	200 practitioners R5 200 000.00 over and above salary	Study leave for practitioners to obtain a specialist qualification
3	**Professional ethos**				
	Proposed professional ethics programme implemented				To become a component of CPD and in-service education provided by employer
	Promotion of nursing at school level	R9 000 000.00			Marketing budgets to promote nursing as a career of choice
	Collaborative partnerships				Ongoing by all stakeholders
4	**Governance, Leadership, Legislation and Policy**				
	Promote effectiveness of SANC				Monitoring & evaluation
	Mechanism to regulate CHWs Database developed Regulatory body established	 R 800 000.00 R10 000 000.00			Dependent on system selected
	Institutional governance				Monitoring and evaluation by institutions Promote ethical governance
5	**Positive Practice Environments**				
	Structured rollout of PPE in conjunction with Office of Standards Compliance	Incorporated in Core Standards roll out			Negotiate with the Office of Standards Compliance to ensure that core standards are sensitive to nurses'/midwives' needs
	Framework for recognition of post graduate qualifications				Policy to be developed which will determine a process and related cost
	CPD system for nurses and midwives				SANC responsibility – cost dependent on system selected
	Improve ICT use in profession				Each employer will be responsible for this cost and should be specific for systems and equipment acquired for the service
6	**Compensation and benefits**				
	Improve OSD				Bargaining process
	Improved incentives for				

	nurses/midwives				Bargaining process
	White uniforms for nurses and midwives: Female (3 dresses, 2 tunic tops, 1 skirt, 1 pair of slacks, 1 pair of step on shoes, 1 long sleeve cardigan, cape Male (5 pairs of trousers, 5 tunic tops, 1pair of shoes, 1 long jersey, 1 long sleeve jacket) Total number of nurses: 115 000 Female: 103 500 Male: 11 550 **TOTAL**	R2 236.80/person R2 848.30/person R231 508 800.00 R 32 755 450.00 **R264 264 250.00**			Based on statistics provided of nurses in public sector, total number of nurses is 115 000; males are estimated to be 10% of total
7	**Human resources for health**				
	Model for future supply of practitioners in all sectors				Draft of safe staffing guidelines for hospitals and PHC developed
	Improved SANC database	R1 200 000.00			SANC responsibility
	Nurse/midwife staffing guidelines				Draft of safe staffing guidelines for hospitals and PHC developed
	Implications for training to meet policy requirements				To follow finalisation of safe staffing guidelines
	Facilitate return of retired and other nurses who left the profession	Funded posts required			Policy for recruitment and appointment of retired and returning nurses and midwives

10. Availability of the Comprehensive Report, Annexures and References

The comprehensive report, annexures and references are available from:

The Director-General	
National Department of Health	20th Floor
Private Bag X399	Civitas Building
Pretoria	CnrAndries&Struben Streets
0001	Pretoria, 0001

Annexures:

- Nursing Compact 2012
- Results of a snap survey amongst 50 Professional Nurses in Johannesburg
- Key global developments in health professional education
- Model for Clinical Education and Training
- Responsibilities: CNO at national level
- Responsibilities: CNO at provincial level
- SANC Audit tool
- Sample performance contract for a nursing manager
- Policy guidelines for nurses returning to practice
- Self-assessment and audit tools for PPE
- Framework for the recognition of post-graduate qualifications
- Specs for a contemporary white nurses uniform
- Developing Safe Nurse Staffing norms: A proposal for discussion

Annexures

Annexure 1 Nursing Compact 2012

2011 Nursing compact

We, the nurses of South Africa, supported by our stakeholders, gathered in the Sandton Convention Centre from the 5th - 7th of April 2011 for the National Nursing Summit on Reconstructing and Revitalising the nursing profession for a long and healthy life for all South Africans; guided by the Government's vision as contained in the Negotiated Service Delivery Agreement (NSDA) as well as the four strategic outputs therein; and rights as enshrined in the Constitution of the country;

(d) Taking note of the president's challenge to nurses in his keynote address;
(e) Taking note of the agreed ten-point plan;
(f) Recalling the National Nursing Summit held in 1999;
(g) Recalling the National Nursing Strategy;
(h) Recognising the skills and experience brought by retired nurses;
(i) Deeply concerned at the lack of progress in addressing the quadruple burden of disease and that South Africa will not be able to meet internationally agreed goals including the Millennium Development Goals if the current state of affairs is maintained, in particular to reduce maternal mortality, to reduce child mortality and to combat HIV, AIDS and TB;
(j) Concerned at the declining life expectancy;
(k) Disturbed about the decline in quality of care;
(l) Taking note of inadequate health system effectiveness;
(m) Deeply concerned about the negative image and social position of nurses in the community; and
(n) Recognising that nurses, as the engine of an effective health system, play a pivotal role in service delivery;

We hereby declare as follows:

We reaffirm that the reengineering of the health care system must drive the refocusing of service delivery and developments in the nursing profession, particularly the development of a District Health System (DHS) based on the following three streams of PHC:

- *Multi-disciplinary teams of clinically competent professionals in which nurses play a critical role;*
- *Community ward-based multi-disciplinary health teams with nurses playing a critical role; and*
- *The effective implementation of national school-based PHC system led by nurses.*

We urge the NDoH to establish a task team that will develop and implement a comprehensive national policy on nursing education and training which examines the new Nursing Qualifications' Framework and which addresses among other things: student status, funding models, the positioning of public and private nursing education, norms and standards for nursing, and specialised skills.

Noting that nursing and midwifery practice must inform nursing education, we urge SANC to finalise and promulgate the scope of practice regulations for nurses (basic and post-basic).
We urge government to declare nursing education a national competency.
We call on the Minister of Health to facilitate the declaration of public nursing colleges as Higher Education Institutions.

We call upon SANC in collaboration with NDoH, CHE and SAQA to fast-track the processing and implementation of the new Nursing Qualifications' Framework and appropriate transitional arrangements.

We urge the nursing education institutions to strengthen the implementation of Recognition of

Prior Learning for access and entry into nursing training programmes in line with national policy and SANC guidelines.

Reiterating the commitment to produce clinically competent nurses we:

- *Call on SANC, after consultation with relevant nursing stakeholders, to develop core national standards for curricula that respond to national population health and health system needs;*
- *Urge the National department of health (NDoH) with relevant stakeholders to cost and evaluate an appropriate clinical training model and for SANC to regulate for its implementation; and*
- *Call on the NDoH to increase investment in nursing education.*
- *Call on the NDoH to develop, implement and allocate adequate resources for a national nursing educator and nurse manager development programme.*

We urge the NDoH to urgently review the occupation specific dispensation (OSD) and other financial incentives for all categories of nurses, and to ensure the alignment of nurses' remuneration with other health professionals in the health care team.

We urge the NDoH urgently to establish dedicated structures with executive decision-making powers to deal with nursing issues at the national, provincial and district levels.

We call on government to prioritise the creation of a conducive environment for student learning, including:

- *Recognising the overwhelming support for a stipend paid through PERSAL, we urge the NDoH to standardise and implement financial assistance for nursing students;*
- *A standardised national model for student funding; and*
- *Appropriate accommodation, transport and learning materials for students.*

Recognising the overwhelming support for a standardised white uniform, we call on the government and private employers to issue nurses with complete outfits.
We support the establishment of the office of standards compliance.

Noting with concern the shocking state of some of the nursing education institutions and clinical facilities, we urge the NDoH to give urgent attention to the revitalisation of these education and training institutions including accommodation for students and nurses, and non-infrastructure related requirements in support of training of nurses.

We urge the NDoH to develop staffing norms, and to fund and fill vacant nursing posts.
We note the negative impact of strikes on the provision of essential services and the health of the community and therefore urge employers and organised labour to urgently address the matter.

We call upon all categories of nurses to commit to the nurses' pledge and the rights provisions of the South African Constitution and international treaties.

We call on the Nursing Summit organizing committee to develop a Strategic Plan for nursing, taking into account the national Nursing Strategy and the detailed inputs of the commissions at the Summit. We urge the NDoH to ensure implementation of the strategic plan, a biennial review, and ongoing monitoring and evaluation.

Recognising the need for a positive practice environment for nurses, we urge employers to ensure implementation of ICN guidelines as well as the provision of appropriate ICT support.

We urge government, the private sector, professional associations and labour unions to ensure the development of nurse leaders able to lead and implement change.

We urge government and the private sector to develop and implement policy for succession planning, career progression and access to continuing learning for all categories of nurses.

Recognising the negative health system consequences of moonlighting, we urge the NDoH and the private sector to implement measures to manage moonlighting.

We urge the NDoH to develop regulations for the control of nursing agencies in South Africa.

Annexure 2 Results of a snap survey on ethics in nursing amongst 50 Professional Nurses in Johannesburg

It is certainly no an accident or evolutionary or genetic change that nurses attitudes have changed – clearly there must be a root cause for this situation. In a snap survey of 50 professional nurses in the Jo'burg NEA region, it was clear that nurses are feeling maligned and under-valued and are angry and resentful of the community's view that their "attitudes" are "bad." The following are some of the comments made:

- "Ethos and ethics needs to be revived – they are very much outdated and do not represent the modern nurse."
- "(We need) respect for the nursing profession. Nurses should not be seen as walkovers. Nurses give valuable input. If nurses were included in national health care decision making we will have improvement within the health care system"
- "You get victimized by society. We are working 7 days a week for minimum wage to care for other people and then you neglect your own family."
- "Ethics should be re-assessed – it is difficult to apply what the public and minister see as ethical as they are not in the nurses' shoes."
- "The nursing profession is stressful – nurses are not well cared for and are oppressed by the Department of health and the Nursing Council."
- "Let the employer care for the nurses so that they can care for their patient in a very satisfactory mood."

There were however a large number of responses that acknowledged that all is not well in terms of ethical behaviour in nursing. Responses included:

(i) "The public deserves the quality of health services that are provided by the nurse. Nursing is classified as an essential service and I therefore think that nurses should not embark on a strike actions. (sic)"

(j) "Nurses attend to their patients with negative attitudes. Patients wait for a long time in queues to be attended to.

(k) "There is a saying that I have heard in almost every ward I have worked in in the public sector 'When in Rome, do what the Romans so" It is a saying that haunts our profession and the health system because nurses have defeatedly decided that under the workload and lack of resources, the easy way out is the best option – never to fight, never to change but to ALWAYS take the easy way out. This ranges from small issue like cutting workload by giving 10:00 and 14:00 medicines at 09:00 (in the renal unit I might add), to skipping the full protocol of declaring patients brain dead and allowing doctors to switch off ventilators in pressured situations. The ethos is to bend with the pressure – and pressure is what the entire system is faced with."

(l) "Nurses are not committed. Nurses are not passionate. Nurses do not respect themselves anymore. Nurses are becoming destructive not only to themselves but to the work environment and their patients."

(m) "We are more union driven than profession driven. We are in it for the money."

Many had a very clear view of how nurses should behave. Responses included:

(ii) Since nursing is a noble profession, the nurses should be able to have caring for all patients and should be professional in all spheres – the way they speak to patients, to their colleagues and the community should be professional."

(iii) "Nursing as a professional constantly changes – it is dynamic. "

(iv) "The nurse is expected to put the patient above all else when rendering care. The nurse must be accountable for her actions at all times. The nurse must abide by the nursing regulations of the Nursing Council."

(v)"The nursing profession should maintain their professional status. Nurses and nursing are the backbone society. "

(vi) "Ethics are enforced through knowledge and leadership which comes through education and protocols."

(vii) "The Minister must know that nurses have to render good quality services to patients. Patient must be treated with dignity at all times. All nurses has to strive for provision of best care without discrimination."

It was also clear from the responses that the working environment is sub-optimum which is fuelling the problem as nurses are finding it difficult to work. Responses included:

- "Government should pay suppliers the outstanding money as the patients are the ones who are suffering."
- "In the current SA environment the ethics and ethos of nursing is eroded, tarnished and shamed by a general lack of personnel, greed and laziness…"
- "South Africa has the potential to be top in the world again. Change should be done from the management at all levels – all of them. They should be qualified to do their jobs first."
- "In order to work holistically we need staff and equipment. This is going to help us to nurse the patients with ease."
- "The government should also consider our rights as human beings serving the nation because customers (patients) are the most disrespectful even assaulting the health care workers."
- 'Is it ethical to have nurses working in a dangerous environment (thefts, violence, building safety)?"

From the snap survey it appears that nurses know what should be done in terms of ethical behavior, acknowledge it is not being done but are saying that their working environments are so poor that it is not possible to behave in the manner they know is required.

We can argue, and probably should argue, that ethics teaching must move from principle based ethics to virtue ethics, but we also have to acknowledge that we need to improve the psycho-social and physical working environment of the nurse before we can realistically expect a change to occur.

The professional organisations have an important role to play, as does the employer, in assisting nurses to work together in harmony and as functional teams and to unite in their efforts to bring about a change in "attitudes" of nurses and to ensure that the community and the nurses themselves start valuing their roles. The media could assist greatly in this quest as could religious organisations as anecdotal evidence shows that the majority of nurses have strong affiliations with religious organizations. This is not to say the religious organisations have a role in 'teaching" nurses ethics, but to encourage positive regard for nurses within the community which in turn will bring about a change in the way nurses see themselves which should translate into a change in ethical behaviour for the better.

Annexure 3 Key global developments in health professional education: 2009-2011

Year	Significant Developments
2009	1. World Health Organization (WHO) & US President's Emergency Plan for AIDS Relief (PEPFAR) embarked on work programme to address the technical requirements essential to make the transformative scale up of health professional education a reality. 2. The intended outcome is a set of evidence-based guidelines for scaling up education of health care professionals.
2009	3. PEPFAR's Medical and Nursing Education Partnership Initiatives (MEPI & NEPI) aim to assist African medical and nursing education institutions and universities to improve the quality, relevance and retention of their graduates.
2010	4. The final Global Code of Practice on the International Recruitment of Health Personnel discussed at the World Health Assembly in May 2010. The Code includes: 5. Resolutions on effective health professional education strategies; 6. Strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs; 7. Continuing professional education of migrant health personnel; 8. Using education as a retention strategy in under-served geographical areas.
2010	9. The Sub-Saharan African Medical School Study, part of PEPFAR's MEPI, published in *The Lancet* in November 2010. 10. The study examined the challenges, innovations, and emerging trends in medical education in sub-Saharan Africa. 11. Many countries prioritising medical education scale-up as part of health-system strengthening 12. Despite many innovations, there are critical staff shortages in basic and clinical sciences, weak physical infrastructure, and little use of external accreditation. 13. Ten recommendations ranging from campaigns to develop capacity of medical school faculties to revitalising the African Medical Schools Association provide guidance for efforts to strengthen medical education in sub-Saharan Africa.
2010	14. The Commission on Education of Health Professionals for the 21st Century, consisting of 20 professional and academic leaders from diverse countries, published its findings in *The Lancet* in November 2010. 15. Commission proposed a shared vision and a common strategy for post-secondary education in medicine, nursing, and public health in the light of global, health and health system challenges and the mismatch between health professional education and these challenges. 16. Commission's vision is that: '*all health professionals in all countries should be educated to mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams*.' 17. Ultimate purpose is to ensure universal coverage of high quality comprehensive services and to promote health equity.
2010	18. The Institute of Medicine in the United States of America (USA) released report: *The Future of Nursing: Leading Change, Advancing Health* in November 2010 19. *The impending health care reforms* in the USA provided the impetus for the initiative, which examined the role of the nursing profession, as the largest segment of the health care workforce. The report offers four recommendations: 20. Ensure that nurses can practice to the full extent of their education and training;

Year	Significant Developments
	21. Improve nursing education; 22. Provide opportunities for nurses to assume leadership positions and to serve as full partners in health care redesign and improvement efforts; 23. Improve data collection for workforce planning and policy-making.
2010	24. Global Consensus for Social Accountability of Medical Schools released in December 2010 25. 130 organizations and individuals from around the world with responsibility for health education, professional regulation and policy-making participated 26. The Consensus consists of ten strategic directions for medical schools to become socially accountable, highlighting required improvements to: a. Respond to current and future health needs and challenges in society; b. Reorient their education, research and service priorities accordingly; c. Strengthen governance and partnerships with other stakeholders; d. Use evaluation and accreditation to assess performance and impact.
2011	27. Draft WHO document: *Transformative scale-up of medical, nursing and midwifery education* discussed at special session at the Global Health Workforce Alliance meeting in Bangkok, Thailand in January 2011. 28. Propose a new era for health professional education with training of more professional health workers 29. Efforts to scale up medical, nursing and midwifery education must increase the quantity, quality and relevance of the providers in order to meet population health needs. 30. Reforms in education must be informed by community health needs and evaluated with respect to how well they serve these needs. 31. Stronger collaboration between the education and health sectors, other national authorities, and private sector 32. Educational institutions need to increase capacity 33. Need for reforms in recruitment, teaching methods and curricula in order to improve the quality and social accountability of graduates 34. Role of International community in supporting country-led efforts.

Sources: Frenk et al[i], Institute of Medicine[ii]; Mullan et al[iii]; Social accountability[iv]; WHO[v,vi]

Annexure 4 Model for Clinical Education and Training

1. ASSUMPTIONS OF THE MODEL

The clinical training model:

- Applies to theprofessional education of both **basic/undergraduate and post basic/ postgraduate students; "**basic" includes students in the enrolled/staff nurse and auxiliary nurse programmes
- Operates from designated **clinical training units/departments** within clinical facilitiesthat espouse a **team approach** to the clinical training of nurses.
- Is based on a curriculum that supports clinical education and training.
- Distinguishes between **clinical practica for learning** (experiential learning), in which students work with patients but they do not form part of any service team, and **clinical practica for role taking** (work-based learning), during which students form part of the service team. Jointly they contribute to work-integrated learning (WIL).
- Uses a range of WIL approaches (including experiential and work-based learning) for authentic integration of theory and practice and enhancement of students' clinical learning.
- Is based on a dedicated, coordinated system of **clinical preceptors** to ensure a minimum level of clinical teaching and support for students during work-integrated learning practices in the districts and district clinics, hospitals, NGOs and Community-based organizations.
- Includes designated persons who will coordinate the total clinical training system and ensure its functioning and quality:

1. **Clinical Placement Coordinator,** based at the provincial office of the DNS, and
2. **Clinical Programme Coordinator,**based at the health services.

- Requires students to be placed only in clinical facilities where a certain level of quality of nursing care based on clearly defined standards i.e. **Positive Practice Environments (PPEs)**.
- Relies on **Nurse Educators** who are professional and clinically competent in their field and form part of the clinical preceptor team.
- Requires all involved in the clinical education and training of nurses to role-model professionalism and competent practice.
- Requires the approval of clinical teaching facilities to be decentralized and to be delegated to the NEIs/HEIs based on clear criteria formulated by SANC, and these facilities should be inspected and monitored by SANC during designated inspection visits.

2. STRUCTURAL COMPONENTS OF THE MODEL

Key partners in the clinical education and training of nurses are the NEIs and HEIs, the clinical facilities and the Provincial Departments of Health. The clinical education and training team comprises nurse educators, specialist and generalist clinical preceptors, clinical supervisors, and a Clinical Placement Coordinator, who will ensure a coordinated system of clinical placements in public sector facilities and NGOs. Central to the model is the Clinical Programme Coordinator (CPC) who will coordinate and manage the clinical training of nursing students from **all**programmes, through a high quality preceptorship system.

Depending on the course followed and the level of training, students are distributed in a range of clinical facilities which includes but are not limited to:

- District hospitals (small, medium and large)
- Clinics in the Districts
- Regional hospitals
- Tertiary hospitals
- Central hospitals
- Specialised hospitals (e.g. psychiatric hospitals)

Figure 1 below shows the structural relations of the clinical training model. The model seeks to strengthen collaboration between NEIs/HEIs, clinical facilities and the provincial government (DNS) for the purpose of integrating the theory and practice of nursing, espoused by the Nursing Strategy for South Africa (2008).

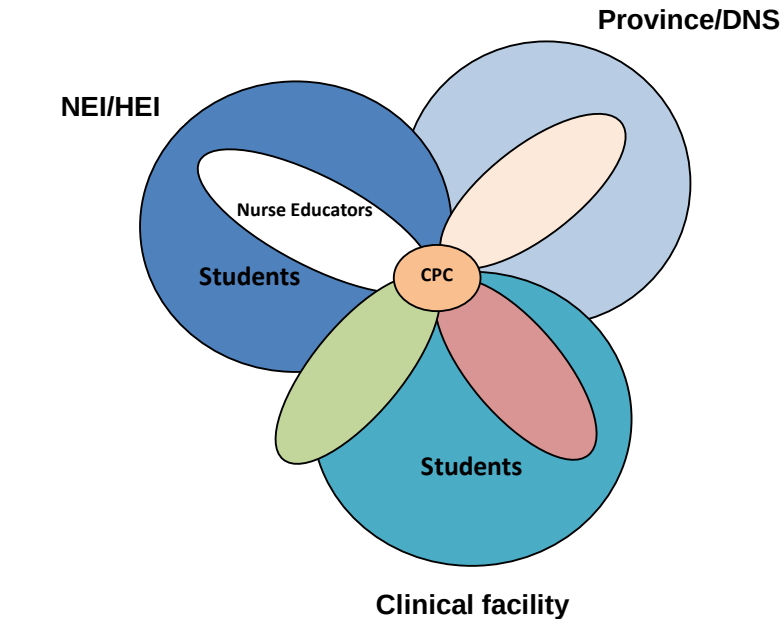


Figure 1: Proposed Model for Clinical Education and Training

2.1 Distribution of theory and practica

The teaching of both the theory and the practice of nursing has been dogged by several factors that collectively, have become known as the "shortage of nurses". The overall growth of registered professional nurses between 1996 and 2010 was only 28% (Draft HR strategy for the Health Sector, 2011) amounting to 115,244 registered nurses'; 2011 statistics show a growth rate of less than 3% to 118,262 RNs. Approximately 47% of the nursing workforce is over the age of 50 years and 16% have reached the age of 60 years; it is estimated that over 51,200 nurses are needed to replace those retiring over the next 10 years. Coupled with decreased involvement in clinical teaching and supervision by professional nurses in health units and services, high teacher-student ratios are experienced. The success of this model is dependent on teacher-student ratios that facilitate

individual learning and that support the achievement of competence. International norms suggest groups of not greater than 15 and ideally teacher to student ratios of 1:10 for pre-registration clinical training and supervision. Ratios of 1:15-20 for supervising basic students and 1:2-5 for post basic students are recommended, with the view to achieving more favourable ratios within the next 5 years.

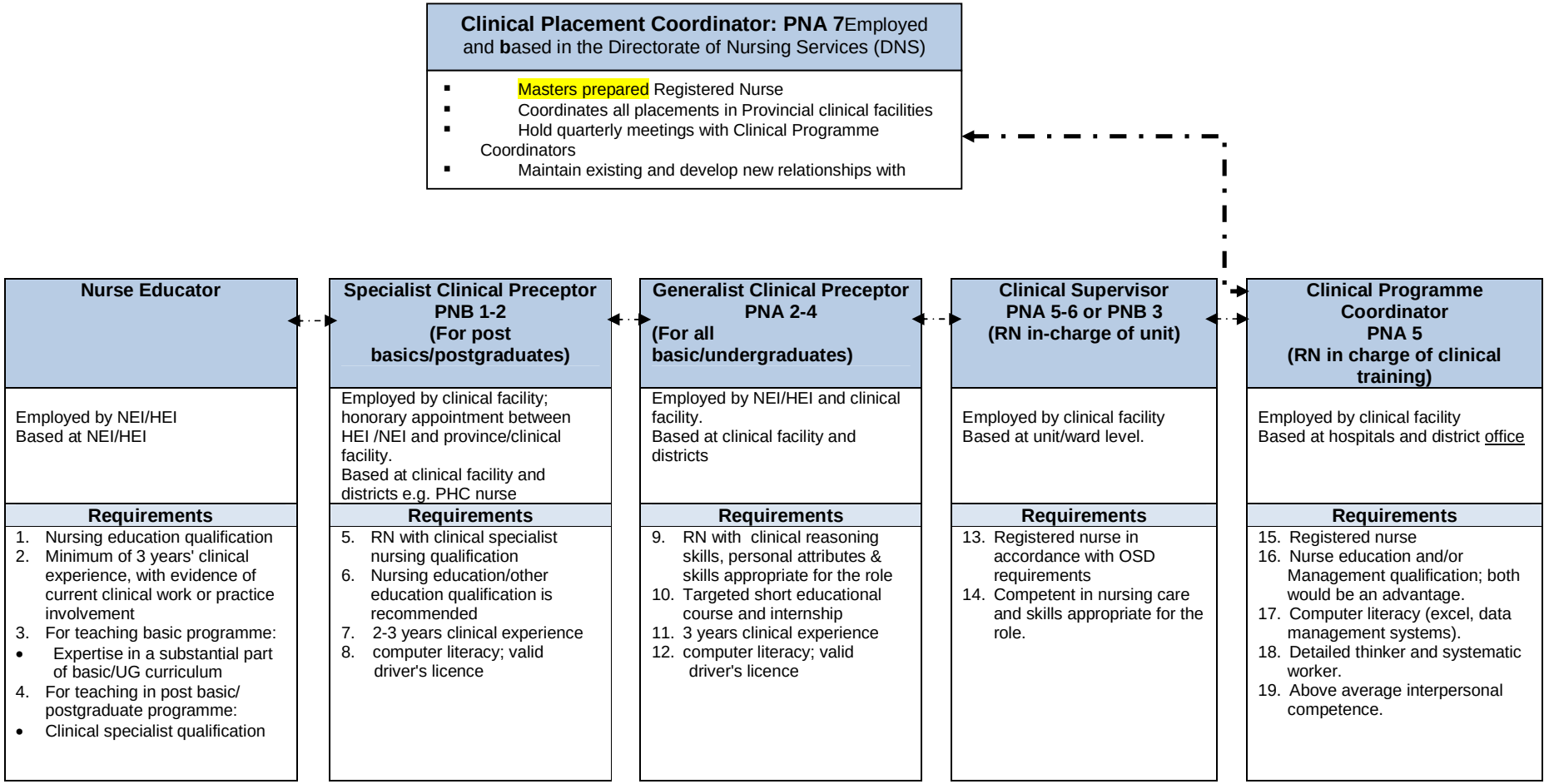
Similarly, a ratio of theory to practica that do not undermine the practice base of nursing is vitally important for the preparation of competent nursing professionals. It is therefore recommended that a minimum of 50% of a nursing curriculum be attributed to integrated practica. Recommended ratios for theory to practica and for clinical teaching and supervision for each programme type are shown in Table 1.

Table 1: Ratios for Teaching and Clinical Supervision

PROGRAMME TYPE	RATIOS		
Basic/Undergraduate Programmes	**Theory: Practica**	**Distribution of Clinical Practica**	**Teacher-Student Ratio**
Professional Nurse	50:50 (clinicalpractica = 50%)	**For learning: 20%** • 80% by clinical preceptors • 20% by educators **For role-taking: 30%**	1:15-20
Staff Nurse/Enrolled Nurse	40:60 (clinicalpractica = 60%)		1:15-20
Auxiliary Nurse	30:70 (clinicalpractica = 70%)		1:15-20
Post Basic/Postgraduate Programmes			
All clinical specialities 1 Diploma 2 Masters	 30:70 50:50		1:2-5
Midwifery	50:50		1:8-10

2.2 Roles and Responsibilities of the Clinical Training Team

One of the assumptions of the model refers to a **"team approach"** in the clinical education and training of nurses. It follows that each team member has clear roles and responsibilities that collectively support and enhance students' clinical learning experiences. Figure 2 outlines the requirements, roles and responsibilities of the team members.


Clinical Placement Coordinator: PNA 7Employed and based in the Directorate of Nursing Services (DNS)
Masters prepared Registered Nurse
Coordinates all placements in Provincial clinical facilities
Hold quarterly meetings with Clinical Programme Coordinators
Maintain existing and develop new relationships with
Nurse Educator
Employed by NEI/HEI
Based at NEI/HEI
Requirements
1. Nursing education qualification
2. Minimum of 3 years' clinical experience, with evidence of current clinical work or practice involvement
3. For teaching basic programme:
• Expertise in a substantial part of basic/UG curriculum
4. For teaching in post basic/ postgraduate programme:
• Clinical specialist qualification
Specialist Clinical Preceptor PNB 1-2 (For post basics/postgraduates)
Employed by clinical facility; honorary appointment between HEI /NEI and province/clinical facility.
Based at clinical facility and districts e.g. PHC nurse
Requirements
5. RN with clinical specialist nursing qualification
6. Nursing education/other education qualification is recommended
7. 2-3 years clinical experience
8. computer literacy; valid driver's licence
Generalist Clinical Preceptor PNA 2-4 (For all basic/undergraduates)
Employed by NEI/HEI and clinical facility.
Based at clinical facility and districts
Requirements
9. RN with clinical reasoning skills, personal attributes & skills appropriate for the role
10. Targeted short educational course and internship
11. 3 years clinical experience
12. computer literacy; valid driver's licence
Clinical Supervisor PNA 5-6 or PNB 3 (RN in-charge of unit)
Employed by clinical facility
Based at unit/ward level.
Requirements
13. Registered nurse in accordance with OSD requirements
14. Competent in nursing care and skills appropriate for the role.
Clinical Programme Coordinator PNA 5 (RN in charge of clinical training)
Employed by clinical facility
Based at hospitals and district office
Requirements
15. Registered nurse
16. Nurse education and/or Management qualification; both would be an advantage.
17. Computer literacy (excel, data management systems).
18. Detailed thinker and systematic worker.
19. Above average interpersonal competence.

Strategic Plan for Nursing Education, Training and Practice 2012/13 – 2016/17

ROLES & responsibilities
20. Programme development and curriculum design: • Emphasise outcomes (roles) and competencies that are integrated &/or sequenced • Review every 3-5 years 21. Develop/review clinical nursing standards jointly with clinical facilities 22. Design valid, reliable assessment criteria and tools 23. Teach, accompany, supervise and assess for clinical competence 24. Integrate theory and practice: ▪ Use clinical scenarios/PBL ▪ Use simulation laboratory & clinical setting effectively ▪ Use evidence-based teaching strategies i.e. visual & work-based 25. Maintain clinical competence: 1. Spend 10% teaching time per year in clinical setting related to subject/ beings taught. 26. Role model professionalism and competent practice. 27. Conducts clinical research. 28. Supervise and support preceptors:

ROLES & responsibilities
29. Responsible for clinical training of nurses in specialist programmes. 30. 10-15% of employment time dedicated to: aching specialist content at EI/HEI; onsultancy for academic staff 1. Clinical teaching, supervision and assessment of post basic/ postgraduate students. 2. Teach and support nursing staff: newly appointed/ CSNs/nurses on rotation etc 3. Maintain a close working relationship with nurse educators and act as liaison between service and NEI/HEI. 4. Role model professionalism and advanced practice skills and behaviours. 5. Is lead nurse for research in a specialty area.

ROLES & responsibilities
6. Responsible for clinical training in basic nursing programmes. 7. Clinical teaching, supervision & accompaniment for integration of theory & practice **(Main role: clinical practica for learning)** 8. Spend 10% of time teaching e.g. lecture-demonstrations. 9. Monitor student's achievement of learning outcomes 10. Assist nurse educators with clinical assessments 11. Maintain a close working relationship with nurse educators and act as liaison between service & NEI 12. Participate in the formulation of clinical learning outcomes 13. Schedule working time over weekends, night duty, NEI/HEI vacation or inter-block times 14. Role model professional nursing and complex clinical behaviours. 15. Identifies opportunities for and fosters clinical nursing research.

ROLES & responsibilities
33. Clinical governance in clinical facility: management primarily for patient care 34. Provide direct patient care 35. Clinical teaching & supervision **(Primary role: clinical practica for role-taking)** 36. Work closely with clinical preceptors & nurse educators 37. Contribute to student progress/ competence reporting and reports 38. Role model professional nursing and complex clinical behaviours. 39. Identifies opportunities for and fosters clinical nursing research. 40. Collaborate in research to improve clinical nursing practice.

ROLES & responsibilities
41. Jointly plan with NEI and coordinates clinical placements within clinical facility. 42. Schedule and chair monthly Clinical Coordination meetings 43. Evaluate units/wards for PPE status and monitor compliance 44. Jointly develop and monitor a quality assurance system for clinical training 45. Maintain compliance with SANC and CHE requirements with regard to clinical training. 46. Manage clinical placements electronically using relevant software; record-keeping of clinical training outcomes and nurse competence. 47. Recruit clinical preceptors; participate in selection and appointment of preceptors. 48. Organise training of preceptors in consultation with NEI/HEI. 49. Monitor schedule of flexitime of all preceptors.

2. Pay structured visits to clinical areas 3. Offer needs-based clinical training & development				

Figure 2: Requirements, Roles and Responsibilities of the Clinical Training Team

3. A CURRICULUM FOR CLINICAL EDUCATION AND TRAINING

a. Principles that Support the Clinical Component in the Curriculum are:

1. Appropriate linking and sequencing of practica following theoretical instruction.
2. Provision for both clinical practica for learning and clinical practica for role-taking
3. Review of curricula every 3-5 years to ensure that priorities in clinical practice are taught in theory and theory is appropriate for current practice.
4. Outcomes (role and function) and competencies are emphasised rather than skills only; content selected must support learning goals/outcomes and addition of content to the curriculum must be balanced with deletion of content.
5. When planning and monitoring clinical learning experiences, roles, functions and competencies should be the focus rather than minimum clinical hours and procedures.
6. Theory and practica in the curriculum must be structured according to programme requirements (table 1), with provision for *clinical practica for learning* and *clinical practica for role-taking*.
7. Preparation for clinical practica is based on simulation and this may form part of the proportion allocated to *clinical practice for learning*.
8. Allocation for clinical practica must be planned jointly between designated *academics/nurse educators from the NEI/HEI* and *the CPC* in the services in a manner that shows programme coherence, continuity and vertical integration of knowledge and skills.
9. Pre-clinical discussions must be held with preceptors to prepare for and brief students on specific expectations.
10. Clinical placement for not less than one month in a clinical area should be implemented for role-taking practica.

3.2 Structures to Support the Clinical Component of the Curriculum

3.2.1 At Clinical Facility Level:

1. A designated **Clinical Teaching Unit (CTU)** or **Clinical TeachingDepartment (CTD)** must be established at each clinical facility and in the case of districts, at each District Office; such units will be responsible for 1) the clinical training of student nurses, 2) the staff development and in-service training of qualified nursing staff, and 3) the induction and orientation of new nursing staff and community service nurses (CSN).
2. A designated person, called a **Clinical Programme Coordinator (CPC)** must be appointed by the clinical facility whose job it is to coordinate clinical learning opportunities of students from all programmes. This person should have a sufficiently senior position (see roles and responsibilities in Table 1).
3. **Clinical preceptors** are integral to the clinical training model and work closely with the CPC, nurse educators and clinical supervisors. Clinical preceptors must be differentially appointed for basic and post basic programmes and referred to as *generalist clinical preceptors* and *specialist clinical preceptors* respectively.

- *Generalist clinical preceptors* are employed by and report to the NEI/HEI but are physically placed in the services with at least an honorary appointment in the clinical facility where students are placed and have full access and involvement in service issues that impact on clinical training.

- *Specialist clinical preceptors* are employed by and report to the clinical facility (CPC) and have an honorary appointment in the NEI/HEI that places and trains post basic/ postgraduate students

4. Recommended ratios of 1 Generalist Clinical Preceptor for every 15-20 students and 1 Specialist Clinical Preceptor for every 2-5 students must be adhered to (see table 1). International norms for adequate clinical supervision in basic nursing programmes suggest a ratio of 1:10, which must be the aim within the next 5 years.

5. Registered nurses (Operational managers) in charge of units are responsible for teaching and supervising students allocated to their units for practica for role-taking to ensure their integration into the health care team. These RNs make up the **clinical supervisor** structure, which is vital for the successful implementation of the model by optimising the following roles:
   - *Professional caring* for patients/clients
   - *Teaching* for patient/client care
   - *Managing* patient care and *administering* nursing practice
   - *Researching* to improve care and advance nursing practice

6. Clinical facilities must show evidence of Positive Practice Environments (PPEs) – the following are criteria for the selection of PPEs, based on the Government Criteria as listed as domains and (sub-domains):

   1. Patient Rights (Respect and dignity; Information to patients; Physical access; Continuity of care; Reducing delays in care; Emergency care; Delivery of package of services; and Complaints management)

   2. Patient Safety, Clinical Governance and Clinical Care (Patient care; Clinical Leadership; Clinical management of priority health programmes; Clinical Risk; Infection prevention and control; Adverse events)

   3. Clinical Support services (Pharmaceutical services; Clinical support services; Clinical equipment and supplies; Medical records; Healthcare technology maintenance)

   4. Public Health (Population based service planning and delivery; Health promotion and disease prevention; Disaster preparedness)
   5. Leadership and Corporate Governance (Planning; Strategic Leadership; Stakeholder representation; Oversight; Risk management; Communication and public relations; Quality improvement)

   6. Operational management (Human resource management and development; Employee wellness; Financial resource management; Supply chain management; Transport and fleet management; information management)

   - Facilities and infrastructure (Buildings and grounds; Machinery and utilities; Safety and Security; Hygiene and cleanliness; Waste management; Linen and laundry; food services)

   - Other criteria:

      1. RN and other team members accept teaching as part of their role
      2. Develop expertise to assist practitioners to modernise their practice through, outreach approaches for educational interventions and feedback on performance
      3. Understanding patients' perceptions and concerns
      4. Strengthening health systems

3.2.2 At Provincial Level:

- A **Directorate of Nursing Services (DNS)** with a *Sub-directorate of Nurse Education and Training* must be established at Provincial Health Departments, with a professional nurse appointed as Director of Nursing Services (WCPG model).

- A **Clinical Placement Coordinator** based at the DNS for the development and implementation of a *coordinated clinical placement system* to ensure regulated and appropriate placement of students.

- The Clinical Placement Coordinator has the following roles and responsibilities:

    - Coordinates placement of all student nurses in provincial health services and NGOs to ensure achievement of clinical outcomes in the curriculum without overburdening the services, patients and clients; clinical placements should be done with due consideration of:

    - Numbers of students in the programme(s) and the number of units to which they can be allocated;

    - Previous commitment of a specific service facility to a specific programme;

    - Equity – all the nursing education providers should have equitable access to public health services;

    - Specific needs and learning opportunities of the curriculum of each NEI/HEI e.g. sequencing; correlation of theory and practice.

    - Monitors compliance with SANC (and CHE) requirements, including situational analyses, of clinical facilities to ensure that they are appropriately selected/used to meet the clinical outcomes of the curriculum.

    - Receives and manages all requests and applications for clinical placement, and ensures that service level agreements are in place between the services and NEIs/HEIs.

    - Holds quarterly meetings with CPCs and designated nurse educators from NEIs/HEIs for the purpose of monitoring clinical placements and standards of PPE.

3.2.3 At NEI or HEI Level:

- **Nurse educators** involved in theoretical teaching are also fully responsible for clinical teaching and for assisting students to integrate theory and practice at all levels through the use of appropriate teaching approaches and learning facilitation techniques.

- Nurse educators must be appropriately qualified for their *teaching and learning facilitation roles* and to carry out designated responsibilities (see Figure 2).

- Nurse educator currency and competence is essential to prepare nurses who are professional, competent and workplace-ready. This requires nurse educators to:

    - Work/have direct patient or client contact in clinical areas related to the discipline they teach for 10% of their time in an academic year e.g. in a 44-week academic year it means a total of 176 hours - 4 hours per (40hr) week or 22 days per year.

    - Participate in academic and scholarly activities that take place *in clinical facilities* such morbidity and mortality meetings, teaching rounds, seminars etc.

- Academic planning and personal timetables/calendars must reflect structured visits to and meetings with clinical areas by nurse educators, professional development and competence (as above) and clinical accompaniment.

- Group supervision sessions run by nurse educators for clinical preceptors are essential to ensure quality, staff development and optimal linking of theory with practice.

- The conduct of relevant research by nurse educators is essential to develop scholarship of clinical teaching.

- NEIs/HEIs will be required to enter into MOAs/service level agreements with clinical facilities (see Clinical Placement Coordinator above); honorary appointments for clinical preceptors must form part of the agreement between NEI and clinical facilities.

- NEI/HEI should create opportunities for part-time education towards higher education qualifications to make career progression possible for clinical preceptors, clinical supervisors and CPCs.

- The competence of **nursing students** and their professional socialization into nursing must be the main goal of the clinical training model. Whilst:

    - enrolled in a nursing programme, students must fulfil all the theoretical and clinical requirements for practice and for registration with SANC in order to practice as a nurse;

    - in community service, nurses must be considered as doing an internship with the first six (6) months focussing on patient/client care and the last 6 months on managing a unit, clinical service and the health care team.

(Outcomes should be developed and a package of what should be done with students during that period will have to be developed).

3.2.4 Professional Regulatory Body:

- The South African Nursing Council (SANC) as the regulatory body of the nursing profession must exercise its legal prerogative to ensure the safety of the inhabitants of the Republic of South Africa. In so doing it must prescribe *professional competencies* to be met for licensure and practice as a nurse (all categories) and as a midwife.

- These professional competencies should form the foundation for a *curriculum for clinical education* in all nursing programmes – basic, post basic/postgraduate and midwifery.

- Clinical facilities utilized for the achievement of clinical competencies should be inspected by SANC during its 5-yearly accreditation inspection of the NEI/HEI; approval of new clinical facilities to be used must be devolved to the NEI/HEI with direct accountability to SANC.

- The minimum number of hours specified for the achievement of competence requires support by recent evidence and if its continued use is unavoidable, a composite framework of credits and notional hours must be explored and implemented.

▪ IMPLEMENTATION PLAN

A Working Group must be appointed to champion the implementation of this model. This group should consist of the nursing education stakeholder (NES) group and two (2) Human Resources representatives from the national and provincial Departments of Health.

Table 2: Implementation Plan

Activity	Responsibility	Stakeholders	Time
Establish DNS; create post for Clinical Placement Coordinator	Provincial DoH	National and Provincial DoHs; NES	End of 2012
Establish dedicated CTDs/CTUs for preceptors	Clinical facilities	Provincial DoH/DNS, NEIs and clinical facilities	End of 2012
Create posts for CPCs	Provincial DoH;	Provincial DoH/DNS and clinical facilities	End of 2012
Prepare focussed short course for clinical preceptors	NEI/HEI	NEI/HEI & clinical facilities	2012
Develop physical infrastructure for preceptors and CPC	Clinical facilities	Provincial DoH/DNS, NEIs and clinical facilities	End of 2012
Recruit and appoint CPC	Clinical facilities	Provincial DoH/DNS, NEIs and clinical facilities	2013
Identify PPEs for clinical placement	CPC	Clinical Placement Coordinator/DNS, NEIs and clinical facilities	2013
Set electronic system for student placement	CPC	Provincial DoH/DNS; NEI/HEI; CPC	2013
Create positions for preceptors	Clinical facilities	Clinical facilities management; CPC	2012/13
Recruit and appoint preceptors	CPC	CPC and NEI/HEI	2012/13
Re-orientate all RNs to clinical supervisor role	CPC	CPC and NEI/HEI and clinical facilities management	2012/13
Training of preceptors and current clinical supervisors	NEI/HEI nurse educators	NEI/HEI and CPC	2013 to end of 2014
Prepare and sign MOAs	DNS	DNS; NEI/HEI and clinical facilities	Beginning of 2013
Honorary appointment of clinical preceptors and clinical supervisors in terms of MOA	NEI/HEI management	NEI /HEI and clinical facilities	Beginning of 2013
Quality Assurance (QA) system for clinical education and training	NEI/HEI management	DNS; NEI/HEI and clinical facilities QA structures	2013
Prepare clinical facilities for new system	NEI/HEI and clinical facilities	DNS, NEI /HEI and clinical facilities	2012/13
Prepare NEIs/HEIs for new system	NEI/HEI and clinical facilities	DNS, NEI /HEI and clinical facilities	2012/13
New approach to approval of clinical facilities put into regulations	SANC	DNS; NEI/HEI and clinical facilities	2013
Test and evaluate implementation of the model using 1 Private NEI and 1 Public NEI	NES and Task Team	NEI/HEI and clinical facilities	
Research on clinical training model	NEI	NEI and clinical facilities	Long term 2012- 2016

- **BUDGETARY IMPLICATIONS**

For clinical facilities where there is no CTD or CTU space allocated, such space must be made available. A projected budget is presented in Table 3 below.

Based on the proposed human resource requirements for the model annexure 2 illustrates the budget projected for the 2011/12 financial year through to the 2014/15 financial year. The following categories are considered in the budget:

- Clinical Placement Coordinator (PNA 7)
- Clinical Programme Coordinator (PNA 5)
- Specialist Clinical Preceptors (PNB 1-2)
- Generalist Clinical Preceptors (PNA 2-4)

The Gauteng province was used to illustrate the projected costs of clinical training within a basic and undergraduate nursing curriculum (4-year diploma/degree, 2 year EN Diploma and

1-year ENA certificate) based on current student numbers, preceptors and number of health facilities (Annexure 3).

Table 3: Projected Budget for CTD or CTU set-up

Subject	Number	Cost per annum
PC's (Computer)	1	R 8000,00 (once off)
Desk	1	R1500,00 (once off)
Chairs	3	R 2000,00 (once off)
Vehicle	1	R140 000,00 (once off)
Vehicle running cost per annum	1	R 12 000,00 This will change according to current vehicle leasing costs and fuel
Lecture room chairs (optional)	60	R30 000,00 (once off)
Data projector & laptop computer	1	R18 000,00 (once off)
Doll's (intubation; CPR), DVD's, etc	package	R100 000,00 (once off)
Media upgrades per annum	Per annum	R10 000,00
Start-up cost for first year:		**R321,500.00**
Total running cost per annum:	**(estimated)**	**R300 000,00**

Clinical Model ANNEXURE 1

MINISTERIAL TASK TEAM ON NURSE EDUCATION AND TRAINING

REFERENCE GROUP: CLINICAL EDUCATION AND TRAINING

REPORT ON VISIT TO GREY'S HOSPITAL AND NURSING COLLEGE, PIETERMARITZBURG

16 MARCH 2012

- **PURPOSE**

The purpose of the visit to Grey's Hospital and Nursing College was to determine best practice in the clinical training of nurses. This involved meeting with key individuals to:

- Learn about the **clinical training model,** jointly implemented by the Hospital and the Nursing College with reference to:
    a. management/governance structures
    b. relationship internally and externally e.g. KZN dept of Health, Universities etc
    c. overall purpose and role
    d. resources (people, equipment etc)
- **Visit the clinical teaching department/unit** and associated units to determine location, physical layout, resources and logistics
- Learn about the **role andfunctions of the clinical teaching department** with reference to:
    a. Clinical training of basic and post basic students
    b. Staff development; induction of new staff
    c. Setting and maintaining of standards of care/quality of care

- **REPORT**

a. Location and Context

The Nursing College at Grey's Hospital (500 beds) is located on the hospital premises and is referred to a **Campus of the Kwazulu-Natal College of Nursing.** Mrs ThombenhleMathebula is the campus principal.

The teaching staff (nurse educators) complement at the College according to subjects taught in all programmes is as follows:

- General nursing: 21
- Community nursing: 6
- Psychiatric nursing: 3
- Midwifery: 5

In total there are 519 students distributed in the following four (4) programmes:

- 4-year Diploma for RNs
- 2-year Diploma for ENs (Bridging programme)
- 2-year Diploma for ENs, and the
- 1-year Diploma in Midwifery.

Students are **not supernumerary** and are required to do a 40-hour week when not in block, and includes working shifts, night duty and weekends. Clinical allocation is done jointly by the Hospital (Assistant Nurse Manager) and the College (Deputy Principal and HODs). College blocks vary between 2-6 weeks from 07h00- 16h00.
This College does not offer any specialist/post basic courses for nurses even though the hospital offers a range of learning opportunities.

b. Clinical Teaching Department (CTD)

The CTD is based in the College and is staffed by five (5) registered nurses called **clinical sisters**; four (4) are supplied and paid for by the Hospital and one (1) by the College. These five staff members are responsible for the clinical training component of **General Nursing** only in the three programmes offered at the College.

The CTD is an **open-plan unit** which is fitted with:

- Desks and chairs for each staff member
- Resource room, mainly with forms (assessment, reports etc and other stationery supplies)
- One computer – locked in a side room.

A well-maintained paper-based student record system is place that enables tracking of student progress towards competence. A computer-based record system is being explored.

c. Demonstration room

This is the space used for actual clinical teaching/demonstrations before students are allocated to the wards, for supervised practice sessions and for assessment of competence. There are two rooms (14x14 ft) fitted with basic equipment and areas such as sluice room, store room etc. This area is also used for hospital staff development and in-service training.

d. Work assignment model

Clinical sisters are based at college but spend most of their day in the hospital depending on number of students and activities according to block programmes. They work hand-in-hand with college tutors, who are allocated "clinical days", which are time-tabled; CTD gets a copy of time tables in advance so they know who they will be working with and how many there will be the units on a daily basis.

Standards of care (procedures etc) are common to both and standardized between the hospital and the college. These standards are used to assess and determine students' competence. The standards are reviewed regularly – no specific time frame was given. Clinical sisters and college tutors have the following clinical training responsibilities:

Clinical sisters:

1. Assist tutors with clinical demonstrations and take full responsibility for the "aseptic block" for all three basic programmes
2. Supervise and mentor students allocated to the wards; this includes students from other NEIs even though they have their own clinical preceptors/teachers.
3. Do formative assessments only and assist with final assessments and OSCEs only if required.
4. Are assigned lectures (theory) that are related to practicals; these are done annually, time-tabled and divided among them.
5. Do lectures for staff and students on a **needs basis** depending on problem areas identified in practice e.g. report-writing.
6. Orientate new staff and newly qualified staff (ENs and RNs); sessions are done monthly or less frequently depending on the staff needs and academic programme needs.
7. Arrange for and do in-service training and staff development for all nurses employed by the hospital.

Clinical sisters are sometimes called upon as relief staff when there is a serious staff need or in the case of a disaster or major emergency. This is very rare and happened once only in 2011.

College tutors:

- Are assigned "clinical days" – I day per week, which are time-tabled (and thus compulsory); their role is clinical teaching and not service provision.

- Do the majority of final assessments but are assisted by clinical sisters depending on other blocks running.
- In **Psychiatric** and **Community Health Nursing:**
  - Are responsible for all practica
  - Are supported by student liaison person in the districts, municipal clinics etc.
- In **Midwifery:**
  - Are supported by student liaison person in maternity areas
  - Do all clinical teaching and supervision, assisted by a **dedicated clinical sister, based in maternity.**

The College recently budgeted for and advertized three clinical lecturers/facilitators' posts. One has been filled by an RN (registered as a tutor with SANC) who forms part of the clinical team for General Nursing (see 2.2)

e. Liaison and communication

There is no direct reporting line or communication with the KZN Department of Health. The Campus principal attends an annual meeting a required.

All clinical sisters and student liaison persons belong to the **Campus Board** and attend meeting three times a year in March, July and November.

f. General

Clinical sisters have no specific job description. They are appointed at PND level and the responsibilities are amended for clinical teaching, according to the generic professional nurse's job description (EPMDS). They are required to set a work plan for the year with goals and activities against which they are rated and evaluated; they spend 90% of their time in the clinical areas; the remainder is spent on classroom teaching, giving lecture-demonstrations as determined in advance (see 2.4).

Judith Bruce
23 March 2012

Clinical Model ANNEXURE 2

2011/12 FY

GAUTENG

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Preceptors - 1/20	PNA 2-4	183 732.00	259	12	47 586 588.00	3 965 549.00	6 186 256.44	8 578 080.00	2 486 400.00	7 770.00	68 810 643.44
Specialist Preceptors - 1/5	PNA 1-2	149 391.00	100	12	14 939 100.00	1 244 925.00	1 942 083.00	3 312 000.00	960 000.00	3 000.00	22 401 108.00
Operational Manager	PNA 5	260 790.00	35	12	9 127 650.00	760 637.50	1 186 594.50	1 159 200.00	336 000.00	1 050.00	12 571 132.00
Assistant Manager	PNA 7	330 360.00	1	12	330 360.00	27 530.00	42 946.80	33 120.00	9 600.00	30.00	443 586.80
					71 983 698.00	5 998 641.50	9 357 880.74	13 082 400.00	3 792 000.00	11 850.00	**104 226 470.24**

NATIONALLY

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Operational Manager	PNA 5	260 790.00	452	12	117 877 080.00	9 823 090.00	15 324 020.40	14 970 240.00	4 339 200.00	13 560.00	162 347 190.40
Assistant Manager	PNA 7	330 360.00	9	12	2 973 240.00	247 770.00	386 521.20	298 080.00	86 400.00	270.00	3 992 281.20
					120 850 320.00	10 070 860.00	15 710 541.60	15 268 320.00	4 425 600.00	13 830.00	**166 339 471.60**

2012/13 FY

GAUTENG

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Preceptors	PNA 2-4	192 918.60	259	12	49 965 917.40	4 163 826.45	6 495 569.26	8 578 080.00	2 486 400.00	7 770.00	71 697 563.11
Specialist Preceptors	PNA 1-2	156 860.55	100	12	15 686 055.00	1 307 171.25	2 039 187.15	3 312 000.00	960 000.00	3 000.00	23 307 413.40
Operational Manager	PNA 5	273 829.50	35	12	9 584 032.50	798 669.38	1 245 924.23	1 159 200.00	336 000.00	1 050.00	13 124 876.10
Assistant Manager	PNA 7	346 878.00	1	12	346 878.00	28 906.50	45 094.14	33 120.00	9 600.00	30.00	463 628.64
					75 582 882.90	6 298 573.58	9 825 774.78	13 082 400.00	3 792 000.00	11 850.00	**108 593 481.25**

NATIONALLY

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Operational Manager	PNA 5	273 829.50	452	12	123 770 934.00	10 314 244.50	16 090 221.42	14 970 240.00	4 339 200.00	13 560.00	169 498 399.92
Assistant Manager	PNA 7	346 878.00	9	12	3 121 902.00	260 158.50	405 847.26	298 080.00	86 400.00	270.00	4 172 657.76
					126 892 836.00	10 574 403.00	16 496 068.68	15 268 320.00	4 425 600.00	13 830.00	**173 671 057.68**

2013/14 FY

GAUTENG

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Preceptors	PNA 2-4	202 564.53	259	12	52 464 213.27	4 372 017.77	6 820 347.73	8 578 080.00	2 486 400.00	7 770.00	74 728 828.77
Specialist Preceptors	PNA 1-2	164 703.58	100	12	16 470 357.75	1 372 529.81	2 141 146.51	3 312 000.00	960 000.00	3 000.00	24 259 034.07
Operational Manager	PNA 5	287 520.98	35	12	10 063 234.13	838 602.84	1 308 220.44	1 159 200.00	336 000.00	1 050.00	13 706 307.41
Assistant Manager	PNA 7	364 221.90	1	12	364 221.90	30 351.83	47 348.85	33 120.00	9 600.00	30.00	484 672.57
					79 362 027.05	6 613 502.25	10 317 063.52	13 082 400.00	3 792 000.00	11 850.00	**113 178 842.81**

NATIONALLY

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Operational Manager	PNA 5	287 520.98	452	12	129 959 482.96	10 829 956.91	16 894 732.78	14 970 240.00	4 339 200.00	13 560.00	177 007 172.66
Assistant Manager	PNA 7	364 221.90	9	12	3 277 997.10	273 166.43	426 139.62	298 080.00	86 400.00	270.00	4 362 053.15
					133 237 480.06	11 103 123.34	17 320 872.41	15 268 320.00	4 425 600.00	13 830.00	**181 369 225.81**

2014/15 FY

GAUTENG

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Preceptors	PNA 2-4	212 692.76	259	12	55 087 423.93	4 590 618.66	7 161 365.11	8 578 080.00	2 486 400.00	7 770.00	77 911 657.71
Specialist Preceptors	PNA 1-2	172 938.76	100	12	17 293 875.64	1 441 156.30	2 248 203.83	3 312 000.00	960 000.00	3 000.00	25 258 235.77
Operational Manager	PNA 5	301 897.02	35	12	10 566 395.84	880 532.99	1 373 631.46	1 159 200.00	336 000.00	1 050.00	14 316 810.29
Assistant Manager	PNA 7	382 433.00	1	12	382 433.00	31 869.42	49 716.29	33 120.00	9 600.00	30.00	506 768.70
					83 330 128.41	6 944 177.37	10 832 916.69	13 082 400.00	3 792 000.00	11 850.00	**117 993 472.47**

NATIONALLY

POST DESIGNATION	SALARY LEVEL	NOTCH	AMOUNT OF STAFF	AMOUNT OF MONTHS	SALARY	SERVICE BONUS	EMPLOYER CONTRIBUTION TO GEPF	MEDICAL SCHEME MAX	HOUSING ALLOWANCE	LABOUR	PACKAGE PER YEAR
					GUARANTEED			POTENTIAL			
Operational Manager	PNA 5	301 897.02	452	12	136 457 453.04	11 371 454.42	17 739 468.90	14 970 240.00	4 339 200.00	13 560.00	184 891 376.36
Assistant Manager	PNA 7	382 433.00	9	12	3 441 897.00	286 824.75	447 446.61	298 080.00	86 400.00	270.00	4 560 918.36
					139 899 350.04	11 658 279.17	18 186 915.51	15 268 320.00	4 425 600.00	13 830.00	**189 452 294.72**

Clinical Model ANNEXURE 3

Projected HR clinical training costs for Gauteng

Post Designation	Salary Level	Salary notch		Supervi-sion ratio	No. of Students (2011)	Amount - current	Amount - needed	
Clinical Preceptors	PNA 2-4	212,692		1:20	8000	40 (univ) 85 (coll)	275	58.5m
Clinical Programme Coordinator	PNA 5	301,897				0	29 Hospitals 6 Distr. offices	10.6m
Clinical Placement Coordinator	PNA 7	382,433				0	1	382,433
								R69,482,433

Annexure 5 Responsibilities: CNO at national level

Responsibilities of the CNO at national level:

- Ensures the provision of quality nursing education that meets the country's health needs and disease profile.
- Establishes the vision for and provides leadership in the delivery of excellent patient care and in the achievement of a variety of national and international initiatives.
- Provides expert advice on nursing and midwifery to Government and helps to develop, implement and evaluate Government health policies, leading on nursing and midwifery policies and strategies in support of the Government's objectives.
- Provides input into the development of the HR plan for nursing and midwifery services, including the support staff, and informs the national HR strategy.
- Provides ethical, professional leadership and stewardship to the nursing and midwifery professions in South Africa, working closely with the provincial CNOs, professional statutory bodies, professional and staff associations, unions, and other health stakeholders.
- Ensures an effective South African contribution to nursing and health policy including input into policy development and policy implementation through stakeholder consultations, monitoring and evaluation of the policies and participating in international forums, for example the World Health Organisation, ICN, ICM, SADEC, the Commonwealth and Africa.
- Contributes to the National Health Department's central task of managing and supporting service delivery.
- Is part of the bargaining process to negotiate nursing issues at the Bargaining Chambers.
- Ensures branding and marketing of the nursing profession to position the profession appropriately
- Ensures that matters of national interest and priority are communicated to the nursing profession and relevant stakeholders across the country
- Ensures promotion of research at all levels, implementation of the recommendations and informing policy decisions.
- Renders strategic support, supervision in the context of monitoring and evaluation of services in nursing practice and nursing education.
- Ensures that policies arising from political decisions are implemented.
- Liaises with the private sector stakeholders

Experience Requirements:

- Comprehensive knowledge of health care issues, delivery systems and regulations.
- Well developed managerial skills and experience, in order to organise and direct assigned areas of responsibility
- Minimum of 10 years of executive experience within a healthcare organisation. This includes clinical and management experience demonstrating progressive leadership development and competency.
- Knowledge and insight into general nursing practice and nursing education.
- A proven ability to work collaboratively with other clinical and administrative disciplines to accomplish strategic initiatives and clinical quality goals.
- Knowledge and insight into Industrial Relations.

Education Requirements:

- The minimum of a Masters degree in nursing. Knowledge attained through a Doctoral degree would be an added advantage.

- Comprehensive knowledge of health care management, nursing education and communication skills at a level normally acquired through a qualification in nursing education and health administration, business administration or a related field.

Certification requirements:
Licensed and registered as a Professional Nurse in South Africa with a valid certificate to practice.

Annexure 6 Responsibilities and requirements for Provincial CNO

Responsibilities:

- Identifies and articulates the vision and strategic direction for the development of quality nursing care in the province, consistent with the national mission, vision and values
- Creates a nursing environment in which collaboration is valued and excellence in clinical care, education and research is promoted and achieved
- Leads quality and patient safety initiatives, and benchmarks on best practices within and outside the country
- Promotes and facilitates an organisational culture that provides a safe and enriching environment for patients and employees.
- Takes responsibility for the practice of nursing and ensuring consistency in the standard of practice across clinical settings. Assures nursing services provided meet standards and requirements of all applicable legislation, regulations and regulatory bodies through the implementation of the National Core Standards for health establishments.
- Provides ethical, professional leadership and direction in the development of strategies to promote the recruitment, retention and recognition of excellence in nursing and midwifery including oversight and recommendations regarding compensation and benefit programmes for nursing and midwifery staff.
- Assumes responsibility for identified problems, collaboratively generates solutions, anticipates the effects of those decisions in the province, and ensures implementation and evaluation.
- Participates in setting and achieving operational and financial goals for the province.
- Ensures that policies arising from political decisions are implemented.
- Participates in addressing health stakeholder complaints in the province.
- Liaises with the private sector stakeholders

Experience Requirements:

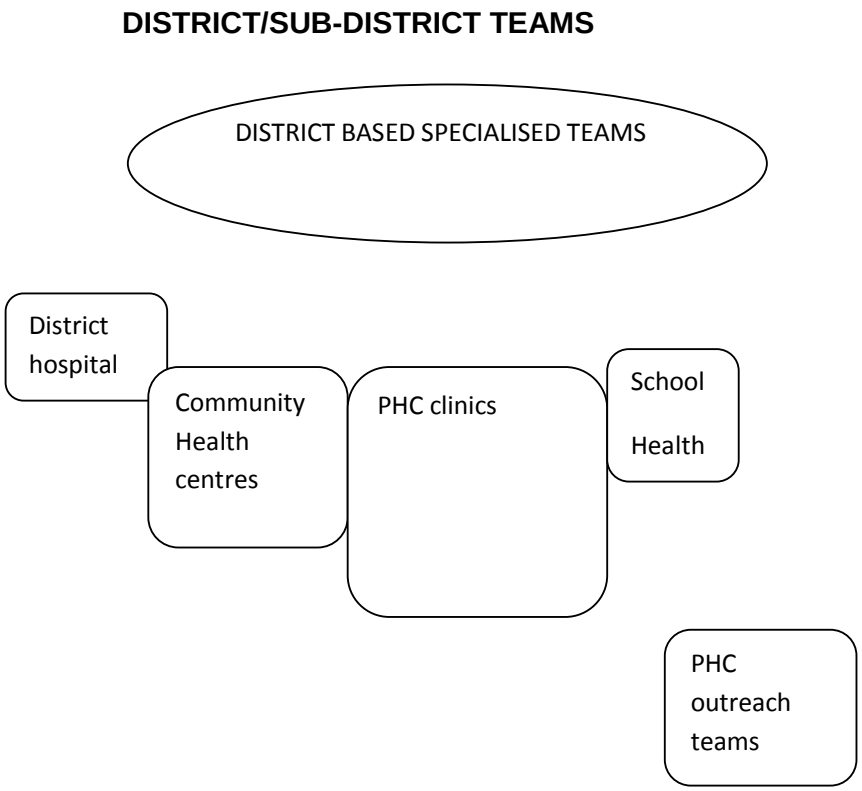
- Comprehensive knowledge of health care issues, delivery systems and regulations.
- Well developed managerial skills and experience, in order to organise and direct assigned areas of responsibility
- Minimum of 7 years of executive experience within a healthcare organisation. This includes clinical and management experience demonstrating progressive leadership development and competency.
- Knowledge and insight into general and nursing education.
- A proven ability to work collaboratively with other clinical and administrative disciplines to accomplish strategic initiatives and clinical quality goals.
- Knowledge and insight into Industrial Relations.

Education Requirements:

- The minimum of a Masters' degree in nursing.
- Comprehensive knowledge of health care management, nursing education and communication skills at a level normally acquired through, nursing education and health administration, business administration or a related field.

Certification requirements:
Licensed and registered as a Professional Nurse in South Africa with a valid certificate to practice.

The District Health Team is a team of clinical experts from various professions.



The proposed structure: District based specialists: gynaecologist, paediatrician, anaesthetist, family physician, advanced midwife and primary health care nurse; these specialists are to give support to every district

PHC clinics: Doctor, PHC nurse, Prof Nurse, pharmacy assistant and a counsellor

School health services: It is proposed that there must be a school nurse at every school; however this is not feasible in the short to medium term.

PHC Outreach teams: Prof Nurse, Health promoter, Environmental Health Officer and Community Health Worker

Annexure 7

SANC AUDIT TOOL

CRITERION	EVIDENCE	YES	NO	COMMENT
1. Vision, Mission, Values, Objectives & Strategy	The SANC has a vision and mission			
	The SANC has a mission statement which states its primary focus in relation to the education and training and quality of care			
	The core values of the SANC are available			
	The SANC has organizational objectives If yes - Operational plan to realize mission, vision and objectives • Monitoring & evaluation mechanism			
	The SANC has a strategic plan with an appropriate budget, and an Annual Report is published			
2. The SANC has the capacity and the resources to perform its designated functions	The SANC organogram structure is indicative of its appropriate functions If yes: are all posts filled? If no: what is the vacancy rate and is temporary staff available? What is the management vacancy rate? What is the SANC annual employee turnover rate for the past 3 years? Are exit interviews done and, if so, provide evidence thereof			
	The SANC has human resource policies and procedures, encompassing key areas such as succession planning, recruitment & selection, appointment, induction, promotion, termination and confidentiality			
	Are there service delivery agreements between the employer and the employees - KPAs and Job Descriptions?			
	Are there any H R services that are outsourced? If yes, are there any agreements with service providers/ consultants?			
	Staff profile shows that staff are suitably qualified and or competent to carry out their duties The SANC has a Performance Management System If yes, provide an example of a Performance Management Tool			
	A workplace skills plan is indicative of capacity building among staff			
	The SANC's business plan shows that adequate business and financial planning has been undertaken. This includes details of valuable financial resources, cash flow projections, income-generating strategies and budgets			
	Financial management, auditing systems and policies are in place			
	Audited financial statements are timeously available			

	If appropriate to the sector, the business plan includes proposed strategies for the waiving or subsidizing of certain charges in order to address the NQF objective relating to redress and access			
SANC FINANCIAL CHECKLIST	*SANC written description of all its financial systems and procedures*			
	The description of financial systems and procedures are updated regularly			
	There is evidence of financial staff training, including continuous development, in the use of the SANC financial systems and procedures			
	There is a system in place to ensure that financial controls are maintained in the event of the absence or loss of key staff			
	The people involved in financial administration check each other's work			
	These work checks are fully documented (signed and dated)			
	Bank statements are checked regularly, and income & expenditure balanced			
	Banking takes place regularly and the amount banked is reconciled with the amount recorded in the cashbook and supported by receipts			
	Bank records are regularly checked to ensure that there are no irregularities in income or expenditure			
	Evidence that PFMA guidelines are adhered to, including the appointment of an Audit Committee			
	Payments made, including to staff, are properly authorized			
	There is a clear delegation of responsibility for staff issues and authority to make changes to staff conditions of service, including salaries			
	SANC maintains proper accounting records, the records are retained for an approved period prescribed			
	All financial transactions are traceable from original documentation to accounting records, and from accounting records to original transactions			
	Any alterations to original documentation (e.g. invoices and orders) are clearly made in ink and legibly initialled			
	All accounting records are kept secure (in a fire proof safe or strong room) when not in use			
	Only authorized staff have access to SANC Financial records			
	Funds donated for specific purposes are used for the purposes for which they were donated; accounting reporting mechanisms			
	Assets and infrastructure management systems are in place			
3. HR Related legislation	Evidence of compliance to relevant constitutional, labour, employment, health and safety and any other applicable legislation is available			
4. The SANC has an acceptable quality	• Documentary evidence of quality management policies and procedures is supplied. The system should encompass the following			

	management system	• Quality management policies which define the quality which the SANC wishes to achieve; e.g. Assessment Policy • Quality management procedures which enable the SANC to practice its defined quality management policies; and Assessment Policy Guideline • Review mechanisms which ensure that the quality management policies and procedures defined are applied and remain effective • Internal audit If yes ; provide Quality Evaluation tool • Products and services • Customer needs (learners, providers) • Customer communications • Internal communications • Data and record control • Document control			
5.	Processes for the accreditation of education & training institutions are effective and efficient	The SANC accreditation requirements for providers cover the criteria for providers set out by SAQA, namely that a provider • Is registered in terms of applicable legislation; • Has a quality management system including policies, procedures and review mechanisms; • Is able to develop, deliver and evaluate learning programmes which culminate in specified registered standards or qualifications; • Has the necessary financial, administrative and physical resources; • Has policies and practices for staff selection, appraisal and development; • Has policies and practices for learner entry, guidance and support systems; • Has policies and practices for the management of off-site practical or work-site components; • Has policies and practices for the management of assessment; • Has the ability to achieve the desired outcomes, using available resources and procedures considered by the SANC to be needed to develop, deliver and evaluate learning programmes which culminate in specified registered standards or qualifications; • Has not already been granted accreditation by or applied for accreditation to another ETQA			
		Documentation relating to accreditation (e.g. accreditation forms and files, handbooks and guidelines) is thorough, clear and user-friendly			
		Criteria for the accreditation of providers are defined and contextualized in the			

	SANC policies, procedures and guidelines in relation to the SANC's primary focus, the nature of the sector and NQF principles			
	Accreditation conditions are attached, and agreements and timeframes regarding provider accreditation are set out where necessary			
	The SANC's own tools and mechanisms for verifying provider information are clearly set out			
	The SANC's business plan makes provision for the SANC to offer support and capacity building in the accreditation process for those providers who need it			
	Any de-accreditation decisions are well documented, and valid reasons and appropriate evidence are available to support such decisions			
	There is a process for providers to appeal against unfavorable accreditation decisions			
6. Quality amongst providers is effectively and efficiently promoted (Communication)	Evidence of communication strategies to promote quality provision is provided. Examples are: • Feedback to all providers regarding developments in primary focus areas. • Results of research and surveys undertaken by the SANC • Capacity building in the sector in relation to good practice in areas such as moderation, assessment and RPL • Promotion of discussion and debates around quality assurance issues • Information dissemination of all above to constituent providers, learner audiences, communities, Departments of Health, professionals, constituencies, stakeholder bodies, other regulatory bodies – If yes , provide report and highlights on such consultations / engagements with stakeholders Provide plan of actions/interventions on issues raised • An accessible, updated and informative website • Generation of funds and public support for the SANC • Evidence of a standard for response to complaints and queries within an acceptable time frame			
	• Evidence of public participation/involvement in matters of concern to the public • Allows stakeholders an opportunity to be present and be heard when there are matters justifying participation and recommendations			

7. Assessment and facilitation of moderation among constituent providers are effective and efficient	Accreditation criteria for providers clearly articulate principles and best practices for assessment and moderation, and offer guidance in these areas. Examples are: • Examination policies, including examination paper security • Assessment and moderation policies • Criteria for the recognition of prior learning • Procedures and features for assessment design • Procedures and features for assessment implementation • Procedures for determining theory and practice, cognitive, affective & psychomotor skills • Procedures and features of the moderation cycle • Communicating with learners • Record keeping • Submission of results • Evaluation and review of assessment system • Criteria for assessment personnel			
	Mechanisms for sample moderation, site visits or other forms of validation of submitted learners assessment results are in place			
8. Constituents' assessors are registered for specified registered standards or qualification according to established criteria	The SANC has formulated its own criteria for the registration of assessors in the context of SAQA's Guidelines to SANC for the registration of assessors			
	There is a process in place for checking that assessors have met the requirements of the generic assessor standard			
	The SANC maintains a database of registered assessors			
	Any de-registration decisions are well documented, and valid reasons and appropriate evidence are available to support such decisions			
	There is a process for assessors to appeal against de-registration decisions			
9. An acceptable database and archiving system is maintained (Information System)	The database and information system includes the following access, storage, retrieval/archiving, reporting and operating requirements: • All information, policies and procedures required by SAQA • All accredited NQF standards and qualifications • ETQAs and examining or professional bodies appointed or accredited for the same standards and qualifications • Details of providers, including certificates of accreditation, and annual records of quality audits, evaluations and reviews of providers • Learner records (all ETQAs are required to maintain records on learners from the date of registration of the learner with the provider) • Details of all education & training undertaken by a learner as well as full			

	qualifications acquired • Number and details of accredited public nursing education and training institutions per province • Number and details of accredited private nursing education and training institutions per province			
	Registry • Number of accredited training programmes • How many nurses are registered nationally per programme/ qualification e.g. advanced midwives, critical care, psychiatric etc.? • Annual returns received from : - Education institutions - Health establishments			
	• Nurses per category: o Professional Nurses o Enrolled nurses o Nursing Auxiliary o Learner nurses • Nurses' personal details, including demographics, qualifications and employer (if any) • If any nurses removed from the register, how many • How many restored in the register • Numbers of marking centres available • Number of qualified markers Access is only provided to authorized employees and noted in a register Information is stored for the mandatory period			
10. Quality of professional conduct	• Investigation of complaints against institutions and health professionals' misconduct • Number of investigations undertaken; • Outcomes of investigations; • Disciplinary/intervention measures undertaken			
11. Processes for Foreign Recruitment are effective and efficient	• The SANC has a foreign recruitment policy and procedure o Records kept, including ▪ Training records ▪ Examination results o Criteria for registration			

Annexure 8 Sample performance contract for nursing manager

Critical success factor	Key performance indicator	Benchmark	Target	Measurement	Comment	Score
1. Efficiency management (25%) Ensure adequate supply and optimal utilisation of resources including skilled human resources	**Promote personnel retention:** • Ensure implementation of all 3 phases of Orientation and "On-boarding". • Monitor exit interview data and actively manage trends.		• 100% of all new employees • Personnel turnover <12% per annum	• Training report • HR Report		
	Ensure optimal utilisation of skilled nursing personnel: • Ensure the compilation of a realistic nursing personnel budget. • Ensure compliance with discipline specific mix as advised by the Integrated Staffing Model (ISM) and as agreed with the regional team. • Proactively manage flexible working hours to ensure consistent compliance with advised personnel levels. • Ensure continuation of efficiency practices in night duty, over weekends and during holiday periods. • Audit personnel work schedules to ensure that fixed personnel shifts are discouraged and personnel planned according to unit trends and patient acuity.		• Unit specific skill mix • Monthly Rand/Bed day value & nursing cost as % of Turnover (hospital specific) • Unit specific ISM target • Unit & hospital specific ISM	• Personnel budget • ISM monthly unit report • Financial & ISM report • ISM report • Financial & ISM report		

	• Ensure progress to achieving efficiency target.		targets			
Critical success factor	**Key performance indicator**	**Benchmark**	**Target**	**Measurement**	**Comment**	**Score**
1. Efficiency management (25%) Ensure adequate supply and optimal utilisation of resources including skilled human resources.	**Facilitate strong partnerships with Human Resources Dept. To develop and maintain a proactive approach to nursing recruitment:** • Ensure compliance with turnaround times defined in the "guideline for critical skills recruitment and selection process".		• As per defined turnaround times in policy	• Stipulated guideline recruitment activity report		
	Monitor the management of absenteeism within the hospital: • Ensure that sick leave is within the required norms and that deviations are managed according to the "policy guidelines for absenteeism management".		• ≤ 2.2%	• HR report		
	Ensure that an effective stock management system is implemented in all units: • Monitor the management of under and over recoveries. • Monitor aged and expired stock levels. • Recovery Error Factor (REF). • Obsolete and waste. • Consumables – Rand/bed day managed as budgeted.		• As close to R0 as possible • Aged stock – 15% • REF ward – 4% • REF theatre – 10% • < 2.5% of total stock/year			

Strategic Plan for Nursing Education, Training and Practice 2012/13 – 2016/17

Critical success factor	Key performance indicator	Benchmark	Target	Measurement	Comment	Score
1. Efficiency management (25%) Ensure adequate supply and optimal utilisation of resources including skilled human resources.	**Ensure effective capital management within the nursing department:** • Ensure participation of the nursing department in the compilation of a realistic capital budget.		• Hospital specific	• Capital budget		

2. Quality management (25%)
Support the Company's goal of being the preferred acute care hospital service provider through ongoing commitment to quality care.
	Drive a quality improvement culture within the nursing department:
	• Drive the implementation of a hospital specific "Back to Basics", viz:
	  • ……
	  • ……
	• Support the implementation of the 'Patient Journey' processes within the hospital.
	• Drive awareness of the Hospital Event Management (HEM) system as a patient safety reporting system with an emphasis on clinical events.
	• Monitor patient safety trends on an ongoing basis within departments and ensure that appropriate action is taken:
	  • Medicine related
	  • Patient falls
	  • Skin lesions
	• Action plans focus on preventing reoccurrence through system improvement, reporting of events on HEM and potential medico-legal cases to the legal department and
		• x/1000 bed days
		• x/1000 bed days
		• x/1000 bed days
			• Hospital specific project
			• Company specific project
			• Clinical events – x/1000 bed days
			Hospital specific target:
			• ……
			• ……
			• ……
			• 100%
			•
			• 100%
				• Nursing Management (NM) report
				• HEM report
				• Quality Improvement Projects (QIP's)		

	performance management.					
Critical success factor	**Key performance indicator**	**Benchmark**	**Target**	**Measurement**	**Comment**	**Score**
2. Quality management (25%) Support the Company's goal of being the preferred acute care hospital service provider through ongoing commitment to quality care.	Investigate patient and doctor complaints and give feedback as stipulated in the 'compliments and complaints policy'.			• Compliments & complaints register		
	Continue with the implementation of care bundles as part of Best Care…Always (BCA) campaign: • Implementation of care bundles. • Actively participate in hospital BCA committee. • Ensure monthly reporting of BCA progress.	• 2 bundles throughout hospital by 2012	• NM attendance at 50% of meetings • 100% monthly submissions	• BCA committee minutes • BCA report		
	Provide support and leadership with regard to nursing elements in COHSASA accreditation process: • Monitor the progress to achieving and maintaining accreditation standards.		• 80% compliance	• COHSASA hospital report		
	Monitor patient satisfaction results: • Monitor and discuss monthly patient satisfaction results and oversee the development of action plans and progress in addressing low scores.	• 75%	• Hospital specific targets	• Patient satisfaction results		
	Maintain effective doctor communication: • Visits all admitting doctors at least once per year. • Conducts management rounds in Theatre at least once per month.		• 100% • 100%	• NM record • NM record		

Critical success factor	Key performance indicator	Benchmark	Target	Measurement	Comment	Score
3. People management (25%) Develop positive people relationships within a culture of accountability and excellence.	**Ensure effective communication within the hospital and that staff (including night/ theatre personnel) are empowered through information via regular meetings and verbal & written communication, including:** • Company values. • Functional goals and objectives. • Trends in clinical risks and quality improvement initiatives. • Information sharing from Head office, region and other functions.		• Unit specific goals and objectives • Min. of 1 nursing management meeting/month • Quarterly meeting with night personnel. • All relevant communication shared to unit personnel level. • Visit each unit, including Theatre, monthly.	• Hospital specific nursing and unit goals and objectives aligned with Company goals and objectives. • Minutes of meetings and memoranda • Unit and night personnel communication tool • NM record		
	Serve as a role model in people-centred management style which promotes the professional development and mentoring of personnel: • Ensure that decisions taken consider the individual/ personnel needs as far as is reasonable. • Display a consultative approach in making decisions.			• Markinor personnel survey • Exit interviews • Line manager observation		

Critical success factor	Key performance indicator	Benchmark	Target	Measurement	Comment	Score
3. People management (25%) Develop positive people relationships within a culture of accountability and excellence.	**Implement and maintain an objective performance review system within the nursing department:** • Ensure that all personnel have bi-annual performance ratings. • Audit rating scores to identify problems associated with subjective reviews.		• 100% • 25% per unit	• HR report • NM report		

	Ensure continuous professional development of personnel:
	• Implement, support and monitor Mediclinic Assessment Point (MAP) policy within the hospital:
	  • PN – 25 points
	  • EN – 15 points
	  • ENA – 10 points
			• 75% per category	• MAP report		

	Ensure that the Company's employee relations policies are implemented to manage unacceptable deviation in required behavior: • Monitor corrective counseling and disciplinary reports. • Develop unit managers to chair disciplinary hearings.		• 100% • 50% of nursing management team trained	• Disciplinary documents • Training records		
	Promote reward and recognition initiatives within the hospital: • Encourage the recognition of high performers and loyal employees at unit and hospital level.			• NM report		

Continued…

Critical success factor	Key performance indicator	Benchmark	Target	Measurement	Comment	Score
3. People management (25%) Develop positive people relationships within a culture of accountability and excellence.	**Support the employment equity plan within the hospital:** • Ensure that Employment Equity (EE) targets are met. • Manage identified barriers to the EE plan.	• 40% of C4 - C5 appointments	• Hospital specific EE targets	• EE Report		
	Support formal nursing education: • Ensure hospital participation in the student recruitment process. • Monitor the allocation of students in units. • Ensure communication between operations and training. • Attend management and training meeting. • Ensure correct implementation of Guided Practical Learning (GPL) hours. • Monitor updated training files/ information (Regulations etc.) other legislation files, policies and procedures that govern nursing and nurse training.		• Attend 50% of meetings	• Feedback from Learning Centres Student`s allocation list • Minutes of Management & Training Meeting • Refer formal training audit document and training policies		
	Develop a succession plan for critical positions within the nursing department: • Identify suitable candidates • Devise an individual development plan for candidates.		• 100% of identified candidates	• Written succession plan • Individual development plan		

Continued…

Critical success factor	Key performance indicator	Benchmark	Target	Measurement	Comment	Score
4. Risk management (25%) Identify risks to patient safety and actively drive programmes to mitigate these.	**Support the IPC programme within the hospital:** • Ensure that the ICNet (Infection Control Software application) system is used optimally within the hospital. • Monitor the Healthcare Associated (HAI) rates. • Be aware of and communicate outbreaks and resistant organisms to Regional Nursing Manager (RNM) and National IPC Specialist, and support the CRM in managing these. • Support and sponsor hand washing campaigns within the hospital. • Ensure a dedicated person is allocated to relieve the CRM to ensure continuity & consistency in surveillance.	• Daily hospital accessing and monitoring of Alert organism & new imports. • x/1000 bed days	• Clinical Risk Manager (CRM) to access ICNet& monitor for Alert organisms & new imports daily • Hospital specific • 100% • Identified and trained nursing staff member	• IPC Medi.Data (Mediclinic data warehouse) report • Monthly IPC report • Monthly IPC report • Training records • Succession plan		

Critical success factor	Key Performance Indicator	Benchmark	Target	Measurement	Comment	Score
4. Risk management (25%) Identify risks to patient safety and actively drive programmes to mitigate these.	**Ensure that a risk based personnel training programme is in place:** • Basic Life Support (BLS) • Advanced Cardiovascular Life Support (ACLS) provided to relevant staff • Training programmes developed for hospital specific risks • Ensure implementation of Work Skills Plan.	Skills plan 60% - Department of Labour`s target	• 100% of all personnel over a period of 2yrs. • 100% of identified personnel over a period of 2 years • Hospital specific	• Training records • QIPs & training records • Work skills plan		
	Ensure competent nursing personnel: • Annual evaluation of basic procedures.		• Minimum of 5 per annum/person	• Training records		
	Utilise the CURA (risk management software) audit to manage risks within the hospital: • Submit audit within specified timeframe. • Develop action to address identified exceptions.		• 100% • 100%	• CURA report • Action plans		
	Enhance accurate clinical coding and effective case management: • Ensure that the nursing units provide accurate clinical information within required daily timeframes.		• Co-morbidity - >20% • Complications >5% • Equipment charging - 100% • Body Mass Index (BMI) - 80%	• Clinical coding audit report • Charging committee meeting minutes • BMI report		

Critical success factor	Key Performance Indicator	Benchmark	Target	Measurement	Comment	Score
4. Risk management (25%) Identify risks to patient safety and actively drive programmes to mitigate these.	**Monitor and action 'data base' reports:** • Apache data capturing. • Mortality Index • Vermont-Oxford data capturing. • Request action plans to address deviations from acceptable results.		• 80% compliance hospital specific	• Apache compliance report • Vermont-Oxford Network quarterly report • QIP reports		
	Support the re-introduction of the comprehensive documentation audit: • Personally audit 3 patient folders per month. • Ensure monthly unit audits of patient documentation.		• 3/month	• Audit report		
	Risk based clinical audits: • Post-operative observations audit.		• 10% of surgical cases	• Audit report		

Annexure 9 Policy guidelines for nurses returning to clinical practice

1 South African nurses wishing to return from abroad

1.1 Advertisements

- On-line advertisement in both the United Kingdom and the Gulf countries
- Advertisements in the monthly United Kingdom *Nursing Times* (cost R35,000), which is circulated across all the NHS hospitals and is available on-line, as well as the DENOSA *Nursing Update*
- Establishing networks/liaising with recruitment agencies in those countries where many South African nurses are living

1.2 Selection Process, Positioning and Placement

- Selection done on paper, or by teleconference, whilst the incumbent is still at work overseas
- Years of experience in both South Africa and overseas considered in positioning them
- Home address and placement of a person nearer to her home considered, unless the applicant indicates that she/he can work anywhere or has preferences

1.3 Induction and continuing professional development

- Proper induction and continuing professional development provided, especially on current legislation, guidelines, health priorities, etc

1.4 Employment conditions

- Applicants should apply and commence their duties after a month's rest on returning from overseas, thus allowing them to manage all the administrative processes that go with re-location, as well as allowing them time to rest before the start of another work life phase.
- Applicants must not be older than 70 years at the time of their initial appointment. As much as this constitutes discrimination, the practice ensures that, in terms of age, the incumbent will still be spending a fair amount of time within the Department.
- Should the incumbent reach 70 years and remain in the employ of the Department, he/she will be required to produce a medical certificate declaring his/her fitness to continue practising every two years.
- The applicant should be registered with SANC.
- The applicant should be advised to affiliate with a professional association for indemnity and professional development.
- All interviews should be conducted in line with the HR requirements of recruitment and selection of the Department or the respective organisation.
- Institutions need to utilise their own vacant posts or funded posts to control undue institutional over-expenditures.
- Testimonials/references should be obtained from the previous institutions, local and overseas
- The state of their health when they left the last institution should be considered in terms of placement
- Night duty can be allowed after the probation period of six months, and the allowance be payable as per institutional conditions, where the need shows benefit.
- General conditions of service shall apply after the probation period
- The employees older than 65 years should be on an annual renewable contract, subject to review after every expiry.
- Tax deductions will be effected and other deductable requirements as stipulated by law e.g. UIF and medical aid
- Flexible working hours can be considered on the basis of needs of the employer, coupled with the necessary adjustments of salary expectations.
- Leave provisions are defined in DPSA.
- A contract should be signed on assumption of duties and all the conditions of service should be defined in the employment contract.
- In the event of termination of the contract, the party that is instituting the process should give notice of one (1) calendar month.

2. Nurses who have left the profession for other positions

In addition to the other strategies presented in this section, advertisements would need to be considered in print media in this country, e.g. the Denosa*Nursing Update*, as well as on-line (Gigajobs.com and Bestjobs.co.za).

3. Nurses who have accepted Voluntary Severance Packages

Many of these nurses have retired or left the country so the strategies would be similar to those 2 categories of nurses.

4. Retired nurses

Guidelines on the appointment of the retired nurses would be similar to the recruitment of nurses from abroad, excepting:

- Applicants should apply and commence their duties after a rest period of two months
- Testimonials/references need only be obtained from the previous institutions, should the applicant wish to work in a different institution from the one where he/she retired.
- The state of their health when they left the institution can be considered in terms of placing them in less difficult areas if need be.
- Pension deductions will not be effected

Annexure 10 Self-assessment and audit tools for PPE that can be adapted for South African use

POSITIVE PRACTICE ENVIRONMENTS[7]:

QUALITY WORKPLACES = QUALITY PATIENT CARE

Information and Action Tool Kit

Nurse Work Environment Assessment Tool

The following questions are intended to stimulate thinking and develop strategies that lead to positive work environments. Each organisation or health facility varies depending on the context of care. Consequently, the answers to the questions will be unique to the setting.

Organisations

- Does the environment/organisation recognise nurses as professionals?
- Do nurses receive adequate compensation for their work?
- Are there opportunities for career advancement in nursing?
- Do the working conditions allow for optimal nurse recruitment and retention?
- Does the organisation have policies in place to guide work environments?
- Are there work environment/organisational policies that address occupational health hazards and promote safe working environments?
  - o Is policy enforcement monitored?
  - o Are policies reviewed regularly and revised as required?
- Is safe equipment available and well maintained?
- Are there effective grievance procedures?
- Are there "whistle blowing" procedures? Are there policies that protect the "whistle blower"?
- Is there a policy in place to give nurses control over their practice and scheduling?
- Is there a policy in place that establishes predictability and job specification?
- Are retention and recruitment policies in place?
- Are the turnover and vacancy rates excessive or negatively affecting patient outcomes?
- Are there programmes of recognition and reward?
- Are there policies about workplace violence?
- Does staff participate in the organisation's decision-making?

Nurses

- Does the nursing staff practice under an overarching code of ethics?
- Is there good communication between nurses and other health disciplines?
- Are there rewards/incentives for nurses who demonstrate strong communication skills with other nurses and between disciplines?
- Are there programmes that encourage personal health?
- Are there adequate physical and equipment supports that encourage safe practice?
- Are there policies in place that allow nurses to address workload issues?
- Are mentorship and coaching programmes readily available?
- Do nurses have access to continuing education programmes?

Government

- Is there a specialty area within the government for health care (with Nursing specifically defined)?
- Does the government allot funding to continue/commence work environment research?

- Are there any provincial and regional strategies?
- Does the government policy support the nursing workforce to adopt/maintain a professional status?
- Does the government provide a regulatory framework for ensuring safe working environments?
- Does the government invest in health and work environments?
- Is there enough funding/support from the government towards its health care system?

National Nursing Association (NNA)

- Does the NNA advocate for and promote healthy work environments for nurses?
- Does the NNA advocate for and promote professional standards for nurses?
- Is the NNA involved in educating the public about nursing and professional development?
- Does the NNA encourage and provide opportunities for continuing education?
- Are alliances sought with patient organisations or other professional groups to ensure a safe work environment?
- Is there a way for nurses to provide comments or feedback to the NNA?

Regulatory Body

- Does the body regularly review scopes of practice and competencies?
- Are practice standards clearly communicated and upheld?
- Are there appropriate sanctions in the case of violations?
- Is there an appeal process and is it widely known?
- Does the body analyse trends to inform employers and the government of emerging workforce issues?

Best Practice Guidelines: Environmental Assessment Tool **Instructions**[8]

Keeping your work unit in mind (i.e., team, department, organization) depending on your position, complete the following Work Environment Assessment.

- Read each numbered component of the Work Environment Assessment and rate the component on the five (5) parameters of: Culture, Structure, Processes, Knowledge, and Resources using the three point rating scale.
- Tally the score out of 15 for each component of the work environment such that you have a score for Leadership; Collaborative Practice; Professionalism; Embracing Cultural Diversity in Health Care: Developing Cultural Competence; Workplace Health, Safety, and Well-Being of the Nurse; and Developing and Sustaining Effective Staffing and Workload Practices.
- Plot the points on the "Organizational Profile: Components of the Work Environment" attached.
- Tally the score out of 18 for each of the five (5) parameters within each work environment component.
- Plot the points on the "Organizational Profile: Parameters Influencing Work Environment Components" attached.

1. Leadership *Culture*	***Structure***	***Processes***	***Knowledge***	***Resources***
Is there a culture of "every nurse a leader"- clinical and managerial leadership; is transformational leadership supported; is there an understanding of clinical leadership and that leadership is a behaviour rather than a position	Are there structures for leadership mentoring and leadership development; is leadership part of the role expectation for every nurse and assessed as part of performance appraisal; are there forums for discussing leadership	Are there processes that reinforce participatory decision making and transformational leadership; Is leadership skill assessed in team meetings; are leadership goals set; are their opportunities to develop leadership skills	Does staff have knowledge of leadership theory and skills; are they interested in learning and development in this area; is knowledge of leadership evident in nursing practice behaviour. Are there programs to develop leadership among staff	Are there resources to support leadership development and participation, autonomy and ongoingcommunication. Are there creative ways used to maximize resources
1 2 3	**1 2 3**	**1 2 3**	**1 2 3**	**1 2 3**

2. Collaborative Practice *Culture*	***Structure***	***Processes***	***Knowledge***	***Resources***
Is there a culture of nursing team work and supporting each other as team members within nursing and across the professions; does team functioning support change and innovation	Are there structures to support team behaviours, i.e. time to meet as a team, space to have team meetings, evaluation as to team functioning, inclusion of team work in position descriptions and performance appraisal; clarity of roles and responsibilities	Are there processes that reinforce team work, such as ongoing evaluation, team building exercises, recognition of highly functioning teams; opportunities to meet as a team; do teams have processes for making decisions that are effective; are decisions and their outcomes evaluated	Does staff have knowledge of group theory? Are they interested in learning and development in this area. Is knowledge evident in team behaviour, i.e. respect for team members, positive team functioning, total team efforts not just a few close knit staff; are there programs of education for staff	Are there resources to support team work and ongoing team communication. Are there creative ways used to maximize resources?
1 2 3	**1 2 3**	**1 2 3**	**1 2 3**	**1 2 3**

3. Professionalism *Culture*	***Structure***	***Processes***	***Knowledge***	***Resources***
Is there a culture of professional practice supporting the attributes of: knowledge, spirit of inquiry, accountability, autonomy, advocacy, innovation, collegiality and collaboration, and ethics and values	Are there structures for promoting professional behaviour, i.e. times and places to discuss ethical issues, rewards for innovation; effective change management; inclusion of professionalism in performance appraisal and position descriptions	Are there processes that reinforce the 8 attributes of professionalism, i.e. regular nursing and interprofessional rounds that enable these areas to be reinforced and addressed; regular reflective practice behaviours and expectations, such as writing for publication, membership in professional organization	Does staff have knowledge of professionalism? are they interested in development in this area; is knowledge evident in ongoing client nurse, nurse nurse, nurse other professional behaviour; are there educational programs; do nurses regularly update their knowledge	Are there resources to support Professionalism, i.e. time for reflection, education, autonomy and ongoing communication, advocacy; are there opportunities to test out innovative ideas; are there creative ways used to maximize resources
1 2 3	**1 2 3**	**1 2 3**	**1 2 3**	**1 2 3**

4. Embracing Cultural Diversity in Health Care: Developing Cultural Competence *Culture*	***Structure***	***Processes***	***Knowledge***	***Resources***
Is there a culture of support for cultural diversity in which the values of inclusivity respect, valuing differences, equity and commitment are evident and supported	Are there structures for promoting self awareness re cultural diversity Are expectations re embracing cultural diversity embedded in position descriptions and performance appraisals; are there structures within the setting to support attaining cultural understanding, i.e. resources to use for assistance, policies that reflect respect for cultural differences	Are there processes that support cultural diversity, opportunities to learn from each other, processes to resolve differences; Mentoring programs for internationally educated nurses, recruitment strategies that enable hiring of a broad cohort of staff, open discussion of who are we and how are we doing together	Does staff have knowledge of cultural diversity and how it affects them in the workplace, do staff have knowledge of their own comfort level with diversity, Are staff interested in learning, are there educational programs to address cultural diversity	Are there resources to support embracing cultural diversity and development of cultural competence, are there - tools to learn about cultural differences and similarities; are there creative approaches used to maximize resources to focus on this area, i.e. obtaining funding for research, building healthy work environments through a focus on embracing cultural

				diversity
1 2 3	**1 2 3**	**1 2 3**	**1 2 3**	**1 2 3**

5. Workplace Health, Safety and Well-Being of the Nurse *Culture*	***Structure***	***Processes***	***Knowledge***	***Resources***
Is there a culture of support for workplace health safety and well being of the staff as well as patient safety; do staff feel cared for and cared about; is there a culture of erring on the side of precaution as far as staff safety goes? Is there a culture of work life balance within an environment of healthy work challenges	Are there structures for monitoring environments and processes for safety; are they connected to decision making bodies within the organization; is action taken based on recommendations; are there policies related to staff safety that are consistent with relevant legislation, are there policies and programs related to workplace health and safety	Are there processes in place for monitoring staff safety, are there rewards given for identifying unsafe practices or structures; are there programs to address workplace well being	Does staff have knowledge of work place health and safety issues and knowledge of what to do when safety is an issue; are staff interested in learning; are there educational programs to address workplace health safety and well being	Are there resources to support safe, healthy work environments; are there creative approaches used to maximize resources to focus on this area, i.e. obtaining funding for research, building healthy work environments through a focus on workplace safety and worker wellbeing
1 2 3	**1 2 3**	**1 2 3**	**1 2 3**	**1 2 3**

6. Developing and Sustaining Effective Staffing and Workload Practices *Culture*	***Structure***	***Processes***	***Knowledge***	***Resources***

Is there a culture of workload balance for nurses and others; is there awareness that nursing judgment is critical in assessing staffing requirements; Is there a culture of linking planned and unplanned change to impact on workload	Are there structures for obtaining nursing input to workload and staffing practices at the strategic, logistical and tactical levels; are there forums for nurses to evaluate impact of workload and staffing decisions on patient safety and patient outcomes; is there a fair approach to staffing; are there mechanisms to adjust to changes in patient/client acuity	Are there processes in place for monitoring workload practices; are there forums to raise issues related to workload and staffing practices; do staffing and workload practices that have negative impacts get resolved; are there processes to make reasonable changes in staff schedules as needed	Does staff have knowledge of work load and staffing practices; are staff encouraged to be involved in staffing decisions; is there education offered related to approaches to planning and implementing staffing decisions and evaluating impact	Are there resources to support safe, ethical staffing practices; are there resources to empower nurses to make appropriate staffing decisions that result in safe, competent ethical care; Is there evidence of creativity in maximizing resources?

Rating: 1: most indicators are absent

2: many indicators are evident

3: most indicators are evident Score: _____

TOTAL SCORE ___/_____

Culture Score: ___ Structure Score:__ProcessesScore:___Knowledge Score__ Resources Score:____

AMERICAN NURSES CREDENTIALING CENTRE

Pathway to Excellence® Organizational Self Assessment[9]

(Recommended prior to submitting a formal intent to apply for Pathway to Excellence)

The first step in pursuing recognition as a Pathway to Excellence healthcare organization is a Self-Assessment. The Self-Assessment must be deliberate and honest if it is to serve as an organizational measure of whether or not to pursue the Pathway to Excellence designation. This process requires an organization to compare itself against the compulsory elements of the Pathway to Excellence program to assess the organization's current state. Specific guidance on the Self-Assessment can be found in the 2012 Pathway to Excellence Application Manual.

1. Are all members of the nursing staff actively engaged in and aware of the Pathway to Excellence application?	Y	N
2. Are staff nurses involved in decision-making and all phases of projects that affect nursing, including quality processes?	Y	N
3. Is there evidence that a delineated nursing shared governance model is in place and integrated throughout the organization?	Y	N
4. Is there a policy indicating that mandatory overtime is not required for nursing staff except in the event of a disaster?	Y	N
5. Do nurses use new knowledge and evidence-based findings to develop and implement initiatives that improve nursing practice?	Y	N
6. Is there substantive input by direct care nurses into daily and long- range staffing decisions, including the hiring of new nursing staff?	Y	N
7. Are protective security measures in place for patients and staff?	Y	N
8. Are prevention measures in place to decrease injury, illness, stress and accidents?	Y	N
9. Are nurses engaged in the decision–making process regarding safety strategies and product evaluation?	Y	N
10. Are employee support structures in place for reporting and addressing safety related events or concerns?	Y	N
11. Are there systems in place that ensures nurses can report, without negative consequences, any concerns they may have about patient care and professional practice?	Y	N
12. Are there educational offerings provided to nurses about how to address patient care and professional practice concerns, excluding orientation?	Y	N
13. Does the organization monitor patient care and professional practice concerns for trends?	Y	N
14. Is there evidence of how preceptors individualize the orientation of a nurse using actual needs?	Y	N
15. Are nurses evaluated and given feedback throughout the orientation process?	Y	N
16. Is there a process that prepares preceptors for their role?	Y	N

17. If nurses are assigned to an area other than their primary area, is there a process that identifies how nurses are deemed competent to work in variable practice settings?	Y	N
18. Does the CNO have a bachelor's degree or higher in *nursing* (i.e. BSN, MSN, DNSc)	Y	N
19. Is the CNO visible and accessible to nurses at all levels?	Y	N
20. Is the CNO an effective advocate for direct care nurses and their patients?	Y	N
21. Is there an established performance evaluation process in place for the CNO that is based on predetermined outcomes measures?	Y	N
22. Is there evidence of a comprehensive staff development program in place that nurses use to enhance their knowledge, skills and provides advancement opportunities?	Y	N
23. Does the direct care nurse have input into the selection of educational offerings provided?	Y	N
24. Is there a mentoring program in place that helps nurses at all levels develop professionally?	Y	N
25. Does the organization evaluate compensation packages in the marketplace to ensure nurses are compensated fairly, equitably and competitively?	Y	N
26. Is there evidence of monetary or nonmonetary retention incentives received by direct care nurses?	Y	N
27. Is there evidence of how nurses are recognized for achieving quality outcomes or benchmarks?	Y	N
28. Is there evidence of recognition awarded by an external entity to the organization in which nursing was highlighted by the external entity?	Y	N
29. Are flexible staffing options provided for direct care nurses?	Y	N
30. Is there evidence of how the input of direct care nurses impact routine schedules?	Y	N
31. Are there programs and policies in place that reflect a commitment to a balanced lifestyle for employees?	Y	N
32. Does the organization promote and encourage self–care for nurses on the job?	Y	N
33. Are there education sessions that address how to facilitate communication or collaboration among employees?	Y	N
34. Are there non-retaliatory protections established for reporting and addressing disrespectful conduct, abuse or violence? Are established procedures utilized to constructively manage interdisciplinary conflict?	Y	N
35. Is there evidence that employees know how to access the non-retaliatory system in place for reporting disrespectful conduct?	Y	N
36. Is there a performance evaluation process in place for the nurse manager that is based on annual predetermined goals?	Y	N
37. Is the nurse manager an effective advocate for direct care nurses and their patients?	Y	N
38. Are nurse managers visible and accessible to the direct care nurses and other	Y	N

nursing staff?		
39. Is there evidence the organization implements quality initiatives based on internal or external benchmarks?	Y	N
40. Are direct care nurses provided multiple opportunities for participating in and learning about quality initiatives?	Y	N
41. Is there evidence that nurse representation on an interdisciplinary quality team influenced a quality initiative?	Y	N
42. Are research findings or evidence based practices systematically evaluated and implemented to improve patient care?	Y	N

Annexure 11 Framework for recognition of post graduate qualifications

Professional programme area	**Category**	**Professional registration**	**Academic recognition**	**Academic qualification**	**Professional recognition**
Basic programmes	Nursing Auxiliary	SANC	NEI – Schools, Colleges	Certificate	
	Enrolled nurse	SANC	NEI – Schools, Colleges	Certificate Phase out	
	Prof Nurse – General (Bridging)	SANC	NEI – Schools, Colleges	Diploma Phase out	
	Staff Nurse	SANC	HEI- Colleges	Diploma	
	Professional Nurse	SANC	NEI Universities HEI non–universities	Degree	
Specialised* nursing/midwifery	Clinical Specialist	SANC	Universities & HEI Colleges	Post Grad Diploma	
	Education & Management	SANC	Universities & HEI Colleges	Post Grad Diploma	
Advanced Practitioner*	Clinical Practitioners		Universities & HEI	Masters or PhD	NEA/FUNDISA or ANSA to develop administrative process to recognise based on agreed criteria

The Nurse/Midwife Specialist[10]

Definition

A nurse or midwife specialist is a professional person who has been prepared beyond the level of a generalist and is authorised to practise as a specialist in a field of nursing or midwifery (adapted from ICN 2009:6).

Criteria designating nurse/midwifery specialities (ICN 2009)

In order for a Nurse Specialist to be registered or credentialed, the area of specialisation has to be recognised as such by the Regulatory Body. The following criteria are considered essential for such recognition by the SA Nursing Council:

The specialty has to

3. Subscribe to nursing.
4. Adhere to the foundational registration of a professional nurse.
5. Be sufficiently complex and advanced beyond the scope of a general professional nurse.
6. Exist due to a demand and need for the speciality.
7. Focus on a reoccurring problem that lies within the nursing discipline.
8. Be based on a core body of nursing or midwifery knowledge, informed by research.
9. Have established educational and practice standards.
10. Have expertise obtained through approved professional advanced educational programmes.

Only seventeen (17) specialist areas, leading to additional qualifications, are identified in the Higher Education Framework (ETQA, SAQA) and by the SANC for South Africa. Many speciality areas (like multiple sclerosis, Parkinson's disease, and geriatrics), are additionally internationally identified areas of specialist nurse practice in health care. In some healthcare systems up to 60 specialist areas are recorded. These are not acknowledged areas in South Africa. Several aspects such as wound care, HIV care and stoma care and many more like neonatal care are speciality practice areas identified in South Africa which are not presently accommodated by the educational and qualifications framework in South Africa nor recognised by the SANC for registration, and need consideration.

Recommendation:
The SA Nursing Council should establish an administrative process by which formal recognition will be given to an increased number of specialty areas in South Africa. There should be scope for not only clinical qualifications, but also other new qualifications like ICT, research and others to be included. NEIs should not be confined by a prescribed list. HEIs can register, accredit and offer a programme that has a demand and need without having to wait the protracted periods from a body like SANC. This should also then be an area that can be recognised by SANC

This objective can be achieved with a single regulation where the professional qualification states "Specialist in Clinical Nursing (Midwifery): XXX (=*specialist area*) with an administrative procedure to add recognition of 'new' clinical specialist areas from time to time as the need arises. Such a procedure should require a professional organisation to submit an application to the SANC providing evidence of compliance with the following criteria:

- The need for the new specialist practitioners.
- The competencies that the specialist practitioners should have and how the role of this practitioner will interlink with other nursing/midwifery and multi-professional healthcare teams,

- Employment opportunities for the candidates on successful completion of the education and training programme i.e. the system should make provision for funded positions to include these practitioners,
- Availability of practitioners to offer the programme. This could be a multi-professional team or international experts in the specialist field that offer the training initially, therefore practitioners not necessarily registered as educators at the onset of the programme,

Once the SANC has approved the addition of a new specialist programme, providers can submit their programmes.

Professional nurses who specialise in education and/or management must retain separate regulations.

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An Advanced Nurse / Midwife Practitioner[11]

Definition

An advanced nurse/midwife practitioner is a registered nurse/midwife clinician with a Masters degree in nursing or midwifery, who has acquired the expert clinical competence that includes complex decision-making skills and clinical competencies for expanded practice and is currently in practice in the field.

An Advanced Nurse or Midwife Practitioner is specialist clinician with a broad clinical, autonomous practice and include case loading with the right to prescribe within the specialty area. This nurse/midwife practitioner may function as first entry point and needs to be able to make a “medical diagnosis” in the particular field. This may require the need for diagnostic test and treatment beyond the normal practice of the nurse/midwife. In South Africa this nurse may practice as a private practitioner. A framework of competencies for this category of nurse or midwife is outlined in Annexure 3.

Characteristics of Advanced Practice

The nature of the advanced practice includes:

1. A high degree of autonomy and independence functioning
2. Case management and caseload
3. Recognition of advanced clinical competencies
4. The ability to integrate research, education and clinical management in practice
5. The ability to provide consultancy to other health professionals
6. Recognition as a first point of entry of service
7. Development of best practice in specialty field. (evidence based research)
8. Policy development for improved practice

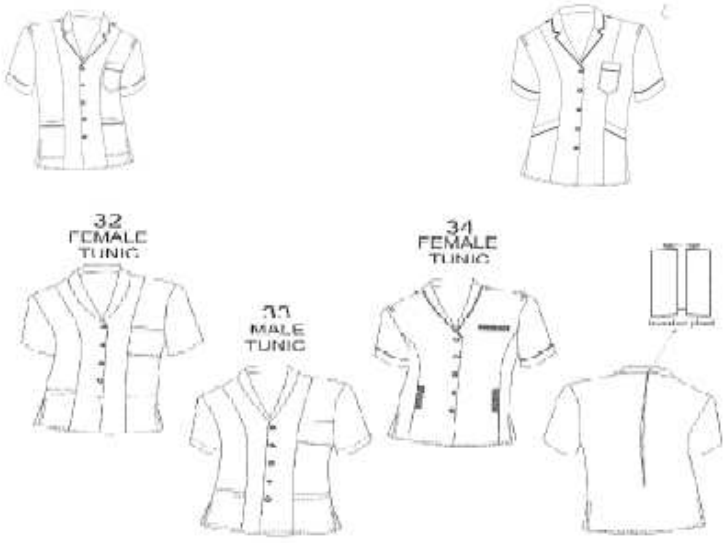
Recommendation:

The profession should recognise a field of Advanced Practice and establish an administrative process that will give formal recognition to an advanced practice field and to an Advanced Nurse Practitioner in South Africa.Organisations proposed that could manage this process are NEA/FUNDISA or the Academy for Nursing of South Africa (ANSA).

Annexure 12Specs for a contemporary white uniforms

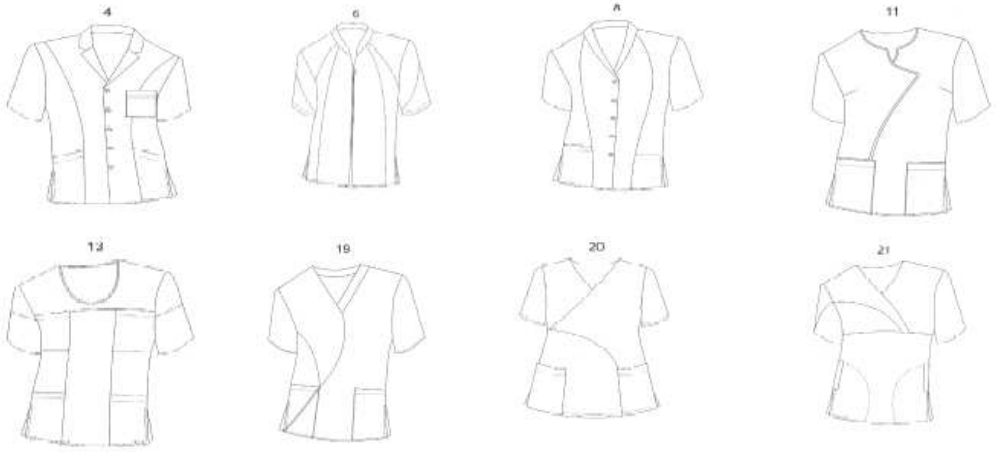
- The employer should issue tender specifications after consultation with labour and staff. Tender specifications must be written in such a way to protect the quality, durability and colourfastness of the uniforms.
- Institute a one-colour, one-employer regulation regarding uniforms. It is recommended that female and male nurses and midwives have a simple, plain white uniform [dress, skirt, blouse, pants, shirt, navy cape, blazer/cardigan, navy shoes,] with navy accessories. Discussions need to be undertaken about the uniforms to be worn by all categories of staff.

The following are examples of uniforms for females and males:



7

FABRIC: MINIMATT -100% POLYESTER
- Used for both Male & Female garments.
- Very durable.
- Easy wash and wear (little or no ironing at all).
- No fading.
- Very good drape on body.
- Tried and tested in Corporate Wear and most ladies garments in the market are currently made in polyester.



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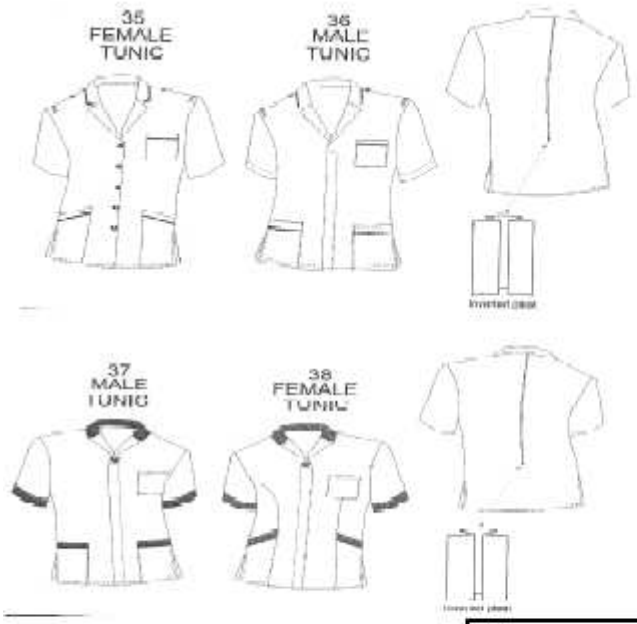

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FABRIC: MINIMATT -100% POLYESTER
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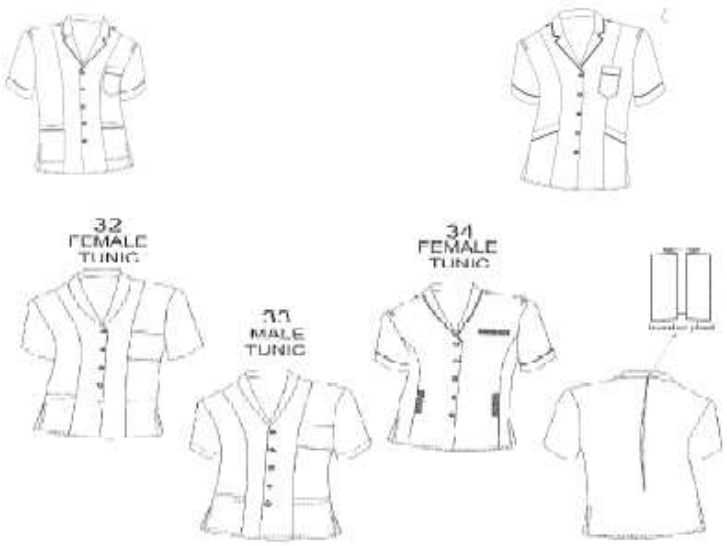

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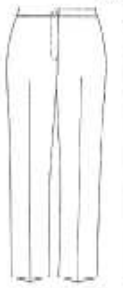
LADIES SLAX

58



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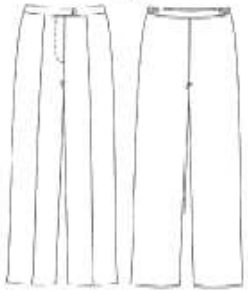
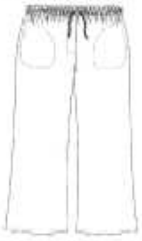


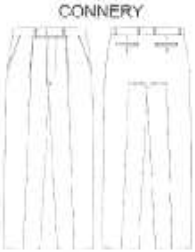
60
UNISEX
SCRUBS BOTTOM



MALE TROUSER

61
LATRIX

62
CONNERY



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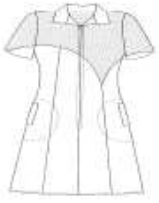

14

FABRIC: MINIMATT -100% POLYESTER
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Annexure 13 PROJECT TO DEVELOP AND IMPLEMENT OF HOSPITAL SAFE STAFF NURSING NORMS, DETERMINE THE STAFFING GAP, TRAINING REQUIREMENTS AND COST IMPLICATIONS.

GOAL:

To develop an approach to safe nurse staffing norms which is affordable, relevant and can be implemented for the acute and chronic hospital settings in South Africa.

PROJECT OBJECTIVES:

- **Develop safe nurse staffing norm project team including the public and private hospital sectors, provincial departments of health and the World Health Organisation**. This team must include:
  - Representatives from project teams for each province (including nurses responsible at facility level);
  - All private sector hospital organisations;
  - NGOs;
  - A project manager to facilitate change management, business analyst and 2 data analysts.

- **Investigation phase:**
  - Literature study on safe nurse staffing norms;
  - Investigate the current approach to nurse staffing used in the public sector and private sectors in South African hospitals;
  - Refine safe staffing norms for Staffing Plans proposed in MTT Reference Group 9 document:
    - Develop range of norms per unit
    - Agree on National HPPD (Hours Per Patient Day) and skill mix per unit type
      - per unit (include names of units, matching description, unit activity, filled positions per category).
      - per hospital (nursing management positions filled per job title).
      - test the template in a sample of provincial hospitals;
    - Develop and approach for Emergency and theatres (based on hospital definitions and levels);
  - Refine unit descriptions of hospitals;
  - Develop and pilot an acuity assessment tool.

- **Audit:**
  - Refine template proposed in MTT Reference Group 9 document;
  - Undertake an audit of hospitals on nurses by category by unit using the template;
  - Determine per unit and hospital, the following:
    - The required number of FTE's per nursing category, based on activities;
    - The gap between required staffing and actual positions filled for the existing nurse categories and new categories which include the new staff nurse

        - Propose a phasing plan for the introduction of the new staff nurse;
    - Determine the formal (including bridging) training implications of meeting appropriate safe nurse staffing norms, and the cost implications of the training;
    - Determine continuing professional development training implications based on nursing needs per category of nurse;
    - Determine financial implications with scenarios of filling employment posts to meet safe staffing norms in the public sector.

- **Research and Development on safe nurse staffing norms for South Africa**
    - Refine the methodology of the safe nursing staff model based on the audit;
    - Develop a Hospital Staffing Plan tool which incorporates a reporting tool with dashboard analysis on nursing norms and relevant management information;
    - Include budget and expenditure information in the Hospital Staff Plan management tool;
    - The outcome of the R and D phase must be:
        - A staffing card and excel tool which all hospital nurse staff managers can use and understand
        - An optimal staffing process
        - Change management material for implementing the Hospital Staffing Plan approach using activity based workload norms;
    - Cost nursing services and develop costing scenarios;
    - Develop a package for each institution which includes:
        - An excel model tool
        - A staff card
        - Change management training material;
    - Develop a quality monitoring tool and process for the safe nurse staffing model
        - Patient satisfaction
        - Nurse satisfaction
        - Cost.
    - Develop other interventions relevant to implementing safe nurse staffing norms.

- **Implementation Phase**
    - Ensure a project leader for each stakeholder and province;
    - Develop an implementation plan;
    - Ensure the implementation of nursing norms through strengthening the capacity of provincial departments of health and health facilities to develop and implement Hospital Staffing Plans based on Safe Nurse Staffing Guidelines;

Replace excel tools with software application for all provincial public sector hospitals to manage Safe Nursing Staffing Norms.

Table 1. Extract of Excel template to gather data from public and private sector hospitals to determine current staffing and evaluate against draft safe nurse staffing guidelines

Province:																						
Hospital name:																						
Document completed by:				Date:			Nurses in the unit during the previous month															
Type of unit	Unit name in hospital	Matching description	Number of beds in the unit	Activity in the previous month			Employed nurses: Number of heads						Learners: Number of hours worked									
							UM or Charge PN	PN	EN	ENA	Other care workers		Students				Bridging students		PEN		PENA
													4th yr	3rd yr	2nd yr	1st yr	2nd yr	1st yr	2nd yr	1st yr	1st yr
Theatre Complex				Number of cases																		
Theatre Complex				Number of cases																		
Casualty				Number of cases																		
Casualty				Number of cases																		
Out Patient Clinics				Number of patients seen																		
Out Patient Clinics				Number of patients seen																		
Out Patient Clinics				Number of patients seen																		
Out Patient Clinics				Number of patients seen																		
Out Patient Clinics				Number of patients seen																		

Table 2 Unit definitions and draft safe staff guidelines (Hours per Patient Day and skill mix)

Unit Type	Description	HPPD	% PN	% EN	% ENA
Maternity: Antenatal ward	A unit in which patients are nursed in various stages of pregnancy for minor, moderate or major conditions.	6-8	40	30	30
Maternity: First stage labour	Sue	9-14	70	20	10
Maternity: Labour ward	A unit in which patients are nursed during the first, second and third stage of normal vaginal delivery. This will include induction of labour and complicated delivery i.e. vacuum extraction or instrument delivery.	14-16	80	10	10
Maternity: Post natal	A Post-natal ward is a ward in which patients are nursed that has delivered their babies by normal vaginal delivery or caesarean section. Babies of all mothers that have delivered stay with mothers unless the mother or baby's condition does not allow this.	8-12	40	30	30
Maternity: Nursery	A unit in which babies are nursed usually for the first 4-6 hours after birth or when the mother or baby's condition dictate that the baby needs to be nursed in the nursery.	3-5	20	0	80
Maternity: MOU	Sue	8-12	50	20	30
Neonatal: Critical care / High care	A unit in which neonates are nursed with different conditions ranging form minor to major disease. This implicate that some of the babies might be ventilated or on CPAP.	12-16	60	30	10
Neonatal: Critical Care	A unit in which critically ill premature and full term infants are nursed. 80% of the infants are ventilated, receive life-sustaining medication and require one-on-one nursing by a suitably qualified nurse.	20-24	90	0	10
Neonatal: High Care	A unit in which very ill infants premature or full term are nursed. The infants are not ventilated but receive oxygen continuously or intermittently. Require close supervision by Professional and lower categories of staff directly or indirectly supervised by Professional nurses.	12-16	50	30	20
Neonatal: Perm	A unit in which premature infants are nursed to grow optimally until they reach a goal weight of approximately 2kg. Full term infants requiring closer monitoring and care than normal will also be nursed here.	4-6	20	0	80
Neonatal: Kangaroo	A unit in which babies are nursed with their mothers in attendance on a 24 hour basis. Nursing supervision and care are needed on a limited basis. The babies are clinically stable.	2-4	20	0	80
Surgical: Mixed	A ward in which patients are nursed that have undergone minor and more advanced surgery on different parts of the anatomy. Length of stay vary from same day (discharged on the same day of surgery), day surgery (stay of 24 hours and include an overnight stay) or stay in hospital for longer than 24 and 48 hours.	5-7	30	30	40
Surgical: Minor	A ward in which patients receive treatment for minor diseases and injuries including surgery or diagnostic procedures. Most patients are discharged on the same day of the surgery, treatment or procedure and less that 20% of patients stay overnight in the	2-4	30	40	30
Surgical: Moderate	A ward in which patients are nursed that have undergone moderate type surgery. Patients are usually mobile within 6-12 hours after surgery and are discharged within 24-48 hours after surgery. Less than 20% of the patients stay in hospital longer than 48 hours.	5-7	30	30	40
Surgical: Major	A ward in which patients are nursed that have undergone complex surgery which include surgery such as major surgery to the musculoskeletal system, brain and nervous system. The length of stay is longer than 48 hours and patients in general are not mobile within the first 12-24 hours.	7-9	30	30	40
Medical: Minor / Chronic care	Sue	2-4	30	30	40
Medical: Moderate/Major mix	A ward in which patients are nursed that suffer from a moderate to major medical disease. Patients are in general independent and only 20% are mostly at bed rest. Patients stay in the ward for 24-48 hours. Only 20% of the patients have a length of stay longer than 48 hours.	5-8	30	30	40
Medical: Major	A ward in which patients are nursed that suffer from major medical conditions and receive complex treatment i.e. oncology. 80 % of the patients are dependent on nursing staff for basic activities of living and they are mostly at bed rest.	8-11	40	20	40
Psychiatry: Voluntary	Sue to provide this info	Sue			
Psychiatry: Involuntary		Sue			
Psychiatry: Forensics		Sue			
Psychiatry: Chronic		Sue			
Psychiatry: Day		Sue			
Psychiatry: Psycho geriatrics		Sue			
Psychiatry: Adolescent		Sue			
Psychiatry: Intellectual disabilities		Sue			
Psychiatry: Mixed		Sue			
Psychiatry: 72-hours		Sue			
Paediatrics: Moderate/Major mix	A ward in which children from 0-12 years are nursed with diseases, injuries or that have received surgical interventions of any part of the anatomy. In most instances the children are dependent on the nursing staff for basic activities of living. 20% of the children are independent but require close supervision.	7-9	40	40	20
Paediatrics: Major	A ward in which children from 0-12 years are nursed with major diseases, injuries or who have undergone major surgery such as surgery to the skeletal system or brain or who are receive complex treatment such as chemotherapy.	9-12	60	20	20
Paediatrics: High Care	A unit in which children 0-12 years are nursed with major diseases or injuries. Patients are not mechanically ventilated but may receive oxygen continuously or intermittently. Patients are usually haemodaynamically stable but require close monitoring by a team of nurses.	14-16	60	20	20
Paediatrics: Critical Care	A unit in which critically ill children from 0-12 years are nursed. Most of the children will be mechanically ventilated and heamodynamically unstable. They will be totally dependent on the nursing staff for care. One-on-one nursing care is required by specialist trained nurses.	22-24	90	0	10
Paediatrics: CCU/HC	A unit in which both critically and seriously ill or injured children, or children who have undergone major or moderate surgery to any part of the anatomy, are nursed. 20% or more of the children will be ventilated and all children will be dependent on specialist trained nurses to provide care.	16-20	70	10	20
Adult CCU: High Care only	A unit in which adult patients are nursed who require constant monitoring and continuous nursing care. The patients are not ventilated and are usually haemodinamically stable.	10-12	60	20	20
Adult CCU: Critical Care only	A unit in which critically injured, or critically ill patients are nursed. 80% of the patients are usually mechanically ventilated and additional life sustaining equipment will be used. The patients are haemodynamically unstable and life sustaining medication is given continuously.	20-24	70	20	10
Adult CCU: CCU/HC mix	A unit in which a mix of critically ill and high care patients are nursed as reflected above. The intensity is determined by the number of ventilators available.	16-20	60	20	20
Step down: Terminal and other care	A ward to which patients are discharged after treatment or surgery. Further treatment or care might be required that is not available at home. The care might also include end of life care, pain control or physical rehabilitation.	6-8	20	20	60

Unit Type	Description	HPPD	% PN	% EN	% ENA
Out patient clinics: Poly clinic OPD		Sue			
Out patient clinics: Speciality OPD		Sue			
Out patient clinics: Ante-natal OPD	A clinic in which patients are assessed during the period of pregnancy. This includes normal and complicated cases.	Sue			
		Sessions			
Dialysis: Renal	A unit in which patients undergo sessions of haemodialysis in session that last usually 4 hours. Units are usually able to provide two sessions per day. Patients in chronic renal failure need holistic care and there is a link with the national transplant program. Specialized nursing care is required by appropriately trained nurses.	1:6 patients (4 hour sessions)	100		
Theatres: General	A complex of theatres / operating rooms in which surgery of a general nature is performed. The surgery usually does not require complex technology but could include general and specific endoscopic surgery.	Norms are dependant on the following variables: Number and acuity of cases, number of slates utilized and number of operating rooms.			
Theatres: General and Speciality	A complex of theatres / operating rooms in which both general and very complex surgery is performed. Advanced technology is required for the complex procedures such as orthopaedics, vascular surgery, brain or cardiac surgery.				
Casualty: Mixed	An emergency unit which provides care for minor, moderate and seriously injured or ill patients. Units such as these are usually described as providing care for level one to three cases. Specifically trained nursing staff is required and a doctor with a qualification in emergency medicine is in attendance on a 24 hour basis.	Norms based on number and complexity of cases and trends of patient admissions (peak times) and level of unit.			
Casualty: Medical	An emergency unit which provides care for patients suffering form minor to major medical conditions. Appropriately trained nurses and a doctor with the relevant training and experience are in attendance on a 24 hour basis.				
Casualty: Trauma and Emergency	An emergency unit which provides care for critically ill or injured patients. 80% of the patients are level one patients. Specifically trained nurses and a doctor with a qualification in emergency medicine is in attendance on a 24 hour basis. The unit is supported by appropriately equipped and staffed theatres, Intensive care units and diagnostic services. Referral to the full spectrum of specialists is available.				
Rehabilitation: General	Units in which patients are nursed that require rehabilitation for traumatic spinal cord or brain injury or / and other debilitating injury or disease that require functional, social rehabilitation. The patients are highly dependant on multi-disciplinary treatment and progress is generally slow.	6-8	20	20	60

[i] Shaw, C.D., et al., *Sustainable healthcare accreditation: messages from Europe in 2009.* Int J Qual Health Care, 2010. **22**(5): p. 341-50.

[ii] Bouchet, B., M. Francisco, and J. Ovretveit, *The Zambia quality assurance program: successes and challenges.* Int J Qual Health Care, 2002. **14 Suppl 1**: p. 89-95.

[iii] Han, M.C., *New horizon in quality care--Asian perspective.* World Hosp Health Serv, 1997. **33**(2): p. 8-13.

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