Interpretation of the Scope of Practice (Regulation 2127) for the South African professional critical care nurse: A Round Table discussion

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Introduction

The specialist critical care nurse (CCN) has progressed from merely being the doctor's right arm to a key critical care team member. It is of the utmost importance that the CCN and the critical care team members understand and appreciate the professional-ethical responsibilities of the CCN.

With practical examples, this paper aims to describe the professional-ethical responsibilities of the South African bedside CCN. The Scope of Practice – Regulation 2127 of 2022 (hereafter referred to as Scope of Practice)[1] regulates these responsibilities. The Scope of Practice is informed by the Nursing Act, Act number 33 of 2005),[2] developed by the South African Nursing Council (SANC) and promulgated by the Minister of Health.

This regulation is not specialisation-specific and is not always well understood by the practising CCN. It is also very important that all critical care team members understand and appreciate the professional-ethical responsibilities of the CCN. The professional-ethical responsibilities of the CCN provide a yardstick against which accountability can be measured.

Methodology

The round table discussion was a Critical Care Society of Southern Africa (CCSSA) Nursing Forum project that the CCSSA Council endorsed. This interpretation arose from a full day of in-person detailed discussion and two two-hour virtual meetings and was informed by the following:

- Nursing Act (Act No. 33 of 2005)[2]
- Scope of Practice[1]
- Acts and of Omissions, Regulation 387 of 1985 as amended[3] (not repealed yet) and Acts and of Omissions, Regulation 767 of 2024 [4]
- Regulation relating to the approval of and the minimum requirements for the education and training of a student leading to registration as a nurse specialist or midwife specialist, Regulation 635 of 2020.[5]

After the round table discussions, a draft document was circulated to the consensus group for comments and suggested modifications. After a formal round of consultation, the draft interpretation was made openly available on the Critical Care Society of Southern Africa website[6] from 1 October 2024 for six weeks, and CCSSA members were invited to review and comment on the proposed draft. The site was open to public view during this time.

This interpretation of the Scope of Practice focuses only on the specialist CCN. SANC defines a nurse specialist as a "Professional Nurse who has undergone and met the theoretical and practical requirements of a specific postgraduate nursing programme of at least one-year duration, has in-depth knowledge and expertise in a specific practice area and is registered as such by the SANC."[7]

The definitions of specific concepts used in the Scope of Practice[1] and in this interpretation are shown in Table 1. A brief discussion of accountability, according to Bergman,[8] will be given as an underpinning for the interpretation of the Scope of Practice.

Table 1 Scope of Practice definitions of concepts [1]

Assistant surgeon	"a person who assist a surgeon, who is also medical practitioner, to perform tasks that fall within the scope of practice of a medical practitioner"
Basic nursing care	**"**nursing interventions that assist health care users with activities of daily living to promote and maintain their health status through the application of prescribed standards of care"
Comprehensive nursing	"means nursing interventions that integrate and apply the scientific process of the full range of nursing, that is general, community, midwifery and mental health, that promote and maintain the health status of healthcare users in all contexts of healthcare delivery"
Direct supervision	"means provision of guidance and oversight to a supervisee by a physically present and experienced registered nursing practitioner; do we need this kind of definition"
General nursing care	"nursing interventions that involve the promotion of health, the prevention of illness, the treatment of all health problems and rehabilitation of individuals, groups and includes managing a health care unit as a subdivision of a health establishment"
General nurse	"a person educated and competent to practice general nursing in the manner and to the level prescribed, who is capable of assuming responsibility and accountability for such practice and is registered as such in terms of the Act"
Indirect supervision	"provision of guidance and oversight to a supervisee by an experienced registered nursing practitioner who is within a health establishment and is available to provide assistance as and when required"
Health establishment	"means the whole or part of **a** public or private institution, facility, building or place whether for profit or not, that is operated or designed to provide in patient or outpatient treatment, diagnostic or therapeutic interventions, whether nursing, rehabilitative, palliative, convalescent, preventive or other health services"
Healthcare unit	"means a subdivision of a health establishment"
Integrated nursing care plan	"means a plan of care that adopts a multidisciplinary approach to improve the physical, emotional and social wellbeing of health care users in all contexts of nursing care delivery"
Plan of care	"means a plan of care developed for a healthcare user by a professional nurse, midwife and general nurse"
Prescribed	**"** means giving the written directions by an authorized person to those who are providing the treatment, nursing care, coordinating, collaborating and patient advocacy functions essential to the effective execution and management of the nursing regimen; or it holds the meaning as defined in the Act"
Quality improvement plan	"means an integrated plan of care which includes all activities or processes that are designed to improve the acceptability, efficiency and effectiveness of nursing care provision and contribute to better health outcomes on an ongoing basis"
Standardised plan of care	"means a generic care plan developed for specified conditions or interventions"
Supportive care	"means all services which enhance the other elements of care essential to individualised care, including health education, advocacy and counselling"
Treatment	"selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen"
Registered person	"shall mean a person who is registered as a nurse or as a midwife in terms of the Act"

Accountability as the underpinning principle for the interpretation of the Scope of Practice

For Bergman [8] to be accountable, certain preconditions should be fulfilled, namely ability, responsibility and authority (Figure 1). These concepts regarding the CCN practice will be briefly discussed.

Figure 1 Accountability according to Bergmann[8]

Ability

Ability is the basic precondition and consists of knowledge, skills and values that the CCN should have before a nursing interaction can occur. Nurses are often given the responsibility and are expected to be accountable without having the ability base or the formal authority.[8] The ability base of the CCN is very complex and varied. The CCN should have an in-depth knowledge of the pathophysiology of critically ill patients, the ability to use high-technology equipment and treatments and clear ethical values. The ability of the CCN is regulated by SANC, which sets a minimum standard for training through Regulation 635 of 2020.[5]

Responsibility

The CCN should be given and take responsibility for the actions undertaken.[8] These responsibilities are outlined in the CCN's post description, Scope of Practice Regulation 2127 [1] and the Acts and Ommissions Regulations.[3, 4]

A nationally registered profession requires a description of its scope of practice to ensure that only persons registered in that profession are permitted to conduct related actions related to it. The description of the scope of practice indicates how far a specific profession can expand legally.

Certain subrules of the Acts and Omissions Regulation[3] are pertinent to the CCN's practice. Subrule 18(1) forbids a CCN to perform an act for which they have inadequate training, except in an emergency. Subrule 22 (a) implies that the CCN is accountable for acquiring medical help in life-threatening situations where the patient's treatment is beyond the CNN's scope of practice. Subrule 22 (b) states that the CNN should use their judgement in an emergency, such as administering emergency medication. However, the CCN remains accountable for her acts and omissions. Subrule 22 (c) implies that when a CCN has not executed a doctor's prescription, the doctor should be notified immediately, regardless of the reason.

Authority

Authorisation to perform critical care nursing actions requires the formal backing and legal right to take action.[8] Legal authority is given to the CCN to practice in terms of the Nursing Act,[2] Scope of Practice [1]and Acts and Omissions.[3, 4] Managerial responsibilities and day-to-day duties of the CCN are authorised by their job description and standard unit policies.

Accountability

The CNN can only be accountable for actions taken when the above preconditions are met[8]. Bergmann [8]addresses the question of who is accountable to whom and for what. The who-to-whom combinations are endless. The CCN is accountable to the patient, the patient's significant others, the critical care team, other health team members, the hospital authorities, society and the nursing profession.

Interpretation of the Scope of Practice

1. *The professional CCN takes responsibility and accountability for the following:*

a) *"advocating for the profession and facilitating the establishment and maintenance of an environment in which health care can be provided safely and optimally"*

To advocate for the profession and facilitate and maintain a healthcare environment in which safe and optimal care is delivered seems like an unrealistic expectation of the bedside CCN. However, the CCN can and should use their voice at all healthcare levels, from the unit where they work to the national level. This role should not be confused with patient advocacy. Using their voice to advocate for the profession will ensure the CCN can facilitate and maintain a healthcare environment where safe and optimal care is delivered. In addition, the CCN will grow professionally and contribute to empowering the next CCN generation. However, for the CCN to fulfil this role, they must have a credible voice – a voice that is believable (knowledgeable) and trustworthy.

The CCN's advocacy responsibility starts at grassroots level, at the bedside and in the critical care unit. This is where important issues can be addressed. The critical care team is at the core of delivering quality critical care. The CCN is tasked to advocate and ensure a safe work environment for the team comprising the nurses and the healthcare professionals working in the unit. The CCN should be the safety net for the team, the assertive (not aggressive) voice that ensures that high-quality critical care is delivered that protects the team, for example, intervening when bullying occurs.

CCNs are encouraged to join or establish communities of practice, and it is important to ensure that junior CCNs join. Communities of practice in nursing focus on sharing best practices and creating new knowledge to advance a domain of professional practice, such as critical care. Interaction on an ongoing basis is essential.

Nurses, in general, are very slow to give their input when there is a call from, for example, SANC for input into national policies. These policies influence the CCN's practice, and the CCN needs to contribute.

It is recommended that the CCN be an active member of a professional society or association. As an active member, the CCN will contribute to a collective voice that can

advocate for critical care nursing nationally and will also benefit in terms of knowledge, skills and leadership development.

b) *"providing safe and quality comprehensive nursing care in a scientific, integrated and evidence-based approach in all health care settings"*

k) *"implementing relevant evidence-based nursing protocols and guidelines"*

For the CCN to render comprehensive nursing as defined by SANC, the CNN must be cognisant that they are not nursing a diagnosis but a patient with a diagnosis. Nursing a patient with a diagnosis entails using the whole-person approach of body, mind and spirit.

Safe and quality nursing requires a scientific, integrated and evidence-based approach and the implementation of relevant evidence-based and context-appropriate nursing protocols and guidelines. The CCN needs to be cognisant that scientific evidence is not stagnant; what you were taught during your critical care training might not be relevant six months or six years later. It is the individual CCN's responsibility to stay abreast of the evolvement of scientific evidence. It is also important that the CCN is critical of the scientific evidence, for example, tight glycaemic control[9]. The original research was done in a cardiothoracic unit. Patients were randomised into a control group and an intensive insulin group whose glucose was maintained between 4.4 and 6.1 mmol/L by the research team. It was concluded that maintaining blood glucose levels between these parameters significantly lowered morbidity and mortality among the trial patients. Tight glycaemic control was then widely implemented internally in medical and surgical critical care units with mixed results, often detrimental. Two lessons were learned from this trial. You have to be careful to extrapolate research results obtained in a homogenous group of patients to all critical care patients. The research team monitored and maintained the blood glucose levels; this was difficult to do safely in critical care units where nurse-patient ratios were not optimal.

With the rate at which scientific evidence evolves, it can be challenging for the CCN to stay current. Continuous professional development activities, journal clubs and attending critical care symposia and congresses can assist – when you know better, you can do better.

c) *"practising in terms of the Code of Ethics for Nursing Practitioners in South Africa"*

The Scope of Practice stipulates that the CCN must practise in terms of the SANC Code of Ethics for Nursing Practitioners in South Africa.[10] The premise of the Code of Ethics is that the CCN has respect for life, human dignity and the rights of other persons. Therefore, the application must be considered with all applicable South African laws and international policy documents, such as the Universal Declaration of Human Rights,[11] the International Council of Nurses Code of Ethics[12] and the Patients' Rights Charter.[13]

The Code of Ethics reminds the CCN of their:

> responsibilities towards individuals, families, groups and communities, namely, to protect, promote and restore health, to prevent illness, preserve life and alleviate suffering. These responsibilities will be carried out with the required respect for human rights, which include cultural rights, the right to life, choice and dignity without consideration of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.[10]

The Code of Ethics is also a declaration of the CCN that they will always afford due care to critical care patients and their families to the best of their ability while supporting each other in the process. It is important to note that the Code of Ethics guides nurses in their ethical decision-making process and is a binding document, the content of which they must comply.[10]

The critical care unit is riddled with complex ethical dilemmas without one-size-fits-all solutions. The Code of Ethics provides ethical direction within which a CCN practice should be framed, yet it will not provide solutions for day-to-day ethical dilemmas in the critical care unit[10]. The CCN's integrity is important when addressing ethical dilemmas in critical care. However, the CCN must be cognisant that addressing ethical dilemmas is a consultative process with all the appropriate stakeholders, including the patient and their significant others.

d) *"facilitating the attainment of optimum health for the individual, the family, groups and the community"*

e) *"promoting health and empowering healthcare users through health counselling and education to secure their active participation in achieving self-reliance"*

f) *"assessing and interpreting the health information needs of individuals and groups, so as to plan and respond accordingly"*

For critically ill patients, optimum health does not necessarily mean the absence of illness but the optimum for the patients' context – the patients' new normal. The patients' new normal will determine the new normal of their significant others, the groups they belong to and the community they return to.

Promoting health and empowering patients through health counselling and education to secure their active participation in achieving self-reliance is not a concept often associated with the high-tech critical care environment. However, the CCN is in the ideal position to do so. The patient and their significant others usually trust and respect the abilities of the CCN, which is essential for counselling and education. Patients confronted with a critical illness go through various stages of acceptance and have different health information needs. The CCN should, therefore, be sensitive and guide the patient and their significant others accordingly. For example, a patient who has just had a myocardial infarction has difficulty accepting their new physical status; attempts by the CCN to educate them on the "do's and don'ts" might have a negative effect. The CCN should rather guide the patient towards accepting their new physical status.

The bedside CCN focuses on the critically ill patient and their significant others; therefore, engaging with the community in this context is challenging. The CCN can empower patients and their significant others to become change agents, thereby indirectly influencing the community.

g) *"diagnosing and prioritising individual health and nursing care needs, based on a comprehensive analysis and the interpretation of data"*

h) *"developing an integrated nursing care plan for the promotion of activities of daily living, self-care, treatment and rehabilitation of health care users, taking cognisance of their physical and psycho-social, cultural and religious needs"*

o) *evaluating a healthcare user's progress towards expected outcomes and revising health and nursing care plans in accordance with the newly identified needs emanating from the evaluation"*

Diagnosing and prioritising individual health and nursing care needs, based on a comprehensive analysis and data interpretation, is the CCN's core function and requires a high level of ability – knowledge, skills and values. Honesty and integrity of the CCN are of the utmost importance when data are collected, as incorrect data or made-up data from one shift may influence the assessment and diagnosis of the CCN in the next shift. For example, performing neurological observations on a patient with a traumatic brain injury requires the CCN to be able to perform the assessment and to have the knowledge and skills to interpret it. CCNs cannot always see the pupils in a patient with brown eyes or cannot correctly assess pupils' response to light, yet they still chart pupil reaction.

In critical care, where the patient's condition may be labile, nursing care plans should be an active document with a continuous process of assessing, planning, implementing and evaluating appropriate to the patient's condition. Developing and implementing an integrated nursing plan in critical care has advantages but poses several challenges.

A well-developed nursing care plan directs the patient's nursing care and serves as a legal document. It is questioned if all CCNs understand why the nursing care plans are necessary as they are often regarded as extra paperwork that they are audited for completing or not completing. Developing and implementing nursing care plans is time-consuming and labour-intensive, which is challenging when caring for a labile patient.

It is important for the CCN to note that a planned action is not done; it must be acknowledged that it was not done, and the reason must be stated. When planning nursing actions, the CCN must be cognisant of the patient's physical and psycho-social, cultural and religious needs and, where possible and appropriate, accommodate the needs. The CCN must be aware that important standard nursing care actions, such as preventing decubitus ulcers, done conventionally can be detrimental to the labile patient, and the CNN should be creative to ensure the safe implementation of the scientific nursing action.

i) "delegating nursing care, ensuring that tasks are delegated to competent nurse practitioners or persons"

t) "providing direction for the implementation of the nursing care plan"

The CCN must be cognisant when delegating nursing care to another practitioner that this should be done with the practitioner's professional status in mind. The question arises: can a CCN delegate the nursing care of an unstable critical care patient to a practitioner other than a CCN? The practitioner must have the appropriate ability (knowledge, skills, and values) to undertake the task, take responsibility for their action, and have the authority to undertake and be accountable for as indicated by that practitioner's scope of practice and the Acts and Omissions regulations. [3, 4]

SANC does not define direct, and it is unknown if they imply supervision of a nursing care plan. The Oxford Dictionary [14] defines direction as "the management or guidance of someone or something". If the CCN is going to guide and manage the implementation of the nursing care plan, the same principles as those for delegation will apply.

j) "preparing and providing supportive nursing care to a patient throughout the administration of diagnostic, surgical and therapeutic acts"

The Scope of Practice [1] defines supportive care as "all services which enhance the other elements of care essential to individualised care, including health education, advocacy and counselling."

Supportive care ensures that patients get the treatment they need. It is about assisting the patient throughout different stages of diagnostic, surgical or therapeutic procedures. Supportive care should not only focus on physical support but also psychological support.

Indirectly, the patient is ensured supportive care when the CNN support the professional executing the procedure. For example, when the doctor performs a bronchoscopy, among other, the CCN monitors the patient to ensure they remain haemodynamically stable, do not become hypoxic, and are adequately sedated.

l) "providing emergency care"

q) *"referring a healthcare user timeously and appropriately to other members of the multidisciplinary team"*

Emergency care does not only imply cardiopulmonary resuscitation. Often, stable critical care patients unexpectedly decompensate, or unstable patients show subtle signs of deterioration. An important focus of the CCN is to recognise the deteriorating patient and escalate care before the patient needs further emergency interventions.

If emergency interventions are required, several aspects need to be considered. The CCN must be competent to contribute meaningfully as a critical care team member or initiate resuscitation if necessary. The CCN's resuscitation competence must be current and maintained. When the CCN needs to initiate the resuscitation, other critical care team members must be mobilised to assist. If the CCN remains the most senior resuscitation team member, starting with the least invasive and effective methods is advisable. If an invasive action such as intubation is required, the CCN can only intubate if they have proof of competency to do so.

Signed and dated protocols are valuable to guide the CCN in the treatment and, specifically, in the delivery of emergency care in specific situations. The CCN, however, needs insight into when it is inappropriate to follow the protocol for a specific patient; for example, a patient may have another pathology that deems the protocol dangerous to follow. The CCN must be aware that different doctors may have different protocols for treating patients with the same diagnosis.

Emergency care also requires emergency equipment to be available and in working condition. The CCN must ensure a system is in place in the critical care unit where emergency equipment is checked correctly and regularly – maybe even more than once a day, depending on the number of emergencies that occur. The equipment should be checked by a practitioner with insight, and a record should be kept.

m) *"providing appropriate palliative and end of life nursing care"*

Palliative care aims to improve the quality of life of patients and their significant others facing challenges associated with life-threatening illness, whether physical, psychological,

social or spiritual. On the other hand, end-of-life care offers treatment and support for patients near the end of their life. Both of these are fundamental to critical care nursing. Although palliative and end-of-life nursing care is multifaceted, the pain management of patients receiving these is often suboptimal. The CCN must be aware of this and ensure that these patients receive appropriate palliative and end-of-life nursing care in all facets.

South Africa has many cultures. The CCN should know and be sensitive to the various practices regarding the dying patient and the dead body. The CCN must communicate with the family to be cognisant of their wishes and treat them with respect and dignity.

An increasing number of critical care patients are admitted with advance directives – living wills, durable power of attorney and do not resuscitate orders. The legitimacy, execution and acknowledgement of advanced directives in critical care are evolving, and the CCM must stay abreast of this narrative. When patients have advance directives, communication between all critical care team members and the patient's significant others is paramount, and the CCN is central to facilitating communication. The Critical Care Society of Southern Africa has published a family counselling form to assist this communication. The CCN must also be aware of the hospital's policies regarding advance directives and end-of-life care.

n) *managing nursing care of individuals, groups and communities; integrating psycho-social care in the management of individuals, groups and communities"*

In the critical care unit, the CNN's focus was traditionally on the critical care patients, and we only regard patients with hospital numbers as healthcare users. However, internationally, critical care patients' significant others are regarded increasingly as health care users, for example, the recognition of the post-intensive care syndrome – family.[15]

The psycho-social care of the patient's significant others is extremely important in critical care. Various stressors in critical care contribute to the psycho-social well-being of the patient's significant others being challenged. Two significant stressors are restricted visiting hours and excluding them from patient care. The CCN must embrace open visiting hours and include the patient's significant others in the care of patients. In units with unrestricted visits, visitors were asked to ensure that anybody touching a patient washed their hands.

The result was a notable drop in nosocomial infections; it was in the visitors' interest that the patient did not develop a nosocomial infection.

Due to the unpredictable physical condition of critical care patients, their psycho-social care is often neglected in critical care, resulting in delirium that may result in increased hospital stay and cost, mortality, impaired long-term cognitive ability and dementia. There is no effective pharmaceutical treatment for delirium, and many of the interventions are nursing-related. The CNN must recognise, assess, and implement interventions such as reorientating patients, cognitive stimulation, early mobilisation, and limiting unnecessary noise and use of restraints.

The CCN focuses on the critical care of patients and their significant others, and they do not get directly involved in the nursing care of groups and communities.

p) *"creating and maintaining a concise, complete and accurate nursing record for individual healthcare users"*

Critical care nursing records are vital for effective communication, and meticulous documentation is essential. It is said that if it has not been recorded, it has not been done. Although the statement is true, it has also led to hospitals requiring more recordkeeping. However, more records do not always imply quality records. The challenge for the CCN is to record relevant information that reflects the patient's condition, as discussed in g), h) and o). What does "the patient had a good night" really mean?

An increasing number of critical care units are using electronic record systems. A diverse range of recordkeeping systems are used, each with its own advantages and disadvantages. The CCN must ensure they know how to use the system correctly and the specific disadvantages associated with the system used in their unit. A challenge for the CCN is that they must avoid treating the screen and not the patient, as there is an increased work burden associated with electronic record keeping. A vast amount of information captured on some systems may result in a high (data) noise-to (clinical) signal ratio that may impede assessing the patient's needs.

r) *"facilitating continuity of care in collaboration with relevant members of the healthcare team"*

The CCN is in the best position to facilitate the continuity of care of the critical care patient as they are next to the patient's bed 24 hours a day, seven days a week. Communication is key to fulfilling this role and speaks to communication in its wider form.

Traditionally, critical care delivery has been seen to be delivered within the boundaries of the critical care unit. Critical care not only starts before the healthcare user arrives in the critical care unit but also continues long after they have left the unit, as described by the post-intensive care syndrome for patients and families. One way of ensuring the continuation of critical care is for the CCN to advocate and be involved in post-ICU clinics.

Coordination of care is an important professional function of the CCN, as various healthcare professionals care for critically ill patients. For example, one doctor can order a diuretic, while another can order a fluid challenge for the same patient. The CCN should be aware of and point out discrepancies in care and even challenge such orders. For the CCN to be an effective communicator, they should be knowledgeable and have effective communication skills. It is not only "what" was said but also "how" it was said.

Communication technology is continuously evolving, and the CCN must understand the technology they use and the legal requirements regarding its use in healthcare. For example, critical care healthcare professionals currently frequently use WhatsApp to communicate. WhatsApp uses end-to-end encryption as a method of data protection. Opperman and Janse van Vuuren [16] highlight several concerns. Identifiable and sensitive patient data are communicated, and mobile phones are often lost, stolen, or used by an unauthorised person. This may lead to a breach of data security. Furthermore, WhatsApp communication is not always included in patients' records. If healthcare professionals do not respond to a WhatsApp message, it leaves an open communication loop and responsibility. "If information is shared among [critical care] healthcare [professionals] on WhatsApp without the consent of a patient, it must be justifiable in the eyes of the law, in the patient's best interest and able to withstand moral judgment if questioned on professional boards."[16]

s) *"initiating and maintaining a therapeutic relationship for all health care users"*

For the CCN to facilitate continuity of care, they must establish and maintain therapeutic relationships with healthcare users in critical care, the patients and their significant others.

The CCN must be cognisant that critical care healthcare users will have different needs, and therapeutic relationships with healthcare users should be individualised. It is important that the CCN be aware of the boundaries of a therapeutic relationship.

u) *"ensuring safe implementation of nursing care, the execution of treatment and the administration of medication prescribed by an authorised registered person"*

The CCN should have in-depth, up-to-date knowledge of the nursing care they implement, the treatment they execute and the medication they administer. Nursing care that is considered basic care in the critical care unit, such as pressure care, mouth care, and bronchial toilet, is often delivered in a "ritual" fashion, not to patients' individual needs. Furthermore, the CCN is not always aware of the latest evidence or controversies that exist in the evidence.

The indications, complications and treatment of adverse events should be part of the CCN knowledge base before a treatment program is executed or medication is administered.

If the registered person who prescribed the treatment or medication makes a mistake, and the CCN who executes the treatment or gives the prescribed medication does so without questioning the prescription, both are accountable for the wrong action. Critical care units often use standing prescriptions for medications such as inotropes. These prescriptions must adhere to the legal and institutional requirements.

The CCN must know how a critically ill patient will react to treatment or medication as it may differ from less critically ill patients. For example, the dose of certain antibiotics should be adjusted according to the patient's needs. A patient with renal dysfunction may need a smaller than standard dose, whereas a septic patient with increased capillary permeability may need a higher than standard dose to achieve an effective serum antibiotic level.

It is the patient's human right to receive effective pain management. Pain management is an example of ritualised care. Often, the CCN will only administer analgesia eight hourly as prescribed regardless of the pain the patient experiences. The CCN must be aware of the

current pain management approach of the objective pain assessment and administrating multimodal analgesia accordingly.

The Scope of Practice does not specify or limit any route of medication administration. The routes for medication administration evolve, and the CCN should keep abreast of new developments as they are accountable not only for their acts but also for omissions. Although the epidural route for medication administration has been around for decades, some CCNs remain reluctant to use this route. It is important that the CCN use this route to administer analgesics and not for anaesthetic purposes. SANC's 2023 letter to the South African Society of Anaesthesiologists [17] regarding the epidural route of medication administration states that the professional nurse should be trained to undertake the procedure followed by a competency-based assessment; evidence of the training should be produced when required. Context-specific standard operating procedures and protocols should be developed to guide and regulate the procedure. It is the responsibility of the CCN to be up-to-date and competent not only with evolving routes of medication administration but also with how different medications are administrated; for example, some antibiotics that were previously given as a bolus are now given as continuous infusions.

Monitoring the critically ill patient's vital signs, invasively and non-invasively, is an important part of the CCN's direct patient care. Vital sign monitoring is a dynamic field in critical care, constantly developing new technology. The CCN is responsible for obtaining the knowledge and skills to use new technology safely. Furthermore, the CCN should know the advantages and limitations of invasive and non-invasive monitoring methods. It is known that blood pressure, an important parameter for many years, has limitations. For example, blood pressure is a product of flow and resistance and does not always reflect the body's needs. Regional blood flow measurements, such as capillary blood flow measurement or cerebral oximetry, may be of far greater value.

It is the policy in certain units to monitor vital signs hourly; however, vital sign monitoring should be done according to the patient's individual needs. Accurate recording of changing vital signs is essential. It is also important that patients should be assessed holistically – they are not just a blood pressure or an oxygen saturation. Individual parameters should be evaluated within the total clinical picture. For example, immediate therapeutic action

should not be taken if the patient's oxygen saturation is suddenly unexpectedly low. Assess the patient's clinical state as a whole, and if this low measurement is in keeping with the total clinical picture, undertake the appropriate action. If not, determine why this is an inappropriate reading. Is the probe positioned correctly? Is the tracing adequate or being influenced by poor perfusion?

v) "ensuring disaster preparedness and response"

Disaster preparedness and response have become synonymous with the 2020 – 2022 COVID-19 pandemic. However, disasters manifest in different forms, each with unique challenges, such as mass casualties, electricity and water shortages, or no supply. The CCN next to the patient's bedside is not in a position to take full responsibility for disaster preparedness and response; however, they do have an important role. When asked, the CCN can give valuable input in planning and evaluating disaster preparedness and should have a voice in planning committees from unit to national level. The CCN's main responsibility is to keep the patient allocated to their care safe. The CCN cannot be held responsible for a functional hospital backup generator when there is no electricity supply, but the CNN must ensure that the ventilated patient in their care has a functional bag valve mask and knows how to use it safely. The CCN needs to learn from their experiences during disasters, be up-to-date with the unit's disaster preparedness programmes and know how to activate these programmes when required.

w) "preventing and managing healthcare user's adverse events"

Adverse events are classified as preventable and not preventable. In critical care, adverse events are complex and often blamed on the individual CCN. However, when a thorough systems analysis is done, multiple factors contribute. For example, bedsores, incontinence and diarrhoea cannot be attributed to the person who identified them. Adverse events must be a learning experience; the causes must be identified and addressed to prevent reoccurrence. Communication between the critical care team members is important, and the lack of communication and accessibility to the team contributes to adverse events.

Unfortunately, the critical care culture is predominantly “punitive” rather than “just”. The CCN must be aware, especially regarding preventative adverse events of the legal consequences.

x) “managing and coordinating nursing care effectively within a health establishment”

A health establishment is a whole or part of a public or private institution, facility, building or place where healthcare is delivered. A concern is that it is not clear how the CCN, working in a busy critical care unit, can also take on the responsibility of managing and coordinating nursing care effectively within a health establishment without compromising the safe, quality and comprehensive nursing care she is expected to deliver to critical care patients as expected by the Scope of Practice.

2. A professional nurse must:

a) “implement and manage a quality improvement plan for own context of practice”

b) “review nursing practice continuously against professional standards within a relevant context; and take responsibility to monitor their actual application in practice”

In order to implement and manage a quality improvement plan in critical care, the CCN must know the principles of quality improvement, identify shortcomings in the critical care unit, and address the shortcomings using a structured process. The CCN must recognise that quality improvement is an iterative process and that it is the CCN’s responsibility to stay updated with current professional standards.

c) “supervise and mentor student nurses and other nursing categories”

No explanation is needed.

3. The scope of practice of a Professional Nurse shall include the scope of practice of a midwife.

Pregnant patients do get admitted to the critical care unit, and it is therefore appropriate that the CCN must have the competencies to care for these patients.

4. A professional nurse may not

a) "set up a private practice without registration as a nurse specialist"

No explanation is needed.

b) "act as an assistant surgeon to a medical practitioner"

Not allowing the CCN to act as an assistant surgeon to a medical practitioner is twofold. Firstly, it is to protect the CCN, who, at times, is expected to fulfil this function without having the necessary competence. Secondly, to protect the CCN, who unwillingly and sometimes willingly undertakes this function, is unaware that if anything happens and the surgeon cannot complete the surgery, the CCN must take over the surgeon's role.

Conclusion

The ethical-professional responsibilities of the CCN are complex and not always understood by the practising CCN and the other critical care team members. The CCN is only one of the categories of nurses working in the critical care unit, and their scope of practice must be interpreted within the context of critical care.

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