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Interpretation of the scope of practice (Regulation 2127) for the South African critical care nurse specialist: A round-table discussion

J Scribante,[1] PhD; **B Karstens,**[2] M Soc Sc; **S Buthelezi,**[2] MSc (Nurs Sci); **M Jooste,**[2] MA (Nurs Sci); **E le Roux,**[2] M Phil HPE; **N Geyer,**[3] PhD

[1] *Surgeons for Little Lives and Department of Paediatric Surgery, School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*

[2] *Specialist Critical Nurse, Nurse Educator*

[3] *Department of Nursing, School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, Nursing Education Association*

Corresponding author: *J Scribante (juan.scribante@wits.ac.za)*

The new scope of practice for nurses (Regulation 2127) was promulgated in 2022; however, it is not specialisation-specific and is not always well understood by critical care nurses or the broader critical care team. Understanding what this scope of practice means and how to work within it is essential for critical care nurses to ensure quality patient care and legal compliance. Using practical examples where appropriate, this article provides an interpretation of the scope of practice of the bedside critical care nurse specialist (CCNS), one of the categories of nurses working in critical care. A round-table discussion, which included an in-person meeting and three two-hour virtual meetings, was held. The panel comprised three members of the Critical Care Society of Southern Africa (CCSSA) Nursing Forum, a nursing legal expert with a critical care nursing background, and two active CCSSA nursing members with expertise in critical care nursing management, education, research and clinical practice. While comprehensive, this interpretation of the scope of practice is by no means exhaustive. Readers should be aware that interpretation of the CCNS's scope of practice may change over time as critical care advances and the CCNS's role evolve accordingly.

Keywords. Critical care nurse specialist, scope of practice, accountability, responsibility

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Contribution of study

The new scope of practice for nurses (Regulation 2127) was promulgated in 2022; however, it is not specialisation-specific and is not always well understood by critical care nurses or the broader critical care team. Understanding what this scope of practice means and how to work within it is essential for critical care nurses to ensure quality patient care and legal compliance. Using practical examples where appropriate, this article provides an interpretation of the scope of practice of the bedside critical care nurse specialist, one of the categories of nurses working in critical care.

The critical care nurse specialist (CCNS) has progressed from being perceived as subservient and merely following orders[1] to becoming a skilled, independent practitioner and a key member of the critical care team.[2] The CCNS is only one of the categories of nurses working in the critical care unit and is defined as a 'nurse practitioner who has undergone and met the theoretical and practical requirements of a specific postgraduate nursing programme and is registered as such by the [South African Nursing] Council'.[3] Other categories of nurses, namely professional, general, auxiliary and enrolled nurses, also play important roles in critical care; however, they do not meet the theoretical and practical educational requirements required for registration with the South African Nursing Council (SANC) as a CCNS.

The scope of practice, Regulation 2127 of 2022 (hereafter referred to as the scope of practice),[4] regulates the professional and ethical responsibilities of all categories of nurses. The Nursing Act (Act No. 33 of 2005)[5] informs the scope of practice and is developed by the SANC and promulgated by the Minister of Health. Geyer[6] highlights:

> 'The scope of practice is compiled as a flexible framework in order to make provision for different areas of practice, and to allow for new developments in health, nursing or midwifery care. The scope of practice can never be limited to a list of tasks because it negates the true nature of nursing and midwifery, which is considerably more than only tasks and procedures. The broad guidelines set out in the regulations allow for the expansion and development of the nurse or midwife's role in order to keep pace with technology and advances in the health, nursing or midwifery field.'

The CCNS and all critical care team members must understand and appreciate the professional and ethical responsibilities of the CCNS, as well as those for which they are accountable. The scope of practice

provides the CCNS with a yardstick against which accountability can be measured. According to Bergman,[7] certain preconditions, namely ability, responsibility and authority, must be fulfilled for professional accountability to be upheld.

The scope of practice is not specialisation-specific and is not always well understood by the CCNS or the broader critical care team; however, understanding it is essential to ensure quality patient care and legal compliance.[8] Using practical examples where appropriate, this article aims to interpret the scope of practice of the South African (SA) bedside CCNS and to make it easier for the CCNS and the critical care team to understand and apply.

Methods

The interpretation of the scope of practice was a Critical Care Society of Southern Africa (CCSSA) Nursing Forum project endorsed by the CCSSA Council. The interpretation was undertaken by means of a round-table discussion. A round-table discussion is a method that elucidates a subject through discussion and debate and is an effective way to foster understanding of a difficult subject.[9] This discussion included an in-person meeting and three two-hour virtual meetings. The panel comprised three CCSSA Nursing Forum members, a nursing legal expert with a critical care nursing background, and two active CCSSA nursing members. The members had expertise in critical care nursing management, education, research and clinical practice. The interpretation was informed by the following:

- Nursing Act (Act No. 33 of 2005);[5]
- Scope of practice;[4]
- Acts and Omissions, Regulation 387 of 1985, as amended[10] (not yet repealed), and Acts and Omissions, Regulation 767 of 2014;[11]
- 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;[3] and
- Bergman's model of accountability.[7]

The discussions were electronically recorded and transcribed by author JS and compiled into a draft document. The draft document was circulated to the panel members for comment, and suggested modifications were made during a virtual meeting. The draft document was made available on the CCSSA website[12] from 1 October 2024 for seven weeks for CCSSA members to comment. The CCSSA secretariat sent three emails during this period inviting CCSSA members to comment. Three comments were received: two thanked the Nursing Forum for the document, and one was unrelated.

The definitions of specific concepts encountered in the scope of practice[4] and in this article are shown in Table 1.

The scope of practice[4] states that the CCNS must take responsibility and be accountable for the 30 statements in the regulation for professional nurses. The authors argue that, for the CCNS to be held accountable, the preconditions for accountability outlined by Bergman[7] must first be satisfied. A brief discussion of Bergman's preconditions for accountability is provided,[7] followed by the interpretation of the scope of practice.

Bergman's model of accountability

According to Bergman,[7] certain preconditions, namely ability, responsibility and authority, must be fulfilled for professional accountability to be upheld (Fig. 1).

Ability

Ability is the basic precondition and consists of the knowledge, skills and values that the CCNS should possess before a nursing interaction can occur. Nurses are often assigned responsibility and expected to be accountable without having the necessary ability base or formal authority.[7] The ability base of the CCNS is complex and varied. The CCNS should have in-depth knowledge of the pathophysiology of critically ill patients, the ability to use advanced technology equipment and treatments, and clear ethical values. The ability of the CCNS is regulated by the SANC, which sets minimum training standards through Regulation 635 of 2020.[3]

Responsibility

The CCNS should be assigned responsibility and should take responsibility for their actions.[7] These responsibilities are outlined in the CCNS's job description, scope of practice[4] and the Acts and Omissions Regulations.[10,11]

A nationally registered profession requires a description of its scope of practice to ensure that only persons registered in that profession are permitted to perform actions related to it. The scope of practice defines the legal boundaries within which a specific profession may practice and expand.

Certain subrules of the Acts and Omissions Regulation[10] are pertinent to CCNS practice. Subrule 18(1) prohibits a CCNS from performing an act for which they have inadequate training, except in an emergency. Subrule 22(a) implies that the CCNS is accountable for obtaining medical assistance in life-threatening situations where the patient's treatment falls beyond the CCNS's scope of practice. Subrule 22(b) states that the CCNS should use their judgement in an emergency, such as when administering emergency medication. However, the CCNS remains accountable for their acts and omissions. Subrule 22(c) implies that if a CCNS has not carried out a doctor's prescription, the doctor should be notified immediately, regardless of the reason.

Authority

Authorisation to perform critical care nursing actions requires formal backing and the legal right to take action.[7] Legal authority is granted to the CCNS to practise in terms of the South African Nursing Act,[5] the scope of practice[4] and the Acts and Omissions Regulations.[10,11] Managerial responsibilities and day-to-day duties of the CCNS are authorised through the job description and standard unit policies.

Accountability

The CCNS can only be held accountable for actions taken when the above preconditions are met.[7] Bergman[7] addresses the question of who is accountable to whom and for what. The possible who-to-whom combinations are endless. The CCNS is accountable to the patient, the patient's significant others, the critical care team, other healthcare team members, hospital authorities, society and the nursing profession.

Interpretation of the scope of practice

In developing this interpretation, the round-table panel members debated and discussed each statement in the SANC scope of practice or, where logical, combined related statements. Practical examples are provided where relevant to further elucidate the interpretation.

The professional CCNS takes responsibility and accountability for the following:

Table 1. Scope of practice definitions of concepts[4]

Assistant surgeon	A person who assists a surgeon, who is also medical practitioner, in performing tasks that fall within the scope of practice of a medical practitioner.
Basic nursing care	Nursing interventions that assist healthcare users with activities of daily living to promote and maintain their health status through the application of prescribed standards of care.
Comprehensive nursing	Nursing interventions that integrate and apply the scientific process of the full range of nursing, namely general, community, midwifery and mental health, that promote and maintain the health status of healthcare users in all contexts of healthcare delivery.
Direct supervision	The provision of guidance and oversight to a supervisee by a physically present and experienced registered nursing practitioner.
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 and groups and includes managing a healthcare unit as a subdivision of a health establishment.
General nurse	A person educated and competent to practise general nursing in the manner and to the level prescribed, and who is capable of assuming responsibility and accountability for such practice and is registered as such in terms of the Act.
Indirect supervision	The 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	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 inpatient or outpatient treatment, diagnostic or therapeutic interventions, whether nursing, rehabilitative, palliative, convalescent, preventive or other health services.
Healthcare unit	A subdivision of a health establishment.
Integrated nursing care plan	A plan of care that adopts a multidisciplinary approach to improve the physical, emotional and social wellbeing of healthcare users in all contexts of nursing care delivery.
Plan of care	A plan of care developed for a healthcare user by a professional nurse, midwife or general nurse.
Prescribed	Giving the written directions by an authorised person to those who are providing the treatment, nursing care, co-ordinating, 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	An integrated plan of care that includes all activities or processes designed to improve the acceptability, efficiency and effectiveness of nursing care provision and contributes to better health outcomes on an ongoing basis.
Standardised plan of care	A generic care plan developed for specified conditions or interventions.
Supportive care	All services that 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	A person who is registered as a nurse or as a midwife in terms of the Act.

a) 'advocating for the profession and facilitating the establishment and maintenance of an environment in which healthcare can be provided safely and optimally'

Advocating for the profession (actively supporting, promoting and protecting the role, rights and contributions of the nurse), as well as facilitating and maintaining a healthcare environment in which safe and optimal care is delivered, may seem like unrealistic expectations for bedside CCNSs. However, the CCNS can and should use their voice at all healthcare levels, from the unit in which they work to the national level. This role should not be confused with patient advocacy. By using their voice to advocate for the profession, the CCNS can help facilitate and maintain a healthcare environment in which safe and optimal care is delivered. In addition, the CCNS will grow professionally and empower the next generation of CCNSs. However, for the CCNS to fulfil this role, they must have a credible voice that is both knowledgeable and trustworthy. If the CCNS does not use their voice, decisions that affect them will be made on their behalf.

The CCNS's advocacy responsibility begins at grassroots level, at the bedside and within the critical care unit. This is where important issues should first be addressed. The critical care team is central to delivering quality critical care. The CCNS is tasked with advocating for and helping to ensure a safe work environment for all healthcare team members in the unit. The CCNS should be the safety net for the critical care team – an assertive (not aggressive) voice that ensures the delivery of high-quality critical care and protects the team, for example by intervening when bullying occurs.

CCNSs are encouraged to join or establish communities of practice, and it is important to encourage junior CCNSs to participate.



Fig. 1. Accountability according to Bergman.[1]

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. Ongoing interaction is essential.

In general, nurses are often slow to provide input when there is a call from, for example, the SANC for contributions to national policies. As these policies directly influence their practice, CCNSs should actively contribute.

It is recommended that the CCNS be an active member of a professional society or association. As an active member, they not only contribute to a collective voice that advocates for critical care nursing nationally, but also gain benefits in terms of knowledge, skills and leadership development. This growth also enables them to serve as role models for other CCNSs.

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

k) 'implementing relevant, evidence-based nursing protocols and guidelines.'

For the CCNS to provide comprehensive nursing as defined by the SANC, they must recognise that they are not merely nursing a diagnosis, but a patient with a diagnosis, which requires a whole-person approach encompassing body, mind and spirit.

Safe, high-quality nursing care requires a scientific, integrated and evidence-based approach, as well as the implementation of relevant, evidence-based and context-appropriate nursing protocols and guidelines. The CCNS needs to be cognisant that scientific evidence is not static – what was taught during their critical care training may no longer be relevant six months or six years later. The individual CCNS is therefore responsible for staying abreast of and critically evaluating evolving scientific evidence.

This principle is aptly demonstrated by the landmark tight glycaemic control study.[9] The original research was conducted in a cardiothoracic unit. Patients were randomly assigned to either control or intensive insulin-therapy groups, and their blood glucose levels were maintained between 4.4 and 6.1 mmol/L. It was concluded that maintaining blood glucose levels within these parameters significantly reduced morbidity and mortality among the participants. Thereafter, tight glycaemic control was implemented internationally in medical and surgical critical care units, with mixed and often detrimental results. Two lessons were learned from this trial. First, care must be taken when extrapolating research results obtained from a homogenous group of patients to all critical care patients. Second, the research team had monitored and maintained the blood glucose levels, which is difficult to achieve safely in critical care units where nurse-to-patient ratios are not optimal.

Given the pace at which scientific evidence evolves, it can be challenging for the CCNS to remain current. Continuous professional development activities, journal clubs, and critical care symposia and congresses can assist. The development of new technologies, such as artificial intelligence, also has implications for how the CCNS will access, evaluate and use scientific evidence in future, while remaining aware of both the benefits and limitations.

'practicing in terms of the Code of Ethics for Nursing Practitioners in South Africa'

The scope of practice stipulates that the CCNS must practice in accordance with the SANC Code of Ethics for Nursing Practitioners in South Africa.[13] The premise of the Code of Ethics is that the CCNS respects life, human dignity and the rights of others. Its application must be considered alongside all applicable SA laws and international policy documents, such as the Universal Declaration of Human Rights,[14] the International Council of Nurses Code of Ethics[15] and the National Patients' Rights Charter.[16]

The Code of Ethics reminds the CCNS of their responsibilities toward individuals, families, groups and communities, namely to protect, promote and restore health; prevent illness; preserve life; and alleviate suffering. These responsibilities must be carried out with due respect for human rights, including cultural rights, the right to life, choice and dignity, without discrimination on the basis of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.[13]

The Code of Ethics is also a declaration that the CCNS will always provide due care to critically ill patients and their families or significant others to the best of their ability, while supporting one another in the process. It is important to note that the Code of Ethics is a binding document that guides the ethical decision-making of nurses and must be complied with.[13]

Critical care is rife with complex ethical dilemmas that do not have one-size-fits-all solutions. Although the Code of Ethics provides the ethical framework within which CCNS practice should be grounded, it does not provide solutions for the day-to-day ethical dilemmas encountered in the critical care unit.[13] In these situations, the CCNS's integrity and knowledge of ethics are essential. However, the CCNS must be cognisant that resolving these dilemmas is a consultative process involving all appropriate stakeholders, including the patient and their significant others.

d) 'facilitating the attainment of optimal health for the individual, family, groups and 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 a critically ill patient and their significant others, optimal health does not necessarily mean the absence of illness, but rather the best possible outcome within the patient's context. If there has been a change in the patient's condition, this may represent their new normal. This new normal will also influence the lives of their significant others, the groups to which they belong and the community to which they return.

Promoting health and empowering patients through health counselling and education to secure their active participation in achieving self-reliance is not a concept commonly associated with the high-technology critical care environment. However, the CCNS is ideally positioned to do so. Patients and their significant others usually trust and respect the abilities of the CCNS, which is essential for effective counselling and education. Patients confronted with critical illness go through various stages of acceptance and have different health information needs. The CCNS should be sensitive to these stages and guide the patient and their significant others accordingly. For example, a patient who has just had a myocardial infarction may have difficulty accepting their changed physical status, and immediate attempts by the CCNS to educate them about lifestyle restrictions or 'do's and don'ts' may have a negative effect. Instead, the CCNS should first support the patient in coming to terms with their new physical status.

The bedside CCNS focuses primarily on the critically ill patient and their significant others; therefore, engaging with the community in this context may be challenging. The CCNS can empower patients and their significant others to become agents of change, 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 healthcare users, taking cognisance of their physical and psychosocial, cultural and religious needs'*

o) *'evaluating a healthcare user's progress toward 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 CCNS's core function and requires a high level of ability – knowledge, skills and values. Honesty and integrity are of utmost importance when data are collected, as incorrect or fabricated information from one shift may influence the assessment and diagnosis made by the CCNS during the next shift. For example, performing neurological observations on a patient with a traumatic brain injury requires the CCNS to be able to perform the assessment accurately and to have the knowledge and skills to interpret the findings appropriately. CCNSs may sometimes struggle to assess pupils accurately in patients with brown eyes or may incorrectly assess pupillary light responses, yet still document pupil reactions.

In critical care, where the patient's condition may be unstable, nursing care plans should be living documents that reflect a continuous process of assessment, planning, implementation and evaluation appropriate to the patient's condition. Developing and implementing an integrated nursing plan in critical care has clear advantages but also presents several challenges.

A well-developed nursing care plan directs patient care and serves as a legal document. However, it is questionable whether all CCNSs fully understand the purpose of nursing care plans, as they are often regarded merely as additional paperwork for audit purposes. Developing and implementing nursing care plans is time-consuming and labour-intensive, which becomes particularly challenging when caring for an unstable patient.

It is important for the CCNS to note that if a planned action is not carried out, this must be clearly documented, together with the reason it was not done. When planning nursing actions, the CCNS must be cognisant of the patient's physical and psychosocial, cultural and religious needs and, where possible and appropriate, accommodate these needs. The CCNS must also recognise that important standard nursing care actions, such as preventing pressure injuries, may, if performed conventionally, be detrimental to an unstable patient. The CCNS should therefore be creative and strive to ensure the safe implementation of evidence-based nursing care.

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'*

Before a CCNS delegates nursing care duties to another practitioner, they should first consider that practitioner's professional status and competence. The question arises whether a CCNS can delegate the nursing care of an unstable, critically ill patient to a practitioner other than a CCNS. The practitioner must have the appropriate ability (knowledge, skills and values) to perform the task, take responsibility for their actions, and have the authority to undertake the task and be held accountable for those actions, as determined by the practitioner's scope of practice and the Acts and Omissions Regulations.[10,11]

SANC does not define 'direction', and it is unclear whether this implies supervision of the nursing care plan. *The Oxford Dictionary*[17] defines direction as 'the management or guidance of someone or something'. If the CCNS is expected to guide and manage the implementation of the nursing care plan, the same principles that apply to delegation should also apply here.

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

The scope of practice [4] 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 receive the treatment they need. It involves assisting the patient throughout the different stages of diagnostic, surgical or therapeutic procedures. Supportive care should focus not only on physical support, but also on psychological support.

Indirectly, the patient also receives supportive care when the CCNS supports the healthcare professional performing the procedure. For example, when a doctor performs a bronchoscopy, the CCNS monitors the patient to ensure that 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 refer only to cardiopulmonary resuscitation. Stable critical care patients may unexpectedly decompensate, while unstable patients may show subtle signs of deterioration. An important responsibility of the CCNS is recognising early signs of deterioration and escalating care before further emergency interventions become necessary.

If emergency interventions are required, several aspects must be considered. The CCNS must be competent to contribute meaningfully as a member of the critical care team and be able to initiate resuscitation if necessary. The CCNS's resuscitation competence must be current and regularly maintained. If the CCNS needs to initiate the resuscitation, other critical care team members must be mobilised to assist. If the CCNS remains the most senior resuscitation team member, it is advisable to begin with the least invasive yet effective interventions. If an invasive procedure such as intubation is required, the CCNS may only perform the procedure if they have proof of competency to do so.

Although signed and dated protocols are valuable in guiding the CCNS in treatment and, specifically, in the delivery of emergency care in particular situations, the CCNS must also have the clinical insight to recognise when it may be inappropriate to follow a protocol for a specific patient. For example, a patient may have another or underlying pathology that renders strict adherence to the protocol dangerous.

In addition, the CCNS should be aware that different doctors may use different approaches to treating patients with the same diagnosis. Emergency care also requires that emergency equipment be readily available and in working condition. The CCNS must ensure that a system is in place within the critical care unit for emergency equipment to be checked correctly and regularly – possibly more than once a day, depending on the frequency of emergencies – and that these checks are appropriately recorded.

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 who face challenges associated with life-threatening illness, whether physical, psychological, social or spiritual. End-of-life care provides treatment and support for patients nearing the end of life. Both are fundamental aspects of critical care nursing. Internationally, some critical care units have dedicated palliative care teams,[18] but in SA, palliative care management is often the responsibility of the CCNS.

Although palliative and end-of-life nursing care is multifaceted, pain management for these patients is often suboptimal. The CCNS must be aware of this and ensure that these patients receive relevant and appropriate palliative and end-of-life nursing care across all facets.

SA has many cultures and religions. The CCNS should be aware of and sensitive to the various practices surrounding the dying patient and the care of the body after death. The CCNS must communicate with the family regarding their wishes and treat them with respect and dignity.

An increasing number of critical care patients are admitted with advance directives, including living wills, power of attorney and do-not-resuscitate orders. The legitimacy, execution and acknowledgement of advanced directives in critical care are evolving, and the CCNS should remain informed of these developments. When patients have advance directives, communication among all critical care team members, as well as the patient's significant others, is paramount, and the CCNS is central to facilitating this communication. The CCNS must also be aware of the hospital's policies regarding advance directives and end-of-life care. The CCSSA has published a family counselling form to support this communication.[19]

n) 'managing nursing care of individuals, groups and communities; integrating psychosocial care in the management of individuals, groups and communities'

Traditionally, the focus of the CCNS has been the critical care of patients within the critical care unit, and only patients with hospital numbers were regarded as healthcare users; therefore, CCNSs were not regarded as being directly involved in the nursing care of groups and communities. However, internationally, the patient's significant others are increasingly being recognised as healthcare users, for example through recognition of post-intensive care syndrome – family.[20]

The term 'significant other' may be used rather than 'family'. A patient's significant others include people whom the patient regards as significant and may or may not include family members as traditionally defined.

The psychosocial care of the patient's significant others has become an important component of critical care. Various stressors within the critical care environment affect their psychosocial wellbeing, two significant stressors being restricted visiting hours and exclusion from patient care. The CCNS should embrace open visiting hours and include the patient's significant others in patient care where appropriate. When significant others are involved in patient care, it should take place under the direct supervision of the CCNS.

Owing to the unpredictable physical condition of critically ill patients, their psychosocial care is often neglected. This may contribute to delirium, which can prolong hospital stays, increase costs and mortality, impair long-term cognitive function and increase the risk of dementia. There is no effective pharmacological treatment for delirium, and many of the interventions are nursing related. The CCNS must timeously recognise delirium, assess contributing factors and implement interventions such as reorientating patients, providing cognitive stimulation, promoting early mobilisation and limiting unnecessary noise and the use of restraints.

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 often said that if it has not been recorded, it has not been done. Although there is truth in this statement, it has resulted in hospitals requiring increasingly extensive recordkeeping. However, more records do not necessarily mean better-quality records.

The challenge for the CCNS is to record relevant information that accurately reflects the patient's condition, as discussed in g), h) and o), and to understand the relevance of that information. For example, what does a note such as 'the patient had a good night' actually mean?

An increasing number of critical care units are implementing electronic record-keeping systems. A diverse range of systems is used, each with its own advantages and disadvantages. The CCNS must ensure that they know how to use the system correctly and are aware of the specific limitations associated with the system in their unit.

A further challenge for the CCNS is avoiding the tendency to treat the screen rather than the patient, as electronic record-keeping is often associated with an increased administrative burden. The vast amount of information captured by some systems may result in a high data-to-clinical-signal noise ratio, which may impede accurate assessment of the patient's needs.

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

The CCNS is in the best position to facilitate continuity of care for the critically ill patient, as they are at the patient's bedside 24 hours a day, seven days a week. Communication is key to fulfilling this role and extends beyond simple information exchange; it is a complex and time-consuming process.

Co-ordination of care is an important professional function of the CCNS, as various healthcare professionals care for critically ill patients. For example, one doctor may prescribe a diuretic, while another orders a fluid challenge for the same patient. The CCNS should recognise and point out discrepancies in care and, when necessary, challenge such prescriptions. For the CCNS to be an effective communicator, they should be knowledgeable and possess effective communication skills. It is not only what is said, but also how it is said.

Communication technology is continuously evolving, and the CCNS should understand the technology they use, as well as the legal requirements governing its use in healthcare. For example, critical care healthcare professionals frequently use WhatsApp (WhatsApp Inc., USA) to communicate. WhatsApp uses end-to-end encryption as a method of data protection. Opperman and Janse van Vuuren[21] highlight several concerns. Identifiable and sensitive patient data are often communicated, and mobile phones may be lost, stolen or accessed by unauthorised persons. This may lead to breaches of data security. Furthermore, WhatsApp communication is not always included in patient records. If healthcare professionals do not respond to a WhatsApp message, it creates an open communication loop and unclear responsibility.

Opperman and Janse van Vuuren[21] note: '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.'

Traditionally, critical care delivery has been confined to the boundaries of the critical care unit. However, critical care begins before the healthcare user arrives in the critical care unit and continues long after discharge, as reflected in post-intensive care syndrome affecting both patients and their significant others. One way of ensuring the continuity of care is for the CCNS to advocate for and be involved in post-ICU clinics.

s) 'initiating and maintaining a therapeutic relationship for all healthcare users'

For the CCNS to facilitate continuity of care, therapeutic relationships must be established and maintained with critically ill patients and their significant others.

The CCNS must be cognisant that healthcare users have different needs, and therapeutic relationships should therefore be individualised. It is also important for the CCNS to be aware of the professional 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 CCNS should have in-depth, up-to-date knowledge of the nursing care they implement, the treatment they carry out and the medication they administer. Nursing care that is considered 'basic' in the critical care unit, such as pressure care, mouth care and bronchial toilet, is often delivered in a ritualised manner rather than according to the individual needs of the patient. Furthermore, the CCNS is not always aware of the latest evidence or controversies emerging from the evidence base.

The incidence, complications and management of adverse events should form part of the CCNS's knowledge base before a treatment programme is initiated or medication is administered.

If the registered person who prescribed the treatment or medication makes an error, and the CCNS who carries out the treatment or administers the medication does so without questioning the prescription, both are accountable for that error. Critical care units often use standing prescriptions for medications such as inotropes. These prescriptions must adhere to legal and institutional requirements.

The CCNS must understand how a critically ill patient may respond differently to treatment or medication compared with 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 require a smaller-than-standard dose, whereas a septic patient with increased capillary permeability may require a higher-than-standard dose to achieve an effective serum antibiotic level.

Although it is the patient's human right to receive effective pain management, this has also become an example of ritualised care. The CCNS may administer analgesia only eight-hourly, as prescribed, regardless of the pain the patient experiences. The CCNS must be aware of the current approach to pain management, including objective pain assessment, and administer multimodal analgesia accordingly.

The scope of practice does not specify or limit any route of medication administration. Routes for administration continue to evolve, and the CCNS should stay abreast of new developments, as they are accountable not only for their acts but also for omissions. Although the epidural route of medication administration has been used for decades, some CCNSs remain reluctant to use it. It is important that the CCNS uses this route for the administration of analgesics and not for anaesthetic purposes. The SANC 2023 letter to the South African Society of Anaesthesiologists[22] 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 this training should be available when required. Context-specific standard operating procedures and protocols should be developed to guide and regulate the procedure.

It is the responsibility of the CCNS to remain up to date and competent not only in evolving routes of medication administration, but also in how different medications are administrated. For example, some antibiotics that were previously given as an intermittent infusion are now administered as continuous infusions.

Monitoring the critically ill patient's vital signs, both invasively and non-invasively, is an important part of the CCNS's direct patient care. Vital sign monitoring is a dynamic field in critical care, with new technologies constantly emerging. The CCNS is responsible for acquiring the knowledge and skills required to use these technologies safely and effectively. Furthermore, the CCNS should be aware of the advantages and limitations of invasive and non-invasive monitoring methods. For example, it is well recognised that blood pressure measurement, an important clinical parameter for many years, has limitations. Blood pressure is a product of flow and resistance and does not always accurately reflect the body's needs. Regional blood flow measurements, such as capillary blood flow measurement or cerebral oximetry, may be of far greater value in certain circumstances.

In some units, it is policy to monitor vital signs hourly; however, vital sign monitoring should be performed according to the patient's individual needs. Accurate recording of changes in vital signs is essential. It is also important that patients are assessed holistically – they are not merely a blood pressure reading or an oxygen saturation value. Individual parameters should be evaluated within the overall clinical picture. For example, immediate therapeutic action should not be automatically taken if a patient's oxygen saturation is suddenly and unexpectedly low. The patient's overall clinical condition should first be assessed. If the low measurement is consistent with the total clinical picture, appropriate action should be taken. If not, the reason for the inappropriate or inaccurate reading should be determined. Is the probe positioned correctly? Is the tracing adequate, or is it being affected 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 various forms, each with unique challenges, such as mass casualties and disruptions to electricity and water supplies. Although the CCNS at the patient's bedside is not in a position to take full responsibility for disaster preparedness and response, they do play an important role. When consulted, the CCNS can provide valuable input into planning and evaluating disaster preparedness and should have a voice in planning committees at all levels, from the unit to the national level. The CCNS's primary responsibility is to ensure the safety of the patient allocated to their care. For example, the CCNS cannot be held responsible for ensuring that the hospital backup generator is functional when there is no electricity supply, but they must ensure that the ventilated patient in their care has access to a functional bag-valve mask and that they know how to use it safely. The CCNS must learn from previous disaster experiences, remain 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 either preventable or unpreventable.[23] In critical care, adverse events are complex and often attributed to the CCNS responsible for the patient's care at the time the event occurred. However, when a thorough systems analysis is undertaken, multiple contributing factors are usually identified. For example, bedsores, incontinence and diarrhoea cannot simply be attributed to the person

who first identified them. Adverse events should be viewed as a learning experience, and the contributing factors should be identified and addressed to prevent recurrence. Communication among critical care team members is essential, as poor communication and limited accessibility within the team contribute to the occurrence of adverse events.

Unfortunately, the culture in critical care is predominantly 'punitive' rather than 'just'. The CCNS must be aware of the legal consequences, especially regarding preventable adverse events.

x) 'managing and co-ordinating nursing care effectively within a health establishment'

A health establishment is defined as the whole or part of a public or private institution, facility, building or place where healthcare is delivered. A concern is that it is unclear how the CCNS, working in a busy critical care unit, can also take responsibility for managing and co-ordinating nursing care effectively within a health establishment without compromising the safe, quality and comprehensive nursing care expected for critically ill patients under the scope of practice.

A professional nurse must: (*i*) 'implement and manage a quality improvement plan for own context of practice'; (*ii*) 'review nursing practice continuously against professional standards within a relevant context, and take responsibility to monitor their actual application in practice'; and (*iii*) 'supervise and mentor student nurses and other nursing categories'.

To implement and manage a quality improvement plan in critical care, the CCNS must understand the principles of quality improvement, identify shortcomings within the critical care unit and address these shortcomings using a structured process. The CCNS must recognise that quality improvement is an iterative process and that it is their responsibility to remain up to date with current professional standards.

s) 'The scope of practice of a Professional Nurse shall include the scope of practice of a midwife.'

Pregnant patients are admitted to critical care units, and it is therefore appropriate that the CCNS has the competence to care for these patients. In addition, a professional nurse may not (*i*) 'set up a private practice without registration as a nurse specialist'; and (*ii*) 'act as an assistant surgeon to a medical practitioner'.

Prohibiting the CCNS from acting as an assistant surgeon to a medical practitioner serves two purposes. First, it protects the CCNS from being expected to fulfil this role without having the necessary competence. Second, it protects the CCNS who, whether unwillingly or willingly, undertakes this function without realising that, if complications arise and the surgeon is unable to complete the procedure, they may be expected to assume responsibilities beyond their legal and professional scope.

Conclusion

The ethical and professional responsibilities of the CCNS are complex. The scope of practice that regulates these responsibilities is not specialisation-specific and is not always well understood by the CCNS or the broader critical care team. While comprehensive, this interpretation of the scope of practice is by no means exhaustive.

This article aimed to provide bedside CCNSs with practical guidance on how to apply the scope of practice in their daily practice and to give the critical care team a better understanding of the CCNS's contribution to quality care. However, readers should be aware that this interpretation of the CCNS's scope of practice may change as critical care advances and the role of the CCNS evolves accordingly.

The CCNS is only one of the categories of nurses working in the critical care unit. It is recommended that the scope of practice of the other categories of nurses working in critical care also be interpreted.

Data availability statement. The data used for this study are available from the first author upon request.

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