

The nursing crisis in paediatrics in South African state hospitals – an unaddressed problem

South African (SA) state hospitals face a myriad of problems, ranging from the deterioration of physical structures to drug shortages, and a lack of human resources. The shortage of trained nurses of all ranks – professional, enrolled and auxiliary – is perhaps the most severe. In paediatrics, nursing is an essential component of care because children require near-constant supervision. In addition to their need for emotional support and comfort, hospitalised children are absolutely dependent on nurses for the monitoring of their general condition and vital signs, administration of medication, delivery and monitoring of intravenous fluids, feeding, bathing, and nappy changes. Nurses also need to cope with enormous administrative and bureaucratic burdens; they act as porters, cooks, and cleaners when called to do so. They are the interface between parents, caregivers, and other health service providers and the burden of their clinical workload is arguably much heavier than that of the rest of the healthcare team.

Ironically, nursing staff numbers are dwindling at a time when medical staffing is relatively robust owing to the 2-year internship programme and community service obligations, which have generally bolstered the ranks of junior doctors in the paediatric wards. In the past 2 years (2015 - 2016), our 39-bed ward, which is one of four general paediatric wards at the Chris Hani Baragwanath Academic Hospital, has had a night-time nursing team comprising of four individuals on average: a professional nurse and three enrolled or auxiliary nurses. Staff numbers were marginally better during the day, when we had an average seven-member nursing team of three to four professional nurses, and the remainder comprising of enrolled and/or auxiliary nurses. During this time, we admitted ~2 600 children to our ward. The majority of these patients suffered from lower respiratory tract infections and required supplemental oxygen. Neonates, who generally require more intensive nursing, comprised about 20% of all admissions. Because at any given time there can also be children with medical complexities (e.g. severe neurological impairment) who need intensive and prolonged nursing during a period of prolonged hospitalisation in the ward at any one time, the nursing staff often struggle to provide adequate care to all admitted children. This has consequences: there is an increased risk of nosocomial infections, medication administration errors are likely to occur more frequently, and the supervision and administration of feeding becomes difficult. These adverse events are more likely to affect children with medical complexity, which further increases the duration of their hospitalisation. Furthermore, in medicolegal cases, nurses may be blamed for causing patient harm despite the fact that staff shortages may have indirectly contributed to suboptimal patient management; for example, a nurse may be blamed if a child suffered circulatory, neurological, vascular, or muscular damage after failing to notice and remove a tourniquet timeously post venous cannulation. This creates a vicious cycle where the working conditions in the paediatric wards make it difficult to recruit and retain new nursing staff – this lowers the morale of existing staff and perpetuates the nursing crisis.

Notwithstanding the nursing shortage in SA, a great proportion of healthcare delivery, especially in rural and underserved areas, is dependent on nurse-based systems. If we continue to fail to deal with the existing nursing crisis, we risk further collapse of the healthcare system. Nursing has been described as a ‘profession in peril’^[1] and the National Department of Health estimated that there was a shortage of ~45 000 professional nurses in the state sector in 2010; that year, only ~3 600 professional nurses registered with

the South African Nursing Council.^[1] Rispel and Bruce^[1] have identified several critical problem areas that need to be tackled to solve the nursing crisis: (i) nursing education reforms, (ii) the lack of nursing involvement in policy-making, (iii) the use of nursing agencies to provide temporary nursing staff and moonlighting services, and (iv) measures to improve the work experiences of nurses (such as lessening the clinical workload, reducing the risk of physical and psychological harm, and offering professional support and prospects for professional development and job satisfaction). Nonetheless, even if drastic measures are taken to tackle these problems immediately, the nursing shortage is likely to persist for the next decade or so.

In the meantime, what can be done to help nurses?

Firstly, there is an urgent need to define what the minimum nursing paediatric workloads are, and the time and nursing staff numbers (across all categories – professional, enrolled and auxiliary) needed to complete a defined number of paediatric nursing procedures or activities, e.g. the time needed to feed a neonate using a cup and spoon or the time required to accurately draw up and administer an intravenous antibiotic. Although ideal nursing ratios for professional, enrolled, and auxiliary nurses have been proposed for the SA state health system,^[2] these norms are unlikely to be reached in the short term. It is critically important that activity-based guidelines be developed urgently, so that task shifting can be planned, with registered nurses supervising enrolled and auxiliary nurses to provide safe and effective paediatric nursing care.^[3]

Secondly, doctors need to improve on their communication with nursing staff, and include the senior nursing staff in discussions about patient management in the context of the nursing staff numbers. Without endangering patient outcomes and likely improving them, doctors need to evaluate if nursing-intensive procedures and activities are essential – for example, the continued administration of intravenous antibiotics where an oral substitute is suitable. In the context of the nursing crisis, avoiding prolonged hospitalisation should be a medical priority and options to manage stable children as outpatients should be fully explored. Doctors should inform parents, legal guardians, and caregivers about the challenges that nurses face in providing the best care for their children under difficult situations. For children with medical complexity, doctors and the allied medical staff, including dietitians, physiotherapists, speech and occupational therapists, need to discuss their respective management plans with the nursing staff and determine which activities and procedures could be reasonably performed with a certain degree of competence by the nursing staff. In addition, many stable children are often unnecessarily left to wait in wards for procedures, such as specialised radiological investigations, which have no direct bearing on the child’s management. The power dynamics within doctor-nurse relationships will almost certainly require recalibration so that nurses have improved opportunities to suggest, implement, and monitor the effects of innovative methods that have been devised to optimise nursing care, lessen job stress, and minimise bureaucratic tasks.

Thirdly, senior competent nurses who have passed retirement age, and who would like to remain in state service, should be kept in full-time employment with appropriate remuneration.

Urgent interventions are required to resolve the nursing crisis in state hospital-based paediatric practice. As paediatricians we need to serve as advocates, not only for the children we treat, but also for the nursing care that children depend on.

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