AN INVESTIGATION INTO THE CURRENT PRACTICE OF THE PRIVATE NURSE WORKING IN THE COMMUNITY IN SOUTH AFRICA

by

JEMIMA ELIZABETH SMITH

submitted in fulfilment of the requirements for
the degree of

MASTER OF ARTS IN NURSING SCIENCE

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF MVLH LOCK

JOINT SUPERVISOR: MS SP HUMAN

NOVEMBER 1996

SUMMARY

AN INVESTIGATION INTO THE CURRENT PRACTICE OF THE PRIVATE NURSE WORKING IN THE COMMUNITY IN SOUTH AFRICA

STUDENT:	JE Smith
DEGREE:	Magister Artium in Nursing Science
DEPARTMENT:	Advanced Nursing Sciences, University of South Africa
SUPERVISOR:	Prof MVLH Lock
JOINT SUPERVISOR:	Miss SP Human

Little is known about the current practice of the nurse practising as an independent private practitioner in South Africa. There is also limited information available about his/her needs for establishing and maintaining a private practice. In this exploratory, descriptive study the AFFIRM model was applied and specific data regarding the practice and needs of the nurse in private practice was collected through a questionnaire.

Based on the analysed data, it would appear that the majority of private nurse practitioners are married females and fall into the age group below 44 years. Although a variety of nursing services are offered, quality control appears to be minimal. It was found that private nurse practitioners have specific learning needs particularly regarding business management skills, quality control and current nursing practices. Recommendations were made for the maintenance of standards in private practices and the introduction of short courses for nurses in private practice.

KEY TERMS:

Private nurse; independent practitioner; entrepreneurship; innovator; AFFIRM model; community nursing practice; business management skills; communication; multidisciplinary teams; financial management; cost control; health promotion.

Student number 408-708-9

I declare that **AN INVESTIGATION INTO THE CURRENT PRACTICE OF THE PRIVATE NURSE WORKING IN THE COMMUNITY IN SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

JE Smith

.....

SIGNATURE

(MRS JE SMITH)

30 November 1996

.....

DATE

To:

Johan, Estél, Pierre and André

ACKNOWLEDGEMENTS

My sincere gratitude to the Lord for being a constant source of strength.

I wish to express my sincere gratitude and appreciation to all those persons who contributed in so many ways to the completion of this study. In particular I would like to thank the following people:

- Prof Margo Lock, my supervisor, for her guidance and encouragement throughout this research project.
- Ms Sarie Human, my joint supervisor, for her valuable contribution.
- Ms Rina Coetzer who typed and ably assisted me with the layout and presentation of the dissertation.
- All the respondents without whom this study would not have been possible.
- Ms Berra Kemp and the Department of Computer Services for their assistance.
- The Centre for Science Development for the bursary.
- Mr Paul Mostert of Unisa, for his assistance in the statistical analysis of the data.
- Dr LA Barnes of Unisa, for editing the dissertation.
- My colleagues of the Department of Advanced Nursing Sciences for their moral support and encouragement.
- My family and friends for their interest, encouragement and support.

TABLE OF CONTENTS PAGE

CHAPTER 1

Orientation to the area of study

CHAPTER 2

Literature review

TABLE OF CONTENTS PAGE

TABLE OF CONTENTS PAGE

TABLE OF CONTENTS PAGE

CHAPTER 5

Conclusions, recommendations and limitations of the study

TABLE OF CONTENTS PAGE

LIST OF TABLES PAGE

CHAPTER 1

CHAPTER 3

CHAPTER 4

LIST OF TABLES PAGE

LIST OF TABLES PAGE

CHAPTER 5

LIST OF FIGURES PAGE

CHAPTER 4

LIST OF ABBREVIATIONS

ANC	African National Congress
ANF	American Nursing Foundation
DENOSA	Democratic Nursing Organisation of South Africa
NHP	National Health Plan
RAMS	Representative Association of Medical Schemes
RDP	Reconstruction and Development Programme
SANA	South African Nursing Association
SANC	South African Nursing Council
SAS	Statistical Analysis Systems
UK	United Kingdom
Unisa	University of South Africa
USA	United States of America

LIST OF ANNEXURES

CHAPTER 1

Orientation to the area of study

1.1 INTRODUCTION

South Africa is a capitalistic country where the free-market system is highly valued and encouraged. The government is expected in terms of the RDP and the NHP for South Africa to provide community services of a high quality. This includes modern hospitals, good roads, effective communication systems, schools and education of a high standard, care for the aged and handicapped, chronic diseases and many more. The result is that the financial load on government services is heavy. The government therefore decided to transfer many of its functions and responsibilities to the private sector, where profit making companies will deliver services on a competitive base (ANC 1994a:71; ANC 1994b:34; Dellatola 1988:4).

This school of thought is also supported by the NHP for South Africa and the RDP where active and dynamic cooperation between public and private sectors is encouraged to promote a positive climate in which the two sectors can work together

with the common goal of achieving health for all on a partnership basis (ANC 1994a:71; ANC 1994b:80).

Basic principles identified as important for the privatisation of health care in South Africa, include the following:

- Health care is an individual responsibility and privilege.
- The responsibility of the state includes the provision of public services for the handicapped, the aged and the disadvantaged.
- The state subsidises the health consumer, not the health care deliverer.
- Services should be provided cost-effectively, in other words, these services should be financially viable and those health consumers who can pay must pay.
- Effective competition and a free market system is encouraged and over-regulation is eliminated.
- Appropriate cost-effective standards of health care should be implemented. Minimum standards found to be financially non-recoverable, should be avoided (ANC 1994a:71; Van Rensburg, Fourie & Pretorius 1992:82).

Traditionally the role of the nurse in South Africa was mainly curative and institutionally based. Private practice was limited primarily to the midwife and the district nurse. Factors such as a higher living standard, an increase in the number of aged, the advance in technology, and an increasing interest and consciousness of consumers in personal health care caused a shift of emphasis from this purely institutional type care to aspects such as pre-admission tests, post-hospitalisation rehabilitation, home health care, maintenance of health and physical fitness (Barger 1991:5; Perold & Cronje 1996:372; Powell 1984:33).

In addition to this, the economic climate, rationalisation of health services and the inflation rate have resulted in many people being unable to afford health services and as a result not visiting the services when needed. Primary health care has therefore become essential and the preferred approach in the delivery of health care. Kurten (1991:11) is of the opinion that in such an approach "the private nurse practitioner is to a great extent the answer to primary health care services in certain areas, provided that there is deregulation in this regard".

This view is also supported by the ANC (1994a:71) who see the private practitioner as an important, often underestimated resource at the primary health care level who plays an important role in improving access to the health system, especially in underserved areas.

1.2 THE CONCEPTUAL FRAMEWORK, RESEARCH QUESTIONS AND THE PURPOSE OF THE STUDY

Little is known about the nurse in private practice in the community in South Africa. Using the AFFIRM model as the conceptual framework for the study, the research questions and purpose of the study are outlined in the following table:

Table 1.1 refers to **the nurse in private practice in South Africa.**

Table 1.1: The conceptual framework, research questions and purpose of the study

RESEARCH QUESTIONS	PURPOSE OF THE STUDY (OBJECTIVES)
AVAILABILITY	
WHO is the nurse in private practice?	To determine the profile of the nurse in private practice.
HOW did the nurse in private practice determine the needs for her practice?	To determine the extent to which nurses in private practice assessed the needs for their practice.

RESEARCH QUESTIONS	PURPOSE OF THE STUDY (OBJECTIVES)
FORMULATION AND FACTUAL INFORMATION	
WHY did the nurse in private practice decide to establish a private practice?	To determine the reasons why nurses decided to go into private practice.
WHAT is the scope of practice of the nurse in private practice?	To analyse the task of the nurse in private practice.
WHAT are the learning needs of the nurse in private practice?	To determine the learning needs of the nurse in private practice.
REFERRAL	
WHAT referral systems does the nurse in private practice use?	To determine the referral systems in the private practice of the nurse.
MONITORING AND EVALUATION	
HOW are standards controlled and maintained in the private practice of the nurse?	To determine the measures taken to control and maintain standards in the private practice of the nurse.

1.3 THE SIGNIFICANCE OF THE STUDY

Privatisation is seen as an important component of the integrated comprehensive health services planned for South Africa. Privatisation is also seen as an essential element in enabling health care services to be provided in non-institutionalised settings and in climates where emphasis is given to preventive and promotive health care services.

In view of the fact that there is a shift in emphasis from expensive curative services to more realistic preventive and promotive health services, the role of the nurse in private practice will have to expand. She should play a major role in encouraging community involvement, self-help approaches and more equitable distribution of services.

It has therefore become important to identify the extent of the practice of the nurse in private practice in the community as well as her learning needs, and problems, if strategies and learning packages are to be developed to support the nurse in private practice in the future. Knowledge of the nurse in private practice is also essential to facilitate expansion of her services as an integral part of the planned health services and to render a more cost-effective practice.

1.4 ASSUMPTIONS

In this study the following assumptions were made:

- **Assumption 1**

There are a large number of nurses in private practice in South Africa.

- **Assumption 2**

The scope of practice of nurses in private practice is diversified.

- **Assumption 3**

The nurse in private practice has special learning needs.

- **Assumption 4**

Monitoring of standards of practice within the private practice of the nurse is limited.

1.5 DEMARCATION OF THE AREA OF STUDY

Using the AFFIRM model as the conceptual framework for this study the private practice of the nurse in South Africa was studied under the following headings:

- Availability of services
- Formulation and factual information
- Referral
- Monitoring and evaluation

1.6 DEFINITION OF TERMS

1.6.1 Practice

According to the Concise Oxford Dictionary (1982:867) practice means "professional work, business or connection". For the purpose of this study a practice is seen as a health care service provided by a private nurse in the community in South Africa.

1.6.2 Private nurse

For the purpose of this study a private nurse is a nurse registered with the SANC who has her own private practice in the community in South Africa.

1.6.3 Community

For the purpose of this study a community is a group of individuals who make use of the health care service provided by a nurse in private practice in South Africa.

1.6.4 Learning needs

Learning needs are the knowledge and skills needed by the nurse in private practice in the community in South Africa.

1.6.5 Client

For the purpose of this study a client would be the person who utilises the services of the nurse in private practice in the community.

1.7 CONCLUSION

In this chapter an attempt was made to describe the background and aspects of importance of the area of study. The purpose of the study was emphasised and the demarcation of the study was described.

In the following chapter the literature with regard to the nurse in private practice will be discussed.

1.8 OVERVIEW OF THE STUDY

This study was expounded as follows in the dissertation:

- CHAPTER 1: Introduction; the conceptual framework, research questions and the purpose of the study; significance; assumptions; demarcation of the area of study; definition of terms.

- CHAPTER 2: Literature study using the AFFIRM model as conceptual framework, an overview of the nurse in private practice was given.

- CHAPTER 3: Research methodology; the population and sampling method; data collection; analysis of the data.

- CHAPTER 4: Analysis and discussion of data.

- CHAPTER 5: Overview of conclusions; recommendations and limitations.

CHAPTER 2

Literature review

2.1 INTRODUCTION

The literature review was done with the aid of the following computer assisted data based bibliographies, namely Medline; Cumulative Index to Nursing and Allied Health Literature; the Social Sciences Index and Sociofile.

The major area of reference related to the role of the nurse in private practice; clinical and management strategies in nursing specifically and in the private sector in general; changing health policies; primary health care approaches; health care in non-institutional settings and the AFFIRM model (see 2.2, page 11) as the conceptual framework of the study. Particular attention was given to the latest articles on privatisation in health care, the nurse in private practice and business management approaches.

The review revealed that, although there was considerable literature available on the community nurse, there was little literature on the nurse in private practice in the community in South Africa.

The review also revealed three major broad trends that had implications for future health care delivery, namely demographic trends, increasing costs of health care and competition in the health care sector for the scarce resources available. These three broad trends have major implications for health care delivery world-wide and particularly for the nurse in private practice. To be effective in these scenarios the nurse in private practice needs to become a highly productive, cost conscious generalist, flexible enough to accommodate the rapidly changing circumstances.

Privatisation is now an accepted concept that is used in health policies both nationally and internationally (ANC 1994a:71; ANC 1994b:80; Van Rensburg *et al* 1992:81).

The government in South Africa has also chosen to transfer many functions and responsibilities to the private sector where profit orientated companies and organisations will function on a more competitive basis. In these scenarios it is expected that people will make the best use of their opportunities, work harder and enjoy higher standards of living. Based on these expectations the NHP for South Africa and the RDP promotes a partnership relationship between the public and private sectors to facilitate the achievement of the common goal, health for all. This approach was recently endorsed by President Mandela when he returned from Germany fully committed to carry through privatisation in South Africa and establish an investor friendly environment (ANC 1994a:71; ANC 1994b:80; Mediese diens 1993:2).

In this context according to McGregor (1987:107), privatisation means "the systematic transfer of appropriate functions, activities or property from the public to the private sector, where services, production and consumer are regulated more effectively by the market and price indexes". The purpose of privatisation is to promote the economy by the effective use of production factors, optimal functioning of market values and the increase of the percentage netto fixed investments in the private sector. In the health scenarios, especially with the recently announced free health services at primary health care level, the privatisation concept also facilitates the optimal utilisation of all the resources in an area.

Smith (1986:33) maintains that the expected expansion of the private sector, especially in the health care services, will create an interesting career for the nurse in private practice. This statement is supported by the NHP for South Africa (1994a:71) where the private practitioner is seen as an important and often underestimated resource for primary health care (ANC 1994a:71).

To accommodate the needs outlined above in South Africa, emphasis today is given to a primary health care approach and a fully integrated, coordinated health care system that includes the private sector. In this context nurses in private practice and especially those working in the community, are now recognised as having an important role to play in not only reducing the overall costs of health care, but also in making the health care provided more acceptable, affordable, accessible and equitable (Dreyer, Hattingh & Lock 1993:8).

2.2 AFFIRM MODEL

The AFFIRM model was chosen as the conceptual framework to guide the study as it was a model used to guide nurses in assisting families with care in the home situation (Rew 1988:40).

The acronym AFFIRM stands for:

A - Availability
F - Formulation
F - Factual
I - Information
R - Referral
M - Monitoring

The model was considered appropriate for the nurse in private practice as it is based on a philosophical principle which empowers interdependence - a principle which is considered compatible with the complimentary role of the professional nurse in private practice. Empowerment in this context is seen as a positive statement in terms of what

a person does and what is expected of the individual as professionalism grows (Rew 1988:40).

2.2.1 Availability

Availability in terms of the model, referred to the availability of services or products. In the private practice situation this would refer to both the potential client as well as the nurse in private practice (Rew 1988:40).

- **Potential client**

Questions that could be asked with regard to the needs of potential clients could relate to aspects such as the

- availability of similar services
- accessibility of these services to clients
- actual needs in terms of the services provided

- **The nurse in private practice**

Questions that could be asked in terms of the needs of the nurse in private practice relate to aspects such as

- time needed for development of practice
- promotion and maintenance of a business
- funds available for initial costs
- social and professional support needed
- knowledge of referrals; who will refer potential clients?; why are they referred?; to whom can the nurse refer clients and when will this be done? (Rew 1988:40)

2.2.1.1 Accessibility

Changes in factors affecting the economy of health care systems continuously influence

the access to health care delivery systems. In this regard a reduction in the number of admissions to hospitals and an increase in the early discharge of patients are some of the most important changes which have occurred. The increasing need for self-care in terms of preventive measures, responsibility for one's own health and knowledge of health principles were never before so evident. Due to earlier discharge, clients today must have alternatives for after care (ANC 1994a:71; Holmes 1985:65).

These trends in health care together with the recently announced free primary health care services have major implications in terms of the privatisation concept and particularly for the nurse in private practice in the community (Department of Health 1996:2).

According to Regina Herzlinger (Coddington, Keen, Moore & Clarke 1991:17), a professor at the Harvard School of Business and a known critic of the United State of America's health care system, "the American health care industry is sick and many Americans cannot get the services they need. They are plagued by ubiquitous ailments which reduce their productivity, like backaches, sore feet and digestive difficulties and find services to be fragmented, impersonal, inconveniently located and offered at unsuitable times, while the quality of care itself leaves much to be desired".

A similar situation is found in South Africa. According to *Beeld* (Mandela vasbeslote 1996:2) the fragmentation of the health services, the poor economic climate, the increase in life expectancy, as well as increasing urban isolation contribute towards making health services unaffordable and in many instances for this reason unaccessible. There is a need for a cost-effective health care packet that everybody can afford. Since it has become clear that the conventional, curative hospital based, high technology health care has not met the needs for health care, aspects such as promotion of health, sanitation, education, transport and community involvement are increasingly emphasised. All these aspects once again stress the important task of the nurse in private practice and her role in making health care more accessible at local level.

2.2.1.2 Needs assessment

It is a well-known fact that we live in a time of scarce resources including those related to health care. The question is, how can the available health care goods and services be distributed?

Is it a question of macro-allocation for a population or country or a question of micro-allocation for specific individuals and situations? From an economic point of view the question asked is: How can effective health care be provided in the most cost-effective way? In terms of nursing this approach also has ethical ramifications. In the development of a health care system the nurse in private practice would need to identify which of the principles could be used to distribute the available resources fairly.

Raw (in Hoeffer 1983:31) supports this view and states that whatever services are available, should be available to all, not just as a shift in quantity of services to the most needy, but also in the nature of services to those that would ensure favourable health care outcomes for the least advantaged.

Social forces also provide the opportunity for nurses to establish themselves in the private practice. The concept of equality amongst the members of the community is very strong today. In this regard too the women's movement has also contributed considerably to extend opportunities for women. However, despite this, although the education of nurses is currently comprehensive in nature and based on strong theoretical models which promote entrepreneurial skills, there are few institutional systems which permit nurses to be fully autonomous and use their potential as independent private practitioners to the benefit of health care services and clients as a whole (Hawken 1989:22; Slauenwhite, Dewitt & Grivell 1991:24).

The ways in which nurse practitioners have approached the problem of identifying health needs when planning private practice in the community have not changed since 1977 (Jacox & Norris 1977:36). These needs include the following:

- The documentation of a high risk population or a group with a specific need.
- Reaction to the outspoken needs and requests for services of a community.

- The identification of gaps or shortages in health services.
- Women's organisations identifying unfulfilled needs of women.
- Involving nurses in health care planning and doing research on the identification of health needs (Jacox & Norris 1977:36; SANA 1994a:4).

In this regard, the first thing that the nurse in private practice should do is an assessment of needs in an area as well as the needs of the community to determine what the consumers' reaction will be to the planned services. The needs assessment should include the following:

- An evaluation of the need for the proposed private practice.
- An analysis of potential and existing competition.
- An analysis of suitable venues so that a decision can be made.
- Identification of the potential employees required.
- Research on marketing options (Brent 1990:205; Lambert & Lambert 1996:12).

A good survey should highlight the following aspects:

- The number of health care consumers in an area.
- Social, psycho-physiological and demographic characteristics of the health care consumers.
- Attitudes towards the health services to be provided, as well as existing attitudes held by the health care consumer and health care provider.
- Services that will be accepted in the community. Acceptance will lead to informed decisions about the services to be offered and will enhance the prospect of success.
- Shortages, surpluses, as well as use and abuse of current health resources.
- The needs of the community as a whole as well as the individual members.
- The demand for private practice and ways in which private practice can fulfil these needs.
- Whether there will be sufficient potential clients for the private health services to be provided.
- Whether the private practice has the potential to be profitable.

- Whether similar services have been offered successfully by other health care providers.
- How the private health services are funded (eg medical aid, health insurances).
- Whether the potential private practice is considered appropriate (ANASA 1994:4; Dennill, King, Lock & Swanepoel 1995:91; Dreyer *et al* 1993:144; Lynch 1982:3; Vogel & Doleysh 1988:88).

2.2.2 Formulation - extent and focus of the practice

After the needs for a private practice have been identified, formulation in terms of the model clarifies the scope and focus of the private practice, in other words permits the exact nature of the private practice to be identified (Rew 1988:41).

Information that will be needed in this regard relates to

- the type of service and/or product to be provided
- the circumstances under which these services and/or products will be provided
- who the clients are
- who pays for the services
- where a service will be provided
- at what times the services will be provided
- what other services are available

In terms of private practice, additional information that would be needed relates to

- the changing role of the nurse in private practice in the community
- types of private practice
- the reasons for establishing a private practice
- problems experienced in private nursing practices
- innovation and entrepreneurship in private practice (Perold & Cronje 1996:372; Rew 1988:41)

Answers to these questions assist in appropriate decision-making at a later stage.

2.2.2.1 The changing role of the nurse in private practice in the community

Community nurses have always been seen as providers of essential health services, particularly in developing countries. These nurses not only manage and staff community health centres, but often supervise and train community health workers and assistants.

Over the past twenty five years the practice of these nurses has changed considerably and today in these services they initiate risk taking behaviours and spear-headed entrepreneurial activities (Baker & Pulcini 1990:169; Lambert & Lambert 1996:11).

Research by Salvage (1991:1) has shown that people prefer to see a nurse rather than a doctor when they contact health services for the first time. It has also been revealed that nurses are more skilled in tasks such as health evaluation, counselling and preventive health care. Nurses also constitute a considerable part of the health manpower and provide a great variety of services in different spheres. They also have a constant caring relationship with the people they meet, more so than any other persons in the health sector. In the researcher's experience the opposite could also be true as many of the complaints submitted relate to the quality of nursing care given in the community or in institutions.

Private practice today is seen as an emergent entrepreneurial effort for more and more nurses. This approach to nursing care is not new as private practice in the form of home nursing played a role in nursing for decades. Today, however, greater autonomy, self-direction and expertise is expected from the nurse in private practice who of necessity must as well become more business orientated in the management of her services (Hamric & Spross 1989:435; SANA 1994a:1).

The historical origin of the nurse in private practice in the USA developed as a result of a health care crisis in the mid-sixties (Gardner & Weinrauch 1988:46). Consumers demanded an improvement in the accessibility and availability of quality primary health care. They wanted value for the rising health care dollar.

During the last two decades there has also been an increase in the number of nurses who practised independent business in the USA. Private practice is the choice of most doctors, dentists, auditors and other service providers - why not nurses? Nurses traditionally worked for doctors and hospitals. Therefore there is a serious shortage of empirical theoretical knowledge on nurses in private practice. Research in this area is still in its infancy and in terms of today's trend in the delivery of health care will need to grow (Aydelotte, Hardy & Hope 1988:24; Dickerson & Nash 1985:327; Gardner & Weinrauch 1988:46; Perold & Cronje 1996:372).

A similar situation is found in South Africa which is one of the few countries in the world where the free market system in health care prevails. This type of health care system was typical of the USA during the early forties and until a decade ago also in Australia (Pera 1988:13).

2.2.2.2 The nature of private practice

2.2.2.2.1 Types of business formats

The practice of the private nurse can be in the format of a number of options, namely sole proprietorship, partnership, a closed corporation, or a group practice.

- **Sole proprietorship**

Sole proprietorship in private practice is seen in the format of a simple enterprise which obtained its legal existence out of the private ownership of individuals. In sole proprietorship the enterprise is owned by a single owner, with the possibility that other employees are involved (Marx, Rademeyer & Reynders 1991:107). According to this structure, the nurse as owner is concerned with the drawing up of the enterprise's policy and accepting full responsibility for all management decisions. In this way redtape, legal fees and payments of accounts can be limited to a minimum. In practice this is the type of service most frequently adopted by the nurse in private practice.

- Advantages

The advantages of using this type of business format are that it is easy to start a business as less money is needed; few legal formalities are required; it is easy to sell or close the business; the owner can plan his/her own retirement. All profits by the owner are for personal use or for re-investment in the business. There is no limitation in terms of income (money) and time invested. The owner also has total control over the practice and has direct contact with clients.

- Disadvantages

There are also a number of disadvantages in this type of business enterprise, namely unlimited accountability for debts incurred by the enterprise; less emotional support from colleagues; less leisure time and loss of income in the case of illness of the practitioner. The owner is also responsible for negligent action of employees and the nurse probably does not have the necessary expertise in business skills (Klopper 1990:13; Marx *et al* 1991:107; Vogel & Doleysh 1988:127).

□ **Partnership**

A partnership can be seen as an association of members which normally does not exceed twenty (Marx *et al* 1991:109).

According to the SANC (Rule 19 (1) (a) of Regulation R387), a registered nurse may not enter into a partnership with a person who is not registered or enrolled in terms of the Nursing Act, without the approval of Council (SANC 1985:7).

In forming a partnership the nurse must enter into an agreement with the partner. This agreement is a written contract which specifies the rights, responsibilities and duties of each member and includes details of the profits and losses as well as the time spent by each partner. This may be the type of format preferred in the future by the nurse in private practice in terms of optimal utilisation of health services and the emphasis given to partnership approaches in the delivery of health care.

- Advantages

The advantages of a partnership include the following: it is easy to form; decision-making is relatively flexible; the partnership is better provided with capital than the sole proprietorship; partners can plan their retirement cooperatively; partners can specialise in tasks and in some aspects the business is an entity on its own, apart from the owners.

- Disadvantages

Disadvantages of a partnership include the following: accountability has no limitations; individuals and not the partnership pay tax for the income of the business and are responsible for the costs; new partnership agreements must be written when a partner dies, withdraws or retires, or when a new partner is appointed; control and decision-making is divided between different people and it may be difficult to place a value on the part of the business which belongs to each partner (Klopper 1990:13; Marx *et al* 1991:109; Vogel & Doleysh 1988:127).

□ **The closed corporation**

A closed corporation can be seen as an economical legal unit, which is incorporated in the Act on Close Corporations, with or without a profit aim. The members consist of not more than 10 original members who each make a contribution to the capital and through membership obtain a specific interest (Marx *et al* 1991:120).

The present emphasis on small business enterprises in South Africa as part of the government's privatisation campagne has led to the institution of the Act on Closed Corporations (69 of 1984, as amended) (South Africa 1984a).

According to legal advice obtained by the SANC, the Nursing Act 50 of 1978 does not permit nurses to practise in this way. An individual who is registered with the SANC, and not a corporation, is accountable for professional matters. The SANC is thus in a position to discipline a person in the case of professional misconduct. SANA (now DENOSA), however, has made a recommendation to the Minister to reconsider this

matter (Klopper 1990:13; Perold & Cronje 1996:389).

- Advantages

The advantages of a closed corporation include the following: it can be accomplished simply and easily; members can participate actively in management and daily activities; the corporation can buy out the interest of a member; members enjoy limited accountability and continuity is advantageous.

- Disadvantages

The disadvantages of a closed corporation include the following: a member can join the closed corporation in transactions with third parties, even though the member does not have authorisation according to the original agreement; circumstances can arise where members lose their limited accountability; the trustworthiness between members is valued highly and the limited membership can handicap the growth and development of the enterprise (Klopper 1990:13; Marx *et al* 1991:123; Vogel & Doleysh 1988:127).

□ **Group practice**

A group practice refers to a multidisciplinary practice consisting of professionals in the health and other related fields. The purpose of group practices is to provide cost-effective care to individuals and communities. Members of this group are individually accountable and must comply with the legislation governing their profession. The nurse in a group practice shares the costs of the practice, but charges her own fees for the care s/he provides (Searle & Pera 1995:387; Perold & Cronje 1996:390).

2.2.2.2.2 What is private practice?

Aydelotte *et al* (1988:16) maintain that independent private practice in the context of nursing and health care services provided by nurses is that practice over which nurses have full control. In these situations the nurse in private practice is characterised by the extent to which she

- owns an undertaking which provides services to clients
- is responsible for all aspects of the services offered
- defines and controls the nature of services provided by the undertaking
- is fully autonomous in the ownership
- determines the nature of the client relationship
- is fully accountable for the quality of the relationship and the actions which take place in the relationship
- is a licensed, registered nurse who exercises full control over the nursing care provided
- is independent and autonomous only in those services for which she had been prepared (Aydelotte *et al* 1988:16; Brathwaite 1983:3).

In South Africa a nurse in private practice is defined as a nurse

- registered with the SANC
- controlled by the scope of practice regulations of the SANC
- who is self employed
- who offers a nursing service or employs other nurses to offer such a service
- who has a contractual agreement with individual clients and offers her service in a consulting room, in the house of a client or in an institution (SANA 1994a:1)

It is interesting to note that in these two definitions the scope of practice of the nurse in private practice is basically the same.

In today's health scenario and particularly in private practice the scope of nursing practice is expanding. Nursing basically meets the needs of the public, because nursing is concerned with the problems of everyday life. Today the public expect convenient, effective, safe and low cost health care. Consumers are also better informed and can make a choice themselves with regard to health care provision (ANC 1994a:71; Faust & Meaker 1991:621; Gardner & Weinrach 1988:46).

Two terms commonly used in health care in South Africa to indicate the expanded role of the nurse outside the traditional setting are those of *independent practitioner* and *private practitioner*. Both these terms imply professional responsibilities and privileges

which flow from self-employment duties.

The nurse in private practice provides health services complementary to those traditionally offered by doctors and in this regard is not the doctor's substitute as is often presumed. Services in private practice are usually more cost-effective and generally better, as the role of the nurse in private practice meets the expectations of the community, with a service which is freely available, easily accessible and more comprehensive in terms of health needs. Although nurses in private practice are not known as consultants, they actually function in that role. The client asks for help, the nurse determines a plan of action and then assists the client to implement the plan (Davis 1992:37; Salvage 1991:1; SANA 1994a:1; Wright 1981:34).

Despite the changes in the health care systems and the emphasis on private practice the general public tend to see nurses as employees of hospitals and government institutions who still work under doctor's orders. Nurses are today becoming more vocal in their need to practice independently without limitations of the hierarchical model under which most of these institutions function. In the USA, and more recently in the UK, nurses went into private practices, determined to use their skills and influence the health of their communities by giving a choice to their clients - a choice as to who would provide the service as well as the type of health service offered (Hawken 1989:22; Slauenwhite *et al* 1991:24). This also appears to be the trend in South Africa.

According to SANA (1994b:1), nurses in private practice in South Africa will play an important role in terms of the privatisation concept in the RDP and the ANC's NHP for South Africa. This group of practitioners is seen as an important resource, due to their availability and expertise over a wide spectrum of health services offered, from antenatal care through to the care of terminally ill patients.

Nurses in private practice make a major contribution in the following areas, provided the services offered are not restricted by over-regulation, as is the case at present in South Africa:

- ante-natal care
- post-natal care

- family planning
- child health care
- home care for people who would otherwise need hospitalisation
- the creation of facilities for nursing care of long-term clients, for example, nursing care institutions for AIDS clients
- home care for patients with special needs, for example, oncology, orthopaedics, rehabilitation and many more
- occupational health services
- mental health care
- the entire spectrum of primary health care (SANA 1994b:1)

2.2.2.3 Reasons for going into private practice

The literature shows that nurses both in South Africa and internationally choose private practice for many different reasons. These include:

- more flexible hours
- financial gain
- acquiring experience in a certain area
- existing and/or unacceptable working conditions in hospitals and other institutions
- salary scales related to responsibilities
- limited autonomy in clinical situations
- little involvement in hospital management
- meeting unfulfilled community or client needs
- assisting the underprivileged and poor
- educating the public on health issues
- obtaining authority and independence in the nursing practice
- achieving better client contact
- proving that nurses can be successful as private practitioners
- raising standards in nursing and health care
- obtaining greater prestige as a nurse
- testing a nursing theory (Durham & Hardin 1985:59; Iglehart 1987:645; Private sector 1989:360; Regensburg 1986:4; Stanhope & Lancaster 1996:839)

2.2.2.4 Advantages and disadvantages of private practice for nurses

The literature shows that private nursing practice has both advantages and disadvantages and that although, on the one hand the nurse in private practice was challenged, motivated and gained job satisfaction, on the other hand she experienced a number of problems which needed to be resolved.

- **The advantages of private practice for the nurse have been identified as follows:**

- Money: One of the most important incentives for private practice is the potential to make money.

- Control: To have control over one's own practice. For the majority of individuals being ones own boss is a very important incentive. The nurse in private practice is free to make her own decisions within professional, ethical and legal limitations.

- Management of time: The nurse in private practice has control over her own time.

- Diversity and personal growth: The area of expertise can be expanded according to need and the experience of the nurse.

- Prestige: Except for large research institutions, there is more prestige attached to a private practice.

- Research: The nurse in private practice is free to do research of her own choice (Browning & Browning 1986:11; Perold & Cronje 1996:372; Pressman & Siegler 1983:3).

- **Disadvantages of private practice**

There are a number of problems associated with private practice that have been

identified both internationally and in South Africa.

- Risk: The greatest disadvantage of private practice is that there is no guarantee that money will come in.

- Salary versus fees: In private practice a person only earns money when health care is given to a client. Holidays or sick leave are not usually reimbursed.

- Business management: In private practice a person must learn to be a business manager. All the red tape of administration and financial control is the responsibility of the private nurse herself. This includes the full range of managerial duties.

- Responsibility for clients: In private practice the main responsibility for the client's welfare rests on the shoulders of the private nurse. The legal responsibility for the welfare of a client falls in the category of malpractices and a malpractice claim can be instituted against a nurse in private practice for harm to a client.

- Isolation: Many nurses in private practice find private practice isolating as there is no one with whom they can discuss problems.

- Stress: The nurse in private practice handles both the stress of a business as well as of client care. In this context business together with financial pressures is often the greatest cause of stress to the nurse in private practice.

- Succes-failure: The nurse in private practice is also responsible for the success or failure of her practice. She is her own public relations officer and must reach out to the community as well as other health care providers to make her practice known.

- Structure and guidance: To be successful in private practice one should be a "self-starter", have a high level of self-discipline and self-confidence. The private nurse should be able to function well without much structure or guidance.

- Leisure time: Leisure time may become a rarity (Browning & Browning 1986:13; Ellis 1992:5; Pressman & Siegler 1983:3).

2.2.3 Factual Information

In terms of the model, factual information is required to develop and maintain a practice (Rew 1988:41). In this context the nurse may need additional knowledge and skills to function effectively.

Factual information will also have to be provided to both current and potential clients, other health care providers as well as to those involved in the referral network in the community or in support services. Factual information relates to aspects such as

- health education
- specific skills needed in clinical practice
- time obligations in terms of programme or services to be offered
- who will be involved in providing the services
- how the services will be provided
- the costs of the services offered
- planning a business
- starting a business
- legal requirements and supporting legislation policies and procedures
- identifying, establishing and maintaining consulting rooms/facilities
- obtaining, tendering, storing and controlling equipment and supplies
- financial management (budgeting, auditing and accounting systems)
- marketing and advertising
- record-keeping
- factors that promote failure and success (ANASA 1994:1; Rew 1988:41; SANA 1994a:7)

2.2.3.1 Information needed for starting a business

To become a private practitioner, it is essential to develop a businesslike approach, if in the final analysis, sufficient profit is to be shown and job satisfaction is to be

maintained without financial problems. If this is to be achieved, advantages and disadvantages should be carefully analysed and balanced before a decision is made and an agreement signed to commence the practice (Regensburg 1986:40).

Starting one's own business, according to Hoffman (1984:158) and MacDonald and Zavers (1992:11), includes "assessing" the market, "implementing" your strategies, and "evaluating" the results. Starting a business is not always easy; it requires courage, a sense of business, imagination, determination and confidence. To be successful the following questions should be asked:

- Is the product or service in demand?
- Of what benefit will it be to the community?
- How will it influence the family of the nurse in private practice?
- What are the personal rewards or disadvantages of such a business?
- How did other people start such a business?
- Why is this service necessary?
- What research is necessary?
- Is the person excited, enthusiastic and a hard worker?
- Is it the right product or service, at the right time, for the right price and for the right target group? (Hoffman 1984:158; MacDonald & Zavers 1992:11; SANA 1994a:3).

After the questions above have been considered, the first consideration in a private practice is to define exactly what type of services will be offered. For example, basic home nursing, wound care and surgical nursing, geriatric nursing, stoma therapy, incontinence advisory service or mother and child services. It is very important to ensure that the nurse in private practice is competent and conversant with the care to be provided (Regensburg 1986:4; SANA 1994a:3).

2.2.3.2 Knowledge and skills needed in business management

A major problem encountered by nurses who enter into private practice, is lack of business skills, knowledge and experience. Knowledge in this context is necessary with regard to aspects such as marketing, fee-structures, accountancy practices,

business and personal insurance, how to rent a consulting room and design an office, telephone systems, and legal aspects of a business (Dickerson & Nash 1985:328). According to Brathwaite (1983:4), "there is a real need to be trained in simple accounting, financial matters and marketing".

Brent (1990:205) supports this as in his view nurses are not generally familiar with establishing and managing a business as they usually work as employees and not employers. Their training often does not give them the necessary competence and expertise to manage a business.

According to Clark and Quinn (1988:11), without this business competence and expertise, marketing and the financial aspects of a business becomes very stressful.

In this context research has shown that if the nurse as an independent practitioner is to survive the first year in private practice, she must be conversant with business principles and concepts. According to Gardner and Weinrauch (1988:46), 80 percent of all new products/services fail in the open market. It is therefore imperative that when starting off in private practice, the stumbling blocks in terms of lack of business skills, knowledge and experience is overcome.

This is particularly important in South Africa where according to SANA (1994a:1), nurse training today does not necessarily prepare the nurse to enter the competitive business of self-employment.

2.2.3.3 Entrepreneurship and innovation in private practice

□ **Entrepreneurship in private practice**

Lee (1987:5) defined an entrepreneur as someone who organises, manages and accepts the risk of a business.

Durham and Hardin (1985:59) maintain that since entrepreneurship does not usually form part of the nursing education curricula, most nurses are not skilled in identifying and solving problems regarding the establishment and promotion of services.

Norris (1991:100) maintains that "The future is bright for nurse entrepreneurs". It does not matter which plan is implemented, a decrease in health care costs will always be a top priority issue. Nurses provide cost-effective preventive care/education and effective disease control, better than anyone else, and as such will fulfil a prominent role in any cost control scenario.

In South Africa, there is also an urgent need to prepare nurses for entrepreneurial skills, which include developing outstanding communication skills, a low need for status fulfilment, an awareness of overall business objectives and a solemn need to serve (Perold & Cronje 1996:373). To be entrepreneurial a person must unlearn old behaviours and learn new ones (Carson, Carson & Roe 1995:18).

- **Empowerment of nurses in private practice**

Effectiveness of the nurse in private practice depends on nursing empowerment. The nurse who is empowered has the ability to provide a health care service that meets the needs of the community she serves. In private practice empowerment is important both in terms of professional, clinical and management skills.

Empowerment includes the power to make choices, to participate in change and to grow and learn continuously. Empowerment is probably more descriptive of successful women than the concept of risk taking, because it means a sense of inherent self-efficacy and not the idea of a dangerous environment which is often associated with risk taking. Empowered persons do not jump from buildings; they live daily with a sense of responsibility and with the realisation that anxiety and fear can be controlled. Self-empowerment basically means that the source of personal power is in the self-ability to be the locus of control for purposeful activities. Empowerment is based on a certain sense of self worth mixed with a sure sense of professional value. Successful nurses repeatedly demonstrate this combination (Winstead-Fry 1990:50).

In this context Riccardi and Dayani (1982:6) see nurse entrepreneurs as an exciting group of people with perseverance, enthusiasm, leadership, pride, endurance, nerves and acuteness, who take the responsibility for a business. Intense dedication, involvement and personal sacrifices enabled them to achieve what they described as

the most rewarding experience of a lifetime.

- **Advantages and responsibilities of entrepreneurship for nurses in private practice**

In private practice entrepreneurship holds certain advantages and responsibilities. An entrepreneur should have the kind of personality which will flourish in an unstructured environment, an independence which will develop itself, self-discipline, creativity, driving force and desire, self-confidence, a tolerance for risk, and the ability to handle unpredictable pay cheques. At the same time the nurse in private practice as an entrepreneur must have a comprehensive knowledge of not only the nursing practice, but also of regulatory requirements, tax legislation, time management, networking and her/his own strong and weak points. The onus is on the nurse in private practice to keep the practice up to date. S/he is responsible for timely and complete documentation. Likewise, s/he is also responsible for continuity in the service and coverage and support for clients when s/he is not there (Caserta 1991:7; SANA 1994a:4; Stull & Pinkerton 1988:19).

- **Entrepreneurship and innovation in private practice**

Entrepreneurship also involves innovation. "An entrepreneur seeks for change, responds to it, and exploits it as an opportunity" (Wolfson & Neidlinger 1991:40). The nurse in private practice to survive must function in an innovative and entrepreneurial way by paying attention to the social trends and needs and identifying how specific skills can be isolated and marketed. Chinn (1992:149) in this regard said: "In the nursing profession we need to hear more from those who dare to dream, who take brave leaps into unknown territory".

The entrepreneurial process can be divided into six steps which the nurse in private practice as an entrepreneur can use. These steps include:

- determining the business opportunity

- accumulating resources
- marketing products and services
- providing the product
- building an organisation
- responding to government and community needs (Wolfson & Neidlinger 1991:42)

Nurses in private practice are also innovators who accept risks. Innovation requires strong, intelligent leadership which can influence both people and ideas. The pillars on which successful change rest, include dedication to change, the ability to take risks, and the ability to think creatively. The driving forces which encouraged these changes, include the desire for independence, control and autonomy (Baker & Pulcini 1990:169; Lachman 1992:11; Manion 1990:9).

2.2.3.4 Marketing and advertising in private practice

Williams and Williams (1988:7) define marketing as "the process or way of thinking which focuses the agent's efforts and actions on identifying and satisfying the client's needs".

The primary objective of marketing is therefore to offer a service to clients, while a secondary objective is to promote the exchange of client and agent values.

Marketing is unfortunately sometimes misunderstood by the nurse in private practice. Marketing strategies should address factors such as increasing competition, the distribution patterns of other health professionals, the expectations of clients, changes in terms of new treatment options, invention of new medicines and health promotion and maintenance activities. In this context the success of a business in private practice can be attributed to marketing skills and identifying differences in the practice of other health care providers.

Nurses in private practice should learn to develop a marketing information system formally and systematically, but should also learn to utilise informal marketing systems. A marketing information system enables nurses to identify marketing opportunities, prevents expensive mistakes and provides a better service to the consumer. A minor

business marketing function that nurses could acquire, is the creation of a data bank for their business with regard to nursing trends, legislation and business aspects which can influence their economic survival. According to Gardner and Weinrauch (1988:46), nurses are not primarily marketing researchers, they have to acquire marketing skills themselves or obtain the assistance of marketing authorities.

SANA (1994a:8) supports this view and considers it absolutely essential to let people know about a practice. This can be done through a written communication which is expensive or by a personal interview, which is time consuming. Whatever the method used, clear aims and objectives put out in a professional way is considered the best approach and absolutely essential.

The most difficult aspect of marketing lies in the broad area of advertising, personal sales, marketing promotion, liaison and publicity.

- **Marketing strategies in private practice**

Advertisements, news reports, brochures, newsletters, letterheads "flyers" and business cards can be used to inform clients about the services of the nurse entrepreneur.

Marketing the business personally and informally includes the following: The development of good listening skills; identifying client problems and needs; the demonstration of actual nursing care benefits; addressing client concerns; good time management and the follow-up of client satisfaction as well as the satisfaction of other health care providers. Publicity and liaison can form an important part of the marketing of the independent nursing practice. Personal interviews on radio and television may help the nurse to market her services. Informative talks, news reports or articles can inform the public with regard to the nature, venues and times of services offered by nurses (Gardner & Weinrauch 1988:49; Lister & Thayer 1992:297; Nichols 1990:130).

Marketing is essential for success. Although time consuming, the most effective form of marketing, is personal contacts. If assistance is needed with a marketing plan, successful business owners, colleagues and/or a marketing consultant, should be consulted. It requires practice and specific skills to sell yourself and your business in

a professional way. If necessary, the nurse in private practice should

- follow a course in verbal communication
- arrange to talk at meetings where potential clients are present
- network over a wide spectrum in which full detail of their practice are given
- become active in the community (Bramble 1991:142; Schneider 1992:44)

□ The marketing process in private practice

It is an accepted fact that marketing is an important factor in successful business enterprises. Nurses also today realise the value of marketing. The steps of the marketing process and those of the nursing process given in the table below are similar.

Table 2.1: Steps in the nursing and marketing planning process

NURSING PROCESS		MARKETING PLANNING PROCESS	
1	Collect data	1	Analyse the situation
2	Identify problems	2	Identify problems and opportunities
3	Determine objectives	3	Determine objectives
4	Develop plans of action	4	Develop strategies and programmes
5	Evaluate care plans	5	Provide coordination and control
6	Revise plans	6	Revise plans

Nine characteristics identified as essential for a nurse as a marketing manager are

- communication skills
- rapport and credibility with doctors and other health care providers
- clinical knowledge
- problem-solving ability
- organisational skills
- ability to understand the philosophy of the organisation
- involvement with nursing and community organisations
- assertiveness skills
- the ability to take risks (Gannon 1985:90; Stanhope & Lancaster 1996:352)

The nurse, when marketing her private practice, should sell the service and also interpret the benefits to the consumer, so that the consumer would be willing to be involved in the exchange process. Marketing helps the organisation to keep in constant touch with the consumer, to assess these needs, develop products or services which will satisfy these needs and to build a communication programme to carry out the objectives of the organisation (Durham & Hardin 1983:25).

In South Africa, when marketing, the nurse is limited to advertising in accordance with paragraph 7(1) of the Rules declared by Government Notice number Regulation R387, as amended by Regulation R2490 of 26 October 1990 (SANC 1985:2). The SANC, however, does specify certain actions that can be taken which are not seen as advertising such as informing other health professionals of the nurses' private practice and listing the private practice in the telephone directory (Perold & Cronje 1996:398; SANA 1995a:3).

2.2.3.5 Establishing a private practice

□ **Planning a private practice**

The first step in planning a private practice as a business is to identify clearly which type of practice will be established, what type of business will be implemented. This requires clear goals and objectives that are both short and long-term based on community needs, the estimated cash flow needed for the business and licensing criteria. Lack of planning is often sighted as the major contributing factor to the failure of many nurses in private practice (Brent 1990:205; Dreyer *et al* 1993:143; Durham & Hardin 1985:59).

The establishment of a successful private nursing practice is a major undertaking requiring thorough preparation, planning, hard work and perseverance. Nurses as entrepreneurs must compete with doctors, other nurses and professionals in the actual business world. This requires special skills, expertise and knowledge. The nurse intending to go into private practice should speak to colleagues in and outside the nursing profession, as well as to potential clients. Marketing research is essential to determine whether there is sufficient interest in such an undertaking by both the health care consumer and the health care provider (Clark & Quinn 1988:9; Schneider 1992:43).

In this regard Giesbrecht (1987:3) stated that when she established her private practice she read many articles, books and attended meetings and workshops, wrote out standards of practice, position statements, policies and procedures and developed a brochure. She then asked different individuals to critique her preparation. Looking back, she found this a very profitable time of preparation.

□ Mission statement for a private practice

A "mission statement" expresses the goals and objectives of a business. The mission statement should be the first item on the business plan. A business plan is the blueprint of the business planned for a period. It consists of the marketing plan, the initial budget, and a proposed time schedule, as well as short and long-term goals. The plan must be re-evaluated and revised periodically. Budgeting expenses and expected incomes must be realistic and in this regard it is better to start small and expand. According to Schneider (1992:44), the time needed to establish a fully functional, well-established business enterprise is usually three to five years (Lambert & Lambert 1996:12).

□ Financial considerations in private practice

Financial considerations are usually one of the most important aspects when thinking of a private practice. The nurse in private practice would need to know how much money should be invested; how much money is needed to start the business; how much money would be required for day to day expenses. A sound business plan is necessary to obtain financing. The plan should include the following information:

- nature of the practice
- professional and financial objectives
- a marketing plan
- a specification of initial costs
- profit and loss projections for three years
- a summary and personal financial states (Brent 1990:208; Dickerson & Nash 1985:328; Regensburg 1986:4)

Under-capitalising or an insufficient amount of money to support the business in the

initial stage, can be an important cause of failure. If money is a problem an auditor should be consulted about the best way to increase tax benefits legally. It will often include a loan from the bank. The auditor and the attorney should go through the documents together with the nurse, so that she can be sure of her rights and obligations (Brent 1990:212; Lambert & Lambert 1996:16).

For the day to day management and for long-term financial planning a business needs a transmission account. This account could be kept at the same bank as the personal account of the nurse, but should be administered independently. Bank costs and overdraft facilities should be discussed with the bank manager beforehand to prevent confusion and misunderstandings later. Nurses intending to go into private practice must ensure that they are fully conversant with this important component and should obtain expert advice on these aspects (Regensburg 1986:5).

- **Health insurance and fees in private practice**

According to SANA (1995b:11), there are currently two sets of scales of benefits for use by nurses in private practice in South Africa when submitting their claims to the various medical schemes. One set was published by SANA and has been used as a basis for negotiations between the nursing profession and the RAMS. The RAMS document was finally agreed upon and nurses in private practice were advised to use this document (see Annexure D) (SANA 1995b:11).

In the past SANA was concerned about the manner in which medical aid schemes processed claims by nurses in private practice. Some medical aid schemes did not recognise the independent practice of the nurse and therefore limited the remuneration of her services. They also appeared to be unaware of the benefits of nursing care in terms of saving hospital costs. It was felt very strongly by SANA that the nurse in private practice has an extremely important role to play and in no way should there be discrimination in terms of tarrifs against her (SANA 1994c:4).

McCue and Ficalora (1991:133) suggest the following principles when negotiating fees:

- Tariff schedules and billing procedures are necessary. To ignore them is not idealistic, it is unfair to clients. Tariffs should never be the focus point of a client's visit. Clients, however, show willingness to discuss fees, paying procedures and insurance problems.

- Nobody likes surprises: information on tariffs should be open and accessible.

- A clear policy on tariffs and billing procedures should be established, and made known to clients and potential clients.

- A fair tariff for good quality service does not give offence. Medical care is very important for everybody, and few people will be prepared to save a few rand at the expense of quality care.

- Complaints in terms of tariff schedules should be dealt with immediately.

These principles are reflected in the guidelines drawn up by SANA currently in use for setting fees. Many nurses, however, choose to set their own fees, often according to the fees individual medical aids pay. It should be kept in mind that the tariffs set should be within the reach of clients, but at the same time, realistic enough to cover costs and show a reasonable profit (Regensburg 1986:5; SANA 1994a:9).

□ Legislation applicable in private practice

In planning a private practice it is important that the nurse is fully conversant with all the relevant legislation and is aware of pending new legislation. This applies regardless of where she works, whether in hospitals, for a home health care agency, or in a private practice. The first question which should be answered is: Do I need doctor's orders to carry out this aspect of care? In answering this question it is sometimes necessary to take legal advice. Legal advice permits the scope of practice specifically needed for the nurse in private practice, to be documented based on a specific state's statutes (Brent 1990:20; Holmes 1985:67; SANA 1994a:15). Currently the scope of practice for nurses in private practice in South Africa is much wider than in the past. It also requires much greater responsibility and accountability.

□ South African Nursing Council regulations

The nurse in private practice in South Africa is in all circumstances accountable for her professional conduct to the SANC. Different regulations in this regard control all aspects of nursing practice (SANA 1994a:15).

According to SANA (1994a:12), a nurse in private practice must be registered at the SANC. S/he is also strongly advised to obtain indemnity insurance if s/he practises in South Africa as s/he is directly exposed to the danger of malpractice suites (Geyer 1995:37).

According to SANA (1994a:15) legislation applicable in private practice and which is of concern to the nurse in private practice in South Africa, includes the following:

- Nursing Act, 50 of 1978 (as amended)
- Regulations regarding the scope of practice of persons registered or enrolled under the Nursing Act, 50 of 1978, Government notice Regulation R1598 of 30 November 1984; Regulation R1469 of 10 July 1987; Regulation R2676 of 16 November 1990 and Regulation R260 of 15 January 1991
- Regulations relating to the acts or omissions in respect of which the Council may take disciplinary steps: Government Notice Regulation R387 of 15 February 1985, as amended
- Regulations regarding the distinguishing devices and uniforms for persons registered or enrolled in terms of the Nursing Act, 1978: Government Notices Regulation R1740 of 29 September 1971, as amended; Regulation R1747 of 29 September 1972, as amended; Regulation R1201 of 31 July 1970, as amended
- Basic Conditions of Employment Act, Amendment 137 of 1993
- Medical Scheme Act 72 of 1967, as amended
- Medicines and Relating Drugs Control Act 101 of 1965

- The Abuse of Dependence - Producing Substances and Rehabilitation Centres Act 41 of 1971

- Compensation for Occupational Injuries and Disease Act 130 of 1993

- Occupational Health and Safety Act 85 of 1993

- Unemployment Insurance Act 30 of 1966

- The Income Tax Act 58 of 1962

- Other health related acts including the

  - Medical, Dental and Supplementary Health Service Professions Act 56 of 1974
  - Pharmacy Act 53 of 1974
  - Associated Health Service Professions Act 63 of 1982
  - Abortion and Sterilisation Act 2 of 1975
  - Health Act 63 of 1977
  - Births, Marriages and Deaths Registration Act 81 of 1963
  - Mental Health Act 18 of 1973
  - Blood Transfusion Regulations, Government Notice Regulation R1950 of 30 November 1962, as amended

□ **Limitations of current legislation in terms of private practice**

Research done by Bierman (1994:152) showed that certain provisions in the following legislation limited the practice of the primary health care nurse. The researcher is of the opinion that these limitations could also have an impact in terms of the nurse in private practice.

- The Medical, Dental and Supplementary Health Service Professions Act, section 36 (1) (b) and (c), in relation to the physical examination and diagnosing of a patient and the prescribing of treatment.

- The Pharmacy Act, section 29 (2) (d) and (e), in relation to advice that can be given on medication and the limitation in terms of the supply of medicines to patients in hospital.

- The Nursing Act, section 38 A, in relation to the limitations imposed on nurses in certain primary health care areas and Government Notice Regulation R2598 of 30 November 1984 in relation to the scope of practice of the registered nurse and the definitions of "diagnosis" and "prescribing" and "treating".

- The Medicines and Related Substances Control Act, section 22 A (12), in terms of which conditions are prescribed which limit the primary health care nurse in her functioning.

It should be realised that many of the abovementioned Acts are currently being revised by the new government of National Unity. It remains the nurse's responsibility to keep up to date and informed on these changes.

□ **Registration of private practice**

SANA also recommends that the area managers of SANA (now provincial managers of DENOSA) should be informed of a prospective private practice. Registration at the local office of the Receiver of Revenue as a provisional taxpayer as well as at the RAMS and the SANC is essential (SANA 1994a:8).

□ **Identifying a place for consultation in private practice**

The size and location of a private nurse practice depends mainly on the specific community and the specific needs identified. For some practices a single office will be sufficient, others will need an office, a group therapy room, and an examination room (ANASA 1994:4; Holmes 1985:66).

Where to locate a consulting room can be a difficult decision. Renting office space as well as buying a house for business purposes can be very expensive. Most nurses in private practice start their practices at home until the practice has become viable. They

may then move to other premises or adapt their own homes to meet expanding needs. For these changes the local authority, however, should first be consulted about business rights and licencing. It is also important to keep in mind who the target group is and how accessible the consulting room is for the clients.

In the long-term, it is more cost-effective to limit the practice to a specific area, as travelling costs escalate and this could affect the income (Regensburg 1986:4; SANA 1994a:7; Wright 1981:35).

- **Equipment and supplies needed for private practice**

In planning for a private practice the other costs which should be kept in mind are office and nursing equipment, supplies and telephones, answering services, stationary, etc. Equipment used should be in good working condition and not outdated (SANA 1994a:10; Wright 1981:35).

In this regard Pearson (1986:58) maintained: "I elected to spend a little more and buy quality because I felt that "user friendly" examination and waiting rooms would legitimise my role".

According to Nichols (1990:129), she had no problems obtaining equipment. She visited doctors who planned to retire or who were changing consulting rooms or giving up their practices. She also obtained bargains from medical providers of both new and used equipment. In consultation with local doctors and with experience from the past, a list was drawn up of the necessary cost-effective medical equipment.

- **Accounting systems in private practice**

One of the best investments a nurse intending to go into private practice can make, is to consult an auditor, and possibly employ one, preferably somebody who is interested and has knowledge of medical practice accountancy (Clark & Quinn 1988:10; Brathwaite 1983:4; Dickerson & Nash 1985:328; Regensburg 1986:4).

In this regard, without adequate advice and support, nurses who have been trained in health services, and who then work exclusively with private patients and employ themselves can be placed in stressful situations (Private sector 1989:361).

A good bookkeeping system is essential for any business. Procedures which clearly represent the income, expenses, loans and equipment purchased, to mention only a few, should be instituted. Good bookkeeping can protect the business against additional work and expenses which are necessary to fulfil tax requirements. Accurate information can also be made available to tax auditors and others who question the financial operation of the business (ANASA 1994:3; Brent 1990:213).

A good accounting system is the pillar of any business. The simpler the system, the less chances there will be for mistakes. Bills should be sent out regularly and should include all details required by medical aid schemes for paying accounts. It is also essential that credit control should be strict. If accounts are overdue and have already been followed up by letters and telephonic reminders, a final reminder should be sent. This usually bears excellent results.

- **Income tax pertaining to private practice**

It is necessary to register the business at the Receiver of Revenue as a sole proprietorship. When a person's income exceeds R100 000,00 s/he is accountable for provisional tax, in other words, income tax is payed twice a year in advance according to estimations of previous income. Most expenses in the practice are deductible from tax, for example, salaries, uniforms, equipment and rental of consulting room or space used at home. An auditor or local Receiver of Revenue will be able to give information regarding these aspects (ANASA 1994:1; Klopper 1990:37; Regensburg 1986:5; SANA 1994a:8).

2.2.3.6 Education for nurses in private practice

An important consideration for the practitioner who plans a private practice, is the educational and clinical preparation and qualifications which are necessary for the task. Some nurses with only a minimum formal preparation and clinical experience, succeed

in their private practices, but they are the exception. A nurse can never be over-prepared. To be successful the nurse in private practice should be at least as well prepared as her competitor. The nurse in private practice frequently competes with doctors, psychologists and other professional persons. Sometimes the nurse collaborates with the full range of health care providers. The private nurse's skills and preparation must enable both competition and collaboration (Lynch 1982:119; Perold & Cronje 1996:380).

Several nurses in private practice have maintained that their nurse training did not prepare them sufficiently to be entrepreneurs (Clark & Quinn 1988:140; Dickerson & Nash 1985:438; McKee 1990:4).

In this context Grau and Floyd (1992:10) maintain that degree students in nursing are showing an increasing interest in the development of health care business. It is anticipated that this new generation of nurses will contribute substantially to the promotion of change in terms of private practice and the educational needs of the nurse in private practice.

According to Batra (1990:35), a nursing entrepreneurship project was included for six years as part of their degree course in Community Health Nursing Science at the D'Youville College. In this project students were introduced to the concept of entrepreneurship by a panel of nurses who have successful private practices in the local community. The success of this project lay in the fact that students literally walked through the process of establishing a business, not only on paper, but in reality, through community organisations, professional business and agent contacts.

The objectives of the course were to enable students to

- analyse health care trends which influence the climate for nurse entrepreneurs
- analyse the characteristics of successful nurse entrepreneurs
- evaluate opportunities for entrepreneurial intervention
- analyse the role of the nurse consultant
- analyse the basic elements of a marketing plan
- develop a business plan

- identify researchable problems in the health services of nurse entrepreneurs (Barger 1992:5)

West in Clark and Quinn (1988:5) supports this approach and maintained that changes in nursing school curricula designed to expose students more to business principles, budgeting and finances, will prepare nurses better to win the struggle in the promotion of the status and value of their profession in the open market.

In their view "nurses have not been trained to be business people, and this is really a business issue. Educators can play a key role by fostering assertiveness, business ... and negotiation skills in their students" (Clark & Quinn 1988:15).

□ **Continuing education of the nurse in private practice**

One of the most difficult aspects of any profession is that of continuing education. The nurse in private practice is no exception and is not only confronted with the necessity to absorb the continual flow of nursing material, but also the present treatment modalities. The need to keep up to date with present information is primarily the responsibility of the individual. The first step in such an approach is self-evaluation of professional interests and practice needs (ANASA 1994:4; Wackenhut 1987:132).

According to SANA (1994a:14), it is essential that the private nurse practitioner keep herself up to date and well informed about developments in nursing and in her particular field of practice. Suggestions to achieve this include the following:

- Attend seminars, symposia, etc.
- Subscribe to professional journals and publications.
- Make sure that SANA regional manager (now provincial manager of DENOSA) knows about your practice.
- If there is a local professional society for private nurse practitioners, join them.
- Make yourself part of a peer system (SANA 1994a:14).

2.2.3.7 Why nurses in private practice fail or succeed

According to research on private practice by Durham and Hardin (1985:60), the following aspects were identified as reasons why nursing practices fail or succeeded:

□ **Practices that succeeded**

Nurses whose practices succeeded attributed the success to

- their knowledge, skills and expertise
- the fact that they were at the right place at the right time
- satisfied clients
- good referral resources
- hard work
- networking activities
- limited competition
- personality traits
- working relationships with other practitioners including doctors (Durham & Hardin 1985:60)

McCue and Ficalora (1991:215) maintained that there are seven rules for a successful practice:

- be accessible
- tell your clients what to expect
- do to others what you would want to have done to yourselves
- keep promises
- give attention to clients between visits
- do not avoid appearances in public
- employ employees who practise what they preach
- be likable

In South Africa the Association of Nursing Agencies of South Africa (ANASA) supports many of these principles (ANASA 1994:1-5).

□ **Practices that failed or grew at a slower rate**

Nurses whose practices grew slower than the expected tempo attributed it to the following factors:

- lack of aggressive promotion of their practices
- diversions related to other interests or responsibilities
- problems regarding third party payments
- poor referrals from nurses and doctors
- not being accepted as private practitioners
- not being known by the community
- a generally poor economy (Durham & Hardin 1985:60)

2.2.4 Referrals in private practice

The fourth concept in the AFFIRM model is directly concerned with referrals (Rew 1988:42). Questions that need to be asked in this context include the following:

- Who will refer potential clients to the practice?
- Why are they referred?
- To whom will the nursing practice refer clients?
- When will clients be referred to other sources?

In reality both actual and potential clients are often referred between health care workers in terms of the needs of clients or the skills and expertise of the multi-professional team. Knowledge of the members of the multiprofessional team's ability is essential to facilitate this process (Perold & Cronje 1996:398; Rew 1988:42).

The need to establish a referral system for a private nursing practice is imperative if the service is to survive and if it is to meet the needs of the clients. The multisectoral approach of dialogue and collaboration among disciplines to form a network and create partnerships, is a strategy that is essential if the referral system established is to be effective (ANC 1994a:22; Dennill *et al* 1995:104; Shoultz, Hatcher & Hurrell 1992:59).

Referrals are an important integral part of the total marketing system that the nurse entrepreneur should cultivate. The successful establishment of a private practice is dependent upon the development of good networking procedures to enable an increase in referrals. It consists of a systematic and effective communication programme to inform other health care providers that the nurse entrepreneur is available to offer high quality health care. Publications in recognised journals are an excellent way to get referrals from other professional persons (Browning & Browning 1986:12; Gardner & Weinrauch 1988:49).

In many communities establishing a private practice may be a threat to the local medical community. It usually helps if the private nurse informs the medical practitioner of her practice and the nature of her practice. It is important to realise that she does not need to ask permission. In this context it may also help to get the cooperation and support of a few doctors with whom the nurse has a good working relationship. This may bring about the cooperation and support of others. High quality of practice, delivered in a professional way, results in satisfied clients which could in turn enhance the credibility and acceptability of the nurse in private practice to other members of the health team (ANASA 1994:1; Holmes 1985:67; SANA 1995a:3).

According to Regensburg (1986:6), referrals usually come from doctors, paramedical colleagues, hospitals, social agents and many other sources. Visits and follow-up, as well as regular written reports regarding clients, are ethical and also enable good liaison. Most medical aid schemes require a referral from a doctor before they pay. The doctor should therefore be informed when a client receives nursing intervention.

McShane (1985:9) said that one of the most rewarding aspects of her private nursing practice was the development of an active support network of nurses in the area. The network included midwives, health practitioners, clinical specialists, nurse educators and staff nurses. This is supported by the views of ANASA (ANASA 1994:1).

Hawken (1989:23) maintained that allowing nurses to make direct referrals to specialists and diagnostic services and prescribing a limited range of medications would further enhance the cost-effectiveness of services provided by domiciliary midwives as well as the nurse in private practice in the community.

2.2.4.1 Communication in private practice

The nurse in private practice both elsewhere and in South Africa is required to know the limitations of her scope of practice. Such limitations require her to make referrals if the client's problem falls outside the scope of her practice. To overcome these problems, a convenient communication pattern with a variety of qualified health professionals should be established to facilitate referral, including referrals in times of emergency (ANASA 1994:1; Dennill *et al* 1995:139; Perold & Cronje 1996:398; Rew 1988:2).

Good communication skills are essential for effective networking. An individual needs several interpersonal skills in order to communicate well. These are: a strong self-concept, ability to listen, clear expression, ability to cope with anger, be transparent, open and honest (Dennill *et al* 1995:135; Puetz 1983:57).

Campaigns that were successful in networking were those in which the community was informed in advance about the service to be offered. This included people who offered other services such as counsellors, dieticians and ministers, as well as other practitional health care providers. The result of such campaigns was a better understanding of the services offered that could be mutually beneficial. Dickerson and Nash in Clark & Quinn (1988:8) maintained that such campaigns resulted in effective referrals. Another important benefit gained from these campaigns was the fact that the opposition of doctors was reduced due to the fact that they were informed in advance (Clark & Quinn 1984:8).

2.2.4.2 Networking as a strategy in private practice

Networking is mainly the process of exchanging information among individuals. Nurses who network successfully consult with each other for advice about problems, refer to different sources, make recommendations and/or give feedback about personal and professional situations. Nurses who network effectively also function as mentors to assist others with their practices (Booyens 1993:481; Puetz 1983:7).

Hacker (1992:78) maintains that if networking is to be effective it is very important to think clearly, plan and organise the approaches to be used for networking. In his view networking is simply to establish a communication system of contacts. This contact permits a person to have access to valuable sources which can serve as a catalyst for one's efforts both personally and professionally. The following steps serve as a basic framework for establishing a personal network system:

(1) Identify and make a list of existing personal and professional contacts.
(2) Categorise the people on the list according to the most valuable information.
(3) Organise a card referral system with alphabetical headings referring to the subject, speciality, product or service.
(4) Prioritise each contact with a code, such as a letter or number in pencil or coloured dots to indicate who the A or I category contacts are.
(5) Sort out the card system every year and reprioritise contacts.
(6) Carry a few business cards with your name, address, telephone/fax numbers, area of expertise, products or services offered, with you.
(7) Develop a priority list of contacts to keep up to date regarding the progress in the business, new services, resource information, education programmes, etc.

In establishing a network system the nurse in private practice can send out brochures to contacts regularly, with a personal note attached to it. She should also remember to send Christmas and birthday cards regularly to special contacts. Networking requires continuous attention, give and take of sources and information, feedback from colleagues and contacts with mutual referrals for expert information. The establishment and maintenance of an active network system takes time, nurturing and effort, but the benefits are many (Hacker 1992:78).

In this context Cormack (1990:259) suggests the following:

- "Be clear about what you want and what you can offer.
- Always be honest to yourself and others.
- Respect others in the network.
- Organise yourselves.
- Take time - the answers are not always available immediately but will come in the

course of time.

- If somebody gives advice, consider it seriously, even if it does not seem right at that time.
- Emphasise professional issues, rather than informal talks.
- Keep promises made.
- Be clear about what you can and cannot do, as well as about what you want to or will not do.
- Keep in contact with the network, even if there is no business".

2.2.5 Monitoring a private practice

Monitoring in terms of the AFFIRM model includes measures for

- monitoring the client's progress
- evaluation of practice in terms of meeting the objectives set
- evaluating the success of the individual nurse as an independent practitioner

(Rew 1988:42)

In this context information is needed

- on the extent of the client's progress in terms of outcome objectives
- evaluation on the extent to which all objectives have been met
- the time and way in which self-evaluation or peer-evaluation is done

Success in monitoring a private practice depends on general and individual progress reports, performance appraisal reports and written policies, procedures and standards against which the success of the service can be judged (ANASA 1994;2; Rew 1988:42).

To ensure this success, the nurse in private practice would need to evaluate the quality of care given according to the following criteria:

- **Acceptability**

This would include factors such as

- providing clients with the necessary information and involving them in decision-making
- recognising clients' opinions and expectations with regard to health and health care and meeting these expectations
- acknowledging the right of the client to have control over information regarding his/her illness and also confidentiality regarding this aspect

□ **Accessibility**

In terms of accessibility

- the locality of the service must be convenient and in reach for clients
- services such as home visits should be available for clients
- clients should be provided with the necessary skills and knowledge which should include referring them to appropriate services
- health care should be available when needed by the client

□ **Appropriateness**

In terms of appropriateness

- holistic care should meet the physical, psychological and social needs of the client
- the care provided should suit the age, educational level, physical and socio-economical abilities of the client

□ **Effectiveness**

Effectiveness would be ensured by

- monitoring and evaluating whether the health care goals and objectives have been met against standards of care
- the appropriate use of health care equipment, supplies and manpower

□ **Efficiency**

Efficiency would be promoted by

- using time productively, and by meeting more than one need
- the effective utilisation of available sources
- ensuring the availability and maintenance of necessary equipment, supplies and medicines

□ **Equity**

The equity principle is facilitated by

- ensuring that there is no discrimination in terms of services provided regarding gender, race, age, sexual orientation or residence
- taking steps to provide special services for specific needs (ANC 1994a:1; Dreyer *et al* 1993:141; Perold & Cronje 1996:302)

Hawken (1983:23) says "Monitoring bodies appropriate to the nature of practices should be established to facilitate independent nurse practitioners in demonstrating professional accountability for their practice activities ...". Nurses would then be demonstrating professional accountability and concern for public safety, more directly than any other health profession. This can be done by evaluating the private practice against the criteria laid down in the different legislation controlling her practice such as the regulations of the SANC, namely regulations relating to the scope of practice, Regulation R2598, 30 November 1984, as amended and rules setting out the acts or omissions, Regulation R387, 15 February, as amended, the Pharmacy Act, local authorities, etc (SANC 1984b; SANC 1985).

According to Dickerson and Nash (1985:329), evaluation of the practice is a continuous process. Profit and loss should be determined each month, for example, by financial audits. Marketing efforts and transparency of the practice should also be evaluated regularly, for example, by keeping client statistics and obtaining regular feedback through questionnaires or verbally from clients and other health care providers.

Revision should be done based on evaluation data, but always in the framework of the objectives of the practice (Stanhope & Lancaster 1996:261).

2.2.5.1 Record-keeping in private practice

Record-keeping is an important tool in the evaluation of a private practice. Just as with any accounting system, it is essential to keep a simple system of accurate and concise records. Information may be recorded on cards or in files, depending on needs and preferences. It should be emphasised that printing costs should be limited to a minimum, until the appropriate format has been finalised (Dreyer *et al* 1993:22; Regensburg 1986:6).

□ **Patient records**

Accurate and complete records should be kept of all clients and their details. These documents are confidential and nobody should have access to these without the permission of the patient. They are legal documents and should be kept safe for five years. The full nursing assessment, diagnosis, nursing intervention, planning and implementation should be clearly recorded. Evaluation and revision of the nursing care plan should be done during each visit (Perold & Cronje 1996:393; SANA 1994a:10).

Evaluation of records can also be done by auditing patient records and checking whether set standards have been met (Booyens & Minnaar 1996:327). The appointment book should also be kept up to date.

Kaplan (1991:181) says "Keep a log or journal of things that you learn along the way. Using your appointment book as a journal with anecdotal notes after each scheduled appointment works well for some people, while a computerised list of entries by dates may work better for others".

□ **Income and expenditure records**

Records should be kept of all income and expenses, as they are subject to inspection. Records such as financial statements, counterfoils of all cheques, copies of all patients'

accounts, receipt books and copies of bank deposit slips should be kept safely (Perold & Cronje 1996:393). These records may be audited and should be submitted to the Receiver of Revenue. The assistance of an accountant, or at least a bookkeeper, is strongly recommended (SANA 1994a:10).

According to Smith (1986:35), "Harold Geenen, a very successful head of the International Telephone and Telegraph Company said: When all is said and done, an individual, a company, an organisation are judged by one criterion alone - performance".

Satisfied clients are the only criterion for the expansion of a private practice, therefore client needs should be the focus of every interaction (Perold & Cronje 1996:399).

2.2.5.2 Peer review in private practice

Nurses themselves carry the primary responsibility for the quality nursing care their clients receive. They should therefore also accept responsibility for the institution of peer review in their speciality area. The American Nursing Association defines peer review in nursing as a process through which practising, registered nurses assess, monitor and judge the quality of nursing care rendered by their peer group systematically, according to the professional standards of practice (McAndrew 1988:6).

Kaplan (1991:181) suggests "asking a colleague or peer to review or preview your work to make comments and suggestions. Constructive criticism will help to keep us on our toes".

SANA (1994a:14) advises nurses in private practice to make themselves part of a peer group, to get together regularly and act as a support group for each other. In South Africa the Professional Society for private nurse practitioners fulfills these needs. ANASA is a similar group.

2.2.5.3 Self-assessment in private practice

The nurse in private practice is faced not only with the necessity of absorbing the continuing flow of nursing material, but also the current treatment modalities in related

medicine. It is the responsibility of the individual nurse to keep abreast of current information, therefore, it is essential to do a self-assessment of professional interests and practice needs. By focusing on areas of practice which need strengthening or where one might want to expand one's knowledge, an effective plan on continuing education can be formulated. A good method of keeping up to date with current trends and developments in a specific field is to read relevant journals applicable to the private practice of the nurse (Perold & Cronje 1996:380; Wackenhut 1987:132).

2.3 CONCLUSION

The literature review was done using the AFFIRM model as a framework. From this review it is apparent that there are a multitude of factors that can influence the private practice of the nurse in the community.

The literature study showed that

- privatisation is an accepted concept and the nurse in private practice is seen as an important and often underestimated provider of primary health care in the community which should be accessible and cost-effective

- the traditional role of the community nurse has changed and s/he currently has greater autonomy, self-direction and expertise in the wide range of services s/he offers according to the health needs in the community

- the nurse in private practice needs additional skills and knowledge to function effectively in areas such as: how to start a business, business management, entrepreneurship and innovation in private practice, marketing and advertising, establishing a private practice and why nurses in private practice fail or succeed

- referral is an important aspect in the private practice of the nurse and a referral system should be established in order for the practice to survive and to meet the needs of the clients. Referral systems also contribute to the development of support systems and a partnership relationship.

- monitoring and evaluation is essential in the private practice of the nurse to determine clients' progress, the extent to which objectives have been met and the success of the individual nurse as an independent practitioner

The AFFIRM model was appropriate as it addressed the majority of the research questions given in Table 1.1 on page 3.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

In this chapter the methodology used in the study is discussed using the AFFIRM model as a conceptual framework (Table 1.1, page 3). The purpose of the study was to analyse the extent to which nurses were in private practice in South Africa by obtaining answers to the following questions:

- **WHO** is the nurse in private practice?
- **HOW** did the nurse in private practice determine the needs for her practice?
- **WHY** did the nurse in private practice decide to establish her own private practice?
- **WHAT** is the scope of practice of the nurse in private practice?
- **WHAT** are the learning needs of the nurse in private practice?

- **WHAT** referral systems does the nurse in private practice use?
- **HOW** are standards controlled and maintained in the private practice of the nurse?

3.2 RESEARCH METHODOLOGY

Using the AFFIRM model as the conceptual framework for the study (Table 1.1, page 3), a quantitative, non-experimental, exploratory, descriptive design using a survey method was used to collect data on the nurse in private practice in South Africa.

Polit and Hungler (1993:14) maintain that exploratory research is aimed at exploring the dimensions of a phenomenon, the way in which it is manifested and other related factors. Exploratory studies are especially appropriate when a new area or topic is investigated.

A descriptive study includes observation, description and classification, raises questions based on ongoing events of the present and is of considerable value to the nursing profession (Dempsey & Dempsey 1992:8; Polit & Hungler 1993:14).

An exploratory study was selected to identify the current role of the nurse in private practice in South Africa as little research has been done previously in this field (Polit & Hungler 1993:89).

The research problem was stated in the interrogative form, that is research questions. A hypothesis was therefore not considered necessary as the researcher was more interested in learning about the phenomenon and was engaged in a fact finding mission (Polit & Hungler 1993:88; Treece & Treece 1986:152).

The survey (questionnaire) method was used to collect data. According to Polit and Hungler (1993:148) a survey is designed to obtain information regarding the prevalence, distribution and interrelationships of variables within a population and collects information on people's actions, knowledge, intentions, opinions, attitudes and values.

3.3 THE POPULATION AND SAMPLING METHOD

The total number of nurses known to be in private practice in South Africa were selected as the target population, namely those on the list available from SANA.

Polit and Hungler (1993:38) state that "the term population refers to the aggregate or totality of all objects, subjects or members that conform to a set of specifications".

Nurses wishing to establish a private practice are required to register with the SANC as a private practitioner. However, the list kept by the SANC is not current as not all nurses register with them as private practitioners.

All persons intending to enter private practice are required to register with the RAMS in order to obtain a practice number. With the permission of the RAMS a computer printout was obtained listing more than 1 000 nurses as being in private practice in South Africa (SANA 1994a:8).

Considering that there were over 1 000 names on the list, it was decided to select only persons who were living in the old Transvaal Province and letters were sent to 611 people to determine which nurses were actually currently in private practice (Annexure A).

All nurses on this list were not in fact still in private practice and the list was thus not current.

Number of letters sent out	611
Responses from persons not currently in private practice	255
Letters sent back, address unknown	64
Letters received from persons currently in private practice	98

These statistics showed that the list from the RAMS was not current.

During the same period SANA compiled a list of nurses in private practice in South Africa. This list was found to be the most accurate in terms of nurses currently in private

practice in South Africa. According to this list there were 280 nurses in private practice throughout South Africa.

It was on the basis of this list (280 nurses) that the population for the study was selected.

The number of 280 nurses was considered a relatively small number and after discussing this with a statistician the total population was chosen covering the whole of South Africa.

According to Polit and Hungler (1993:184), researchers are usually advised to use the largest sample possible as the larger the sample, the more representative of the population it is likely to be.

3.4 DATA COLLECTION

3.4.1 Research instrument

Using the AFFIRM model as the conceptual framework and the research questions posed, a closed-ended questionnaire was designed to obtain data for this study.

Questionnaires in general are known to have a poor response rate. It was deemed however, appropriate to use a questionnaire for this study as the respondents were situated over the whole of South Africa and in terms of time and cost it was not feasible to conduct personal interviews (Polit & Hungler 1993:205).

Questionnaires also have the following advantages over interviews:

- They are less costly and time consuming for the researcher.
- Complete anonymity can be ensured.
- Questionnaires permit the respondent to complete the questionnaire in privacy thus preventing bias in the responses made (Polit & Hungler 1993:205).

3.4.1.1 Development of the research instrument

After completion of an in-depth literature study, the questionnaire was designed and developed specifically for this study.

3.4.1.2 Permission for the study

As all the respondents were nurses in private practice, permission was asked in a covering letter attached (Annexure B) to each individual's questionnaire. The respondents were given the choice as to whether they wished to complete the questionnaire or not.

The questionnaire was sent out in both English and Afrikaans (Annexure B).

Table 3.1: Content of the questionnaire according to the AFFIRM model

Using the AFFIRM model as a conceptual framework the questionnaire was structured as follows:

CONTENT	QUESTIONS IN QUESTIONNAIRE
Availability of services and personal details of respondents.	1.1 to 2.4
Formulation and factual information - extent and focus of the private practice.	3.1 to 4.3
Referral of patients.	5.1 to 5.4
Monitoring/Evaluation.	6.1 to 6.6
The individual items are discussed below.	

Regarding **availability** questions were asked related to personal details (age, sex, marital status, number of children, nursing qualifications) as well as to a survey done prior to starting a private practice.

Under **formulation** and **factual information** questions were asked concerning the reasons why respondents chose to enter private practice, length of time in private practice, type of services offered, liaison with various institutions, number of patients seen per day, after hours service, indemnity insurance, other employment, financial viability of the practice, personnel employed, stock and equipment, financing of the practice, methods used to inform patients about the practice, tariffs and procedures, health care counselling, inservice training and continuous education.

Referral included questions related to the extent in which patients were referred from and to their practice, how patients were referred and how they initially heard about the practice.

Under **monitoring** and evaluation information was requested on problems experienced in the practice of the private nurse, records and statistics, as well as the extent to which standards were controlled in the private practice of the nurse.

3.4.1.3 Pretesting of the research instrument

A pretest is the trial administration of a newly developed instrument to identify flaws or assess time requirements (Polit & Hungler 1993:443).

The questionnaire was presented to the study leader, the joint study leader, a statistician and colleagues at Unisa including two persons who had been previously engaged in private practice.

The objective of pretesting the questionnaire is to obtain maximum validity and reliability, by ensuring that the instrument is clearly worded, free from major biases and whether it solicits relevant information (Polit & Hunger 1993:203). The respondents who participated in the pretest were requested to comment on the following aspects:

- time needed for completing the questionnaire
- the format, style and language
- relevance of questions
- suggestions for improvement and additional questions

The questionnaires were distributed and collected personally. The main criticism was that the questionnaire was too long. The questionnaire was therefore revised and only important questions which were relevant were included. After changes were made, the questionnaire was finalised (Annexure B).

□ **Validity of the research instrument**

Validity refers to the degree to which an instrument measures what it is supposed to measure. An unreliable instrument cannot possibly be valid (Polit & Hungler 1993: 249).

The face and content validity of the instrument was tested by presenting it to five community nurses to ensure that the included items were representative of this topic.

According to Polit and Hungler (1993:250), content validity is necessarily based on judgement, as there are no objective methods to ensure adequate content coverage of an instrument. As mentioned earlier in paragraph 3.4.1.3 respondents who participated in the pretest confirmed the content validity of the instrument by their subject expertise and experience.

□ **Reliability of the research instrument**

According to Polit and Hungler (1993:244), "the reliability of an instrument refers to the degree of consistency with which the instrument measures the attribute".

Reliability therefore means stability, consistency or dependability of an instrument.

A pretest was implemented as mentioned in paragraph 3.4.1.3 and reliability of the questionnaire was ensured by the following:

- Questions were clearly worded in order to be interpreted correctly (Polit & Hungler 1993:203).

- The comprehension of questions were ensured by the use of simple language.

- Questionnaires were presented in English as well as in Afrikaans to limit any misinterpretation (Annexure B).

- Questions which were not interpreted correctly during the pretest were reconstructed.

The reliability of the questionnaire was tested in that respondents who participated in the pretest interpreted the questions in the same way as respondents who participated in the actual study. No significant measuring instrument defects were identified. To test the reliability of the questionnaire the Cronbach's alpha method was used. The value which was obtained was 0,83 and the coefficient indicates an acceptable level of reliability.

3.4.1.4 Distribution of the questionnaires

Two hundred and eighty questionnaires with stamped return envelopes were posted to all the respondents identified on the list obtained from SANA.

The respondents were requested to return the questionnaire within one month.

□ **Response date**

At the cut-off date of one month 35,4% of the questionnaires had been returned. Reminders were sent out to the remaining respondents and after a period of another month, a further 7,9% were returned (Annexure C). As a result of this, there was a response rate of 43,2%. In terms of research this response rate was expected as the normal response rate for mailing questionnaires can be as low as 10,0% and rarely higher than 50,0% (STA206-R Only Study Guide 1992:53).

The response rate was considered an acceptable level for this research. Positive reaction was received with many of the questionnaires, expressing good wishes for the research project or confirming the need for such a study. Several requests were made for the results of the research to be made known.

- **Ethical aspects**

Respondents participated in this study voluntarily on request and were under no obligation to complete the questionnaire.

Anonymity of respondents was ensured by not expecting them to put their names on the questionnaire.

A questionnaire with a stamped return envelope included was sent to each respondent personally enabling them to complete the questionnaire in privacy.

3.5 ANALYSIS OF THE DATA

The analysis of the data was done with the assistance of a statistician using the SAS statistical software package.

The questionnaire was designed in such a way that respondents had to code their own answers to facilitate the processing by computer and also to minimise processing by the researcher (see Annexure B).

The data was presented with the aid of tables and diagrams in chapter 3.

3.6 CONCLUSION

In this chapter the research methodology was discussed.

CHAPTER 4

Data analysis

4.1 INTRODUCTION

In this chapter a discussion will be given regarding the statistical analysis of the data obtained from the questionnaire. The SAS statistical software package was used to carry out the analysis.

The questionnaire was divided according to the AFFIRM model and the research questions asked.

Availability included personal details of the nurse in private practice and availability of services for the private practice of the nurse in South Africa.

The research questions asked were:

- **WHO** is the nurse in private practice?

- **HOW** did the nurse in private practice determine the needs for her practice?

Formulation and **factual information** included information on the extent and focus of the practice as well as information needed for establishing a private practice in South Africa.

The research questions asked were:

- **WHY** did the nurse in private practice decide to establish a private practice?
- **WHAT** is the scope of practice of the nurse in private practice?
- **WHAT** are the learning needs of the nurse in private practice?

Referral included information regarding referral of clients in the private practice of the nurse in South Africa.

The research question asked was:

- **WHAT** referral systems does the nurse in private practice use?

Monitoring included information on the evaluation and control on the quality of care given in the private practice of the nurse in South Africa.

The research question asked was:

- **HOW** are standards controlled and maintained in the private practice of the nurse?

4.2 PERSONAL DETAILS OF THE NURSE IN PRIVATE PRACTICE

Item 1.1: The age of nurses in private practice

Table 4.1: The age of nurses in private practice (n = 121)

AGE OF THE NURSE IN PRIVATE PRACTICE	FREQUENCY (f)	PERCENTAGE (%)
25 to 29	10	8,3
30 to 34	21	17,4
35 to 39	28	23,1
40 to 44	24	19,8
45 to 49	11	9,1
50 to 54	12	9,9
55 to 59	9	7,4
60 and older	6	5,0
TOTAL:	**121**	**100,0**

From Table 4.1 it is clear that the majority of the respondents, namely 83 (68,6%) are in the age group below 44 years. In particular 73 (60,3%) respondents are aged between 30 and 44. This is consistent with the age range found in a study on nurses in private practice done by the American Nurses Foundation where the age of the majority of subjects ranged from 30 to 39 (35,3%) and from 40 to 49 (39,5%) (Aydelotte, Hardy & Hope 1988:26).

Item 1.2: The gender of nurses in private practice

Table 4.2: The gender of nurses in private practice (n = 121)

GENDER	f	%
Male	6	5,0
Female	115	95,0
TOTAL:	**121**	**100,0**

Table 4.2 indicates that the majority of nurses in private practice are women, namely 115 (95,0%). This is to be expected in terms of the composition of the nursing profession in South Africa where 96,0% of registered nurses are female and only 4,0% male (SANC 1994:17).

Item 1.3: The marital status of nurses in private practice

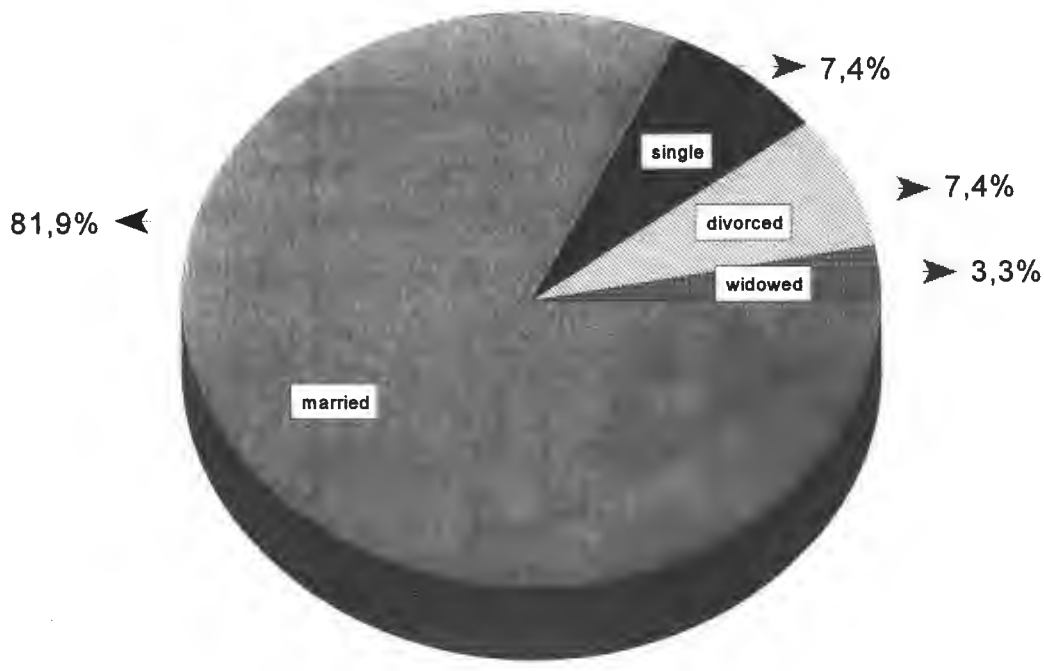

Figure 4.1: The marital status of nurses in private practice (n = 121)

Figure 4.1 shows that the majority of the respondents, namely 99 (81,9%) were married. This is higher than the number in the study done by the American Nurses Foundation which was 68,5% (Aydelotte *et al* 1988:26).

This may be due to the fact that married women have a need to function more independently as a result of family commitments. Family support may also enable them to function more independently. Married women usually also have the financial security of the husband which makes it easier to take the risk of establishing a private business.

Item 1.4: Number of children of nurses in private practice

The majority of the respondents, namely 109 (90,0%) had three or less children which is consistent with findings in other studies (Aydelotte *et al* 1988:26). These findings may also support the need for the nurse to be more independent and to have more flexible working hours.

Item 1.5: Basic nursing qualifications held by nurses in private practice

Table 4.3: Basic nursing qualifications held by nurses in private practice (n = 121)

BASIC NURSING QUALIFICATIONS HELD BY NURSES IN PRIVATE PRACTICE	GENERAL		OBSTETRICS		PSYCHIATRY		COMMUNITY NURSING	
	f	%	f	%	f	%	f	%
N/a	1	0,8	22	18,2	86	71,1	83	68,6
Degree	19	15,7	13	10,7	10	8,3	13	10,7
Diploma	101	83,5	86	71,1	25	20,6	16	13,3
Non-degree	-	-	-	-	-	-	9	7,4
TOTAL:	**121**	**100,0**	**121**	**100,0**	**121**	**100,0**	**121**	**100,0**

The majority of respondents, namely 120 (99,2%) had either a diploma or degree in general nursing while 99 (81,8%) had a degree or a diploma in midwifery. The one (0,8%) respondent who did not have a qualification in general nursing most probably was practising only as a midwife. Not many of the respondents, namely 35 (28,9%) had a qualification in psychiatric nursing whilst only 38 (31,4%) held a qualification in

community nursing. The nurses who were registered as psychiatric and community health nurses at a basic level most probably obtained these qualifications through the four year integrated nurse training programme.

Table 4.4: Number of basic qualifications per respondent (n = 121)

NUMBER OF BASIC QUALIFICATIONS PER RESPONDENT	f	%
One qualification	16	13,2
Two qualifications	56	46,3
Three qualifications	31	25,6
Four qualifications	18	14,9
TOTAL:	**121**	**100,0**

It is encouraging to see that most of the respondents, namely 105 (86,8%) had more than one basic qualification. The value of more than one qualification in terms of the required generalist approach in health service provision should be taken cognisance of.

Item 1.6: Post-basic nursing qualifications held by nurses in private practice

Table 4.5: Post-basic nursing qualifications held by nurses in private practice (n = 121)

POST-BASIC NURSING QUALIFICATIONS OBTAINED BY NURSES IN PRIVATE PRACTICE	NURSING EDUCATION		NURSING ADMINISTRATION		COMMUNITY NURSING	
	f	%	f	%	f	%
N/a	94	77,7	100	82,6	92	76,0
Degree	12	9,9	9	7,4	10	8,3
Diploma	10	8,3	6	5,0	19	15,7
Non-degree	5	4,1	6	5,0	-	-
TOTAL:	**121**	**100,0**	**121**	**100,0**	**121**	**100,0**

According to Table 4.4 the majority of nurses in private practice do not hold registrable post-basic qualifications. Only 21 (17,4%) respondents held qualifications in nursing administration, 27 (22,3%) held qualifications in nursing education and 29 (24,0%) held qualifications in community nursing.

The findings in terms of community nursing may be misleading as information in this regard was requested in Items 1.5 and 1.6 on pages 71 and 72. It is possible that those respondents who responded to this item did in fact do community nursing after they completed their general nurse training.

Table 4.6: Number of post-basic nursing qualifications per respondent (n = 121)

NUMBER OF POST-BASIC NURSING QUALIFICATIONS PER RESPONDENT	f	%
One qualification	24	19,8
Two qualifications	13	10,7
Three qualifications	8	6,6

It is a matter of concern to note that only relatively few nurses held postbasic qualifications as the need for these, especially in terms of management and clinical competence is considered very important for the viability of a private enterprise.

Item 1.7: Highest nursing qualifications held by nurses in private practice

Table 4.7: Highest nursing qualifications held by nurses in private practice (n = 121)

HIGHEST NURSING QUALIFICATIONS OBTAINED BY NURSES IN PRIVATE PRACTICE	f	%
Diploma	85	70,5
B-degree	26	21,4
Honours	3	2,7
Master's	7	5,4
TOTAL:	**121**	**100,0**

The highest academic nursing qualifications of nurses in private practice are presented in Table 4.7. The majority of respondents, namely 85 (70,5%) had a diploma in nursing. Only 26 (21,4%) respondents held a degree, whilst only three (2,7%) held an honours degree and seven (5,4%) held a master's degree in nursing. These findings would have had more significance if the respondents had been asked to indicate their areas of specialisation.

Item 1.8: Non-nursing qualifications held by nurses in private practice

Only 17 (14,1%) respondents indicated that they had non-nursing qualifications in fields such as small business management, marketing management. Ten (8,3%) respondents had a qualification in computer skills. Other qualifications relevant to nursing and/or the management of private practice included breast-feeding, fitness instruction, occupational health, emergency care, psychology and a diploma in public speaking. In terms of business management competence and corresponding learning needs these findings are significant.

Table 4.8: Non-nursing qualifications held by nurses in private practice (n = 121)

NON-NURSING QUALIFICATIONS HELD BY NURSES IN PRIVATE PRACTICE	f	%
One course	33	27,3
Two courses	4	3,3
Three courses	0	0,0
Four courses	1	0,8

These courses included education in small business management, market management, computer skills, emergency care, etc. Most of these self-initiated courses were related to the nature of the practice.

Item 1.9: Additional training needed by nurses in private practice

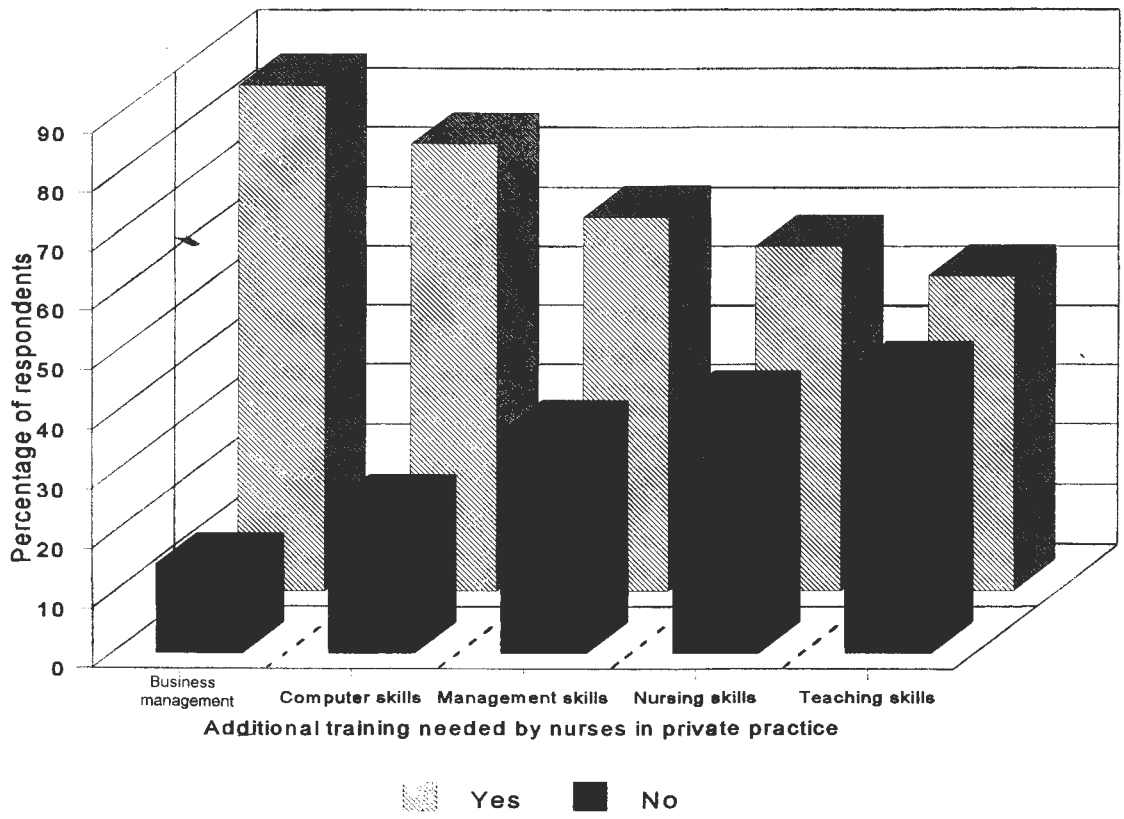

Figure 4.2: Additional training needed by nurses in private practice (n = 121)

Figure 4.2 indicates that in order to prepare appropriately for a private practice, 103 (85,1%) respondents indicated that it was essential to have additional training in business management, 91 (75,2%) in computer skills, 76 (62,8%) in management skills and 70 (57,9%) in nursing skills. The respondents were uncertain as to whether training in teaching skills was needed. It is therefore evident that the majority of the respondents need more information in business management and computer skills. This may be due to the fact that these aspects are in general not addressed in any depth in basic nurse training programmes (Lambert & Lambert 1996:11). The need for further training in these skills is supported by the findings in Item 1.8 on page 74.

Item 1.10: The degree to which nurses were adequately prepared in their basic nurse training programmes for private practice

Respondents were asked to answer this item on a scale of one to four (1-4).

Table 4.9: The degree to which nurses were adequately prepared in their basic nurse training programmes for private practice (n = 121)

DEGREE TO WHICH NURSES WERE PREPARED IN THEIR BASIC NURSING PROGRAMMES FOR PRIVATE PRACTICE	f	%
Not at all	45	37,2
Slightly	47	38,8
To a large extent	23	19,0
To a very large extent	6	5,0
TOTAL:	**121**	**100,0**

Table 4.9 indicates that the majority of respondents, namely 92 (76,0%) indicated that they received no training or very little preparation in their basic training regarding the needs of a private practice.

These findings appear to be significant as they correlate with the findings in Table 4.3 which indicated that 120 (99,2%) respondents were registered as general nurses, and 99 (81,8%) as midwives.

4.3 AVAILABILITY OF SERVICES FOR THE PRIVATE PRACTICE OF THE NURSE

Item 2.1: Surveys conducted by nurses prior to starting a private practice

Only 91 (75,2%) respondents answered Items 2.1 to 2.4. All 91 (75,2%) of the total of 121 respondents indicated that they had conducted a survey prior to commencing their practice.

It is significant that only 91 (75,2%) respondents answered the question and a matter of concern as it would appear that the remaining nurses did not do a survey prior to commencing private practice. A survey is considered essential as a baseline on which to build when planning a private practice (Lambert & Lambert 1996:12).

Item 2.2: Resources consulted and used as guidelines by the nurse in private practice for establishing a private practice

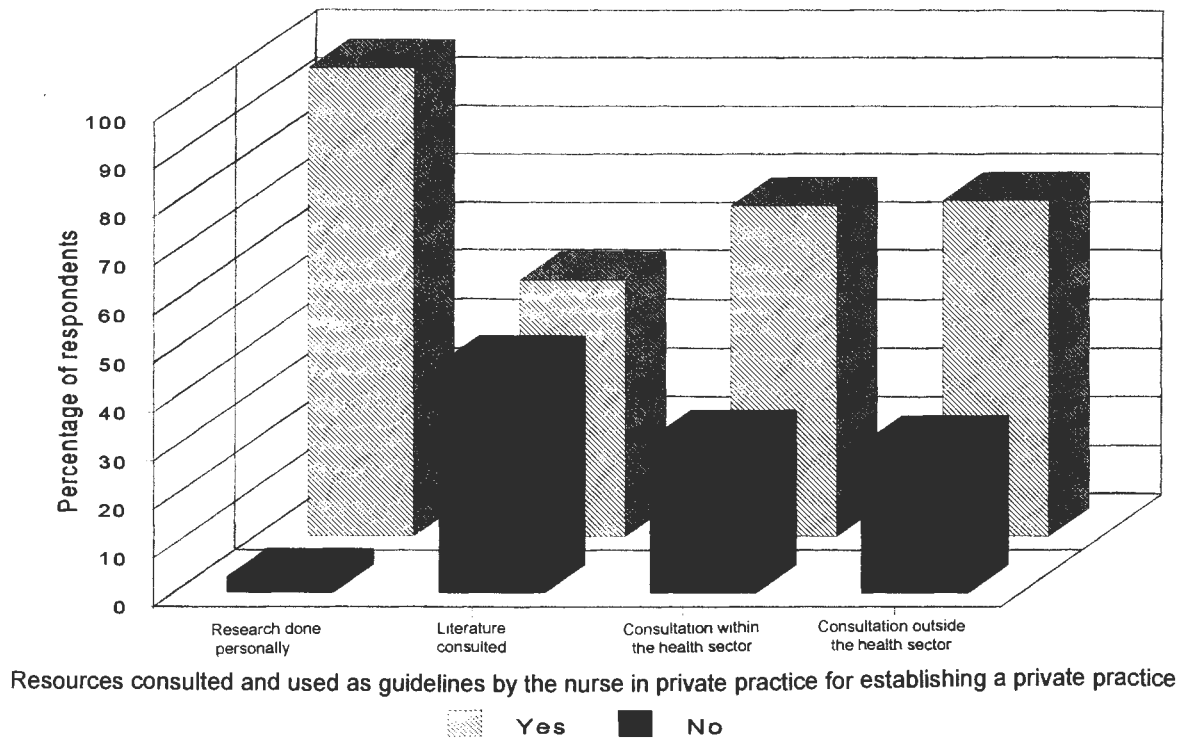

Figure 4.3: Resources consulted and used as guidelines by the nurse in private practice for establishing a private practice (n = 91)

Figure 4.3 shows that the majority of respondents made extensive enquiries prior to commencing their private practice. Eighty eight (96,7%) respondents obtained data from research done personally, 48 (52,7%) from literature consulted, 62 (68,1%) from consultation within the health sector and 63 (69,2%) from consultation outside the health sector.

Item 2.3: Persons consulted by nurses prior to establishing a private practice

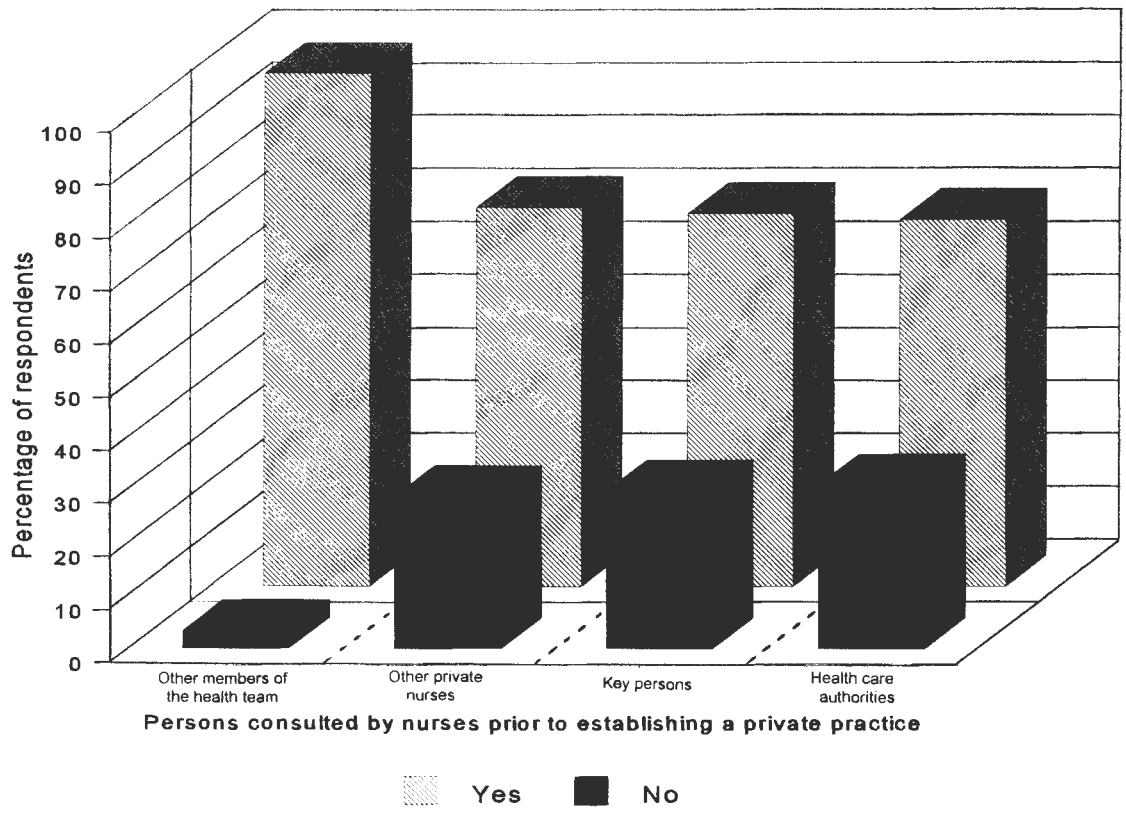

Figure 4.4: Persons consulted by nurses prior to establishing a private practice (n = 91)

Figure 4.4 shows that the respondents in general consulted widely when determining the needs of potential clients: 88 (96,7%) used information from other members of the health team, 65 (71,4%) used the knowledge of other private nurses for the needs assessment, 64 (70,3%) used the information from key persons in the target population whilst 63 (69,2%) consulted the health care authorities in their area.

It is of concern to note, however, that a number of respondents did not consult widely when determining the needs and resources in an area. Lack of wide consultation could ultimately affect the effectiveness of the services to be provided, especially in terms of referral, cooperation and recognition.

Item 2.4: Factors assessed to determine the needs for private practice

In this item the researcher attempted to determine whether the respondents carried out research in the areas listed. Some of the respondents did not answer all the questions. More than one response was also possible for this item.

Table 4.10: Factors assessed to determine the needs for private practice (n = 91)

FACTORS ASSESSED TO DETERMINE THE NEEDS FOR PRIVATE PRACTICE	n	YES		NO	
		f	%	f	%
Potential for the growth and development of private practice planned	85	81	95,3	4	4,7
Availability of health services	88	82	93,2	6	6,8
General description of health care needs in geographic area	87	69	79,3	18	20,7
General and specific health care needs of target populations	86	68	79,1	18	20,9
Affordability of existing health services	86	68	79,1	18	20,9
Specific health care needs of the community	89	68	76,4	21	23,6
Financing of existing health services	86	52	60,5	34	39,5
Existing infrastructure such as transport	82	41	50,0	41	50,0

The majority of the respondents, namely 81 (95,3%) included the potential for growth and development of their service in their needs assessment, 82 (93,2%) included the availability of other health care services within the geographic border of their practice and 69 (79,3%) included a general description of the need for health care. A total of 68 (79,1%) respondents included general and specific health care needs, whilst 68 (76,4%) included only specific health care needs in the needs assessment. A total of 68 (79,1%) respondents included the affordability of other health services, 52 (60,5%) included the financing of the existing health services in the needs assessment, whilst the existing infrastructure was not included by 41 (50,0%) respondents. The existing infrastructure is an important aspect not considered, as if transport was a problem it could affect the accessibility of the services.

It is significant to note that the majority of respondents took account of all the factors that could have an impact on their practices when doing a needs assessment. This is significant in terms of effective planning for the implementation of a private practice.

4.4 FORMULATION - FOCUS OF THE PRIVATE PRACTICE OF THE NURSE

The exact nature of the private practice of the nurse was established by requesting information on the following aspects.

Item 3.1: Reasons why nurses established a private practice

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.11: Reasons why nurses established a private practice (n = 121)

REASONS FOR ESTABLISHING A PRIVATE PRACTICE	YES		NO		UNCERTAIN	
	f	%	f	%	f	%
Function independently	110	90,9	8	6,6	3	2,5
To meet community needs	109	90,1	4	3,3	8	6,6
Client contact	99	81,8	13	10,7	9	7,5
Improve standards of nursing and health care	96	79,3	12	9,9	13	10,8
Flexible hours	87	71,9	28	23,1	6	5,0
Further experience	70	57,9	39	32,2	12	9,9
Financial gain	69	57,0	40	33,1	12	9,9
Prove successfulness in private practice	64	52,9	43	35,5	14	11,6
Status as a nurse practitioner	44	36,4	61	50,4	16	13,2
Unrealistic workloads	37	30,6	66	54,5	18	14,9
Test specific nursing theories	20	16,5	85	70,3	16	13,2

It was interesting to note that the following were not given as important reasons for establishing a private practice: the enhancement of status for the private nurse, 44 (36,4%), an unrealistic workload in hospitals, 37 (30,6%) and to test a specific nursing theory, 20 (16,5%). Similar findings were found in the research done by the ANF (Aydelotte *et al* 1988:29).

The major reasons listed as the factors that contributed towards establishing a private practice were the need to function independently, 110 (90,9%), to meet community needs, 109 (90,1%) and to have client contact, 99 (81,8%). Eighty seven (71,9%) respondents indicated that the reason why they established a private practice was the need for more flexible hours. This could be due to the fact that 108 (90,0%) respon-

dents had three or less children (Item 1.4, page 71) and needed more flexible hours for family commitments.

Table 4.1 indicates that the majority, namely 73 (60,3%) of the respondents are in the age group 30 to 44 years. This may also relate to the need for more independence in the working arena.

These findings are consistent with the basic needs of the caring role of the nurse and her need to function autonomously.

Item 3.2: Number of years nurses have been in private practice

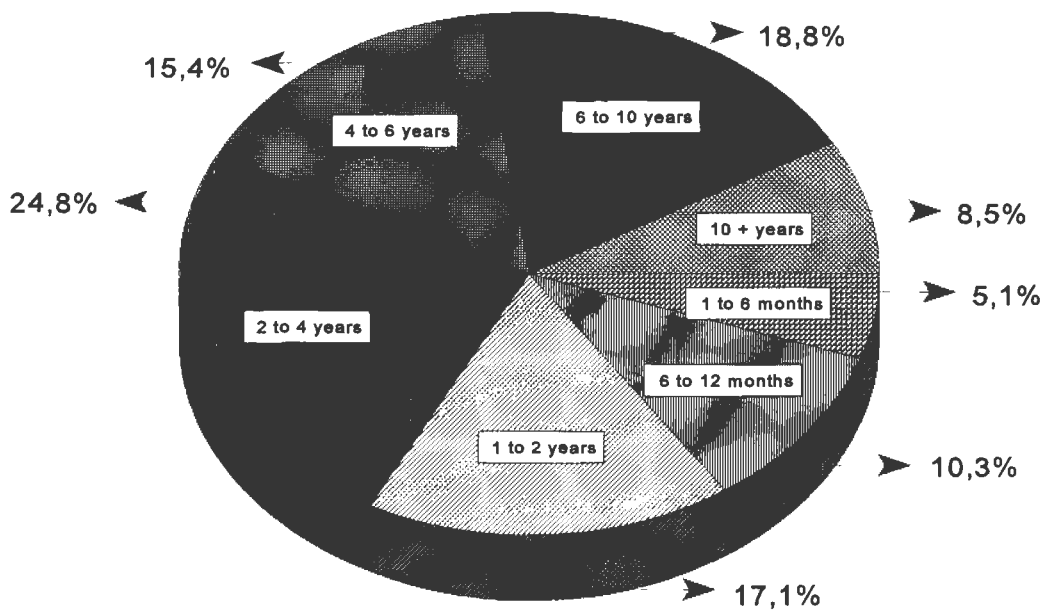

Figure 4.5: Number of years nurses have been in private practice (n = 121)

Figure 4.5 shows that only 22 (18,8%) respondents had been in private practice for more than six years with the majority, 49 (41,9%) being in private practice from one to four years.

These findings are significant as it would appear that the majority of respondents had relatively little experience in private practice which is consistent with the findings in the literature that private practice is a relatively new concept in the health care system of

South Africa (Perold & Cronje 1996:372).

Item 3.3: Services offered by nurses in private practice

Table 4.12: Services offered by nurses in private practice (n = 121)

SERVICES OFFERED BY NURSES IN PRIVATE PRACTICE	YES		NO	
	f	%	f	%
Health care guidance	87	71,9	34	28,1
General nursing care	65	53,7	56	46,3
Health care mother/child	64	52,9	57	47,1
Geriatric nursing	50	41,3	71	58,7
Oncology nursing	36	29,8	85	70,2
Paediatric services	30	24,8	91	75,2
Maternity services including child birth at home	29	24,0	92	76,0
Occupational health care services	25	20,7	96	79,3
Orthopaedic services	24	19,8	97	80,2
Psychiatric services	24	19,8	97	80,2
Cardiac rehabilitation	13	10,7	108	89,3

Table 4.12 shows a wide range of services offered by the nurse in private practice. Of greater significance is the fact that 87 (71,9%) respondents gave health care guidance as one of the major services provided. This finding augers well for the future where emphasis is given to preventive and promotive health care and non-institutionalised health care.

In this context the effect of the current economic situation on health care has further compounded the need for early discharge of patients from hospitals. This will result in even greater demands for the services offered by nurses in private practice.

Other factors that will increase the need for such services include:

- The trend to keep the geriatric client in the community for as long as possible.
- Emphasis on community based psychiatric services which will result in more non-institutionalised care for these clients.
- Managed health care.

Item 3.4: Liaison with other institutions/persons by the nurse in private practice

More than one response was possible for this question.

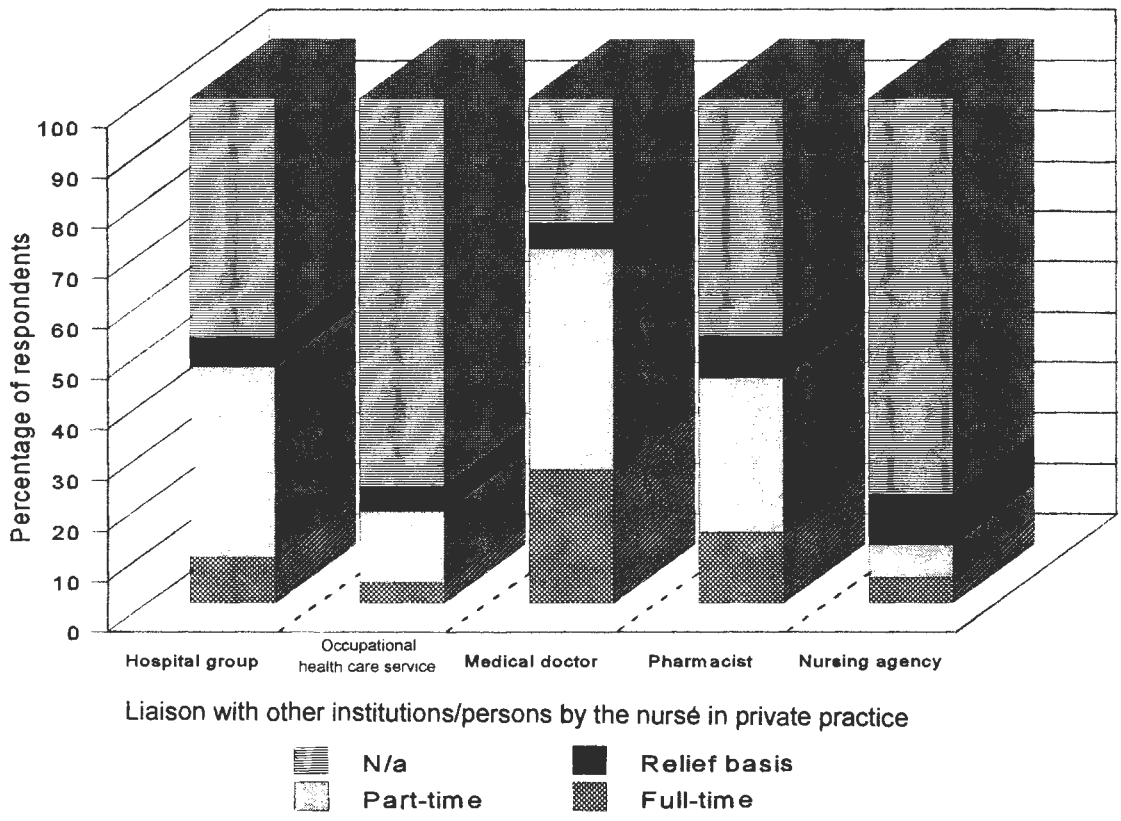

Figure 4.6: Liaison with other institutions/persons by the nurse in private practice (n = 121)

A small number of respondents, namely 11 (9,1%) liaised on a full-time basis with a hospital group, five (4,1%) with an occupational health care service, 32 (26,4%) with a medical doctor, 17 (14,0%) with a pharmacist and six (5,0%) with a nursing agency. An average of 31 (25,6%) respondents liaised on a part-time basis with the above-mentioned institutions/persons. Only 12 (9,9%) respondents in private practice liaised on a relief basis with these institutions/persons. These findings may be significant in

terms of referral and the need for cooperation and integration of these services with other health care providers.

It appears therefore that an average of 66 (54,5%) respondents did not liaise with the above-mentioned persons/institutions and that cooperation with other institutions/persons could improve. It would appear that these findings are not consistent with the findings in Item 2.3 on page 78 which may indicate that the question was not interpreted correctly.

Item 3.5: Number of clients seen per day by the nurse in private practice

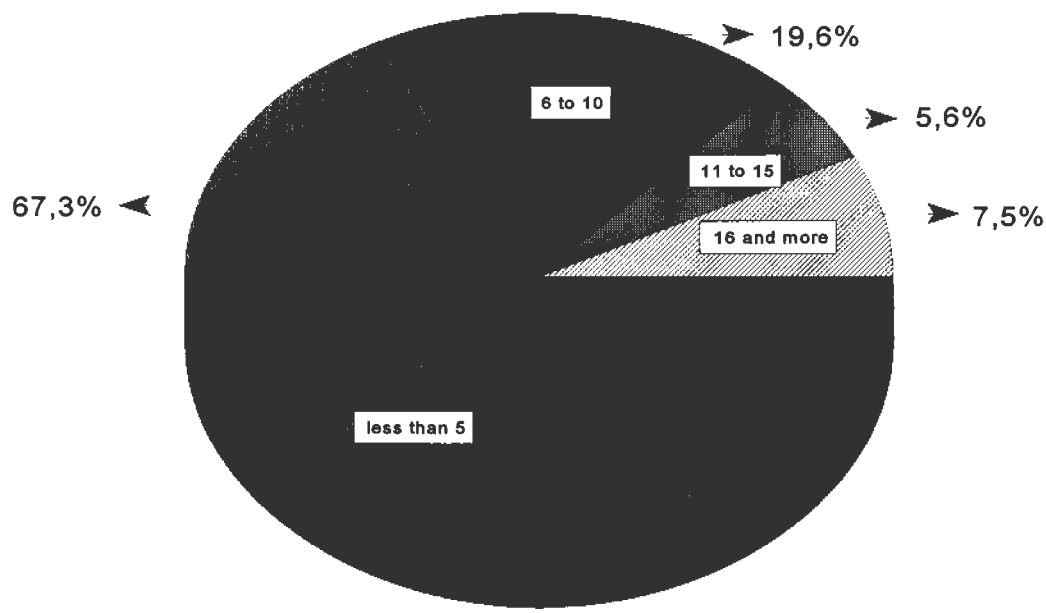

Figure 4.7: Number of clients seen per day by the nurse in private practice (n = 107)

According to Figure 4.7 the majority of respondents, namely 72 (67,3%) saw an average of only one to five clients per day. This may be due to the fact that according to Item 3.8 on page 86 almost half, namely 53 (43,8%) respondents have other forms of employment and therefore have limited time for their private practice. These findings could also be important in terms of the financial viability of a private practice.

Item 3.6: After hours service provided by the nurse in private practice

It was interesting to note that the majority of respondents, namely 91 (75,2%) provide an after hours service. These findings could be influenced by the fact that it would appear that for many of the respondents their private practice was not their only form of employment. In such cases it is presumed that the services provided were after their normal working hours.

Item 3.7: Indemnity insurance available to the nurse in private practice

It would appear that only 47 (38,8%) of the nurses in private practices were covered by indemnity insurance which is an alarming finding and certainly needs attention. The response to this item may also be misleading as nurses who are members of DENOSA (SANA) have automatic indemnity insurance, but may not be aware of this. If this is the case, it is also an alarming situation. Until three years ago, membership of the former SANA was compulsory, but since then it has been voluntary (SANC 1993:2). Currently nurses can obtain indemnity insurance through membership of a number of organisations.

Item 3.8: Other areas of employment indicated by the nurse in private practice

It is of interest to note that almost half of the respondents, namely 59 (48,8%) were not employed in full-time private practice.

Fourteen (11,5%) of those respondents who indicated that they were employed elsewhere were employed in hospitals, six (4,9%) part-time in occupational health services, one (0,8%) as a part-time lecturer, others were employed part-time in areas such as ante-natal clinics, pathology laboratories, first aid training courses, geriatric services, pharmaceutical services and psychiatric clinics. In terms of the effectiveness of the private practice these findings could be significant.

Item 3.8.1: Factors that motivated nurses in private practice to seek additional areas of employment

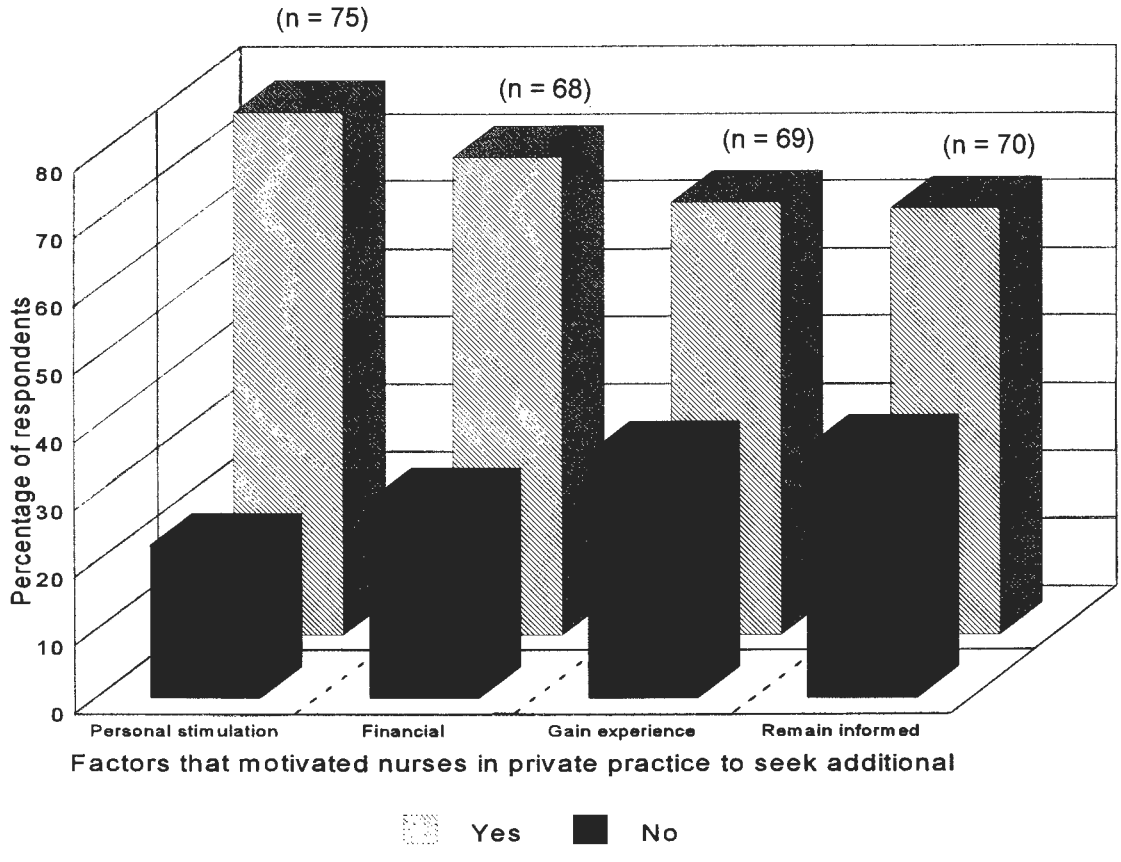

Figure 4.8: Factors that motivated nurses in private practice to seek additional areas of employment

According to Figure 4.8 the majority, namely 58 (77,3%) respondents indicated that the reason for seeking additional employment was personal stimulation. Forty eight (70,6%) respondents gave financial reasons, 44 (63,8%) wanted to gain experience and 44 (62,9%) wanted to remain informed. There seems to be a significant relationship between the findings in Item 3.5 where the majority, namely 72 (67,3%) respondents saw between one to five clients per day and the fact that 59 (48,8%) indicated that they had additional sources of income.

Item 3.9: The extent to which the private practice of the nurse was viable

Figure 4.9 indicates the opinion of the respondents in terms of the financial viability of their practices.

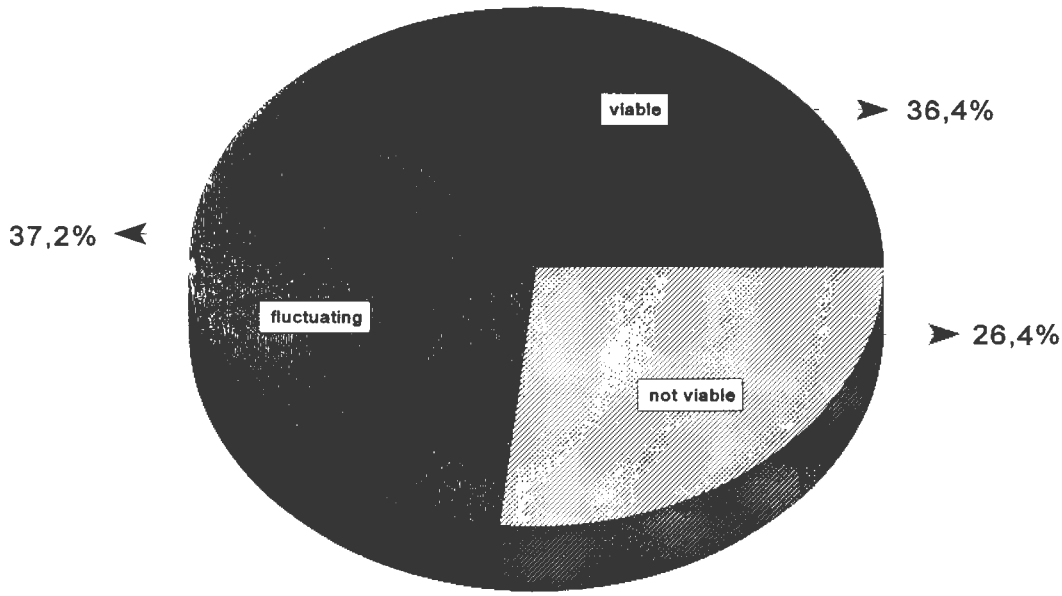

Figure 4.9: The extent to which the private practice of the nurse was viable (n = 121)

It is alarming to note that only 44 (36,4%) respondents found their practice financially viable. It would appear that there is a significant correlation with this finding and the fact that only 62 (51,2%) respondents are in full-time employment in private practice. Fifty nine (48,8%) respondents (Item 3.8, page 86) indicated that they had additional areas of employment. This might also be a result of the fact that 103 (85,1%) respondents indicated in Item 1.9 on page 75 that they needed additional training in business skills.

Item 3.10: Personnel employed by the nurse in private practice

The majority, namely 102 (84,2%) of the respondents did not employ other personnel in their practice. Only 19 (15,8%) respondents indicated that they employed other

personnel such as professional nurses, enrolled nurses, nursing auxiliaries, receptionists, bookkeepers, messengers, domestic workers and lay workers.

These findings correlate with the findings in Figure 4.7 which indicates the relatively low number of clients seen by the respondents and the fact that many of these respondents, namely 59 (48,8%) have alternative forms of employment and presumably only offer private practice services on a part-time basis (Item 3.8, page 86).

Item 3.11: Stock and equipment used by nurses in private practice

In Items 3.11.1 to 3.11.5 respondents were asked to indicate how stock and equipment were ordered, maintained and controlled. They were also asked to indicate the manner of payment and whether they encountered any problems in this regard.

Item 3.11.1: Manner in which equipment, dressings and medicines were provided to the clients of nurses in private practice

The majority of respondents, namely 47 (43,5%) out of 108 respondents indicated that they were responsible for providing all the equipment, dressings and medicines needed by the client. Forty two (38,9%) respondents indicated that the client provided some of the stock and 19 (17,6%) indicated that the client was responsible for obtaining all the supplies they needed.

Item 3.11.2: Sources from which pharmaceutical supplies were ordered by nurses in private practice

Figure 4.10 indicates the sources as well as the extent to which these sources were used by the nurse in private practice.

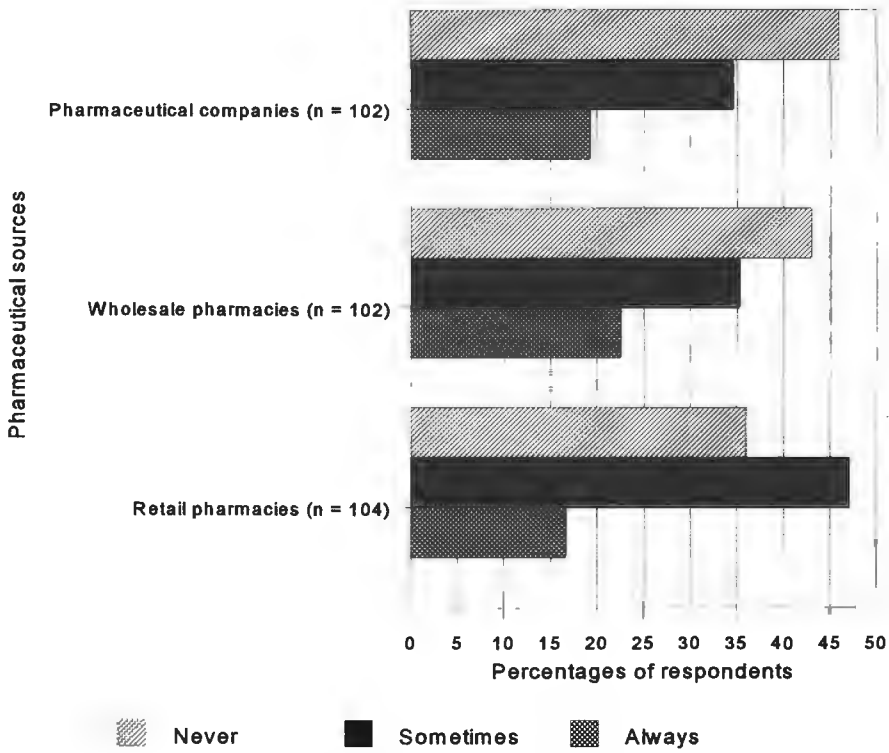

Figure 4.10: Sources used for ordering supplies by nurses in private practice

The fact that an average of 43 (41,5%) respondents did not order supplies from these sources could be due to the fact that many of the clients served, obtained their own supplies.

Item 3.11.3: Stock control by nurses in private practice

More than one answer was possible for this question. Approximately half of the respondents, namely 53 (52,5%) out of 101 respondents used continuous checklists for stock control, whilst a large percentage of respondents, namely 79 (80,6%) out of 98 respondents did not use computerised records for stock control. In general it can be presumed that nurses in private practice cannot afford computerised services if their services are still small. These findings correlate with the findings in Item 1.9 on page 75 where 91 (75,2%) respondents indicated that they needed training in computer skills.

Item 3.11.4 Problems experienced in stock control

Although the respondents totalled 121, not all the respondents answered all the questions. More than one response was possible for this question.

Table 4.13: Problems experienced in stock control (n = 121)

PROBLEMS EXPERIENCED IN STOCK CONTROL	n	TO A GREAT EXTENT		SOMETIMES		NEVER	
		f	%	f	%	f	%
Theft	108	2	1,9	12	11,1	94	87,0
Insufficient time for record-keeping	102	7	6,9	25	24,5	70	68,6
Ineffective record systems	103	6	5,8	17	16,5	80	77,7

Table 4.10 shows that in general only minimal problems were found in stock control. Fourteen (13,0%) respondents indicated that they experienced problems in terms of theft, 32 (31,4%) indicated that they had insufficient time for record-keeping and 23 (22,3%) had problems with ineffective record systems. These findings could be due to the fact that 47 (43,5%) respondents were directly responsible for their own stock (Item 3.11.1, page 89).

Item 3.11.5: Specified accounts issued by the nurse in private practice

The data for this item indicate that 93 (83,8%) out of 111 respondents issued a specified account to their clients. It is presumed that the remaining respondents may have had an alternative form of agreement with their clients, such as a verbal agreement.

Item 3.12: Factors that influenced the financing of the private practice of the nurse

Item 3.12.1: Payment of accounts

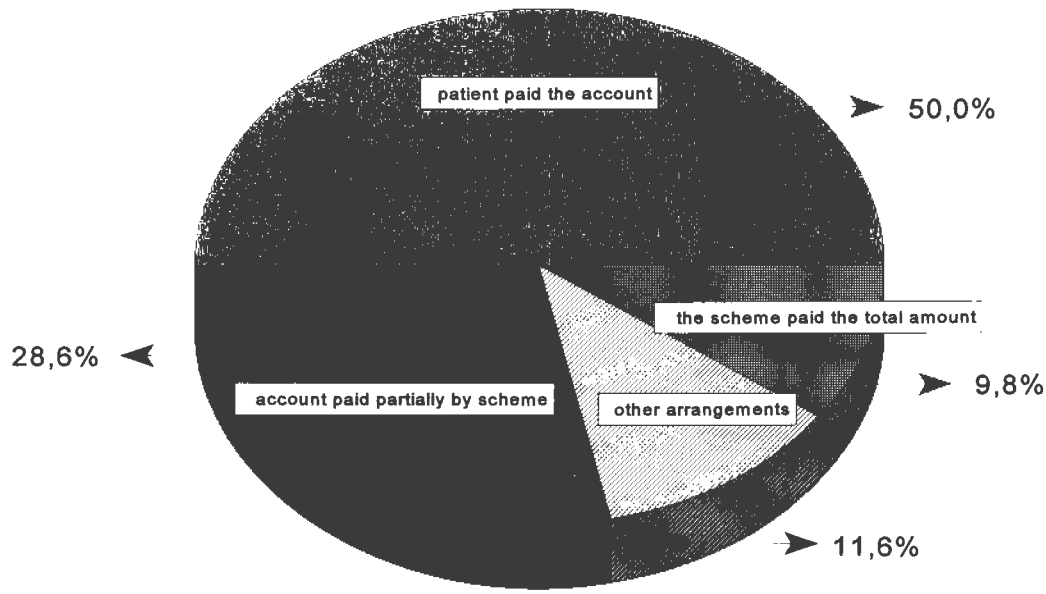

Figure 4.11: Payment of accounts (n = 112)

According to Figure 4.11, 56 (50,0%) respondents indicated that the clients paid the total costs of the services provided. Only 32 (28,6%) respondents indicated that the medical aid schemes paid part of the cost, 11 (9,8%) indicated that the total cost was paid by the medical aid schemes and 13 (11,6%) indicated that other ways of payment were used, for example, the client paid the total cost and then claimed from the medical aid scheme.

Item 3.12.2: Problems experienced with the payment of accounts by the nurse in private practice

It is significant to note that 65 (56,5%) out of 115 respondents indicated that they had problems with the payment of services provided.

Problems which were stated, included late payments, patients moving away without paying and patients only partially meeting their accounts. Lack of communication and understanding in terms of the procedures of medical aid schemes was another problem that was identified.

Item 3.12.2: Basis on which tariffs were determined by the nurse in private practice

The majority of respondents, namely 88 (78,6%) out of 112 respondents determined their tariffs on the basis of fee for service and 24 (21,4%) determined their tariffs on a prepaid service basis. Figure 4.11 supports the findings in this item.

Item 3.12.4: Sources of capital available to the nurse in private practice

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.14: Sources of capital available to the nurse in private practice (n = 121)

SOURCES OF CAPITAL AVAILABLE FOR PRIVATE PRACTICE	n	YES		NO	
		f	%	f	%
Banking institutions	106	24	22,6	82	77,4
Building societies	100	2	2,0	98	98,0
Loan from private sources	102	17	16,3	85	81,7
Small Business Development Corporations	102	5	4,9	97	95,1
Own savings	112	99	88,4	13	11,6

A total of 24 (22,6%) respondents obtained capital from a bank or building society. Seventeen (16,3%) respondents obtained a loan from a private person and five (4,9%) obtained capital from the Small Business Development Corporation. The majority of the respondents, namely 99 (88,4%) used their own savings to start a private business.

These findings are important and may indicate a lack of knowledge of procedures to follow in obtaining finance for business purposes. Lack of sufficient initial capital funds could also be a major reason why private practices appear to have problems in remaining viable (Item 1.9, page 75).

Item 3.12.5: Bookkeeping practices used by the nurse in private practice

Figure 4.12 shows who was responsible for the bookkeeping practices of the nurse in private practice.

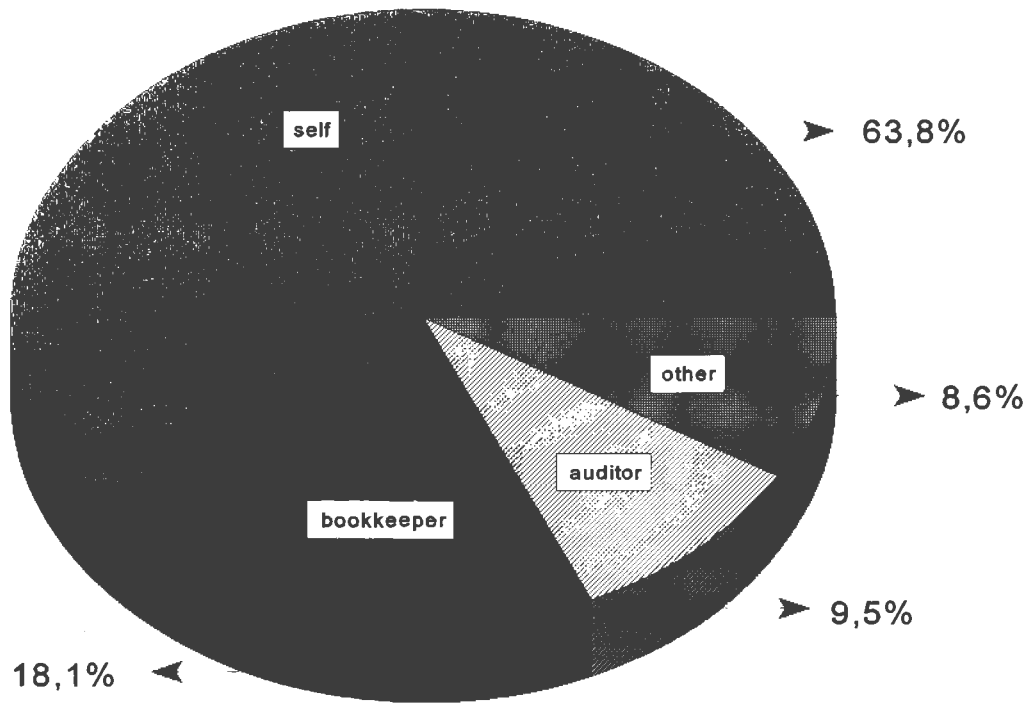

Figure 4.12: Bookkeeping practices used by the nurse in private practice (n = 116)

It is clear that the majority of the respondents, namely 74 (63,8%) were responsible for their own bookkeeping practices. These findings may indicate the reason why in many of the cases there were problems with the financial viability of the practices. In terms of learning needs this appeared to have a high priority (Item 1.9, page 75).

4.5 FACTUAL INFORMATION NEEDED FOR ESTABLISHING A PRIVATE PRACTICE

In this section nurses in private practice were asked to indicate what measures they had used to develop and maintain their practices.

Item 4.1: Methods of communication between the nurse in private practice and her clients

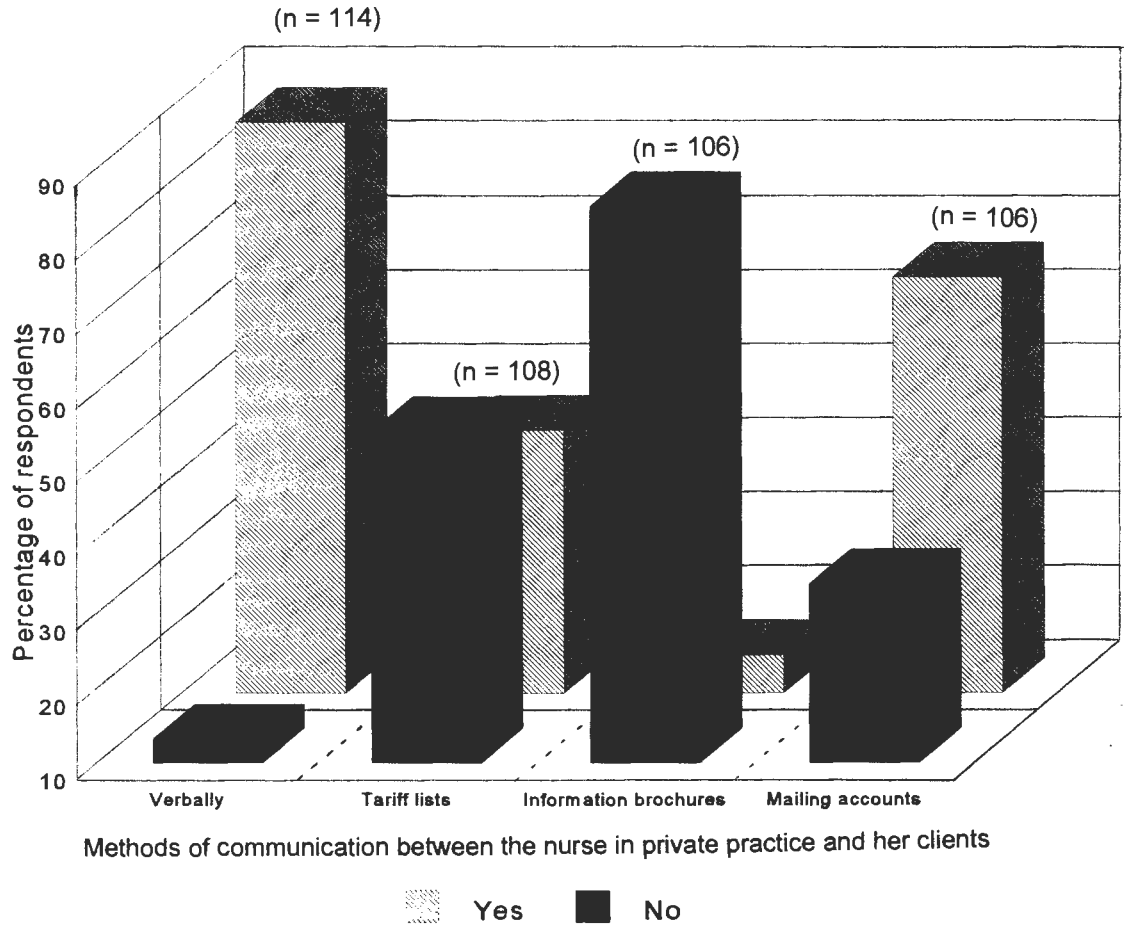

Figure 4.13: Methods of communication between the nurse in private practice and her clients

More than one response was possible for this question. The majority of respondents, namely 99 (86,8%) informed their clients verbally about tariffs and procedures. Legally and for clarity this has major significance and is an area that needs to be streamlined. Forty nine respondents (45,4%) also informed the clients by means of tariff lists. A

small number of respondents, namely 16 (15,1%) informed their clients by means of brochures and a significant number of respondents, namely 70 (66,0%) informed their clients by mailing accounts and/or invoices.

Item 4.2: Health care guidance and counselling

Item 4.2.1: Groups to which health care guidance was given by the nurse in private practice

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.15: Groups to which health care guidance was given in the private practice of the nurse (n = 121)

PERSONS/GROUPS COUNCELLED	n	NEVER		SOME-TIMES		ALWAYS	
		f	%	f	%	f	%
Children	108	50	46,3	43	39,8	15	13,9
Adolescents	108	43	39,8	47	43,5	18	16,7
Parents or families	114	11	9,6	45	39,5	58	50,9
Pregnant women or mothers	109	33	30,3	23	21,1	53	48,6
The aged	110	36	32,7	29	26,4	45	40,9
Corporate or industrial employees/employers	104	62	59,6	24	23,1	18	17,3
Social work groups or voluntary workers	105	55	52,4	40	38,1	10	9,5

More than one response was possible for this question. It is encouraging to note that 58 (50,9%) respondents always gave health care guidance to the parents or families of clients, 53 (48,6%) gave health care guidance to pregnant woman or mothers and 45 (40,9%) gave health care guidance to the aged.

Items 4.2.2 and 4.2.3: Situations in which health care guidance was given by the nurse in private practice

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.16: Situations in which health care guidance was given by the nurse in private practice (n = 121)

SITUATIONS IN WHICH HEALTH CARE GUIDANCE WAS GIVEN	n	YES		NO		N/A	
		f	%	f	%	f	%
On request	106	83	78,3	14	13,2	9	8,5
By appointment	108	64	59,3	26	24,1	18	16,6
Informally	112	94	83,9	10	8,9	8	7,2
Continuously during nursing care	115	104	90,4	1	0,9	10	8,7
After nursing care	108	75	69,4	14	13,0	19	17,6

More than one answer was possible for this question. The basic conclusion is that the nurse in private practice gives health care guidance in all situations. Eighty three (78,3%) respondents gave health care guidance on request, 64 (59,3%) by appointment, 94 (83,9%) informally, 104 (90,4%) during nursing care and 75 (69,4%) on completion of nursing care. One hundred and seventeen (96,5%) of the respondents indicated that they themselves gave health care guidance in one or more of the situations listed.

Item 4.3: In-service training and continuous education of the nurse in private practice

Item 4.3.1: Methods considered important for updating the knowledge of the nurse in private practice

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.17: Methods considered important for keeping the nurse in private practice informed (n = 121)

METHODS USED TO KEEP NURSES IN-FORMED	n	VERY IMPORTANT		FAIRLY IMPORTANT		NOT IMPORTANT	
		f	%	f	%	f	%
Monthly meetings	117	59	50,4	48	41,0	10	8,6
Formal correspondence courses	110	28	25,5	58	52,7	24	21,8
Informal short courses	116	76	65,5	34	29,3	6	5,2
Formal short courses	111	62	55,9	39	35,1	10	9,0
Information brochures	118	85	72,0	26	22,0	7	6,0
List of experts	114	86	75,4	26	22,8	2	1,8
Library facilities	115	62	53,9	44	38,3	9	7,8

More than one response was possible for this question. However, the majority of respondents (above 50,0%) indicated a need to update their knowledge in private practice. The methods considered most important by respondents for updating their knowledge were information gained from experts, 86 (75,4%), information brochures 85 (72,0%) and informal short courses 76 (65,5%).

Item 4.3.2: The involvement of the nurse in private practice in professional activities

The following table gives an indication of the extent to which the nurse in private practice was involved in professional activities.

Table 4.18: The involvement of the nurse in private practice in activities that promote professional development (n = 121)

PROFESSIONAL DEVELOPMENT ACTIVITIES	n	MONTH-LY		HALF YEARLY		ANNUAL-LY		FIVE YEARLY		NO INVOLVE-MENT	
		f	%	f	%	f	%	f	%	f	%
Lectures	115	38	33,0	40	34,8	19	16,5	5	4,4	13	11,3
Seminars	115	14	12,2	48	41,7	31	27,0	5	4,3	17	14,8
Congresses	111	5	4,5	19	17,1	26	23,4	19	17,1	42	37,9
Ward rounds	110	26	23,7	3	2,7	4	3,6	1	0,9	76	69,1
Case studies	107	27	25,2	8	7,5	12	11,2	3	2,8	57	53,3
Meetings of professional associations	114	35	30,7	38	33,3	11	9,7	-	-	30	26,3
Reading professional journals	118	98	83,1	9	7,6	6	5,1	-	-	5	4,2

From Table 4.15 it is clear that the majority of respondents, namely 98 (83,1%) regularly read journals. It would appear that other professional activities are not so well-supported. This may be due to a limited time factor and a heavy workload especially with those respondents who are employed in more than one capacity. The fact that such a high percentage of nurses read professional journals is encouraging as it is one of the most effective ways to keep abreast with current trends and developments.

Items 4.3.3 and 4.3.4: Attendance at refresher courses and courses in business management by the nurse in private practice

Although the population totalled 121, only 118 of the respondents answered all the questions.

Table 4.19: Frequency of attendance at refresher courses by the nurse in private practice (n = 118)

FREQUENCY OF ATTENDANCE AT REFRESHER COURSES	f	%
Within the last three months	43	36,4
Between three and six months ago	19	16,1
Between six months and one year ago	12	10,2
More than a year ago	18	15,3
Never	26	22,0
TOTAL:	118	100,0

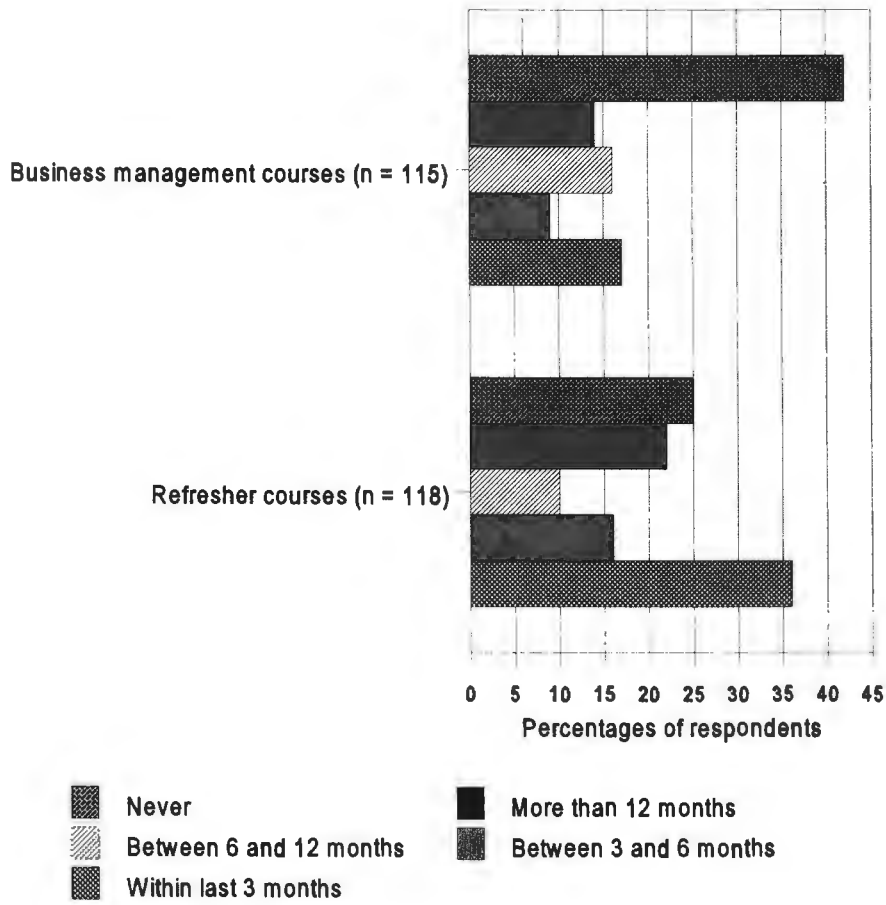

Figure 4.14: Attendance at refresher courses and business management courses by the nurse in private practice

A matter of concern is that it would appear that 26 (22,0%) respondents have never attended refresher courses related to the area of their practice, while an alarming number of respondents, namely 49 (42,6%) have never attended a course on aspects related to business management.

These findings correlate with the learning needs identified in Item 1.9 on page 75 where 76 (62,8%) respondents indicated that they needed further training in management skills, and 103 (85,1%) in business skills Further contributing factors could be that the nature of the practice and the workload as well as financial implications for nurses in private practice were such that time to attend refresher courses was limited.

4.6 REFERRAL SYSTEMS IN THE PRACTICE OF THE PRIVATE NURSE

In this section questions were asked in relation to referrals to and from the practice of the private nurse.

Item 5.1: Referral sources used by nurses in private practice

The population consisted of 121 respondents, however, not all the respondents answered all the questions.

Table 4.20: Clients referred from the private practice of the nurse to health and health related sources (n = 121)

REFERRAL SOURCES USED BY NURSES IN PRIVATE PRACTICE	n	FREQUENTLY		SOMETIMES		NEVER	
		f	%	f	%	f	%
Doctors	117	64	54,7	50	42,7	3	2,6
Hospitals	115	28	24,4	65	56,5	22	19,1
Voluntary organisations	114	25	21,9	60	52,6	29	25,5
Pharmacists	114	22	19,3	48	42,1	44	38,6
Nurses	112	17	15,2	55	49,1	40	35,7
Ministers of religion	116	13	11,2	38	32,8	65	56,0
Social workers	114	12	10,5	50	43,9	52	45,6
Paramedics	112	6	5,4	32	28,5	74	66,1
Industrial health care services	110	4	3,6	18	16,4	88	80,0

More than one response was possible in this question which is related to the extent to which patients are referred from the private practice of the nurse to other institutions/persons. It was significant to note that 114 (97,4%) respondents referred clients to doctors, 93 (80,8%) to hospitals, 85 (74,5%) to voluntary organisations, 72 (64,3%) to other nurses and 70 (61,4%) to pharmacists. The respondents referred patients to a lesser extent to social workers, 62 (54,4%), ministers of religion, 51 (44,0%), industrial health care services, 22 (20,0%) and paramedics, 38 (33,9%).

These findings are important as it would appear that referrals within the multidisciplinary health team concept were accepted and used but little use was made of other services on a wider basis. In terms of the fully integrated comprehensive health services planned in which private practice plays an integral part, this is an aspect that will need to be strengthened.

Items 5.2 to 5.4: Sources of referrals to the private practice of the nurse

The population consisted of 121 respondents, however, not all respondents answered all the questions.

Table 4.21: Sources of referrals to the private practice of the nurse (n = 121)

SOURCES OF REFERRALS TO THE PRIVATE PRACTICE OF THE NURSE	n	FREQUENTLY		SOMETIMES		NEVER	
		f	%	f	%	f	%
Previous clients	115	79	68,7	32	27,8	4	3,5
Doctors	116	77	66,4	32	27,6	7	6,0
Nurses	117	53	45,3	51	43,6	13	11,1
Hospitals	113	47	41,6	45	39,8	21	18,6
Voluntary organisations	112	19	17,0	43	38,4	50	44,6
Pharmacists	113	14	12,4	53	46,9	46	40,7
Ministers	113	11	9,7	27	23,9	75	66,4
Social workers	113	10	8,9	32	28,3	71	62,8
Industrial health care services	112	9	8,0	19	17,0	84	75,0
Paramedics	111	2	1,8	19	17,1	90	81,1

The question in Item 5.2 related to the extent to which clients were referred to the private practice of the nurse from other institutions/persons. A significant number of clients were referred to the private practice, namely 104 (88,9%) from other nurses, 109 (94,0%) from doctors, 67 (59,3%) from pharmacists, 62 (55,4%) from voluntary organisations, 111 (96,5%) from previous clients and 92 (81,4%) from hospitals. The fact that referrals from doctors were so high, namely 109 (94,0%) could be artificial as some medical aid funds require a referral from a doctor before paying the account.

Clients were referred to a lesser extent from social workers, 42 (37,2%), ministers of religion, 38 (33,6%), industrial health care services, 28 (25,0%) and paramedics, 21 (18,9%). These findings have important implications as it would appear that more use is made of referrals to the nurse in private practice than the other way round indicating perhaps the increasing need for nursing or follow-up nursing in home care situations.

Item 5.3: Marketing strategies used for referral within the multidisciplinary team

In terms of the way in which clients came to hear of the private practice, 112 (97,4%) out of 115 respondents indicated that clients were informed verbally.

A large number of nurses, namely 75 (68,8%) out of 109 respondents used their business cards for this purpose. Twenty nine (28,4%) out of 102 respondents indicated that advertising did not play a major role in marketing the private practice of the nurse. The reason for this could partially be due to legislation that currently controls the extent to which nurses may advertise (SANA 1995a:3).

4.7 MONITORING/EVALUATION STRATEGIES USED BY NURSES IN PRIVATE PRACTICE

Item 6.1: Problems experienced by the nurse in private practice

In this section respondents were asked to indicate on a sliding scale (1-4) the extent to which they experienced problems with the different factors listed.

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.22: Factors that gave rise to problems in the private practice of the nurse (n = 121)

PROBLEM AREAS IN THE PRIVATE PRACTICE	n	SERIOUS EXTENT		LARGE EXTENT		LESS EXTENT		NOT AT ALL	
		f	%	f	%	f	%	f	%
Regulations	112	18	16,1	21	18,8	35	31,2	38	33,9
Insufficient support	118	17	14,7	28	24,1	41	35,3	32	25,9
Financial factors	114	16	14,0	33	29,0	39	34,2	26	22,8
Referral system	114	16	14,0	34	29,8	31	27,2	33	29,0
Cooperation with doctors	116	13	11,2	38	32,8	33	28,4	32	27,6
Professional support	114	7	6,1	21	18,4	45	39,5	41	36,0
Business skills	114	6	5,3	26	22,8	45	39,5	37	32,4
Family responsibilities	116	4	3,4	26	22,4	46	39,7	40	34,5
Stock supply	113	3	2,7	5	4,4	27	23,9	78	69,0

More than one response was possible to this question. In terms of Table 4.22 it would appear that the majority of the respondents experienced some problems with regard to the items listed. The areas that appeared to give the greatest problems to the nurse in private practice related to cooperation with doctors, 51 (44,0%), referral systems, 50 (43,8%) and financial factors, 49 (43,0%).

Item 6.2: Methods used by the nurse in private practice to determine satisfaction

The population consisted of 121 respondents, however, not all the respondents answered all the questions.

Table 4.23: Methods used by the nurse in private practice to determine client satisfaction (n = 121)

METHODS USED FOR DETERMINING CLIENT SATISFACTION	n	YES		NO	
		f	%	f	%
Questionnaire	114	24	21,1	90	78,9
Attendance figures	114	65	57,0	49	43,0
Increase in referral	114	89	78,1	25	21,9
Verbal feedback	116	111	95,7	5	4,3
Written feedback	113	67	59,3	46	40,7

The methods used most frequently to determine client satisfaction were verbal feedback, 111 (95,7%), increase in referrals, 89 (78,1%) and written feedback, 67 (59,3%), mostly in the form of letters, cards and questionnaires, 24 (21,1%).

It is of concern to note that questionnaires were not frequently used. This is a matter of concern as in terms of maintaining standards and planning more factual information is needed.

Item 6.3: Evaluation of the private practice of the nurse by outside organisations/institutions

Table 4.24 indicates the extent to which specific institutions assessed/inspected the private practice of nurses.

Although the population totalled 121, not all the respondents answered all the questions.

Table 4.24: The extent to which the private practice of the nurse was assessed by outside organisations/institutions (n = 121)

INSTITUTIONS/ORGANISATIONS RESPONSIBLE FOR ASSESSING THE PRIVATE PRACTICE OF THE NURSE	n	NEVER		BI ANNUALLY		ANNUALLY		INFREQUENTLY	
		f	%	f	%	f	%	f	%
South African Nursing Council	112	101	90,2	-	-	2	1,8	9	8,0
Authorities (health)	114	92	80,7	3	2,6	4	3,5	15	13,2
Peer groups	112	73	65,2	10	8,9	7	6,3	22	19,6
Other professional groups	110	69	62,7	10	9,1	5	4,5	26	23,5

It would appear from the findings in Table 4.24 that there is little or no involvement by outside organisations in the assessment or evaluation of the private practice of the nurse.

This is an alarming situation in terms of integration of services, control and ensuring continuing standards of care.

Item 6.4: Types of records kept by nurses in private practice

The total population consisted of 121 respondents, however, not all the respondents answered all the questions. More than one response was possible for these questions.

Table 4.25: Types of records kept by nurses in private practice (n = 121)

TYPES OF RECORDS KEPT BY NURSES IN PRIVATE PRACTICE	n	YES		NO	
		f	%	f	%
Patient records	117	114	97,4	3	2,6
Receipt books	117	113	96,6	4	3,4
Appointment books	117	105	89,7	12	10,3
Invoice books	117	99	84,6	18	15,4
Reference records	117	81	69,2	36	30,8
Registration with authority	117	81	69,2	36	30,8
Cash books	117	80	68,4	37	31,6
General ledgers	116	69	59,5	47	40,5
Medical records	117	50	42,7	67	57,3
Inventory records	116	45	38,8	71	61,2
Staff leave	116	21	18,1	95	81,9
Injuries on duty	116	17	14,7	99	85,3
Application for sick leave	117	14	12,0	103	88,0
Grievances procedures	116	8	6,9	108	93,1

Looking at Table 4.25 it would appear that all the records listed were used to a greater or lesser extent in the private practices of the nurses. This is a satisfactory finding in terms of control. One hundred and fourteen (97,4%) respondents kept patient records, 113 (96,6%) receipt books and 105 (89,7%) appointment books. These findings are also important as they facilitate control and the continuity of services and permit auditing and financial control.

Item 6.5: The extent to which the nurse in private practice considers statistics important for the management of her services

Figure 4.15 indicates to what extent the nurse in private practice regards the use of statistics important in her private practice.

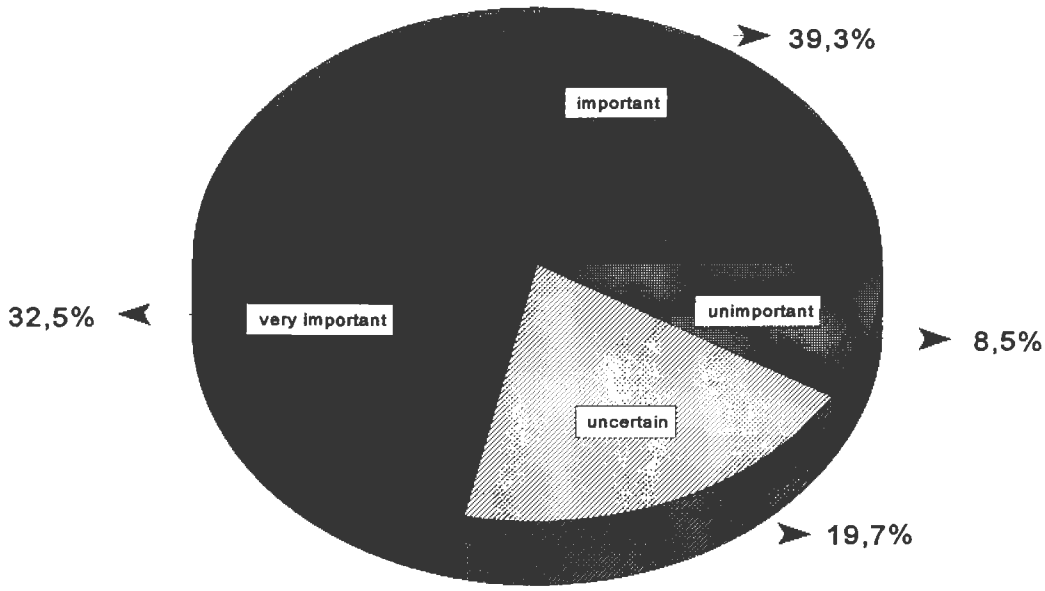

Figure 4.15: The extent to which the nurse in private practice considers statistics important for the management of her services (n = 117)

The majority of the respondents, namely 84 (71,8%) regarded the use of statistics important. This augers well for the future planning and management of these services. Only 23 (19,7%) respondents were uncertain whether the use of statistics were important. The ten (8,5%) who said that statistics were unimportant possibly did not use statistics and were unaware of their importance.

Item 6.6: The use made of statistics by the nurse in private practice

Although there were 121 respondents, not all the respondents answered all the questions.

Table 4.26: The use made of statistics by the nurse in private practice (n = 121)

THE PURPOSE FOR WHICH STATISTICS WERE USED IN PRIVATE PRACTICE	n	YES		NO	
		f	%	f	%
Evaluation	114	74	64,9	40	35,1
Research	110	40	36,4	70	63,6
Later reference	111	71	64,0	40	36,0
Submission to local authorities	110	29	26,4	81	73,6

The respondents that regarded the keeping of statistics as fairly important, used them mainly for evaluation purposes, 74 (64,9%), for future reference, 71 (64,0%) and some for research purposes, 40 (36,4%). A small number of nurses, namely 29 (26,4%) used statistics for submission to the local authorities.

4.8 CONCLUSION

In this chapter the findings of this study were discussed.

CHAPTER 5

Conclusions, recommendations and limitations of the study

5.1 INTRODUCTION

This chapter sets out conclusions and recommendations based on the data analysis. Certain limitations of the study are also identified.

A descriptive exploratory study was done and a postal survey was undertaken by means of questionnaires. The questionnaire was developed according to the framework of the AFFIRM model.

As the researcher selected an exploratory study, the problem was in the form of research questions that were linked to the purpose of the study and the conceptual model illustrated in Tabel 1.1 on page 3.

5.2 CONCLUSIONS

The conclusions based on the findings of the survey done, are discussed according to the AFFIRM model and the research questions.

5.2.1 Availability

Under this section questions were asked in terms of the academic and demographic profile of the nurse in private practice as well as the availability and need for the service of this practitioner.

5.2.1.1 Who is the nurse in private practice?

The conclusions based on the data obtained are as follows:

- The majority of the nurses in private practice are female (95,0%), in the age group 30 to 44 years (60,3%) are married (81,9%), and have three or less children (90,0%) (Items 1.2-1.4, pages 69-71).

- The majority of nurses in private practice are registered at diploma level with the SANC as a general nurse (99,2%), and in most cases also as a midwife (81,8%) with very few nurses in private practice holding additional qualifications in nursing management (administration) (17,4%), nursing education (22,5%), community nursing (22,3%) or qualifications that promote business management skills (14,1%) (Items 1.5, 1.6 and 1.8, pages 71-73).

- Although the scope of practice for the majority of nurses related to the field of general nursing and midwifery, it would appear that the nurse in private practice provided a wide variety of services and that she was not sufficiently prepared for the challenges of a more extended private practice as few of these nurses held qualifications at post-basic level (Item 1.6, page 71).

5.2.1.2 How did the nurse in private practice determine the need for her practice?

The conclusions based on the data obtained are as follows:

- Extensive surveys and a comprehensive assessment of the needs for a private practice were done by the majority of nurses themselves (96,7%) prior to commencing their private practice (Item 2.1, page 77).

  It was interesting to note that so many of the nurse practitioners performed extensive surveys before commencing their practices, as the importance of surveys is a need clearly identified in the literature (Dennill *et al* 1995:91; Lambert & Lambert 1996:12).

- The number of nurses in private practice is still relatively small. However, the number of nurses identified and used for the research may not be a true reflection of the actual number in practice, as the mechanism for listing nurses in private practice in South Africa by the SANC, DENOSA (SANA) and RAMS, is not conclusive (Item 1.2, page 68). It would appear too that in accordance with developing health trends in South Africa, that the need for nurses in private practice will increase in future (Perold & Cronje 1996:399).

5.2.2 Formulation and factual information: the extent and focus of the private practice of the nurse

Under this section the nurse in private practice was asked why she decided to go into private practice, what type of service she offered, and what her actual tasks or functions were and how she perceived her learning needs.

5.2.2.1 Why did the nurse in private practice decide to establish her own practice?

The conclusions based on the data obtained are as follows:

- The majority of nurses in private practice (90,9%) selected private practice in order to function more independently. These findings are significant as they

correlate with the age of the respondents and the fact that most of them had children (Item 3.1, page 80).

- Very few nurses in private practice (8,5%) had been in private practice for more than ten years, with 41,9% indicating that they had only been in private practice for one to four years. This is to be expected as the nurse in private practice in South Africa is still a growing concept. In a study done by Ellis (1992:19) in the USA the average period of years for most nurses in private practice was found to be 7,3 years (Item 3.2, page 82).

5.2.2.2 What type of services were offered?

The conclusions based on the data obtained are as follows:

- A wide variety of services were offered by nurses in private practice with general nursing care (53,7%) and mother and child care services (52,3%) being the services offered most frequently (Item 3.3, page 83). These services may change in the future in terms of current needs and aspects such as the managed health care concept where the main emphasis is on *health* and *health promotion* and not only on medical care (SANA 1996:42).

- In general the extent to which nurses in private practice liaise with other health care providers/institutions appeared to be limited (26,4%). This may be due to the fact that only just over half of the nurses (56,2%) were in full-time employment as a private nurse with the remaining nurses indicating that their private practice was a secondary area of employment (43,8%) and in this regard they functioned independently (Item 3.5, page 85).

- The average number of clients seen by the nurse in private practice was five per day. This small number of clients may also be due to the fact that the time available for private practice was limited as many nurses had other areas of employment as 75,2% of the respondents provided after hours services (Item 3.6, page 86).

- Indemnity insurance coverage had only been taken out by 38,8% of the nurses in private practice. This may be as a result of several factors. Until three years ago membership of the former SANA was compulsory which automatically included indemnity coverage. Since then membership of DENOSA (SANA) is voluntary. In a study done by Ellis (1992:25) in the USA only 10,3% of the respondents reported having no malpractice insurance (Item 3.7, page 86). Nurses in private practice in South Africa as well as in the USA are now becoming aware of the importance of indemnity coverage and the need for malpractice insurance and it is anticipated that nurses will in future ensure that they are adequately covered.

- More than a quarter of the nurses in private practice (36,4%) indicated that their practices were not financially viable (Item 3.9, page 88). This could be due to a variety of factors namely that the majority of nurses appear to lack business and management skills as well as the fact that in general the private practice of the nurse was small, offered on a part-time basis and usually in the evening.

- The majority of nurses (84,2%) in private practices were solo nurse practitioners who did not employ other personnel. This finding was consistent with the fact that in general practices were small and part-time (Item 3.10, page 88).

- Very few nurses in private practice appeared to have any problems in the management of their stock (14,6%). This links with the fact that the nurses were managing their own business and did not employ other personnel (84,2%) (Items 3.10 and 3.11.4, pages 88 and 91).

- The majority of nurses in private practice used their own savings to start their practice (88,4%) and personally issued specific accounts to their clients (Item 3.12.4, page 93). Lack of knowledge regarding financing for business purposes could be a contributing factor, or it could also be because many of the respondents had other forms of employment thus enabling the practice to be funded until the time it would be financially viable.

- Half of the nurses in private practice appeared to have problems with payment for their services (50,5%) with the majority (78,6%) determining their own tariffs on a fee for service basis (Item 3.12.1-3.12.2, pages 92-93). It is presumed that these problems were closely linked with the fact that nurses in private practice basically had little formal knowledge regarding the financial management of their business and managed their own bookkeeping (63,8%).

5.2.2.3 What does the nurse do in her private practice?

The conclusions based on the data obtained are as follows:

- Information in terms of how the practice functions and the tariffs for services offered was in general given verbally (88,6%). This may account for many of the problems experienced in terms of non-payment of fees and non-viable practices. This practice too in the future could have major legal implications (Item 4.1, page 95).

- Health care guidance was given according to needs and circumstances pertaining in a wide variety of situations (Items 4.2.1-4.2.3, pages 96-97). In terms of the total health care needs this was considered a most important finding.

- It would appear that nurses in private practice have learning needs in a wide variety of areas as very few of the nurses (22%) actively kept up to date by attending refresher courses or becoming involved in professional activities. In most instances nurses kept up to date by reading professional journals applicable to their situations (83,1%), with 42,6% of the respondents indicating that they had never attended a course on business management skills (Items 4.3.1-4.3.4, pages 97-99).

5.2.3 Referrals

Under this section questions were asked in terms of the referrals made within the private practice of the nurse.

5.2.3.1 What referral systems does the nurse in private practice use?

The conclusions based on the data obtained are as follows:

- Mutual referral between the nurse in private practice and other members of the health team is extensive with 97,4% of the respondents indicating that they referred clients to doctors, while 94% of clients were referred by doctors to the private practice of the nurse (Item 5.1, page 101).

- Referral to and from other services such as ministers of religion and social workers was done to a lesser extent (Items 5.1-5.4, pages 101-104).

- Marketing strategies used for referral included verbal communication (97,4%), business cards (68,8%) and to a much lesser extent advertising (28,4%) (Item 5.3, page 104).

5.2.4 Monitoring, evaluation and control of the private practice of the nurse in the community

Under this section questions were asked regarding the way standards were maintained and controlled in the private practice of the nurse.

5.2.4.1 How is the practice assessed and controlled?

The conclusions in relation to the research question asked are as follows:

- The major problems encountered in terms of monitoring and control were those related to financial factors (42,9%), referral systems (43,8%) and cooperation with doctors (44%) (Item 6.1, page 104).

- In general, informal methods were used to determine the satisfaction level of patients such as verbal feedback (95,7%), increase in referrals (78,1%) and attendance figures (57%) (Item 6.2, page 105).

- From the findings it is clear that hardly any evaluation of the private practice of the nurse was ever done. An average of 16% of the respondents indicated that they were assessed by outside organisations infrequently, 4% indicated that they were assessed annually and 74,1% indicated that they had never been assessed (Item 6.3, page 106). This is an alarming finding as there needs to be a systematic strategy to ensure that standards are maintained and quality care ensured.

- It is encouraging to see that all types of records such as patient records (97,4%), receipt books (96,6%), appointment books (89,7%) and invoice books (84,6%) were used by the respondents. This may be due to the fact that record-keeping is emphasised throughout the basic nursing training programmes. More than two thirds of the respondents, namely 71,8% regarded the use of statistics important and mainly used them for evaluation purposes or for reference purposes at a subsequent visit (Item 6.4-6.5, pages 107-108).

5.3 SUMMARY OF THE RELATIONSHIP BETWEEN THE RESEARCH QUESTIONS, PURPOSE OF THE STUDY, THE AFFIRM MODEL, CONCLUSIONS AND RECOMMENDATIONS

The relationship of the research questions, purpose of the study, the AFFIRM mode, conclusions and recommendations are illustrated in the table on page 119.

Table 5.1: Relationship of the research questions, purpose of the study, the AFFIRM model, conclusions and recommendations

RESEARCH QUESTION	PURPOSE OF THE STUDY (OBJECTIVES)	CONCLUSIONS	RECOMMENDATIONS
AVAILABILITY **WHO** is the nurse in private practice in South Africa?	To determine the profile of the nurse in private practice.	The nurse in private practice in the community is female, younger than 44 years of age, registered as a general nurse and midwife.	A current list of all nurses in private practice should be maintained by the SANC. Mechanisms should be implemented to ensure lists remained current.
HOW did the nurse in private practice in South Africa determine the needs for her practice?	To determine the extent to which - nurses in private practice assessed the needs for their practice.	The majority of the respondents did an extensive assessment before they started a private practice. However, all nurses indicated a need for further knowledge on how to commence a private practice.	Guidelines on how to do a survey and commence a private practice should be developed and offered through short courses. These guidelines should be developed through research and the input from a wide variety of disciplines.

RESEARCH QUESTION	PURPOSE OF THE STUDY (OBJECTIVES)	CONCLUSIONS	RECOMMENDATIONS
FORMULATION AND FACTUAL INFORMATION **WHY** did the nurse in private practice decide to establish her own private practice?	To determine the reasons as to why nurses decided to go into private practice.	The main reason for starting a private practice appears to be the need for nurses to have flexible working hours and to work independently.	Further research should be done to determine why the nurse in private practice discontinues the private practice. Further research should also be done to determine the qualities and characteristics needed for the nurse to succeed.
WHAT is the scope of practice of the nurse in private practice?	To analyse the task of the nurse in private practice.	The majority of the respondents offered general nursing and mother and child care services with the rest offering a wide variety of other nursing services. Many of the respondents appeared to have alternative forms of employment, offered an after hours service and were in solo practice.	Further research is needed regarding the perception, knowledge and expectations the client in the community has about the nurse in private practice as well as current needs of the client. Nurses should be encouraged to join peer group associations for support and sharing of knowledge and skills.

RESEARCH QUESTION	PURPOSE OF THE STUDY (OBJECTIVES)	CONCLUSIONS	RECOMMENDATIONS
WHAT are the learning needs of the nurse in private practice?	To determine the learning needs of the nurse in private practice.	The majority of the respondents indicated that they had very little preparation for private practice in their basic training and that they needed training in business and financial management skills as well as in computer skills and to a lesser extent updating in nursing skills.	Greater emphasis should be given to the development of entrepreneurial skills in the basic nurse training programme of the nurse. Courses should be developed for nurses intending to start a private practice which include aspects such as: • business and financial management skills • marketing skills • computer skills • leadership and entrepreneurship • updating in current nursing practices (legal aspects: pharmacology, special nursing skills). Nurses should be encouraged to attend refresher courses in terms of specific learning needs and to join peer group organisations such as ANASA.

RESEARCH QUESTION	PURPOSE OF THE STUDY (OBJECTIVES)	CONCLUSIONS	RECOMMENDATIONS
REFERRAL			
WHAT referral systems does the nurse in private practice use?	To determine the referral systems in the private practice of the nurse.	There was extensive referral to and from the nurse in private practice, especially between health professionals. Referrals were made to a lesser extent to social workers, ministers of religion and industrial health care services.	The nurse in private practice should develop networking skills, as well as marketing skills to include al the members of the multidisciplinary team and all stakeholders.

RESEARCH QUESTION	PURPOSE OF THE STUDY (OBJECTIVES)	CONCLUSIONS	RECOMMENDATIONS
MONITORING AND EVALUATION **HOW** are standards controlled and maintained in the private practice of the nurse?	To determine the measures taken to control and maintain standards in the private practice of the nurse in South Africa.	It appears that there are insufficient measures to control and maintain standards in the private practice of the nurse.	Further research should be done to determine how the private practice of the nurse is evaluated, monitored and controlled. More formal methods should be developed to control standards and the quality of care in the private practice of the nurse. A system of peer support/review and control should be established.

5.4 LIMITATIONS IDENTIFIED DURING THE STUDY

During the course of the study certain limitations came to light. Some of these limitations offer scope for further research. The most significant limitations were the following:

- Initially it was difficult to identify all the nurses in private practice in South Africa as there was not a current list or register. The cost of identifying these people by postal questionnaires was high and it is also not certain due to lack of live registers or lists of nurses in practice whether all nurses in private practice were consulted.

- There was very little information on the nurse in private practice in South Africa and mainly overseas literature had to be used. Therefore the specific needs of nurses in private practice in South Africa may not have been fully covered in the questionnaire.

- A limitation of the study was the fact that the nurses in private practice specialised in a variety of disciplines and their service areas accordingly were broad and difficult to define specifically. Questions asked had to be based on broad principles to accommodate these variations whereas more specific information could have focused the findings of the study. This made the scope of the study very broad and it was difficult to cover all aspects in sufficient depth.

- According to the model and conceptual framework the client in the private practice of the nurse was often mentioned. Because of the extent of the study, the emphasis was on the nurse in private practice and not on the client.

- As a result of the scope of the study the questionnaire was too long and some important aspects such as personal characteristics had to be omitted.

- Interviews would have given more satisfactory results, but because the respondents were spread throughout the whole of South Africa, this was impossible in terms of cost and time. In-depth interviews with individual nurses in specialist field in a smaller geographical area would have provided a more comprehensive overview.

5.5 RECOMMENDATIONS ARISING FROM THE RESEARCH PROJECT

The results of this exploratory study are potentially useful for community nursing and nurses currently in private practice as well as nurses who plan to enter private practice.

- A current list of all practising nurses in private practice should be established to ensure safe standards of practices and control. Such lists, if kept centrally, can form a focus point for nurses in private practice and can be contacted for service in a particular area. It is recommended that a live register in this regard be kept by a central body such as the SANC as all practising nurses should be registered with this Council and the SANC regulates the profession. It is further envisaged by the SANC to create a mechanism to ensure that all practising nurses regularly update their knowledge and skills in order to maintain competency (SANC 1996:5).

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

- It is recommended that further research should be done on the perception of other members of the health team regarding nurses in private practice.

- Further research could also be done in the community to determine their knowledge and perception of the nurse in private practice.

- As there seems to be a dire need for education in business and management skills for the nurse in private practice, short courses should be developed to meet this need and to prepare the nurse before starting a private practice. In view of the increasing need for innovation and

entrepreneurship such courses should be implemented in basic nurse training programmes.

- As it would appear that there is lack of evaluation strategies in the private practice of the nurse, further research could be done on this specific aspect.

- Support systems for the nurse in private practice could be investigated as it would appear that there is a need for intradisciplinary and multidisciplinary support.

5.7 ASSUMPTIONS

The findings of the study substantiate the assumptions made in chapter 1.

□ **Assumption 1**

There are a large number of nurses in private practice in South Africa.

This was found not to be the case as only 280 nurses were on the most up to date list available. It was thought that there were more nurses in private practice in South Africa than there were on the list at SANA (DENOSA). However, it would appear that the current listing of private nurse practitioners is not effective as it is not compulsory and thus it is not certain whether all nurses in private practice were contacted.

□ **Assumption 2**

The scope of practice of nurses in private practice is diversified.

According to the findings, nurses were involved in many different areas, eg geriatric nursing, oncology nursing, paediatric services, occupational health services but the majority offered general and mother and child nursing care.

□ **Assumption 3**

The nurse in private practice has special learning needs.

Respondents indicated that they had special learning needs regarding management skills, business skills, computer skills and nursing skills.

□ **Assumption 4**

Monitoring of standards of practice within the private practice of the nurse in the community is limited.

This was found to be the case. There is an urgent need to draw up standards for control purposes, especially if services are to expand and more than one person's to be employed.

5.8 CONCLUSION

If the private practice of the nurse is to become an integral part of the comprehensive health care system planned for South Africa, the nurse in private practice will have to become far more involved and astute in identifying the health needs in the community and in drawing up appropriate programmes to meet these needs.

She will need to develop skills in

- assessing the epidemiological situation and identifying health problems
- determining priorities and trends
- drawing up feasible strategies
- including all sectors in her planning strategy
- identifying and describing constraints
- estimating costs
- integrating the service with other available services
- reorganising and reorientating the service offered
- using programme budgeting for decision-making

- strategic planning and marketing
- quality assurance and management

A short course for nurses in private practice which include the following topics is suggested:

- business and financial management skills
- marketing skills
- computer skills
- leadership and entrepreneurship skills
- quality assurance and setting of standards
- current issues pertaining to nursing practice

The following quote could be applicable to sum up the present situation in South Africa:

> "With a changing health care system, nurses are in a prime position to negotiate the delivery of appropriate, acceptable and cost-effective health care as independent practitioners" (Lambert & Lambert 1996:11).

BIBLIOGRAPHY

ANASA. 1994. *Contract guidelines and guidelines for nursing agencies.*

ANC. 1994a. *A national health plan for South Africa.* Maseru: Bähr.

ANC. 1994b. *The reconstruction and development programme.* Johannesburg: Umanyano.

Aydelotte, MK; Hardy, MA & Hope, KL. 1988. *Nurses in private practice. Characteristics, organizational arrangements, and reimbursement policy.* Missouri: American Nurses Foundation.

Baker, MM & Pulcini, JA. 1990. Innovation: nurse practitioners as entrepreneurs. *Nurse Practitioner Forum* 1(3):169-174.

Barger, SE. 1991. Entrepreneurial nursing: the right course at the right time. *Nurse Educator* 16(5):5-8.

Batra, C. 1990. Socializing nurses for nursing entrepreneurship. *Nursing and Health Care* 11(1), Jan:34-37.

Bierman, J. 1994. Legal limitations in primary health care nursing practice in South Africa (Part I). Reprinted from the *International Journal of Medicine and Law* 13(1/2).

Booyens, SW. 1993. *Dimensions of nursing management.* Kenwyn: Juta.

Booyens, SW & Minnaar, A. 1996. Management of a private nursing practice, in *Introduction to health services management*, edited by SW Booyens. Kenwyn: Juta.

Bramble, K. 1991. Mimi Secor: nurse practitioner entrepreneur. *Nurse Practitioner Forum* 2(3):142-143.

Brathwaite, D. 1983. The development of a nursing practice ... or so you want to go into private practice? *Michigan Nurse* 56(2):3-5.

Brent, NJ. 1990. Setting up your own business. Facing the future as an entrepreneur. *AORN Journal* 51(1):205, 208, 210-213.

Browning, CH & Browning, BJ. 1986. *Private practice handbook. The tools, tactics & techniques for successful practice development*. California: Duncliff's International.

Carson, KD, Carson, PP & Roe, CW. 1995. *Management of health care organizations.* South Western College Publishing: an International Thomson Publishing Co.

Caserta, JE. 1991. Editors View. The entrepreneural spirit. *Home Health Care* 9(2), March/April:7.

Chinn, PL. 1992. From the editor. Challenging, visionary, innovative. *Nursing Outlook* 40 (4):148-149.

Clark, L & Quinn, J. 1988. The new entrepreneurs. *Nursing and Health Care* 9(1):6-15.

Coddington, DC; Keen, DJ; Moore, KD & Clarke, RL. 1991. *The crisis in health care. Costs choices and strategies*. San Francisco: Jossey-Bass Publishers.

Concise Oxford Dictionary. 1982. 7th edition. S.v. "practice". Oxford: Clarendon Press.

Cormack, DFS. 1990. *Developing your career in nursing*. London: Chapman.

Davis, J. 1992. Expanding Horizons. *Nursing Times* 88(47), 18 Nov:37-39.

Dellatola, L. 1988. Privatisation means business. *Southern Africa Today* 5(5):2-7.

Dempsey, PA & Dempsey, AD. 1992. *Nursing research with basic statistical applications*. 3rd edition. Boston: Jones & Bartlett Publishers.

Dennill, K, King, L, Lock, M & Swanepoel, T. 1995. *Aspects of primary health care. Community health care in Southern Africa*. Halfway House: Southern Book Publishers.

Department of Health. 1996. *Restructuring the national health system for universal primary health care* (circular).

Dickerson, PS & Nash, BA. 1985. The business of nursing. *Nursing and Health Care* 6(6):326-329.

Dreyer, M, Hattingh, S & Lock, M. 1993. *Fundamental aspects in community health nursing. Community health care in Southern Africa*. Halfway House: Southern Book Publishers.

Durham, JD & Hardin, SB. 1983. Promoting private practice in a competitive market. *Nursing Economics* 1(1):24-28.

Durham, JD & Hardin, SB. 1985. Promoting advanced nursing practice. *Nurse Practitioner: American Journal of Primary Health Care* 10(12):59-62.

Ellis, DM. 1992. *Certified nurse-midwives in private practice: a descriptive study*. The University of Utah College of Nursing. Michigan: UMI Dissertation Services.

Faust, L & Meaker, MK. 1991. Private practice occupational therapy in the skilled nursing facility: creative alliance or mutual exploitation? *The American Journal of Occupational Therapy* 45(7):621-626.

Gannon, K. 1985. Nursing's impact on a business venture. *Nursing Administration Quarterly* 10(1):90-95.

Gardner, KL & Weinrauch, D. 1988. Marketing strategies for nurse entrepreneurs. *Nurse Practitioner: American Journal of Primary Health Care* 13(5):46, 48-49.

Geyer, N. 1995. Professional indemnity. *Nursing News* 19(6), June:37.

Giesbrecht, V. 1987. From dream to reality. *The Kansas Nurse* 62(7):3-4.

Grau, P & Floyd, J. 1992. Nurse entrepreneurs achieve full council status. *Pennsylvania Nurse* 47(4):10.

Hacker, B. 1992. Nurturing your network: A first step to becoming a successful entrepreneur/intrapreneur. *Pennsylvania Nurse* 47(3):28.

Hamric, AB & Spross, JA. 1989. *The clinical nurse specialist in theory and practice*. Philadelphia: WB Saunders.

Hawken, L. 1989. Not an illogical move. *New Zealand Nursing Journal* 82(4):22-23.

Hoeffer, B. 1983. The private practice model: an ethical perspective. *Journal of Psychosocial Nursing and Mental Health Services* 21(7):31-37.

Hoffman, VR. 1984. *New directions for the professional nurse*. New York: Arco Publishing.

Holmes, BC. 1985. Private practice in oncology nursing. *Oncology Nursing Forum* 12(3):65-67.

Iglehart, JK. 1987. Health policy report. Problems facing the nursing profession. *New England Journal of Medicine* 317(10):646-651.

Jacox, AK & Norris, CM. 1977. *Organizing for independent nursing practice*. New York: Appleton-Century-Crofts.

Kaplan, SM. 1991. The absolute basic concepts of being a nurse entrepreneur. *Pediatric Nursing* 17(2), March/April:179-183.

Klopper, AG. 1990. *An investigation into the financial and legal aspects of private nursing practice in Port Elizabeth*. Submitted as partial fulfilment of the requirement for the degree of Baccalaureus Curationis Honores.

Kurten, WJ. 1991. Briewe. *Nursing RSA Verpleging* 6(6):10-11.

Lachman, V. 1992. Entrepreneuring in PA. Who is the nurse entrepreneur/intrapreneur? *Pennsylvania Nurse* 47(5), May:11-13.

Lambert, VA & Lambert, CE. 1996. Advanced practice nurses: starting an independent practice. *Nursing Forum* 31(1):11-21.

Lee, C. 1987. Concept of entrepreneurship. *Kansas Nurse* 62(7):5.

Lister, EM. & Thayer, MB. 1992. Private practice: the time is now. *Pediatric Nursing* 18(3), May/June:295-298.

Lynch, ML. 1982. *On your own: professional growth through independent nursing practice*. Monterey: Wadsworth Health Science Division.

MacDonald, N & Zavers, A. 1992. Independent nursing practice? *Alberta Association of Registered Nurses* 48(5):10.

Mandela vasbeslote oor privatisering. 1996. *Beeld*, 25 Mei:2.

Manion, J. 1990. *Change from within. Nurse intrapreneurs as health care innovators*. Kansas City: American Nurses Association.

Marx, S, Rademeyer, WF & Reynders, HJJ. 1991. *Bedryfsekonomie. Riglyne vir ondernemingsbestuur*. Pretoria: Van Schaiks.

McAndrew, T. 1988. Peer review for the independent practitioner. *Pennsylvania Nurse* 43(6):6-7.

McCue, JD & Ficalora, RD. 1991. *Private practice. A guide to getting started.* Boston: Little Brown.

McGregor, R. 1987. *McGregor's privatisation in South Africa.* Cape Town: Juta.

McKee, BA. 1990. Women in business. From bedside to business. *Nation's Business* 78, Jan:50.

McShane, NG. 1985. Reflections on five years of private practice. *Pennsylvania Nurse* 40(5):9.

Mediese diens se tekort R200 miljoen meer as verwag. 1993. *Beeld*, September:4.

Nichols, JS. 1990. How to start a practice on shoestring. *Journal of the American Academy of Nurse Practitioners* 2(3):129-131.

Norris, D. 1991. Why nurses become entrepreneurs. *NSNA/Imprint* 38(3), Sept/Oct:100-102.

Pearson LJ. 1986. Nancy Dirrubo: Fighting for the rights of NP's in private practice. *Nurse Practitioner: American Journal of Primary Health Care* 11(9):57-58.

Pera, S. 1988. A profile of professional nursing practice in the private sector in the RSA. *Curationis* 11(2):13-21.

Perold, A & Cronje, A. 1996. Management of a private nursing practice in, *Introduction to health services management*, edited by SW Booyens. Kenwyn: Juta.

Polit, DF & Hungler, BP. 1993. *Nursing Research. Principles and methods.* Philadelphia: JB Lippincott.

Powell, DJ. 1984. Nurses - high touch entrepreneurs. *Nursing Economics* 2(1):33-36.

Pressman, RM & Siegler, R. 1983. *The independent practitioner. Practice management for the allied health professional.* Illinois: Dow Jones-Irwin.

Private sector offers a wide range. Career development. 1989. *The Professional Nurse* 4(7):360-361.

Puetz, BE. 1983. *Networking for nurses.* London: Aspen.

Regensburg, DJ. 1986. Private practice. Practical guidelines for the nurse practitioner. *Nursing RSA Verpleging* 1(6):4-6.

Rew, L. 1988. Affirm the role of clinical specialist in private practice. *Clinical Nurse Specialist* 2(1):39-43.

Riccardi, BR & Dayani, EC. 1982. *The nurse entrepreneur.* Virginia: Reston.

Salvage, J. 1991. *Nurse practitioners. Working for change in primary health care nursing.* London: Kings Fund Centre.

SANA. 1994a. *A practical guide to private nurse practice.* Pretoria: SANA.

SANA. 1994b. The nursing and midwifery professions can play a major role in the implementation of the Reconstruction and Development Programme (RDP). *Nursing News/Verpleegnuus* 18(10), Oct :1.

SANA. 1994c. Nursing News Verpleegnuus. *Nursing News//Verpleegnuus* 18(11), Nov:4.

SANA. 1995a. Letters from our readers. *Nursing News/Verpleegnuus* 19(2):Feb:3.

SANA. 1995b. Newswatch. *Nursing News/Verpleegnuus* 19(10), Oct:11.

SANA. 1996. A challenging new dimension in nursing. *Nursing News/Verpleegnuus* 20(11), Nov:42.

SANC, *vide* South Africa. 1978.

SANC, *vide* South Africa. 1984b.

SANC, *vide* South Africa. 1985.

SANC, *vide* South Africa. 1993.

SANC. 1994. Statistical returns for the calender year:17.

SANC. 1996. Circular to all nursing schools. *A unified nursing education system for South Africa.*

Schneider, B. 1992. Establishing an independent practice. *Journal of Pediatric Health Care* 6(1), Jan/Feb:43-44.

Searle, C & Pera. SA. 1995. *Professional practice: a South African nursing pespective.* 3rd edition. Durban: Butterworths.

Shoultz, J; Hatcher, PA & Hurrell, M. 1992. Growing edges of a new paradigm: the future of nursing in the health of the nation. *Nursing Outlook* 40(2), March/April:57-61.

Slauenwhite, C; Dewitt, P & Grivell, M. 1991. Independent nurse practitioners. *Canadian Nurse* 10(10), Nov:24.

Smith, JA. 1986. The role of the private nurse practitioner: a family practitioner's viewpoint. *Nursing RSA Verpleging* 1(6):33-35.

South Africa. 1978. Nursing Act, no 50, 1978 (as amended). Pretoria: Government Printer.

South Africa. 1984a. Act on closed corporations, no 69, 1984. Pretoria: Government Printer.

South Africa. 1984b. Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978 (Act no 50, 1978, as amended). Regulation R2598, as amended. Pretoria: Government Printer.

South Africa. 1985. Rules setting out the acts or omissions in respect of which the Council may take disciplinary steps. Regulation R387, as amended. Pretoria: Government Printer.

South Africa. 1993. Nursing Amendment Act, Act 145 of 1993. Government Gazette 15172. Government Notice 1864. Pretoria: Government Printer.

STA206-R Only Study Guide, *vide* University of South Africa. Department of Statistics. 1992.

Stanhope, M & Lancaster, J. 1996. *Community health nursing. Promoting health of aggregates, families and individuals*. 4th edition. St. Louis: CV Mosby.

Stull, MK & Pinkerton, SE. 1988. *Current strategies for nurse administrators*. Maryland: Aspen.

Treece, EW & Treece, JW. 1986. *Elements of research in nursing*. St. Louis: CV Mosby.

University of South Africa. Department of Statistics. 1992. Statistics: Only Study Guide for STA 206-R (sample surveys). Pretoria.

Van Rensburg, HCJ, Fourie, A & Pretorius, E. 1992. *Health care in South Africa: structure and dynamics*. Pretoria: Academica.

Vogel, G & Doleysh, N. 1988. *Entrepreneuring. A nurses guide to starting a business.* New York: National League for Nursing.

Wackenhut, JS. 1987. Practice Management. Strategies for maintaining continuing education in private practice. *Pediatric Nursing* 13(2), March/April:132.

Williams, SD & Williams, JR. 1988. *How to market home health care services.* New York: John Wiley & Sons.

Winstead-Fry, P. 1990. *Career planning. A nurse's guide to career advancement.* New York: National League for Nurses.

Wolfson, B & Neidlinger, SH. 1991. Nurse entrepreneurship: opportunities in acute care hospitals. *Nurse Economics* 9(1):40-43.

Wright, BL. 1981. The nurse consultant. An independent practice setting. *Canadian Nurse* 77(2):34-36.

ANNEXURE A

LETTER AND QUESTIONNAIRE SENT TO NURSES ON THE LIST KEPT BY RAMS

254 Olive Road
Hennopspark
VERWOERDBURG
0157

26 March 1992

Dear Colleague

I am currently involved in research to determine the extent of practice of nurses in private practice in the community as well as any problems they may have. It is my intention based on the findings of my research to draw up a learning package to assist the nurse in private practice if this is needed.

The list of nurses in private practice registered with the Representative Association of Medical Schemes is not current and therefore in order to obtain an updated list, I would be most grateful if you could complete the attached form and return it to me in the stamped self-addressed envelope as soon as possible. It would also be of extreme value to my research if you could give your reasons as to why you either did not commence private practice or discontinued private practice.

Thanking you in anticipation.

Yours sincerely

Betsie Smith

BETSIE SMITH

(Tel no (012) 64-4398)

Name: .....

Address: .....
.....
.....

Telephone number: .....

(Mark the appropriate answer with a tick).

		Office use
		1 2 3 ☐☐☐
	Yes ☐ No ☐	☐ 4
1	Did you ever start a private nurse practice?	
2	If your answer is **"YES"** indicate the period of time you were in practice or have been practice	
	Years ☐☐	5 ☐☐ 6
	Months ☐☐	7 ☐☐ 8
3	If your answer is **"NO"**, what were the reasons for not commencing private practice? **(Tick the appropriate response/responses).**	
	Family commitments ☐	☐ 9
	Financial factors ☐	☐ 10
	Lack of business knowledge ☐	☐ 11
	Location of the practice ☐	☐ 12
	Insufficient demand for the practice ☐	☐ 12
	Lack of support from the community and other health workers ☐	☐ 14
	Other (give reasons) ..... ☐	☐ 15
	.....	
	.....	
	.....	

		Office use
4	If you commended a private practice and then discontinued what were the reasons for this?	
	Family commitments ☐	☐ 16
	Financial factors ☐	☐ 17
	Lack of business knowledge ☐	☐ 18
	Insufficient demand for the practice ☐	☐ 19
	Lack of support from the community and other health workers ☐	☐ 20
	Other (give reasons) ..... ☐	☐ 21
	.....	
	.....	
	.....	
5	Would you be prepared to participate in the research if I sent you a questionnaire? Yes ☐ No ☐	☐ 22

Oliveweg 2
Hennopspark
VERWOERDBURG
0157

26 Maart 1992

Geagte Kollega

Ek is tans betrokke by navorsing oor die omvang van die praktyk van privaatverpleegkundiges in die gemeenskap asook enige probleme wat hulle mag ondervind. Ek beoog om 'n leerpakket saam te stel gebaseer op die bevindings wat hieruit voortspruit, om die verpleegkundige in die privaatpraktyk behulpsaam te wees indien dit nodig is.

Die adreslys van verpleegkundiges in die privaatpraktyk wat geregistreer is by die Verteenwoordigende Vereniging van Mediese Skemas is nie op datum nie. Ek sal dit dus waardeer indien u die aangehegte vorm sal voltooi en so gou as moontlik aan my terugstuur in die geadresseerde koevert. Dit sal ook van besondere waarde wees vir my navorsing indien u die redes verstrek waarom u nie met 'n praktyk begin het nie, of waarom u opgehou het.

Baie dankie by voorbaat.

Die uwe

BETSIE SMITH

(Tel nr (012) 64-4398)

Naam: .....

Adres: .....
.....
.....

Telefoonnommer: .....

(Merk die toepaslike antwoord).

		Kantoorgebruik
		1 2 3 ☐☐☐
	Ja Nee	
1	Het u ooit as verpleegkundige met 'n privaatpraktyk begin? ☐☐	☐ 4
2	Indien u antwoord **"JA"** is, dui aan hoe lank u gepraktiseer het, of al praktiseer.	
	Jare ☐☐	5 ☐☐ 6
	Maande ☐☐	7 ☐☐ 8
3	Indien u antwoord **"NEE"** is, wat was die redes dat u nooit 'n privaatpraktyk begin het nie? **(Merk die toepaslike antwoord).**	
	Gesinsverpligtinge ☐	☐ 9
	Finansiële faktore ☐	☐ 10
	Gebrek aan besigheidskennis ☐	☐ 11
	Plasing van die praktyk ☐	☐ 12
	Onvoldoende behoefte aan die praktyk ☐	☐ 12
	Onvoldoende ondersteuning van die gemeenskap en ander gesondheidswerkers ☐	☐ 14
	Ander (gee redes) ..... ☐	☐ 15
	.....	
	.....	
	.....	

		Kantoorgebruik
4	Indien u 'n privaatpraktyk begin en toe opgehou het, wat was die redes daarvoor?	
	Gesinsverpligtinge ☐	☐ 16
	Finansiële faktore ☐	☐ 17
	Gebrek aan besigheidskennis ☐	☐ 18
	Onvoldoende behoefte aan die praktyk ☐	☐ 19
	Onvoldoende ondersteuning van die gemeenskap en ander gesondheidswerkers ☐	☐ 20
	Ander (gee redes) ..... ☐	☐ 21
	.....	
	.....	
	.....	
5	Is u bereid om u samewerking met die navorsing te gee indien ek 'n vraelys aan u sou pos	
	Ja ☐ Nee ☐	☐ 22

ANNEXURE B

COVERING LETTER AND QUESTIONNAIRE SENT TO NURSES ON THE LIST KEPT BY SANA

254 Olive Road
Hennopspark
VERWOERDBURG
0157

30 June 1994

Dear Colleague

I am currently undertaking a survey for my master's degree on the practice of the private nurse in the community. Unfortunately, at this stage, there appears to be little information on the role and contribution of the private nurse in the provision of health care.

You, as a key person in the rendering of health care, are therefore requested to please complete the attached questionnaire as fully as possible. it is estimated that not more than 45 minutes will be needed to complete the questionnaire.

All information given will be handled in the strictest confidence. If you have any problems or queries, please contact me at Pretoria (012) 64-4398 (home) or (012) 429-6754 (work - 08:00-13:00).

Your cooperation will contribute significantly to the study, but if for some other reason you do not wish to complete the questionnaire, please return it to me.

A stamped, addressed envelope is included for the return of the questionnaire.

I will appreciate it if you could please return the questionnaire before 15 August 1994.

Thanking you in anticipation for giving up your valuable time to complete the questionnaire and making my research possible.

Yours sincerely

Betsie Smith

BETSIE SMITH

Mrs J E Smith	MA(Cur)

QUESTIONNAIRE

OBJECTIVE OF THE STUDY

AN INVESTIGATION INTO THE CURRENT PRACTICE OF THE PRIVATE NURSE IN THE COMMUNITY

ALL INFORMATION WILL BE TREATED AS STRICTLY CONFIDENTIAL

INSTRUCTIONS:
Please answer all the questions.
Answer each question objectively, as it applies to your situation.
For each question you are requested to write the appropriate number in the square provided, e.g. [4][0].

[ ][ ][ ][ ] 1-4

Card [1] 5

AFFIRM MODEL: AVAILABILITY

1. PERSONAL DETAILS

1.1 Age in years: ..... [ ][ ] 6-7

1.2 Sex: Male = 1 Female = 2 ..... [ ] 8

1.3 Marital status:
Married = 1 Never married = 2 Divorced = 3 Widowed = 4 ..... [ ] 9

1.4 Number of children: e.g. 1 child [0][1] ..... [ ][ ] 10-11

1.5 Which of the following basic nursing qualifications have you obtained?

General: Degree = 1 Diploma = 2 ..... [ ] 12

Obstetrics: N/a = 0 Degree = 1 Diploma = 2 ..... [ ] 13

Psychiatry: N/a = 0 Degree = 1 Diploma = 2 ..... [ ] 14

Community Nursing Care:
N/a = 0 Degree = 1 Diploma = 2 Non-degree qualification = 3 [ ] 15

1.6 Which of the following post-basic nursing qualifications have you obtained?

Nursing education:
N/a = 0 Degree = 1 Diploma = 2 Non-degree qualification = 3. [ ] 16

Nursing Administration:
N/a = 0 Degree = 1 Diploma = 2 Non-degree qualification = 3. [ ] 17

Community Nursing:

N/a = 0 Degree = 1 Diploma = 2 ..... ☐18

Other = 3 ..... ☐19

(If OTHER, please specify) .....

1.7 What is the highest academic nursing qualification you have obtained? (Specify the discipline in which you achieved this qualification)

Diploma = 1 B-degree = 2

Honours = 3 Masters = 4 Doctorate = 5 ..... ☐20

Discipline .....

1.8 Have you obtained any non-nursing qualifications which could be to your benefit in a private practice?

Yes = 1 No = 2 ..... ☐21

If YES, please specify .....

1.9 In order to prepare you appropriately for a private practice, do you consider it necessary to have further training in the following:

Yes = 1 No = 2

Nursing skills ..... ☐22

Management skills ..... ☐23

Business skills ..... ☐24

Teaching skills ..... ☐25

Computer literacy ..... ☐26

(If OTHER, please specify) .....

1.10 Indicate the degree to which, in your opinion, you were adequately prepared during your basic nursing training for private practice.

Not at all = 1 To a slight degree = 2

To a large degree = 3 To a very large degree = 4 ..... ☐27

2. AVAILABILITY OF SERVICES

2.1 Did you conduct a survey regarding the needs for your services prior to starting your practice?

Yes = 1 No = 2 ..... ☐28

If your answer is YES, proceed from question 2.2
If your answer to the question is NO, proceed to question 3 on p. 4.

2.2 Did you obtain guidelines from any of the following sources in determining the needs for your private practice?
Yes = 1 No = 2

Own research ..... ☐29

Literature consulted ..... ☐30

Consultation within the nursing profession ..... ☐31

Consultation outside the nursing profession ..... ☐32

Other ..... ☐33

(If OTHER, please specify) .....

2.3 In determining the needs of target groups, did you make use of the following sources:
Yes = 1 No = 2

Key persons from the target population for whom the service was planned ..... ☐34

Other private practitioners ..... ☐35

Other members of the health team e.g. medical doctors, pharmacists ..... ☐36

Health care authorities in your area ..... ☐37

Other ..... ☐38

(If OTHER, please specify) .....

2.4 Indicate the aspects which you included in your assessment of needs for your service:
Yes = 1 No = 2

General description of the need for health care within the geographic borders of your practice ..... ☐39

Specific health care needs of the general community within the geographic borders of your practice, with the purpose of determining specific target groups ..... ☐40

The general and specific health care needs of the target group ☐41

The availability of other health care services within the geographic borders of your practice ..... ☐42

The existing infrastructure, e.g. transport ..... ☐43

Affordability of the existing services ..... ☐44

Financing of the existing services ..... ☐45

The potential for growth and development of the services that you planned ..... ☐46

aFFIRM MODEL: FORMULATION AND FACTUAL INFORMATION

3. FORMULATION - EXTENT AND FOCUS OF YOUR PRIVATE PRACTICE

3.1 Indicate, using the key given below, the reasons why you chose to go into private practice

Yes = 1 No = 2 Uncertain = 3

More flexible hours ..... ☐47

For financial gain ..... ☐48

To gain further experience ..... ☐49

An unrealistic work load in hospitals ..... ☐50

To function more independently ..... ☐51

To meet the needs of the community and/or clients ..... ☐52

To establish greater client contact ..... ☐53

To prove that nurses can be successful in private practice .... ☐54

To improve the standards of nursing and health care ..... ☐55

To enjoy an enhanced status as a nursing practitioner ..... ☐56

To test a specific nursing theory ..... ☐57

Other ..... ☐58

(If OTHER, please specify) .....

3.2 For how long have you been in private practice?

1 - 6 months = 1 6 months - 1 year = 2 1 - 2 years = 3
2 - 4 years = 4 4 - 6 years = 5 6 - 10 years = 6
10 years and longer = 7 ..... ☐59

3.3 Which type of service is offered in your practice?

Yes = 1 No = 2

General nursing care (medical or surgical) ..... ☐60
Occupational health care services ..... ☐61
Geriatric nursing ..... ☐62
Health care guidance ..... ☐63
Cardiac rehabilitation ..... ☐64
Maternity services, including child birth at home ..... ☐65
Health care for mother and child ..... ☐66
Oncology nursing ..... ☐67
Orthopaedic services ..... ☐68
Paediatric services ..... ☐69
Psychiatric services ..... ☐70
Other ..... ☐71
(If OTHER, please specify) .....

3.4 Using the key given below indicate the extent to which you liaise with any of the following institutions/persons

Full-time = 1 Part-time = 2 Relief basis = 3 Not applicable = 4

A hospital group ..... ☐72
An occupational health care service ..... ☐73
A medical doctor ..... ☐74
A pharmacist ..... ☐75
A nursing agency ..... ☐76
Other ..... ☐77
(If OTHER, please specify) .....

Card [2] 1

3.5 How many clients do you see per day? (average) ..... [ ][ ][ ] 2-4

3.6 Do you provide an after-hours service to clients, e.g. maternity and/or emergency services?

Yes = 1 No = 2 ..... [ ] 5

3.7 Is your practice covered by indemnity insurance?

Yes = 1 No = 2 ..... [ ] 6

(If YES, please specify) .....

3.8 Apart from your private practice, are you employed in any other way? (Nursing or other)

Yes = 1 No = 2 ..... [ ] 7

3.8.1 If YES, specify the area and indicate whether any of the reasons given below motivated you in your choice:

Area of employment .....

Yes = 1 No = 2

Financial ..... [ ] 8

To remain informed and in touch with certain clinical skills and/or knowledge ..... [ ] 9

To gain experience in a specific field ..... [ ] 10

For personal stimulation and satisfaction ..... [ ] 11

3.9 Do you consider your practice financially viable?

Yes = 1 No = 2 Fluctuating/Uncertain = 3 ..... [ ] 12

3.10 Which of the following category of personnel do you employ?

Yes = 1 No = 2

Professional nurses ..... [ ] 13

Enrolled nurses ..... [ ] 14

Nursing auxiliaries ..... [ ] 15

Receptionists ..... [ ] 16

Bookkeepers ..... ☐17

Messengers ..... ☐18

Domestic workers ..... ☐19

Lay workers ..... ☐20

Other (please specify) .....

3.11 STOCK AND EQUIPMENT

3.11.1 How are clients provided with equipment, dressings, medicines, etc.

The client provides everything = 1
The client provides some stock = 2
The nurse provides all stock to the client = 3 ..... ☐21

3.11.2 Using the key provided, indicate to what extent you order stock from the following sources:

Always = 1 Sometimes = 2 Never = 3

Retail pharmacies ..... ☐22

Wholesale pharmacies ..... ☐23

Pharmaceutical companies ..... ☐24

Other ..... ☐25

(If OTHER, please specify) .....

3.11.3 Do you control your stock using?

Yes = 1 No = 2

Continuous check lists ..... ☐26

Computerised records ..... ☐27

Other ..... ☐28

(If OTHER, please specify) .....

3.11.4 Using the key provided, indicate to what extent the following cause problems in the management of your stocks

To a great extent = 1 Sometimes = 2 Never = 3

Theft ..... ☐29

Insufficient time for record keeping ..... ☐30

Ineffective record systems ..... ☐31

Other ..... ☐32

(If OTHER, please specify) .....

3.11.5 Is each item/service that you provide to the client indicated separately on the account?

Yes = 1 No = 2 ..... ☐33

3.12 FINANCING

3.12.1 Who is usually responsible for the payment of accounts sent to the client?

The client pays the account for the total costs = 1

The medical scheme pays for part of the costs = 2

The medical scheme pays for the total costs = 3

Other = 4 ..... ☐34

(If OTHER, please specify) .....

3.12.2 Have you encountered any problems with payment for services rendered?

Yes = 1 No = 2 ..... ☐35

(If YES, please specify) .....

.....

3.12.3 On which basis do you determine your tariffs?

Fee for service = 1 Prepaid service = 2 ..... ☐36

3.12.4 Where did you obtain capital to start your practice?

Yes = 1 No = 2

A Banking institution..... ☐37

A Building society ..... ☐38

A loan from a private person ..... ☐39

Small Business Development Corporation ..... ☐40

Own savings ..... ☐41

Other ..... ☐42

(If OTHER, please specify) .....

3.13 Who manages the bookkeeping for your practice?

Yourself = 1 Bookkeeper on a consultation basis = 2
Auditor on a consultation basis = 3 Other = 4 ... ☐43

(If OTHER, please specify) .....

4. FACTUAL INFORMATION NEEDED FOR ESTABLISHING A PRIVATE PRACTICE

4.1 Which of the following methods do you use to inform clients about tariffs and procedures used in your practice?

Yes = 1 No = 2

Verbally ..... ☐44

In writing ..... ☐45

By means of tariff lists ..... ☐46

By means of information brochures on specific procedures ..... ☐47

By mailing accounts and/or invoices ..... ☐48

Other ..... ☐49

(If OTHER, please specify) .....

4.2 HEALTH CARE COUNSELLING

4.2.1 To what extent is health care counselling given to the following persons/groups in your practice?

Never = 1 Sometimes = 2 Always = 3

Children ..... ☐50

Adolescents ..... ☐51

Parents or families ..... ☐52

Pregnant women or mothers of babies ..... ☐53

The aged ..... ☐54

Corporate or industrial employees/employers ..... ☐55

Social work groups or voluntary workers ..... ☐56

Other ..... ☐57

(If OTHER, please specify) .....

4.2.2 If you do give health care guidance to the above-mentioned persons/groups is it given

Yes = 1 No = 2 Not applicable = 3

On request ..... ☐58

By appointment ..... ☐59

Informally ..... ☐60

Continuously during nursing care ..... ☐61

After completion of nursing care ..... ☐62

4.2.3 Indicate who gives health care counselling in your practice

Yourself = 1 Other = 2 ..... ☐63

(If OTHER, please specify) .....

4.3 IN-SERVICE TRAINING AND CONTINUOUS EDUCATION

4.3.1 Using the key provided, indicate the extent to which you feel that the following are important in updating your knowledge in private practice

Very important = 1 Fairly important = 2 Not important at all = 3

Monthly meetings with other private nurses ..... ☐64

Formal correspondence courses ..... ☐65

Informal short courses, lasting 1-2 weeks ..... ☐66

Short courses specifically targeted, presented for 4-8 hours .. ☐67

Information brochures ..... ☐68

A list of experts whom you could contact as the need for this arises ..... ☐69

Accessible library facilities ..... ☐70

Other ..... ☐71

(If OTHER, please specify) .....

4.3.2 Using the key provided, indicate the extent to which you are involved in professional activities

At least once per month = 1 At least every 6 months = 2
At least once per year = 3 At least every 5 years = 4
Not at all = 5

Lectures ..... ☐72

Seminars ..... ☐73

Congresses ..... ☐74

Ward rounds ..... ☐75

Case studies ..... ☐76

Meetings of professional associations e.g. private practitioners in your area ..... ☐77

Reading professional journals ..... ☐78

Other ..... ☐79

(If OTHER, please specify) .....

4.3.3 When did you last attend a refresher course related to your area of practice?

Within the last three months = 1
Between three and six months ago = 2
Between six months and one year ago = 3
More than a year ago = 4
Never = 5 ..... ☐80

Card [3] 1

4.3.4 When did you last attend a course on aspects related to business management?

Within the last three months = 1 Between three and six months ago = 2
Between six months and a year ago = 3 More than a year ago = 4
Never = 5 ..... [ ] 2

AFFIRM MODEL: REFFERAL

5. REFERRAL OF CLIENTS WITHIN THE PRACTICE OF THE NURSE IN PRIVATE PRACTICE

5.1 Using the key provided, indicate the extent to which clients are referred FROM your practice TO:

Frequently = 1 Sometimes = 2 Never = 3

Nurses ..... [ ] 3
Doctors ..... [ ] 4
Social workers ..... [ ] 5
Ministers of religion ..... [ ] 6
Hospitals ..... [ ] 7
Pharmacists ..... [ ] 8
Industrial health care services ..... [ ] 9
Paramedics ..... [ ] 10
Voluntary organisations ..... [ ] 11
Other ..... [ ] 12
(If OTHER, please specify) .....

5.2 Using the key provided, indicate the extent to which clients are referred TO your practice FROM:

Frequently = 1 Sometimes = 2 Never = 3

Nurses ..... [ ] 13
Doctors ..... [ ] 14
Social workers ..... [ ] 15
Ministers of religion ..... [ ] 16
Hospitals ..... [ ] 17

Pharmacists ..... ☐18

Industrial health care services ..... ☐19

Paramedics ..... ☐20

Voluntary organisations ..... ☐21

Previous clients ..... ☐22

Other ..... ☐23

(If OTHER, please specify) .....

5.3 **Using the key provided, indicate the way in which clients are referred to other members of the multidisciplinary team**

Always = 1 Frequently = 2 Sometimes = 3 Never = 4

Verbally ..... ☐24

In writing ..... ☐25

Other ..... ☐26

(If OTHER, please specify) .....

5.4 **How did clients come to hear about your practice?**

Yes = 1 No = 2 Uncertain = 3

Verbally ..... ☐27

In writing ..... ☐28

On business cards ..... ☐29

Through advertisements ..... ☐30

Other ..... ☐31

(If OTHER, please specify) .....

AFFIRM MODEL: MONITORING

6. MONITORING/EVALUATION AND CONTROL STRATEGIES IN THE PRACTICE OF THE NURSE IN PRIVATE PRACTICE

6.1 **Using the key provided, indicate the extent to which you experience problems with the following:**

Serious = 1 To a large extent = 2

To a lesser extent = 3 Not at all = 4

Financial factors (cash flow) ..... ☐ 32

Lack of business skills ..... ☐ 33

Family duties ..... ☐ 34

Insufficient support from the community ..... ☐ 35

Co-operation with doctors ..... ☐ 36

Provision of stock and equipment ..... ☐ 37

Professional support structures ..... ☐ 38

Insufficient referral systems ..... ☐ 39

Regulations and legislation ..... ☐ 40

Other ..... ☐ 41

(If OTHER, please specify) .....

6.2 Do you use any of the following methods to determine client satisfaction?
Yes = 1 No = 2

Questionnaires ..... ☐ 42

Attendance figures ..... ☐ 43

An increase in referral ..... ☐ 44

Verbal feedback ..... ☐ 45

Written feedback ..... ☐ 46

Other ..... ☐ 47

(If OTHER, please specify) .....

6.3 Using the key provided, indicate the extent to which the following institutions conduct an evaluation of your practice

Never = 1 Every six months = 2
Annually = 3 Infrequently = 4

SANC ..... ☐ 48

Official health care authorities (e.g. Department of Health) .. ☐ 49

Peer groups ..... ☐ 50

Other professional persons (e.g. Doctors) ..... ☐ 51

Other ..... ☐52

(If OTHER, please specify) .....

6.4 Are any of the following types of records used in your practice?

Yes = 1 No = 2

Appointment books ..... ☐53

Inventory records ..... ☐54

Invoice books ..... ☐55

Cash books ..... ☐56

Receipt books ..... ☐57

General ledgers ..... ☐58

Client records ..... ☐59

Medication records/registers ..... ☐60

Reference records ..... ☐61

Records of staff leave ..... ☐62

Application forms for sick leave ..... ☐63

Forms for grievances procedures ..... ☐64

Records of injuries on duty ..... ☐65

Registration with authorities ..... ☐66

Other ..... ☐67

(If OTHER, please specify) .....

6.5 Using the key provided, indicate the extent to which you regard the use of statistics important in private practice

Uncertain = 1 Unimportant = 2

Important = 3 Very important = 4 ..... ☐68

6.6 Indicate whether you make use of statistics:

Yes = 1 No = 2

For evaluation ..... ☐69

For research ..... ☐70

For later reference ..... ☐71

For submission to the local authorities or other relevant institutions ..... ☐72

Other ..... ☐73

(If OTHER, please specify) .....

7. **You are most welcome to share with me any additional remarks/comments on the study, the questionnaire or your practice.**

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

MY SINCERE APPRECIATION FOR YOUR CO-OPERATION

Oliveweg 254
Hennopspark
VERWOERDBURG
0157

30 Junie 1994

Geagte Kollega

Ek onderneem tans 'n opname vir my meestersgraad oor die praktyk van die privaatverpleegkundige in die gemeenskap. Daar blyk op hierdie stadium min inligting te wees oor die rol en bydrae van die privaatverpleegkundige in die voorsiening van gesondheidsorg.

U, as 'n sleutelpersoon in die lewering van gesondheidsdienste, word dus versoek om asseblief die aangehegte vraelys so volledig as moontlik in te vul. Dit behoort u nie langer as 45 minute te neem om dit te voltooi nie.

Alle inligting sal streng vertroulik hanteer word. Indien u enige probleme ondervind of vrae het, kontak my asseblief by Pretoria (012) 64-4398 (huis) of (012) 429-6754 (werk - 08:00-13:00).

U samewerking sal betekenisvol bydra tot die studie, maar indien u om een of ander rede nie die vraelys wil invul nie, stuur dit asseblief aan my terug.

'n Gefrankeerde, geadresseerde koevert word ingesluit vir die terugstuur van die vraelys.

Ek sal dit baie waardeer indien u die vraelys aan my sal terugstuur voor 15 Augustus 1994.

By voorbaat baie dankie dat u van u waardevolle tyd afstaan om die vraelys te voltooi en so my navorsing moontlik te maak.

Die uwe

Betsie Smith

BETSIE SMITH

Mev J E Smith	MA(Cur)

VRAELYS

DOEL VAN DIE STUDIE

'N ONDERSOEK NA DIE HEDENDAAGSE PRAKTYK VAN DIE PRIVAATVERPLEEGKUNDIGE IN DIE GEMEENSKAP

ALLE INLIGTING SAL AS STRENG VERTROULIK HANTEER WORD

INSTRUKSIES:
Beantwoord asseblief alle vrae.
Antwoord asseblief elke vraag objektief en soos dit op u van toepassing is.
Skryf telkens die toepaslike nommer in die blokkie, bv. [4][0].

[ ][ ][ ][ ] 1-4

Kaart [1] 5

AFFIRM MODEL: AVAILABILITY (Beskikbaarheid)

1. PERSOONLIKE GEGEWENS

1.1 Ouderdom in jare: ..... [ ][ ] 6-7

1.2 Geslag: Manlik = 1 Vroulik = 2 ..... [ ] 8

1.3 Huwelikstatus:
Getroud = 1 Nooit getroud = 2 Geskei = 3 Weduwee = 4 ..... [ ] 9

1.4 Aantal kinders: bv. 1 kind [0][1] ..... [ ][ ] 10-11

1.5 Oor watter van die volgende basiese verpleegkundige kwalifikasies beskik u?

Algemeen: Graadvlak = 1 Diplomavlak = 2 ..... [ ] 12

Verloskunde: Nvt = 0 Graadvlak = 1 Diplomavlak = 2 ..... [ ] 13

Psigiatrie: Nvt = 0 Graadvlak = 1 Diplomavlak = 2 ..... [ ] 14

Gemeenskapsverpleegkunde:
Nvt = 0 Graadvlak = 1 Diplomavlak = 2 Nie-graad doeleindes = 3 [ ] 15

1.6 Oor watter na-basiese verpleegkundige kwalifikasies beskik u?

Verpleegonderwys:
Nvt = 0 Graadvlak = 1 Diplomavlak = 2 Nie-graad doeleindes = 3 [ ] 16

Verpleegadministrasie:
Nvt = 0 Graadvlak = 1 Diplomavlak = 2 Nie-graad doeleindes = 3 [ ] 17

Gemeenskapsverpleegkunde:
Nvt = 0 Graadvlak = 1 Diplomavlak = 2 ..... ☐18

Ander ..... ☐19

(Indien ANDER, spesifiseer) .....

1.7 **Wat is die hoogste akademiese verpleegkunde kwalifikasie wat u behaal het? (Spesifiseer die dissipline waarin u dit behaal het)**
Diploma = 1 B-graad = 2 Honneurs = 3 Magister = 4
Doktoraal = 5 ..... ☐20

Dissipline .....

1.8 **Is u in besit van 'n nie-verpleegkundige kwalifikasie wat u in u privaatpraktyk kan help, byvoorbeeld boekhou?**
Ja = 1 Nee = 2 ..... ☐21

1.9 **Ten einde u voldoende toe te rus vir u privaatpraktyk, sou u verdere opleiding wou ontvang in:**
Ja = 1 Nee = 2

Verpleegkundige vaardighede ..... ☐22

Bestuursvaardighede ..... ☐23

Besigheidsvaardighede ..... ☐24

Onderrigvaardighede ..... ☐25

Rekenaargeletterheid ..... ☐26

(Indien ANDER, spesifiseer) .....

1.10 **Dui aan tot watter mate u na u mening voorbereiding in u basiese verpleegopleiding ontvang het vir toetrede tot die privaatpraktyk.**

Geensins = 1 Geringe mate = 2
Groot mate = 3 Baie groot mate = 4 ..... ☐27

2. BESKIKBAARHEID VAN DIENSTE

2.1 **Het u 'n behoeftebepaling gedoen voordat u die praktyk begin het?**
Ja = 1 Nee = 2 ..... ☐28
Indien NEE, gaan voort vanaf vraag 3 op p. 4.

2.2 Het u riglyne gekry oor hoe om die behoeftebepaling aan te pak uit die volgende bronne?

Ja = 1 Nee = 2

Eie navorsing ..... ☐29

Literatuur geraadpleeg ..... ☐30

Konsultasie binne verpleging ..... ☐31

Konsultasie buite verpleging ..... ☐32

Ander ..... ☐33

(Indien ANDER, spesifiseer) .....

2.3 Het u die volgende bronne gebruik om behoeftes te bepaal van die teikengroepe:

Ja = 1 Nee = 2

Sleutelpersone uit die teikengroep vir wie die diens beplan was ☐34

Ander privaatverpleegkundiges ..... ☐35

Ander lede van die gesondheidspan, bv. geneeshere, aptekers ... ☐36

Gesondheidsowerhede in u area ..... ☐37

Ander ..... ☐38

(Indien ANDER, spesifiseer) .....

2.4 Dui die aspekte aan wat in u behoeftebepaling ingesluit is:

Ja = 1 Nee = 2

Algemene beskrywing van gesondheidsbehoeftes binne die geografiese grense van u praktyk ..... ☐39

Spesifieke gesondheidsbehoeftes van die breë gemeenskap binne die geografiese grense van u praktyk met die doel om die spesifieke teikengroep vir u praktyk te bepaal ..... ☐40

Algemene en spesifieke gesondheidsbehoeftes van die teikengroep ☐41

Beskikbaarheid van ander gesondheidsdienste binne die geografiese area van u praktyk ..... ☐42

Bestaande infrastruktuur bv. vervoer ..... ☐43

Bekostigbaarheid van die reeds bestaande dienste ..... ☐44

Finansiering van die reeds bestaande dienste ..... ☐45

Potensiaal vir die groei en ontwikkeling van die diens wat u beplan ..... ☐46

aFFIRM MODEL: FORMULATION AND FACTUAL INFORMATION
(Formulering en Feitelike inligting)

3. OMVANG EN FOKUS VAN U PRIVAATPRAKTYK

3.1 Dui die redes aan waarom u tot die privaatpraktyk toegetree het.

Ja = 1 Nee = 2 Onseker = 3

Meer buigbare ure ..... ☐47

Vir finansiële gewin ..... ☐48

Om verdere ondervinding op te doen ..... ☐49

Onrealistiese werkslading in hospitale ..... ☐50

Om meer outonoom te funksioneer ..... ☐51

Om onvervulde gemeenskap- en/of kliëntbehoeftes aan te spreek ☐52

Om verhoogde kliëntkontak te bewerkstellig ..... ☐53

Om te bewys dat verpleegkundiges suksesvol kan wees in die privaatpraktyk ..... ☐54

Om standaarde van verpleegkunde en gesondheidsorg te verhoog .. ☐55

Om groter status as verpleegkundige te geniet ..... ☐56

Om 'n spesifieke verpleegteorie te toets ..... ☐57

Ander ..... ☐58

(Indien ANDER, spesifiseer) .....

3.2 Hoe lank is u al in die privaatpraktyk?

1 - 6 maande = 1 6 maande - 1 jaar = 2 1 - 2 jaar = 3

2 - 4 jaar = 4 4 - 6 jaar = 5 6 - 10 jaar = 6

10 jaar en langer = 7 ..... ☐59

3.3 Watter tipe diens word deur u praktyk aangebied?

Ja = 1 Nee = 2

Algemene verpleegsorg (medies of chirurgies) ..... ☐60

Beroepsgesondheidsdiens ..... ☐61

Geriatriese dienste ..... ☐62

Gesondheidsvoorligting ..... ☐63

Kardiale rehabilitasie ..... ☐64

Kraamdienste, insluitende tuisbevallings ..... ☐65

Moeder en kind gesondheidsorg ..... ☐66

Onkologiese verpleging ..... ☐67

Ortopediese dienste ..... ☐68

Pediatriese dienste ..... ☐69

Psigiatrie ..... ☐70

Ander ..... ☐71

(Indien ANDER, spesifiseer) .....

3.4 Gebruik die onderstaande sleutel en dui aan tot watter mate u met die volgende persone/institusies skakel:

Voltyds = 1 Deeltyds = 2 Aflos = 3 Nvt = 4

'n Hospitaalgroep ..... ☐72

'n Beroepsgesondheidsdiens ..... ☐73

'n Dokter ..... ☐74

'n Apteker ..... ☐75

'n Verpleegagentskap ..... ☐76

Ander ..... ☐77

(Indien ANDER, spesifiseer) .....

Kaart [2] 1

3.5 **Hoeveel kliënte hanteer u per dag? (gemiddeld)** ..... [ ][ ][ ] 2-4

3.6 **Bied u na-ure dienste vir kliënte, bv. kraam- en/of nooddienste?**
Ja = 1 Nee = 2 ..... [ ] 5

3.7 **Is u gedek deur enige versekering ten opsigte van u praktyk, bv. indemniteitsdekking?**
Ja = 1 Nee = 2 ..... [ ] 6

(Indien JA, spesifiseer) .....

3.8 **Is u bo en behalwe u privaatpraktyk ook nog betrokke by 'n ander werk? (Verpleegkundig of ander)**
Ja = 1 Nee = 2 ..... [ ] 7

3.8.1 **Indien JA, spesifiseer die area en dui aan of enige van die onderstaande redes u gemotiveer het in u keuse:**

Area van dienslewering .....
Ja = 1 Nee = 2

Finansieël ..... [ ] 8

Om op die hoogte te bly van sekere kliniese vaardighede en/of kennis ..... [ ] 9

Om ervaring in 'n spesifieke veld op te doen ..... [ ] 10

Vir persoonlike stimulering en bevrediging ..... [ ] 11

3.9 **Is u praktyk 'n finansiële sukses?**
Ja = 1 Nee = 2 Wisselvallig/Onseker = 3 ..... [ ] 12

3.10 **Watter van die volgende kategorieë personeel het u in diens?**
Ja = 1 Nee = 2

Professionele verpleegkundige ..... [ ] 13

Ingeskrewe verpleegkundige ..... [ ] 14

Verpleeghulp ..... [ ] 15

Ontvangsdame ..... ☐16

Boekhoudster ..... ☐17

Bode ..... ☐18

Bediende ..... ☐19

Leke hulpwerkers ..... ☐20

(Indien ANDER, spesifiseer) .....

3.11 BEVOORRADING EN TOERUSTING

3.11.1 Hoe word kliënte voorsien van toerusting, verbande, medisyne, ens?

Kliënt voorsien alles self = 1

Kliënt voorsien sommige self = 2

Verpleegkundige voorsien alles aan kliënt = 3 ..... ☐21

3.11.2 Waarvandaan bestel u u voorrade?

Altyd = 1 Soms = 2 Nooit = 3

Kleinhandel apteke ..... ☐22

Groothandel apteke ..... ☐23

Farmaseutiese firmas ..... ☐24

Ander ..... ☐25

(Indien ANDER, spesifiseer) .....

3.11.3 Op watter wyse hou u kontrole oor u voorrade?

Ja = 1 Nee = 2

Deurlopende kontrolelyste ..... ☐26

Gerekenariseerde rekordstelsel ..... ☐27

Ander ..... ☐28

(Indien ANDER, spesifiseer) .....

3.11.4 Wat sou u sien as belangrike probleme met betrekking tot die kontrole en beheer van voorrade?

Tot 'n groot mate = 1 Soms = 2 Nooit = 3

Diefstal ..... ☐29

Nie voldoende tyd vir rekordhouding van voorrade nie ..... ☐30

Oneffektiewe rekordstelsels ..... ☐31

Ander ..... ☐32

(Indien ANDER, spesifiseer) .....

3.11.5 Word elke item/diens wat deur u aan die kliënt voorsien word apart op die rekening aangedui?

Ja = 1 Nee = 2 ..... ☐33

3.12 FINANSIERING

3.12.1 Wie is gewoonlik verantwoordelik vir die betaling van die rekening wat aan die kliënt gestuur word?

Die totale koste word deur die kliënt self gedra = 1

Die grootste gedeelte word deur die Mediese skema betaal = 2

Die totale koste word deur die Mediese skema betaal = 3

Ander = 4 ..... ☐34

(Indien ANDER, spesifiseer) .....

3.12.2 Ondervind u enige probleme met die betaling vir dienste deur u gelewer?

Ja = 1 Nee = 2 ..... ☐35

(Indien JA, spesifiseer) .....

3.12.3 Op watter basis word u tarieve vasgestel?

'n Fooi vir diens = 1

'n Voorafbepaalde tarief vir 'n reeks prosedures = 2 ..... ☐36

3.12.4 Waar het u kapitaal bekom om u praktyk mee te begin?

Ja = 1 Nee = 2

'n Bankinstansie ..... ☐37

'n Bouvereniging ..... ☐38

'n Lening by 'n privaat persoon ..... ☐39

Die Kleinsake Ontwikkelingskorporasie ..... ☐40

Eie spaargeld ..... ☐41

Ander ..... ☐42

(Indien ANDER, spesifiseer) .....

3.13 Wie behartig die boekhouding van u praktyk?

Uself = 1 Boekhouer op konsultasiebasis = 2

Ouditeur op konsultasiebasis = 3 Ander = 4 ..... ☐43

(Indien ANDER, spesifiseer) .....

4. FEITELIKE INLIGTING BENODIG OM 'N PRIVAATPRAKTYK TE BEGIN

4.1 Op watter wyse word die kliënt ingelig oor tariewe en prosedures?

Ja = 1 Nee = 2

Mondeling ..... ☐44

Skriftelik ..... ☐45

Tariewelys ..... ☐46

Brosjures met inligting oor spesifieke prosedures ..... ☐47

Deur die uitstuur van rekeninge en/of fakture ..... ☐48

Ander ..... ☐49

(Indien ANDER, spesifiseer) .....

4.2 GESONDHEIDSVOORLIGTING

4.2.1 Tot watter mate word gesondheidsvoorligting aan die volgende persone/groepe in u praktyk gegee?

Nooit = 1 Soms = 2 Altyd = 3

Kinders ..... ☐50

Adolessente ..... ☐51

Ouers of gesinne ..... ☐52

Swanger vroue of vroue met babas ..... ☐53

Bejaardes ..... ☐54

Besigheids of industriële werknemers/werkgewers ..... ☐55

Welsynsgroepe of vrywillige werkers ..... ☐56

Ander ..... ☐57

(Indien ANDER, spesifiseer) .....

4.2.2 Wanneer gee u gesondheidsvoorligting aan bogenoemde persone/groepe?

Ja = 1 Nee = 2 Nvt = 3

Op versoek ..... ☐58

Per afspraak ..... ☐59

Informeel ..... ☐60

Deurlopend met verpleegsorg ..... ☐61

Na afloop van verpleegsorg ..... ☐62

4.2.3 Dui aan deur wie gesondheidsvoorligting by u praktyk aangebied word

Uself = 1 Ander = 2 ..... ☐63

(Indien ANDER, spesifiseer) .....

4.3 INDIENSOPLEIDING EN VOORTGESETTE OPLEIDING

4.3.1 Dui aan tot watter mate u meen dat die volgende belangrik is in die privaatpraktyk om u kennis op te knap.

Baie = 1 Redelik = 2 Glad nie = 3

Maandelikse byeenkomste met ander privaatverpleegkundiges ..... ☐64

Formele korrespondensie kursusse ..... ☐65

Kort informele kursusse van 1-2 weke aaneenlopend ..... ☐66

Kort gerigte kursusse vir bv. 4-8 ure per week ..... ☐67

Inligtingsbrosjures ..... ☐68

'n Lys van deskundiges wat u kan kontak indien die behoefte ontstaan ..... ☐69

Toeganklike biblioteekfasiliteite ..... ☐70

Ander ..... ☐71

(Indien ANDER, spesifiseer) .....

4.3.2 Hoe dikwels woon u die volgende besprekings van professionele belang by?

Ten minste een maal per maand = 1 Ten minste elke 6 maande = 2
Ten minste elke jaar = 3 Ten minste elke 5 jaar = 4
Glad nie = 5

Lesings ..... ☐72

Seminare ..... ☐73

Kongresse ..... ☐74

Saalrondtes ..... ☐75

Gevallebesprekings ..... ☐76

Vergaderings van professionele genootskappe bv. van privaatpraktisyns in u area ..... ☐77

Lees van professionele joernale ..... ☐78

Ander ..... ☐79

(Indien ANDER, spesifiseer) .....

4.3.3 Hoe onlangs het u 'n opknappingskursus bygewoon met betrekking tot die dissipline waarin u tans praktiseer?

Binne die laaste drie maande = 1 Tussen drie en ses maande gelede = 2
Tussen ses maande en 'n jaar gelede = 3 Meer as 'n jaar gelede = 4
Nog nooit nie = 5 ..... ☐80

Kaart [3] 1

4.3.4 **Hoe onlangs het u 'n kursus bygewoon oor finansiële aspekte verwant aan besigheidsbestuur?**

Binne die laaste drie maande = 1 Tussen drie en ses maande gelede = 2
Tussen ses maande en 'n jaar gelede = 3 Meer as 'n jaar gelede = 4
Nog nooit nie = 5 ..... ☐2

AFFIRM MODEL: REFFERAL (Verwysing)

5. KLIËNTVERWYSINGS IN DIE PRAKTYK VAN DIE VERPLEEGKUNDIGE IN DIE PRIVAATPRAKTYK

5.1 Dui aan tot hoe 'n mate kliënte VANAF u praktyk verwys word NA:

Dikwels = 1 Soms = 2 Nooit = 3

Verpleegkundiges ..... ☐3

Geneeshere ..... ☐4

Maatskaplike werkers ..... ☐5

Predikante ..... ☐6

Hospitale ..... ☐7

Aptekers ..... ☐8

Bedryfsgesondheidsdienste ..... ☐9

Paramediese persone ..... ☐10

Vrywillige organisasies ..... ☐11

Ander ..... ☐12

(Indien ANDER, spesifiseer) .....

5.2 Dui aan tot hoe 'n mate kliënte NA u praktyk verwys word DEUR:

Dikwels = 1 Soms = 2 Nooit = 3

Verpleegkundiges ..... ☐13

Geneeshere ..... ☐14

Maatskaplike werkers ..... ☐15

Predikante ..... ☐16

Hospitale ..... ☐17

Aptekers ..... ☐18

Bedryfsgesondheidsdienste ..... ☐19

Paramediese persone ..... ☐20

Vrywillige organisasies ..... ☐21

Vorige kliënte ..... ☐22

Ander ..... ☐23

(Indien ANDER, spesifiseer) .....

5.3 Gebruik die onderstaande sleutel en dui aan op watter wyse kliënte verwys word

Altyd = 1 Dikwels = 2 Soms = 3 Nooit = 4

Mondelings ..... ☐24

Skriftelik ..... ☐25

Ander ..... ☐26

(Indien ANDER, spesifiseer) .....

5.4 Hoe het kliënte van u praktyk te hore gekom?

Ja = 1 Nee = 2 Onseker = 3

Mondelingse verwysing ..... ☐27

Skriftelike verwysing ..... ☐28

Besigheidskaartjies ..... ☐29

Advertensie ..... ☐30

Ander ..... ☐31

(Indien ANDER, spesifiseer) .....

AFFIRM MODEL: MONITERING

6. MONITERING/EVALUERING EN BEHEERSTRATEGIEë IN DIE PRAKTYK VAN DIE VERPLEEGKUNDIGE IN DIE PRIVAATPRAKTYK

6.1 Dui aan tot watter mate u probleme ondervind met onderstaande faktore:

Ernstig = 1 Tot 'n groot mate = 2
Tot 'n mindere mate = 3 Glad nie = 4

Finansiële faktore ..... ☐ 32

Gebrek aan besigheidskennis ..... ☐ 33

Gesinsverpligtinge ..... ☐ 34

Onvoldoende ondersteuning van die gemeenskap ..... ☐ 35

Samewerking met geneeshere ..... ☐ 36

Bevoorrading en toerusting ..... ☐ 37

Professionele ondersteuningstruktuur ..... ☐ 38

Onvoldoende verwysingsisteme ..... ☐ 39

Regulasies en wetgewing ..... ☐ 40

Ander ..... ☐ 41

(Indien ANDER, spesifiseer) .....

6.2 Op watter wyse bepaal u kliënt tevredenheid?

Ja = 1 Nee = 2

Vraelyste ..... ☐ 42

Bywoningsyfers ..... ☐ 43

Toename in verwysing ..... ☐ 44

Mondelinge terugvoer ..... ☐ 45

Skriftelike terugvoer ..... ☐ 46

Ander ..... ☐ 47

(Indien ANDER, spesifiseer) .....

6.3 Hoe dikwels word daar deur die volgende instansies eksterne of objektiewe evaluering van u praktyk gedoen?

Glad nie = 1 Elke ses maande = 2
Jaarliks = 3 Ongereeld = 4

SA Raad op Verpleging ..... ☐48

Amptelike gesondheidsowerhede (bv. Departement Gesondheid) .... ☐49

Portuurgroepe ..... ☐50

Ander professionele persone (bv. Geneeshere) ..... ☐51

Ander ..... ☐52

(Indien ANDER, spesifiseer) .....

6.4 Meld die aard van rekords wat u in u praktyk gebruik

Ja = 1 Nee = 2

Afspraakboek ..... ☐53

Inventaris rekord ..... ☐54

Faktuurboek ..... ☐55

Joernaal ..... ☐56

Kwitansieboek ..... ☐57

Grootboek ..... ☐58

Kliënte rekords ..... ☐59

Medikasierekords/register ..... ☐60

Verwysingsrekords ..... ☐61

Verlofvorms ..... ☐62

Siekverlofvorms ..... ☐63

Griewevorms ..... ☐64

Besering aan diens rekords/vorms ..... ☐65

Registrasie met owerhede ..... ☐66

Ander ..... ☐67

(Indien ANDER, spesifiseer) .....

6.5 Tot watter mate beskou u statistieke as belangrik in 'n praktyk?

Onseker = 1 Onbelangrik = 2

Belangrik = 3 Baie belangrik = 4 ..... ☐68

6.6 Dui aan of u die statistieke soos volg benut:

Ja = 1 Nee = 2

Verwerk dit vir evaluering ..... ☐69

Gebruik vir navorsing ..... ☐70

Bewaar dit na verwerking = vir latere verwysing ..... ☐71

Stuur na plaaslike owerheid of ander relevante instansie ..... ☐72

Ander ..... ☐73

(Indien ANDER, spesifiseer) .....

7. U is welkom om enige bykomende opmerkings/kommentaar oor die studie, die vraelys of u praktyk aan my mee te deel.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

BAIE DANKIE VIR U SAMEWERKING

ANNEXURE C

REMINDING LETTER SENT TO NURSES IN PRIVATE PRACTICE WHO DID NOT RESPOND

254 Olive Road
Hennopspark
VERWOERDBURG
0157

19 August 1994

Dear Colleague

With reference to the questionnaire posted to you in July, I would like to urgently request you to complete the questionnaire and return it to me as soon as possible.

If you, for some reason (eg if you are not currently practising) do not want to complete the questionnaire, please return it to me. If you have perhaps mislaid the questionnaire or destroyed it, please contact me at telephone (012) 64-4398 and I will send you another copy.

If in the meantime, you have already completed and posted the questionnaire, please ignore this letter.

Thank you for your participation - I appreciate it.

Yours sincerely

Betsie Smith

BETSIE SMITH

Oliveweg 254
Hennopspark
VERWOERDBURG
0157

19 Augustus 1994

Geagte Kollega

Met verwysing na die vraelys wat ek in Julie aan u gepos het, wil ek 'n vriendelik, dog dringende beroep op u doen om die vraelys te voltooi en so gou moontlik aan my terug te stuur.

Indien u om een of ander rede (bv as u nie op die oomblik praktiseer nie), nie die vraelys kan of wil invul nie, stuur dit in elk geval terug. Indien u dalk die vraelys verlê of reeds vernietig het, kontak my asseblief by telefoon (012) 64-4398 sodat ek 'n ander een aan u kan pos.

Indien u intussen die vraelys voltooi en gepos het, ignoreer asseblief hierdie brief.

Baie dankie vir u samewerking - ek waardeer dit.

Die uwe

Betsie Smith

BETSIE SMITH

ANNEXURE D

RAMS RECOMMENDED BENEFIT SCHEDULE FOR SERVICES BY REGISTERED NURSES IN PRIVATE PRACTICE

REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES
VERTEENWOORDIGENDE VERENIGING VAN MEDIESE SKEMAS

NB : THIS BENEFIT SCHEDULE REPLACES ALL PREVIOUS SCHEDULES/
LW : HIERDIE VOORDELE SKEDULE VERVANG ALLE VORIGE SKEDULES

13 Dec/Des 1995
docs/rsob/96nurse

TO ALL MEDICAL SCHEMES/
AAN ALLE MEDIESE SKEMAS:

RECOMMENDED BENEFIT SCHEDULE FOR SERVICES BY REGISTERED NURSES IN PRIVATE PRACTICE, EFFECTIVE FROM 1 JANUARY 1996/AANBEVOLE VOORDELE SKEDULE VIR DIENSTE DEUR GEREGISTREERDE VERPLEEGSTERS IN PRIVAATPRAKTYK, EFFEKTIEF VANAF 1 JANUARIE 1996

This Association recommends the following fees as a guide for schemes which wish to determine the level of benefits in respect of services rendered by registered nurses/Hierdie vereniging beveel die volgende fooie, as riglyn vir skemas wat voordele ten opsigte van dienste deur geregistreerde verpleegsters wil bied, aan.

It is recommended that when such benefits are granted, the following should be clearly specified in the scheme's rules/Dit word aanbeveel dat, wanneer voordele toegestaan word, die volgende duidelik in die skemas se reëls gespesifiseer moet word.

- The annual limitation, if any, for such benefits/Die jaarlikse beperking, indien enige, vir sulke voordele.

It is recommended that schemes should consider paying accounts rendered in accordance with this schedule direct to the nurse practitioner. If accounts are rendered at rates in excess of this schedule, the applicable benefit should be paid as a reimbursement to the member/Dit word voorgestel dat skemas dit moet oorweeg om rekeninge direk aan die verpleegkundige te betaal, indien dit in ooreenstemming met die skedule gelewer is. Indien rekeninge gelewer word teen gelde wat die skedule oorskry, moet die toepaslike voordeel aan die lid betaal word.

A. GENERAL INFORMATION/ALGEMENE INLIGTING

This is a recommended benefit schedule for **registered** nurses and midwives only **(not enrolled nurses)** in private practice/Hierdie is 'n aanbevole voordele skedule slegs vir **geregistreerde** verpleegsters en vroedvroue in privaat praktyk **(nie vir ingeskrewe verpleegsters nie)**.

A registered nurse or midwife is a nurse or midwife registered with the South African Nursing Council in terms of the Nursing Act 50 of 1978 (as amended)/'n Geregistreerde verpleegster of vroedvrou is 'n verpleegster of vroedvrou geregistreer by die Suid-Afrikaanse Verpleegstersraad in terme van die Verpleegsterswet 50 van 1978 (soos gewysig).

All accounts must be presented with the following information clearly stated/Alle rekeninge moet voorgelê word en die volgende duidelik aangedui word :

- name of nurse practitioner/naam van verpleegkundige;
- qualifications of the nurse practitioner/kwalifikasies van verpleegkundige;
- RAMS practice number/VVMS praktyknommer;

3rd Floor 37 Bath Avenue Rosebank
P O Box 2324 Parklands 2121
Phones (011) 880-8900/5 Fax (011) 880-8798

3de Verdieping Bathlaan 37 Rosebank
Posbus 2324 Parklands 2121
Fone (011) 880-8900/5 Faks (011) 880-8798

- postal address and telephone number/posadres en telefoonnommer;
- date on which service/s were provided/datum waarop diens(te) gelewer is;
- applicable item codes/toepaslike itemnommers;
- diagnosis (where a consultation and/or prolonged consultation is charged)/diagnose (waar 'n konsultasie en/of verlengde konsultasie gehef word);
- the surname and initials of the member/die van en voorletters van die lid;
- the first name of the patient/die eerste naam van die pasiënt;
- the name of the scheme/die naam van die skema;
- the membership number of the member/die lidmaatskapnommer van die lid;
- where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the nurse/waar die rekening 'n fotokopie van die oorspronklike is, sertifisering deurmiddel van 'n rubberstempel of handtekening van die verpleegster; and/or
- a statement of whether the account is in accordance with the recommended benefit schedule/'n verklaring of die rekening in ooreenstemming met die aanbevole voordele skedule is.

Fees may be reduced. The time and practice pattern of a private nurse practitioner will vary and this may influence the fee charged/Fooie mag verlaag word. Die tyd en praktykpatroon van 'n privaat verpleegkundige sal wissel en dit mag die fooi wat gehef word beïnvloed.

The fees in this schedule may only be charged by the registered nurse performing the procedure/Die fooie in hierdie skedule mag slegs gehef word deur 'n geregistreerde verpleegster wat die prosedure verrig.

The **current value of the unit** (from 1 January 1996) is R3.00 including VAT. This will be reviewed every year and the revised fee will be applicable as of 1 January of every new year/Die **huidige waarde van die eenheid** (vanaf 1 Januarie 1996) is R3.00, BTW ingesluit. Dit sal elke jaar hersien word en die hersiende fooi sal van toepassing wees vanaf 1 Januarie elke nuwe jaar.

B. GENERAL RULES/ALGEMENE REëLS

1. CONSULTATION/KONSULTASIES

Consultation: This refers to a situation where the **nurse practitioner personally** takes down a patient's history, if indicated performs an appropriate health examination including observations, and plans appropriate intervention(s)/treatment. A consultation may **not** be charged where the sole purpose of the visit was to perform a procedure and no other interaction between patient and nurse practitioner took place. In all cases where a consultation is charged, a diagnosis is essential/**Konsultasies:** Dit verwys na 'n toestand waar die **verpleegkundige persoonlik** die pasiënt se geskiedenis neerskryf, indien aangedui 'n toepaslike gesondheidsondersoek wat observasie insluit uitvoer, en toepaslike intervensie(s)/behandeling beplan. 'n Konsultasie mag **nie** gehef word waar dit die enigste doel van die besoek is om 'n prosedure toe te pas en geen ander interaksie tussen pasiënt en verpleegkundige plaasvind nie. In alle gevalle waar 'n konsultasie gehef is, is 'n diagnose noodsaaklik.

Prolonged consultation: This refers to a consultation with a duration of longer than 30 minutes due to an emergency situation or the necessity for the nurse practitioner's prolonged attention to a patient. This may **not** be charged where the sole purpose of the visit was to perform a procedure and no other interaction between patient and nurse practitioner took place. In all cases where a prolonged consultation is charged, a diagnosis is essential, as well as the time spent/**Verlengde konsultasie:** Dit verwys na 'n konsultasie met 'n tydsduur van langer as 30 minute as gevolg van 'n noodsituasie of die noodsaaklikheid vir die verpleegkundige se verlengde aandag aan die pasiënt. Dit mag **nie** gehef word waar die enigste doel van die besoek was om 'n prosedure te doen en geen ander interaksie tussen die pasiënt en die verpleegkundige plaasgevind het nie. In alle gevalle waar 'n verlengde konsultasie gehef word, is 'n diagnose noodsaaklik, sowel as die tyd gespandeer.

2. NORMAL HOURS AND AFTER HOURS/NORMALE URE EN NA-URE

Normal working hours refer to the period 08h00 to 17h00 on Mondays to Fridays and the period 08h00 to 13h00 on Saturdays. IT INCLUDES all other periods voluntarily scheduled (even when for the convenience of the patient) by a nurse practitioner eg evening clinics/Normale werksure verwys na die periode 08h00 tot 17h00 op Maandae tot Vrydae en die periode 08h00 tot 13h00 op Saterdae. DIT SLUIT alle ander periodes vrywilliglik geskeduleer deur die verpleegkundige IN (selfs wanneer dit vir die pasiënt se gerief is) bv aandklinieke.

After hours applies to all other periods including public holidays on which involuntary scheduled work is performed and where a nurse has to travel to the patient. This includes travel from the nurse's home to the consulting rooms/Na ure is van toepassing op alle ander periodes, insluitend publieke vakansiedae waarop onvrywillige geskeduleerde werk verrig word en waar 'n verpleegster moet reis na die pasiënt. Dit sluit die reis vanaf die verpleegster se huis tot by die spreekkamers in.

The fee for after hours shall be the total fee plus 50 percent. Modifier 0001 to be quoted/Die fooi vir na-uurse werk sal die totale fooi plus 50 persent wees. Wysiger 0001 moet gemeld word.

3. PROCEDURES/PROSEDURES

If a procedure is performed at the time of a consultation, the fee for the consultation plus the fee for the procedure(s) is charged/As 'n prosedure uitgevoer is tydens a konsultasie, is die fooi vir die konsultasie plus die fooi vir die prosedure(s) hefbaar.

The fee in respect of more than one procedure performed at the same time during a consultation shall be the fee in respect of the major procedure plus five units in respect of each subsidiary or additional procedure. If the procedure fee is less than five units, the lower fee shall be charged. Modifier 0002 to be quoted/Die fooi van toepassing op meer as een prosedure wat tydens dieselfde tyd as 'n konsultasie uitgevoer is, sal die fooi wees ten opsigte van die hoof prosedure plus vyf eenhede in geval van elke bykomende of addisionele prosedure. Indien die prosedure minder as vyf eenhede is, moet die laagste fooi gehef word. Wysiger 0002 moet gemeld word.

4. FEES/FOOIE

The fee that may be charged in respect of rendering a service not listed in this benefit schedule shall be based on the fee in respect of a comparable service. Modifier 0003 to be quoted/Die fooi wat gehef mag word vir 'n diens wat gelewer is en wat nie gelys is in hierdie voordele skedule nie sal gebaseer word op die fooi van toepassing op 'n soortgelyke diens. Wysiger 0003 moet getoon word.

Unless timely steps are taken to cancel an appointment for a consultation the relevant fee shall be charged. Timely shall mean up to 12 hours prior to the appointment. The patient shall be informed that a cancellation fee will be charged at the time of making an appointment. Each case shall however be considered on merit and if circumstances warrant no fee shall be charged/Tensy vroegtydige reëlings getref word vir die kansellasie van 'n konsultasie sal die toepaslike fooi gehef word. Vroegtydig sal beteken op tot 12 ure voor die afspraak. Die pasiënt sal in kennis gestel word dat 'n kansellasiefooi gehef sal word wanneer die afspraak gemaak word. Elke geval sal egter op meriete oorweeg word en indien omstandighede dit regverdig, sal geen fooi gehef word nie.

No additional fees may be charged for any procedure done by staff employed by registered nurses or midwives/Geen addisionele fooie mag gehef word vir enige prosedure wat deur die personeel in diens van die verpleegsters of vroedvroue gedoen is nie.

In exceptional cases where the fee is disproportionately low in relation to actual services rendered by a nurse practitioner, a higher fee may be negotiated/In uitsonderlike gevalle waar die fooi uitermatig laag is in vergelyking met die diens deur die verpleegkundige, mag ooreengekom word vir 'n hoër fooi.

Where interest is charged on outstanding accounts this is to be borne by the client and not the medical aid/Waar rente gehef word op uitstaande rekeninge moet dit deur die pasiënt gedra word en nie deur die mediese skema nie.

5. COST OF MATERIALS, MEDICINE AND LOTIONS/KOSTE VAN MATERIAAL, MEDISYNE EN VLOEIMIDDELS

Single items below R1 150.00 (VAT included) may be charged for at cost price plus 20%. The charges for medicine used in treatment are not to exceed the retail ethical price list/Enkele items minder as R1 150.00 (BTW ingesluit) mag gehef word teen kosprys plus 20%. Die kostes vir medisyne gebruik tydens behandeling moet nie die kleinhandelsprys in die etiese pryslys oorskry nie.

For single items in excess of R1 150.00 (VAT included), cost plus 10% may be charged to a maximum of R1 710.00 (inclusive of VAT). The code 0201 is to be quoted/Vir enkele items meer as R1 150.00, mag koste plus 10% gehef word tot 'n maksimum van R1 710.00 (BTW ingesluit) Die kode 0201 moet getoon word.

6. EQUIPMENT HIRE/HUUR VAN TOERUSTING

In cases where a registered nurse is hiring her equipment to a patient this may be charged for under code 88302. If equipment hire is chargeable, exact details of the said equipment must be indicated on the account/In gevalle waar 'n geregistreerde verpleegster haar toerusting verhuur aan die pasiënt mag dit onder kode 88302 gehef word. Indien toerusting verhuur word, moet die presiese besondhede van die toepaslike toerusting op die rekening getoon word.

7. MIDWIFERY/VERLOSKUNDE

When a registered midwife treats a patient in the antenatal period and after starting the confinement requests a doctor to take over the case, the registered midwife shall calculate the units of her fee for work done thus far including/Wanneer 'n geregistreerde vroedvrou 'n pasiënt behandel in die voorgeboortelike periode en na die begin van die bevalling 'n dokter vra om die geval oor te neem, sal die geregistreerde vroedvrou die eenhede van haar fooi bereken vir die werk wat sover gedoen is insluitend :

- for all antenatal consultations she has performed/vir alle voorgeboortelike konsultasies wat sy gedoen het
- for visits to the patient during confinement, with a maximum of three visits/vir besoek aan die pasiënt gedurende die bevalling met 'n maksimum van drie besoeke

Where intravenous infusions (including blood or blood cellular products) are administered as part of the after treatment after confinement, no extra fees will be charged as this is included in the global maternity fees. Should the midwife attending to the maternity case prefer to ask a medical practitioner to perform intravenous infusion, then the midwife (and not the patient) is responsible for remunerating such practitioner for the infusions/waar binneaarse infusie (bloed- of bloedselvorming produkte ingesluit) geadministreer word as deel van die nabehandeling na bevalling, mag geen ekstra fooie gehef word nie omdat dit ingesluit is in die globale kraamfooie. Sou die vroedvrou wat die kraamgeval bywoon verkies om 'n mediese praktisyn te vra om die binneaarse infusie te verrig, is die vroedvrou (en nie die pasiënt) verantwoordelik vir die betaaling van sodanige praktisyn se infusie.

The Global Obstetric Fee of 188 units (R564.00) is to be charged where the midwife attends the entire four stages of delivery and includes the 6 weeks postnatal visit. Code 88403 to be quoted/Die Globale Obstetriese Fooi van 188 eenhede (R564.00) moet gehef word waar die vroedvrou alvier stadiums van die bevalling bywoon en sluit die 6-weeklikse nageboorte besoek in. Kode 88403 moet getoon word.

8. TRAVEL FEE/REISGELDE

In cases where the nurse practitioner has to travel to the patient, 5 units should be added to the consultation or procedure (if a consultation was not performed) and the account should specify that the consultation/procedure was conducted at the patient's home/In gevalle waar die verpleegkundige moet reis na die pasiënt, moet 5 eenhede bygevoeg word by die konsultasie of prosedure (indien 'n konsultasie nie plaasgevind het nie) en die rekening moet spesifiseer dat die konsultasie/prosedure by die pasiënt se woning plaasgevind het.

Where stomaltherapy is not provided as a hospital service a stomaltherapist may charge 5 units for travelling to treat a hospitalised patient. Modifier 0004 to be quoted/Waar stomalterapie nie as 'n hospitaaldiens verskaf word nie, mag 'n stomalterapeut 5 eenhede vir reisgelde hef om 'n pasiënt in die hospitaal te behandel. Wysiger 0004 moet getoon word.

MODIFIERS/WYSIGERS

0001 The fee for after hours shall be the total fee plus 50%/Die fooi vir na-ure sal die totale fooi plus 50% wees.

0002 Only 5 units in respect of subsidiary/additional procedures may be charged/Slegs 5 eenhede mag gehef word ten opsigte van bykomende/addisionele prosedures.

0003 Fee for similar procedures/fees not listed in the recommended benefit schedule/Fooi vir soortgelyke prosedures/fooie wat nie gelys is in die aanbevole voordele skedule nie.

0004 Travel by a stomaltherapist to treat a hospitalised patient/Reis deur 'n stomalterapeut om 'n pasiënt in hospitaal te besoek.

NOTE : VAT INCLUDED/LET WEL : BTW INGESLUIT

REGISTERED NURSES GUIDE TO FEES/
GEREGISTREERDE VERPLEEGSTERS LEIDRAAD TOT GELDE

Item No Item Nr	Procedure/ Prosedure	Units/ Eenhede	R
	CONSULTATIONS (the Pathology/Diagnosis must be stated)/ **KONSULTASIES** (die Patologie/Diagnose moet getoon word)		
88001 88002	Consultation (minimum 30 minutes)/Konsultasie (minimum 30 minute) .. Prolonged consultation after 30 minutes (5 units for every 15 minutes of part thereof)/Verlengde konsultasie na 30 minute (5 eenhede vir elke 15 minute of deel daarvan)	12	36.00
	HEALTH EDUCATION/HEALTH GUIDANCE/ GESONDHEIDSONDERRIG/GESONDHEIDSLEIDING		
88010	In group, per person, per 30 minutes/In groep, per persoon, per 30 minute	2	6.00

Item No Item Nr	Procedure/ Prosedure	Units/ Eenhede	R
	SPECIMENS/MONSTERS This must form part of a consultation where a consultation is charged. Where a consultation was not performed and the nurse attended to the patient with the sole purpose of obtaining a specimen, the item code 88020 is to be used/Dit moet deel vorm van 'n konsultasie. Waar 'n konsultasie nie plaasgevind het nie en die verpleegster die pasiënt behandel het met die uitsluitlike doel om 'n monster te bekom, moet item kode 88020 gebruik word.		
88020	Specimens - obtaining, care and despatching to laboratory or using own machine to test - state type/Monsters - verkryging, sorg en versending na laboratorium of gebruik van eie masjien vir toets - meld tipe	6	18.00
88025	**OBSERVATIONS/OBSERVASIES** This must form part of a consultation where a consultation is charged. Where a consultation was not performed and the nurse attended to the patient with the sole purpose of doing an observation, the item code 88025 is to be used/Dit moet deel vorm van 'n konsultasie waar 'n konsultasie gehef word. Waar 'n konsultasie nie plaasgevind het nie en die verpleegster behandel die pasiënt uitsluitlik om observasie te doen moet item kode 88025 gebruik word	6	18.00
88030	**ADMINISTRATION OF MEDICATION/ TOEDIEN VAN MEDIKASIE** This must form part of a consultation where a consultation is charged. Where a consultation was not performed and the nurse attended to the patient with the sole purpose of administering medication, the item code 88030 is to be used, and the route of administration of medication to be stated/Dit moet deel vorm van 'n konsultasie waar 'n konsultasie gehef word. Waar 'n konsultasie nie plaasgevind het nie en die verpleegster behandel die pasiënt uitsluitlik om medikasie toe te dien moet item kode 88030 gebruik word	6	18.00
	CARE OF WOUNDS (The pathology must be stated)/ **VERSORGING VAN WONDE** (Die patologie moet getoon word)		
88040	Treatment of simple wounds/burns requiring dressing only/Behandeling van eenvoudige wonde/brandwonde wat slegs verbinding benodig	12	36.00
88041	Treatment of extensive wounds/burns requiring extensive nursing management eg irrigation, etc/Behandeling van omvattende wonde/ brandwonde wat omvattende verplegingsbestuur benodig bv uitspoeling ens	17	51.00
88042	Treatment of moderate wounds/drains or fistulas/Behandeling van matige wonde/dreinerings of fistel	15	45.00

Item No Item Nr	Procedure/ Prosedure	Units/ Eenhede	R
	RESPIRATORY SYSTEM/RESPIRATORIESE STELSEL		
88050	Nebulization/Inhalation/Nebulisasie/Inaseming	5	15.00
88051	Tracheostomy care/Tragеotomiese sorg	10	30.00
88052	Peak flow measurement/Spitsvloeimetings	4	12.00
	For ICU trained nurses registered with SANC and nurses working in the occupational health setting only/Slegs vir ISE opgeleide verpleegsters geregistreer by SAVR en verpleegsters werksaam in die arbeidsgesondheids-omgewing :		
88053	Flow volume test: inspiration/expiration using ELF/similar machine/ Vloei volume toets: inaseming/uitaseming gebruik van ELF/soortgelyke masjien	17	51.00
	CARDIO-VASCULAR SYSTEM/ KARDIO-VASKULÊRSTELSEL		
88060	Cardiopulmonary resuscitation/Kardiopulmonologie resussitasie	30	90.00
88061	Performing ECG only/Slegs EKG uitgevoer	6	18.00
	For ICU trained nurses registered with SANC only. A medical practitioner must be available in the event of a resuscitation being required/Slegs vir ISE opgeleide verpleegsters geregistreer by SAVR. 'n Mediese praktisyn moet teenwoordig wees in geval 'n resussitasie benodig word :		
88062	Effort test - bicycle/Inspanningstoets - fiets	22	66.00
88063	Effort test - multistage treadmill/Inspannings toets - meerfasige trapmeul	50	150.00
	MUSCULOSKELETAL SYSTEM/ SPIER-SKELETSTELSEL		
88070	Application/removal splints, traction and prosthesis/Aanwend/ verwydering van splinte, traksie en prostese	5	15.00
	GASTRO INTESTINAL SYSTEM/ MAAGDERMSTELSEL		
88080	Nasogastric tube insertion, feeding or removal/Nasogastriese buis inplasing, voeding of verwydering	5	15.00
88081	Colonic lavage/Dikderm uitspoeling	14	42.00
88082	Enema administration (retained/disposable)/Toedien van lawement	12	36.00
88083	Aspiration of stomach + /- gastric lavage/Aspirasie van maag +/- gastriese uitspoeling	9	27.00
88084	Faecal impaction/manual removal/Fesesimpaksie/manuaal verwydering	11	33.00

Item No Item Nr	Procedure/ Prosedure	Units/ Eenhede	R
	URINARY SYSTEM/URIENSTELSEL		
88090	Any urinary tract procedure including catheterisation, bladder stimulation and emptying/Enige urinêre prosedure, kateterisasie, blaas stimulasie en lediging ingesluit	12	36.00
88091	Condom catheter application, penile dressing, catheter care including bag change or catheter removal/Kondoomkateter aanwending, peniele verbinding, katetersorg, vervanging van sak of kateter verwydering ingesluit	5	15.00
88092	Daily peritoneal dialysis/Daaglikse peritoneale dialise	22	66.00
88093	Incontinence mangement (30 minutes)/Beheer van inkontinensie (30 minute)	12	36.00
	This fee includes intermittent catheterisation, external sheath drainage, taking of history, providing literature and teaching/Hierdie fooi sluit intermitterende kateterisasie, eksterne kondoom dreinering, neem van geskiedenis, voorsiening van literatuur en onderrig.		
	GENERAL CARE/ALGEMENE SORG		
88100	This includes all aspects of elementary or general nursing care performed at a patient's home which may include : Bath/ bedbath, getting patient out of bed, making of bed, hairwash, mouth hygiene, nail care, shave, put patient back to bed, pressure area care, per visit/Dit sluit alle aspekte van elementêre of algemene verplegingsorg in wat by die pasiënt se woning plaasvind en wat die volgende mag insluit: Bad/bedbad, om pasiënt uit die bed te help, opmaak van bed, haarwas, mondhigiene, naelsorg, skeer, pasiënt in die bed te plaas, druk area sorg, per besoek	21	63.00
	STOMALTHERAPY NURSING/ STOMALTERAPIE VERPLEGING **Recommended for stomaltherapy trained registered nurses who are members of SASA and working as private practitioners/Aanbeveel vir opgeleide stomalterapie geregistreerde verpleegsters wat lid is van SASV en werk as privaat praktisyns**		
88200	Simple stomal management including stomal haemorrhage, treatment of stomal encrustation/dermatological complications/ Eenvoudige stomal bestuur, stomal bloedingsterapie of stomal onderrig ingesluit	5	15.00
88201	Complex stomal management and sphincter saving procedures, including Mainz, Indiana, Kock and ileoanal pouches, vesi- /nephrostomy management and fistula management/Gekompliseerde stomal bestuur en sfinkter besparingsprosedure, insluitend Mainz, Indiana, Kock en ileoanal sakkies, vesi-/nefrostomie bestuur en fistelbestuur	10	30.00
88203	Global Stomaltherapy Fee/Globale Stomalterapie fooi	136	408.00
	This fee includes 5 post-operative and 2 clinic visits and travelling/Hierdie fooi sluit 5 na-operatiewe en 2 kliniek besoeke en reiskostes in.		

Item No Item Nr	Procedure/ Prosedure	Units/ Eenhede	R
	HIRE OF EQUIPMENT/HUUR VAN TOERUSTING		
88302	Equipment hire - daily. Exact details of the equipment must be indicated/Toerusting huur - daagliks. Presiese besonderhede van die toerusting moet aangetoon word	6	18.00
	FEMALE REPRODUCTIVE SYSTEM/MIDWIFERY/ VROULIKE VOORPLANTINGSTELSEL Ante natal visits/family planning/post natal visits are to be charged for under consultations and prolonged consultations/ Voorgeboortelike besoeke/familie beplanning/nageboortelike besoeke moet gehef word onder konsultasies en verlengde konsultasies. For all stages of labour after hours fees are to be calculated according to modifier 0001 to a maximum of 25 units/Vir alle stadiums van bevalling na-ure moet die fooi bereken word volgens wysiger 0001 tot 'n maksimum van 25 eenhede. When a registered midwife treats a patient in the ante-natal period and after starting the confinement requests a doctor to take over the case, the registered midwife shall calculate the units of her fee to a maximum of R526.40 for work done thus far as follows/Wanneer 'n geregistreerde vroedvrou 'n pasiënt in die voorgeboortelike periode behandel en na die begin van die bevalling 'n dokter vra om die geval oor te neem, sal die geregistreerde vroedvrou die eenhede van haar fooi bereken tot 'n maksimum van R526.40 vir die werk gedoen tot sover as volg :		
88400	**First Stage Monitoring** (max 10 hours), per hour/**eerste stadium monitering** (maks 10 ure), per uur	16	48.00
88401	**Second and Third stage labour**. Vaginal delivery including episiotomy/tear and repair and general obstetric care/**Tweede en derde stadium kraam**. Vaginale bevalling insluitend skedesnit/skeur en herstel en globale obstetriese sorg	176	528.00
88402	**Fourth Stage/Vierde stadium**	16	48.00
88403	**Global Obstetric Fee/Globale Obstetriese Fooi :**	188	564.00
	This is charged where the midwife managed the entire four stages of delivery, and includes the six week postnatal visit/Dit word gehef waar die vroedvrou die volledige vier stadiums van bevalling gehanteer het, en sluit die ses weeklike nageboortelike besoek in. **For advanced midwives registered with SANC only/Slegs vir gevorderde vroedvroue geregistreer by SAVR:**		
88404	Cardiotocography - maximum three times per pregnancy/Kardiotokografie - maksimum drie keer per swangerskap	13	39.00
88405	Phototherapy, per day (maximum of 3 days)/Fototerapie, per dag (maksimum van 3 dae)	20	60.00

Item No Item Nr	Procedure/ Prosedure	Units/ Eenhede	R
	PSYCHIATRY/PSIGIATRIE		
	Only for nurses with a psychiatric qualification registered with SANC/Slegs vir verpleegsters met psigiatriese kwalifikasies geregistreer by SAVR:		
	Interview/Assessment, per hour/Onderhoud/Waardebepaling, per uur		
88500	Individual adult/child/school/employer / Individuele volwassene/kind/ skool/ werkgewer	26	78.00
	Psychiatric Nursing Therapy per therapeutic hour (ie 50 minutes)/Psigiatriese verpleegingsterapie per terapeutiese uur (dws 50 minute):		
	Suggested minimum qualification for specialised therapy: specialisation in area claimed eg play therapy, nurse has a masters degree in child and adolescent psychiatry/Voorgestelde minimum kwalifikasie vir gespesialiseerde terapie: spesialisasie in area geëis bv speel-terapie, verpleegster het 'n meestersgraad in kind en adolessente psigiatrie.		
88501	Individual therapy/Individuele terapie	40	120.00
88502	Family/marital/group per patient - specify number/Familie/huwelik/ groep per pasiënt	8	24.00
88503	Play therapy/Home stimulation programme/Speelterapie/Tuis stimulise-rings program	22	66.00
88504	Co-therapist/Mede terapeut	22	66.00

PROF A D ROTHBERG
DIRECTOR: POLICY AND PROFESSIONAL LIAISON
DIREKTEUR: BELEID EN PROFESSIONELE SKAKELING