1. Public Health Facilities audit results: Office of Health Standards Compliance (OHSC) briefing

2. Chairperson: Ms M Dunjwa (ANC)

3. Date of Meeting: 16 March 2016

4. Summary

The Office of Health Standards Compliance (OHSC) presented its 2014/15 findings on health facilities in South Africa. Approximately 10% of all healthcare facilities in the country were inspected, although the OHSC’s aim is to inspect 25% of the facilities. The report focused on the Primary Healthcare Clinics (PHCs) and hospitals (including central and district hospitals). Common to all facilities were challenges regarding patient safety being compromised, good pharmacy practice (GPP) not being adhered to, waste mismanagement, lack of cleanliness, as well as poor maintenance of grounds and equipment. There was some evidence of good practice however that included adequate signage for healthcare facilities, and some facilities had good storage records, cleanliness and waste disposal management.

The compliance judgement framework used to analyse the facilities uses a six-tier system from A to F, where A is the top grade and F is the poorest grade. The criteria by which the institutions are judged includes leadership and corporate governance, patient safety, public health and operational management, to name a few. Overall, the poorest ranked provinces were Limpopo and the Eastern Cape and the best provinces were Gauteng and KwaZulu-Natal. The best hospital was found to be Steve Biko Academic Hospital in Gauteng and the worst was De Aar Hospital in the Northern Cape.

PHCs and hospitals face many challenges yet across the board the issue seems to be with leadership and corporate governance above all else. The OHSC stressed the importance of how poor management and leadership has negatively affected healthcare facilities. With respect to hospitals, the best performing province was KwaZulu-Natal and the worst was Limpopo. The average scores for hospitals across the nine provinces varied from the lowest, which was Limpopo at 37% to Gauteng at 58%.

During the discussion, Members repeatedly questioned what the recommendations from the OHSC would mean for institutions that did not comply. Members all expressed concern about the consequences for non-compliance and the provincialisation of metros was raised. Members said that provincialising metro clinics may be a way to better healthcare services as the mandate will become clearer. Discussion centred on the powers of the OHSC and the OHSC urged the Committee to push for the promulgation of standards to create a firm legislation. This promulgation would ensure that non-compliance could be acted upon by the OHSC and the Minister of Health to ensure that healthcare facilities are run correctly.

5. Minutes
Office of Health Standards Compliance (OHSC) findings on health facilities in South Africa

Mr Bafana Msibi, acting Chief Executive Officer: OHSC, spoke about the 417 health establishments covered in the 2014/15 financial year. Seventy-two were in the Eastern Cape, thirty-four in the Free State, eighty in Gauteng, fifty-one in KwaZulu-Natal, fifty-eight in Limpopo, twenty-nine in Mpumalanga, sixty-three in the North-West, thirty-eight in the Northern Cape and thirty-nine in the Western Cape; all chosen randomly. These numbers account for approximately 10% of all healthcare establishments in the country that were audited. The inspections done by the Office of Health Standards Compliance (OHSC) are done for the records of inspections to have written evidence and minutes to foster accountability and generate legal compliance and institutional memory. The types of documentation are through observation measures, interviews, and testing to determine the standards of an institution.

Problems with Clinics

The institutions assessed in this report are Public Health Clinics (PHCs), District Hospitals and Other Hospitals. The broad problems picked up in the report are that the policies given to guide staff are either not available or are outdated entirely. In Mpumalanga there is an issue of expired medication remaining on shelves, test tubes and other usable equipment are also expired. Generally, it was noted that Good Pharmacy Practice (GPP) was not followed as evident through the use of expired test tubes in PHCs. Patients were not treated with respect and their privacy was reported to be compromised as they were being tested and consulted in open areas and not behind closed doors. In some cases, the privacy and confidentiality of patients would be compromised, as they would have as many as four consultations at the same time in the same room.

The report noted that some of the medication was not dispensed according to the Pharmacy Act. The medication is to be issued with the correct labels that advises the patient on the treatment. Moreover, medication was not locked away in cupboards, which is not in line with GPP and some of that medication was stocked on the floor, which is a safety hazard. The protocols on infection prevention and control practices were not adhered to such an extent that unsterilised instruments were used on patients. GPP was further not adhered to as food was stored in the fridges intended for medication storage. Patient safety was further compromised as protocols relating to the drug register and Schedule 5 drugs were not recorded and up to date, which indicates a lack of oversight. The final concern with PHCs is the safety of patients not being assured as the equipment is not properly stored and managed such that the resuscitation trolleys were not properly stored.

Concerns with Hospitals

Mr Msibi highlighted the myriad of issues with hospitals. The procedures to manage queues and waiting times were not followed and no triage was followed in these areas. In hospitals such as Mamelodi District Hospital, the respect and dignity of patients was compromised as patients were found to be sleeping on the floor and left unattended. Patient safety was found to be compromised with improvisation of equipment, as well as a lack of emergency preparedness for patients in emergency circumstances. In terms of GPP, there was an issue with the expiration of medication, where the expiration dates of the medication had been manually changed by staff, particularly at Charlotte Maxeke Hospital in Gauteng. In post-natal care, situations were recorded where two babies were put in the same incubator – indicating that the hospitals were too full.

Other issues recorded were the poor storage of medical records, particularly at De Aar Hospital in the Northern Cape. Sharps were not safely managed and disposed correctly; there was a large deal of waste mismanagement noted. In other circumstances, grounds around the hospitals were not well-maintained: it was found that was was redundant furniture and medical equipment. There was a great deal of poor waste disposal and storage of general waste recorded, particularly at Charlotte Maxeke Hospital. It was recorded that many hospitals had the entirely wrong cleaning equipment than what is designated specifically for hospital cleaning. At De Aar Hospital, cleanliness was a big issue as it was found that the ablution facilities were very dirty and that there was generally poor maintenance at De
Aar and Mamelodi Hospitals.

Evidence of Good Practice: Public Health Clinics (PHCs):
With respect to good practice in PHCs, it was found that there was, overall, good signage about the services offered at PHCs. Particularly in the Zululand District it was found that the grounds were well maintained, medical waste was properly stored and there were very clean ablution facilities. It was found that there was good practice in terms of notices of danger and warning and as well as many clinics adhering to GPP, particularly in Warden and Driefontein in KwaZulu-Natal.

Evidence of Good Practice: Hospitals:
It was found that with respect to good practice in hospitals that there was adequate signage to access hospitals. It was commended that there was the correct cleaning equipment, as well as clean facilities at Holy Cross Hospital in the Eastern Cape, upon which there has been improvement since the last recommendation. It was found that Inkosi Albert Luthuli Central Hospital in KwaZulu-Natal had clean facilities, too. Steve Biko Academic Hospital in Gauteng was noted for having a good system for the storage of medical records. In terms of medicine management and GPP, Oudtshoorn Hospital was noted as having a commendable achievement. Oudtshoorn was also noted for having adopted, of their own accord, a surgical safety checklist for theatre practice from the World Health Organisation (WHO). Patient safety was assured at Bongani Regional Hospital in the Free State in terms of adequate handrail support in ablution facilities as well as having the correct plug safety covers.

Compliance judgement framework:
This section dealt with how the institutions were measured and judged in terms of their compliance. There are six levels, from A to F where A is the best and F is the worst possible ranking. Less than 20% of institutions are inspected by the OHSC and this entails four yearly inspections of the chosen institutions. Those ranked at levels E and F are considered to be non-compliant with the standards, and those at level F are advised for enforcement actions.

The Eastern Cape has no grade A or B institutions, but it has forty clinics and one central hospital currently ranked in grade F. The Free State has no A grade institutions but it has one regional hospital ranked in grade B. Gauteng has five clinics and three central hospitals ranked in grade A. Limpopo is problematic because it has forty-three clinics, two central hospitals and one district hospital in grade F. The Western Cape has eight clinics in grade F, and one central hospital in grade A.

Healthcare institutions are measured and ranked through a number of mechanisms including: patient rights, patient safety/clinical governance/clinical care, clinical support services, public health, leadership and corporate governance, operational management, and facilities and infrastructure. These systems work to create an overall picture of how the institutions function. The best clinic was Rosslyn Clinic in Gauteng and the worst clinic was Umhlanga Clinic in KwaZulu-Natal. The best hospital is Steve Biko Academic Hospital in Gauteng and the worst hospital is De Aar Hospital in the Northern Cape. De Aar Hospital only scored 37% in its inspection with problems mainly relating to management throughout the hospital.

Clinic performance:
The measurements of clinic performance are: patient rights, patient safety/clinical governance/clinical care, clinical support services, public health, leadership and corporate governance, operational management, and facilities and infrastructure.
The problems affecting the provinces are as follows:
• Eastern Cape: leadership and corporate governance, and public health.
• Free State: public health, and leadership and corporate governance.
• Gauteng: operational management.
• KwaZulu-Natal: public health.
• Limpopo: leadership and corporate governance, public health and patient safety.
• Mpumalanga: operational management, and facilities and infrastructure.
• North West: leadership and corporate governance, and operational management.
• Northern Cape: leadership and corporate governance, and operational management.
• Western Cape: public health.

Clinic priority areas:
The clinics all need to improve in some way. The areas to be improved for the provinces are as follows:
• Eastern Cape: cleanliness, and improve patient safety.
• Free State: cleanliness, and improve patient safety.
• Gauteng: cleanliness, and improve the availability and supply of medicines.
• KwaZulu-Natal: improve the availability and supply of medicines and improve patient safety.
• Limpopo: cleanliness, infection prevention and control, positive and caring attitudes, improve patient safety and availability and supply of medicines.
• Mpumalanga: availability and supply of medicines, and cleanliness.
• North West: cleanliness.
• Northern Cape: availability and supply of medicines, and cleanliness.
• Western Cape: patient safety and security.

Clinic performance scores:
In the Free State, of twenty-five clinics inspected, eight of those clinics ranked between 40-49%. In the Eastern Cape, of the sixty-five clinics inspected, a whopping thirty-two clinics were ranked between 30-39%, with sixteen clinics performing between 40-49%. Gauteng performed well as it had one clinic performing between 90-99% and four clinics performing between 80-89%. The Western Cape had only one clinic performing between 70-79%, with the majority of clinics (sixteen of them) performing between 40-49%. KwaZulu-Natal performed mostly in the upper ranges with only one clinic performing between 10-19%. Limpopo was problematic with thirty of its fifty inspected clinics performing between 30-39% and with thirteen performing between 20-29%, indicating the severity of the problem in Limpopo. Mpumalanga was not much better as thirteen of its twenty-five inspected clinics performed between 30-39%.

Hospital performance scores:
District hospital performance indexes indicated that ten of the twenty-seven district hospitals scored less than 50%, with the majority sitting between 50-79%. These district hospitals scored the following:
• Klerksdorp (NW): 82%
• Surtie (NC): 55%
• Dihlabeng (FS): 75%
• Bongani (FS): 59%
• Kafaund (G): 66%
• Edendale (KZN): 81%
• Mahatma Gandhi (KZN): 72%
• Port Shepstone (KZN): 82%
• Tshilidzini (L): 62%
• Pietersburg (L): 61%

It is clear that KwaZulu-Natal is the strongest performing province and the weakest province is Limpopo.

These central hospitals scored the following:
• Universitas: 62%
• Charlotte Maxeke: 72%
• Dr George Mukhari Academic: 62%
• Steve Biko Academic: 96%
• Chris Hani Baragwanath: 71%
• Nelson Mandela Academic: 62%
• Inkosi Albert Luthuli: 89%
• King Edward VIII: 66%
• Groote Schuur: 88%
• Tygerberg: 73%

The OHSC averaged out the scores for the provinces with respect to their hospitals and they scored as follows:
• Eastern Cape: 42%
• Free State: 49%
• Gauteng: 58%
• KwaZulu-Natal: 52%
• Limpopo: 37%
• Mpumalanga: 44%
• North West: 43%
• Northern Cape: 42%
• Western Cape: 47%

Discussion
Dr W James (DA) questioned the regulatory framework in place at healthcare institutions. He said that with respect to waste removal, often the wrong people are trained and that nurses should be briefed about waste removal and not the cleaners because the problem starts with the nurses. He asked whether the recommendations that come out of the analysis are adhered to by the institutions and he questioned what becomes of the recommendations after the report. Dr James also commented on the appointments of the board members of the OHSC and said that in favour of fairness, the members should be independently appointed rather than the Minister of Health making those appointments.

Dr H Volmink (DA) mentioned that he was disturbed by the findings, yet he commended the OHSC on their work. He mentioned that leadership and corporate governance is clearly the problem with under-performing healthcare institutions. He believed that the OHSC is not sufficiently resourced or empowered to ensure full compliance with its recommendations, yet he asked how, in terms of the National Health Act, might the OHSC be able to issue a notice of non-compliance and what would happen subsequently.

Dr H Chewane (EFF) seconded Dr Volmink’s questions about what happens to those institutions who do not comply with the standards. He commented on the patients lying on hospital floors and said it was a common occurrence. He noted that the PHCs where patients may be denied ARVs, are the very same clinics that have expired ARVs. Dr Chewane also mentioned that they have heard complaints about the attitudes of staff and asked if there was a plan to increase public confidence in that.

Ms L James (DA) reiterated that there is a large degree of noncompliance and she asked what would happen with respect to that. The challenges with mismanagement and infrastructure are old, persisting problems and these have been raised before yet there is still no change. She asked about the potential for provincialisation of metro clinics to make a more uniform health sector to ease the burden of the poor management in those clinics, which cater to the poorest of the poor.

Mr A Shaik Emam (NFP) thanked the OHSC for the presentation. He asked how the OHSC ensures that there are consequences when compliance standards are not met. He noted that there may be issues with the documentation of these results because results can be manipulated so he asked that they be allowed to visit the clinics with the OHSC. Mr Shaik Emam asked to whom the OHSC reports and the procedure after having done so with respect to its mandate. The Free State is in a shocking condition
and he asked why a whole province is reported to be non-compliant. He commented on the poor management and the problems associated with those institutions and asked how many of those institutions have the same, persisting problems. Unless those institutions have pressure on them and one pleads with them, nothing will change so he asked that there be a report back on those problematic institutions.

Ms D Senokoanyane (ANC) asked on what basis the OHSC chooses to revisit and re-inspect some institutions. She observed that the traditionally poor provinces are the ill-performing ones and that this may be due to a lack of resources. The same issue pertains to infection control and cleanliness as a result of a lack of resources. She raised concerns with equating and comparing different hospitals: it is problematic to compare De Aar Hospital and Charlotte Maxeke Hospital because they are a central hospital and a district hospital respectively so it is an unfair comparison. Lastly, she asked if the report is submitted to the Department of Health and what happens to it subsequently.

Mr A Mahlalela (ANC) said the presentation was an eye-opener on the state of the healthcare facilities in South Africa. He asked whether the risks of dispensing expired medicines are tabled and considered because it is very serious. The financial implications of using expired drugs is also problematic because over-stocking may be wasteful. He commented on the attitudes of staff and said that it is quite a subjective measure and said that it all depends on how it is measured. He asked for a review on the metro clinics and questioned if they perform poorly because health does not fit into the core mandate of those municipalities. Mr Mahlalela said he had not consulted the legislation but he asked what happens when facilities simply ignore the legislation. He asked if the Committee could hold those facilities accountable for the lack of compliance.

The Chairperson also mentioned the subjectivity of the measure of attitudes and said it was a two-way street with community engagement. She expressed concern that only two metros within the Eastern Cape were visited and it was all focused only on one side of the Eastern Cape and she asked why that was the case.

Prof Lizo Mazwai, Chairperson: OHSC, addressed the independence of the appointments. He said the OHSC members have a legislative mandate to monitor and enforce compliance by the Minister of Health. The OHSC reports to the Minister and advises and recommends actions but only when a situation is severe and very urgent can the OHSC suggest that a facility be closed, but that can only be done through the consultation with the Minister. He noted that they work in a difficult environment and said that he is unsure of what the three levels of government each consider their core mandates to be, but he is assured that the department has to implement their recommendations.

Prof Ethelwynn Stellenberg, Board Member: OHSC, noted that many of the questions raised by the Committee have a common thread. She said that the regulations have not been promulgated and without that being the case, the OHSC is in a difficult position. She said that they have limited resources to cover the entire country and that the OHSC needs support because the current funding does not cover everything. Their coverage has reached 10%, and the OHSC is still trying to increase the coverage. The issue is that the OHSC cannot just take any person on board to do the inspections; they must be specialised in their fields and they have to be trained as inspectors. There are currently eight inspection teams comprised of six members each yet the OHSC still needs an additional three teams to meet their target level of inspections of 25%. It is estimated they reach every health institution once every four years so they need more resources to improve on that.

Prof Stuart Whittaker, Board Member: OHSC, commented on the regulations and said because they are not law, the OHSC cannot act on them. He said the Minister of Health is unable to do anything until such a time that the regulations are promulgated. Once that is done, the OHSC needs to adapt its information systems that will allow the OHSC to provide valid and reliable data. Following that, the facility will get a notice and they will have a day to respond and explain the lack of compliance.
Following which, there is potential for management to be prosecuted. Unfortunately, the OHSC can do nothing as they currently just evaluate and take a step back because they do not have enough resources. He asked that all stakeholders get together behind this and ensure they promulgate standards for PHCs.

Ms K Ngwenya, OHSC, said that the reason for the focus on one part of the Eastern Cape was because the other side would be done in the following year. On the performance of the metros, she asked what would happen once the metros become provincialised because the change will mean a change in responsibility and mandate. She commented on the interests of different stakeholders and said that perhaps this has not worked because stakeholders have different interests.

Mr Msibi addressed the tenders relating to cleaning staff and waste management and said the underlying problem lies with operational managers who need to understand what is required of the facilities. The comparison between district and central hospitals is actually acceptable because the standards by which they are both judged are core standards that are not specific to any one institution. With respect to the expired medication, Mr Msibi said that the staff simply remove them from the shelves and place them elsewhere so the issue is not about actually dispensing expired medication.

Prof Mazwai noted that their power is compromised by the legislation but the promulgation of standards can fix that. He noted that there is a great deal of subjectivity with measuring attitudes of staff and he said often the problem lies with dissatisfaction with waiting for long periods of time. He suggested that there should be information desks at these facilities to arrange a person-to-person situation that will allow patients to be better cared for. Prof Mazwai expanded on what Ms Ngwenya said about the stakeholders and said the problem is actually the labour because they need to be consulted with every change. When the OHSC was set up, it took two years to move forty inspectors over to the OHSC and this is where labour issues become problematic. Prof Mazwai noted that although the OHSC has a target of evaluating 25% of healthcare facilities, they are still only on 10% which is a problem.

The Chairperson asked what parties might respond to provincialisation given that there are two unions operating in that sphere. She noted that over the last few years since 1994, the population has been increasing rapidly yet the facilities have not increased in relation to the rate at which the population has been growing. Thus, sometimes sleeping on the floor is not due to negligence but rather that there are not enough facilities.

Dr James noted that personal health is a mandate stipulated in the Constitution and municipalities are social determinants for health so these clinics are much needed by the general population. He asked that labour issues be settled so that everything can operate as efficiently as possible.

Mr S Jafta (AIC) brought to attention the medication where the dates had been altered. He said that this was clearly done with the intention to use expired medication, which obviously would compromise patient safety.

Ms Senokoanyane noted that the regulations have not been promulgated but asked what the role of the Minister of Health is in the meantime and what interventions were to happen in spite of that. She said there are ways of disposing of medicine safely and it puts additional pressure on the budget if those medicines are not properly used. She agreed with the Chairperson’s comment about the floor being the best option in terms of sleeping arrangements when they simply do not have enough resources, yet she noted how putting two babies into the same incubator is very challenging and problematic.

Prof Mazwai thanked the Chairperson for raising the issue of an increasing population vis-à-vis limited resources. Overcrowding is a serious issue and the growth rate of the population has not been proportionate to the growth rate of facilities, which in turn impacts on the ability to provide good services. He agreed that in some cases where the date on expired medication is changed it is actually
criminal and very dangerous and that it should be addressed. He noted that the OHSC needs more than R60 million to meet their required target of 25% inspections.

The Chairperson thanked the OHSC delegation for the comprehensive presentation and for the work that they have done in healthcare. The meeting was adjourned.