Webinar

OHSC Recommendations and Just Culture

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Presentation Outline

- ❑ Purpose
- ❑ OHSC Overview
- ❑ Background
- ❑ Findings
- ❑ Just Culture
- ❑ Recommendations
- ❑ Conclusion

EWS National Overview Recommendation Report 2024

❑Purpose

- ❑To present the **Early Warning System National Overview Recommendation Report for 2024** and **Just Culture** to participants of the webinar: Doing quality differently with the NHI Fund.

Vision and Mission of the OHSC

OHSC

VISION

Assuring safe and quality healthcare for all

MISSION

To monitor and enforce healthcare safety and quality standards in health establishments independently, impartially, fairly, and fearlessly on behalf of healthcare users.

Functions of the OHSC

Section 79 of the National Health Act, 2013

a) Mandatory

1) Advise the Minister on health norms and standards.
2) Inspect, certify, or withdraw certification of health establishments.
3) Investigate complaints and monitor risks, reporting breaches promptly.
4) Recommend compliance interventions to relevant health departments.
5) Publish information on standards; recommend quality management systems.
6) Maintain activity records for all functions as needed.

b) Discretionary

1) Issue guidelines on implementing norms and standards.
2) Collect information from health establishments and users (Early Warning System, Annual Returns).
3) Coordinate and exchange information with other regulatory bodies.
4) Negotiate agreements to ensure consistent application of the Act.

EWS National Overview Recommendation Report 2024

❑Background

- ❑The EWS is a surveillance system used by the OHSC to monitor indicators of risk to serious breaches to norms and standards regulations. Currently 11 EWS indicators are being monitored which forms an important component to the OHSC's mandate to monitor compliance with norms and standards by the health establishments.

- ❑The **EWS Recommendations Report** is compiled annually to provide an overview of EWS incidents that were reported to the OHSC either by health establishments or identified through other sources such as media alerts.

- ❑The aim of the report is to share key trends in incidents reported, make recommendations.

Findings

1. Reported Incidence

Total = 2 068 incident reports by 326 HEs

from both the public sector and private hospital groups

A total of 199 reports received did not align with the 11 risk indicators specified in the regulations

Public	Private
1 668 incidents by 218 HEs	**400 incidents by 108 HEs**
Denominator: Public: 3,859 public health facilities of various types, distributed across nine provinces and 52 districts	Denominator: Private: 538 health establishments, which includes private acute and day hospitals

Findings

2. Reporting Trends by Health Establishments

Private

5 Main private health groups	No of private health establishments as per OHSC database	No of reporting private health establishment	Proportion of health establishments reporting EWS incidents per health group in 2024
Clinix Health Group	8	4	50%
Life Healthcare	64	38	59%
Mediclinic SA	56	20	36%
National Hospital Network	218	2	1%
Netcare	48	44	92%

Public

Province	Number of public health establishments as per OHSC database	Number of reporting public health establishments	Proportion of health establishments reporting EWS incider
Eastern Cape	860	9	1%
Free State	253	21	8%
Gauteng	407	27	7%
KwaZulu-Natal	691	58	8%
Limpopo	526	6	1%
Mpumalanga	321	15	5%
North West	313	12	4%
Northern Cape	174	11	6%
Western Cape	390	59	15%
SA Total	**3935**	**218**	**6%**

Findings

3. EWS Indicators classified by nature of incidents

❑Incidents related to safety & Security risk

- ✓ Missing Minor – 16 cases reported by public HEs. All minors found safe with their parents of guardians
- ✓ Suicide of inpatients- 18 Incidents reported; 11 by public hospitals and 7 by private hospitals
- ✓ Acts of harm to patients and staff; 522; 409 by public and 113 by private sectors

❑Incidents related to unavailability of resources

- ✓ Unavailability of radiological services – 71 incidents by public; 3 incidents by private
- ✓ Unavailability of water for >24 hours – 38 incidents by public ; 4 Incidents by private
- ✓ Unavailability of hand washing soap – 10 incidents by public

❑Incidents related to clinical quality and safety risks

- ✓ Retained foreign object in a patient following a surgical/ invasive procedure – 88 incidents by private; 21 incidents by public
- ✓ Procedure-related avoidable deaths - 79 incidents by private ; 11 Incidents by private
- ✓ Wrong site surgery -18 incidents by private; 3 by public

Findings

4. Alerts: Incidents sourced from the Media and Other Sources.

- In addition to voluntary incident reporting by health establishments to the OHSC; various incidents are reported through different media platforms by other relevant stakeholders; including Humanitarian and civil organisations, such as the Public Protector of South Africa and the Human Rights Commission
  - ✓ some of the incidents are discussed in OHSC forum.

- A total of 38 incidents were identified from media reports across various provinces in 2024
  - ✓ 13 alerts were directly linked to the 11 EWS indicators
  - ✓ 10 alerts from the OHSC Complaints Management and Office of the Health Ombud were escalated to the EWS Unit via the Dedicated EWS Online System.
  - ✓ The alerts are accounted for in the 2 068 incidents reported under the period of review

Findings

5. Contributory Factors for the Reported Incidents

- Submitted documents by HEs are carefully examined to assess their clinical appropriateness and potential areas of weaknesses that may explain the occurrence of adverse events.

  - ✓comprehensive reports requested from the HEs include quality improvement plans; standard operating procedures (SOPs) and clinical practice guidelines

  - ✓The OHSC provide feedback on the submitted documents and areas where they could be strengthened.

  - ✓The submitted documents are scrutinized to determine **Root Cause Analysis conducted by Health Establishments**.

Just Culture

Just Culture in healthcare

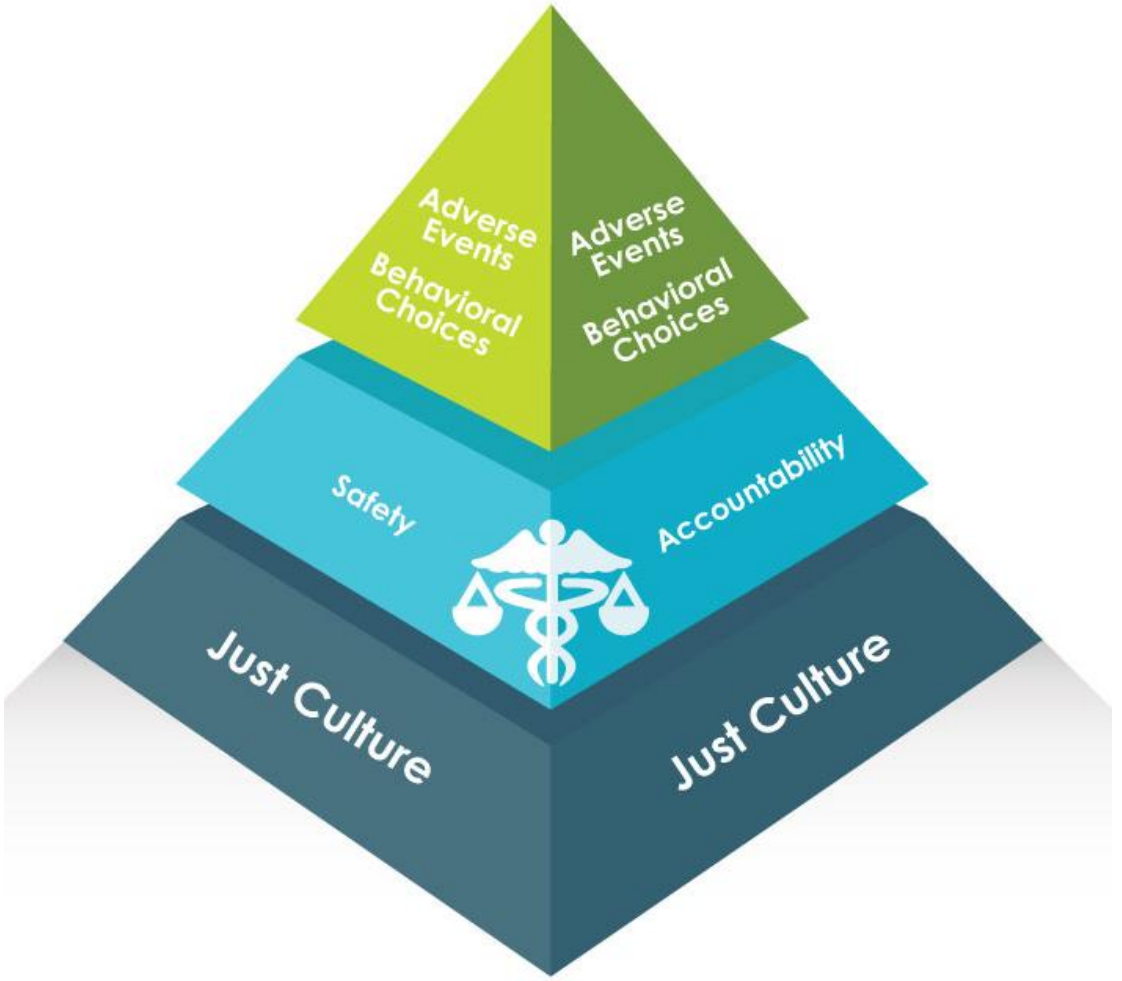
- A Just culture in healthcare is a system that promotes patient safety by fostering an atmosphere of trust where healthcare personnel are supported and treated fairly when something goes wrong with patient care.

- Just culture creates an environment in which healthcare personnel feel safe to report errors and concerns about issues that pose a threat to patient safety, without fear of blame or punishment.

Goal of a Just Culture

- The goal of a Just Culture environment is to design safe systems that will reduce the opportunity for human error and capture errors before they happen or reach the patient

- Safe systems should facilitate the staff to make good decisions and behavioural changes that make it difficult to make errors.



Key principles of a just culture

Openness and trust:

- ❑ It creates an atmosphere where staff feel safe to report errors, near misses, and safety hazards, which are crucial for identifying weaknesses in the system.

Focus on learning:

- ❑ The primary goal is to learn from mistakes to improve patient outcomes, rather than simply assigning blame.

Fair assessment:

- ❑ It uses a common language to evaluate provider conduct in the context of the specific situation, distinguishing between different types of behaviors.

Shift in focus:

- ❑ It shifts the focus from individual blame to system design and how to facilitate better, safer behavioral choices.

Importance of just culture for patient safety

- By encouraging the reporting of errors, a just culture provides valuable data for identifying systemic vulnerabilities that could lead to future adverse events and mitigate them.
- It helps create a learning culture where organizations can adapt and improve their processes and prevent recurrence of incidents, ultimately leading to better patient safety outcomes.
- It ensures a fair process for all parties involved in an incident, moving towards a restorative approach to justice that focuses on repairing harm, restoring well-being.

Recommendations

- The OHSC recommends the review of the norms and standards regulations (2018), due to its limitations highlighted in the Review of the Norms and Standards Recommendations report
- In addition to includes health outcome measurements during the review of norms and standards regulations based on the EWS quality and safety-related incidents reported by the health establishments.
- Implementation and monitoring of the quality improvement plans
- Provincial and Private health groups EXCO to provide oversight

Conclusion

- The OHSC has seen a gradual improvement in the voluntary reporting of incidents related to the 11 EWS indicators since inception of the surveillance system in March 2020.
- A notable underreporting has been observed in some of the provinces and health establishments.
- The OHSC continuously strives to engage with relevant stakeholders (HODs, Executive Management Groups, Health Establishments) to increase awareness and provide support and encouragement to uphold the regulatory mandate of reporting by health establishments.

ngiyathokoza! ro livhuwa!

dankie! ke a leboga! enkosi!

thank you! ndo livhuwa!

inkomu!

ke a leboha! ngiyabonga!

siyabonga!

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