ANNUAL INSPECTION REPORT

2015 / 2016

OHSC

Office of Health Standards Compliance

Ensuring quality and safety in health care

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Foreword by the Chairperson of the OHSC

The Chairperson of the Office of Health Standards Compliance is pleased to present the 2015/2016 National Core Standards Inspectorate Annual Report. This is the second annual report compiled and produced by the Office of Health Standards Compliance on issues of quality and safety of South Africa's health establishments.

"Achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all its citizens. This involves measuring the gap between implementing standards and actual practice, and working out ways to close the gap". 2007 Quality Policy, National Department of Health.

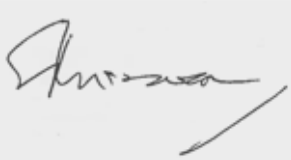
The OHSC is a legislated independent entity tasked to make sure that health care service provided to South Africans is safe and of high-quality. One of OHSC core business is to plan and undertake random health establishments inspections in order to assess the quality of care given to patients, identify areas of strength and encourage overall care services to improvement in areas where health establishment has not done well. This year's report highlights health establishments inspected and monitored to make sure they meet fundamental Core Standards of quality and safety. As per OHSC communication protocol the inspections findings are presented to health establishments management teams for their attention and Service Quality Improvement Plans with remedial actions submitted to Office and the plans implementation monitored make sure quality service compliance is achieved.

The Inspection Report shows increasingly challenging circumstances experienced at organisational and management levels, some areas of good care being delivered and encouraging levels of improvement taking place in some re-inspected health establishments. Health establishments do not exist in isolation and are directly and indirectly affected by global and domestic socio-economic and political factors. The combination of a burden of disease with long term conditions and a challenging economic climate means greater demand on public health services and more problems. As result the OHSC is seeing and is concerned by some evidence of significant deterioration in the quality care at inspected health establishments which undermines Patients Rights. Health establishment governance and oversight including responsive, hands-on leadership, effective, decisive management team is an area of significant concern and needs attention by Political Executives, Senior and Middle Management at National and Provincial Departments of Health.

Indeed budget constraints has had direct impact on adequate funding of vacant clinical and allied professional posts, inadequate infrastructure and maintenance budget, medical equipment, medical supplies, consumables including pharmaceuticals have been reported but there is no funding available.

We are committed as OHSC to exploring and using 21st technology to pckage our health establishment data in most exciting and user friendly manner in order to facilitate and support prompt decision making and interventions. We are testing and looking for innovative ways to strengthen our information gathering, analysis and management sytems. We are committed to enhance our current OHSC services and build closer partnerships with our stakeholders at National, Provincial and other levels of government and Statutory bodies—which will benefit all of us in the future.

I wish to express my gratitude to the Chairperson of the CEC, Prof. L. Rispel, as well as the Acting CEO, Mr. B. Msibi, for the leadership and guidance they provided during the reporting period.



Prof Lizo Mazwai
Chairperson

Executive Summary

This Inspection Report represents the results of OHSC on Health Establishment(HE) Inspections conducted during 2015/2016 financial year. The inspections were conducted at selected sites across the nine provinces by seven teams of inspectors and the inspection coverage was according the Annual Performance Plan. The Inspectorate managed to achieve its targets by inspecting 495 facilities out of 3816 public health establishments and also conducted 132 additional re- inspections by revisiting some of the facilities that were inspected. This has resulted in the overall performance score of 13% for inspection coverage and 34% of facilities re-inspected by end of quarter four noting that the re inspections of HE's inspected in the last quarter will be conducted in the last 2 quarters of the financial year 2016 /2017.

From the HE inspections conducted in 2015/2016 financial year the total number was 627 (495 Routine Inspections of HE + 132 re-inspections). Different categories of health establishments were inspected in each province and some re inspected across all the 9 Provinces and these include 4 Central Hospitals, 11 Provincial Tertiary Hospitals, 9 Regional Hospitals, 27 District Hospitals, 9 CHC and 567 Clinics. The intended coverage was exceeded because the inspection teams were increased from 5 teams to 7 during the 2015/2016 financial year.

In summary, the OHSC HEs inspections found deficiencies in complying with National Core Standards and the Ministerial Six Priority Areas as well as areas where improvements are warranted. The first observations below is the most significant in that it addresses a number of ongoing health establishments organisational development including, processes, systems and human relations compliance deficiencies. These areas are summarized below and detailed in the attached body of the report:

At Central Hospital Levels

For 2015/2016 financial year four (4) Central Hospitals were inspected based on Compliance Inspections Operational Plan, namely:

1. Dr. George Mukhari Central Hospital- Gauteng Province
2. King Edward VIII Central Hospital- KwaZulu-Natal Province
3. Charlotte Maxeke Central Hospital- Gauteng Province
4. Nelson Mandela Central Hospital- Eastern Cape Province

From the Central Hospitals inspections conducted, the results for each hospitals are available in detail in this report but in summary the inspections indicated a number of recurring significant National Core Standards compliance deficiencies in particular Domains Outcomes and they were in:

- Domain 1: Patients Rights
- Domain 2: Patient Safety and Clinical
- Domain 3: Clinical Support Services
- Domain 4: Public Health
- Domain 5: Leadership and Corporate Governance
- Domain 6: Operational Management
- Domain 7: Facilities and Infrastructure

Domain 4 Public Health scored below 60% across all 4 Central hospitals except Charlotte Maxeke hospital with a score of 85%. King Edward VIII and Dr. George Mukhari were the worst performing hospitals with regard to Leadership and Corporate Governance. Nelson Mandela was also the lowest scoring hospital with regard to Patients' Rights and Patient Safety/ Clinical Governance/Clinical Care, Clinical Care and Operational Management. Dr. George Mukhari was the worst performing hospital with regard to Facilities and Infrastructure.

Ministerial Priorities Performance

Nelson Mandela was worst performing hospital with regard to patients waiting times, positive attitudes and availability of medicines and supplies. Dr. George Mukhari was the worst performing hospital with regard to cleanliness and King Edward VIII performed the worst in improve patient safety and security. At the same time King Edward shows positive significant waiting times for patients 82% and Charlotte Maxeke infection prevention and control is significantly high 84%. However of major concern is hospitals basic cleanliness which does not only cover the physical cleanliness but also the availability of cleaning materials. Not as single Central Hospital scored above 70% the highest was only 69%. The question for Central Hospital which needs urgent attention and intervention is given the fact that patients lives are at risk is what is the problem with basic cleanliness? Who should do it?, what are weaknesses identified, what is being done at the hospitals about the problems and what remedial action management and staff have taken since last inspection feedback. Has the situation changed? in preparation for the next inspection.

At Provincial Tertiary Hospital Levels

For 2015/2016 financial year the OHSC inspected twelve (12) Tertiary Hospitals as per Compliance Inspections Operational Plan, namely:

1. **In Eastern Cape Province the following hospitals were inspected:**
   - Frere Hospital
2. **In Free State Province the following hospitals were inspected:**
   - Pelonomi Hospital
3. **In Gauteng Province the following hospitals were inspected:**
   - Helen Joseph Hospital
   - Kalafong Hospital
   - Tembisa Hospital
4. **In KwaZulu-Natal Province the following hospitals were inspected:**
   - Grey Hospital
   - Ngwelezana Hospital
5. **In Mpumalanga Province the following hospital were inspected:**
   - Witbank Hospital
6. **In Limpopo Province the following hospitals were inspected:**
   - Mankweng Hospital
   - Pietersburg Hospital
7. **In Northern Cape Province the following hospital were inspected:**
   - Kimberly Hospital
8. **In Western Cape Province the following hospital were inspected:**
   - Red Cross Children Hospital

Domains Outcomes

The inspection scores vary widely by domain with the lowest score of 22% in Domain 4 (public health) and 5, leadership and governance score of 16% and the highest score of 91% was recorded in Domain 2 (patient safety clinical governance and care). Domain 5 Leadership and Cooperate governance was scored below 50% by the 5 Hospitals in the 4 Provinces (Tembisa in Gauteng, Kimberly in Northern Cape, Red cross in Western Cape, Pelonomi in Free State and Frere in Eastern Cape.

Also Domain 4 public health was scored less than 50% by 4 Hospitals in different provinces (Kimberly in Northern Cape, Red Cross Memorial in Western Cape, Pelonomi Hospital in Free State and Helen Joseph in Gauteng. Grey Hospital performed exceptionally well in all the 7 Domains and the lowest being Public Health with above 70 % and the highest being patient safety clinical governance and clinical care with above 90%. The lowest performing hospital in all the Domains is Kimberly Hospital in the Northern Cape with leadership as the less scored domain with below 20% and patient safety as the highest scored with just above 50%.

Ministerial Priority Performance Areas

The Provincial Tertiary Hospitals scores on the six priority quality areas (waiting times, cleanliness, values and attitudes, patient safety, infection prevention and control and availability of medicines) varied widely with the highest score of 94 % in

availability of medicines and supplies for Grey Hospital and lowest score observed in cleanliness 34 % and 44 % in waiting times for Pelonomi Hospital. Out of 12 hospitals inspected only 2 hospitals scored above 70% in all the six priority areas and both hospitals are from KZN and offer the same package of service (that is Grey hospital and Ngwelezana hospital). The question on what and why a hospital would obtain a score 34% on basic cleanliness is a serious area of concern including issues values and staff attitudes with needs management and staff attention on what and issues identified from the inspections are resolved before the next re-inspection is critical.

At Regional Hospitals Levels

For 2015/2016 financial year 7 Regional Hospitals were inspected based on Compliance Inspections Operational Plan:

1) Cecilia Makiwane Hospital- Eastern Cape Province
2) Bongani Hospital- Free State Province
3) Dihlabeng Hospital- Free State Province
4) Mamelodi Hospital- Gauteng Province
5) Tambo Memorial Hospital- Gauteng Province
6) Rahima Moosa Hospital- Gauteng Province
7) Letaba Hospital- Limpopo Province

Domains Performance

The inspection scores vary widely by Domain with the lowest score of 29% in Domain 5 (leadership and governance) and 4 of the hospitals from 3 different provinces scored less than 40 %the highest score of 81% was recorded in domain 2 (patient safety clinical governance and care). Domain 4 (public health) was also not well scores by 3 hospitals from two provinces (Free state and Eastern Cape with the score of less than 50% whereas Free State is the lowest with the score of 30 -44%.

Ministerial Performance Areas

On the six priority quality measures (waiting times, cleanliness, values and attitudes, patient safety, infection prevention and control and availability of medicines) also varied widely with the highest score of 90 % (for Rahima Moosa in Gauteng) in availability of medicines and supplies and lowest score observed in cleanliness 38 % and 48 % in waiting times (for Dihlabeng Hospital in Free state).

The question on what and why a hospital would obtain a score 38% on basic cleanliness is a serious area of concern including issues values and staff attitudes with needs management and staff attention on what and issues identified from the inspections are resolved before the next re-inspection is critical.

At District Hospital Levels

Domains and Ministerial Performance Areas

Four district hospitals which provide the same package of care, out of the four hospitals 2 hospitals performed satisfactorily in all the domains (Holly cross and Peddie) with the scores ranging between 42 and 73% and both of this hospitals have a performance outcome score of above 60% nationally. However, only one hospital Nessie Knight performed poorly in the three of the six priority with the scores of less than 40% in cleanliness, improve patient safety and waiting times.

Two district hospitals, which provide the same package of care, Katleho Hospital performed satisfactorily in the six priority areas and managed to achieve scores ranging from above 50% - 63%. However, Diamond _ Diamant hospitals performed poorly in six priority areas with infection prevention and control having scored below 40% .In the seven domains one of the two hospitals performed badly in patient's rights, public health, leadership and corporate governance including operational management with the performance score of less than 40%.

Re-Inspections Performance Outcome

Re inspections conducted in 2015/2016 Holy Cross Hospital is the one that was falling outside the 6 months' time frame of this report as per the indicator for re inspection although it was re inspected as it was triggered inspection as reported by Section 27 and caught a lot of media attention. Out of the 4 re inspections conducted in 2015-2016 only Malamulele in Limpopo improved from 51 – 63%, whereas the other 3 inspected health

establishments St Elizabeth, Niemeyer and Nkonjeni did not show significant improvement.

In all 9 provinces in the country, the average performance outcome of district hospitals inspected in the financial period 2015/2016 ranges between 41 -64 %. Gauteng is the only province with the highest score of 64% whilst 4 provinces (Northern Cape, Free State, Eastern Cape and Limpopo) scored below 50%.

At Clinic Levels

Mature and effective partnership and collaboration is required from from both OHSC and National Department of Health: PHC management and staff. The roles and responsibility including who does what, when and how is important to be defined and clarified. OHSC has a legal mandate in terms of the implementation of National Core Standards (Regulations) and Ministerial Priority Areas of health establishments including clinics. What and how the PHC Ideal Clinics experiences in conducting and measuring clinics performance in the context of what the role and responsibility of OHSC is by law needs to be discussed and clarified soon to avoid causing uncesssary confusion and tension at all provincial, districts and clinics levels. Effective communication at all levels is important so that planned objectives are achieved and that quality service delivery at clinic levels is strengthened.

Emerging issues from the inspections is that hospitals irrespective of the levels of care need to have the following to strengthen overall health care and respond to inspection findings and they are:

- There is a need for a better system to gather information for both hospitals and clinics management and performance for analytical, managerial and reporting purposes.
- The delegated authority between province and districts in terms procurement, finance and overall health establishments management needs to be communicated in a clearer manner.
- Team work- in order to have high performing teams is another area of importance. Effective performance and consenquence management including issues of roles, responsibility, accountability, professional ethics and honesty needs attention from management and staff at all levels of care including National, Province, District and Clinic levels.
- Human Resourcing - Clinical, Nursing, Allied and support staff requires review to ensure proper skill sets are in place for a changing and more demanding environment.
- Health Establishment work standards and protocols to have a benchmark for internal assessment and to facilitate an understanding with patients on what standard of service can be expected.

OHSC inspections findings and observations identified significant problem areas with specific areas of weaknesses. OHSC Management feedback report to health establishments should be appropriately responded to as a whole, making any specific priority ranking of identified areas and Improvement Plan in place to turn things around before the next inspection. There is urgent need for hospitals, clinics, districts and provincial management and staff to operate on a more professional and proactive basis and, be better positioned to withstand scrutiny of OHSC environment that is certain to become more demanding. The OHSC is grateful for the support and cooperation from health establishment stakeholders, province and national department of health in providing useful and constructive feedback on what and how the office can improve going forward.

Introduction

Protecting the health, safety and well-being of South African residents is the Office of Standards Compliance's (OHSC) legal mandate and priority. The OHSC conducts annual inspections to ensure that health facilities comply with National Core Standards regulatory requirements. To comply with National Health Amendment Act 12 of 2013 requirements, the OHSC writes facilities reports to Health Establishments, which documents, the inspections findings and highlight areas requiring intervention or remedial action. This second Annual Inspection Report was collated and submitted to the OHSC Board in this financial year 2016/2017.

1.1 Purpose of the Inspectorate Unit

According to the National Health Amendment Act 12, 2013, the purpose of the Office of Health Standards Compliance (OHSC) is to inspect Health Establishments for systems, processes and procedures that promote and ensure quality health services in the public and private sectors. The National Core Standards have been informed by the South African public health policy context and are, to a large extent, based on existing legislation, policies, guidelines and protocols mostly specific to the Department of Health. Others policies emanate from Treasury, Department of Public Service Administration and the King III Guidelines on Corporate Governance. These policies embody what and how managers and employees are expected to deliver quality and safe health care at Health Establishments (HEs) within efficient proper governance framework. Achieving compliance with National Core Standards will facilitate and ensure that comprehensive systems and processes are put in place to avoid and manage potential risks and harm to quality care of patients.

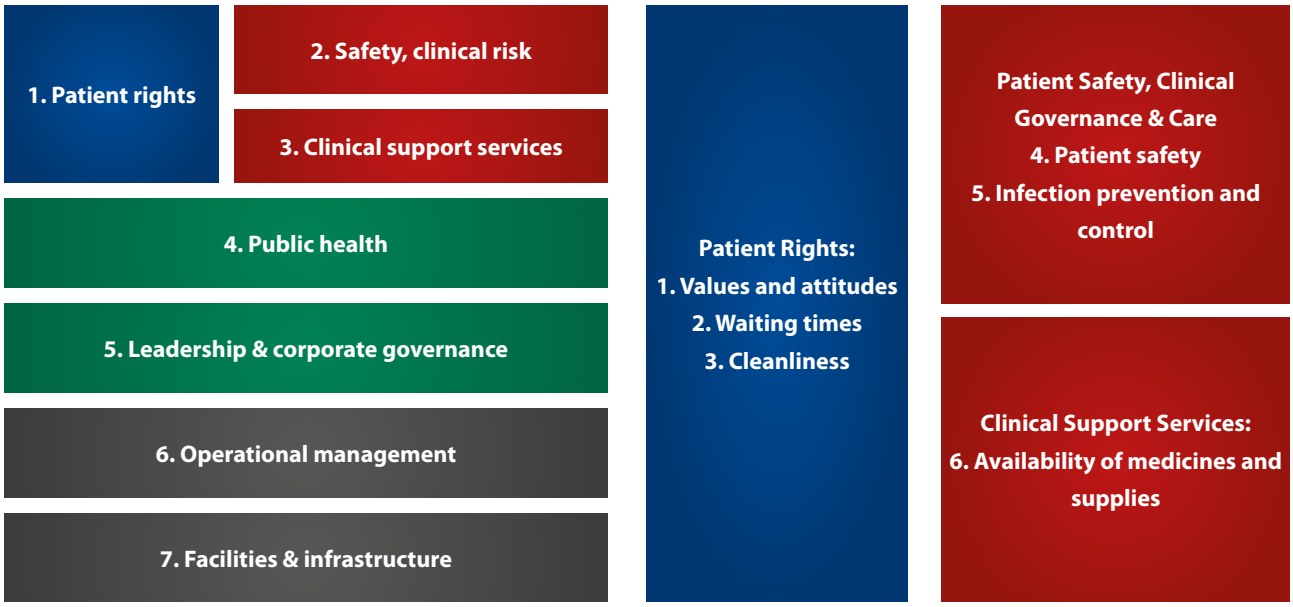
1.2 The Six Priorities Areas of the National Core Standards

By law it is expected that all Health Establishments will ensure compliance with the National Core Standards Regulations, which are in the process of being regulated and would be finalized for implementation possibly in the next financial year 2017/2018. However, improving quality of care at health facilities takes time and is a process, which depends on effective leadership, partnerships and empowerment of management and staff to lead and achieve the stated goals and objectives expectations. In this report six critical areas were prioritized as many HEs (especially in the public sector) need much improvement and they are:

1) Availability of medicines and supplies;
2) Cleanliness;
3) Patient safety;
4) Infection prevention and control;
5) Positive and caring attitude;
6) Waiting times.

These priority areas are fundamental to the provision of responsive safe care to all. The diagram below shows the seven domains on which HEs are inspected. The six priority areas are mainly embedded in the first three domains.

Figure 1: Domains Integration with Six Priorities Areas



The compilation of this report is informed and guided by the goal of the Inspection Unit, which has been established by law as part of the OHSC and more importantly to share HEs development journey in facilitating the implementation of National Core Standards to strengthen quality of care.

Scope of each Domain

The domain of Patient Rights sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with Batho Pele principles and the Patient Rights Charter.
The Patient Safety, Clinical Governance and Clinical Care domain covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to health care users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events, including health care associated infections; and support any affected patients or staff
The Clinical Support Services domain covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology, as well as systems to monitor the efficiency of the care provided to patients.
The Public Health domain covers how health facilities should work with NGOs and other health care providers along with local communities and relevant sectors, to promote health, prevent illness and reduce further complications; and ensure that integrated and quality care is provided for their whole community, including during disasters.

The Leadership and Governance domain covers the strategic direction provided by senior management, through proactive leadership, planning and risk management, supported by the hospital board, clinic committee as well the relevant supervisory support structures and includes the strategic functions of communication and quality improvement.

The Operational Management domain covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and of information and records.

The Facilities and Infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and functional, well managed hotel services; and effective waste disposal

1.3 The Inspectorate Unit Goal

The goal of the Inspectorate Unit is to inspect the Health Establishments in order to assess and encourage compliance with National Core Standards.

1.4 Objective of the OHSC:

The Office is mandated by Chapter 10 of the National Health Amendment Act No: 12 of 2013 to conduct National Core Standard inspections in health establishments at any reasonable time.

From the Act the main objective of the office is to protect and promote the health and safety of people using health services by:

- monitoring and enforcing compliance by the health establishments with norms and standards prescribed by the Minister in relation to the national health system; and
- Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.

Table 1: Programme performance indicators and annual targets for 2015/16

Programme Performance Indicator	Strategic Plan Target	Estimate performance				Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
# and % public health establishment inspected annually by the OHSC	20%	•	•	•	10%	10% (382 0f 3816)	17% (649 of 3816)	18% (689 to 816)
# and % of private sector health establishment inspected annually by the OHSC	30%	•	•		New indicator	20% (74 of 369)	25% (92 of 369)	30% (111 of 329)
% of provisionally non-complaint health establishments	8 0%	•	•	•	30%	35%	40%	45%
# compliance inspectors accredited as competent	60				New indicator	20	20	20

From the OHSC a dedicated Chief Directorate Inspection and Compliance has been established has been as per National Act. The Chief Directorate roles and responsibilities are: To monitor compliance with the National Core Standards;

- To continue with mock inspections as a means of providing on-going training to inspectors in preparation for the implementation of regulated norms and standards and certification thereof;
- To raise awareness of the health care providers needed for implementing the NCS.

Sampling and Selection: How and Why the identified HEs were selected?

In order to be able to select the health facilities that will be inspected without being bias the OHSC uses a statistical sampling method to represent all the facilities throughout the country.

The sampling methodolofy takes into consideration the distance between the health facilities, budget, time and limited number of inspectors the OHSC available to conduct the inspections. A cluster and systematic sampling is used. In cluster sampling OHSC divide health facilities into area groups which in this case were sub-districts. The area groups consist of provinces, districts and sub districts. With systematic sampling OHSC select elements from the list at random and then every kth element on the list is selected.

The sampling of health establishments was carried out in this manner; firstly, the health facilities were grouped by the sub districts and then systematically select the sub districts to be inspected. After selecting the sub districts, we systematically select 8 facilities from each selected sub district, but this will not be the case for sub districts which has a number of facilities less than eight.

Inspection teams are made up of 4-5 inspectors, data capturer and a team leader. In a week a team is allocated to inspect facilities and can inspect 8 clinics or 6 clinics and 1 CHC or 1 hospital and 2 clinics. The inspectors visit the health establishment for inspections twice a month for a week.

Sources and Methods of Obtaining Information:

The inspection of health establishments was conducted using the following data collection methods:

- Document review and analysis
- Direct Observation
- Patient Record Assessment
- Patient interview
- Staff interview

What was the Health Establishments Inspection Process?

The inspections were conducted at selected sites across the nine provinces by seven teams of inspectors: to address the inspection coverage in the Annual Performance Plan, which was set at 10%. Each inspection team had a team leader and 4-5 inspectors, and a data capturer. A total of 627 conducted in 485 Health Establishments inspections (4 central hospitals; 11 provincial/ tertiary hospitals, 9 regional hospitals; 27 district hospitals, 9 community health centres and 567 clinics) health establishments. In one week a team inspected 6 to 8 clinics and 1 CHC or 1 hospital and 2 clinics in a geographical area.

The target for 2015/16 was to inspect 10% of the health establishments and an additional indicator aimed at re inspecting a portion of health establishments found to be non-compliant within a period of 6 months from the initial inspection. The target for the re inspections was set at 30%. It is important to note that the inspectors visit the health establishment for inspections twice a month for a week in and week out.

The inspectorate managed to achieve its targets by inspecting 495 facilities out of 3816 public health establishments and also conducted 132 additional re inspections by revisiting some of the facilities that were inspected. This has resulted in the overall performance score of 13% for inspection coverage and 34% of facilities re inspected by end of quarter 4 noting that the re inspections of HE's inspected in the last quarter will be conducted in the last 2 quarters of the financial year 2016 /2017.

Inspection Report Limitations

During 2015/2016 inspection period the report limitations experienced were although random sampling of health establishment some of the inspected health establishment were not originally sampled but had to be included to substitute those that were not due to:

- Closure, Name changes and DHIS data-base not updated as such.
- Inspectors could not locate the geographical location of the health establishment
- Inaccessibility due to lack or road or community protests
- Some health clinic which only operates in certain days of the week were not open
- Budgetary constraints and number of inspection teams had an impact on the Inspection unit to cover majority of health establishment in South Africa
- Design and size of inspection tool (data collection tool) limits the inspection team of two inspectors particularly of clinics to one clinic in a day.
- Patients and staff interviews as a method of data collection has to some extent a degree of subjectivity depending on the day, mood or feeling of the interviewee can result in either facts being exaggerated or minimized.

Inspection results approach

The data was analyzed using DHIS 112 software version updated in August 2015. The results were calculated on overall performance score weighted with the number of standards by score range, priority area and domains for an example.

Figure 2:

Priority Area by risk

Risk Rating

Priority Area	Weighted Score	Actual			
		X	V	E	D
Availability of medicines and supplies	48.32%	83% 0.83/1	100% 2/2	35.12% 5.97/17	N/A 0/0
Cleanliness	52.79%	N/A 0/0	53.86% 3.77/7	33.33% 1/3	100% 2/2
Improve patient safety and security	43.31%	44.75% 1.79/4	41.39% 7.45/18	43.26% 13.41/31	60% 3/5
Infection prevention and control	70.85%	100% 2/2	77.83% 4.67/6	54.55% 6/11	N/A 0/0
Positive and caring attitudes	64.53%	0% 0/1	N/A 0/0	73.5% 11.76/16	50% 1/2
Waiting times	52.63%	N/A 0/0	0% 0/1	57.14% 4/7	100% 2/2

Weighted Score per Domain

Domain	Weighted Score	Actual			
		X	V	E	D
1. Patient's Rights	56.89%	44.5% 0.89/2	60.67% 3.64/6	54.97% 17.59/32	70.91% 7.8/11
2. Patient Safety/Clinical/Governance/Clinical Care	48.41%	59% 2.36/4	45.8% 4.58/10	45.88% 7.8/17	43% 0.43/1
3. Clinical Support Services	48.75%	68.5% 1.37/2	44.25% 3.54/8	48.73% 12.67/26	0% 0/1
4. Public Health	11%	N/A 0/0	N/A 0/0	16.5% 0.99/6	0% 0/6
5. Leadership and Corporate Governance	0%	N/A 0/0	0% 0/1	0% 0/4	0% 0/1
6. Operational Management	41.24%	N/A 0/0	33.33% 1/3	47.15% 6.13/13	0% 0/2
7. Facilities and Infrastructure	53.72%	N/A 0/0	60.33% 5.43/9	47.37% 9/19	60% 6/10

A questionnaire was prepared and variety of questions respondents were asked to respond to, to determine if the health establishments had complied or not complied with standards and criteria. Some questions were considered to be more critical than others for an example the requirement for a ward/unit to have Oxygen will be rated Extreme because it has direct impact on patient safety and a signage board at the entrance of the health establishment will be rated developmental due to the less impact it has on patient safety.

The component measures for each standard were classified according to a risk-rating approach, using a risk matrix adapted from the Australian Capital Territory Government (2009) tool and assessing the severity of the impact as well as the likelihood of a risk occurring in each case. This reflects the possible risk and severity of this area, based on what the impact could be and the likelihood of a failure is occurring. Based on this risk rating the respective measures have then been placed in four risk levels and weighted accordingly:

Table 2:

Weighting Values			
X (Extreme)	**V (Vital)**	**E (Essential)**	**D (Developmental)**
40	30	20	10

The weighting values above have cut offs that the HEs must achieve in order to be compliant with the standards. The extreme cut off is 100%, vital is 90% and above, essential is 80% and above and developmental is 60% and above.

Below are results of the health establishments assessed in the nine provinces from April 2015 to March 2016. It is important to indicate that the number of health establishments inspected during this period differs from province to province as explained above under the heading: Why the HEs were selected.

Reporting on inspections

According to section 82A of the National Health Amendment Act the inspector may issue the person in-charge of the health establishment with a compliance notice if the health establishment does not comply with the prescribed norms and standards.

In order to comply with the draft procedural regulations (R6) the Office of Health Standards Compliance has started a new format of giving feedback to the person in charge of the health establishment. The person in-charge will be afforded 20 days to review and comment on the preliminary report and forward those comments to OHSC. The Office will then within 20 days of receipt of the person in-charge's response consider the comments and write the final report. The process has undergone the 1st pilot for all inspections conducted on the 4th quarter of 2015 – 2016.

Table 3: Inspections conducted per province year 2015/2016
Intended Coverage Breakdown for Public Health Establishments

Province	No of Districts	Sub districts	No of Health Est	%	Proportionate Coverage intended
EC	8	26	858	10	85
FS	5	22	252	10	25
GP	5	27	395	10	39
KZN	11	51	671	10	67
LP	5	25	509	10	50
MP	3	18	317	10	31
NC	5	27	175	10	17
NW	4	19	335	10	33
WC	6	32	334	10	33
Total= 9	**52**	**247**	**3846**	**10**	**380**
High risk and EWS Inspections in all provinces					

EC, KZN, LP have the highest numbers of facilities followed by GP, NW, WC, MP, FS & NC with the least of health establishments. Coverage was based on the 10% coverage as stipulated in the APP of Inspectorate Unit but also influence by number of inspection teams.

A
LEGISLATIVE MANDATES AND OTHER MANDATES

2.1 Legislative Mandates:

As part of overall health system strengthening to address and improve health service delivery, improving quality is fundamental in improving South Africa's current poor health outcomes. Better quality of care will restore patients' and staff confidence in the public and private health care system.

Quality in the health system can be defined as getting the best possible results with the available resources. A number of governing acts, regulations and policies influence the quality of healthcare in South Africa, including the following.

2.1.1 Constitution of the Republic of South Africa, Act No.108 of 1996:

Underpinning the entire health system are the constitutional imperatives enshrined in the Bill of Rights. Specifically, section 27 of the Constitution guarantees everyone the right of access to healthcare services, including reproductive health services and emergency medical treatment. The Constitution further requires the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of this right.

The realization of socio-economic rights has been tested multiple times by the Constitutional Court in relation to housing, social assistance and health rights. In the majority of these decisions, the Constitutional Court examined the reasonableness of government measures in realizing these socio-economic rights (James, 2012). Put differently, the Courts focused on whether government had sufficient plans and policies in place to fulfil the obligations set out in the Bill of Rights. The regulation of the quality of health services charts a path for all health establishments to comply with policy priorities and minimum standards of care. In this manner, the regulation of quality contributes directly to government's progressive realization of its constitutional obligations.

The constitutional imperatives set out in the Bill of Rights cannot be achieved without the collective efforts of all spheres of government. Hence, section 41 of the Constitution requires all three spheres of government to work cooperatively to secure the wellbeing of the people of the Republic, and to preserve the peace, national unity and indivisibility of the Republic. This principle of cooperative government is particularly important in health services, which are a functional area of concurrent competence across national and provincial governments as defined in Schedule 4 of the Constitution.

National government is responsible for developing and monitoring policies, legislation and norms and standards for the health sector. Provincial government can discharge their constitutional obligations by passing provincial legislation in the area of health services, but remain responsible for the implementation of national policy and legislation, while local government is responsible for municipal and environmental health functions. Section 44 of the Constitution gives the National Assembly the authority to pass legislation with regard to functional areas of concurrent competence and to prescribe minimum norms and standards.

2.1.2 The National Health Act, 2003 (the Act):

The Act re-affirms the constitutional rights of users to access health services and just administrative action. As a result, Section 18 allows any user of health services to lay a complaint about the manner in which he or she was treated at a health establishment. The Act further obliges MECs to establish procedures for dealing with complaints within their areas of jurisdiction. Complaints provide useful feedback on the areas within health establishments that do not comply with prescribed standards or pose a threat to the lives of users and staff alike.

The Act provides the overarching legislative framework for a structured and uniform national healthcare system. It highlights the rights and responsibilities of healthcare providers and healthcare users, and ensures broader community participation in healthcare delivery from a health facility level up to national level. With respect to the sections now being amended, although never promulgated, the Act provided for the creation within the National Department of Health of an OHSC with provincial Inspectorate units. The OHSC as then envisaged would advise on health standards, carry out inspections and monitor compliance, report on non-compliance, issue or withdraw a certificate of compliance, and advise on strategies to improve quality and included an Ombud.

2.1.3 The National Health Amendment Act (2013):

Chapter 10 of the National Health Act relating to the OHSC was repealed in its entirety (and other minor changes were enacted) through the promulgation of the National Health Amendment Act No 12 of 2013, which replaced the previous provisions (that had never been brought into effect) with a new independent entity, the Office of Health Standards Compliance.

The Objects of the Office are reflected in the Act as being:

To protect and promote the health and safety of users of health services by:

1. *Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister in relation to the national health system; and*

2. *Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner"*

In terms of the Act the OHSC must:

- **Advise the Minister** on matters relating to the determination of norms and standards to be prescribed for the national health system and the review of such norms;
- **Inspect and certify** health establishments as compliant or non-compliant with prescribed norms and standards, or where appropriate and necessary, withdraw such certification;
- **Investigate complaints** relating to the national health system;
- **Monitor indicators of risk** as an early warning system relating to serious breaches of norms and standards and report any breaches to the Minister without delay;
- **Identify areas and make recommendations for intervention** by a national or provincial department of health or a health department of a municipality, where it is necessary, to ensure compliance with prescribed norms and standards;
- **Recommend quality assurance and management systems** for the national health system to the Minister for approval;
- **Keep records** of all its activities; and
- **Advise the Minister** on any matter referred to it by the Minister.

In addition the OHSC may:

- **Issue guidelines** for the benefit of health establishments on the implementation of prescribed norms and standards;
- **Publish any information relating to prescribed norms and standards** through the media and, where appropriate, to specific communities;
- **Collect or request any information relating to prescribed norms and standards** from health establishments and users;
- **Liaise with any other regulatory authority** and may, without limiting the generality of this power, require the necessary information from, exchange information with and receive information from any such authority in respect of (i) matters of common interest; or (ii) a specific complaint or investigation; and
- **Negotiate cooperative agreements with any regulatory authority** in order to (i) coordinate and harmonise the exercise of jurisdiction over health norms and standards; and (ii) ensure the consistent application of the principles of this act.
- OHSC enforcement powers given the mandate and functions would be investigated and communicated to the Board by TA legal advisor.

2.2 Policy Mandates:

2.2.1 National Core Standards for Health establishments in South Africa:

The "National Core Standards for Health establishments in South Africa" (NCS) have gone through successive phases of development based on input from the numerous stakeholders involved in the process as well as extensive use in the field. The document was finally approved by the policy-making body (the National Health Council) and issued by the Minister in February 2011.

This set of standards is based on the existing policy environment and tailored to South Africa's healthcare context, while also reflecting international best practice and a strong evidence base. The purpose of the NCS is to:

- "Develop a common definition of quality care which should be found in all health establishments in South Africa, as a guide to the public and to managers and staff at all levels;
- Establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised; and
- Provide for the national certification of compliance of health establishments with mandatory standards."

A subset of these standards, focusing on six critical areas of most concern to patients, has been prioritised throughout the public health system. These areas cover:

- Values and attitudes
- Waiting times
- Cleanliness
- Patient and staff safety and security
- Infection prevention and control
- Availability of medicines and supplies

2.3 Process of conducting inspections

2.3.1 Introduction

The inspection is an activity that allows teams of inspectors to utilize assessment tools structured to collect different types of evidence. An organized plan is followed to prepare, conduct and report findings of inspections. The two way process involves the Heath Establishment staff and OHSC inspectors. A validation of results follows the conclusion of inspection findings.

Expectations are set by law for the health establishment to close gaps identified during inspections. Other regulatory steps are to be applied post the inspection as health establishments that are found to be non compliant are issued with a notice of non compliance. Risk imposed by non compliance receives a specialized approach to pursue compliance.

2.4 Inspectorate Functional model:

2.4.1 Team and inspectors

Each team inspects an allocated health establishment for a number of days ranging from one to three depending on the type and size of the health establishment. Each team comprises a team leader to oversee the execution of the inspection plan and the inspectors and administrative support staff.

2.4.2 Health Establishments

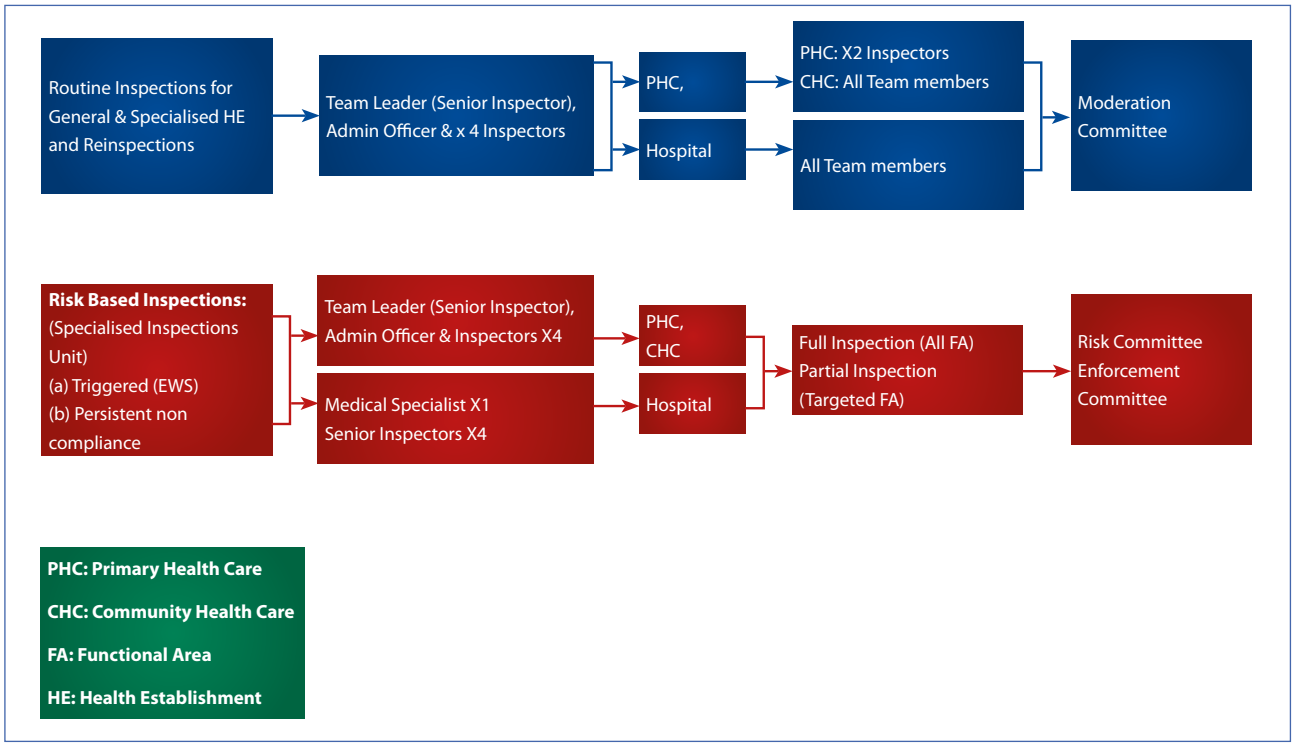
Inspections are currently conducted in hospitals, community health centres and hospitals in the public sector. Plans are in place to commence inspections in the private health sector in 2016. The overarching principle is that inspections look into the health system problems/challenges within a health facility and not at individuals rendering services.

2.4.3 Notice of inspection

Inspector upon arrival at the health establishment will issue them with notice of inspection which should include the following information

(a) The purpose of the inspection;
(b) The date of the inspection;
(c) The estimated duration;
(d) The inspection plan
(e) The number of authorised personnel expected to take part in the inspection;
(d) The contact details of the inspector primarily responsible for the inspection;
(e) The responsibilities of the health establishment.

Figure 3: Inspection Team per health establishment

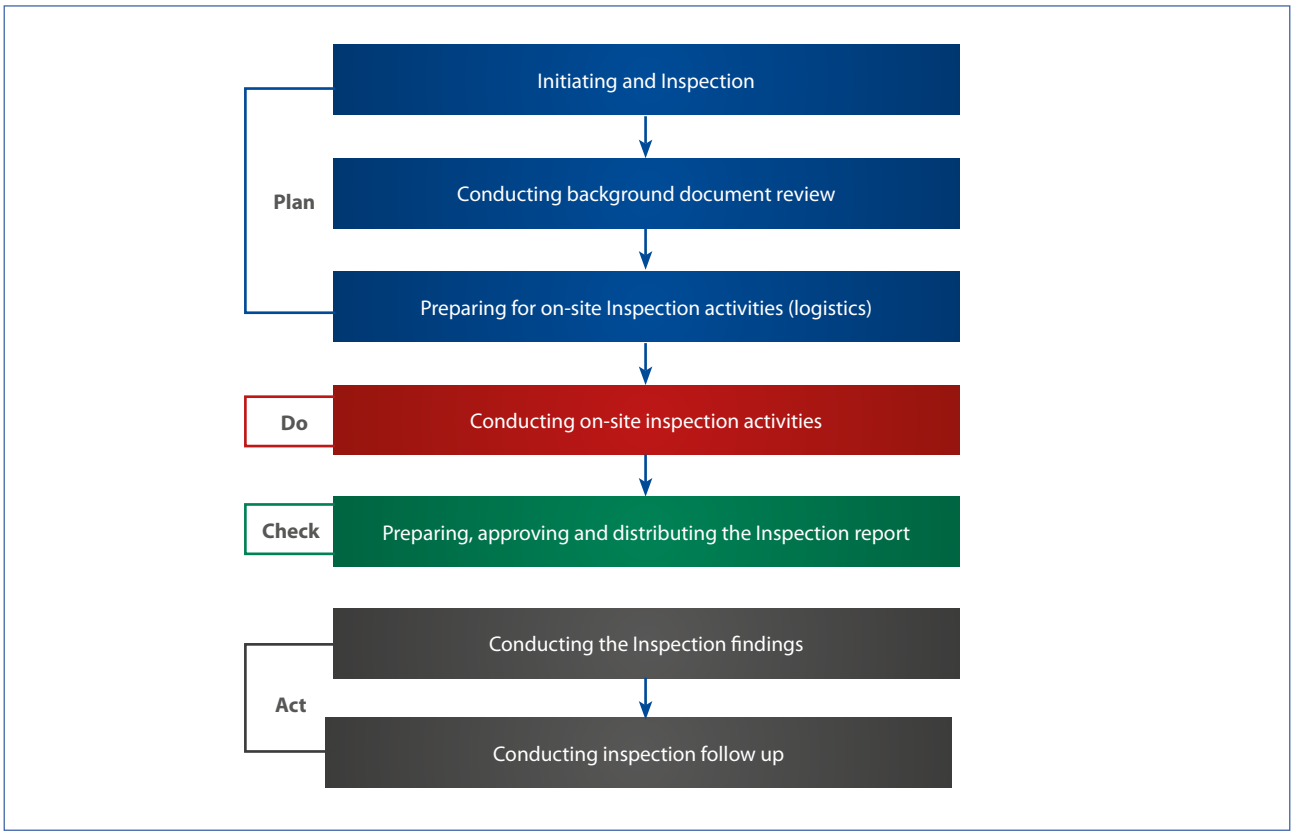


2.5 Inspection Process: pre, during, post inspections:

The major steps in an inspection also follow a logical Plan-Do-Check-Act cycle which indicates that even within the processes of the inspectorate unit quality improvement circles are continuously part of the way things are done; resulting in continuous improvement in the tools and methods of the unit.

Each major step has a series of sub steps which can be defined and placed within a Standard Operating Procedures type document or Inspectors Manual. Each sub step is defined below including the job title responsible for completing that step and the estimated time to completion.

Figure 4: The following main inspection process flow is utilised which is in line with ISO 90011:2002:

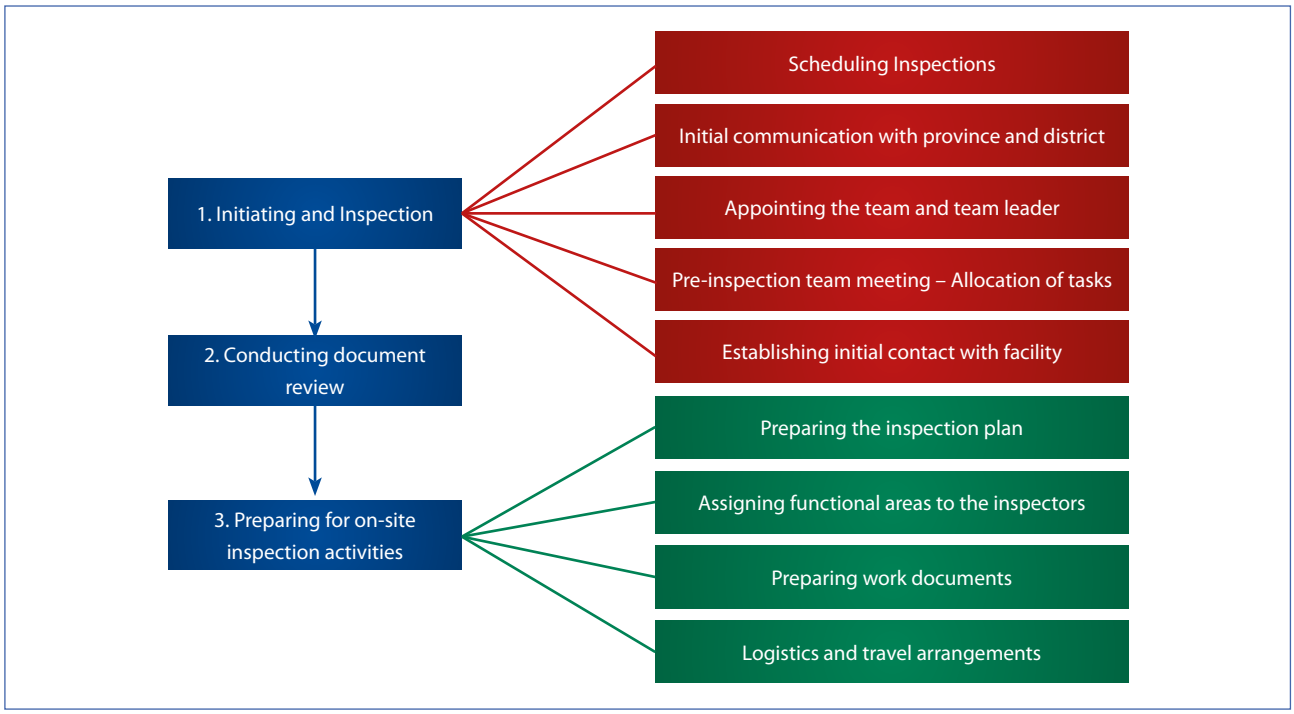


2.5.1 Planning phase:

The planning phase encompasses three steps:

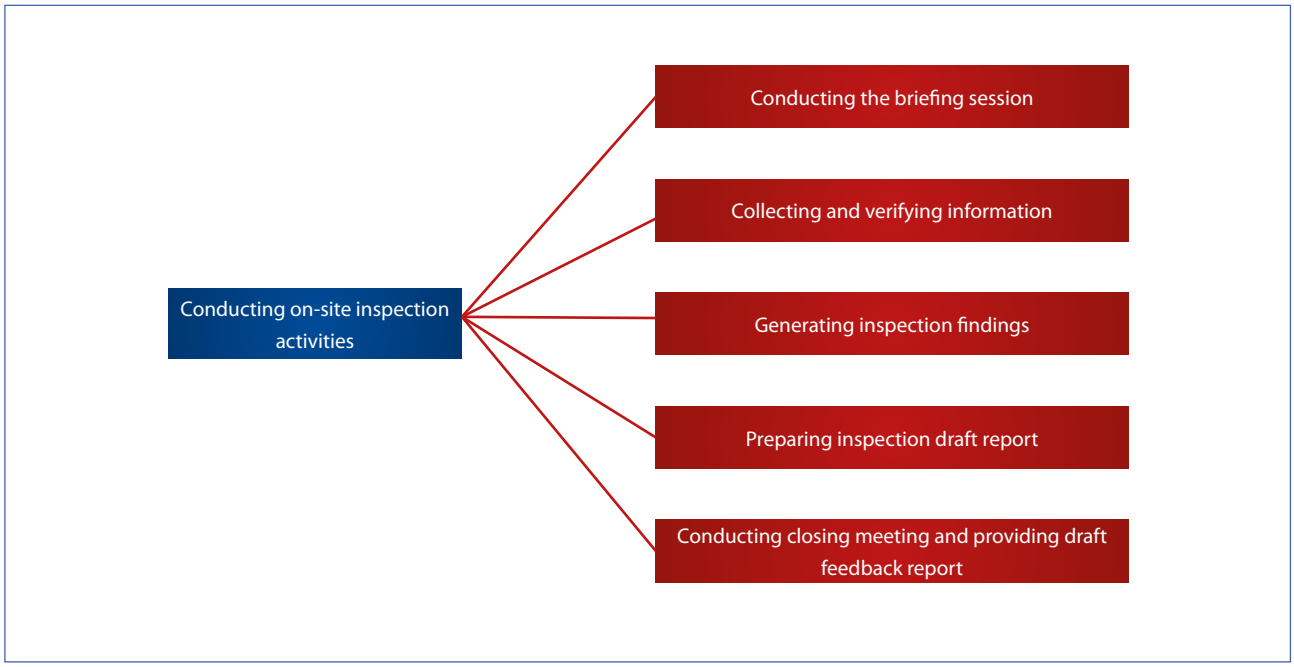
(a) Initiating an inspection
(b) Conducting document reviews
(c) Preparing for onsite inspection activities

Figure 5: Planning phase



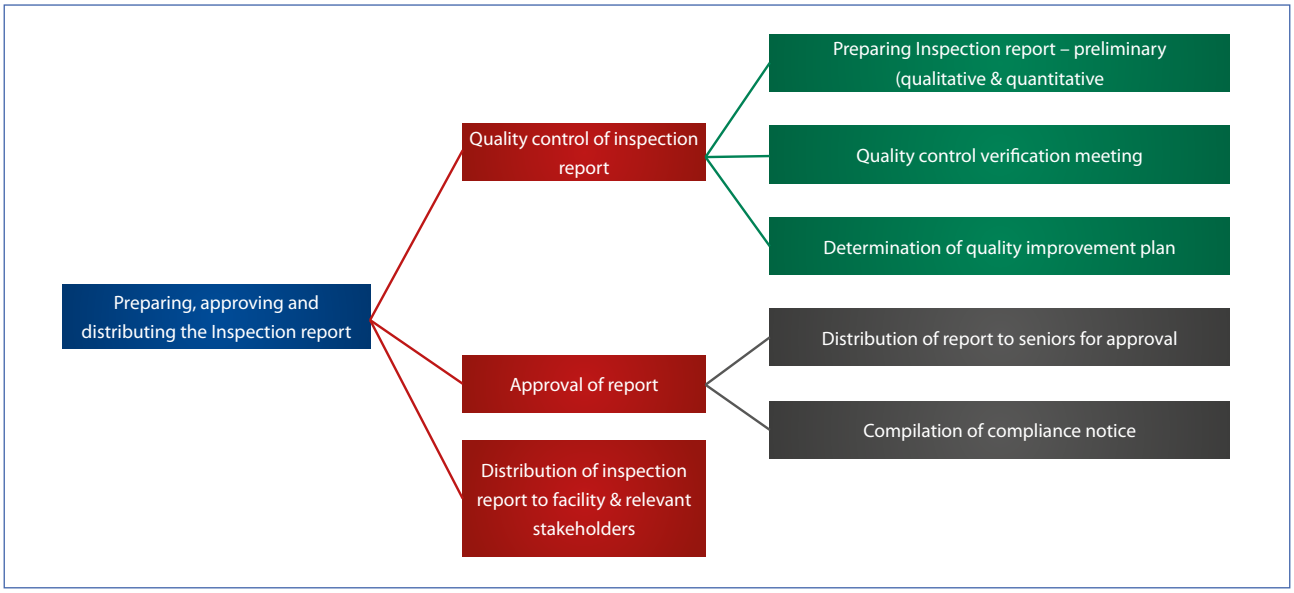
2.5.2 Do phase:

Figure 6: The Do phase encompasses the inspection including the briefing sessions before and feedback session of provision findings after the inspection.



2.5.3 Check phase:

Figure 7: The Check phase encompasses verification and validation of the inspection findings through internal quality control processes both within an inspecting team and between inspecting teams.



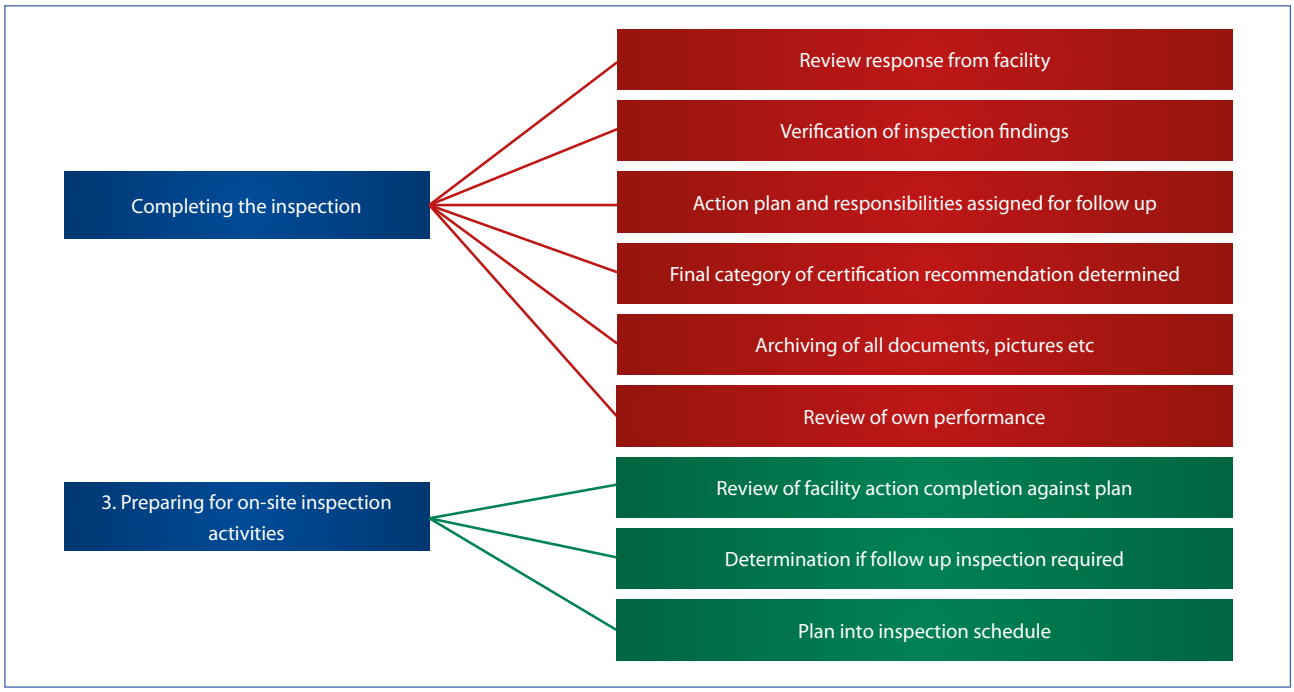
2.5.4 The quality control process can be divided into 3 major parts as reflected in the Table below:

Figure 8: Every inspection tool will be validated according to the Data quality control standard operating procedure to ensure the validity of inspection process and Quality control steps.

During inspection	In office – Self validation/buddy review	In office – Team Peer Review
• Within functional area with manager (blanks, comments, NC's) • Ao's check before data capturing (blanks, Comments) • Team meting – qualitative impressions, comments and NC's in reports • Team generates "Summary of Findings" • DHIS draft report generated – correlate impressions, summary of findings with results and score for consistency • Evaluate the report for feedback purpose	• AO's provide "assessment questionnaire with results" by functional area • Self evaluate comments, NC's and consistency	• Validate changes made by each inspector per facility • Evaluate inconsistencies within and between inspectors and departments and correlate with general impressions and summary of findings • Generate provisional report post quality control meeting – signed by team leader (copied to Director and CD?)

2.5.5 Act phase:

Figure 9: The Act phase encompasses the response by the facility to the inspection findings and their plan of action to address the findings with the issuing of a compliance notice to that facility. It includes the archiving of all relevant information related to the inspection. And finally the planning of follow up visits for facilities deemed necessary.



2.6 Guiding Principles

The conduct of inspections in the OHSC is guided by the following principles:

i. **Results Oriented:** The inspection processes should geared towards measuring desired results and obtaining evidence that will be useful in decision-making.
ii. **Standardisation:** Data collection methods and inspection tools should be standardised across the country. Data collection tools should be streamlined to avoid duplication and increased efficiency.
iii. **Independence:** Inspectors should be free from control or undue influence from policy makers and programme managers.
iv. **Sustainability:** Budget allocation for OHSC should take into account the cost implications of building and maintaining a functional, effective inspectorate unit
v. **Capacity building and Competence:** A competent team of inspectors should be developed with relevant clinical knowledge, skills and experience to develop and sustain functional inspectorate system
vi. **Impartiality:** Inspections should be conducted in an impartial manner. The inspection should be free from bias in sampling and methods of data gathering, data analysis, interpretation of findings, as well as formulation of conclusions and recommendations.
vii. **Due diligence:** Applying careful consideration of all relevant factors during and after conducting an inspection
viii. **Confidentiality:** Handle information with due care and discretion and to protect and secure information that is sensitive or confidential.
ix. **Fairness and truthfulness:** Make sure that audit results are fair and presented as such and to make sure that important concerns are reported adequately
x. **Integrity and professionalism:** Abide by all applicable legal requirements applicable to the profession; to manage the unscrupulous pressures that may be imposed upon it and the influences that may affect professional judgment.
xi. **Independent and impartial decision making:** Maintain independence from the inspection process, not to take side and always be free of bias.
xii. **Evidence-based approach:** Rely on evidence to make findings that are consistent and reliable

Table 4

Facility type	EC	FS	GP	KZN	LP	MP	NW	NC	WC	Total
Clinics	100	53	49	90	59	57	52	42	65	567
CHC/CDC	0	1	2	0	0	1	1	2	2	9
District Hospital	5	2	2	4	3	3	1	3	4	27
Regional Hospitals	2	2	4	0	1	0	0	0	0	9
Provincial Hospitals	1	1	3	1	2	1	0	1	1	11
Central Hospitals	1	0	2	1	N/A	N/A	N/A	N/A	0	4
Total	**109**	**59**	**62**	**96**	**65**	**62**	**54**	**48**	**72**	**627**

Table 4 above indicate the number all inspections 2015 -2016 which amounts to the total number of 627 (495 Routine Inspections of HE + 132 Re inspections). Different categories of health establishments were inspected in each province and some re inspected across all the 9 Provinces and these include 4 Central Hospitals, 11 Provincial Tertiary Hospitals, 9 Regional Hospitals, 27 District Hospitals, 9 CHC and 567 Clinics. The intended coverage was exceeded because the inspection teams were increased from 5 teams to 7 during the 2015/2016 financial year.

Eastern Cape (Provincial Alphabetical Order)

Figure 10: Health Establishments inspected in each province per facility type

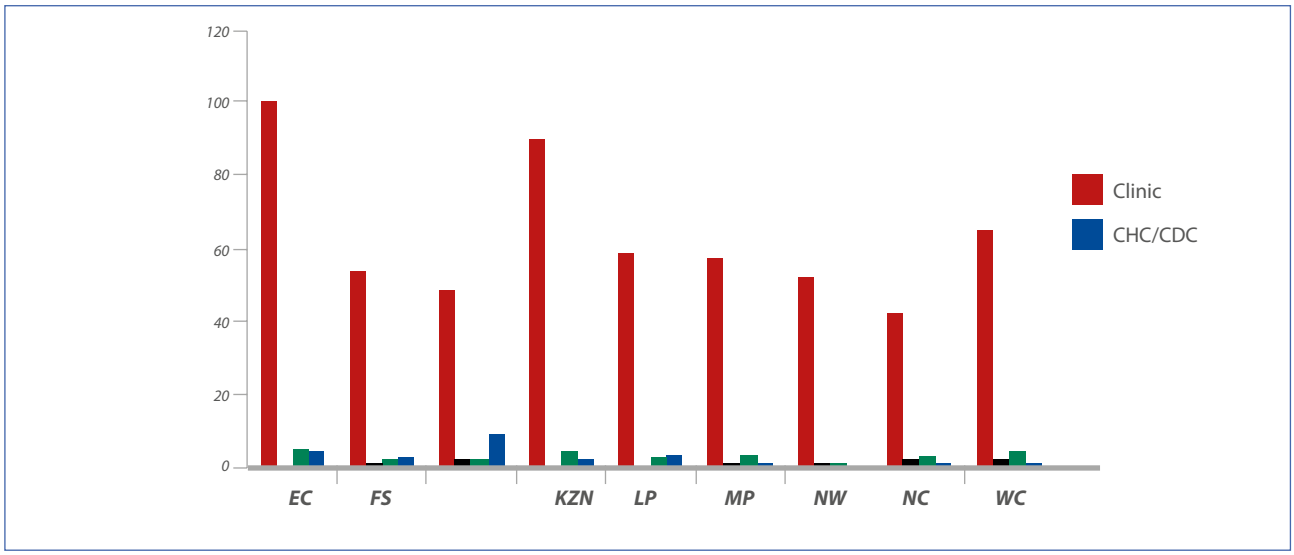


Figure 10 above shows the facilities inspected per province and Eastern Cape having the high number of Health Establishments inspected as most of their Health Establishments is clinics followed by KZN then Western Cape. In both the table and the graph above, no CHC`s were inspected in EC, KZN and LP during the financial year.

Figure 11: Eastern Cape Inspections

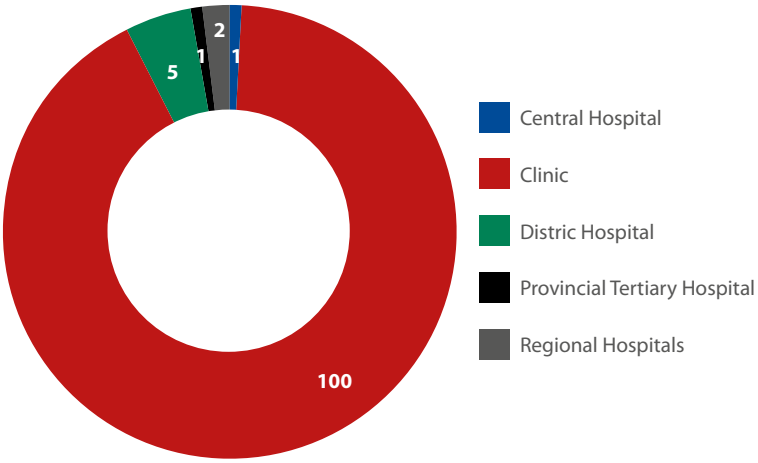


Figure 11 shows the facilities inspected in Eastern Cape for the financial 2015-2016, amongst the categories of Health Establishments inspected, no CHC's were inspected and the bulk of the inspected facilities were clinics. All different levels of hospitals were also inspected.

Figure 12: Free State Inspections

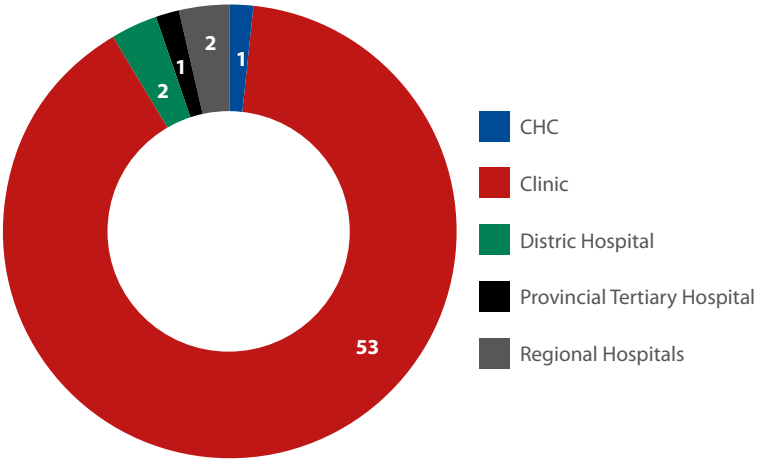


Figure 12 shows the facilities inspected Free State for the financial year 2015-2016 and all categories of Health Establishments were inspected and not all levels of hospitals were inspected.

Figure 13: Gauteng Inspections

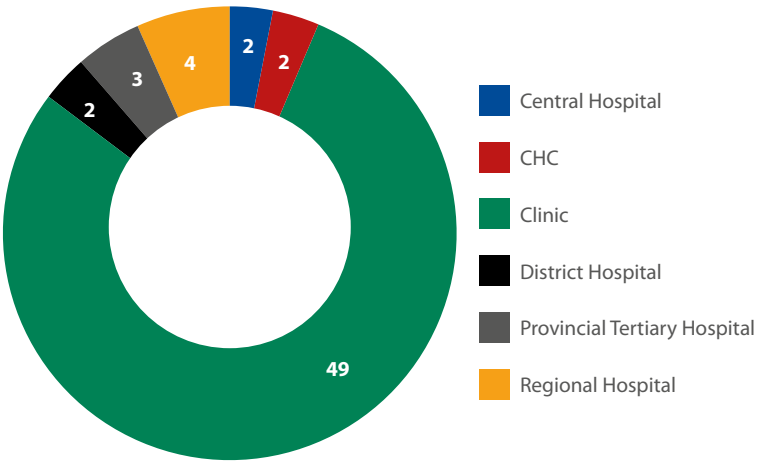


Figure 13 shows the facilities inspected in Gauteng for the financial year 2015-2016 and all categories of Health Establishments were inspected and all levels of hospitals were inspected. The bulk of inspected facilities are also clinics and in this province most of their clinics are under the Municipality.

Figure 14: KwaZulu Natal Inspections

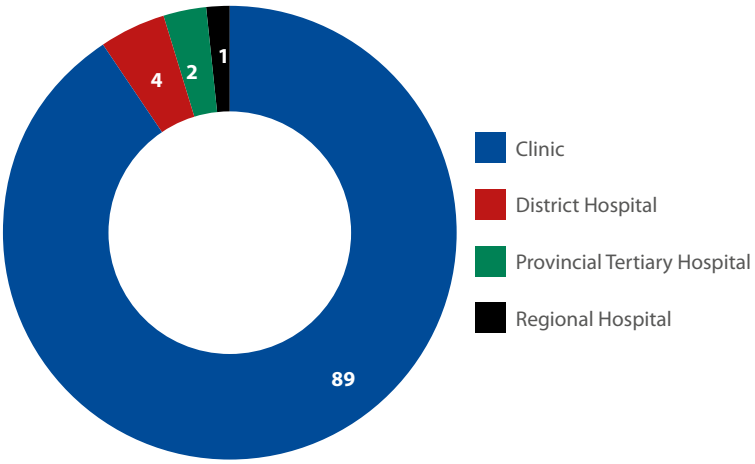


Figure 14 shows the facilities inspected in KwaZulu Natal for the financial years 2015- 2016, no CHC's were inspected. Most of the clinics in this province attached to the hospitals and are owned by the municipality and mostly clinics were inspected.

Figure 15: Limpopo Inspections

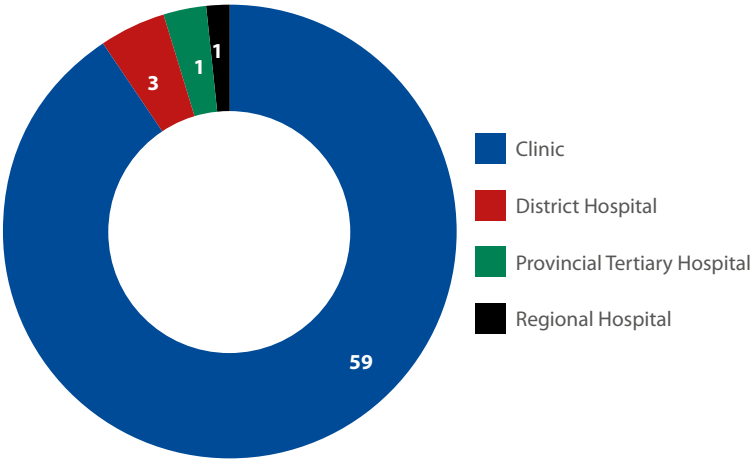


Figure 15 shows the facilities inspected in Limpopo for the financial year 2015-2016. No CHC's were inspected and mostly clinics were inspected and different levels of hospitals were inspected as there's no Central Hospital in the Province.

Figure 16: Mpumalanga Inspections

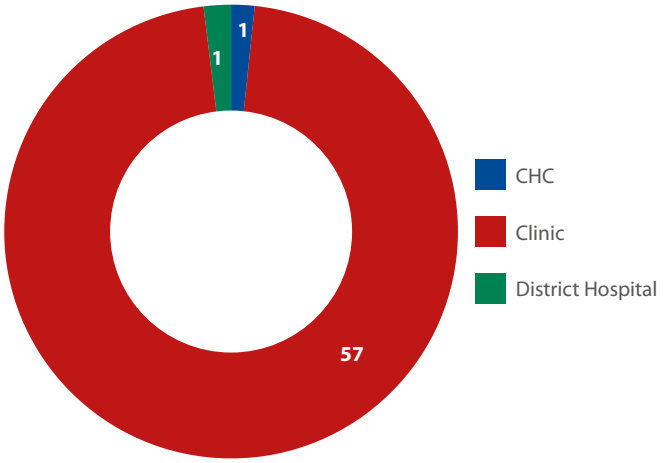


Figure 16 shows the facilities inspected in Mpumalanga for the financial year 2015-2016 and all categories of Health Establishments were inspected, with the clinics forming bulk of the inspected health Establishments.

Figure 17: North West Inspections

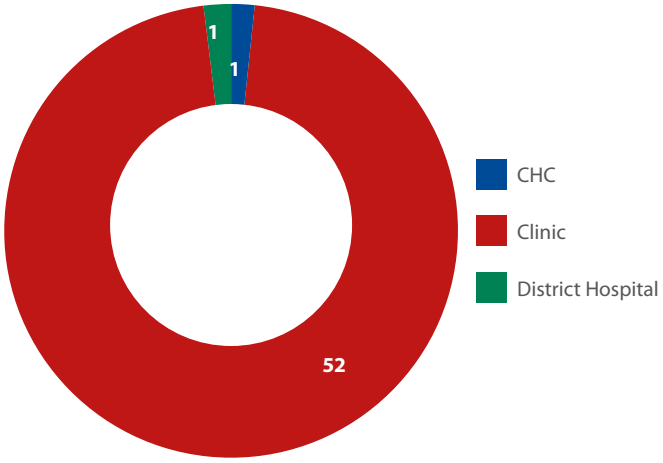


Figure 17 shows the facilities inspected in North West for the financial year 2015-2016 and all categories of Health Establishments were inspected though only 1 Hospital and 1 CHC were inspected.

Figure 18: Northern Cape Inspections

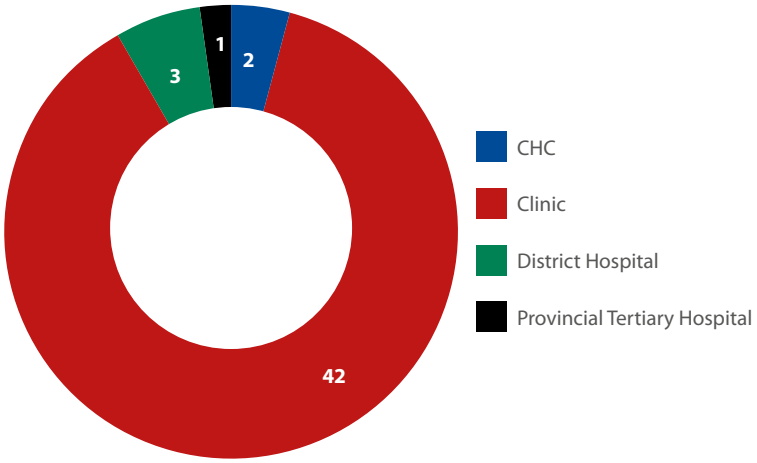


Figure 18 shows the facilities inspected in Northern Cape for the financial year 2015-2016 and all categories of Health Establishments were inspected with the majority being clinics.

Figure 19: Percentage outcome per province

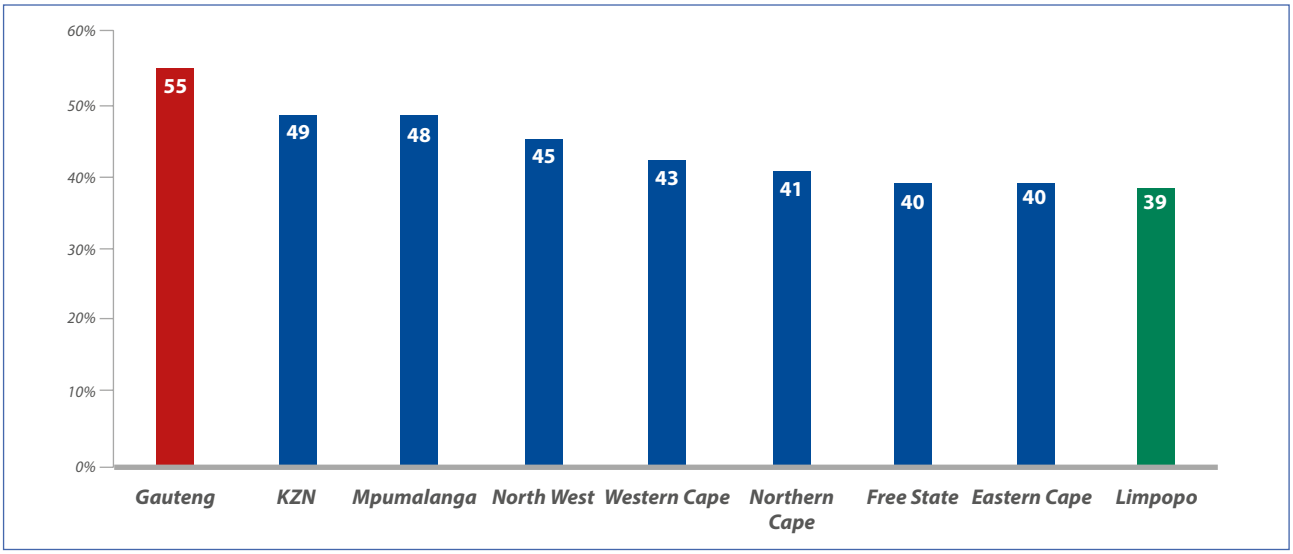


Figure above reflects the percentage outcomes per province for all Health Establishments inspected in 2015-2016 and Gauteng found to be leading with the highest percentage score of 55% and Limpopo being the lowest with 39 percent as the province is under administration and the CEO's of hospitals have no delegations entrusted on them. The majority of the provinces have an overall performance below 50% with the exception of Gauteng.

B

INSPECTION RESULTS: CENTRAL HOSPITALS

- DR GEORGE MUKHARI CENTRAL HOSPITAL
- KING EDWARD VIII CENTRAL HOSPITAL
- CHARLOTTE MAXEKE CENTRAL HOSPITAL
- NELSON MANDELA CENTRAL HOSPITAL

3.1 According Regulation 185 of National Health Act 61 of 2003:

6. (1) A Central Hospital:-

a) Must provide tertiary hospital services and central referral services and may provide national referral referral services;
b) Must provide training of health care providers;
c) Must conduct research;
d) Receives patients referred to it from more than one province;
e) Must be attached to a medical school as the main teaching platform; and
f) Must have a maximum of 1200 beds

3.2 Inspected Central Hospitals

There are 10(ten) central hospitals in South Africa which provides varying specialized services as will be defined in their individual profiles. For 2015/2016 financial year, 4 Central Hospitals were inspected based on Compliance Inspections Operational plan:

1. Dr. George Mukhari Central Hospital- Gauteng Province
2. King Edward VIII Central Hospital- KwaZulu-Natal Province
3. Charlotte Maxeke Central Hospital- Gauteng Province
4. Nelson Mandela Central Hospital- Eastern Cape Province

In the next section below the Central Hospitals profile and inspections performance is discussed in detailed as per Domains and Six Priority Areas (National Core Standards).

3.3 Dr. George Mukhari Academic Hospital

Brief Profile

Dr. George Mukhari Academic Hospital (DGMAH), formerly known as Ga- Rankuwa Hospital, was built in 1972 and is situated in Ga-Rankuwa, on the North-Western part of Tshwane Region of Gauteng Province.

DGMAH was initially a Regional Hospital and later tertiary services were added subsequent to the establishment of Medical University of South Africa (MEDUNSA) in 1974, to which DGMAH serves as the health sciences teaching platform.

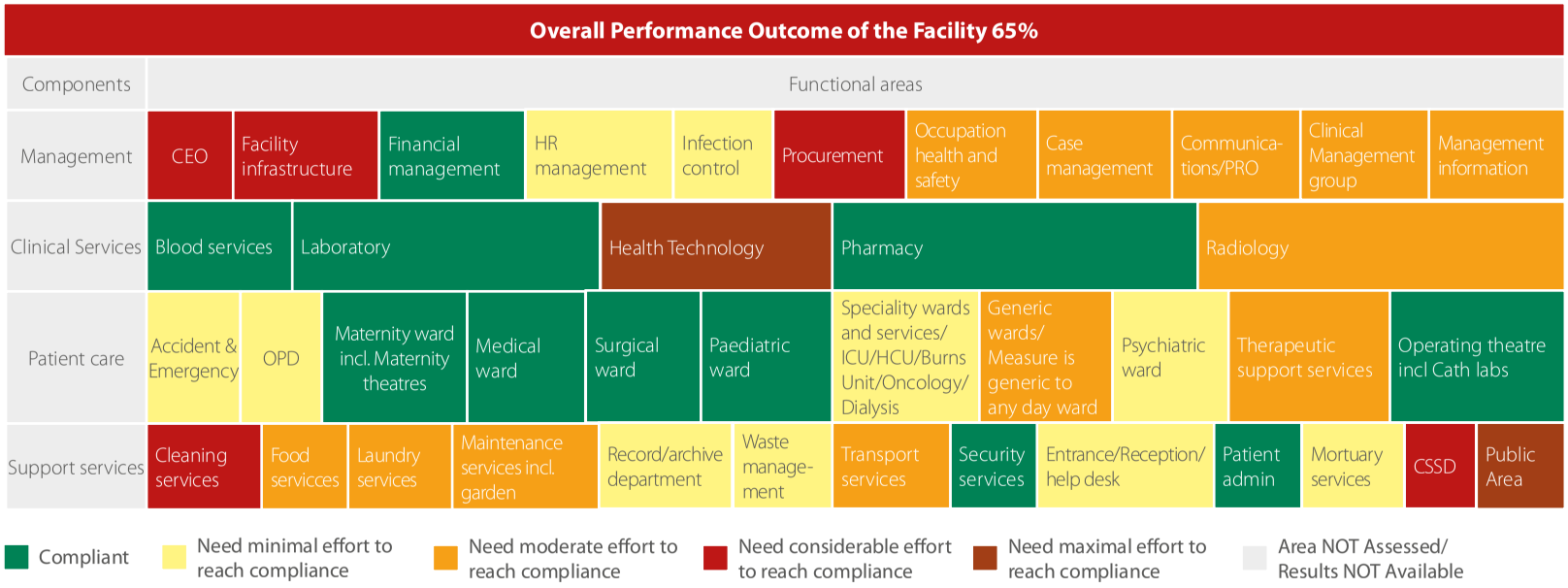
DGMAH gained academic status in 2011which was followed by the establishment of the new Sefako Makgatho Health Sciences University (SMU), building on the legacy of the old Medunsa. DGMAH is also a teaching platform for the Ga-Rankuwa Nursing College.

DGMAH has a total of 1652 approved beds and the drainage\catchment area population is 1 200 000 (Census 2011) referral system Number of building sites.

Table 5

Surgical Cluster	Medical Cluster	Critical Care Cluster	Mother and Child Cluster	Diagnostic Cluster
General surgery	Internal medicine	Trauma unit	Obstetrics & Gynaecology	Obstetrics & Gynaecology
Orthopedics	Family medicine (including Emergency unit and level 1)	Intensive Care Unit (ICU)	Pediatrics	Pediatrics
Plastic surgery	Family medicine (including Emergency unit and level 1)	Theatre		
Neurosurgery	Mental health (Psychiatry)	Anesthesiology		
Urology	Mental health (Psychiatry)	Anesthesiology		
Cardiothoracic surgery	Community Health			
Pediatric surgery	Cardiology			
Ear, Nose and Throat (ENT)	Neurology			
	Gastroenterology			
	Nephrology			
	Dermatology			

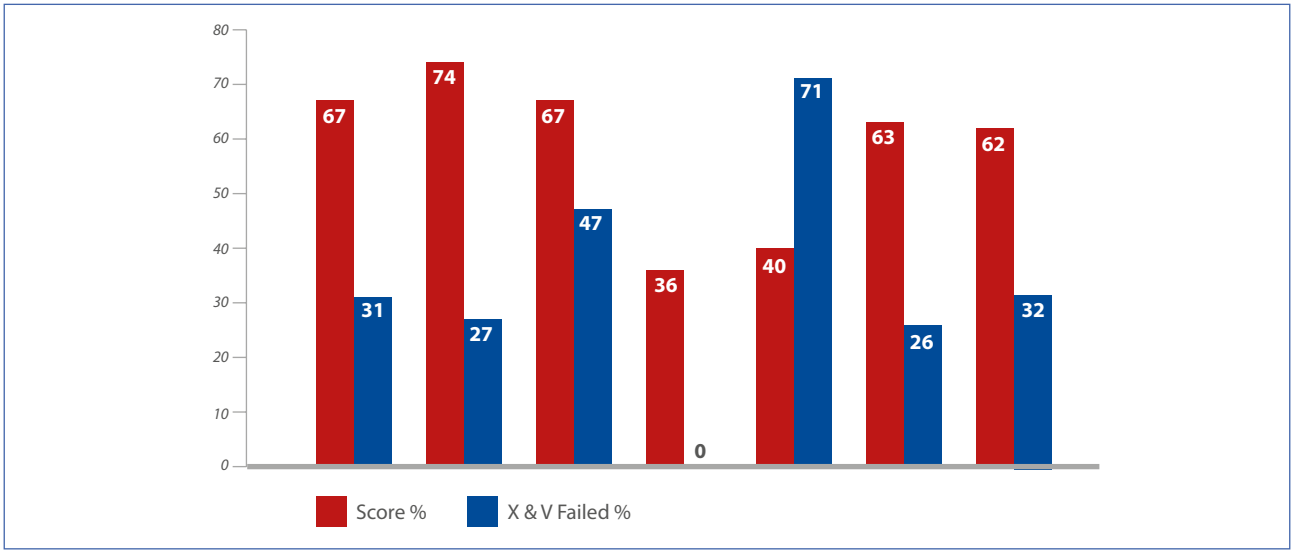
Table 6: Outcomes as per components



Hospital Summary Components Outcome

- Management component needs moderate to considerable effort to reach compliance status.
- Clinical Services component needs minimal to maximal effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component minimal to maximal effort to reach compliance status.

Figure 20: DGMAH Domain Outcome (Extreme and Vital)



The DGMAH Health Establishment was inspected and achieved an overall score of **65% compliance**. During the inspection period 2015/2016 the following are the score achieved per domain:

- Patients` Rights 67%
- Patient Safety 74%
- Clinical Support Services 67%
- Public health 36%
- Leadership and Corporate Governance 40%,
- Operational Management 63; and
- Facilities and Infrastructure 62%.

Table 7: Some DGMAH's Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Patients consent forms not appropriately filled e.g. no second witness signature, abbreviations used.	• Toilets used as storage area. • Poor segregation of waste observed. • Some ramps are of a very high gradient and but without rails. • Patient referral policy document in draft and also not covering all critical protocol aspects. • Procedure document governing the handover of patients from EMS to hospital staff not signed • Procedure document governing the handover of patients from EMS to hospital staff not signed and did not emphasise speedy hand over

Domain 2: Patient Safety/Clinical	
Extreme	Vital
• Initial assessment of maternity high risk patients does not reflect identification of risk factors. • Patient peri-operative documents incomplete e.g. Antibiotic prophylaxis not recorded as given. • Policy for handling emergency resuscitations not signed/ approved by head of institution, also not covering all aspects of check list. • Emergency trolley not checked daily, trolley missing some items e.g. Adult laryngoscope, oxygen cylinder not available. • Protocol on the administration of blood not followed e.g. Details of transfusion not documented or need for blood not stated. • Emergency blood not available blood in fridge A&E unit - blood also out of stock from blood bank. • Infectious TB patients not separated by means of adequate physical barriers from non-TB patients. • Appropriate isolation accommodation do not have all essential equipment e.g. Masks, No toilet in isolation unit.	• Clinical audits of priority programmes not done. • Report on health initiatives or programmes not available. • Documented procedure for conducting and acting on risk assessments of patients with reduced mobility not available. • Protocol for the management of patients on 72 hours observation-Policy not up to date. • Risk assessment conducted on patients at risk of developing pressure sores-No consistency in assessment. • Particle counts and bacterial growth not done bi-annually Oct 2013 + 6/2015. • Minutes of the forum reviewing resuscitations meetings not available - forum has not met and no minutes. • Minutes of the forum reviewing adverse events not available. • Minutes of the forum reviewing infection control do not indicate action taken consistently. • Statistics on common health care associated infections not available. • Procedure for reporting needle stick injuries newly developed not signed. • Sharps are not safely managed and disposed of e.g. Recapping observed and over full containers.
Domain 3: Clinical Support	
Extreme	**Vital**
• Not all functional essential equipment is available(Wards).	• SOP on how Schedule 5&6 medicines are to be managed, document ownership not stated. Document contains AZP, fluconazole as scheduled drugs. - document does not cover the wards. • Dispensing not done as per GPP e.g. Patients surname not written no permanent record of medicines issued. • Patients not informed about side effects of medicine dispensed. • The minutes of the forum which deals with adverse drug reactions shows no action plans. • No up to date records furnished on the maintenance plan for critical devices such as defibrillators. • Evidence of adverse events involving medical equipment, not available/document and no zero reporting. • Contact and SLA for CSSD document dated 1/08/15 and not signed. • No SLA to monitor decontamination services • Licence for sterilization equipment not available

Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Up to date copy of delegations of authority for CEO not available. • Operation plan quarterly targets not established • Minutes of the forum reviewing quality available, but no evidence of action to improve.
Domain 6: Operational Management	
Extreme	**Vital**
	• Minutes of the occupational health and safety committee / forum not available. • Medical examinations performed for all health care workers who are exposed to potential occupational hazards were never performed facilities have just started 01/07/2013/.
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Evidence that the unit is covered by emergency backup power - not available. A&E not covered by emergency back power system. • System available but no supply of medical gas since 2010. • Piped vacuum not working	• Daily inspections of cleanliness not carried out in all areas. Records of non-clinical areas produced. • Toilets and bathrooms dirty. • Facility not clean, linen stored on the floor behind units, mould observed in the kitchen • Some cleaning items not available • Essential cleaning equipment not all available e.g. window squeegee, janitor trolley. • Document showing monitoring of SLA for waste removal not available.

Table 8: In terms of Ministerial Priorities, the Health Establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	71.56%
Cleanliness	**47.14%**
Improve patient safety and security	68.6%
Infection prevention and control	69.68%
Positive and caring attitudes	67.5%
Waiting times	70%

The above Table reflects the performance of the health establishment in relation to the Six Ministerial Priority Areas. In this regard the Health Establishment is experiencing problems with basic hospital cleanliness not only physical cleanliness but also the availability of cleaning materials. The question is, what is the problem with basic cleanliness at our hospitals? and what remedial action has been taken since inspection feedback. Has the situation changed?

3.4 King Edward VIII Central Hospital

Brief Profile

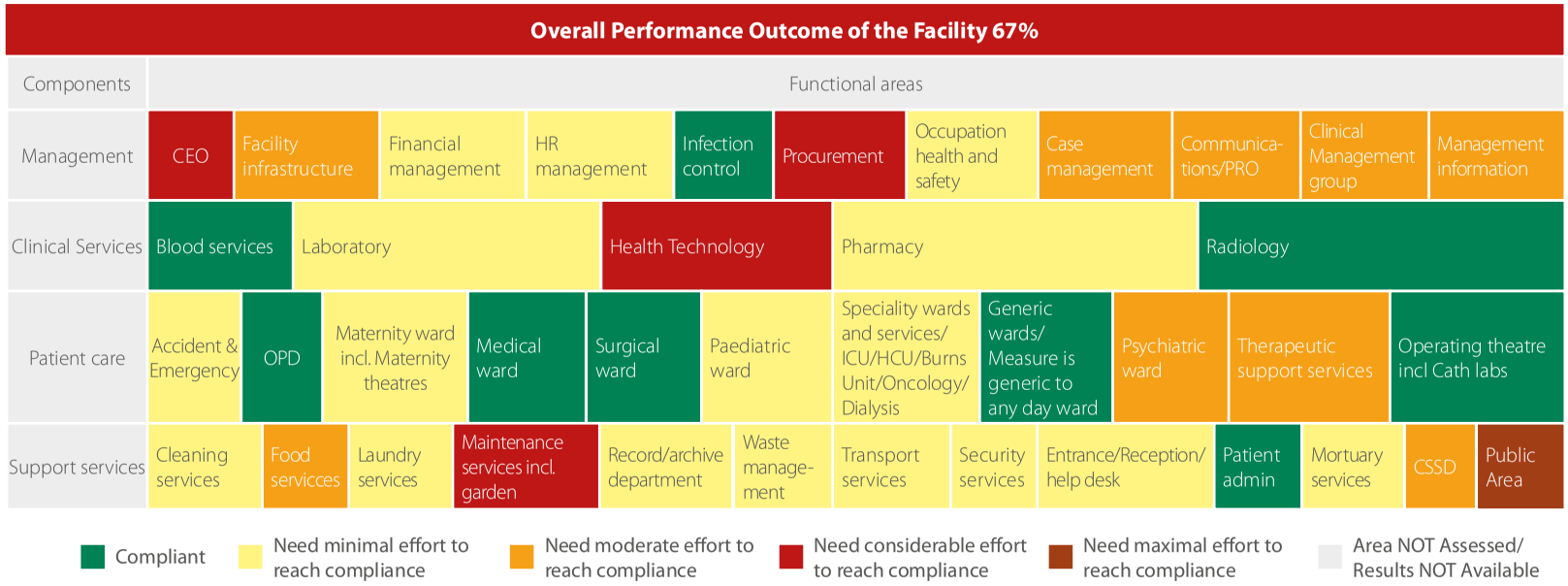
King Edward VIII hospital is the second largest hospital in the Southern hemisphere, providing Regional and Tertiary services to the whole of KZN and Eastern Cape. King Edward VIII is a 922 bedded hospital with +/-360 000 out patients. The hospital is situated in ward 33 in eThekwini Municipality.

King Edward VIII is a teaching hospital for the University of KwaZulu Natal's Nelson R Mandela School of Medicine and has a Nursing College attached to it with these specialties: Paediatrics and Advance Midwifery.

Table 9: Clinical and Aliied Health Care Services Offered

Services Offered	Services Offered
• Obstetrics & Gynae • Paediatrics • Psychiatric services • Neonatal ICU • Maxilo Facial • Ear Throat & Nose (ENT) • General Medicine • ICU • Emergency and Trauma Unit • Theatres • Special clinic services • Pharmacy • Telemedicine site	• Dietetics • Speech & Audio • Physiotherapy • Occupational Therapy • Full Radiology Unit • Social work

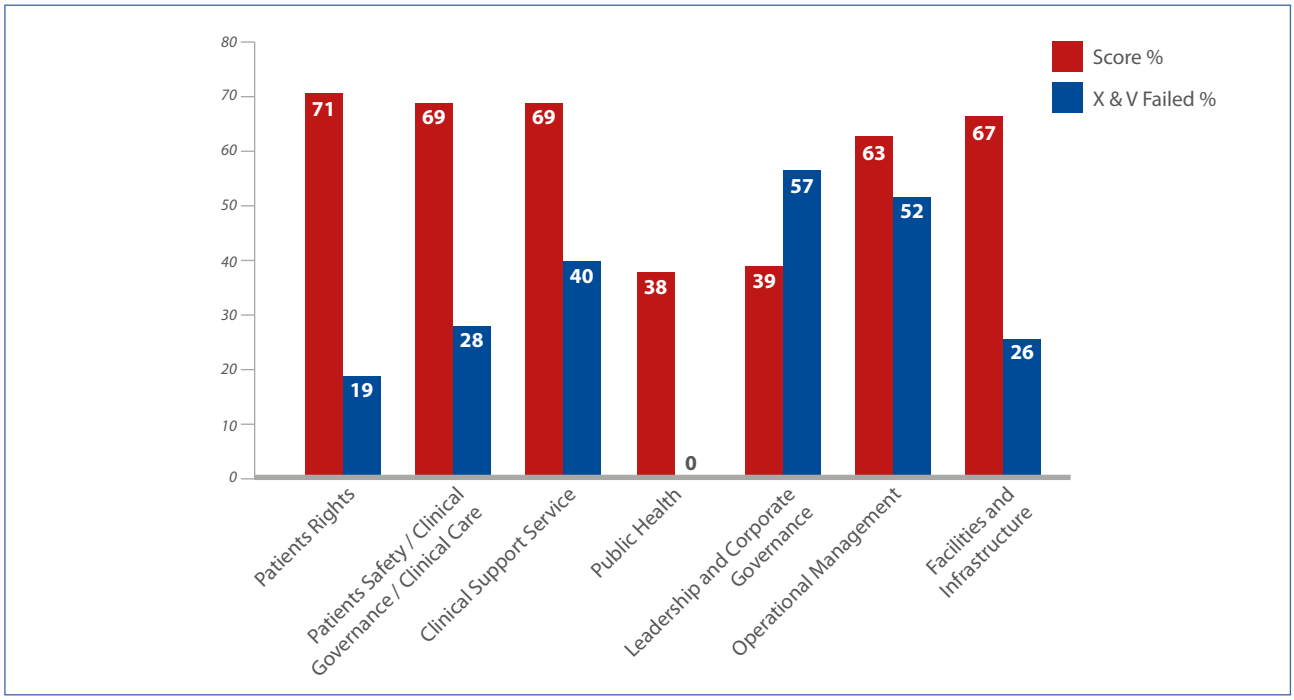
Table 10: KEH Outcomes as per components



KEH Summary Components Outcome

- Management component needs moderate to considerable effort to reach compliance status.
- Clinical Services component needs minimal to considerable effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component minimal to maximal effort to reach compliance status.

Figure 21: KEH Domain Outcome (Extreme and Vital)



The KEH Health Establishment was inspected and achieved an overall score of 67% compliance. The following are the score achieved per domain:

- Patients` Rights 71%
- Patient Safety 69%
- Clinical Support Services 69%
- Public health 38%
- Leadership and Corporate Governance 39%
- Operational Management 63%
- Facilities and Infrastructure 67%

Table 11: KEH Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for informed consent were not witnessed.	• Six areas checked for state of cleanliness were, Hospital Store Room are dirty and not neatly packed. • Patient Referral Policy not available. • Correct handover procedure was not followed between EMS staff and establishment e.g. Time of arrival and mode of transfer was not indicated.

Domain 2: Patient Safety/Clinical	
Extreme	**Vital**
• Security measures were not adequate to safeguard new born e.g. no security personnel at the entrance. • Emergency trolley was not appropriately stocked e.g. tracheal tubes, NG tubes, Laryngeal mask airways and eye protection not available. • Isolation accommodation not available for patients with communicable diseases.	• Minutes provided for one month only for monthly maternal and perinatal morbidity and mortality meetings. • Clinical audit on priority programmes not available. • Reports on health initiatives not available. • Patients safety checks not correctly done during transferring of patients. • Minutes of the forum reviewing resuscitation was not available. • Protocol regarding safe administration of medicines was outdated, was due for review in 2014. • Safety of patients receiving medications was not assured e.g. Side effects not explained. • Minutes of the forum reviewing adverse events produced were for November 2014. • Sharps were not disposed safely such as recapping of needles observed.
Domain 3: Clinical Support	
Extreme	**Vital**
• Not all tracer medicines were available. • Some functional equipment not available.	• Dispensing not done in accordance with applicable policies and legislation e.g. patients name not legible on the prescription. • Patients not given a comprehensive knowledge of their medication. • Interviewed patients verbalises that Side effects were not explained to them. • Minutes of the forum which deals with adverse drug reaction was not available. • Staff interviewed were unable to explain how cold chain is ensured for all blood products. • A report showing adverse events involving medical equipment was not available. • Contract and service level agreement was not available. • Service Level Agreement for decontamination services was not available • All sterilisation equipment was not licenced.

Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Evidence that exit interview were conducted with all managers who have resigned and action plans are put in place to address issues raised was not available. • Evidence regarding the health establishment responses to the public during a recent health related issues such as an outbreak was not available. • Policy or protocol for obtaining a consent form was not signed by relevant authorities.
Domain 6: Operational Management	
Extreme	**Vital**
	• Evidence of staff patient ratios in key areas are in accordance with the approved staffing plan was not available. • Evidence that action is taken to deal with absenteeism and staff vacancies was not available. • Evidence that exception reports are compiled where expenditure on high risks areas deviates from budgets by more than 5 percent was not available. • SOP for request and retrieval /filing of patients files not available.
Domain 7: Facilities and infrastrure	
Extreme	**Vital**
• Documented evidence in the event of power disruption emergency power supply is available in critical clinical areas was not available.	• Some vulnerable patient areas do not have a security system such as Maternity, Paediatric Wards. • Evidence of dust seen, dusting not done, not all areas are clean. • Not all cleaning material, chemicals and equipment were available. • Records to show that waste management monitors and manages the service level agreement for waste removal was not available.

Table 12: In terms of Ministerial Priorities, the Health Establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	77%
Cleanliness	**64%**
Improve patient safety and security	65%
Infection prevention and control	70%
Positive and caring attitudes	75%
Waiting times	82%

The above Table reflects the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to cleanliness which does not only cover the physical cleanliness but also the availability of cleaning materials.

The health establishment was also not performing well with regard to patient safety and security as compared to other priority areas. The question what is the problem with basic cleanliness, safety and security of patients and what remedial action have been taken since management inspection feedback. Has the situation changed?

3.5 Charlotte Maxeke Academic Hospital

Brief Profile

The Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) is an accredited Central Hospital with 1088 beds serving patients from across the Gauteng province and neighbouring provinces. It offers inpatient and specialist outpatient's services mainly level 3 and level 2.

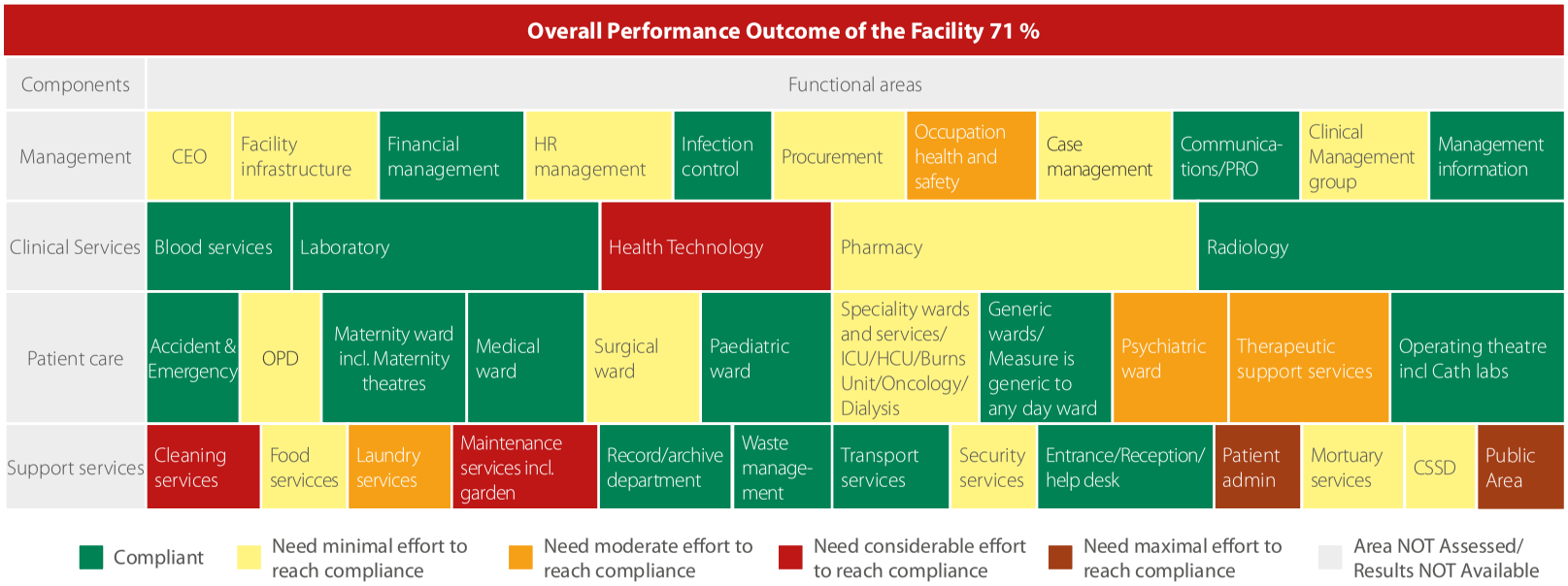
The hospital's professional and support staff exceeds 4000 Clinical, Allied and support staff and it includes a mix of in-house, outsourced and other government agencies, e.g. maintenance through Public Works.

The hospital offers a full range of tertiary, secondary and highly specialized services. The costs of providing these services to the population of Gauteng Province and in addition to the neighbouring provinces are funded by a National Tertiary Services Grant as well as Provincial allocation. The hospital is located in Parktown and it is also a referral hospital for a number of hospitals in its referral chain. The services are highly expensive, with unique specialist skills and are high tech which accounts for the cost per patient compared to primary health care centres.

The Charlotte Maxeke Johannesburg Academic Hospital has a private wing Folateng a Sotho name meaning "Place of healing". Each ward gives the patient the quality and convenience of private health care with specialist physicians and cutting edge technology that only a long-established hospital has the capacity to offer.

The hospital is also the main teaching hospital for The University of the Witwatersrand, faculty of Health Sciences. The institution provides the service base for undergraduate and post-graduate training in all area of health professions. The joint staff produces world-class research and collaborates with several universities in the continent and abroad.

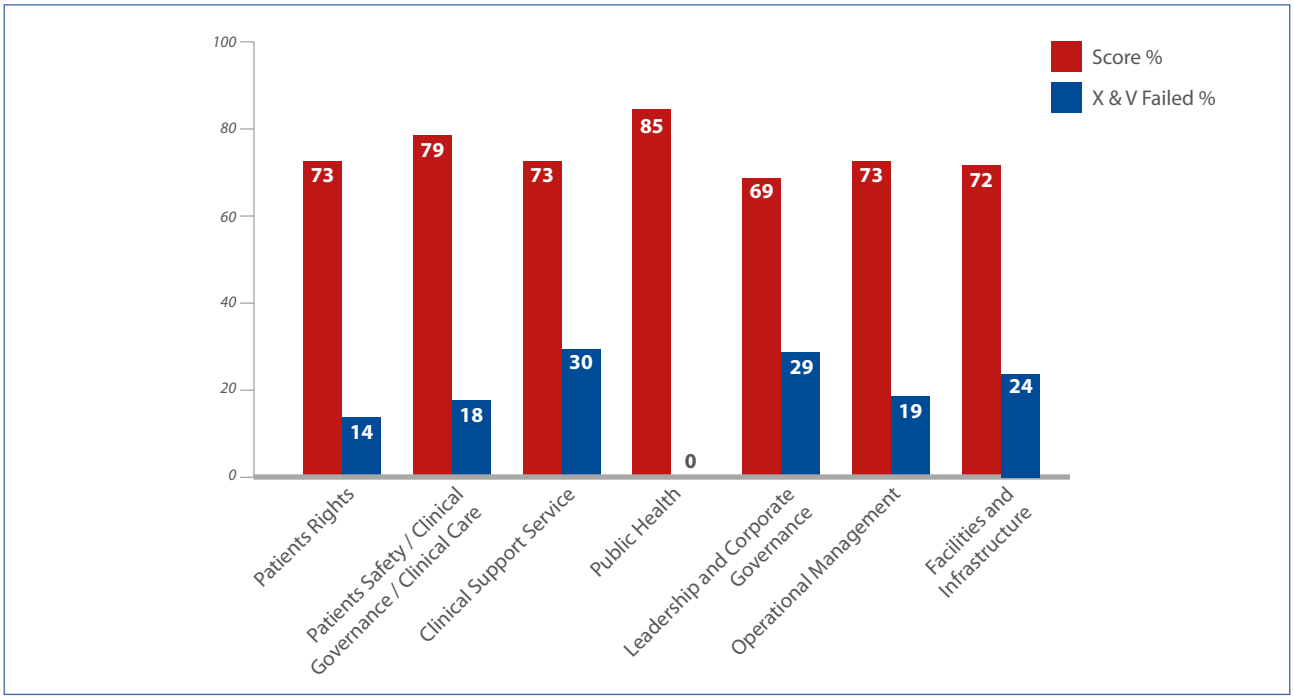
Table 13: MJAH Outcomes as per components



CMJAH Hospital Summary Components Outcome

- Management component needs minimal to moderate effort to reach compliance status.
- Clinical Services component needs minimal to considerable effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component minimal to maximal effort to reach compliance status.

Figure 22: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an **overall score of 76% compliance**. The following are the score achieved per domain:

- Patients` Rights 73%
- Patient Safety 79%
- Clinical Support Services 73%
- Public health 85%
- Leadership and Corporate Governance 69%
- Operational Management 73%
- Facilities and Infrastructure 72%

Table 14: Extreme & Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Consent forms were incomplete, no second witness signatures • Forms used for consent forms not completed correctly for an example doctor's performing the procedure missing signature	• Patient referral protocol produced not signed and not dated. • Not all medication dispensed in one patient's script, chloroquine reported to be out of stock.
Domain 2: Patient Safety	
Extreme	**Vital**
• High risk maternity records-week's foetal presentation not recorded. • Some details of peri-operative safety checks are not recorded such as concerns for recovery and management of patients. • Emergency trolley not regularly checked, adrenaline expired in 01/2016. • Emergency trolley not appropriately stocked and not regularly checked such as laryngoscope blade set were not available and defibrillator was not checked daily. • Emergency trolley not appropriately stocked, the following items were not available such as BP cuff, thermometer, xylocaine spray and suction catheters. • Oxygen cylinder not ready for use, regulator not connected. • Protocol on administration of blood not adhered to such as patient's vital signs prior administration of bloods not done.	• Clinical audits were not conducted in all programmes such as in PMTCT. • Report on health initiatives or programmes not available. • Minutes of forum reviewing clinical risk not available. • Written policy regarding physical and chemical restraints is no signed by CEO, in 72-hour assessment. • Written policy regarding chemical and physical restraints not signed by CEO. • Patients are not classified for risk and there are no nursing care plans. • Document on particle counts and bacterial growth not available • Minutes of the resuscitation forum not available • Safe administration of medicines protocol not reviewed and not signed by relevant authorities. • Nurse did not identify the patient and did not explain to patients the side effects of medication • Immediate actions and root cause analysis for documented adverse events not available. • Sharps not safely disposed such as recapping noted.

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Emergency trolley not appropriately stocked such as HB metre, tracheotomy and cut-down set not available. • Functional essential equipment not all are available such as ECG machine not in use. ECG paper for that specific machine is not available.	• Standard operating procedure is not signed by relevant authorities for control and distribution of schedule 5 and 6 medication. • Dispensing not done in accordance with applicable policies and legislation such as no dosage form, no reference number on affixed label. • Clear understanding not given to patients such as Potential side effects not explained. • Clinical audits were not conducted in all programmes such as in PMTCT. • Minutes of forum dealing with adverse drug reactions not available. • Fridge temperature and blood transportation not known by both staff members. 1 member do not know minimum or maximum temperature levels. • Both sampled staff did not know the temperature including transportation of blood. • Interviewed staff was not aware of the temperature of transporting blood products. • Documentation on adverse blood reactions not availed. • No maintenance schedule for defibrillator and anaesthetic machine. • System to monitor items requiring replacement or ordering not in place. • Report indicating adverse events involving medical equipment not available.
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Action plans on exit interview conducted not in place. • Policy on obtaining consent form not available.
Domain 6: Operational Management	
Extreme	**Vital**
	• Evidence of monitoring of staff performing remunerated work outside the establishment not done • Job descriptions (for who?) not available at time of inspection

Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• No documented evidence of power supply in the event of power disruption is not available. • The piped suction had low pressure vacuum. • Bins are not lined and have no lids.	• Checking of water supply was not done consistently; records have gaps. • Facility was not clean, basement dirty, cockroach observed in medicine store room. • Not all cleaning material and equipment were available e.g. No janitors trolley and squeegee. • Records produced are from 1998-7 no date. Evidence produced is of all health professional's members, not of all the cleaners. • Pest control was not done monthly for all areas.

Table 15: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	75%
Cleanliness	**59%**
Improve patient safety and security	77%
Infection prevention and control	84%
Positive and caring attitudes	80%
Waiting times	65%

The above Table reflects the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to cleanliness, which does not only cover the physical cleanliness but also the availability of cleaning materials and general hospital cleanliness. The health establishment was also not performing well with regard to patients waiting times as compared to other priority areas. The question what is the problem with basic cleanliness and waiting times so what remedial action have been taken since management inspection feedback. Has the situation changed?

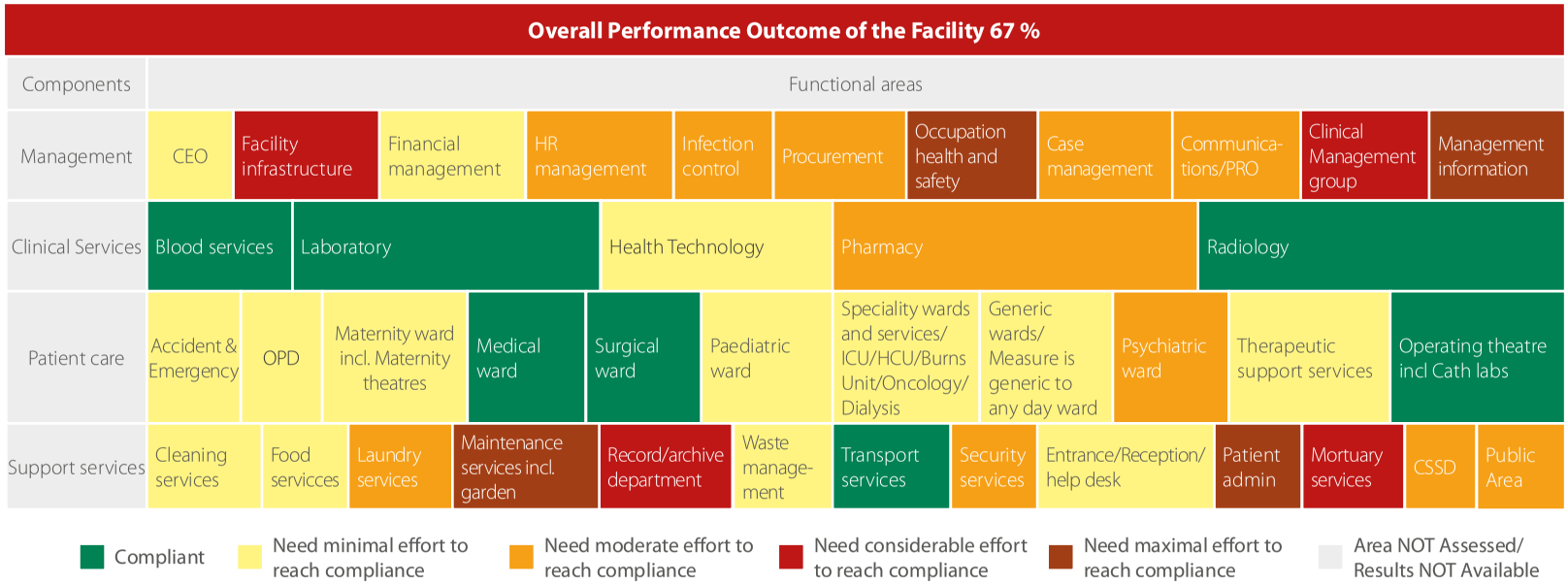
3.6 Nelson Mandela Academic Hospital

Brief Profile

Nelson Mandela Academic Hospital (NMAH) is a large Provincial government funded hospital situated in central Mthatha in Eastern Cape Province. The hospital is a designated tertiary teaching hospital and forms part of the Mthatha Hospital Complex.

The hospital departments include Emergency department, Pediatric ward, Maternity ward, Obstetrics/Gynecology, Out Patients Department, Surgical Services, Medical Services, Operating Theatre & CSSD Services, Pharmacy, Anti-Retroviral (ARV) treatment for HIV/AIDS, Post Trauma Counseling Services, Ophthalmology Out-patients Clinic, Occupational Services, X-Ray Services, Physiotherapy, NHLS Laboratory, Oral Health Care Provides, Laundry Services, Kitchen Services and Mortuary.

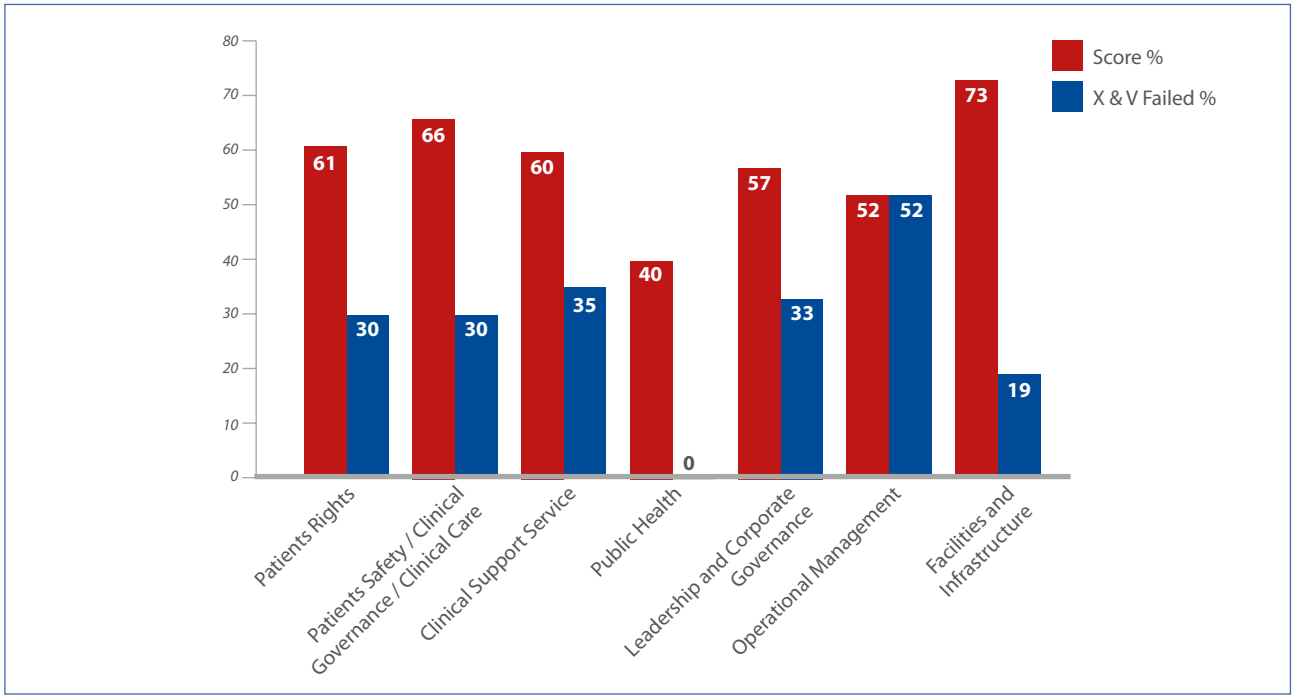
Table 16: NMAH Outcomes as per Components



NMAH Summary Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal to moderate effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component minimal to maximal effort to reach compliance status.

Figure 23: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall compliance score of 64%. The following are the score achieved per domain:

- Patients` Rights 61%
- Patient Safety 66%
- Clinical Support Services 60%
- Public health 40%
- Leadership and Corporate Governance 57%
- Operational Management 52%
- Facilities and Infrastructure 73%

Table 17: Extreme and Vital Measures Failed

Domain 1: Patient Rights	
Extreme	**Vital**
• Informed consent forms not legible and appropriately completed.	• Paper and gloves included inside sharps containers. • Patient referral policy insufficient and does not address the checklist. • No health professional allocated for triaging. • No person allocated for sorting. • Spersallerg eye drops not issued as prescribed. • Procedure governing the handover of patients from EMS to hospital staff-The policy does not address EMS staff. • Procedure emphasises the speedy handover of patients to reduce handover time from EMS to hospital staff-No emphasis on speedy hand over.
Domain 2: Patients Safety	
Extreme	**Vital**
• The emergency trolley is not appropriately stocked-No O2 cylinder. Some medication out of stock. e.g, laryngeal, 20% stock does not correspond with list. • Consent form not available for the administration of blood. • Assessed patients' files did not have demonstrated evidence that safety checks have been conducted during and after surgery. • Appropriate isolation for patients with viral haemorrhagic diseases not available.	• Audited patient's files of the recently discharged patients did not have all notes as required. • Assessed discharged patient's files did not have all aspects required to show comprehensive clinical assessment and diagnosis been done. • Evidence for conduction of clinical audits not produced. • QIP for health initiatives unavailable. • Protocol for the safe administration of medicine- does not include children. • Nurse did not explain to patients how to take medicine and side effects. • Patients observed receiving medication, it did not confirm patient's safety being assured. • No protocol regarding the safe administration of medicine to patients was available to be produced. • Minutes of the forum reviewing adverse events not available. • Reporting system for needle stick injuries incomplete. • Sharps not safely managed and disposed e.g., recapping of needles. • Paper towels and gloves found in sharps containers.

Domain 3: Clinical Support Service	
Extreme	**Vital**
• Not all tracer medicines as per applicable EDL or formulary were available, Abacavir solution. • Essential equipment such as IV cut down and instrument set not available.	• SOP on the management of Schedule 5 and 6 medicines document is not valid as it was not signed. • Dispensing not done in accordance with applicable policies and legislation including labelling. • Interviewed patients did not have a clear understanding on side effects. • Staff could not explain a cold chain for blood products e.g, minimum/maximum temperature. • Interviewed staff members did not explain about the temperature monitoring and ranges to maintain cold chain. • Not all essential equipment as listed was available in the labour ward. • Some equipment not available, lockable medication cupboard, diagnostic set etc.
Domain 5: Public Health	
Extreme	**Vital**
	• No evidence of exit interviews. • Policy for the obtaining of patient consent if patient identifiable information needs to be communicated to a 3rd Party-Policy not available.
Domain 6: Operational Management	
Extreme	Vital
• No reports and remedial action for harm to staff. • No measure in place to prevent incidents of harm to staff.	• No staffing ratios available • Some staff members file does not have performance reviews. • Minutes of the occupational health and safety committee / forum-No minutes available. • Medical examination for all health care workers who are exposed to potential occupational hazards when performing their duties (e.g. radiation / infectious diseases including TB / chemicals) not done. • No records of needle stick injuries. • No evidence of turnaround times. • No written SOP for file retrievals.

Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• No documented evidence that in the event of power disruption emergency power supply is available in critical clinical area such as ICU/ Theatre was available. • No piped oxygen available in some units. • No piped suction available in some units. • No documented evidence that in the event of a power disruption, emergency power supply is available in such as theatre was available/ produced.	• Records of daily water supply not checked daily. • Security Policy not signed by the CEO. • Not all cleaning materials of the checklist are addressed. e.g., plain liquid soap, disposable sponges etc., not available.

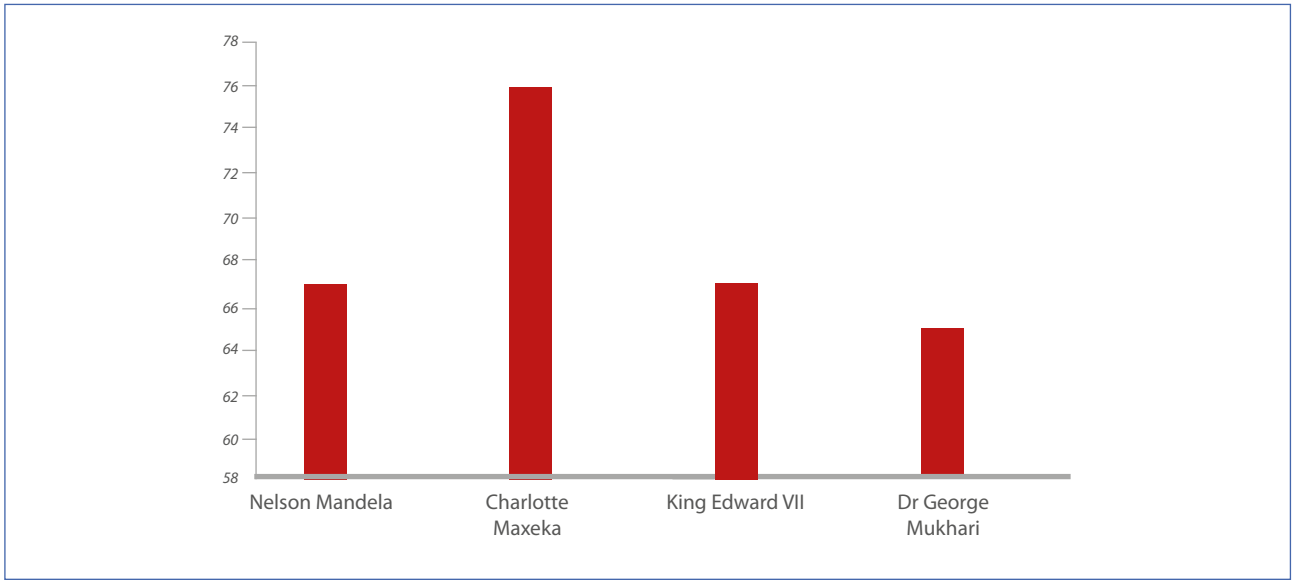
Table 18: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	62%
Cleanliness	69%
Improve patient safety and security	67%
Infection prevention and control	61%
Positive and caring attitudes	62%
Waiting times	**40%**

The above table reflects the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to patients waiting times, infection prevention and control. Availability of medicines and supplies is another area of concern the question is what and how this situation has been improved what has been differently to respond to identified areas of weakness.

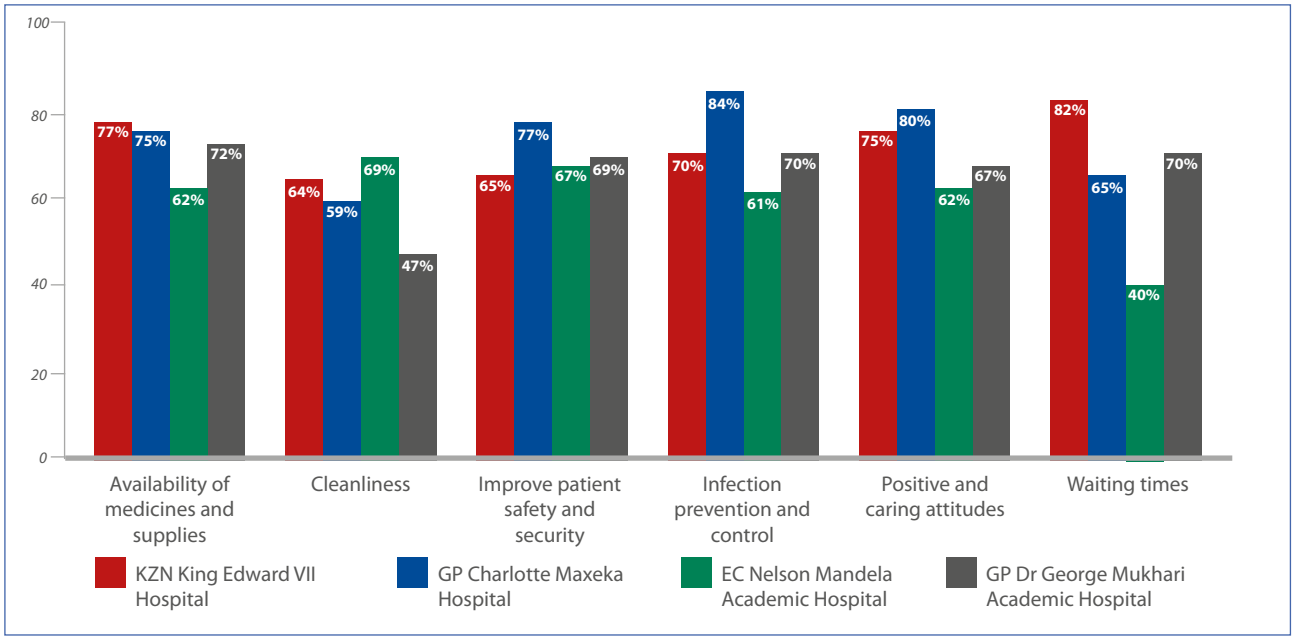
3.7 Central Hospitals Overall/Combined Scores

Figure 24: Central Hospitals Performance Scores



From the figure above out of the 4 inspected Central Hospitals in 2015/16 financial year Charlotte Maxeke hospital was the best performing and George Mukhari being the worst in comparison. Areas of weaknesses were identified in the four hospitals and require management and their team performance improvement initiatives to facilitate and strengthen quality service experience for South African citizens using these facilities.

Figure 25: Central Hospitals Performance Scores in respect of the Six Priority Areas



From the table above shows that Nelson Mandela was worst performing hospital with regard to patients waiting times, positive attitudes and availability of medicines and supplies. Dr. George Mukhari was the worst performing hospital with regard to cleanliness and King Edward VIII performed the worst in improve patient safety and security. At the same time King Edward shows positive significant waiting times for patients 82% and Charlotte Maxeke infection prevention and control is significantly high 84%.

Figure 26: Central Hospitals Performance Scores by Domains

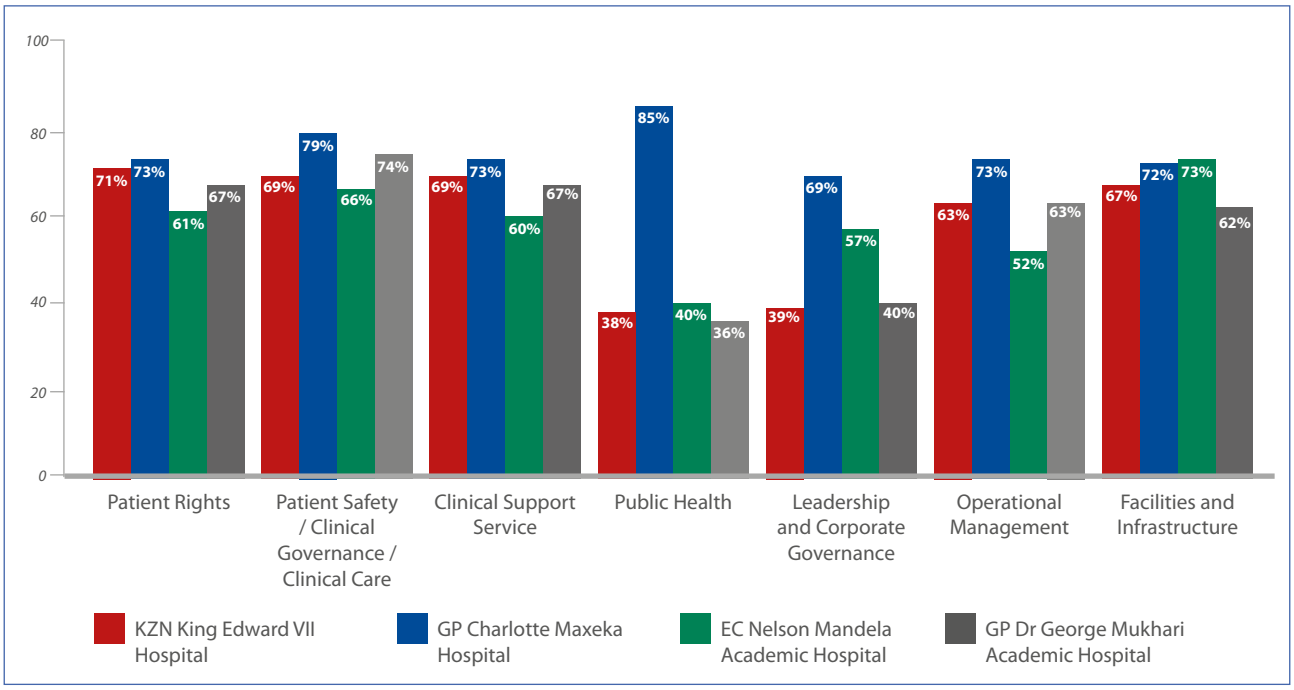


Figure Above demonstrate that the domain of Public Health scored below 60% across all 4 Central hospitals except Charlotte Maxeke hospital with a score of 85%. King Edward VIII & Dr. George Mukhari were the worst performing hospitals with regard to Leadership & Corporate Governance. Nelson Mandela was also the lowest scoring hospital with regard to Patients' Rights and Patient Safety/clinical Governance/Clinical Care, Clinical Care and Operational Management. Dr. George Mukhari was the worst performing hospital with regard to Facilities and Infrastructure.

C

INSPECTION RESULTS: PROVINCIAL TERTIARY HOSPITALS

Definition of Tertiary Hospital as per Regulation 185 of National Health Act 61 of 2003.

A Tertiary Hospital:

a) Provides specialist level services provided by regional hospitals;
b) Provides subspecialties of specialist referred to in paragraph (a);
c) Provides intensive care services under the supervision of a specialist or specialist intensivist;
d) May provide training for health care service providers;
e) Receives referrals from regional hospitals not limited to provincial boundaries; and
f) Has between 400 and 800 beds

4.1 Inspected Tertiary Hospitals

For 2015/2016 financial year the OHSC inspected twelve (12) Tertiary Hospitals as per Compliance Inspections Operational Plan planned activities:

1. **In Eastern Cape Province the following hospitals were inspected:**
   - Frere Hospital
2. **In Free State Province the following hospitals were inspected:**
   - Pelonomi Hospital
3. **In Gauteng Province the following hospitals were inspected:**
   - Helen Joseph Hospital
   - Kalafong Hospital
   - Tembisa Hospital
4. **In KwaZulu-Natal Province the following hospitals were inspected:**
   - Grey Hospital
   - Ngwelezana Hospital
5. **In Mpumalanga Province the following hospital were inspected:**
   - Witbank Hospital
6. **In Limpopo Province the following hospitals were inspected:**
   - Mankweng Hospital
   - Pietersburg Hospital
7. **In Northern Cape Province the following hospital were inspected:**
   - Kimberly Hospital
8. **In Western Cape Province the following hospital were inspected:**
   - Red Cross Children Hospital

4.2 Frere Tertiary Hospital

Hospital Profile

Frere Hospital is a 916 bedded Provincial Tertiary hospital situated in East London, Eastern Cape Province. It was established in 1881 and is a tertiary teaching hospital. Frere Hospital is named after Sir Henry Bartle Frere, Governor of the Cape Colony from 1877 to 1880.

Hospital Departments and Services

The hospital departments include Trauma and Emergency Department, Orthopedics Surgery, Pediatrics, Obstetrics/ Gynecology, Surgery, Internal Medicine, ARV clinic for HIV/AIDS in adults and children, Anesthetics, Family Medicine, Dermatology, Oncology for adult and Pediatric patients and Burns Unit.

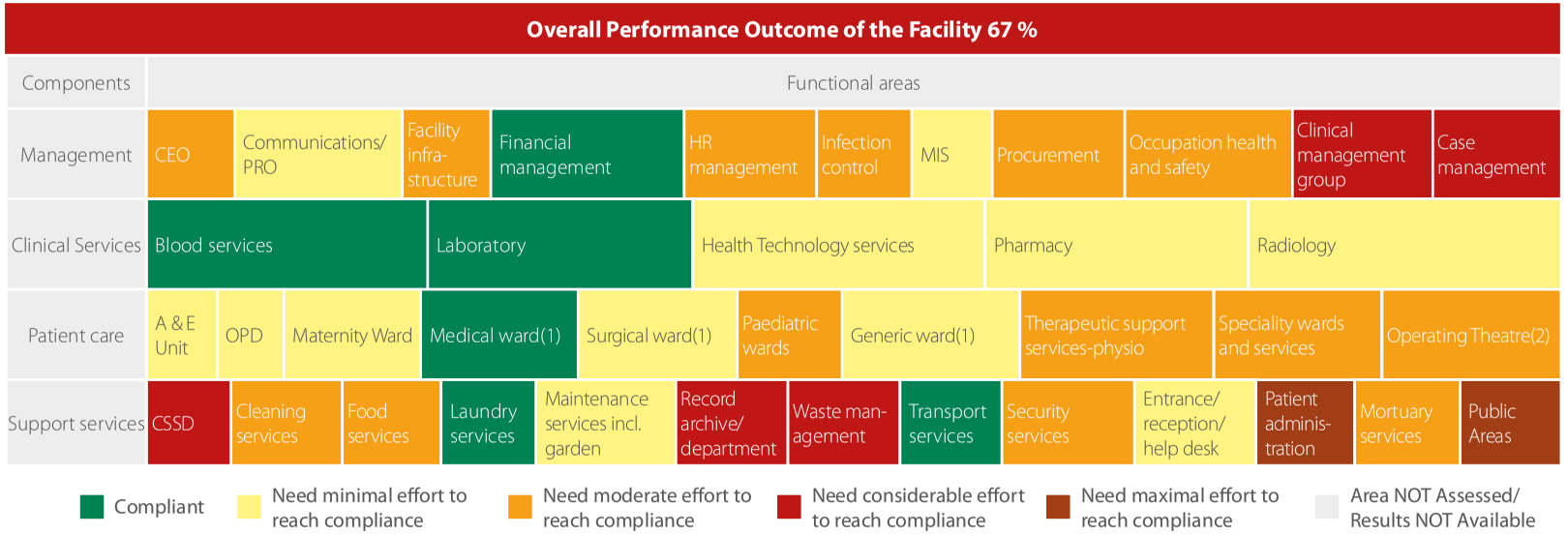
The other surgical specialties include Neurosurgery, Urology, Pediatric Surgery, Otolaryngology (ENT), Ophthalmology and Maxillofacial surgery.

The facilities include Operating Theatre, Endoscopy Theatre, Intensive Care Unit (ICU) for adult, Pediatric and Neonatal patients, High Care Wards for General and Obstetric patients and Hemodialysis Suite.

Frere also offers Allied Health Services such as Physiotherapy, Occupational Therapy, Speech and Language Therapy, Audiology, Psychology, Social workers, Orthotics, Dentistry and Dietetics.

Other services include CSSD Services, Pharmacy, Occupational Services, X-Ray Services with Computed Tomography (CT), Magnetic Resonance Imaging (MRI) and Mammography facility, NHLS Laboratory, Blood Bank, Laundry Services, Kitchen Services and Mortuary.

Table 19: Outcomes as per Components

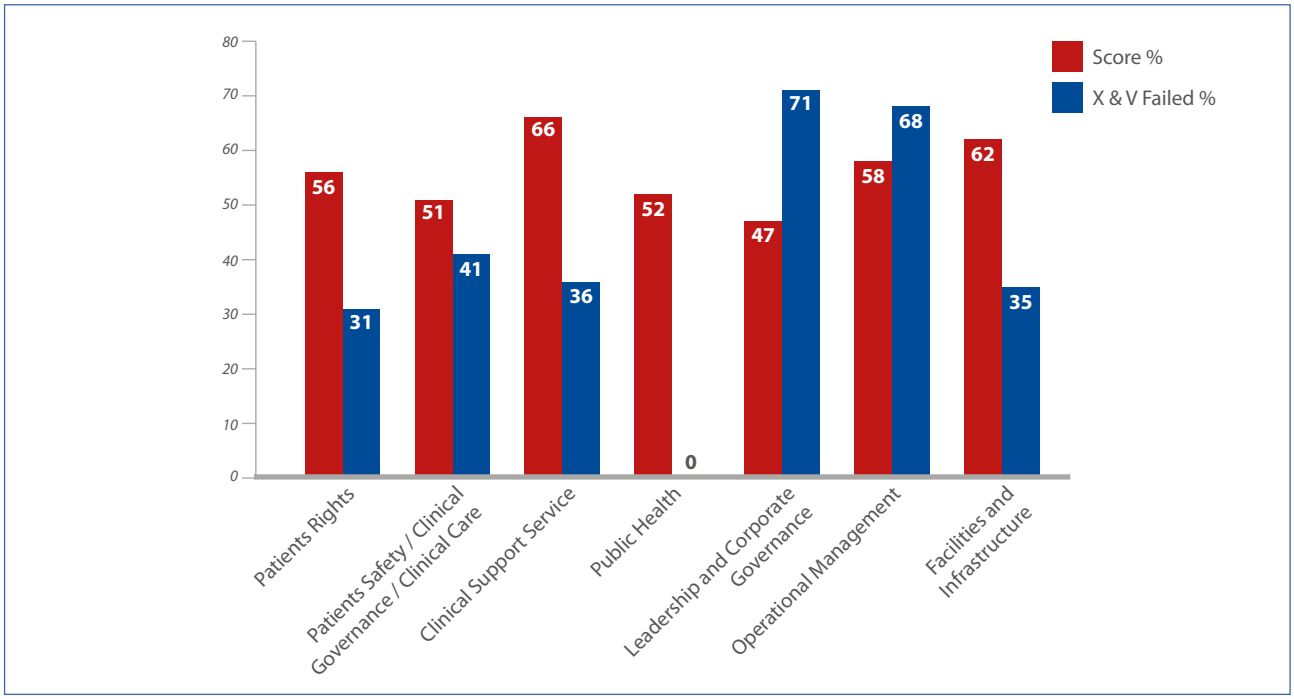


Hospital Components Outcome

From the above information components dashboard Frere Hospital overall performance is 57% from the findings management component needs considerable effort to reach compliance status and other components findings are:

- Clinical Services component minimal and responsive effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component needs minimal to maximal effort to reach compliance status

Figure 27: Domain Outcome (Extreme and Vital)



From the table above Domain Outcome Frere Hospital was inspected and achieved an overall score of 57% compliance. The following are the score achieved per domain: Patients` Rights – 56%, Patient Safety – 51%, Clinical Support Services – 66%, Public health 52%, Leadership and Corporate Governance – 47%, Operational Management – 58 and Facilities and Infrastructure – 62%.

Table 20: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Consent form not signed by two witnesses • Informed consent names and designation not legible.	• Toilets not clean medical waste not appropriately contained. • Ramps available and handrails are broken on each side • Referral Policy out dated developed in 2007 • Referral Policy is out dated was due for review in 02/2014 but that has not happened • Procedure for the speedy handover of patients to reduce handover time from EMS to hospital Staff-Not available.

Domain 2: Patient Safety/Clinical	
Extreme	**Vital**
• Safety of high risk patients not assured, illness not indicated, no height, no FM • Safety inadequate, no security person, visiting hours not adhered to • Peri operative documents -allergies not written. • Emergency trolley not standardised, no ET tubes sizes 8.5,5.5 not checked daily • Lack of some of the essential stock e.g. paeds ambubag and tracheal tubes • Protocol on administration of blood not adhered to e.g. indication not noted, vital signs not recorded. • Isolation accommodation is not appropriate e.g. it has no separate toilet • Isolation accommodation has no signage to inform community/ family about no visitors, highly infections principle.	• Files of patients Discharged-Clinical assessment not complete, past medical history not asked, no provisional diagnosis. • Clinical of priority programmes audits not conducted. • Required criteria with respect to 72-hour observation of patient is not met e.g. policy not available. • Policy regarding chemical and physical restraint is not available. • Initial assessments of high risk patients not done e.g. not classified • Policy to ensure patients safety checks not available. • Infection control measures of particle counts and bacterial growth are performed in each theatre every 6 months-No document produced. • Safety not assured, child not observes, no explanation of side effects. • Minutes of the forum reviewing infection Control-Minutes provided are for October 2015 only and not indicating, Infection control surveillance data and control measure discussed. • Staff do not comply with safety measures of disposing sharps, recapping observed. • Hand washing drive not conducted, only in service training were done.
Domain 3: Clinical Support Services	
Extreme	**Vital**
• Essential equipment-no examination table.	• Dispensing is not done in accordance with applicable policies e.g. opportunity to ask questions not given to patients. • Patients have no clear understanding on how to take medication e.g. side effects not explained. • Side effects not explained and medicine to be taken with or without food not explained. • No maintenance records for AED machine. • Service Level Agreements for decontamination services -No SLA available. • Sterilisation equipment is validated / Licensed-Not available.

Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Minutes of the relevant forum reviewing Quality-Actions are taken but no evidence of follow through with records. • 3 Senior managers left for different reasons - no Exit Interviews for all of them were available.
Domain 6: Operational Management	
Extreme	**Vital**
	• Staff patient ratios-Insufficient, evidence, no system to calculate ratios • Objectives for some files not aligned to start plan e.g. nurses, allied and letters of outcomes not issued in same file. • Minutes of the occupational health and safety committee-no minutes. • Performed only in X-ray department. Oncology, orthopaedic theatre (nurse and doctors) examinations not performed. • Requesting of files policies available- however SOP for retrieving and filing of patient files.
Domain 7: Facilities and Infrastructure Management	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency not available.	• Collapsing ceiling and loose electrical wires observed in one of the consulting rooms • Not all security measures are in place e.g. no security committee established • No security system in place at vulnerable areas such as maternity, paediatric ward • Cleaning equipment incomplete e.g. no sponges, paper towels unsterile gloves. • Outside bin poses health risk- bad odour.

Table 21: In terms of Ministerial Priority Areas, Frere Tertiary Hospital Performance

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	68.63%
Cleanliness	56.26%
Improve patient safety and security	59.64%
Infection prevention and control	**42.62%**
Positive and caring attitudes	58.01%
Waiting times	66.2%

The table above demonstrates the hospital Ministerial Priority Areas performance highest achievement being availability of medicines and supplies at 68,63%. However, the health establishment has significant operational challenges in particular infection prevention and control lowest score at 42,62%, cleanliness, staff positive and caring attitudes, improve patient safety and security scored below 60%. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed?

4.3. Pelonomi Tertiary Hospital

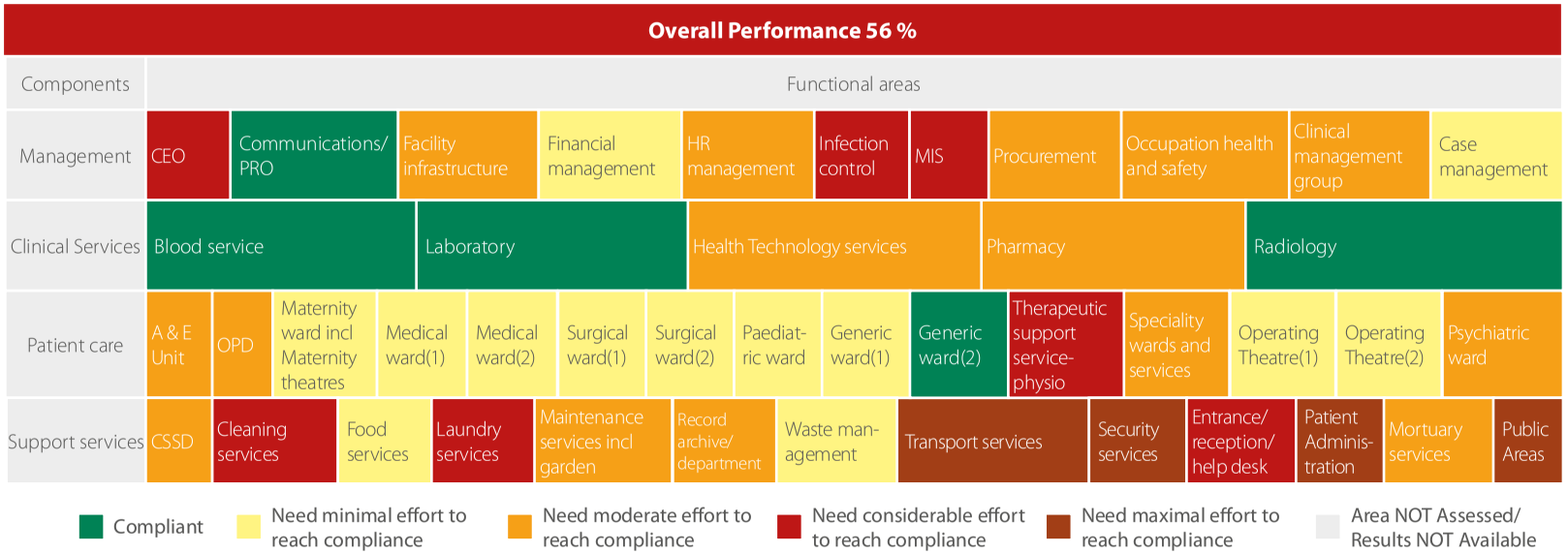
Profile

Pelonomi Hospital was gazetted as the only Tertiary hospital in the Free State Province. The hospital has 720 commissioned beds (usable beds 588) and referral hospital for regional hospitals including Xhariep and Mangaung district hospitals. In addition the hospital provides services to neighboring Provinces and Lesotho. The hospital specializes in clinical tertiary services in particular trauma, spinal and burns including levels 1, 2 and 3 clinical services as demonstrated in table below.

Table 22: Pelonomi Tertiary Hospital Services

RADIOLOGY	Ultrasonography	CT	MRI	Panorax
	Bone Density	Vascular	Screening	General X-rays
SURGERY	Gen Surgery	Urology	Burns	Stoma clinic
	Paeds Surgery	ENT		
ORAL HEALTH	Orthodontics	Maxillofacial	Dental therapy	
Obstetrics and G	High risk clinic	ANU	PNU	Labour
ALLIED HEALTH	Audiology &Dietetics	Physiotherapy	Occupational therapy	Social work
ORTHOPAEDICS	GENERAL ORTH	Spinal Unit	Hand Surgery	Paeds Ortho
TRAUMA & EMERGENCY	Trauma Unit	Casualities	Neuro-Surgery	
INTERNAL MEDICINE	General Medicine	Gastroenterology & Bronchoscopy Unit	Renal Unit	C. Psychology
PAEDIATRICS	General Peads	Neonatal Unit		
ALLIED HEALTH	Audiology	Physiotherapy	Occupational Therapy	Social Work
PROGRAMMES	HAST	Disaster	Quality	IPC& TB
ANEASTHESIA	MULTIDISCIPLINARY ICU	PEADS ICU	PSYCHIATRY	PHARMACY
CLINICAL	ENGINEERING	OCCUPATIONAL HEALTH		

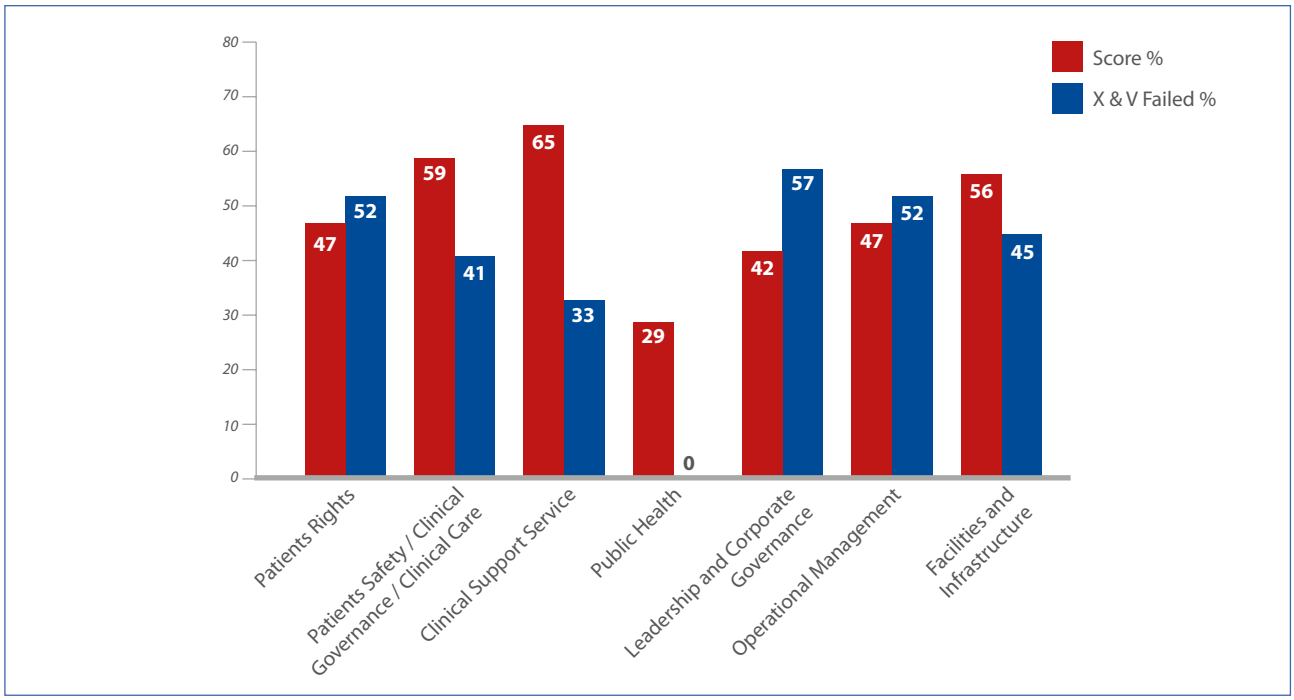
Table 23: Outcomes as per components



PTH Summary Components Outcome

- Management component needs minimal to considerable effort to reach compliance status.
- Clinical Services component needs moderate effort to reach compliance status.
- Patient Care component needs minimal to considerate effort to reach compliance status.
- Support Service component needs minimal to maximal effort to reach compliance status.

Figure 28: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 56% compliance. The following are the score achieved per domain:

- Patients` Rights 47%
- Patient Safety 59%
- Clinical Support Services 65%
- Public health 29%
- Leadership and Corporate Governance 42%
- Operational Management 47%
- Facilities and Infrastructure 56%

Table 24: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for informed consent were not completed correctly by the health professionals e.g. informed consent was having blanks on the consent form.	• 6 Areas checked for the state of cleanliness were not clean as required e.g. cupboard not neatly packed and not locked • 6 Areas checked for the state of cleanliness were not clean as required e.g. mixing of waste with sharps observed and toilets were dirty with bad odours • The security guards at the gate do not stop or search vehicles upon entry or exit. • No ramp and handrails. • Patient referral policy and protocol was outdated 04/2015. • The health care professional responsible for patient reviewing, triaging or assessing and channelling or sorting could not explain procedure how she/he triages or assesses and channels patients • The procedure governing the handover of patients from EMS to hospital staff was not explicit on hand over • Procedure emphasises the speedy handover of patients to reduce handover time from EMS to hospital staff was not explicit on speedy handover.

Domain 2: Patient Safety/Clinical	
Extreme	**Vital**
• Initial assessments of high risk maternity patients did not reflect the identification of specific risk factors e.g. management of labour not indicated • No systems such as security guards in neonatal and labour ward • Security measures were not adequate to safeguard new-borns and unaccompanied children including restricted access and exit monitoring in wards/ identification of new-borns/ children and their parents e.g. security guard was not available in neonatal unit • Patients peri-operative documents demonstrate that safety checks were not completely conducted during and after surgery e.g. skin integrity not checked, team not introducing self before incision • The formal policy for handling emergency resuscitation was not available • Emergency trolley was not appropriately stocked e.g. laryngoscope and tracheal tubes for paeds not available- trolley not checked daily. • Emergency trolley was not appropriately stocked e.g. eye protection, thermometer, scissors, suction catheters were not available. • Patient files demonstrate that the protocol on administration of blood was not adhered to e.g. Clinical need for blood transfusion not documented and there was no consent form. • There was no appropriate isolation accommodation for patients with communicable diseases - as a minimum for hazardous diarrheal diseases e.g. evidence of people traffic management in and out of the room was not available. • Appropriate isolation accommodation for patients with communicable diseases - as a minimum for viral haemorrhagic disease was not available	• The files of patients recently discharged showed that a comprehensive clinical assessment and diagnosis was not done e.g. medical history, physical examination and discharge diagnosis not made. • There was no evidence that the health establishment participates in monthly maternal and perinatal morbidity and mortality meetings. • The clinical audits report conducted of each priority programme reflected that only TB and HIV programmes were monitored • Minutes of the forum reviewing clinical risks from within the last quarter were not available • Procedure for the care of the terminally ill which addresses the needs of the patients and their family was outdated 2003. • Procedure for the management of patients detained for 72 hour observations was not available. • Recapping observed and there are only two sharp containers in a 46 bedded ward which are not sufficient. • Initial assessments of high risk patients did not reflect the identification of specific risk factors e.g. suicidal patient not consistently monitored. • There was no evidence that Infection control measures of particle counts and bacterial growth were performed in each theatre every 6 months • There was no evidence that infection control measures of particle count and bacterial growth were performed in each theatre every 6 months • Minutes of the forum reviewing resuscitations from within the last quarter were not available • Protocol regarding the safe administration of medicines to patients including a protocol for the safe administration of medicines to children was not signed. • There was no qualified and or experienced healthcare professional with designated responsibilities for infection control in the health establishment • Minutes of the forum reviewing infection control from within the last quarter indicated that infection control surveillance data and control measures were not regularly discussed and analysed and actions taken to reduce infections • Statistics on common health care associated infections demonstrated that they were not monitored monthly. • Random selection of clinical areas showed that sharps were not safely disposed e.g. recapping observed and loose fitting lids • Random selection of clinical areas showed that sharps were not safely disposed e.g. loose fitting lids • There was no evidence that a hand washing drive or campaign was held at least annually in the establishment.

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Tracer medicines as per applicable Essential Drugs List were not in stock e.g. Lopinavir/Ritonavir 80/20 not available • Functional essential equipment was not available as required e.g. diagnostic set and ECG machine were not available. • Functional essential equipment was not available as required e.g. HB meter, surgical light and tracheal set were not available	• Random selection of 3 patients receiving medicine indicated that they have no clear understanding of how and when to take their medication e.g. side effect not explained. • 2 staff members interviewed were unable to explain how the cold chain is ensured for all blood products e.g. temperature during transportation. • Functional essential equipment was not available as required e.g. batteries for laryngoscopes, ET tubes size 3.0, 5.5, and 6.0. • Medical equipment and materials were not available and meet minimum requirements for the level of care e.g. Patella hammer. • Records within the last 12 months show that the equipment were not maintained according to a planned schedule or manufacturers instruction e.g. Defibrillator • Records within the last 12 months showed that the equipment as required were not maintained according to a planned schedule or manufacturers instruction e.g. schedule outdated 2013/2014 • There were no reports from within the last 12 months showing that adverse events involving medical equipment were reported and that actions taken to prevent recurrence have been implemented. • There was no contract and Service Level Agreement in place with an approved and legally compliant sterilisation service provide • Records showing that the Service Level Agreements for decontamination services were monitored by the manager in charge was not available • Evidence all sterilisation equipment is validated or licensed was not available.

Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Copy of the delegations of authority for the manager of the health establishment detailing the manager's authority in terms of financial supply chain and human resource management was not available • The documentary evidence that the manager complies with clinical practice law in relation to custodianship of minors, Mental Health Act, re admission for observations and consent in emergency surgery when a patient is unable or has no next of kin was not available • Minutes of the relevant forum reviewing quality from within the last quarter indicating that all quality aspects are regularly discussed, analysed and actions taken to improve quality were not available. • Policy or protocol for the obtaining of patient consent if patient identifiable information needs to be communicated to a 3rd party was not available only internal guidelines produced.
Domain 6: Operational Management	
Extreme	**Vital**
• Measures were not in place to prevent any incident of harm to staff.	• Staff patient ratios in key areas were not in accordance with the approved staffing plan for emergency unit / outpatients / medical/ surgical / paediatrics / ICU wards • There was no evidence that action was taken to deal with absenteeism and staff vacancies • There was no evidence that agreements with staff who perform remunerated work outside the establishment were monitored • The files of members of staff reflected that comprehensive performance reviews were not done based on their performance plans and in accordance with the human resource management policy e.g. PMDS were not available. • Minutes of the occupational health and safety forum from within the last 6 months indicated that occupational risks were not regularly discussed and analysed e.g. Last meeting was held in August 2015. • Records of needle stick injuries showed that those staff have received post exposure prophylaxis and were not re-tested • There was no evidence that exception reports are compiled where expenditure on high risk priority areas deviates from budget by more than 5 percent

Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• There was no documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency • The system to supply piped medical gas to all clinical areas was not available	• Obvious safety hazards were observed during the visit such as loose electrical wires • Security system in place in the establishment that covers the buildings and grounds was not documented in the security policy • No document produced • Security systems were not positioned at vulnerable patient areas such as maternity and access and egress points. • There were no records showing that daily inspections of cleanliness were carried out • Facility was observed not to be clean and hygienic • Cleaning materials were not available as required e.g. N95 mask, janitor trolley and long sleeves gowns or aprons. • Containers for disposal of HCRW were not adequate • The outside bin/waste storage area was not locked nor well maintained, poses health risk. • There was no evidence showing that problem identified during health inspections were rectified.

Table 25: In terms of Ministerial Priorities, the Pelonomi Health Establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	68%
Cleanliness	**34%**
Improve patient safety and security	58%
Infection prevention and control	55%
Positive and caring attitudes	65%
Waiting times	**44%**

The table above demonstrates the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having significant and concerning problems with hospital cleanliness and waiting times. Cleanliness does not only cover the physical cleanliness but also the availability of cleaning materials. Infection prevention and control, improve patient safety and security risk areas scored 60%. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed? Is hospital now clean?

4.4 Helen Joseph Tertiary Hospital

Profile

Helen Joseph Hospital is a government public hospital with a sole key responsibility of providing tertiary health care services to the community of Gauteng. In order to achieve this responsibility, the Hospital relies heavily on the commitment and competency of its ethical and naturally caring employees.

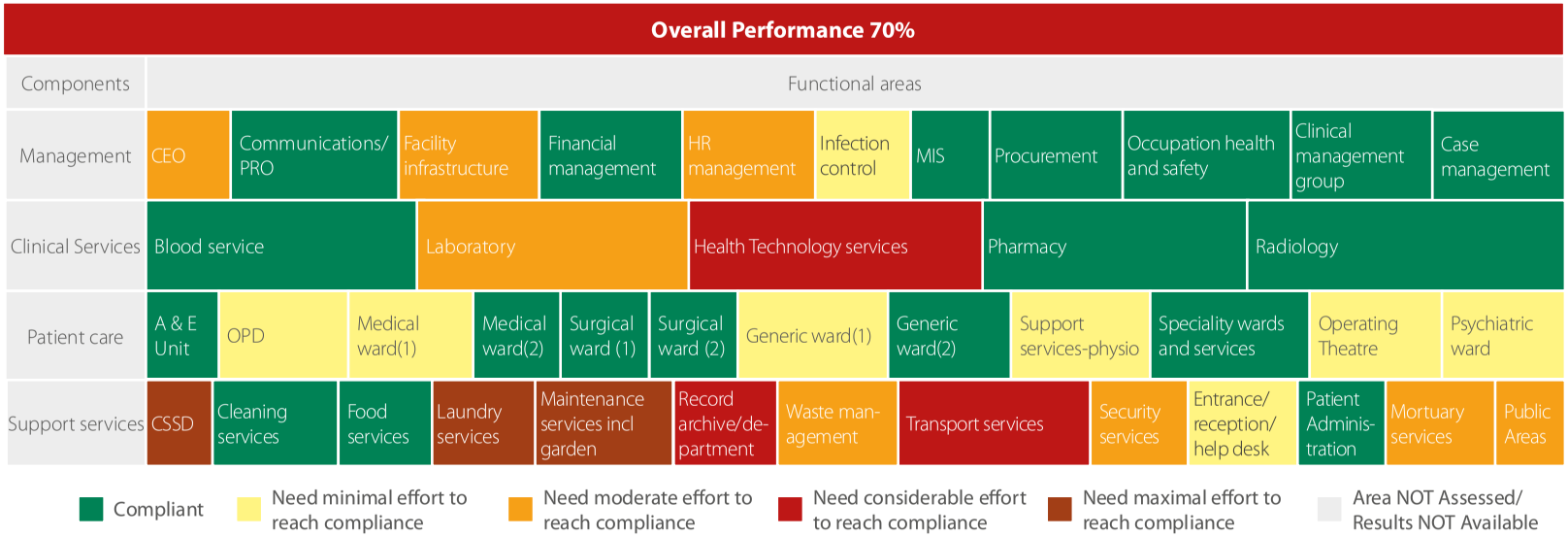
Helen Joseph Hospital re-named on 1st April 1997, to reflect the transformation in the country since the advent of democracy is a tertiary hospital, part of the Wits University circuit responsible for teaching healthcare workers and provision of tertiary health services.

The Hospital provides services to a region with a population of about 1 million. Our catchment area is mainly Region B of the Johannesburg Municipality extending to some parts of Region C and D. We serve the medium to low income segment of the population.

The Helen Joseph Hospital consists of a total 21 (twenty one) in-patient wards, the majority of which are medical wards (11 including 2 Admission wards), Six (6) Surgical wards two (2) of which are Orthopaedic wards, a Psychiatric unit, a 10-bed ICU, a 12 bed-High Care/ Step down unit, a Theatre complex comprising of twelve theatres, nine (9) of which are functional; speciality clinics including Stoma unit, Renal dialysis unit, Pain clinic, Endoscopy unit, Breast clinic, the TB focal point and the Thembalethu HIV clinic.

The total number of staff at the time of inspection was 1886, with the nurses being the majority at 878 as is the norm for hospital healthcare organisations. Other staff categories: Doctors 220, cleaners 149, and 45 porters. We also have Allied Health and support staff on hand. This number changes based on new additional staff, resignations, and retirements

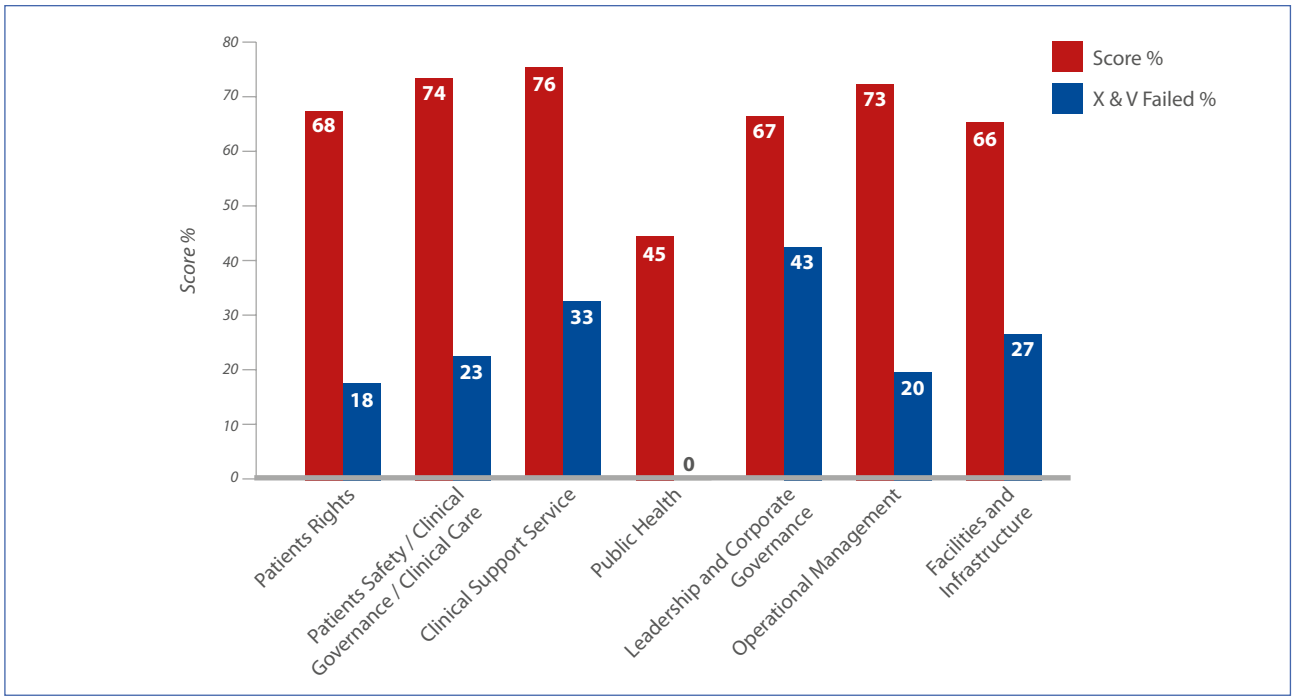
Table 26: Outcomes as per components



HJTH Summary Components Outcome

- Management component needs minimal to moderate effort to reach compliance status.
- Clinical Services component needs moderate to considerable effort to reach compliance status.
- Patient Care component needs minimal effort to reach compliance status.
- Support Service component needs minimal to maximal effort to reach compliance status

Figure 29: Domain Outcome (Extreme and Vital)



HJTH was inspected and achieved an overall score of 70% compliance. The following are the score achieved per domain:

- Patients' Rights 68%
- Patient Safety 74%
- Clinical Support Services 76%
- Public health 45%
- Leadership and Corporate Governance 67%
- Operational Management 73%
- Facilities and Infrastructure 66%

Table 27: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	Vital
• 18/27Consent form not correctly completed- the consent is not signed by the healthcare provider performing the procedure, abbreviations used.	• 6 Areas checked for the state of cleanliness were not all clean e.g. medicine trolley not neatly packed. • Patient referral Policy-Document does not cover all aspects as per checklist. • The procedure governing the handover of patients from EMS to hospital staff was not available • Procedure emphasises the speedy handover of patients to reduce handover time from EMS to hospital staff was not available.

Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Some aspects of safety checks peri-operatively are not documented such as antibiotic therapy. • Resuscitation policy document does not cover all aspects in checklist e.g. Procedure for calling out resus team. • Emergency trolley not Complete-Expired ET tubes 08/15 and 07/15. No paediatric laryngoscope and blades. • Emergency Trolley-Some items are not available such as suction catheters and laryngeal masks. • Some aspects of safe administration of blood are not documented such as reason for blood transfusion. • Isolation room FED available but has no separate toilet. • No isolation facilities for viral haemorrhagic disease. Patients are transferred to Charlotte Maxeke.	• There was no evidence that the health establishment participates in monthly maternal and perinatal morbidity and mortality meetings • Clinical audits of each priority programme such as HIV, STI and TB were not conducted • The report on health initiatives or programmes were not available nor quality improvement plans. • Minutes of the forum reviewing clinical risks (from within the last quarter) were not available • Procedure for the care of the terminally ill which addresses the needs of the patients and their family was not available. • Protocol for the management of patients requiring 72 hours' observation as per the Mental Health Care Act was outdated. • The files of frail or aged patients did not indicate that a risk assessment was conducted of the risk of f falling for example Morse fall scale • The review of 3 files of patients who have been transferred from one department to another or from another institution did not demonstrate that patient safety checks have been applied • There were on records reflecting that infection control measures of particle counts and bacterial growth are performed in each theatre every 6 months. • Minutes of the forum reviewing resuscitations (from within the last quarter) were not available • A random selection of 3 patients receiving medicine indicate that they have no clear understanding of how and when to take their medication e.g. potential side effects not explained. • Minutes of the forum reviewing infection control (from within the last quarter) indicate that infection control surveillance data and control measures were not analysed and action not taken to reduce infections • Statistics on common health care associated infections did not demonstrate that they are being monitored monthly. • 3 random selected clinical areas showed that sharps were not safely managed and disposed e.g. recapping observed in sharps containers and over filling of sharps containers.

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Functional Equipment- no tracheotomy set, no oxygen set with humidifier, no surgical light.	• A random selection of 3 patients receiving medicine indicated that the Pharmacist did not explain side effects of medicine and what each medicine is for. • 2 staff members interviewed were not knowledgeable on how cold chain is ensured for all blood products. • There was no record that all adverse blood reactions are documented and reported to the forum dealing with adverse events on a monthly basis. • Records within the last 12 months shows that the equipment were not maintained according to an annual planned schedule or manufacturers instruction e.g. Defibrillator was last monitored in 2014. • A report (from within the last 12 months) showed that adverse events involving medical equipment are reported and that actions taken to prevent recurrence have not been implemented to prevent recurrence • There was no contract and Service Level Agreement in place with an approved and legally compliant sterilisation service provider. • There was no evidence that all sterilisation equipment were validated / licensed • There was no system in place to monitor all incidents of sterilisation failure whereby failures are documented with detailed action plans where failures occurred
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Copy of the delegations of authority for the manager of the health establishment details only delegation of authentication procurement to the value of R1 200 000.00 in terms of financial supply chain and human resource management. • There was no evidence that the manager complies with clinical practice law in relation to custodianship of minors/ Mental Health Act (re admission for observation) and consent in emergency surgery when a patient is unable or has no next of kin.
Domain 6: Operational Management	
Extreme	**Vital**
	• • Evidence showing that medical examinations are performed for all health care workers who are exposed to potential occupational hazards when performing their duties (e.g. radiation / infectious diseases including TB was not produced.

Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency-Document not available. • Piped Suction is not available in some areas and is weak in some cubicles.	• Security policy on measures to ensure the safety of patients/ staff/ goods and assets in the health establishment was not signed • Cleaning material were not available as required e.g. colour coded buckets disposable sponges. • Cleaning staff did not wear protective clothing while carrying out their duties • There were no records showing that the waste manager monitors and manages the service level agreements for waste removal and disposal • The outside bin/waste storage area were not well maintained and poses health risk

Table 28: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	88%
Cleanliness	**69%**
Improve patient safety and security	71%
Infection prevention and control	**65%**
Positive and caring attitudes	73%
Waiting times	70%

The table above demonstrates the performance of the health establishment in relation to six ministerial priorities. In this regard HJTH is experiencing problems with regard to Infection Prevention and Control and Cleanliness which does not only cover the physical cleanliness but also the availability of cleaning materials because they both have score below 70%. The hospital scored highly 88% with regard to availability of medicines and supplies and is commended. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed? Is hospital now clean?

4.5. Kalafong Tertiary Hospital

Profile

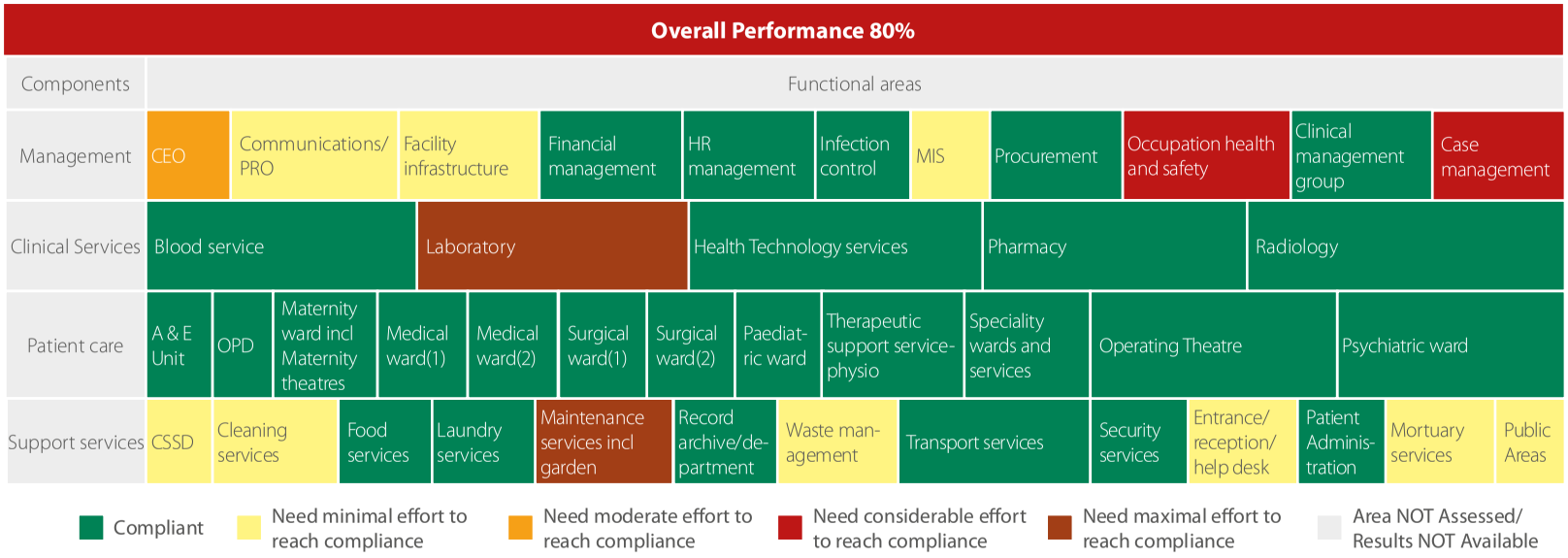
Kalafong Tertiary Hospital (KTH) is one of three Provincial Tertiary Hospitals in Gauteng and It is an academic hospital. The hospital was established in 1972 as a "general hospital", KPTH is still function as a general hospital even though categorised as a tertiary providing Level 1, Level 2 & Level 3 services (T1,). The hospital is also designated to provide tertiary services for populations of Greater Tshwane Municipality but still providing services to the people of Mpumalanga province, as well as Limpopo and parts of North West provinces.

KTH total approved beds is 857 (736 active) 121 beds have been temporarily de-activated because of shortage of nursing personnel. Budget allocation for 2015-2016 Financial Year: R1 bn.

Total approved posts: 1 800. Posts filled: +/-; (11.9% Vacancy Rate).Staff costs have risen from 65% (as % of total expenditure) pre-2007 to 72% since implementation of Occupation-Specific Dispensation for health professionals (OSD) commenced in 2007.

Medical doctors: Interns, Community Service Medical Officers, Registrars, Specialists & Chief Specialists (Heads of Clinical Departments). All Joint Appointees with University except Interns & Community Service MOs.

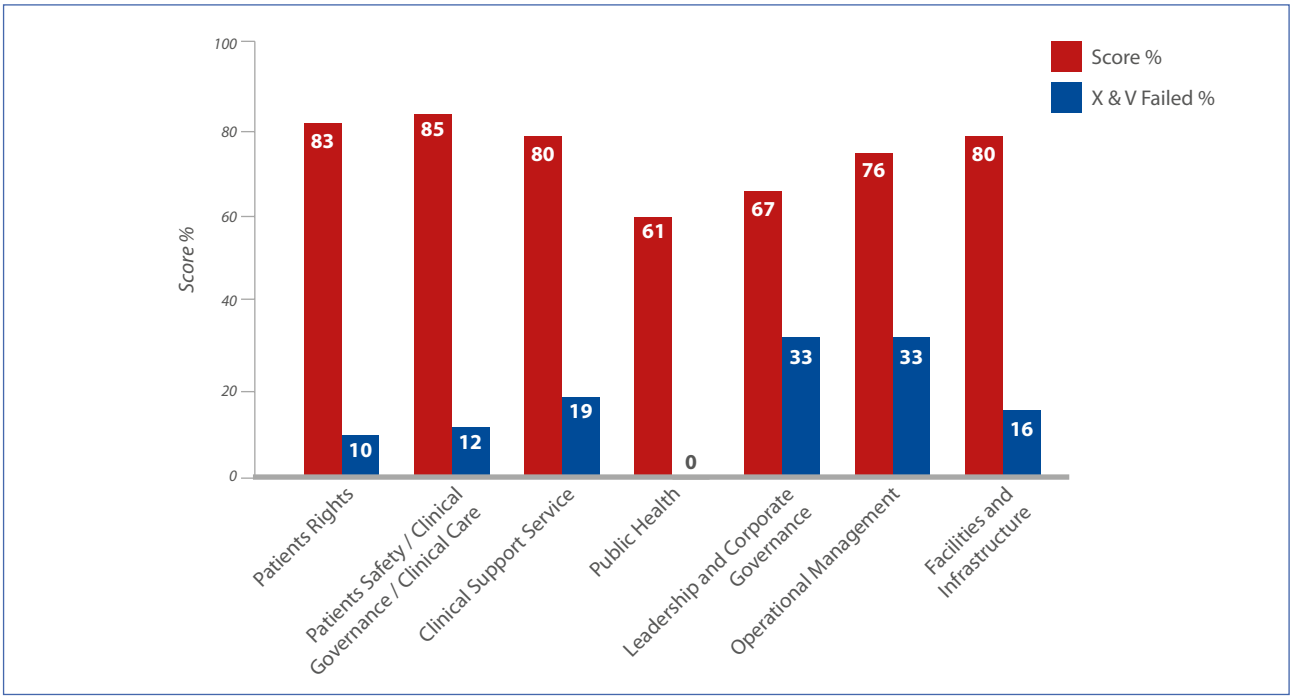
Table 29: Outcomes as per components



KTH Summary Components Outcome

- Management component needs minimal to considerable effort to reach compliance status.
- Clinical Services component needs maximal effort to reach compliance status. (this is also due to the fact that Laboratory Services refused inspectors entry to inspect them and as a result a score of zero was given).
- Patient Care component reached compliance status
- Support Service component needs minimal to maximal effort to reach compliance status

Figure 30: Domain Outcome (Extreme and Vital)



KTH was inspected and achieved an overall score of 80% compliance. The following are the score achieved per domain:

- Patients Rights 83%
- Patient Safety 85%
- Clinical Support Services 80%
- Public health 61%
- Leadership and Corporate Governance 67%
- Operational Management 76%
- Facilities and Infrastructure 80%

Table 30: Extreme & Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Consent was not signed by two witnesses. • The capacity of the person giving the consent was not indicated.	• There was no rehabilitation programme and no weekly climate meeting. • There were no ramps at the entrance. • Some aspects were not included, e.g. Referral including bed and monitoring of data.
Domain 2: Patients Safety	
Extreme	**Vital**
• Initial assessment of high risk maternity patients-Documentation was not completed adequately. • Referral procedure was not stated including the role of management. • Emergency Trolley-There were no scissors and nasogastric tubes -Trolley was checked daily in February and there were no scissors and nasogastric tubes. • Peri-operative documents incomplete -Estimated blood loss and difficult airway not recorded. • Emergency Trolley-Some items were not available, e.g. Laryngeal masks, Naso-pharyngeal airways, face masks, unsterile gloves, etc. • Administration of Blood-Documentation regarding checking of product and informed consent was not found. • Patients peri -operative documents-Many aspects were not documented, e.g. Prophylactic antibiotics, difficult intubation, safety check, etc. • Emergency Trolley-Some items were not in stock, e.g. KY jelly, ET ties, Xylocaine spray expired. • Isolation accommodation for patients with communicable diseases -There was no separate toilet. • Accommodation for patients with viral haemorrhagic disease -There was no separate toilet.	• Nursing care plans were not written • Minutes of the forum reviewing clinical risks -There were no minutes of meetings provided • There was no review date on the policy for restraint of patient. • Policy regarding chemical restraint was not available. • Policy for high risk patients was not available. • Management of sharps -Recapping was noted. Lids were not tightly fitting.

Domain 3: Clinical Support Services	
Extreme	**Vital**
	• Patients receiving medicine were not informed about de effects of their treatment. • Laboratory Staff declined to be assessed. • Not all ventilators had service plans. • Equipment was not validated. There was no regular maintenance carried out by approved service provider.
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
• None of the measures were failed	• None of the measures were failed
Domain 6:Operational Management	
Extreme	**Vital**
• There were no measures to prevent incidents of harm to staff in place.	• Two employees did not have performance development management plan. • Evidence shows that medical examinations are performed for all health care workers who are exposed to potential occupational hazards when performing their duties (e.g. radiation / infectious diseases including TB / chemicals)-Routine medical examinations were not conducted.
Domain 7: Facilities and Infrastruture	
Extreme	**Vital**
• There was no piped medical gas • There was no piped vacuum/ suction • Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency / ECT-There was no documented proof provided.	• Evidence was not provided of daily check of water supply adequacy • Security Policy not available, establishment had no of security committee. • Some cleaning material items were not in stock face shield, wet vacuum pickup.

Table 31: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	91%
Cleanliness	**73%**
Improve patient safety and security	83%
Infection prevention and control	83%
Positive and caring attitudes	84%
Waiting times	94%

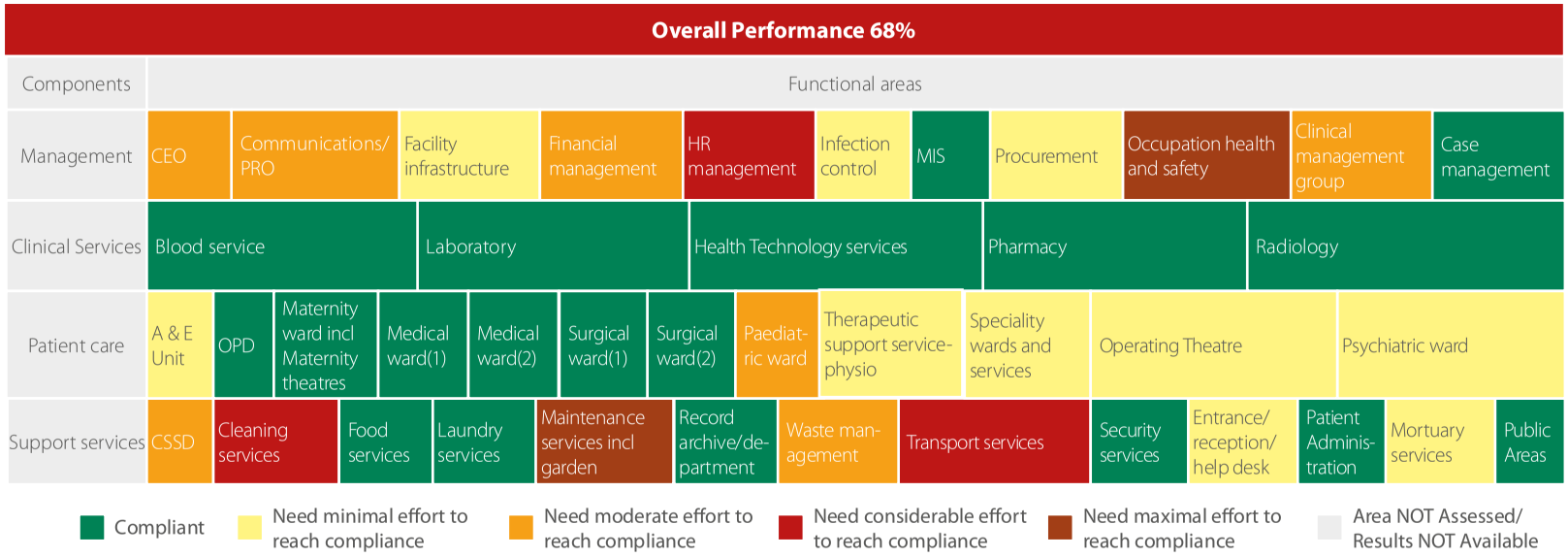
The table above demonstrates the performance of KTH in relation to the six Ministerial Priorities. In this context the health establishment is experiencing problems with regard to cleanliness scored lowest 73% and only cover the physical cleanliness but also the availability of cleaning materials. The question is what is the problem with basic cleanliness and what remedial action has been taken since management inspection feedback. Has the situation changed? Is hospital now clean? However, KTH scored significantly with regard to waiting times at 94% and availability of medicines and supplies at 91%.

4.6. Tembisa Tertiary Hospital

Profile

The hospital was established in 1972 and It is situated in the – NSDR of Ekurhuleni Metro in Gauteng Province. There are 840 approved and useable beds serving catchment population of close to 2 million according to 2011 census not considering foreign nationals. The hospital has approved personnel establishment of 1865 when the inspection was conducted. As a tertiary hospital provides both generalized and specialized health services and it is supported by 1CHC and 1 MOU and 22 local clinics with no extended hours of service, no referral district or regional hospital. The hospital is part of Steve Biko Academic Hospital Cluster. The hospital requires significant infrastructure upgrading because all the wards have not been refurbished since 1971 and it is not sustainable.

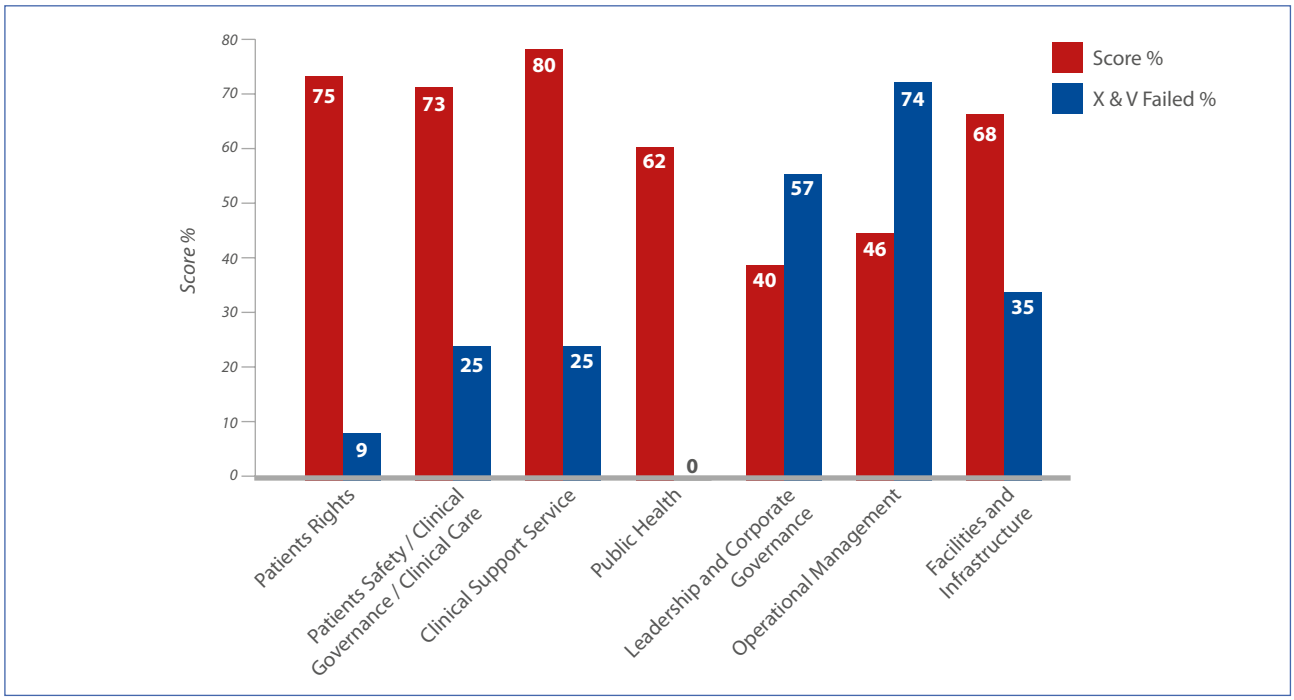
Table 32: Outcomes as per components



TTH Summary Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component reached compliance status
- Patient Care component needs minimal to moderate effort to reach compliance status
- Support Service component needs minimal to maximal effort to reach compliance status

Figure 31: Domain Outcome (Extreme and Vital)



TTH was inspected and achieved an overall score of 68% compliance. The following are the score achieved per domain:

- Patients` Rights 75%
- Patient Safety 73%
- Clinical Support Services 80%
- Public health 62%
- Leadership and Corporate Governance 40%
- Operational Management 46%
- Facilities and Infrastructure 68%

Table 33: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Consent forms not completed correctly, e.g. not signed by two witnesses.	• Referral policy out dated. • Policy available. Some aspects not clearly defined, e.g. responsibility of referring and referral institution. • Evidence could not be availed that correct procedure was followed.

Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Initial assessments of high risk maternity patients-Partograms not completed, labour of summary not done, risks not recorded, Foetal HR not monitored 1/2 hourly. • Security measures to safeguard new-borns and unaccompanied children including restricted access and exit monitoring in wards/ identification of new-borns/ children and their parents not in place. • Peri Operative documents -Document not included in patients' files -Two files did not have checklist. All checks not completed- blood loss estimation not done. • Emergency Trolley-Adult tracheal tubes, not all sizes available. Konakion expired, E-trolley checks not consistently done. • Consent forms for administration of blood not fully completed and not in patients file. • Rooms to be used for confirmed infectious TB patients, no barriers, patients housed in a general cubicle. • Isolation accommodation -People traffic not controlled. • Isolation accommodation for Viral haemorrhagic disease- FED pack for the isolation room was torn, no toilet and "no visitors – highly infections" signage.	• Clinical audits done by the HE was not including HIV, TB, etc. • The procedure for management of patients detained for 72 hrs was invalid as the review date was not adhered to. • Procedure for conducting and acting on risk assessments of frail and aged patients not comprehensive and missing pages. • Particle counts and bacterial growth are performed in each theatre every 6 Months-Not done every six months. Last done in May 2015. • Minutes of the forum reviewing resuscitations-No minutes of forum meeting. • Adverse event reports-No evidence showing that root cause analysis is done. • Minutes of the forum reviewing adverse events -Minutes of meetings not available. • Sharps management -Evidence of recapping noted, lid not fitting correctly, recapping noted.
Domain 3: Clinical Support Services	
Extreme	**Vital**
• Tracer medicines-No Isoniazid tablets and sodium chloride 0.9%.	• Patients receiving medicine -Side effects not explained to patients. • Functional medical equipment-No X-ray viewing box; no pinard stethoscope, no tourniquet.
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• • No delegation of authority for manager of the HE.

Domain 6: Operational Management	
Extreme	**Vital**
• No remedial actions in place for incidents of harm to staff.	• No annual work plans, assessment by moderating committee, approval before performance reward are paid or letters informing employee of final outcome. • Minutes of the occupational health and safety committee / Forum-Minutes were not signed. • Evidence shows that medical examinations are performed for all health care workers who are exposed to potential occupational hazards when performing their duties (e.g. radiation / infectious diseases including TB / chemical-No evidence. • Records of needle stick injuries show that those staff have received post exposure prophylaxis and have been re-tested-No records availed.
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency / ECT-No documented evidence. • Piped medical gas not available. • Piped suction not available.	• Cracked walls, broken windows; opened ceiling holes on roof were observed. • No security guard, gate has lock but is not kept locked. • There are only inspection sheets for toilets and for other areas. • Visitors' toilets and patient ward toilet not clean. • Most cleaning materials are not in place, no yellow bags, no goggles and no disposable sponges.

Table 34: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	81%
Cleanliness	**62%**
Improve patient safety and security	69%
Infection prevention and control	67%
Positive and caring attitudes	**63%**
Waiting times	89%

The table above demonstrates TTH's performance in relation to six Ministerial Priorities. In this context the hospital is experiencing problems with regard to cleanliness which scored lowest 62% not only cover the physical cleanliness but also the availability of cleaning materials followed by positive and caring attitude low at 63%. However the hospital scored significantly high with regard to waiting times 89% and availability of medicines and supplies at 81%. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed? Is hospital now clean?

4.7 Grey's Tertiary Hospital

Profile

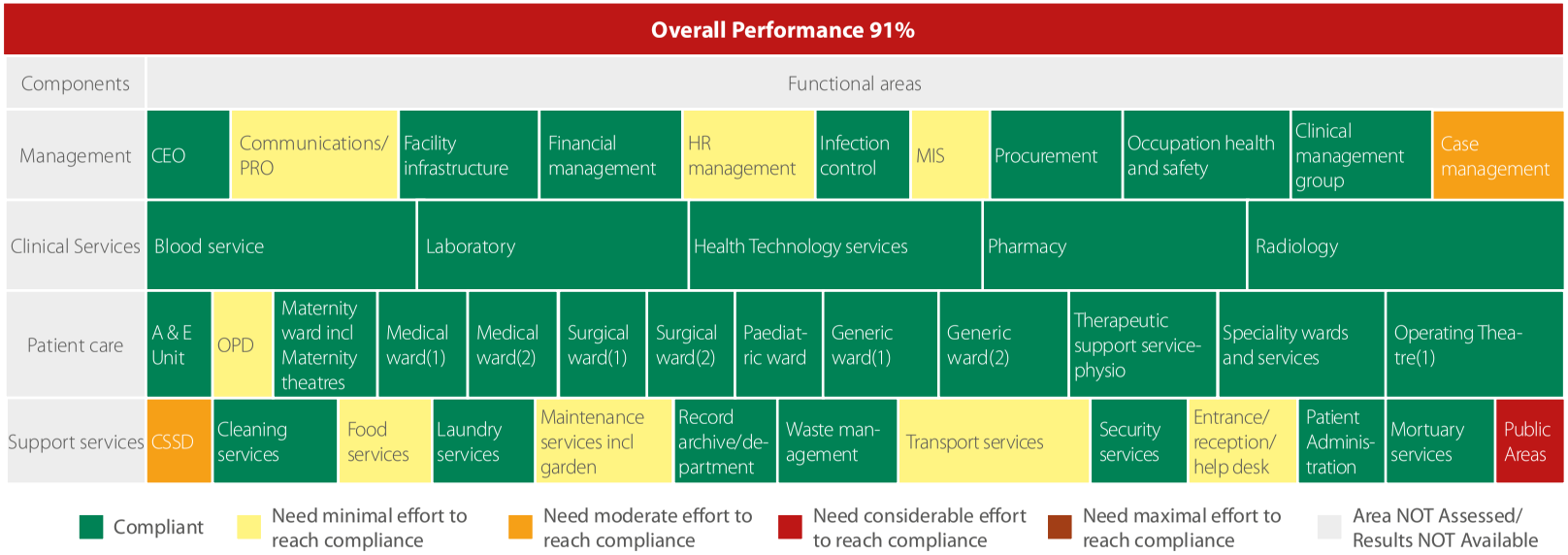
Grey's Hospital is a referral hospital providing 100% tertiary services located in Pietermaritzburg, which falls in the uMgungundlovu health district in KwaZulu-Natal Province. Grey's hospital offers regional health services to the UMgungundlovu district which has an approximate population on 1 million. Tertiary services are offered to the Western half of KwaZulu-Natal - this includes 5 health districts with a total population of 3.5 million. The hospital has 530 commissioned beds and is presently utilizing 507.

Grey's hospital was founded in 1855 and celebrated its 150th birthday in November 2005. The hospital won the Premier's Service Excellence Silver Award in 2004 and the Gold Award in 2005.

Tertiary Services Offered:

- Accident and Emergency Services
- Anaesthetics and Pain Management
- Clinical Psychology
- Dietetics
- Internal Medicine
- Laboratory Services
- Obstetrics and Gynaecology
- Occupational Therapy
- Orthopaedic and sub-specialties
- Pharmaceutical Services
- Physiotherapy
- Radiology
- Radiotherapy and Oncology
- Social Work Services
- Speech and Audiology
- Surgery - general
- Surgery - subspecialty
- General and sup-specialty clinics run by Paediatric outpatients

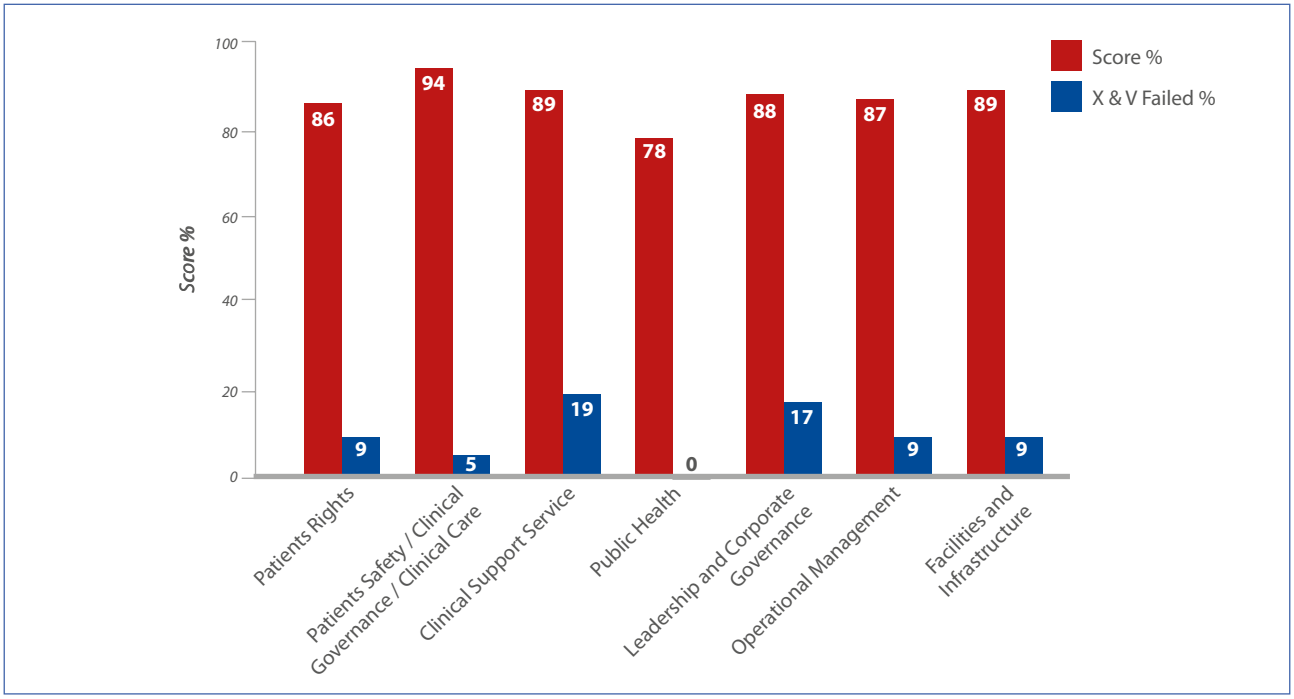
Table 35: Outcomes as per components



GTH Summary Components Outcome

- Management component needs minimal to moderate effort to reach compliance status.
- Clinical Services component reached compliance status
- Patient Care component needs minimal effort to reach compliance status
- Support Service component needs minimal to considerate effort to reach compliance status

Figure 32: Domain Outcome (Extreme and Vital)



GTH was inspected and achieved an overall score of 91% compliance. The following are the score achieved per domain:

- Patients Rights 86%
- Patient Safety 94%
- Clinical Support Services 89%
- Public health 78%
- Leadership and Corporate Governance 88%
- Operational Management 87%
- Facilities and Infrastructure 89%

Table 36: Extreme & Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for informed consent was not correctly completed e.g. procedure for operation was not indicated in one patient's file- 17-year-old signed consent	• Areas checked for the state of cleanliness were not all clean e.g. one patient toilet had bad odour. • Handrails of an acceptable gradient were not available at the entrances to the health establishment/unit and/or where needed.

Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Initial assessment of high risk maternity patients not done e.g. height, urinalysis, counselling for HIV and foetal risks not recorded • Safety checks have been conducted during and after surgery as per WHO guidelines e.g. blood estimation not indicated. • Emergency trolley not appropriately stocked e.g. no paeds Magill forceps. • Emergency trolley was not appropriately stocked e.g. oxygen cylinders not ready for use. • Protocol on administration of blood has not been adhered to e.g. product not checked. • Isolation room did not have notice of traffic control sign.	• A random selection of 3 patients receiving medicine indicated that they have no clear understanding of how and when to take their medication e.g. side effects not explained. • 3 random selected clinical areas showed that sharps were not safely managed and disposed e.g. recapping and mixing of cotton wool and syringes observed in sharps containers.
Domain 3: Clinical Support Services	
Extreme	**Vital**
• Functional essential equipment was not available as required e.g. tracheostomy set.	• Radiology results requested for two patients were not available in the patient`s file • Staff lacked knowledge on the maintenance of the cold chain as they did not know the temperature required to store and transport blood. • Maintenance plan or maintenance records were not available for medical equipment e.g. defibrillator. • There was no contract and Service Level Agreement in place with an approved and legally compliant sterilisation service provider • There was no evidence that all sterilisation equipment were validated / licensed
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Policy or protocol on obtaining of patient consent if the patient identifiable information needs to be communicated to the 3rd party not available.
Domain 6: Operational Management	
Extreme	**Vital**
	• Staff patient rations in key areas such as emergency unit/ outpatients/medical /surgical/paediatric and ICU were not available. • The files of members of staff reflect that Comprehensive performance reviews are not done e.g. outcome letter not signed.

Domain 7: Facilities and infrastructure	
Extreme	**Vital**
• There is no functional system to supply piped medical gas to all clinical areas. • There is no functional system to supply piped suction/ vacuum to all clinical areas.	• Maintenance records did not show that water supplies are checked daily for adequacy and availability from the main reticulation system e.g. record signed/ ticked ahead and some days not signed. • Cleaning materials and equipment were not available as required e.g. plain liquid soap, spray bottle containing dish washing detergent, mop sweeper, protective polymer and wet vacuum pick up.

Table 37: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	94%
Cleanliness	**82%**
Improve patient safety and security	93%
Infection prevention and control	87%
Positive and caring attitudes	91%
Waiting times	93%

The table above demonstrates GTH's performance in relation to the Six Ministerial Priorities. In this regard the health establishment have achieved compliance status of ministerial priority areas. Though high cleanliness scored the lowest as most tertiary and central hospitals

4.8 Witbank Tertiary Hospital

Profile

No data available at the time of report writing

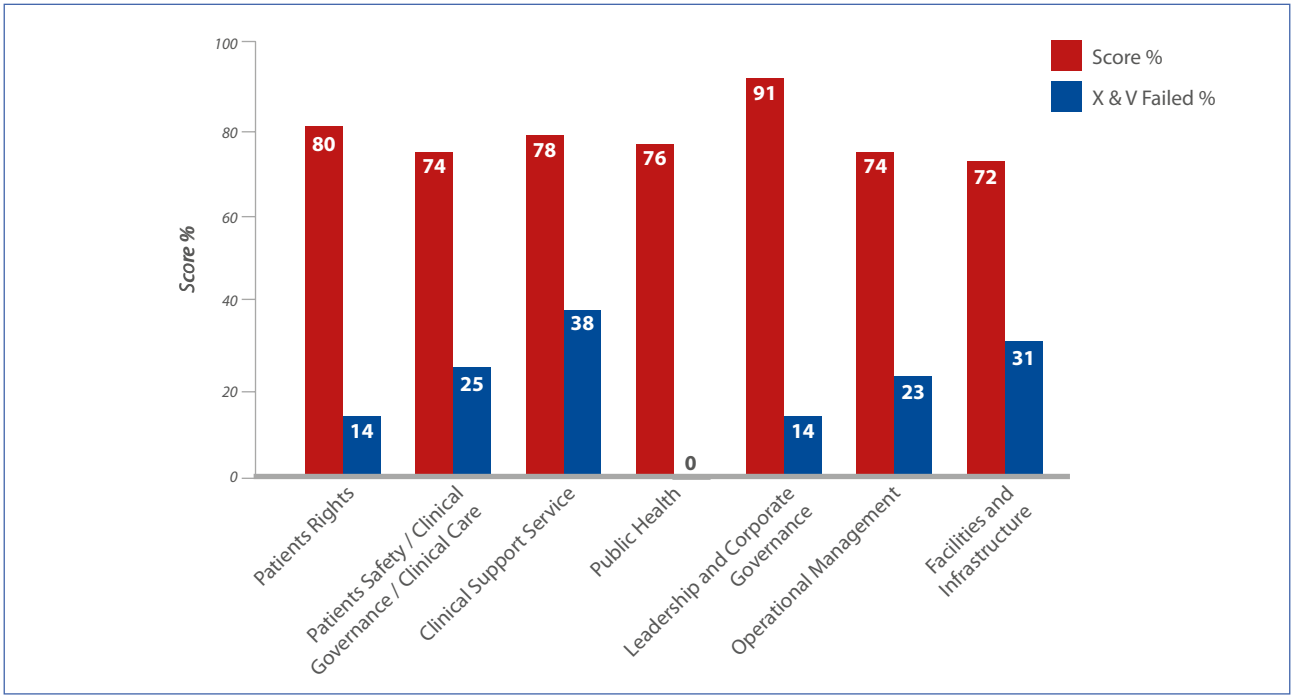
Table 38: **WTH Summary Components Outcome**

Overall Performance Outcome of the Facility 76 %														
Components	Functional areas													
Management	CEO	Communications/ PRO	Facility infra-structure	Financial management	HR management	Infection control	MIS	Procurement	Occupation health and safety	Clinical management group Case management				
Clinical Services	Blood services			Laboratory		Health Technology services			Pharmacy		Radiology	CSSD		
Patient care	A & E Unit	OPD	Maternity Ward Maternity theatres	Medical ward(1)	Surgical ward(1)	Paediatric wards	Therapeutic support services-physio		Speciality wards and services	Operating theatre cath labs -1	Psychiatric ward	Operating Theatre(2)		
Support services	Cleaning services		Food services	Laundry services	Maintenance services incl. garden	Record archive/ department	Waste man-agement	Transport services	Security services	Entrance/ reception/ help desk	Patient adminis-tration	Mortuary services	Public Areas	

Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

- Management component needs minimal to moderate effort to reach compliance status.
- Clinical Services component needs minimal to considerate effort to reach compliance status Patient Care needs minimal to considerate effort to reach compliance status
- Support Service component needs minimal to considerate effort to reach compliance status

Figure 33: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 76% compliance. The following are the score achieved per domain:

- Patients Rights 80%
- Patient Safety 74%
- Clinical Support Services 78%
- Public health 76%
- Leadership and Corporate Governance 91%
- Operational Management 74%
- Facilities and Infrastructure 72%

Table 39: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for informed consent were not witnessed.	• Six areas checked for the state of cleanliness were found to be dirty e.g. kitchen, ward and storage room. • Referral policy was in a draft format. • Referral Policy-Most aspects not included in the policy e.g. referral pathway not detailed. • Correct handover procedure was not followed between EMS and staff e.g. Method of transfer of patient from ambulance to consultation room not recorded.

Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Initial assessment of high risk patients not recorded e.g. Foetal heart not recorded 1/2 hourly. • No security measures are not adequate to safeguard new-borns. • Emergency Resuscitation Policy-Few aspects not covered e.g. referral protocol and all processes and document to undergo an audits. • Emergency trolley are not standardised/not appropriately stocked e.g. AED, was not available, Peads laryngoscope blades not available • Emergency trolley not appropriately stocked and not regularly checked e.g. face mask and Magill forceps not available. • Protocol on administration of blood not adhered to e.g. Vitals signs not monitored. • Not all aspects of blood transfusion are adhered to e.g. reactions not indicated, no verification. • Some aspects are not included such as no signage for highly infectious patients and proper transportation of specimens.	• Clinical Audits did not show that action plans have been put in place for area of concern • Quality improvement plan was not available • Health professionals indicated that they do not have access to adequate supervision. • Minutes of the forum reviewing clinical risks was not available. • Sharps not safely managed e.g. recapping of needles and lid not fitting properly. • Evidence that hand washing drive done was not available.
Domain 3: Clinical Support Services	
Extreme	**Vital**
• Tracer medicines not all were available such as Adrenaline, Ibuprofen, Tenofovir and Lopinavir. •	• Interviewed patients receiving medications verbalises that side effects were not explained to them. • Staff interviewed were unable to explain how the cold chain is ensured for blood products. • Both defibrillator and Ventilator overdue for service. • A report showing that adverse events involving medical equipment was not available. • Records showing all sterilisation equipment is validated/ licensed was not available.
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
• None of the measures were failed	• None of the measures were failed
Domain 6: Operational Management	
Extreme	**Vital**
	• Staff patient's ratio in key areas are not in accordance with the approved staffing plan e.g. the staffing in intensive care for nurse. • Evidence that turnaround times for critical stock are set and monitored regularly was not available. • SOP for request/retrieval of patient files do not exist.

Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas was not available. • Functional system to supply piped medical gas to all clinical areas was not available. • Functional system to supply piped suction to all clinical areas was not available.	• Safety hazards not observed e.g. collapsing of the ceiling. • Maintenance records shows that water supplies are checked weekly. • Cleaning materials and equipment not all were available e.g. Window cleaning squeegee and face shield.

Table 40: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	86%
Cleanliness	**70%**
Improve patient safety and security	**72%**
Infection prevention and control	**74%**
Positive and caring attitudes	79%
Waiting times	92%

The table above demonstrates WTH's performance in relation to the six Ministerial Priorities. In this context the health establishment is experiencing problems with Cleanliness, having Improve Patient Safety, Infection Prevention and Control including scored lowest below 75%. However, WTH scored highest with regard to Waiting times 92%. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed? Is hospital now clean?

4.9 Mankweng Tertiary Hospital

Profile

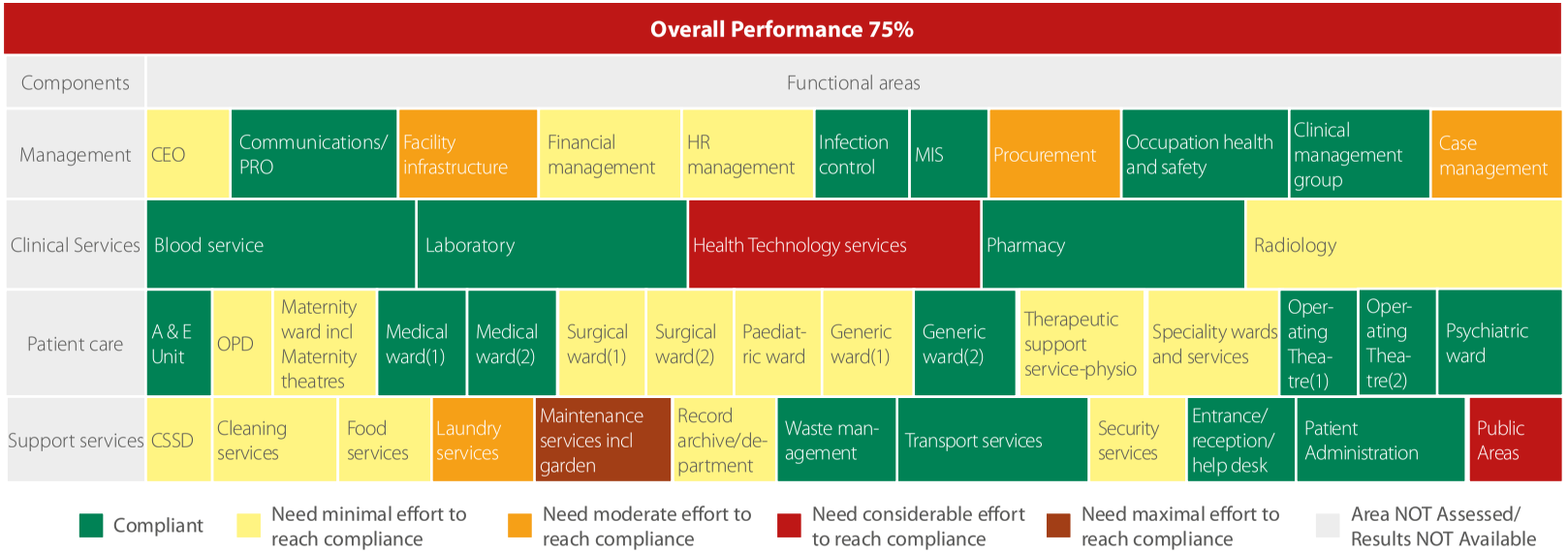
The Polokwane/Mankweng Hospital Complex (PMHC) is a combination of two hospitals - Pietersburg Hospital Campus and Mankweng Hospital Campus. The Role of the PMHC is to provide tertiary services to all Level 1 (District) and Level 2 (Regional) Hospitals in the Limpopo Province

The Pietersburg Hospital, a massive 450 bed Training Institution, runs in collaboration with the Medical University of Southern Africa (MEDUNSA). Pietersburg Hospital Campus is committed to provide holistic, secondary and tertiary health services. If we cannot provide such services in the hospital, we transfer patients to Steve Biko Academic Hospital (formerly Pretoria Academic) and Dr George Mukhari Hospital. Some of the services that we don't have in this campus are, however, provided by our sister campus, Mankweng Hospital.

Mankweng Hospital Campus was established as a result of the requests from Magoshi in the Thabamoopo region for a hospital to cater for their people around Mankweng area.

The Magoshi included, inter alia, Kgoshi Mothapo, Kgoshi Mothiba, Kgoshi Molepo, Kgoshi Dikgale, Kgoshi Sophia Mamabolo and Kgoshi Mamabolo of Segopje. Kgoshi Mamabolo of Segopje donated the land on which the hospital was built. The Magoshi approached the late Dr Cedrick Namedi Phatudi, the then Minister of Lebowa Government, to approach Central Government for funding of the construction of the hospital.

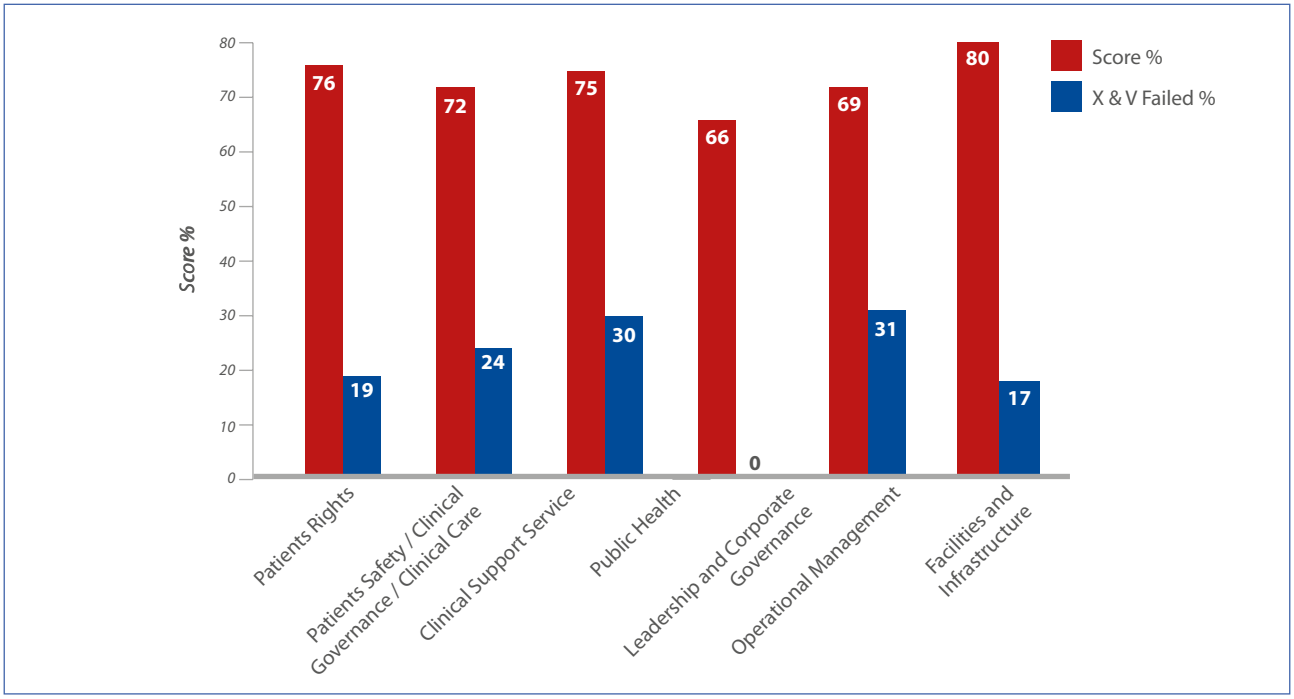
Table 41: Outcomes as per components



MTH Summary Components Outcome

- Management component needs minimal to moderate effort to reach compliance status.
- Clinical Services component needs minimal to considerate effort to reach compliance status Patient Care needs minimal effort to reach compliance status
- Support Service component needs maximal to considerate effort to reach compliance status

Figure 34: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 76% compliance. The following are the score achieved per domain:

- Patients Rights 76%
- Patient Safety 72%
- Clinical Support Services 75%
- Public health 66%
- Leadership and Corporate Governance 72%
- Operational Management 69%
- Facilities and Infrastructure 80%

Table 42: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for informed consent were not completed correctly by the health professionals e.g. column for health professional to sign was not provided. • Assessed forms used for informed consent were not correctly completed, e.g. the signature of the person performing the procedure not indicated.	• Two out of six areas checked for the state of cleanliness were not clean e.g. walls were dirty- Leaking toilet observed with visible stains on the floor in toilets and store rooms. • The referral policy did not cover all aspects as required by the checklist, e.g. referral pathway not specified and monitoring evaluation of data on referrals to and out of the health establishment. • Procedure emphasises the speedy handover of patients to reduce handover time from EMS to hospital staff did not include the emphasis on speedy handover of patients to reduce handover time.
Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Initial assessment of high risk maternity patients did not reflect the identification of specific risk factors e.g. assessment time not noted. • Assessed patients records for patients who underwent surgery did not demonstrate that safety checks have been conducted, e.g. baseline vital signs pre anaesthesia not noted. • Policy for handling emergency resuscitation did not cover all aspects, e.g. referral protocol documentation for the resuscitation not described • Emergency trolleys was not appropriately stocked, e.g. Xylocaine spray expired. • Assessed patient files did not demonstrate that the protocol for administration of blood has been adhered to, e.g. clinical need for blood not indicated.	• Comprehensive clinical assessment and diagnosis of recently discharged patients was not done in 3 of the assessed files e.g. a provisional diagnosis after the initial assessment. • The evidence that the health establishment participates in monthly maternal and perinatal morbidity and mortality meetings reflected only mortality for October, November and December 2015 meetings and maternal morbidity and mortality meetings were not available. • Minutes of forum reviewing clinical risks from within the last quarter were not available. • The procedure for the care of the terminally ill which addresses the needs of the patients and their family was not available. • The procedure for conducting and acting on risk assessment of frail and aged was not available. • The procedure for conducting and acting on risk assessment of patients with reduced morbidity was not available. • Two files of frail or aged patients audited were not having water low scale for pressure sores and Morse fall scale for falling. • Observed 3 clinical areas show that sharps are not safely managed and disposed of e.g. recapping observed. • Minutes of the forum reviewing resuscitations from within the last quarter were not available. • A protocol regarding the safe administration of medicines to patients did not include the safe administration of medicines to children. • Assessed adverse event reports did not reflect immediate actions and root cause analysis

Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
	• Minutes of the forum reviewing adverse events from within the last quarter were not available.
	• Two of three sharps containers as assessed did not show that sharps are safely managed and disposed of e.g. recapping noted.
Domain 3: Clinical Support Service	
Extreme	**Vital**
• Functional essential equipment was not available as required e.g. Electrocardiography and tracheotomy set.	• A random selection of 3 patients receiving medicine indicated that the Pharmacist did not explain side effects of medicine and what each medicine is for. • Four aspect of the questions asked to the patient about understanding of medication received were not compliant, e.g. Side effects not explained to the patient. • The minutes of the forum which deals with adverse drug reactions demonstrates that actions were not taken to report / analyse and take appropriate action regarding adverse drug reactions • Two staff interviewed could not explain how to maintain cold chain of blood product, e.g. temperatures range for transportation of blood product. • Records within the last 12 months show that only two ventilators has been maintained according to a planned schedule or manufacturers instruction. • There is no report showing that adverse events involving medical equipment are reported and action is taken to prevent recurrence. • There was only 1 of the 5 machines having contract and Service Level Agreement in place with an approved and legally compliant sterilisation service provider.
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• There was no evidence that issues raised by resigning managers during exit interviews are addressed with action plans in place.

Domain 6: Operational Management	
Extreme	**Vital**
	• There was no evidence to prove that staff patient ratios in key areas comply with approved staffing plan. • There were no records that agreements with staff who perform remunerated work outside the establishment are monitored • The agreement for staff permitted to perform remunerated work outside the health establishment where they are employed was not available. • Financial projection document did not show that the health establishment will be able to deliver defined service needs within the annual allocated budget. • The documentary evidence that turnaround times for critical stock are set and monitored regularly was not available.
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency was not available.	• There is no maintenance record to show that recommendations of the annual management report on safety hazards are implemented. • Obvious safety hazards were observed during the visit such as loose electrical wiring • There were no maintenance records showing that water supplies are checked daily for availability. • Cleaning materials and equipment such as N95 masks, goggles and protective polymer were not available. • Records showed that pest control was not done in all areas, e.g. Maintenance Services.

Table 43: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	80%
Cleanliness	**61%**
Improve patient safety and security	**74%**
Infection prevention and control	76%
Positive and caring attitudes	80%
Waiting times	83%

The table above demonstrates MTH's performance in relation to six Ministerial Priorities. In this context the health establishment is experiencing significant cleanliness scoring lowest 61% not only cover the physical cleanliness but also the availability of cleaning materials and to Improve Patient Safety, Infection Prevention & Control scoring 74%. However, the hospital scored higher 83% waiting

times and availability of medicines and supplies 80%. The question is what is the problem with basic cleanliness and what remedial action has been taken since management inspection feedback. Has the situation changed? Is hospital now clean?

4.10 Pietersburg Tertiary Hospital

Profile

The Polokwane/Mankweng Hospital Complex (PMHC) is a combination of two hospitals - Pietersburg Hospital Campus and Mankweng Hospital Campus. The Role of the PMHC is to provide tertiary services to all Level 1 (District) and Level 2 (Regional) Hospitals in the Limpopo Province. The Pietersburg Hospital, has 450 bed Training Institution, runs in collaboration with the Medical University of Southern Africa (MEDUNSA). Pietersburg Hospital Campus is committed to provide holistic, secondary and tertiary health services. If the hospital is unable provide such services patients are transferred to Steve Biko Academic Hospital (formerly Pretoria Academic) and Dr George Mukhari Hospital. Services the hospital does not have is provided by sister campus, Mankweng Hospital.

Mankweng Hospital Campus was established as a result of the requests from Magoshi in the Thabamoopo region for a hospital to cater for their people around Mankweng area.

Table 44: Outcomes as per components

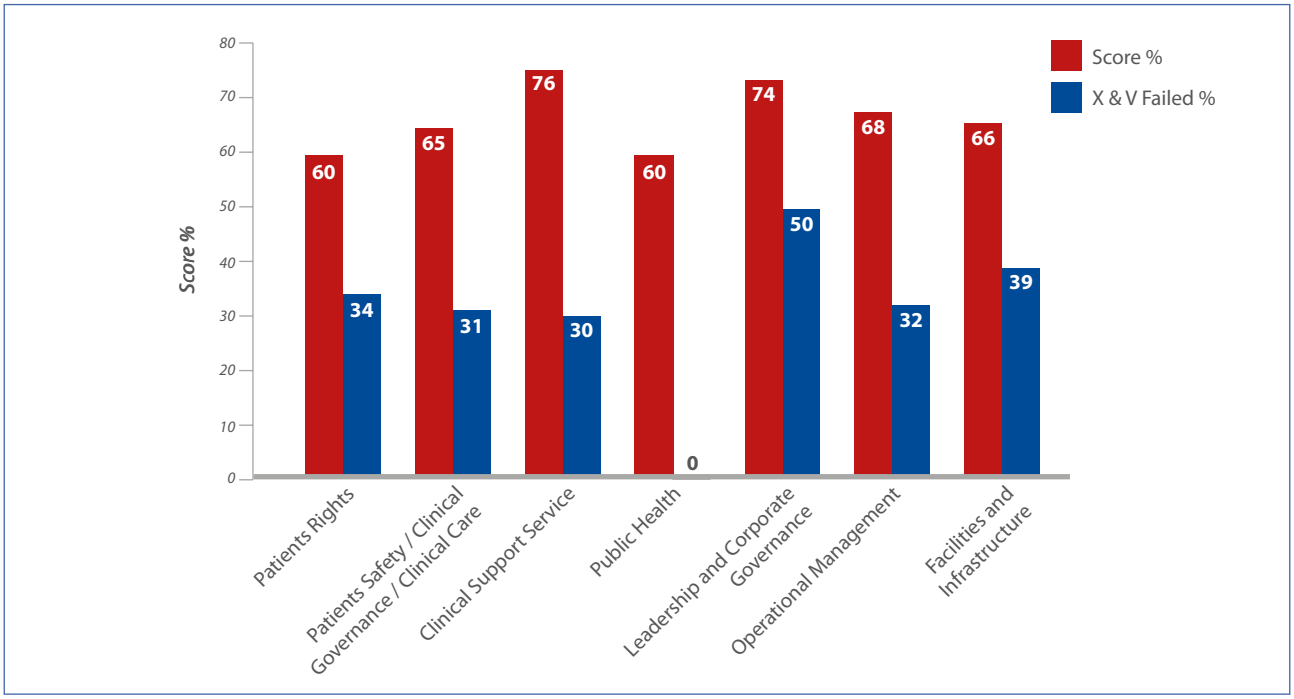
Overall Performance Outcome of the Facility 67 %														
Components	Functional areas													
Management	CEO	Communications/ PRO	Facility infra-structure	Financial management	HR management	Infection control	MIS	Procurement	Occupation health and safety	Clinical management group	Case management			
Clinical Services	Blood services		Laboratory		Health Technology services		Pharmacy		Radiology					
Patient care	A & E Unit	OPD	Maternity Ward Maternity theatres	Medical ward(1)	Surgical ward(1)	Surgical ward(2)	Paediatric wards	Generic ward (1)	Therapeutic support services-physio	Speciality wards and services	Operating theatre (1)	Psychiatric ward		
Support services	CSSD	Cleaning services	Food services	Laundry services	Maintenance services incl. garden	Record archive/ department	Waste man-agement	Transport services	Entrance/ reception/help desk	Mortuary services	Public Areas			

Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

PTH Summary Components Outcome

- Management component needs minimal to considerable effort to reach compliance status.
- Clinical Services component needs minimal effort to reach compliance status
- Patient Care needs minimal effort to moderate to reach compliance status
- Support Service component needs maximal to considerate effort to reach compliance status

Figure 35: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 67% compliance. The following are the score achieved per domain:

- Patients Rights 60%
- Patient Safety 65%
- Clinical Support Services 76%
- Public health 60%
- Leadership and Corporate Governance 74%
- Operational Management 67%
- Facilities and Infrastructure 66%

Table 45: Extreme and Vital Measures Failed by Domain:

Domain 1: Patients Rights	
Extreme	**Vital**
• The informed consent form was not completed fully on two files analysed, e.g. consent form not signed by the operating doctor. • Assessed consent forms were not correctly completed, e.g. 1 of 3 forms had an incorrect date, 2015 instead of 2016.	• Two of the six observed areas were not in a good state cleanliness, e.g. Floors were stained with blood. • Toilets in the unit faulty with water leakage onto the floor. • Referral Policy document did not meet all aspects as required on the checklist e.g. the referral pathway not detailed. • Procedure governing handover of patients from EMS not available. • Procedure for speedy handover of patients from EMS to hospital staff not available.
Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Assessed files of which risk maternity patients did not reflect the identification of specific risk factors, e.g. action plans and interventions risk factors not noted. • Security measures not adequate as not all access and exit points are safe guarded. • One of the three patients assessed peri operational documents did not demonstrate that safety checks were conducted during and after surgery as per WHO guidelines as there was no record. • Formal policy for handling emergency resuscitations was not available or produced. • Emergency trolleys were not properly stocked, e.g. defibrillator was not functional. • Protocol on administration of blood has not been adhered to, e.g. consent form not signed and details of the transfusion are not recorded. • Three of the assessed patients' records did not demonstrate that the protocol on admission of blood has been adhered to, e.g. observations ending before the transfusion are completed. • Room accommodating isolated patients does not have area for disposal of infected linen.	• Assessed files of discharged patients did not show that a comprehensive clinical assessment and diagnosis has been done, e.g. 1 of 3 files did not have a discharge diagnosis. • Produced evidence did not qualify monthly maternal perinatal morbidity and mortality meetings, it was statistics. • Minutes of the forum reviewing clinical risks not available. • Procedure for conducting risks on frail and aged patients is not available. • Required criteria for 72 hours were not met, e.g. policy on use of physical restraints. • Policy on use of physical restrains was not having name of the accounting officer. • Patients were not identified as high risk on their files and have not received treatment in accordance with policy for high risk. • Minutes of the forum reviewing resuscitations are not available. • Protocol regarding safe administration of medicine is not available. • The Standard operating procedure does not include safe administration of children. • Assessed sharps containers did not show that sharps are safely managed and disposed of, e.g. two of the three had recapping noted and the other two also had lids not tightly closed.

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Tracer medicines such as diazepam injection and zidovudine 300mg not in stock. • Not all equipment is available in the unit, e.g. diagnostic set and tracheotomy set.	• Dispensing not done in accordance to legislation, e.g. reference number not written on label, dosage form and quality not written in permanent record. • Probable side effects of medication not explained to patients. • Minutes of the forum dealing with adverse drug reaction not available yet as the committee is still new. • One of the two interviewed staff was not sure on measures to maintain cold chain e.g. storage temperature of red blood cells is not known. • Adverse blood reactions are not documented and not reported to the forum dealing with adverse events
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Piped suction system not functional, connections not available.	• Safety hazards such as collapsing ceiling were observed. • Security systems not positioned at all vulnerable patient area, maternity unit had several egress points, but only one point was guarded. • Cleanliness can be improved, areas were observed to be filthy and cockroaches were seen. • 9 of the 23 items on the checklist were not available, e.g. Colour coded buckets and cloths and window cleaning squeegee.

Table 46: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	76%
Cleanliness	**44%**
Improve patient safety and security	**61%**
Infection prevention and control	75%
Positive and caring attitudes	**62%**
Waiting times	65%

The table above demonstrates the PTH's performance in relation to six Ministerial Priorities. In this context the health establishment is experiencing significant problems with regard to Cleanliness, Improved patient safety & security, Positive & Caring Attitudes and Waiting times. The hospital's reasonable highest score 76% availability of medicines and supplies, and to improving positive and caring staff attitudes 75%. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed? Is hospital now clean?

4.11 Kimberly Tertiary Hospital

Profile

Kimberley Hospital Kimberley Hospital is the only Tertiary Hospital in the NC Province; officially classified as such in active beds, offers 33 different speciality disciplines, all headed by qualified specialists in their respective fields; A satellite training facility of the University of the Free State accredited by the Health Professional Council of South Africa (HPCSA) to train interns and Registrars. The hospital plans to offer T1 services soon. In meantime tertiary services offered at the hospital include:

Cardiothoracic Surgery, Hepatology, Maxillofacial, Surgery, Geriatric, Medicine, Otorhinolaryngology(ENT), Radiation Oncology, Endocrine, Surgery Neurology, Surgical, Gastroenterology, Pulmonology, Trauma Surgery, Rheumatology, Vascular Surgery, Medical Physics, Cardiology Complex & Interventional, Paediatric Cardiology, Endocrinology, Paediatric Surgery, Medical Gastroenterology and Spinal Injury Management

Table 47: Outcomes as per components

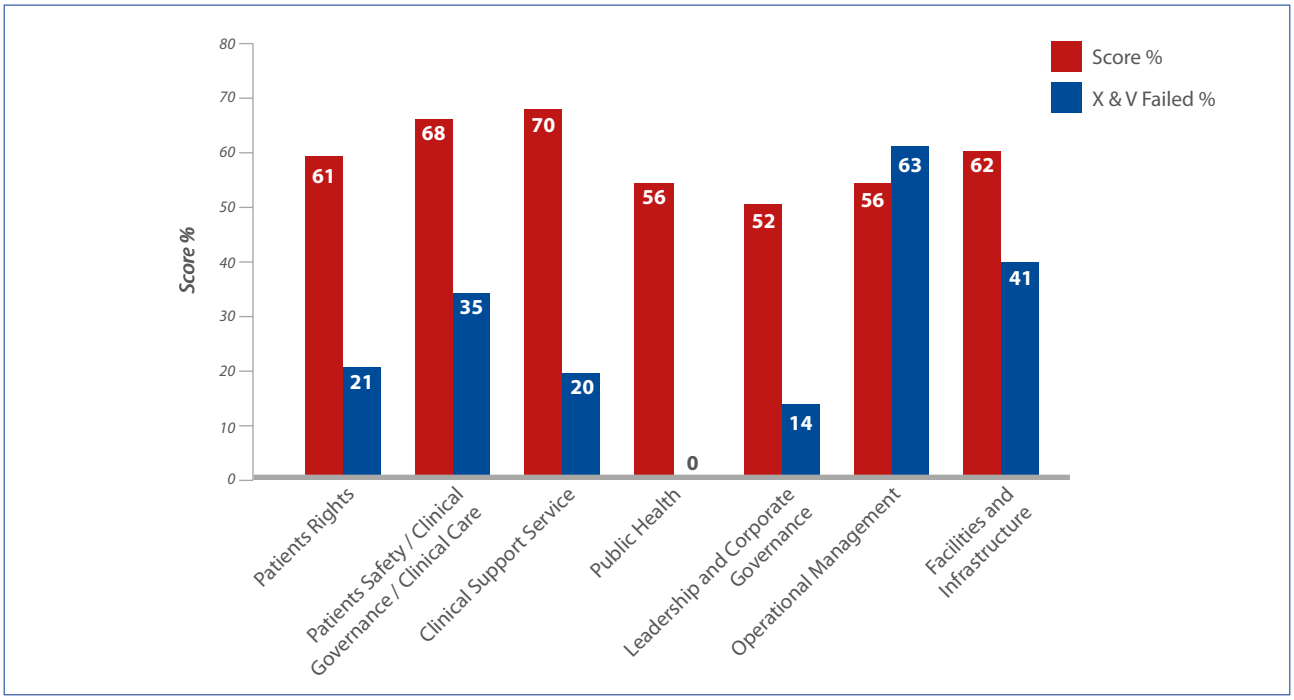
Overall Performance Outcome of the Facility 63 %																
Components	Functional areas															
Management	CEO	Communications/ PRO	Facility infrastruc-ture	Financial manage-ment	HR manage-ment	Infection control	MIS	Procurement	Occupation health and safety	Clinical mangement group	Case management					
Clinical Services	Blood services			Laboratory			Health Technology services			Pharmacy	Radiology		CSSD			
Patient care	A & E Unit	OPD -1	Maternity ward incl Maternity theatres	Medical ward(1)		Surgical ward(1)		Paediatric ward	Therapeutic support services physio	Speciality ward and Services	Operating theatre cath labs -1		Psychiatric ward	Surgical ward -2		
Support services	Cleaning services	OPD -2	Food services	Laundry services	Maintenance services incl garden	Record archive/de-partment	Waste man-agement	Transport services	Medical ward -2	Security services	Entrance/ reception/ help desk	Patient Adminis-tration	Mortuary services	Public areas		

Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

KTH Summary Components Outcome

- Management component needs minimal to considerable effort to reach compliance status.
- Clinical Services component needs minimal effort to considerate to reach compliance status
- Patient Care needs minimal effort to moderate to reach compliance status
- Support Service component needs minimal to maximal effort to reach compliance status

Figure 36: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 63% compliance. The following are the score achieved per domain:

- Patients` Rights 61%
- Patient Safety 68%
- Clinical Support Services 70%
- Public health 56%
- Leadership and Corporate Governance 52%
- Operational Management 56%
- Facilities and Infrastructure 61%

Table 48: Extreme and Vital Measures Failed by Domain

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for Consent-Not all required information was recorded e.g. age not recorded and space not provided in the form. • Forms used for informed consent were not completed correctly e.g. staff members witnessed next to the patients thumb print.	• Respect and dignity of mentally ill patients was not preserved e.g. patients. dressed in dirty clothes. • Six areas checked for the state of cleanliness were found to be e.g. Ward storage room dirty, window seal and steel cabinet full of birds' faeces and toilet dirty. • No security services between 12h00 and 14h00 at the side gate. • Patient referral policy not dated nor signed by relevant authorities • SOP for handover of patients from EMS to hospital staff not dated nor signed by relevant authorities.
Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• High risk assessment not done e.g. foetal presentation at 36wks not recorded, RPR results not recorded. • Security measures not adequate e.g. security measures were not available in the ward. • Patients Peri-Operative Document-Safety checks not conducted e.g. pre anaesthetic vital signs not done. • Policy for handling emergency resuscitation outdated in February 2016. • Emergency Trolley-Expired items observed e.g. tracheal tubes (12/2015) and dopamine injection (December 2015). • Emergency trolley not standardised and not appropriately stocked e.g. Ambu-bags and oxygen cylinder was not available. • Required protocol for emergency blood the following aspects not adhered to e.g. no evidence of checks conducted and transfusion details not documented. • Protocol on the administration of blood not followed e.g. 12 hours post transfusion monitoring not done. • Appropriate isolation accommodation did not exist for patients with communicable diseases. • Bin lids broken & not fitting correctly, commode broken. Hand rub placed inside the room. • At the time of inspection, the isolation rooms did not have hand rub prior entering the room, signage to inform visitors.	• Discharge files shows that comprehensive clinical assessment was not done e.g. treatment plan & health education not given. • Clinical assessment not done e.g. past medical history not noted. No evidence if patients informed on his/ her treatment. • Clinical audits not done for HIV, TB IMCI, STD and PMTCT. • No quality improvement plan implemented • Staff interviewed indicated that supervision was Inadequate. • Minutes of the forum reviewing clinical risks was not available. • SOP for care of terminally patients was not available. • SOP for management of patients detained for 72hrs observations was outdated in 2011. • SOP for conducting and acting on risk assessment done on frail and aged patients was not available. • SOP for conducting and acting on risk assessment of patients with reduced mobility was not available. • Theatre-Particles counts and bacterial growths are performed annually. • Protocol regarding safe administration of medicines was not signed by relevant authorities. • Adverse events report did not reflect root cause analysis done. • Reporting systems for needle stick injuries is not in place. • Sharps not safely managed and disposed such as recapping of needles noted and sharps mixed with paper.

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Required tracer medicines not all were available e.g. Amikacin injection and Furosemide injection. • Tracheostomy set, instrument set not available at the time of inspection. • Functional equipment not all were available e.g. Diagnostic set, glucometer rand HB meter.	• Standard Operating Procedure which indicate how schedule5 and 6 are controlled/stored in accordance with the Medicines and Related Substances Act 101 of 1965 was not approved by relevant authority. • SOP which indicates how schedule 5 and 6 are stored/ controlled was not dated nor signed by relevant authorities. • Dispensing not done in accordance with applicable policies and legislation e.g. prescription reference number not recorded. • Patients interviewed verbalises that possible side effects not explained and opportunity to ask questions not given to them. • Interviewed patients verbalises that possible side effects were not explained to them. • Access denied at NHLS • Two staff members that were interviewed did not know how the cold chain is maintained for the storage of blood. • Records of all adverse blood reactions was not available and there was no zero reporting. • Required equipment not available e.g. surgeon stool and 12 channel ECG. • No service record for the defibrillator and ventilators - no planned schedule for medical equipment in the unit. • Systems not in place to monitor items requiring replacement or ordering. • A report showing that adverse events involving medical equipment's are reported was not available.

Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• Clinical manager consented without a letter of delegation by the head of the health establishment. • Review minutes produced not signed & have no specific targets. No operational plan to verify monitoring against targets and indicators. • Produced minutes of the relevant forum reviewing quality was not signed by relevant authorities.

Domain 6: Operational Management	
Extreme	**Vital**
• No measures in place to prevent any incident of harm to staff.	• Staff patient ratios in key areas are in accordance with the approved staffing plan evidence was not available. • Trends of absenteeism was not monitored • Evidence not available to show monitoring of staff who performs work outside the health establishment • Evidence that show that medical examinations was performed for all health care workers was not available. • Records of needle stick injuries was not available. • Evidence of monitoring turnaround times for critical stock was not available. • There is evidence that expenditure variance reports are compiled at least quarterly and tabled at management meetings where variances are addressed was not available • SOP for request/retrieval of patients files was not signed by relevant authorities.
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Access denied at NHLS • Documented evidence in the event of a power disruption emergency power supply is available in critical aspects such as ICU was not available. • Generator not started and run due to budget constraints. • Piped medical gas was not available in some areas. • Functional system to supply piped suction to all clinical areas was not available.	• Maintenance records do not show that recommendations of annual management inspections report on safety hazards and maintenance needs are implemented. • Safety hazards observed e.g. Unsecured oxygen cylinders in peads and maternity ward. • Maintenance records showing that water supplies are checked daily was not available. • Security system not documented in the security policy. • Required security measures are not in place e.g. in house security not registered with PSIRA and security policy not signed. • No security system in place in vulnerable areas such as maternity wards • No security system at access and exit point. • Records of daily inspection of cleanliness was not available. • The facility was observed not to be clean e.g. smelling offensive odour in patient's toilet. • Required cleaning material not available e.g. goggles and protective polymer. • Required cleaning material and equipment not available e.g. colour coded dusting cloths, goggles and window cleaning squeegee. • Observed cleaning staff did not wear protective clothing while carrying out her cleaning duties at the time of inspection.

Table 49: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	76%
Cleanliness	**41%**
Improve patient safety and security	66%
Infection prevention and control	65%
Positive and caring attitudes	**59%**
Waiting times	**46%**

The table above demonstrates KTH's performance in relation to six Ministerial Priorities. In this regard the hospital is experiencing significant problems with regard to Cleanliness scoring lowest 41%, Positive & Caring Attitudes 45% and Waiting times 46%. These scores are concerning and the question to management and staff what is the problem and what is planned to be done differently in preparation for the next inspection issues of responsibility and accountability critical for all concerned to be effective implemented including performance management.

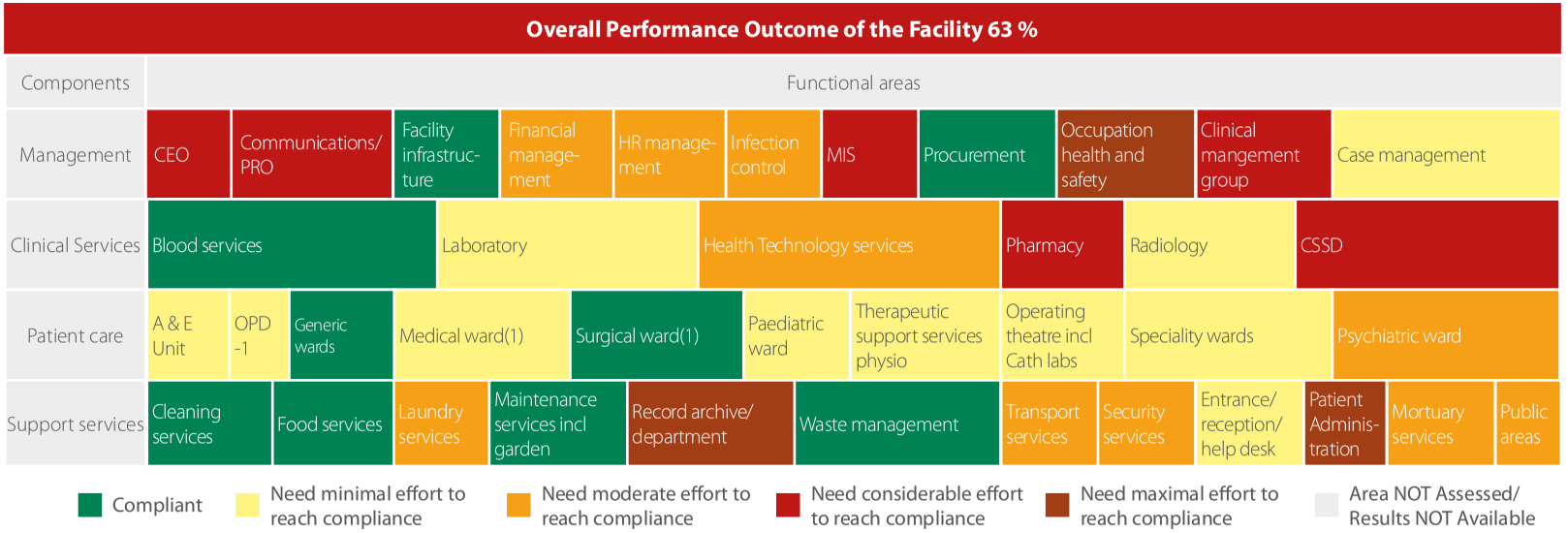
4.12 Red Cross Children Hospital

Profile

The Red Cross War Memorial Children's Hospital was built in 1956 and is the largest, stand-alone tertiary hospital dedicated entirely to child healthcare in Southern Africa. The Hospital is a public, tertiary hospital in Cape Town, South Africa, and is also a teaching hospital for the University of Cape Town. This iconic children's Hospital is world-renowned and is committed to delivering world-class pediatric treatment, care, research and specialist training.

The Red Cross Children's Hospital manages around 260 000 patient visits each year, the majority of which are from exceptionally poor and marginalized communities. One third of the little patients are younger than a year. This extraordinary place of healing advocates that no child will be turned away. There are also no visiting hours as parents are encouraged to be a part of their child's healing journey. Patients are referred from the Western Cape, the rest of South Africa and across broader Africa. The Hospital provides training to pediatric healthcare professionals from the entire sub-continent and conducts ground-breaking research into the childhood illnesses that has a global impact. The Hospital's stature far outweighs its 260 000 annual patient visits. It holds the hope of a healthy childhood, a parent's faith in healing, and a medical professional's gift of prevention and cure for tomorrow's most precious resources – our children.

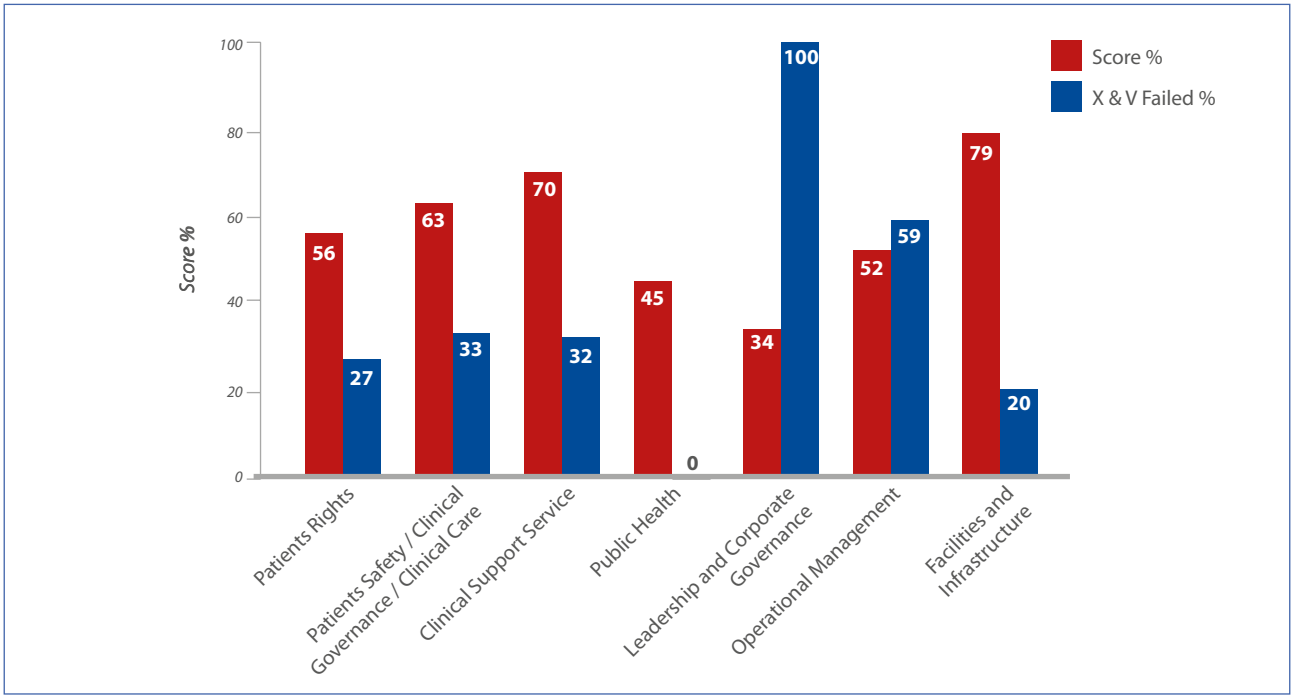
Table 50: Outcomes as per components



RTH Summary Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal effort to considerate to reach compliance status
- Patient Care needs minimal effort to moderate to reach compliance status
- Support Service component needs minimal to maximal effort to reach compliance status

Figure 37: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 62% compliance. The following are the score achieved per domain:

- Patients Rights 56%
- Patient Safety 63%
- Clinical Support Services 70%
- Public health 45%
- Leadership and Corporate Governance 34%
- Operational Management 52%
- Facilities and Infrastructure 79%

Table 51: Extreme and Vital Measures Failed by Domain

Domain 1: Patients Rights	
Extreme	**Vital**
	• Six areas checked for the state of cleanliness this were the findings poor waste segregation in consulting rooms. • Referral policy not signed by relevant authorities. • Health professional responsible for reviewing/ triaging patients was not available.

Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• No security measures to safeguard new born. • Required aspects not covered e.g. equipment problems and concerns for recovery. • Emergency trolley not appropriately stocked and not regularly checked e.g. Adult oxygen mask and/ or nasal cannula not available. • Emergency trolley and defibrillator not checked regularly. One Tracheal tube expired. • Protocol on blood administration not adhered to e.g. informed consent form not available and no evidence for checks conducted. • Health establishment rooms to be used for confirmed infectious TB are not separated by means of adequate physical barriers from non- TB patient e.g. critical care unit and trauma ward. • Isolation accommodation did not exist for patients with communicable diseases e.g. ICU and trauma ward open plan, no isolation room. • Isolation accommodation did not exist for patients with haemorrhagic fever, no separate toilet and signage for highly infectious diseases. • Isolation accommodation not appropriate e.g. no separate toilet, nor signage.	• Clinical audits for each priority programme /health initiatives were not conducted. • Quality improvement plan was not available • Minutes of the forum reviewing clinical risks and adverse events were not available. • Procedure for the management of patients detained for 72hrs observation was not available. • Procedure for conducting and acting on risk assessment of frail and aged patients was not available. • Procedure for conducting and acting on risk assessments of patients with reduced mobility was not available. • No report of 72 hours for assisted patients the health establishment. • Risk assessment not conducted on the files of frail or aged patients. • Particle count done yearly. No evidence of bacterial count. • Protocol regarding safe administration of medicines was not signed by relevant authorities. • Reporting system for needle stick injuries or other related to failure of standard precautions was not available. • Sharps not safely managed and disposed e.g. Recapping of needles observed.

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Tracer medicines as per applicable essential drug list no all were available such as Oxytocin and Cotrimaxole tablets. • Not all the requested listed equipment is available e.g. HB meter, 12 channel electrocardiographic and tracheotomy set.	• Standard operating procedure which indicates how schedule 5and 6 medicines are stored /controlled/distributed in accordance with the Medicines and Related Substances Act 101 of 1965 was not available. • Interviewed patients verbalises that side effects were not explained to them. • Minutes of the forum which deals with adverse drug reactions was not available. • Report of all adverse blood reaction was not available and there was no zero reporting. • System not in place to monitor items requiring replacement and ordering • There was no contract and Service Level Agreement was not in place with an approved and legally compliant sterilisation service provider • Records show that the Service Level Agreements for decontamination services are not monitored by the manager in charge
Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• An up-to-date copy of the delegation of authority for the manager of the health establishment detailing the managers' authority in terms of financial supply chain and human resource management was not available. • Evidence that the manager complies with clinical practice law in relation to custodianship was not available. • No operational plan that is consolidated for the facility. • Minutes of the relevant forum reviewing quality produced were signed before adoption. • there is evidence that exit interviews are not conducted with all managers who have resigned e.g. No interview done for Dr Blake. • evidence showing that the health establishment responded within a reasonable time with communication to the public during a recent health related issue such as an outbreak or public health concern was not produced. • Policy not available. Policy and protocol for obtaining patients consent was not available.

Domain 6: Operational Management	
Extreme	**Vital**
	• There is no evidence that action is taken to deal with absenteeism and staff vacancies. • Minutes of the occupational health and safety committee was not available. • Evidence shows that medical examination is not performed of all health care workers who are exposed to potential occupational hazards when performing their duties e.g. medical ward staff not done. • Records of needle stick injuries was not available. • SOP for request/retrieval of files did not exist
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• Documented evidence in the event of power disruption emergency supply is available in critical areas such as ICU was not available.	• Security policy not available to verify documented security systems. • Required information not covered in the security policy e.g. access of official visitors and security system in vulnerable areas. • Security system for access and egress point not in place. • Security system not functional during the day e.g. day staff deactivate magnet gates. • Records of daily cleanliness inspections was not available. • Equipment and cleaning material not all were available at the time of inspection e.g. plain liquid soap, goggles, spray bottles, window cleaning squeegee, and yellow bags.

Table 52: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	74%
Cleanliness	69%
Improve patient safety and security	65%
Infection prevention and control	60%
Positive and caring attitudes	**59%**
Waiting times	**60%**

The table above demonstrates RCTH's performance in relation to six Ministerial Priorities. In this context the health establishment is having significant problems challenges with regard to Positive and Caring Attitudes with the lowest score of 59% and Waiting Times scored 60%. However, the hospital scored reasonably high with regard to availability of medicines and supplies 74% the rest of the scores are below 75%. The question is what and how management and staff deal effectively with teams performance and other human relations factors (e.g. conflict) which towards negative staff attitudes including issues of accountability and performance in preparation for the next inspections.

4.13 Ngwelezana Tertiary Hospital

Profile

Ngwelezana Hospital is a 554 bedded hospital. It provides District, Regional and Tertiary Services to communities from UThungulu, UMkhanyakude and Zululand Districts. It is situated at Ngwelezana Suburb which is 5km's away from Empangeni. Empangeni is about 20km's from Richards Bay Industrial area, Harbour and Beaches and Airport in KwaZulu-Natal Province

Tertiary Services Offered

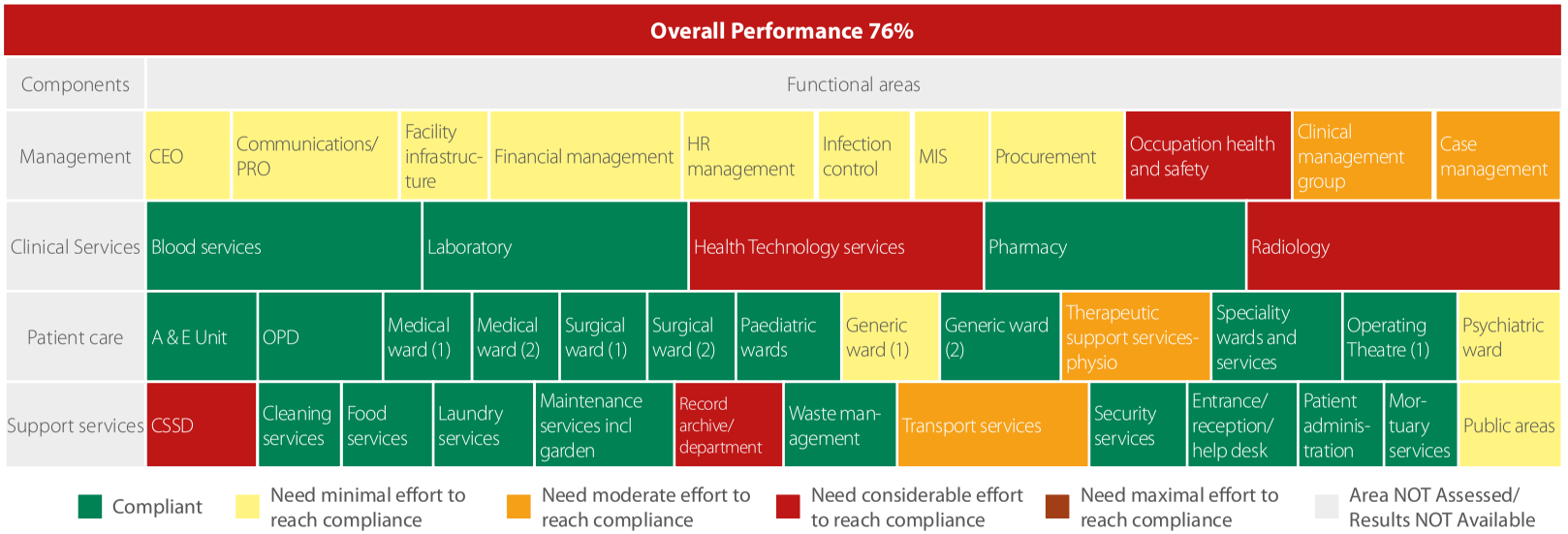
Medical Services

- **General**
  1. Medical (Tertiary-Renal Services and Regional Services)
  2. Orthopedics (District, Regional, Tertiary Services and Post Grad Training)
  3. Surgical (District, Regional, Tertiary Services and Post Graduate Training)
- Pediatrics (District, Regional and Tertiary Services)
- Critical Care (ICU/High Care)
- Ophthalmology (District and Regional)
- Psychiatry (District, Regional and Post Graduate Training)
- Anesthetics (District, Regional and Post Graduate Training)
- Family Medicine (District - PHC Services and Post Graduate Training)
- Laboratory Services (Undergraduate and Post Graduate Training)
- Blood Bank

Paramedical Services

- Occupational therapy
- Physiotherapy
- DIS (CT scan, Ultrasound, Doppler, MRI)
- Speech therapy
- Audiology
- Dietetics
- Dental
- Social Worker
- ARV clinic

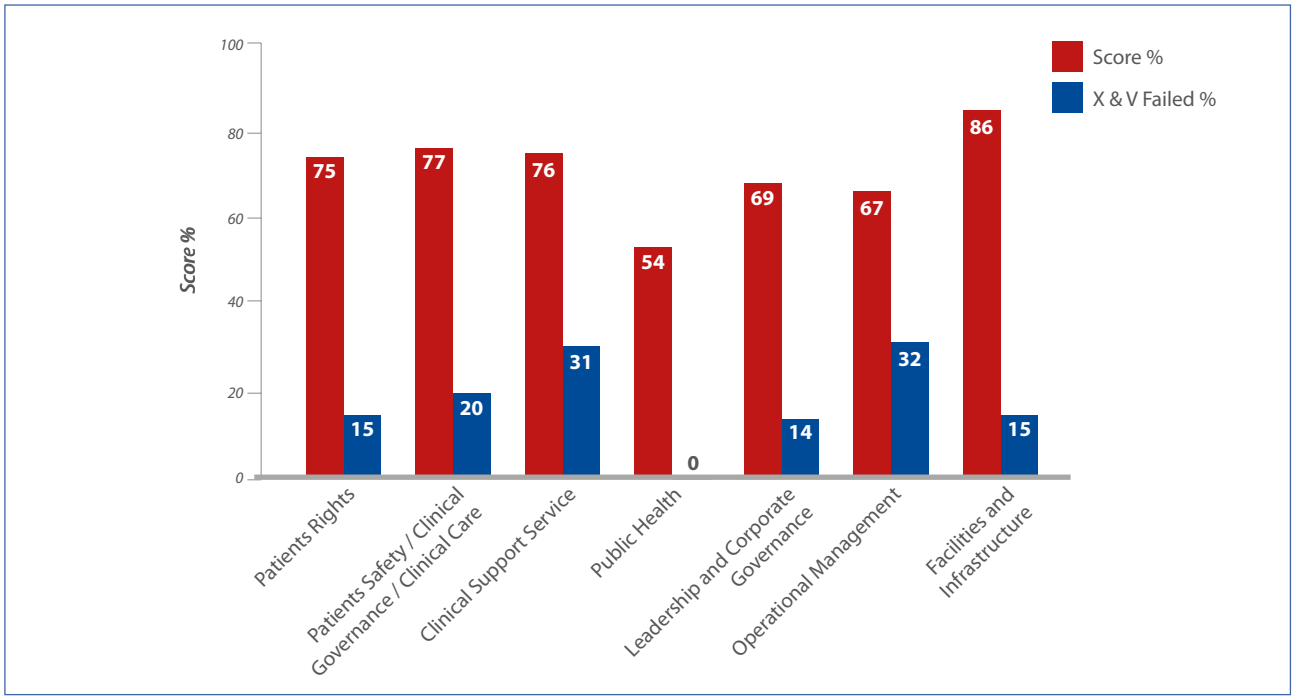
Table 53: Outcomes as per components



NTH Summary Components Outcome

- Management component needs minimal to moderate effort to reach compliance status.
- Clinical Services component needs considerate effort to reach compliance status
- Patient Care needs minimal effort to moderate to reach compliance status
- Support Service component needs moderate to considerate effort to reach compliance status

Figure 38: Domain Outcome (Extreme and Vital)



The health establishment was inspected and achieved an overall score of 62% compliance. The following are the score achieved per domain:

- Patients` Rights 75%
- Patient Safety 77%
- Clinical Support Services 76%
- Public health 54%
- Leadership and Corporate Governance 68%
- Operational Management 67%
- Facilities and Infrastructure 86%.

Table 54: Extreme and Vital Measures Failed by Domain

Domain 1: Patients Rights	
Extreme	**Vital**
• Forms used for informed consent were not completed correctly by the health professionals e.g. Blank space left on used form, • name of patient not completed.	• Mentally ill patients were not treated in such a way that their privacy, self-respect and dignity is preserved e.g. Climate meeting not held • 6 areas checked for the state of cleanliness were not all clean e.g. toilets and store rooms • The patient referral policy and protocol available in the health establishment/unit which includes all critical aspects did not show the approvers and designation, approval authority could not be verified.
Domain 2: Patients Safety/Clinical	
Extreme	**Vital**
• Patients peri-operative documents demonstrate that safety checks were not completely conducted during and after surgery e.g. two patient's files did not have recordings for estimated blood loss • Emergency trolley was not appropriately stocked e.g. paediatric tracheal tubes not available • Emergency trolley was not appropriately stocked e.g. paediatric ET tubes not available, ET tube size 5.0 expired. • Emergency trolley was not appropriately stocked e.g. pulse oximeter and Magill forceps not available. • Patient files demonstrate that the protocol on administration of blood was not adhered to e.g. patients signed at wrong place and selection of blood products not indicated • Patient files demonstrate that the protocol on administration of blood was not adhered to e.g. Clinical need for blood transfusion not documented. • Appropriate isolation accommodation did not appropriately exist for patients with communicable diseases e.g. separate toilet not available • Appropriate isolation accommodation did not exist for patients with communicable diseases - as a minimum for viral haemorrhagic disease e.g. highly infectious sign not available.	• The files of patients recently discharged showed that a comprehensive clinical assessment and diagnosis was not done e.g. vital signs incomplete and no plan of treatment • Clinical audits of each priority programme such as TB, HIV and STI were not conducted. • Procedure for conducting and acting on risk assessment of frail and aged patients was outdated not reviewed in 2013 • Procedure for conducting and acting on risk assessment of patients with reduced mobility was outdated not reviewed in August 2013 • The required criteria with respect to 72-hour observation of patients was not met e.g. SOP for chemical restrains was not available • Protocol for the management of patients requiring 72 hours' observation as per the Mental Health Care Act did not include a policy regarding chemical and physical restrain was not available • Minutes of the forum reviewing resuscitations from within the last quarter were not available. • Statistics on common health care associated infections demonstrated that they were not being monitored monthly e.g. meetings held twice in November 2015 and nothing in Dec 2015 and Jan 2016 • Random selection of clinical areas showed that sharps were not safely disposed e.g. recapping observed

Domain 3: Clinical Support Services	
Extreme	**Vital**
• Tracer medicines as per applicable Essential Drugs List were not in stock e.g. Lamivudine 150 or 300mg • Functional essential equipment was not available as required e.g. HB meter, Mobile emergency light	• Dispensing was not done in accordance with applicable policies and legislation e.g. address of health establishment not written and one patients was not given the opportunity to ask questions • Random selection of 3 patients receiving medicine indicated that the side effect of medications was not explained to them. • Records within the last 12 months were not available showing that the required equipment such as defibrillator were maintained according to a planned schedule or manufacturers instruction. • A report from within the last 12 months showing that adverse events involving medical equipment are reported and that actions taken to prevent recurrence was not available • There was no contract and Service Level Agreement in place with an approved and legally compliant sterilisation service provider • Records showing that the Service Level Agreements for decontamination services were monitored by the manager in charge was not available • Evidence all sterilisation equipment is validated or licensed was not available. • System to monitor all incidents of sterilisation failure whereby failures are documented with detailed action plans was not in place

Domain 5: Leadership and Corporate Governance	
Extreme	**Vital**
	• There was no evidence that action plans are put in place that address issues raised during exit interviews conducted with all managers who have resigned.

Domain 6: Operational Management	
Extreme	**Vital**
	• Staff patient ratios were not available in key areas in accordance with the approved staffing plan for emergency unit / outpatients / medical/ surgical / paediatrics / ICU wards • The files of members of staff reflected that comprehensive performance reviews were not done based on their performance plans and in accordance with the human resource management policy e.g. PDPs not available • There were no evidence showing that medical examinations are performed for all health care workers who are exposed to potential occupational hazards when performing their duties e.g. radiation, infectious diseases including TB and chemicals • There was no evidence that exception reports were compiled where expenditure on high risk and priority areas deviates from budget by more than 5 percent. • Written standard operating procedures for requests / retrieval / filing of patient files was not signed and dated appropriately
Domain 7: Facilities and Infrastructure	
Extreme	**Vital**
• The system to supply piped medical gas to all clinical areas was not functional • The system to supply piped suction/vacuum to all clinical areas was not functional	• There were no maintenance records showing that recommendations of annual management inspection report on safety hazards and maintenance needs were implemented • Obvious safety hazards were observed during the visit such as loose electrical wires. • Cleaning materials were not available as required e.g. Disposable sponges, goggles, windows cleaning squeegee, dishwashing soap, protective polymer and wet vacuum pick up. • Records show that Pest control was last done on 17/02/15

Table 55: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	86%
Cleanliness	**76%**
Improve patient safety and security	**77%**
Infection prevention and control	78%
Positive and caring attitudes	80%
Waiting times	83%

The table above demonstrates NTH's performance in relation to six Ministerial Priorities. In this context the hospital is experiencing problems with regard to Cleanliness scoring lowest 76%, Improve Patient Safety and Infection Control 77%. What and how the hospital management and staff build on this firm foundation and better improve scores in the identified three areas below 80% would an area of development and effort for everyone. However, the hospital scored the highest with regard to availability of medicines and supplies 86% and positive and caring attitudes 80%.

4.14 Provincial Tertiary Hospitals Performance Scores

Figure 39: Overall Tertiary Hospitals Scores

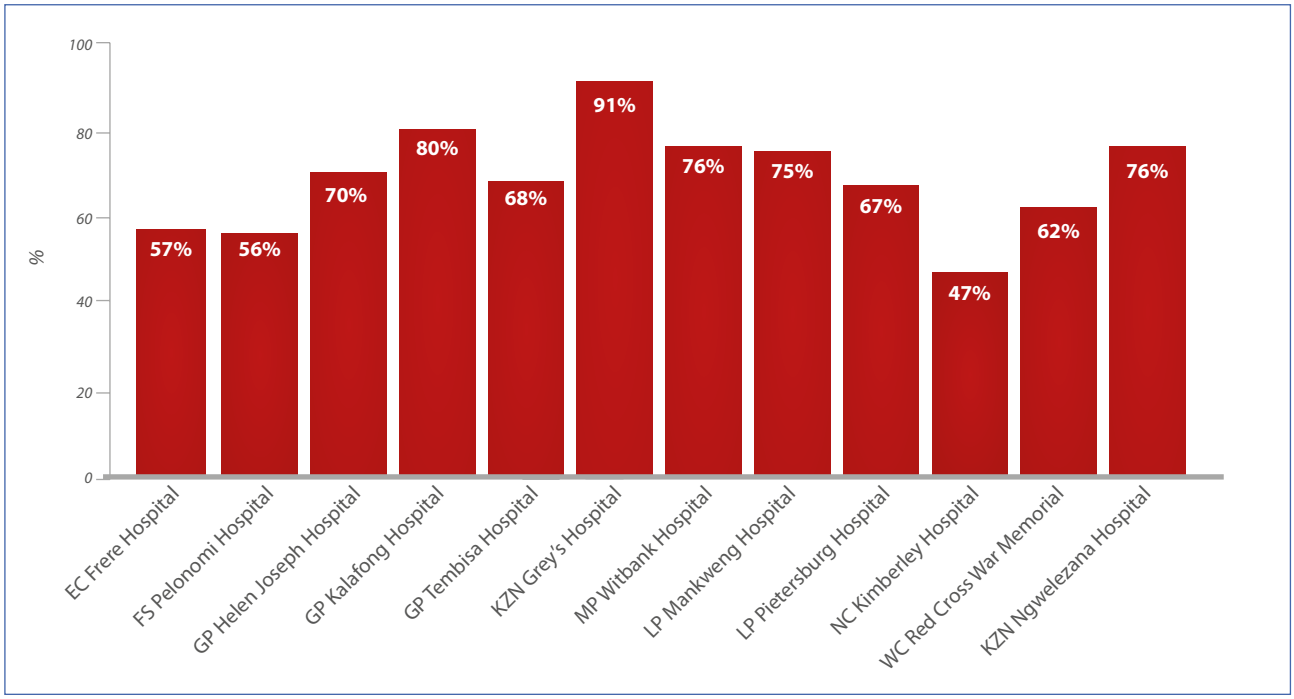


Figure above shows 12 Provincial Tertiary hospitals inspected and that out of 12 Hospitals Grey Hospital scored the highest with 91% followed by Kalafong Hospital 80% , Ngwelezana and Witbank Hospitals 75%. The lowest performing provincial tertiary hospital is Kimberly Hospital in Northern Cape, which scored 47%.

KZN was found to be leading with compliance score ranging between 76 -91% as two of their provincial tertiary hospitals were inspected (Grey Hospital and Ngwelezana). The question is overall the issue of hospital cleanliness is major area of concern, which has been an area of weakness with regard to Ministerial Priority Areas. What and how hospital management and staff work together to respond and do something different to address are of weakness before the next inspection is now critical.

3.14.1 Terformance outcome for Provincial Tertiary Hospitals per province

Figure 40: Performance Outcome for Provincial Tertiary Hospitals per Province

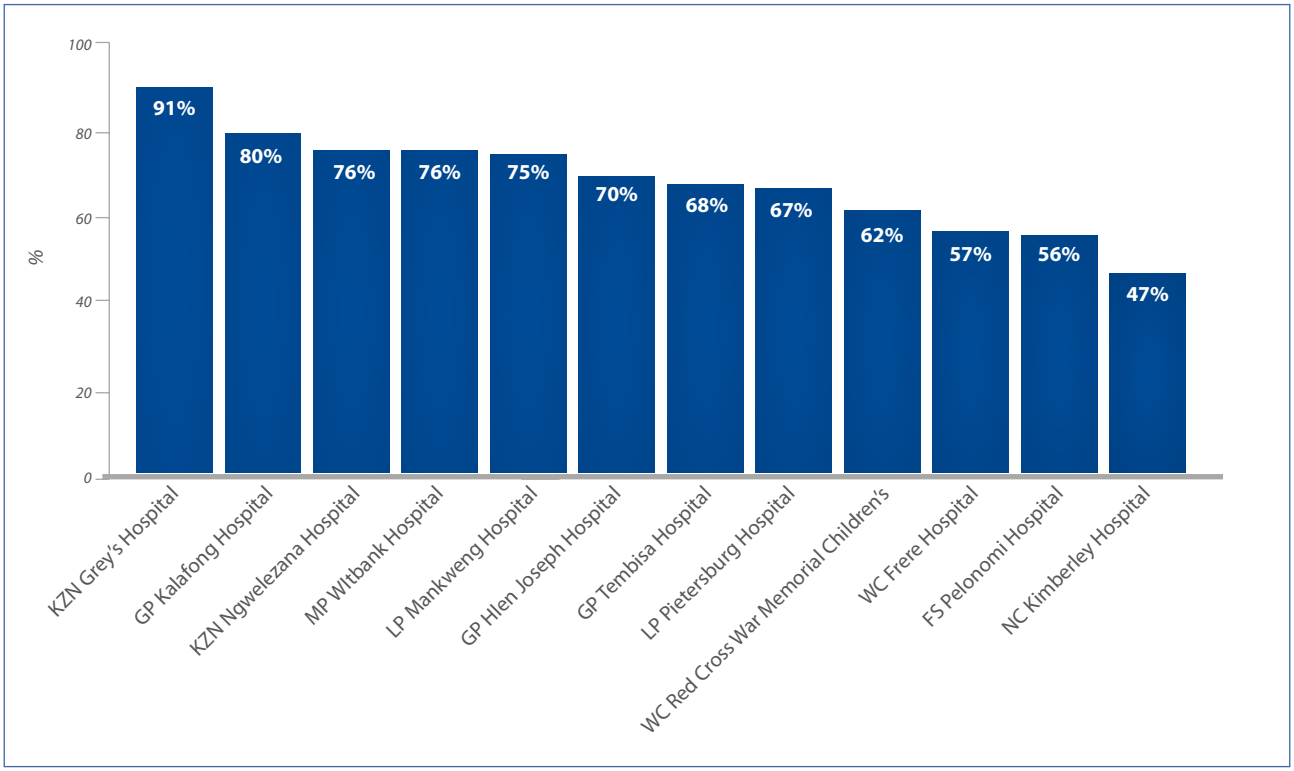


Figure above reflects that out of the Provincial Tertiary Hospitals inspected in 2015-2016 the performance outcome scores per province ranged between 47 – 84 %. Gauteng was found to be leading with 84 % and Limpopo Province was found to be the lowest performing province.

4.14.2 Re-inspections of Provincial Tertiary Hospitals(2012 – 2016)

Figure 41: Re-inspections of Provincial Tertiary Hospitals

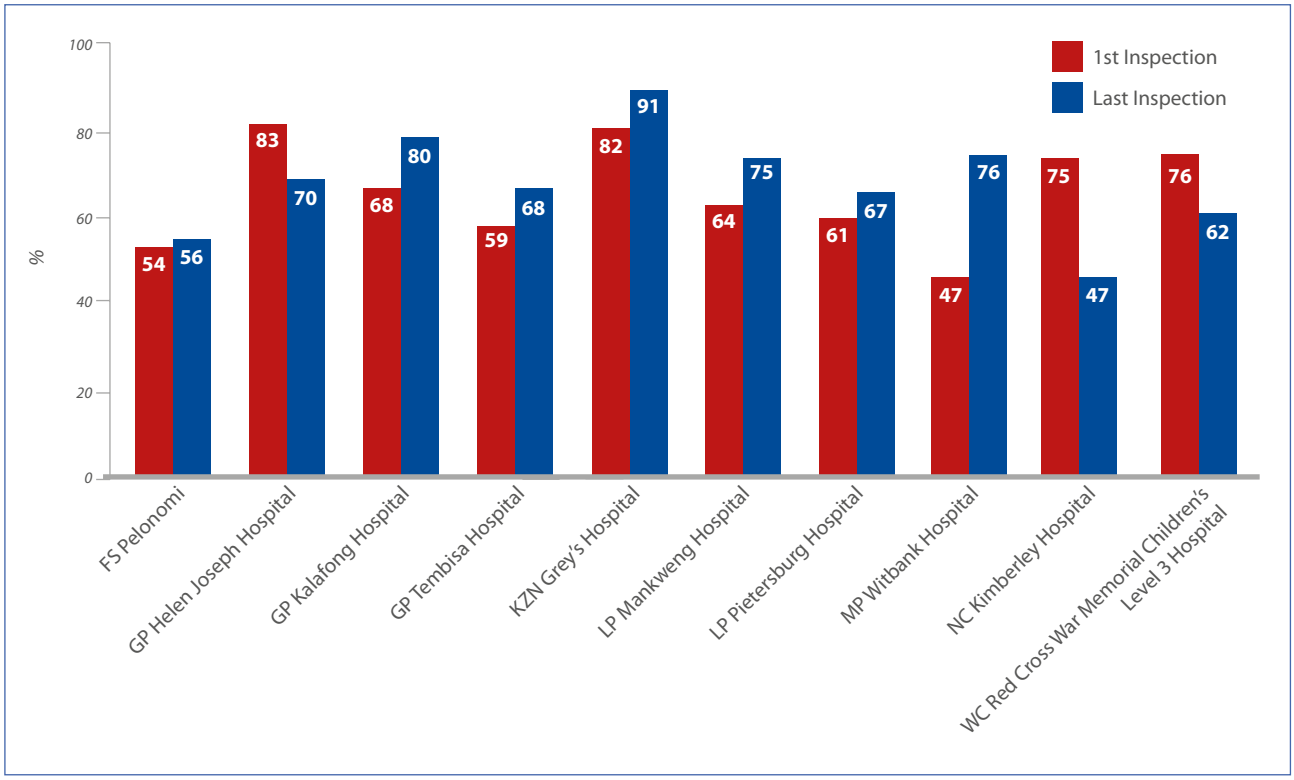


Figure above reflects the 10 re inspections of Tertiary Hospitals inspected between 2012- 2016 and of the 10 re inspections Grey Hospital is the only one that improved from 82 -91 % and was found to be leading in the Country as it attained above 90 %. The rest of the 9 Tertiary Hospitals did not show any significant improvement whereas hospitals like Kimberly Hospital in Northern Cape and Red Cross in Western Cape their performance scores dropped.

4.14.3 Provincial tertiary hospital-domains-comparison

Table 56: Provincial tertiary hospital-domains-comparison

	EC Frere Hospital	FS Pelonomi Hospital	GP Helen Joseph Hospital	GP Kalafong Hospital	GP Tembisa Hospital	KZN Grey's Hospital	MP Witbank Hospital	Mankweng Hospital	LP Mankweng Hospital	NC Kimberley Hospital	WC Red Cross War Memorial Children's Level 3 Hospital	KZN Ngwelezana Hospital
Patients Rights	56%	67%	68%	83%	75%	86%	80%	76%	60%	51%	56%	75%
Patients Safety / Clinical Governance/ Clinical Care	51%	59%	74%	85%	73%	94%	74%	72%	65%	55%	63%	77%
Clinical Support Services	66%	65%	76%	89%	80%	89%	78%	75%	76%	47%	70%	76%
Public Health	52%	29%	45%	52%	62%	78%	76%	66%	60%	22%	45%	54%
Leadership and Corporate Governance	47%	42%	67%	67%	40%	88%	91%	72%	74%	16%	34%	69%
Operational Management	58%	47%	73%	76%	46%	87%	74%	69%	68%	25%	52%	67%
Facilities and Infrastructure	62%	56%	66%	80%	68%	89%	72%	80%	66%	53%	79%	86%

Table above reflect the performance of the Provincial Tertiary Hospitals on the 7 Domains. The inspection scores vary widely by domain with the lowest score of 22% in Domain 4 (public health) and 5, leadership and governance score of 16% and the highest score of 91% was recorded in Domain 2 (patient safety clinical governance and care). Domain 5 Leadership and Cooperate governance was scored below 50% by the 5 Hospitals in the 4 Provinces (Tembisa in Gauteng, Kimberly in Northern Cape, Red cross in Western Cape, Pelonomi in Free State and Frere in Eastern Cape.

Domain 4 public health was scored less than 50% by 4 Hospitals in different provinces (Kimberly in Northern Cape, Red Cross Memorial in Western Cape, Pelonomi Hospital in Free State and Helen joseph in Gauteng. Grey Hospital performed exceptionally well in all the 7 Domains and the lowest being Public Health with above 70 % and the Highest Being Patient safety clinical governance and clinical care with above 90%. The lowest performing hospital in all the Domains is Kimberly Hospital in the Northern Cape with leadership as the less scored domain with below 20% and patient safety as the highest scored with just above 50%.

4.14.4 Provincial tertiary hospital-priority areas-comparison

Table 57: Provincial tertiary hospital-priority areas-comparison

	EC Frere Hospital	FS Pelonomi Hospital	GP Helen Joseph Hospital	GP Kalafong Hospital	GP Tembisa Hospital	KZN Grey's Hospital	MP Witbank Hospital	Mankweng Hospital	LP Mankweng Hospital	NC Kimberley Hospital	WC Red Cross War Memorial Children's Level 3 Hospital	KZN Ngwelezana Hospital
Availability of medicines and supplies	69%	68%	88%	91%	81%	94%	86%	80%	76%	54%	74%	86%
Cleanliness	56%	34%	69%	73%	62%	82%	70%	61%	44%	46%	69%	76%
Improve patient safety and security	60%	58%	71%	83%	69%	93%	72%	74%	61%	48%	65%	77%
Infection prevention and control	43%	55%	65%	83%	67%	87%	74%	76%	75%	53%	60%	78%
Positive and caring attitudes	58%	65%	73%	84%	63%	91%	79%	80%	62%	53%	59%	80%
Waiting times	66%	44%	70%	94%	89%	93%	92%	83%	65%	63%	61%	83%

Figure above reflects the score on the six priority quality areas (waiting times, cleanliness, values and attitudes, patient safety, infection prevention and control and availability of medicines) varied widely with the highest score of 94 % in availability of medicines and supplies for Grey Hospital and lowest score observed in cleanliness 34 % and 44 % in waiting times for Pelonomi Hospital. Out of 12 hospitals inspected only 2 hospitals scored above 70% in all the six priority areas and both hospitals are from KZN and offer the same package of service (that is Grey hospital and Ngwelezana hospital).

D

INSPECTION RESULTS: REGIONAL HOSPITALS

Definition of Regional Hospital as per Regulation 185 of National Health Act 61 of 2003.

Regional hospitals

4.(1) A regional hospital must, on a 24 hour basis, provide—

(a) health services in the fields of internal medicine, paediatrics, obstetrics and gynaecology, and general surgery;

(b) health services in at least one of the following specialties—

(i) orthopaedic surgery;

(ii) psychiatry;

(iii) anaesthetics;

(iv) diagnostic radiology;

(c) trauma and emergency services;

(d) short term ventilation in a critical care unit;

(e) services to a defined regional drainage population, limited to provincial boundaries and receives referrals from several district hospitals; and

(f) where practical, provide training for health care service providers

(2) A regional hospital receives outreach and support from tertiary hospitals.

(3) A regional hospital has between 200 and 800 beds.

Inspected Regional Hospitals

For 2015/2016 financial year 7 Regional Hospitals were inspected based on Compliance Inspections Operational plan:

1. Cecilia Makiwane Hospital - Eastern Cape Province
2. Bongani Hospital - Free State Province
3. Dihlabeng Hospital - Free State Province
4. Mamelodi Hospital - Gauteng Province
5. Tambo Memorial Hospital - Gauteng Province
6. Rahima Moosa Hospital - Gauteng Province
7. Letaba Hospital - Limpopo Province

5.1 Cecilia Makiwane Hospital

Profile

Cecilia Makiwane Hospital (CMH) is a large, provincial, government funded hospital situated in the Mdantsane township of East London, Eastern Cape in South Africa. It is a tertiary teaching hospital and forms part of the East London Hospital Complex with Frere Hospital. It is named after Cecilia Makiwane, the first African woman to become a professional nurse in South Africa.

History

Chief Mqalo Health Minister of Ciskei renamed the Mdantsane Hospital to Cecilia Makiwane Hospital in 1977 to commemorate, Cecilia Makiwane, the first Black nurse in South Africa. On 30 April 1982, the Department of Posts and Telecommunications of the Republic of Ciskei honored her with a philatelic stamp and a first day cover, detailing her life.

Departments and service

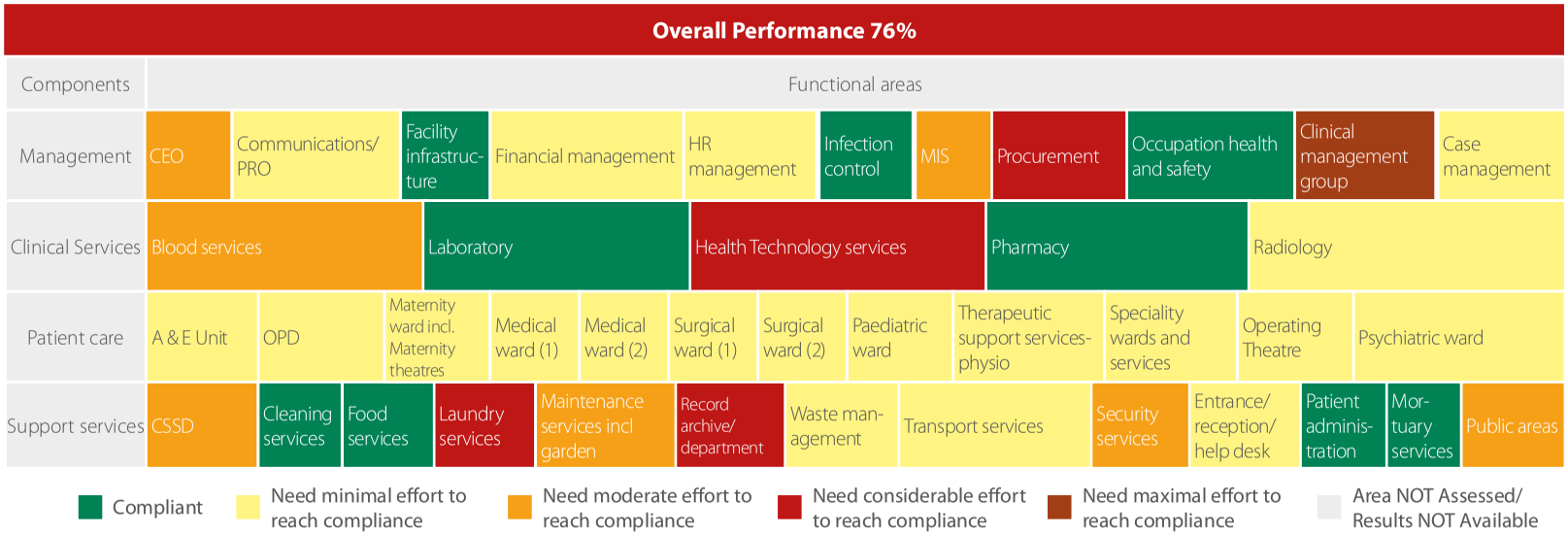
The hospital's departments include: Trauma and Emergency department, Paediatrics, Obstetrics/Gynecology, Surgery, Internal Medicine, ARV clinic for HIV/AIDS in adults and children, Anesthetics, Pediatric Surgery, Family Medicine, Psychiatry, Dermatology, Otolaryngology (ENT), Ophthalmology and burns unit. The Orthopedic department runs a weekly clinic.

Other facilities include Operating Theatre, Intensive Care Unit (ICU) for adult, pediatric and neonatal patients and high care wards for general and obstetric patients.

It also offers allied health services such as Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology, Social worker, Dentistry and Dietetics.

Other services include CSSD Services, Pharmacy, Post Trauma Counseling Services, Occupational Services, X-Ray Services with Computed Tomography (CT) facility, NHLS Laboratory, Blood Bank, Laundry Services, Kitchen Services and Mortuary

Table 58: Outcomes as per components

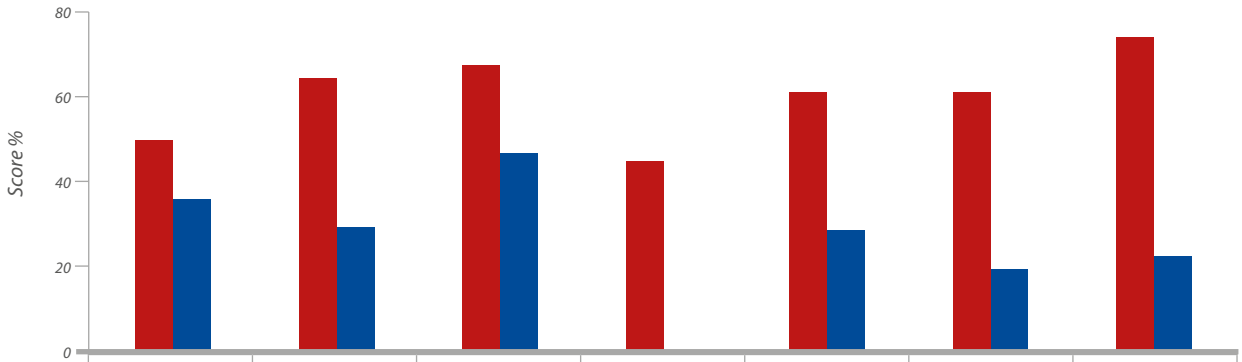


Components Outcome.

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal to considerate effort to reach compliance status.
- Patient Care component needs minimal effort to reach compliance status.
- Support Service component needs minimal to considerate effort to reach compliance status

5.1 Domain Outcome (Extreme and Vital)

Figure 42: Domain Outcome EC Cecilia Makiwane



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	51	66	69	45	63	63	76
X & V Failed %	37	30	48	0	29	20	23

The health establishment was inspected and achieved an overall score of 65% compliance. The following are the score achieved per domain:

- Patients` Rights 51%
- Patient Safety 66%
- Clinical Support Services 69%
- Public health 45%
- Leadership and Corporate Governance 63%
- Operational Management 63%
- Facilities and Infrastructure 75%.

Table 59: Extreme and Vital Measures Failed by Domain:

Domain 1	
Extreme	**Vital**
• Forms for informed consent not correctly filled, e.g. full name of patient not recorded and no two witnesses' signatures. • The nature of the operation is not written in full abbreviations.	• Not all areas are clean, patient toilets having a bad odour, kitchen bins not lined, mixing of waste. • Three of six areas checked were not in the good of cleanliness, e.g. patient toilet had bad odour. • The kitchen and the toilets have bad odour, there are some leaking drain in the kitchen. • Patients referral policy is not dated was supposed to be reviewed in February 2010. • Produced referral policy and protocol did not include criteria aspect, e.g. Management of patient requiring emergency. • handover procedure not followed method of transfer not recorded, vitals and times not recorded. • Guidelines regarding stabilisation of patients not adhered to, vitals not monitored or recorded. • There is no procedure governing the handover of patients from EMS to hospital staff.

Domain 2	
Extreme	**Vital**
• Fetal movement and heart was not reflected on one file and all items on admission assessment form were not completed. • Safety checks are not accurately conducted as team members have no evidence that they have introduced themselves to the patients. • The policy for handling resuscitations is not available. • Emergency trolley not standardised, e.g. dopamine injection expired. • Protocol on administration of blood not adhered to vital signs not monitored pre, during and after. • There is no evidence of checking the identity of patient as blood cross match forms not completed. • Two aspects of isolated room for patient with communicable diseases e.g. alert system for control of visitors. • 2 aspects of isolated room were not complying, e.g. measure for disposal of linen.	• The is no evidence showing patient was informed about treatment of health education. • There is no evidence that the health establishment participates in monthly mortality perinatal, morbidity and maternal meetings. • Procedure for management of patients detained for 72 hours' observation is not available. • Procedure for conducting risk assessments of patients with reduced morbidity is not available. • Only policy for the use chemical and physical restrain was not signed by an accounting officer on the record of 72 hours. • Checklist on protocol for the management of patients requiring hours' observation was not complying, only with policy use of chemical and physical restrain and policy not signed. • Aged patient file was found without risk assessment forms. • Patient safety checks were not applied, e.g. 2 out of 3 files analysed, patients are not entered and potential safely risks not documented. • Particle count and bacterial growth are not performed in theatre. • Minutes of the forum reviewing adverse events are not available. • Sharps not safely managed, e.g. lids not fitting tightly and recapping observed.

Domain 3	
Extreme	**Vital**
• Not all tracer medicines were found in stock, e.g. caffeine capsules 400mg Hexaxim vaccine and salbutamol were available. • Essential equipment like electrocardiography 12 channels and tracheotomy set not in stock.	• Patients not gave instruction on the use of medication. Patients' addresses are not recorded on labels. • Patients interviewed indicated that they did not have an understanding of their medication, e.g. side effects not explained. • One of the two staff interviewed was not sure of the correct temperature to store blood products. • 2 interviewed staff were not able to explain how cold chain for blood product for ordering storage, issuing is maintained, e.g. temperature range for transportation of blood. • Document for maintenance record document for equipment is not available, e.g. ventilator maintenance records. • The establishment failed to produce documentary proof of any system it uses. • There is no report showing how adverse events involving use of medical equipment is being handled in the health establishment. • There is no service level agreement with an approved sterilisation service provider. • Service level agreement for decontamination services not available.
Domain 5	
Extreme	**Vital**
	• Operational plans for HE are not available.
Domain 7	
Extreme	**Vital**
• Supply of piped medical gas is not installed. • System to supply piped vacuum to the clinical areas is not available.	• Security policy produced is not signed and not dated. • Security system guard is not positioned at the peads ward. • Not all cleaning material was available, e.g. polish, window squeegee, colour coded buckets. • Nine cleaning material and equipment was not available, e.g. janitor trolley and yellow bags, colour coded buckets.

Table 60: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	73.67%
Cleanliness	62.05%
Improve patient safety and security	61.77%
Infection prevention and control	74.07%
Positive and caring attitudes	**52.84%**
Waiting times	67.61%

The table above reflects the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to all ministerial priorities and Positive & Caring Attitudes being the lowest 52,84%.

5.2 Bongani Hospital

Profile

Bongani Regional Hospital is a bed government-funded hospital in Welkom, Free State. The hospital is a Level 2 referral hospital for clinics and hospitals in the following areas: Welkom, Theunissen, Virginia, Ventersdorp, Winburg, Wesselsbron, Hoopstad, Dealesville, Bothaville, Allanridge and Odendaalsrus.

Specialist Services Offered include: 24-hour Casualty Service

- Burns Unit, Dispensary, Level II Adult and Child Care, Maternity, Medical and Surgical Wards
- Neonatal ICU and ICU, Obstetrics and Gynaecology, Occupational Therapy
- Orthopedics, Pediatrics, Physiotherapy, Radiography, Septic Ward, Social Work
- Speech and Hearing Therapy and Theatre

Out Patients Clinics:

- Anti-Retroviral (ARV) Treatment for HIV/AIDS
- Dental
- Occupational Health
- Oncology
- Ophthalmology
- Orthopedics and Surgical
- Psychology
- Renal Unit

Table 61: Outcomes as per components

Components	Functional areas											
Management	CEO	Communications/ PRO	Facility infrastruc- ture	Financial management	HR management	Infection control	MIS	Procurement	Occupation health and safety	Clinical management group	Case management	
Clinical Services	Blood services		Laboratory		Health Technology services			Pharmacy		Radiology		
Patient care	A & E Unit	OPD	Maternity ward incl Maternity theatres	Medical ward (1)	Surgical ward (1)	Paediatric ward	Generic ward (1)	Therapeutic support services- physio	Speciality wards and services	Operating Theatre incl labs	Psychiatric ward	
Support services	CSSD	Cleaning services	Food services	Laundry services	Maintenance services incl garden	Record archive/ department	Waste man- agement	Transport services	Security services	Entrance/ reception/ help desk	Patient adminis- tration	Mor- tuary services	Public areas

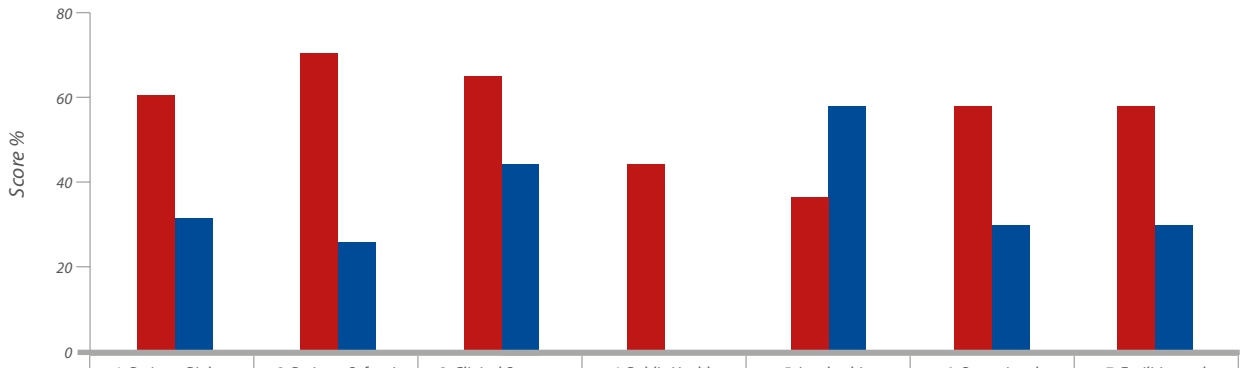
Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal to maximal effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component needs minimal to maximal effort to reach compliance status

5.1 Domain Outcome (Extreme and Vital)

Figure 43: Domain Outcome FS Bongani Hospital



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	59	69	64	44	36	57	57
X & V Failed %	32	26	43	0	57	30	30

The health establishment was inspected and achieved an overall score of 62% compliance. The following are the score achieved per domain:

- Patients Rights 59%
- Patient Safety 69%
- Clinical Support Services 64%
- Public health 44%
- Leadership and Corporate Governance 36%
- Operational Management 57%
- Facilities and Infrastructure 67%

Table 62: Extreme and Vital Measures Failed by Domain:

Domain 1	
Extreme	**Vital**
• Consent forms not filled correctly, e.g. Abbreviations used, writing not legible, not signed by two witnesses.	• Some areas not appearing clean, e.g. Stretcher storage area dirty, bins not having lids. • Some areas not clean, e.g. Kitchen bins not having lids, toilets having odour. • Not all areas were clean, e.g. Bins without lids. Toilets leaking water, peeling off paints, etc. • Referral Policy not signed. • Handover procedure was followed between EMS staff and establishment staff -Times of hangover not recorded.
Domain 2	
Extreme	**Vital**
• Patients Peri-Operative Documents-Precautions to maintain skin integrity not assessed. • Peri operative checks not consistently done, e.g. Lacking anaesthesia safety checks. • Policy for handling emergency resuscitations -Designation of approver not reflected. • Emergency Trolley-Paediatric laryngoscope blade not available-Paediatric tracheal tubes, not all sizes available, only had 1x size 3.5 and 1x size 6. • Protocol on administration of blood has not been adhered to-Consent not obtained from patients. • Isolation rooms not covering all aspects of checklist, e.g. Disposal of linen. • Appropriate isolation Accommodation-Not appropriate, e.g. Lacking toilet traffic not controlled. • Isolation accommodation is not appropriate for patients with communicable diseases, e.g. No FED packs.	• Monthly maternal/perinatal morbidity and mortality meetings -Meetings not taking place on monthly basis, last held in February 2015. • Clinical audits not conducted for some programmes. • Interviewed staff member verbalised that there is no adequate supervision. • Infection control measures of particle counts and bacterial growth are not performed in each theatre every 6 Months-Last results were in October 2014. • Minutes of the forum reviewing Resuscitations-Minutes not available. • Protocol regarding the safe administration of medicines -Designation of approver not reflected. • No adverse events report reflecting actions taken to prevent recurrence. • Sharps containers lids not fitting tightly. • Observed sharps containers did not have tight fitted lids and recapping noted in one container.

Domain 3	
Extreme	**Vital**
• Tracer Medicines-Some items not available, e.g. haloperidol injection and zidovudine 300mg. • Essential Equipment-Not all were available, ECG, Tracheotomy set, light surgical mobile.	• Standard operating procedure is available which indicates how schedule 5 and 6 medicines are stored / controlled / distributed -SOP is not available. • Possible side effects not explained to patients. • Minutes of the forum which deals with adverse drug reactions-No recent minutes meeting last held in June 2015. • Evidence for maintenance/service not provided for ventilations and defibrillators. • Systems for monitoring, ordering and receiving of equipment not in place. • Service Level Agreements for decontamination services -SLA not monitored.
Domain 5	
Extreme	**Vital**
	• Consent in emergency surgery document is not signed. • Exit interviews evidence not produced.
Domain 6	
Extreme	**Vital**
• Measures are in place to prevent any incident of harm to staff -Documented evidence not available	• Evidence of turnaround times for critical stock being set and monitored was not available. • Standard operating procedures exist for requests / retrieval / filing of patient files-SOP out dated.
Domain 7	
Extreme	**Vital**
• There is no evidence that emergency power supply will be available in critical clinic areas.	• Safety hazards are observed during the visit -Uneven broken floors observed throughout the hospital. • Water supplies not checked daily. • No security committee in the facility. Audits were not done. Security services not communicated to staff. • No security at the neonatal and the maternity unit.

Table 63: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	71.12%
Cleanliness	**50.57%**
Improve patient safety and security	68.58%
Infection prevention and control	65.54%
Positive and caring attitudes	66.88%
Waiting times	68.12%

The table above reflects the performance of the health establishment in relation to six Ministerial Priorities. In this regard the health establishment is having challenges with regard to most ministerial priorities in particular cleanliness which scored 50,57% lowest. The only reasonable score is availability of medicines and supplies, which scored 71,12% the rest of the scores are below 71%. The question is what and how management and staff respond and decisively addressed identified areas of weaknesses before the next inspection starting with basic hospital cleanliness.

5.3 Dihlabeng Hospital

Profile

State Hospitals - Dihlabeng Regional Hospital - Bethlehem, Free State, South Africa

Dihlabeng Regional Hospital is a secondary hospital situated in Bethlehem, in the Eastern Free State, Thabo Mofutsanyana District. It serves as a specialised referral facility for five district hospitals, i.e. Phekolong, Nketoana, Phutholoha, Itemoheng and John Daniel Newberry, which are situated in three local municipal areas in the district. The patients seen at the hospital are predominantly referred from the aforementioned district hospitals, as well as some of the local private medical practitioners. The hospital provides level 2 specialised services in eight of the nine basic disciplines for a regional hospital and some level 3 (tertiary) services.

The hospital operates 135 beds, with 378 employees, including both the health professionals and support staff.

Specialized OPD Clinics

The following clinics are run on rotational basis and they serve ±3000 patients monthly.

- Diabetic
- Oncology
- Surgical
- Medical
- Ophthalmology
- Orthopaedic
- Haematology
- Human Genetics
- Gynaecology
- Urology

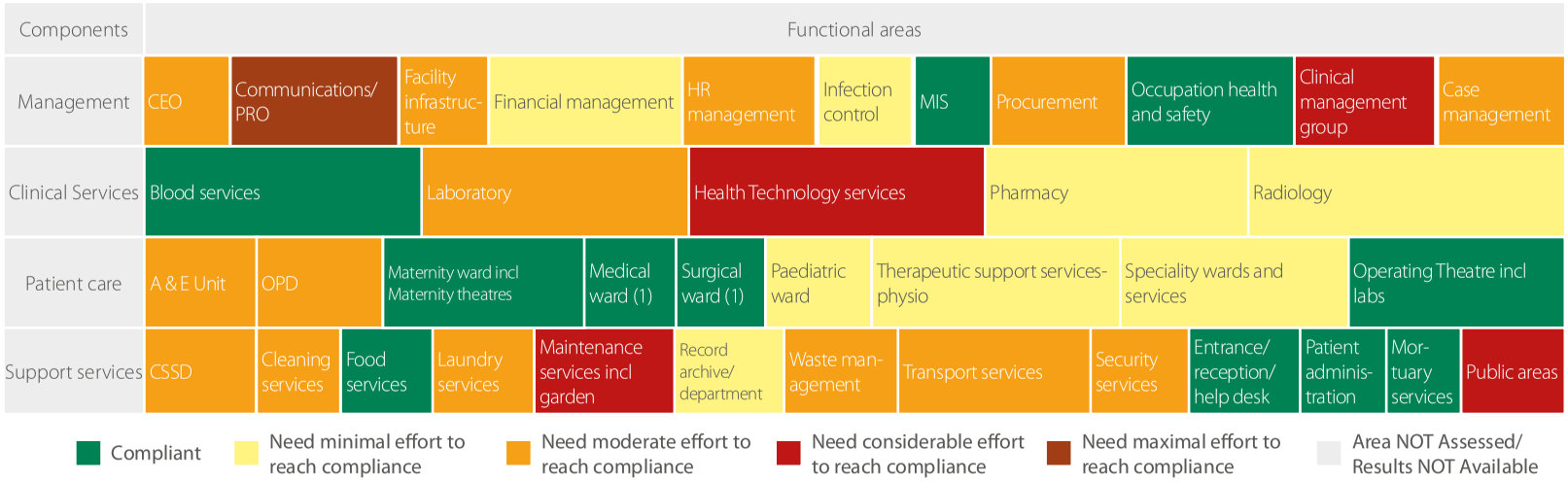
Clinical Support Services

The following clinical support services play a critical role in ensuring comprehensiveness of the patient care.

- Radiographic services
- Physiotherapy
- Speech and Audiology
- Occupational Therapy
- Dietetics
- Social Work
- Clinical Psychology

Pharmaceutical Service, Telemedicine Unit and Radiological Services

Table 64: Outcomes as per components

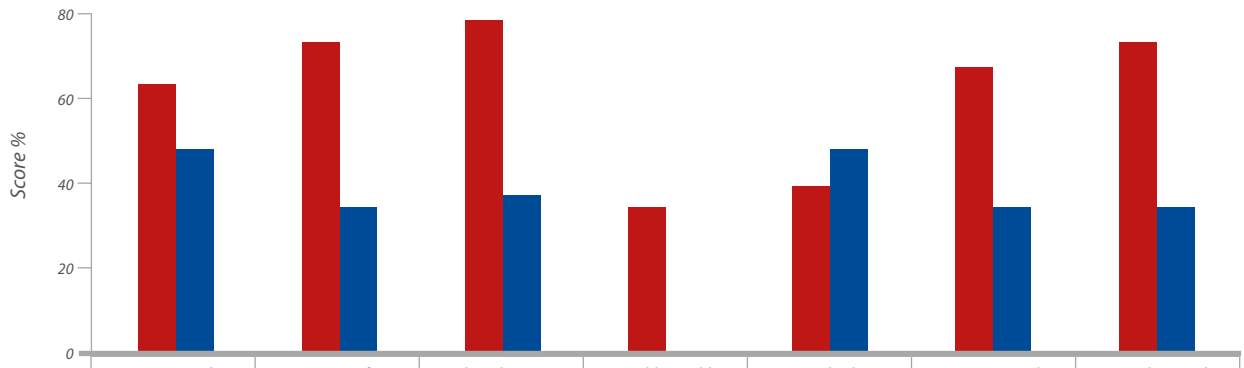


Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal to considerate effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component needs minimal to considerate effort to reach compliance status

5.3.1 Domain Outcome (Extreme and Vital)

Figure 44: Domain Outcome FS Dihlabeng Hospital



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	56	65	70	30	35	60	65
X & V Failed %	43	31	33	0	43	31	30

The health establishment was inspected and achieved an overall score of 61% compliance. The following are the score achieved per domain:

- Patients` Rights 59%
- Patient Safety 65%
- Clinical Support Services 70%
- Public health 30%
- Leadership and Corporate Governance 35%
- Operational Management 60%
- Facilities and Infrastructure 65%

Table 65: Extreme and Vital Measures Failed by Domain

Domain 1	
Extreme	**Vital**
• Informed consent form not completed correctly- Patient did not sign	• Referral policy incomplete -Feedback to family and profile of patients were not included. • Scripts in pharmacy were correlated with medication dispensed to ensure that all medication was received as prescribed-Some medications out of stock. E.g. Ibrufen • Patients not triaged and sorted as there is no responsible person
Domain 2	
Extreme	**Vital**
• Initial assessments of high risk maternity patients-Management of labour form not well noted. • Policy for handling emergency resuscitations outdated. • Emergency Trolley-Oxygen masks not available and Dopamine injection expired 06/2014. • Isolation room not prepared for patients. Items are not readily available • Isolation Accommodation- Dedicated room does not allow the separation of equipment. • The Isolation unit does not have appropriate accommodation for viral haemorrhagic diseases.	• Minutes of monthly maternal and perinatal morbidity and mortality meetings not dated nor signed • Clinical audits of each priority programme/health initiative-Some programmes not audited • No health initiatives or programmes QIPs in place • Sharps are safely managed and disposed of-Papers and cotton wool in sharps container. Recapping noted. Lids not tightly closed.
Domain 3	
Extreme	**Vital**
• Some tracer meds not available.	• Observed staff members were handling blood tubes without gloves. • No evidence of maintenance plan was available • No maintenance records
Domain 6	
Extreme	**Vital**
• No Measures are in place to prevent any incident of harm to staff	• Staff Files-No PMDs for 2014/2015. available PMDs is for 2013/2014 • Staff Needle Stick Injuries-No re-testing done, staff members does not come for re-test.
Domain 7	
Extreme	**Vital**
• No piped medical gas. • No piped suction	• Most toilets found to be dirty • Generally, facility not clean. • Some cleaning materials are not available e.g. Janitor Trolley

Table 66: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	75%
Cleanliness	**38%**
Improve patient safety and security	64%
Infection prevention and control	66%
Positive and caring attitudes	68%
Waiting times	**48%**

The table above reflects the performance of the health establishment in relation to six Ministerial Priorities. In this regard the health establishment is significant and concerning problems cleanliness scoring 38% and waiting times 48% the two lowest scores. Availability of medicines and supplies scored the only highest 75%. Management and staff need to respond and to address the most of the identified issues including issues of responsibility, accountability and performance. Implementation of consequence management is critical.

5.4 Mamelodi Hospitals

Profile

Mamelodi Provincial Hospital is located in Serapeng Street, Buffer Zone, Mamelodi East in Gauteng. Nearby main roads are M8 to the North of the hospital and the R104 to the South. Mamelodi East is situated 20.2km East of Pretoria Central. The hospital started as a clinic, then CHC and developed into a hospital with bed capacity of 90 and occupancy of +120. The hospital serve areas around Pretoria East and its emerging squatter areas. The hospital was built in 1980 and started operating in 1981 as 'day hospital' under the leadership of Kalafong Hospital management and received the status of the hospital in 1985, serve the community of-+ 600000 population around Pretoria East, Cullinan, Bronchospruit and some of Mpumalanga areas. But still managed 45km away. in 1999 the hospital was managed by another hospital Pretoria Academic only personnel section and the procurement section the hospital become autonomous in 2000 with the first own superintendents three superintendent in succession. In 2001 the first Chief Executive Officer was appointed. All functions were taken back from other hospitals that assisted.

Clinical Support Services:

- The waiting time for the orthopaedics operation is less than week
- Theatre utilisation rate has increased for example doing around 440 per month
- Human Resource development in specialised areas has improved e.g. produced post graduate clinical diplomas in areas such as Anaesthesia, Paediatrics and Obstetrics. Nursing also produced diploma in Operating theatre technique,paeditrics,critical care, trauma and advanced midwifery.
- Pharmacy waiting time is 30min (bench mark is 80 min)
- Management and Support:
- Food services: The client satisfaction survey indicates that patients are satisfied with the food that we offer
- External audit on National Core Standard reflected hospital cleanliness as an area of excellence
- Management: One member of management has obtained Master's Degree in Corporate Law

Table 67: Outcomes as per components

Components	Functional areas																
Management	CEO	Communications/ PRO	Facility infrastruc- ture	Financial management	HR management	Infection control	MIS	Procurement	Occupation health and safety	Clinical management group	Case management						
Clinical Services	Blood services			Laboratory			Health Technology services			Pharmacy			Radiology				
Patient care	A & E Unit	OPD	Maternity ward incl Maternity theatres	Medical ward (1)	Medical ward (2)	Surgical ward (1)	Surgical ward (2)	Paediatric ward	Generic ward (1)	Generic ward (2)	Therapeutic support services- physio	Speciality wards and services	Operating Theatre	Psychiatric ward			
Support services	CSSD	Cleaning services	Food services	Laundry services	Maintenance services incl garden	Record archive/ department	Waste man- agement	Transport services	Security services	Entrance/ reception/ help desk	Patient adminis- tration	Mor- tuary services	Public areas				

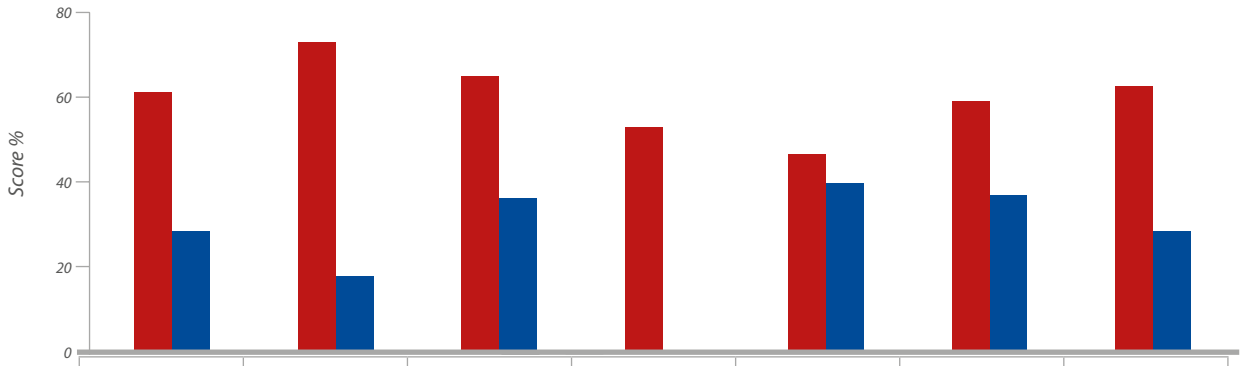
Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal to moderate effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component needs minimal to considerate effort to reach compliance status

5.4.1 Domain Outcome (Extreme and Vital)

Figure 45: Domain Outcome GP Mamelodi Hospital



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	67	80	71	58	51	65	68
X & V Failed %	31	19	30	0	43	40	31

The health establishment was inspected and achieved an overall score of 71% compliance. The following are the score achieved per domain:

- Patients Rights 67%
- Patient Safety 80%
- Clinical Support Services 71%
- Public health 58%
- Leadership and Corporate Governance 51%
- Operational Management 65%
- Facilities and Infrastructure 68%

Table 68: Extreme and Vital Measures Failed by Domain

Domain 1	
Extreme	**Vital**
• Forms used for informed consent are not completed correctly -Designation of the person doing the procedure not recorded.	• Areas checked were not clean e.g. Mixing of waste in sharps containers observed, Floor with stains bins without lids, door handles off. • There was no referral policy. • Procedure governing the handover of patients from EMS to hospital staff not available.
Domain 2	
Extreme	**Vital**
• Identification of specific risk factors not always done e.g. Summary of foetal condition not recorded • Safety checks as per WHO guidelines not completed e.g. Site marking and estimated blood loss and anticipate critical events not indicated • Formal policy for handling emergency resuscitations not available. • Emergency trolley not appropriately stocked e.g. No peads oxygen mask, NG tubes not available. • Consent forms do not indicate who gave consent e.g. Patients pest blood transfusion recording not done • 4/8-Protocol on safe administration of blood has not been adhered to e.g. Checks not conducted prior to admin of blood. • Isolation accommodation -Evidence of people traffic control not available, toilet facilities also not available.	• Clinical audits not done on priority programmes. • Reasons for referral, results of investigation names of referring health care professional who agreed to the transfer not indicated. • Minutes of the forum reviewing resuscitations not available. • Minutes of the forum reviewing adverse events not available. • Recapping noted in some rooms and a needle was left on the injection trolley.
Domain 3	
Extreme	**Vital**
• Diagnostic set not available and instruments set for central line not available.	• Dispensing not done in accordance with legislated e.g. Patient information not complete • Side effects were not explained and questions were not encouraged • Other relevant information not given to patients receiving medication e.g. Side effects not explained • Patients do not have clear understanding of has to take medication e.g. With or without food. • No Radiology report not available in some files • Staff interviewed did not know how the cold chain is ensured for all blood products • Staff do not know the storage and transportation temperature of blood. • Service level agreement for Decontamination not available.

Domain 5	
Extreme	**Vital**
	• Minutes of the relevant forum reviewing quality not available.
Domain 6	
Extreme	**Vital**
	• Performance Reviews -Multiple aspects of non-compliance e.g. Final assessment reports were not moderated • Medical examinations are not done to personnel exposed to potential occupational hazards
Domain 7	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency / -Document not available at the time of inspection.	• No evidence of daily inspection of cleanliness • Area checked bathrooms are not properly clean • Some areas are not properly cleaned e.g. Casualty • Some cleaning material items is not available e.g. Antimicrobial soap, N95 mask and yellow bags

Table 69: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	85%
Cleanliness	**67%**
Improve patient safety and security	70%
Infection prevention and control	75%
Positive and caring attitudes	75%
Waiting times	83%

The table above demonstrates the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to cleanliness with the lowest score of 67% and the rest of scores below 85%. The hospital's highest score is 85% availability of medicine and supplies. Collective effort and accountability between management and staff is responding to other areas of improvement is critical before the next inspection.

5.5 Tambo Hospital

Profile

Tambo Memorial Hospital is a regional hospital situated in the Ekurhuleni Metro, in the town of Boksburg. The hospital is one of the oldest hospitals in Gauteng. It began as a joint hospital of the state and East Rand Property Mine on August 1905. The hospital developed rapidly with new wards and clinical services. The State assumed full control over the hospital in 1984. The hospital's name changed to Tambo Memorial Hospital on 17 April 1997 in honor of Mr. Oliver Reginald Tambo. Tambo Memorial Hospital has 540 functional beds and its catchment population is approximately 1,2 million (based on the 2011 census) in Boksburg, Benoni, Kempton Park, part of Germiston and surrounding informal settlements

Clinics:

- Internal Medicine, Surgery, Orthopedics, Obstetrics & Gynaecology, Paediatrics
- Family Medicine, Ophthalmology, Optometry, ENT, Pharmacy, Emthonjeni Clinic (ARV)
- Stoma Clinic, Wound Clinic, Prem Clinic, Dermatology , Antenatal Clini and Post Natal Clinic

Table 70: Outcomes as per components

Components	Functional areas											
Management	CEO	Communications/ PRO	Facility infrastruc-ture	Financial management	HR management	Infection control	MIS	Procurement	Occupation health and safety	Clinical management group	Case management	
Clinical Services	Blood services		Laboratory		Health Technology services			Pharmacy		Radiology		
Patient care	A & E Unit	OPD	Maternity ward incl Maternity theatres	Medical ward (1)	Surgical ward (1)	Paediatric ward	Generic ward (1)	Therapeutic support services-physio	Speciality wards and services	Operating Theatre incl labs	Psychiatric ward	
Support services	CSSD	Cleaning services	Food services	Laundry services	Maintenance services incl garden	Record archive/ department	Waste man-agement	Transport services	Security services	Entrance/ reception/ help desk	Patient adminis-tration	Mor-tuary services	Public areas

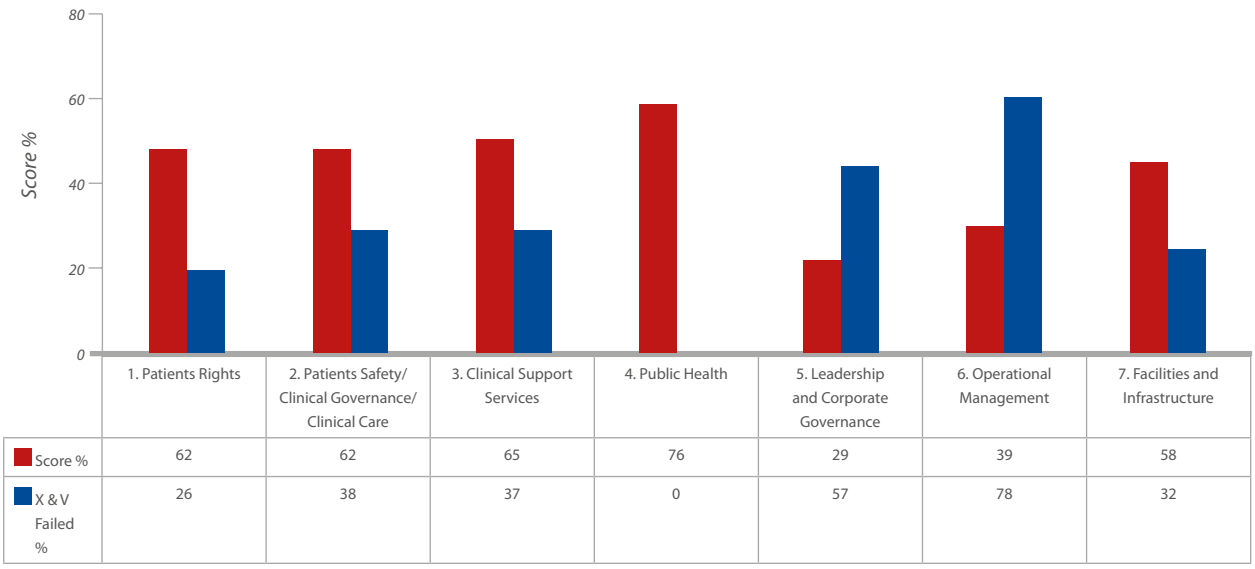
Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

Components Outcome

- Management component needs moderate to maximal effort to reach compliance status.
- Clinical Services component needs minimal to moderate effort to reach compliance status.
- Patient Care component needs minimal to moderate effort to reach compliance status.
- Support Service component needs moderate to maximal effort to reach compliance status

5.5.1 Domain Outcome (Extreme and Vital)

Figure 46: Domain Outcome GP Tambo Memorial



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	62	62	65	76	29	39	58
X & V Failed %	26	38	37	0	57	78	32

The health establishment was inspected and achieved an overall score of 57% compliance. The following are the score achieved per domain:

- Patients Rights 62%
- Patient Safety 62%
- Clinical Support Services 65%
- Public health 76%
- Leadership and Corporate Governance 29%
- Operational Management 39%
- Facilities and Infrastructure 58%

Table 71: Extreme and Vital Measures Failed by Domain

Domain 1	
Extreme	**Vital**
• Audited consent forms did not indicate the health care provider gaining the consent.	• Walls and corners not clean, mixing of waste observed recapping observed. Male patients' toilet smells urine. Cupboards not neatly packed. • Patient referral guideline produced no policy and protocol. • Audited patients' records did not demonstrate that the correct procedure was followed between EMS staff and health establishment staff e.g. No handing-over time. • Audited patients' records did not indicate that guidelines regarding examination and stabilisation are adhered to e.g. Only initial vital signs are recorded. • Procedure governing the handover of patients from EMS to hospital staff-No procedure in place.
Domain 2	
Extreme	**Vital**
• Initial assessments of high risk maternity patients -High risk items not noted. • Pre-operative document not indicating all safety checks e.g. Patient with difficult airways. Baseline vital signs not available. • No formal policy for handling resuscitation. • Emergency trolley not standardised e.g. Nasal cannula. Asics expired 07/2015. Aspirin no expiry dates. • Only 2 files were audited. Audited patients' files for blood transfusion did not demonstrate that protocol for administration of blood has been adhered to e.g no dates on consent for blood. • Protocol of blood not adhered to e.g. Time of blood commenced not written. • Isolation accommodation does not accommodate have a separate toilet. No elbow laps.	• Clinical audits not done for priority programme. • Junior staff verbalises that senior staff does not teach them voluntarily. • Minutes of the forum reviewing clinical risks-No minutes of forum just meetings monthly. • No procedure for the care of the terminally ill. • No procedure for the management of patients detained for72 hours. • No procedure for conducting risk on the aged and frail. • Protocol regarding the safe administration of medicines to patients is available including a protocol for the safe administration of medicines to children -Copy expired January 2015. • Observation of patients receiving medication confirmed that patient safety is assured e.g. Prescribed medication times are not adhered to. • Staff member did not follow safety protocols for medication giving. • Files produced with actions taken but no evidence that analysis and root cause done is aligned with adverse events policy and procedure as they are not available in facility. • Poor waste management needles recapped after use. Poor segregation of waste.

Domain 3	
Extreme	**Vital**
• Some essential equipment not available e.g. Diagnostic set.	• Patients not told about the side effects of medication and not given opportunity to ask questions. • Patient has no clear understanding on how to take medicine e.g. Side effects not explained. • Forum which deals with adverse drug reactions demonstrates that actions have been taken to report / analyse and take appropriate action regarding adverse drug reactions-No forum only minutes of discussion within the hospital. • Staffs interviewed were not able to explain how cold chain is ensured for all blood stored and transporting e.g. One said the temperature is kept between 1 and 6 Celsius for storage and between 1 and 10 Celsius for transportation.
Domain 5	
Extreme	**Vital**
	• No policy or protocol for obtaining patient consent when needs to communicate to 3rd party.
Domain 6	
Extreme	**Vital**
• Recent reports/stats within the last 12 months show what remedial actions have been taken in the event of an incident of harm to a staff member- No report. • Measures are in place to prevent any incident of harm to staff -Not produced.	• Minutes of the occupational health and safety committee -Signed off minutes scribbled with corrections & no regular discussion of occupational risks.
Domain 7	
Extreme	**Vital**
• No documents available for power disruption. • No piped medical gas. • No piped vacuum.	• Loose electrical wires observed. • Security policy not available. • Security measures not in place e.g. Security committee not yet established. • Not all cleaning material was available e.g. Colour coded buckets and cloths.

Table 72: In terms of Ministerial priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	62%
Cleanliness	63%
Improve patient safety and security	**59%**
Infection prevention and control	**57%**
Positive and caring attitudes	60%
Waiting times	73%

The table above demonstrates the performance of the health establishment in relation to six Ministerial Priorities. In this regard the health establishment is having challenges with regard to infection prevention and control scoring lowest 57% and improving patient safety and security scoring 59%. However, the hospital scored higher 73% and the rest of the scores are below 73%. Collective responsibility, performance and accountability between management and staff is critical in responding to the findings before the next inspection is undertaken.

5.6 Rahima Moosa Hospital

Profile

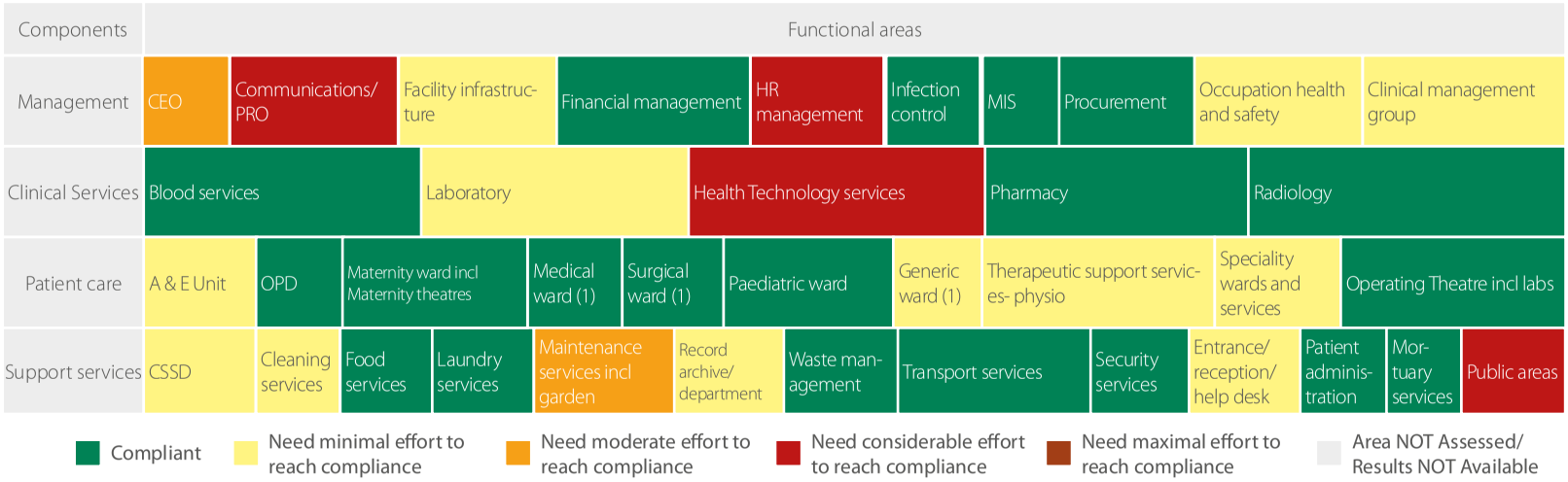
The Department of Paediatrics and Child caters for both in-patients (admissions) and out-patients. The in-patient service is provided for by four general wards of between 20-30 beds each and two neonatal wards with 35 beds and an additional 12 beds for Kangaroo Mother Care.

In addition, there is a Neonatal Intensive Care Unit that has six beds and a high care area within this unit that has another 4 beds. The ambulatory patients are seen either by the Paediatrics outpatient department (POPD), or are attending one of the sub-specialty clinics known as the Paediatrics Specialist Clinics.

Services Provided

- Obstetrics and Gynae, Paediatrics, ENT, Orthopedics, Dental, Anesthesiology, Nursing
- Physio/Occupational/Speech therapy, Dietetics, Pharmacy, Psychiatry/Psychology (Child and adolescent)
- Social work, Radiology/Radiography, Emergency services (Casualty and Polyclinic)
- Empilweni clinic. (HIV and Aids), Podiatry.

Table 73: Outcomes as per components

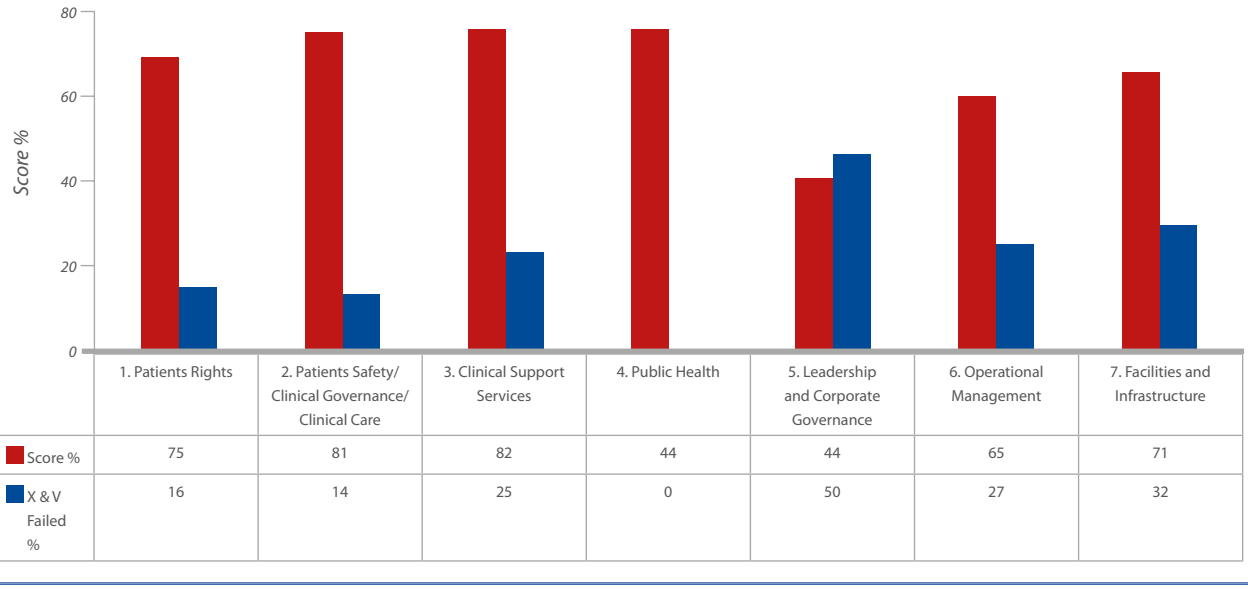


Components Outcome

- Management component needs minimal to considerate effort to reach compliance status.
- Clinical Services component needs minimal to considerate effort to reach compliance status.
- Patient Care component needs minimal effort to reach compliance status.
- Support Service component needs minimal to considerate effort to reach compliance status

5.6.1 Domain Outcome (Extreme and Vital)

Figure 47: Domain Outcome GP Rahima Moosa



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	75	81	82	44	44	65	71
X & V Failed %	16	14	25	0	50	27	32

The health establishment was inspected and achieved an overall score of 73% compliance. The following are the score achieved per domain:

- Patients Rights 75%
- Patient Safety 81%
- Clinical Support Services 82%
- Public health 82%
- Leadership and Corporate Governance 44%
- Operational Management 65%
- Facilities and Infrastructure 71%

Table 74: Extreme and Vital Measures Failed by Domain

Domain 1	
Extreme	**Vital**
• Forms used for informed consent are not completed correctly by the health Professionals-Age not indicated	• Public toilets smelly, bin has no lids, corners are dirty • Some areas in the ward to not appear clean such as stains and insects in toilets • Referral Policy not available • Time of arrival and hand over and method of transfer not indicated in handover of patients between EMS staff and establishment staff.

Domain 2	
Extreme	**Vital**
• Specific risk factors of high risk maternity patients not identified e.g. items on admission not completed • Emergency Trolley-Some items not functional e.g. AED-Some equipment not available e.g. paeds laryngoscope blades and adrenaline 1mg expired. • Consent not signed by patient and details of transfusion not recorded • Some aspects of appropriate isolation and not available such as control of people traffic • Some aspects of appropriate isolation are not available such as the sign for no visitors.	• Clinical Audits on priority programmes not conducted • No QIP for Health Initiatives or programmes • No minutes of meeting of the forum reviewing clinical risks. • Patient not observed taking and swallowing medication • Adverse events -Root cause analysis not done in incidents • Recapping observed and lids loose in sharps containers

Domain 3	
Extreme	**Vital**
• Some functional essential equipment is not available such as tracheostomy set.	• Patients not given opportunity to ask questions about medicine dispensed • Patients receiving Medicine-Side effects not explained • Interviewed staff are not aware of safe temperature for storage or transport of blood products • Some aspects of cold chain management are not known to all staff such as temperature at transporting patients • No maintenance plan for Defibrillator

Domain 5	
Extreme	**Vital**
	• No operational plan for the HE.

Domain 6	
Extreme	**Vital**
• Recent reports/stats within the last 12 months show what remedial actions have been taken in the event of an incident of harm to a staff member-No zero reporting • No measures are in place to prevent any incident of harm to staff	• Personal development plan not reflected in files of personnel • Medical examinations not done on staff exposed to occupational hazards

Domain 7	
Extreme	**Vital**
• The available document does not detail how power will continue in power failure • No piped oxygen cylinder used • No piped suction/ vacuum	• There are pockets of cleanliness and areas that do not appear clean such as insects in toilets on the Gynae ward and stains in toilets • Some cleaning items not available e.g. janitor trolley, window cleaning squeegee

Table 75: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	90%
Cleanliness	**66%**
Improve patient safety and security	74%
Infection prevention and control	82%
Positive and caring attitudes	70%
Waiting times	72%

The table above reflects the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to cleanliness lowest score 66% the rest of the scores above 70%. The hospital achieved highest score 90% availability of medicines and supplies. The question is what is the problem with basic cleanliness and what remedial action has been taken since inspection feedback. Has the situation changed? What and how?

5.7 Letaba Hospital

Profile

The hospital is situated in Tzaneen Lydenburg Road (R36), Letaba in Limpopo province. The hospital is located 13.2km South-East of Tzaneen on the R36 and 105km West of Phalaborwa along the R71 and R36. The hospital has total number of beds available 400.

Services Provided

Day Clinic, Theatres, 24 hours' emergency service, Obstetrics, Dental Facilities , Vascular Surgery, Reproductive Health, Eye Services and Clinical Laboratory Service

Table 76: Outcomes as per components

Components	Functional areas											
Management	CEO	Communications/ PRO	Facility infrastruc-ture	Financial management	HR management	Infection control	MIS	Procurement	Occupation health and safety	Clinical management group	Case management	
Clinical Services	Blood services		Laboratory		Health Technology services			Pharmacy		Radiology		
Patient care	A & E Unit	OPD	Maternity ward incl. Maternity theatres	Medical ward (1)	Surgical ward (1)	Paediatric ward	Therapeutic support services-physio	Speciality wards and services		Operating Theatre incl. labs		Psychiatric ward
Support services	CSSD	Cleaning services	Food services	Laundry services	Maintenance services incl. garden	Record archive/ department	Waste man-agement	Transport services	Security services	Entrance/ reception/ help desk	Patient adminis-tration	Mor-tuary services	Public areas

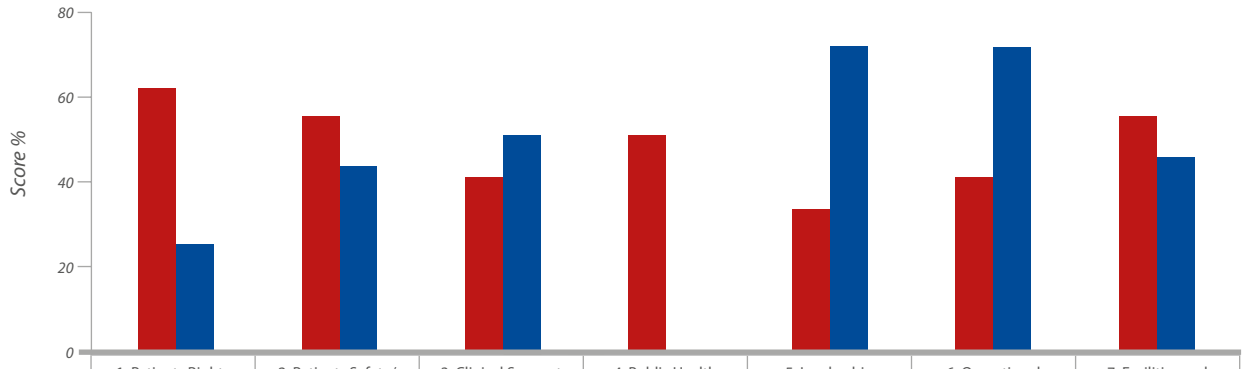
Compliant | Need minimal effort to reach compliance | Need moderate effort to reach compliance | Need considerable effort to reach compliance | Need maximal effort to reach compliance | Area NOT Assessed/ Results NOT Available

Components Outcome

- Management component needs minimal to maximal effort to reach compliance status.
- Clinical Services component needs minimal to maximal effort to reach compliance status.
- Patient Care component needs minimal to considerate effort to reach compliance status.
- Support Service component needs minimal to maximal effort to reach compliance status

5.7.1 Domain Outcome (Extreme and Vital)

Figure 48: Domain Outcome LP Letaba Hospital



	1. Patients Rights	2. Patients Safety/ Clinical Governance/ Clinical Care	3. Clinical Support Services	4. Public Health	5. Leadership and Corporate Governance	6. Operational Management	7. Facilities and Infrastructure
Score %	61	54	40	50	33	39	55
X & V Failed %	25	42	50		71	70	45

The health establishment was inspected and achieved an overall score of 50% compliance. The following are the score achieved per domain:

- Patients Rights 61%
- Patient Safety 54%
- Clinical Support Services 40%
- Public health 50%
- Leadership and Corporate Governance 33%
- Operational Management 39%
- Facilities and Infrastructure 55%

Table 77: Extreme and Vital Measures Failed by Domain

Domain 1	
Extreme	**Vital**
• Only 1 file was available to be assessed. Assessed file consent form did not have patient age and the personnel gaining/ obtaining the consent.	• Mentally ill patients were observed to be nursed in an unclean and unpleasantly smelling area. • Not all areas are clean e.g. Cupboards are not tidy. • Referral Policy not available. • Not all items prescribed were available. • Assessed patients' records did not demonstrate that the correct handover of patients was followed e.g. Time of arrival & handing over not indicated.
Domain 2	
Extreme	**Vital**
• No record of labour form in the patient's maternity records. • Patients peri-operative document-No checklist in the patient's files. Some safety checks are not conducted. • Policy for handling emergency Resuscitations-Policy not available. • Not all emergency trolley items were available e.g. No laryngoscope blade for peads. Items are not checked regularly and other stock is expired. No thermometers and suction catheters. Peads ambubag not available. • The 3 assessed patients' files did not demonstrate that the protocol on administration of blood has been adhered to e.g. No consent for giving of blood. • The health establishment does not have an appropriate isolation accommodation for patients with communicable diseases.	• Clinical Audits on priority programmes not done. • Health professional has indicated that there is no supervision from management. • Frail and aged patients are not assessed for risk. • The patients requiring 72 hours' observation are not cared in a suitable accommodation. • A produced document of medical/ physical and chemical restrain was not complete. • The initial assessment of high risk patients did not reflect that the identification of specific risk factors was noted. • Protocol regarding the safe administration of medicines to patient -Protocol does not include children and no review date. • Produced document did not indicate that infection control surveillance data & control measures are regularly analysed and actions taken to reduce infection. • Produced document does not indicate that recommendations on antibiotic usage based on the micro-organic profiles sensitivity are adhered to, were available. • Standard precautions not adhered to e.g. Recapping observed.

Domain 3	
Extreme	**Vital**
• Not all tracer drugs are available e.g. Ethambutol, Ibrufen & morphine injection	• Not all essential medical equipment as listed e.g. Thermometer and Hb meter. • No scheduled maintenance for equipment. • No system given for items requiring replacement. • No report of adverse event involving medical equipment.
Domain 5	
Extreme	**Vital**
	• Policy or protocol for the obtaining of patient consent if patient identifiable information needs to be communicated to a 3rd party -Document not available.
Domain 7	
Extreme	**Vital**
• Documented evidence that in the event of a power disruption emergency power supply is available in critical clinical areas such as ICU / Theatre / Accident and Emergency / ECTNo documented evidence provided. • No supply of piped medical gas. • No piped medical gas available.	• Hanging electrical wires observed. • Security Policy not available. • Security measures not in place e.g. No security in maternity • Not all cleaning material was available e.g. Colour coded buckets and cloths. • Pest control not done in all areas.

Table 78: In terms of Ministerial Priorities, the health establishment performed as per the following table:

Priority Area by Risk	Weighted Score
Availability of medicines and supplies	**34%**
Cleanliness	**49%**
Improve patient safety and security	50%
Infection prevention and control	56%
Positive and caring attitudes	51%
Waiting times	63%

The table above demonstrates the performance of the health establishment in relation to six ministerial priorities. In this regard the health establishment is having challenges with regard to availability of medicines and supplies with the lowest score 34% followed by cleanliness score 49% and most scores are below 63% which is the highest score. The question is what and how management and staff deal effectively with teams performance and other human relations factors (e.g. conflict) which towards negative staff attitudes including issues of accountability and performance in preparation for the next inspections.

5.8 Regional Hospitals Hospital's Performance Scores

Figure 49: Regional Hospital Performance Score

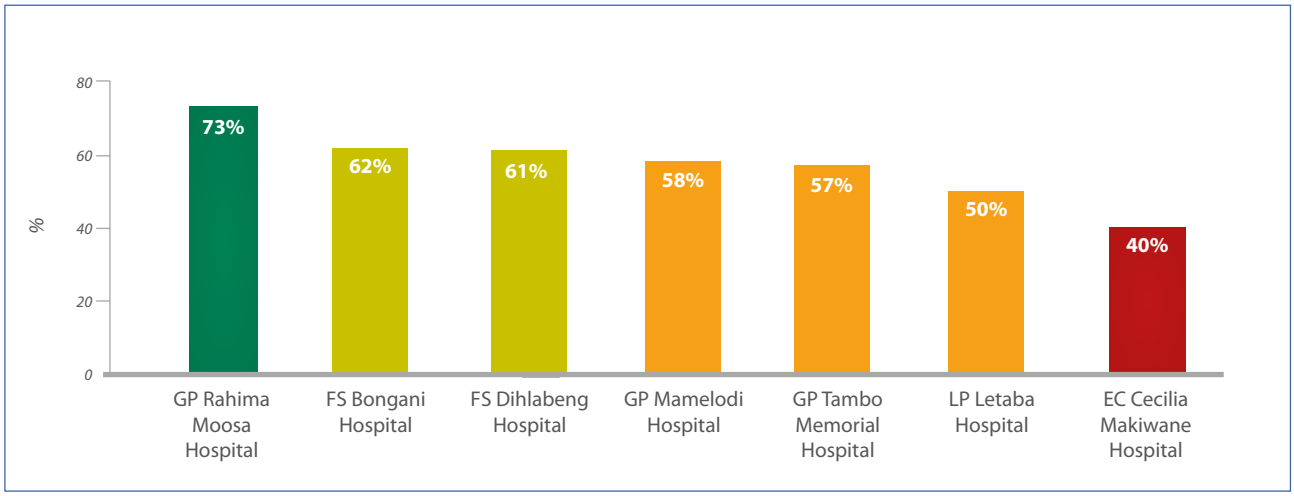


Figure 37 reflects 7 Regional hospitals inspected with the performance scores ranging between 50 - 73%. There are 3 Hospitals inspected in Gauteng with the performance scores ranging between 57 – 73% and Gauteng found to be leading in the whole 7 Health establishments inspected with the highest score of 73% for Rahima Moosa. The lowest performing hospital is Letaba Hospital in Limpopo, which scored 50%.

5.8.1 Regional Hospitals Performance Scores by Domains

Table 79 : Regional Hospitals Performance Scores by Domains

Domain	Tambo Memorial Hospital Weighted Score	Dihlabeng Hospital Weighted Score	Cecilia Makiwane Hospital Weighted Score	Mamelodi Hospital Weighted Score	Letaba Hospital Weighted Score	Rahima Moosa Hospital Weighted Score	Bongani Hospital Weighted Score
1. Patient's Rights	62%	58%	51%	67%	61%	75%	59%
2. Patient Safety/Clinical/ Governance/Clinical Care	62%	65%	66%	80%	54%	81%	69%
3. Clinical Support Services	65%	70%	69%	71%	40%	82%	64%
4. Public Health	76%	30%	46%	58%	50%	82%	44%
5. Leadership and Corporate Governance	29%	35%	63%	51%	33%	44%	36%
6. Operational Management	39%	60%	63%	65%	39%	65%	57%
7. Facilities and Infrastructure	58%	65%	76%	68%	55%	71%	67%

Figure above shows the compliance scores of the 7 regional hospitals by Domain. The inspection scores vary widely by domain with the lowest score of 29% in Domain 5 (leadership and governance) and 4 of the hospitals from 3 different provinces scored less than 40 %the highest score of 81% was recorded in domain 2 (patient safety clinical governance and care). Domain 4 (public health) HEs did not perform well with 3 hospitals from two provinces (Free state and Eastern Cape with the score of less than 50% whereas Free State is the lowest with the score of 30 -44%.????

5.8.2 Regional Hospitals Performance Scores in respect of the six priority areas

Table 80 : Regional Hospitals Performance Scores by Six Priority Areas

Priority Area	Tambo Memorial Hospital Weighted Score	Dihlabeng Hospital Weighted Score	Cecilia Makiwane Hospital Weighted Score	Mamelodi Hospital Weighted Score	Letaba Hospital Weighted Score	Rahima Moosa Hospital Weighted Score	Bongani Hospital Weighted Score
Availability of medicines and supplies	62%	75%	74%	85%	39%	90%	71%
Cleanliness	63%	38%	62%	67%	49%	66%	50%
Improve patient safety and security	59%	64%	62%	70%	50%	74%	69%
Infection prevention and control	57%	66%	74%	75%	56%	82%	66%
Positive and caring attitudes	60%	68%	53%	75%	51%	70%	67%
Waiting times	73%	48%	68%	83%	63%	72%	68%

Figure above demonstrates the scores on the six priority quality measures (waiting times, cleanliness, values and attitudes, patient safety, infection prevention and control and availability of medicines) also varied widely with the highest score of 90 % (for Rahima Moosa in Gauteng) in availability of medicines and supplies and lowest score observed in cleanliness 38 % and 48 % in waiting times (for Dihlabeng Hospital in Free state).

E
INSPECTION RESULTS: DISTRICT HOSPITALS

6.1 District Hospitals Performance Scores

6.1.1 District Hospitals Performance Scores

Figure 50: District Hospitals Performance Score

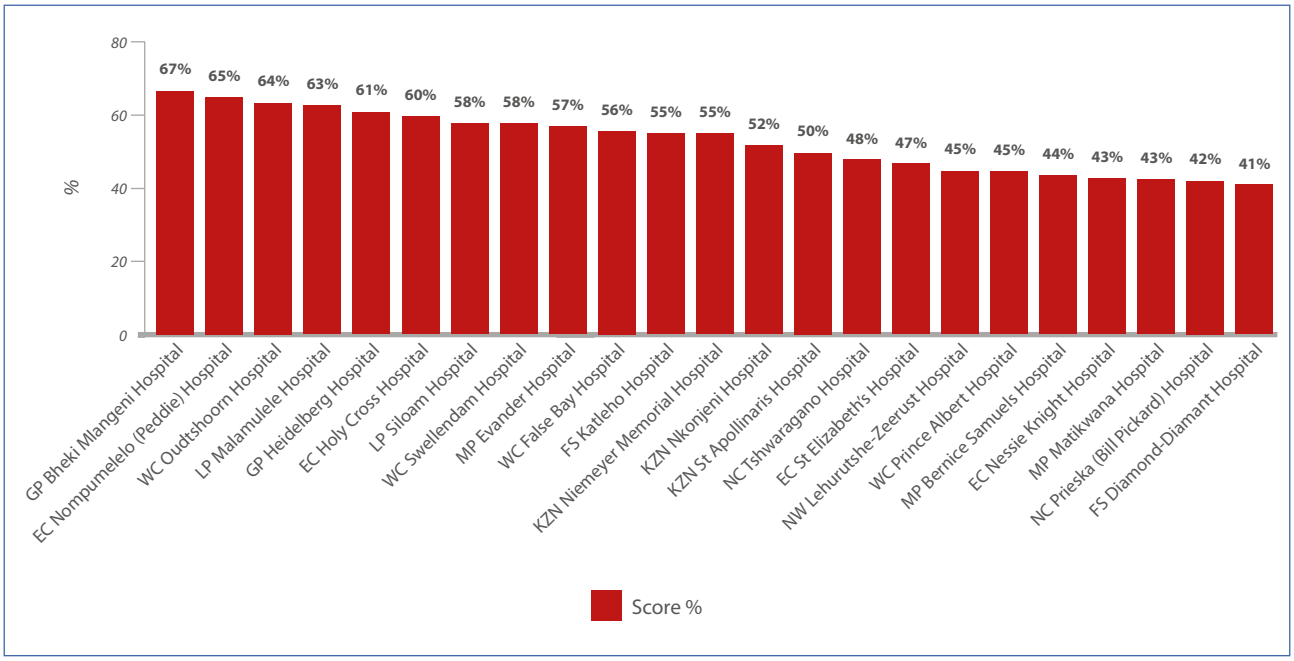


Figure 50 shows 23 District hospitals inspected ,9 Scored between 40%-49%, Eight (8) scored between 50%-59% and six (6) scored between 60%-69%.

Bheki Mlangeni hospital (GP) was the highest performing and Diamond_Diamant hospital scored the lowest at 41%.

District Hospitals Priority area and domains by Province

6.2 Eastern Cape Hospitals

6.2.1 Average Inspected Hospitals by Domain Outcome

Figure 51: Eastern Cape District Hospitals Performance Scores

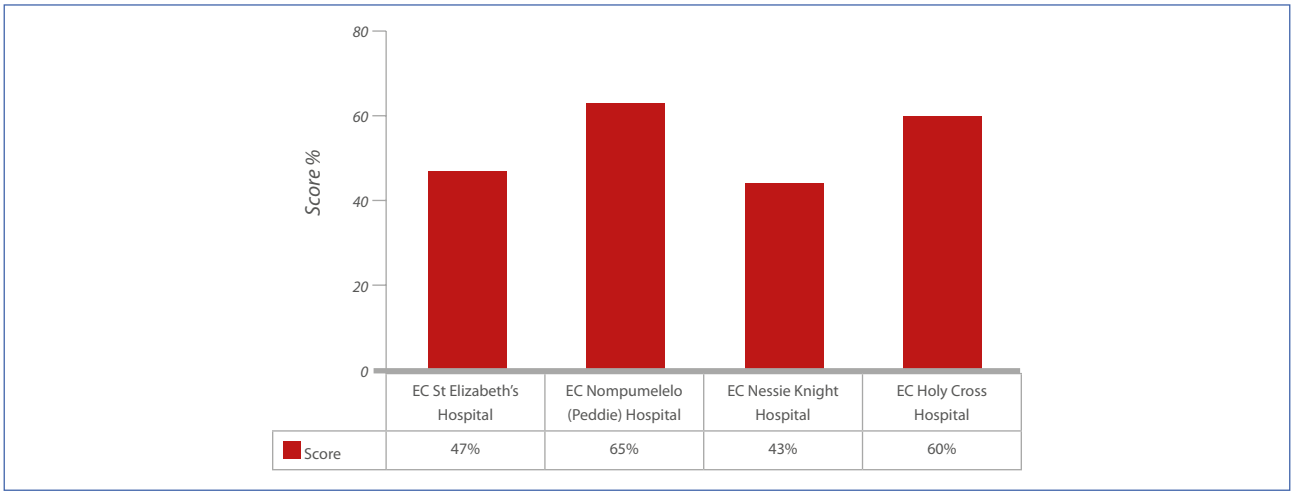
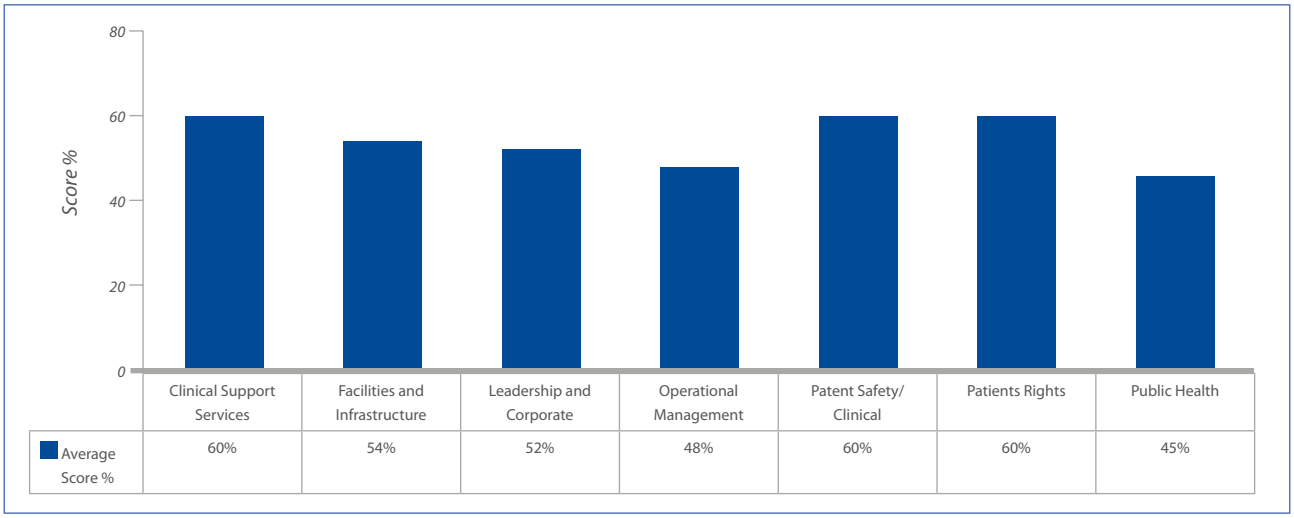


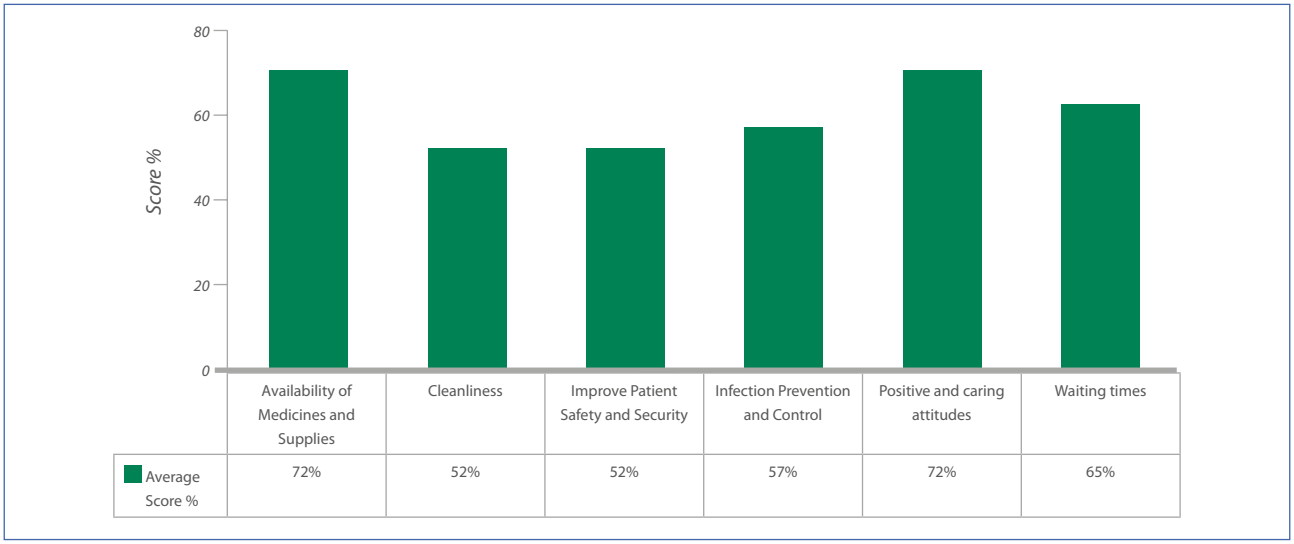
Figure 52: Average inspected Hospitals by Domain Outcome



The above figure demonstrates that on average the hospitals in the Eastern Cape Province are performing above the 50% threshold in all Domains except in Operational Management and Public Health. Leadership & Corporate Governance, Clinical Support Services, Facilities & Infrastructure, Patient Safety/Clinical Care and Patients' Rights performed between 52%-60%. Operational Management performed below all domains at 48%.

6.2.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 53: 2015/16 Priority Area scores for District Hospitals in Eastern Cape



The above figure demonstrates that on average the clinics in Eastern Cape Province are performing above the 50% threshold in all Priority Areas. Availability of Medicines, Cleanliness, Improve Patient Safety & Security, Infection Prevention & Control, Positive & Caring Attitudes and Waiting Times performed between 52%-72%. Cleanliness and Improve Patient Safety & Security performed below all Priority Areas at 52%.

6.3 Free State Hospitals

6.3.1 Average Inspected Hospitals by Domain Outcome

Figure 54: Free State District Hospitals Performance Scores

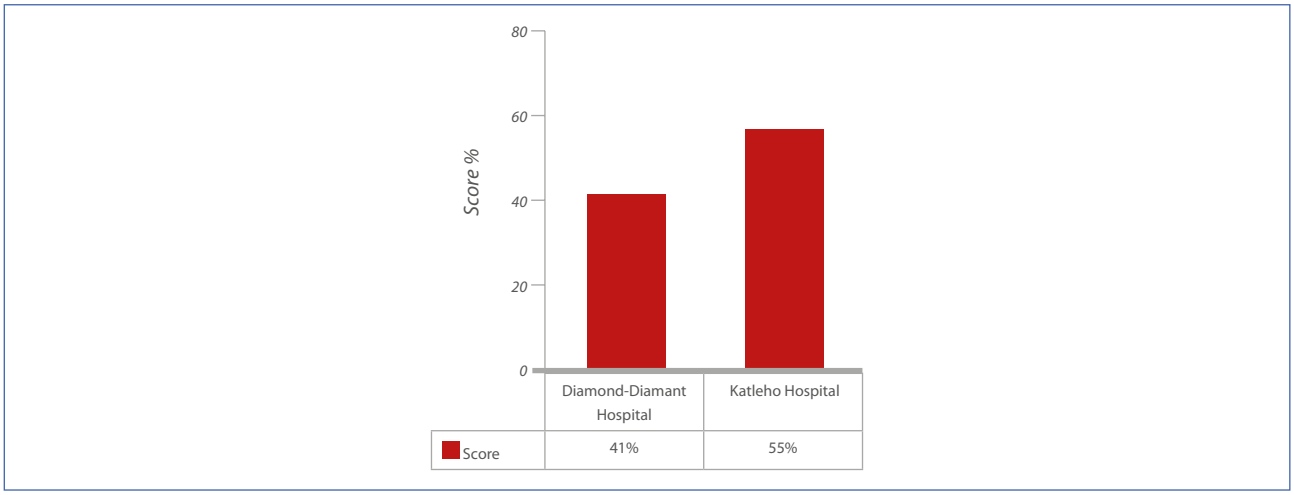
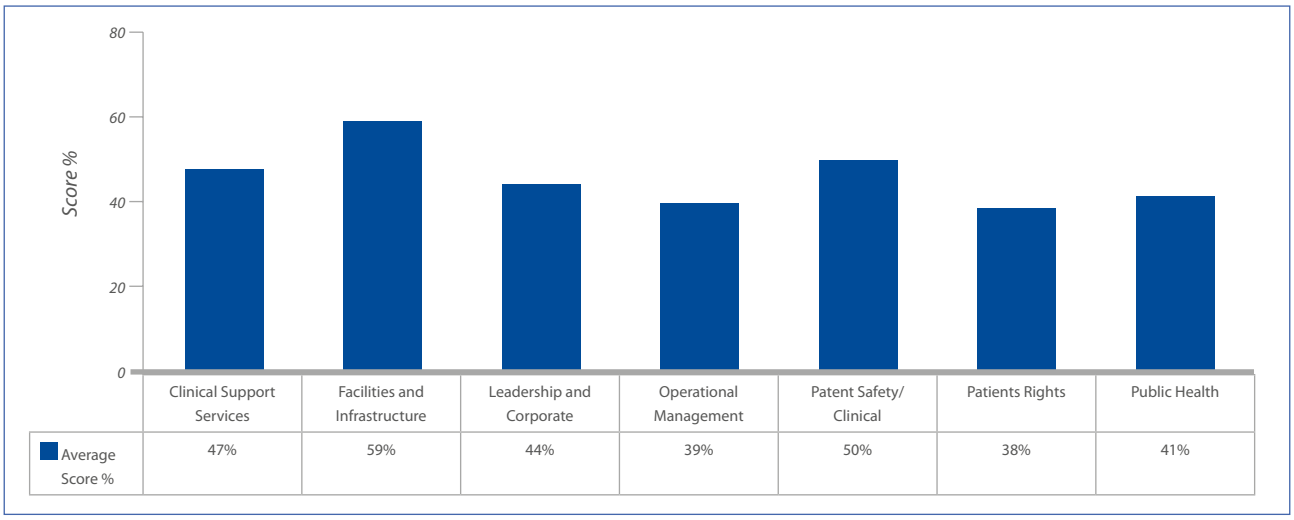


Figure 55: Average inspected Hospitals by Domain Outcome

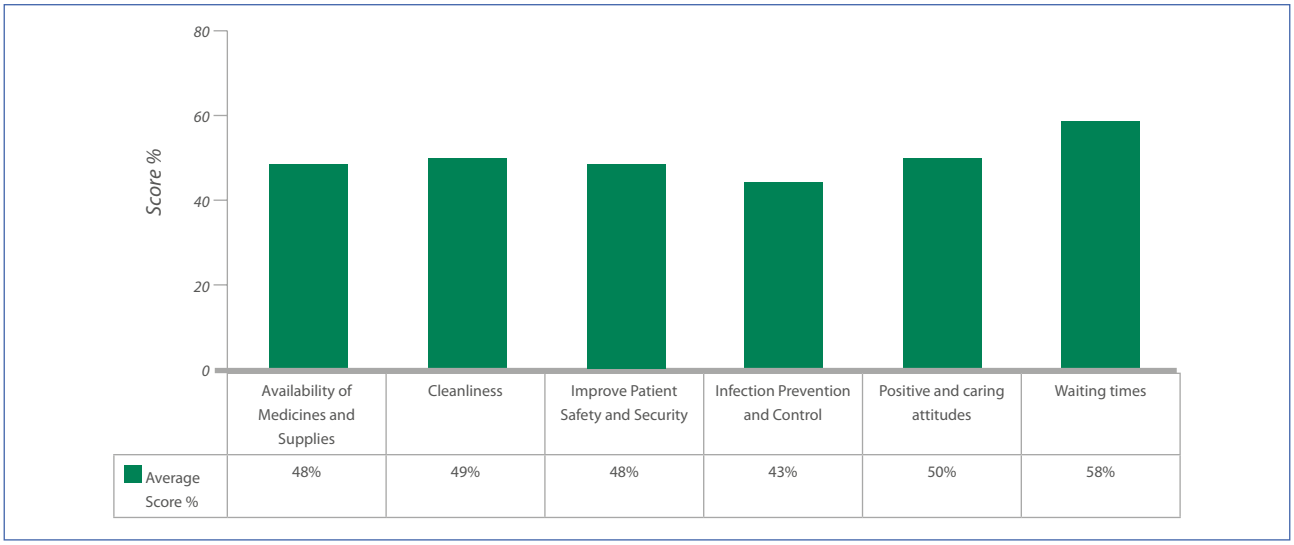


The above figure demonstrates that on average the clinics in Free State Province are not performing above the 50% threshold in all Domains except in Facilities & Infrastructure and Patient Safety/Clinical Care. Leadership & Corporate Governance, Clinical Support Services, Public Health, Patients' Rights and Operational Management performed between 38%-47%. Patients' Rights performed far below all domains at 38%.

5.3.2 Average Inspected Hospitals by Priority Areas Outcome

The above figure demonstrates that on average the hospitals in Free State Province are not performing above the 50% threshold in all Priority Areas except Positive & Caring Attitudes and Waiting Times. Availability of Medicines, Cleanliness, Improve Patient Safety & Security and Infection Prevention & Control performed between 43%-49%. Infection Prevention & Control performed below all Priority Areas at 43%.

Figure 56: 2015/16 Priority Area scores for District Hospitals in Free State



6.4 Gauteng Hospitals

6.4.1 Average Inspected Hospitals by Domain Outcome

Figure 57: Gauteng District Hospitals Performance Scores

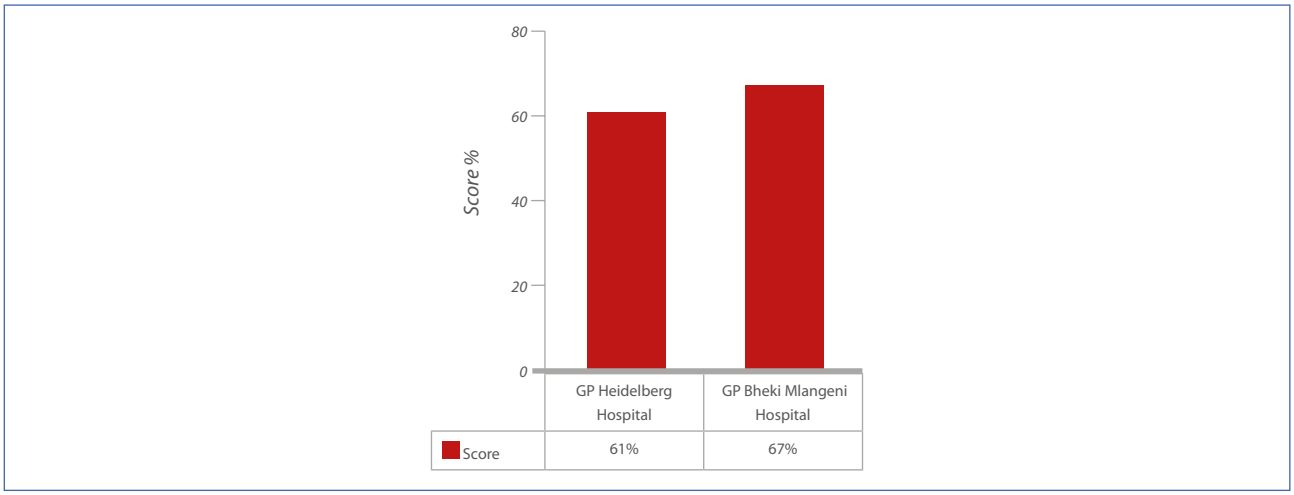
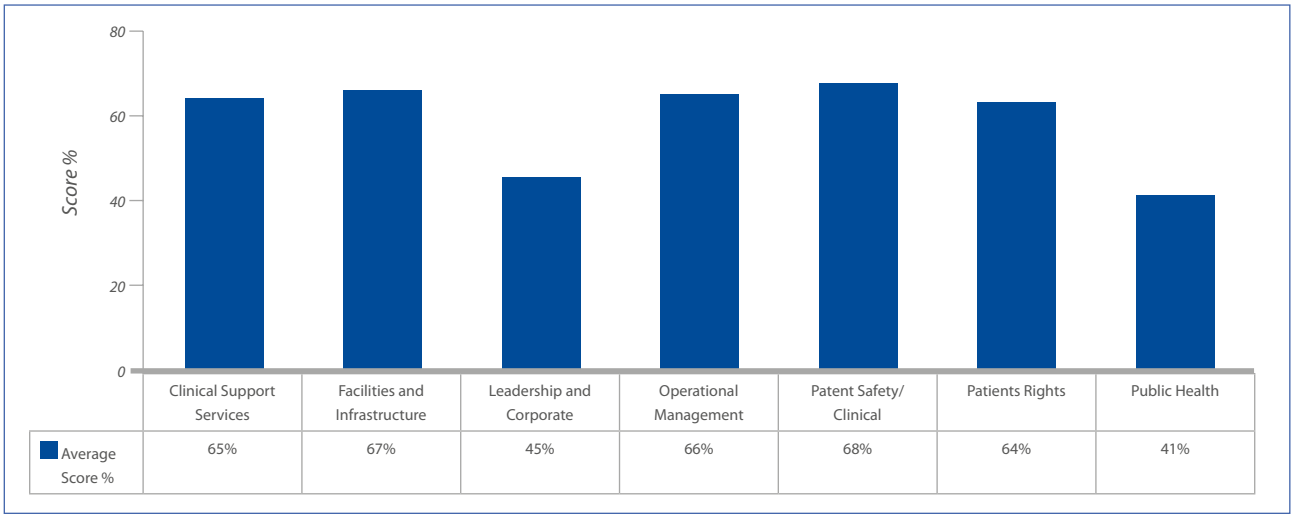


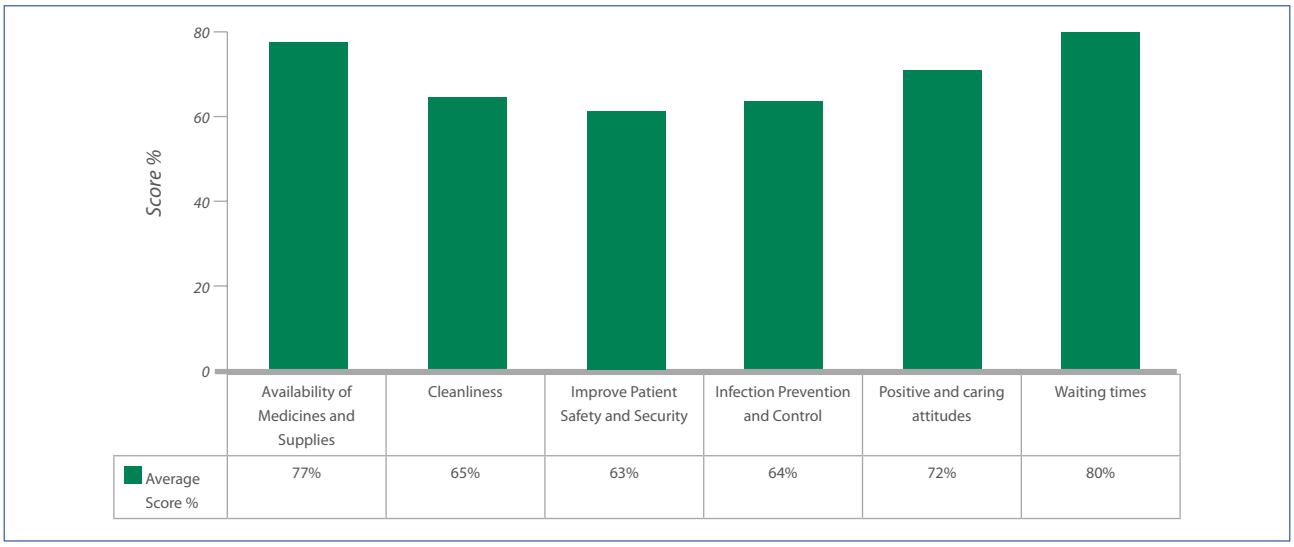
Figure 58: 2015/16 Domain scores for District Hospitals in Gauteng



The above figure demonstrates that on average the hospitals in Gauteng Province are performing above the 50% threshold in all Domains except in Public Health and Leadership & Corporate Governance. Clinical Support Services, Facilities & Infrastructure, Operational Management, Patient Safety/Clinical Care and Patients' Rights performed between 64%-68%. Leadership & Corporate Governance performed below all domains at 45%.

6.4.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 59: 2015/16 Priority Area scores for District Hospitals in Gauteng



The above figure demonstrates that on average the hospitals in Gauteng Province are performing above the 50% threshold in all Priority Areas. All Priority Areas in Gauteng performed between 63%-80%. Improve Patient Safety & Security performed below all Priority Areas at 63%.

6.5 KwaZulu-Natal Hospitals

6.5.1 Average Inspected Hospitals by Domain Outcome

Figure 60: KwaZulu-Natal District Hospitals Performance Scores

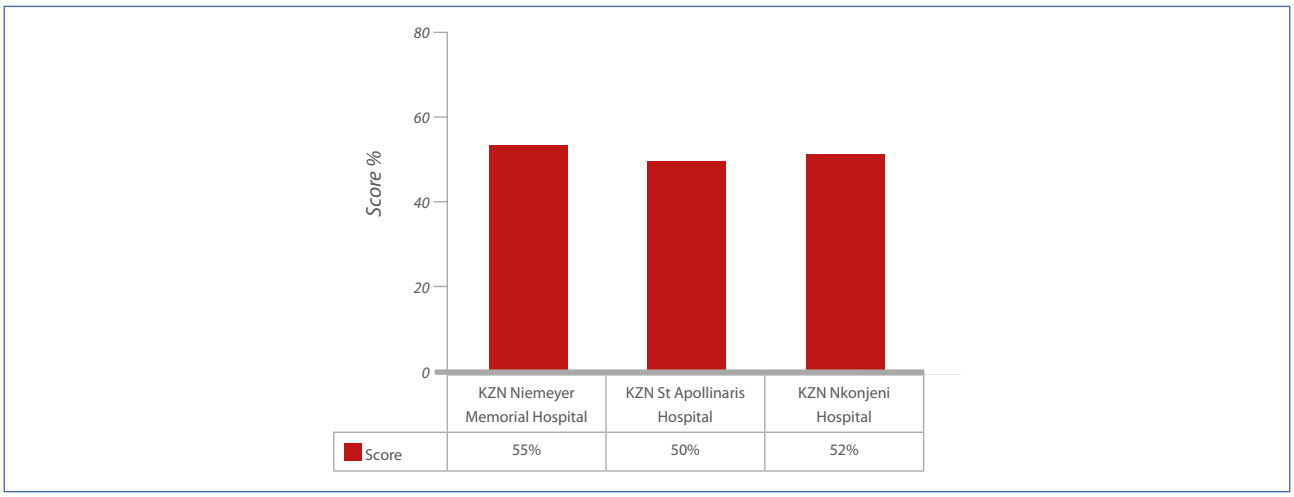
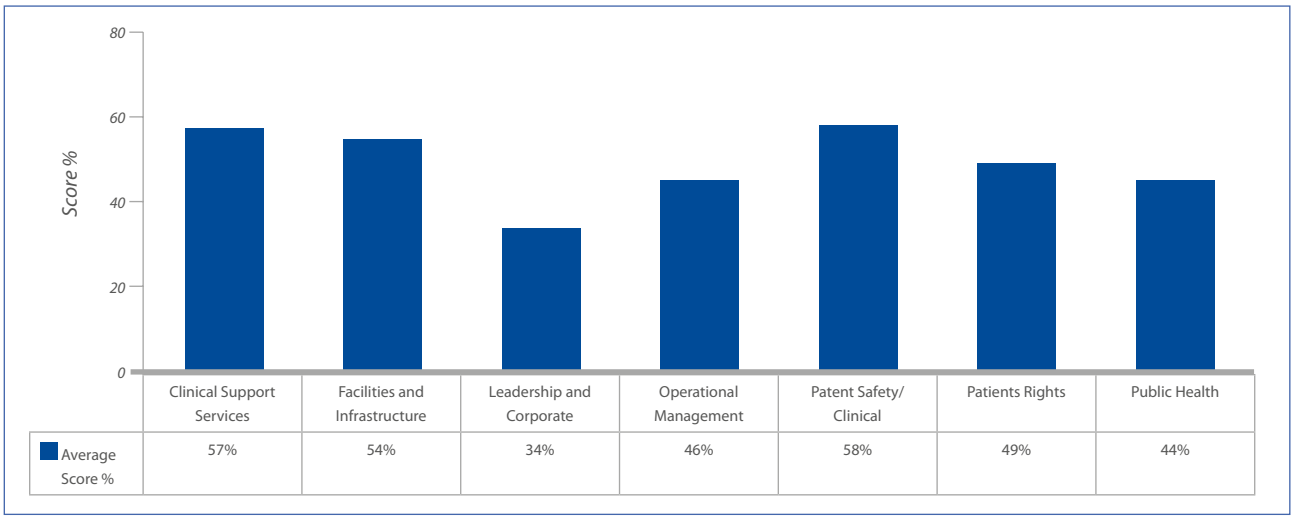


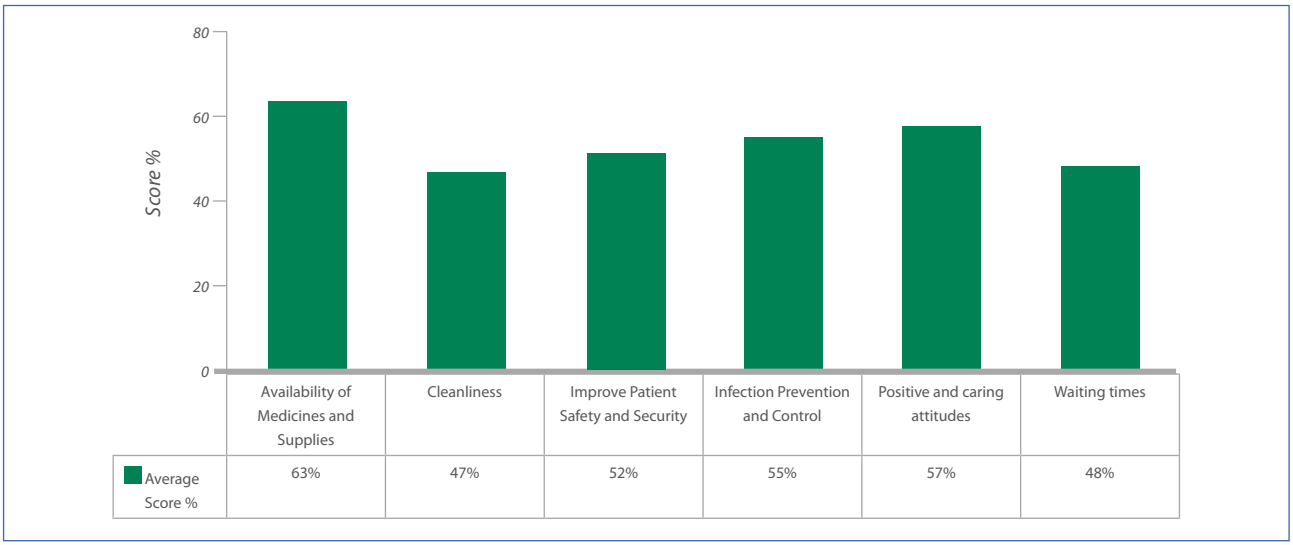
Figure 61: 2015/16 Domain scores for District Hospitals in KwaZulu-Natal



The above figure demonstrates that on average the hospitals in KwaZulu Natal Province are not performing above the 50% threshold in all Domains except in Clinical Support Services, Facilities & Infrastructure and Patient Safety/Clinical Care. Leadership & Corporate Governance, Operational Management, Patients' Rights and Public Health performed between 34%-49%. Leadership & Corporate Governance performed far below all domains at 34%.

6.5.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 62: 2015/16 Priority Area scores for District Hospitals in KwaZulu-Natal



The above figure demonstrates that on average the hospitals in KwaZulu-Natal Province are performing above the 50% threshold in all Priority Areas except Cleanliness and Waiting Times. Availability of Medicines, Improve Patient Safety & Security, Infection Prevention & Control and Positive & caring Attitudes performed between 52%-63%. Cleanliness performed below all Priority Areas at 47%.

6.6 Limpopo Hospitals

6.6.1 Average Inspected Hospitals by Domain Outcome

Figure 63: Limpopo District Hospitals Performance Scores

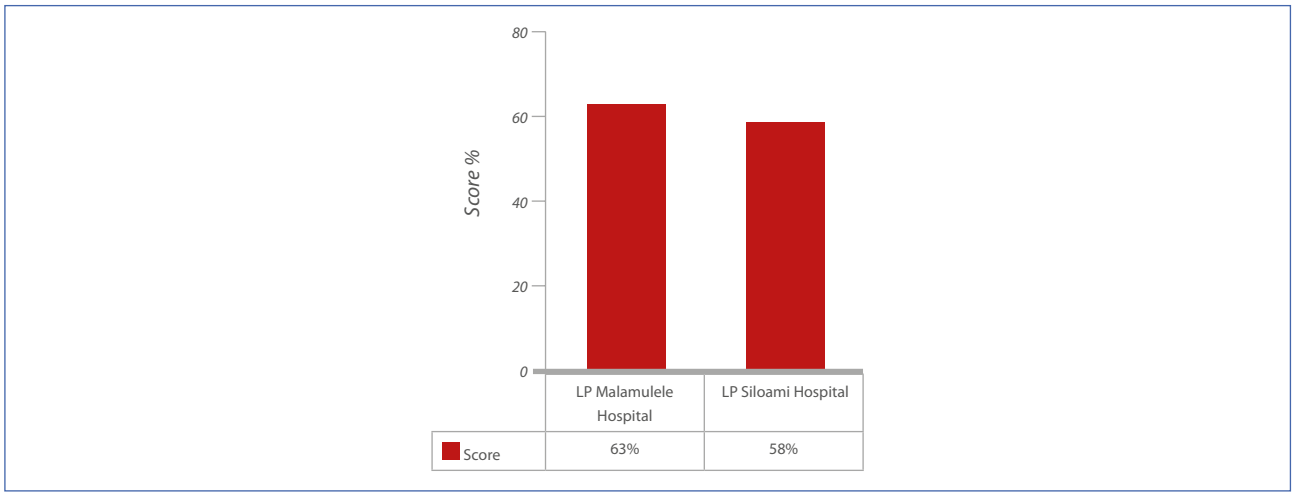
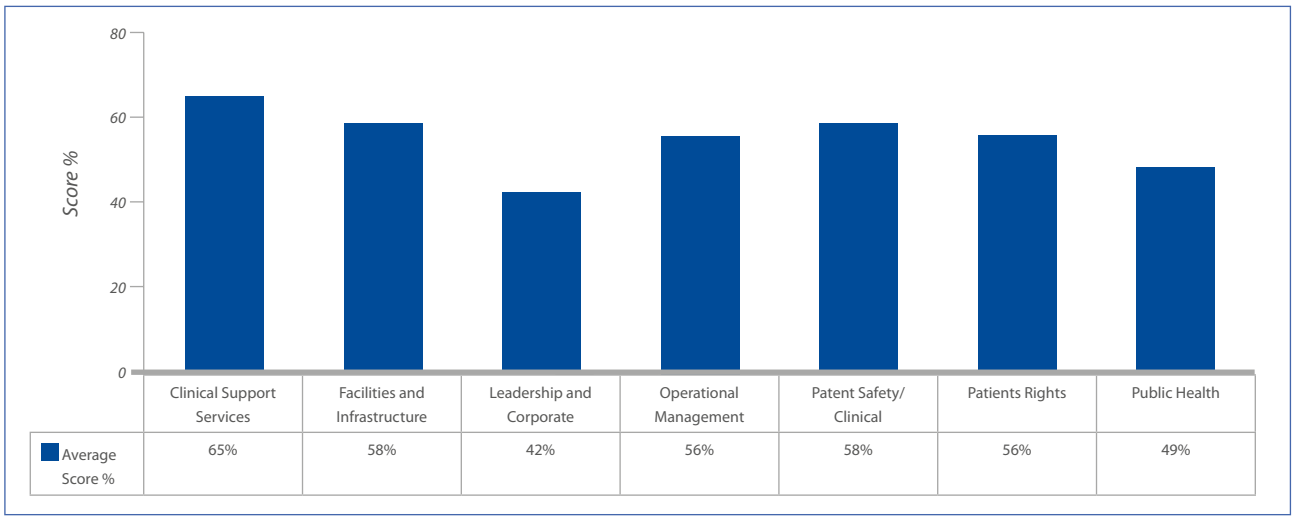


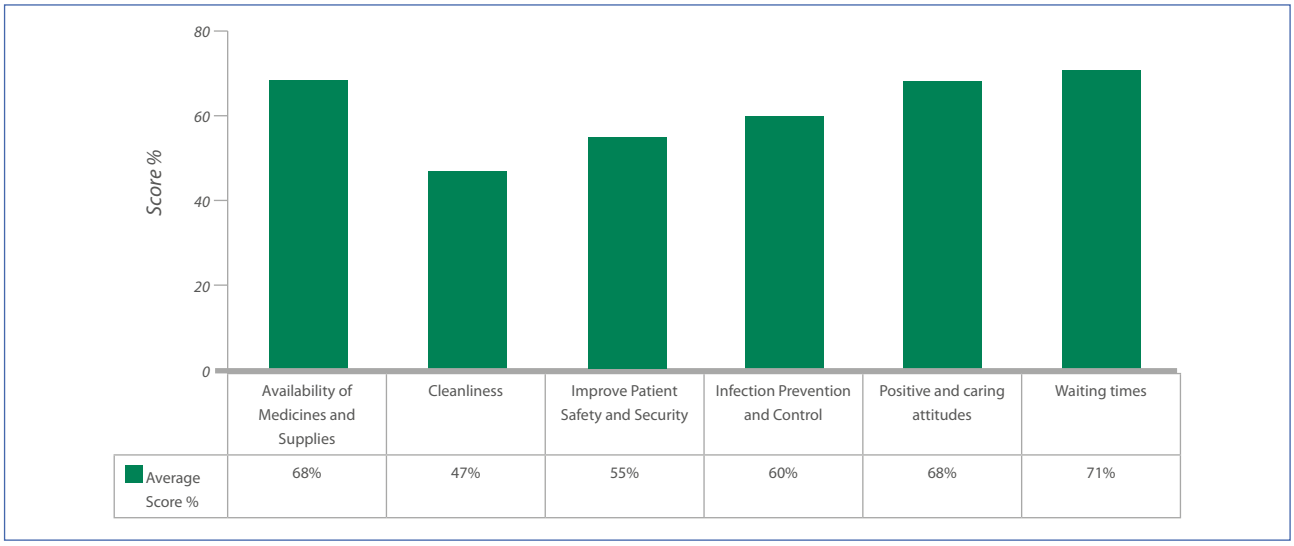
Figure 64: 2015/16 Domain scores for District Hospitals in Limpopo



The above figure demonstrates that on average the hospitals in Limpopo Province are performing above the 50% threshold in all Domains except in Leadership & Corporate Governance and Public Health. Clinical Support Services, Public Health, Operational Management, Patient Safety/Clinical Care and Patient Rights performed between 56%- 65%. Leadership & Corporate Governance performed far below all domains at 42%.

6.6.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 65: 2015/16 Priority Area scores for District Hospitals in Limpopo



The above figure demonstrates that on average the hospitals in Limpopo Province are performing above the 50% threshold in all Priority Areas except Cleanliness. Availability of Medicines, Improve Patient Safety & Security, Infection Prevention & Control, Positive & caring Attitudes and Waiting Times performed between 55%-71%. Cleanliness performed below all Priority Areas at 47%.

6.7 Mpumalanga Hospitals

6.7.1 Average Inspected Hospitals by Domain Outcome

Figure 66: Mpumalanga District Hospitals Performance Scores

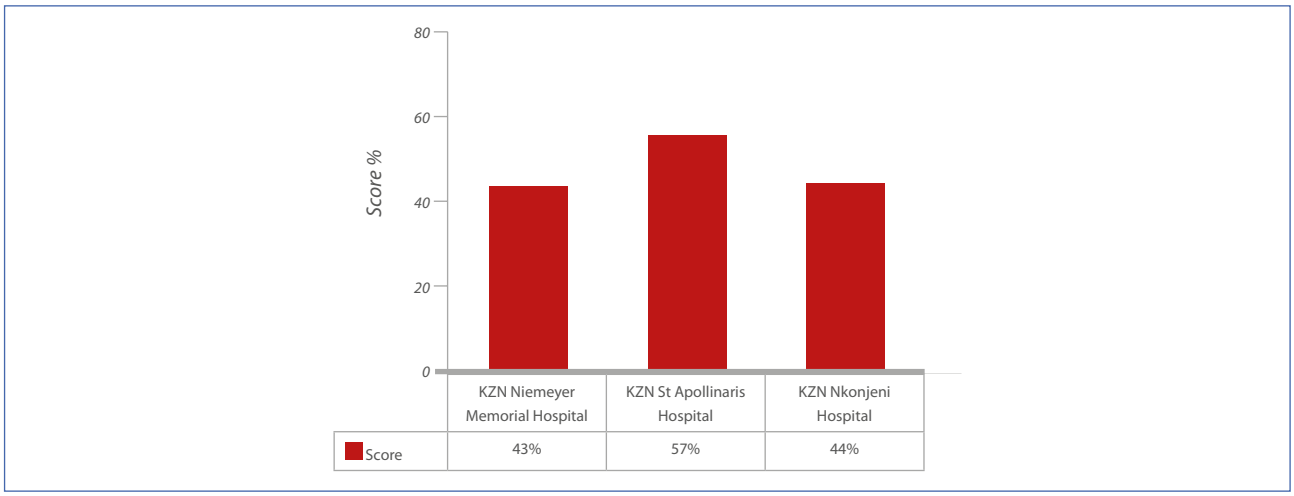
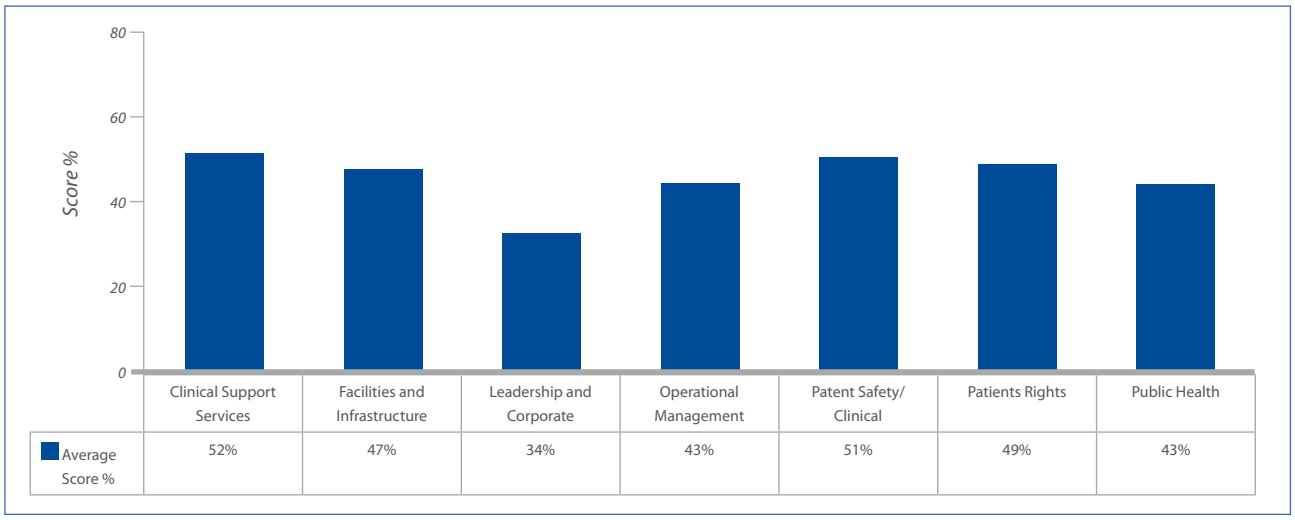


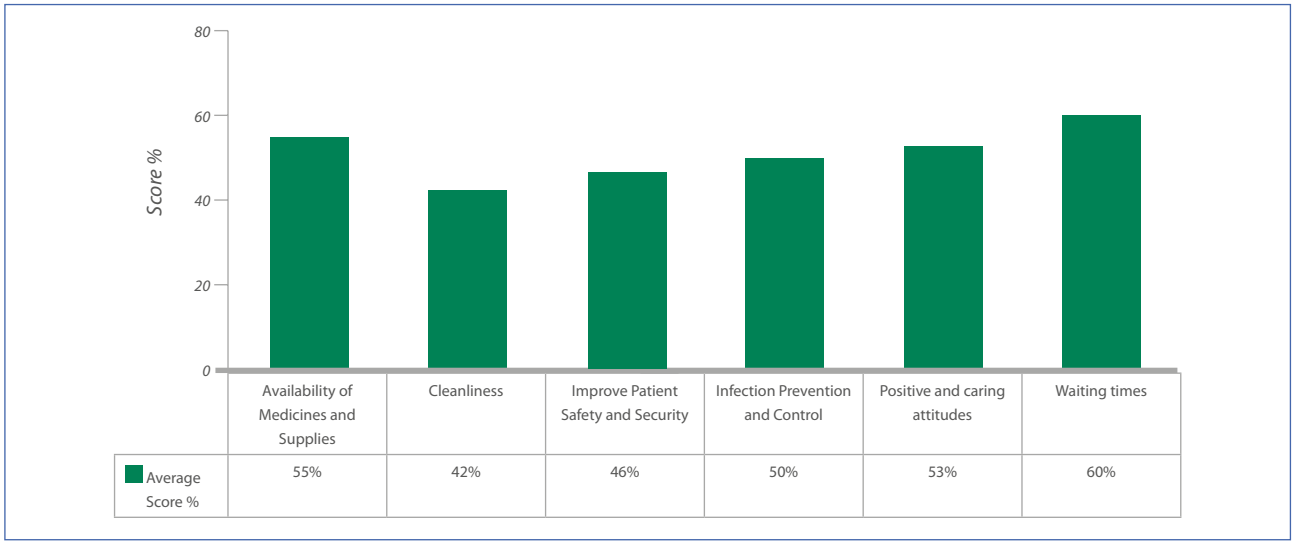
Figure 67: 2015/16 Domain scores for District Hospitals in Mpumalanga



The above figure demonstrates that on average the hospitals in Mpumalanga Province are not performing above the 50% threshold in all Domains except in Clinical Support Services and Patient Safety/Clinical Care. Facilities & Infrastructure, Leadership & Corporate Governance, Operational Management, Patients' Rights and Public Health performed between 34%-47%. Leadership & Corporate Governance performed far below all domains at 34%.

6.7.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 68: 2015/16 Priority Area scores for District Hospitals in Mpumalanga



The above figure demonstrates that on average the hospitals in Mpumalanga Province are performing above the 50% threshold in all Priority Areas except Cleanliness and Improve Patient Safety & Security. Availability of Medicines, Infection Prevention & Control, Positive & caring Attitudes and Waiting Times performed between 50%-60%. Cleanliness performed below all Priority Areas at 42%.

6.8 North West Hospitals

6.8.1 Average Inspected Hospitals by Domain Outcome

Figure 69: North West District Hospitals Performance Scores

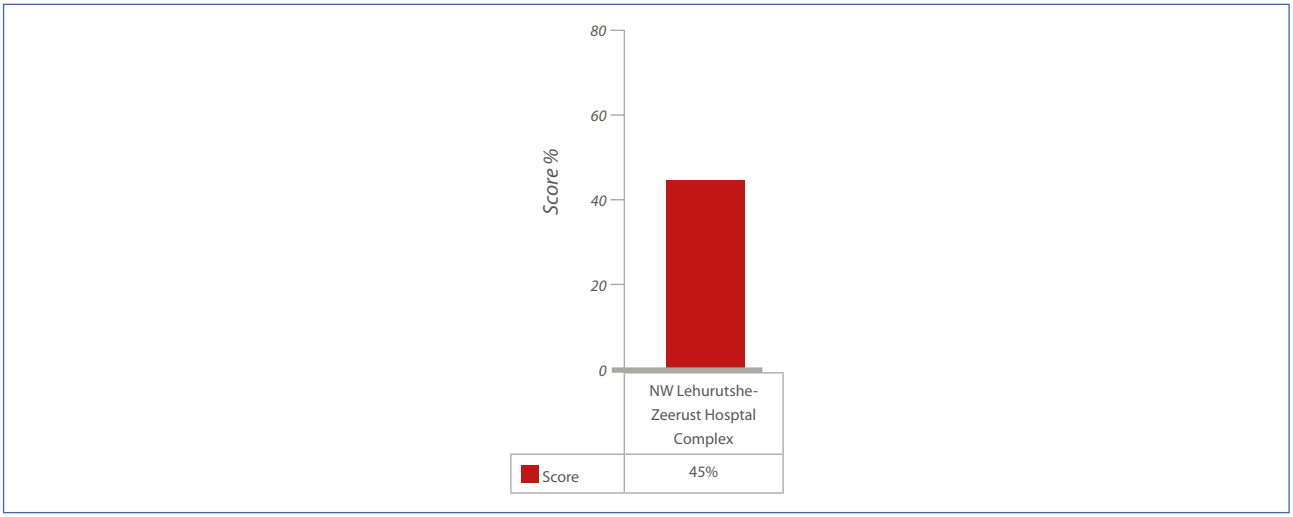
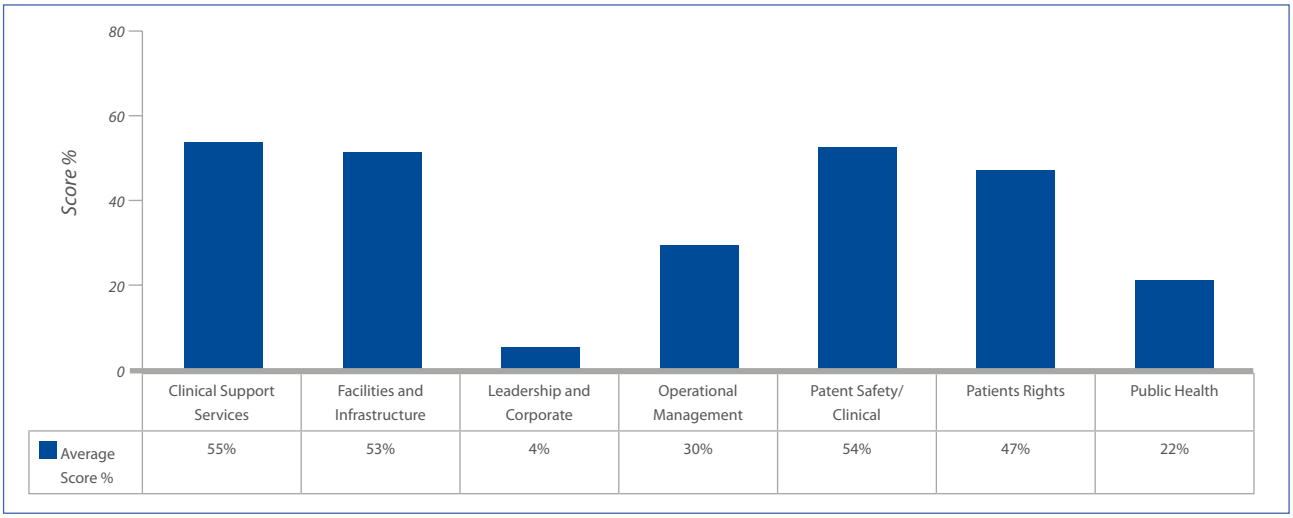


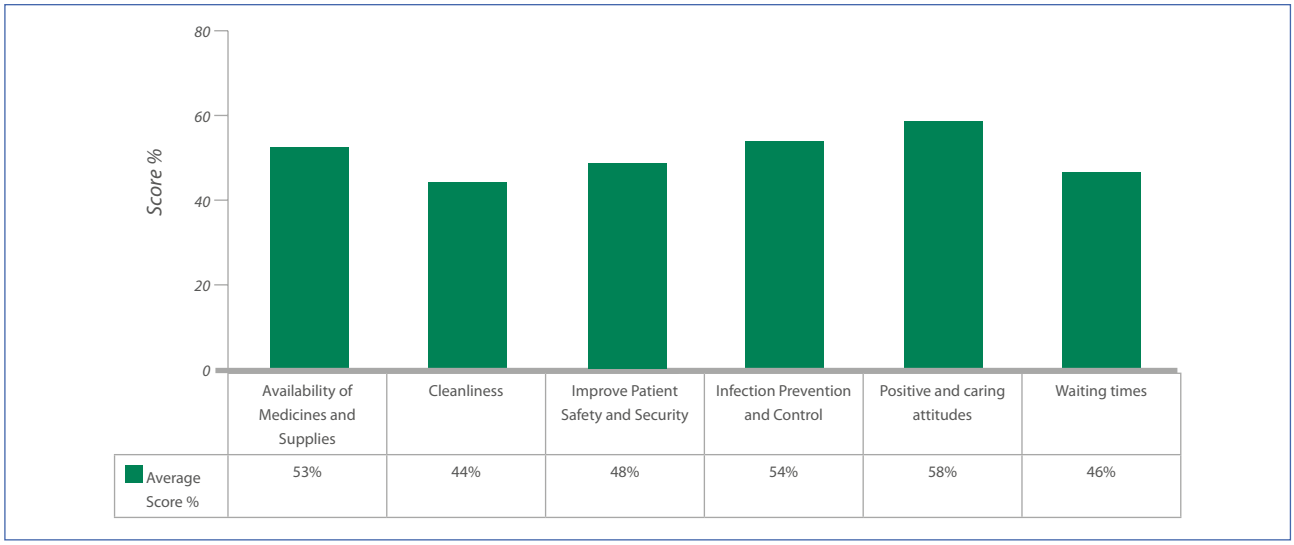
Figure 70: 2015/16 Domain scores for District Hospitals in North West



The above figure demonstrates that on average the hospitals in North West Province are not performing above the 50% threshold in all Domains except in Clinical Support Services, Facilities & Infrastructure and Patient Safety/Clinical Care. Leadership & Corporate Governance, Operational Management, Patients' Rights and Public Health performed between 4%-47%. Leadership & Corporate Governance performed far below all domains at 4%.

6.8.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 71: 2015/16 Priority Area scores for District Hospitals in North West



The above figure demonstrates that on average the hospitals in Mpumalanga Province are performing above the 50% threshold in three (3) Priority Areas except Cleanliness and Improve Patient Safety & Security and Waiting Times. Availability of Medicines, Infection Prevention & Control Positive & caring Attitudes performed between 53%-58% whereas Improve Patient Safety & Security and Waiting Times performed between 44%-48%. Cleanliness performed below all Priority Areas at 44%.

6.9 Northern Cape Hospitals

6.9.1 Average Inspected Hospitals by Domain Outcome

Figure 72: Northern Cape District Hospitals Performance Scores

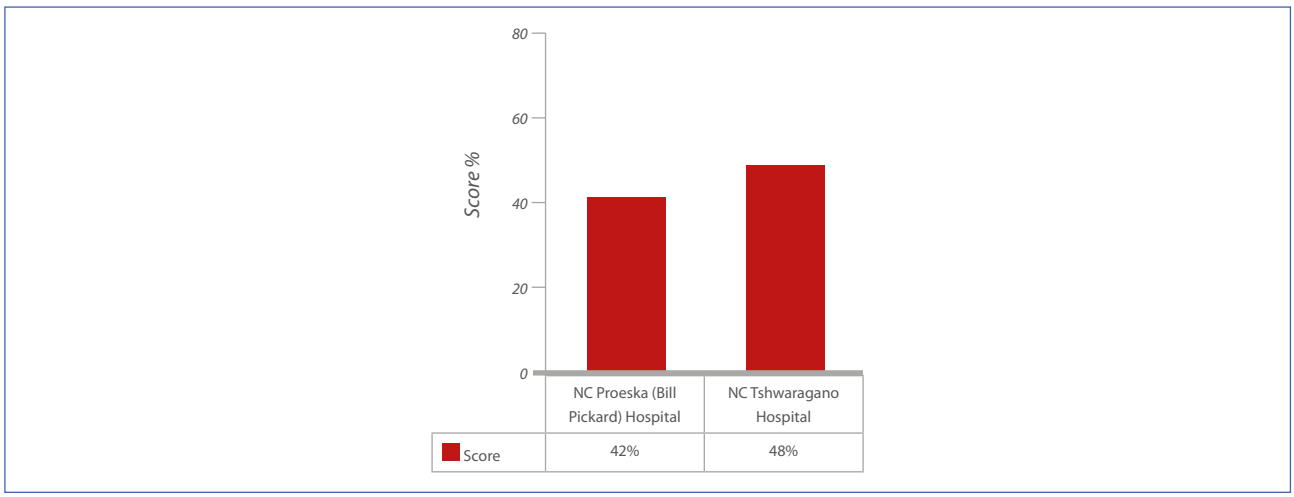
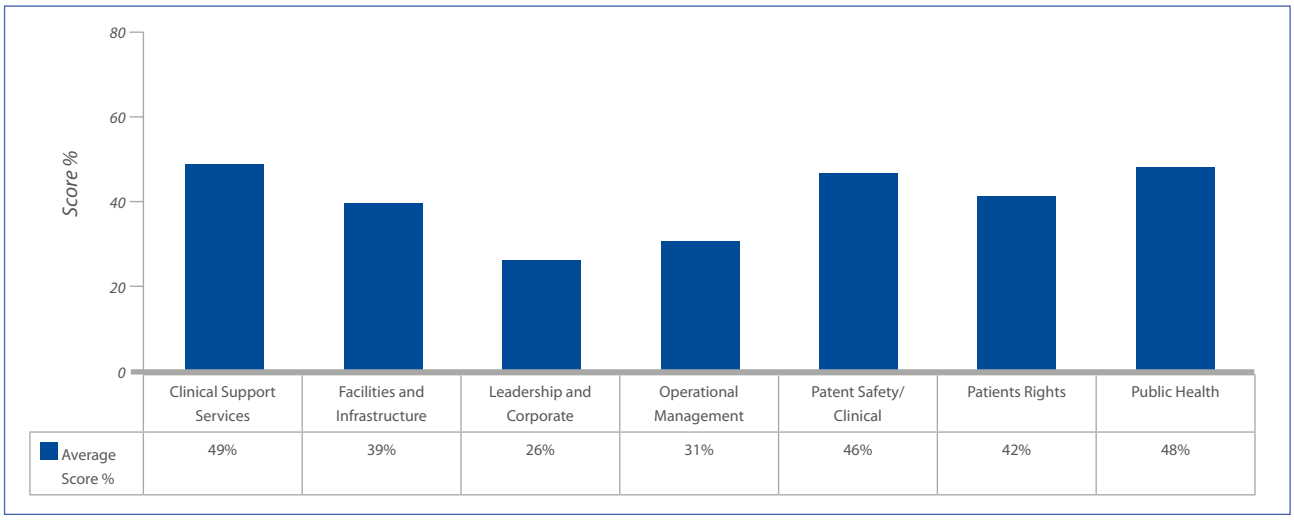


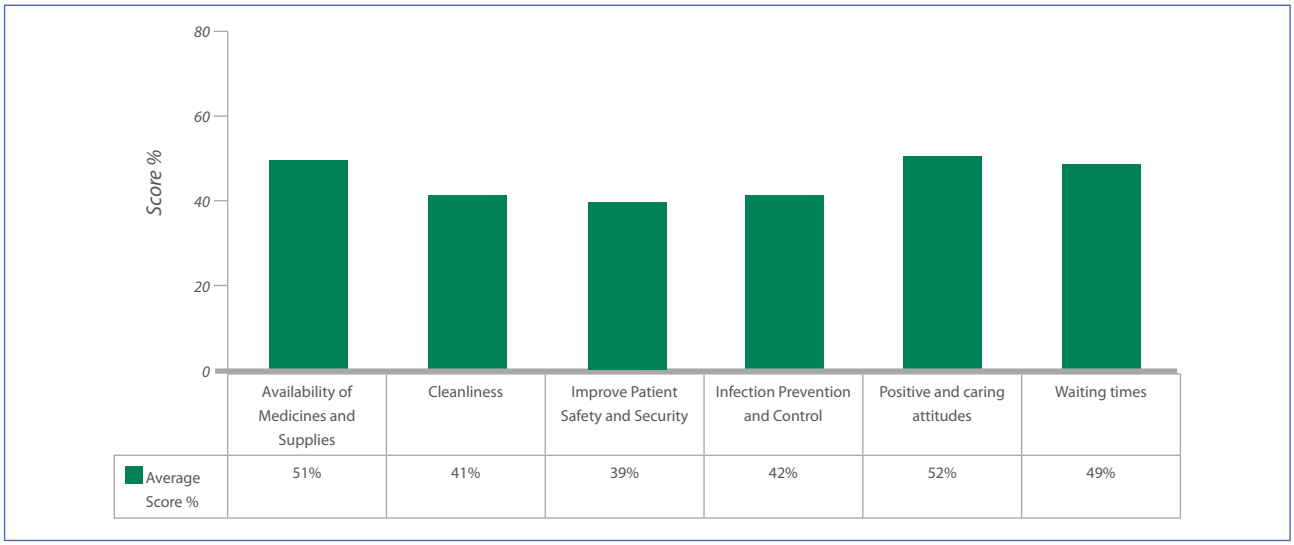
Figure 73: 2015/16 Domain scores for District Hospitals in Northern Cape



The above figure demonstrates that on average the hospitals in Northern Cape Province are not performing above the 50% threshold in all Domains. All domains have performed between 26%-49%. Leadership & Corporate Governance performed far below all domains at 26%.

6.9.2 Average Inspected Hospitals by Priority Areas Outcome

Figure 74: 2015/16 Priority Area scores for District Hospitals in Northern Cape



The above figure demonstrates that on average the hospitals in Northern Cape Province are not performing above the 50% threshold in all Priority Areas except Availability of Medicines and Positive & caring Attitudes. Cleanliness, Improve Patient Safety & Security, Infection Prevention & Control and Waiting Times performed between 39%-49%. Improve Patient Safety & Security performed below all Priority Areas at 39%.

6.10 Western Cape Hospitals

6.10.1 Average Inspected Hospitals by Domain Outcome

Figure 75: Western Cape District Hospitals Performance Scores

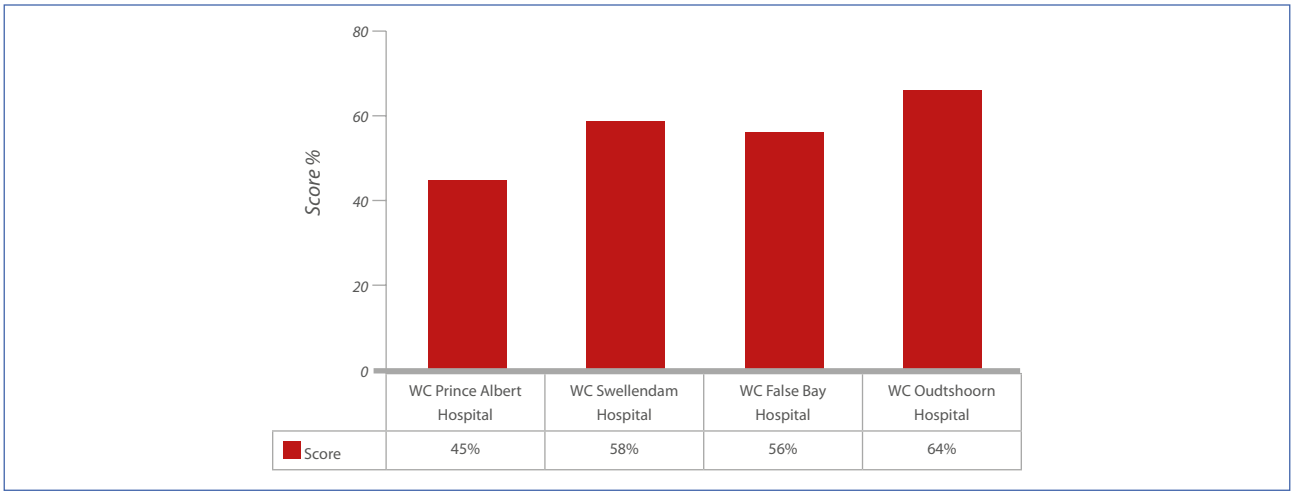
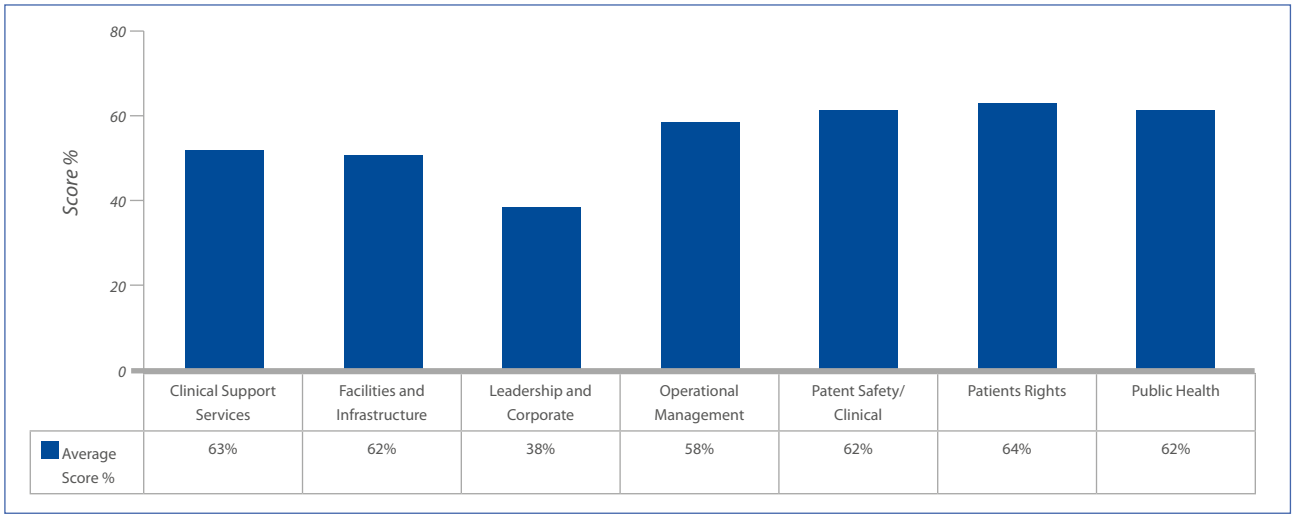


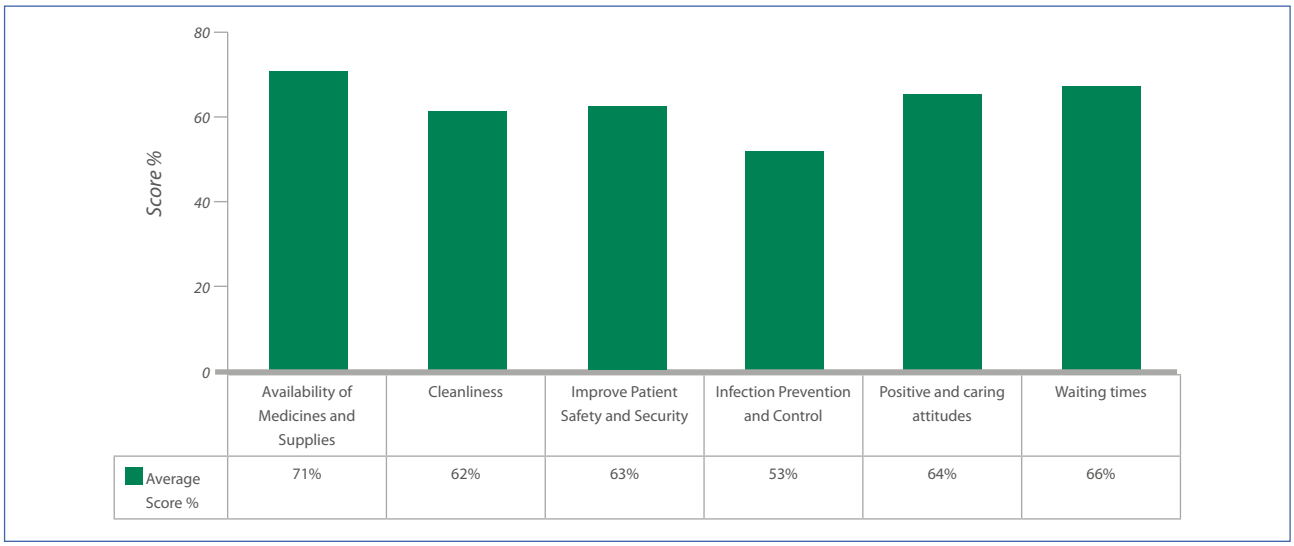
Figure 76: 2015/16 Domain scores for District Hospitals in Western Cape



The above figure demonstrates that on average the hospitals in Western Cape Province are performing above the 50% threshold in all Domains except in Leadership & Corporate Governance. Clinical Support Services, Facilities & Infrastructure, Operational Management, Patient Safety/Clinical Care, Patients' Rights and Public Health performed between 58%-64%. Leadership & Corporate Governance performed far below all domains at 38%.

6.10.2 Average Inspected Hospitals by Priority Areas Outcome

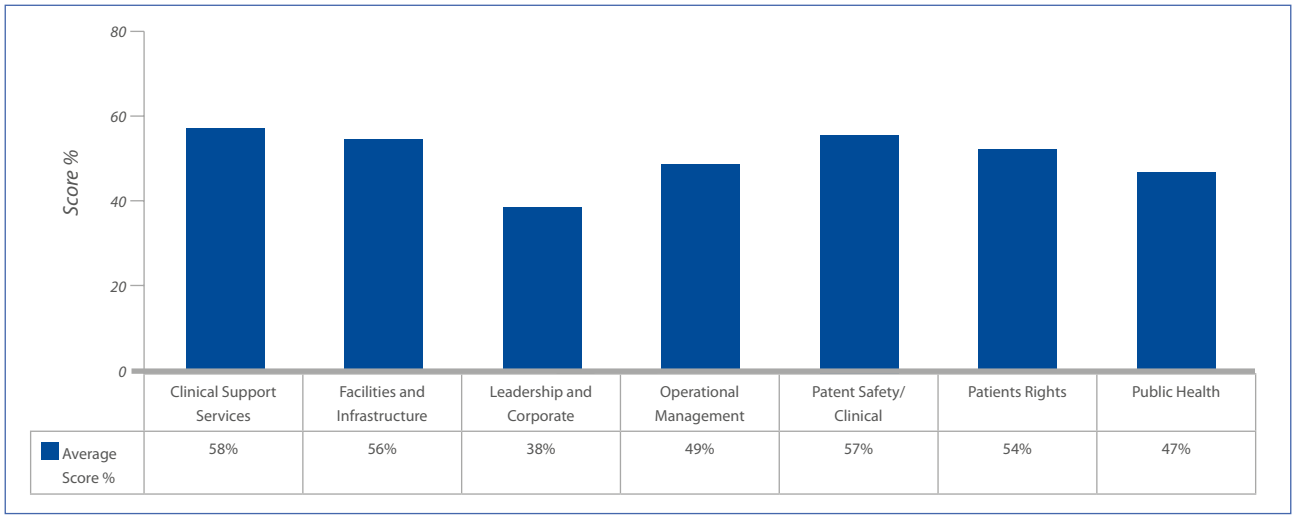
Figure 77: 2015/16 Priority Area scores for District Hospitals in Western Cape



The above figure demonstrates that on average the hospitals in Western Cape Province are not performing above the 50% threshold in all Priority. All Priority Areas in Western Cape performed between 53%-71%. Infection Prevention & Control performed below all Priority Areas at 53%.

6.11 Overall Performance of District Hospitals Inspected (2015/16) by Domain

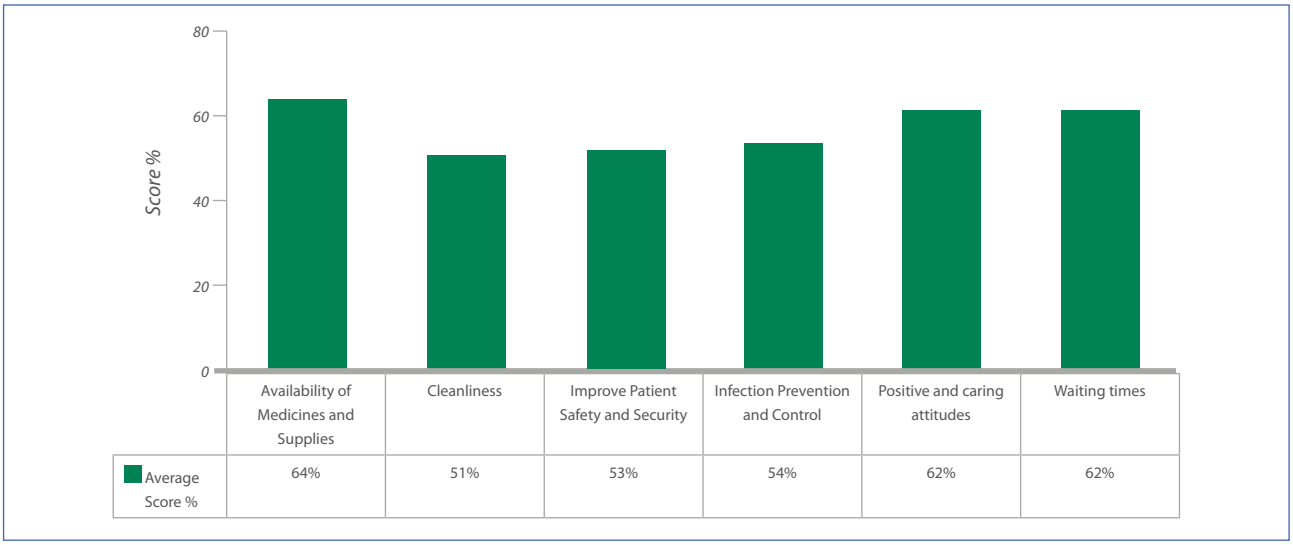
Figure 78: 2015/16 Domain scores for District Hospitals in South Africa



The above figure demonstrates that on average the inspected District hospitals during 2015/16 financial year are not performing above the 50% threshold in 4 Domains ranging between 54%-58%. Whereas other 2 domains performed between 38%-49%. As reflected in majority of provinces Leadership & Corporate Governance domains was the least performing domain and followed by Operational Management.

6.11.1 Overall Performance of District Hospitals Inspected (2015/16) by Priority Areas

Figure 79: 2015/16 Priority Area scores for District Hospitals in South Africa



The above figure demonstrates that on average the inspected District hospitals during 2015/16 financial year are performing above the 50% threshold in all Priority Areas ranging between 51%-64%. As reflected in majority of provinces Cleanliness was the least performing Priority Area followed by Improve Patient Safety & Security.

INSPECTION RESULTS: CLINICS COMMUNITY HEALTHCARE CENTRES AND PRIMARY HEALTHCARE CENTRES

Inspections Overview

Table 81: Primary Health Care Centres Inspections conducted per province

	Clinics	CHC/CDC	District Hospitals	Regional Hospital	Provincial Tertiary	Central Hospital	Total
Eastern Cape	l00	0	5	2	1	1	109
Free State	53	1	2	2	1	0	59
Gauteng	49	2	2	4	3	2	62
KwaZulu-Natal	90	0	4	0	1	1	96
Limpopo	59	0	3	1	2	NA	62
Mpumalanga	57	1	3	0	1	NA	65
North-West	52	1	1	0	0	NA	54
Northern Cape	42	2	3	0	1	NA	48
Western Cape	65	2	4	0	1	0	72
Total	**567**	**9**	**27**	**9**	**11**	**4**	**627**

Table 76 above shows that the OHSC inspected a total of five hundred and sixty-seven (567) primary healthcare clinics (PHC`s) and nine (9) community health centres (CHC`s) in the 2015/2016 financial year. The number of PHC`s and CHC`s inspected in each province is as follows respectively, Eastern Cape: 100 PHC`s, Free-State: 51 PHC`s and 1 CHC, Gauteng: 49 PHC`s and 2 CHC`s, Kwa-Zulu Natal: 91 PHC`s, Limpopo: 59 PHC`s, Mpumalanga: 57 PHC`s, North-West: 52 PHC`s and 1 CHC, Northern Cape: 42 PHC`s and 2 CHC`s, and Western Cape: 65 PHC`s and 2 CHC`s.

Figure above also illustrates that clinic inspections is the highest in number, as clinics constitutes eighty percent (80%) of public health establishments in South Africa. Therefore, the number of clinics inspected in all provinces are the most as compared to hospitals and community health centres.

Overall Clinics Outcomes by Province

7.1 Eastern Cape Clinics

7.1.1 Performance Comparison by Overall Score

Figure 80: Eastern Cape Clinics

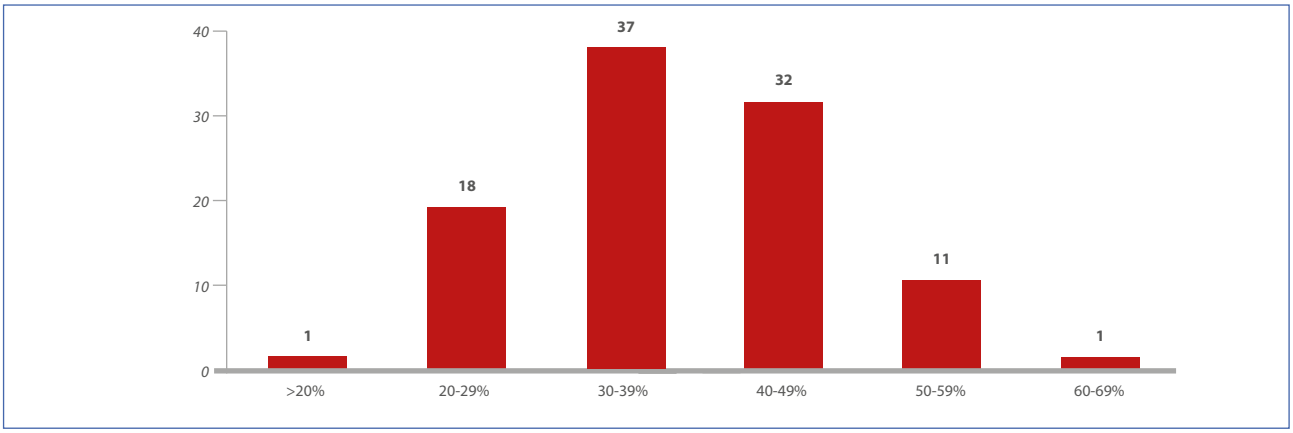


Figure 81 reflects that out of the one hundred (100) primary healthcare clinics (PHC) inspected, 37 attained a compliance score of between 30-39%, whilst 32 attained the score of between 40-49%. 18 clinics attained a score of between 20-29%. Only 11 of the clinics attained compliance scores of between 50-59%. Whereas only one clinic attained a score of between 60-69% another one attained the lowest compliance score of below 20%. It is clear that majority of the clinics in the Eastern Cape are not performing well. Only 12% of the clinics are performing at 50% or above.

7.1.2 Average Inspected Clinics by Domain Outcome

Figure 81: 2015/16 Domain scores for Clinics in Eastern Cape

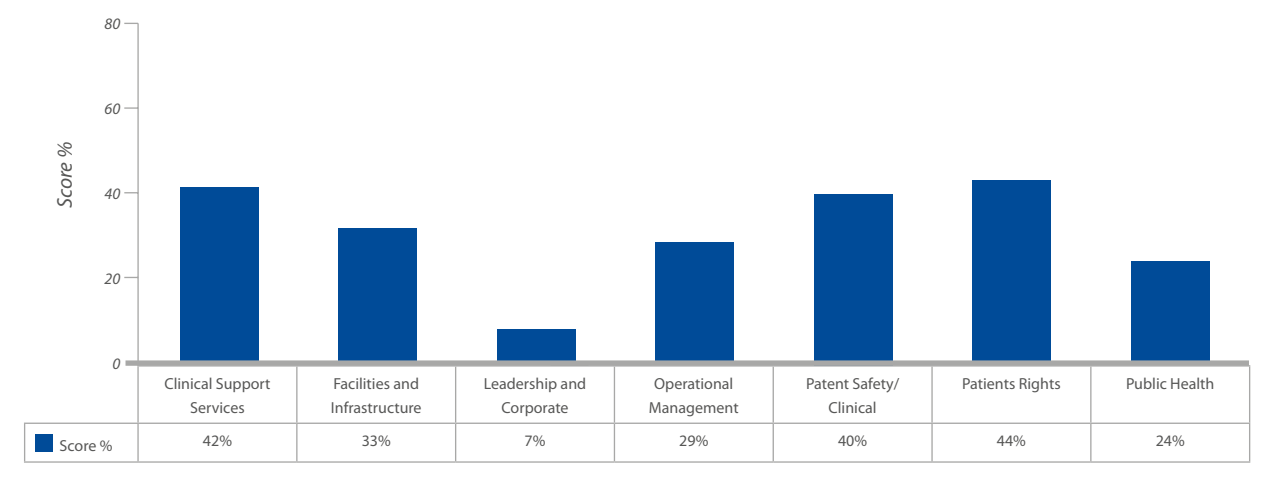
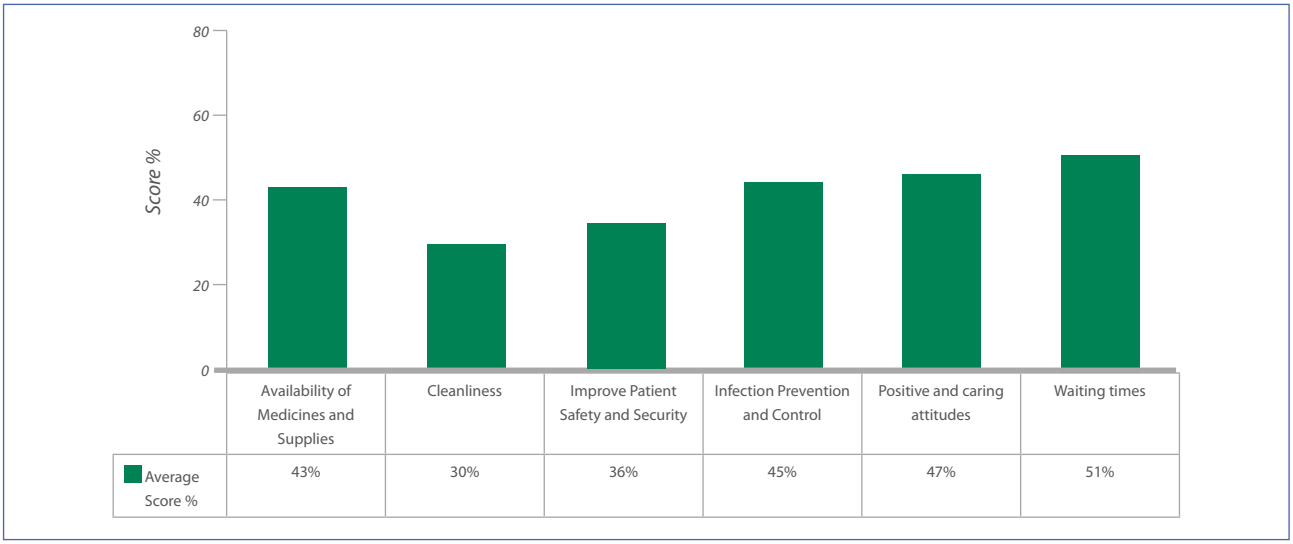


Figure 82 demonstrates that on average the primary health establishments in Eastern Cape Province are not performing above 50% in all Domains. Leadership and Corporate Governance, Public Health and Operational Management performed below 30%. Leadership and Corporate Governance performed far below all domains at 7%.

7.1.3 Average Inspected Clinics by Priority Areas Outcome

Figure 82: 2015/16 Priority Area scores for District Hospitals in Eastern Cape



The above figure demonstrates that on average the primary health establishments in Eastern Cape Province are not performing above 50% in five Priority Area except Waiting Times which is at 51%. Cleanliness, Improved Patient Safety and Security performed between 30-37%. Cleanliness performed below all Priority Areas at 30%.

7.2 Free State Clinics

7.2.1 Performance Comparison by Overall Score

Figure 83: Free-State Clinics

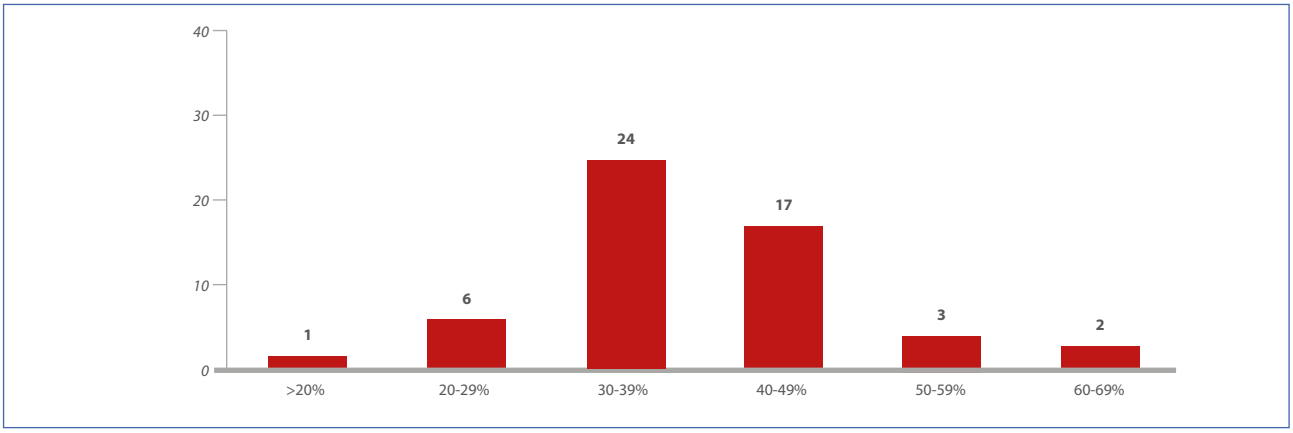
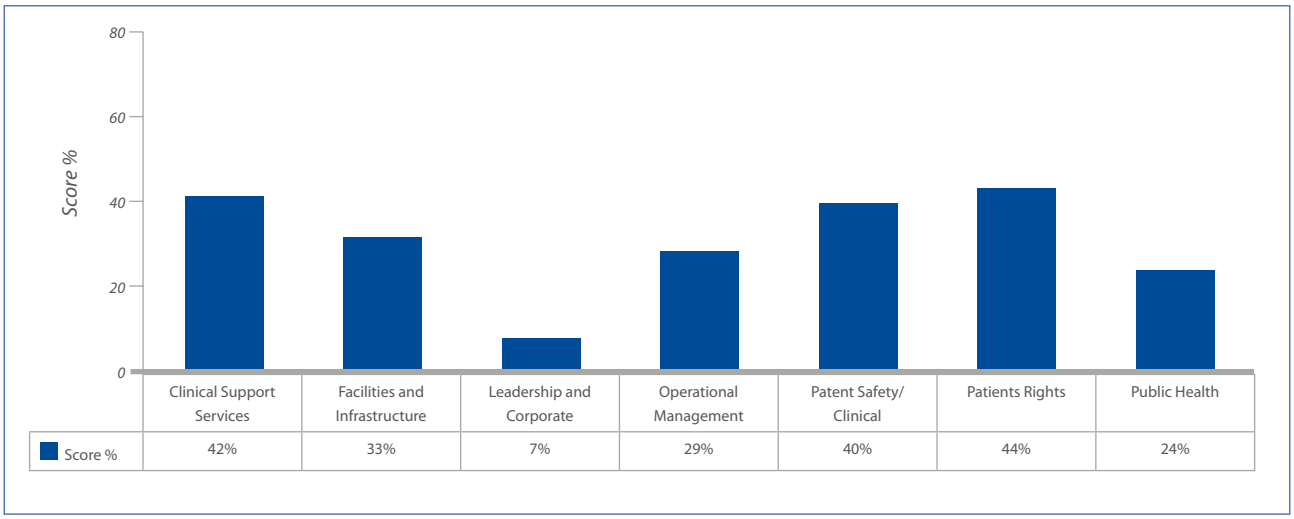


Figure 84 reflects that in Free-State Province, twenty-four of the clinics attained between 30-39% compliance score. Whilst seventeen of them attained between 40-49%. Only three of them managed to achieve a score of between 50-59%. Out of the total of 53, only two managed a score of between 60-69%, and with one clinic achieving below 20%. The serious cause for concern in the Free-State is that only five clinics managed to score between 50-69%.

7.2.2 Average Inspected Clinics by Domain Outcome

Figure 84: 2015/16 Domain scores for Clinics in Free State

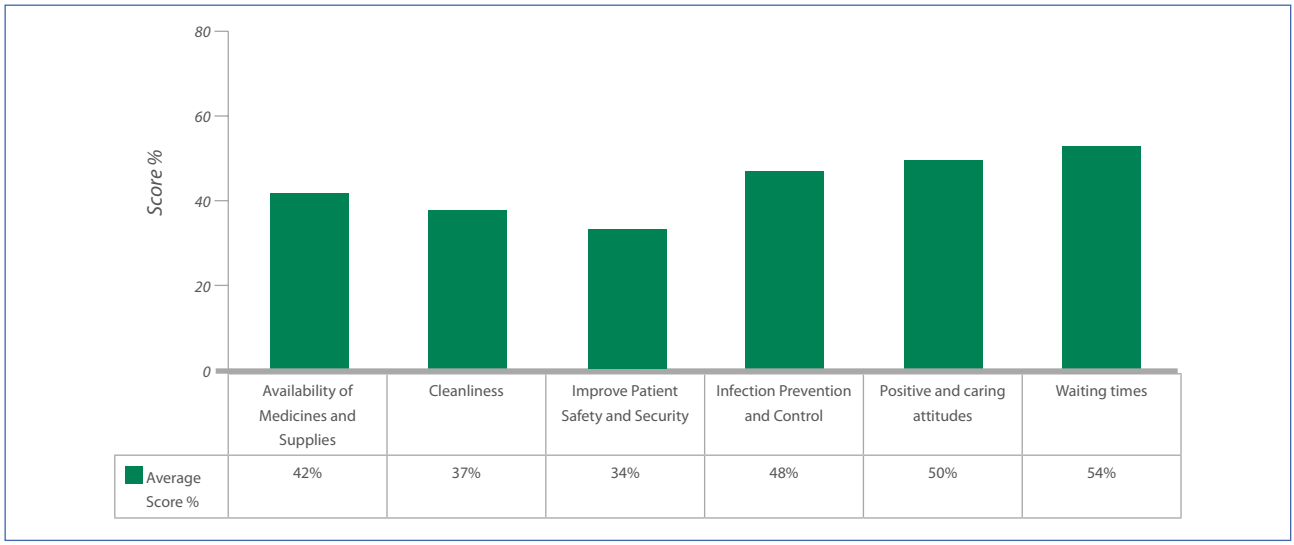


	Clinical Support Services	Facilities and Infrastructure	Leadership and Corporate	Operational Management	Patent Safety/ Clinical	Patients Rights	Public Health
Score %	42%	33%	7%	29%	40%	44%	24%

The above figure demonstrates that on average the primary health establishments in Free State Province are not performing above 50% in all Domains. Leadership and Corporate Governance, Public Health and Operational Management performed below 40%. Leadership and Corporate Governance performed far below all domains at 8%.

7.2.3 Average Inspected Clinics by Priority Areas Outcome

Figure 85: 2015/16 Priority Area scores for District Hospitals in Free State



	Availability of Medicines and Supplies	Cleanliness	Improve Patient Safety and Security	Infection Prevention and Control	Positive and caring attitudes	Waiting times
Average Score %	42%	37%	34%	48%	50%	54%

Figure 86 demonstrates that on average the primary health establishments in Free State Province are not performing above 50% in four Priority Area except Positive and Caring Attitude and Waiting Times which performed above 50%. Cleanliness and Improved Patient Safety and Security performed between 34-37%. Improve Patient Safety and Security performed below all other Priority Areas at 34%.

7.3 Gauteng Clinics

7.3.1 Performance Comparison by Overall Score

Figure 86: Gauteng Clinics

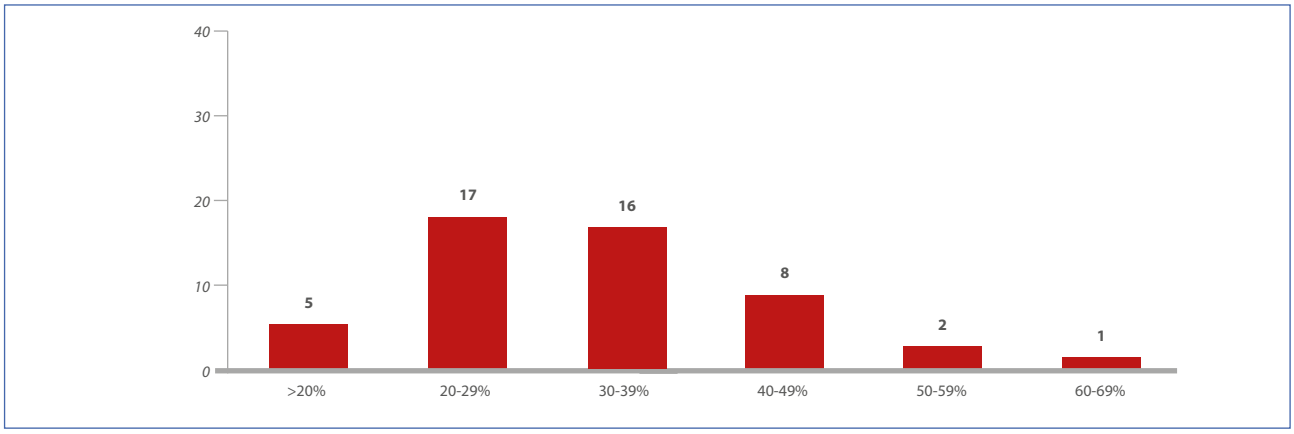


Figure 87 above reflects that 49 clinics were inspected in Gauteng in the financial year under review. Of those, only one attained a score of between 80-100%, whereas seventeen attained between 40-49%. Only sixteen of the clinics in Gauteng managed to achieve a score of between 50-59%. Eight clinics scored between 60-69%, Five clinics between 30-39% and only two managed a score of between 70-79%.

7.3.2 Average Inspected Clinics by Domain Outcome

Figure 87: 2015/16 Domain scores for Clinics in Gauteng

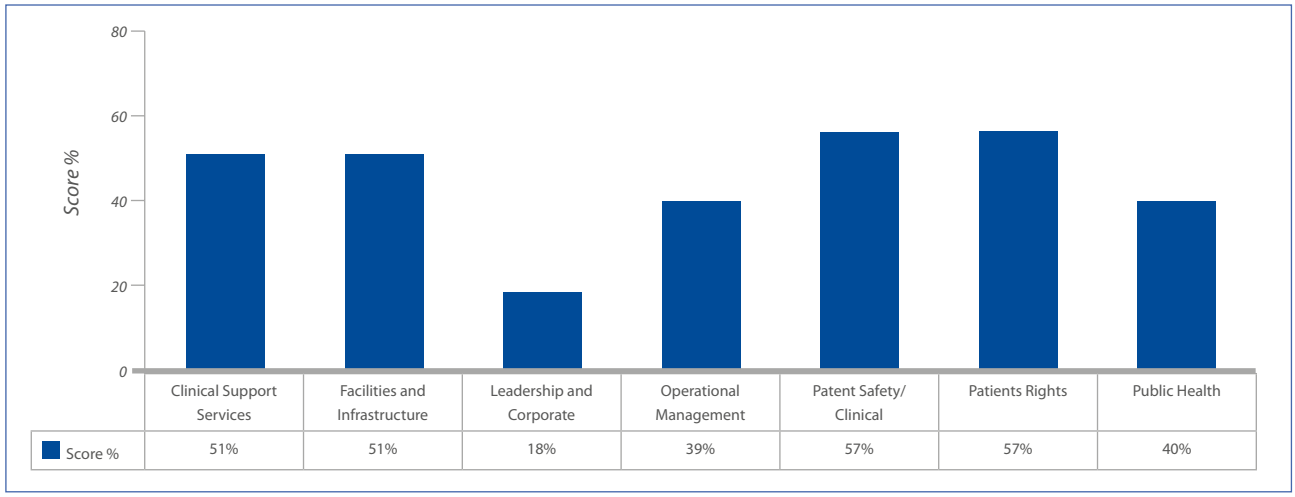
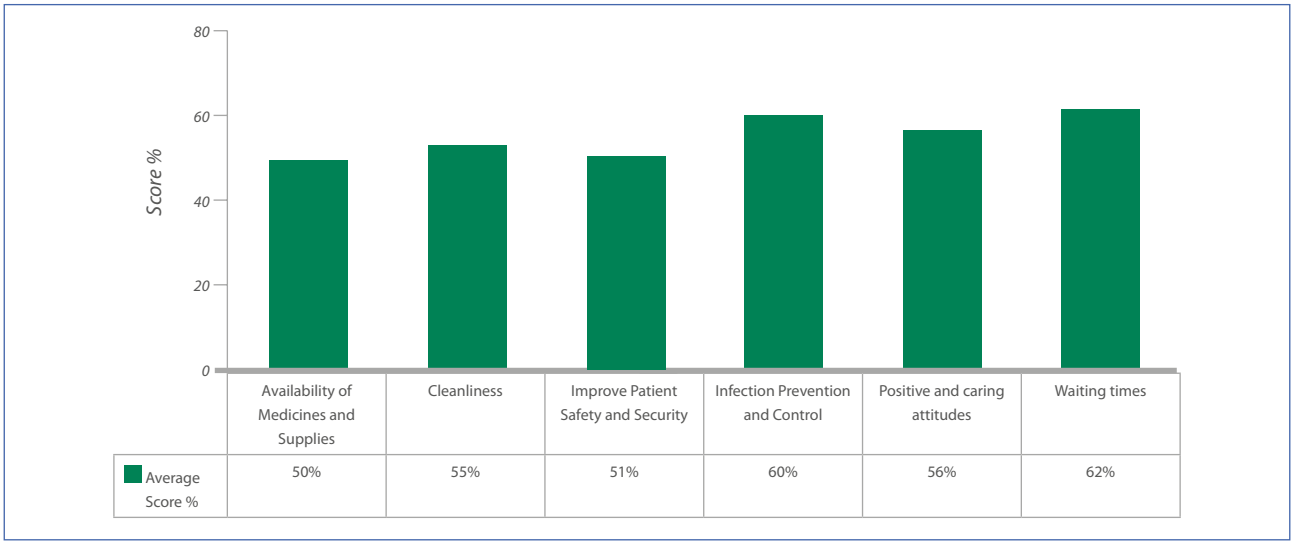


Figure 74 demonstrates that on average the primary health establishments in Gauteng Province have performed above 50% in four Domains except Leadership and Corporate Governance, Public Health and Operational Management performed between 10-40%. Leadership and Corporate Governance performed far below all domains at 18%.

7.3.3 Average Inspected Clinics by Priority Areas Outcome

Figure 88: 2015/16 Priority Area scores for District Hospitals in Gauteng



The above figure demonstrates that on average the primary health establishments in Gauteng Province are performing above 50% in all Priority Area. Infection prevention and control and Waiting Times performed between 60-62%. Availability of Medicines and Supplies performed below all Priority Areas at 50%.

7.4 KwaZulu-Natal Clinics

7.4.1 Performance Comparison by Overall Score

Figure 89: KwaZulu-Natal Clinics

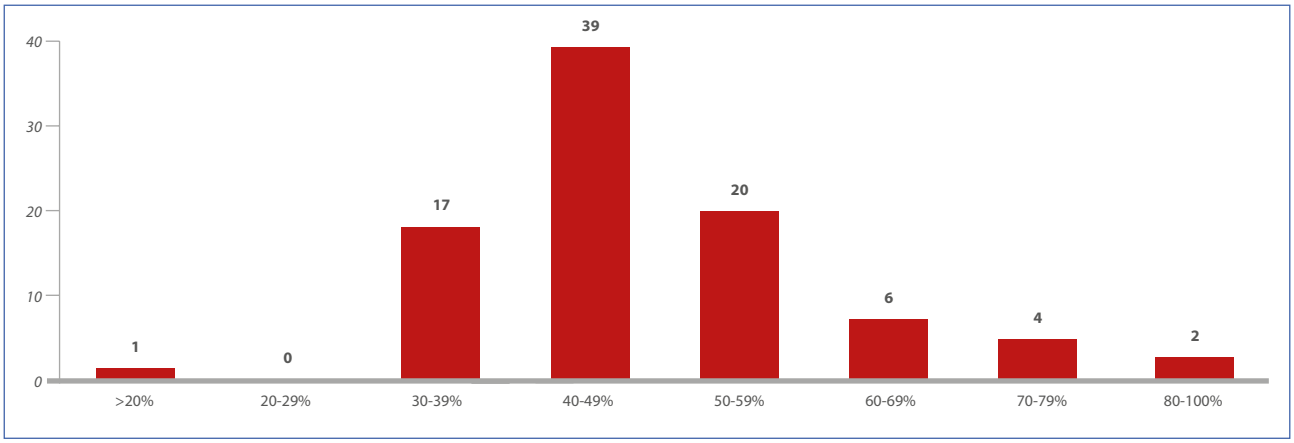
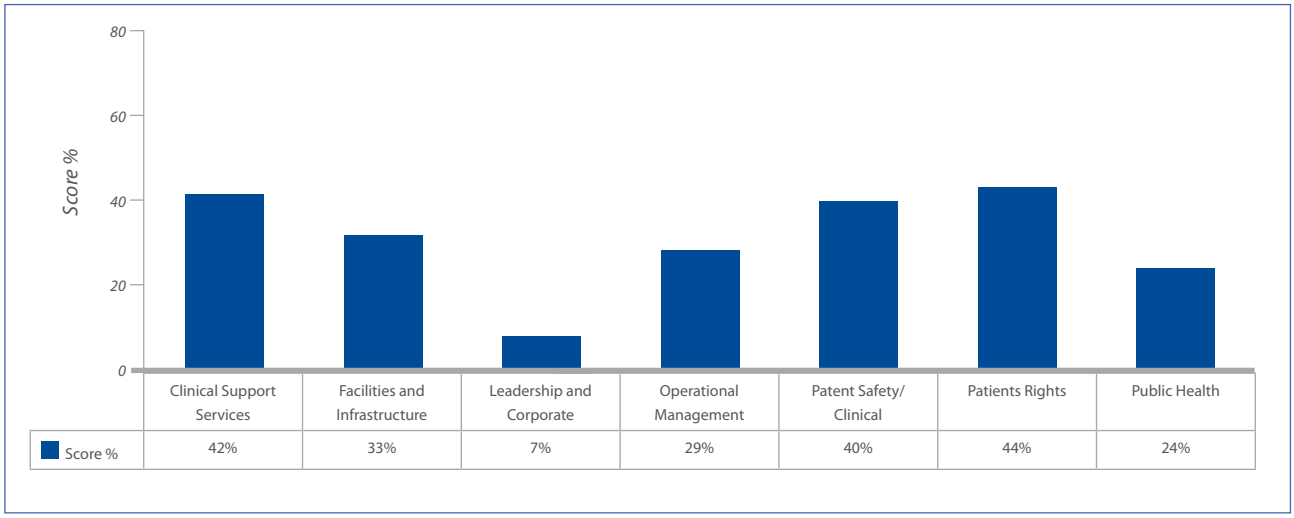


Figure 91 reflects 89 primary healthcare clinics were inspected in Kwa-Zulu Natal and only two of them attained compliance score of between 80-100%. Four attained between 70-79%. Six clinics attained between 60-69%. Seventeen clinics achieved a score of between 30-39% compliance. Twenty clinics got between 50-59%. Thirty-nine clinics achieved below 50% in a range of between 40 to 50%. One clinic performed extremely worse with a compliance score of below 20%.

7.4.2 Average Inspected Clinics by Domain Outcome

Figure 90: 2015/16 Domain scores for Clinics in KwaZulu-Natal

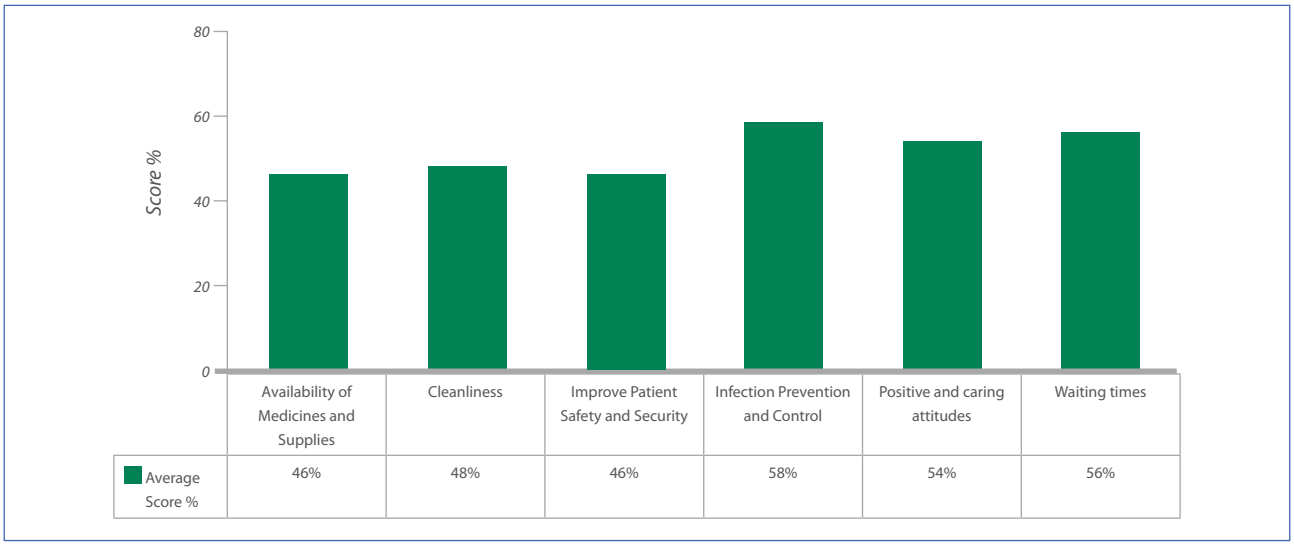


	Clinical Support Services	Facilities and Infrastructure	Leadership and Corporate	Operational Management	Patent Safety/ Clinical	Patients Rights	Public Health
Score %	42%	33%	7%	29%	40%	44%	24%

The above figure demonstrates that on average the primary health establishments in Kwa-Zulu Natal Province have performed above 40% in four Domains except Leadership and Corporate Governance, Public Health and Operational Management performed between 10-39% threshold. Leadership and Corporate Governance performed far below all domains at 19%.

7.4.3 Average Inspected Clinics by Priority Areas Outcome

Figure 91: 2015/16 Priority Area scores for District Hospitals in KwaZulu-Natal



	Availability of Medicines and Supplies	Cleanliness	Improve Patient Safety and Security	Infection Prevention and Control	Positive and caring attitudes	Waiting times
Average Score %	46%	48%	46%	58%	54%	56%

The above figure demonstrates that on average the primary health establishments in Kwa-Zulu Natal Province are performing above 50% in three Priority Areas. Availability of Medicines and Supplies, Cleanliness and Improved Patient Safety performed between 46-48%. Improve Patient Safety and Security and Availability of Medicines and Supplies performed below all other Priority Areas at 46% respectively.

7.5 Limpopo Clinics

7.5.1 Performance Comparison by Overall Score

Figure 92: Limpopo Clinics

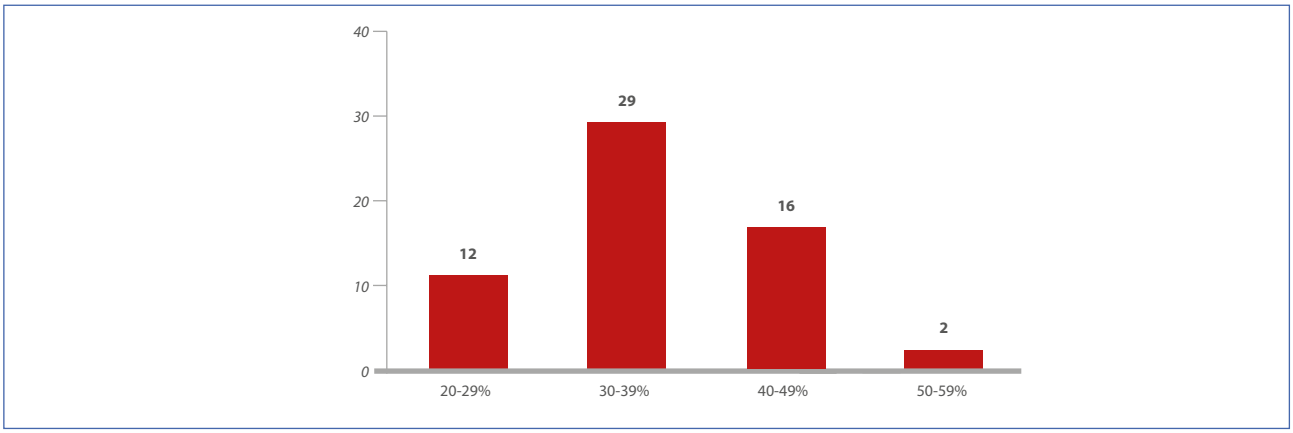


Figure 94 above reflects that 59 clinics were inspected in Limpopo province and twenty of them, which represents a majority, scored between 30-39%. Sixteen clinics achieved scores between 40-49%. Twelve clinics performed at below 30%. Only two clinics achieved scores above 50 but below 60%.

7.5.2 Average Inspected Clinics by Domain Outcome

Figure 93: 2015/16 Domain scores for Clinics in Limpopo

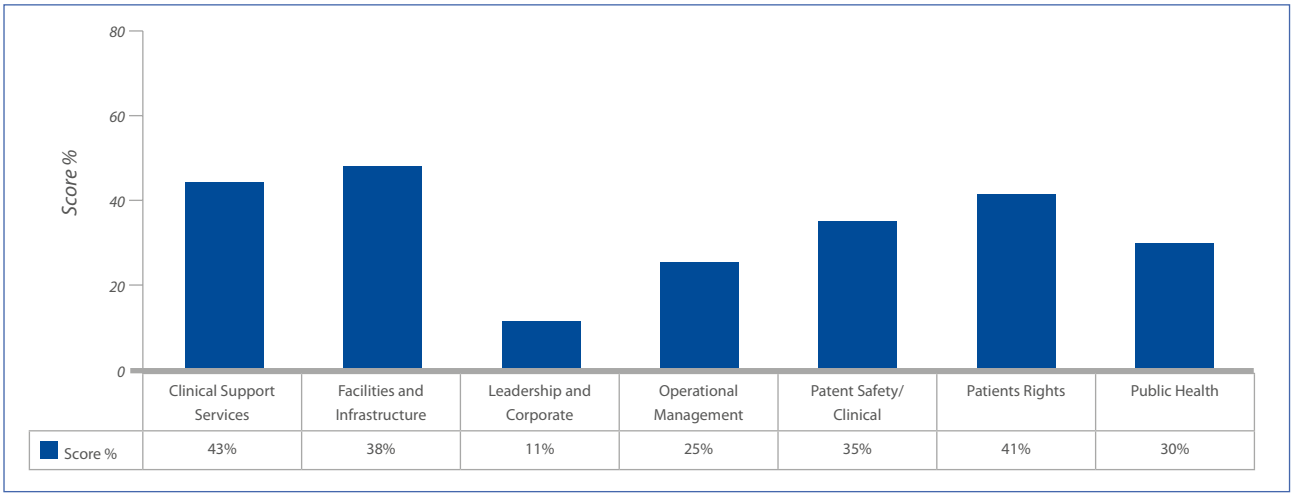
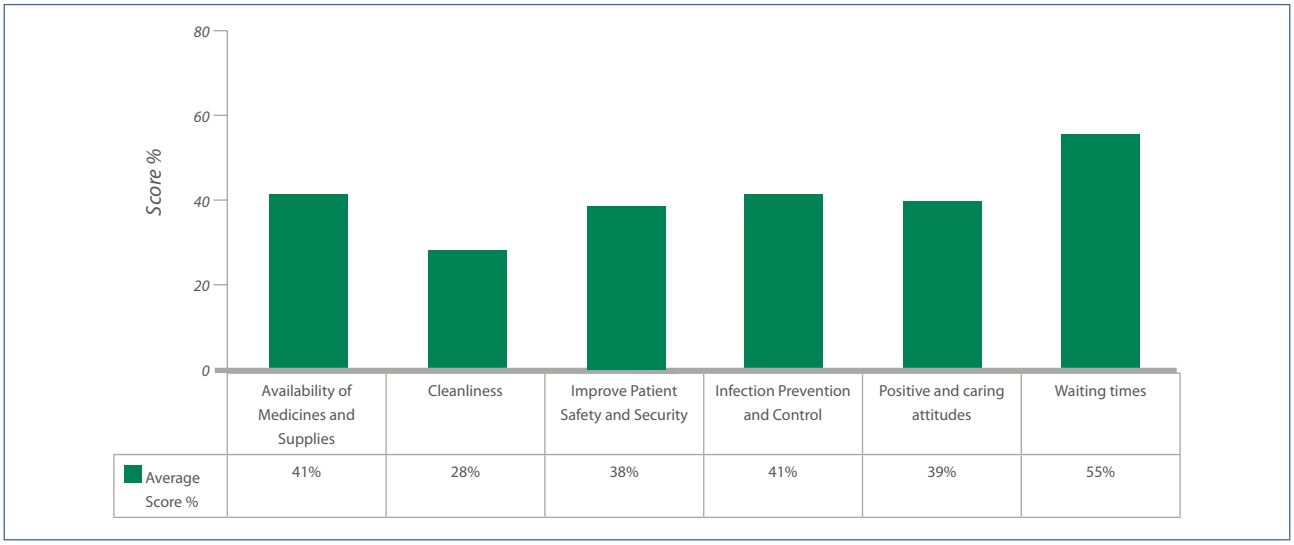


Figure 95 demonstrates that on average the primary health establishments in Limpopo Province are not performing above 45% in all Domains. Leadership and Corporate Governance, Public Health and Operational Management performed between 10-40% threshold. Leadership and Corporate Governance performed far below all domains at 11%.

7.5.3 Average Inspected Clinics by Priority Areas Outcome

Figure 94: 2015/16 Priority Area scores for District Hospitals in Gauteng



The above figure demonstrates that on average the primary health establishments in Limpopo Province are not performing above 50% in five Priority Areas except Waiting Times. Availability of Medicines and Supplies, Cleanliness, Improved Patient Safety and Infection Prevention & Control performed below 50%. Cleanliness performed below all other Priority Areas at 28%.

7.6 Mpumalanga Clinics

7.6.1 Performance Comparison by Overall Score

Figure 95: Mpumalanga Clinics

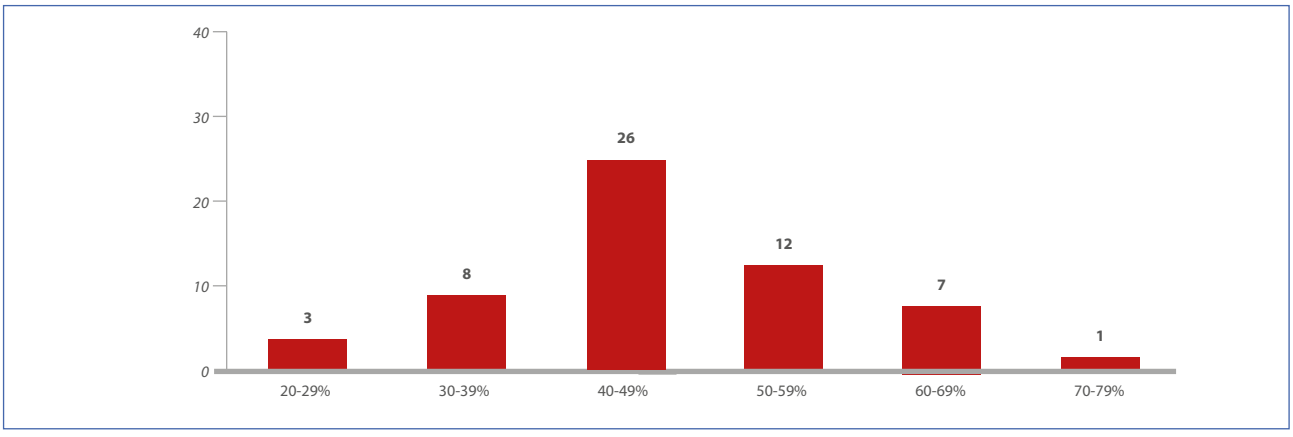
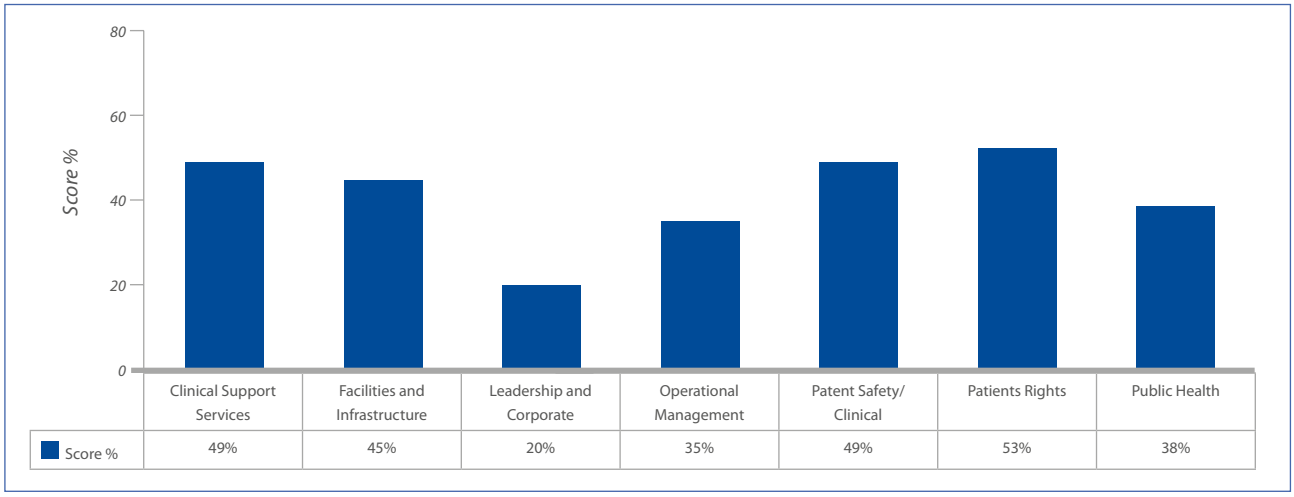


Figure 82 reflects that of the 57 clinics inspected, twenty-six clinics achieved between 40-49%. Twelve clinics attained between 50-59% score. Eight clinics performed scores of between 30-39%. Seven clinics performed between 60-69%. Three clinics performed between 20-29%. One clinic scored between 70-79%.

7.6.2 Average Inspected Clinics by Domain Outcome

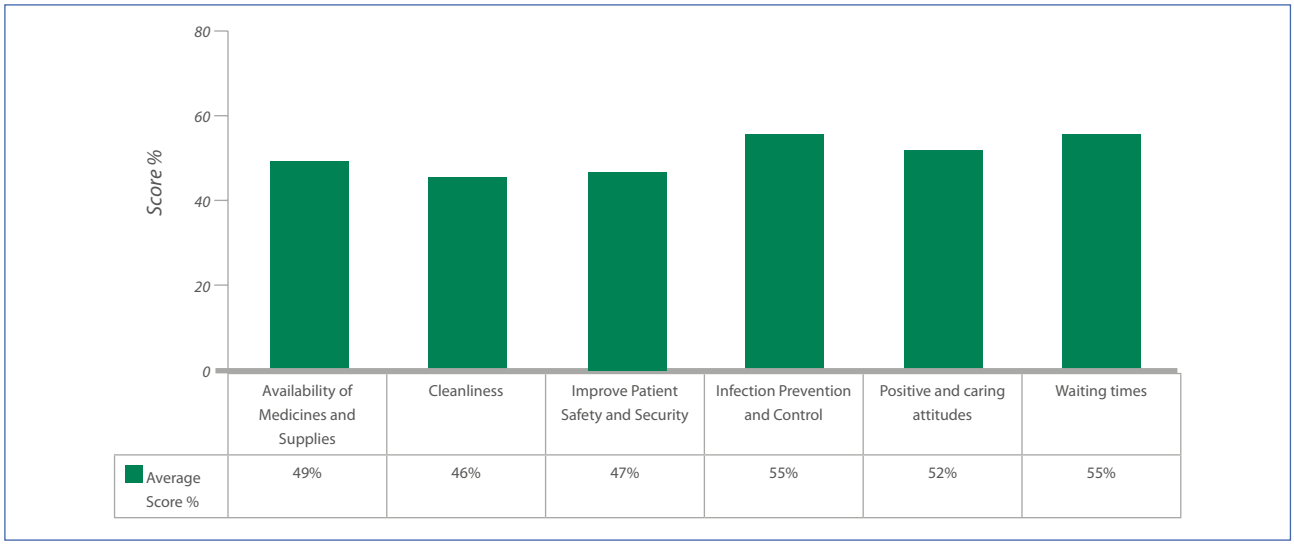
Figure 96: 2015/16 Domain scores for Clinics in Mpumalanga



The above figure demonstrates that on average the primary health establishments in Mpumalanga Province were performing below 50% in 6 Domains except Patient Safety/Clinical Care which was above 50%. Leadership and Corporate Governance, Public Health and Operational Management performed between 20-40%. Leadership and Corporate Governance performed below all domains at 20%.

7.6.3 Average Inspected Clinics by Priority Areas Outcome

Figure 97: 2015/16 Priority Area scores for District Hospitals in Mpumalanga



The above figure demonstrates that on average the primary health establishments in Mpumalanga Province are not performing above 50% in three Priority Areas except Waiting Times, Infection Prevention and Control and Positive and Caring Attitude which performed between 52-55%. Cleanliness performed below all other Priority Areas at 46%.

7.7 North-West Clinics

7.7.1 Performance Comparison by Overall Score

Figure 98: North-West Clinics

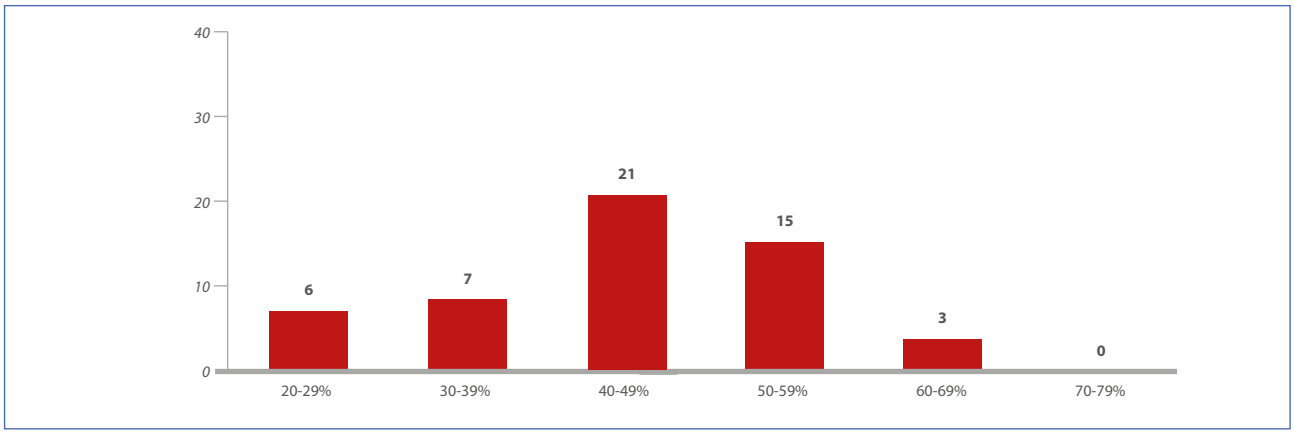
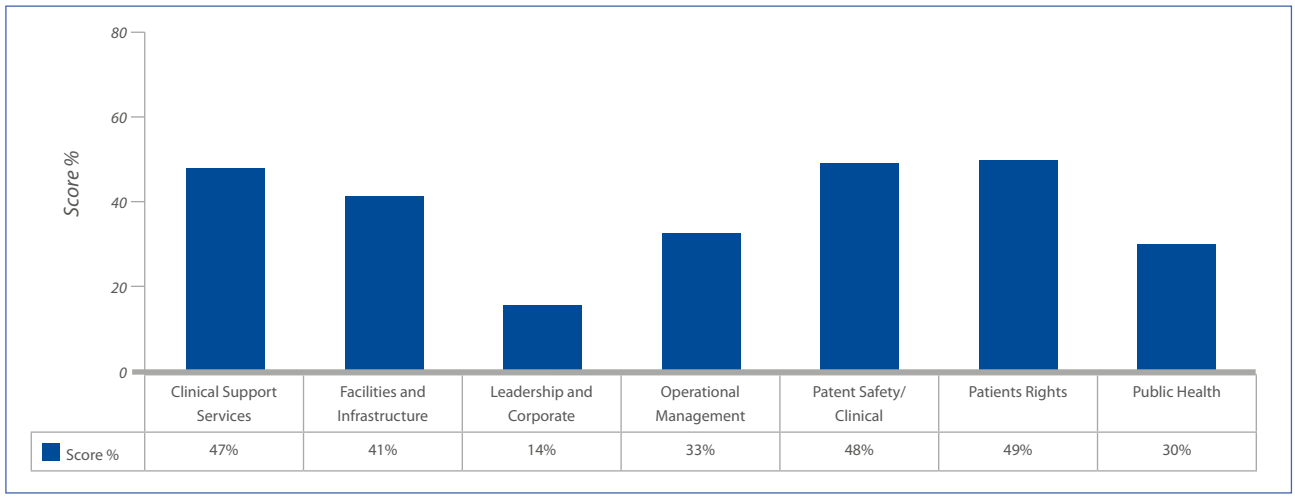


Figure 98 above reflects that only 52 clinics were inspected in the North-West and their compliance score is reflected in the chart as twenty-one clinics having achieved between 40-49%, Fifteen clinics achieved between 50-59%, Seven clinics achieved between 30-39%, Six clinics between 20-29%. The province had only three clinics with scores between 60-69%.

7.7.2 Average Inspected Clinics by Domain Outcome

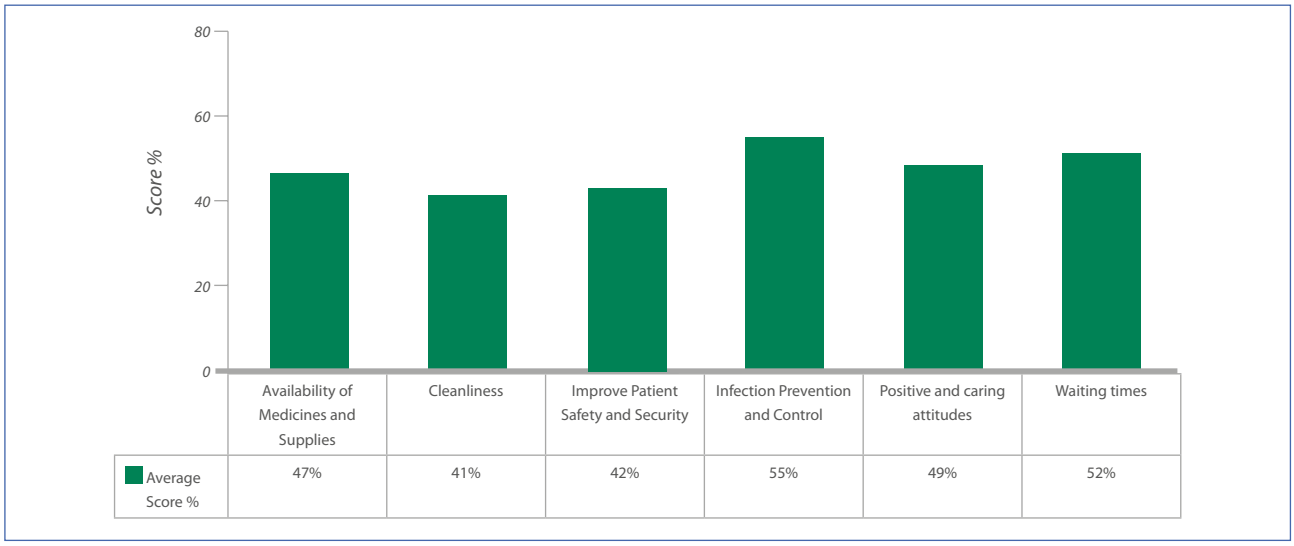
Figure 99: 2015/16 Domain scores for Clinics in North-West



The above figure demonstrates that on average the primary health establishments in North West Province were performing below 50% in all Domains. Leadership and Corporate Governance, Public Health and Operational Management performed between 10-33%. Leadership and Corporate Governance performed below all domains at 14%.

7.7.3 Average Inspected Clinics by Priority Areas Outcome

Figure 100: 2015/16 Priority Area scores for District Hospitals in Mpumalanga



The above figure demonstrates that on average the primary health establishments in North West Province are not performing above 50% in four Priority Areas except Waiting Times and Infection Prevention and Control which performed between 52-55%. Cleanliness performed below all other Priority Areas at 41%.

7.8 Northern Cape Clinics

7.8.1 Performance Comparison by Overall Score

Figure 101: Northern Cape Clinics

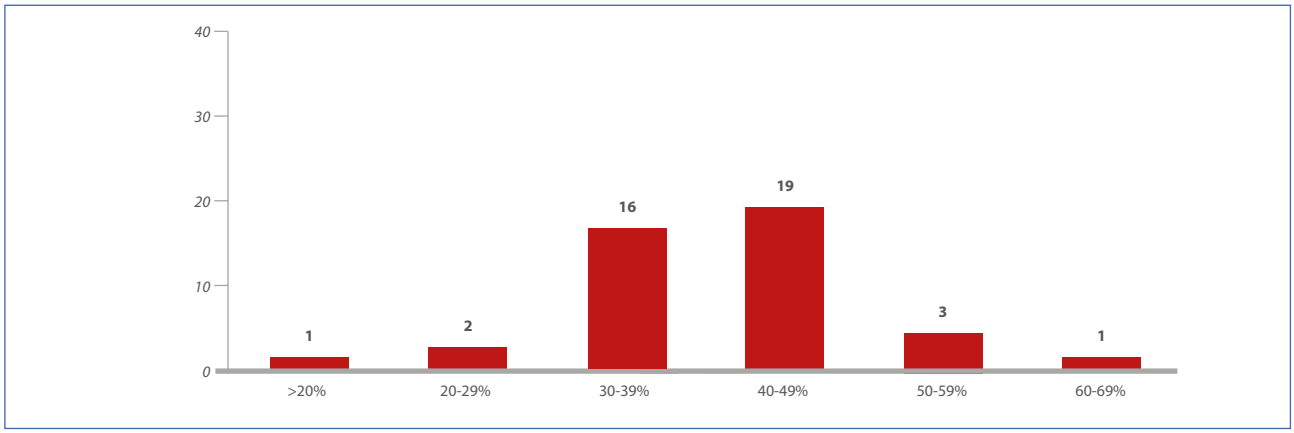
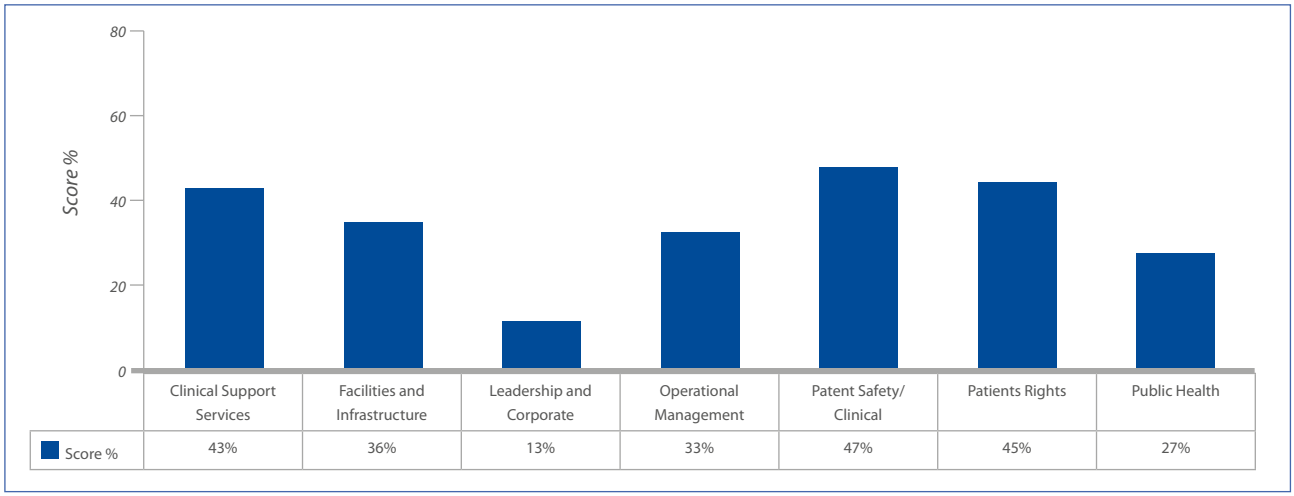


Figure 101 above reflects that only 42 clinics were inspected in the Northern Cape. Nineteen of the clinics in the province performed at between 40-49%, sixteen of them attained a score of between 30-39%. Three clinics managed to score between 50-59%. Two clinics also attained a score of between 20-29%. One of the clinics is found with a score of below 20%, with one clinic achieving a score that is between 60-70%.

7.8.2 Average Inspected Clinics by Domain Outcome

Figure 102: 2015/16 Domain scores for Clinics in Northern Cape

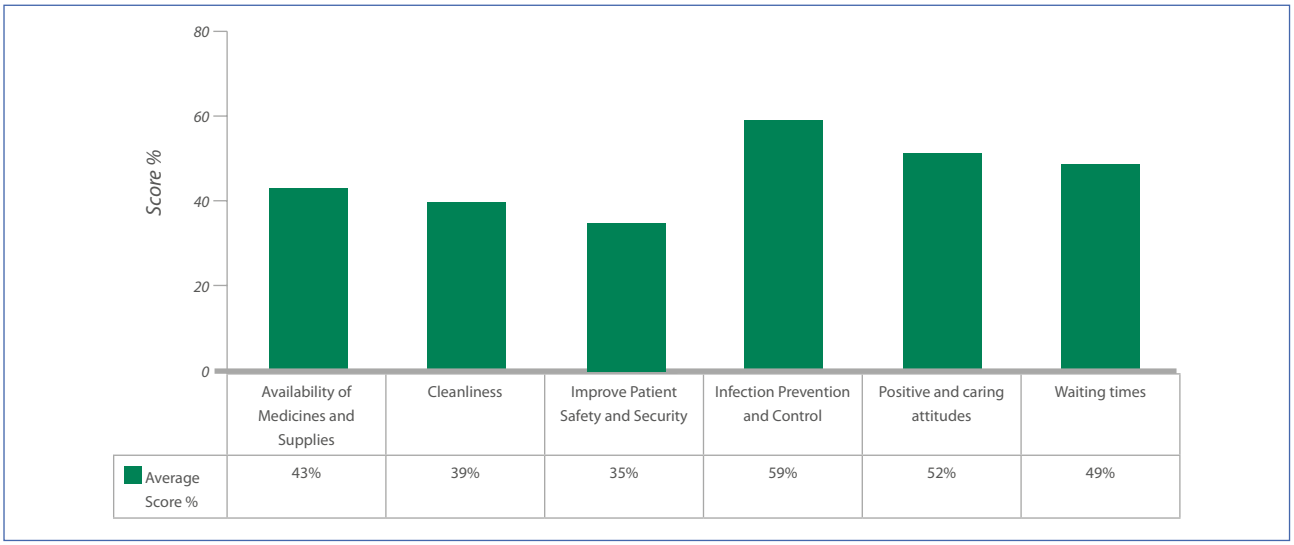


	Clinical Support Services	Facilities and Infrastructure	Leadership and Corporate	Operational Management	Patent Safety/ Clinical	Patients Rights	Public Health
Score %	43%	36%	13%	33%	47%	45%	27%

The above figure demonstrates that on average the primary health establishments in Northern Cape Province were performing below 50% in all Domains. Leadership and Corporate Governance, Public Health, Operational Management and Facilities and Infrastructure performed between 13-35% threshold. Leadership and Corporate Governance performed below all domains at 13%.

7.8.3 Average Inspected Clinics by Priority Areas Outcome

Figure 103: 2015/16 Priority Area scores for District Hospitals in Northern Cape



	Availability of Medicines and Supplies	Cleanliness	Improve Patient Safety and Security	Infection Prevention and Control	Positive and caring attitudes	Waiting times
Average Score %	43%	39%	35%	59%	52%	49%

The above figure demonstrates that on average the primary health establishments in North West Province are not performing above 50% in four Priority Areas except Positive and Caring Attitude and Infection Prevention and Control which performed between 52-59%. Cleanliness performed below all other Priority Areas at 39%.

7.9 Western Cape Clinics

7.9.1 Performance Comparison by Overall Score

Figure 104: Western Cape Clinics

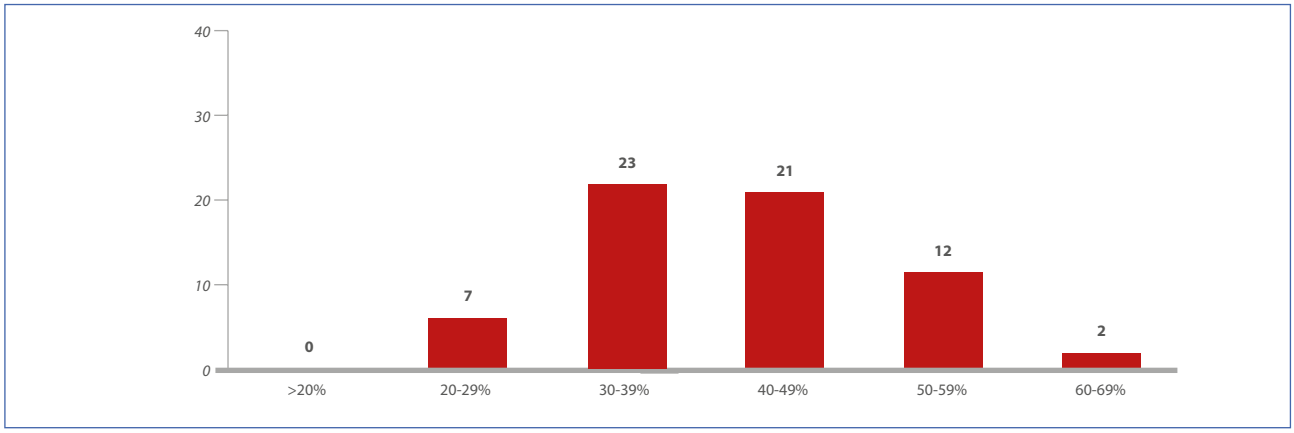
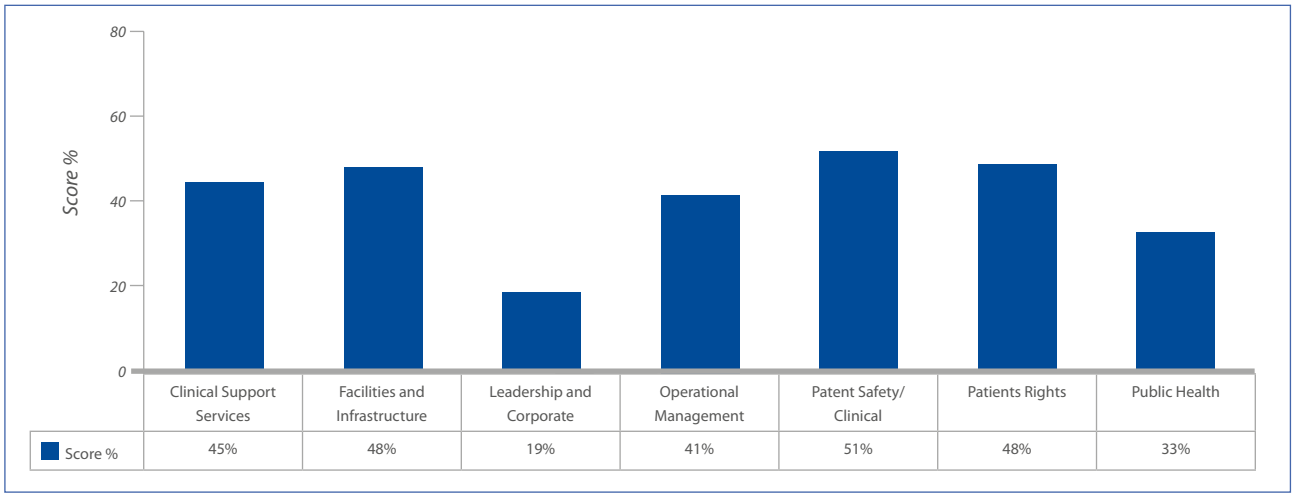


Figure 104 above reflects 65 clinics were inspected in the Western Cape. Twenty-three of them scores ranging between 30-39%. Twenty-one of them achieved scores of between 40-49%, and twelve of them achieve a score of 50-59%. Seven clinics scored between 20-29%. Only two clinics in the province performed with the scores of between 60-69%.

7.9.2 Average Inspected Clinics by Domain Outcome

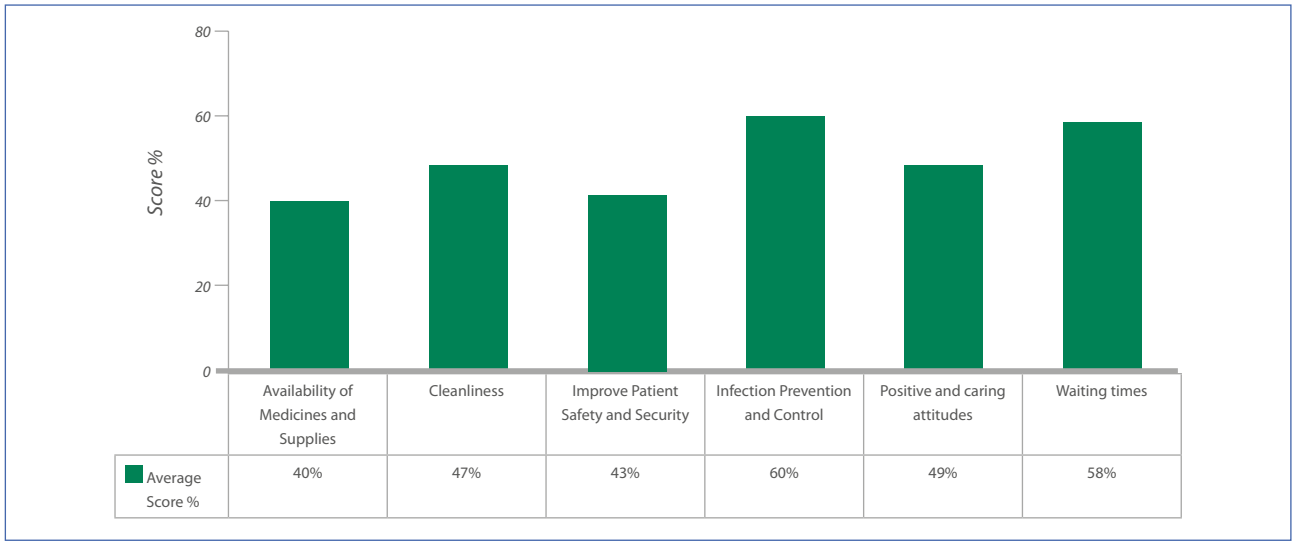
Figure 105: 2015/16 Domain scores for Clinics in Western Cape



The above figure demonstrates that on average the primary health establishments in Western Cape Province have performed below 50% in six Domains except Patient Safety/Clinical Care at 51%. Public Health and Operational Management performed between 33% and 41%. Leadership and Corporate Governance performed below all other domains at 19%.

7.9.3 Average Inspected Clinics by Priority Areas Outcome

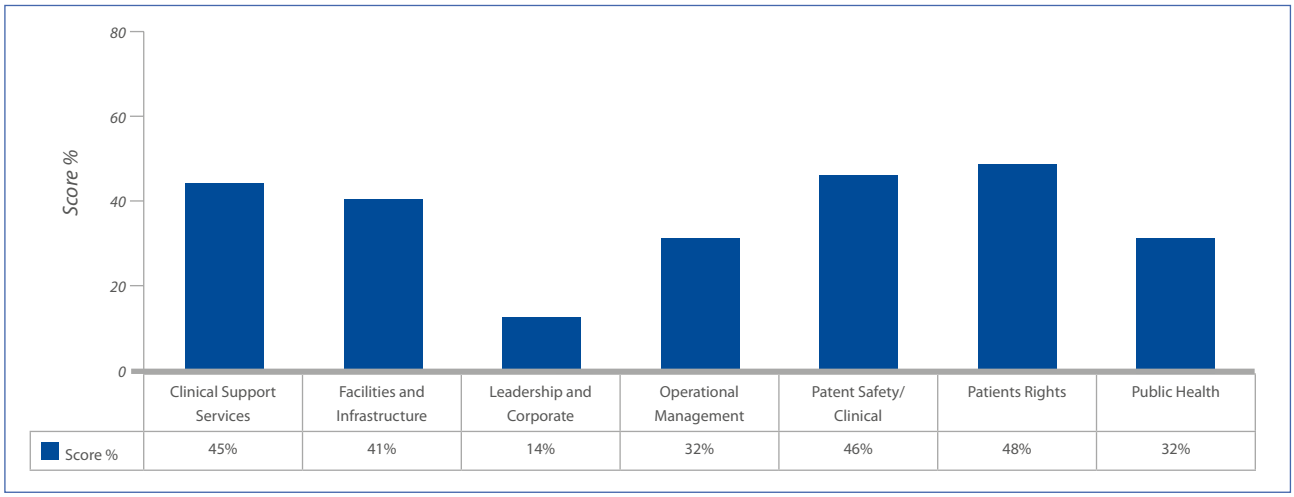
Figure 106: 2015/16 Priority Area scores for District Hospitals in Western Cape



The above figure demonstrates that on average the primary health establishments in Western Cape Province are not performing above 50% in four Priority Areas except Waiting Times and Infection Prevention & Control which performed between at 58% and 60% respectively. Availability of Medicines and Supplies performed below all other Priority Areas at 40%.

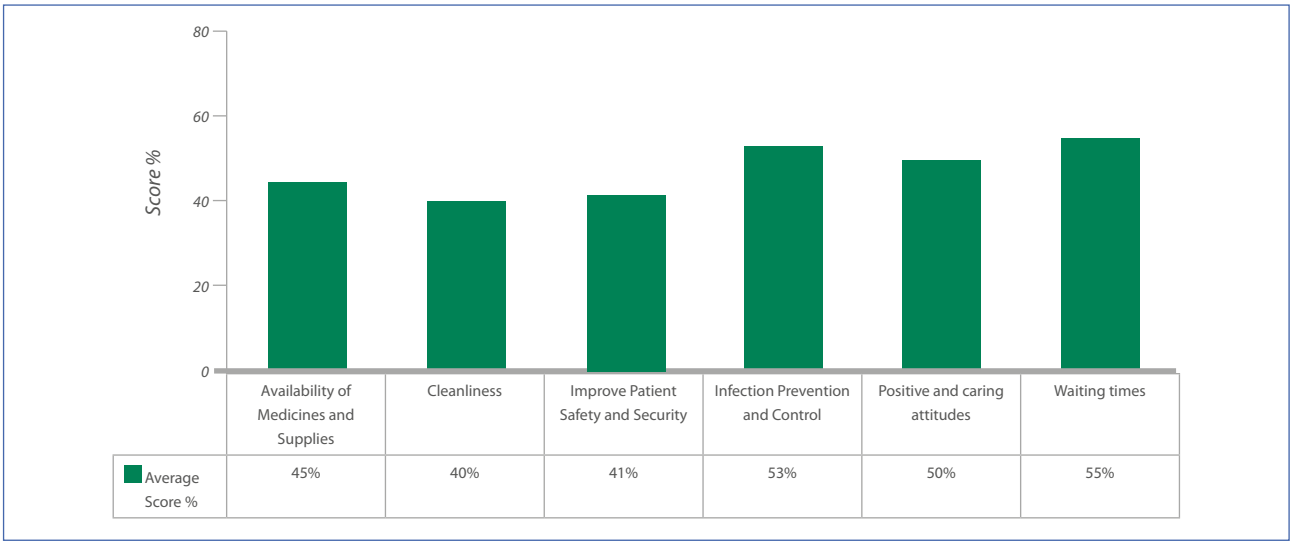
7.10 Overall Performance of Clinics Inspected 2015/16 by Domain Outcome

Figure 107: 2015/16 Domain scores for Clinics in South Africa



7.11 Overall Performance of Clinics Inspected 2015/16 by Priority Areas Outcome

Figure 108: 2015/16 Priority Area scores for District Hospitals in South Africa



7.12 Community Health Care Centres inspections for 2015/16

Figure 109:CHC Performance scores

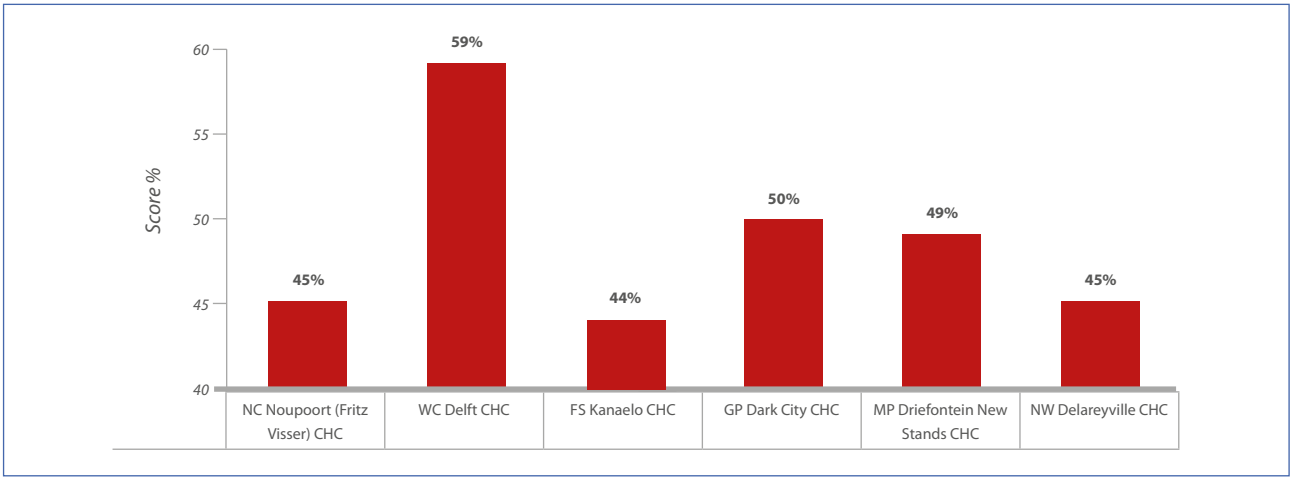
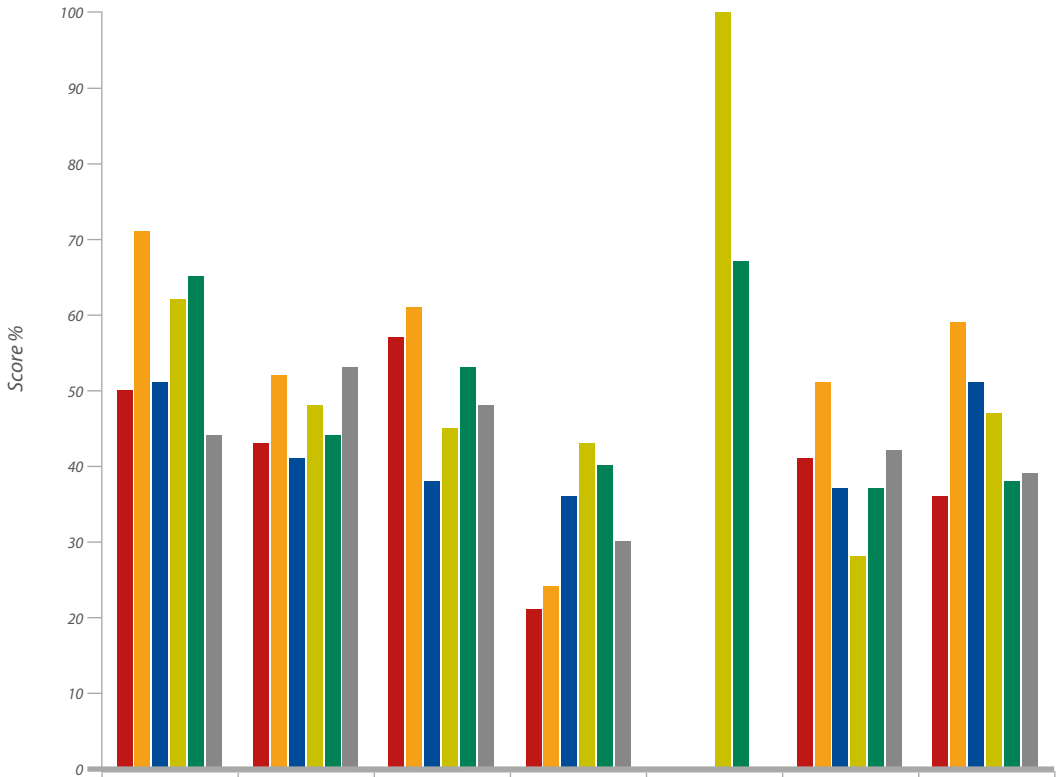


Figure 109 above reflect all CHC inspected in the financial year 2015/16, none of the CHC's managed to get a performance score of above 60%. Out of the 6 CHS's inspected 4 scored less than 50%.

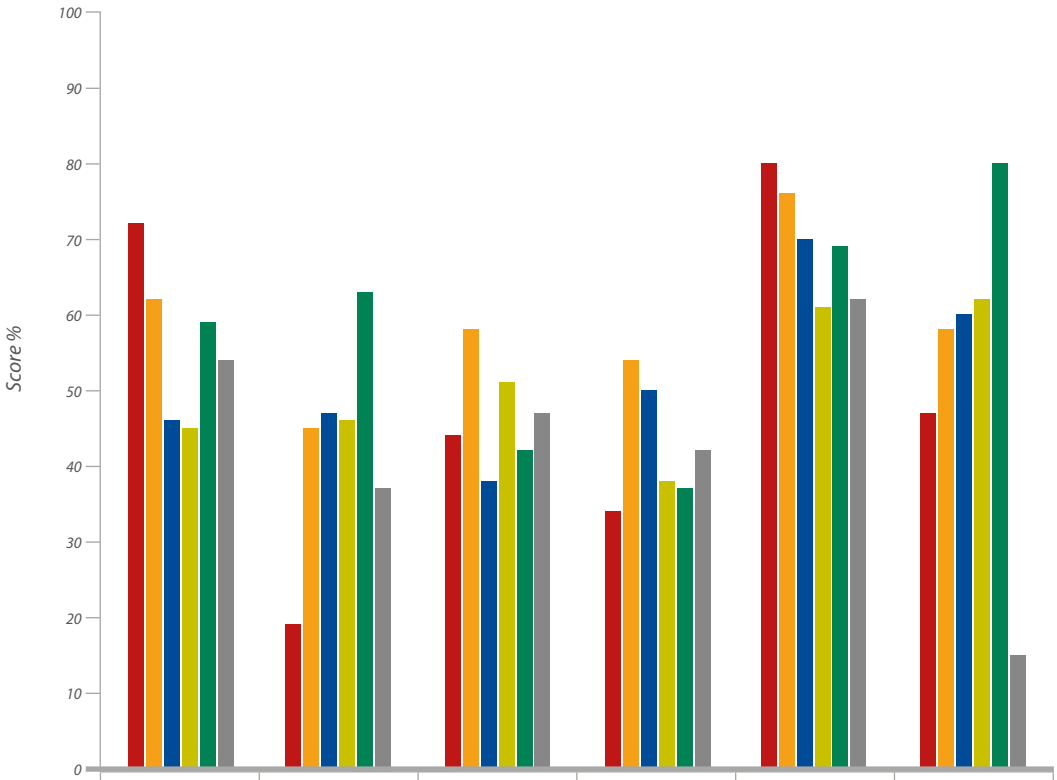
Figure 110: CHC Domains Comparison



	Patients Rights	Patent Safety/ Clinical Governance / Clinical Care	Clinical Support Services	Public Health	Leadership and Corporate Governance	Operational Management	Facilities and Infrastructure
NC Noupoort (Fritz Visser) CHC	50%	43%	57%	21%	0%	41%	36%
WC Delft CHC	71%	52%	61%	24%	0%	51%	59%
FS Kananelo CHC	51%	41%	38%	36%	0%	37%	51%
GP Dark City CHC	62%	48%	45%	43%	100%	28%	47%
MP Driefontein New Stands CHC	65%	44%	53%	40%	67%	37%	38%
NW Delareyville CHC	44%	53%	48%	30%	0%	42%	39%

Figure 110 demonstrate that the domains of Patient Safety/Clinical Governance/Clinical Care , Public Health, Operational Management and Facilities and Infrastructure (Domains 2, 4, 6 and 7) scored below 60% by all 6 CHS's .Domain 5 was also scored 0% by the 4 CHC's (Delarey, Kananelo, Noupoort (Fritz Visser and Delft CHC.

Figure 111: CHC Priority Areas Comparison



	Availability of Medicines and Supplies	Cleanliness	Improve Patient Safety and Security	Infection Prevention and Control	Positive and caring attitudes	Waiting times
NC Noupoort (Fritz Visser) CHC	72%	19%	44%	34%	80%	47%
WC Delft CHC	62%	45%	58%	54%	76%	58%
FS Kananelo CHC	46%	47%	38%	50%	70%	60%
GP Dark City CHC	45%	46%	51%	38%	61%	62%
MP Driefontein New Stands CHC	59%	63%	42%	37%	69%	80%
NW Delareyville CHC	54%	37%	47%	42%	62%	15%

Figure 111 above reflects the score on the six priority quality areas (Waiting Times, Cleanliness, Positive and Caring Attitudes, Patient Safety, Infection Prevention and Control and Availability of Medicines) varied widely with the highest score of 80 % in Positive and Caring Attitude and Waiting Times. Improve Patient Safety and Infection Prevention and Control were scored less than 60% by all CHC's.

G
FINANCIAL INFORMATION

Report of the Auditor-General to Parliament on the Office of Health Standards Compliance

Report on the financial statements

Introduction

1. I have audited the financial statements of the Office of Health Standards Compliance, which comprise the statement of financial position as at 31 March 2016, the statement of financial performance, statement of changes in net assets, cash flow statement and the statement of comparison of budget information with actual information for the year then ended, as well as the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting authority's responsibility for the financial statements

2. The accounting authority is responsible for the preparation and fair presentation of these financial statements in accordance with South African standards of Generally Recognised Accounting Practice (SA standards of GRAP) and the requirements of the Public Finance Management Act, 1999 (Act No. 1 of 1999) (PFMA) and for such internal control as the accounting authority determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-general's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with International Standards on Auditing. Those standards require that I comply with ethical requirements, and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

4. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Office of Health Standards Compliance as at 31 March 2016 and its financial performance and cash flows for the year then ended, in accordance with SA standards of GRAP and the requirements of the PFMA.

Report on other legal and regulatory requirements

7. In accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) and the general notice issued in terms thereof, I have a responsibility to report findings on the reported performance information against predetermined objectives of selected programmes presented in the annual performance report, compliance with legislation and internal control. The objective of my

tests was to identify reportable findings as described under each subheading but not to gather evidence to express assurance on these matters. Accordingly, I do not express an opinion or conclusion on these matters.

Predetermined objectives

8. I performed procedures to obtain evidence about the usefulness and reliability of the reported performance information of the following selected programmes presented in the annual performance report of the public entity for the year ended 31 March 2016:

   - Programme 3: Compliance Inspectorate on pages 28 to 30 of the Annual Report 2015/2016
   - Programme 4: Complaints Management and Ombud on pages 30 to 32 of the Annual Report 2015/2016
   - Programme 5: Health Standards Design, Analysis and Support on pages 32 to 35 of the Annual Report 2015/2016

9. I evaluated the usefulness of the reported performance information to determine whether it was presented in accordance with the National Treasury's annual reporting principles and whether the reported performance was consistent with the planned programmes. I further performed tests to determine whether indicators and targets were well defined, verifiable, specific, measurable, time bound and relevant, as required by the National Treasury's Framework for managing programme performance information (FMPPI).

10. I assessed the reliability of the reported performance information to determine whether it was valid, accurate and complete.

11. I did not identify any material findings on the usefulness and reliability of the reported performance information for the selected programmes.

Additional matters

12. Although I identified no material findings on the usefulness and reliability of the reported performance information for the selected programmes, I draw attention to the following matter:

Achievement of planned targets

13. Refer to the annual performance report on pages 22 to 35 for information on the achievement of the planned targets for the year.

Adjustment of material misstatements

14. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were on the reported performance information of Programme 4: Complaints Management and Ombud. As management subsequently corrected the misstatements, I did not identify any material findings on the usefulness and reliability of the reported performance information.

Compliance with legislation

15. I performed procedures to obtain evidence that the public entity had complied with applicable legislation regarding financial matters, financial management and other related matters. My material findings on compliance with specific matters in key legislation, as set out in the general notice issued in terms of the PAA, are as follows:

Annual financial statements

16. The financial statements submitted for auditing were not prepared in accordance with the prescribed financial reporting framework as required by section 55(1) (b) of the Public Finance Management Act.

17. Material misstatements of property, plant and equipment, service bonus provision, related parties and the loss on transfer of functions identified by the auditors in the submitted financial statement were subsequently corrected, resulting in the financial statements receiving an unqualified audit opinion.

Procurement and contract management

18. One contract with a transaction value above R500 000 was procured without inviting competitive bids, as required by Treasury Regulations 16A6.1. The deviation was approved by the accounting authority even though it was not impractical to invite competitive bids, in contravention of Treasury Regulation 16A6.4.

Internal control

19. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with legislation. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on compliance with legislation included in this report.

Financial and performance management

20. Management did not adequately review the financial statements and annual performance report for accuracy and completeness prior to submission for audit.

21. Management incorrectly interpreted legislation, resulting in the deviation from procurement processes.

Auditor - General

Pretoria

31 July 2016

AUDITOR-GENERAL
SOUTH AFRICA

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

Index

The reports and statements set out below comprise the annual financial statements presented to the Parliament of the Republic of South Africa in the OHSC Annual Report 2015/2016:

The Accounting Authority is required by the Public Finance Management Act (Act 1 of 1999), to maintain adequate accounting records

ACCOUNTING AUTHORITY'S RESPONSIBILITIES AND APPROVAL

and is responsible for the content and integrity of the annual financial statements and related financial information included in this report. It is the responsibility of the Accounting Authority to ensure that the annual financial statements fairly present the state of affairs of the entity as at the end of the financial year and the results of its operations and cash flows for the period then ended. The external auditors are engaged to express an independent opinion on the annual financial statements and were given unrestricted access to all financial records and related data.

The annual financial statements have been prepared in accordance with Standards of Generally Recognised Accounting Practice (GRAP) including any interpretations, guidelines and directives issued by the Accounting Standards Board.

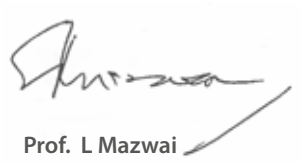
The annual financial statements are based upon appropriate accounting policies consistently applied and supported by reasonable and prudent judgements and estimates.

The Accounting Authority acknowledges that it is ultimately responsible for the system of internal financial control established by the entity and places considerable importance on maintaining a strong control environment. To enable the Accounting Authority to meet these responsibilities, it sets standards for internal control aimed at reducing the risk of error or deficit in a cost effective manner. The standards include the proper delegation of responsibilities within a clearly defined framework, effective accounting procedures and adequate segregation of duties to ensure an acceptable level of risk.

The Accounting Authority is of the opinion, based on the information and explanations given by management, that the system of internal control provides reasonable assurance that the financial records may be relied on for the preparation of the annual financial statements. The entity is wholly dependent on the NDoH for continued funding of operations. The annual financial statements are prepared on the basis that the entity is a going concern and that the NDoH has neither the intention nor the need to liquidate or curtail materially the scale of the entity.

The annual financial statements set out on pages 62 to 92, which have been prepared on the going concern basis, were approved by the Accounting Authority on 28 July 2016 and were signed on its behalf by:

Mr. B Msibi
Acting Chief Executive Officer



Prof. L Mazwai
Chairperson of Board

The Accounting Authority submits its report for the year ended 31 March 2016.

ACCOUNTING AUTHORITY'S REPORT

1. Incorporation

The OHSC is a Schedule 3A Public Finance Management Act (Act1 of 1999) public entity established in terms of the National Health Amendment Act, 12 of 2013. It commenced its operations on 1April 2015 and its Executive Authority is the Minister of Health.

2. Review of activities

Main business and operations

The OHSC's mandate is to protect and promote the health and safety of users of health services by:

- Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system; and
- Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.

The operating results for the year were satisfactory given that it was its first year of operation.

The OHSC recorded a surplus of R26 487 862 during its first year of operation.

3. Going concern

We draw attention to the fact that as at 31 March 2016, the entity had an accumulated surplus of R26 487 862 and that the entity's total assets exceed its liabilities by R26 487 862.

The annual financial statements have been prepared on a going concern basis and the Accounting Authority has no reason to believe that the entity will not be a going concern in the foreseeable future.

4. Subsequent events

The members are not aware of any matter or circumstance arising since the end of the financial year that needs to be disclosed in the annual financial statements.

5. Accounting policies

The annual financial statements have been prepared in accordance with the prescribed Standards of Generally Recognised Accounting Practices (GRAP) issued by the Accounting Standards Board as the prescribed framework by the National Treasury.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2016

Figures in Rand	Note(s)	2016
Assets		
Current Assets		
Receivables from exchange transactions	6	63 858
Receivables from non-exchange transactions	7	24 600
Cash and cash equivalents	8	32 149 886
		32 238 344
Non-current assets		
Property, plant and equipment	3	3 693 955
Intangible assets	4	438 934
		4 132 889
Total assets		**36 371 233**
Liabilities		
Current liabilities		
Operating lease liability	5	293 771
Payables from exchange transactions	10	6 100 742
Provisions	9	3 488 858
		9 883 371
Total liabilities		**9 883 371**
Net assets		**26 487 862**
Accumulated surplus		**26 487 862**

STATEMENT OF FINANCIAL PERFORMANCE

Figures in Rand	Note(s)	2016
Revenue		
Revenue from exchange transactions		
Interest received	12	194 489
Revenue from non-exchange transactions		
Transfer revenue		
Government grant	13	88 906 000
Total revenue	**11**	**89 100 489**
Expenditure		
Compensation of employees	14	(39 478 925)
Board fees and related costs	31	(1 429 669)
Depreciation and amortisation		(655 203)
General expenses	15	(21 048 831)
Total expenditure		**(62 612 627)**
Surplus for the year		**26 487 862**

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

STATEMENT OF CHANGES IN NET ASSETS

Figures in Rand	Accumulated surplus	Total net assets
Balance at 1 April 2015	-	-
Changes in net assets		
Surplus for the year	26 514 996	26 514 996
Gains (losses) from transfer of functions between entities under common control (refer to note 20)	(27 134)	(27 134)
Total changes	26 487 862	26 487 862
Balance at 31 March 2016	26 487 862	26 487 862

CASH FLOW STATEMENT

Figures in Rand	Note(s)	2016
Cash flows from operating activities		
Receipts		
Grants		88 906 000
Interest received from investment		194 489
		89 100 489
Payments		
Compensation of employees		(37 030 288)
Suppliers		(14 885 775)
Other payments		(1 397 969)
		(53 314 032)
Net cash flows from operating activities	**18**	**35 786 457**
Cash flows from investing activities		
Purchase of property, plant and equipment	3	(3 174 212)
Purchase of intangible assets	4	(462 359)
Net cash flows from investing activities		**(3 636 571)**
Net increase/(decrease) in cash and cash equivalents		**32 149 886**
Cash and cash equivalents at the end of the year	**8**	**32 149 886**

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

Budget on Cash Basis						
Figures in Rand	**Approved budget**	**Adjustments**	**Final Budget**	**Actual amounts on comparable basis**	**Difference between final budget and actual**	**Reference: Notes 30 & 32**
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Interest received - investment	-	-	-	194 489	194 489	
Revenue from non-exchange transactions						
Transfer revenue						
Government grants & subsidies	88 906 000	-	88 906 000	88 906 000	-	
Total revenue	**88 906 000**	**-**	**88 906 000**	**89 100 489**	**194 489**	
Expenditure						
Compensation of employees	53 100 362	-	53 100 362	39 478 925	(13 621 437)	
Board fees and related costs	1 056 108	-	1 056 108	1 429 669	373 561	
Depreciation and amortisation	-	-	-	655 203	655 203	
General expenses	30 385 707	-	30 385 707	21 048 831	(9 336 876)	
Total expenditure	**84 542 177**	**-**	**84 542 177**	**62 612 627**	**(21 929 550)**	
Operating surplus	**4 363 823**	**-**	**4 363 823**	**26 487 862**	**(22 124 039)**	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

Budget on Cash Basis						
Figures in Rand	**Approved budget**	**Adjustments**	**Final Budget**	**Actual amounts on comparable basis**	**Difference between final budget and actual**	**Reference: Notes 30 & 32**
Statement of Financial Position						
Assets						
Current Assets	-	-	-	63 858	63 858	
Receivables from exchange transactions						
Receivables from non-exchange transactions	-	-	-	24 600	24 600	
Cash and cash equivalents	-	-	-	32 149 886	32 149 886	
	-	-	-	32 238 344	32 238 344	
Non-current assets						
Property, plant and equipment	155 000	-	155 000	3 693 955	3 538 955	
Intangible assets	4 208 823	-	4 208 823	438 934	(3 769 889)	
	4 363 823	-	4 363 823	4 132 889	(230 934)	
Total assets	**4 363 823**	**-**	**4 363 823**	**36 371 233**	**32 007 410**	
Liabilities						
Current liabilities	-	-	-	293 771	293 771	
Operating lease liability						
Payables from exchange transactions	-	-	-	6 100 741	6 100 741	
Provisions	-	-	-	3 488 859	3 488 859	
	-	-	-	9 883 371	9 883 371	
Total liabilities	**-**	**-**	**-**	**9 883 371**	**9 883 371**	
Net assets	**4 363 823**	**-**	**4 363 823**	**26 487 862**	**22 124 039**	

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

ACCOUNTING POLICIES

1. Presentation of Annual Financial Statements

The annual financial statements have been prepared in accordance with the Standards of Generally Recognized Accounting Practice (GRAP), issued by the Accounting Standards Board in accordance with Section 55 (1) (b) of the Public Finance Management Act (Act 1 of 1999).

These annual financial statements have been prepared on an accrual basis of accounting and are in accordance with historical cost convention as the basis of measurement, unless specified otherwise.

In the absence of an issued and effective Standard of GRAP, accounting policies for material transactions, events or conditions were developed in accordance with paragraphs 8, 10 and 11 of GRAP 3 as read with Directive 5.

Assets, liabilities, revenues and expenses are not offset, except where offsetting is either required or permitted by a Standard of GRAP.

A summary of the significant accounting policies, which have been consistently applied in the preparation of these annual financial statements, is disclosed below.

1.1 Presentation currency

These annual financial statements are presented in South African Rand, which is the functional currency of the OHSC.

1.2 Going concern assumption

The annual financial statements have been prepared based on a going concern basis and the Accounting Authority has no reason to believe that the entity will not be a going concern in the foreseeable future. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of business.

1.3 Transfer of functions between entities under common control

Accounting by the entity as acquirer

Initial recognition and measurement

As of the transfer date, the entity recognises the assets transferred and liabilities assumed in a transfer of functions. The assets transferred are recognised at fair value and liabilities assumed are recognised at their carrying values.

The difference between the carrying amounts of the assets acquired, the liabilities assumed and the consideration paid to the transferor, is recognised in the surplus.

ACCOUNTING POLICIES

1.4 Significant judgements and sources of estimation uncertainty

In preparing the annual financial statements, management is required to make estimates and assumptions that affect the amounts represented in the annual financial statements and related disclosures. Use of available information and the application of judgement is inherent in the formation of estimates. Actual results in the future could differ from these estimates which may be material to the annual financial statements. However, no material differences are envisaged.

Effective interest rate

The entity uses an appropriate interest rate taking into account guidance provided in the standard, and applying professional judgement to the specific circumstances to discount future cash flows. The entity used the repo rate to discount future cash flows.

Impairment testing

The recoverable amounts of cash-generating units and individual assets have been determined based on the higher of value-in-use calculations and fair values less costs to sell. These calculations require the use of estimates and assumptions. It is reasonably possible that the assumption may change which may then impact our estimations and may then require a material adjustment to the carrying value of property, plant and equipment and tangible assets.

1.5 Property, plant and equipment

Property, plant and equipment are tangible non-current assets (including infrastructure assets) that are held for use in the production or supply of goods or services, rental to others, or for administrative purposes, and are expected to be used during more than one period.

The cost of an item of property, plant and equipment is recognised as an asset when:

- it is probable that future economic benefits or service potential associated with the item will flow to the OHSC; and
- the cost of the item can be measured reliably.

Property, plant and equipment is initially measured at cost.

The cost of an item of property, plant and equipment is the purchase price and other costs attributable to bring the asset to the location and condition necessary for it to be capable of operating in the manner intended by management. Trade discounts and rebates are deducted in arriving at the cost.

Where an asset is acquired through a non-exchange transaction, its cost is its fair value as at date of acquisition.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

ACCOUNTING POLICIES

Where an item of property, plant and equipment is acquired in exchange for a non-monetary asset or monetary assets, or a combination of monetary and non-monetary assets, the asset acquired is initially measured at fair value (the cost). If the acquired item's fair value was not determinable, it is deemed that cost is the carrying amount of the asset(s) given up.

When significant components of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

Costs include costs incurred initially to acquire or construct an item of property, plant and equipment and costs incurred subsequently to add to, replace part of, or service it. If a replacement cost is recognised in the carrying amount of an item of property, plant and equipment, the carrying amount of the replaced part is derecognised.

Recognition of costs in the carrying amount of an item of property, plant and equipment ceases when the item is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Costs incurred subsequently to add, to replace part of, or service any asset are recognised in the carrying amount of the related asset if the recognition criteria is met. Subsequent to the initial recognition, items of property, plant and equipment are measured at cost less accumulated depreciation and impairment losses.

Where the carrying amount of an item of property, plant and equipment is greater than the estimated recoverable amount, it is written down immediately to its recoverable amount and an impairment loss is charged to the statement of financial performance.

Items of property, plant and equipment are derecognised when the asset is disposed of or when there are no further economic benefits or service potential expected from use of the asset. The gain or loss arising on the disposal of an asset is determined as the difference between the proceeds from the disposal and the carrying value of the assets, and is recognised in the statement of financial performance.

The useful lives of items of property, plant and equipment have been assessed as follows:

Item	Depreciation method	Average useful life
Buildings	Straight line	20 years
Furniture and fixtures	Straight line	10 years
Motor vehicles	Straight line	5 years
Office equipment	Straight line	5 years
Computer equipment	Straight line	5 years
Leasehold improvements	Straight line	Lease period

ACCOUNTING POLICIES

1.6 Intangible assets

An asset is identifiable if it either:

- is separable, i.e. is capable of being separated or divided from an entity and sold, transferred, licensed, rented or exchanged, either individually or together with a related contract, identifiable assets or liability, regardless of whether the entity intends to do so; or
- arises from binding arrangements (including rights from contracts), regardless of whether those rights are transferable or separable from the entity or from other rights and obligations.

A binding arrangement describes an arrangement that confers similar rights and obligations on the parties to it as if it were in the form of a contract.

An intangible asset is recognised when:

- it is probable that the expected future economic benefits or service potential that are attributable to the asset will flow to the entity; and
- the cost or fair value of the asset can be measured reliably.

The entity assesses the probability of expected future economic benefits or service potential using reasonable and supportable assumptions that represent management's best estimate of the set of economic conditions that will exist over the useful life of the asset.

Recognition of costs in the carrying amount of an item of intangible asset ceases when the item is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Where an intangible asset is acquired through a non-exchange transaction, its initial cost at the date of acquisition is measured at its fair value as at that date.

Expenditure on research (or on the research phase of an internal project) is recognised as an expense when it is incurred.

Intangible assets are carried at cost less any accumulated amortisation and any impairment losses.

The amortisation period and the amortisation method for intangible assets are reviewed at each reporting date.

Reassessing the useful life of an intangible asset with a finite useful life after it was classified as indefinite, is an indicator that the asset may be impaired. As a result the asset is tested for impairment and the remaining carrying amount is amortised over its useful life.

Where the carrying amount of an item of intangible asset is greater than the estimated recoverable amount, it is written down immediately to its recoverable amount and an impairment loss is charged to the statement of financial performance.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

ACCOUNTING POLICIES

Items of intangible assets are derecognised when the asset is disposed of or when there are no further economic benefit or service potential expected from the use of the asset. The gain or loss arising on the disposal of an asset is determined as the difference between the proceeds from the disposal and the carrying value of the assets, and is recognised in the statement of financial performance.

Amortisation is provided to write down the intangible assets, on a straight line basis, to their residual values as follows:

Item life	Useful
Computer software	5 years or license period

Intangible assets are derecognised:

- on disposal; or
- when no future economic benefits or service potential are expected from its use or disposal.

1.7 Financial instruments

In the course of the OHSC operations it is exposed to interest rate, credit, liquidity and market risk. The risk management process relating to each of these risks is discussed under the headings below.

Credit risk

Financial assets, which potentially subject the OHSC to the risk of non-performance by the counter-parties and thereby subject to credit concentrations of credit risk, consist mainly cash and cash equivalents and receivables from exchange transactions.

The OHSC manages/limits its treasury counter-party exposure by only dealing with well-established financial institutions approved by the National Treasury through the approval of the investment policy in terms of Treasury Regulations.

Market risk

The OHSC is exposed to fluctuations in the employment market, for example, sudden increases in events, unemployment and changes in the wage rates. No significant event occurred during the year that the OHSC is aware of.

Liquidity risk

The OHSC manages liquidity risk through proper management of working capital, capital expenditure and actual expenditure vs. forecasted cash flows and its cash management policy. Adequate reserves and liquid resources are also maintained.

ACCOUNTING POLICIES

Fair values

The OHSC's financial instruments consists mainly of cash and cash equivalents. No financial instrument was carried at an amount in excess of its fair value and fair values could be measured for all financial instruments. The following methods and assumptions are used to determine the fair value of each class of financial instruments.

- Investments

Investments consists of short-term deposits invested in registered commercial banks, and are measured at fair value. Interest on investments calculated using the effective interest method is recognised in the statement of financial performance as revenue from exchange transactions.

Investments are derecognised when the rights to receive cash flows from the investments have expired or have been transferred or when substantially all risks and reward of ownership have been transferred.

- Cash and cash equivalents

Cash and cash equivalents is made up of cash on hand, cash held at banks and deposits with banks. The carrying amount of cash and cash equivalents approximates fair values.

- Other receivables from exchange transactions

The carrying amount of other receivables from exchange transactions approximates fair values due to the relatively short-term maturity of these financial assets.

- Trade and other receivables

Trade receivables are recognised as financial assets; loans and receivables are initially recognised at fair value, and are subsequently measured at amortised cost using the effective interest rate method. Appropriate allowances for estimated irrecoverable amounts are recognised in surplus/ (deficit) when there is an objective believe that the asset is impaired. Significant financial difficulties of the debtor, and default or delinquency in payments are considered indicators that the trade receivable is impaired. The allowance recognised is measured for all debtors with indication of impairment. Impairments are determined based on the risk profile of each debtor. Amounts that are receivable within 12 months from the reporting date are classified as current. The carrying amount of an asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the statement of financial performance within the operating expenses. When a trade receivable is uncollectable, it is written off against the allowance account for trade receivables. Subsequent recoveries of amounts previously written off are recognised as recoveries in the statement of financial performance.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

ACCOUNTING POLICIES

1.7 Financial instruments (continued)

- Trade and other payables

Financial liabilities consist of payables and borrowings. They are initially measured at fair value and are subsequently measured at amortised cost using the effective interest rate method, which is the initial carrying amount, less repayments, plus interest.

Derecognition

Financial assets

The entity derecognises financial assets using trade date accounting. The entity derecognises a financial asset only when:

- the contractual rights to the cash flows from the financial asset expire, are settled or waived;
- the entity transfers to another party substantially all of the risks and rewards of ownership of the financial asset; or
- the entity, despite having retained some significant risks and rewards of ownership of the financial asset, has transferred control of the asset to another party and the other party has the practical ability to sell the asset in its entirety to an unrelated third party, and is able to exercise that ability unilaterally and without needing to impose additional restrictions on the transfer. In this case, the entity:
  - derecognises the asset; and
  - recognise separately any rights and obligations created or retained in the transfer.

If, as a result of a transfer, a financial asset is derecognised in its entirety but the transfer results in the entity obtaining a new financial asset or assuming a new financial liability, or a servicing liability, the entity recognise the new financial asset, financial liability or servicing liability at fair value.

On derecognition of a financial asset in its entirety, the difference between the carrying amount and the sum of the consideration received is recognised in surplus or deficit.

If the transferred asset is part of a larger financial asset and the part transferred qualifies for derecognition in its entirety, the previous carrying amount of the larger financial asset is allocated between the part that continues to be recognised and the part that is derecognised, based on the relative fair values of those parts, on the date of the transfer. For this purpose, a retained servicing asset is treated as a part that continues to be recognised. The difference between the carrying amount allocated to the part derecognised and the sum of the consideration received for the part derecognised is recognised in surplus or deficit.

If a transfer does not result in derecognition because the entity has retained substantially all the risks and rewards of ownership of the transferred asset, the entity continue to recognise the transferred asset in its entirety and recognise a financial liability for the consideration received. In subsequent periods, the entity recognises any revenue on the transferred asset and any expense incurred on the financial liability. Neither the asset, and the associated liability nor the revenue, and the associated expenses are offset.

ACCOUNTING POLICIES

1.7 Financial instruments (continued)

Financial liabilities

The entity removes a financial liability (or a part of a financial liability) from its statement of financial position when it is extinguished — i.e. when the obligation specified in the contract is discharged, cancelled, expires or waived.

An exchange between an existing borrower and lender of debt instruments with substantially different terms is accounted for as having extinguished the original financial liability and a new financial liability is recognised. Similarly, a substantial modification of the terms of an existing financial liability or a part of it is accounted for as having extinguished the original financial liability and having recognised a new financial liability.

The difference between the carrying amount of a financial liability (or part of a financial liability) extinguished or transferred to another party and the consideration paid, including any non-cash assets transferred or liabilities assumed, is recognised in surplus or deficit. Any liabilities that are waived, forgiven or assumed by another entity by way of a non-exchange transaction are accounted for in accordance with the Standard of GRAP on Revenue from Non-exchange Transactions (Taxes and Transfers).

1.8 Taxation

The OHSC is exempt from income tax in terms of section 10(1) of the Income Tax Act No 58 of 1962.

1.9 Leases

Operating leases - lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. The difference between the amounts recognised as an expense and the contractual payments are recognised as an operating lease asset or liability.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

ACCOUNTING POLICIES

1.10 Employee benefits

Short-term employee benefits

The cost of short-term employee benefits, (those payable within 12 months after the service is rendered, such as paid vacation leave and sick leave, bonuses, and non-monetary benefits such as medical care), are recognised in the period in which the service is rendered and are not discounted.

Defined contribution plans

Payments for defined contribution retirement plans are charged as an expense as they become due. Payments made to industry managed (or state plans) retirement benefit schemes are dealt with as defined contributions plans when the entity's obligation under the scheme is equivalent to those arising in a defined contribution retirement benefit plan.

1.11 Provisions and contingencies

Provisions are recognised when:

- the OHSC has a present obligation as a result of a past event;
- it is probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation; and
- a reliable estimate can be made of the obligation.

The amount of a provision is the best estimate of the expenditure expected to be required to settle the present obligation at the reporting date.

Where some or all of the expenditure required to settle a provision is expected to be reimbursed by another party, the reimbursement is recognised when, and only when, it is virtually certain that reimbursement will be received if the OHSC settles the obligation. The reimbursement is treated as a separate asset. The amount recognised for the reimbursement does not exceed the amount of the provision.

Provisions are reviewed at each reporting date and adjusted to reflect the current best estimate. Provisions are reversed if it is no longer probable that an outflow of resources embodying economic benefits or service potential will be required, to settle the obligation.

A provision is used only for expenditures for which the provision was originally recognised. Provisions are not recognised for future operating deficits.

Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed in note 22.

ACCOUNTING POLICIES

1.12 Commitments

Items are classified as commitments when an entity has committed itself to future transactions that will normally result in the outflow of cash.

1.13 Revenue from exchange transactions

Revenue from exchange transactions refers to revenue that accrued to the entity directly in return for services rendered or goods sold, the value of which approximates the consideration received or receivable. Revenue is recognised to the extent that it is probable that the economic benefits will flow to the OHSC and revenue can be reliably measured. Revenue is measured at fair value of the consideration receivable on an accrual basis. Revenue includes investments and non-operating income exclusive of value added taxation, rebates and discounts

Interest received

Revenue arising from the use by others of entity assets yielding interest is recognised when:

- It is probable that the economic benefits or service potential associated with the transaction will flow to the entity, and
- The amount of the revenue can be measured reliably.

Interest is recognised, in surplus or deficit, using the effective interest rate method.

1.14 Revenue from non-exchange transactions

Revenue from non-exchange transactions refers to transactions where the entity received revenue from another entity without directly giving approximately equal value in exchange. Revenue from non-exchange transactions is generally recognised to the extent that the related receipt or receivable qualifies for recognition as an asset and there is no liability to repay the amount.

Government grants

Government grants are recognised as revenue when:

- it is probable that the economic benefits or service potential associated with the transaction will flow to the entity,
- the amount of the revenue can be measured reliably, and
- to the extent that there has been compliance with any restrictions associated with the grant.

1.15 Borrowing costs

Borrowing costs are interest and other expenses incurred by an entity in connection with the borrowing of funds. Borrowing costs are recognised as an expense in the period in which they are incurred.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

ACCOUNTING POLICIES

1.16 Unauthorised expenditure

Unauthorised expenditure is defined as:

- overspending of a program or a main division within a program; and
- expenditure not in accordance with the purpose of a program or, in the case of a main division, not in accordance with the purpose of the main division.

All expenditure relating to unauthorised expenditure is recognised as an expense in the statement of financial performance in the year that the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

1.17 Fruitless and wasteful expenditure

Fruitless expenditure means expenditure which was made in vain and would have been avoided had reasonable care been exercised.

All expenditure relating to fruitless and wasteful expenditure is recognised as an expense in the statement of financial performance in the year that the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

1.18 Irregular expenditure

Irregular expenditure as defined in section 1 of the PFMA is expenditure other than unauthorised expenditure, incurred in contravention of or that is not in accordance with a requirement of any applicable legislation, including -

(a) this Act; or
(b) the State Tender Board Act, 1968 (Act No. 86 of 1968), or any regulations made in terms of the Act; or
(c) any provincial legislation providing for procurement procedures in that provincial government.

All expenditure relating to irregular expenditure is recognised as an expense in the statement of financial performance in the year that the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

Irregular expenditure that was incurred and identified during the current financial year and for which condonement is being awaited at year end is recorded in the irregular expenditure register. No further action is required with the exception of updating the note to the financial statements.

Where irregular expenditure was incurred in the previous financial year and is only condoned in the following financial year, the register and the disclosure note to the financial statements is updated with the amount condoned.

ACCOUNTING POLICIES

1.19 Budget information

Entities are typically subject to budgetary limits in the form of appropriations or budget authorisations (or equivalent), which is given effect through authorising legislation, appropriation or similar.

General purpose financial reporting by entity shall provide information on whether resources were obtained and used in accordance with the legally adopted budget.

The approved budget is prepared on an accrual basis and presented by economic classification linked to performance outcome objectives.

The approved budget covers the fiscal period from 2015-04-01 to 2016-03-31.

The Statement of comparative and actual information has been included in the annual financial statements as the recommended disclosure when the annual financial statements and the budget are on the same basis of accounting as determined by National Treasury.

The annual financial statements and the budget are not on the same basis of accounting therefore a reconciliation between the statement of financial performance and the budget have been included in the annual financial statements. Refer to note 30 & 32.

1.20 Related parties

The entity operates in an economic sector currently dominated by entities directly owned by the South African Government. As a consequence of the constitutional independence of the three spheres of government in South Africa, only entities within the national sphere of government are considered to be related parties.

Management are those persons responsible for planning, directing and controlling the activities of the entity, including those charged with the governance of the entity in accordance with legislation, in instances where they are required to perform such functions.

1.21 Events after reporting date

Events after reporting date are those events, both favourable and unfavourable, that occur between the reporting date and the date when the financial statements are authorised for issue. Two types of events can be identified:

- those that provide evidence of conditions that existed at the reporting date (adjusting events after the reporting date); and
- those that are indicative of conditions that arose after the reporting date (non-adjusting events after the reporting date).

The entity will adjust the amount recognised in the financial statements to reflect adjusting events after the reporting date once the event occurred.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

2. New standards and interpretations

2.1 Standards and Interpretations issued and effective

Standards/ Interpretation:	Effective Date:	Expected Impact:
GRAP 18: Segment reporting	1 April 2015	Statement is not relevant to the OHSC.
GRAP 105: Transfer of functions between entities under common control	1 April 2015	Statement is relevant to the OHSC
GRAP 106: Transfer of functions between entities not under common control	1 April 2015	Statement is not relevant to the OHSC
GRAP 107: Mergers	1 April 2015	Statement is not relevant to the OHSC
Directive 11: Changes in measurement bases following the initial adoption of standard of GRAP	1 April 2015	No impact on the current financial statements

2.2 Standards and interpretations issued, but not yet effective

Standards/ Interpretation:	Effective Date:	Expected Impact:
GRAP 20: Related party disclosures	Not yet effective	The OHSC has disclosed related party transactions
GRAP 32: Service concession arrangements: Grantor	Not yet effective	Statement is not relevant to the OHSC
GRAP 108: Statutory receivables	Not yet effective	No statutory receivables were received
GRAP 109: Accounting by principals and agents	Not yet effective	Statement is not relevant to the OHSC

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

3. Property, plant and equipment

	2016		
	Cost / Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Office equipment	775 933	(151 915)	624 018
Furniture and fixtures	1 207 898	(76 529)	1 131 369
Computer equipment	1 498 125	(281 969)	1 216 156
Leasehold improvements	843 777	(121 365)	722 412
Total	**4 325 733**	**(631 778)**	**3 693 955**

Reconciliation of property, plant and equipment - 2016

	Opening balance	Additions	Additions through transfer of functions (Refer to Note 15)	Depreciation	Total
Office equipment	-	590 421	185 511	(151 914)	624 018
Furniture and fixtures	-	656 263	551 635	(76 529)	1 131 369
Computer equipment	-	1 083 751	414 374	(281 969)	1 216 156
Leasehold improvements	-	843 777	-	(121 365)	722 412
	-	**3 174 212**	**1 151 520**	**(631 777)**	**3 693 955**

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

4. Intangible assets

	2016		
	Cost / Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Computer software	462 359	(23 425)	438 934

Reconciliation of intangible assets - 2016

	Opening balance			
Computer software	-	462 359	(23 425)	438 934

5. Operating lease liability

Current liabilities	293 771
	293 771

Office space which contains 10% escalation per annum has resulted in the difference between the actual payments and the straight-lined amount which resulted in the difference as the liability.

6. Receivables from exchange transactions

Deposits	62 050
Prepaid expenses	1 808
	63 858

7. Receivables from non-exchange transactions

Staff related receivables	24 600
	24 600

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

8. Cash and cash equivalents

Cash and cash equivalents consist of:

Bank balances	9 953 765
Cash on hand	1 632
Short-term investment	22 194 489
	32 149 886

9. Provisions

Reconciliation of provisions

	Opening Balance	Additions	Total
Provision for performance bonuses	-	796 506	796 506
Provision for leave	1 178 655	398 576	1 577 231
Provision for 13th cheque	-	1 115 121	1 115 121
	1 178 655	**2 310 203**	**3 488 858**

10. Payables from exchange transactions

Trade payables	5 346 528
Other accrued expenses	754 214
	6 100 742

11. Revenue

Interest received on investment	194 489
Government grant	88 906 000
	89 100 489

12. Investment revenue

Interest revenue

Bank	194 489

Interest from Standard Bank investment account.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

13. Government grants and subsidies

Operating grants

Government grant	88 906 000

14. Compensation of employees

Basic salaries	27 385 147
Service and performance bonus paid	1 872 819
Medical aid -employer contribution	1 203 571
UIF - employer contribution	38 944
Provision for 13th cheque	1 115 121
Accrued leave provision	534 780
Pension - employer contribution	3 481 124
Other non-pensionable allowances	2 923 030
Bargain council	3 372
Salary accrual	124 511
Provision for performance bonuses	796 506
	39 478 925

15. General expenses

Advertising	1 194 149
Audit costs (refer to note 16)	814 872
Bank charges	57 331
Cleaning services	65 411
Consulting and professional fees	6 283 119
Inventory and other consumables	178 469
IT maintenance and support	79 308
Marketing and publication costs	236 392
Staff relocation	49 412
Printing and stationery	467 749
Telephone communication costs	623 211
Training and skills development	834 619
Travel, subsistence and accommodation	7 861 008
Office utensils	167 814
Water and electricity	184 648
Penalty and interest	5 884

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

15. General expenses (continued)

Catering services	289 810
Operating lease costs	1 416 204
Gains/(loss) from transfer of functions (refer to note 20)	27 134
Venues and facilities	212 287
	21 048 831

16. Audit costs

Internal audit	459 905
External audit	354 967
	814 872

17. Operating lease commitments

17.1 Operating lease liability - Office space

Escalation rate	10%

Future minimum lease payments

Up to one year	1 123 274
Within two years to five years	-
	1 123 274

The OHSC has an outstanding commitment in respect of lease of office space with the South African Medical Research Council. The lease agreement was entered into for a period of two (2) years effective from 01 March 2015.

16.2 Operating lease liability - Photocopying machines

Escalation rate	8%

Future minimum lease payments

Up to 1 year	76 695
2 - 5 years	122 633
	199 328

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

18. Cash generated from operations

Surplus	26 487 862
Adjusted for:	
Depreciation and amortization	655 203
Movements in operating lease assets and accruals	293 771
Increase in provisions	2 310 203
Adjustment for gain (loss) from transfer of functions included in the surplus	27 134
Changes in working capital:	
Receivables from exchange transactions	(62 050)
Receivables from non-exchange transactions	(26 410)
Payables from exchange transactions	6 100 743
	35 786 457

19. Financial instruments disclosure

Categories of financial instruments

2016

Financial assets

	At amortised cost	Total
Trade and other receivables from exchange transactions	63 858	63 858
Other receivables from non-exchange transactions	24 600	24 600
Cash and cash equivalents	32 149 886	32 149 886
	32 238 344	**32 238 344**

Financial liabilities

	At amortised cost	Total
Trade and other payables from exchange transactions	**6 394 514**	**6 394 514**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

20. Transfer of functions between entities under common control

Value of the assets acquired and liabilities assumed

Nature of transfer

Entities involved in the transfer of functions were the NDoH (transferor) and the OHSC (acquirer). The functions relating to the monitoring and enforcing compliance by health establishments with the health norms and standards were transferred to the OHSC. The transfer was in terms of the National Health Amendment Act 12 of 2013. The transfer became effective from 01 April 2015.

Value of the assets acquired and liabilities assumed

Assets acquired	
Property plant and equipment	1 151 521
Liabilities assumed	
Provision for leave	1 178 655
Difference between the assets and liabilities transferred	**27 134**

21. Commitments

The following capital commitments were made by year-end, but the services would be rendered after the end of the financial year

Approved expenditure

Capital expenditure	**267 430**

22. Contingencies

No provision for contingencies has been made as at 31 March 2016.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

23. Related parties

The OHSC has a related party relationship with the NDoH as the Executive Authority of the entity. It further has a related party transaction with Medical Research Council of South Africa through the lease of office space. The OHSC and the Medical Research Council of South Africa report under the same Executive Authority.

Related party transactions

Grant received	
National Department of Heath	**88 906 000**
Reimbursement	
National Department of Health	31 072 341
	31 072 341
Outstanding balance owed to:	
National Department of Health	3 296 271
	3 296 271

Medical Research Council of South Africa

Rental of office space	1 671 734
Leasehold improvements	843 777
Computer equipment (switches for the server)	315 194
	2 830 705

Related party transactions

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

23. Related parties (continued)

Non-executive members	Board fees	Reimbursements	Total
Prof. L Mazwai (Chairperson of the board)	104 601	40 084	144 685
Prof. S Essack	59 055	4 685	63 740
Dr. Z Brey	63 282	549	63 831
Prof. L Rispel (Deputy Chairperson of the board)	75 476	1 931	77 407
Mr. Martin Kuscus	80 010	7 293	87 303
Ms Mabotja	83 820	3 364	87 184
Prof. S Whittaker	75 438	-	75 438
Dr. E Stellenberg	111 633	5 905	117 538
Adv. S Lebala SC	15 240	992	16 232
Ms. T Gwangwa	48 006	20 925	68 931
Prof. G van Zyl	29 718	100	29 818
	746 279	**85 828**	**832 107**

Executive managers	Basic salary	Pension fund	Non-pensionable allowances and other payments	Service bonus	Reimbursements	Total
Mr. Msibi (Acting Chief Executive Officer)	733 657	90 228	498 924	57 642	8 215	1 388 666
Dr. Carol Marshall (Interim Chief Executive Officer) **	244 720	14 989	124 795	66 376	-	450 880
Mr. J Mapatha (Chief Financial Officer) ***	589 210	79 267	149 621	39 377	5 859	863 334
Subtotal	**1 567 587**	**184 484**	**773 340**	**163 395**	**14 074**	**2 702 880**

* Appointed as Acting Chief Executive Officer from 1 August 2015

** From 1 April 2015 to 31 July 2015

*** Appointed on 8 June 2015

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

24. Risk management

Financial risk management

The OHSC's activities expose it to a variety of financial risks: market risk (interest rate risk, credit risk and liquidity risk).

Liquidity risk

The entity's risk to liquidity is a result of the funds available to cover future commitments. The entity manages liquidity risk through an ongoing review of future commitments and credit facilities.

At 31 March 2016	Less than 1 year	Between 1and 2 years	Between 2and 5 years	Over 5 years
Current liabilities	9 883 371	-	-	-

Credit risk

Credit risk consists mainly of cash deposits and cash equivalents. The OHSC only deposits cash with major banks with high quality credit standing and limits exposure to any one counter-party

Interest rate risk

By the end of the financial, the OHSC had significant cash invested in a short term investment account. The OHSC generally adopts an approach ensuring that its exposure to changes in interest rate is on a floating rate basis. The OHSC does not have any interest-bearing borrowings and as a result there is no adverse exposure relating to interest rate movements in borrowings

25. Going concern

The annual financial statements have been prepared on a going concern basis and the Accounting Authority has no reason to believe that the entity will not be a going concern in the foreseeable future.

This basis presumes that funds will be available to finance future operations and that the realization of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of business.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

26. Events after the reporting date

The Accounting Authority is not aware of any matter or circumstance arising since the end of the financial year that needs to be disclosed in the annual financial statements.

27. Unauthorised expenditure

No unauthorised expenditure was incurred during the financial year.

28. Fruitless and wasteful expenditure

Penalty and interest	**5 884**

The penalty and interest was incurred as a result of late payment to SARS.

29. Irregular expenditure

Add: Irregular Expenditure - current year	**1 963 263**

The OHSC was listed in accordance with the PFMA as a Schedule 3A public entity in May 2014. The NDoH requested the OHSC to move out of their office space as soon as possible, and this required the OHSC to find alternative office space on a temporary basis until a long term arrangement was made. The office that was immediately available was found at the South African Medical Research Council, and the OHSC entered into a lease for this office space for a period of one year. The decision was taken and approved by the accounting authority of the OHSC.

30. Reconciliation between budget and statement of financial performance

Reconciliation of budget surplus/deficit with the surplus/deficit in the statement of financial performance:

Net surplus per the statement of financial performance	26 487 862
Adjusted for:	
(Over)/ under collection of revenue	(194 489)
Over/ (under) budget expenditure	(21 929 550)
Net surplus per approved budget	**4 363 823**

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

Figures in Rand	2016

31. Board fees and related costs

Board fees and reimbursements	832 107
Other expenses	597 562
	1 429 669

32. Budget differences

Material differences between budget and actual amounts

Compensation of employees

- The Board commenced with the process for the appointment of the CEO, and by year end, this process was not yet concluded, hence the position of the CEO remained vacant.
- The Ombud is appointed by the Minister of Health, and by year end this process was not yet concluded. This also applies to the staff members in the office of the Ombud.
- At the start of the financial year, the OHSC did not have the full staff complement, and the recruitment process continued throughout the financial year with some savings realized from the budget of the positions which were filled later in the year.

Goods and services

- The communications and stakeholder relations strategy was finalised in the latter part of the financial year and will be implemented in the new financial year.
- The process for the procurement of the call centre, which will assist in complaints management, will be finalised in the new financial year.
- Additional savings were realised in administrative expenditure such as telephone costs due to delayed implementation of the call centre, audit fees, computer maintenance as well as leasing of office space.

Capital expenditure

- The budget for intangible assets largely related to software for the server infrastructure, which the OHSC did not have, as it utilised the server infrastructure provided by the South African Medical Research Council. The budget was utilised to procure computer equipment and furniture for the OHSC, whilst ensuring that the expenditure remained within the budget.

Notes

Notes

Telephone:
012 339 8699

Physical address:
The Office of Health Standards Compliance,
Medical Research Council Building,
1 Soutpansberg Road,
Prinshof, Pretoria

GPS Coordinates:
25d, 44m, 15.8s ; East 28d, 12m, 00.1s

Postal address:
OHSC
Private Bag X21
Arcadia 007