

EARLY WARNING SYSTEM RECOMMENDATIONS REPORT NATIONAL --- 2023



Office of Health Standards Compliance
Ensuring quality and safety in health care



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Abbreviations and Acronyms

EC	Eastern Cape Province
EWS	Early Warning System
FS	Free State Province
GP	Gauteng Province
HE	Health Establishment
KZN	KwaZulu-Natal Province
LP	Limpopo Province
MHCU	Mental Health Care User
MP	Mpumalanga Province
NHA	National Health Act
NHAA	National Health Amendment Act
NC	Northern Cape Province
NW	North West Province
OHSC	Office of Health Standards Compliance
WC	Western Cape Province
WHO	World Health Organisation

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1.Introduction and overview

1.1 Background

The early warning system (EWS) is a surveillance system used to collect information on specific indicators (events) and is used as part of monitoring indicators of risk related to breaches to the norms and standards regulations. In accordance with the procedural regulations pertaining to the functioning of the OHSC and handling of complaints by the Ombud (2016), the Office must guide health establishments on the indicators of risk by category of health establishment, the approach to measuring and calculating the indicators of risk, the frequency of collection of the indicators of risk and the reporting of such indicators.

The EWS system provides regular and continuous monitoring of eleven (11) specific indicators used to identify establishments posing significant risks to quality of care and safety of users and to enable prompt interventions aimed at addressing health establishment and health system gaps responsible for the occurrence of adverse events. The OHSC started implementing the EWS surveillance as part of its regulatory processes in March 2020. The implementation of the system followed consultation and training workshops that were conducted to orientate and guide health establishments on the mechanism for reporting of EWS incidents.

The 2023 Early Warning System (EWS) report provides an overview of EWS incidents that were either reported to the Office of Health Standards Compliance (OHSC) by health establishments or identified through other sources such as media reports. As part of the monitoring process, the Office makes follow up with the health establishments upon receipt of incident reports or identification of media alerts to request additional information to establish the veracity, clinical context and circumstances, as well as root cause analysis (RCA) conducted and mitigation strategies in a form of quality improvement plans (QIPs). The other objective of requesting additional information is to enable the Office to review the micro and macro systems in place as well as the health establishments' efforts to comply with norms and standards regulations. This report includes all reported EWS incidents from the private and public sector.

1.2. Introduction

The OHSC is mandated to monitor indicators of risk as an early warning system relating to serious breaches to the norms and standards in section 79(1) of the National Health Act 61 of 2003 as amended in 2013, as well as to identify areas and make recommendations for intervention by relevant authorities to ensure compliance with prescribed norms and standards. The information gathered by the EWS is key in identifying gaps in patient safety and other aspects of quality of care within health establishments. As the regulator mandated to promote and protect the health and safety of users in South Africa, the monitoring of compliance through the EWS is a critical mechanism in ensuring that areas of concern are identified, analysed, communicated and addressed, to avoid and reduce harm as well as to prevent recurrence of such incidents within the health system.

1.3 Methodology and Process

The EWS current submission process and requirements are that the health establishments are required to report to the OHSC on specific indicators (incidents) following their occurrence within twenty four (24 hrs) hours after they became aware of such incidents. The incidents are captured on the prescribed EWS reporting form which is emailed to ews@ohsc.org.za or through the dedicated EWS online system. The EWS online system went live on 1 April 2022 with the aim of gradually phasing out the use of email system (HALO) for EWS reporting. The phasing out of the email system has been communicated to stakeholders

1.3.1 Incidents reported by health establishments

A total of 11 EWS indicators have been developed in line with the promulgated norms and standards and health establishments are required to report on these identified sentinel events. The review of these indicators will be undertaken as part of strengthening the process informed by the current reporting trends and other relevant health system quality of care considerations. Table 1 below provides a complete list of the current EWS indicators that must be reported on by all health establishments. These 11 incidents are to some extent proxy indicators of systemic and systematic weaknesses in quality of care, and also suggest possible breaches to specific norms and standards regulations indicated in the right column of the Table.

1.3.2 Incidents identified through alerts

In addition to the direct reporting by health establishments to the OHSC, the Office also uses other monitoring means through the various media platforms and sources to identify reports relating to these EWS indicators not reported by health establishments. These other sources include the various media platforms (mainstream print and online platforms including social media), complaints lodged with the OHSC, and whistle-blower (usually staff within the HEs) reports as well as reports and referrals by other regulators.

Indicator (Incident to be reported to the OHSC)		Norms and Standards Regulation
1	Missing minor	17(1) The health establishment must have systems to protect users, health care personnel and property from security threats and risks
2	Abscondment of a patient	
3	Suicide of an in-patient	
4	Acts of harm to staff	
5	Acts of harm to patients	
6	Unavailability of Radiological services (CT-scan, X-ray and sonar service)	(1) The health establishment must ensure that diagnostic services are available and safe for users and for health care personnel involved in delivering these services 19(2)(a) The health establishment must, as appropriate to the size and type of health establishment, have and implement a human resource plan that meet the needs of the health establishment
7	Unavailability of handwashing soap	(2)(a) A health establishment must ensure that there are hand washing facilities in every service area
8	Unavailability of water for > 24 hours	15(2) A health establishment must have 24-hour electrical power, lighting, medical gas, water supply and sewerage disposal system
9	Retained foreign object in a patient following a surgical/invasive procedure	7(2)(b) the health establishment must establish and maintain systems, structures and programmes to manage clinical risk
10	Wrong-site surgery	
11	Procedure-related avoidable deaths	

2. Reported incidents

2.1 Number of reported incidents per province

According to the OHSC health establishment register and database, South Africa has about 3932 public health establishments of various categories, distributed across the nine (9) provinces and 52 districts. Whilst the private sector hospital groups have approximately 400 health establishments made up of private acute and day hospitals. The reporting trends from both the public and private sectors remain suboptimal taking into consideration the incidence and prevalence of the healthcare quality challenges within the health systems in the country. Of all the health establishments from the public sector and private hospital groups, a total of 1865 incidents reports were received during the period under review and this represents an increase of approximately 350 reports compared to the previous year. A total of 116 reports received were not aligned to the 11 indicators. Figure 1 is a depiction of the total number of reports received disaggregated by province.

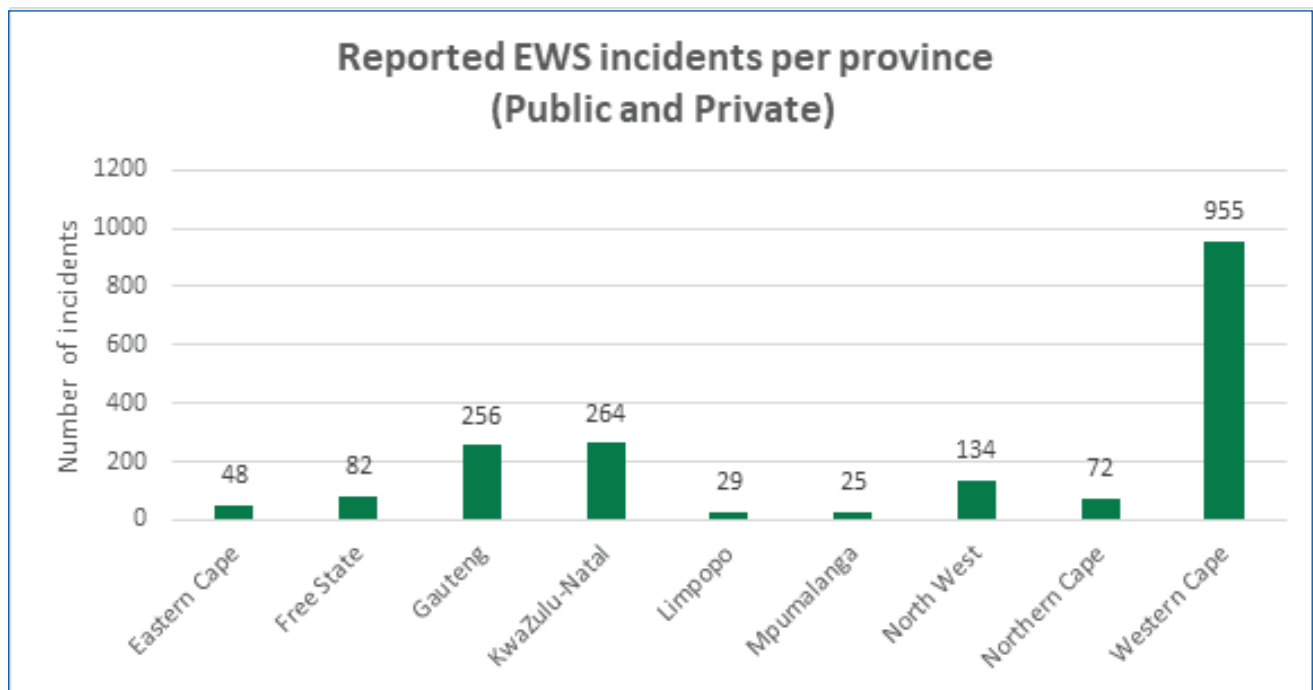


Figure 1: Number of EWS incidents reported per province and sector

2.2 Number of reported incidents between public and private health sectors

The reporting trends for the EWS incidents between the private and public sectors have shown gradual improvement in the period under review in both sectors, despite the fact that there might still be significant number of incidents that go unreported. The public sector reported 1661 incidents while 204 incident reports were received from the private sector. The improvement in the reporting trends could be attributed to the OHSC's ongoing guidance and support workshops related to the EWS reporting requirements and processes. Figure 2 shows the number of reported incidents per sector.

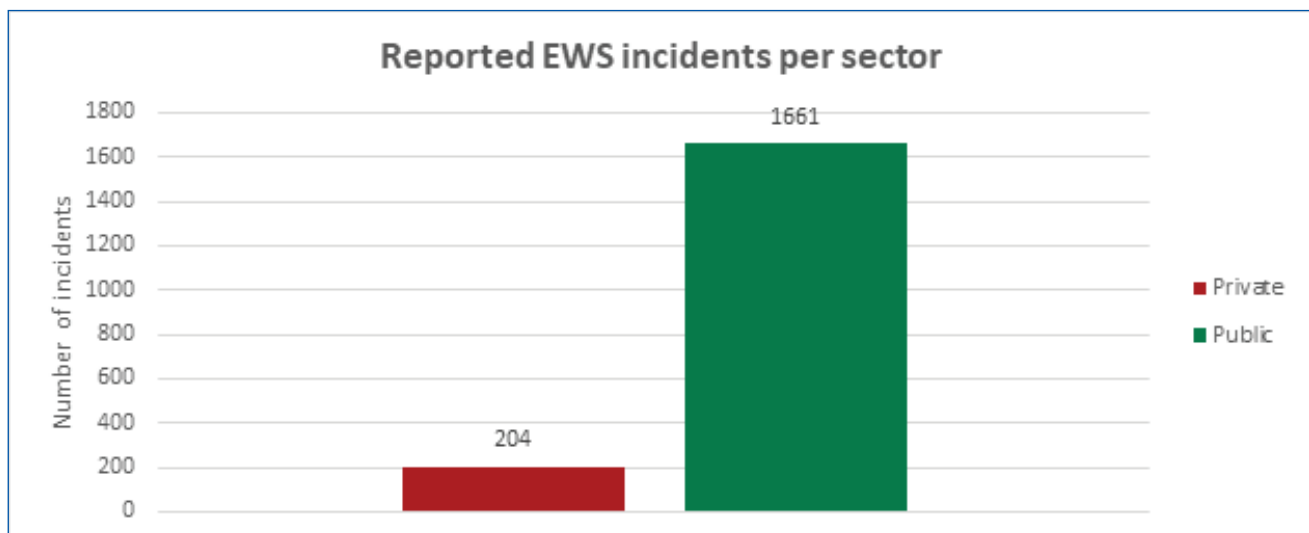


Figure 2: Number of reported incident per sector

2.3. Trends of EWS incidents between 2021 and 2023

The reporting patterns vary across the provinces in the public sector and private health groups in terms of the EWS incident reports submitted between the years 2021 and 2023. For instance, in the case of the Western Cape (WC), there has been a substantial increase in the reports received in 2022 and 2023 as compared to the reports in 2021 because the province only started reporting in the third quarter of 2021. Gauteng and KwaZulu-Natal reporting trends have shown significant improvement whilst Limpopo and Mpumalanga had shown a constant reporting patterns across all the three (3) years. Figure 3 shows the trends of EWS incidents reported over the three years period.

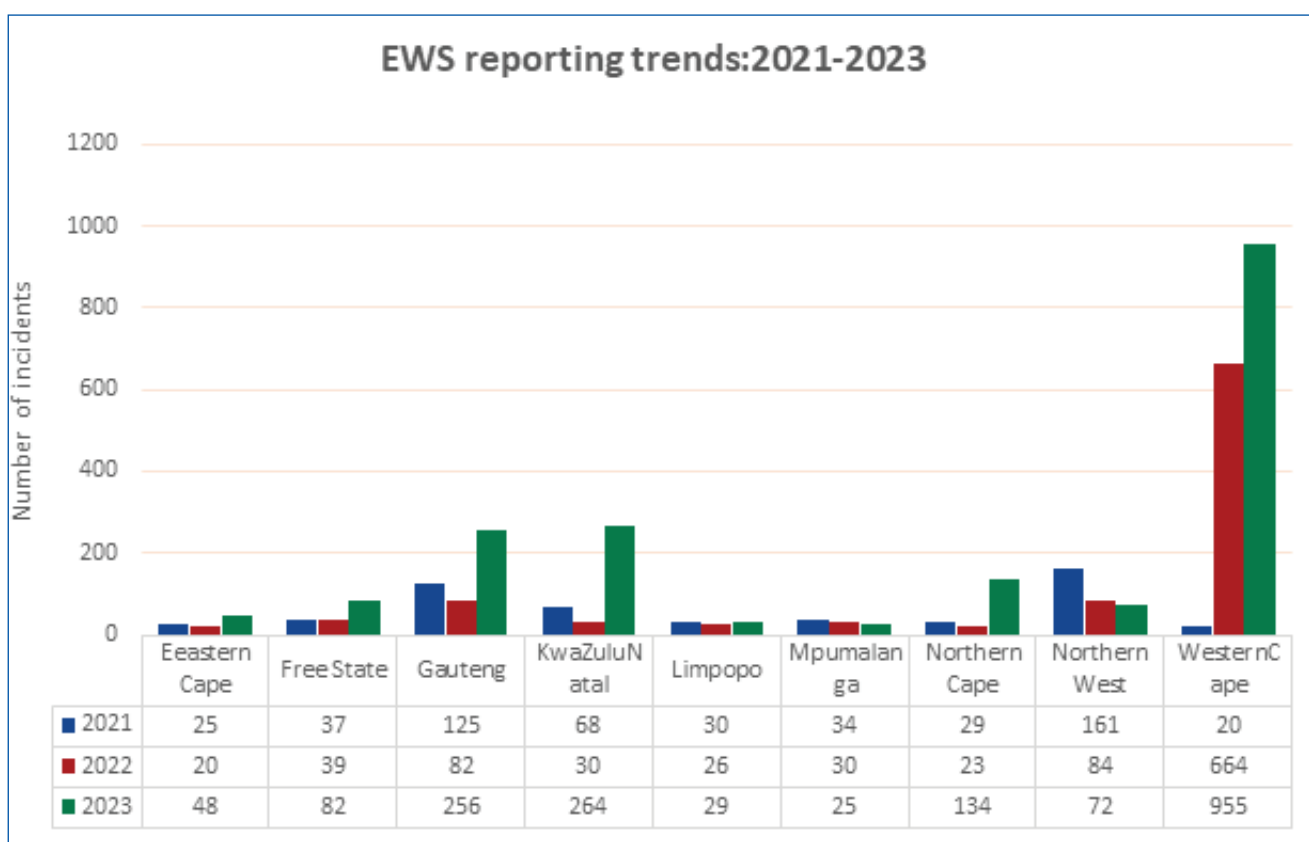


Figure 3: Trends of EWS incidents reported for the three year period of 2021-2023

2.4. Number of health establishments reporting on EWS indicators per province and health group in 2023

Reporting requirements on the early warning systems indicators constitutes a voluntary incident reporting that depends on the health establishments providing in-depth information on the occurred incidents within a specified time of 24 hours of the becoming aware of the event. Voluntary or self-reporting is a form of surveillance for incidents of unsafe or compromised healthcare quality related to the breaches to norms and standards regulations.

The EWS reports received during the period under review were from 256 health establishments in the public sector and 94 private sector health establishments making a total of 350. Western Cape continues to have the highest reporting trends within the public sector while Netcare has demonstrated a higher reporting trend in the private sector. National Health Network was the least reporting group in the period under review considering the highest number of health establishments affiliated to the group. Nevertheless, there is a noteworthy overall increase in the number of health establishments reporting on the EWS indicators as compared with the previous years from both sectors. This development is indicative of the increased general awareness and acknowledgement of the importance of the EWS across the healthcare system. Figure 4 and 5 respectively demonstrate the number of health establishments per sector that reported on the 11 EWS indicators in the period under review.

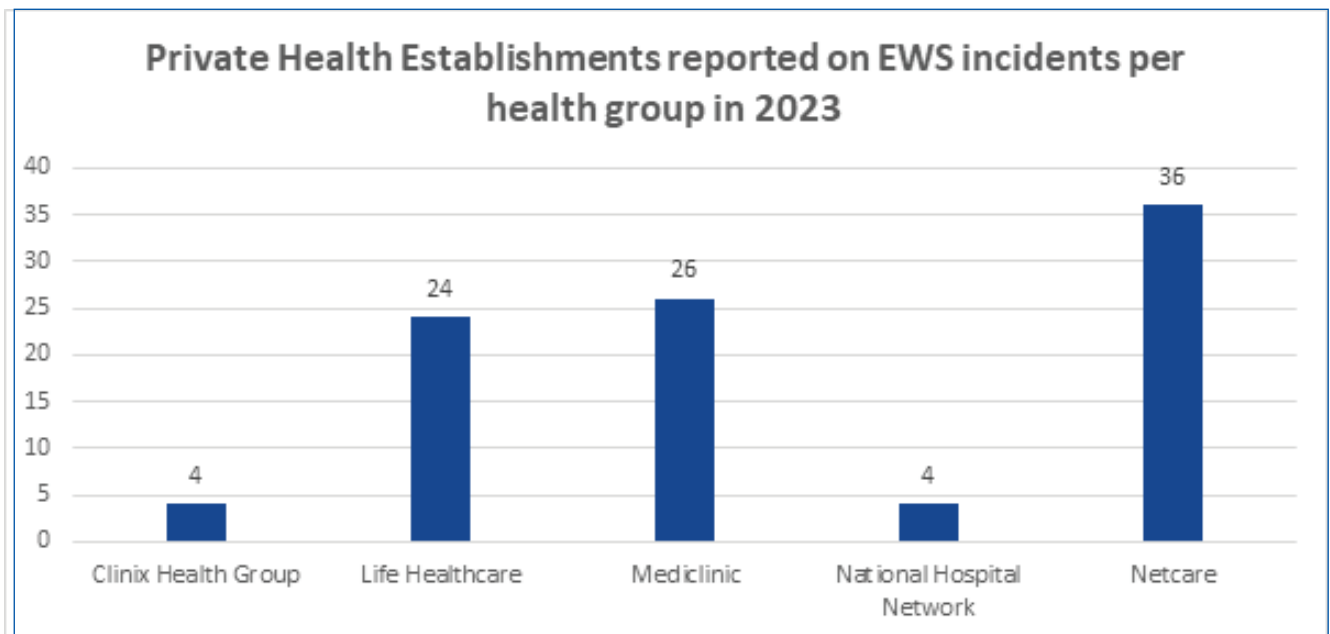


Figure 4: Number of private health establishments reported on the EWS indicators in 2023

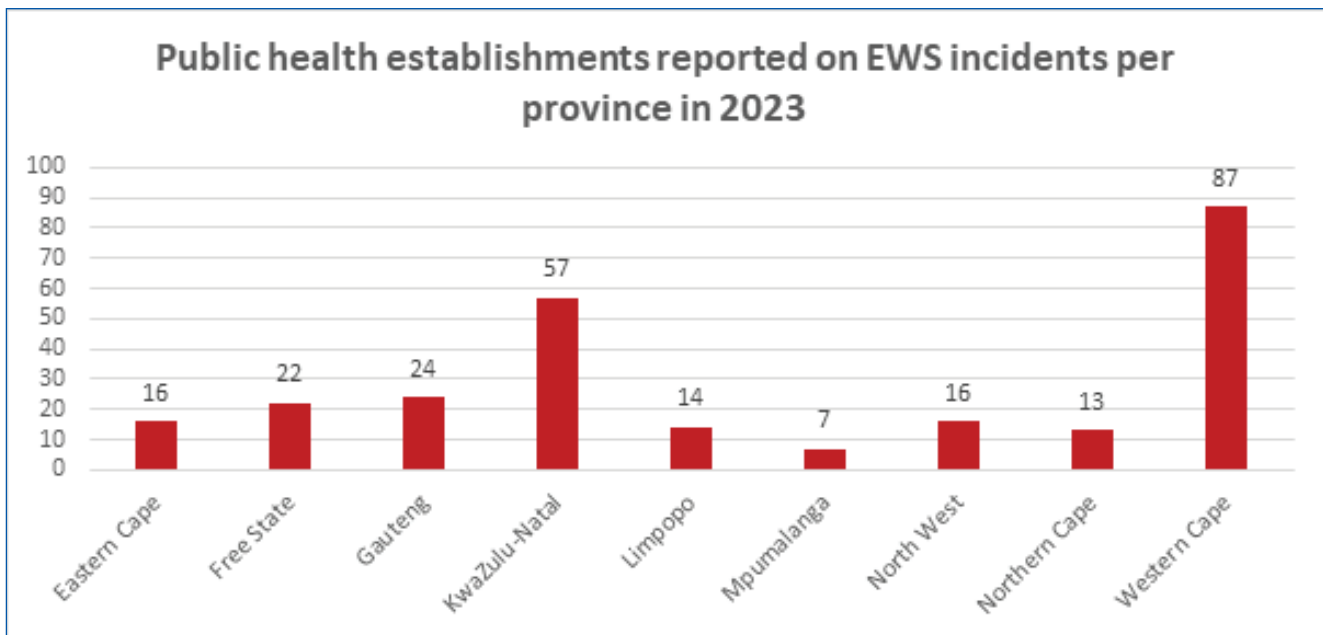


Figure 5: Number of public health establishments reported on the EWS indicators in 2023

2.5 Health Establishments' reporting trends on EWS indicators between 2021 and 2023

The reporting patterns and trends vary across the provinces in terms of the number of health establishments that reported on EWS incidents in the three years from 2021 to 2023. The overall trend shows an increase, albeit marginal, in the number of HEs reporting on EWS incidents.

Although there is an appreciation by the Office of the increasing trends in reporting by health establishments, there remains a concern that the prevalence of these EWS incidents is probably higher within the health system than what is currently reported. This assertion is based on the known challenges that exist within the health system and supported by the relatively higher rate of patient safety incidents reported through the National Annual Patient Safety Incidents and Complaints Report compiled by the National Department of Health. Figure 6 below indicates the trends between 2021 and 2023.

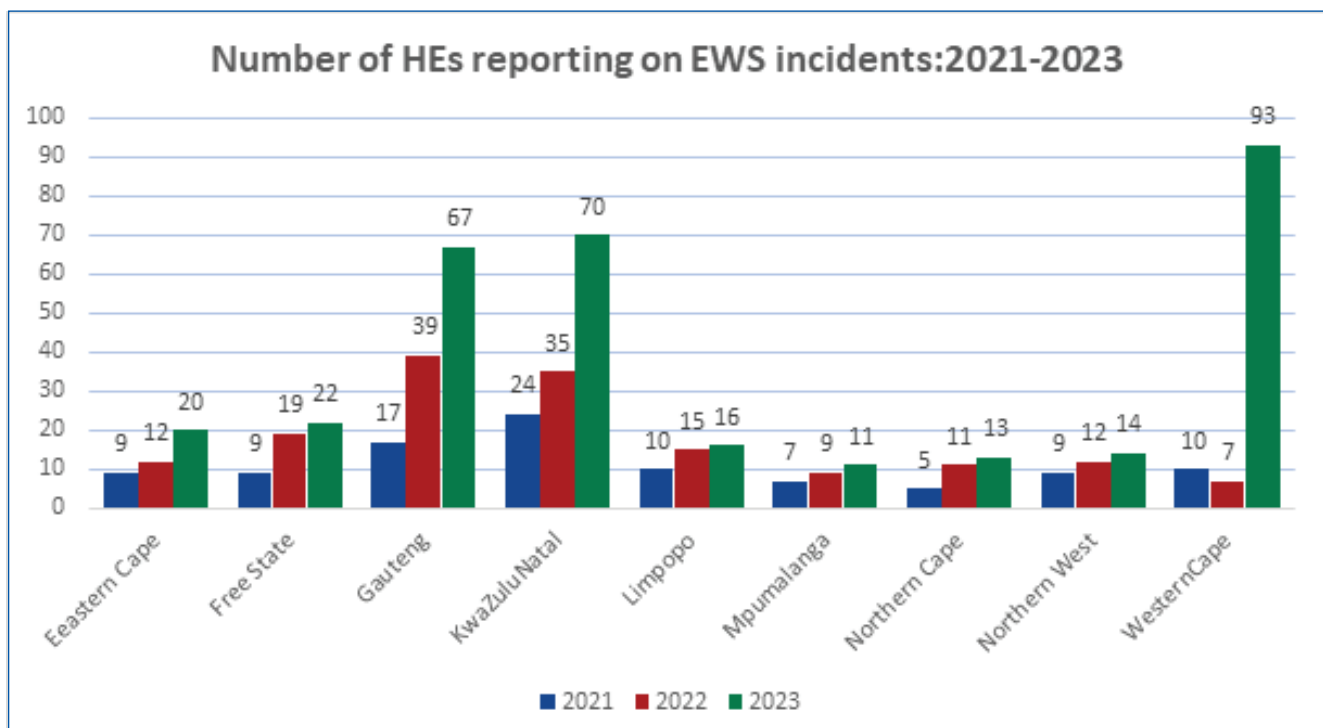


Figure 6: EWS trends of HEs reporting 2021, 2022 and 2023 per province

2.6. Reporting patterns by nature of incident

2.6.1. Missing minor

A missing minor is one of the indicators that signify high risk quality challenges and is indicative of gaps in security measures in a health establishment and relates to a breach to regulation 17(1). Across the nine (9) provinces, six (6) of the provinces submitted reports on this indicator with a total of 14 incidents reported. The private sector as well as three (3) of the provinces (Eastern Cape, Limpopo and Eastern Cape) did not report any incidents of a missing minor as shown in Figure 7.

The analysis of the submitted reports from the health establishments suggest poor or inadequate security systems in the establishments. Of all the reported cases within the period under review, it was noted that seventy-one percent (71%) of the minors were taken out of the health establishments by their next of kin without notifying the personnel, whilst others were either taken by strangers who gain access to the units where neonates are nursed or paediatric users walking out of the health establishments unnoticed.

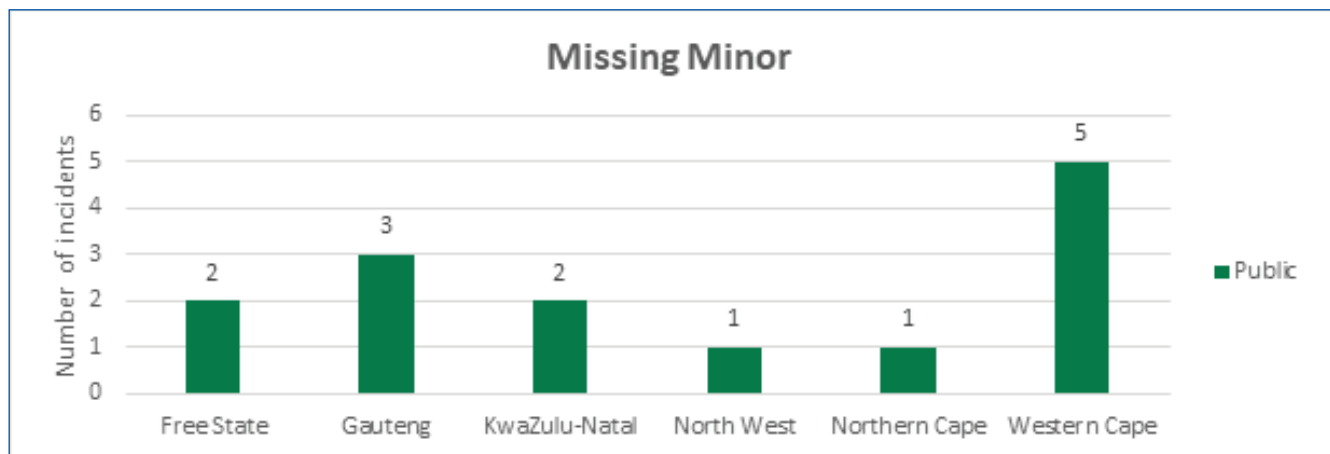


Figure 7: Distribution of incidents of missing minor in the public sector

2.6.2. Abscondment of a patient

Abscondment of users from health establishments constitutes the most reported incident in the public sector. Figure 8 depicts the number of reported abscondments in health establishment per province and sector. A total of 836 incidents of abscondment were reported in the period under review. The Western Cape is the province with the largest number of reported incidents with 437 reports which is slightly lower than what was reported in 2022. This observation, in all likelihood, does not mean that most abscondments are occurring in this particular province but rather an indication that the province has a high reporting pattern than other provinces. The occurrences of these incidents are suggestive of the breach of Regulation 17 (1) which requires that health establishments must have systems to protect users, health care personnel and property from security threats and risks.

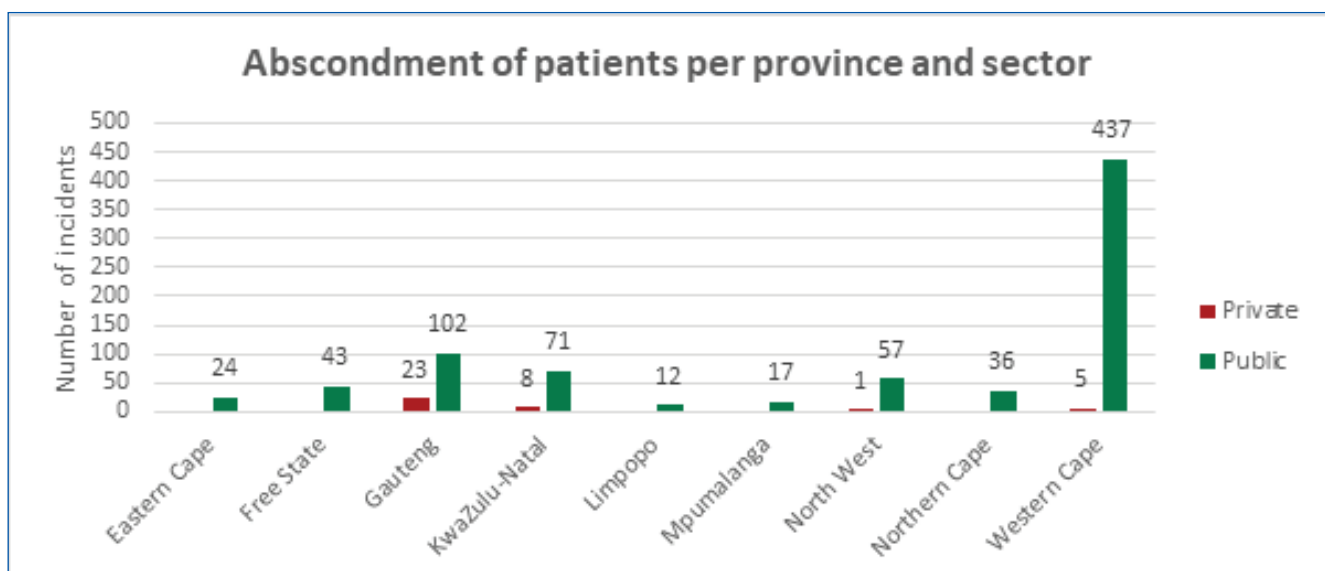


Figure 8: Reported incidents of abscondment of patients per province and sector

2.6.3. Suicide of an inpatient

A total of 34 incidents of suicide of an in-patient were reported during the period under review. These incidents were reported from the seven (7) of the nine (9) provinces with 24 incidents reported from the public sector whilst ten (10) were from the private sector as shown in Figure 9 below. A significant proportion of these incidents occurred among mental health care users whilst others were users with undiagnosed mental health conditions as they were admitted for various medical conditions. The quality of mental healthcare services and related issues remain a concern, considering the current limited attention given within the South African health system. In both private and public sector, these incidents were reported from various functional areas and not exclusively from mental healthcare units. In the period under review, reports of suicide of in-patients indicate an increasing trend as compared to reports received in the preceding period of 2022.

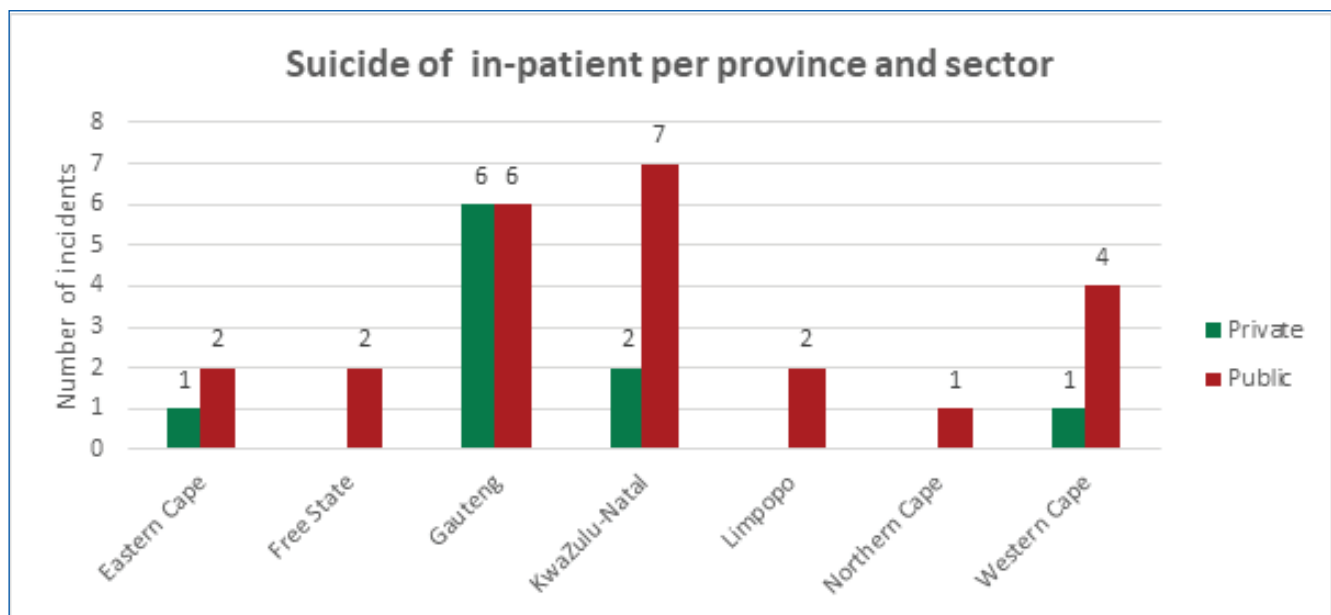


Figure 9: Reported incidents of suicide of an in-patient

2.6.4. Acts of harm to staff

Acts of harm to staff constituted the third most reported EWS incidents that occurred in both the public and private sectors with a total of 215 reported incidents. Of these reported incidents, 174 were reported from the public sector whilst 41 were reported from the private sector as depicted in Figure 10. These incidents were mostly reported from the specialised psychiatric hospitals whilst others were reported from other categories of health establishments. Detailed analysis of incidents show that most acts of harm against staff occur from civilian attacks in general wards, including accident and emergency units, and from mental health users with psychotic features attacking the personnel.

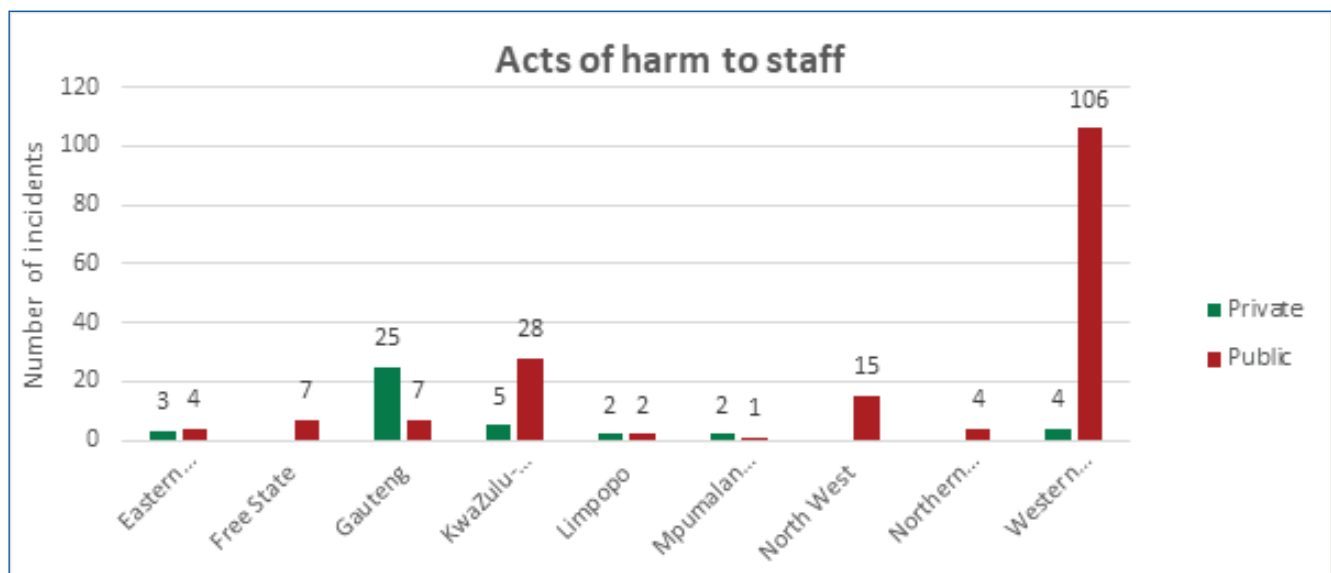


Figure 10: Reported incidents of acts of harm to staff

2.6.5. Acts of harm to patients

A total of 368 incidents related to acts of harm to patients were reported from all the nine (9) provinces in both the public and private sectors as shown in Figure 11 below. This is the second most reported EWS incident, and most often involves mental healthcare users. At least eleven (11) out of 368 incidents of this nature were reported from the private health sector. The highest reported number of incidents was from the Western Cape with 290 reports. The EWS reports received from the Western Cape were mainly from the specialised psychiatric hospitals. And most of these incidents occur among mental healthcare users either as grievous bodily harm and /or sexual assaults.

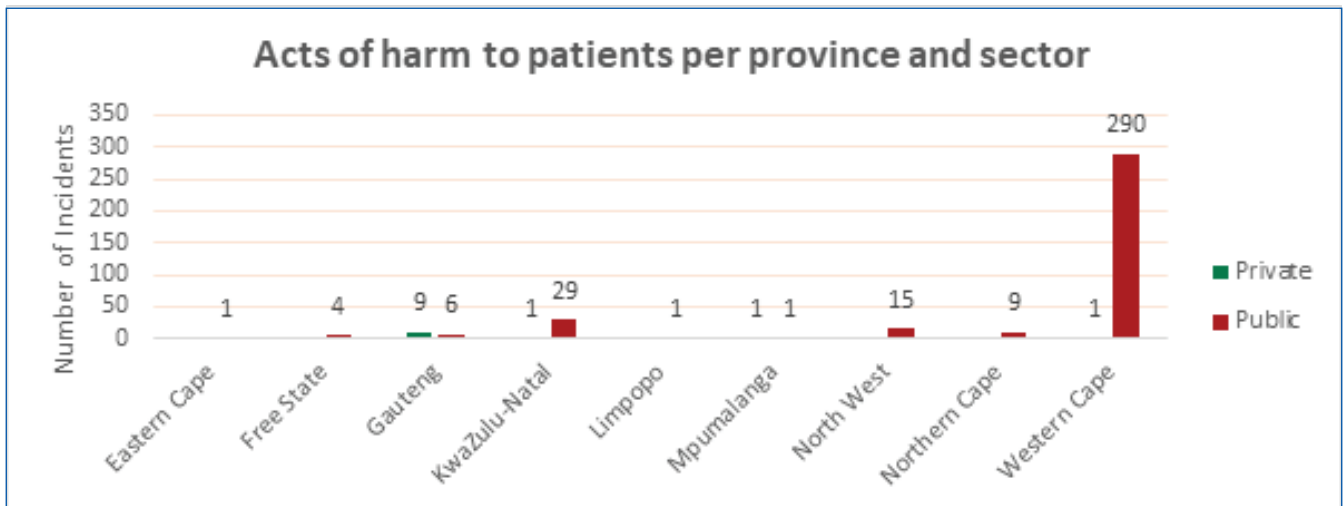


Figure 11: Reported incidents of acts of harm to patients

2.6.6. Unavailability of Radiological services

Radiology services are a crucial and essential component which is a key diagnostic and therapeutic tool for many diseases and has an important role in monitoring treatment and clinical outcomes. According to the WHO, medical imaging is crucial in a variety of medical settings and at all major levels of health care.

A total of 85 incidents of unavailability of radiological services for a period exceeding 3 hours were reported. Of these 85 incidents, 80 were reported from the public sector whereas five (5) were reported from the private sector with North West reporting the highest number at 32, followed by KZN with 18 reported incidents. Most of the incidents that were received from the North West were reported by one health establishments which reported that the challenge had been experienced since March 2023. Figure 12 is an illustration of all reported incidents during the period under review.

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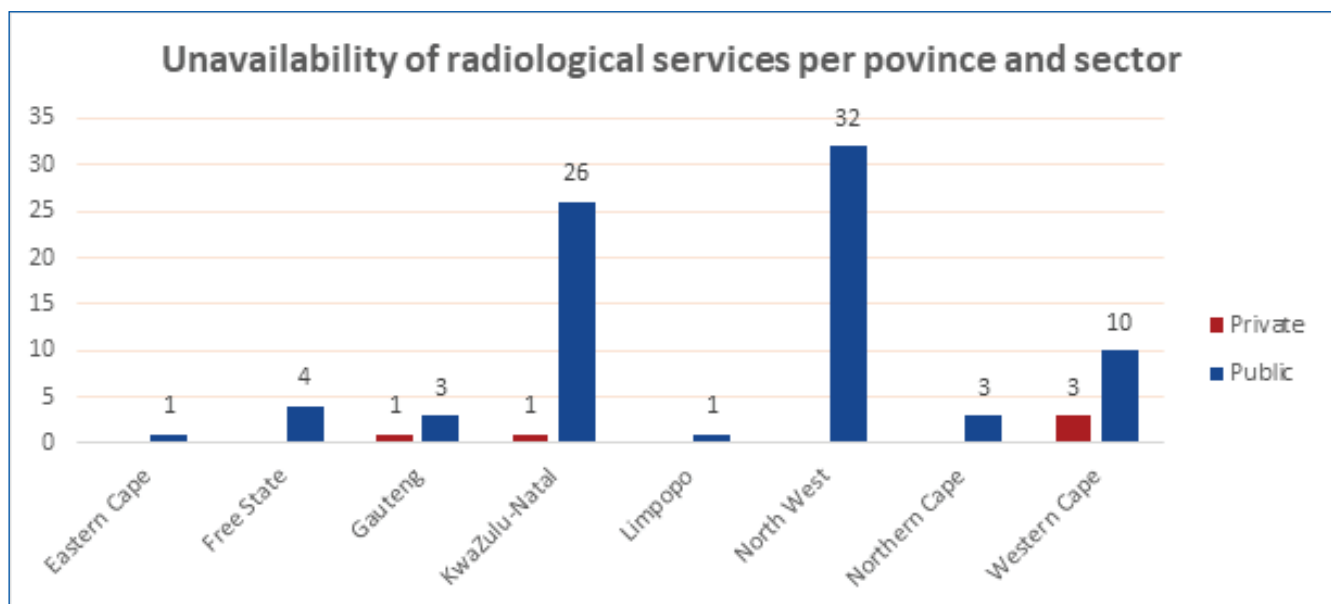


Figure 12: Reported incidents of unavailability of radiological services

2.6.7. Unavailability of handwashing soap

Hand washing facilities are a vital requirement for ideal infection prevention and control (IPC) principles and include availability of handwashing soap. Its importance is for general hygiene maintenance and also for performing sterile procedures essential for safety and quality patient care. The procedures include and are not limited to handwash for surgical procedures, wound dressings and intravenous infusion insertion. Alcohol-based handrubs are usually used in other cases for disinfection purposes, but theater activities need water and soap for scrubbing over and above disinfection.

An overall number of nine (9) incidents of unavailability of handwashing soap were reported and all of these were reported from KZN (public sector) health establishments. The unavailability of hand washing facilities including soap may have a detrimental effect on the users and access to healthcare services as procedures may be delayed or postponed causing backlogs.

2.6.8 Unavailability of water for more than 24 hours

A total of 43 incidents of unavailability of water for more than 24 hours were reported and all were in the public sector. The 43 incidents are less than the 60 incidents that were reported in 2022. This relatively low number of reports in the period under review is possibly suggestive of underreporting considering the fact that the water crisis in the country has worsened with widely reported water outages and interruptions across many municipalities. In this report, only Mpumalanga province did not report on this indicator as depicted in Figure 13

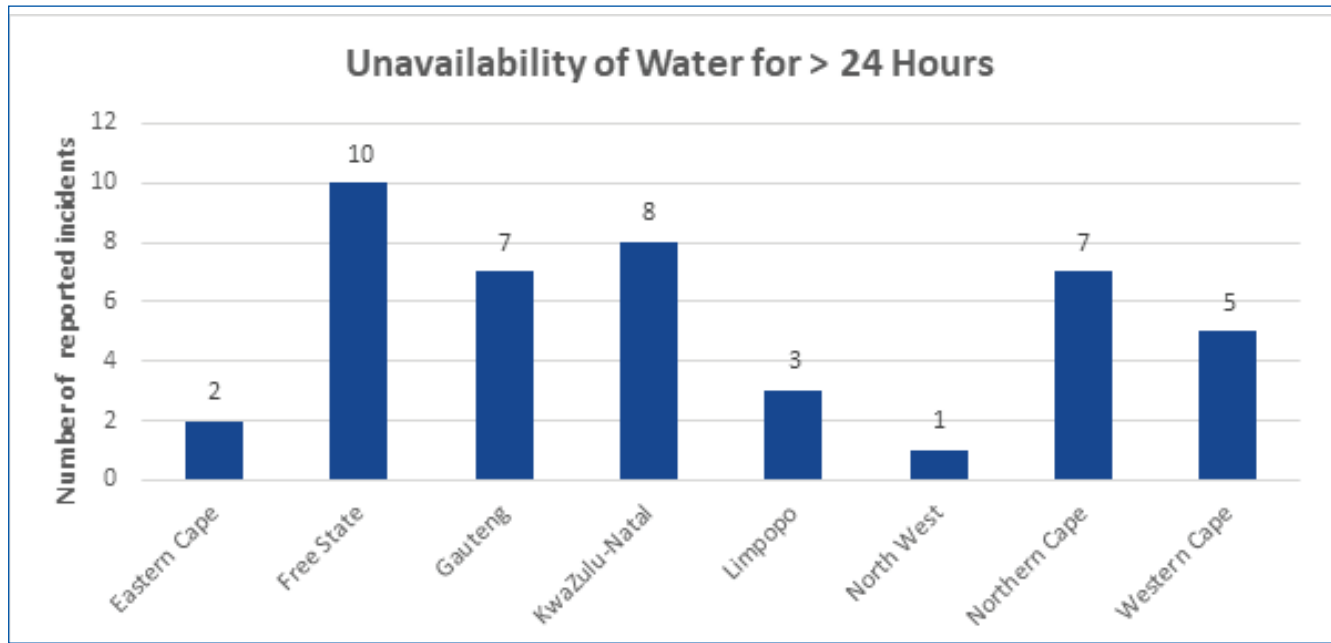


Figure 13: Incidents of unavailability of water for more than 24 hours

2.6.9. Retained foreign object in a patient following an invasive/surgical procedure

This indicator refers to any foreign bodies that unintentionally remain inside the patient post-surgery, usually requiring additional procedures. For the period under review, the incidents relating to retained foreign objects, were reported predominantly by the private sector. A total of 65 incidents of retained foreign object following an invasive procedure were reported from seven (7) of the nine (9) provinces. Of these 65 incidents, 49 were reported from the private sector whilst 16 were reported from the public sector as shown in Figure 14 below.

There was a significant increase of 29 reported incidents relating to this indicator as compared to the 2022 report which had a total of 36. More public sector health establishments have started reporting on this indicator in 2023 although the majority still came from the private health establishments. The observed trend could also be indicative of underreporting of these incidents from the public sector considering the prevalence of surgical procedure related adverse events reported annually to the National Department of Health's patient safety incident register.

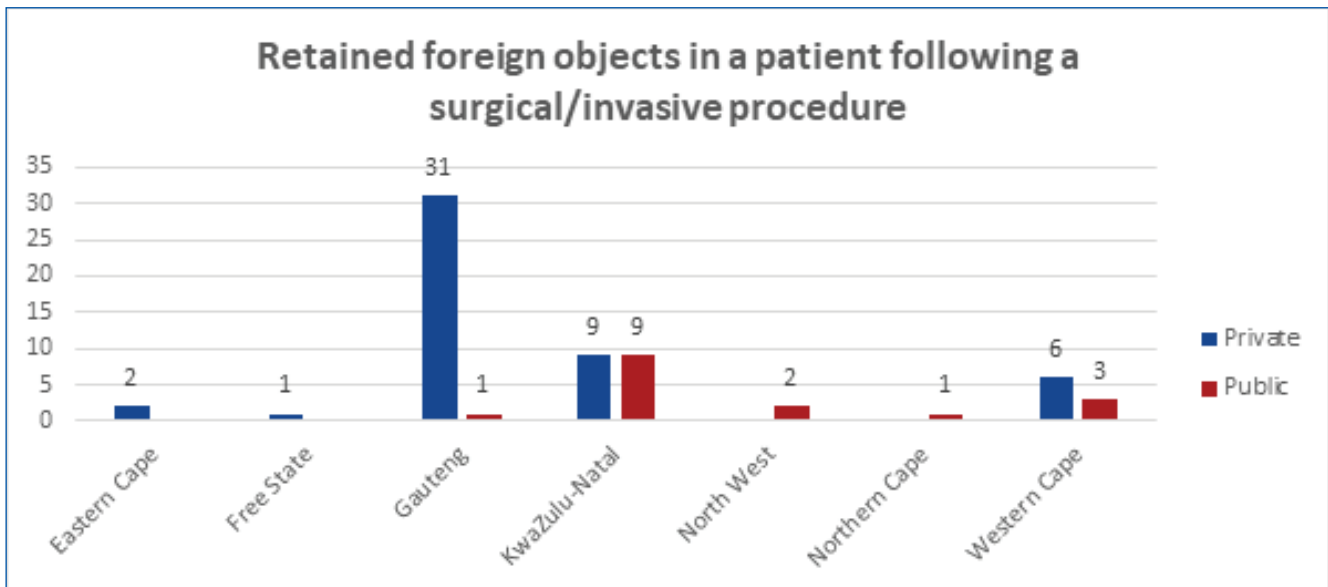


Figure 14: Incidents of retained foreign object in a patient following surgical/invasive procedure

2.6.10. Procedure related avoidable deaths

According to the Inquests Act 58 of 1959, procedure related avoidable deaths constitute the death of a person undergoing, or as a result of a procedure of a therapeutic, diagnostic or palliative nature, or of which any aspect of such a procedure has been a contributory cause. Such deaths are considered to be preventable and may have occurred due to substandard care. It is essential that health professionals recognise the need for greater protection for the vulnerable patient under their authority and care.

A total of 27 incidents of procedure related deaths were reported with 14 of these reported from the public sector whilst 13 were reported from the private sector as shown in Figure 15.

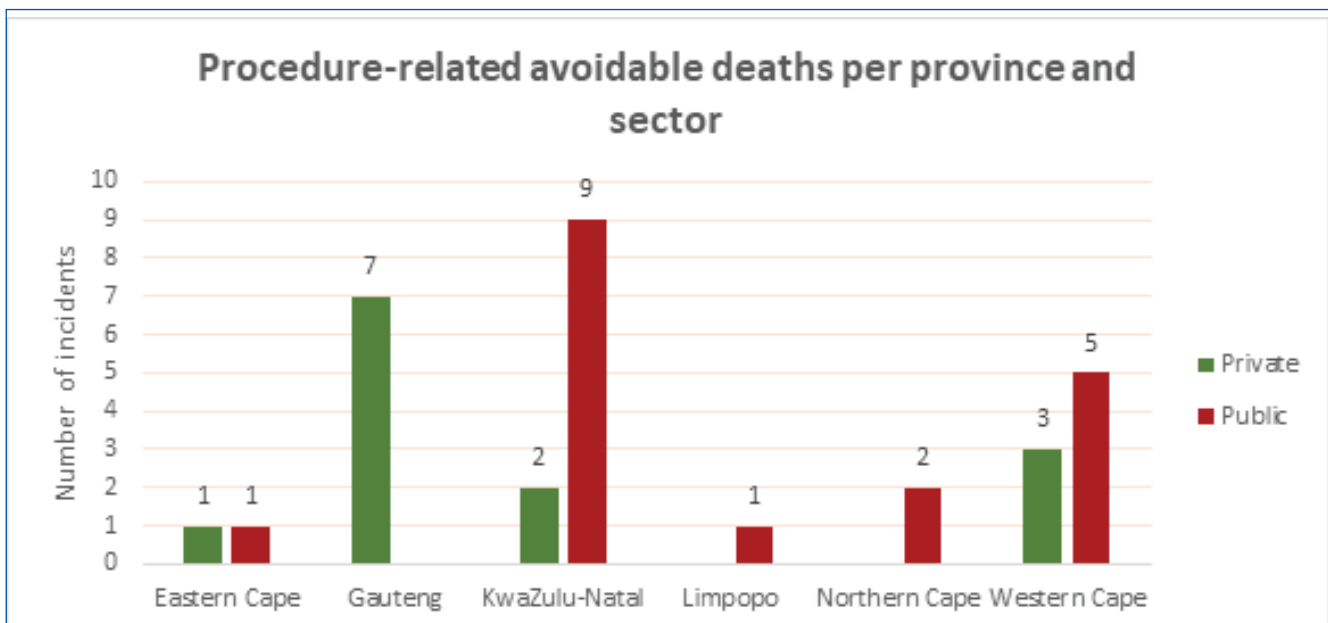


Figure 15: Reported incidents of procedure related avoidable deaths

2.6.11. Wrong site surgery

Similar to the indicator of retained foreign object in a patient following surgical/invasive above, wrong site surgery indicator received significantly higher number of reports as compared to the previous year of 2022. A total of 21 incidents of wrong site surgery were reported in the period under review. Of these 21 incidents, 19 were from the private sector whilst two (2) were from the public sector, as depicted in Figure 16 below. It is worth emphasising that the reporting trends do not necessarily imply that more incidents of wrong site surgery occur mainly in the private sector as there is generally a suboptimal reporting pattern by the public sector health establishments

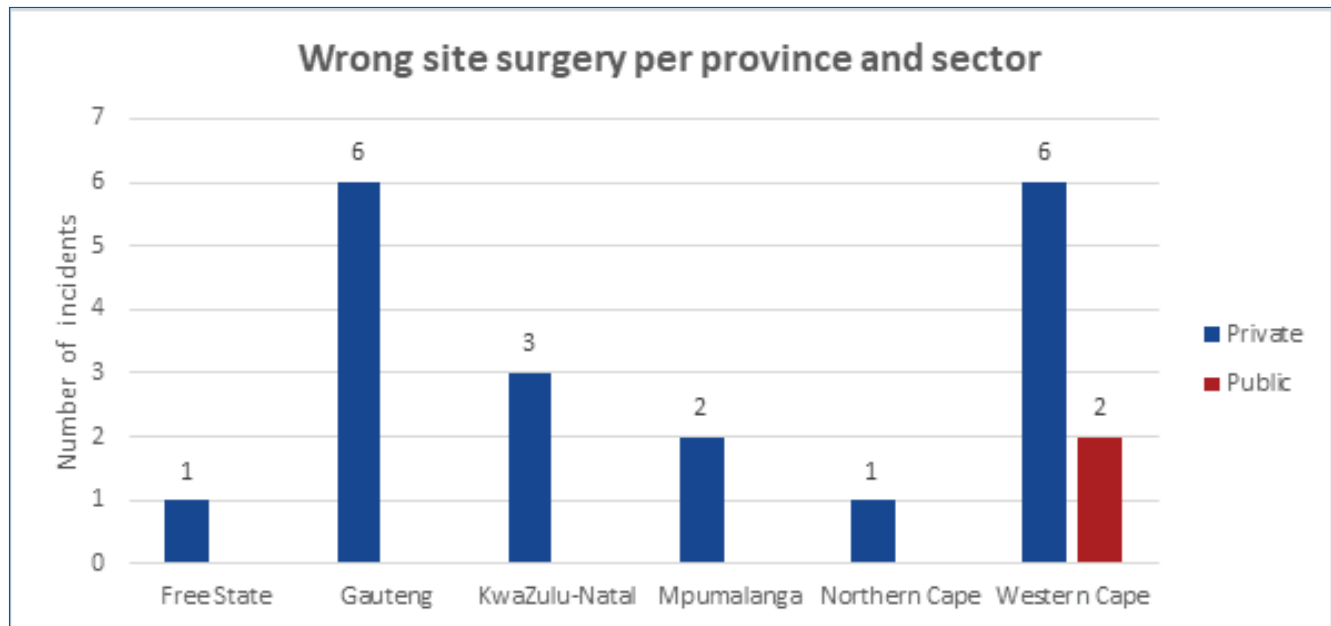


Figure 16: Distribution of reported incidents of wrong site surgery

2.7 Distribution of incidents between public and private sector

The EWS reports were received through the two platforms being the Email system called HALO and the dedicated EWS online platform. Most of the private sector health establishment reported through the online system while the majority of public sector health establishments reported through the email system. The OHSC has decided to migrate to the dedicated online portal reporting platform to streamline reporting and prevent duplicate reporting. This decision has been communicated to the stakeholders during the various engagement sessions in the previous year.

In this report, Figure 17 and Figure 18 below show the number of reported incidents according to the nature of incidents and between the two sectors. Abscondment of users have shown to be the highest reported EWS indicator within the public sector whereas retained foreign objects in patients following surgery was the highest reported indicator from the private sector. There is notable difference in reporting trends between the two sectors disaggregated by the nature of the EWS incidents. Based on the knowledge of quality challenges within the health system, the OHSC remains convinced that the reporting trends cannot be a true reflection of incidence and prevalence of these incidents but rather reflect possible underreporting.

It should be noted that the incidents labelled 'other' in the four figures below represent those that were reported by health establishments but are not in line with the current 11 EWS indicators. While some of these incidents were related to patient safety, others were related to health system challenges such as staff strikes, unavailability of food, cleanliness, etc.

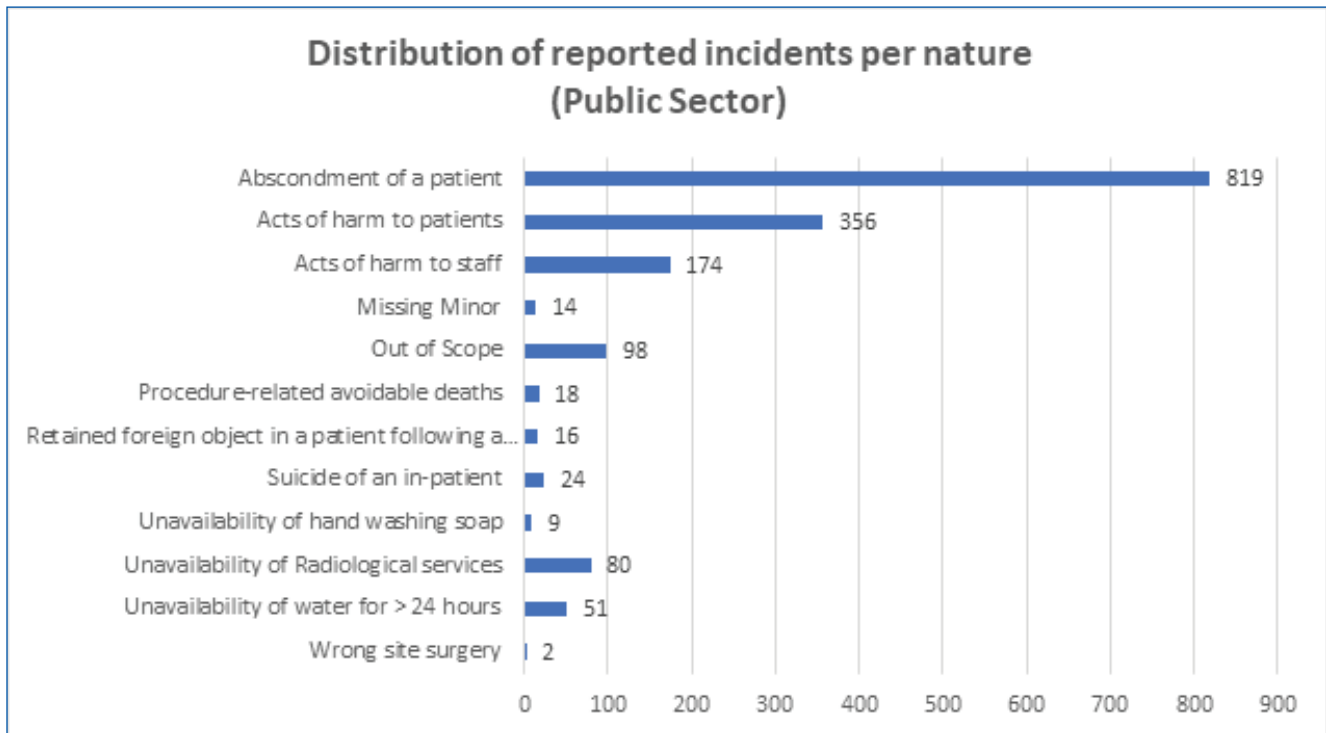


Figure 17: Number of incidents categorised by nature of incident: Public Sector

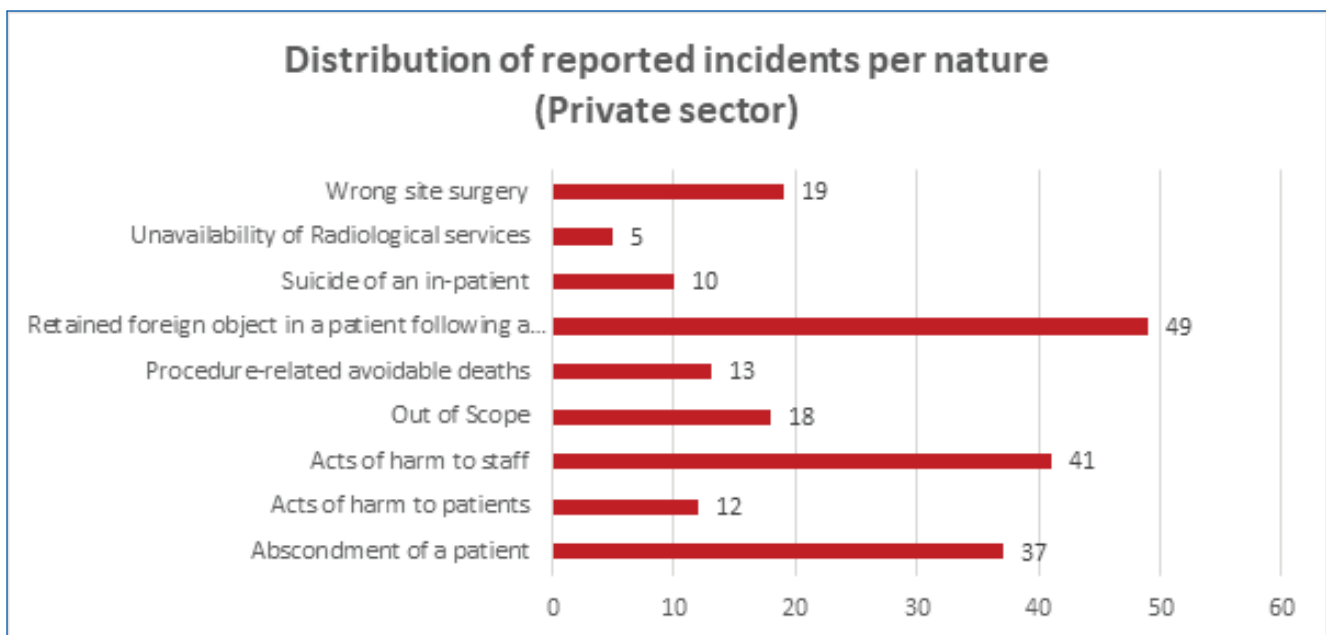


Figure 18: Number of incidents categorised by nature of incident: Private Sector

2.8. Distribution of incidents per province and health group

Figures 19 and 20 respectively are an illustration of incidents reported per sector across the five (5) Health Groups and those that are reported across the nine (9) provinces.

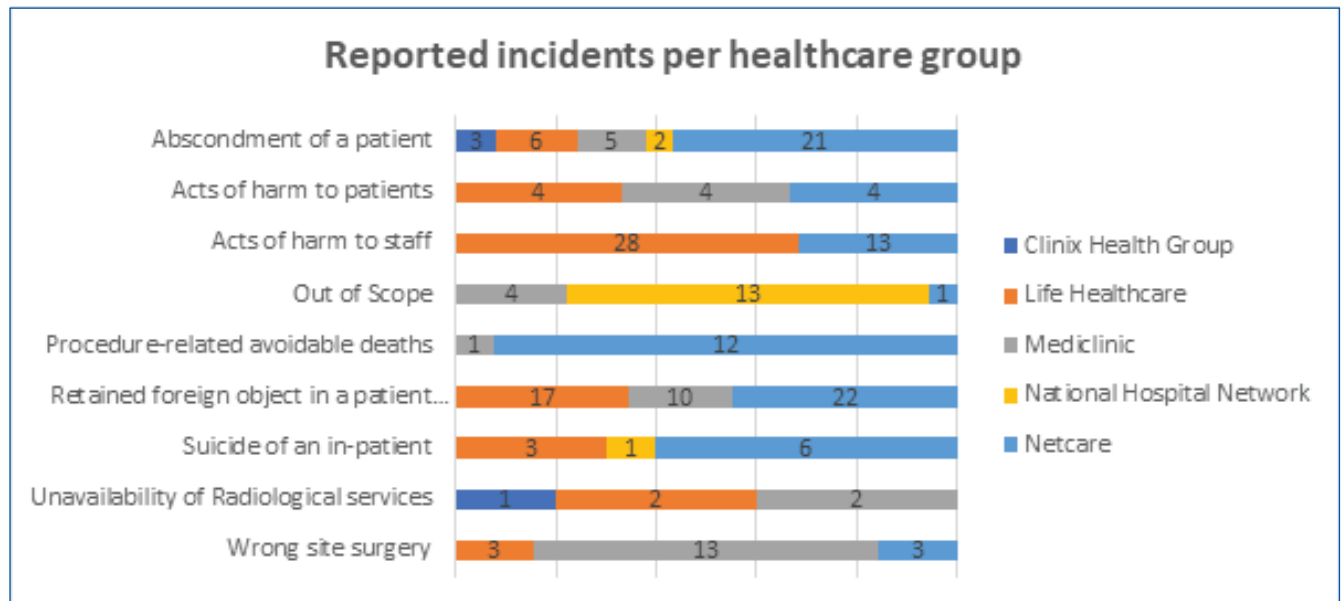


Figure 19: Distribution of reported incidents in private sector per healthcare group

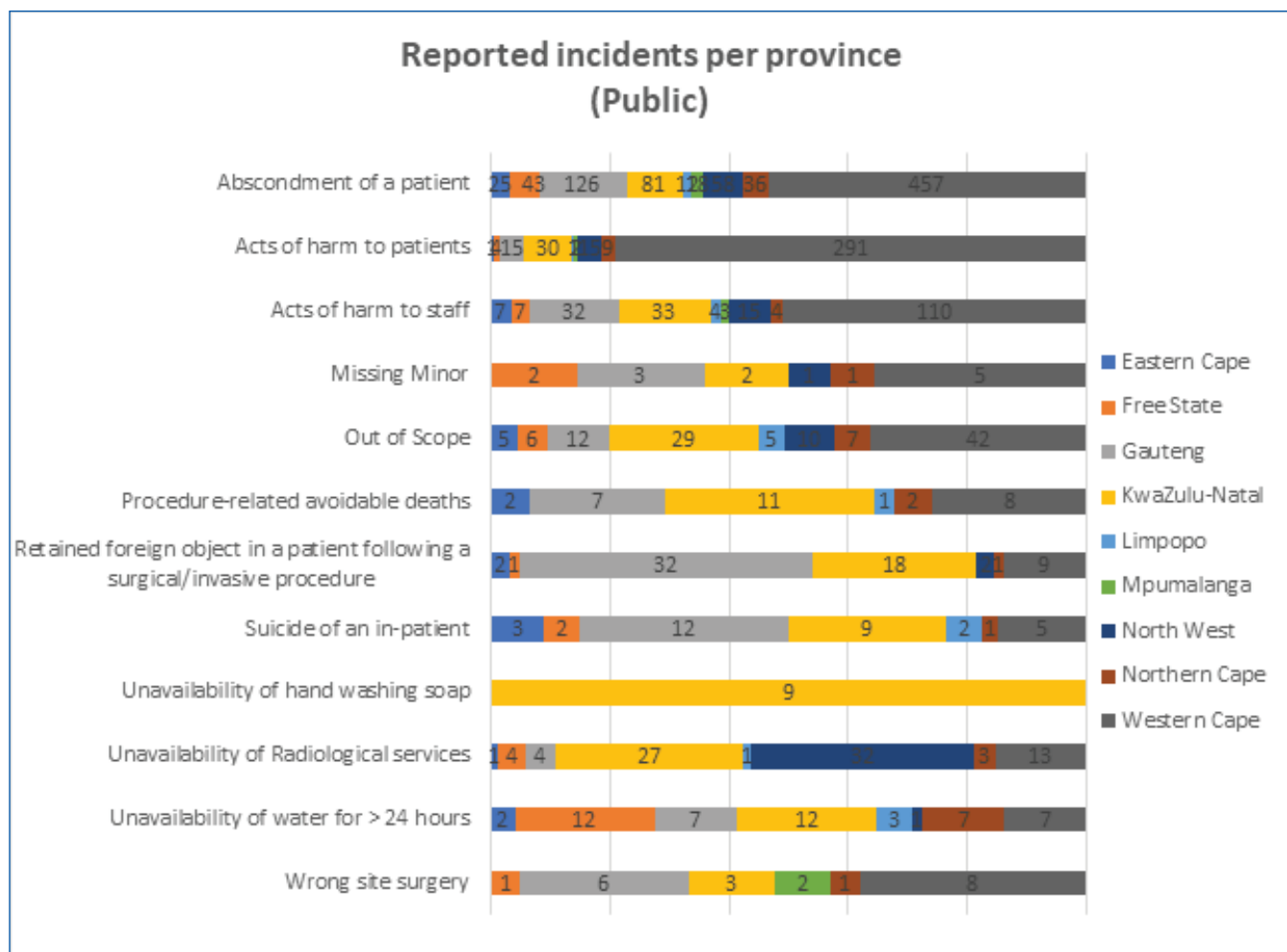


Figure 20: Distribution of reported incidents in public sector and province

3. Alerts or incidents sourced from the media or other sources

In the period under review, the OHSC was able to identify numerous incidents from the mainstream media platforms, social media platforms and others that were referred to the OHSC's complaints unit. No reports were received from whistleblowers. There were also healthcare quality incidents that attracted media attention because they posed a significant threat to the quality of health and safety of the users, even when they were not aligned with the 11 EWS indicators.

The OHSC has responded to approximately forty-two (42) incidents reported in the the various media platforms. Of the 42 incidents, 19 were directly in line with the outlined 11 EWS indicators. Some of these incidents reported through the media included cases of refusal of access to healthcare services; acts of harm to patients; unavailability of water in health establishments; shortage of food; suicide of inpatients; dilapidated infrastructure and unhygienic facilities; shortage of medications, etc. The OHSC continues to follow up on all alert cases that are in breach of the norms and standards regulations

4. Discussion

An early warning system's (EWS) usability and proper functioning are largely reliant on the availability of accurate, timely and reliable information that health establishments submit as well as comprehensive analysis of submitted reports by the OHSC in order to provide relevant feedback to stakeholders to enable evidence based decisions and actions to reduce address, mitigate and adress risks to quality of care including safety of users and staff. In addition, thorough data analysis and timely feedback to the affected healthcare facilities has the potential to result in improvement in the quality of healthcare services.

Although the rate of reporting by healthcare facilities has slightly improved over the past three years, all healthcare facilities still need to be encouraged to report on the EWS indicators as required.

Upon receiving the reports from health establishments, the OHSC requests comprehensive clinical reports detailing the series of events, clinical circumstances and context, the investigation findings and the quality improvement plans to mitigate the recurrence of the incidents of similar nature. Some of the reviewed reports received from various health establishments in private and public sector are highlighted in the sections below. The incidents are grouped according to the norms and standards regulations as aligned to the 11 EWS indicators

Incidents related to security breaches

Incidents of breaches to security are highly reported in the public sector. These incidents include abscondment of patients, acts of harm to staff and patients, as well as suicide of an in-patient. Requirements for evaluating security measures within health establishments during routine inspections to ensure compliance with applicable regulations have been developed and included in the regulatory inspection tools. These requirements include, but are not limited to, making sure that security personnel are equipped to handle risks, threats, and security incidents. In addition, all health establishments must develop and execute plans for quality improvement or corrective action if a security breach occurs. The reported EWS incidents and trends show that security breaches continue to occur, which may be a sign of systemic failures or ineffectiveness of security systems in health establishments.

Suicide of an in-patient

Suicide of inpatients relate to the issues of clinical risk management as well as security measures, especially in the context of mental health illnesses. It is thus important, in the follow up of the reported incident or alert, that the Office also requests to be furnished with the substantial clinical details including differential diagnoses, final diagnoses and the management of the user. The predisposing factors and even trigger for suicide may at times be attributed to the clinical condition such as major depression, a recent diagnosis of a life threatening condition, as well as worsening clinical condition.

In this report, an alarmingly high number of 33 incidents of suicide of an in-patient were reported. According to the analysis from the reports provided by the health establishments, an inference could be made that there is a gap in the clinical assessment and screening for users at risk. The use of suicide predictor models is currently not a standard practice in most of the health establishments, resulting in diagnostic and management gaps including prevention of such adverse events. It is noted that, even in instances where the users are admitted to the health establishments presenting with explicit psychiatric features and/or conditions, there is evidence of inadequate or inability to manage these users effectively. There are factors that may be the enablers of successful occurrences of suicides within the health establishments, such as human factors and infrastructural factors

Human factors:

- Unskilled and unqualified personnel caring for users with suicide risk. Some of the units admitting these users do not have psychiatry trained staff allocated in every shift which poses a risk to missing critical signs.
- Absence of and/or inability to interpret and apply conventional and validated suicide predictor models
- Allocation of users at risk of suicide in isolated rooms that are far from the nurses' station and without monitoring equipment.

Infrastructural factors:

In some instances, the structural components of the buildings and related devices that are meant for security, end up being the tools used by the users to commit suicide. Various incident reports have revealed that suicides occurred where users used window burglar bars, shower heads, open ceilings and some were found hanging in dilapidated and abandoned sections of health establishment buildings following what was thought to be an abscondment. However, it is worth noting that not all enablers of suicide were related to infrastructure, as some of the users utilised other items such as their own clothing, bed sheets and shoe laces.

Abscondment of patients

Abscondments of users incidents are reported from all categories and functional areas of the health establishments. It is worth noting that a significant proportion of abscondments were reported from specialised psychiatric facilities in the period under review. In psychiatric facilities, general mental health users and state patients are often granted leave of absence (pass-out) regularly to visit their families and it appears that sometimes they do not return at the agreed upon dates and times but ultimately do return within a day or two. These instances of delayed returns after an official pass out constitute to the substantial number of reported abscondment incidents from the psychiatric facilities. The absconding of patients from health establishments may pose a significant risk for the users themselves depending on their clinical diagnosis and condition but may also have implications for the general public as well.

The contributory factors associated with the occurrence of these incidents as informed by the analysis of reports from the relevant health establishments are outlined below:

- users wearing civilian clothes in the health establishment's possibly due to lack/shortage of dedicated hospital attire in health establishments. There are challenges related to shortage of hospital attire that the health establishment are supposed to issue to all admitted users to wear throughout their admission period.
- infrastructural defects such as abandoned and dilapidated buildings, broken windows, and weaknesses in perimeter fences that enable users to exit the hospitals unauthorised.
- lack of user awareness regarding their rights to refuse hospital treatment (RHT). The National Health Act 61 of 2003 provides for the implementation of refusal of hospital treatment (RHT) framework, thus states that health care providers must inform users of the user's right to refuse health services, including an explanation of the implications, risks and obligations of such refusal. Appropriate application of the RHT requirements by the healthcare providers and health establishments may potentially contribute to fewer abscondments.

- Poor counselling of users regarding clinical procedures and estimated period of admission may lead to anxiety and fear among users leading to abscondments.
- Patients wandering the hospital premises and accessing amenities outside of hospitals unsupervised (for e.g., smoking purposes, walking visitors out after visiting times, walking out of hospital gates to buy cigarettes and snacks). Health establishments are not prisons, however, it seems as if the freedom of movement which is unsupervised or monitored in some cases creates opportunities for users to abscond.
- Signs of anxiety and fear among users that lead to abscondments are in some instances overlooked and ignored by the health personnel. The reports indicate that some of the signs that a user may be contemplating to escape include refusing to wear hospital attire, and/or changing into their own civilian clothing without a valid reason.

Acts of harm to staff and patients

Notably, some of these incidents of acts of harm to patients and staff occurred in mental health units or in psychiatric hospitals. Analyses of the reports have revealed that some of the incidents were a result of mental health care users assaulting other patients either physically or sexually, as well as some staff being victims of physical assault by patients. There were also reports of staff being assaulted by relatives of users in the accident and emergency departments. These types of incidents indicate breaches or gaps in security measures to safeguard both patients and staff. The sometimes unpredictable violent behaviour of mental health care users, especially those with psychotic features, seems to be catching personnel unprepared for such events.

While reviewing and analysing the health establishments' submitted reports, the OHSC has noted that mental healthcare units are often overcrowded as this factor is often identified as a contributory cause. In addition, users are sometimes cared for by personnel without relevant skills. For example, the unit will be manned by the enrolled nurse and assistant nurse. While it is acceptable for these categories of staff to work in such units, there should always be a psychiatric nurse to lead the nursing team.

In other instances, the mental health users are admitted to general wards in the health establishments for a 72-hours assessment as outlined in the Mental Health Care Act. The Mental Health Care Act (MHCA), 2002 (Act No. 17 of 2002), prescribe that, if the facilities at the health establishment are unsuitable for the 72-hours assessment or personnel within that health establishment are unable to cope the mental healthcare user due to potential harm which may inflict on themselves or others or property, that health establishment must transfer the user to another health establishment with suitable personnel or facilities to conduct such assessment. The health establishments are aware of this prescript within the Act, however, they report challenges with capacity of the potential receiving health establishment in terms of space, hence the user remains under their custody. This analysis possibly points to the need for expansion of these units as well as training of more personnel to cater for the mental health care users' needs.

Incidents related to clinical quality and patient safety breaches

Regulation 7 (2) (b) of the norms and standards regulations states that the health establishment must establish and maintain systems, structures and programmes to manage clinical risks. These incidents relate to adverse events that are a result of errors in direct clinical care provision and their impact often result in significant or catastrophic consequences for the health of users.

Following an occurrence of an adverse event or outcome from a clinical procedures, it is expected that the health establishment would have in place clinical risk management structures such as morbidity and mortality platform (also known as M & M meeting) or a clinical quality forum where these incidents are presented, analysed, and discussed in detail to determine the the root causes and develop mitigation strategies in a form of quality improvent plans (QIPs). The purpose of QIP is to promote a common concept and methodology for implementation of quality improvement among all health establishments.

The EWS indicators discussed herein include; procedure avoidable deaths; wrong site surgery; and retained foreign object in a patient following surgery/invasive procedure. Retained foreign objects following surgeries were the highest reported of all clinical related indicators, predominantly from the private sector with 46 reports as compared to the 16 reports from the public sector.

Some of the objects that were reported to be retained unintentionally in a patient following various clinical procedures included drains and swabs. Wrong site surgeries and procedure avoidable deaths reports were 19 and 13 respectively also from the private sector. Upon clinical review and scrutiny of the wrong site surgeries reported in the period under review, some were found to be misclassified as the surgical sites were correct, however the procedures undertaken were wrong and not the one that the patient had been booked for. For example, there was report of a wrong size of orthopaedic prosthesis fitted, removal of fallopian tubes and ovaries instead of the fallopian tubes only etc.

Some of the documents received from the health establishments that outline their clinical operations related to the reported incidents include standard operating procedures (SOPs) and clinical practice guidelines. These type of documents are developed to be a guide or framework that sets a standardised manner of performing tasks to ensure minimal or no errors in delivering certain types of clinical processes. The submitted documents are scrutinised to determine clinical appropriateness and potential areas of weaknesses that may explain the occurrence of adverse events. The OHSC would then provide feedback to the health establishment on the submitted documents and areas where they could be strengthened.

Unavailability of radiological services

The use of diagnostic imaging services is essential in confirming, assessing and documenting the course of many diseases and response to treatment. Radioillogy services includes ultrasonography, X-rays, mammography, computed tomography (CT scans), and nuclear medicine. The unavailability of these services impacts the users negatively, as it may result in undetected diseases, uncertainty of treatment modalities, and disease progression with no relevant or suitable and delayed interventions.

There have been health establishments that have been without these services for a prolonged period. Some of the reasons provided by health establishments for the unavailability of these services were: shortage or unavailability of critical staff such as radiologists and radiographers; and broken radiology equipment due to loadshedding effects and lack of maintenance. Even though contingency measures such as referral to the nearest health establishments may be in place, unavailability and/or disruptions to radiology services have serious impact for access and quality of healthcare services for the users.

Unavailability of water for more than 24 hours

South Africa is a water scarce country and with the evolving climate change the situation has become worse. Though the water crisis is known and has been reported widely in the country, fewer health establishments have reported on this indicator in the period under review. Shortage and interruption of water supply across all provinces and municipalities has been reported through media and in some cases these interruptions have affected health establishments. For the period under review, only some public sector health establishments have reported on this indicator.

Since unavailability of water is widespread it is likely that the health establishments have assumed that the OHSC would be aware of this protracted issue and therefore did not see the necessity of reporting. However, due to the importance of water in the provision of healthcare services, it is important for the OHSC to receive the reports and provide recommendations to the relevant health authorities to ensure that this issue is managed appropriately.

5. Recommendations

According to Section 79(1) (e) of the NHAA of 2013, the Office must make recommendations for intervention by national or provincial department of health, a health department of a municipality or health establishment, where necessary, to ensure compliance with prescribed norms and standards.

The Office continues to engage with and analyse the reports submitted by specific health establishment and respond accordingly with recommendations specific to the EWS indicators reported upon. However, it is important for the OHSC to also analyse the reports and trends with a global view in order to provide recommendations at health system level. In this regard, following comprehensive analysis of the submitted reports during the period under review, the OHSC recommends the following:

- That the provincial, district, private hospital groups', and health establishments' authorities implement a regular, monitoring and evaluation process to ensure that health establishments report accurately and timeously on the 11 EWS indicators as part of their quality management responsibilities. This intervention will result in significant improvement in reporting rates and provide an opportunity for the OHSC to provide guidance to the health system on how to address user safety and other healthcare quality challenges in the system. The health authorities should request access to the OHSC online system to view EWS reports and trends for the health establishments under their management jurisdiction.
- That health establishments be supported by relevant health authorities including the healthcare quality directorates, to build their capacity to carry out root cause analyses (RCA) as part of their continuous quality improvement interventions to deal with systemic and systematic challenges related to implementation of security systems to deal with user and staff safety.
- A dedicated intervention strategy at national and provincial level to improve the quality of mental healthcare services. This strategy must include explicit interventions to expand the service capacity (mental health units in districts and regional hospitals) of mental healthcare services to address the increasing burden of disease, improve the skills of healthcare providers in management of common mental health illnesses, as well as the strengthening and/or enhancement of security in mental health units and dedicated psychiatric facilities.
- Relevant health authorities to support the procurement and maintenance of radiological equipment in health establishments to prevent interruption of services. In addition, provincial and district health authorities must support installation of power surge prevention equipment and systems for all health establishments to safeguard the integrity and lifespan all radiological equipment and appliances in this challenging period of persistent loadshedding to protect the diagnostic imaging equipment from reported damages attributed to power surges.
- In addition, health authorities are encouraged to engage with relevant local and municipal health authorities and entities within the intergovernmental framework to prioritize the health establishments in relation to provision of water during water outages. The health authorities are urged to consider the procurement of long term solutions such as installations of boreholes as potential sustainable measures to ensure uninterrupted water supply and therefore healthcare services within health establishments.
- Health establishments be supported to implement continuous quality improvement initiatives focussed on the high-risk areas for patient safety issues including but not limited to staff capacitation and training in specialty areas such as theatre, trauma, maternity, and psychiatry.

6. Conclusion

As the healthcare regulatory body, the OHSC depends on health establishments, national, provincial and district health authorities, as well as private hospital groups, and to ensure that the regulations governing the proper reporting of EWS incidents are adhered to and followed. The EWS is a mechanism that has the potential to contribute to the improvement of quality within the healthcare system if all stakeholders play their part in improving its utility.

Therefore, it is the responsibility of the authorities, health facilities' management and employees to ensure that they have mechanisms in place to detect EWS incidents and offer guidance on the reporting procedure. Severe user-related incidents, such as major security system breaches, patient safety breaches and other systemic hazards, should spur appropriate action from health establishment authorities and other health authorities in order to improve quality of healthcare services.





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79 Steve Biko Road | Prinshof
PRETORIA | SOUTH AFRICA
Private Bag X 21 ARCADIA | 0007



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