A CRY FOR BETTER HEALTH SERVICES

Report No. 12 of 2011/12: Report on an investigation into alleged poor service delivery at the Gugulethu Community Health Centre (Western Cape Department of Health)

Accountability • Integrity • Responsiveness
# INDEX

**Executive Summary** 3

1. **INTRODUCTION** 6

2. **THE COMPLAINT** 6

3. **JURISDICTION OF THE PUBLIC PROTECTOR** 8

4. **THE INVESTIGATION** 9

4.1 **KEY SOURCES OF INFORMATION** 9

4.2 **SUMMARY OF THE INVESTIGATION PROCESS AND EVIDENCE** 20

4.3 **EVALUATION OF EVIDENCE** 21

5. **REGULATORY FRAMEWORK** 22

6. **CONCLUSION** 24

7. **ENGAGING THE DEPARTMENT ON THE PUBLIC PROTECTOR’S PROVISIONAL FINDINGS AND PROPOSED REMEDIAL ACTION** 25

8. **FINDINGS** 29

9. **REMEDIAL ACTION** 30

10. **MONITORING** 31
Executive Summary

(i) The Public Protector conducted a systemic investigation on own initiative regarding the alleged poor service delivery at the Gugulethu Community Health Centre (the Centre) which operates under the Western Cape Health Department (the Department).

(ii) Allegations of poor service delivery, undue delays, drunkenness of staff whilst on duty etc. had been expressed by numerous members of the community (including the press), which prompted the investigation.

(iii) The investigation revealed the following:

(a) The Department has to address issues relating to among others, signage, staff discipline and cleanliness at the above Centre. This will contribute towards meeting constitutional and legislative requirements and controlling the quality of health services at the Centre.

(b) It also emerged during the investigation that the facility management of the Centre needs to be improved i.e. timeous repair of plumbing, introduction of air-conditioners or fans, replacement of broken chairs and acquisition of proper dustbins.

(c) The most disconcerting fact that emerged during the investigation was the evidence of several witnesses of accounts where staff, even health profession workers, were under the influence of alcohol. During the second inspection in loco the Public Protector found confirmation of this during normal business hours. It was observed that the cleaner smelled of alcohol, had bloodshot eyes, was loud and rude to patients. It is noteworthy that a certain witness, Mr H, had also stated that the cleaner was “problematic”, that numerous complaints against her had allegedly been lodged with the Management of the Centre, but no action was taken. This confirmed that the situation of use of alcohol by staff when on duty is still not managed
properly. The Centre Manager acknowledged this situation to some extent during a previous meeting and advised that she knows the culprits and some were referred for counselling. It is doubtful whether the measures taken were adequate to send out a clear message that use of alcohol or drunkenness while on duty will not be tolerated.

(iv) The Public Protector found that:-

(a) The allegations of poor service delivery against the above Centre are well founded. Failure on the part of the Centre Manager and staff to manage the cleanliness of the facility, effect repairs timeously, attend to signage inside the Centre and to ensure disciplined and courteous conduct of staff, is found to be in violation of section 27(1) of the Constitution and section 25(2) of the National Health Act, 2003 (National Health Act). It is accordingly improper, and constitutes maladministration.

(b) The investigation also found undue delays on the part of the Centre to provide health services. There seems to be no justifiable reason for the situation as the Centre Manager confirmed that there was no shortage of staff. Such delays violate the rights, values and principles governed by section 27(1) of the Constitution, and constitute maladministration.

(c) The allegations of use/abuse of alcohol by staff whilst on duty were found to be substantiated. This does not only amount to improper conduct in the extreme, but also carries a high risk of impropriety and prejudice towards members of the public. This violates section 27(2) of the National Health Act and accordingly constitutes maladministration.

(v) The following remedial action is to be taken:
(a) There should be proper signage, in all official languages of the Western Cape Province, at both the main entrance and the Maternity Unit entrances regarding the location of the various units/departments within the Centre.

(b) The management of the Centre should ensure that the area outside the main entrance is cleared by the City of Cape Town regularly and that the situation regarding hawkers is managed adequately.

(c) Cleanliness on the inside of the yard of the Centre should be addressed as a matter of urgency.

(d) There should be a system in place to ensure that there is somebody at all times to assist and/or monitor trauma patients.

(e) The Centre Manager should address the conduct of the cleaner, who was clearly rude to patients at the Trauma Unit and exhibited signs of being inebriated on 28 February 2011.

(f) Provision should be made in the budget to acquire air-conditioning or fans at the Centre.

(g) The leaking pipe in the ladies’ toilets should be repaired and sanitary requirements attended to.

(h) The floor tiles with holes, in front of the Reception area door should be replaced as it poses a risk of injuries.

(i) The Centre Manager must immediately introduce management interventions to prevent any use of alcohol. The Head of the Department should facilitate surprise inspections to monitor the situation.

(j) The Head of the Department must monitor the management, administration and service delivery at the Centre until all the deficiencies have been addressed.
REPORT ON AN INVESTIGATION INTO ALLEGED POOR SERVICE DELIVERY
AT THE GUGULETHU COMMUNITY HEALTH CENTRE (WESTERN CAPE
DEPARTMENT OF HEALTH)

1. INTRODUCTION

1.1 This report is submitted to the Head of the Department of Health: Western
Cape (the Department) and the Facility Manager Head of the Gugulethu
Community Health Centre (the Centre) in terms of section 182(1)(b) of the
Constitution of the Republic of South Africa, 1996 (the Constitution) and
section 8(1) of the Public Protector Act, 1994 (the Public Protector Act). The
Head, Facility Manager and any member of staff implicated are afforded the
final opportunity to respond to issues and to provide reasons why a final report
should not be issued.

1.2 The report pertains to a systemic investigation undertaken by the Public
Protector following allegations regarding poor service delivery at the Centre.

2. THE COMPLAINT

2.1 The Public Protector conducted a systemic investigation undertaken on own
initiative regarding the service delivery at the Centre which operates under the
Department.

2.2 During 2009 there were numerous allegations by members of the community,
including the press, regarding poor service delivery at the Centre.

2.3 The plight of the patients at the above Centre were also publicised in the
community newspaper, Vukani, where it was reported that a young woman
gave birth outside the gate because the security officer refused to open the
gate. An enquiry was conducted by the Department and investigators from the
Public Protector’s office obtained a confidential report by the Department. The report found, among other things, that the delivery on the pavement outside the Centre could have been avoided if the lady had presented herself earlier. Furthermore, it was stated that the staff complied with good practice in the management of the patient, and the ambulance response to her call was timely.

2.4 The press also reported on 19 March 2009 how a child died after his mother was turned away from three health care facilities, including the above Centre. Apparently an enquiry was also conducted in this matter by the Department and it was found, inter alia, that there is no clear evidence to confirm that the aforementioned person was turned away by the three health facilities, including the Centre.

2.5 The media and the members of the community/patients that were interviewed regarding the alleged poor service delivery at the above Centre indicated, among other things, that:

2.5.1 The nurses drink alcohol on duty especially during weekends, month ends and night shifts. Some patients indicated that they would rather die on hospital benches than approach the abusive, rude and drunk nurses to discuss their illnesses. Some patients had to be persuaded to move from the Outpatients Section to the Trauma Unit because of a lack of trust in the nurses.

2.5.2 A spokesperson for a union called Solidarity also confirmed that he was aware of nurses drinking alcohol on duty at the above Centre.

2.5.3 A representative of the South African National Civics Organisation (SANCO) also confirmed that the staff at the Centre drink alcohol whilst on duty. The SANCO representative indicated that they are aware of what is happening at the abovementioned Centre because they conduct regular visits at various
health centres and they have personally observed drunken staff members, including the nursing sister in charge.

2.5.4 There were also allegations that the cleaners at the Centre drink alcohol and in the process insult the patients. The allegations regarding drinking on duty were also confirmed by the Centre Manager.

2.5.5 Another Gugulethu resident informed the Public Protector that he also experienced the alleged poor service delivery at the above Centre. He alleges that seriously injured patients are not attended to urgently and some end up losing consciousness whilst waiting to be treated. Furthermore, the Centre is not clean because the staff sometimes leaves the blood on the floor (at the Reception area) without cleaning it. It was also indicated that there is a shortage of doctors to attend to emergency cases. The aforementioned resident also indicated that record keeping at the Centre is poor.

2.5.6 The queues at the Centre are long and most patients end up spending the whole day waiting to be attended to. Most patients arrive at 5 am but still wait for long hours because of the alleged poor service.

3. JURISDICTION OF THE PUBLIC PROTECTOR

3.1 In terms of section 182(1) of the Constitution the Public Protector has the power to investigate any conduct in state affairs, or in the public administration in any sphere of government, that is alleged or suspected to be improper or to result in any impropriety or prejudice. Following an investigation, the Public Protector can report on that conduct and take appropriate remedial action.

3.2 In terms of section 6(4) of the Public Protector Act, the Public Protector is, among other things, competent to investigate, on own initiative or upon receipt of a complaint, any alleged maladministration in connection with the affairs of government at any level. Furthermore, the Public Protector is competent to
investigate abuse or unjustifiable exercise of power, other improper conduct or undue delay by a person performing a public function.

3.3 The complaint accordingly falls within the mandate of the Public Protector.

4. THE INVESTIGATION

The investigation was conducted in terms of section 7(1) of the Public Protector Act, and comprised the following:

(a) Interviews with patients and the public;
(b) Interviews with the Head of the Centre and staff;
(c) Inspections in loco at the Centre;
(d) Interview with member of SANCO: Gugulethu;
(e) Interview with a journalist; and
(f) Correspondence with officials from the Department.

4.1 Key Sources of information

4.1.1 Interviews with patients and the public

4.1.1.1 On 17 March 2009 the Public Protector had a telephonic interview with Mr A (identity verified but protected by the Public Protector). He indicated that:

(a) During January/February 2009 at about 15:00 he took his brother, Mr B to the above Centre for treatment. He observed that the Trauma Unit nurses do not take care of patients. For example, one patient, who was stabbed in the neck, was losing consciousness and there was no staff member attending to him. He took pictures and can make them available.
(b) The staff at the above Centre apparently does not attend to emergencies urgently and there was only one doctor on duty. Furthermore, there was insufficient staff to attend to the patients in the queue.

(c) He was advised to approach Reception, which is in a separate building, to fetch his brother’s folder. At the Reception area there was blood on the floor.

4.1.1.2 On 28 February 2011 during an inspection in loco of the Centre by the Public Protector at about 14:55 a blood stained and disoriented patient, Mr C of Gugulethu, could not find his way to the Trauma Unit and he ended up at Reception. Mr C indicated that he did not know where the Trauma Unit was. Subsequently the Public Protector’s investigators found Mr C on the bench at the Trauma Unit. The Public Protector later contacted Mr C (four hours after having met him at the Reception area) to establish the service rendered. He indicated that he was only attended to at 18:00.

4.1.1.3 Furthermore, on 28 February 2011 at the entrance to the Trauma Unit at about 14:55 a certain gentleman, Mr D, was returning his disabled brother in a wheelchair (Mr E) to the Trauma Unit for the second time. They were apparently turned away on 27 February 2011, after waiting for nine hours, because there was a shortage of doctors.

4.1.1.4 The Public Protector also interviewed Mr F at about 15:10 pm on 28 February 2011, at the entrance to the Trauma Unit. Mr F was lying on the ground and he indicated that he was in pain and has been waiting for assistance since 12:00 pm.

4.1.1.5 Although the Centre is a 24 hours facility, at about 16:00 an elderly lady, Ms G approached the Public Protector’s investigators to enquire where to lodge a complaint regarding an official at Reception who refused to assist her because “it was knock off time”. She indicated that she was suffering from tonsillitis and needed immediate attention.
4.1.1.6 The Public Protector also interviewed Mr H of the Gugulethu Health Forum (Community Based Organisation) and he alleged that there are some problems at the Centre and a certain cleaner was “problematic”. Furthermore, numerous complaints were lodged against the said cleaner with the Management of the Centre, but no action was taken against her.

4.1.1.7 Furthermore, in front of the Sister-in Charge office, a patient was frustrated because her file was lost. However, the doctor later explained to one of the Public Protector’s investigators that the file could not be found because the patient was from the Eastern Cape.

4.1.2 Interviews with the Manager of the Centre and staff

4.1.2.1 On 4 November 2009 the Public Protector held the first meeting with the Manager of the above Centre, Ms N Mabusela. During the aforementioned meeting, she indicated, among other things, that:

(a) She assumed duties as a Manager of the Centre on 11 January 2008. There are challenges but “she is ready for them”.

(b) Apparently she effected environmental changes to the Centre. For example, she paid out of her pocket an amount of more than R10,000,00 to paint murals in the Centre.

(c) She created a questionnaire for the visitors to complete and the responses are very positive regarding the Centre.

(d) She put into place a requirement that there should be a daily doctors’ meeting. Furthermore, she also put in place a staff movement slip in order to ensure that staff starts work on time. She also introduced a “Red Book” in which staff can record challenging incidents they experience with patients.
(e) Initially the Centre was dirty but she motivated the cleaners to do a proper job.

(f) She is aware of issues relating to drunkenness by staff on duty. She also knows the culprits and some of them were referred for counseling. Furthermore, some staff members are afraid to report incidents of drunkenness by their colleagues for fear of intimidation and that the colleagues might lose their jobs. She is not aware of the sister in charge who was drunk on duty.

(g) The Department has allocated enough money towards operation and management of the Centre.

(h) There are long queues at the Reception. However, all patients are attended to. The long queues can be attributed to the fact that the Clinic is a 24 hours facility and attend to anyone irrespective of place of residence.

(i) She is busy with the admission policy and she has instructed her staff to attend to all patients even if they do not have identity documents with them.

(j) Initially there were problems regarding filing and folders. Some folders were lost and there were also duplications. However, Dr de Bruin assisted with a new filing system and they no longer experience problems. It is not true that patients that are critically ill are required to collect their folders from the Reception. If the patient is accompanied by an escort, the escort is required to collect the folder, but the patient will be attended to immediately, in an emergency. If a patient is not accompanied by an escort, the Centre's porter is required to collect the folder for the patient.

(k) At the Pharmacy in order to expedite the queues, the staff now package the prescribed medicine for patients a day before collection.

(l) There are visible posters containing information about the telephone number and other information pertaining to the appropriate complaints mechanism.
(m) An official, Mr Dolweni, is on duty at the Help Desk from 6.00 until 14:00. After 14:00 the security officers perform Mr Dolweni's duties. Furthermore, at every entrance there is a security officer to render assistance to the patients.

(n) There is no staff shortage at the Centre. There are, among others, one principal medical officer, five community service doctors, two maternity unit doctors, one family physician, five clinical nurses, administration officers, cleaners and security officers. Furthermore, the budget for the Centre allows for the employment of additional staff, via agencies.

(o) It is not true that all staff members are rude and unfriendly. There might be some personalities that might be perceived to be unfriendly/rude. Apparently all the staff are professional because they attended training. For example, they attended the Batho Pele Training, Team Building, Skills Development etc.

(p) With regard to the condition of the Centre she wrote a motivation to the Department of Public Works regarding renovation of the Centre.

(q) She was never interviewed by the Cape Times newspaper journalist or any member of the media. Furthermore, she never met with representatives from Solidarity and SANCO.

(r) The issue regarding the birth on the pavement/stoop was investigated by a Commission of Enquiry, which apparently found that the patient had been wrong. Furthermore, the matter that involved the death of a child on her grandmother's back has nothing to do with the Centre. She is not aware of any deaths caused by the long queues at the Centre.

(s) She is not aware of incidents where blood stains on the floor were left unattended and not cleaned at the Trauma Unit. There is a cleaner that follows patients around, cleaning after them. However, she acknowledges that oversights do occur.
(i) Hawkers outside the Centre’s entrance will be assisted regarding shelter.

(u) Maintenance of the area outside the entrance gate of the Centre is the responsibility of the City of Cape Town. The maintenance of the inside is the responsibility of Mr Mdali, a cleaner.

(v) Signage regarding the Centre is obscured by the Hannan Centre.

4.1.2.2 During a brief follow up meeting on 28 February 2011 with Mrs Mabusela she indicated that:

(a) She acknowledged that some problem areas still existed within the Centre. For example, there was no budget for air conditioners.

(b) The Administration Officer, Mr October will brief the Public Protector regarding the organogram, the file management and queue management.

4.1.2.3 Mr October indicated that he was not comfortable because Mrs Mabusela never informed him about the investigation. Mr October responded that:

(a) He is only responsible for the Administration Reception Area and he supervises only the clerks, porters and cleaners.

(b) No problems exist relating to long queues and the filing system in his department. He cannot explain why in some instances people wait for a long time. However, they apply “the first come, first serve principle”, and the aged and disabled are given preferential treatment.

(c) The toilets were fixed and repainted a few months ago.

(d) The boxes and planks lying at the entrance gate are used by hawkers. They leave them at the entrance after work.
(e) There have been drastic changes since November 2009, when the Public Protector conducted the first inspection *in loco*.

(f) The City of Cape Town is responsible for the maintenance of the precinct of the Centre. He will attend to the matter regarding cleaning of the precinct of the Centre. Furthermore, the contractors that mowed the lawn on the inside of the Centre a few weeks ago will be returning in a weeks’ time because they acknowledged that they did not do a perfect job.

(g) There are complaints regarding delays in all state hospitals.

4.1.2.4 During a brief meeting on 28 February 2011 the Public Protector was also furnished with a copy of the organogram which indicates that the Centre has nine operational units and a total of 40 staff members.

4.1.3 *Inspections in loco*

4.1.3.1 On Thursday, 13 October 2009 the Public Protector conducted a first inspection *in loco* at the above Centre. The following observations were made during the inspection *in loco*:

(a) Overgrown grass, weeds and litter on the outside precinct of the Centre could be noticed.

(b) A number of hawkers were selling food at the gate. There was no shelter for them. One of the hawkers, Ms I indicated that they have trading permits to sell outside the Centre’s gate. Apparently, during 2007 they completed forms in the Centre Manager’s office regarding the provision of sheltered stalls, but there was no progress regarding the matter.

(c) The tap next to the parking area was leaking and the area was littered with dead leaves and papers.
(d) At the entrance gate, next to the security officers, there was a stack of black refuse bags, overflowing bins, piles of boxes and broken chairs. The security officer on duty advised the Public Protector that the refuse was collected once a week on Mondays. It is noted that the inspection *in loco* was conducted on a Thursday.

(e) Patients complained about long queues. For example, four patients, three of whom were in wheelchairs (viz Mr J, Mr K, Mr L and Mr M) indicated that most of the time disabled people are left standing in queues without being given preferential treatment. Furthermore, there are delays at the Reception because people wait for a long time before they get their patient files and some of the officials are rude and unprofessional. The example of a cleaning lady that usually shouts at patients when stepping on the wet floor, was offered.

(f) At the Reception most of the patients, for example Ms N, indicated that they waited for 2 hours for their files. Others indicated that they have been waiting since 5.00 am. The interviews with patients were conducted at about 10:40.

(g) Furthermore, it was observed that some of the patients at the Reception were seated on broken chairs whilst waiting to be attended to.

(h) Some of the patients indicated that they did not know where to go for their problems and there was no staff to assist them. The Helpdesk at the Trauma Unit was empty at 10:40.

(i) There was no ventilation/ air conditioners or fans in the whole of the Centre.

(j) Both the ladies and gents toilets at the Outpatient Department were filthy and stuffy. The taps were leaking, basins were overflowing with water and there were dirty tissue papers on the floor.

(k) The Maternity Unit was very stuffy and the floor was dirty.
(l) At the Outpatient Department brown boxes were used as bins.

(m) The corridor next to the Reception was full of broken/damaged crutches and steel cabinets.

4.1.3.2 On Monday, 28 February 2011 a second inspection in loco was conducted at the Centre and brief meetings were held with the Manager and later with Mr October (Administration Officer). The following observations were made during the inspection in loco:

(a) There were slight improvements since 4 November 2009, when the first inspection in loco was conducted. It was observed that, the leaking tap next to the parking lot was fixed, the gents' toilets were clean and the queues were not long.

(b) Unlike in other areas or other public facilities, there is no proper direction or singage anywhere in Gugulethu, the precinct or in any of the nearby main roads (for example the NY1 or NY 78) regarding the location of the above Centre.

(c) The outside precinct of the Centre was still dirty. The area was clearly not cleaned for some time. Furthermore, inside the Centre, next to the parking area at the main entrance there was litter and empty boxes lying around, broken chairs, greasy/dirty paving etc.

(d) It was observed that one of the pipes in the ladies' toilets was leaking and there was no toilet paper and no sanitary disposal bins. One of the toilets was locked. However, the gents' toilets were clean. The cleaner, Mr Phindile Mdane indicated, among other things, that toilet paper was being misused by members of the public and patients.
(e) At about 14:55 the investigators from the Public Protector’s office observed a blood stained and disoriented patient, Mr C of Gugulethu, who could not find his way to the Trauma Unit and who ended up at the Reception. Mr C indicated that he did not know where the Trauma Unit was. Subsequently the investigators found Mr C on the bench at the Trauma Unit. The Public Protector later contacted Mr C (four hours after having met with him at Reception) to establish the service rendered. He indicated that he was only attended to at 18:00.

(f) There is no signage in respect of the directions to the different units within the Centre. However, the signage for one of the Centre’s units, the Hannan Centre was clearly visible from the outside.

(g) At the entrance to the Trauma Unit at about 14:55 a certain gentleman, Mr D, was returning his disabled brother in a wheelchair (Mr E) to the Trauma Unit for the second time. They were apparently turned away on 27 February 2011, after having waited for nine hours, because there was a shortage of doctors. Furthermore, at the entrance to the Trauma Unit at about 15:10, there was a gentleman (Mr O) lying in pain. He indicated, among other things that he has been waiting for assistance since 12:00pm.

(h) At the Trauma Unit, the investigators from the Public Protector’s office also encountered the lady cleaner identified in the complaints. She rudely told patients, who appeared to be in pain, to move because she was cleaning. She smelled of alcohol, had blood shot eyes and was loud. Furthermore, as investigators were busy interviewing a patient, the aforementioned cleaner simply interrupted by indicating that the Trauma Unit has got only two doctors.

(i) At the Pharmacy, queues were well managed and moving fast, and officials were focused on the task at hand.
(j) At about 15:15 in front of the Sister-in Charge office there were two patients who indicated that they have been waiting to see the doctor since 13:00.

(k) Furthermore, in front of the Sister-in Charge office, a patient was frustrated because her file was lost. However, the doctor later explained to one of the investigators that the file could not be found because the patient was from the Eastern Cape.

(l) At the Reception, in front of the door, the tiles had holes and there were broken chairs lying around. The chairs are used by patients whilst waiting to be attended to.

(m) There were still no air-conditioning or portable fans in the whole of the Centre.

(n) At the Reception and the Outpatient Departments, brown boxes were still being used as bins.

4.1.4 Interview with member of SANCO: Gugulethu

On 17 March 2009 the Public Protector contacted Ms P of SANCO and she indicated, among other things, that they conduct spontaneous month end visits to all day hospitals in the Cape Metro. She stated that during January 2009 one of the nurses at the above Centre was drunk. Apparently, the Nursing Sister in charge (name unknown), was also drunk.

4.1.5 Interview with the journalist

On 12 March 2009 the Public Protector contacted the Cape Times journalist, Ms Q Mathosa, who wrote the article published in the newspaper on 2 March 2009. She indicated, among other things, that:
4.1.5.1 She personally approached the Centre and the nurses (name unknown) were drunk during office hours.

4.1.5.2 A member of SANCO, Ms P also witnessed the drunk nurses.

4.2 Summary of the investigation process and evidence

4.2.1 The information gathered during the investigation revealed the following:

4.2.1.1 During the above two inspections in loco it was evident that there is no signage displayed anywhere in the area regarding the location of the Centre. Furthermore, there was no proper sign, displaying the name of the Centre at the entrance. However, following the second inspection in loco, a new sign was displayed.

4.2.1.2 During the first inspection in loco it was observed that the cleanliness of both the ladies’ and gents’ toilets were inadequate. However, during the second inspection in loco the gents’ toilets were found to be clean. As far as the condition outside the precinct is concerned, it is clear that it perpetuated due to failure to manage the situation of hawkers.

4.2.1.3 Despite the Centre Manager’s denial of poor service delivery at the Centre, the majority of patients that were interviewed complained about the long hours spent while waiting for assistance and of even being turned away and advised to come back the following day.

4.2.1.4 It is undesirable for a health centre not to be able to regulate temperatures by means of air-conditioners or fans. It is unbearable for the public to sit in an unventilated stuffy environment, particularly if the place is crowded.
4.2.1.5 Most disconcerting was the evidence of several witnesses of accounts where staff, even health profession workers, were under the influence of alcohol. During the second inspection in loco the Public Protector found confirmation of this during normal business hours.

4.3 Evaluation of evidence

4.3.1 The information gathered during the investigation clearly indicates that there is a need for improvement of service delivery at the above Centre.

4.3.2 Several interviewees corroborated each other and the Centre Manager also acknowledged that there are certain service delivery areas (for example lack of air-conditioning/fans) that required further attention.

4.3.3 Some of the allegations involving the above Centre were confirmed during the Public Protector’s inspections in loco and interviews with patients, journalist, members of the public and staff at the above Centre.

4.3.4 As mentioned above, it was alarming to listen to the evidence of several witnesses regarding staff who had been under the influence of alcohol. The situation might have improved since 2009, but during the second inspection in loco on 28 February 2011, it was observed that the cleaner mentioned by the complainants, smelled of alcohol, had bloodshot eyes, and was loud and rude to patients. It is noteworthy that the witness Mr H, had also stated that she was “problematic”, that numerous complaints against her had allegedly been lodged with the Management of the Centre, but no action was taken. This confirmed that the practice of use of alcohol by staff while on duty is still not managed properly. The Centre Manager acknowledged this situation to some extent during a previous meeting and advised that she knows the culprits and some were referred for counselling. It is doubtful whether the measures taken were adequate to send out a clear message that the use of alcohol, or drunkenness while on duty, will not be tolerated.
4.3.5 With regard to the allegations that seriously injured patients are not attended to urgently, the inspection \textit{in loco} confirmed that a blood stained and disorientated patient had not been attended to for more than three hours.

4.3.6 It should be acknowledged that a second inspection \textit{in loco} revealed that long queues had been addressed and no evidence could be found of inadequate file management.

5. REGULATORY FRAMEWORK

5.1 The legal prescripts applicable to service delivery are derived from the Constitution as well as from national legislation and prescripts.

5.1.1 The Law

5.1.1.1 The Constitution

(a) The Constitution provides in section 27(1) \textit{inter alia} that everyone has the right to have access to health care services. Furthermore, section 27(2) provides that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.

(b) Section 24 of the Constitution provides, among others, that everyone has a right to an environment that is not harmful to their health or well-being

5.1.1.2 National Health Act, 2003

(a) The National Health Act, 2003 (National Health Act) provides among others, a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.
(b) Section 3(2) of the above Act provides that the national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.

(c) In terms of section 25(2) the Head of a Provincial Department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province, control the quality of all health services and facilities.

5.1.2 Policies

5.1.2.1 The Provincial Department of Health’s Strategic Plan 2010/11 – 2014/15

(a) According to the Department’s Strategic Plan: 2010 – 2014 (page 1) the Vision of the Department is “[e]qual access to quality health care”. The Mission is “[t]o improve the health of all people in the Western Cape and beyond, by ensuring the provision of a balanced health care system, in partnership with all stakeholders, within the context of optimal socio-economic development.

(b) The abovementioned Strategic Plan also indicates that the core values that will be reflected in the way in which the vision and mission are achieved, are integrity; openness and transparency; honesty; respect for people and commitment to high quality service.

5.1.3 Batho Pele

5.1.3.1 Batho Pele Principles provide for the following framework regarding acceptable service delivery in the public service:
(a) Consultation with customers;
(b) Setting of service standards;
(c) Increased access to services;
(d) Ensuring courtesy;
(e) Provision of information about services;
(f) Increased openness and transparency about services;
(g) Redress of service failures; and
(h) Provision of value for money.

6. CONCLUSION

6.1 The investigation revealed that the Department has to address issues relating to among others, signage, staff discipline and cleanliness at the above Centre. This will contribute towards meeting constitutional and legislative requirements and controlling the quality of health service at the Centre. Adherence to the regulatory framework will lead to the achievement of a more effective, efficient health service in Gugulethu.

6.2 It also emerged during the investigation that the facility management of the Centre needs to be improved i.e. timeous repair of plumbing, introduction of air-conditioners or fans, replacement of broken chairs and acquisition of proper dustbins.

6.3 The most disconcerting fact that emerged during the investigation was the evidence of several witnesses of accounts where staff, even health profession workers, were under the influence of alcohol. During the second inspection in loco the Public Protector found confirmation of this during normal business hours. It was observed that the cleaner smelled of alcohol, had bloodshot eyes, was loud and rude to patients. It is noteworthy that witness Mr H had also stated that she was “problematic”, that numerous complaints against her had allegedly been lodged with the Management of the Centre, but no action was
taken. This confirmed that the situation of use of alcohol by staff when on duty is still not managed properly. The Centre Manager acknowledged this situation to some extent during a previous meeting and advised that she knows the culprits and some were referred for counselling. It is doubtful whether the measures taken were adequate to send out a clear message that use of alcohol or drunkenness while on duty, will not be tolerated.

7. ENGAGING THE DEPARTMENT ON THE PUBLIC PROTECTOR’S PROVISIONAL FINDINGS AND PROPOSED REMEDIAL ACTION

7.1 Introduction

7.1.1 At the conclusion of an investigation and during the preparation of a report in terms of Section 182(1)(b) of the Constitution and section 8(1) of the Public Protector Act, the Public Protector may request the parties involved and implicated in the complaint to respond to the report.

7.1.2 The parties are afforded an opportunity to comment respond to the provisional findings, at draft stage, those prior to publication of the report. The context is that of compliance with section 7(9) of the Public Protector Act and, more generally, with the requirements of fair procedure and constitutional justice. Section 7(9) of the Public Protector Act provides that:

"If it appears to the Public Protector during the course of an investigation that any person is being implicated in the matter being investigated and that such implication may be to the detriment of that person or that an adverse finding pertaining to that person may result, the Public Protector shall afford such person an opportunity to respond in connection therewith, in any manner that may be expedient under the circumstances."

7.1.3 This process is in line with best practice amongst inquisitorial bodies such as ombudsmen all over the world. The objective is to afford any person who
may be affected by the decision of the ombudsman a reasonable opportunity to know the matters which may be likely to affect the decision of the ombudsman against their interest. Any person whose rights may be affected by such a decision may bring any evidence or matter of substance and importance, having the potential to influence the outcome of the investigation, to the ombudsman's attention.

7.1.4 While this is also an opportunity to seek agreement on the relevant facts with the parties concerned, the consultation process is not intended to subject the Public Protector's intended findings and remedial action to the consensus or approval of the parties. The public body concerned or complainant is not requested to "review" the Public Protector's investigation and provide a critique on the Public Protector's adjudication of the complaint in advance of the report being finalized. In terms of the Public Protector Act the Public Protector is the sole, independent adjudicator of the complaint or matter reported to him/her and has to deal with the matter to his/her satisfaction and in accordance with the standards expected by law – without fear, favour or prejudice.

7.1.5 The engagement between the Public Protector and the parties prior to the release of the report also assists the Public Protector to take remedial action which flows logically from the report and which are proportionate having regard to the maladministration and adverse effect where this is established.

7.2 **Response by the Head of the Department**

7.2.1 On 28 March 2011 the Public Protector advised the Head of the Department of Health that the investigation might result in adverse findings pertaining to his Office, the Centre Manager and the member of staff implicated ("Sdudla") and they were afforded the final opportunity to respond thereto:

7.2.2 On 11 July 2011 the Head of the Department responded as follows:
"... I am pleased to respond that the Department of Health accepts the findings of the report and commits to the implementation of the report recommendation.

Your report has highlighted a number of service delivery concerns at the Gugulethu CHC which are viewed in a very serious light. The Department aims to provide the highest standards of care to local people and reports of this nature are always treated seriously and used as an opportunity to learn and improve services.

**Departmental response in terms of your findings:**

a) The issue of signage, staff discipline and cleanliness, as well as the timeous repairs of infrastructure (leaking pipes, broken floor tiles etc.), introduction of air-conditioners and the replacement of assets e.g. chairs and consumables such as proper dustbins are operational matters and will be addressed by the centre manager, supported and monitored by the Primary Health Care and Substructure Managers.

- An action plan to effectively address and correct these matters has been developed....

b) In terms of staff discipline with specific reference to staff being drunk on duty the following interventions will be effected:

- The ‘cleaner with alcohol breath and bloodshot eyes and who was clearly rude to patients on the 28 February 2011’ who has been implicated in your report will be dealt with in terms of the Disciplinary Code and Procedure for Public Service.

- Circular H116/2009: Guidelines for dealing with substance abuse (alcohol and drugs) whilst on duty, will be communicated to all and will be dealt with at personnel meetings and if needs be it will be workedshoped with supervisors to ensure effective implementation of the policy.
• The reporting of such incidences by the community will be encouraged through the community governance structures. Posters in terms of Complaint and Compliments handling procedures have been exhibited within all the Community Health Centres which will facilitate the reporting of ill-behaviour by staff and poor service delivery directly to senior management.

c) The reporting of a lack of 'someone to monitor and/or assist trauma patients' are (sic) a contravention of the South African Triage System Policy. This policy was introduced by the Department to ensure that patients that are urgent and in need of emergency medical care gets attended to immediately and those that are less urgent gets attended to within a reasonable time and capacity was provided for the effective implementation of the policy in terms of staff appointments and in terms of training and development of these staff members.

• The Department will ensure that the respective manager(s) ensure the re-introduction of the said policy within the health facility.

d) Your report articulates that the findings in terms of section 27(1) of the Constitution and Section 25(2) of the National Health Act, 2003 are violations by the centre manager (facility manager), which is improper and constitutes maladministration, are regarded as very serious and demands appropriate remedial action.

• The Department will follow due process in this regard and will ensure that the appropriate action is taken against the centre manager.

The Department of Health wants to thank the Public Protector for the manner in which these investigations were conducted and reported to the Department. The Department will ensure implementation of these remedial actions by incorporating it into its monthly supervisory visits.

7.3 Conclusion
7.3.1 In view of the response of the Head of the Department the Public Protector wishes to acknowledge the cooperation of the Department and its Head in the investigation and commend the Department for taking responsibility for the service failures and for the commitment to taking steps to correct its conduct.

8. FINDINGS

8.1 The allegations of poor service delivery against the above Centre are well founded. Failure on the part of the Centre Manager and staff to manage the cleanliness of the facility, effect repairs timeously, attend to signage inside the Centre and to ensure disciplined and courteous conduct of staff, is found to be in violation of section 27(1) of the Constitution and section 25(2) of the National Health Act. It is accordingly improper, and constitutes maladministration.

8.2 The investigation also found undue delays on the part of the Centre to provide health service. There seems to be no justifiable reason for the situation as the Centre Manager confirmed that there was no shortage of staff. Such delays violate the rights, values and principles governed by section 27(1) of the Constitution, and constitute maladministration.

8.3 The allegations of use/abuse of alcohol by staff whilst on duty were found to be substantiated. This does not only amount to improper conduct in the extreme, but also carries a high risk of impropriety and prejudice towards members of the public. This violates section 27(2) of the National Health Act and accordingly constitutes maladministration.

9. REMEDIAL ACTION
9.1 The following remedial action in terms of section 182(1)(c) of the Constitution is to be taken:

9.1.1 There should be proper signage, in all official languages of the Western Cape Province, at both the main entrance and the Maternity Unit entrances regarding the location of the various units/departments within the Centre.

9.1.2 The management of the Centre should ensure that the area outside the main entrance is cleared by the City of Cape Town regularly and that the situation regarding hawkers is managed adequately.

9.1.3 Cleanliness on the inside of the yard of the Centre should be addressed as a matter of urgency.

9.1.4 There should be a system in place to ensure that there is somebody at all times to assist and/or monitor trauma patients.

9.1.5 The Centre Manager should address the conduct of the cleaner, who was clearly rude to patients at the Trauma Unit and exhibited signs of being inebriated on 28 February 2011.

9.1.6 Provision should be made in the budget to acquire air-conditioning or fans at the Centre.

9.1.7 The leaking pipe in the ladies toilets should be repaired and sanitary requirements attended to.

9.1.8 The floor tiles with holes, in front of the Reception area door should be replaced as it poses a risk of injuries.

9.1.9 The Centre Manager must immediately introduce management interventions to prevent any use of alcohol. The Head of the Department should facilitate surprise inspections to monitor the situation.
9.1.10 The Head of the Department must monitor the management, administration and service delivery at the Centre until all the deficiencies have been addressed.

10. MONITORING

10.1 The Public Protector has recorded the Department’s acceptance of her findings and remedial action, as well as the submission of an action plan for implementation.

10.2 The Head of the Department must provide the Public Protector with a progress report on the implementation of the remedial action within 30 days of the date of the report, and thereafter submit bi-monthly reports on the progress made with the implementation of the above-mentioned corrective measures.

ADV T N MADONSELA
PUBLIC PROTECTOR OF THE
REPUBLIC OF SOUTH AFRICA

DATE: 21 09 2011

Assisted by: Mr W Kamsela and Adv M Lebeko, Investigators: Western Cape