FACTUAL REPORT OF THE PUBLIC PROTECTOR’S OBSERVATIONS REGARDING INSPECTIONS AT VARIOUS HOSPITALS IN GAUTENG, MPUMALANGA, EASTERN CAPE, KWAZULU NATAL AND LIMPOPO
INDEX

EXECUTIVE SUMMARY .................................................. 3
1. Introduction .................................................................... 4
2 Background ..................................................................... 6
3. Observations from the inspection .................................. 7
3.1 Gauteng ........................................................................ 7
3.2 Jubilee Hospital ............................................................ 8
3.3 Dr George Mukhari Academic Hospital ......................... 11
3.4 Steve Biko Academic Hospital ...................................... 13
3.5 Lillian Ngoyi Hospital .................................................. 16
3.6 Chris Hani Baragwanath Academic Hospital .................. 19
3.7 Charlotte Maxeke Johannesburg Academic Hospital ......... 23
3.8 Mpumalanga ................................................................ 27
3.9 Themba Hospital .......................................................... 27
3.10 Eastern Cape ............................................................... 35
3.11 Sulenkama - Nessie Knight Hospital ............................. 38
3.12 Umtata Hospital .......................................................... 51
3.13 Livingstone Tertiary Hospital ....................................... 58
3.14 Uitenhage Hospital ...................................................... 69
3.15 Limpopo ................................................................. 75
3.16 Limpopo Capricorn District ......................................... 75
3.17 WF Knobel Hospital ..................................................... 75
3.18 Kwa-Zulu Natal .......................................................... 82
3.19 Christ the King Hospital .............................................. 83
3.20 Reitvlei Hospital .......................................................... 85
3.21 Mbongolwane Hospital ................................................ 88
3.22 St Marys Kwa Magwaza Hospital ................................. 90
4. Common issues identified across all hospitals ............... 93
5. Interventions ................................................................. 99
6. Conclusion ................................................................. 118
7. Expectation and way-forward ....................................... 119
Executive Summary

(i) On Monday, 23 March 2020, President Cyril Ramaphosa announced that the country will be on a 21-day lockdown effective from Thursday, 26 March 2020 as part of measures aimed at containing the fast-spreading Coronavirus, which is also known as Covid-19.

(ii) Due to Covid-19, the Deputy Public Protector, Advocate Kholeka Gcaleka (the DPP) and I embarked on nationwide visits to Provinces to conduct inspections at various hospitals to ascertain the state of readiness to cope with the COVID-19 pandemic.

(iii) The purposes of this report are:

(a) To inform the Minister of Health, Dr Zweli Lawrence Mkhize (the Minister) about the challenges relating to healthcare facilities received during my inspections across the five provinces;

(b) To identify common cause issues at the various hospitals; and

(c) To request implementation plans with clear and definite timelines from the affected authorities where concessions on inadequate service delivery have been made, and in cases where interventions are already underway.

(d) The systemic investigation covers accountability and undertaking for inadequate service delivery. My office implores a diagnostic systemic approach with a view of establishing factors behind a flood of complaints or potential flood of complaints received or to be received by my office. The investigation focused on factors or gaps behind all the problems or complaints reported in some of the five (5) provinces.
1. INTRODUCTION

1.1. My office is established in terms of the Constitution of the Republic of South Africa to strengthen constitutional democracy.

1.2. I have the power, as regulated by national legislation, 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; report on that conduct and take appropriate remedial action.

1.3. My office must be accessible to all persons and communities.

1.4. I have additional powers and functions as prescribed by national legislation.

1.5. One of the pieces of national legislation referred to above is the Public Protector Act 23 of 1994, which empowers the Public Protector to investigate undue delays in the delivery of public services; unfair, capricious or discourteous behaviour; abuse of power; abuse of state resources, dishonesty or improper dealings in respect of public money and improper enrichment.

1.6. In addition, to effectively and efficiently implement the institutional mandate, a detailed plan titled the Public Protector Vision 2023 has been developed and is relied upon, in part, in an effort to essentially take the services of the Public Protector to the grassroots communities such as farms, rural villages, townships and informal settlements.
1.7. The vision rests on (8) eight pillars, namely:

1.7.1. Enhancing access to services;

1.7.2. Engaging communities in vernacular for effective communication;

1.7.3. Increasing the institution’s footprint;

1.7.4. Leveraging stakeholder relations to advance institutional interests through Memoranda of Understanding;

1.7.5. Projecting the image of a stronghold for the poor;

1.7.6. Ensuring that people are well-versed on their rights and freedoms;

1.7.7. Persuading organs of state to have effective in-house complaints resolution means to offload some of the burden from the institution’s shoulders; and

1.7.8. Inspiring people to be their own liberators.

1.8. The institution has 19 offices across the country through which walk-in services are rendered. In addition and to make up for accessibility shortcomings, the institution uses the Outreach Programme to reach out to and deliver services to grassroots communities.
Key components of the Outreach Programme are the annual Public Protector Roadshow and the commemoration of national events. These see the Public Protector travelling to all the provinces to interact with the public, the provincial executives, the respective legislatures and other state institutions.

**BACKGROUND:**

Every year the Public Protector tours the country as part of a Stakeholder Roadshow aimed at interacting and renewing ties with key stakeholders as well as advancing the institution’s constitutional mandate.

On Monday, 23 March 2020, President Cyril Ramaphosa announced that the country will be on a 21-day lockdown effective Thursday, 26 March 2020 as part of measures aimed at containing the fast-spreading coronavirus, which is also known as Covid-19.

The regulations governing the lockdown stressed the need for social distancing, among other things. This included the prohibition of mass gatherings.

The President has since extended the lockdown albeit with the easing of some restrictions. However, mass gatherings remain prohibited.

There is, therefore, a need to refrain from commemorating national days in a traditional way and or conduct outreach programmes, given the lockdown restrictions such as the prohibition of mass gatherings.
2.6. Despite the lock-down restrictions, the need and to pursue the Public Protector Vision 2023 and to take the services of the institution to the grassroots communities has remained. I instead, opted to pursue objectives of the Vision by visiting hospitals to evaluate their state of readiness to contribute towards the stemming of the corona virus pandemic.

3. OBSERVATIONS FROM THE INSPECTIONS

3.1 Gauteng Province

3.1.1 The objective of the inspection was to:

3.1.1.1 Observe the state of hospitals designated to act as emergency centres for the treatment of Coronavirus patients.

3.1.1.2 Their capability to treat those patients and the level of readiness to deal with the surge of cases.

3.1.1.3 Observe progress on projects of the construction of new wards at these hospitals.

3.1.1.4 The working conditions of health workers and the procurement and provision of PPEs to health workers.

3.1.1.5 The inspection in loco was conducted on 18 - 20 August 2020 at the following Hospitals: Jubilee Hospital, Dr George Mukhari Hospital, Steve Biko Pretoria Academic Hospital, Chris Hani Baragwanath Academic Hospital, Lillian Ngoyi Health Clinic and Charlotte Maxeke Johannesburg Academic Hospital.
3.2 JUBILEE HOSPITAL

3.2.1 The inspection was conducted on 18 August 2020 and the following observations were made:

3.2.2 The hospital has a staff complement of 826. The hospital services the North West and Limpopo Provinces patients and supports 8 clinics.

3.2.3 The hospital has the bed capacity of 1400 and has a designated total of 300 beds for Covid-19 patients but the management did not have any information as to what informed the total number of beds needed. The hospital was expecting a donation of 300 beds from BMW SA on 24 August 2020.

3.2.4 Staff members that had tested positive were 94 and 79 have recovered. One Doctor passed on as a result of Covid-19 and 41 patients tested positive. The hospital is not capacitated to conduct Covid-19 tests but the tests are sent to George Mukhari hospital.

3.2.5 There was also a call center at the hospital that was designated to provide psychological support to staff members. A psychologist was appointed to provide support to staff.

3.2.6 During the *inspection in loco* it was noted that there was construction underway at the hospital to house Covid-19 patients and the construction will end in October 2020. However the hospital Management was not engaged in the decision making regarding the processes followed in respect of the said construction at the hospital but Management currently does form part of meetings. Ostensibly, there was no needs analysis done by the Provincial Department regarding the infrastructure needs.

3.2.7 There is additional recruitment of staff on a contractual basis for a period of 12 months, as per the decision at Provincial level with the aim of capacitating the Covid19 team. Accordingly the contractual agreements
were to lapse by the end of March 2021 and if the need arose the hospital was hopeful that the contractual agreements would be extended beyond March 2021.

3.2.8 Vacancies that were prioritised at the hospital included that of general nurses, specialized nurses and that was to the exclusion of Doctors.

3.2.9 The hospital has Occupational Health and Safety Committee which is chaired by the Clinical Manager and various levels of staff and the Union are represented therein.

3.2.10 There was a workable system put in place by the hospital to ensure that patients received their chronic medication for the duration of 3 months in order to ensure the minimization the increase of Covid-19 positive cases.

3.2.11 With regards to the procurement of PPEs, the hospital does not necessarily play a major role as procurement is done at the Provincial level and their hospital is only advised to collect PPEs at a centralized warehouse.

3.2.12 **The following challenges were noted during the inspection** -

3.2.13 There is insufficient procurement, distribution and provisioning of PPEs to ensure that the staff and the Covid-19 patients were adequately protected from the surge of the pandemic.

3.2.14 The PPEs are collected at the warehouse and they are procured by the Department.

3.2.15 There were challenges encountered with regards to kitchen facilities i.e. broken taps.

3.2.16 There are issues regarding staff capacity within the Covid-19 wards and this affected the smooth running of the hospital. This resulted in the closure of the ICU and theatre unit. The Department allocated 63 posts (Doctors, nurses and cleaners). Some posts were for a period of 12 months only.
3.2.17 According to the submission of the Acting CEO, there was no collaboration between the hospitals and medical aid schemes.

3.2.18 The Union is part of the Covid-19 Task Team but more could be done in terms of information sharing and communication.

3.2.19 There are no drivers appointed to specifically collect PPEs and as such the delays in collection becomes a challenge.

3.2.20 There are challenges regarding leave applications i.e. in that people who tested positive for Covid-19 were not given special leave but required to use their sick leave.

3.2.21 The Hospital is not capacitated to conduct Covid-19 tests. There are delays in the issuing of results of Covid-19 patients as there is no capability in place to conduct tests. The specimens are done in batches and they would be taken to George Mukhari hospital for testing resulting in delays in obtaining results.

3.2.22 The hospital does not have sufficient PPE and that there is no dedicated driver appointed to collect PPE’s at the warehouse and as such this contributes to the delay in receiving stock. Further, staff is required to use one PPE the entire day, i.e. after every consultation with patients, staff is required to change their body suits but it is not the case at the hospital.

3.2.23 Challenges regarding the turnaround time in the washing of the linen at the hospital. The laundry would be sent to Masakhane in Rosslyn to be washed but it is not returned timeously.

3.2.24 Challenges regarding the response times of the ambulances at the hospital due to the fact that the hospital has an overflow of patients and referrals from the cluster clinics in the area and some patients would approach the hospital directly without being referred.
3.2.25 The ICU unit had to be closed as there was insufficient capacity to deal with the overflow and elective surgeries had to be postponed. The hospital does not have a recovery plan in terms of commencing with the elective surgery.

3.2.26 Lack of communication between management and staff was raised in that regular meetings are not held to inform staff of any Covid-19 developments.

3.3 Dr George Mukhari Academic Hospital

3.3.1 The inspection in loco was conducted on 18 August 2020 and during the inspection, the following observations were made:

3.3.2 The hospital was dedicated a Covid-19 hospital in March 2020. The hospital supports the North West Province, the Limpopo and Mpumalanga Provinces and as such the hospital is in disadvantaged position in that the servicing of three additional provinces is not supported by funding.

3.3.3 The Hospital has a staff complement of 4700 and 3300 patients. The Hospital was designated as a Covid-19 emergency center in March 2020.

3.3.4 The hospital has 1652 beds of which 430 were allocated to Covid-19 patients. Twelve (12) wards were converted into Covid-19 wards with 480 beds. At the date of the visit, each ward was carrying 46 patients but initially carried 26 patients.

3.3.5 The hospital had 4 staff members and 1 patient that died due to Covid-19. The hospital uses tents to screen patients before admission to the hospital. The Covid-19 wards have HVAC system which is used to control the airflow in the wards.
3.3.6 The hospital was allocated money but subsequently that money was redirected to Steve Biko hospital. The hospital was allocated 150 temporary Covid-19 positions by the department.

3.3.7 It was observed that medical waste was lying on the corridors in the hospital and it was not secured.

3.3.8 The hospital Management indicated that procurement is centralized at the provincial level and as such there are delays in receiving PPE’s. The hospital indicated that there was a lot of red tape when it comes to procurement and that the Hospital should be given authority to make its own procurement.

3.3.9 The hospital also raised an issue with regards to the role of the board and requested that there should be an intervention in terms of clarifying their role in whether it is advisory or a management Board. The Public Service Commission was approached to assist in this regard.

3.3.10 The discrepancy in the procurement threshold was raised by the hospital and that they are not able to service broken lifesaving machines. Management had requested the Province to procure the radiology machine for the past 3 years and to date it has not been procured.

3.3.11 They advised that the CEO’s threshold is R 500 000 whereas the threshold of the CEO of Sefako Makgatho is R 5 million and this is not legislated and the Treasury regulations are not prescriptive in this regard. As a result, this is negatively impacting on service delivery and their allocated budget which they have no control over.

3.3.12 The hospital advised that the current structures that are built in the hospital can only be used as field hospitals and that building of a hospital was required.
3.3.13 The South African National Defence Force (SANDF) has deployed its members to assist the hospital. However, no medical practitioners were deployed to help capacitate the hospital.

3.3.14 The following challenges were observed -

3.3.15 There was no proper process for securing and disposing of medical waste at the hospital due to the conduct of the appointed service provider. Medical waste were found lying, unsealed in the corridors.

3.3.16 The procurement of PPEs is done by the Department and once procured, they are collected at the warehouse. Centralization of procurement was raised as a challenge.

3.3.17 In terms of procurement and maintenance threshold, the CEO is not allowed to procure any PPEs above the value of R 500 000 but the CEO of Sefako Makgatho Hospital can procure up to R 15 million.

3.3.18 The role of the governing structure being the Board was not clarified whether it is advisory or management Board.

3.3.19 The South African National Defense Force (SANDF) had deployed its members to assist the hospital. The hospital required medical practitioners to assist capacitate the hospital and not only assistance with logistics.

3.3.20 Salaries of Covid-19 contract workers were not paid and reasons for non-payment were not provided.

3.4 STEVE BIKO ACADEMIC HOSPITAL

3.4.1 The inspection in loco was conducted on 18 August 2020, followed by a meeting on 8 September 2020 relating to concerns of Risk Management of Covid-19 as well as issues of an alleged communication breakdown between labour and management.
3.4.2 The hospital was designated as a Covid-19 hospital in February 2020 and has a staff complement of 4500. The hospital was allocated contract workers, 7 professional nurses, 21 staff nurses, 8 Doctors and 5 Specialists.

3.4.3 The hospital has a bed capacity of 835 of which 240 were initially allocated to Covid-19 patients. However, Covid-19 patients were occupying 448 beds at the time of the visit.

3.4.4 The hospital recorded 135 Covid-19 deaths which excluded staff members as no staff member had been infected with Covid-19.

3.4.5 The hospital has rental tents that were erected in April and May 2020 at the entrance of the hospital with a capacity of 20 patients each. The tents are piped with oxygen which is supplied by Afros Company;

3.4.6 Procurement of all Personal Protective Equipment (PPE) is done by the Province and the procurement threshold for the hospital is limited to R 500 000 and there is undue delay by the Province to provide PPE.

3.4.7 The hospital has a machine that is being used to sterilize face masks for re-use.

3.4.8 It was indicated by the hospital that the hospital was concentrating on the Covid-19 cases whilst the other areas of the hospital was neglected.

3.4.9 There is no training that is provided in relation to the control and management of Covid-19.

3.4.10 **The following challenges were observed** -

3.4.11 The Hospital has a Risk Committee that does not deal with Covid-19 infection and prevention control issues. The risk committee has not met since the beginning of the financial year.
3.4.12 The CEO and management are not communicating effectively in that the staff`s concerns are not addressed. Staff was not given ample time to study reports which will be discussed in meetings and such reports are only submitted during the meeting.

3.4.13 Staff members with comorbidities are not accommodated and the patient nurse ratio does not complement each other.

3.4.14 Infections control unit is non-existent and staff members allege not to have been trained on Covid-19, irrespective of their pleas to management in this regard.

3.4.15 Maternity wards are not provided with proper PPEs;

3.4.16 The Occupational Health and Safety (OHS) should form part of the steering committee which should also look into issues relating to infectious diseases and the efficiency of the hospital.

3.4.17 Only the Doctors were provided with full PPEs but other staff members were not. PPEs (masks) are re-used and when the issue was raised with management, they were advised that the hospital will run out of PPEs. The usage of M95 PPEs vis a vis KN95 was raised as a challenge in that the M95 were made for construction purposes.

3.4.18 The hospital does not have sufficient ambulances.

3.4.19 Notwithstanding the Department of Public Service and Administration (DPSA), Circular 38 which states that staff can work unlimited hours, there is a 30% limit on overtime.

3.4.20 There is non-compliance with building safety standards for the hospital, safety doors and lighting detectors are not working, files and patients
records are on the floor and inspectors had visited the premises but to date, the report was not communicated to staff.

3.4.21 There are no medical practitioners deployed by the SANDF to assist in the medical wards. The only assistance provided by SANDF was with regard to logistics in the hospital.

3.5 LILLIAN NGOYI HEALTH CLINIC

3.5.1 During the inspection on 19 August 2020, it was noted that the Clinic serves as a day care clinic which is capacitated with 18 Primary Care Providers, 8 Midwives, 13 Professional Nurses and 10 Doctors.

3.5.2 The non-payment of salaries of the Skeem security guards deployed to guard the premises was raised as a concern.

3.5.3 Patients that were interviewed indicated that they were waiting for the Doctor who went out for lunch and was unavailable for over 3 hours and Doctors are not signing the attendance register. Doctors that are dismissed for misconduct are reinstated and processes of reinstatement may have not been complied with.

3.5.4 There was concern regarding the geyser that was not working for 3 months. The issue was raised with the Department of Infrastructure Development (DID) but was never resolved for months. The clinic does not have heaters and hot water and the staff resorted to boiling water for patients to enable them to wash themselves.

3.5.5 It was also observed that there was dirty linen lying around and the staff attributed it to a delay in providing clean linen by the Baragwanath hospital that does the laundry for the clinic.

3.5.6 Patients that sleep over during an emergency are not given proper food but only bread, soft porridge or oats in the evening to eat. The Environmental Inspector stopped the delivery of frozen food to the clinic.
and advised that the food was not of good consumption but the frozen food was never replaced with alternative quality food.

3.5.7 The telephones were not working for over 2 months, printer and copier not working for over 2 years and Doctors and nurses use their own money to make copies outside the clinic. A mobile telephone was provided by the District office to the clinic and had only R 400 airtime which was insufficient to cover all the staff in the hospital. If the cell phone is in another unit, the other units are not able to access it, especially during emergencies thereby leaving the staff with no options to run to the unit where the phone would be at.

3.5.8 The response time of ambulances was long especially in urgent cases.

3.5.9 There is undue delay in the filling of posts. The position of Chief Clerk has not been filled for 2 years.

3.5.10 There was no proper support of the staff complement during the pandemic and there was no adequate training to the staff regarding the pandemic.

3.5.11 Procurement is centralized at the district level and there was undue delay that negatively impacted the clinic in dealing with the patients overflow and there was insufficient provisioning of PPEs. The official at the district office would instruct the clinic in terms of what to procure instead of delivering what the clinic submitted in respect of the needs analysis, quality and procurement specifications. When equipment was procured, there will be no consultation with the end user.

3.5.12 They are not able to utilize budget allocated to them as it is centralized but if there was over expenditure, the CEO of the clinic was accountable even though she was not controlling and managing the budget.

3.5.13 The staff have not been provided with uniform since 2017. During 2018-2019, the clinic submitted a request to procure uniform and the budget for uniform has not been used but to date there has been no response from the district.
3.5.14 The Department of Infrastructure is delaying with regards to machinery and/or appliance that needs to be repaired or serviced. The issues were brought to the attention of the CEO but to no avail.

3.5.15 There was a response protocol with the Department of Infrastructure regarding the renovations at the hospital, however the management of the hospital was not engaged regarding construction.

3.5.16 There was no psychological support to the staff at the hospital by the district office.

3.5.17 Human Resources is centralized at the provincial level and that caused delay in making appointments and capacitating the hospital.

3.5.18 The risk committee was non-existent and it is placed at the district level and as such the clinic staff is not aware of its existence and processes.

3.5.19 The quality of the PPE provided to the hospital were not as per the specifications sent through by the hospital management as they were of low quality. There was no consultation with the end user. Despite specifications and motivation specifying the goods needed, the goods and PPEs ordered are not as per specification.

3.5.20 The clinic was not able to utilize the budget allocated to them as it is centralized at district level but if there was over expenditure or under expenditure, the clinic CEO must account.

3.5.21 The following challenges were observed:

3.5.22 The non-payment of salaries of the security guards.

3.5.23 Undue delay and availability by some Doctors to timeously attend to patients.

3.5.24 Undue delay to provide staff with uniform, procure and servicing of broken equipment’s, i.e. geyser, heaters, telephones and printers and the substandard quality of PPE.
3.5.25 Undue delay in the ambulance response times and provision of clean linen to the clinic.

3.5.26 Failure to provide patients with healthy and nutritious meals while admitted to the clinic.

3.5.27 Undue delay in the filling of vacant posts and lack of communication between the clinic management and the district.

3.6 **CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL**

3.6.1 The *inspection in loco* was conducted on 19 August 2020 followed by an unannounced visit on 11 September 2020. The unannounced visit related to employee unrest which occurred as a result of inadequate availability of PPE for employees on 10 September 2020.

3.6.2 The hospital has a staff complement of 6324 filled positions and 812 vacant positions. The hospital was allocated an amount of R 68.2 million to further fill 282 posts. The hospital was allocated budget in terms of various phases, i.e. R14 982 million for phase 1, R68.2 million for phase 2 and R98 280 million for phase 3. The Covid-19 patient death rate is at 445, 6 staff fatalities, 540 patients infected, 39 in isolation and the 443 PUI patients.

3.6.3 The hospital commenced with the Covid-19 renovations in March 2020 and was provided with 10 wards. There were 480 beds set aside by the hospital to deal with the overflow of Covid-19 patients and 500 critical care beds planned. The hospital has 10 tents for Covid-19 cases which are fitted with air cons, heaters and ablution facilities. The medical and maternity ward was re-purposed to house Covid-19 patients.

3.6.4 The psychiatry patients that test positive for Covid-19 do not have a specific ward allocated to them and they cannot be taken to a general Covid-19 ward.
3.6.5 The oncology unit was taking too long to be completed.

3.6.6 The hospital received positions for contract workers, 15 professionals, 14 enrolled nurses and 13 ward clerks in June 2020 but the health care ratio per patient is not balanced. There is a challenge in the filling of posts and Doctors that were appointed to posts declined the appointments and there is no senior appointments made.

3.6.7 The hospital has an OHS Risk Committee which is managed by a Doctor who was appointed to work 3 days in a week. A psychologist has been appointed to assist staff to cope with the Covid-19 related issues.

3.6.8 Staff that are above 50 years with comorbidities and some who are pregnant are expected to work in the Covid-19 wards.

3.6.9 Elective surgery was put on hold for patients who will not have complications in the next 3-12 months to give priority to Covid-19 cases and that resulted in a backlog of surgeries. Ostensibly, no plans were put in place to clear the backlog.

3.6.10 Procurement of PPEs and maintenance of equipment is done by the Province and this results in undue delay by the hospital to receive the PPE. The hospital raised an issue with regard to the uneven provisioning of PPE amongst staff and between March and June 2020, staff were without PPE.

3.6.11 The hospital received PPE stock from a warehouse and the quality of the PPE received, especially the unsterilized gowns are not fit for purpose as they are short and not able to protect staff.

3.6.12 The SANDF members are deployed to the hospital and are provided with full PPE whereas they only work with logistics.

3.6.13 The taps and basins in the kitchen are not working and the facilities and logistics manager has not addressed these concerns despite submissions sent to repair same.
3.6.14 Patients that were interviewed indicated that there is no porter service and there are required to push other patients on wheelchairs. Patience arrive at the hospital a night before only to be assisted the next day.

3.6.15 **During the inspection the following challenges were highlighted** -

3.6.16 There was unavailability of PPE and non-sterile gowns in high risk areas and the PPE stock levels at the warehouse where PPE`s are collected are very low.

3.6.17 There is no communication to staff in this regard also with regards to all Covid-19 related issues.

3.6.18 The Province issues a circular in terms of what the hospital may and may not procure but when the essential stock becomes unavailable, it results in undue delays for the hospital to receive stock and it becomes a challenge for the hospital to procure any PPE. The hospital is not receiving the requested number of PPE stock and they actually receive less. i.e. 1000 overalls were requested but only received 300.

3.6.19 The hospital received a Covid -19 testing machine but they were not able to utilize it as the service provider was not accredited and there is undue delay in the issuing of the medical surveillance assessment reports which in turn delays appointment of new staff.

3.6.20 Conversion and refurbishment of wards was a directive from the Province and the Department of Infrastructure Development (DID) and not based on a needs analysis.

3.6.21 There is a delay in creation and appointments for Covid-19 posts in that appointees accept posts but do not show up to assume duty. The centralization of the PERSAL production functions at the provincial level, contributed to these delays as well as human capital constraints.
experienced in the HR department to manage the Covid-19 appointments. There was a lack senior personnel as their appointments were done only at provincial level.

3.6.22 Capacity challenges at E- Government poses a risk of delayed payment of salaries.

3.6.23 Specialized doctors were not appointed during the pandemic, but junior doctors were appointed instead as, they did not have any comorbidities and could work for longer hours. The appointments made were on a contractual basis which lapses in March 2021.

3.6.24 The issue of renewal and extension of contracts of employment was delegated at the provincial level and not the hospital.

3.6.25 The SANDF did not deploy any medical practitioners to assist with the overflow of patients.

3.6.26 Employees are appointed specifically for the Covid 19 ward despite having underlying conditions i.e. some were even pregnant.

3.6.27 There was non-delivery of the procured PPE's by the appointed service provider who was on the provincial database. Treasury provided a database from which suppliers should be appointed to provide PPEs.

3.6.28 At some point there were substandard PPEs that were delivered to the hospital as the gowns were unsterile and they did not fit the staff compliment.

3.6.29 There were challenges faced by the hospital in distributing PPEs to relevant staff members. Staff was induced to re-use PPEs and the normal process of procuring of the PPEs was not followed.
3.6.30 The end user was not provided with PPEs timeously, unlike the SANDF deployed officials who merely assisted with logistics at the hospital.

3.6.31 There is inadequate IT infrastructure at the hospital.

3.6.32 The hospital has Occupational Health and Safety (OHS) and risk Committee but the OHS professionals are over stretched. The hospital advertised the position of OHS but the Doctor appointed is working only 3 days in a week despite the advert requiring a full time OHS person.

3.6.33 The hospital had a service provider who was contracted to conduct Covid tests for staff but the contract has expired and staff are not tested and there is no support for staff with Covid-19 and only one psychologist is appointed to assist staff and it is not sufficient.

3.6.34 The infrastructure in the Oncology ward is inadequate and not completed and the psychiatric patients that tested positive for Covid-19 cannot be taken to a general ward.

3.6.35 There was undue delay to service and repair taps in the kitchen, the laundry machine as such repairs are managed by the Department of Infrastructure.

3.6.36 Ambulances are not serviced, cleaned and sanitized and as such, the health of the patients and staff is compromised.

3.6.37 There are no Porters to assist in pushing/transporting patients in the hospital.

3.7 CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

3.7.1 The inspection in loco was conducted on 20 August 2020 and the following observations was made:
3.7.2 The hospital was designated as a Covid hospital in March 2020. It has a staff complement of 5000, receives referrals from 14 hospitals in Gauteng and other Provinces. It serves as a training centre for University of the Witwatersrand (Wits), Sefako Makgatho Health Sciences University (Sefako Makgatho) and University of Johannesburg (UJ).

3.7.3 The hospital has 596 positive Coronavirus (Covid-19) cases but only allocated 300 beds for Covid-19 patients.

3.7.4 The hospital was divided into 3 zones (Red, Yellow and Orange) and PPE was distributed in terms of the zone which a staff member works.

3.7.5 The following challenges were noted during the inspection -

3.7.6 There was a delay in the filling of specialized positions (Clinical positions) in the hospital due to the centralization of recruitment at the provincial level.

3.7.7 Staff members who contracted the Covid-19 were expected to take sick leave instead of taking special leave.

3.7.8 The delivery and collection of PPEs was centralized at the provincial level and that caused delays in the provision of service delivery. The depot is situated at Centurion and there is no dedicated vehicle to collect PPEs and they use the laundry truck.

3.7.9 The procured PPE's was not as per the specification (specs) and had to be returned to the depot and this resulted in the CEO procuring PPE as per the required treasury practice notes. The hospital is not requested to provide specifications but are just instructed to collect PPE’s which are substandard. For 3 months (April – June) staff was using substandard tissue like PPEs.
3.7.10 The Chief Executive Officer’s (CEO) budget threshold was limited to a total of R500 000 and that negatively affected procurement of goods needed by the hospital.

3.7.11 There was inconsistency and undue delay by the service provider (Buhle) to collect medical waste which is subsequently kept in a toilet in the Covid-19 red zoned area. The waste is not environmentally safe and the boxes provided does not have the cautionary linings. The quantity of the boxes supplied was also less than agreed upon.

3.7.12 There were issues regarding the procurement and maintenance (repairs done at Provincial level) of the MRI, Radiology, Oxygen and machines due to lack of contracts with service providers. Despite request made to procure the machines, there has been no movement and this affects service delivery.

3.7.13 Whether the hospital has an employee assistance program (EAP) to assist staffers, especially nurses, with support programmes to cope with the effects and impact of Covid-19. Mental health issues, pre and post Covid were not addressed.

3.7.14 Staffers received medical bills for Covid-19 screening even though the request for screening was a directive from management.

3.7.15 During the inspection there was no oxygen in the hospital and medical equipment ordered in January 2020 was only received in the beginning of August 2020.

3.7.16 There was no consultation with the hospital when the Department designated Charlotte Maxeke as a Covid-19 centre.

3.7.17 There was a lack of communication or circular relating to processes for staffers testing positive for Covid-19.
3.7.18 The hospital was not provided with the surgical soap since February 2020 and the staff had to use non-surgical (green) soap instead.

3.7.19 Due to a lack of a proper IT infrastructure, record-keeping was inefficient. Areas that were sanitized, had no Certificate of Sanitization.

3.7.20 Albeit for the lack of medical practitioners in the hospital, the South African National Defence Force (SANDF) only deployed officials to assist with administrative processes.

3.7.21 Inadequate protection for Healthcare workers and other staff members due to a lack of PPE. Laundry staff were not provided with proper protective clothing and linen staff were induced to soak the laundry of Covid 19 patients with their bare hands. The nurses that were interviewed indicated that the hospital procured small sizes PPE (body suits) and they were torn immediately when they put them on and they were allowed only one body suit per day. They are forced to wear that suit even if it is torn, thereby risking their health.

3.7.22 Nurses were not provided with transport and had to use public transport which compromised their safety. A nurse was raped while waiting for a taxi in the early hours of the morning and another nurse was attacked and robbed.

3.7.23 Occupational Health and Safety (OHS) committee was only trained on 20 May 2020.

3.7.24 The Province is only focusing on Covid-19 which became additional work but other functions were not taken away and this resulted in more work for staff.

3.7.25 Staffers who treated Covid-19 patients were not tested and advised to test after 5 days. They were forced to report for duty and had to use public transport, putting the public at risk.
3.7.26 There were no risk assessments done.

3.7.27 Staffers who completed forms for comorbidities, received no response from management on how they would be accommodated.

3.7.28 The food provided by the service provider was rotten. The manager who was responsible for the food at the hospital indicated that there were instances where patients complained about the quality of the food.

3.7.29 Signage for Covid-19 was not efficiently displayed in the hospital.

3.8 MPUMALANGA

3.8.1 I identified the following health facility in Mpumalanga, to be visited for the inspection: Themba Hospital in the Ehlanzeni District in Mpumalanga.

3.8.2 The inspection of public healthcare facilities continued in the first week of September 2020 in Mpumalanga. This followed my tour of various hospitals in Gauteng earlier in the month of August 2020 to observe first-hand the challenges that staff and the public alike grapple with regarding the provision of services, more so in light of the Covid-19 pandemic.

3.9 THEMBA HOSPITAL IN KABOKWENI:

3.9.1 I and my team met with Hospital Management led by the Chief Executive Officer (CEO), Mr. Mduduzi Shabangu. The Provincial Office was also represented by the Chief Director for Hospital Services, Ms. MD Mohale. There was further representation from the various trade unions including NEHAWU, PSA, DENOSA and HOSPERSA.

3.9.2 The mandate of the Public Protector and the purpose of the visit as well as remedies that the office offers was highlighted. The importance of
Labour in working together with management to address issues that affect staff was also recognized. The CEO, highlighted the following during the engagement:

3.9.3 **State of the facilities -**

3.9.4 The hospital has infrastructure challenges in that they do not have sufficient space. They had to convert some of the wards to accommodate Covid-19 patients. The situation has improved due to lower COVID 19 infections but the challenges will persist should the province experience another surge in positive cases.

3.9.5 The current infrastructure is old as the hospital was built in 1974, the population has increased but they are still using the same number of delivery beds.

3.9.6 There is a shortage of space in the maternity wards in that they only have eight (8) beds to accommodate mothers who are due to give birth and those who have complications. The hospital experiences a challenge when more mothers are ready to give birth at the same time, which happens frequently, as beds are then allocated based on the severity of each case. In many instances some of the mothers are requested to recoup whilst sitting on the chairs.

3.9.7 The design for a new maternity wing was completed more than 5 years ago but has not been implemented, allegedly due to the lack of funds. The Department of Public Works is responsible for this project and has not provided hospital management with the costing.

3.9.8 The Hospital has an Allied Health Service, which includes Occupational Health, Psychology etc. that is provided in a ward which is not suitable for this purpose. There is a violation of privacy and patients’ rights in that there are insufficient consultation rooms. The consultation rooms are shared by
up to 4 doctors at a time, leading to sensitive patient information being discussed in front of other patients. Patients are also examined and provided treatment in the presence of other patients, which is again a problem and violates their privacy.

3.9.9 Hospital Management stated further that there is over population in the area and the hospital is old. Maintenance which is the responsibility of Public Works is bad as the hospital only has eight (8) officials to maintain the hospital, there is no capacity and funding is a challenge. These officials have to remove hazardous and other waste material from the wards and other parts of the hospital that by the time they have to go and tend to the garden and other maintenance issues, it is too late. The impact thereof is that buildings are falling apart leading to an unsafe working environment (e.g. Maternity, Allied Health Centre and most of the building structure, and ablution system breaks).

3.9.10 There is an in-house Maintenance Manager who reports to the Provincial Department. The Corporate Service Manager is supposed to coordinate the activities and maintenance to be done with the Maintenance Manager but this cannot be done because the position of Corporate Service Manager has been vacant for a long time. The former Corporate Service Manager was taken through a disciplinary process which has been concluded but has resolved to remain at the provincial office where he was placed during the enquiry. The position has not been advertised. Each ward has a works order on what needs to be done and it has to be completed and submitted. Funding is from the hospital side. They are now outsourcing some of the work due to conflict within public works.

3.9.11 Laundry Services -

3.9.12 Themba Hospital has an in-house laundry service. Public Works has appointed a contractor to fix laundry machines which are not so old, but because of poor maintenance they break regularly. The hospital would report any malfunction of the machine to the contractor to come and fix the
problem and whilst their turnaround time has been reasonable, the challenge is that they lack the capacity and skills to effect the necessary repairs. The contractor (Muraba) is only capable of fixing basic repairs resulting in insufficient linen and gowns being provided due to delays in fixing the problems with the machines. There is suspicion that the machines may have been vandalized machines by the old contractor. There are only two machines working.

3.9.13 Some of their orders are still hanging because the machines are not working. The hospital as resolved that no payment will be made until the machines are in proper working order. There is an on-site contractor, Management requested permission to deviate from using the Public Works appointed contractor and to rather source a skilled and experienced one in order to minimise the negative impact on the hospital operations and service delivery.

3.9.14 The question was asked by the DPP if the capacity of the service provider has been reassessed. The response was that the Hospital reported the contractors to the province, infrastructure unit. The Hospital was not privy to the Service Level Agreement. The cooling system at X-Ray was not working for some time, the turnaround time was a challenge patients had to go to neighbouring hospitals.

3.9.15 This was said to have resulted in a huge loss, soiled linen and patient clothing that have to be disposed of to minimise contamination. The speed of replenishing the lost linen is also slow and has a lot of financial implications as it results in unnecessary replacement. Shortage of linen has serious impact on operations of the hospital. Some operations had to be cancelled because there is no linen. There are shortages of linen in circulation and although they have received funding but it was not sufficient.
3.9.16 **Human Resources** -

3.9.17 Thembha Hospital received 16 appointments of Assistant Nurses during Covid-19. They are still waiting for 23 Professional Nurses for ICU and Trauma Unit and other Units. According to Management, there is generally a shortage of staff, and this has been made obvious by COVID-19.

3.9.18 There were few appointments of doctors, nurses, cleaners, porters and grounds men last year, but they are not enough to service the needs of the communities. The Hospital see about 300-400 outpatients on a daily basis and is not coping. They still need to replace retired and resigned staff members which takes time.

3.9.19 If the hospital does not replace staff within 3 months of the position being vacated, they forfeit the funds for the post. Unfortunately it takes time to process the applications because of the high volume of applications as sometimes they would receive about 4000 applications and it is not possible to finalise the recruitment process within 3 months. If the process is not finalised within that period then the forfeit the post because it would no longer be funded. The process to fill the post is also cumbersome in that they first have to make a submission to provincial office to inform them of the pending recruitment process.

3.9.20 The Hospital does not advertise, they make a request from province. The CEO, who is at a director level as Thembu is a Regional Hospital, does not have the necessary delegation to facilitate the filling of positions without the approval of the provincial office. They have about 900 staff members. The Hospital is approved for 623 beds capacity but currently they have 382 active beds. The balance is to be covered by the Maternity wards which has not been constructed or renovated. Management proposed that the National Department should revive the revitalization programme which assisted with infrastructure development in the past.
3.9.21 There are new services not catered for where the Hospital has to utilise or consume from old staff establishment, such as Bambanani Wellness clinic mainly for HIV and AIDS patients, new General Ward (that was built for World Cup), Clinical Engineer Workshop (where they repair medical equipment), they all operate with old staff as no additional staff was provided. The matter was brought to the attention of the province but they have raised funding as a challenge.

3.9.22 The information on the ratio between the Nurses per patient and Doctor per patient could not be provided. Management added that the general principle is that a hospital must have 75% usage of the beds and 25% space for any eventuality. Similar to most hospitals that have been visited especially in the Gauteng province, the CEO has a threshold not exceeding R500,000.00 to procure goods and services, where there is no contract.

3.9.23 **Equipment**

3.9.24 For Covid-19 the Hospital requested lifesaving equipment, which they have received, with the exception of a few machines that are still awaiting delivery. The hospital received ECG, blood pressure machines, ventilators, ICU and normal beds. They also received portable ventilators. They requested 8 incubators and received 4. There was a shortage of ventilators for adults, it is approved and will be delivered.

3.9.25 **Personal Protective Equipment (PPE)**

3.9.26 The Hospital has been sufficiently provided with PPE. Unlike some of the hospitals in Gauteng who had to reuse the PPE, staff have been provided with PPE at all times. There is a shortage of N95 masks but staff use KN95 masks, which have been approved and surgical masks where appropriate. There challenge has been the availability of required sizes for some of the PPE especially with the boots. At some stage they had challenges with insufficient goggles and boots.
3.9.27 The Hospital managed to maintain the provision of all other services and operations even during the surge of Covid-19. There was a challenge when Covid-19 started, staff members who were infected were 99 in total with 1 fatality. The risk assessment was done and all categories of staff affected were from theatre. It is assumed that they didn’t observe safety measures during break.

3.9.28 No replacement of staff was done during infections, but shifts assisted. No members of the SANDF were assigned to the hospital to assist. Dr Onali is the Chair of Structure on Covid-19. He mentioned that there were not many challenges except for space since dealing with an infectious disease required more space. There were challenges with the infrastructure and had to negotiate with rehabilitation department to utilise their space for COVID-19.

3.9.29 **Comments from the Trade Unions -**

3.9.30 The unions reiterated the issue of space (infrastructure) as a major challenge especially with COVID-19. The issue of mental health patients with COVID 19 also posed difficulty in that they have to be accommodated in the same wards as other patients. These patients can compromise the safety of other patients and staff when their illness leads to outbursts.

3.9.31 Mothers with symptoms couldn’t be serviced, as the maternity ward only provide for ordinary patients, further highlighting the urgent need to address infrastructure problems.

3.9.32 The Hospital Organogram is almost 10 years old. As indicated above, managing staff is a challenge because of the extra services provided by the hospital which have not been allocated additional staff.
3.9.33 They reiterated the poor quality of maintenance as presented by management.

3.9.34 At ICU there is still not sufficient space to keep patients. There is a shortage of ICU beds in the province and it is a struggle to get them resulting in patients being sent to other provinces.

3.9.35 Province provided wall mounted sanitizers which have assisted in maintaining adherence to the regulations. The province only has Rob Ferreira Hospital tertiary hospital but does not have an academic hospital. The Hospital has daily transport to Steve Biko Academic Hospital in Pretoria which enables transfer of patients where there are no sufficient ICU beds.

3.9.36 There is no dedicated psychiatry hospital when there are more mental health patience it becomes a problem. The Unions added that critical posts are not being filled e.g. Corporate Service Manager, almost a year without it being filled. Supply Chain Position, the process was done but not completed, there was a dispute relating to the interviews and it was never addressed or resolved.

3.9.37 The Hospital explained that there was a labour dispute with regard to the Corporate Service Manager, Department had to do a precautionary transfer to head office. The person was no longer interested to return. Once the individual was absorbed the post will be filled. This affects hospital services as no one was responsible for overseeing operations, leaving the CEO to shoulder this additional responsibility.

3.9.38 The hospital has an in-house kitchen. The food is served to patients using a standard menu drafted by province.
3.9.39 **The inspection –**

3.9.40 My team and I conducted an inspection around the Hospital premises. The following was observed and noted:

3.9.41 Thembu Hospital has converted 2 delivery beds to high care but there is not enough space. The hospital delivers at least 15 to 18 babies a day. They facilitated delivered 519 births in the month of August alone. There is a shortage of midwives. There is a definite need for a new maternity ward.

3.9.42 Women are taken to the main theatre when they experience complication which has reduced the number of deaths. However, they have to leave the maternity ward and wait when there are other emergencies resulting in the foetus getting distressed. The wards is so small and there is no privacy. However, ever since the consultant was appointed who suggested the separation of space, the mortality rate has reduced. There is shortage of staff. Staff use a small table as a nurses’ station.

3.9.43 There are only 2 toilets and 2 baths at the maternity ward, there are high risk pregnancies without beds. Some beds are broken and the top of trolley is utilised to improvise. Mattresses are taken out, already foul-smelling. A maternity wing was promised since 2007 to date nothing has happened. The Hospital engaged the Department in 2015/16 but to no avail.

3.10 **EASTERN CAPE**

3.10.1 In July 2020, a number of media outlets made several allegations against the health facilities in the Eastern Cape (EC), which are generally -

a) There was a shortage of water supply at some hospitals.
b) A bath was used to store water in one hospital in Port Elizabeth area. A bath was filled up whenever there was supply and then staff members use a small bucket to scoop some out to flush toilets and wash their hands.

c) This is how health workers at the Emergency Medical Services (EMS) facility in the Eastern Cape survive, as there was no running water at some facilities.

d) The EMS staff members do not have enough water to shower when they return after picking up and dropping off patients at hospital, as required under Covid-19 protocols.

e) Patients have to walk down the passage to wash their hands – even in their weak state of health.

f) There are no bathrooms or showers for the nurses working at some facilities. Staff members alleged that even making a cup of tea was a mission.

g) The facilities also do not have enough ambulances.

h) Staff shortages mean they battle to cope as one nurse can end up attending up to fifty (50) patients.

i) There are prevailing unhygienic conditions at health facilities.


k) Used drips, mattresses, gloves and plastic aprons litter the floor, with rats converging around open drains and feeding off the litter and blood spatter.

l) Waste material is everywhere. In the corridors of the hospital, dirty laundry and boxes marked “danger, infectious waste” lie in the passages.

m) The afore-mentioned are some of the challenges health workers in the Eastern Cape experience on a daily basis.

n) There are reported 500 patients on the waiting list to receive cancer treatment and there is a breakdown of vital machines that causes a further delay in the provision of treatment.
o) Nurses are forced to act as cleaners in some instances and security guards are often forced to cover up for absent medical staff and carry patients into casualty.

p) New-born babies have died in overcrowded and understaffed wards.

q) All the above reported systemic or institutional failures are alleged to have been exposed by the outbreak of Covid 19.

r) The health system in the EC is alleged to be collapsing or crumbling in the height of the global pandemic of Covid 19 virus.

3.10.2 In order to obtain clarity as to what is alleged in the media, the DPP visited certain identified health facilities in the EC and conducted site inspections. The inspection entailed indiscriminately interviewing staff members, union representatives and patients.

3.10.3 The investigation therefore sought to examine a number of factors, including the availability of health care, human resources, physical infrastructure and vital equipment, machinery, personal protective equipment (PPE) and staff morale in hospitals, in the light of the strain added by outbreak of Covid 19 pandemic¹.

3.10.4 On 4 to 5 August 2020, the following hospitals were visited and inspected by the investigation team led by the DPP –

a) Sulenkama Hospital (also known as Nessie Knight)

b) Umthatha Hospital

c) Livingstone Hospital

d) Uitenhage Hospital

¹ Eastern Cape like the rest of South Africa, faces an unprecedented crisis following the invasion of the COVID-19 virus, which poses a clear and present danger to human life.
3.11 Observations, interviews and inspections in loco conducted at Sulenkama - Nessie Knight Hospital -

3.11.1 The following is a list of most visible systemic, administrative and infrastructural challenges and deficiencies made during the site inspection conducted by the investigation team:

3.11.2 Building Plan is an old house built in 1929 by missionaries as humanitarian work and it was not originally designed to be a hospital;

3.11.3 Problems with buildings and fixtures (for example shortages of space, leaking roofs, broken toilets, toilets shared by males and females, unsecured cracking building walls with old paint peeling off);

3.11.4 Non-payment to service providers appointed to conduct renovations, resulting in termination of services and leaving site without notice or knowledge of the hospital management;

3.11.5 The facility faces serious water challenges as it is still using boreholes and some of its blocks within the facility have no water at all;

3.11.6 Staff shortages in all areas such as clinical, nursing and support services such as cleaners, porters and general assistants were also recorded as being further exacerbated by infection with Covid 19 of about 25 existing skeletal staff;²

3.11.7 Infection of staff by Covid 19 was attributed to inadequate supply of PPE and lack of infrastructure such as quarantine room that is inappropriate;

3.11.8 Total lack of equipment such as piped oxygen, the facility is still using one old cylinder gas oxygen with no more spares;

² Health workers are integral to the functioning of the health care system. Without sufficient numbers of health workers no health care system can fulfil its obligations (my emphasis).
3.11.9 Blood Pressure and X-Ray machines are not enough, susceptible to regular breakdown due to lack of maintenance and being irreparable;

3.11.10 Laundry machines are old and irreparable as a result the facility is no longer able to wash its own linen but rely on neighbouring hospitals for the laundry services;

3.11.11 Old and insufficient motor vehicles often breakdown, leaving the hospital with no means to deliver and collect its laundry from other hospital where it is washed;

3.11.12 There is no Intensive Care Unit (ICU) and no High Care Unit (HCU) available in the facility;

3.11.13 Facility has only one room for Patient Under Investigation (PUI);

3.11.14 Shortages of supplies (medical, office, cleaning and maintenance).

3.11.15 The observations recorded above are further supported by photographs that my team took on 5 August 2020 during site inspection at Nessie Knight. Some of these photographs are shown below:
Submission made by management:

3.11.16 On 13 August 2020, my team received further submissions from the Nessie Knight hospital management addressing the following areas:

Profile of Nessie Knight Hospital:

3.11.17 Nessie Knight is a level 1 district hospital located in deep rural area of Sulenkama. It was built in 1929 with mud blocks except the OPD/casualty which was built with a concrete blocks with asbestos roof that is still intact.

3.11.18 The hospital serves eighty six thousand seven hundred and twenty five (86 725) population according to 2016 Statistics South Africa report with thirteen (13) feeder clinics and eighteen (18) municipal wards within twenty six (26) wards for the whole Mhlonto Local Municipality, in OR Tambo District Health Municipality. It is 30 km away from Qumbu town.

3.11.19 There are one hundred and fifty (150) approved beds and one hundred (100) usable but was reduced to sixty eight (68) in August 2018 due to the closure of male ward with twenty (20) beds and a TB ward with sixteen (16) beds. These structures were unsafe to both staff and patients.
3.11.20 It provides all district hospital level 1 services according to the hospital package except rehabilitative services which are referred to other hospitals due to inability to attract rehabilitation staff.

**Physical Infrastructure:**

3.11.21 Nessie Knight Hospital is characterised by dilapidated physical building and other infrastructure.

**State of emergency for trauma:**

3.11.22 There is no designated space for casualty, the hospital uses spaces closed with curtains as an emergency area.

**Medical emergency area:**

3.11.23 All emergency cases are attended to in the emergency trauma unit in OPS, as there is no designated area for emergencies.

**Intensive care unit and high care unit:**

3.11.24 No ICU and High Care units in the hospital. A high care unit has been catered for in the current renovations that are being done. There are renovations currently underway, the male adult ward with 20 beds, a female ward with 14 beds and a TB ward.

3.11.25 The double storey building (Umhlobo) has been demolished and a ward with 20 beds will be built. The renovations were done in the kitchen, Central Sterilizing Supply Department building (CSSD) and the ceiling in the passage. A concrete driveway to the OPD is in progress.
3.11.26 There is no generator room, as it was demolished by Khethwayo Construction Company due to its dilapidated state.

**Operating theatre:**

3.11.27 The layout is not appropriate for an operating theatre, it does not meet the current standard as it does not have piped medical gases, nitrite oxide etc.

**Store room:**

3.11.28 Supplies are kept in different areas throughout the hospital, as there is no storeroom.

**Gateway Clinic:**

3.11.29 The Gateway Clinic was operating from a partitioned hall.

**Laundry:**

3.11.30 Laundry room needs renovation, as it is in a bad state.

**X-RAY Building:**

3.11.31 The X-Ray department is in a dire state and needs renovation.

**Hospital Fencing:**

3.11.32 The building is well fenced with installation of a new gate by Amanzabantu Construction Company.

**Underground water pipes:**

3.11.33 The underground water pipes are made of asbestos and galvanised steel. This will pose disaster in future if not changed.
Water and electricity supply:
3.11.34 The hospital uses borehole water supply and electricity is available.

State of Mortuary:
3.11.35 All fifteen (15) drawers are functional.

State of accommodation for nursing and clinical staff:
3.11.36 Amanzabantu Services (Pty) Ltd Construction Company has built a state of the art accommodation for nurses and clinical staff. The rooms are categorized as follows:
- One bedroom house - Forty (40)
- Two bedroom house – Twelve (12)
- Three bedroom house – Three (3)
- The total number of house is fifty five (55), however one of the bedroom house is used as a generator room for an artisan.

3.11.37 All the houses are furnished and electrified. Water supply is currently being connected from the reservoir tank and water pump. Each house has a solar system as a backup for electricity interruptions.

Exposed electric cables:
3.11.38 Khethwayo Construction Company absconded on the 28th February 2019 and left cables exposed. The area is fenced but cables remain exposed.

Sheltered corridors:
3.11.39 Sheltered corridors will be highly appreciated, as there are currently none.
**Landscaping of the hospital ground:**

3.11.40 The ground is uneven and difficult to maintain. One staff member got injured whilst cutting grass.

**Outside toilets for store’s department staff:**

3.11.41 Toilets used by the store’s staff members are in a derelict state.

**Old nurses home:**

3.11.42 The home is in a dire state, the electricity wiring was condemned for use by Sakhiwo Consortium technicians.

**Paediatric Ward:**

3.11.43 The ward does not have a staff toilet and bathroom. There is only one entrance that will make it difficult to evacuate patients during disaster.

**Pharmacy department:**

3.11.44 There is no pharmacy in the hospital, pharmaceuticals service are provided in a small dispensary room.

**Security Guard Room:**

3.11.45 There is no security guard room. Khethwayo Construction Company demolished it and provided a small movable container.

**Operating Theatre**

3.11.46 The operating theatre table is old but functional.
Helipad:

3.11.47  There is no dedicated space for the helicopter, which make it difficult to transfer a maternity case by helicopter.

Workshop:

3.11.48  The building is in a dire state and needs renovation.

The effect of construction to patients and staff during renovations:

3.11.49  Staff and patients are not negatively affected by renovations.

3.11.50  There was no need for transferring patients to other hospitals due to renovations in progress.

Construction companies on site:

3.11.51  Amanzabantu Services (Pty) Ltd for the new residence and fencing which both have been completed. Currently installing water supply in the houses.

3.11.52  Mayibuye i-Afrika renovating male, female and TB wards.

3.11.53  Ntshengele Company for concrete drive way.

3.11.54  Public Works staff members (in house) renovating the kitchen, CSSD, building and putting new ceilings in the ward’s passage.


Motor Vehicles

3.11.56  The following vehicles are available:

<table>
<thead>
<tr>
<th>VEHICLE TYPE/MODEL</th>
<th>REGISTRATION</th>
<th>ODOMETER AS AT 31 JULY 2020</th>
</tr>
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<tbody>
<tr>
<td>Toyota Corolla Quest</td>
<td>GGZ 819 EC</td>
<td>157606 km</td>
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<tr>
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<td>94 012 km</td>
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<td><strong>ISUZU Double Cab</strong></td>
<td>GGV 743 EC</td>
<td>147170 km</td>
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<tr>
<td><strong>Toyota Hilux Single Cab</strong></td>
<td>GGZ 534 EC</td>
<td>169159 km</td>
</tr>
</tbody>
</table>

**Equipment**

3.11.57 Vital medical equipment/machinery shortages

**Laundry**

3.11.58 The non-functional laundry equipment (washing machine, dryer, iron) were donated by the Japanese long time ago. The hospital does its laundry in other nearby hospitals since May 2020.

**X-ray machine**

3.11.59 The X-ray machine is very old, working but breaks now and then.

**Kitchen and food service**

3.11.60 There are two (2) 5 plate stoves and one (1) 3 plate stove. Only the 3 plate stove is functional. There is also a 3 plate gas stove that is used during power outages. There are no appropriate food trolleys.

**Medical equipment**

3.11.61 There is a shortage of medical equipment such as CPAP, ultrasound, baby warmers, BP machines, suction machines, mobile X-ray, dyna map and ECG machines
Piped oxygen

3.11.62 There is no piped oxygen throughout the hospital including operating theatre. SMARTech Woman (Pty) Ltd from Gauteng did an assessment for piped oxygen and ventilators.

OXYGEN REPORT AS AT 12 AUGUST 2020

<table>
<thead>
<tr>
<th>ITEM</th>
<th>QUANTITY</th>
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<tbody>
<tr>
<td>Oxygen Cylinders in the storeroom</td>
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<tr>
<td>Oxygen cylinders in the wards (in use)</td>
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</tr>
<tr>
<td>Oxygen cylinders (spare)</td>
<td>8</td>
</tr>
</tbody>
</table>

Oxygen bank

3.11.63 There is no oxygen bank in the hospital.

State of bed linen

3.11.64 The Provincial Office supplied the hospital with bed linen in February 2020.

Diesel tanks

3.11.65 There are currently two (2) tanks.

Water tanks

3.11.66 No backup water tanks, should water pumps be broken.
Personal protective equipment stock at hand at stores department:

3.11.67 Minimum levels of PPE are available and are ordered from Mthatha Depot, as they provide approved quality of PPE.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>QUANTITY AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>KN95</td>
<td>1000</td>
</tr>
<tr>
<td>Surgical masks</td>
<td>90 Boxes X 40 inside with 200 pieces</td>
</tr>
<tr>
<td>N95</td>
<td>650 pieces</td>
</tr>
<tr>
<td>Sterile gloves</td>
<td>1500 pairs</td>
</tr>
<tr>
<td>Disposable gowns</td>
<td>600</td>
</tr>
<tr>
<td>Head caps</td>
<td>1200</td>
</tr>
<tr>
<td>Shoe covers</td>
<td>3000</td>
</tr>
<tr>
<td>Eye shields</td>
<td>200</td>
</tr>
<tr>
<td>Goggles</td>
<td>600</td>
</tr>
<tr>
<td>Exam gloves</td>
<td>30 Boxes X 10 inside, 50 in a box</td>
</tr>
<tr>
<td>Scrub soap</td>
<td>75 Litres</td>
</tr>
<tr>
<td>Sanitizer</td>
<td>500ml X 19</td>
</tr>
<tr>
<td></td>
<td>5 Litres X 8</td>
</tr>
</tbody>
</table>

Human Resource

Staff Composition

Total number of posts = 267 as at 25 May 2020

3.11.68 Number of filled posts = 243
3.11.69 Number of vacant posts = 24
3.11.70 Vacancy rate = 8.9%

Additional staff provided by the province as a result of corona virus outbreak

3.11.71 The facility was allocated ten (10) Expanded Public Works Programme (EPWP) workers and three (3) nursing assistants.

Transversal systems

3.11.72 There are no systems (BAS, Logis, and Persal). The hospital depends on Dr Malizo Mpehle Memorial Hospital and the District office.

The impact of covid-19 on staff

3.11.73 There were twenty eight (28) confirmed cases, twenty seven (27) recovered and at least one (1) died.
A distress session will be conducted by the employee wellness officer from the district office for staff members on the 19th August 2020. Wards and units with confirmed cases were fumigated.

**Arrangements in place to handle covid-19 patients**

The province provided two (2) VIP toilets and a tent with hundred (100) chairs, to be utilised as a waiting area for clients waiting to be screened. Renovations for thirty-four (34) additional beds for Covid-19 patients are in progress. Staff members are undergoing training on Covid-19 and receiving emotional support.

**Committees**

Risk, OHS and IPC are in place and functional.

**Observations, interviews and inspection in loco conducted in Umthatha Hospital:**

a) No vehicles are available at the facility, all vehicles were attached by the sheriff due to the hospital owing service providers and this is impeding services such as outreach activities and deliveries;

b) The facility has no mortuary as a result bodies certified dead often remain in the ward for a long period waiting for transportation to the neighbouring hospital. Covid bodies are highly infectious.

c) Shortages of bed linen and staff are sometimes forced to treat patients on beds with no linen;
d) Insufficient oxygen points;

e) Shortage of vital medical equipments/machines, as a result same vital equipment must be wheeled from one unit to another and sharing same equipment between Covid and non-Covid wards;

f) Inadequate supply of PPE such as (N95 masks for high risk areas). Sometimes substandard PPE and normal surgical masks are used in high risk areas such as Covid wards thereby putting lives of the frontline workers at risk;

g) Emergency for Trauma has only three (3) beds as a result triage is done in the tent outside the building;

h) Medical Emergency only has four (4) beds as a result there is often congestion and overflow of patients to the corridors;

i) The facility has no Person Under Investigation (PUI) unit for the maternity ward for suspected cases of Covid;

j) No approved organogram, the facility is currently using split structure;

k) Staff shortages of nursing and clinical services has been an old problem and Covid19 is further exposing this shortage as more staff members get infected and has to quarantine;

l) Too many unfilled vacant positions with people acting without permanent appointment such as the Chief Executive Officer (CEO), Head of Clinical Unit and Senior Manager Medical Services positions.

Submission by the Umthatha hospital management:

3.12.2 On 14 August 2020, my team received further submissions from the Umthatha hospital management addressing the following areas:
Profile of Umthatha Hospital

3.12.3 Umthatha Regional Hospital (MRH) serves a population of 1.3 million people over a 12,096 square km area. Serving referring institutions including:

- St Barnabas Hospital
- Nessie Knight Hospital
- Canzibe Hospital
- Madzikane Hospital
- Zithulele Hospital
- CHC (Nganelizwe, Mbekweni, Mhlakulo, Baziya)
- Isilimela Hospital
- Dr Malizo Mpehle Hospital

Disease Profile:

3.12.4 Communicable = TB, HIV/AIDS and Diarrhea,
3.12.5 Non-communicable = Hypertension, Diabetes, Trauma and Accidents.

Leading causes of death:

3.12.6 TB, HIV/AIDS (both males and females, trauma in males between 15 - 24 years (80%) and most currently Covid-19.

3.12.7 Currently the facility is faced with challenges that may result in health workers not able to do their best.

Physical Infrastructure:

Covid and Patients Under Investigation (PUI) Wards

3.12.8 Both the Covid and Patient under Investigation (PUI) wards have thirty (30) beds each. They were created by repurpose of paediatric,
gynaecology and surgical wards that led to the limitation of these discipline function. Infrastructure support is needed to create extra beds for infectious disease outbreak.

**Filing space**

3.12.9 There is no proper designated space for filing, as a result files are scattered in various areas (wards) within the institution. Failure to retrieve files timeously lead to late responses to Promotion of Access to Information Act (PAIA) requests.

**State of mortuary**

3.12.10 The hospital shares mortuary with Nelson Mandela Academic Hospital (NMAH).

**Laundry**

3.12.11 Laundry services are shared with NMAH. Daily linen supply does not meet patients’ needs.

**Office space**

3.12.12 Three (3) sections are sharing one small office space and it’s not conducive for work environment. Renovations of the old lab inside the complex would bring relief.

3.12.13 Communication department’s office is very small, the office is shared by the Senior Manager and Personal Assistant, and there is not enough space to store communication equipment.

3.12.14 The Occupational Health and Safety department does not have office space and tea room.
Network

3.12.15 There is no network connection for virtual services, due to financial constraints.

Motor vehicles

3.12.16 There are currently two (2) vehicles shared between NMAH and MRH, making it difficult for smooth operation. Litigation cases against Eastern Cape Department of Health (ECDoH) resulted into attachment of vehicles assigned to MRH complex and sheriffs removed twelve (12) of the hospital's vehicles. Immediate intervention from National Head Office is required to release the vehicles.

Maternity area

3.12.17 There is no designated space for boarder mothers.

Covid -19 Isolation Ward

3.12.18 The ward has leaking pipes in the roof, as a result of damaged ceiling in the passage and cubicles. There are only thirteen (13) oxygen points.

Equipment

3.12.19 Vital medical equipment/machinery shortages

Computers

3.12.20 Eleven (11) staff members in Finance and Supply Chain Management (SCM) share one (1) desktop, this result in SCM processes being delayed. There is only one (1) laptop, one (1) cellphone each for Quality Assurance (QA) and Infection Prevention and Control (IPC). There is no furniture, electric appliances, and printers and communication equipment.
X-Ray Machine and Personal Protective Equipment (PPE)

3.12.21 There is no portable X-Ray. There is also shortage of PPE for dealing with Covid-19 and protective clothing for staff working in theatre and labour ward.

Human Resources

Staff Composition

3.12.22 Total number of posts : 1300
3.12.23 Number of filled posts : 800
3.12.24 Number of vacant posts : 500
3.12.25 Vacancy rate : 38.4
Staff shortages

3.12.26 There are staff shortages in critical departments within the facility and these departments ensure that the day to day operations are implemented. As a result there are challenges in the following areas:

- Medical Officers;
- Head of Clinical Unit;
- Clinical Support;
- Facilities;
- Supply Chain;
- HR and General Admin and
- Strategic Support Services.

3.12.27 Critical posts have been abolished on the personal establishment. Among the four (4) ICU trainers, three (3) are working in the Neonatal high care and the other one (1) is in High Care Unit with eight (8) beds.

3.12.28 The Finance and SCM departments depend on interns to function. There are four (4) staff members in the electrical and mechanical section under facilities. The electrical staff render services to both MRH and Sir Henry Elliot hospital.

3.12.29 Currently there is no staff in the clinical engineering section and Strategic Support Service office. Staff has been allocated to the QA and IPC office as there is no designated permanent staff for these offices.

3.12.30 Professional nurse from casualty has taken the duties of an OHS practitioner, creating a gap at casualty. The communication office is understaffed, only one (1) member staff is allocated to this office.
3.13 **Observations, Interviews and inspections in loco conducted In Livingstone Tertiary Hospital:**

3.13.1 The following is a list of most visible systemic, administrative and infrastructural deficiencies made during the site inspection conducted by the investigation team:

a) Instability in leadership caused by undue delays in filling senior management positions such as CEO;
b) Structural discontent, lack of organogram and severe under-funding of the facility;
c) Lack of synergy and support of the facility by provincial government due to weak administration of the current Head of Department (HOD);
d) Overcrowding of the facility due to lack of district hospital in the area to treat patients with minor illnesses;
e) Psychiatric patients are still accommodated within the facility, as a result casualty must still deal with psychiatric patients who are dangerous;
f) Shortage of PPE, such as gumboots, gloves, body bags, thermometers;
g) Shortage of nursing and non-clinical staff such as cleaners, porters as a result the facility is often unhygienic;
h) Surge of Covid 19 infections amongst the staff, 340 workers have been infected;
i) Drainage area is problematic in the facility and worsens the rat infestation;
j) Laundry for Dora Ngiza Hospital add to the strain in the facility and the health care workers and nurses end up doing the laundry and cleaning;
k) Laundry is sometimes outsourced and as a result it gets lost and remains unaccounted for;
l) Theft of medication is also a cause for concern;
Food services remain a major concern as there is no material to cover patients food after being dished;

One of the kitchens has been lying unused since 2010; and

Vital machines are not being maintained as a result patients get transferred to private hospitals at high costs.

**Submission by the Livingstone Tertiary Hospital management and National Education, Health and Allied Workers Union (NEHAWU)**

3.13.2 On 19 August 2020, my team received further submissions from the Livingstone Tertiary Hospital (LTH) hospital management as well as from the Regional Secretary of NEHAWU in Thabo Moshoeshoe region addressing the following areas:

**Profile of the hospital**

3.13.3 LTH is situated in Port Elizabeth (PE), within the Nelson Mandela Bay Health District (NMBD) and services a population of 1,742,974 (one million seven hundred and forty two thousand nine hundred and seventy four) namley, (1,263,051 in NMBD and 479,923 in Sara Baartman District) as per 2016 mid-year population statistics. The area incorporates PE, Uitenhage and Dispatch, stretching from Colchester (on the east) to Jeffreys Bay (on the west). LTH receives patients from:

(a) Uitenhage
(b) Paterson
(c) Somerset East
(d) Graff Reinet
(e) Cradock
(f) Middelburg
(g) Humansdorp
(h) Hankey

---

3 NEHAWU as a stakeholder at Livingstone Tertiary Hospital.
(i) Petensie (Langkloof)  
(j) Joubertina  
(k) Port Alfred  
(l) Grahamstown  
(m) Alexandria  
(n) Kareedouw  
(o) Willowmore and other clinics CHC’s and hospitals in the Province.

3.13.4 LTH consists of two hospital sites, namely: Livingstone and Port Elizabeth Provincial Hospital (PEPH). Livingstone has six hundred and sixty one (661) beds and Port Elizabeth Provincial has two hundred and sixty six (266) beds).

3.13.5 The current Infection Prevention and Control Coordinator appointed ratio for LTH is 1:667 and the norm is 1: 250 beds.

**Leading causes of admission in LTH:**

<table>
<thead>
<tr>
<th>A – Chronic Illness</th>
<th>B – Acute Illness</th>
<th>C – Psychiatric Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Gastro Enteritis</td>
<td>Psychosis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Malnutrition</td>
<td>Suicides</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Viral Meningitis</td>
<td></td>
</tr>
<tr>
<td>Heart Failure/Heart conditions</td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS and Opportunistic Infections</td>
<td>Hepatitis A and B</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Infection e.g. scabies, dermatitis, allergies,</td>
<td></td>
</tr>
<tr>
<td>Cervical, Breast, Oesophagus and Prostate cancer</td>
<td>Cataracts</td>
<td></td>
</tr>
</tbody>
</table>
Cerebral Vascular Accidents | Trauma
---|---
Meningitis | Drug overdose
Urological conditions | Tonsillectomy
Haematology | Septic Circumcision
| Priapism

**Physical building infrastructure at LTH:**

3.13.6 Some hospital buildings do not comply with the Infection Prevention and Control (IPC) Regulations. No environmental IPC controls, no cross ventilation in ICU, Out Patient Department (OPD’s) and Accident and Emergency Units. The hospital depends on natural ventilation only.

<table>
<thead>
<tr>
<th>LIVINGSTONE TERTIARY HOSPITAL</th>
<th>PORT ELIZABETH PROV HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The buildings are in good condition except for some areas in the nurse’s home, the roof is in poor condition and the cost to repair will be five million rand (R 5 million)</td>
<td></td>
</tr>
<tr>
<td>There is currently a contract in place to do the repairs to the buildings.</td>
<td></td>
</tr>
<tr>
<td>There is no fencing at LTH and that has resulted in a number of employees being robbed and assaulted by criminals who have easy access to the facilities.</td>
<td></td>
</tr>
<tr>
<td>The site is health hazard, there is little to no ventilation.</td>
<td></td>
</tr>
<tr>
<td>Paint is peeling from the walls, floors are uneven and pose risk to patients and staff.</td>
<td></td>
</tr>
<tr>
<td>The waiting area is small, not enough seating, no drinking water for patients except in the toilets.</td>
<td></td>
</tr>
<tr>
<td>No intercom to communicate with patients and staff alike.</td>
<td></td>
</tr>
<tr>
<td>Some areas have been renovated and the biggest section of the hospital is in poor state including the nurse’s home.</td>
<td></td>
</tr>
<tr>
<td>The nurse’s home is unsafe and need drastic measures.</td>
<td></td>
</tr>
<tr>
<td>The hospital has procured an automated kitchen facility system, which was to benefit all patients. The intention was to ensure proper food preparation that will contribute towards quality health care and ensure the food reaches the patients in its desired state according to dietary requirements.</td>
<td>The union is concerned about the level of neglect around the maintenance of hospital infrastructure especially the nurse’s home at PE provincial hospital. The hospital still accommodate employees and students even after it was declared inhabitable by the Department of Public Works.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>The hospital has procured an automated kitchen facility system, which was to benefit all patients. The intention was to ensure proper food preparation that will contribute towards quality health care and ensure the food reaches the patients in its desired state according to dietary requirements.</td>
<td>The union is concerned about the level of neglect around the maintenance of hospital infrastructure especially the nurse’s home at PE provincial hospital. The hospital still accommodate employees and students even after it was declared inhabitable by the Department of Public Works.</td>
</tr>
<tr>
<td>A mortuary at the LTH and PEPH sites, has a capacity of sixty (60)</td>
<td>Mortuary cabinets are not in good condition but there is a contract in place to do the repairs.</td>
</tr>
</tbody>
</table>
| Good infrastructure relating to electricity and there are generators in place during power outages.  
LTH site has an extra 6.6 Kva line feeding sections of the hospital and the cost to remove this extra incoming line is R 7 million | A total of five (5) generators supply the hospital with power during outages.  
The switch gear is over fifty (50) years old and needs urgent replacement. |
| Currently water supply is through holding tanks with a capacity of 1.2 million litres  
There is contract in place to deal with water issues. | The site receives water directly from the municipality.  
Due to the life span of the water tank, water leaks occurs. |
Equipment and machinery

3.13.7 General lack of resources such as vital clinical machines, oxygen points, linen, laundry services and poor food service. In the therapeutic and radiation sphere, equipment is almost non-existent, the plan has been drawn to purchase new machinery but the budget is not enough to purchase the new machine. Equipment is not calibrated.

3.13.8 There are no industrial technicians and clinical engineers to assist with minor repairs, everything depends on non-existent Service Level Agreements (SLA’s). No maintenance contracts and SLA in place for critical equipment such as C-ARMS, Fluoroscopy etc.

3.13.9 Regular breakdown of laundry machines. The central laundry that is located at LTH is currently neglected, the initial plan for that laundry was to cater for whole region, it had staff complement of 108 employees but currently, there are only 34 employees due to resignations, death and attrition. The Department of Health has opted to outsource the laundry services for the district and now it is only serving three (3) hospitals (Dora Nginza, LTH and PEPH).

3.13.10 Insufficient supply of clean linen, patients use their own bedding because of the shortage. Casualty does not have enough linen for patients.

3.13.11 LTH does not have a dedicated women’s imaging section where mammography and bone densitometry etc. takes place. In general equipment should be replaced with the latest technology available, as this improves imaging and is necessary in training facility like LTH.

3.13.12 The Cath-lab that was procured in 2018 with the intention to ensure quality service and suspend the use of Private Hospitals, has not been used to date. Purchased at an amount of seventeen million eight hundred thousand rand (R17, 800.000.00) without maintenance plan, the machine has not been fully installed and warranty is no longer valid.
Kitchen facility and food service

3.13.13 The kitchen equipment was procured in the year 2010 and has not been in use ever since it was installed. In the year 2010 during the preparations for the Soccer World Cup which was hosted by South Africa, LTH procured an automated kitchen facility system costing millions of rands. This was to benefit all patients who were going to be admitted at the facility.

3.13.14 The intention was to ensure that a proper food preparation system that will contribute towards the quality health care for all patients was in place and, a legacy of ensuring that food reaches the patient in its desired state and according to dietary requirements. The LTH Management submitted a plan to Head Office to ensure there are proper staffing ratios at the Main Kitchen to render the services and achieve the desired efficiency and effectiveness on food provision. To date this kitchen remains unused.

State of mortuary at LTH

3.13.15 There is a mortuary at LTH and PEPH sites which can keep a total of 60 bodies. PEPH site cabinets are not in good condition, however a contract has been put in place to do repair works to the cabinets in the mortuary.

Personal Protective Equipment (PPE)

Internal factors

3.13.16 Vast quantities of PPE were required for the protection of all categories of staff, this outstripped the ordering capacity and consumable budget for LTH.

3.13.17 There was no obvious Covid-19 budget for LTH for PPE. A new procurement team that was solely for the provision of PPE was formed from the existing staff and supply chain, procurement and systems had to
be learned from scratch. End-users of certain items, such as gloves were not equipped to make big orders.

3.13.18 Supply chain revealed large deficiencies with regards to good relationships with companies due to non-payment for goods and services and this was at institutional and metro level with the depot.

3.13.19 The quality of certain stock leaves much to be desired and called into question its very procurement. Unfortunately the staff is not in a position to question quality as it is in dire need. Stock arrived unpacked, unlabelled and of varying sizes and types as one delivery and furthermore, many delivery notes were incorrect with an inadmissible vagueness.

**External factors**

3.13.20 The inability to import goods due to lockdown, led to inflation of prices due to high demand and this resulted to failure for many requests due to buy outs/deviations from LTH before central procurement took over.

3.13.21 LTH has currently reached middle ground of PPE’s usage with increased awareness from all categories of staff, with regards to correct use of PPE’s and what the norms are for day to day use and in what areas. This coupled with an improved procurement insight and support from Head Office has helped quell some initial PPE troubles that were experienced in March, April and May 2020.

3.13.22 There are still troublesome areas, these are still in the domain of gloves, both sterile and non-sterile for which there is still no answer. Due to trade issues and raw material the supply of N95 masks is short, and the KN95 masks is not an adequate alternative for many because of size and fit.
Description of PPE stock and availability:

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital Thermometer</td>
<td>37 (donated stock)</td>
</tr>
<tr>
<td>Surgical masks</td>
<td>92195</td>
</tr>
<tr>
<td>Apron</td>
<td>56700 (donated stock)</td>
</tr>
<tr>
<td>Surgical gloves</td>
<td>1200 + 42030</td>
</tr>
<tr>
<td>Examination gloves</td>
<td>16500</td>
</tr>
<tr>
<td>Mask respirator</td>
<td>19835 (6520 donated stock)</td>
</tr>
<tr>
<td>Boot covers</td>
<td>192</td>
</tr>
<tr>
<td>Eye protection</td>
<td>413</td>
</tr>
<tr>
<td>Sanitizers and Disinfectants</td>
<td>15124, 4460 litres of stock on hand is donated stock</td>
</tr>
<tr>
<td>Body Bags</td>
<td>2510</td>
</tr>
<tr>
<td>Gowns</td>
<td>10995</td>
</tr>
<tr>
<td>Coverall</td>
<td>883</td>
</tr>
<tr>
<td>Visor</td>
<td>12153 (donated stock)</td>
</tr>
</tbody>
</table>

Human Resources

3.13.23 Staff members leaving the system are not replaced. A three (3) months process is prolonged to eighteen or twenty (18-20) months due to Provincial Cost Containment Committee (PCCC).

3.13.24 Non clinical posts not being filled resulting in health professionals assisting with clerical and porting duties etc.

3.13.25 Medical Casualty is the busiest area in the hospital with insufficient physicians and is poorly staffed. The current organogram is equivalent to that of a district hospital. Some services such as rehabilitation had to be stopped due to staff shortage.
3.13.26 The optometry department’s has only two (2) staff members that consult with +/- four hundred (400) patients per week. Chronic nursing staff shortage and lack of professional nurses to staff the areas optimally, as a result patient care gets compromised.

3.13.27 There is no dedicated porter services, nurses and doctors have to transport patients from casualty reception to casualty and X-rays etc.

3.13.28 There is a need for defined functional psychiatry referral services for the Nelson Mandela Metro.

3.13.29 Trauma unit has high number of gunshot wound injuries (gang related) and motor vehicle accidents and it requires dedicated nursing resources, security personnel and infrastructure to keep staff safe.

3.13.30 Shortage of cleaners, especially during the night. In recent months there has been an exodus of Senior Managers at LTH due to whistleblowing done by organised labour for gross financial misconduct in the institution. To date, the institution has managed to stand on its feet because of dedicated officials who showed loyalty and took it upon themselves to ensure that services and leadership remain paramount. To date, the posts approved for the hospital to function optimally are still hanging between Head Office Human Resources and the PCCC.

**STAFF COMPOSITION**

<table>
<thead>
<tr>
<th>TOTAL NUMBER OF POSTS</th>
<th>: 2517</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of filled posts</td>
<td>: 2233</td>
</tr>
<tr>
<td>Number of vacant posts</td>
<td>: 284</td>
</tr>
</tbody>
</table>
Impact of Covid-19 on the staff:

3.13.31 There was an almost total failure of support services during the run up and height of the initial surge of Covid 19. This led to huge amounts of stress in the entire system. There was no Information Technology (IT) and administrative assistance available and everything had to be done by doctors alone at huge cost.

3.13.32 Doctors and sisters were compelled to spray beds themselves, clean floors and surfaces, buy their own bleach and mops and provide any cleaning assistance. Deficiencies in staff were highlighted with regards to portering services, general assistance, laundry, linen bank, seamstresses and nursing staff. Total collapse of EMS with inability to collect patients and move patients from hospitals to a transfer facility such as the field hospitals.

3.13.33 A phase based approached has been employed at LTH to assist staff with psychological sequelae of the pandemic. Managers are provided with
concise but useful information to manage distress within their specific units. Any staff members experiencing distress related to Covid-19 can arrange to be seen by psychologist.

3.13.34 Stress management and general coping workshops have been presented. Staff and supporting staff was educated on Covid-19 and all its aspects such as donning/doffing etc.

Covid-19 patients

3.13.35 Wards P2 and P3 have been revamped to accommodate Covid-19 patients. A renovated P1 ward through the Business Chamber resulted in additional eighty (80) beds capacity. Oncology department was moved to create space to be used as rooms for additional isolation beds for Patients Under Investigation. Medical wards on fourth and fifth floor were utilised for PUI and Covid space, and basement with seventy (70) extra oxygen points in case of the surge being identified.

3.14 Observations, Interviews and inspections in loco conducted in Uitenhage Hospital:

3.14.1 The following is a list of most visible systemic, administrative and infrastructural deficiencies made during the site inspection conducted by the investigation team:

a) Delays in filling all vacant positions including senior management positions such as CEO and Clinical Manager;

b) Chronic staff shortages in all areas and has been exacerbated by about 90 staff members who tested positive for Covid-19 and two deaths as a result of Covid-19;
c) Hospital is gazetted as Regional Hospital but it is functioning as a District hospital and this has resulted in staff complement being disproportional;
d) Workload for the doctors is too high and are often expected to work excessive hours as a result of clinical staff shortages;
e) The contract for a Triage Tent has expired and the structure is weak, cannot withstand strong wind, as a result it has blown down during assessment of patients;
f) Shortage of disposable bins, decanters, oxygen points, PPEs;
g) Medical equipment such as portable X-Ray machines are not too bad and remain in working condition;

Submission by the Uitenhage hospital management

3.14.2 On 18 August 2020, my team received further submissions from the Uitenhage hospital management addressing the following areas:

Profile of Uitenhage Hospital

3.14.3 Uitenhage Provincial Hospital (UPH) was categorised as a regional hospital in 2012. The hospital serves a population of three hundred and forty four thousand one hundred and twenty five (344 125) from Sub district B and sixty four thousand and one (64 001) from Sunday valley municipality, with 13 (thirteen) feeder community health clinics (CHC), two (2) satellite clinics, three (3) despatch (Joe Slovo, Masekhane, Kwa Nobuhle) and five (5) CHC (Rosedale, Middle Street, Park Centre, satellites: Kruis river, Rocklands).

3.14.4 Uitenhage Hospital refer patients to Dora Nginza Hospital (DNH), LTH, Elizabeth Donkin Hospital (EDH) and TB hospitals. There is a total of 246 approved beds in paediatrics, post-natal, surgical, theatre, internal medicine, obstetrics and gynaecology, nursery etc.
Physical infrastructure

3.14.5 There is limited space for filing, archiving and ventilation is also a challenge in the facility.

State of mortuary

3.14.6 The mortuary has seven (7) operational trays and has a shortage of eight (8) trays. The Covid 19 container has capacity of six (6) double shelved trays that can accommodate twelve (12) bodies.

Vehicles

3.14.7 Currently the Uitenhage hospital has only three (3) cars, one (1) 17 seater bus that transports patients and two (2) sedans, one is for official duties and the other one is for patients.

3.14.8 There is a need for two (2) additional sedans, as the current ones have high mileage and the other will assist with outreach which is compromised.

Intensive Care Unit and High Care Unit

3.14.9 The high care unit has five (5) beds, two (2) isolation single bed wards and three (3) general beds with wall-mounted, multi-parameter monitor, infusion pumps, oxygen points with compressed air and ventilator.

Accommodation for nursing and clinical staff

3.14.10 Doctors residence was upgraded in 2016 (repainting, doors and electrical). All flats were fitted with security gates and burglar bars in 2018. Extra flats were built to accommodate eight (8) students.
3.14.11 There is no accommodation for nurses currently, as the home building was damaged by a leaking reservoir in the roof. Community service nurses are accommodated in the Doctor's quarters when space is available.

**Lifts and access doors**

3.14.12 There is an urgent need to fix the lifts, as they pose a risk to both patients and staff. Access doors and air conditioners are not working especially in the wards, theatre, pharmacy and emergency unit. There is also a need for extra security guards and lighting of dark areas within the hospital premises.

**Equipment and Machinery**

3.14.13 Awaiting repairs of dysfunctional oxygen points. All equipment in High Care Unit is in working order.

**Kitchen and laundry**

3.14.14 Three food warmers and conventional ovens are not functional. Fumigation is not done monthly as it should. The hospital is currently using Advance Laundry Services, due to shortage of staff and equipment.

**Human Resources**

3.14.15 **Staff composition**

**Total Staff Establishment: 697**

Number of filled posts : 610  
Number of vacant posts : 87  
Vacancy rate : 23%
3.14.16  The posts of CEO and Clinical Manager (Medical) were advertised and the closing date was the 07th August 2020. Preparation for the recruitment and selection process are underway to fill the posts as soon as possible.

Impact of Covid -19 on staff

3.14.17  Emotional stress regarding impact on their health, family relations and increase of number of deaths due to Covid-19. Exhaustion of sick leave and stigmatization if diagnosed. Delay in remuneration for overtime worked due to rotation of staff in the human resource department. Shortage of nursing staff posed a challenge as there were only two professional nurses allocated per shift, this was not ideal in an intensive care setting where infectious patients are treated.
Mitigation of psychological stress

3.14.18 Staff members are encouraged to access Psychology services available by means of telephonic consultation.

Report of the Risk Assessment Committee

3.14.19 All departments were visited and assessed regarding risk of exposure and guidance given in terms of risk reduction strategies. Each department has been tasked to look at mitigation strategies focusing on the following:

(a) Engineering controls
(b) Administration controls
(c) PPE and equipment
(d) Safe work practice.

3.14.20 Basic risk reduction strategies implemented -

(a) All staff members were trained on Covid-19 related issues.
(b) Daily screening of staff members and availability of testing services.
(c) All patients to be screened before entering the facility.
(d) Entry points reduced.
(e) Flu vaccine offered to all health workers.
(f) Sick employees were encouraged to stay home and follow OHS procedures.
(g) Basic hand hygiene measures and availability of alcohol based hand rub (ABHR)
(h) Surgical masks to be worn at all times.
(i) Social distancing measure etc.
Personal Protective Equipment (PPE)

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3.15 LIMPOPO

3.16 Capricorn District of the Limpopo Province

3.17 WF Knobel Hospital

3.17.1 On 1 September 2020, I visited WF Knobel Hospital in the Capricorn District of the Limpopo Province in order to do the following -

3.17.1.1 Inspect the infrastructure that has been developed and / or under construction;
3.17.1.2 Inspect conditions at the public health facility;

3.17.1.3 Ascertain whether there is sufficient capacity to deal with the surge in intake of cases;

3.17.1.4 Determine if there are any systemic challenges that may obstruct the efficient provision of healthcare service to the public;

3.17.1.5 Determine the provision and quality of personal protective equipment procured and allocated to the front health care officials;

3.17.1.6 Determine how the healthcare officials are coping with the number of patients that are admitted to the hospital; and

3.17.1.7 Meet with hospital management as well as organized labour to obtain first-hand information from both perspectives and how the institution is dealing with the challenges presented by the pandemic.

3.17.2 Non-provision/provision of personal protective equipment (PPEs) -

3.17.2.1 The Acting Chief Executive Officer, Dr MD Netshilonga, indicated that the procurement of PPEs is centralised and rests with the Provincial Department.

3.17.2.2 The hospital is in a position to procure equipment and consumables up to a threshold value of R300 000, 00, the District Office between R300 000, 00 and R500 000, 00 and that procurements above R500 000, 00 fall within the scope of the Provincial Office.

3.17.2.3 He pointed out that, from the start of the pandemic, there has been enough supply of the PPE’s but that at the beginning, they had problems with the supply. The hospital was initially forced to supply patients with the PPE’s but that the problem has since been resolved through the government regulation calling upon all members of the public, at their own expense, to
procure and wear face masks whenever they go out into the public. It was emphasised that masks are of good quality.

3.17.3 COVID-19 WARD

3.17.3.1 The Acting Chief Executive Officer pointed out the following -

a) Employees working at the Ward have not tested positive.
b) Patients who are admitted recover speedily but that some stayed over 10 days because of their sugar levels.
c) The recovery rate is at 100%
d) The hospital has both the Quality Assurance and Occupational Health and Safety Committees to deal with the pandemic in terms of compliance.

3.17.3.2 Observations and challenges/needs – Covid ward -

a) One (1) bed was on bricks
b) There are no tilting beds
c) No ventilators
d) No resuscitation machines
e) Samples drawn for tests are sent to Mankweng Hospital and it takes 48 hours to get the results during the week. Weekend and public holidays create further delays and results may be received after 72 hours or more.
f) No ablution or bathing facilities in the Covid ward.
g) Waste is outsourced and collected only on Thursdays.

3.17.4 General condition of the hospital

3.17.4.1 The hospital serves more than 100 surrounding villages and it is an old hospital with aging infrastructure.
3.17.4.2 There is a concerted need for general maintenance, including maintenance of electrical appliances and plumbing installations.

3.17.4.3 There are no sufficient supply and maintenance of equipment, such as X-Ray machines and dental equipment.

3.17.4.4 There is no sufficient laundry equipment and laundry trolleys and the staff uses a hospital bed base to transport laundry around the hospital.

3.17.4.5 There is no tea room or eating area for staff working at laundry.

3.17.4.6 There are no ablution facilities at the laundry.

3.17.4.7 There are no fire extinguishers or exit signs indications to direct building occupants in case of a fire emergency.

3.17.4.8 There is no shed for sorting out dirty laundry and this presents a problem during rainy or cold days as currently the laundry has to be sorted in an open area.

3.17.3.9 The hospital environment, including the wards, is not clean.

3.17.3.10 There are water leaks visible everywhere.

3.17.5 Human Resources

3.17.5.1 The Acting Chief Executive Officer indicated that the hospital has:

a) 21 Doctors, including 08 sessional Doctors
b) 09 Pharmacists
c) 05 Radiographers
d) 05 Physiotherapists
e) 06 Occupational Therapists
f) 04 Dieticians
g) 01 Speech Therapist
3.17.5.2 The Acting Chief Executive Officer indicated that the hospital has the following support staff compliment -

a) 192 Nurses made up of 78 Professional Nurses, 51 Enrolled Nurses and 63 Enrolled Auxiliary Nurses.
b) General Workers (number not provided).
c) 09 Cleaners.
d) Less than 10 Ward Attendants.
e) 04 Porters.
f) 04 HR Officers.
g) 02 Risk and Security Officers.
h) 13 OPD administration staff to deal with information, records.

3.17.5.3 In terms of frontline workers vacancy rate, the following vacancies were identified -

a) There are 26 Doctors in terms of the Structure, however there are currently only 21 Doctors.

b) Nurses - no information was available on hand.

3.17.5.4 There is a shortage of staff that cuts across all sections of the hospital.

3.17.5.5 Three (3) Doctors posts were advertised and only one (1) application was received. It was indicated that rural hospitals face a challenge that not many Doctors are interested in working in rural areas.

3.17.5.6 It is also ± 40 to 50 km to the nearest hospital from WF Knobel Hospital.

3.17.6 Kitchen

3.17.6.1 Food is cooked on the hospital premises by the hospital kitchen staff.
3.17.6.2 The kitchen was found to be generally clean and the staff working there indicated that they are happy.

3.17.6.3 The Kitchen operates well and it is also able to provide food for different diets.

3.17.6.4 Different types of food are provided on different days.

3.17.7 **X-ray room**

3.17.7.1 The room is falling apart and a new structure is urgently needed.
3.17.7.2 There is a great challenge during rainy days as patients have to wait outside.
3.17.7.3 There is no adequate furniture.
3.17.7.4 There are no reception or waiting area where patients can sit while waiting for assistance.
3.17.7.5 There are no ablution facilities for both the staff and the patients.
3.17.7.6 The X-ray machine is currently not working.
3.17.7.8 There are no change rooms.
3.17.7.9 The facility is very dirty with patients' blood visible on the floor.

3.17.8 **Wards**

3.17.8.1 The hospital has 03 general wards which are, male, female and paediatric wards.
3.17.8.2 The hospital also has a Maternity ward which is further subdivided into 03 other wards: Labour, Pre-natal and Post-natal wards.
3.17.8.3 There are 03 Doctors in these wards and 02 professional nurses.
3.17.8.4 Maternity ward lack baby warmers and ventilators for babies.
3.17.8.5 Wards were nearly empty and the Acting CEO indicated that it was because a high number of patients were discharged.
3.17.8.6 The hospital has a capacity of 150 beds and usually admits about 80 patients a day.

3.17.8.7 The staff indicated that sometimes there is shortage of linen.

3.17.8.8 Due to shortage of staff, nurses in the wards work from 07h00 to 19h00 without a break.

3.17.8.9 The furniture in the wards is very old and needs to be replaced.

3.17.8.10 The emergency areas in the wards were very dirty.

3.17.9 Personal Protective Equipment for staff

3.17.9.1 Staff indicated that they only received comfortable personal protective equipment (PPE) because there was a visit by the Limpopo Legislature. Before the visit they were not provided with comfortable PPEs.

3.17.9.2 The sanitizer provided by Tsopane Pharmacy is too strong on the nostrils and the fumes make some people to feel dizzy.

3.17.9.3 Some of the masks provided were not of a good quality.

3.17.9.4 Some of the masks had a bad smell and need to be washed first before one could wear them.

3.17.9.5 Screening of patients is only done during the week and no longer done during weekends.

3.17.10 Trade unions

3.17.11 The following trade unions have representatives at the Hospital:

3.17.11.1 Democratic Nursing Organisation of South Africa (DENOSA)
3.17.11.2 National Health and Allied Workers Union (NEHAWU)
3.17.11.3 Public Service Association (PSA)
3.17.11.4 Hospital and Other Service Personnel Trade Union of South Africa (HOSPERSA)

3.17.12 It is clear there are a serious problems between the unions and the management.
3.17.12.1 Ms Monica Modisha of PSA indicated that management is not honest and that the state of the hospital is worse and morale of staff is at all-time low. Staff is being intimidated by the management and anyone who dares to challenge management faces suspension from duty and possible disciplinary action. Request for tools of trade is the root cause of problems between management and unions.

3.17.12.2 Members of the union were suspended since 12 June 2020 with the total number of suspended staff currently at 11. The same sentiments were also share by the only remaining chairperson of the DENOSA Mr Shika.

3.17.12.3 He also complained about the fact that the CEO does not meet the requirements of the post and when he was appointed the department disregarded the requirements it has set in its own advertisement.

3.17.12.4 He was also surprised by the fact that the hospital constructed a parking lot while neglecting to procure basic tools such as BP Machines and other tools of trade. Overtime was also withdraw by the department in terms of Circular 43.

3.18 KWA-ZULU NATAL

3.18.1 The Deputy Public Protector visited and inspected health institutions/hospitals in the province of KwaZulu-Natal on the 6th and 7th of October 2020.

3.18.2 On the 6 and 7 October 2020, the following hospitals in KwaZulu-Natal were visited and inspected by a team of officials of the Public Protector Kwazulu-Natal Provincial Office, led by the DPP -

3.18.2.1 Christ the King District Hospital – Ixopo;
3.18.2.2 Rietvlei District Hospital – uMzimkhulu;
3.18.2.3 Mbongolwane District Hospital – Eshowe – Mbongolwane Reserve;
3.18.2.4 KwaMagwaza District Hospital – Melmoth;

3.18.3 **Purpose of the inspections in loco**

3.18.3.1 The objectives of the DPP’s visits and inspections were to determine whether:

a) There was sufficient availability of health care services, human resources, physical infrastructure, vital equipment, machinery, PPE and staff in hospitals, in the light of the strain added by the outbreak of the Covid 19 pandemic.

b) Whether the conditions and/or administration within the hospitals in the province of KwaZulu-Natal impede on delivery of a proper health care services.

**Observations, interviews and inspections in loco conducted**

3.19 **Christ the King District Hospital - Ixopo**

3.19.1 The following is a list of the most visible systemic, administrative and infrastructural challenges and deficiencies observed during the site inspection conducted by the investigation team and referred to in submissions made by the hospital management:

3.19.1.1 The building of the hospital is old. It was built in 1937 by the Missionary Sisters of the Precious Blood, as humanitarian work. The hospital was originally registered for 32 beds. Formerly run by the nuns at Sacred Heart Convent, the hospital was taken over by the provincial government in 1984.
3.19.1.2 The hospital serves the area of the Ubuhlebezwe Local Municipality and surroundings, with a population of 101,691 and an area of 1,604.03 square kilometres.

3.19.1.3 The population in the area is growing and the hospital cannot effectively deal with the large influx numbers of patients from the surrounding areas.

3.19.1.4 The pharmacy has shortage of space for the waiting area for patients and for storage for pharmaceuticals.

3.19.1.5 The space accommodating the Supply Chain Management Department is small and has leaks and mould. Stock on hold gets ruined and sometimes has to be disposed of leading to fruitless and wasteful expenditure.

3.19.1.6 The Outpatient Department (OPD) is combined with casualty and it is too small to cater for the population and to handle capacity of massive casualties.

3.19.1.7 Maternity and all wards are hybrid i.e. everybody is admitted in one huge ward. The infectious and non-infectious patients are not separated. Patients with mental health challenges are mixed with other patients. The space in the wards does not allow for their free movement.

3.19.1.8 Information Technology (IT) systems are continuously malfunctioning and staff cannot timeously complete tasks on Persal or BAS and have to use devices in the district office or travel 90 kilometres to the provincial offices in Pietermaritzburg in order to be connected to enable them to process their work.

3.19.1.9 Issues with IT systems also result in late payment of service providers and thus a contravention of section 38 of the Public Finance Management Act, 1999 (PFMA).

3.19.1.10 Shortage of storerooms in wards to store equipment safely.
3.19.1.11 No rest rooms for staff to relax during breaks.

3.19.1.12 Shortage of staff residences as most of the staff are not from the area. This has an impact on recruitment and retention of staff.

3.19.1.13 Shortage of parking for staff and members of the public.

3.19.1.14 Shortage of filing space which leads to loss of patient’s records used for continuous monitoring of patients and records required for litigation matters.

3.19.1.15 There is shortage of staff due to moratorium and long procedures to be followed in respect of filling “non-critical” posts, as a result of which the hospital is experiencing numerous challenges at the catering unit (kitchen, laundry, pottering services, administration clerks, human resources clerks and supply chain clerks).

3.19.1.16 The washing machines in the laundry are old.

3.19.1.17 There is no safety officer, waste management officer, no foreman (maintenance), no plumber and no electrician.

3.20 Rietvlei District Hospital – Umzimkhulu

3.20.1 The following is a list of the most visible systemic, administrative and infrastructural challenges and deficiencies observed during the site inspection conducted by the investigation team and referred to in submissions made by the hospital management:

3.20.1.1 The Rietvlei District Hospital is located in the deep rural area of uMzimkhulu. The Dutch Reformed Church (DRC) started a mission at Rietvlei during the 1930’s. Medical work was first done in a rondavel by
missionary sisters. On the 1st December 1956, a missionary hospital with 36 beds was opened.

3.20.1.2 In 1976, with the independence of then Transkei homeland, the hospital came under the control of the then Transkei Department of Health and ceased to be mission hospital. Rietvlei has grown from the single rondavel to a well-established 205 bed hospital. It also serves as a referral hospital for surrounding districts. The laboratory serves the surrounding hospitals and outbreaks of infectious diseases like typhoid fever can be monitored at a bacteriological level.

3.20.1.3 Rietvlei District Hospital is a level 1 district hospital with 13 feeder clinics and 3 mobile clinics. The hospital has an approved capacity of 205 beds capacity and 188 usable beds.

3.20.1.4 The hospital serves a population of 180 302 and an area of 2436 square kilometres.

3.20.1.5 Access to IT systems is problematic as there is often an issue of connectivity, including with telephone lines. This also affects the fire protection system of the hospital as a break in connection disables the system from sensing a fire.

3.20.1.6 There is limited workspace in the Outpatient Department (OPD), Casualty, Stores and filling rooms.

3.20.1.7 The parking space at the hospital is also limited.

3.20.1.8 Management of the hospital reported that in most cases the hospital is operating on “out of stock”.

3.20.1.9 There is a shortage of staff at the hospital, particularly in the support services area due to a moratorium in respect of “non-exempted” posts.
3.20.1.10 The Hospital Management further reported the following shortage of staff:

(a) Twenty one (21) staff nurses were translated to professional nurses with effect from May 2020 of which 9 are from Primary Health Care (PHC) facilities and 12 from the hospital.

(b) There are no cleaners at the clinics and the management has resorted to using EPWP employees, even though they are restricted to grounds maintenance.

(c) There are no artisan services in the maintenance units. There is no electrician, no plumber and no foreman. The hospital only has a handyman who has to attend to all maintenance related needs.

(d) There is shortage of staff in the kitchen i.e. no supervisors, food service personnel, food service orderly and food service aid.

(e) In the laundry unit there are no unit supervisors, no linen orderly and sewing orderly.

(f) There is shortage of telecommunication operators. The Hospital Management has resorted to the use of the General Orderly to assist.

(g) There is shortage of drivers and the hospital makes use of staff from other components.

(h) There is a shortage of personnel in the Pharmacy, Radiology, Occupational and Speech Therapy, Dietician and Dental Assistant Departments.

(i) There is no Occupational Health and Safety officer, no Public Relations Officer. There is no shift Security Officer and security services are outsourced.
(j) The filling of vacant positions is delayed as the Department of Public Service and Administration (DPSA) takes long to advertise posts.

3.21 **Mbongolwane District Hospital – Mbongolwane Reserve – Eshowe**

3.21.1 The following is a list of the most visible systemic, administrative and infrastructural challenges and deficiencies observed during the site inspection conducted by the investigation team and referred to in submissions made by the hospital management:

3.21.1.1 The Mbongolwane Hospital is a district hospital with 196 authorized beds and 162 usable beds. The hospital is located at the Mbongolwane Reserve in the area of the uMlalazi Municipality, ± 45 km away from Eshowe the in King Cetshwayo District (Formerly known as uThungulu district). It is a 24 hour hospital with 5 fixed clinics and 2 mobile clinics serving 41 points.

3.21.1.2 The hospital serves a rural population of about 69 000 and has 8 wards.

3.21.1.3 It was built in 1937 by Roman Catholic missionaries and was taken over by the government in 1978.

3.21.1.4 The old structure is difficult to renovate and there is a delay as all buildings and infrastructure redesigns have to be done and/or approved through the provincial offices of the Department of Health.

3.21.1.5 The Female Ward does not conform to Infection Prevention and Control (IPC) standards as it is a single ward. There is one big open unit which accommodates female patients with a variety of health problems. As everyone is admitted in one huge ward, infectious and non-infectious patients are not separated.

3.21.1.6 The laundry does not conform to IPC standards. There is only one entrance which is used for soiled and clean linen, no change rooms, poor
ventilation, no backup system for electricity, no dining room for the staff as a result they dine in the sewing room.

3.21.1.7 In the Outpatient Department, casualty and resuscitation area, acute, chronic and paediatric patients are attended to in the same space as adults thus compromising service delivery and exposing children to infections.

3.21.1.8 The Outpatient Department is small and there is no Gateway Clinic. The second patient administration office has been converted into a resuscitation room to try and improve the level of service delivery.

3.21.1.9 Maternal, child and women’s health services are inadequate.

3.21.1.10 The Maternity Ward is very small and the hospital has to place beds in the passages of the in order to accommodate mothers needing maternity services. There is no high care area, no consultation room and thus the labour ward is used. There is no duty room and there is a kitchen situated next to the toilet.

3.21.1.11 There is no separate ward for mental health patients.

3.21.1.12 There is no space for archives which thus creates a problem of storing and retrieving old files when they are needed.

3.21.1.13 Due to the area being deeply rural, regular power outages occur, which impacts service delivery.

3.21.1.14 Information Technology (IT) services are lacking. IT connectivity is unreliable, and the Hospital Management stated that it was difficult to obtain laptops that will enable them to ensure proper service delivery.

3.21.1.15 There is general shortage of staff due to the moratorium imposed by the KZN Department of Health in the following areas:
3.21.1.16 Maintenance section with inadequate skills. The hospital only has a handyman and chief artisan. There is no plumber, no foreman, no engineer and no electrician. It is difficult to get support on some maintenance issues.

3.21.1.17 Nursing section especially enrolled nurses and enrolled nursing assistants since they are classified as non-exempted posts. Staff nurse positions can only be filled by cross transfers.

3.21.1.18 There is high clinical staff turnover due to the difficulties in retaining employees at a rural hospital. Safety and security of staff residing within the premises also impacts on staff turnover.

3.21.1.19 Lack of skills in midwifery and psychiatry services. Mental health care users stay more than 72 hours due to referral difficulties.

3.22 St Marys Kwamagwaza District Hospital – Melmoth

3.22.1 The following is a list of the most visible systemic, administrative and infrastructural challenges and deficiencies observed during the site inspection conducted by the investigation team and referred to in submissions made by the hospital management:

3.22.1.1 The KwaMagwaza Hospital is a district hospital situated in the area of the Mtonjaneni Municipality (Melmoth), which falls in King Cetshwayo District. It has 147 authorised beds, 08 fixed clinics and 2 mobile clinics. The catchment population is approximately 60 000.

3.22.1.2 The hospital was established in 1907 and was taken over by the KZN Department of Health from the Diocese of Zululand on 01 November 2000.

3.22.1.3 The hospital offers all essential services for a level B district hospital, these include medical, surgical, paediatrics, obstetrics and gynaecology,
medical male circumcision, dental and eye clinic, HAST/TB clinic and a Covid 19 unit.

3.22.1.4 KwaMagwaza District Hospital is characterised by dilapidated physical buildings and other infrastructure, the management block being the most affected. The administration block is also in a dilapidating state and most staff members do not have adequate offices.

3.22.1.5 The resuscitation rooms, theatre and Outpatient Department have wall cracks and roof leaks.

3.22.1.6 The Male Ward has cracks and roof leaks wherein buckets are used to collect water to prevent patients falling due to the slippery floor.

3.22.1.7 Male and Female wards do not conform to Infection Prevention and Control (IPC) standards as they are the same space. There is one big open unit which accommodates all same sex patients with a variety of health problems. Everybody is admitted in one huge ward which does not separate infectious and non-infectious patients.

3.22.1.8 The staff accommodation is in a dilapidating state and needs to be urgently renovated. Some units have cracks and peeling walls because of rainwater.

3.22.1.9 The Hospital Management reported that water floods when it rains.

3.22.1.10 The HIV and TB clinic has an asbestos roof that is still intact.

3.22.1.11 IT systems and connectivity is problematic. This leads to the delay in the placing of orders which affects proper service delivery.

3.22.1.12 The records area is too small and this has led to loss of files.
3.22.1.13 The Hospital Management reported that there are water cuts sometimes and the reservoir tank is small and it is combined with the access to water by the community. Further that there is a switch that is accessed by the community and this switch is sometimes turned off by the community members and the hospital would not have access to water.

3.22.1.14 The Hospital Management reported that waste management in the establishment and surrounding environment is not compliant with legal requirements, national standards and good practice. They stated that their waste storage area was not built and there was also no designated area for the disposal of Covid -19 waste.

3.22.1.15 The hospital does not have adequate tools and equipment. There is no equipment such as monitors, resuscitation materials, defibrillator, infusion pumps, humidifier and gauge for the oxygen, emergency trolleys and stretchers. The Hospital Management reported that the procurement processes to address the gaps are ongoing. All the mentioned equipment has been purchased and was awaiting delivery.

3.22.1.16 The floor in the Paediatric Unit has holes, the roof is leaking and there was no playing area for patients.

3.22.1.17 It was reported that the hospital does not have adequate staff to meet the demands of the institution.

3.22.1.18 Hospital Management reported difficulties with staff retention due to lack of suitable accommodation and the rurality of the hospital.

3.22.1.19 Management also reported a high rate of absenteeism due to staff burn out. This is directly attributed to the moratorium imposed on the employment of non-exempted staff. Non-critical/non-exempted posts are not filled when staff vacate their positions.
3.22.1.20 In the maintenance unit there is no Senior Maintenance Officer, no bricklayer, carpenter and electrician. There is a chief artisan who is expected to perform all the duties of the above.

3.22.1.21 According to the hospital’s organogram, the hospital is supposed to have 182 professional nurses but it only has 72. Further, it’s supposed to have 140 enrolled nurses but there are only 49. The hospital is supposed to have 110 enrolled nursing assistants but only has 25.

4. COMMON ISSUES IDENTIFIED ACROSS ALL HOSPITALS:

4.1 Personal Protection Equipment:

4.1.1 There was insufficient procurement, distribution and provisioning of Personal Protection Equipment (PPEs) to ensure that the staff and the Covid-19 patients were adequately protected from the surge of the pandemic.

4.1.2 It was a cause for concern that the PPEs were collected at the warehouse and they are procured by the Department and not hospital.

4.1.3 There are no dedicated drivers appointed to collect PPEs at the warehouse and as such this contributes to the delay in receiving stock.

4.1.4 Hospitals did not have sufficient PPE.

4.1.5 Centralization of procurement was a challenge.

4.1.6 At some hospitals staff are required to use one PPE the entire day.

4.1.7 Some wards not provided with proper PPEs.

4.1.8 Only Doctors were provided with full PPEs and not all staff members.
4.1.9 PPEs (masks) are re-used.

4.1.10 Incorrect PPE masks procured i.e. the usage of M95 PPEs *vis a vis* KN95.

4.1.11 Incorrect sizes of PPE.

4.1.12 Inadequate protection for Healthcare workers and other staff members due to a lack of PPE.

4.1.13 Nurses only allowed one body suit per day.

4.1.14 Incorrect sizes (body suits) that tear immediately.

4.1.15 Nurses are forced to wear body suits even if it is torn, thereby risking their health.

4.1.16 The procured PPEs not as per the specifications.

4.1.17 PPEs that are substandard.

4.1.18 PPE stock levels at the warehouse where PPEs are collected are very low.

4.1.19 Non-delivery of the procured PPE’S by the appointed service provider who was on the provincial database.

4.1.20 At some point there were substandard PPE’s that were delivered to the hospitals as the gowns were unsterile and they did not fit the staff compliment.

4.1.21 Availability of required sizes for some of the PPE i.e. boots/goggles.

4.1.22 Shortage of thermometers.
4.1.23 Shortage of disposable bins, decanters, oxygen points, PPE's.

4.2 **Capacity/Vacancies:**

4.2.1 Lack of staff capacity affects the smooth running of the hospitals.

4.2.2 Posts are not being filled which has an adverse effect on service delivery.

4.2.3 Shortage of staff /insufficient capacity to deal with elective surgeries/ clinical, nursing and support services.

4.2.4 Delays in the filling of specialized positions (Clinical positions) in the hospital due to the centralization of recruitment at the provincial level.

4.2.5 Non clinical posts not being filled resulting in health professionals assisting with clerical and porting duties.

4.2.6 Chronic nursing staff shortage and lack of professional nurses to staff the areas optimally.

4.2.7 Workload for the doctors was too high. Doctors are often expected to work excessive hours as a result of clinical staff shortages.

4.3 **Union:**

4.3.1 Lack of communication between management and staff.

4.3.2 High infection rate of employees.

4.3.3 Poor relationships between management and labour.

4.3.4 Lack of cooperation between staff and labour.
4.4 Psychiatry wards:

4.4.1 It was a serious concern that patients with mental health challenges were mixed with other patients.

4.5 Linen/Laundry:

4.5.1 There are delays regarding the turnaround time in the washing of the linen at hospitals.

4.5.2 Linen staff washing the laundry of Covid 19 patients with no gloves.

4.5.3 Poor maintenance of laundry machines leads to them breaking regularly.

4.5.4 Shortage of linen has serious impact on operations of hospitals.

4.5.5 Patients being treated on beds with no linen.

4.5.6 Non-functional laundry equipment (washing machine, dryer, iron).

4.5.7 Insufficient supply of clean linen, patients have to use their own bedding because of the shortage.

4.6 Response times/Ambulances:

4.6.1 Challenges regarding the response times of the ambulances.

4.6.2 Hospitals do not have sufficient ambulances.

4.6.3 Ambulances are not serviced, cleaned and sanitized.
4.7 **State of Facilities/Building Space:**

4.7.1 There was non-compliance with building safety standards for hospitals, safety doors and lighting detectors are not working.

4.7.2 Files and patients’ records are on the floor, there is an evident lack of filing rooms/space for storage of files.

4.7.3 Lack of a proper IT infrastructure.

4.7.4 Hospitals have infrastructure challenges in relation to space.

4.7.5 Infrastructure is old as some hospitals were built from 1930 with no proper upgrades. Old hospitals with aging infrastructure.

4.7.6 Infrastructure problems with buildings and fixtures (leaking roofs, broken toilets, toilets shared by males and females, unsecured cracking building walls, old paint).

4.7.7 Lack of network connections for virtual services.

4.7.8 Population has increased in certain areas with no proportional increase in hospital space.

4.7.9 Shortage of Intensive Care Unit (ICU) beds.

4.7.10 Insufficient consultation rooms.

4.7.11 Maintenance which is the responsibility of the Department Public Works is not up to standard as capacity and funding is a challenge.

4.8 **Cleanliness of hospitals:**

4.8.1 Medical waste lying on the corridors in hospitals.
4.8.2 Lack of proper process for securing medical waste boxes i.e. lack of linings and delays in the collection and disposal of medical waste.

4.9 **Lack of Equipment:**

4.9.1 Poor ventilation in hospitals.

4.9.2 Lack of equipment such as piped oxygen.

4.9.3 Old cylinder gas oxygen being used which has no spares.

4.9.4 Insufficient oxygen points.

4.9.5 General Blood Pressure and X-Ray machines are not enough, susceptible to regular breakdown due to lack of maintenance and being irreparable.

4.9.6 Laundry machines are old and irreparable.

4.9.7 Shortage of medical equipment (CPAP, ultrasound, baby warmers, BP machines, suction machines, mobile X-ray, dyna map and ECG machines)

4.9.8 Old and insufficient motor vehicles.

4.9.9 Delays in the maintenance at Provincial level of the MRI, Radiology, Oxygen machines due to lack of contracts with service providers.

4.9.10 Old and outdated X-ray machines.

4.9.11 Delays in procurement and servicing of geyser, heaters, telephones and printers.
4.9.12 Delays by the Department of Infrastructure to service/repair taps and repair the laundry machines.

5. INTERVENTIONS:

5.1 Gauteng

5.1.1 Jubilee Hospital

Short term interventions

5.1.1.1 The Department to ensure that it capacitates the hospital with respect to conducting its own Covid-19 tests. The procurement of the Covid-19 machine /kit will assist in alleviating the turnaround time for the tests especially in light of a possible second wave of Covid-19.

5.1.1.2 The Department must ensure that sufficient and adequate PPEs are received by hospitals upon collection from the depots. The PPEs must be in line with the requested specifications.

5.1.1.3 The Department to immediately train all staff in relation to the risk strategy and the work of the risk management committee.

Medium term interventions

5.1.1.4 The Department must ensure that the hospital has a Business Continuity Management plan regarding the manner in which elective surgery is phased in post Covid-19.

5.1.1.5 The Department must ensure that there is sufficient ambulances to cater for the needs of the masses who must access health care. During the
inspection we observed that the patients were dissatisfied with the response time of the ambulances.

5.1.2 **George Mukhari Hospital:**

**Short term interventions**

5.1.2.1 There were allegations of undue delay by the Department to pay salaries of additional Covid-19 employees. However, the Department has rectified the delay as the staff have since been remunerated.

5.1.2.2 The Department must ensure that there is training of all officials in the employ of the hospital regarding the Covid-19 risk strategy.

**Medium term interventions**

5.1.2.3 The Department must expedite the timeous procurement of the medical equipment which the hospital has ordered.

5.1.2.4 The Department must and ensure that the contract for waste management is finalised in order to ensure that there is adequate, efficient and effective service delivery at the hospital, as failure thereof would negatively impact on the health of staff and the patients.

5.1.3 **Steve Biko Academic Hospital (SBAH):**

**Background to proposed interventions –**

5.1.3.1 Some measures have already been taken by my office in an effort to assist Steve Biko Hospital, particularly in as far as its Risk Management and Business Continuity is concerned. The Risk Manager at my office, Mr Magapane Makaba was requested to conduct an assessment of the SBAH
Risk Management Function and provide advice based on the applicable standards and risk management legislative framework.

5.1.3.2 In as far as his assessment is concerned the following legal provisions were canvassed *inter alia* -

(a) In terms of Public Finance Management Act 01 of 1999 (PFMA) Section 38 (a) (i), the accounting officer for a department, trading entity or constitutional institution must ensure that department, trading entity or constitutional institution has and maintains effective, efficient and transparent systems of financial and risk management and internal control.

(b) Section 6(2)(a) of the PFMA empowers the National Treasury to prescribe uniform norms and standards in terms of Risk Management Framework.

(c) Treasury Regulations\(^4\) paragraph 3.2.1 requires the following:

i. The accounting officer must ensure that a risk assessment is conducted regularly to identify emerging risks of the institution;

ii. A risk management strategy, which must include a fraud prevention plan, must be used to direct internal audit effort and priority;

iii. To determine the skills required of managers and staff to improve controls and to manage these risks, and

iv. The strategy must be clearly communicated to all officials to ensure that the risk management strategy is incorporated into the language and culture of the institution.

(d) **Assessment:**

i. A regular risk assessment has been conducted although the timing on which the assessment was conducted does not provide an adequate

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\(^4\) Treasury Regulations for departments, trading entities, constitutional institutions and public entities of March 2005
time period to implement the required action plans within the current financial year.

ii. Therefore, while the aim is to improve internal controls and avoid audit queries it might be late for risk action plans to be implemented.

iii. It cannot be ascertained if the Risk Management Strategy has been communicated to all staff members as a requirement per standard practice and Risk Management Framework. Also to support this notion, during the meeting of 08 September 2020 with Management and Labour representatives this concern was raised.

(e) The Public Sector Risk Management Framework:

Institutions are expected to develop their systems of risk management by adopting the principles and standards set out in the Framework, and adapting the models and operational practices to match their specific institutional requirements.

(f) In terms of Public Sector Risk Management Framework, a Risk Management Policy should outline the following:

i. Communicate the institution’s risk management philosophy in the context of how risk management is expected to support the Institution in achieving its objectives;

ii. Incorporate a statement committing the Institution to implementing and maintaining an effective, efficient and transparent system of risk management;

iii. Define risk and risk management as they apply within the institution’s particular context;

iv. Spell out the objectives of risk management;

\(^5\) National Treasury Public Sector Risk Management Framework published on 01 April 2010
v. Outline the risk management approach and identify the key role players and their responsibilities;
vi. The risk management policy should be communicated to all incumbent officials and arrangements should be made for communicating the policy to all new recruits.

(g) **Assessment:**

i. The Risk Management Policy complies with most of the listed guidelines of Public Service Risk Management Framework although it cannot be ascertained if it has been adequately communicated to the general staff members. This notion was expressed during the meeting of 08 September 2020 with Management and Labour representatives.

ii. The policy has not been reviewed and updated regularly to ensure it remains relevant to the current challenges and opportunities as a standard practice (i.e. at least within three years) due to the fact that risks are dynamic and interrelated and therefore need a constant re-evaluation of the environment.

(i) **The Risk Management Committee and Chapter 13 (24) 2 Public Sector Risk Management Framework:**

i. Chapter 13(24)2 of the The Public Sector Risk Management Framework provides that membership of the Risk Management Committee should comprise both management and external members with the necessary blend of skills, competencies and attributes, including the following critical aspects:

   a) an intimate understanding of the Institution’s mandate and operations;

   b) the ability to act independently and objectively in the interest of the Institution; and
c) a thorough knowledge of risk management principles and their application.

ii. The chairperson of the Risk Management Committee should be an independent external person, appointed by the Accounting Officer / Authority.

(j) Assessment:

i. It is clear that the level of personnel constituting SBAH Risk Management Committee is not adequate and not complying to the above guideline particularly in respect of the chairperson.

ii. It does not seem there is any personnel at Executive Management level in the committee, it is filled with more than 90% middle and lower level staff members. Therefore there is non-compliance on the part of management.

iii. In regard to Risk Management principles and knowledge is clear that there is very limited knowledge in regard to risk management in the committee (only the Chief Risk Officer) and therefore the value add by the Committee to the operations of the institution can only be limited.

iv. Based on the engagements with Management and Labour representatives during our last meeting on 19 October 2020, the committee had never held a single risk committee meeting for the current financial year sighting COVID-19 as a reason for non-compliance. This only attest to the inadequacy and the ineffectiveness of the committee.
v. There is no proof that there were quarterly risk committee reports presented to Audit Committee and also if there were any interactions with Audit Committee.

(k) **Business Continuity Management Plan:**

i. In terms of ISO22301, Business Continuity Management (BCM) is a holistic management process to identify potential threats to an organization and the impacts those threats, if realized might cause and provides a framework for building resilience and the capability for an effective response that safeguard the interests of its key stakeholders, reputation, brand and value-creating activities.

(l) **Assessment:**

i. The hospital's Business Continuity Management Plan only focuses on COVID-19 operation disruptions not any other business/operational disruptions such as natural disasters e.g. floods/fire. Therefore assumption can be made that a Business Impact analysis and risk assessment were not conducted.

(m) **Recommendation:**

i. Risk Management is a valuable management tool which increases an Institution's prospects of success through minimising negative outcomes and optimising opportunities.

(n) **Risk Management and Business Continuity Interventions:**

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6 This document specifies requirements to implement, maintain and improve a management system to protect against, reduce the likelihood of the occurrence of, prepare for, respond to and recover from disruptions when they arise. The requirements specified in this document are generic and intended to be applicable to all organizations, or parts thereof, regardless of type, size and nature of the organization. The document is developed by the International Organization for Standardization. (https://www.iso.org/standard/75106.html)
i. Re-constitute a new Risk Management Committee whereby all Branches are represented (i.e. All the Directors/Executive Managers are members and some of the critical units are represented by managers as standing invitees).

ii. Ensure that the Risk Committees is chaired by an external independent person with knowledge of risk management principles, governance and Government administration legislative.

iii. Ensure that Risk Management Committee meetings are held for every quarter to review activities/operations and provide monitoring guidance and assurance to Audit Committee.

iv. Conduct a review of Risk Management enablers (Risk Policy, Risk Management Strategy, Whistle Blowing Policy, Fraud Prevention Plan and others) on a regular basis. At least every two years.

v. Conduct a proper Business Continuity Management Plan, Business Impact Analysis and Risk Assessment to develop a holistic and relevant BCM Plan which is ready for all potential disasters and not only focusing on COVID-19.

vi. Create awareness for all staff members either through workshops or circulars for all Risk Management enablers (Risk Management documents such Risk Management Policy, Risk Management Strategy, Whistle Blowing Policy and Fraud Prevention Plan) especially after update/review.

vii. Conduct Anti-Fraud and Corruption Awareness at least once per year for all staff members. Emphasis on the whistle blowing policy and anti-fraud hotline.
5.1.4 Lillian Ngoyi Hospital

Short term interventions

5.1.4.1 During the inspection loco the team identified dysfunctional geysers, heaters, printers, telephone lines and photo copier machines. However, after the intervention of my office the dysfunctional infrastructure was fixed and is currently operational.

5.1.4.2 The Department must ensure that there is sufficient provision of clean linen at the health care centre, as we observed dirty linen on a baby cot during the inspection.

5.1.4.3 The Department must oversee the continuous provision of nutritious quality food to the centre in order to comply with the dietary needs of the patients. During the inspection we observed that patients at the centre were served bread and tea without any supplementary food in order to ensure that they are provided a balanced meal.

5.1.4.4 The Department must ensure that the hospital effectively and efficiently reduce the waiting period of patients being attended to by the medical staff at the centre, as during the inspection we observed that the waiting period of patients was longer than necessary.

5.1.4.5 The Department must assist the hospital in ensuring that there is establishment of Occupational Health and Safety (OHS) committee which is operational and efficient, as during inspection we observed that the centre does not have an OHS committee.
5.1.5 Chris Hani Baragwanath Hospital

Short term interventions

5.1.5.1 During the inspection loco the team identified that there were dysfunctional taps, basins and laundry machines at the hospital. However, after the intervention of the office the dysfunctional infrastructure was fixed and is currently operational.

5.1.5.2 The Department must ensure that there is sufficient availability of good quality PPEs at the warehouse which must be timeously delivered to the hospitals to avoid the third wave of the pandemic and disgruntled employees.

Medium term interventions

5.1.4.3 The Department must ensure that the hospital must ensure that there is a business continuity management plan regarding the manner in which elective surgery is phased in post Covid-19.

5.1.4.4 The Department must ensure that there is sufficient ambulances to cater the needs of the masses who must access health care. During the inspection we observed that the patients were dissatisfied with the response time of the ambulances.

5.1.5 Charlotte Maxeke Johannesburg Hospital

Short-term interventions

5.1.5.1 The Department must ensure that there is enough waste storage at Charlotte Maxeke, as during the inspection we observed that the toilet was
used as a waste storage for new and used waste boxes and this presents a health hazard.

5.1.5.2 The Department must ensure that sufficient and adequate PPEs are received by hospitals upon collection from the depots. The PPEs must be in line with the required specifications.

5.1.5.3 The Department must ensure that there is timeous collection of medical waste at the hospital by the appointed service provider by effectively and efficiently managing the contract of the appointed service providers.

Medium term interventions

5.1.5.4 The Department must expedite the timeous procurement of the medical equipment which the hospitals have ordered.

5.1.5.5 The Department must expedite procurement of a motor vehicle dedicated for the collection of PPEs as the hospital was utilising its laundry vehicle to collect the PPE from the warehouse.

5.2 Mpumalanga

5.2.1 Themba Hospital:

Interventions:

5.2.1.1 The hospital has infrastructure challenges due to its age and lack of proper maintenance and the Department should start planning to address it. To put in motion the implementation of the plan to revamp the maternity wing that was promised since 2007. Four (4) delivery beds are not enough for a hospital that delivers 450 births per month.
5.2.1.2 More space to be created for the Allied Health Services and to be provided in a suitable ward to avoid the violation of patients’ rights.

5.2.1.3 The Department to engage Public Works on the issue of maintenance capacity for the building as eight (8) officials do not seem to be enough for Themba Hospital to take responsibility for both the cleaning of wards, removal of waste and maintenance of the grounds and other facilities.

5.2.1.4 The Department to consider and plan for the revision of the Organogram and start planning to recruit the relevant staff members such as Doctors, Nurses, Cleaners, Porters and Grounds men. This should include catering for new services such as Bambanani Wellness clinic mainly for HIV and AIDS, new General Ward, Clinical Engineer Workshop as they are all operating with old staff. The Department should also fast track the appointment and or allocation of the 23 Professional Nurses for ICU and Trauma Unit.

5.2.1.5 The Department to consider making provision for mental health patients in the province.

5.2.1.6 The Department of Health to engage with the Department of Public Works and ensure that the service provider appointed to maintain and fix the laundry machines gets capacity to fix the machines or the contract should be terminated and another service provider appointed. In the meantime, the Department should be able to contract the work to other capable service providers as and when the need arise. The proper maintenance and repairs of the laundry machines will assist in alleviating the shortage of linen to a certain extent.

5.2.1.7 The Department to review its policy of taking away the funding of posts that could not be filled within three months as this reduces the human resource capacity of the Hospital and put a strain on the available staff members.
5.2.1.8 The provision of the outstanding equipment such as the lifesaving equipment, of which they have received some. ECG, blood pressure, ventilators, ICU beds, incubators, ventilators for adults, etc. should be expedited.

5.2.1.9 The matter of the Corporate Service Manager, who has not been at the Hospital for almost a year must be resolved without any further delay. The dispute pertaining to the Supply Chain position must be resolved.

5.2.1.10 There is an urgent need to identify space to accommodate more beds for the maternity ward, pending the revival of the revitalisation programme or another solution to provide better infrastructure.

5.2.1.11 There were stained curtains in the maternity ward which can be replaced without a protracted procurement process and within the delegation of the accounting officer.

5.3 Eastern Cape

5.3.1 Sulenkama- Nessie Knight Hospital; Umtata Tertiary Hospital; Livingstone Hospital and Uitenhage Hospital

Interventions

5.3.1.1 The following are the quick wins or interventions which the Department of Health can implement in all four inspected hospitals in order to address identified challenges in the short term, medium to long term -

(a) To increase PPE supplies for frontline workers.
(b) To fast-track payment of contract workers and judgement debts in order to avoid judicial attachment of critical hospital assets such as vehicles etc.
(c) To take active steps in order to strengthen risk management processes;
(d) To expedite the provision of critical medical equipment and supplies, e.g. ventilators, X-Ray machines, trolleys, etc.
(e) To take active steps in order to urgently fill all vacancies;
(f) Stabilize management-labour relationship;
(g) Improve general and regular maintenance of the health facilities in the province;
(h) Full and regular conditional assessments of hospital facilities;
(i) Finalize classifications of hospitals;
(j) Attend to the review of delegations of authority in respect of procurement thresholds; and
(k) Human Resource processes to be decentralized and be done at hospital levels in order to avoid unnecessary delays and red-tape.

5.4 Limpopo

5.4.1 WF Knobel Hospital:

Short Term Interventions:

5.4.1.1 Provision of the following basic equipment is regarded as urgent-

(a) Baby warmers
(b) Blood Pressure Machines
(c) Pads used in Theatre
(d) Electrocardiogram (ECG) Machines
(e) Ventilators
(f) X-Ray machines
(g) Working boiler machine
(h) Working Fridges in the mortuary (Only 3 out of 9 are in good working condition).
(j) Ensure that the mortuary fridges that are working and clean.
(j) Ensure that trolleys used to carry corpses at the mortuary are repaired.
(k) Chairs and plastic curtaining

5.4.1.2 The following areas also need urgent attention -

(a) Improved labour relations.
(b) Better liaison between staff and management.
(c) Cleaning of the outside areas of the hospital.
(d) Provision of quality PPEs and sanitizers.
(e) Uplifting of staff morale.

5.4.1.3 Long Term Interventions:

(a) Overall plumbing needs attention, including the ablution facilities for staff and public.
(b) Fixing of windows that are either broken or not closing properly.
(c) Heaters in the wards needed.
(d) General Maintenance of the hospital as the buildings are in a bad condition.
(e) Better management of the institution.
(f) Improve demand management in Supply Chain Management (SCM) including decentralization of procurement of goods and services.
(g) Filling of critical posts.
(h) Appointment of groundsmen to clean the outside of the hospital;
(i) A full assessment of the condition of the buildings to determine whether there is a need to build a new hospital as it is dilapidated or refurbishment of the hospital.
(j) Appointment of Operational Managers in the wards.
(k) Creation of the waiting area and staff tea room, reception for visitors at the mortuary.
(l) Improved financial management of the institution.
(m) Provision of tools that will enable staff to perform their duties better and more efficiently.

5.5 **KWAZULU NATAL**

5.5.1 **Christ the King Hospital:**

**Short Term Interventions:**

5.5.1.1 The following is proposed as immediate intervention at the hospital -

(a) Appointment of an IT official or provision of adequate or sufficient internet connectivity to ensure that tasks are completed timeously and that service providers are paid on time, as per section 38 of the PFMA.

(b) Repairing of leaks in the storerooms, which will thus decrease the amount of stock that has to be disposed of due to water and/or mould damage.

(c) Review of the moratorium imposed in relation the filling of posts identified as “non-critical” in order to ensure effective health services delivery as per the obligations imposed by the Constitution and the law.

(d) The performance of caesarean section operations requires urgent attention and proper equipment to enable the nursing staff to assist doctors.
(e) The Gateway Clinic should be reopened, properly staffed, equipped and upgraded to help ease the congestion of outpatients at the Casualty Ward.

(f) The CEO and the Hospital Board should ensure that a Hospital SCM policy is developed, under the guidance of the Provincial Health Department in line with National Supply Chain Management Policy and develop such system and processes to ensure that there is no perpetual violation of section 38 of the PFMA.

(g) The Maternity Ward requires urgent attention as it is overly populated and bigger space is necessary to alleviate congestion and create a conducive environment for women in labour.

(h) Create a designated area to be used by staff as a canteen and/or rest area.

5.5.2 Rietvlei District Hospital:

5.5.2.1 Short Term Interventions:

(a) A review of the moratorium imposed in relation to posts identified as “non-critical” in order to ensure effective health services delivery as per obligation imposed by the Constitution and the law.

(b) Appointment of an IT official or provision of adequate/sufficient and reliable internet connectivity to ensure that tasks are completed timeously and that service providers are paid on time. Further to ensure that the hospitals fire systems is operating optimally and can be of assistance in the event of a fire outbreak.
(c) To expedite and finalize the procurement and installation of CCTV cameras on strategic points within the hospital as per the Safety and Security Assessment conducted by the Provincial Security services.

(d) Five (5) clinics require an upgrade and professional nurses should be appointed to provide proper primary health care to patients where the clinics are located within the district.

(e) The Casualty Ward requires urgent attention as it is overpopulated and more beds and equipment are needed in order to provide proper service per sickness categories.

(f) Patients with mental illness should be separated and not be accommodated at the casualty ward and efforts should be made to immediately ferry patients with mental illness to the psychiatric institution within the Province.

(g) According to the Medical Manager, there are more deaths reported at homes as a result of Covid 19 pandemic and therefore more health practitioners should visit the homesteads via the hospital outreach program in order to conduct testing of residents.

(h) Consider the appointment of cleaners for the clinics, a Psychologist, Audiologist, Speech Therapist, Dietician and Dental Assistant.

5.5.3 Mbongolwane District Hospital:

5.5.3.1 Short Term Interventions:

(a) To ensure that there is reliable and sufficient internet connectivity in order to timeously place and process orders and that officials have access to Persal and BAS system, expedite the delayed procurement of beds.
(b) To ensure that security officers are placed at strategic / high risk areas within the institution. Trees near the fence to be constantly cut off / or trimmed to increase visibility.

(c) To prioritize and expedite the approval regarding redesigning of infrastructure in order to comply with IPC standards.

(d) A review the moratorium imposed in relation to posts identified as “non-critical” in order to ensure effective health services delivery as per obligation imposed by the Constitution and the law, should be conducted.

5.5.4 St Marys Kwamagwaza Hospital:

5.5.4.1 Short Term Interventions:

(a) The hospital management reported that there is a planned project for the hospital to renovate wards and the project will start with replacing the roof. These renovations would be done in phases however there were no time lines given. It is recommended that, due to the extremely dilapidating state of the hospital, the renovations at the hospital be expedited.

(b) To consider additional wards in order to accommodate various categories of patients that are currently lodged together, for example, medical, surgical, TB, psychiatric, chronic and acute patients are all in one ward.

(c) To review the moratorium imposed in relation to posts identified as “non-exempted” in order to ensure effective health services delivery as per obligation imposed by the Constitution and the law.
(d) To expedite delivery of procured equipment to ensure effective health care services.

6. **CONCLUSION:**

6.1 These are the observations made from the inspections conducted at the various hospitals.

6.2 This is a factual report which requires the Minister and Members of the Executive Council (MEC) for Health, intervention.

6.3 The observations contained herein obtained were from the inspections carried out at the various hospitals.

6.4 There are number of issues that the Minister and MEC’s can address before the public can enjoy access to health care service as envisaged in Section 27 of the Constitution of the Republic of South Africa.

6.5 In essence there were a variety of issues which makes it difficult for the health practitioners to render exceptional services to communities. These issues range from *inter alia*:

6.5.1 Shortage of staff (this will include professional and general staff) means that the available staff is overworked whilst other services are not provided due to lack of specialist doctors.

6.5.2 Shortage of equipment means they are unable to deliver certain deliverables at times.

6.5.3 The existing infrastructures are unable to cater for certain services like storage rooms for files, space to accommodate more wards etc.

6.5.4 The management of different contracts or lack thereof has frustrated the ability of most of the health facilities to delivery health care services to their communities.
6.5.5 Some of the issues could be attributed to the following:

6.5.5.1 Bureaucratic red tape.

6.5.5.2 Budgetary constraints.

6.5.5.3 Lack of capacity/equipment.

7. **EXPECTATION AND THE WAY FORWARD:**

7.1. The oversight role of the Minister and MEC’s are important in steering the process of assessment of the effectiveness of hospitals to achieve good governance.

7.2. This is a factual report for intervention and that your office submit an action plan on how the affected hospitals will address the issues that were raised during the inspections.

Best wishes

[Signature]

ADV. BUSISIWE MKHWEBANE
PUBLIC PROTECTOR
OF THE REPUBLIC OF SOUTH AFRICA
DATE: 14/12/2020