HLABISA HOSPITAL
QUATERLY MORTALITY
AND MORBIDITY
REPORT

JANUARY 2005 TO MARCH 2005
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1. Introduction

This document is the first attempt by the medical manager, medical officers, professions allied to medicine and the facility information officer at Hlabisa hospital to present data relevant to the work we are doing reflecting both the level of activity in the hospital, selected indicators and a mortality and morbidity profile for inpatients.

The process is still in evolution and the data collection was far from complete but hopefully this report will act as a baseline from which we can as an institution build a robust data collection and reporting system that can inform the way we deliver healthcare in Hlabisa and act as a monitor of our effectiveness.

Future plans for the data that will be collected and presented are given in the conclusions.

Martin Dedicoat
Medical Manager

Acknowledgments to people involved in collecting the data presented here and providing patient care

1. Miss L Reiman Physiotherapy
2. Miss K Heine Occupational therapy
3. Mr D Gumede Physiotherapy
4. Dr M Kheswa Surgery
5. Dr B Manukuza Surgery
6. Dr K Govender Medicine
7. Dr R Naicker Paediatrics
8. Dr R Duys Maternity
9. Dr K Miller Medicine
10. Dr S Dlamini High care unit / Antiretroviral therapy
11. Dr R Gounder Outpatients / Clinics
12. Dr D Mbatha Outpatients
13. Dr D Sloane Tuberculosis
14. Ms A Moultrie Psychology
15. Mr P Gumede Social work
16. Mr N Buthelezi Facilities information officer
17. All ward clerks

Thanks must also go to Mrs Zungu, hospital manager for supporting the process.
2. Outpatient Statistics

A) Total number of outpatients seen in January 1825
B) Total number of outpatients seen in February 1762
C) Total number of outpatients seen in March 1937

Average number of people attending outpatients by day of the week

A) Monday’s 90
B) Tuesday’s 83
C) Wednesday’s 82
D) Thursday’s 60
E) Friday’s 53
F) Saturday’s 40
G) Sunday’s 18

Average number of patients seen on a daily basis in OPD (January to March 2005)

Comments

The statistics presented for OPD are very basic. It is planned to present a more comprehensive picture of the work of the OPD department in the next issue. It can bee seen from the figures and graph that the department is very busy and also the work is unevenly distributed across the week. Efforts will be made to provide appropriate staffing to cover the fluctuations in patients and reduce waiting times. A waiting time survey will be conducted shortly.
3. Female Medical Ward

Data for January to March 2005

Number of beds 39
Total admissions 339
Total deaths 85
Death rate 25%
Mean length of stay 6.7 days
Bed occupancy 57%
Bed turnover rate 2.9
Estimated HIV associated morbidity 185/254 (73%)
Estimated HIV associated mortality 66/85 (77%)

Morbidity profile

1. Pulmonary tuberculosis 49/254 (19%)
2. Gastroenteritis 32/254 (13%)
3. Diabetes mellitus 20/254 (8%)
4. Cryptococcal meningitis 16/254 (6%)
5. Meningitis 12/254 (5%)
6. Hypertension 11/254 (4%)
7. HIV 10/254 (4%)
8. Pneumonia 10/254 (4%)
9. Stroke 8/254 (3%)
10. Pericardial tuberculosis 7/254 (3%)

Mortality profile

1. Gastroenteritis 18/85 (21%)
2. Pulmonary tuberculosis 16/85 (19%)
3. Pneumonia 11/85 (13%)
4. Meningitis 7/85 (8%)
5. HIV 7/85 (8%)
6. Cryptococcal meningitis 6/85 (7%)
7. Stroke 5/85 (6%)
8. Cardiac failure 3/85 (4%)
9. Diabetes mellitus 2/85 (2%)
10. Abdominal tuberculosis 2/85 (2%)

Comments.

The female medical ward is a busy ward with one of the highest admission rates in the hospital and also one of the highest mortality rates due to HIV. It is hoped antiretroviral therapy (ART) will impact on this. Patients admitted on ART or starting ART as inpatients will be recorded from now on.
4. Male Medical ward

Data for January to March 2005

Number of beds 28  
Total admissions 199  
Total deaths 45  
Death rate 23%  
Average length of stay 5.9 days  
Bed occupancy 47%  
Estimated HIV related morbidity 80%  
Estimated HIV related mortality 80%

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Bed turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>67</td>
<td>15</td>
<td>2.4</td>
</tr>
<tr>
<td>February</td>
<td>61</td>
<td>14</td>
<td>2.2</td>
</tr>
<tr>
<td>March</td>
<td>71</td>
<td>16</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Morbidity profile

1. Pulmonary tuberculosis 66/199 (33%)
2. Gastroenteritis 19/199 (10%)
3. Meningitis 10/199 (5%)
4. Lower respiratory tract infection 9/199 (5%)
5. HIV / AIDS 9/199 (5%)

Mortality profile

1. Tuberculosis 17/45 (38%)
2. HIV / AIDS 7/45 (16%)
3. Gastroenteritis 5/45 (11%)
4. Lower respiratory tract infection 5/45 (11%)
5. Stroke 3/45 (7%)

Comments.

The male medical ward is in a state of poor repair which does impact on the level of care that staff can offer. Mortality and morbidity reflect the high prevalence of HIV infection. Hopefully ART will impact on this as mentioned above.
5. Tuberculosis ward

Data for January 2005 to March 2005

1. Total number of beds 62
2. Number of male beds 26
3. Number of female beds 36
4. Bed Occupancy Rate 22%
5. Number of admissions 160
6. Number of discharges 128
7. Number of deaths 32
8. Number of in-patient days 1278
9. Death rate as % of admissions 20%
10. Average length of stay 8 days
11. Mean bed turnoer rate per month 0.85
12. Estimated HIV related morbidity 80%
13. Estimated HIV related mortality 80%

Morbidity profile

1. Pulmonary tuberculosis 78%
2. Lower respiratory tract infection 12%
3. HIV / AIDS 8%
4. Tuberculosis site unspecified 5%
5. Tuberculosis MDR 4%

Mortality Profile

1. Pulmonary tuberculosis 81%
2. HIV / AIDS 6%
3. Tuberculosis unspecified site 3%
4. No diagnosis 0.6%
5. Abdominal tuberculosis 0.3%

Comments

The tuberculosis (TB) ward cares for patients with TB who are too sick to go home. Most of these patients also have HIV infection. A proportion of the patients on TB ward do not have TB and are suffering with other conditions such as Kaposis sarcoma. The high mortality rate reflects the high HIV co-infection rate. Hopefully ART will impact both on the admissions to TB ward and on the outcome of patients admitted. Multidrug resistant TB is an emerging problem and increased surveillance is planned. HIV status was reported in only around 8% of cases.
6. Female surgical ward

Data for January to March 2005

Number of beds 14
Total admissions 224
Total deaths 7
Death rate 3%
Average length of stay 2.7 days
Bed occupancy 47%
Estimated HIV associated admissions 40%

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Bed turnover</th>
</tr>
</thead>
<tbody>
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<td>4</td>
<td>5.8</td>
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<td>4.9</td>
</tr>
<tr>
<td>March</td>
<td>74</td>
<td>3</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Morbidity profile

1. Incomplete abortion 42/224 (19%)
2. Infection 32/224 (14%)
3. Trauma 26/224 (11%)
4. Pelvic inflammatory disease 15/224 (7%)
5. Snakebite 12/224 (5%)

Mortality Profile

1. Infection 4/7 (57%)
2. Tuberculosis 1/7 (14%)
3. Head injury 1/7 (14%)

Comments

The female surgical and gynaecology ward is currently housed in one bay of the female medical ward. The staff are working under very cramped conditions and the rapid bed turnover is a testament to their hard work. It is hard to comment of facilities and equipment as the ward is temporary. There is not an accurate note of discharges and mortality and morbidity are not quantified, these things will be corrected for the next report.
7. Male surgical ward

Data for January to March 2005

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of beds</td>
<td>27</td>
</tr>
<tr>
<td>Total admissions</td>
<td>156</td>
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<tr>
<td>Total deaths</td>
<td>3</td>
</tr>
<tr>
<td>Death rate</td>
<td>2%</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>6 days</td>
</tr>
<tr>
<td>Bed occupancy</td>
<td>17%</td>
</tr>
<tr>
<td>Estimated HIV related admissions</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Bed turnover</th>
</tr>
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<tbody>
<tr>
<td>January</td>
<td>43</td>
<td>1</td>
<td>1.6</td>
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<td>50</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>March</td>
<td>63</td>
<td>2</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Morbidity profile

1. Trauma 65/156 (42%)
2. Snakebite 13/165 (8%)
3. Septic wounds 9/165 (6%)
4. Burns 3/165 (2%)
5. Abscess 3/165 (2%)

Mortality profile

1. Carcinoma of the oesophagus 1/3 (33%)
2. MVA 1/3 (33%)
3. Tuberculosis 1/3 (33%)

Comments
HIV did not appear to play such a big role in the admissions to the male surgical unit, trauma being the biggest problem. Accurate morbidity and mortality data need to be recorded and this will be instigated before the next review.
8. Paediatric Unit

Nursery

Data for January to March 2005

- Beds: 5
- Total admissions: 143
- Total deaths: 11
- Death rate: 8%
- Mean length of stay: 3.5 days
- Bed occupancy: 111%

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Bed turn over rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>38</td>
<td>1</td>
<td>7.6</td>
</tr>
<tr>
<td>February</td>
<td>55</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>March</td>
<td>50</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

Morbidity Profile

1. Prematurity: 49/143 (34%)
2. Merconium aspiration: 19/143 (13%)
3. Low Apgar score: 18/143 (13%)
4. Convulsion: 7/143 (5%)
5. Jaundice: 5/143 (4%)

Mortality Profile

1. Prematurity: 4/11 (36%)
2. Pneumonia: 3/11 (27%)
3. Jaundice: 1/11 (9%)
4. Merconium aspiration: 1/11 (9%)
5. Congenital abnormalities: 1/11 (9%)
6. Convulsions: 1/11 (9%)

Comments

Nursery has a very rapid turn of patients. The fairly low mortality rate is a testament to the high standard of nursing care. With children of this age assigning HIV as a cause of mortality or morbidity is difficult and was not attempted.
Paediatric Ward

Data for January to March 2005

Number of beds (38 cots / 10 beds)  48
Total admissions  396
Total deaths  27
Death rate  7%
Average length of stay  4 days
Bed occupancy  37%
Estimated HIV associated admissions  40%

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Bed turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>148</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>February</td>
<td>131</td>
<td>9</td>
<td>2.7</td>
</tr>
<tr>
<td>March</td>
<td>117</td>
<td>10</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Morbidity profile
1. Lower respiratory tract infection  53/396 (13%)
2. Tuberculosis  44/396 (11%)
3. Gastroenteritis  39/396 (10%)
4. Protein energy malnutrition  21/396 (5%)
5. Poisoning  21/396 (5%)
6. Fractures  12/396 (3%)
7. Abscess  12/396 (3%)
8. Sepsis  10/396 (3%)
9. Burns  10/396 (3%)
10. Snakebite  9/396 (2%)

Mortality Profile
1. Protein energy malnutrition  7/27 (26%)
2. Pneumonia  5/27 (19%)
3. Enema syndrome  4/27 (15%)
4. Tuberculosis  3/27 (11%)
5. Gastroenteritis  3/27 (11%)

Estimated HIV / AIDS associated deaths 20/27 (74%)

Comments.

The paediatric unit is very busy. Turnover rate is high as is the number of admissions. It is a testament to the dedication of the nursing and medical staff that the through put of patients is maintained and that mortality is relatively low in spite of the high prevalence of HIV infection in the district. It is hoped that ART will impact on the number of admissions to the unit.
9. Maternity Unit

Data for January to March 2005

Number of beds          73
Total admissions        1062
Total deaths on unit    0
Mean length of stay     6.2 days
Bed occupancy           65%
Bed turn over rate      14.5

Selected indicators (full list available in PPIP2 files)
(Data for January to March 2005)

1. Deliveries          908
2. PNMR                 41.9/1000
3. C-section rate       14.3%
4. Positive syphilis serology  0.6%
5. Mothers aged <18     11.1%
6. Born out of hospital / clinic  1.6%

Comments
The majority of maternity data is collected and reviewed separately in the perinatal review meetings. Data presented here reflect ward activity. More accurate recording of discharges and of HIV status are needed to accurately reflect the work of the unit and burden of disease.
10. High Dependency Unit

Data for January to March 2005

Number of Beds: 5
Total admissions: 52
Total deaths: 12
Death rate: 12/52 (23%)
Mean length of stay: 3.8 days
Bed occupancy: 38%
Bed turnover: 3.5 per month
Estimated HIV associated admissions: 10/52 (19%)

Number of Admissions and Deaths

<table>
<thead>
<tr>
<th>Month</th>
<th>Admissions</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults</td>
<td>Paeds</td>
</tr>
<tr>
<td>January</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>February</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>March</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>

Morbidity Profile

1. Trauma      8/52 (15%)
2. Tuberculosis 7/52 (14%)
3. Snakebite    4/52 (8%)
4. Diabetes     4/52 (8%)
5. Cardiac failure 3/52 (6%)

Mortality Profile

1. Tuberculosis 2/12 (16%)
2. Seizure      2/12 (16%)
3. Stroke       1/12 (8%)
4. Snakebite    1/12 (8%)
5. Meningitis   1/12 (8%)

Comments

HDU is currently operating under extremely difficult conditions. Since the start of building work and the demolition of the old HDU patients have been accommodated in a bay at the end of post natal ward. Conditions are very cramped and all staff, especially the nursing staff are doing a remarkable job to keep going and provide a quality service. Data on length of stay was not consistently recorded but this will be rectified. Also mortality data was not available at the time of writing but will be added later.
11. Therapy Department

Occupational therapy

Number of Inpatients and Outpatients Treated (Excluding PHC clinic patients)

<table>
<thead>
<tr>
<th>Month</th>
<th>Inpatients</th>
<th>Outpatients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>14</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>February</td>
<td>8</td>
<td>37</td>
<td>45</td>
</tr>
<tr>
<td>March</td>
<td>17</td>
<td>35</td>
<td>52</td>
</tr>
</tbody>
</table>

Physiotherapy

Number of Patients Seen in Different Settings (Includes OT patients seen in PHC clinics)

<table>
<thead>
<tr>
<th>Month</th>
<th>Inpatients</th>
<th>Outpatients</th>
<th>ANC</th>
<th>Ortho</th>
<th>PHC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>67</td>
<td>71</td>
<td>0</td>
<td>7</td>
<td>36</td>
<td>181</td>
</tr>
<tr>
<td>February</td>
<td>153</td>
<td>122</td>
<td>0</td>
<td>13</td>
<td>65</td>
<td>353</td>
</tr>
<tr>
<td>March</td>
<td>171</td>
<td>169</td>
<td>48</td>
<td>22</td>
<td>107</td>
<td>517</td>
</tr>
</tbody>
</table>

Comments

The therapy department is working under very difficult conditions. Due to construction work it is currently situated in one section of the tuberculosis ward this is far from ideal. The department currently has a physiotherapist acting as manager, a community service physiotherapist and a community service occupational therapist. Currently six outside clinics are being visited. A wide range of patients are being seen and dedicated clinics are planned for certain conditions. Constraints of space and equipment restrict some of the activities of the department but new facilities will be available hopefully by the end of the year and equipment has been ordered.
12. Social Work Department

Number of Clients Seen by the Social Worker per Month

<table>
<thead>
<tr>
<th>Month</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>29</td>
<td>111</td>
<td>140</td>
</tr>
<tr>
<td>February</td>
<td>18</td>
<td>62</td>
<td>80</td>
</tr>
<tr>
<td>March</td>
<td>8</td>
<td>21</td>
<td>29</td>
</tr>
</tbody>
</table>

Comments

The social work department is run by a single social worker Mr P Gumede. The work load is heavy and involves a lot of traveling to patients homes as well as seeing clients in the hospital and in clinics. Mr Gumede was away during most of March reflected in the small number of clients seen. We are planning to motivate for another social worker and a dedicated vehicle for use by the social work department.

13. Dental Department

A) Number of treatments undertaken in January  61  
B) Number of treatments undertaken in February  111  
C) Number of treatments undertaken in March     0  

Comments

The dental department is staffed by a dental therapist and two assistants. The dental therapist was away during March therefore no treatments were undertaken. We plan to try and employ a dentist in the future. The department is awaiting inspection before the decision as to whether to allocate a dentist is made.
14. Psychology Department

Number of Sessions Performed by Setting (Statistics for March only)

<table>
<thead>
<tr>
<th>Month</th>
<th>Outpatients New / Old</th>
<th>Inpatients New / Old</th>
<th>PHC patients New / Old</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>21 / 18</td>
<td>9 / 11</td>
<td>6 / 0</td>
<td>65</td>
</tr>
</tbody>
</table>

Also 1 group session performed

Morbidity profile – by number of sessions performed

1. Schizophrenia 20 sessions
2. Diagnosis uncertain 10 sessions
3. Adjustment disorder with depressed mood 9 sessions
4. Major depressive disorder 7 sessions
5. Learning disability 7 sessions
6. Attempted suicide 4 sessions
7. Personality disorder 3 sessions
8. Bereavement 2 sessions
9. Sexual abuse 2 sessions

Comments

The psychology department is staffed by a community service psychologist and a psychiatric trained professional nurse. The department has purpose build facilities situated in the hospital crisis centre. The service is still relatively new but is developing rapidly.

15. Antiretroviral Therapy and HIV/AIDS Department

Antiretroviral data for 2005, patients on therapy at the end on March 2005.

Patients currently on therapy
Males 62
Females 129
Regimen 1a 104
Regimen 1b 76

Children on therapy 9 Total 189

Comments

The data shown here are just a snapshot of the activity of the department. More detailed data will be presented in the next issue. It is hoped that total number of HIV tests, total number of CD4 counts, number of people of treatment and number of people with suppressed viral loads will be reported.
16. Conclusions

The data presented here are far from perfect. Many indicators are missing, especially discharge data which meant that certain indicators had to be calculated from a combination of the number of admissions and an estimate of total number of discharges. The problems with the data are almost certainly teething problems as the hospital has a new facilities information officer and he has yet to become established and undertake training of the ward and various department staff on the correct data recording and collection techniques. Despite the inconsistencies in data collection the report shows the great effect of HIV/AIDS on the majority of the work done in the majority of the hospitals departments. It is hoped that ART will have a positive effect of the amount and spectrum of conditions seen.

The hospital is currently in a state of some disarray due to building work. Many wards are doubling or even tripling up at present. For example the female surgical ward is currently lodging on the female medical ward, which was itself already lodging on the paediatric ward. The hospital laboratory is also lodging on the paediatric ward. Other departments under great stress are the high dependency unit, therapy department and male medical and surgical wards. The completion of the building project will help these services.

Future quarterly reports will aim to collect the above data in a more accurate fashion. Also data will be added on the work of the antiretroviral programme, theatre statistics, OPD statistics, pharmacy data, radiology data, waiting time audits, mortality and morbidity reviews, quality improvement programmes, audits and some data from the primary health care clinics. The process will be slow but it is hoped that over the coming year this report will evolve into a document that is useful for the hospital management and staff, the district office and eventually the consumers (people of Hlabisa) by indicating the type and quality of work under taken by the hospital.

Martin Dedicoat
Medical Manager