Leadership, Governance, and Organisational Accountability

The human factor: from the bedside to the boardroom

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SAMLA CONFERENCE | 9 OCTOBER 2026

Outline

- Over risks visible
- Patient safety culture
- Building trust
- Accountability
- Governance

THE MATERNITY WARD

Thabo is one of two professional nurses and the only midwife in a busy maternity ward. He cannot properly care for a high-risk teenage girl because he is running between five patients. Because of staff shortages, he has team members complete all clinical documentation at the end of the shift, as they have no time to do so during the shift.

A night shift. A harm. An earlier warning.

THE SHIFT

- Over capacity.
- Below planned cover.
- No qualified midwife on duty.

THE INCIDENT

- Fetal monitoring is not interpreted promptly.
- Delivery is delayed.
- APGAR score is forged.
- The baby is harmed.

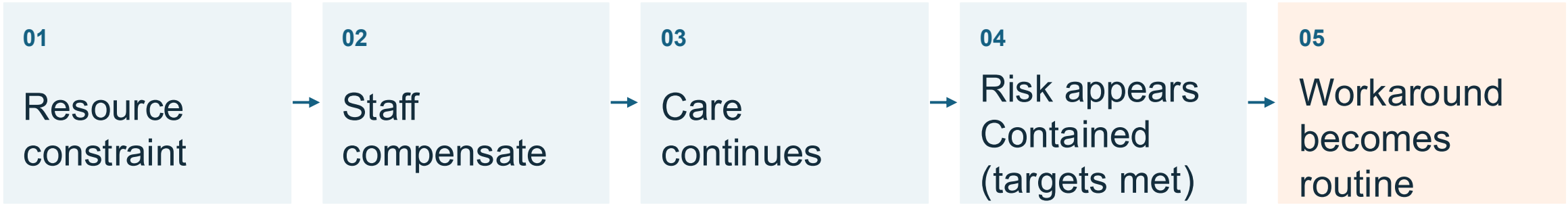
THE EARLIER SIGNAL

An audit had identified monitoring and escalation gaps.

TARGET: Improve patient monitoring practices by 30% and clinical documentation by 20%.

Would another quality alert or training address the problem and improve clinical outcomes?

The service continued. The hazard remained.



THE UNDERLYING CONSTRAINT REMAINS IN THE SYSTEM and DEVIENCE IS NORMALISED.

Normalisation of deviance in healthcare occurs when repeated, unsafe departures from standard operating procedures gradually become routine, accepted practice because they do not immediately result in patient harm. (American Society for Health Care Risk Management)

Resilience without justice

> If a health system requires extraordinary resilience from ordinary healthcare workers every day simply to function, the ethical question is not whether workers are resilient enough, but whether the system is just. The governance question is not whether staff are coping. It is whether the organisation is managing risk.

Is the system managing risk or asking people to carry it?

MAKING RISKS VISIBLE

Read the incident against the conditions of the shift

DEMAND AND ACUITY

Who needed care?

STAFFING AND SKILL MIX

Who was actually on duty?

SUPERVISION

Who was available and called?

EQUIPMENT AND PROCESSES

What was usable?

COMMUNICATION

What information travelled?

PREVIOUS WARNINGS

What had already been raised?

What was demanded? What was available? What choices remained?

PERFORMANCE AND INCENTIVES

A target is not a resource.

TARGET

What result are we asking the team to achieve?

CAPACITY

What would safe care require?

CONSEQUENCES

What happens when the team cannot meet targets?

Measure the result and the conditions required to achieve it safely.

Look for the adaptations and co-create solutions; implement, MONITOR, ADJUST!

Scarcity is real but not the end.

LEADERSHIP AND CULTURE

Culture is what happens when a concern is raised

THE POLICY

"Please speak up."

THE EXPERIENCE

Was I heard?
Was I treated fairly?
Did anything change?

Leaders set the tone through the response, not the invitation.

PATIENT-SAFETY AND ETHICS SURVEYS

Ask. Listen. Act. Report back.

VOICE

I can safely raise a concern.

EXPECTATIONS

Targets reflect our working conditions.

ACTION

Risks raised are acted on.

ETHICS SUPPORT

I can access ethics support.

DIGNITY AND SAFETY

Patients' dignity and safety is protected.

FEEDBACK

We hear what changed after reporting.

Use findings to open enquiry and agree visible action.

RECIPROCAL ACCOUNTABILITY

Accountability has to travel both ways.

CLINICIAN	Judgement, honest communication and professional conduct.
MANAGER	Support the team, assess concerns and escalate unresolved risk.
EXECUTIVE	Make priorities, resource decisions and residual risks explicit.
OVERSIGHT*	Seek assurance, monitor improvement, challenge decisions and follow through.

Ask about authority, knowledge, decisions and response.

PEOPLE, DIGNITY AND FAIRNESS

Human rights belong in governance.

Equal moral worth. Different roles and obligations.

PATIENTS

Dignity and privacy
Voice and respectful care
Fair access

HEALTH WORKERS

Respect and support
Safe routes to raise concerns
Fair working expectations

Whose voice is missing from the decision?

Medicolegal audits

Finding in sampled folders	Hospital A	Hospital B	Hospital C
Sterilisation consent taken during labour	0 of 11	2 of 14	5 of 19
Interpreter recorded where one was needed	40%	25%	12%
Child abuse reports filed against suspected cases	5 of 6	2 of 5	1 of 9
Restraint charts complete for mental health users	70%	55%	30%
Patients operated without signed informed consent	0 of 10	7 of 10	9 of 10

Synthetic data — illustrative only

The incident form asks what the ward looked like at the time

Captured with every incident

- Beds occupied against approved / active beds
- Acuity score of the ward on that shift
- Staff on duty against staff planned
- Scarce skill present: midwife, ICU-trained nurse, anaesthetist
- Supervising consultant contactable and called
- Time of day and day of week

61%

Of serious adverse incidents happened on shifts staffed below plan for the measured acuity

9

of those shifts had no one on duty holding the qualification the case required

412 incidents in twelve months across the district: 38 severe, 96 moderate, 278 minor or near miss. Maternity accounts for 31 percent of the severe ones.

Synthetic data — illustrative only

ACCOUNTABILITY IN ACTION

Identify the cause before fixing

What identified gap is the action intended to address?

IDENTIFIED GAP	POSSIBLE RESPONSE
Knowledge gap	→ Targeted education and support
Roster or skill-mix gap	→ Staffing plan, mitigation and escalation
Supervision gap	→ Clear call criteria and accessible senior cover
Form or process gap	→ Redesign and test the workflow

Training may be appropriate. It should not be the automatic answer.
Litigation and complaints are a proxy for ethics and human rights violations

Risk must travel up. Decisions must come back.

- The high revenue generator

  = *economic capital*

- The only orthopaedic

  surgeon in the district

  = *expert capital*

- The influential practitioner

  = *sociopolitical capital*



"Noted" is not resolved. Escalation is not the end of the response.

INTERNAL AND EXTERNAL TRUST

Trust needs a visible response.

Inside: staff experience. Outside: patients and families.

HEAR	ACKNOWLEDGE	INVESTIGATE	ACT	REPORT BACK
Listen to the concern	Say what is known	Examine the evidence	Address what is found	Explain and monitor improvement

Show what changed, what remains unresolved and why.

A PRACTICAL GOVERNANCE PROMPT

Five questions for leadership.

SEE	HEAR	ENABLE	RESPOND	LEARN
What risk are we missing?	Can people tell us the truth?	Have we made safe work possible?	Who acts when risk is raised?	What changed and did it work?

Clinical, operational, human rights, and ethics risks.
Medical litigation is a proxy for unresolved ethical and governance failures.

He who conceals his disease cannot be healed (African proverb)

OHSC AUDITS

The district has a green emergency-readiness score. The emergency trolleys are available with evidence of daily checks and are fully stocked. After the audit, staff return equipment, drugs and other items to the units and facilities from which they were borrowed. A week after the audit a polytrauma patient died in the emergency department because there was no suitable endotracheal tube to initiate assisted ventilation.

HEALTHCARE GOVERNANCE

THE AUDIT WAS GREEN.
THE PATIENT WAS NOT SAFE.

When compliance becomes a performance rather than a commitment to patient safety.

THREE GOVERNANCE FAILURES

01 **FAILURE OF OVERSIGHT**

Leadership accepted evidence of readiness without assurance of everyday operational safety.

02 **FAILURE OF ETHICAL ACCOUNTABILITY**

Borrowing equipment to pass an audit concealed risk rather than addressing it.

03 **FAILURE OF CONTINUOUS ASSURANCE**

The system measured compliance on inspection day, not sustained readiness to save lives.

"Good governance is not demonstrated by what is available when auditors arrive, but by what remains available when patients need care."

Measure results, conditions, voice and response.

RESULTS

Outcomes, delays and missed care.
Who may be missing from the average?

CONDITIONS

Acuity, skill mix, equipment and supervision.
What did safe delivery require?

VOICE AND DIGNITY

Patient feedback, language support, safety and ethics surveys. Can concerns be raised?

RESPONSE

Named owners, overdue actions and feedback.
What changed after the concern?

Listen to what the measures miss. Act on both.

Fair accountability examines conduct and conditions.

INDIVIDUAL CONDUCT

- Judgement and actions
- Honesty and communication
- Realistic alternatives = Reasonableness

AND

ORGANISATIONAL CONDITIONS

- Resources and workload
- Incentives and authority
- Response to earlier concerns
- Undue pressure

Who knew what, held which authority, and did what next?

A PRACTICAL LEADERSHIP PROMPT

Five questions for leadership.

Before the next shift, ask...

01

SEE

What risk are we missing?

02

HEAR

Can people tell us the truth?

03

ENABLE

Have we made safe work possible?

04

RESPOND

Who acts when risk is raised?

05

LEARN

What changed and did it help?

Conclusion: A hidden hazard is not a resolved hazard.

LEADERSHIP | makes it safe to speak

GOVERNANCE | makes risks visible

ACCOUNTABILITY | makes the response traceable

SEE THE RISK | SUPPORT THE PEOPLE | CLOSE THE LOOP

Thank you!

What would have needed to change before the next shift?

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