Issue 01/08/2019

HPCSA
Health Professions Council of South Africa

Emergency Care NEWS

Newsletter for Emergency Care Professional Board

Overview of the Professional Boards' strategic outcome of Annual Performance Plan activities

The Professional Board developed and approved an annual performance plan 2018/19 and below is a report on the progress achieved of actual annual performance key activities set out in the annual plan in the year under review. The Annual performance plan set out three primary strategic goals (programmes) aligned to relevant performance indicators; (1) Guidance and Regulation to Emergency Care Professionals, (2) Advocacy, and (3) Sustainability and Accountability of the Board.

Goal (Programme) 1 (1.1 – 1.5): Guidance and Regulation to Emergency Care Professionals

Compliance with accreditation criteria; The annual accreditation cycle was adhered to resulting in 9 evaluations conducted with 6 evaluations for re-accreditation of existing emergency care programmes and 3 newly accredited emergency care programmes. In addition, the annual Moderation cycle was observed with about moderation of emergency care programmes examinations of the 14 training institutions was conducted as part of the professional board quality control measure.

Quality assurance of CPD; the Clinical Practice Guidelines (CPGs) were published on 13 August 2018 for use and implementation by emergency care providers. Practitioners are encouraged to obtain training on the new skills before practising the said new skills.

The process of approval of the new and/or additional medications is underway by the South African Health Products Regulatory Authority (SAHPRA), therefore the Board will announce once approval has been sought. Institutions wishing to offer training on the new skills in this regard are encouraged to apply for accreditation with the Board approved Accreditors (the list of approved accreditors is available of the Boards' website) and to sought approval for accreditation to offer the new skills in line with the CPGs.

Compliance with the rules, regulations, policies norms, values and standards of the profession; the Board reviewed and finalised most policies in line with new developments in the profession, namely the Board specific restoration guidelines, accreditation guidelines and reporting templates and the recognition Agreement with some of the Higher Education Institutions to conduct full assessments for short courses for those practitioners who have been off the register and wish to restore their names back to the register and/or those practitioners that obtain qualification and did not register with the HPCSA immediately after obtaining qualifications.

Furthermore, in the year under review, the Board approved establishment of the task team for the minimum standards where minimum requirements for the Bachelors' degree in Emergency Medical Care and Advanced Certificate in Emergency Medical Rescue were finalised; and a task team aimed to address stakeholder related issues related to the approved clinical practice guidelines.

Goal (Programme) 2 (2.1 – 2.2): Advocacy

*Development and Implementation of Stakeholder Engagement Plan; the Board approved the stakeholder engagement plan in the year under review. Further, t*he Board engaged several stakeholders on matters of mutual interest to the profession, namely; the Higher Education Institutions, National Committee for Emergency Medical Services (NCEMS) task team, South African Health Products Regulatory Authority (SAHPRA), Continuous Professional Development (CPD) Accreditors, participation at the Safety Symposium organised by the Cape Peninsula University of Technology and the Provincial Government of the Western Cape.

Goal (Programme) 3 (3.1 – 3.5): Sustainability and Accountability of the Board

Performance management of the Board and its committees. In the year under review, the Board approved the terms of references of the education, executive and clinical advisory committees to ensure that the committees activities were in line within their respective mandates.

The Board and related committees' annual performance was evaluated and reported to the Education, Training and Quality Assurance committee of council.

The Board through its mandate to the education committee managed to ensure that processes and procedures were adhered resulting in all submitted compliant as per the Board requirements foreign qualified registration and restoration of names were attended to and finalised in terms of the specified approval timeframes.

The Board and its committees handled and addressed all matters at the convened Board meetings by adhering to principles of good governance in line with with its legislative mandate, set Boards' processes, rules, policies and regulations.

The Health Committee and the Pre-hospital Emergency Care Provider

Mr W Van der Net

The Emergency Medical Services (EMS) in South Africa (SA) is arguably one of the most unique systems of healthcare in the country, and potentially the world. The EMS providers are faced with many challenges in the performance of their daily duties. These challenges may include work pressures, increasing risk of attacks carried out against the EMS providers and the lack of quality clinical governance systems within EMS providers.

The above challenges play an important role in the mental well-being of the EMS providers, and when added to the normal stress of everyday life in SA, situations may become overwhelming, even to the most experienced and "well-balanced" provider. For many of the EMS providers the need to function at a particular level within a system may result in the feeling that they cannot "cope" with the stress of their work or home lives. Unfortunately this may lead to the providers trying alternative ways of coping with the stress. When these coping mechanisms lead to an improved and healthier lifestyle, they will result in an improved focus and ultimately improved patient care when at work. When the coping mechanisms sought are unhealthy ones, such as drug or alcohol misuse, may lead to the EMS provider's inability to function in their respective discipline. This may result in poor decision making and, through the act of commission or omission, eventually patient care is neglected and the EMS provider becomes a risk to the patient, the prehospital emergency care profession and eventually their own lives.

In terms of the mandate of the Health Professions Council of South Africa (HPCSA) which is to "guide the professions and protect the public", the HPCSA is responsible for ensuring that our practitioners are *fit to practice*, and are *not impaired due to any physical or mental ill health*. As such, the Health Committee was established and is committed to the prevention, early identification, treatment and **rehabilitation** of impaired students and healthcare practitioners.

The Health Committee regulates/advises impaired practitioners who suffer from mental or physical conditions, or the abuse of or dependence on chemical substances, which affects the competence, attitude, judgment or performance of a student or a person registered in terms of the Health Professions Council Act, (Act 56 of 1974) section 51.

As can be seen above, the aim of the Health Committee is not a punitive one, but to protect the public from potentially harmful decision making by registered students and healthcare providers, but also to prevent any potentially serious health concerns, and ultimately rehabilitate registered persons so that they can continue performing the valuable work they are doing which is providing high quality prehospital emergency care to all, within the country.

As EMS providers, the decision to enter into this profession was hopefully one based on the need/desire to provide the best possible patient care within your specific scope of practice and then safely transporting them to the most suitable medical facility for definitive care and by doing so afford the patient the best possible opportunity to make a full recovery and return to their normal lives. When the stressors associated with our profession cloud our judgement, it may be time to acknowledge that we too are human, and as human beings we also need to sometimes pause, take stock of where we are and why we are doing what we are doing, and then if necessary reach out for help, before it is too late. This is not a sign that you cannot cope, but actually a sign that you are a mature, professional person acting in your own best interests as well as in the best interests of the patient.

For more information on the functions of the Health Committee, and the processes involved in ensuring safe practice, please visit the website at:

www.hpcsa.co.za/professionals/fitnesstopractice

Drowning is a preventable and under-recognised public health threat

Dr Colleen Saunders and Dr Navindhra Naidoo

[1] Division of Emergency Medicine, University of Cape Town; [2]Lifesaving South Africa, [3] Cape Peninsula University of Technology

Introduction:

Drowning cases, including both fatal and non-fatal incidents, are an under-recognised burden on the South African emergency care system.

Drowning is a preventable and under-recognised public health threat:

Drowning is defined as the process of experiencing respiratory impairment from submersion/immersion in liquid and can have one of three outcomes: a non-fatal incident with full recovery, a non-fatal incident with associated morbidity or death.[1] In 2012, the WHO African region accounted for approximately 20% of global drowning deaths.[2]

In recent years, there has been increased recognition of drowning as a contributor to injury deaths within South Africa. However there is limited surveillance data available to inform intervention programmes and the strategic implementation of prevention efforts in our resource-limited setting.

A 2018 systematic review of fatal drowning in South Africa[3] aimed to review the available data describing fatal drowning in South Africa and identify priority intervention areas. This review included 40 articles and reports publishing data collected between 1995 and 2016, but was largely focused on urban settings. The fatal drowning burden in South Africa was found to be stable at approximately 3,0 per 100 000 population (an average of 1541 drownings a year between 2011 and 2015) and is increasing as a proportion of all non-natural deaths. Drowning mortality rates are high in children under the age of 15 years, most particularly in children under the age of five years old.

This increased recognition of the drowning burden in South Africa has also led to the development of a regional strategy for drowning prevention and water safety within the Western Cape.[4,5] The development of this strategy was a collaboration between many Western Cape Government departments, the South African Medical Research Council and University of Cape Town, as well as rescue and emergency services within the Western Cape.

These two reports build on our understanding of the key risk factors that contribute to preventable drowning deaths and injury in South Africa. Briefly, these are:

- Sex: The ratio of male-to-female drowning deaths is approximately 4:1
- Age: The highest drowning rates are seen in children under five years old, with high rates also seen in young, adult males (20-34 years) and the elderly
- Blood alcohol content: Alcohol has been detected in approximately 40% of drowning fatalities where blood analysis was done.[6]

Exposure: Fatal drowning incidents occur predominantly over weekends and public holidays, and between 12h00-20h00

Both reports highlight lack of data describing non-fatal drowning, and call for more robust and routine surveillance of the factors contributing to both fatal and non-fatal drowning in South Africa. There is evidence to suggest that there are differences in the factors contributing to drowning in rural and urban settings, as well as differences between age groups. Robust data will allow for a more nuanced approach to drowning prevention in different at-risk groups, and contribute to the elimination of 1500 preventable deaths every year.

References:

1. Van Beeck EF, Branche CM, Szpilman D, et al. A new definition of drowning: towards documentation and prevention of a global public health problem. Bull World Health Organ 2005;83:853–6.
2. Peden MM, McGee K. The epidemiology of drowning worldwide. Inj Control Saf Promot 2003;10:195–9.
3. Saunders, CJ, Sewduth, D, Naidoo, N. Keeping our heads above water: A systematic review of fatal drowning in South Africa. South African Medical Journal 2018; 108(1):61-68
4. Saunders CJ, Adriaanse R, Simons A, and van Niekerk, A. Fatal drowning in the Western Cape, South Africa: a 7-year retrospective, epidemiological study. Injury Prevention 2018; doi: 10.1136/injuryprev-2018-042945
5. https://www.westerncape.gov.za/project/western-cape-strategic-framework-drowning-prevention-and-water-safety-0
6. Donson H, Van Niekerk A. Unintentional drowning in urban South Africa: a retrospective investigation, 2001-2005. Int J Inj Contr Saf Promot 2013;20:218–26.

FREQUENTLY ASKED QUESTIONS RELATING TO CLINICAL PRACTICE GUIDELINES

NATURE OF ENQUIRY	RESPONSE
Have the Clinical Practice Guidelines (CPGs) been officially adopted by the Health Professions Council of South Africa (HPCSA) Professional Board for Emergency Care (PBEC)?	Yes, the CPGs have formally been adopted by the PBEC.
May registered persons practice the skills that were previously not on their related scopes of practice?	Yes, provided that, you have successfully completed an accredited CPG Continuing Professional Development (CPD) activity.
What is the current situation regarding additional/new medications that have been added to the relevant scopes of practice?	Registered persons are encouraged to undergo CPG CPD activities related to these medications. However, until approval by the South African Health Products Regulatory Authority (SAHPRA) approval, these may not be used in clinical practice yet. Registered persons will be notified when approval has been obtained. The finally approved SAHPRA list may appear different to the current list.
What is an accredited CPG CPD activity?	These are CPD activities offered by accredited service providers or service providers where the specific activities related to the CPGs have been assessed and accredited.
Who currently offers the CPG CPD activities?	Please visit the HPCSA website to see a list of providers.
Who may apply to offer CPD activities related to the CPGs?	Any individual, service provider or accredited service provider may apply to offer CPG CPD activities via an Accreditor.
Why do I have to undergo CPG CPD related activities for skills or medications that I may already be familiar with or have previously used?	It is possible that at the time of the offering of your specific qualification, this teaching/training of that skill/medication may not have formed part of that curriculum/course (subsequently added to the scope of practice without additional training). Therefore, to ensure patient safety, these skills/medications require CPG CPD related activities. In addition, the context of the skill and medication that previously was on the scope of practice may have changed.
Has a task team been established by the HPCSA and National Department of Health regarding the CPGs and what is its function?	Yes, this was an internal advisory and discussion forum. Decisions emanating from this task team were sent to the PBEC for final consideration and communication.
There was confusion around the 31st of December 2018 date mentioned in the last formal communication related to the CPGs. What did this date mean?	This served merely as a familiarisation period, and to allow existing emergency service providers an opportunity to adjust their human resource structure. Skills and medications previously on the relevant scopes of practice must have and should have ceased by the 31st of December 2018.
Should I have been familiar with all of the content of the CPGs by the 31st of December 2018?	No, the document is of such a nature that ongoing training and education regarding the CPGs will continue well into 2019 and 2020.

NATURE OF ENQUIRY	RESPONSE
Will I be allowed to continue with training and education of the CPG content and related material beyond 31 December 2018?	Absolutely, this is an expectation and is absolutely encouraged.
May my employer instruct me to practice outside of my scope of practice?	No, this is not permitted. You must practice within your relevant scope of practice, as you as an individual is registered with the HPCSA, not your employer
May I transfer a patient on medications or on equipment/devices that are not within my scope of practice?	Permission and consultation with the transferring healthcare provider must be sought. Where additional interventions (commencement) or alterations of in-situ medications and equipment/devices (which are not in the scope of practice) are likely, this transfer should be undertaken by a registered Emergency Care Provider with a relevant skill set. Where no considerable alterations/ amendments to the medications or equipment/devices are necessary, this transfer may be undertaken (this is strictly applicable to an interfacility transfer context). Registered persons undertaking these transfers must be prepared to act in the case of acute deterioration.
Is a more definitive, prescriptive guide to clinical practice being developed?	Yes, by using the existing CPGs, a more regimented guide to clinical practice is currently being explored. This will be particularly relevant to common conditions and scenarios.
Will the CPGs and related scopes of practice change in future?	Yes, this is the first guide of its kind in the South African emergency care context, and updates and amendments will follow.

SAFETY OF EMERGENCY CARE PERSONNEL, AUGUST 2018

Mr Victor Voorendyk

The Professional Board for Emergency Care has noted the increasing and disturbing trend of criminal attacks on emergency medical service (EMS) professionals at work. Between January and June 2018, there were eight reported incidents of such attacks on EMS personnel working for the Western Cape Department of Health alone[1]. While members of the profession have called for more stringent safety measures to be introduced by their employers, it is important to keep the principles of personal safety in mind when attending to incidents in the *out-of-hospital* setting.

Persons in distress become highly vulnerable when a medical emergency strikes, and it is the responsibility of EMS professionals to render aid in these circumstances. To an extent then, a patient's vulnerability becomes shared by their attending EMS provider, whose main focus in the heat of the moment is to provide care for the victim – this makes the scene of a medical emergency a particularly easy situation for criminals to exploit. EMS professionals are easily overwhelmed by their sense of duty towards patients and the public, sometimes to an extent where the most basic principles of personal safety are either neglected or forgotten.

The responsibility for the personal safety of EMS professionals at work is a multi-faceted one, ranging from public safety authorities – such as the South African Police Service (SAPS) and other law enforcement bodies – to employers, and even to members of the communities which we as EMS professionals serve. The greatest and final responsibility, however, remains on the shoulders of the individual EMS provider concerned. From this point of view, EMS professionals are encouraged to always remember (and actively think about) the golden rule of *"safety first".*

Taking responsibility for one's personal safety at work involves developing a keen sense of situational awareness. This means being aware of what is happening around you in terms of where you are, where you are supposed to be, and whether anyone or anything around you is a threat to your health and safety. It is absolutely critical for EMS professionals to briefly stop and think about any actual or potential hazards that may be attached to a particular incident type, location and even time.

Interestingly, but unsurprisingly, Statistics SA found that night time remains the most preferred time for incidents of crime to occur. There have been unfounded and ill-informed calls in recent times from trade unions to simply suspend the delivery of EMS services at night, this approach completely flies in the face of the values and norms of the EMS profession. It is essential to find a fair balance between the employment rights of EMS professionals and their ethical duties towards the public. For instance, it is ethically and professionally justifiable for an ambulance crew to delay their entry into an area of known danger in order to wait for SAPS support, and similarly for them to withdraw from any scene where their personal safety becomes compromised. It is, however, wholly inexcusable to either threaten violence or interrupt service delivery to the public as a collective organisation or body of professionals due to the mere fact of crime.

In this regard, EMS employers and health authorities must develop and progressively implement relevant guidelines and policies for the assurance of employees' safety in the workplace. It is the responsibility of the EMS agency or employer to ensure that its personnel properly understand and can implement scene safety policies and protocols that will help protect them and their patients[5]. It is also important to have a highly integrated level of involvement between EMS agencies, healthcare authorities and the police respectively to ensure that adequate and speedy support is available for EMS professionals on the ground in a manner that will not unduly delay the provision of urgent medical care to patients in need.

Personal safety in the workplace is a shared responsibility. Whooped sense of situational awareness.

REFERENCES

1. Smith, G. 2018. At least 8 EMS attacks, robberies recorded in WC since January. *Eyewitness News,* 12 June. https://ewn.co.za/2018/06/12/at-least-8-ems-attacks-robberies-recorded-in-wc-since-

january Date of access: 1 August 2018.

2. Health and Safety Executive (HSE). 2012. Information sheet from Seven Step, Step 6. www.hse.gov.uk/construction/lwit/assets/downloads/situational-awareness.pdf Date of access: 1 August 2018

3. Statistics South Africa (Stats SA). 2017. *Report 03-40-04 - Crime statistics series vol IV: Exploring the extent of and circumstances surrounding housebreaking/burglary and home robbery*, 2015-2016). http://www.statssa.gov.za/?page_id=1854&PPN=Report%2003-40-04&SCH=7018 Date of access: 4 August 2018

4. Mashaba, S. Paramedics threaten to end night shift. *Pretoria News*, 23 May 2018. https://www.iol.co.za/pretoria-news/paramedics-threaten-to-end-night-shift-15116088 Date of access 2 August 2018.

5. National EMS Safety Council. 2017. Guide for developing an EMS Agency Safety Program. *www.naemt.org/docs/.../ems...safety.../nemssc/ems-safety-program-guide-10-11-17.pdf Date of access: 2 August 2018.*

The Constitution of the Republic of South Africa,

"REPORTING OF CHILD ABUSE BY EMERGENCY CARE PROVIDERS" ABRIDGED AND REVISED VERSION

Act 108 of 1996 notes, amongst others, that "a child's best interests are of paramount importance in every matter concerning the child". Section 28 of the Constitution also gives every child the right to be protected from maltreatment, neglect, abuse or degradation.

On 1 April 2010 the Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) was enacted. The main objective of the Children's Act is to give effect to children's constitutional rights. The Children's Act further highlights that "health professionals are also obliged by law to report suspected cases of abuse and deliberate neglect."

Section 110(1) of The Children's Act expands the range of professionals that are legally obliged to report abuse of children, but limits what must be reported on:

- Sexual abuse;
- Physical abuse causing injury; and
- Deliberate neglect.

Section 110 reads:

"(1) ...on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official."

Based on this, it is evident that, when called to provide assistance to a child, the responsibility of the emergency care provider extends beyond that of clinical intervention, but also to identify and report child abuse and/or neglect. In cases where the emergency care provider has a high index of suspicion of child abuse and/or neglect then:

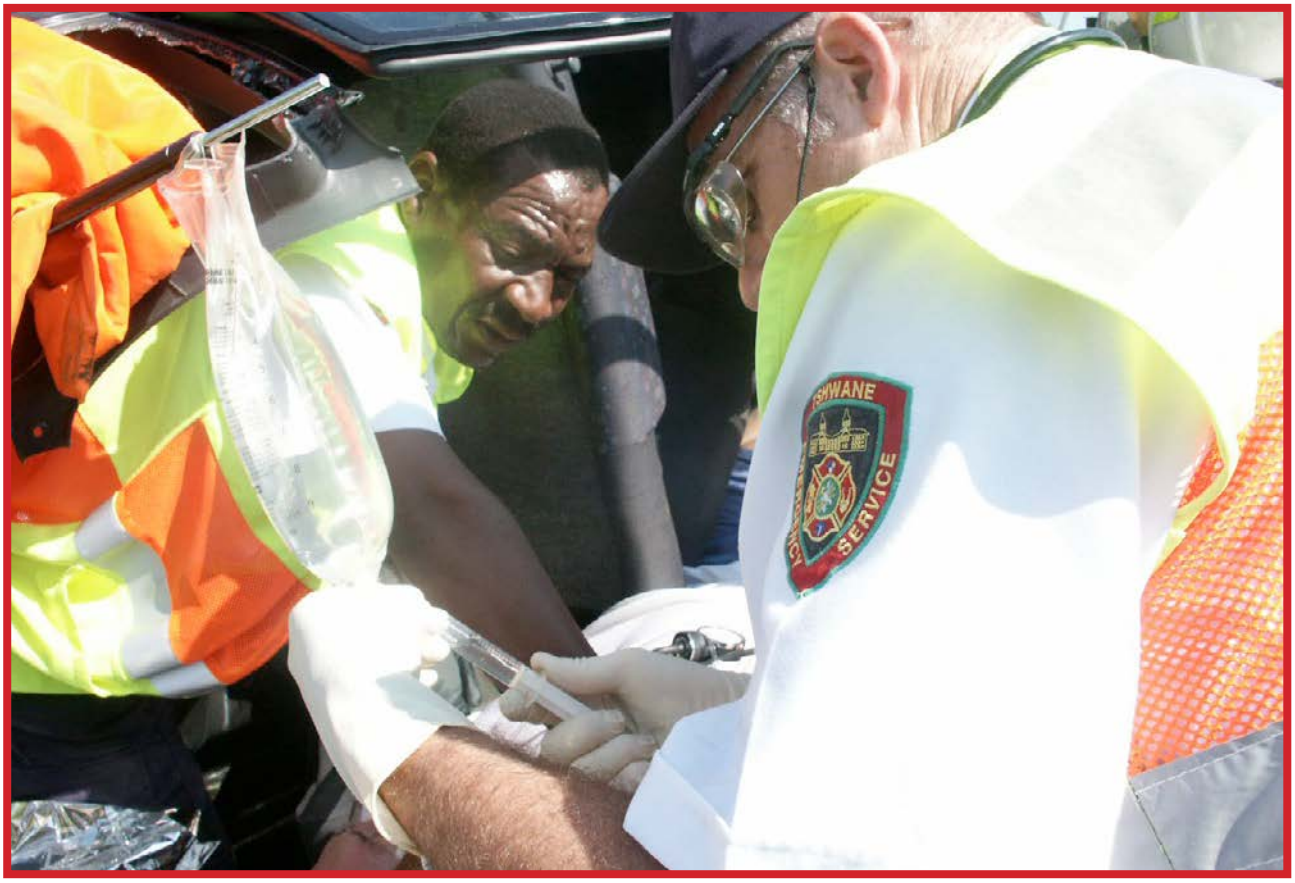
- In all instances, complete and accurate documentation is paramount.
- In the event that a paediatric patient is

transported by emergency care providers to a medical facility, there is a responsibility of the emergency care provider to provide a detailed handover as well as documentation to the receiving healthcare professional.

- The suspicion of abuse and/or neglect must be reported to the Unit Manager/ Head of the Unit.
- Following this, the Unit Manager/ Head of the Unit can then follow the guidelines in the relevant Act/s.
- In the event that a paediatric patient is not transported, emergency care providers must report the suspicion of abuse and/or neglect to the nearest South African Police Service official. If the reporting is done in *Good Faith* with adequate substantiation to the relevant authorities, emergency care providers responsible for the reporting will not be held liable for any further action if no abuse and/ or neglect has occurred.

This document is to be read in conjunction with:

- Practice Guideline: Emergency Care provider's obligation to report abuse against children, and
- Children's Act Guide for Health Professionals, 5th addition, December 2013.



PROFESSIONAL REGISTRATION CATEGORY CONSOLIDATION

The Health Professions Act 56 of 1974, the Professional Board for Emergency Care (PBEC) is responsible for the professional registration of the holders of recognised qualifications in emergency care in the relevant registration and practice categories. Within the current regulatory framework, the PBEC is in the process of aligning the categories of registration within the emergency care profession with three tiers of practice.

The following categories of registration exist within the emergency care profession:

- Basic Ambulance Assistant (BAA)
- Ambulance Emergency Assistant (AEA)
- Paramedic (ANT)
- Emergency Care Assistant (ECA)
- Emergency Care Technician (ECT)
- Emergency Care Practitioner (ECP)
- Operations Emergency Care Orderly (OECO)
- Various Student Registers

In line with the Clinical Practice Guidelines (CPGs), the PBEC will ultimately define three scopes of practice (Emergency Care Assistant, Paramedic and Emergency Care Practitioner). It is envisaged that all professionals registered with the PBEC will practice within one of these scopes of practice after the completion of PBEC recognised qualifications and learning activities.

The PBEC has received a number of queries regarding educational progression as well as the movement from one registration category to another. Regarding educational progression, registered persons are encouraged to contact the Higher Education Institutions offering the emergency care qualifications to determine their academic standing, access options and Recognition of Prior Learning (RPL) policies.

The PBEC is encouraged by an initiative that involves a programme, which after successful completion, will lead to access to study one of the higher education emergency care qualifications in line with higher education institution specific access requirements. This will prove to be particularly useful for those who do not currently hold the minimum requirements to gain access to the higher education qualifications. The PBEC supports employer involvement and support for employee further education and training.

Regarding the movement from one registration to another, the PBEC wishes to advise that after successful completion of a recognised qualification leading to registration within a specific category, holders of the qualification are able to apply to the PBEC for registration within a specific category. For existing emergency care providers, where personal desire exists, the PBEC envisages that:

- Existing BAAs, currently on the BAA register, register in the ECA category after successful completion of the one-year Higher Certificate in Emergency Care;
- Existing AEAs, currently on the AEA register, register in the ECA category after completion of PBEC approved Short Learning Programme (SLP) which is still to be developed;
- Existing OECOs, currently on the OECO register, register in the ECA category after completion of PBEC approved SLP which is still to be developed;
- Existing ECTs register in the Paramedic (ANT) category after completion of a PBEC approved SLP which is still to be developed;
- Emergency Care Assistants (ECA), after successful completion of a recognised bridging programme, complete the Diploma (NQF 6) in Emergency Medical Care programme allowing for registration in the Paramedic (ANT) category.
- Diploma (NQF 6) in Emergency Medical Care currently on the Paramedic (ANT) register, after successful completion of a recognised bridging programme, complete the professional Bachelor's degree allowing for registration in the ECP category.
- Existing Paramedics (in the ANT category), in line with their academic standing, approach higher education institutions to determine a suitable point of entry for one of the HEI qualifications;
- Considering the above, the PBEC wishes to state that, all registered persons who wish to remain in their existing registers have the option to do so.

It must be noted that persons that do not move into an alternative registration category, will be entitled to practice within the registration category in which they remain registered. Naturally, movement from one registration category to the next will require formal registration application to the Health Professions Council of South Africa (HPCSA).

GENERAL INFORMATION

Health Professions Council of South Africa

For any information or assistance from the Council direct your queries to the Call Centre.

Tel: 012 338 9300/01

Fax: 012 328 5120

Email: info@hpcsa.co.za

Where to find us

Corner Hamilton and Madiba Streets

Arcadia, Pretoria

P. O. Box 205

Pretoria 0001

Working Hours:

Monday – Friday: 08:00 – 16:30

Weekends and public holidays – Closed

Certificate of Good Standing/Status, certified extracts verification of licensure

Stanton Prinsloo

Tel: 012 338 3940

Email: hpcsacgs@hpcsa.co.za

Service Delivery

Tel: 012 338 9301

Email: servicedelivery@hpcsa.co.za

Complaints Against Practitioners: Legal Services

Fax: 012 328 4895

Email: Legalmed@hpcsa.co.za

Statistical Information and Registers:

Yvette Daffue

Tel: 012 338 9354

Email: yvetted@hpcsa.co.za

Registrations Related Matters

Tel: 012 338 9469

Email: registrationgroup@hpcsa.co.za

Continuing Professional Development (CPD)

Helena da Silva

Tel: 012 338 9413

Email: cpd@hpcsa.co.za

Raylene Symons

Tel: 012 338 9443

Emails: raylenes@hpcsa.co.za

Change of contact details

Email: records@hpcsa.co.za

Ethics and professional practice, undesirable business practice and human right of Council:

Namhla Manciya –

Nati Hoho

Tel: 012 338 9446

Tel: 012 338 9322

Email: Professionalpractice@hpcsa.co.za

Finance Related Matters

Email: FinanceDept@hpcsa.co.za

Public Relations and Communications Related

Connie Parasaruman

Tel: 012 338 9397

Email: ConnieP@hpcsa.co.za

Communication with the Board

Email: Emergencycare@hpcsa.co.za

Tel: 012 338 9497/3922/3964