

QUESTIONNAIRE: PRIVATE HOSPITAL APPLYING FOR "A" STATUS

quest. A
October 1992

**QUESTIONNAIRE
FOR COMPLETION BY A PRIVATE HOSPITAL
APPLYING FOR "A" STATUS IN TERMS OF
THE SCALE OF BENEFITS**

NAME OF INSTITUTION: _____

ADDRESS : _____

POSTAL ADDRESS : _____

TELEPHONE NUMBER : _____

PERSON IN CHARGE : _____

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The answers to this questionnaire are to be interpreted by the Surveyors in accordance with the guidelines as set down in the Manual of Criteria for awarding a Private Hospital “B” Status in terms of the Scale of Benefits.

Those items in the questionnaire marked with an asterisk, thus *, are to be regarded as essential elements. Failure to comply with these items will result in the applying hospital being refused “B” Status recognition.

Recommendations by the surveyors can only be made following an on-site inspection of the respective hospital.

The following documents and records, if applicable, should be made available for scrutiny by the surveyors at the time of inspection:

	Seen
Current Certificate of Registration in terms of R.158	_____
Registration Certificate of Pharmacy issued by Pharmacy Council	_____
Patient Register	_____
Operation Register	_____
Maternity Register	_____
Drug Register	_____

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1. REGISTRATION

<p>1.1 Does your institution comply with the Regulations governing Private Hospitals as published under Government Notice R.158 in Government Gazette 6832 dated 1 February 1980?</p>	<p>Yes/No</p>
<p>1.2 Has the institution been granted any exemption from compliance with these regulations?</p>	<p>Yes/No</p>
<p>1.3 Date of original registration _____</p>	

1.4 **Copy of current Certificate of Registration to be attached hereto.**

SURVEYORS’ COMMENTS:

2. WARD ACCOMMODATION

<p>2.1 Bed Numbers:</p> <p>Number of beds in general wards</p> <p>Number of beds in semi-private wards</p> <p>Number of beds in private wards</p> <p>Total number of beds</p>	<hr/> <hr/> <hr/> <hr/>
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2.2	Bed numbers in category:	
	Number of beds usually allocated to:	
	Surgical	_____
	Medical	_____
	Maternity	_____
	Paediatric	_____
	Day Beds	_____
	Psychiatric	_____
	Other	_____
*2.3	Services	
	* 2.3.1 Are the hospital wards piped for oxygen?	Yes/No
	* 2.3.2 Are the hospital wards piped for vacuum?	Yes/No
	* 2.3.3 Does each bed have an adequate nurse call system?	Yes/No
	* 2.3.4 Can every bed be made private through the use of inter-bed curtains?	Yes/No
	2.3.5 Are all toilets and bathrooms serviced by a call system?	Yes/No
2.4	Emergency Trolley	
	*2.4.1 Does each ward section have access to an emergency trolley?	Yes/No
	2.4.2 Does each emergency trolley contain adequate equipment and drugs as listed below?	
	Intubation aparatus	Yes/No
	Defibrilator	Yes/No

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	Monitor	Yes/No
	CPRBoard	Yes/No
	Ambu Bag / Equivalent	Yes/No
	Suction Apparatus	Yes/No
	Correct emergency drug supplies	Yes/No
	Emergency Oxygen Supply	Yes/No
2.5	Staffing – wards only	_____
	Number of SRN's	_____
	Number of SEN's	_____
	Number of ENA's	_____

SURVEYORS' COMMENTS:

* Staffing Ratios Adequate? **Yes/No**

3. OPERATING THEATRE UNIT

3.1 Theatre facilities

3.1.1 State total number of theatres: _____

3.1.2 Specify if any to the theatres are dedicated / specialised

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*	3.1.3	Piped services: Oxygen	Yes/No
		Nitrous Oxide	Yes/No
		Vacuum	Yes/No
		Compressed Air	Yes/No
		Alarm Panels	Yes/No
	3.1.4	Number of diathermy machines available (at least one per operating theatre)	_____
	3.1.5	Number of socket outlets per theatre	_____

3.2 Anaesthetic facilities

*	3.2.1	Number of anaesthetic machines available (at least one per operating theatre)	_____
*	3.2.2	Type or make _____ _____	
*	3.2.3	Number of ECG Monitors available (at least one per operating theatre)	_____
	3.2.4	Type or make _____ _____	

	3.2.5	Are scavenging facilities available?	Yes/No
3.3	Recovery Room		
*	3.3.1	State number of recovery room beds / trolleys	_____
*	3.3.2	Piped services: Oxygen	Yes/No
		Vacuum	Yes/No
		Alarm Panels	Yes/No
*	3.3.3	Is a properly-equipped emergency trolley as per 2.4 located in the recovery room area?	Yes/No

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* **3.4 Central Sterilising Department**

3.4.1 Number of autoclaves by type:

Steam _____

Ethylene Oxide _____

Other (specify) _____

3.4.2 Specify facilities for storage of sterile packs

3.5 Staffing

3.5.1 Theatres

Number of SRN's (with theatre diploma) _____

Number of SRN's (without theatre diploma) _____

Number of SEN's _____

Number of ENA's _____

3.5.2 Recovery Room

Number of SRN's _____

Number of SEN's _____

Number of ENA's _____

3.5.3 C D S

Specify staff category and number

* **3.5.4** Specify what arrangements are made for after hours and Emergency calls:

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SURVEYORS’S COMMENTS:

* Staffing Ratios Adequate **Yes/No**

4. **MATERNITY** (if applicable)

4.1 Number of licensed beds _____

4.2 Is a theatre for Caesarean Sections available? **Yes/No**

* 4.3 Specify what nursery facilities are available other than general Nursery:

Neo-natal nursery	Yes/No
Isolation nursery	Yes/No

* 4.4 If a neo-natal nursery is provided, indicate below what equipment is provided in the neo-natal nursery. Stipulate type or model as well as how many.

I C U Cribs _____

Incubator _____

Respirator / Ventilator _____

I V Controller _____

E C G Monitor _____

O² Monitor _____

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	Piped Services: Oxygen		Yes/No
	Vacuum		Yes/No
	Nitrous Oxide		Yes/No
4.5	Are phototherapy lights available in the nursery?		Yes/No
4.6	Number of labour wards	_____	
4.7	Delivery Rooms		
*	4.7.1 Number of delivery rooms	_____	
	4.7.2 Piped Services: Oxygen		Yes/No
	Vacuum		Yes/No
	Nitrous Oxide		Yes/No
*	4.7.3 Is entonox available on demand?		Yes/No
*	4.7.4 Is an infant resuscitation unit available in each delivery room?		Yes/No
*	4.8 Is a properly equipped emergency trolley located in the delivery room area?		Yes/No
4.8	Staffing – labour ward, nursery and post-natal ward.		
	Number of SRN's (with midwifery diploma)	_____	
	Number of SRN's (without midwifery diploma)	_____	
	Number of SEN's	_____	
	Number of ENA's	_____	

SURVEYORS'S COMMENTS:

* Staffing Ratios Adequate **Yes/No**

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5.	INTENSIVE CARE UNIT (if applicable) Ordinary Surgical / Medical ICU	
5.1	Number of beds: Surgical _____	
	Medical _____	
5.2	Is an isolation cubicle available?	Yes/No

5.3 Equipment in ICU. Specify number and type

- * Ventilators _____
- * Defibrillator _____
- * Blood gas analyser _____
- * I V Controllers _____
- * Monitors _____

Are monitors linked to a central console? **Yes/No**

*	5.4 Piped Services: Oxygen	Yes/No
	Vacuum	Yes/No
	Compressed Aid	Yes/No
*	5.5 Is a properly equipped emergency trolley located in the ICU?	Yes/No
*	5.6 Number of Power Points per bed	_____
*	5.7 Is the unit service by an air conditioner	Yes No
*	5.8 Staffing in ICU	
	Number of SRN's (with ICU diploma)	_____
	Number of SRN's (without ICU diploma)	_____
	Number of SEN's	_____
	Number of ENA's	_____
	5.9 Cardiac / Thoracic ICU (if applicable)	

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	5.9.1	Number of beds	_____
	5.9.2	Equipment specify number and type	_____
		❖ Ventilators _____	
		❖ IV Controllers _____	
		❖ Monitors _____	
		❖ Defibrillator _____	
		❖ Blood Gas Analyer _____	
		❖ Are monitors linked to central console?	Yes/No
*	5.9.3	Piped services: Oxygen	Yes/No
		Vacuum	Yes/No
		Compressed Air	Yes/No
*	5.9.4	Is a properly equipped emergency trolley located in the ICU?	Yes/No
*	5.9.5	Number of Power Points per bed	_____
*	5.9.6	Is the unit service by an air conditioner?	Yes No
	5.9.7	Staffing in Cardiac / Thoracic ICU	
		Number of SRN's (with ICU diploma)	_____
		Number of SRN's (without ICU diploma)	_____
		Number of SEN's	_____
		Number of ENA's	_____

SURVEYORS'S COMMENTS:

* Staffing Ratios Adequate **Yes/No**

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6. HIGH CARE WARD (if applicable)

6.1 Number of beds: Surgical _____

Medical _____

6.2 Equipment in H C W. Specify number and typ _____

* Monitor _____

* Respirator _____

* Defibrilator _____

* I V Controllers _____

* 6.3 Piped services : Oxygen **Yes/No**

Vacuum **Yes/No**

* 6.4 Is a properly equipped emergency trolley located in the H C W area? **Yes/No**

6.5 Staffing in H C W

Number of SRN's _____

Number of SEN's _____

Number of ENA's _____

SURVEYORS'S COMMENTS:

* Staffing Ratios Adequate **Yes/No**

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7. PHARMACY SERVICE

- | | | |
|-------|--|---------------|
| 7.1 | Is a dispensary serving the hospital located on the premises? | Yes/No |
| 7.2 | If no, how are dispensary requirements obtained?

_____ | |
| * 7.3 | If yes, attach a copy of the current Pharmacy Board approval of registration | |
| 7.4 | How many full-time qualified pharmacists are employed? | _____ |
| * 7.5 | Do the pharmacists offer a 24-hour call-service? | Yes/No |
| * 7.6 | Is a properly equipped emergency cupboard Available in the hospital? | Yes/No |
| 7.7 | Is an inflammable-store facility available? | Yes/No |

SURVEYORS'S COMMENTS:

- | | |
|----------------------------|---------------|
| * Staffing Ratios Adequate | Yes/No |
|----------------------------|---------------|

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8. CATERING FACILITIES

8.1 Is a main kitchen provided on the premises? **Yes/No**

8.2 If no, how are patient meals provided?

8.3 What food delivery system is employed in the hospital?

SURVEYORS'S COMMENTS:

9. LAUNDRY

9.1 Is a laundry located on the premises? **Yes/No**

9.2 If no, how is laundry processed?

9.3 If yes, does the laundry process all the hospitals laundry? **Yes/No**

9.4 If no, answer 9.2

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SURVEYORS’S COMMENTS:

10. PLANT AND EQUIPMENT

- | | | | |
|---|------|--|---------------|
| * | 10.1 | Hot water and / or steam supply | |
| | | Supplied by: Diesel / Gas / Coal-fired boilers | Yes/No |
| | | Electrical boilers | Yes/No |
| | | Steam generators | Yes/No |
| * | 10.2 | Disposal of waste other than refuse:
Incinerator | Yes/No |
| | | Macerator | Yes/No |
| * | 10.3 | Emergency power plant: | |
| | * | 10.3.1 Is an emergency power plant installed? | Yes/No |
| | * | 10.3.2 Does the system operate automatically in the event of a power failure | Yes/No |
| | * | 10.3.3 Are the operating theatre lights connected to a U P S? if not, is some other emergency lighting system available? | Yes/No |
| | * | 10.3.4 List of facilities which are served by the emergency power plant | |
| | | Theatre Lights | Yes/No |
| | | Delivery Room Lights | Yes/No |
| | | Strategic Corridor Lights | Yes/No |
| | | Socket Outlets – I C U | Yes/No |
| | | H C W | Yes/No |

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		Theatres	Yes/No
		Neo-Natal Nursery	Yes/No
		Recovery Rooms	Yes/No
		Delivery Rooms	Yes/No
		Air compressor	Yes/No
		Bed lift	Yes/No
*	10.3.5	What is the KVA rating of the emergency power plant?	_____

10.4 Air conditioning System

10.4.1 Wards

Are the ward areas air conditioned? **Yes/No**

If yes, what kind of system is installed **Yes/No**

10.4.2 Operating Theatres

Specify the kind of chilling, air-handling and filtration system installed in the plant which services the Operating theatres.

10.5 Maintenance

10.5.1 Does the hospital employ its own maintenance staff **Yes/No**

If yes, what is the staff compliment by category?

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10.5.2 If no, how is preventive maintenance and/or repairs effected?

10.5.3 What is the general state of all plant rooms and workshop facilities?

10.6 Fire Protection

10.6.1 Specify number and type of fire extinguishers installed in the hospital

10.6.2 Specify any other form of fire protection device installed in the hospital

10.6.3 Specify Emergency / Evacuation planning

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10.7 Vacuum System

* 10.7.1 Specify type of system installed

* 10.7.2 What back-up facilities are available in the even of a power failure?

10.8 Oxygen and Nitrous Oxide Supply

* 10.8.1 Specify the type of supply system installed

* 10.8.2 What back-up facilities are available in the event of a failure of the main system?

* 10.8.3 What low-level alarm system is in use?

10.9 Lifts - applicable in multi-story buildings

* 10.9.1 Specify the number, type and size lifts available in the building

10.10 Compressed air supply

* 10.10.1 Specify type of system installed

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SURVEYORS’S COMMENTS:

11. RADIOLOGY FACILITIES

* 11.1 Indicate what radiology facilities are available in the hospital

* 11.2 Are emergency X-ray facilities available after hours? **Yes/No**

SURVEYORS’S COMMENTS:

12. LABORATORY FACILITIES

12.1 Is a pathology laboratory located on the premises? **Yes/No**

12.2 If no, what arrangements are made for the collection of specimens?

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13. PLEASE RECORD ANY OTHER FACTS OR OPINIONS WHICH YOU MAY WISH TO BRING TO THE ATTENTION OF THE SURVEYORS:

SURVEYORS’S COMMENTS:

14 NAME OF PERSON COMPLETING QUESTIONNAIRE _____

DESIGNATION _____

SIGNATURE _____

DATE _____

KINDLY RETURN THE COMPLETED QUESTIONNAIRE TOGETHER WITH THE APPROPRATE SURVEY FEE TO:

THE PCNS DEPARTMENT
Board of Healthcare Funders of S.A
P. O Box 2324
PARKLANDS
2121

