

QUESTIONNAIRE FOR CLASSIFICATION OF AN APPROVED DAY CLINIC / UOTU

Quest.dc
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**QUESTIONNAIRE
FOR COMPLETION BY A DAY CLINIC OR
UNATTACHED OPERATING THEATRE UNIT
APPLYING FOR CLASSIFICATION AS AN
APPROVED UNATTACHED OPERATING THEATRE UNIT**

NAME OF INSTITUTION: _____

ADDRESS : _____

POSTAL ADDRESS : _____

TELEPHONE NUMBER : _____

PERSON IN CHARGE : _____

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Items in this questionnaire marked with an asterisk, thus*, are to be regarded as essential elements. Failure to comply with these items will result in the application for classification as an approved day clinic / unattached operating theatre unit not being considered.

An on-site inspection of the relevant clinic will be required in all instances.

The following records shall be made available for scrutiny by the surveyors at the time of inspection:

	Seen
Current Certificate of Registration in terms of R158	_____
Patient / Operation Register	_____
Drug Register	_____

1. REGISTRATION

<p>* 1.1 Does your clinic comply with the regulations governing unattached operating theatre units as published under government notice R158 in government Gazette 6832 dated 1 February 1980?</p>	<p>Yes / No</p>
<p>1.2 Has the clinic been granted any exemptions 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:

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<p>2. OPERATING THEATRE UNIT</p> <p>2.1 Theatres</p> <p>2.1.1 State total number of theatres : _____</p> <p>2.1.2 Piped services: Oxygen Nitrous oxide Vacuum Compressed air</p>	<p>_____</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>
<p>* 2.1.3 Electrical</p> <p>Number of socket outlets in each theatre _____</p> <p>* 2.1.4 Red-line area</p> <p>Is a sterile “red-line area within the theatre area Demarcated and correctly managed?</p> <p>If “no”, please explain.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are adequate change-room facilities for doctors and staff provided?</p> <p>2.2 Anaesthetic facilities</p> <p>* 2.2.1 Number of anaesthetic machines available (at least one per operating theatre) _____</p> <p>* 2.2.2 Number of ECG monitors available (at least one per operating theatre) _____</p> <p>* 2.2.3 Are schedule 5,6 and 7 drugs stored in an appropriate drug cupboard?</p>	<p>_____</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>

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SURVEYORS' COMMENTS:

3. RECOVERY FACILITIES

- * 3.1 Explain the method adopted and accommodation provided for the recovery of patient's post-anaesthetic

3.2 State number of recovery room beds / trolleys	_____
* 3.3 Piped services : Oxygen Vacuum	Yes / No Yes / No
* 3.4 Is a properly-equipped emergency trolley as described in Annexure A easily accessible to both the recovery room and the theatre staff?	Yes / No
* 3.5 Are screening-off facilities for patients provided?	Yes / No
* 3.6 Number of socket outlets provided	_____

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SURVEYORS' COMMENTS:

***4 STERILISING FACILITIES**

4.1 Number of autoclaves by type :

Steam _____

Ethylene oxide _____

Other (specify) _____

4.2 Specify facilities for storage of sterile packs

SURVEYORS' COMMENTS:

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*5. SLUICING FACILITIES	
5.1 Are adequate sluicing facilities provided?	Yes / No

SURVEYORS' COMMENTS:

6 PLANT AND EQUIPMENT

* 6.1 Emergency power plant :	
* 6.1.1 Is an emergency power plant / UPS installed?	Yes / No
* 6.1.2 Does the system operate automatically in the event of a power failure?	Yes / No
* 6.1.3 Are the following served by the emergency plant / UPS?	
Operating theatre lights	Yes / No
Strategic ward lights	Yes / No
Socket outlets in operating theatre	Yes / No
Socket outlets in recovery area	Yes / No
* 6.1.4 What is the KVA rating of the emergency power plant / UPS?	_____
* 6.2 Disposal of waste other than refuse :	
6.2.1 Does the clinic make use of an incinerator or Macerator?	Yes / No

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6.2.2 If “no” to both of the above, how is waste disposed of?

<p>* 6.3 Hot water and/or steam supply (if applicable)</p> <p>Supplied by : Electrical geyser</p> <p style="padding-left: 40px;">Steam generators</p> <p style="padding-left: 40px;">Other (specify) _____</p>	<p>Yes / No</p> <p>Yes / No</p>
<p>6.3 Air conditioning system</p> <p>6.4.1 Is each operating theatre serviced by an air-conditioning system or unit?</p>	<p>Yes / No</p>

6.4.2 Briefly describe the system employed

6.4 Fire protection

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

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6.5 Vacuum system

6.6.1 Specify type of system installed

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

6.7 Oxygen and Nitrous oxide supply

* 6.7.1 Describe the type of supply systems installed

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

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

<p>6.8 Lifts - applicable in multi-storey buildings and if clinic is not located on ground floor.</p>	<p>Yes / No</p>
<p>If applicable, is the lift capable of taking a patient Stretcher?</p>	<p>Yes / No</p>
<p>If the lift is not capable of taking a patient stretcher, can the stairway accommodate a patient stretcher?</p>	<p>Yes / No</p>

SURVEYORS' COMMENTS:

7. STAFFING

7.1 Specify by category number of staff employed

SRN's (with theatre diploma) _____

SRN's (without theatre diploma) _____

SEN's _____

ENA's _____

Other (Specify) _____

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7.2 Specify how these staff are deployed between the various functions
Such as reception, theatre and recovery, ward areas.

SURVEYORS' COMMENTS:

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

9. NAME OF PERSON COMPLETING QUESTIONNAIRE _____

DESIGNATION _____

SIGNATURE _____

DATE _____

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

The PCNS Department
The Board of Healthcare Funders
P. O Box 2324
PARKLANDS
2121

10. RECOMMENDATIONS OF SURVEYORS TO BHF

10.1 Date of on-site inspection of hospital _____

10.2 The _____ clinic should / should not be granted recognition in terms of the Scale of Benefits.

10.3 Reasons for recommendation

10.4 BHF advised of recommendation on _____

10.5 Clinic advised of recommendation on _____

Names of Surveyors	Designation	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____