PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 November 2024

PCNS APPLICATION VERIFICATION QUESTIONNAIRE FOR PRIVATE HOSPITAL APPLYING FOR CATEGORY "A or B" STATUS

Status A (under 100 beds)	☐	Status B (over 100 beds)	☐

(Please tick the appropriate discipline)

This document is to be submitted together with the Application form; supporting documents and completed criteria to pcns_admin@bhfglobal.com

Name of Facility : _____

Name/s of Owner/s : _____

Physical Address : _____

_____

_____

Telephone No. : _____

Facsimile No : _____

Emergency Tel No : _____

E-Mail Address : _____

PROPRIETOR

Person in Charge : _____

Qualifications : _____

01 November 2024

CONTACT DETAILS:

Name of Person Completing Questionnaire: _____

Designation : _____

Date of Completion : _____

- The answers to this questionnaire are to be interpreted by the Surveyors in accordance with the guidelines as set down in the Checklist of Criteria (Annexure 1) for awarding a Private Hospital Status "A" or "B".
- Those items in the questionnaire marked with an asterisk, thus *, are to be regarded as essential elements (B). Failure to comply with these items will result in the application being refused appropriate Status ("A" or "B") 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/R187	
Registration Certificate of Pharmacy issued by Pharmacy Council	
Patient Register	
Operation Register	
Maternity Register	
Drug Registers	

01 November 2024

1. REGISTRATION

	☑
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?	Yes/No
1.2. Has the institution been granted any exemption from Compliance with these Regulations	Yes/No
1.3. Date of original registration	Yes/No
1.4. Copy of current Certificate of Registration to be attached hereto.	Yes/No

SURVEYORS' COMMENTS:

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2. WARD ACCOMMODATION	☑
2.1. Bed Numbers:	
2.1.1. Number of beds in general wards	
2.1.2. Number of beds in semi-private wards	
2.1.3. Number of beds in private wards	
Total number of beds	
2.2. Bed numbers in category:	
Number of beds usually allocated to:	
2.2.1. Surgical	
2.2.2. Medical	
2.2.3. Maternity	
2.2.4. Paediatric	
2.2.5. Day Beds	
2.2.6. Psychiatric	
2.2.7. Other	
2.3. Services	
2.3.1. * Are the hospital wards piped for oxygen?	
2.3.2. * Are the hospital wards piped for vacuum?	
2.3.3. * Does each bed have an adequate nurse call system?	
2.3.4. * Can every bed be made private through the use of inter-bed curtains?	
2.3.5. * Are all toilets and bathrooms serviced by a call system?	
2.4. Emergency Trolley	
2.4.1. *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?	Yes/No
2.4.2.1. Incubation Apparatus	Yes/No
2.4.2.2. Defibrillator	Yes/No
2.4.2.3. Monitor	Yes/No
2.4.2.4. C P R Board	Yes/No
2.4.2.5. Ambu Bag / Equivalent	Yes/No
2.4.2.6. Suction Apparatus	Yes/No
2.4.2.7. Correct emergency drug supplies	Yes/No
2.4.2.8. Emergency Oxygen Supply	Yes/No
2.5. Staffing – wards only	
2.5.1. Number of SRN's	
2.5.2. Number of SEN's	
2.5.3. Number of ENA's	

SURVEYORS' COMMENTS:

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*** 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	Yes/No
3.1.3. * Piped services:	
3.1.3.1. Oxygen	Yes/No
3.1.3.2. Nitrous Oxide	Yes/No
3.1.3.3. Vacuum	Yes/No
3.1.3.4. Compressed Air	Yes/No
3.1.3.5. 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)	
3.2.1.1. * Type or make	
3.2.2. * Number of ECG Monitors available (at least one per operating theatre)	
3.2.2.1. * Type or make	
3.2.3. 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:	
3.3.2.1. Oxygen	
3.3.2.2. Vacuum	
3.3.2.3. Alarm Panels	
3.3.3. * Is a properly equipped emergency trolley as per located in the recovery room area?	Yes/No
3.4. Central Sterilising Department	
3.4.1. Number of autoclaves by type:	
3.4.1.1. Steam	
3.4.1.2. Ethylene Oxide	
3.4.1.3. Other (specify)	
3.4.1.4. Specify facilities for storage of sterile packs	
3.5. Staffing	
3.5.1. Theatres	
3.5.1.1. Number of SRN's (with theatre diploma)	
3.5.1.2. Number of SRN's (without theatre diploma)	
3.5.1.3. Number of SEN's	

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3.5.1.4. Number of ENA's	
3.5.2. Recovery Room	
3.5.2.1. Number of SRN's	
3.5.2.2. Number of SEN's	
3.5.2.3. Number of ENA's	
3.5.3. C S D	
Specify staff category and number	
3.5.4. *Specify what arrangements are made for after hours and emergency calls:	

SURVEYORS' COMMENTS:

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

4. MATERNITY (if applicable)

	☑
4.1. Number of licensed beds	
4.2. * Is a theatre for Caesarean Section available?	Yes/No
4.3. * Specify what nursery facilities are available other than general nursery:	
4.3.1. Neo-natal nursery	
4.3.2. Isolation nursery	
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.	
4.4.1. I C U Cribs	
4.4.2. Incubator	
4.4.3. Respirator / Ventilator	
4.4.4. I V Controller	
4.4.5. E C G Monitor	
4.4.6. O^2 Monitor	
4.4.7. Piped Services:	
4.4.7.1. Oxygen	Yes/No
4.4.7.2. Vacuum	Yes/No
4.4.7.3. 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:	
4.7.2.1. Oxygen	Yes/No
4.7.2.2. Vacuum	Yes/No
4.7.2.3. 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

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4.9. Staffing – labour ward, nursery and post-natal ward.	
4.9.1. Number of SRN's (with midwifery diploma)	
4.9.2. Number of SRN's (without midwifery diploma)	
4.9.3. Number of SEN's	
4.9.4. Number of ENA's	

SURVEYORS' COMMENTS:

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

5. INTENSIVE CARE UNIT (if applicable)

	☑
5.1. Ordinary Surgical / Medical ICU	Yes/No
5.1.1. Number of beds:	
5.1.1.1. Surgical	Yes/No
5.1.1.2. Medical	Yes/No
5.2. Is an isolation cubicle available?	Yes/No
5.3. Equipment in ICU. Specify number and type	
5.3.1.1. * Ventilators	
5.3.1.2. * Defibrillator	
5.3.1.3. * Blood gas analyser	
5.3.1.4. * I V Controllers	
5.3.1.5. * Monitors	
5.3.1.6. Are monitors linked to a central console	Yes/No
5.4. * Piped Services:	
5.4.1. Oxygen	
5.4.2. Vacuum	
5.4.3. Compressed Air	
5.5. * Is a properly equipped emergency trolley located in the ICU?	Yes/No
5.6. Number of Power Points per bed	Yes/No
5.7. * Is the unit service by an air conditioner	
5.8. * Staffing in ICU	
5.8.1. Number of SRN's (with ICU diploma)	
5.8.2. Number of SRN's (without ICU diploma)	
5.8.3. Number of SEN's	
5.8.4. Number of ENA's	
5.9. Cardiac / Thoracic ICU (if applicable)	
5.9.1. Number of beds	
5.9.2. *Equipment specify number and type	
5.9.2.1. Ventilators	
5.9.2.2. IV Controllers	
5.9.2.3. Monitors	
5.9.2.4. Defibrillator	

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5.9.2.5. Blood Gas Analyzer	
5.9.2.6. Are monitors linked to central console?	Yes/No
5.9.3. * Piped services:	
5.9.3.1. Oxygen	Yes/No
5.9.3.2. Vacuum	Yes/No
5.9.3.3. 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	
5.9.7.1. Number of SRN's (with ICU diploma)	
5.9.7.2. Number of SRN's (without ICU diploma)	
5.9.7.3. Number of SEN's	
5.9.7.4. Number of ENA's	

SURVEYORS' COMMENTS:

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

6. HIGH CARE WARD (if applicable)

	☑
6.1. Number of beds:	Yes/No
6.1.1. Surgical	
6.1.2. Medical	
6.2. Equipment in H C W. Specify number and type	
6.2.1. * Monitor	
6.2.2. * Respirator	
6.2.3. * Defibrillator	
6.2.4. * I V Controllers	
6.3. Piped services:	
6.3.1. Oxygen	Yes/No
6.3.2. Vacuum	Yes/No
6.4. * Is a properly equipped emergency trolley located in the HCW area?	Yes/No
6.5. Staffing in H C W	
6.5.1. Number of SRN's	
6.5.2. Number of SEN's	
6.5.3. Number of ENA's	

SURVEYORS' COMMENTS:

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

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' COMMENTS:

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

8. CATERING FACILITIES

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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?	Yes/No

SURVEYORS' COMMENTS:

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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?	

SURVEYORS' COMMENTS:

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10. PLANT AND EQUIPMENT

	☑
10.1. * Hot water and / or steam supply	
Supplied by:	Yes/No
10.1.1. Diesel / Gas / Coal-fired boilers	
10.1.2. Electrical boilers	
10.1.3. Steam generators	
10.2. * Disposal of waste other than refuse:	
10.2.1. Incinerator	
10.2.2. Macerator	
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 UPS? 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	Yes/No
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
Theatres	Yes/No
Neo-Natal Nursery	Yes/No

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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	
10.4.1.1. Are the ward areas air conditioned?	Yes/No
10.4.1.2. If yes, what kind of system is installed?	Yes/No
10.4.2. Operating Theatres	
10.4.2.1. Specify the kind of chilling, air-handling and filtration	
10.4.2.2. 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
10.5.2. If yes, what is the staff compliment by category?	
10.5.3. If no, how is preventive maintenance and or repairs effected?	
10.5.4. 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 devices installed in the hospital	
10.6.3. Specify Emergency / Evacuation planning	
10.7. Vacuum System	
10.7.1. Specify type of system installed	
10.7.2. What back-up facilities are available in the event of a power failure?	
10.8. Oxygen and Nitrous Oxide Supply	
10.8.1. Specify the type of supply system installed	

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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. Elevators - applicable in multi-story buildings	
10.9.1.* Specify the number, type and size elevators available in the building	
10.10. Compressed air supply	
10.10.1. * Specify type of system installed	

SURVEYORS' COMMENTS:

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11. RADIOLOGY FACILITIES

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11.1. * Indicate what radiology facilities are available in the hospital	
11.2. * Are emergency X-ray facilities available after hours?	Yes/No

SURVEYORS' COMMENTS:

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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?	

SURVEYORS' COMMENTS:

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

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SURVEYORS' COMMENTS:

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14. NAME OF PERSON COMPLETING QUESTIONNAIRE _____

DESIGNATION _____

SIGNATURE _____

DATE _____

01 November 2024

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

The PCNS Department
pcns_admin@bhfglobal.com

OFFICIAL USE ONLY
RECOMMENDATIONS OF THE INSPECTION TEAM
RECOMMENDATIONS OF SURVEYORS TO BHF

15.1 Date of on-site inspection of hospital _____

15.2 The _____hospital should / should not be granted recognition in terms of the PCNS Application Requirements.

15.3 Reasons for recommendation

_____

_____

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15.4 BHF advised of recommendation on _____

15.5 Hospital advised of recommendation on _____

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