PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 November 2024

PCNS APPLICATION VERIFICATION QUESTIONNAIRE
FOR COMPREHENSIVE PHYSICAL REHAB CENTER

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. : _____

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 per the guidelines as set down in the Manual of Criteria for awarding a Private Hospital Comprehensive Rehabilitation Unit Status in terms of the Benchmark Tariffs.
- 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 Comprehensive Rehabilitation Unit 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/R187	
Patient 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. Services	
2.2.1. Are the hospital wards piped for oxygen?	
2.2.2. Are the hospital wards piped for vacuum?	
2.2.3. Does each bed have an adequate nurse call system?	
2.2.4. Can every bed be made private through the use of inter-bed curtains?	
2.2.5. Are all toilets and bathrooms serviced by a call system?	
2.3. Emergency Trolley	
2.3.1. Does each ward section have access to an emergency trolley?	Yes/No
2.3.2. Does each emergency trolley contain adequate equipment and drugs as listed below?	Yes/No
2.3.2.1. Incubation Apparatus	Yes/No
2.3.2.2. Defibrillator	Yes/No
2.3.2.3. Monitor	Yes/No
2.3.2.4. C P R Board	Yes/No
2.3.2.5. Ambu Bag / Equivalent	Yes/No
2.3.2.6. Suction Apparatus	Yes/No
2.3.2.7. Correct emergency drug supplies	Yes/No
2.3.2.8. Emergency Oxygen Supply	Yes/No
2.4. Staffing – wards only	
2.4.1. Number of SRN's	Yes/No
2.4.2. Number of SEN's	Yes/No
2.4.3. Number of ENA's	Yes/No

SURVEYORS' COMMENTS:

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

3. THERAPEUTIC FACILITIES

	☑
3.1. Services rendered in respect of following disease conditions to be indicated:	
Stroke	Yes/No
Brain Dysfunction (traumatic and non-traumatic)	Yes/No
Spinal Cord Dysfunction (traumatic and non-traumatic)	Yes/No
Orthopaedic (Lower Joint Replacements)	Yes/No
Amputations (Lower Extremity)	Yes/No
Cardiac	Yes/No
Pulmonary	Yes/No
Major Multiple Trauma	Yes/No
Other Neurological or Orthopaedic impairments	Yes/No
3.2. How is the multi-disciplinary team structured in terms of specific categories of health care providers and number in each category?	
Categories of Health Care Providers	Number
3.3. Describe the therapeutic area/s available to the multi-disciplinary team	
Is there an ADL facility?	Yes/No
Is there a hydrotherapy area?	Yes/No
*** * Staffing Ratios Adequate?**	Yes/No

SURVEYORS' COMMENTS:

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4. INTENSIVE CARE UNIT (if applicable)

	☑
4.1. Number of beds	

	☑
4.2. Is an isolation cubicle available?	Yes/No
4.3. Equipment in ICU. Specify number and type	
4.3.1.1. Ventilators	
4.3.1.2. Defibrillator	
4.3.1.3. Blood gas analyser	
4.3.1.4. I V Controllers	
4.3.1.5. Monitors	
4.3.1.6. Are monitors linked to a central console	Yes/No
4.4. Piped Services:	
4.4.1. Oxygen	
4.4.2. Vacuum	
4.4.3. Compressed Air	
4.5. Is a properly equipped emergency trolley located in the ICU?	Yes/No
4.6. Number of PowerPoints per bed	Yes/No
4.7. Is the unit serviced by an air conditioner	
4.8. Staffing in ICU	
4.8.1. Number of SRN's (with ICU diploma)	
4.8.2. Number of SRN's (without ICU diploma)	
4.8.3. Number of SEN's	
4.8.4. Number of ENA's	
*** Staffing Ratios Adequate?**	Yes/No

SURVEYORS' COMMENTS:

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5. HIGH CARE WARD (if applicable)

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5.1. Number of beds:	
5.2. Equipment in H C W. Specify number and type	
5.2.1. Monitor	
5.2.2. Respirator	
5.2.3. Defibrillator	
5.2.4. I V Controllers	
5.3. Piped services:	
5.3.1. Oxygen	Yes/No
5.3.2. Vacuum	Yes/No
5.4. Is a properly equipped emergency trolley located in the HCW area?	Yes/No
5.5. Staffing in HCW	
5.5.1. Number of SRN's (with ICU diploma)	
5.5.2. Number of SEN's (without ICU diploma)	
5.5.3. Number of SEN's	
5.5.4. Number of ENA's	
*** Staffing Ratios Adequate?**	Yes/No

SURVEYORS' COMMENTS:

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6. PHARMACY SERVICE

	☑
6.1. Is a dispensary serving the hospital located on the premises?	Yes/No
6.2. If no, how are dispensary requirements obtained?	
6.3. If yes, attach a copy of the current Pharmacy Board approval of registration	
6.4. How many full-time qualified pharmacists are employed?	
6.5. Do the pharmacists offer a 24-hour call-service?	Yes/No
6.6. Is a properly equipped emergency cupboard available in the hospital?	Yes/No
6.7. Is an inflammable-store facility available?	Yes/No
*** Staffing Ratios Adequate?**	Yes/No

SURVEYORS' COMMENTS:

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7. CATERING FACILITIES

	☑
7.1. Is a main kitchen provided on the premises?	Yes/No
7.2. If no, how are patient meals provided?	
7.3. What food delivery system is employed in the hospital?	Yes/No

SURVEYORS' COMMENTS:

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8. LAUNDRY

	☑
8.1. Is a laundry located on the premises?	Yes/No
8.2. If no, how is laundry processed?	
8.3. If yes, does the laundry process all the hospitals laundry?	

SURVEYORS' COMMENTS:

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9. PLANT AND EQUIPMENT

	☑
9.1. Hot water and/or steam supply	
Supplied by:	Yes/No
9.1.1. Diesel / Gas / Coal-fired boilers	
9.1.2. Electrical boilers	
9.1.3. Steam generators	
9.2. Disposal of waste other than refuse:	
9.2.1. Incinerator	
9.2.2. Macerator	
9.3. Emergency power plant:	
9.3.1. Is an emergency power plant installed?	Yes/No
9.3.2. Does the system operate automatically in the event of a power failure?	Yes/No
9.3.3. Are the operating theatre lights connected to a UPS? if not, is some other emergency lighting system available?	Yes/No
9.3.4. 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 – ICU	Yes/No
HCW	Yes/No
Theatres	Yes/No
Neo-natal nursery	Yes/No
Recovery rooms	Yes/No
Delivery rooms	Yes/No
Air compressor	Yes/No
Bed lift	Yes/No
9.3.5. What is the KVA rating of the emergency power plant?	
9.4. Air Conditioning System	
9.4.1. Wards	
9.4.1.1. Are the ward areas air-conditioned?	Yes/No
9.4.1.2. If yes, what kind of system is installed?	Yes/No
9.5. Maintenance	
9.5.1. Does the hospital employ its own maintenance staff	Yes/No
9.5.2. If yes, what is the staff complement by category?	
9.5.3. If no, how are preventive maintenance and or repairs affected?	
9.5.4. What is the general state of all plant rooms and workshop facilities?	

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9.6. Fire Protection	
9.6.1. Specify number and type of fire extinguishers installed in the hospital	
9.6.2. Specify any other form of fire protection devices installed in the hospital	
9.6.3. Specify Emergency / Evacuation planning	
9.7. Vacuum System	
9.7.1. Specify type of system installed	
9.7.2. What back-up facilities are available in the event of a power failure?	
9.8. Oxygen and Nitrous Oxide Supply	
9.8.1. Specify the type of supply system installed	
9.8.2. * What back-up facilities are available in the event of a failure of the main system?	
9.8.3. *What low-level alarm system is in use?	
9.9. Elevators - applicable in multi-story buildings	
9.9.1. * Specify the number, type and size elevators available in the building	
9.10. Compressed air supply	
9.10.1.* Specify type of system installed	

SURVEYORS' COMMENTS:

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10. RADIOLOGY FACILITIES

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

SURVEYORS' COMMENTS:

11. LABORATORY FACILITIES

	☑
11.1. Is a pathology laboratory located on the premises?	Yes/No
11.2. If no, what arrangements are made for the collection of specimens?	

SURVEYORS' COMMENTS:

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

SURVEYORS' COMMENTS:

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13. NAME OF PERSON COMPLETING QUESTIONNAIRE _____

DESIGNATION _____

SIGNATURE _____

DATE _____

14. 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

14.1 Date of on-site inspection of hospital _____

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

14.3 Reasons for recommendation

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14.4 BHF advised of recommendation on _____

14.5 Hospital advised of recommendation on _____

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