



PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PCNS QUESTIONNAIRE DAY CLINIC & UNATTACHED OPERATING THEATRE UNIT

For completion by a Day Clinic or unattached operating theatre unit applying for classification as an Approved Unattached Operating Theatre unit.

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

Executive in charge: _____

Qualifications : _____



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CONTACT DETAILS:

Name of Person Completing Questionnaire : _____

Designation : _____

Date of Completion : _____

- The answers to this questionnaire will be used by the inspection team evaluating your facility as per the guidelines as set down in the PCNS Application Criteria for a Day Clinic or Unattached Operating Theatre Unit.
- 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.
- Recommendations by the inspecting team can only be made following an on-site inspection of your facility.

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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	Yes / No
• Patient / Operation Register	Yes / No
• Drug Register	Yes / No



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1. REGISTRATION

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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?	Yes / No
1.2. Has the clinic been granted any exemptions from Compliance with these regulations?	Yes / No
1.3. Date of original registration	
1.4. Copy of current certificate of registration to be attached hereto.	Yes / No

SURVEYORS' COMMENTS:

2. OPERATING THEATRE UNIT

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

SURVEYORS' COMMENTS:

3. RECOVERY FACILITIES

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



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

SURVEYORS' COMMENTS:

4. STERILISING FACILITIES

4.1. Number of autoclaves by type:

4.1.1. Steam :

4.1.2. Ethylene oxide :

4.1.3. 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?	Yes / No
• 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

6.2.2. If "no" to both of the above, how is waste disposed of?

6.3. Hot water and/or steam supply (if applicable)	☒
6.3.1. Supplied by:	
• Electrical geyser	Yes / No
• Steam generators	Yes / No
• Other (specify _____)	Yes / No
6.4. Air conditioning system	



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6.4.1. Is each operating theatre serviced by an air-conditioning system or unit?	Yes / No
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6.4.2. Briefly describe the system employed

6.5. Fire protection

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

6.6. 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?

6.8. Elevators - applicable in multi-storey buildings and if clinic is not located on ground floor.	☒
6.8.1. If applicable, is the elevator capable of taking a patient Stretcher?	Yes / No
6.8.2. If the elevator is not capable of taking a patient stretcher, can the stairway accommodate a patient stretcher?	Yes / No

SURVEYORS' COMMENTS:

7. STAFFING

7.1. Specify by category number of staff employed

7.1.1. SRN's (with theatre diploma):

7.1.2. SRN's (without theatre diploma):

7.1.3. SEN's:

7.1.4. ENA's:

7.1.5. 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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10. 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

10.1 Date of on-site inspection of hospital _____

10.2 The _____ clinic should / should not be granted recognition in terms of the PCNS Application Requirements.

10.3 Reasons for recommendation

10.4 BHF advised of recommendation on _____

10.5 Clinic advised of recommendation on _____

Names of Surveyors

Designation

Signature

_____	_____	_____
_____	_____	_____
_____	_____	_____