# Hospital Services Summary Form

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|---|
| Name of Hospital / Facility: |
| Address: |
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| | |
|---|---|
| Telephone Number: | Facsimile Number: |
| E-mail: | Contact: |

| |
|---|
| Current Insurer: |
| Turnover For Last 12 Months: |
| Projected Turnover: |
| Are there any structural changes, renovations or developments proposed in the next 12 / 24 / 36 months: Yes No (Delete as Appropriate) |
| If Yes, please outline full details: |
| |
| |
| |
| Are there any additional services proposed in the next 12 / 24 / 36 months: Yes No |
| If Yes, please outline full details: |
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| |

# Staff

| | Total Number of Employees | Total Wageroll |
|---|---|---|
| What is the Projected Total number of Staff employed & Wageroll | | |

Please provide details of numbers and wageroll
For the following categories of staff:

| | Number of Employees | Wages |
|---|---|---|
| Consultants | | |
| Registrars | | |
| Senior House Doctors | | |
| Nurses – Post Registration | | |

# Staff Continued

| | | |
|---|---|---|
| Nurses – Pre Registration | | |
| Care Assistants / Attendants | | |
| Administrative / Clerical Staff | | |
| Allied Healthcare Professionals | | |
| Maintenance Staff | | |
| Catering Staff | | |

| | | |
|---|---|---|
| Cleaning / Household Staff | | |
| Other Categories - Please List: | | |
| | | |
| | | |
| Total | | |

Is there a system of check and record that all qualified personnel employed or permitted to use the facilities are registered with the Medical Council? Yes No

Is there a system of check and record that all Nursing personnel employed (including Agency Nurses) are on the Live Register of An Bord Altranais? Yes No

Is there Pre-Employment Screening for:
Permanent Employees Yes No
Temporary Employees Yes No

Are there written guidelines for Needle Stick / Sharps Injuries? Yes No

Is there a Training Programme for Care Attendants? Yes No

# Services

**Bed Count & Breakdown**

Please supply the following details:

| Bed Category: | Number of Beds | Average Daily Occupancy | Bed Category: | Number of Beds | Average Daily Occupancy |
|---|---|---|---|---|---|
| Age Related Medicine | | | Intensive Care Unit - Adult | | |
| Cardiac Surgical | | | Intensive Care Unit – Paediatric | | |
| Coronary Care Unit | | | Intensive Care Unit – Neonatal | | |
| Cosmetic Surgery | | | Labour Ward | | |
| Day Care Unit | | | Maternity / Obstetric Unit | | |
| Drug / Alcohol Dependency | | | Neurosurgery | | |
| Dental | | | Oncology | | |
| Endocrinology | | | Ophthalmic | | |

# Services Continued

| Bed Category: | Number of Beds | Average Daily Occupancy | Bed Category: | Number of Beds | Average Daily Occupancy |
|---|---|---|---|---|---|
| ENT Surgery | | | Orthopaedics | | |
| General Medicine | | | Paediatrics | | |
| General Surgery | | | Psychiatric | | |

| | | | | | |
|---|---|---|---|---|---|
| GU Medicine | | | GU Surgery | | |
| High Dependency Unit | | | | | |
| Other Please State: | | | | | |
| | | | | | |
| | | | | | |
| Total Number of Adult Beds | | | | | |
| Total Number of Paediatric Beds | | | | | |
| Total Number of Neonatal Cots / Bassinets | | | | | |
| Total Number of In-patient Admissions last year? | | | | | |
| Total Number of Day Case Admissions last year? | | | | | |
| Total Number of Outpatients last year? | | | | | |

## Health & Safety

| | | |
|---|---|---|
| Is there a Manual Handling Training Programme? | Yes | No |
| Is it mandatory that all staff attend? | Yes | No |
| Is there a system of check and record that all staff attend the Training Programme? | Yes | No |

## Fire Safety

| | | |
|---|---|---|
| Does your facility comply with current Fire Regulations? | Yes | No |
| Are staff instructed annually in Fire and Emergency Procedures? | Yes | No |
| How often are Fire Evacuations / Drills conducted? | | |
| Please state date of last Drill | | |

## Risk Management

| | | |
|---|---|---|
| Is there a formal Risk Management Programme? | Yes | No |
| Is there a Risk Management Committee in place? | Yes | No |
| If Yes how often does it meet? | | |
| Is the Complaints Procedure visible and available to all patients and their families? | Yes | No |
| Does a Registered Nurse always administer drugs / medications? | Yes | No |
| Is there a system of check and record that all contractors engaged by the Hospital / Facility carry appropriate insurance? | Yes | No |

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| If Yes, please provide full details: |
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## Waste Management

| | | |
|---|---|---|
| Do you comply with the Waste Management Act 1996, updates thereof and any subsequent legislation in relation to waste collection, recovery and / or disposal? | Yes | No |
| Is there a system of check and record that contractors used by the Hospital / Facility operate with adequate permits and / or licenses? | Yes | No |

Is there a system of check and record that contractors used by the Hospital / Facility carry appropriate insurance with an indemnity provided to you? Yes No

Is there a system of check and record that all contractors engaged by the Hospital / Facility carry appropriate insurance? Yes No

Is Clinical Waste incinerated on-site? Yes No

## Property

Please advise reinstatement values in respect of the following

A) Buildings €

B) Contents €

C) Patients / Clients effects €

D) Loss of Revenue €

## Claims Experience

Within the last 5 years are you aware of any claim made against you? Yes No

If respect of Public Liability / Medical Malpractice are you aware of any circumstances / incidents that in the future may give rise to a claim?
Yes No

If Yes, please outline full details:

Signature of Proposer _____ Date _____

Title _____