|  |  |  |
| --- | --- | --- |
| HealthCert | **Notification of reconfiguring services or a new building** |  |

|  |
| --- |
| **1. Premises** |
| Legal entity name |
| Enter legal entity name. |
| Premises name |
| Enter premises name |

|  |
| --- |
| **2. Proposal description** |

Please tick the box or boxes that best describes your proposal.

|  |  |
| --- | --- |
|  | increase in patient/client capacity |
|  | the transfer of current clinical services |
|  | a new build (eg, hospital, extension, wing, etc) |
| Please describe the proposal. | | |
| Enter description of proposal. | | |
| **3. Services and bed numbers** | |

Please provide details of services and bed numbers in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Service type** | **Existing bed numbers[[1]](#footnote-1)** | **Proposed changes to bed numbers[[2]](#footnote-2)** | **Proposed final bed numbers[[3]](#footnote-3)** |
| Hospital Services – Medical services |  |  |  |
| Hospital Services - Child Health |  |  |  |
| Hospital Services – Mental Health |  |  |  |
| Hospital services – Maternity |  |  |  |
| Hospital Services – Surgical |  |  |  |
| Residential Disability Services – Physical |  |  |  |
| Residential Disability Services – Sensory |  |  |  |
| Residential Disability Services – Intellectual |  |  |  |
| Residential Disability Services – Psychiatric |  |  |  |
| Hospital/rest home (dual service) |  |  |  |
| Hospital services – Geriatric (excluding psychogeriatric) |  |  |  |
| Hospital services – Geriatric (psychogeriatric) |  |  |  |
| Secure Dementia care |  |  |  |
| Rest home care (excluding secure dementia care) |  |  |  |
| Total bed numbers |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **4. Contact Person to do with changes** | | | | | | | | |
| Title |  | Given name(s) | | |  | Surname | | |
| Enter title of the new premises contact person. |  | Enter the new premises contact person’s given name(s). | | |  | Enter the new premises contact person’s surname. | | |
| Position | | | | | | | | |
| Enter the new premises contact person’s position. | | | | | | | | |
| Phone number | | |  | Mobile number | | |  | Fax number |
| Enter the new premises contact person’s phone number. | | |  | Enter the new premises contact person’s mobile number. | | |  | Enter the new premises contact person’s fax number. |
| Email address | | | | | | | | |
| Enter the new premises contact person’s email address. | | | | | | | | |
| **5. Returning form** | | | | | | | | |

Please email to [certification@health.govt.nz](mailto:certification@health.govt.nz):

Notification form

Statutory declaration

Floor plan showing the proposed changes or the new premises

Transition plan

If you have any questions, please contact HealthCERT on 0800 113 813.

**Statutory declaration**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (full name of agent or employee of the company)

of, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

solemnly and sincerely declare that the statements made in the above application are true and correct.

Declared at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_

Signature of applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Before me:

Full name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A person authorised under section 9 of the Oaths and Declarations Act 1957 to take this declaration.

A declaration made in New Zealand must be made before:

a) a barrister or solicitor of the High Court

b) a Justice of the Peace

c) a notary public

d) the Registrar or a Deputy Registrar of the Supreme Court

e) the Registrar or a Deputy Registrar of the Court of Appeal

f) the Registrar or a Deputy Registrar of the High Court or a District Court

g) some other person authorised by law to administer an oath

h) a member of Parliament

i) a person who is a fellow of the New Zealand Institute of Legal Executives and is acting in the employment of a practising barrister and solicitor of the High Court

j) an employee of the New Zealand Transport Agency authorised for that purpose by the Minister of Justice or an employee of Public Trust authorised or an officer in the service of the Crown or of a local authority authorised for that purpose.

## Transition plans – new or existing build

| **Subsection** | | **Evidence** Must relate to the new or existing build |
| --- | --- | --- |
| 2.4 | **Service provider availability** |  |
| * There is a planned staff orientation and emergency training for staff in the new clinical area (eg, copy of plan, attendance to orientation and emergency training for clinical staff) | <Click here to enter text> |
| * If there is an increase in bed numbers, staff levels and skill mix processes have been undertaken | <Click here to enter text> |
| 3.5 | **Nutrition, safe food and fluid management** |  |
|  | * Evidence of current Food Safety Inspection Certificate (eg, against HACCP) (eg, evidence that kitchen/servery in the new build meets standards) | <Click here to enter text> |
| 5.5 | **Management of waste and hazardous substances** |  |
| * Emergency management plan | <Click here to enter text> |
| * HSNO management, particularly after hours, interface with cleaning/orderly staff | <Click here to enter text> |
| 4.1 | **Facility specifications** |  |
| * BWOFs and/or CPU for new and current facilities (CPU to be submitted prior to transfer of patients/clients) | <Click here to enter text> |
| * Amenities, fixtures, equipment and furniture are selected located installed and maintained for service users, safety, needs and abilities | <Click here to enter text> |
| 4.1 | **Toilet, shower and bathing facilities** |  |
| * On-site visit to clinical areas completed – report on issues | <Click here to enter text> |
| 4.1 | **Personal space/bed areas** |  |
| * On-site visits to clinical areas completed – report on issues | <Click here to enter text> |
| 4.1 | **Communal areas for entertainment, recreation, and dining** |  |
| * Comment on dedicated areas for service types (eg, paediatrics, long-term care) |  |
| 5.5 | **Cleaning and laundry services** |  |
| * Processes for new services or increased capacity have been planned and completed | <Click here to enter text> |
| 4.2 | **Essential, emergency and security systems in respect of the new build and/or services** |  |
| * Fire evacuation plans | <Click here to enter text> |
| * Methods of keeping patients/public/staff aware of environmental hazards | <Click here to enter text> |
| * Call bells functioning | <Click here to enter text> |
| * Emergency responsiveness, including clinical teams, specific earthquake response teams etc | <Click here to enter text> |
| * Impact on security service report | <Click here to enter text> |
| 4.1 | **Natural light, ventilation and heating** |  |
| * No internal rooms are used for overnight patient stays | <Click here to enter text> |
| 5.1 | **Infection prevention and control** |  |
| * There has been a process of consultation and sign off with infection control team for the new build/new services | <Click here to enter text> |

1. Enter details of the **existing** services and bed numbers being provided. [↑](#footnote-ref-1)
2. Enter details of the **proposed changes to** services and bed numbers. [↑](#footnote-ref-2)
3. Enter details of the **proposed total** services and bed numbers after changes are made. [↑](#footnote-ref-3)