
**A UNIQUE AND COMPREHENSIVE INSURANCE
FOR
NURSING AND RESIDENTIAL HOMES AND
HOSPICES**

MALPRACTICE PROPOSAL FORM



Camberford Law plc

Innovative Insurance solutions – Since 1958

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MALPRACTICE PROPOSAL FORM

NURSING AND RESIDENTIAL HOMES AND HOSPICES

SECTION 1

| | | |
|---|-----|-------|
| 1. Full name and address of Home/Hospice: | | |
| Telephone | Fax | Email |

| | |
|--|-----------------------------|
| 2. Name (s) of Owner (s) or Partners and details of experience / qualifications: | |
| Name | Experience / Qualifications |
| 3. How long have you operated under the present management ? | |

| |
|---|
| 4. Please state your gross annual income for the last financial year |
| |
| 5. Please state your estimated gross annual income for the current financial year (and the date of your year end) |
| |
| 6. Please state your estimated gross annual income for the next financial year |
| |
| Please advise if you are maintained in whole or in part by public funds or endowment |

If so, please provide brief details, including percentage split of funds received :

- a) Government / Public:
- b) Private Funding:
- c) Charity Donations:

What percentage of your patients are :

- a) Government / Public:
- b) Private Funding:
- c) Charity Donations:

7. Please advise how patients / clients are referred and by whom ?

8. Please provide details of your premises :

- a) Number of floors
- b) Number of rooms
- c) Age of structure
- d) Was the premises erected for the purpose or has it been converted for present use, if so when ?
- e) Distance to nearest fire station (miles)
- f) Details of hydrants, extinguishers, sprinklers, fire exits, including the date of the last inspection undertaken by a qualified consultant or fire officer of the equipment/procedures set in place
- g) Are direct phone links to the Fire Brigade installed
- h) Are all staff, including part time and temporary / contract staff, instructed in the fire protection procedures
- i) When was the last time that you carried out a fire practise and how often are these carried out

9. Please state the number of employed staff / self employed staff in each of the following classifications :

| | EMP | S-EMP |
|---|-------|-------|
| a) General Practitioners | | |
| b) Undergraduate/Student Nurses | | |
| | Day | |
| | Night | |
| c) Graduate Nurses | | |
| | Day | |
| | Night | |
| d) Pharmacists | | |
| e) Complementary Practitioners | | |
| f) Residential Medical Officers | | |
| g) Mental Health Nurses | | |
| | Day | |
| | Night | |
| h) Supplementary Professionals (i.e. Dentists/Opticians/Chiropodists audiologists/dieticians) | | |
| i) Auxiliaries | | |
| | Day | |
| | Night | |

10. Are all professionally qualified staff required to maintain their own Malpractice Insurance coverage through RGN / MDU or similar?

If NO, please provide details :

11. Please state the approximate division of your patients/residents between

- a) Dementia
- b) Mental Disorder/Psychiatric
- c) Surgical
- d) Learning Disability
- e) Drug/Alcohol
- f) Sensory Impairment
- g) Physical Disability
- h) Respite
- i) Emergency Admissions
- j) Terminally Ill
- k) Other (please be specific)

Please provide the total number of patients admitted last year

Please state what percentage of your patients were from USA/CAN last year (if known)

12. Please provide % split of patients by age group

- a) Under 16
- b) 16 – 21

c) Under 65

d) 65 and over

13. Other than those disclosed under Question 11, please provide a FULL description of your additional activities (including details of any training / teaching facilities that you maintain)

14. Do you provide facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that effective cross infection control methods are employed

If NO, please advise

15. Do you have a protocol for Needlestick Injuries

If NO, please advise

16. Do you comply with the current guidelines for the safe collection / disposal of the following :

Dressings / Surgical waste / Clinical waste / Sharps / General Waste / Any blood or blood products

If NO, to any of the above then please advise

17. Are any counselling services provided to any clients/patients ?

If YES, please provide full details (including type of counselling and forum in which it is conducted)

Please also confirm whether or not all counsellors have appropriate qualifications and maintain their own cover in force

18. Do you expect to make any fundamental changes to your activities / situation within the next 24 months ?

If YES, please provide full details

19. Do you own any ambulances

If YES, please provide full details, including maintenance agreements currently in place

20. Do you have protocols/procedures in place for

- a) Behaviour Management/Bullying
- b) Restraint
- c) Administration of Rectal Diazepam
- d) Contact with relatives and friends
- e) Unauthorised absence
- f) Complaints

If NO, please give details

21. Are you duly licensed and registered in accordance with the Care Standards Act 2000 and do you carry a certificate of registration from the National Care Standards Commission ?

If YES, please enclose the following additional documentation :

- a) Copy of your NCSC application for registration
- b) Copy of your Statement of Purpose (if applicable, as required by your application)
- c) Copy of your Service Users Guide (as required by your application)
- d) Copy of your Policies and Procedures (as required by your application)
- e) Copy of your Staff Training and Development (as required by your application)
- f) Copy of the most recent NCSC inspection report

(If you are registered with the NCSC please continue to Section 2)

If NO, or if you are unable to provide any of the above, please provide details, including anticipated date of registration and then continue to Section 3.

SECTION 2.

1. Has your registration with the NCSC ever been :

- a) Approved with Conditions ? YES/NO
- b) Refused ? YES/NO
- c) Varied ? YES/NO
- d) Cancelled ? YES/NO
- e) Cancelled under Urgent Order ? YES/NO

If you have answered YES to any of the above, please provide FULL details

2. Have you been recently inspected by the NCSC

If YES, please provide details of date of last inspection and the performance grade that you were given

3. Have you ever been or are in currently in dispute with the NCSC, regarding an assessment decision or the contents of an assessment report

If YES, please provide full details

SECTION 3.

1. Do you have any other Malpractice or Public Liability Insurance ?

2. Have any Lloyd's or Company Underwriters ever cancelled, declined, refused to renew or only accepted on special terms, your Malpractice or Public Liability Insurance ?

If YES, please provide full details :

3. Have any claims for Malpractice or Negligence ever been made against you or are you aware of any circumstances which may result in such claim being made against yourselves ?

YES/NO

If YES, please provide full details on an additional sheet

4. Is there any further information that should be made known to Underwriters so that they may form a proper estimate of the risk ?

YES/NO

If YES, please provide full details:

SECTION 4 (Not applicable to those facilities registered by NCSC)

1. Have you ever been the subject of an enquiry, by Social Services or similar ?

If YES, please provide FULL details:

2. Do you ensure that all references and qualifications are taken up / checked and that all appropriate police checks are carried out on all staff, be they full / part time or temporary / contract staff and do you ensure that only competent and adequately trained staff are employed and that all staff are kept under proper supervision ?

If NO, please provide full details

3. Are you duly licensed and registered in accordance with the law and any applicable regulatory body to practise at the address(es) stated in your answer to Question 1

If NO, please provide full details

If YES, has your license has ever been revoked, suspended, declined etc or have you ever had any additional conditions / warranties attached

If YES, please provide full details:

ONLY APPLICABLE to those care facilities providing services to persons under the age of 18 yrs.

1. Please provide the following:

a) Total number of Children/young adults

0-4yrs 5-10yrs 10-18yrs

b) Number of males

c) Number of females

d) Total number of bedrooms

e) Number of children/young adults per bedroom

f) Segregation/supervision arrangements

DECLARATION

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed or mis-stated any material facts and I/we agree that this Proposal Form shall be the basis of the contract with the Underwriters.

Name of the Proposer:

.....

Signature:

.....

Official Position:

.....

Dated the day of 20

This Proposal Form, duly completed, together with any supplementary information, must be signed in ink. Signature of the form does not bind the Proposer or the Underwriters to complete the insurance.

NOTICE TO SOLE TRADERS / INDIVIDUALS

The European Union Third Non-Life Directive on Pre-Contractual Disclosure Requirements requires you to be provided with the following information prior to a contract being concluded:

Notice to the Proposer/Assured:

The Parties are free to choose the law applicable to this Insurance Contract. Unless specifically agreed to the contrary, this insurance shall be subject to English Law.

Any enquiry or complaint should be addressed in the first instance to your Broker. If you are not satisfied with the way a complaint has been dealt with, you may ask the Complaints Department at Lloyd's to review your case without prejudice to your rights in law. The address is:
Complaints Department, Lloyd's, One Lime Street, London, EC3M 7HA. Telephone: 020 7327 6950.