

**ACCIDENT & EMERGENCY SERVICES
IN IRELAND**

- A standard for the new millennium

**Irish Accident & Emergency Association
February 1999**

PREFACE

This document has been developed from that prepared by the Standards Sub-committee of the I.A.E.A. – *Standards for Accident & Emergency Departments in Ireland* - and approved by the association in late 1997.

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1. INTRODUCTION.

The Irish Accident & Emergency Association (I.A.E.A.) was established in 1991. It consists of Consultants in Accident & Emergency Medicine working in the Republic of Ireland. One of its objectives is to establish the standards of provision of Accident & Emergency Services that should be available throughout the Republic of Ireland. It is with this aim in mind that we have produced the following document which represents the Association's position on the role of the Accident & Emergency (A&E) Department in the provision of Emergency Medical Services, the staffing of such departments and aspects of design of such departments to fulfil the demands made upon them.

2. ROLE OF THE ACCIDENT & EMERGENCY DEPARTMENT

2.1. The Emergency Medical Services (EMS)

Every acutely ill or injured person in the country must have rapid access to the Emergency Medical Services (EMS) – the Accident & Emergency Services in their broadest sense. The EMS consists of the ambulance service and access to it, pre-hospital care systems, Accident & Emergency Departments, intensive care facilities and definitive care services. The Accident & Emergency Department and the specialty of Accident & Emergency form the core of the EMS. This pivotal role must be recognised. As it is only in the recent past that consultants have begun to be appointed to Accident & Emergency departments throughout this country these services have not, as yet, been developed to an appropriate level.

2.2. Primary Accident & Emergency Department Function

An Accident & Emergency Department should provide optimal facilities for the initial reception and treatment of patients with acute injuries and sudden unexpected illness so that the best possible outcome may be achieved.

2.3. Training of Staff in Accident & Emergency Work

Accident & Emergency Departments should contribute to the professional development of medical, nursing and other staff by providing formal training as well as opportunities of gaining experience under the supervision of experienced staff.

2.4. Research and Accident Prevention

Accident & Emergency Medicine should contribute to the improvement of the management of injury and sudden illness by information collection and research. In addition, the service should contribute to the prevention of accidents by co-operating with other agencies with similar aims and help in education of the public.

2.5. Major Incident Planning

The EMS is crucially important in the provision of the response to major incidents. The Accident & Emergency (A&E) Department provides the focus for the hospital response to such incidents.

2.5.1 Each hospital should have a Hospital Major Incident Plan. The vitally important role of the A&E Department should be recognised

in this plan. Such Major Incident Plans may reflect particular hazards within the catchment area of a given hospital e.g. an airport but plans will contain many ingredients common to most hospitals. It is important that such plans are practised and lessons learnt from enactment or practice runs. Budgetary provision should be made at hospital level for the extra equipment required for the management of major incidents.

2.5.2 Provision should be made for an individual A&E Department to cope with large-scale emergencies which may occur within the hospital campus.

2.5.3 A&E Departments are often expected to provide medical and nursing staff to cover major events within the catchment area of the service e.g. concerts, football matches etc.

Key A&E staff should be encouraged to attend Major Incident management courses.

2.6. Continuing Care

The majority of patients should be discharged from the care of the Accident & Emergency Department after their first visit. A&E Departments however should take account of the fact that a proportion of patients will require further departmental review. Such review does not supplant the requirement for General Practitioner follow up. Accident & Emergency staff should have access to appropriate clinics for continuing care of emergencies e.g., Fracture clinics, Ophthalmic clinics, Ear Nose and Throat clinics. Accident & Emergency staff should be aware however that it is more appropriate for all but emergency hospital clinic appointments to be made by referral by the patient's General Practitioner. In this regard the A&E department should not be used inappropriately to circumvent normal channels of referral.

2.7. Accident & Emergency Bed Facilities

There are certain conditions that are most effectively observed and treated in a ward area allied to the Accident & Emergency Department. In view of this a number of designated beds should be provided for their care. Such beds should be "protected" from being used as overflow by other hospital departments. See 4.2.

2.8. Other Services

Accident & Emergency Departments are also involved in the provision of a number of additional services to the public in times of need e.g. telephone advice, bereavement counselling etc. Such services must also be taken into account when considering staffing and design of Accident & Emergency Departments.

3. CATEGORISATION OF ACCIDENT & EMERGENCY DEPARTMENTS

To ensure that all patients throughout the country receive an appropriate level of emergency care Accident & Emergency Departments in all Regional Hospitals, University Teaching Hospitals and large General Hospitals should have a ***Comprehensive Accident & Emergency Facility*** with smaller General hospitals providing a ***General Accident & Emergency Facility***.

However all Comprehensive and General A&E services should be under the direction of Consultants in Accident & Emergency Medicine. See 6.1.

Comprehensive Accident & Emergency Facility

Such a facility should have the following specialties on site: -

Acute Medicine

Cardiology

General Surgery

Orthopaedics

Anaesthetics

Intensive/Coronary Care

Radiology (with 24 hour access to a CT Scanner)

Pathology (with 24 hr access to Haematology, Chemical Pathology and Blood transfusion)

Gynaecology

Paediatrics

Psychiatry

General Accident & Emergency Facility

At least General Medicine, General Surgery, Anaesthetics and X-ray facilities should be on site.

See **Appendix 2 Supporting Specialties for an Accident & Emergency Facility** for further requirements.

4. BED REQUIREMENTS

4.1. General Bed Requirements

Once the decision is taken by Accident & Emergency Medical staff (in conjunction with the admitting specialty) that an individual patient requires hospital admission it is imperative that a suitable bed be available in a timely fashion. Undue delay for admission from an Accident & Emergency department to a hospital bed (more than 4 hours) is both unacceptable from the point of view of patient care and the efficient running of an A&E Department. Delays in transferring patients to a ward result in a progressive deterioration in the ability of the A&E Department to perform its primary function. This has safety implications both for patients remaining in the A&E Department inappropriately and for those arriving subsequently whose access to facilities and overstretched staff within the department is compromised. If for any reason more than one patient is awaiting admission for more than 4 hours an extra qualified staff nurse should be provided from elsewhere in the hospital.

4.1.1. Each hospital with an Accident & Emergency Department should have clear admission policies and effective bed management and utilisation structures in place to ensure adequate beds for emergencies

4.1.2. Provision should be made at hospital and/or regional level to enhance hospital capacity to respond to the annual surge in emergency medical admissions during the winter months.

4.2. Accident & Emergency Department Beds

Beds should be available in a dedicated ward setting within Accident & Emergency Departments (as described in 2.7) for patients who are anticipated to require brief stays. Local policies, agreements and guidelines will determine the case-mix and throughput in these units.

The following general principles however should govern their use: -

- a) This ward should be provided to admit patients from the Accident & Emergency Department to allow observation or emergency treatment.
- b) It should function on a 24-hour basis and be under the administrative and clinical control of the Accident & Emergency Department.
- c) The decision to admit should be that of the Accident & Emergency staff.
- d) Such beds should be ring-fenced from the General hospital pool

There should be one bed per 5,000 new patient attendances per year.

5. PROCESSES AND SERVICE INDICATORS

5.1. Guidelines and Protocols

Accident & Emergency Departments should have guidelines; protocols and policies in place as applicable. These will require regular updating, authorisation and dissemination. They should be conveniently stored and must be readily accessible to all relevant staff.

5.2. Accident & Emergency Records

A record should be maintained on each patient who attends an Accident & Emergency Department. This record should contain: -

- Date, Time and Method of Arrival
- Triage information and classification
- History, relevant additional medical information and physical examination findings
- Details of other specialty involvement including time of referral
- Tests requested and results
- Treatment given and response
- Management plan including treatment prescribed and advice to patient / relatives
- Patient disposal
- Names and signatures of attending doctor and nurse

The A&E record or copy should go with the patient if they are admitted

5.3. Information Technology

Accident & Emergency departments should have relevant information technology systems in place. The presence of such clinical and administrative systems should enable accurate information collection, dynamic patient flow monitoring, clinical audit and research. It will also facilitate exchange of information between centres

5.4. Triage

An effective system of triage should be in place. Relevant triage information should be recorded by a suitably trained nurse and a Triage category assigned in accordance with a recognised Triage standard.

5.5. Communication with External Agencies

Systems and structures for communication with General Practitioners, the Ambulance service, Gardai, Search and Rescue services and other external agencies should be in place.

5.6. Risk Management

A&E Departments are high-risk areas for litigation. It is imperative that hospital management instigates suitable formalised risk management strategies in consultation with the responsible Consultant(s) in Accident & Emergency.

5.6.1. Each A&E Department should have a system in place to ensure that all x-rays taken on patients attending A&E Departments are formally reported by a Radiologist and reports received within 2 working days and that results at variance with the A&E doctors interpretation are flagged for urgent action.

5.6.2. Laboratory reports similarly need to be reviewed and unexpected results / positive findings communicated to the patients General Practitioner or otherwise acted upon

5.6.3. Information from complaints and litigation should be fed back into the risk management strategy.

5.7. Checking of Equipment

Suitable systems need to be in place to ensure regular checking and calibration of departmental equipment and recording of same. Resuscitation Room equipment, defibrillators etc should be checked daily and Major Incident Equipment on a weekly basis.

5.8. Teaching Environment

Each A&E Department should promote a culture of learning and teaching in its environs with both mono- and multidisciplinary education. A suitable induction programme should be provided for new nursing and medical staff (although it is appreciated that the current six-month senior house officer contracts beginning in January and July militate against this) and each department should have an ongoing teaching programme. Encouragement should also be given to staff to attend suitable life support and other relevant internal and external courses.

5.9. Ongoing Monitoring of Departmental Performance

Each A&E department should seek to monitor its waiting times (ideally by triage category), complaints, adverse incidents / near misses, quality of casenotes etc with a view to improving its performance.

The above quality targets will require appropriate additional resources and personnel

6. ACCIDENT & EMERGENCY DEPARTMENT PERSONNEL

6.1. Medical Staffing

6.1.1. Consultant Medical Staffing

It is imperative that all Accident & Emergency Facilities be under the direction of Consultants in Accident & Emergency. Such individuals will have completed formal training in Accident & Emergency Medicine and be qualified to the standards laid down by Comhairle na nOspideal.

The I.A.E.A. considers that Consultants should be working in units of three consultants. In the case of the larger Accident & Emergency Departments in metropolitan areas the number of Consultants in post should be increased to three. In some cases one or more Consultants of the three Consultant lead unit may have sessions in or be fully responsible for a neighbouring *General Facility*. Elsewhere within a Health Board area or service, Consultants also may share the responsibility for Accident & Emergency departments and other services on a local or regional basis. However it would be expected that they be grouped in units of three Consultants with a lead hospital in which all three Consultants would have sessions. The levels of commitment and responsibility and how these are allocated will be determined at local level. These may well vary from area to area in the light of geography and service configuration.

Appropriate resources must be provided firstly to enable Consultants pursue these tasks but also to provide adequate cover for annual leave, study leave for Continuing Medical Education and other contractual obligations.

6.1.2. Non-consultant Medical Staffing – Middle Grade Staffing

Accident & Emergency departments provide a service first and foremost and training to staff thereafter. Currently A&E services are primarily delivered by senior house officers (S.H.O.s) often at a very early stage of their training. **The I.A.E.A. believes strongly that the doctor of first contact for patients attending an A&E Department should be experienced and clinically competent.** It therefore proposes that a grade of Associate Specialist is introduced in order to ensure that the vast majority of care provided in an A&E Department is provided by a doctor of greater seniority and experience. It is envisaged that this grade

would have a structured training programme consisting of four years post-internship concluding with an exit exam (A.F.R.C.S. Edinburgh in Accident & Emergency or equivalent). Such staff would work both in *Comprehensive* and *General Accident & Emergency Facilities*. Should an incumbent decide to embark on the path to achieving a Certificate of Completion of Specialist Training (C.C.S.T.) they will be eligible for entry to Specialist Registrar (SpR) training

The calculation of non-consultant staff numbers needed to service an A&E department has to be made considering a number of factors: -

- number of total patient attendances
- provision of holiday and CME/Study leave etc.
- the length of the working week
- the requirement to cover the department 24 hours a day.

Safe working practice demands that, because of the particularly intensive nature of A&E work, the working week of staff should not exceed 40 hours. The I.A.E.A. thus recommend 1 non-consultant doctor per 3,000 patient attendances based on a 40-hour week.

A department with 24,000 attendances would thus require 8 non-consultant medical staff. This in fact represents the minimum needed to run a 24-hour service regardless of attendances.

6.1.3. Non-consultant Medical Staffing – Trainees

The Accident & Emergency department is an ideal site for staff in training (S.H.O.s) in a variety of specialties. These trainees would not provide a full service commitment. Trainees would ideally be from the fields of Medicine, Surgery, General Practice, Anaesthetics and Accident & Emergency Medicine. The I.A.E.A. believes that the ratio of middle grade to trainee staff should be a minimum of 3 : 1.

6.1.4. Non-consultant Medical Staffing – Specialist Registrars

In A&E Departments accredited for Specialist Registrar (SpR) training, this grade of middle grade staff will be available to the department from time to time. Because of the obligation of doctors in this grade to go on secondment outside the parent A&E Department, their contribution to the service can only be calculated as 0.5 wte of a Middle Grade (as in 6.1.2)

6.2. Nurse Staffing

6.2.1. Staffing Levels

There should be a minimum of one staff nurse per 1,250 patient attendances per year. Factors requiring additional nurse staffing over and above this minimum include the following: case mix, additional roles (e.g. triage, nurse practitioner, other extended roles), physical layout of the department and periods of peak demand for services. The presence of an A&E / observation ward will also require additional nurse staffing. Where for any reason more than one patient awaits a bed for longer than four hours, an extra qualified nurse should be provided. Nursing staff should be of sufficient numbers to allow patient care and flow take place with sufficient leeway to administer to emergencies that may arise.

6.2.2. Nurse Management

Suitable nurse management structures should be in place in all A&E Departments. The exact model will depend on the size of an individual department. Very large departments may have a dedicated nurse manager and a number of sisters whereas smaller departments may only have a single sister post.

6.2.3. Training Levels for Staff nurses

The minimum level of training required of a staff nurse in an Accident & Emergency department should be six months post-registration and a four week orientation period working in the Accident & Emergency Department as a supernumerary with an experienced nurse mentor. Two-thirds of nursing staff in all Accident & Emergency Departments should have completed a post-registration Accident & Emergency course. The I.A.E.A. believes that all nursing staff working in Accident & Emergency Departments should complete recognised Trauma, Cardiac and Paediatric Resuscitation Courses within two years of commencing employment in the department.

6.2.4. Nursing Auxiliary Personnel

Nursing auxiliary personnel may also be necessary. The duties and responsibilities of such personnel should be clearly delineated. Departmental workload and patient case mix will determine the numbers of such personnel.

6.3. Other Staff

All non-professional staff who are working in the Accident & Emergency department should have some training in Basic Life Support (B.L.S.) and have completed an orientation programme.

6.3.1. Reception / Clerical Staff

The Reception staff are often the first point of contact with the patient. Their crucial role thus needs to be appreciated. The importance of patient documentation and prompt chart retrieval similarly can not be over emphasised.

In *Comprehensive Accident & Emergency Facilities* the reception needs to be manned 24 hours per day. Other cover arrangements may be adequate in a *General Facility*.

6.3.2. Secretarial Staff

A minimum of one departmental secretary is required in a *Comprehensive Accident & Emergency Facility*. There should be full cover for absence due to leave.

Further secretarial time will be required depending on:-

- a) Number of Consultants
- b) Additional commitments of a Consultant such as Medical Advisory role to the ambulance service.
- c) Commitments outside the lead department e.g. responsibility / sessional commitment to other A&E facilities.
- d) Academic requirements e.g. in a teaching hospital setting.

6.3.3. Portering / Attendant Staff

Porters should be available at all times over the twenty-four hours to move patients, equipment etc. In general, as patients can arrive at the Accident & Emergency department at any time there should be a porter in the department to deal with them in addition to a porter who may have gone to a ward with a patient.

6.3.4. Domestic Staff

There is a requirement for a full-time domestic within *Comprehensive and General Accident & Emergency Facilities* during the working day. Cleaning staff must be available at all other times as spillages occur throughout the day and night.

6.3.5. Security Staff

An Accident & Emergency department remains open at all times. No person is excluded from entry. Patients, relatives and staff are thus vulnerable to violent episodes. A&E staff will meet people of a violent nature on a regular basis. As violent incidents may occur without warning it is important that a Security presence be in the Department at all times. It is not sufficient that a security officer be elsewhere on the hospital campus.

Additionally suitable security measures to protect the public and staff should be in place. These will vary from department to department but may include security screens, CCTV, personal alarms etc

6.3.6. Physiotherapy Service

One full-time physiotherapist is required per 40,000 patient attendances per year. Departments seeing fewer patients than this should have a service provided on a pro rata basis.

6.3.7. Social Work support

Every Accident & Emergency department should have access to Social services around the clock. At least one full-time Social Worker should be assigned to a *Comprehensive Accident & Emergency Facility*. *General Accident & Emergency Facilities* should have ready access to Social Work support.

6.3.8. Other Supporting Staff

All *Comprehensive* and *General Accident & Emergency Facilities* have a need for ready access to the following services:-

- Pastoral Care
- Interpretation Services
- Volunteer Services
- Public Relations

7. SUPPORTING DEPARTMENTS AND SERVICES

7.1. Categorisation of Facilities

The availability of in-hospital services will, to a large extent, determine the categorisation of a hospital's Accident & Emergency Department. See **Section 3** and **Appendix 2**.

7.2. Interface With Social Services and External Agencies

The very nature of the Accident & Emergency services means that the specialty and the departments must cope with many disparate and needy groups of people such as the homeless, alcoholics, drug abusers, victims of domestic violence, victims of non-accidental injury and others. The Accident & Emergency service must be staffed, structured and designed to address these issues. Each department should have ready access to social work support on a 24 hour basis and should be aware of the presence of local facilities e.g. Rape Crisis centre, refuge for victims of domestic violence, shelters for homeless etc.

7.3. Non-clinical Support

All Accident & Emergency Departments should have ready access to laundry, pharmacy and sterile supplies. Suitable arrangements should be in place to ensure out-of-hours access. Provision for emergency out-of-hours maintenance support needs to be made.

7.4. Cardiac Arrest and Trauma Teams

Each hospital with an Accident & Emergency Department should have active Cardiac Arrest and Trauma Teams in place. Larger A&E Departments may have the capacity to be self-sufficient and provide these teams from among the Department's own personnel.

8. DESIGN FEATURES OF AN ACCIDENT & EMERGENCY DEPARTMENT

8.1. Accessibility

Each Accident & Emergency Department should be clearly signposted from all hospital entrances and from major hospital thoroughfares. Such signs should follow the convention of “Accident & Emergency Department” in white lettering on a red background.

Departments must be accessible to those with disabilities.

8.2. Space

Visits to an Accident & Emergency Department fluctuate greatly from day to day and from hour to hour. Space requirements should therefore be estimated on the basis of peak loads, taking into account the urgency of clinical problems. Therefore there may be some variations from standard recommendations. The I.A.E.A. recommend a minimum space requirement of 1,000 square metres gross per 100 visits per day.

Space within the Accident & Emergency department can be divided into:

- Primary Activity Space (Those areas where patient care is given)
- Support and Administrative Space

8.3. Primary Activity Space

The Clinical Area can be regarded as comprising the Triage Area, Waiting Area, Resuscitation Room, Cubicles (Major & Minor), Plaster Room, Minor Operating Theatre, Interview room, Clinical station, Staff Clinical Room and Accident & Emergency Ward.

8.4. Support and Administrative Space

This area is the administrative and rest area. It should include offices for Consultant Staff, Sister, Secretary, NCHD staff, Reception and Medical Record Storage Area, Library / Conference / Teaching Area, Bedroom for the On-Call doctor, Staff Rest room, Staff Changing area (including Showers)

Further details of space requirements are provided in **Appendix 1**

8.5. Special Design Features

8.5.1. Entrances

There should be two entrances. One entrance should be for walking wounded and lead by the reception desk to the waiting area. The other entrance should be for ambulance patients and should have immediate access to resuscitation or cubicle areas. The ambulance entrance should have a canopy over it to protect patients from the elements during transfer.

The approach to this area should be designed to allow for maximum manoeuvrability of ambulances and parking facilities for ambulances delivering patients to the Department. Parking of private cars will need to be prohibited and this prohibition enforced so that access by the Emergency Services is not hampered. However parking facilities for patients and their relatives should be available nearby as should set-down facilities.

8.5.2. Access Within the Department

Corridors within the department should be wide and all doors should allow for the passage of trolleys. There should be ease of access to resuscitation and treatment areas for medical and nursing staff. While it is vitally important that all patients within the department should be observable, they should not be on view to the public. Patients being transferred through the department or to other areas such as radiology should be exposed as little as possible to public scrutiny.

8.5.3. The Reception Area

The waiting area should be visible from here and there should be direct access from the reception area to the clinical area.

There needs to be a sufficient number of "hatches" to ensure that patients do not wait unduly for registration. Inputting information on modern computer systems takes 7-10 minutes therefore there should be the availability of a station per 6 patients per hour at peak times. A&E records for the previous and current year should be available in or adjacent to this area.

8.5.4. The Waiting Area

The waiting area should be well-lit, spacious but internally divided to provide for smaller groupings of patients and relatives. There should be separate waiting areas for adult and paediatric patients and their friends and relatives. Toilet and baby changing / feeding facilities as well as payphones / cardphones are required.

Waiting areas should be pleasantly decorated and equipped with beverage machines. There should be a television and/or music. Signage within the department is important and should allow for information to be transmitted to those waiting. The I.A.E.A. strongly recommends the provision of such facilities and communication (especially on waiting times) to ensure that violence and aggression is minimised.

8.5.5. Triage

A room adjacent to the Reception area needs to be set aside for initial nursing assessment so that an appropriate Triage category can be assigned. This room needs to be strategically positioned so that the Triage nurse can monitor the Waiting Area.

8.5.6. Staff Facilities

A staff rest room is mandatory. This needs to be slightly away from the clinical area so that patients will not get upset if noise comes from it. It should contain snack making facilities as staff in Accident & Emergency Departments need to remain close by in case they are needed urgently. It needs to be of sufficient size to accommodate nursing, medical and support staff.

In addition adequate facilities for staff changing and showering must be provided as contamination is a common event in an A&E Department.

8.5.7. On-call Facilities

A separate bedroom with an en-suite facility should be provided for night medical staff. This should be sufficiently close to the Department to allow a rapid response when summoned.

8.5.8. Office Facilities

There should be sufficient office space to facilitate nursing, medical and secretarial staff. Consultant and middle grade medical staff will require separate office facilities

8.5.9. Teaching Facilities

Conference room facilities and general teaching facilities must be provided within the Accident & Emergency Department in *Comprehensive Accident & Emergency units*. It is also necessary to provide a Library area where junior staff can refer to appropriate texts as the need arises. Less comprehensive teaching facilities may be needed in a *General Accident & Emergency Unit* but must be available elsewhere in the hospital

8.5.10. Major Incident Capability

In the design of the Accident & Emergency Department consideration should be given to the ability of the department to increase its capacity to handle casualties from a Major Incident. In addition *Comprehensive Accident & Emergency departments* should have facilities to allow for patient isolation and decontamination.

8.5.11. Miscellaneous

Comprehensive Accident & Emergency Units should give consideration to providing separate facilities for ambulatory patients and a primary care unit.

9. FACILITIES AND EQUIPMENT

9.1. Resuscitation Room

The number of bays required in the resuscitation area is indicated in **Appendix 1**. An overhead x-ray gantry should be standard equipment within the Resuscitation Room in all new facilities. Consideration should be given to retrofitting this equipment in pre-existent facilities. Each resuscitation bay should be large enough to accommodate one height adjustable and tilting trolley with 1 metre clearance on all sides of the trolley. Equipment in each bay should include:-

- Airway board accommodating all equipment for intubation
- Monitoring equipment enabling monitoring of
 - pulse rate,
 - electrocardiogram (ECG),
 - non-invasive blood pressure (NIBP),
 - Oxygen saturation (SaO₂),
 - End-tidal Carbon Dioxide (ETCO₂)
 and at least one invasive channel.
- Defibrillator with External Pacing
- Ventilator
- Medical gases, suction
- Ophthalmoscope/Auriscope
- Ceiling mounted tracks for Intravenous fluids
- High intensity adjustable mounted light

The Resuscitation room should contain a Refrigerator, Blood & Fluid warming equipment (which should allow high-volume infusion), an Anaesthetic machine and a drug cupboard (including access to Controlled drugs and Anaesthetic agents)

9.2. Major Treatment Area

The number of cubicles required should be as indicated in **Appendix 1**. Each cubicle in this area should have a height adjustable and tilting trolley. There should be facilities for airway care, suction and monitoring of ECG, SaO₂ and NIBP. Facilities for ophthalmoscopy and auriscopy must be available in each cubicle. An overhead intravenous track should be fitted.

9.3. Minor Treatment Area

Every *Comprehensive Accident & Emergency Department* should contain four minor treatment cubicles. These cubicles should be

equipped similarly to the major treatment cubicles (including having a height adjustable and tilting trolley) except that cardiac monitoring apparatus is not required. There must be a defibrillator available to the area. An adjustable mounted, high intensity light should be provided in each cubicle.

9.4. Paediatric Treatment Area

Departments that see both adults and children should have a separate paediatric examination and treatment room. This room should be walled and sound-proofed. It should be equipped as a Major Treatment Room but with paediatric equipment and consumables. It should be rendered child friendly and decorated appropriately.

9.5. Plaster Room

This should have facilities for reduction of fractures, including anaesthetic equipment etc. There should be an evacuation system for removing plaster dust.

9.6. Clinical Station

This station should have a view of the entire working area. If this is not possible an additional smaller sub-station may be needed. It should be of sufficient size to allow Accident & Emergency medical and nursing, as well as visiting staff to work. It would be preferable if the visiting staff could have their own area. It will need to be designed to accommodate computers, telephones, fax, paper, request forms, a photocopier, X-ray viewing boxes, desks, chairs etc.

9.7. Minor Operating Theatre

A minor operating theatre is required in all *Comprehensive Accident & Emergency Facilities*. This should be the size of and have the normal facilities (anaesthetic equipment etc) of a standard hospital operating theatre.

9.8. Interview Room

A room needs to be available to interview patients in private. This room should have two exits so that if a patient becomes violent there is an escape for the clinical person.

9.9. Bereaved Relatives Room

An office sized room should be available close to the Resuscitation room where relatives of seriously ill patients or deceased patients can grieve away from the public eye. This should be appropriately decorated, have tea / coffee making facilities, have a telephone and be adjacent to toilet facilities. Information in the form of leaflets, telephone numbers of support groups etc. should be near at hand to facilitate the bereaved.

9.10. Temporary Mortuary

A suitable sideroom should be available to act as a temporary mortuary pending transfer to the main hospital mortuary.

9.11. Procedures Room

There should be one room available within the department to allow for specialised procedures.

9.12. Staff Clinical Room

There is need for an office type room where staff matters may be dealt with in private. Such things as off duty etc. would be held here. It also allows for private discussions between members of staff, post resuscitation debriefs etc at appropriate times.

9.13. Teaching Facilities

A teaching/seminar/conference room needs to be provided. A screen and projectors (slide and OHP) should be available.

9.14. Utility Areas

Clean and dirty utility areas should be adjacent to the cubicle area. These should be similarly equipped to acute wards.

9.15. Accident & Emergency Ward

This needs to be fully equipped as an acute ward. In addition to normal ward furniture, nurses station etc., the ward should have its own toilet and bathroom facilities.

9.16. Storage Facilities

The Accident & Emergency Department requires adequate room for storage of equipment, linen etc.

It may require a separate storage area for equipment, labels etc. to be used in the event of a Major Incident.

9.17. Special Equipment Store

Equipment is required for providing life support in transit within and outside the hospital. Similar equipment must also be available for hospital teams involved at accident or disaster sites.

9.18. Self Contained Radiology Suite

Every department should have a dedicated radiology suite adjacent to it.

9.19. Emergency Investigation Laboratory

This would be used for Blood gas analysis etc.

9.20. Additional Privacy

Some patient presentations (suspected child abuse, gynaecological presentations etc) require even greater degrees of sensitivity and privacy than the average. Consideration therefore needs to be given to ensuring that all departments have an adequate number of suitable siderooms, fitted out to the same standard as minor treatment cubicles, that can be used in these situations.

APPENDIX 1 SCHEDULE OF ACCOMMODATION

<i>Main Entrance Draught Lobby</i>	20 square metres
<i>Reception Area</i> visits	20 square metres for 20,000 + 5 square metres per extra 10,000 visits / year
<i>Main Waiting Area</i> visits	30 square metres for 20,000 + 5 square metres per extra 10,000 visits / year
<i>Children's Waiting / Play Area & Nappy Change</i> year	12.5 square metres for 20,000 visits + 1.5 square metres per extra 10,000 visits /
<i>Infant Feeding Room</i>	4 square metres
<i>Patients & Escorts WC</i>	2 X 2 square metres for 20,000 visits + 2 square metres per extra 10,000 visits / year
<i>Disabled Persons' WC</i>	4 square metres
<i>Clean Utility</i>	10 square metres
<i>Dirty Utility</i>	10 square metres
<i>Clinical Staff Room</i>	10 square metres
<i>Specimen WC</i>	4 square metres
<i>Decontamination Area</i>	12 square metres
<i>Bereaved Relatives Room</i>	10 square metres
<i>Interview Room</i>	12 square metres
<i>Consultant's Office</i>	12 square metres per Consultant
<i>Secretary's Office</i>	18 square metres + 6 square metres per additional Consultant
<i>Staff Rest Room</i> visits year	10 square metres for 20,000 + 2.5 square metres per extra 10,000 visits /
<i>Sister's Office</i>	10 square metres

<i>Medical Staff / Audit Office</i>	13 square metres
<i>Trolley / Wheelchair parking area</i>	6 square metres for 20,000 visits + 2 square metres per extra 10,000 visits / year
<i>Records store</i>	8 square metres for 20,000 visits + 3 square metres per extra 10,000 visits / year
<i>Supplies Storage space</i> visits	30 square metres for 20,000 + 5 square metres per extra 10,000 visits / year

MAIN CLINICAL AREAS

<i>Triage Bay</i>	5 square metres
<i>Resuscitation Area</i>	Minimum two bays for 20,000 visits 1 extra bay for each additional 15,000 visits / year
2 Bay Resuscitation Area	46.5 square metres
3 Bay Resuscitation Area	56.5 square metres
4 Bay Resuscitation Area	69 square metres
5 Bay Resuscitation Area	85 square metres
<i>Major treatment area</i>	8 Cubicles minimum for 20,000 visits 1 extra cubicle for each additional 2,250 visits / year Each cubicle should be a minimum of 9 square metres
<i>Minor treatment area</i>	Minimum 4 cubicles
<i>Plaster Room</i>	Minimum two bays for 20,000 visits 1 extra bay for each additional 20,000 visits / year
<i>Clinical Station</i>	18 square metres for 20,000 visits An extra 9 square metres for each additional 10,000 visits / year

APPENDIX 2 SUPPORTING SPECIALTIES FOR AN ACCIDENT & EMERGENCY FACILITY

A Comprehensive Accident & Emergency Facility requires as a minimum that the following specialties be available and readily accessible on site:-

Acute Medicine.

Cardiology.

General Surgery.

Acute Orthopaedics.

Anaesthetics.

Intensive/Coronary Care.

Radiology (with 24 hour access to a CT Scanner).

Pathology (with 24 hr access to Haematology, Chemical Pathology and Blood transfusion).

Gynaecology.

Paediatrics.*

Psychiatry.*

* If a department receives Paediatric Accident & Emergency or Psychiatric patients there must be ready access to Acute Paediatrics and Psychiatry to allow advice / support to be given. Ideally these facilities should be on site.

The following specialties need not necessarily be on site but suitable access is required:-

Ear, Nose & Throat.

Ophthalmology.

Care of the Elderly.

Neurosurgery and Neurology.

Obstetrics.

Cardiothoracic Surgery.

Oral & Maxillofacial Surgery.

Plastic Surgery (& Burns Unit).

Genitourinary Medicine.

Other Specialist Surgery e.g. Vascular Surgery, Urology etc.

Substance Abuse

The hospital should support an active Trauma Team and a Cardiac Arrest Team.

A General Accident & Emergency Facility should have available to it as a minimum the following specialties on site:-

Acute General Medicine.

Acute General Surgery (including major theatre availability 24 hours a day).

Anaesthetics.

Intensive / Coronary Care Facilities.

Radiology.

Pathology (Haematology, Chemical Pathology and access to blood transfusion products 24 hours a day).

Ready access is required to the following specialties:-

Gynaecology.

Paediatrics.

Acute Orthopaedics.

Psychiatry.

Ear, Nose & Throat.

Ophthalmology.

Care of the Elderly.

Neurosurgery and Neurology.

Obstetrics.

Cardiothoracic Surgery.

Oral and Maxillofacial Surgery.

Plastic Surgery (and Burns Unit).

Genitourinary Medicine.

Other specialist surgery e.g. Vascular Surgery, Urology etc.

Substance abuse

The hospital should support an active Trauma Team and a Cardiac Arrest Team.