Clyde
Emergency Medicine

Royal Alexandra Hospital

Inverclyde Royal Hospital

December 2020

INTRODUCTION

Welcome to the Emergency departments of the Royal Alexandra Hospital & Inverclyde Royal Hospital. We hope you will enjoy your time working with us.

Over the forthcoming months you will see a very wide range of conditions, some of which you will never have seen before.

If you are uncertain as to what to do in a particular situation, please ask a senior member of staff for help. Information is also available in the books stored in the department and in the clinical guidelines website which can be accessed through the PCs in the department. www.cem.scot.nhs.uk (password cem!)

Please remember that the nurses are very experienced and are a particularly useful source of advice and information.

Many patients in the department are in pain or are frightened, or both, so try to relieve these conditions as soon as possible. Always be polite and pleasant to your patients **and their relatives**, especially parents whose children are the most important thing in the world to them. There are more complaints to this department about the perceived attitude of doctors than there are complaints about the failure to make a correct diagnosis.

Consultant Staff

There are 23 Emergency Medicine Consultants in Clyde

Dr Euan McMillan (Clinical Director)
Dr Monica Wallace (Clinical lead-RAH)
Dr David Stoddart (Clinical lead-IRH)
Dr Gordon McNaughton
Dr Iain Young
Dr Neil Mukherjee
Dr Chris MacDonald
Dr Lucy Thomas
Dr Frank Westerduin
Dr Kirsty Ray
Dr Douglas Maxwell
Dr Alasdair Corfield
Dr Niall McMahon
Dr Raghavendra Nayak
Dr Alan Exton
Dr Santosh Bongale
Dr Alex Turner
Dr Victoria McWhinnie
Dr Stephen Hearns
Dr Zoe Smeed
Dr Frances Cameron
Dr Catriona Wallace
Dr Darren Thom

Nursing staff

The nursing staff are fundamental to the smooth running of the departments and many of them have a lot of ED experience. The nurses will perform the initial observations, apply dressings, etc. We also have HCWs who can perform ECGs, insert cannulae and take bloods. If they are busy you should expect to do these tasks yourself- they remain **medical** tasks. Some of the senior nursing staff are trained as Emergency Nurse Practitioners (ENP) and can examine patients with minor injuries, order x-rays and decide on patient management. Remember we are all part of a team working together.

COVID

There is a section within the CEM website regarding this. Please read over, and make yourself familiar with the documents

Triage

All patients attending the departments are seen by a trained senior nurse and assigned an appropriate “triage category”. This ranks the patients according to their medical need and is based on the nationally agreed “Manchester triage scale”. So you will be seeing patients in order of medical priority. Patients in the resus room will ordinarily take precedence over patients in the corridor.

Manchester Triage Scale

To be seen within

1. Red — Immediately
2. Orange — 10 minutes
3. Yellow — 1 hour
4. Green — 2 hours
5. Blue — 4 hours
0. — Used when processing patients using minor injury streaming

Physiotherapy

At the RAH we have an excellent resident physiotherapist. We are able to arrange out patient physiotherapy follow up directly from the Emergency dept

Senior Cover

A Consultant is on duty:

RAH Mon-Fri 8am -1130pm and Saturday/ Sunday 9am-1130 pm.

A middle grade ED doctor is on duty in both sites 24 hours per day.

There is a Consultant on duty at Inverclyde Royal Hospital, 9am-5pm Monday to Friday

You should ask their help for cases that you are uncertain about how to manage and should involve them in the management of all patients you are treating in the resus room.

Out of the above hours the on-call consultant is available via the switchboard.

ADMISSIONS/ REFERRALS

Cardiothoracic surgery, vascular surgery, spinal injuries, neurosurgery, maxillofacial surgery, plastics/ burns, paediatrics and ENT are not present on-site at the RAH. It is a similar state at IRH.

Ophthalmology provides cover both sites out of hours and the on-call reg is available through the switchboard.

Emergency ENT is based at QEUH
Paediatrics are based at RHC
Obstetrics & Gynaecology are based at RAH.

To admit a patient you should page the on-call middle grade for the appropriate speciality.

Please note

- **Specialities cannot refer patients back to the Emergency Department**
- **Do not accept telephone advice to discharge a patient. If referring a patient to the on-call middle grade then they must review the patient in the ED**
- **ED staff can admit directly to the Acute Medical Unit/Medical Assessment Unit at RAH. Discuss admissions with ED middle grade or consultant prior to admission.**
- **An explanation of workings of the medical receiving system will be given at induction**
- **Most patients can be referred on clinical grounds alone. If bloods have been taken then do not waste time waiting for results before referring. This unnecessarily prolongs the patient's stay in the ED.**

Out Patient Clinic referrals. Refer patient back to their GP. We are not a conduit for quick clinic referrals.

AMBULANCE SERVICE

The ambulance crew can provide very useful information about the situation in which they collected the patient and any changes, either improvement or deterioration, in the patients condition during transfer to hospital. This is given both verbally and printed on the white ambulance **Patient Report Form**. (PRF). These should be completed and handed in for all ambulance arrivals. They give important info about transfer times. Ensure these are in notes for all patients especially deaths and major trauma.

Standby

Advanced warning of critical cases en-route to the hospital should be given. This will usually be via the radio at the doctor's station. Info should be obtained about patient's status and ETA. Standby form to be completed

AUDIT

There may be several audits ongoing in the department. Your help in completing these is greatly appreciated. Should you have any ideas/interest in completing an audit during your time in the ED then please discuss with the consultant staff.

CLINICS

We review a small number of patients. Please use common sense when appointing patients to the clinics as they can rapidly become overloaded. Discuss with middle grades whether or not a patient should be brought back to a clinic

RAH Clinics

1. SOFT TISSUE CLINIC **see overleaf for info regards patients to be referred to clinics**
   Thursday mornings from 0915am
   Consultant led. Major soft tissue injuries. If a patient requires crutches for mobilisation then they must been seen back in the clinic. Generally leave 2 weeks before review.

2. DAILY REVIEWS
   Held Monday-Friday mornings from 11am. No weekend reviews
   For troublesome wounds/burns. **MAXIMUM 5 per day**
   These patients are reviewed by the consultant staff

   The vast majority of wounds can be followed up at GP practice. The nursing staff will arrange this for you.
   At the start of your job all reviews must first be authorised by the middle grade staff

IRH Clinics

1. SOFT TISSUE CLINICS
   Monday and Thursday mornings from 10am
   For major soft tissue injuries as per RAH.

2. DAILY WOUND REVIEWS
   similar numbers as per RAH. Again these patients should be reviewed by the duty consultant. No weekend reviews

   FRACTURE CLINICS
   Virtual Fracture Clinics IRH & RAH:

   Previously patients were brought back for fracture clinic review the next day. They are now discharged with a 'virtual' fracture clinic leaflet and asked to give details to reception on leaving the dept. Fracture clinic will contact them by phone over the next 48hrs to discuss follow up

   If you think a fracture may require surgery then refer to the orthopaedics on-call. In the early weeks of your post it is best to discuss fracture management with senior ED staff prior to arranging discharge & follow up.

   At RAH & IRH some fractures can be discharged with advice leaflet & no follow up. A list of the types of fractures is on the wall at the minors area

Royal Alexandra Hospital
Corsebar Road
PAISLEY
PA2 9PN

M E M O R A N D U M
Emergency Department

NHS
Greater Glasgow and Clyde

Soft Tissue Clinic Patients

Please note that the following information should be used as a guide to soft tissue referrals at all three sites.

- **Minor Soft Tissue Injuries**

The majority of minor soft tissue injuries can be referred with the standard treatment of mobilisation and ice. The majority of simple, uncomplicated soft tissue injuries should be discharged from the Emergency Department and the only follow-up necessary should be by the patient's GP.

This category includes weight bearing patients with Grade 1 mild ankle ligament sprain and weight bearing knee injuries where there is no effusion present.

Do not appoint atraumatic joint pains to the soft tissue clinics

- **Moderate Soft Tissue Injuries**

These are the patients who should be referred to a Soft Tissue Clinic. They generally include patients where there is some diagnostic uncertainty as to the exact injury and the patient needs a further assessment. A senior review at the time of attendance may help with the decision making. The patient should be treated in the standard fashion and brought for review at approximately 7 -10 days.

Patients in this category would include non-weight bearing ligament sprains of the knee and ankle, which may require a further assessment and referral to physiotherapy from the STC.

- **Significant Soft Tissue Injuries (including internal knee injury)**

The majority of patients in this category are non-weight bearing and have physical evidence of serious injury. They include patients with significant ligamentous disruption around major joints. Where joint laxity is suspected these patients should be referred either to the receiving orthopaedic team or to the next available fracture clinic, depending on the clinic scenario.

ANY PATIENT THAT YOU SUSPECT OF HAVING INTERNAL DERANGEMENT OF THE KNEE, OR EXTERNAL KNEE LIGAMENT RUPTURE SHOULD BE REFERRED TO THE NEXT AVAILABLE FRACTURE CLINIC FOR URGENT ORTHOPAEDIC ASSESSMENT.

NO ATRAUMATIC KNEE PAINS TO BE BROUGHT BACK TO THE CLINIC

CHILD PROTECTION

See attached leaflet

COMPLAINTS

Complaints are a relatively uncommon, but unpleasant feature of life in the Emergency department. They are most often due to inadequate communication between doctor and patient/relative, or doctor and GP. In dealing with all medical litigation, the strength of your defence depends upon careful history taking and good, accurate, legible note making.

Try to avoid complaints being made by being courteous and helpful to patients and relatives at all times.

Record the time you first saw the patient.

If you encounter a situation, which you suspect will result in a complaint, do try to discuss it with the consultant, if possible at the time of the incident. It may well be helpful to get one of the seniors involved to defuse the situation at the time.

Consultant Call Guidelines: RAH and IRH

Inform duty consultant of

When Consultant on duty in department

- All standby calls
- All significantly unwell patients admitted to the Resuscitation Room (including receiving cases)
- All helicopter transfers, major incidents or team call-outs
- All patients to be transferred to another hospital
- Clinical or administrative problems, which cannot be solved by the duty middle grade doctor or senior nurse.
- **Presence of Consultant from other specialty in Resus. Applies any time day/night**

When Consultant on call from home

- Major trauma patients
- Seriously ill or injured children
- Patients likely to require ventilation, intensive care, or surgical intervention
- Diagnostic or therapeutic uncertainty

and

- All seriously ill or injured patients to be transferred to another hospital
- All potential major incidents or team call-outs
- Clinical or administrative problems, which cannot be solved by the duty middle grade doctor or senior nurse.

DEATH

For all patients who die in the department, you should notify:

1. Relatives
2. General Practitioner, by phone
3. Procurator Fiscal, if appropriate

It is the duty of the Procurator fiscal to enquire into all **sudden, suspicious, accidental, unexpected and unexplained deaths.** Many of the deaths in the ED are in these categories and must be reported. Some will be expected e.g. known malignancy and these can be certified, after discussion with the GP, and without reporting to the PF. In suspicious cases out of hours contact the police.
At RAH write the names of patients to be reported to the PF on the white board at the doctor's station. Leave the case notes in the black 'death folder'.

At RAH either the consultant or middle grade will deal with the admin around any death. It is advisable to contact the GP first, both to inform them of the death and also to get more past medical history. (Also helpful to get old notes for patient) Once all information has been obtained, fill in the death questionnaire on TRAK then inform the secretaries. They will pass the information on to the deaths unit.
A similar system exists at IRH.

Please inform the nurse in charge of progress, as they will be able to contact relatives for collection of the death certificate if issued.

Where death is unexpected but explained, the PF may agree with you issuing the death certificate after discussion.

Please read the notes in the death certificate book and the booklet "death and the procurator fiscal". Be particularly aware of the list of "deaths to be reported…." and "deaths under medical care/medical mishap"

DOCUMENTATION

Writing up your ED card is slightly different to your usual medical/surgical clerk in.

Important points to note when filling out ED card

1. **Ensure you document the date and time you saw the patient.**
   This probably seems trivial, but many complaints include exaggerated claims about the length of time the patient waited. The only way we can refute this is with the written evidence.
2. Make notes brief and to the point.
3. Include drawings to show site of injury. Use the anatomical stamps/stickers if you cannot draw.
4. Include lengths of wounds & number of sutures inserted. Important if you are called to court.
5. Always sign & print name on any medical note you make.
6. A basic electronic GP letter is generated by the TRAK system. If you wish to add extra information then you may edit the letter prior to printing.
7. If advice is given to patients then document in the card what you have told them.

BLOOD RESULTS

We have moved to a paperless system for blood results, accessed through clinical portal. If a patient has had bloods taken and is going to be discharged home from the department then **you must** ensure that the results are 'reviewed & signed off' on portal. It is your responsibility to ensure this is done

ECGs: Emergency Department 12 lead ECG policy

- Medical staff must ensure they clearly document their ECG interpretation in the patients ED card.
- All ECG machines will have interpretation software active
- ECGs that are interpreted as abnormal- by hospital staff or by the ECGs diagnostic software- must be reviewed by an experienced member of medical staff (middle grade or consultant)
- The interpretation by the experienced member of medical staff must be documented

TRAK CARE

The departments use a computer system called TRAK to generate cards/blood forms/x-ray requests/discharge letters. You will be given a tutorial & user name/password for the system prior to working in the department.

EDUCATIONAL SUPERVISORS

You will be allocated an educational supervisor for your post. They will review your e-portfolio and assess your progress. It is **your** responsibility to ensure that you meet with them on at least 3 occasions. Introduction, mid point, end of post. Your ES will complete your supervisors report.

GENERAL PRACTICE

The standard of primary care in our area is very high. We wish to maintain our good relations with local general practitioners. This is done by maintaining good communications:

- Where appropriate phone the GP to discuss the case.
- GPs must be telephoned to inform them of a death of one of their patients.
- Do not refer patients to Inverclyde out-of-hours service.
- A small number of patients may be sent from triage to the OOH service at RAH by the triage nurses

HOSPITAL AT NIGHT

Both RAH & IRH have Hospital at Night teams. This should have minimal impact on the Emergency department. You will be given information on referral pathways for night time working on starting you post.

INTERHOSPITAL TRANSFER

The Consultant and middle grade on duty should be involved in such cases. Where the airway has been lost or is at risk during transfer**, the patient should be transferred by the duty anaesthetist.**
For all other cases the responsibility for medical escort lies with the transferring speciality appropriate to the patient's diagnosis.

KEY FOBS

Access to the main department at RAH is controlled by security doors. A key fob to enable access is available from the secretaries. (£10 refundable deposit required)

LIBRARY ACCESS

As you are no doubt aware that PMETB standards state:

'There must be access to educational facilities (including a library), and resources (including access to the Internet in all workplaces) of a standard to enable trainees to achieve the outcomes of the programme as specified in the curriculum.'

There is a very good Library in the RAH. It is your responsibility to join the library should you wish to use it.

LEGAL

Documentation see previous notes

Police

Try to assist the Police-we usually have a good relationship with them and they often help us out in the department.

In the Emergency department the police are particularly helpful in dealing with problems related to death in the department of unknown patients e.g. tracking down relatives. They will also compile a police report which is submitted to the procurator fiscal.

When dealing with the police please note:

- They are not allowed to look at the patient attendance registrar
- Except in relation to road traffic offences they are not allowed to have access to information about a patient without the patient's permission. This constitutes a breach of medical confidentiality.
- Police may ask you if a patient is fit to be detained. This is not your decision to make. You can however let them know if a patient is fit for discharge. Detention is decided by Custody sergeant/police surgeon.

The Court System

Patients seen in the department may be either victims or perpetrators of crime. You may well be required, at a significantly later date, to give factual evidence to a court of law. This is where your notes need to be detailed and accurate.

If a court case is planned, relating to a patient you have seen, you will be issued with a precognition notice from the police to attend the Procurator fiscal's office to give a statement. If the date/time on the notice is inconvenient then contact the fiscal to arrange a more suitable time. You will be paid a fee for this from the fiscal's office.

Prior to the trial you will be sent a court summons. This gives date/time you are required. If you are due to be working on this date then contact the fiscal's office the day before and ask to be put on "standby" This means you can still go to work on the date of attendance but the fiscal will phone you approx. 1hour before you will be called, giving you enough time to make your way to court.

Recent changes in payments mean that you will not be paid for legal aid cases.

The consultants can give you advice about appearing in court

MAJOR INCIDENT POLICY

This is a document outlining the function and responsibilities of all members of medical, nursing, administrative and ancillary staff in the hospital should a major incident arise. There is a copy of this on the wall at the doctor's station. Action cards indicating individual's role are on the wall at the doctor's station. Make sure you are familiar with your role should such an incident occur.

MEDICAL CERTIFICATES

Patients can sign themselves off work for the first seven days following their injury. Subsequent upon that they require a doctor's note- known as the Med.3 certificate. We do not keep these in the department and patients need to see their general practitioner for this form.

Patients sometimes ask for letters to give to their insurance company indicating their attendance/injuries. In this instance advise them to get their insurance company to contact the ED secretaries and they can arrange this.

MINOR INJURIES 'STREAMING'

At RAH we have introduced minor injuries 'streaming'. This means that patients with minor injuries are separated from the main pile of cards to be seen at the doctor's station. The minor injuries are seen at the top of the corridor in rooms 7 & 8.

Staffing 0900-1300, Consultant, Junior, ENP
1300-1700, Consultant, Middle grade, Junior, ENP
1700-2100, Middle grade, junior, ENP
This system runs where staffing allows Monday-Friday 9am-9pm.

PRESCRIBING

There is a small box on the inside the ED card in which you **must** prescribe any drugs given to the patient both in the department and on discharge. If the prescription is not written correctly (legibly in block capitals and in the format of the in-patient Kardex) the nursing staff will not issue the prescription.

We have a small range of drugs available in outpatient packs to give to patients to take home. These include cocodamol, Ibuprofen, PenV, Flucloxacillin, Amoxicillin, Augmentin

If you prescribe opiates then you must fill in the Controlled drugs book.

We rarely use outside prescriptions in this department. If there is a very good reason for needing some medication which is not available in the department, it is possible to order this from pharmacy. You will need to speak to one of the senior nurses about this.
Ensure any medications given to a patient on discharge are documented on the GP letter

PROFORMAS

Generally all notes are written up in the Emergency department card. We do however use some proformas for specific conditions.

- Emergency Department Assessment (used for all medical admissions).
- Head injury
- Self harm/mental health crisis
- DVT clinical assessment
- Suspected pulmonary embolism
- Low risk upper GI haemorrhage
- Chest pain assessment unit

Full list available in the CEM website

PROTECTION (Hepatitis B)

You must be immunised against Hepatitis B
You should wear theatre scrubs and gloves for all patient contacts
Use plastic aprons, water repellent gowns and masks when appropriate.
Wear lead aprons in resus when appropriate.
Take care with sharps. **If you use a sharp (e.g. suture or needle) then it is your responsibility to ensure that it is discarded. This is not a nurse's job.**

ROTA

You will all have received a copy of the rota for the next 4-6 months.

It is your responsibility to know when you are on duty. It is essential that you are in the department, changed into your scrubs and ready to work at the appropriate time. **REMEMBER**, your colleagues cannot leave until you arrive.

If you need to swap a shift then this must first be discussed with the consultants. Once a swap has been agreed then you **must** inform the secretaries and change the rota held at the doctor's workstation.

Handovers

Handing over the care of a patient at change of shift to one of your colleagues is one area where medico legal problems may arise. Ensure your documentation is complete and you have fully discussed the patient with your colleague. Try not to hand over very complicated cases.

If a patient has been handed over to you then you will have to re-examine the patient and document your examination/findings in the ED card. It is simply not good enough to look at x-rays and decide upon treatment without examining the patient. Approach any handover as a new patient.

Head Injury Observation Ward

At the RAH we have a short stay observation ward for patients following minor head injury. Below is a list of the patients we look after. Paediatric patients (under 16s) should be referred to surgeons at RHC. Adult patients are admitted to ward 22.

Any patients admitted to the ward should have their name and diagnosis written up on the white board at the doctor's station. Ensure that any medications they might require whilst in hospital are written up on a kardex **before** they leave the department. A basic clerking must be done, including past medical history and assessment of current active medical problems. **Patients over 65 should have an ECG**. Consider Pabrinex and GMAWS if alcoholic. See 'Alcohol related problems' in departmental guidelines book.

Ward Admission: Ward 22

1. Head injury patient as per head injury guidelines (see below).
   All children <16yrs requiring head injury observation -refer RHC surgical registrar
2. Post sedation patient. e.g. reduction of dislocations- refer orthopaedic if not going to be discharged within a few hours.
3. All admissions should be discussed with ED middle grade or consultant
4. All patients over 40 years or with significant medical history should have ECG & routine bloods checked, **and** results documented in notes (or printed out)
5. All patients should have medications & analgesia prescribed

Elderly Falls/Head injury.

You will frequently come across the elderly patient who attends with a head injury. When assessing them it is important to enquire about and document

- Past medical history
- Drugs especially use of warfarin/DOACs
- Social support
- Circumstances surrounding the head injury.

The injury may be simply due to a trip and fall. If it has occurred in the context of recurrent falls or syncope then these patients are best cared for by the medics as it is unlikely the will be discharged within 48hrs.

The following patients are not to be admitted to the ED ward but are to be referred to the appropriate speciality.

1. Alcohol Poisoning (MEDICINE)
2. Syncope requiring investigation (MEDICINE)
3. Seizures due to epilepsy/alcohol withdrawal (MEDICINE)
4. Fractures/dislocations failing to mobilise (ORTHO)
5. Frequent falls with multiple medical problems-see above
6. Vomiting/pyrexial children with trivial head injury >48 hours since injury (PAEDS)
7. Trauma patient-no injury but significant mechanism of injury. Refer surgeons
8. Chest trauma/rib fractures admitted for analgesia (SURGEONS)

TEACHING

During your post you will have regular protected teaching as follows

- Thursdays 2pm-4pm protected teaching via telemedicine

TRAVEL EXPENSES

You may claim for travelling to IRH. Forms for this are available from the secretaries. GRI is used as base hospital. Distance is calculated as difference between Home-GRI & Home-RAH/IRH. You are not paid for the 1st eight miles

STUDY LEAVE

Study leave is incorporated into your rota. To attend courses/exam, you may have to swap shifts with your colleagues. It is **your** responsibility to arrange any swaps required for study leave. We do not get locums to cover for study leave. Study leave forms are available from the secretaries.

Vale of Leven Hospital

A nurse led minor injury unit is open on site 9am-9pm, 7 days per week.
There continues to exist an acute medical receiving unit at the VOL, however ambulances may bypass if patient deemed critically unwell.

Inverclyde Royal Hospital

Paediatric Medicine

There is no in-patient paediatric service.
After discussing the case with the Emergency Dept. Middle grade refer paediatric cases to the on call paediatric registrar at RHC. Patients requiring admission to RHC will be transferred by ambulance.

Paediatric Surgery

Children < 16 years old with surgical problems should be referred to on on-call surgeon at RHC.

Paediatric Orthopaedics

Refer initially to orthopaedics at IRH. They will then discuss the case with orthopaedics at RHC

Obstetrics & Gynaecology

This service is based at RAH. Discuss referrals with on-call gyn/obs at RAH.

SATA

Specialty Assessment & Treatment Areas

These are the ‘red zones’ in each of the hospital receiving areas. At both RAH & IRH they are located in the day surgery units adjacent to the Emergency Depts

As you will be well aware, we should suspect possible COVID infection if patients present with
new persistent cough
Unexplained fever
Loss of sense of taste/smell
New breathlessness

Patients may be referred to the SATA units by GPs for assessment by general medicine/surgery. These patients are assessed by and are the responsibility of the receiving teams.
Patients may also end up in SATA having self-presented/been brought by ambulance. These patients will be directed to the SATA unit from the front door of the hospital
Emergency dept staff will assess/manage/admit or discharge these patients.
They will have their initial obs/NEWS2 score and may have their bloods & swabs taken by the SATA nurses (please note that if bloods/swabs not done, then it is your responsibility to do them)
The notes will then be brought to the ED and left in our pile of cards in order of triage category. If next card in pile, then go and see the patient

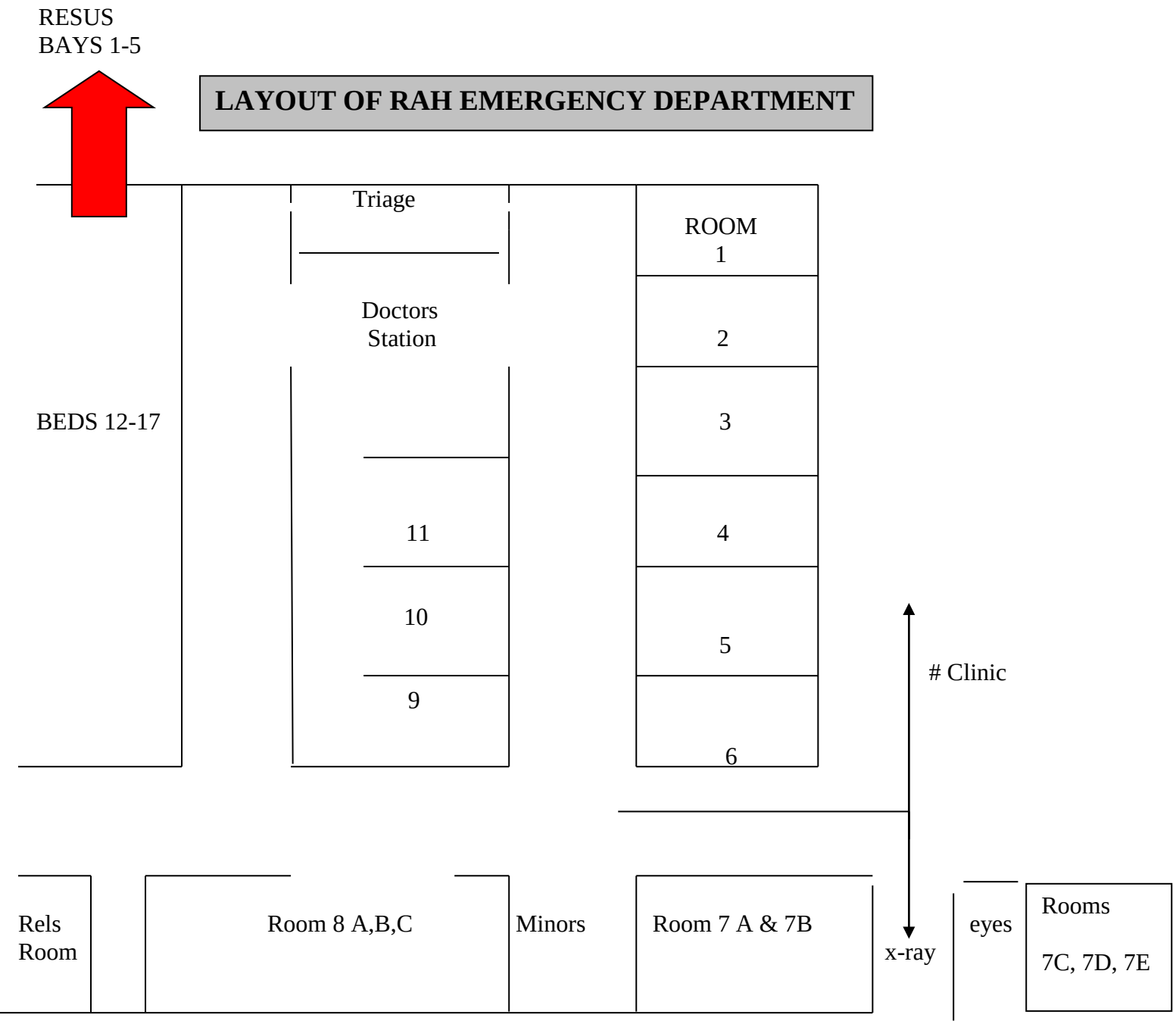
Overnight a sensible approach is expected. If the ED is quiet and receiving teams are busy, we would expect the ED staff to help if unwell patient in SATA, irrespective of them having been referred or not

Once assessed, please discuss your findings/management plan with an ED senior

All SATA patients get a COVID swab. If discharged home, then they should be given a discharge leaflet which is available on the CEM website

Use of PPE is essential in SATA. This means
eye protection
surgical mask
apron
gloves (same as for wearing when examining resus/majors patients in the ED)
please ensure you have been fit tested for an FFP3 mask and know its make/type. Let the ED secretaries know what you have passed on

If you have previously undertaken a risk assessment indicating that you should not have face to face interaction in high-risk areas then please let Dr McMillan (clinical director) know, otherwise all staff are expected to see patients in SATA


RESUS
BAYS 1-5
LAYOUT OF RAH EMERGENCY DEPARTMENT
Triage
Doctors
Station
ROOM
1
2
3
4
5
6
BEDS 12-17
11
10
9
Clinic
Rels
Room
Room 8 A,B,C
Minors
Room 7 A & 7B
x-ray
eyes
Rooms
7C, 7D, 7E

LAYOUT OF IRH EMERGENCY DEPARTMENT