



香港急症科醫學院

HONG KONG COLLEGE OF  
EMERGENCY MEDICINE

APPLICATION FOR TRAINING CENTRE IN  
EMERGENCY MEDICINE – HOSPITAL DATA FORM

**Section 1 : Hospital**

**1. General Information**

Name of hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Tel.: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Hospital Chief Executive: \_\_\_\_\_

Name of Clinical Service Co-ordinator: \_\_\_\_\_

Total no. of acute beds (as at MM/YYYY): \_\_\_\_\_

Date of data form completion: \_\_\_\_\_

**2. Clinical and supportive service**

Availability of clinical departments (with in-house full time specialists)

General surgery	Yes / No	(if no, name of cluster supporting hospital _____)
General medicine	Yes / No	(if no, name of cluster supporting hospital _____)
Orthopaedics	Yes / No	(if no, name of cluster supporting hospital _____)
Obs / Gyn	Yes / No	(if no, name of cluster supporting hospital _____)
Paediatric and Adolescent	Yes / No	(if no, name of cluster supporting hospital _____)
Anaesthesiology	Yes / No	(if no, name of cluster supporting hospital _____)
Psychiatry	Yes / No	(if no, name of cluster supporting hospital _____)
ENT	Yes / No	(if no, name of cluster supporting hospital _____)
Clinical Oncology	Yes / No	(if no, name of cluster supporting hospital _____)
Ophthalmology	Yes / No	(if no, name of cluster supporting hospital _____)
Neurosurgery	Yes / No	(if no, name of cluster supporting hospital _____)
Burn Unit	Yes / No	(if no, name of cluster supporting hospital _____)
Cardiothoracic	Yes / No	(if no, name of cluster supporting hospital _____)

OMF/Dental Yes / No (if no, name of cluster supporting hospital \_\_\_\_\_)

Others, specify: \_\_\_\_\_

#### Allied health and supportive service

Pharmacy Yes / No (Service hours, if not 24hr: \_\_\_\_\_)

Physiotherapy Yes / No

Occupation Therapy Yes / No

Prosthetic & Orthotic Yes / No

Speech Therapy Yes / No

Social Worker Yes / No

#### Availability of special care units

Adult ICU Yes / No Number of beds: \_\_\_\_\_ (if no, cluster supporting hospital \_\_\_\_\_)

CCU Yes / No Number of beds: \_\_\_\_\_ (if no, cluster supporting hospital \_\_\_\_\_)

PICU/ NICU Yes / No Number of beds: \_\_\_\_\_ (if no, cluster supporting hospital \_\_\_\_\_)

Burn Yes / No Number of beds \_\_\_\_\_ (if no, cluster supporting hospital \_\_\_\_\_)

OTHERS Please specify: \_\_\_\_\_ (e.g. HBO, PIC, TRL...)

#### Availability of 24 hours diagnostic / laboratory support

Laboratory support Yes / No

Blood bank Yes / No

Mini-blood bank inside A&E Yes / No

Plain X-Ray Yes / No

CT scan Yes / No

Urgent Radiologist Consultation Yes / No

Reporting of CT / XR Yes / No Scope of Reporting:

#### Availability of hospital arrangement / support of the followings:

Primary PCI for STEMI Yes / No (If yes, service hours: \_\_\_\_\_)

Thrombolytic/Thrombectomy therapy for ischemic stroke Yes / No (If yes, service hours: \_\_\_\_\_)

Hospital Multi-discipline Trauma Team Yes / No (If yes, service hours: \_\_\_\_\_)

Psychiatry service to A&E / EMW Yes / No (If yes, service hours: \_\_\_\_\_)

Geriatrics Support Yes / No (If yes, service hours: \_\_\_\_\_)

(Inspectors' Comments):

### 3. Training Resources

Facilities for educational activities	Yes / No
Meeting Room	Yes / No
WiFi Access in Meeting Room	Yes / No
Simulation Training Manikin/Equipments	Yes / No
Common folder or website to store training materials	Yes / No
Others	

(Inspectors' Comments):

## Section 2. Accident & Emergency Department

### 1. General

Name of Chief of Service: \_\_\_\_\_

Name of Training Supervisor \_\_\_\_\_

No. of full-time equivalent Consultant(s) (Associated Consultant  
excluded): \_\_\_\_\_

Name: \_\_\_\_\_ Full-time / Part-time ( \_\_\_\_\_ % FTE)

Name: \_\_\_\_\_ Full-time / Part-time ( \_\_\_\_\_ % FTE)

Name: \_\_\_\_\_ Full-time / Part-time ( \_\_\_\_\_ % FTE)

Name: \_\_\_\_\_ Full-time / Part-time ( \_\_\_\_\_ % FTE)

No. of FHKAM Fellows / Trainers: \_\_\_\_\_ / \_\_\_\_\_ (please submit list of  
trainers)

No. of Clinical Toxicology Fellows: \_\_\_\_\_

No. of Fellows with ICM / CCM Fellowship: \_\_\_\_\_

College Accredited Emergency Medicine Toxicology Training center (EMTTC) Yes / No

No. of Clinical Toxicology (Diploma/Fellowship) Trainees: \_\_\_\_\_

No. of HKCEM Higher / Basic Trainees: \_\_\_\_\_ / \_\_\_\_\_

Patient statistics (MM/XXXX – MM/XXXX) (recent 1-year period)

Total attendance: 1<sup>st</sup>: \_\_\_\_\_ Trauma: \_\_\_\_\_ % Non-trauma: \_\_\_\_\_ %  
F.U.:

Admission rate: \_\_\_\_\_ %

Triage categories(%):

Category	1.	_____ %
	2.	_____ %
	3.	_____ %
	4.	_____ %
	5.	_____ %

## 2. **Manpower** (full-time equivalent numbers)

<b><u>Clinical:</u></b>	<b><u>No.</u></b>
Consultants (full-time equivalent)	
SMO / AC	
MO (specialist)	
MO (trainee)	
MO (non-training):	
<b><u>Academic</u></b> (if applicable):	
Professor	
Associate Prof.	
Assistant Prof.	

<b><u>Nursing/supportive</u></b>	<b><u>No</u></b>
DOM	
WM	
NO (APN)	
NS / NC	
RN	
EN	
Secretary	
Clerk / Executive Assistant	
PCA	
POP artisan support	Yes / No
Phlebotomist support	Yes / No

## 3. **Equipment**

### Resuscitation & Monitoring

Basic physiologic monitor	Yes / No
Waveform Capnometer	Yes / No
Video assisted intubation device	Yes / No
Portable ventilator	Yes / No
Non-invasive ventilator	Yes / No
Mechanical chest compression device	Yes / No
Intraosseous device	Yes / No
Fluid warmer	Yes / No
Incubator	Yes / No
Temperature control facilities	Yes / No
Infant resuscitation equipments	Yes / No

## Investigations

X-ray facilities: resuscitation	Yes / No	(ceiling mount / portable)
Point-of-care analyser	Yes / No	
Blood gas machine	Yes / No	
Electrolyte / Chemistry	Yes / No	
Bedside Toxicology Kit	Yes / No	
Bedside Ultrasound machine	Yes / No	No. of ultrasound machine (in A&E and EMW):
Access to urgent CT scan	Yes / No	
Others		

## (Inspectors' Comments):

## **4. Physical Setup**

Triage station            Yes / No

No. of cubicles:            Resuscitation room \_\_\_\_\_  
  Acute area \_\_\_\_\_  
  Ambulatory care area \_\_\_\_\_

Airborne Infection Isolation Room (AIIR)            Yes / No

Observation Ward:            No. of beds: \_\_\_\_\_  
  Service hours: \_\_\_\_\_

Emergency Medicine Ward: No. of beds: \_\_\_\_\_ *(charging, length of stay >24hr)*  
  No. of nursing and supporting staff \_\_\_\_\_

Nurse Clinic                    No. of sessions \_\_\_\_\_

Special rooms/area:	Psychiatric holding room	Yes / No
	EYE	Yes / No
	ENT	Yes / No
	Obstetric / Gynaecology	Yes / No
	Paediatric	Yes / No
	Bereavement	Yes / No
	HAZMAT / REA Area	Yes / No
	Temporary Mortuary	Yes / No
Procedure rooms	Minor O.T	Yes / No
	POP	Yes / No
	Treatment	Yes / No
Staff room		Yes / No
Staff offices		Yes / No
Facilities for educational activities		Yes / No

**(Inspectors' Comments):**

**5. Department Policies and Protocols**

Written guidelines

Clinical protocols	Yes / No
Disaster Contingency Plan	Yes / No
Infection Control Contingency Plan	Yes / No
HAZMAT Contingency Plan	Yes / No
Access of staff to Guidelines:	

**(Inspectors' comments):**



## 6. Supervision and Training

	<u>Weekdays</u> (hours)	<u>Sat</u> (hours)	<u>Sun / PH</u> (hours)
<b><u>Onsite cover</u></b>			
Consultant			
SMO / AC	_____	_____	_____
If SMO / AC <24hr coverage, SMO / AC / specialists coverage	_____	_____	_____
<b><u>On call cover</u></b>			
Consultant			
SMO / AC	_____	_____	_____
Specialist	_____	_____	_____

Regular medical audit (e.g. mortality & morbidity meeting) in department Yes / No

Frequency: \_\_\_\_\_ Duration of each session: \_\_\_\_\_

**Training activities** (please submit a separate report of ALL department training activities in the 1-year period concerned\*)

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**Rotational training:** (Please submit a separate list of the arrangement for mandatory and elective rotation of trainees in the past two years and the mode of inter-department collaboration, e.g. mutual exchange, unidirectional secondment, unidirectional secondment with supplementary RT given etc.)

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**(Inspectors' comments)**

## 7. Departmental Audit and Quality Improvement activities

List the Audit and Quality Improvement activities carried out in your department in the past year (MM/YYYY – MM/YYYY) (*other than the regular medical audit listed above under Section 6*).

- \_\_\_\_\_  
- \_\_\_\_\_

(Inspectors' comments):

## 8. Research and Teaching

Is the department involved in teaching of medical students

Yes / No

No. of FT/PT academic staff for teaching of undergraduate medical students in the department:

FT \_\_\_\_\_

PT \_\_\_\_\_

No of instructors:

BLS \_\_\_\_\_

ACLS \_\_\_\_\_

ATLS \_\_\_\_\_

PALS \_\_\_\_\_

ALSO \_\_\_\_\_

Simulation Training \_\_\_\_\_

Others e.g. PHTLS /  
ITLS / AMLS / BLSO \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

