Guidelines of the Polish Society of Anaesthesiology and Intensive Therapy determining principles, conditions and administrative aspects of anaesthesiology and intensive therapy services

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Moreover, other hospital employees, in particular physicians working at the surgical departments, may also be interested in the guidelines or their parts.

EXPLANATIONS AND INSTRUCTIONS HOW TO USE THE GUIDELINES

The guidelines include instructions for rational and safe provision of health care services in anaesthesia, intensive therapy, resuscitation, management of pain irrespective of its cause, and sedation. While preparing the guidelines, expected health-related benefits for patients, necessary expenditure (cost-effect ratio) and other anticipatable effects resulting from implementation of the guidelines were considered [1–31].

POTENTIAL CONFLICTS OF INTEREST OF AUTHORS AND CONSULTANTS

None declared.

INTRODUCTION

Until 30 June 2012, the “standards” in anaesthesiology and intensive therapy were regulated by two regulations of the Minister of Health which were the executive acts to the Act of 30 August 1991 on health care institutions, i.e. the regulation of the Minister of Health of 27 February 1998 on
standards of medical management and procedures during provision of anaesthesiology and intensive therapy services in health care institutions (management standards) [32] and the regulation of the Minister of Health of 2 February 2011 regarding professional and sanitary requirements that the facilities and equipment of the health care institutions should meet (equipment standards) [33].

On 1 July 2012, the regulation of the Minister of Health of 26 June 2012 came into force concerning detailed requirements that the facilities and equipment of entities conducting therapeutic activity should meet [34], which replaced the regulation of the Minister of Health of 2 February 2011 on professional and sanitary requirements for facilities and equipment of health care institutions [33]. The regulation, however, did not contain “standards” in the field of anaesthesiology and intensive therapy.


Due to the prolonging works in the Ministry of Health on the regulation project of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity [36, 37] (that was to replace the regulation of the Minister of Health of 27 February 1998 on standards of medical management and procedures during provision of anaesthesiology and intensive therapy services in health care institutions [32]), there was a well-grounded and urgent need to prepare the guidelines of the Polish Society of Anaesthesiology and Intensive Therapy determining principles, conditions and administrative aspects of anaesthesiology and intensive therapy services. The present Guidelines were approved by the Supreme Board of the Polish Society of Anaesthesiology and Intensive Therapy on 28 September 2012 and sent for publication to be disseminated.

The publication of the Guidelines is to limit possible negative effects that patients might experience if the regulation of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity is not published by 31 December 2012.

The guidelines of the Polish Society of Anaesthesiology and Intensive Therapy determining principles, conditions and administrative aspects of provision of anaesthesiology and intensive therapy services were based on the document prepared by the Working Group appointed by the National Consultant in anaesthesiology and intensive therapy, the members of which were Prof. Krzysztof Kusza, MD, PhD, Prof. Andrzej Kübler MD, PhD, Prof. Dariusz Maciejewski MD, PhD, Mariusz Piechota, MD, PhD, Adam Mikstaki, MD, PhD. This document in its substantially shortened form was the basis for the regulation project of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity [36, 37].

Many solutions presented in the Guidelines, although clearly serving the good of patients, were not included (or were regulated in some other ways) in the provisions of the regulation project of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity [36, 37]. The reasons for such a stand of the Ministry of Health included legal (lack of delegation of legislative powers), financial (additional costs that therapeutic entities would have to incur) or staff-related issues (shortage of medical or nursing personnel). The present Guidelines do not contain some of these limitations (legal issues). In some other issues, the position of the Polish Society of Anaesthesiology and Intensive Therapy differs from that of the Ministry of Health (financial and personnel-related issues). The Guidelines contain also the regulations not included in the regulation project of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity [36, 37], e.g. they comprehensively describe the functional and structural requirements which the departments of anaesthesiology and intensive therapy should meet.

Considering the patient safety, it is essential to include in the provisions of the regulation project of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity [36, 37] the adjustment period, particularly concerning the requirements related to medical devices and equipment of the therapeutic entities.

The level of standards included in the provisions of the regulation project of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity, which is lower than that in the Guidelines, should be considered the minimum level once the regulation of the Minister of Health on standards of medical management in anaesthesiology and intensive therapy for entities conducting therapeutic activity has been published and has come into force.

GUIDELINES OF THE POLISH SOCIETY OF ANAESTHESIOLOGY AND INTENSIVE THERAPY DETERMINING PRINCIPLES, CONDITIONS AND ADMINISTRATIVE ASPECTS OF PROVISION OF ANAESTHESIOLOGY AND INTENSIVE THERAPY SERVICES

The Guidelines define the principles, conditions and administrative aspects of provision of anaesthesiology and
intensive care services, i.e. anaesthesia, intensive care, resuscitation, management of pain irrespective of its cause, and sedation services.

Definitions of terms used in guidelines:
— anaesthesia — general or regional anaesthesia performed for surgical procedures and for diagnostic as well as therapeutic purposes;
— intensive therapy — management to maintain vital functions and treatment of patients with life-threatening conditions caused by potentially reversible failure of one or several major systems, especially respiratory, circulatory, or central nervous system;
— a specialist in anaesthesiology and intensive care — a physician with the 2nd degree of speciality or the title of specialist in anaesthesiology and intensive therapy, a specialist in anaesthesiology or anaesthesiology and resuscitation or anaesthesiology and intensive therapy;
— an anaesthesiologist — a physician with the 1st degree of speciality in anaesthesiology and intensive therapy;
— a resident in training — a physician specializing in anaesthesiology and intensive therapy;
— an anaesthesiological nurse — a nurse with the speciality in anaesthesiological and intensive care nursing or a nurse who completed the specialist training in anaesthesiological and intensive care nursing;
— resuscitation — interventions to stop the potentially reversible process of dying;
— sedation — activities to eliminate anxiety or fear or to calm down patients;
— an emergency surgery — a procedure carried out immediately after the operator’s decision about intervention in patients with life-threatening conditions, at risk of losing the limb, organ or their function; the patient’s condition is stabilised simultaneously with the procedure;
— an urgent surgery — a procedure performed within maximum 6 hours after the operator’s decision in patients with acute symptoms of disease or deteriorated clinical condition, which are potentially life-threatening or pose a risk for limb or organ preservation or those with other health problems untreatable conservatively;
— an expedited surgery — a procedure performed within several days after the operator’s decision in patients requiring early surgical treatment yet the effects of the disease on the patient’s clinical condition have no features described for emergent and urgent procedures;
— an elective surgery — a procedure performed according to the schedule of surgeries in patients with optimal general conditions, timed suitably for the patient and the operator.

**GENERAL PRINCIPLES**

1. Hospitals that deliver anaesthesiology and intensive care services for adult patients should have departments of anaesthesiology and intensive therapy; if services regard anaesthesia exclusively, departments of anaesthesiology should be organised in these hospitals.
2. In therapeutic entities with two or more hospitals providing anaesthesia and intensive therapy services, departments of anaesthesiology and intensive therapy should be organised in each of these hospitals.
3. Hospitals providing anaesthesia and intensive therapy services for children should have departments of paediatric anaesthesiology and intensive therapy; when services concern anaesthesia exclusively, departments of paediatric anaesthesiology should be created.
4. To provide appropriate quality of services and to optimise costs, health care services in the departments of anaesthesiology and intensive therapy and the departments of paediatric anaesthesiology and intensive care should be provided at three referential levels.
5. Minimum criteria for the appropriate referential levels for departments of anaesthesiology and intensive care (for adults) are as follows:
   a) third referential level — a department at this referential level should primarily meet the following criteria:
   ■ minimum 8 intensive therapy beds;
   ■ a therapeutic entity provides in its structure:
     • an operating suite with at least one operating theatre continuously ready for providing health care services to trauma patients,
     • a diagnostic and interventional endoscopic unit, available on a 24-hour basis,
     • a diagnostic imaging laboratory with interventional radiology, available on a 24-hour basis,
     • a diagnostic laboratory, available on a 24-hour basis,
     • a microbiological laboratory, available on a 24-hour basis,
     • the department of general surgery or multiple organ trauma surgery,
     • the department of orthopaedics and traumatology of the musculoskeletal system,
     • the department of neurosurgery or general surgery with a neurotraumatology profile,
     • the department of vascular surgery or general surgery with a vascular surgery profile;
   ■ distinct 24-hour medical care — simultaneously minimum 3 physicians (a specialist in anaesthesiology and intensive therapy or an anaesthesiologist or a resident in training in anaesthesiology), including at least one specialist in anaesthesiology and intensive therapy, 7 days a week (which
cannot be combined with other departments or provision of anaesthesia services);
- distinct 24-hour nursing care — minimum shift staffing — one nurse per 1.2 intensive therapy beds.

b) second referential level — a department at this levels should primarily meet the following criteria:
- minimum 6 intensive therapy beds;
- a therapeutic entity provides in its structure:
  - an operating suite with at least one operating theatre continuously ready for providing health care services to trauma patients,
  - a diagnostic and interventional endoscopy unit, available on a 24-hour basis,
  - a diagnostic imaging unit, available on a 24-hour basis,
  - a diagnostic laboratory, available on a 24-hour basis,
  - the department of general surgery,
  - the department of orthopaedics and traumatology of musculoskeletal system,
  - the department of neurosurgery or general surgery with a neurotraumatology profile;
- distinct 24-hour medical care — simultaneously minimum 2 physicians (a specialist in anaesthesiology and intensive therapy or an anaesthesiologist or a resident in training), including at least one specialist in anaesthesiology and intensive therapy, 7 days a week (which cannot be combined with other departments or provision of anaesthesia services);
- distinct 24-hour nursing care — minimum shift staffing — one nurse per 1.5 intensive care stations.

c) first referential level — a department at this referential level should primarily meet the following criteria:
- minimum 4 intensive therapy beds;
- a therapeutic entity provides in its structure:
  - an operating suite with at least one operating theatre continuously ready for providing health care services,
  - a diagnostic imaging unit, available on a 24-hour basis,
  - a diagnostic laboratory, available on a 24-hour basis,
  - at least one surgical or non-surgical department;
- distinct 24-hour medical care — simultaneously minimum one specialist in anaesthesiology and intensive therapy, 7 days a week (which cannot be combined with other departments or provision of anaesthesia services);
- distinct 24-hour nursing care — minimum shift staffing — one nurse per 2 intensive care stations.

6. Minimum criteria for departments of paediatric anaesthesiology and intensive therapy at appropriate referential levels are as follows:
a) third referential level — a department at this referential level should primarily meet the following criteria:
- minimum 8 intensive therapy beds, including 4 for neonates;
- minimum 5 general anaesthesia machines with an anaesthetic ventilator enabling pressure-controlled ventilation adjusted to anaesthetic procedures in neonates and children;
- minimum 4 ventilators enabling the regulation of oxygen concentration in the range of 21–100% designed for all age groups of children;
- minimum 4 ventilators enabling the regulation of oxygen concentration within the range of 21–100% designed for neonates;
- minimum 3 open incubators enabling phototherapy and weighing of children;
- minimum 2 closed incubators enabling phototherapy and weighing of children;
- a therapeutic entity provides in its structure:
  - an operating suite with at least one operating theatre continuously ready for providing health care services to underage patients, especially neonates,
  - a diagnostic and operative interventional endoscopy unit, available on a 24-hour basis,
  - a diagnostic imaging unit with interventional radiology, available on a 24-hour basis,
  - a diagnostic laboratory, available on a 24-hour basis,
  - a microbiological laboratory, available on a 24-hour basis,
  - the department of paediatric surgery or paediatric multiple trauma surgery,
  - the department of orthopaedics and traumatology of the musculoskeletal system,
  - the department of neurosurgery or general surgery with a neurotraumatology profile;
- distinct 24-hour medical care — simultaneously minimum 3 physicians (a specialist in anaesthesiology and intensive therapy or an anaesthesiologist or a resident in training in anaesthesiology), including minimum one specialist in anaesthesiology and intensive therapy and with at least 3 years of experience in paediatric anaesthesiology and intensive therapy, available 7 days a week (which cannot be combined with other departments or provision of anaesthesia services);
b) second referential level — a department at this referential level should primarily meet the following criteria:

- minimum 6 intensive therapy beds, including 3 beds for neonates; adjustment period;
- minimum 2 general anaesthesia machines with an anaesthetic ventilator enabling pressure-controlled ventilation designed for neonatal and paediatric anaesthesia;
- minimum 3 ventilators enabling the regulation of oxygen level in the range of 21–100% designed for all age groups of children;
- minimum 3 ventilators enabling the regulation of oxygen level in the range of 21–100% designed for newborns;
- minimum 2 open incubators enabling phototherapy and weighing of children;
- minimum one closed incubator enabling phototherapy and weighing of children;
- a therapeutic entity provides in its structure:
  - an operating suite with at least one operating theatre continuously ready for providing health care services to underage patients, particularly neonates;
  - a diagnostic and interventional endoscopy unit, available on a 24-hour basis,
  - a diagnostic imaging unit, available on a 24-hour basis,
  - a diagnostic laboratory, available on a 24-hour basis,
  - the department of paediatric surgery enabling provision of services in traumatology of the musculoskeletal system and neurosurgical emergencies;
- distinct 24-hour medical care — simultaneously minimum one specialist in anaesthesiology and intensive therapy with at least 3 years of experience in paediatric anaesthesiology and intensive therapy, available 7 days a week (which cannot be combined with other departments or provision of anaesthesia services);
- distinct 24-hour nursing care — minimum shift staffing — 1 nurse per 2 intensive therapy beds.

7. The head of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy or the department of paediatric anaesthesiology should be a specialist in anaesthesiology and intensive therapy.

8. The head of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy periodically assesses the quality of health care services provided in the department, especially the compliance of management with the guidelines of scientific societies, the accordance of available documentation and occurrence of medical events stated in Art. 67a of the Act of 6 November 2008 on patient rights and the Ombudsman of Patient Rights (Journal of Laws of 2012, item 159).

9. The head nurse of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy or the depart-
ment of anaesthesiology or the department of paediatric anaesthesiology in a hospital should be a nurse with the speciality in anaesthesiology and intensive care.

10. Patients are qualified for departments of anaesthesiology and intensive therapy according to the guidelines of the Polish Society of Anaesthesiology and Intensive Therapy determining the measures of classification and criteria of admission of patients to departments of anaesthesiology and intensive therapy.

**QUALIFICATIONS OF PERSONNEL PROVIDING ANAESTHESIA SERVICES**

1. Anaesthesia-related health care services consisting in administration of general anaesthesia or regional anaesthesia, epidural and spinal, can be provided only by specialists in anaesthesiology and intensive therapy.

2. An anaesthesiologist can render anaesthesia-related services (stated in paragraph 1) independently and unaided in cases of anaesthesia in patients aged over 3 years whose physical status is scored as I, II or III according to the American Society of Anaesthesiologists (ASA) Classification System. In the remaining cases, an anaesthesiologist can administer anaesthesia services with the written approval of the head of the department of anaesthesiology and intensive therapy, an anaesthesiologist or a resident in training in anaesthesiology and intensive therapy.

3. A resident in training can perform anaesthesia if directly supervised by a specialist in anaesthesiology and intensive therapy.

4. A specialist in anaesthesiology and intensive therapy can simultaneously supervise three residents in training administering anaesthesia to patients whose ASA physical status score is I, II or III when the residents have minimum a 2-year speciality training in anaesthesiology and intensive therapy as well as adequate knowledge and skills to perform anaesthesia, and with the approval of the head of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy.

5. The completion of a 2-year speciality training by residents and their adequate knowledge and skills to perform anaesthesia, stated in paragraph 4, are confirmed in a written form by the head of specialisation. This written confirmation is filed in the personal records of a resident.

**RULES OF MANAGEMENT DURING PROVISION OF ANAESTHESIA SERVICES IN A HOSPITAL**

1. The director of a therapeutic entity running a hospital, with the approval of the head of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy or the department of anaesthesiology, should define the preparation procedures for anaesthesia, including diagnostic and laboratory tests to ensure safety during emergency, urgent, expedited or elective procedure.

2. The director of a therapeutic entity with the approval of the head of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy should establish the mode of emergency communication.

3. The schedule of procedures carried out in a hospital should be prepared together with the head of the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy or the department of anaesthesiology or the department of paediatric anaesthesiology; the schedule should take into account the rule of superiority of lesser risk for the health and life of patients, and should be adjusted to the number of physicians providing anaesthesia services and to medical devices and equipment of a therapeutic entity adequate for provision of such services.

4. In hospitals where adult and paediatric procedures are performed, the schedule should additionally take into account the rule of time or space separation of procedures for these two groups of patients.

5. A specialist in anaesthesiology and intensive therapy, an anaesthesiologist or a resident in training in anaesthesiology and intensive therapy supervised by a specialist in anaesthesiology and intensive therapy should familiarise themselves with medical records of the patient and necessary laboratory results compiled by an attending physician as well as examine the patient within 24 hours preceding the procedure to qualify him/her for anaesthesia according to the patient’s health condition and medical indications; a specialist in anaesthesiology and intensive therapy, an anaesthesiologist or a resident in training in anaesthesiology and intensive therapy supervised by a specialist in anaesthesiology
and intensive therapy can order additional examinations or consultations necessary to qualify patients for anaesthesia.

6. In under age patients, examinations to qualify them for anaesthesia should not be carried out in rooms designed for adult patients.

7. A physician qualifying the patient should complete the premedication chart when qualifying the patient.

8. Written consent for anaesthesia is attached to the medical history.

9. A physician performing anaesthesia can anaesthetise only one patient; during anaesthesia, an anaesthesiological nurse cooperates with him/her; this also includes anaesthetic procedures carried out outside the operating theatre.

10. Before the anaesthetic procedure, a performing physician, or in the case of a resident also a supervising physician, should:
    a) check the equipment of anaesthesia workstation,
    b) check the efficiency of anaesthetic machine and monitoring devices,
    c) check proper labelling of infusion fluids, syringes with anaesthetic agents, syringes with drugs used during anaesthesia,
    d) check the compatibility of the recipient with each blood unit or its component if a transfusion is needed,
    e) identify the patient undergoing anaesthesia.

11. A physician performing the anaesthetic procedure should be in the direct vicinity during the entire anaesthesia.

12. A physician performing the anaesthetic procedure should complete the anaesthesia chart, taking into account mainly the data regarding the course of anaesthesia, dosage of anaesthetics and other drugs, current vital signs and possible complications.

13. If another physician continues the anaesthetic procedure, he/she is responsible for anaesthesia since the onset of continuation; he/she is obliged to familiarise himself/herself with all the information concerning the anaesthetised patient, course of anaesthesia and devices; taking over the responsibility for anaesthesia should be confirmed in writing on the anaesthesia chart.

14. A physician performing the anaesthetic procedure can leave the anaesthetized patient to resuscitate another patient if this does not pose the direct threat to the patient’s life; in such cases, the patient is accompanied by an anaesthesiological nurse until the physician performing the anaesthetic procedure returns.

15. Transport of the patient immediately after completion of anaesthesia should be supervised by a specialist in anaesthesiology and intensive therapy, with the portable source of oxygen, a ventilator, devices monitoring vital signs and other necessary equipment, if need be.

16. In the immediate post-operative period, the patient should stay in the post-anaesthesia care unit.

17. At the post-anaesthesia beds in the post-anaesthesia care unit, direct observation should be provided or cameras equipped with the autostart function should be used, enabling observation of the patient’s face, in particular.

QUALIFICATIONS OF PERSONNEL PROVIDING INTENSIVE THERAPY SERVICES

1. Intensive therapy is provided exclusively by a specialist in anaesthesiology and intensive therapy.

2. Intensive therapy services can be provided by an anaesthesiologist or resident in training in anaesthesiology, if his/her work is directly supervised by a specialist in anaesthesiology and intensive therapy.

3. Intensive therapy services can be administered by a resident in training in other specialities or an intern in the department of anaesthesiology and intensive therapy provided that his/her work is supervised by a specialist in anaesthesiology and intensive therapy.

MANAGEMENT PRINCIPLES DURING PROVISION OF INTENSIVE THERAPY SERVICES IN A HOSPITAL

1. Intensive therapy of patients in a hospital is interdisciplinary.

2. Basic vital signs are continuously monitored, available therapeutic methods and techniques are used, especially invasive methods and those supporting basic functions of the main body systems.

3. Provision of health care services requires the continuous presence of a specialist in anaesthesiology and intensive therapy and an anaesthesiological nurse in the department.

4. The nursing surveillance station enables direct observation.

5. Patient isolation should be ensured; equipment as well as monitoring and therapeutic devices should be available to enable specialist interventions in life-threatening conditions.

6. If the patient’s condition does not require further intensive therapy management, the treatment should be taken over by other departments or a relevant hospital.

PAIN MANAGEMENT

1. Pain management services can be provided in the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and in-
tensive therapy or the department of anaesthesiology or the department of paediatric anaesthesiology.

2. An anaesthesiological consultation is the basic pain management service delivered in the department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology.

3. The team dealing with acute pain treatment, mainly postoperative, can be organized in the department of anaesthesiology and intensive therapy and the department of paediatric anaesthesiology.

4. The department of anaesthesiology and intensive therapy or the department of paediatric anaesthesiology and intensive therapy can also hospitalise patients requiring invasive diagnostic and therapeutic procedures for pain management or monitoring of these procedures and treatment delivered.

**RESUSCITATION**

The called specialist in anaesthesiology and intensive therapy takes over resuscitation and decides on its discontinuation.

**DEPARTMENT LOCATION**

The location of the department of anaesthesiology and intensive therapy should provide optimal communication with the operating suite, emergency or admissions departments and all inpatient hospital wards.

**NUMBER OF INTENSIVE THERAPY BEDS IN THE DEPARTMENT**

1. The number of intensive therapy beds in the department of anaesthesiology and intensive therapy should constitute at least 5% of the total number of beds in a hospital. The number of intensive therapy beds in a university department of anaesthesiology and intensive department should constitute at least 10% of the total number of beds in a hospital.

2. It is recommended that each department of anaesthesiology and intensive therapy should have minimum 6 intensive therapy beds. The optimal number of intensive therapy beds ranges from 8 to 12.

**ADDITIONAL REQUIREMENTS DETERMINING PROPER FUNCTIONING OF THE DEPARTMENT OF ANAESTHESIOLOGY AND INTENSIVE THERAPY IN A HOSPITAL**

1. A therapeutic entity with two or more hospitals included in its structure should ensure that each hospital with the department of anaesthesiology and intensive therapy has:
   a) minimum one department with an interventional (surgical) profile;
   b) an operating suite with at least one operating theatre continuously ready for providing health care services to trauma patients;
   c) a diagnostic and interventional endoscopy unit, available on a 24-hour basis.

2. It is not recommended to organise the department of anaesthesiology and intensive care in a hospital without the department of an interventional (surgical) profile.

3. For proper provision of intensive therapy services, a therapeutic entity running a hospital ensures that necessary radiological and laboratory examinations can be carried out on a 24-hour basis, particularly: analyzing blood gasometry, biochemical and haematological tests, including blood clotting and cross-matching testing.

**STRUCTURE OF THE DEPARTMENT OF ANAESTHESIOLOGY AND INTENSIVE THERAPY**

The department of anaesthesiology and intensive therapy should primarily consist of:

1. intensive therapy beds,
2. anaesthesia stations,
3. post-anaesthesia care unit,
4. hospital administration, storage and social facilities.

**ACCOMMODATION CONDITIONS**

1. The area of bedrooms in the department of anaesthesiology and intensive care should be as follows:
   a) one-station room — minimum 25.0 m²,
   b) multi-station room — minimum 20.0 m² per one station.

2. The area of bedrooms in the post-anaesthesia recovery room should be as follows:
   a) one-station room — minimum 18.0 m²,
   b) multi-station room — minimum 16.0 m² per one station.

3. The area of facilities (administrative, storage and social) should be at least as large as that of bed area.

4. Administrative rooms should include in particular:
   a) head office — minimum 20.0 m²,
   b) secretary’s office — minimum 15.0 m²,
   c) doctor’s office — minimum 20.0 m²,
   d) seminar and conference room — minimum 40.0 m²,
   e) reception area and rooms for relatives — minimum 15.0 m².

5. Storage rooms should include in particular:
   a) warehouse for consumable materials - minimum 5.0 m²/bed,
b) warehouse for durable equipment — minimum 5.0 m²/bed,
c) separate clean utility and dirty utility rooms — minimum 40.0 m² in total.

6. Social rooms should include in particular:
   a) office of a physician on duty — minimum 20.0 m²,
   b) staff lounge — minimum 20.0 m².

7. The department should include special procedures room (minimum 35.0 m²) and drug preparation room (minimum 15.0 m²).

EQUIPMENT OF THE DEPARTMENT OF ANAESTHESIOLOGY AND INTENSIVE THERAPY

1. The department of anaesthesiology and intensive therapy should be equipped with the following medical devices and equipment:
   a) electric suction machine — minimum 1 per 3 intensive therapy beds, not less than 2 per department;
   b) cardiac output measurement device — minimum 1 per department;
   c) continuous renal replacement therapy machine — minimum 1 per department;
   d) bronchofibrescope — minimum 1 per department;
   e) device for direct monitoring of intracranial pressure — minimum 1 per department;
   f) bedside X-ray unit;
   g) bedside ultrasound machine;
   h) defibrillator enabling cardioversion and external heart stimulation — minimum 1 per department;
   i) transport ventilator — minimum 1 per 4 stations;
   j) device for measurements of laboratory critical parameters;
   k) kit to secure “difficult airways” should include at least:
      ■ laryngoscope with flexible blade tip,
      ■ short handle,
      ■ laryngeal masks in different sizes,
      ■ long and flexible intubation guide (bougie type),
      ■ fibre-optic guide or video laryngoscope,
      ■ oropharyngeal tubes,
      ■ laryngeal tube,
      ■ conicopuncture kit,
      ■ tracheotomy kit.

2. An intensive therapy station should be equipped with:
   a) intensive care bed with bedsore prevention mattress,
   b) ventilator enabling regulation of oxygen level in the range of 21–100%,
   c) sources of electricity, oxygen, air and vacuum,
   d) intubation and ventilation kit with a self-inflating bag,
   e) devices for quick and regulated fluid transfusions, including at least 6 infusion pumps,
   f) cardiac monitor,
   g) pulse oximeter,
   h) capnograph,
   i) device for automated non-invasive measurement of
c) device for invasive measurement of blood pressure,
d) mattress for warming patients,
e) phonendoscope.

3. An anaesthesia workstation should be equipped with:
   a) general anaesthesia device with anaesthetic ventilator,
   b) self-inflating bag and oropharyngeal tubes,
   c) source of oxygen, air and vacuum,
   d) suction machine,
   e) endotracheal intubation kit with intubation tubes and two laryngoscopes,
   f) defibrillator enabling cardioversion and electrostimulation — at least one per combined anaesthesia workstations or separate operating theatre,
   g) anaesthetic gas scavenger system,
   h) electric power source with an emergency system,
   i) normalized anaesthetic cart,
   j) source of light,
   k) equipment for intravenous administration of drugs,
   l) phonendoscope or precordial stethoscope for children,
   m) sphygmomanometer,
   n) thermometer,
   o) pulse oximeter,
   p) monitor of oxygen level in the anaesthetic circle with alarm for border values,
   q) cardiac monitor,
   r) capnometer,
   s) muscle relaxation monitor,
   t) monitor of anaesthetic gases,
   u) equipment for invasive measurements of blood pressure,
   v) intravenous fluid warming device,
   w) device for patient warming,
   x) equipment for quick fluid transfusions,
   y) equipment for regulation of fluid transfusions,
   z) minimum 3 infusion pumps.

4. Anaesthesiological equipment of a general anaesthesia workstation with the use of artificial lung ventilation should be additionally equipped with:
   a) excessive respiratory pressure alarm,
   b) respiratory circle disconnection alarm,
   c) device for continuous measurements of respiratory rate,
   d) device for continuous measurements of respiratory volumes.

5. A station where long and extensive surgical procedures are carried out should be equipped with additional
anaesthesiological devices appropriate for the type of surgery or patient's condition.

6. A post-anesthesia care unit should be equipped with:
   a) resuscitation cart and conicotomy kit,
   b) defibrillator enabling cardioversion,
   c) ventilator enabling regulation of oxygen level in the range of 21–100% — minimum 1 per 3 post-anesthesia recovery stations,
   d) electric suction machines — minimum 1 per 3 post-anesthesia recovery stations.

7. A post-anesthesia care unit bed should be equipped with:
   a) source of oxygen, air and vacuum,
   b) sphygmomanometer,
   c) ECG monitor,
   d) pulse oximeter,
   e) thermometer.

References:
34. Rozporządzenie Ministra Zdrowia z dnia 26 czerwca 2012 r. w sprawie szczegółowych wymagań, jakim powinny odpowiadać pomieszczenia i urządzenia podmiotu wykonującego działalność leczniczą (Dz.U. 2012 nr 0 poz. 739) http://isap.sejm.gov.pl/DetailsServlet?id=WDU20120000739

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