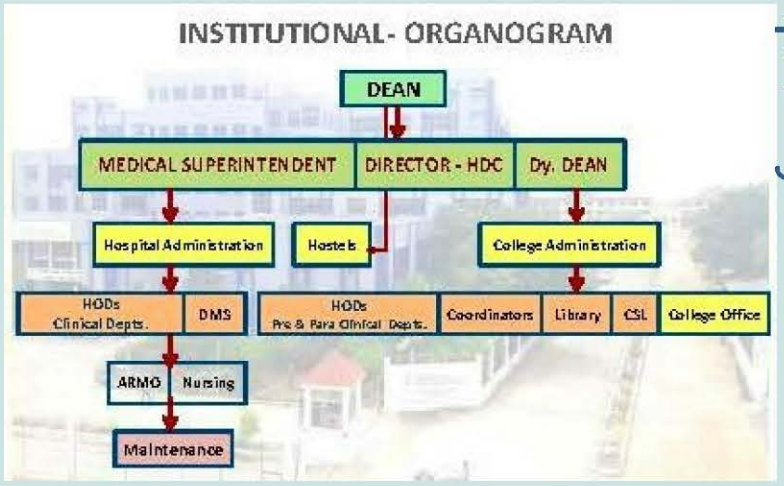
VINAYAKA MISSION'S
KIRUPANANDA VARIYAR
MEDICAL COLLEGE & HOSPITALS

STANDARD OPERATING PROCEDURE

Strive for quality

VINAYAKA MISSION'S KIRUPANANDA VARIYAR MEDICAL COLLEGE & HOSPITALS



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VINAYAKA MISSION'S
RESEARCH FOUNDATION
(Deemed to be University under section 3 of the UGC Act 1956)

Greatness is not where we stand, but in what direction we are moving..

VINAYAKA MISSION'S
KIRUPANANDA VARIYAR
MEDICAL COLLEGE & HOSPITALS

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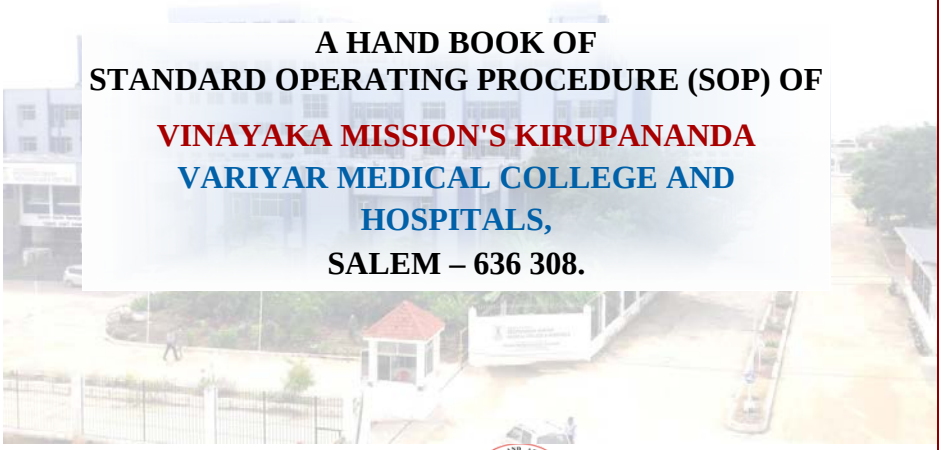
A HAND BOOK OF STANDARD OPERATING PROCEDURE (SOP) OF

VINAYAKA MISSION'S KIRUPANANDA VARIYAR MEDICAL COLLEGE AND HOSPITALS,

SALEM – 636 308.



VINAYAKA MISSION'S
RESEARCH FOUNDATION
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Draft prepared by
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I . Foreword

The Internal Quality Assurance Cell (IQAC) Team of Vinayaka Mission's Kirupananda Variyar Medical College and Hospitals, Salem has prepared the Standard Operating Procedure in line with the Institution policy for Quality Monitoring and Quality Improvement. The feedback was taken from all stakeholders for preparation of the Standard Operating Procedures (SOP). The SOP was reviewed and approved by the Dean and Registrar / Vice Chancellor.

II. Introduction

Vinayaka Mission's KirupanandaVariyar Medical College is located in Salem, Tamilnadu, in a vast area of 50.10 acres/202747.50 sqmt and strives for achieving academic excellence. When it was started in 1995, it was affiliated to the TamilnaduDr. MGR Medical University, Tamilnadu and in 2005-06 it became a constituent unit of Vinayaka Mission's Research Foundation – Deemed to be University, Salem, Tamilnadu. Students are admitted through All India Common, National Eligibility cum Entrance Test (NEET).

The Institution has a limpid Vision of providing service to the humanity at large, by making available, the best form of health care possible in the world to the local community.

The unitary campus houses a Medical College, Teaching Hospital, Administrative Buildings, UG Hostels for Boys and Girls and Variyar Interns Postgraduate Quarters (VIPQ) with adequate space for future expansion.

INSTITUTION'S VISION – MISSION – STATEMENT

Vision:

1. To provide service to the humanity at large by making available best form of

health care.

Mission:

1. To provide the student a highest quality of education in branches of medicine and to provide a perfect learning experience and atmosphere.
2. To demonstrate appreciable skill and knowledge and to participate actively in professional growth of self of Institution and of country's knowledge base.
3. To contribute to the development of medicine by active participation in scholarly in medical field.

4. To develop team spirit and ability to work along with other health personnel.

Quality Policy

1. To develop a system for consistent and catalytic action to improve the administrative and academic performance of the University.
2. To collaborate with other academic institutions and agencies globally for improvement of quality and brand image of the University.
3. To promote measures for institutional functioning towards quality enhancement through institutionalization of best practices and internalization of quality culture.

1. Scope

This document describes the SOP for maintenance of all facilities located in the campus of Vinayaka Mission's Kirupananda Variyar Medical College is located in Seeragapadi, Salem.

2. Normative References

No need of normative references for establishing Standard Operating Procedure.

3. Maintenance of Computer Facilities

The following procedures are adapted for maintenance of computer facilities.

An agreement has been made with central IT deprtment Vinayaka Mission's Kirupananda Variyar Medical College is located in Salem,, to maintain the IT infrastructure of the campus.

The External Service Provider will deploy one person in the campus to check all the equipments and take necessary actions. The ESP

will ensure timely replacement or servicing of any parts as necessary.

Mr. Arun, IT Chief Operation: Contact No: 94438 48613

4. Maintenance of Classrooms

The Housekeeping maintenance department headed by Resident Medical Officer (RMO) taking care for cleaning of classrooms twice, on daily basis. The cleanliness is supervised by administrators of Vinayaka Mission's Kirupananda Variyar Medical College is located in Salem, Any problem in the class room is reported to the Dean or Deputy Dean and Administrators for appropriate measures to be taken to correct the Problem.

5. Maintenance of Laboratories

1. UG and PG laboratories are well equipped and maintained by the departmental trained technicians according to Standard Operating Procedures of each equipments.
2. Clinical side laboratories are equipped with advanced instruments and maintained by Biochemistry, Pathology and Microbiology departments.
3. Quality control and standard is being monitored.
4. Annual stock verification is being conducted by the IQAC of the institute.

6. Maintenance of Indoor Sports

1. The indoor sports are maintained by the Sports committee of the Institute.
2. Interim maintenance is performed as and when required.
3. The purchase requests are forwarded to the Dean of the Institution.

4. The condemned sports equipments are discarded after the stock verification from the committee.

7 . Maintenance of Rest rooms

1. The cleaning of classrooms twice morning and evening on daily basis is done by the
   sweepers and cleaning staff appointed by the selection committee for recruitments,
   Vinayaka Mission's Kirupananda Variyar Medical College and Hospitals, Salem.
2. The Administrator and housekeeping and maintenance department of the institution
   supervise and review the status of the cleanliness regularly.
3. Separate Rest rooms for boys and girls provided in the campus, cleaning being done thrice on daily basis.
4. Any breakage of the restroom fitting is reported to the maintenance department for the replacement.
5. An Appropriate sign boards and charts are displayed for proper usage of the restroom facilities and to maintain cleanliness.

8. Maintenance of Electrical Facilities

Maintenance of Electric facilities is contracted to Central Maintenance & Services department of Vinayaka Mission's Kirupananda Variyar Medical College, Salem.

The details are as follows: Vinayaka Mission's Kirupananda Variyar Medical College is located in Salem.
Contact Name: Er. Kuppuraj
Mobile No: 82480 92913

9. Maintenance of Lift Facilities

Maintenance of Lift facilities is maintained by centrally, Vinayaka Mission's Kirupananda Variyar Medical College is located in Salem.

10. Maintenance of ICT Facilities

Maintenance of Audio and Visual Services, CCTV Cameras and Tele Communications is managed by centrally IT and electricity dept., Vinayaka Mission's Kirupananda Variyar Medical College is located in Salem.

Contact Name: Er. Jayavel / Mobile No: 94432 30903

11. Maintenance of Security

Security is outsourced to a security agency to maintain the safety and prevention of any untoward incidents.

12. Maintenance of Medical Services

The Institution has 700bededmultispeciality and well equipped hospital with all types of emergency facilities, working round the clock for 365 days in college campus.

Any serious emergencies, is referred immediately to the hospital in the campus.

The details of the doctors available at RMO office. Medical superintendent and front desk manager/ Citizen Charter.

13. Bank Services

The campus has an exclusive branch of IOB and ICICI in the university campus.

The opening hours of the bank is - 9.00 am to 6.00 pm. (Except :Second and fourth Saturday, Sunday and public holidays)

24 hrs. ATM facilities available at the university campus by ICICI, and SBI bank.

14. Maintenance of Fire Extinguishing Equipments

The equipments are maintained by the University outsourced ESP.

Fire services and equipments are provided by an ESP and the details of the ESP are as given below:

CENTRAL LIBRARY

15. Library Opening hours

The library is kept open from S.a.m. to 12 midnight on all working days.

Membership:

The Library is open to all students and members of the staff of the college and hospitals.

Outsiders and students who have left the college, dismissed or under suspension cannot have the privilege of using the library except with the special permission of the Dean.

Issue and Return of books:

No student will be allowed to take books or journals outside the library.

Loss of Books:

Those who borrow library materials are personally responsible for the safe custody and return of the materials issued to them.

The loss of books should be reported to the Librarian and it must be replace by the borrower by a new one within a month, failing which he will be required to pay double the cost of the books.

Reference books / rare and valuable books will not be issued to anyone.

The Central library will be open on all working days from 8.00 am to 11.00 pm. During exam times library will remain same.

16. Issue Return of Books

Issue and return of books is facilitated through registers and card system.

Each student is permitted to keep the book for 7 days.

Each student is permitted to borrow two books at a time.

17. Online Public Access Catalogue (OPAC)

OPAC Facility is available through a public access link.

18. Reprographic Service

Reprographic facility is provided in the library.

Maintenance of the reprographic machine is provided by manufacturer of the facility.

19. Weeding of Books

Books are weeded whenever the new edition is published, replacing them with new books.

20. Periodic Maintenance of Books

Dusting is conducted daily. Damaged books are repaired as and when necessary

21. Pest Control

Pest Control is conducted on a regular basis, in collaboration with an external agency and monitoring by Campus Environment Committee.

22. Library Audit

Yearly audit is conducted to maintain the diversity of books, and to ensure the new books are included by Institutional Library Committee.

BIOMEDICAL WASTE MANAGEMENT

23. Dry and Wet Biomedical Waste

Building infrastructure maintained and any minor civil work may done by civil department of Vinayaka Mission's Kirupananda Variyar Medical College, Salem.

Management

The Institution has placed separate bins to collect dry and wet waste in different parts of the campus.

The Institution has appointed RAMKY Pvt. to collect the dry and wet waste from the bins located in the campus and dump the waste to Municipal bins, on a daily basis.

24. E-Waste Management

The Institution has a designated storage space for temporarily storing all electronic waste and half yearly audited and disposed to the University.

25. Civil Contractor

Civil related work of campus of the Vinayaka Mission's Kirupananda Variyar Medical College, Salem maintained by a team of civil engineers.

26. Management of Waste Generated through discarding of old records

Maintenance and service department is being done theManagement of Waste Generated through discarding of old records in the campus of Vinayaka Mission's Kirupananda Variyar Medical College & Hospital, Salem.

27. Maintenance of Kitchen Facilities in Girls Hostel

Kirupa Block, Ladies Hostel, VIPQ PG Hostels and Gents Hostels Maintained and managed by KV STAR Property management.

28. Maintenance of Rooms and Furniture in Girls Hostel

Hostels Maintained and managed by KV STAR Property management.

29. Extension Activities

All medical camps are carried out through Urban Health Center, Primary & Rural Health Center and Tribal Health Center at Papprapatti and Nallampatti, Attayampatti, Salem Block to catering needs of people on free diagnosis, investigation and treatment organised by Camp Coordinator with skilled medical team of Depatment of community Medicine, Vinayaka Mission's Kirupananda Variyar Medical College & Hospital, Salem.

30. Social Responsibility

NSS Unit of Vinayaka Mission's KirupanandaVariyar Medical College & Hospital, Salem is being organized various awareness program of Public health to the people nearby villages by Student volunteers.

HOSPITAL SERVICES

HOSPITAL SERVICES:

1. Introduction
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14. Management of patients in Triage and Observation area:
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    f. Casualty Manager
    g. Junior residents (JR) (PG students)
    h. CMO:
    i. RP/RS on Duty

j. RP / RS on Call, POC / SOC on Call
k. Casualty In-Charge (CIC)/ ECRO (Emergency Control Room Officer):
l. Trauma Care Nodal Officer (TNO) m. Superintendent:

25. Casualty & Trauma Care Meetings/reviews
26. Ethics of Casualty & Trauma Care ***

1. Introduction

Public perception and opinion regarding a hospital is based on their visit to the accident & emergency department. This facility usually accounts for a substantial number of hospital admissions. An accident (trauma) or an emergency (casualty) is an injury or illness that is acute and poses an immediate risk to a person's life or long term health. Casualty and Trauma Care patients often present with potentially life threatening symptoms such as headache, chest pain, abdominal pain, collapse of unknown cause and severe injury mostly due to road traffic accidents. Trauma patients sustain injury which is unexpected, unannounced leading to damage, deformity and/ or death.

Such patients have pressing need(s) and may reach hospital without prior appointment. They may report to the unit on their own or by ambulance. It is a great task for the health authorities to manage such patients. This Standard Operating Procedure (SOP) has been written to:

- Identify the procedure for the triage and clear and precise assessment of patients arriving in the Emergency Department for the overall management of all patients through the department.
- Improve the flow of patients from initial reception through discharge or admission to a ward.
- To ensure that all patients receive proper care and treatment they need in the appropriate time.

- To enable the staff to work as a multi-disciplined team enabling care and treatment to all the patients however busy the department may be.

2. Policy

All health facilities shall mandatorily provide Casualty and Trauma Care Services and is mandatory. The manner of disposal of a patient starting from the entry in to Casualty and Trauma Care department till the exit from the hospital reflects the alertness and promptness of the hospital.

3. Goal

The goal is to establish efficient and effective Casualty and Trauma Care services to reduce disability, morbidity and mortality in hospitals by providing right treatment at right time, right place, with right resources, science, sympathy and speed.

4. Basic function of Casualty and Trauma Care Department/Unit

The Casualty and Trauma Care department/unit shall operate a 24-hour service and provide initial treatment for a broad spectrum of illnesses and injuries, which may be life threatening and require immediate attention. All efforts are made to provide all essential care and investigation in the same hospital premises to save 3 the life of trauma/emergency patients. No patient requiring emergency medical care shall be refused adequate treatment even if no bed is available and the particular specialisation is nonexistent.

- The Casualty and Trauma Care shall provide immediate appropriate life saving care and service both efficient & effective and sensitive to emotional needs and arrange subsequent disposition.
- The Casualty and Trauma Care shall serve as the definitive specialised care facility, properly equipped and staffed to

provide rapid and varied emergency care to all people with life-threatening conditions.

- The Casualty and Trauma Care shall use a triage system of screening and classifying clients to determine their priority needs and to provide patient care efficiently.

d. Financial consideration should not be a barrier to the initial treatment of the patient.

- The Casualty and Trauma Care shall play a key role in times of critical interventions of all kinds.
- Liaison with courts & police in medico legal cases.
- Public relation information, communication and feedback.
- Provide ambulance service.
- Education, training & research.

5. Casualty & Trauma Care Team(s)

- An emergency core team (physically present at all times, shift wise) should comprise (per shift):- Casualty Medical Officer (one), Casualty Manager (one), Pharmacist (one), Nurses (4), Lab Technician (one), ECG technician (one), Attendant (four), Ambulance driver (3), Sweeper (2), Data Entry Operators (2), Record clerk (1). They shall work in three shifts.

- The Expanded Team should comprise the following:

Asst Professor/ Senior Resident on emergency duty one from each department like Surgery, Orthopaedic, Neurosurgery, Plastic Surgery, Nephrology, Radiology, Anaesthesia, Ophthalmology, ENT, and any other departments as may be required. The designation shall be as follows: i. Senior Residents –RP/RS on Duty (Resident Physician/Surgeon on Duty) ii. Assistant Professor - RP/RS on Call (Resident Physician/Surgeon on Call) iii. Associate Professor – POC/SOC 1st Call (Physician / Surgeon on 1st

Call) iv. Professor - POC/SOC 2nd Call (Physician / Surgeon on 2nd Call)

- The Unit shall be headed by CMO.
- There will be one Casualty In-charge (CIC) and a Trauma Care Nodal Officer (TNO) who shall supervise the day to-day running of the unit. 4
- The Medical Superintendent shall be responsible for the overall activity in Casualty & Trauma Care unit and shall supervise twice weekly and as and when required.
- Continuous Professional Development

  It is to be ensured that all those working in Casualty and Trauma Care have regular training, discussions in emergency care. Core Team members (e.g. doctors, physician assistants and nurses) should at least be trained in:

  i. Basic Life Support
  ii. Advance Cardiac Life support
  iii. Advance Trauma Life Support
  iv. Paediatric Advance Life Support
  v. Triaging
  vi. Recognition and Management of the critically ill

- The staff engaged in Casualty and Trauma Care unit shall not be directly or indirectly linked with any private clinical establishments.
- All the Core team staff shall be changed with a new team in every three months.
- The staff should be sympathetic and well trained who can render immediate and appropriate life saving treatment and must be able to meet the emotional requirement of patient and its attendants. It must be understood that the persons visiting the casualty are mentally upset because of the acute illness in their relatives. They need utmost sympathy and courtesy. The Casualty and Trauma Care Service staff must bear in mind all the time that Courtesy does not cost

anything but creates an enormous amount of good will. To maintain the dignity and the decorum of the casualty all the employees posted in the casualty must put on the proper hospital dress (white coat etc.) and display their name plates or special identity cards.

6. Arrangements in the Casualty and Trauma Care unit:

The Dean & Principal, Medical Superintendent, CIC & TNO shall see that the

following arrangement is made in the Casualty and Trauma Care unit.

1. Help Desk/Reception/Registration
2. Waiting area
3. Triage area.
4. A resuscitation area/ beds /a room for patient stabilization.
5. A transient area for patient observation and treatment
6. Procedure room for minor cases/Operation Theatre /dressing room, plaster room.
7. Trauma ICU
8. Trauma OT
9. Laboratory for bedside diagnosis 5
10. Ambulance & Trolley bay
11. Drinking water facility & Toilet
12. 24 x 7 availability of Pathology, X-Ray.USG,CT,MRI,
13. Money receipt counter.
14. Internal Security and Police post

7. Standard Instruments, Equipment and drugs:

The CIC /TNO must ensure the availability of minimum instruments, equipments and drugs required for efficient and timely management of Casualty and Trauma Care cases.

The instruments and equipments must be checked periodically for proper functioning.

8. Reception of Patients:

Any Patients seeking treatment or advice shall approach the reception in theCasualty and Trauma Care unit. Computerised registration shall be made quickly incorporating the preliminary data of the patient as under. But if the condition of the patient is grave the treatment should start immediately followed by paper work.

- Name. Age Sex, Father's name
- Address including, Police Station and temporary address for non-residents
- Telephone numbers including temporary numbers for non-residents
- Marital status and Next of Keens including their contact details
- Presenting complaint
- Mode of arrival
- Time since incident.
- Special information on whether alcohol or a weapon was involved or not
- Whether the assailant was identified
- Precise location of event
- Time of day and day of week of event
- Whether or not the police have been or will be notified

9. Management of patients in Triage area:

The triage means assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties. The main aim of triage is

- To expedite the delivery of timely treatment for patients with life-threatening conditions
- To ensure that all people requiring emergency care are appropriately categorized according to their clinical condition.

  c. To improve patient flow.

- To improve patient satisfaction.
- To decrease the patient's overall length of stay.
- To facilitate streaming of less urgent patients.
- To be user-friendly for all levels of health care professionals

  On arrival the patient shall immediately be taken from the reception to the waiting / triage area accompanied by an attendant and the registration slip shall be handed over to the CMO. This will be supervised by the casualty manager. The CMO shall make a quick examination (within 2 -4 minutes) and assess the nature of service that may be required according to condition of patient like life threat, haemorrhage, pain, conscious level, temperature and acuteness. The type of service may be as follows:

  i. *Immediate* - The patient shall be attended within (0 to 1 minutes) and immediately be taken to resuscitation bed earmarked for resuscitation equipped with oxygen, ventilator and other Cardio Pulmonary Cerebral Resuscitation requirements and after stabilisation shall be shifted to respective ward, from where after relief can be discharged.

  ii. *Very urgent* – The patient shall be attended within (15 minutes) and immediate intervention is to be made.

  iii. *Urgent* - The patient shall be attended within (30 minutes)

  iv. *Less urgent* - The patient shall be attended within (60 minutes)

  v. *Non Urgent* - The patient shall be attended within (120 minutes), treated in observation bed and shall be discharged after relief or sent to appropriate departmental ward. NB: The above time frame is applicable when the patient load is more and discrimination is required for initiation of treatment, otherwise all the patients shall be attended immediately. After stabilisation the patient shall be

shifted to respective ward/ trauma ward, from where after relief can be discharged.

vi. *Dead* – Identification must be made and shifted to Mortuary till handed over to appropriate person or police.

vii. *Court of Law*- In all above cases if it is a medico legal case police information shall be given after maintaining due procedure.

viii. Immediate call to the Resident Physician/Surgeon on duty shall be given to manage the cases by admitting in the trauma ward or in respective department. (The Post Graduate students may accompany any such doctors on duty/call but shall not independently attend the call. They shall manage cases under supervision of RP/RS/POC/SOC) If the call is not attended then at half an hour intervals the call can be given in the following order to: (a) the RP/RS on Call, (b) POC/SOC (1st call), (c) POC/SOC (2nd call) d) Casualty I/C and Superintendent shall be informed to make alternative arrangement for immediate examination and treatment of the patient. The superintendent shall subsequently enquire in to the matter for such non attendance to a call and if no justified reason is found necessary action deemed proper shall be initiated against such doctor.

ix. No patient shall remain in triage area for more than 2 hours.

10.Management of patients who die in Casualty/ Trauma ward.

- Patients who die in casualty should be given death certificate by the CMO or the senior resident of the clinical/surgical unit.
- The CMO should ensure that the body is sent to the mortuary with due care and consideration and should promptly inform the relatives of the patient who dies in

the casualty. When the relatives arrive in the casualty, the CMO should show due courtesy and sympathy to them and help them in every possible way in the disposal of the dead body.

- Every death in the casualty department should be reported in writing and sent directly to the Medical Superintendent, giving particulars of the case and brief resume.

11.Management of patients who are brought dead to casualty.

- All cases "brought in dead", and where the actual cause of death is not known, should be handed over to the police for suitable action.
- The name of such cases should be entered in the casualty attendance register along with all the possible details about the dead person obtained from the accompanying relatives whose name and address should also be noted and recorded in the register.
- In case where death has occurred due to natural causes and there is no suspicion of any foul play, the dead bodies may be handed over to the relatives on their request and this must be recorded with signatures of relatives or attendants.
- All other cases where death has occurred due to accident, assault, burns, suicide, poison, rape or any other causes where it is suspected that death has not been due to natural causes, must be registered as medico-legal cases (MLC) and the police authorities informed accordingly observing due procedure.
- In all the above cases, the out-patient tickets and the death reports duly completed must be forwarded to the Medical Records Section and Registrar Birth & Death.

12.Management of Medico-legal cases:

- A medico-legal situation is defined as one where there is an allegation, confession or suspicion of causes attributing to body injury or danger to life. The CMO must not enter into any arguments with the patient, relatives or attendants regarding the medico-legal aspects of the case. This problem must be left entirely to the Police Constable on duty.
- The CMO's foremost duty is to render medical aid to the patient.
- All such cases should be promptly entered in the medico-legal case register available in the Casualty.
- The CMO should see that the register pages have been properly numbered and that each entry is properly and adequately made.
- Special emphasis should be given to clear and legible entry of the name, address, time of arrival of the patient and to the cause and nature of injury.
- Signature should be in full with the name of CMO /RS/RP given in capital letters. At least two marks of identification of the patient should be carefully entered. A copy of the report and the register should be handed over to the police for safe custody.
- No unauthorised person, should have access to the medico-legal records (including medico-legal register) without the written consent of Medical Superintendent or any other officer authorised by him.
- Nature of injuries should be recorded in every MLC case. X-ray reports should be entered within 7 days in MLC register. X-ray department is requested to provide the X-ray report within 48 hours. Remarks of the specialists should be entered in the MLC register and signed by the specialist with his/her name clearly written in block letters. All exhibits of legal importance (gastric

lavage etc.) should be immediately sealed and delivered to the police and their signatures obtained in the book.

vi. In all medico-legal matters, where the CMO is in need of expert advice, the faculty on call from the Department of Forensic Medicine should be contacted and proper guidance obtained.

- The MLC reports should be prepared by the CMO /RP/RS and not by the Interns / Junior residents (PG). The police officer posted in the casualty should expedite the completion of all MLC reports within 7 days.

13. Preparation of Case Sheet and management policy.

- Case Sheet must be prepared with utmost care to avoid future legal implications. It must be legibly written with full signature, designation, date and time of call as well as examination. Writing in a haphazard manner with omissions and commission of facts is to be strictly avoided. If the patient's condition is grave the treatment must be started immediately and Case Sheet is to be maintained subsequently keeping in mind that Case Sheet is a legal document.
- The Name of patient, age, sex, father's name, full address, name of accompanying person must be clearly written in capital letters.
- The provisional diagnosis must be written in capital letter.
- Brief and pertinent examination findings (signs and symptoms) must be written clearly in appropriate space of the ticket.
- Investigations if required must be mentioned on the body of Case Sheet on left margin. Only the investigations which are essential for diagnosis and immediate management shall be advised. Clear direction shall be given to do investigation like pathology, X Ray, USG, CT, MRI in the hospital. The patient must be guided

properly where to do the investigation and if required the help of the Casualty Manager shall be taken. Direct or indirect indication to do the investigations by private agencies is strictly condemned and is punishable.

- Every physician/surgeon should prescribe drugs with generic names legibly and preferably in capital letters and he/she shall ensure that there is a rational prescription and use of drugs.
- There shall be periodical prescription audit and the erring officer shall be held responsible and action as deemed fit shall be initiated.
- Legal action may be taken against the erring staff who mislead the patients leading to harassment of patients. Utmost care shall be taken so that no patient incurs expenditure during stay in Casualty and Trauma Care unit.

14. Management of patients in Triage and Observation area:

- No serious patient needing admission should remain under observation without admission and proper case notes.
- The staff nurses shall manage the treatment of patients as per the advice of the physician/ surgeon. The staff nurse must check the status of life saving drugs, oxygen etc. available before taking over the charge of the shift. For any shortage indent must be made immediately and kept in stock.
- Privacy must be provided to patients while doing any dressings of private parts.
- Intravenous Drugs or Intramuscular drugs to gluteal region must not be administered in sitting position. Intramuscular drugs in upper limb can be administered while the patient is sitting with a back rest (e.g. a chair not a stool).
- The injection or drug distribution area must be in a separate room or segregated from the ward by partition screen.

- Aseptic precaution must be taken before giving any drug parenterally.
- The dilution and speed of administration of any injection must be made as per specification.
- Before giving any injection the date of expiry and route of administration must be verified in each vial or ampoule.
- Any medicine or injection dispensed to a patient must be recorded in a register against the registration number.
- The drugs and medicines, surgical must be kept well arranged on the table or rack and the surrounding must be clean.
- The rate of intravenous infusions, rate of oxygen must be strictly as per advise of doctor.
- The procedure of administration of drug intramuscular/ intravenous, dressings of wounds and other nursing cares shall be periodically supervised 10 by the CMO and appropriate training or advice shall be given on spot in a descent way.
- Bio Medical Wastes must be properly disposed in appropriate buckets. Syringes and Needles must be destroyed before disposal.

15. Casualty & Trauma Care Admission Policy

- Only patients whose assessment during triage falls under immediate, very urgent and urgent shall be admitted to the trauma ward for further management. Trauma ward is only for giving emergency care & management but not for keeping the patient for continued treatment.
- It must be ensured that the various clinical departments/units while admitting patients in their departmental wards first priority shall be given to patients already admitted in trauma ward followed by patients attending OPD. They shall not keep beds vacant in their departmental wards while occupying beds in trauma wards. They will not admit any patient on such vacant

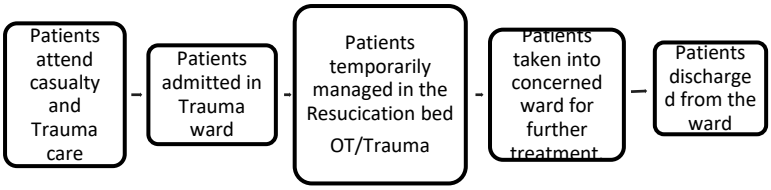
beds from the OPD unless they have taken all the patients admitted in the Trauma Ward.

- No gravely ill patient can be denied attention and admission on the ground of non-availability of beds. Under emergency situations, the CMO can take permission of the Medical Superintendent to admit a seriously ill patient in any vacant bed in the hospital after consultation with RP/RS.
- When the patient requires the intervention of multiple departments, call can be given to appropriate departmental emergency doctors and the priority of treating department shall be decided. Such patient shall be admitted first to such priority departmental ward and subsequently referred to other department as per priority. Priority decision shall be as follows:
    1. Multiple injuries: In patients with injuries involving abdomen as well as other systems. the general surgical unit on-call would take the primary responsibility of the patient care. As a rule, a patient with altered sensorium due to head injury will be admitted under Neurosurgery though she/he may be having other system injuries.
    2. Combination of Surgical and Medical diseases: In such situations, the problem of immediate importance would decide the primary responsibility. For example, an impending gangrene in a diabetic may primarily need medical care for the control of diabetes while a typhoid patient with acute abdominal perforation would need immediate surgical help.
    3. Medicine versus Medical Superspeciality: Where the patient requires specific cardiologic, neurologic, nephrologic, endocrinologic or

gastroenterological therapeutic measures shall be managed by the concerned Superspeciality department on advise of the Senior Resident.

4. General Surgery versus Surgical Superspeciality: Where the patient requires specific therapeutic measures related to Neurosurgical, 11 Cardio-thoracic, Surgical Gastroenterology, Paediatric surgery or Plastic surgery, shall be managed by the concerned Superspeciality department on advice of the Senior Resident. Same principle is applicable for Obstetrics and Gynaecology and Psychiatric cases.
5. The above priority decision is only indicative. The CMO, along with RP/RS/POC/SOC of concerned departments may sit together and decide the priority on the basis of above guidelines. If the priority still remains unsettled the decision of the Superintendent shall be final. But in no case the treatment can be stopped or patient is neglected or deprived of treatment.
6. Patients with infectious disease if requires treatment with isolation, a call shall be given to the concerned doctor in-charge of ID ward and shall be admitted to the ID ward and when no more isolation is required the patient can be shifted to appropriate ward for further management or discharged with advise.

- It is the responsibility of the triage officer (CMO) to direct all patients whose triage assessment falls under less urgent / non urgent, to the physician or surgeon available for appropriate advise and disposal.
- Scheme of admission: (In the above process there is no provision for any back ward movement of patients)



16.Management in Trauma ward:

- The trauma ward shall be mostly used for accident/ surgical patients.
- The trauma ward shall be managed on rotation by department of Surgery, and Orthopaedics of the institution. The rotation shall be done on monthly basis i.e. surgery department will manage one month followed by orthopaedic department. The HOD of the above departments shall prepare the day wise distribution of units for the above duty. The Concerned RS/RP on Call of the unit shall be in-charge of the trauma ward for the day. He must make rounds frequently and see that the patients in the trauma ward are managed by the concerned department and shift the patients to their respective ward in time. In case of need he may give a call to the RS/RP on Call of concerned department.
- Every day in morning by 9.00 AM the concerned POC/SOC shall take all cases admitted in the trauma ward to the respective departmental ward. The post operative cases (Operated in Trauma OT only) may be kept in trauma ward till recovery from anaesthesia and stabilisation and if does not require ICU management can be shifted to respective ward. The CIC / TNO shall ensure the shifting of such patients. No patient once admitted to respective ward or treated in respective departmental OT shall again be brought back to trauma ward. Patient attends Casualty & Trauma care Patient admitted in Trauma ward Patient temporarily managed in Resuscitation bed / OT/ ICU / Trauma ward Patient taken to concerned departmental ward for further treatment Patient discharged from departmental ward

- All investigations which may be required for immediate diagnosis and management only may be advised. The pathological/haematological, X-Ray, USG shall be done in the Casualty & Trauma Care itself. The CT scan and MRI shall be done in the institutional unit which shall operate 24 X 7. No patient shall go to private agencies while in the trauma ward. The money receipt counter shall be in the Casualty and Trauma Care unit.
- Any medicines prescribed shall be procured from the Pharmacy counter which will be in the Casualty.
- Blood transfusion if required as a life saving measure shall be made available maximum up to two units. Attendants of patients shall be encouraged to donate equal units of blood.
- Disposition of Patients from the Emergency Department

i. Transfers

1. The attending doctor must personally evaluate a patient in the Emergency unit prior to the transfer to another ward.
2. In the transfer of patients all safety measures and appropriate care shall be provided.
3. The transferring doctor is responsible for completing the appropriate documentation.
4. The transferring doctor should ensure that a mutual decision with the receiving department/unit has been reached.

ii. Discharge/Leave Against Medical Advice /Refuse treatment:

1. The doctor at the time of discharge of a patient is responsible for providing the patient with verbal and legibly written instructions for follow up care at home and fills up the discharge certificate. The discharge certificate must contain the details of the

patient, admission date, investigations done, diagnosis, treatment given and follow up advice. The full name of treating doctor / unit of the department must be clearly mentioned.

2. Patients refusing further management should be requested to complete and sign the Discharge on Request (DOR) form and should be attached to the patient's Case sheet. Refusal to sign the DOR form should be documented on the Case Sheet and the DOR form and witnessed.

3. A patient who leaves the unit prior to starting of treatment should have such information noted on the Case Sheet, and the reason if known, as to why the patient left, should be documented, timed, and signed.

4. The patient who leaves the hospital against a medical advice and without the knowledge of the hospital staff should be marked as LAMA in the Case Sheet and police shall be intimated. A register of all such LAMA cases may be maintained.

17. Treatment in OT

- The OT must function 24 x 7.
- All trauma or emergency patients requiring surgical intervention must be sent to OT from the triage area. In case the OT table is not vacant the patient may be kept under observation in the trauma ward.
- After the patient comes out of the OT, after recovery from anaesthesia and being stabilised, and if no ICU is required then it is to be shifted to respective ward. No patient shall be kept in the trauma ward after being stabilised so that the ward remains ready for needy patients.

- In case of poly trauma after the patient receives treatment as per first priority and after stabilisation can be sent to departmental ward from where it can be shifted to next departmental ward on priority for management.

18.Treatment in ICU:

- If the CMO decides that a patient requires ICU management, the patient is to be immediately shifted to the ICU.
- The casualty manager will ensure speedy shifting of the patient taking the help of one attendant on duty. After handing over the patient to the ICU medical officer, the Casualty Manager shall also apprise the attendants of the patient regarding the status of the patient and the line of management and probable outcome and make a brief counseling to reduce the anxiety of the attendants.
- The patients from trauma OT, if requires ICU, will be managed in the trauma ICU.
- The moment the patient recovers from the critical condition and is stabilised the patient should be shifted to respective ward. No patient shall be kept in ICU even after recovery from critical illness. If required the patient may be kept in respective departmental ICU or central ICU but preferably not in trauma ICU. The trauma ICU must be kept in readiness to accept needy cases from triage area.

19.Interdepartmental Coordination

- The Casualty and Trauma Care unit is the face of the Hospital. A prompt, appropriate and well coordinated care of emergency and trauma patients increases the confidence of public at large on the health care delivery system.
- All the departments along with the Casualty and Trauma Care unit must work as one team.
- Shifting of responsibility to manage the patient by one department to another on silly technical grounds leading to suffering of the patients is strongly condemned. All departments when receive a patient being referred from another department must examine immediately and give appropriate advice. In case of conflict in management e.g. in poly trauma cases all departments 14 must sit together and discuss the modalities of treatment and who to start first.
- All the departments must be in round the clock preparedness to accept any patient on emergency and manage actively with all available skill, knowledge and resource. Interdepartmental referral shall be done by giving a call to the concerned department and recording such call in the call register.
- In case of epidemics like hepatitis, dengue, swine flu, food poisoning, alcohol tragedy and other natural calamities or disasters all appropriate departments shall share equal responsibility of managing the emergency situation in a well coordinated way as one team. In such cases the superintendent shall be the overall supervising authority and the ECRO shall be the chief coordinator. In these situations all staff of Casualty and Trauma Care unit and other departments shall obey the directions of superintendent and the ECRO, for smooth management. The decision of the Superintendent is final and binding in this regard. f. Any call given by the CMO to RP/RS or POC/SOC of any department shall attend the patient

immediately and take the patient to their department if felt appropriate for patient management.

20.Investigation facility (Pathology / Biochemical /X Ray, USG, CT Scan, MRI):

- Ideally the Pathological / Biochemical /X ray, USG, CT Scan, MRI should be available in one building. In case the units are wide apart, while advising for such investigation, the Casualty Manager shall help the patients in going to the appropriate building.
- The fees are to be deposited in the appropriate counter and under no circumstances once the fees are deposited, the investigating authority shall deny performing the test.
- The doctors while advising for investigation shall also inform the patient regarding the location of the investigation site so that no patient goes to private agencies.
- The Superintendent must ensure 24 x 7 operation of investigating units. Periodic prescription audit shall be made by Superintendent to assess whether the investigation is done in side campus or outside.

21. Free Medicine supply-VMKVMC&H Pharmacy:

- No patient shall be advised to buy medicine from outside.
- All patients attending casualty / trauma care must be provided free medicine from VMKVMC&H Pharmacy.
- Appropriate instruction and information is to be given to the patient regarding the place of availability of Pharmacy.
- Doctors must know the medicines available in Pharmacy and list of such medicines must be displayed. The doctors must manage the patients by

administering the medicines available in Pharmacy as all the medicines required in a standard treatment protocol are available in Pharmacy.

- Regular check up by the Superintendent is to be done to assess if the medicines are prescribed to buy from outside. Action may be taken against erring officers or staff for advising the patients to buy medicines from outside.
- The superintendent must make regular meetings with the Physicians or Surgeons to discuss regarding the effectiveness of available drugs in Niramaya and accordingly suggest Government for procurement of newer drugs if required.

22.Management of Ambulance:

- When the patient is required to be transported to a departmental ward the ambulance shall be utilised.
- The ambulances shall park near by the Casualty/ Trauma care unit.
- Two third of available battery cars must be in use and one third may be parked for charging.
- Each vehicle shall be allotted one driver and one attendant.
- A register regarding the time of transportation and return time must be maintained and to be supervised by casualty manager. The mobile numbers of drivers and attendants must be available in casualty.

23.Registers and records to be maintained:

The following records and resisters must be maintained

- Casualty OPD register
- Casualty admission register
- Attendance registers of all staff in all shifts.
- Physician/Surgeon call register
- Indent register

- Stock ledger
- Daily Issue register
- Duty register (one for all staff)
- Medico legal case register
- Injury register
- Police information register
- LAMA register
- Ambulance / battery car register showing movement of each vehicle
- Register of record of all meetings and proceedings. The above registers must be signed daily by the CIC / TNO as the case may be and twice weekly by the Superintendent.

24.Duties and responsibilities of different staff and officers:

a. CLEANERS

i. Will keep the area neat and clean.
ii. He will give clean and disinfected urinal and bedpans as and when required .
iii. Will carry urine and stool samples to laboratory.
iv. Will transport dead bodies to the mortuary and dispose of dead foetus and other body parts to the incinerator.
v. Will clean the soiled linens with bleach solution and send to laundry for further cleaning.
vi. Will take all personal precaution while handling infectious bio materials.
vii. He will be courteous to the patients and attendants.
viii. Will do any other work as may be assigned by authority.

b. STRETCHER BEARER:

i. He will be on duty near the entrance of the casualty or in ambulance.
ii. Will assist in transferring the patient from ambulance to the casualty or ward by a stretcher or wheel chair/ trolley.
iii. Should also be conversant in providing first aid treatment. iv. Will manage any other duty as may be assigned by CMO.
iv. He should be polite and sympathetic to patients.

c. SECURITY PERSONNEL

i. Must be polite, tact full, courteous and sympathetic under all circumstances.
ii. Do duty as per roster prepared by security officer.
iii. Regulate the flow of patients.
iv. Is responsible for the security of the area under his charge and is responsible for any untoward incidences.
v. Will perform any other duty as may be given by his supervisor/ security officer.

d. ATTENDANTS:

i. Dusting and disinfection of casualty ward and rooms.
ii. Assist nursing personnel in patient care.
iii. Getting the indent from store, sterilised items from CSSD
iv. Take the referral call to different departments.
v. Provide first aid to patients when required.
vi. Assist in transfer of patients to different departments for treatment, investigation, or other diagnostic procedures.

vii. Provide special attention to MLC/ critically ill patients until the staff nurse or doctor take charge of the patient.

viii. Assist the nursing staff in packing the dead body for transporting to mortuary.

ix. Must be courteous and polite to patients or its attendants.

x. Perform any other duty as may be assigned to them by authority.

e. STAFF NURSES

i. Will attend the patients with sincerity and devotion.

ii. She/he will make the bed, feed the patients, administer injections, infusions, medicines and arrange for investigation and diagnostic procedures to the patient with the assistance of Casualty manager.

iii. She/he will carry out administration of oxygen, catheterisation, dressing and toilet of the patient.

iv. She/he will maintain a record of pulse, BP, medications / injections administered by the order of doctor with date and time.

v. She should be polite and sympathetic to patients.

f. CASUALTY MANAGER

i. She/he shall be under the administrative control of the Superintendent and directly work under Casualty Medical Officer. She/he can be assigned any duties in the, Casualty Department by the CMO / Casualty In-charge.

ii. She/he shall be responsible for maintenance of all records pertaining to the patients coming to the hospital like admission, management, inter-facility transfer etc by the help of the record clerk and guide him.

iii. On receipt of a patient in the reception of Casualty & Trauma Care shall coordinate in OPD / IPD registration, shifting the patient to triage area, then as per advice of the CMO shall take the patient to Resuscitation bed/ room, to ICU or Trauma OT or admit to trauma ward. She/he will facilitate the shifting of the patient to appropriate departmental ward by battery car / Govt. ambulance and keep a record of it.

iv. In case of death of any patient brought by 108 ambulance services at the casualty department shall maintain records of such deaths.

v. Take necessary action for proper treatment of unknown/destitute patient and also burn patient who are brought to casualty.

vi. To coordinate the patient during mass casualty /natural calamity and religious celebrations like Diwali & Holi etc.

vii. Co-ordinate all employees posted in casualty department like nurses, attendants, drivers of ambulance and battery cars to provide proper effective treatment and assistance to the patients.

viii. Supervision of sanitation and cleanliness, Coordinate with Electricity / PHD Security Service / Police for proper functioning of casualty dept.

ix. To co-ordinate the patients with RSBY/BKKY/OSTF facility available in the hospital.

x. Assisting the patients regarding Govt. supply of medicines in NIRAMAYA counter, facilities of investigations available like pathological / microbiological / X ray, USG and other imaging methods advised in the Casualty & Trauma Care doctors.

xi. Any other work assigned by the authority from time to time.

g. JUNIOR RESIDENTS (JR) (PG STUDENTS)

i. He will perform duties in Casualty and Trauma Care on rotation basis.

ii. He will carry out treatment as advised by the RP/RS or POC/SOC as the case may be.

iii. He will write patients case sheet in neat and legible handwriting without missing any important relevant findings and in strict accordance with MCI guidelines and shall put his full signature with time of writing such case sheet. It must be countersigned (full signature with date & time) by the senior doctor advising him to do so. The JR will not put his/her signature for any senior doctor.

iv. He will perform minor operative procedures, dressings under guidance of Senior Resident.

v. He will make rounds of patients under short observation along with Senior Resident / RP/RS /POC /SOC and perform all work assigned to him during such round.

vi. He will be tact full in handling patient's relatives or attendants during the time of death of patients.

h. CMO:

i. The CMO must remain in the casualty with high preparedness to attend any patient immediately. No patient shall be denied of being treated in casualty justifying that it is not of emergency nature. The patient can be counselled not to do so after treatment is given.

ii. All effort shall be made not to get irritated and understand the physical and psychological condition of the patient as well as its attendants in the casualty.

iii. In cases of extreme unruliness of the attendant of patient or by patient itself the security personnel and police may be intimated to interfere and immediate information to the CIC / TNO and Superintendent must be given.

iv. Must reach the casualty at least 10 minutes before starting of the shift so that time is spent for observation of the status of casualty and allow timely relieve of the staff of previous shift.

v. Before starting the shift the CMO must see that the life saving drugs, oxygen are not exhausted and if so must be immediately indented & kept ready.

vi. Must manage the patients in triage area without delay and attendants of patients shall be asked to wait in waiting area.

vii. In casualty the CMO is the final authority and he/she is fully responsible for the complete management of the patient. Therefore, the CMO must behave like the treating doctor

and not merely as a medical clerk referring patients from one Senior Resident to the other

viii. Call to RS/RP or SOC/POC if required must be made instantly by phone and to be recorded in the call register. Actual time of attending the patient by the RS/RP or SOC/POC shall be maintained. No person shall put a signature on the call register on behalf of the RS/RP or SOC/POC.

ix. Under no circumstances the CMO should send the patients to the wards or the operation theatre without first having been seen or advised by the Senior Resident or Faculty member of the concerned unit-on-call. But in case of emergency situations where provision of a bed is essential the CMO can admit a patient directly to any vacant bed in the hospital on consultation with RP/RS and Superintendent.

i. RP/RS ON DUTY (Senior Residents):

i. To examine all patients and give prompt treatment. For all serious patients must take consultation of RP/RS on Call.

ii. He will transfer the patients to ward / OT /ICU on advice of RP/RS on call.

iii. He will cooperate with CMO in preparation of Medico Legal records of the patient.

iv. He must see that the history, examination findings, laboratory investigations advised, provisional diagnosis are written on the Case Sheet and countersign it (full signature with date & time)

v. He is responsible for certifying death of patients. vi. He should be courteous and polite to the patients and its attendants.

j. RP / POC on Call, RS / SOC on Call:

i. It is the duty of the faculty-on-call and their Senior Residents to inform the CMO of their whereabouts and the mobile numbers. Whenever a call is given to RP/POC or RS/SOC from the Casualty & Trauma Care unit, must attend immediately and should not wait to finish off the OPD or ward round.

ii. They should be available in their duty rooms during the night.

iii. A call register shall be maintained in each department and a staff nurse shall be in-charge of it.

iv. On receiving a call over telephone, the staff nurse shall record call time and the RP/POC/RS/SOC shall be intimated by phone.

v. On attending the patient in Casualty & Trauma Care unit, if admission is required, shall be done immediately and patient be taken to ICU/ OT/ Trauma ward or respective departmental ward. Deferring the admission and not taking the patient to ward on the plea that no bed is vacant is not permissible.

vi. In case of patients requiring immediate surgical intervention shall be done in Trauma OT.

vii. He should guide the Junior Resident (PG) under him in history taking and examination of medico legal cases.

viii. He will train all junior doctors in handling of all types of emergency patients.

ix. Undue delay in attending a patient shall be reviewed by the CIC /TNO / Superintendent

and if unjustified, action as deemed proper shall be initiated against the erring officer.

k. CASUALTY IN-CHARGE (CIC)/ ECRO (EMERGENCY CONTROL ROOM OFFICER):

i. The CIC must visit the Casualty every day by 9.00 AM.
ii. Shall prepare the duty chart of all staff.
iii. Must counter sign the attendance and records maintained in Casualty and Trauma Care department.
iv. Shall forward any leave application of staff to the superintendent after making due arrangements.
v. The CIC must assess the readiness of the Casualty for the day.
vi. Cleanliness, sanitation, lighting & ventilation. appropriate indent of drugs including life saving drugs or oxygen shall be ensured.
vii. All life saving measures like drugs, equipments and instruments, Oxygen, Ampule Bag etc must be made sufficiently available and the functionality of the equipments and instruments must be assessed periodically.
viii. Shall examine patient as and when required.
ix. Shall make periodical drill for disaster management / mass casualty situations.
x. Shall organise regular training programme for all casualty staff involving all departments

l. TRAUMA CARE NODAL OFFICER (TNO):

i. The TNO must visit the Trauma ward/ Trauma OT / Trauma ICU every day by 9.00 AM.

ii. Shall prepare the duty chart of all staff.

iii. Must counter sign the attendance and records maintained in Trauma Care department.

iv. Shall forward any leave application of staff to the superintendent after making due arrangements.

v. The TNO must assess the readiness of the Trauma ward/ OT /ICU for the day.

vi. Cleanliness, sanitation, lighting & ventilation. appropriate indent of drugs including life saving drugs or oxygen shall be ensured.

vii. All life saving measures like drugs, equipments and instruments, Oxygen, Ambu Bag etc must be made sufficiently available and the functionality of the equipments and instruments must be assessed periodically.

viii. Shall examine patient as and when required.

ix. Shall make periodical drill for disaster management / mass casualty situations.

x. Shall organise regular training programme for all casualty staff involving all departments.

m. SUPERINTENDENT:

i. The Superintendent shall be the highest supervising authority.

ii. He must visit the casualty at least twice weekly and ensure that the patient management is done as per the procedure mentioned above.

iii. He must review the call register and verify the time lag for attending the patients in casualty. For undue delay in attending to a call must be examined and if not justified then action as deemed proper shall be initiated.

iv. No staff on duty shall be allowed to take leave unless arrangement is made to manage his/her duty in his absence and he / she is officially allowed to take leave. Otherwise it will be treated as unauthorised absence. It is to be ensured that the mobile number, alternate mobile number and residential address must be available in the Casualty and Trauma Care unit.

v. The superintendent shall assess the functioning of the Casualty and Trauma Care unit periodically and give suggestions for any modifications for smooth management.

vi. The Superintendent while deploying staff in Casualty and Trauma Care must ensure that the staff is not directly or indirectly linked with any private clinical establishments. An undertaking to the effect must be obtained from the staff before deployment. Any staff subsequently found to be indulged in diverting the patients from hospital to private nursing homes or diagnostic centres shall be removed from Casualty and Trauma Care and action deemed fit shall be initiated against her/him.

vii. During mass casualty the Superintendent and the Dean together shall ensure mobilisation of adequate manpower to Casualty and Trauma Care unit, make availability of adequate life saving medicines and other requirements, establish special enquiry /help desk counter with half hourly update of data regarding status of patients, control the mob, deploy adequate security personnel, volunteers, and inform police for maintaining any law and

order situation, make arrangements for maintaining traffic enabling smooth and quick shifting of patients from ambulances and also disposal of patients by ambulances so that no life of a patient is lost for mere ambulance / public congestion.

25. Casualty & Trauma Care Meetings/reviews:

There shall be at least:

- Monthly meeting on Clinical updates / Sensitisation of all staff of Casualty and Trauma Care unit organized by the CIC/TNO for better preparedness and efficiency for management in emergency.
- Bi-monthly mortality meeting.
- Quarterly inter-departmental or inter-unit meeting / reviews /seminars for deciding the best steps of management / methodology for immediate, very urgent or urgent cases in triage for best outcome of treatment. Such methodologies shall be recorded and to be circulated amongst all staff of Casualty and Trauma Care and all concerned departments.

26.Ethics of Casualty & Trauma Care:

All citizens of India have their right to emergency medical care. To fulfil this right, emergency care providers shall:

- Abide by institutional and or Government guidelines on patient management.
- Respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.
- Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
- Communicate truthfully with patients and/or attendants (in case patient is unable to communicate) secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.

- Manage the patient with due consideration to psychological, social and financial condition of the patient.
- Respect patient privacy and disclose confidential information only with consent of the patient/guardian or when required by an overriding duty such as the duty to protect others or to obey the law.
- Deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired or incompetent, or who engage in fraud or deception.
- Work cooperatively with other stakeholders in the care of emergency patients.
- Engage in continuing study to maintain the knowledge and skills necessary to provide high quality care for emergency patients.
- Act as responsible stewards of the health care resources entrusted to them.
- Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all.

*** Approved by Dean
Variyar Administrative Board ***

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HAND BOOK ON

STANDARD OPERATING PROCEDURE - VMKVMCH