

Civil Hospital Gurgaon	Standard Operating Procedure No 2	Document No CH/GGN/OPD/1
	OPD	Date of Issue: 01-01-2016

SOP 1: ACCIDENT AND EMERGENCY DEPARTMENT

1.0 POLICY:

Emergency care has to be provided to all patients seeking emergency medical services irrespective of caste, creed or paying capacity.

Any patient seeking emergency medical services is screened & first aid care to be provided if required

Triage is initiated whenever faced with a situation of mass casualties

2.0 PURPOSE:

To ensure that the entire patient's coming to the emergency are provided with the appropriate medical care irrespective of caste, creed or paying capacity.

To ensure that all the MLC cases coming to the hospital have proper documentation, timely information, a methodical and thorough examination—including all relevant investigations and referrals, etc, are all that are necessary to see such cases through, successfully.

Triage is the sorting of casualties by priority of treatment

- If faced with large number of casualties need to prioritise management
- The aim is to 'do the best for the most'
- Performed by a 'RMO or Medical Officer on duty' (who is nominated by PMO) who assesses casualties without giving treatment
- Divides patients into categories
- Casualties may be given coloured triage label

3.0 ABBREVIATION:

MRD Medical Record Department

4.0 SCOPE:

Any patient reporting to the emergency department for medical assistance

The following cases should be considered as medico-legal and as such the medical officer is “duty-bound” to intimate to the police regarding such cases:

1. All cases of injuries and burns –the circumstances of which suggest commission of an offence by somebody. (Irrespective of suspicion of foul play)
2. All vehicular, factory or other unnatural accident cases specially when there is a likelihood of patient's death or grievous hurt.
3. Cases of suspected or evident sexual assault.
4. Cases of suspected or evident criminal abortion.
5. Cases of unconsciousness where its cause is not natural or not clear.
6. All cases of suspected or evident poisoning or intoxication.

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7. Cases referred from court or otherwise for age estimation.
8. Cases brought dead with improper history creating suspicion of an offence.
9. Cases of suspected self-infliction of injuries or attempted suicide.
10. Any other case not falling under the above categories but has legal implications.
11. Any person brought by Police for Medical Examination.

5.0 RESPONSIBILITY:

All the doctors, Medical staff and the paramedical staff of the emergency department, MRD and the area police station

6.0 DISTRIBUTION:Emergency department, PMO, Hospital Administrators and Nursing Superintendent, RMO

7.0 PROCESS DETAILS:

7.1 DESCRIPTION OF THE PROCESS

- Emergency department on 24 X 7 bases provides emergency care. Admission or discharge to home or transfer to another organization from emergency department is recorded.
- All patient vital signs & complaints have to be recorded.
- Depending upon the situation required treatment is started by Medical officer on Duty / RMO.
- Resuscitation / Treatment are started as per the requirement.
- Required investigations are done.
- Clinical consultant is informed & details of line of medical management will be recorded.
- After stabilizing the patient, the patient is shifted to respective ward or referred to higher centre if required.
- In case of brought dead patient , hospital only declares the patient and no PI is been sent

ACTIVITIES AND RESPONSIBILITY:

S. No.	Procedural steps	Responsibility
1.	As soon as the patient comes to emergency necessary treatment is provided by Medical officer on Duty	Causality Medical Officer
2.	The attendants and the crowd is also managed	Security at Causality Gate
3.	Medical Officer on Duty directs the patient/relative to registration counter for registration formality	Causality Medical Officer
4.	In case of MLC Medical Officer on Duty informs the detail to the concerned police station & to patient's relatives about the required procedure	Causality Medical Officer
5.	On confirmation of admission registration the patient is shifted to respective wards or department after stabilization	Casualty staff

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6.	If the patient requires any urgent radiology / pathology investigation the needful shall be done before shifting the patient to ward	Casualty staff
7.	Any such investigation done at emergency is entered in the Admission File and informed to the ward	Casualty staff
8.	Any patient who requires isolation due to any infection or immuno compromised state shall be informed to the ward before bed arrangement	Casualty staff

PRIMARY SURVEY

Remember to spell C-A-B

The American Heart Association uses the acronym of CAB — circulation, airway, breathing — to help people remember the order to perform the **steps of CPR**.

Circulation: Restore blood circulation with chest compressions

1. Put the person on his or her back on a firm surface.
2. Kneel next to the person's neck and shoulders.
3. Place the heel of one hand over the centre of the person's chest, between the nipples. Place your other hand on top of the first hand. Keep your elbows straight and position your shoulders directly above your hands.
4. Use your upper body weight (not just your arms) as you push straight down on (compress) the chest at least 2 inches (approximately 5 centimetres). Push hard at a rate of about 100 compressions a minute.
5. If you haven't been trained in CPR, continue chest compressions until there are signs of movement or until emergency medical personnel take over. If you have been trained in CPR, go on to checking the airway and rescue breathing.

Airway: Clear the airway

1. If you're trained in CPR and you've performed 30 chest compressions, open the person's airway using the head-tilt, chin-lift manoeuvre. Put your palm on the person's forehead and gently tilt the head back. Then with the other hand, gently lift the chin forward to open the airway.

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2. Check for normal breathing, taking no more than five or 10 seconds. Look for chest motion, listen for normal breath sounds, and feel for the person's breath on your cheek and ear. Gasping is not considered to be normal breathing. If the person isn't breathing normally and you are trained in CPR, begin mouth-to-mouth breathing. If you believe the person is unconscious from a heart attack and you haven't been trained in emergency procedures, skip mouth-to-mouth rescue breathing and continue chest compressions.

Breathing: Breathe for the person

Rescue breathing can be mouth-to-mouth breathing or mouth-to-nose breathing if the mouth is seriously injured or can't be opened.

1. With the airway open (using the head-tilt, chin-lift manoeuvre), pinch the nostrils shut for mouth-to-mouth breathing and cover the person's mouth with yours, making a seal.
2. Prepare to give two rescue breaths. Give the first rescue breath — lasting one second — and watch to see if the chest rises. If it does rise, give the second breath. If the chest doesn't rise, repeat the head-tilt, chin-lift manoeuvre and then give the second breath. Thirty chest compressions followed by two rescue breaths is considered one cycle.
3. Resume chest compressions to restore circulation.
4. If the person has not begun moving after five cycles (about two minutes) and an automatic external defibrillator (AED) is available, apply it and follow the prompts. Administer one shock, and then resume CPR — starting with chest compressions — for two more minutes before administering a second shock.
5. Continue CPR until there are signs of movement or emergency medical personnel take over.

SECONDARY SURVEY

Secondary survey is the systemic assessment of the entire patient. It should be performed after:

- Primary survey
- Stabilization and initial treatment of life-threatening airway, breathing, or circulatory difficulties
- Cervical immobilization as needed

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The purpose of the secondary survey is to uncover problems which are not life threatening, but which could become life threatening to the patients in future or cause irreparable bodily harm.

HEAD AND FACE

- Observe for deformities, asymmetry, bleeding
- Palpate for deformities, tenderness, and crepitus
- Rechecking airway
- Eyes: pupils, foreign, contact lenses, tearing etc
- Nose: deformity, bleeding, discharge or movement of Ala nose etc
- Ears: bleeding, discharge, bruising behind ears etc

NECK

- Recheck for deformity or tenderness if not already immobilized
- Observe for wound, neck vein dissention, and use of neck muscles for respiration altered voice and medical alert tags
- Palpate for crepitus, tracheal shift & tracheal tug, Stridor

CHEST

- Observe for wound, chest wall movement
- Palpate for tenderness, wound, fracture, crepitus, unequal rise of chest
- Have patient take deep breath-observe for pain, symmetry, and air leak from wounds
- Auscultate chest for rales, wheezes, rhonchi or decreased breath sounds & any abnormal heart sounds.

ABDOMEN

- Observe for wounds, bruising, and distension
- Palpate all four quadrants for tenderness or rigidity

PELVIS

- Palpate and compress lateral pelvic rims, symphysis pubis, for tenderness or Instability

UPPER EXTREMITES:

- Both Shoulders/upper extremities-movement of the joints
- Observe for angulation, protruding bone ends, deformities, wounds and symmetry
- Palpate for tenderness, crepitus, swelling
- Note distal pulses, colour and medic alert tags (**triage alert tag**) and skin and nails
- Check sensation
- Test for weakness if no obvious fracture present
- If no obvious fracture, gently move arms to overall function

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LOWER EXTREMITIES

- Observe for angulations, protruding bone ends, symmetry
- Note distal pulses, colour
- Check sensation
- Test for weakness if no obvious fracture
- If no obvious fracture, gently move legs

BACK

- Immobilize if any suspicion of back injury
- Palpate for wounds, fracture or tenderness
- Recheck motor and sensory function as appropriate

7.2 Handling of Medico Legal cases Policy

Any patient seeking emergency medical services is screened & first aid care to be provided if required. Doctor on duty decides whether a case is a medico legal one or not. All MLC are notified to the police as per Document.

- ❖ All MLC are recorded and marked as MLC.
- ❖ MLC records are stored separately under secure custody.
- ❖ All Medical Examinations done are entered in computer and soft copy stored in the computer. One copy automatically goes to the server in Chandigarh.

ACTIVITIES AND RESPONSIBILITY:

Following Procedures & Document are followed to handle MLC.

S. No.	Procedural steps	Responsibility
1.	All complaints & events are recorded	Causality Medical Officer /Doctor on duty
2.	Each Event to be recorded in detail with mentioning the date, time & place of the event & involvement of person & vehicle during the event	Causality Medical Officer, Doctor on duty
3.	If event to be informed to police, it will be first inform to the patients about the policy.	Causality Medical Officer, Doctor on duty/ Nursing
4.	Process of MLC is explained to each patient	Causality Medical Officer , Doctor on duty/ Nursing,

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5.	A written consent has to be obtained from all the MLC cases, after clarification of all doubts.	Causality Medical Officer, Doctor on duty/ Nursing
6.	After confirming with patient / relative, a communication should be made to respective police station	Causality Medical Officer, Doctor on duty ,
7.	All MLC cases after registration, to be issued for IPD cases & should be marked “MLC”. Stamp all paper and cover	Causality Medical Officer, Doctor on duty ,
8.	Clinical notes are entered in IPD / OPD case paper & in a MLC form book. Stamp all paper and cover	Causality Medical Officer
9.	MLC notes & patient’s data is also entered in the MLC Software also.	Doctor on duty, Computer Operator
10.	A separate register is maintained for each MLC cases with required data at emergency.	Nurse on duty
11.	Counter sign from police station to be achieved from representative of police stations in a manual patient’s MLC form.	Nurse on duty
12.	Police representative details in the form of police station with phone No., designation & buckle No. of representative is noted in MLC form & in software	Security /Nursing
13.	Time of informing police & time of arrival of police is entered in MLC form.	Nurse on duty
14.	If any patient refuses for MLC then it should be immediately inform to CMO for further line of procedure.	Doctor on duty
15.	All MLC cases registered with the hospital should always be informed to RMO immediately in case Second opinion is required.	Doctor on duty
16.	In case of any doubt, about registering the case as a MLC or not, the case is to be referred to the MLC consultant on panel.	Doctor on duty (Forensic Specialist)
17.	Any patient, registered under MLC, expires during hospitalization – Post mortem is a mandatory procedure & patient’s body should not be handed over to patient’s relative but it should be handed over to respective police station for PM to be performed to local district hospital.	Doctor on duty
18.	Case summary is provided to the police at the time of handing over the dead body for submission of the same at district hospital	Doctor on duty
19.	All MLC cases at the time of discharge are informed to same police station.	Nurse on duty
20.	All MLC discharge cases are registered at every place – same	Nurse on duty /

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	way recorded at the time of admission.	Doctor on duty
21.	All the reports of the investigation are kept as a second copy with the MRD file before discharging patient.	Nurse on duty
22.	Patients / relative sign are obtained in our MRD file about handing over of the documents & reports.	Nurse on duty
23.	After the discharge, MRD files of all MLC cases are separately stored & are under control of a designated person.	Medical Record Department
24.	Responsible MRD person will arrange to prepare injury certificate with the help of RMO	Medical Record Department
25.	MRD person preserves signed certificate till police authority collects it.	Medical Record Department
26.	At the time of handing over the certificate to police the designation & BUCKLE No. of the police representative should be noted in second copy & sign of the police should be taken.	Medical Record Department
27.	Monthly reporting of all MLC cases should be a responsibility of MRD to PMO	Medical Record Department
28.	Original injury certificate is only issued to police & not to patient or relatives.	Medical Record Department

7.3 Triage Policy

Triage is initiated whenever faced with a situation of mass casualties.

The senior nurse of the emergency department functions as a triage nurse and shall initiate the triage activity when required. She will also inform other staff about occurrence of mass casualties

Triage categories

Cat	Definition	Colour	Treatment	Example
P1	Life-threatening	Red	Immediate	Tension pneumothorax
P2	Urgent	Yellow	Urgent	Fractured femur
P3	Minor	Green	Delayed	Sprained ankle
P4	Dead	Black		

Methods of triage

Triage can be performed rapidly by assessing

- Airway
- Response to verbal command
- Respiratory rate

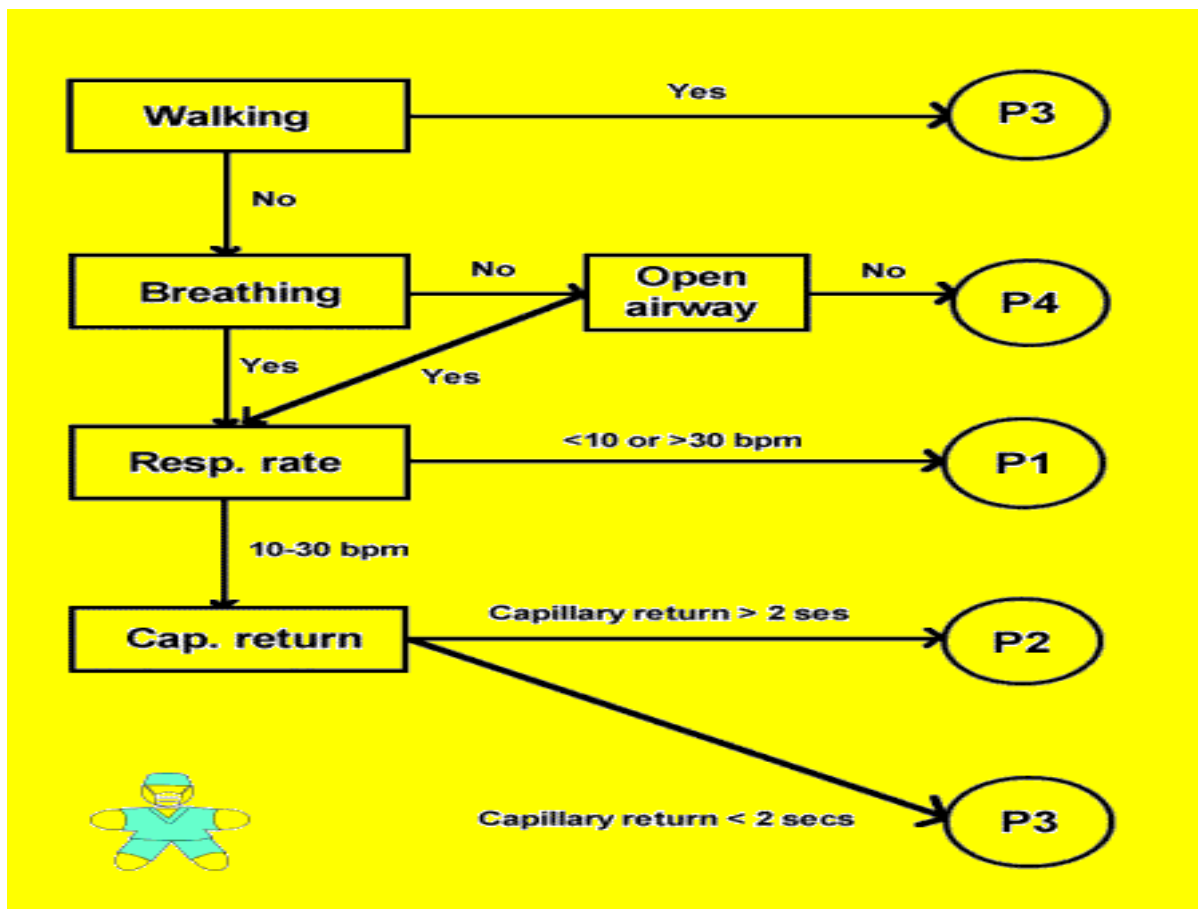
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- Circulation rate: Pulse rate or capillary return
- Pupillary reaction

Scene assessment

- Recognize environmental hazards to rescuers, secure area for treatment
- Recognize hazard for patient, protect from further injury.
- Identify number of patients, initiate triage if appropriate.
- Observe position of patient, mechanism of injury and surroundings.
- Identify yourself
- Contact dispatch if hospital resources require mobilization, asks for back up if needed.



Staff is trained on the procedures for care of emergency patients. They are oriented to policies and practices through trainings and shall be trained in BLS and ACLS.

8.0 REFERENCES:

9.0 RECORDS AND FORMATS :Medico legal Records

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