PROJECT MANAGEMENT UNIT
Primary & Secondary Healthcare Department

ACCIDENT AND EMERGENCY DEPARTMENT

STANDARD OPERATING PROCEDURE

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REVISION SHEET

Page #	Rev. #	Date	Reason of Change	Signature

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1. ABBREVIATIONS

A&E	Accident and emergency
AAC	Access, assessment, and continuity of care
ABGs	Arterial blood gases
ACLS	Advance cardiac life support
AC	Alternating current
ADL	Activities of daily living
AMS	Addition medical superintendent
ATLS	Advance trauma life support
BHU	Basic healthcare unit
BLS	Basic life support
BP	Blood pressure
BSR	Blood sugar random
CCU	Coronary care unit
CMO	Causality medical officer
CN	Charge nurse
CNIC	Computerized national identification card
CNS	Central nervous system
COP	Care of patient
CPR	Cardio-pulmonary resuscitation
CQI	Continuous quality improvement
CSSD	Central sterile services department
CT	Computed tomography
DHQ	District head quarter hospital
DMS	Deputy medical superintendent
DNS	Deputy nursing superintendent
DOB	Date of birth
DOR	Discharge on request
ECG	Electrocardiography
EMO	Emergency medical officer
EPI	Expanded program on immunization

ETT	Endotracheal tube
FMS	Facility management and safety
GIT	Gastrointestinal tract
GTN	Glyceryl trinitrate
HCE	Healthcare establishment
HCP	Healthcare provider
HIC	Hospital infection control
HIMS	Hospital information management system
HIV	Human immunodeficiency virus
HN	Head nurse
HRM	Human resource management
ICN	Infection control nurse
ICU	Intensive care unit
ID	Identification
IMS	Information management system
INJ	Injection
IPD	Inpatient department
IV	Intravenous
LAMA	Leave against medical advice
LHV	Lady health visitor
LMA	Laryngeal mask airway
LP	Liquefied Petroleum
mg	Milligram
MHA	Master in hospital administration
ml	Milliliter
MLC	Medico-legal case
MLR	Medico-legal report
mmol	Milimoles
MO	Medical officer
MOM	Management of medication
MPH	Master in public health
MR NO	Medical registration number

MRI	Magnetic resonance imaging
MS	Medical superintendent
MSDS	Minimum service deliver standards
NGT	Nasogastric tube
NPSA	National patient safety agency
OPD	Outpatient department
OT	Operation theatre
P&SHD	Primary & secondary health department
PCA	Patient-controlled analgesia
PHC	Punjab healthcare commission
PMDC	Pakistan medical and dental council
PNC	Pakistan nursing council
PPE	Personal protective equipment
PPM	Planned preventive maintenance
PRE	Patient rights and education
RHC	Rural health Centre
RN	Registered nurse
SC	Subcutaneous
SHC & MED	Specialized healthcare and medical education department
THQ	Tehsil head quarter hospital
USG	Ultrasonography

2. PREFACE:

Punjab is the most densely populated province of Pakistan consisting of 36 administrative districts. District Headquarter (DHQ) hospitals serve catchment populations of the respective districts (approx. 2 million in each district) and provide a range of specialist care in addition to basic out-patient and in-patient services. The DHQ hospitals typically have about 100-300 beds and offer broad range of specialized services including surgery, medicine, pediatrics, obstetrics, gynaecology, ENT, ophthalmology, orthopaedics, urology, neurosurgery etc. DHQ Hospital is the referral point for Basic Health Unit (BHU), Rural Health Centre (RHC) and Tehsil Headquarter (THQ) hospital. DHQ hospital also provides emergency healthcare to a wide range of patients totally free of cost.

The use of hospital's Accident and Emergency (A&E) departments is growing day by day due to increasing population, urbanization, traffic accidents, violence, disasters and rising prevalence of chronic diseases in Pakistan. Primary & Secondary Healthcare Department (P&SHD) is committed to ensure provision of free emergency services to the critically ill and injured patients at all DHQ hospitals in the province as per the vision of the Chief Minister of Punjab.

Strengthening of A&E services in terms of physical infrastructure development, human resource development and steady provision of essential drugs and supplies is the need of the hour as timely availability of emergency services and critical care can prevent and reduce a number of deaths.

The Government of Punjab is committed to the improvement of the Healthcare Services and has mandated the Punjab Healthcare Commission (PHC) to prepare and prescribe Minimum Service Delivery Standards (MSDS) for various categories of Healthcare Providers (HCPs), and to get the same implemented in all public and private Healthcare Establishments (HCEs) in Punjab for grant of license, without which no HCEs can function. P&SHD has been tasked with improving service delivery in the most extensive public healthcare infrastructure revamping in the province.

The goal of these Standard Operating Procedures (SOPs) is to involve more of the personnel working in DHQ and THQ hospitals of the P&SHD who have a special interest or expertise in A&E. The Government of Punjab has taken another revolutionary step to bifurcate the responsibilities of Health Department into P&SHD and the Specialized Healthcare and Medical Education Department (SHC&MED) for improvement of healthcare services at all levels. P&SHD is implementing multiple initiatives to improve the healthcare standards and ensuring compliance with the MSDS through a comprehensive revamping program.

MSDS for hospitals, prescribed by PHC and approved by the Government of Punjab, are the minimum set of standards that a hospital must comply with while providing healthcare services.

The standards can only be complied with if the HCEs have proper infrastructure, and material and human resources to provide the required care. Accordingly, the Project Management Unit (PMU) is currently reviewing and improving the facilities and human resources for the improvement of the services. Development of A&E Department Manual is a component of the larger effort in this regard.

The main aim of this manual is to update A&E services in all THQ and DHQ hospitals of Punjab according to the revamping program charted by the P&SHD. This manual will provide the structure to help the consultants work together effectively to enhance the quality of A&E services in THQ and DHQ hospitals of Punjab in accordance with the revamping program designed/implemented by PMU.

3. SCOPE

The A&E Department in DHQ hospital offers emergency care twenty-four hours a day with the help of medical, nursing and paramedical staff fully supported by diagnostic services. Apart from trauma and burns victims, patients with heart attack, kidney failure, breathlessness, pains and reactions, etc. also report in (A&E). As most of patients' visits to the A&E are unplanned, the A&E department must be able to provide initial treatment for a broad variety of illnesses and injuries, some of which may be life-threatening and may require immediate attention.

3.1 Types of patients managed in the a&e department:

1) Cardiology cases
2) Internal medicine cases
3) Orthopedic cases
4) Polytrauma cases
5) Head injury
6) Spinal injuries
7) Chest and abdominal injuries
8) Cut wounds
9) Surgery cases
10) Psychiatry case
11) Neurosurgery cases
12) Neurology cases
13) Pediatrics cases
14) OB-Gynecologist
15) Oncology cases
16) Dental and Maxillo-facial trauma
17) Poison and toxicology cases

In Pakistan A&E departments have become important access points to medical care for many people especially the unprivileged segment of society because all services provided here are quick, efficient, free of cost and they don't have to wait for hours in queues.

A&E Departments at HCEs are also a major service provider to affected community in case of a natural and man-made disaster. An efficient A&E department can not only save the lives of many disaster victims but can also reduce the disability and morbidity to a great extent.

The SOPs provided in this manual are applicable to all the staff working in DHQ hospitals, especially to the A&E staff to ensure uniform care for all patients.

4. LEGAL AND ETHICAL CONSIDERATION

Whenever an injured person is brought to a hospital, it is mandatory to provide medical aid without delay on priority basis. This medical aid will be provided irrespective of any other medico-legal formalities and no police officer shall interfere during the period an injured person is under treatment in a hospital. (Injured Persons' Medical Aid Act, 2004)

The environment of A&E Department is always emotionally charged due to unplanned health related events, critical nature of medical condition, uncertainty about the consequences/outcomes, waiting at an unfamiliar place filled with strangers, scene of serious and traumatized patients, expectation of high quality outcome and death-denying culture in local community.

With rapid pace of events in such high-pressure environment, it is little wonder that patients feel annoyed but often, their frustrations are turned into violence and aggression towards hospital staff which has become an everyday phenomenon in Pakistan affecting the patient care and the safety of infrastructure and staff of the HCE.

Healthcare Providers (HCPs) working in A&E face unique ethical challenges which range from dealing with patients who may or may not be in a position to give Informed Consent to the need to maintain privacy and confidentiality, caring for unknown patients and abuse victims, or even having to decide whose life to save when not everyone can be saved. These consequences challenge the ethical quality of emergency care.

A&E departments have a role in identifying, reporting and managing cases of workplace and domestic violence against women, children and elderly while all of them rarely admit to what has happened even though the injuries are strikingly evident and suggestive. To respond appropriately to these moral and ethical challenges, medical, nursing and paramedical staff need knowledge of moral concepts and principles and they must be equipped with ethical reasoning skills duly supported by public education program to strengthen the emergency services. Emergency medical staff may assume a distinctive social role and responsibility to act as HCPs of last resort for many patients who have no other ready access to healthcare.

5. PHYSICAL SETTING:

A&E Department should be easily accessible for general public. It should be close to parking area preferably having a separate entrance. A&E Department should always be on ground-floor with easy access to IPD and OPD, and should be adjacent to diagnostic facilities and Radiology Department.

Access to A&E should be ensured by both stairs and ramps, clearly designed for patient arrival and departure. The pathways should facilitate free movement of patient's trolley, stretcher etc. Adequate space for wheelchairs and patient trolleys should be ensured. The availability of porter service must be ensured. A&E must be able to accommodate transportation of large of number of patient in case of a disaster. Effective and standard signage for the guidance of patients should be ensured.

Fast and easy connections have to be established with the following:

1) Blood bank
2) Main Pharmacy
3) Technical support services especially Biomedical Department.
4) Clinical Laboratory
5) Imaging services

5.1 The Functional Areas of A&E:

1) A&E The entrance to A&E should have;
   a. Ramp and stairs
   b. Area for porters
   c. Area for stretchers, trolleys and wheel chairs
   d. Sufficient space for parking of ambulance and unloading of patients
2) A&E Department reception/Patient registration counter
3) Madadgar Counter
4) Triage area
5) Resuscitation Room
6) Nursing station
7) Patient care area (Medical/Surgical/Pediatric)
8) Procedure Room
9) Minor Operation Theatre
10) Major Operation Theatre
11) Pharmacy Services
12) Lab counter with LCD display of tests
13) X-Ray /USG
14) Administration office
15) Security office
16) Doctor's office
17) Nurses office

18) Storage area for biomedical equipment/accessories
19) Washroom for patients
20) Waiting area for attendants

6. HUMAN RESOURCE

DMS Emergency	1) Physician on consultant level with MBBS or equivalent qualification with postgraduate MPH/ MHA/or any other equivalent qualification 2) Valid registration with PMDC 3) Preference will be given to those with specialization in emergency medicine and care of patients 4) Certified in all life support trainings (BLS, ACLS, ATLS)
Casualty Medical Officer	1) MBBS or equivalent qualification recognized by PMDC 2) Valid registration with PMDC 3) Preference will be given to those with experience of working in A&E 4) Certified in all life support trainings (BLS, ACLS, ATLS)
Emergency Medical Officer	1) MBBS or equivalent qualification recognized by PMDC 2) Valid registration with PMDC 3) Additional postgraduate qualification/ or training completed FCPS/ MCPS/ diploma in medicine, surgery, peads, gynae, ortho etc 4) Preference will be given to those with experience of working in A&E 5) Certified in all life support trainings (BLS, ACLS, ATLS)
Staff Nurses	1) Diploma in general nursing and Midwifery /BSN 2) Valid registration with PNC 3) Preference will be given to those with experience of working in A&E 4) Certified in all life support trainings (BLS, ACLS, ATLS)
Registration clerk , Dispenser, Dresser, OT in-charge, Porters, Pharmacy Technician, Blood transfusion officer	

6.1 Responsibility Matrix

DMS Emergency	1) Is accountable for entire management of A&E Department. 2) Supervises proper maintenance of records, allocation, and appropriate utilization of manpower and other resources to their optimum effectiveness in the unit. 3) Ensures the preparation and implementation of the duty roster for his unit. 4) Develops contingency plans and coordinates emergencies and after duty hours, when necessary. 5) Implements quality improvement program in the department in collaboration with quality assurance department. 6) Participates in the budget planning and designing of the unit facilities including the selection and approval of supplies and equipment prior to its procurement. 7) Monitors the implementation of continuing education and training programs of staff from all disciplines contributing to the care of the neonates and pediatric patients. 8) Collaborates with unit nursing-supervisor in the provision of direction in the delivery of service of the unit and implementation of policies and procedures. 9) Establishment of **MULTIDISCIPLINARY COMMITTE --- An operational committee in A&EA&E having members from all disciplines that are directly involved in the delivery of care to the patients admitted and in the maintenance of the unit. The other core functions of the Committee are as follows:** a. It will oversee and guide the ongoing administrative and clinical functions of the department. b. It will convene periodic meetings on monthly basis and document the proceedings of the meetings in the form of minutes. c. It will be responsible for developing, reviewing, and revising of policies and procedures for the provision of patient care. d. It will ensure enforcement of the policies**.** 10) Coordinates with other departments of the hospital that may have direct or indirect influence in the operation of the department. 11) Attends hospital-wide committee meetings regularly.

Casualty Medical Officer	1) Examines the patients directly reporting in the A&E in detail and prioritizes the patients as per Triage criteria. 2) Guides the nursing staff about the necessary orders to be carried out. 3) Coordinates and educates the patient and/or his/her family and answers their queries, apprehensions and complaints 4) Ensures the availability of life saving drugs and that the emergency tray is always ready. 5) Attends Medico Legal Cases (MLCs) according to SOPs on the subject. 6) Issues death certificate as per hospital policy in case patient expires in A&E. 7) Ensures compliance with all SOPs of A&E Department 8) Ensures that instruments/equipment being used in examinations and procedures is properly sterilized. 9) Ensures that all staff participating in the procedures is physically well protected by using personal protective equipment i.e. gowns, masks, caps, gloves and shoes. 10) Checks the punctuality of the staff. 11) Checks the cleanliness of the Department. 12) Ensures that responsible staff regularly upkeeps and maintains electro-medical equipment of the A&E to ensure their functionality at all times. 13) Writes objective Performance Evaluation Reports (PERs) of the subordinate staff.

Emergency Medical Officer	1) Examines the patients directly reporting in the A&E in detail and records brief history, findings and probable diagnosis and treatment with date, time, and signatures; and affixes name stamp. 2) Undertakes all life saving measures e.g. CPR with full protocol. 3) Advises and interprets appropriate laboratory and radiological investigations as per patient's needs 4) Performs life-saving medical/surgical procedure 5) Takes consent for the emergency treatment from the patient/family 6) Discusses urgent matters relating to patient's management with specialists on telephone and acts accordingly. 7) Prescribes discharge medicines to be taken at home in case it is considered that the consultation of a specialist is not required. 8) Guides the nursing staff about the necessary orders to be carried out. 9) Coordinates and educates the patient and/or his/her family to answer their queries, apprehensions and complaints. 10) Instructs and supervises the transfer of critical patient from A&E to IPD and writes the transfer summary and admission orders carefully. 11) Refers the patients to other specialists & facilities as per policy. 12) Admits the patients as advised by the specialists/consultants. 13) Issues death certificate as per hospital policy in case the patient expires in A&E.

Nursing Supervisor/ staff	1) A&E nurses perform comprehensive patient assessment and monitor vitals, oxygen saturation, BSR etc. 2) A&E nurses formulate and develop plans of care based on the assessment findings. 3) A&E nurses are trained to perform the following procedures: (only staffs that have passed competency assessment of the procedures will be allowed to perform these. Skill review should be conducted annually.) a. Initial resuscitation b. IV cannulation c. ECG d. Casting e. NGT insertion f. Catheterization g. Dressing 4) A&E nurses perform administration of high-risk medications under the supervision of the A&E physicians 5) Nurses are expected to abide by the established standards of patient care, set as guidance that is ethically and legally required to deliver safe care to patients and clients. 6) Nurses will check and ensure that consent for emergency treatment has been taken from the patient/family. 7) Nursing Supervisor ensures that instruments/equipment being used in examinations and procedures is properly sterilized and functional. 8) Nursing Supervisor ensures that life-saving equipment should be available all the time, checking for its proper functioning every shift. 9) Nursing Supervisor ensures that all staff participating in the procedures is physically well protected by using personal protective equipment i.e. gowns, masks, caps, gloves and shoes. 10) Perform any other professional duty assigned by the in-charge.

7. GENERAL POLICY GUIDELINES FOR ACCIDENT & EMERGENCY DEPARTMENT

1) Emergency medical care will be made available to all members of the public 24 hours a day, seven days a week, without any discrimination.
2) Unrestricted access to appropriate emergency medical and nursing care must be ensured.
3) DHQ Hospital envisions a smooth continuum among emergency healthcare providers and providers of definitive followup care.
4) Resources should exist in the A&E department to accommodate each patient from the time of arrival through evaluation, decision making, treatment and discharge.
5) A&E should be staffed by qualified personnel with knowledge and skills sufficient to evaluate and manage the patients in A&E.
6) A&E personnel must establish effective working relationships with other HCPs and entities with whom they must interact.
7) Emergency patient evaluation and stabilization must be provided to each individual who presents with an emergency medical condition, to the degree reasonably possible.
8) CMO/EMO/Consultants are responsible for the medical care provided in the A&E department. This includes medical evaluation, diagnosis and recommended treatment and discharge of the emergency patient as well as the direction and coordination of all other care provided to the patient.
9) A&E must maintain a control register identifying each individual who reports to the facility seeking emergency care.
10) A medical record must be maintained for every individual who presents himself for emergency care and it should be retained as per hospital policy.
11) Equipment and supplies must be of highly quality and should be appropriate to the reasonable needs of all patients anticipated by the A&-E.
12) Diagnostic services like laboratory, radiology etc should be readily available.
13) All patients will have full set of vital signs recorded in a timely fashion. All children with medical complaints will have rectal or oral temperatures taken, with the exception of hematology/oncology patients who will have oral or axillary temperature taken.
14) All abnormal vital signs will be brought to the attention of the physician and will be repeated and addressed prior to discharge from the A&E.
15) All patient weights will be documented in Kilograms and all temperatures will be documented in Centigrade.

16) All patients discharged or transferred from an A&E department must be issued specific, printed or legibly written aftercare /followup instructions.

17) Patients must not be transferred from an A&E department unless appropriate evaluation and stabilization procedures have been initiated within the capacity of the facility.

18) A&E staff must familiarize themselves with prescription, administration and storage of medicine policies

19) DHQ Hospital takes measures to protect patient's possessions from theft or loss but takes no responsibility for any loss or theft.

20) Patients/attendants must be informed about their rights, privileges and responsibilities.

21) DHQ Hospital employees must be informed about their rights and responsibilities.

22) DHQ Hospital will make necessary arrangement to educate patients and their families about process of launching complaints regarding patient's clinical care or hospital services.

8. RECEIVING OF THE PATIENT

8.1 Purpose

To facilitate the safe transfer of patient into the A&E

8.2 Responsibility

Ward Boy/Nursing Assistant at the entrance of A&E

8.3 Procedure

1) MS/DMS Incharge/Chief A&E willensure the availability of wheel chairs /stretcher at the receiving area of A&E.
2) MS/DMS Incharge/Chief A&E is responsible for maintaining a duty roster of Ward Boys/Help Desk Officer in morning, evening and night shift who will shift the patient to A&E.
3) Duty Ward Boy/Help Desk Officer will be stationed at the entrance of A&E.
4) Duty Ward Boy/Help Desk Officer will be responsible for maintenance of patient shifting equipment like wheel chairs, patient trolley and stretchers.
5) Patient may arrive in A&E through the following modes
   a. **Category 1** Walk in patients- if the patient is mobile
   b. **Category II** Through ambulance/private vehicle
   c. **Category III** Through public service like Police/Rescue 1122
6) Non-ambulatory patients in category II & III will be received by the A&E support staff deputed at A&E or by the staff designated at help desk. They will shift the patient onto wheel chair stretcher depending upon the clinical condition of patient and transport him inside the A&E.
7) Ambulatory patient may walk directly to A&E or may be shifted on wheel chair/stretcher depending upon the clinical condition of the patient.
8) Duty Ward Boy/ Help Desk Officer will get alert at the sight of ambulance/private vehicle approaching A&E premises.
9) As soon as the ambulance stops in front of A&E, the Ward Boy/ Help Desk Officer will approach the rear door of ambulance and will help open it.
10) Duty Ward Boy/ Help Desk Officer will access the patient and will decide which equipment (wheel chairs, patient trolley and stretchers) to be used for shifting of patient into A&E.
11) Duty Ward Boy/ Help Desk Officer will shift the patient into A&E using appropriate patient shifting equipment .He may ask for more help from A&E if needed.
12) After handing over the patient to nursing staff, Ward Boy/ Help Desk Officer will report back to his duty station and will place the patient shifting equipment at designated area.
13) Duty Ward Boy/ Help Desk Officer will guide the attendant to report to A&E reception for registration.
14) Duty Ward Boy will clear the entrance of the A&E.

9. REGISTERATION OF THE PATIENT

9.1 Purpose:

To facilitate the registration and admission (if required) of a patient in A&E.

9.2 Responsibility

Registration Clerk /Receptionist appointed at registration desk of A&E.

9.3 Procedure

1) MS/DMS A&E will ensure the availability of Registration Clerk round the clock at the registration desk of A&E.
2) All patients coming to A&E will be registered at A&E registration counter regardless of their clinical status.
3) Critical patients are transported directly to A&E and their registration formalities will be completed afterwards.
4) Following information must be obtained during registration process:
   Name, age, gender, address, contact phone number, date and time of arrival (should be in bullets format)
5) For referred patients, following information must be obtained along with above parameters
   a. Name of referring facility
   b. Reason for referral
   c. Referral form issued by referring HCE if available.
6) A Medical Record Number will be issued to patient after recording all information on Emergency Control Register /HIMS (please give complete name with the abbreviation in parenthesis) and Emergency Registration Card
7) Family member accompanying the critical/serious patient will be asked to complete the registration process.
8) If the patient has been brought to A&E by an ambulance and is accompanied by a family member, the family member will be asked to complete the registration process. If the family member is not available, the ambulance staff will have to register the patient at reception.
9) For children, the name of accompanying adult or name of school or nursery as appropriate are also recorded.
10) Medicolegal Cases (MLCs) will be marked as ***MEDICO-LEGAL*** on registration card and information will be communicated to the CMO on duty as well.
11) All unidentified patients will be registered as Medico-legal and information will be provided to CMO/ Police.

10.INITIAL TRIAGE OF THE PATIENT

10.1 Purpose

1) To provide a standardized system whereby patients seeking medical care in the A&E are seen by a physician in order of priority based upon their acuity level.
2) To assess priorities of care in critical situations and high-pressure environment

10.2 Responsibility:

On duty nursing staff and doctors

10.3 Procedure

1) All the patients coming to A&E must be assessed by nurse/ doctor on duty
2) Triage will be based on clinical need of the patient. Ensure that the sicker is the patient, the earlier he/she is seen.
3) Triage will be done by the Triage Nurse/ CMO immediately after arrival of patient in A&E. It will be done according to ***TRIAGE ACUITY SCALE***
4) Patients will be assigned to one of the 3 categories.
5) Priority 1 & 2 require immediate medical attention to save the life, limb, vision. Delay in initial physical evaluation could be harmful to the patient. EMO will be notified immediately. Frequent reassessment is required until the patient is stabilized.
6) For Priority 3, treatment room placement and initial nursing assessment should be expedited. EMO will be notified upon completion of initial nursing and triage assessment. Notifications will be documented. EMO shall seek help of concerned department/consultant if required. Reassessment is the responsibility of EMO and will be performed based on patient condition and response to treatment.
7) Priority 4 and 5 are potentially serious but not life threatening. Initial nursing assessment should be performed in a timely manner. If a treatment room is not available upon completion of initial assessment, periodic reassessment will be performed until evaluated by a physician. EMO will be notified upon completion of initial nursing assessment. Notifications will be documented and reassessment will be completed based on patient condition and response to treatment.
8) Trauma cases/ critically ill patients should be treated by the doctor and nurse together. A doctor shall be acting as the team leader.
9) CMO/ EMO on duty may activate the trauma team if required.
10) Code Blue will be announced only if the patient need resuscitation according to Triage Acuity Scale.
11) A&E nurse will immediately check the vitals of the patient along with presenting condition of patient
12) Either the EMO or A&E nurse can monitor vitals. If both EMO and Nurse are busy with a patient, the CMO can monitor vitals of the second patient and vice versa.
13) Before giving any treatment, obtain consent for emergency treatment

11.TRIAGE ACUITY SCALE

Triage Category	Acuity	Response Time	Examples
IMMEDIATE (Resuscitation)	Patient requires life-saving intervention immediately	Immediate Zero minutes	1) Cardiopulmonary arrest 2) Burns with smoke inhalation 3) Anaphylaxis 4) Shock of any etiology 5) Massive uncontrolled hemorrhage
EMERGENCY	Patient suffering from imminently life threatening condition and requires significant intervention within 15 minutes	15 Minutes	1) Severe respiratory distress 2) Chest Pain (Myocardial Infarction) 3) Seizure 4) Stroke 5) Major Fracture with bleeding 6) Ingestion/exposure to rapidly acting poison/drug
URGENT	Patient suffering from potentially life threatening condition and requires significant intervention within 30 minutes	30 Minutes	1) Unstable Angina 2) Fracture without bleeding 3) Hypertensive urgency 4) Dehydration 5) Acute Abdomen 6) Active GI bleeding 7) Sickle cell crisis 8) Inability to urinate for more than 8 hours 9) Fever of more than 38.3 degree centigrade in patients lees than 2 months old, in patients with cancer or other immune compromised patients 10) Severe headache
SEMI URGENT	Patient suffering from potentially serious conditions with less severe symptoms requires intervention within 60 minutes	60 Minutes	1) Migraine 2) Sprains 3) Foreign body in eye or ear 4) Sexual assault with in last 24 hours 5) Earache
NON URGENT	Requires treatment but time is not a critical factor and needs treatment within 2 hours Victim with relatively minor injuries/ailment	120 Minutes	1) Rash 2) Skin lesions 3) Chronic Headache 4) Cold symptoms 5) Non-acute GI/GU complaint(constipation) 6) Abrasion /superficial laceration

12.ASSESSMENT AND EMERGENCY MANAGEMENT OF PATIENTS

12.1 Purpose

To establish a uniform system for assessment and management of patients in A&E, to monitor clinical progress of patients and to modify plan of clinical care if required. This practice will facilitate:

1) In preserving life.
2) In preventing deterioration before more definitive treatment can be given.
3) In restoring patient to useful living.
4) In providing psychological support to patient and family.

12.2 Responsibility

On duty nursing staff, EMO, Consultants

12.3 Procedure

12.3.1 INITIAL ASSESSMENT INCLUDES BUT IS NOT LIMITED TO:

1) Detailed history of patient
2) General physical examination
3) Focused systematic clinical examination

Primary Survey - a rapid systematic assessment to identify and treat i the life-threatening situation immediately.

Secondary Survey - systematic, head to toe, front and back assessment of the Stabilized patient.

12.3.2 PRIMARY SURVEY AND INTERVENTIONS

1) Establish patent airway with cervical spine protection and provide adequate ventilation by;
    a. Placing the patient in supine position (Head tilt chin lift maneuver, Jaw-thrust maneuver)
    b. Inspecting for facial, mandible, tracheal and laryngeal fractures.
    c. Inspecting the mouth for any foreign bodies causing airway obstruction.
    d. Suction of the secretions.
    e. Administering oxygen.
    f. Performing Endotracheal Intubation or insertion of oropharyngeal/ nasopharyngeal airway if needed.
    g. Exposing the chest and assessing for chest injuries, chest wall excursion, Auscultating to assess air flow in the lungs, assessing for tension pneumothorax, flail chest, massive hemothorax and open pneumothorax.
2) Look for obvious signs of breathing
    a. Look for the rise and fall of chest, nose fluctuations, opening and closing of mouth
    b. Do a breath check
        i. Place your hand near her nose and mouth to feel any breath
        ii. Otherwise lean your head down close to patient's mouth and feel for breath
        iii. Check for respiratory rate, breath and rhythm
3) Evaluate and restore cardiac output by doing the following;
    a. Attach to cardiac monitor
    b. Control hemorrhage and its consequences.
    c. Prevent and treat shock by doing the following;
        i) Establish IV access, collect blood sample for investigations, start IV infusions or blood transfusion.
        ii) Insert Foley catheter to monitor urine output.
    d. Maintain effective circulation
4) Determine neurologic status, ability to follow command, motor skills, pupillary size and reactivity by the use of Glasgow coma scale.

5) Undress the patient for whole body examination and cover with warm blanket to maintain room body temperature.
6) Splint suspected fractures.
7) Protect and clean wound; apply sterile dressing.

12.3.3 SECONDARY SURVEY AND CARE

1) Obtain general history. This includes;
   a. Cause of illness/injury
   b. Type of injury sustained (if accident)
   c. Time of occurrence of illness/injury
   d. Mode of transfer to hospital
   e. Health status prior to present condition
   f. Past medical history including medicines being taken
   g. Last meal eaten
   h. Condition of patient when found
   i. Initial treatment given, if any, prior to hospitalization
2) Do complete physical assessment.
   a. Observe for signs and symptoms of shock:
      i) Early or compensatory shock
         - Anxiety or restlessness.
         - Slight increase in heart rate with a pulse that may be bounding or thread.
         - Increased rate and depth of respiration.
         - Decreased cardiac output.
         - Normal or slightly increasing systolic blood pressure, rising diastolic blood pressure, possible decreasing pulse pressure.

      ii) Intermediate or progressive shock
         - Restlessness, apathy, confusion or decreased response to pain.
         - Falling systolic blood pressure and rising diastolic blood pressure, resulting in a narrowing pulse pressure.
         - Tachycardia with a weak, thready pulse.
         - Rapid, shallow respiration.
         - Decreased urine output (less than 30ml/hr.).
         - Cool, moist, pale skin with possible cyanosis.

      iii) Late or irreversible shock:
         - Unconscious or Unresponsiveness
         - Absent reflexes
         - Progressively falling blood pressures
         - Slowing of the heart rate
         - Weak, thready pulse with possible pulse deficit
         - Cardiac arrhythmias
         - Anemias

   b. Neurologic

i. Use Glasgow coma scale

c. Cardio-Vascular
   i. Blood pressure
   ii. Heart rate, rhythm
   iii. Observe for arrhythmias on the cardiac monitor
   iv. Peripheral pulses

d. Respiratory system
   i. Rate, rhythm and pattern of respiration
   ii. O2 saturation monitoring
   iii. Color for pallor or cyanosis
   iv. Bilateral chest expansion
   v. Signs and symptoms of pheumothorax/hemothorax
      - Diminished or absent breath sound on affected side.
      - Rapid pulse
      - Decreasing blood pressure
      - Dyspnea
      - Deviated trachea (away from tension)

e. Genito-Urinary tract
   i. Distention
   ii. Hematuria
   iii. Pain/trauma
   iv. Incontinence

f. Musculo-Skeletal system
   i. Weakness
   ii. Spasm/pain
   iii. Obvious deformity/fracture
   iv. Muscle tone/strength
   v. Limitation/loss of function

3) Initial assessment should lead to a working diagnosis and plan of care accordingly.
4) Treatment plan is followed as per doctor's advice
5) EMO will reassess and manage the patient till the patient becomes stable. On becoming stable, the patient will be discharged.
6) Frequency of reassessment depends upon clinical conditions and triage category of patient.
7) If radiology diagnostic tests are required, the patient will be taken to radiology department by A&E Support Staff, where the emergency patients will be given priority over other patients.
8) If laboratory tests are required, specimen will be sent to laboratory and they will provide results on priority basis.
9) If minor invasive or non-invasive procedure is required, write notes for every procedure, which should include name, site, indication, consent, sterile prep and anesthesia procedure.

10) Coordinate with concerned specialist/consultant for referral
11) Provide psychological support and privacy to patient and family
12) If the patient is recommended for admission, prepare the file and coordinate with admission office.
13) Document the following:
    a. Information obtained from history taking
    b. Time of arrival in the hospital
    c. Provisional Diagnosis
    d. Immediate intervention rendered
    e. Laboratory and radiological investigation or invasive procedure done in A&E if any
    f. Medications given
    g. Referral made
    h. Time and mode of transfer from A&E
    i. All the patient records are dated, timed, named and signed by concerned person(doctor/nurse/consultant)

12.4 Special Considerations:

1) For unaccompanied patient, DMS Incharge will be responsible for informing the family.
2) Any previously treated or operated patient who initially reported in emergency, when returns with any complication again to A&E, the relevant Department will be called.
3) Stay of patient in A&E should not exceed 4 hours. If the patient needs to stay more than 4 hours ,he/ she should be admitted in hospital to ensure bed availability in A&E.

12.5 Personal Belongings:

1) Upon arrival of unconscious and unaccompanied patient in A&E, his/her personal belongings will be taken by the attending nurse and will be given to the Head Nurse/Charge Nurse who in turn will write the items in Patient Personal Property register witnessed by the CMO and both of them will sign and these belongings will be kept safe. But in case, an attendant/ relative is available for unconscious patient, then personal belongings will be counted in front of the patient attendant and handed over to him/her.
2) For conscious patients, all personnel belongings will be accounted for in front of the patient and Handed over to patient or patient's attendant.

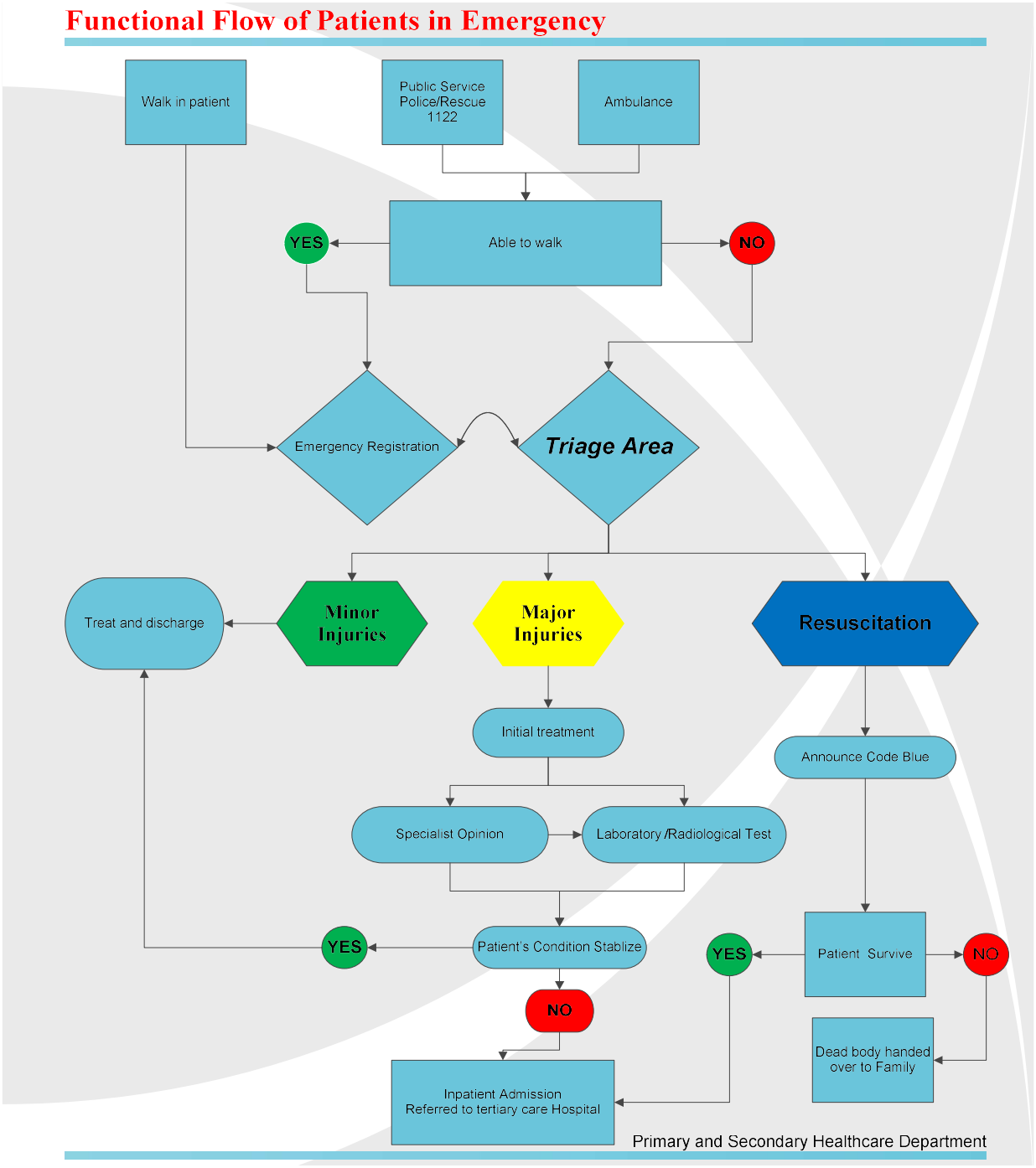
12.6 Tetanus prophylaxis:

1) Tetanus toxoid is given to all trauma cases with open/punctured wound.
2) If the patient is already vaccinated, then booster dose is given.
3) Children below 5 years are generally covered by EPI, but people coming to DHQ/THQ hospital are not previously covered generally.
4) Schedule should be mentioned for vaccination subsequent to tetanus vaccination on discharge slip.

12.7 Rabies Prophylaxis:

1) Post exposure first dose will be given.

2) Vaccination schedule must be mentioned on discharge slip.



Referred to A&E Treatment Card attached in **Annexure-01**

13.CALLING OF CONSULTANTS TO A&E

13.1 Purpose:

To establish guidelines about how to summon of specialists in the A&E for the purpose of consultation and to solicit opinions concerning the management of patient condition.

13.2 Responsibility:

CMO, EMO, on duty nursing staff and Consultants.

13.3 Procedure:

1) There should be Consultants /Specialists who are available on-call 24-hours-a-day and can be summoned for opinions regarding necessary management.
2) Heads of Clinical Departments are responsible for maintaining a duty roster of doctors in morning, evening and night shift, making sure that one senior doctor is available for consultation in A&E in all shifts.
3) On-call Consultant roster for the next month shall be forwarded by Head of concerned clinical department and shall be available in A&E by the 25th of every month.
4) This roster for on-call Consultants will contain name, designation of doctor along with his/her PTCL phone number, mobile phone number and residential address.
5) Nurse In-charge A&E will coordinate with all clinical departments for timely availability of on call Consultant duty roster.
6) Nurse In-charge A&E is responsible for maintenance of on-call Consultant rosters in a proper file folder for ready reference.
7) All CMOs will review the all on-call Consultant roster at the start of every month to get them familiar for smooth functioning.
8) CMO/ EMO on duty may contact the on call Consultant/doctor for any patient who needs Consultant opinion. After call he/ she will note down the timing of call on A&E registration form
9) Time for initial assessment and decision to call the concerned specialist doctor must not exceed 10-15 minutes.
10) CMO/ EMO on duty shall communicate with the on-call Consultant and shall explain the clinical condition of the patient.
11) Concerned Consultant on-call may be consulted over phone depending upon the Triage level. If necessary, the Consultant shall visit the patient in A&E , access the clinical condition of the patient and make orders accordingly.
12) On-call Consultant shall endorse his/her clinical assessment notes in Patient Registration and treatment card.
13) Consultants when called, should be available to A&E within 30 minutes.
14) All orders will be carried out by the CMO/EMO and nurse on-duty immediately.
15) In case of verbal or telephonic orders, they are duly verified prior to execution.
16) If concerned on-call Consultant is not answering the call, next on-call doctor should be informed. This should preferably be done by doctors, and not by the nurses.
17) Arrange for laboratory and radiological procedures as ordered.
18) Informed Consent should be signed before conducting any procedure.

a. For high risk or emergency procedure, where the life of the patient is at stake, EMO and one Consultant are required to sign as witnesses.
b. For unconscious patients or patients not having available relatives to sign for the consent. but need life-saving procedure or surgery, two (2) Consultants and one unit Nurse can sign for the consent.

19) CMO/ EMO on-duty may repeat the call, if required.
20) If concerned Consultant feels that patient's treatment is beyond his/her capabilities, he may involve other relevant consultants

Referred to A&E Treatment Card attached in **Annexure-01**

14.ASSESSMENT AND MANAGEMENT FOR MEDICO-LEGAL CASES

The policy shall be in line with legal requirements with reference to documentation and information to the police. Medico-Legal Cases / Medico Legal Reports (MLCs/MLRs) will be defined by the HCE in the light of the statutory rules. MLC/MLR must be handled by the Medical Officers; CMOs who have received capacity building training with relevant applicable laws and must follow the instructions issued from time to time by the Surgeon, Medico-legal Punjab.

14.1 Purpose

To establish a uniform system for assessment, management and discharge of MLCs in A&E.

14.2 Responsibility

On duty nursing staff, CMO, Consultants

14.3 Procedure

1) CMO on duty will examine the MLCs and will record the details of injuries properly.
2) CMO will note the complete particulars of the patient, along with marks of identification and relevant information (like arrival time, brought/accompanied by etc.) will be forwarded to the police station nearest to the DHQ hospital. It will then be the responsibility of said police station to disseminate the information to concerned police station in whose area, the incident took place.
3) CMO will explain all procedures of medico-legal examination to patient suspected or known to have MLC and documented as statement of oath and consent.
4) CMO will examine the patient as per policy of Surgeon, Medico-Legal Punjab.
5) Female victims of MLC/MLR must be dealt by the female doctors, if not available in the A&E department, then a female doctor from the Gynecology Department must be appointed in A&E, with her name and telephone number noted.
6) No case will be declared MLC on request of patient/attendants/family
7) If the patient is serious, resuscitation and stabilization of the patient will be ensured on priority and medico-legal formalities will be completed subsequently.
8) Cases of trauma will be labeled as medico legal, if there is suspicion of foul play, even if the incident is not of recent origin.
9) Confidentiality of medico-legal documents must be ensured.
10) In case of injury to bones, joints, the MLC report will be finalized after receiving MLC X-ray reports from X-ray department, through police.
11) Samples and specimens collected for medico-legal purpose will be properly sealed, labeled and handed over to the police for chemical examination.
12) In case of the death of MLC patient, no cause of death will be mentioned in death certificate.
13) Exact cause will be ascertained by postmortem examination only.
14) The dead body of a MLC case will be handed over to the police only.

15) If the patient is transferred /referred to DHQ Hospital, report will be provided by the referring HCE.
16) MLR will be provided to police by the concerned CMO. The initial MLC report may be incomplete because some injuries may be kept under observation.
17) In case of serious injuries when patient is discharged from the hospital, the operation notes will be obtained from the ward in which patient remained admitted, through police.
18) In suspected poisoning or rape case, the final MLR will be declared only after receiving all such reports from concerned quarters. The final MLC report will be then handed over to the police.
19) Clothing worn by the patient showing evidence of injury such as tears, bullet holes, cuts, blood stains, etc. will be encircled and handed over to the police.
20) Bullets recovered from body will be handed over to police. All evidence will be mentioned in MLR.
21) In case of suspected poisoning, gastric lavage, vomits, soiled clothing, blood, urine and any other relevant body fluid will be sent to chemical examiner through police.
22) In case of burns and carbon monoxide poisoning, pieces of clothing, scalp hair and blood for carbon monoxide level will be sent for chemical examination through police.
23) In case of sexual offences, clothing worn by the patient, showing evidence of blood stains, seminal stains, etc; and vaginal and anal swabs will be sent for chemical examination through police.
24) Medico-legal record will be maintained as policy of Surgeon Medico-Legal Punjab Pakistan.

14.4 Suspected OR Potential Medico-Legal Case

1) Alcohol abuse, inappropriate use of alcoholic beverages resulting in intoxication-disturbances in the level of consciousness, cognition, perception, behavior and other physiological functions and responses.
2) Narcotic abuse, use of narcotics that is not in accordance with the desired therapeutic level; effects of which is contrary to the positive expected outcome of the substance that consequently results in addiction.
3) Sexual abuse, an act of taking advantage of another person through physical fondling, rape or forcing another to take part in unnatural sex acts or any other perverted behavior; to which minors are the victims, they tend to get a harmful feeling of loss of control of themselves.
4) Sexual assault is the act of forcing sexual contact with another person male or female without his/her consent. Legal definition varies in different community.

5) Physical assault and Trauma
6) Vehicular accidents (includes railways and other modes of transport)
7) Burn injuries
8) Intoxication and poisoning
9) Hanging
10) Drowning
11) Suspected Homicide/ Murders
12) Suicidal attempts
13) Patient brought dead or die shortly after admission
14) Gunshot wounds
15) Fall injury
16) Asphyxia
17) Sudden death (Healthy Patient)
18) Quackery
19) Criminal Abortion
20) Unknown unconscious person
21) Injection or fang marks
22) Dead Bodies for Post-mortem examination
23) Discoloration of the Body
24) Police torture case

Referred to Medico legal Record Register & Pakistan Penal Code attached in **Annexure-02**

15. DISCHARGE OF A&E PATIENTS

The possible outcomes for the patient during treatment can be as follows:

1) Discharge from A&E
2) Referral to other hospital
3) Admission in hospital
4) Leave against medical advice
5) Death

15.1 Discharge from A&E Department

15.1.1 PURPOSE

To provide guidelines for discharge of patients from A&E to ensure continuity of care.

15.1.2 RESPONSIBILITY

Consultants, Specialists, CMO, EMO

15.1.3 PROCEDURE

1) EMO/Concerned consultant will document discharge orders/instruction in patient emergency registration card
2) Patient/attendants will be informed about discharge and discharge process will be discussed with patient and family.
3) Doctor will complete the A&E Discharge Summary Form and hand it over to the patient after signatures.
4) The discharge summary must include
   a. Reason of admission
   b. Brief progress notes
   c. Significant clinical finding
   d. Final diagnosis and co-morbidities
   e. Significant findings of investigations done
   f. List of medications used in A&E
   g. Treatment advised
   h. Details of procedure, if performed any
   i. Follow up instructions
   j. Follow up appointment
5) Before discharge, instructions regarding medication/side effects/precautions and restrictions on activities/diet must be given to the patient/ attendant in writing and explained verbally.
6) Remove the IV cannula, in-dwelling catheter etc.
7) Discharge time must be noted on the A&E Registration Form.
8) Record must be maintained in emergency register of DHQ hospital. Photocopy of discharge slip must be retained for medical record
9) Nursing staff will facilitate the transportation of the patient.
   Referred to A&E Treatment Card attached in **Annexure-01**

15.2 REFERRAL TO OTHER HOSPITAL

15.2.1 PURPOSE

Timely referral of patients who need more complex and specialized care to a tertiary care hospital

15.2.2 RESPONSIBILITY

Consultants, Specialists, CMO, EMO, Staff Nurse

15.2.3 PROCEDURE

1) CMO/EMO on duty will decide that the patient requires referral to tertiary care/specialized hospital for further treatment.
2) If patient's clinical condition is unstable ,he/she must be stabilized clinically by providing initial treatment before referral
3) The indications for referral may be
   a) Need of medical care is not available in DHQ hospital
   b) Non-availability of hospital bed
   c) Patient's preference
4) CMO/EMO on duty will contact the concerned specialist/Consultant on telephone or through a written call. If required concerned Consultant will physically attend the patient and assess the need for referral.
5) If the patient's clinical condition is serious and any delay in treatment may endanger her/his life, CMO/EMO on duty may refer the patient without Consultant's consent
6) CMO/EMO on duty/Consultant will identify the facility where patient could/should be referred.
7) Patient/attendants/family will be informed about need and reasons for referral
8) Contact the referring facility and doctor on-duty if possible and inform him regarding patient needs .
9) Medical/Nursing /paramedical staff may accompany the patient if required
10) Referring CMO/EMO/Consultant must ensure the continuity of care and patient safety during the transfer of patient.
11) Duly filled referral form is provided to attendants/family explaining the clinical condition at referral, reasons for referral and name of hospital to whom he/she is being referred along with brief history , treatment provided in the A&E, investigations and reports
12) Clinical documentation must be completed as per HCE policy and must be available in referring facility.
13) Record must be maintained in referral register of DHQ hospital. Photocopy of referral form must be retained for medical record
14) Ambulance used must be equipped with necessary equipment for resuscitation and ambulance staff must be trained in Basic Life Support

Referred to Referral Form attached in **Annexure-03**
Referred to Referral Register attached in **Annexure-06**

15.3 ADMISSION IN THE HOSPITAL

15.3.1 PURPOSE

Provide general guidelines on timely admission of patient in DHQ hospital who need indoor care

15.3.2 RESPONSIBILITY

Consultants/ Specialists, CMO, EMO, Nursing staff, Receptionist

15.3.3 PROCEDURE

1) All patients coming to the A&E for treatment or consultation should be considered an emergency case unless otherwise. If the condition of the patient is stabilized, he/she is ordered by the physician for discharge from the A&E.
2) CMO/ EMO on duty will decide that the weather the patient requires indoor admission in DHQ hospital for further treatment or not.
3) Systematic approach should be adopted in the assessment of the emergency case patients. A&E personnel should consider that most dramatic injury might not always be the most serious case. Primary and secondary survey should be provided by the A&E personnel to help identify and prioritize patient needs.
4) CMO/EMO on duty will contacts the concerned specialist/consultant on telephone or through a written call. If required concerned consultant will physically attend the patient and will assess the need for indoor admission
5) If multiple departments are involved because of the clinical condition of the patient and no consultant is willing to admit the patient under his/ her services, the decision DMS/MS on the matter will be considered as final.
6) Admitting/treating physician must mention which clinical area the patient should be transferred i.e. ward /ICU /CCU /OT.
7) After admission decision by CMO/ EMO /Consultant, patient/attendants/family will be informed about need and reasons for indoor admission.
8) In case of patient's refusal to admission, statement of refusal i.e. Discharge on request (DOR) should be signed before discharging the patient from A&E.
9) If patient's clinical condition is unstable, he/she must be stabilized clinically by providing initial treatment before indoor admission.
10) CMO/EMO on duty will initiate the admission process of patient after advice of concerned consultant and consent of patient/family
11) CMO/EMO on duty will fill the admission request form and shall refer the patient to hospital reception for further process.
12) Receptionist/Almoner will demand hospital admission form duly filled by CMO/EMO.
13) Receptionist will enter bio data of the patient (CNIC No, Phone & cell no) in file and inpatient record form.
14) Receptionist will also enter the Patient bio data in to the admission register/EMR.
15) Receptionist on duty will guide the patient/family to A&E.
16) Complete admission orders including drug prescription will be written clearly by CMO/EMO on duty in consultation with admitting physician/surgeon

17) Nursing staff will carry out the initial lab, radiological and medication orders, and put ID band on the patient.
18) CMO/EMO will communicate with the concerned doctor on duty in admitting Ward/ICU/CCU and will inform him about the patient.
19) Nursing staff on duty in A&E will communicate with the concerned nursing staff on duty in admitting Ward/ICU/CCU and will inform her about patient. A&E nursing staff will hand over the complete patient documents to receiving nursing unit.
20) Paramedical/Nursing staff will accompany the patient and detailed record of the patient will be given to receiving staff.

15.4 DISCHARGE ON REQUEST/ LEAVE AGAINST MEDICAL ADVICE

15.4.1 PURPOSE:

To establish guidelines in discharging patient from A&E against doctor's advice. This policy will protect treating doctor or hospital from any unexpected lawsuits.

15.4.2 RESPONSIBILITY:

Consultants, CMO, EMO, Nursing staff

15.4.3 PROCEDURE:

15.4.3.1 DOR (Abbreviation):

1) Any patient who refuses admission should be advised to fill up and sign the DOR Form which is countersigned by the EMO/CMO/consultant.
2) If the patient refuses admission after the admission procedure is already processed and a room is allotted. Inform the admitting doctor and the nursing supervisor who in turn will notify the DMS on duty. Let the patient or relative sign the DOR consent form and countersigned by the admitting consultant/ unit doctor.
3) Doctor will complete the A&E discharge summary form (refer to discharge policy) and hand it over to the patient after signature. One copy must be kept in record.
4) Remove the I/V cannula, ID band , indwelling catheter etc
5) Nursing staff will assist the patient in leaving.

15.4.3.2 LAMA:

1) In case the patient leaves A&E without information, fill the Quality Assurance Leave against Medical Advice notification and submit it to the nursing supervisor with attached patient treatment card.
2) LAMA date and time must be noted on the A&E Registration Form. Nursing staff will sign and CMO/EMO on duty will countersign it.
3) Record must be maintained in LAMA register of DHQ hospital

Referred to A&E Treatment Card attached in **Annexure-01**

15.5 Death in the A&E

15.5.1 PURPOSE

Notification of the death of patient to his/her family and issuance of death certificate

15.5.2 RESPONSIBILITY

Consultants, Specialists, CMO/EMO, Nursing staff

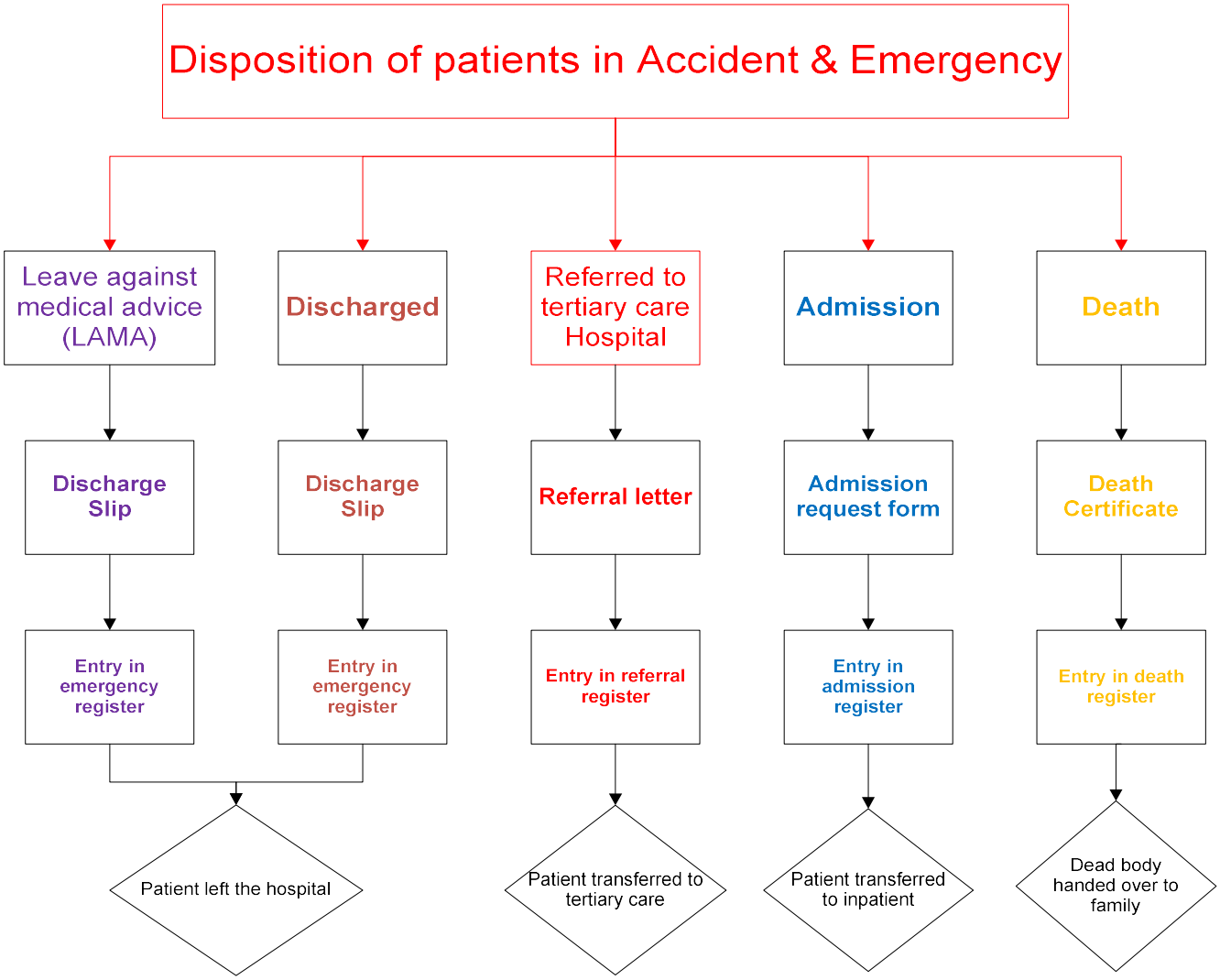
15.5.3 PROCEDURE

1) If a patient dies during treatment in the A&E, CMO/EMO on duty will confirm death by observing respiration, auscultation, palpate carotid pulse, check pupil and corneal reflex.
2) Only CMO/EMO on duty will declare the death of patient.
3) CMO/EMO on duty will inform the family/attendants and counsel them if needed.
4) Complete appropriate clinical documentation on progress sheet
5) CMO/EMO on duty will issue the death certificate as per hospital policy.
6) Handing over of dead body to relatives by taking their CNIC and signatures upon receiving.
7) Record must be maintained in death register of DHQ hospital.

15.5.4 SPECIAL CONSIDERATIONS:

15.5.4.1 Received Dead:

1) First inform security incharge and then the relatives of the patient.
2) Grieving counselling will be done by EMO/CMO on duty.
3) Handing over of dead body to relatives will be carried out by taking their CNIC and signatures upon receiving.
4) Record must be maintained.
   Referred to Death Certificate attached in **Annexure-04**
   Referred to Death Register attached in **Annexure-06**


Disposition of patients in Accident & Emergency
Leave against medical advice (LAMA)
Discharged
Referred to tertiary care Hospital
Admission
Death
Discharge Slip
Discharge Slip
Referral letter
Admission request form
Death Certificate
Entry in emergency register
Entry in emergency register
Entry in referral register
Entry in admission register
Entry in death register
Patient left the hospital
Patient transferred to tertiary care
Patient transferred to inpatient
Dead body handed over to family

16.AMBULANCE CONDUCTION:

16.1 Purpose:

To provide quick and safe transportation of patients that need necessary medical and intensive care.

16.2 Responsibility:

DMS A&E, CMO, EMO, Nursing Supervisor, Rescue 1122

16.3 Procedure:

1) There will be an established Rescue 1122 desk in A&E department of HCE. Their main role is to provide ambulance services to patients requiring advance level of care.
2) Ambulance used must be equipped with necessary equipment for resuscitation, and ambulance staff must be trained in BLS, ACLS, and ATLS. They will ensure safety of patient during transport.
3) Designated Rescue 1122 staff will receive the request for ambulance service. Ambulance form is attached in annexure.
   Annexure-03
4) Medical Director on duty should be informed about transporting patient to and from other hospital.
5) Transporting patient from DHQ/THQ
   a. Head Nurse/Charge Nurse from A&E will inform the rescue 1122 regarding the following:
      i) Patient name, MR Number, Bed Number
      ii) Patient condition
      iii) Place of destination
      iv) Time of departure
   b. The Ward boy will take the ambulance stretcher to the concerned area.
   c. The patient will be transferred to the ambulance stretcher with straps on, accompanied by necessary equipment as needed
   d. The Nursing Staff and Rescue 1122 Staff will ensure that Referral form, X –Rays and laboratory results are sent with the patient.
   e. The attending nurse will accompany the patient during transfer to ambulance.
   f. The ambulance driver, rescue 1122 staff and ward boy will ensure safe shifting of the patient to the ambulance on a stretcher, wherever required, with the help of the accompanying attendant and family members of the patient.
   g. Only one relative or companion will be allowed to travel in the patient compartment of the ambulance.
   h. Before movement, the driver/ rescue 1122 staff will check the status of fuel, oxygen cylinder and other necessary equipment as per the checklist provided to him.
   i. The driver/rescue 1122 staff will ensure use of oxygen cylinder/other lifesaving equipment by the patient, if required.
   j. On completion of patient transfer, the ambulance driver will ensure that linen or supplies are replaced.
6) Transporting patients to DHQ/THQ hospital

a. Referring hospital staff will communicate with the concerned Consultant to ensure availability of required services.
b. The receiving hospital Consultant will inform the A&E staff regarding transfer of patient.
c. If ambulance is not available at that time, then receiving hospital shall contact the rescue 1122 desk and ambulance will be sent to receive the patient.
d. Upon arrival to A& E, patient is examined by the EMO and admitted under the name of the Consultant.

7) After transporting infected patient, ambulance must be cleaned and disinfected with surface disinfectant.
8) Ambulance checklist should be updated daily in the morning.
   a. Before driving any ambulance, a driver must have the following documentation:
      i) Current, valid Driving License
      ii) "Clean" Driving Record from the local Traffic Police Office (No Record of Reckless Driving, not more than two moving violations in the past one year).
   b. Following vehicle documents are required:
      i) Certificate of Registration,
      ii) Certificate of Road Worthiness/Fitness,
      iii) Tax Receipt
      iv) Insurance Certificate
      v) Pollution Certificate
   c. Operational checklist:
      i) Fuel
      ii) Brake Oil
      iii) Gear Oil
      iv) Coolant
      v) Lifesaving equipment
      vi) Stretcher in place
      vii) Vehicle is clean
      viii) Hooter is working
      ix) Battery for the Mobile Phone is fully charged.

17.PROVIDING CARE TO AN UNACCOMPANIED MINOR

17.1 Purpose:

To provide appropriate attention and care to minor patients needing assistance and to provide safety for minor patients during their stay in the facility.

Minor means patient below 18 years of age coming to the A&E seeking medical consultation and appropriate health management of his/her presented health problems.

Unaccompanied Minor means patient of minor age coming to the A&E alone to seek medical attention.

17.2 Responsibility:

DMS Incharge / EMO/ CMO/ Nursing staff

17.3 Procedure:

1) When an unaccompanied minor goes to the A&E to seek treatment, the receptionist calls the attention of the DMS A&E/ DMS incharge
2) DMS assesses patient for information about the family and to make a call to the family, as necessary.
3) Nursing Supervisor of unit provides assistance to the patient.
    a. Providing information using the language that the patient understands.
    b. Ensuring safety and security to the patient during his/her entire stay in the facility.
        i) A&E staff makes frequent checks on the patient while in the waiting area to make sure that patient is safe and sound.
        ii) Assists in the personal needs of the patient, when necessary.
        iii) Ensures that the patient understands the treatment instructions given.
4) DMS determines the safety of the patient in leaving the hospital and going home.

a) Coordinates with the family to pick-up the patient from the hospital, when necessary.
b) Ensures that the patient is dispatched home safely.

18.VISITING RULES

18.1 Purpose:

1) To provide visiting guidelines for patients admitted in the unit.
2) To provide secure and healthful surroundings for patients, staff and visitors.
3) To satisfy the psycho-social needs of the patient.
4) To control the flow of visitors coming in and out of the A&E.
5) To promote patient privacy during observation and treatment.
6) To prevent any hospital problem regarding infection control

18.2 Responsibility:

DMS incharge/ CMO/ Unit staff/ Security guard

18.3 Procedure:

1) DMS in charge will have an overall responsibility of implementing visiting rules and recommending changes, if applicable.
2) A&E staff will:
   a. Explain rules and regulations to relatives and attendants in the A&E.
   b. Block unknown guest from entering the unit.
3) Security guard to be informed by the unit personnel, when needed.
4) Relatives and attendants are not allowed to be with the patient inside A&E.
5) Only one relative is allowed in case the patient condition requires his/her presence.
6) Relative or attendant of infant or pediatric patient is allowed to stay with the patient.
7) During treatment procedure, relative is allowed to be in the vicinity of the treatment room. Children are not allowed to be with the patient inside the A&E.
8) Board with clear instructions should be displayed outside the A&E by MS.
9) Flexibility to the policy on visiting rules may be applied for dying patients or patients in critical condition.

19.INTEGRATION OF RADIOLOGY DEPARTMENT WITH A&E

19.1 Purpose

To ensure safe shifting of patient from A&E to Radiology department of hospital without any delay

19.2 Responsibility

DMS, CMO, EMO, Nursing Managers, Nursing staff, Ward Boys,
Radiologist, Radiographer

19.3 Procedure

1) MS/DMS A&E/Incharge A&E will ensure the availability of radiology services for A&E patients round the clock.
2) Consultant Radiologist/MS is responsible for maintaining a duty roster of Radiologists/Radiographers in morning, evening and night shift for emergency coverage.
3) CMO/EMO/Consultant will advise for radiological test/intervention (e.g. X-Ray, USG, CT Scan, and MRI)as per clinical need of the patient and will document it on treatment card
4) CMO/EMO/Staff Nurse on duty will generate the radiological test/ intervention request form.
5) Radiology Department will be informed on telephone by nursing/paramedical staff on duty in A&E.
6) Patient will be guided /transported to Radiology Department by the Ward Boy/ nursing assistant on duty in A&E.
7) Radiological test/intervention will be performed by the Radiologist/Radiographer on duty as standard procedure of Radiology Department.
8) The patient will be shifted back to A&E after radiology test/intervention is done.
9) The report will be generated immediately. Even when the immediate generation of the report is not possible, the delay should not exceed15 minutes.
10) Reporting of critical results will be immediate and the Radiologist will communicate the results to the CMO/EMO/Consultant without any delay.

20.INTEGRATION OF PATHOLOGY DEPARTMENT WITH A&E

20.1 Purpose

To ensure provision of pathology services round the clock to A&E Department for timely diagnosis and treatment of patients

20.2 Responsibility

DMS, CMO, EMO, Nursing Managers, Nursing staff, Ward Boys, Pathologist, Phlebotomists, Laboratory Technicians/Assistants

20.3 Procedure

1) MS/DMS A&E/Incharge A&E will ensure the availability of pathology services for A&E patients round the clock
2) Consultant Pathologist/MS are responsible for maintaining a duty roster of Phlebotomists / Laboratory Technicians in morning, evening and night shift for emergency coverage.
3) CMO/EMO/Consultant will advise for Laboratory test as per clinical need of the patient and will document it on treatment card
4) CMO/EMO/Staff Nurse on duty will generate the Laboratory test/ request form.
5) Pathology Department reception will be informed on telephone by nursing/paramedical staff on duty in A&E.
6) Phlebotomist will collect the sample/ specimen from A&E.
7) Report will be generated immediately.
8) Reporting of critical results will be done immediately and Pathologist/Laboratory Technician will communicate them to CMO/EMO/Consultant without any delay.

21.SHIFTING OF CRITICAL PATIENTS FROM A&E TO INPATIENT DEPARTMENT

21.1 Purpose

To ensure safe shifting of patient from A&E to other departments of hospital without any delay

21.2 Responsibility

CMO, EMO, Nursing Managers, Nursing staff, Ward Boys,

21.3 Procedure

1. Nurse Incharge A& E is responsible for maintaining a register to keep the record of patients shifted from A&E to other department of hospital after admission.
2. CMO/EMO on duty shall instruct the nursing staff on duty to shift the patient to concerned clinical department as critical patient.
3. CMO/EMO on duty shall explain the clinical condition and prognosis of patient to attendant in detail and shall document it in the file of the patient mentioning the name and relation of attendant.
4. CMO/EMO on duty shall communicate with the duty doctor of concerned department and shall inform him about the patients and patient's clinical condition so that receiving department can make necessary arrangement.
5. Staff nurse on duty in A&E shall communicate with the staff nurse of the concerned department and will inform her about the patients and patient's clinical condition so that receiving department can make necessary arrangements.
6. Shifting of critical patients from A&E to other department of hospital will be supervised by staff nurse.
7. No nursing students will be involved in shifting of critical patients from A&E to other departments of hospital
8. Shifting staff nurse must be sure of destination i.e. where to shift the patient.
9. Before shifting she will ensure that
    a. A bed is available in the admitting department
    b. Patient's admission file is available
    c. Patient's Registration and treatment card has been filled properly by duty CMO, Staff Nurse and Consultant.
    d. Patient's Registration and treatment card has been attached in patient's file
    e. Admission form dully filled has been attached in patient's file
    f. CMO/EMO on duty has endorsed his/her shifting notes in patient's file
    g. Staff Nurse on duty has endorsed his/her shifting notes in patient's file
    h. Family/attendants have been informed about shifting and destination of patient.
10. Shifting must be accompanied by a close relative
11. Shifting nursing staff will hand over the patient to staff nurse of the receiving department.
12. Receiving staff will endorse her signature with name, Hospital ID No, time and date in emergency register

13. In case of serious/critical patient who need to be shifted immediately, all these formalities will be fulfilled as early as possible after providing appropriate medical care.
14. No nursing staff is allowed to communicate with patient's attendant about clinical condition of the patient. Clinical condition will be explained by doctors from concerned department only.

22.SHIFTING OF NON-CRITICAL PATIENTS FROM A&E TO INPATIENT DEPARTMENT

22.1 Purpose

To ensure safe shifting of patient from A&E to other department of hospital without any delay

22.2 Responsibility

CMO, EMO, Nurse Incharge, Ward Boys, Nursing staff,

22.3 Procedure

1) Nurse Incharge A& E is responsible for maintaining a register to keep the record of patients shifted from A&E to other department of hospital after admission.
2) CMO/EMO on duty shall instruct the nursing staff on duty to shift the patient to concerned unit as a stable patient.
3) CMO/EMO on duty shall communicate with the duty doctor of concerned department and shall inform him about the patient and patient's clinical condition so that the receiving department can make necessary arrangement.
4) Duty staff nurse in adult emergency shall communicate with the staff nurse of concerned department and shall inform her about the patient and patient's clinical condition so that the receiving department can make necessary arrangements.
5) Before shifting, the staff nurse on duty will ensure that
   a. A bed is available in the receiving/admitting unit
   b. Patient's admission file is available
   c. Patient's Registration and treatment card have been filled properly by duty CMO
   d. Patient's Registration and treatment card have been attached to the patient's file
   e. Admission form has been attached to the patient's file
   f. CMO/EMO on duty has endorsed his/her shifting notes in patient's file
   g. Staff Nurse on duty has endorsed his/her shifting notes in patient's file
   h. Family/attendants have been informed about shifting and destination of patient.
   i. Shifting nursing assistant/Ward Boy has endorsed his name with signatures in A&E register
6) Shifting of stable patients from A&E to other departments of hospital will be done by the Ward Boy.
7) No nursing students will be involved in shifting of patients from A&E to other departments of the hospital.

8) Shifting Ward Boy must be sure of the destination i.e. where to shift the patient.
9) Shifting must be accompanied by a close relative of the patient.
10) Shifting Ward Boy will hand over the patient to staff nurse of the concerned department where the patient has been shifted.
11) Receiving staff will endorse her signature with name, time and date in A&E register.

23.NURSING ENDORSEMENT

23.1 Purpose:

1) To provide as a baseline for comparison and indicate the kind of care to be anticipated on the next shift.
2) To identify priorities to which incoming staff must attend.
3) To give basic identifying information about each patient - name, bed number, bed designation, current diagnosis, etc.
4) To give a summary of each newly admitted patient, including his/her diagnosis, age, plan of therapy, and general condition.
5) To report patients who have been transferred or discharged.

23.2 Responsibility:

CMO, EMO, Nurse in charge, Nursing Staff, Ward boys

23.3 Procedure:

1) Face to face handover of patient must occur between nursing staff during shift changes in A&E; i.e. morning, evening and night.
2) The responsible staff must provide essential information regarding the patient confidentially. It should be accurate, complete, concise, and current.
3) Endorsements should start on time attended by all incoming nurses. The time when shifts start is as follows:
    a. Morning shift - 7:00 AM - 7:30 AM,
    b. Evening shift - 1:30 PM – 2.00 PM
    c. Night shift – 7:30 PM – 8:00 PM.
4) Nursing endorsement should be given by Head Nurse.
5) All clarifications should be made during the time of endorsement.
6) Outgoing nurses should not leave the unit until all notes are completed and/or any question about patient have been answered.
7) Endorsement must be communicated in a language that is understood by all.
8) The following must be endorsed to the incoming shift:
    a. Total census
    b. Number of admissions/deaths
    c. Number of discharges
    d. Number of patients transferred to other departments
    e. Number of Referrals
9) Following must be discussed during handover between leaving and coming medical/nursing staff to ensure error-free transition.
    a. Patient's clinical details
    b. Provisional diagnosis and major problems
    c. Relevant co-morbid conditions
    d. Progress and important clinical events during the shift
    e. Any invasive procedures performed during the shift
    f. Important investigation results / pending results

g. Current orders (especially any newly changed orders in medication, IV fluids, diet and activity level)
h. Changes in medical condition and response to medical therapy
    i. Probable plan of care for the next shift
    i) Consultant opinion
    ii) Discharge
    iii) Admission
    iv) Referral
j. Any significant interaction with family/relatives

23.4 Special Considerations:

1) Unprofessional and judgmental comments about the patient must be avoided, as this could pre-dispose incoming nurses to view and respond to patient negatively.
2) Any conflict that happened between nurses during endorsement must be settled by the Head Nurse

24.GENERAL POLICIES FOR PROCEDURAL INTERVENTIONS

1) A&E patients often require urgent, high-risk diagnostic and therapeutic procedures including surgery. It is important for the medical/nursing personnel to be familiar with the general and specific complications of these procedures to ensure patient safety and to reduce adverse events. Only medical/nursing staff with adequate training is permitted to attempt a procedure
2) Examples of medical/surgical procedures
    a. Endotracheal intubation
    b. Chest intubation
    c. Tracheostomy
    d. Feeding Tubes
    e. Lumbar puncture
    f. Foleys' catheterization / Suprapubic catheterization

3) Following uniform strategy must be adopted before every procedure by medical/nursing staff in collaboration
    a. Nursing staff on duty must be informed about procedure to be performed to make necessary arrangement.
    b. Patient and/or his/her attendants should be informed about the procedure needed to done
    c. Patient and/or his/her attendants should be informed about the risks and benefits involved in the procedure
    d. Informed written Consent should be obtained as per hospital policy
    e. Rigid adherence to *aseptic procedures* is the only way to ensure that a patient is at minimal risk of infection.
    f. Ensure all equipment ,instruments and disposables required are readily available during procedure
    g. Ensure that all equipment and instruments being used are properly sterilized.
    h. PPE must be used by all medical/nursing personnel carrying out the procedure (gloves, apron, cap ,face mask)
    i. Effective hand hygiene is mandatory for every procedure even if gloves are being used as the use of gloves does not eliminate the need for hand hygiene.
    j. Ensure proper disposal of healthcare waste as per hospital waste management policy
    k. Patient must be monitored for complications after the procedure and managed accordingly.

25.CLINICAL PRIVILEGES

25.1 Purpose:

To establish guidelines as to the types of procedures to be done only by qualified or privileged personnel.

25.2 Responsibility:

MS, DMS In charge, DNS,

25.3 Procedure:

1) Established special procedures should only be carried out by privileged personnel in A&E.
2) Personnel not meeting the criteria to perform special procedures may work only under close supervision of the qualified personnel or Consultant.
3) Special procedures in the A&E include the following:
    a. Central line insertion
    b. Inter-costal chest tube insertion
    c. Percutaneous long-line insertion
    d. Intubation
    e. CPR
    f. Minor suturing
    g. Casting
    h. Back Slab
4) Central Line Insertion
    a. Anesthesiologists or Cardiologists can perform central line insertion.
    b. In emergency situations, A&E physicians can do insertion.
5) Inter-costal Chest Tube/Percutaneous Long-Line Insertion
    a. Anesthesiologist, cardiologist, medicine and surgery Consultant may perform this.
    b. In emergency situation, A&E physicians can also perform insertion.
6) Intubation
    a. Anesthesiologists, ICU specialist, Cardiologists, or A&E physicians can perform intubation procedures.
    b. Specialists lacking experience in intubating the patient are not allowed to perform the procedure unless there are no available qualified personnel to do it and the situation is a life/death one.
    c. These physicians should be ACLS certified.
    d. Staff nurses are not supposed to perform the procedures unless they have undergone specialized training on intubation supported by training and competency certificates, specifically ACLS and ATLS provider.
7) CPR
    a. A&E personnel, including doctors, nurses, and paramedics can perform CPR provided they are at least CPR or BLS certified.
8) Minor Suturing
    a. EMOs/ CMO can perform the suturing. However, if the patient requests for the Plastic Surgeon to perform the procedures, the Plastic Surgeon can be called on.
9) Casting & Back Slab
    a. Only Orthopedic doctors and EMOs with orthopedic experience can do casting in the A&E.

26.INFORMED CONSENT

26.1 Purpose:

To establish guidelines in securing Informed Consent from patient and/or family in order to protect patient against unsanctioned practice and to protect hospital against claims of negligence.

Informed Consent – Permission granted in full knowledge of proposed treatment, procedure or act of care with possible risks and benefits. Informed Consent is given by a patient to a doctor.

26.2 Responsibility:

CMO, EMO, Consultant, DMS Incharge, Nursing Staff,

26.3 Procedure:

1) Consent must be obtained from all patients coming to A&E Department prior to initiation of any treatment. The procedures for which every patient should grant Informed Consent are listed below.
    a. Invasive procedures such as surgical incision, biopsy, cystoscopy, or paracentesis.
    b. When anesthesia is in use.
    c. High risk procedures such as arteriogram.
    d. Invasive therapeutic or diagnostic procedures
    e. Resuscitation
    f. Radiation or cobalt therapy.
    g. Blood Transfusion
    h. Administering high risk medication
2) Consent shall be written in patient's mother language.
3) If the patient is not competent to give consent, the substitute consent giver should sign the consent form. The substitute consent giver may be:
    a. A decision-maker duly appointed by the patient at such a time that he/she was not incompetent (was competent). Ideally this appointment will be in writing and witnessed.
    b. The legal guardian who may either be an individual or an agency can sign the consent document.
    c. An adult relative who has had substantial personal involvement with the patient in the preceding 12 months can sign the consent forms.
    The sequence of priority is: Spouse, Father, Mother, Brother, Sister
    d. Friends cannot give or withhold consent for the performance of an emergency medical treatment/procedure
4) An intervention should be initiated without consent when an emergency situation exists. Where all the following criteria are fulfilled, consent is not required for emergency treatment
    a) There is immediate threat to life or health.
    b) Treatment cannot be delayed.
    c) The patient is not capable of giving consent.

d) For minors, the person legally capable of consenting on behalf of the minor is not available.

5) The clinical circumstances that necessitated emergency procedure without a signed consent should be documented in the progress note by CMO/EMO on duty.
6) If the patient's emergent need for blood and blood components does not permit obtaining consent, the transfusion should proceed without delay and the clinical circumstances that necessitated emergency transfusion without a signed consent should be documented in the progress note by CMO on duty.
7) If the consent is obtained by telephone, two nurses should monitor the call and sign the form which will be signed later by the patient's legal representative on arrival at the hospital. The call may be recorded on an electronic device if possible.
8) On duty doctor or nurse must document the fact that all attempts were made to contact a substitute consent giver in the medical record of the patient.
9) Unit nurse is responsible to ensure that consent is completely filled up with correct data duly signed by the patient, witnessed by a relative and treating doctor.

ہسپتال کی ایمرجنسی میں اپنے مریض کی رجسٹریشن کرنے سے سارے
ہسپتال انتظامیہ کے طبعی عملے کو ہر قسم کے علاج بعشمول ادویات، ٹیسٹ،
سرجری وغیرہ کی اجازت دے رہے ہیں۔
(ہسپتال انتظامیہ)

27.CODE BLUE PROCEDURES

27.1 Purposes:

To sort or classify all in coming patients and to set priorities for care by performing safe, effective and efficient triage in order to reduce number of disabilities and complications.

Code Blue- the term used over the public address system to summon assistance for patients with impending or in cardiorespiratory arrest.

27.2 Responsibility:

EMO/CMO, Nursing staff, Code Blue team.

27.3 Equipment's / Supplies:

1) Cardiac monitor with pulse oximeter.
2) Defibrillator.
3) Ambu bag.
4) Air ways
5) Laryngoscope
6) Air way maintaining equipment.(air way, LMA, ETT,etc).
7) Oxygen flow meter with Humidifier.
8) Suction Regulator with suction bottle and suction catheter.
9) Cardiac Board
10) Emergency Crash Cart with all medical supplies and emergency drugs.
11) For documentation (Patient files, Resuscitation form, Code Blue monitoring form).

27.4 Procedures:

1) All staff must be aware of how to call for code blue.
2) All members of the Code Blue Team should be present during the Code Blue.
3) Each member of the Code Blue Team should be aware of his/her responsibilities.
4) Code Blue announcement will be made by Charge Nurse or by the doctor who discovers the patient irresponsive. Announcement includes (department, bed number, gender, and floor or area).
5) Shift Supervisor will ensure emergency medications and equipment are inventoried and restocked on a weekly basis and immediately following a Code Blue (or an emergency kit may be ready in ICU, and after announcement of Code Blue, team member from ICU will reach the location with emergency kit). Code Blue must be announced for all the Department.

6) EMO/CMO shall
   a. Confirm that patient is:
      i) Unresponsive
      ii) No breathing
      iii) No pulse in carotid or femoral artery
   b. Call for Code Blue and state the exact location on Code Blue speakers.
   c. Position the patient in supine, remove pillows and put cardiac board at the back of the patient.
   d. Initiate one man CPR while waiting for the Code Blue Team to arrive.
      i) Open airway (head tilt-chin lift maneuver).
      ii) Assess for breathing (look, listen and feel) for 3-5 seconds.
      iii) Give breathing (2 seconds each) with the aid of an ambo bag
      iv) Prevent airway obstruction that maybe caused when the tongue falls back.
      v) Use proper sizeed face and nose mask.
      vi) Support the mask with left hand and compress the bag with right hand.
      vii) Check carotid pulse (5-10 seconds).
      viii) Locate the area (lower half of the sternum) and start giving compression and ventilation at 15:2 ratio.
      ix) Check pulse after 1 minute, if no pulse is detected, continue CPR until the help arrives.
7) Nurse assigned for Crash Cart shall do the following:
   a. As soon as the Code Blue is announced by the operator, crash cart should be brought to the location of the Code Blue.
   b. Put the cardiac board at the back of the patient.
   c. Connect ambo bag to oxygen and apply to the patient.
   d. Assist in 2 rescuer CPR with 5:1 ratio until the Code Blue Team arrives.
   e. Connect patient to cardiac monitor.
   f. CPR will be continued by the Code Blue Team as soon as they arrive.
8) Assigned Nurse
   a. Will give a brief information to the Code Blue Team regarding the diagnosis and the condition of the patient prior to code blue.
   b. Will take blood pressure and do suction as needed.
9) Code Blue Team functions as follows:
   a. Anesthesiologist / ICU Specialist
      i) Continue ventilation (ambu bag).
      ii) Intubate if needed and maintain patient airway.
      iii) Establish and maintain IV access if none.
   b. ICU Nurse
      i) Assist the anesthesiologist/ Code leader in intubation.
      ii) Administer emergency medicines as per ACLS guidelines.

c. Cardiologist
    i) Continue with cardiac massage.
    ii) Order emergency medicines.
    iii) Monitor cardiac status of the patient.
    iv) Apply external defibrillator if indicated with specified number of joules.
d. Nursing Supervisor
    i) Nurse Supervisor will record, or delegate RN, to record the event on the Emergency Response Sheet. The Emergency Response Sheet will be placed in the patient record and a copy is forwarded to Quality Assurance Department.
    ii) Obtain additional equipment and help as necessary.
    iii) Assist the Code Blue team.
    iv) Clear the room of all personnel who are not included in the Code Blue team.
e. Assigned Nurse
    i) Assist in the transfer of patient.
    ii) Endorse patient to receiving
f. Biomedical Engineer remains on standby for any malfunction of the machine.
g. X-Ray Technician
h. Lab Technician
i. Security Guard
j. Support Staff (Ward Boy, Ward helper)

10) To continue Code Blue depending upon the patient's response to the treatment for at least 30-45 minutes.
11) As soon as the patient is stabilized, the patient is transferred to ICU after making necessary arrangements like bed availability, ventilator per order of cardiologist/anesthesiologist accompanied by the Code Blue Team.
    a. Document the following
        i) Time when Code Blue was announced.
        ii) Time CPR was initiated.
        iii) Time of arrival of the Code Blue Team and management done.
        iv) Medications given.
        v) Observations made.
        vi) Time of transfer and condition of patient upon transfer.
12) Following the use of cart, replace all used items and notify the pharmacy to arrange for the timely restocking of medications, to be ready for next use.
13) Do not forget to attach cardiac monitor and defibrillator for recharging.
14) Portable oxygen cylinder for refilling.

27.5 Resuscitation Form

Referred to A&E Treatment Card attached in **Annexure-01**

28.CRASH CART

28.1 Purpose:

To provide necessary items needed for cardio-pulmonary resuscitation in the event of Code Blue.

Crash Cart - is a life-saving medical trolley equipped with all the necessary items and vital components of cardio-pulmonary resuscitation.

28.2 Responsibility:

DMS A&E, CMO, Nursing Supervisor, Nurse assigned for Crash Cart.

28.3 Procedure:

1) Crash Cart contents must be checked per Crash Cart list for completeness at the start of each shift daily and ensure that the following are available and are in good working condition
   a. Defibrillator - properly charged
   b. ECG monitor - loaded with ECG paper
   c. Required medicines - expiry date and quantity
   d. Supplies needed - expiry date and quantity
   e. Laryngoscope, penlight with batteries
   f. Portable O_2 Tank - filled with O_2
2) In the event of Code Blue, the nurse who checked the Crash Cart should be the one to attend.
3) All staff in the unit should be well oriented with the contents and use of Crash Cart.
4) Availability of adequate supply of emergency drugs, equipment and medical supplies is a must according to standard list.
5) Update crash cart of the required medicines. All expiring medicines should be returned to pharmacy 3 months prior to their expiry date.
6) All supplies and medicines must be used only for emergency cases.
7) All equipment should be functioning properly and medical supplies should be in proper order.
8) Defibrillator machine should always be plugged in AC Power and test load be done every shift.
9) Preventive maintenance should be carried out.
10) Checking must be done immediately after each Code Blue. Used items should be replaced.
11) Any medicines or items not available in the Crash Cart must be endorsed to the head nurse for immediate requisition and replacement.
12) Crash Cart should be cleaned and kept in usual order. Locations of medicines and lifesaving items should not be interchanged to avoid misguiding the staff and to locate easily when needed.
13) Instruments and equipment should be cleaned and disinfected after each use.
14) The Crash Cart should be kept in a place accessible for all and could be taken easily without any interference or difficulty.

Item	Suggested availability
Pocket mask with oxygen port	Immediate
Oxygen mask with reservoir	Immediate
Self-inflating bag with reservoir	Immediate
Clear face masks, sizes 3, 4, 5	Immediate
Oropharyngeal airways, sizes 2, 3, 4	Immediate
Nasopharyngeal airways, sizes 6, 7 (and lubrication)	Immediate
Portable suction (battery or manual) with Yankauer sucker and soft suction catheters	Immediate
Supraglottic airway device with syringes, lubrication and ties/tapes/scissors as appropriate	Immediate/Accessible
Oxygen cylinder (with key where necessary)	Immediate
Oxygen tubing	Immediate
Magill forceps	Immediate
Stethoscope	Immediate
Tracheal tubes, cuffed, sizes 6, 7, 8	Immediate/Accessible
Tracheal tube introducer (stylet)	Immediate/Accessible
Laryngoscope handles (x 2) and blades (size 3 and 4) Spare batteries for laryngoscope and spare bulbs (if applicable)	Immediate/Accessible
Syringes, lubrication and ties/tapes/scissors for tracheal tube	Immediate/Accessible
Waveform capnograph - with appropriate tubing and connector	Immediate/Accessible

Item	Suggested availability
Defibrillator Manual and/or automated external defibrillator Pacing function ifneeded	Immediate
Adhesive defibrillator pads	Immediate
Razor	Immediate
ECG electrodes	Immediate
Intravenous cannulae (selection of sizes) and 2% chlorhexidine/alcohol wipes, tourniquets and cannula dressings	Immediate/Accessible
Adhesive tape	Immediate/Accessible
Intravenous infusion set	Immediate/Accessible
0.9% sodium chloride (1000 ml)	Immediate/Accessible
Selection of needles and syringes	Immediate/Accessible
Intra-osseous access device	Accessible
Central venous access - Seldinger kit, full barrier precautions (hat, mask, sterile gloves, gown) and skin preparation (2% chlorhexidine / alcohol)	Accessible
Ultrasound / echocardiography	Accessible

Item	Suggested availability
Clock/timer	Accessible
Gloves, aprons, eye protection	Immediate
Nasogastric tube	Accessible
Sharps container and clinical waste bag	Immediate
Large scissors	Accessible
2% chlorhexidine / alcohol wipes	Accessible
Blood sample tubes	Accessible
IV extension set	Accessible
Pressure bags for infusion	Accessible
Blood gas syringe	Accessible
Blood glucose analyser with appropriate strips	Immediate/Accessible
Drug labels	Accessible

Cardiac Arrest Drugs - First Line for Intravenous use		
Item	**Suggested availability**	**Comments**
Adrenaline 1mg (= 10 ml 1:10,000) as a prefilled syringe x 3	Immediate	Number of syringes depends on access to further syringes. 1mg needed for each 4-5 min of CPR
Amiodarone 300mg as a prefilled syringe x 1	Accessible	First dose required after 3 defibrillation attempts

Cardiac Arrest & Peri-Arrest Drugs for Intravenous use		
Item	**Suggested availability**	**Comments**
Adenosine 6 mg x 5	Accessible	
Atropine - 1mg x 3	Accessible	
Adrenaline 1mg (= 10 ml 1:10,000) prefilled syringe	Accessible	Further syringes should be accessible for prolonged resuscitation attempts
Amiodarone 300mg x 1	Accessible	If decision is made to give further doses of amiodarone
Calcium chloride 10 ml 10% x 1	Accessible	Calcium gluconate can be used as an alternative. Note: 10 ml 10% Calcium chloride = 6.8 mmol Ca2+ 10 ml 10% Calcium gluconate = 2.26 mmol Ca2+
Chlorphenamine 10 mg x 2	Accessible	Second-line treatment for anaphylaxis, can also be given intramuscularly
Hydrocortisone 100 mg x 2	Accessible	Second-line treatment for anaphylaxis, can also be given intramuscularly
Glucose for intravenous use	Immediate/Accessible	
20% lipid emulsion 500 ml	Accessible	For use in areas where large doses of local anaesthetic are used for regional blocks, according to Association of Anaesthetists Guidelines.
Lidocaine 100 mg x 1	Accessible	Inclusion to be determined locally
Magnesium sulphate (2 g = 8 mmol) x 1	Accessible	
Midazolam 5 mg in 5 ml x 1	Accessible	NPSA Alert
Naloxone 400 microgram x 5	Accessible	
Potassium chloride	Accessible	Formulation to be determined locally. Potassium chloride concentrate solutions. Patient safety alert. The National Patient Safety Agency. July 2002.
Sodium bicarbonate 8.4% or 1.26%	Accessible	Volume and concentration according to local policy

Other Drugs		
Item	**Suggested availability**	**Comments**
Adrenaline 1mg (1 ml 1:1000)	Immediate	First-line treatment for anaphylaxis - 0.5 mg intramuscular injection in adults.
Aspirin 300 mg and other antithrombotic agents	Accessible	For acute coronary syndrome according to local policy
Furosemide 50 mg IV x 2	Accessible	
Flumazenil 0.5 mg IV x 2	Accessible	
Glucagon 1 mg IV x 1	Accessible	
GTN spray	Accessible	
Ipratropium bromide 500 microgram nebules x 2 (and nebuliser device)	Accessible	
Salbutamol 5mg nebules x 2 (and nebuliser device) and IV preparation for infusion	Accessible	
0.9% sodium chloride or Hartmann's solution 1000 ml x 2 cooled to 4°C	Accessible	For induction of therapeutic hypothermia as part of post-cardiorerspiratory arrest care

Reference:

1. *https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/*

29.PATIENT IDENTIFICATION

29.1 Purpose:

To establish guidelines for proper identification of patients which will ensure safety of patient at all times.

29.2 Responsibility:

DMS Incharge, CMO, EMO, Nursing Supervisor.

29.3 Procedure:

1) Every admitted patient should have an identification band (ID Band).

2) ID band is applied securely; neither tight nor loose.

   a. For adults, ,right wrist, unless contraindicated (as long as it is not interfering in the gadgets or treatment)

   b. Pediatric ,right wrist or right lower leg with the use of pediatric size ID band

3) ID band should bear the complete name and MR number of patient that should be clear and readable.

4) When administering patient care, identify patient by calling his/her name and compare with ID band applied.

5) Upon discharge, Nursing staff will remove the ID band.

29.4 Special Considerations:

1) For patient treated in A&E staying 1-4 hours for minor OT or; for observation, should have I.D. band, plus a bed tag with proper identification.

2) No discharged patient should be allowed to leave the hospital with ID band still attached to wrist or leg.

30.PREPARATION AND ADMINISTRATION OF ORAL AND PARENTERAL MEDICATION

Medication Preparation - is one of the nursing functions of setting the medicines ready for administration. The process involves accurate dosage, calculation, measurement and proper handling of medicines.

Medication Administration - is an act of giving the medicines according to the route, drug preparation and safety of the patient.

Routes

1) **Oral**
   a. Oral
   b. Sublingual
   c. Buccal
2) **Parenteral**
   a. Subcutaneous
   b. Intramuscular
   c. Intravenous
   d. Intradermal
   e. Intrathecal
   f. Intra articular

30.1 Purpose: To Ensure Patient and Staff Safety

Responsibility:

Pharmacist, Staff Nurses, LHVs, Trained Midwife and Medical Staff (EMO, CMO, MO, Consultants, Specialists, Anesthesiologist)

30.2 Equipment/Supplies

1) Prescribed medicine
2) Medication tray
3) Syringe and needle of different size
4) Medication cups
5) Sterile gauze
6) Alcohol swabs, band aids, tongue depressor
7) Disposable gloves, blue pads
8) Scissor
9) Saline solution, Sterile water
10) Sharp disposal container
11) Razor (if needed)
12) Water soluble lubricant
13) Tissues Mortar and pestle
14) Butterfly needle
15) Stethoscope
16) Sphygmomanometer
17) Thermometer

30.3 Policy:

1) Preparation:
   a. Aseptic technique and proper procedure in handling and preparation of medication must be observed.
   b. Special precaution should be taken for the preparation of cytotoxic drugs.
   c. Follow standard drug calculation and measurement in preparing medications.
   d. Physician must be informed about the non-availability of the medicines and or if any substitute drug is issued.
   e. Never leave prepared medicine unattended.
   f. Any doubt about the doctor's order should be referred to HN/CN and the attending physician.
   g. The nurse must be aware of the pharmacological interactions of different drugs during preparation as follows:
      i) Drugs that are incompatible should not be given together.
      ii) Liquids or syrups should not be poured from one bottle to another.
      iii) Drugs that have changed color, odor, consistency; any expired and unlabeled bottle should never be given.
   h. Intrathecal medication will not be prepared during preparation of any other agent.
   i. Medicines should be prepared in properly lit medication preparation area.
2) Administration**:**
   a. Observe 6 rights in giving medication
      i) Right patient
      ii) Right medicine
      iii) Right dose
      iv) Right time
      v) Right route
      vi) Right documentation
   b. Observe and maintain patients' rights in giving medication
      i) The patient should be informed of drug name, purpose, action and potential undesired effects.
      ii) The patient may refuse a medication regardless of the consequences.
      iii) The patient may have qualified nurse or physician at hand to assess a drug history including allergies.
      iv) The patient has a right not to receive unnecessary medications.
      v) The patient may receive appropriate treatment in relation to drug therapy.
      vi) The patient may receive labelled medication safely without discomfort in accordance with 6 rights in drug administration.
   c. Medication should be administered by the qualified nurse who prepares it. The one giving the medicine must have a sound knowledge about the use, action, usual dose, and side-effects of drugs being administered.
   d. Before administration of medications, a registered nurse must make sure that prescription is valid, clear and legible. She can clearly read and understand the prescription and there is no confusion.

e. If **prescription is not clear and legible** and nursing staff responsible for administration of medicine cannot understand it or have confusion regarding medicine orders, he/she should not administer the relevant medicines and should stop to avoid any errors.
f. About medicines that cannot be administered/given for whatever reason, Head Nurse and attending physician should be notified.
g. About any error incurred during administration of medicine, Head Nurse and attending physician should be informed.
h. Verify and double check for high risk medications by independently comparing the Product contents in hand versus written orders by physicians.
i. Pre-aspirated medicine should be used immediately.
j. Never leave the patient until the medicine has been swallowed.
k. Self-administration of medication is not allowed in DHQ hospital. DHQ hospital also does not allow administration of patient's medication brought from outside the hospital.
l. Automatic cancellation of medicines, narcotics, controlled drugs and/or anticoagulants for patient who will undergo operation must be followed.

3) Labeling:
   a. Prepared medications must be labelled immediately upon preparation prior to preparation of second drug, as this is particularly important for administration of medication in OT during anesthesia, Neonatal, Pediatric units and ICU.
   b. No prepared drug should be left unlabelled.
   c. Medicines must be labelled clearly and legibly.
   d. Label should contain
      i) Patient name and second identifier (MR No, CNIC, DOB, etc.)
      ii) Full generic name of drug
      iii) Date and time of preparation
      iv) Date of administration
      v) Route of administration
      vi) Total dose to be given,
      vii) Total volume required to administer this dosage,
      viii) Date and time of expiration when not for immediate use.

4) Storage
   a. Never leave a medicine cabinet or cart unlocked or unattended.
   b. Excess medicine or medicine refused by the patient should not be returned to stock cabinet or medicine cart.
   c. Any unused and/or left over medicine should be returned to the pharmacy as soon as patient is discharged.
   d. Separate storage for preparations for oral use and those for topical use is a must.
   e. Those medicines that require to be refrigerated must be kept in medicine refrigerator at required temperature of 2-8 degree centigrade.
   f. A system of stock rotation must be operated to ensure that there is no accumulation of old stocks (e.g. first in, first out).
   g. Regular stock checks should be carried out every shift daily.
   h. Medicines that will expire within 3 months should be returned to the pharmacy to be replaced by fresh stock.

i. Multi-dose vials will be dated with date first used/the seal is broken and will expire at the earliest of the following dates:
   i) Multi-dose Injectable: 30 days
   ii) Allergy Clinic Preparations: 30 days
   iii) Multi-dose Ophthalmic Preparations for clinic use: 14 days
   iv) Nasal Preparations: 30 days
   v) Otic Drops: 30 days
   vi) Inhalation Solution: 7 days

30.4 Procedures:

1) Wash hands before the procedure and wear gloves if necessary.
2) Prepare the needed equipment and supplies.
3) Calculate correct drug dose and double check calculation.
4) Preparation:

Oral

a. Tablet/Capsule
   i) Pour required amount into bottle cap and transfer to medication cup without touching with fingers.
   ii) Package tablet/capsule to be placed directly into medicine cup without removing the wrapper.
   iii) Place all tablets/capsules given at the same time in one cup except for those requiring pre-administration assessment (pulse rate or blood pressure).
   iv) Take the prepared or measured medicine in the medication tray to the patient.
   v) Identify the patient by asking his/her name.
   vi) Explain the purpose and action of medicine and the common side-effects. Observe necessary precautions.
   vii) Assist patient in a sitting position if not contraindicated.
   viii) Offer water with the medicine.
   ix) Stay with the patient until he/she swallows the medicine. For sublingual administration, instruct the patient to place the medicine under the tongue and not to swallow.
   x) Dispose used medicine cup in appropriate container.
   xi) Wash hands.

30.5 Parenteral

a. Intramuscular

i) Place the prepared injectable medicine in the tray together with alcohol swab, band aid and small sharp container.

ii) Identify the patient carefully by:
asking his/her name

iii) Explain the purpose and action of each medication and the common expected side-effects.

iv) Select site for injection using anatomical land mark.

- Vastus Lateralis located in the anterior aspect of the thigh.
- Ventrogluteal Muscles located deep and away from major blood vessels and nerves.
- Dorsolateral Muscles muscles in the upper outer quadrant of the buttocks.
- Deltoid Muscle located in the upper arm.

v) After selecting appropriate site, wipe the site by using antiseptic swab.

vi) Hold syringe between thumb and forefinger in a dart like fashion.

vii) Pinch skin tightly. If irritating medicine, use Z track method.

viii) Inject needle quickly and firmly at 90 degrees angle. Then release skin.

ix) Grasp the lower end of the syringe with non-dominant hand and position dominant hand to the end of the plunger. Do not move the syringe.

x) Pull back the plunger to ascertain if needle is in a vein. If no blood appears, slowly inject the medication. If blood appears in the syringe, discard the medicine and prepare again to start a new procedure.

xi) Quickly withdraw the needle while applying pressure on the antiseptic swab after the medicine is consumed.

xii) Gently massage the site unless contraindicated.

xiii) Discard the uncapped needle and syringe in the sharp container.

b. Subcutaneous

i) Take the medication tray containing the syringe with prepared medicine, alcohol swab and small sharp container to the patient bed.

ii) Identify the patient carefully by asking his/her full name.

iii) Explain the purpose and action of each medication and the common expected side-effects (if any).

iv) Select the appropriate injection site. The most common site used are the outer aspect of abdomen, anterior aspect of the thigh, posterior aspect of the upper arm.

v) Assist patient in a comfortable position.

vi) Clean site with antiseptic swab.

vii) Remove cap from needle by pulling it straight off.

viii) Hold syringe correctly between thumb and forefinger of dominant hand as in dart fashion.

ix) For average size patient, spread skin tightly across injection site or grasp skin with non-dominant hand. For obese patient, grasp skin at site.

x) Inject needle firmly and quickly at 45 degrees or 90 degrees, then release skin if grasp.
xi) Give the injection at a 90 degree angle, if you can grasp 2 inches of skin between your thumb and first finger, if you can grasp only 1 inch of skin, give the injection at a 45 degree angle.
xii) Pull back the plunger of the syringe to check if the needle is not in the vein (optional). If no blood returns, inject the medicine slowly.
xiii) If blood appears, remove and prepare a new one.
xiv) Then withdraw the needle while applying alcohol swab gently above or over injection site.
xv) Gently massage the site if not contraindicated.
xvi) Discard needle and syringe in sharp container.

c. Intradermal
   i. Place the prepared injectable medicine in the tray together with the medication card, alcohol swab and small sharp container.
   ii. Identify the patient correctly by asking his/her name
   iii. Explain the procedure/reason why the drug is being given.
   iv. Provide privacy and assist patient in comfortable position
   v. Select site for injection:
      - Extend elbow and support it to place forearm in flat surface.
      - Inspect site for bruises, inflammation, lesion discoloration, edema, masses and tenderness.
      - Forearm site should be 3-4 finger width below ante cubital space and one hand width above the wrist on inner aspect forearm.
   vi. Use antiseptic swab in a circular motion to clear skin at site.
   vii. While holding the swab with non-dominant hand, pull cap from needle.
   viii. With non-dominant hand, stretch the skin over site with forefinger and thumb.
   ix. Insert needle slowly at 5 -15 degrees angle, level-up, until resistance is felt; advance to no more than 1/8 inch below the skin. The middle tip should be seen through the skin.
   x. Do not aspirate, slowly inject the medication until resistance will be felt. Note a small bleb, like a mosquito bite forming under the skin pressure.
   xi. Withdraw needle while applying antiseptic swab.
   xii. Do not massage the site.
   xiii. Draw circle around the perimeter of injection site using black ink.
   xiv. Dispose syringe with needle in the sharp container.
   xv. After 30 minutes, inform the physician to evaluate the result.

d. Intravenous
   i) Place the prepared injectable medicine in the tray together with the alcohol swab, Band-Aid, disposable gloves, butterfly needle, tourniquet and small sharp container.
   ii) Identify the patient carefully by asking his/her name.
   iii) Explain the procedure, reason why the drug is being given and the expected common side-effects.

iv) Provide privacy. Assist patient in a comfortable position.
v) If there is an existing cannula or IV line, check the site for infiltration and phlebitis. Give prepared medicine slowly.
vi) If there is no IV access, administer through butterfly needle.
vii) Connect the syringe with medicine to the port of the butterfly tubing and push slowly the plunger to fill the tubing with medicine and to expel the air.
viii) Select the site for the IV insertion.
ix) Place the tourniquet 4-6 inches above the selected site, ask the patient to open and close his/her fist.
x) Clean the site with alcohol swab.
xi) Inject the needle at an angle of 25-45 degrees and check for return flow.
xii) Release the tourniquet and stabilize the needle with one hand.
xiii) When return flow is present, slowly inject the medicine.
xiv) Pinch the tubing after medicine is completely injected and replace the syringe with saline syringe and flush the tubing.
xv) Place sterile gauze with alcohol swab over the insertion site and remove the needle.
xvi) Apply band aid over the site
xvii) Inspect the area for redness, pain, swelling, and edema.

5) Assist patient to a comfortable position.
6) Observe closely for adverse reaction as the drug is administered and for several times thereafter.
7) Wash hands.
8) Dispose all supplies used.

30.6 Special Considerations:

1) Crush the tablet with mortar and pestle if medicine is to be given in powdered form.
2) Enteric-coated pills should not be crushed, since the purpose of coating is to delay absorption, thus preventing gastric irritation.
3) Tablets for buccal or sublingual administration should not be crushed.
4) Protect patient against aspiration by giving a tablet or capsule one at a time.
5) For intramuscular injection, solutions that are oily and viscous or those that contain suspended particles must be given through needles of larger diameter.
6) Drug that are injected subcutaneously should be non-irritating.
7) The volume of subcutaneous injection should be less than 2ml.
8) For drug known to be irritating or staining to the skin, a Z track injection method is advised. This method is used for injection of iron salts and for necrotizing or for highly irritating substances.
9) Providing truthful information when dealing with children is very important to gain cooperation.
10) Medium for IV injection must be isotonic solutions (saline of 5% Dextrose).
11) Rapid delivery of large volume of drug during IV injection can lead to embolism, pulmonary edema, elevated BP, or excessive pharmacological responses.
12) If diazepam or chlordiazepoxide HCl is given through IV push, flush with bacteriostatic water instead of saline to prevent drug precipitation due to incompatibility.
13) After heparin injection by SC route, do not rub or massage the site to avoid minute hemorrhage or bruises.

14) Streptomycin is not given during the first trimester of pregnancy to avoid staining of teeth of the fetus in later life.

31.SAFETY PRACTICES

31.1 Purpose:

These have been designated;

1) to prevent inadvertent or hazardous event from taking place.
2) to protect the patient from any harm during the course of hospitalization.
3) to caution patient, relative, and the staff of any hazardous events.
4) to urge the patient/healthcare providers to observe safety measures to avoid dangers when performing duties.

Safety security; freedom from danger, injury, damage, and harmful side-effects.

Precautions actions, words, or signs by which warning is given or taken before any inadvertent or hazardous event might takes place.

31.2 Responsibility:

Patients, CMO/EMO, Nursing staff

31.3 Procedure:

Safety precaution should be strictly observed at all times. It is the responsibility of every hospital employee. Patients and relatives are not excused from observing safety measures for their benefit.

31.3.1 FOR PATIENTS:

1) Bedside rails should always be on.
2) Safety belt is always applied in transporting patient by stretcher or wheelchair.
3) Prior explanation of the procedure/operation to be done is given to patient/relative
4) Patient is always identified properly and correctly when dealing with him/her.
5) Written consent is obtained for a procedure/operation whenever necessary.
6) Observe fall precaution measures at all times and document them.
7) Assistance and support to patient is rendered whenever needed.
8) Sharps and blunt objects are not allowed especially to Psychiatrist patient.
9) Medicines are prepared and administered safely and correctly. Follow six rights in medication administration.
10) All medicines of any type are properly stored and labeled.
11) Medicines shall be administered by authorized and trained staff permitted by law including doctors, nurses, dispensers etc
12) Patient is identified by staff before administration of medicine by asking the patient himself/herself, MR no, by checking the identification band and verifying the details from drug prescription chart
13) Right drug, right dose, right route, and right time is verified from drug prescription chart before administration. Details of medicine administered must be documented with name of drug, dose, and route, time with date. Nurse will affix the signature thereafter.

14) Health teachings such as preventive maintenance; coping up with daily activities; proper ambulating techniques; instructions to take home medications; and follow-up appointment are given to every patient before discharge.
15) Ensure that wound drainage, IV cannula and the likes, are removed, unless indicated.
16) Every patient is accompanied by help desk officer and is assisted in wheelchair from the room to the hospital exit, if needed.

31.3.2 FOR STAFF

1) Observe infection control measures at all times.
2) Submit yourself for annual physical check-up, which is provided free of charge for all hospital employees. Priority is given to high-risk staff.
3) Immunization vaccination should be provided regularly, especially when there is an epidemic.
4) Medical investigations and treatment should be provided to staff exposed to health-hazards showing manifestations such as allergy, pain, or trauma as a result of injury, etc.
5) Needle stick injury policy should be strictly followed.
6) Wear proper uniform and safety gadgets or devices as required.
7) Wear anti-static shoes as indicated when entering sterile areas.
8) Observe proper waste disposal.
9) Label the procedure.
10) Observe proper handling of cytotoxic.
11) Comprehensive orientation on safety should be given to staff that includes:
    a. Fire Safety training about how to use firefighting equipment and to evacuate patients safely in the event of fire.
    b. Infection Control.
    c. Cardio-Pulmonary Resuscitation (CPR).
    d. Proper operation of new machines and medical equipment.
12) Faulty machines, electrical wiring and connections should be labeled and sent immediately to the Maintenance Department for repair.
13) Do not insist on using defective machine. It can endanger lives.
14) Machines and electrical equipment should be properly labeled as to their voltage and safety warnings..
15) Plug machines and electrical equipment into the outlet according to the correct voltage.
16) Do not use an open wire to conduct electricity.
17) Do not insist on entering a restricted area where there are danger warning signs.

31.4 Special Considerations:-

1) Fire safety gadgets provided within the hospital vicinity are as follows:
    a. Fire Alarm
    b. Fire Extinguisher
    c. Fire House
    d. Smoke Detector
2) Each nursing care procedure has safety measures that must be strictly followed for patient and staff safety.

32.FALL PRECAUTIONS

Fall Precautions-: safety measures observed to protect and prevent patient from sustaining accidental fall.

32.1 Purpose:

1) To make all staff and family members aware of the enforced precautionary measures.
2) To identify patients at risk of falls, initiate interventions to prevent falls and thus reduce the risk of injury due to falls.

32.2 Indications:

1) Partial Paralysis
2) Loss of limb
3) Blindness
4) Deafness
5) Impaired mobility
6) Other physical limitation or impaired sensorium/ uncooperative patient
7) Confusion/disorientation
8) Sedation/anesthesia
9) Slow reaction time
10) Lack of coordination
11) History of syncope
12) Convulsion/seizures
13) Transient Ischemic Attack (TIA)
14) 70 years or older
15) Nocturia
16) Recent significant blood loss
17) Previous fall (date _____)

32.3 Procedure:

1) All patients at risk will be assessed for fall risk and evaluated immediately upon admission within a maximum of 3-4 hours after admission.
2) Registered Nurse will do the fall risk assessment by using the FALL RISK ASSESSMENT form attached in annexure.
   Annexure-05
3) Following assessment by the nurse, if the patient is found to be at high risk for falls, the fall protocol will be initiated. The fall protocol consists of the following:
   a. Red placard will be placed as signage at foot part of bed.
   b. The patient will need assistance for transfers, ambulation and ADLs. The patient may not be left unattended in his/her room or bathroom while up or in a chair.
   c. The patient must be positioned in the bed with all side rails up in the position
   d. Beds will be kept in the lowest position at all times with brakes locked.
   e. Ensure that head and footboard of the bed is attached.

   f. Patients will be checked at least every 2 hours with the frequency being adjusted more frequently according to assessed patient needs.

g. Patients at high risk will be placed in beds close to nurse's station to allow more frequent observation.
h. Patient and family will be educated regarding the fall prevention program. Education will be documented.
i. All patients will be instructed regarding their activity level.
j. Physical Therapy Department will be consulted for gait and/or strengthening exercises, if needed.
k. The status of the patients at risk for falls will be a routine part of the end of shift or transfer report.

4) Reassessment must be performed for all patients at risk for fall. Following are the indications for reassessment:
    a. Every shift
    b. Following Procedural Sedation
    c. Medication effects, such as those anticipated with sedation or diuretics
    d. Immediate Postoperative (Within 48 hours post-surgery)
    e. Narcotic administration such as PCA or epidural analgesia
    f. Change in conscious level or mental status
    g. Changing in ambulation
    h. Transfer between Nursing unit/clinic
    i. whenever there is a fall incident.
5) All falls will be documented and reported.
6) The environment will be kept clean and clutter-free all the times. Adequate lighting will be provided.
7) All wheeled equipment will be placed on a routine preventive maintenance program.
8) There will be a cooperative effort between the nursing staff and patient's family to ensure the safety of the patient. When present, assistance of family member may be required for patients found to be at high risk for falls.
9) Signage will be placed in patient wards to educate and inform patients, family and visitors of safety precautions.
10) Wet floor signs will be available in each unit for use in the event of a spill.

33.DISASTER PLAN

33.1 Purpose:

To enable the A&E Department respond appropriately and effectively during the course of disaster.

Disaster: an event or incident that happened accidentally overwhelming local and regional resources that may cause damage or injuries to hospital personnel or properties.

Divisions of Disaster:

1) Bomb threat
2) Flood
3) Earthquake
4) Fire
5) Major Accident

Multi-Casualty Incident refers to an isolated incident, geographically focused event that produces a limited number of casualties that are managed within a community.

External Disaster implies a more destructive event producing a large number of casualties damaging the social and physical environment of a community or region.

33.2 Responsibility:

MS, DMS A&E, CMO/EMO, Nursing Supervisor,

33.3 Procedures:

1) Every DHQ/THQ hospital should develop written action plan for the A&E.
2) A procedural guideline on the specific nature of disaster should be available to the unit staff.
3) A&E personnel should have written responsibilities during the course of disaster occurrence.
4) DMS A&E and CMO acts as general A&E coordinator and are responsible for forming and supervising personnel to cover the Red, Yellow, and Green areas.
   a. Initiate triage.
   b. Allocate triage area.
   c. Supervises the evacuation of A&E of existing patients as quickly as possible using the following guidelines:
      i) Patients requiring admission will be admitted to the appropriate unit immediately.
      ii) Patients waiting for the A&E doctor will either be redirected to the nearest emergency facility for care or be advised to go home and to return at a later date on cases of non-urgent complaints.
   d. Provide emergency treatment
   e. Report to the Medical Superintendent regarding disaster status in the unit.
   f. Call up other department heads for contingent supports, when necessary.

5) Emergency Medical Officer
    a. If he/she is the one to receive the call or information about the disaster, EMO must ask the caller to identify his/her name, rank if official, nature of the event, time of incident, expected time of arrival of the casualties, and the telephone number of the caller.
    b. Instructs the hospital operator to initiate the paging system (if installed) in case the casualties arrive without advanced or early notification to the hospital.
    c. Notifies the nursing supervisor of A&E, orthopedic surgeon on duty and the general surgeon.
6) Nursing Supervisor:
    a. Ensures the casualties are triaged and treated according to their clinical needs.
    b. Clears and arranges extra rooms for the incoming anticipated casualties.
    c. Assigns responsible personnel to stay by the telephone to receive information and instructions.
    d. Ensures pharmacy, stores, and CSSD supplies are adequate and identifies further requirements according to the anticipated needs of the expected injuries.
    e. Identifies additional staffing requirements according to the anticipated number of patients and liaises with the Nursing Supervisor to arrange transport.
    f. Notifies the Bed Bureau of the available beds and ventilators in critical areas for immediate use and updates them regularly.
    g. Assigns a qualified A&E male nurse with first aid training to the external rescue team, if required.
    h. Conducts mock drills with duty acknowledgement of every staff.

Note: *Please develop protocol for Disaster Plan as per needs of your facility, these are generalized protocols)*

33.3.1 Bomb Threat

Via telephone, mail, or delivered package

1) If information is relayed through the telephone, keep the caller talking. Open any conversation to establish the motivation and the purpose of the act.
2) Do not hang up the telephone under any circumstances.
3) Inform police about the call and the area, the landmarks or the description of the site, and the your telephone number.
4) Never touch any possession of the suspect. Follow the orders of the police.
5) Evacuate the area according to the instructions of the police or the DMS in charge.

33.3.2 EARTHQUAKE MANAGEMENT

1) When present inside the building of hospital or housing compound - stay inside. Do not attempt going out into an open space.
2) Move away from the objects that can possibly fall on you. Take shelter if possible. Try to get cover under a strong table, desk, or counter and be prepared to move with them.
3) Do not stand in the doorway immediately after the earthquake. Move with caution since the floors may be littered with fallen equipment, broken glasses, spilled solutions, and scattered supplies.
4) Shut down the air conditioning unit in the exposed area.

5) Transfer patients to the observation room.

33.3.3 FLOOD

1) Make announcement for flood warning.
2) Turn off the electricity and gas outlets.
3) Shift the admitted or visited patients from ground floor to upstairs.
4) Co-ordinate with rescue services to provide transport medical team with their equipments to injured people outside.

33.3.4 FIRE

33.3.4.1 Discovery

1) The person discovering a fire would activate the R.A.C.E. protocol as explained below.
2) For any smoke coming from behind a closed door, cautiously feel the door using back of the hand.
3) Do not panic.
4) If the door is cool or warm to touch, crouching low and using the door as a shield, open the door slowly. If safe, enter the room on your hands and knees, staying as close to the floor as possible and search for signs of anybody being in the room and for the source of smoke and fire.

33.3.4.2 Rescue

1) Remove any patient and other individuals to the designated Safe Area.
2) If someone is trapped either in the bathroom or in the room itself, evacuate him/her first and close the door.

33.3.4.3 Alarm

1) Pull the nearest fire alarm.
2) Call operator and give the following information slowly and clearly:
   a. Your name and position
   b. The location of the fire
   c. Condition of fire
   d. Victims if any, and the severity of injuries

33.3.4.4 Confine

1) After making sure that the rooms are empty, close all windows and doors.

2) Place a flammable sign on the outside of the door of all rooms that have been checked to ensure no one is inside.

3) Place a towel or sheath underneath the door of the room having the fire/smoke to minimize the passage of smoke to other areas.

4) Ensure the oxygen cut-off switch has been turned off, after supplementary oxygen cylinders have been provided for the patients requiring oxygen.

5) Vehicles parked at the exit and entrance ports of the hospital should be moved and parked at a safe distance. Stay alert for incoming Fire Department Vehicles.

6) If the fire is in the vicinity of the laboratory, the Lab. Technician must turn off the LP Gas supply at the cut-off switch in the LP cylinder shed.

33.3.4.5 Extinguish

1) After removing any patient from immediate danger, sounding the alarm, and getting other staff members to inspect other rooms and closed doors, if the fire is small and confined to the area where it started, staff must try to extinguish the fire using the proper type of extinguisher for the fire.

2) Utilize the P.A.S.S method when using a fire extinguisher.

3) Never leave an extinguished fire unattended. Stay until the fire department/and or fire rescue team arrives, unless it is dangerous to stay in the vicinity of the fire.

33.3.4.6 Evacuate

1) Escort all patients to the nearest safe exit doors and to the designated fire assembly point.

2) Nursing Supervisor shall designate staff to retrieve the following:

    a. ACLS bag, Cardiac monitor, Defibrillator, portable suction, etc.

34.MEDICAL RECORD KEEPING

34.1 Purpose:

To establish guidelines and the responsibilities of various disciplines who depend on the medical record as the primary tool for communicating information important to patient care.

34.2 Responsibility:

CMO, EMO, Consultants, Nursing staff

34.3 Procedure:

1) Systematic documentation of a single patient's history and care across time in A&E is mandatory and it is primary responsibility of all healthcare providers i.e. Consultants/ Specialists, doctors, nurses, etc.
2) Medical record of a particular patient is confidential and his/her right to privacy must be respected at all times
3) Medical records must be maintained for every individual who receives care in A&E department.
4) Patient file containing all the medical records will remain in the custody of nursing staff during the entire stay of patient in A&E and DHQ hospital.
5) Every authorized person shall request the nursing staff on duty for patient's file to endorse his/her entry.
6) The author of entry in medical records is identified through signatures, names and designation.
7) The author of entry must make sure that every entry fulfills the following criteria
   a. Date of entry
   b. Time of entry
   c. Authenticated by his/her legible name ,signature and designation
8) After the discharge/death/referral /admission of patient, nursing staff on duty shall complete the medical record in all aspects and hand it over to Medical Record Section
9) Medical record must contain
   a. Medical Record Number along with patient bio-data, date and time of admission,
   b. Duly signed informed written consent for emergency treatment by authorized personnel
   c. Patient's first evaluation including relevant investigations and vital signs.
   d. Time and mode of arrival.
   e. Reason for visiting A&E with diagnosis/provisional working diagnosis
   f. Plan of care
   g. Chronological details of treatment/procedure/investigations done in A&E
   h. Patient disposition, transfer to the ward, ICU or other department, with time of disposition.
   i. Discharge/ LAMA/Referral/Death Certificate
10) All entries must be legible, accurate, clinically relevant and authenticated.

Referred to A&E Treatment Card attached in **Annexure-01**

35.STATISTICAL RECORDS

35.1 Purpose:

To establish guidelines to maintain patient's statistical record, duties record of personnel, equipment records etc.

35.2 Responsibility:

DMS Incharge/ CMO, Nursing Supervisor

35.3 Procedure:

1) Details of all patients seeking treatment in A&E must be documented in record register which will include patient demographic data, date & time of visit, diagnosis along with disposition details.
2) All MLCs must be documented in MLC record register.
3) There should be a separate record register for LAMA cases.
4) All expired cases in A&E and received dead in A&E must be documented in A&E death record register.
5) There should be record maintained for duty replacements of medical and paramedical staff inside A&E.
6) Daily generated waste in A&E may be entered in waste record register.
7) Evidences of trainings conducted for A&E staff must be maintained in training file.
8) There should be a separate file for equipment used in A&E with their inventory list, service history record, PPM record, inspection checklists.
9) Nursing supervisor and DMS A&E will be responsible for assembling, archiving and retrieving of all these records.

Referred to Patient Record Register attached in **Annexure-06**

36.INFECTION CONTROL

36.1 Purpose:

To establish guidelines and practices in the unit in conformity with the hospital- wide infection control program in order to:

1) Protect healthcare workers from blood borne infections.
2) Minimize, if not prevent infection, from patients having blood-borne viruses and pathogenic bacteria from recognized and unrecognized sources.
3) Implement isolation precaution for infections that are virulent or communicable hence, prevention of their transmission to other patients is attained.
4) Establish guidelines for vaccination against hepatitis B for susceptible patients.

36.2 Responsibility:

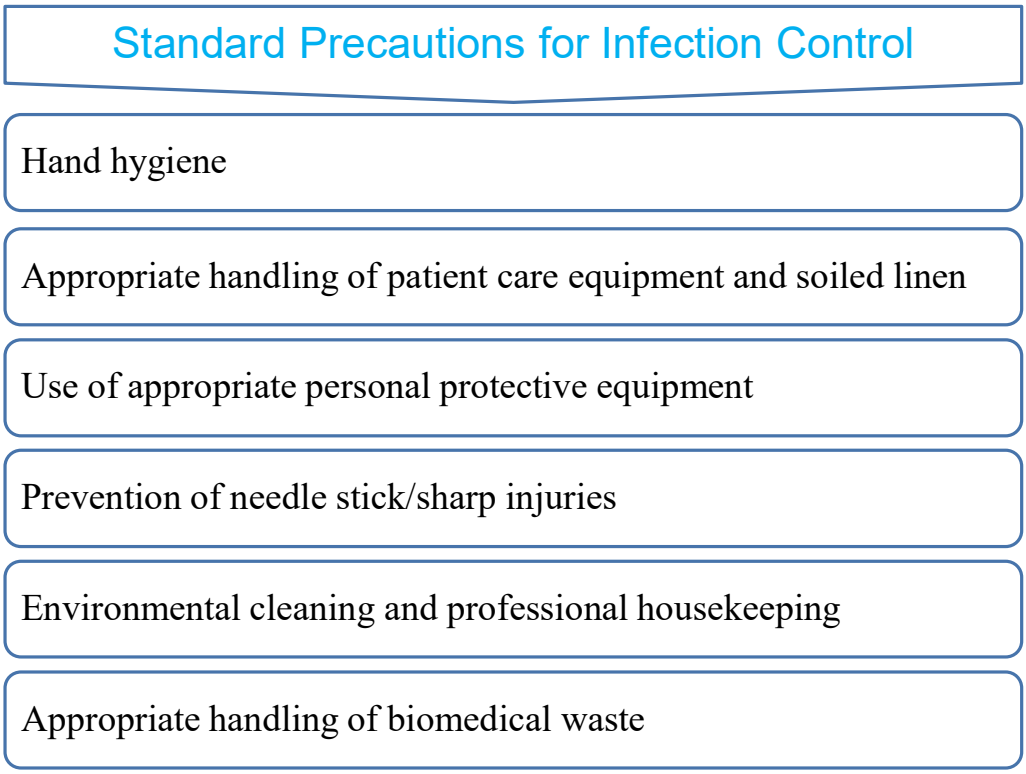
ICN, EMO, CMO, Consultant, Nursing supervisor, DMS Incharge.

36.3 Protocols:

Transmission of infections in healthcare facilities can be prevented by adopting following standard precautions and protocols

1) Ensuring hand hygiene
2) By promoting the use of appropriate PPE while handling patient's blood, body fluids, excretions and secretions.
3) Ensuring prevention of needle stick/sharp injuries
4) By ensuring environmental cleaning and professional housekeeping
5) Through appropriate handling of biomedical waste
6) Through appropriate handling of patient care equipment and soiled linenand by ensuring all reusable equipment is cleaned and reprocessed/sterilized.
7) By reducing the number of visitors/attendants in A&E
8) Through education for visitors on the importance of hand hygiene
9) By controlling rodents, pests and other vectors.

(Reference; Practical guidelines for infection control in healthcare facilities SEARO Regional Publication No. 41)

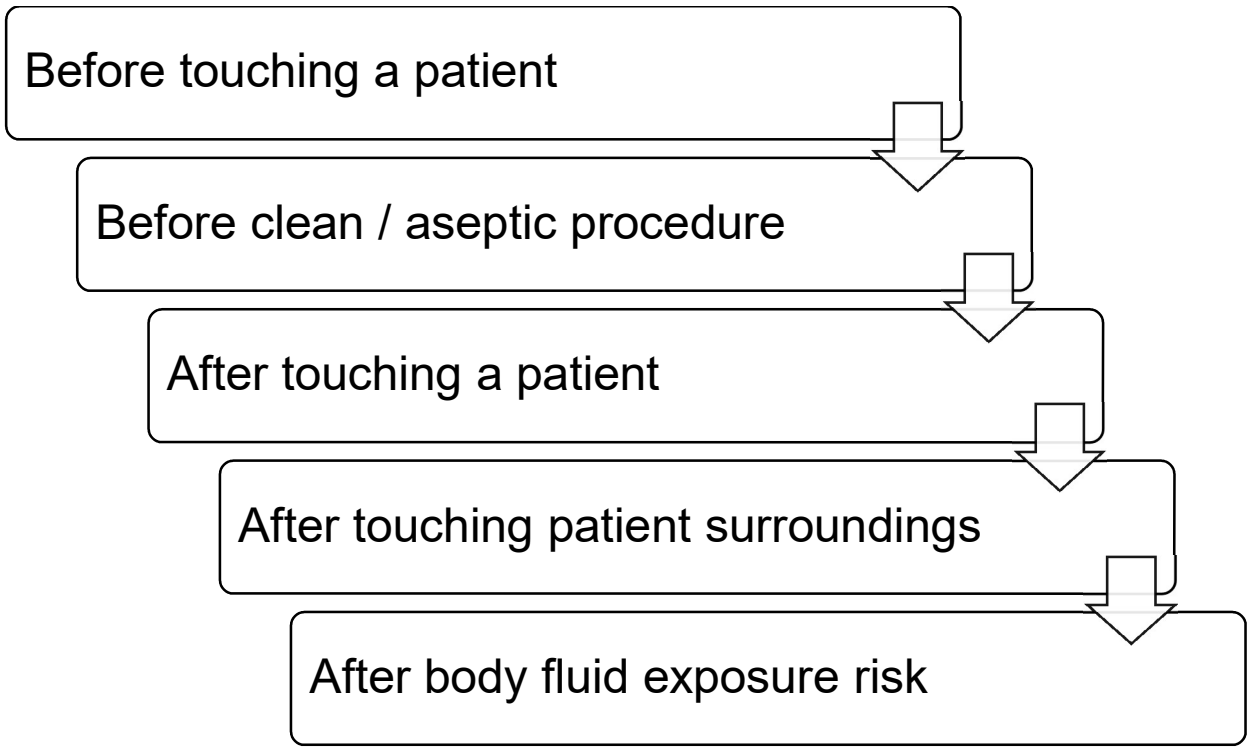


36.4 Procedure:

1) All A&E staffs should perform proper hand washing techniques on following occasions:
   a. coming to duty
   b. before and after wearing gloves
   c. before and after patient contact
   d. after removal of gloves
2) All nursing staff and ward boys should wear a designated uniform.
3) All A&E staff should comply with policy of wearing protective barriers in following events.
   a. In contact with blood or contaminated equipment.
   b. Touching body fluids, secretion, contaminated items or blood.
   c. Avoids touching surface with gloved hands that will be subsequently touched with ungloved hands.
4) Cleaning of blood spills should be done by bleaching chemical.
5) Keep number of personnel and conversation in the unit to a minimum.
6) Relatives should be limited to a minimum number.
7) A triage person should be trained to identify patients with probable transmissible infections.
8) Patients who appear unusually ill, especially with cough, should be isolated from other patients if possible.
9) Appropriate patient preparation should be done in accordance to infection control guidelines.
10) Patient should leave as soon as treatment is completed.
11) Comply with the infection control policies on cleaning and storage of equipment.

12) All disinfections and sterilization of all equipment used during procedures should be done in the Sterilization Unit.
13) Clean and disinfect surface areas of beds and tables with 70% Isopropyl alcohol and bleaching solution.
14) Needles and sharps should be disposed only in a specified sharp container (puncture resistant, leak proof)
15) Place linens soaked with blood and body fluids in a separate yellow bag properly labeled. (if contaminated with Hep B, C , HIV, then in red bag properly labelled)
16) Nursing Supervisor
    a. Assists with the infection control officers in the formulation, review, and revision of infection control policies and procedures.
    b. Ensures all nursing staffs comply with the established infection control policies and procedures.
    c. Provides information, orientation, and continuing education program regarding infection control of nursing staffs in coordination with the infection control committee.
    d. Serves as a resource person for support personnel, patients, and families regarding infection control.

Essentials of Hand Hygiene



37.TOXICOLOGY EMERGENCY MANAGEMENT

37.1 Purpose:

To establish guidelines about the management of toxicological emergencies in order to

1) Remove or deactivate the poison before it is absorbed.
2) Give supportive care to maintain vital organ function.
3) Use the specific antidote to neutralize the poison.
4) Give treatment to hasten the elimination of the absorbed poison.

37.2 Responsibility:

CMO, EMO, Consultant, Nursing staff

37.3 PROCEDURE:

1) Observe infection control policy.
2) Police authority should be informed by A&E doctor if a case of suspected suicidal attempt is brought to A&E.
3) The treatment goals of toxicological emergencies are:
   a. Supportive
   b. Preventive
4) **Airway** check for the presence of gag reflex and assess if intubationis needed. Maintain an open airway. Some ingested substances may cause soft tissue swelling of the airway.
5) **Breathing** assess the adequacy of oxygenation and ventilation with pulse oximetry and ABG.
6) **Circulation** assess heart rate and rhythm, blood pressure and the adequacy of perfusion.
7) Try to determine; the product taken, where, when, why, how much, who witnessed the event and time since ingestion.
8) Identify an antidote for a known toxic agent.
9) Continue the focused assessment, observing any significant deviations from normal. Different poisons will affect the body in different ways.
10) Check and monitor vital signs and neurologic status which includes level of consciousness, pupil size and reactivity.
11) Initiate large-bore IV access.
12) Administer oxygen for respiratory depression.
13) Monitor and treat shock.
14) Prevent aspiration of gastric contents by positioning on side with head down, use of oropharyngeal airway and suctioning.
15) Give supportive care to maintain vital organ systems.
16) Insert an indwelling urinary catheter to monitor renal function, fluid and electrolyte imbalance.
17) Support the patient having seizures. Many poisons excite the CNS, or the patient may develop convulsion from oxygen deprivation.
18) Administer antidotes depending upon the poison taken.
19) Prevent or minimize the absorption of toxins.
20) Obtain blood and urine samples for diagnostic studies.
21) Administer activated charcoal with cathartic to hasten excretion.
22) Induce emesis with syrup of ipecac.

23) Perform gastric lavage for obtunded patient. Save gastric aspirate for toxicology screening.
24) Continue to monitor and treat for complications:
    a. hypotension
    b. coma
    c. cardiac dysrhythmia
    d. seizures
25) Transfer patient to special areas for admission after proper coordination with Admission Office.
26) Document the following:
    a. Time of arrival
    b. Vital signs.
    c. Neurologic status which includes level of consciousness, pupil size and reactivity.
    d. Manifestation of seizures if noted.
    e. Type of poison taken.
    f. Management and interventions given.
    g. Laboratory investigations done.

37.4 Special Considerations:

1) Emesis should not be induced on the following conditions:
    a. After ingestion of
        i) Caustic substances such as acids and alkalis
        ii) Hydrocarbons
        iii) Iodides
        iv) Silver Nitrates
        v) Petroleum distillates
        vi) Anticonvulsant
    b. Patient who is:
        i) drowsy or unconscious
        ii) having seizures
        iii) pregnant
2) Procedures to enhance the removal of the ingested substance if the patient is deteriorating.
    a. Forced diuresis with urine pH alteration to enhance renal clearance.
    b. Hemoperfusion is the process of passing blood through an extracorporeal circuit and a cartridge containing an absorbent, such as charcoal, after which the detoxified blood is returned to patient.
    c. Hemodialysis used in selected patients to purify blood and accelerate the elimination of circulating toxins.
    d. Repeated doses of activated charcoal for binding nonabsorbed drugs/toxins.
    e. Gastric lavage may be used in conjunction with activated charcoal and a cathartic to maximize elimination of the substance.

38. SOP'S FOR POISONING

(*These sop's are for generalized guideline, Treatment will be provided as per patient condition & Physician decision)*

SALICYLATE (ASPIRIN)

38.1 Poisoning

1) Gastric Lavage
2) Activated Charcoal Every 2-4 Hours
3) Treat Metabolic acidosis with I/V Sodium Bicarbonate
4) Alkalization of urine
5) Hemodialysis may be life- saving indicated in severe metabolic acidosis

38.2 Paracetamol (Acetaminophen)

POISONING

1) Activated Charcoal for GIT decontamination if the patient reports within 4 hours of ingestion
2) Acetyl cysteine (antidote); first give loading dose of 140 mg/kg orally followed by 70 mg / kg every 4 hours; continue for 72 hours
3) It should be started within 8-10 hours after ingestion

38.3 Opiod Poisoning

MORPHINE, HEROINE (PUPILS CONSTRICTED, EUPHORIA, DROWSINESS)

1) Protect airway
2) Assist ventilation (with oxygen and mechanical ventilator)
3) Naloxone injection (Inj. Naloxone 0.4 mg)
4) Give 0.4-2 mg I/V and repeat as needed to awaken the patient
5) Repeated dose may be required after 2-3 hours

38.4 Organophosphate and Carbamate Insecticide Poisoning

1) Admit in ICU if accidental ingestion (if suicidal, inform police also)
2) 0_2 inhalation
3) Gastric Lavage
4) Administer activated charcoal
5) If skin and hair have been affected, wash with soap and water
6) Atropine to reveals muscarinic stimulation
7) Administer 2 mg I/V every 15 minutes until bronchial and other secretions are controlled
8) Repeated doses or constant atropine infusion (0.02-0.08 mg / kg / hour) may be necessary for several days
9) If the heart rate is more than 130/ minutes then for protection of heart reduce the heart rate with I/V diltiazem or Propranolol (use I/V verapamil instead of diltiazem and metoprolol)

10) Pralidoxime (Contrathion) dose is 1-2 g I/V over 5-20 minutes (5-10 vials of Contrathion are dilated in 100 cc of distilled water. Dose may be repeated every 4-6 hours
11) Signs of full atropinization

a. Dry, hot, flushed skin
b. Dry Secretions
c. Pulse more than 70/minutes
d. Dilated pupils

38.5 Benzodiazepine Poisoning

1) Gastric lavage not advised in pure benzodiazepine overdose
2) Activated charcoal should be given repeatedly for decontamination of GIT
3) Impaired consciousness requires attention to maintain air way
4) Pulse oximetry to monitor O_2 saturation
5) Observation should be for at least 06 hours post ingestion
6) Flumazenil (Inj. Anexate 0.1 mg) to reverse respiratory depression
7) It is given in incremental dose of 0.2, 0.3 and 0.5 mg at one minute intervals

38.6 Nicotin (Tobacco) Poisoning

1) If Nicotine has contaminated the skin ,wash with water and soap
2) If ingested, Gastric lavage
3) Administer activated charcoal
4) A purgative such as sodium sulphate, 15 gm in 100 ml of water is useful
5) 0_2 Inhalation
6) Symptomatic treatment

38.7 Carbon Monoxide Poisoning

1) The patient must be removed to fresh air
2) Body warmth maintained
3) No further treatment if the patient is conscious
4) 0_2 inhalation
5) Whole blood transfusion is useful in severe cases
6) Prophylactic antibiotics

38.8 Nuxvomica (Kuchila)

1) Patient should be kept in bed in dark
2) If Spasms occur, administer quick anesthesia with chloroform
3) I/V Barbiturate
4) Gastric Lavage with potassium permagnate dilated solution.
5) Activated charcoal administration
6) Barbiturate like phenobarbital sodium should be given I/V in doses of 500 – 750 mg
7) Anesthesia per rectum in a dose of 250 mg repeated as required
8) Intravenous Diazepam in a dose of 2.5 mg
9) Artificial respiration
10) Supporting therapy

38.9 Petroleum (Kerosine Poisoning)

1) If ingested stomach should be washed with warm water containing 5 % Sodium Bicarbonate
2) Absorption can be should be giving 250 ml of liquid paraffin orally
3) If the poison has been inhaled, the person must be removed to the open air and artificial respiration
4) The rest of the treatment is symptomatic

38.10 Wheat-Pill Poisoning

1) The management of AAIPP (Aluminum Phosphide) remains purely supportive because no specific antidote exists
2) Mortality rate is 60 %
3) Gastric Lavage with potassium permegnate (1: 10000)
4) Magnesium sulphate I/V is helpful to some extent in some studies
5) Invasive hemodynamic monitoring
6) Early resuscitation with I/V fluids and vasoactive agents

38.11 Alcohol

1) Preventing absorption by Gastric Lavage
2) Use of bicarbonate to combat acidosis
3) Whole bowel irrigation is excellent if facilities permit
4) Hypoglycemia will need intravenous glucose
5) Hemodialysis is also recommended for patients with signs of severe poisoning and serum ethanol levels above 600mg/dl.
6) If respiratory depression is noticed then resort to artificial respiration

39.CONTINUOUS QUALITY IMPROVEMENT:

39.1 Purpose:

To establish an effective process which leads to measurable improvement in health care services provided to the patient by identifying factors affecting service quality.

39.2 Responsibility:

MS, DMS Quality Control, Quality Assurance Officer, DMS Incharge A&E, Nursing Supervisor A&E

39.3 Procedure:

1) The CQI Committee comprises of the following individuals:
   a. MS of the HCE,
   b. Medical Consultant
   c. Surgical Consultant
   d. DMS Quality Control
   e. Quality Assurance Officer
2) A Multidisciplinary committee in A&E comprises of the following individuals:
   a. DMS Incharge A&E
   b. CMO
   c. Nursing Supervisor
3) All quality improvement efforts in A&E are guided by following MSDS from MSDS reference manual of PHC.
   a. Access, Assessment and continuity of care AAC(lab and radiological services provided to emergency patients)
   b. COP 1. Emergency services
   c. COP 2. Blood bank services provided to A&E patients
   d. COP 4. and COP 5 for patients undergoing A&E surgeries.
   e. Management of medication MOM
   f. Patient Rights and Education PRE
   g. Hospital Infection Control HIC
   h. Facility Management and Safety FMS
   i. Human Resource Management HRM
   j. Information Management System IMS
4) In addition to these, the A&E participates in the required MSDS quality monitors for:
   a. Appropriate patient assessment including treatment course and its documentation in medical record(A&E treatment card).
   b. Laboratory and radiology safety and quality control programs (including defined SOPs, implementation, documented training on SOPs, and training on occupational health and safety SOPs, external validation)
   c. Monitoring of invasive procedures and adverse events like return to operating room within 24 hours and re admission within 24 hours.

d. Monitoring of adverse drug reactions
e. Use of anesthesia and any adverse outcome
f. Use of blood and blood products and any adverse outcome.
g. Review of medical records to ensure availability, content and use of medical records.
h. Risk management and surveillance, defined sentinel events and after that control and prevention of such events that affect the safety of patients, family and staff.

5) These functions are overseen by key committees, including, but not limited to,
   a. Multidisciplinary Committee in A&E
   b. Infection control Committee
   c. Blood Bank Committee
   d. Operation theatre Management Committee
   e. Medical Record Review Committee.
   f. Medication Usage and Evaluation Committee
   g. Continuous Quality Improvement Committee.
6) Once in a month CQI meeting will be held and all relevant information derived from quality improvement activities shall be shared to administration and concerned area of problem ,so that action can be taken at the right level to solve identified problems and to avoid duplication of effort.
7) Minutes of meeting will include defined agenda, issues discussed, conclusion/ recommendation, target date for action plan and the responsible person.
8) Documentation of review meeting shall be maintained in a confidential file by DMS Incharge A&E.

(*Refer to CQI Manual for further details)*

40. FAQS

40.1 Are children of patients or their attendants allowed in the A&E department?

Owing to the nature of the A&E Department, and the variety of patients with different injuries and prognoses, it is not recommended for families to bring children under the age of 13 to visit with patients. However, if patients have no option but to keep children with them, it is under the assumption that the family will ensure strict discipline and good behavior of the child. If the family is unable to do so, the attendants may be asked to take the children outside the A&E Department.

40.2 Are patients allowed to use their mobile phone to call relatives and friends?

This must be reviewed on a situational basis. Ideally, patients or their attendants should not use cellular devices while in the A&E Department because of the risk that there will be interference of medical monitoring equipment. However, there may be circumstances where it is essential for patients or their attendants to contact friends or family, such as in instances of patient death.

It is recommended that the healthcare provider take a gentle approach while talking to patients requesting to use a cellular device, and explain the situation to patients, or request for attendants to take telephone calls outside.

40.3 What is Triage?

Triage refers to the process assigning of priority to patients that have reported to the A&E for treatment and is based on how critical the patient is. Patient wait times are determined via this process and is a means of ensuring that the patient with a risk of serious morbidity or mortality have to wait less than patients who have no such risk.

40.4 How do we counsel patients regarding wait times?

Patients or their attendants must be informed of the process of triage and be informed that the wait times are determined by patient prognosis prior to treatment. Prominently displaying the wait times is highly recommended. .

It must be recognized that this process may appear counterintuitive to patients and attendants who may be expecting treatment on a first-come-first-serve basis and may be the source of significant frustration. Consequent to the positionality of a healthcare provider, the burden of counseling falls on the HCE staff, and a calm and polite counselling session is required to alleviate the patient's frustration. However, if the patient or their attendants become belligerent, or there is a risk of physical injury or insult, it is recommended that the healthcare provider calls Security.

40.5 Why is the door to the treatment area always locked?

It is important for the HCE staff to limit exit and entry into the Emergency Department, to ensure the safety of patients and staff.

40.6 Why are people referred to an opd clinic?

If the person's condition does not require specialist A&E care we may refer the patient to the OPD clinic to be seen by concerned specialty. However, it must be noted that the details of patients referred to the OPD must be entered into the Emergency Control Register, along with treatment and patient disposition.

40.7 Why would a patient be transferred to another hospital?

Not all services are provided at every DHQ or THQ hospital. The A&E Department care will be the same but, depending on ongoing needs, patients may be transferred to the tertiary care hospital that has the specialty required for continued treatment.

41.ANNEXURE-01 A&E TREATMENT CARD

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

EMERGENCY CARD

Patient Name | Father/Husband Name | MR No.

CNIC No. _____-_____-_____ Age _____ Gender ☐ M ☐ F ☐ T

Mobile No. _____ Address _____

☐ **MLC** *(In case of MLC, mention MLC No. / Document No.)* _____

Date of Admission	(.....dd..... /.....mm..... /.....yy.....)
Time of Admission	(..... : ..... AM / PM)
Date of Exit	(.....dd..... /.....mm..... /.....yy.....)
Time of Exit	(..... : ..... AM / PM)
Medical Officer:	
Consultant:	

میں اپنا/اپنے مریض کا داخلہ ایمرجنسی وارڈ میں کرواتا/کرواتی ہوں اور ہسپتال کے طبی عملے کو اپنے/اپنے مریض کے ہر قسم کے علاج اور اس کیلئے ضروری ٹیسٹ، پروسیجرز اور ادویات دینے کی اجازت دیتا/دیتی ہوں۔

نام مریض _____

نشان انگوٹھا _____ دستخط _____ نام رشتہ دار _____

Informed to:(In case the patient / relative is not available / incapacitated / unable to give consent)

ایمرجنسی میڈیکل آفیسر | ڈپٹی/ایڈیشنل میڈیکل سپرنٹنڈنٹ | دستخط سٹاف نرس

Diagnosis	Differential Diagnosis (If Any)	Receiving Notes
		Time Seen By Nurse ..... : ..... AM/PM By Doctor..... : ..... AM/PM

Mode of Arrival	Condition on Arrival	Triage Category	Vitals	
☐ Walk In	☐ Alert	☐ Resuscitation	BP	RBS
☐ Stretcher	☐ Verbal	☐ Emergency	Pulse	**Pain**
☐ Wheel Chair	☐ Unconscious	☐ Urgent	Temp	☐ Mild
☐ Public Service (Police/Rescue Team)	☐ Reacts to Painful stimuli	☐ Semi Urgent	R/R	☐ Moderate
	☐ Other	☐ Non Urgent	SpO_2	☐ Severe

Presenting Complaint _____

Brief History _____

Examination

- ☐ Head & Neck
- ☐ CNS
- ☐ CVS / Pulmonary
- ☐ GIT
- ☐ GUT
- ☐ Extremities
- ☐ Integumentary
- ☐ **Oedema:** *(If Yes)*
  - ☐ Pitting
  - ☐ Non-pitting
  - ☐ Pedal
  - ☐ Sacral

1

Previous Medical & Surgical History

Allergies ☐ No ☐ Yes _____

Immunization Status: _____

Previous Medication, (If Any)

Drug	Strength	Dose	Frequency	Duration

	HTN	IHD	DM	Asthma	Hep B/C	Other
Past Hx						
Family Hx						

Social Hx ☐ Alcohol ☐ Smoking ☐ IV Drug ☐ Other

Any significant previous Surgical History _____

☐ Re-admission within 72 hours, (If Yes) ☐ Same Hospital ☐ Other Hospital _____

☐ If Specialist Care Required		Notes
Time Called: ..... : ..... AM/PM	Department:	
Time Call Received: ..... : ..... AM/PM	Name of Doctor on call:	
Time Seen: ..... : ..... AM/PM	Dr. Signature / ID on call:	

Resuscitation Form *(In case CPR is performed, write treatment in this section)*

Resuscitation Required ☐ Yes ☐ No

Time of Arrest	Time Resuscitation Started	Time Resuscitation Ended	Total Duration of Resuscitation
..... : ..... AM/PM	..... : ..... AM/PM	..... : ..... AM/PM	

Resuscitation Team

Name	Signature	ID	Speciality

Outcome: ☐ Revived ☐ Expired ☐ Admitted ICU / Ward ☐ Referred

Drug	Strength	Dose	Route	Time	Signature
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	

Procedures	Details	Post Procedure Vitals				
		BP	Pulse	Temp	R/R	SpO2
Compressions						
Defibrillator						

Emergency Treatment Chart

Drug	Strength	Dose	Route	Time	Signature: Order by	Signature: Administered by
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		

IV Fluids / Blood	Quantity	Time Started	Time Ended	Signature: Order by	Signature: Administered by
		..... : ..... AM/PM	..... : ..... AM/PM		
		..... : ..... AM/PM	..... : ..... AM/PM		
		..... : ..... AM/PM	..... : ..... AM/PM		
		..... : ..... AM/PM	..... : ..... AM/PM		

Others

2

Vitals

Time			
Resp. Rate	≥ 25		3
	21-24		2
	12-20		
	9-11		1
	5-8		3
SpO_2	≥ 96		
	94-95		1
	92-93		2
	≤ 91		3
Inspired O_2.%	%		
Temp	39.1		2
	38		1
	37		
	36		
	≤35		1
			3
Blood Pressure	220	SYSTOLIC	3
	210		
	200		
	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		1
	90		2
	≤80		3
	≥120	DIASTOLIC	
	110		
	100		
	90		
	80		
	70		
	60		
	50		
	≤40		
Heart Rate	140		3
	130		2
	120		
	110		1
	100		
	90		
	80		
	70		
	60		
	50		1
	40		
	30		3
Level of Consciousness	Alert		
	V /P / U		3
Blood Sugar			
TOTAL NEW SCORE			
Additional Parameters	Pain Score		
Urine Output			
Monitoring Frequency			
Initials			

Investigations Done, (If Any)

- ☐ **CBC**

Hb	ESR	TLC	PLT
P	L	M	E

- ☐ **LFTs**

☐ Bilirubin	☐ S/Protein
☐ ALT	☐ S/Albumin
☐ AST	

- ☐ **S/Electrolytes** — ☐ **Blood Group**
  - ☐ Na^{+1} ☐ K^{+1} ☐ Ca^{2+}
- ☐ **RFTs**

☐ S/Urea	☐ S/Creatinine

- ☐ **CSF**

Protein	Sugar
TLC	RBCs
WBCs	

- ☐ **Urine C/E**

Sp. Gravity	pH	Protein	Sugar
RBCs	Cast	Pus Cells	Ketones

- ☐ **ABGs**

PH	PaO_2	$PaCO_2$
HCO_3	Base Excess	

- ☐ **Bleeding Profile** — ☐ **B-HCG**
  - ☐ PT ☐ APTT
- ☐ **Cardiac Enzymes**
  - ☐ CPK ☐ CK-MB ☐ Troponin ☐ LDH
- ☐ **Viral Markars**
  - ☐ Hep B ☐ Hep C ☐ HIV ☐ Syphilis
- ☐ **X-Ray:** _____
- ☐ **CT Scan:** _____
- ☐ **USG:** _____
- ☐ **MRI:** _____

Procedures Done, (If Any)

☐ ETT	☐ Thrombolytic Therapy
☐ NG Tube/Gastric Suction	☐ Bladder Catheter
☐ IV Fluids	☐ OBS/Gynae Care
☐ Blood Transfusion	☐ Orthopaedic Care
☐ Nebulizer Therapy	☐ Wound Care
☐ Other	

Post Procedure Detail

(In case of any procedure done, record vitals in news chart with + sign in times row)

3

☐ Any complication during emergency stay:

Mode of Exit

☐ Discharge		☐ Advised by Doctor
☐ Referral	☐ Emergency ☐ Non-Emergency	☐ On Patient/Relative Request
Referred to: Hospital Name	☐ Known Drug Allergy	☐ Other_____
	Instructions for Patient Transfer:	Reason_____
	Ambulance Call Time: (..... : .....) AM/PM	
	Patient Departure Time: (..... : .....) AM/PM	
☐ Admission	☐ Medicine ☐ Surgery ☐ ICU ☐ Paeds ☐ Gynae	
	☐ Burn Unit ☐ Dialysis Unit ☐ Ortho ☐ Other	
☐ LAMA	*(in case of LAMA or DOR, please fill in the relevant box below)*	

LAMA

In case a patient leaves against medical Advice without informing record the patient details as soon as this comes to attention of the Duty Doctor.

Date of LAMA:_____

Time of LAMA:_____

Informed to staff on duty: _____

Staff's Name & Signature: _____

Doctor's Name & Signature: _____

DISCHARGE ON REQUEST (DOR) STATEMENT

ہمیں اپنے مریض کی حالت بارے آگاہ کر دیا گیا ہے۔ ہم اپنی مرضی سے ہسپتال سے چھٹی لے کے جانا چاہتے ہیں۔ مریض کی جان کو ہونے والے نقصان کے ہم خود ذمہ دار ہوں گے۔ ہمیں ہسپتال کے عملہ یا ڈاکٹر سے کوئی شکایت نہیں ہے۔

نام رشتہ دار/مریض:_____

نشان انگوٹھا: _____ تاریخ: _____ دستخط: _____

شناختی کارڈ:

						-									-		

Response to Treatment	☐ Improved	☐ Unchanged	☐ Deteriorated	☐ Other			
Patient Condition on Exit	☐ Alert	☐ Responds to Verbal Command			☐ Unconscious	☐ Other	
Patient Vitals on Exit	Pulse	BP	Temp	R/R	SpO2	☐ Stable	☐ Unstable

Treatment Advice

Medicine	Strength	Dose	Timing	Duration
ادویات	طاقت	خوراک	ہدایات اوراوقات	دورانیہ علاج
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	

ہدایات برائے دوبارہ معائنہ:

تاریخ معائنہ:_____ شعبہ:_____

عمومی ہدایات برائے مریضاں:_____

ہدایات برائے خوراک:_____

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں

Prepared BY:	Doctor Name:	Signature/ID:	Designation
	Date(.....dd...../ .....mm...../ .....yy.....)		Time (..... : ..... AM/PM)
Scanned BY:	Scanner Name:	Signature/ID:	Designation
	Date(.....dd...../ .....mm...../ .....yy.....)		Time (..... : ..... AM/PM)

4

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

EMERGENCY CARD

Admission | Discharge | Referral

Patient Name | Father/Husband Name | MR No.

CNIC No. _____-_____-_____ Age: _____ Gender: ☐ M ☐ F ☐ T

Mobile No. _____ Address _____

Triage: ☐ Resuscitation ☐ Emergency ☐ Urgent ☐ Semi Urgent ☐ Non Urgent

Date of Admission (dd /mm /yy)

Time of Admission (.... : .... AM / PM)

Date of Exit (dd /mm /yy)

Time of Exit (.... : .... AM / PM)

Presenting Complaint

Significant Clinical History & Examination Findings

Significant Investigations & Values

Diagnosis

Emergency Management

Drug	Strength	Dose	Route	Drug	Strength	Dose	Route

Procedures Undertaken (If Any)

☐ CPR	☐ IV Fluids	☐ Bladder Catheter
☐ Defibrillator	☐ Blood Transfusion	☐ OBS/Gynae Care
☐ ETT	☐ Nebulizer Therapy	☐ Orthopaedic Care
☐ NG Tube/Gastric Suction	☐ Thrombolytic Therapy	☐ Wound Care
☐ Other		

Post Procedure Detail

☐ Stable ☐ Unstable

☐ Any Complication:

Emergency Exit Portal

☐ Admission ☐ Discharge ☐ Referral

☐ Advised by Doctor
☐ On Patient/Relative Request
☐ Other _____

Reason _____

Response to Treatment	☐ Improved	☐ Unchanged	☐ Deteriorated	☐ Other	
Patient Condition at Exit	☐ Alert	☐ Responds to Verbal Command		☐ Unconscious	☐ Other
Patient vitals at Exit	Pulse	BP	Temp	R/R	SpO2

Discharge Note (*In case of Discharge, please fill the following*)

Treatment Advice

Medicine	Strength	Dose	Instruction	Treatment course
ادویات	طاقت	خوراک	ہدایات اور اوقات	دورانیہ علاج
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	

ہدایات برائے دوبارہ معائنہ: درج ذیل تاریخ کو ہسپتال ہذا کے درج ذیل شعبہ میں معائنہ کیلئے تشریف لائیں۔

تاریخ (................/................/................) شعبہ: ____________________

عمومی ہدایات برائے مریضاں:

____

____

ہدایات برائے خوراک: ____________________

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں: ____________________

____

Admission Note (*In case of Admission, please fill in the following*)

☐ ICU ☐ Burn Unit ☐ Dialysis Unit ☐ Medicine ☐ Surgery ☐ Ortho ☐ Paeds ☐ Gynae ☐ Other ____________

Referral Note (*To be filled in by Referring Doctor, in case of Referral*)

Nature of Referral: ☐ Emergency ☐ Non-Emergency	Referred to:
Any Known Drug Allergies:	
Instructions to be carried out during patient transfer:	Ambulance Call Time: (............ :............) AM/PM
	Patient Departure Time: (............ :............) AM/PM
Treatment given during patient transfer (*To be filled in by PTS staff*)	Ambulance Staff Name
	Signature
	Designation

Referred Hospital Receiving Notes (*To be filled in by Receiving Doctor of Referred Hospital*)

Patient Arrival Time: (……..:………) AM/PM	Patient Condition: ☐ Stable ☐ Unstable ☐ Expired	
Receiving Doctor Name:	Signature/ID:	Designation:

Prepared BY:	Doctor Name:	Signature/ID:	Designation
	Date(.....dd......./ .....mm......../ .....yy.........)		Time (..................... : .... AM/PM)

Scanned BY:	Scanner Name:	Signature/ID:	Designation
	Date(.....dd......./ .....mm......../ .....yy.........)		Time (..................... : .... AM/PM)

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42.ANNEXURE-02 PAKISTAN PENAL CODE

Shajjah, Its Types and Punishments

SHAJJAH, ITS TYPES AND PUNISHMENTS

Definition Of Shajjah (شجہ):

Where a person inflicts some injury or harm to another person and such injury does not come within the definition of loss of body organ or loss of capacity of body organ and such injury is not on other parts of body but on the head and face of the victim then such an injury is known as Shajjah (شجہ). According to sec. 337 Pakistan Penal Code when a person inflicts injury on the face or head of another person and it does not fall under definition of loss of limb or loss of capacity of limb then it is called Shajjahشجہ .

Types OfShajjah:

Following are the types of Shajjah;

1) ShajjahHafeefa(شجہ خفیفہ):
In the injury where the bone is not revealed then such injury is called ShajjahHafeefaشجہ خفیفہ .

2) ShajjahMozzaha(شجہ موضحہ):
In the injury where the bone is revealed but it is not fractured then the same is called ShajjahMozzahaشجہ موضحہ .

3) ShajjahHashma(شجہ ہاشمہ):
In the injury where the bone is fractured but it is not displaced then it is what is known as ShajjahHashmaشجہ ہاشمہ .

4) ShajjahManqla(شجہ منقلہ):
In the injury where bone is not only fractured but displaced as well then such injury is ShajjahManqlaشجہ منقلہ .

5) ShajjahAma' (شجہ آمہ):
In the injury where the bone is fractured in such a way that the injury is touching the membrane of brain then it is called as ShajjahAma' شجہ آمہ .

6) ShajjahDamgha(شجہ دامغہ):
Where the injury to the head is so severe that the bone of head is fractured in such a way that the brain membrane also gets torn then it is called ShajjahDamghaشجہ دامغہ .

Punishments For Shajjah (شجہ):

Under sec. 337-A punishments for different types of Shajjah are mention which are as under;

1. Punishment For ShajjahHafeefa(شجہ خفیفہ):
The guilty of ShajjahHafeefa will be held for "Zama'n" (ضمان) and also the guilty would get imprisonment of either description which can be up to TWO years.

2. Punishment For ShajjahMozzaha (شجہ موضحہ):
The guilty of ShajjahMozzaha would be held for "Qisa's" (قصاص) in consultation with the authorized medical officer and if, keeping in view the Islamic principles of equity (مساوات), the principle of Qisa's cannot be implemented then the guilty would be held for "Arsh" (ارش) which would be 5% of the "Diyyat" (دیت) and imprisonment up to FIVE years of either description can be awarded as "Tazeer" (تعزیر).

3. Punishment For ShajjahHashma(شجہ ہاشمہ):
The guilty of ShajjahHashma would be held for "Arsh" (ارش) which would be calculated at 10% of "Diyyat" (دیت) and would also get imprisonment up to TEN years of either description as "Tazeer" (تعزیر).

4. Punishment For ShajjahManqla(شجہ منقلہ):
The guilty of ShajjahManqla would be held for "Arsh" (ارش) which would be calculated at 15% of "Diyyat" (دیت) and would also get imprisonment up to TEN years of either description as "Tazeer" (تعزیر).

5. Punishment For ShajjahAma' (شجہ آمہ):
The guilty would be held for "Arsh" (ارش) which would be calculated at half the "Diyyat" (دیت) and would also get imprisonment up to TEN years of either description as "Tazeer" (تعزیر).

6. Punishment For ShajjahDamgha(شجہ دامغہ):
The guilty of ShajjahDamgha would be held for "Arsh" (ارش) which would be calculated at half the "Diyyat" (دیت) and would also get imprisonment up to FOURTEEN years of either description as "Tazeer" (تعزیر).

Govt. of Punjab Health Department

MEDICO LEGAL EXAMINATION CERTIFICATE

Name _____ Caste _____

Son/Daughter/Wife of _____

Age & Sex _____ Occupation _____

Address _____

NIC No. _____

Two Identification marks:

(mention complete description & exact anatomical location)

(1) _____

2) _____

Accompanied by _____

Date & Time of (a) Arrival _____

(b) Examination _____

No. & date of Police docket/Court Order _____

Name & No. of Police Constable _____

Admitted date & time of (a) Admission _____

(b) Discharge _____

Date & time of Report sent to Police _____

o not accordance by Police

میں حلفیہ بیان کرتا/کرتی ہوں کہ میں نے اس سے پہلے اپنا/اپنے بچے/بچی _____ کا جسمانی ملاحظہ نہیں کروایا۔ میں اس ملاحظہ کروانے کی اجازت دیتا/دیتی ہوں جس کے بارے میں مجھے مکمل طور پر آگاہ کر دیا گیا ہے۔ میں نے تمام کوائف اور حقائق درست بتائے ہیں۔

دستخط _____ نشان انگوٹھا

نام _____ قومی شناختی کارڈ نمبر _____

مکمل پتہ بمعہ فون نمبر _____

نابالغ بچے/بچی کا نشان انگوٹھا

ote:- In cases of sexual assault, samples should be sent for DNA test.

Teaching/DHQ/THQ Hospital/RHC _____ Book No. _____ Serial No. _____ MLC No. _____

Brief History:

Examination of Clothes:

General Physical Examination/Symptoms:

Description of Injures (Mark injuries on the body diagram on the back of this page)

Investigation Advised _____ Samples sent for Laboratory Examination _____

Opinion of specialist/Operation Notes/X-Ray report: _____

Nature of Injuries _____ Possibility of fabrication if any YES/NO

(Qisas & Diyat Law)

Probable Duration of injuries: _____ Kind od weapon used / Poison suspected _____

Final opinion for KUO Injuries: _____

(to be given within 21 days _____

MLC کی کاربن کاپی، نقشہ معذوری پولیس کی ڈاکٹر صاحب اور نشان زدہ پرچہ جات میڈیکل Expert کی رائے کیلئے خط/ایکسرے فارم وغیرہ وصول شدہ Sample شدہ برائے مثل شدہ ظاف برائے لیبارٹری تجزیہ وصول ہائے میں، زندہ ہوں کہ لیبارٹری کیلئے Sample فوراً حفظ لیبارٹری میں جمع کروادوں گا اور ایکسرے میڈیکل Expert کی رائے کیلئے بھی کوئی تاخیر نہ کروں گا۔ قانون کے مطابق پابند ہوں گے ذیر مشاہدہ ضروریات کو مندرجہ بالا تقاضے پورے کرنے کے بعد جلد از جلد حفظ/ڈاکٹر سے مکمل کروالوں گا۔

دستخط پولیس/کنسٹیبل تفتیشی آفسر _____ نام بمعہ نمبر _____

تھانہ ضلع _____

تاریخ _____

نشان انگوٹھا

Government Fee Rs..... Receipt

Medico Legal Examiner

(Name & Designation)

43.ANNEXURE-03 REFERRAL FORM

Patient's Name				**w/o, d/o, s/o**			
Age		**Gender**	**M**		**F**	**Medical Record No.**	
Consultant				**Diagnosis**			
Date of Admission				**Date of Shifting**		**Time of Shifting**	
Address							
Nature of Referral	Emergency			Non-Emergency			

Reason for the Referral (Tick the relevant)			**Condition at Referral** (Tick the relevant)			
1	Patient's/Attendant request		Alert		Pulse	b/min
2	Clinical Assessment		Respond to Verbal command		BP	mm/Hg
3	Medico legal Case		Unconscious		R.R	Breaths/min
4	Any other reason		Other(Specify)		Temp	F

Name of receiving hospital

Brief Clinical History & Examination

Diagnostic Investigations Done at DHQ Hospital

Treatment Given at DHQ Hospital

Name & Signature of Duty Medical Officer

AMBULANCE FORM

☐ Referral ☐ Discharge

Patient Name	Father / Husband Name:	MR No
CNIC/SNIC		Age
Mobile No	Address	

MEDICAL CONDITION

Diagnosis

Physical Condition of Patient on Transfer

VITALS

B.P	Pulse	Temp	R/R
BSL	SpO_2%	Drains	Dressing
Nurse Name & Sign:		Hospital ID	Date: _____/_____/_____

TRANSFER DATA

Reason of Transfer_____

Transfer To

☐ Home *(If Yes, Specify)* Address _____

☐ Hospital *(If Yes, Specify)* Name _____

☐ Others *(If Yes, Specify)* _____

EQUIPMENT NEEDED DURING TRANSFER

Escorted By	☐ Physician ☐ Nurse ☐ Other
Time Requested ..... : ..... AM/PM	Actual Time of Transfer..... : ..... AM/PM

Treating Physician Name, Signature & ID	Date & Time
	..... / ..... / .... : ..... AM/PM

EVENTS / ANY CHANGE OF PATIENT CONDITION DURING TRANSFER

TREATMENT GIVEN DURING PATIENT TRANSFER

AT RECEVING END

Time of Arrival ..... : ..... AM/PM

Patient Condition Upon Arrival ☐Alert ☐ Respond to Verbal Command ☐ Unconscious ☐ Other _____

Received By

☐ Family Member	Name	Sign
☐ Hospital Staff	Name	Sign

44.ANNEXURE-04 DEATH CERTIFICATE

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT
DHQ / THQ HOSPITAL -

DEATH CERTIFICATE

DECEDENT

Name:	Father/Husband Name:	Age:	Gender: ☐ M ☐ F ☐ T
Address:		City	District
CNIC ☐☐☐☐☐-☐☐☐☐☐☐-☐	Date of Birth: (……../……../……..)	Date of Death: (……../……../……..)	
Religion:	Marital Status:	Surviving Family Name:	Time of Death: …… : ……. AM/PM

NEXT OF KIN

Name:	Father/Husband Name:	Age:	Gender: ☐ M ☐ F ☐ T
Address:		City	District
CNIC ☐☐☐☐☐-☐☐☐☐☐☐-☐	Date of Birth: (……../……../……..)		
Religion:	Marital Status:	Occupation:	

ADMISSION DIAGNOSIS | **FINAL DIAGNOSIS**

HOSPITAL COURSE OF TREATMENT & MANAGEMENT

PROCEDURE PERFORMED

SIGNIFICANT LAB FINDINGS

BRIEF SUMMARY OF FACTS SURROUNDING DEATH

CAUSE OF DEATH

Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a ____ DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST** b ____ DUE TO (OR AS A CONSEQUENCE OF):	
c ____ DUE TO (OR AS A CONSEQUENCE OF):	
d	

MANNER OF DEATH				Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
☐ Natural	☐ Homicide	☐ Accident	☐ Suicide	☐ Yes ☐ No	☐ Yes ☐ No
☐ Pending Investigation		☐ Could not be determined			

CERTIFIER *(Check only one box)*

☐ CERTIFYING PHYSICIAN *(Physician certifying cause of death when another physician has pronounced death)*
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN *(Physician both pronouncing death and certifying to cause of death)*
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause (s) and manner as stated.

میں تصدیق کرتا/ کرتی ہوں کہ میں نے اپنے رشتہ دار/عزیز کی لاش ہسپتال ہذا سے وصول کر لی ہے اور ہسپتال کی جانب سے متوفی کے تمام اثاثہ جات ایمانداری کے ساتھ میرے حوالے کر دیے گئے ہیں۔

نام رشتہ دار _____ متوفی سے رشتہ _____

شناختی کارڈ نمبر _____ فون نمبر _____

پتہ _____

Name & Signature of Certifier:	PMDC No:	Date & Time ……. / ……. / ……. …… : ……. AM/PM
Name and Signature of Pronouncing Physician:	PMDC No:	Date & Time ……. / ……. / ……. …… : ……. AM/PM
Medical Superintendent Signature:	PMDC No:	Date filed ……. / ……. / …….

45.ANNEXURE-05

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL -

Patient Name:		Father / Husband Name:		MR No:
CNIC/SNIC:			Age:	Gender: ☐ M ☐ F ☐ T
Ward No.	Bed No.	Unit	Diagnosis	

FALL RISK ASSESSMENT

DIAGNSOSIS				DATE:							
	PARAMETER	SCORE	ASSESSMENT	TIME:							
MENTAL STATUS	**A** Level of Consciousness / Mental Status	0	Alert, Oriented, Reliable, Safety Awareness, or Comatose								
		2	Diminished, Safety Awareness								
		4	Poor Recall, Judgment, Safety Awareness								
MOBILITY / CONSTEMENT	**B** Ambulatory Status	0	Ambulatory / continent								
		2	Impaired Mobility / Continent (Assist with toileting) / with Urinary Catheter								
		4	Ambulatory / Incontinent								
	C Gait / Balance	**To assess the patient's Gait/Balance, observe him/her while standing on both feet without holding onto anything; Walk straight forward; walk through a doorway; make a turn. Score each area with 1, if condition is present and N/A if problem is not determined. Note: Score 0 if patient is normal after doing assessment of Gait / Balance.**									
		0	No Balance problem while standing								
		1	Problem while walking								
		1	Decreased Muscular Coordination								
		1	Change in gait pattern when walking through doorway								
		1	Jerking or unstable when making turn								
		1	Requires use of assistive devices (cane, walker, furniture, etc.)								
MEDICAL STATUS / HISTORY	D Vision Status	0	Adequate (with or without glasses)								
		2	Poor (with or without glasses)								
		4	Legitimate Blind								
	E Orthostatic Blood Pressure (Systolic)	0	No note drop between lying or sitting and standing								
		2	Drop **LESS THAN** 20mmHg between lying or sitting and standing								
		4	Drop **MORE THAN** 20mmHg between lying or sitting and standing								
	F Falls History (Immediately / Past 3 months)	0	No Falls in past 3 months								
		2	1-2 Falls in past 3 Months								
		4	3 or **MORE FALLS** in past 3 months								
	G Medications (if Total is greater than 2, may refer to physician for assessment)	**Respond below based on the following types medications: Anesthetics, Antihypertensive, Antiselzure, Benzodiazepines, Diuretics, Hypoglycemic, Narcotics, psychotropic, and Sedatives / Hypnotics, Laxatives**									
		0	NONE of these medication taken currently within 7 days								
		2	TAKES 1-2 of these medications currently and/or within 7 days								
		4	TAKES 3-4 of these medications currently and/or within 7 days								
		+1	If patient has had a change in medication and/or change in dosage in the past 5 days ---- Score 1 additional point								
	H Predisposing Diseases / Conditions	**Respond below based on the following predisposing conditions: Hypotension, Hypertension, Vertigo, CVA, Parkinson's Disease, Loss of Limb(s), Seizure, Arthritis, Osteoporosis, Fracture, Dementia, Anemia, Wandering, Anger, Diabetes, Guilin Barre' Syndrome, Myasthenia Gravis, COPD**									
		0	NON PRESENT								
		2	1-2 PRESENT								
		4	3 OR MORE PRESENT								
		+1	If patient's Age ≥ 60 Years old, Score 1 Additional Point								
RISK LEVEL	Low	0-5	Implement Standard Fall Precaution	TOTAL SCORE							
	Moderate	6-9	Implement Standard Fall Precaution and Moderate Risk Precaution	Nurse Name							
	High	≥ 10	High Risk fall prevention interventions, plus standard and moderate fall precautions Precaution	Signature & ID							
				Date ...../...../..... Time: ..... : ..... AM/PM							

NURSING MEASURES

LOW RISK – STANDARD FALLS PRECAUTIONS & MODERATE RISK FALL PREVENTION INTERVENTION

- ☐ Patient Teaching – Orientation To Room, Call Bell, Fall Risk Medication Information, caution For Ambulation Following Sedation / Analgesia, Call For Assistance With Ambulation, Use Rubber Or Non-Slip Footwear To Prevent Slipping.
- ☐ Secure Call Bell, Phone And Bed Table Within Reach.
- ☐ Ensure Clothing Does Not Interfere With Mobility.
- ☐ Keep Bathroom Lights On, Floor Dry.
- ☐ Use Raised Toilet Seat Or Stool In The Shower As Necessary.
- ☐ Maintain Bed In The Lower Position, Ensure Wheels Locked.
- ☐ Use Safety Straps On Stretcher, Wheelchair While Transporting Patient.
- ☐ Identify As **Fall Risk** On Medical Record & **WHITE Placard** As A Signage At Foot-Part Of The Bed.
- ☐ Assist And / Or Supervise Ambulation.
- ☐ Monitor For Reversal Causes – Orthostatic Hypotension, Hydration & Blood Sugar.
- ☐ Move Patient Closer To Nursing Station.
- ☐ Add Round The Clock Lighting Such As Night Light at Room
- ☐ Hourly Safety Checks, Attending To The 4 P's Concerns Of The Patient.
- ☐ Regular Pain Assessment, Provide Lowest Dose Of Analgesia
- ☐ Raise Side Rails, Assess Patient After Visitors Leave To Ensure Safety Measures In Place.
- ☐ Patient, Families, Watcher Teachings – Calls For Assistance With Ambulation, Do Not Lower Side Rails Notify Nurse If Leaving The Patient.

HIGH RISK FALL PRESENTATION INTERVENTIONS (PLUS ALL LOW AND MODERATE RISK INTERVENTIONS)

- ☐ **RED Placard** As A Signage At Foot-Part Of The Bed.
- ☐ Raise Both Upper And Lower Side Rails & Apply Gap Protectors.
- ☐ Place Mattress On Floor, As Appropriate.
- ☐ Healthcare Providers Collaboratively Review Medication.
- ☐ Consult Physical Therapy For Gait And/or Strengthening Exercise If Needed.
- ☐ Initiate Constant Observation As Appropriate To Patient Need.

INDICATIONS FOR REASSESSMENT

- ☐ Every Shift.
- ☐ Following Procedural Sedation.
- ☐ Medication Effects, Such As Those Anticipated With Sedation Or Diuretics.
- ☐ Immediate Postoperative (Within 48 Hours Post Surgery)
- ☐ Narcotic Administration Such As PCA Or Epidural Analgesia.
- ☐ Change In Conscious Level Or Mental Status
- ☐ Changing In Ambulation
- ☐ Transfer Between Nursing Unit / Clinic
- ☐ After Whenever There Is A Fall Incident

46.ANNEXURE-06 A&E REGISTERS

HOSPITAL NAME _____

Emergency Patient Record Register

S.No	Date	Name	MR#	Age	Sex	Address	Contact #	Arival Time		Arrival Status					Time Seen by Dr.	MLC
								Self	Amboulance	Non Emergency	Red	Yellow	Green	Code Blue / Dead		

HOSPITAL NAME _____

Emergency Patient Record Register

diagnosis	Procedure performed with time					Blood Transfusion	Admission			Discharge/ LAMA/ expiry/refferal							Revisit with in 72 hours	
	thrombolytic therapy	CT scan	Gastric lavage	Pain management	CPR		Time of Admission	Ward	Critical Care	Left before seen	Time of LAMA	Time of Referral	Ambulance call time	Time of Referral	Time of Expiry	Time of Body handed over	Revisit date/time	revist complaint

REFERRAL REGISTER

S.No	Name	MR#	Age	Gender	CNIC	Address	Diagnosis	Treating Consultant	Date of Adminssion	Date of Refferal	Referred To	Cause of Referral	Remarks	Name Sign & ID

DEATH RECORD REGISTER

S.No	Name	MR#	Age	Gender	CNIC	Address	Diagnosis	Treating Consultant	Date of Adminssion	Date of Expiry	Time of Expiry	Cause of Death	Body Handed Over To	Remarks	Name Sign & ID