STANDARD OPERATING PROCEDURE (SOP)

EMERGENCY RESPONSE SYSTEM

Title

Emergency Response SOP for Medical, Mental Health, and Ragging-related Incidents

Objective

To ensure prompt, coordinated, and effective response to all emergencies, including medical crises, mental health issues, and ragging-related incidents, in compliance with NMC guidelines.

Scope

Applicable to all students, faculty, staff, and visitors within CHRI campus, hospital, and hostels.

Emergency Response System

24×7 Medical Facility: Available

Ambulance Services: Available round the clock

Admission through Emergency

Step 1: Patient reports to emergency

Step 2: Patient is immediately attended by the duty medical officer and Nursing staff

Step 3: The Concerned specialist decides whether the patient requires admission or can be managed as out patient

Step 4: If patient requires admission, emergency nurse will call the front office executive.

Step 5: Front office executive makes the admission with the admission order slip which is given by the consultant and generate an IP file. A bed is assigned to the patient on the basis of the patient's clinical condition.

Step 6: Sick patients are shifted immediately to the critical care unit. Others are shifted as per the bed of their choice.

Step 7: A nurse transfers the patient to the assigned room / ward

Emergency Response Team (ERT)

Nodal Officer (Overall supervision)

Medical Officer (Clinical care)

Psychiatrist/Psychologist (Mental health emergencies)

Security Officer (Safety and crowd control)

Hostel Warden (Student coordination)

Standard Response Protocol

Step 1: Identification & Reporting

Any emergency must be immediately reported to the control room or designated authority.

Step 2: Immediate Action

Ensure safety of the individual

Provide first aid (if trained)

Prevent crowding

Step 3: Medical Management

Shift patient to emergency department

Activate ambulance if needed

Step 4: Escalation

Inform Nodal Officer/Dean

Inform Anti-Ragging Committee (if applicable)

Inform family members

Step 5: Legal Compliance

In case of serious incidents (suicide/ragging/violence), FIR shall be registered promptly as per Supreme Court directive

Procedure for transfer- in, out or referral of stable, unstable patients

Purpose:

This documented procedure ensure patient transfers, referrals and discharge are undertaken safely and efficiently to and from the hospital

Scope:

The scope encompasses all the patients who are transfers, referrals and discharge of patients to other facility.

Responsibility:

Treating doctor, nursing staff, Front office executive, billing staff and shifting staff.

Policy:

Policies to guide the transfer-in of patients to the organization:

Policies to guide the transfer-out/referral of unstable patients to another facility in an appropriate manner:

Hospital has a policy to transfer the unstable patient in a safe manner in a well-equipped ambulance accompanied by trained professionals.

Policy to guide the transfer-out/referral of stable patients to another facility in an appropriate manner:

Hospital has a policy to transfer the stable patient in a safe manner in an ambulance equipped with basic life support accompanied by a trained nurse. However the hospital allows the stable patient to choose his mode of transport.

Policy to guide identification and safe transportation of patients to imaging services:

Hospital has a policy on safe transportation to imaging services in stretcher/wheel chair accompanied by trained staff.

Procedures:

Intra Hospital Transfer:

A) From Emergency to OT

Such patients are very critical require immediate surgical intervention. These patients are accompanied to the OT by the nurse.

B) From one Specialty to other Specialty:

That referral shall be made on the Referral Form for IPD patients

Stable Patient:

In case if a patient requires opinion of other specialty doctor, a detailed doctor's note is left in the patient's medical record and patient is sent to the required department. Information is given to the consultant over the phone by Emergency Medical Officer.

Unstable Patient:

In case of an unstable patient concerned doctor is called to the required place where the patient has been treated.

INITIAL ASSESSMENT & REASSESSMENT

1. **Purpose:**

The purpose of this Procedure is to provide guidelines for the initial assessment and reassessment of the patients attending in the hospital.

2. **Scope:**

This Procedure is applicable to all those who perform initial assessment in OPD, Emergency and In-patient.

3. **Responsibility:**

Consultants, Duty Medical Officers and Staff Nurses

4. **Procedure:**

4.1 General:

- All patients cared for the hospital undergo an established initial assessment by doctors and nurses.
- The content of nursing assessments is clearly defined for out-patients, emergency and in-patients.
- Hospital has clearly defined the personnel who can perform such assessments.
- Hospital defines the timeframe within which the initial assessment is completed.

- **The following are authorized to perform assessments related to their functional areas:**
    - Consultants
    - Duty Medical Officers
    - Nurse

4.2 Time Frame of Initial Assessment:

- Outpatient assessment to be done as soon as Patient reporting to the OP nurse which is followed by doctor's assessment.
- Emergency initial assessment should be completed within 15 minutes and documented in the emergency initial assessment form.
- For In-patients, Doctor's initial assessment should be completed within 24 hours or earlier.
- The Nursing Initial assessment for in Patient can be taken maximum 30 minutes and it should be completed within 4 hours of admission.
- Results of initial assessment are monitored in subsequent re-assessments. This is also documented in Doctor's progress notes and Nurses notes.

4.3 Contents of Initial Assessment:

The contents of the initial assessment include the following:

- Patient's Name, age, Sex, UHID No, Bed No and Doctor Name
- Drug Allergies & other allergies
- Present Complaints
- Vital parameters
- Pain assessment
- Past Medical History
- Past Surgical History
- Current medications, if any
- Systemic assessment
- Diagnosis
- Plan Of Care

DISCHARGE PROCEDURE

1. **Purpose:**
   - There is well planned and documented discharge process
   - Coordination among various departments so that the discharge process are complete well with in time.
   - Planned discharge process which also involve patients and their family in their care
   - Discharge Summary is given to all patients.
2. **Scope:**
   This procedure is applicable for all discharges happening at wards of Chettinad Hospital.
3. **Responsibility:**
   Consultants, Nurses, Front office executive, Discharge summary typists
4. **Procedure:**
   The following procedures are common to all planned & unplanned discharges

4.1 Contents of discharge summary: The discharge summary shall have the following details.

a) Name, Address, Age, Phone, UHID No, IP No, Age/Gender, Bed no, Date of Admission, Date of Surgery/Procedure, Date of Discharge, Billing type, Referred By, Surgeon Name, Consultant Name

b) Reasons for admission

c) Diagnosis

d) Name of the Surgery/Procedure

e) Presenting Complaints

f) Obstetric History

g) Clinical Findings

h) Investigation Results

i) Course in the Hospital

j) Operative Notes

k) Treatment Given

l) Condition on discharge

m) Advice Medicine on Discharge

n) Diet Advice

o) Physiotherapy

p) Physical Activity

q) Review On

r) Others

s) When and how to obtain urgent care

4.2. Billing department informs the patient on final bill and bill is handed over to the patient attender for payment after collecting the amount, patient is given the discharge slip.

4.3. On submitting the discharge slip the Nurse explains about the follow-up, diet, discharge medications etc. Patient / bystanders can clear their queries regarding medications. They also double-check the medicines with the prescription.

4.4. At the time of discharge the original discharge summary is handed over to the patient / relative and a copy sent to Medical Records. For MLC patients police are informed.

4.5. Discharge summary incorporates instructions about when and how to obtain urgent care. Feedback is taken from the patient and documented and the patient is allowed to leave.

5.1 Discharge at Request:

5.1.1 If the patient is stable & wishes to leave the hospital earlier than the discharge time advised by the consultant, then with the permission of the consultant, the patient shall be discharged at request.

5.1.2 In such cases the patient/relative are explained about the condition of the patient, consequences of leaving the hospital and consent will be taken for discharge at request from the patient/relative before the discharge process is initiated and proceeded.

5.1.3 Discharge summary is prepared & issued to the patient, mentioning as Discharge at request and the condition of the patient while discharge is added in the summary and in the final note of the medical record by the Duty Medical Officer.

5.2 Patient Death

5.2.1 If a patient is expired, death certificate is prepared and handed over to the patient relative once the billing clearance is made.

5.2.2 In case of death the summary of the case also includes the cause of death.

PROCEDURE FOR HANDLING EMERGENCY CASES INCLUDING MLC CASES

1. **Purpose:**

The documented procedure ensures Emergency Services including ambulance are guided by documented procedures and applicable laws and regulations.

2. **Scope:**

Patients coming to the emergency department including MLC Cases and patient availing ambulance services

3. **Responsibility:**

Doctors, Nursing Staffs, Front Office Staff

4. **Procedure:**

4.1 Reception of the patient:

4.2.1 In our hospital Emergency department located in ground floor to give easy access to the patients.

4.2.2 Diagnostic areas like laboratory and X ray is located near to the Emergency department in the ground floor itself.

4.2.3 Emergency staff shall ensure availability of wheelchairs and stretcher trolleys at Ground Floor Entrance.

4.2.4 In cases where the patient is unaccompanied / unconscious, life, sight and limb saving measures shall be instituted.

4.2.5 When receiving the patient with emergency, security will call and inform the Staff nurse in the Emergency department. All emergency patients should be accompanied by Staff Nurse and Housekeeping staff while shifting to emergency department.

4.2.6 Registration of Emergency patient will be handled by the attender who brought the patient to the Emergency and UHID Number will be created for further reference.

5. **Assessment & Provision of Care:**

5.1.1. Assessment will be carried out within 15 minutes and documented as per the hospital policy. Assessment includes checking of vitals, Presenting complaints, systemic examination etc and documented in the Emergency Doctor Assessment Form

5.1.2. Emergency nursing assessment will be carried out by Qualified Nurses by assessing the patient's vitals, pain score and the Nursing care plan will be formulated based on the patient's condition and documented in Emergency Nursing Assessment Form

5.1.3. Provision of patient care is done as per the Hospital protocol and policies, and patients are cared for based on priority**.**

5.1.4. After examining the patient and immediate resuscitative and stabilization care, the Duty Medical Officer (DMO) shall contact the Resident Medical Officer/Consultant on-call in the relevant specialty by means of the telephone and inform the Doctor on call in the relevant **specialty. Duty**

Medical Officer shall apprise the Consultant of the patient's condition and take instructions regarding investigations and treatment.

5.1.5. DMO/Consultant shall fill out the Admission Order Slip if the patient requires admission. A patient is to be admitted only when the Consultant advises admission.

5.1.6. Patients shall be discharged or transferred to the allocated bed at the earliest after screening diagnostic test results are available or earlier if the patient condition so requires.

5.1.7. If required after diagnostic test results are performed and on verification of the test results by the consultant, decisions are made and the patient is shifted to the appropriate ward/ICU/OT for further treatment.

5.1.8. If the patient is advised for observation, they are monitored for a stipulated time frame by the nurses and doctors and on completion if required, they are discharged or advised for admission depending on their medical condition.

5.1.9. If the patient is not willing for admission, a LAMA consent (Leaving against Medical Advise) is obtained**.**

6. Transfer/Discharge of the patient:

6.1.1. All patients coming to the Emergency Department are provided with first aid before transferring them to another centre.

6.1.2. After providing first aid, if the patient care requirement is not available as per the hospitals scope of services, then they are referred to another Hospital.

6.1.3. In case patients are discharged to their home or transferred to another hospital, then a discharge note is provided to them which incorporate the investigation done, their results and the treatment given. The same will be documented in the Emergency nominal register and also transfer register for further reference.

7. Handling Medico legal Cases:

7.1.1. At CSSH, the emergency department receives all the medico legal cases and provides treatment.

7.1.2. The details of the accident is collected and entered in the accident register (3 Copies).

7.1.2.1. One Copy-Handed over to Police

7.1.2.2. Second Copy-To attach with Case sheet

7.1.2.3. Third Copy-Kept in Register

7.1.3. The case is informed to the police station nearest to the site of accident with informed by the emergency department.

7.1.4. The police collect's the accident register copy and a FIR (First Information Report) is booked against the case.

7.1.5. With reference to any medico legal case a wound certificate is issued to the police on request.

7.1.6. If the MLC case patient dies in the Hospital, then, the body is handed over to the Police, along with the original death certificate and death summary and after retaining copies of the same.

7.1.7. If the patient is brought dead by a known or unknown person, it will be treated as an MLC if the situation satisfies anyone of the points mentioned below:

- Assault and battery, including domestic violence and child abuse.
- Accidents like road traffic accidents (RTA), rail accidents, industrial accidents or any other unnatural mishap.
- Cases of trauma with suspicion of foul play.
- Electrical injuries.
- All cases of suspected or evident poisoning or intoxication.
- Cases of unconsciousness where its cause is not natural or not clear.
- Undiagnosed coma.
- Chemical injuries.
- Burns and scalds.
- Sexual offences.
- Criminal abortions.
- Suspected or evident homicides or suicides.
- Attempted suicide.
- Cases of asphyxia as a result of hanging, strangulation, drowning, suffocation etc.
- Custodial deaths.
- Unnatural deaths.
- Death due to snake bite or animal bite – if not well established clinically.
- Fire arm injuries.
- Drug overdose and abuse.
- Cases of suspected self-infliction of injuries or attempted suicide.
- Cases brought dead with improper history creating suspicion of an offence.
- Brought dead cases on suspicion of foul play or deaths occurring within 24 hours of hospitalization without establishment of a diagnosis.
- Cases referred from court.
- Any other case not falling under the above categories but has legal implications.
- Medico-legal case records are preserved permanent or till the case is disposed off in the court.

8. Ambulance Services

- The hospital shall provide ambulance services with emergency medicines and basic life support and outsourced advanced cardiac life support to facilitate efficient and timely transportation of a patient to and from the hospital under the care of trained nursing staff / doctors.

- The ambulance is designed and is appropriately equipped to respond to medical emergencies.
- Ambulance kit with emergency medications shall be checked on a daily basis.
- Our hospital has separate place for parking ambulance.

Retention & Destruction of Medical Records.

5.1.7 The retention period of the medical records is as per the table given below:

S.NO.	NAME & DESCRIPTION OF RECORD	TYPE OF RECORD	MINIMUM RETENTION PERIOD	STORAGE AREA	DISPOSAL METHOD
1.	Inpatient Medical Records	Files	5 years from the date of last visit	MRD	Shredded
2.	Deceased Patient Files	Files	Permanent	MRD	-
3.	Medico Legal Files	Files	Till the case is disposed of in court or permanent.	MRD	-
5.	MLC Register	Register	Permanent	MRD	-
6.	Birth & Death Register	Register	Permanent	MRD	-

After the defined retention periods, the Medical Records staff makes a note of the records that are to be destroyed and obtain approval from the management

Destruction process: