INDIRA GANDHI INSTITUTE OF MEDICAL SCIENCES, PATNA

SOP OF TRAUMA AND EMERGENCY

	Policy/Procedure:-	SOP OF TRAUMA AND EMERGENCY IGIMS, PATNA	
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SOP for Trauma and Emergency Patient Management

1. All patients coming to Emergency will be registered at Trauma & Emergency Counter and sticker will be pasted on Patient Emergency Card.(Patient Emergency Card is attached.)
2. Emergency triage, consultation and management will be done by SR/JR posted in emergency under supervision of consultant on duty.
3. After triage lifesaving treatment should be started immediately for immediate, very urgent and urgent category patients.
4. **Medical or Surgical emergency will be identified and patient will be admitted in Emergency under department of Emergency Medicine.**
5. During initial stabilization, other than T & E team, patient should be attended by the Senior Resident of concerned specialty (Medicine/Surgery/Orthopedics) and patient should be shifted to their ward **within 6 hours** from triage area. Immediate outcome should be recorded on file with time and also prognosis is communicated to the patient attendant.
6. A patient needing other/super specialty care should be promptly attended by the particular specialty SR (within 30 to 60 minutes of call) however, in case of non-availability of such consultation or bed, treatment will continue under the broad specialty (Medicine/Surgery/Orthopedics) till the patient is duly transferred to other specialty. Emergency treatment or admission cannot be denied for non-availability of such specific consultation or bed. General guidelinesfor specialty prioritization are attached below.
7. If the call is not attended within 30 to 60 minutes interval, then the call should be given in the following order to:- a) Senior Resident in Ward b) Specialty Consultant c) HOD d) Medical Superintendent in case of non-compliance. (e) Director (f)
8. In case of non-availability of bed in theward of that particular Specialty/Subspecialty, Medical Emergency patients will remain in Emergency Medicine.
9. All efforts should be made to transfer these patients to departmental wards **within 24 hours,** However, if there is no vacant bed available, emergency patient will get priority for shifting on immediately next vacant bed and patients from OPD cannot be admitted unless they have taken all the patients admitted in the emergency ward and waiting to be shifted.
10. All procedures & case sheet will be same as any admitted patient in other wards and unit or miscellaneous charge will be applicable as per existing system.
11. No serious patient needing admission should remain under observation without admission and proper case notes. Under emergency situations, the emergency SR/Faculty can take permission of the Medical Superintendent to admita seriously ill patient on any vacant bed in the hospital after consultation with particular admitting department.
12. Patients visiting Trauma & Emergency who require only OPD consultation should be directed to OPD during OPD hours. For patients visiting in off hours, emergency consultation will be given on Patient Emergency Card after emergency registration. They should not be admitted and should be disposed after emergency consultation within 1 hours.

13. Trauma Emergency nurse coordinator shall maintain all patient record on Emergency Patient Flow Sheet and will get it verified by T & E Faculty Incharge for the day. Any noncompliance should be highlighted and reported to MS for necessary action. For first month zero reporting is applicable (even if there is no non-compliance, report should be send to MS Office.)
14. All MLC cases should be managed as per protocol on advice of Forensic Medicine.
15. 24 hour Emergency Anesthesia, Laboratory and Radio-Diagnosis service back up is mandatory.
16. Head of the Departments of Medicine, Surgery, Orthopaedics, Neurosurgery & Anesthesia are supposed to nominate their faculty in-charge Emergency (solely for administrative purpose **Emergency Incidence Response Team**). This is different that the faculty on emergency call who will be responsible for clinical services.
17. All emergency surgeries done should be reported daily by the Nursing In-charge OT including emergency LSCS. Similarly, pending emergency surgeries to be reported by the department to MS.
18. Sign in & Sign out time of all emergency surgeries with daily census should be reported to MS Office.

T & E faculty should be ensured by Dr. Saurav Shekhar, Asst. Professor, Dr. Siddharth Singh, Asst Prof, they will works as coordinator of Emergency Medicine Department.

General rules for specialty prioritization

When the patient requires the intervention of multiple departments, call can be given to appropriate departments. Patient will be initially admitted in the primary treating department and subsequently referred to other department as per priority. Broad guidelines for priority decision are as below:-

1. **Multiple injuries:-**In patients with injuries involving abdomen as well as other systems, the general surgical unit on-call would take the primary responsibility of the patient care. A patient with altered sensorium due to head injury will be admitted under Neurosurgery through she/he may be having other system injuries.
2. **Combination of Surgical and Medical Emergency:-**Surgical emergency will be in priority for admission responsibility however the problem of immediate importance should be resolved simultaneously. For example, an impending gangrene in a diabetic may primarily need medical care for the control of diabetes while a thyroid patient with acute abdominal perforation wouldneed immediate surgical intervention.

3. **Medicine versus Medical Superspecialty:-** where the patient requires specific cardiologic, neurologic or gastroenterological therapeutic measures shall be managed by the concerned Superspecialty department.
4. **General Surgery versus Surgical Superspeciality:-** Where the patient requires the specific therapeutic measures related to Neurosurgical, Cardio-thoracic, Surgical Gastroenterology, Pediatric Surgery shall be managed by the concerned Superspeciality department.
5. The above priority decision is only indicative. The emergency, SR, along with SR/Consultant of concerned departments may sit together and decide the priority on the basis of above guidelines. If the priority still remains unsettled the decision of the T & E Faculty will prevail. For any dispute decision of Superintendent shall be final.

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Patient Emergency Card

CR No.....

Patient's Name_____Age/Sex_____

S/D/W/o:_____

CR No:-_____Date_____Time_____

Address:-_____Mob no_____

_____

MLC ☐ Yes

☐ No MLC No_____Police intimation ☐ Yes ☐ No

Prognosis & Management Explained to : Name of Attendant.....

Full Signature of Attendant.....

Doctor's Notes

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Patient Flow Sheet

CR No.....

Patient Name:-

Sl no	Event	Date	Time	Outcome	Person/Name of Dr. & Dept.
1	Registration				
2	Triage initial stabilization & Specialty identification				
3	Transfer from triage area to specific ward (Medicine Emergency ward /Surgical Emergency ward/Specific IPD ward_____)				
4	Procedure/Surgical/Medical in first 24 hrs_____ Details				
5	Immediate outcome (2hrs)				
6	Transfer from MEW/SER to specific wards (_____)				
7	Final outcome (Discharge/Referred/LAMA/ Death				

Verified by On Duty Faculty T & E

Name of Doctor.....

Signature of Doctor.....

Flow Chart: Trauma & Emergency