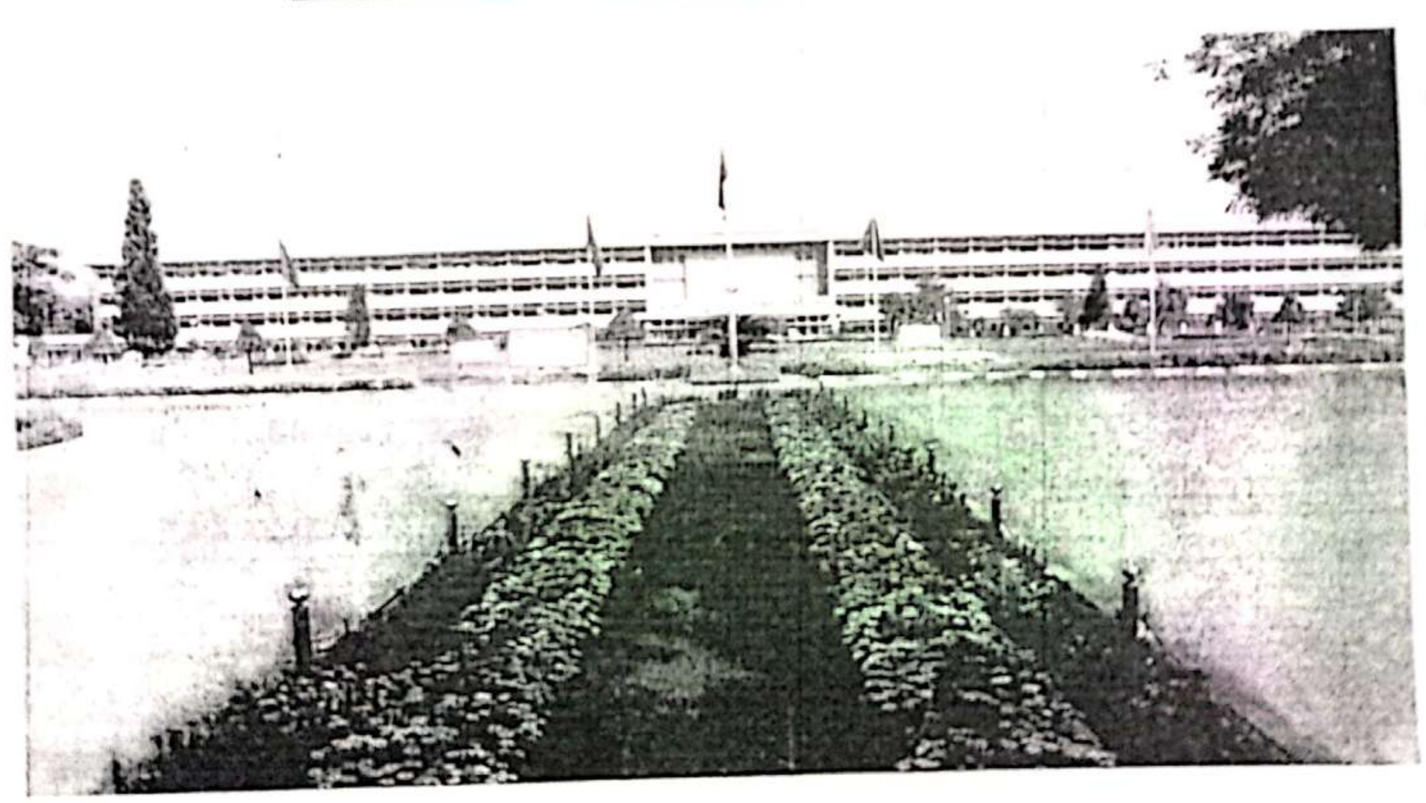
MILITARY HOSPITAL

ARMY MEDICAL CORPS

JALANDHAR CANTT.



SOP :- ADMISSION OF PATIENT

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ACTION TO BE TTAKEN ON RECEPTION AND ADMISSION OF PATIENT

1.All patients for admission to hospital will report at the reception room. These reporting during hospital off hours will be seen by MOI/C room medical officer

2. the examining medical officer will complete AFMS8A and 8B thick and thin flimsy. Brief notes regarding condition on admission and treatment given/ ordered will be entered on the reverse of the flimsy. As far as possible a complete case sheet on AFMS 7A will be written by duty medical officer / asst duty medical officer.

3.He will also record o the reverse of the flimsy about

-money and valuables deposited

-whether in possession of full kit

-whether in possession of identity card

-whether infectious case necessitating disinfection of kit

4.Patients able to do so,will themselves draw hospital linen from retail stores and deposit their kit inpack stores. Nursing assistant at reception will draw the hospital linenand deposit kit in respect of stretcher cases. Receipt in respect of hospital unconscious or mental patients the hospital linen will be signed by the nursing assistant.

5.Money and valuables will be withdrawn by medical officer in charge and receipt issued. These will be deposited with the registrar and receipt obtained.

Patients will be guided or carried to wards admitted by the reception staff. An acutely ill patient to be accompanied by DMO/JDMO to ICU / acute wards.

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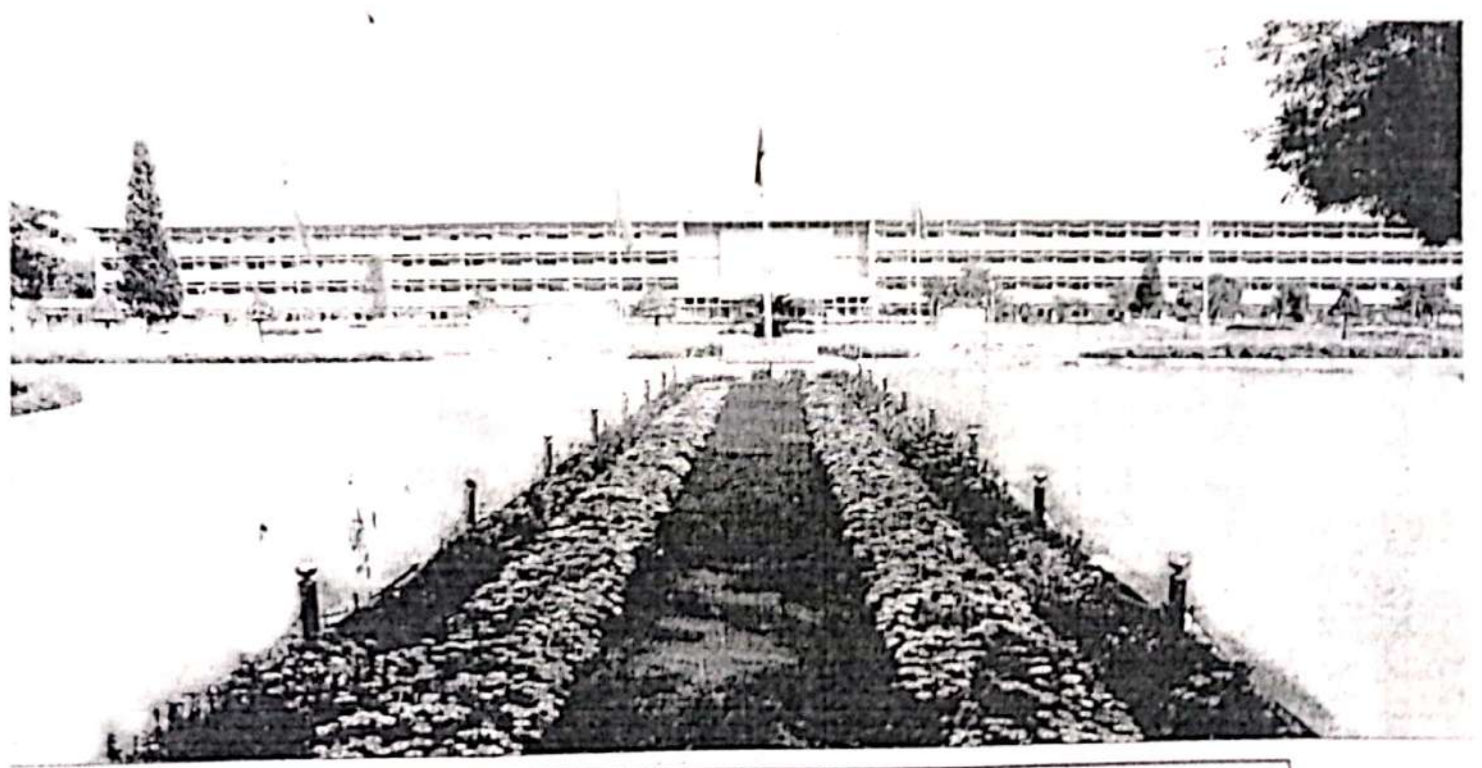

SOP: MEDCO LEGAL CASE

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SOP ON MEDICOLEGAL CASES

1. A Medico-legal Case (MLC) is a case of injury or illness where the attending Medical Officer, after eliciting history and examining the patient, is of the opinion that investigation by law enforcement agencies is essential to establish and fix responsibility for the occurrence of injury or illness in accordance with the existing orders. (Section 39 of Cr PC gives the list of incidents) All medico legal cases must be reported to the police by the medical officer, irrespective of outcome of the incident / inv.

2. **The Medico-legal cases :-**

The following cases are to be registered as medico-legal cases :

(a) Vehicular accidents, factory accidents or any other unnatural mishaps.

(b) Suspected or evident homicides, suicides including attempted ones.

(c) Suspected or evident poisonings.

(d) Burn injuries due to any cause.

(e) Injury cases where foul play is suspected, (if the Medical Officer thinks that the patient is an accused or a victim in a crime, which can have an impact on fitness or lead to disability claim).

(f) Injury cases where there is likelihood of death in near future / the injury is of grievous nature (fractures, life threatening blunt injuries, loss of teeth etc).

(g) Suspected or evident sexual offences.

(h) Unconsciousness when the cause of unconsciousness is not clear.

(j) **Medico-legal deaths**. As a rule the following deaths are reported as ML deaths.

(i) Un-natural Deaths

(ii) Un-identified Deaths

(iii) Un-diagnosed Deaths

(iv) Unattended Deaths (including found dead and Sudden death cases).

(v) Deaths due to industrial occupational diseases, food poisoning etc too are reported as ML deaths as these are not naturally occurring diseases.

(vi) All operation room, labour room and post invasive procedure deaths, where death is directly linked to the procedure.

(k) In addition the attending medical offer may at his / her discretion, declare any case as medico legal as provided in para (1).

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3. **Registration of a Medico-Legal case procedure**

(a) In all medico-legal cases that are not brought by the police, written intimation must be sent to the Police Station in whose jurisdiction the hospital or health care centre reporting the case is located.

(b) Guide lines in the event of MLC

(i) Treatment to be initiated by the MO/DMO as soon as the individual reports or is brought to the MI-Room with total disregard to entitlement to begin with, aim being to stabilise the patient first and to look into other aspects thereafter.

(ii) The case sheet should be written by the MO / DMO attending the case. It should include:-

Personal particulars.
Identification Marks
Particulars of individual who brings / accompanies the patient incl address and tele No.
Date and time of reporting to the hospital.
Brief history to include date and time of incidence, place and mode of occurrence.
Prior treatment received, if any
FIR if any initiated prior to reporting at this hospital.
General & systemic examination with detailed description of injuries.
Diagnosis
Treatment /Resuscitation measures taken to be endorsed in detail.
Inv advised, X-Ray, Inv report to be attached.
Case to be recorded in MLC Register.
MLC initiated to be endorsed in case sheet with the Sr No of MLC and date and time.

(iii) Following to be informed after initiation of MLC.
(aa) Sr Registrar MH
(ab) CO unit of individual.
(ac) HQ 11 Corps (A & Med Branch) Col (DV) Sub Area.
(ad) CMP
(ae) Civil police.

(iv) Disposal of the case i.e admission to ward / referral to concerned specialist and further treatment adv.

(c) Referred/ Transferred cases :- Although legally not mandatory to re-register in the new station, it is advisable to report the case to the local police authorities in the new station to avoid problems if the patient dies at the hospital.

(d) At the time of discharge/transfer/death of the case, the police station with which the case is registered as MLC should be informed.

(e) Battle casualties and casualties on classification at field firing ranges will not be reported . Ref SAO 6/S/2000.

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4. **Hospital death of medico-legal case.** Should a case admitted and reported to the police as MLC die in the hospital, the dead body should be sent to the mortuary and intimation regarding death should be sent by the hospital administration to the police. Under no circumstances the dead body should be handed over to relatives directly. The concerned police officer (IO) will take over such a body for inquest and will hand over the body to the relatives only after the decision that the same is no more required for any investigation / examination by the police.

5. **Action to be taken in a case of Medico legal death in MI-Room.**

(a) All 'Found Dead' cases are Medico legal cases even though the death could be due to natural cause. Unless the police inquest/ coroner's inquest / military court of inquest, rule out the element of suspicion of foul play, the dead body can not be handed over to the next of kin of deceased for further disposal.

(b) Guidelines for reference in the event of Found dead / sudden death cases :

(i) Resuscitative measures to be initiated by MO attending the case before declaring found dead.

(ii) ECG tracing may be taken if facility for same exists, however, it is not mandatory.

(iii) Death certificate (AFMSF-93) Part-I to be completed by MO / DMO in r/o deceased with complete details, viz personal particulars, date & time of declaring death, diagnosis (Found dead – Cause unknown), duly signed & stamp affixed.

(iv) Case Sheet in respect of deceased to be made by MO / DMO. The following salient points to be endorsed in case sheet :-

(aa) Personal particulars of individual.

(ab) Identification marks of individual.

(ac) Personal particulars and address of the person who brought the dead body.

(ad) Date & time brought to MI-Room.

(ae) Brief history viz date and time of occurrence, place of occurrence and mode of occurrence / accident.

(af) General & systemic examination with specific attention to injuries, bite / fang marks, any significant ante mortem findings etc.

(ag) Resuscitative measures carried out to be endorsed in detail.

(ah) Declared dead at _________ on ________. Death certificate on AFMSF- 93 Part –I.

(aj) Diagnosis - Found Dead (Cause Unknown)

(ak) MLC initiated to be endorsed on case sheet with Sr No of MLC with date and time

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Police auth. ... for safe custody till handed over to

(c) Following to be informed after initiation of MLC :-

(i) Sr Registrar MH
(ii) CO Unit of the indl
(iii) 11 Corps HQ ('A' Br & Med Br) Col (DV), Sub Area
(iv) CMP
(v) Civil Police

(d) Body should be handed over to civil police by CWM for getting the post mortem conducted in civil hospital. Proper handing taking over of body will be ensured in all cases.

(e) In case safe keeping of mortal remains in mortuary after post mortem / embalming is required, pending arrangements for handing over to NOK / tpt to native place, request for same, duly signed by CO of individual unit will be furnished to MH, alongwith death certificate of the deceased. In case embalming is required for tpt of mortal remains, requisition for embalming, duly signed by CO of unit of individual, to be given to service hospital for necessary action.

(f) The following documents will be handed over to the stats section for processing of fatal case documents.

(aa) AFMSF- 8B (Admission flimsy)
(ab) AFMSF- 7A (Case Sheet)
(ac) AFMSF- 93 Part – I (Death Certificate)
(ad) Handing Taking over certificate of the dead body.
(ae) Post mortem report / Police clearance certificate.
(af) Any other relevant documents (Inv reports, X-Ray, CT, MRI report).

(g) In case of medico legal death cases of dependents / others , the NOK will take over the body from the police.

(h) The dead body to be removed from MI room and kept in mortuary. This may ot be consistent with the legal practice, since when the death occurs under unnatural, unexplained and unexpected circumstances, the dead body is not to be removed until and unless police has investigated the circumstances of the death. However for the morale of troops, it is better that the dead body is shifted from MI-Room.

(j) The police holds and inquest (Panchnama). The pachnama gives the opinion and the disposal of the body in the following manner :-

(k) There is suspicion of foul play and dead body is sent for post-mortem examination.

(l) There is no suspicion of foul play. Dead body can be handed over to the relatives for further disposal.

(m) In case post-mortem is mandatory and could not be carried out in civil, military court of inquest has to be undertaken (AO20/2001/DV).

(n) The procedure for holding Military Court of Inquest is laid down in AO 54 / 75.

(o) On receipt of the order from Presiding Officer, Military Court of Inquest the OC Military Hospital will issue a written order for the Pathologist / MO to carry out the

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medico – legal autopsy on the dead body and submit a post mortem report to Military Court of Inquest for finalisation.

(p) When the dead body is handed over to police for inquest, a certificate is to be obtained from police stating the fact that the police authorities have taken over the dead body. When the dead body is handed over to the relatives, a certificate to be obtained from relatives that the dead body has been received by the relatives.

6. **Documentation.** The fatal case documents will consist of

(a) (i) **Original Set**

(i) Death certificate (AFMSF-93 Part-I)

(ii) Medical Case Sheet (AFMSF-7A)

(iii) Flimsy Card (Thin) (AFMSF-8B) 'BROUGHT –IN DEAD' written on top in RED INK.

(iv) Postmortem / histopathology / Chemical Analysis report if available.

(v) Any other relevant documents.

(b) (ii) **Duplicate Set**

(i) Death certificate (AFMSF-93 Part-I)

(ii) Medical Case Sheet (AFMSF-7A) Typed copies

(iii) Attributability Certificate (AFMSF 93 Part II)

(iv) Postmortem / Histopathology / chemical Analysis report

(v) Copy of C of I, if any

(vi) Any other relevant documents

7. Disposal of fatal case documents to be done in accordance with Army HQ, Med Dte letter No 11952/Pol/DGMS-5(A) dated 26 Mar 76.

(a) A rep from the individual unit will take over the body from civil police after post mortem is conducted. Authority letter for same will be furnished by unit, duly signed by CO unit of individual. Proof of identity of unit rep authorized to receive body of the deceased will also be furnished by them to civil police at the time of handing / taking over of body. A certificate has to be obtained from unit rep that they have taken over the body from the police. (Handing / Taking over certificate format att as Appx ___),

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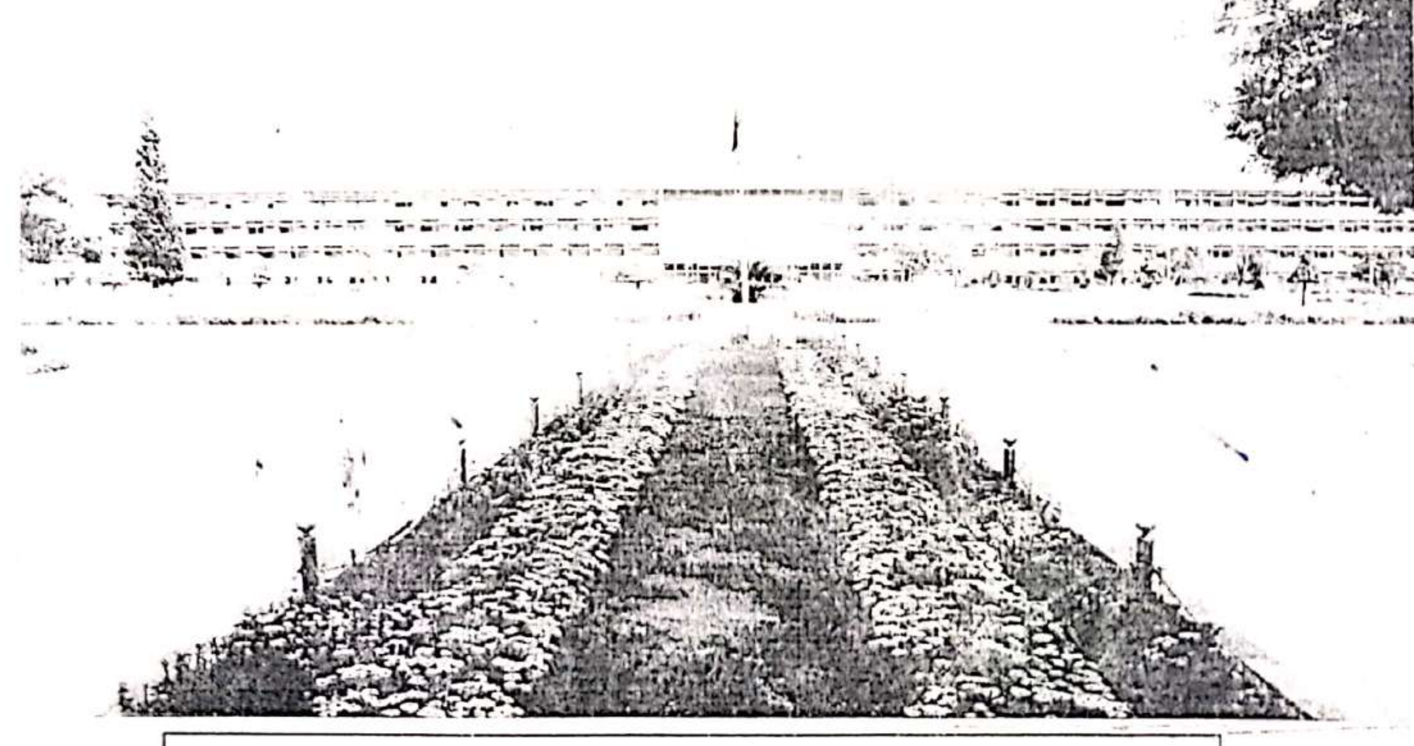

SOP: BIO MEDICAL WASTE MANAGEMENT

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SOP

BIOMEDICAL WASTE (BMW) MANAGEMENT

MILITARY HOSPITAL JALANDHAR

Introduction

1 Biomedical waste means any waste which is generated during the diagnosis, treatment or immunization of human beings or animal or in research activities pertaining there to or in the production or testing of biological fluids and including human anatomical waste, microbiology and bio-technology waste, waste sharps, discarded medicines, cytotoxic drugs, solid waste, liquid waste, chemical waste etc. Govt of India has issued a Gazette notification in this context dt 28 Mar 2016 laying down the rules for management of biomedical waste generated by the hospitals. This SOP lays down the policy of Military Hospital Jalandhar, which is scientific and ecologically sound and it also meets the legal requirements of the Gazette Notification.

2 Military Hospital Jalandhar is a multi specialty hospital. Biomedical waste is produced from all the Wards/ Depts including the OT, ICU, Pathology Laboratory, Radiology Dept, MI Room and OPDs, MDC, 11 CDU, ECHS Polyclinic and all MI Rooms of Stn.

AIM

3 The aim of this SOP is to :-

(a) Educate all the staff about the importance of the scientific disposal of hospital waste.

(b) Lay down ground rules to be followed in the hospital to implement the guidelines for proper disposal of hospital generated waste.

(c) Implementation of safety measures and prevent infections of all those involved in handling of hospital waste.

(d) Reduce incidence of hospital acquired infections and thus further prevent bacterial antibiotic resistance.

(e) To give the hospital campus a clean, hygienic and aesthetic look.

Classification of Hospital Waste

4 The hospital waste will be classified as under:

(a) General Waste In spite the general concept, 80-85% of the waste generated in a hospital is non-infectious or general and can easily be managed, if segregated properly at source and can be disposed off along with other house hold waste. General waste includes items like papers, cardboard, plastic, kitchen waste etc.

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(b) Infectious Waste: Beside general waste, a hospital also generates highly infectious and hazardous waste. This waste, though small in quantity (10- 15%), is the primary cause of concern. Pathological waste including body parts, body fluids, soaked dressing, placenta etc. are highly infectious and must be segregated. Such waste is treated by incineration/microwave or autoclaving.

(c) Infectious Plastics: Disposable items like syringes, tubes, gloves, IV sets and IV bottles are to be segregated in a red container, autoclaved and then shredded. Plastic should never be incinerated, as their incineration can emit dioxins and furans. Dioxins and Furans are carcinogenic.

(d) Sharps: Sharps are the most dangerous content of hospital waste that can injure the health care workers and all those coming into contact with hospital waste. Sharps can be metal needles, surgical blades and scalpels need to be segregated. Needles, blades, scalpels are to be chemically disinfected by 1% hypochlorite solution before disposal. Metal sharps are put into metals sharps container.

(e) Glass ware: Glass ware can either be ampoules, vials and chemical bearing glass container need to be segregated separate container containing detergent solution to be soaked and wash and then chemically disinfected by 1% sodium hypochlorite solution.

5 **Quantum of Waste.**

Quantum of waste generated in hospital varies depending upon type of health problems, care provided and the waste management practices of the hospital. It is estimated that approx 1 to 2 kg of waste is generated "per patient per day". All wards/depts., will ensure that the colored poly bags containing the segregated waste will be securely tied, marked, labeled (as per appx 'O' to DGAFMS) and placed into the appropriate colored drums on the respective kerb point/site.

Organization

6. **Commandant**. will be responsible for the implementation of the various provisions under the rules of BMW in the hospital. He will ensure the following:-

(a) To make the application form
(b) To make annual report
(c) To report any accident in his hospital
(d) To appoint a BMW management committee and review from time to time.

7. **Biomedical Waste Management Committee.**

(i)	Commandant	-	Chairman
(ii)	Senior Registrar	-	OIC
(iii)	Senior Advisor (Pathology)	-	Member
(iv)	Principal Matron	-	-do-
(v)	QM	-	-do-
(vi)	OC SHO	-	-do-
(vii)	JCO I/C Health	-	-do-

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8 **Function of Biomedical Waste Management Committee**

The committee will ensure the following aspects

(a) • Segregation of waste at source

(b) Ensure timely collection, storage, labeling (as per Appx N & O of DGAFMS), transportation of the waste to the site of final treatment and disposal point

(c) Maintenance of waste registers-weight and category wise.

(d) Maintenance of record of point of generation, kerb collection point, final treatment and end disposal point using appropriate forms (Appx 'P' of DGAFMS)

(e) Increase of awareness of the rules among all person and bring about an attitudinal & behavior change among the hospital staff for observation of universal precaution and practices in BMW

(f) Use of protective clothing by health care workers who are involved in BMW mgt

(g) Identity, procure and supply the quantity of consumables such as colored containers bags, mask, trolley clothing etc.

(h) Health & safety measures for health care workers.

(j) Bio-Medical Waste management committee should meet at least once in six month and minutes submitted with Annual Report

9 **Health and Safety of health care workers.** Waste management committee will ensure health and safety measures for health care workers as under:

Precaution for waste handlers

(a) All health care workers, especially Nursing Officers and Nursing Asst will wear double gloves while handling infectious waste and sharps

(b) All Housekeepers will be provided with gloves, masks, gum boots, apron and eye shield to safeguard against infectious wastes.

(c) All health care workers who deal with infectious wastes will be vaccinated against Hepatitis B, Typhoid and TT. Post exposure prophylaxis and surveillance register will be maintained by MO I/C MI Room

10 **Duties of MO and Nursing Offrs In charge Ward/Depts**

(a) All wards/depts will demand plastic bags in advance from QM office and have at least reserve stock of three weeks available at all times.

(b) Ensure availability of colored bins of Red, Blue, Cardboard boxes with Blue colored marking, Yellow & White (Transparent).

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(c) Each bin will have inner plastic bags of same color to facilitate removal of the waste.

(d) The waste will be segregated into appropriate colored containers.

(e) Each ward/depts will account for the biomedical waste generated/disposed off by using appropriate forms (Appx P)

(f) All ward will be provided with needle destroyer as auth. All syringes and needles will be destroyed after use.

(g) All sharps waste like needles, blades etc will be disinfected with 1% hypochlorite solution in a transparent/PET container. The contact period with the disinfection should be at least one hour. The hypochlorite solution will be changed every day.

(h) All glassware either broken or discarded will be segregated separately in blue containers, and disinfected by soaking, cleaning with detergent and 1%sodium hypochlorite solution.

(j) All infected plastic waste like IV sets, blood bags, catheters, gloves etc will be disinfected with 1% hypochlorite solution in a Red colored bags. The contact period with the disinfection should be at least one hour. The hypochlorite solution will be changed every day.

(k) Polybags placed in a bin will be changed when they are full. They are then tied up properly labeled (as per Appx 'O' DGAFMS) and disposed off to kerb points.

11. **Duties of Housekeeping Staff**

(a) All buckets will be cleaned thoroughly with soap and clean water by housekeeper immediately after clearance.

(b) Soiled linen and clothing coming out of the OT and Labour room will be disinfected with 1% Hypochlorite solution prior to sending to the laundry.

(c) Poly bags placed in bins will be changed when they are full. They are then tied and labeled up properly and disposed off to kerb site drums of their respective kerb points.

(d) All IV bottles, IV sets, Blood bags, catheters and gloves etc should be mutilated with the help of scissors at segregation points.

12. **Duties of QM**

(a) QM will ensure procurement of adequate number of buckets and bags for early and timely replacement.

(b) QM will arrange to procure the specified plastic bags and buckets in adequate quantity.

(c) The bags will be of non-chlorinated and high density polythene.

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Bio-degradable bags/Buckets/Containers/Colour code

13. It is of utmost importance to identify the waste material and segregate it correctly. Colored bio-degradable bags are provided from the QM office and they should be used appropriately as per the color code mentioned below. The buckets/waste bins in which these bags are put should also belong to the same color. The types of containers for various waste mentioned in Para 4 above as under:

BIOMEDICAL WASTE CATEGORIES AND THEIR SEGREGATION, COLLECTION, TREATMENT, PROCESSING AND DISPOSAL OPTIONS

Cate-gory	Type of waste	Type of Bag or Container	Treatment	Disposal
(1)	(2)	(3)	(4)	(5)
Yellow	(a) Human Anatomical waste	Yellow colored bucket and non-chlorinated plastic bags	Incineration	Ash pit
	(b) Animal Anatomical waste (not applicable)	-do-	- do-	- do –
	(c) Soiled Waste	-do-	- do-	- do –
	(d) Expired or Discarded Medicines	-do-	To be returned back to the manufacturer or supplier for incineration at temperature >1200° C	- do –
	(e) Chemical Waste (Non liquid chemicals waste and discarded disinfectants)	-do-	Incineration	-do-
	(f) Chemical Liquid Waste	Separate collection systems	Pre treatment with 1% Sodium hypochlorite	Discharge into STP
	(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid.	Non-chlorinated yellow plastic bags or suitable packing material	Non chlorinated chemicals disinfection (Cresoli Liquid black 5%) then incineration	Ash pit
	(h) Microbiology, Biotechnology and other clinical laboratory waste.	Yellow colored bucket and non-chlorinated plastic bags	Pre-treat to sterilize with non chlorinated chemicals disinfection (Cresoli Liquid black 5%) then incineration	Ash pit

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Red	**Contaminated solid waste (Recyclable)**	Red colored bucket and non-chlorinated plastic bags	Pre treatment with 1% Sodium hypochlorite then Autoclaving/ Microwaving, Shredding	Treated waste to be sent to registered or authorized recyclers
White (Translucent)	**Waste sharps including Metals**	Puncture proof, leak proof, tamper proof containers	Pre treatment with 1% Sodium hypochlorite then Autoclaving or dry heat sterilization.	Sanitary land fill or designated concrete waste sharp pit.
Blue	**(a) Glassware**	Cardboard boxes with blue colored marking	Soaked and washed with detergent solution then treatment with 1% Sodium hypochlorite solution then Autoclaving/ Microwaving.	Treated waste to be sent to registered or authorised recyclers
	(b) Metallic body Implants	-do-	-do-	-do-
Green	**General non infectious waste**	Green colored bucket and non-chlorinated plastic bags	Nil	In cantt board dustbin.
Black	**Food waste**	Black colored bucket and non-chlorinated plastic bags	Nil	Sell to auth vendors

- All infected plastic/rubber waste should be disinfected with 1% hypochlorite or bleaching solution (10gmX 1 Ltr water) or 5% Dettol or Cresol Liquid Black.

14. Precautions must be taken by all staff handling infectious biomedical waste:

(a) Blood, body fluids, and tissues of all patients should be considered potentially infectious and precaution taken against them accordingly.

(b) Personal protection in the form of thick rubber gloves, face mask, water proof gowns and boots (long boots) should be worn by all staff handling or transporting infectious waste. Eye glasses will be worn when anticipating splash of blood/body fluids.

(c) Special care must be taken when handling sharps (needles, blades, broken ampoules and broken glass).

(d) Sharps should be collected and transported in puncture proof containers.

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(e) Hands or skin contaminated with blood, body fluids or waste should be washed immediately with soap and water.

(f) All staff handling biomedical waste will be immunized against tetanus, typhoid and hepatitis.

15. **Further Disposal** Waste will be transported from the point of generation in the wards/departments on daily basis to the designated kerb collection areas in covered hand trolleys or suitable motor vehicle. The trolleys will be carried by dedicated and designated staff, who are provided with personal protective gear like heavy duty gloves, masks and apron. Larger containers with similar color code will be kept at area kerb sites for collection of waste bags from various wards and departments and storage for final treatment/ disposal by incineration/deep burial/shredding, as applicable.

(a) **Segregation.** All ward/dept will ensure proper segregation of hospital waste.

(b) **Kerb.** All segregated waste will be put in to their respective kerb point.

KERB SITE NO	LOCATION	CATCHMENT AREA
KS1	Behind Blood bank	OPD Complex, Maty Ward and Labour Room, Lab, NICU, Psy I
KS2	First Floor Adjacent to Ramp	Family Wards, Cardiology, ICU, Surg I, OT, Psy II
KS3	Second Floor Adjacent to Ramp	Med Wards, Dialysis Centre, Paediatric Ward, Surg Wards
KS4	Third Floor Adjacent to Ramp	Dermatology, Surgical Ward IV

16. **Central Garbage Point.** A central garbage collection point already exists at Health Sec of this hospital. The bags will be disposed as under:-

(a) Green bags will be collected by the station garbage/ cantonment vehicle.

(b) Daily garbage disposal is to be ensured.

(c) Periodic spraying will be done to avoid fly and other insects breeding.

17. **Transportation.** The bags from the kerb sites will be lifted by the Housekeeper through trolley to the disposal area (Disposal room).

18. **Disposal Room.** All bags will be collected from kerb point to be kept in disposal room for further disposal to microwave, incinerator and deep burial.

19. **Final disposal.** Final disposal will be made as per accepted guidelines on the subject in column 5 of para 13.

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20. **Incineration.**

(a) The yellow bags collected from disposal room will be incinerated in incinerator.

(b) Approx 60 kg hospital waste will be required to operate the incinerator.

(c) The incinerator will be fired from 1000 hrs to 1300 hrs.

(d) The waste will be charged in the incinerator under the guidance of operating staff (MES).

(e) The ash from the incineration will be collected by MES rep/Housekeeper and buried in secured land fill to be made ready for the purpose.

(f) The process of incineration including disposal of ash will be supervised by JCO/NCO I/C Health of hospital.

(g) The maintenance of incinerator will be done by the MES.

21. **Microwave.**

(a) The Red bags collected from disposal room will be disinfected in microwave.

(b) The microwave will be operated from 1100 hrs to 1300 hrs.

(c) The disinfected plastic waste will be weighted and entered in record book.

23. **Shredder.**

(a) The disinfected plastic waste will be crushed in shredder.

(b) The shredder waste will be weighted and kept in separate room for selling to authorized vendors.

24. **Conclusion.** The above guidelines have been framed to ensure effective implementation of govt policy on handling of biomedical waste.

Auth: (a) Gazette Notification of India Ministry of Environment, Forest and climate change dated 28 Mar 2016.

(b) IHQ MoD Army letter No -3548/1(d)/BMW/DGAFMS/DG-3A dt 10 Dec 2016 and DGMS letter No 76910/DGMS/MS-5(B) Policy/2017 dt 31 May 2017.

Military Hospital Jalandhar

Dated: Jan 2018

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SOP: PROVISION OF MEDICAL CARE

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SOP: PROVISION OF MEDICAL CARE

INTRODUCTION

1. The basic function of a medical facility is to provide comprehensive medical care to patients. In the case of military hospital, this medical care is provided to entitled serving personal and their dependents, veterans and their dependents (ECHS/Non ECHS members). However, irrespective of entitlement, all emergency cases are to be attended to in MHs as provision for the same exist in DSR and RMSAF.

AIM

2. The aim of this SOP is to lay down the guidelines for providing medical care to all patients including emergencies reporting to MH Jalandhar, irrespective of entitlement during/after working hours and disseminate the same to rank and file of this hosp.

REPORTING OF PATIENTS

ROUTINE CASES

3. When a patient reports to the MI Room/ Reception of this hosp during working hours, the following action will be taken based on clinical condition of the patient -

(a) Patient or his attendants will be requested to register the patient for consultation.

(b) The entitlement to treatment will be checked by the paramedical staff on duty in MI Room.

(c) Pending turn for consultation, the patient and his attendant will be asked to wait in the designated waiting area.

(d) The patient will be attended to by the medical officer on duty in MI Room as per his/her turn.

(e) After consultation, patient will be directed by paramedical staff to appropriate dept for collection of medicine & undergoing investigation, as advised by medical officer

(f) Queries, if any, related to review/treatment will also be addressed by paramedical staff/medical officer as applicable.

(g) **In case dependent card/ECHS card is not available with dependent** -

(i) Patient will be attended to by the medical officer and treatment provided. However, he/she will be advised to report with requisite documents on next visit in case only OPD treatment is required.

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(ii). In case patient requires admission, he/she will be admitted as a welfare measure. A sum of Rs 5000/- will be deposited by the patient/attendant as security deposit pending receipt of valid dependent card (Detailed SOP laying down guidelines for admission of patients against security deposit is already available in hosp for ready ref). In case patient is unable to provide security deposit, action to be taken is also outlined in SOP referred to above. Under no circumstances will the patient be denied treatment /admission on account of inability to furnish valid entitlement docu to avail medical treatment in service hospital /Security Deposit instantly.

(h) **Veterans and their dependents (Non ECHS Members)** Action to be taken as outlined in para 3 (g) (i) & (ii) above for outpatient and inpatient treatment respectively.

(j) **Veterans and their dependents (ECHS Members):** The existing policy for provision of treatment to ECHS members and their dependents entails their referral to service hospital through ECHS polyclinics for consultation/treatment /inv. However, on no account will they be mistreated /not attended to in the absence of requisite referral. The medical officer on duty in MI Room will use his/her discretion in providing requisite assistance to the patient to tide over the immediate problem. In addition, these patients will be advised to report through proper channel in future. This will be recorded in their docu for info of all concerned.

EMERGENCY CASES

4. All emergencies brought to MI Room will be attended to by the staff on duty with alacrity, irrespective of entitlement. Immediate life saving measures will be initiated to tide over the immediate medical/surgical crisis. Documentation and establishing bonafides for entitlement to treatment in service hosp will be accorded secondary consideration in these cases. Further course of action by the staff in MI Room will based on following criteria:-

(a) **Entitled personnel** They will furnish proof of entitlement to medical treatment as applicable:-

(i) Serving personnel and their dependent - Dependent card, identity cards etc

(ii) Veterans and their dependents (ECHS members) ECHS Smart Card

(iii) Veterans and their dependents (Non ECHS members)- Discharge book, PPO number.

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admission of patient against security deposit who is already available in hosp. will be adhered to.

(c) In case patient though entitled is unable to not only furnish entitlement docu but also security deposit, he/she will be admitted as an emergent measure after permission from Comdt MH. Relevant docu/ security deposit will be obtained from the patient/his relatives subsequently.

5. Due care will be taken to ensure veterans and their dependents who are ECHS members are not denied admission in service hosp on pretext of their being also entitled to treatment in empanelled hosp. In case they are tfr/refd to empanelled hospital for further management, all requisite assistance including providing ambulance for transporting patient will be provided by MI Room.

6. **Non entitled personnel.** In case of non entitled emergency reporting to MI Room, he/she will be provided requisite treatment. Subsequently, the patient will be referred to civil hospital for further management. Amb will be provided for transporting these patients to civil hospital. However, if the patient is unfit to withstand the journey to civil hospital, he/she may be admitted as non entitled case after seeking permission of Comdt & with concurrence of patients relatives. HSR as applicable for NE cases will be recovered from the patient. Advance security deposit will be taken at time of admission if feasible under circumstances, else same will be deposited by relatives of patient within 24 h of admission.

CONCLUSION

7. The guidelines laid down in this SOP will be disseminated to rank and file in the hospital. They will be implemented in letter and spirit to provide patient care which embodies the ethos of 'CARE WITH COMPASSION'.

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Army College of Nursing
Jalandhar Cantt

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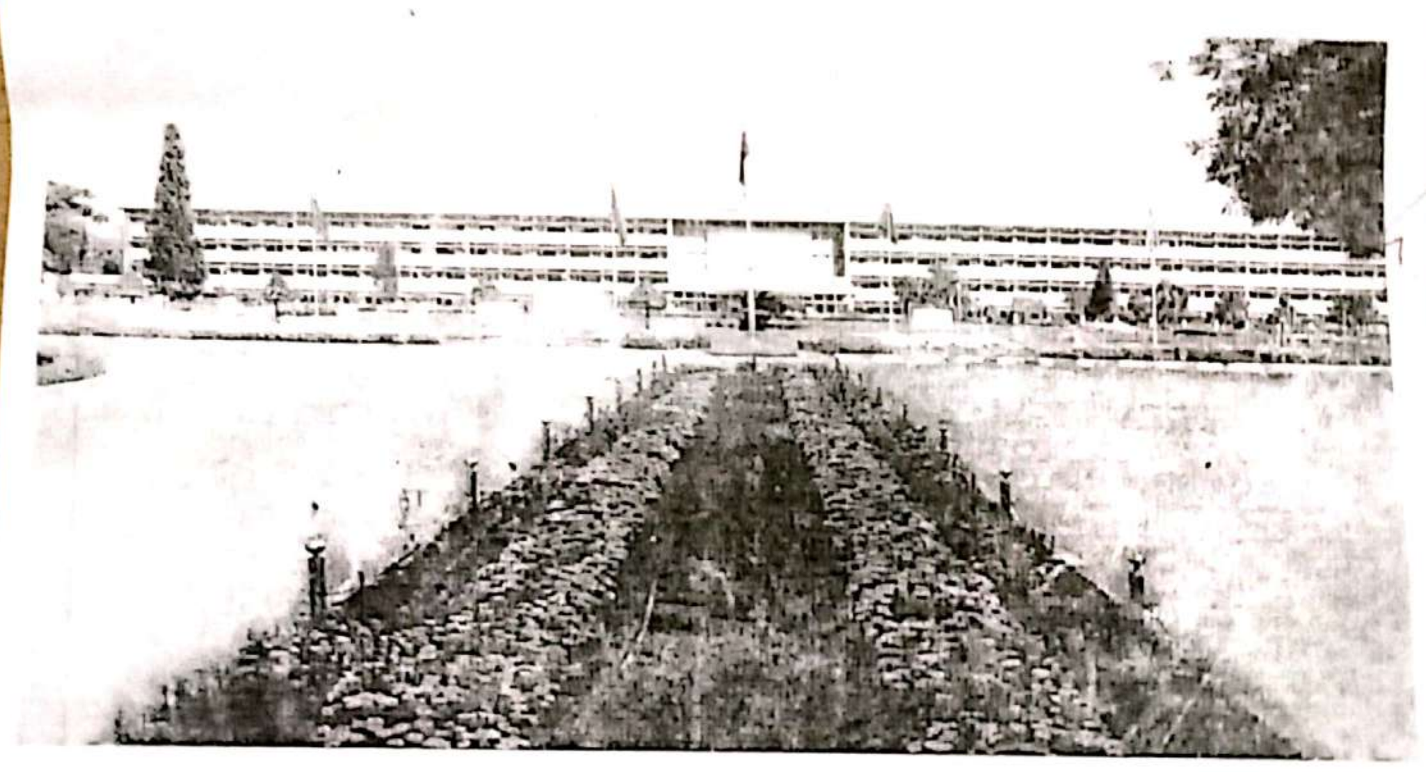
MILITARY HOSPITAL

ARMY MEDICAL CORPS

JALANDHAR CANTT.



SOP: DISASTER MANAGEMENT PLAN

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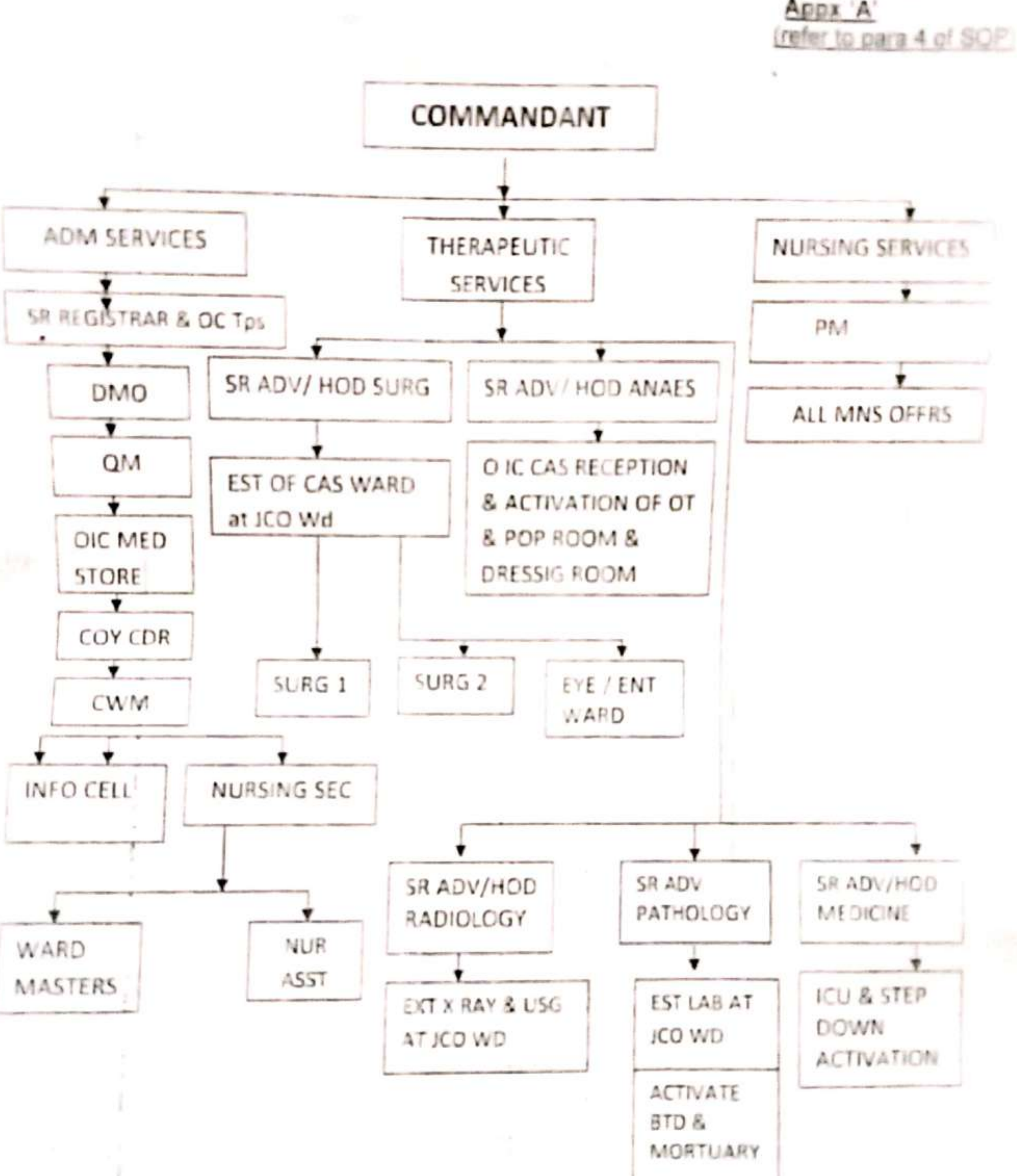
Appx 'A'
(refer to para 4 of SOP)



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Appx 'B'
(refer to para 13 of SOP)

Available med assets around Cas Reception Centre

ADM BLOCK

ASSEMBLY AREA FRO PERSONNEL

MRI CENTRE

CT SCAN CENTRE

MI ROOM

MED STORE

X RAY DEPT

TRIAGE CENTRE & CAS RECEPTION CENTRE

LAB

BTD

QM STORE

NEW OPD COMPLEX

MORTUARY

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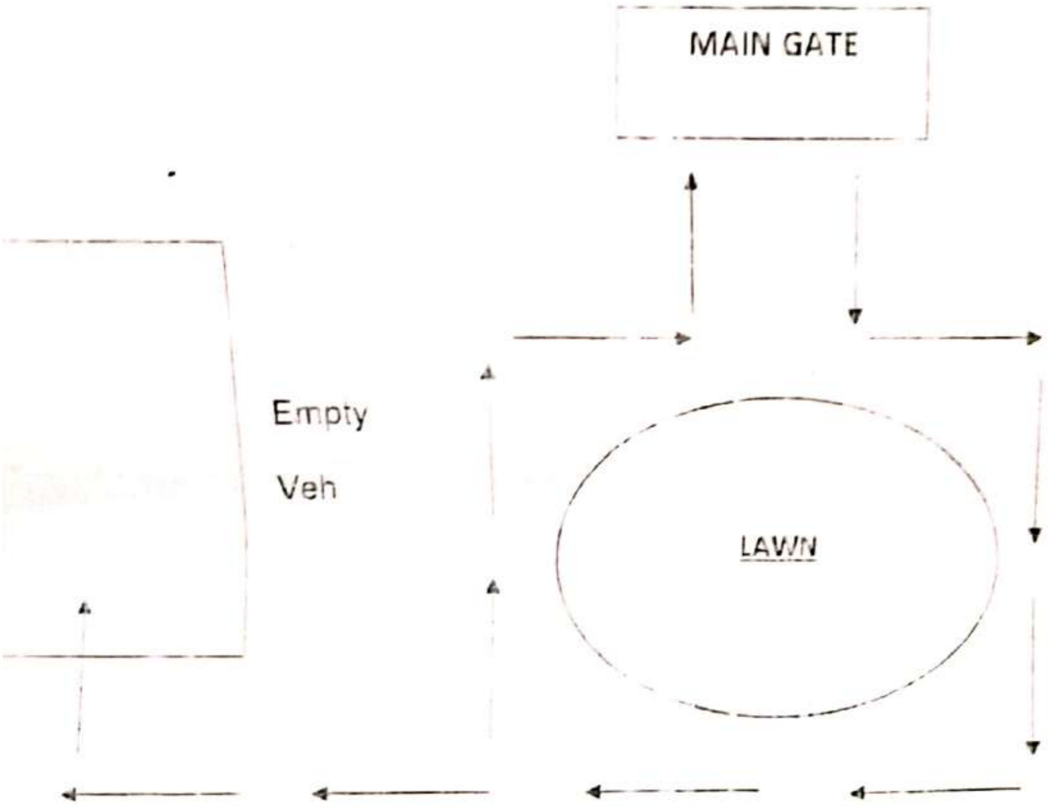
Appx 'C'
(refer to para 14 of SO

ROUTE OF CASUALITY VEHICLE



RECEPTION AT VAJRA HALL

P3 Time

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INTRODUCTION

1. MH JRC is a large multi speciality zonal hospital with 850 beds. It is expected that the hospital must be prepared at all times to receive and deal mass cas of various type at any time.

2. The aim of this SOP is to lay down the disaster plan to be put in place for management of mass cas. Cas recd in NBC environment are excluded from this SOP as, this hospital does not have a cas decontamination centre as yet.

SCOPE

3. This SOP has been prepared to deal with approximately 50 cas at one time. However inherent flexibility and quick flow of cas through the system has been incorporated to ensure more cas can be handed with ease. Ingenuity of the involved staff is required to keep the handling of cas a dynamic process.

4. The distribution of responsibilities and control of manpower is as shown in Appx 'A'.

EXECUTION OF PLAN

5. Receipt of info.

(a) The following are likely to be the entry portal for info about mass cas situation

(i) Comd

(ii) Sr Registrar

(iii) DMO or MO I/C MI Room

(iv) Duty clk

(b) The following contact numbers are available at MI Room :-

(i) Tele Number - 0181-2661800

(ii) Mobile Number - 7347268605

(iii) Army Number - 5611 (DMO) 5511 (JCO I/C)

(c) The receiver of information shall ascertain the following and record it.

(i) Particulars of informant/ Tele

(ii) Place of occurrence of casualty

(iii) Type of occurrence (Blast/earthquake/fire etc)

(iv) Time of occurrence

(v) Distance from hospital

(vi) Approx No of casualty

(vii) Nos being/reqd evacuation to hospital

(viii) Nos of cas arrival at hospital

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(b) **Sr. Registrar and OC Tps** He will ensure dissemination of this information & inform all HsODs and Staff Offrs

(c) **Sr Adviser Surg** He will instruct all surgeons to be available in hospital and ensure their availability at the designated areas as per SOP

(d) **Sr Adviser Medicine** He will instruct all physicians to be available in hospital and ensure their availability at the designated areas as per SOP

(e) **Sr Adviser/HOD Anaesthesiology** He will instruct all anaesthesiologists to be available in hospital and ensure their availability at the designated areas as per SOP

(f) **Sr Adviser/HOD Pathology** He will instruct all pathologists to be available in hospital and ensure their availability at the designated areas as per SOP

(g) . **Sr Adviser/HOD Radiology** He will instruct all radiologists to be available in hospital and ensure their availability at the designated areas as per SOP.

RINGING OF ELECTRIC SIREN

7. By D+2mins the order for ringing the electric siren is relayed to MI room. The switch for the siren is loc at the reception desk of MI Room complex. On hearing the siren all hospital personnel shall assemble section wise on the lawn in front of CT scan centre and await further instructions. Assembly will be completed by D+10 mins.

ACTIVATION OF QRMT

8. Medical team comprising of ADMO, Nursing asst, amb asst and JCO will pick up the QRMT stores kept in QRMT room and move out from MI room in Amb veh to site of cas occurance. This will be accomplished by D+5 mins. The staff will be replaced by nursing staff from JCO ward and Offr ward and stand by amb veh will be positioned in MI room from MT. The med offr on reaching the site will info DMO on mobile about no of cas, severity of injuries and requirement for further amb veh and personnel. He will carry stores to provide first aid to 10-12 cas at the site of accident. The DMO will requisition further QRMT store bricks from the Med store in case required. It is expected that the first cas will reach the hosp by D + 30 mins, by which time the cas reception centre will be active. If required QRMT-1 and QRMT-2 which have been detailed in Part I will be dispatched as indicated by the situation.

ACTIVATION OF SOP

9. Sr Registrar and OC Tps or in his absence DMO will be responsible for activation of SOP. The SOP which envisages est of a cas reception centre will be activated only if more that 15 cas are expected. For situations of less than 15 cas, the existing emergency care services ex MI room and Vajra Hall area will be utilized for the management. Cas Reception centre will not be activated in Psy 1 and crisis expansion ward will not be activated.

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In order to accommodate the sudden influx of patients orderly shifting of patients will be done at the discretion of ward MO as detailed below:-

(a) Patients from Eye / ENT Wd to be shifted to Surg IV. 20 empty beds to created in Eye / ENT ward. 05 beds to created in ICU and 05 beds in Step Down ICU

(b) Crisis expansion ward to be activated to cater to spill over from the other wards during the shifting phase and to treat the walking wounded needing admission

PREPARATION OF CAS RECEPTION CENTRE

13 Overall responsibility of above centre will be with Sr Adv Surgery. The centre will function in the present location of Vajra Hall. 12 x Trolleys will be laid out in Vajra Hall. The available assets are as shown schematically in **Appx B**. The following personnel will be available in the centre as detailed below. Respective HOD viz Surgery, Anaesthesia will detail the offrs and name of designated offr to be maint in duty roster file along with this SOP. The responsibility of detailing the MNS offrs and Ward Sahayikas will be with the PM Chief Ward Master and Adm SM will detail the JCOs/OR and list of such personnel to be attached with SOP. Total 08 teams will be activated at reception for effective & efficient handling of causalities in smmoth manner.

(a)	Surgeon	01
(b)	Anaesthesiologist	01
(c)	Psychiatrist & Dermatologist	02
(d)	Med Offrs /Inters	04
(e)	MNS Offr	08
(f)	NT JCO / Nur JCO	01
(g)	Nursing Asst	08
(h)	ORA	02
(j)	Amb Asst	16
(k)	House Keeper	02
(l)	Ward Sahayika	02

14 Sentries or sign posting will be put up to direct cas bearing vehicle to enter main gate and move in clockwise direction and unload cas at the parking area by the side of PSY-1 ward. The vehicle after disembarkation will move round the hospital and exit without going back toward entry gate. Route of cas entry is as shown schematically in **Appx C.**

15 **Est. of stretcher/Trolley Bay** One Med offr working in MI Room will be overall in charge of Trolley bay. Sec I/C Amb Sec will position available ambulance asst at parking area. Stretcher /trolley bay will be created by mobilizing all available stretcher trolleys and shifting to reception area. 10 stretcher trolleys will be in position by the time the 1st vehicle rolls in. Approx 30 mins time is allotted for est stretcher bay. It will be located in the parking lot of the hospital adjacent to PSY 1 ward

16 **Est of emergency diagnostic eqpt**. Portable X ray, USS machine for bedside USG and CSR capable of doing Hb, PCV and ABO Rh typing will be set up inside the cas reception centre by respective Depts to be active by D+30 mins. HsOD radiology and Lab will be responsible the est of these facilities inside the cas reception centre.

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10 During working hour manpower is readily available. In events outside working hou DMO will inform the following and deploy key personnel as detailed below.

Sr No	Action	Responsibility
1	Alert all section I/C in personnel line to move to assemble area.	Duty Offr, Duty JCO & Duty Clk
2.	Info all nursing offrs to assemble at Vajra Hall OT matron +2 MNS Offrs to proceed to OT 02 MNS Offrs to augment ICU 01 MNS Off react to Surg 1 & 2 Ward 08 MNS Offrs at reception 06 MNS Offrs at JCO Ward 02 MNS Offrs at Eye/ENT Ward	PM
3.	Info BTA, X-Ray Technician, CT Scan, JCO I/C OT, JQM, JCO I/C Med Store. All to move to respective depts.	JCO I/C MI Room
4.	To ensure manpower availability. Erect sign posting kept in disaster store of MI Room. Est seating for relatives and attendants of cas and arrange drinking water at New OPD Complex Direct the sentries to guide the cas bearing veh to Cas reception centre.	Coy Cdr
5.	To be available in hospital for activation of stores.	QM
6.	Ensure timely dispatch of med bricks to MI Room, OT, ICU, JCO Ward, Eye/ENT Ward, Surg 1 & 2	MO I/C Med Store
7.	12 Trolley will be laid out at Vajra Hall and Disaster store boxes kept in MI Room to be opened and laid out	JCO I/C MI Room
8.	To inform respective specialists to be deployed as per SOP.	All Sr Adv/HsOD
9.	Inform Stn HQ, HQ 11 Corps, CO 4011 Fd Amb, FMSD, RMOs College of Nsg, CMP, Civil Police and designated civil medical assets for additional help. List of key personnel and their contact details to be maint in separate file to be available with Duty Clk.	Sr Registrar & OC Tps
10.	To activate & prepare ward for casualities	MO I/C JCO Wd MO I/C Eye / ENT Wd

11 **Time frame for activation of SOP.** The entire process of dissemination of info should be completed in 15 mins. Exchange will be informed to keep lines to MI Room /DMO open. Civil telephone in ICU will be used. DMO Mobile phone will also be used for this

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22. Available personnel will be detailed so that there is no duplication of effort and all patients are attended to without chaos.

(a)	Intern Med Offr/ MO	1 per 5 beds
(b)	MNS Offrs	1 per 5 beds
(c)	NT/Nursing JCO	1 to asst MO I/C JCO Ward
(d)	Amb Asst	1 per 5 beds
(e)	Nur Asst	1 per 2 beds
(f)	ORA	02
(g)	HK	02
(h)	Ward Sahayika	02

23. ENT Surgeon and one Gynaecologist will be made available in JCO ward for resuscitation. Five beds will be readied for advanced cardiac life support (ACLS) and monitoring equipment will be kept available.

24. When a cas occupies a bed the detailed personnel will do the following actions.

(a) Initiate trauma case sheet
(b) Administer Tetanus Toxoid analgesic and antibiotics
(c) Obtain blood for Hb, PCV, ABO/Rh
(d) Start IV access with RL
(e) Start oxygen, if indicated
(f) Arrest hemorrhage, splint fracture, clear air way
(g) Start BT if indicated.
(h) Order portable X Ray if needed. Concerned specialist will address need for CT, ECG or other investigations.

25. **Disposal from JCO ward**. Once stabilized, documented, resuscitated the cas will be disposed as below.

(a) Severely injured requiring intensive care to be shifted to ICU.
(b) Cases requiring surgery to be shifted to OT once called for from OT.
(c) Orthopedic cas to be shifted to Surg -2
(d) Chest, Abd and Head injuries, in stable stage to be shifted to Surg -1
(e) All others to be shifted to Surg 4 and crisis expansion ward

26. **Disposal of dead body**

(a) The officer in charge Mortuary will be pathologist.
(b) All found dead/death in hospital cases will be kept in mortuary.
(c) CWM will prepare necessary documents.
(d) The dead body will be handed over to the next-of-kin/unit after clearance from police/military court of inquest.
(e) The copy of the post mortem will be given to the next of kin at the earliest but not later than seven days after the post mortem.
(f) The copies of the death certificate will be given to unit/NOK.
(g) Any dead body which remains unidentified/unclaimed will be disposed under the orders of station commander/civil police.
(h) The Senior Registrar will approach station HQ for provision of guard for dead bodies and necessary arrangements for funeral.

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17 Asst registrar will be overall in charge of registration. He will be assisted by Civil with 2 clks. The registration cum trauma case sheet initiation will be done in reception area. No patient will be held up after registration. The registration team will move among the patients in the beds and simultaneously register patients. Sample registration form cum trauma case sheet is shown as **Appx 'D'**

TRIAGE

18 Senior Medical Officer as detailed in Part I will be designated Triage Offr. The following categorization and their disposal will be initiated. The patients will be tagged with appropriate colour coded discs around the wrist. 2 nursing asst will be detailed in triage centre to assist the medical officer.

(a) (P-1) Casualty – **Color Code Red**- requiring immediate Resuscitation to be resuscitated at ICU/ JCO Ward and to be shifted to JCO Wd / ICU by lift/ramp

(b) (P-2) Casualty- Color Yellow- requiring immediate surgery to be shifted to JCO Wd / ICU by lift/ramp

(c) (P-3) Walking wounded- **Color Code Green** - with minor injuries not requiring resuscitation to be shifted to Eye/ ENT Wd by ramp only

(d) (P-4) Dead body – **Color Code Black** – to be shifted to mortuary

ACTION IN CASUALTY WARD

19 **Overall in charge of JCO ward will be MO I/C JCO Ward** Thirty beds will be created. Each bed will have IV stand with Ringers Lactate drip connected. IV Cannula tape for securing cannula. 10 ml disposable syringe and specimen bottles. The medical bricks provided to JCO wd will be opened and items laid out as required. Advance information to med stores will be given to mobilize the reserve bricks if the need arises depending on number of cas.

20 The following resources will be kept at easily accessible central place in JCO ward. Two Dressing trolleys will be made available one each from Surg-I and Surg-II. The trolleys will be wheeled to bedside for dressings in JCO Wd :-

(a) Long leg splint x 10
(b) Short leg splint x 10
(c) Long arm splint x 20
(d) Thomas splint x 05
(e) Cervical collar x 10
(f) Triangular sling x 20
(g) Crepe bandages x 50
(h) Gauze drums x 2
(j) Dressing materials

21 Additional medical bricks containing disaster stores will be procured from med Store

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(a) The disaster medical stores as per Appx E' will be kept ... stores itself for QRMT and disaster ward as per Appx 'F' & Appx 'G'

(b) The QM stores as required in cas reception centre will be kept ready in QM store and demanded by OIC of the centre

(c) The Medical stores will keep three bricks of med stores (each brick capable of treating 10 casualties) always ready as in Appx'G'.

(d) The stretcher and few wheel chairs and other ord stores will be kept in stores in disaster ward, for carriage of patients while shifting the ward patients and receiving the cas in the ward.

(e) 50 sets of documentation papers will be kept in box earmarked for med stores.

EST OF INFO CELL

33 Asst registrar will be I/C of info cell. This will be established in New OPD complex Bulletin Board with name of cas, present status, ward No. will be put up and periodically updated. He will also liase with relatives/NOK for dissemination of information.

EST OF WAITING AREA

34 Coy Cdr will est seating and shelter for NOK and relatives at the New OPD Complex, Provision for tea, refreshments and water will be made. The wet canteen and STD booth will be activated to cater to the relatives.

DISASTER MANAGEMENT COMMITTEE

35. The entire disaster preparedness of the hospital will be monitored by this committee. The committee will be detailed by Comdt and will comprise of a senior Medica Officer and a NT JCO The team will confirm availability of disaster stores at designat areas, turnover the stores to ensure there is no wastage, maintain contact details of all th key personnel and ensure regular rehearsals of the disaster mgt drill. When proceeding o lve/TD the members of the committee will be changed as notified from to time in the Pa orders.

(Avinash Das)
Brig
Commandant

Station : Jalandhar

Dated : Sep 2018

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27 **Disposal of Patient Belongings**. All belonging of the patients including valuables will be listed and taken over on a voucher (3 copies) by chief ward master assisted by one SKT. Valuables like cash, gold will be deposited with Asst registrar and a receipt will be made. Copy of voucher will be with the patient if conscious or to be handed over to the next of kin/relative/unit rep. In case no relative/NOK/unit rep is available, the second copy will accompany the case sheet or admission slip. Third copy of the voucher will be the spare copy. Belongings will be handed over to the patient on his discharge from hospital or the same may be handed over to NOK, after verification and obtaining receipt.

OPERATION THEATER

28 On receipt of activation order OIC OT will ensure readiness of OT, POP Room, dressing room. Two Surgeons and two Anaesthesiologists will be available in OT. Emergency stores will be procured from medical store. On completion of surgery patients will be shifted to ICU, Surg-I, Surg-II, Eye / ENT wards as indicated.

ICU

29. The available Medical Specialists will be deployed in the ICU to continue advanced Life support and post operative care. Five beds will be created by shifting patients to acute wards.

DISPOSAL OF CHRONIC/COLD CASES

30. In order to augment bed availability cold cases will be disposed off. Disposal of all surgical cases will be done by Eye Specialist and Gynaecologist. All medical cases will be disposed off by medical spl. All awaiting recat board patients will be discharged with appropriate advice.

MEDICAL STORES

31 **Medical supplies**

(a) Non expendable stores for reception, resuscitation and disaster ward will be collected from medical stores.

(b) Transfusion fluids will be collected from BTD.

(c) **Replenishment of Medical Stores**. OIC medical stores will contact all MOs I/C Wards/Depts after initial issue of medical stores and replenish the IV fluids and other expendable stores with the help of other medical stores staff.

(d) **DISASTER RELIEF BRICKS**. The med stores will prepare and stock one medical brick and one basic surgical brick as defined in DGAFMS note No 44239/DGAFMS/DG-1C dt 31 May 2008. These are meant to cater for 50 **patients** for 7 days and are at the disposal of medical officer detailed to provide disaster relief as part of a medical relief team. These bricks will be moved only on specific instructions from OIC disaster management cell at office of DG (Army). This brick is not to be confused with medical bricks for disaster plan which are meant for use within the hospital.

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NON EXP MEDICAL STORES FOR DISASTER WARD

Sl No	Nomenclature	Qty
1	Portable defibrillator cum ECG monitor	01
2	Cylinder oxygen portable complete	03
3	Oxygen concentrator and Venturi mask with tubing	02
4	Cylinder oxygen 1245 ltrs	10
5	Laryngoscope set complete with different size blades	04
6	Endotracheal tubes all sizes(adult and pediatric)	20
7	Stethoscope	10
8	Laryngeal mask airway (adult and pediatric)	05
9	Oesophageal Obturator airway	02
10	Face Mask (adult and pediatric)	10
11	Bains circuit	03
12	Presser infusor	05
13	Cardiac multiparameter monitor	06
14	BP apparatus	08
15	Infusion pumps	02
16	Apparatus suction electric	02
17	Drum dressing	06
18	Thomas splint	06
19	IV stand	15
20	Ambu resuscitation bag	04
21	Trolleys (dressing & drugs)	03
22	Tray deep size	10
23	Tray kidney shaped	10
24	Tray shallow size	10
25	Tracheotomy set	02

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Appx L
(refer to para 32(a) of S...

EQUIPMENT AND MED STORE ITEMS FOR DISASTER PLAN : QRMT

S No	Equipment	Qty/Nos
1	RL	96 Bottles
	IGS	96 Bottles
	NS	96 Bottles
	5% Dextrose	24 Bottles
	Haemaccel	24 Bottles
2	Transfusion sets	100
3	**Drugs and injections**	
	Inj morphine	20amp
	Inj Pethidine	20amp
	Inj Diazepam	05 amp
	Inj TT	50 Doses
	Inj Voveran	10 Amp
	Inj Hydrocortisone	2 Vials
	Inj Avil	2 Vials
	Inj Adrenaline	5 Amp
	Inj Tramadol	10 Vials
	Inj Gentamycin	15 Vials
	Oxygen Cylinder (Large)	04
	Tab Voveran	50
	Tab Aspirin	50
	Tab Avomine	50
4	**Dressing Material**	
	Bandage 2"	40
	Bandage 4"	50
	Bandage 6"	20
	Abdominal Bandage	10
	Triangular Bandage	10
	Sterile gauze in drums	02
	Vaseline gauze	02 tins
	Sterile cotton in drums	02
	Betadine Lotion	05 bottles
5	**Splints**	
	Thomas splint	04
	Wire gauze splints of assorted size	20

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Appx G
(Refer to para 32(a) of ...

BRICK OF EXPENDABLE MEDICAL STORE : DISASTER WARD

Sl No	Nomenclature	A/U	Qty
1.	Inj Adrenaline	Amp	40
2	Inj Dopamine	Amp	20
3.	Inj Nor adrenaline	Amp	05
4	Inj Vasopressin	Amp	05
5	Inj Mephentine	Amp	05
6	Inj Lasix	Amp	50
7	Inj Nitroglycerine	Amp	05
8.	Inj Atropine	Amp	50
9	Inj Sodabicarb	Amp	50
10	Inj morphine	Amp	50
11	Inj Fortwin	Amp	30
12	Inj Pethidine	Amp	30
13	Inj voveran/Tramadol	Amp	100
14	Inj paracetamol	Amp	50
15	Inj Hydrocotisone	Amp	50
16	Inj Sodium dilantin	Amp	10
17	Ringer lactate	Bottles	150
18	Normal Saline	Bottles	96
19	Hexastarch	Bottles	50
20	5% Glucose IV fluid	Bottles	20
21.	IV sets	Nos	300
22	Intra caths Size 16,18,20,22,24	Nos	100
23.	Inj Cifran	Amp	35
24	Inj Gentamycin	Amp	185
25	Inj Flagyl	Amp	100
26	Inj Ampicillin	Amp	276
27.	Inj Cefaperazone	Amp	30
28.	Inj Cefotaxime	Amp	25
29	Disposable Gloves	Nos	150
30.	Lotion Savlon	Bottles	05
31	Lotion tincture benzoin	Bottles	05
32.	Spirit	Bottles	03
33.	Foleys Catheter all size	Nos	40
34	Triangular bandage	Nos	50
35.	Roller Bandages 15,10,6 cms	Nos	300
36	Crepe Bandage 15,10 cms	Nos	200
37.	Urobags	Nos	50
38.	Central lines	Nos	15
39	Silver S/diazine cream	Jars	02
40	Sofra tulle	Nos	10
41	Syringes 2,5,10,20,50 ml	Nos	300
42	Eye antibiotic oint with eye pad	Nos	25
43	Ryle's tube and suction catheter	Nos	50
44	Chest Tube of all size (18/20 & 28/32/34/36 FG)	Nos	20

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