MILITARY HOSPITAL

JALANDHAR CANTT.

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Military Hospital Jalandhar Cantt

STANDING ORDER FOR BIOMEDICAL WASTE (BMW) MANAGEMENT

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 biotechnology 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

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and can be disposed off along with other house hold waste. General waste includes items like papers, cardboard, plastic, kitchen waste etc.

(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 blue container, autoclaved and then shredded. Plastic should be never be incinerated, as their incineration can emit dioxins and furans. Dioxins and furans are carcinogenic.

(d) Sharps: Sharps are the most dangerous contents 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 metal sharps container.

(e) Glass Ware: Glass ware can be either be ampoules, vials and chemical bearing glass container need to be segregated separated separate container containing detergent solution to be soaked and washed 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 colour 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.**

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(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-

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 and 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 and 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.

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).

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

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

(e) Each wards/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.

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(g) All sharps waste like needles, blades 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.

(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.

(i) 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.

(j) Poly bags 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.

Bio- degradable bags/ Buckets/ Containers/ Color code

13. IT is of a almost 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.

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

Category	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	Municipal land fill/Deep burial
	(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 manufacturer or supplier for incineration at temperature >1200° C	-do-
	(e) Chemical Waste (Non liquid waste and discarded disinfectants)	-do- Separate collection systems	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 (Dettol/Cresoli Liquid black 5%) then incineration	Municipal land fill/ Deep burial
	(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 (Dettol/Cresoli Liquid black 5%) then incineration	Municipal land fill/ Deep burial
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

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White	Waste sharps including metals	Puncture proof tamper proof, leak proof containers	Pre treatement with 1% sodium hypochlorite then autoclaving or dry heat sterilization	Sanitary landfill 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 authorized recyclers
	(b)Metallic body implants	-do-	-do-	-do-
black	General non-infectious waste 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 (10 gram x 1 liter water) or 5% Dettol or cresol liquid black.

14. Precaution must be taken by all staff handing infectious biomedical waste.

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

(b) Personal protection in the form of thick rubber , gloves ,facemask, waterproof 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.

(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.

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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 the personal protective gear like heavy duty gloves, mask and apron. Larger containers with similar color coding 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 wards /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 Points:** 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 infected 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 the kerb point to 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.

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 1300hrs.

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(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.

22. **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.

23. **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 & Climate change dated 28 march 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.

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Appendix O to 3548/19d0/BMW/
DGAFMS/DG-3A 10 Dec 2016

LABEL FOR TRANSPORTING BIO-MEDICAL WASTE BAGS OR CONTAINERS

Day.......................Month....................Year.......................

Date of generation..

Waste category Number....................................

Waste quantity...............................

SPECIMEN

Sender's Name and Address

Phone Number.........................

Contact Person..........................

Receiver's Name and Address

Phone Number.........................

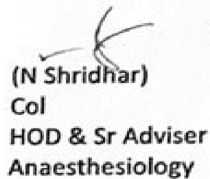
Contact Person.......................

In case of emergency please contact:

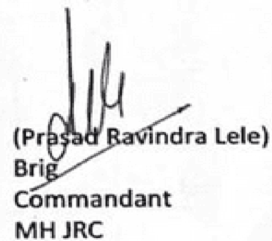
Name and Address:

Phone No:

Note: Label shall be non washable and prominently visible.



(N Shridhar)
Col
HOD & Sr Adviser
Anaesthesiology



(Prasad Ravindra Lele)
Brig
Commandant
MH JRC

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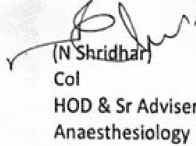
6. Kerb Collection Point:

CATEGORY OF BMW	POINT OF GENERATION			KERB COLLECTION POINT		FINAL TREATMENT ON SITE (MODE OF TREATMENT) /OUT SOURCED			END DISPOSAL POINT		
	No of Bags	Disinfection Done	Sign & Date	No of Bags	Sign & Date	No of Bags	Type of Treatment	Sign & Date	No of Bags	Type of Disposal	Sign & Date

INSTRUCTIONS:

1. THE FORM WILL BE INITIATED IN 4 COPIES AT EACH POINT OF GENERATION OF HOSPITAL WASTE.
2. ONE COPY EACH WILL BE RETAINED AT POINT OF GENERATION, KERB COLLECTION POINT, FINAL TREATMENT AND END DISPOSAL POINT.
3. # RECEIPT OF WASTE/ RECYCLABLE WASTE WILL BE OBTAINED FROM THE CBMWTF/ VENDOR IF OUTSOURCED.



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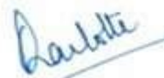

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RESTRICTED

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MI ROOM

SOP: DISASTER MANAGEMENT PLAN

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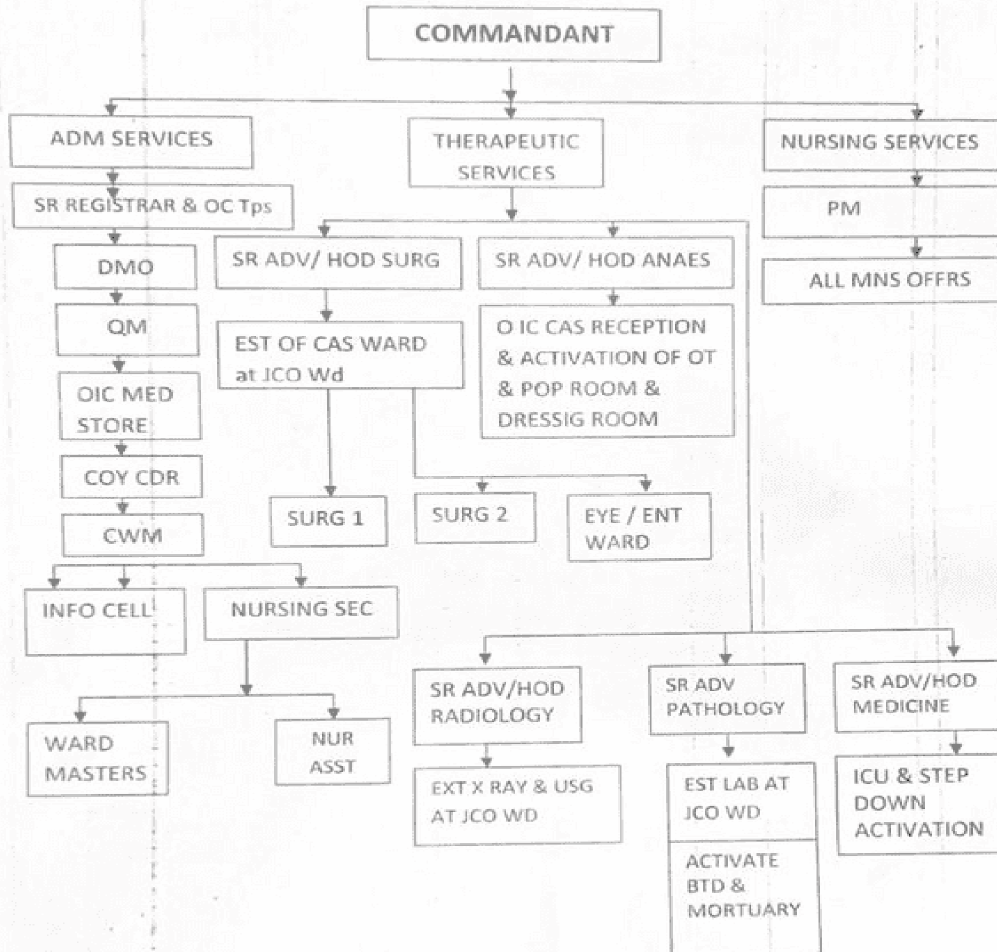

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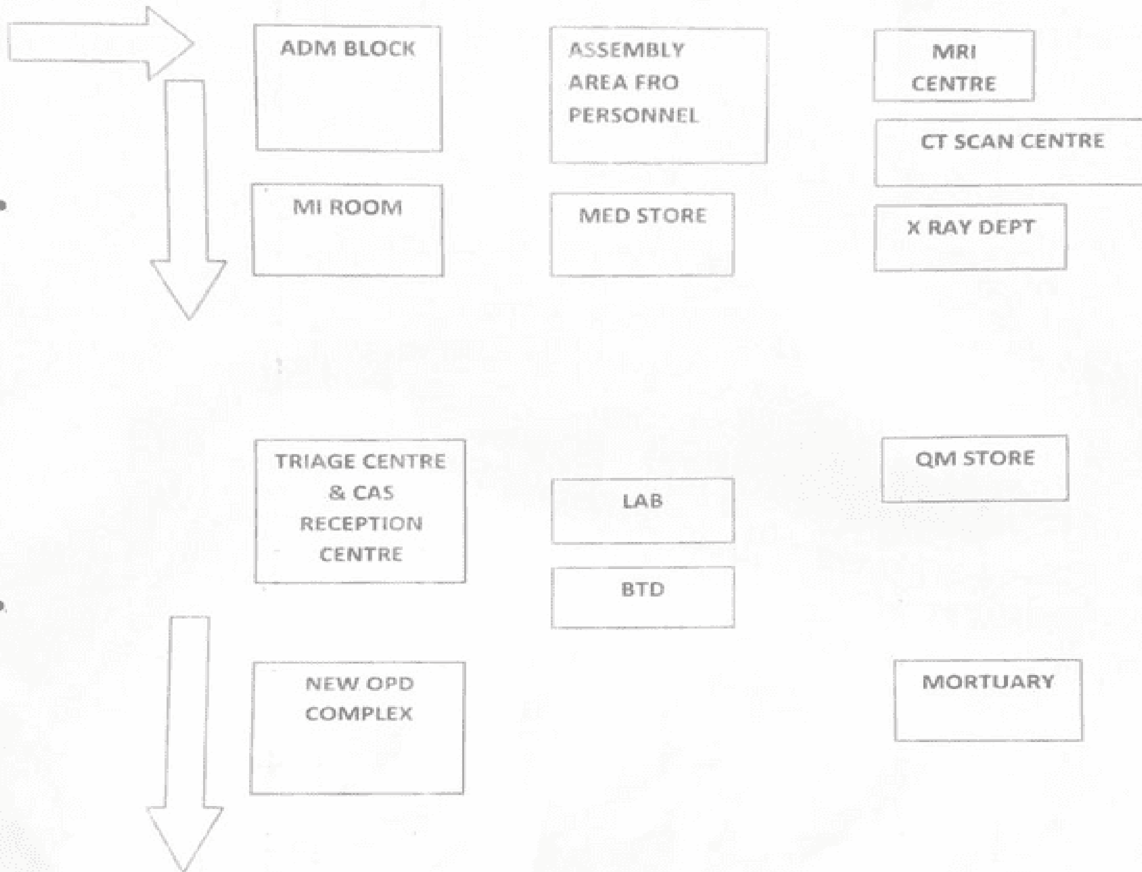
Appx 'B'
(refer to para 13 of SOP)

Available med assets around Cas Reception Centre



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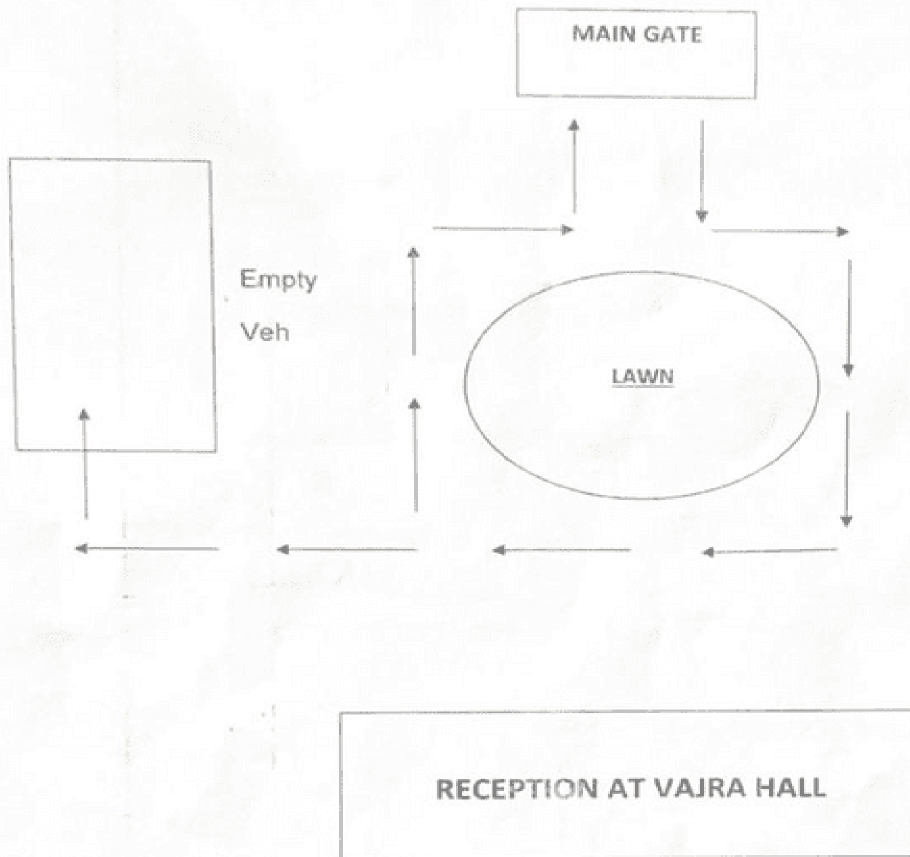
Appx 'C'
(refer to para 14 of SOP)

ROUTE OF CASUALITY VEHICLE



RECEPTION AT VAJRA HALL

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SOP

DISASTER MANAGEMENT PLAN : MH JRC

INTRODUCTION

1. MH JRC is a large multi specialty zonal hospital with 850 beds. It is expected that the hospital must be prepared at all times to receive and treat 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) Comdt
(ii) Sr Registrar
(iii) DMO or MO/IC MI Room
(iv) Duty clk

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

(i) Tele Number - 0181-2661800
(ii) Mobile Number - 7347266605
(iii) Army Number - 5511 (DMO), 6511 (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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6. The information thus received will be promptly conveyed to the following

(a) **Commandant**

(b) **Sr. Registrar and OC Tps** He will ensure dissemination of this information and 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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10. During working hour manpower is readily available. In events outside working hour 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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SHIFTING PLAN

12. 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 be 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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REGISTRATION

17. Asst registrar will be overall in charge of registration. He will be assisted by CWM 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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22. Available personnel will be detailed bed wise 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 of 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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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 the 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 **100 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 DGMS (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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32. **Disaster stores:**

(a) The disaster medical stores as per Appx'E' will be kept earmarked in med 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 Medical Officer and a NT JCO. The team will confirm availability of disaster stores at designated areas, turnover the stores to ensure there is no wastage, maintain contact details of all the key personnel and ensure regular rehearsals of the disaster mgt drill. When proceeding on lve/TD the members of the committee will be changed as notified from to time in the Part I orders.

Station : Jalandhar

Dated : Sep 2018

(Avinash Das)
Brig
Commandant

Principal
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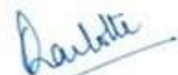
Jalandhar Cantt

Appx 'E'
(refer to para 32(a) of SOP)

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'F'
(refer to para 32(a) of SOP)

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 'G'
(Refer to para 32(a) of SOP)

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

Narinder Pal
Lt Col AMC

Prasad R Lele
Brig
Commandant
M H Jalandhar

Principal
Army College of Nursing
Jalandhar Cantt

RESTRICTED

MILITARY HOSPITAL

JALANDHAR

MI ROOM

SOP: ADMISSION OF PATIENT AGAINST SECURITY DEPOSIT

RESTRICTED

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Jalandhar Cantt

SOP: ADMISSION OF PATIENTS AGAINST SECURITY DEPOSIT

INTRODUCTION

1. MH Jalandhar is a multispecialty zonal hospital which provides both out patient and inpatient treatment to serving personnel, veterans and their dependents. Dependents are admitted after verifying entitlement on the basis of dependent card issued by unit/records concerned. However, as a welfare measure, the hospital is admitting patients without dependent card against refundable security deposit, pending receipt of valid dependent card. In exceptional cases/emergent cases, non entitled patients are also being admitted after sanction of Comdt/competent authority against security deposit.

AIM

2. The aim of this SOP is to lay down the guidelines for admitting entitled patients without dependent card and non entitled patients who have been accorded sanction for the same against security & the disposal of this security deposit

ADMISSION OF PATIENTS AGAINST SECURITY DEPOSIT

3. **Entitled Patients**

(a) As a welfare measures, veterans, dependents of serving pers and veterans without valid dependent card will be admitted against security deposit if advised admission.

(b) A minimum amount of Rs 5000/- will be deposited by the patient as security deposit, pending receipt of dependent card.

(c) This will be deposited daily in RTC by the CWM.

(d) HSR will be raised as non entitled case by CWM office on discharge of these patient in case dependent card is not produced till such time also. However, this HSR will not be adjusted against security deposit of patient for a period of 03 months pending receipt of dependent card.

(e) Simultaneously intimation will be sent by the CWM office through Stats Sec in the form of a signal to the unit/records of the patient for dispatch of dependent card immediately as money once deposited as HSR in Govt treasury is non refundable.

(f) The security deposit will be refundable in toto on submission of valid dependent card by the patient to CWM office within 3 months from the date of admission.

...2/-

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(g) The security deposit will be refundable through cheque to the patient concerned by the Accts Sec on receiving intimation from CWM office, duly signed by MO i/c MI Room, vide para 3 (f) above.

(h) In case dependent card is not received by the hospital even after lapse of three months from dt of admission of patient, security deposit will be adjusted against HSR and deposited through MRO in Govt treasury.

(j) Further, in case dependent card is not received by the hospital within the stipulated period of 3 months from dt of admission and amount on account of HSR exceeds the security deposit to the patient, the following action will be taken:-

(i) HSR will be fwd to PAO (OR) concerned incase of serving personnel to debit the amount and fwd MRO for the same, under intimation to unit & records concerned.

(ii) CDA(P) Allahabad will be informed in case of a similar contingency pertaining to veterans and their dependents, under intimation to patient and Records concerned.

(k) HSR realized from patients by CWM office will be fwd to Accts Sec for onward deposition in Govt treasury through MRO.

4. **Non entitled patients**

(a) In case a non entitled patient is admitted after sanction of Comdt/competent authority, security deposit will be taken as follows:-

(i) Treatment where surgical interference may not be indicated – Rs 5000/-

(ii) Treatment where surgical interference may be indicated/definitely Indicated – Rs 10,000/-

(b) Patient will be admitted in Offrs/JCOs/OR Wd based on his monthly income/status vis-à-vis rank structure in the Army.

.....3/-

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(c) HSR will be raised at the time of discharge based on current rate as applicable. This will include hospital stoppages per day as laid down for the type of ward where admitted plus charges for investigation as applicable.

(d) HSR will be adjusted against the security deposit held with the hospital. In case HSR exceeds the security deposit, the balance amount will be realized from the patient & deposited. In case security deposit held exceeds the HSR, balance amount will be refunded to the patient through cheque by Accts Sec.

(e) Amount recovered as HSR will be deposited in Govt treasury through MRO by Accts Sec. This is non refundable.

EMERGENCY ADMISSION OF VETERANS, DEPENDENTS OF SERVING PERS AND VETERANS

5. In case admission of a veteran, dependents of serving pers and veterans is required as an emergency, life saving measures in the absence of both valid dependent card and money for security deposit, admission may be done as a welfare measure. However, patient/relatives will be asked to deposit the security deposit/ensure signal is sent from unit concerned informing dependency (dependent card to be fwd subsequently within 24 hours from the date of admission failing which patient will be discharged and referred to civil hospital). HSR will be raised for 01 day and realized from patient/relatives before patient is sent to civil hosp.

GEN INSTRUCTION FOR CWM OFFICE

6. No financial transaction will be carried out by CWM office other than receiving security deposit from the patient, where applicable.

7. The security deposit will be deposited in the RTC daily by CWM office along with summary maintained, duly signed by MO i/c MIR.

8. Record will be maintained ,meticulously in CWM office of all such security deposit as per following format.

(a) S.No
(b) Date
(c) Name of the indl
(d) Relationship
(e) Personal particulars of serving personnel/veteran
(f) Unit/Record Office
(g) Address of indl
(h) Tele No/Mobile No
(j) Amount deposited.
(k) Sig of recipient (MO i/c MIR/DMO)
(l) Date refunded to indl
(m) Sig of indl
(n) Sig of CWM
(o) PPO number(if pt is veteran)

......4/-

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SOP: ACTION TO BE TAKEN IN EVENT OF SUDDEN DEATH/ FOUND DEAD CASES BROUGHT TO MI ROOM, MH JALANDHAR

INTRODUCTION

1. There are a number of instances where cases of sudden death/found dead amongst service personnel, veterans and their dependents are brought to the MIR of this hospital. In such cases, the complete chronological sequence of actions to be taken is generally not known to the MO on duty in MI Room. This not only leads to faulty documentation leading to avoidable delay in preparation of fatal case documents but also leads to consequent delay in release of financial benefits to NOK of deceased if the individual involved was a serving soldier.

AIM

2. The aim of this SOP is to lay down the sequential action to be taken by the Medical Officer on duty in MH JRC MI Room in the event of receiving a case of 'Found Dead'/ 'Sudden Death' amongst service personnel, veterans and their dependents.

ACTION TO BE TAKEN AT HOSP MI ROOM

3. The chronological sequence of action to be taken is as follows:-

(a) Brief history of incident shall be elicited from attendants accompanying the case.

(b) Comprehensive quick exam shall be carried out to assess the clinical status of case.

(c) Resuscitative measures to revive the case shall be initiated and continued for a maximum period of 30 minutes.

(d) In case resuscitation is unsuccessful and patient cannot be revived, he/she shall be declared dead by the MO attending to the case.

(e) ECG tracing may be taken to confirm death. However, it is not mandatory.

(f) Death certificate (AFMSF-93 Part I & II) shall be completed by the MO declaring death with particular attention to personal details in respect of deceased, dt & time of death, diagnosis which is required to be put in all such cases is **"Found Dead – Cause Unknown".**

(g) The death certificate duly completed shall be signed by the MO and his/her personal stamp affixed alongwith stamp of appointment, and stamp of place and date.

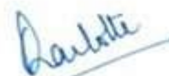
(h) Case sheet in respect of deceased shall be completed by the MO on duty. The following shall be endorsed:-

(i) Personal particulars of deceased

(ii) Identification marks of deceased.

(iii) Brought by (personal particulars of individuals along with complete address and tele nos- mobile and landline)

....2/-



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SOP : DUTIES OF DMO IN MILITARY HOSPITAL JALANDHAR

1. The MI Room of MH Jalandhar provides round the clock medical cover to dependent clientele and attendance to all emergencies, irrespective of entitlement, received in hosp. While the MO i/c MI Room is responsible for the overall functioning of the MI Room, it is manned by the duty medical officer after working hours, to provide requisite medical care to all patients reporting to MIR, as well as in-patients, during this period.

AIM

2. The aim of this SOP is to lay down the duties of Duty Medical Officer of Military Hospital Jalandhar to ensure smooth functioning of MI Room after working hours with consequent provision of requisite medical care during this period to all out patients reporting to hosp and all emergencies, irrespective of entitlement, received in hospital as well as medical attendance to inpatients, as required.

DUTIES OF DMO

3. General : The DMO will report to the MI Room for duty as per following schedule on weekdays and Sundays/holidays:-

(a) Weekdays

(i) Mon to Sat (Summer) : 1330h - 0830h (Next day)

(i) Mon to Sat (Winter) : 1400h - 0845h (Next day)

(b) Sundays/Holidays : 0830h – 0830h (Next day)

4. Duties of DMO

(a) On reporting to the MI Room, he/she will take over the charge of MI Room from the MO i/c MI Room. This will include taking physical charge of the following items:-

(i) 1 x handset (mobile) and charger earmarked for use of DMO after working hours

(ii) One set of keys of QRMT stores.

(b) He/She will ensure functional readiness of the MI Room to deal with emergencies by checking all electro medical equipment and emergency trays.

(c) He/She will ensure paramedical staff on duty in MI Room are physically manning their work stations.

.....2/-

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SOP : RIGHT OF PATIENT AND FAMILY OF PATIENT IN HOSPITAL

INTRODUCTION

1. **The patient is the most important visitor in this hosp- "Mahatma Gandhi"** The very existence of the hospital centers around provision of health care to the patient. While this is the primary aim of the hospital, it also behoves the hospital to ensure that the patients and the medical & para medical staff are conversant with the rights of the patients and their family during provision of medical care. The hospital must be committed at all times to protecting the rights of patients and their family.

AIM

2. The aim of the SOP is to lay down the rights of the patients and his family and guidelines to be followed by the hospital to ensure protection of these rights.

RIGHT OF PATIENT

3. (a) Right to be provided with the highest standard of medical treatment within the hospital resources.

(b) Right to give informed consent for treatment / procedures.

(c) Right to endorse unwilling for surgical treatment / procedures after having been explained risks of such an action.

(d) Right to free medical treatment locally / referral or transfer to higher center if so dictated by clinical condition.

(e) Right to visit by family members / visitors during laid down visiting hours unless dictated otherwise by clinical condition.

(f) Right to information pertaining to disease / disability viz clinical course, prognosis etc.

(g) Right to discharge from hosp on completion of treatment.

(h) Right to discharge against medical advise after duly endorsing the same. This is applicable only for dependents of serving pers, veterans and their dependents.

(j) Right to be informed of payment of HSR in case of dependents of serving pers / veterans and their dependents, non entitled cases.

(k) Right to seek redressal of grievances through laid down channels as follows :-

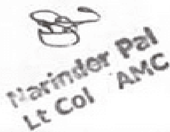
MO i/c Ward

Sr Adv/HOD (Speciality concerned)

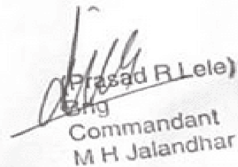
Asst Registrar

Sr Registrar & OC Tps

Commandant



Narinder Pal
Lt Col AMC



(Prasad R Lele)
Brig
Commandant
M H Jalandhar

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RESTRICTED

MILITARY HOSPITAL

JALANDHAR

MI ROOM

SOP: PROVISION 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). <u>In case patient requires admission</u>, he/she will be admitted as a welfare measure. A sum <u>of Rs 5000/-</u> 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) **<u>Veterans and their dependents (Non ECHS Members)</u>** – Action to be taken as outlined in para 3 (g) (i) & (ii) above for outpatient and inpatient treatment respectively.

(j) **<u>Veterans and their dependents (ECHS Members)</u>:** 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.

<u>EMERGENCY CASES</u>

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) **<u>Entitled personnel</u>** 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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(b) In the absence of valid entitlement docu, guidelines as laid down in SOP for admission of patient against security deposit which is already available in hosp will be adhered to.

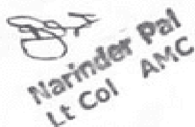
(c) In case patient though entitled is unable to not only furnish entitlement docu but also security deposit, he/she will be admitted as an emergent measure after permission from Comdt MH. Relevant docu/ security deposit will be obtained from the patient/his relatives subsequently.

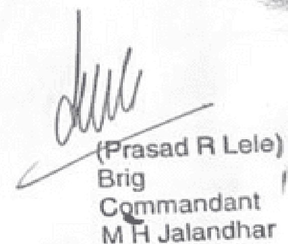
5. Due care will be taken to ensure veterans and their dependents who are ECHS members are not denied admission in service hosp on pretext of their being also entitled to treatment in empanelled hosp. In case they are tfr/refd to empanelled hospital for further management, all requisite assistance including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