चिकित्सा शिक्षा निदेशालय

107, चन्दर नगर, देहरादून– 248001
E-mail:- medicaleducation11@gmail.com
Tel:0135-2723026,

पंत्राकः–615/चि0शि0/02/157/2023 दिनांकः– 31 दिसंबर, 2024

:–कार्यालय आदेशः–

चिकित्सा शिक्षा विभागान्तर्गत संचालित समस्त राजकीय मेडिकल कॉलेजों के प्राचार्यों के साथ दिनांक 31 दिसंबर, 2024 को इमरजेंसी मैनेजमेण्ट के सन्दर्भ में आहूत बैठक में राजकीय दून मेडिकल कॉलेज देहरादून द्वारा उपलब्ध कराए गए प्रस्ताव पर हुई चर्चा के कम में संलग्न मानक संचालन प्रकिया (S.O.P) जारी की जा रही है।

अतः संलग्न मानक संचालन प्रकियानुसार कार्यवाही करना सुनिश्चित करें।

(डॉ0 आशुतोष सयाना)
निदेशक

पंत्राकः–615/चि0शि0/02/157/2023 तद्दिनांकित।

प्रतिलिपिः– निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु सादर प्रेषित।

1. समस्त प्राचार्य, राजकीय मेडिकल कॉलेज, उत्तराखण्ड।
2. निजी सचिव, सचिव, चिकित्सा स्वास्थ्य एवं चिकित्सा शिक्षा, उत्तराखण्ड शासन को सचिव महोदय के संज्ञानार्थ प्रेषित।

(डॉ0 आशुतोष सयाना)
निदेशक

Standard Operating Procedure (SOP) for Emergency Management

The Emergency Department must provide an appropriate medical screening examination, stabilizing treatment and/or an appropriate informed referral/transfer to the concerning department/facility.

Key Components of Emergency Department SOPs:

Emergency department SOPs generally encompass several key areas to streamline operations and enhance patient care. These components include:

- **Triage Procedures**: Establish a systematic approach for assessing and prioritizing patients based on the severity of their conditions.
- **Clinical Protocols**: Outline treatment protocols for common emergencies, including management of trauma, cardiac events, and respiratory issues.
- **Documentation:** Specify the necessary documentation processes to ensure accurate patient records are maintained, which is essential for continuity of care.
- **Quality Assurance**: Incorporate measures for regular audits and feedback mechanisms to evaluate the effectiveness of the SOPs and make necessary adjustments.

ETHICS OF EMERGENCY CARE

All citizens of India have their right to emergency medical care. To fulfil this right, emergency care providers shall:

- ✓ Abide by institutional and or Government guidelines on patient management.
- ✓ Respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.
- ✓ Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
- ✓ Communicate truthfully with patients and/or attendants (in case the patient is unable to communicate) secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.
- ✓ Manage the patient with due consideration to psychological, social and financial condition of the patient.

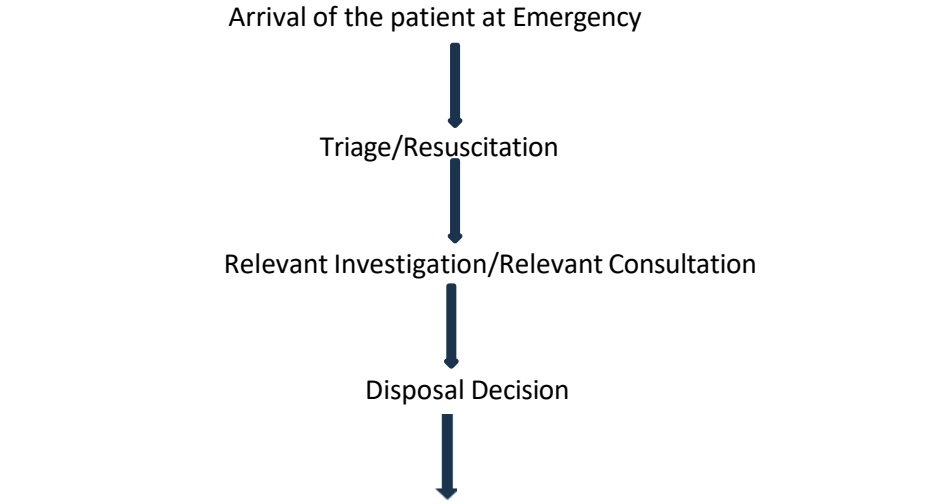
- ✓ Respect patient privacy and disclose confidential information only with consent of the patient/guardian or when required by an overriding duty such as the duty to protect others or to obey the law.
- ✓ Deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired or incompetent, or who engage in fraud or deception.
- ✓ Work cooperatively with other stakeholders in the care of emergency patients.
- ✓ Engage in continuing study/training to maintain the knowledge and skills necessary to provide high quality care for emergency patients.
- ✓ Act as responsible stewards of the health care resources entrusted to them.

PRINCINCIPLES AND GOALS:

- No patient requiring emergency medical care shall be refused adequate treatment even if no bed is available and the particular specialisation is nonexistent.
- The Emergency Department (ED) shall provide immediate appropriate lifesaving care and service both efficient & effective and sensitive to emotional needs and arrange subsequent disposition/transfer.
- The ED shall serve as the definitive specialised care facility, properly equipped and staffed to provide rapid and varied emergency care to all people with life-threatening conditions.
- *It is the duty of the faculty-on-call to inform the EMO of their availability/whereabouts and in-hospital contact details. They must sign in, in the roaster register of the ED on the morning/evening/night of their on-call duty. They should be available in their duty rooms during the night.*
- Undue delay in attending a patient shall be reviewed by the Emergency Incharge /MS and if unjustified, action as deemed proper shall be initiated against the erring EMO/SR/Faculty.
- The Medical Superintendent is the authority to ensure that the staff posted in ED is not directly or indirectly linked with any private clinical establishments. An undertaking to the effect must be obtained from the staff before deployment. Any staff subsequently found to be indulged in diverting the patients from hospital to private nursing homes or diagnostic centres shall be removed from ED and action deemed fit shall be initiated against them.
- The ED is the face of the hospital. A prompt, appropriate and well coordinated care of emergency and trauma patients increases the confidence of public at large in the health care delivery system. Therefore staff/faculty found to be deficient on duty need to be periodically reminded/trained or removed.
- *Shifting of responsibility to manage the patient by one department to another on silly technical grounds leading to suffering of the patients should be strongly condemned and treated as equivalent to medical negligence.*
- Financial consideration should *not be a barrier* to the initial treatment of the patient.

The Forward Operations of Emergency Care:

The forward operations of emergency care cannot be implemented backwards at any point in time



Step 1 – The Triage Assessment

The triage assessment generally should take no more than 2 to 5 minutes with a balanced aim of speed and thoroughness being the essence. The triage assessment is not intended to make a diagnosis.

— Any patient identified as Category/Level 1 or 2 should be taken immediately into an appropriate resuscitation bay or assessment and treatment area

— Vital signs are required for all emergency department patients

— A more complete nursing assessment should be done by the treatment nurse receiving the patient

Assign a priority level based on patient's medical history and current condition according to the following scale:

Level 1 – Resuscitation: (immediate life-saving intervention); eg, cardiac arrest/ impending arrest/ unstable shock

Level 2 – Emergency: severe cardiogenic shock/ life threatening hemorrhage/ polytrauma/ suspected MI etc

Level 3 – Urgent: poisoning, TBI, major trauma, shock etc

Level 4 – Semi-urgent: All category patients without shock or life-threatening hemorrage/conditions

Level 5 – Non-urgent: Chronic conditions with minor exacerbation and or secondary non-serious illness

Category	**Treatment Acuity** (Maximum waiting time for medical assessment and treatment)
Level 1	Immediate
Level 2	with in 05 minutes
Level 3	with in 05 minutes
Level 4	with in 10 minutes
Level 5	with in 10 minutes

ABCDE primary survey: This system is used to assist in triage assessment. The primary survey focuses on the rapid assessment and rapid stabilisation of the patient's airway, breathing, and circulation (the ABCs).

A: Airway

B: Breathing

C: Circulation

D: Drug/Disability/Deformity/Deficiency

E: Environment of the patient's visible symptoms.

Triage in disaster (both internal and external disasters)

The most severe patients are treated and transported first, while those with lesser injuries are transported later.

The following "Sorting Scheme" is used in the field/ED

l. Immediate: Those patients whose injuries are critical eg. patient with a compromised airway or massive external hemorrhage.

2. Delayed: Those patients whose injuries are debilitating but who do not need immediate management to salvage life or limb. E.g.:- Long Bone fracture

3. Expectant: - Whose injuries are so severe that they have only a minimal chance of survival. e.g. Patient with 90% full thickness burns

4. Minimal: - Who have minor injuries that can wait for treatment

5. Dead:

Re-triage

If a patient's condition changes whilst waiting for treatment, or if additional relevant information becomes available that impacts on the patient's urgency, the patient should be re-triaged. If a patient's condition has deteriorated necessitating re-triage to a more urgent triage category, the senior medical officer in charge of

the ED, or their delegate, should be notified immediately.

Step 2 – Registration:

The registration process is important for Identity/ consent/ treatment and disposition. In case of unattended patients/victims, the registration process is completed by PRO/security personnel and other paramedical staff.

- For any disputes regarding Admissions or any matters final decision will be as per Medical Superintendent or Principal.

Step 3 – Treatment

Level 1 patients receive CPR/ airway management: announce code blue to activate CPR team

Level 2 patients: ABCDE Primary Survey and emergency measures:

Lay coma patients in recovery position

Bedside glucostix, SPO2, BP, Pulse, RR, samples for G&C if needed

Suction, IV line, Oxygen, IV dextrose, IM midazolam as warranted

Level 3 patients: Moderate conditions requiring multiple resources. IV antihypertensives/oxygen / nebulisation as needed

Level 4 patients: Less urgent needs that require single resources. Assurance and communication and essential investigations

Level 5 patients: Non-urgent care with no resources needed. First-aid/ vaccination as needed

Step 4 – Reevaluation: Secondary Survey (Head-to-Toe examination)

- The secondary survey follows the completion of the primary survey, after immediate threats to life have been managed and the patient is stable. Continuous assessment of ABCD should occur during the secondary survey.
- Uncover the patient as needed, maintain warmth and privacy. Give appropriate analgesia before the examination.

Unconsciousness

Consider all the following for assessment as diagnosis of exclusions (AEIOU TIPS)

A alcohol, acidosis (metabolic disorders), ammonia (hepatic encephalopathy, arrhythmia

E endocrine, electrolytes or encephalopathy

I infection

O oxygen, overdose or opiates

U uraemia

T trauma, temperature or thrombus

I insulin, intoxication

P poisoning or psychiatric

S seizure, syncope, stroke, space-occupying lesion or shunt.

C-spine

If a spinal injury is suspected, ensure in-line immobilisation is in place with foam collar

Head

Look at the scalp for signs of injury. Feel for skull depressions, irregularities and lumps

Look behind the ear for bruising, i.e. Battle's sign.

Look at the ears for discharge

Face

Look for maxillofacial trauma, including facial injuries, fractures and eye injuries. Proptosis (bulging eye), loss of vision or orbital pain may indicate a retrobulbar haemorrhage.

Look for bruising around the eyes and injury to the eye itself, including penetrating injuries, haemorrhage or hyphaema.

Assess extraocular movement and pupillary response and size.

Look for facial symmetry. Palpate the facial bones, assessing for movement and pain.

Instruct the patient to open their mouth. Assess for jaw pain and malalignment.

Look inside the mouth for oral injuries, including dental trauma, lacerations, bruising or lip lacerations

Look at the nose, check for symmetry, deformity, epistaxis and patency of nares.

Neck

Look at the anterior neck observing for tracheal deviation, signs of injury, distension of the neck veins, carotid pulsation, pain, difficulty swallowing or hoarse voice.

Chest

Look for signs of injury.

Observe for chest expansion, asymmetrical or paradoxical movement, short, shallow breaths, pain on inspiration and/or expiration.

Palpate the sternum, ribs and clavicles.

Auscultate heart and lung sounds.

Listen for clarity of heart sounds. Muffled sounds may indicate a cardiac tamponade

Perform E-FAST if accredited.

Abdomen

Assess the abdomen for injury.

Bruising or injury to the abdomen increases the likeliness of an internal abdominal injury.

Perform E-FAST if accredited.

Gently palpate all four quadrants, assessing for pain or mass. See abdominal focused assessment, if required.

Inspect the external genitalia.

Pelvis:

Look for external genitourinary injuries.

Check for pain on movement or palpation of the hips.

If a pelvic binder or sheet is in situ, do not remove it.

Apply pelvic binder if required.

Extremities

Assess extremities for deformity, pain, bruising, swelling, lacerations or dislocations.

Complete neurovascular assessment for each limb and palpate peripheral pulses.

Provide elevation or splinting, where required.

Log roll

If adequate staff are available, a log roll can be completed to assess for posterior injuries

Ensure C-spine precautions are maintained.

Log roll should be avoided if there is risk of worsening an unstable pelvis.

Additional Assessments:

Depending on the nature of the injury, additional assessments such as neurological exams or specific injury assessments may be warranted.

Step 5 – Disposition/Discharge

In case the services essential for the treatment of the patient are not available in the hospital, the patient is provided with the required first aid and is referred to the alternate hospital with provision for ambulance.

Descriptors for Triage Categories

Clinical descriptors (indicative only)

1. **Immediate***: Simultaneous assessment and treatment*

Immediately life-threatening

Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention

■ Cardiac arrest
■ Respiratory arrest
■ Immediate risk to airway – impending arrest
■ Respiratory rate <10/min
■ Extreme respiratory distress
■ BP <80 (adult) or severely shocked child/infant
■ Unresponsive or responds to pain only (GCS <9)
■ Ongoing/prolonged seizure
■ IV overdose and unresponsive or hypoventilation
■ Severe behavioural disorder with immediate threat of dangerous violence

2. Imminently life-threatening/ Important time-critical treatment/ Very severe pain

Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)

■ Airway risk – severe stridor or drooling with distress
■ Severe respiratory distress
■ Circulatory compromise:
− Clammy or mottled skin, poor perfusion
− HR <50 or >150 (adult)
− Hypotension with haemodynamic effects
− Severe blood loss
■ Chest pain of likely cardiac nature
■ Very severe pain – any cause
■ Suspected sepsis (physiologically unstable)
■ Febrile neutropenia
■ Fever with signs of lethargy (any age)
■ BSL* <3 mmol/L
■ Drowsy, decreased responsiveness any cause (GCS <13)

■ Acute stroke
■ Acid or alkali splash to eye – requiring irrigation
■ Suspected endophthalmitis post-eye procedure (postcataract, postintravitreal injection), sudden onset pain, blurred vision and red eye
■ Major multi trauma (requiring rapid organised team response)
■ Severe localised trauma – major fracture, amputation
■ Suspected testicular torsion
■ High-risk history:
− Significant sedative or other toxic ingestion
− Significant/dangerous envenomation
− Significant pain or other feature suggesting PE, aortic dissection/AAA or ectopic pregnancy
■ Behavioural/psychiatric:
− Violent or aggressive
− Immediate threat to self or others
− Requires or has required restraint
− Severe agitation or aggression

3. **Potentially life-threatening/ Situational urgency/ Humane practice mandates the relief of severe discomfort or distress within 30 minutes**
Assessment and treatment start within 30 minutes
■ Severe hypertension
■ Moderately severe blood loss – any cause
■ Moderate shortness of breath
■ Seizure (now alert)
■ Persistent vomiting
■ Dehydration
■ Head injury with short LOC – now alert
■ Suspected sepsis (physiologically stable)
■ Moderately severe pain – any cause – requiring analgesia
■ Chest pain likely non-cardiac and moderate severity
■ Abdominal pain without high-risk features – moderately severe or patient age >65 years
■ Moderate limb injury – deformity, severe laceration, crush
■ Limb – altered sensation, acutely absent pulse
■ Trauma – high-risk history with no other high-risk features
■ Stable neonate
■ Child at risk of abuse/suspected non-accidental injury

■ Behavioural/psychiatric:
− Very distressed, risk of self-harm
− Acutely psychotic or thought disordered
− Situational crisis, deliberate self-harm
− Agitated/withdrawn
− Potentially aggressive

4. **Potentially serious/ Situational urgency/ Significant complexity or severity / Humane practice mandates the relief of discomfort or distress within one hour**

Assessment and treatment start within 60 minutes

■ Mild haemorrhage
■ Foreign body aspiration, no respiratory distress
■ Chest injury without rib pain or respiratory distress
■ Difficulty swallowing, no respiratory distress
■ Minor head injury, no loss of consciousness
■ Moderate pain, some risk features
■ Vomiting or diarrhoea without dehydration
■ Eye inflammation or foreign body – normal vision
■ Minor limb trauma – sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention – normal vital signs, low/moderate pain
■ Tight cast, no neurovascular impairment
■ Swollen 'hot' joint
■ Non-specific abdominal pain
■ Behavioural/psychiatric:
− Semi-urgent mental health problem
− Under observation and/or no immediate risk to self or others

5. **Less urgent/ Clinico-administrative problems**

Assessment and treatment start within120 minutes

■ Minimal pain with no high-risk features
■ Low-risk history and now asymptomatic
■ Minor symptoms of existing stable illness
■ Minor symptoms of low-risk conditions
■ Minor wounds – small abrasions, minor lacerations (not requiring sutures)
■ Scheduled revisit (e.g. wound review, complex dressings)
■ Immunisation only

■ Behavioural/psychiatric:

− Known patient with chronic symptoms

− Social crisis, clinically well patient

Color Coding: Assigned to the Triage Levels

Red	1	Immediately life-threatening
Red	2	Imminent life-threatening or time-critical condition
Red	3	Potentially life-threatening or situational urgency
Yellow	4	Potentially serious
Green	5	Less urgent

Emergency Admission Policy:

- Only patients whose assessment during triage falls under immediate, very urgent and urgent (Level 1 to 3) shall be admitted to the Emergency ward for further management.
- No seriously ill patient can be denied primary treatment and or admission on the ground of non-availability of beds. Under emergency situations, the EMO can take permission of the Medical Superintendent to admit a seriously ill patient in any vacant bed in the hospital.
- When the patient requires the intervention of multiple departments, priority decision shall be as follows:
  - ✓ Multiple injuries: In patients with injuries involving abdomen as well as other systems, the general surgical unit on-call shall take the primary responsibility of the patient care. As a rule, a patient with altered sensorium due to head injury will be admitted under Neurosurgery even if having other system injuries.
  - ✓ Combination of Surgical and Medical diseases: In such situations, the problem of immediate importance would decide the primary responsibility.
  - ✓ Medicine versus Medical Superspeciality: Where the patient requires specific super speciality intervention (eg, cardiology, neurology, nephrology) the patient shall be primarily managed by the concerned Superspeciality department when available.
  - ✓ General Surgery versus Surgical Superspeciality: Where the patient requires specific therapeutic measures related to Neurosurgery, Cardio-thoracic, Surgical Gastroenterology, Plastic surgery etc, the patient shall be managed by the concerned Superspeciality if available.
  - ✓ The aforementioned priority decision guideline is only indicative. In case the priority remains unsettled the decision of the Superintendent/ Emergency In-charge shall be final and in no case the treatment can be stopped or the patient is neglected or deprived of treatment.
  - ✓ Infectious disease patients requiring isolation: a call shall be given to the concerned doctor in-charge of ID ward and the patient shall be admitted to the ID ward only.
  - ✓ It is the responsibility of the triage officer (EMO) to direct all patients whose triage assessment falls under less urgent / non urgent (Level 4 to 5) to the appropriate consultants

Admission/Management of Multiple injuries/Polytrauma Patients:

The poly trauma victims are best managed by a team. The poly trauma management team consists of general surgeon (team manager), anaesthetist, orthopaedic surgeon, neurosurgeon, , ENT surgeon, cardiothoracic surgeon, nurses and other paramedical staff. During the trauma resuscitation, the trauma team must stabilize the patient, determine the extent of injury, and develop an initial treatment plan for hospitalization.

Step 1: Initial assessment/triaging by Surgery

Step 2: Resuscitative measures undertaken

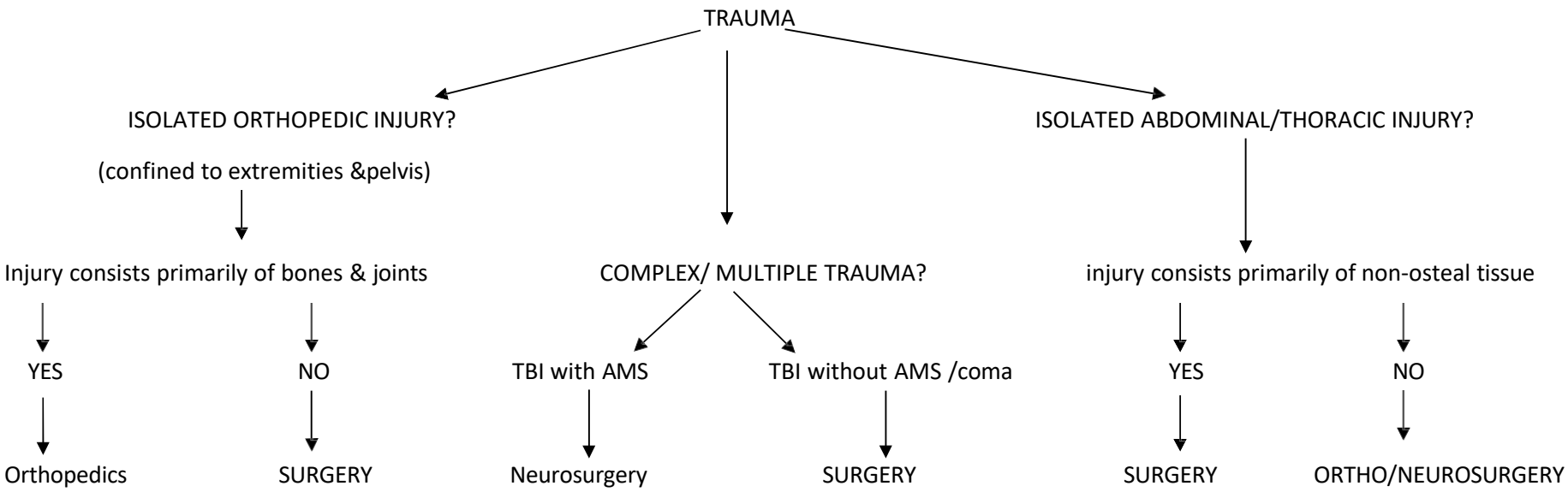
Step 3: Referral to specialties other than initially planned.

Step 4: The specialty referred to by the Surgery has to decide whether to admit or transfer/discharge the patient.

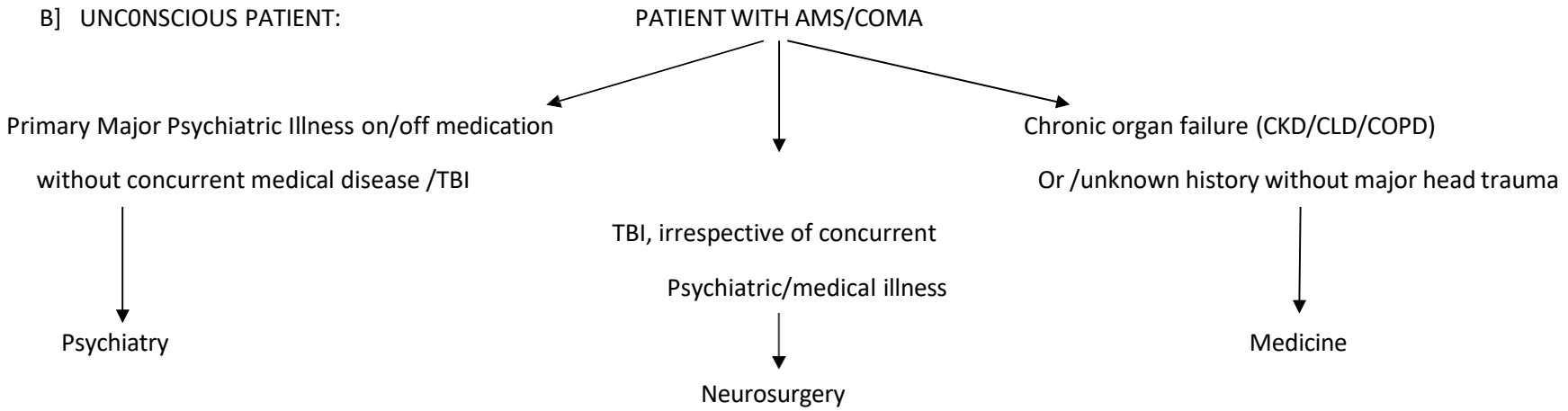
Step 6: Final responsibility/ownership: The specialty which clears the patient in the end should be responsible for discharging the patient.

P R I O R I T Y F L O W C H A R T S :

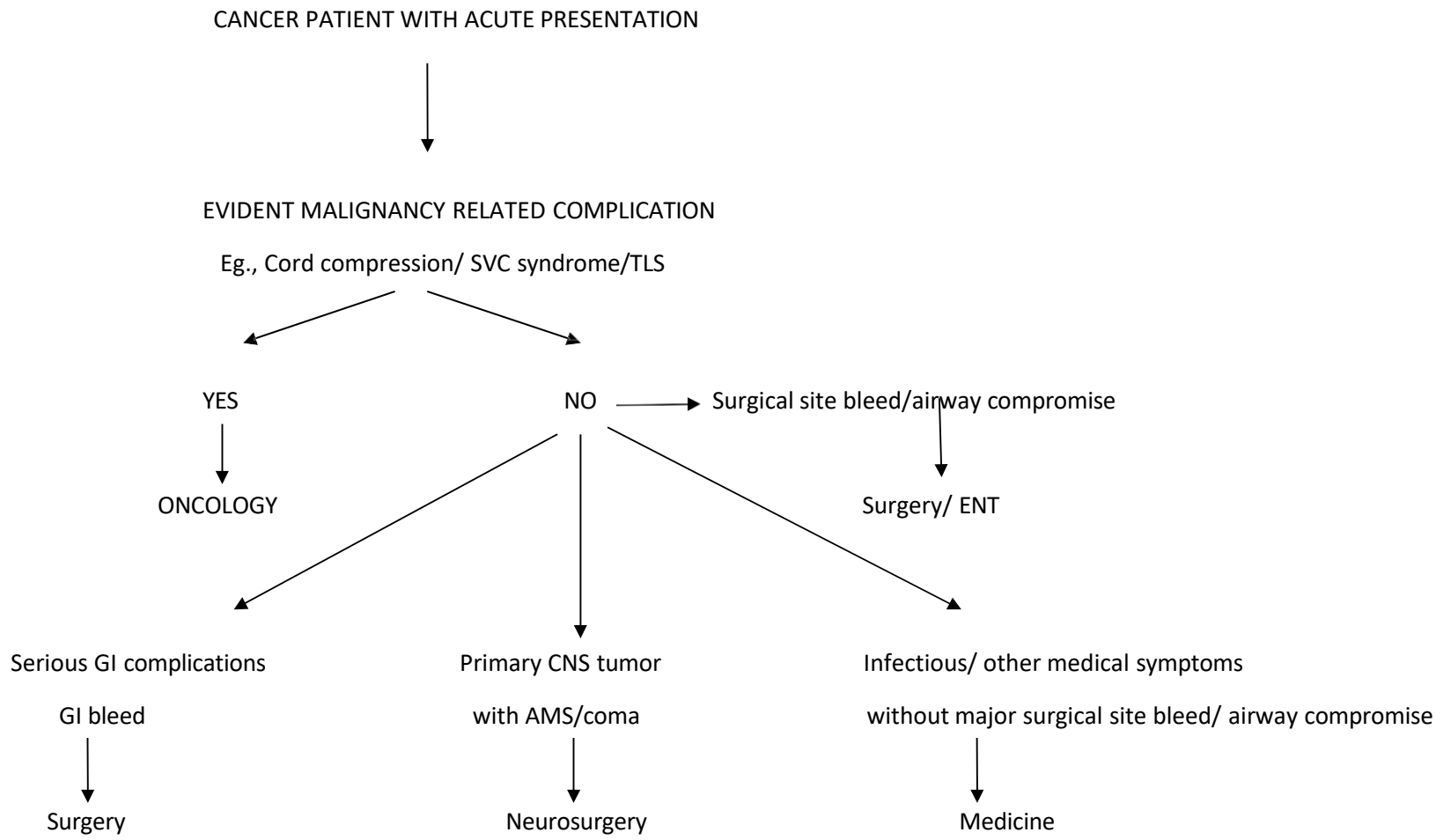
A} POLYTRAUMA



B] UNC0NSCIOUS PATIENT:



C) PATIENT WITH MALIGNANCY:



Guideline for Medico-legal cases: A medico-legal situation is defined as one where there is an evidence, allegation, confession or suspicion of causes attributing to body injury or danger to life.

a) For MLC cases, police are informed after starting the treatment & entry is made in Police Information book. Special emphasis should be given to clear and legible entry of the name, address, time of arrival of the patient and to the cause and nature of injury.
b) The EMO's foremost duty is to render medical aid to the patient; stabilize before documentation.
c) In case the patient dies, or is received as dead, appropriate action is initiated towards conducting the autopsy.
d) The evidence so available such as blood-stained clothes, foreign bodies, gastric lavage sample etc shall be preserved and handed over to police through a document. In addition, a medical report be prepared giving complete details of the patient, nature & type of injury etc. The document and report shall be prepared in duplicate
e) Signature of the EM/SR has to be in full with the name given in capital letters.
f) No unauthorised person, should have access to the medico-legal records (including medico-legal register) without the written consent of the Medical Superintendent.
g) X-Ray reports should be entered within 7 days in MLC register. X-ray department should provide the X-ray report within 48 hours.
h) Remarks of the specialists should be entered in the MLC register and signed by the specialist with his/her name clearly written in block letters.
i) All exhibits of legal importance (gastric lavage etc.) should be immediately sealed and delivered to the police and their signatures obtained in the book.
j) In all medico-legal matters, where the EMO is in need of expert advice, the faculty on call from the Department of Forensic Medicine should be available for guidance.
k) The police posted in the Emergency should expedite the completion of all MLC reports within 7 days

1) **Medicolegal cases:**

The following cases should be considered as medico-legal and as such the EMO is "duty-bound" to intimate to the police regarding such cases:

1. All cases of injuries and burns –the circumstances of which suggest commission of an offence by somebody. (Irrespective of suspicion of foul play)
2. All vehicular, factory or other unnatural accident cases specially when there is a likelihood of patient's death or grievous hurt.
3. Cases of suspected or evident sexual assault.
4. Cases of suspected or evident criminal abortion.
5. Cases of unconsciousness where its cause is not natural or not clear.
6. All cases of suspected or evident poisoning or intoxication.
7. Cases referred from court or otherwise for age estimation.

8. Cases brought dead with improper history creating suspicion of an offence.
9. Cases of suspected self-infliction of injuries or attempted suicide.
10. Any other case not falling under the above categories but has legal implications.
11. Any person brought by Police for Medical Examination.
12. Any injury or death where EMO a suspects foul play/ unnatural cause.

2) **BROUGHT IN DEAD**:

All cases "brought in dead", and where the actual cause of death is not known, should be handed over to the police. However the name along with all the possible details about the dead person should be recorded. The name and address of the attending people should also be noted and recorded in the register.

If medical records show that the death is likely due to natural causes and the chances of any foul play are negligible, the body may be handed over to the relatives on their written request only after such request is attested by at least two of their responsible neighbours/acquaintances.

- All other cases where death has occurred due to accident, assault, burns, suicide, poison, rape or any other causes where it is suspected that death has not been due to natural causes, must be registered as medico-legal cases (MLC) and the police authorities informed accordingly observing due procedure.:
- MLC shall be done in cases of 'brought dead' where death is expected to have occurred due to the following:-
  RTA
  Suicide
  Homicide
  Assault
  If the EMO suspects some offence/negligence leading to death.

3) UNIDENTIFIED BODY/UNKNOWN PERSON:

- If the person is alive EMO initiates resuscitative treatment, stabilizes the patient as per ABCDE approach. Then perform a secondary survey, notes down the injuries, makes entry in to MLC sheets in duplicate and fills up the MLC Police intimation form.
- All the unknown/unidentified patients are treated as MLCs and all the life saving measures are undertaken in the best interest of patient. The left thumb impression (LTI) and Right thumb impression (RTI) is recorded in presence of two witnesses; not below the rank of Senior Resident/AP.
- If the person is not having any signs of life/ brought in dead, register MLC and follow the procedure for MLC brought dead as per document.

4) Death in Emergency:

- Patients who die in ED shall be given death certificate by the EMO/ or the SR of the medical /surgical unit or as decided by M.S.
- The EMO shall ensure that the body is sent to the mortuary with due care and consideration.
- Every death in the ED shall be documented and report sent to the Medical Superintendent.

Records Maintenance: The following records are maintained in the ED:

1. List of Doctors on Emergency Dury and Faculty-on-call
2. Emergency register: Emergency OPD register/ Emergency admission register
3. Attendance registers of all staff in all shifts.
4. MLC register for medico legal cases/ Police information register
5. Drug Inventory Register
6. Controlled Drugs and Psychotropic Drugs Inventory
7. Brought Dead form
8. Death form
9. Death Register
10. Incident reporting form
11. Register of record of all meetings and proceedings.

Disaster Preparedness:

Surge Capacity

Separate Decontamination Area at ED entrance

Separate Disaster Stock in ED

Drill and Debriefing for Disaster Management

Redistribution of pts to other hospitals

Training and Implementation:

Effective execution of SOPs necessitates comprehensive training for all emergency department personnel. This ensures that team members are familiar with the protocols and can efficiently execute them during critical situations. Regular training sessions, simulations, and drills can bolster staff readiness, ensuring that they are equipped to handle diverse emergencies that may arise. Proficiency in primary and secondary assessments is best achieved through hands-on training and practice. First aid courses provide opportunities to develop and refine essential first aid skills, including how to carry out efficient primary and secondary assessments, ensuring responders are prepared to act confidently and effectively in emergency situations.

- Ensure regular training of all staff to deal with cardiac emergency and disaster situation; procedures.
- Conduct workshops and simulations to familiarize staff with triage systems and ensure the utilization of triage area flow chart for the segregation of patients based on the severity of their condition.
- Ensure yearly disaster mock-drills
- Standardization: Establish consistent procedures across different facilities to ensure uniform care standards.