संoसंo–17/विविध 1–96/2025
बिहार सरकार
स्वास्थ्य विभाग

प्रेषक,

रेणु कुमारी,
विशेष कार्य पदाधिकारी।

सेवा में,

सभी प्राचार्य/अधीक्षक,
राजकीय चिकित्सा महाविद्यालय एवं अस्पताल, बिहार।

पटना, दिनांक :– / /2025

विषय :– राज्य के राजकीय चिकित्सा महाविद्यालय एवं अस्पतालों के आपातकालीन इकाई/विभागों के लिए जारी दिशा–निर्देश का दृढ़तापूर्वक अनुपालन किये जाने के संबंध में।

महाशय,

निदेशानुसार उपर्युक्त विषय के सम्बन्ध में कहना है कि राज्य के राजकीय चिकित्सा महाविद्यालय एवं अस्पतालों के आपातकालीन इकाई/विभागों के लिए बुनियादी सिद्धांत जारी किये गये हैं, जिसका अनुपालन सभी चिकित्सा महाविद्यालय एवं अस्पतालों द्वारा दृढ़तापूर्वक किया जाना है।

उक्त के आलोक में राज्य के राजकीय चिकित्सा महाविद्यालय एवं अस्पतालों के आपातकालीन इकाई/विभागों के लिए बुनियादी सिद्धांत संबंधी जारी दिशा–निर्देश की प्रति पत्र के साथ संलग्न कर आवश्यक कार्यार्थ प्रेषित की जा रही है, जिसका अनुपालन सभी संबंधित से कराना सुनिश्चित करेंगे।

अनुलग्नक– 20 प्रति (अधीक्षक कार्यालय के लिए)।
20 प्रति (प्राचार्य कार्यालय के लिए)।

विश्वासभाजन
ह०/–
(रेणु कुमारी)
विशेष कार्य पदाधिकारी।

ज्ञापांक–17/विविध 1–96/2025– 644(17) /पटना, दिनांक–13/06/2025

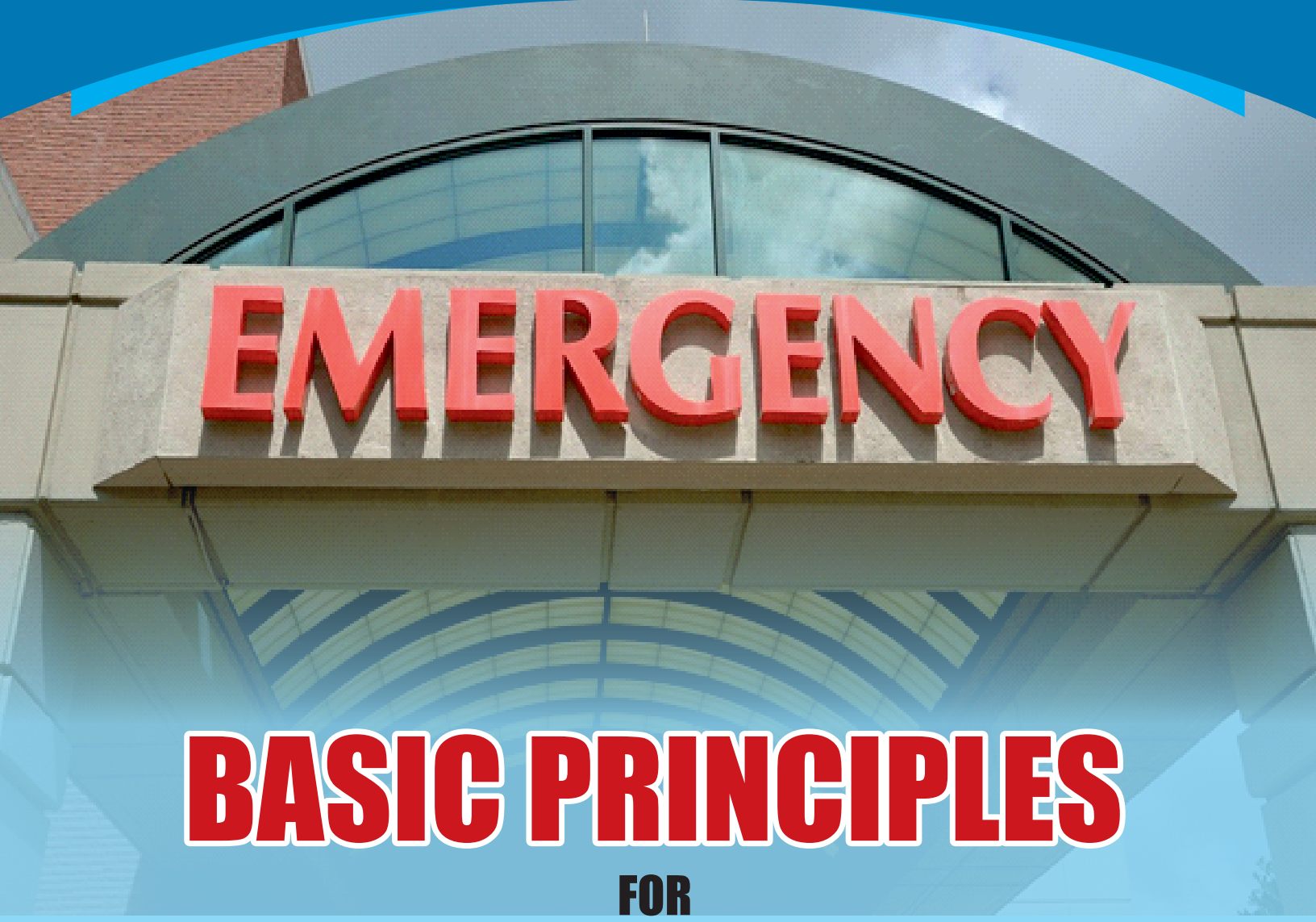
प्रतिलिपि :– माननीय मंत्री, स्वास्थ्य के आप्त सचिव/अपर मुख्य सचिव, स्वास्थ्य के प्रधान आप्त सचिव/प्रशाखा पदाधिकारी–प्रशाखा 01, 02, 03, 07 एवं 10 स्वास्थ्य विभाग को सूचनार्थ प्रेषित।

प्रतिलिपि :– आई० टी० मैनेजर/प्रोग्रामर, स्वास्थ्य विभाग, बिहार, पटना को विभागीय वेबसाईट पर अपलोड करने हेतु प्रेषित।

13/06/2025
विशेष कार्य पदाधिकारी।

D/Raumish sir/Letter

Government of Bihar
DEPARTMENT OF HEALTH



BASIC PRINCIPLES

FOR

EMERGENCY UNIT / DEPARTMENT IN MEDICAL COLLEGE HOSPITALS

जीवन्त बिहार... सपना हो साकार

Contents

Executive Summary

This document outlines the basic principles for an Emergency Unit/Department in Medical College & Hospitals in Bihar.

It defines and outlines the importance of Emergency Units/Departments in hospitals and the purpose of these basic principles. It reiterates that all Medical College Hospitals in Bihar must provide Emergency Services.

The Goal is to establish efficient and effective Emergency Units/Departments to reduce disability, morbidity, and mortality by providing initial treatment for a broad spectrum of illnesses and injuries, 24/7. This book clearly delineates what is an Emergency Team and describes the core and expanded teams, including their roles and responsibilities.

The necessary arrangements in the Emergency Unit/Department, such as help desks, waiting areas, triage areas, resuscitation areas, and more are outlined along with the need to ensure the availability of necessary instruments, equipment, and drugs for efficient patient management.

The importance and working of Triage, a system for categorizing patients based on the urgency of their condition, ensuring timely treatment for those with life-threatening conditions is detailed along with guidelines for managing patients requiring admission as well as those who die in the Emergency Unit/Department and those who are brought dead.

The importance of coordination among departments for effective patient care is emphasized along with the need for regular Review Meetings for clinical updates, mortality reviews, and interdepartmental discussions.

The annexures provide specific details on categorizing patients into red, yellow, and green categories based on non-trauma and trauma settings.

Overall, these basic principles aim to ensure that Emergency Units/Departments in Medical College Hospitals in Bihar provide high-quality, patient-centered care, reducing morbidity and mortality.

Introduction

Emergency unit/ department of a health facility is the mirror of the services provided by that medical facility. It is a critical component of a hospital, providing immediate care to patients with acute illnesses or injuries. This facility usually accounts for a substantial number of hospital admissions.

Emergency refers to a situation or condition that poses an immediate risk to a person's health, safety, or well-being, requiring urgent attention and intervention. In the context of healthcare, an emergency can include:

1. **Life-threatening conditions:** Such as severe injuries, heart attacks, strokes or other critical illnesses that require immediate medical attention.
2. **Acute illnesses:** Sudden onset of severe symptoms or conditions that require prompt medical evaluation and treatment.
3. **Trauma:** Physical injuries caused by accidents, violence, or other external factors that require immediate medical attention.

In general, emergencies are characterized by their urgent nature, requiring prompt action to prevent harm, reduce suffering, or save lives.

Key characteristics of Emergencies:

- **Urgency:** Emergencies require immediate attention and action to prevent harm or reduce suffering.
- **Immediacy:** Emergencies often require prompt intervention to address the situation effectively.
- **Risk:** Emergencies pose a risk to a person's health, safety, or well-being, requiring swift action to mitigate harm.

Such patients have pressing need(s) and may reach hospital without prior appointment. They may report to the unit on their own or by ambulance. It is a great task for the health authorities to manage such patients. Lack of proper management of emergency patients are often responsible for serious law and order situations. In the context of the Emergency Unit/Department guidelines, emergencies are situations that require

immediate attention and intervention to prevent harm, reduce suffering, or save lives. The guidelines aim to ensure that patients receive timely and effective care in emergency situations.

There is an emergent need to reiterate the basic principles of Emergency Unit/ department management. These Basic Principles have been finalized to support government run Medical College and Hospital to prepare detailed order for the Emergency Unit / Department in their respective Medical College and Hospital. Medical Superintendent of the hospital will be responsible to develop SOP with the support of Head of Department from various departments. District hospitals and facilities below are also expected to ensure implementation of these guidelines, as per availability of resources.

The basic principles try to address following :-

- Identify the procedure for the triage and clear and precise assessment of patients arriving in the Emergency Department for the overall management of all patients through the department.
- Improve the flow of patients from initial reception through discharge or admission to a ward.
- To ensure that all patients receive proper care and treatment they need in the appropriate time.
- To enable the staff to work as a multi-disciplined team to ensure care and treatment to all the patients however busy the department may be.
- Empathy being the cornerstone of effective treatment in an environment of trust and well being of the patients.

Policy

All Govt. Medical College and Hospitals in the state of Bihar shall mandatorily provide Emergency Services. The manner of disposal of a patient starting from the entry in to Emergency Unit / Department till the exit from the hospital reflects the alertness and promptness of the hospital.

The Emergency Unit / Department shall operate 24 X 7 throughout the year.

The Emergency Unit/Department should be adequately equipped to provide initial treatment for a broad spectrum of illnesses and injuries.

Patient requiring emergency medical care shall not be refused adequate treatment on the ground of unavailability of beds or particular super / specialization. For easing the load of patients in Casualty/ Emergency unit, regular step down should be done.

Goal

- To establish efficient and effective Emergency Unit / Department to reduce disability, morbidity and mortality.
- To provide right treatment at the right time and right place, with right resources, using latest scientific knowledge.
- To provide immediate appropriate life-saving care and services, efficient, effective, and sensitive to emotional needs of patients and their relatives.

Basic function of Emergency Unit / Department

All efforts are made to provide all essential care and investigation in the same hospital premises to save the life of trauma/emergency patients.

a. It shall provide immediate appropriate life saving care and services which are both efficient & effective and sensitive to emotional needs of patient and his/her relatives.

b. It shall serve as the definitive specialized care facility, properly equipped and staffed to provide rapid and varied emergency care to all people with life threatening conditions.

c. It shall use a triage system of screening and classifying clients to determine their priority needs and to provide patient care efficiently.

d. It shall play a key role in times of critical interventions of all kinds.

Emergency Care Team

The Emergency Team should comprise a core team and an expanded team.

Core Team:

The Core Emergency Team (Physically present at all times in the Emergency Unit / Department) shall comprise (per shift) at the least of : - Casualty Medical Officer (CMO - one), Hospital Manager (one), Pharmacist (one), Nurses (four), Lab Technician (one), X-ray technician (one), Dresser (two) and other support staff.

Expanded Team:

The Expanded Team (physically present at all times in the Emergency Unit / Department) shall comprise of the following: Senior Resident on emergency duty one from each department like Surgery, Orthopaedic, Anaesthesia, Medicine, Neurosurgery, Radiology, ENT and any other departments as may be decided by the Superintendent. The hierarchy of expanded team shall be as follows:

i. Senior Residents (SR) - on Duty in Emergency Unit / Department

ii. Assistant Professor (AP) - on Duty in the hospital premises- shall be available in such a way to ensure that patients can be examined by them in timely manner as prescribed in Table No. 2.

iii. Associate Professor- on call

iv. Professor- on call

The Unit shall be headed by CMO.

The Medical Superintendent shall be responsible for the overall activity in the Emergency Unit / Department and shall supervise it on daily basis and as and when required.

Considering the patients load in a given hospital, Medical Superintendent of respective hospital is authorized to allot additional human resource for core and expanded team posted in the Emergency Unit / Department.

Duty of All Emergency Staffs

The staff should be sympathetic and well trained who can render immediate and appropriate life-saving treatment and must be able to meet the emotional requirement of patient and its attendants. It must be understood that the persons visiting the Emergency Unit/ Department are mentally upset because of the acute illness in their relatives. They need utmost sympathy and courtesy. The Emergency Unit/ Department Service staff must

bear in mind all the time that Courtesy does not cost anything but creates an enormous amount of good will.

To maintain the dignity and the decorum of the Emergency Unit/ Department all the employees posted in the Emergency Unit/ Department must put on the proper hospital dress (white coat etc.) and display their name plates or identity cards.

Arrangements in the Emergency Unit / Department

The Medical Superintendent shall see that the following arrangement is made in the Emergency Unit/Department with proper signages and helpline numbers.

1. Help Desk/Reception/Registration
2. Waiting area
3. Triage area.
4. A resuscitation area/beds/a room for patient stabilization.
5. A transient area for patient observation and treatment
6. Procedure room for minor cases/Operation Theater /dressing room, plaster room.
7. Laboratory
8. Ambulance & Trolley bay
9. Drinking water facility and Toilet
10. 24x7 availability of Pathology and Radiology services like X-Ray, USG, CT, MRI
11. Security post
12. Proper Attendant management with periodical medical bulletin system.

Standard Instruments, Equipment and drugs:

The Casualty Medical Officer must ensure that the Emergency Unit/Department should have standard instruments, equipment, and drugs necessary for efficient and timely management of patients.

The instruments and equipment should be checked periodically for proper functioning.

Management of Emergency patients in Triage area:

Triage is a process used in emergency care to quickly assess and prioritize patients based on the severity of their condition.

The Goal of triage is to:

1. Identify and treat patients who require immediate attention: Those with life-threatening conditions or injuries that require prompt treatment to prevent harm or death.
2. Prioritize patients: Based on the severity of their condition, to ensure that those who need urgent care receive it in a timely manner.
3. Allocate resources effectively: By prioritizing patients, triage helps allocate maximal resources (e.g., medical staff, equipment, and facilities) to those who need them most.
4. To improve patient flow.
5. To improve patient satisfaction.
6. To decrease the patient's overall length of the stay.

Triage Categories:

1. **Red (Immediate) :** Patients with life-threatening conditions or injuries that require immediate attention.
2. **Yellow (Urgent) :** Patients with conditions that require prompt attention, but are not immediately life-threatening.
3. **Green (Non-urgent) :** Patients with minor conditions not requiring immediate attention.

Steps on Arrival of patient

- On arrival, the patient shall immediately be taken from the reception to the triage area and the registration slip shall be handed over to the CMO
- The CMO shall make a quick examination and categorise patients in to red / yellow / green category as per Table 1.

- Considering the illness and category of the patient, CMO shall inform on Duty Senior Resident of respective specialty/ specialities to examine the patient and provide appropriate care.

Guidelines to be followed: -

I. **Immediate -** The patient shall be attended within 1 minute and after prelimnary examination and asessment, the patient should be shifted to resuscitation bed earmarked for resuscitation equipped with oxygen, ventilator and other Cardio Pulmonary Cerebral Resuscitation requirements. After stabilization s/he shall be shifted to respective ward, from where after relief, patient can be discharged.

ii. **Urgent -** The patient shall be attended within (15 minutes) and immediate intervention is to be made.

iii. **Non-Urgent -** The patient shall be attended within (120 minutes), treated in observation bed and shall be discharged after relief or sent to appropriate departmental ward.

No patient shall remain in triage area for more than 24 hours

Note : The Post Graduate students may accompany any such doctors on duty/call but shall not independently attend the call. They shall manage cases under the supervision of SR/ AP/ Associate Professor/ Professor.

Escalation Matrix:

If the call is not attended by Senior Resident then at 15 minutes intervals the call shall be given in the escalating following order:

a. Assistant Professor on Call (Call, if no response from SR within 15 minutes)

b. Associate Professor (Call, if no response from AP within 15 minutes)

c. Professor (Call, if no response from Associate Professor within 15 minutes)

d. Medical Superintendent (Call, if no response from Professor within 15 minutes)

If there is no response from respective Unit(s) / Department(s) within first one hours, Medical Superintendent shall be informed immediately, to make alternative arrangement for immediate examination and treatment of the patient. The superintendent shall subsequently enquire in to the matter for such non attendance to a call and if no justified reason is found, necessary action deemed proper shall be

initiated against such doctor. During this time, CMO shall ensure that patient receives appropriate medical care for stabilization.

Table 1 : Categorization of patient into Red, Yellow and Green Category

Priority (COLOUR)	Level of Urgency	Condition of patient	Annexure
1 (RED)	Immediate	Presence of any altered physiological parameters, any time-sensitive conditions or conditions with increased urgency	Annexure 1.1; 1.2; 1.3; 4
2 (YELLOW)	Urgent	No "Red" criteria but have semi-urgent conditions needing admission for monitoring, evaluation, and treatment	Annexure 2; 5
3 (GREEN)	Non urgent	Required minor treatment and can be discharged	Annexure 3; 6

Table 2: Timeline and responsible doctor as per category

Priority (COLOUR)	Level 1 Consultation	Level 2 Consultation	Level 3 Consultation
1 (RED)	Senior Resident – Immediate (0-1 minute)	Assistant Professor - within 30 minutes	Associate Professr/ Professor – latest by 10 AM next day
2 (YELLOW)	Senior Resident – within 15 minutes	Assistant Professor - within 2 hours	Not Applicable
3 (GREEN)	Senior Resident – within 120 minutes	Not Applicable	Not Applicable

NB: The above time frame is applicable when the patient load is more and discrimination is required for initiation of treatment, otherwise all the patients shall be attended immediately. After stabilization the patient shall be shifted to respective ward, from where patient can be discharged after completion of indoor care.

Management of patients who die in Emergency Unit/ Department

a. Patients who die in casualty should be given death certificate by the Senior Resident of the respective specialty. If patient has died before the examination by the Senior Resident, then CMO should issue death certificate.

b. The Senior Resident / CMO should promptly inform the relatives of the patient who died in the Emergency Unit / Department.

c. The CMO should ensure that the body is sent to the mortuary with due care and consideration and when the relatives arrive in the casualty, the CMO should show due courtesy and sympathy to them and help them in every possible way in the disposal of the dead body.

d. Every death in the Emergency Unit / Department should be reported in writing and sent directly to the Medical Superintendent, giving particulars of the case and brief resume within 24 hours of death.

Management of “brought in dead” cases at Emergency Unit /Department

1. All cases “brought in dead”, and where the actual cause of death is not known, should be handed over to the police for suitable action.

2. The name of such cases should be entered in the casualty attendance register along with all the possible details about the dead person obtained from the accompanying relatives whose name and address should also be noted and recorded in the register.

3. In case where death has occurred due to natural causes and there is no suspicion of any foul play, the dead bodies may be handed over to the relatives on their request and this must be recorded with signatures of relatives or attendants.

4. 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 shall be informed immediately.

5. In all the above cases, the out-patient tickets and the death reports duly completed must be forwarded to the Medical Records Section and Registrar Birth & Death.

Preparation of Case Sheet and management policy.

a. Case Sheet must be prepared with utmost care to avoid future legal implications. It must be legibly written with full signature, designation, date and time of call as well as examination. Writing in a haphazard manner with omissions and commission of facts is to be strictly avoided. If the patient's condition is grave the treatment must be started immediately and Case Sheet is to be maintained subsequently keeping in mind that Case Sheet is a legal document.

b. The Name of patient, age, sex, father's name, full address, name of accompanying person must be clearly written in capital letters.

c. The provisional diagnosis must be written in capital letter.

d. Brief and pertinent examination findings (signs and symptoms) must be written clearly in case sheet.

e. Investigations if required must be mentioned on the body of Case Sheet on left margin. Only the investigations which are essential for diagnosis and immediate management shall be advised. Clear direction shall be given to do investigation like pathology, X-Ray, USG, CT, MRI in the hospital. The patient must be guided properly where to do the investigation. Direct or indirect indication to do the investigations by private agencies is strictly condemned and is punishable.

f. Every doctor should prescribe drugs with generic names legibly and preferably in capital letters and he/she shall ensure that there is a rational prescription and use of drugs.

g. There shall be periodical prescription audit and the erring officer shall be held responsible and action as deemed fit shall be initiated.

h. Legal action may be taken against the erring staff who mislead the patients leading to harassment of patients. Utmost care shall be taken so that no patient incurs expenditure during stay in Emergency unit/ department.

Management of patients in Triage and Observation area:

a. No serious patient needing admission should remain under observation without admission and proper case notes.

b. The staff nurses shall manage the treatment of patients as per the advice of the treating doctor. The staff nurse must check the status of life saving drugs, oxygen etc. available before taking over the charge of the shift. For any shortage indent must be made immediately and kept in stock.

c. Privacy must be provided to patients while doing any dressings of private parts.

d. Intravenous Drugs or Intramuscular drugs to gluteal region must not be administered in sitting position. Intramuscular drugs in upper limb can be administered while the patient is sitting with a back rest (e.g. a chair not a stool).

e. The injection or drug distribution area must be in a separate room or segregated from the ward by partition screen.

f. Aseptic precaution must be taken before giving any drug parenterally.

g. The dilution and speed of administration of any injection must be made as per specification.

h. Before giving any injection the date of expiry and route of administration must be verified in each vial or ampoule.

I. Any medicine or injection dispensed to a patient must be recorded in a register against the registration number.

j. The drugs and medicines, surgical item must be kept well arranged on the table or rack and the surrounding must be clean.

k. The rate of intravenous infusions, rate of oxygen must be strictly as per advise of doctor.

l. Bio Medical Wastes must be properly disposed in appropriate buckets. Syringes and Needles must be destroyed before disposal.

Emergency Unit / Department Admission Policy

a. Only patients whose assessment during triage falls under immediate and urgent shall be admitted to the Emergency Unit / Department for further management. Emergency ward is only for giving emergency care & management but not for keeping the patient for continued treatment.

b. It must be ensured that the various clinical departments/units while admitting patients in their departmental wards first priority shall be given to patients already admitted in emergency ward followed by patients attending OPD. They shall not keep beds vacant in their departmental wards while occupying beds in emergency wards. They will not admit any patient on such vacant beds from the OPD unless they have taken all the patients admitted in the emergency ward.

c. No gravely ill patient can be denied attention and admission on the ground of non-availability of beds. Under emergency situations, the CMO can take permission of the Medical Superintendent to admit a seriously ill patient in any vacant bed in the hospital after consultation with Assistant Professor.

d. When the patient requires the intervention of multiple departments, call can be given to appropriate departmental emergency doctors and the priority of treating department shall be decided. Such patient shall be admitted first to such priority departmental ward and subsequently referred to other department as per priority. Priority decision shall be as follows:

   i. **Multiple injuries:** In patients with injuries involving abdomen as well as other systems, the general surgical unit on-call would take the primary responsibility of the patient care. As a rule, a patient with altered sensorium due to head injury will be admitted under Neurosurgery though she/he may be having other system injuries. If Neurosurgery department is not in the hospital then general surgical unit will admit the patient.

   ii. **Combination of Surgical and Medical diseases:** In such situations, the problem of immediate importance would decide the primary responsibility. For example, an impending gangrene in a diabetic may primarily need medical care for the control of diabetes while a typhoid patient with acute abdomen due to intestinal perforation would need immediate surgical help.

   iii. **Medicine versus Medical Super speciality:** Where the patient requires specific cardiologic, neurologic, nephrologic, endocrinologic or gastroenterological therapeutic measures shall be managed by the concerned Super speciality department on advise of the Assistant Professor.

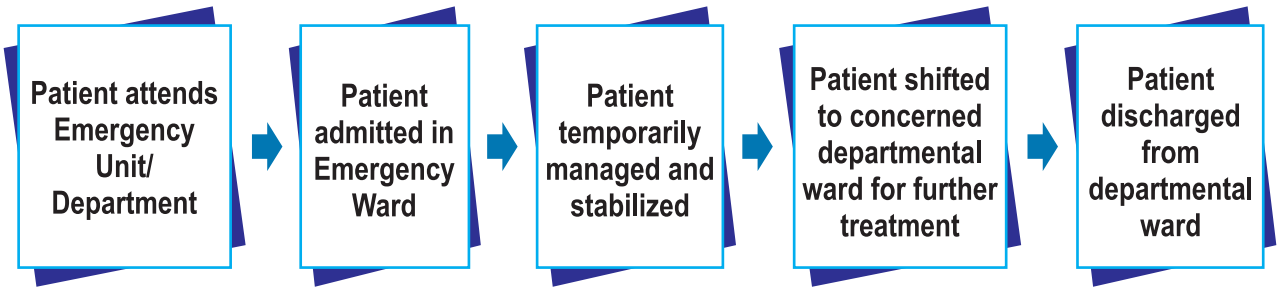
iv. **General Surgery versus Surgical Super-specialty:** Where the patient requires specific therapeutic measures related to Neurosurgical, Cardio-thoracic, Surgical Gastroenterology, Paediatric surgery or Plastic surgery, shall be managed by the concerned Super-speciality department on advice of the Assistant Professor. Same principle is applicable for Obstetrics and Gynaecology and Psychiatric cases.

v. The above priority decision is only indicative. The CMO, along with SR/AP/ Associate Professor/ Professor of concerned departments may sit together and decide the priority on the basis of above guidelines. If the priority still remains unsettled the decision of the Superintendent shall be final. But in no case the treatment can be stopped or patient is neglected or deprived of treatment.

e. Patients with infectious disease if requires treatment with isolation, a call shall be given to the concerned doctor in-charge of Infectious Disease (ID) ward and shall be admitted to the ID ward and when no more isolation is required the patient can be shifted to appropriate ward for further management or discharged with advise.

f. It is the responsibility of the CMO to direct all patients whose triage assessment falls under non urgent, to the physician or surgeon available for appropriate advise and disposal.

g. **Scheme of admission:**



(In the above process there is no provision for any backward movement of patients)

Interdepartmental Coordination

a. The Emergency unit/ department is the face of the Hospital. A prompt, appropriate and well-coordinated care of emergency and injury patients increases the confidence of public at large on the health care delivery system.

b. All the departments along with the Emergency unit/ department must work as one team.

c. Shifting of responsibility to manage the patient by one department to another on silly technical grounds leading to suffering of the patients is strongly condemned. All departments when receive a patient being referred from another department must examine him/her immediately and give appropriate advice. In case of conflict in management e.g. in poly trauma cases all departments must sit together and discuss the modalities of treatment and who to start first.

d. All the departments must be in round the clock preparedness to accept any patient on emergency and manage actively with all available skill, knowledge and resource. Interdepartmental referral shall be done by giving a call to the concerned department and recording such call in the call register.

e. In case of epidemics like Dengue, Covid-19, food poisoning, AES and other natural calamities or disasters all appropriate departments shall share equal responsibility of managing the emergency situation in a well-coordinated way as one team. In such cases the Medical Superintendent shall be the overall supervising authority. In these situations, all staff of Emergency unit/ department and other departments shall obey the directions of Medical Superintendent for smooth management. The decision of the Superintendent is final and binding in this regard.

Emergency Unit /Department review meetings

There shall be at least:

a. Monthly meeting on Clinical updates / Sensitisation of all staff of Emeregncy Unit / Department organized by the CMO for better preparedness and efficiency for management in emergency.

b. Bi-monthly mortality meeting.

c. Quarterly inter-departmental or inter-unit meeting / reviews /seminars for deciding

the best steps of management / methodology for immediate, urgent or non urgent cases in triage for best outcome of treatment. Such methodologies shall be recorded and to be circulated amongst all staff of Emergency Unit / Department and all concerned departments.

Non Trauma Settings

Annexure 1. 1. Non Trauma - Red Category - Altered physiology

(if any one of the following is present on assessment)

Primary Survey	Abnormalities
Airway compromise	Stridor/noisy breathing
	Angioedema involving the face
	Active seizures
Breathing compromise	Talking in incomplete sentences
	Audible wheeze
	RR >22/min or <10/min
	SPO2<90%
Circulation compromise	Pulse <50/min or >120/min (without fever)
	SBP >220 or DBP >110
	SBP <90 or DBP <60
	Shock index >1 (Pulse rate/SBP)
	Active bleeding (Epistaxis, gum bleed, hematemesis, others)
Disability	Altered sensorium (less than “Alert” on AVPU scale)

SBP: Systolic Blood Pressure, DBP: Diastolic Blood Pressure, RR: Respiratory rate, AVPU: Alert, verbal, pain, unresponsive

Annexure 1. 2. Non Trauma - Red Category - Time-sensitive conditions

(if any one of the following is present on assessment)

Acute chest pain (<24 h duration)	Limb weakness<24h duration
Suspected stroke presenting within 24 h of onset	Drowning/Hanging/electrocution/Trauma with dangerous mechanism of injury
Acute-onset shortness of breath within 12 h	Acute limb ischemia <48h duration
Anaphylaxis	Acute scrotal/inguinal pain in young male
Severe pain anywhere in body (VAS >7)	Sudden onset abdominal pain
Sudden-onset severe headache	Acute urinary retention
Any evaluation outside suggesting a time sensitive emergency condition including: Acute coronary syndrome, Aortic dissection, Acute stroke, Sepsis	Fever with (any one) Temperature >39°C Aplastic anemia Acute leukemia History of chemotherapy within 14 days
Serum potassium >5.5 mEq/L in outside reports	History of syncope

VAS: Visual analog scale

Annexure 1. 3. Non Trauma - Red Category - Other conditions with increased urgency

(if any one of the following is present on assessment)

Abdominal pain with vaginal bleeding
Agitated or violent patient
Suspected poisoning/snake bite/scorpion sting
Pregnancy in 3rd trimester with abdominal pain/vaginal bleeding

Annexure 2. Non Trauma - Yellow Category

Patients with normal ABCD but requires further investigation and/or observation.

Annexure 3. Non Trauma - Green Category

Patients with normal ABCD with minor illness

Trauma Settings

Annexure 4. Trauma - Red Category

(Any patient with trauma and having unstable ABCD, e.g., compromised airway, gurgling sounds, labored breathing, SPO2<90%, SBP <90 mmHg, pulse >100/min, respiratory rate >24/min, GCS <10)

Gunshot injuries
Penetrating injury to thorax, abdomen, neck
Major crush injuries
Vascular injuries
Pregnancy
Open long bones fractures
Fracture pelvis
Flail chest, open chest wound (sucking wound), subcutaneous emphysema, pneumothorax
Dangerous mechanism of injury
Traumatic amputation above knee or above elbow
Worsening clinical status on monitoring in yellow area (SPO2<90%, SBP <90 mmHg, pulse >100/min, RR >24/min)
GCS: Glasgow Coma Scale, SBP: Systolic blood pressure, RR: Respiratory rate

Annexure 5. Trauma - Yellow Category

Patients with normal ABCD but requires further investigation and/or observation.

Annexure 6. Trauma - Green Category

Patients with normal ABCD with minor injury

जीवन्त बिहार...
सपना हो साकार

राज्य स्वास्थ्य समिति, बिहार

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