	POLICY	IH.AAC.004 – TRIAGE AND PRIORITY OF PATIENT CARE		
	NABH Reference:	AAC 2 (e)		
	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 1 of 14	Revision No:	00	Version No:	03

\POLICY ON TRIAGE AND PRIORITY OF PATIENT CARE

1. PURPOSE

To provide a streamlined process for Trauma care to reduce mortality and prioritize patient care

2. DEFINITIONS AND ABBREVIATIONS

TRIAGE CARE: Triage is the process of determining the priority of patients' treatments based on the severity of their condition

3. RESPONSIBILITY

Medical Director
Emergency Staff

4. SCOPE

Emergency and OPDs

5. POLICY

The aim of good trauma care is to prevent early trauma mortality. Early trauma deaths may occur because of failure of oxygenation of vital organs or central nervous system injury, or both.

Indus Hospital has the policy of good and effective trauma care through system of TRIAGE.


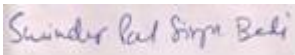
6. PROCEDURE


6.1 Aims of the initial evaluation of trauma patients

- Stabilize the patient.
- Identify life-threatening conditions in order of risk and initiate supportive treatment.
- Organize definitive treatments or organize transfer for definitive treatments.

6.2 Preparation and co-ordination of care

Assessment and management will begin out of hospital at the scene of injury and good communication with the receiving hospital is important. The preparatory measures are outlined below to 'set the scene'.


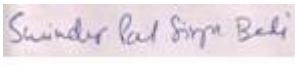
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	NABH Reference:	AAC 2 (e)		
	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 2 of 14	Revision No:	00	Version No:	03

The pre-hospital phase	First Response team	<ul style="list-style-type: none"> • Co-ordination and communication with the receiving hospital so that the trauma team can be alerted and mobilized. • Inform receiving hospital (Indus Hospital) about number of patients • Airway maintenance. • Control of external bleeding shock. • Keeping the patient immobilized. • Information gathering: time of injury; related events; patient history. Key elements are the mechanism of injury to alert the trauma team to the degree and type of injury. • Keeping time at the scene to a minimum.
The hospital phase	Hospital Management	<ul style="list-style-type: none"> • Preparation of a resuscitation area (Located in EMERGENCY DEPARTMENT of INDUS HOSPITAL) • Airway equipment - laryngoscopes, etc (accessible, tested). • Intravenous (IV) fluids (warming equipment, etc). • Immediately available monitoring equipment. • Methods of summoning extra medical help. • Prompt laboratory and radiology backup. • Transfer arrangements with trauma centre. <p>Guidelines on protection when dealing with body fluid should be followed throughout this and subsequent procedures.</p>

6.3. Trauma triage

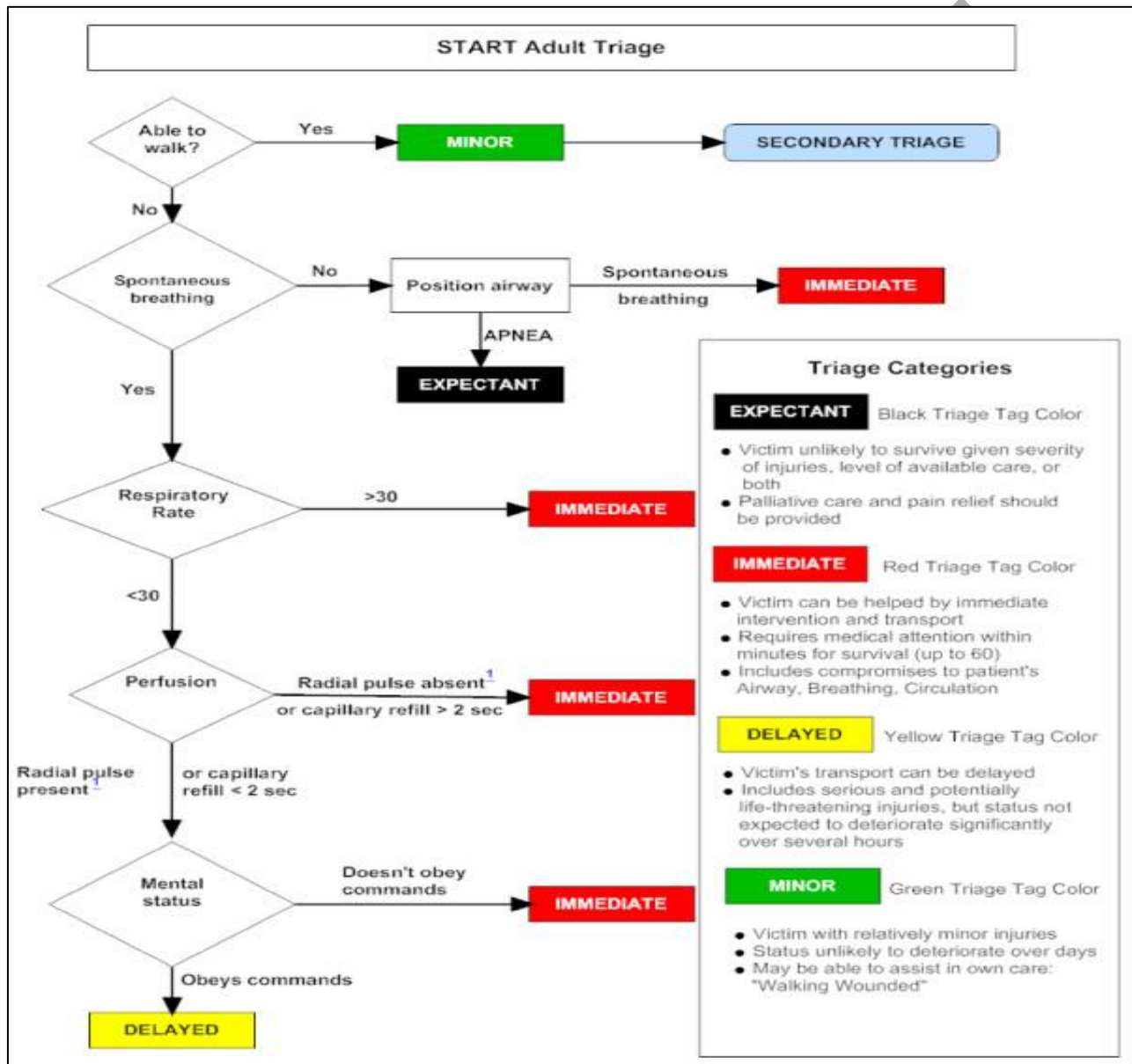
- Trauma triage is the use of trauma assessment for prioritizing of patients for treatment or transport according to their severity of injury.
- **Primary triage** is carried out at the scene of an accident and **secondary triage** at the receiving hospital.
- The primary survey aims to identify and immediately treat life-threatening injuries and is based on the 'ABCDE' resuscitation system:
 - **A**irway control with stabilisation of the cervical spine.
 - **B**reathing.
 - **C**irculation (including the control of external hemorrhage)
 - **D**isability or neurological status.
 - **E**xposure or undressing of the patient while also protecting the patient from hypothermia.

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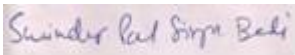
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	NABH Reference:	AAC 2 (e)		
	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 3 of 14	Revision No:	00	Version No:	03


➤ **Priority** is then given to patients most likely to deteriorate clinically and triage takes account of vital signs, pre-hospital clinical course, mechanism of injury and other medical conditions. Triage is a dynamic process and patients should be reassessed frequently.

6.3.1. PRIMARY TRIAGE (at accident site)



Colored ribbons are used as triage bands in hospital.

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 4 of 14	Revision No:	00	Version No:	03

	RED URGENT (P1 or T1)	YELLOW DELAYED (P2 or T2)	GREEN MINOR: (P3 or T3)	BLACK EXPECTANT (P4 or T4)
RESPONSE TIME	Requires immediate life-saving intervention.	Requires significant intervention within 30 minutes.	Needs medical treatment, within 2 hours of patient arrival	Is important to prevent the expenditure of limited resources on those who are beyond help
CATEGORY	Those patients whose injuries are critical but who will require minimal time or equipment to manage and who have a good progress for survival. E.g.:- patient with a compromised airway or massive external hemorrhage	Those patients whose injuries are debilitating but who do not need immediate management to salvage life or limb. E.g.:- Long Bone fracture	Who have minor injuries that can wait for treatment are who may even assist in the intern by comforting other patients.	Who is unresponsive, pulse less, Breathless, in a disaster, resources rarely allow for attempted resuscitation.


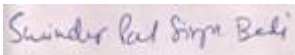
Triage systems are most often used following trauma incidents but may be required in other situations, such as an influenza epidemic. Once further resources are available to hand, the patients will undergo a further, more detailed triage based on vital signs - eg, respiratory rate


6.4 SECONDARY TRIAGE at the hospital

The triage sort or Revised Trauma Score (RTS)

- Used as a triage tool in a pre-hospital setting.
- It is a common physiological scoring system based on the first data sets of three specific physiological parameters obtained from the patient.
- The three parameters are: the GCS, systemic blood pressure (SBP), and the respiratory rate (RR)


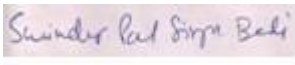
The triage sort or Revised Trauma Score (RTS)


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	NABH Reference:	AAC 2 (e)		
	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 5 of 14	Revision No:	00	Version No:	03

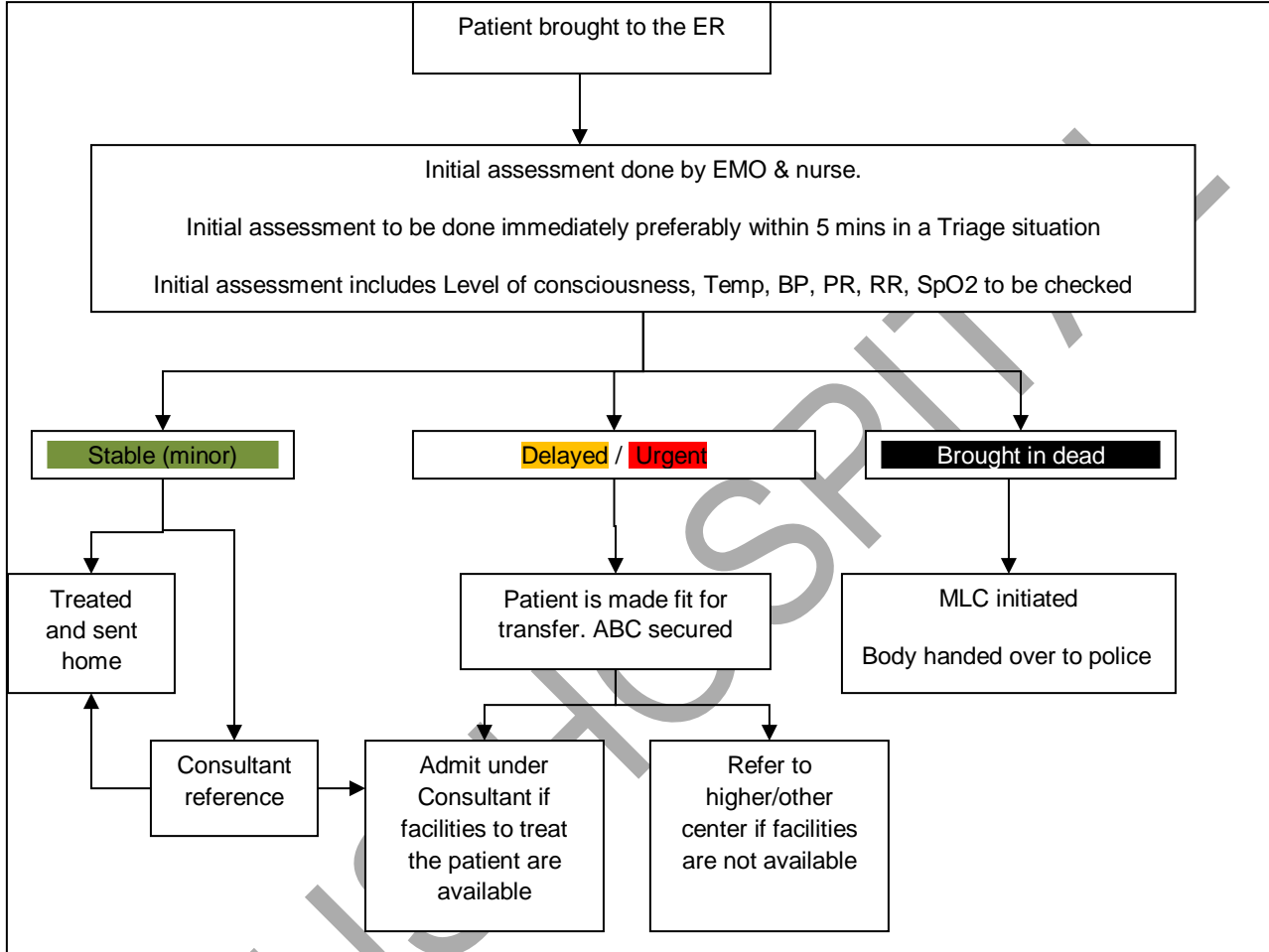
Physiological variable	Value	Score	Patient Score
Respiratory rate	10-29	4	
	>29	3	
	6-9	2	
	1-5	1	
	0	0	
Systolic blood pressure (BP)	>90	4	
	76-89	3	
	50-75	2	
	1-49	1	
	0	0	
Glasgow Coma Scale (GCS)	13-15	4	
	9-12	3	
	6-8	2	
	4-5	1	
	3	0	
TOTAL			

A total score of 1-10 indicates priority T1, 11 indicates T2, and 12 indicate T3. A score of 0 means dead.


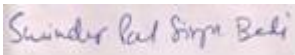
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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 6 of 14	Revision No:	00	Version No:	03

6.5 TREATMENT OF PATIENT ONCE BROUGHT TO THE HOSPITAL



6.6 TRIAGE IN OUTPATIENT AND DIAGNOSTICS:-

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 7 of 14	Revision No:	00	Version No:	03

6.6.1 Outpatients who attend the Booked service are:-

- Generally seen in business hours
- Have a pre-booked appointment
- Access the service for pregnancy assessment
- Access the hospital for any diagnostic test

6.6.2. While waiting for the consultation, or for diagnostic test Suddenly if patient feels sick or is being noticed by PED staff/ Front office Incharge/Nurse/medical officer as showing symptoms of being unwell Such patients will be shown out of their turn on priority basis.

6.6.3. vulnerable patients coming for the diagnostic test and for the consultation are fastly tracked and seen out of their turn as per priority.

6.6.4 Posters for the same has been displayed in all the OPD waiting areas and the OPD staff / Diagnostic staff has been trained on the same


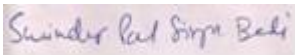
6.6.5 POLICY ON VISUAL TRIAGE


PATIENTS WAITING IN OPD FOR CONSULTATION / INVESTIGATIONS might experience one of the below:

1. Unconscious patient
2. Severe chest or abdominal pain,
3. Breathlessness or difficulty in breathing
4. Feeling faint or discomfort.
5. High fever
6. Patient on wheel stretcher patient on wheel chair or stretcher
7. Pregnancy

FOR PATIENTS EXPERIENCING ANY OF THE ABOVE, VISUAL TRIAGING WILL BE DONE BY THE CONCERNED PERSON BASED ON THE TRIAGE FLOW CHART (**REFERANCE 6.3**). PATIENTS FALLING IN THE RED CATEGORY WILL BE SEEN OUT OF TURN.

6.7 IN SUMMATION

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 8 of 14	Revision No:	00	Version No:	03

6.7.1 In case of any disaster, which shall entail as a number exceeding the normal handling capacity of the ED, patients shall be **triaged, tagged** (see below) and allotted beds in the ED as per the urgency of their medical needs. Considering the surge capacity of the infrastructure and skill sets, a deliberate decision has been taken to define this number as five patients brought in within a half hour period due to any reason. As a part of our Corporate Social Responsibility, the Hospital plans for managing resuscitation and treatment of five, to provide necessary support.

6.7.2 The desired outcome of the triage process is that all Emergency Department patients will receive expedient treatment according to established priorities.

6.7.3 Emergency patients requiring immediate intervention are transferred to the appropriate bed station in the ED to initiate the patient assessment and care process.

6.7.4 The registration process of the patient is also initiated in the ED if the patient condition permits. In case of limb and life threatening situations the registration and consent process are postponed so as to facilitate the initiation of appropriate emergency care.

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

6.7.6 Decision is made about who will be managed first:

Multiple casualties: where the number of patients and severity of injury do not exceed the capacity of the treatment centre, life-threatening injuries and multiple system injuries are treated first.


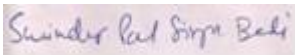
Mass casualties: when the number of patients and severity of injury do exceed capacity of the treatment centre, patients are selected for treatment according to best chance of survival with least expenditure of resources (time, personnel, equipment, supplies).


In a choice between a patient with a catastrophic injury, such as severe open head trauma, a patient with an acute intra-abdominal hemorrhage the proper course of action in an Multiple Emergency Incidents (MEI) is to manage first the **salvageable patient** : - The one with the abdominal hemorrhage. Treating severe head injury patients first probably will cause loss of both the patients.

6.8 RECORDS AND LEGAL CONSIDERTIONS

Remember:

- Keep **meticulous records** (patient details, time of entry, classification, triage code, treated by, timing for all entries, etc). Teamwork with timekeeping and recording of clinical measurements, and observations can be helpful. Some units have a member of the nursing staff whose sole role is to record and collate patient care information accurately.

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 9 of 14	Revision No:	00	Version No:	03

- **Consent** for treatment is not always possible with lifesaving treatment and consent may have to be given later.
- **Forensic evidence** may be required in injuries caused by criminal activity.

Practice tips

Regular training in resuscitation by the whole practice team is recommended. Attention to a team approach is essential.

7. IMPLEMENTATION

Emergency Staff

8. POLICY CROSS LINKAGES –

Nil

9. ATTACHMENTS -

Nil

REFERENCE FOR TRIAGE ASSESSMENT AND TREATMENT.

Initial assessment

This comprises:


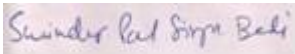
- Resuscitation and primary survey.
- Secondary survey.
- Definitive treatment or transfer for definitive care.


Resuscitation and primary survey

For speed and efficacy a logical sequence of assessment to establish treatment priorities must be gone through sequentially although, with good teamwork, some things will be done simultaneously (resuscitation procedures will begin simultaneously with the assessment involved in the primary survey, *ie lifesaving measures are initiated when the problem is identified*). Special account should be taken of children, pregnant women and the elderly as their response to injury is modified. The primary survey is according to:

A = Airway maintenance cervical spine protection

- Are there signs of airway obstruction, foreign bodies, facial, mandibular or laryngeal fractures? Management may involve secretion control, intubation or surgical airway (eg, cricothyroidotomy, emergency tracheotomy).

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 10 of 14	Revision No:	00	Version No:	03

- Establish a clear airway (chin lift or jaw thrust) but protect the cervical spine at all times.^[9] If the patient can talk, the airway is likely to be safe; however, remain vigilant and recheck. A nasopharyngeal airway should be used in a conscious patient; or, as a temporary measure, an oropharyngeal airway in an unconscious patient with no gag reflex. Definitive airway should be established if the patient is unable to maintain integrity of airway; mandatory if Glasgow Coma Scale (GCS) is less than 8.
- Cervical spine protection is critical throughout the airway management process. Movement of the cervical spine could cause spinal injury so movement of the cervical spine should be avoided unless absolutely necessary for maintaining an airway.^[9] The trauma mechanism or history may suggest the likelihood of a cervical spine injury, but always assume there is a spinal injury until proven otherwise, especially in any multisystem trauma or if there is an altered level of consciousness. Inline immobilization and protection of the spine should be maintained and X-rays can be taken once immediately life-threatening conditions have been dealt with.

B = Breathing and ventilation

Provide high-flow oxygen through a rebreather mask if not intubated and ventilated.^[10] Evaluate breathing: lungs, chest wall, diaphragm. Chest examination with adequate exposure: watch chest movement, auscultate, percuss to detect lesions acutely impairing ventilation:


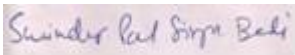
- Tension pneumothorax - requires needle thoracostomy followed by drainage.
- Flail chest - management involves ventilation.
- Haemothorax - will usually require intercostal drain insertion.
- Pneumothorax - may require intercostal drain insertion.


Note: it can be difficult to tell whether the problem is an airway or ventilation problem. What appears to be an airway problem, leading to intubation and ventilation, may turn out to be a pneumothorax or tension pneumothorax which will be exacerbated by intubation and ventilation.

C = Circulation with hemorrhage control

Blood loss is the main preventable cause of death after trauma. To assess blood loss rapidly observe:

- Level of consciousness.
- Skin color.
- Pulse.
- Bleeding - this should be assessed and controlled:

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 11 of 14	Revision No:	00	Version No:	03

- IV access should be achieved with two large cannulae (size and length of cannula is determinant of flow not vein size) in an upper limb. Access by cut down or central venous catheterisation may be done according to skills available. At cannula insertion, blood should be taken for crossmatch and baseline investigations.
- IV fluids will need to be given rapidly, usually as 250 ml to 500 ml warmed boluses (10-20 ml/kg in children). Often a total of 2-3 L of IV fluids is necessary (40 ml/kg in children), which will then need to be followed by blood transfusion (O negative to begin with, if typed blood is not available). Ringer's lactate is the preferred initial crystalloid solution.
- Direct manual pressure should be used to stem visible bleeding (not tourniquets, except for traumatic amputation, as these cause distal ischaemia).
- Transparent pneumatic splinting devices may control bleeding and allow visual monitoring; surgery may be necessary if these measures fail to control haemorrhage.
- Occult bleeding into the abdominal cavity and around long-bone or pelvic fractures is problematic but should be suspected in a patient not responding to fluid resuscitation.

Note: response to blood loss differs in:

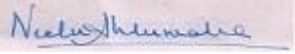
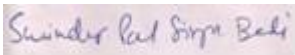
- Elderly - limited ability to increase heart rate; poor correlation between blood loss and blood pressure.
- Children - tolerate proportionately large volume loss but then rapidly deteriorate.
- Athletes - do not show the same heart rate response to blood loss.
- Chronic conditions and medication may affect response and early on in trauma management will not be known about.


D = Disability: neurological status

After A, B and C above, rapid neurological assessment is made to establish:

- Level of consciousness, using GCS.
- Pupils: size, symmetry and reaction.
- Any lateralising signs.
- Level of any spinal cord injury (limb movements, spontaneous respiratory effort).
- Oxygenation, ventilation, perfusion, drugs, alcohol and hypoglycemia may all also affect the level of consciousness.

Patients should be re-evaluated frequently at regular intervals, as deterioration can occur rapidly and often patients can be lucid following a significant head injury before worsening. Signs such as pupil asymmetry or dilation, impaired or absent light reflexes, and hemiplegia/weakness all suggest an expanding intracranial

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 12 of 14	Revision No:	00	Version No:	03

mass or diffuse oedema. This requires IV mannitol, ventilation and urgent neurosurgical opinion. Hypertonic saline can be used as an alternative to mannitol especially in hypovolemic patients.

E = Exposure/environmental control

Undress the patient, but prevent hypothermia. Clothes may need to be cut off but, after examination, attend to prevention of heat loss with warming devices, warmed blankets, etc. Also check blood glucose levels.

Additional considerations to primary survey and resuscitation

ECG monitoring: this can guide resuscitation by diagnosing dysrhythmias, ischaemia, cardiac injury, pulseless electrical activity (PEA) - which may indicate cardiac tamponade - hypovolaemia, tension pneumothorax, and extreme hypovolaemia. Hypoxia or hypoperfusion should be suspected if there is bradycardia, aberrant conduction, and premature beats. Hypothermia produces dysrhythmias.

Urinary/gastric catheters:

- Output of urine can guide fluid replacement (reflects renal perfusion). Adequate output is 0.5-1 ml/kg/hour. **Note:** prior to catheter insertion urethral injury should be excluded - suspect if there is blood at meatus, pelvic fracture, scrotal blood, perineal bruising. Per rectum and genital examination are mandatory prior to catheter insertion.
- Gastric catheters are inserted to reduce aspiration risk. Suction should be applied. **Note:** care should be taken not to provoke aspiration by triggering gagging.


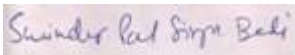
Other monitoring: monitoring of resuscitation by measuring various important parameters measures adequacy of resuscitation efforts. Values for various parameters should be obtained soon after the primary survey and reviewed regularly. Important parameters are:


- Pulse rate, ^[12] blood pressure, ventilatory rate, arterial blood gases, body temperature and urinary output.
- Carbon dioxide detectors may identify dislodged endotracheal tubes.
- Pulse oximetry measures oxygenation of haemoglobin colorimetrically (sensor on finger, ear lobe, etc.).

Remember: blood pressure is a poor measure of perfusion.

Diagnostic procedures: care should be taken that these do not hamper resuscitation. They may be best deferred to the secondary survey. Modifications to the ATLS guidelines have been suggested. ^{[13][14]} X-rays most likely to guide resuscitation early on, especially in blunt trauma, include:

- CXR.

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	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 13 of 14	Revision No:	00	Version No:	03

- Pelvic X-ray. It has been suggested that CT scans may be used in some stable patients.^[13]
- Lateral cervical spine X-ray.

Other useful procedures include FAST (= focused assessment with sonography for trauma), eFAST (= extended focused assessment with sonography for trauma) and/or CT scanning to detect occult bleeding.

Secondary survey

This begins after the 'ABCDE' of the primary survey, once resuscitation is underway and the patient is responding with normalisation of vital signs. The secondary survey is essentially a head-to-toe examination with completion of the history and reassessment of progress, vital signs, etc. It requires repeat physical examinations and may require further X-ray and laboratory tests. It comprises:

History

- **A = Allergies.**
- **M = Medication** currently used.
- **P = Past illnesses/Pregnancy.**
- **L = Last meal.**
- **E = Events/Environment** related to injury

Physical

examination

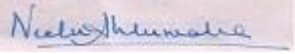
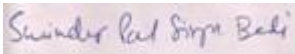
This will repeat some examinations already undertaken in the primary survey and will be further informed by the progress of the resuscitation. It aims to identify serious injuries, occult bleeding, etc. A review of neurological status including GCS score is also undertaken. Back and spinal injuries are commonly missed and pelvic fractures cause large blood loss which is often underestimated.


Beware: burns (fluid requirements, inhalation injury); **cold injury** (continue resuscitation until rewarmed); high-voltage electricity injuries (extensive muscle injury likely to be concealed).

Additional considerations to secondary survey

A range of further diagnostic tests and procedures may be required after the secondary survey. These include ultrasound investigations, contrast X-rays, angiography, bronchoscopy, oesophageal ultrasound, etc.


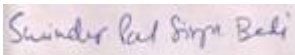
Definitive care

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	NABH Reference:	AAC 2 (e)		
	Issue Date :	30 th SEPTEMBER 2020	Review Date:	31 st AUGUST 2023 (as req)
Page 14 of 14	Revision No:	00	Version No:	03

Choosing where care should continue most appropriately will depend on results of the primary and secondary surveys and knowledge of the facilities available to receive the patient. The closest appropriate facility should be chosen.

INDUS HOSPITAL

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