STUDY OF UTILIZATION OF EMERGENCY SERVICES AT ALL INDIA INSTITUTE OF MEDICAL SCIENCES HOSPITAL, NEW DELHI

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RECOMMENDATIONS

Based on the observations and discussions, the following recommendations are made:

1. Emergency services should be given a departmental status and its staff should be recruited accordingly.

2. Administrative Officer of the rank of Deputy Medical Superintendent should be entrusted exclusive responsibility of emergency services who will also be in-charge of CAO and will also exercise control of admissions of entire hospital.

3. Policies and procedures of emergency services should be clear, in writing and should be displayed. These should cover the following aspects:
   (a) Full authority for admissions should be entrusted to CMOs;
   (b) Hospital policy regarding admission of various cases should be spelt out. Instructions regarding non-admission of certain types of cases should be displayed in casualty like burns cases, quadriplegia not requiring any immediate life-saving treatment, infectious disease cases etc.;
   (c) Detailed policy on observation beds should be formulated. Cases should not lie for long periods; and
   (d) All medico-legal cases are dealt by residents of Forensic Medicine.
Emergency OPD Complex:

4. All examination cubicles and observation beds should have points for piped oxygen and suction.

5. First cubicle in examination and treatment area should have examination couch in centre so that patient can be examined from both sides. This cubicle should be used for extensive injury patient or patients who will be required to be examined from both sides.

6. One additional staff nurse be posted during all shifts for observation bed area which will ease the staffing pattern for nurses.

7. One of the observation beds be converted into cardiac bed and facilities like cardiac monitor be provided for this bed.

8. All the observation beds and examination couch of examination and treatment room be provided with detachable attachments for hanging transfusion bottles.

9. Reception and medico-social desk should be manned round the clock. This desk will also be entrusted jobs like maintenance of emergency OPD complex register of patients, issue and preparation of emergency OPD cards and file. This counter will also help in contacting the doctors required for consultation in the emergency OPD complex.

10. Operation theatre complex of emergency OPD complex should have an internal telephone.

11. ECG room located on 4th floor should have telephone and all cases of emergency OPD complex should have priority.

12. Casualty committee should also have representative from both emergency wards and from specialities having more than 10.0 percent of patients in emergency ward.

Emergency Wards

13. There should be a Medical Officer In-charge of each emergency ward present physically round the clock.

14. Emergency ward should have a demarcation on speciality based rather than on age and sex. Medicine connected specialities like Neurology, Cardiology, Dermatology, Psychiatry, Paediatrics etc. could be admitted in one ward while rest surgical based in another ward. This will help in positioning of a doctor round the clock in the ward.

15. One nursing sister should also be available during ‘B’ shift in each ward.
16. Admission of patients who require some emergency treatment should only be done. Patients attending hospital OPD/Specialist clinics should not be admitted on the pretext of non-availability of beds in their speciality but could be admitted if any emergency treatment is indicated.

17. All transfers and discharges from the emergency wards should be ordered during the morning and evening round and should be completed by 1300 hrs and 2000 hrs respectively.

18. Monitoring of admissions transfers/discharges of regular reminders to unit heads who continue to keep patients for more than 48 hours since admission in emergency wards.

19. Transfer out policy for patients admitted in emergency ward should be clearly spelt and casualty committee should have powers to transfer cases from emergency wards who have overstayed to their respective wards. This committee should also control direct admissions of such units through DMS of emergency services.

20. All beds of emergency wards should have point for piped oxygen and suction.

**Central Admission and Enquiry Office**

21. Reception and information system counter be separated from admission work and should be properly organised. Reception clerk and medico-social aid should man the counter round the clock.

22. CAO should start registration system for all routine admissions on speciality basis. Certain proportion of beds of all specialities should be kept for emergency patients, which will depend on ALS of the speciality/unit and the percentage of beds occupied by the speciality during previous year. Up to-date waiting list of each speciality/unit should be forwarded to the concerned on fortnightly basis so that the patient could be accordingly advised during his/her visit to the OPD/clinic of the speciality concerned.

23. CAO should show all admissions done through emergency OPD complex as’ emergency admission’ irrespective of area of admission.

24. Vacancy report of all wards duly compiled should be forwarded to the CAO by night supervisor.
SUMMARY

The emergency service is a vital component of the hospital and its contributes substantially to the total health care of the community. The emergency services of the hospital has become like a round the clock physician of the community. As such, the emergency services have grown into a highly complex and sophisticated branch of health care delivery system. The present state of the service is ascribed due to:

a) Progress in medical and surgical technique;
b) Development of new equipment which can be used in health services vehicles;
c) The increase in the number of patients or casualties, who are dependent on resuscitation technique; and
d) The need of shifting a patient to a specialised hospital with speed.

The study was conducted at the All India Institute of Medical Sciences with the following objectives:

1. To study existing management pattern (objectives, organisation, staffing, policies and procedures) and coordination in casualty services.
2. To study utilization of emergency beds.
3. To identify the bottlenecks and problems and suggest method to overcome the existing problems.

It was observed that emergency beds have increased from 42 (5.6% of hospital complement) in 1971 to 70 (8.64% of hospital complement) in 1979. During the last 5 years, emergency ward admission has increased by 32.92 percent while emergency outpatient department attendance has gone up by 97.32 percent. During 1979-80, on an average, 16.85 percent of beds (out of 70 beds) in emergency ward are found to be vacant and monthly bed turnover rate is found as 5.66.

Admissions advised in emergency outpatient department complex are made in emergency wards and also directly in concerned speciality ward/intensive care areas if bed is vacant. All obstetrical emergencies report directly to the maternity wing of the hospital. However, hospital statistics show admissions in emergency ward as ‘emergency admission’ whereas all other admissions are reflected as ‘routine admission’. Emergency wards receive 74.48 percent of cases while 25.52 percent of patients are directly admitted in concerned speciality wards/intensive care areas of All India Institute of Medical Sciences Hospital.

Emergency services do not have a departmental status as such emergency outpatient department complex and emergency wards function as two different sections. Technical and
administrative supervision is not very effective as the officers deputed continue to have their full responsibilities/duties in their respective departments.

The Casualty Medical Officers/Assistant Casualty Medical Officers, posted in emergency outpatient department complex are not satisfied with their work as they are not involved in continuous care of patients and surgical Casualty Medical Officers are not involved in any major surgery. On the other hand, Casualty Medical Officers have to deal with medico-legal cases which lead to receiving of court summon for attending courts at later date thereby jeopardizing in their duty schedule.

Casualty Committee do not have representatives from emergency wards as such emergency wards problems are left unattended. There is no technical officer in-charge of ward; neither any doctor is present round the clock in wards. Reception and enquiry counter at Central Admission and Enquiry Office and in emergency outpatient department complex is not properly organised.

Observation beds area is not in position to be observed from nursing station and Casualty Medical Officers desk. Policy for keeping patient on these beds is not clearly spelled out as such patients are found occupying these beds for long period. Documentation of patient in emergency outpatient department complex including patient on observation beds, is inadequate and no record is available once patient leaves the emergency outpatient department complex.

The distribution of patients in emergency wards is on the age and sex basis. Patients admitted in emergency wards are to be transferred to the concerned speciality ward within 48 hours as per the hospital policy. However, this policy is followed by 56.5 percent of cases and the specialities are not keen on implementation of this policy as emergency admissions affect their planned/routine admissions in their respective ward.

Average length of stay in emergency ward is found to be 3.78 days which is 89.0 percent more than the maximum allowable period as laid down by hospital policy. Patients who are operated in operation theatre of emergency outpatient department complex prior to arrival in the emergency ward are found to have average length of stay of 4.68 days while patients who are operated during their stay in emergency ward have average length of stay of 8.55 days. This implies that the concerned specialties have used the emergency ward as their satellite ward.

Trauma cases in study are found to be 16.19 percent. Beginning of week (Monday 18.08% and Tuesday 17.82%) witness 35.90 percent of admissions while weekend days (Saturday 14.95% and Sunday 10.15%) have 25.05 percent of admissions in emergency wards. Therefore, emergency admissions are found to be more during beginning of week rather than on week-end days.
Average length of stay of patients admitted in All India Institute of Medical Sciences Hospital for emergency patients is 11.9 days as against 9.9 days average length of stay of all admitted patients during the same period. Thus, emergency patients have 20.0 percent more average length of stay than all admitted patients.

Based on the study, following recommendations have been made:

1. Emergency services should be given a departmental status and its staff should be recruited accordingly.
2. There should be a medical officer in-charge of each emergency ward present round the clock.
3. Emergency wards be demarcated on medical and surgical based specialities.
4. Emergency beds should be increased to 80 beds (10% of hospital bed complements).
5. Administrative Officer of the rank of Deputy Medical Superintendent be entrusted exclusive responsibilities of emergency services including Central Admission and Enquiry Office.
6. Policies and procedures for emergencies services should be clear, in writing and be displayed.
7. Reception and medico-social desk be manned round the clock for emergency services.
8. Central Reception and Information systems counter should function round the clock at Central Admission and Enquiry Office.