IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

STANDARD

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STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

INTRODUCTION

An outpatient care clinic may be confronted with a client who presents with a deteriorating emergency/urgent clinical condition that requires prompt management to avoid adverse events, disability and death. The care for a patient with an emergency condition must be guided by appropriate policies and procedures.

At the minimum, each outpatient clinic must have provisions for basic emergency management and diagnostic procedures. An outpatient clinic must be manned by a physician and allied health personnel with provisions including secured lifesaving/emergency medications, devices, equipment, and supplies required for immediate use when life-threatening conditions are confronted. A means for obtaining immediate assistance and/or emergency exits must be available in all consultations and treatment rooms.

It is the aim of the Dubai Healthcare City Authority-Regulatory (DHCR) to ensure that all outpatient clinics provide high quality evidence based clinical care treating the presented emergency condition with the highest standards of care including basic and Advanced Life Care Support as outlined in this standard.

1. PURPOSE	
1.1	To define the process for identifying emergency/urgent versus non-emergency medical conditions and prevent delays in the access to care in outpatient care settings.
1.2	To provide direction and guidance to ensure a consistent approach is applied in relation to the management of medical emergencies across all outpatient care settings licensed by Dubai Healthcare City Authority (DHCA).
1.3	To implement an appropriate plan of care in the outpatient care setting and transfer the patient to the nearest health care facility where specific advanced health provision can be provided.
1.4	Standardize the minimum preparedness for medical emergencies in outpatient care settings to ensure patients' safety.

2. SCOPE OF APPLICATION	
2.1	This standard is applicable to all DHCA Licensed Healthcare Operators which fall under the category of outpatient clinics.
2.2	All Healthcare professionals (HCP) working for DHCA Licensed outpatient clinics.

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

3. STANDARD	
3.1. EMERGENCY EQUIPMENT & MEDICATIONS	
3.1.1	Each outpatient clinic must be equipped with appropriate emergency equipment and medications that are immediately available for use in emergency situations.
3.1.2	Emergency equipment and medications must be appropriate for the outpatient clinic's patient population and scope of practice/services offered and must be maintained appropriately.
3.1.3	A Crash Cart must be available and ready for use when required in outpatient clinics (Class B, Class C, Class C-M), Endoscopy units that provide sedation, in addition to Renal Dialysis and Fertility centers. See appendix IV for Minimum Mandatory Emergency Medications and Equipment to be available in Crash Carts.
3.1.4	Outpatient clinics conducting stress test (pharmacological stress test, stress echo with Dobutamine or treadmill testing) shall have Crash Cart available and ready for use when required. The physician shall be physically or immediately available during the provision of stress test procedures and an ACLS trained healthcare professional.
3.1.5	Each outpatient clinic shall maintain an inventory checklist of all the contents of the crash cart with evidence of daily inspection for the functionality of the defibrillator and evidence of at least a monthly inspection for all the equipments are in good working condition including battery and the bulb and the expiry dates of the medications and consumables. This checklist should be kept in a safe place nearby crash cart for inspection.
3.1.6	Crash cart shall be refilled in less than 24 hours or as soon as possible whenever used for whatever reason.
3.1.7	There must be a written protocol for cardiopulmonary resuscitation (CPR) from the most current international guidelines. The charts and algorithms for BLS/ACLS/PALS, tachycardia, bradycardia to be attached to the crash cart.
3.1.8	In Pediatric Clinics there should be a Pediatric drug dosing chart attached to the Crash cart.

3.2. LIFE SUPPORT REQUIREMENTS/QUALIFIED PERSONNEL	
3.2.1	All staff must have relevant training to recognize, provide, and seek urgent medical care for patients with urgent or emergency needs including appropriate level of life support training as per DHCR Life Support Policy, Procedure and Guideline.
3.2.2	All HCPs must have valid Life Support certification renewable every two years and which must remain valid during the term of licensure as per DHCR Life Support Policy, Procedure and Guideline.

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

3.2.3	At least one healthcare professional in an outpatient clinic (Class B, Class C, Class C-M), Endoscopy units that provide sedation, clinics that provide stress test, Renal Dialysis and Fertility centers must have a valid ACLS/PALS certificate and must be present whenever procedures/surgeries are performed in the facility. The facility must consider and ensureadequate staffing and appropriate expertise for the procedure/s carried out.
3.2.4	DHCA-licensed Anesthesiologists must have valid ACLS/PALS certification as applicable according to the patient age group under their care.
3.2.5	ACLS certification is required for HCPs practicing in HCOs whose clinical services provide sedation/stress tests. This list includes but is not limited to: 3.2.5.1. Cardiologists, 3.2.5.2. Interventional Cardiologists, 3.2.5.3. Anesthesiologists, 3.2.5.4. Emergency specialists, 3.2.5.5. Pulmonologists, 3.2.5.6. Medical Oncologists, 3.2.5.7. Respiratory Therapists, 3.2.5.8. Interventional Radiologists, and 3.2.5.9. Hospice and Palliative Medicine Specialists, **Note*: ACLS can replace BLS provided evidence is submitted that the basic life support elements are covered as per DHCR Life Support- Policy, Procedure and Guideline.
3.2.6	In addition to BLS, PALS is required for HCPs practicing in HCOs whose clinical services provide sedation. These include but are not be limited to: 3.2.6.1. Pediatricians, 3.2.6.2. Pediatric sub-specialties, 3.2.6.3. Pediatric Dentists, 3.2.6.4. Anesthesiologists, and 3.2.6.5. Emergency specialists who are working with pediatric patients. *Note: PALS can replace BLS provided evidence is submitted that the basic life support elements were covered as per DHCR Life Support- Policy, Procedure and Guideline
3.2.7	Registered Nurses (RN) providing emergency services must be competent to provide emergency care when needed. Examples of emergency nurse competencies include: 3.2.7.1 Patient Triage: (document target presenting complaint, record vitals, and pick up clinical red flags without delay and notify to the physician) 3.2.7.2 ECG Recording, 3.2.7.3 Pulse Oximetry, 3.2.7.4 Oxygen administration,

	3.2.7.5 Intravenous cannulation, 3.2.7.6 Medication administration, and 3.2.7.7 Valid BLS/ACLS certification

3.3. PATIENT MANAGEMENT	
3.3.1	Each outpatient clinic must have a policy on guiding the front line staff to identify urgent cases that require immediate care. Front line staff must be trained to spot any potential urgent or emergency cases and evidence of trainings with annual refresher mock drills must be maintained.
3.3.2	Front line staff must alert designated healthcare professionals immediately whenever they spot any potential urgent or emergency cases. Visual reminders of urgent/emergency symptoms must be posted in each registration desk as a reminder for staff.
3.3.3	Each outpatient clinic must have arrangements to assist any patient arriving by their own transport but unable to independently walk into the clinic. These patients will be taken directly to the assessment room for assessment.
3.3.4	Flow of patients must be clearly noted and each outpatient clinic must have a designated assessment room accessible and easily identified to manage emergency cases.
3.3.5	Designated and trained staff must be available in each outpatient clinic and be ready to respond upon urgent/emergency announcements.
3.3.6	Designated HCPs must respond immediately to an urgent/emergency call and escort the patient immediately to the assessment room for assessment as per the patient's physiologic needs.
3.3.7	Patient reassessment frequency depends on the medical severity of the case; patients should not be left alone in a room at any moment.
3.3.8	Accordingly, Healthcare professionals must inform the physician / life support trained staff / ambulance staff of patients' abnormal vitals or deterioration see (Appendix I).
3.3.9	Healthcare professionals must collaborate in the planning and implementation of appropriate plan of care.
3.3.10	Healthcare professionals must update the patient's family or related next of kin about the patient's condition as necessary ensuring patient's confidentiality is maintained at all times.
3.3.11	Emergency Care provided to the patient must be documented in the patient's medical record accordingly.
3.3.12	If the patient is not registered and immediate assessment or intervention is required; healthcare providers must document on an assessment form and transfer all documentation to the main medical records as soon as possible.

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

3.4. PATIENT REFERRAL AND TRANSFER	
3.4.1	A documented process must be available for referrals to ensure appropriate and timely referral of patients to other healthcare professionals or healthcare facilities to meet the patients' physiologic needs and continuity of care.
3.4.2	Each outpatient clinic (Class B, Class C, Class C-M), Endoscopy units, clinics that provide stress test, Renal Dialysis and Fertility centers; must have a contract with a hospital preferably in DHCC to refer patients who require admission as a result of an emergency condition.
3.4.3	Each facility must have written criteria for patient transfer that define when transfer is required and responsibilities during the transfer process.
3.4.4	If a patient requires to be transferred by ambulance to the most appropriate in-patient facility, the transfer will be arranged as per the facility's medical emergency patient transfer flowchart. Sample flow chart attached in Appendix III.
3.4.5	The Hospital must be informed of the patient's condition based on the Emergency severity index (ESI) level (see appendix II).
3.4.6	Transferring a patient to a healthcare professional or services outside the facility must be based on the patient's health status and need for continuing care or services. Hence, the receiving facility must be informed about the case and an approval for transfer must be obtained and documented in the patient health record. Patients must not be sent under any circumstances to another facility without prior transfer approval.
3.4.7	The following information must accompany the patient to the receiving facility upon transfer: 3.4.7.1 A documentation of the assessment and care given 3.4.7.2 A written summary/ referral letter that bears the details as concisely as possible. The document must contain at least the patient's presenting main complaint, system review, running diagnosis and lab results and the medications/ care provided and anticipated follow-up care plan at the receiving facility. 3.4.7.3 All relevant media (CD, printed materials) must also be made available at the time of transfer as they are expected to add value in the care of the patient at the receiving facility.
3.4.8	The treating physician of the outpatient clinic is responsible for the timely transfer, providing appropriate information, and the discharge notice from the outpatient clinic to the receiving healthcare facility.
3.4.9	Mode of transport and who should accompany the patient will be decided based on the following: 3.4.9.1 Condition of the patient,3.4.9.2 The treating physician's evaluation, and3.4.9.3 The availability and competence of the ambulance team.
3.4.10	The hand over communication between the transferring facility and the receiving in-patient facility must include all documented essential information including history, physical examinations, diagnostic investigations and reports, medications given, and procedures done.

3.4.11	The treating physician must respect the patient's choice when the patient decides to self-discharge, i.e. Discharge or Leave Against Medical Advice (DAMA/LAMA). DAMA/LAMA should be discouraged but when it becomes inevitable a DAMA/LAMA form must be signed before the patient leaves the facility. It is the responsibility of the treating physician to inform the patient of the possible consequences of premature departure from the facility, ideally in the presence of the facility's legal representative or the PRO and the patient's relative prior to signing the LAMA/ DAMA form. All procedures must be clearly documented prior to the patient' leaving the facility as DAMA/ LAMA carries important legal implications.
3.4.12	Arrangements must be in place to inform patient's family as appropriate.

4 DEFINITIONS	
4.1	**ACLS – Advanced Life Support** is a constellation of clinical interventions for the urgent treatment of cardiac arrest, stroke and other life-threatening medical (non-traumatic) emergencies, which are beyond basic life-support skills and knowledge. ACLS entails airway management, accessing veins, interpretation of ECG/EKGs, application of emergency pharmacology and early defibrillation with automated external defibrillators.
4.2	**BLS - Basic life support** is constellation of emergency procedures needed to ensure a person's immediate survival, including CPR, control of bleeding, treatment of shock and poisoning, stabilization of injuries and/or wounds, and basic first aid.
4.3	**DAMA:** Discharge Against Medical Advice.
4.4	**DHCA:** the Dubai Healthcare City Authority established under Article (4) of the Law, and comprises the Chairperson, the DHCC Board of Directors and the Executive Body.
4.5	**DHCC:** Dubai Healthcare City.
4.6	**DHCR:** Dubai Healthcare City Authority Regulatory is the regulatory arm of Dubai Healthcare City Authority. An independent licensing and regulatory authority for all healthcare providers, medical, educational and other business licensed by DHCA.
4.7	**Emergency care**: is defined as medically necessary services that are required for an illness or injury that require immediate live saving intervention.
4.8	**ESI: Emergency Severity Index:** The Emergency Severity Index (ESI) is a five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs.
4.9	**HCO (Healthcare Operator):** an all-inclusive term meaning a hospital, clinic, laboratory, pharmacy or other entity providing healthcare, engaging in one or more clinical activities.
4.10	**HCP (Healthcare Professional):** HCP licensed to practice by DHCA.
4.11	**LAMA:** Leave Against Medical Advice.

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

4.12	**PALS – Pediatric Advanced Life Support** is assessment and maintenance of pulmonary and circulatory function in the period before, during and after an instance of cardiopulmonary arrest in a child.
4.13	**PRO :** Public Relations Officer.
4.14	**Quality Improvement Department (QID):** The QID is a department within DHCR. It is responsible for accreditation of Outpatient Clinics and the implementation of the quality oversight processes, policies, and procedures for the DHCA licensed Healthcare Operators.
4.15	**Urgent care**: for the one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential threat to life, limb or organ impairment or loss, categorized in emergency severity index as level-2. Examples of potential urgent care situations in adult patients include, but are not limited to the following: Injuries, Acute Illnesses and Immunocompromised patient with fever.

5 APPENDICES (as applicable)	
5.1	Appendix I: Pediatric Fever Considerations, Pediatric Danger Vital Signs and Adult normal and abnormal Vital Signs
5.2	Appendix II: Emergency Severity Index (ESI) Algorithm
5.3	Appendix III: Medical Emergency Patient Transfer Flow Chart
5.4	Appendix IV: Minimum Mandatory Emergency Medications and Equipment to be available in Crash Carts

6 REFERENCE	
6.1	HAAD policy FACL-15-23 HAAD standards for minimum Preparedness for medical emergencies in the ambulatory care setting. https://www.haad.ae/haad/tabid/820/Default.aspx?udt_1550_param_page=3&udt.
6.2	Joint Commission International Accreditation Standards for Ambulatory Care, 4th Edition COP 3 - Care of High-Risk Patients and Provision of High-Risk Services,(pages 90-92).
6.3	Emergency Severity Index (ESI) Handbook 2012 https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf
6.4	American Academy of Urgent Care Medicine: http://aaucm.org/about/urgentcare/default.aspx
6.5	DHA Outpatient Care Facilities Regulation 2012 - Ref. No. HRD/HRS/FRU007

	https://www.dha.gov.ae/Documents/Regulations/Outpatient%20Care%20Facilities%20Regulation.pdf
6.6	Life Support DHCR Policy and Guideline, PP/HCP/005/01: https://dhcc.ae/Documents/LawsAndRegulations/PoliciesAndStandards/Life%20Support%20DHCR%20Policy%20and%20Guideline.pdf
6.7	American Association for Accreditation of Ambulatory Surgery Facilities International Version3.1(AAAASF International) https://www.aaaasf.org/

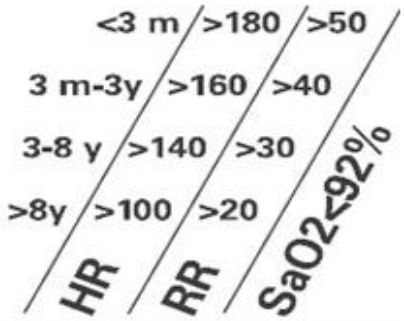
STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

Appendix I

Pediatric Fever Considerations, Pediatric Danger Vital Signs and Adult Normal and Abnormal Vital Signs

Pediatric Fever Considerations	
1.	Temperature more than 38° C
2.	Pediatric Fever >37.5° C with signs of
	- Rash with purple or red spots or dots - Seizure - Difficulty breathing - Stiff neck - Behavior changes which sound like the child is very ill to the nurse - lethargy or confusion - difficult to arouse or unresponsive - inconsolable crying - limp, weak, or not moving - Dehydration (no urine output > 8 hours, sunken eyes, crying without tears, etc.) - Difficulty swallowing or new drooling

Pediatric Danger Vital signs



Adult normal and abnormal Vital Signs

Adult Normal Vital signs	Adult abnormal vital signs
The normal adult Respiratory Rate (RR) is 12-20 breaths/minute	A Clinical Emergency call must be made for a RR of < 8 or > 24
Normal oxygen saturations are between 97-100%.	Oxygen saturations < 90% correlates with very low blood oxygen levels and require urgent medical review.
The normal adult pulse rate is 60 - 100 bpm.	A Clinical Emergency of the pulse rate is < 40 or > 130 bpm

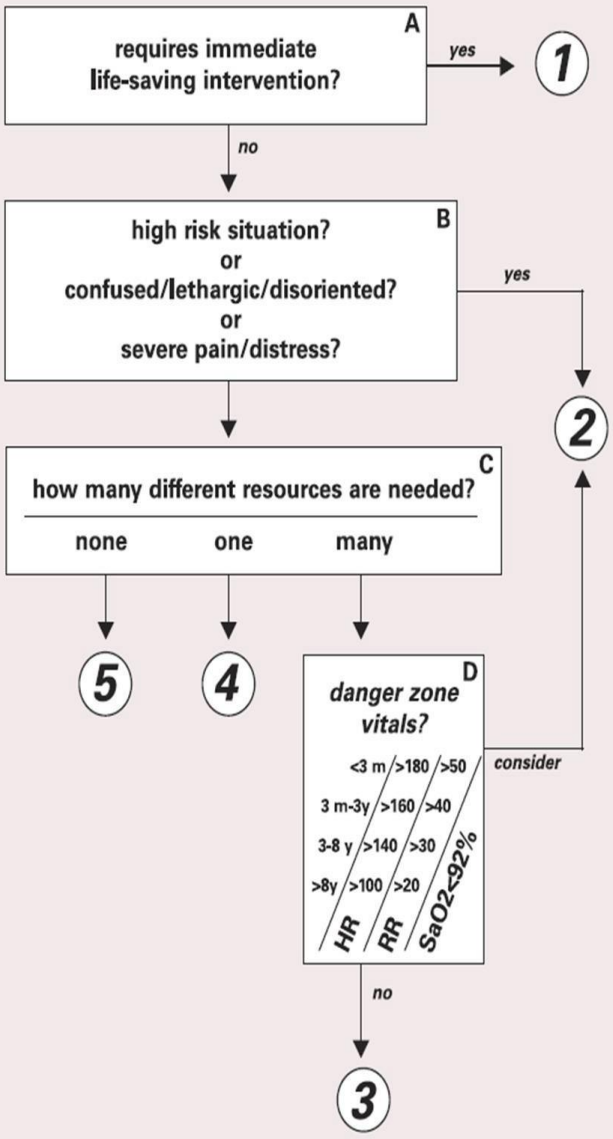
STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

Optimal adult BP should be < 130 mmHg Systolic and < 85mmHg Diastolic.	Severe Hypertension (Urgency) Blood pressure (mm Hg) >180/110 Hypertensive Emergency Blood pressure (mm Hg) Usually >220/140
Normal adult temperature is between 36.1° and 37.5° C.	Temperature more than 37.5° C Temperature less than 36° C
Pain score 0	Patient rating of greater than or equal to 8 on 0-10 pain scale considered emergency.

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

Appendix II:

Emergency Severity Index (ESI) Algorithm



A. Immediate life-saving intervention required: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O2, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SPO_2<90, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either:
(1) nonverbal and not following commands (acutely); or
(2) requires noxious stimulus (P or U on AVPU) scale.

B. High risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (examples: CBC, electrolytes and coags equals one resource; CBC plus chest x-ray equals two resources).

Resources	*Not Resources*
• Labs (blood, urine) • ECG, X-rays • CT-MRI-ultrasound-angiography	• History & physical (including pelvic) • Point-of-care testing
• IV fluids (hydration)	• Saline or heplock
• IV or IM or nebulized medications	• PO medications • Tetanus immunization • Prescription refills
• Specialty consultation	• Phone call to PCP
• Simple procedure =1 (lac repair, foley cath) • Complex procedure =2 (conscious sedation)	• Simple wound care (dressings, recheck) • Crutches, splints, slings

D. Danger Zone Vital Signs
Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric Fever Considerations
1 to 28 days of age: assign at least ESI 2 if temp >38.0 C (100.4F)
1-3 months of age: consider assigning ESI 2 if temp >38.0 C (100.4F)
3 months to 3 yrs of age: consider assigning ESI 3 if: temp >39.0 C (102.2 F), or incomplete immunizations, or no obvious source of fever

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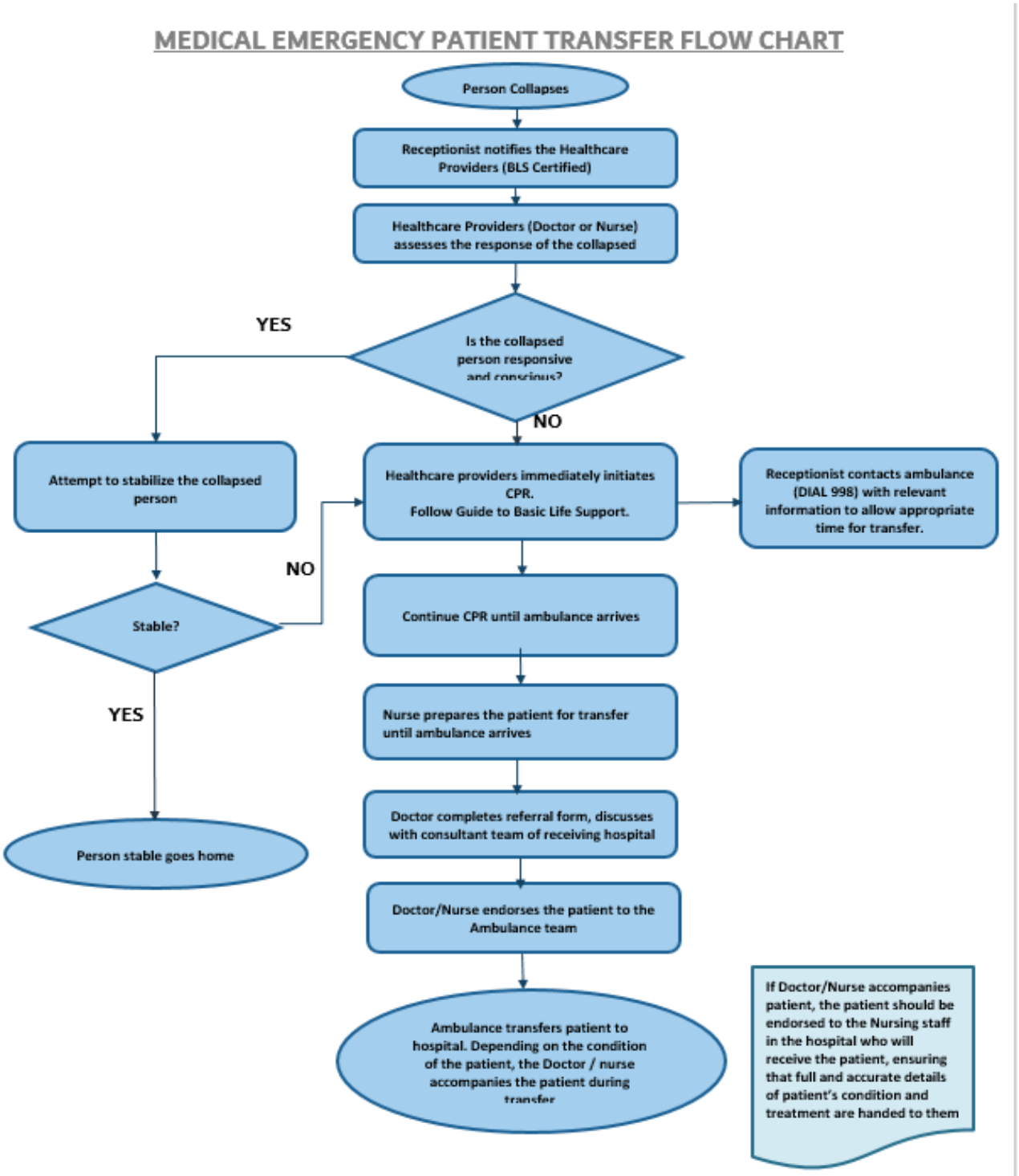
STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

Appendix III

Medical Emergency Patient Transfer Flow Chart



STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

Appendix IV

Minimum Mandatory Emergency Medications and Equipment to be available in Crash Carts

Guidance notes:

- If pediatric patients are treated, then pediatric equipment must be available. Pediatric size AED pads are recommended in facilities that treat children between 1 and 12 years.
- Quantities of equipment should be adjusted according to the size of the facility and the expected frequency and type of medical emergencies and case mix.
- Drug solutions manufactured in pre-filled syringes are preferred.
- Medications that can be administered through subcutaneous, intramuscular, inhalational, sublingual, buccal or intranasal routes are preferred and IV for the management of acute cardio-pulmonary emergencies.
- Any additional requirements to the minimum list provided will be the responsibility of the DHCA licensed Healthcare Facility.

List of emergency medical equipment required to be available in Crash Carts

1. A standard defibrillator
2. Emergency Cart with Cardiac board
3. Patient monitoring equipment (EKG monitor with pulse read out)
4. Pulse oximeters
5. Blood pressure monitoring equipment
6. Oral airways for each size of patient treated in your facility (adult and pediatric)
7. Nasopharyngeal airways and laryngeal mask airways (adult and pediatric)
8. Laryngoscopes with blades of various sizes
9. Battery for laryngoscope which is properly working.
10. Torch for checking the pupil reaction during the code
11. Endotracheal tubes of various sizes
12. Endotracheal stylet
13. Positive Pressure ventilation device (e.g. Ambu™ bag)
14. Source of oxygen supply with appropriate delivery devices (e.g. nasal cannula, face mask).
15. Source of suction is present with appropriate suction device (e.g. tubing, suction tip).
16. Breslow Tape should be present or a printed ready chart of paediatric doses calculations for medications based on age and weight.
17. Diagnostic set
18. Nebulizer
19. Oral airways
20. Patient trolley with IV stand

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

List of Mandatory Emergency Medications to be available in Crash Carts

No.	Description	Quantity	Remarks
1.	Inj. Adrenaline 1:1000	5	Anaphylaxis or acute angioedema
2.	Inj. Atropine 600mcg	10	Bradycardia, Organophosphate and Carbamate overdose
3.	Rectal Diazepam	2	For children with epileptic fits
4.	Inj. Flumazenil (Anexate)	2	Antidote for Rectal Diazepam
5.	Inj. Amiodarone 50mg/Ml	2	Tachyarrhythmia, cardiac arrest
6.	Inj. Dextrose 50% 50ml	2	Hypoglycemia
7.	Inj. Chlorpheniramine 10mg/Ml	5	Adjunctive treatment in anaphylaxis
8.	Inj. Furosemide 20mg/2ml	3	Relief of pulmonary oedema
9.	Inj. Hydrocortisone 100mg/2ml	3	Acute asthma attack and post anaphylaxis
10.	Inj. Dopamine 200mg/5ml	2	Hypovolemic shock cardiogenic shock, CHF
11.	Inj. Aminophylline 250mg/10ml	2	Bronchospasm
12.	Inj. Salbutamol 500mcg/Ml	2	Bronchospasm
13.	Inj. Glucagon 1mg	2	Hypoglycemia
14.	Salbutamol Aerosol Inhalation Nebules	1 Box	Asthma attack
15.	Regular insulin (Fridge Item)	1 Box	For the treatment of Hyperglycemia.
16.	Nitroglycerine patch	5	First line treatment for angina chest pain.
17.	Clopidogrel(Plavix) tab.	5	Add on treatment in confirmed ACS
18.	Aspirin tablets 75 or 300mg	10	First line treatment for angina chest pain.
19.	Inj. Adenosine	6	Supraventricular tachycardia (SVT)
20.	IV Fluids such as: • Ringer Lactate • 5% Dextrose • 5% Dextrose in Normal Saline • Normal Saline (0.9 %)	5 each	For hypovolemia
21.	Water For Injection	1 Box	To mix hydrocortisone inj, etc.
	Normal Saline 10 ml	10	
22.	EpiPen Jr. (for children less than(30 Kg) PFS	2	Anaphylaxis
23.	Epinephrine (Auto-Injectors) PFS	2	Anaphylaxis (not mandatory)

STANDARD – IDENTIFICATION AND MANAGEMENT OF EMERGENCY SERVICES IN OUTPATIENT CARE SETTINGS

Second line emergency medication list (optional)Recommended but not mandated

Second line medications that can be available in Outpatient Care setting; the quantities shall be limited as per the patient need and the facility functional program. No stocking of medication is allowed within the facility premises.

No.	Description	Quantity	Remarks
1.	Lignocaine 4% topical solution	2	For surface anesthesia-30ml
2.	Dexamethasone Injection 4mg/Ml-1ml	3	Allergic reaction/ adjunct to the treatment of bronchospasm
3.	Phenytoin Injection 250mg/5ml	2	Convulsion
4.	Silver Sulfadiazine (Topical)	2	Remedy for superficial skin abrasions
5.	Hyoscine Butyl Bromide injection	5	
6.	Diclofenac Sodium 75 mg injection	5 each	A NSAID- pain killer
7	Diclofenac Sodium 12.5 and 25 mg Supp	5 each	
8.	Paracetamol 125mg and 250mg Supp	5 each	Antipyretic
9	Perfalgan injection	4	
10.	Captopril 25 mg	10	For hypertension
11.	Metoclopramide Inj	5	anti-emetic
12.	Heparin sodium Inj	2	Parenteral anticoagulant
13.	Digoxin Inj	2	Rapid control of HR in Atrial Fibrillation
14.	Dantrolene sodium	6 ampoules	If agents known to trigger malignant hyperthermia are administered.