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PANDEMIC MANAGEMENT PLAN
Govt Medical College
Kottayam

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Pandemic Management Plan 2026

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Message



Kerala Health has consistently recognised that pandemic preparedness is no longer a standalone activity limited to the health sector, but an essential component of public safety, governance resilience, and sustainable development. The experiences of NIPAH outbreaks, COVID-19 pandemic, emerging zoonotic threats, climate-sensitive diseases, and increasing global interconnectedness have clearly demonstrated that future public health emergencies require continuous preparedness, rapid response systems, and strong institutional coordination. In this context, the preparation of comprehensive Pandemic Preparedness Plans by the Department of Health and Family Welfare marks an important landmark towards strengthening Kerala's health security framework.

Today, pandemic management plans must be viewed through the broader lens of the One Health approach, which recognises the interconnectedness of human health, animal health, environmental systems, and ecological balance. Emerging infections are increasingly influenced by environmental degradation, climate variability, urbanisation, migration, and changing human-animal interactions. Therefore, effective preparedness requires coordinated action not only from the Health and Family Welfare Department, but also from departments including Animal Husbandry, Forests, Local Self Government, Disaster Management, Revenue, Education, Transport, Police, Water Resources, and Civil Supplies. Such interdepartmental convergence is critical for surveillance, risk communication, outbreak containment, logistics management, and continuity of essential services during emergencies.

Kerala has always demonstrated exemplary leadership in responding to public health challenges through timely action, scientific decision-making, community participation, and decentralised governance. The integration of pandemic management with disaster management systems further strengthens our capacity to respond to multiple emergencies simultaneously, including outbreaks occurring during floods, heat waves, or other natural disasters. The development of structured protocols, surveillance mechanisms, escalation frameworks, surge planning systems, infection prevention strategies, and institutional coordination models reflects the state's commitment to building a resilient and future-ready health system.

I am informed that Keralam is the only state where the pandemic preparedness plans have been prepared to such a depth right from the Panchayath level to District

and at institutional level upto Medical Colleges. I place on record my sincere appreciation to all those who worked on this endeavour. The dedication, technical expertise, and coordinated efforts demonstrated by the state and district teams are truly commendable. I am confident that these plans will further strengthen Kerala's capacity to effectively prevent, detect, and respond to future public health emergencies while ensuring the safety and wellbeing of our people.

Shri. K Muraleedharan

Minister for Health and Family Welfare and Devasom,
Government of Kerala



Foreword

Kerala Health has been taking efforts to strengthen the Medical Education. Out of various initiatives such as documentation on Medical College developments giving all the details, preparation of Fact Sheets of DME and MCH giving information regarding the outputs and outcomes, Standard treatment protocol, standardization of the units in the Medical Colleges, one more initiative was taken regarding preparedness for health emergencies such as communicable diseases which could transform into an epidemic/ pandemic. COVID has taught us many lessons. But the moot question is, “What learnings have we taken away from the Pandemic, and its aftermath?” Have we understood those learnings and worked on developing the systems for future scenarios?

And now, I say with immense pride that through Kerala Health, every Medical College has excellent pandemic management plans in place.

This preparation of pandemic management plans started with the thought of “What new systems do we need to develop across the State?” The Director of Medical Education and senior Doctors from Community Medicine and other Departments took up the challenge of preparation of plans. An elaborate process was followed by conducting state level meetings. Dr Aravind was asked to prepare a template for the Medical Colleges Plans. That template was validated in the state meeting and shared to all the Government Medical Colleges in the State. After that step, a workshop was conducted at Ernakulam Medical College involving all the teams from Medical Colleges as well as from Apex Cancer Centres. Post this workshop, all the institutions took a series of meetings at their level and completed this commendable work.

It is noteworthy to mention here that after Alappuzha, Thrissur also prepared a comprehensive Pandemic management Plan and Festival management Plan. Unfortunately, during this year's Thrissur Pooram preparations, there was a massive fire accident, but the Thrissur MCH team put the Management Protocol in practice and in a short span of time within 8 minutes, they took care of the fire disaster victims and provided exemplary services. While they were handling the incident, thanks to timely preparation and awareness, they were handling hundreds of emergencies not relating to the disaster during that period. This has clearly demonstrated to all that well-prepared planning and capacity building is the key to mitigating problems.

The Kerala Health program has to keep up with changing times, and so, along with the aforementioned initiatives, we discussed with the Digital University of Kerala

(DuK) to develop Kerala Pandemic Management System. This system envisages end-to-end solution for pandemic management. This will make things easy for the functionaries in the health institutions as well as the field functionaries to update the information. Once the pandemic management plans and Festival management plans are done, the teams will begin developing plans for calamities, other disasters and major accidents.

We are also planning mock drills so as to build the capacities of various teams. This way all the Medical Colleges teams will be well trained to manage any eventuality.

I am confident that all Medical Colleges shall institutionalize updating of plans on a yearly basis, skill building, analysis of any emergency handled and based on the analysis do modifications in the plans. This way it will be a dynamic plan of the Medical College.

For any Health System it is very important to have a system to handle any health emergency, and it is with sense of pride one can say that with the coordinated team work, this huge work was done in exemplary way. It also demonstrates that with shared vision and having 'thinking teams' at state, institution and field level can work on many challenges and deliver results. Therefore, these officers who worked on this project hands-on are mentioned right on the cover page! It is a big achievement for the Kerala Health to lay the foundation of Pandemic Management upon which further developments can be easily done.

I wholeheartedly appreciate the work done by one and all for preparing Pandemic Management Plans.

I am confident that all our Medical Colleges will become centre of excellence and earn recognition for their works. I wish all the success for the future endeavours.

Dr Rajan Khobragade IAS

Additional Chief Secretary
Health & Family Welfare and
AYUSH Department
Govt of Kerala.



Message

The health system of Kerala is defined by a mindset of proactive vigilance, a compassionate attitude toward the most vulnerable, and a historic legacy of resilience in the face of public health crises. Our motto for preparedness is simple—to be prepared and proactive is to safeguard the stability and prosperity of our people. This Pandemic Preparedness Plan is not just a technical manual; it is a shared commitment fuelled by the lessons learned from our past encounters with Nipah and COVID-19. These experiences have taught us that rapid mobilization and early detection are our most effective tools in preventing a public health emergency of international concern.

We have designed this strategy to be agile, moving from routine care to emergency surge levels based on real-time data such as ICU occupancy, staff availability, and disease epidemiology. By utilizing advanced diagnostic tools and regional surveillance cells, we aim to identify threats early, ensuring that life-saving interventions begin the moment a patient reaches our doors. Central to this plan is the safety of our workforce; we are committed to providing the training, equipment, and psychological support necessary to prevent burnout and ensure no healthcare worker faces these challenges alone.

Even in the height of a pandemic, our mission to provide essential care for mothers, children, and emergency cases will not waver. Through seamless coordination with district authorities and the private sector, we are building a networked response that maximizes resources for the benefit of every citizen. I am deeply grateful to the faculty and staff whose expertise shaped this document, and I am confident that by following these protocols, we will continue to lead with competence and compassion.

Dr. K. V. Viswanathan

Director of Medical Education
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Purpose of Document

This document sets out the preparedness and response framework for a potential pandemic or pandemic-like public health emergency at Government Medical College, Kottayam. It is designed to support rapid detection, triage, containment, escalation, continuity of essential services, and safe de-escalation, with emphasis on the first week of response and on prevention of avoidable mortality.

This document serves as a centralized directive to synchronize multidisciplinary efforts, integrating clinical excellence, advanced diagnostics, and rigorous infection prevention with district-level administrative coordination. Ultimately, this plan is designed to provide institutional resilience, ensuring that even under extreme resource scarcity, the facility can provide equitable, high-quality care and maintain critical public health functions.

Key Components Addressed in this Purpose

Operational Readiness: Moving from routine service delivery to crisis management without administrative delay.

Safety & Protection: Explicitly mentioning the implementation of robust occupational safety measures for the protection of the Human Resource Pool (faculty, residents, and staff) alongside supporting mental health and promoting protection and care during sickness

Abbreviations

Term	Meaning / use in this plan
AIIR	Airborne Infection Isolation Room
BMW	Biomedical Waste
DHS	Directorate of Health Services
DME	Directorate of Medical Education.
ETO	Ethylene Oxide
HICC	Hospital Infection Control Committee
IHIP	Integrated Health Information Platform
IDSP	Integrated Disease surveillance Project
ILI/SARI	Influenza-Like Illness / Severe Acute Respiratory Infection.
IPC	Infection Prevention and Control.
KMSCL	Kerala Medical Services Corporation Ltd.
LMO	Liquid Medical Oxygen
NCD	Non-Communicable Disease.
OMU	Outbreak Monitoring Unit
OT	Operation Theatre.
PHEIC	Public Health Emergency of International Concern
PPRC	Pandemic Preparedness and Response Committee
PPE	Personal Protective Equipment
RPEID	Regional Prevention of Epidemic and Infectious Disease
SOP	Standard Operating Procedure

Definitions

Dual-Track System

- This system minimizes the risk of nosocomial transmission by ensuring complete physical and operational separation between infectious and non-infectious patient flows.
- Dedicated staff teams are assigned to each track to avoid cross-deployment and reduce contamination risk.
- Signage, physical barriers, and security personnel are deployed at entry points to strictly enforce track segregation.
- Screening protocols, including symptom checks and exposure history, are conducted at the entry of the Pandemic Track to ensure early identification and containment.

Color-Coded Zoning

- Movement between zones is strictly regulated, with controlled access points and mandatory PPE requirements based on zone classification.
- Each zone has designated healthcare workers, equipment, and waste disposal systems to prevent inter-zone contamination.
- Transition areas (donning/doffing zones) are strategically placed between zones to ensure safe PPE handling.
- Environmental cleaning protocols vary by zone, with Red Zones requiring the highest frequency and level of disinfection.

Red Channel Protocol

- The Red Channel is activated prior to patient movement, with prior intimation to all relevant departments to ensure preparedness.
- Healthcare personnel involved in transport must wear full PPE, including N95 masks, face shields, gowns, and gloves.
- Non-essential staff and patient movement are temporarily restricted during Red Channel use to maintain isolation integrity.
- After transport, a defined downtime is observed following disinfection to ensure adequate contact time for the disinfectant.

1. Introduction & Contextual Analysis

1.1 Background & Purpose

Pandemic preparedness depends on the speed and coordination with which the institution can respond to a new infectious threat. The operational priority is to recognize suspected cases early, isolate them without delay, protect staff, preserve critical care capacity, and maintain continuity of essential non-pandemic services.

1.2 Institutional Geography

Government Medical College, Kottayam (GMC Kottayam) is a premier tertiary care institution in Kerala. It is one of the top-graded medical academic institutions in Central Kerala, serving as a regional referral hospital. The campus is situated in Gandhinagar, Arpookara, approximately 8 km north of Kottayam town in Central Kerala. The campus spans **265 acres** of land shared by two panchayats (Arpookara and Athirampuzha) and the Kottayam municipality. The institution consists of the main Medical College Hospital, Institute of Child Health, Dental College and other allied units. As a tertiary referral Centre with heavy casualty and OP load. The campus requires an organized red-channel system because patient flow, transport routes, and support services must work reliably for referred, walk-in, and critically ill patients.

1.3 District-Specific Risk Profile

- Kottayam district has recurring public health risks such as dengue, leptospirosis, seasonal flooding, and sudden outbreak events.
- The district also receives referral load from surrounding facilities and may experience patient surges during emerging infections such as Nipah, avian influenza, or other zoonotic diseases.
- Preparedness planning must also consider crowding, bystander movement and staff shortages.

1.4 Scope & Objectives

A pandemic preparedness plan is a comprehensive, living document designed to proactively manage the risks and impacts of a pandemic. Covers the entire spectrum from pre-pandemic detection to pandemic response and post-pandemic recovery. It involves a multi sectoral approach to enhance emergency coordination, laboratory networking and clinical care system to detect treat and control the emerging diseases. The objectives being to strengthen the institutional capacity to manage the emerging situation, to strengthen the existing surveillance system to identify early predictive warning signs and to adopt steps to ensure essential services during the pandemic.

1. Establish early warning and rapid response systems for suspected outbreaks.
2. Define command, control, surveillance, triage, treatment, IPC, logistics, communication, and recovery functions.
3. Coordinate with DHS, DME, District Collectorate, ICMR-linked systems, and allied institutions as needed.
4. Reduce avoidable deaths through early isolation, escalation, and rational use of beds, oxygen, staff, and equipment.
5. To strengthen infection prevention and control (IPC)
6. To ensure uninterrupted essential healthcare services
7. To ensure timely triage and appropriate care
8. To protect healthcare workers and students
9. To ensure effective communication and coordination
10. To facilitate efficient use of limited resources
11. To facilitate rapid recovery and post-pandemic evaluation

2. Governance & Command Structure

2.1 Pandemic Preparedness & Response Committee (PPRC)

The PPRC provides top-level leadership and convenes immediately on detection of a suspected emerging infection. The Principal and Medical Superintendent provide administrative authority, with the committee reviewing triggers, resource deployment, and escalation decisions.

Role Key	Responsibilities	Assigned Person	Deputy
Incident Commander	Overall leadership, intersectoral coordination	Medical Superintendent	RMO
Operations Lead	Clinical services, wards, ICUs, triage	Professor & Head – General Medicine	Professor of Anesthesiology/ Pulmonology
Logistics Lead	Oxygen, PPE, equipment, transport	Deputy Medical Superintendent	ARMO
Planning Lead	Surge forecasting, bed expansion	Professor & Head – Community Medicine	RPEID cell Coordinator
Finance Lead	Emergency procurement, budgeting	Accounts Officer	Accounts Assistant

2.2 Multidisciplinary Team

- Core members should include HODs of Medicine and other allied specialties, Surgery and other allied specialties, Infectious Disease Unit, Microbiology, Emergency Medicine, Anesthesiology, Pediatrics, Obstetrics & Gynecology, and other relevant departments.

- Nursing Superintendent, infection control team, biomedical engineering, oxygen war-room/oxygen plant team, pharmacy, laboratory, radiology, security, transport, PRO, and housekeeping must be integrated.
- Clinical and non-clinical staff should work from a shared duty roster so that escalation, backup staffing, waste flow, and patient movement remain coordinated.
- Responsibilities include
- **Clinical & Logistical Oversight:** Responsible for overseeing clinical services, wards, ICUs, triage, oxygen, PPE, equipment, and transport.
- **Surge Management:** Tasked with surge forecasting and executing bed expansion plans.
- The Microbiology department is specifically responsible for managing testing protocols and overseeing infection control measures during a pandemic.
- The Community Medicine department oversees overarching control activities, epidemiological surveillance, and reporting.

2.3 Outbreak Monitoring Unit (OMU)

The OMU functions as the specialized cell for identifying emerging or re-emerging infections, monitoring syndromic alerts, coordinating triage, ensuring sample transport, and maintaining real-time situational awareness. It works closely with the microbiology department and surveillance teams.

The members of OMU are as follows

Sl. No.	Designation	Position in Committee
1	Superintendent, MCH Kottayam	Convenor
2	Professor & HOD, General Medicine	Member
3	Professor & HOD, Pediatrics	Member
4	Professor & HOD, Community Medicine	Member

5	Professor & HOD, Neurology	Member
6	Professor & HOD, Microbiology	Member
7	Professor & HOD, Infectious Diseases	Member
8	Professor & HOD, Pathology	Member
9	Professor & HOD, Forensic Medicine	Member
10	Chief Nursing Officer	Member

2.4 Institutional Medical Board

The institutional medical board should oversee treatment protocols, admission and discharge criteria, back referral decisions, and alignment with state and national protocols.

2.5 HICC (Hospital Infection Control Committee)

Maintained as a strictly functional committee to support institutional preparedness. Integrated as a key component of the Multidisciplinary Team to guide infection prevention and control strategies. HICC has the Hospital superintendent as the chairman and HOD Microbiology as the member secretary. HICC meeting is conducted every 2 months and discussions are made regarding infection prevention and control practices, preventive and corrective actions taken in each area and evaluating the outcomes timely

2.6 RPEID cell

The Regional Prevention of Epidemic and Infectious Disease (RPEID) Cell of this institution does disease surveillance.

The members of RPEID cell are as follows

Sl. No.	Designation	Position in Committee
1	Principal, GMC Kottayam	Chairperson
2	Superintendent, MCH Kottayam	Co-Chairperson
3	Associate Professor, Community Medicine	Coordinator
4	Professor & HOD, Community Medicine	Member
5	Professor & HOD, Pediatrics	Member
6	Professor & HOD, General Medicine	Member
7	Professor & HOD, Microbiology	Member
8	Professor & HOD, Infectious Diseases	Member
9	Professor & HOD, Neurology	Member
10	Professor & HOD, Nephrology	Member
11	Professor & HOD, Gastroenterology	Member

3. Situational Analysis & Resource Mapping

3.1 Infrastructure Audit

- The preparedness plan is centered on CL-4 level isolation and the emergency department red-channel pathway.
- Designated areas include CL-4.1 isolation/ICU functions, CL-4.2 and CL-4.3 ward capacity, pay ward single rooms for suspects when needed, and separate arrangements for pediatric and OBG patients.
- There is a flexibility to convert additional wards, negative pressure units, and operation theatres if the outbreak intensifies.

Reception of patient (Referred / Diagnosed case)

- If a diagnosed case is shifted from a peripheral Centre, after informing the control room; the ambulance will be parked near the end of the block where the lift to ward CL 4.1 is available.
- Initial evaluation of the patient will be done in the ambulance by the Emergency medicine dept; followed by shifting of the stable cases via designated lift to the Isolation room in CL- 4.1.
- In case of need of an emergency intubation/CPR; patient will be shifted to the designated area in the yellow zone and stabilization will be done.

Suspected cases arriving in the OPDs or casualty randomly without prior referral

- These patients are shifted to yellow zone area of the casualty block for evaluation and observation.
- The health workers transporting and accompanying such patients shall be in full PPE (Level B)
- The Lift and the dedicated entrance corridor area must be disinfected with 1% hypochlorite solution and left for a contact time of at least 10 minutes after the transport of suspected / confirmed patients

Triage workflow

1. Stable patient
 - To receive patient near the extreme end of Casualty block
 - Initial evaluation by ED physicians in the ambulance
 - If stable, shift via designated lift to CL 4.1 Isolation room
2. Unstable patient
 - Receive the patient in the yellow zone
 - Initial stabilization and intubation
 - Shift to CL 4. Via designated lift

Lift to be used

1. For shifting patients - The lift at the extreme west end of the CL block
2. Waste disposal - Adjacent lift near the patient lift
3. For staff entry - Lift in front of casualty

Current isolation plan

- Directly receive the patient in CL4 through lift in emergency department
- Receive the patient in CL4 ICU (Designated isolation ICU =11 beds including 2 dialysis beds), primary care unit-IDU, multi-disciplinary approach
- There is a full-fledged hemodialysis facility in the room next to this isolation room, and patients can be shifted in case they need hemodialysis.
- A donning area will be set up in the room before entry to the ICU. Doffing area will be set up towards the end of the corridor.
- N95 masks will be disposed in a bin kept outside the ward; where the HCW will be given a new mask.

For Pediatric patients

- Separate isolation rooms in ICH with separate pandemic triage area
- Allow Child and one attendant only.
- Provide mask to child and caregiver

For OBG patients

- Separate isolation rooms in OBG block will be utilized
- Dedicated entrance to these isolation rooms in OBG block

Transportation –Ambulance 108, PRO /control room

- The control room for the pandemic will be set up, in liaison with the PRO office.
- Calls will be received in the PRO office.

In case of any suspect case, it will be informed to the Infectious Diseases HOD or any other faculty in Infectious diseases dept before shifting to our centre.

3.2 Human Resource Pool

There is a need to identify core, reserve, and volunteer pools, and to activate temporary staff through NHM/HDS or other institutional arrangements when routine staffing is insufficient.

SI No	Category	Sanctioned	Present	Gaps	Mobilization Strategy
1	Faculty (Clinical) Teaching faculty Non-teaching faculty	324 1550			Call back from leave; redeploy from non-critical depts.

2	Residents (SR/ Academic JR/ NAJR) Dental	613 40			Recruit additional temporary doctors through NHM/schemes.
3	Nursing Staff (Permanent)	431			Shift-based duty (6-8 hr shifts); cancel all leave.
4	ICU/Transplant Trained Nurses	0	0	0	Prioritize for Level 3 (Crisis) ICU surge.
5	Nursing Assistants	10	5	5	Deploy for high-touch surface cleaning and food delivery.
6	Hospital Attendants (Gr 1 & 2)	64			Training on 1% hypochlorite use and trolley disinfection.
7	Kudumbasree / Cleaning Staff(Full time+ part time sweepers)	492			Focus on waste management and environmental cleaning.

8	Ancillary (Lab, Rad, Pharm)	LT 52 ECG -17 Radiographer 56 DT 21 Pharmacist 70 Anaesthetic 26			Maintain a standby duty roster for 24/7 coverage.
10	Security & Transport Staff	105			Lead "Red Channel" movement and patient data entry.

Human Resource Mobilization strategy

Sl. No	Category	Current position	Gap / risk	Mobilization strategy
1.	Clinical faculty / residents	Core faculty and residents present, but outbreak surge may exceed routine availability	May be insufficient for 24/7 surge coverage	Call back from leave; redeploy non-critical units; appoint temporary doctors through HDS/NHM
2.	Nursing staff	Permanent and contract nursing staff available across wards	Shift fatigue and leave can reduce resilience	6-8 hour shift system; cancel leave; recruit emergency nurses through HDS/NHM

Sl. No	Category	Current position	Gap / risk	Mobilization strategy
3.	ICU / transplant-trained nurses	Available in limited numbers	Critical for surge ICU	Prioritize to Level 3 / crisis ICU
4.	Nursing assistants	Available for routine care	Need for dedicated isolation support	Deploy for cleaning support, food delivery
5.	Hospital attendants (Gr 1 & 2)	Available for routine care	Need for dedicated isolation support	Training on 1% hypochlorite use and trolley disinfection.
6.	Kudumbasree / Cleaning staff	Available for routine care	Need for dedicated isolation support	Focus on waste management and environmental cleaning.
7.	Lab / radiology / pharmacy	Ancillary services active	24/7 continuity may be affected	Standby roster for round-the-clock coverage
8.	Security / transport staff	Existing institutional staff and protocols	Red-channel movement requires dedicated control	Training on entry control, lift coordination, and route clearing
9.	Volunteer / reserve pool	Potential retired and non-clinical staff	Not activated routinely	Identify in advance and rehearse role assignments

3.3 Equipment & Logistics

- Inventory maintained for ventilators, high flow nasal cannula, oxygen beds, monitors, dialysis support, PPE, sample transport materials, disinfectants, and body bags.
- Oxygen supply is mapped through the oxygen war room, including Liquid medical oxygen reserve capacity, cylinder backup, pipeline reliability, and refill logistics.
- Kerala Medical Services Corporation Limited (KMSCL), stores, biomedical department, and emergency purchase routes can be aligned in advance.

Escalation plan- ICU beds

EXISTING			ESCALATION		
AREA	TOTAL BEDS	VENTILATORS	AREA	TOTAL BEDS	VENTILATORS
CL 4.1 (Isolation/ICU)	17	16	NSICU	7	
CL 4.2 (ward capacity)	12	8	MDICU	24	
CL 4.3 (ward capacity)	12	11	IRCU	4	
ISOLATION ICU	11	7			
NEGATIVE PRESSURE ICU	15	13			
CL3.1	11	7			
CL3.2	8	4			
CL3.3	11	6			
CL3.4	11	6			
CTVS	41	37			
TOTAL	149	115		35	25

Escalation plan- WARDS

EXISTING			ESCALATION		
AREA	TOTAL BEDS	OXYGEN POINTS	AREA	TOTAL BEDS	OXYGEN POINTS
WARD 9	58	44	WARD 1	30	22
			WARD 2	66	42
WARD 9 (A)	40	21	WARD 2(A)	22	17
			WARD 3	60	33
WARD 6	60	42	WARD 5	48	15
PAY WARD (GROUND)	13	10	WARD 10	40	7
			WARD 25	25	18
PAY WARD (1 ST FLOOR)	15	3	PAYWARD (3 rd FLOOR)	12	4
			PAYWARD (4 TH floor)	20	4
TOTAL	186	120		323	162

Institutional Bed Strength and Ward Breakdown

Unit Designation	Current Bed Count	Pandemic Conversion Role
Total Wards	2178	Pandemic Surge
Total ICU beds	297	Primary Pandemic ICU
Total Ventilators	266	SARI Surge
Total ward beds with oxygen supply	509	
Total patient monitors	871	
Total HFNC	20	

4. Graduated Response Framework (Three-Tier Model)

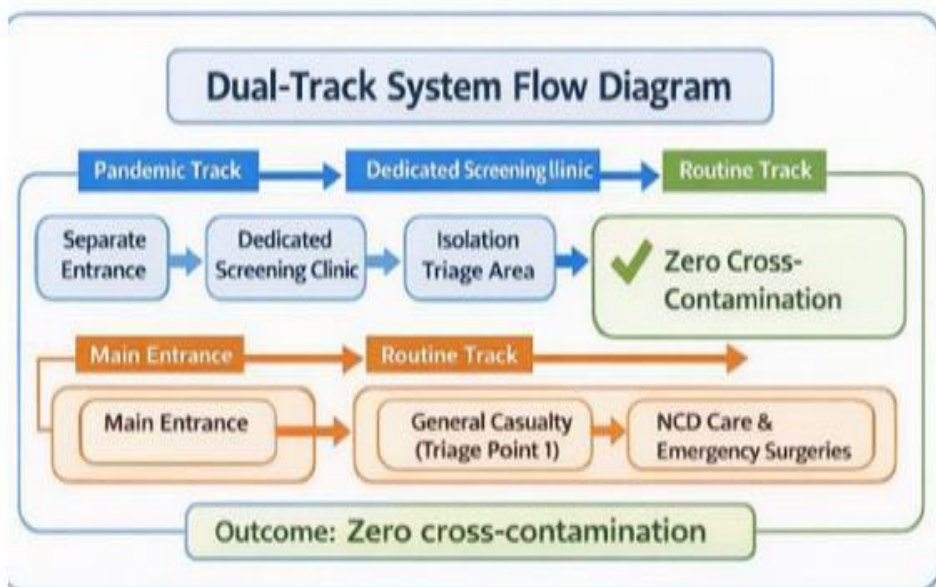
4.1 Escalation Triggers

- Escalation is identified by case load, ICU occupancy, bed availability, staffing gaps, oxygen availability, and evidence of local transmission.
- There are three operational scenarios: Phase 1 / conventional response, Phase 2 / spreading outbreak, and Phase 3 / worst surge.

The **Dual-Track System** is the operational standard to prevent cross-contamination.

1. **Pandemic Track:** Utilizes the separate "Fever Triage" entrance with a dedicated pathway to the COVID Special Ward and Medical ICU.
2. **Routine Track:** Segregated flow for Trauma, NCD care, and Maternal Health.

Dual Track System Flow Diagram



4.2 Tier 1 - Conventional (Best Case)

Operational goal: maintain standard care without dilution of expertise while continuing routine services as far as possible.

Trigger Points	Institutional Action Points
Cases: No confirmed local cases OR sporadic imported cases without local transmission.	Surveillance: Activate ILI/SARI screening at entry points and mandatory IHIP reporting.
Admission: Baseline hospital and ICU admission levels.	Infrastructure: Identify "Red Channel" entry points and start planning for expansion of oxygen beds and ICUs by 20% .
Staffing: Absenteeism <10%.	Training: Conduct refresher training on IPC, PPE donning/doffing, and simulation mock drills.
Logistics: PPE and drug supply days >30.	Logistics: Assess and enhance centralized/decentralized Liquid Medical Oxygen (LMO) to full reserve capacity.

4.3 Tier 2 - Contingency (Moderate Case)

Operational goal: adapt space, staff, and supplies so that care remains functionally equivalent to standard care.

Trigger Points	Institutional Action Points
Cases: Confirmed local transmission and rising suspected cases in OP/IP departments.	Hospital Reorganization: Activate surge annexes (e.g., Ward 9/10 or Paywards) and create barricaded triage areas.
ICU Occupancy: 70–90%.	Clinical Operations: Regulate non-pandemic care and pause/reduce non-urgent elective surgeries .

District Load: Hospital admissions due to the pandemic reaching 10% of total district admissions.	HR Strategy: Implement shift-based duties (6–8 hours) and deploy float pools or tiered staffing models.
Logistics: PPE supply days 7–29; ventilator/O2 constraints beginning.	Logistics: Fill 100% of oxygen reserve capacity and look for potential sources of capacity enhancement.

4.4 Tier 3 - Crisis (Worst Case)

Operational goal: maximize population benefit under severe resource scarcity and activate crisis standards of care.

Trigger Points	Institutional Action Points
Cases: Surge in confirmed admissions; OP load crosses the threshold level.	OP/IP Reorganization: Stop general OP services; convert waiting or non-patient areas into makeshift wards.
ICU Occupancy: >90% (System Overwhelmed).	Critical Care: Activate earmarked pandemic beds in private institutions for government-referred patients.
District Load: Pandemic admissions reaching 25% of total hospital admissions in the district.	Services: Switch to emergency non-pandemic care only ; discharge all stable/recovering patients.
Staffing: Absenteeism >20%.	HR Strategy: Large-scale recruitment of temporary staff; redeployment of non-clinical/academic staff to clinical work.
Logistics: PPE supply <7 days; spare ventilator capacity <10%.	Networking: Full district ICU pooling and activation of field hospitals/CSLTCs.

5. Operational Standard Operating Procedures (SOPs)

Standard operating procedures

1. Testing
2. Infection Control
3. Case Management
4. Safe management of Human remains after death
5. Handling of human remains in the mortuary

5.1.SOP for testing

- The Microbiology dept will coordinate the sample transport and PCR testing for the pandemic.
- The report will be released only by the Microbiology dept.
- The samples should be collected as early as possible (preferably within 4-5 days on onset of illness) with all biosafety precautions and accompanied with detailed history of patients on the proforma.

5. 2. Infection control

- The disposal of wastes from the Isolation area will be in line with the Infection control manual and Protocols set by the HICC of GMC Kottayam.
- Safe waste disposal for potentially infected material including used PPE, linen, clothing of patient according to standard biomedical waste management guidelines.
- All items used in the isolation room of confirmed cases should be disposed in the yellow cover marked of colour code.
- Bags should be sealed tight when three fourth full.
- Keep in designated leak proof container marked as “ISOLATION ROOM”

near the exit.

- These will be carried by the designated persons wearing PPE to the collection room.

5.3. Case management

- A medical board will be set up. Including HODs of key departments.
- All the treatment decisions will be set forth by this board; in line with the state protocol and national protocol.
- Consists of the Superintendent, RMO, HOD/ Nodal officers of all concerned departments or OMU members
- Specimen collection and transportation, management protocol, discharge policy, and back referral policy

5.4. Safe Management of Human remains after death

- Only personnel trained in handling infected human remains and wearing recommended PPE should touch or move any human remains from a person who has died.
- The health worker attending to the dead body should perform hand hygiene, ensure proper use of Level B PPE (water resistant apron, goggles, N95 mask, gloves)
- Plug Oral, nasal orifices of the dead body to prevent leakage of body fluids.
- Do not wash or clean the body.
- Place the dead body in leak-proof plastic body bag. The exterior of the body bag can be decontaminated with 1% hypochlorite. The body bag can be wrapped with a mortuary sheet or sheet provided by the family members

5.5. Handling of Human remains in the mortuary

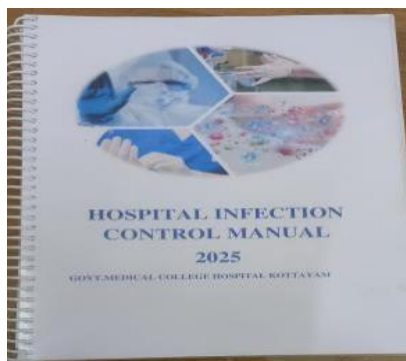
- Mortuary staff handling the body should observe standard precautions.
- The bodies should be stored in cold chambers maintained at approximately 4°C.

- The mortuary must be kept clean. Environmental surfaces, instruments and transport trolleys should be properly disinfected with 1% Hypochlorite solution.
- After removing the body, the chamber door, handles and floor should be cleaned with sodium hypochlorite 1% solution.
- Do not embalm the body.
- Do not perform an autopsy unless it is absolutely necessary.

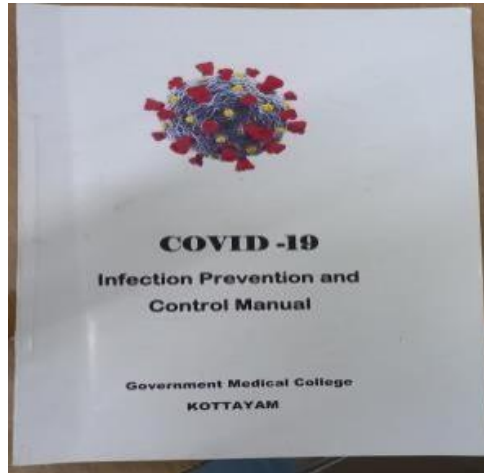
1. Hospital Infection Control Manual



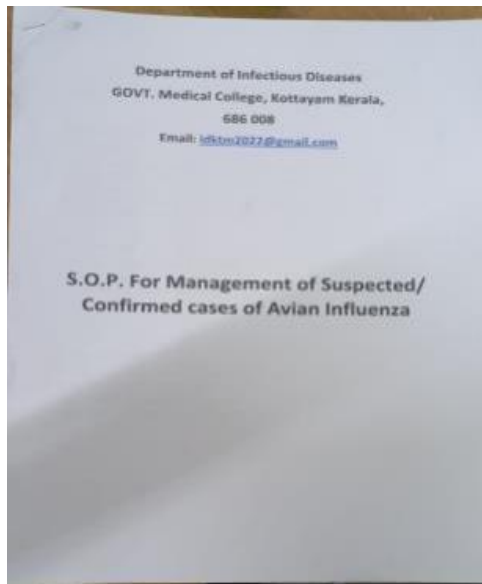
2. Isolation policy



3. SOP-COVID management



4. SOP- AVIAN FLOW



6. Specialized Service Guidelines

6.1 Dialysis Units

- Use the designated dialysis support facility adjacent to the isolation zone when required.
- Follow a defined testing cycle for routine patients, with strict PPE and surface disinfection.

IPC measures to be followed includes:

- All standard precautions must be strictly followed.
- All staff must be trained for cough etiquette, hand hygiene and proper use and disposal of PPE.
- All patients who are routinely coming for hemodialysis must be tested for COVID once in 10 days and a register should be maintained. Rapid antigen test may be used for this purpose
- Ensure that the rapid antigen test for COVID is also done along with other viral markers for cases requiring emergency HD.
- All patients undergoing HD must wear a triple layer mask and face shield. Either patient can use their on face shield or decontaminated permanent shield provided from the department. Also ensure that they are wearing these properly during dialysis .
- Hand sanitizer must be placed in all dialysis cots, should strictly follow hand hygiene before handling any patient and in between two patients.
- Symptomatic health care worker must be tested and refrain from duty till the test report is obtained.
- Thorough cleaning of surfaces and floor must be done with 1% hypochlorite solution. High touch surfaces like bedside tables and lockers, dialysis machines, door knobs, light switches, counter tops, handles, phones, keyboards, toilets sinks etc. must be cleaned two hourly.
- Separate stethoscopes, thermometers, Oxygen saturation probes and blood pressure cuffs between patients with appropriate cleaning and disinfection should

be done in between shifts.

- Dialysis tubings used for COVID positive patient must be disposed according to BMW management rule.
- Dialysis staff should use of all personal protective equipment (PPE) and patients should properly wear disposable three-layer surgical mask throughout dialysis duration. Patients should follow cough etiquettes, hand hygiene etc.

6.2 Management of Deceased

Standard infection prevention control practices should be followed at all times. These include: 1. Hand hygiene.

1. Use of personal protective equipment (e.g., water resistant apron, gloves, masks, eyewear).
2. Safe handling of sharps.
3. Disinfect bag housing dead body; instruments and devices used on the patient.
4. Disinfect linen. Clean and disinfect environmental surfaces.

Training in infection and prevention control practices :All staff identified to handle dead bodies in the isolation area, mortuary, ambulance and those workers in the crematorium / burial ground should be trained in the infection prevention control practices.

Removal of the body from the isolation room or area

5. The health worker attending to the dead body should perform hand hygiene, ensure proper use of PPE (gloves, N95 mask, goggles, water resistant apron).
6. All tubes, drains and catheters on the dead body should be removed.
7. Any puncture holes or wounds (resulting from removal of catheter, drains, tubes, or otherwise) should be disinfected with 1% hypochlorite and dressed with impermeable material.
8. Apply caution while handling sharps such as intravenous catheters and other sharp devices. They should be disposed into a sharps container.
9. Plug oral, nasal orifices of the dead body to prevent leakage of body fluids.

10. If the family of the patient wishes to view the body at the time of removal from the isolation room or area, they may be allowed to do so with the application of Standard Precautions.
11. Place the dead body in leak-proof plastic body bag. The exterior of the body bag can be decontaminated with 1% hypochlorite solution. The body bag can be wrapped with a mortuary sheet or sheet provided by the family members.
12. The body will be either handed over to the relatives or taken to mortuary.
13. All used/ soiled linen should be handled with standard precautions, put in biohazard bag and the outer surface of the bag disinfected with hypochlorite solution.
14. Used equipment should be autoclaved or decontaminated with disinfectant solutions in accordance with established infection prevention control practices.
15. All medical waste must be handled and disposed of in accordance with Biomedical waste management rules.
16. The health staff who handled the body will remove personal protective equipment and will perform hand hygiene.
17. Provide counselling to the family members and respect their sentiments. Environmental cleaning and disinfection All surfaces of the isolation area (floors, bed, railings, side tables, IV stand, etc.) should be wiped with 1% Sodium hypochlorite solution; allow a contact time of 30 minutes, and then allowed to air dry. Handling of dead body in Mortuary
18. Mortuary staff handling COVID-19 dead body should observe standard precautions.
19. Dead bodies should be stored in cold chambers maintained at approximately 4°C.
20. The mortuary must be kept clean. Environmental surfaces, instruments and transport trolleys should be properly disinfected with 1% Hypochlorite solution.
21. After removing the body, the chamber door, handles and floor should be cleaned

with sodium hypochlorite 1% solution.

Transportation

22. The body, secured in a body bag, exterior of which is decontaminated poses no additional risk to the staff transporting the dead body.
23. The personnel handling the body may follow standard precautions (surgical mask, gloves).
24. The vehicle, after the transfer of the body to cremation/ burial staff, will be decontaminated with 1% Sodium hypochlorite.

6.3 Maternal & Child Health

- Use separate isolation rooms for paediatric and OBG patients.
- Allow only essential attendants and maintain dedicated entry routes.

7. Logistics & Ancillary Services

7.1 Supply Chain Management

Track inventory in real time and coordinate with KMSCL, stores, and emergency procurement channels.

7.2 Linen & Laundry

Use leak-proof containers, proper disinfection pathways, and avoid unnecessary double-bagging.

- Place soiled linen directly into containers or bags in the isolation room or area.
- Contain the soiled linen in a manner that prevents the containers or bags from opening or bursting during transport.
- One layer of packing is adequate, provided that the soiled linen can be placed in the bag without contaminating the outside of the bag. Double-bagging is unnecessary.
- Ensure that all persons who handling the soiled linen must use Standard Precautions, and perform hand hygiene after removing PPE.
- Heavy-duty tasks (e.g. cleaning of the environment) require more resistant PPE (e.g. rubber gloves and apron, and resistant closed shoes). Best practices for linen (and laundry) handling
- Always wear reusable rubber gloves prior to handling soiled linen (e.g., bed sheets, towels, curtains).
- Never carry soiled linen against the body. Always place it in the designated container.
- Carefully roll up soiled linen to prevent contamination of the air, surfaces, and cleaning staff. Do not shake it.
- If there is any solid excrement on the linen, such as feces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container
- Place soiled linen into a clearly labelled, leak-proof container (e.g., bag, bucket) in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed.

- Reprocess (i.e., clean and disinfect) the designated container for soiled linen should be reprocessed after each use
- If reusable linen bags are used inside the designated container, do not overfill them, tie them securely, and launder after each use Always use and maintain laundry equipment according to manufacturer's instructions. Always launder soiled linens from patient care areas in a designated area, which should:
- Be a dedicated space for performing laundering of soiled linen
- Have floors and walls made of durable materials that can withstand the exposures of the area (e.g., large quantities of water and steam)
- Have a separation between the soiled linen and clean linen storage areas, and ideally should be at negative pressure relative to other areas
- Have hand washing facilities
- Have Structured Operating Protocols (SOP) and other job aids to assist laundry staff with procedures

7.3 Biomedical Waste Management

- Healthcare Facilities having isolation wards need to follow these steps to ensure safe handling and disposal of biomedical waste generated during treatment;
- Keep separate bins/bags/containers (yellow colour) in isolation wards and maintain proper segregation of waste as per BMWM Rules, 2016 as amended and Central Pollution Control Board (CPCB) guidelines for implementation of BMW Management Rules.
- As precaution double layered bags (using 2 bags) should be used for collection of waste from isolation wards so as to ensure adequate strength and prevent leaks;
- Collect and store biomedical waste separately prior to handing over the same to Common Biomedical Waste Treatment and Disposal facility (CBWTF).
- Use a dedicated collection bin labelled as "X" to store infectious waste and keep separately in temporary storage room prior to handing over to CBWTF. Biomedical waste collected in such isolation wards can also be lifted directly from ward into CBWTF collection van.
- In addition to mandatory labelling, bags/ containers used for collecting biomedical

waste from isolation wards, should be labelled as “X Waste”. This marking would enable CBWTF is to identify the waste easily for priority treatment and disposal immediately upon the receipt.

- Mixing of X waste with the biomedical waste from other wards, general waste etc. should be avoided.
- General waste other than biomedical waste should be disposed as per Solid Waste Management (SWM) Rules, 2016 only after proper disinfection.
- Maintain separate record of waste generated from X isolation wards. - Use dedicated trolleys and collection bins in isolation wards. A label “X Waste” to be pasted on these items also.
- The (inner and outer) surface of containers/bins/trolleys used for storage of COVID-19 waste should be disinfected with 1% sodium hypochlorite solution.
- Maintain separate record keeping.

7.4 Support Services

Coordinate dietary services, psychiatry support, and social work support for patients and staff.

8. Communication, Monitoring & Research

Tertiary care hospitals should serve as research hubs during pandemics—supporting clinical trials, epidemiological modelling, and outcome analysis. Transparent and consistent communication—to patients, families, healthcare workers, and public health agencies—is critical to manage misinformation and ensure compliance with containment measures. In Kerala, partnerships with local panchayats and community groups can enhance trust and cultural appropriateness of public health interventions. Post-pandemic evaluation, including after-action reviews and policy audits, will ensure iterative improvement of preparedness frameworks and strengthen the state's health system resilience.

8.1 Surveillance Systems

Integrate institutional reporting with IHIP, IDSP, ICMR-linked systems, and state dashboards.

Data collection, compilation, analysis

1. State dashboard, central dashboard
2. IDSP and IHIP
3. ICMR
4. The National Animal Disease Referral Expert System (NADRES) Purpose of surveillance data
 - Comprehensive and timely reporting
 - Analysis and interpretation of surveillance data for outbreak detection
 - Informed decision-making for a response.
 - Include early warning and community-based surveillance components to ensure wider coverage and comprehensive capture of potential public health events

Plan is to utilize a team of doctors and data entry operators and use the help of medical students under the leadership of institutional PIED cell to provide the data

to the various state and central bodies. They will utilize the help of data entry operators from microbiology department regarding the data for lab testing

8.2 Media & Risk Communication

Use a designated spokesperson and maintain accurate, timely updates at a controlled media location.

Communication roles

- Risk communication should be handled by the control room with support from the treating team.
- Media communication should be coordinated by the PRO and the nodal officer / Medical Superintendent.
- Surveillance should be supported by DHS staff, the PIED cell, and designated data-entry teams.

Risk communication, patient and stakeholder communication - By the treating doctors themselves at this point of time

Media communication - By the P R O and the Nodal officer/Medical Supdt

Risk communication

- Real-time exchange of information, accurate information and actionable advice to affected communities.
- Advice and opinions between experts, community leaders or officials and the people who are at risk.
- The purpose of risk communication is to prevent and mitigate the impact of an emergency by a dialogue with the affected people to persuade them to take appropriate action.
- Will be handled by the Control room

8.3 Control Room Operations

Coordinate patient arrivals, bed assignment, duty rosters, and daily review meetings through the control room.

Control Room – Administration

Overall Supervision: Medical Officers

Control Room Activities

1. Food Services: Managed by Nursing College Staff
2. Patient Movement & Statistics: Managed by Junior Residents
3. Patient counselling: Managed by Dental College Faculty
4. Store and Purchase: Managed by Pharmacy College Faculty
5. First call: Managed by Dental College House surgeons
6. Patient movement in and out of the hospital is constantly monitored.
7. Information regarding cases are collected and stored online.



8.4 Research Collaboration

Support clinical, zoonotic, One Health, and outcome-based research where institutional conditions permit.

- Zoonotic disease
- One health approach
- Human health
- Animal healthb(both livestock and wildlife)
- Environment sectors

The college is equipped with modern laboratories for pre-clinical and clinical subjects, allowing collaborative ventures with the District Hospital and General Hospital for community-based research and clinical trials. Functions as a Regional Medical Education Center under the National Medical Commission (NMC), facilitating academic research.

9. Recovery & De-escalation

Recovery and de-escalation involve a strategic, phased process moves away from acute emergency responses toward a "new normal," balancing epidemiological, social, and economic factors, often relying on surveillance data, health system capacity enabling restarting deferred elective services while managing burnout among healthcare workers

9.1 Discharge & Back Referral

Use state protocol for discharge, back referral, and transfer of mild or moderate cases to appropriate peripheral facilities. Institutional Medical Board will oversee treatment and discharge

General instructions regarding admissions and discharge

1. The Security staff must enter in the register provided regarding the patient details including bystander details, present address, and vehicle no and the time of entry to the COVID-19 OP. If taking admission, enter the admission details else out time.
2. Category C patients are supposed to be admitted. Category A and B patients who are admitted in pay wards should sign the consent that after getting relieved from symptoms they should cooperate with treating doctors regarding shifting towards or CFLTCs.
3. Patients should be shifted to concerned ward or pay ward as early as possible.
4. Inform nodal officer in charge and SPEID cell for surveillance and monitoring
5. Admitted patients should be accompanied by staff and make sure that the patient reached the concerned area safely
6. It should be mandatory to keep an ID band for the admitted patients
7. Security staff should be alert when the patients come out of OPD.
8. Before allotting bed /room to the patient make sure about the cleanliness of room, working condition of fan, light etc.
9. All HCWs should treat the patient with courtesy even if the patient is provoking. Inform higher officials in case of any incident.
10. There should not be any delay in food for the patients.

11. If there is any unusual incidence happening in ward/ payward it should be informed to concerned authorities and document in incident report register.
12. The relatives should be informed regarding the discharge and they should be shifted without any delay.
13. Discharges at night should be avoided especially for female patients.
14. The patient should be shifted to ward/ICU or other hospital only after ensuring the bed is readily available.

9.2 Financial Plan

Create a dedicated emergency response fund and mobilize state, central, and NGO support when needed.

- Will be mobilizing other available funds
- Supports from state/centre
- NGO support

9.3 After-Action Reviews

Conduct post-event audits, capture lessons learned, and update policy and SOPs accordingly.

10. Index of Standard Operating Procedures (SOPs) & Guidelines

Standard Operating Procedures (SOPs)

1. Patient admission
2. IPC & biomedical waste management
3. Patient management
4. Patient discharge/back referral
5. Bystander management
6. Communication
7. Dead body management
8. Environment cleaning – Malayalam
9. Security - malayalam

Index of Annexures

All the major institutions shall keep the following Annexures with all details ready at their respective institution level. The SoPs shall be updated / modified as per the research and information available regarding the respective pathogens..

1. Triage and Red channel protocol
2. Patient transport protocol during pandemics
3. SOP for Patient care equipment
4. SOP Hand hygiene
5. SOP Cough etiquette
6. Personal safety measures and PPE use
7. SOP for environmental cleaning
8. Environmental and Engineering controls
9. SOP for Makeshift Isolation enclosures
10. SOP for pandemic operation theatre
11. Guidelines for Dialysis units
12. Protocol for handling of deceased
13. Guideline on dead body management in context of COVID 19
14. SOP for Safe Linen Use
15. Biomedical Waste Management [BMW] Protocols in Isolation wards:
16. Medical Board Constitution
17. SOP for transporting a Suspect/ Confirmed case
18. CPCB Guidelines – Biomedical Waste Management
19. Mapping of laboratories
20. Infection Prevention and Control Manual-GMCH

Contact Details

Name of college	Contact Points	Contact Number
GMC Trivandrum	Information counter	4712528225
	General enquiry	4712528083
	Duty PRO	8281529159
GMC Kollam	Control Room	4742575050
GMC Konni	Control Room	4682344888
GMC Alappuzha	Control Room	4772281000
	Duty PRO	8281002947
GMC Kottayam	Control Room	9188528533
GMC Idukki	Casualty	04862232444
	Control Room	4862232555
GMC Ernakulam	Control Room	04842754000 04842751001 8075774769
	Duty PRO-	9778082825
GMC Thrissur	Control Room	04872472002 8075011853
	Duty PRO-	9383400082
GMC Manjeri	Control Room	8078253515
GMC Kozhikode	Control Room	4952350349
	Duty PRO-	9497669040
	IMCH Control room	4952350395
GMC Wayanad	Duty PRO-	8129428785
GMC Kannur	Control Room	04972882200, 8078041358
	General enquiry-	4972882100
	Duty PRO-	04972882390 9048600970
GMC Kasaragod	Control Room	8289908320