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PANDEMIC MANAGEMENT PLAN **Govt Medical College Kasaragod**

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KERALA.HEALTH

**Govt. Medical College
Kasaragod**



**Pandemic Management Plan
2026**

KERALA.HEALTH

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 the 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
Government of Kerala

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Objective of Document

This document establishes a structured framework for the pandemic response at **GMC Kasaragod**, centering on the phased activation of the **500-bed hospital block** (under-construction) and the academic block. The plan transitions the campus from its current outpatient-only status into a functional inpatient facility by systematically scaling up **oxygen infrastructure, ICU beds, and human resource readiness**. It prioritizes early detection and the safety of healthcare workers, students, and staff to ensure the **continuity of essential OP and academic services**. While the facility will now accommodate internal admissions as the new block becomes operational, it maintains a critical referral link to **GH Kasaragod (~28 km away)** for cases exceeding local capacity, providing a balanced roadmap for clinical escalation and campus-wide biosecurity.

Abbreviations

ACH	Air Changes per Hour
AIIR	Airborne Infection Isolation Room
BMW / BMWM	Bio-Medical Waste / Bio-Medical Waste Management
CBWT	Common Biomedical Waste Treatment and Disposal Facility
CSC	Crisis Standards of Care
CSLTC	Community Second-Line Treatment Centre
DME	Directorate of Medical Education
DMO	District Medical Officer
ETO	Ethylene Oxide (Sterilization)
GH	General Hospital (specifically GH Kasaragod)
GMC	Government Medical College
HCW	Healthcare Worker
HDC	Hospital Development Committee
HDS	Hospital Development Society
HEPA	High-Efficiency Particulate Air (Filtration)
HFNC / HFNO	High-Flow Nasal Cannula / High-Flow Nasal Oxygen
HICC	Hospital Infection Control Committee
HOD	Head of the Department
HPRT	Hospital Pandemic Response Team
HVAC	Heating, Ventilation, and Air Conditioning
ID	Identification (as in ID Banding)
IHIP	Integrated Health Information Platform
ILI	Influenza-Like Illness

IPC	Infection Prevention & Control
KMSCL	Kerala Medical Services Corporation Limited
LMO	Liquid Medical Oxygen
LPM	Litres Per Minute
LSGD	Local Self-Government Department
NHM	National Health Mission
NIV	Non-Invasive Ventilation
OMU	Outbreak Monitoring Unit
PAPR	Powered Air-Purifying Respirator
PEID	Prevention of Epidemic and Infectious Disease
PHEIC	Public Health Emergency of International Concern
PPE	Personal Protective Equipment
PPRC	Pandemic Preparedness & Response Committee
PRO	Public Relations Officer
PSA	Pressure Swing Adsorption (Oxygen Plant)
RAT	Rapid Antigen Test
RPEID Cell	Regional Prevention of Epidemic and Infectious Disease Cell
RTPCR	Reverse Transcription Polymerase Chain Reaction
SARI	Severe Acute Respiratory Infection
SOP	Standard Operating Procedure
SWM	Solid Waste Management

1. Introduction & Contextual Analysis

1.1 Background & Purpose:

GMC Kasaragod (Ukkinadka Campus) functions solely as an outpatient facility. It serves as a screening, early-detection, surveillance and training hub for the district. All serious/unstable/suspect patients are stabilised (if possible) and referred to GH Kasaragod. The 500-bedded hospital block is 55 % complete; C-Block is being prioritised for completion with 60 oxygen beds and an 8-bed ICU. Objectives include rapid response within the first week to prevent a PHEIC, early warning, intersectoral coordination and mortality mitigation.

1.2 Institutional Geography:

Ukkinadka Campus- 28 km from Kasaragod town. Transportation via road alone. Hospital building (Blocks A, B, C, D) inside the campus under construction. Dedicated referral pathway to GH Kasaragod, attached teaching hospital (~28 km).

1.3 District-Specific Risk Profile:

Lessons from the previous pandemic highlight early oxygen- demand escalation, need for buffer capacity, staff rotation, mental-health support, clear triage/referral protocols and round-the-clock availability of biomedical technicians. Coordination with district administration and referral hospitals remains critical.

1.4 Scope & Objectives:

Applies to OP services (all departments), academic activities (UG students & nursing), administrative/support staff, and the developing hospital infrastructure. Framework covers early warning, IPC/PPE protection, technical support to district team, HR training, continuity of essential OP services, rapid safe referral, and phased surge capacity as C-Block becomes functional.

2. Governance & Command Structure

2.1 Pandemic Preparedness & Response Committee (PPRC)

Leadership

- **Chairperson:** Principal.
- **Member:** Medical Superintendent.

Core Members

- **Clinical Leadership:** All Heads of Departments.
- **Nursing Oversight:** Nursing Superintendent.
- **Infection Control:** Infection Control Nodal Officer.
- **Epidemiology & Surveillance:** RPEID Cell Nodal Officer.
- **Administration:** Administrative Officer / Lay Secretary.

Primary Functions

- Phase activation (e.g., Red/Yellow channels)
- Resource allocation (PPE like PAPRs, ventilators)
- Daily review meetings for situational assessment
- Referral coordination between intra-hospital and inter-hospital transfers
- Reporting to district/state health authorities

2.2 Multidisciplinary Team:

Heads of Departments (General Medicine, Pulmonary Medicine, Paediatrics):

Responsible for clinical protocol standardisation, triage management, and overseeing the surge capacity of ICU and isolation wards.

HOD Microbiology & HICC (Hospital Infection Control Committee):

- Supervision of diagnostic testing and surveillance.
- Implementation of strict Infection Prevention and Control (IPC) bundles.

- Continuous monitoring of Bio-Medical Waste (BMW) management and PPE compliance.

Nursing Superintendent: Coordination of nursing manpower, shift rotations for high-risk zones, and ensuring the availability of bedside consumables.

Operational Support & Infrastructure (Contingency Activation)

- **Biomedical Engineering Wing:**
 - *Requirement:* Dedicated engineer (or contracted agency) for 24/7 maintenance of ventilators, HFNO machines, and multipara monitors.
 - *Plan:* Immediate empanelment of external service providers to be triggered upon "Level 1" pandemic alert as currently no persons are posted.

Oxygen War Room Management:

- Real-time monitoring of Liquid Medical Oxygen (LMO) levels, pressure stability, and cylinder manifold management.
- To be led by a designated Nodal Officer (Technical) with a dedicated team of technicians to prevent "dry outs" during peak demand.

Public Relations Officer (PRO) & Risk Communication:

- A dedicated desk for media briefings, managing patient inquiry helplines, and countering misinformation.
- *Plan:* A PRO shall be posted and designated as the 'Institutional Media Liaison' to ensure transparent communication with the public and the Directorate.

Biomedical Engineering, Oxygen War Room Management and PRO- Currently no staff posted at present

2.3 Outbreak Monitoring Unit (OMU):

Specialized cell for identifying emerging/re-emerging infections, triaging, and multiplex PCR diagnostic platforms.

Convenor	Name	Designation
Member	Dr Praveen R	Medical Superintendent
Member	Dr Anoop Kumar N	Associate Professor & Gen. Medicine
Member	Dr Sindhu T G	Professor i/c, Paediatrics
Member	Dr Jithin Raj V	Assistant Professor & Gen. Medicine (Neurology)
Member	Dr Aswathy T Mohan	Assistant Professor, Microbiology
Member	Dr Kandha Elangovan M	Assistant Professor, Pathology
Member	Dr Neethu M Babu	Assistant Professor, Forensic Medicine
Member	Dr Bindu V	Professor & HOD, Community Medicine
Member	Dr Lekshmi Rajeev	Assistant Professor, Community Medicine
Member	Smt. Sidhumol M R	Nursing Superintendent

2.4 Institutional Medical Board:

The Institutional Medical Board (IMB) in GMC Kasaragod, is activated upon confirmation of pandemic cases or outbreaks to standardize patient management, auditing, and reporting

Functions:

- Daily case load review
- Clinical decision-making in treatment and discharge
- Bed & oxygen allocation
- Staff deployment
- Surge activation decisions
- Coordination with district administration

Oversight for clinical treatment protocols and discharge policies.

3. Situational Analysis, Resource Mapping & Gaps

3.1 Infrastructure Audit: -

Category	Current Status / Capacity
Operational Status	Only OP Block is currently functional.
Hospital Block	500-bed project; 55% work completed. C-Block prioritized for initial commissioning.
ICU Infrastructure	8 Functional Beds (located in C-Block).
Ventilation Support	6 Units (Invasive & Non-Invasive).
High-Flow/NIV Beds	2 Beds currently capable of HFNC/NIV.
Immediate Surge Area	15 Beds (Post-operative recovery: 6; Emergency observation: 9).
Secondary Escalation	12 Beds on the First Floor (designated Phase 3).

Oxygen Infrastructure & Inventory

- Bulk Storage: 10 KL Liquid Medical Oxygen (LMO) Plant (Installation prepared/ready).
- Generation: PSA Plant with 1000 LPM capacity.
- Cylinder Bank: B-Type: 136 Units
 - D-Type: 260 Units
- Current Utilization: Average consumption is 1 Litre/day (subject to daily review for pandemic surge modelling).

Major Gaps & Constraints

The following critical gaps limit the institution's independent pandemic response:

1. **Clinical Limitations:** Absence of Inpatient (IP) beds, operational Intensive Care Units (ICU), and functional Operation Theatres (OT) at the Ukkinadka Campus.

2. **Diagnostic Gap:** Lack of advanced on-site diagnostic facilities.
3. **Referral Dependency:** All serious or surge-related cases must currently be referred to **General Hospital (GH) Kasaragod**.
4. **Transfer Risk:** While portable oxygen cylinders are used for stabilization during transit, the distance to referral centres remains a high-risk factor for critically ill patients.

3.2 Human Resource Pool

Mapping of sanctioned vs. present staff (Professors to temporary staff) and a three-tiered staffing plan (core, reserve, volunteer).

Sl No	Category	Sanctioned	Present	Gaps	Mobilization Strategy
1	Faculty (Clinical)	44	18	26	Call back from leave; redeploy from non-critical depts.
2	Residents (SR/ Academic JR/ NAJR)	52	33	19	Recruit additional temporary doctors through NHM/schemes.
3	Nursing Staff (Permanent)	80	47	33	Shift-based duty (6-8 hr shifts); cancel all leave.
4	Nursing Staff (Contract)	0	0	0	Recruitment of emergency temporary nursing staff.
5	ICU/Transplant Trained Nurses	0	0	0	Prioritize for Level 3 (Crisis) ICU surge.
6	Nursing Assistants	10	5	5	Deploy for high-touch surface cleaning and food delivery.
7	Hospital Attendants (Gr 1 & 2)	30	14	16	Training on 1% hypochlorite use and trolley disinfection.

8	Kudumbasree / Cleaning Staff (Full time + part time sweepers)	8	5	3	Focus on waste management and environmental cleaning.
9	Ancillary (Lab, Rad, Pharm)	9+5+3	4+5+0	5+0+3	Maintain a standby duty roster for 24/7 coverage.
10	Security & Transport Staff	1	1	1	Lead "Red Channel" movement and patient data entry.
11	Volunteer/ Reserve Pool	110	110	0	Medical and Nursing Students shall be mobilized Identify retired HCWs and those in non-clinical roles.

3.3 Equipment & Logistics:

- Ventilator beds: 6 (Planned in upcoming C block)
- HFNC/NIV: 2 beds (Planned in upcoming C block)
- LMO: 10 KL
- PSA plant: 1000 LPM
- Cylinders: B-type 136, D-type 260
- Basic screening tools (thermal scanner, pulse oximeter) at OP entry
- Buffer stock of PPE and essential drugs to be maintained; daily stock monitoring.

4. Graduated Response Framework (Three-Tier Model)

4.1 Escalation Triggers

The transition between levels is determined by the daily monitoring of:

- **Clinical Load:** Volume of ILI (Influenza-Like Illness) and SARI (Severe Acute Respiratory Infection) cases.
- **Resource Trends:** Bed occupancy rates and daily oxygen consumption.
- **Logistics:** PPE burn rate and staffing availability (as per the ICU Escalation Plan).
- **Epidemiology:** Evidence of a sustained community surge.

OP load of suspects, community surge, bed/oxygen consumption trends, staffing availability (from ICU escalation plan).

4.2 Level 1: Conventional Response

Scenario: Routine operations with isolated suspect cases.

Operational Goal: Maintain the standard of care without dilution of expertise while maximizing routine elective services.

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.

- **Key Actions:**
 - Surveillance: Daily ILI/SARI monitoring and mandatory Integrated Health Information Platform (IHIP) reporting.
 - Screening: Single-entry point screening utilizing thermal scanning and standardized symptom questionnaires.
 - Patient Flow: Implementation of a "Red Channel" for suspect cases with clear route maps and signage.
 - Readiness: Regular staff training, mock drills, and strategic PPE stock-building.

4.3 Level 2: Contingency Response (Moderate Surge)

Scenario: Sustained increase in suspect cases; strain on existing infrastructure.

Trigger Points	Institutional Action Points
Cases: Confirmed local transmission and rising suspected cases in OP/IP departments.	Hospital Reorganization: Activate surge annexes 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.

- **Operational Goal:** Adapt space, staffing, and supplies to maintain care functionally equivalent to standard care.
- **Key Actions:**
 - **Triage:** Activation of a dedicated Pandemic Screening OP with barricaded triage zones.

- **Resource Reallocation:** Prioritizing or pausing non-essential elective services to free up manpower.
- **External Linkage:** Strengthening referral protocols with **GH Kasaragod** (including mandatory pre-intimation).
- **Staffing:** Recruitment of temporary staff (via HDC/NHM) as required; daily reporting to the District Control Room

4.4 Level 3: Crisis Response (Maximum Surge)

Scenario: Resource scarcity requiring the activation of Crisis Standards of Care (CSC) and use of non-traditional clinical spaces.

- Operational Goal: Maximize population-level benefit under extreme resource constraints.

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.
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- Key Actions:
 - **Access Control:** Limit general OP to life-threatening emergencies only.
 - **Patient Categorization:**
 - *Suspect (Stable):* Swab collection followed by mandatory home isolation.
 - *Suspect (Unstable):* Immediate stabilization and 108 Ambulance referral to GH Kasaragod with a referral slip, clinical records, and a designated attendant.
 - **ICU Escalation Matrix:**
 - Phase 1: Optimization of the 8 core ICU beds.
 - Phase 2: Conversion of 15 surge beds (6 Post-Op + 9 Emergency Observation).
 - Phase 3: Activation of 12 additional beds on the First Floor.
 - Phase 4: Total diversion/referral to higher tertiary centers.
 - Administrative: Suspension of all elective procedures; transition of all academic activities to online platforms.

Actions:

- Limit general OP to emergencies only; categorise patients (non-suspect /suspect stable / suspect unstable).
- Suspect stable → swab + home isolation; unstable → stabilise + 108 ambulance referral to GH Kasaragod with slip, records & attendant.

- ICU Escalation: Phase 1 (optimise 8 ICU beds), Phase 2 (convert 15 convertible beds), Phase 3 (additional 12 beds), Phase 4 (referral to higher centres).
- Academic activities online; stop elective procedures.

Feature	Level 1 (Conventional)	Level 2 (Contingency)	Level 3 (Crisis)
Electives	Full Maintenance	Selective Pausing	Total Suspension
OP Focus	Standard Care	Pandemic Screening OP	Emergency Only
Referrals	Routine	Pre-intimated (GH Kasaragod)	Stabilize & Transfer (108)
Staffing	Standard Roster	Adaptive/Temporary Hiring	Maximum Redeployment

GRADUATED PANDEMIC RESPONSE FRAMEWORK

4.1 ESCALATION TRIGGERS: DAILY MONITORING


Clinical Load
(ILI/SARI)


Resource Trends
(Bed Occupancy, O₂)


Logistics
(PPE, Staffing)


Epidemiology
(Community Surge)

LEVEL 3: CRISIS RESPONSE

Scenario: Resource scarcity, Crisis Standards of Care (CSC)

Goal: Maximize population benefit under extreme constraints

Trigger Points

- Overwhelmed system (>90% ICU)
- Large absenteeism (>20%)
- High admissions
- Low PPE/ventilators



Institutional Action Points

- Stop general OP
- Stop non-urgent surgery
- Discharge stable patients
- Large scale recruitment
- Redeploy academic staff
- District ICU pooling
- Makeshift wards
- Field hospitals / CSLTCs

Patient categorization
> Suspect cases

ICU Escalation Matrix:
Phase 1: 8 beds
Phase 2: 15 surge beds
Phase 3: 12 first floor beds
Phase 4: Higher referral

Emergency OP only

LEVEL 2: CONTINGENCY RESPONSE

Scenario: Sustained suspect cases, infrastructure strain

Goal: Adapt space, staffing, supplies for functional care

Trigger Points

- Local transmission
- 70-90% ICU
- Rising pandemic admissions



Institutional Action Points

- Surge annexes
- Regulate non-pandemic care
- Shift duties (6-8 hrs)
- float pools
- Full O₂ reserve
- temp staff (HDC/NHM)



GH Kasaragod

LEVEL 1: CONVENTIONAL RESPONSE

Scenario: Routine operations, isolated suspect cases

Goal: Maintain standard of care, maximize routine services

Trigger Points

- no/sporadic cases
- normal admissions
- low absenteeism
- ample PPE



Institutional Action Points

- activate surveillance (ILI/SARI, IHIP)
- Plan expansion (20% O₂ beds/ICU)
- Training/mock drills
- LMO reserve



Key actions

- Patient categorization and supec cases
- Suspension of electives



5. Operational Standard Operating Procedures (SOPs)

5.1 Triage & Red Channel Protocol:

Dual-stream triage (Green/Red zones), dedicated transport routes, unidirectional flow, clear signage, segregation of clean/contaminated zones, and lift/trolley disinfection with 1% hypochlorite. Details added as Annexure

5.2 Patient Care Equipment:

Hand hygiene, cough etiquette, PPE donning/doffing, environmental cleaning with 1 % hypochlorite. Details added as Annexure (Details included in Annexures)

5.3 Infection Prevention & Control (IPC):

Sample collection with IPC protocols, linkage with district/state labs, safe transport SOPs. (Details included in Annexures)

6. Specialized Service Guidelines

- Referral Protocol (mandatory for all serious/suspect cases): Stabilise, prepare duplicate referral slip + OP ticket + reports, inform GH Kasaragod casualty, arrange 108 ambulance, record in OP register, mandatory attendant.
- Management of deceased and other specialised services as per district guidelines.

7. Logistics & Ancillary Services

7.1 Supply Chain Management:

Supply Chain Management: Drug Procurement: Advance indenting, buffer stock of antibiotics/antivirals/sedatives, government supply chains, daily monitoring, emergency local procurement with KMSCL coordination.

Procurement & Indenting

- **Advance Indenting:** The Pharmacy Department and HPRT will implement advance indenting based on epidemiologic modelling (Ro) and current OP footfall to prevent stock-outs.
- **KMSCL Coordination:** Primary procurement remains through the Kerala Medical Services Corporation Limited (KMSCL) web portal with real-time tracking.
- **Emergency Local Purchase:** In the event of KMSCL stock-outs during Phase III (Crisis), the Principal/Medical Superintendent is authorized for emergency local procurement via the Hospital Development Society (HDS) or emergency response funds

Monitoring & Inventory Control

- **Daily Monitoring:** The Pharmacist-in-charge will provide a daily "Critical Stock Report" to the Pandemic Preparedness & Response Committee (PPRC).
- **Buffer Levels:**
 - **Level 1 (Conventional):** Maintain >30 days of PPE and essential drug supply.
 - **Level 2 (Contingency):** Alert triggered when supplies drop to 7–29 days.
 - **Level 3 (Crisis):** Emergency local procurement activated if supply drops below 7 days.

7.2 Linen & Laundry

SOPs for Linen and Laundry attached as Annexure

7.3 Biomedical Waste Management

Added as Annexure

7.4 Psychological Support & Mental Health Plan

7.4.1. Dedicated Psychosocial Support Team

- **Composition:** Led by the **Department of Psychiatry** at GMC Kasaragod. More psychiatrists, psychologist, psychiatric social workers, and trained nursing staff to be included with the help of DMHP as the institution has limited human resources including clinical psychologists.
- **Function:** To provide emotional first aid, crisis intervention, and long-term mental health support to staff, patients, and their families.

7.4.2. Support for Healthcare Workers (HCWs) and Staff

- **Burnout Management:** Implementation of regulated 6–8-hour shift rotations to prevent physical and mental exhaustion.
- **Peer Support Groups:** Creation of "Safe Space" WhatsApp groups or brief daily huddles for staff to share concerns and receive peer validation.
- **Counselling Access:** A dedicated, confidential helpline or outpatient hour at the Psychiatry OP for staff experiencing high stress, insomnia, or anxiety related to pandemic duties.

7.4.3. Patient and Family Support

- **Tele-Counselling:** Providing psychological support via telephone for Stable Suspected patients who are referred for home isolation to manage the stress of quarantine.
- **Grief Support:** Specialized counselling for families in cases of mortality, ensuring protocols for the management of the deceased are handled with dignity and clear communication.

8. Communication, Monitoring & Research

8.1 Surveillance Systems:

The Regional Prevention of Epidemic and Infectious Disease (RPEID) Cell coordinates disease surveillance and inter-agency activities during a pandemic.

RPEID Cell, GMC Kasaragode		
Position	Name	Designation
Chairperson	Dr Arun Kumar A	Principal
Vice chair	Dr Praveen R	Medical Superintendent
RPEID coordinator	Dr Lekshmi Rajeev	Assistant Professor, Community Medicine
Member	Dr Bindu V	Professor & HOD, Community Medicine
Member	Dr Sindhu T G	Professor i/c, Paediatrics
Member	Dr Anoop Kumar	Associate Professor, General Medicine
Member	Dr Aswathy T Mohan	Assistant Professor, Microbiology
Member	Dr Jithin Raj V	Assistant Professor & Gen. Medicine (Neurology)
Member	Dr Raveendran M	Assistant Professor, Pulmonology

- **IHIP Integration:** The RPEID Cell is responsible for the mandatory daily uploading of disease surveillance data into the **Integrated Health Information Platform (IHIP)**.
- **Daily Reporting:** All surveillance data from the institution is transmitted to the **State PEID Cell** on a daily basis to ensure real-time situational awareness at the state level.
- **Monitoring:** The cell oversees ILI (Influenza-Like Illness) and SARI (Severe Acute Respiratory Infection) screening at all outpatient counters.

8.2 Media & Risk Communication:

8.2.1 Unified Command and Spokesperson

- **Designated Spokesperson:** To prevent conflicting information, only the Principal (Incident Commander) or a designated Public Relations Officer (PRO) is authorized to issue official statements.
- **Centralized Messaging:** All internal departments, including the RPEID Cell and HODs, must channel data through the spokesperson before public release.
- **Liaison with District:** The spokesperson ensures that institutional updates are synchronized with the District Medical Officer (DMO) and the District Control Room to maintain a "single voice" across the district.

8.2.2 Accurate Status Reporting

- **Daily Bulletins:** The **Control Room** at GMC Kasaragod generates daily reports on screening numbers, samples collected, and the number of unstable patients referred to GH Kasaragod.
- **Factchecking:** The Outbreak Monitoring Unit (OMU) and RPEID Cell verify all clinical and diagnostic data to counter misinformation or rumours within the community

8.3 Control Room Operations

in Coordination of patient arrivals, duty roster management, and daily review meetings.

8.4 Research Collaboration

In coordination with the other departments and as per the state guidelines, Clinical trials, outcome analysis, and other research studies will be conducted. The Institutional Research Committee and Ethics committee shall expedite the research related to the pandemic.

9. Recovery & De-escalation

9.1 Discharge & Back Referral

Referral criteria per guidelines

The de-escalation strategy at Government Medical College, Kasaragod is conceived as a calibrated and data-driven transition from emergency pandemic response to normalized healthcare delivery, ensuring that gains achieved during crisis management are preserved while routine services are safely restored. Central to this approach is the gradual reduction of designated COVID care beds, guided by declining caseloads, test positivity rates, and hospital occupancy trends. Rather than abrupt withdrawal, bed capacity is strategically tapered in phases, maintaining a buffer for potential resurgence while simultaneously releasing infrastructure for non-COVID care. This measured approach ensures preparedness is retained even as pressure on the system eases.

Parallely, the restoration of routine healthcare services is undertaken in a prioritized and structured manner, with special emphasis on elective procedures, outpatient services, and management of non-communicable diseases that may have been deferred during the surge period. Workforce normalization is carefully orchestrated by redeploying staff from pandemic-specific duties back to their parent departments, addressing fatigue through appropriate rest cycles, and re-establishing standard duty rosters. At the same time, resources—including oxygen infrastructure, equipment, and critical drugs—are judiciously redistributed across departments to align with evolving service demands. This holistic de-escalation framework ensures that the institution transitions smoothly from crisis mode to comprehensive care delivery, while remaining vigilant and resilient against future public health contingencies.

- Gradual reduction of pandemic earmarked beds
- Restoration of routine services
- Workforce normalization
- Resource redistribution

9.2 Financial Plan:

Special pandemic preparedness and emergency response fund to cater all the activities mentioned in the preparedness plan

9.3 After-Action Reviews:

Policy audits and post-pandemic evaluations for iterative improvement.

10 Index of Standard Operating Procedures (SOPs) & Guidelines

10.1 Clinical & Triage Protocols

- **Dual Stream Triage:** Segregation of ILI/SARI cases from general patients at entry. *(Management of increasing Fever Cases - Kerala State Treatment Guidelines for ILI & SARI cases in the context of co-circulation of SARS-COV-2 and Influenza virus - Health & Family Welfare Department; G.O.(Rt)No.1489/2023/H&FWD Dated, Thiruvananthapuram, 23-062023)*
- **Red Channel Protocol:** Step-by-step movement of positive patients, including lift blocking and security coordination. *(COVID-19 (n-Corona) Virus Outbreak Control and Prevention State Cell Health & Family Welfare Department Government of Kerala Reference Guide for Converting Hospitals into Dedicated COVID Hospitals.)*
- **Patient Admission & ID Banding:** Mandatory ID bands and registration of bystanders/vehicle details. *(COVID 19 treatment guidelines Ref No 31/F2/2020/ H&FWD dated 15th August, 2020, Govt. of Kerala)*
- **Testing Strategy:** 10-day testing cycle for routine dialysis patients and use of Rapid Antigen Tests (RAT). Testing strategy to be optimized based on the pathogen characteristics *(Advisory on purposive testing strategy for COVID 19; No 46/31/F2/2020/ H&FWD dated 11th Jan, 2022, Govt. of Kerala)*

10.2 Infection Prevention & Control (IPC)

- **Donning & Doffing:** Mandatory refresher training for all staff levels, including housekeeping and drivers. *(COVID 19 - PPE use. Reg. No 31/F2/2020/ Health - dated 25th March 2020, F &FW, Govt. of Kerala)*
- **Hand Hygiene & Cough Etiquette:** Standardized practices as per the Institutional IPC Manual. *(COVID -19 Infection Prevention and Control Manual, Govt Medical College, Thiruvananthapuram date of issue 16.4.2020)*
- **Environmental Cleaning:** Two-hourly cleaning of high-touch surfaces (switches, handles) with 1% hypochlorite. *(Standardized practices as per the Institutional IPC*

Manual. (COVID -19 Infection Prevention and Control Manual, Govt Medical College, Thiruvananthapuram date of issue 16.4.2020)

- **Patient Equipment Reprocessing:** Sterilization of heat-sensitive (ETO/ Sterrad) and heat-stable (Autoclave) items. (Standardized practices as per the Institutional IPC Manual. (COVID -19 Infection Prevention and Control Manual, Govt Medical College, Thiruvananthapuram date of issue 16.4.2020)

10.3 Engineering & Infrastructure SOPs

- **AIR Conversion:** Guidelines for blocking return air vents and achieving 12 Air Changes per Hour (ACH).
- **Operation Theatre (OT) Modification:** Converting to 100% once-through HVAC systems for pandemic surgeries.
- **Makeshift Enclosures:** Setting up temporary cubicles or tents with localized HEPA filtration.

10.4 Logistics & Waste Management

- **Biomedical Waste (BMW):** Use of double-layered yellow bags and specific "X Waste" labelling.
- **Linen & Laundry:** Protocol for leak-proof containers and avoiding double-bagging to reduce waste.
- **Oxygen War Room:** Real-time oxygen mapping and reserve capacity enhancement.

10.5 Specialized & Support Service Guidelines

- **Dialysis Unit SOP:** Use of dedicated tubing for positive patients and face shield requirements.
- **Management of the Deceased:** Disinfection of body bags with 1% hypochlorite and plugging of orifices.
- **Psychological Support:** Counselling for families and staff to manage burnout and anxiety.

- **Food & Dietary Services:** Coordination with Local Self-Government Departments (LSGD) for timely patient meals.

Annexures

Instructions for safe use of linen

Packing and transporting linen and laundry from isolation areas

- 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

Patient care equipment SOP for emerging pathogens

- Dedicated instruments must be used for suspected patients and confirmed cases.
- Staff on duty must check the availability of the equipment in each shift.
- Proper cleaning and disinfection is necessary.
- Thermometer, stethoscope, glucometer, BP apparatus, Pulse oximeter etc. to be the dedicated patient care equipment
- The HCW must wear PPE properly while reprocessing instruments.
 - Disposable items must never be reused.
 - Heat stable items after decontamination using 1% bleach solution for 10min, clean with water & detergent and sterilize by autoclaving. Heat sensitive items can be sterilized by ETO sterilizer or Sterrad.
 - All medical/surgical/dental devices must be sterilized according to manufacturer's instructions.

Biomedical Waste Management [BMW] Protocols in Isolation wards:

- 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 BMW 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.

Protocol for handling of deceased during pandemics [prototype-covid 19]

The main driver of transmission of COVID-19 is through droplets. There is unlikely to be an increased risk of COVID infection from a dead body to health workers or family members who follow standard precautions while handling body. But in case of diseases like Ebola, Marburg, CCHF etc HCW can get infections from the deceased as well. Only the lungs of dead COVID patients, if handled during an autopsy, can be infectious. Standard Precautions to be followed by health care workers while handling dead bodies of COVID. Standard infection prevention control practices should be always followed.

These include:

1. Hand hygiene.
2. Use of personal protective equipment (e.g., water resistant apron, gloves, masks, eyewear).
3. Safe handling of sharps.
4. Disinfect bag housing dead body; instruments and devices used on the patient.
5. 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

- The health worker attending to the dead body should perform hand hygiene, ensure proper use of PPE (gloves, N95 mask, goggles, water resistant apron).
- All tubes, drains and catheters on the dead body should be removed.
- Any puncture holes or wounds (resulting from removal of catheter, drains, tubes, or otherwise) should be disinfected with 1% hypochlorite and dressed in impermeable

material.

- Apply caution while handling sharps such as intravenous catheters and other sharp devices. They should be disposed into a sharps container.
 - Plug oral, nasal orifices of the dead body to prevent leakage of body fluids.
 - 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.
 - 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.
 - The body will be either handed over to the relatives or taken to mortuary.
 - 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.
 - Used equipment should be autoclaved or decontaminated with disinfectant solutions in accordance with established infection prevention control practices.
 - All medical waste must be handled and disposed of in accordance with Biomedical waste management rules.
 - The health staff who handled the body will remove personal protective equipment and will perform hand hygiene.
 - 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
- Mortuary staff handling COVID-19 dead body should observe standard precautions.
 - Dead 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.

Transportation

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

General instructions regarding admissions and discharge of patients

(Prototype- COVID -19)

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 to wards or CFLTCs.
3. Patients should be shifted to concerned ward or pay ward as early as possible.
4. Inform COVID-19 nodal officer in charge and PEID cell if COVID 19 positive MCH, HCW /student get admitted.
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 COVID -19 patients

7. Security staff should be alert when the patients come out of OPD.
8. If both mother and child is admitted in MCH, inform Superintendent and retain baby here and take admission for Maternity Block (SAT/ICH/IMCH)
9. Before allotting bed /room to the patient make sure about the cleanliness of room, working condition of fan, light etc.
10. All HCWs should treat the patient with courtesy even if the patient is provoking. Inform higher officials in case of any incident.
11. There should not be any delay in food for the patients.
12. If there is any unusual incidence happening in ward/ payward it should be informed to concerned authorities and document in incident report register.
13. RAT negative patients can be shifted in ambulance for home isolation. The name of ambulance driver and his contact number should be noted to avoid any issues to the patient.
14. The relatives should be informed regarding the discharge, and they should be shifted without any delay.
15. Discharges at night should be avoided especially for female patients.
16. The patient should be shifted to ward/ICU or other hospital only after ensuring the bed is readily available.
17. Post COVID -19 Symptomatic patients can be tested for RTPCR if they have ILI otherwise RAT is preferred. 18. Vacant bed (discharge/death) should be informed to Dedicated control room number as early as possible.

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