EXTERNAL DISASTER
POLICIES & PROCEDURES
KANOWIT HOSPITAL

JABATAN KESIHATAN NEGERI SARAWAK
HOSPITAL KANOWIT

DOCUMENT: EXTERNAL DISASTER POLICIES AND PROCEDURES KANOWIT HOSPITAL	
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DOCUMENT:
External Disaster Policies and Procedures Kanowit Hospital.

OBJECTIVE:

1) To ensure effective and efficient management of external disaster for Kanowit Hospital

SCOPE: All Staff of Hospital Kanowit.

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DISASTER PLAN

EMERGENCY AND TRAUMA
KANOWIT HOSPITAL

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SECTION 1 : INTRODUCTION

"Not every Multiple Casualty Incident is a disaster and not every disaster is a Multiple Casualty Incident."

A disaster is an emergency of such a magnitude as to severely overtax the capacity of an EMS System to deal adequately with the sick or injured.

The important aspect in a disaster is the ability of the EMS System to respond to the situation, even though the system has been hampered by the situation itself.

Although the principles of managing MCI (Multiple Casualty Incident) and disaster are the same, the after effects of a disaster usually lasts over a longer period of time and require greater support from the outside agencies. Experiences has shown that even the best-trained team have difficult times managing in a disaster.

One way to minimize the operating difficulties of a disaster is for every personnel to be familiar with the local disaster plan. A disaster plan is a pre-defined set of instructions which works as a guideline for various agencies in the event of a disaster. It is critical that other responding units are informed of this fact.

For operational purposes, a disaster can be defined as an event in which the needs exceed the immediately available resources.

This disaster plan serves as an add-on to complement the current existing Directive No. 20 of National Security Council for Malaysia, which states the role of other various governmental agencies if a disaster were to occur.

A. PURPOSE

We adopted the concept of PRE-DISASTER Paradigm™ used in National Disaster Life Support Foundation to develop our disaster plan. The component of PRE-DISASTER Paradigm™ is detailed below:

P – **Planning and Practice** (written Disaster Plan, Tabletop Exercise, Functional Exercise, Field Exercise Drill)
R – **Resilience** (the ability of individuals and communities to rebound to a reasonable state of normalcy after exposure to disasters or stressful or traumatic events)
E – **Education and training** (effective education and training can help minimize the impact of a disaster as well as build resiliency)

D – Detection
I – Incident Management
S – Safety and Security
A – Assess Hazards
S – Support
T – Triage and Treatment
E – Evacuation
R – Recovery

Written Disaster Plan – this booklet that you are reading.
Tabletop Exercise – small group exercise to improve staff coordination, communication and decision-making.
Functional Exercise – significant number of hospital staff response in simulated field conditions in BRM course.
Field Exercise Drill – involve whole hospital and other agencies to test the command, activation, mobilization, support, coordination and most importantly communication through the division or district emergency operation center (EOC) or Operation Room (Ops Room).
An all-hazards approach is utilized as the basic principle of disaster casualty management. All-hazards approach is a standardized approach in which all disaster casualty management are the same, regardless of the cause of the event.

1. To provide a policy for response to both internal and external disaster situations that may affect hospital staff, patients, visitors and the community.

2. To identify responsibilities of individuals, departments and other agencies in the events of a disaster.

3. To identify Standard Operating Guidelines for emergency activities and responses

B. LINE OF AUTHORITY (MAIN COORDINATOR)

Once the detection and confirmation of a disaster is recognized, **Red Alert** is activated.
The following person shall be contacted as soon as possible (in descending order of precedence), and shall assume the role of Main Coordinator of all aspects of operations:

1. Hospital Director
2. Deputy Director or Assistant Director
3. Head of Emergency and Trauma Department
4. Hospital Matron
5. Hospital Senior Assistant Medical Officer (SAMO)
6. Nursing Sister on general duty
7. Medical Officer on duty at ED or active call

The role of Main Coordinator will be assumed by the person who first arrived in the Command-and-Control Center (CCC), as mentioned in the list above. The Main Coordinator shall use this plan as a guide and modify it at his/her discretion as necessary. The Main Coordinator shall assume the responsibility of the Hospital Director before the arrival of the latter, or the person higher in rank in the line of authority. Once relieved from the original duty, the officer shall be reassigned a new duty as authorized by the new Main Coordinator.

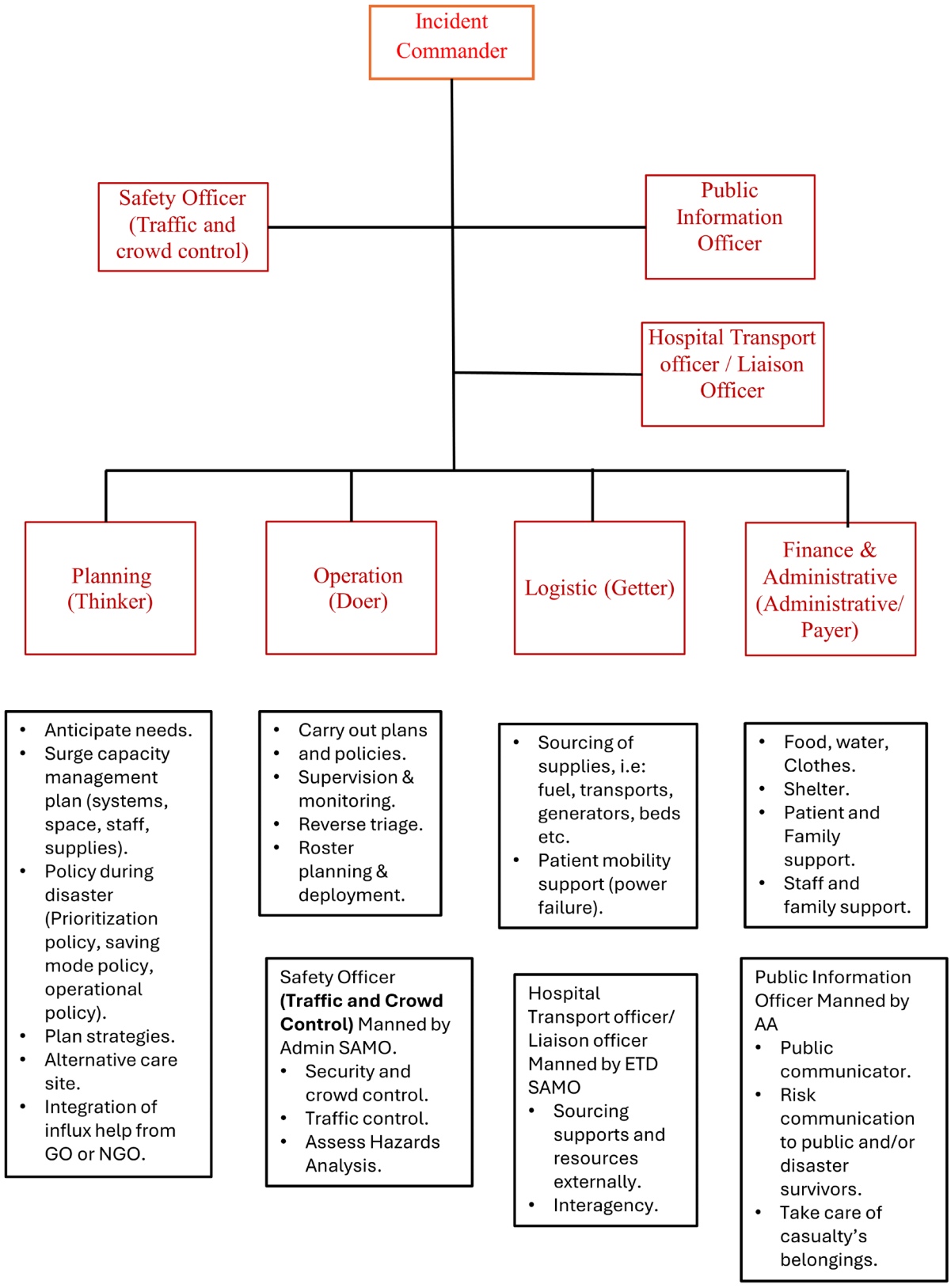
In the event of expecting prolonged period of disaster defined as more than 6 hours from the time EMT (Emergency Medical Team) arrives at scene or hospital receive first casualty, whichever comes first, an “Incident Command” system at hospital level will be set up at the Bilik Mini Mesyuarat **(Hospital Operation Room, HOR)** and respective roles assigned in order to sustain the functional operation of the hospital.

The function of the HOR (Hospital Operation Room) is:

(1) To compile and communicate latest information to the higher authority.
(2) To release accurate information or official statement to the media or public after the approval from higher authority
(3) To assign roles and responsibilities to the individual staff.
(4) Serves as the place for references of duty roster and rotation of staffs to take place.

This incident command serves to accommodate the surge capacity (make available of the resources) and surge capability (the ability to care) in disaster. The goal is maximizing the greatest good to greatest number of casualties presenting to the hospital while minimizing the compromise of existing standard inpatient care.

HOSPITAL INCIDENT COMMAND TEAM



Alternative Care site: indoor stadium, Dewan Suarah

C. ROLES AND RESPONSIBILITIES OF INDIVIDUALS AND DEPARTMENTS / UNITS

1. Hospital Coordinator - Hospital Director

The Hospital Coordinator will have the overall authority of the hospital. The duties include: -

i. Declaration of alert phase (yellow/red alert)
ii. Activation of supporting healthcare facilities such as KK Song, KK Machan, Hospital Sarikei, Hospital Sibu (if needed)
iii. Reporting to the Divisional Health Office/State Health Department and Ministry of Health.
iv. Liaise with relevant agencies.
v. In-charge of Hospital Operation Room (HOR) / Command Control Centre (CCC)
vi. Public information and press release
vii. In-charge of declaring stand down

2. Clinical Coordinators

i. In a major disaster, the deputy director / most senior clinician will perform the Director's functions, if he/she is absent.
ii. Head of Department or designated of each discipline will take charge on all matters related to clinical issues and patient management in their own wards as well as roles given during disaster activation.
iii. Head of Department or designated will call in their own personnel as needed after reporting to the Command-and-Control Center.

3. Administrative Coordinator – Administrative Officer (Penolong Pegawai Tadbir)

i. In-charge of the organization of the facility, accommodation of patients and deployment of non-clinical manpower.
ii. Supervise all other administrative personnel.
iii. Person in-charge of contacting respective embassy for disaster patients with no valid/proper identification.

4. Hospital Supervisor / Assistant Medical Officer U32 (Admin)

i. Is responsible for crowd control and security of the hospital.
ii. Is responsible for assessing hazards and analyzing security situations.
iii. Is in-charge of traffic control at the hospital.
iv. Will lead the security guards in the event of disaster activation.
v. Leads the AMOs below him and is responsible to ensure that other unit SAMOs are playing their roles which will be further described during disaster role description

5. Head of Nursing (Matron)

i) Response Phase

(1) Yellow Alert

(a) Upon receiving a Yellow Alert, the Matron will report to Command Control Centre (CCC) through telephone or in person and stay at own unit/department.
(b) The Matron will also reply in the WhatsApp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) Matron will alert all matrons and sisters who are on duty and off-duty.
(d) The matron will do a head count on all staff available on floor for deployment and also available to call back and keep track of that information.
(e) Matron will also ask for a report of the existing number of patients in all the wards including the number of patients that can be discharged, the number of beds available.
(f) Matron will start the bed arrangement planning, ward overflow planning and HDU bed planning with the help of her nursing sisters.

(2) Red Alert

(a) Upon receiving Red Alert, the Matron will report to CCC, and coordinate the nursing response for incidence, and assist Hospital Commander regarding all nursing requirement during incident / disaster response.
(b) She will also inform all nursing personnel and call in off-duty personnel if needed.
(c) The Matron shall arrange or assign their staff duties and responsibilities depending on the needs.

ii) Implementation Phase (Red Alert)

(1) In-charge of setting up and organizing the Disaster Ward.
(2) Responsible for the nursing services and activities during disaster.
(3) Ensure that matrons and nurses under her are aware of their roles and responsibility and that additional nursing personnel and attendants are called back if needed.

6. General Administrative Staffs

i) Response Phase

(1) Yellow Alert

(a) After receiving the Yellow Alert, the staff at work will report to CCC through telephone or in person and stay at their own unit/department.
(b) The Administrative Coordinator will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) Staff in-charge (Administrative Coordinator) will alert all their personnel who are on duty and off-duty.

(d) The administrative coordinator will do a head count on all staff available on floor for deployment and also available to call back and keep track of that information.
(e) The administrative coordinator will look at the existing financial status and keep the information readily available in case it is needed.

(2) **Red Alert**

(a) Upon receiving the Red Alert, the staff in charge shall report to CCC and inform all their personnel and call in off-duty personnel to the hospital if necessary.
(b) The staff in-charge shall arrange or assign their staff duties and responsibilities depending on the needs.
(c) Call in extra personnel if required.

ii) Implementation Phase (Red Alert)

(1) 2 persons are assigned to help out at the ED admission counter as soon as possible.
(2) 1 of the staff will be in charge of keeping track of disaster red zone and disaster yellow zone patients and updating CCC from time to time
(3) Second general admin staff will be in charge of keeping track of disaster green zone and non-disaster patients and updating CCC if sufficient staffs are available.
(4) In the event of an internal disaster, staffs are to prepare for evacuation to a safe area.
(5) Periodically, check and send update to CCC/ HOR

iii) Recovery Phase

(1) Refer to recovery phase (Section 4)

iv) Other Considerations
(1) As required depending on the nature of emergency

7. <u>Admission/ Discharge Counter Staffs (Unit Hasil)</u>

i) Response Phase

(1) Yellow Alert

(a) After receiving the Yellow Alert, the staff at work will report to CCC through telephone or in person and stay at own unit/department.
(b) The staff in-charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) Staff in-charge will alert all their personnel who are on duty and off-duty.
(d) Staff in-charge will do a head count on all staff available on floor for deployment and also available to call back and keep track of that information.
(e) Staff in-charge will be prepared for a surge of discharges in the event if the yellow alert proceeds to Red alert.

(2) **Red Alert**

(a) Upon receiving the Red Alert, the staff in charge shall report to CCC and inform all their personnel and call in off-duty personnel to the hospital if necessary.
(b) The staff in-charge shall arrange or assign their staff duties and responsibilities depending on the needs.
(c) Call in extra personnel if required.

ii) Implementation Phase (Red Alert)

(1) A responsible person(s) shall be assigned to help out at the ED admission counter as soon as possible.
(2) A separate staff(s) shall be put in-charge of routine non-emergency admissions if sufficient staffs are available.
(3) In the event of an internal disaster, staffs are to prepare for evacuation to a safe area.
(4) Periodically, check for update from CCC/ HOR

iii) Recovery Phase

(1) Refer to recovery phase (Section 4)

iv) Other Considerations
(1) As required depending on the nature of emergency

8. <u>Dietary & Food Services (Dietician / Kitchen staff)</u>

i) Response Phase

(1) **Yellow Alert**

(a) After receiving the Yellow Alert, the unit in-charge (Dietician unless not available) will report to CCC through telephone or in person and stay at own unit/department.
(b) The unit in-charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) Unit in-charge will alert all their personnel who are on duty and off-duty.
(d) Unit in-charge will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) Unit in-charge will check food and supplies readily available and also make available the contact numbers of vendors to replenish supplies if needed.
(f) Unit in charge will check facilities, equipment and utilities to ensure it is functioning well.

(2) Red Alert

(a) Upon receiving the Red Alert, the unit in-charge shall inform all their personnel and call in off-duty personnel to the hospital if needed
(b) The unit in-charge shall arrange or assign their staff duties and responsibilities depending on the needs.

(c) Order urgent food supplies if necessary.
(d) Ensure sufficient food is available to hospital staffs on duty/patients
(e) Ensure that a group is assigned to provide necessary food/refreshments for the victim's relatives.

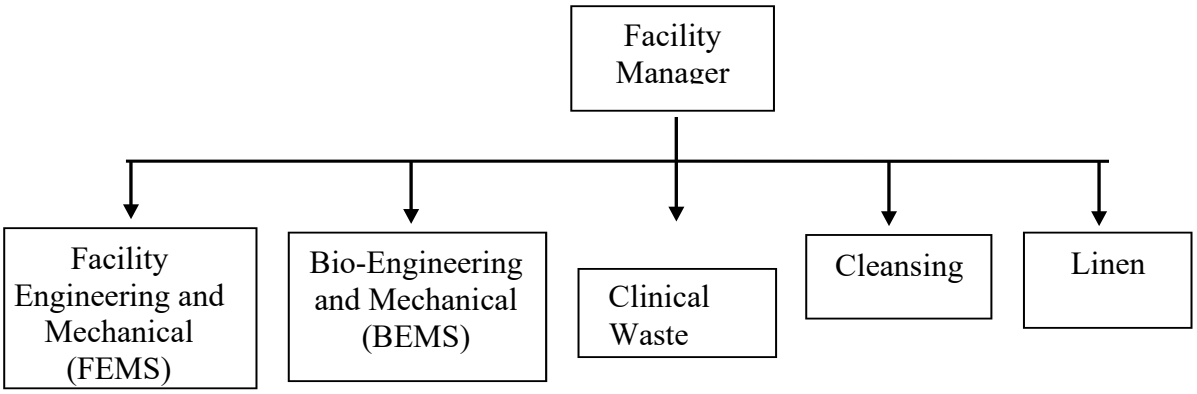
ii) Implementation Phase (Red Alert)

(1) Prepare to provide food / refreshments to ambulatory patients, inpatients and personnel as the need arises.
(2) Responsible for setting up menus in a disaster situation.
(3) Call in extra personnel if required.
(4) Obtain extra utilities, supplies, and etc if required.
(5) If it is an internal disaster, be prepared for evacuation to safe area.
(6) Periodically, check for update from CCC / HOR

iii) Recovery Phase
(1) Refer to recovery phase (Section 4)

iv) Other Considerations
(1) To maintain adequate food and supplies to last throughout the disaster
(2) Maintain a list of supplies and contact numbers.
(3) Food suppliers shall be able to supply food immediately

9. Hospital Support Services (HSS)



The organization of Hospital Support Services is as shown above.

i) Response Phase

(1) Yellow Alert

(a) After receiving the Yellow Alert, the unit in-charge (usually Facility manager unless on leave) will report to CCC through telephone or in person and stay at own unit/department.
(b) The unit in-charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.

(c) Unit in-charge will alert all their personnel in all their sub-units who are on duty and off-duty.
(d) Unit in-charge will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) FEMS will check all facilities and equipment to ensure all are functioning well and will fix all 'spoilt' / broken items as soon as possible if detected.
(f) BEMS will check all facilities and equipment to ensure it is functioning well.
(g) Linen will check the amount of clean linens available.
(h) Clinical waste and cleansing will check to ensure that supplies needed for their unit is sufficient in amount.

(2) Red Alert

(a) Upon receiving the Red Alert, the unit in-charge shall inform all their personnel and call in off-duty personnel to the hospital if needed.
(b) The unit in-charge shall arrange or assign their staff duties and responsibilities depending on the needs.

ii) Implementation Phase (Red Alert)

(1) All subunits of HSS will ensure full operation and availability of their facilities and/or equipments.
(2) FEMS are in charge of setting up extra beds in hospital if needed, as well as transporting storeroom supplies and bringing in extra supplies from other areas if needed
(3) BEMS unit will bring in extra equipments if needed / available.
(4) Cleansing subunit will be available to help clean receiving area, and clean rooms between cases in treatment areas. They also have to ensure that items needed for cleaning are sufficient in amount
(5) Linen subunit will be prepared to supply additional linens as required
(6) Clinical waste subunit will ensure that there are sufficient biohazard bags and ensure proper disposal of clinical wastes.
(7) If an internal disaster happens, all subunits are to be prepared for evacuation to safe area.
(8) Periodically, check for update from CCC / HOR

iii) Recovery Phase
(1) Refer to recovery phase (Section 4)

iv) Other Considerations
(1) As required depending on the nature of emergency

10. Operating Room, Anesthesiology

i) Activation Phase

(1) Yellow Alert

(a) Upon receiving yellow alert, anesthesiologist reports to CCC, through telephone or in person and stay at own unit/department.

(b) The anesthesiologist call will also reply in the WhatsApp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) Anesthesiologists will alert all their personnel who are on duty and off-duty.
(d) Anesthesiologist will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) Elective cases shall be postponed.
(f) To complete current on-going case
(g) Identify and prepare Operating Room for possible Emergency Surgery.
(h) To identify and transfer out stable ICU patients.
(i) To prepare extra ICU beds if possible.
(j) Check available supplies and equipment and ensure all are functioning well

(2) Red Alert

(a) Upon receiving Red Alert, the anesthesiologist will call in all needed personnel to the hospital.

ii) Implementation Phase (Red Alert)

(1) Assign and direct scrub nurses and runners.
(2) Requests for additional help to carry out surgery and treatments in Operating Rooms and Recovery Room if needed.
(3) Notify CCC/HOR when Operating Rooms and Recovery Room is available for more patients.
(4) To call patients to OT according to priority of patient
(5) Transfer out stable ICU patient if not yet done.
(6) Prepare extra ICU beds if needed.
(7) Keep the list of supplies available and be prepared to process additional sterile supplies quickly.
(8) If there is an internal disaster, prepare for evacuation to safe area.
(9) Periodically, check for update from CCC/HOR

iii) Recovery Phase

(1) Refer to recovery phase (Section 4).
(2) Upon stand-down, recalled personnel that are not needed will be released.
(3) Postponed elective cases will be considered whether to proceed or rescheduled after discussion with primary team.
(4) To readjust the ICU staff roster if the number of patients exceeds the acceptable amount.

11. <u>Clinical Wards</u>

i) Response Phase

(1) Yellow Alert

(a) Upon receiving Yellow Alert, the sister in charge of respective ward will report to CCC through telephone or in person and stay at own unit/department.

(b) The unit in charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) The unit in charge will alert all their personnel who are on duty and off-duty.
(d) The unit in charge will do a head count on all staff available on the floor for deployment and also available to call back and keep track of that information.
(e) To check all facilities and the amount of equipment available.
(f) To check the amount of beds/stretchers available in the ward.
(g) Identifies stable patients and plans to cohort all non-disaster patients and prepares acute beds to accommodate critical disaster patients.
(h) Unit in charge to report existing number of patients in their wards including the number of patients that can be discharged, and the number of beds available to the nursing sister and/or head matron and/or sister on call.
(i) Unit in charge together with Head Matron will start the bed arrangement planning, ward overflow planning and HDU bed planning.

(2) Red Alert

(a) Upon receiving the Red Alert, the unit in charge shall inform all their personnel and call in off-duty personnel to the hospital if needed.
(b) The unit in charge will arrange or assign their staff duties and responsibilities depending on the needs.

ii) Implementation Phase (Red Alert)

(1) Stable patients are discharged, and existing patients are rearranged to create more room for casualties.
(2) Ensure that extra supplies (i.e., CSSD, linen and dietary) are available to prepare for the surge of patients.
(3) If internal disaster happens, prepare for evacuation of patients to safe area.
(4) Periodically, check for update from CCC/HOR
(5) Ward in charge shall ensure that security is tightened allowing only needed relatives to enter the ward

iii) Recovery Phase
(1) Refer to recovery phase (Section 4)

iv) Other Considerations
(1) At stand-down, all recalled personnel that are not needed will be released.
(2) To readjust the staff's roster if more manpower is needed.
(3) Allocate runners as messengers if the telephone system fails.

12. Medical Imaging

i) Response Phase

(1) Yellow Alert

Office hour

(a) Upon receiving Yellow Alert, the unit in charge will report to CCC through telephone or in person and stay at their own unit/department.
(b) The unit in charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) The unit in charge will alert all their personnel who are on duty and off-duty and put them on standby.
(d) The unit in charge will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) The unit in charge will count the equipment which may be needed for a large surge of x-rays later and keep track of the information.
(f) The unit in charge will communicate with CCC to get further information and instructions.

After office hour (on call)

(a) The technologist on call will be alerted by the telephone operator. This technologist will be the radiology officer in charge of the x-ray department and will report to CCC for further information.
(a) This technologist is to inform their unit in charge and any other personnel as needed.

(2) Red Alert

(a) Upon receiving Red Alert, the unit in charge shall inform all their personnel and call in off-duty personnel if needed.
(b) The unit in charge shall arrange and assign their staff duties and responsibilities depending on the needs.
(c) Ensure that extra supplies and consumables are available and to be brought in if needed.

ii) Implementation Phase (Red Alert)

(1) Coordinates and manages staffs and situations.
(2) Manages all radiological investigations needed
(3) To ensure that extra personnel is called back if required.
(4) Ensure that there is adequate supply of consumables needed
(5) If an internal disaster happens, prepare for evacuation to a safe area.
(6) Periodically, check for update from CCC/HOR

iii) Recovery Phase

(1) Ensures rooms used are cleaned and tidied up
(2) Ensures that equipment are cleaned
(3) During stand-down, all recalled personnel not needed will be released.
(4) Refer to recovery phase (Section 4)

iv) Other Considerations

(1) As required depending on nature of emergency
(2) In the event of Power Failure
   a) Ensure that equipment is plugged in to plug points which are connected to emergency power sources.
   b) To triage the patients needed for x-ray i.e. prioritize patients to undergo the x-ray investigation.
   c) Activate Poliklinik Kapit to do certain stable cases that can be transported there. Approval shall be sought through Hospital Director from District Health Officer.
   d) Collaboration with other healthcare facilities like Sibu Hospital, Sarikei Hospital, KK Machan to take some of the cases who can be safely transported

13. Pathology / Blood Bank (Laboratory)

i) Response Phase

(1) Yellow Alert

(a) Upon Yellow Alert, the unit in charge will report to CCC through telephone or in person and stay at their own unit/department.
(b) The unit in charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) The unit in charge will alert all their personnel who are on duty and off-duty.
(d) The unit in charge will do a head count on all staff available on floor for deployment and also available to call back and keep track of that information.
(e) To check consumables, facilities and equipment functionality and availability.
(f) Laboratory staff to count the available blood products and keep track of it.
(g) Laboratory staff will also check the amount of reagents, vacutainers available and keep track of it.

(2) Red Alert

(a) Upon receiving Red Alert, the unit in charge shall inform all their personnel and call in off-duty personnel to the hospital if needed
(b) The unit in charge shall arrange or assign their staff duties and responsibilities depending on the needs.

ii) Implementation Phase (Red Alert)

(1) Call in additional staff if needed
(2) Make arrangements to obtain additional blood, equipment and supplies from nearby agencies if needed.
(3) If internal disaster, prepare for evacuation to safe area.
(4) Periodically, check for update from CCC/ HOR

iii) Recovery Phase
(1) Refer to recovery phase (Section 4)

iv) Other Considerations
(1) As required depending on the nature of emergency

14. Stationary Store

i) Response Phase

(1) Yellow Alert

(a) Upon Yellow Alert, the unit in charge will report to CCC through telephone or in person and stay at own unit/department.
(b) The unit in charge will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) The unit in charge will alert all their personnel who are on duty and off-duty.
(d) The unit in charge will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) Check all supplies and keeps an updated list of everything available as well as the amount of supplies available.

(2) Red Alert

(a) Upon Red Alert, the unit in charge shall inform all their personnel and call in off-duty personnel to the hospital if needed
(b) The unit in charge shall arrange or assign their staff duties and responsibilities depending on the needs and availability.

ii) Implementation Phase (Red Alert)

(1) Be prepared to supply needed supplies to all departments
(2) Keeps track of supplies which are being used.
(3) Arrange for more supplies if it is running low.
(4) If internal disaster, prepare for evacuation to a safe area.
(5) Periodically, check for update from CCC/HOR

iii) Recovery Phase
(1) Refer to recovery phase (Section 4)

iv) Other Considerations.
(1) To have a list of suppliers who can quickly supply extra materials.

15. Pharmacy/ surgical store

i) Response Phase

(1) Yellow Alert

(a) Upon Yellow Alert, the Head of Department will report to CCC through telephone or in person and stay at own unit/department.
(b) The Head of department will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) The head of department will alert all their personnel who are on duty and off-duty.
(d) The head of department will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) The head of department will do a stock check and keep track of all available medications and prepare to replenish floor medication stocks if yellow alert becomes a red alert.

(2) Red Alert

(a) Upon Red Alert, the department head or unit in charge shall inform all their personnel and call in off-duty personnel to the hospital if needed
(b) The department head shall arrange or assign their staff duties and responsibilities depending on the needs.

ii) Implementation Phase (Red Alert)
(1) Prepared to supply all departments with needed supplies.
(2) Keeps track of medication / supplies used and the amount remaining.
(3) If internal disaster, prepare for evacuation to safe area.
(4) Periodically, check for update from CCC

iii) Recovery Phase
(1) Refer to recovery phase (Section 4)

iv) Other Considerations.
(1) Have a list of drug suppliers that can provide emergency supplies quickly.
(2) Keeps a minimum supply of emergency drugs at hand at all times.
(3) Pharmacy should open on extended hours and have a runner to deliver needed medicines to all areas.

16. Security

i) Response Phase

(1) Yellow Alert

(a) Upon Yellow Alert, the head of security will report to CCC through telephone or in person and stay at own unit/department.
(b) The head of security will also reply in the whatsapp group 'Pengurusan Hospital Kanowit'if telco service is available.
(c) The head of security will alert all their personnel who are on duty and off-duty.
(d) The head of security will do a head count on all staffs available on floor for deployment and also available to call back and keep track of that information.
(e) The head of security will liaise with Administrative Chief Assistant medical officer to plan the security setting of the hospital in the event a red alert takes place.
(f) The head of security will make sure all walkie-talkie are functioning and fully charged.
(g) Head of security will also be prepared for the surge of discharge patients from the wards.

(2) Red Alert

(a) Upon Red Alert, the head of security shall inform all their personnel and call in off-duty personnel to the hospital if needed
(b) The head of security shall arrange or assign their staff duties and responsibilities depending on the needs.
(c) The head of security shall then liaise with Hospital Supervisor SAMO U36 (admin) and follow further instructions and orders from SAMO

ii) Implementation Phase (Red Alert)

(1) Help Hospital supervisor SAMO U32 (admin) to regulate the flow of traffic and parking.
(2) Crowd control especially at Emergency & Trauma Department and families and relatives center.
(3) Assist as needed.

iii) Recovery Phase

(1) Refer to recovery phase (Section 4)

iv) Other Considerations.

(1) To call and involve the Police Department if required.

17. Nursing Personnel and Assistant Medical Officer Assigned to Disaster Victim.

i) Response Phase

(1) Yellow Alert

(a) Upon Yellow Alert, report to CCC and stay at own unit/department.
(b) Follow instructions given by CCC.

(2) Red Alert

(a) Upon Red Alert, proceed to Emergency and Trauma Department.
(b) Reports to CCC.
(c) Follow instructions given by CCC.
(d) Prepare the designated disaster zones

ii) Implementation Phase (Red Alert)

(1) Help MO or AMO to give necessary first aid & basic treatment
(2) To get information & particular from patient if available.
(3) Monitor vital signs & proper documentation
(4) To make sure victim tagging done in pocket triaging upon receiving patients
(5) Prepare the appropriate lab forms and x-ray required with patient's particular
(6) Patients who are admitted to the hospital should have the duplicate copy of the patient's record form placed in ETD
(7) If a patient is transferred, be sure to indicate on the tag and board which hospital he/she has been sent.
(8) Escort patient to ward when needed.

D. ESTABLISHMENT OF CENTRES

HOSPITAL OPERATION ROOM (HOR)

1. The hospital operation room is located at Bilik Mini Mesyuarat.
2. It is the room for command, communication, and coordination. It functions as the coordination center in the early phase of disaster activities and is the source of all information.
3. It also maintains staff control and keeps track of the amount of staff working in ETD and Disaster field during a disaster.
4. At least one messenger will be assigned to HOR to deliver messages, obtain casualty counts from triage,etc.
5. The Incident Commander will take over the major role if
    a) The incident lasts more than 6 hours
    b) When a state of resource modification / discontinuation decisions are needed
    c) When the decision for staff, patients or visitors relocation is needed for both inside or outside the facility
    d) When the amount of staff and other resources obtained needs to be reviewed again.
6. HOR will continue to focus on patient tracking, severity classification and documentation of patient movement.

COMMAND-AND-CONTROLCENTRE (CCC)

1. The Command-and-Control center is located inside the Emergency and Trauma Department. (Triage Counter/Room)
2. This room is the first point of contact in the event of disaster activation for all staff in the hospital as it is the site for reporting duty and assignment of roles.
3. It is the room for command, communication, and coordination. It functions as the coordination center in the early phase of disaster activities and is the source of all initial information.
4. It serves as a point of information feedback regarding casualty information and victim identification in disaster zone ETD to higher chain of command situated in HOR.
5. It is the point of information feedback from Field Triage Team regarding assessment of situation and updates regarding real-time casualties and victims involved on scene.

FAMILY CARE CENTER

A Family Care Center will be set up at the Bilik Conference (Center for families of victims). If the room is too small due to the large amount of crowd, it will be set up in the Dewan Suarah. It shall only permit admission of authorized personnel and relatives of victim. It will be equipped with chairs, tables, and light refreshments. The function of the center is:

1. To provide a comfortable environment for the family members to rest while they are waiting for news or update regarding the casualty.
2. To provide accurate and reliable information to family members and relatives,
3. To provide counseling or bereavement services to the family members of the victims.
4. To prevent unnecessary overcrowding in wards or Emergency Department to facilitate patient's movement and workflow.
5. Staff's family members can be fostered here while staff is working.
6. To provide counseling, reassurance & emotional support
7. To provide CCC / HOR with a list of the family members that are there.
8. Act as a liaison officer to social welfare department, district office, and resident office to get more social support (such as food, shelter, etc)

E. COMMUNICATION SYSTEMS/ FACILITIES

1. Telephone lines will be made available for outgoing and incoming calls.
2. One line will be designated as the open line to the external Command Center.
3. The person in-charge will assign one staff member to monitor the phone.
4. The main mode of communication will depend on the area of disaster. If there is no Government Integrated Radio Network (GIRN) coverage at disaster scene, mobile phones will be the main mode of communication. However, phone line coverage at certain place is still poor due to the geographical condition of Kanowit.
5. In the event of communication breakdown i.e. Telephone Communication breakdown, PA system breakdown,

a) The 2 hailers available (1 in the operator room, 1 in CCC) will be used to announce the red or yellow alert.
b) If the disaster is an external disaster, the hailer will be brought to the disaster scene to call out to victims.
c) If the disaster is an internal disaster, the hailer can be used to announce the alerts (if the PA / telephone system breakdown)
d) Man Messengers shall be deployed if hailers are at disaster scene and the telephone communication / PA system breaks down.
e) Relevant staffs with their addresses shall be kept and maintained.
f) Drivers will be deployed to get the relevant staff to hospital if needed.

F. EQUIPMENTS AND SUPPLIES

1. This is under the incident commander team.
2. Extras supplies will be obtained from Surgical Store and Pharmacy through runners.
3. Outside supplies will be ordered by the Purchasing Officer and brought into the hospital.
4. In the event of power failure,

a) Equipment are plugged in to plug points which are connected to emergency power source.

b) To re-triage the patients needed for x-ray i.e. prioritize patient to undergo the x-ray investigation.
c) Activate KK Machan to do certain stable cases that can be transported there. Approval shall be sought through the Hospital Director from District Health Officer.
d) Collaboration with other healthcare facilities like Sibu Hospital, Sarikei Hospital, KK Machan and KK Song to take some of the cases who can be safely transported.

G. VALUABLE AND CLOTHINGS

1) This is under the incident commander team and the public information officer will take charge of the patient's valuable and clothing.
2) Valuables/clothing of disaster victims will be put inside large plastic bags and labeled with their particulars.
3) It will be kept at a special assigned place (Bilik Pentadbiran) while awaiting to be claimed by patient/family members.

H. VICTIM IDENTIFICATION FACILITIES

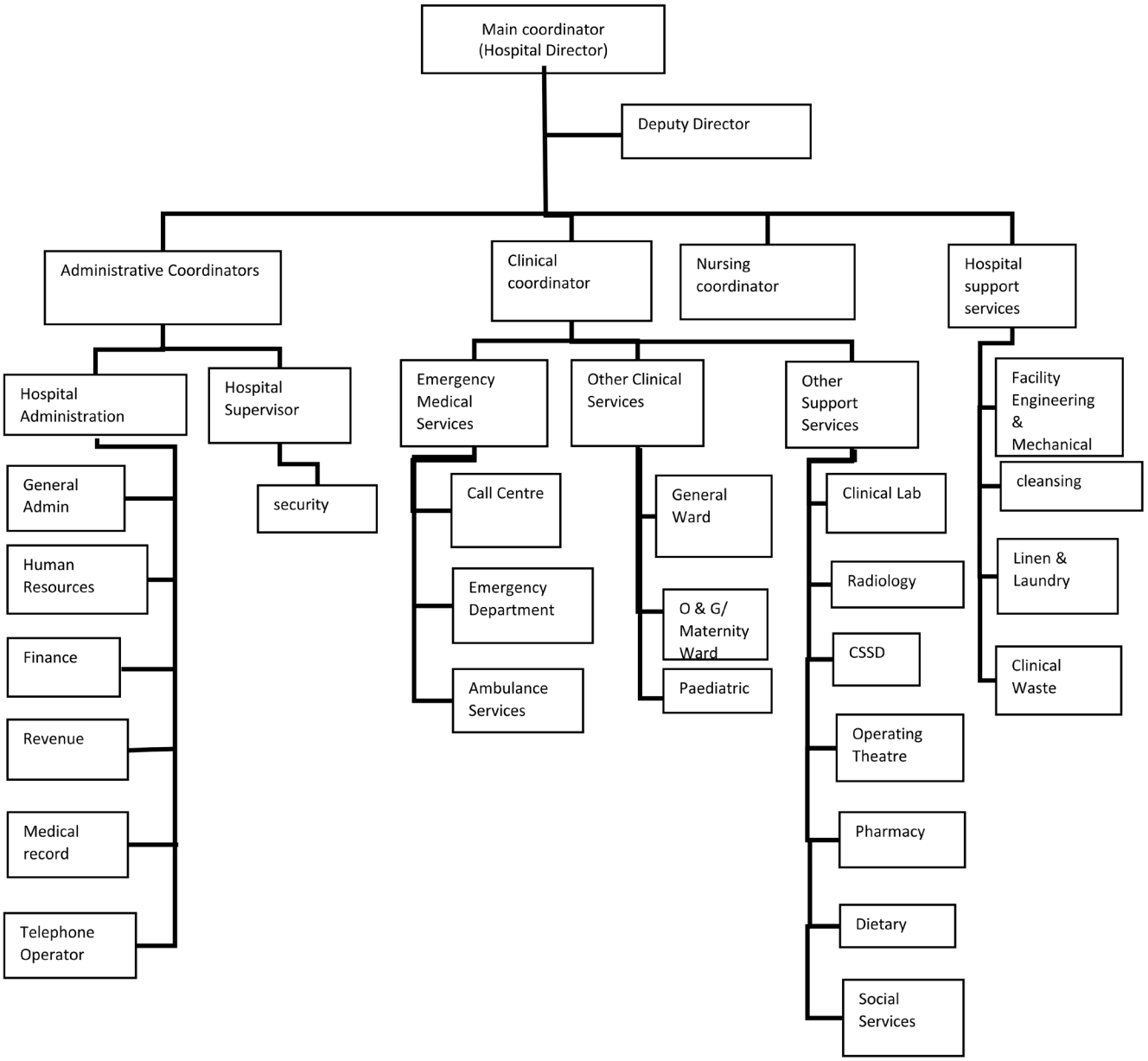
1) In the event where a disaster patient did not bring or lost their Identification documents (i.e. IC/ Passport/ Birth Certificate, etc.), the process of identification will depend on the patient's conscious level.
2) In the event where the patient is conscious, the patient's full name, IC number and address (as much as patient can remember) will be written down. Such patient identification will be passed on to the police to verify the correct identity. If a family member can identify the victim, they will be asked to get their identification documents from home (if patient forgot to bring) or if lost, to lodge a police report.
3) In the event where the patient is semi/unconscious and is unable to provide any sort of information, such patient will be given a temporary Identity, i.e., DV 1, DV 2, DV 3, etc. DV being the short form for Disaster Victim. All these patients will then be notified to the police where further investigation and determination of identification will be done by the police team (and foreign embassy if applicable). If there are relatives or friends who can identify the patient's identity, they will be asked to bring the identification document. If they are unable to produce such documents, the police team will have to search for the patients' identity. The valuables of such patients will be kept inside large plastic bags labeled with their temporary identity and kept in the special assigned place (Bilik Pentadbiran) until their identification is found and/or their family members / patient are fit to claim it back. All belongings will be under the charge of Penolong Pegawai Tadbir.
4) In the event where such patients are foreigner, the embassy will be included to search for their identity.
5) The preliminary identity will be given from field triage. The confirmation of identity will be done at the hospital.
6) Patients at field triage will be identified based on their triage colour tags. Individual disaster clerking papers will be put inside their triage tags and will stay on the patient until a wrist tag with the identity is put on each patient. Once the wrist tag is securely placed on the disaster victims, the triage card may then be removed in the respective hospital disaster zones.
7) The main person in charge of this process will be Public Information officer. However, all staffs who attend to patient during field or hospital triage, is required to identify the patient and put on the wrist tag with patient's identity/ temporary identification.

I. MORGUE FACILITIES

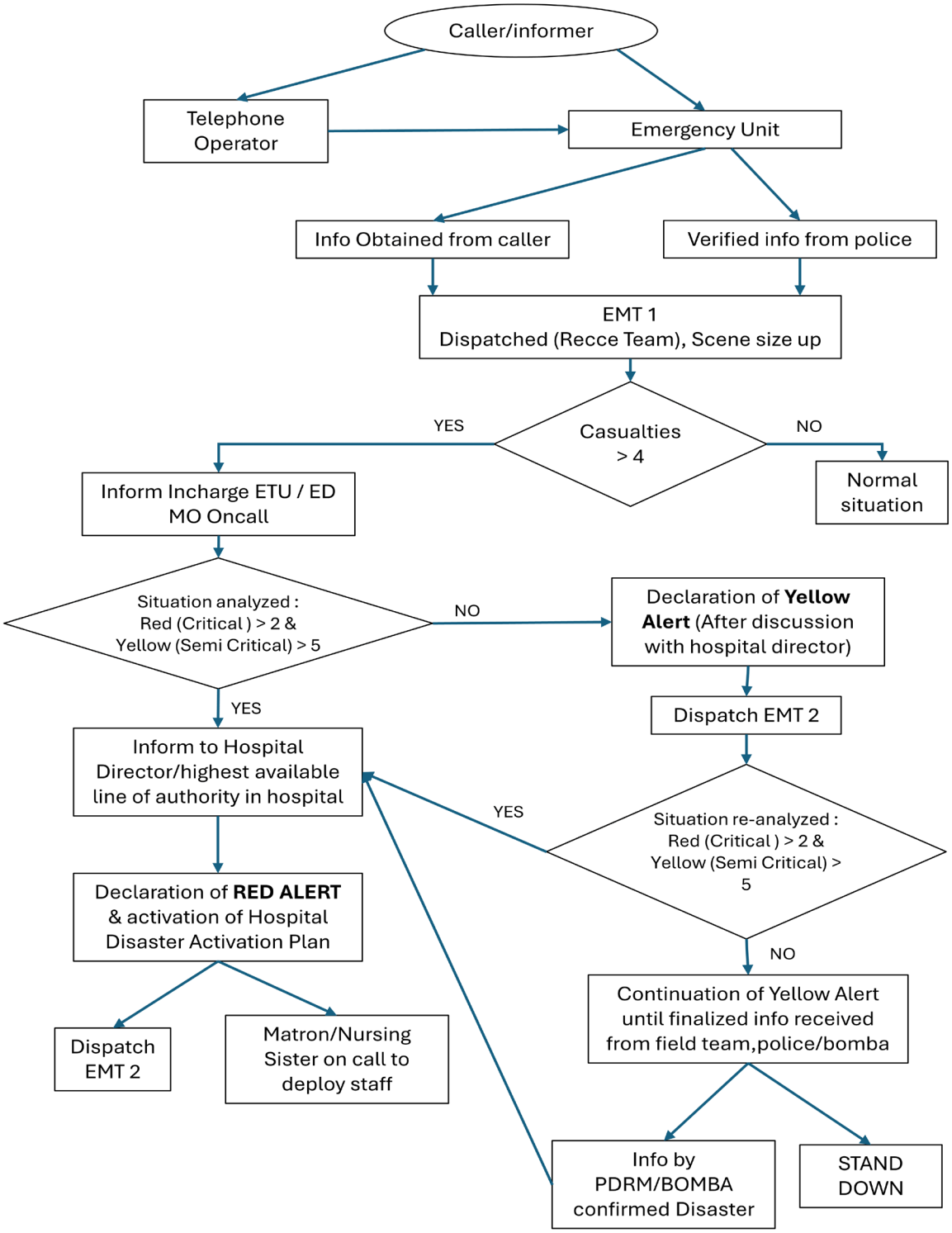
1. Mortuary unit's freezer container will be mobilise to store bodies of the victims as necessary.
2. Patients pronounced DOA will be tagged with a White Disaster Tag.
    a. The personal belonging and effect are not to be removed.
    b. The top sheet of the tag will be taken to the Command Control Center in Emergency Department for its casualty list purposes.
    c. **Staff are to ensure that the deceased has been tagged for identification prior to removing the top sheet of the tag.**
3. If the identity of the dead body CAN be identified either by police, Bomba or health personnel, the information will be labeled on the White Disaster Tag.
4. If the identity of the dead body CANNOT be identified, it is for the police to search for the identity. In the meantime, a temporary identity will be given.
5. The Medical Incident Commander at disaster scene will relay deceased information back to command center.
6. Bodies will be removed by police or BOMBA to mortuary or temporary morgue service at hospital support service cold storage area for clinical waste.
7. A complete record of all bodies shall be kept at mortuary including the name of the agency removing them e.g. police, fire department, undertakers, etc.

SECTION 2 : HOSPITAL PHASE OF DISASTER ACTIVATION

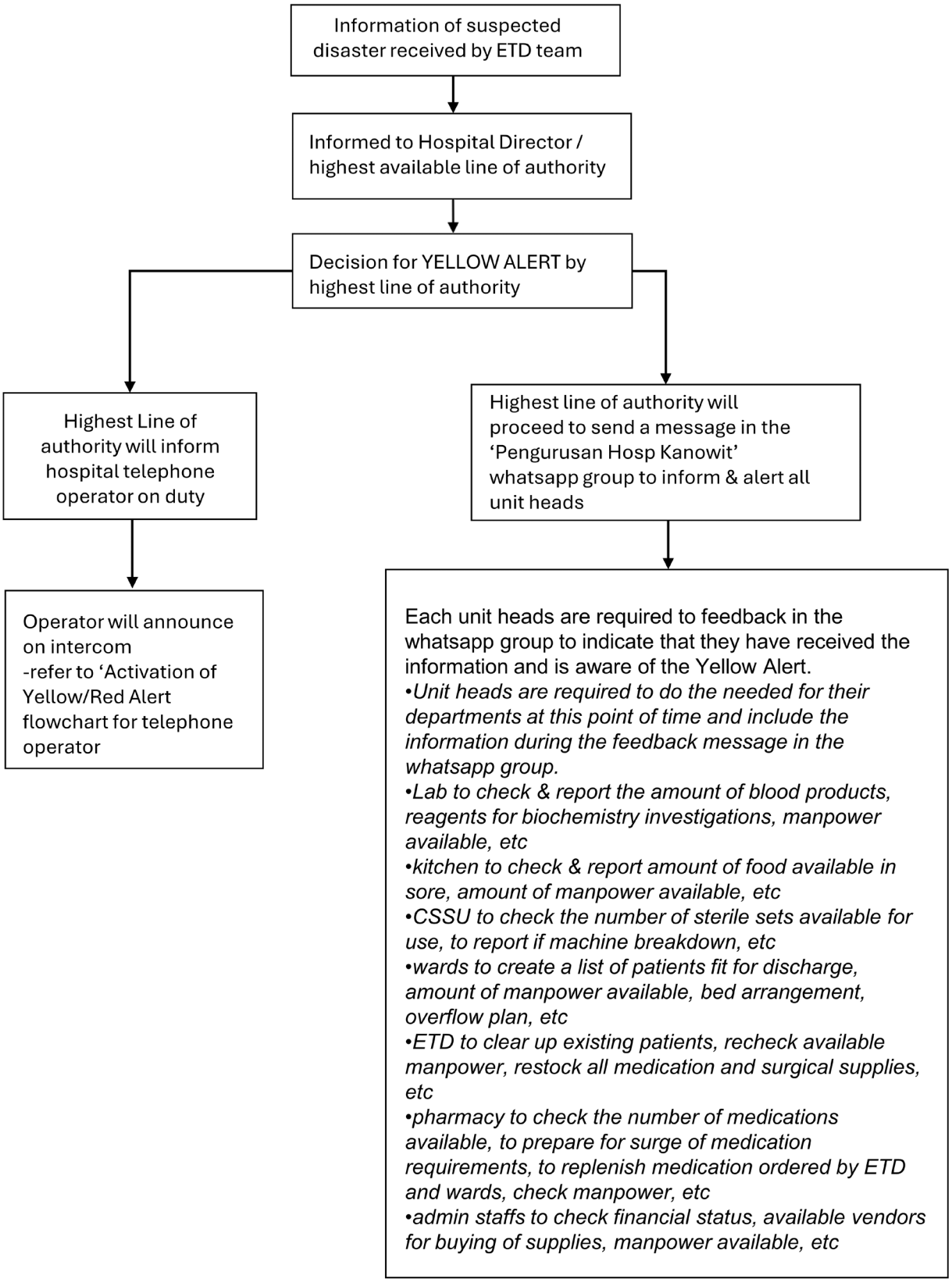
HOSPITAL DISASTER ORGANISATION CHART



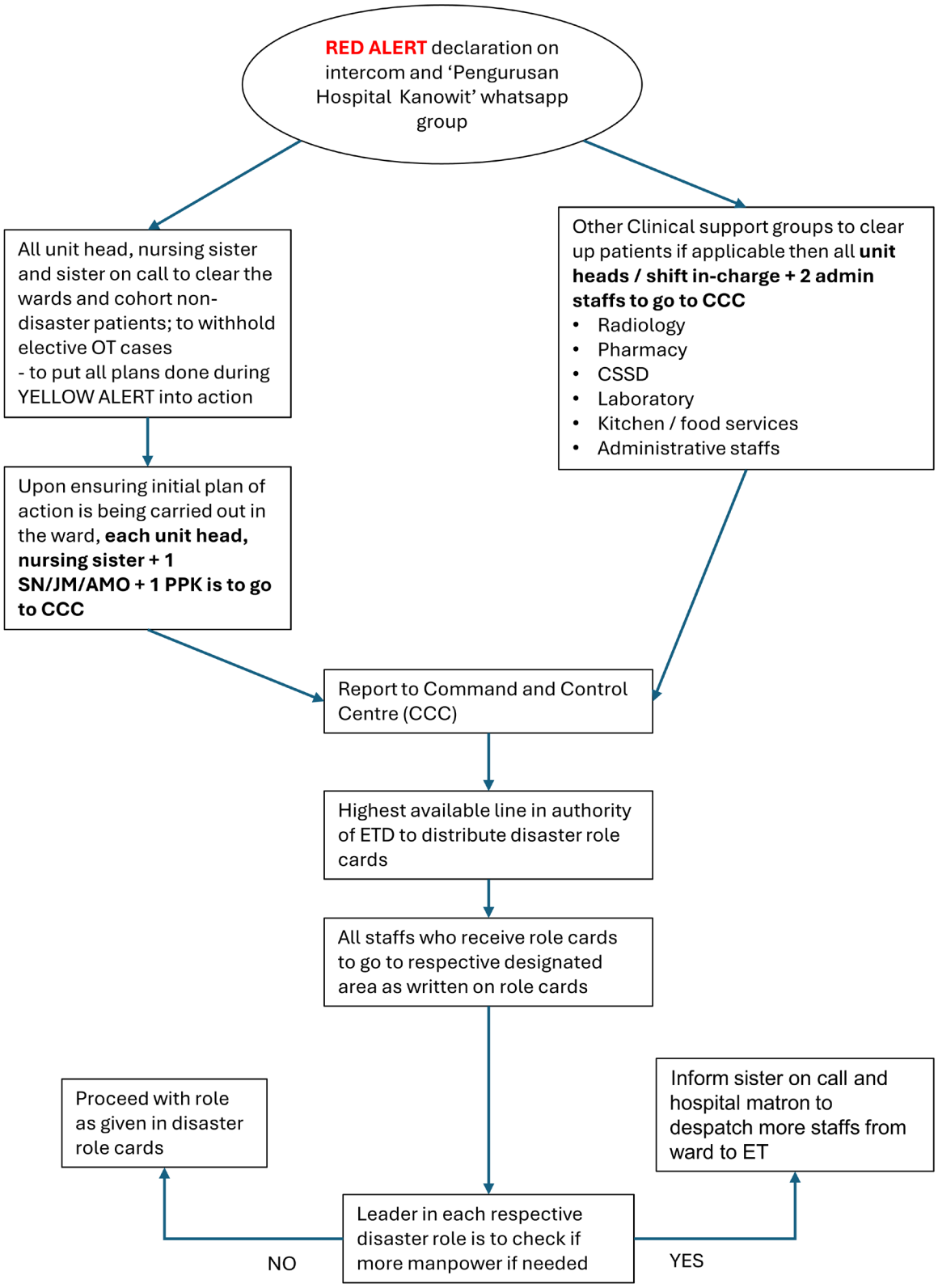
OUT OF HOSPITAL DISASTER ACTIVATION FLOW CHART



COMMUNICATION FLOW CHART FOR HOSPITAL STAFF IN YELLOW ALERT PHASE

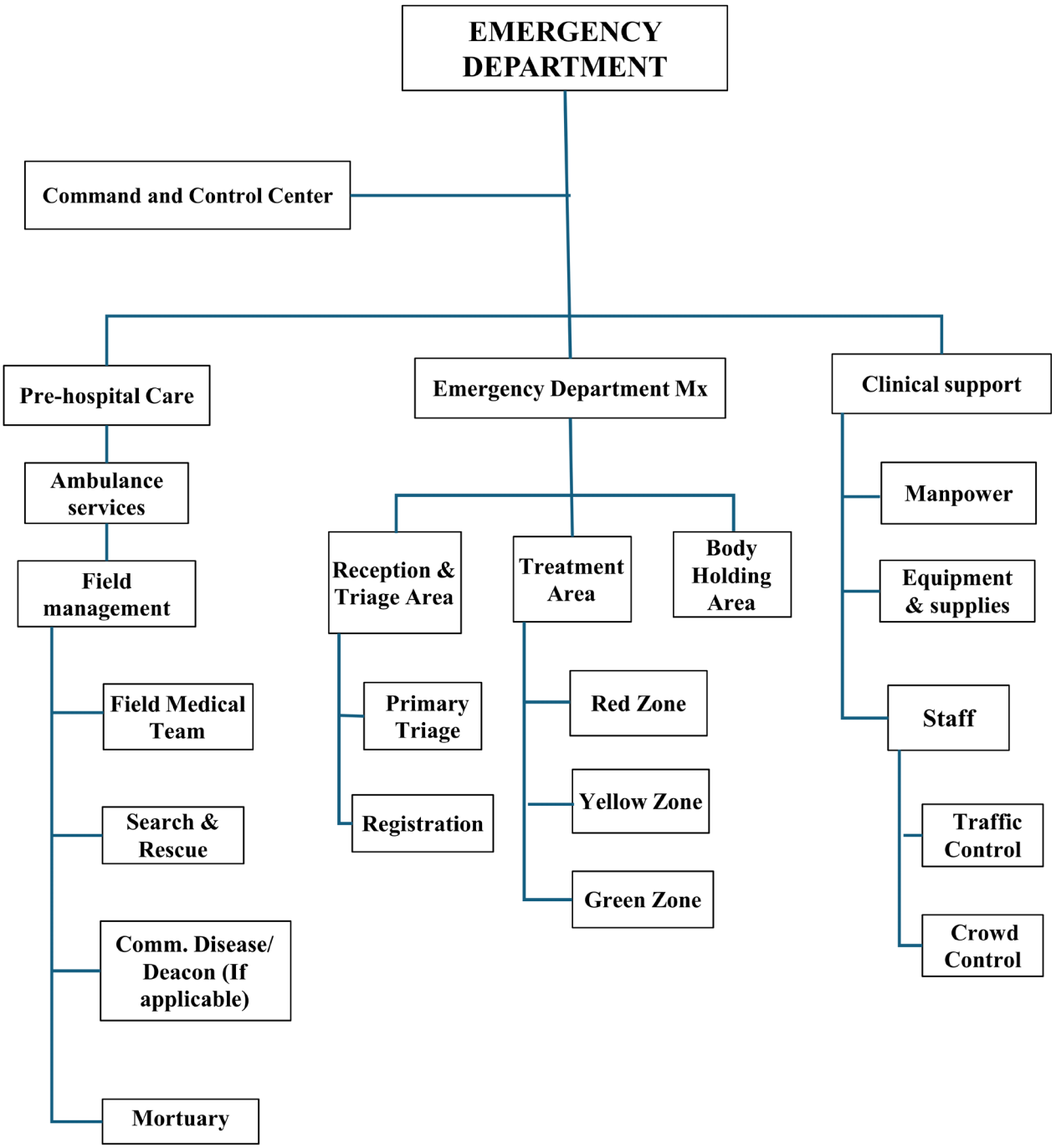


WORK FLOW FOR HOSPITAL STAFF UPON RED ALERT ACTIVATION



A. EMERGENCY DEPARTMENT RESPONSE PHASE

1. Organization of the Emergency Department once the Alert System is activated will be as follows:



2. Identify key ED personnel.

Once the Alert System has been activated, the Emergency Department will be organized with each function headed by a Senior Assistant Medical Officer/ Emergency HOD as follows:

No	Personnel	Responsibility
1	Emergency Department Medical Officer	In charge of CCC and overall coordination of Disaster activation in ED and/or Disaster site
2	Senior Assistant Medical Officer (ETD)	Ambulance Control & Dispatch Center (Hospital Transport Officer)
3	Assistant Medical Officer Shift in-charge	Despatch EMT Team & organize escort Services
4	Assistant Medical Officer on shift (EMT-1)	Field Team & Field Management
5	Assistant Medical Officer Shift in-charge / ED Nursing SIster	Emergency Department Arrangement & Facilities, equipment, and supplies

B. ESTABLISHMENT OF SPECIFIC ZONE / CENTERS / TEAMS

1. Emergency Department Command-and-ControlCenter (CCC)

The Triage Room of the Emergency Department will act as a Command-and-Control Center. This center will be manned by the following personnel:

1. Main Coordinator (ETD MO or the next in line according to the line of authority)
2. Hospital Matron (To be replaced with a Nursing Sister in the event of Hospital Matron were to become the Main Commander)
3. Call taker/Liaison Officer – (To be assigned by the Main Coordinator)
4. Runner (To deliver message, get updated casualty count from the triage counter etc) The function of this center is:
    - To coordinate activities between the ambulance services, Field medical team (Field Team), accident site and the hospital.
    - To keep track on number of casualties and patient movement.
    - To relay and answer to the needs at ED and the incident site.
    - To relay and update the Hospital Operation Room located in matron office.

2. Emergency Medical Team (EMT)

1. The existing EMT team during normal working days will be modified accordingly during disaster activation.
2. The team members for EMT-1 will be as per the daily duty roster of EMERGENCY Department.
3. EMT 2, EMT 3 and EMT 4 will be assigned by the Command-and-ControlCenter (CCC), which would consist of personnel recalled from off-duty, other disciplines and PKD Kanowit / Klinik Kesihatan Machan if needed.
4. Ambulance will be loaded with needed equipment as soon as it is parked at ED.
5. Additional equipment and supplies will be assembled and ready for dispatch if required.

EMT team members during disaster activation:

Category	EMT-1	EMT-2	EMT-3
Medical Officer	-	MO passive call	MO passive call
AMO	EMT 1	EMT 2	EMT 3 (call back)
Nurses	EMT 1	Male ward nurse on shift 1	EMT 3 (call back)
Attendant / PPK	Will be sent with any team if sufficient PPK available		
Driver	Driver on shift	ED Driver Standby 1	ED Driver Standby 2

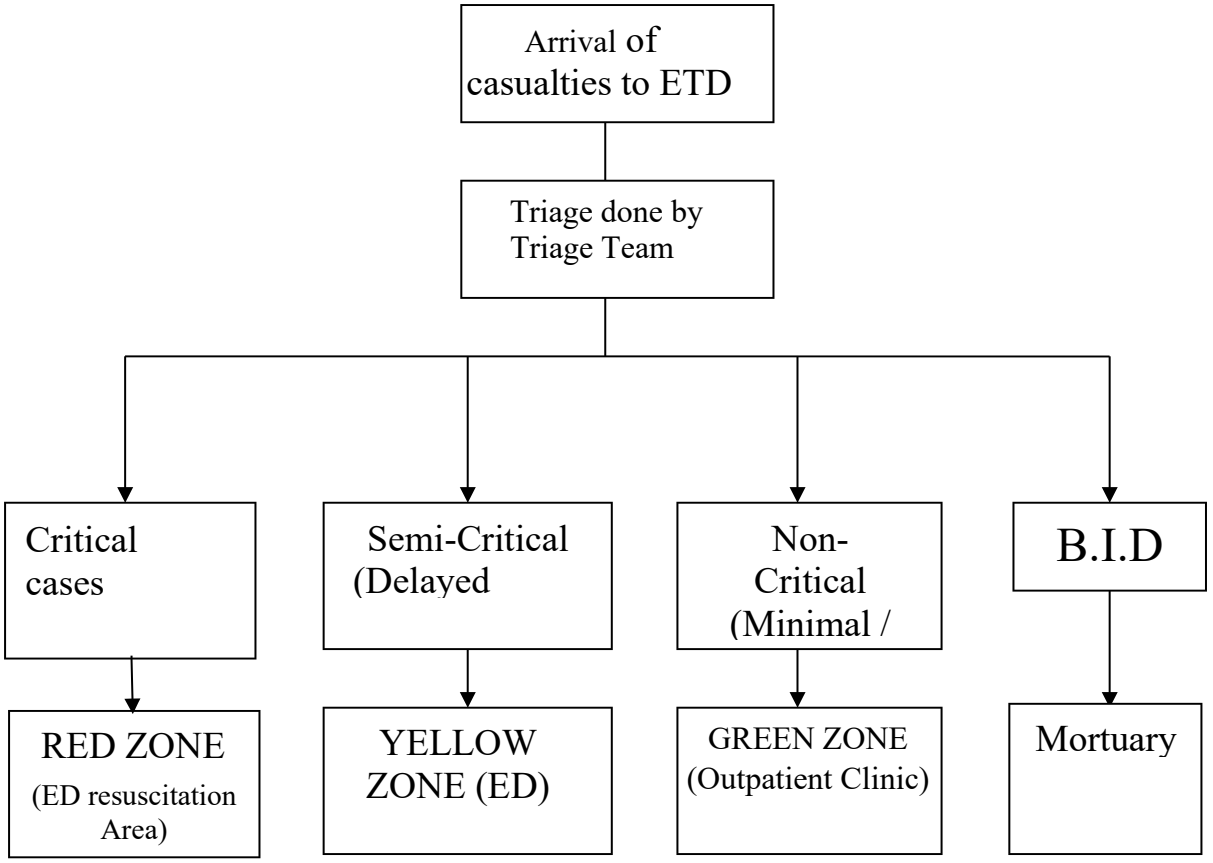
Field Team:

Category	Field Team-1	Field Team-2
Medical Officer	MO passive call* - functions as MIC	MO passive call - functions as field treatment officer
AMO	EMT-1 AMO** - functions as field triage officer	EMT 2 AMO - functions as Liaison officer unless told by MIC to be field triage officer
Nurses	EMT-1 Nurse -functions as field treatment officer	EMT 2 nurse - functions as field treatment officer
Attendant / PPK	Functions as a runner if available	

Note: For massive disaster, which is beyond the capacity of the hospital, the CCC (Command Center) will seek external help including KK Song, KK Machan, PKD Kanowit, Hospital Sarikei and / or Hospital Sibu.

*EMT-2 MO will become the Medical Incident Commander on field.
**EMT-1 AMO will be the Temporary Medical Incident Commander while awaiting MO to arrive. Once MO is available, EMT 1 AMO will function as a Field Triage Officer (Refer to Line of Command on Field for further clarification).

ETD TRIAGE ZONE FLOW CHART DURING DISASTER



3. Patient Reception and Triage Area

The patient reception and triage area will be located at the front entrance of the ED. This area is designated for triaging and sorting out patients. Patients after being sorted will be sent to their respective zones which are managed by the respective doctors and teams.

Hospital Triage Team

Team leader: Medical Officer 1
Members: Triage AMO, Runner nurse/ AMO, General office staff 1 (registration), General office staff 2 (registration), ED PPK, AMO from other department 1(NCD/JPL), AMO from other department 2(HDU/OT)

Hospital Triage Area

- Area will be located at the usual triage counter.

4. Non-disaster ETD patients

A team will be formed upon disaster activation to continue treating non-disaster patients and also to clear the other remaining patients in ED.

Non-disaster ETD Team

Team Leader : Medical Officer Standby
Members : ED nurse 2, ED PPK (call back), Female Ward nurse 1

Non-disaster Area

- As the existing ETD area is very small, patients will have to share area with disaster patients. However, arrangements to divide them will be made as well as possible as ordered by MO in-charge.

5. Disaster Red zone (Resuscitation and Critical Zone)

This area is designated for all critical and unstable patients. The management of patients in this zone will be carried out by a Trauma team lead by the MO ED oncall. They will be assisted by the MO ED passive call. A team of 3 to 6 members will manage the critical patients. The number of staffs running this zone will be proportional to the number of critical patients if the condition permits.

Red Zone Team

Team Leader : MO ED Oncall

Co-Leader : MO Passive, ED nursing sister

Member : MW Nurses, FW nurse 1, MW PPK, runners, MW PPK (help both Disaster red and yellow), OPD PPK (help both Disaster red and yellow)

Red Zone Area

- If the number of critical patients is less than 2, use the existing Red Zone area
- If the number of critical patients is more than 2, the current Yellow Zone (ETD Clinical Area) will be converted into Red Zone

6. Disaster Yellow Zone (Semi-critical Zone)

This area is designated for semi-critical patients who require some amount of help but can wait for a while before their treatment is given. This zone will be led by the Medical Officer and assist by ED Nurse and ED AMO.

Yellow Zone Team
Team Leader: Medical Officer,
Co-leader: MO 1, ED AMO, ED Nurses,Pediatric Nursing Sister
Members: Maternity nurse 1, FW nurse 1, PPK, runners

Yellow Zone Area
- If the number of yellow zone casualties is less than 3, and the number of Red Zone casualties is less than 2, the current Yellow Zone will remain as Yellow Zone.
- If the number of Yellow Zone casualties is more than 5, and the number of Red Zone cases is more than 2, the current OPD area will be converted into Disaster Yellow Zone.

7. Disaster Green Zone (Non-critical Zone)

This area is designated for non-critical patients who mostly will require outpatient type of treatment such as wound dressing, anti-tetanus injection, or analgesia. This zone will mainly be led by MO JPL and AMO NCD/JPL 1.

Green Zone Team
Team Leader : MO
Team Members : Pediatric ward nurse, OPD nurses, pediatric ward PPK (also helps with non-disaster patients), runners

Green Zone Area
- Location of the green zone area will depend on the number of casualties in Red Zone and Yellow Zone. If the number of Red Zone Casualties is less than 2 and the number of Yellow Zone Casualties is less than 3, green zone area will remain at the current Green Zone.

- If the number of casualties in Red Zone is more than 2 and Yellow Zone more than 5, Green Zone will be located at the Patient Waiting Area (Outside OPD).

Note: The number of casualties is based on information received from the caller or disaster site.

Duty Roster for AMO In ETD

Consist of 3 shifts:

3 MA on duty		
	Usual day	**RED ALERT**
1st AMO	Triage	Triage
2nd AMO	Green zone	EMT – 1
3rd AMO	Yellow/Red Zone	EMT 2 / command center (temporary) / red zone

2 MA on duty		
	Usual Day	**RED ALERT**
1st AMO	Triage/Green Zone	Command center (Temporary) / Red zone/ Triage
2nd AMO	Yellow Zone/Red Zone	EMT - 1

Night duty		
	Usual Day	**RED ALERT**
1st AMO	Triage/Green Zone	Command center (Temporary til MO arrive) / Red zone/ Triage
2nd AMO	Yellow Zone/Red Zone	EMT - 1
MO oncall	Whole hospital	Command center (Temporary till commander arrives) / Red zone

C. RESPONSIBILITIES OF INDIVIDUALS AND DEPARTMENTS

a) Main Coordinator - Hospital Director

The Main Coordinator (Hospital Director) will have the overall authority of the hospital. The duties included:

i) Declaration of alert phase
ii) Activation of supporting hospital
iii) Reporting to the Divisional Health Office/State Health Office and Ministry of Health.
iv) Identity Clinical Coordinator
v) Identify Administrative Coordinator
vi) Liaise with relevant agencies/Private hospital. Establish Control Centre's.
vii) Public information and press release.

b) Clinical Coordinators

i) In a major disaster, the Senior Assistant Medical Officer (Admin) will perform the Director's functions, if he/she is absent.
ii) Department head or designee of each discipline will take charge on all matters related to clinical issues and patient management.
iii) Department head or designee with call in their own personnel as needed after reporting to Command-and-ControlCentre.

c) Administrative Coordinator Administrative Officer

i) In-charge of the organization of the facility, accommodation of patients and deployment of nonclinical manpower
ii) Is responsible for notifying ail department head or alternates.
iii) Supervise all other administrative personnel.

d) Hospital Supervisor/Senior Assistant Medical Officer (Admin)

i) In a major disaster will do the Director's functions, if he/she is absent.
ii) Is responsible for the public order and security of the hospital.
iii) Will set up the hospital Disaster Operation Centre at the Bilik Sumber.
iv) Responsible to call and deploy additional Assistant Medical Officers when necessary. (This can be assigned to the unit coordinator but must be aware of the number of medical assistants corning in.) Have them keep a list of those notified.

e) Head of Nursing (Matron)

i) In a major disaster will do the Hospital Supervisor's functions, if he is absent?
ii) Will set up a Hospital Information Centre and centre for families and relatives.
iii) Is responsible for the nursing services and activities of the hospital during disaster.
iv) Responsible to set up and organize the Disaster Ward.
v) Responsible to set up and organize the Disaster Ward.
vi) Responsible to call and deploy additional nursing personnel and attendants, this can be assigned to the Unit Coordinator or other nurse but must be aware of the number oi nurses corning in.) Have them keep a list of those notified.

f) Admission Room

i) Assign responsible person to the admission counter as soon as possible.
ii) Department head or designee will call in their own personnel as needed after having reported to the command control center.
iii) Notify Command-and-Control Centre if infernal disaster is involved.
iv) Do not accept routine non-emergency admissions.
v) Assign an admission person to aid with discharge of hospital patients if requested.

g) Dietary

i) Department head or designee Wii! call in their own personnel as needed after reporting to Command-and-Control Center.
ii) Prepare to serve nourishment to ambulatory patients, inpatients, and personnel as the need crises.
iii) Be responsible for setting up menus disaster situation and maintain adequate supplies.

h) Facility Engineering and Mechanical

i) Department head or designee will call in their own personnel as needed after reporting to Command-and-Control Center.
ii) Maintain full operation of all facilities.
iii) Be responsible for setting up extra beds in hospital if needed, as well as transporting storeroom supplies and bringing in extra supplies from other areas.

i) Bio-Engineering and Mechanical

i) Department head or designee will call in their own personnel as needed after reporting to Control Centre.
ii) Maintain full operation of all equipment.

j) Housekeeping and Laundry

i) Department head or designee will call in their own personnel as needed after reporting to the Command-and-Control center.
ii) Be available to help clean receiving area, and clean rooms between cases in treatment areas.
iii) Be prepared to supply additional linens as requested.
iv) Be sure oil hallways or traffic areas are clear of cleaning carts, equipment and etc.

k) Operating Room Anaesthesia

i) Department head or designee will call in all needed personnel after repotting to Command-and-Control Center.
ii) Check area for supplies and equipment.
iii) Ask for additional help to carry out surgery and treatments in the Operating Rooms and Recovery' Room.
iv) Assign and direct scrub nurses and runners.
v) Notify Command-and-Control Centre when Operating Rooms and Recovery Room are available for more patients.
vi) Keep a minimum list of supplies on hand and be prepared to process additional sterile supplies quickly.

l) Wards

i) Prepare for expansion by notifying Hospital Support Service of number of extra beds needed and where to set them up.
ii) Discharge and rearrange movement of hospital patients to create more room for casualties
iii) Send extra supplies needed for purchasing CSSD, laundry and dietary.
iv) If internal, prepare for evacuation of patients to safe area.
v) Periodically, check for update from Command-and-Control Centre.

m) Medical Imaging

i) The department head or designee Wii) find out the number of patients involved and any other pertinent information from the Command-and-Control Center.
ii) The department head or designee will be responsible for calling in any and all personnel needed to sufficiently handle the patient load.
iii) The technologist on duty or on call for the Radiology Department will be alerted by the telephone operator. This technologist will be considered the designee of the pray department and will report to the Command-and-Control Centre for further information.
iv) It will be the duty of this technologist to call for extra help as needed. All extra help called in will report directly to Radiology.

Duties of Medical Imaging Personnel

Department Head will:

1) Call any or all personnel needed
2) Arrange for extra supplies to be brought in if needed.
3) Coordinate flow of work and delegation of work areas.
4) Other technologies will:
5) Perform all x-ray exams as needed and assigned.
6) Perform all clerical duties.

n) Clinical Lab/Brood Bank

i) Department Head or designee will call in their own personnel as needed after reporting to Command-and-Control Center.
ii) Call personnel from nearby hospitals and clinics as necessary.
iii) Have arrangements made to obtain additional blood, equipment, and supplies from area agencies.

o) Medical Store

i) Department Head or designee will call in their own personnel as needed after reporting to Command-and-Control Center.
ii) Be prepared to supply all departments with needed supplies.
iii) Have an up-to-date list of suppliers who can quickly supply extra materials.

p) Pharmacy

i) Report to Command-and-Control Centre then remain in the Department.
ii) Have a list of drug suppliers that can provide emergency supplies quickly.
iii) Always keep minimum supply of emergency drugs on hand.
iv) Pharmacy should remain open and have a runner to deliver needed meds to areas.

q) Social Services

i) Led by Physiotherapist
ii) Report to Command-and-Control Centre and be prepared to stay with relatives of victims at the families and relatives center at the parking bay administrative block.
iii) Will provide Command Control Centre with a list of the family members that are here.

r) Security

i) Report to Command-and-Control Center.
ii) Regulate the flow of traffic and parking.
iii) Crowd control especially at the Emergency Department and families and relatives centre.
iv) Assist as needed.

s) Nursing Personnel and Assistant Medical Officer Assigned to Disaster Victim.

i) Obtained information and full out available information and time on disaster tags and patient's record form. All casualties will be marked with Numerical Number on the disaster tag by personnel the disaster site before being transferred to the hospital Even if no information is available as to identity, give information as to condition, types of injuries, etc.
ii) Do not leave your patient unattended, Patient may be signed off to person in charge when admitted to the ward/unit.
iii) Give aggressive first aid treatment.
iv) Make out the appropriate lab slip and x-ray requisition with disaster number,
v) Patients who have been admitted to the hospital's ward should have the duplicate copy of the patient's record form placed in the Command-and-Control Centre in the Emergency Department.
vi) If a patient is transferred, be sure to indicate on the tag to which hospital he has been sent.
vii) Sign disaster tag.

D. DUTIES OF VARIOUS OFFICERS DURING A DISASTER

(Role will be as written on the role card)

a) Hospital Director

You are the Main Coordinator.

i) **Initial Role**

1) Declaration of alert phase
2) Take command at the ED Command and Control
3) Identify Clinical Coordinator, if not done
4) identify Administrative Coordinator if not done.
5) Supervise and co-ordinate all activities.

ii) **Subsequent Role**

1) Establish Hospital Operation Room
2) Take command at Hospital Operation Room
3) Activation of supporting hospitals.
4) Reporting to the Divisional Health Office/State Health Office and Ministry of Health.
5) Liaise with relevant agencies OR the nearest hospital.
6) Public information and press release.

b) Head of Emergency Department/Medical Officer

i) Temporary Commander until taken over by Hospital Director.
ii) Take charge of the Emergency Department Command and Control centers
iii) Go to the field and take charge as the field team leader if more than three medical teams are dispatched.

c) Senior Medical Assistant ED

i) Take charge of the triage team at the ED.
ii) Brief the Assistant Medical Officer, and Medical Officers, who will be under your charge.
iii) Supervise the triage of patients of ED.

d) Senior Medical Assistant

i) Supervise the treatment in the Red Zone.
ii) Your co-leader will be the ED Medical Officer

e) Senior Medical Assistant on-call II

i) Supervise treatment in the Yellow Zone.
ii) Your co-leader is the ED Assistant Medical Officer.

f) Assistant Medical Officer KUP

i. Supervise the management and treatment of patients in the Green Zone.
ii. Your members are the AMOs and Nursing Staff.

g) Other AMOs and Nurses

i. Report to the Command-and-Control Centre of ED and remain on stand-by. Deployment will be as assigned by the Main Coordinator as deem required.

h) Medical Officers

i. **Medical Officers of the Emergency Department**

a) Decide the dispatch of the medical team and activation of the disaster protocol. The dispatched medical team must have at least one Assistant Medical Officer, a Jururawat Masyarakat, an attendant and one Ambulance Driver.

Preferably, one Medical Officer will remain in ED to prepare the ED and divert non-emergency cases to other facilities.

b) Take charge of the ED Red Zone together' with the Ketua Jururawat. Your team member will be AMOS, ED nurse, 2 or 3 Ward Nurses.

If you are the only Medical Officer working at the time :

a) Inform the other medical officer-on-call to come down to ED to prepare for the patients.
b) Recall the next Medical Officer to come to ED to be co-leader for the Red Zone team.

Recalled from off-duty Assistant Medical Officers will either be in the triage team or dispatched to the site.

ii. **Other Medical Officer**

- Help prepare ED and see the remaining emergency cases including the non-disaster cases while waiting for the first disaster victim.
- Work in the Red Zone after that.

iii. **Senior Assistant Medical Officer**

- Work with the Primary Triage Team
- I AMO will stand-by at ED with the 2nd Medical Team
- One AMO will go with the 2nd Medical team if required at the site.

iv. **Senior Assistant Medical Officer.**

- Work in the Yellow Zone.
- Another AMO with stand-by at ED for the 3rd medical team.
- Go with the 3rd Medical Team if the 3rd team is dispatched.

v. **Other Assistant Medical Officers**

Any other Assistant Medical Officers will be called, when deem necessary. Follow the instructions of the main coordinator of operation.

You will be assigned duties by the Main Coordinator, or any officer authorized by him. You will be one at the first to be contacted and be available to be part of the teams going out or to work in the triage/green/yellow/red zones depending on the needs. This is especially so if the disaster occurs after office hours.

All officers must report to the Command-and-Control Centre at Emergency Department. Briefing will be conducted at the Command-and-Control Centre (Seminar room) by the Main Coordinator, or any officer authorized by him.

i.) Assistant Medical Officers

a. Senior Assistant Medical Officer/Hospital Supervisor (Admin),

1. Report to the Command-and-Control Centre at ED ASAP.
2. Assist in establishing the Hospital Operation Room as instructed by the Main Coordinator.
3. Stationed himself at the Hospital Operation Room.
4. Take charge of all the Assistant Medical Officer.
5. Recall and deploy all Assistant Medical Officer from other units/disciplines or off-duty as deem required,
6. Co-ordinate all activities of the Assistant Medical Officer.
7. Co-ordinate with the divisional or state Chief Assistant Medical Officer if additional Assistant Medical Officer is required.
8. Coordinate security.

b. Senior Assistant Medical Officer (ED)

1. Take temporary command of the operation until taken over by Deputy Director or Director of the hospital.
2. Perform the duties of the Head of ED if he is not available.
3. Assist with the operation and take charge of the Command-and-andControl Centre.

c. Senior Assistant Medical Officer I/C OPD

1. Assume the role of Senior Assistant Medical Officer ED until the later arrived.
2. Assist and supervise patient's management at the ED.
3. Take charge of all ED Assistant Medical Officers.
4. Recall all off-duty ED personnel.

d. Senior Assistant Medical Officer II

1. Take charge of the ED facilities, equipment and supplies.
2. Your team members will be One ED nurse, Medical Ward Nurse or Sister and attendant.
3. Prepare patient's treatment areas/zones, i.e. Triage & reception, Red Zone, Yellow Zone.
4. Supervise attendants to prepare ED for disaster and transport of patients.

e. **Senior Assistant Medical Officer Pre-Hospital Care (ED)**

1. Take charge of ambulance and transportation.
2. Supervise preparation of ambulance team and medical teams.
3. Supervise drivers to prepare ambulances and other vehicles.
4. Supervise preparation of equipment and supplies for ambulances and medical teams.

f. **Assistant Medical Officer**

AMO Incharge of shift

1. Take up initial command of operation until the appropriate person arrives.
2. Inform the telephone operator and all ED staff of the incident and activation of the disaster operation.
3. Inform Head of ED and all ED supervisory staff.
4. Informed telephone operator to call back off duty ED staff if necessary.
5. Work at the Command and Control Centre after all the preceding steps have been done and the appropriate personnel have arrived.

AMO Primary Triage

1. Take charge of Primary Triage.
2. Divert non-emergency cases.
3. Work with the Medical Officer in the Triaging Area,

AMO Secondary Triage

1. Help to prepare ED for receiving casualties.
2. Clear ED area and divert non-emergency cases.
3. Check and prepare equipment and facilities for receiving victims.
4. Stay with the ED counter and assist with the transportation and preparation team.
5. Take charge of registration and documentation after the preceding steps have been done and appropriate personnel have arrived.

AMO Red Zone

1. Help prepare the Red Zone for receiving Casualties.
2. Continue to work in the Red Zone.
3. Form part of the resuscitation team in the Red Zone.
4. Coordinate with Command-and-Control centre if more staff is required.

AMO Yellow Zone

1. Prepare the Yellow Zone to receive casualties.
2. Continue working in the Yellow Zone.
3. Take charge of the Yellow Zone with the MO on-call.
4. Coordinate with Command and Control Centre if more staff is required.

AMO EMT-I

Will be the leader of the first Ambulance Team dispatched to the site.

Other Assistant Medical Officers remaining including those recalled from other units and off-duty will be assigned by the Main Coordinator or any officer authorized by him. Some will form part of the Ambulance and Medical Team dispatched to the site.

All Assistant Medical Officer recalled must report at the ED Command and Control Center as soon as they arrived at the ED.

g. Nursing

i) Head of Nursing

(1) Report to the Command and Control Center at ED ASAP.
(2) Take charge and co-ordinate all nursing activities.
(3) Recall and deploy all nurses and health attendants from other units/disciplines or off-duty nurses as deem required.
(4) Prepared and organize respective ward.
(5) Prepare and organize Hospital Information Center.
(6) Prepare and organize families and relatives center.
(7) Stationed herself at the Hospital Operation Room.
(8) Co-ordinate with the divisional or state Nursing Matron if additional nurses and health attendants are required.

(ii) Nursing Supervisor U32

(1) Report to the Command and Control Center at ED ASAP.
(2) Assist Head of Nursing to supervise and co-ordinate all nursing activities.
(3) Stationed herself at the Hospital Operation Room
(4) Other duties will be as assigned by the Main Coordinator.

iii) Nursing Sister on-duty/on-call

(1) Report to ED ASAP.
(2) Assume the role of Main Coordinator from the AMO I/C of shift until a more senior officer arrive.
(3) Assume the role of the Head of Nursing until the later arrived.
(4) Upon arrival of the Head of Nursing, your role and duties will be scale down

to the usual Nursing sister on-call.

iv) ED Nurses

(1) ED Nurse — I/C of Red Zone

(a) Prepare the Red Zone to receive more casualties.

(b) Request and prepare additional equipments and consumables in the Red Zone if required.

(c) Assign staff in the Red Zone as required.

(d) Form the resuscitation team in the Red Zone. Co-ordinate with the Control Center if more staff is required.

(2) Ward Nurse — I/C of Yellow Zone

(a) Prepare the Yellow Zone to receive more casualties.

(b) Request and prepare additional equipments and consumables in the Yellow Zone if required.

(c) Assign staff in the Yellow Zone as required.

(d) Form the treatment team in the Yellow Zone. e Co-ordinate with the Command-and-Control Center if more staff is required.

(3) **JM-I Nurse**

(a) EMT-I nurse will form part of the first Ambulance Team to the site.

(4) **Other ED Nurses**

(a) Other off-duty ED nurses responded will report to the ED Command and Control Center and deployed as required. Some will form the Ambulance and Medical Team.

(5) **Male Ward Nurses**

(a) Work in the Red Zone.

(b) One nurse will be part of the 2nd Medical team, if the 2nd team is formed.

(6) **Female Ward Nurses**

(a) Work in the Red Zone

(7) **Maternity/Peadiatric Nurses**

(a) Work in Yellow Zone

(b) Assist in the preparation and organization of the current ED Reception Area and Waiting Area into Yellow Zone

(i) Move existing waiting chairs to the Ambulance's Bay.

(it) Check and acquire adequate resuscitative equipment and drugs.

(iii) Ensure sufficient linens. Etc.

(8) **Other Nurses**

(a) Other nurses will be called as needed.

(b) All responding nurses will report at the Command and Control Center and deployed as required

h. Attendants

i) Help to clear ED
ii) Help the transport and preparation team.
iii) As assigned by the Coordinator or any officer authorized by him.

i. Drivers

i) Check, prepare and assemble all ambulances and transport vehicles at the ED.
ii) Prepare, check and load all the necessary equipment.
iii) Form part of the Ambulance and Medical Team.

j. Other Clinical and support Services.

1. Report to the Command and Control Center at ED or Hospital Operation Room ASAP.
2. Prepare and assemble your own team as required.
3. Liaise with the Command and Control Center regarding the status of the disaster.
4. Other duties may be as assigned by the Main Coordinator or any officer assigned by him.

*For duplicated role, the first person to arrive will be given the original role card. The subsequent person to arrive will be given a runner role card and will perform tasks as assigned by command center.

Note:

All staffs deployed to ER are required to fill in the registration sheet in their respective department (attached to disaster plan) upon declaration of red alert.

Called back staffs are required to fill in the registration sheet and report to nursing sister or unit manager in charge upon arrival to their own unit.

Deployed staffs are required to be physically present at command center as assigned, wait for further instructions, sign attendance, and collect their role tags.

DEPARTMENT – EMERGENCY STERILE SETS STOCK

NO.	ITEMS/ SETS	QUANTITY
1	Dressing Sets	**20**
2	Toilet and Suture Sets	**5**
3	CVP Sets	**2**
4	VE Sets	**5**
5	Catheterization Sets	**2**
6	Underwater Seal Sets	**2**
7	Injection Trays	**5**
8	Dressing Scissors	**5**
9	Stich Scissors	**5**
10	Alcohol Swab	**2 boxes**
11	Swab 10pcs Packs	**50**
12	Gauze 6pcs Packs	**50**
13	Gamgee	**20**
14	Burn Gauze	**20**
15	Dressing Towels	**20**

SECTION 3: DISASTER SCENE MANAGEMENT

A. OBJECTIVES:

- To ensure the provision of rapid and appropriate emergency medical care to the most possible patients through a coordinated response system based on incident management principle.
- To minimise the morbidity and mortality associated with large scale emergency patient care incidents.

B. ROLES OF FIELD MEDICAL GROUP:

1. **Medical Incident Commander (usually Medical Officer)**
   a) Has overall command of the Field Medical Operation Group
   b) Has to be an experienced MO or AMO
   c) Responsible for the implementation of the Incident Action Plan within the Medical Branch
   d) Reports to the Command and Coordination Centre (CCC)
   e) Repeat the medical assessment of incident and work with Incident Commander to request additional resources and personnel if needed for triage and litter teams or patient transport.
   f) Supervises Triage Officer, Treatment Officer, Transport Officer and Liaison Officer
   g) Reports casualty information to the Command-and-Control Center in the hospital
   h) Usual work site is at the Command Post with the Commander of Disaster Operations

2. **Triage Officer Leader (First MA to arrive at scene)**
   a) Coordinates the triage of all patients
   b) Supervises Triage Personnel/ Logistics officer (Letter Bearers) and Morgue Officer
   c) Once all casualties are in appropriate zones then automatically becomes a part of the treatment officer
   d) Reports to the Medical Incident Commander
   e) Document patient details -update number to Field Commander

3. **Triage Officer**
   a) Responsible for triaging of patients in a dynamic way
   b) Assigns patients to appropriate treatment areas.
   c) Once all casualties are in the appropriate zone then automatically become registration officer at the field to keep track of the patient movement, progress and documentation.
   d) Reports to Triage Officer Leader

4. **Morgue Officer**
   a) Responsible for Morgue Area functions
   b) Reports to Triage Unit Leader

5. **Treatment Officer Leader**
   a) Might have dual role as MIC depending on availability of manpower.
   b) Coordinates on scene emergency medical treatment of all victims
   c) Reports to Medical Incident Commander
   d) Supervises Treatment Personnel

e) To liaise with Transport Officer regarding urgency/sequence of each patient to be evacuated

6. Treatment Officer (Red, Yellow, Green)

a) Provide on-scene emergency medical treatment to all casualties according to zone.
b) Reports to Treatment Officer Leader

7. Transport Officer

a) Might have dual function as Logistic officer depending on manpower.
b) Coordinates the evacuation of patients from on scene to hospital/ definitive medical treatment.
c) Reports to Medical Incident Commander
d) To liaise with Treatment Unit Leader regarding urgency/sequence of each patient to be evacuated
e) Set up ambulance waiting area and patient transport area
f) Establish flow of patient and ambulance in evacuation of the scene

8. Liaison Officer (chosen by MIC)

a) Coordinates effort with other agencies and jurisdiction
b) Get enough suppliers of medication, consumables, food, water, clothes etc
c) To coordinate with other agencies to set up shelter according to treatment zone
d) Reports to Medical Incident Commander

9. **Logistic Officer**

a) If there is sufficient manpower at scene.
b) Plan and carry up the uni-directional route for ambulance or vehicle movement, to work together with police traffic team
c) Help transport officer in sending off the casualties
d) To help transfer patient to different area(s) on scene upon request
e) Take care of the belongings of hospital, i.e., assets, inventory, tent etc
f) Take care of casualty's belongings
g) Take care of staff's belongings if applicable
h) Be letter bearers, can be together with RELA or other non-medical agencies
i) Reports to Medical Incident Commander

C. FIELD RESPOND

1. Receiving incident
   1.1. Ambulance call or incident report to be received from the public, fire department or police department.
   1.2. To use ambulance call form as a guide for records of caller and incident particular
   1.3. EMT 1 will be dispatched as the Recce team.

2. Scene Communication
   2.1. GIRN (Government Integrated Radio Network) sets are available but not completely reliable due to the poor coverage.
   2.2. As of currently, mobile phones will be used as the main means of communication on scene and to hospital.

3. Initial Duties for First-In, Second-In and Subsequent EMT

3.1. EMT-1/ Recce team

3.1.1. Consist of 1 Assistant Medical Officer (AMO EMT 1 on shift), 1 Staff Nurse (SN EMT 1 on shift), and 1 Driver (EMT 1 Driver on shift)

3.1.2. To bring Recce bag to scene

3.1.3. Upon arrival to scene, Recce team to do the initial scene size-up and "SALT triage" assessment to establish:

a) Confirmation of reports of an actual Mass Casualty Incident (MCI)
b) Type of Incident (trauma, medical, Hazmat or combination)
c) Exact location and boundaries
d) Incident magnitude
e) Estimated number of potential or actual number of victims (if known)
f) Additional response resources (type and numbers) if needed

3.1.4. To communicate back with Command-and-Control Center regarding provisional scene size up.

3.1.5. To report to Incident Commander (IC) on scene for Situation Report (Sit Rep) and to get recommended Triage, Treatment, Transportation and Ambulance Area from IC.

3.1.6. AMO: Temporary Medical Commander and Field Triage Officer until relieved by the MO from EMT-2, SN: Field Treatment Officer and field triage officer 2, Driver: Ambulance Driver

3.1.7. For Field Triage please refer to the "Triaging" Section.

3.1.8. To inform ETD HOD if the casualty were to be triaged more than 5 Yellow or 3 Red

3.2 EMT-2

3.2.1 Consisting of 1 MO, 1 AMO (ETD AMO if available. If not available to send other dept AMO (HDU or OT), 1 SN (General ward), and 1 Driver (Driver standby 1)

3.2.2 To bring Disaster bag (Wound bag), Airway Bag, and Medication Bag to scene.

3.2.3 To report to Incident Commander and Temporary Medical Commander

3.2.4 EMT-2 MO to set up treatment area and initiate treatment for victims on scene; MO will be the Medical Incident Commander and Field Treatment officer Leader.

3.2.5 EMT-2 AMO will be the Liaison Officer unless told by MIC to be Field Triage Officer

3.2.6 EMT 2 Nurse will be the Field Treatment Officer Assisting the MO

3.2.7 EMT-1 Nurse can now escort one patient back to hospital on EMT-1 ambulance while EMT 2 ambulance will be the standby ambulance

3.2.8 EMT 2 PPK if available will act as the runner for both medical base and as escorting personnel depending on command by MIC

3.3 EMT-3

3.3.1 Consists of 1 MO, 1 AMO (AMO ED called back), 1 SN(ED SN called back), and 1 Driver(Driver Standby 2)

3.3.2 EMT-1 SN who just escorted victim back from scene will follow EMT 3 back to scene if the patient escorted is settled

3.3.3 To bring Disaster bag and other medical supplies needed.

3.3.4 To report to Incident Commander and Medical Incident Commander.

3.3.5 EMT-3 MO will assist EMT 2 MO as treatment officer.

3.3.6 EMT-3 AMO will be field triage officer if still required. Otherwise, will function as Field treatment officer.

3.3.7 EMT- 3 SN will be Field Treatment Officer to assist in patient treatment.

3.3.8 EMT-1 AMO to remain as Triage Officer. If field triage is done, to assist as Medical Triage Officer (re-triage) at the entrance of Treatment Area/ Medical base.

3.3.9 EMT 1 SN that comes back to medical base will assist in patient treatment and patient escort as determined by MIC

3.4 Subsequent teams

3.4.1 Every team that arrives at the disaster site will first report to the On Scene Commander.

3.4.2 Second, to report to the Medical Incident Commander and will be directed. to Treatment area/ medical base for staffing of Immediate, Delayed and Minor Treatment Areas

3.4.3 Assign Transport Officer by Medical Incident Commander if required.

3.4.4 The ambulance is to be directed to the Ambulance waiting area and to report to Transport Officer.

3.4.5 Drivers stay with their vehicle in the Ambulance area while awaiting assignment.

3.4.6 Liaison Officer and Morgue Officer to arrive with subsequent teams if required.

4. Scene Organization

4.1. Triage Area

4.1.1. Triage area will be set up after discussion with On Scene Commander and also after considering the optimal ingress/egress route for ambulance movement.

4.1.2. Triage is done using “SALT” method of triaging. An initial announcement calling out to those who are able to walk to go to go to the designated area, while the remaining requires assistance, will be moved by logistics officer or anyone available to the designated Treatment Area. Such patients will be re-triaged at medical base before sending them to their respective zones.

4.1.3. Victims who are non-ambulatory and/or not responsive are triaged accordingly at where they lie.

4.1.4. A Separate Triage Area may be created if there is a hazard/potential hazard or if the physical location is not conducive for patient triage.

4.1.5. All the patients will be triaged and tagged.

4.1.6. The deceased are left where they lie or if adequate resources are available, a morgue area will be set up. Such patients usually tagged black / white (Expectant) will be moved to a separate morgue area along with their personal effects. However, they will be the last priority. Usually, the Police force or BOMBA will handle the deceased.

4.1.7. If the MCI is a crime scene, the deceased are not removed without prior approval of the Police.

4.2. Treatment Area

4.2.1. In a small incident, one Treatment Area may be set up with patients grouped together according to triage levels: Immediate (Red Zone), Delayed (Yellow Zone), Minimal(Green Zone), and Expectant; according to the availability of the resources).

4.2.2. For larger incidents, separate Immediate, Delayed and Minimal Treatment Areas are established as allowed by the On Scene Commander as well as the geographical location of the disaster site.

4.3. Patient Transport Area

4.3.1. This area is for loading patients into transporting vehicles.

4.3.2. Ideally, the loading area should be adjacent to the treatment area(s) and in-line with the one-way traffic from the Treatment area.

4.3.3. When a one-way traffic pattern is not possible due to the topography, scene personnel will improvise.

4.4. Morgue Area

4.4.1. In most cases the deceased are left where they lie

4.4.2. A Morgue Area may be established when adequate resources are available and/or it becomes necessary to remove deceased patients from the impacted site

4.4.3. Deceased patients are the last priority to be removed from the scene.

4.4.4. This area should be located away from the treatment area(s) and is the responsibility of the Morgue Officer

5. Medical Group Operation

5.1. Medical Incident Commander

5.1.1. Ensures Command-and-Control of all activities within the Medical Group and the integration of all activities with the overall operational response.

5.1.2. This includes ensuring that adequate personnel and resources are available to the Medical Group to accomplish its assigned objectives.

5.1.3. Will be in charge of keeping track of number of patients in Disaster treatment area as well as number of patients sent to hospital.

5.1.4. Decides on urgency/ priority of patients to be transported to the hospital especially if Field Treatment officer Leader is having difficulty in decision making.

5.2. Triage Team

5.2.1. The Triage Team shall rapidly triage and tag all patients
5.2.2. Emergency medical care during the triage process is generally limited to establishing an airway and controlling hemorrhage.
5.2.3. All patients are triaged and tagged prior to leaving the Triage Area.
5.2.4. The Triage Unit Leader is responsible for tallying and reporting the total number of victims to MIC
5.2.5. Result of the tally are reported as total number of patients and their triage categories
5.2.6. Triage Unit Leader to report this information to the Medical Incident Commander (MIC)

5.3. Treatment Team

5.3.1. Treatment area will be set up with equipment from the second ambulance and equipment will be further supplied if needed
5.3.2. MO, AMO or SN not designated to any other areas will be required to report to the Treatment Unit Leader
5.3.3. Once the patient is in the Treatment Area, treatment will consist of:
5.3.3.1. Re-triaging the patients.
5.3.3.2. Checking and recording vital sign and chief complaint on the triage tag
5.3.3.3. Establishing and maintaining an airway and controlling hemorrhage
5.3.3.4. First aid, BLS and ALS level care depending on provider training, availability of personnel and resources, and only if the situation safely allows for it
5.3.3.5. Preparing patients for transport

5.4. Patient Transport Area

5.4.1. Patient Transport Area to be as close to Treatment Area as possible.
5.4.2. Patient will be moved from the Treatment Area to the Patient Transport Area only when:
5.4.2.1. A patient is “packaged” and ready to go
5.4.2.2. A transport vehicle is ready to go
5.4.3. The Transport Officer is responsible for securing transport vehicle and maintaining a “Patient Log” for patients leaving the scene which includes:
5.4.3.1. Triage Tag number
5.4.3.2. Triage Level
5.4.3.3. Patient name (if known)
5.4.3.4. Patient Age and Gender
5.4.3.5. Chief complaint
5.4.3.6. Type of transport unit
5.4.3.7. Transport unit and provider unit phone number
5.4.3.8. Destination
5.4.3.9. Date and time of departure

D. TRIAGING

1. It is used to identify patients that have the most immediate need for medical care versus those that may wait.
2. Triage is the primary tool used in determining the most appropriate allocation of available medical care resources in a large multi-casualty incident.
3. Using Voice Triage upon arriving on field, then proceed with SALT Triage (Sort, Individual Assessment, Life-Saving Intervention, Treatment and Transport).
4. SALT Triage are designed for use in only disaster and multi-casualty situations, not for daily EMS or hospital triage.
5. During the SALT Triage evaluation, the victims are labelled with one of the four colour coded triage level categories:
   i. Immediate (Red) : Life-threatening injury
   : Require immediate care
   ii. Delayed (Yellow) : Serious non-life threatening injury
   : Can delay care for 1 hour Iii. Minimal (Green) : Walking wounded
   : Can delay care up to three hours
   Iv.Expectant/Deceased (White/Black) : Pulseless / Non-salvageable
   : Not breathing or imminent demise

6. Triage categories are indications of the desired time to receive treatment as well as priority to be treated. In large scale incident, actual time to treatment may vary based on the availability of resources.

E. EMERGENCY DEPARTMENT STAFF CALL-BACK LIST

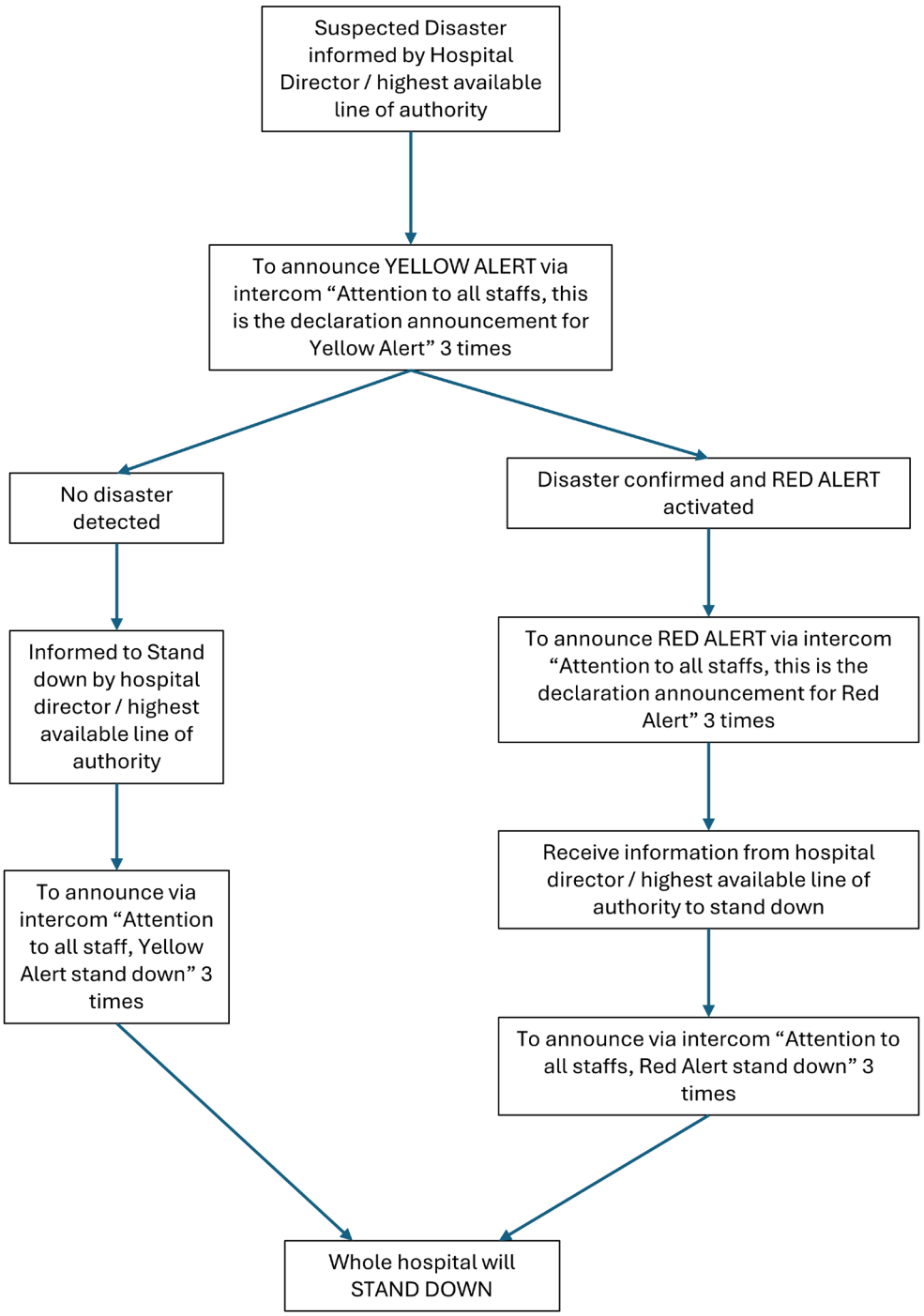
Upon receiving notification of a disaster, the Assistant Medical Officer stationed at the Call Center/ Triage Counter should inform the following officers below in the order as stated as soon as possible:

LIST 1 (During Office Hours)	**LIST 2 (After Office Hours)**	
1. ETD HOD		
2. Chief AMO	2. Chief AMO	7. Off-duty ED Nurses
3. Senior AMO / AMO shift in charge	3. Senior AMO	8. Off-duty Health Attendants
4. Medical Officer on duty	4. Medical Officer on duty	9. Off-duty Ambulance Drivers
	5. Off-duty Medical Officers	

NB: Call up of ED AMOs must be done by the ED AMO in-charge for CC while waiting for the arrival of the next in command. The telephone operator should assist in calling up.

1. ACTIVATION OF YELLOW/ RED ALERT FLOW CHART

(Hospital Telephone Operator work flow)



2. OPERATOR CALL-UP LIST

Upon activation of Yellow/ Red Alert, the telephone operator shall call up the relevant personnel listed below in the level of priority:

Priority 1

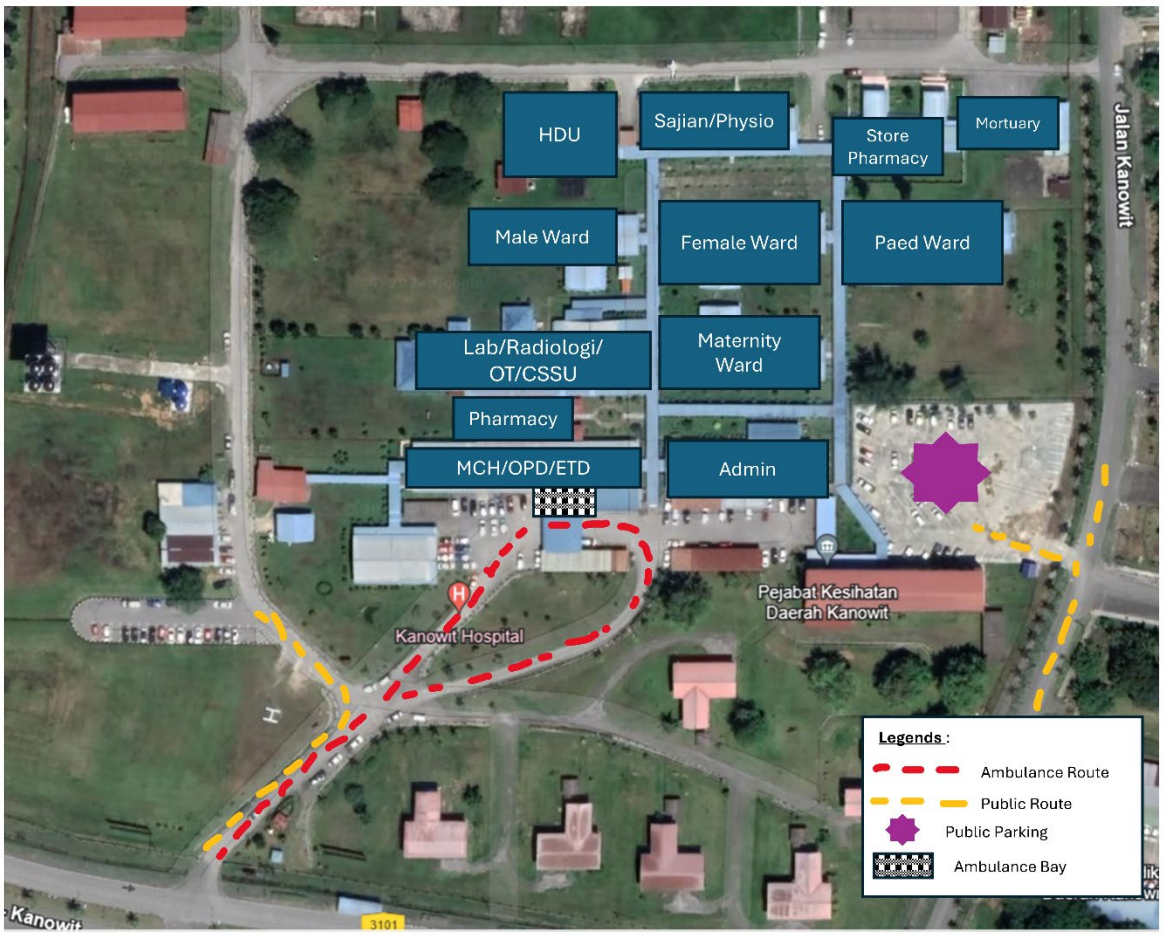
1. Hospital Director
2. Head of Emergency Department
3. Chief Assistant Medical Officer (Admin)
4. Head of Nursing
5. Nursing Sifter on duty (after office hours)
6. Medical Officers
7. Wards (Nursing Teams)
   a. Male Ward
   b. Female Ward
   c. Pead Ward
   d. Maternity Ward
8. Administrative Officer
9. Head of Hospital Support Services
10. Security

Priority 2

1. Heads of Clinical Support Services
   a. intensive Care Unit
   b. Operation Theatre
   c. CSSD
   d. Radiology
   e. Clinical Lab/Blood Bank
   f. Pharmacy
   g. Kitchen
2. HDU
3. Officers on-call
   a. Radiographer
   b. Med. Lab. Technologist
   c. Pharmacist
4. Mortuary Attendant

Note: All Off-duty ED staff will be called up by the Assistant Medical Officer In-charge of shift through ED with the exception of off-duty Medical Officers.

3. AMBULANCE ROUTE FLOW CHART IN HOSPITAL



a. Ambulances will load and unload patient at the ambulance bay in front of the triage counter at Emergency Trauma Department.
b. All public vehicles with or without patients will be diverted to alternative routes directed by Security Services which is lead by Hospital Crowd and Traffic Control Officer.
c. To limit vehicles movement into the hospital compound.
d. At least 2 security guards will be stationed at the entrance gate.
e. Access is only allowed to:
   a) Ambulance or staff car
   b) Public vehicles carrying patients

4. TERMINATION OF DISASTER ACIVITIES

The decision to terminate the whole disaster activities lies with the Hospital Director or Deputy Director or any person authorized by the latter. His / Her decision will be based on:

(1) The arrival of the last responding ambulance from disaster site

(2) ED is clear of its last remaining victim

(3) After assessment of situation and receiving information from the last ambulance crew leader and after verifying with Medical Incident Commander

After taking into consideration the above factors, the Hospital Director or Deputy Director or any person authorized by the latter may declare the whole disaster operation is over through the intercom system.

SECTION 4: RECOVERY PHASE

A. DEBRIEFING

Upon termination of disaster activities / stand down, a debriefing session will be held as soon as feasible.

1) Staffs directly involved with the disaster events will undergo a debriefing session and also be offered support session/s coordinated by the Social Worker Team.
2) Regular briefing/debriefing sessions within ETD will be held for those responsible for coordination of operations.
3) A joint debriefing will be scheduled as soon as possible following Stand down of Red alert. Place of debriefing will be will be located in the New Conference Room / determined later upon availability (if NCR is in used).

B. WRITTEN REPORT

1) A detailed report pertaining to the whole disaster activities at disaster site as well as Emergency department will be submitted by the Chief Assistant Medical Officer or the Senior Assistant Medical Officer of the Emergency Department. It will be first verified by the ETD HOD and then sent to the Hospital Director's office on the following working day.
2) Upon returning to the normal level of operation, an impact assessment will be conducted separately by all the departments involved to assess damage and replacement needs (i.e. overtime, supply replacement).
3) All Departments involved will perform a performance evaluation and critiques to determine if response was appropriate and where improvements can be made.
4) Individual departmental summaries and evaluations are to be submitted to the Hospital Director and Incident Commander(Hospital Director unless not around during disaster event).
5) The "return to normal level of operations" may take several days, weeks or months, depending on the extent of the disaster incident earlier.

SECTION 5: DEVELOPMENT AND MAINTENANCE

1) This Disaster Plan was developed by the Disaster Subcommittee of the Safety Committee and with the cooperation of all departments in the hospital.
2) All departments are responsible for maintaining an up-to-date disaster manual and notifying the Disaster Subcommittee regarding any changes in their departments.
3) This plan will be reviewed annually during external disaster committee meeting or as changes in departments or hospital occur.

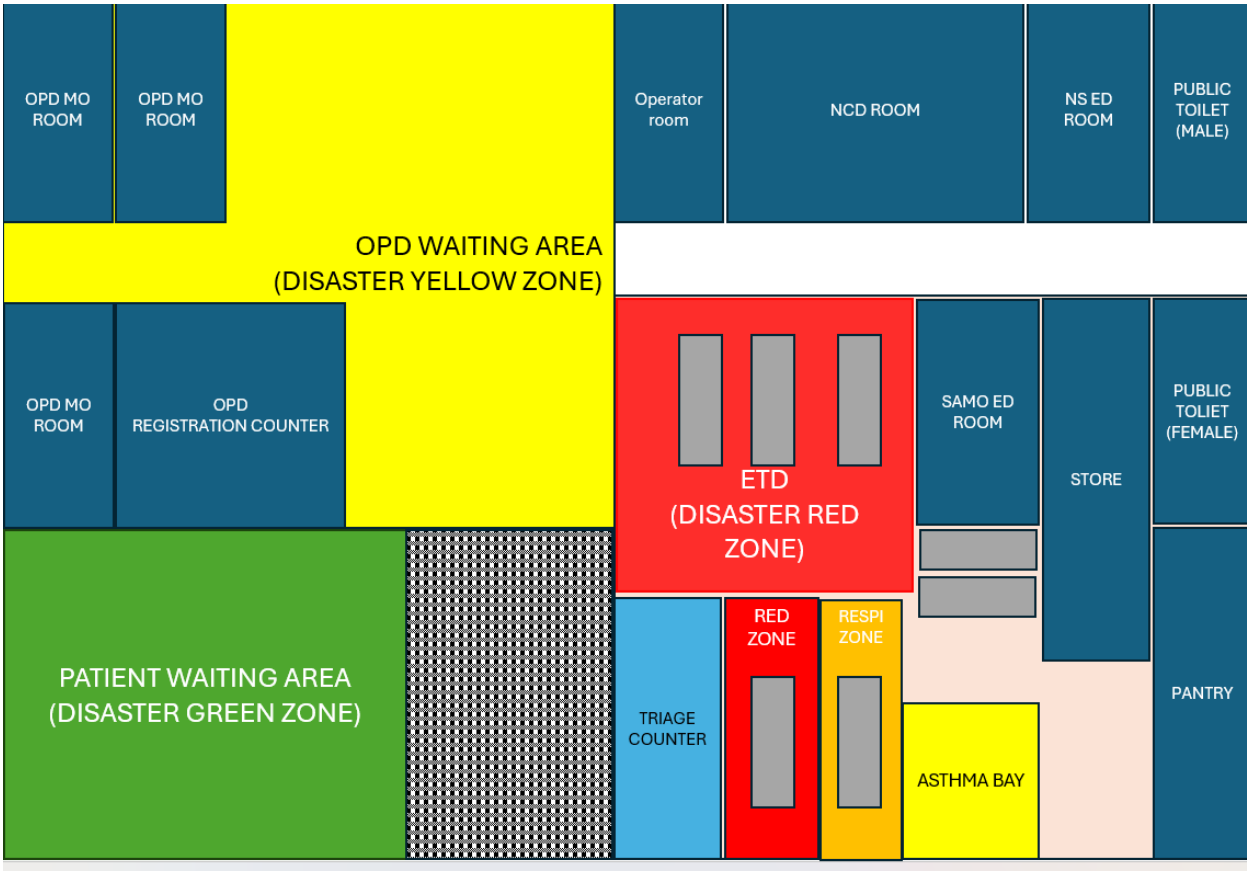
APPENDIX

DISASTER PLAN FOR EMERGENCY & TRAUMA

Original ETD Area Setting

DISASTER PLAN FOR EMERGENCY & TRAUMA

Location for All Zones During Disaster



To be signed after reading this disaster plan by all staffs in the unit

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