**Epidemic Disaster Preparedness and Response Plan**

Nobel College of Health and Education Foundation (P) Ltd

**NOBEL HOSPITAL**

**(29 Jan, 2020)**

**Sinamangal, Kathmandu**

[www.nobelhospital.com](http://www.nobelhospital.com)

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# **Epidemic Disaster Response Committee**

There will be two committee, executive committee (Epidemic Disaster Management Committee) and Epidemic disaster response committee.

**Members:**

1. Hospital Director -Mr. Santoshmani Neupane
2. Medical Coordinator -Dr. Lochan Karki
3. MDGP -Dr. Anu Kushwaha
4. Physiotherapist -Dr. Prakash Kumar Mahto
5. Orthopedics -Dr. Shreeraj Shrestha
6. Hospital Manager -Mr. Krishna Bdr Nepali
7. Nursing -Mrs. Rubina Bajracharya
8. HOD Anesthesia -Dr. Anuj Jung Rayamajhi
9. MO In-charge -Dr. Nilesh Kumar Mishra
10. Emergency In-Charge -Mr. Nageshwor Yadav
11. Accountant -Mrs. Hasina Bajimaya

## **Epidemic Disaster Management Committee (Executive committee)**

This committee will work on improving the capacity of the hospital to response to epidemic disaster. Members of the committee will be selected or positional as per hospital rules. Name of present members of the committee are as follows.

1. Emergency Registrar -Dr. Anu Kushwaha
2. MO In-charge -Dr. Nilesh Kumar Mishra
3. Hospital Manager -Mr. Krishna Bdr Nepali
4. Nursing -Mrs. Rubina Bajracharya
5. OT In-charge -Mrs. Asodha Panchkoti
6. Emergency In-Charge -Mr. Nageshwor Yadav
7. Maintenance In-charge -Mr. Ratan B.K.
8. Hose Keeping In-Charge - Mr. Dhiraj Niraula
9. Communication Officer -Ms. Nidhi Bajimaya
10. OPD In-Charge -Mr. Sitaram Nagarkoti
11. HOD Nursing (obel College) -Ms. Surya Devi Bajracharya

### **Functions**

* To update the epidemic disaster response plan.

To ensure all staff have read the epidemic disaster preparedness document.

To ensure that all new staff have epidemic disaster training.

* To keep the supplies required for epidemic disaster in readiness.
* To liaise with other hospitals/health service providers in coordinating the epidemic disaster response.
* To liaise with health ministry as a part of national epidemic disaster response plan.
* To advise the administration to strengthen the structural and non-structural components of the hospital such that the hospital will continue to function at the time of epidemic disaster.

## **Hospital Incident Command Center**

***Figure 1: Hospital incident command center***

# **Introduction**

“The number of cases indicating the presence of an epidemic varies according to the agent, size and type of population exposed, previous experience or lack of exposure to the disease and time and place of occurrence.” (WHO,2007)

# **Epidemic Disease Disaster**

Epidemic can be defined as "The occurrence in a community or region of cases of an illness, specific health related behavior, or other health related events clearly in excess of normal expectancy.

## **Minor Epidemic Disaster**

**LESS THAN 10- Patients (P1 and P2)**

* Patient will enter reception and will be attended by on duty Doctor.
* Patient will be managed in a normal way.
* May develop into a Major Disaster.

## **Major Epidemic Disaster**

**Over 10 Patients (P3) or (LESS THAN 10 PATIENTS IF ALL ARE RED)**

1. The decision to declare a **“Epidemic Disaster State”** should be made by (or in consultation with) incident commander.
2. The Receptionist must be instructed to announce the “Epidemic Disaster State” over the loudspeakers, and put on the siren.
3. The Epidemic Disaster Plan must be activated.
4. The main emergency entrance must be closed, and patients directed to enter via Gate-5, leading to the Triage Area
5. The hospital disaster preparedness and response plan will be activated.

# **Epidemic Disaster Management Plan**

* The plan must function day and night.
* During working days **(OPD hours: 8am to 5 pm)** patients must be directed out of the hospital via exit of RED/YELLOW area (Gate No. 2 and 3) for ER Patient and green area (Gate no: 5) for OPD patient.
* The OPD area will already be clear by OPD staff.
* If there is disaster in off hours, emergency on duty registrar or emergency duty staff or senior nursing staff should inform hospital incident commander.

# **Activation of Epidemic Disaster Plan**

**Calling “Epidemic Disaster State”**

**Information from surveillance Team of Hospital/ EDCD**

**Inform ER on Duty MO/ER duty In-charge**

**On duty Emergency MO /Emergency In-Charge**

Verified following information

***Type of Infectious Disaster***

***Estimated number of victims***

***Estimated severity of cases (ICU vs Ward)***

**On duty Emergency MO /Emergency on Duty In-Charge**

Give verified information to Incident Commander

Incident commander verifies information

**“EPIDEMIC DISASTER STATE”**

**Epidemic Disaster Plan is activated through Reception-Siren**

Figure 1: Epidemic Disaster activation plan.

# 

# **Hospital Incident Command System (HICS)**

This is the facility from which the execution of the response operation is managed. It is in **Hospital Manager's office**. Its main functions are:

1. **Communication**:
   1. With the departments of the hospital for information on casualties, manpower and other resources.
   2. With other external agencies like police for information on further victims arriving, estimated time of arrivals etc.
   3. With other hospitals for possible patient transfer.
2. **Information processing**:

All information received must be analyzed, its effect determined and decisions made.

1. **Identification of capacity:**

It must develop, maintain and display information on current bed status, stretchers, wheel chairs, medicines, transfer facilities etc.

1. **Resource management**: Identification of resources requirement and its sources.
2. **Management of media inquiry:** Must give information to press, develop and post victim manifest and update it from time to time.
3. **Record keeping**: Record of decisions made in HICC and the reason for the decisions should be maintained. (Personnel in the command center are accountable for their decisions and hence the importance of such record keeping.)

# **Triaging**

1. Patients must be assessed and triaged (sorted) on arrival at the triage area, and directed to the correct treatment area for their condition.
2. It is essential that the triage area is set up and manned in the before main entrance ER of hospital.
3. At the triage area, the designated triage officer will rapidly assess the patients, and tag the victims as per the triage categories.

## **Triage category**

|  |  |  |
| --- | --- | --- |
| **Triage categories:** | | |
| **Category** | **Classification** | **Treatment area** |
| **Red** | Immediate care  (life in danger) | ER RED AREA |
| **Yellow** | Urgent care  (**Serious, but life not in danger**) | ER YELLOW AREA |
| **Green** | Minor care (W**alking wounded)**  **(cuts and bruises)** | OPD GREEN AREA |
| **Black** | Dead /Hopeless | MORGUE/NEAR MORGUE |

Table 1: Triage category

1. Victims already in the hospital at the time of the disaster will need “triaging backwards” in order to make as much space as possible they should be sent to the treatment area that best fits their condition, or else be admitted or discharged.
2. Requires two doctors to sign to declare dead, so all suspected dead to be referred. In case of dead declared by community, dead body can be placed temporarily at half way home.

## **Triage area: for P1 and P2 (If victim come without notification)**

|  |
| --- |
| G  A  T  E  4  Gate 3  G  A  T  E  2  **YELLOW**  G  A  T  E  1  **TRIAGE**  E  N  T  R  A  N  C  E  **Passage**  **RED** |

**Picture 1: Triage area.**

## **Triage officer**

Senior on duty ER MO will be triage officer. In absence of Senior ER MO, Physiotherapist will take the responsibility.

## **Triage card**

The triage card is rectangular card with a plastic sheath with four color squares with a string to go around neck. The color squares can be removed and placed in the front which depicts the victim's triage category.

On the triage card, there is patient number allocated in front of the card. The patient identification to be complete also requires an alphabet in front i.e. R (for red), Y (for yellow), G (for green) and B (for Black). For example, if the patient is category red and the triage card has number 1, he will be R1. This will make it easy for the x-ray and lab staff to prioritize the investigation and will also tell them which area to send the report. In case of change of triage area it will be replaced as R1Y... The first letter is the place where patient is initially and last letter is the place where patient is shifted. The triage number should be mentioned clearly in the patient card initially and immediately after shifted the treatment area.

The triage cards will be collected by nurse -in -charge before patients are discharged. These should be handed over to logistics officer.

## **Method of triaging**

### **START (Simple Triage and Rapid Treatment)**

This allows the triaging personnel to triage the victims in sixty seconds or less. This is done by assessing **Respiration, temperature, Perfusion and Mental status**.

**Steps:**

1. Asses the patient for ventilatory rate and adequacy of respiration. If the victim is not breathing, check for foreign bodies causing airway obstruction. Do a chin lift or jaw thrust. If this does not initiate ventilatory effect**, tag black**. If respiratory rate is more than 30 per minute, **tag red**. If respiratory rate is less than 30, do not tag yet, but asses for perfusion.
2. Assess capillary refill for perfusion by pressing nail bed or lips and release. Color should return in less than two seconds. If capillary refill is more than two seconds, **tag red**. If capillary refill is normal, do not tag yet but assess for mental status. If there is obvious external bleeding, control hemorrhage by pressure.
3. Use simple command to assess the mental status like 'open and close your eyes' or 'squeeze my fingers'. If patient is not responding to these commands, **tag red**. If patient responds well, **tag yellow**.
4. Patients who have only minor illness should be **tagged green**.

# **Triage and Treatment Areas**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **Location** | **In-charge** | **Staff from** |
| Triage | In front of OPD | On duty ER MO/Physiotherapist | Staff from GW,  Nursing co-ordinator-3rd yr |
| RED | ENT OPD | MDGP or INCHARGE MO OR ORTHOPAEDICIAN | Staff from ER/ICU  Nursing co-ordinator-4th yr |
| YELLOW | Physiotherapy Dept | Senior MO/Gynecologist | Staff from GW, HDCU  Nursing co-ordinator-2nd yr |
| GREEN | OPD Waiting Passage | MO or Dental Surgeon or OPD In-charge | Staff from OPD, Dental,  Nursing student, vol.  Nursing co-ordinator-1st yr |
| BLACK | Morgue/Near Morgue | Ward In-charge | WA, HK in-charge |

#### **Triage and Treatment Area during Epidemic Disaster (P3)**

**WARD AREA**

Gate 5 ENTRY

**Blood Bank**

**GREEN AREA**

Parking Area

Secondary Triage

**RED**

**AREA**

Primary Triage

**OPD BLOCK**

BLACK AREA

**YELLOW AREA**

## **Teams**

1. There are many “teams” of people taking part in the disaster plan.
2. Each team needs a “captain” to ensure all the jobs on his team’s checklist get done. Ideally the captain should be a department head, but he/she may not be immediately available. Therefore a deputy (or anybody) from that team should assume the team captain’s role immediately, and pass the job over to a more senior person, if available, later.
3. Each team has a “team clipboard” which defines the role and jobs of that team. There are boxes to be ticked when jobs have been done. These team clipboards are located in a special rack in the **Major Incident Box located at Emergency Room**. So, when you arrive in the hospital, first see if your team’s clipboard has been taken. If not, you must take the clipboard, and assume the team captain’s role

# **Crowd control**

1. Is crucial because once the hospital is over-run it is impossible to work.
2. Ideally the crowds are prevented from entering the clinical areas.
3. In an “evolving epidemic disaster” or where no prior warning is given, the crowds often get inside the clinical areas from the start. In this case they must be gently but firmly removed.
4. Certain doors must be opened or closed by security/administration, and all access points posted with guards.
5. Each patient is allowed to enter the primary and secondary triage area with one friend/helper.

# **Epidemic Disaster victims**

1. Patients do not pay for tests or treatment initially, but the costing should be recorded on the card.
2. Depending on the type of disease severity may need to be kept at area “yellow” for ongoing treatment.
3. It is important to clear treatment areas as soon as possible for possible further inflow of victims. Patient should be transferred to wards as soon as possible via **Gate no 3 and 4**.
4. Should fill the chare of all patients.
5. Green victims should be discharged as soon as possible and victims at other area transferred with priority to those who are in red.

# **Disaster supplies**

1. The epidemic disaster stock should have large amounts of saline, dressings, PPE, mask, Gloves, Disinfectant, etc.
2. Mattresses and disaster supplies are kept in the disaster supply room and need to be brought out in a disaster.

# **Aftermath**

**Once the** acute phase of disaster is over, a lot of work still needs to be done. Staff should check with their department heads to make sure that there is nothing more to do before leaving.

The hospital command center should declare the epidemic disaster state is over when:

* No further victims are likely to be brought in.
* All patients in area red and yellow have been transferred to the ward (isolation ward).
* All patients in green area have been discharged.

# **Debriefing**

A hot debriefing will be conducted in the conference room as soon as the epidemic disaster state is over.

A cold debriefing will be conducted within a period of two weeks after the disaster in the grand round. This will be conducted by the hospital director.

# **Management of media and Relatives**

## **Management of Media**

The media person will be informed timely at main gate no 5. Media person with identity card will be allowed to enter through main gate. They will not be allowed to enter other area of hospital. In all possible condition timing of press releases and place should be informed to security at door and if possible it should be printed and posted in the front main gate. Media will be addressed at parking area.

## **Guidelines for the official spokesperson**

1. Do not give names of the dead until next of kin have been officially notified.
2. Avoid speculation and personal opinion.
3. Always tell the truth. If you do not know the answer to a question, admit it.
4. Prepare a brief written statement about the situation and provide it to media representatives (include background information, photographs, and audiotapes or videotapes if appropriate).
5. Do not give exclusive interviews. Schedule a press conference with all the media representatives and give them all the same information at the same time. If you are going to read a prepared statement and not answer questions until later, say so at the beginning of the conference.
6. Be as accessible as possible to take follow-up questions from the media so they don’t think you are avoiding them.
7. Stay calm.

## **Proactive approach to media relations for the official spokesperson**

1. Do not wait for the media representatives to contact you. Study the patterns and type of reporting done in your area and determine which media seem to be the best informed, the most responsible, and the most effective, and contact them. Begin with one representative and contact others after you have gained some experience.
2. Write and state clearly and consistently not only the facts, but the message you want to convey.
3. Explain in each interview the importance of the issues you have discussed and how they fit into the general context of public health practices.
4. Do what you can to maintain an image of sincerity, experience, and candor.
5. Respond to the media when they contact you. They remember who helps them and who does not.

## **Management of relatives**

1. List of patient will be listed out at the Mass casualty information board.

## 

## **Referral protocol**

Unavailability of Services

* + 1. Vascular surgery
    2. Cardiothoracic
    3. Burn & Plastic Surgery
    4. Opthalmology
    5. Maxilofacial Surgery
    6. CT and MRI
    7. Specific test and investigation

# **Appendix – Phone numbers**

## **HICC Members**

|  |  |  |
| --- | --- | --- |
| **Position** | **Name** | **Phone number** |
| **IC** | **Dr. Santoshani Neupane** | **9851043274** |
| **OD** | **Dr. Lochan Karki** | **9851056689** |
| **Logistic Officer** | **Ms. Rubina Bajracharya** | **9867244368** |
| **Planning Officer** | **Mr. Krishna Bdr. Nepali** | **9843102920** |
| **Finance Officer** | **Ms. Hasina Bajimaya** | **9841315460** |
| **Communication Officer** | **Ms. Nidhi Bajimaya** | **9843435686** |
| **Security Officer** | **Mr. Tenji Sherpa** | **9818778063** |

## **Head of departments**

|  |  |  |
| --- | --- | --- |
| **Position** | **Name** | **Phone number** |
| ER In-charge | Mr. Nageshwor Yadav | 9841287457 |
| ICU In-charge | Ms. Tika Bastola | 9846774207 |
| Ward In-charge | Ms. Rubina Bajracharya | 9867244368 |
| OT In-charge | Ms. Ashodha Panchkoti | 9860365814 |
| HOD Radiology | Dr. Bikash Bikram Singh | 9841318051 |
| HOD Pathology | Dr. Sampurna Tuladhar | 9851070677 |
| HOD Surgery | Dr. Ashish Rajbhandari | 9861438986 |

## **Authorities and agencies**

|  |  |  |
| --- | --- | --- |
| **Position** | **Name** | **Phone number** |
| HEOC | Mr. Tulasi Dahal |  |
| Police Constable | Mr. Tek Bahadur | 9848850970 |
| Security In-charge | Mr. Tenji Sherpa | 9818778063 |

## **Ambulances**

|  |  |  |
| --- | --- | --- |
| **Name of Hospital** | **Position** | **Phone number** |
| **Civil Service Hospital** | Driver (Bishwa)  Driver (Binod)  Driver (Arjun)  Driver (Ram Hari) | 9847044771  9841510363  9841159790  9841212855 |
| **Everest Hospital** | Driver (Ram Krishna) | 9849595046 |
| **Venus Hospital** | Administration | 4475120  4490255 |
| **KMCTH** | Driver | 9843203119 |
| **Kantipur Hospital** | Driver (Bashu) | 9849162177  4111627 |
| **Tilganga Eye Hospital** | Admin (Deepak Khanal) | 9851051994 |
| **Nobel Hospital** | Kapil Subedi (Driver)  Manoj Khadka (Driver) | 9841919051  9851200615 |

# **Emergency Services**

|  |  |  |
| --- | --- | --- |
| **Name** | **Address** | **Phone Number** |
| **Police** | Kathmandu | 100, 110, 120 |
| **Fire Brigade** | Kathmandu Bhaktapur  Pulchok | 101, 4221177 101, 6610044  101, 5521111 |
| **Blood Bank** | Nobel Hospital, SinamangalSolti Mode Bhaktapur | 4110842, 4110893/944288486 6611661 |

# **Disease Epidemic Disaster Surveillance Committee**

|  |  |  |
| --- | --- | --- |
| **Position** | **Name** | **Phone Number** |
| Hospital Manager | Krishna Bdr Nepali | 9843102920 |
| OT Incharge | Asodha Panchkoti | 9860365814 |
| MDGP | Dr Anu Kushwaha | 9841315359 |
| In-charge MO | Dr. Nilesh Kumar Mishra | 9813508757 |
| Supervisor/Ward In-charge | Rubina Bajracharya | 9867244368 |
| ER In-charge | Nageswor Yadav | 9841287457 |
| OPD In-charge | Sitaram Nagarkoti | 9841513081 |
| Communication Officer | Samod Shrestha | 9851070603 |
| HK In-Charge | Dhiraj Niraula | 9819000334 |
| Driver | Kapil Subedi | 9841919051 |
| HOD Nursing (Nobel College) | Surya Devi Bajracharya | 9841199278 |

# 

# **Hospital capacity**

* Total number of staff: 150
* Hospital bed: 100
* ICU Bed: 8
* Ventilators: 4
* Water source: Yes
* Water storage: Yes
* Electricity: Yes
* Power Backup: Yes
* Alternative backup: Generator-2
* Ambulance:2
* Food stock: No Food Stock
* Sanitation: safety tank which drains into local sewage system

## **Resource Sharing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S.N. | **Hospital** | **Can Contribute** | **Need Help** | **Hub Role** |
| 1. | **Nobel Hospital** | Blood Bank/Apheresis  OT Room (1)  Patient Ward (20 pts)  Ambulance (1)  ICU Beds-3  Nursing students-20 | Physician/MO  Anesthesia  Orthopedic  Neuro Surgeon  Logistics  CT scan | Use blood bank  Water supply  KMC MO student mobilize  KMC surgeon |
| 2. | **Bharosa Hospital** | OT Room (1)  OT Staff &Equipments  Patient Ward (Post Op)-4 | Surgeon  Anesthesia | KMC surgeon |
| 3. | **HAMS Hospital** | ICU -1 bed  NICU- 2 bed  OT- 1  Nursing Student Volunteer-20 | Orthopaedic  Surgeon  Medicine | ICU/PICU - Civil |
| 4. | **Everest Hospital** | MO-1  Paramedic- 2  Nursing Staff- 5  OT Room- 2  Nursing Students-20  Medicine(Drugs) | Surgeon  Anesthesia  MDGP  Orthopaedic | Surge capacity |
| 5. | **Kantipur Hospital** | OT- 1  OT Staff-2  MO-1  Ambulance-1 | Surgeon  Tent  Medical Supply | Surge capacity |
| 6. | **KMC Hospital** | Medical Students-20  Burn ward – 30 bed  Neurosurgery  Dialysis | Nothing | Medical student and possible medical officers  Use dialysis service |
| 7. | **Venus Hospital** | Staff Nurse (Medical Ward)- 1  Paramedic-1  OT Room-1  Dialysis  ICU Room with Ventilator-1 | Blood  CT Scan  Ambulance  NICU/CCU  Surgeon | Blood bank – Nobel  Use dialysis service |
| 8. | **Tilganga Eye Hospital** | Opthalmologist/Opthalmic Asst.- 3  Anaesthesiologist |  | Eye injuries |

**APPENDIX -I**

**Nobel Hospital**

Sinamangal, Kathmandu

**Mass Casually Information Center**

Event: …………………………………… Date: ……………….......

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **S.N** | **Name of Patient** | **Age** | **Sex** | **Address** | **Triage** | **RE** |
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# **Communication and coordination**

**List of Planning officer and Runner with contact details**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SN | **Name of hospital** | **Planning officer (Name)** | **Designation**  **(In Hospital)** | **Contact no** | **Email.** | **Runners** | **Designation**  **(In Hospital)** | **Contact No** |
| 1 | **Civil Hospital** | **Ranjana Nepal** | Admin Officer | 9841275567 | info@civilservicehospital.org | 1.Bishnu PsdPokhrel  2.Bishow Panthi  3.Santosh Dhimal | Admin Staff  Driver  Plumber | 9843647608  9847044771  9841412360 |
| 2 | **Kathmandu Medical College** | **Dr. Chanda Karki** | Principal | 9849569320 | info@kmc.edu.np | Govinda Chauhan | G. Commander | 9841634364 |
| 3 | **Tilganga Eye Hospital** | **Sunita K.C.** | Communication Officer |  | info@tilganga.org | BabuKajiPancha  Hari Krishna Nakarmi | Senior Helper Officer | 9841371720  9841252551 |
| 4 | **Nobel Hospital** | **Krishna Bdr. Nepali** | Hospital Manager | 9843102920 | info@nobelhospital.com | KapilSubedi  Manoj Khadka  Dhiraj Niraula | Driver  Driver  HK Incharge | 9841919051  9851200615  9819000334 |
| 5 | **Kantipur Hospital** | **Dr. A.B. Hamal** | Medical Registrar | 9851077073 |  | Santosh | Runner | 9813826169 |
| 6 | **Venus Hospital** | **Sikshya Neupane** | Admin Officer | 9849731208 |  | 1. JagatRegmi  2.Sanam Chaulagain  3. PradeepKhatri | Maintenance  Maintenance  Security | 9867295393  9817362786  9824138398 |
| 7 | **Bharosha Hospital** | **Surya Prasad Acharya** | Administration | 9849184809 | Surya\_acharya@hotmail.com | GunjaBdr. Rana  ShyamBdr, Bhujel |  | 9841513929  9812232732 |
| 8 | **Everest Hospital** | **Dipak Baral** | AdminChief | 9841348081 | everesthospital@gmail.com | Ram Krishna | Driver | 9849595046 |
| 9 | **HAMS Hospital** | **AnirudraDahal** | AdminOfficer | 9843703036 | info@hamshospital.org | HariBudhathoki  AmritKarki | Runner  Runner | 9841692414  9741331006 |

**EPIDEMIC DISASTER MANAGEMENT AND TRIAGE SYSTEM**

**TRIAGE**

**In-front of ER Gate**

**Triage By Triage Officer**

**MO/PHYSIOTHERAPIST**

**Staff from GW - 1**

**Nursing Co-coordinator- 3rd Yr- 1**

**BLACK ZONE**

**Morgue/Near Morgue**

**YELLOW ZONE**

**Emergency YELLOW area**

**RED ZONE**

**Emergency RED area**

**GREEN ZONE**

**OPD area**

**AREA HEAD**

**MDGP or INCHARGE MO OR ORTHOPAEDICIAN**

**AREA HEAD**

**Senior MO/Gynecologist**

**Staffs from**

**WA- 2**

**Security- 1**

**AREA HEAD**

**Nursing In-Charge**

**Staffs from**

**Staff from OPD- 2**

**Dental- 2**

**Nursing student/vol.- 2**

**Nursing co-ordinator-1st yr-1**

**Staffs from**

**Staff from GW- 1**

**HDCU - 1**

**Nursing co-ordinator-2nd yr-1**

**Staffs from**

**ER/ICU - 4-6**

**Nursing co-ordinator-4th yr-1**

**MO /OTHOPAEDICIAN- 2**

**AREA HEAD**

**MO or Dental Surgeon or OPD In-charge**