Policy Title: MOH Standardized Code Orange Policy.	
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Approvals	**Signature**
Approved by: Council of Emergency Medicine.	
Approved by: MOH Committee on Hospital Clinical Services and Policies.	
Approved by: MOH Technical Directorate.	
Approved by: MOH Assistant Undersecretary of Technical Affairs.	

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1. Purpose:

1.1 The objective of this policy is to guide all involved personnel (committees, departments, units or teams) in the MOH health care facilities (primary, secondary and tertiary with respective supportive services) to the organized, triaged and staged care of patients involved in external disasters ensuring the most efficient utilization and designation of resources and thus optimal care provision and best outcome to the patient population at times of disasters and mass casualty incidents.

2. Policy Statement:

2.1 External hospital disasters are incidents, occurring outside the hospital's physical boundaries that impact its ability to function, or require the hospital to respond to a surge in patients. Such disasters may result in disruption of hospital functions in which the demands exceed the hospital resources. Disasters may contribute to patients' morbidity and mortality. Code Orange is a designated agreed upon color code, which when activated within a health care facility, is aimed at initiating preparedness in such disasters to ensure that the number of resources, in recipient hospitals and the respective health care system is sufficient to maintain a high-quality standard of care to all patients in need of those resources.

2.2 START triage stands for Simple Triage and Rapid Treatment (or Transportation), a fast and efficient system used by first responders during mass casualty incidents (MCIs). It helps categorize victims into four colored groups, black (expectant), red (immediate), yellow (delayed) and green (walking wounded) based on their injuries to ensure the sickest patients receive immediate, life-saving care. The assessment focuses on respiration, perfusion, and mental Status, and can be completed in approximately 30 seconds per patient, often without requiring any equipment. The START triage system will be applied in code orange activation over this policy accordingly.

2.3 Code orange is the initial step in the External Hospital Disaster Plan activation.

3. Definitions:

3.1 **External Hospital Disaster:** refers to an incident occurring outside the hospital's physical boundaries that impacts its ability to function or requires the hospital to respond to a surge in patients.

3.2 **MCI: Mass Casualty Incident:** describes an incident in which the resources of emergency medical services , such as personnel and equipment are overwhelmed by the number and severity of casualties.

3.3 **Code Orange:** is a color code assigned to inform all health care employees that there is a mass casualty incident/external disaster.

3.4 **First responder:** the designated first person (e.g. a field officer, EMS or HCW on incident site) to witness or called to witness or called to evaluate a disaster or mass incident and relay the information to the recipient MOH HCF accordingly.

3.5 **PA system:** Public Announcement System.

3.6 **Repeat x3:** Repeat 3 times.

3.7 **MOH**: Ministry Of Health.

3.8 **HCF**: Health Care Facility.

3.9 **HCW:** Health Care Worker.

3.10 **BLS:** Basic Life Support.

3.11 **ATLS:** Advanced Trauma Life Support.

3.12 **PHTLS:** Prehospital Trauma Life Support.

3.13 **ACLS:** Advanced Cardiac Life Support.

3.14 **ED**: Emergency Department.

3.15 **MOI:** Ministry Of Interior.

3.16 **Incident Commander:** the incident commander is the overall leader responsible for managing the response, establishing command, assessing the situation, and determining the priorities for resource allocation and patient care.

3.17 **Backup Team:** a team of health care providers designated by their respective department/unit leadership, to provide backup/support to their index facility services when deemed necessary.

3.18 **Field Team:** a team of health care providers (other than the backup team) designated by their respective department/unit leadership, to provide backup/ supportive services to any destination/site outside their index facility (e.g. incident site, other primary or secondary health care facilities), when deemed necessary.

3.19 **EMS:** Emergency Medical Services.

3.20 **CMO:** Chief Medical Officer.

3.21 **ICU:** Intensive Care Unit.

3.22 **HDU:** High Dependency Unit.

3.23 **TSH:** Thyroid Stimulating Hormone.

3.24 **HBA1C:** Glycated Hemoglobin.

3.25 **IV:** Intravenous.

3.26 **IM:** Intramuscular.

3.27 **PHC:** Primary Health care.

3.28 **ECG:** Electrocardiogram.

3.29 **OT:** Operative Theatre.

3.30 **IT:** Information Technology.

3.31 **STAT:** an abbreviation from the Latin word statim, meaning "immediately".

4. Procedures:

4.1 Source of Code Orange Activation:

Upon receipt of information, from the first responder(s), regarding an external or mass casualty incident, the following are the personnel, within a health care facility, designated to evaluate, decide and activate code orange:

4.1.1 The recipient health care facility emergency room team leader (or designee).

4.1.2 The recipient health care facility emergency department head (or designee).

4.1.3 The chair of the council of emergency medicine.

4.2 Criteria for Code Orange Activation (one or more):

4.2.1 The expected number of incoming transfers from the incident site, requiring care, to match, or exceed, the emergency department's available bed capacity at the time of the call.

4.2.2 The predicted number of incoming transfers from the incident site, requiring care, is expected to match or exceed 35% of the emergency department's total bed capacity.

4.2.3 The predicted number of incoming transfers from the incident site, requiring care, is expected to match or exceed the emergency department's total bed capacity.

4.2.4 The predicted number of incoming transfers from the incident site, requiring care, is expected to match or exceed 3-5% of the recipient health care facility total bed capacity.

4.2.5 The site of the incident is a public/private facility of expected affected occupancy exceeding 35% of the recipient health care facility emergency department's total bed capacity.

4.2.6 The site of the incident is a public/private facility or building of expected affected occupancy exceeding 3-5% of the recipient health care facility total bed capacity.

4.3 The Process of Code Orange Activation:

4.3.1 Roles and Responsibilities of The First Responders:

4.3.1.1 Upon arrival and assessment of the incident and incident site, the designated field officer(s), or first responder(s), must notify the receiving hospital resuscitation room or emergency room team leader (attached contact numbers per facility).

4.3.1.2 Information relayed to the recipient health care facility ED team leader, should be detailed using the **M.E.T.H.A.N.E method**, as follows:

4.3.1.2.1 **M:** Mass incident declared.

4.3.1.2.2 **E:** Exact location.

4.3.1.2.3 **T:** Type of incident.

4.3.1.2.4 **H:** Hazards present.

4.3.1.2.5 **A:** Access and egress.

4.3.1.2.6 **N:** Number of casualties and severity.

4.3.1.2.7 **E:** Emergency services required.

4.3.1.3 The **field** officer(s) or first responder(s) is expected to provide updates on the situation on site, number of transfers and the condition of those transferred en route or pending transfer on a regular basis.

4.3.1.4 The field officer(s) or first responder(s) and designated EMS staff responsibilities Include assessment, resuscitation and management of the incident related patient(s) in accordance with BLS/ ATLS /PHTLS and or delegated official duties, responsibilities and training. Field management should not delay transfer and standard EMS/Ambulance service policies should be adhered to at all times.

4.3.1.5 The field officer(s) or first responder(s) maybe instructed to direct the EMS, transporting patients/casualties, to the recipient health care facilities based on the agreed the START injury acuity triaging color code, and/or the directions of the recipient HCF emergency room team leader (e.g. the more severe cases to the closest HCF, the less severely injured to the back up facility when deemed so).

4.3.2 **Roles and Responsibilities of The ED Team Leader:**

4.3.2.1 Upon receipt of the notification from the field officer or first responder, the team leader should estimate if the criteria for code orange activation is met and the availability of the necessary resources.

4.3.2.2 If criteria for code orange activation is expected/predicted to be met, the team leader should activate/declare code orange and inform the following:

4.3.2.2.1 Chair of the ED (or designee) accordingly.

4.3.2.2.2 Senior registrars (or designee) of the facility respective services (e.g. medical, surgical and anesthesia departments).

4.3.2.2.3 Assistant head nursing officer of the facility.

4.3.2.2.4 Public Relation Officer.

4.3.2.2.5 MOI security point/office/regional station.

4.3.2.2.6 HCF security personnel.

4.3.2.3 The team leader should ensure the availability of resources necessary for the number of incoming patients.

4.3.2.4 The team leader should inform the chair of ED, or designee, and or the field officer/site command officer, about limitations of resources and the need to redirect cases to back up health care facilities in accordance with the table set in this policy.

4.3.2.5 The team leader should ensure the resuscitation room(s), in the ER, shall be cleared for the arrival of critically ill patients, as deemed possible, by disposition of the respective patients accordingly (e.g. admission, discharge or transfer to another facility).

4.3.2.6 The team leader should ensure the observation beds, in the ER, shall be cleared for the arrival of patients (from the incident), as deemed possible, by disposition of the respective patients in the ER accordingly (e.g. admission, discharge or transfer to another facility).

4.3.2.7 The team leader should ensure that multiple triage points are designated with the appropriate/necessary trained personnel and resources allocated to them.

4.3.2.8 The team leader should ensure that the multiple triage points are equipped with the necessary color signs (e.g. bands, cards, etc.) required for triaging patients in accordance with ATLS mass casualty incident (MCI) standards as follows:

4.3.2.8.1 **Red:** critically ill and need to be seen immediately.

4.3.2.8.2 **Yellow:** moderately ill and need to be seen within 30 minutes.

4.3.2.8.3 **Green:** minimally ill and shall be seen after the red and yellow color-coded patients.

4.3.2.8.4 **Black:** dead on arrival.

4.3.2.9 The team leader should ensure that the areas designated by the HCF code orange policy/MCI plan, to receive the triaged patients in accordance with article **4.3.2.8**, are ready (in personnel and resources) for receipt of incoming patients.

4.3.2.10 The team leader should ensure that the cases triaged in accordance with article 4.3.2.8 are directed to the respective locations designated in the health care facility's code orange/MCI policy/plan points.

4.3.2.11 The team leader may delegate tasks and responsibilities to HCP member of team with oversight to fulfill the above set responsibilities when deemed fit and possible.

4.3.3 **Roles and Responsibilities of The ED Chair:**

4.3.3.1 Upon Code Orange activation, the ED chair must assume the role of "Incident Commander".

4.3.3.2 The ED chair must notify the Chief Medical Officer (CMO).

4.3.3.3 The ED chair will hand over the responsibilities of incident commander to the CMO, or designee, once the CMO, or designee, is present, informed and assumes command responsibilities.

4.3.3.4 The ED chair must ensure articles **4.3.2.2** to **4.3.2.10** are implemented.

4.3.3.5 The ED chair must regularly follow up the ER, and HCF, bed and resource status, identifying and declaring limitations of resources and the need to redirect cases to back up health care facilities, when deemed so, in accordance with the table set in this policy.

4.3.3.6 The ED chair must assess the situation for the need to activate back-up teams and Hospital Mobile teams. (Refer Appendix B.1 for complete MOH Standardized Back-up Hospital List).

4.3.3.7 The ED chair (or designee) must oversee, and assist in, guiding and directing personnel and resources to areas or populations, within the HCF, in need (with the respective clinical and supportive chairs of departments, or designees).

4.3.4 **Roles and Responsibilities of The Chief Medical Officer (CMO):**

4.3.4.1 Upon Code Orange activation and being informed by the ED chair, the CMO is to be present in the hospital and assume the responsibilities as "Incident Commander".

4.3.4.2 The CMO shall inform the hospital director who will, in turn, inform the following departments, to implement their external disaster plans, and convene with the CMO for management plans, updates and debriefs:

4.3.4.2.1 Public Relations.
4.3.4.2.2 Ministry of Interior representative in the HCF.
4.3.4.2.3 Engineering and maintenance.
4.3.4.2.4 Transportation and hospitality.
4.3.4.2.5 Information and technology.
4.3.4.2.6 Finance.

4.3.4.3 The CMO shall convene with the heads of the following health care facility departments, assessing the situation, and ensuring all departments activate their respective External Hospital Disaster Plans:

4.3.4.3.1 Heads of clinical departments and units (ED, general surgery, medical, radiology, etc.).
4.3.4.3.2 Head of laboratory and blood bank.
4.3.4.3.3 Head of biomedical engineering.
4.3.4.3.4 Head of planning and quality council.
4.3.4.3.5 Public health office.
4.3.4.3.6 Infection control department.
4.3.4.3.7 Radiation protection directorate.
4.3.4.3.8 Kuwait Poison Control Centre.
4.3.4.3.9 Kuwait Centre for Disease Prevention and Control.

4.3.4.4 The CMO shall provide the MOH leadership with updates through the designated MOH liaison officer and the MOH media representative.

4.3.5 **Roles and Responsibilities of The Chairs of Clinical and Supportive Departments:**

4.3.5.1 Upon notification of a mass casualty incident and/or code orange activation, by the ED team leader, the most senior on call members of the HCF clinical and technical units/departments (e.g. medical, surgical, radiology, labs etc.) should inform the head/chairs of their respective units/departments.

4.3.5.2 All services/departments/units with admission privileges and inpatient services should expedite the following:

4.3.5.2.1 The processes of triage for admission/discharge/transfer of emergency patients.
4.3.5.2.2 The triage and discharge/transfer of stable ward patients.
4.3.5.2.3 The clearance of the respective wards' beds for incoming incident related patients.

4.3.5.2.4 Assessment and preparation of the necessary resources for incoming incident related patients.

4.3.5.2.5 The assessment, clearance and preparation of the auxiliary locations in the HCF (e.g. operation theaters, post-operative recovery rooms, high dependency units, infusion rooms etc.).

4.3.5.3 All services/departments/units with admission privileges and inpatient services should update the ED Team Leader, and/or incident commander, of the available beds and resources designated for the mass casualty incident/ Code Orange.

4.3.5.4 The back-up teams from the departments are to be allocated to assist in the Code Orange and patient care.

4.3.5.5 All services/departments/units with admission privileges and inpatient services/wards should re-allocate their department's resources (e.g. space, equipment, and manpower) when deemed necessary to assist in patient care and accommodate Code Orange/Incident patient needs.

4.3.5.6 Operation/Interventional theatre staff shall inform their staff in-charge of the code orange activation, hold calling on elective and urgent cases until instructed otherwise by the senior on-call surgeon/Interventionist.

4.3.5.6.1 Operation/Interventional theatre staff shall designate the emergency rooms for mass incident related patients/procedures and designate rooms for emergent non-incident related surgeries/procedures (and ensure their preparation).

4.3.5.7 The staff nurse in charge shall activate the mass incident on call rota and back up nursing staff to ensure manpower is available, when deemed necessary, for the mass incident designated operating/Interventional room(s) as needed.

4.3.5.8 The seniors on-call members of the general surgery department (and respective subspecialties) and the anesthesia department are responsible for:

4.3.5.8.1 Cancellation and rescheduling of elective cases.

4.3.5.8.2 Triaging the flow of emergent/urgent non-incident related procedures to their designated operation rooms.

4.3.5.8.3 Triaging the flow of emergent/urgent incident related procedures to their designated operation rooms.

4.3.5.8.4 Re-allocation of their respective department resources (e.g. equipment, pharmaceuticals, and manpower) to accommodate Code Orange activation demands.

4.3.5.8.5 Maintain communication with supportive services of needs, requirements and progress (e.g. laboratory, pharmacy, radiology, ICU/HDU/recovery room).

4.3.5.9 For proper distribution of manpower and resources, during a code orange,

and to avoid early burnout of the involved departments, the chairs of clinical and supportive departments should put into effect the mass incident/hospital disaster on call schedule ensuring steady distributed flow of manpower for patient care over a period extending beyond the incident (e.g. >72-96 hours).

4.3.5.10 The ER Head Nurse or designee shall inform the assistant Head Nursing Officer who will in turn proceed with the following see algorithm:

4.3.5.10.1 Activation of nursing back-up teams.

4.3.5.10.2 Notifying on-call allied services (radiology, laboratories, and pharmacy).

4.3.5.10.3 Notifying Hospital Nursing Director.

4.3.6 **Roles and Responsibilities of The HCF Laboratory:**

4.3.6.1 Upon activation of Code Orange, the on-call senior laboratory technician (or designee) shall inform their respective superiors/chair and ensure the following:

4.3.6.1.1 Activate the laboratory disaster plan.

4.3.6.1.2 Halt the processing of all tests originating from the following sources/sites in accordance with laboratory disaster policy**:**

4.3.6.1.2.1 Outpatient.

4.3.6.1.2.2 Primary health care facilities.

4.3.6.1.2.3 Wards (tests labelled as follow up, investigative, Non stat, non-urgent, non-emergent e.g. TSH, HBA1c).

4.3.6.1.3 Continue processing tests labeled urgent, emergent or stat.

4.3.6.1.4 Ensure system checks, reagents and consumables are available for the incoming case flow.

4.3.6.1.5 Ensure a baseline stock of blood products is available.

4.3.6.1.6 Ensure available stock of blood products to support a massive transfusion protocol, if activated.

4.3.6.2 Upon activation of Code Orange, the laboratory respective chair should ensure the following:

4.3.6.2.1 To activate the disaster plan call rota.

4.3.6.2.2 To ensure halting the processing of all pending elective, non-urgent, non-emergent, and non-stat tests (originating from primary health care, outpatient, or ward settings).

4.3.6.2.3 To activate the disaster patient identification protocol (e.g. using HCF issued medical record numbers, rather than civil ID, for sample identification).

4.3.6.2.4 To communicate with the Central Blood Bank, relaying the activation of code orange, and requesting standby blood products (as expected or deemed necessary).

4.3.6.2.5 To ensure blood products stored in the index HCF are sufficient to

support a massive transfusion protocol, if activated, pending further supplies from the Central Blood Bank.

4.3.6.2.6 To ascertain reagents/consumables stocks are sufficient for 2-4 weeks.

4.3.6.2.7 To communicate with the MOH central supplying facilities/stores/departments when deemed necessary for restocking of reagents/consumables.

4.3.6.2.8 To activate the laboratory business continuation plan if deemed necessary.

4.3.7 **Roles and Responsibilities of The HCF pharmacy:**

4.3.7.1 Upon activation of Code Orange, the on-call senior pharmacist (or designee) shall inform their respective superiors/chair and ensure the following:

4.3.7.1.1 Activate the pharmacy disaster plan (maintaining communication with central stores, pharmacies of other designated back up HCF, transportation etc.).

4.3.7.2 Upon notification of a mass casualty incident and/or code orange activation, by the ED team leader, the most senior on call member of the HCF pharmacy shall ensure all necessary medications (e.g. epinephrine, atropine, IV Fluids, opioids) are sufficiently stocked for the needs of incoming patients and the functioning of the HCF.

4.3.8 **Roles and Responsibilities of The HCF Security Personnel:**

4.3.8.1 Upon activation of Code Orange, the security personnel shall ensure that all hallways are clear and not obstructed.

4.3.8.2 The security personnel shall ensure visitors are not allowed in the health-care facility until the code is cleared and visitation hours are restated by the HCF leadership (director/CMO).

4.3.8.3 The HCF security personnel should prevent/contain/diffuse any incidence of violence or active disruption to the ongoing medical care occurring in the HCF during code orange.

4.3.8.4 If an incident/confrontation/altercation is escalating, or fails to be contained/diffused, the HCF security personnel should report to 112/dispatch, or the MOI designated security point (if available on HCF site) any incidence of violence or active disruption of medical care occurring in the HCF during code orange.

4.4 **Criteria for referral/redirection of incoming incident related patients to MOH designated backup hospitals:**

4.4.1 Redirection may be total or partial/triaged (based on color code or acuity).

4.4.2 The indications for redirection/referral maybe is subject to the discretion and judgement of the incident commander (or designee) based on any of the following criteria:

4.4.2.1 The expected number of incoming transfers from the incident site, requiring care, exceed the emergency department's available bed capacity at the time.

4.4.2.2 The predicted number of incoming transfers from the incident site, requiring care, is expected to exceed the emergency department's total bed capacity.

4.4.2.3 The predicted number of incoming transfers from the incident site, requiring care, is expected to exceed 70 % of the emergency department's total bed capacity.

4.4.2.4 The predicted number of incoming transfers from the incident site, requiring care, is expected to exceed 10 % of the recipient health care facility's total bed capacity.

4.4.2.5 The site of the incident is a private/public facility of expected affected occupancy exceeding 70 % of the recipient health care facility emergency department's total bed capacity.

4.4.2.6 The site of the incident is a private/public facility or building of expected affected occupancy exceeding 10 % of the recipient health care facility total bed capacity or 70% of ER total bed capacity.

4.4.3 **Tiers of MOH incident/disaster designated facilities for referrals of incident related patients to:**

4.4.3.1 **Tier 1:** The designated recipient/regional secondary HCF.

4.4.3.2 **Tier 2:** The backup designated secondary HCF (nondisaster cases referral or color-coded incident related patients).

4.4.3.3 **Tier 3:** The regional designated primary health care facilities (nondisaster cases referral and green and yellow color-coded patients).

4.4.3.4 **Tier 4:** The primary health care facilities of the designated back up health district/facility.

4.4.3.5 **Tier 5:** Field teams to designated sites as necessary (e.g. other HCF, PHC etc.).

4.4.4 **Criteria of Patient Referral from Secondary HCF To Designated Back Up PHC facilities In Code Orange:**

4.4.4.1 Lack of resources (human and/or facility) in the recipient secondary HCF to provide services for nonincident related walk in patients.

4.4.4.2 Lack of resources (human and/or facility) in the recipient and back up secondary HCF to provide services for incident related patients designated the color code green.

4.4.4.3 Lack of resources (human and/or facility) in the recipient and back up secondary HCF to provide services for incident related patients designated the color code yellow.

4.5 **Primary Health care Facilities in Code orange:**

4.5.1 The PHC facilities of the different MOH districts in Kuwait provide tier 3 and 4 support for secondary MOH health care facilities receiving mass incident patients.

4.5.2 The PHC leadership/director of the regional health districts, being a member of the regional health district external disaster committee, is responsible for designation, and setting up of the PHC facilities for support and back up of MOH secondary and tertiary HCF during disasters. They are furthermore responsible for the planning coordination and implementation of the plans accordingly at times of external disasters.

4.5.3 The patient population referred to PHC disaster designated facilities by the regional secondary HCF In Code Orange include the following:

4.5.3.1 Non-incident related stable walk in patients.

4.5.3.2 Incident related patients designated as green in color code.

4.5.3.3 Incident related patients designated as yellow in color code.

4.5.4 **Resources Required in PHC facilities Designated for Tier 3 and 4 External Disasters Referrals:**

4.5.4.1 Health care services in nonincident settings provided 24/7.

4.5.4.2 Sufficient HCP manpower to ensure 24/7 services at times of external disasters.

4.5.4.3 Observation/Resuscitation Room(s).

4.5.4.4 Facility electricity backup generator(s).

4.5.4.5 Proximity to an MOH secondary/tertiary HCF.

4.5.4.6 Laboratory services (with 24/7 service capabilities).

4.5.4.7 Pharmacy (with 24/7 service capabilities).

4.5.4.8 Basic radiological services (if possible).

4.5.4.9 Oxygen Sources/Supply.

4.5.4.10 Vital Signs Monitors.

4.5.4.11 Crash Carts, hemodynamic and airway support equipment and competencies.

4.5.4.12 Designation as by regional and central leadership as a disaster back up PHC facility.

4.5.4.13 Designated with back up MOH secondary/regional facility for transfer of complex patients.

4.5.4.14 HCP with valid licenses to practice and certification in BLS/ACLS.

4.5.5 **Services Provided in PHC facilities Designated for Tier 3 and 4 External Disasters Referrals:**

4.5.5.1 IV hydrations.
4.5.5.2 IV antibiotics.
4.5.5.3 IM analgesia.
4.5.5.4 Pulmonary Nebulization.
4.5.5.5 ECG.
4.5.5.6 Oxygenation with face mask.
4.5.5.7 Wound assessment, stitching and dressing.
4.5.5.8 Laboratory services.
4.5.5.9 Basic radiology services (when available in some facilities, e.g. X-rays, ultrasound).
4.5.5.10 Home care services.
4.5.5.11 Emergency room/observation room care.
4.5.5.12 Hemodynamic and airway support capabilities/equipment and competencies.

4.6 **Ending a Code Orange:**

4.6.1 Criteria to terminate/end code orange in a code activating HCF should include one or more of the following:

4.6.1.1 Resolution of the incident(s) resulting in casualties.
4.6.1.2 No further expected incoming casualties/patients.
4.6.1.3 Management and disposition of all the incident related casualties (in index and/or back up HCF).
4.6.1.4 Depletion of resources and maximum allocated bed capacity, for code orange patients, in the code activating/recipient HCF and the redirection of incoming patients to back up facilities.

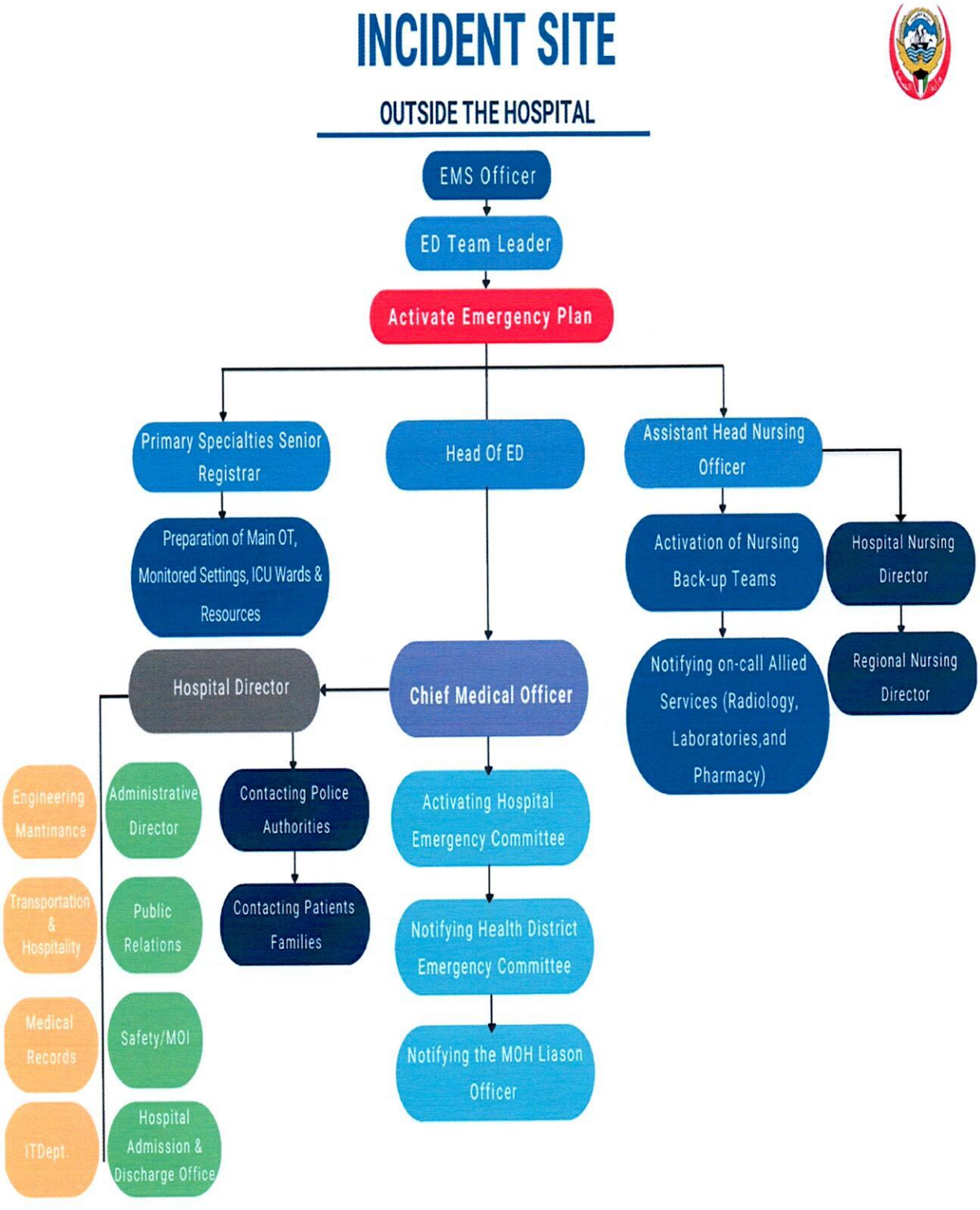
4.6.2 When the criteria for ending code orange is met, the incident commander is to declare the order and inform a designee (ED chair, physician or nurse) to declare the end of code orange.

4.6.3 Following the decision to end Code Orange, a code shall be cleared via the PA system and repeated three times (e.g. "Code Orange Cleared", declared three times).

4.7 **All Code Orange activations must be treated as genuine, followed up and investigated.**

4.8 **The incident command team** will coordinate with the Hospital Quality Surveillance team to organize a debrief of each activation with key personnel and follow-up with an After-Action report.

Appendix A - **MOH - Code Orange Incident Site**



EXTERNAL DISASTERS NOTIFICATION CHECKLIST

EMS Officer

Name:

Number	Action	Checklist	Time and Date	Notes
1	Notifying ED Team Leader at Hospital	○ Done		Name:

1

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

ED Team Leader

Name:

Number	Action	Checklist	Time and Date	Notes
1	Activated Emergency Plan	○ Done		
2	Notifying Head of ED	○ Done		Name:
3	Notifying Primary Specialties Senior Registrars	○ Done		Name(s):
4	Notifying Assistant Head Nursing Officer	○ Done		Name:

2

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

Head of ED

Name:

Number	Action	Checklist	Time and Date	Notes
1	Notifying CMO	○ Done		Name:
2	Notifying Head Emergency Medicine Council	○ Done		Name:
3	Notifying Heads Back-up Emergency Departments	○ Done		Names:

3

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

Primary Specialties Senior Registrars

Name:

Number	Action	Checklist	Time and Date	Notes
1	Preparing Main Operating Theatres, ICU and Clinical Wards	○ Done		
2	Notifying Head of Primary Specialties Departments	○ Done		Name(s):
3	Activation of Primary Specialties Back-up Teams	○ Done		Name(s):

4

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

Assistant Head Nursing Officer

Name:

Number	Action	Checklist	Time and Date	Notes
1	Activation of Nursing Back-up Teams	○ Done		
2	Notifying on-call Allied Services (Radiology, Laboratories, and Pharmacy)	○ Done		
3	Notifying Hospital Nursing Director	○ Done		Name:

5

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

Hospital Nursing Director

Name:

Number	Action	Checklist	Time and Date	Notes
1	Notifying Regional Nursing Director	○ Done		Name:

6

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

Chief Medical Officer

Name:

Number	Action	Checklist	Time and Date	Notes
1	Activating Hospital Emergency Committee	○ Done		Name:
2	Notifying Health District Emergency Committee	○ Done		Name:
3	Notifying the MOH Liaison Officer	○ Done		Name:
4	Notifying Hospital Director	○ Done		Name:

EXTERNAL DISASTERS NOTIFICATION CHECKLIST

Hospital Director

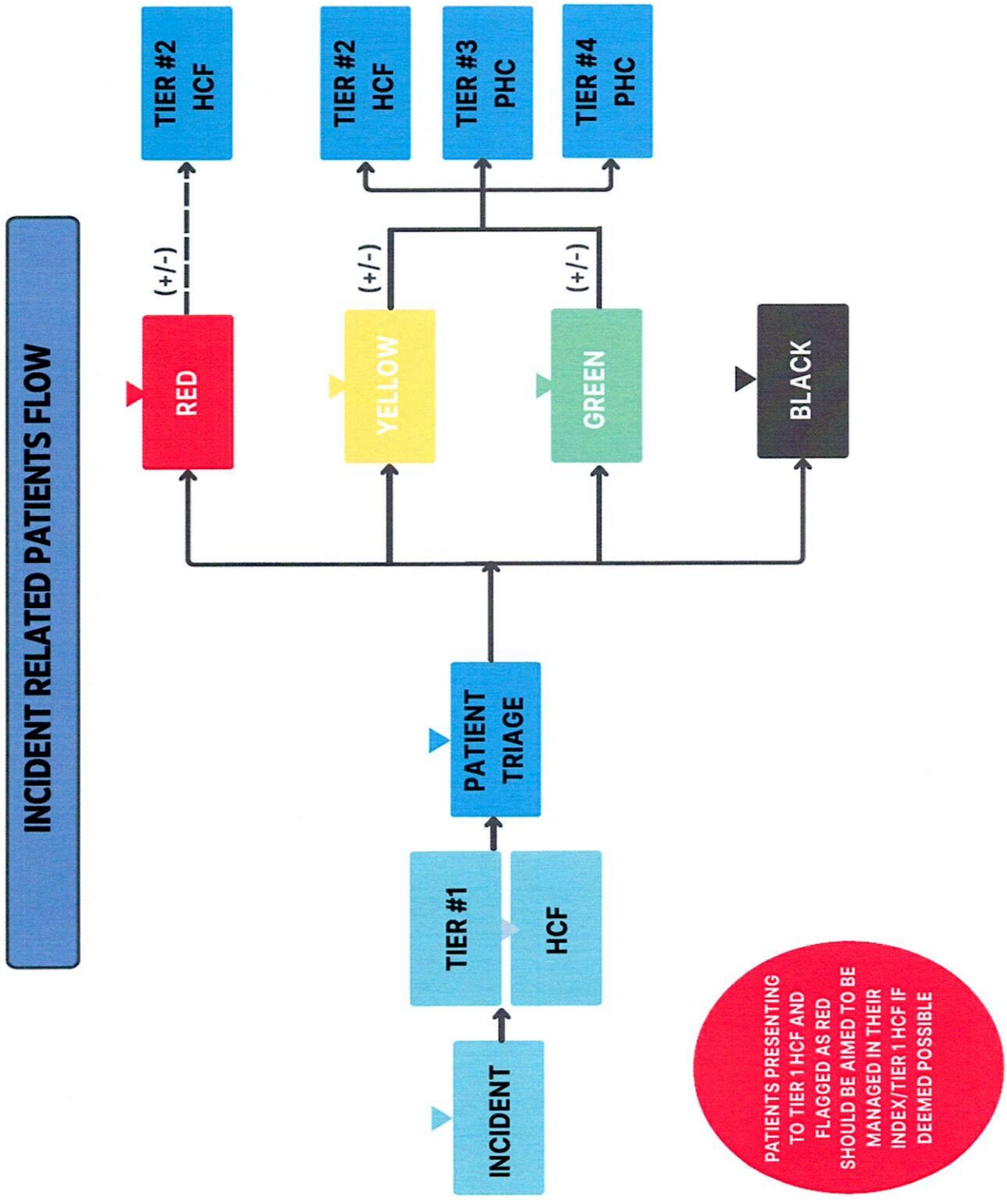
Name:

Number	Action	Checklist	Time and Date	Notes
1	Contacting Police Authorities	○ Done		Name:
2	Contacting patients' families	○ Done		Name(s):

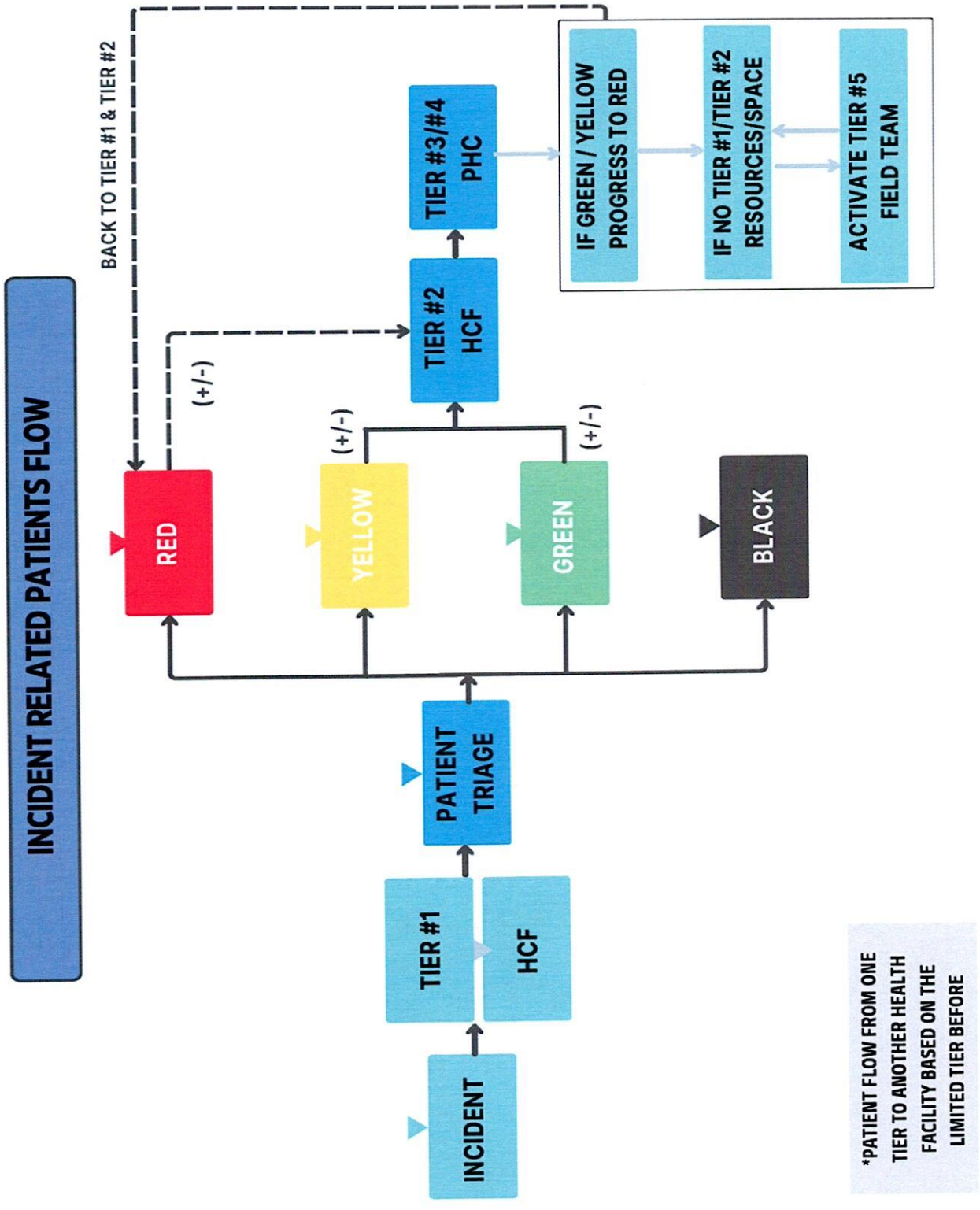
EXTERNAL DISASTERS NOTIFICATION CHECKLIST

3	Notifying Administrative Director	○ Done		Name:
4	Notifying Public Relations	○ Done		Name:
5	Notifying Safety/MOI	○ Done		Name:
6	Notifying Hospital Admission and Discharge Office	○ Done		Name:
7	Notifying Engineering and Maintenance	○ Done		Name:
8	Notifying Transportation and Hospitality	○ Done		Name:
9	Notifying Medical Records	○ Done		Name:
9	Notifying IT Dept.	○ Done		Name:

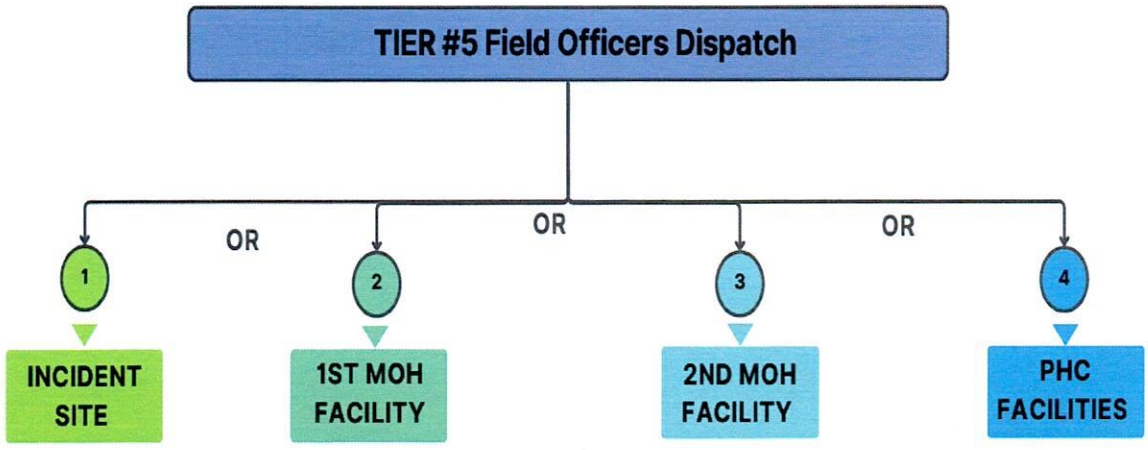
Appendix B - **MOH - Code Orange Patient Triage - Flow chart 1.**



Appendix C - **MOH - Code Orange Patient Triage - Flow chart 2.**



Appendix D - **MOH - Code Orange Incident Dispatch Flow.**



Appendix E – **MOH - Designated Backup hospital scheme.**

HOSPITAL	FIRST BACK-UP	SECOND BACK-UP
FARWANIYA	SABAH	JAHRA
JAHRA	FARWANIYA	SABAH
ADAN	MUBARAK	FARWANIYA
AMIRI	MUBARAK	ALSABAH
MUBARAK	AMIRI	ADAN
SABAH	AMIRI	FARWANIYA
JABER	MUBARAK	FARWANIYA
SABAH ALAHMAD CENTER	ADAN	MUBARAK

Appendix F - **MOH - Hospital resuscitation / emergency room contact numbers.**

RESUSCITATION ROOM CONTACT NUMBERS

Amiri	**MKH**	**Farwaniya**	**JAH**	**Adan**
22468869	25310410	24892508	25305093	23966870
Jahra	**Al Sabah Medical**	**Al Sabah Surgical**	**Kuwait Toxicology Center**	**Sabah Al Ahmad**
24593938	24617208	24617123	1804774	23600162
	24617209	24617124		