MINISTRY OF HEALTH MALAYSIA

In partnership with Canada

GUIDELINES OF

HUMAN RESOURCE MOBILIZATION DURING PUBLIC HEALTH EMERGENCIES

BY
DISASTER, OUTBREAK, CRISIS, AND EMERGENCY MANAGEMENT SECTOR
PREPAREDNESS, SURVEILLANCE, AND RESPONSE SECTION
DISEASE CONTROL DIVISION
MINISTRY OF HEALTH MALAYSIA
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DIRECTOR GENERAL OF HEALTH

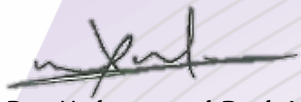
Malaysia is one of the countries that experienced firsthand the challenges of managing the Coronavirus Disease (COVID-19) pandemic in 2020. The rapid rise in COVID-19 cases led to a human resource crisis, especially in the healthcare setting, due to the continuous and overwhelming demand on the workforce. This crisis was primarily caused by the sharp increase in the number of patients in a very short time. Failure to manage human resources effectively can negatively impact clinical management, prevention, and control of the pandemic. In contrast, well-planned management of human resource mobilization can ensure a sustainable and sufficient workforce to meet these demands.

Following the World Health Organization's (WHO) declaration of COVID-19 as a public health emergency, it became necessary to activate response teams across all Malaysian healthcare facilities. Upon activation, a workforce mobilization team, including the Emergency Medical Team (EMT), is required during pandemics to fulfil requests for human resource aid within Ministry of Health Malaysia facilities.

The "Guidelines of Human Resource Mobilization During Public Health Emergencies" cover all aspects of management, including the responsibilities or roles of the team, management of deployment, personal preparedness, and assessment. These guidelines facilitate supervision at district, state, and national levels for any deployment or mobilization of Emergency Medical Team (EMT) needed in affected areas. The mobilization of human resources is imperative to strengthening and establishing resilient healthcare systems.

It is my sincere hope that all staff will find these guidelines useful and utilize them optimally for managing human resource mobilization during public health emergencies, not only during pandemics but also in all hazard scenarios. Lastly, I would like to acknowledge the contributions of the technical working group in developing these guidelines.

Thank you.



Datuk Dr. Muhammad Radzi Abu Hassan
Director General of Health

FOREWORD

DEPUTY DIRECTOR GENERAL OF HEALTH (PUBLIC HEALTH)

First and foremost, I would like to take this opportunity to express my gratitude and appreciation to the organizing committee for the completion of the "Guidelines of Human Resources Mobilization During Public Health Emergencies."

One of the main roles of the Ministry of Health's (MOH) Emergency Medical Team (EMT) is to provide medical and health specialists with the necessary skills, qualifications, and training to support emergency response in affected areas. The need for deployment of Emergency Medical Team (EMT) during any disaster or event is imperative.

Therefore, these "Guidelines of Human Resources Mobilization During Public Health Emergencies" is crucial in enhancing the preparedness and readiness of the Emergency Medical Team (EMT) of the Ministry of Health Malaysia. These guidelines are essential for managing outbreaks, disasters, crises, and emergencies, especially those that can cause emergencies of national or international concern resulting in loss of lives, properties, and financial losses.

The "Guidelines of Human Resources Mobilization During Public Health Emergencies" will fulfil one of ASEAN's strategies to conduct workshops and training related to disaster health management. Thus, these guidelines will serve as a new reference not only in Malaysia but also for ASEAN countries.

Lastly, I would like to convey my sincere gratitude and appreciation to all agencies for sharing their experiences and expertise, and for making the publication of the "Guidelines of Human Resources Mobilization During Public Health Emergencies" possible.

Thank you.

Datuk Dr. Norhayati Rusli
Deputy Director General of Health
(Public Health)

ACKNOWLEDGEMENT

The development of the Guidelines of Human Resource Mobilization During Public Health Emergencies has been a collaborative effort involving the dedication and expertise of numerous individuals and organizations. We would like to extend our heartfelt gratitude to the following:

- Special Acknowledgement
  We extend our heartfelt gratitude to ASEAN Secretariat, Global Affairs Canada (GAC), Datuk Dr. Chong Chee Kheong, Senior Advisor for ASEAN Mitigation of Biological Threats (MBT) Programme and Dr. Novia Kuswara, Project Coordinator for ASEAN Emergency Operations Centre (EOC) Network for their unwavering dedication in developing the guidelines. Your vision and commitment have significantly impacted our progress, inspiring us all to strive for excellence. Thank you for your guidance and support.

- Expert Contributors
  We express our deepest appreciation to the experts in emergency response, disaster management, public health, and related fields who generously shared their knowledge and insights throughout the development of these guidelines. Your expertise has been invaluable in ensuring the relevance, accuracy, and effectiveness of the guidelines.

- Stakeholders and Partners
  We extend our sincere thanks to the governmental agencies, NGOs, academic institutions, and other stakeholders who provided valuable input, feedback, and support during the development process. Your collaboration and commitment to improving emergency response capabilities have been instrumental in shaping these guidelines.

- Reviewers and Evaluators
  We are grateful to the individuals and organizations who diligently reviewed and evaluated the draft guidelines, providing constructive feedback and suggestions for improvement. Your thorough assessments have contributed significantly to the refinement and enhancement of the final document.

- Administrative and Technical Support
  We would like to acknowledge the administrative and technical support teams who facilitated the logistics, coordination, and communication throughout the development and dissemination of the guidelines. Your dedication and professionalism have been indispensable in ensuring the smooth progression of this project.

- Funding Agencies
  We acknowledge the financial support provided by funding agencies and donors that enabled the development, publication, and distribution of these guidelines. Your investment in strengthening emergency response capacities is greatly appreciated and will have a lasting impact on the resilience of communities worldwide.

- End Users
  Finally, we express our gratitude to the end users of these guidelines, including emergency responders, healthcare professionals, policymakers, and community leaders. It is your commitment to excellence and your tireless efforts to safeguard lives and livelihoods that inspire and drive our collective pursuit of preparedness and resilience.

The successful completion of these guidelines would not have been possible without the dedication, collaboration, and support of all those mentioned above. Thank you for your unwavering commitment to excellence in emergency response and for your tireless efforts to build a safer, more resilient

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ABBREVIATIONS

AADMER	ASEAN Agreement on Disaster Management and Emergency Response
AHA Centre	ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management
AHP	Allied Health Professional
APC	Annual Practicing Certificate
ARC	Annual Renewal Certificate
ASEAN-ERAT	ASEAN Emergency Response and Assessment Team
ASEAN	Association of Southeast Asian Nations
ATLS	Advance Trauma Life Support
BLS	Basic Life Support
CAs	Competent Authorities
CBRNe	Chemical, Biological, Radiological, Nuclear, and explosives
CC	Contact Centre
CPRC	Crisis Preparedness and Response Centre
CTN	Commodity Tracking Number
DOCE	Disease, Outbreak, Crisis, and Emergency
DHO	District Health Office
DVI	Disaster Victim Identification
EIP	Epidemic Intelligence Programme
EMR	Emergency Medical Response
EMTCC	Emergency Medical Team Coordination Cell
EMT	Emergency Medical Team
EMT-MDS	Emergency Medical Team-Minimum Data Set
EWARS	Early Warning Response System
GIRN	Government Integrated Radio Network
GPS	Global Positioning System
HADR	Humanitarian Assistance and Disaster Relief
HEOC	Health Emergency Operations Centre
HNA	Health Needs Assessment
HuMOCC	Humanitarian-Military Operations Coordination Cell
ICRC	International Committee of the Red Cross
I-EMT	International Emergency Medical Team
IFRC	International Federation Red Cross and Red Crescent
IHR	International Health Regulations
INSARAG	International Search and Rescue Advisory Group
IMS	Incident Management System
IPC	Infection Prevention and Control
JOCCIA	Joint Operation Coordination Centre for International Assistance
JOCCA	Joint Operations and Coordination Centre of ASEAN
MERT	Medical Emergency Response Team
MHPSS	Mental Health and Psychosocial Support
MMC	Malaysian Medical Council
MNCC	Malaysian National Computer Confederation
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
NADMA	National Disaster Management Agency
NDCC	National Disaster Command Centre
N-EMT	National Emergency Medical Team
NFP	National Focal Point
NGO	Non-Governmental Organization

OCHA	Office for the Coordination of Humanitarian Affairs
OFA	Offer for Assistance
OMC	On-Site Medical Commander
OR	Operation Room
OSCP	On-Scene Command Post
OSOCC	On-Site Operations Coordination Centre
PALS	Paediatric Advanced Life Support
PFA	Psychological First Aid
PHEIC	Public Health Emergency of International Concern
PHEOC	Public Health Emergency Operations Centre
PIC	Person in Charge
PM	Prime Minister
POE	Point of Entry
PPE	Personal Protective Equipment
RAT	Rapid Assessment Team
RRT	Rapid Response Team
RDC	Reception and Departure Centre
RFA	Request for Assistance
SARS	Severe Acute Respiratory Syndrome
SASOP	Standard Operating Procedure for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations
SDCC	State Disaster Command Centre
SME	Subject Matter Expert
SMS	Short Message Service
SOP	Standard Operating Procedure
TOR	Terms of Reference
TPC	Temporary Practicing Certificate
UCC	USAR Coordination Cell
UN	United Nations
UNDAC	United Nations Disaster Assessment and Coordination
UNDSS	United Nations Department of Safety and Security
USAR	Urban Search and Rescue
VOSOCC	Virtual On-Site Operations Coordination Centre
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

CHAPTER 1

INTRODUCTION

1.1 Background

Malaysia has experienced many public health events which include outbreaks, disasters, and Chemical, Biological, Radiological, Nuclear, and explosives (CBRNe) which resulted in loss of lives, property, and financial loss. Therefore, the need for deployment of Emergency Medical Team (EMT) for medical countermeasures and public health actions during any disaster or event is imperative.

In Malaysia, disaster management policy and mechanism are regulated by National Disaster Management Agency (NADMA) Directive No. 1, under the auspice of the NADMA, which is the National Focal Point on Disaster Management, including the international Humanitarian Assistance and Disaster Relief (HADR), based on the mandate of legally-binding the ASEAN Agreement on Disaster Management and Emergency Response (AADMER) and the relevant non-binding United Nations Resolutions. Ministry of Health (MOH) is the National Focal Point Unit for health response and coordination, including EMT coordination.

Crisis Preparedness and Response Centre (CPRC) as the Public Health Emergency Operations Centre (PHEOC) shall coordinate with NADMA on the health response, including the deployment of Malaysia International EMT (I-EMT), and the coordination of the National and Foreign EMT.

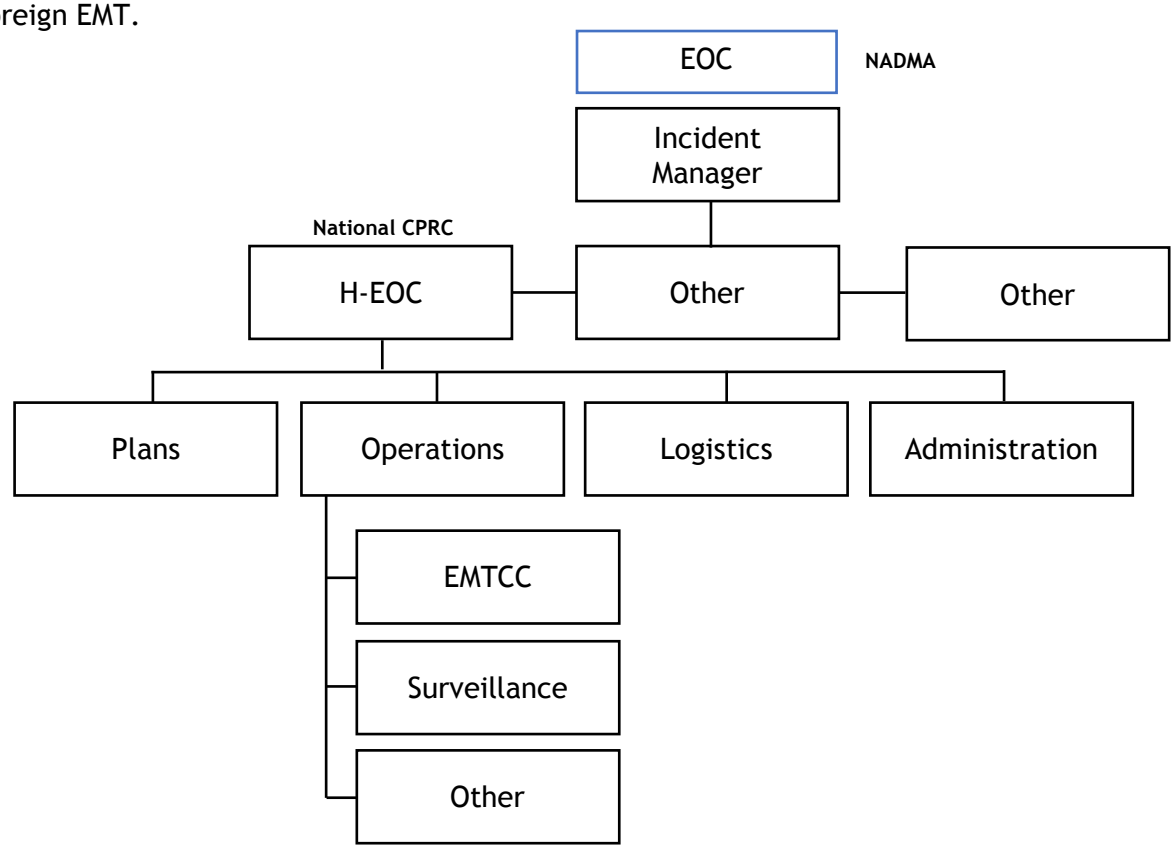


Figure 1.1 EMTCC integration within the Health Emergency Operations Centre

Malaysia continues to develop its disaster management structure and policies to meet emerging and chronic disaster risks, as well as enhance its evolving role as a Humanitarian Assistance and Disaster Relief (HADR) leader in the region.

1.2 Incident Management System (IMS)

Incident Management System or known as IMS is the standardized structure and approach adopted to manage CPRC responses to public health events and emergencies, and to ensure that the organization follows best practices in emergency management. The IMS structure has four (4) core sections that are scalable, expandable, adaptable, and modular needed to appropriately support an emergency response. The early activation of an IMS in the CPRC is an important component of an emergency response, from which other public health actions flow. The EMTCC in relation to the IMS Core Structure is shown in Figure 1.2.

The CPRC coordinates all activities and response related to Disaster, Outbreak, Crisis, and Emergency (DOCE) events based on the IMS Organizational Chart, Roles of Personnel, and Functions of each section. The flexibility of the IMS is supported by the staff mobilization process which brings in the necessary number of people with the right skills and experience to work on a response in a timely manner. During a response, surge capacity is the ability to draw on additional resources to sustain operations and increase capacity.

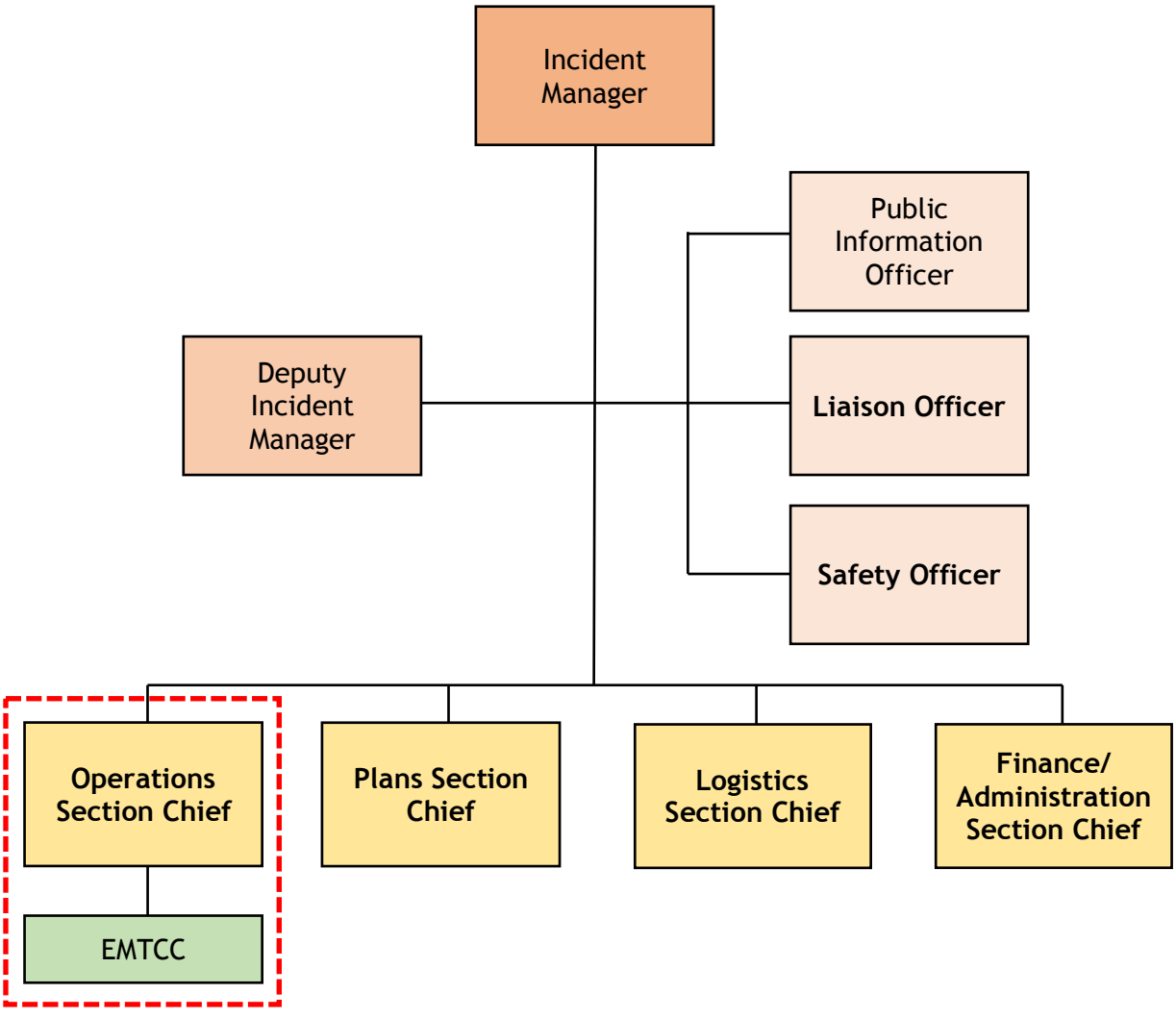


Figure 1.2 EMTCC in Relation to IMS Core Structure

1.3 Public Health Emergencies

Public Health Emergencies can arise from a wide range of causes, including infectious disease epidemics/ pandemics, life-threatening diseases, natural disasters, chemical contamination of the environment, and the release of radiation. In emergencies, large numbers of people may require medical attention, health care systems may be overstretched, and public order may be threatened [International Health Regulations (IHR), 2005].

Some serious public health events that endanger international public health may be determined under the regulation to be Public Health Emergencies of International Concern (PHEIC). The term PHEIC is defined in the IHR (2005) as an extraordinary event which is determined, as provided in the regulations:

i. To constitute a public health risk to other States through the international spread of disease; and

ii. To potentially require a coordinated international response. This definition implies a situation that: is serious, unusual, or unexpected; carries implications for public health beyond the affected State's national border; and may require immediate international action.

The examples for deployment of EMT in public health events/ emergencies in Malaysia are shown in Table 1.1.

Table 1.1 Public Health Events/ Emergencies in Malaysia Which Involved Deployment of EMT

YEAR	EVENTS/ EMERGENCIES	DEPLOYMENT OF EMT
1998 - 1999	Nipah Encephalitis outbreak (Negeri Sembilan)	Multi States Deployment
2002 - 2004	SARS Pandemic	Multi States Deployment
2004	Tsunami (Kedah and Pulau Pinang)	Multi States Deployment
2004, 2005	Humanitarian Mission for Tsunami Disaster in Acheh, Indonesia	Multi States Deployment from both Government and Non-Governmental Organizations (NGOs) Sector
2009	H1N1 Pandemic	Multi States Deployment
2014	Major flood (Kelantan, Terengganu, Pahang, and Johor)	Multi States Deployment
2014	Missing of Malaysia Airlines Flight MH370 and Malaysia Airlines Flight MH17 plane crash	Government and NGOs Deployment
2014	Selangor Flood Humanitarian Mission	Multi States Deployment

YEAR	EVENTS/ EMERGENCIES	DEPLOYMENT OF EMT
2014, 2015	Humanitarian Mission for Ebola Outbreak	MOH and Epidemic Intelligence Programme (EIP) Team Deployment
2016, 2018, 2021	Methanol Poisoning (Selangor, Federal Territory of Kuala Lumpur, Federal Territory of Putrajaya, Perak, and Negeri Sembilan)	MOH and EIP Team Deployment
2017	Rabies (Sarawak)	MOH and EIP Team Deployment
2019	Kim Kim River toxic pollution (Johor)	Multi States Deployment
2019	Poliomyelitis case (Sabah)	MOH and EIP Team Deployment
2020 - 2023	Pandemic COVID-19	Multi States Deployment
2021	Major flood (Kelantan, Federal Territory Kuala Lumpur, Melaka, Terengganu, Perak, Pahang, Negeri Sembilan, dan Selangor)	Multi States Deployment
2022	Batang Kali landslide (Selangor)	Inter-agency Deployment

1.4 Definition of Emergency Medical Team (EMT)

Emergency Medical Team (EMT) is defined as groups of health professionals, including doctors, nurses, paramedics, support workers, and logisticians, who treat patients affected by an emergency or disaster. They come from governments, NGOs, the military, civil protection, international humanitarian networks, and the private-for-profit sector. They work according to minimum standards agreed upon by the EMT community and its partners and deploy fully trained and self-sufficient so as not to burden an already stressed national system (WHO, 2021).

1.5 Objectives

The objectives of this guideline are as follows:

i. To understand the process of deployment of EMT during public health emergencies;

ii. To categorize EMT;

iii. To guide on registration of EMT;

iv. To outline the basic requirements of identified personnel for EMT;

v. To provide information on deployment preparedness;

vi. To explain the procedure for deployment;

vii. To guide EMT on action to be taken upon arrival and on-site operation;

viii. To outline the demobilization process; and

ix. To describe the post-deployment procedure.

1.6 Scopes

The scope of this guideline is to provide guidance on the deployment of EMT to the affected area in terms of:

i. Roles and functions of EMT;

ii. Coordination of deployment;

iii. Deployment process; and

iv. Support.

1.7 Mission Cycle Category

EMT deployment follows five (5) interrelated phases of activity. The mission cycle will help EMT personnel anticipate and plan operational activities in the field, following Disaster Management Cycle. Each chapter in this guideline will discuss the stages of the EMT Mission Cycle (Figure 1.3).

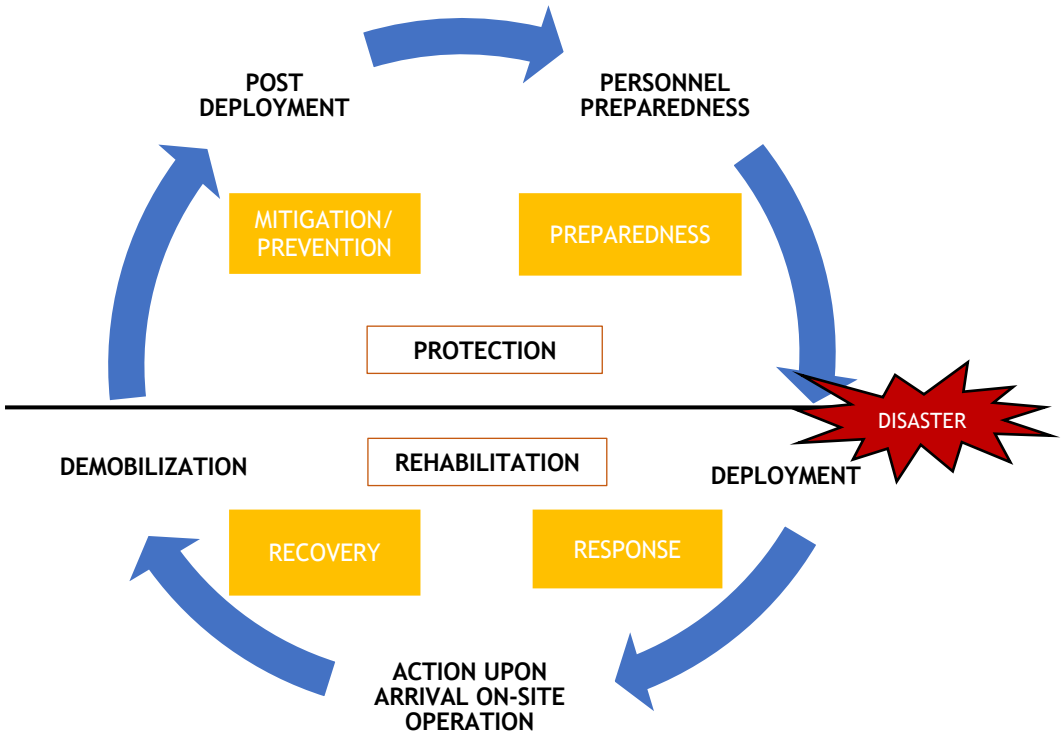


Figure 1.3 EMT Mission Cycle

CHAPTER 2

EMERGENCY MEDICAL TEAM (EMT)

CHAPTER 2

EMERGENCY MEDICAL TEAM (EMT)

The EMT is a group of personnel ready to be mobilized for public health emergencies. It may comprise of:

i. Medical Emergency Response Team (MERT);

ii. Rapid Assessment Team (RAT) and Rapid Response Team (RRT);

iii. Specialist Care Services;

iv. Mental Health and Psychosocial Support (MHPSS) Team;

v. Disaster Victim Identification (DVI) Team;

vi. Subject Matter Expert (SME);

vii. Military personnel; and

viii. NGOs and volunteers, including international humanitarian networks.

2.1 Medical Emergency Response Team (MERT)

A Medical Emergency Response Team (MERT) quickly responds to emergency situations and provides medical care to patients at the scene of an emergency or during transport to a medical facility. MERTs are typically composed of doctors, nurses, Assistant Medical Officers (Physician Assistants), and other supporting staffs who have the necessary training and expertise to administer life-saving care to patients in critical situations.

2.2 Rapid Assessment Team (RAT) and Rapid Response Team (RRT)

Rapid Assessment Team (RAT) is a team mobilized from the nearest District Health Office (DHO) to the incident site immediately upon receiving an alert in order to assess the situation and to provide crucial information for immediate response planning.

Rapid Response Team (RRT) is a predetermined trained team identified based on individual expertise and experience. The team is assembled by matching expertise and event needs in order to provide rapid response in managing the public health events or emergencies.

2.3 Specialist Care Services

During a disaster, specialized medical care is essential to address the specific needs and challenges that arise. These specialized medical professionals work in collaboration with other healthcare providers and emergency response teams to ensure comprehensive care for those affected by the disaster, addressing both immediate and long-term medical needs.

Specialized services may include burn care, dialysis, and care of crush syndrome, maxillofacial surgery, orthoplastic surgery, intensive rehabilitation, maternal health, neonatal and paediatric, transport, retrieval, and others.

Mental Health and Psychosocial Support (MHPSS) Team

Mental Health and Psychosocial Support (MHPSS) Team members should consist of experienced mental health service providers such as registered Counsellor, Psychologist, Psychiatrist, Family Medicine Specialists, Public Health Medicine Specialists, nurses, Assistant Medical Officer (Physician Assistant), and other trained personnel in mental health. However, for those who lack of experience on the Mental Health and Psychosocial Support (MHPSS) Services, they will be given on-site briefing and can be included in the team.

2.5 Disaster Victim Identification (DVI) Team

The Disaster Victim Identification (DVI) team is a combination of several experts with a multi-disciplinary approach involving many different disciplines and agencies during disasters involved in dead bodies and human remains management. They may comprise a trained and experienced recovery team, Investigating Police Officer, Forensic Pathologists, Odontologists and Anthropologists, Radiologist, fingerprint or friction ridge experts, and DNA experts. The team members may also consist of various categories of personnel, including Medical Officers, Forensic Science Officers, Assistant Medical Officers (Physician Assistant), Radiographers, and Dental Technicians.

2.6 Subject Matter Experts (SMEs)

Subject Matter Experts (SMEs) shall be mobilized for specific tasks in any disaster or public health emergencies. They may consist of Toxicologists, Aviation Medicine Specialist, Physicist, Field Epidemiologist, Underwater Medicine Specialist, CBRNe Specialist, and others relevant experts, depending on the needs and complexity of public health emergencies.

2.7 Military Personnel

Military personnel can be included in EMT as needed depending on the severity and requirements of a particular mission/ emergency.

2.8 Non-Governmental Organizations (NGOs) and Volunteers Including International Humanitarian Networks

The organizations or institutions have the capacity to provide direct clinical care in all-hazard emergencies and complementary expertise or resources. They work according to minimum standards agreed upon by the EMT community and its partners and deploy fully trained and self-sufficient so as not to burden an already stressed national system.

2.9 Categories of EMT

2.9.1 National EMT (N-EMT)

National Emergency Medical Team (N-EMT) refers to all types of local EMT that are mobilized within the country during emergencies and disasters to provide health-related services.

2.9.2 International EMT (I-EMT)

International Emergency Medical Team (I-EMT) refers to EMT that are mobilized during emergencies and disasters to affected countries to provide health-related services.

There are two (2) sub-categories of I-EMT which include:

i. Inbound I-EMT

Refers to all types of foreign EMT that are mobilized during emergencies and disasters to Malaysia to provide health-related services.

ii. Outbound I-EMT

Refers to all types of Malaysian EMT that are mobilized during emergencies and disasters to affected countries to provide health-related services.

2.10 Classification of EMT

The classification of EMT is shown in Table 2.1.

Table 2.1 EMT Classification

TYPE	DESCRIPTION	CAPACITY
1 Mobile	Mobile outpatient teams. Remote area access teams for the smallest communities.	>50 outpatients a day.
1 Fixed	Outpatient facilities +/- tented structure.	>100 outpatients a day.
2	Inpatient facilities with surgery.	>100 outpatients and 20 inpatients 7 major or 15 minor surgeries daily.
3	Referral-level care, inpatient facilities, surgery and high dependency.	100 outpatients and 40 inpatients Including 4–6 intensive care beds 15 major of 30 minor surgeries daily.
Specialist Cell	Teams that can join national facilities or EMTs to provide supplementary specialist care services.	Any direct patient care-related service can be termed a specialist cell when given in emergency response by EMT providers, such as rehabilitation, paediatric or surgery.

CHAPTER 3

EMERGENCY MEDICAL TEAM COORDINATION CELL (EMT)

CHAPTER 3

EMERGENCY MEDICAL TEAM COORDINATION CELL (EMTCC)

3.1 Background

The Emergency Medical Team Coordination Cell (EMTCC) is a specialized entity activated and responsible for coordinating and supporting the deployment and operation of incoming Emergency Medical Teams (EMTs) during large-scale emergencies and disasters in affected countries. It is designed to address the unique challenges and complexities involved in managing EMTs and ensuring their effective coordination. Deployment of outgoing I-EMTs shall be coordinated without the activation of the EMTCC.

The concept of the EMTCC was developed by the World Health Organization (WHO) in collaboration with other international partners and stakeholders. It emerged in response to the need for standardized coordination mechanisms and support structures for EMTs deployed in emergency settings. It focuses specifically on the coordination of medical response activities, ensuring that EMTs are deployed appropriately, integrated into the overall response efforts, and adhere to established standards and guidelines.

The Emergency Medical Team Coordination Cell (EMTCC) works closely with the On-Site Operations Coordination Centre (OSOCC) in collaboration and coordination within the broader context of emergency response.

The schematic representation of the EMTCC within the Humanitarian Response System (Figure 3.1) aims to improve the effectiveness of the response by ensuring greater predictability, accountability, and partnership. This suggests the use of a single approach and a common technical platform for the coordination of both National Emergency Medical Teams (N-EMTs) and International Emergency Medical Teams (I-EMTs), at least during the operations phase.

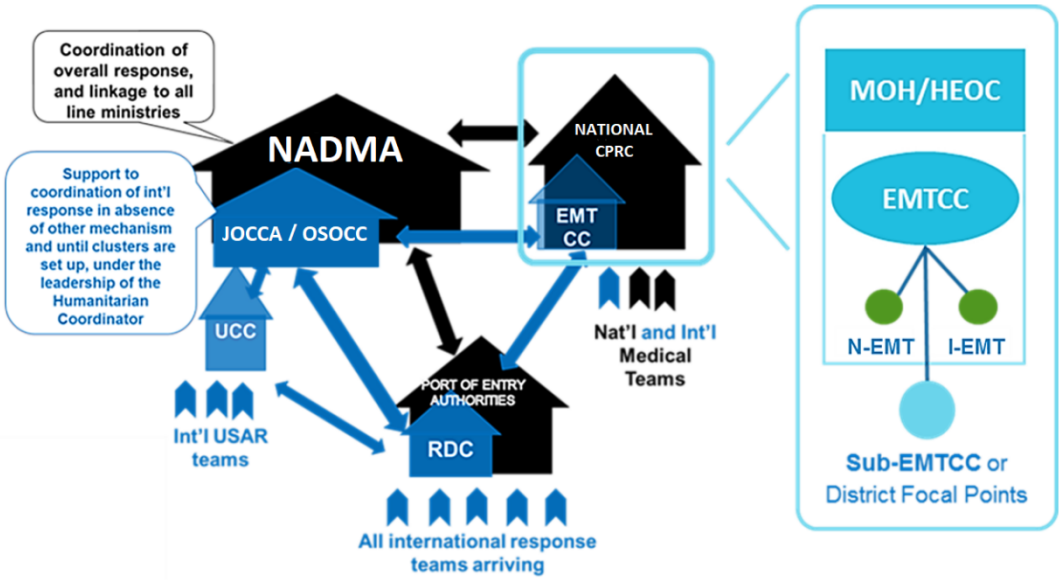


Figure 3.1 EMTCC within the Humanitarian Response System

3.1.1 National Crisis Preparedness and Response Centre (CPRC)

National CPRC or PHEOC under Disaster, Outbreaks, Crisis and Emergency Sector, Disease Control Division, Ministry of Health Malaysia is the National Focal Units for EMT Coordination as listed in Standard Operating Procedure for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations (SASOP), a document prepared as part of ASEAN Agreement on Disaster Management and Emergency Response (AADMER) signed by ASEAN Member States.

The MOH shall be the primary entity responsible for the overall coordination of National Emergency Medical Teams (N-EMTs) and International Emergency Medical Teams (I-EMTs) which are deployed to support N-EMTs. EMTCC is integrated within the existing national PHEOC for an effective integration of the I-EMTs with existing national health services. The EMTCC can be established and managed at the state level, State CPRC (which is as Sub-EMTCC), and also at District Health Office Emergency Operation Centre if the local PHEOC is activated.

For local mobilization not involving I-EMTs, EMTCC is integrated within State CPRC, and District Health Office Emergency Operation Centre will be termed Sub-EMTCC.

3.1.2 On-Site Operations Coordination Centre (OSOCC)

Following a major disaster, an On-Site Operations Coordination Centre (OSOCC) is established as soon as possible, often by the UNDAC team deployed by OCHA. OSOCC is a coordination mechanism that is activated during emergencies or disasters to facilitate the coordination of response efforts. The OSOCC serves as a central hub for information exchange, decision-making, and coordination among various responding entities, including government agencies, humanitarian organizations, and other stakeholders.

Virtual OSOCC (VOSOCC), a component of OSOCC System, is a real-time online coordination platform that allows information exchange early in an emergency. Situation reports and other updates will be posted to the applicable sections of the VOSOCC by national authorities, OCHA, regional organizations and others involved in the response efforts.

3.1.3 Joint Operations and Coordination Centre of ASEAN (JOCCA)

The Joint Operations and Coordination Centre of ASEAN (JOCCA) is an onsite coordination system to enhance ASEAN's collective response particularly during large - scale disaster emergencies in the ASEAN region to support the government of the Party affected by the disaster. Upon consent by the Party affected by the disaster, the AHA Centre can establish the Joint Operations and Coordination Centre of ASEAN (JOCCA), manned by ASEAN-ERAT to support the Requesting or Receiving Party to coordinate the ASEAN response. The JOCCA will provide a direct coordination interface between ASEAN response teams and the NFP of the Requesting or Receiving Party (NADMA).

3.1.4 Urban Search and Rescue (USAR) Coordination Cell (UCC)

Urban Search and Rescue (USAR) refers to specialized teams and operations that are specifically trained and equipped to respond to and rescue people trapped or in distress in urban or structural collapse incidents, such as building collapses, earthquakes, or explosions. USAR teams are typically composed of highly skilled personnel from various disciplines, including firefighters, paramedics, structural engineers, canine search teams, and technical rescue specialists.

In major disaster responses with the deployment of international urban search and rescue teams, a USAR Coordination Cell (UCC) will also be established, either by the government or by the first arriving trained USAR or UNDAC team.

3.1.5 Reception and Departure Centre (RDC)

As part of the OSOCC, a Reception and Departure Centre (RDC) is also typically established at the Point of Entry (POE) for I-EMTs, usually the international airport or seaport, with a view to guiding arriving teams to the relevant coordination mechanism for further tasking — the process of assigning a location, a specific role, and a reporting channel to arriving EMTs.

Ideally, the RDC is set-up by national authorities with support from the UNDAC team or the first arriving response team trained in RDC methodology. INSARAG - classified USAR teams are responsible for establishing the initial RDC if they are the first to arrive, and may continue to support RDC operations throughout.

Similarly, incoming I-EMTs support the set-up and running of the RDC, or carry out a similar role if none already exists, until it is taken over by the ministry of health with the support of WHO for coordination of the health response.

Under SASOP, MOH shall designate official(s) to provide an initial briefing to the I-EMTs at a staging point or RDC, where ASEAN-ERAT will support the process, immediately after the completion of the CIQ processes, to ensure seamless on-site coordination.

3.1.6 National Disaster Management Agency (NADMA)

The National Disaster Management Agency (NADMA) is an agency that operates at the national level and is responsible for coordinating and managing disaster management efforts in Malaysia. NADMA works closely with other relevant ministries, departments, and stakeholders involved in disaster management and emergency response. NADMA as National Focal Point (NFP) on disaster management is an entity designated and authorised by each Party to receive and transmit information pursuant to the provision of the legally binding AADMEER. NFP is also required to coordinate with the Competent Authorities (CAs), for example with regard to approval for processing request and offer of assistance, and on other matters not within their jurisdiction.

3.1.7 National Disaster Management Mechanism

Under NADMA Directive No. 1, EMTCC will coordinate with National Disaster Command Centre (NDCC) and On-Scene Command Post (OSCP) for assignment of EMTs.

3.2 Objective and Scope of EMTCC

The primary objective of an Emergency Medical Team Coordination Cell (EMTCC) is to ensure effective coordination and support for both national and international Emergency Medical Team (EMT) during emergency and disaster response. The scope of EMTCC can be divided into four (4) broad areas:

3.2.1 Leadership and Coordination

i. The EMTCC offers technical expertise and support to EMTs, including guidance on best practices, training materials, and capacity-building initiatives. It promotes the development of EMT skills and knowledge to enhance their effectiveness in emergency response.

ii. The EMTCC would facilitates the deployment of EMTs within the local or regional area affected by the emergency. This includes matching EMT capabilities and resources to the specific needs of the affected population and ensuring appropriate integration into the local healthcare system.

3.2.2 Information and Communication

i. The EMTCC would gather, analyze, and disseminate relevant information regarding the emergency situation, medical needs, available resources, and response efforts. This helps to maintain situational awareness among EMTs and other stakeholders involved in the response.

ii. The EMTCC would facilitate collaboration and communication among EMTs, local healthcare facilities, government agencies, NGOs, and other relevant stakeholders involved in the emergency response. This includes coordinating joint operations, sharing best practices, and addressing any operational challenges or gaps.

3.2.3 Quality Assurance

The EMTCC would promote adherence to quality standards, guidelines, and protocols for emergency medical care within the local context. This includes monitoring and evaluating the performance of EMTs, providing feedback, and promoting continuous improvement in their operations.

3.2.4 Supportive Services

The EMTCC would play a role in managing and coordinating the allocation of resources required by EMTs, such as medical supplies, equipment, personnel, and transportation. This ensures the efficient and effective use of resources within the local response (Refer **Annex 5**, SASOP).

3.3 Roles of EMTCC

The roles of EMTCC include, but are not limited to:

i. Collecting and updating data for the classification of the actual type, capacity, and services of EMTs throughout the whole response.

ii. Screening incoming I-EMTs based on approved global professional standards, leading to their eventual on-site authorisation.

iii. National registration of authorized I-EMTs, based on the global classification and registration formats, including self-declaration from the I-EMT leader that the team adheres to the global standards.

iv. Ensuring and reinforcing EMT accountability to health authorities, including compliance with existing or forthcoming national guidelines and reporting requirements.

v. Providing background and up-to-date information on the situation and assigning a place of operations and local reporting/ liaison contact.

vi. Providing sound and valuable support to expedite all the related authorizations during operations of 'authorized' EMTs.

vii. Providing standardized forms for periodic reporting, exit reporting, and referral of patients to national facilities.

viii. Providing and supporting the strategic and operational framework of the EMT response.

ix. Formulating priorities based on analysis.

x. Mapping of 'who does what, where, and when' and 'how' through quality assurance field visits.

xi. Informing NADMA and other national or international authorities, to ensure embedding in the broader health sector emergency coordination (including the health cluster if there is a need for its activation).

3.4 EMTCC Life Cycle

The EMTCC life cycle is a general workflow for potential coordination activities in a chronological sequence as they might typically occur before, during, and immediately after an emergency response deployment (Figure 3.2).

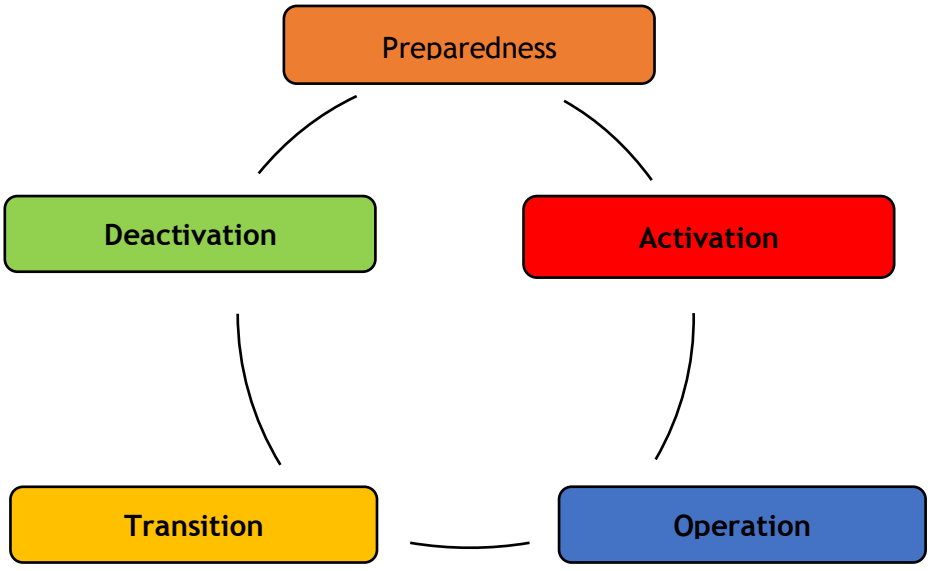


Figure 3.2 EMTCC Life Cycle

3.4.1 Preparedness

i. EMT Coordinator to provide mentorship and support to EMTs.

ii. EMT Secretariat to coordinate the mentorship and verify phases of EMTs.

iii. MOH to identify EMTCC focal point(s) to lead on national preparedness measures, identify where the cell would be structurally positioned.

iv. Assess the potential need for international assistance.

3.4.2 Activation

i. Formally activate EMTCC in accordance with national criteria of activation.

ii. Establish an EMTCC coordination activities centre.

iii. Confirm I-EMT Arrival and Registration SOPs.

iv. Ensure continuous EMTCC representation at the RDC.

v. Collate and input EMT operational information on central database to provide an overview of available resources.

vi. Match and task EMT to identified areas of need, in accordance with local needs.

3.4.3 Operation

i. Map in real-time all EMT deployments.

ii. Establish and maintain regular contacts with EMTs and local (districts) authorities.

iii. Conduct Field Quality Assurance and Support visits to EMTs.

iv. Establish referral system including SOPs.

v. Collect, analyse, process, and disseminate reporting data from EMTs.

vi. Keep track of all anticipated EMT transition/ departure dates and identify/ address possible gaps in service provision.

vii. Identify key steps for transitioning the EMTCC to mainstream structures within the National Health System.

viii. Conduct Field Quality Assurance and Support Visits to EMTs.

ix. Provide Departure Package for EMTs, including departure SOPs.

x. Keep track of all anticipated EMT transition/departure dates and identify/ address possible gaps in service provision Identify key steps for transitioning the EMTCC to mainstream structures within the National Health System.

3.4.4 Transition

i. Confirm handover and exit plan of all EMTs.

ii. Confirm handover of all medical notes as declared by EMT on Exit Report.

iii. Support the compilation of a master list of donated items and their re-allocation according to needs.

3.4.5 Deactivation

i. Collect, input, and analyze Exit Report data from all EMTs, and generate overall Exit Report.

ii. Confer Letter of Appreciation on receipt of all exit documents.

iii. Collate, input, and analyze Evaluation Survey data from all EMTs.

iv. Collect Lessons Learned Report to inform improvements (**Annex 15**).

3.5 Organization Structure

EMTCC consist of specialized trained personnels to manage multiple tasks during disaster:

i. Coordinator;

ii. Deputy Coordinator;

iii. Liaison Officer/ Focal Point;

iv. Information Management;

v. Operation Support; and

vi. Technical Support.

Each personnel hold specific roles to facilitate the specific duties and responsibilities (Figure 3.3).

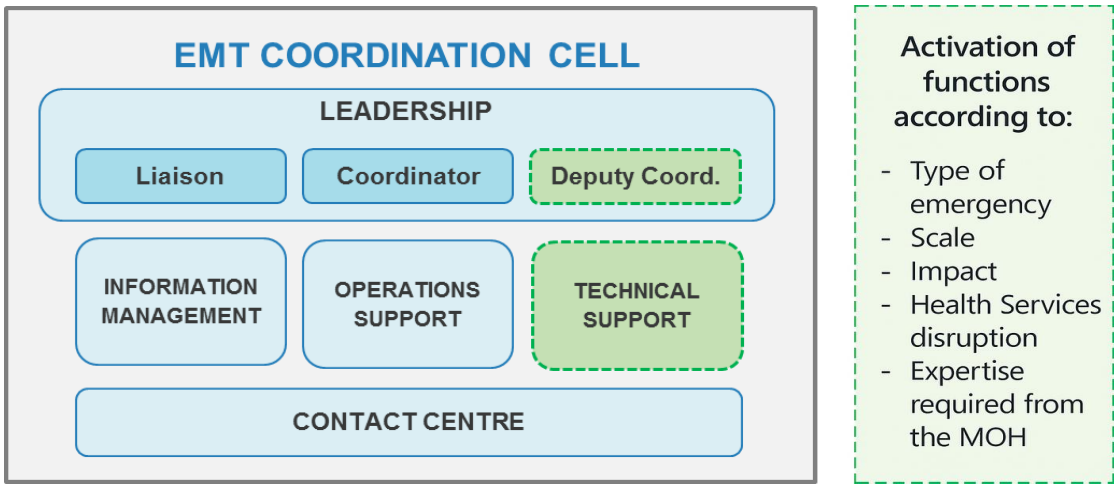


Figure 3.3 EMTCC Organization Structure

3.5.1 Team Roles within the EMTCC

Team roles are presented to facilitate the understanding of duties and responsibilities (Table 3.1).

Table 3.1 Roles Within EMTCC and List of Duties and Responsibilities

ROLE	DUTIES AND RESPONSIBILITIES
Coordinator	• Operational strategy and updates. • Strategic planning and direction. • Coordination of EMTs. • Direct link with main stakeholders including other national authorities, OSOCC, UNDAC team, Health Cluster, RDC, and other partners.
Deputy Coordinator	• Daily management of operations. • Oversee reporting and information management. • Safety and Security planning for the cell. • Manage the cell members' handover and replacement process.
Liaison Officer (and/ or Focal Points)	• Identify and link up with key stakeholders from local agencies and affected communities to international responders. • Establish the link between the Civilian and Military components of the response, including through the OSOCC and/ or the Humanitarian-Military Operations Coordination Cell (HuMOCC). • Provide a forum for stakeholder groups to provide input into the response process.
Information Management	• Reporting and information management. • Establish the filing and archiving system. • Provide daily/ weekly data analysis to support the monitoring of the response. • Mapping of deployed teams and resources.
Operations and Team Support	• Office set up and logistic support to Contact Centre (CC) including management/ admin of CC resources. • Support the set up and running of the CC (daily contact and correspondence with EMTs). • Coordination of required logistic support for EMTs and medical response.

ROLE	DUTIES AND RESPONSIBILITIES
Contact Centre (CC)	• Registration of EMTs and filing. • Managing daily contact and correspondence with EMTs. • First point of contact for EMTs. • Note: Past experience has shown that the volume of enquiries can be very high in the initial phase of the emergency response, requiring up to three dedicated full-time staff members to manage all enquiries. Despite the staffing demands, the ability to reliably respond to the information needs of EMTs, particularly in the earliest stages of the response, is extremely valuable for building visibility, credibility, and EMT confidence in the EMTCC.
Technical Support	(Requirements based on the situational needs) • Rehabilitation Advisor. • Clinical Advisor. • Epidemiologist. • Public Health Advisor. • Logistics Advisor. • Water, Sanitation, and Hygiene (WASH) Engineer. • Structural Engineer. • Safety and Security Focal Point. • Infection Prevention and Control (IPC) Advisor. • Training Advisor.

3.5.2 **Medical Coordinator**

The functions of the Medical Coordinator include the provision of information, support, and coordination. The Medical Coordinator will function as a liaison officer for I-EMT, with the provided job description:

i. To provide and share information updates to I-EMT (from EMTCC/ Sub EMTCC).

ii. To facilitate I-EMT arrival, movement, and logistic arrangements, work process (referral within local healthcare facilities).

iii. To support/ assist the operation of I-EMT:

   a. To facilitate communication between I-EMT and EMTCC/Sub EMTCC;
   b. To facilitate patient transportation to I-EMT;
   c. To facilitate logistics needed by I-EMT;
   d. Ensure safety and security of the I-EMT at operation site and during travelling/ transporting equipment; and

e. To facilitate Coordination and supervision of whole relief process at incident site.
   - To ensure I-EMT follows the required work processes set up by host country.
   - To facilitate data management (MDS) and report submission to EMTCC/ Sub EMTCC.
   - Involvement in Quality Assurance aspects.

Competencies of Medical Coordinator include:

i. Fluent in English (Written and Speaking), with fluency in other relevant languages is preferred;

ii. Trained in disaster and crisis management in Malaysia;

iii. Good knowledge of International/ ASEAN regional disaster management/ disaster health management framework;

iv. Well-versed with local organizational structure, system, and community; and

v. Able to give full commitment for a gazetted period of time, able to work under shift system or roster schedule.

Qualifications of Medical Coordinator include:

i. Medical or Allied Health personnel registered with local governing bodies;

ii. EMT trained/ involved in previous EMT deployment and coordination; and

iii. Physically and mentally fit.

3.6 Role of Reception and Departure Centre (RDC)

RDC is composed of officers from various agencies (Table 3.2).

Table 3.2 Composition of Officers at RDC

AGENCY	PERSONNEL
NADMA	1
ASEAN- Emergency Response and Assessment Team (ERAT)	1
UNDAC	1
Special Malaysia Disaster Assistance and Rescue Team (SMART)	3
Ministry of Foreign Affairs (MOFA)	1
Malaysia Armed Forces (MAF)	2
Royal Malaysia Police (RMP)	1
Immigration Department of Malaysia	1
Royal Malaysian Customs Department	1
Department of Malaysian Quarantine and Inspection Services (MAQIS)	1
MOH	2

As the first contact point for incoming I-EMTs, RDC operations are focused on:

i. Registering incoming teams and passing this information to the EMTCC and OSOCC to facilitate operational planning;

ii. Briefing arriving teams on the evolving emergency situation;

iii. Providing arriving teams with available information related to practicalities such as logistical support, airport/ port procedures, and services, security and the EMTCC/ OSOCC location; and

iv. Supporting point-of-entry authorities in coordinating the arrival of international resources, including air/ ground traffic control, ground services, storage, procedures, and liaison.

Factors that can facilitate an effective and efficient tasking process are:

i. Pre-identifying at-risk areas and facilities;

ii. Assigning EMTs during the pre-registration phase;

iii. Ensuring EMT capabilities (and self-sufficiency) are cross-checked;

iv. Verifying site availability using local contacts and virtual maps (if possible);

v. Verifying the primary and secondary risks associated with the event for each location;

vi. Considering proximity with existing health facilities; and

vii. Correlate the levels of care with the importance of the three levels in relation to EMTs.

3.6.1 Accreditation of Foreign Medical License

Temporary Practicing Certificates (TPC) or equivalent approvals shall be granted to foreign medical practitioners in accordance with the criteria established by the Malaysia Medical Council (MMC) and other relevant regulatory bodies. These prerequisites must be met before they are authorized to practice in Malaysia as part of International Emergency Medical Teams (I-EMTs). Detailed information about I-EMT team members must be provided using the EMT Registration Form (**Annex 1**).

3.6.2 Importation and Use of Controlled Medicine

The list of medicines brought by I-EMTs shall be subject to checking and approval by Pharmacy Enforcement Officers on duty at RDC.

3.6.3 Importation and Use of Communication Tools

There is no restriction on telecommunication tools used by I-EMTs.

3.7 EMTCC Information Management

Information management is one of the key support functions for EMT coordination. EMTCC requires readily accessible and up-to-date information about all responding EMTs (and their types) in order to make decisions about the optimal distribution of the EMTs.

Information management encompasses all steps from data collection (in which the CC plays a key role) to dissemination (Figure 3.4). Specific examples relevant to the EMTCC operations are also shown for each step.

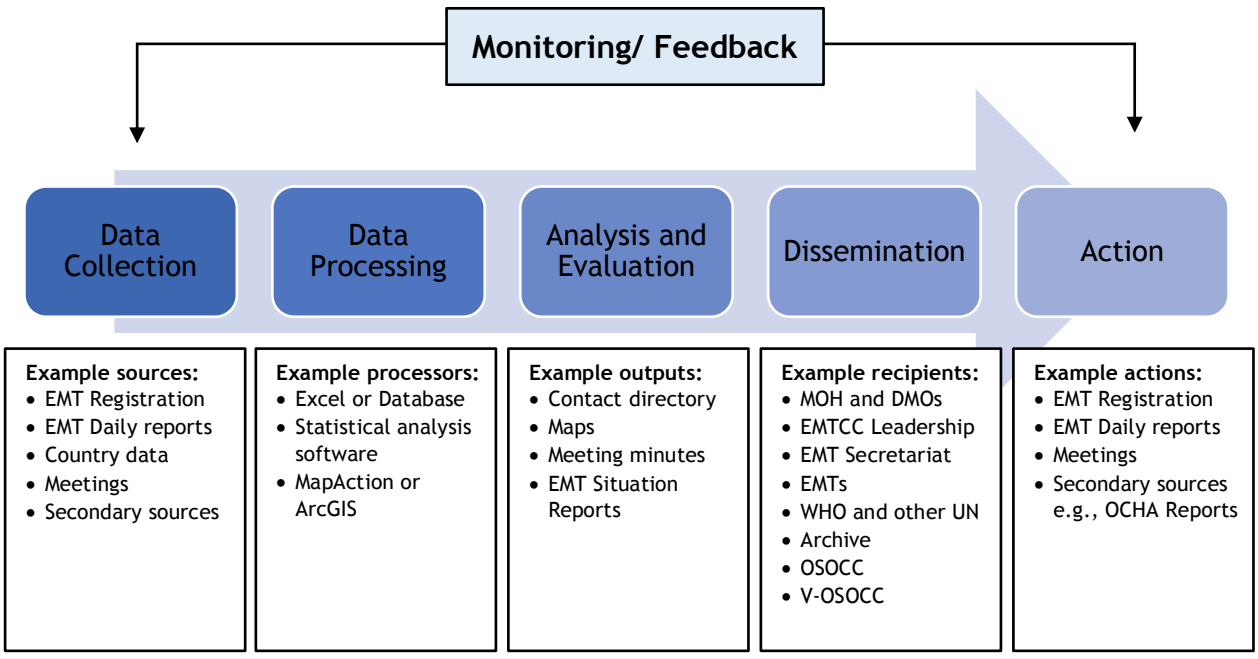


Figure 3.4 EMTCC Information Management

3.7.1 EMT Reporting

Reported information from deployed EMTs is extremely valuable for multiple purposes, which include:

i. Providing real-time situational and needs assessments at the local or district level, which informs the EMTCC in their tasking or re-tasking decisions, as well as the overall humanitarian situation analysis;

ii. Providing an indication of longer-term needs when rehabilitation indicators, such as the number of lower limb amputees, spinal cord injuries (SCI), and complex fractures, are included in the reporting. This can be used to guide the development of longer-term strategies;

iii. Contributing to, and strengthening the national communicable disease surveillance and early warning system; and

iv. Forming part of the quality assurance and accountability of EMT activities.

EMT reporting should be conducted using the standardized Medical Record Form (**Annex 2**) and Emergency Medical Team - Minimum Data Set (EMT-MDS) Tally Sheet (**Annex 3**). Standardised reporting allows for meaningful aggregation of reports across EMTs using EMT-MDS Daily Report Form (**Annex 4**), which is submitted by EMTs to the EMTCC or Sub-EMTCC to report their activities on daily basis.

3.7.2 Data Management Platforms

Data management platforms vary in complexity and accessibility, including:

i. Basic paper forms and records with an organised, physical filing system;

ii. Simple excel database with manual data entry and report generation;

iii. Electronic document collection (including scanning of paper forms), stored, and organized on a hard drive, networked drives, or a web-based shareable drive although caution is necessary in relying on a third-party controlled platform; and

iv. More complex, purpose-built data management platforms that allow storage and analysis of all the info provided by EMTs.

The choice of platform will depend on the available infrastructure, such as reliable electricity and/ or internet connectivity, and the available expertise within the EMTCC team.

3.7.3 Mapping

Mapping of the locations of all deployed EMTs and their types, as a minimum, would be a useful tool for visualizing potential coverage gaps, which will help inform tasking decisions. Additional layers of information, including location, status, and capabilities of pre-existing healthcare facilities, areas of need, and transport or supply routes, may be added.

3.7.4 EMTCC Situation Reports

The EMTCC Situation Report is an important information product of the EMTCC. The report is generated from the summation and evaluation of information from EMT Reports, EMT coordination meetings, and reports from other agencies, among other sources. The report should highlight the current capacity and distribution of EMTs, and any priority issues, and residual needs (gaps) (**Annex 5**). The EMTCC or Sub-EMTCC shall submit this form to the PHEOC of the MOH at the end of the first day and the third day. Also, EMTCC shall send EMTCC-MDS Feedback Form to I-EMTs in a timely manner (**Annex 6**).

3.7.5 EMT Coordination Meetings

Meetings can be extremely useful for information sharing and coordination. Potential uses of EMT Coordination Meetings include:

i. Establishing key strategic directions of the response;

ii. Disseminating information (including situation updates, SOPs, contact details);

iii. Obtaining and sharing of information from and between EMTs;

iv. Tasking of EMTs;

v. Coordinating logistical resources; and

vi. Networking between EMTs.

EMT coordination meetings should include essential information for on-site operation including but not limited to:

i. Situation update to the extent known;

ii. Secured access to operating grounds;

iii. Status of health facilities in the affected area;

iv. Details on the coordination with local hospitals for patient referral;

v. EMTs in operations;

vi. Meeting schedule and venue;

vii. Details on the coordination with EMTCC;

viii. Medical waste management;

ix. Management of dead bodies in disaster;

x. Provincial medical incident command system and local authorities;

xi. Maps and information on incident sites, operation sites, law enforcement stations, drug stores, shops, and patrol stations;

xii. Contact person/ focal units/ liaison personnel/ interpreter;

xiii. Available channels of communication;

xiv. Sanitation concern including epidemic disease, endemic disease, sporadic disease, tap water purification, excretion, and toilet management;

xv. Security and mobile escort; and

xvi. Reporting mechanism/ information management system for EMT.

Report of the meeting shall be done in accordance to EMT Coordination Meeting Minutes (**Annex 7**). It is important to ensure that meetings are time efficient and useful to all. This includes publishing and adhering to an agenda, beginning and ending on time, and employing good meeting facilitation skills to ensure equal participation.

3.8 EMT Field Quality Assurance and Support Visits

Field visits to all EMT sites of operation should be undertaken once EMTCC operations are reasonably well established, ideally after the first week of operations using Site Visit Checklist (Quality Assurance) Form (**Annex 8**). Field visits should not only focus on the verification of EMT operations (quality assurance), but also on providing support and guidance. The three (3) main objectives of the field visits are to:

i. Share information (including district and overall situation updates, new or updated SOPs and guidelines).

ii. Confirm EMT operations, including:

   a. Site of operation (compared to allocated site);
   b. Type(s) of service (compared to declared type and services);
   c. Compliance with minimum standards, including medical record-keeping, reporting, and referral requirements;
   d. Compliance with recommended or national treatment protocols;
   e. Acceptance from the community;
   f. Integration with local service providers and coordination mechanisms; and
   g. Exit strategy (including anticipated date of departure).

iii. Support EMT operations, including:

   a. Feedback on potential improvements (including addressing Minimum Standard shortfalls);
   b. Updated guidelines or treatment protocols;
   c. Assistance with any operational issues, such as referral gaps, logistical needs, or safety and security; and
   d. Coordination of other complementary assistance needed by the affected population, as identified by the EMTs, such as food distribution, non-food items, water, and sanitation and others.

3.9 Deactivation of the EMTCC

Deactivation planning should consider whether functions are to be:

i. Handed over;

ii. Terminated; and

iii. Returned to baseline.

Additionally, consideration should be given to whom the identified functions will be handed over and what capacity building activities need to be undertaken during EMTCC operations to ensure smooth handover.

The transition and exit plan (including timing) should be confirmed in collaboration with other stakeholders within the MOH/ HEOC and communicated widely to the EMTs and relevant components of the international response system.

3.10 Management of Complaints Against Teams

The formal channel for lodging complaints against any healthcare service, including EMTs, should remain with the MOH or relevant national authority. Therefore, complaints may potentially be lodged initially through the EMTCC, in which case the following three (3) key steps become necessary:

i. Acknowledge and respond;

ii. Reporting to other relevant authorities, if required; and

iii. Document.

The EMTCC should respond to a complaint by assessing the potential harm (s) or risk of harm to the affected population, including service quality and coverage shortfalls, and provide appropriate supportive or directive guidance to the EMT to improve quality and prevent harm.

The EMTCC should maintain its own record of lodged complaints, including the nature of the complaint, name of the complainant, name of the EMT and their site of operation, any EMTCC findings and actions, and the findings and outcomes of any further national authority investigations.

3.11 Managing Across Cultural Differences

Managing cultural differences is an important role of the EMTCC in between stakeholders. These cultural differences are not only ethno-geographic, but also organisational, derived from each group's specific operating principles, history, mandate, and training, among other drivers. The achievement of this may be assisted by applying the following framework, which is comprised of four sequential and dependent steps:

i. Preparation;

ii. Awareness;

iii. Identify cultural differences between organizations; and

iv. Bridge differences.

Lastly, having developed an understanding of the cultural gaps between organisations, strategies can be applied by the EMTCC to bridge such gaps. For example, the EMTCC can act as an intermediary that is able to relay communications between two (2) organisations using the most culturally effective manner for each.

CHAPTER 4

PERSONNEL PREPAREDNESS

CHAPTER 4

PERSONNEL PREPAREDNESS

4.1 Background

EMT personnel who are involved in the disaster or crisis response are expected to maintain a high level of readiness including health status, current professional qualifications, practical experience, basic training requirements, training for selection, teamwork, and language skills.

4.2 Registration Procedures

National CPRC will coordinate registration for EMTs. Any health professionals and supporting staff who are interested in joining EMT need to be registered with State CPRC by submitting a complete application form known as EMT Database Form (**Annex 9**). This database shall be updated every three (3) months. State CPRC will compile and submit all application forms to National CPRC.

National CPRC has the authority to select the eligible personnel for EMT deployment based on their expertise, experience, and health status. Selected personnel will be formally appointed by letter of authorization. The appointed personnel of EMT must be ready at any time for deployment to the affected area. For classified EMT, they need to notify National CPRC (National Focal Point) prior to deployment.

4.3 Basic Requirement for National and International EMT

EMT personnel may be deployed within national level or to internationally. Basic requirements for both national and international EMT as shown in Table 4.1.

Table 4.1 Basic Requirement for National and International EMT

CRITERIA	NATIONAL	INTERNATIONAL
Scope of Service	• Professional competence and basic knowledge of disaster medicine and EMT operations. • Adaptation to technical and non-technical professional capacities into low-resource and emergency context. • To be ensured before domestic deployment.	• Preparation for an effective team performance in foreign countries. • To be ensured before international deployment.

CRITERIA	NATIONAL	INTERNATIONAL
Health Status	• Physical and mentally fit. • Free of infectious diseases. • Those who have chronic medical illness shall be certified fit by a registered medical practitioner before joining EMT. • Fulfill vaccination requirement accordingly. • Health status self-declared at the stage of application will be evaluated in the later stage pre-deployment health screening.	
Current Professional Qualification	• Medical Doctors: Annual Practicing Certificate (APC). • Nurses: Annual Practicing Certificate (APC). • Assistant Medical Officers: Annual Renewal Certificate (ARC). • Environmental Health Officers/ Assistant Environmental Health Officers: Allied Health Professional (AHP). • Others: Registered and licensed by respective governing bodies.	
Practical Experience	• Experienced in domestic or international deployment to disaster affected area will be advantage. • However, inexperienced applicant with appropriate qualification also can be considered.	
Basic Training Requirement	• Basic Life Support (BLS). • Standard First Aid. • Mental Health Preparedness and self-care.	
Training for Selection	• Completed an induction or pre-deployment briefing courses. • Required to undertake theoretical courses and/or workshops to enhance knowledge on disaster medicine and EMT operation. • Field training courses and/or field training exercises to practice own skills and learn how to operate within low-resource and emergency contexts.	• Completed a standardized training curriculum which has been widely accepted by all ASEAN Member States or international bodies such as WHO, International Committee of the Red Cross (ICRC), International Federation Red Cross and Red Crescent (IFRC). • Relevant topics-medical, treatment, intercultural management, resources management, communication skill, healthcare system in affected country, AADMER, SASOP, SOP for EMTs.

CRITERIA	NATIONAL	INTERNATIONAL
Teamwork	• Able to work well with others as part of the team. • Build up teamwork and foster team-to-team communication and collaboration.	• Build up teamwork and foster good communication and collaboration with the EMTs of the affected countries and between International Emergency Medical Teams (I-EMTs).
Language Skill	-	• Must possess basic English language skill.

4.4 Personnel Readiness

A personnel plan or detailed checklist should be prepared:

i. Personal items must be self-prepared and bring together during deployment. Suggestion items can be referred to **Annex 10**.

ii. Informing family members on the nature of duties.

iii. Arrange care for family, pets, and plants while absent.

iv. Update all personal commitment (insurance, liabilities, wills, and others).

A comprehensive plan or checklist will ensure that nothing is forgotten when in a hurry and mobilizing for mission deployment.

4.4.1 Official Documents

i. Official letter for deployment.

ii. Identity card.

iii. International Passport.

iv. Staff identification card.

v. Travel itinerary.

vi. Upload softcopy of essential documents in cloud, for example, Dropbox, Google Drive, and others.

vii. Emergency contact numbers (CPRC, team leader, next of kin, and others).

viii. Hard or electronic copies of latest relevant reference material and other key guidelines.

ix. Mission-specific information, including latest situation reports, maps, contact information, and others.

4.4.2 Self-Sufficient

EMT personnel must be self-prepared and self-sufficient during deployment. All items can be put together in survival kit (Emergency Bag) which is easy to grab during emergency evacuation and consist of following items as stated in Table 4.2.

Table 4.2 Survival Kit (Emergency Bag)

NO.	ITEM
1.	Personal Items and Documents (**Annex 10**)
2.	Personal Gear (**Annex 10**)
3.	Reasonable Amount of Cash
4.	Ration and Drinking Water
5.	Mobile phone and Installation of Application with Charger, Universal Adapter and Power Bank

4.4.3 Training

i. Purpose of Training System

Training program should offer EMT personnel didactic training and hands-on field experience in disaster preparedness and response as well as provide an avenue to develop competency in emergency operations management.

ii. Training Modules

The following is an overview of training that are mandatory and a list of additional recommended advanced training (Table 4.3).

Table 4.3 List of Training Modules

NO.	TRAINING	LEVEL	REMARKS
1.	First Aid Training	Basic	Mandatory
2.	Basic Life Support (BLS)	Basic	Mandatory
3.	Basic Disaster Life Support/ Malaysian Disaster Life Support	Basic	Mandatory
4.	Pre-deployment training (CPRC)	Basic	Mandatory
5.	Safety and Security	Basic	Mandatory
6.	Basic Risk Communication	Basic	Mandatory
7.	Team Building	Basic	Optional
8.	Psychological First Aid (PFA)	Basic	Mandatory
9.	Disaster Assessment and Coordination	Basic	Optional
10.	Incident Management System (IMS)	Basic	Optional
11.	Basic Public Health Training	Basic	Optional
12.	Advance Trauma Life Support (ATLS)	Advanced	Optional
13.	Paediatric Advanced Life Support (PALS)	Advanced	Optional
14.	Communication Set/ Government Integrated Radio Network (GIRN) Training	Advanced	Optional
15.	Communicable Disease Control	Advanced	Optional
16.	Advanced Public Health Training	Advanced	Optional
17.	Emergency Medical Response (EMR)	Advanced	Optional
18.	Humanitarian Logistic Training	Advanced	Optional
19.	Leadership Training	Advanced	Optional

iii. Training Providers

A training and learning programme are available either directly organized by EMT or by outsourcing to training providers. Training should be conducted at least once a year by relevant agencies. EMT personnel will also be able to obtain training from non-governmental or international organizations that provide training in the aforementioned modules.

CHAPTER 5

DEPLOYMENT

CHAPTER 5

DEPLOYMENT

5.1 Background

EMTCC has well-established and practised procedures to ensure that a team can be alerted, mobilized, and deployed within a timeframe as either National (N-EMT) or International (I-EMT). EMT can be deployed within 12 to 48 hours after a request is made and should be able to deploy rapidly. This chapter explains the work process on pre-mission preparedness for individuals and describes.

5.2 Work Process for EMT Deployment

EMT registered are eligible to be deploy at any circumstances needed. Work Process for EMT deployment shown in Figure 5.1.

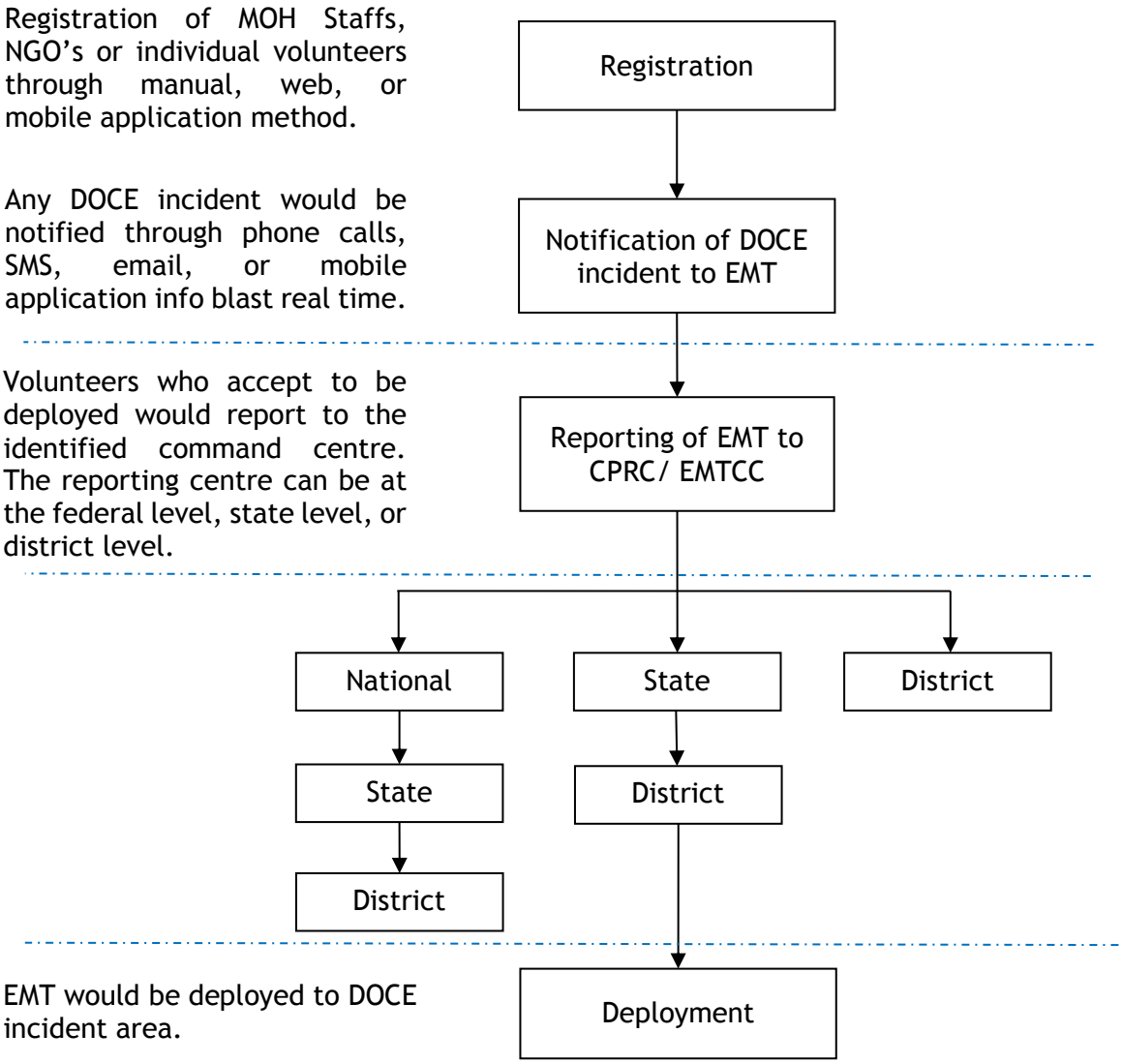


Figure 5.1 Work Process for EMT

The process for national and international deployment follows three (3) stages below:

i. M1 – Alert
ii. M2 – Activation Standby
iii. M3 - Dispatch

i. Alert (M1)

Alert Notification of the EMT:

a. When DOCE event occurs, or is anticipated, EMTCC opens a discussion topic on through automated SMS messages and alerts EMT if required.
b. An automated SMS and e-mail are sent to National/ State CPRC/ OR informing them of the alert (M1) and asking the team availability.
c. National/ State CPRC/ OR confirm their team members availability, and if required with the EMTCC.
d. National/State CPRC/ OR reply through the automated SMS messages, indicating their availability, contact details, closest airport and earliest time available to depart.
e. In rare cases, an M1 can be canceled due to unforeseen circumstances. In these cases, a stand down message will be sent out.

ii. Activation Standby (M2)

a. National CPRC/ EMTCC selects an EMT from among the available teams/ personnel according to the type of disaster, relevant skills, language skills, and others.
b. National CPRC/ EMTCC sends an automated SMS and e-mail activation message (M2) to selected State CPRC/ EMT Personnel indicating teams selected to be on standby.
c. Selected State CPRC/ EMT Personnel confirm receipt of the M2 standby message directly to National CPRC.

iii. Dispatch (M3)

National Dispatch (N-EMT)

a. CPRC from deploying state takes the decisions on final team composition and dispatch. A final team list shall be sent to National CPRC/EMTCC and affected state CPRC for further coordination action. The receiving state CPRC shall submit the name list to the affected district via automated SMS and e-mail.
b. State CPRC of the deploying state will make travel arrangements. Receiving state will provide accommodation for the EMT.
c. Selected members depart on mission.

International Dispatch (I-EMT)

a. National CPRC makes the decisions on final team composition and dispatch. A final team list shall be sent to NADMA for further coordination action.
b. The dispatch message is sent by National CPRC through phones and e-mail to the selected I-EMT members and State CPRC.
c. National CPRC completes travel authorization request with United Nations Department of Safety and Security (UNDSS) for all selected I-EMT members, which should preferably be received by I-EMT members before departure. National CPRC may make travel arrangements for the selected I-EMT members and prepares for their departure and arrival (airport pickup, hotel arrangements).
d. Selected I-EMT members depart on mission.

5.2.1 Work Process for Deployment N-EMT

Deployment of a N-EMT will commence upon the occurrence, or early warning of DOCE event in which preliminary information indicates that an EMT might be needed based on results of risk assessment by the District RAT.

Coordination of the emergency response at District Health Office (DHO) Operation Room (OR) shall be led by Incident Manager as stated in CPRC SOP. The flow of N-EMT deployment shown in Figure 5.2.

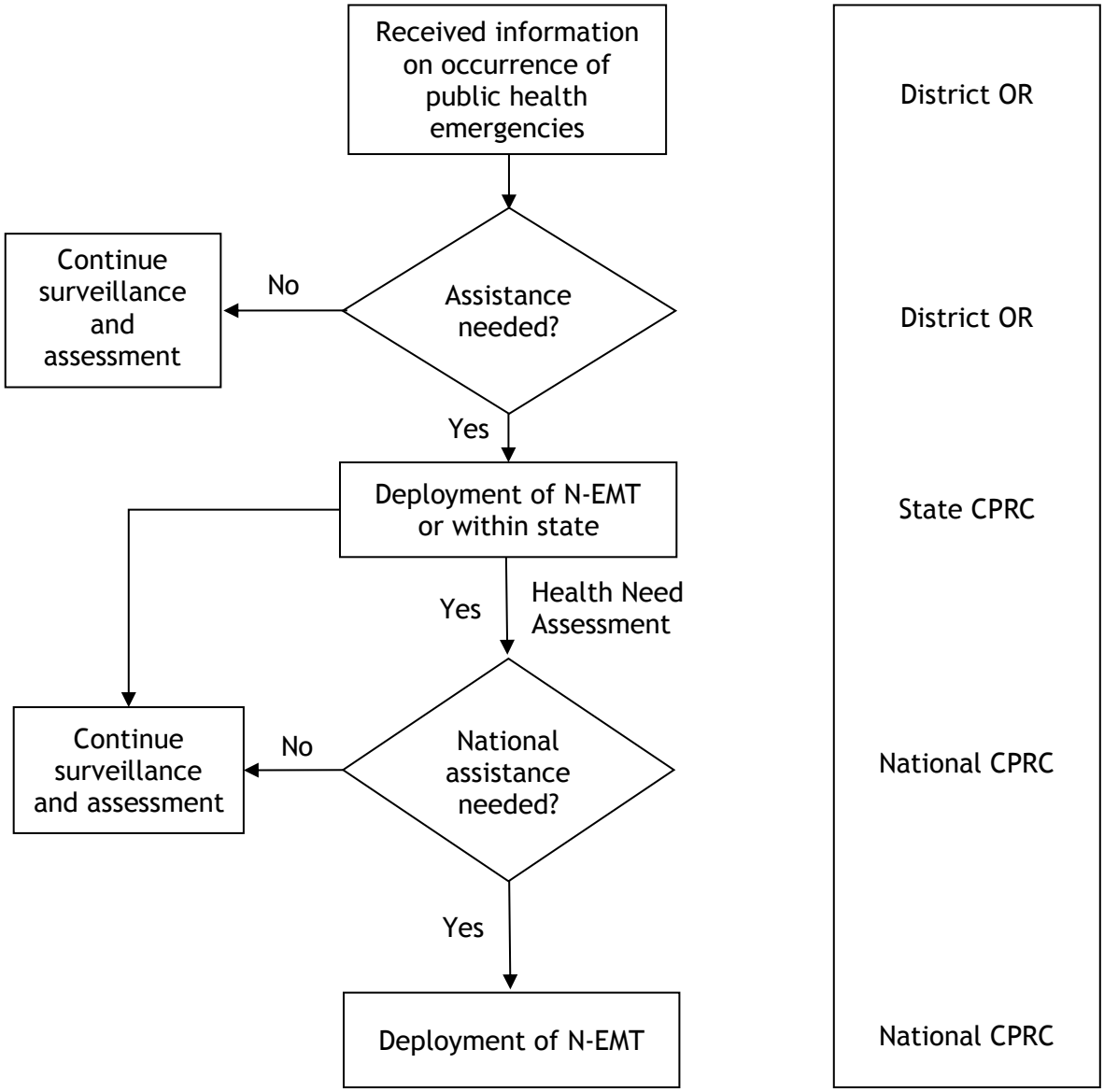


Figure 5.2 Work Flow for Deployment of N-EMT

5.2.2 Work Process for Deployment I-EMT

International deployment of Malaysian I-EMT can occur following two (2) trigger points for example, following a Request for Assistance (RFA) by the affected country or an Offer for Assistance (OFA) by Malaysia to the affected country.

A registry of I-EMT should be kept and updated at all times by the EMTCC and the level of notification with regards to the deployment will follow the levels explained earlier for example, alert, activation standby, dispatch, and stand down. Figure 5.3 depicts the workflow involving the process of international deployment of Malaysian I-EMT.

When mobilizing EMT, National CPRC needs to ensure that the assets and capacities of EMT provided to the affected country meet the standards set out in the Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (WHO, 2013) and other relevant existing standards and requirements of the affected country. National CPRC also needs to ensure that EMT are self-sufficient with their subsistence requirements so as not to further burden the affected country in the course of operating within its territory.

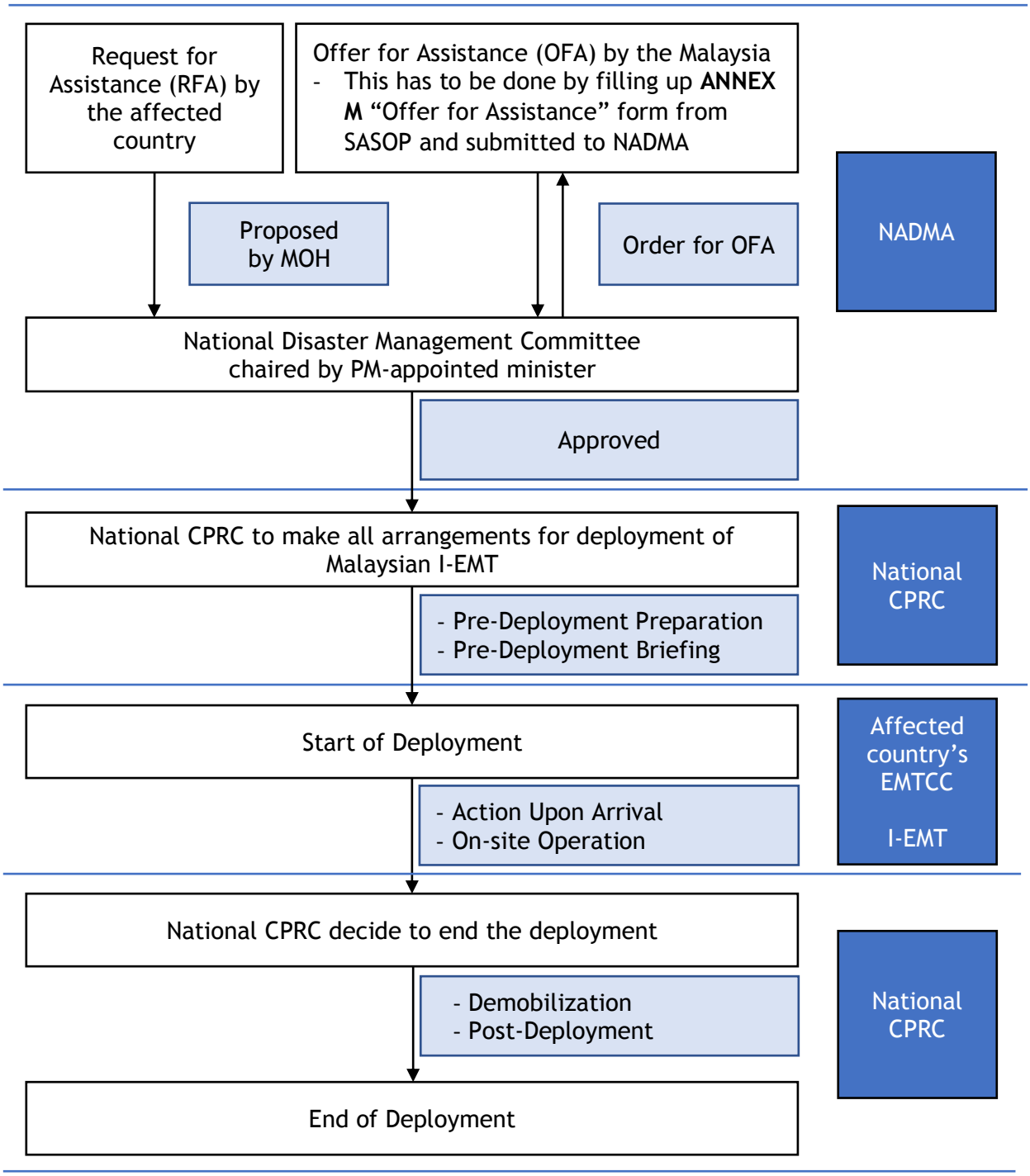


Figure 5.3 Work Flow for Deployment of I-EMT

5.3 Pre-Deployment Preparation

Pre-deployment preparation should be implemented at the individual and National CPRC level.

5.3.1 Individual Preparation

As soon as the team composition is known, final individual preparations should be made. For further details please refer to 4.4.

5.3.2 National CPRC Preparation

Table 5.1 National CPRC Preparation

ACTIVITIES	EXPLANATION AND REMINDERS
Travel Arrangement	i. An official notification letter to NADMA is required. NADMA will then notify the Malaysian Embassy in the host country, the host country's Embassy in Malaysia and the country desk in MOFA. ii. The National CPRC needs to prepare the Terms of Reference (TOR) and briefing kit for mission members, including reporting templates and relevant devices. iii. A budget plan is required to cover the team's day-to-day operations costs (accommodation, meals, travel/ rentals, and contingency funds). Since all transactions are conducted in cash, especially during disasters, sufficient cash allocation is mandatory. The relief budget should be referred to Emergency Finance mobilization. iv. Travel arrangements, including visas, flights, and briefings, are managed by the National CPRC prior to team deployment.
Mission Inventory	i. The mission inventory for the team on the same flight is as follows (sent via email to the counterpart in the host country prior to departure by NADMA): at a minimum, the inventory should include the following details; a. Contents by crate/ box number, dimensions, and weight of each box, serial numbers of electronic/ telecommunications equipment, the quantity of each item deployed, and the Commodity Tracking Number (CTN) provided by the National CPRC logistics personnel. b. Two (2) printed copies of the final inventory are carried by the team leader, and logistics officer for customs procedures. c. The packing list must identify all equipment in each container (box, duffle bag, and others) to facilitate customs inspections.

ACTIVITIES	EXPLANATION AND REMINDERS
Inform the Counterpart in the Host Country	i. The National CPRC to communicate officially with their counterpart in the host country upon the decision to respond and provide information such as objective of the deployment, number of mission members, duration of stay and types of supplies to be brought into the country (refer to mission inventory) as required by JOCCA, OSOCC, and AHA Centre.
Communicate with the International Humanitarian Community (WHO, UNOCHA, AHA Centre and others) via VOSOCC	i. In an instance of UN international appeal/ WHO appeal for EMT team; National CPRC will need to notify WHO of their readiness to deploy via VOSOCC.
Mission Briefing	i. A mission briefing is required for all mission members prior to team departure by National CPRC. ii. The mission team leader contacts the counterpart head of operations to inform of arrival plans and for any final updates.

5.4 Pre-Deployment Briefing

Pre-deployment briefing is intended to establish a baseline physical and mental health status of responders and to give some information on what to expect when they arrived on the crisis/ disaster area.

5.4.1 Components of pre-deployment briefing.

i. Crisis/ Disaster.
   a. Site;
   b. Time;
   c. Number of victims;
   d. Teams' allocation;
   e. Logistics;
   f. Available resources and services; and
   g. Specific safety and security concerns

ii. Term of reference and expected responsibilities for responders.

iii. Deployment duration/ schedule.

iv. Information of responders' next of kin.

v. Mental health preparedness/ self-care/ burnout prevention and mental health alert card.

vi. Physical health screening.

vii. Mental Health Screening.

5.4.2 Location of Pre-Deployment Briefing

Pre-deployment briefing will depend upon local or international deployment. Briefing can be conducted physical or virtually.

i. International deployment (I-EMT) – Conducted by National CPRC.

ii. Local deployment (N-EMT) – Conducted by State/ National CPRC.

CHAPTER 6

ACTION UPON ARRIVAL

CHAPTER 6

ACTION UPON ARRIVAL

6.1 Background

This chapter describes the procedures that need to be taken by EMTs mobilized into and out of Malaysia. The chapter contains three parts as follows:

Part 1: National EMT mobilization (N-EMT).

Part 2: Receiving Inbound International EMT (I-EMT).

Part 3: Arrival of Outbound International EMT (I-EMT) in foreign countries.

6.2 Part 1: National EMT Mobilization (N-EMT)

Stage 1: Team Arrival at State/ District EMTCC

i. The designated EMT is deployed to the State/ District EMTCC by the National EMTCC.

ii. The EMT then reports duty to the PIC at State/ District EMTCC.

iii. Upon arrival at State/ District EMTCC, the team leader is given a briefing by the PIC at State/ District EMTCC on the latest situation, safety, and security.

iv. The team leader will obtain a map and Global Positioning System (GPS) coordinate for the locations from the EMTCC.

v. Any potential conflict between mission requirements and security measures needs to be identified and addressed at the earliest stage.

Stage 2: Team Arrival at Designated Area of Operations.

i. EMT team is then mobilized to the Incident site where they report to the On-site Medical Commander (OMC).

ii. The EMT team is then provided with an area by the OMC at the incident site to establish their base.

iii. The team should identify a base from which it can operate-preferably as close as possible to the main logistic line.

iv. The deployed team members are expected to adhere to activities outlined in their TOR given for a particular mission and maintain their professionalism in exercising their assigned duties.

v. Team leader provides briefing and debriefing sessions daily to team members.

Stage 3: EMTCC Coordination Meeting

i. The team leader of EMT will have to attend the State/ District EMTCC Coordination meeting as scheduled on a regular basis.

Stage 4: Submission of Report

i. All EMT should submit reports to State/ District EMTCC according to the reporting format and time set by EMTCC. The list of reports is as follows:

   a. EMT-MDS Daily Report Form
   b. Notification form (Rev 2010) of any notifiable infectious diseases according to the Prevention and Control of Infectious Diseases Act 1988 (Act 342) must be reported immediately within 24 hours (**Annex 11**).
   c. Incident Reporting Form (IR 2.0) - ALL "patient safety incidents" that happen, "near miss".

Stage 5: Demobilization

i. All EMT teams that have completed their operations should inform OMC regarding the demobilization of the team and must submit an EMT exit report to respective State/ District EMTCC depending on deployed location.

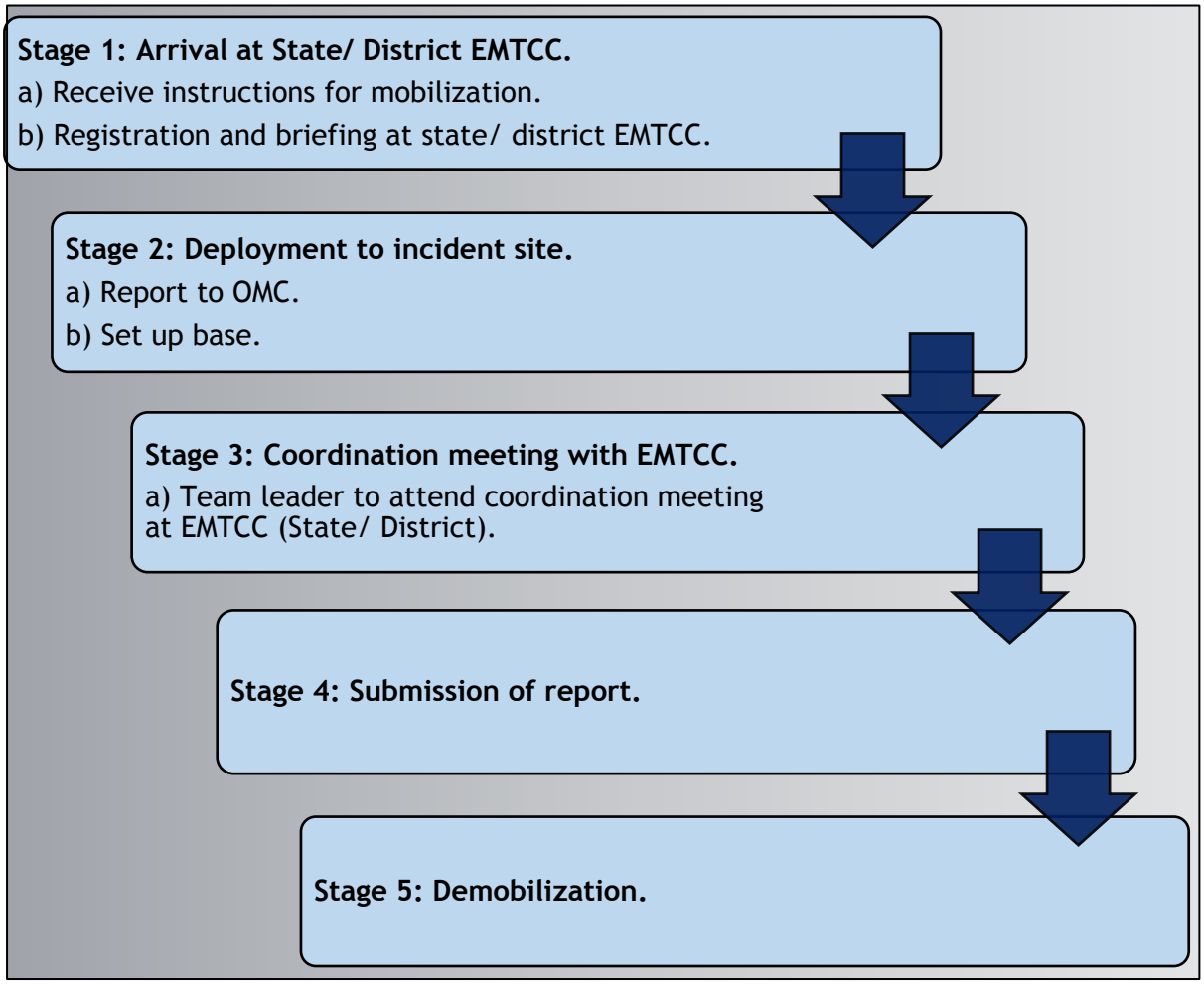


Figure 6.1 Stages of Receiving National EMT

6.3 Part 2: Receiving International EMT (Inbound I-EMT)

Stage 1: Inbound International EMT arrival at the Point of Entry (POE) in Malaysia

i. Upon arrival of the International EMT at the pre-determined POE, the team will need to register at the RDC after undergoing immigration, customs clearance, and health screening.

ii. The RDC is set up by NADMA and managed by multiple agencies at the POE (Table 4).

iii. Temporary Practicing Certificates will be issued to all foreign medical practitioners according to criteria set by Malaysia Medical Council before they are allowed to practice in Malaysia as I-EMT. (Refer 3.6.1).

iv. Medicine brought for the mission needs to be declared and need to be checked by the officer of the pharmacy enforcement division according to the country's existing procedure (Refer 3.6.2).

v. There is no restriction on telecommunication tools brought for the mission (Refer 3.6.3).

vi. The representative of the incoming team must complete the registration process for the team via Virtual On-site Operations Coordination Centre (VOSOCC) and the Malaysian system at the RDC.

vii. The personnel on duty at the RDC will brief the incoming team(s) on the latest scenario of the event/ disaster. The teams will also be informed regarding the location of the Joint Operation Coordination Centre for International Assistance (JOCCIA) to report their arrival for the assignment of the task.

viii. I-EMT can be directly deployed to state/district EMTCC or will undergo staging at JOCCIA depending on the directives from National EMTCC.

Stage 2: Arrival at Joint Operation Coordination Centre for International Assistance (JOCCIA) by NADMA.

i. Staging is conducted by National EMTCC at JOCCIA.

ii. I-EMT then awaits at JOCCIA pending deployment to the incident site.

iii. I-EMT teams are expected to be self-sufficient during the waiting period at JOCCIA.

Stage 3: Deployment to the incident site

i. The I-EMT is deployed to the state/ district EMTCC by the national EMTCC.

ii. Upon arrival at state/district EMTCC the team leader is given a briefing by the PIC at state/ district EMTCC on the latest situation, safety, and security.

iii. I-EMT is then mobilized to the Incident site where they report to OMC (On-site Medical Commander).

iv. The I-EMT is then provided with an area by the OMC at the incident site to establish its base. The team is expected to be self-sufficient during the process.

v. The deployed team members are expected to adhere to activities outlined in their TOR given for a particular mission and maintain their professionalism in exercising their assigned duties.

vi. Team leader provides briefing and debriefing sessions daily to team members.

Stage 4: Coordination Meeting with EMTCC

i. The team leader of International EMT will have to attend the EMTCC Coordination meeting as scheduled on a regular basis.

ii. All I-EMT should submit reports to state EMTCC according to the reporting format and time set by EMTCC. The list of reports is as follows:

a. EMT-MDS Daily Report Form.
b. Notification form (Rev 2010)-any notifiable infectious diseases according to the Prevention and Control of Infectious Diseases Act 1988 (Act 342) must be reported immediately within 24 hours (**Annex 11**).
c. Incident Reporting Form (IR 2.0) - ALL "patient safety incidents" that happen, "near miss".

Stage 5: Demobilization of International EMT

i. All I-EMT that have ended their operations should inform OMC regarding the demobilization of the team and must submit an international EMT exit report to respective State/ National EMTCC.

ii. Any medical supplies or equipment that are intended to be left behind must be listed in the I-EMT exit report.

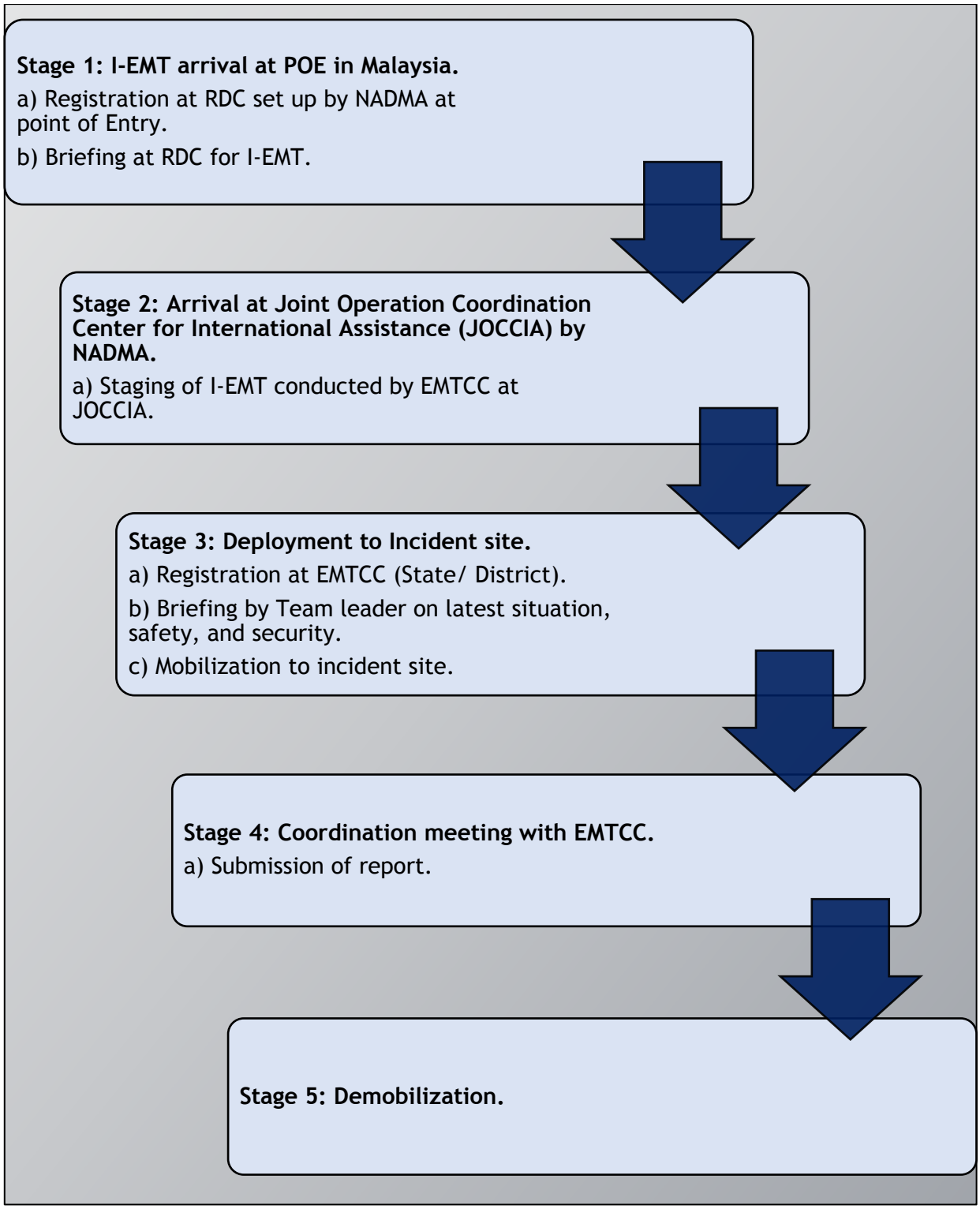


Figure 6.2 Stages of Receiving International EMT

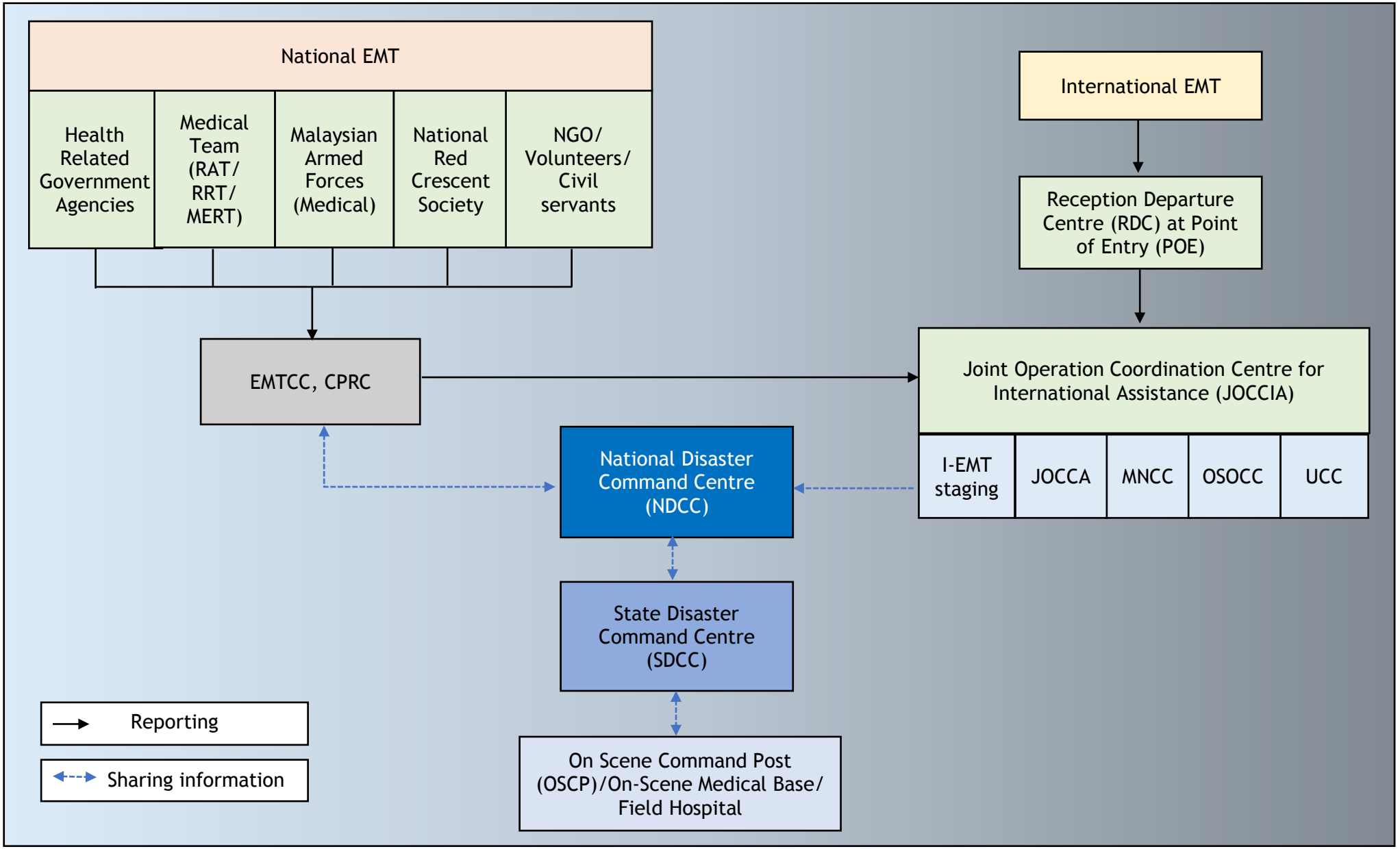


Figure 6.3 Illustration of the Flow of Receiving National and International EMT to Affected Area

6.4 Part 3: Actions of Outbound International EMTs (I-EMT) in the host country

Upon arrival in a host country, Outbound International EMTs (I-EMT) should keep in mind the following recommendations:

i. Registration and Legal Requirements:
The EMT needs to obtain the necessary permissions, licenses, or permits to operate in the host country. Register and comply with all the legal requirements of the relevant agencies. On arrival to the host country, the Malaysian EMT will have to go through customs and immigration clearance and subsequently report to the RDC or other relevant agencies in the host country.

ii. Coordination and Needs Assessment:
The EMT will need to establish communications with the authorities in the host country. The team will need to participate in coordination meetings to understand the host country's specific needs, priorities, and response plans. Upon arrival in the area of operation, the EMT is required to inform the local EMTCC in the host country, set up base operations, and implement services.

iii. Cultural Sensitivity and Respect:
The EMT is required to respect and acknowledge the local culture, customs, and norms. They adapt their practices and behavior accordingly to foster a collaborative and respectful working relationship with the local population and healthcare professionals.

iv. Security and Safety:
The EMT is advised to strictly follow security protocols and guidelines provided by the host country or local authorities. The team leaders need to ensure the safety of their team members and take necessary precautions to mitigate risks associated with the operating environment.

v. Assessing Local Resources:
The EMT will be required to assess existing healthcare resources in the host country prior to departures. Assessment could include medical facilities, equipment, supplies, and human resources.

vi. Collaboration with Local Healthcare Providers:
The EMT plays a role to collaborate with local healthcare providers in the host country to understand their local healthcare system, referral pathways, and available medical services.

vii. Language and Communication:
If there is a language barrier, the EMT should arrange for interpreters or translators to facilitate effective communication with patients, healthcare providers, and the local community.

viii. Adaptation to Local Context:
The EMT team is advised to adapt its medical protocols, guidelines, and treatment approaches to align with the host country's healthcare standards and available resources.

ix. Reporting and Information Sharing:
The EMT is always advised to maintain accurate and timely documentation and submit the relevant reports that are required.

x. Self-sustaining supplies:
The EMT deployed to another country should be equipped with an adequate amount of supplies such as (food items, water, basic needs, medicine, health equipment, and logistics for the setup of base camps).

xi. Briefing and situational awareness:
The EMT should be provided with the briefing on situational awareness of the event at host country.

CHAPTER 7

ON-SITE OPERATIONS

CHAPTER 7

ON-SITE OPERATIONS

7.1 Background

On-site operations for any disaster consist of a medical and public health team, supported by NGOs, led by an appointed Team Leader. The appointed team leader should be the most qualified and experienced in disaster management.

The Team Leader is required to:

i. Continually conduct a risk/ hazard analysis of the situation, travel routes and assigned work area and take appropriate mitigation action;

ii. Ensure safety and security considerations are included in the plan of action and briefings;

iii. Ensure a warning system and evacuation plan is established, briefed and exercised;

iv. Regular roll call of all personnel should be maintained throughout the mission;

v. Ensure that team personnel adhere to the-buddy system;

vi. Continually monitor the weather forecast;

vii. Ensure biomedical control measures are adhered to (for example, body recovery, patient handling, sanitation, hygiene, and others);

viii. Investigate and document all accidents;

ix. Ensure personnel and equipment decontaminating practices are followed prior to leaving the work site and entering the base of operation;

x. Ensure that all team personnel have reliable means of communications;

xi. Ensure adequate rest, rotation, hydration, and feeding of team members;

xii. Monitor personnel for signs and symptoms of stress-related health problems and implement stress management techniques as appropriate;

xiii. Monitor the team's nutrition and hydration needs; and

xiv. Ensure health and hygiene practices are strictly followed.

The existing chain of command, and specifically to whom and how the Team Leader reports, must be quickly established to ensure continuity throughout the operation.

7.2 Emergency Medical Services

Immediate assessment for response will be based on the Concept of 5S:

i. **S**afety of affected area.

ii. **Sc**ene size up.

iii. **S**end information to hospital base.

iv. **S**et up medical base at on-site.

v. **S**TART or any type of field triage.

Primarily the responding Medical Team, either from Hospital or Health Clinic, will provide emergency care to disaster-related victims. This includes First Aid, Psychological First Aid and Forensic services (*Refer to existing local Hospital Disaster Plan).

Scope of service:

Depending on the type of EMT's that are deployed, the EMT will provide:

(All Types of EMT has been summarized in a Table 2 in Chapter 2, suggest refer to table).

7.2.1 EMT Type 1: Outpatient Emergency Care

Provides outpatient initial emergency care of injuries and other significant health care needs.

Key services:

i. Triage, Assessment and First Aid.

ii. Stabilization and referral of severe trauma and non-trauma emergencies.

iii. Definitive care for minor trauma and non-trauma emergencies.

Type 1 EMTs can work from suitable existing structures, or supply their own fixed or mobile outpatient facilities, such as tents or special equipped vehicles. They should be available to arrive in the fastest possible time, ideally within 24–48 hours, and be considered light and portable. Their staff should be experienced in those elements of initial trauma care that relates to triage on a mass scale, wound and basic fracture management, basic emergency care of paediatric, obstetric, mental health and medical presentations.

Type 1 EMTs should be in a position to stay for at least 2–3 weeks, or even longer if they are specialised in ambulant follow up for long term wound care and rehabilitation.

7.2.2 EMT Type 2: Inpatient Surgical Emergency Care

Provides inpatients acute care, general and obstetric surgery for trauma and other major conditions

Key services:

i. Intake/ Screening of new and referred patients and counter-referral;

ii. Surgical triage and assessment;

iii. Advanced life support;

iv. Definitive wound and basic fracture management;

v. Damage control surgery;

vi. Emergency general and obstetric surgery;

vii. Inpatient care for non-trauma emergencies;

viii. Basic anesthesia, X-ray, sterilization, laboratory, and blood transfusion; and

ix. Rehabilitation services and patient follow-up.

Type 2 EMTs must be able to provide inpatient care, and have the ability to receive, screen and triage new and referred patients. Type 2 EMTs may either be offered within a suitable existing structure, or provide a temporary facility.

7.2.3 EMT Type 3: Inpatient Referral Care

Provides complex inpatient referral surgical care including intensive care capacity

Key services:

i. Intake/ Screening of referred and new patients, surgical triage and assessment, plus counter-referral;

ii. Capacity to provide Type 2 services when needed;

iii. Complex reconstructive wound and orthopedic care, when required enhanced, X-ray, sterilization, laboratory, and blood transfusion services;

iv. Rehabilitation services and patient follow-up;

v. High level pediatric and adult anesthesia; and

vi. Intensive care beds with continuous monitoring and the ability to ventilate.

Type 3 EMTs should be considered an option to provide a high-level referral service to those Type 1 and 2 teams (both local and foreign) that cannot provide services of that standard. These must include 4–6 intensive care beds with the ability to ventilate patients and reconstructive wound and orthopaedic capability, but can also include other specific specialist groups and services (e.g. maxillo-facial, specialist paediatric, and others.). The original provider of the type 3 EMTs may bring these or may declare themselves capable of receiving and integrating specialised care teams (see below) to work within their facility (e.g., an ortho-plastic reconstructive group of surgeons and operative nurses).

7.3 Health Needs Assessment (HNA)

Health needs assessment during a disaster is a crucial step in understanding the impact of the disaster on the affected population and identifying their specific health-related needs. It involves gathering data and information to guide the planning and implementation of appropriate healthcare interventions.

The deployed team members are expected to adhere to the activities outlined in their TOR given for a particular mission. However, the usual onsite activities during disaster are as outlined below.

7.3.1 Establishing Early Warning and Response System (EWARS)

Mobilize team to contribute to establishing and maintaining an appropriate Early Warning and Response System (EWARS), regularly report on health services delivered to the affected population and the situation in the areas where they work.

The team should establish an appropriate health monitoring/surveillance system that provides regular data on mortality, morbidity, injury treatment and rehabilitation, potential health risks, and health service performance.

7.3.2 Food Safety and Nutritional Assessment

Food safety involves handling, preparation, and storage of food in ways that prevent food-borne illness. Apply the five (5) key principles of food safety, according to WHO[1]:

i. Prevent contaminating food with pathogens spreading from people, pets, and pests;

ii. Separate raw and cooked foods to prevent contaminating the cooked foods;

iii. Cook foods for the appropriate length of time and at the appropriate temperature to kill pathogens;

iv. Store food at the proper temperature; and

v. Do use safe water and safe raw materials.

During disasters, regular community practices are disrupted, populations often become displaced, and normal production of food and care for children is disturbed. It is critical to identify the most vulnerable groups in the population, as malnutrition emerges quickly among these groups when their nutritional needs are not met.

These are usually identified as:

i. Infants and young children.

ii. Pregnant and lactating women.

iii. Elderly.

iv. People with special needs.

7.3.3 Water Supply, Sanitation and Hygiene Promotion (WASH)

The aim of the health team is to promote good personal and environmental hygiene in order to protect health.

i. Hygiene promotion.

ii. Clean water supply.

iii. Excreta disposal.

iv. Vector control.

v. Solid waste management.

vi. Drainage.

7.3.4 Shelter and Settlement

During a disaster, providing shelter and settlement is a critical component of emergency response and recovery efforts. It involves ensuring safe and healthy housing options for individuals and communities affected by the disaster in terms of basic services and infrastructure (clean water, sanitation facilities, ventilation, and space).

7.4 Mental Health and Psychosocial Support (MHPSS)

MHPSS refers to the services and interventions that aim to promote psychological well-being, provide emotional support, and address mental health needs in individuals and communities affected. This includes:

i. Triaging Mental Health and Psychosocial Problems;

ii. Psychological First Aid;

iii. Psychoeducation;

iv. Psychological Support/ Ventilation Session for Volunteers/ Disaster Responders/ Affected Families and Personnel;

v. Distribution of Information on Coping Skills; and

vi. Address Grief and Trauma.

7.5 Specialized Care Services

During a disaster, specialized medical care is essential to address the specific needs and challenges that arise. These specialized medical professionals work in collaboration with other healthcare providers and emergency response teams to ensure comprehensive care for those affected by the disaster, addressing both immediate and long-term medical needs. Specialized services may include:

i. Burn Care
   a. Specialist surgical +/- allied health teams with expertise in management of burns and burn complications.

ii. Dialysis and Care of Crush Syndrome
   a. Specialist nephrology and renal care teams for the care of crush syndrome and expert advice on mass dialysis.

iii. Maxillofacial Surgery
   a. Specialist maxillo-facial surgical teams with or without operative teams with expertise in the management of complex facial trauma and facial reconstruction.

iv. Orthoplastic Surgery
   a. Specialist orthopaedic and plastic teams, ideally with operative theatre and allied health and rehabilitation support to provide complex orthopaedic and wound surgical care and reconstruction.

v. Intensive Rehabilitation
   a. Specialist rehabilitation teams to provide support to EMTs and hospitals unable to provide rehabilitation services.

vi. Maternal Health
   a. Specialist providers of midwifery and obstetric surgical care when EMTs are unable to do so.

vii. Neonatal and Paediatric
   a. Provide specialist paediatric and neonatal care.

viii. Transport and Retrieval
   a. Specialist teams for the transfer of critically ill patients in specific circumstances after consultation with the host ministry of health.

Additional services may be provided by other agencies or the local health services.

7.6 Patient Referral

Patients requiring referral to secondary or tertiary care should be informed to EMTCC and Patient Referral Form (**Annex 12**) filled to be brought along with patient. Transportation shall be coordinated by EMTCC depending on feasibility of mode of transportation (land/ air).

7.7 Response to Medical Accident

Ministry of Health (MOH) Malaysia has implemented the Incident Reporting and Learning System which is a system of reporting patient safety incidents that happen in healthcare, investigate or review why the incident happens, learn from the incident, take appropriate action to prevent similar incident from happening, and share with others. It involves "holistic improvement of the system" and not about "finding an individual to be blamed". The key steps in managing patient safety incident are as shown in Figure 7.1. With open concept of reporting, ALL "patient safety incidents" that happen, "near miss" need to be reported using the IR 2.0 Form (**Annex 13**) and submitted to EMTCC.

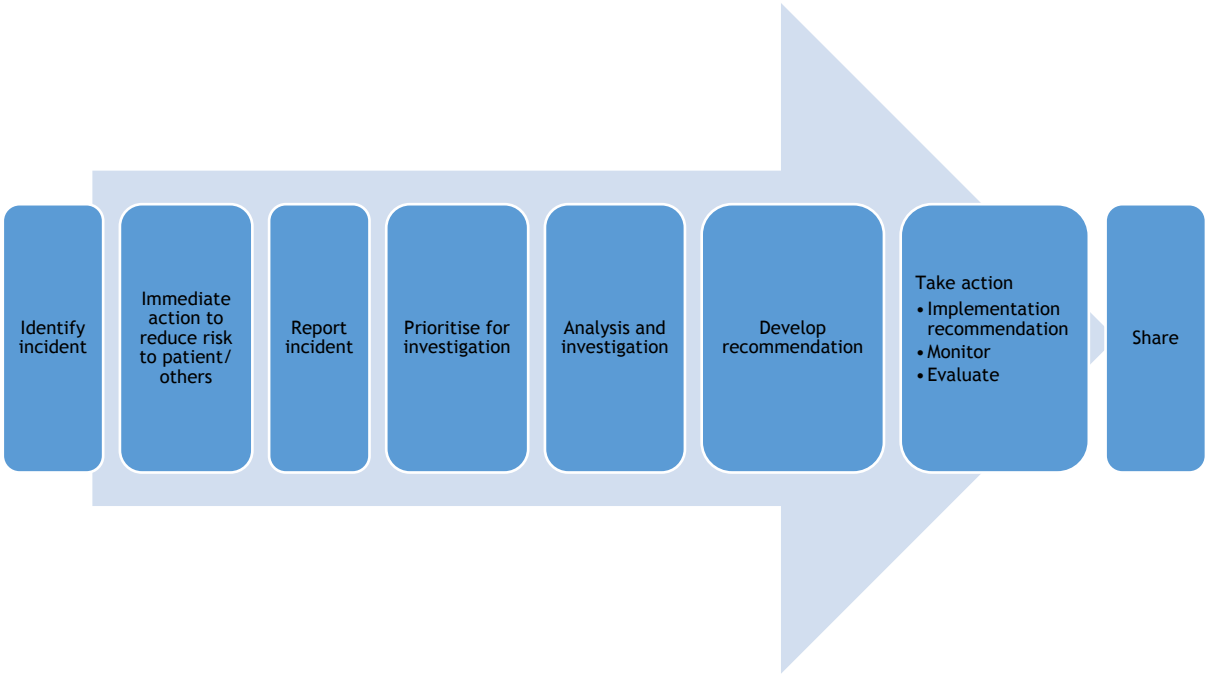


Figure 7.1 Key Steps in Managing Patient Safety Incident

7.8 Clinical Waste Management

Clinical waste shall be defined as:

i. Any waste which consists of wholly or partly of human or animal tissues, blood or other body fluids, excretions, used drug, swabs dressings, syringes, needles or other instruments, being waste which unless rendered safe may prove hazardous to any other person coming into contact with it; and

ii. Any other waste arising from medical, laboratory, nursing, dental, veterinary, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which cause infection to any other person coming into contact with it.

There are five (5) groups of clinical waste namely:

i. Group A: Waste contaminated with blood and other bodily fluids (for example, soiled gloves, plasters, swab, cotton wool, dressing, bandages and others), and pathological waste shall be placed into yellow biohazard bag.

ii. Group B: Sharp waste shall be placed into sharp bin.

iii. Group C: Waste from laboratory shall be placed into blue biohazard bag for autoclave before putting into another layer of yellow biohazard bag.

iv. Group D: Pharmaceutical waste shall be placed into sharp bin.

v. Group E: Disposable medical instruments (non-sharp) shall be placed into yellow biohazard bag.

The flow chart for types of waste and its segregation is as shown in Figure 7.2.

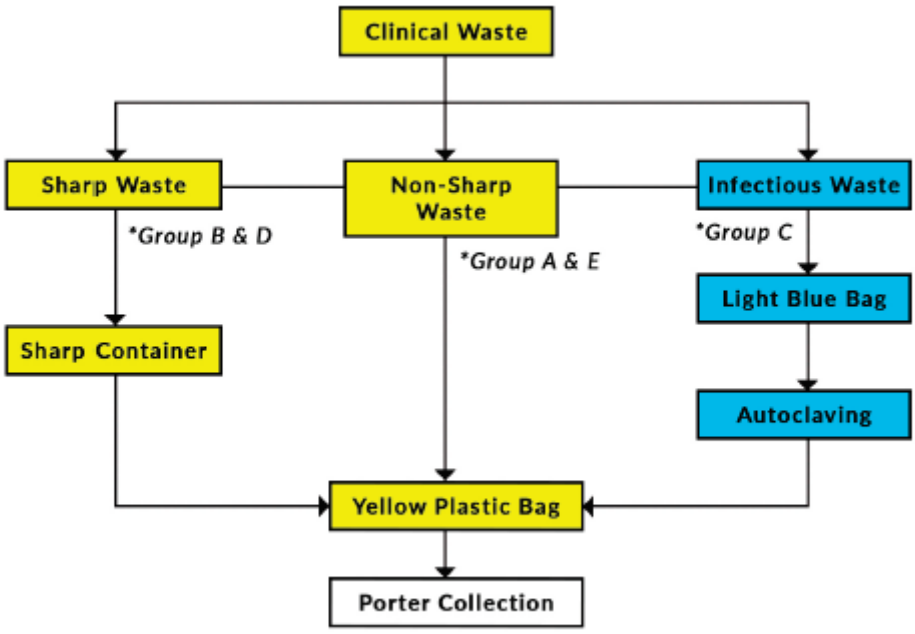


Figure 7.2 Flow Chart for Types of Waste and Its Segregation

I-EMTs with self-sufficiency including incineration facilities may dispose of their clinical waste by incineration process. Discussions to be made to facilitate clinical waste disposal using current Malaysia's system of clinical waste collection by concession companies.

7.9 Management of Dead Bodies and Human Remains

Dead bodies and human remains management is a critical aspect of emergency response and recovery operations. It involves the proper handling, identification, and disposal of deceased individuals with dignity, respect, and sensitivity. Some important points to be considered include:

i. Safety
   a. Assess and address potential hazards.
   b. Use Personal Protective Equipment (PPE).

ii. Coordination and Documentation
   a. Coordinate efforts among relevant agencies.
   b. Document information for each body/ body parts.

iii. Identification
   a. Collect identifying details (belongings, visual identification, dental records, and others).
   b. Involve trained personnel for identification if needed.

iv. Preservation and Storage
   a. Preserve bodies/ body parts to prevent decomposition.
   b. Use refrigeration or temporary morgues if necessary.

v. Respect Cultural Sensitivity
   a. Conduct management with respect and sensitivity.
   b. Involve local communities, religious leaders, and cultural representatives.

vi. Burial and Cremation:
   a. Follow cultural, religious, and legal requirements.
   b. Consider mass burials if needed.

Ministry of Health Malaysia Standard Operating Procedures of Forensic Medicine Services 2012 shall be the guiding document for ensuring uniformity of quality Forensic Medicine Services that is systematic and in accordance to existing mechanism. (*Pelan Pengurusan Bencana*, 2025)

CHAPTER 8

DEMOBILIZATION

CHAPTER 8

DEMOBILIZATION

8.1 Background

Demobilization of EMT after a disaster refers to the process of systematically and safely winding down and releasing the personnel, equipment, and resources that were deployed during the emergency response.

The decision to terminate the EMT mission will be decided by the National CPRC/ EMTCC in consultation with the State CPRC/ EMTCC, and EMT Leader. After the decision is taken, the EMT should brief the CPRC/ EMTCC (when appropriate, the national authorities) on their demobilization plan.

8.2 Internal Debriefing

The Team Leader has to hold an internal debriefing with the team, including analysis of the overall mission, SWOT analysis (strengths, weaknesses, opportunities, and threats), mission closure, and the psychological impact (professional follow-up if necessary). Details will be explained in Chapter 9 - Post Deployment.

8.3 Handover/ Exit

When completing a mission, a proper handover and exit strategy are crucial to ensure a smooth transition and maintain the continuity of operations. This includes:

i. Defining what services should be handed over and which should be terminated.

ii. Community/ local authorities' empowerment to ensure sustainability of services.

iii. Confirming administrative procedures and logistics of departure in cooperation with National CPRC/ EMTCC.

iv. Where applicable, support National CPRC/ EMTCC in arranging an external evaluation of the mission.

A detailed handover note should be prepared, specifying what functions, assets, and services are being handed over and to whom. In many cases, the handover note can be annexed to the End of Mission Report. For those taking over coordination functions, this should include:

i. **Situation:**
Situation reports, maps, update on the current situation, themes, and likely future developments.

ii. **Mission Objectives:**
Past and current, likely and future, early recovery, concerns and remarks.

iii. **Key Actors/ Partners:**

National authorities, NGOs, United Nations, military, donors, and others, presented as a contact list, who-what-where overview, and others.

iv. **Activities and Processes to Continue:**
For example, inter-cluster coordination structures, leadership functions, information management, and other coordination functions.

v. **Evaluation of Current Status:**
What has been accomplished, what has not been done – but should be, strengths and weaknesses of the coordination mechanisms.

vi. **Operational Information:**
Safety, security, logistics, communications.

vii. **Administration, Finance, In-Country Support:**
Includes what should continue and the financial implications (when the EMT departs, mission funding cease). A separate handover note for administrative procedures may be required.

8.4 End of Mission/ Exit Report

At the end of each mission, it is important to draft a mission report. This is usually for the benefit of the government, but is also intended for sharing with the wider community of response partners. The report should focus on what the team has done, including best practices from this response, suggested improvements to future contingency plans, and suggested updates to the EMT methodology. This can be done using EMT Exit Report Form (**Annex 14**) and also AMS I-EMT Lessons Learnt Report (**Annex 15**).

The mission report should be regarded as an integral part of the exit and handover strategy. While this report is the responsibility of the EMT Leader, all team members should contribute to the process. Many EMT members, based on their mission experiences, can offer recommendations on future disaster response preparedness.

While the team is in a unique position to offer advice, to be properly effective, it is important that recommendations can be followed up as part of a wider, ongoing response preparedness programme. It is therefore important to capture such recommendations in the mission reporting process for follow-up by the National CPRC and other relevant partners. The recommendations may be the starting point for more targeted disaster response preparedness activities that the MOH system could support, or feed into initiatives already underway.

Mission reporting is also an excellent opportunity to capture good practices that may be used for updates to the EMT methodology and training purposes. Bear in mind that the EMT methodology should be dynamic and move forward. The best way of doing this is by capturing and working on mission experiences so they can be considered for future references.

In addition to the mission report, National CPRC/ EMTCC will prepare a short End of Mission Report that captures the key points from the mission and will share this with the EMT member's sponsoring government/ organization.

8.5 Administrative Matters

All EMT members should complete an Expense Report or 'Travel Claim Form' as soon as possible following their return from the mission to enable rapid settlement of their entitlements. To process the expense report, team members should send the following scanned documents via email. EMT members should also keep a photocopy of all original documents sent to National CPRC/ EMTCC for their own records.

i. Originals of all boarding passes and any air tickets issued.

ii. Originals of all attachments relevant to personal expenses incurred, for example, excess baggage charges, airport taxes, receipts for taxis, official phone calls, or Internet usage, and others.

However, this is subject to the financial support/ procedure for each particular mission.

CHAPTER 9

POST DEPLOYMENT

CHAPTER 9

POST-DEPLOYMENT

9.1 Background

Post-Deployment are initiatives taken in response to a disaster with a purpose to achieve early recovery and rehabilitation of responders in helping them return to their daily routine (Figure 9.1).

The purpose of this phase is to inform responders on the signs and symptoms they may experience in the first few weeks after returning from the crisis/ disaster area. Health assessment will also be conducted in making sure the responders are mentally and physically stable.

The responders will be advised on things and matters need to be taken care of which may include the following:

a) Maintaining a healthy diet, routine exercise, and adequate rest/sleep.

b) Spending time with family and friends.

c) Paying attention to health concerns.

d) Meeting neglected daily personal tasks (for example, household chores).

e) Reflecting upon what the experience has meant personally and professionally.

f) Getting involved in personal and family matters.

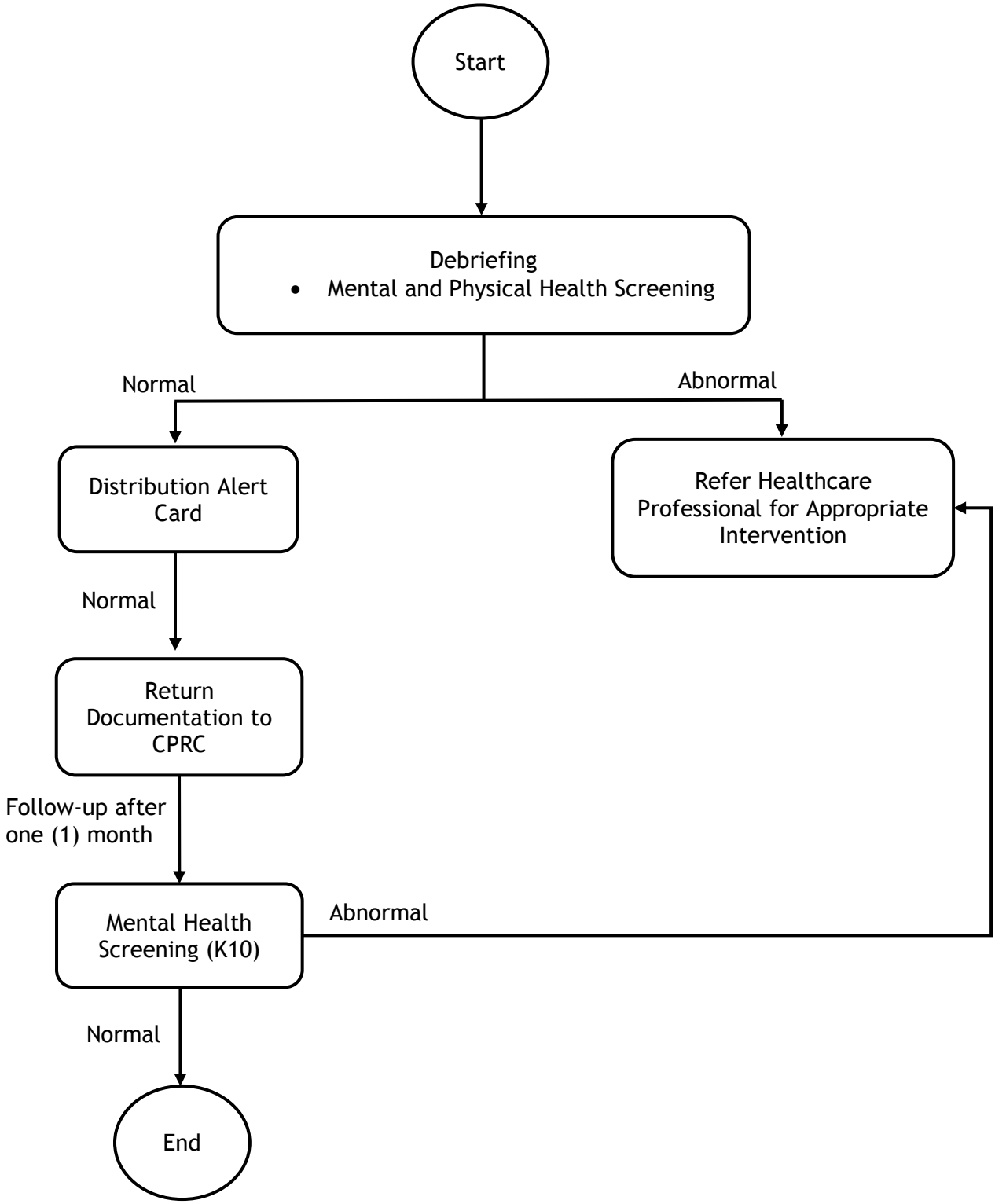


Figure 9.1 Post-Deployment Flowchart

9.2 Psychological and Physical Assessment

Upon the completion of duty/ returning from duty in a disaster area, disaster responders: (Refer to Post-Deployment Procedure in Table 9.1):

a) Shall be assessed physically (basic medical check-up) - within 30 days after completion of mission.

b) Shall be assessed for mental status and given psychoeducation.

c) Shall be issued a Health Alert Card by CPRC if applicable (comprising physical health and mental health component) depending on nature/ location of mission. Refer General Health Alert Card.

Those identified with physical and psychological symptoms will be referred to health professionals for further intervention. Documentation will be returned to CPRC.

Assessment using mental health questionnaires Kessler 10 (**Annex 22**) will be done after a month upon returning from the mission (done by local administration).

Table 9.1 Post-Deployment Procedure

NO.	DETAILS	ACTIVITIES	RESPONSIBILITY
1.	Debriefing.	During this session, General and Mental Health assessment session will be conducted. Tools: ● Whooley (**Annex 16**) ● GAD2 ● PHQ9/ GAD7	CPRC/ Individual agency coordinator.
2.	General and Mental Health alert cards distribution.	General and Mental health alert card will be given to all responders involved.	CPRC/ Individual agency coordinator.
3.	Referral to Health Professional.	During assessment, responders identified to have psychological/health issues will be referred to health professionals such as medical officers, counsellors, clinical psychologists or psychiatrist for referral and follow up.	CPRC/ Individual agency coordinator/ Health professionals/ Local administrator/ Head of Department.
4.	Return Documentation to CPRC.	All documentations on post deployment activities will be reported to CPRC for record purposes.	Individual agency coordinator/ Health professionals/ Local administrator/ Head of Department.
5.	Mental Health Screening.	Mental health screening will be conducted one (1) month after demobilisation. Tool: Kessler Psychological Distress Scale (K10).	Individual agency coordinator/ Health professionals/ Local administrator/ Head of Department.

EMT REGISTRATION FORM

MINISTRY OF HEALTH MALAYSIA	EMT *Country, Event, Year*	World Health Organization

EMT Name		**#ID EMT Global Classification**	###
EMT Type		**Date and Time of offer**	dd / mm / yyyy HH:MM

☐ We agree to comply with EMT guiding principles and standards, available at https://extranet.who.int/emt/sites/default/files/EMT_guidelines_september2013.pdf

Internal Office Use Only				
Team Status:	☐ Approved	☐ Pending	Reason:	
	☐ Tasked	☐ Declined	Reason:	
Check:	☐ WHO Classified	☐ Airport	☐ Field Visit	☐ Other:
Allocated Site:	*Location* *GPS Coordinates*	**Allocation Date:**	dd / mm / yyyy	
Other Comments:	*(e.g., reason for changing type vs the self-declaration from the team)*			

EMT INFORMATION	
ORGANIZATION:	
ORGANIZATION TYPE: ☐ NGO NATIONAL ☐ NGO INT ☐ GOVERNMENTAL ☐ MILITARY ☐ OTHER:	
COUNTRY:	**NUMBER OF EMTs:** ## DE ## (TOTAL EMT DEPLOYED)
TIME (HOURS/DAYS) OR ESTIMATED DATE OF ARRIVAL:	**TIME (HOURS/DAYS) TO START SERVICES PROVISION:**
ESTIMATED LENGHT OF STAY (DAYS):	
ORGANIZATION PRIMARY CONTACT (HQ)	
NAME:	**POSITION:**
ADDRESS:	
EMAIL:	**PHONE:** + country - area - phone number
EMT TEAM LEADER	
NAME:	**POSITION:**
EMAIL:	**EMAIL EMT:**
LOCAL PHONE:	**SATELLITE PHONE:**

EMT	EMT CAPABILITY	NAME EMT/ID WHO CLASSIFICATION

EMT TYPE

☐ TYPE 1 Mobile ☐ TYPE 1 Fixed ☐ TYPE 2 ☐ TYPE 3

☐ Specialized Cell *(Specify)*:

☐ The team brings a field facility (state bed capacity ###, estimated number of tents/ containers ###/###, total #### m^2 required)

LOGISTIC SUPPORT

Any logistical limitations or support required:
☐ NO ☐ YES Specify (e.g., transport should include total volume and weight).

Outpatient Capacity (patients/day):	
Inpatient Capacity (bed capacity):	
Surgical Capacity (number of surgical tables):	
Surgical Capacity (major and minor procedures /day):	

Other Capabilities:

☐ General Anaesthesia
☐ Intensive Care
☐ X-Ray
☐ Ultrasound
☐ CT Scan
☐ Laboratory
☐ Blood bank
☐ Pharmacy
☐ Rehabilitation
☐ Isolation area

CLINICAL SERVICES OFFERED	PUBLIC HEALTH CAPABILITIES

☐ We agree to comply with EMT guiding principles and standards, available at https://extranet.who.int/emt/sites/default/files/EMT_guidelines_september2013.pdf

EMT GLOBAL CLASSIFICATION STATUS:

☐ No Account ☐ EOI Submitted ☐ Mentorship ☐ Classified ☐ ID:

PREVIOUS DEPLOYMENT EXPERIENCE (LAST FIVE ONLY)

YEAR	COUNTRY	EVENT	EMT(s) TYPE	DURATION (DAYS)

EXISTING OR PREVIOUS WORKING RELATIONSHIP IN COUNTRY

ORGANIZATION	LOCATION	RELATIONSHIP

STAFFING DETAILS		EXPECTED LOCAL STAFF REQUIRED	
PHYSICIANS		PHYSICIANS	
SURGEONS		SURGEONS	
NURSES		NURSES	
MIDWIVES		MIDWIVES	
PSYCHOLOGISTS		PSYCHOLOGISTS	
ALLIED HEALTH PERSONNEL		ALLIED HEALTH PERSONNEL	
MANAGEMENT		MANAGEMENT	
LOGISTICS		LOGISTICS	
ADMINISTRATION		ADMINISTRATION	
Other		Other	
Other		Other	

DOCUMENTS CHECKLIST	NAME (person compiling the form):
☐ Professional Practice Licence ☐ CV or Resume (if applicable) ☐ Copy of Passports ☐ Visa documents (if applicable) ☐ Packing List ☐ Others required by the authorities	**Email:** **Signature:**

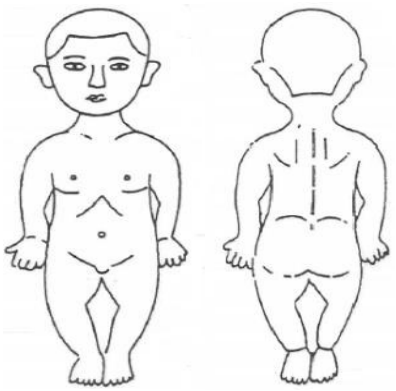
END OF REGISTRATION FORM

MEDICAL RECORD FORM

EMERGENCY MEDICAL TEAM MEDICAL RECORD (MDS+)

MDS - Check all that apply					
Age			_____ □ Month □ Year □<1, □1-4, □5-17, □18-64, □65-		
Sex	1	□	Male		
	2	□	Female non-preg.		
	3	□	Female pregnant		
Health Events – Trauma	4	□	Major head / spine injury	Require care at EMT Type 2/3	
	5	□	Major torso injury		
	6	□	Major extremity injury		
	7	□	Moderate injury EMT Type 1 capable		
	8	□	Minor injury EMT Type 1 mobile capable		
Health Events – Infectious disease	9	□	Acute respiratory infection		
	10	□	Acute watery diarrhea		
	11	□	Acute bloody diarrhea		
	12	□	Acute jaundice syndrome		
	13	□	Suspected measles		
	14	□	Suspected meningitis		
	15	□	Suspected tetanus		
	16	□	Acute flaccid paralysis		
	17	□	Acute haemorrhagic fever		
	18	□	Fever of unknown origin		
Health Events – Additional	19	□			
	20	□			
	21	□			
	22	□			
Health Events – Emrg.	23	□	Surgical emergency (Non-trauma)		
	24	□	Medical emergency (Non-infectious)		
Health Events – Other key diseases	25	□	Skin disease		
	26	□	Acute mental health problem		
	27	□	Obstetric complications		
	28	□	Severe Acute Malnutrition (SAM) *		
	29	□	Other diagnosis, not specified above		
Procedure and Outcome – Procedure	30	□	Major procedure (excluding MDS31)		
	31	□	Limb amputation excluding digits *		
	32	□	Minor surgical procedure		
	33	□	Normal Vaginal Delivery (NVD)		
	34	□	Caesarean section		
	35	□	Obstetrics others		
Procedure and Outcome – Outcome	36	□	Discharge without medical follow-up		
	37	□	Discharge with medical follow-up		
	38	□	Discharge against medical advice		
	39	□	Referral		
	40	□	Admission		
	41	□	Dead on arrival		
	42	□	Death within facility *		
	43	□	Requiring long term rehabilitation *		
Context – Relation	44	□	Directly related to event		
	45	□	Indirectly related to event		
	46	□	Not related to event		
Context – Protection	47	□	Vulnerable child *		
	48	□	Vulnerable adult *		
	49	□	Sexual Gender Based Violence (SGBV)*		
	50	□	Violence (non-SGBV) *		

Date	/ / (dd/mm/yyyy)		
ID			
Name		(nickname)	
Present Address			
Breast-feed	□ Y □ N □ Unknown	Arm circumference (<5yo)	cm
Vaccination	Measles □ Y □ N □ Unknown		
	Tetanus □ Y □ N □ Unknown		
Allergy	□ Y (Drug / Food / Other) □ N □ Unknown		
Past History	□ Y (HT / DM / BA / Other) □ N □ Unknown		
Medication	□ Y (HT / DM / BA / Other) □ N □ Unknown		
Chief Complaints			
Vital Signs	BT ℃	BP /	mmHg
	PR / min	RR	/ min
	Wt. Kg	Ht.	cm
History of Present Illness			



Diagnosis				
Drug Name / Dose				
Staff Signature	Reception	Doctor	MDS	Nurse
			(Dr.)	
	Drug	Examination	Data Input	

EMT MDS Tick box for 10 patients

			MDS - Check all that apply	1	2	3	4	5	6	7	8	9	10
			Memo										
Demographic	Age												
	Sex	1	Male	□ 1	□1	□1	□1	□1	□1	□1	□1	□1	□1
		2	Female non-pregnant	□ 2	□ 2	□ 2	□ 2	□ 2	□ 2	□ 2	□ 2	□ 2	□ 2
		3	Female pregnant	□ 3	□ 3	□ 3	□ 3	□ 3	□ 3	□ 3	□ 3	□ 3	□ 3
Health Events	Trauma	4	Major head/ spine injury	□ 4	□ 4	□ 4	□ 4	□ 4	□ 4	□ 4	□ 4	□ 4	□ 4
		5	Major torso injury	□ 5	□ 5	□ 5	□ 5	□ 5	□ 5	□ 5	□ 5	□ 5	□ 5
		6	Major extremity injury	□ 6	□ 6	□ 6	□ 6	□ 6	□ 6	□ 6	□ 6	□ 6	□ 6
		7	Moderate injury	□ 7	□ 7	□ 7	□ 7	□ 7	□ 7	□ 7	□ 7	□ 7	□ 7
		8	Minor injury	□ 8	□ 8	□ 8	□ 8	□ 8	□ 8	□ 8	□ 8	□ 8	□ 8
	Infectious disease	9	Acute respiratory infection	□ 9	□ 9	□ 9	□ 9	□ 9	□ 9	□ 9	□ 9	□ 9	□ 9
		10	Acute watery diarrhea	□ 10	□ 10	□ 10	□ 10	□ 10	□ 10	□ 10	□ 10	□ 10	□ 10
		11	Acute bloody diarrhea	□ 11	□ 11	□ 11	□ 11	□ 11	□ 11	□ 11	□ 11	□ 11	□ 11
		12	Acute jaundice syndrome	□ 12	□ 12	□ 12	□ 12	□ 12	□ 12	□ 12	□ 12	□ 12	□ 12
		13	Suspected measles	□ 13	□ 13	□ 13	□ 13	□ 13	□ 13	□ 13	□ 13	□ 13	□ 13
		14	Suspected meningitis	□ 14	□ 14	□ 14	□ 14	□ 14	□ 14	□ 14	□ 14	□ 14	□ 14
		15	Suspected tetanus	□ 15	□ 15	□ 15	□ 15	□ 15	□ 15	□ 15	□ 15	□ 15	□ 15
		16	Acute flaccid paralysis	□ 16	□ 16	□ 16	□ 16	□ 16	□ 16	□ 16	□ 16	□ 16	□ 16
		17	Acute haemorrhagic fever	□ 17	□ 17	□ 17	□ 17	□ 17	□ 17	□ 17	□ 17	□ 17	□ 17
		18	Fever of unknown origin	□ 18	□ 18	□ 18	□ 18	□ 18	□ 18	□ 18	□ 18	□ 18	□ 18
	Additional	19		□ 19	□ 19	□ 19	□ 19	□ 19	□ 19	□ 19	□ 19	□ 19	□ 19
		20		□ 20	□ 20	□ 20	□ 20	□ 20	□ 20	□ 20	□ 20	□ 20	□ 20
		21		□ 21	□ 21	□ 21	□ 21	□ 21	□ 21	□ 21	□ 21	□ 21	□ 21
		22		□ 22	□ 22	□ 22	□ 22	□ 22	□ 22	□ 22	□ 22	□ 22	□ 22
	Emerg.	23	Surgical emergency (Non-trauma)	□ 23	□ 23	□ 23	□ 23	□ 23	□ 23	□ 23	□ 23	□ 23	□ 23
		24	Medical emergency (Non-infectious)	□ 24	□ 24	□ 24	□ 24	□ 24	□ 24	□ 24	□ 24	□ 24	□ 24
	Other key diseases	25	Skin disease	□ 25	□ 25	□ 25	□ 25	□ 25	□ 25	□ 25	□ 25	□ 25	□ 25
		26	Acute mental health problem	□ 26	□ 26	□ 26	□ 26	□ 26	□ 26	□ 26	□ 26	□ 26	□ 26
		27	Obstetric complications	□ 27	□ 27	□ 27	□ 27	□ 27	□ 27	□ 27	□ 27	□ 27	□ 27
		28	Severe Acute Malnutrition (SAM) *	□ 28	□ 28	□ 28	□ 28	□ 28	□ 28	□ 28	□ 28	□ 28	□ 28
		29	Other diagnosis, not specified above	□ 29	□ 29	□ 29	□ 29	□ 29	□ 29	□ 29	□ 29	□ 29	□ 29

Procedure and Outcome	Procedure	30	Major procedure (excluding MDS31)	□ 30	□ 30	□ 30	□ 30	□ 30	□ 30	□ 30	□ 30	□ 30	□ 30
		31	Limb amputation excluding digits *	□ 31	□ 31	□ 31	□ 31	□ 31	□ 31	□ 31	□ 31	□ 31	□ 31
		32	Minor surgical procedure	□ 32	□ 32	□ 32	□ 32	□ 32	□ 32	□ 32	□ 32	□ 32	□ 32
		33	Normal Vaginal Delivery (NVD)	□ 33	□ 33	□ 33	□ 33	□ 33	□ 33	□ 33	□ 33	□ 33	□ 33
		34	Caesarean section	□ 34	□ 34	□ 34	□ 34	□ 34	□ 34	□ 34	□ 34	□ 34	□ 34
		35	Obstetrics others	□ 35	□ 35	□ 35	□ 35	□ 35	□ 35	□ 35	□ 35	□ 35	□ 35
	Outcome	36	Discharge without medical follow-up	□ 36	□ 36	□ 36	□ 36	□ 36	□ 36	□ 36	□ 36	□ 36	□ 36
		37	Discharge with medical follow-up	□ 37	□ 37	□ 37	□ 37	□ 37	□ 37	□ 37	□ 37	□ 37	□ 37
		38	Discharge against medical advice	□ 38	□ 38	□ 38	□ 38	□ 38	□ 38	□ 38	□ 38	□ 38	□ 38
		39	Referral	□ 39	□ 39	□ 39	□ 39	□ 39	□ 39	□ 39	□ 39	□ 39	□ 39
		40	Admission	□ 40	□ 40	□ 40	□ 40	□ 40	□ 40	□ 40	□ 40	□ 40	□ 40
		41	Dead on arrival	□ 41	□ 41	□ 41	□ 41	□ 41	□ 41	□ 41	□ 41	□ 41	□ 41
		42	Death within facility *	□ 42	□ 42	□ 42	□ 42	□ 42	□ 42	□ 42	□ 42	□ 42	□ 42
		43	Requiring long term rehabilitation *	□ 43	□ 43	□ 43	□ 43	□ 43	□ 43	□ 43	□ 43	□ 43	□ 43
Context	Relation	44	Directly related to event	□ 44	□ 44	□ 44	□ 44	□ 44	□ 44	□ 44	□ 44	□ 44	□ 44
		45	Indirectly related to event	□ 45	□ 45	□ 45	□ 45	□ 45	□ 45	□ 45	□ 45	□ 45	□ 45
		46	Not related to event	□ 46	□ 46	□ 46	□ 46	□ 46	□ 46	□ 46	□ 46	□ 46	□ 46
	Protection	47	Vulnerable child *	□ 47	□ 47	□ 47	□ 47	□ 47	□ 47	□ 47	□ 47	□ 47	□ 47
		48	Vulnerable adult *	□ 48	□ 48	□ 48	□ 48	□ 48	□ 48	□ 48	□ 48	□ 48	□ 48
		49	Sexual Gender Based Violence (SGBV) *	□ 49	□ 49	□ 49	□ 49	□ 49	□ 49	□ 49	□ 49	□ 49	□ 49
		50	Violence (non-SGBV) *	□ 50	□ 50	□ 50	□ 50	□ 50	□ 50	□ 50	□ 50	□ 50	□ 50
Memo														

Annex 3

Insert MOH Logo

EMT-MDS Tally Sheet

World Health Organization

Ver 2019 WHO

● Team Name:	● Location:
● Date of Activity:	● Staff Name:

※How to: 1. Determine the vertical column according to the case's age group. 2. Check all the MDS items that apply for the case. 3.Count up the number of checks in each cell. ※Tally should be conducted daily per location of activity.

	MDS Items	No	<1 y.o.	1-4 y.o.	5-17 y.o.	18-64 y.o.	65- y.o.	Total
Sex	**Male**	1						
	Female non-preg.	2						
	Female pregnant	3						
			<5 years old			>=5 years old		
Trauma	**Major head / spine injury** Require hospitalization and/or general anesthesia (EMT Type 2&3)	4						
	Major torso injury Require hospitalization and/or general anesthesia (EMT Type 2&3)	5						
	Major extremity injury Requiring hospitalization and/or spinal or general anesthesia. (EMT Type 2&3)	6						
	Moderate injury Requiring conscious sedation or regional blocks (EMT Type 1 Fix)	7						
	Minor injury Requiring first aid and light dressing care with/without local anesthesia. (EMT Type 1 Mobile capable)	8						
Infectious disease	**Acute respiratory infection** Cough, colds or sore throat with or without fever	9						
	Acute watery diarrhea Loose stools, 3 or more in the past 24hrs w/wo dehydration	10						
	Acute bloody diarrhea Loose stools with visible blood	11						
	Acute jaundice syndrome Yellow eyes or skin with or without fever	12						
	Suspected measles Fever with rash	13						
	Suspected meningitis Sudden onset of fever (>38°C) with severe headache and stiff neck	14						
	Suspected tetanus Spasms of neck and jaw (lock jaw)	15						
	Acute flaccid paralysis Acute flaccid paralysis in a child aged < 15 years	16						
	Acute haemorrhagic fever Fever with spontaneous bleeding	17						
	Fever of unknown origin Fever (body temperature >38.5 °C) for >48 hours and without other known etiology	18						
Additional		19						
		20						
		21						
		22						
Emrg.	**Surgical emergency (Non-trauma)** Non-trauma case which needs emergency surgery	23						
	Medical emergency (Non-infectious) Non-infectious case which needs emergency intervention without surgery	24						
Other key diseases	**Skin disease** Skin diseases (excluding wound and burn)	25						
	Acute mental health problem Mental illness and psychological disorders requiring immediate treatment and/or psychological support	26						
	Obstetric complications Acute pregnancy related complications, e.g.) severe bleeding, eclampsia etc.	27						
	Severe Acute Malnutrition (SAM) * Visible severe wasting, or by the presence of nutritional oedema	28						
	Other diagnosis, not specified above Other diagnosis, not specified above	29						
Procedure	**Major procedure (excluding MDS31)** Procedures usually needs general anesthetics and/or hospitalization	30						
	Limb amputation excluding digits * Upper or lower limb amputations, excluding toe and finger amputations	31						
	Minor surgical procedure Procedures acceptably performed without general anesthetics nor hospitalization	32						
	Normal Vaginal Delivery (NVD) Vaginal delivery	33						
	Caesarean section Delivery by Caesarean section	34						
	Obstetrics others Other obstetrics procedure	35						
Outcome	**Discharge without medical follow-up** Discharge without follow up	36						
	Discharge with medical follow-up In/outpatient who get instruction to visit medical facilities again	37						
	Discharge against medical advice Patient left against medical advice	38						
	Referral Patient who referred/transferred to other medical facilities.	39						
	Admission Patient who have admitted to the facility on the day	40						
	Dead on arrival Dead on arrival	41						
	Death within facility * Death within facility	42						
	Requiring long term rehabilitation * Require long term rehabilitation	43						
Relation	**Directly related to event** Patient visit with injury or illness directly caused by an emergency event	44						
	Indirectly related to event Patient visit with injury or illness caused or worsened by situational change after an emergency event	45						
	Not related to event Patient visit with health problem not directly/indirectly related to the emergency event	46						
Protection	**Vulnerable child *** Vulnerable child who are in urgent needs for protection	47						
	Vulnerable adult * Vulnerable adult who are in urgent needs for protection	48						
	Sexual Gender Based Violence (SGBV) * Sexual & Gender Based Violence	49						
	Violence (non-SGBV) * Violence (non-SGBV)	50						

MINISTRY OF HEALTH MALAYSIA

EMT-MDS Daily Reporting Form

Ver 2019 WHO

Team information

a	Organization name:				
b	Team name:				
	Type 1 mobile	Type 1 fixed	Type 2	Type 3	Specialized cell
c					
d	Contact Person(s) name(s):				
e	Phone No.:				
f	Email:				
g	Estimated date of departure (dd/mm/yyyy):				

h	Date of activity (dd/mm/yyyy):	
i	Time of reporting (dd/mm/yyyy/hh:mm(24h)):	
	Location †	
j	State etc. (admin1)	
k	City etc. (admin2)	
l	Village etc. (admin3)	
m	Facility name:	
n	Geo-tag	_____ (Lat) _____ (Long)

† Submit one form per one activity day and location. For Admin 1 = e.g. State, Province, Governorate; Admin 2 = e.g. County, District, City, Municipality; Admin 3 = e.g. Sub-district, Village, Payam.

Daily Summary

Number of patient / Bed Count

o	Patients	Total Number of new consultation ‡		36	Outcome	Discharge without medical follow-up		44	Relation	Directly related to event	
p		New admission (=MDS40)		37		Discharge with medical follow-up		45		Indirectly related to event	
q		Live Birth		38		Discharge against medical advice		46		Not related to event	
r	Bed	Total bed capacity		39		Referral		47	Protection	Vulnerable child *	
s		Empty inpatient bed (Non-ICU)		41		Dead on arrival		48		Vulnerable adult *	
t		Empty Intensive Care Unit Bed (ICU)		42		Death within facility *		49		Sexual Gender Based Violence (SGBV) *	
u				43		Requiring long term rehabilitation *		50		Violence (non-SGBV) *	

MDS statistics ‡

‡ Consider 24 hours period from midnight or other agreed cut off time for reporting. MDS statistics report outpatient consultations, inpatient admissions, as well as preformed procedures (MDS No.30-35), outcomes (MDS 36-43) and contextual issues (MDS No.44-50) newly counted during the reported period. MDS No.43 is a subset of MDS No.37-38. MDS No.47-50 are a subset of MDS No.53.

Demographic MDS statistics

No		Age Categories	<1	1-4	5-17	18-64	65-	Total
1	Sex & Age	Male						
2		Female non-preg.						
3		Female pregnant						

Health Events and Procedure MDS statistics

No		Health Events	<5	>=5	Total
4	Trauma	Major head / spine injury			
5		Major torso injury			
6		Major extremity injury			
7		Moderate injury			
8		Minor injury			
9	Infectious disease	Acute respiratory infection			
10		Acute watery diarrhea			
11		Acute bloody diarrhea			
12		Acute jaundice syndrome			
13		Suspected measles			
14		Suspected meningitis			
15		Suspected tetanus			
16		Acute flaccid paralysis			
17		Acute haemorrhagic fever			
18		Fever of unknown origin			
19	Additional §				
20					
21					
22					
23	Emrg.	Surgical emergency (Non-trauma)			
24		Medical emergency (Non-infectious)			
25	Other key diseases	Skin disease			
26		Acute mental health problem			
27		Obstetric complications			
28		Severe Acute Malnutrition (SAM) *			
29		Other diagnosis, not specified above			
		Procedure	**<5**	**>=5**	**Total**
30	Procedure	Major procedure (excluding MDS31)			
31		Limb amputation excluding digits *			
32		Minor surgical procedure			
33		Normal Vaginal Delivery (NVD)			
34		Caesarean section			
35		Obstetrics others			

Needs and Risks

Free text reporting to EMTCC / MOH on the following issues.

51	Immediate report	Unexpected death *	☐
52		Notifiable disease *	☐
53		Protection issues #	☐
54		Critical incident to EMT and/or community	☐
55		Any other issue requiring immediate reporting	☐
56	Community Risks	WASH	☐
57		Community / suspected over infectious disease	☐
58		Environmental risk / exposure	☐
59		Shelter / Non food items	☐
60		Food insecurity	☐
61	Operational constraints	Logistics / operational support	☐
62		Supply	☐
63		Human resources	☐
64		Finance	☐
65		Others	☐

Detailed comment for (No.)

Detailed comment for (No.)

Detailed comment for (No.)

Detailed comment for (No.)

* Line list (including detailed information) should be submitted with this MDS form to relevant authorities. § Additionals are used for context specific reporting items indicated by the relevant authorities e.g. Malaria / Dengue / TB / Leptospirosis / Rabies / Hazmat etc. # Protection issues to be reported confidentially to appropriate authority or protection cluster in locally agreed manner.

MINISTRY OF HEALTH MALAYSIA

World Health Organization

Emergency Medical Team Coordination Cell

SITUATION REPORT

Reporting Period:

☐ **Daily** (24-hour period up to and including 16.59pm) Date: dd/mm/yyyy

☐ **Weekly** (7-day period up to and including day of report) Week End Date: dd/mm/yyyy

Location: _____

A. Situation Overview

B. Emergency Medical Teams

1. Current EMT Capacity (number of teams):

	NEW this Period	EXITS this Period	Current TOTAL	Type 1 Mobile	Type 1 Fixed	Type 2 No Facility	Type 2 with Facility	Type 3	Special Cell: *Specify*	Special Cell: Other
Operational *Tasked and deployed to site*										
Awaiting *Awaiting tasking or deployment*										
TOTAL										

2. Map of Deployed EMTs

(Attach map of geographical distribution of currently operational and tasked EMTs, color-coded by type. If possible, include existing local resources as well as areas of need or residual gaps)

C. Priority Needs

Location	Needs and Gaps

D. Key Indicators

Number of EMTs Reporting: ### out of ### teams *(i.e. proportion of EMTs that are reporting)*

Service Demand		Mortality and Morbidity	
Total Outpatient Consultations		Overall (Inpatient) Mortality Rate	
Total Inpatient Admissions		Under 5 (Inpatient) Mortality Rate	
Total Bed Capacity		New Cases of Event-related Trauma	
Average Bed Occupancy		New Cases with Rehabilitation Needs*	
Total Surgical Procedures			
Insert Other Service Indicators		*Insert Other Relevant Conditions*	

**New Cases with Rehabilitation Needs estimated by sum of new lower limb amputations, external fixations and spinal cord injuries (some duplicate counting will occur)*

Are there any indications of a potential outbreak?

☐ Yes (if so, what outbreak: _____ and where: _____)

☐ No

E. Other Issues

Consider, for example, Safety and Security situation, Environmental issues, Remote Area Access, Gender issues etc.

Report Compiled by: _____ **Signature:** _____

Position: _____

END OF REPORT

F. EMT Arrival and Departure List (Supplement)

Reporting Period: dd/mm/yyyy to dd/mm/yyyy

EMT Arrivals this Period

Team Name (Country)	Type	Deployment Location	Date of Arrival
Insert Rows as Needed			

EMT Departures this Period

Team Name (Country)	Type	Deployment Location(s)	Date of Departure
Insert Rows as Needed			

MINISTRY OF HEALTH MALAYSIA

EMTCC-MDS Feedback Form

Ver 2019 WHO

EMTCC information					
a	Name of EMTCC:		h	Date of activity *1 (dd/mm/yyyy):	
b	Contact Person(s) name(s):		i	Time of feedback (dd/mm/yyyy/hh:mm(24h)):	
c	Phone No.:		j	Total number of MDS daily reports aggeregated:	
d	Email:		k		
e	Location:		l		
f	Facility name:		m		
g	Geo-tag	_____ (Lat) _____ (Long)	n		

*1 Date of EMT Activity for this feedback report.

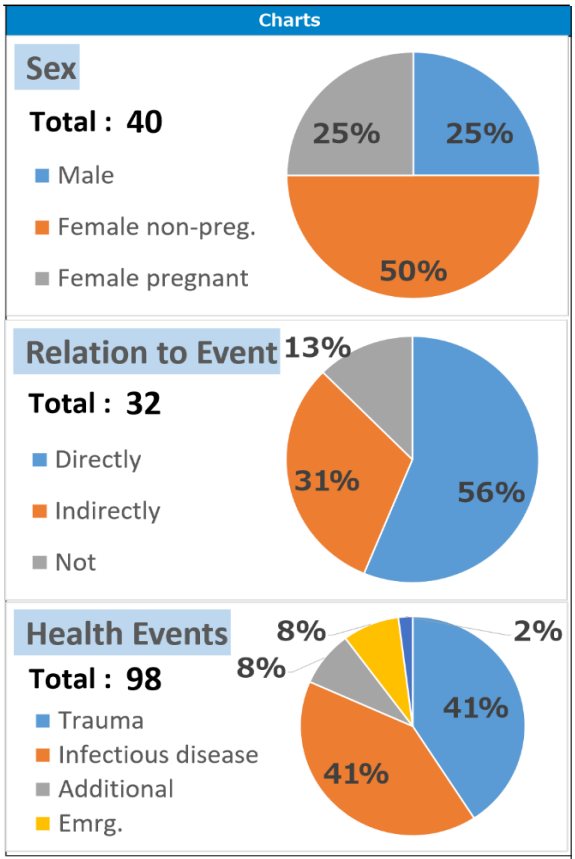
Daily Summary			Number of patient / Bed Count	MDS statistics ‡							
o	Patients		Total Number of new consultation ‡	36	Outcome	Discharge without medical follow-up		44	Relation	Directly related to event	
p			New admission (=MDS40)	37		Discharge with medical follow-up		45		Indirectly related to event	
q			Live Birth	38		Discharge against medical advice		46		Not related to event	
r	Bed		Total bed capacity	39		Referral		47	Protection	Vulnerable child *	
s			Empty inpatient bed (Non-ICU)	41		Dead on arrival		48		Vulnerable adult *	
t			Empty Intensive Care Unit Bed (ICU)	42		Death within facility *		49		Sexual Gender Based Violence (SGBV) *	
u				43		Requiring long term rehabilitation *		50		Violence (non-SGBV) *	

‡ MDS statistics report outpatient consultations, inpatient admissions, performed procedures (MDS No.30-35), outcomes (MDS 36-43) and contxtual issues (MDS No.44-50) which were newly counted at the reported period.

Demographic MDS statistics	No	Age Categories	<1	1-4	5-17	18-64	65-	Total
Sex & Age	1	Male						
	2	Female non-preg.						
	3	Female pregnant						

Health Events and Procedure MDS statistics	No		Health Events	<5	>=5	Total
Trauma	4		Major head / spine injury			
	5		Major torso injury			
	6		Major extremity injury			
	7		Moderate injury			
	8		Minor injury			
Infectious disease	9		Acute respiratory infection			
	10		Acute watery diarrhea			
	11		Acute bloody diarrhea			
	12		Acute jaundice syndrome			
	13		Suspected measles			
	14		Suspected meningitis			
	15		Suspected tetanus			
	16		Acute flaccid paralysis			
	17		Acute haemorrhagic fever			
	18		Fever of unknown origin			
Additional §	19					
	20					
	21					
	22					
Emrg.	23		Surgical emergency (Non-trauma)			
	24		Medical emergency (Non-infectious)			
Other key diseases	25		Skin disease			
	26		Acute mental health problem			
	27		Obstetric complications			
	28		Severe Acute Malnutrition (SAM) *			
	29		Other diagnosis, not specified above			
			Procedure	<5	>=5	Total
Procedure	30		Major procedure (excluding MDS31)			
	31		Limb amputation excluding digits *			
	32		Minor surgical procedure			
	33		Normal Vaginal Delivery (NVD)			
	34		Caesarean section			
	35		Obstetrics others			

Charts



Comment(s)

* Line list (including detailed information) should be submitted with this MDS form.§ Additionals are used for context specific reporting items indicated by the relevant authorities e.g. Malaria / Dengue / TB / Leptospirosis / Rabies / Hazmat etc.

MINISTRY OF HEALTH MALAYSIA

World Health Organization

Country, Event, Year

EMT COORDINATION MEETING MINUTES

Date: dd/ mm/ yyyy

1. Welcome and opening remarks

This aims to be an operationally focused Coordination meeting for teams providing medical and health-related care to the population affected by the event.

2. Updates from the chair (MOH) and co-chairs

Situation overview, requests from MoH/ National Authorities, identified needs.

3. Response Overview (EMTs)

 # EMTs (both National and International) with breakdown by type and location, feedback on daily reporting, sharing of SOPs, and treatment guidelines.

4. Standing Items

- *Safety and security.*
- *Transport and common logistical needs.*
- *Remote area access.*
- *Cultural issues and guidance.*
- *Environmental issues.*
- *Gender issues.*
- *Reporting requirements.*
- *Other issues.*

5. EMT Tasking/Update from EMTs

Key updates by location, introduction of newly arrived EMTs.

Meeting practicalities (next meeting, time, and location)

SITE VISIT CHECKLIST (QUALITY ASSURANCE) FORM

MINISTRY OF HEALTH MALAYSIA

EMT Name		#ID EMT Global Classification	
EMT Type		Date of Site Visit	dd / mm / yyyy

Internal Office Use Only					
Team Status:	☐ Approved	☐ Pending	Reason:		
	☐ Tasked	☐ Declined	Reason:		
Check:	☐ WHO Classified	☐ WHO Mentorship	☐Airport	☐ Field Visit	☐Other:
Allocated Site:	Location GPS Coordinates		Allocation Date:	dd / mm / yyyy	
Other Comments:	(e.g. reason for changing type vs the self-declaration from the team)				

PREPARATORY CHECKLIST	TEAM COMPOSITION		
☐ Registration form ☐ Deviation from EMT Minimum Standards (Y/N) ☐ Compliance with reporting system (Y/N) ☐ Data analysis report ☐ Comments/Complaints registered by the Contact Center ☐ Other (please state).....	1	Name	
	2	Name	
	3	Name:	

	EVIDENCE CRITERIA	YES	NO	NA	COMMENTS
EMT CAPACITY AND CAPABILITY *Direct observations from facility tour including layout and patients flow, questions to staff and patients (please refer to the services and staff indicated in the registration form)*	**Rapidly deployable temporary shelter, outpatient clinic and inpatient** facility ✓ **YES/NO** following the below list				
	• Triage/ waiting area	☐	☐	☐	
	• Resuscitation area	☐	☐	☐	
	• Outpatient clinical care areas	☐	☐	☐	
	• Delivery area	☐	☐	☐	
	• Operating Theatre	☐	☐	☐	
	• Intensive Care area	☐	☐	☐	
	• Recovery area	☐	☐	☐	
	• Inpatient ward care areas	☐	☐	☐	
	• Inpatient paediatric ward	☐	☐	☐	
	• Rehab	☐	☐	☐	
	• Laboratory	☐	☐	☐	
	• Sterilisation	☐	☐	☐	
	• X-Ray	☐	☐	☐	
	• Pharmacy	☐	☐	☐	
	• Stores	☐	☐	☐	
	• Morgue	☐	☐	☐	

	EVIDENCE CRITERIA	YES	NO	NA	COMMENTs
EMT CAPACITY AND CAPABILITY (cont.)	Recognized triage system for Emergency and Surgical care; including acute Medical and Obstetrics	▫	▫	▫	
	Basic/ Advanced life support	▫	▫	▫	
	Capable of a safe uncomplicated delivery with midwifery level care +/-	▫	▫	▫	
	Emergency caesarean section and surgical care	▫	▫	▫	
	Do they have a patient registration and unique patient identification system in place? ..... What is the average time patients spend in the waiting area? ..... Do they have a temporary isolation capability? ..... Is the privacy and confidentiality maintained within the facility? ..... Are they fully staffed, with the right technical skill sets and staffing ratios for the type of EMT?				
OPERATING THEATRE *(Direct observations and documentation review)*	**EVIDENCE CRITERIA**	**YES**	**NO**	**NA**	**COMMENTs**
	Surgical documentation available and in use • Informed consent • Procedure records (OT logbook) • Safe surgery checklist	▫ ▫ ▫	▫ ▫ ▫	▫ ▫ ▫	
	Lighting system sufficient to visualize deep intra-abdominal	▫	▫	▫	
	Back up power supply	▫	▫	▫	
	Cold chain and drug control; including locked drug storage	▫	▫	▫	
	Adult and Paediatric Anaesthesia care	▫	▫	▫	
	Emergency surgical care (including obstetrics and gynaecology) +/-	▫	▫	▫	
	Reconstructive and Specialist surgical care	▫	▫	▫	
	Are there appropriate climate and vector control measures in place within the operating theatre area?				

OPERATING THEATRE (cont.)	Is there a one-way movement system in place of the surgical instruments and medical devices from the contaminated to clean area for sterilization i.e., operating theatres to sterilization area? .... Is there a standard operating procedure and available equipment for the reversal of sedation? ..... Is there appropriate pre, peri and post-operative and review care given, as described in the patients notes? .... Is the theatre environment clean with appropriate infection, prevention and control (IPC) measures in place? Evidenced by environment check: ▫ Clean ▫ Acceptable ▫ Not Acceptable/ Poor IPC ..... Is there evidence of appropriate quantities and types of medical consumables available (including pharmaceuticals) for the expected management of surgical cases?				
TECHNICAL SERVICES	**EVIDENCE CRITERIA**	**YES**	**NO**	**NA**	**COMMENTs**
	Sterilisation ● Basic steam autoclave or disposable equipment	▫	▫	▫	
	● Full surgical autoclave with traceability	▫	▫	▫	
	X-ray and (+/-) ultrasound Able to provide plain or digital x-ray; adequate quality for diagnostic use	▫	▫	▫	
	Capable of point of care and basic rapid detections tests: ● Blood Glucose ● Urine dipstick analysis ● Hemoglobin/ WBC ● Malaria ● HIV ● Other as indicated	▫ ▫ ▫ ▫ ▫ ▫	▫ ▫ ▫ ▫ ▫ ▫	▫ ▫ ▫ ▫ ▫ ▫	
	ABO and Rh screening	▫	▫	▫	
	Walking Blood Bank (or equivalent), compliant with WHO guidelines for the selection, screening and administration of donor blood: ● Fresh whole of blood ● Other forms of blood ● Blood fridge ● Blood donor and administration documentation	▫ ▫ ▫ ▫ ▫	▫ ▫ ▫ ▫ ▫	▫ ▫ ▫ ▫ ▫	

TECHNICAL SERVICES (cont.)	Is there a documented record of the surgical sterilisation and traceability procedures undertaken? ..... Are there appropriate radiation control measures in place, to mitigate for time / distance and shielding? i.e., provision of appropriate lead shielding and personal dosimeters; a cordoned off safety area surrounding the x-ray tent, adequate signage etc. ..... Are X-ray undertaken in compliance with the standards of justified practice i.e., clear record of requests, rationale and reporting in the patients notes? ..... Are there appropriate laboratory equipment and consumables available, with quality assurance to undertake a walking blood bank or alternative? (T2 upwards) ..... Is there appropriate blood donor screening, testing, donation and administration procedures in place i.e., clear record of the processes noted in the patients and donor's notes? ..... Is there a standards operating procedure in place for a potential or actual blood transfusion reactions?				
PHARMACY *(Direct observations, documentation review and questions to staff)*	**EVIDENCE CRITERIA**	**YES**	**NO**	**NA**	**COMMENTs**
	Stock within expiry date, medications are labelled (in local language where possible) and individually dispensed with authorized prescription	☐	☐	☐	
	Cold chain compliance / equipment	☐	☐	☐	
	WHO Essential medication list or equivalent (National), must include;				
	• Oral and parental analgesia	☐	☐	☐	
	• Antibiotics	☐	☐	☐	
	• Tetanus toxoid or Tetanus and Diphtheria	☐	☐	☐	
	• Tetanus Immunoglobulin (or ability access)	☐	☐	☐	
	• Other as indicated to treat anticipated cases	☐	☐	☐	
	• Paediatric forms available	☐	☐	☐	
	A register of all scheduled/ controlled substances and dispensing is maintained	☐	☐	☐	
	Pharmacy stock control system in place	☐	☐	☐	

PHARMACY (cont.)

Are there any stock disruptions reported?

.....

Is there a daily record of the external and internal temperature of the pharmacy stores (ideally twice day)?

.....

Is there a reporting procedure in place for the management of medication errors?

.....

REFERRAL CAPACITY

(Documentation review, questions to staff and patients. Please indicate which/how many documents have been revised)

EVIDENCE CRITERIA	YES	NO	NA	COMMENTs
Ability to identify and manage referrals to higher/lower levels of care	☐	☐	☐	
Methods of transfer/ transport are identified for referral cases	☐	☐	☐	
Patient transfer equipment and consumables available to support a transfer i.e. oxygen for patient	☐	☐	☐	
Referral form available and in use	☐	☐	☐	

What are the main reasons for referral to another structure?

.....

.....

To what structure the patients are mainly referred?

.....

.....

Which means of transport is used? Has the EMT own means of transport?

.....

.....

Average time for referral (from decision to transport)?

.....

.....

Level of completeness and accuracy of referral forms?

.....

.....

MEDICAL RECORDS AND REPORTING SYSTEM

Documentation review (please indicate which/how many documents have been revised)

EVIDENCE CRITERIA	YES	NO	NA	COMMENTs
System set up to maintain confidential, individual patient records and report on regular basis				
✓ YES/NO following the below list				
• Outpatient & Inpatient Individual Patient Record	☐	☐	☐	
• Triage Register	☐	☐	☐	
• Discharge Card	☐	☐	☐	
• Births and Deaths Register	☐	☐	☐	
• Consent form	☐	☐	☐	
• Others	☐	☐	☐	
Reporting at regular intervals, using the identified national or international reporting format i.e. Minimum Data Sets (MDS)	☐	☐	☐	

Is there a unique system to identify and verify patient's identity?

.....

.....

MEDICAL RECORDS AND REPORTING SYSTEM (cont.)

Average length of stay (total inpatient days of care/ total admissions)?

.....

Does the EMT have a paper based or paper and electronic or just electronic based medical records system in place, with a fail over plan?

.....

Is there appropriate data and patient records management i.e. safe and secure storage of patient's records?

.....

WASTE MANAGEMENT

(Direct observations, questions to staff)

EVIDENCE CRITERIA	YES	NO	NA	COMMENTs
Waste management system to ensure patient, staff and community safety including				
• Segregation	▫	▫	▫	
• Handling/ Transfer	▫	▫	▫	
• Treatment	▫	▫	▫	
• Disposal	▫	▫	▫	
Safe handling and disposal of sharps	▫	▫	▫	
Waste management area demarcated/fenced	▫	▫	▫	

Does the EMT use a segregated coloured coding system for their waste management?

.....

Do EMT staff use personal protective equipment in handling waste?

.....

What waste treatment and disposal system do they use? i.e. on or off site using an external source.

.....

What measures does the EMT take when a needle stick /sharps is reported?

.....

Use of incinerator? ▫ Yes ▫ No Type: .....

WATER, HYGIENE, AND SANITATION

(Direct observations, questions to staff and patients)

EVIDENCE CRITERIA	YES	NO	NA	COMMENTs
Adequate quantities of safe drinking water available	▫	▫	▫	
Adequate quantity and quality of water to cover hand washing, personal hygiene, cleaning, and laundry needs	▫	▫	▫	
Adequate number of toilets and showers for patients and staff(min 2 x per/100 outpatients and 2 x 20 inpatients)	▫	▫	▫	
Hand washing stations available in all key areas of the facility	▫	▫	▫	

Water No. litres/ day: .....

Total Water Storage Capacity: .....

What is the water treatment plan?

▫ Filtering ▫ Sedimentation ▫ Chlorination ▫ Flocculation ▫ Other

.....

WATER, HYGIENE, AND SANITATION (cont.)	Is there a record of the water testing and treating regimes undertaken? ..... No. of toilets/ patients: ..... Are the latrines used by the patients? ▫ Yes ▫ No Is there a disabled access toilet? ▫ Yes ▫ No No. of toilets/staff:				
Self Sufficiency *(Direct observations, questions to staff and patients)*	**EVIDENCE CRITERIA**	**YES**	**NO**	**NA**	**COMMENTs**
	Shelters Adequate numbers of shelters available, that provide a safe, secure working and living conditions for team members and patients	▫	▫	▫	
	Power Capacity to provide power to all required sources i.e. mains power, lighting etc.	▫	▫	▫	
	Suitable lighting sources available for safe working environment	▫	▫	▫	
	Communication Emergency communication equipment available, such as:	▫	▫	▫	
	• BGAN	▫	▫	▫	
	• High frequency Radio (VHF)	▫	▫	▫	
	• Satellite Phone	▫	▫	▫	
	• Mobile Phone	▫	▫	▫	
	The shelter system used is climate appropriate and able to maintain comfortable internal operating temperatures? ..... Fuel is stored safely and has a supporting hazard management plan?				

SUMMARY			
OVERALL RATING	**COMPLIANCE ▫**	**NON-COMPLIANCE ▫**	**OTHER ▫**
COMMENTS/ RECOMMENDATIONS			
Signatures			

Annex 9

Borang Pendaftaran EMT
EMT Registration Form

Maklumat perlu diisi oleh pegawai yang berminat dan diserahkan kepada Pejabat Pengarah untuk tindakan selanjutnya. (Pastikan semua maklumat lengkap diisi).
Information should be submitted by interested officers and submitted to the Director's Office for further action. (Make sure all the information is filled completely).

***Borang yang lengkap diisi dan diberi ulasan oleh Ketua Jabatan perlu dihantar kepada CPRC Negeri**
**Forms that are completed and commented by the Head of Department must be sent to the State* CPRC.

Maklumat Pegawai *Officer Details*	
Nama Penuh: *Name:*	
No. Kad Pengenalan: *Identification No:*	
Umur: *Age:*	
Gelaran: *Tittle:*	Jantina: Lelaki/ Perempuan *Gender: Male/ Female*
Alamat Rumah: *Home Address:*	
	Poskod: *Postal Code:*
No. Tel (R): *Phone (Home):*	
No. Tel (HP): *Mobile Phone:*	
Emel: *E-mail:*	
Maklumat Perkhidmatan ***Service Details***	
Nama Fasiliti Kesihatan/ PID/ NGO: *Health Facility Name:*	No. Tel. Pejabat: *Office Phone No.:*
Jabatan/ Unit: *Department/ Unit:*	
Jawatan: *Position:*	Gred: *Position Grade:*
Kelulusan Kepakaran/ Pos Basik: *Specialist/ Post Basic Qualification*	
Tahun Diperolehi: *Registered Year:*	
No. APC/ ARC/ AHP/ lain-lain: *APC/ ARC/ AHP No./ Others:*	Tahun diperolehi: *Registered Year*:
Pengalaman kerja: *Working experience:* i. Bertugas *i. Current Service*	

Jabatan/ Unit *Department/Unit*	Tahun/ *Year*
i.	
ii.	
iii.	
iv.	
v.	

ii. Penglibatan Pengurusan Bencana
ii. Disaster Management Involvement

a. Dalam Negara
a. Nationally

Jenis Bencana *Type of Disaster*	Tahun *Year*
i.	
ii.	
iii.	

b. Luar Negara
b. Internationally

Jenis Bencana *Type of Disaster*	Tahun *Year*
i.	
ii.	
iii.	

Maklumat Tempat Bertugas *Place of Service Information*	
	Poskod: *Postal Code:*

Adakah terdapat sebarang masalah kesihatan yang perlu dimaklumkan sekiranya berlaku sebarang kecemasan
Are there any health problems that need to be reported in the event of an emergency

Ya/ Tidak *Yes/ No*

*Potong mana yang tidak berkenaan
**Cross out any that do not apply*

Sekiranya Ya, Jelaskan (Senaraikan) *If Yes, Please explain (List it)*

Maklumat Waris (Sekiranya berlaku kecemasan) *Next of Kin (In case of emergency)*	
No. Kad Pengenalan: *Identification No.:*	
Umur: *Age:*	
Gelaran: *Tittle:*	Jantina: Lelaki/ Perempuan *Gender: Male/ Female*
Hubungan dengan Pegawai: *Relationship with Officials:*	
Alamat Rumah: *Home Address:*	
	Poskod: *Postal code:*
No. Tel (R): *Home Phone:*	
No. Tel (HP): *Mobile Phone:*	

Ulasan Ketua Jabatan:
Department of Head Comment:

Sokong/ Tidak Sokong:
Approve/ Not Approve:

……

Nama:
Name: _____

Jawatan:
Position: _____

Cop Rasmi:
Official Stamp:

Tarikh:
Date: _____

***Potong mana yang tidak berkenaan**
******Cross out any that do not apply***

Annex 10

PERSONAL ITEMS AND PERSONAL GEAR

a) Personal Items

Personal items must be self-prepared and bring together during deployment.
Minimum personal items that should be brought along to the field as in the following table:

NO.	ITEMS	REMARK
1.	Four (4) shirts/ collared T-shirts. At least one must be long sleeve	Working attire ***Please do not wear army-like clothing**
2.	Two (2) light weight tough pants (only long pants, preferably with multiple pockets)	Working attire
3.	One (1) pair of trekking shoes and two (2) pair of socks	Working attire
4.	Two (2) T-shirt	Leisure/ sleeping
5.	One (1) pair of track bottoms or bermuda shorts	Leisure/ sleeping
6.	One (1) Sarong	Multi-purpose
7.	Undergarments	At your discretion
8.	One (1) pair of sandals	To wear at the campsite/ accommodation site
9.	Praying clothes for muslim (especially for female)	
10.	Personal medicine/ supplement	Paracetamol, actal, fabric plaster and required personal medication/ supplement
11.	Bath towel (if possible quick dry)	Personal hygiene
12.	Personal toiletry articles a) Bath soap b) Shampoo c) Toothpaste & brush d) Razor e) Sanitary pad (for females) f) Toilet paper g) Wet wipes	Personal hygiene
13.	Eating utensils (plate, cup, fork, spoon and others)	For own use
14.	Water bottle (500ml-1 litre)	For own use
15.	Energy bar	For own use
16.	Reasonable amount of cash	For personal use

b) Personal Gear

NO.	ITEMS	REMARKS
1.	Lightweight sleeping bag or lightweight blanket	For own use
2.	Small flashlight and extra batteries	
3.	Hat/ cap	For protection against direct sunlight
4.	Rain coat	For own use
5.	Insect repellent	For own use – protection against mosquitoes and other insects
6.	For own use – protection	For own use – protection
7.	Multipurpose pocket knife	Not to put in hand luggage
8.	Power bank and universal adapter	
9.	Note book and pen	
10.	USB pendrive	For storage of documents
11.	Appropriate boot	Depending on type of disaster
12.	Whistle	
13.	Reflector vest	

Annex 11

NOTIFICATION FORM (REV 2010)

"SCHEDULE
(Regulation 2)
Form
(Regulation 2)
PREVENTION AND CONTROL OF INFECTIOUS DISEASES ACT 1988
PREVENTION AND CONTROL OF INFECTIOUS DISEASES (NOTICE FORM) (AMENDMENT) REGULATIONS 2011

Notification Form: Rev/2010
Serial No:

NOTIFICATION OF COMMUNICABLE DISEASES TO BE REPORTED

(Section 10, Prevention And Control Of Communicable Diseases Act, 1988)

A. PATIENT INFORMATION

1. Full Name (CAPITAL LETTER):

Accompany by(Mother/Father/Guardian):
(If under age/without Identity Card)

2. Identity Card Number / Travelling Document: ☐ Self ☐ Accompany by
(For Non Citizen)

Hospital/Clinic Reg. Number: Ward:_____ Date of Admission: / /

3. Citizenship:
Citizen
☐ Yes Race/Ethnic:
Sub Ethnic:
(For Aborigines, Native of Sabah/Sarawak)
☐ No Country of origin:
Status of Entry: ☐ Legal ☐ Illegal ☐ Permanent Resident

4. Gender: ☐ Male ☐ Female

5. Date of birth: / /

6. Age: ☐ Year ☐ Month ☐ Day

7. Occupation:_____
(If unemployed, please state self reference)

8. Telephone No.: ☐ Resident ☐ H.phone ☐ Office -
(Contact purposes)

9. Current Address:

10. Address of Employer/School/College/University:

B. DISEASE DIAGNOSIS

☐ 1. Poliomyelitis	☐ 16. Hand, Food and Mouth Disease	☐ 31. Syphilis - Acquired
☐ 2. Viral Hepatitis A	☐ 17. Human Immunodeficiency Virus Infection	☐ 32. Tetanus Neonatorum
☐ 3. Viral Hepatitis B	☐ 18. Influenza	☐ 33. Tetanus *(Others)*
☐ 4. Viral Hepatitis C	☐ 19. Leprosy *(Multibacillary)*	☐ 34. Typhus - *Scrub*
☐ 5. Viral Hepatitis *(Others)*	☐ 20. Leprosy *(Paucibacillary)*	☐ 35. Tuberculosis - *PTB Smear Positive*
☐ 6. AIDS	☐ 21. Leptospirosis	☐ 36. Tuberculosis - *PTB Smear Negative*
☐ 7. Chancroid	☐ 22. Malaria - *Vivax*	☐ 37. Tuberculosis - *Extra Pulmonary*
☐ 8. Cholera	☐ 23. Malaria - *Falciparum*	☐ 38. Typhoid - *Salmonella typhi*
☐ 9. Dengue Fever	☐ 24. Malaria - *Malariae*	☐ 39. Typhoid - *Paratyphoid*
☐ 10. Dengue Haemorrhagic Fever	☐ 25. Malaria - *Others*	☐ 40. Viral Encephalitis - *Japanese*
☐ 11. Diphtheria	☐ 26. Measles	☐ 41. Viral Encephalitis - *Nipah*
☐ 12. Dysentery	☐ 27. Plaque	☐ 42. Viral Encephalitis - *(Others)*
☐ 13. Ebola	☐ 28. Rabies	☐ 43. Whooping Cough / Pertussis
☐ 14. Food Poisoning	☐ 29. Relapsing Fever	☐ 44. Yellow Fever
☐ 15. Gonorrhoea	☐ 30. Syphilis - *Congenital*	☐ 45. Others: *please specify:* _____

Besides by written notification, the following diseases must be notified by telephone within 24 hours, such as:- Acute Poliomyelitis, Cholera, Dengue, Diptheria, Ebola, Food Poisoning, Plague, Rabies and Yellow Fever.

11. Case detection classification:
☐ Case ☐ Contact ☐ FOMEMA
☐ Screening Test _____

12. Status of patient:
☐ Live/alive
☐ Died - -

13. Date of Onset: - -

14. Laboratory investigation:
Investigation: (i)_____
(ii)_____ (iii)_____
Date of specimen taken: - -

15. Laboratory investigation result:
☐ Positive (_____)
☐ Negative
☐ Pending

16. Diagnosis Status:
☐ Provisional/Suspected
☐ Confirmed
Date of Diagnosis - -

17. Relevant Clinical Information:

18. Comment:

C. NOTIFIER

19. Name of Medical Practitioner:

20. Name and address of Hospital/Clinic:

21. Date of Notification: - -

.....
Signature of Medical Practitioner

KEMENTERIAN KESIHATAN MALAYSIA

Country, Event, Year

World Health Organization

PATIENT REFERRAL FORM

Date: dd/mm/yyyy

Referral to: Name of facility or service

Focal point: Full name Phone: + country - area - phone number

Location: Address/Site/District Email: example@who.int

Referring from: Name of facility or service

Focal point: Full name Phone: + country - area - phone number

Location: Address/Site/District Email: example@who.int

Patient Information

Full Name		Phone	+ country - area - phone number
Date of birth	dd/mm/yyyy	Gender	
Address of discharge destination (if known)			
Accompanied by care provider ☐ Yes ☐ No			

Primary Diagnoses: 1. _____

2. _____

3. _____

Other Diagnoses: _____

_____

Treatments initiated:

- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing

*Please attach copy of medication chart at discharge **or** list of current medications (including dose and time of last dose)

Reason for referral: ☐ Inpatient ☐ Outpatient ☐ Community

_____

_____

Transportation needs: Transfer requirements, special considerations, frequency

Follow-up requirements: Such as date of surgical review, removal of cast, or removal of external fixator

Functional Status

Mobility ☐Bed bound ☐Wheelchair ☐Crutches ☐Walking frame ☐Requires assistance ☐Independent

Precautions: Such as weight-bearing restrictions or spinal precautions

Self-care ☐Carer dependent ☐Requires commode ☐Requires modified latrine/ washroom ☐Independent

Cognitive impairment ☐ No ☐ Yes _____

Assistive devices(s) provided: _____

Assistive device(s) required: _____

Compiled by: _____ **Signature:** _____

Position: _____

NOTE: This form must accompany the patient's medical file and a copy of the form should be retained by the referring team.

END OF REFERRAL FORM

IR 2.0 FORM

IR 2.0/2017

SULIT

MINISTRY OF HEALTH MALAYSIA
PATIENT SAFETY INCIDENT REPORTING FORM

DATE OF REPORTING ____/____/____

***Borang boleh diisi dalam Bahasa Malaysia**

SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT

INCIDENT DESCRIPTION (Please fill in the blanks)

1.	**NAME OF FACILITY/ INSTITUTION**		**PATIENT'S NAME**	
2.	**DATE OF INCIDENT**	☐☐ / ☐☐ / ☐☐☐☐		**IF UNCERTAIN** APPROXIMATE DATE: ___/___/___
3.	**TIME OF INCIDENT**	☐☐ : ☐☐ AM/ PM		**IF UNCERTAIN** APPROXIMATE TIME: _____ :____AM/ PM
4.	**PATIENT'S RN/ OTHER INDENTIFICATION NUMBER:** _____ **AGE:** _____ **ETHNIC:** _____ **GENDER:** MALE/ FEMALE/ UNKNOWN **STATUS:** ALIVE/ DECEASED **LANGUAGE BARRIER:** YES/ NO (Please circle) **DIAGNOSIS:** _____			

5. **TYPE OF PATIENT** (please tick one)

☐	INPATIENT	☐	DAY CARE
☐	OUTPATIENT	☐	OTHERS: SPECIFY ----------
☐	A&E		

LOCATION/ WARD/ CLINIC: _____

DEPARTMENT(S) INVOLVED (please tick)

☐	MEDICAL	☐	O&G	☐	ONCOLOGY
☐	SURGICAL	☐	PHARMACY	☐	GERIATRIC
☐	ORTHOPAEDIC	☐	RADIOLOGY & IMAGING	☐	REHABILITATION
☐	PAEDIATRIC	☐	A&E	☐	ICU/ CCU
☐	LABORATORY	☐	PSYCHIATRY	☐	
☐	OTHERS: SPECIFY _____				

6. **TYPE OF INCIDENT** **_____ Actual** **_____ Near Miss**
(Please tick one)

Examples of incidents that need to be reported: (Note that this list is not exhaustive)

☐	i.	Wrong surgery/ procedure –wrong site, side or patient
☐	ii.	Unintended retained foreign body in patient after an operation/procedure
☐	iii.	Error in transfusion of blood/ blood products
☐	vi.	Medication error (please fill in MERS form as well)
☐	v.	Patient fall in the facility
☐	vi.	Obstetric related incidents
☐	vii.	Adverse outcome of clinical procedure
☐	viii.	Pre-hospital care and ambulance service-related incident
☐	ix.	Radiotherapy related incident
☐	x.	Patient suicide/ attempted suicide
☐	xi.	Patient discharged to wrong family members / next-of -kin
☐	xii.	Assault/ battery of patient
☐	xiii.	Unanticipated Fire – Fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility
☐	xiv.	**Others type of incident:** _____

7. **BRIEF DESCRIPTION OF WHAT HAPPENED** (Please fill in the blanks)
The description should explain what happen prior and during the incident and how it occurred. Do include any additional information which you think may lead to the incident.

PATIENT OUTCOME (please tick one) **& IMMEDIATE ACTION – ONLY FOR ACTUAL INCIDENT**

8. OUTCOME OF INCIDENT

	NONE
	MILD
	MODERATE
	SEVERE
	DEATH
	CURRENTLY CANNOT BE DETERMINED

9. IMMEDIATE ACTION FOLLOWING INCIDENT

REPORTED BY

10. DESIGNATION: (please tick one)

	NURSE		SPECIALIST
	HOUSE OFFICER		PHARMACIST
	MEDICAL OFFICER		OTHERS:

SIGNATURE OF REPORTER:

NAME:

DATE:

Note: As part of good leadership and clinical governance, please inform the incident to your Head of Department(s) immediately.

SECTION B: TO BE COMPLETED BY THE RISK MANAGER/ QUALITY MANAGER OF HOSPITAL

1. ACTION TAKEN:

Mandatory Root Cause Analysis:

1) *Incident with Severe or Death outcome.*
2) *Other incident/near miss based on the Risk Manager/ Quality Manager assessment.*
3) *Directive from State Health Department/ Ministry.*

(Please tick)

	"PRESCRIPTION SLIP"
	MONITOR THE TREND FIRST
	RCA
	MIRCA (Multi-incident Root Cause Analysis)

Additional comments:

2. e-IR SUBMITTED?

Please submit to e-IR **within 5 days** from the date of the incident.

Date of Submission: _____ - _____ - _____

3. RISK MANAGER/ QUALITY MANAGER OF HOSPITAL

(Please fill in the blanks)

NAME:
SIGNATURE:

DESIGNATION:
DATE:

Annex 14

Insert MOH Logo World Health Organization *Insert EMT Logo*

Country, Event, Year

Emergency Medical Team Exit Report

Insert Team/ Organization Name

A. Team Details

Name of Team Leader: ______________________________
Current or Most Recent

Original Registration: ☐ WHO ☐ Ministry of Health ☐ Other: ____________
Select all that apply

Team Classification: ☐ Type 1 Fixed ☐ Type 1 Mobile
☐ Type 2
☐ Type 3
☐ Special Cell(s): *(Please specify)* ____________

Date of Arrival (in-country): dd/mm/20yy

Date Service Provision started: dd/mm/20yy Operational Duration: ### Days

Date (or intended date) of Departure: dd/mm/20yy **Total Duration of Mission:** ### **Days**

Contact Person post-deployment: *(For follow-up after return home)*

Name: ______________________ Position: ____________

Email: ______________________ Phone: + ### - ## - ### - ####

B. Activities and Services Provided

Deployment(s):
If the team provided services at a fixed facility, but simultaneously provided mobile or outreach services to another site, please document as separate entries

Dates	Location	Fixed or Mobile	On-site Partner(s) *I.e., with existing agreements*
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: e.g. Name of Facility or Village	☐ Fixed Facility ☐ Outreach/ Mobile	☐ MOH/ District Health ☐ National EMT ☐ International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: e.g. Name of Facility or Village	☐ Fixed Facility ☐ Outreach/ Mobile	☐ MOH/ District Health ☐ National EMT ☐ International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: e.g. Name of Facility or Village	☐ Fixed Facility ☐ Outreach/ Mobile	☐ MOH/ District Health ☐ National EMT ☐ International EMT

Start: dd/mm/20yy End: dd/mm/20yy	District: Site: e.g. Name of Facility or Village	☐ Fixed Facility ☐ Outreach/ Mobile	☐ MOH/ District Health ☐ National EMT ☐ International EMT

Services and Outcomes:

Services	Total	Outcomes	Total
Outpatient Consultations		Facility Deaths	
Inpatient Admissions		Patients with ongoing Rehabilitation Needs	
Major Surgical Procedures		Referrals/ Transfers	
Minor Surgical Procedures		*Specify Referral/ Transfer Destination(s):*	

Other Services: ☐ WASH ☐ Nutrition

☐ Health Education ☐ Psychosocial Support

☐ Surveillance ☐ Other: _____

C. Experience and Feedback

1. Needs Identified and Addressed

2. Challenges and Issues Encountered

3. Remaining or Ongoing Needs

4. Recommendations and Remarks

D. Transition and Exit

1. Services and Facilities of EMT have been:
   - ☐ Closed
   - ☐ Handed over to National MOH
   - ☐ Handed over to a National EMT: _____
   - ☐ Handed over to an International EMT: _____
   - ☐ Other: *(Please specify)* _____

2. Post-operative Surgical Follow-up Arrangements:
   - ☐ Yes, specify: _____
   - ☐ No, reason: _____
   - ☐ Not Applicable

3. Number of Remaining Inpatients at Departure: ###

   Transfer Destination, if applicable: _____

   Please complete and attach Section E. Transferred Patients at Exit (If applicable)

4. Have all relevant medical files and notes been handed over? *(Includes medical files of transferred patients, patients requiring follow-up, and patients with ongoing rehabilitation needs)*
   - ☐ Yes, specify: _____
   - ☐ No, reason: _____
   - ☐ Not Applicable

   Please complete and attach Section F. Patients with Ongoing Follow-up or Rehabilitation Needs (If applicable)

5. Equipment and Supplies Donated at Departure?
   - ☐ Yes, specify recipient(s): _____

     If yes, please complete and attach Section G. Donated Medications List and/ or Section H. Donated Equipment or Supply List.
   - ☐ No

6. Waste Management Arrangements completed:
   - ☐ Yes, specify: _____
   - ☐ No, reason: _____

Report by: _____ Signature: _____ Date: dd/mm/20yy

END OF EXIT REPORT

E. Transferred Patients at Exit (Exit Report Supplement)

Name	Age	Gender	Address (Village/ Town)	Diagnosis	Transfer Destination	Medical Files Handed Over
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

F. Patients with Ongoing Follow-up or Rehabilitation Needs (Exit Report Supplement)

Name	Age	Gender	Address (Village/ Town)	Diagnosis	Follow-up or Rehabilitation Needs	Medical Files Handed Over
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

G. Donated Medicated List (Exit Report Supplement)

Please complete a separate sheet for each Recipient Facility

Recipient Facility Name: _____

Person Responsible for Receiving Donations: _____

Medication *State generic and brand name, dosage and form, e.g.; Amoxicillin (Amoxil) 250mg capsules*	**Quantity** *Include units, e.g. tablets, amputes*	**Expired Date** *DD/MM/YYYY*	**Additional Notes**

H. Donated Equipment or Supply List (Exit Report Supplement)

Please complete a separate sheet for each Recipient Facility

Recipient Facility Name: _____

Person Responsible for Receiving Donations: _____

Item	Quantity	Training*	User Manual*	Additional Notes

**Please indicate Yes/ No for whether training has been provided to local staff and/ or a user manual provided in relation to the donated medical equipment; or N/A if not applicable.*

AMS I-EMT LESSON LEARNT REPORT

ANNEX 13-1

AMS INTERNATIONAL EMERGENCY MEDICAL TEAM (AMS I-EMT)

LESSONS LEARNT REPORT

I. Event

Country, Event, Year

II. Team Details

Please refer to the "EMERGENCY MEDICAL TEAM EXIT REPORT"

Name of Team/Organization: _____

Team Classification: ☐Type 1 Fixed ☐Type 1 Mobile

☐ Specialized Cell(s): *(Please specify)* _____

Date of Arrival (in-country): Please select date here

Date Service Provision started: Please select date here

Service Duration: ## Days

Date of Departure: Please select date here

Total Duration of Mission: ### Days

Contact Person post-deployment: *(For follow-up after return home)*

Name of Contact person: _____ Position: _____

Email: _____ Phone: + ### - ## - ### - ####

III. Services Provided

Please refer to the "EMERGENCY MEDICAL TEAM EXIT REPORT"

Deployed Location; _____

Date; Start: Please select date here

End: Please select date here

Services and Outcomes

Services	Total	Outcomes	Total
Outpatient Consultations	##	Facility Deaths	##
Major Surgical Procedures	##	Patients with ongoing Rehabilitation Needs	##
Minor Surgical Procedures	##	Referrals/Transfer	##

Please attach additional information including statistical summary of your EMT's MDS results.

ANNEX 13-2

IV. Report to AHA Centre

Please refer to final report to AHA Centre "END OF MISSION" FORM (SASOP ANNEX O)

Evaluation of the Role of AHA Centre and/or Other Party
(Please evaluate the role of the AHA Centre and/ or the party in the facilitation of resource mobilisation)

Recommendation to the AHA Centre

V. Process evaluation for deployment of AMS I-EMT

A. Offer of Assistance and Registration of EMT

Date of submission for "Offer of Assistance"; Please select date here

Date of receiving "Acceptance of AMS I-EMT"; Please select date here

Please describe any problems or constraints and solutions to address the problems/constraints.

B. Mobilisation of EMT

1. Had your EMT completed essential preparation for entry into the affected country including visa and custom clearance, prior to the departure?

   ☐ YES ☐ NO

Please describe any problems or constraints and solutions to address the problems/constraints.

2. Had your EMT prepared registration requirements including EMT Registration Form, copies of passport, copies of licence/certificates for medical professional, prior to the departure?

   ☐ YES ☐ NO

ANNEX 13-3

Please describe any problems or constraints and solutions to address the problems/constraints.

3. How many days or hours did your EMT take to arrive at entry point of affected country after receiving "Acceptance of AMS I-EMT"; (##) days (##) hours

4. How did your EMT complete Immigration procedures and custom clearance?

If any problems, please indicate them and solutions to address the problems.

5. Did your EMT register its arrival and team information at the RDC set up at entry point of affected country?

☐ YES ☐ NO

If "No", Please specify the reasons.

6. What kind of information did your AMS-EMT get at the RDC?

Please describe any problems or constraints and solutions to address the problems/constraints.

7. When and where did your EMT receive authorization to practice for medical professionals?

☐Before the deployment ☐At the RDC ☐PHEOC (Date; Please select date here)

Local PHEOC (Date; Please select date here)

ANNEX 13-4

Please describe any problems or constraints and solutions to address the problems/constraints.

8. How did your EMT decide a site for its activities? And if any problems, please indicate them and solutions to address the problems.

9. How did your EMT move to the site and start its activity? And if any problems, please indicate them and solutions to address the problems.

10. Were local medical staffs and interpreters assigned to your AMS-EMT?

☐ YES ☐ NO

If yes, how many? (##) Medical staffs (##) Interpreters (##) Other, please specify: _____

Please describe any problems or constraints and solutions to address the problems/constraints.

C. On-Site Operations of EMTs

11. Was your EMT provided necessary information for on-site operations such as situation update, secured access to operating grounds and others by the local PHEOC or EMTCC?

☐ YES ☐ NO

Please describe any problems or constraints and solutions to address the problems/constraints.

12. Was your EMT provided any logistical supports by the local POEOC or EMTCC?

☐ YES ☐ NO

ANNEX 13-5

If "YES", Please specify items and contents provided

Please describe any problems or constraints and solutions to address the problems/constraints.

13. Did your EMT secure enough controlled medical substances such as anaesthetic and blood products?

☐ YES ☐ NO

If "NO", Please specify the reasons;

14. Did your EMT get enough water supply and set up appropriate drainage system?

☐ YES ☐ NO

If "NO", Please specify the reasons;

15. How many patients did your AMS-EMT transfer to referral hospitals?

Number of transferred patients; (##)

Did your EMT use the Patient Referral Form (SOP Annex 8) for the transfer of the patients

☐ YES ☐ NO

If "NO", Please specify the reasons;

ANNEX 13-6

Please describe any problems or constraints for the transfer of the patients and solutions to address the problems/constraints.

D. Health Needs Assessment

16. Did your EMT conduct any activities for Health Needs Assessment?

☐ YES ☐ NO

If "YES", Please describe summary of your activities for Health Needs Assessment.

E. Direction and Coordination of Assistance

17. Did your EMT attend meetings organized by PHEOC (or Local PHEOC) or EMTCC (or Sub EMTCC)?

☐ YES ☐ NO

If "YES", how many times? (##)

Please describe any problems or constraints and solutions to address the problems/constraints.

F. Periodic Reporting/Daily Report

18. Did your AMS-EMT submit its MDS Daily Reports?

☐ YES ☐ NO

19. How many daily reports were submitted during the EMT working days?

(##) reports in (##) days

Please describe any problems or constraints and solutions to address the problems/constraints.

ANNEX 13-7

G. Demobilisation of Assistance

20. How did your EMT decide the end date for operation.

20. When did your EMT inform the Local PHEOC or EMTCC of your anticipated end- of operation date?

Date; Please select date here (How many days before the end date; ##)

22. How did your EMT conduct your exit operation?

1) Handover of medical documents

Document	To whom	Date of Handover
Example; Medical Records of Patient	EMTCC	7/1/2020
		Date
		Date
		Date
		Date

Please describe any problems or constraints and solutions to address the problems/constraints.

2) Handover of equipment/medical consumables/medicine

Item No.	Items	To whom	Remark

ANNEX 13-8

Please describe any problems or constraints and solutions to address the problems/constraints.

3) Waste Management and disposal

Please describe the method

Please describe any problems or constraints and solutions to address the problems/constraints.

H. Reporting (Handover and Exit Phase)

23. Did your EMT submit its Exit Report?

☐ YES ☐ NO

If "NO", Specify the reasons;

VI. Good Practice

Please describe good practices on your EMT operation.

Phase of deployment	Good practice
Pre-deployment	
Mobilisation of EMT	
On-Site Operations	
Health Needs Assessment	

ANNEX 13-9

Direction and Coordination of Assistance	
Periodic Reporting/Daily Report	
Reporting (Handover and Exit Phase)	
De-mobilization	
Overall/ Other	

VII. Recommendations

1. Recommendations to improve the regional tools such the SOP for Coordination of Emergency Medical Teams (EMTs) in ASEAN.

2. Recommendations for ASEAN Collective Measures on AMS I-EMT deployment (in ASEAN)[1].

[1] ASEAN Collective Measures on AMS I-EMT deployment (in ASEAN) aims to pursue the rapid, effective and quality EMT deployment under the One ASEAN ONE Response Framework, by supporting AMS's efforts to meet the Classification and Minimum Standards for EMTs (WHO), and taking advantage of the strength of the existing ASEAN regional network, system and structure.

Annex 16

WHOOLEY QUESTIONNAIRE

A. MAKLUMAT KLIEN

1	Nama Penuh	:	.....			
2	No. K/P @ Passport	:	.....			
3	Jantina	:	Lelaki	☐	Perempuan	☐
4	Umur	:	..... tahun			
5	Warganegara	:	Warganegara	☐	Bukan Warganegara	☐
6	Bangsa	:	Melayu	☐	Bumiputera Sabah	☐
			Cina	☐	Bumiputera Sarawak	☐
			India	☐	Lain-lain (Nyatakan) :	.....
7	No. Telefon	:	Rumah	.....		
		:	HP	.....		
8	Sejarah Penyakit	:	Ya	☐	Tidak	☐
			Diabetes	☐		
			Darah Tinggi	☐		
			Kolesterol Tinggi	☐		
			Kanser	☐		
			Lain-lain (nyatakan) :	.....		

B. SARINGAN MINDA SIHAT (WHOOLEY)			
Dalam sebulan yang lepas, adakah anda terganggu oleh masalah berikut? Over the past one month, have you been bothered by the following problems?			
ARAHAN: Sila tanda "√" untuk menyatakan jawapan anda		Ya/Yes	Tidak/No
1.	Merasa murung, sedih atau tiada harapan? Feeling down, depressed or hopeless?		
2.	Kurang minat atau keseronokan dalam melakukan kerja-kerja? Having little interest or pleasure in doing things?		
PENILAIAN SOALAN WHOOLEY			
Berisiko dan perlu menjawab soalan PHQ-9 jika jawapan 'YA' pada salah satu atau kedua-dua soalan.			

C.SARINGAN MINDA SIHAT (GAD-2)						
ARAHAN: Sila tanda "√" untuk menyatakan jawapan anda						
Dalam tempoh 2 minggu yang lepas, berapa kerap anda terganggu oleh masalah berikut? Over the last 2 weeks, how often have you been bothered by any of the following problems?						
0		1	2	3		
Tidak pernah sama sekali Not at all		Beberapa hari Several days	Lebih dari seminggu More than half of the week	Hampir setiap hari Nearly everyday		
No.	Soalan		0	1	2	3
1	Berasa resah, gelisah atau tegang. Feeling nervous, anxious, or on edge.					
2	Tidak dapat menghentikan atau mengawal kebimbangan Not being able to stop or control worrying.					

SKOR GAD-2		
• Kira Jumlah skor kesemua 2 item/soalan mengikut kotak yang di tanda (√) • Jumlah Skor bagi kesemua 2 item/soalan adalah di antara 0 – 6		
PENILAIAN SOALAN GAD-2		
SKALA	Jumlah Skor	Tindakan
Tidak Berisiko	0-2	Pendidikan kesihatan dan amalan cara hidup sihat
Berisiko	≥3	Berisiko dan perlu menjawab soalan GAD-7

IF USER ANSWERED **Yes to any one** of the questions **in Whooley** or **scores 3 or more in GAD2** to proceed with further evaluation: **PHQ9/ GAD7**

Annex 17

VOLUNTEER DATABASE

BORANG MAKLUMAT PEGAWAI

Maklumat perlu diisi oleh pegawai yang berminat dan diserahkan kepada Pejabat Pengarah untuk tindakan selanjutnya. **(Pastikan semua maklumat lengkap diisi).**

Maklumat Pegawai	
Nama Penuh:	
No. Kad Pengenalan:	
Gelaran:	Jantina: Lelaki/ Perempuan
Alamat:	
Poskod:	
No. Tel (R):	
No. Tel (HP):	
Emel:	

Maklumat Perkhidmatan	
Nama Hospital:	No. Telefon Pejabat:
Jabatan/ Unit:	
Jawatan :	Gred:
Kelulusan Kepakaran/ Pos Basik: Tahun Diperolehi:	
No. APC:	

Pengalaman:

i. Bertugas

Jabatan/ Unit	Tahun
i.	
ii.	
iii.	
iv.	
v.	

ii. Penglibatan Pengurusan Bencana (Sebelum ini).

a. Dalam Negara

Jenis Bencana	Tahun
i.	
ii.	
iii.	

b. Luar Negara

Jenis Bencana	Tahun
i.	
ii.	
iii.	

Alamat Tempat Bertugas :

Poskod :

Adakah terdapat sebarang masalah Kesihatan yang perlu dimaklumkan sekiranya berlaku sebarang kecemasan?

***Ya/ Tidak** **potong mana yang tidak berkenaan*

Sekiranya Ya, Jelaskan:

Maklumat Waris (Sekiranya Beraku Kecemasan) :	
Nama Penuh:	
No. Kad Pengenalan:	
Gelaran:	Jantina: Lelaki/ Perempuan
Hubungan dengan pegawai:	
Alamat (Sekiranya berlainan dengan alamat di atas):	
	Poskod :
No. Tel (R):	
No. Tel (HP):	

Ulasan Ketua Jabatan : ***Sokong/ Tidak Sokong**

_____
_____
_____
_____
_____
_____

.....

Nama :_____

Jawatan :_____

Cop Rasmi :

Tarikh :

**potong yang mana tidak berkenaan*

PERSONAL ITEMS

a) Personal items must be self-prepared and bring together during deployment.

Minimum personal items that should be brought along to the field as in the following table:

- **Personal Items**

NO.	ITEM	REMARKS
1.	4 shirts/ collared T-shirts. At least one must be long-sleeve	Working attire
2.	2 Lightweight, tough pants (only LONG pants, preferably with multiple pockets)	Working attire
	Please do not wear army-like clothing	
3.	1 pair of Trekking shoes and	Working attire
	2 pairs of socks	
4.	1 T-shirt	Leisure/ sleeping
5.	1 pair Track bottoms *OR* Bermuda shorts	Leisure/ sleeping
6.	1 Sarong	Multi-purpose
7.	Undergarments	At your discretion
8.	1 pair of sandals	To wear at the campsite/ accommodation site
9.	Praying clothes for muslim (especially for female)	
10.	Personal Medicine	Recommended - Paracetamol, Actal, fabric plasters and required personal medication
11.	Bath towel (if possible quick dry)	Personal hygiene
12.	Personal toiletry articles	Personal hygiene
	a) Bath soap	
	b) Shampoo	
	c) Tooth paste and brush	
	d) Razor	
	e) Sanitary pad (for females)	
	f) Toilet paper	
	g) Wet wipes	
13.	Eating utensils: plate, cup, fork, spoon (if possible; mess tin)	For own use
14.	Water bottle (500ml-1 litre)	For own use
15.	Energy Bar	For own use
16.	Reasonable amount of cash	For personal use

b) Personal Gear

NO.	ITEM	REMARKS
1.	Lightweight sleeping bag or Lightweight blanket	For own use
2.	Small flashlight and extra batteries	
3.	Hat/ cap	For protection against direct sunlight
4.	Rain coat	For own use
5.	Insect repellent	For own use – protection against mosquitoes and other insects
6.	Hand sanitizer	For own use
7.	Multipurpose pocket knife	Not to put in hand luggage
8.	Power bank	
9.	Note book and pen	
10.	External hard disc	For storage of documents
11.	Rubber boot	For personal protection

c) Mission Equipment

1. Reconnaissance or assessment team

NO.	ITEMS	REMARKS
1.	Tent (4 – 6 person)	For sleeping
2.	Food and water supply	Basic needs for team
3.	Small water filter	Basic need for team
4.	Field stove	
5.	Compass/ GPS	For direction
6.	Map	
7.	Laptop	
8.	Communication equipment/ satellite telephone	For communication to any relevant authorities/ partners
9.	Stationeries – note book, pen, pencil	
10.	Camera	
11.	Local SIM Card	For communication
12.	First aid kit	For team use
13.	Local currency or US currency (not more than USD 10,000 per person)	For team use – accommodation, transportation, food, secure logistics for in- coming response teams

2. Response Teams

2.1 Health Team

NO	ITEM	PURPOSE
1.	Pesticide spray can	For insecticidal
2.	Fogging machine	For insecticidal
3.	Disinfectant	
4.	Chlorine	Well chlorination
5.	Activated Charcoal	
6.	Health education material (for local mission)	
7.	Water sampling equipment	
8.	Food sampling equipment	
9.	Rodent control Equipment	Rat control
10.	Plastic bag	For general waste
11.	PPE – mask, glove (latex glove, heavy duty rubber glove), boot	For protection

2.2 Emergency Medical Team (EMT)

All equipment and medicines prepared for mission are based on type of emergency medical team (EMT) deployed.

a) Type 1

NO.	ITEM	TYPE 1 MOBILE	TYPE I FIXED
1.	Tent (for working area)	-	+ / -
2.	Trauma bag (basic first aid, basic life support)	+	+
3.	Medication (as Appendix)	+	+
4.	Immobilisation set (upper limb, lower limb, cervical collar, pelvic binder, spinal board)	+	+
5.	Monitoring equipment (BP set, transport monitor)	+	+
6.	AED	+	+
7.	Basic rapid detection test (glucometer, urine deep stick, haemoglobin test)	+	+
8.	Nebuliser machine	+	+
9.	Portable oxygen tank	+	+
10.	Consumables including PPEs (as Appendix)	+	+

** The amounts of items for Type 1 mobile will be less compared to Type 1 fixed.

b) Type 2

Equipment and medicines are for outpatient, basic in-patient pediatric care, emergency surgical care including O&G emergency surgery; day and night service.

- 1 OT for 7 major or 15 minor operations.
- Basic general anesthesia service.
- Basic X-ray service – chest, limbs, pelvis and spine.
- 20 in-patient beds.
- Basic in-patient testing and safe blood transfusion capability (walking blood bank).
- Adequate and sufficient medicine and consumable items for 2 weeks services.

** Medicines and consumables as Appendix 3-1 and Appendix 3-2.

c) Type 3

Equipment and medicine are for complex in-patient referral surgical care including intensive care capability. Complex reconstructive wound and orthopaedic care, enhanced X-ray, blood transfusion, lab and rehab services. Deployment for two (2) months.

- 1 OT with 2 OR – 15 major, 30 minor operations per day.
- 40 in-patient beds.
- 6 intensive beds.
- Ultra sound.
- Drill, plates, external fixator.

Additional medicines and equipment based on specialized services provided.

2.3 MOH DVI team (Ministry of Health Disaster Victim Identification Team)

Equipment required by the MOH DVI team during deployment are as follows;

NO.	ITEM	UNIT
1.	Walkie Talkie	2 Units
2.	Distance Meter	1 Unit
3.	Labeller	1 Box
4.	Full Face Mask with Filter	3 Sets
5.	Manual Saw and Spare Blades	1 Set
6.	Jump Suit	5 Units (2M, 2L, 1XL)
7.	Goggles	5 Units
8.	Deployment Bag	2 Units
9.	Head lamp	1 Unit
10.	Torch light	1 Unit
11.	Mask	1 Unit
12.	Spade	1 Unit
13.	Post-mortem Set	1 Set
14.	Note Book (Heavy Duty)	1 Unit
15.	Waterproof Case for camera	1 Box
16.	Camera with Battery	1 Unit
17.	Extra Battery	1 Pcs

2.4 Mental Health and Psychosocial Support Team

NO.	EQUIPMENT	REMARKS
1.	Screening tools	• DASS-21(Depression Anxiety Stress Scale)
		• Kessler 10
		• Coping Skills Questionnaire
		• Burnout Inventory
2.	Walkie Talkie	
3.	Crayons/ colour pencils	
4.	A4 papers	
5.	Stress ball	
6.	Art therapy Activities	
	• Blob tree	
	• Body Outline	
	• Playdoh	
7.	Hand Sanitizer	
8.	Tissue Paper	

Other than equipment, the team should ensure that to bring these documents during international mission/ deployment.

- List of team members with copy of passport.
- Valid Annual Practice Certificate (for doctor, pharmacist, staff nurse and assistant medical officer).
- Authorisation letter from receiving countries (host countries) – if possible with translation of affected country.
- Authorisation letter from MOH via CPRC.
- Team travel itinerary including return ticket.
- Proof of place of stay.

All the items brought into the affected country should be accompanied by;

- Drug manifest (refer Appendix 3-3).
- Equipment manifest (refer Appendix 3-4).
- Consumables manifest (refer Appendix 3-5).
- Dry food manifest (refer Appendix 3-6).

** Precaution

Any items with batteries should be separated from batteries.

Laptop need to be hand carried.

Power bank - hand carried.

Annex 19

MENTAL HEALTH ALERT CARD

To the responders / volunteers / individuals coming back from the outbreak area

Please tick (/) if you are experiencing any of the following symptoms:

- ❑ Easily anxious
- ❑ Difficulty in sleeping
- ❑ Feeling extremely sad
- ❑ Feeling hopeless/helpless
- ❑ Feeling guilty
- ❑ Easily irritated /angry
- ❑ Flashbacks /nightmares
- ❑ Crying without any specific reasons

If you are experiencing any of the above please seek professional help from nearest clinic/hospital and present this card for further assessment.

To the Doctor

The person who's presenting this mental health alert card has returned from a disaster/crisis/outbreak area _____

_____

If the person presents with symptoms related to mental health problems, kindly perform further assessment and appropriate intervention for him/her.

Annex 20

Depression Anxiety Stress Scale (DASS)

SMS

SARINGAN MINDA SIHAT

Nama : _____

I/C No. : _____

Jantina : _____

Umur : _____

Bangsa : _____

Pekerjaan : _____

No. Telefon : _____

Tarikh : _____

Ceraikan keratan ini untuk disimpan oleh klien.

KEPUTUSAN SARINGAN MINDA SIHAT

Nama : _____ Tarikh : _____

Jantina : Lelaki/Perempuan Umur : _____

Ujian	Keputusan		
	Stres	Anzieti	Kemurungan
DASS			

SARINGAN MINDA SIHAT

SOAL SELIDIK DASS

Langkah 1	:	Sila baca dan jawab soal selidik DASS.
Langkah 2	:	Masukkan skala markah jawapan ke dalam ruangan kosong dibahagian 2, mengikut soalan (S) bagi setiap kategori (Stres, Anzieti dan Kemurungan).
Langkah 3	:	Jumlahkan skala markah bagi setiap kategori bagi mengetahui tahap status kesihatan mental anda.
Langkah 4	:	Sila isikan keputusan dalam bahagian 3 dan isikan dalam keratan di muka hadapan.

BAHAGIAN 1

Sila baca setiap kenyataan di bawah dan **bulatkan** jawapan anda pada kertas jawapan berdasarkan jawapan **0, 1, 2 atau 3** bagi menggambarkan keadaan anda sepanjang minggu yang lalu. Tiada jawapan yang betul atau salah. Jangan mengambil masa yang terlalu lama untuk menjawab mana-mana kenyataan.

*Please read each statement and **circle** number **0, 1, 2 or 3** which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.*

0 = **Tidak Langsung** menggambarkan keadaan saya
***Did not** apply to me at all*

1 = **Sedikit atau jarang-jarang** menggambarkan keadaan saya
*Applied to me to some **degree,** or **some of the time***

2 = **Banyak atau kerapkali** menggambarkan keadaan saya
*Applied to me to a **considerable degree**, or a **good part of time***

3 = **Sangat banyak atau sangat kerap** menggambarkan keadaan saya
*Applied to me **very much**, or **most of the time***

1.	Saya dapati diri saya sukar ditenteramkan *I found it hard to wind down*	0	1	2	3
2.	Saya sedar mulut saya terasa kering *I was aware of dryness of my mouth*	0	1	2	3
3.	Saya tidak dapat mengalami perasaan positif sama sekali *I couldn't seem to experience any positive feeling at all*	0	1	2	3
4.	Saya mengalami kesukaran bernafas (contohnya pernafasan yang laju, tercungap-cungap walaupun tidak melakukan senaman fizikal) *I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)*	0	1	2	3
5.	Saya sukar untuk mendapatkan semangat bagi melakukan sesuatu perkara *I found it difficult to work up the initiative to do things*	0	1	2	3
6.	Saya cenderung untuk bertindak keterlaluan dalam sesuatu keadaan *I tended to over-react to situations*	0	1	2	3
7.	Saya rasa menggeletar (contohnya pada tangan) *I experienced trembling (eg, in the hands)*	0	1	2	3
8.	Saya rasa saya menggunakan banyak tenaga dalam keadaan cemas *I felt that I was using a lot of nervous energy*	0	1	2	3
9.	Saya bimbang keadaan di mana saya mungkin menjadi panik dan melakukan perkara yang membodohkan diri sendiri *I was worried about situations in which I might panic and make a fool of myself*	0	1	2	3
10.	Saya rasa saya tidak mempunyai apa-apa untuk diharapkan *I felt that I had nothing to look forward to*	0	1	2	3
11.	Saya dapati diri saya semakin gelisah *I found myself getting agigate*	0	1	2	3
12.	Saya rasa sukar untuk relaks *I found it difficult to relax*	0	1	2	3
13.	Saya rasa sedih dan murung *I felt down-hearted and blue*	0	1	2	3
14.	Saya tidak dapat menahan sabar dengan perkara yang menghalang saya meneruskan apa yang saya lakukan *I was intolerant of anything that kept me from getting on with what I was doing*	0	1	2	3
15.	Saya rasa hampir-hampir menjadi panik/cemas *I felt I was close to panic*	0	1	2	3
16.	Saya tidak bersemangat dengan apa jua yang saya lakukan *I was unable to become enthusiastic about anything*	0	1	2	3
17.	Saya rasa tidak begitu berharga sebagai seorang individu *I felt I wasn't worth much as a person*	0	1	2	3
18.	Saya rasa saya mudah tersentuh *I felt that I was rather touchy*	0	1	2	3
19.	Saya sedar tindakbalas jantung saya walaupun tidak melakukan aktiviti fizikal (contohnya kadar denyutan jantung bertambah, atau denyutan jantung berkurangan) *I was aware of the action of my heart in the absence of phycial exertion (eg, sense of heart rate increase, heart missing a beat*	0	1	2	3
20.	Saya berasa takut tanpa sebab yang munasabah *I felt scared without any good reason*	0	1	2	3
21.	Saya rasa hidup ini tidak bermakna *I felt that life was meaningless*	0	1	2	3

BAHAGIAN 2

Panduan Mengira Skor :-
Masukkan skala markah jawapan bagi soalan (S) bagi setiap kategori.

STRES								
Soalan	S1	S6	S8	S11	S12	S14	S18	Jumlah
Markah								

ANZIETI								
Soalan	S2	S4	S7	S9	S15	S19	S20	Jumlah
Markah								

KEMURUNGAN (DEPRESSION)								
Soalan	S3	S5	S10	S13	S16	S17	S21	Jumlah
Markah								

Selepas dijumlahkan, sila rujuk kepada petak skor saringan dan terjemahkan jumlah skor untuk mengetahui tahap status kesihatan mental anda.

SKOR SARINGAN			
	Kemurungan	Anzieti	Stres
Normal	0 - 5	0 - 4	0 - 7
Ringan	6 - 7	5 - 6	8 - 9
Sederhana	8 - 10	7 - 8	10 - 13
Teruk	11 - 14	9 - 10	14 - 17
Sangat Teruk	15 +	11 +	18 +

BAHAGIAN 3

Isikan keputusan **(normal, ringan, sederhana, teruk atau sangat teruk)** dalam jadual di bawah.

KEPUTUSAN UJIAN DASS	
Ujian	Tahap
Stres	
Anzieti	
Kemurungan	
SKOR DASS	

Annex 21

SQD: Screening Questionnaire for Disaster Mental Health

Instruction:

"People who have experienced [repeat the traumatic event] often report that their lives have changed dramatically and they are constantly under various kinds of stress. Have you experienced any of the symptoms listed below in the past month?"

GENDER: MALE/ FEMALE		**AGE :**	
No.	Question	Tick	
Q1	Have you noticed any changes in your appetite?	Yes	No
Q2	Do you feel that you are easily tired and/or tired all the time?	Yes	No
Q3	Do you have trouble falling asleep or sleeping through the night?	Yes	No
Q4	Do you have nightmares about the event?	Yes	No
Q5	Do you feel depressed?	Yes	No
Q6	Do you feel irritable?	Yes	No
Q7	Do you feel that you are hypersensitive to small noises or tremors	Yes	No
Q8	Do you avoid places, people, topics related to the event?	Yes	No
Q9	Do you think about the event when you do not want to	Yes	No
Q10	Do you have trouble enjoying things you used to enjoy?	Yes	No
Q11	Do you get upset when something reminds you of the event?	Yes	No
Q12	Do you notice that you are making an effort to try not to think about the event, or are trying to forget it?	Yes	No
SQD-P: Q3+Q4+Q6+Q7+Q8+Q9+Q10+Q11+Q12=			

SQD-D: Q1+Q2+Q3+Q5+Q6+Q10=

SQD-P: 9-6 = Severely affected (**possible PTSD**)
5-4 = Moderately affected

3-0	= Slightly affected (**currently little possibility of PTSD**)	
SQD-D: 6-5 = More likely to be depressed		
4-0	= Less likely to be depressed	80

Journal from A Simple Interview-format Screening Measure for Disaster Mental Health:
An instrument newly developed after the 1995 Great Hanshin Earthquake in Japan

- The Screening Questionnaire for Disaster Mental Health (SQD)

Kessler Psychological Distress Scale (K10)
Source: Kessler R. Professor of Health Care Policy, Harvard Medical School, Boston, USA.

This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4-week period.

Why use the K10
The use of a consumer self-report measure is a desirable method of assessment because it is a genuine attempt on the part of the clinician to collect information on the patient's current condition and to establish a productive dialogue. When completing the K10 the consumer should be provided with privacy.

(Information sourced from the NSW Mental health Outcomes and Assessment Training (MH-OAT) facilitator's Manual, NSW Health Department 2001)

How to administer the questionnaire
As a general rule, patients who rate most commonly "Some of the time" or "All of the time" categories are in need of a more detailed assessment. Referral information should be provided to these individuals. Patients who rate most commonly "A little of the time" or "None of the time" may also benefit from early intervention and promotional information to assist raising awareness of the conditions of depression and anxiety as well as strategies to prevent future mental health issues.

(Information sourced from the NSW Mental health Outcomes and Assessment Training (MH-OAT) facilitator's Manual, NSW Health Department 2001)

K10 Test

These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

1. During the last 30 days, about how often did you feel tired out for no good reason?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

2. During the last 30 days, about how often did you feel nervous?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

4. During the last 30 days, about how often did you feel hopeless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

5. During the last 30 days, about how often did you feel restless or fidgety?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

6. During the last 30 days, about how often did you feel so restless you could not sit still?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

7. During the last 30 days, about how often did you feel depressed?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

8. During the last 30 days, about how often did you feel that everything was an effort?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

10. During the last 30 days, about how often did you feel worthless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

Scoring

FOR DOCTOR'S EYES ONLY

This is a questionnaire for patients to complete. It is a measure of psychological distress. The numbers attached to the patients 10 responses are added up and the total score is the score on the Kessler Psychological Distress Scale (K10). Scores will range from 10 to 50. People seen in primary care who

* Score under 20 are likely to be well
* Score 20-24 are likely to have a mild mental disorder
* Score 25-29 are likely to have moderate mental disorder
* Score 30 and over are likely to have a severe mental disorder

13% of the adult population will score 20 and over and about 1 in 4 patients seen in primary care will score 20 and over. This is a screening instrument and practitioners should make a clinical judgement as to whether a person needs treatment.

Scores usually decline with effective treatment. Patients whose scores remain above 24 after treatment should be reviewed and specialist referral considered.

Kessler Psychological Distress Scale (K10) – Malay Version

TARIKH: _ _ / _ _ / _ _ _ _

K10

PENEMUDUGA:
ID PENEMUDUGA:

NOMBOR KAJIAN

NAMA :	
NAMA LAIN :	
TARIKH LAHIR : _ _ / _ _ / _ _ _ _	JANTINA : □ LELAKI □ PEREMPUAN
ALAMAT :	

Soalan-soalan di bawah adalah mengenai perasaan anda dalam tempoh 4 minggu kebelakangan ini.
Sila tanda satu kotak yang dapat menyatakan perasaan anda dengan paling dekat

Dalam tempoh empat (4) minggu kebelakangan ini, berapa kerap kah anda:	**1 Tidak pernah sekali**	**2 Jarang**	**3 Kadang-kadang**	**4 Hampir setiap masa**	**5 Setiap masa**
1. Berasa letih tanpa sebarang sebab?					
2. Berasa cemas?					
3. Berasa cemas sehingga tiada apa yang mampu menenangkan anda?					
4. Berasa tiada harapan?					
5. Berasa gelisah atau resah?					
6. Berasa sangat gelisah sehingga tidak boleh duduk diam?					
7. Berasa murung?					
8. Berasa semuanya memerlukan usaha?					
9. Berasa sangat sedih sehingga tiada apa yang mampu menceriakan anda?					
10. Berasa diri tiada nilai dan guna					

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