ANNEXES

1. Annex A – Protocols, Systems and Guidelines

1A. Emergency Response and Care

The **Emergency Response and Care** is a component of the Emergency Medical Services continuum that begins upon arrival of the EMS team at the scene of the incident to include scene assessment, patient assessment, triaging, initial management and transport until the patient is loaded to ambulance/emergency vehicle for patient transport.

- **OBJECTIVES:**

  General Objective:
  To have an efficient and systematic response protocol in delivering emergency care to pre-hospital or on-site patients during emergencies and disasters.

  Specific Objectives:

  - *To strengthen the emergency response procedures before, during and after operations.*
  - *To establish guidelines regarding safety of the scene, safety and well-being of the responders and patients.*
  - *To establish a standardized procedure in sorting, handling and caring of patients.*
  - *To ensure adherence to legal and moral standards for the protection of both the responders and the patient.*

- **LEGAL BASIS**

  - AO 2016-0029 – Rules and Regulations Governing the Licensure of Ambulances and Ambulance Service Providers.
  - Presidential Decree No. 1566 of 1978: Strengthening Philippine Disaster Control Capability and Establishing National Program on Community Disaster Preparedness.
  - Memorandum Circular (MC) 06-07-2016 dated July 21 – states that the code "911" shall be made available for the use of the Philippine Government.
  - Memorandum Order (MO) 07-07-2016 dated July 20 – stipulates the use of code 911 as emergency hotline number nationwide.
  - Article 275 No. 1 and 2 Act of # 3815 of the Philippine Revised Penal Code Book Two: "Abandonment of person in danger and abandonment of one's own victim"

Moral, Ethical and Legal Responsibilities

❖ ***An Emergency Medical Responder should:***

- Provide service to patients based on Standard of Care.
- Provide services based on human needs with compassion and respect for human dignity.
- Practice utmost professionalism in giving care to patients.
- Respect and hold confidence all information of a confidential nature obtained in the course of professional service unless required by law to divulge such information.
- Should address social media issues with discretion and refer it to persons in authority and capacity.

- ***Consent must be obtained before providing care.***

  - Expressed consent – must be informed.
  - Implied consent – assumed consent, follows local laws and protocols, regulating bodies and organizations.
  - Should be free from coercive factors.

- ***Minors are not permitted to provide consent for treatment.***

  - Obtain consent from parent or legal guardian
  - Possible exceptions:
    - In loco parentis (in place of a parent) - refers to the legal responsibility of a person or organization to take on some of the functions and responsibilities of a par.
    - Emancipated minors
    - Life-threatening illness or injury
    - Minors who have children
    - Minors serving in the armed forces

- ***Mentally incompetent adults are not allowed to provide consent neither for themselves nor for other persons.***

  - State and local laws and protocols permit transport and treatment of such patients under implied consent.

- ***Patients may refuse care or transport.***

  - Legally able to sign refusal and release form
  - Have a witness to the refusal
  - Mentally competent and oriented
  - Fully informed of risks
  - Consult responsible authorities or contact law enforcement
  - Contact family member
  - Document refusal

- ***Negligence***

  - An emergency medical responder has a duty to provide care, and when on duty is obligated to deliver care if there is no threat to safety.
  - Failure to do so warrants legal sanctions.

- ***Abandonment***

  - Once initiated, care should be continued until a personnel of equal or greater training assumes the care.
  - Failure to do so may constitute abandonment.

- ***Evidence Preservation***

  - Should minimize impact on the scene and should be careful with what you touch.
  - Should work with the police.
  - Should do proper documentation and reporting.

- **THE EMERGENCY MEDICAL RESPONSE TEAM**

  - **Composition**

    An Emergency Response Team shall be composed of the following:

    - ✓ Team Leader
    - ✓ Triage Officer/s
    - ✓ Communicator
    - ✓ Responders/Extricators

  - **Capacity/Capability Requirements**

    - ❖ A member of the Emergency Medical Response Team shall at least have training/s in:
      - ✓ EMT
      - ✓ EMR
      - ✓ BLS with AED
      - ✓ ACLS/ATLS
      - ✓ Standard First Aid

    - ❖ The Emergency Medical Response Team should respond to an emergency scene in a safe manner.

      - ✓ Use information available from the dispatcher, consider scene safety and pre-arrival assessment prior to contact with the patient.
      - ✓ Request appropriate additional resources including logistics and manpower when necessary.
      - ✓ Warning devices and siren should be used with discretion and only as appropriate for the nature of the response and given information.

  - **Governing Policies on Emergency Response**

    - ❖ No person will be denied treatment or transport on the basis of age, sex, race, creed, color, origin, economic status, language, sexual preference, disease, or injury.
    - ❖ The safety of the responders shall be the top most priority at all times.
    - ❖ The team on duty must wear uniform; must be mentally, physically, emotionally and psychologically prepared to perform their tasks.
    - ❖ Ask the patient, relative or proper authority for permission to take photos for documentation. Edit the photos to be used by placing a black bar over the eyes to hide the identity of the patient or victim.
    - ❖ Universal Precautions
      - ✓ EMS personnel are responsible to use appropriate personal protective gear (PPG).
      - ✓ PPG should be removed immediately after the patient contact to avoid contamination of other surfaces (steering wheel, door handles, clip boards, pens and many others).
      - ✓ EMS personnel should be assessed regarding the need for immunization.
      - ✓ Hand washing is the most important infection control procedure. EMS personnel should wash their hands:
        - ➢ After removing PPG
        - ➢ After each patient contact

- After handling potentially infectious material
- After cleaning/decontaminating equipment
- After using the restroom
- Before eating or preparing food

- Post Exposure
  - ✓ Any EMS personnel exposed to potentially infectious material will immediately wash the exposed area with soap and water or an alcohol-based solution (saline wash if the eyes are involved).
  - ✓ Any EMS personnel having an occupational communicable disease exposure will immediately report the exposure to his/her supervisor. Needlestick injuries will be reported to the designated officer immediately.
  - ✓ Exposure to infectious or potentially-infectious materials should be medically evaluated within the first hour after exposure as some prophylactic treatments are only effective if initiated within the time period. The following events will be considered potentially high risk exposure:
    - Hollow needlestick injuries
    - Breaks in the skin caused by potentially contaminated objects
    - Splash of blood or other potentially infectious material into the eyes, mucous membranes, or non-intact skin
  - ✓ Whenever possible, the source patient will be traced to the receiving facility by the designated officer. The designated officer will notify the receiving facility that a communicable disease exposure has taken place, and request an infectious disease determination as provided.

- **SCENE SAFETY PROTOCOLS**
  - Take standard precautions
  - Note the mechanism of injury or nature of patient's illness
  - Determine the number of patients
  - Decide if additional resources are necessary

Approaching the Scene:

- Look and listen for other emergency units approaching
- Look for signs of a collision-related power outage
- Observe traffic flow
- Look for smoke in the direction of the scene
- Appropriate personal protective gear

Within Sight of the Scene:

- Look for clues to escaped hazardous materials
- Look for collision victims on or near the road
- Look for smoke not seen at a distance
- Look for broken utility poles and downed wires
- Be alert for persons walking alongside of road toward collision scene
- Watch for signals of police officers and other emergency personnel
- Beware of traffic hazards

On-Scene:

- Establish **DANGER ZONE** (evaluate hazardous and restricted areas based on threat level)

- **EXTRICATION**

  - Principles of Extrication
    - ✓ Evaluate (size up) the situation.

- ✓ Provide for the safety of rescue personnel and the patient.
- ✓ Secure the scene.
- ✓ Gain access of the patient.
- ✓ Provide emergency medical care (stabilize the patient).
- ✓ Disentangle the patient.
- ✓ Prepare the patient for transfer.
- ✓ Transfer the patient.

- Examination of Spinal Injury
  - Ask the patient or witness about the nature of the accident.
  - Ask the patient carefully about areas of pain, numbness or weakness.
  - Look for contusion, laceration and abrasion about the face, head, or trunk and look for any deformity of the spine.
  - Feel for any irregularity, deformity or point of tenderness along the spinous process posteriorly. Check arms and legs for decreased sensation.
  - Check for weakness or paralysis by asking the patient to wiggle his/her fingers and toes, unassisted.

- Emergency Care for Spinal Injury
  - Maintain the patient's breathing and ensure adequate ventilation. Perform C-Spine control and or jaw thrust maneuver.
  - Control serious bleeding using local pressure dressing.
  - Most importantly, immobilize the victim before you move him.

- Helmet Removal
  - When the facemask or visor interferes with adequate ventilation or with your ability to restore an adequate airway.
  - When the helmet is so loose that securing it to the spinal immobilization device will not provide adequate immobilization of the victim's head.
  - When life-threatening hemorrhage under the helmet can only be controlled by its removal.
  - When using it as a part of the spinal immobilization will cause extreme flexion of the neck (this situation usually occurs in children).

- Immobilization of Spinal Injury
  - Immediately begin stabilization by holding the head firmly with two hands. Gently lift the head to the position where the victim's eyes are looking straight ahead and the head and torso are in-line (neutral in-line position). At no time should the head or neck be twisted or excessively flexed or extended. Manual support must continue until the patient is completely secured to the spinal immobilization device.
  - In certain circumstances, movement of the head to the neutral in-line position should not be pursued. You should not force the head into this position if:
    - Neck muscle spasm occurs
    - Pain increases
    - Numbness, tingling or weakness develops
    - The airway or ventilation becomes compromised.

    In the presence of these circumstances, stop and immobilize the victim in the deformed position.

  - Use cervical collar if available. If none, improvise (rolled blanket or towel):
    - Should be appropriately sized (correct size).

- Should rest on the shoulder girdle, firm under both mandible.
- Must not prevent opening the mouth to clear the airway.
- Should never obstruct ventilation in any way.

- Manual support must continue even after the collar is applied until the patient is completely secured to a spinal immobilization device (long spine/back board).
- Avoid hyperextension or hyperflexion of the neck when you secure the head. In most adults, the neutral in-line position will create a space between the head and the spinal immobilization device.
- Adequate patting should be placed between the head and the device. In contrast, small children will need padding placed between the shoulder and the device to prevent hyperflexion of the neck when secured to the device. This situation occurs because the child's head is relatively large, and securing the child to a flat surface naturally forces the head to flex on the trunk.
- Secure all straps snugly to minimize motion. However, they should not restrict chest expansion or circulation to the limb.
- Be certain that the patient's mouth can be opened to clear the airway.
- Secure the victim well to the spinal immobilization device (long spine/back board) with the head, torso and pelvis aligned so that no motion will occur between any of these parts during movement and transport. The patient should be so well secured that the entire body can be turned to one side to facilitate airway management or vertical extrication if necessary.

o Rescue from Automobile

- It is usually not necessary to move a victim from an automobile before a professional/trained resource arrives; automobiles do not often explode after accidents.
- If you can do so without moving the victim, turn off the ignition and set the parking brake.
- If you must remove the patient from an automobile because he/she is in immediate danger, first immobilize the neck and back with a short backboard.
- If you have no board, you will have to weigh the urgency of moving the patient without a board against waiting for professional help with proper equipment.
- Insert a board behind the patient's back while one is securing the head (C-Spine Control), being careful not to cause any unnecessary movement of the neck and back. The board should extend from the victim's head to below his/her buttocks.
- Immobilize the patient's neck by gently wrapping a towel around it.
- Secure the patient by binding him/her firmly to the board in at least 4 places: around the forehead, around the neck (over the towel and more over the chin), under the armpits, and around the lower abdomen. If possible, secure the victim's arms to the board as well.
- Tie the patient's knees and ankles together. This will help prevent twisting of the body as you remove the victim from the automobile.
- Remove the patient from the automobile being careful not to twist or bend his body. Do not pull on the backboard, as this causes the victim to slip off.

o Specific Body Injuries

- Always care for wounds before applying a splint.
- Splint an injury in the position in which you found it. You will need strong supports to make a splint. Possibilities include boards, sticks, cardboard, poles, branches, broom handles, umbrellas, baseball bats, or rolled newspapers or magazines. If you have nothing rigid on hand, use a pillow or blanket. Sometimes you can tape an injured part of the body to an uninjured part to prevent movement.

- The splint must extend both above and below the injured area to keep it immobilized.
- Secure the splint to uninjured parts of the body. Put ties or tape above and below but not on top of the injury. For ties, you can use cloth strips, neckties, torn sleeves, belts, etc.

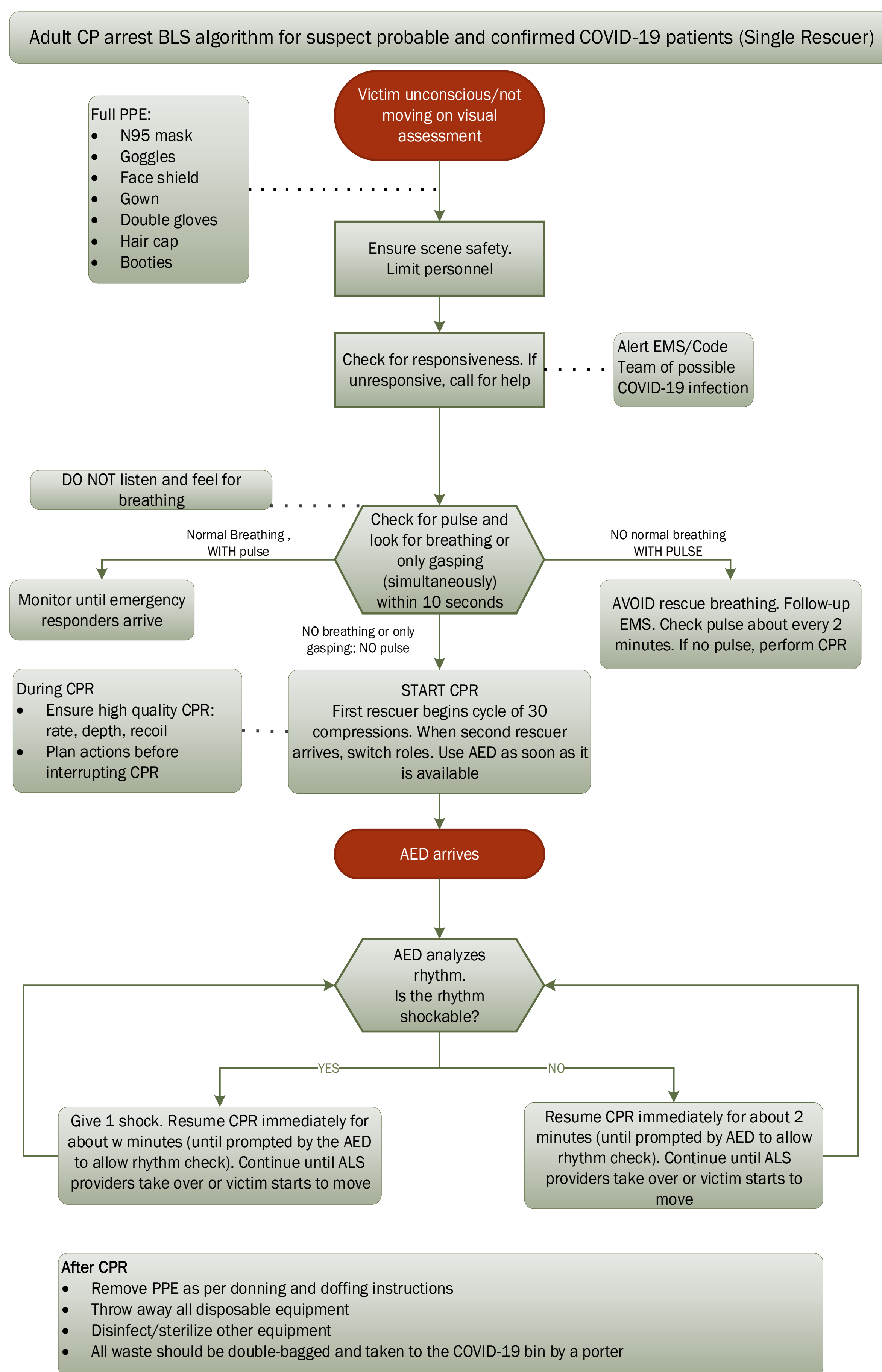
Lifting and Moving of a Patient

- Position feet properly
- Use legs
- Never turn or twist
- Do not compensate when lifting with one hand
- Keep weight as close to your body as possible
- Whenever possible, use stair chair when carrying a patient on stairs
- Keep back in locked-in position
- Avoid twisting while reaching
- Avoid reaching more than 15-20 inches in front of body
- Avoid prolonged reaching when strenuous effort is required
- Push, don’t pull
- Back locked in
- Line of pull through center of body
- Weight close to body
- When weight is below waist, use kneeling position
- Avoid pushing or pulling overhead
- Elbows bent, arms close to side

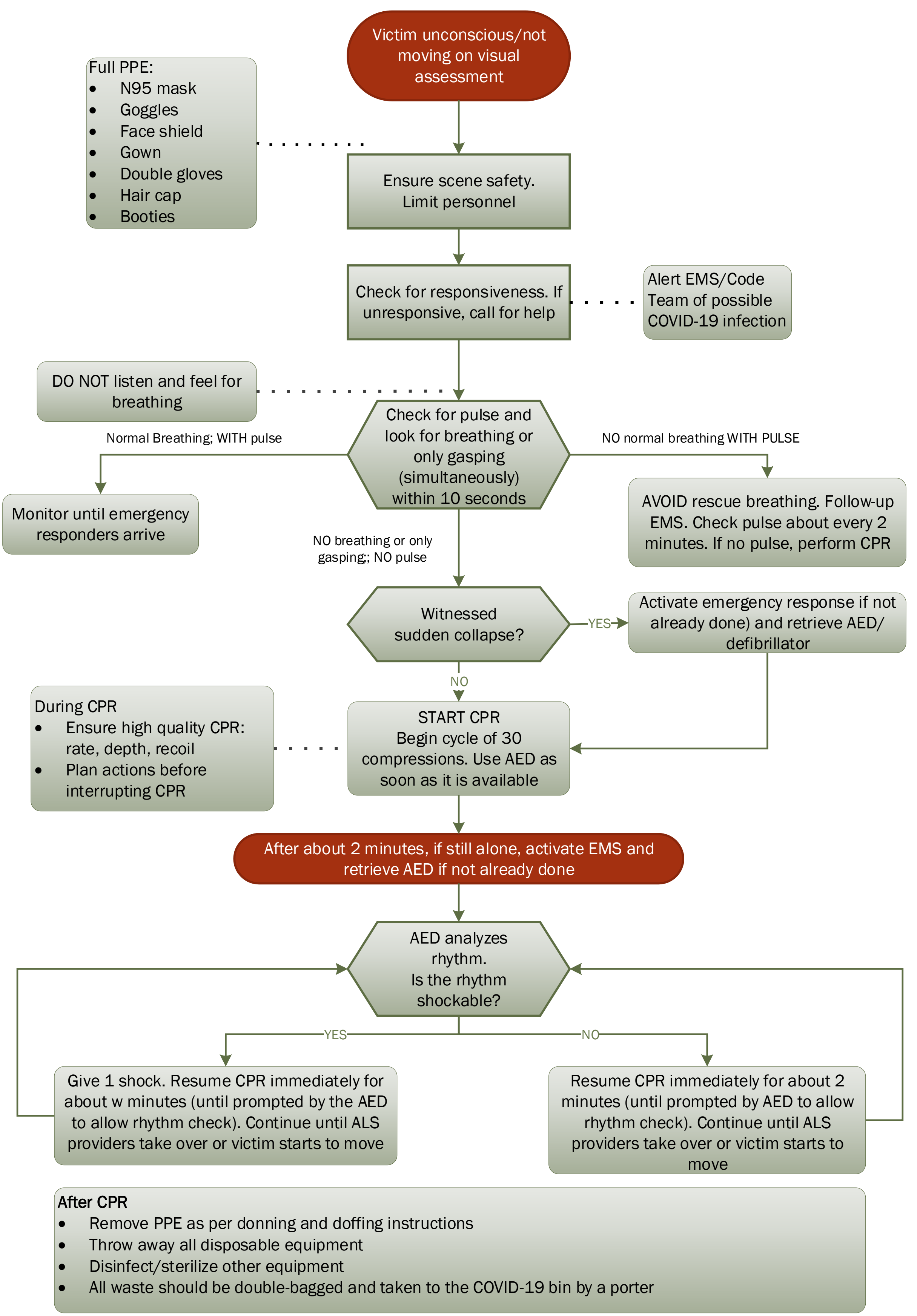
- **THE EMERGENCY RESPONSE CARE ALGORITHM**
  - STANDAR RESPONSE

Is the scene
- YES
  - SINGLE
    - TRAUMA
      - PATIENT ASSESSMENT
        a. Physical Examination
        b. Vital Signs
        c. History
      - INITIAL MANAGEMENT + STABILIZATION
      - PREPARE FOR TRANSPORT
    - MEDICAL
      - PATIENT ASSESSMENT
        a. History
        b. Vital Signs
        c. Physical Examination
      - INITIAL MANAGEMENT
      - PREPARE FOR TRANSPORT
  - MULTIPLE
    - TRIAGING (Follow START System)
      - GREEN / YELLO / RED → PATIENT ASSESSMENT → FOLLOW MANAGEMENT PROTOCOL
      - BLACK → ENDORSED TO AUTHORIZED
- NO
  - Inform the Safety Officer/Responsible Person

- COVID-19 SCENARIO – ADULT CP ARREST BLS ALGORITHM



- COVID-19 SCENARIO – PEDIATRIC CP ARREST BLS ALGORITHM



- **TRIAGE**

  - During Mass Casualty Incident (MCI), priority should be based on:
    - ✓ Severity of injury
    - ✓ Number of injured or casualties
    - ✓ Available resources
    - ✓ Survival chances of the patients

  - Triage Procedures
    - ✓ Do not take more than 60 seconds per patient
    - ✓ Use **Simple Triage And Rapid Treatment** (START) Method

Respiration:

- Does not initiate respiratory effort – tag BLACK
- RR > 30/min – tag RED
- RR < 30/min – DO NOT TAG YET – assess Perfusion

Perfusion/Circulation:

- >2 secs – tag RED
- <2 secs – DO NOT TAG YET – assess Mental Status

Mental Status:

- Simple commands: “Open and close eyes” / “Squeeze my hands”
- Cannot follow – tag RED
- Can follow – tag YELLOW

  - Categories of Patients
    - Deceased (BLACK)
    - Immediate (RED)
    - Delayed (YELLOW)
    - Minor (GREEN)

FLOW CHART FOR START METHOD

Is the patient ambulatory?

YES → All Walking Wounded — Minor Injuries GREEN

NO ↓

Is the patient breathing?

NO → Open Airway and Reassess Breathing x2

- YES → Urgent RED
- NO → Deceased BLACK

YES → Is Respiration Adequate?

- RR = >30/min → Urgent RED
- RR = <30/min → Check Perfusion/Pulse

Check Perfusion/Pulse

- Capillary Refill = >2 secs → Control Bleeding → Urgent RED
- Capillary Refill = <2 secs → Check Mental Status

Check Mental Status → Can Follow Simple Commands?

- YES → Delayed YELLOW
- NO → Urgent RED

- **RESPONSE TO HAZARDOUS MATERIAL**

  - The EMS team gathers complete information – the exact location, address, and landmarks close to the scene and nature of call.
  - Complete information of possible patients, status and number and special problems or other pertinent information of the scene.
  - The EMS shall always have a direct communication with the dispatch to confirm the response and record the time upon leaving, en route and upon arrival at the scene.
  - Safe practices shall always be observed. Fasten seatbelt while en route, wear vest and don PPG.
  - Simultaneous flashing of warning lights and sirens en route to scene.
  - While on scene, the ambulance shall be parked in a safe location or distance away from fires, explosive hazards, downed wires and structures that might collapse, uphill, and upwind. Always leave the warning lights of the ambulance on.
  - EMS team request the dispatch of HAZMAT team once the incident is recognized as one involving hazardous materials.
  - EMS team shall use the ambulance public address system to alert individuals who are near the scene.
  - EMS team focuses on activity that will ensure the safety and survival of the greatest number of people.
  - EMS team shall receive, assess and treat decontaminated patients and prepare for transport to receiving facility.

Management of Patient Exposed to Hazardous Material

- After receiving patients from HAZMAT response team, the EMS team leader assesses patient status, initiates management and communicates with the online medical doctor for additional instructions to be carried out.
- Most serious injuries and deaths from HAZMAT result from airway and breathing problems, thus EMS crew must make sure to maintain the airway open. If patient appears to be in distress, EMS crew can give oxygen at 12 to 15 lpm with a non-rebreather (NRB) mask.
- If signs indicate that respiratory distress is increasing, EMS crew may provide assisted ventilation with bag valve mask (BVM) device and high-flow oxygen.
- The team leader or crew member will document all interventions in the PCR form.
- The ambulance team prepares to transport the patient if necessary.
- EMS team leader reports the total tally of patients treated.
- The EMS driver prepares the ambulance en route to hospital and notifies dispatch that you are leaving the scene.
- The team leader gives instruction to dispatch to inform the receiving hospital that the patient came from a HAZMAT scene, in order for the hospital to make the necessary preparations.
- The EMS crew completes the PCR form.
- Special Care: In critical patients who may be in respiratory distress or needs immediate transport, the time necessary for full decontamination may prove fatal.
  - ✓ EMS team increases the amount of personal protective gear (PPG): two pairs of gloves taped at all sides to prevent contamination of skin, goggles or a face shield, a protective coat, respiratory protection and a disposable fluid-impervious apron.
  - ✓ It may be necessary for the EMS crew to simply cut the patient's clothing and do a rapid rinse to remove the majority of the contaminating matter before transport.
  - ✓ If decontamination cannot be performed adequately, EMS crew should make every attempt to prevent the spread of contamination and at the very least, remove patient clothing and wrap the patient in blankets, followed by body bags or plastic or rubber sheets to lessen the likelihood of contamination to equipment and others.
  - ✓ If wooden backboard is used, EMS crew should cover it with disposable sheet or it may have to be discarded afterwards. Equipment that comes in contact with the patient should be segregated for disposal or decontamination.
  - ✓ The EMS crew tapes the cabinet doors shut.
  - ✓ The EMS crew removes any equipment kits, monitors and other items from the patient compartment that will not be used while en route, and place them in front of the ambulance.
  - ✓ Before loading the patient, the Ambulance Driver turns on the power vent switch and the patient compartment air-conditioning unit fan.
  - ✓ Unless the weather is too severe, the Ambulance Driver keeps the windows in the driver's/passenger's side and the sliding side windows in the patient compartment open.
  - ✓ If you are leaving the scene, the team leader informs the hospital that you are transporting a critically injured patient who has not been fully decontaminated at the scene.
  - ✓ The team leader reports to dispatch upon arrival at the hospital, and note the time.
  - ✓ The Ambulance Driver parks the ambulance in an area away from the emergency room or go directly to a pre-designated decontamination center or area, thereby limiting exposure to hospital facilities.
  - ✓ Patients should not be brought to emergency department before ambulance personnel receive permission from hospital staff in order to protect them and other patients.

- ✓ The EMS crew enters the emergency room, informs hospital staff of all the details and waits for further instruction before the patient is unloaded and brought in.
- Check with the hospital to determine where the ambulance can be decontaminated and the availability of equipment for this purpose.
- The ambulance crew decontaminates exposed personnel.
- The team leader or crew notifies dispatch of the departure from hospital, and if there are enough ambulance on the scene. The EMS team may proceed to base for proper decontamination of personnel, equipment and ambulance.
- The ambulance crew performs the necessary decontamination and finishes documentation upon arrival at the station.
- The EMS team leader conducts defusing for the team upon arrival at the station.

- **SPECIAL EQUIPMENT/RESOURCES UTILIZED/REQUIRED**

  - 3rd Tier – LGUs with existing advanced EMS system shall have a wide-range of available equipment in the provision of BLS and ALS interventions.
  - 2nd Tier – LGUs with beginning EMS system should have complete equipment for BLS. The need to have readily available ALS equipment is desirable but would still depend on the training and capability of emergency personnel.
  - 1st Tier – LGUs without organized EMS system yet may provide at least basic first aid kits in all of its barangays. This would assure that such equipment is readily available within the community that may be provided once needed.

1B. Emergency Dispatch

The **Emergency Dispatch** involves the immediate identification and prioritization of emergency situations, the timely dispatch of the most appropriate resources and full endorsement to the receiving hospital. Dispatch encompasses all aspects of communication including request processing, coordination and support, documentation and monitoring, and endorsement to the receiving health facility or hospital.

Legal Basis:

- **Memorandum Circular 06-07-2016 dated July 21.**
  States that code "911" shall be made available for the use of the Philippine government.
- **Memorandum Order 07-07-2016 dated July 20.**
  Stipulates the use of code "911" as emergency hotline number nationwide.
- **RA 10121, Sec 12 (c) (23).**
  Disaster Risk Reduction Management Act of 2010 stating the establishment of Provincial/City/Municipal/Barangay Disaster Risk Reduction and Management Operations Center.

Emergency Operations Center (EOC). Memorandum Order 07-07-2016 dated July 20, 2016, states that

"Due to the variance in the implementation of EMS System in the country, it is directed that:

Local government units shall use their existing local hotline numbers that will be contacted during emergencies. This hotline number shall only be applicable within the jurisdiction of the LGU."

The roles of the EOC manned by designated and trained dispatch officers at the provincial, city/municipality level shall include the following:

- Prioritization of emergency situations through **phone triaging** guided by a chart/algorithm and description of symptoms from the caller
- Processing of requests/calls
- Coordination of EMS teams
- Recording/documentation and monitoring of outcomes that may facilitate improvement of injury registry/database

Standardization of protocols including certification of trainings per level, phone triaging shall be applied.

When receiving a call, the Dispatch Officer shall gather the following data:

Type of incident (Trauma, Medical)

- Exact location/landmarks
- Number of patients
- Extent of injuries
- Nature of illness
- Name of caller
- Contact number of the caller
- Weather condition on-site

EMS TEAM COMPOSITION

Each EMS team shall have an adequate number of qualified, trained and competent staff to ensure efficient and effective delivery of quality services.

The ambulance service provider to be dispatched shall consist of:

- A minimum of at least two (2) responders, excluding the driver.
- Additional staff depends on the nature of the emergency as determined by the management of the service provider

Expected Response Time

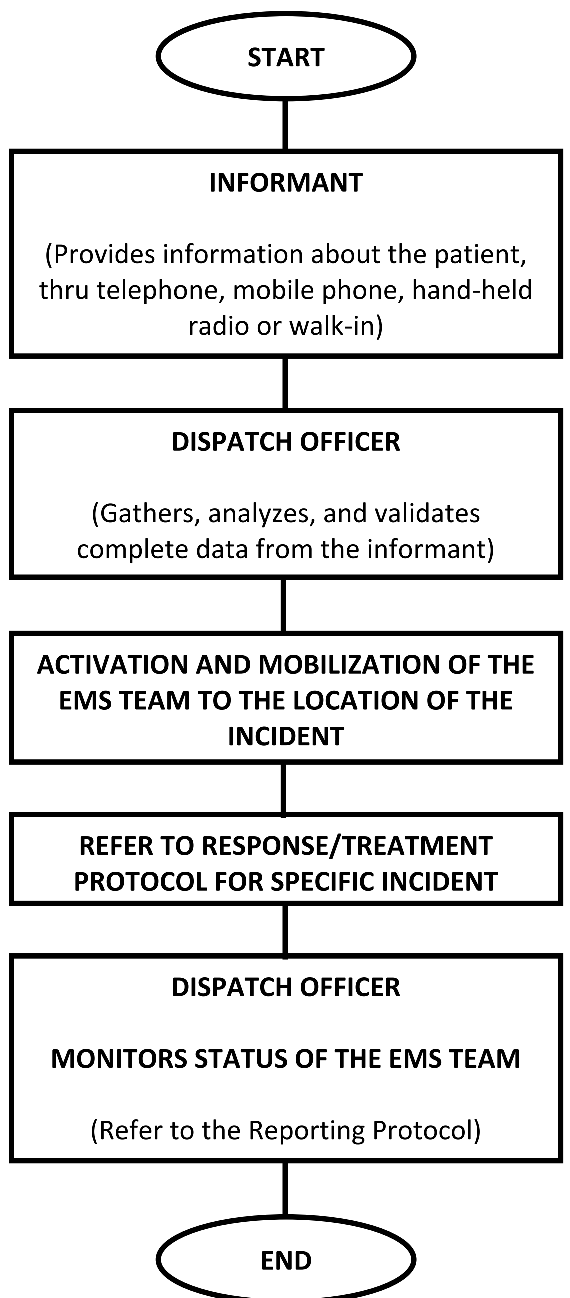
Set standards for response time shall be attained depending on the:

- Availability and accessibility of communication lines
- Number of available teams
- Back-up teams from neighboring municipalities
- Quality of ambulances
- Proximity of the station/base to the site of emergency including its accessibility (geographic considerations)
- Traffic situation
- Quality and network of roads

Due to the variance in the implementation of EMS system in the country, the expected response time from notification to the arrival on-scene:

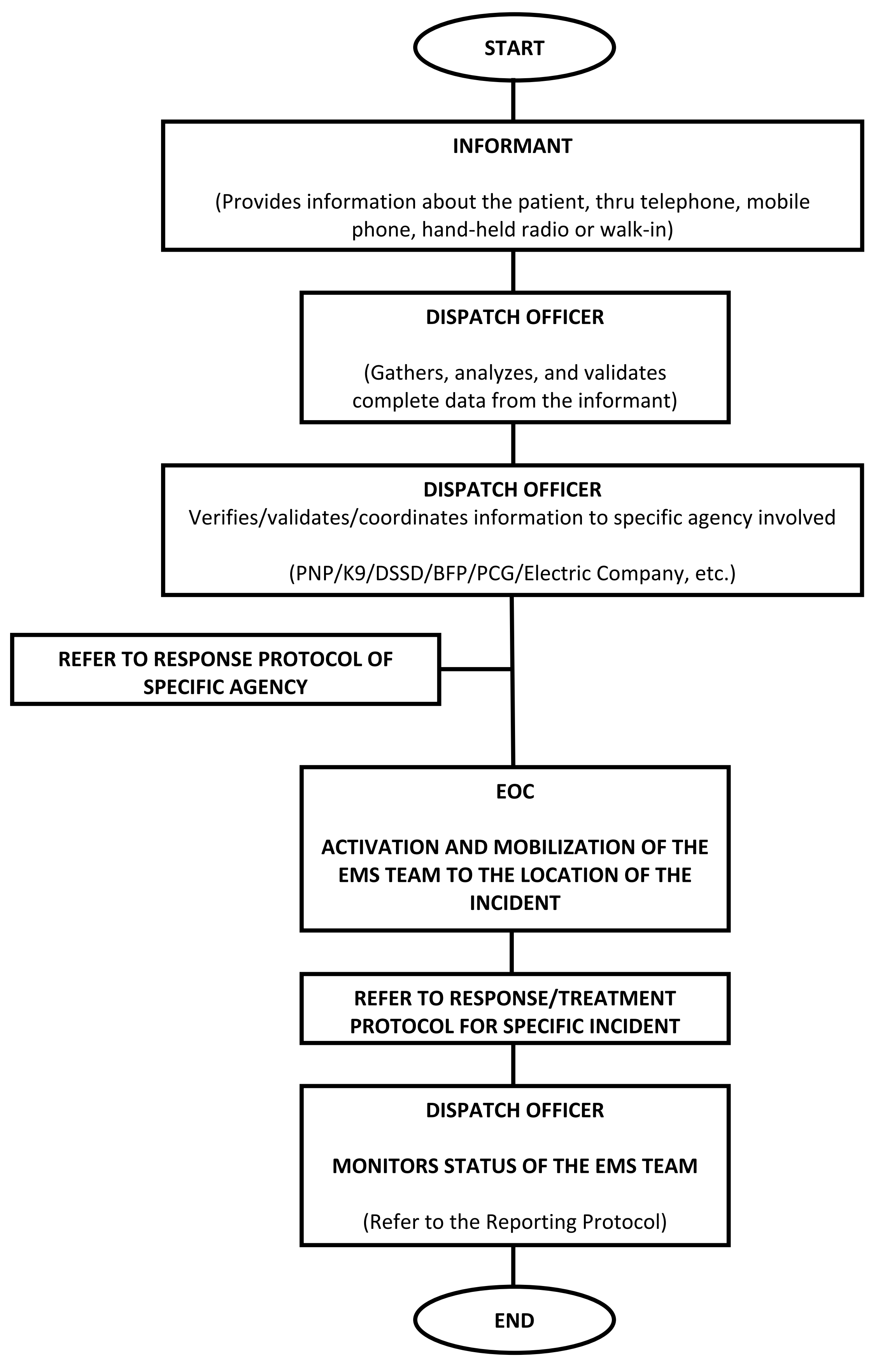
- Urban Areas – 7-10 minutes
- Sub-urban Areas – 10-20 minutes
- Geographically Isolated and Disadvantaged Areas (GIDA) – 20-40 minutes

NORMAL DAY-TO-DAY OPERATIONS AT THE EMERGENCY OPERATIONS CENTER (Medical and Trauma)



INCIDENTS INVOLVING MULTISECTORAL AGENCIES

Shooting Incident, Stabbing, Mauling/Hacking, Civil Disturbance, Fire, Drowning, Electrocution, Bombing, Mass Casualty Incident (MCI), Collapsed Structure, HAZMAT



REPORTING PROTOCOL

START

EMERGENCY CALL RECEIVED

EMS TEAM Dispatched

EMS TEAM Arrives at the Scene

EMS team reports back to Dispatch Officer

EMS team en route to the health facility

EMS team arrives at the receiving health facility

EMS team departs from the receiving health facility

EMS team back to the Emergency Operations Center

END

INFORMATION FLOW CHART

START

INFORMANT
(Through hotline numbers, mobile phone or hand-held radio)
Relay complete details of incident to the Dispatch Officer

DISPATCH OFFICER
- Gathers complete information from the informant/caller (*Type of Incident, Exact Location, Number of Patients, Extent of Injuries, Nature of Illness, Caller's Telephone Number, and Caller's Name*
- Relay Information to the Operations Officer at the EOC

Is Operations Officer Available?

NO

Operations Officer
(Not Available)

EMS TEAM LEADER
(Designate)
Analyze the situation and will activate team to respond

EMS TEAM

Upon Arrival
- Analyze the situation on scene
- Inform EOC about the situation.

If situation is critical, the team is advised to call the Online Medical Doctor/Operations Officer for assistance
- Relay all information of the patient to the Dispatcher when transport is requested

YES

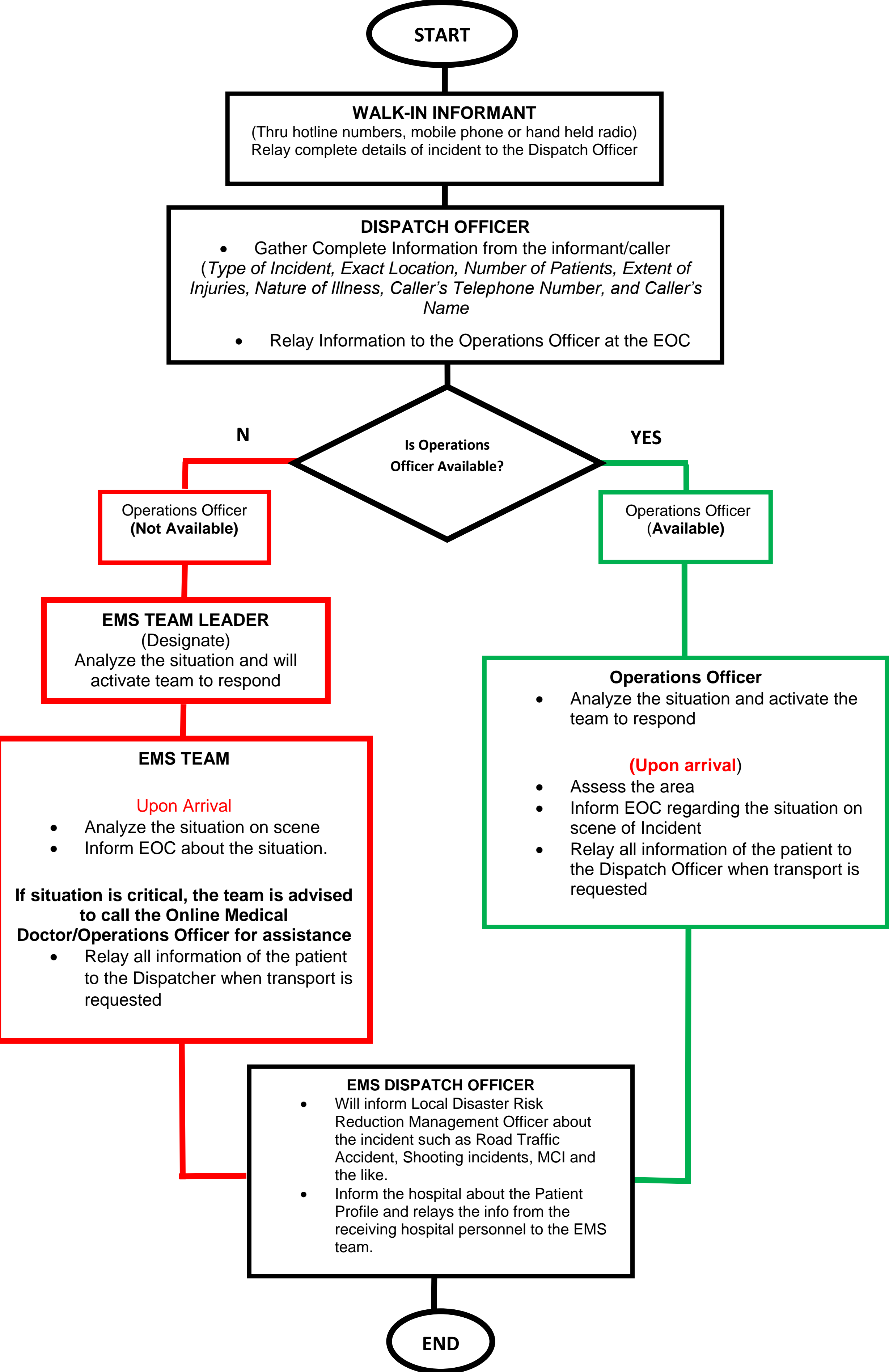
Operations Officer
(**Available)**

Operations Officer
- Analyze the situation and activate the team to respond

(Upon arrival)
- Assess the area
- Inform EOC regarding the situation on scene of Incident
- Relay all information of the patient to the Dispatch Officer when transport is requested

EMS DISPATCH OFFICER
- Will inform Local Disaster Risk Reduction Management Officer about the incident such as Road Traffic Accident, Shooting incidents, MCI and the like.
- Inform the hospital about the Patient Profile and relays the info from the receiving hospital

END


START
WALK-IN INFORMANT
(Thru hotline numbers, mobile phone or hand held radio)
Relay complete details of incident to the Dispatch Officer
DISPATCH OFFICER
• Gather Complete Information from the informant/caller
(Type of Incident, Exact Location, Number of Patients, Extent of Injuries, Nature of Illness, Caller's Telephone Number, and Caller's Name
• Relay Information to the Operations Officer at the EOC
Is Operations Officer Available?
N
YES
Operations Officer
(Not Available)
Operations Officer
(Available)
EMS TEAM LEADER
(Designate)
Analyze the situation and will activate team to respond
EMS TEAM
Upon Arrival
• Analyze the situation on scene
• Inform EOC about the situation.
If situation is critical, the team is advised to call the Online Medical Doctor/Operations Officer for assistance
• Relay all information of the patient to the Dispatcher when transport is requested
Operations Officer
• Analyze the situation and activate the team to respond
(Upon arrival)
• Assess the area
• Inform EOC regarding the situation on scene of Incident
• Relay all information of the patient to the Dispatch Officer when transport is requested
EMS DISPATCH OFFICER
• Will inform Local Disaster Risk Reduction Management Officer about the incident such as Road Traffic Accident, Shooting incidents, MCI and the like.
• Inform the hospital about the Patient Profile and relays the info from the receiving hospital personnel to the EMS team.
END

PHASES OF DISPATCH:

- **Alert and Mobilization**
    - Once an alert was raised, the EMS teams on duty, both Medical and Technical Rescue Teams, must be on pre-deployment status and awaits command for deployment.
    - If situation requires additional assistance, an alert will be sent through any means of communication to other EMS teams who are not on duty.
    - An alert shall be established by the EOC in order to properly notify EMS teams.

- **Preparation for Dispatch**
    - All EMS teams must be ready to be deployed as soon as dispatch order is released by the EOC.
    - The Team Leaders of the EMS teams must organize their members and assign specific tasks.
    - All responders must be in proper uniform with identification and personal protective equipment (PPE).
    - In the event of emergencies/disasters, volunteers/staff must report immediately to the EOC for proper briefing, mobilization or deployment.

- **While En Route**
    - The EMS teams shall ensure that proper information regarding the emergency call is acquired.
    - The EMS teams shall advice EOC through radio of their deployment and maintain constant communication while en-route to the scene.
    - The EOC may recall its deployment command anytime in accordance with the changes in the situation or when the emergency situation has been lowered to stand-down.
    - All emergency cases must be reported immediately to the EOC for proper monitoring and assistance as needed by the team leaders.
    - Status or condition of the patient/s must be regularly reported to the EOC.

ON-SCENE:

- The EMS teams must observe and follow the chain of command and operational structure at all times.
- The designated team leaders shall have the command and control on-scene unless other personnel such as the operations officer, EMS technical staff and officer-in-charge shall take over the responsibility. Proper turn over and endorsement must be made.
- Status or condition of the patients must be regularly reported to EOC.
- In case of MCI or situations aggravating the incident and may require major assistance, the team leader must inform the EOC for possible additional deployment of EMS teams.
- Incident Command System must be established at all times.
- All EMS teams through the Field Command Post established must provide constant communication and information of the present status on-scene and movement of all personnel to the EOC.

STAND DOWN:

- The over-all team leader in the scene shall monitor the situation in the emergency area, and upon confirmation of stand down, immediate report must be given to all personnel in the ground and at the EOC.

- For stand down, the team must advise the EOC that they will be returning to base.

EMS OPERATIONAL CHART FOR SPECIAL EVENTS
(Mass Casualty Incident, Search and Rescue)

1.) PREPARATION

2.) ACTIVATION and MOBILIZATION

3.) OPERATIONS

4.) DEACTIVATION And DEMOBILIZATION

5.) POST-OPERATIONAL ACTIVITIES

3.1 SECURING THE AREA

3.2 INITIAL ASSESSMENT

3.2.1 COMPILE INFORMATION

3.2.2 COMMAND POST

3.2.3 OPERATIONAL OBJECTIVES

3.2.4 ASSIGN TASK

3.2.5 REASSESS and ADJUST

3.3 SEARCH and LOCATE

3.4 GAIN ACCESS TO PATIENT

3.5 STABILIZE THE PATIENT

3.6 EXTRICATE THE PATIENT

Phase 1. Pre-Mobilization

- Brief team members.
- Ensure availability of personnel protective gear (PPG).
- Ensure availability of tools and equipment. It is very important to maintain them in proper ***working condition*** and ready for mobilization to work site.

Phase 2. Mobilization (Upon receipt of request to respond)

- Request transportation.
- Pack and load equipment.
- Notify team members.
- Obtain information on incident. This includes information such as type, location and topography, magnitude/area, number of people affected, number of buildings affected, weather, access routes.

Phase 3. Operations

- **Stage 1: Securing the Area**
- **Stage 2: Initial Assessment**

  The initial assessment consists of the following:

  Step 1: Once at the scene, consult local authorities, gather data and conduct a needs analysis. Confirm and update all information obtained in the activation phase.

  Step 2: Establish Command Post.

  Step 3: Establish operational objectives, such as:
  - General access to the disaster site
  - Strategic planning and priorities
  - Allocating resources and personnel
  - Managing operations

  Step 4: Assign tasks to rescue squads.

  Step 5: Reassess the situation and make necessary adjustments.

- **Stage 3: Search and Locate**

  Conduct a search using a specific set of techniques to obtain a response or indications of the presence of live victims in a void space inside a collapsed structure.

- **Stage 4: Gain Access to the Victim**

  Remove rubble, break and breach materials and create a passageway to access the void space where a live victim is believed to be located.

- **Stage 5: Stabilize the Victim**

  Perform basic life support on-site before extricating the victim in order to improve later chances of survival.

- **Stage 6: Extricate the Victim**

  Remove rubble surrounding the victim, ensure no further injury. Ensure no additional pressure is applied to any trapped portions of the body. Turn over the victim to a more advanced medical care after extrication.

Phase 4. Demobilization

- Confirm no other operations are needed.
- Account for all tools and equipment. Prepare tools and equipment and pack them for transportation.
- Confirm that personnel have all their personal items.
- Arrange for transportation.

Phase 5. Post-Operational Activities

- Psychological First Aid
- Medical examination for rescue personnel.
- Equipment rehabilitation
- Operational debriefing with rescue team.
- After-Action Report for institutional management.

1C. Emergency Transport

The **Emergency Transport** involves transporting the patient from the scene to the most appropriate facility and continued provision of care en route.

- **OBJECTIVES**

  General Objective:

  To institutionalize guidelines to be followed by all EMS teams on the flow of Emergency Transport of the sick and the injured from the scene to the referral facility.

  Specific Objectives:

  a. *To establish the algorithm during emergency medical transport of patient from the scene to the appropriate health facility.*
  b. *To identify roles and functions of EMS teams during emergency transport.*

  Scope:

  Start from loading of the patient to the ambulance until properly endorsed to the receiving facility and return to the EOC.

- **FLOW**

  Transfer of the patient to the ambulance:

  - Secure the patient and properly pack on the longboard.
  - Ensure patient safety while loading into the ambulance.
  - Make sure that the stretcher is properly fixed to the ambulance.

- Properly attach and secure necessary patient monitors, intravenous fluids and many others.
- Keep the patient comfortable.

Transport Phase:

- Inform the dispatcher for the transport decision, number of patients, the receiving facility, and the expected time of arrival.
- Continue patient assessment and check management en route to the health facility until proper endorsement has been done.
- Check vital signs every 15 minutes for stable patients and every 5 minutes for unstable patients in comparison with the baseline vital signs.
- For conscious patients, perform history-taking by using the following mnemonics: SAMPLE and OPQRST whenever applicable.

  S – Signs and Symptoms,
  A – Allergies
  M – Medications
  P – Past Medical History
  L – Last Meal Taken
  E – Events Leading to the Injury; and

  O – Onset of
  P – Pain/Discomfort, Precipitating/Provoking Factor
  Q – Quality
  R – Radiation/Region
  S – Severity
  T – Time
- Stay with the patient to allay fear and anxiety.
- Document management on the Patient Care Report Form/Run Report Sheet:
- Number of patients being transferred.
- The present condition.
- Management given and effects.
- Expected time of arrival.
- Prepare necessary equipment and medicines needed.

Arrival Phase:

- Inform the Dispatch Officer at the EOC upon arrival at the health facility.
- Endorse the patient to the receiving health facility personnel:
- Report arrival to the triage nurse or health facility personnel.
- Make bedside verbal report based on the Patient Care Report Form/Run Report Sheet to the health facility personnel and must be signed by the receiving physician.
- Transport the patient to the receiving facility even without folks, if necessary. Inform the DSSD/Police for location of folks.
- Leave the receiving health facility upon advice by the receiving physician/health facility personnel.

Enroute to EOC:

- Inform the officer of the return to the EOC.
- Clean and disinfect the ambulance and the used equipment.
- Replenish used ambulance supplies.

Post-Run Phase:

- Inform the Dispatch Officer upon arrival at the EOC and ready for redeployment.
- Accomplish all documentary requirements.
- Clean, disinfect, decontaminate, sterilize, restock, maintain and refuel the

FLOW CHART ON EMERGENCY TRANSPORT
Purpose: To establish procedure in the emergency transport of patient
Scope: This covers from the time patient is loaded until completion of transport to the health facility

Responsible Person	Procedure	Remarks
Emergency Medical Technician (EMT)/ Paramedical Personnel/ Responders/ Medical Car Providers who are members of the Ambulance Response Team	Start	
	Transport patient	
	Prepare referral note (Patient Care Report Form/Run Sheet)	Referral note may be done or completed while on transit.
	Continuous assessment, provision of intervention, checking of interventions, and documentation (Patient Care report Form/Run Sheet)	Basic first aid and basic life support/ advanced life support provided to the patient depending on the capability of the paramedics team.
	Inform Dispatch of arrival	
EMT/Responders Ambulance Driver	Endorsed patient to Receiving health facility	The responder shall endorse to the responsible person in the receiving facility
	Received return slip	
	File return slip in EOC (Logbook or Folder of Pre-hospital Responses)	The return slip is filled up by the receiving officer, detach the return slip from the referral form, and gives the said slip to the referring EMT/Responder
	Equipment and Vehicle care	
	End	

ambulance.

1D. Early Warning System

BACOLOD CITY DRRMO EARLY WARNING SYSTEM FLOW OF COMMUNICATION

START

BCDRRMO COMCEN MONITORS THE CURRENT EMERGENCY SITUATION

GET INFO FROM RELIABLE SOURCES:
NDRRMC, RDRRMC/OCD, DILG, PAGASA, PHIVOLCS AND OTHER RELATED AGENCIES

ALERT RDANA TEAMS
ALERT FIELD MONITORING TEAMS
ALERT BARANGAY MONITORING TEAMS

DO ASSESSMENT AND GATHER RELEVANT INFOS

REPORT BACK TO COMCEN

COORDINATE WITH THE BARANGAY EMERGENCY OPERATIONS CENTER

SEND BULK ALERT TEXT MESSAGES TO BDRRMCs AND OR TO AFFECTED BARANGAYS ONLY

INFORM BCDRRMO EXECUTIVE ASSISTANT AND LDRRMOs

MAKE SITREPS AND SUBMIT TO CHAIRPERSON, BCDRRMC, OCD, DILG AND OTHER CONCERNED AGENCIES

INFORM P.I.O. AND LOCAL CHIEF EXECUTIVE

INFORM THE GENERAL PUBLIC

END

2. Annex B – Standard Manual of Operations

This is the Standard Manual of Operations on special occasions/events.

BCDRRMO ALERT LEVEL AND EMERGENCY ACTION PLAN:

ALERT LEVEL	Description	SITUATION	Triggering Factor	RESPONSE
ALPHA	>Heightened Monitoring > Minor Incident Routine Activity	> Minor Medical/Trauma Cases > Medical Transport Needed	>Preparedness And Deployment	> Treatment of minor medical/trauma cases in assigned stations > Single patient ambulance/ERV transport
BRAVO	> Medium - Scale Incidents	> Above-Minor incidents Where assigned responders needs external logistical/ transport/specialized responders support	> Request for augmentation/assistance from responders > Stationed responders task is overwhelmed by multiple injuries/incident	>Deployment of personnel and logistical support > Coordinate with other units to support requesting responders
CHARLIE	>Large scale emergency/disaster requiring various level of sectoral responses/rescue	> Crisis Management Level > Bombing > Mass Casualty Incident >Human Induced/Natural Disaster/Emergencies	> Coordinate with IC (PNP) re: ICM > Deploy appropriate number of responders > Mobilize logistic assets of BCDRRMO > Emergency Management Intervention based on CM task	

Concept of Operations:

- On execution of **Alert Alpha** and **Alert Bravo** levels, the BCDRRMO and other operating units shall be guided by the Standard Operating Procedures specified below.
- On **Alert Level Charlie** caused by crime related incident, e.g. bombing, bomb threat, and terroristic attacks, the BCDRRMO and other operating and reserve units shall adopt the ICS formulated by the PNP BCPO.
- On **Alert Level Charlie** caused by human-induced/natural hazards, e.g. fire, and earthquake, the BCDRRMO and other operating units shall respond accordingly as prescribed by RA 10121. The BCDRRMC shall convene.

S.O.P.

- The Rescue Unit's Team Leader shall be the Head of Operation in their assigned Area of Responsibility (AOR). He shall check in his team at the BCDRRMO Command Center where his/her team is assigned;
- The Team Leader shall ensure the utmost, prompt and proper Emergency Care Management to the patient. The team shall ensure that the patient is attended in the most appropriate way;
- The team should assess thoroughly the extent of the patient's injury and apply the necessary care. (E.g. Emergency Action Principles: 1. Survey the Scene; 2. Do the Primary Survey of the Patient; 3. Activate Medical Assistance; 4. Do the Secondary Survey DCAP BTLS);

- The Team Leader or his designated person shall decide in case the patient needs ambulance transport to the nearest medical facility;
- The assistance of the BTAO Team shall be requested to have an easy road access to emergency lane/streets nearest to the hospital;
- For Minor Injuries, all first aid management shall be done in the designated first aid/medical station in his/her area;
- The Team Leader shall report promptly to the Command Center immediately all Emergency Care assistance provided to the patient(s);
- The Team Leader shall immediately seek the assistance of the BCPO in a crime situation e.g. shooting/stabbing incident or in case the team's safety and security is threatened, Police Protocols shall be upheld in dealing with injuries caused by crime;
- In case of a Mass Casualty Incident (MCI) caused by human-induced emergency and/or disasters e.g. stampede, terrorist attack, crime, etc., the Team Leader shall report the same to the Command Center. If possible, commence the Incident Command System (ICS), set up a command post, and act as On-Scene Commander (OSC) until turned over to BCPO/PNP. If imminent danger and threat to the team has been recognized, the Team Leader shall issue a stand down order and evacuate the team to the pre-designated rendezvous area identified by the team and report immediately to the Command Center.
- MCI caused by natural disasters e.g. earthquake, BCDRRM Officer will act as Incident Commander (IC).
- In case of serious emergencies e.g. bombing, stampede, all operatives shall rendezvous at a pre-designated Incident Command Post (ICP) identified by the BCDRRMO. See Attached Matrix.
- The CODE for Immediate Evacuation of operatives to a safer area shall be: **TIMBER!**
- Team Leaders should pre-identify the advance medical post or patients triage/collecting area.
- All operatives shall wear their respective uniform, ID, vest, etc.
- Operatives shall seek clearance from the Communication Center (ComCen) before Standing Down.

Communication:

- All operating units shall provide the command center their radio working frequencies, other contact information and their focal person for an efficient communication and coordination flow.
- Team leaders must check/log-in to the Command Center (146.400 mhz) as soon as they have established their respective command post in their AOR. At the operational level, all unit leaders will use Channel 2 of the radio provided by BCDRRMO as official channel in communicating BCDRRMO Command Center.
- Operating units at the tactical level shall use their organizations working frequencies and protocols in their AOR.
- All communication in the operational level shall be controlled by and centralized to the command center when Alert Level Bravo or Charlie is raised.
- All operating units must inform the command center before stand down.

Reporting, Evaluation and Debriefing:

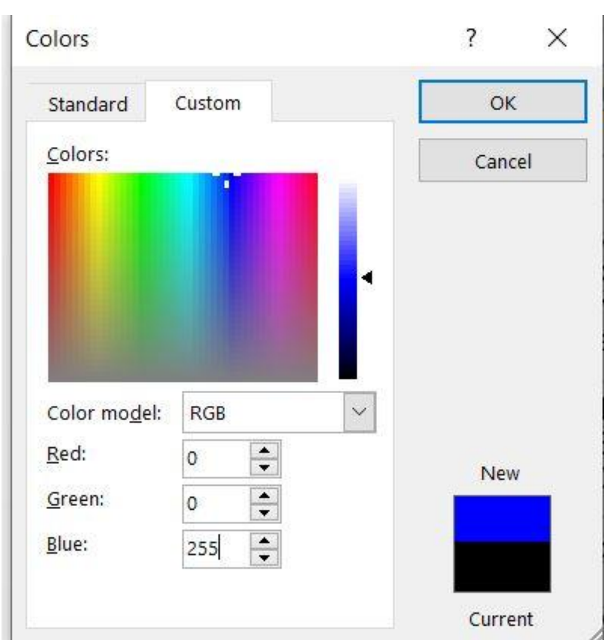
Operating units shall render update report every hour. End of operation report shall be submitted to the Command Center on their situations. Debriefing of all personnel shall be immediately done by their respective Rescue Units. The BCDRRMO shall call an evaluation meeting after the celebration/event.

- **BCDRRMC Reporting System Format**

  The BCDRRMC through its BCDRRM Operations Center Standard Operating Procedures and Guidelines has the following format of reports: Initial Report, Situational Report and Final Reports in order to capture the information needed to be reflected in the consolidated report at the local level.

  In addition, when writing the overall report, the following should be observed

  - Use the form of Memorandum for the BCDRRMC Chairperson, Members of BCDRRMC Council, RDRRMC VI Council, OCD VI Regional Director, DILG Bacolod City Director
  - Use font Arial with font size 12.
  - Indicate any change/new entries in a progress in the report using the font color blue RGB (0,0,225);



Initial (Preparedness Measures) Report Format

I. Situational Overview
   - Tropical Cyclone Advisories, Tropical Cyclone Bulletins, Heavy Rainfall Advisories, Earthquake Information, Volcano Bulletins, EMS Reports, ERS Reports, other local agency reports.

II. Disaster Preparedness
   - BCDRRMC
   - BDRRMC

Situational Report Format

I. Situational Overview
- Tropical Cyclone Advisories, Tropical Cyclone Bulletins, Heavy Rainfall Advisories, Earthquake Information, Volcano Bulletins, EMS Reports, ERS Reports, other local agency reports.

II. Effects
A. Affected Population
B. Incidents Monitored
C. Casualties
D. Suspension of Classes
E. Status of Lifelines
F. Status of Ports
G. Damaged Houses
H. Cost of Damages to Infrastructure and Agriculture
I. Declaration of State of Calamity

III. Disaster Preparedness
- BCDRRMC
- BDRRMC

IV. Disaster Response
A. Cost Assistance
B. Food and Non Food Items
C. Protection, Camp Coordination and Management (PCCM)
D. Health (WASH, Medical, Nutrition, and Medical Health/Pschosocial Services)
E. Search, Rescue, and Retrieval
F. Logistics
G. Emergencies Telecommunications
H. Education
I. Clearing Operations
J. Damage Assessment and Needs Analysis

Final Report Format

V. Situational Overview
- Tropical Cyclone Advisories, Tropical Cyclone Bulletins, Heavy Rainfall Advisories, Earthquake Information, Volcano Bulletins, EMS Reports, ERS Reports, other local agency reports.

VI. Effects
A. Affected Population
B. Incidents Monitored
C. Casualties
D. Suspension of Classes
E. Status of Lifelines
F. Status of Ports
G. Damaged Houses
H. Cost of Damages to Infrastructure and Agriculture
I. Declaration of State of Calamity

VII. Disaster Preparedness
- BCDRRMC
- BDRRMC

VIII. Disaster Response

A. Cost Assistance
B. Food and Non Food Items
C. Protection, Camp Coordination and Management (PCCM)
D. Health (WASH, Medical, Nutrition, and Medical Health/Pschosocial Services)
E. Search, Rescue, and Retrieval
F. Logistics
G. Emergencies Telecommunications
H. Education
I. Clearing Operations
J. Damage Assessment and Needs Analysis

- **RDANA Form**

<table>
<tr><td colspan="2">RAPID DAMAGE ASSESSMENT AND NEEDS ANALYSIS
INITIAL REPORT FORM</td></tr>
<tr><td colspan="2">Site Location/Address:</td></tr>
<tr><td>Date and Time of Occurrence:</td><td>Type of Incident:</td></tr>
<tr><td>Time RDANA Team Arrival:</td><td>Time RDANA Team Departure:</td></tr>
<tr><td colspan="2">Local Authorities/Persons Interviewed:</td></tr>
<tr><td colspan="2">Summary of Disaster/Incident:</td></tr>
<tr><td colspan="2">Initial Effects:
Total Population: ____ men ____ women ____ children ____ pregnant ____ elderly ____ PWDs
Affected : ____ men ____ women ____ children ____ pregnant ____ elderly ____ PWDs
Displaced : ____ men ____ women ____ children ____ pregnant ____ elderly ____ PWDs
Dead : ____ men ____ women ____ children ____ pregnant ____ elderly ____ PWDs
Missing : ____ men ____ women ____ children ____ pregnant ____ elderly ____ PWDs
Injured : ____ men ____ women ____ children ____ pregnant ____ elderly ____ PWDs</td></tr>
<tr><td colspan="2">Status of Lifelines and Critical Facilities:</td></tr>
<tr><td>Roads and Bridges:
Electricity:
Communication Network:
Hospitals:
Schools:
Airports:
Sea Ports:
Water Supply System:
Market:
Residential Houses:
Others:</td><td></td></tr>
<tr><td colspan="2">Initial Needs Assessment Checklist:</td></tr>
<tr><td>Summary of Damages</td><td>Priority Need</td></tr>
</table>

<table>
<tr><td colspan="2">Health:

Food and Nutrition:

WASH:

Shelter and NFIs:

Protection:

Others:</td><td>Health:

Food and Nutrition:
WASH:

Shelter and NFIs:

Protection:

Others:</td></tr>
<tr><td colspan="3">Initial Response Actions:</td></tr>
<tr><td>Response Groups Involved:

Assets Deployed:

Number of Families Served:

Extent of Local Assistance:</td><td colspan="2">

_____ men _____ women _____ children _____ pregnant _____ elderly _____ PWDs</td></tr>
</table>

- **Status of Equipment/Tools/Vehicles Purchased**

Name of Equipment	Date Purchased	Status of Equipment (Excellent, Needs Repair, Unserviceable)	Location	Personnel In-charge	Remarks

- **Search, Rescue and Retrieval**

<table>
<tr><td>Date:
Time of Arrival:
Time of Departure:</td></tr>
<tr><td>Site Location/Address:</td></tr>
<tr><td><u>Team Deployed</u>
▪ Team Leader:
▪ Members:

▪ Driver:</td></tr>
<tr><td>Initial Effects:
Total Population: _____ men _____ women _____ children _____ pregnant _____ elderly _____</td></tr>
</table>

PWDs Affected : _____ men _____ women _____ children _____ pregnant _____ elderly _____ PWDs Displaced : _____ men _____ women _____ children _____ pregnant _____ elderly _____ PWDs Dead : _____ men _____ women _____ children _____ pregnant _____ elderly _____ PWDs Missing : _____ men _____ women _____ children _____ pregnant _____ elderly _____ PWDs Injured : _____ men _____ women _____ children _____ pregnant _____ elderly _____ PWDs
Status of Operation:
Other Remarks:

- **Supplies/Relief Goods**

Name of Supplies/Relief Goods	Location	Actual Stock on Hand	Required Stock	Gap	Remarks

3. Annex E – Directories

BACOLOD CITY
EMERGENCY
NUMBERS

CITY OF BACOLOD PHILIPPINES

DISASTER RISK REDUCTION & MANAGEMENT OFFICE 432-3879

DRRMO

EMERGENCY 911 HOTLINE

432-3871 432-3872 432-3873

09302434706 / 09561976151

Ambulance Fire Rescue Traffic

(for Police, Fire, Rescue and Ambulance Services & other Emergencies)

Amity 433-3244
Chamber 432-0111
Red Cross 435-0324

Bureau of Fire Protection
434-5022 / 23
09213417002

BTAO
704-1443

Police Assistance

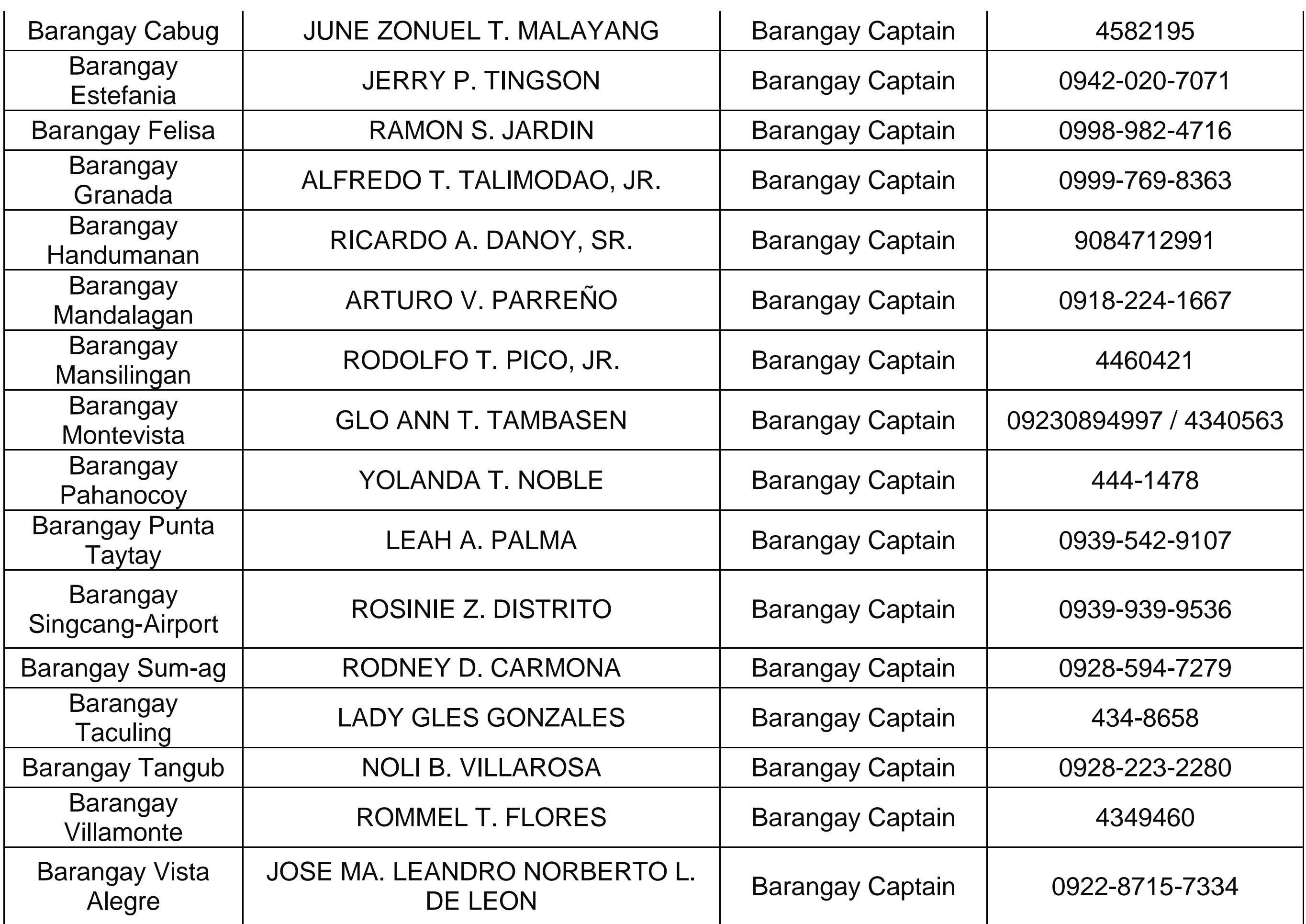
POLICE

Bacolod City Police Office Headquarters 431-2077

Station 1 - San Juan - 445-2403 / 09985987460 / 09107236975
Station 2 - 13th Lacson - 445-2495 / 09985987462
Station 3 - Mandalagan - 474-0209 / 09283458287
Station 4 - Villamonte - 708-3771
Station 5 - Granada - 708-8291
Station 6 - Taculing - 468-0341 / 0998-5987473
Station 7 - Mansilingan - 446-2802 / 09985987473
Station 8 - Tangub - 431-1424
Station 9 - Sum-ag - 09985987478
Station 10 - Handumanan - 709-9151 / 09985987480

BACOLOD CITY BARANGAYS DIRECTORY

Barangay	Official's Name	Position	Contact Number
Barangay 1	CESAR B.RELLOS, JR.	Barangay Captain	9199444523
Barangay 2	IMELDA J BANGUANGA	Barangay Captain	9636172408
Barangay 3	LEONIDAS S. ASAN	Barangay Captain	9124749953
Barangay 4	ANTONIO B. ONGSINCO	Barangay Captain	444-06-03
Barangay 5	RAYMUNDO S. SALAVERIA	Barangay Captain	0928-554-9389
Barangay 6	RUDY BAYDO, SR.	Barangay Captain	
Barangay 7	HERCY S. SIBUG	Barangay Captain	09997847051 / 709-7006
Barangay 8	JOHANNA M. MAGALONA	Barangay Captain	9982179347
Barangay 9	RONNIE S. SERRANO	Barangay Captain	446-2942
Barangay 10	MELVIN L. BRAVO	Barangay Captain	714-0623
Barangay 11	EVELYN C. TA-ASAN	Barangay Captain	0929-200-0388
Barangay 12	ELY C. ALCANTARA, JR.	Barangay Captain	
Barangay 13	TANYA T FAMILIARAN	Barangay Captain	9075595058
Barangay 14	CARL JOHN P. MAGNO	Barangay Captain	9230877885
Barangay 15	ANTHONY JOSE LOTH ALFREDO I. AYCO	Barangay Captain	432-3206
Barangay 16	JOSEPH N. DE LOS SANTOS	Barangay Captain	9704944009
Barangay 17	ROGELIO A. PABIANIA, JR.	Barangay Captain	
Barangay 18	MADELINE B. DIAZ	Barangay Captain	441-33-69
Barangay 19	JIM PIRAMO	Barangay Captain	706-6297
Barangay 20	EDWARD YEE	Barangay Captain	9702450952
Barangay 21	FELIPE G. RIFE,JR.	Barangay Captain	0917-763-4847
Barangay 22	DIOSDADO C. MAYO	Barangay Captain	9514841883
Barangay 23	WENCESLAO D. PARLAN, JR.	Barangay Captain	0912-8908-866
Barangay 24	LOPE A. LEDESMA	Barangay Captain	9916773335
Barangay 25	JOSEPH ANTHONY F. ORTILLO	Barangay Captain	0908-2245-542
Barangay 26	JHUN MHARBY D. OROLA	Barangay Captain	9231975730
Barangay 27	FREEMAN N. MADALAG	Barangay Captain	
Barangay 28	JUNE MARK T. CARPIO	Barangay Captain	
Barangay 29	EDNER A. GIGJIE	Barangay Captain	443-60-28
Barangay 30	JAN MARK C. PETIERRE	Barangay Captain	9278852136
Barangay 31	GERMAN T. BULLOLAZA, JR.	Barangay Captain	441-95-25
Barangay 32	ERNESTO N. YAP, JR.	Barangay Captain	458-7311
Barangay 33	JOHN T. MALAYANG	Barangay Captain	435-3233
Barangay 34	TEODORO H, YULO	Barangay Captain	435-8137
Barangay 35	RUBEN JAMES H. MIRANDA	Barangay Captain	706-3250
Barangay 36	JOEMARIE F. BIASCA	Barangay Captain	434-37-85
Barangay 37	ADRIAN GREGORY Y. GARRUCHO	Barangay Captain	9566510432
Barangay 38	GENER B. AGPALO	Barangay Captain	432-9598
Barangay 39	JUDE S. SALUSADA	Barangay Captain	63942092689
Barangay 40	ELMER T. VILLANUEVA	Barangay Captain	700-7292
Barangay 41	SALVACION R. PENUELA	Barangay Captain	9108982671
Barangay Alangilan	DIGIE G. TANISTA, SR.	Barangay Captain	
Barangay Banago	RICKY F. MIJARES	Barangay Captain	9517514786
Barangay Bata	ANGELITO V. ABARING	Barangay Captain	9128081100



Barangay Cabug	JUNE ZONUEL T. MALAYANG	Barangay Captain	4582195
Barangay Estefania	JERRY P. TINGSON	Barangay Captain	0942-020-7071
Barangay Felisa	RAMON S. JARDIN	Barangay Captain	0998-982-4716
Barangay Granada	ALFREDO T. TALIMODAO, JR.	Barangay Captain	0999-769-8363
Barangay Handumanan	RICARDO A. DANOY, SR.	Barangay Captain	9084712991
Barangay Mandalagan	ARTURO V. PARREÑO	Barangay Captain	0918-224-1667
Barangay Mansilingan	RODOLFO T. PICO, JR.	Barangay Captain	4460421
Barangay Montevista	GLO ANN T. TAMBASEN	Barangay Captain	09230894997 / 4340563
Barangay Pahanocoy	YOLANDA T. NOBLE	Barangay Captain	444-1478
Barangay Punta Taytay	LEAH A. PALMA	Barangay Captain	0939-542-9107
Barangay Singcang-Airport	ROSINIE Z. DISTRITO	Barangay Captain	0939-939-9536
Barangay Sum-ag	RODNEY D. CARMONA	Barangay Captain	0928-594-7279
Barangay Taculing	LADY GLES GONZALES	Barangay Captain	434-8658
Barangay Tangub	NOLI B. VILLAROSA	Barangay Captain	0928-223-2280
Barangay Villamonte	ROMMEL T. FLORES	Barangay Captain	4349460
Barangay Vista Alegre	JOSE MA. LEANDRO NORBERTO L. DE LEON	Barangay Captain	0922-8715-7334

BACOLOD CITY LOCAL/REGIONAL/NATIONAL OFFICES AND AGENCIES DIRECTORY

OFFICE/DEPT.	TEL. NO.	OFFICE/DEPT.	TEL. NO.
Administrator's Office	433-5848/435-0623/433/6191	DPS	433-3532/433-9425/708-1755
Accounting	433-1885/708-0775	ENRO	432-2386
Agriculture	446-1593/434-5461/4336331	Governor's Office	435-1177
APSA	446-3573	GSO	432-0529/433-8060/707-5393
Assessor	709-0353	GSO-Bodega	434-0724
ATO	434-6470/432-0117	GSIS	444-0982/444-2887/708-1815
BACGEM	432-3321/707-7096	Hall of Justice	435-0357/707-4252
BAYS Center	708-0465	HRMO	433-4813/432-0664
BAC	708-3070/707-0008	Liga ng mga Barangay	435-8684
BCGEU-HCP	435-4769	Local Investment Center	434-7987
BCC	707-7469	LTO	709-0108/435-3972
Bureau of Fire - San Juan	434-5022 -23	LTFRB	435-3834
Bldg. Adm.-NGC	432-9369	Markets-Burgos	434-6606
BHA	433-7108/434-4051	Markets-Central	432-1110
BIR	446-3915	Markets-Libertad	433-0568
BFAR	432-1815	MASO	433-9718
BFAD	433-7761	MITCS	435-4168
BJMP	433-1766/707-5300	MTCC	434-8365/434-5238
BACIWA	433-4601/433-2141/4334628	NAPOLCOM	434-4806

BTAO	704-1443	NBI	709-0971
Boy's Home	708-1760	NFA	435-4792/434-4954
Boy Scouts- Bacolod City	709-1210	NTC - Neg. Occ.	708-0009
CHO Dr. Pornan 707-1327	434-8584/434-4098/431-3673	NOCGEM	432-1507
City Coop.	709-8008	NSO	435-0574
City Budget	433-8062/709-1766	OCD-DND VI	33-337-6671/336-9353
City Legal Office	434-3821	SPORTS OFF. BAY CENTER	436-5257
CEO-Admin	708-0412/708-0386/708-2328	OBO	434-7742
CEO-Motorpool	432-3551	OSCA	432-0883/434-7741
CEO-Electrical	708-2328/432-3098	OWWA	432-2873
CENECO	435-3641/1621	PAGCOR	434-0588/434-6911
CENRO	433-4589	Pag-IBIG	707-1737/707-3399
CHED	433-8319	PAAD	433-7323/434-8485
Comm. On Human Rights	435-3140	Public Affairs Div. - Capitol	434-0631
City Prosecutors Office	433-7934	Phil. Coast Guard	441-0946
City Library	435-3831/434-4448	PANAAD	446-1581/446-3151(fax)
CMO-Admin	435-5879/435-6165	Parole & Probation	433-3094
CMO-Executive Staff	435-0055/707-0718	PHILHEALTH	709-0133
CMO-Records	434-4420	Bureau of Immigration	433-8581
CMO-Radio Room	708-0816	PESO	441-9634
CMO-Sec to the Mayor	433-7144/433-5425/707-0000	Phil. Army Reserve 605th	446-1469
CMO-Supplies	434-9804	Phil. Army 305th	434-0686
CMO-Permits & Licensing	435-2606/433-3795	Post Office	707-2577
CMO-PSEMS/117	432-3879/117	PNP-Bacolod	433-6566/434-8873
CMO-PIO 708-0463	434-9122/434-7425(fax)	PNP-Province	432-7408/708-9179
COA	435-6619	Phil. Red Cross	435-0324
COA Prov'l. Office/NIR	709-0792	PIA	435-3933
COMELEC	434-8689	POPCOM	708-7366/434-8541
CTO-Admin	435-0785	POEA	434-7391
CTO-Cash	434-3810/433-9132/434-3983	PDMT	433-6563
CTO-Land Tax	433-8820	PCSO - Bacolod	435-1883
CTO-License	435-0077	Public Attorney's Office	434-8358
CPDO	434-3184/435-8125	Public Plaza	708-3567
Civil Registrar	435-4790	Printing Section	09429571617 - Ruben Pedalino
Civil Service Comm.	708-8184	Provident Fund Assn.	431-1041
City Veterinary Office	433-3669/433-2391	Provincial Hospital (CLMMRH)	433-2697/435-1591
DEP-ED - Bacolod	433-8841-42	RTC	434-7481/434-7483/435-0350
DEP-ED - Neg. Occ.	434-4479/433-3960	Register of Deeds	432-1296
DENR	707-0425/709-5689/708-5637	Sangguniang Panlungsod	707-7503/435-3603
DBM-PS	433-7138	Sectoral Concerns	434-9853
DILG-Bacolod	704-2363/434-7223	SDC (Magsaysay Ave.)	433-8492
DFA	434-8338/441-2681/441-2675	SSS	434-4749
DOST	433-9182	Tourism (Bacolod)	708-3066
DSSD	435-7134/432-1602	Tourism (Neg. Occ.)	433-2515

DOLE	434-2219/434-2218/434-2214	TESDA	495-6622
DPWH	433-2804/434-7994	UBSD	708-1422
DTI	434-7920/704-2203	Vice Mayor's Office	703-1284

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- *Bacolod City Local Disaster Risk Reduction Management Plan 2020-2022*
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- *Bacolod City Development Plan 2020-2022*
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- *City of Bacolod 2017-2026 CLUP Comprehensive Land Use Plan Vol. 1*
- *Quezon City Local Disaster Risk Reduction Management Plan 2021-2027*
- *Bacolod City Fire Station – Bureau of Fire Protection Fire Hazard Analysis 2015-2019*
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CITY OF BACOLOD

DISASTER RISK REDUCTION AND MANAGEMENT PLAN

2026-2028