Major Incident Plan

Salisbury NHS Foundation Trust

March 2011

Role responsible for revisions - Emergency Planning Lead
Foreword by Trust Chief Executive

Introduction to the Plan

Emergency Department

Action Card No 1 - Nurse Co-ordinator

Action Card No 2 - ED Medical Co-Ordinator (MCO)

Action Card No 3 - Triage Nurse

Action Card No 4 - Triage Runner

Action Card No 5 - Triage Area Receptionist

Action Card No 6 - Immediate Area Nurse

Action Card No 7 - Immediate Area Nurse

Action Card No 8 - Immediate Area Nurse

Action Card No 9 - Immediate Area Nurse

Action Card No 10 - Immediate Area Doctor

Action Card No 11 - Immediate Area Doctor

Action Card No 12 - Immediate Area Doctor

Action Card No 13 - Immediate Area Doctor

Action Card No 14 - Immediate Area Runner

Action Card No 15 - Immediate Area Receptionist

Action Card No 16 - Urgent Area Nurse

Action Card No 17 - Urgent Area Nurse

Action Card No 18 - Urgent Area Nurse
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

ACTION CARD No 19 URGENT AREA NURSE ................................................................. 46
ACTION CARD No 20 URGENT AREA NURSE ................................................................. 47
ACTION CARD No 21 URGENT AREA NURSE ................................................................. 48
ACTION CARD No 22 URGENT AREA NURSE ................................................................. 49
ACTION CARD No 23 URGENT AREA NURSE ................................................................. 50
ACTION CARD No 24 URGENT AREA DOCTOR .............................................................. 51
ACTION CARD No 25 URGENT AREA DOCTOR .............................................................. 52
ACTION CARD No 26 URGENT AREA DOCTOR .............................................................. 53
ACTION CARD No 27 URGENT AREA DOCTOR .............................................................. 54
ACTION CARD No 28 URGENT AREA RUNNER ............................................................. 55
ACTION CARD No 29 URGENT AREA RECEPTIONIST .................................................. 56
ACTION CARD No 30 NON-URGENT AREA NURSE ...................................................... 57
ACTION CARD No 31 NON URGENT AREA DCTOR ....................................................... 59
ACTION CARD No 32 NON-URGENT RUNNER .............................................................. 61
ACTION CARD No 33 NON-URGENT AREA RECEPTIONIST ........................................ 62
ACTION CARD No 34 DRUG & INFUSION NURSE ......................................................... 63
ACTION CARD No 35 EXIT RECEPTIONIST RUNNER ................................................... 64
ACTION CARD No 36 EXIT RECEPTIONIST ................................................................. 65
ACTION CARD No 37 NON - URGENT RUNNER PLASTIC OUTPATIENT DEPARTMENT ....... 66
ACTION CARD No 38 NON URGENT RECEPTIONIST (Plastic OPD) ................................. 67
ACTION CARD No 39 NON URGENT AREA NURSE (Plastic OPD) ................................. 68

Anaesthetics / ITU .............................................................................................................. 69

ANAESTHETICS ................................................................................................................. 70
ACTION CARD No 1 ON-CALL CONSULTANT ANAESTHETIST (ANAESTHETIC TRIAGE OFFICER) ..... 70
ACTION CARD No 2 OFF-DUTY ANAESTHETIC CONSULTANTS ..................................... 71
ACTION CARD No 3 CONSULTANT ANAESTHETIST IN CHARGE OF THEATRE ................. 72
ACTION CARD No 4 ANAESTHETIC ADMINISTRATION CO-ORDINATOR ......................... 73
ACTION CARD No 5 ON-CALL INTENSIVE CARE CONSULTANT .................................... 74
ACTION CARD No 6 RECOVERY UNIT CONSULTANT INTENSIVIST ................................ 75
ACTION CARD No 7 SENIOR NURSE IN CHARGE OF RADNOR WARD/INTENSIVE CARE & HIGH DEPENDENCY UNIT ................................................................. 76

Control Room ................................................................................................................... 77

ROLE OF THE CONTROL ROOM IN A MAJOR INCIDENT .................................................. 78
ACTION CARD No 1 MEDICAL DIRECTOR (OR DEPUTY, WHO WILL BE THE DUTY SURGICAL / MEDICAL CONSULTANT) ................................................................. 80
ACTION CARD No 2 NURSING DIRECTOR OR DEPUTY (e.g. Directorate Senior Nurse (DSN)) ................. 81
ACTION CARD No 3 DUTY MANAGER ............................................................................ 82
ACTION CARD No 4 CHIEF EXECUTIVE OR DEPUTY ....................................................... 84
ACTION CARD No 5 HOSPITAL AMBULANCE CONTROL OFFICER (HACO) ......................... 85
ACTION CARD No 6 RUNNERS 1-3 .................................................................................. 86
ACTION CARD No 7 PATIENT TRACKERS 1-2 ................................................................. 87
ACTION CARD No 8 ORTHOPAEDIC OUTPATIENT STAFF ............................................ 88

Public Relations Team ....................................................................................................... 89

ACTION CARD No 1 PRESS OFFICER ............................................................................. 90
Major Incident Media Log Sheet ....................................................................................... 92

Designated Media Areas ................................................................................................. 93
ACTION CARD No 2 PRESS SUPPORT OFFICER – SENIOR MANAGER ......................... 95
ACTION CARD No 3 SUPPORT TO PRESS OFFICER – A&C ........................................... 96

Customer Care Department & Bereavement ................................................................ 97

Bleep Holders & Key Nursing Staff ................................................................................ 100

ACTION CARD No 1 DIRECTORATE SENIOR NURSE – FIRST TO ARRIVE CONTROL ROOM 3 .... 101
ACTION CARD No 2 CLINICAL SITE BLEEP HOLDER (TITLE CLINICAL SITE CO-ORDINATOR) ..... 103
ACTION CARD No 3 CLINICAL SITE CO-ORDINATOR – DEPUTY .................................... 104
ACTION CARD No 4 Nurse CCOT (Critical Care Outreach Team) ...................................... 105
ACTION CARD No 5 NURSE IN CHARGE LAVERSTOCK .................................................. 106
ACTION CARD No 6 NURSE in CHARGE - Endoscopy - IN HOURS (title NURSE IN CHARGE Endoscopy) 107
ACTION CARD No 7 NURSE in CHARGE DISCHARGE LOUNGE (In-hours) ....................... 108

AUTHOR: OWEN AINSLEY
DATE OF REVIEW: March 2012

DATE: March 2011

MAJOR INCIDENT PLAN

VERSION: 1.2
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

ACTION CARD No 6 OFF-DUTY SURGICAL SHO/HO ................................................................. 162
ACTION CARD No 7 ON-CALL ORTHOPAEDIC CONSULTANT (SENIOR SURGEON THEATRES) ... 163
ACTION CARD No 8 OFF-DUTY ORTHOPAEDIC CONSULTANT ........................................... 164
ACTION CARD No 9 DUTY ORTHOPAEDIC REGISTRAR ......................................................... 165
ACTION CARD No 10 OFF-DUTY ORTHOPAEDIC REGISTRAR ............................................... 166
ACTION CARD No 11 DUTY ORTHOPAEDIC HOUSE OFFICER ............................................. 167
ACTION CARD No 12 OFF-DUTY ORTHOPAEDIC SENIOR HOUSE OFFICER ....................... 168
ACTION CARD No 13 DUTY ORAL SURGEON .................................................................... 169
ACTION CARD No 14 DUTY OPHTHALMOLOGIST ................................................................. 170
ACTION CARD No 15 SENIOR SURGEON PRE-OP (DUTY UROLOGY CONSULTANT) ............ 171
ACTION CARD No 16 NURSING BLEEP HOLDER FOR OBSTETRICS & GYNAECOLOGY ....... 172
ACTION CARD No 17 ON DUTY CONSULTANT OBSTETRICIAN ........................................ 173

Theatres ..................................................................................................................................... 174

ACTION CARD No 1 CLINICAL CO-ORDINATOR OR DEPUTY (MOST SENIOR PRACTITIONER AVAILABLE) ................................................................. 175
ACTION CARD No 2 THEATRE ADMINISTRATORS x2 ............................................................... 176
ACTION CARD No 3 NURSE IN CHARGE OF RECOVERY AREA ........................................... 177
ACTION CARD No 4 THEATRE PORTERS ............................................................................. 178
ACTION CARD No 5 RUNNER ............................................................................................... 179

Burns ....................................................................................................................................... 180

SUMMARY OF ROLE OF BURNS UNIT .............................................................................. 181
ACTION CARD No 1 ON-CALL BURNS CONSULTANT .......................................................... 182
ACTION CARD No 2 OFF-DUTY BURNS CONSULTANT ....................................................... 183
ACTION CARD No 3 REGISTRAR .......................................................................................... 184
ACTION CARD No 4 SENIOR NURSE BURNS UNIT ............................................................ 185
ACTION CARD No 5 SENIOR NURSE BURNS UNIT IDENTIFIED DEPUTY ......................... 186
ACTION CARD No 6 OFF-DUTY SURGICAL SHO/HO ........................................................... 187

APPENDICES ......................................................................................................................... 188

APPENDIX 1 Requirements for the Departments ................................................................. 189
APPENDIX 2 Telephone Numbers .......................................................................................... 190
APPENDIX 3 Procedure for calling together a Mobile Medical Team ..................................... 192
APPENDIX 4 Department of clinical radiology - major incident plan for forensic emergency/incident requiring radiology services e.g. plane crash / terrorist attack etc. ........................................ 193
APPENDIX 5A Internal Contact Personnel within each Department ...................................... 195
APPENDIX 5B External Contact Personnel ........................................................................... 196
APPENDIX 6 Major Incident Call Log Sheet .......................................................................... 199
APPENDIX 7 Notification of Death - Use by BEREAVEMENT TEAM Staff ONLY ................ 200
APPENDIX 8 Major Incident Enquiry Log – For Use by CUSTOMER CARE DEPARTMENT staff ........................................................................................................ 201
APPENDIX 9 Inpatient Notification - For Use by CUSTOMER CARE DEPARTMENT staff ONLY ..................................................................................................... 202
APPENDIX 10 Linked Documents .......................................................................................... 203
APPENDIX 11 Major Incident in Progress Notification ............................................................ 204
APPENDIX 12A Mass Casualty Diagram – Level 1 Major Incident ........................................ 205
APPENDIX 12B Mass Casualty Diagram – Level 2 Major Incident ........................................ 206
APPENDIX 12C Mass Casualty Diagram – Level 3 Major Incident ........................................ 206
APPENDIX 12C Mass Casualty Diagram – Level 3 Major Incident ........................................ 207
APPENDIX 13 Mass Casualty Communication Cascade ....................................................... 208
APPENDIX 14 Patient Tracking Sheet .................................................................................... 208
APPENDIX 14 Patient Tracking Sheet .................................................................................... 209
APPENDIX 15 Patient Information Sheets (For use by receptionists only) .............................. 210
APPENDIX 16 Patient Log Sheet ............................................................................................ 211
APPENDIX 17 Patient Categories used by ED ....................................................................... 212
Emergency Department Chemical Incident Plan

Introduction to the Plan

1. PURPOSE OF THE DOCUMENT

2. STAKEHOLDER INVOLVEMENT & PLAN CIRCULATION

3. BACKGROUND TO CRBNE

4. DEFINITIONS

5. ENDORSEMENTS

6. SUPPORTING PLANS

7. STRATEGIC RESPONSIBILITIES – THE TRUST BOARD

8. DEVELOPMENT OF THE PLAN

9. EMERGENCY DEPARTMENT DECONTAMINATION UNIT

10. TRIGGERING A CHEMICAL INCIDENT

11.0 ACTIVATING THE CHEMICAL INCIDENT PLAN

11.1 Stand-by

11.2 Live

11.3 Stand Down

11.4 DEALING WITH THE CHEMICAL INCIDENT THE PRINCIPLES

11.5 DEPARTMENTAL PRESENTATION

11.6 RECEPTION & TRIAGE

11.7 DECONTAMINATION

11.8 POST DECONTAMINATION CARE

11.9 STAFF PERSONAL PROTECTIVE EQUIPMENT

ACTION CARD No 1 – ED SHIFT CO-ORDINATOR

ACTION CARD No 2 – DECONTAMINATION TEAM LEADER

ACTION CARD No 3 – HOT ZONE NURSE

ACTION CARD No 4 – DECONTAMINATION SHOWER UNIT PERSONNEL x 2

ACTION CARD No 5 – WARM ZONE NURSE

ACTION CARD No 6 – DUTY MANAGER

APPENDIX 1 Glossary of Terms
<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX 2</td>
<td>Decontamination Protocol</td>
<td>18</td>
</tr>
<tr>
<td>APPENDIX 3</td>
<td>Setting up the Decontamination Area</td>
<td>22</td>
</tr>
<tr>
<td>APPENDIX 4</td>
<td>Guidance for Staff working in the Contaminated Area</td>
<td>23</td>
</tr>
<tr>
<td>APPENDIX 5</td>
<td>Information for Contaminated Persons</td>
<td>24</td>
</tr>
<tr>
<td>APPENDIX 6</td>
<td>Rinse-wipe-rinse method of casualty decontamination</td>
<td>25</td>
</tr>
<tr>
<td>APPENDIX 7</td>
<td>Example of proposed questionnaire for chemical casualties</td>
<td>26</td>
</tr>
<tr>
<td>APPENDIX 8</td>
<td>Chemical Incident Core Trainers</td>
<td>28</td>
</tr>
<tr>
<td>APPENDIX 9</td>
<td>Triage Sieve</td>
<td>29</td>
</tr>
<tr>
<td>APPENDIX 10</td>
<td>DOH Information on CPPE</td>
<td>30</td>
</tr>
<tr>
<td>APPENDIX 11</td>
<td>NHS Framework Product Guidance</td>
<td>32</td>
</tr>
<tr>
<td>APPENDIX 12</td>
<td>Memorandum of Understanding</td>
<td>33</td>
</tr>
<tr>
<td>APPENDIX 13</td>
<td>(Reproduced from Respirex Guidance Booklet Mk3 suits)</td>
<td>34</td>
</tr>
<tr>
<td>APPENDIX 14</td>
<td>Respirex Suit Label</td>
<td>37</td>
</tr>
<tr>
<td>APPENDIX 15</td>
<td>Preparation for Use CPPE</td>
<td>38</td>
</tr>
<tr>
<td>APPENDIX 16</td>
<td>Further guidance on chemical incident management</td>
<td>-0-</td>
</tr>
</tbody>
</table>
Foreword by Trust Chief Executive

At Salisbury Foundation NHS Trust as with all NHS organisations we have a responsibility to provide planned and emergency services but also to respond to a Major Incident if one occurs.

Health Services and their provision are always important to local people. This is all the more true if a Major Incident occurs.

It is expected that the response to an incident will be appropriate and well co-ordinated within the hospital and with the emergency services, other health partners and local authorities. This does not happen by chance and well documented, well understood plans are vital in providing a framework which allows staff to perform at their best during periods that inevitably test systems and capacity.

Much of this plan (which is endorsed by the Trust board) is about communications internally and externally and getting this right is crucial to the effectiveness of an organisation during a significant Incident.

Recent events, well publicised in the media, tell us that nowhere is immune to the potential for incidents resulting in significant numbers of casualties and it is necessary that we as an organisation and all our staff prepare to provide a response to such an incident. That response must provide high quality care to patients and be sustainable over the duration and after an incident.

The Major Incident Plan has been produced to ensure that we are able to respond to the demands of an incident and that we are able to meet our responsibilities as a “category one” responder under the Civil Contingencies Act. (CCA) These include:

- Assessing the risk of emergencies occurring and use this to inform contingency planning;
- Putting in place emergency plans;
- Putting in place Business Continuity Management arrangements;
- Putting in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Sharing information with other local responders to enhance co-ordination;
- Co-operating with other local responders to enhance co-ordination and efficiency

Every member of Trust staff is responsible for ensuring that they are well prepared to take the necessary actions to enable the Trust to respond to a major incident. It is therefore your responsibility to read this Major Incident Plan carefully. Make sure that if a major incident happens, you know the following:

- What is expected of you
- What the role of the department in which you work is
- How your responsibilities integrate with those of your colleagues and other departments with whom you work

I therefore commend this plan to you and urge you to read it and to discuss it within your departments, service units, and directorates to help you and the organisation as a whole prepare to meet the challenge.

Peter Hill
Interim Chief Executive
Introduction to the Plan

1. PURPOSE OF THE DOCUMENT

The aim of this plan is to enable Salisbury NHS Foundation Trust to respond effectively to a Major Incident. It provides guidance for staff in the assessment and subsequent management of both internal and external Major Incidents. The plan includes:

- Initial action in the event of a Major Incident and subsequent stages for future operational management
- Membership and key responsibilities for the main teams
- Key locations
- How the SDH site will operate during a Major Incident
- Confirmation of communication channels
- Management of mass casualty, biological or chemical Incidents
- Management of burn major incident patients and the Trust’s response to a national burns major incident
- Action Cards for key staff
- CRBN Plan

This local response to an Incident is part of a Health Economy wide response, the Wiltshire element of which is reflected in the Wiltshire-wide Major Incident response plan.

NB: Accident and Emergency (A&E) is called ED (Emergency Department) in this plan

2. STAKEHOLDER INVOLVEMENT AND PLAN CIRCULATION

This plan reflects collaboration within Salisbury NHS Foundation Trust and with partner organisations via the Local Resilience Forum Health Sub-Group, which includes representation from Acute Trusts, Primary Care, the Health Protection Agency, the Ambulance Service, Wiltshire Police, Mental health and the Military.

The plan has been widely circulated in its final form to partner organisations who are to be alerted to significant changes in the plan should they occur.

3. DEFINITION OF A MAJOR INCIDENT

A Major Incident is defined as: “any occurrence which presents a serious threat to the health of the community, disruption to operational services or causes such numbers of casualties as to require special arrangements to be implemented by the emergency services”. A Major Incident will normally be invoked by the Ambulance Service, Police or Fire Brigade, but the implementation of this plan may also be initiated by the ED Consultant or the Trust's Duty Manager particularly where an Incident or Incidents overwhelm local resources and routine capacity. The Local Authority or Primary Care Trusts may also invoke a Major Incident.

4. ENDORSEMENT

This plan is endorsed by:-
- Salisbury NHS Foundation Trust (SFT) CEO
- Emergency Department lead clinician
- Trust Emergency Planning Lead
- Emergency Planning lead at NHS Wiltshire
5. SUPPORTING PLANS

- This plan is supported by:-
- The Wiltshire & Swindon Health Services Major Incident Strategic Response
- SFT Pandemic Influenza Plan
- SFT Business Continuity Policy
- Facilities Directorate Major Incident Plan
- National Burns Major Incident Plan
- Great Western Ambulance Service Major Incident Plan

6. COMMAND & CONTROL

In the event of a Major Incident, command and control arrangements will be established by the emergency services. If there is a Major Incident scene, a Forward Control Point will be established on site called Bronze (or Operational) Control. A Silver (or Tactical) Control point may then be established just outside the scene to manage resources approaching the scene, and a Gold (or Strategic) Command Centre will be established at some considerable distance away from the Incident scene. Gold Command, if needed, is likely to be established at Police Headquarters in Devizes. The NHS may also establish Command & Control arrangements, and are likely to establish the NHS Silver Control Centre either at the Avon, Gloucestershire & Wiltshire Strategic Health Authority in Chippenham, or at the offices of the relevant Primary Care Trust. If such command control arrangements are established, Silver or Gold Command will inform the Trust Control room team which forms the link between these external command and control structures and the internal response.
7. INITIATING THE TRUST'S MAJOR INCIDENT RESPONSE

In flow diagram form the initiation looks like this:-

**Detail of initiation**
Upon receiving a call alerting the ED to a potential Major Incident the ED Nurse Co-ordinator (NCO) will contact the ED consultant (MCO). The MCO will decide if stand-by needs to be declared.

**7.1 Stand-by** This indicates that the hospital *may* need to respond to a Major Incident.

**STAND-BY** can only be called by the MCO, or, in the absence of an MCO and in the event of failure to contact one, by the NCO.

**7.1.2 Stand-by key Actions:**

a) If stand-by is declared the NCO will contact switchboard and request that the Control room team and Burns On-call consultant (if Burns Major Incident) are called out.

b) The NCO will contact the site co-ordinator and inform them that the hospital is on STAND-BY to receive patients.

c) Members of the Control room Team, including the MCO will make their way immediately to Major Incident Control Room 1, which is situated in the Orthopaedic outpatient department.
d) The Clinical Site Co-ordinator will be asked by the NCO to obtain accurate current and potential bed-states.

e) The Control room Team will assess the situation with the MCO and will decide whether to remain on STANDBY, or whether to proceed to LIVE Major Incident status. **Most staff will therefore only be informed of a Major Incident at the live phase.**

f) At Major Incident Standby, the ED Team will prepare to receive casualties. The NCO will make immediate arrangements for the admission or discharge of existing ED patients. Patients in the ED Waiting Area will be informed of the situation and advised to seek treatment from alternative health care providers including GP practices and NHS Walk-in Centres as appropriate. Orthopaedic outpatients and plastic outpatient departments will be asked to inform patients currently waiting of the STAND-BY phase.

7.2 Live - This means the hospital is actively involved in a Major Incident response and all staff must implement the Major Incident Plan immediately. The implementation of this plan will vary depending on the nature of the Incident. **LIVE** can only be called by the MCO or the Duty Manager and will usually be called jointly following discussion.

7.2.1 LIVE Key Actions

7.2.1 If the Major Incident is LIVE, the Duty Manager will instruct Switchboard to call in those staff on their prepared list. Those called by switchboard will implement their respective action cards including cascading to colleagues if indicated.

7.2.2 If the Major Incident is LIVE, the specialty receiving is **BURNS** and we are either the receiving ED or host burn service, then the National Burn Bed Bureau must be contacted immediately by the Duty Manager following discussion with the burns on-call consultant. Contact details can be found in Control Room 1 box file.

7.2.3 Once a Major Incident is LIVE, a broadcast message will be sent out by the Press Manager (Appendix 11) informing all staff to keep the use of computers to a minimum and to refrain from using the telephone system. Further broadcast messages will be sent out updating staff on current situation by the Press Officer. Messages will also be displayed on the Plasma screens in waiting areas informing patients waiting for outpatient appointments.

7.2.4 If SDH is declaring the Major Incident the ‘Emergency Planner – Wiltshire’ should be paged by the duty manager – pager number as on the telephone list.

7.2.5 If anticipated casualty numbers are greater than can be accommodated in appropriate specialist beds the receiving ward will be Laverstock which should be alerted to implement its action cards and clear beds.

7.2.6 Throughout the Major Incident the Facilities Department will operate their own Major Incident plan which is available in a separate document but key points linked to this, a copy can be found in Control Room 1 box file.

7.2.7 Requests for staffing help should be directed via control room 3 and discussed with either the Medical Director or the Nursing Director.

**Useful phone numbers are listed as an appendices to this document**

7.2.9 Inform orthopaedic outpatients and plastic outpatients that their respective areas need to be used for Major Incident Patients.

7.3 Stand Down - This indicates that the hospital's response to the Major Incident is to be concluded. **STAND DOWN** can only be called by the Control room/Duty Manager.

8. MAJOR INCIDENT TEAMS

8.1 The ED Team

Responsible for making arrangements to ensure the initial reception and treatment of Major Incident patients. The ED Team consists of:
8.2 The Control Room Team
Responsible for ensuring that the Trust is able to respond adequately to a Major Incident. The control room is the link between the internal response and external command and control structures – especially Gold Command. The Control room Team consists of:

- Duty Manager
- Chief Executive Officer
- Medical Director
- Nursing Director
- Facilities manager
- Hospital Ambulance Control Officer
- Police documentation team
- Loggists to ensure full documentation and to act as runners as required
- Site Co-ordinator

8.3 The Cascade Team
This is a virtual team that is responsible for initiating departmental plans to ensure the Trusts’ comprehensive response to the Major Incident. The Cascade Team are those people who are called by switchboard or a person nominated within the plan and whose individual action cards require them to call in colleagues.

8.4 Mobile Medical Team
The Mobile Medical Team (MMT) are responsible for undertaking clinical assessment and treatment at the scene of a Major Incident. The team is set up by the MCO following the departmental policy (see appendix 3). If SDH is designated as the main receiving Hospital for Major Incident patients, Salisbury NHS Foundation Trust will not normally be required to provide a MMT to the Major Incident scene.

8.5 The IT Department
The IT On-call Technician will be responsible for calling out a Senior IT manager. The Senior IT Manager will report to Control Room 1 and will take over as the IT contact. The department will then ensure that all affected areas have sufficient equipment to assist them both during and after the ‘Live Phase’.

8.6 Customer Care Department and Bereavement Support
The Customer Care and the Bereavement Team will be based in Hedgerows. The main contact number for this area will be 2743 or 2764. Relatives will be directed to Hedgerows coffee area with surrounding offices being used as required. The Bereavement team will liaise directly with the Mortuary staff, Coroner’s staff, Police, Pathologists, Chaplains and Undertakers.

9. KEY MAJOR INCIDENT ROLES

There are a number of key individual roles in relation to a Major Incident. These include:
9.1 **Medical Director** - Responsible for leading and co-ordinating the hospitals’ clinical response to a Major Incident. This role may be taken on by the Trust Medical Director or a deputy, who will be the duty surgical/medical consultant. Based in Control Room 3.

9.2 **Hospital Ambulance Control Officer (HACO)** - Responsible for liaising between the receiving hospital and the ambulance service, to ensure that effective arrangements are in place for the transfer of Major Incident casualties. The HACO will be based in Control Room 2.

9.3 **Duty Manager** - Responsible for the overall operational management of the Incident in liaison with the rest of the control room team. A particular focus of the role is managing capacity. If funding needs to be applied immediately the cost centre/code is 154750/749203. This is a specially allocated code held within the medical directorate exclusively for emergency planning usage. All funds expended should be allocated to this code to ensure that costs are readily identified/reclaimed. Based in Control Room 1.

9.4 **Trust On Call Executive** - Responsible for the management of the media with support from the Trust's Press Officer. Also responsible for ensuring effective collaboration with other health and non-health agencies and planning for the longer term impact of a Major Incident on the normal operational running of the Trust. Based in Control Room 1.

9.5 **Nursing Director** – Responsible for allocation of nursing resource, during and after the Major Incident. Based in Control Room 3.

9.6 **Clinical Site team** - Supplying bed states to the Duty manager and allocation of beds to patients requiring admission. They will be based in Control Room 1 and on the wards. They will be in contact via portable radio’s.

9.7 **Press Officer** - Responsible for managing the local media response to the Incident and for internal communications to staff not directly involved in the Incident, once the Media Centre and Press Support Office are ready they will be based in Trust Offices.

9.8 **Customer Care Team and Bereavement Team** – Based in Hedgerow's Coffee Lounge and staffed by the Customer Care Team and Bereavement Team office staff along with Senior Helpdesk Managers, they will offer advice and support to patients, relatives and staff. The will also co-ordinate the Bereavement Service.

10. **KEY LOCATIONS**

10.1 **ED** - All patients involved in any Major Incident will initially be assessed and treated in ED.

10.2 **Major Incident Control Rooms 1-3** - These are located in the Orthopaedic Outpatient department on level 3. Equipment and documentation for the control room is kept in the ED Major Incident Cupboard, by the ED ramp/reception in a green storage box. Setting up the control rooms is the duty of the first arriving member of the control room team. In the event of this area being unavailable for use in an incident (for example if there were issues around contamination of security) the Trust Library in SDH central can be utilised as an alternative facility. Access and set up details are contained within the set up box.

10.3 **Laverstock** - In the event of casualty numbers exceeding the receiving specialty bed numbers this is where all Major Incident patients, requiring a bed will be admitted, excluding paediatrics unless Sarum is full. The ward will be supported by the appropriate specialty medics i.e. the receiving specialty.

10.4 **Discharge Lounge** - This is the holding area for all patients (major incident and non-major incident patients) who are awaiting discharge. It is the responsibility of ward senior nurses to identify appropriate patients for the Discharge Lounge.

10.5 **Relatives Reception Centre – (Hedgerows)** In the event of a Major Incident it will be the responsibility of the Customer Care Department office or allocated DSN/Senior Nurse who is first on-site to set up this facility. All telephone calls from the public will be transferred to ext 2743.

10.6 **Media Centre** - The Boardroom will be used as the Major Incident Media Centre. It will be the responsibility of the Press Officer to set up this facility.

10.7 **Minor Injury over-spill – (Plastic Outpatients Department)** - In the event of large numbers of Major Incident trauma patients requiring minor treatment, the Plastic Outpatients department will
be used for over-spill from the ED. It is probable that if running, clinics will have stopped as the medical staff respond to the Incident. A plan of the area and locations can be found in control room 1 and in the folder kept within the department. If the major incident is a CBRN event, then this area will be used for non-contaminated patients to report to and wait whilst ED is used for the major incident patients.

10.8 **Children’s Unit** - The children’s unit will be the holding area for all children ‘un-injured’ who have been separated from their guardian, during working hours only. All outpatient clinics will have been cancelled to allow this area to be used solely for Major Incident patients. The Customer Care Department and Bereavement team in hedgerows will need to be kept informed of children in this area.

10.9 **Sarum Ward** – Patients on the ward will be discharged where possible. Remaining patients will be moved to one area within the ward to continue to receive nursing care. The ward will then be used to take ‘minor injury’ patients identified in ED by the paediatric medical co-ordinator.

10.10 **Endoscopy Unit** – Holding area for patients discharged from wards who require additional facilities to those in the Discharge Lounge.

11. **CONTAMINATION INCIDENTS**

11.1 If ED is contaminated the ED team will implement the prepared contingency plan held in the ED.

11.2 In the event of a contamination Incident with any form of local decontamination – beit of people or other facilities, the Environmental Protection Agency should be contacted by the Duty Manager to invite them to attend.

12. **INCIDENT TYPES/RECEIVING SPECIALTIES**

Each potential receiving specialty has its own section in the plan

12.1 **Trauma Major Incident:** In the event of a Trauma Major Incident, **Surgery** will be the receiving Specialty see Surgical Specialties action cards.

12.2 **Inhalation/Chemical/Biological Major Incident:** In the event of an Inhalation, Chemical or Biological Incident, **Medicine** will be the receiving specialty.

12.3 **Major Outbreak of Infection:** In the event of a Major Outbreak of Infection, **Medicine**, with support from Microbiology / infection control, will be the receiving specialty.

12.4 **Burns Major Incident:** In the event of a Burns Major Incident, **Burns** will be the receiving specialty.

12.5 **Paediatric Major Incident** In the event of a Paediatric Major Incident, **Paediatrics** will be the receiving specialty.

13. **STAFFING**

13.1 Individual departments will be responsible for calling in additional staff as required in the event of a Major Incident. A full record of extra staff called should be kept by the individual department or ward including the time the staff commenced on duty. This record should be given to the relevant DSN after Incident stand-down, this will be used to identify staff to be thanked for their response and to identify the financial impact of the Incident, this can be reclaimed by the Trust if costs are over a determined level.
13.2 In the event of a Major Incident, it is likely that off duty staff will arrive at SDH to offer assistance. Such staff should report to the person in charge of their normal area of work and await further instructions.

13.3 It is important to ensure that wherever possible staff already scheduled to come on duty within the next 24 hours should not be called in to help in the event of a Major Incident. It is advisable to contact staff on annual leave or days off first. This helps to reduce the amount of time and effort spent arranging and re-arranging staffing.

13.4 Requests for additional staffing during the Major Incident should be made via the Medical Director or Nursing Director in control room 3.

14. SIGNAGE/TRAFFIC MANAGEMENT/REFRESHMENTS

Detailed information is reflected in the facilities Major Incident plan. Important key notes to be aware of:

14.1 **Signage** – Facilities staff will be responsible for placing signs around the site road perimeter for relatives, these can be found in the CCTV cupboard, situated near the porters lodge. Exact placement locations are indicated in the facilities major incident plan document.

14.2 **Traffic Management** – The site will adopt the following traffic system. Emergency vehicles only to access site via Entrance A, all other vehicles via Entrance B. Both entrances will be manned by facilities staff and signs warning traffic of the one-way system. **Car Park 10** will be solely for use by relatives.

14.3 **Refreshments** – Facilities staff will be responsible for opening up Hedgerow’s and Spring’s coffee lounge. For distributing refreshment trolleys to Control Room Area, Porter’s Lodge, Boardroom, Nunton and ED/X-ray.

15. THE MEDIA

15.1 Consideration should be given to the use of local media to help call in additional staff to help the Trust to respond to a Major Incident. This is likely to be especially important in the event of a Mass Casualty Incident.

15.2 No member of Trust staff should provide information to any members of the media without the prior explicit approval of the Trust Press Officer or On Call Executive.

15.3 The Trust Press Officer and On Call Executive will take the lead on all media management issues. The Wiltshire-wide plan for the management of media issues will be available to the press officer.

16. CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR (CBRN) INCIDENTS

16.1 In the event of a CBRN Major Incident, the ED NCO will be responsible for the allocation of appropriate Personal Protective Equipment (PPE) to trained nursing and medical staff, initiating the set up of the local decontamination facility (as defined in the department policy) and liaison with Wiltshire Fire Brigade in relation to decontamination support.

16.2 If a patient requires decontamination at SDH prior to treatment (*normally this will be for self presenting patients – patients delivered via the emergency services should be decontaminated at scene*), it is expected this will be carried out in the decontamination area on the ED Ramp. The department decontamination plan protects the department from contamination as much as is possible. Patients are to be held on the ramp prior to decontamination as per the plan.
16.3 If contamination occurs on the SDH site, the contaminated area must be immediately cordoned off to contain the contamination and prevent any further contamination. Staff movements should be reduced to a minimum or where possible stopped completely. Estates Technical Services (ETS) should be asked to shut down any ventilation of the contaminated and neighbouring areas. Police, Fire and Ambulance services should be contacted immediately and arrangements will be made to decontaminate any staff or patients affected / transfer them to appropriate specialist centres for treatment.

16.4 The ED CBRN plan and protocols are included as an attachment to the MI Plan. These have been updated following assessment and guidance conducted by the South West SHA in 2010.

16.5 Further advice on the management of chemical and biological Incidents can be found in The Wiltshire Hazardous Materials Incidents Guidance – copies available in ED and the control room. The Wiltshire Mass Casualty Plan also provides detailed information on the local multi-agency response to Major chemical Incidents.

17. NATIONAL BURN INJURY MAJOR INCIDENT

17.1 Declaration of a Major Burn Incident can occur by different levels of control. This may be the Ambulance Incident Commander (AIC) or by the Medical Incident Commander at the scene of the incident. The receiving departments may call a Burns Major Incident or it may be the local burn service when there is realisation that their resources are going to be overwhelmed.

17.2 In the event of a Major Burn Incident, the National Burns Bed Bureau (NBBB) must be informed on the initiation of the MI Plan, standby and live.

17.3 Where burn injuries are part of a major incident, prompt involvement of the burn service is required for optimal patient care.

17.4 In the event of a Major Burn Incident, there may be a requirement to mobilise a Burn Assessment Team (BATS) to the referring emergency departments who will advise clinicians in the departments and assess the injured. BAT’s may come from the host service but also from burns and plastic surgery services within or outside the network.

17.5 If Salisbury is the Host Burn service, once the BAT has carried out a formal burn assessment of patients and fed this back to the hospital, the senior burn surgeon, in collaboration with the hospital control team will use information from the NBBB to decide on the intended destination of each of the referred patients. This information will then be communicated to the referring emergency departments, the ambulance service and gold control. Gold control will decide whether the transfer will be done by the primary responding ambulance service or by mutual aid arrangements.

17.6 Repatriation to the local service should be considered as soon as clinically appropriate.

17.7 In the event of such an incident, there would inevitably be a profound reduction in the burns and plastic surgery service to deal with routine activity. The knock-on effect to other services on which burn care heavily depends will also be profoundly affected for a long time. These include critical care, pathology services.

17.8 Further information relating to the National Burns Major Incident can be found in the document entitled ‘National Major Incident Plan for Burn Injury’. A copy can be found in the Control Room 1 Box File.
A. NHS Acute Trusts and Primary Care Trusts should access the following four items by contacting their local NHS Ambulance Service Trust Emergency Control Room:

1. **Equipment Pod**: respiratory support for 100 people (80 adults/20 children).
2. **Modesty Pod** for use after decontamination to dry and dress 100 people.
3. **Nerve agent antidote pod** containing atropine, saline, water and pralidoxime chloride injections to treat 90 people.
4. **Dicobalt edetate pod** containing dicobalt edetate injection and glucose 50% injection for treatment of cyanide poisoning in 90 people.

B. NHS Acute Trusts should access the following two items through their hospital blood bank. The blood bank must ring their local National Blood Service Issue Department to request:

1. **Obidoxime** to treat nerve agent poisoning in patients failing to respond to pralidoxime chloride.
2. **Botulinum antitoxin**

Supplies for treatment in usual situations should be obtained from the nearest designated centre. Please refer to the British National Formulary [BNF]. For major incidents, access is through the local blood bank.

C. NHS Acute Trusts and Primary Care Trusts should access the following six items through the Department of Health Major Incident Coordination Centre 0845 000 5555:

Callers should clearly give the details of the incident, the number of pods requested and their contact details:

1. **Biological pods (oral ciprofloxacin)** to treat 100 or 250 adults, or 50 or 100 children, for 5 days, with post-exposure prophylaxis for anthrax, plague or tularemia.
2. **Further stocks of ciprofloxacin** to complete a treatment course, and stocks of doxycycline to change treatment if required.
5. **Potassium iodate tablets** to block the uptake of radioactive iodine, plus information leaflets for the public.
6. **Prussian blue for the treatment of thallium poisoning**

Decision making re the above

The decision to request these medical supplies will normally be taken by the local CCDC, DPH, or Consultant in Public Health Medicine, who must inform the Regional Director of Public Health of their request.

The CEO in our Major Incident control room should contact Gold Command (see telephone directory linked to the Wiltshire wide Major Incident plan) to inform them of the need to access the above/that a request is to be made. In some circumstances, it is possible that Gold command will inform the Trust via the Control room of the need to make a request.
19. BOMB THREATS

In the event that a bomb threat is made against Salisbury NHS Foundation Trust, the SDH site should not be evacuated unless this is advised by the Police or Fire Brigade. Staff should check their areas for suspicious packages, and if any are found, the police and the Duty Manager should be advised of this immediately. Staff and patients should be moved away from the package if possible, and further instructions should be awaited from the Police.

20. MASS CASUALTY INCIDENTS

In the event of an Incident occurring which results in excess of 50 seriously injured casualties, the Wiltshire Mass Casualty Plan will be invoked.

21. OUTBREAK OF INFECTION

In the event that a Major outbreak of infection results in a Major Incident, the Control room Team should refer to the Trust’s Plan for Controlling Outbreaks of Infection.

22. SUSTAINABILITY

People who are acting in roles designated in the plan should consider handing over the role to a colleague of similar seniority and experience either at the time they have to leave the Trust due to other commitments or at the time when they have been acting in the role so long that they feel their effectiveness may become impaired if they continue in the role. Eight hours would generally be considered long enough.

23. ACCESS TO MILITARY, LOCAL AUTHORITY AND MUTUAL AID SUPPORT

To access these a request should be made by the Control room to Gold command.

24. STAND DOWN

The Stand-down order will be given by the control room and will be cascaded by the respective clinical managerial and departmental teams.

25. HUMAN RIGHTS ACT

The basic tenants of the act have been reflected and considered in the preparation of this plan.

26. EXERCISING

The Major Incident plan will be subjected to testing every year. Every two years that testing will be reflected in a ‘live’ exercise involving partner organizations and stakeholders. In a year when a live exercise does not take place the plan will in total or in part be subjected to internal testing via a tabletop exercise or ‘notional play’. Ensuring this takes place and that learning is reflected in revisions to the plan will be the responsibility of the Trusts’ Emergency planning lead (EPL).
27. TRAINING

The plan is written so that as much as possible all staff are acting within their normal roles or are at least doing jobs with which they are fully familiar. Notwithstanding this, some departments (ED in particular) will need training in some elements of the response, especially, where processes will be ‘outside’ normal working practices e.g. decontamination of casualties. It is the responsibility of those departments who have key roles within the plan to assess their state of readiness to implement those roles and to bridge any gaps in that state of readiness. This also applies to individuals who may find themselves in a key role in the plan e.g. consultant medical and surgical staff who may be asked to fulfill named roles within the plan and managers who may be required to take on a control room role. Self-assessment is critical and departments or individual staff should approach the EPL for support in bridging any gaps they identify.

28. VIP VISITS

The Chief Executive or their nominee will have a key role to play in managing and conducting VIP visits. Such visits will be conducted with the necessary protection of patients and relatives privacy and dignity. VIP’s will not normally be expected to visit ED when Major trauma or serious illness is being managed. Where necessary the CEO will call upon off-duty managers who are not actively involved in the Major Incident response to support VIP visits. The Public relations team will also provide advice and support.

29. LEGAL ISSUES

29.1 Preservation of Forensic Evidence
The primary purpose of the Trust is to provide health services. However, following a Major Incident there is likely to be an investigation into the event that caused the Incident. This will be true whatever the nature of the Incident. Patient’s property and belongings may be required after the event and nothing should be discarded or destroyed no matter what condition it is in. Preservation of life and limb should not be compromised by a reluctance to damage a patients clothing (e.g. cutting it off to gain access to the patient) or property (e.g. cutting off a ring or other jewelry) however, damage should be kept to what is necessary only. Property should be labeled accurately and kept with its owner where practicable or stored securely if not.
In the event of a patient’s death (or DoA) the minimum possible should be done to the body prior to it being fully labeled and sent to the mortuary, no medical devices or foreign bodies should be removed.

29.2 Tracking of Patients During an Incident
In a major incident the Police Hospital Documentation Team will liaise with ED and the Control room regarding the whereabouts of patients. Primarily this is for the purpose of liaising with the casualty bureau who will be dealing with enquires from relatives etc. However, in the event of an incident with a suspect criminal element, the Police will also need to keep track of patients in order to obtain witness statements or question suspects.

29.3 Logging communications
All staff taking and making telephone calls and/or making decisions and committing resources (including staffing resources) are reminded of the importance of logging communications/decisions and actions. This is important for the following reasons:

- Ensuring that learning can take place after the Incident
- Generating a contemporaneous record
The Trust has a pool of trained loggists (see appendix 23) who will be called upon to ensure contemporaneous record of the Control Room Team’s decisions are maintained.
30. LOCAL RISKS

In order to encourage an integrated approach, the CCA places a responsibility on Category 1 responders to co-operate with each other in maintaining a Community Risk Register. The Trust works closely with partner agencies within the Wiltshire Local Resilience Forum (LRF) to assess the potential risks and hazards that may require the implementation of emergency plans. These risks are collated via the Community Risk Register.

Examples of high and very high risks from the Wiltshire Community Risk Register include Road accidents involving transport of fuel/explosives; Localised industrial accidents involving large toxic release (‘big bang’ incidents); Pandemic Influenza and Low temperatures and heavy snow (‘rising tide’ incidents).

The core catchment area of the Trust covers both urban and rural areas and there are a number of specific organisations in the locality reflected in the risk register, for example the military garrisons on Salisbury Plain, Boscombe Down Airfield and the HPA site and the Defence Science & Technology Laboratory at Porton Down.

31. BUSINESS CONTINUITY AND CONTINGENCY PLANNING

At Salisbury NHS Foundation Trust, business continuity and contingency planning is regarded as a separate process from Major Incident planning although it is recognized that there are potential overlaps. Business continuity and contingency planning is subject to a formalized structured process of risk assessment and response planning reflected in the Trusts’ ‘Continuity Policy’ and related documentation.

Contingency plans are held in readiness both in the relevant departments and in areas adjacent to those departments (so a copy is available if the response is to something that may have destroyed the copy in the department).

32. COMMUNICATIONS FAILURE

In the event of an internal communications failure the contingency plan held by switchboard will be implemented.

33. EXTERNAL CIRCULATION LIST

- HPA – AGW StHA
- NHS Wiltshire Emergency Planner – Southgate House
- Emergency Planner Great Western Ambulance Service
- Emergency Planner Wiltshire Fire Brigade
- Emergency planning lead Wiltshire Police – Police HQ Devizes
- CEO NHS Wiltshire
- Boscombe Down Airfield
- Emergency Planner Southampton University Trust
- Emergency Planner – Great Western Hospital (Swindon)

34. DEBRIEFING POST INCIDENT

Debriefing will be led by the Trust emergency planner and will take place on two levels:
- The control room team with senior Staff from key responding departments
• At individual responding department level

This double approach will ensure that local command and control issues are captured at a ‘high level’ whilst also giving the opportunity for low level local learning to take place.

Debriefing will take place within 14 days of an Incident and the Major Incident plan will be updated and re-circulated reflecting any learning within 12 weeks of the Incident.
Major Incident

ACTION CARDS

Emergency Department
Summary of Role
To ensure the department is prepared to receive MI casualties and to co-ordinate the nursing and reception response to the MI, taking particular responsibility for the communication with the MI Control Room. No direct patient care responsibilities.

You will be known as ‘Nurse Co-ordinator’ (NCO)
You will be based at the ED nurses station. Do not leave this area; use the urgent area runner to communicate with triage and the ED Medical co-ordinator (MCO) (on-call ED consultant)

Communication

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard or Incoming phone call</td>
<td>Duty ED consultant</td>
<td>ED Nurses station</td>
<td>Link with MCO Report to Duty manager control room 1</td>
</tr>
<tr>
<td>Orthopaedic Outpatient Sister</td>
<td>Plastic Outpatient Sister</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS

Standby
- Unlock the Major Incident Cupboard (keys in Key Press in reception) and collect tabards and NCO Major Incident file
- Summon all nursing, medical and non-medical staff to the ED nurses station
- Handout the Action Cards (being clear about the alert status i.e. standby or live phase) completing the action card list (in the NCO file) and Tabards
- Wear the tabard indicating that you are the 'Nurse Co-ordinator’
- Maintain a list of all patients requiring immediate transfer to wards (if a live phase is declared) and pass details to the Clinical Site Co-ordinator.
- Communicate with the rest of the hospital via control room 1, ext 4178. All requests for additional resources/staff should be via control room 3, ext 4179.
- Log all your actions/communications/patient transfers etc on the NCO’s log which is attached to the Action card.
- If CRBNE incident ensure trained staff are on standby.

Live phase
- Ensure all actions in ‘Standby’ above are completed
- Arrange for placement and transfer of patients currently in the ED requiring ward transfer via the clinical site co-ordinator on bleep 1312.
- **Staff Major Incident areas according to number and category of incoming casualties and available staff. Supplement with off duty staff as they arrive**
  - Immediate area – (resus 3 bays) 1 nurse, 1 doctor per patient (max 4 patients)
  - Urgent area – (Majors area) 1 nurse per bay and 4 SHO’s in total (max 10 patients)
  - Non-urgent area (Minors, SSEU and then when reached full capacity Plastic OPD level 3) – minimum of 1 nurse and 1 SHO
• Co-ordinate the management of all patient activity with the MCO, utilising the MI white-board to form an accurate record of the patients journey, interventions and destinations
• Maintain a bank of ED staff (in the staff room), rotating to allow for breaks etc.
• The reception will hand you the completed Patient Information Sheets
• Liaise with MCO reference x-ray queue management and ward placement/discharge of patients
• Do not leave the nurses station until you are relieved for a break or told to stand down

After stand down ensure:
Adequate staffing of the next shift
Appropriate debriefing of staff
Ensure that reception staff are collating the ED paperwork. This includes:
• Each MI patient will have a copy of the trauma chart, an original Patient information sheet and a set of blank ED notes. This should be filed in the ED reception area as normal
• Ensure that all MI patients have been placed onto iPM and ED system
  • That replacement sets of MI notes are being prepared and that enough sets are available for a future MI as required

X-ray Queue management
The medical staff clinically involved with each patient will document all x-rays required on a normal x-ray request form and this form will be brought to you by the runners.

Contact the MCO to identify which x-rays are to be taken in the ED (highlight clearly on the x-ray form) and the queue order of patients.

Communicate this information verbally or with a list to the radiology department ensuring that the patients receive the right x-rays in the right order.

When the patient leaves the ED a copy of the x-ray form must go with the patient so that any further x-rays required (i.e. those NOT done in the ED) can be done in the receiving ward/unit areas (Radiology will make the copy).

Admission and Discharge from the ED
Admission destinations during an MI can only be:
• LAVERSTOCK (or another designated MI receiving ward)
• Sarum Ward
• Theatres
• Radnor

Each clinical team will ask the MCO to review the patient/destination. The MCO will confirm placement for each patient and inform the NCO.

The NCO will request and confirm availability of the destination and deploy porters when required. Log destination and time of leaving in the Patient Information Sheet log. Check this matches with the exit receptionists log. ENSURE that all patient destinations are accounted for.

Patients being discharged home must be seen by the MCO prior to discharge.

In Event of CRBNE Incident Declared:
Nominate trained staff for decontamination team. If insufficient ED staff available – call in decontamination trained staff from Chemical incident call-in sheets
• Decontamination Team Leader
• Hot Zone Nurse
• Decontamination Shower Unit Personnel
• Warm Zone Nurse
Inform the Division of Chemical Hazards & Poisons at the Health Protection Agency – 0844 892 0555
Continue to monitor the situation and liaise with the decontamination safety officer at the ambulance bay doors
Liaise with ED Shift Co-ordinator
At the end of the incident, ensure that the replacement unit and any suits provided by the ambulance service are stored in the major incident store
Complete the CBRN audit form
Post incident organise a hot debrief for members of the decontamination team and other staff involved in the incident. Which should feed into any organisational debrief.
EMERGENCY DEPARTMENT

ACTION CARD No 2 ED MEDICAL CO-ORDINATOR (MCO)

Duty ED Consultant or SpR

Summary of Role
To assess the situation and decide if the Trust is to declare a Major Incident in consultation with the duty manager. To ensure the department is prepared to receive MI casualties and to co-ordinate the medical response to the MI, Taking particular responsibility for the immediate area, x-ray organisation and admission/discharge of patients. There are NO direct care responsibilities.

You will be known as the ‘ED Medical Co-ordinator’ MCO
You will be based in the ED’s Urgent area (Major incident white-board)

Communication Summary:
You will be informed by:
- Nurse co-ordinator (NCO)
- senior nurse ED
You inform:
- ED Medical Team
You go to:
- Link with NCO
You report to:
- Duty Manager in control room 1

ACTIONS
Upon the department being informed of a potential Incident ensure that the switchboard has called the control room staff into the control room.

Standby
- Inform Orthopaedic outpatient Nurse in Charge (during working hours) that we are on STAND-BY for a major incident.
- Assess the information available and determine in consultation with the Duty manager (if available) in the control room whether to declare the Incident live.
- Collect action cards (for MCO and doctors staffing the ED) and tabard from the NCO based at the Major Incident white board (Urgent area)
- Distribute the action cards and allocate medical staff to specific areas
  1 senior doctor per patient in the immediate areas
  1 doctor per 2 patients in the Urgent area (increase as required)
  1 doctor in the Non-Urgent area (increase as required)
- Ensure that the medical staff are assessing current ED patients ref admission/discharge
- If you require Anaesthetists, surgical or orthopaedic doctors, then request their presence from the medical director in control room 3, ext 4179
- Communicate with the control room and NCO only
- Log all your actions/communications/patient transfers on the MCO’s log and back of the action card

Live Phase
- Ensure all actions in ‘Standby’ are completed
- Base yourself in the URGENT area with the NCO close to the Major Incident white board
- Be available to give advice to any clinical team in the ED
- Inform the NCO when the immediate area is full and confirm where the placement of the next immediate patient should be
• Respond to any emergency situation in the ED (identified by emergency call system). Call the cardiac arrest team if required (response will be medical HO and anaesthetic SHO.) If you require other specialist input, request via the control room
• Assess each x-ray request and identify x-rays to be done in ED prior to admission/discharge, *(can be delegated to another ED senior if appropriate)*
• Prioritise the x-ray requests into a queue *(can be delegated to another ED senior if appropriate)*
• Confirm admission placement of ALL patients i.e. ward, theatres or ITU
• Review ALL patients prior to discharge home. ensure priority duties are carried out before this action. Patients will be waiting in discharge lounge, ensure follow up arrangements are arranged and clear to the patient. *(can be delegated to another ED senior if appropriate)*. Ensure that a discharge letter is completed by yourself or your deputy *(APPENDIX 22)*, give patient one copy to give to GP second copy to be securely placed in the patients notes.
• Advise the Control Room, ext 4178, if the ED is no longer capable of taking further patients
• The Duty Manager in the Control room may advise you that there is no more capacity in the Hospital for seriously injured patients
• Liaise with the Surgical Triage Officer and Duty Consultant Physician to appraise them of any situation update
• Ensure medical staff are deployed effectively and allow rotation for breaks as appropriate
• **Do not stand down until you are advised to do so by the Major Incident control room**
EMERGENCY DEPARTMENT

ACTION CARD No 3 TRIAGE NURSE

Summary of Role
You will communicate to and assess the needs of the patients in the waiting room.
You will then be based at the MI triage point (ambulance entrance), prioritising all patients arriving and
directing them to the appropriate areas for treatment/care

Communication Summary:

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse co-ordinator (NCO)</td>
<td>ED Nurses station</td>
<td>NCO</td>
</tr>
</tbody>
</table>

ACTIONS

Standby
• In conjunction with an ED SHO/Registrar go to the main waiting room and explain to all patients that
due to a Major Incident all those with minor injuries should either go home or to their GP as the
waiting times may be excessive
• Administer first aid and give advice as required
• Document actions for those given care/advice including self discharge
• Place ED notes in reception for those who have left and in the relevant MI area for those who are
staying as part of the MI
• Patients who require ED treatment and those who insist on staying will remain in the ED and become
part of the Major Incident. Use Current ED notes and move to Major Incident triage point.

Live phase
• Ensure all Standby actions have been completed
• Assess all patients arriving during the MI using the grid below. This includes non MI patients who are
seen as part of the Major Incident and allocated notes and a number
• Direct all patients/ambulance crews to the appropriate MI receiving area using the grid below

<table>
<thead>
<tr>
<th>Category</th>
<th>Condition</th>
<th>Area</th>
<th>Area identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Respiratory rate &lt;10 or &gt; 29 or intubated</td>
<td>Immediate</td>
<td>RESUS and MINORS AREA</td>
</tr>
<tr>
<td></td>
<td>Capillary refill &gt; 2 seconds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Stretcher patients with respiratory rate of</td>
<td>Urgent</td>
<td>Trolleys 1-10 MAJORS AREA</td>
</tr>
<tr>
<td></td>
<td>between 10-29 and Capillary refill &lt; 2 seconds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>Walking/chair</td>
<td>Non-urgent</td>
<td>MINORS until declared as reaching full</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>capacity by Medical co-ordinator (MCO)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>then allocate to SSEU then</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plastics OPD</td>
</tr>
</tbody>
</table>

• Dead patients certified on scene will go straight to the mortuary NOT via ED
• Certification of death CANNOT occur by the triage officer; these patients should be immediately
assessed as a P1
• If patients arrive without a 'Cambridge crucifix', document their triage category on the front of their MI notes

• Use the triage runner to assist in the transfer of patients in wheel chairs or out of area ambulance crews to the correct MI receiving areas

• Do not leave the triage area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 4 TRIAGE RUNNER

Porter

Summary of Role
To prepare the MI triage point
To assist in the transfer of patients from the Major Incident triage area to their designated MI clinical areas within the ED
To assist the MI Triage Nurse and receptionist in their roles

ACTIONS
Alert or Live Phase

• Make up all the spare ED trolleys in the resus alcove, check oxygen and suction and move into the corridor.
• Collect all available wheel chairs in the ED and place in the resus alcove and replenish as required during the MI keeping a stock level for immediate use.
• At the request of the triage nurse accompany patients/ambulance crews to their allocated MI area:
  • Immediate to resus
  • Urgent to bays 1-10 (MAJORS)
  • Non urgent to Minors, / SSEU (and then when reached full capacity Plastic OPD level 3)
• Communicate between the triage nurse and the Nurse co-ordinator (NCO)
• Assist the Triage nurse and the receptionist in their roles
• Do not leave the triage area until you are relieved for a break or told to stand down
ACTION CARD No 5 TRIAGE AREA RECEPTIONIST

Receptionist – senior on duty

Summary of Role
Your role is to call in the staff required to man the Major Incident and then to give out the Major Incident notes at the MI triage point (ambulance entrance) at the ambulance reception window.

Actions
Standby

• Collect rotas and ‘Call-in’ log sheet from Major Incident Box in the Major Incident Cupboard (nursing, medical and reception) and proceed to the nurse co-ordinator (NCO) based at the nurse station (who will identify who is to be phoned).

• Give a list of staff to be called to the Director of Nursing in control room 3, they will assist with calling in staff

• Go to the Sister/Charge Nurse office and phone staff until you put the following number of people on ‘stand by’
  • ED nurses plus the ED senior nurse
  • Five further receptionists
  • 4 ED SHOs plus all ED middle and consultant grades

• State clearly “This is the Emergency Department phoning. We are on Major Incident ALERT. DO NOT attend ED yet. IF REQUIRED could you attend immediately?” For those who can, ask them to await further instructions at home

• Keep a record of staff contacted and put on stand by

• When your task is completed return to the NCO and hand them the list

Live phase

• Lock down reception area and external doors

• Ignore actions in Standby if you go immediately into the live phase

• Collect rotas (nursing, medical and reception) and proceed to the nurse co-ordinator based at the nurse station (who will identify who is to be phoned).

• Go to the Sister/Charge Nurse office and phone staff until you get the following number of people on route to the ED:
  • ED nurses plus the ED senior nurse
  • Five further receptionists
  • 4 ED SHOs plus all ED middle and consultant grades

• State clearly “This is the Emergency Department phoning. A Major Incident has just been DECLARED. This is not a practice. Can you report for work immediately?” If so take estimated time of arrival at the ED. Then inform staff “when you arrive, report to the nurses station in the ED and report to the NCO. Please ensure you have your ID badge, uniform is not essential.” Do not waste time by giving any further details

• If you get an answer machine do not leave a message, move on to the next staff member on the call in list. Try again later if you still require staff

• Keep a record of staff contacted and on route

• When your task is completed return to the NCO and hand them the list and collect the Triage Log.

• Go to the MI triage point (ambulance entrance) and prepare the MI notes (in Major Incident cupboard)
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

- You are responsible for ensuring that every patient arriving has a set of MI notes and a MI wristband. No patient details are taken at this stage.
- Complete the MI Triage log for every patient arriving (MI number and priority category). Mark clearly on the triage log any patient who is NOT part of the MI.
- Every 15 minutes take a photocopy of the Patient Information Sheet and ask the runner to take the copy to control room 1 and one to the NCO. Continue updating the triage log and issuing it every 15 minutes.
- Every 30 minutes FAX a copy of the triage log to Hedgerows for the Customer Care Department and Bereavement Support Staff. The Number is 01722 425234.
- **Do not leave the triage area until you are relieved for a break or told to stand down.**

**Stand Down Phase**

- On instruction from the NCO phone staff put on stand by (but not called in) to stand them down.
- Collate the information into a set of ED notes i.e. printed ED notes, copy of the trauma chart and an original Patient information sheet. This should be filed in the ED reception area as normal.
- Ensure that all MI patients have been placed onto iPM and ED system.
- Complete the ED computer system sections as follows:
  - Presenting complaint - Major Incident
  - Triage as Major Incident
  - Diagnosis
  - Destination
  - Departure time
  - Identify as MI in free text

Ensure that replacement sets of MI notes are being prepared and that enough sets are available for a future MI as required.
EMERGENCY DEPARTMENT

ACTION CARD No 6 IMMEDIATE AREA NURSE

Registered Nurse (resus)

Summary of Role
You will clear the resus room of current patients (or care for them as part of the MI)
You will then form a clinical team (with one middle grade doctor) and deliver care to ONE immediate category patient within the immediate area.

ACTIONS

Standby
- Proceed to the immediate area in resus.
- Prepare equipment (airway, breathing, circulation, monitoring, resuscitation etc)

Live Phase
- Ensure Standby actions have occurred
- Request any additional equipment, staff or specialist skills via the immediate runner (who will request from the nurse co-ordinator (NCO))
- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- If you require IV fluids or O negative blood verbally request via your runner
- If you require drugs (including CD's) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card (Radiology will make the copy) MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- Restock your equipment levels continually using your runner
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the ED medical co-ordinator (MCO) will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
- When you return to the ED go to the resuscitation area to sign for any CD’s administered and then proceed to the NCO for further instructions.
- Do not leave the immediate area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 7 IMMEDIATE AREA NURSE

Registered Nurse (Resus Room)

Summary of Role
You will clear the resus room of current patients (or care for them as part of the MI)
You will then form a clinical team (with one middle grade doctor) and deliver care to ONE immediate
category patient within the immediate area.

ACTIONS

Standby
• Proceed to the immediate area in ED (minors area)
• Collect the Resuscitation trolley from the SSEU and take to the minors area (DEDICATED
  IMMEDIATE AREA in a Major Incident)
• COLLECT the anaesthetic machine from X-ray It is located opposite X ray room 7, and connect to the
  wall oxygen supply in minors area (DEDICATED IMMEDIATE AREA in a Major Incident)
• Prepare equipment (airway, breathing, circulation, monitoring, resuscitation etc)

Live Phase
• Ensure Standby actions have occurred
• Request any additional equipment, staff or specialist skills via the immediate runner (who will request
  from the NCO).
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number
  only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IVI fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl.
  Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff
  hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical co-
  ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-
  ray. A copy of the x-ray card (Radiology will make the copy) MUST go with the patient when
  admitted, so that any further x-rays can be done in the receiving area.
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform
  the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who
  will arrive when it is your turn for transfer.
• Restock your equipment levels continually using your runner
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life
  support. Remain in your area and await support. (the MCO will respond and call the cardiac arrest
  team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving
  hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then
  proceed to the NCO for further instructions.
• Do not leave the immediate area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 8 IMMEDIATE AREA NURSE

Registered Nurse (Off-duty)

Summary of Role
You will clear the resus room of current patients (or care for them as part of the MI)
You will then form a clinical team (with one middle grade doctor) and deliver care to ONE immediate
category patient within the immediate area.

ACTIONS
Standby
• Proceed to the immediate area in resus.
• Prepare equipment (airway, breathing, circulation, monitoring, resuscitation etc)

Live Phase
• Ensure Standby actions have occurred
• Request any additional equipment, staff or specialist skills via the immediate runner (who will request
  from the NCO).
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number
  only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IV fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl.
  Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff
  hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then
  identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray
  card (Radiology will make the copy) MUST go with the patient when admitted, so that any further x-
  rays can be done in the receiving area.
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform
  the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who
  will arrive when it is your turn for transfer.
• Restock your equipment levels continually using your runner
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life
  support. Remain in your area and await support. (the medical co-ordinator will respond and call the
  cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving
  hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then
  proceed to the NCO for further instructions.
• Do not leave the immediate area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 9 IMMEDIATE AREA NURSE

Registered Nurse (Off-duty)

Summary of Role
You will clear the resus room of current patients (or care for them as part of the MI)
You will then form a clinical team (with one middle grade doctor) and deliver care to ONE immediate
category patient within the immediate area.

ACTIONS
Standby
• Proceed to the immediate area in ED (minors area)
• Prepare equipment (airway, breathing, circulation, monitoring, resuscitation etc)

Live Phase
• Ensure Standby actions have occurred
• Request any additional equipment, staff or specialist skills via the immediate runner (who will request from the NCO).
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IVI fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl.
  Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card (Radiology will make the copy) MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area.
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• Restock your equipment levels continually using your runner
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Do not leave the immediate area until you are relieved for a break or told to stand down
**EMERGENCY DEPARTMENT**

**ACTION CARD No 10 IMMEDIATE AREA DOCTOR**

Middle grades in appropriate specialties as requested by the MCO

**Summary of Role**
To treat seriously injured patients in the IMMEDIATE area - resus. You will form a clinical team (with one ED or critical care nurse) and deliver care to ONE immediate category patient.

**ACTIONS**

**Standby**
- The ED Medical Co-ordinator (MCO) will assign you to a Resuscitation bay.
- Prepare equipment

**Live phase**
- Ensure all actions in ‘Standby’ above are completed
- All patients will arrive with a MI number and set of MI notes containing x-ray and path forms
- Your initial role is to identify and treat life-threatening injuries in order of priority.
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- Restock your equipment levels continually using your runner
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- **Do not leave the immediate area until you are relieved for a break or told to stand down**

*Use the MCO for any clinical or patient management advice.*

**NB:** In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

EMERGENCY DEPARTMENT

ACTION CARD No 11 IMMEDIATE AREA DOCTOR

Middle grades in appropriate specialties as requested by the MCO

Summary of Role
To treat seriously injured patients in the IMMEDIATE area – (ED) You will form a clinical team (with one ED or critical care nurse) and deliver care to ONE immediate category patient.

ACTIONS

Standby
• The ED Medical Co-ordinator (MCO) will assign you to a Resuscitation bay
• Prepare equipment

Live phase
• Ensure all actions in ‘Standby’ above are completed
• All patients will arrive with a MI number and set of MI notes containing x-ray and path forms
• Your initial role is to identify and treat life-threatening injuries in order of priority
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy)
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer
• Restock your equipment levels continually using your runner
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer patient with all paperwork.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
• Do not leave the immediate area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice.

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
EMERGENCY DEPARTMENT

ACTION CARD No 12 IMMEDIATE AREA DOCTOR

Middle grades in appropriate specialties as requested by the ED Medical Co-ordinator (MCO)

Summary of Role
To treat seriously injured patients in the IMMEDIATE area - resus. You will form a clinical team (with one ED or critical care nurse) and deliver care to ONE immediate category patient.

ACTIONS
Standby
- The MCO will assign you to a Resuscitation bay
- Prepare equipment

Live phase
- Ensure all actions in ‘Standby’ above are completed
- All patients will arrive with a MI number and set of MI notes containing x-ray and path forms
- Your initial role is to identify and treat life-threatening injuries in order of priority.
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- Restock your equipment levels continually using your runner
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- Do not leave the immediate area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice.

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
EMERGENCY DEPARTMENT

ACTION CARD No 13 IMMEDIATE AREA DOCTOR

Middle grades in appropriate specialties as requested by the ED Medical co-ordinator (MCO)

Summary of Role
To treat seriously injured patients in the IMMEDIATE area – ED. You will form a clinical team (with one ED or critical care nurse) and deliver care to ONE immediate category patient.

ACTIONS
Standby
- The MCO will assign you to a Resuscitation bay.
- Prepare equipment

Live phase
- Ensure all actions in ‘Standby’ above are completed
- All patients will arrive with a MI number and set of MI notes containing x-ray and path forms
- Your initial role is to identify and treat life-threatening injuries in order of priority.
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- Restock your equipment levels continually using your runner
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- Do not leave the immediate area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice.

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
EMERGENCY DEPARTMENT

ACTION CARD No 14 IMMEDIATE AREA RUNNER

HCSW – minors/off duty

Summary of Role
You will assist in the clearing of Majors and minors and the preparation to receive MI casualties

You will then be based in the IMMEDIATE AREA (resus).
You will circulate continuously through the patients and clinical teams in this area. They are unable to leave their patient and will rely on you for all communication and supplies.

ACTIONS
Standby
• Continue to treat patients on minors
• Assist immediate area nurse to prepare x2 Resuscitation bays, separated by lead screen, spinal immobilization equipment from Majors area
• Await further instructions from the registered nurses

Live Phase
• Assist the registered nurse and doctor in discharging or admitting of current ED patients
• Proceed to the immediate area
• Circulate continuously through the areas ensuring that each clinical team with a patient has contact with you regularly (minimum of every 3-5 minutes)
• You may be asked to:
  • Locate the ED Medical Co-ordinator and direct him to clinical teams requiring advice
  • Collect drugs and IVIs from the drugs nurse (based in resus)
  • Collect additional supplies from within the ED
  • Communicate with the Nurse Co-ordinator (NCO) (based at the nurses station)
  • Deliver x-ray cards to the NCO

Do not leave the immediate area until you are relieved for a break or are stood down
EMERGENCY DEPARTMENT

ACTION CARD No 15 IMMEDIATE AREA RECEPTIONIST

Receptionist – on or off duty

Summary of Role
Your role is to take additional details from all patients in the IMMEDIATE area attending during a Major Incident, booking them onto Symphony and PiMs using a unique Major Incident number and preparing a set of ED notes.

ACTIONS
Live Phase

• You are based in the IMMEDIATE area (resus)
• Each patient will already have a set of MI notes and a MI number.
• Go to each patient and record the following details on the patient information sheets, held in the Major Incident Box in reception (held by the Nurse co-ordinator (NCO)).
  • Surname/forename
  • DOB/age
  • Address
  • GP
• Photocopy each patient information sheet as they are generated and take to the control room based in orthopaedic outpatients’ and the NCO
• Return to reception and search for each patient on iPM. Allocate the MI hospital number if they are not known and register.
• Enter all details onto the Symphony computer system and print out one set of ED notes
• Place the ED notes in reception (they will later be amalgamated with the Patient Information Sheet and the Trauma Chart Copy and filed in the ED).

Patients notes (already registered) will be requested (if available) by the receiving area – it is not part of your role to do this unless they are required whilst in the ED.

Do not leave the immediate area until you are relieved for a break or are stood down
Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS
Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible
• Patients awaiting pick-up from relatives should be discharged to the Discharge Lounge on level 2
• For patients requiring admission the NCO will pass details to the clinical site co-ordinator who will allocate beds and inform the relevant in-patient teams. Porters will transfer the patients to the wards.

• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment.
• Request any additional equipment, staff or specialist skills via the (immediate) urgent runner.
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc).
• If you require IV fluids or O negative blood verbally request via your runner.
• If you require drugs (including CDs) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED medical co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about.
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response).
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving.

Do not leave the urgent area until you are relieved for a break or told to stand down.
EMERGENCY DEPARTMENT

ACTION CARD No 17 URGENT AREA NURSE

Registered Nurse (Off-duty)

Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS

Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible.
• Patients awaiting pick-up from relatives should be discharged to the Discharge lounge on level 2
• For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will transfer the patients to the wards.

• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment.
• Request any additional equipment, staff or specialist skills via the immediate urgent runner
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IVI fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The Ed medical co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 18 URGENT AREA NURSE

Registered Nurse (Off-duty)

Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area.
There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS
Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible.
• Patients awaiting pick-up from relatives should be discharged to the Discharge lounge on level 2.
• For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will transfer the patients to the wards.
• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment
• Request any additional equipment, staff or specialist skills via the immediate urgent runner
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IV fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED medical co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down
Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS
Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible.
• Patients awaiting pick-up from relatives should be discharged to the Discharge lounge on level 2
• For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will transfer the patients to the wards

• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment.
• Request any additional equipment, staff or specialist skills via the immediate urgent runner
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IVI fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED medical co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down
ACTION CARD No 20 URGENT AREA NURSE

Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS
Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible.
• Patients awaiting pick-up from relatives should be discharged to the Discharge Lounge on level 2
• For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will arrive to transfer the patients to the wards.

• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment.
• Request any additional equipment, staff or specialist skills via the immediate urgent runner
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IV fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down
Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area.
There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS
Standby
- With the SHO assess all current Majors and minors patients and identify which patients require admission.
- Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
- Ensure all actions in ‘Standby’ above are completed
- Discharge all current patients home where possible.
- Patients awaiting pick-up from relatives should be discharged to the Discharge Lounge on level 2.
- For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will arrive to transfer the patients to the wards.
- The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment.
- Request any additional equipment, staff or specialist skills via the immediate urgent runner
- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- If you require IVI fluids or O negative blood verbally request via your runner.
- If you require drugs (including CD's) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
- All drugs/ fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical Co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Notify the MCO of any patient you are concerned about
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving the trauma chart copy to the NCO.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
- Patients being discharged home MUST be assessed by the MCO prior to leaving
Do not leave the urgent area until you are relieved for a break or told to stand down.
EMERGENCY DEPARTMENT

ACTION CARD No 22 URGENT AREA NURSE

Registered Nurse (Off-duty)

Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS

Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible
• Patients awaiting pick-up from relatives should be discharged to the Discharge Lounge on level 2.
• For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will arrive to transfer the patients to the wards
• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment
• Request any additional equipment, staff or specialist skills via the immediate urgent runner
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
• If you require IV fluids or O negative blood verbally request via your runner
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical Co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 23 URGENT AREA NURSE

Registered Nurse (Off-duty)

Summary of Role
To clear the current patients in the Majors and minors areas, identifying those that can go home and those that need admission.
You will then be based in the urgent area (bays 1-10) and will care for the urgent patients in this area.
There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS

Standby
• With the SHO assess all current Majors and minors patients and identify which patients require admission.
• Pass this admission list to the Nurse Co-ordinator (NCO) based at the nurses station.

Live Phase
• Ensure all actions in ‘Standby’ above are completed
• Discharge all current patients home where possible.
• Patients awaiting pick-up from relatives should be discharged to the Discharge Lounge on level 2
• For patients requiring admission the NCO will pass details to the bed manager who will allocate beds and inform the relevant in patient teams. Porters will arrive to transfer the patients to the wards.
• The urgent area runner will deliver an urgent area equipment box for each new MI patient. This will contain basic equipment for one patient. Check and prepare this equipment.
• Request any additional equipment, staff or specialist skills via the immediate urgent runner
• Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc).
• If you require IV fluids or O negative blood verbally request via your runner.
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner.
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
• Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical Co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
• Notify the MCO of any patient you are concerned about
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
• Transfer your patient with all paperwork (apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.
• When you return to the ED go to the resuscitation area to sign for any CD’s administered and then proceed to the NCO for further instructions.
• Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 24 URGENT AREA DOCTOR

ED Doctor (on or off duty)

Summary of Role
To assess the current patients in the Majors and minors areas of the ED, identifying those that can go home and those who require admission.
You are based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS

Standby
- Assess all current Majors and minors patients and identify which patients require admission.
- Pass this admission list to the Nurse Co-co-ordinator (NCO) based at the nurses station.

Live Phase
- Ensure all actions in ‘Standby’ above are completed
- Discharge all current patients home where possible
- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Notify the MCO of any patient you are concerned about
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer your patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
EMERGENCY DEPARTMENT

ACTION CARD No 25 URGENT AREA DOCTOR

ED Doctor (on or off duty)

Summary of Role
You are based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be a maximum staffing of one nurse per bay and one doctor per two bays.

ACTIONS

Live Phase

- Ensure all actions in ‘Standby’ above are completed
- Discharge all current patients home where possible.

- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The Ed Medical Co-ordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Notify the MCO of any patient you are concerned about
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer your patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
Summary of Role
You are based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be at maximum staffing one nurse per bay and one doctor per two bays.

ACTIONS

Live Phase

- Ensure all actions in ‘Standby’ above are completed
- Discharge all current patients home where possible.

- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical Coordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Notify the MCO of any patient you are concerned about
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer your patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
EMERGENCY DEPARTMENT

ACTION CARD No 27 URGENT AREA DOCTOR

ED Doctor (on or off duty)

Summary of Role
You are based in the urgent area (bays 1-10) and will care for the urgent patients in this area. There will be at maximum staffing one nurse per bay and one doctor per two bays.

ACTIONS

Live Phase

- Ensure all actions in ‘Standby’ above are completed
- Discharge all current patients home where possible.

- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The ED Medical Coordinator (MCO) will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient when admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Notify the MCO of any patient you are concerned about
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Transfer your patient with all paperwork.
- When you return to the ED go to the resuscitation area to sign for any CDs administered and then proceed to the MCO for further instructions.
- Patients being discharged home MUST be assessed by the MCO prior to leaving

Do not leave the urgent area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice

NB:
In the event of a Major Incident you may have to treat a large number of seriously injured patients in a short period of time. You may be able to do no more than identify and treat life-threatening injuries. If you spend too long on the assessment and treatment of one patient then others may suffer.
EMERGENCY DEPARTMENT

ACTION CARD No 28 URGENT AREA RUNNER

Health Care Support Worker (Majors/twilight)

Summary of Role
You will assist in the clearing of Majors and minors and the preparation to receive MI casualties.

You will be then be based in the urgent area (bays 1-10).
You will **circulate continuously** through the patients and clinical teams in this area. They are unable to leave their patient and will rely on you for all communication and supplies.
You will also link with the Nurse Co-ordinator (NCO) based at the nurses station.

ACTIONS
Standby
- Continue to treat/admit patients in Majors
- Await further instructions from the registered nurses

Live Phase
- Assist the registered nurse and doctor in discharging or admitting current ED patients in the minors/Majors area.
- Collect 12 urgent area equipment boxes from the MI cupboard. Place one in each of the 10 urgent bays, keeping 4 boxes as a buffer. As each clinical team transfers their patient they will hand you a used box. Place a new box into the area and restock the used box ensuring that you always have a stock of new boxes to hand out as required.
- Circulate continuously through the areas ensuring that each clinical team with a patient has contact with you regularly (minimum of every 3-5 minutes)
- You may be asked to:
  - Locate the ED Medical Co-ordinator (MCO) and direct him to clinical teams requiring advice
  - Collect drugs and IVIs from the drugs nurse (based in resus)
  - Collect additional supplies from within the ED
  - Communicate with the NCO (based at the nurses station)
  - Deliver x-ray cards to the NCO

Do not leave the urgent area until you are relieved for a break or are stood down
EMERGENCY DEPARTMENT

ACTION CARD No 29 URGENT AREA RECEPTIONIST

Receptionist (on or off duty)

Summary of Role
Your role is to take additional details from all patients in the URGENT area attending during a Major Incident, booking them onto ED System and PiMs using a unique Major Incident number and printing a set of ED notes.

ACTIONS

Live Phase.

• You are based in the urgent area (trolley area 1-10).
• Collect blank Patient Information Sheets from the Nurse Co-ordinator (NCO), appendix 15.
• Each patient will already have a set of MI notes and a MI number.
• Go to each patient and record the following details on patient information sheets
  • Surname/forename
  • DOB/age
  • Address
  • GP
• Photocopy each patient information sheet as they are generated and take to the control room based in orthopaedic outpatients’ and the NCO.
• Return to reception and search for each patient on iPM. Allocate the MI hospital number if they are not known and register.
• Enter all details onto the ED computer system and print out one set of ED notes
• Place the ED notes in reception (they will later be amalgamated with the Patient Information Sheet and the Trauma Chart Copy and filed in the ED).

Patients notes will be requested (if available) by the receiving area – it is not part of your role to do this unless they are required whilst in the ED.
EMERGENCY DEPARTMENT
ACTION CARD No 30 NON-URGENT AREA NURSE
Registered Nurse (Minors)

Summary of Role
To clear Minors in preparation for expected casualties.
To then care for the NON URGENT category Major Incident patient in Minors.

ACTIONS
Standby
- In conjunction with the designated Minors SHO assess the current patients
- Inform all patients that due to a Major Incident we may need to admit them or discharge them home
- Make a list of all patients who will need admission (if we progress to the live phase) and pass to the nurse co-ordinator (NCO) (based at the nurses station in ED)

Live Phase
- Ensure Standby actions have occurred
- The NCO will arrange for admission of your patients to appropriate wards, await porters.
- Discharge all other patients home
- Give advice as required / document actions for those given care/advise including self discharge
- Patients awaiting pick-up from relatives should be discharged to the Discharge Lounge on level 2
- Collect the non-urgent area equipment boxes x 2 from the MI cupboard (this includes the Manchester Triage book)
- Prepare and check the area and equipment
- Collect extra chairs from fracture clinic waiting area if required
- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- All patients will receive a secondary triage by you using the Manchester triage system on arrival in the non-urgent area. This will determine the queue order in which the SHO will see them
- All patients MUST receive a set of baseline observations, GCS and pain score by the non-urgent nurse or SHO
- Patients can be triaged, examined and treated in any appropriate area of the Minors (bay bed, bay chair or side room)
- Request additional equipment/staff/specialist skills via non-urgent runner (who will request from NCO)
- If any patient deteriorates and needs to be transferred into the immediate/urgent area inform the NCO via your runner. Notify the ED Medical co-ordinator (MCO) of any patient you are concerned about
- If you require IVI fluids verbally request via your runner
- If you require drugs (including CDs) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner. The CD book for signatures for administration is in resuscitation room, this should be completed as soon as possible.
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc.
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. Ensure the patient is taken to x-ray in Phase 2 (room 14). A copy of the x-ray card MUST go with the patient if admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy)
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Await porters, who will arrive when it is your turn for transfer.
- Restock your equipment levels continually using your runner
• If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the MCO will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)

• If you need to admit a patient and there is only 1 registered nurse in the non-urgent area request additional staff. **Transfer** the patient with all paperwork apart from a copy of the trauma chart). As you are leaving hand the trauma chart copy to the NCO.

• **Patients being discharged home MUST be assessed by the MCO prior to leaving**

• **As each patient is discharged send a copy of the trauma chart to the NCO**

Do not leave the non urgent area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 31 NON URGENT AREA DCOTOR

ED Doctor (Minors)

**Summary of Role**
To admit or discharge existing patients from Minors and to prepare the reception of non urgent casualties.
To receive, assess and treat all patients in the non urgent area, discharging ONLY after the ED Medical Co-ordinator (MCO) has assessed the patients.

**ACTIONS**

**Standby**
- Assess all current Minors patients and inform the non urgent nurse which patients would require admission (in the event of progression to the live phase).

**Live phase**
- Ensure all actions in ‘Standby’ above are completed
- The ED nurse co-ordinator (NCO) will arrange for admission of your patients to appropriate wards
- Discharge all other patients home:
- Give advice as required and document actions for those given care/advise including self discharge
- Assist the non urgent nurse in preparing the area to receive patients
- Patients will arrive with a Major Incident wristband and notes. They will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. trauma chart, x-ray and path forms etc)
- The registered nurse will place patients in a queue order for you to assess
- All patients MUST receive set of baseline observations, GCS and pain score by the non urgent nurse or SHO
- Patients can be triaged, examined and treated in any appropriate area of the Minors (bay bed, bay chair or side room)
- Request any additional equipment, staff or specialist skills via the non urgent runner (who will request from the NCO)
- If any patient deteriorates and needs to be transferred into the immediate/urgent area inform the MCO via your runner. Notify the MCO of any patient you are concerned about
- All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc. Ensure you sign the CD book if appropriate (in the resuscitation room)
- Treat minor injuries as rapidly as possible.
- Plaster suspected fractures and ask them to re-attend the next day.
- Ask patients who require further treatment to re-attend in the next day or two (ring first for an appointment time).
- Request ALL x-rays/scans on the x-ray form. Give the form to your runner. The MCO will then identify the x-rays to be done whilst in the ED and arrange for transfer to x-ray. A copy of the x-ray card MUST go with the patient if admitted, so that any further x-rays can be done in the receiving area (Radiology will make the copy).
- Patients requiring admission will go to a ward, theatre or ITU. When treatment is complete inform the MCO, via your runner. The MCO will confirm placement and arrange transfer. Escort the patient if required.
- If your patient arrests (respiratory or cardiac) pull the emergency bell and begin basic/advanced life support. Remain in your area and await support. (the medical co-ordinator will respond and call the cardiac arrest team if required, you will then get a medical and anaesthetic response)
- Patients being discharged home MUST be assessed by the MCO prior to leaving
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

- Inform the MCO if Minors is full and over-spill to SSEU and then Plastics Outpatient Department for non urgent patients is likely/indicated. (Liaise with Plastic Outpatient Department see Action Card 1 Plastic Outpatient Reception)
- Do not leave the non urgent area until you are relieved for a break or told to stand down

Use the MCO for any clinical or patient management advice.

NB:
In the event of a Major Incident you may have to treat a large number of injured patients in a short period of time. Be wary of “well” patients who may have serious underlying pathology.
EMERGENCY DEPARTMENT

ACTION CARD No 32 NON-URGENT RUNNER

Health Care Support Worker (Minors)

Summary of Role
You will assist in the clearing of Minors and the preparation to receive MI casualties

You will be based in the non urgent area (Minors).
You will **circulate continuously** through the patients and Staff in this area. They are unable to leave this area and will rely on you for all communication and supplies.

**ACTIONS**

**Standby**
- Continue to care for patients in Minors
- Await further instructions from the registered nurse

**Live Phase**
- Assist the registered nurse and doctor in discharging or admitting current Minors patients
- You are already in the non urgent area, remain there
- Circulate continuously through the area ensuring that the nurse/s and doctor/s have contact with you regularly
- You may be asked to:
  - Locate the ED Medical co-ordinator and direct him to the non urgent area
  - Collect drugs and IVIs from the drugs nurse (based in resus)
  - Collect additional supplies from within the ED
  - Communicate with the Nurse Co-ordinator (based at the nurses station)
  - Do minor dressings/observations etc
  - Escort patients to x-ray or on admission
  - Talk to patients and reassure them
  - Make tea and coffee as appropriate

*Do not leave the non urgent area until you are relieved for a break or are stood down*
EMERGENCY DEPARTMENT

ACTION CARD No 33 NON-URGENT AREA RECEPTIONIST

Receptionist (off duty)

Summary of Role
Your role is to take additional details from all patients attending in the NON URGENT area during a Major Incident, booking them onto ED system and iPM using a unique Major Incident number and printing a set of ED notes.

ACTIONS
Live Phase.

• You are based in the non-urgent area (Minors).
• Collect blank Patient Information Sheets from the ED Nurse co-ordinator
• Each patient will already have a set of MI notes and a MI number
• Go to each patient and record the following details on patient information sheets
  • Surname/forename
  • DOB/age
  • Address
  • GP

• Photocopy each patient information sheet as they are generated and take to the control room based in orthopaedic outpatients’ and the NCO based in ED.
• Return to reception and search for each patient on iPM. Allocate the MI hospital number if they are not known and register.
• Enter all details onto the ED computer system and print out one set of ED notes
• Place the ED notes in reception (they will later be amalgamated with the Patient Information Sheet and the Trauma Chart Copy and filed in the ED).
• You will receive information from the Minor Injury Overspill area which will need to be logged on the patient information sheets.

Patients notes will be requested (if available) by the receiving area – it is not part of your role to do this unless they are required whilst in the ED.
Summary of Role
To receive extra pharmacy supplies of emergency drugs
To prepare drug therapy and intravenous infusions

Standby
- Collect the drugs keys from the nurse co-ordinator (NCO) (based at the nurses station)
- Collect drugs required from other drug storage areas (i.e. anti-tetanus etc)
- Collect 20 x 1 litre Hartman’s from the store cupboard
- Collect 1 box of 5, 10 & 20 ml syringes and green needles from the store cupboard
- Collect a stock of kidney bowls
- Proceed to the resuscitation room
- Unlock drugs cupboards and drugs fridge
- Ensure you have adequate intra-venous analgesia, anaesthetic and other relevant drugs i.e. anti-tetanus vaccine
- Inform the NCO if you require additional supplies

Live phase
- Ensure the actions in the Standby above have been completed.
- Request the Immediate area runner to collect 4 units of O negative blood in a cool box from the Blood Bank.
- Store the O negative blood appropriately when it arrives, do not run it through giving sets.
- Run 5 litres of Hartman’s through blood giving sets, and maintain this level during the MI.
- Runners will request drugs and fluids from you.
- Drugs – details of drug name and dose will be written on a kidney bowl, which will also have a patient MI identification sticker (contains the patient MI number).
- Dispense drugs and mixer solutions (H2O etc) into the kidney bowl. Do not open vial or mix the drugs. Place appropriate syringes and needles into the bowl and give to the runner.
- In the case of controlled drugs, dispense as above documenting the patient MI number in the CD book. Also document the dose (vial dispensed), date, time and sign in the “checked by” column.
- When clinical teams have completed care and transferred the patient they will arrive to sign the CD book (actual dose given, any additional/altered times, signature for “given by” and signature for “checked by”).
- IVI’s and O negative blood – requests will be verbal. Give the runners the appropriate IVI run through a BLOOD giving set or O negative blood with BLOOD giving set in packaging.
- When you have been stood down return any unused O negative blood and ensure that all CDs dispensed have been signed for in the CD book. Inform the NCO if there are any CDs unaccounted for.
- Do not leave your area until you are relieved for a break or told to stand down.
EMERGENCY DEPARTMENT

ACTION CARD No 35 EXIT RECEPTIONIST RUNNER

HCSW (off duty) / ADMIN staff (on/off duty)

Summary of Role
You will assist the exit receptionist in monitoring and logging the exit and re-entry flow of major incident patients.
You will be stationed at the exit fire doors between the SSEU area and main hospital street level 3.
You are to report to EXIT AREA RECEPTIONIST for duties.

ACTIONS

Standby or Live Phase

- Set up a station/check point at exit between SSEU and level 3 hospital street.
- Prevent any other unauthorised persons entering the ED, report to ED Nurse Co-ordinator (NCO) any concerns.
- Assist exit receptionist role in monitoring all MI patient movements in and out of the ED.
- Photocopy updated exit log twice every 15 minutes
- Distribute exit log information to the NCO and Control room 1 every 15 minutes
- Do not leave the exit area until you are relieved for a break or told to stand down
SAUSBY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

EMERGENCY DEPARTMENT

ACTION CARD No 36 EXIT RECEPTIONIST

Receptionist (off duty)

Summary of Role
You will monitor and log the exit and re-entry flow of major incident patients.
You will be stationed at the exit fire doors between the SSEU area and main hospital street level 3.
You are to report to the ED Nurse Co-ordinator (NCO) via exit receptionist runner.

ACTIONS
Standby or Live Phase
• Collect the MI exit reception log from the NCO based at the nurses station.
• Set up a station/check point at exit between SSEU and level 3 hospital street.
• Prevent any other unauthorised persons entering the ED, challenge all staff to produce hospital ID if not displayed.
• Report any concerns to NCO.
• Monitor all non-MI patient movements in and out of the ED.
• Monitor all MI patient movements in and out of the ED.
• Maintain a current exit log of all MI traffic detailing:
  • MI number
  • Surname (if known)
  • Forename (If known)
  • DOB (if known)
  • Destination
  • Time of exit
  • Time of return (if leaving department for investigation)

• Ensure all patients have a MI identification wrist band number in place
• Distribute exit log information to the NCO and Control room 1 every 15 minutes using the exit area receptionist runner to make copies
• Do not leave the exit area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 37 NON - URGENT RUNNER PLASTIC OUTPATIENT DEPARTMENT

HCSW (off duty) / ADMIN staff (on/off duty)

Summary of Role
You will assist in the clearing of Plastic OPD in preparation to receive MI casualties.
You will be based in Plastic OPD.
You will report to the SENIOR NURSE Plastic OPD.
Your main role is to provide a direct communication link between the senior nurse in Plastic OPD and the ED Nurse Co-ordinator (NCO)

ACTIONS
Standby
Report to senior nurse Plastic OPD.

Live phase
Assist the senior nurse in Plastic OPD to clear the department.
Assist nursing staff to set up treatment station.

• You may be asked to:
  • Report to the ED Medical Co-ordinator (MCO)
  • Communicate with the NCO (based at the nurses station)
  • Photocopy (2 copies) and communicate up to date MI patient information sheets (prepared by the Plastic OPD receptionist) together with updated patient tracker form (prepared by Plastic OPD SENIOR NURSE) to the ED NCO and control room 1 every 15 minutes
  • Collect drugs and IVI’s from the drugs nurse (based in resus)
  • Collect additional supplies from within the ED
  • Do minor dressings/observations etc
  • Escort patients to x-ray or on admission
  • Talk to patients and reassure them
  • Make tea and coffee as appropriate

• Do not leave the exit area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 38 NON URGENT RECEPTIONIST (Plastic OPD)

Receptionist off duty

Summary of Role
Your role is to take additional details from all patients attending in the NON URGENT area during the major incident.
You are to report to ED Nurse Co-ordinator (NCO) via (NON-URGENT RUNNER Plastic OPD).

ACTIONS
Live Phase

• You will be based in the non-urgent area (Plastic OPD)
• Collect Patient information sheets/tracker forms from the NCO via the (NON-URGENT RUNNER Plastic OPD).
• Each patient will already have a set of MI notes and a MI number
• Go to each patient and record the following information on patient information sheets
  • Surname
  • DOB/age
  • Address
  • GP
• Photocopy each patient information sheet every 15 minutes and take a copy to control room 1 via the (NON - URGENT RUNNER Plastic OPD)
• Take the original to the Senior Nurse (Plastic OPD)
• Collate all patient tracker sheets and return to Action Card Holder 33.
• Maintain an exit log record of all patients leaving the area (Appendix 16).

Patients notes will be requested (if available) by the receiving area – it is not part of your role to do this unless they are required while in the (Plastic OPD)

Do not leave the exit area until you are relieved for a break or told to stand down
EMERGENCY DEPARTMENT

ACTION CARD No 39 NON URGENT AREA NURSE (Plastic OPD)

Registered Nurse (off duty)

Summary of Role
To help clear Plastic OPD in preparation for expected causalities.
To then care for the NON URGENT category major incident patients in the Plastic OPD

ACTIONS
Live Phase

• You will be based in the non-urgent area
• You are required to utilise your ED assessment and treatment skills as appropriate and act as a link between Plastic OPD and ED
• Assist nurse in charge of TREATMENT TEAMS (Plastic OPD) to set up treatment station, and retriage patients
• Check adequate oxygen, suction and emergency resuscitation equipment available and working
• Equipment from non urgent major incident box (hamper) should be set out on a trolley
• Spare trolleys/chairs may be found in other clinic rooms in the department
• Re-triage all patients as they arrive using ‘Manchester Triage’ system to assess which receive priority treatment
• Patients will arrive with a major incident wristband and notes; they will be identified by a MI number only. The MI notes contain all the forms you will require (i.e. Trauma chart, x-ray and path forms etc)
• All patients MUST receive a set of baseline observations, GCS and a pain score by the non-urgent nurse or SHO
• Patients can be triaged, examined and treated in any appropriate area of Plastic OPD (bay bed, bay chair or side room)
• Treat patients in collaboration with medical staff
• Request additional equipment/staff/specialist skills via the non-urgent runner (who will request from ED Nurse Co-ordinator (NCO))
• If any patient deteriorates and needs to be transferred into immediate/urgent area inform the NCO via your runner. Notify the ED Medical Co-ordinator (MCO) of any patient you are concerned about
• If you require IV fluids verbally request via your runner
• If you require drugs (including CD’s) write the details (drug name and dose) on a kidney bowl. Place a patient MI sticker on the kidney bowl and give to the runner. The CD book for signatures for administration is in the ED resuscitation room, this is to be completed as soon as possible
• All drugs/fluids etc must be prescribed on the trauma chart prior to administration and clinical staff hold responsibility for checking that the patient is receiving the correct drugs/blood etc
• Request ALL x-rays/scans on the x-ray form. Give the form to the runner. The MCO will then identify the x-rays to be done in Radiology B (Room 14). A copy of the x-ray card must go with the patient if admitted, so that any further x-rays can be done in the receiving area (Radiology will make a copy)
• Patients requiring admission will go to a ward, theatre or ITU. When treatment is completed inform Site via your runner, based in orthopaedic outpatients reception. Site will confirm patient placement. Request porters to collect patient via control room 1.
• Restock your equipment levels continually using your runner
• If your patient arrests (respiratory or cardiac) pull the emergency bell and alert the cardiac arrest team on 2222 begin basic/advanced life support. Remain in your area and await support
• If you need to admit a patient transfer with all the paperwork, inform the SENIOR NURSE (Plastic OPD) as you leave so that the patient TRACKER form can be completed
• Patients being discharged must be assessed by the MCO prior to leaving

Do not leave the NON-URGENT (Plastic OPD) area until you are relieved for a break or told to stand down
Major Incident

ACTION CARDS

Anaesthetics / ITU
ANAESTHETICS

ACTION CARD No 1 ON-CALL CONSULTANT ANAESTHETIST (ANAESTHETIC TRIAGE OFFICER)

This is not a treatment role

Summary of role
To co-ordinate deployment of Anaesthetic staff between ITU, ED and Theatres.
You have been notified by Switchboard that a major incident has occurred.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Anaesthetic Registrar Anaesthetic Admin Co-ordinator</td>
<td>ED</td>
<td>MCO in ED</td>
</tr>
</tbody>
</table>

ACTIONS

- Initiate call in of Anaesthetic staff and administration staff. Delegate this responsibility to the admin co-ordinator (Action Card No. 4) and proceed to hospital. All anaesthetic staff to report to anaesthetic office.
- Nominate a consultant colleague to take up role of anaesthetist in charge for theatres.
- Proceed to ED and liaise with the ED Co-ordinator (ED Consultant) and Surgical Triage Officer (Surgical Consultant). Pick up your tabard from the ED Nurse Co-ordinator.
- Contact the Anaesthetic office, ext 2050 and advise them of where to deploy staff. Ensure that the appropriately skilled number of anaesthetists are in ED. You can also expect requests for staff from ITU, Theatres, Recovery and Laverstock Ward.
- Co-ordinate the resuscitation of patients, liaise with the Surgical Triage Officer and decide the order of priority with which patients should be sent to Laverstock, Theatres, Recovery and ITU.
- Liaise with the Medical Director in Control Room 3, ext 4179, and advise of your progress or any special needs, e.g. locum staff.
- Ensure that you are the person that communicates between the ITU Consultant, Control Room and Consultant in charge of Theatre (Anaesthetic Consultant), so everyone gets the same information.
- Pivot role in communication (See example below).

- Consider the possibility of running DSU theatres for emergencies and delegate staff accordingly.
- After the major incident has finished, stay behind and ensure that adequate staffing is available to cover the next few days.
A major incident has been declared.

Summary of role

The Duty Anaesthetic Consultant has assumed the role of Anaesthetic Triage Officer, and is based in the Emergency Department.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetic admin co-coordinator</td>
<td>Anaesthetic Office</td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to the Anaesthetic Office
- There you will receive instructions via the Duty Registrar or Deputy on where you are most needed.
- You may be volunteered/nominated by on-call consultant to take over role of Consultant in charge of Theatre.
A major incident has been declared.

**Summary of role**
Co ordinate the running of the theatre department, communicate with anaesthetics, ITU and ED.

**Communications Summary:**

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetic admin co-ordinator</td>
<td>Anaesthetic office</td>
<td>On-call consultant anaesthetist</td>
</tr>
</tbody>
</table>

**ACTIONS**

- This will primarily be a co-ordinating role.
- Assess the number of theatres that can run and deploy anaesthetic staff accordingly
- Co ordinate with the ITU Consultant
- Co ordinate with the On call consultant anaesthetist (based in ED) regarding staffing needs etc.
- Standby arrangements for emergency obstetrics

- NB. Recovery area will be required for ITU overspill patients. Anaesthetic rooms may need to be used to recover patients.
A major incident has been declared.

Summary of role
To co ordinate call in of anaesthetic staff after liaising with on call consultant anaesthetist.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call Consultant Anaesthetist</td>
<td>Anaesthetic Staff</td>
<td>Anaesthetic Office</td>
<td>On call Consultant Anaesthetist</td>
</tr>
</tbody>
</table>

ACTIONS

- This will primarily be a communication role.
- Consult with the on call consultant anaesthetist regarding call-in of staff.
- Ensure that staffing levels are maintained in all areas.
- Provide administrative/general support including telecommunications and act as a liaison link for other departments to communicate with.
- Ensure telephone communication is covered at all times; e.g. divert calls to Main Theatre Department should you need to leave the department.
ANAESTHETICS

ACTION CARD No 5 ON-CALL INTENSIVE CARE CONSULTANT

Summary of role
To co ordinate the running of ITU, communicating with Theatres, ED and Anaesthetics.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetic admin co-ordinator</td>
<td>Radnor Ward</td>
<td>On call Consultant Anaesthetist</td>
</tr>
</tbody>
</table>

- Attend Radnor Ward.
- Identify existing Radnor patients who could be discharged to the medical/ surgical ward and inform Radnor sister.
- Notify the site co-ordinator on bleep 1312 and the on-call consultant anaesthetist in the emergency department of the available capacity on the critical care unit.
- Nominate an Intensive Care Consultant colleague to be responsible for a second critical care unit to be set up in recovery. (Theatre patients will be induced in theatre and recovered in the anaesthetic rooms)
- Liaise with
  - the Recovery Consultant Intensivist
  - the two co-ordinating Consultant Anaesthetists, based in theatres and ED
  - the ED Department Co-ordinating Consultant
  - Control Room 1
  - Use runners, the phones will be busy.
- Assess severity/nature of incident and direct trainee staff accordingly
- In a protracted response, make plans to minimize the development of emotional and physical fatigue in clinical staff.
ANAESTHETICS

ACTION CARD No 6 RECOVERY UNIT CONSULTANT INTENSIVIST

Summary Of Role
Being responsible for a second intensive care unit, which needs to be set up in Recovery.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call Consultant Anaesthetist</td>
<td>Theatres Recovery area</td>
<td>On call Consultant Anaesthetist</td>
</tr>
</tbody>
</table>

ACTIONS

• You have been nominated by the Radnor Consultant to be responsible for a second Intensive Care Unit which needs to be set up in Recovery.

• Prepare the recovery room to provide critical care for admissions from theatre and ED. The following will be required:
  • Nurses will be called in by Radnor nursing staff
  • Ventilators and monitors may be moved from the anaesthetic rooms in main theatres
  • Pumps can be requested from the equipment library and from Radnor

• Liaise with:
  • The Radnor Consultant Intensivist
  • The two co-ordinating Consultant Anaesthetists, based in theatres and ED

• Assess severity/nature of incident and direct trainee staff accordingly
• In a protracted response, make plans to minimize the development of emotional and physical fatigue in clinical staff.
Radnor Ward - Intensive Care & High Dependency Unit

ACTION CARD No 7 SENIOR NURSE IN CHARGE OF RADNOR WARD/INTENSIVE CARE & HIGH DEPENDENCY UNIT

Summary of Role
To co-ordinate deployment of nursing staff between Radnor Ward and Theatre Recovery critical care facilities.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Site Co-ordinator</td>
<td>Radnor Nursing Team</td>
<td>ICU/HDU</td>
</tr>
</tbody>
</table>

**ACTIONS**

- Liaise with the on call Consultant Intensivist to identify existing Radnor patients who could be discharged to medical/surgical ward areas.
- Liaise with the Clinical Site Co-ordinator on bleep 1312 to arrange transfer of the above patients to identified ward locations where possible. Inter-hospital critical care patient transfers are unlikely to be undertaken initially as local ambulance crews will be deployed to the site of the major incident.
- Nominate a Sister/Senior Staff Nurse colleague to act as Nurse Co-ordinator for a satellite critical care facility to be temporarily established in Theatre Recovery. Theatre patients will be induced in the Operating Theatre and recovered in the Anaesthetic Room. Additional mechanical ventilators and patient monitoring equipment may be obtained from Anaesthetic Rooms in Main Theatres. Additional infusion pumps and syringe drivers may be obtained from the Medical Device Management Centre.
- Liaise with the Senior Nurse in charge of Theatre Recovery/Main Theatres Nurse Co-ordinator to identify Nursing Staff and Operating Department Practitioners to assist in providing care for additional critical care patients.
- Instruct Nursing Staff to expedite the transfer of identified patients to ward areas and Theatre Recovery as appropriate. Where reasonably possible most level 2 (high dependency) patients will be cohorted in Theatre Recovery and most level 3 (intensive care) patients will be cohorted in Radnor Ward.
- Initiate call in of additional Nursing Staff, Support Workers, Technician Support and Administrative Staff as required. Ensure sustainability of service particularly during 24-48 hour period following the major incident. Deploy available staff between both critical care facilities as most appropriate.
- Continue to liaise with the Radnor Consultant Intensivist, Theatre Recovery Consultant Intensivist and Theatre Recovery Critical Care Nurse Co-ordinator regarding critical care patient admissions, transfers and discharges.
- Keep Control Room 1 apprised of the critical care bed state of both Radnor Ward and Theatre Recovery via the Site co-ordinator.
Major Incident

ACTION CARDS

Control Room
ROLE OF THE CONTROL ROOM IN A MAJOR INCIDENT

Co-ordination of Hospital response to a Major Incident. Liaison with Major Incident command Structures (i.e. Gold and Silver Command). Facilitation of the deployment of staff. Liaison with the scene’s Ambulance Headquarters via the Ambulance Hospital Control Officer in the control room. Planning for the consequences of the Major Incident, e.g. staffing, cancellation of elective operations etc.

It will be staffed by:
1. Medical Director (Major Incident control room 3)
2. Nursing Manager (Major Incident control room 3)
3. Duty Manager (Major Incident control room 1)
4. Chief Executive (Major Incident control room 1)
5. Clinical Site co-ordinators (Major Incident control room 1)
6. Facilities Manager (Major Incident control room 1)
7. Ambulance Hospital Control Officer (HACO)+ radio and telephone (Major Incident control room 2)
   NB. This role is also known as the Ambulance liaison officer
8. Police Documentation Team (Major Incident control room 2)
9. Loggist (see appendix 23 for details of loggist pool)

Supported by:
Patient Trackers and Runners (Major Incident control room 1)

To facilitate the actions of the control room team the area designated for the team is within the orthopaedic outpatient department. This template allows for a meeting area within the waiting room template where there is a television. The television has access to Freeview with BBC News 24 and Sky News to ensure the team are able to keep up to date with the live situation. In addition there are designated breakout rooms as allocated above for members of the control room team where discussion and decision making can take place in a quieter reflective environment.

Broad explanation of roles: -
Medical and Nursing Directors co-ordinate the clinical response including allocating staff.

Clinical Site co-ordinators maintain record of available beds and allocate beds for patients. A site co-ordinator is permanently based in control room 1.

Duty Manager and Chief Executive co-ordinate non-clinical staff resources, manage Hospital capacity and manage external communications. The Duty manager will also liaise with Gold Command.

The Facilities manager will ensure liaison between facilities services and integration of the facilities response into the overall Trust response.

HACO manages patient transport in and out of the hospital.
Police Documentation Team manages Patient identification and relatives enquiries.

Loggist - The role of the loggist is a vital one to ensure that decisions made during any meeting are accurate records against the information available at the time, provided the Trust with a log of who did what, when and why.

Further Important Information:
The link below will take you to the HPA Deliberate and Accidental Release webpage’s http://www.hpa.org.uk/infections/topics_az/deliberate_release/defaultDAR.htm
The link below will take you to the Initial Investigation and Management of Outbreaks and Incidents of Unusual Illnesses - A Guide for Health Professionals, the new version 4.0, 19 November 2007 is available at: 

Sub-documents for specialist professions, extracted from the full document, are also available for each of the following:

- Ambulance service
- Hospital clinicians, including Emergency Departments
- General Practitioners
- Occupational Health Services (New!)
- Histopathologists and Anatomical Pathology Technologists
- Local laboratories
- Public Health professionals
CONTROL ROOM

ACTION CARD No 1 MEDICAL DIRECTOR (OR DEPUTY, WHO WILL BE THE DUTY SURGICAL / MEDICAL CONSULTANT)

Summary of Role
Monitor the medical response to the Major Incident. Facilitate the response where necessary. Co-ordinate the deployment of medical staff.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Manager or Switchboard</td>
<td>Control Room 3</td>
<td>Duty Manager</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to Control Room 3 (in the orthopaedic outpatient department level 3) collect Control Room 3 folder and assume your role.
- Maintain a log of all your main decisions. A file will be provided for this purpose in the control room 3 folder, further copies can be found at Appendix 6.
- Your room is Major Incident control room 3
  - Telephone lines 01722 410079
  - 01722 410083
  - Internal ext. 4179
- You will be joined in control room 3 by the Nursing manager.
- Establish the type of Incident – see Sections 11 and 12, page 12 in the introduction to this policy.
- Ensure that the appropriate receiving speciality(ies) are identified and the response tailored appropriately.
- Monitor situation in ED, Theatres, Laverstock, Outpatients and Laboratories.
- Send additional staff to where they are required, (this should happen automatically).

Note that medical staff will report to the following areas to await deployment:
- Anaesthetists will report to the Anaesthetics office.
- Surgeons will all report to Control Room 3 or Laverstock as specified on individual action cards.
- Physicians will report to MAU.
- Paediatricians will report to Sarum.

- Respond to requests for additional specialist staff, liaise with Control room 1 (extension 4178 for broadcast messages to be undertaken requesting Trust wide help, if deemed appropriate).
- Monitor patient flow (Patient Trackers) and bed state (Site co-ordinator) and on scene activity Hospital Ambulance Control Officer (HACO)
- Advise HACO if this Hospital is no longer able to take any further patients. (He/she will also be advised by the Ambulance Liaison Officer in ED)
- Facilitate in the transfer of patients to other Hospitals (liaise with the General Managers and HACO)
- Authorise the dispatch of a mobile medical team if requested. Liaise with the ED Nurse co-ordinator.
  N.B. SDH should not normally send a mobile medical team if it is the receiving hospital.
- Advise Press Liaison Officer concerning press briefs.
- Ensure Senior Doctors have adequate staffing levels for at least the next 24 hours.
- Authorise exception costs as necessary, e.g. for locum staff, equipment, etc.
- Consider cancelling routine operations/admissions for following week, depending on degree of disruption. (Do this in conjunction with the Theatres Manager and Duty Surgical Consultant).
- Remain in Hospital subsequent to Incident stand down in order to manage continuing demands on resources for discharges/transfers.
CONTROL ROOM

ACTION CARD No 2 NURSING DIRECTOR OR DEPUTY (e.g. Directorate Senior Nurse (DSN))

Summary of Role
You will be notified by the duty manager or Switchboard that a Major Incident has occurred and the nature of the Incident.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Control Room 3</td>
<td>Duty Manager</td>
</tr>
</tbody>
</table>

ACTIONS

- Maintain a log of all your main decisions. A file will be provided for this purpose in the control room 3 folder, further copies can be found at Appendix 6.
- Proceed to the Major Incident control room 1 (In the orthopaedic outpatient suite level 3) collect control room 3 folder and assume your role.
- Your room is Major Incident control room 3
  Telephone lines 01722 410079
  01722 410083
  Internal ext 4179
- You will be joined in control room 3 by the Medical Director manager.
- Familiarise yourself with the content of the Major Incident Plan.
- The DSN in charge for calling out staff will handover the current staffing status on your arrival at the hospital.
- Control Room 3 is the call-in point for all general nursing staff and medical staff.
- The voluntary services manager will request volunteers to report to you for deployment where appropriate.
- ITU and Theatre staff will go directly to their own departments.
- Liaise with senior nursing staff in ED, ITU, Laverstock and all relevant wards and ensure that there are adequate staffing levels.
- Ensure the posts of Nurse in Charge Discharge lounge and Nurse in Charge of Relatives in Hedgerows are filled. *(Ensure the DSN's are attached to the appropriate areas during the course of the major incident).*
- ED may ask you to assist with their call in of staff.
- Link with Socials services and inform them of the Incident – they may be able to support relatives in hedgerows and/or help release capacity through expedited discharge.
- Ensure that senior nursing staff have addressed staffing needs for the following 12 hours at least.
- Authorise exception costs as required, e.g. agency staff, equipment, etc.
- Direct Runners as required.
- Remain at the Hospital subsequent to stand down in order to manage continuing demands on resources for discharge/transfers.
CONTROL ROOM

ACTION CARD No 3 DUTY MANAGER

You link with ED Senior Nurses and doctors to assess the situation and declare the Major Incident live if this is the decision
You prime role is to manage capacity (creating it where possible) within the hospital. You will be the link between theatres/wards etc and ED – transfers will be routed through you.

Summary of Role
You have been notified by Switchboard that a Major Incident has occurred.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You inform – Once the Incident is live:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>In hours - resuscitation officer</td>
<td>Control Room 1</td>
<td>Gold Command</td>
</tr>
<tr>
<td>Press liaison officer – a senior manager tasked to support the press officer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS

Standby
- Open the Major Incident Folder in the duty manager’s bag (replicated in ‘control room’ box in the Major Incident cupboard adjacent to the relatives room see floor plan appendix 24). If you are a Directorate Manager on-call as Duty Manager, call out the next available Manager on the list before leaving home/office. Ask them to take on the ‘normal’ Duty manager role/Major Incident lead dependant on distance from Trust.
- Switchboard will ensure the following Major Incident roles are filled:
  - Medical Director or Consultant Physician or Consultant Surgeon
  - Nursing Manager or next Directorate Manager/Directorate Senior Nurse
  - Chief Executive or On-call Executive Director
- Proceed to ED major incident cupboard (key in ED reception) and collect the ‘Green storage box’ & ‘Telephone Box’ which hold all the equipment/folders for the control rooms – there is a map of the control rooms layout in your box file. The cupboard is found next to ED reception/ambulance entrance. The access code for the orthopaedic outpatient department can be found in Control Room 1 box file.
- Set up the control rooms in the orthopaedic outpatient department level 3 referring to the Plan in your file
- Get an accurate bed state from the clinical site team
- Check with the clinical site lead that Laverstock is being cleared ready to take admitted MI patients.
- If it is this Trust declaring a Major Incident Page the Wiltshire emergency planner – Pager Number in telephone list
- You will be joined in control room 1 by the Chief Executive
- Familiarise yourself with the content of the plan
- Liaise with colleagues as they arrive and divide up tasks
- In consultation with the Medical Director and ED Medical co-ordinator (MCO) establish/agree the type of Incident – see section (11 & 12) of the introduction to this plan
- In consultation with the control room team and the MCO determine if the Incident should be declared LIVE - if yes inform Switchboard to call in staff from their list. If no - inform switchboard.
- If GWAS have declared STANDBY you can obtain updates by phoning 0800 2215 354 and stating our unique identify number 9664 (details are available in Control Room 1 box file).
Live phase

- Communicate with ED ONLY via the ED cordless phone that will be held by the ED Nurse Coordinator (NCO) **Extension Number: 4156**
- Allocate a senior manager as Press Liaison Officer.
- Keep up to date with casualty numbers and where they are in the Hospital. This information will be collated by two Patient Trackers, and displayed on a white board.
- Keep up to date with the bed state (liaise with Site co-ordinator based in control room 1).
- Keep Gold command informed regarding hospital capacity particularly with reference to specialist beds – burns/ITU etc. Alert Gold Command as capacity becomes near to fully utilised.
- Alert the senior mortuary technician that a Major Incident has occurred (via switchboard out of hours) and inform them of the likely mortuary capacity required.
- Facilitate transfer of patients to other Hospitals (liaise with Medical Director/Nurse Director).
- Ensure that the Control Room has at least two Runners. If none are immediately available then nominate suitable staff.
- If volunteer groups would be helpful (e.g. St John's Ambulance Brigade, WRVS) liaise with Gold command and request same.
- Organise a Relief Duty Manager in the event of a prolonged Major Incident.
- Prepare an Incident summary in conjunction with your colleagues.
- If GWAS have declared LIVE you can obtain updates by phoning 0800 2215 354 and stating our unique identify number **9664** (details are available in Control Room 1 box file)

Stand-down

- Remain in the Hospital subsequent to the 'Incident Stand Down' in order to manage continuing demands on resources for discharge/transfers.
- Call together key managers the day following the Incident to plan recovery and return to normal – ensure that this meeting goes ahead with a full and current hospital status report:–
  - Bed No’s
  - Theatre capacity
  - Any pertinent staffing issues
  - Cancellations needed etc
- Ensure all expenditure is correctly coded to the emergency planning code – 154750/749203.

Contamination Incident

In the event of a contamination Incident with any form of local decontamination – beit of people or other facilities the Environmental Protection Agency should be contacted by the Duty Manager to invite them to attend.

**In Event of CRBNE Incident Declared:**

Inform Consultant in Communicable Disease Control (CCDC) at the Public Health protection Unit, via medicom on (Local Number).

Inform Police of CRBNE Incident
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

CONTROL ROOM

ACTION CARD No 4 CHIEF EXECUTIVE OR DEPUTY

Communications:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Manager or Switchboard</td>
<td>Control Room 1</td>
<td>Duty Manager</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to Control Room 1 (In the orthopaedic outpatient department level 3)
- Familiarise yourself with the folder and content entitled ‘Chief Executive’.
- Contact the Wiltshire On-call emergency planner via their pager.
- Liaise with your counterpart in other Hospitals involved in the Major Incident.
- Ensure that SWPCT and the StHA are informed of the Trusts’ Major Incident status – standby/live/stand-down and of any moves from one status to another.
- Assess the impact on the Hospital function over the next few days.
- Help prepare press statements with the Press Liaison Officer and the Medical Director.
- Prepare an Incident summary with the rest of the Control Team, which will include any outstanding issues and will cover any areas of the Hospital unable to return to normal work.
- Prepare for follow-up visits by the media and dignitaries.
- Maintain a log of all your main decisions. Paperwork will be included in your folder.
- After the Incident has resolved you are responsible for the debriefing/learning exercise and should arrange this with control room colleagues.
CONTROL ROOM

ACTION CARD No 5 HOSPITAL AMBULANCE CONTROL OFFICER (HACO)

Summary of Role:
It is recognised that there will be a wide range of communications requirements at the receiving hospital(s) and that it will be impossible for the ALO to undertake all of the required tasks. The HACO will therefore act as a communications link between the Ambulance Service Control Centres and the Hospital Authorities.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold Command</td>
<td>Control Room 2</td>
<td>Duty Manager</td>
</tr>
</tbody>
</table>

Your room is Major Incident control room 2

ACTIONS
- Liaise with the Hospital Medical Director and the ACC regarding the throughput of patients and any problem areas that are developing or likely to develop.
- Maintain co-operation with the Hospital Co-ordinating team in regard to the de-canting of patients to secondary hospitals, and any potential saturation in the ED Department or other areas in the hospital. Note that the Salisbury NUPT contract may not be with Wiltshire – ask for details from the Duty manager in the control room.
- Maintain liaison with the ALO as appropriate.
- Maintain records of all messages, either sent or received, including timings, etc.
CONTROL ROOM

ACTION CARD No 6 RUNNERS 1-3

Summary of Role
Act as a ‘Runner’ between Control Room 1, 2 or 3 and other areas of the Hospital undertaking duties as requested.

ACTIONS

• The Duty/On-call Manager in Control Room 1 will allocate the role and control room allocated to you.

• You will:
  - On arrival collect on-call sheet from main switchboard
  - collect information from key areas on response/special requirements
  - you will use message/reply notes (available from the Control Room)
  - report back to the Control Room
  - be prepared to undertake other duties as required
  - do not stand down until told to do so by the Duty Manager
SUMMARY OF ROLE
To maintain a log of the name and/or Major Incident number allocated to Major Incident patients and log patient journey through the hospital so that their whereabouts is known.

ACTIONS
• Receive and collate information from trackers in
  • Clinical Site Co-ordinator
  • ED
  • Plastic Surgery Outpatients (if in use for minor injuries)
  • Laverstock
  • Discharge lounge
  • Hedgerows – Customer Care Department support

• Ensure the information received is updated in the patient administration system (iPM, often referred to as PIMS).
CONTROL ROOM

ACTION CARD No 8 ORTHOPAEDIC OUTPATIENT STAFF

Summary of Role
To vacate the orthopaedic outpatient area of clinic attendances, informing the patients that a major incident has been called and that clinic appointments are having to be cancelled.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Consultant On-call /Duty Manager</td>
<td>Orthopaedics</td>
<td>Duty Manager/Director Of Nursing on completion of actions on card</td>
</tr>
</tbody>
</table>

ACTIONS

STAND-BY

1. You will have been informed that the Trust is on STAND-BY to receive a major incident. Ensure consulting room 1 is vacated (this is the room immediately opposite the reception desk) as this is control room 1 (main control room).

2. Inform patients in the waiting area that the Trust is on STAND-BY to receive a major incident and that clinic appointments may need to be re-scheduled.

3. Pull together the clinic lists for the remainder of the day and following day.

4. On confirmation that the Trust is now in the LIVE phase of a major incident, inform all patients that clinic appointments are to be cancelled. To ensure the area can be cleared quickly inform patients that another appointment will be sent in the post to them.

5. Allocate staff members to phone patients to cancel their outpatient appointment, informing them that a major incident has occurred and that the Trust is receiving causalities and outpatient clinics are being cancelled. Inform them that a further appointment will be sent through the post to them. DO NOT PROVIDE ANY FURTHER INFORMATION TO THESE PATIENTS ON THE MAJOR INCIDENT. If you are not able to contact a patient highlight this on the clinic list.

6. Ensure rooms available for use during the major incident as soon as the LIVE phase is called.

7. It may be that your staff will be required to help out in other areas of the Trust with staffing, once the above tasks have been completed and all patients contacted, inform the Director Of Nursing of available staff for deployment. If you have been unable to contact a patient, ensure a member of staff stays in the department to inform the patient of the situation.
Major Incident

ACTION CARDS

Public Relations Team
Summary of Role:
- To establish public relations team – Press Officer, Press Support Officer and a member of the Administrative and Clerical staff.
- Set up Boardroom as Media Room.
- To liaise with Trust Chief Executive, control room 1 ext 4178, Police and Ambulance officers in control room 2, ext 4172.
- To support media enquiries, requests for information and arrange/provide interviews if necessary.
- The Public should be kept informed of developments and what we need them to do through the media.
- To inform SFT staff not directly involved in the Incident of progress of the Incident via e-mail bulletins/broadcasts.

WHO:
Senior manager designated by Duty Manager pending arrival of Press Officer if senior manager arrives first.
Senior manager to take role of Press Support Officer when Press Officer arrives.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Manager / Switchboard</td>
<td>A&amp;C support staff</td>
<td>Set up press area in boardroom. You are then based in the control room</td>
<td>CEO in the control room</td>
</tr>
</tbody>
</table>

ACTIONS
- You have been informed that a Major Incident has occurred and the nature of the Incident.
- Pick up Major Incident File (Purple box file) from Control room 1 and refer to Public Relations Action Card 1.
- Call-in Administrative and Clerical support from the prepared list in the press box. (Duty Manager will have called Press Officer and one other senior manager).
- Proceed to Chief Executive’s corridor and set-up Media Room in the Boardroom. (Access via Chief Executive’s corridor, outside boardroom door opens from inside).
- One corner at back must be set aside for press conference if/when required. Update board next to this and media arranged opposite.
- Open the following offices to be used as back up for journalists to interview: Offices include:
  - Trust Chairman
  - PA to the Chief Executive
  - Trust Secretary
  - Sec to Director of Operations office for access to fax
- When press support officer arrives return to control room.
- Liaise with Chief Executive/Police/Ambulance about opening press statement and press conference.
  
  
  Please note: check whether Media Centre has been set up by Gold Command (the off site co-ordination body) to standardise messages * see additional information at end of card.

- Check to see if additional staff needed * see additional information at end of card
- Ensure press are briefed to direct all requests for information about relatives or requests by relatives for information to Police in the control room
• Continue to liaise with Chief Executive about press statements/briefings and possible interviewees such as Chief Executive, Medical Director, medical specialists.
• Use the internal email system to inform Trust staff of the Incident’s progress. Standard text for initial e-mail can be found in Major Incident Box.
• The plasma screens in clinical outpatient areas will be used to inform patients of the LIVE phase of a Major Incident and that clinic appointments will be cancelled.
• When Incident complete ensure duty manager has made arrangements to deal with press and relative’s enquiries.
• When Incident complete prepare final Press Release and prepare for any subsequent visits by media and dignitaries.
• If appropriate use the plasma screens in outpatient areas to inform patients of current situation.

• Additional information
  If called to comment/write press release, stick to facts. Do not comment outside your area ‘health’.
  - Time Incident called/ hospital alerted
  - Nature of Incident if known (car crash, plane crash, fire - not details
    - Where patients are coming from
    - How many casualties in this hospital (Check OK with Media Centre/Police)
    - Type of injuries
    - Where are patients being treated (specialist areas ITU, burns plastics)
    - What procedures in place ( calling staff in, cancelled ops, discharging non urgent)
    - How are staff coping

• Use local radio in following order to call in staff if needed.
  Spire FM 01722 416644
  BBC Wilts Sound 01793 513652
  Radio Solent 02380 631311
  2CR 01202 256256
  Vale FM 01747 855711

  “ A Major Incident has occurred. Would all Salisbury District Hospital staff please report directly to their Major Incident reporting areas without phoning the hospital.”

  If too many staff have come in:

  “No further staff are required at Salisbury District Hospital to deal with the Major Incident. Would members of staff please remain available at home if not on duty. Please do not phone the hospital.”

List of Administration staff
PA To CEO
PA to Director of operations

Stand down
Prepare a debrief for staff within a week of the Incident
### Major Incident Media Log Sheet

<table>
<thead>
<tr>
<th>CALLERS NAME</th>
<th>ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME OF CALL</td>
<td>DEADLINE</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTACT NUMBER</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DETAILS OF ENQUIRY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

RESPONSE AND TIME (Must be signed off by Press Officer)

<table>
<thead>
<tr>
<th>OTHER COMMENT/FOLLOW UP ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

CALL TAKEN BY:  SIGNED OFF BY:  

---

AUTHOR: OWEN AINSLEY  DATE OF REVIEW: March 2012  MAJOR INCIDENT PLAN

VERSION: 1.2  DATE: March 2011
Major Incident

Designated Media Areas

There are three designated areas for the Media:

- **MEDIA ROOM - The Boardroom**

  This is the media centre and acts as a holding area where information about the Incident is provided and an area where press conferences can be staged.

  _________________________________

In addition, there are two other areas where the media **UNDER SUPERVISION** are able to view and get photographs of ambulances or helicopters coming into the hospital:

- **MEDIA AREA 1 - Car Park 1 (near the Sight Centre)**

  Under supervision cameraman are able to get wide view shots of people arriving by ambulance from the vantage point of Car Park 1 (no close ups). In addition, reporters can do pieces to camera from this point or on the zigzag going down to Main Entrance.

- **MEDIA AREA 2 - Car Park 7 (Spinal Unit Car Park)**

  Under supervision cameraman are able to get wide view shots of people arriving by helicopter (no close ups).
SUMMARY OF ROLE
Act as Press Officer if Press Officer has not yet arrived. *(Follow this action card when arrive).*

Assist in the management of the press, liaise with facilities to ensure media and broadcast vehicles are positioned around The Green at Entrance B. Act as a link getting information from the control room for the Press Officer.

COMMUNICATIONS

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Manager</td>
<td>A&amp;C support staff</td>
<td>Boardroom</td>
<td>Press officer</td>
</tr>
</tbody>
</table>

ACTIONS

- You will have been called in by the Duty Manager and picked up Public Relations Team Action Card 2.
- Proceed to Boardroom and assist Press Officer in setting up for media.
- Remain in boardroom to allow press officer to return to control room 1.
- Ring switchboard and tell them that the Media Room (Boardroom) is established and to put through only MEDIA Major Incident calls. All other calls: Normal in hours 2170. Out of hours - to the clinical site team.
- Issue press with badges. Ensure media and broadcast vehicles are situated by The Green, Entrance B.
- Liaise with facilities on security to ensure journalists routed to Boardroom and not wandering around site.
- Ensure the press do not enter the main part of the Hospital UNLESS accompanied by the Press Officer or yourself.
- Liaise with press officer in control room via A&C support runner.
- Pin statement and subsequent statements to front of board, set up in boardroom, clearly marking time and date with time of next briefing
- Through Press Officer, continue to liaise with Duty Manager in control room 1 for up to date information and keep media informed
- Contact facilities manager if provisions/refreshments required
PUBLIC RELATIONS

ACTION CARD No 3 SUPPORT TO PRESS OFFICER – A&C

Summary of Role
Assist in the management of the press.
Provide support to the Press Officer and the Press Support Officer.

A Major Incident has been declared

ACTIONS

• You will have been called in by the Press Officer.
• Proceed to the Boardroom In Trust Offices.
• Make your presence known to the Press Officer and to the senior manager who is Press Support Officer.
• Provide support as requested.
Major Incident

ACTION CARDS

Customer Care Department & Bereavement
Plan for Customer Care and Bereavement Service

Summary of role

- To offer advice and support to patients, their relatives and staff
- To co-ordinate the Bereavement Service

Actions

1. Call out Customer Care and Bereavement Team – Telephone numbers to be held by switchboard.

2. Open and prepare Hedgerows (Facilities staff to do) including Hedgerows Meeting room, complaints office and Litigation office

3. Put up signs for:
   - Bereavement Office – Complaints
   - Waiting area – Canteen
   - Quiet Room – Litigation

4. Collect emergency box files from Customer Care office Level 3, which will contain:
   - Key contacts
   - Medical cards
   - GP forms
   - Patient Property forms
   - Cards for roles
   - Log sheets
   - Flow chart
   - Organ donation information and forms and Portsmouth Transplant Coordinator telephone number
   - Signs for doors in Hedgerows; Waiting area (Canteen), Reception area (Canteen), Quiet room (Litigation Office), Bereavement Office (Complaints Office)
   - A-Z Deceased folder with log forms
   - A-Z folder with patient information log forms
   - Call log folder

5. Establish contact team in Complaints office to log incoming calls via phone, fax and email (Customer Care Staff, DSN’s Senior Managers). Sequential log sheets held in emergency box. ED will fax through Up-to-date log sheets to fax number 425234 (complaints office). Children’s Unit (during office hours) will update you on children in this area with a log sheet on a regular basis.

6. Bereavement Team to: Liaise with Mortuary staff, Coroners staff, Police, Pathologists, Chaplains, Undertakers, GP’s Press Officer

7. Customer Care team to ensure log sheets are actioned/followed up

8. Establish team to break bad news:
   - Chaplains
   - Customer Care
   - Bereavement
   - Hospice Staff
   - DSN’s
   - Coroners Team
• Police

9. Obtain medical records as required (Medical Records Team)

10. Head of Customer Care to co-ordinate and support both teams
Major Incident

ACTION CARDS

Bleep Holders & Key Nursing Staff
Summary of Role
Initiate call in of nursing staff
Provide a Directorate Senior Nurse to Support relatives in the Hedgerows Coffee lounge

Communications

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Nurse in Charge Laverstock</td>
<td>Orthopaedic Outpatient Department</td>
<td>Nursing Director control room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waiting area level 3</td>
<td></td>
</tr>
<tr>
<td>DSNs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in Charge Endoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in Charge Discharge lounge</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in Charge Plastic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>outpatients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Critical Care Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team (CCOT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in Charge MAU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in Charge SAU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in Charge SAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DSU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in charge of Laverstock</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in charge Beatrice 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in charge spinal unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior Nurse theatres</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior Nurse on CCU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior Nurse in Burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in charge of Radnor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse in charge of Sarum</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You have been informed that a Major Incident has been confirmed.

ACTIONS
- Proceed to the Orthopaedic Outpatient department and control room 3, if out-of-hours the code is with the ED nurse co-ordinator. Contact the Directorate senior Nurse on duty and ask them to report to the Orthopaedic Outpatient reception area for briefing.
- Allocate one DSN to Hedgerows coffee lounge as support to relatives. If a DSN unavailable allocate a suitably senior Nurse.
• Telephone the following and ensure that they implement their ward action cards and start to call in off-duty staff,
• Whiteparish Ward – ask them to cascade to medical and elderly care wards
• Laverstock - to cascade to Surgical wards/Orthopaedics
• Beatrice 3 to cascade to Obs and Gynae
• Spinal unit
• Discharge lounge - in hours
• DSU - In hours
• Out of Hours ensure that staff are allocated to the discharge lounge as a priority
• Send one DSN or first available member of nursing staff to the residences to call in off duty staff. Key codes for the residences are available from switchboard.
• On completion of the call-out of staff, report to the Nursing Director for deployment to DSN roles not yet filled.
BLEEP HOLDERS AND KEY NURSING STAFF

ACTION CARD No 2 CLINICAL SITE BLEEP HOLDER (TITLE CLINICAL SITE CO-ORDINATOR)

Summary of Role
Provide and maintain accurate bed states to the control room

Communications

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Off-duty colleague</td>
<td>Orthopaedic Outpatients – Control room 1</td>
<td>Nursing Director control room</td>
</tr>
<tr>
<td></td>
<td>Main theatres senior practitioner on duty</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You have been informed that a Major Incident has been confirmed.

ACTIONS
- Proceed to the Orthopaedic Outpatient department and control room 1, if out-of-hours the code is with the ED nurse co-ordinator. If you are the first person to arrive at orthopaedic outpatients obtain the ‘green storage box’ from the Major Incident Cupboard in ED and return to orthopaedic outpatients.
- Go to control room 1 (plan in your box file in the green storage box) and leave the storage box in this room. Ensure your box file is handed over to your deputy on arrival.
- Using the ‘Bed State’ log in your box file to collect bed states.
- Prior to the arrival of your site-team colleague visit wards to determine current bed availability. Your deputy will bleep you on her arrival, report to Control Room 1, provide an update of the current bed status at this point and collect your portable radio.
- In HOURS a member of the medical records team will report to you/deputy in Control Room 1 - this person will be used to maintain a record of all patients associated with Major Incident, they will be based in Control Room 1.
- On arrival of your site-team colleague, continue to visit wards monitoring bed availability and update your colleague in Control Room 1 via portable radio.
- Do not stand down until told to do so.
**SUMMARY OF ROLE**
Allocate beds to those patients requiring admission
Collate and maintain accurate bed states working with the Clinical Site Co-ordinator and Patient Trackers

**COMMUNICATIONS**

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Site Co-ordinator (on-duty)</td>
<td></td>
<td>Control Room 1</td>
<td>Clinical Site co-ordinator</td>
</tr>
</tbody>
</table>

You have been informed that a Major Incident has been confirmed.

**ACTIONS**

- Collect 2 portable radio’s (1 for you, 1 for your colleague) from the site office. You should put these onto channel 4. Bleep your colleague and ask them to collect the radio from you in control room 1.

- Proceed to the Orthopaedic Outpatient department waiting area on level 3 and report to Control Room 1. Here you will find a box file for the Major incident. On arrival bleep the Site co-ordinator to confirm that you are now on-site. Your colleague will now report to Control Room 1 to collect the radio and provide latest bed states.

- In HOURS a member of the medical records team will report to you - this person will maintain a record of all patients associated with Major Incident, they will be based in Control Room 1.

- Maintain a log of all requests for inpatient admissions, allocating available beds as they come in. Ensure that ED is informed of patient placements via the NCO.

- Update the clinical site co-ordinator of patients placed.

- Continue to update the Duty Manager of the bed states using the ‘Bed state’ form in your box file.

- Ensure the patient tracker is maintaining the visible state of beds and patients in the hospital.

- Do not stand down until told to do so by the Director of Nursing.
ACTION CARD No 4 Nurse CCOT (Critical Care Outreach Team)

Summary of role
To support the care of seriously injured patients

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSN</td>
<td>Other on duty / off duty PART team members</td>
<td>Orthopaedic Outpatient department waiting area level 3</td>
<td>Clinical site Co-ordinator</td>
</tr>
</tbody>
</table>

ACTIONS
Report to the Orthopaedic Outpatient department waiting area from where the Clinical Site Co-ordinator will deploy you as needed.
Summary of Role
Clearance of LAVERSTOCK
Preparations for treatment of Major Incident patients
Treatment of Major Incident patients

Communications Summary:
You will be informed by:-
DSN

ACTIONS
• Arrange for transfer/discharge of patients. Please liaise with site for placement of those patients who are:
  • Seriously ill patients to wards in SDH North
  • Less seriously ill to any available bed
• If you require additional nursing staff to assist with clearing the ward then phone the Nursing Director in Control Room 1 on ext 4179.
• Send patients suitable for discharge home to the discharge lounge. Keep a register of discharged patients and where they were sent. If TTO’s are not available, send drug chart with patient to the discharge lounge, where a Pharmacist will arrange for TTO’s.
• Arrange for 20 made-up empty beds to be available, initially clearing additional beds, if casualty numbers dictate.
• Site will continually liaise with you for and up-to-date bed state. All moderately/severely injured Major Incident patients will come to LAVERSTOCK or ITU.
• While waiting, arrange for 2nd Nurse-in-charge to prepare trolleys for dressings and IV drips.
• Allocate one registered Nurse per bay in first instance, then one registered Nurse per patient and one Runner per bay.
• Send patients to Theatre as required and receive patients back from the Recovery Room.
• After the Major Incident has finished, send the log of discharged patients to the Major Incident Control Room.
**summary of role**
Provide staff to support Theatres/Recovery/Laverstock

In the event of discharged patients requiring nursing assistance until transport etc has arrived, provide holding accommodation for these patients. In extreme circumstances of more casualties than can be accommodated on Laverstock requiring hospitalisation, provide holding accommodation until beds can be provided or patients can be transferred to another hospital.

**communications summary:**

| You will be informed by: | DSN |

**actions**

- Send able patients home; those requiring transport should be sent to the discharge lounge level 2.
- Cancel all lists for the remainder of the day and cancel those patients who are on-site and currently waiting for their procedure.
- Patients needing to remain in Hospital should be discussed with site on bleep 1312.
- Remain in Endoscopy.
- Contact the Director of Nursing in control room 3 on extension 4179 to determine if staff are required in theatres, recovery or Laverstock, if not staff remain on unit for further instructions.
- Trolleys may be needed by ED. Contact ED Nursing Co-ordinator (identifiable by a tabard) and ask if these are required.
BLEEP HOLDERS AND KEY NURSING STAFF

ACTION CARD No 7 NURSE in CHARGE DISCHARGE LOUNGE (In-hours)
DSN (Out-of hours)

Summary of role
To accommodate patients awaiting discharge transport or TTO’s.
Provide a waiting area for Major Incident patients who sustained minor injuries and whose treatment is completed.

Communications Summary
<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You call in:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSN</td>
<td>Discharge lounge</td>
<td>HCSW/Admin to act as the Tracker for Non-MI patient discharges</td>
<td>Clinical Site lead</td>
</tr>
</tbody>
</table>

ACTIONS
1. Patients being discharged
   - Increase the available accommodation to cater for 30 patients awaiting discharge - The Nunton day hospital staff will be clearing space for you to expand.
   - Identify a member of staff to keep an accurate log of all patients arriving including where from and where to.
   - Use the Pharmacy runner supplied by the Nunton team.

2. Minor injury treated patients
   - Set up a second holding area for patients who have completed treatment and who have been sent to the discharge lounge.
   - Keep a log of all patient movements - ensure it is clear that these patients are Major Incident patients.
   - Observe these patients - any who deteriorate should be returned to ED triage.
   - Do not release these patients until authorised to do so by the Duty manager in the control.
   - Inform the control room of numbers waiting hourly.
   - If you need additional staff phone the Nursing Director in Control Room 3 on extension 4179
   - Ensure no patient leaves without a copy of the discharge summary letter (APPENDIX 22), this will be completed by the ED MCO or his deputy.

Stay in the department until stood down
BLEEP HOLDERS AND KEY NURSING STAFF

ACTION CARD No 8 PERSON IN CHARGE NUNTON UNIT (In-hours)

Summary of role
To create additional space for the discharge lounge

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSN</td>
<td>On-duty and Off-duty (if needed) members of Nunton staff</td>
<td>Nunton Unit</td>
<td>Nurse in Charge Discharge lounge</td>
</tr>
</tbody>
</table>

ACTIONS
- Send home as many patients as is possible
- Stop the attendance of patients who are yet to arrive
- Support discharge lounge staff in caring for patients who are to be discharged
- Provide a pharmacy runner to collect TTO's from pharmacy at the request of the Nurse in Charge of Discharge lounge
BEEP HOLDERS AND KEY NURSING STAFF

ACTION CARD No 9 TRACKER OF NON-MAJOR INCIDENT PATIENT DISCHARGES

Summary of role
You will be based in the Discharge Lounge and your role will be to assist in the organisation of non-major incident patients who are to be discharged or transferred to either home, a community hospital or specialist hospital. You are to relay this information to the patient tracing in Major Incident Control Room 1.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse in Charge of Discharge Lounge</td>
<td>Nunton Unit</td>
<td>Nurse in Charge Discharge lounge</td>
<td></td>
</tr>
</tbody>
</table>

Actions

- Report to the Nurse in Charge of the Discharge Lounge and collect this action card
- Maintain a record of each patient’s name, date of birth, hospital number, ward discharged from and destination.
- Relay the above information to the patient tracker in Major Incident Control Room 1, extension 4178
- Ensure the information is updated on the iPM system.
- Assist in other tasks as requested by the Nurse in Charge of Discharge Lounge
- Do not stand down until told to do so
BLEEP HOLDERS AND KEY NURSING STAFF

ACTION CARD No 10 DIRECTORATE SENIOR NURSE ALLOCATED TO RESPOND TO MORTUARY VIEWINGS

Summary of role
To support relatives of deceased patients.
Escorting them to the mortuary when required.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSN</td>
<td>Hedgerows Coffee lounge</td>
<td>Nursing Director control room &amp; Police Bureau</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to Hedgerows and the Customer Care Department team.
- Use Hedgerows meeting room for confidential discussion – ensure this is vacated if necessary.
- Request additional HCSW support as needed from control room 3 on extension 4179
- Share information with the Police bureau in the control room – route queries there if appropriate.
- Arrange escorting of relatives as required to the mortuary (Key code for the mortuary is included in the Bereavement Team box file)
- Stay in role until stood down
Major Incident

ACTION CARDS

Medical Records
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

MEDICAL RECORDS

ACTION CARD No 1 First SENIOR PERSON NOTIFIED

Summary of Role
To co-ordinate and deploy activity of medical records staff.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>On and off duty records Staff</td>
<td>Medical Records entrance</td>
<td>Duty manager control room</td>
</tr>
</tbody>
</table>

ACTIONS

- Initiate Medical Records call out system. Call out three staff, one for the control room and two to remain in the medical records department.
- On arrival at the Hospital, position yourself in Medical Records. Inform the Duty manager in the Control Room of your arrival at the Hospital.
- Distribute Action Cards in the following order of priority.
  - Major Incident Control Room
  - Discharge lounge
- Establish a reserve call out of staff who can be called in if needed
- Any additional staff to be used as Runners.
MEDICAL RECORDS

ACTION CARD No 2 RECORDS OFFICER Major Incident Patients (patient tracker)

DISCHARGE LOUNGE

Summary of Role
You will be based in the Discharge Lounge. Your role is to collate all information once the patient treatment has been completed and to arrange follow-up clinics and to take a log of this information to Major Incident Control Room 1.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical records officer</td>
<td>Medical records to pick up card then to Discharge lounge</td>
<td>Senior nurse discharge lounge</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to the Discharge Lounge - report to the nurse in charge.
- Position yourself in the newly created holding area for Major Incident patients who have completed treatment.
  - Ensure you have access to the following follow up clinic lists:
    - Accident & Emergency Consultant Review
    - Accident & Emergency Dressing Clinic
    - Miscellaneous (e.g. ENT, Dental, Ophthalmology).

- Collect all patient documentation and arrange follow-up appointments as appropriate. Mark on the lists bought down by the patient the date and time of the follow-up appointment.
- Place all patients' completed documentation in box marked 'Major Incident Control Room' for the Runner to collect and return to the Major Incident Control Room.
- Ensure that the iPM system is updated with the clinic appointments booked.
- Liaise with Patient Tracker in Major Incident Control Room 1 regarding those patients who have been discharged home, following completion of treatment. Give the following details:
  - Patient's name (if known)
  - Patient's age (if known)
  - Patient's Major Incident number
  - Triage category (if known)
  - Destination

- Do not stand down until told to do so or relieved.
MEDICAL RECORDS

ACTION CARD No 3 PATIENT TRACKER MAJOR INCIDENT CONTROL ROOM

Summary of Role
You will be based in Major Incident Control Room 1 situated in the Orthopaedic outpatient Department. Your role will be to co-ordinate/collate all information on each patient admitted from the Major Incident and to receive information on non-Major Incident patients being discharged/transferred from this hospital.

You will be notified by the Medical Records Department that a Major Incident has occurred.

ACTIONS
• Report to Medical Records and collect this Action Card.
• Receive from Runners all documentation on each patient admitted from the Major Incident.
• Write the following information on the white board provided:
  • Patient's name (if known)
  • Patient's age (if known)
  • Patient's Major Incident number
  • Triage category
  • Location
• Maintain a running total of all patients involved in the Major Incident having been received by the Hospital, you will find a log sheet in the Site box file.
• Maintain a record of all non-Major Incident patients who have been discharged/transferred out, you will find a log sheet in the site box file.
• Liaise with the Patient Trackers in Discharge Lounge and ED.
• Identify those patients' records that will require follow-up appointments and place in identified boxes labelled 'ED Consultant Review Clinic', 'ED Dressing Clinic' and 'Miscellaneous', e.g. ENT, Max Fax. Appointments for Miscellaneous will need to be made the following day. Make sure this work is allocated before you leave.
• Do not stand down until told to do so or relieved
Major Incident

ACTION CARDS

Medicine
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

MEDICINE

ACTION CARD No 1 DUTY CONSULTANT PHYSICIAN

Summary of Role
1. Determine whether Physicians are required to assist in ED.
2. Be the receiving speciality in the event of inhalation or biological Incidents – see section 12 of the introduction to this document
3. Deploy medical staff where needed. Note section 13 in the introduction to the plan
4. Create bed space.
5. Enable direct admission of all GP medical cases to MAU.
6. Ensure that the hospital resuscitation team is maintained

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Consultant physician colleague</td>
<td>ED</td>
<td>Medical Director or deputy in control room 3</td>
</tr>
</tbody>
</table>

A Major Incident has been declared.

ACTIONS

- Contact a second Consultant Physician and place them in charge of the medical wards. Their role is to create bed space and to identify patients for discharge with help from the Duty SpR.
- Allocate action card 2 to either the medical secretary (in-hours) or the Duty F1 (out-of-hours).
- Proceed to ED.
- Contact the Medical Co-ordinator (Duty ED Consultant) and the Surgical Triage Officer (Duty Surgical Consultant). They will advise you if specific help from Physicians is required.
- If your help is not required, then report to the Control room.
- You may be asked to fill the role of Medical Director. If so, you will be given a different Action Card by the Duty Manager.

Do not stand down until advised to do so by the Control Room.
MEDICINE

ACTION CARD No 2 DR IN CHARGE MEDICAL WARDS - (NON-DUTY CONSULTANT)

Summary of Role
Oversee bed clearance on SSEU, MAU, Pitton, Tisbury, Redlynch, Rockbourne and Pembroke wards (in that order) and deployment of Medical Staff to where they are needed. You are in charge of medical admissions.

The Duty Consultant Physician has informed you that a Major Incident has been declared.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The duty Physician</td>
<td>Duty SpR and F1, F2 posts</td>
<td>MAU</td>
<td>On duty physician</td>
</tr>
</tbody>
</table>

ACTIONS

- The Duty Consultant Physician (in ED or Control room) will advise you whether to ask staff to stay on stand-by or whether they need to come in.
- Ensure adequate cover for MAU and all Medical wards.
- Medical patients in ED maybe sent straight to MAU/Medical wards in order to create space for Major Incident patients.
- In conjunction with the Duty Registrar, allocate action card 4 and start identifying patients who can be discharged. These patients should NOT be discharged until requested to do so by the Control Room.
- Medical Patients outlying on Laverstock should be discharged or repatriated to a medical ward as a matter of urgency.
- Send junior staff to ED and/or Laverstock if requested to do so by Duty Consultant Physician in ED.
- Keep the Medical Director in Control Room 3 informed of your progress.

Do not stand down until told to do so by the Duty physician
MEDICINE

ACTION CARD No 3 PERSON RESPONSIBLE FOR CALL IN OF MEDICAL STAFF (E.G. WITHIN HOURS - MEDICAL SECRETARY CO-ORDINATOR/OUT-OF-HOURS – F1/F2)

Summary of Role
Call in off duty staff

The Senior Doctor in charge of medical wards has advised you that a Major Incident has occurred.

ACTIONS
• You have been asked to call in all medical staff who are not on duty. Their contact numbers are kept on MAU.
• Senior Doctor in charge will advise you on the message to transmit. This will either be to stand by, or to come to the Hospital and report to the MAU level 4
• Advise them to bring ID as this will make it easier for them to cross the Police Cordon line.
• Advise them if any route to the Hospital has been blocked. This information may be available from Switchboard.
• Once call in complete report back to the Duty Consultant and seek deployment to other tasks/ actions

If H@NT on-call please ensure that you have called in all other senior registrar’s on-call for:
• Plastics
• General Surgery
• Orthopaedics
• Medicine
MEDICINE

ACTION CARD No 4 DOCTOR IN CHARGE OF BED CLEARING
(DUTY MEDICAL REGISTRAR OR F2)

Summary of Role
Continue as part of crash team for non-Major Incident patients.
Identify patients fit for discharge.

You have been informed that a Major Incident has been declared.

ACTIONS

• Establish number of medical patients that need to be moved off of Laverstock, Pitton and Tisbury.
• Proceed to MAU.
• Team up with the Senior Nurse Medicine - Begin to identify patients potentially manageable on discharge lounge.
• Control Room 1 will have opened a dialogue with all-local community hospitals and DGH’s. They will advise you of bed availability in these hospitals.
• Begin discharging patients ONLY IF ADVISED TO DO SO by Doctor in charge Medical Wards (non-duty consultant) or by the Control Room.
• Relatives of patients may be available to take patients home directly.
• Discharged patients with no available relatives should be sent to Discharge Lounge level 2 to await transport.
• Patients should be discharged with TTO’s where practicable. If none are available then discharge the patient to Discharge lounge with a completed TTO sheet. A Runner can take the sheet from there to Pharmacy.
• Report to Dr In charge medical wards on progress/to receive further instructions

Do not stand down until told to by Doctor in charge medical wards or until relieved by a Consultant colleague.
MEDICINE

ACTION CARD No 5 ANY REGISTRAR OR F2 NOT-ON-CALL

Summary of Role
Assist in the resuscitation of Major Incident patients.

A Major Incident has been declared.

ACTIONS
• Go to MAU and identify the Doctor in charge medical wards.
• You may be told to present to ED or Laverstock.
• If you go to ED, identify the ED Medical Co-ordinator who will be wearing a yellow tabard.
• You will be deployed as appropriate.
• If you are sent to Laverstock then identify the Senior Surgeon.
• You will be deployed as appropriate.

Do not stand down unless told to by a Senior Doctor or until you are relieved.
MEDICINE

ACTION CARD No 6 MEDICAL F2’S ON-CALL

Summary of Role
Treatment of Medical Patients

A Major Incident has been declared.

ACTIONS

• Treat non-Major Incident medical patients arriving on MAU during the Major Incident.

• All Medical/Care of the Older People will be sent to the Medical Admissions Unit. Treat them in order of priority.

• All emergency medical admissions to this Hospital will be sent to MAU for the duration of the Major Incident.
MEDICINE

ACTION CARD No 7 MEDICAL F2’s NOT ON-CALL

Summary of Role
Assist in the resuscitation of Major Incident patients.

A Major Incident has been declared.

ACTIONS

• Go to MAU and identify the Doctor in charge of medical wards.
• Tell the Senior Doctor if you have any ED experience.
• You may be told to present to ED or Laverstock Ward.
• If you go to ED, identify the ED Medical Co-ordinator who will be wearing a yellow tabard.
• You will be deployed as appropriate.
• If you are sent to Laverstock then identify the Senior Surgeon Pre-Op.
• You will be deployed as appropriate.

Do not stand down unless told to by a Senior Doctor or until you are relieved.
ACTION CARD No 8 NURSE IN CHARGE OF CCU

Summary of Role
Clear bed space for reception of either stable ITU patients or Major Incident patients. ITU will need to make bed space available at short notice. You may be asked to take stable, non-Major Incident ITU patients.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical site team</td>
<td>CCU</td>
<td>Duty Manager control room</td>
</tr>
</tbody>
</table>

A Major Incident has been declared.

ACTIONS
- Identify patients who can be moved to other medical wards
- Liaise with ITU and determine whether CCU beds are required.
- Move patients as necessary in liaison with the site co-ordinator.
- Keep the Site co-ordinator on bleep 1312 informed of your bed state.
Major Incident

ACTION CARDS

Plastic Outpatients Department
Summary of Role
To vacate the plastic outpatient area of clinic attendances, informing the patients that a major incident has been called and that clinic appointments are having to be cancelled.

Communications

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse on Duty</td>
<td>Plastic Outpatients</td>
<td>Senior Nurse on Duty</td>
</tr>
</tbody>
</table>

ACTIONS

1. You will have been informed that the Trust is on STAND-BY to receive a major incident. Ensure all the reception staff in this area are informed of status.

2. Inform patients arriving in the waiting area that the Trust is on STAND-BY to receive a major incident and that clinic appointments may need to be re-scheduled.

3. Pull together the clinic lists for the remainder of the day and following day.

4. On confirmation that the Trust is now in the LIVE phase of a major incident, inform all patients that clinic appointments have been cancelled. To ensure the area can be cleared quickly inform patients that another appointment will be sent to them in the post. Those requiring transport should be sent to the Discharge Lounge on Level 2 to wait.

5. Identify a member of staff to start setting up the reception area and admin paperwork to receive major incident patients.

6. Allocate staff members to phone patients to cancel their outpatient appointment, informing them that a major incident has occurred and that the Trust is receiving causalities and outpatient clinics are being cancelled. Inform them that a further appointment will be sent through to them in the post. DO NOT PROVIDE ANY FURTHER INFORMATION TO THESE PATIENTS ON THE MAJOR INCIDENT. If you are not able to contact a patient highlight this on the clinic list.

7. Ensure rooms available for use during the major incident. A plan of the department with rooms to be used and room numbers are available in the department Major Incident folder and these rooms should be labelled accordingly.

8. Inform Senior Plastic Nurse on duty once plastic outpatients is clear and able to accept patients.

NB If SSEU is full they will over-spill to the Plastics Outpatient Department for non urgent patients is likely/indicated. (Liaise with Non Urgent Area Doctor see ED Action Card 31)
PLASTICS OUTPATIENT DEPARTMENT

ACTION CARD No 2 DOCTOR TREATING WALKING WOUNDED

Summary of Role
Treatment of the less seriously injured from a Major Incident in the Plastic Outpatient Department.

You have been deployed by the ED Medical Team Co-ordinator (MCO)

ACTIONS

• Proceed to the Plastic Outpatient department.
• Make yourself known to the nurse in charge. She will form teams of nurses to treat patients.
• Set up treatment stations using equipment from the emergency hamper. Analgesics, anaesthetics, antibiotics and tetanus boosters will be supplied via pharmacy.
• Treat patients as necessary.
• Radiology may have capacity to X-ray your patients. If no X-ray facilities are available, then arrange for patients to be plastered in a backslab. X-rays will be performed at follow-up.
• Arrange for patients to be added to the list of patients for follow-up as necessary - see nurse in charge. Patients may be brought back to ED Consultant Review (fractures and soft tissue injuries), ED Dressings Clinic, or told to see their GPs. Patients whose treatment is completed should be sent to Discharge Lounge to await collection.
• Any patient whose clinical condition seriously deteriorates should be sent back to the ED.

Do not leave your post until you are either stood down or a relief doctor arrives.
Summary of Role
You are in charge of the treatment area
Treatment of Walking wounded
Documenting interventions and follow-up plans

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Site team that a Major Incident has been declared</td>
<td>Plastic Outpatient Department</td>
<td>NCO in ED</td>
<td></td>
</tr>
<tr>
<td>The NCO (senior nurse) in ED will inform you if the department needs to treat minor injuries</td>
<td>Colleague</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing staff in Orthopaedic, Eyes, ENT, Med/Surg Outpatients. Laser Centre Staff Oral Surgery Staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS
- If necessary obtain the department swipe-card from main reception
- Inform patients in the waiting area that the Trust is now in STAND-BY to receive a major incident and that clinic appointments may need to be re-scheduled. Once a LIVE phase has been called inform all patients remaining that outpatient appointments are being cancelled and the area cleared to treat emergency patients.
- Identify an admin/receptionist member of staff to be responsible for cancelling Outpatient Department Clinics immediately once a Major Incident has been declared ‘LIVE’ – although the department may not be used Doctors will be called away to the Incident.
- Nurses in the department should remain on standby to put the department into operation as the minor injuries area if called on to do so.

In the event of Plastic OPD being called on to manage Minor Injuries:-
- Form three teams of nurses, each consisting of at least one trained Nurse, one Health Care Assistant and send teams to allocated area. Make requests for staff to make up the teams to the Nursing Director in control room 3, on ext 4179.
- Set up three treatment areas using equipment from hamper stored in the department.
- Medical staffing will be supplied by the ED Medical Team Co-ordinator - send a runner to ED if patients arrive before medical support and request urgent action to supply a suitable Doctor or Doctors.
- TTO drugs will be brought to Outpatients by an ED Nurse. Further TTO’s can be obtained from the Pharmacy.
- Keep accurate logs of all patients treated and the outcome using the patient Information Sheet.
- Obtain a supply of Tetanus toxoid/local anaesthetics etc. by referring to the pre-prepared list in the departments Major Incident file.
- Any patient who deteriorates should be sent back to the ED Triage for re-assessment.
PLASTIC OUTPATIENT DEPARTMENT

ACTION CARD No 4 NURSE IN CHARGE OF TREATMENT TEAM (1-3)

Summary of Role
Set up treatment area using equipment from hamper
Treat minor injuries

ACTIONS
• Set up treatment station.
• Equipment in hamper should be set out on a trolley.
• Spare trolleys may be found in other clinic rooms in the department.
• Treat patients in collaboration with medical staff.
• When treatment completed, patients to be sent to Discharge lounge level 2 clearly identified as Major Incident patients.
You have been informed that a Major Incident has occurred

**Summary of Role**  
Administration support to the Plastic outpatient department minor injuries treatment area

**ACTIONS**

- Proceed to Plastic Outpatient Department and report to Sister in Charge.
- Photocopy enough Logs (appendix 16), enough tracking sheets (appendix 15)
- Record patients into the treatment area and out again when treatment is complete on the tracking sheet (appendix 14). Ensure a copy of this log is taken round to Control Room 1 every hour.
- Arrange for patients to be taken to the Discharge lounge once treatment is complete. Ensure they are accompanied by their notes and checklist indicating where appropriate any follow-up required. Photocopy the checklist twice, one copy is for the patient to keep and the other will be filed in the patient notes.
- Ensure a copy of the patient log sheet (appendix 16) is copied to Senior Nurse in Orthopaedic Outpatients for those patients who will require follow-ups for fractures/soft tissue injuries.
- Ensure a copy of the patient log sheet (appendix 16) is copied to the ED receptionist for those patients who will require follow-up for wound/dressings.

**Stay in the department until stood down/relieved**
Major Incident

ACTION CARDS

Paediatric Department
ACTION CARD No 1 DUTY PAEDIATRIC CONSULTANT *This is not (primarily) a treatment role*

Summary of Role
To co-ordinate the Paediatric response to a Major Incident.

To triage affected children in ED/Laverstock/Plastic outpatient department and send to Sarum for ongoing treatment as soon as possible, if appropriate. Aim to protect children from exposure to severely traumatised adults.

Sarum ward will be the preferred admissions ward for paediatric casualties – if numbers are such that many paediatric patients need admitting redirecting Medical and nursing staff to Laverstock and admitting there needs to be considered.

To co-ordinate the transfer of child casualties to another hospital where necessary

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>On call medical registrar and SHO</td>
<td>ED</td>
<td>Medical Director in the control room</td>
</tr>
<tr>
<td></td>
<td>Off-duty Consultant colleague</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS
- Contact another Paediatric Consultant to act as *Senior Doctor for paediatrics*. Remind them to collect their action card from Sarum.
- Contact on-call Medical Registrar and SHO
- Proceed to ED and identify the Doctor wearing the tabard marked ED Medical Co-ordinator. Ascertain if Paediatric input is needed.
- If Input ‘IS’ required then request a member of the nursing staff and the off-duty SHO to come to ED, where deployment to a suitable area will be identified.
- Keep your consultant colleague on Sarum Ward up-dated on individual patients who will be admitted.
- Liaise with Paediatric colleagues at Southampton General Hospital regarding casualties to be transferred. This must be done in consultation with the Duty Manager in Control Room 1.
- Requests for transport should be made through the HACO (ambulance officer) in Control Room 2 after discussion with the Duty Manager.
- If ‘NO’ input is required, then advise the off-duty Consultant and On-call register to stand down

Do not stand down until told to do so by, the ED Medical Co-ordinator.
PAEDIATRIC DEPARTMENT

ACTION CARD No 2 NON-DUTY PAEDIATRIC CONSULTANT

Summary of Role
Provide paediatric cover whilst your colleague is managing the paediatric response to the Major Incident

The Duty Paediatric Consultant will be based in ED.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call Duty Paediatric Consultant</td>
<td>Off-duty consultant colleagues (if appropriate)</td>
<td>Sarum</td>
<td>On-call Paediatric Consultant</td>
</tr>
</tbody>
</table>

ACTIONS

- You are to act as duty consultant.
- Liaise with Paediatric Consultant in ED to determine extent of Paediatric involvement in the Major Incident.
- The nominated HCSW/telephonist is calling in off-duty SHO’s and Registrars.
- Send the off-duty SHO to ED if the on-call consultant requests this.
- With the Registrar, SHO, Senior Nurse, identify patients for discharge and complete discharge paperwork. Discharged patients should wait on the ward for pick up.
- All Paediatric casualties who need admission will come directly to Sarum Ward with Laverstock as the overflow paediatric base. You will therefore be required to make beds available if there are many paediatric casualties.
- Ensure outpatient clinics are cancelled if any are occurring at this time.

Do not leave your post until advised to do so by the Duty Paediatric Consultant or until you are relieved.
Summary of Role
Cover Paediatrics until relieved by a non-duty Consultant.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Paediatric consultant</td>
<td>Sarum Ward</td>
<td>Duty Paediatric consultant</td>
</tr>
</tbody>
</table>

**ACTIONS**

- You are in charge of Paediatrics until you are relieved by an off-duty Paediatric Consultant.
- Until the arrival of the consultant, with the Senior Nurse start to identify patients for discharge and complete the necessary paperwork. On arrival of the Off-duty Consultant work together to complete this work if outstanding. Discharged patients will be kept on the Ward to await pick up.
- When discharge plans are complete you should discuss re-deployment if necessary with the non-duty Consultant on the ward.
- Assist the Off-duty consultant in treating all Major Incident patients sent directly to you from ED.
- Constantly update Consultant in ED on Bed State.

- **Do not leave your post until advised to do so by the off-duty Consultant.**
PAEDIATRIC DEPARTMENT

ACTION CARD No 4 PAEDIATRIC TELEPHONIST (WARD CLERK, HCSW OR SECRETARY)

Summary of Role
Call in off-duty medical and nursing staff.

The Senior Nurse has informed you that a Major Incident has been declared.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse</td>
<td>Sarum Ward</td>
<td>Senior Nurse</td>
</tr>
</tbody>
</table>

- You have been asked to contact members of the Paediatric Nursing and Support staff. The list is kept in Sarum Ward Major Incident file.
- Call in off duty paediatric staff, starting with Paediatric Registrars and SHO’s.
- Advise them of any routes to the Hospital that may have been blocked during the course of the Major Incident.
- Advise them to bring any ID with them if at all possible.
- This will help them to cross the Police Cordon line (if one has been set up).
- Nursing staff and Doctors should present to Sarum Ward for deployment
- When you have finished this task you must present yourself to the Senior Nurse for redeployment.
Summary of Role
The senior nurse will have told you that a Major Incident has been declared.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse/Ward Clerk</td>
<td>Sarum Ward</td>
<td>Senior Nurse</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to ED/Laverstock as directed.
- Identify the Nurse in charge of that area.
- Tell the Nurse-in-charge who you are.
- You will be deployed as necessary.

Do not leave your post until stood down or relieved.
PAEDIATRIC DEPARTMENT

ACTION CARD No 6 DUTY PAEDIATRIC SHO

Summary of Role
Help with the treatment of patients.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Paediatric consultant</td>
<td>Sarum Ward</td>
<td>Duty Paediatric consultant</td>
</tr>
</tbody>
</table>

ACTIONS

- Remain on Sarum ward, treating both non-major incident patients and major incident patients as directed by the consultant on Sarum ward, until told otherwise.

- Tell the Consultant in charge if you have any previous ED experience. If you have, then deployment to the ED Department may be necessary if staffing levels permit.
Summary of Role
You have been told that a Major Incident has been declared.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Paediatric consultant</td>
<td>Sarum Ward</td>
<td>Duty Paediatric consultant</td>
</tr>
</tbody>
</table>

ACTIONS

- When Called in report to the consultant in charge on Sarum Ward
- Tell the Consultant in charge if you have any previous ED experience. If you have it may be that you will be re-deployed to ED, if staffing levels permit and patient volume indicates the need.
- Remain on Sarum ward, treating both non-major incident patients and major incident patients as directed by the consultant on Sarum ward, until told otherwise.
PAEDIATRIC DEPARTMENT

ACTION CARD No 8 SENIOR NURSE PAEDIATRICS (DUTY BLEEP HOLDER OR SENIOR SISTER)

Summary of Role
Clearing beds for casualties
Providing paediatric nursing expertise where needed

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You inform:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSN</td>
<td>Sarum Ward</td>
<td>Ward Clerk</td>
<td>Paediatric telephonist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children's Outpatient Department Reception</td>
<td></td>
</tr>
</tbody>
</table>
MOBILE MEDICAL TEAM DOCTOR (a Paediatric Consultant or SpR)

Summary of Role
In the event that SDH is NOT a receiving hospital provide paediatric expertise at the Major Incident scene

You have been informed that a Major Incident has been declared.

ACTION
Present to Senior Sister in Accident & Emergency.
Summary of Role
To cancel outpatient clinics
To maintain list of children in area and the time they leave the department
Keep Customer Care Department office, based in Hedgerows up-to-date with children’s details

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse on Sarum</td>
<td>Children’s Outpatient department</td>
<td>Senior Nurse on Sarum</td>
</tr>
</tbody>
</table>

ACTIONS

- On confirmation that the major incident is for ‘paediatric’ cases, ensure any clinics running are cancelled.
- On cancellation of all clinics running inform the Senior Nurse that this has been completed on Sarum Ward
- Ensure on arrival of all children that a log is made of their details (Appendix 18)
- Keep the Customer Care Department office (they are based in hedgerow’s) and control room 1 (based in orthopaedic outpatients) up-to-date on numbers and details of children in the department. These details should be taken every hour to these areas either by yourself or by a colleague.
Major Incident

ACTION CARDS

Clinical Support Staff
CLINICAL SUPPORT STAFF

ACTION CARD No 1 ON-CALL MLSO BLOOD TRANSFUSION LABORATORY

Summary of Role
Ensure adequate bloodstocks are available

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Laboratory / Blood bank</td>
<td>Control Room 1</td>
</tr>
</tbody>
</table>

A Major Incident has been declared

ACTIONS

Please note:
- Nature of Incident
- Place of Incident
- Estimate of casualties

Telephone:
- Out of Hours: - One other MLSO on the on-call list
- Duty Consultant Haematologist
- Regional Blood Transfusion
- One office support staff

- Assess bloodstocks.
- Ensure 4 units of ‘O neg’ blood are available for collection by ED staff
- Prepare to reserve non-urgent cross-matched blood and prepare for emergency cross-match procedures.
- Liaise directly with Regional Blood Transfusion Services.
CLINCAL SUPPORT STAFF

ACTION CARD No 2 ON-CALL BIOCHEMISTRY TECHNICIAN

Summary of Role
A Major Incident has been declared.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Biochem lab</td>
<td>Medical director - control room</td>
</tr>
</tbody>
</table>

ACTIONS:

Please note:

- Nature of Incident
- Place of Incident
- Estimate of number of casualties

- Telephone other members of staff as required.
- Liaise with Medical Director in Control Room 3, ext 4179 and inform him if you have any problems by telephone or Runner.
ACTION CARD No 3 RESUSCITATION OFFICER (In hours)

Summary of Role
To facilitate with resuscitation of patients in the Emergency Department. Respond to non-Major Incident related crash calls

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Manager</td>
<td>ED</td>
<td>MCO</td>
</tr>
</tbody>
</table>

ACTIONS

- Contact your colleagues and ask them to proceed to ED
- Go to ED yourself
- Identify the NCO and request deployment
- You may be deployed either to the Resuscitation Room if appropriate, or you may be re-deployed in a support role, e.g. acting as a message runner etc.
CLINICAL SUPPORT STAFF

ACTION CARD No 4 DUTY PATHOLOGY TECHNICIAN 1 MORTUARY

Summary of Role
To provide mortuary capacity to meet the needs of the clinical services

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Mortuary</td>
<td>Duty Manager - control room</td>
</tr>
</tbody>
</table>

Control room 1 will give an indication of the size of the Incident and an estimate of the number of mortuary places that might arise as a result

ACTIONS

• Inform the head of service that a Major Incident has occurred
• Review current mortuary capacity
• If this exceeds the estimated requirement then stand by but take no further action
• Additional capacity
  • If additional capacity is likely to be required contact undertakers to remove appropriate bodies from the mortuary
• Switch on the cooling for the over-flow fridge area
• Report back to the Duty Manager Control room what capacity is available and/or could be made available within 4 hours

Communications

• Telephone other members of staff as required
• Continue liaison with Duty Manager in the Control Room, and inform them if you have any problems on telephone (ext 4178) or Runner
• Liaison with Customer Care Department & Bereavement team in Hedgerows on extension 2743 or 2764

Notes

An emergency mortuary has been set up on scene by the Police. Bodies from the scene of the Incident will NOT come into the Hospital.
CLINICAL SUPPORT STAFF

ACTION CARD No 5 DISPENSARY (EXT 4268) - WITHIN WORKING HOURS

ON-CALL PHARMACIST - OUT-OF-HOURS

Summary of Role

Supply of pharmacy products to treatment areas and TTO’s to discharged patients.

You will have been informed by switchboard that a Major Incident has been declared.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Pharmacy</td>
<td>Medical director - control room</td>
</tr>
</tbody>
</table>

ACTIONS

- The on-call Pharmacist will call in the Chief Pharmacist and Deputy out of hours. If they are not available then call in other Pharmacists.
- The first available Pharmacist will staff the Pharmacy.
- The second will proceed to the Discharge lounge taking with them a range of TTO packs and facilitate dispensing of these TTO’s.
- Assemble and deliver immediate emergency drugs to the ‘Drugs and Infusion Nurse’ in the Emergency Department.
- Keep the Duty Manager in control room 1 informed of the status of the pharmacy response.
- Major Incident drug packs should be supplied to Plastic Outpatients for any ED overflow.
- Call in additional staff as required.
CLINICAL SUPPORT STAFF

ACTION CARD No 6 CHAPLAIN

Summary of Role
Support to relatives patients and staff

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Chapel</td>
</tr>
</tbody>
</table>

ACTIONS

- The on-call Chaplain to contact other Chaplains and request their attendance at the Hospital.
- Meet in the Chapel area on level 3.
- On-call Chaplain to allocate other Chaplains to other areas of need.
- One Chaplain should be allocated to Plastic Outpatients Department where relatives of the minor injured will be based.

- Other areas requiring cover may include:
  - SSEU
  - Mortuary
  - ED (liaise with the NCO)
  - Laverstock Ward
  - ITU
  - Hedgerows (relatives base)
CLINICAL SUPPORT STAFF

ACTION CARD No 7 MEDICAL DEVICES MANAGEMENT CENTRE

HEAD OF SERVICE - WITHIN WORKING HOURS or EQUIPMENT CO-ORDINATOR* - OUT OF HOURS

*Head of Service or senior member of Medical Device Management Centre staff

Summary of Role
Call in other members of the Medical Device Management Services.
Supply of loan library equipment to clinical areas.
Relocation of equipment to provide back-up as required.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Control Room 3</td>
<td>Medical director - control room</td>
</tr>
</tbody>
</table>

ACTIONS

- Assess Incident equipment needs
- Review availability of all medical equipment
- Relocate as required
- Determine appropriate level of competence prior to reallocation of equipment. Provide support as required.
- Record location of all reallocated equipment.
CLINICAL SUPPORT STAFF

ACTION CARD NO 8 DEPARTMENT OF CLINICAL RADIOLOGY

Major Incident Action Cards (Out of Hours)

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>x-ray</td>
<td>Medical Director - control room</td>
</tr>
</tbody>
</table>

ACTIONS:

- Proceed to the Superintendent Radiographer's office/ED X-ray viewing room and locate the Departmental Major Incident Plan
- Note who authorised Major Incident Activated
- Stand-by Radiographer to call, on call Radiographer (if not already in SDH) e.g. Twilight’s immediately.
- Check who is on call Radiologist, CT Radiographer and Specials Radiographer.
- Stand-by Radiographer to phone Superintendent/Senior to put plan into action from home. Inform them who authorised Major Incident and name of staff above and Radiologist, also type and magnitude of incident if know e.g. RTA, bus, rail etc.
- Liaise with the Medical Director in Control Room 3 situated in orthopaedic outpatients, by telephone on ext 4179 or by Runner, and inform him of any problems
- The x-ray co-ordinator should make themselves known to the MCO in ED
- The x-ray co-ordinator should keep an overview of demands on the imaging service. The nature of the Incident and anticipated casualty numbers available from the MCO will help inform this decision.
- Stand by Radiographer should open up department switch on CR readers if off, warm up rooms not already in use e.g. room 2 and room 14 (orthopaedic OP room).
- Check plastic aprons and gloves are available in all rooms.
- Superintendent/Senior will inform duty Radiologist and then call additional staff to cover emergency, from home.
- After calling in sufficient staff Superintendent/Senior will proceed to SDH, then act as x-ray co-ordinator unless it would be more appropriate to designate this role to another member of staff. Designated person to make themselves known to ED co-ordinator.
- Until Superintendent/Senior arrives the stand by Radiographer is in charge and will designate teams to work in each room as they arrive.
- Stand-by and on call Radiographers to cancel and clear outstanding work as appropriate quickly.
- On call Radiologist will proceed to SDH after receiving telephone call to ‘hot report’ and perform examinations as required. This Radiologist will decide if they need to call in colleagues for additional support dependent on type of major incident.
- Walking wounded will be sent around from plastic outpatients to wait in Room 14 waiting area and dealt with in Room 14. Room 2 may be used where numbers exceed capacity in Room 14 if it is not needed for major patients from A/E.
- All patients will have to be entered into ROP’s as new patient using identifiers on request card e.g. only major incident 10000. All patients will be entered on the ROP's before being x-rayed using the specified incident number (no given names, even if known) fill in Male/Female if known, and DOB as – 01.01.01 for everybody. This will be updated for digital systems as applicable.
- Some examinations may be delayed until later depending on demand on the department resources. If some examinations written on the request card are not done please photocopy the card cross off the examinations completed (and indicate on original), and send photocopy thus amended back with the patient so they can be arranged at a later more suitable time, (probably from Laverstock Ward).
- Order of work will be arranged via the x-ray co-ordinator through the ED Consultant. These two will decide if it is necessary to delay some of the requested examinations as above.
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

- Staff must wear ID and uniform where appropriate and enter the hospital not via the ED ramp. Hospital roads will be ‘one way’ in Entrance A and out via Entrance B.

Staff to be called in dependent on expected influx:
- Duty Radiologist
- Minimum of 10 Radiographers – to include CT & specials on-call Radiographers and more as seen fit/available.
- 1 nurse
- Minimum of 2 helpers dependent upon Radiographer availability
- Minimum of 2 Assistant practitioner/Helpers
- ±4 Clerical staff – to man MRI reception, main reception, ED and Room 14 Receptions and secretarial cover for reporting.
CLINICAL SUPPORT STAFF

ACTION CARD NO 9 DEPARTMENT OF CLINICAL RADIOLOGY

Major Incident Plan within Normal Working Hours for the Department of Clinical Radiology

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>x-ray</td>
<td>Medical director - control room</td>
</tr>
</tbody>
</table>

**ACTIONS**

- Note who ‘Authorised’ Major Incident activated and any available information – e.g. Nature and magnitude of incident if known (and if possible expected number of casualties).

- Request the receptionist to inform Radiology Service Manager if available and ED Superintendent or Senior in Charge of that area, and/or Consultant Radiologist of the day.

- If available, Radiology Service Manager or Senior staff manager as above to inform Clinical Director (Radiologist in charge) and Superintendents present within the department.

- Ultimately the decision to cancel appointments will lie with the Hospital Clinical Director/Radiologist in charge in liaison with colleagues, Radiology Services Manager and Superintendents as available.

- Assuming the incident is of such a magnitude that all out-patient clinics are suspended all non-appointment patients will be turned away (i.e. Outpatients and casual attendees).

- Superintendent/Senior in charge of ED will suspend all ward work, cancel any planned equipment services, arrange for AMX4 to be brought down to main department, ensure all outstanding work is finished or cancelled quickly, as appropriate, and check the department is ready to receive casualties as required, (delegate as necessary to ensure gloves, aprons, cleaning equipment etc., are in plentiful supply).

- Portering Services are aware of our needs to return any inpatients back to the wards and any patients already undergoing investigation after they are completed, PLUS a portering implication between ED and all Radiology Services once the casualties start been examined.

- Otherwise proceed as for out of hours Major Incident Plan.
summary of role
To provide administrative support to the radiology department during a major incident.

communications summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology Co-ordinator</td>
<td>Radiology Department</td>
<td>Radiology Co-ordinator</td>
</tr>
</tbody>
</table>

actions

• Make sure patients major incident details are put onto the Radiology system with the correctly requested examinations from the request card and the appropriate labels produced.

• Copy the request cards where later non urgent examinations will be required and ensure this goes back with the patient with the further imaging required highlighted on the form.

• Make sure the temporary reports go back to the appropriate patient after the Radiologist has produced them if the reports cannot be put straight onto the RIS system.

• Keep an eye on any patients left in the waiting area and call for nursing or radiographic assistance if any patient concerns you in any way.

• Assist with patient transfers as required.

• Communicate any problems or concerns to the co-ordinator immediately.

• Any other duties the co-ordinator sees fit to ask you to undertake e.g. showing patients where to change and ensuring a ready supply of clean gowns where necessary.
Summary of Role
To provide call out of voluntary staff for help around Trust site.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You will be based at:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Home</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

ACTIONS:

You have been informed of a major incident

- Call out volunteers who have identified themselves as willing to help during a Major Incident. Ask them to go to the orthopaedic outpatient reception on level 3. They should report to control room 3 within this area and to the Director of Nursing.

- Once all calls have been made to volunteers, phone the Director of Nursing on extension 4179 to inform her of the number of volunteers attending site.

- Remain contactable should further assistance from voluntary services be required.
Major Incident

ACTION CARDS

Surgical Specialties
SUMMARY OF ROLE OF SURGICAL SPECIALTIES

If Salisbury District Hospital is a Receiving Hospital (i.e. taking Major Incident patients):
1. Cancel non-essential in-patient operations
2. Cancel day case surgery if staff need to be re-deployed as is probable
3. Call in off-duty staff
4. Clear Laverstock Ward
5. Staff Laverstock Ward
6. Keep lines of communication open with ED and Anaesthetics
7. Prioritise patients for theatre
8. Care for post-op patients
9. Keep the Medical Director in Control Room 3 informed of your progress
10. Anticipate disruption caused to your Specialities over the following days/weeks.
11. Ensure adequate staffing for the next day.

If Salisbury District Hospital is asked to act as a Support Hospital for those hospitals who are receiving Major Incident patients:
1. Accept stable non-Major Incident patients from receiving hospitals.
2. Donate staff to act as part of a Mobile Surgical Team.
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

SURGICAL SPECIALTIES

ACTION CARD No 1 ON-CALL CONSULTANT SURGEON (SURGICAL TRIAGE OFFICER)

This is not a treatment role

Summary of Role
To co-ordinate the deployment of Surgical, Orthopaedic and other surgical speciality staff to meet the needs of the Major Incident.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Off duty consultant colleague</td>
<td>ED</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>

ACTIONS

• Call in an off-duty Consultant colleague and ask them to implement the role of the off-duty Consultant Surgeon (see below).
• Proceed to ED and liaise with the ED Medical Co-ordinator (MCO) and Anaesthetic Triage Officer.
• Maintain liaison with Senior Surgeon Pre-Op (Duty UROLOGY Consultant) on Laverstock Ward and Senior Surgeon Theatres (Duty Orthopaedic Consultant).
• All available Surgical staff report to the Senior Surgeon Pre-Op Laverstock Ward for deployment.
• Requests for Surgical staff must be made through the medical director in Control room 3.
• Agree order of priority for patients who need Theatre/ITU with Anaesthetic Triage Officer and the Senior Surgeon Pre-Op.
• Keep Medical Director in Control Room 3 informed of events.
• Do not leave the Hospital after the medical Incident has finished.
• Ensure that there are adequate staffing levels for the following day.
• Ensure lists have been cancelled (and patients informed) if there are no available beds/staff.
Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On duty colleague</td>
<td>Off-duty colleagues</td>
<td>Laverstock</td>
<td>Senior Surgeon Pre-op</td>
</tr>
</tbody>
</table>

Summary of Role
Call in of duty colleagues
Treatment of Casualties

A Major Incident has been declared.

**ACTIONS**

- If you are the first off-duty Consultant to be contacted, then your first task is to call in all other off-duty Consultants. Tell them to report to the Senior Surgeon pre-op (the Duty UROLOGY Consultant) on Laverstock Ward. When you have finished, go to Laverstock ward and request deployment.
- If you are the second (or later) contacted, then proceed to Laverstock Ward and identify the Senior Surgeon Pre-Op
- Seek deployment where your skills are most needed

**NB:**
You may be asked to assume the role of Senior Surgeon Pre-Op. Accept this role if you think it desirable to do so.
SUMMARY OF ROLE
Ensure initiation of call out of off-duty Surgical Registrar and PRHO staff. Clear Laverstock Ward and prepare it for new admissions.

COMMUNICATIONS SUMMARY

<table>
<thead>
<tr>
<th>You will be informed by</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Junior surgeon staff (HO or SHO)</td>
<td>Laverstock</td>
<td>Senior Surgeon Pre-op</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to Laverstock Ward.
- Delegate the call in procedure for off-duty Surgical staff to the HO or SHO the list of staff is held in Surgical Co-ordinators office (Miss Chave’s Office) on level 4.
- Liaise with the Senior Nurse and together initiate the clearance of Laverstock Ward. It may be necessary to receive patients before the whole ward is clear. Try to make a bay available as soon as possible.
- Liaise with the Senior Surgeon Pre-Op (the Duty UROLOGY Consultant) when he/she arrives.
- Well patients may be sent home with their relatives.
- Send patients awaiting transport home to Discharge lounge Level 2.
- All patients who are discharged should have TTO’s and a follow-up appointment.
- Send patients who are too unwell to go home to other wards.
- Seriously ill should go to Britford ward.
- Stable patients may be sent to Orthopaedic wards.
- Inform the Surgical Triage Officer (Duty Surgical Consultant) in ED when LAVERSTOCK WARD is ready for Major Incident patients (via Phone a Runner).
- Inform Duty Manager in Control Room 1 on ext 4178 and the site co-ordinator when the ward is cleared.
- Report to the Senior Surgeon Pre-Op on Laverstock Ward for redeployment.

If H@NT on-call please ensure that you have called in all other senior registrar’s on-call for:
- Plastics
- Orthopaedics
- Medicine
SURGICAL SPECIALTIES

ACTION CARD No 4 OFF-DUTY SURGICAL REGISTRAR

Summary of Role
Treatment of patients

A Major Incident has been declared.

ACTIONS
• Proceed to Laverstock Ward.
• Identify the Senior Surgeon Pre-Op (Duty UROLOGY Consultant).
• You will be deployed where your skills are most needed.
SUMMARY OF ROLE
Initiate call out of off-duty Surgical staff (Registrar’s, SHO’s and HO’s)
Help clear Laverstock ward to receive casualties

COMMUNICATIONS SUMMARY

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty SpR</td>
<td>Off Duty junior surgical staff</td>
<td>Miss Chave’s Office</td>
<td>Senior Surgeon Pre-op</td>
</tr>
</tbody>
</table>

You have been informed that a Major Incident has occurred.

ACTIONS
- Proceed to the General Surgery/Urology department co-ordinators office on level 4 (Miss Chave’s Office) and locate the blue folder on the desk with all the Surgical Registrar’s and Junior Doctor’s contact numbers, **DO NOT REMOVE THE FOLDER FROM THIS OFFICE**.
- Initiate the call out of off-duty Surgical staff.
- If the Major Incident has occurred within normal working hours, you may need to locate colleagues who are working in other hospitals or clinics. Bleep numbers can be found in this folder.
- Inform colleagues that a Major Incident has occurred. Ask them to report to Laverstock Ward for deployment.
- Inform the Medical Director in Control Room 3 when the call out is completed.
- Proceed to LAVERSTOCK WARD.
- Report to the Surgical Registrar and help to facilitate the clearance of LAVERSTOCK WARD.
- Report to the Senior Surgeon Pre-Op on LAVERSTOCK WARD for deployment.
A Major Incident has been declared.

**ACTIONS**

- Proceed to Laverstock Ward.
- Identify the Senior Surgeon Pre-Op (Duty UROLOGY Consultant).
- You will be deployed where your skills are most needed.
SURGICAL SPECIALTIES

ACTION CARD No 7 ON-CALL ORTHOPAEDIC CONSULTANT (SENIOR SURGEON THEATRES)

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Orthopaedic Consultant Colleague</td>
<td>Theatres</td>
<td>Medical director Control room</td>
</tr>
</tbody>
</table>

Summary of Role

Deployment of Surgical teams in Theatres
Liaison with your counterparts in ED and in Laverstock Ward to ensure that theatres response is planned to meet demand arising from the Major Incident and existing urgent cases.

You have been informed that a Major Incident has occurred.

ACTIONS

- Call an Orthopaedic Consultant colleague and ask them to contact the other Orthopaedic Consultants and registrars and send them to Laverstock Ward (ensure one registrar goes to ED) for deployment by the Senior Surgeon Pre-Op. When they have finished telephoning, they should proceed to ED and report to the ED Medical Co-ordinator and request deployment.
- Proceed to Theatres and liaise with the Theatre Manager/Bleep Holder.
- Contact the Senior Surgeon Pre-Op (Duty Urology Consultant) on LAVERSTOCK WARD and the Surgical Triage Officer in ED (Duty Surgical Consultant) Ensure that staff are deployed to where they are needed (ED, Theatres and Laverstock Ward).
- Together ensure that all non-essential operations have been cancelled.
- Together ensure that appropriate extra material will be available from TSSU.
- Form Treatment teams from Surgical staff as they become available.
- Liaise with the Duty Surgical Consultant, who is acting as the Senior Surgeon (Triage) in the ED and the Senior Surgeon (Pre-Op) who is running the admissions Laverstock Ward. Determine the extent of the Major Incident and agree a prioritisation list for patients for theatre.
- Inform the Medical Director in Control Room 3 of your progress and of any special needs you may have.
- Inform Medical Director when you are no longer able to accept more patients.

Do not stand down until told to do so by the Medical Director.
Summary of Role
Patient treatment

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O/C consultant colleague</td>
<td>Off duty consultant colleagues</td>
<td>Laverstock if second</td>
<td>Senior surgeon pre-op if in Laverstock</td>
</tr>
</tbody>
</table>

A Major Incident has been declared.

**ACTIONS**

- Call in your off-duty consultant colleagues
- Report to Laverstock ward, report to the Senior Surgeon pre-op and request deployment to where your skills are most needed.
Summary of Role
Treatment of Major Incident patients in the Accident & Emergency Department.

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard</td>
<td>Junior colleagues</td>
<td>ED</td>
<td>Surgical triage officer</td>
</tr>
</tbody>
</table>

ACTIONS
- Contact your House Officer and ensure that they have started the call out procedure of all Junior Doctors (SHO’s and PRHO’s) who are not on call. Contact numbers can be found in Orthopaedic Coordinator’s office on level 4 (corridor in Amesbury/Chilmark suites)
- Proceed to ED and identify the Surgical Triage Officer (the Duty Surgical Consultant) or the ED MCO and request deployment.

If H@N T on-call please ensure that you have called in all other senior registrar’s on-call for:
- Plastics
- General Surgery
- Orthopaedics
- Medicine
SURGICAL SPECIALTIES

ACTION CARD No 10 OFF-DUTY ORTHOPAEDIC REGISTRAR

Summary of Role
Patient treatment

A Major Incident has been declared.

ACTIONS
• Proceed to Laverstock Ward and identify the Senior Surgeon Pre-Op (the Duty Urology Consultant).
• Request deployment where your skills are most needed.
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

SURGICAL SPECIALTIES

ACTION CARD No 11 DUTY ORTHOPAEDIC HOUSE OFFICER

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Orthopaedic SpR</td>
<td>Off Duty colleagues</td>
<td>Secretaries office level 4 then to Laverstock</td>
</tr>
</tbody>
</table>

Summary of Role

Call in off duty staff.
Patient care

ACTIONS

• Proceed to the Orthopaedic Co-ordinators office on level 4 (Chilmark/Amesbury suite corridor) and locate the blue folder on the desk with all the Surgical Registrar’s and Junior Doctor's contact numbers, **DO NOT REMOVE THE FOLDER FROM THIS OFFICE.**
• Contact all off-duty SHOs and House Officers.
• Tell them to go to Laverstock Ward and identify the Senior Surgeon Pre-Op, who will be the Duty UROLOGY Consultant or deputy. They will be deployed where necessary
• When you have finished, update the Medical director in control room 3 on ext 4179 and proceed to LAVERSTOCK WARD for redeployment.
SURGICAL SPECIALTIES

ACTION CARD No 12 OFF-DUTY ORTHOPAEDIC SENIOR HOUSE OFFICER

Summary of Role

Treatment of patients

A Major Incident has been declared.

ACTIONS

• Proceed to Laverstock Ward and identify the Senior Surgeon Pre-Op.
• Request deployment where your skills are of most value.
SURGICAL SPECIALTIES

ACTION CARD No 13 DUTY ORAL SURGEON

Summary of Role
Patient treatment

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:-</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard requested via Laverstock</td>
<td>Laverstock</td>
<td>Senior Surgeon pre-op</td>
</tr>
</tbody>
</table>

A Major Incident has been declared.

ACTIONS

- Proceed to Laverstock Ward.
- Identify the Senior Surgeon Pre-Op (Duty UROLOGY Consultant).
- You will be deployed where your skills are most needed.
SURGICAL SPECIALTIES

ACTION CARD No 14 DUTY OPHTHALMOLOGIST

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard requested via</td>
<td>Laverstock</td>
<td>Senior Surgeon pre-op</td>
</tr>
<tr>
<td>Laverstock</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Role
Treatment of patients

A Major Incident has been declared.

ACTIONS

- Go to Laverstock Ward and identify the Senior Surgeon Pre-Op (the Duty Urology Consultant).
- You will be deployed where your skills are most needed.
SURGICAL SPECIALTIES

ACTION CARD No 15 SENIOR SURGEON PRE-OP (DUTY UROLOGY CONSULTANT)

Summary of Role
Co-ordinate clearance of Laverstock Ward
Oversee treatment of Pre-Op patients
Hand over this role to an off-duty Surgical Consultant when one becomes available and if desirable.

A Major Incident has occurred.

ACTIONS

- Call in an off-duty Consultant colleague to cover Urology duties.
- Proceed to Laverstock Ward and liaise with the Surgical Registrar and House Officer. Ensure a call out of all Surgical staff by the Surgical House Officer is underway. They will be asked to come to LAVERSTOCK WARD and ask you for deployment.
- Liaise with the Senior Nurse and Surgical Registrar or deputy. Ensure that bed clearance is underway.
- Liaise with the Surgical Triage Officer (Duty Surgical Consultant) in ED and with the Senior Surgeon Theatres (Duty Orthopaedic Consultant)
- Establish their staffing requirements
- Inform Anaesthetic Triage Officer in Accident & Emergency of your requirements for Anaesthetists
- Deploy staff between ED, Theatres and LAVERSTOCK WARD
- Prepare to receive Major Incident patients to LAVERSTOCK WARD
- Re-triage patients arriving from ED and treat as necessary
- Keep the Medical Director in Control Room 3 informed of your progress

Do not stand down until told to do so by the Medical Director.
SURGICAL SPECIALTIES

ACTION CARD No 16 NURSING BLEEP HOLDER FOR OBSTETRICS & GYNAECOLOGY

Summary of Role
1. Identify available beds
2. Identify patients fit for discharge
3. Prepare for reception and Treatment of non-Major Incident patients

A Major Incident has been declared.

LAVERSTOCK WARD will receive all Major Incident patients. The Duty Urology Consultant will co-ordinate the running of this area.

You may be required to accept stable patients from other specialities

ACTIONS

• Contact all O&G wards and ask them to provide a bed state
• Pass this information to the Site team on bleep 1312
• Liaise with the Duty Obstetrics & Gynaecology Registrar and start a ward round.
• If the Registrar is in Theatres, then proceed alone until joined by an off-duty Consultant.
• Identify patients who are fit for discharge. Ask any visiting relatives to stay, as they can act as transport.
• Ensure TTO’s and follow-up appointments have been made.
• Do not discharge Obstetrics & Gynaecology patients home without authorisation from the Control Room.
• Discharged patients can be sent home with relatives if available. Otherwise, send to Discharge Lounge level 2 to await transport.

Prepare to receive stable patients from other specialities
SURGICAL SPECIALTIES

ACTION CARD No 17 ON DUTY CONSULTANT OBSTETRICIAN

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard via Nursing bleep holder</td>
<td>Beatrice (Post-natal)</td>
<td>Senior Surgeon pre-op</td>
</tr>
</tbody>
</table>

Summary of Role
Treatment of patients

A Major Incident has been declared.

ACTIONS

- Go to Beatrice Ward (post-natal) and commence ward round to identify those patients who can be discharged.
- Report to the Senior Surgeon pre-op once ward round completed for deployment
Major Incident

ACTION CARDS

Theatres
THEATRES

ACTION CARD No 1 CLINICAL CO-ORDINATOR OR DEPUTY (MOST SENIOR PRACTITIONER AVAILABLE)

A MAJOR INCIDENT HAS BEEN DECLARED

Summary of Role

Organisation and coordination of theatres.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Site Team</td>
<td>Theatres</td>
<td>Nurse Director Control Room</td>
</tr>
</tbody>
</table>

ACTIONS

- Call in the Clinical Lead and Theatre Administrators
- Give Administrators their Action Card (Action Card No. 2)
- Designate staff who can act as Runners.
- Stop and cancel lists, return patients to wards NB. Laverstock Patients will have to go to Britford ward.
- Set up Four Major Incident Theatres:
  - 2 x General/Vascular
  - 2 x Orthopaedic
- Nominate a member of staff to take charge of Recovery and give them their Action Card (Action Card No.3.)
- Keep the Nurse Director and Medical Director in Control Room 3 informed of your progress.
- Keep the duty manager in Control Room 1 informed of your progress.
- Distribute tabards and ensure all appropriate staff wear accordingly.
- Clear wipe board for use.
A MAJOR INCIDENT HAS BEEN DECLARED

Summary of Role

Reception and Runner Duties

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Co coordinator</td>
<td>Main Theatre</td>
<td>Clinical Co coordinator</td>
</tr>
<tr>
<td></td>
<td>Department</td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS

- Liaise with theatres Clinical Co coordinator
- Call in extra staff – including ODO’s (Porters)
- Ensure reception is staffed at all times
- Send messages through the theatre runners
- All messages to be logged and conveyed appropriately
- Act as link between Main Theatre Department team and other areas.
A MAJOR INCIDENTAL HAS BEEN DECLARED

Summary of Role

1. Prepare recovery for Major Incident patients.
2. Prepare recovery to receive ventilated patients if ITU is full

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Coordinator</td>
<td>Main Theatre</td>
<td>Clinical Coordinator</td>
</tr>
<tr>
<td>or Administrator</td>
<td>Department</td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS

- Clear Recovery as soon as possible. Report progress to theatre Clinical Co-ordinator.
- Assess staff needs. Confirm needs with Senior Practitioner, prepare call in list for administrator.
- Check stocks – identify short falls to senior practitioner.
- Make areas ready to receive patients.
- Prepare to accept possible ventilated patients if ITU is full.
A MAJOR INCIDENT HAS BEEN DECLARED

Summary of Role
Support to Theatre Staff

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>Main Theatre</td>
<td>Clinical Co coordinator</td>
</tr>
<tr>
<td></td>
<td>Department</td>
<td></td>
</tr>
</tbody>
</table>

ACTIONS

- Assist in returning patients to wards.
- Prepare and stock all available trolleys
- Collect extra oxygen cylinders
- Collect extra blankets, sheets, scrub suites etc.
- Identify one person so act as “Runner”
- Assist in incident as instructed by Senior Practitioner in charge
- Be prepared to remain on duty or to change shifts.
A MAJOR INCIDENT HAS BEEN DECLARED

Summary of Role

Support clinical co coordinator acting as link between Main Theatre Department and other areas.

Communications Summary:

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>Main Theatre Department</td>
<td>Clinical Co coordinator</td>
</tr>
</tbody>
</table>

ACTIONS

- Liaise with theatre Clinical Co coordinator regarding tasks
- Convey and receive messages from Administration Staff
Major Incident

ACTION CARDS

Burns
SUMMARY OF ROLE OF BURNS UNIT

If Salisbury District Hospital is a Receiving Hospital (i.e. taking Major Incident patients) for patients with Burns:

1. Cancel non-essential operations.
2. Contact the National Burn Bed Bureau (NBBB) and inform them of the implementation of the MI plan.
3. The plan is to admit Major Incident burns patients to a single area – Burns unit if enough beds or Laverstock if not.
4. Call in off-duty staff.
5. Clear as many burns unit beds.
6. Support Laverstock Ward with experienced burns unit staff if there are too many casualties to accommodate in cleared burns unit beds.
7. Keep lines of communication open with ED and Anaesthetics.
8. Keep the Medical Director and Director of Nursing in Control Room 3 informed of your staffing progress.
9. Keep the Site co-ordinator and duty manager informed of your capacity
10. Anticipate disruption caused to your Specialities over the next days/weeks in terms of capacity and consumables.
11. Ensure adequate staffing for the next day.

If Salisbury District Hospital is asked to act as a Support Hospital for those hospitals who are receiving Major Incident patients:

1. Accept stable non-Major Incident patients from receiving hospitals.
2. Donate staff to act in support of a burns receiving hospital if requested to do so.
Summary of Role
To co-ordinate the deployment of Burns unit Medical staff, on-site and off-site.
Triage patients in ED
Treat patients

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You inform:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchboard requested via the ED Medical Co-ordinator (MCO)</td>
<td>Off-duty consultant On-call registrar Senior Nurse in Burns Unit</td>
<td>Orthopaedic outpatients - control room 1</td>
<td>MCO</td>
</tr>
</tbody>
</table>

ACTIONS

- Call in off-duty consultant and request they attend site and report to the Burns Unit to identify suitable patients for discharge/transfer
- Call in on-call registrar and request they attend site and report to the Burns Unit and work with the off-duty consultant to identify suitable patients for discharge/transfer.
- Call Burns Unit Senior Nurse on duty and request a senior nurse attend orthopaedic outpatients, control room 1 with a list of current beds and number of potential discharges/transfers.
- Proceed to control room 1 and liaise with the ED Medical Co-ordinator (ED Consultant), Anaesthetic Triage Officer, Duty Manager and Senior Burns Nurse to determine if sufficient resources are available to take burn injury patients.
- If insufficient resources, then the National Burn Bed Bureau (NBBB) must be contacted informed that the plan is live.
- If potentially sufficient resources the NBBB must be contacted and put on standby. The Duty manager must then remain in contact with the NBBB.
- Proceed to ED and triage patients with the anaesthetic triage officer, burns senior nurse and the MCO. Agree order of priority for transfer of patients to the Burns Unit/theatres.
- Continue to maintain liaison with the off-duty consultant and registrar on the burns unit.
- Maintain liaison with Senior Surgeon Pre-Op (Duty UROLOGY Consultant) on Laverstock Ward and Senior Surgeon Theatres (Duty Orthopaedic Consultant).
- Requests for additional Surgical staff must be made through the medical director in Control room 3.
- Request deployment of burns medical staff to theatres or Laverstock ward via the Medical Director in control room 3.
  Remain in ED until triage of patients complete or until you are required in theatres or the ward. Maintain links with the ED department if this happens.
  Do not leave the Hospital after the incident has finished. Ensure that there are adequate staffing levels for the following day.
- Liaise with the Duty Manager to arrange a formal debriefing process and analysis of the incident.
- Ensure lists have been cancelled (and patients informed) if there are no available beds/staff. The MI will have an impact on the delivery of the services for both plastics and burns patients.
- Continue to monitor and identify patients for repatriation of patients to their local host service at the earliest opportunity.
## Summary of Role
Treatment of Patients
Call in Off-duty burns medical staff

A Major Incident has been declared.

## Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-duty Colleague</td>
<td>Burns Unit</td>
<td>Medical Director - control room 3</td>
</tr>
</tbody>
</table>

## ACTIONS
- Report to the Burns Unit
- Call in off-duty burns medical staff and ask them to report to the Burns Unit. Once all posts required are filled, additional staff should report to the Medical director in orthopaedic outpatients, control room 3.
- Identify those patients on the unit suitable for discharge/transfer with the on-call registrar and senior nurse on the ward
- Inform the site co-ordinator of the number of beds available on the unit
- Remain on the ward ensuring discharges/transfers are completed unless requested by the on-call consultant or Medical Director to deploy to another area.
- Treat patients arriving from ED/Theatres etc as part of the major incident.
- Liaise with the on-call Burns consultant throughout
- Do not stand down until told to do so

**NB:** You may be asked to assume the role of Senior Surgeon Pre-Op. Accept this role if you think it desirable to do so.
SUMMARY OF ROLE
TREATMENT OF PATIENTS

You have been informed that a Major Incident has occurred by a senior colleague.

COMMUNICATIONS SUMMARY

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call consultant</td>
<td>Burns Unit</td>
<td>On-call consultant</td>
</tr>
</tbody>
</table>

ACTIONS

- Proceed to the BURNS UNIT.
- With the on-call consultant and senior nurse identify the number of patients that can be discharged/transferred and subsequent number of beds that will be available. Consider sending patients who are too unwell to go home to other wards. Discussion must be made with the site co-ordinator on bleep 1312.
- Remain on the ward completing discharges and transfers for those patients.
- Cascade information concerning the referred patients on ED from the Senior Burns Nurse in ED and cascade this down to the Senior nurse on the burns unit.
- All patients who are discharged should have TTO’s and follow-up appointments made prior to leaving hospital
- Treat patients arriving from ED/Theatres etc as part of the major incident.
Summary of Role
To co-ordinate nursing staff on ward
To co-ordinate possible transfers and discharges
To co-ordinate new admissions

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSN</td>
<td>Burns Unit</td>
<td>Director of Nursing – Control Room 3</td>
</tr>
</tbody>
</table>

ACTIONS

- Identify suitable trained member of staff to report to the Control Room 1 and remain in ED for triage of patients.
- Ensure triage nurse in ED has bed numbers and potential discharge information on leaving the ward
- Call in A&C member of staff if not already present
- Identify nursing staff to call in and begin this process if no ward clerk cover. On arrival of ward clerk hand this role over to her.
- On arrival of the on-call consultant and registrar identify the number of patients that can be discharged/transferred and subsequent number of beds that will be available. Consider sending patients who are too unwell to go home to other wards.
- Inform the site co-ordinator of the number of beds available
- Following arrival of the off-duty consultant and registrar, Inform the senior burns nurse in ED and the on-call consultant the number of potential discharges/transfer and number of beds available. Send a runner to ED with this information.
- Remain on the ward at all times and do not stand down until told to do so.
BURNS

ACTION CARD No 5 SENIOR NURSE BURNS UNIT IDENTIFIED DEPUTY

Summary of Role
Organisation and co-ordination of burns nursing response
Triage of patients in ED

Communications Summary

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Burns Nurse</td>
<td>Orthopaedic outpatients – control room 1</td>
<td>Senior Burns Nurse</td>
</tr>
</tbody>
</table>

A Major Incident has been declared

ACTIONS

- Report to orthopaedic outpatients, control room 1 at the request of the On-call consultant.
- Remain in the ED department and triage patients with the on-call consultant and anaesthetic triage officer.
- Keep the site co-ordinator, registrar, ED nurse co-ordinator and senior nurse on burns informed of those patients who will require admission
- Remain in the ED departments until triage of patients has been completed or until you are required on the ward, maintain links with the ED NCO if you leave ED.
- Do not leave the hospital after the incident has finished.
- Continue to monitor and identify patients with the on-call consultant which are clinically suitable for repatriation to their local host service.
SUMMARY OF ROLE
To call in off-duty staff
To undertake admin roles as required for new admissions, transfers and discharges

COMMUNICATIONS SUMMARY

<table>
<thead>
<tr>
<th>You will be informed by:</th>
<th>You go to:</th>
<th>You report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse Burns Unit</td>
<td>Burns Unit</td>
<td>Senior Nurse Burns Unit</td>
</tr>
</tbody>
</table>

ACTIONS

- On arrival continue with the call in of off-duty staff, updating the senior nurse in charge with numbers on completion
- Undertake administrative duties as and when requested by nursing staff and the senior nurse
- Ensure computer system up-to-date with patient information
- Ensure all outpatient appointments are booked for discharge patients prior to leaving hospital
- Do not stand down until told to do so
## APPENDIX 1  Requirements for the Departments

<table>
<thead>
<tr>
<th>AREA</th>
<th>DEPARTMENTAL RESPONSIBILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td>Keep at least two copies of the Major Incident Plan (Nursing Director/Deputy will collect a copy from ED if a MI has occurred).</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>Keep up to date lists of telephone/bleep numbers of all clinical staff.</td>
</tr>
<tr>
<td>Bereavement Team</td>
<td>Ensure switchboard has up to date list for MI contacts for your office.</td>
</tr>
<tr>
<td>Burns Unit</td>
<td>Keep up to date lists of telephone/bleep numbers of all staff</td>
</tr>
<tr>
<td>Press Officer</td>
<td>Ensure an up to date list of MI administration staff is kept at the switchboard.</td>
</tr>
<tr>
<td>Customer Care Department</td>
<td>Ensure switchboard has up to date list for MI contacts for your office.</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Establish a reserve call out list of staff, including telephone numbers, who can be called out if an MI occurs.</td>
</tr>
<tr>
<td>Medical Assessment Unit</td>
<td>Keep up to date lists of telephone/bleep numbers of all clinical staff.</td>
</tr>
</tbody>
</table>
| Plastic and Oral Surgery Outpatients | Ensure emergency hamper is fully ready at all times and stored in the department  
Keep up to date lists of telephone/bleep numbers of all clinical staff                                                                                     |
| Sarum Ward                   | Keep up to date list of paediatric nursing and support staff and telephone numbers in Sarum Ward Major Incident file.                                                                                                         |
| Clinical Support             | Keep up to date lists of on call staff in all relevant services including telephone numbers in case of Major Incident occurring.                                                                                               |
| Pharmacy                     | Keep up to date list of on call Pharmacy staff and telephone numbers in case of Major Incident occurring.                                                                                                                   |
| Chaplains                    | Keep up to date list of Chaplain staff and telephone numbers in case of Major Incident occurring.                                                                                                                        |
| Laverstock Ward              | Keep up to date lists of telephone/bleep numbers of all surgical staff.                                                                                                                                                     |
| Theatre                      | Ensure up to date MI call in list is kept in the department.                                                                                                                                                                |
| Voluntary Services           | Maintain an up-to-date list of volunteers with telephone numbers able to assist during a Major Incident                                                                                                                   |

ALL DEPARTMENTS SHOULD KEEP A COPY OF THE MAJOR INCIDENT PLAN TO HAND.
## Major Incident contact numbers

<table>
<thead>
<tr>
<th></th>
<th>IN HOURS</th>
<th></th>
<th>OUT OF HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Number</strong></td>
<td><strong>Alternative Number</strong></td>
<td><strong>Switchboard</strong></td>
<td></td>
</tr>
<tr>
<td>ED</td>
<td>4156/7/4155 (Majors)</td>
<td>4163</td>
<td></td>
</tr>
<tr>
<td>ED Consultants</td>
<td>4159/4839</td>
<td>4173</td>
<td>Switchboard</td>
</tr>
<tr>
<td>ED X-ray</td>
<td>4204</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amesbury ward</td>
<td>3104</td>
<td>3117</td>
<td></td>
</tr>
<tr>
<td>Anaesthetic SHO - on call</td>
<td>Bleep 1178</td>
<td>2055</td>
<td></td>
</tr>
<tr>
<td>Anaesthetics Office</td>
<td>2055</td>
<td>2050</td>
<td>Switchboard</td>
</tr>
<tr>
<td>Beatrice 3</td>
<td>2183/8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Management</td>
<td>Bleep 1312</td>
<td>4886/4460</td>
<td></td>
</tr>
<tr>
<td>Britford Ward</td>
<td>4380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burns Unit</td>
<td>3139</td>
<td>3504</td>
<td></td>
</tr>
<tr>
<td>CEO Control Room 1</td>
<td>4178</td>
<td>Switchboard</td>
<td></td>
</tr>
<tr>
<td>Chaplain</td>
<td>4271</td>
<td>Switchboard</td>
<td></td>
</tr>
<tr>
<td>Chilmark ward</td>
<td>3144</td>
<td>3141</td>
<td></td>
</tr>
<tr>
<td>Consultant ENT Surgeon On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant General Surgeon On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant in Burns On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Maxillo-facial Surgeon On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Ophthalmologist On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Orthopaedic Surgeon On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Paediatrician On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Physician on-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Obstetrician on-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Urologist On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer Care Department &amp; Bereavement Team</td>
<td>2743 (Hedgerows)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Surgery Unit</td>
<td>4553</td>
<td>4550</td>
<td></td>
</tr>
<tr>
<td>Discharge Lounge</td>
<td>4457</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Downton Ward</td>
<td>2539</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duty Manager Control Room 1</td>
<td>4178</td>
<td>Switchboard</td>
<td></td>
</tr>
<tr>
<td>ON call Exec. - Wiltshire</td>
<td>pager - 07699757981</td>
<td>Southgate House 01380 733701</td>
<td>Pager as in hrs</td>
</tr>
<tr>
<td>HACO Hospital Ambulance Control Officer</td>
<td>#6 304</td>
<td>01380 733417</td>
<td>Switchboard</td>
</tr>
<tr>
<td>Hedgerows</td>
<td>2063</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HICC (Health Incident Coordination Centre)</td>
<td><a href="mailto:control.room@wiltshire.nhs.uk">control.room@wiltshire.nhs.uk</a></td>
<td>01380 733701</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td>2111 Bleep</td>
<td>1636</td>
<td></td>
</tr>
<tr>
<td>Laverstock Ward</td>
<td>4312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director control room 3</td>
<td>4179</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical House Officer - on call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Major Incident contact numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>IN HOURS</th>
<th>Alternative Number</th>
<th>OUT OF HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Records</td>
<td>4317</td>
<td>4358</td>
<td></td>
</tr>
<tr>
<td>Medical Registrar on-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Specialist Registrar on-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MLSO/Biotechnology Team On-call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortuary</td>
<td>2319</td>
<td></td>
<td>Switchboard</td>
</tr>
<tr>
<td>Nurse Co-Coordinator, ED nurses station</td>
<td>4156</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Manager Control Room 3</td>
<td>4179</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedic Outpatients Department</td>
<td>4176</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>4096</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Trackers control room 1</td>
<td>4178</td>
<td>4268</td>
<td>4268</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>4264</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery Outpatients</td>
<td>3550</td>
<td>3551</td>
<td></td>
</tr>
<tr>
<td>Pitton Ward</td>
<td>4660</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police - Headquarters Control Room</td>
<td>411444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Press officer</td>
<td>4178</td>
<td>2772</td>
<td>Switchboard</td>
</tr>
<tr>
<td>Radnor</td>
<td>4373/4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation Officer</td>
<td>4303</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarum Ward</td>
<td>2560/1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Unit (reception)</td>
<td>2430</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSEU</td>
<td>2427</td>
<td>2429</td>
<td></td>
</tr>
<tr>
<td>Sterilisation and disinfection Unit</td>
<td>4213</td>
<td></td>
<td>Switchboard</td>
</tr>
<tr>
<td>Surgical House Officer - on call</td>
<td>Bleep 1125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Registrar - on call</td>
<td>Switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatre Recovery</td>
<td>4283/9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatres</td>
<td>4414</td>
<td>4288</td>
<td></td>
</tr>
<tr>
<td>Tisbury Ward</td>
<td>4187/88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>2476</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whiteparish Ward</td>
<td>4183</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wiltshire Health Protection Unit</td>
<td>01380 723511</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT contact PAGER</td>
<td>07699 757981</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 3  Procedure for calling together a Mobile Medical Team

Request for a MOBILE MEDICAL TEAM.
This could be to attend a Major Incident scene or a small Incident which is not related to a Major Incident.

1. Pass ambulance control request for a team to nurse in charge or senior doctor in the ED (emergency Department) if immediately available. If not available pass to a qualified nurse in ED
2. Whoever takes the call should:
   Identify the caller and take a contact number.
   Write down the following details:
   - Type of Incident
   - Location of Incident
   - Number of casualties
   - Type of care the patient/s require i.e. airway management/anaesthesia
3. Contact the duty ED Consultant immediately (either in person or by air pager).
4. The duty ED Consultant takes responsibility for agreeing to or declining to dispatch the mobile medical team and the organisation of the team. This includes identifying and informing staff who are to be part of the team. This could be deployment of ED, anaesthetic, orthopaedic or surgical medical staff (accessed via their duty consultant) dependent on the needs of the patient.
5. The Nurse in charge of the ED will co-ordinate the drugs, equipment and protective clothing for the mobile team. (The equipment and clothing is in the MI cupboard, the drugs are kept in the SSEU drugs fridge.)
6. The mobile team should meet in the ED to collect the equipment and will be picked up from there by the ambulance service who will provide the transport to the scene.
7. Mobile medical teams should NOT be dispatched if SDH is receiving casualties from a Major Incident.
8. ED nurses will NOT travel with the mobile medical team if it depletes the ED nurse staffing levels.
APPENDIX 4 Department of clinical radiology - major incident plan for forensic emergency/incident requiring radiology services e.g. plane crash / terrorist attack etc.

Information received from the Regional Emergency Planning Officer states:

Where such an incident involves 5 or more fatalities National Plans have been drawn up to implement emergency responses at Regional Levels. Locally and for the South West Region a site for use as a temporary Mortuary has been designated and is situated in Warminster. The allocation of staffing, equipment and facilities have also been accounted for in the national planning. These do not involve the Clinical Radiology Department at SDH, Miles Woodford, Superintendent Radiographer Spinal unit is on the National Register and may be called away.

In an incident where less than 5 fatalities are involved or the emergency measures cannot cope with the influx, local hospitals may be asked to assist and in these cases the following plans for Salisbury District Hospital will come into effect.

- These type of incidents will have a marked effect on any Radiology Department designated to receive such cases.
- Only staff prepared to deal with this type of incident should be involved (nobody should feel obliged to deal with such cases).
- The on-call or other nominated Radiologist/s to be assigned to the incident and report all films before they leave the department.
- Notification of such an incident must be routed via a Radiologist / Superintendent Radiographer firstly and then implemented as for any other Major Incident but only involving staff as above. A list of such staff will be kept with the policy and updated annually.
- A nominated ‘Team Leader’ will identify any real or perceived dangers or problems e.g. Infection/contamination, presence of explosives sharp objects etc., (x-ray nursing staff will fill this role). They will also prioritise cases in liaison with staff presenting these cases to the department.
- Depending on type and number of cases expected to be imaged, sufficient staff must be made available to include a minimum of 2 radiographers/room, and nursing/helper/clerical assistance for each area of the department involved as remote sites e.g. spinal x-ray, orthopaedic x-ray, Room 14, CT as well as main x-ray could all be included.
- The Medico-Legal situation means 2 radiographers must be involved and identified on each case. From a safety point of view and for counselling considerations they must NEVER be left alone with any case and regular breaks taken as needed.
- Wherever possible these situations to be arranged so as not to interfere with normal working hours.
- These cases must be kept separate within the department from live/route cases.
- Areas of SDH Radiology likely to be involved:-
  1. CT Scanner – very useful and quick (use as deemed appropriate by radiologist).
  2. Screening facilities – according to availability both in main x-ray and spinal x-ray.
  3. General radiology – both in spinal x-ray and main x-ray using Room 2 and isolating ED to be kept for routine work, or use ED rooms keeping the surrounding doors closed and keeping Room 2 for routine work dependent on time and expected throughput.
  4. Ultrasound – of limited use.
  5. MRI – not useful not safe.

- Staff involved must wear theatre clothes and not regular uniforms. Gloves, gowns, hats, masks and aprons as appropriate dependent on contamination risks. Everything used should be carefully and appropriately disposed of and clearly labelled – Team Leader/Nursing staff to co-ordinate this.
- NB: Nothing should be left in the rooms following the event and the rooms properly cleaned before session is closed. Nursing staff will advise and assist here after assessing risk and best practice for cleaning.
SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

- Careful identification of each body part/patient (and clearly identified on each film), corresponding with catalogued name/number already assigned to specimen/body must be made NB: use lead side markers R&L wherever possible. Both radiographers initials to be annotated onto image before sending to PACS.

- Patients entered onto ROP’s as new patients with identifiers given on request.

- Reports should be kept together with each specimen/body throughout the whole incident. (As no ‘locked safe’ is currently available for storage within SDH, Radiology Department).

- All examinations must be input onto the department computer system correctly after the incident and PACS to ensure the department is compensated properly and a list made. These images will be burnt to CD as soon as is practically possible after the event.

As with all other Major Incidents time-off and pay will be awarded to all staff involved. Time-Off to be negotiated to be taken when convenient to both staff and routine department running.
The following personnel, both external and internal, have been designated as Lead for ensuring the Major Incident Plan is updated:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Ward</th>
<th>Number of Copies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare Holbrooke-Jones</td>
<td>Britford Ward</td>
<td>1</td>
</tr>
<tr>
<td>David Osment</td>
<td>ED</td>
<td>5</td>
</tr>
<tr>
<td>Nicola Webb</td>
<td>Radiology</td>
<td>3</td>
</tr>
<tr>
<td>Anne Seaman</td>
<td>Spinal Unit</td>
<td>2</td>
</tr>
<tr>
<td>Di Green</td>
<td>Discharge Lounge</td>
<td>1</td>
</tr>
<tr>
<td>June Sobucinska</td>
<td>Switchboard</td>
<td>1</td>
</tr>
<tr>
<td>Kate Merrifield</td>
<td>Chief Exec</td>
<td>1</td>
</tr>
<tr>
<td>Rebecca Smith</td>
<td>Duty Manager file</td>
<td>1</td>
</tr>
<tr>
<td>Neal Cleaver</td>
<td>Radnor Ward</td>
<td>1</td>
</tr>
<tr>
<td>Heidi Lewis</td>
<td>Burns Unit</td>
<td>1</td>
</tr>
<tr>
<td>Janet Hope</td>
<td>Theatres</td>
<td>1</td>
</tr>
<tr>
<td>Alyson Hill</td>
<td>Anaesthetics</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Medical Director</td>
<td>1</td>
</tr>
<tr>
<td>Patrick Butler</td>
<td>Public Relations</td>
<td>1</td>
</tr>
<tr>
<td>Tracey Nutter</td>
<td>Director of Nursing</td>
<td>1</td>
</tr>
<tr>
<td>Brian Moody</td>
<td>Laboratory Medicine</td>
<td>1</td>
</tr>
<tr>
<td>Jo Jarvis</td>
<td>Voluntary Services</td>
<td>1</td>
</tr>
<tr>
<td>Ron Perry</td>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td>Julia Galley</td>
<td>Clinical Site Team</td>
<td>1</td>
</tr>
<tr>
<td>Anne Veale</td>
<td>Social Care Department</td>
<td>1</td>
</tr>
<tr>
<td>Jenny Lang</td>
<td>Library</td>
<td>1</td>
</tr>
<tr>
<td>Nichola House</td>
<td>Medical Devices</td>
<td>1</td>
</tr>
<tr>
<td>Tracey Johns</td>
<td>Orthopaedics</td>
<td>1</td>
</tr>
<tr>
<td>Maria Smale</td>
<td>Pharmacy</td>
<td>1</td>
</tr>
<tr>
<td>Sue Borrett</td>
<td>Medical Physics and Bio Medical Engineering</td>
<td>1</td>
</tr>
<tr>
<td>Emma Austin</td>
<td>Directorate Secretaries office</td>
<td>1</td>
</tr>
<tr>
<td>Wendy Young</td>
<td>Medicine</td>
<td>1</td>
</tr>
<tr>
<td>Heidi Lewis</td>
<td>Laverstock</td>
<td>1</td>
</tr>
<tr>
<td>Tori Appleford</td>
<td>Surgery</td>
<td>1</td>
</tr>
</tbody>
</table>
## External Contact Personnel

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Bob Young Robert.Young@wiltshire.pnn.police.uk | Major Incident Planning  
Wiltshire Police  
Police HQ  
London Road  
Devizes  
SN10 2DN  
Tel – 01380 735735  
DDI – 01380 734101  
Mobile: 07977 197192 |
| Christopher Scott Medical.typist@boscombedown.raf.nmod.uk or BSDRAFSU-BOSMedNCO@boscombedown.wnfus.afpaa.mod.uk | Practice Manager  
Station Medical Centre  
MOD Boscombe Down  
Amesbury  
SP4 0JE  
Tel – 01980 664352  
Fax – 01980 663133 |
| Melanie Wilkey Melanie.wilkey@gwh.nhs.uk | Interim Emergency Planning Manager  
Great Western Hospital  
Marlborough Road  
Swindon  
SN3 6BB  
Tel - 01793 605938 |
| Dr Gabriel Scally Regional Director Public Health | South West Strategic Health Authority  
South West House  
Blackbrook Park Avenue  
Taunton  
Somerset TA1 2PX  
United Kingdom  
Tel: 01823 361245  
PA Julia Rogers (julia.rogers@southwest.nhs.uk) Tel 01823 361245 |
| Jody James – Associate Director Regional Resilience | South West Strategic Health Authority  
South West House  
Blackbrook Park Avenue  
Taunton  
Somerset TA1 2PX  
01823 631240 |
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Information</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deborah Haynes –</td>
<td>Emergency Planning Manager</td>
<td><a href="mailto:Deborah.haynes@wiltshire.nhs.uk">Deborah.haynes@wiltshire.nhs.uk</a></td>
<td>1</td>
</tr>
<tr>
<td>Mr James Rimmer</td>
<td>Director of Operations (EP Lead)</td>
<td><a href="mailto:james.rimmer@ruh.nhs.uk">james.rimmer@ruh.nhs.uk</a></td>
<td>1</td>
</tr>
<tr>
<td>Alex Massey</td>
<td>Emergency Planning Lead</td>
<td><a href="mailto:Alex.massey@ruh.nhs.uk">Alex.massey@ruh.nhs.uk</a></td>
<td>1</td>
</tr>
<tr>
<td>Avril Webb</td>
<td>Emergency Planning Liaison Officer</td>
<td><a href="mailto:Avril.webb@ruh.nhs.uk">Avril.webb@ruh.nhs.uk</a></td>
<td>1</td>
</tr>
<tr>
<td>Mark Kimberlin</td>
<td>Head of Emergency Planning Service</td>
<td><a href="mailto:mark.kimberlin@wiltshire.gov.uk">mark.kimberlin@wiltshire.gov.uk</a></td>
<td>1</td>
</tr>
<tr>
<td>Jeff James</td>
<td>CEO NHS Wiltshire</td>
<td><a href="mailto:Jeff.james@wiltshire.nhs.uk">Jeff.james@wiltshire.nhs.uk</a></td>
<td>1</td>
</tr>
<tr>
<td>Name</td>
<td>Contact Information</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>David Griffiths</td>
<td><a href="mailto:David.griffiths@suht.swest.nhs.uk">David.griffiths@suht.swest.nhs.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Planning &amp; Business Continuity Manager</td>
<td>Southampton General Hospital Tremona Road Southampton Hampshire SO16 6YD Tel - 023 8079 8497 Fax: 023 8079 4712</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HPA South West Team (North)</td>
<td><a href="mailto:SWT-northHPU@hpa.org.uk">SWT-northHPU@hpa.org.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPA (Southwest Team (north)</td>
<td>121 Lansdowne Court Gloucester Business Park Brockworth Gloucester GL3 4AB Tel - 0845 5048668 (in hours) Tel - 01454 455433 (OOH) Fax – 01452 378968</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Mahoney (LRF Lead)</td>
<td>Wiltshire FRS <a href="mailto:james.mahoney@wiltshire.gov.uk">james.mahoney@wiltshire.gov.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wiltshire Fire and Rescue</td>
<td>T: 01380 731194 M: 07850 945317</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Andy Goves</td>
<td><a href="mailto:andy.goves@wiltshire.gov.uk">andy.goves@wiltshire.gov.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Fire Officer and Chief Executive</td>
<td>Tel - 01380 731104 Mobile - 07802 335618 Fax - 01380 729264</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
### Major Incident Call Log Sheet

<table>
<thead>
<tr>
<th>Your Name</th>
<th>Today’s Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your Major Incident Role (on your action card):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Caller’s Name</th>
<th>Caller’s Organisation</th>
<th>Call Time Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caller’s Contact Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nature of Call/Enquiry</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response given immediately</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Further Action</th>
<th>Time Action Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Further Feedback to Caller</th>
<th>Time Feedback given</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Call Closed and by whom</th>
<th>Time Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Notes/ongoing follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D.O.B</td>
<td></td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>HOSPITAL NUMBER</td>
<td></td>
</tr>
<tr>
<td>GP:</td>
<td></td>
</tr>
<tr>
<td>PLACE OF DEATH:</td>
<td></td>
</tr>
<tr>
<td>IDENTIFYING FEATURES – E.G. CLOTHES/JEWELLERY ETC.</td>
<td></td>
</tr>
<tr>
<td>NEXT OF KIN:</td>
<td>NAME:</td>
</tr>
<tr>
<td>RELATIONSHIP:</td>
<td></td>
</tr>
<tr>
<td>CONTACT NUMBERS:-</td>
<td>HOME:</td>
</tr>
<tr>
<td>WORK:</td>
<td>MOBILE:</td>
</tr>
<tr>
<td>WHO INFORMED YOU:</td>
<td></td>
</tr>
<tr>
<td>HOW WERE YOU INFORMED:</td>
<td></td>
</tr>
<tr>
<td>DATE INFORMED:</td>
<td></td>
</tr>
<tr>
<td>YOUR NAME:</td>
<td></td>
</tr>
</tbody>
</table>
### Major Incident Enquiry Log – For Use by CUSTOMER CARE DEPARTMENT staff

<table>
<thead>
<tr>
<th>LOG NO.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PERSON ENQUIRY ABOUT</td>
<td></td>
</tr>
<tr>
<td>D.O.B</td>
<td></td>
</tr>
<tr>
<td>ADDRESS, IF KNOWN</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>IDENTIFYING FEATURES – E.G. CLOTHES/JEWELLERY ETC.</td>
<td></td>
</tr>
<tr>
<td>ANY SIGNIFICANT MEDICAL HISTORY/DENTAL RECORDS HELD ONLY ASK IF NECESSARY!!</td>
<td></td>
</tr>
<tr>
<td>NAME OF ENQUIRER</td>
<td></td>
</tr>
<tr>
<td>RELATIONSHIP (NOMINATED CONTACT PER FAMILY)</td>
<td>NAME: RELATIONSHIP: CONTACT NUMBERS:- HOME: WORK: MOBILE:</td>
</tr>
<tr>
<td>QUESTIONS ASKED</td>
<td></td>
</tr>
<tr>
<td>INFORMATION GIVEN TO ENQUIRER</td>
<td></td>
</tr>
<tr>
<td>FOLLOW UP NEEDED/FURTHER ACTION?</td>
<td></td>
</tr>
<tr>
<td>ACHIEVED?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>IF NO, WHAT NEEDS TO HAPPEN NEXT?</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 9 Inpatient Notification - For Use by CUSTOMER CARE DEPARTMENT staff ONLY

| Name |  
|------|------|
| D.O.B |  
| Address |  
| Hospital Number |  
| GP |  
| WARD/ PLACE OF DEATH |  
| IDENTIFYING FEATURES – E.G. CLOTHES/JEWELLERY ETC. |  
| Next of Kin: | NAME: |
| | RELATIONSHIP: |
| | CONTACT NUMBERS:- HOME: WORK: MOBILE: |
| Who informed you: |  
| How were you informed: |  
| Date informed: |  
| Your name: |  

AUTHOR: OWEN AINSLEY  
DATE OF REVIEW: March 2012  
MAJOR INCIDENT PLAN  
VERSION: 1.2  
DATE: March 2011  
- 202 -
• Facilities Major Incident Plan

• National Burns Major Incident Plan
MAJOR INCIDENT IN PROGRESS

The Trust is currently in the ‘LIVE’ phase of a major incident

Please minimise your use of iPM, Results Reporting, PACS and the Internet

Please refrain from using the hospital telephone system unless an emergency

Further information, updates and requests will be sent out via the computer in this way. Please remain logged into HAS to receive these.

Patrick Butler
Public Relations Manager
APPENDIX 12A

SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN

Mass Casualty Diagram – Level 1 Major Incident

Incident Occurs

Is this a mass casualty incident

YES

No/unknown

Communication cascade level 1
Refer to diagram 3

Is this a major incident?

YES

NO

Is this major incident manageable within the local health economy?

NO

YES

Activate local major incident plans
APPENDIX 12B

MAJOR INCIDENT PLAN

Mass Casualty Diagram – Level 2 Major Incident

LEVEL 2 MAJOR INCIDENT

Manageable within one SHA health economy?

NO

YES

Communication cascade level 2
Refer to diagram 3

Activate SHA wide major incident co-ordination and communication plan/s

Does this incident require limited mutual support from neighbouring SHAs? (Mass casualty standby)

NO

YES

Is the requirement likely to need the combined resources of the three SHA’s?

YES

NO

Escalate to Level 3
APPENDIX 12C

Mass Casualty Diagram – Level 3 Major Incident

(Level 2 incident)

Activate pan SHA mass casualty Command and control arrangements (Mass casualty declared)

Communication cascade level 3 Refer to diagram 3

Authorise enactment of NHS mass casualty plans and special arrangements

LEVEL 3 MASS CASUALTY
APPENDIX 13

Diagram 3 - Mass casualty communication cascade arrangements

Although this plan is escalatory it does not have to be activated sequentially

Level 1 - Major Incident
This is likely to involve 10's of patients

PCT/Acute Trust or Ambulance Trust in the Lead

Are numbers and patients type manageable locally?

YES

NO

Trigger level 2 or 3 Arrangements!

1. Ensure PCT are notified via on call if not already involved
2. Contact on call Exec Director of SHA for information.
3. Ensure that the DPH for PCT and HPA (LHPU) are kept informed to ensure they are kept in the loop and on standby if need be

Level 2 - Major Incident
This is likely to involve 100's rather than 10's

SHA in the lead with own resources or with mutual aid/ support from 2 neighbouring SHA's

Are numbers and types of patients manageable within one SHA economy/and or/ with support from neighbouring SHA’s?

YES

NO

Trigger level 3 Arrangements!

1. Ensure neighbouring SHA’s are alerted
2. Inform RDPH and RD (HPA)
3. Notify Dept of Health and put them on ‘Stand-by’

Level 3 - Mass Casualty Incident
This is likely to involve many 100's or even 1000's of patients

All 3 SHA’s working collaboratively with joint decision making across this defined health region

Are the numbers and types of patients manageable within the 3 SHA economies?

YES

NO

1. 3 SHA Chief Executives or deputies decide where health response will be run from and control room established
2. NHS Mass casualty incident management team convened
3. Keep RDPH/ RD (HPA) informed
4. Keep DH informed

1. Activate DH Operational Control Room and DH Comms
2. Activate Regional Resilience through Government office
### Patient Tracking Sheet

*To be used by patient trackers*

<table>
<thead>
<tr>
<th>Time</th>
<th>Hospital Number/Major Incident Number</th>
<th>Name</th>
<th>From</th>
<th>To</th>
<th>Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 15

**Patient Information Sheets (For use by receptionists only)**

<table>
<thead>
<tr>
<th>MI Number</th>
<th>Surname</th>
<th>Forename</th>
<th>DOB</th>
<th>Address</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Patient Log Sheet

<table>
<thead>
<tr>
<th>MI number</th>
<th>Patient Name/DOB</th>
<th>Address</th>
<th>Time In</th>
<th>Time Out</th>
<th>Soft Tissue/Fracture follow-up required</th>
<th>Wound/Dressing follow-up required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Condition</td>
<td>Area</td>
<td>Area Located</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>------------</td>
<td>------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td>Respiratory rate &lt;10 or &gt; 29 or intubated</td>
<td>Immediate</td>
<td>RESUS and MINORS AREA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Capillary refill &gt; 2 seconds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Stretcher patients with respiratory rate of between 10-29 and Capillary refill &lt; 2 seconds</td>
<td>Urgent</td>
<td>Trolleys 1-10 MAJORS AREA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>Walking/chair</td>
<td>Non-urgent</td>
<td>MINORS until declared as reaching full capacity by Medical co-ordinator (MCO) then allocate to SSEU then Plastic OPD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**APPENDIX 17**

**Patient Categories used by ED**

**AUTHOR:** OWEN AINSLEY  
**DATE OF REVIEW:** March 2012  
**MAJOR INCIDENT PLAN**  
**VERSION:** 1.2  
**DATE:** March 2011
### Children's Outpatient Log Sheet

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>DOB/Age</th>
<th>Address</th>
<th>Status (1=Treated pt. 2=Waiting)</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## APPENDIX 19  Abbreviations used in Major Incident Plan

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;C</td>
<td>Admin &amp; Clerical</td>
</tr>
<tr>
<td>ACC</td>
<td>Ambulance Control Centres</td>
</tr>
<tr>
<td>AIC</td>
<td>Ambulance Incident Commander</td>
</tr>
<tr>
<td>ALO</td>
<td>Ambulance Liaison Officer</td>
</tr>
<tr>
<td>BATS</td>
<td>Burns Assessment Team</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>CBRNE</td>
<td>Chemical, Biological, Radiological, Nuclear &amp; Explosive Incidents</td>
</tr>
<tr>
<td>CCU</td>
<td>Critical Care Unit</td>
</tr>
<tr>
<td>CDs</td>
<td>Control Drug's</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>DGH's</td>
<td>District General Hospital's</td>
</tr>
<tr>
<td>DSU</td>
<td>Day Surgery Unit</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EPL</td>
<td>Emergency Planning Lead</td>
</tr>
<tr>
<td>GWAS</td>
<td>Great Western Ambulance Service</td>
</tr>
<tr>
<td>HACO</td>
<td>Hospital Ambulance Control Officer</td>
</tr>
<tr>
<td>HCSW</td>
<td>Health Care Support Worker</td>
</tr>
<tr>
<td>HEPA</td>
<td>Health Emergency Planning Advisor</td>
</tr>
<tr>
<td>HO</td>
<td>House Officer</td>
</tr>
<tr>
<td>iPM</td>
<td>Information Patient Manager (PIMS)</td>
</tr>
<tr>
<td>MAU</td>
<td>Medical Assessment Unit</td>
</tr>
<tr>
<td>MCO</td>
<td>ED Department Senior Doctor (Medical Co-ordinator)</td>
</tr>
<tr>
<td>MI</td>
<td>Major Incident</td>
</tr>
<tr>
<td>MLSO</td>
<td>Medical Laboratory Scientific Officer</td>
</tr>
<tr>
<td>MMT</td>
<td>Mobile Medical Team</td>
</tr>
<tr>
<td>NBBB</td>
<td>National Burns Bed Bureau</td>
</tr>
<tr>
<td>NCO</td>
<td>ED Nurse Co-ordinator</td>
</tr>
<tr>
<td>ODO's</td>
<td>Operating Departmental Orderlies</td>
</tr>
<tr>
<td>OPD</td>
<td>Outpatient Department</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>PRHO</td>
<td>Pre-Registered House Officer</td>
</tr>
<tr>
<td>RIS System</td>
<td>Radiology Information System</td>
</tr>
<tr>
<td>ROP's</td>
<td>Remote Operations Panel</td>
</tr>
<tr>
<td>SFT</td>
<td>Salisbury Foundation Trust</td>
</tr>
<tr>
<td>SHO</td>
<td>Senior House Officer</td>
</tr>
<tr>
<td>SSEU</td>
<td>Short Stay Emergency Unit</td>
</tr>
<tr>
<td>SWPCT</td>
<td>South Wiltshire Primary Care Trust</td>
</tr>
<tr>
<td>TAR</td>
<td>Triage Area Receptionist</td>
</tr>
<tr>
<td>TN</td>
<td>Triage Nurse</td>
</tr>
<tr>
<td>TR</td>
<td>Triage Runner</td>
</tr>
<tr>
<td>TSSU</td>
<td>Theatre Sterile Supplies Unit</td>
</tr>
<tr>
<td>TTO's</td>
<td>To Take Away Drugs</td>
</tr>
</tbody>
</table>
APPENDIX 20  Contents of Major Incident Boxes 1 -3, and Press Box

Control Room 1

The Control Room 1 box is colour coded RED.

The contents you will find in this box are as follows:

- Notebook, sellotape, bluetak, post-it notes, pens and pencils
- Control Room Door sign
- Plan of orthopaedic outpatients and control rooms
- Patient identified area during an incident
- Call Log sheet (APPENDIX 6)
- Patient log sheet for patient trackers (APPENDIX 16)
- Communication sheets
- Next of Kin Details log sheet
- 2004 Wiltshire & Swindon Major Incident Hazardous Materials Guide
- 10/05/08 GWAS MI Cascade Notification
- 2006 National Burn Care Group MI Plan
- Fracture Clinic Door code (to access unit)
- Loggist Pool contact details
- Emergency Log Book no:7505

Control Room 1 (Site)

The SITE Control Room box is colour coded RED.

The contents you will find in this box are as follows:

- Notebook, pens and pencils
- Plan of orthopaedic outpatients and control rooms
- Patient identified area during an incident
- Bed State sheets

Control Room 2

The Control Room box is colour coded YELLOW.

The contents you will find in this box are as follows:

- Pens & Pencils, Bluetak
- Control Room Door Sign
- Plan of orthopaedic outpatients and control rooms
- Patient identified area during an incident
- Communication Sheets
- Next of Kin details log sheet
APPENDIX 21 Contents of Major Incident Boxes 1 -3 and Press Box – (Continued)

Control Room 3

The Control Room box is colour coded GREEN.

The contents you will find in this box are as follows:

Notebook, Pens & Pencils, Bluetak, post-it notes

Control Room Door Sign
Plan of orthopaedic outpatients and control rooms
Patient identified area during an incident
Call Log sheet (APPENDIX 6)
Communication Sheets
Next of Kin details log sheet
Copy of Medical Devices contact details

Press Box

The Press box is colour coded PURPLE

The contents you will find in this box are as follows:

Notebook, Pens & Pencils, post-it notes
MI Plan
Action Cards for Press Office
Map of Media Area
Description of Media area
Media Log Sheets
20 Press Badges
Dear Doctor

Your Patient: 

Date of Birth

Hospital Number

NHS Number

Emergency Department Attendance No: 

No. of Previous attendances:

Your patient attended the ED department on at

Source of referral:

Presenting Complaint

The incident occurred at:

He/She was examined by:

Investigations

Diagnosis

Interventions

Radiology

ED Clinician Seen

Comments for the GP

Following treatment the outcome was

Emergency Department Follow Up

If you require full attendance details please contact ED Secretary quoting ED reference No. above

Dr N Robinson – Lead Clinician
Mr N C Burrows – Consultant
Mr S Davies – Consultant
Dr J Lynch – Consultant
Dr J Klein – Consultant

Dr S Assheton – Consultant
Mr L Gray – Consultant
Dr A Hughes – Consultant
Mrs H Benfield – Acting Lead Nurse
Dr B Lockey – Consultant

Emergency Department
Salisbury NHS Foundation Trust
Salisbury
Wiltshire
SP2 8BJ

Telephone (01722) 336262 Ext. 4163
## APPENDIX 23 Loggist Pool Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Work Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kate Merrifield</strong></td>
<td>01722 429249 (ext 4249)</td>
</tr>
<tr>
<td>PA Chief Executive</td>
<td></td>
</tr>
<tr>
<td><strong>Tracey Johns</strong></td>
<td>01722 345539 (ext 2441)</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Department Coordinator</td>
<td></td>
</tr>
<tr>
<td><strong>Tori Appleford</strong></td>
<td>01722 336262 ext 2603</td>
</tr>
<tr>
<td>Surgical Secretariat Manager</td>
<td>Bleep 2035</td>
</tr>
<tr>
<td><strong>Hayley Pozzi</strong></td>
<td>01722 336262 ext 2764</td>
</tr>
<tr>
<td>Customer Care Administrator,</td>
<td></td>
</tr>
<tr>
<td><strong>Jane Willis-Newman</strong></td>
<td>01722 3362 62 ext 3554</td>
</tr>
<tr>
<td>Plastic &amp; Oral Surgery,</td>
<td>Bleep 1451</td>
</tr>
<tr>
<td>Department Coordinator</td>
<td></td>
</tr>
<tr>
<td><strong>Maryann Pearce</strong></td>
<td>01722 336262 ext 4080 or 4078</td>
</tr>
<tr>
<td>Office Manager, Genetics</td>
<td></td>
</tr>
<tr>
<td><strong>Davina Stephens</strong></td>
<td>01722 336262 Ext 4766</td>
</tr>
<tr>
<td>Theatre Booking Manager</td>
<td></td>
</tr>
<tr>
<td><strong>Jane Podkolinski</strong></td>
<td>01722 666262 ext 2577</td>
</tr>
<tr>
<td>Midwife, Maternity &amp; Neonatal</td>
<td></td>
</tr>
<tr>
<td><strong>Tracey Merrifield</strong></td>
<td>01722 336262 ext 2770</td>
</tr>
<tr>
<td>Project Manager, Operations</td>
<td></td>
</tr>
<tr>
<td>Directorate</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 25 MI Key Site Locations
Introduction:
This document outlines our approach to evacuating areas of the site in the event of a fire. It should be read in conjunction with the:

- Major Incident Plan
- Trust Fire Precautions Policy
- Ward / Department Fire Emergency Plans
- Business Continuity Plans

It should be noted that although there is a very limited risk to severe disruption by fire and a much lesser risk of total evacuation, following the fires that occurred in London Hospitals in recent we need to be prepared for large scale evacuation in necessary.

Prevention and Containment
The majority of clinical services are located within SDH North which has a compartmentalised architectural design to minimise the risk of fire spreading beyond one section of the building. Local / department plans are therefore the first line in terms of evacuation. This plan contains information on local plans, as well as alternative locations (on and off site) that could be accessed in the event of more widespread or prolonged disruption.

Local Evacuation Plans
Each ward and department has a fire evacuation plan and a copy is held locally within the ward and centrally by the Fire Safety Manager. An example plan for Britford Ward is included at the end of this document.

Evacuation Points and Capacity Management:
In the event of a small, localised Evacuation, each plan identifies initial assembly and evacuation points in order to allow staff and patients to be promptly evacuated to a place of safety. Localised evacuation will be flagged to the duty manager who will work with Site Coordinators and Directorate Senior Nurses to manage onward capacity and demand issues.

In the event of fire or other incident causing more widespread access issues for wards and departments, this would be treated as an internal Major Incident and Command and control arrangements as per the Major Incident Plan will be instigated.

The control room team will assess the impact and potential disruption and take appropriate steps to decrease demand, for example:

- Emergency Department Ambulance Divert
- Cancelling routine elective surgery
- Cancelling of Outpatient clinics
- Accelerated discharge / repatriation

Lateral / Horizontal Evacuation
If evacuation is necessary then the senior person present will take responsibility for local evacuation to the adjacent zone as defined in the area plan as the initial place of safety. Lateral evacuation would normally be the first step and only in extreme circumstances would vertical evacuation be the starting point.

Vertical Evacuation
This would only occur if there were no alternate and happen in a simple method by using the dedicated lifts and the tug access ramps in the central courtyard for patients being transported by bed or wheelchair, and the stairwells for mobile patients.

Where stairwells are being used for vertical evacuation it is ideal to keep the stairwell closest to the risk area as free from obstruction as is possible for fire-fighting purposes.
Patients Notes
Learning from the experience of the London Hospital Fires, patients notes should be evacuated along with patients. This information has been updated in local fire emergency plans.

On Site Locations for Inpatient Evacuation / Transfer
The geographical layout of the site (see site map appendix 25 of MIP) means there are geographically separate and distinct areas of the site that provide the opportunity to create temporary inpatient accommodation separate from the main clinical block in SDH North.

Alternative locations (short term):

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Scope</th>
<th>Time to operationalise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery Unit</td>
<td>SDH Central</td>
<td>Operating suite for GA and LA cases and / or 28 inpatient beds</td>
<td>Immediate</td>
</tr>
<tr>
<td>Old Pembroke Ward</td>
<td>Beatrice Corridor, SDH Central</td>
<td>26 bed spaces</td>
<td>&gt; 4 hours</td>
</tr>
<tr>
<td>Old Breamore Ward</td>
<td>Beatrice Corridor, SDH Central</td>
<td>28 bed spaces</td>
<td>&gt; 2 hours</td>
</tr>
<tr>
<td>Pre-op Assessment Area</td>
<td>Beatrice Corridor, SDH Central</td>
<td>8 bed spaces</td>
<td>&gt; Immediate</td>
</tr>
<tr>
<td>Old Sarum Ward</td>
<td>Beatrice Corridor, SDH Central</td>
<td>20 paediatric bed spaces</td>
<td>&gt; 4 hours</td>
</tr>
<tr>
<td>Clarendon Suite</td>
<td>SDH Central</td>
<td>4 bed spaces</td>
<td>Immediate</td>
</tr>
</tbody>
</table>

Alternative locations (Medium Term)

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Scope</th>
<th>Time to operationalise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farley Ward</td>
<td>SDH South</td>
<td>22 Bed spaces</td>
<td>8-10 weeks</td>
</tr>
<tr>
<td>Fovant Ward</td>
<td>SDH South</td>
<td>16 Bed spaces</td>
<td>8-10 weeks</td>
</tr>
</tbody>
</table>

Off Site Locations for Inpatient Evacuation / onward Transfer
In the event of widespread disruption, the control room team would work with the Ambulance Services and NUPT through the major incident arrangements to transfer patients to suitable alternative NHS providers (SUHT, GWH, RBCH, RUH, QAH, Winchester Hospital, Community Hospitals).

In addition to NHS providers, the Trust also has an SLA covering NHS work with New Hall Hospital that could be utilised in the event of disruption to services, via the Directorate Managers and Central Booking Office.

Alternative Location for Major Incident Control Room in Event of Fire Disruption:
In the event of the Major Incident Control Room in Orthopaedic Outpatients being unavailable for use in an incident, the Trust Library in SDH central can be utilised as an alternative facility. Access and set up details are contained within the control room set up box in ED.
# FIRE EMERGENCY PLAN EXAMPLE

<table>
<thead>
<tr>
<th>Address of premises:</th>
<th>Salisbury District Hospital, Odstock Rd, Salisbury SP2 8BJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward/Dept:</td>
<td>Britford ward Sector 13 level 4</td>
</tr>
<tr>
<td>Date plan produced and/or amended:</td>
<td>April 2008</td>
</tr>
<tr>
<td>Name of person producing plan (Print name):</td>
<td>A R Andrews</td>
</tr>
<tr>
<td>Job Title:</td>
<td>Fire Safety Manager</td>
</tr>
<tr>
<td>Description of Dept:</td>
<td>A 56 bedded surgical ward</td>
</tr>
</tbody>
</table>

**Action to be taken by person discovering a fire.**

1) Operate the nearest fire alarm call point  
2) Dial 2222 and inform the switchboard of the details of the incident.  
3) Move patients nearest the fire out of their room/ward and close the doors.  
4) Evacuate patients either into the adjoining ward or into the hospital street.

**How the Fire Brigade is to be called and who is responsible.**

By switchboard via 999 system

**Description of fire warning system and location of system panels.**

2 stage alarm with electronic sounders, continuous in the affected area and intermittent in adjacent areas

**Evacuation procedures**

All patients can be evacuated on their beds initially to Downton Ward, no manual handling procedures necessary

**Medical Notes for Inpatients**

Staff should ensure that medical notes are evacuated with inpatients to their new location to reduce risks to continuity of care.

**Assembly points.**

Downton Ward or hospital street, then onward according to patient needs

**Duties and identities of employees with specific responsibilities.**

1) Porters will meet and direct fire service to the location  
2) Fire warden to take patient notes and duty rota and take a roll call

**Arrangements for safe evacuation of patients and disabled persons**

All patients can be evacuated on their beds. Other persons who have accessed the ward will be able to leave by the same method – there are no stairs or steps to negotiate

**Fire fighting equipment provided? (locations and details)**
**SALISBURY NHS FOUNDATION TRUST MAJOR INCIDENT PLAN**

<table>
<thead>
<tr>
<th>9 and 6ltr Water plus 2kg co2 extinguishers are located throughout the ward and adjacent to each exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific arrangements for high fire risk areas</td>
</tr>
<tr>
<td>No high fire risk areas.</td>
</tr>
</tbody>
</table>

**Procedures for liaison with Fire Brigade on arrival**

1. The nurse in charge of the ward will make themselves known to the senior fire officer present and inform them of the status of patients, visitors and staff.
2. Estate staff responding will make themselves known to senior fire officer present and respond to any requests concerning fire alarms, services to be shut down etc.
3. Site Manager to liaise with senior fire officer present.
Emergency Department Chemical Incident Plan

Salisbury NHS Foundation Trust

March 2011

Role responsible for revisions - Emergency Planning Lead
Emergency Department Chemical Incident Plan

Introduction to the Plan

1. PURPOSE OF THE DOCUMENT
2. STAKEHOLDER INVOLVEMENT & PLAN CIRCULATION
3. BACKGROUND TO CRBNE
4. DEFINITIONS
5. ENDORSEMENTS
6. SUPPORTING PLANS
7. STRATEGIC RESPONSIBILITIES – THE TRUST BOARD
8. DEVELOPMENT OF THE PLAN
9. EMERGENCY DEPARTMENT DECONTAMINATION UNIT

9.1 Plan of Decontamination Area

10. TRIGGERING A CHEMICAL INCIDENT

11.0 ACTIVATING THE CHEMICAL INCIDENT PLAN

11.1 Stand-by
11.2 Live
11.3 Stand Down
11.4 DEALING WITH THE CHEMICAL INCIDENT THE PRINCIPLES
11.5 DEPARTMENTAL PRESENTATION
11.6 RECEPTION & TRIAGE
11.7 DECONTAMINATION
11.8 POST DECONTAMINATION CARE
11.9 STAFF PERSONAL PROTECTIVE EQUIPMENT

ACTION CARD No 1 – ED SHIFT CO-ORDINATOR

ACTION CARD No 2 – DECONTAMINATION TEAM LEADER

ACTION CARD No 3 – HOT ZONE NURSE

ACTION CARD No 4 – DECONTAMINATION SHOWER UNIT PERSONNEL x 2

ACTION CARD No 5 – WARM ZONE NURSE

ACTION CARD No 6 – DUTY MANAGER

APPENDIX 1 Glossary of Terms

APPENDIX 2 Decontamination Protocol

APPENDIX 3 Setting up the Decontamination Area

APPENDIX 4 Guidance for Staff working in the Contaminated Area

APPENDIX 5 Information for Contaminated Persons

APPENDIX 6 Rinse-wipe-rinse method of casualty decontamination

APPENDIX 7 Example of proposed questionnaire for chemical casualties
Introduction to the Plan

1. PURPOSE OF THE DOCUMENT

The aim of this plan is to enable Salisbury NHS Foundation Trust to respond effectively to a CRBNE event. It provides guidance for staff in the assessment and subsequent management of a CRBNE incident and should be read in conjunction with the Trust’s Major Incident Plan.

2. STAKEHOLDER INVOLVEMENT & PLAN CIRCULATION

This plan reflects collaboration within Salisbury Foundation Trust and with partner organisations who have seen drafts of the plan for comment. Such organisations include members of the Wiltshire Emergency Planning Group, the local PCT, Wiltshire Fire Service. This plan has been widely circulated in its final form to our partner organisations who will be notified of any significant changes in the plan should they occur.

3. BACKGROUND TO CRBNE

For many years the NHS has had a duty to care for casualties contaminated with hazardous materials. Since 11 September 2001 the deliberate release of Chemical, Biological, Radioactive and Nuclear material by terrorist groups has been added to the more traditional accidental releases of hazardous material (Hazmat) from industrial and commercial premises, transport accidents and the illegal disposal of contaminated waste.

Hazmat incidents have become more frequent and have the potential to produce large numbers of casualties. Many might self refer to Emergency Departments (ED), particularly if they cannot get treatment at the scene or the onset of symptoms may be delayed. Admitting such casualties, without decontamination, may result in the contamination of staff and other patients, closure of EDs or even whole hospitals. Dealing with such casualties without Chemical Personal Protective Equipment (CPPE) places staff at an unacceptable risk.

In 2002, the government introduced a number of initiatives designed to improve the response to such scenarios including the provision of mass decontamination facilities to the Fire & Rescue Services. As a part of these measures, the Department of Health issued National Standard Chemical Personal Protective Clothing (CPPE) and Mobile Decontamination Units (MDU) to ambulance services, acute and foundation Trusts. Ambulance, acute and foundation Trusts were mandated to train appropriate numbers of staff to operate the equipment and maintain it in a state of readiness. In 2007 new CPPE suits were issued which are easier to use. In addition, NHS National Reserve Stocks for Major Incidents are strategically placed across the UK with a number of Ambulance Services and the Blood and Transplant Service. These vehicles contain extra equipment and countermeasures that could be used in a large scale incident they are activated through the local ambulance service and are coordinated nationally for mutual aid. Staff training should include the awareness of this equipment, its use and the method of activation.

4. DEFINITIONS

With the new emphasis on terrorist activity have come new incident definitions;

HAZMAT: Is an accidental release of a substance, agent or material which may result in illness or injury to the public or the denial of an area or the interruption of the food chain.

CBRNE (Chemical, Biological, Radioactive, Nuclear, and Explosive): Is a deliberate murderous and malicious act, the intention of which is to kill, sicken or prevent society from continuing with their normal daily business.

Since 2002 further guidance and legislation has been introduced to further enhance the response capability to such incidents. The Civil Contingencies Act 2004 named acute and foundation Trusts as Category 1 Responders and placed a statutory duty on them to have in place plans;
to deal with any emergency and to deal with any threat to the provision of normal services during an emergency.

In 2005 the Department of Health issued ‘The NHS Emergency Planning Guidance’ which updated best practice in dealing with major incidents and offered guidance to all NHS bodies as to how they might comply with the Civil Contingencies Act.

The purpose of this guidance is to standardise the way in which casualty decontamination is carried out throughout England, It is intended that Scotland and Wales will have similar guidance so that Hospital Decontamination Teams have the ability to work seamlessly with the Ambulance Service and the Fire and Rescue Service all of whom have national arrangements.

As with all tasks carried out in the NHS, safety (including patient safety) is paramount. Safety within a decontamination environment can only be achieved with appropriate training and practice which must be regularly refreshed. Only properly trained decontamination staff should be allowed to wear Chemical Personal Protection Equipment, (CPPE) in exercises and incidents.

The content of this document is based on guidance issued by the Department of Health, the Scottish Government Health Directorates (SCGD) and Welsh DoH. It reflects current best practice in respect of CBRNE and Major Incident response.

5. ENDORSEMENTS
The plan is endorsed by:
Salisbury NHS Foundation Trust (SFT) CEO
Emergency Department Lead Clinician
Trust Emergency Planning Lead

6. SUPPORTING PLANS
The plan is supported by:
SFT Major Incident Plan
The Wiltshire & Swindon Health Services Major Incident Strategic Response
Wiltshire Hazardous Materials Incident Guidance
The Wiltshire Mass Casualty Plan

7. STRATEGIC RESPONSIBILITIES – THE TRUST BOARD
The Trust Board has a statutory responsibility for ensuring that their Hospital meets their obligations to provide effective treatment for all casualties attending Emergency Departments and protect their staff and the public (Health and Safety at Work Act 1974) who may be in and around the emergency department.

‘Every emergency department must have the ability to deliver decontamination facilities for casualties that may be contaminated and continue to provide normal A & E services through the department’. (Business Continuity Plans, Civil Contingencies Act 2004).

The decontamination response must be of such a level as to mitigate the effects of the contamination and protect staff and the public.

An extract from the 2010/2011 Operating Framework states ‘all NHS organisations, other contracted healthcare providers, local authorities and other local organisations should give high priority to putting in place and testing plans and arrangements to deliver an effective response to threats and hazards. This should include chemical, biological, radioactive and nuclear (CBRN) threats and those from conventional terrorism.

The Civil Contingencies Act 2004 requires all Category 1 responders to plan and prepare their response to a civil emergency to protect the public and to cooperate with other agencies mentioned in the Act. These organisations have “A duty to assess risk, duty to maintain plans, a duty to maintain
business continuity management plans and a duty to communicate with the public”. Failure to comply could result in criminal proceedings and civil litigation.

This organisational responsibility is of such importance that it must be led by a Trust Board Director who will assure the board at least annually that the organisation is meeting its obligations.

SFT will develop a systematic approach following best practice and guidance to develop and deliver an effective decontamination programme that is proportionate, practical and clinically effective. The Trust will select and train a cadre of staff to implement the plan. These staff (ED NCOs/competent persons) should lead any response and their training should reflect this role.

8. DEVELOPMENT OF THE PLAN
The Emergency Department Hazmat/CBRNE plan has been developed by appropriate knowledgeable staff from the Trust and linked with our multi agency partners to produce an integrated emergency plan.

The group consists of:

Trust Emergency Planning Lead
ED Lead Consultant
Trust Health & Safety Advisor
Trust Risk Manager
Trust Estates Manager
SFT Security Manager
ED NCO

The plan will be shared with our external multi agency partners as required such as ambulance service, fire service and Health Protection Agency.

Following Board approval, staff must be trained in the operation of the plan, and the plan should be exercised and evaluated, reviewed, amended and retested on a regular basis.

Hazardous material plans and equipment will be subject to annual audit on behalf of the Department of Health or as required in the Trust’s NHS contract. The specific requirements of the audit will be shared with the Trust but particular emphasis will be on training records and maintenance of equipment.

9. EMERGENCY DEPARTMENT DECONTAMINATION UNIT
The Trust has a dedicated decontamination unit, which is situated at the top of the ED ramp with access direct from the ramp into the decontamination area. See 9.1 for diagram of area.

The decontamination unit ensures we can:

Maintains access to the ED for ambulances and uncontaminated casualties
Allows sufficient space to locate Mass Decontamination Facilities
Ensures that the necessary services (hot water, lighting etc) are available
Provides dignity for patients who need to undress or remove contaminated clothing.
Prevents contaminated water flowing to the clean side of the ED
9.1 Plan of Decontamination Area
10. TRIGGERING A CHEMICAL INCIDENT
A chemical incident may be heralded by any of the following triggers:
Warning from the emergency services, industrial sites, the military or other sources
Major Incident Standby or Live declaration
The unannounced presentation of small or large numbers of casualties with collapse, skin blistering/burns, visual disturbance, sweating, breathing difficulties, lachrymation, salivation, convulsions, muscle tremors, hoarseness or major Gastro Intestinal Tract disturbance A combination of the above.

11.0 ACTIVATING THE CHEMICAL INCIDENT PLAN
A chemical incident plan will be put into effect if a trigger event occurs. It would be usual to notify in the same way as Major Incident via a call to Switchboard which will trigger a call to ED:

In flow diagram form the initiation looks like this:-

Call Alerting to a potential for a Major Incident/CRBN Incident

Call received by Switchboard

Switchboard contacts ED (Emergency Department)

Call received by ED

ED NCO Contacts Switchboard to request call out of Control room team

YES

Nurse Co-ordinator (NCO) Contacts ED Consultant (MCO) to determine if Standby should be declared

NO

Control room team and MCO decide if LIVE should be declared

LIVE DECLARED

YES

Duty Manager (DM) contacts Switchboard to inform them of LIVE Status and requests call out of staff on the Switchboard (facilities)

NO

Major Incident plan

Stand down Switchboard and ED

Switchboard commences call out of staff and informing of key personnel as identified in their Major Incident plan

Detail of initiation
Upon receiving a call alerting the ED to a potential Major Incident the ED Nurse Co-ordinator (NCO) will contact the ED consultant (MCO). The MCO will decide if stand-by needs to be declared.
11.1 Stand-by  This indicates that the hospital may need to respond to a Major Incident.

STAND-BY can only be called by the MCO, or, in the absence of an MCO and in the event of failure to contact one, by the NCO.

11.1.2 Stand-by key Actions:

g) If stand-by is declared the NCO will contact switchboard and request that the Control room team and Burns On-call consultant (if Burns Major Incident) are called out.

h) The NCO will contact the site co-ordinator and inform them that the hospital is on STAND-BY to receive patients.

i) Members of the Control room Team, including the MCO will make their way immediately to Major Incident Control Room 1, which is situated in the Orthopaedic outpatient department.

j) The Clinical Site Co-ordinator will be asked by the NCO to obtain accurate current and potential bed-states.

k) The Control room Team will assess the situation with the MCO and will decide whether to remain on STANDBY, or whether to proceed to LIVE Major Incident status. Most staff will therefore only be informed of a Major Incident at the live phase.

l) At Major Incident Standby, the ED Team will prepare to receive casualties. The NCO will make immediate arrangements for the admission or discharge of existing ED patients. Patients in the ED Waiting Area will be informed of the situation and advised to seek treatment from alternative health care providers including GP practices and NHS Walk-in Centres as appropriate. Orthopaedic outpatients and plastic outpatient departments will be asked to inform patients currently waiting of the STAND-BY phase.

11.2 Live - This means the hospital is actively involved in a Major Incident response and all staff must implement the Major Incident Plan immediately. The implementation of this plan will vary depending on the nature of the Incident. LIVE can only be called by the MCO or the Duty Manager and will usually be called jointly following discussion.

11.2.1 LIVE Key Actions

11.2.1 If the Major Incident is LIVE, the Duty Manager will instruct Switchboard to call in those staff on their prepared list. Those called by switchboard will implement their respective action cards including cascading to colleagues if indicated.

11.2.2 If the Major Incident is LIVE, the specialty receiving is BURNS and we are either the receiving ED or host burn service, then the National Burn Bed Bureau must be contacted immediately by the Duty Manager following discussion with the burns on-call consultant. Contact details can be found in Control Room 1 box file.

11.2.3 Once a Major Incident is LIVE, a broadcast message will be sent out by the Press Manager (Appendix 11 Major Incident Plan) informing all staff to keep the use of computers to a minimum and to refrain from using the telephone system. Further broadcast messages will be sent out updating staff on current situation by the Press Officer. Messages will also be displayed on the Plasma screens in waiting areas informing patients waiting for outpatient appointments.

11.2.4 If SDH is declaring the Major Incident the ‘Emergency Planner – Wiltshire’ should be paged by the duty manager – pager number as on the telephone list.

11.2.5 If anticipated casualty numbers are greater than can be accommodated in appropriate specialist beds the receiving ward will be Laverstock which should be alerted to implement its action cards and clear beds.

11.2.6 Throughout the Major Incident the Facilities Department will operate their own Major Incident plan which is available in a separate document but key points linked to this, a copy can be found in Control Room 1 box file.

11.2.7 Requests for staffing help should be directed via control room 3 and discussed with either the Medical Director or the Nursing Director.

Useful phone numbers are listed as an appendices to this document.
11.2.8 Inform orthopaedic outpatients and plastic outpatients that their respective areas need to be used for Major Incident Patients.

11.3 Stand Down - This indicates that the hospital's response to the Major Incident is to be concluded. STAND DOWN can only be called by the Control room/Duty Manager.

The Emergency Department.
The ED team (Hazmat Lead should assess the Risk of the incident and as appropriate trigger the plan at the appropriate level. (The hospital may be seriously affected by an incident and it may require a combined response from other departments to support the decontamination process and include: Local Emergency Services, On-call Public Health/ Health Protection Agency, Chemical Incident Provider Unit (or National Poisons Information Service).

11.4 DEALING WITH THE CHEMICAL INCIDENT THE PRINCIPLES
All casualties who self present from the scene of a suspected chemical incident are considered to be contaminated.
In chemical incidents the actions in order of priority are: containment, decontamination, resuscitation, primary treatment and then definitive care.
The HAZMAT LEAD should carry out a Risk Assessment and decide the most appropriate level of:
Personal Protective Equipment
Type of Decontamination (Bucket(s) of water, full decontamination or mass decontamination.
Requirement for Treatment before decontamination
Staff receiving contaminated casualties must be in full Chemical Personal Protective Equipment (CPPE) when the contaminant is unknown or if known and advised by the Ambulance Service from the incident site to use full CPPE or the patient is displaying serious burns or Difficulty in Breathing giving cause for concern.
Primary triage (triage sift) will take place on arrival, outside the Emergency Department, prior to decontamination.
Prior to and during decontamination only Basic Life Support and First Aid (simple airway opening manoeuvres, bag-valve-mask ventilation, and pressure on wounds) will be possible. A snatch bag containing disposable equipment including a method of triage such as plastic wrist bands would be useful for such an event.
It is recommended that coloured plastic wrist bands (Slappers) are used as triage markers.
Patients must be decontaminated before entering the Emergency Department.
After decontamination, casualties should be triaged for emergency medical care.
With the help of the Chemical Incident Provider Unit try and identify the likely chemical involved and any treatment/countermeasures.

11.5 DEPARTMENTAL PRESENTATION
Minimum departmental equipment should include body, hand and respiratory PPE, CPPE suits, buckets, sponges & soft brushes, detergent, cloth & paper towels, blankets, sheets, some form of modesty clothing and access to an external (preferably warm) water supply.
A Chemical Triage Officer should be nominated, clothed in CPPE, and deployed at the entrance to the Emergency Department if required.
Staff behind the decontamination unit (clean side) should wear normal clothing but should be alert in case of wind variations.
Where it is deemed necessary a decontamination team of five personnel is formed, clothed in CPPE, and deployed to the decontamination area at the entrance to the Emergency Department.
Decontamination is carried out by the decontamination team under the direction of the Chemical Triage Officer or Safety Officer.
If the number of chemically contaminated casualties exceeds the departmental capacity then mass casualty decontamination procedures will be commenced. This should be via the Memorandum of Understanding (MOU) with the local Fire and Rescue Service. It should be clearly known when the MOU is to be activated i.e. when the hospital cannot cope with the number of self presenters. In all cases the ambulance service should be notified. (This document has to be agreed in conjunction with Wiltshire Fire & rescue).
Patients in the Emergency Department should be moved to an area of safety if there is any danger of chemically contaminated patients coming in to the ED.
Entry and exit routes to and from the department must avoid areas of chemical contamination.
Consider if ‘Hospital Lock Down’ is required.
11.6 RECEPTION & TRIAGE
The Chemical Triage Officer should use the triage sift to prioritise patients for decontamination. The triage and treatment priorities for contaminated children are as for adults. For an equivalent level of exposure in general, children are more likely to exhibit greater toxic effects than adults, this should be considered within the triage sift.

11.7 DECONTAMINATION
The decontamination team should carry out decontamination. All clothing must be removed from chemically contaminated casualties, gender and religious beliefs need to be considered, disrobing to allow for patient dignity is required in a separate tented area, prior to entering the decontamination unit. All removed clothing must be suitably bagged and marked so that the owner can be linked to the property or for forensic purposes. Patients who are capable should be encouraged to carry out their own decontamination process. In the interest of safety all clothing and personal effects will be treated as contaminated items. Personal items such as Mobile phones, coins, jewellery, keys etc, should be decontaminated wherever possible and returned to their owners. No attempt should be made to decontaminate items which might absorb or otherwise harbour contaminant. Such items should be bagged and labelled. Current evidence suggests that water plus detergent (10 ml added to a bucket of water) is the decontaminant of choice for most chemicals. The facial area should be decontaminated prior to the application of any ventilation equipment; patients with contact lenses should not be asked to remove them while contaminated unless they are causing difficulty. (eyes should be washed with normal saline). Single casualties are then completely decontaminated using the rinse-wipe-rinse method (Appendix 6). At the end of decontamination, contaminated clothing, equipment and effluent, where at all possible, should be stored in a safe area for appropriate disposal or forensic purposes.

11.8 POST DECONTAMINATION CARE
Patients leaving the decontamination area should be covered as soon as possible to prevent hypothermia and kept wherever possible in a draft-free and warm environment with some form of clothing to protect their dignity. Patients will then be triaged and treated as appropriate. Due consideration should be given to the fact that children will be more likely to develop toxic sequel and hypothermia more readily than adults. Advice should be sought from Chemical Regional Service Provider Units (RSPUs) for further patient & staff care and monitoring. A questionnaire assessment of casualties may be required for mass casualty chemical incidents (Appendix 7).

11.9 STAFF PERSONAL PROTECTIVE EQUIPMENT
Where deemed necessary from the Risk Assessment CPPE should be worn by all personnel who come into contact with chemically contaminated casualties. On leaving the decontamination area, staff should remove their CPPE inline with manufactures guidance in a safe manner (Appendix 13). CPPE must be fully decontaminated after use and sent to an authorised body for further decontamination and inspection before reuse.
EMERGENCY DEPARTMENT

ACTION CARD No 1 – ED SHIFT CO-ORDINATOR

CRBNE INCIDENT ONLY

In Event of CRBNE Incident Declared:

Nominate trained staff for decontamination team. If insufficient ED staff available – call in decontamination trained staff from Chemical incident call-in sheets.

- Decontamination Team Leader
- Hot Zone Nurse
- Decontamination Shower Unit Personnel
- Warm Zone Nurse

Inform the Division of Chemical Hazards & Poisons at the Health Protection Agency – 0844 892 0555

Continue to monitor the situation and liaise with the decontamination safety officer at the ambulance bay doors

Liaise with ED Shift Co-ordinator

At the end of the incident, ensure that the replacement unit and any suits provided by the ambulance service are stored in the major incident store

Complete the CBRN audit form

Post incident organise a hot debrief for members of the decontamination team and other staff involved in the incident Which should feed into any organisational debrief.
EMERGENCY DEPARTMENT

ACTION CARD No 2 – DECONTAMINATION TEAM LEADER

CRBNE INCIDENT ONLY

In Event of CRBNE Incident Declared:

Responsibilities:

Primary: Ensure the safety of all members of the decontamination team

Action:

Lock down waiting area patient entrance doors (key is in reception key press)

Don theatre ‘blues/greens’

Go to the toilet

Take oral fluids

Remove all jewellery

Gather equipment

- permanent marker pen

- decontamination team monitoring board

- ‘tuff cut’ scissors

umber all staff as they enter the warm zone and log the time on the board

Monitor all personnel for signs of exhaustion, problems.

After maximum of one hour, remove personnel from the warm zone and assist out of suits as per instruction booklets. Log time on the board.

Log all information from decontamination team board onto hard copy and give to Lead Nurse ED

Liaise with Police and Division of Chemical Hazards and Poisons at the Health Protection Agency re security, decontamination and possible return of property to patients.
EMERGENCY DEPARTMENT

ACTION CARD No 3 – HOT ZONE NURSE

CRBNE INCIDENT ONLY

In Event of CRBNE Incident Declared:

Responsibilities:

Primary:
To be the 1st member of the decontamination team into the hot zone. To welcome patients on arrival.
To start decontamination of casualties prior to formal decontamination in unit
Triage of contaminated patients using triage sieve

Action:

Don theatre ‘blues/Greens’
Go to the toilet
Take oral fluids
Remove all jewellery
Don full PPE
Tuff cut scissors
Modesty packs
Marker pen
Sponges
Carry out patient decontamination/treatments prior to formal decontamination in decontamination unit
If required triage patients using triage sieve for order of decontamination
Inform decontamination team of order of priority
Assist colleagues in decontamination area in appropriate treatments and decontamination of patients.
EMERGENCY DEPARTMENT

ACTION CARD No 4 – DECONTAMINATION SHOWER UNIT
PERSONNEL x 2

CRBNE INCIDENT ONLY

In Event of CRBNE Incident Declared:

Responsibilities:

Primary: Decontamination of casualties

Action:

Don theatre ‘blues/Greens’
Go to the toilet
Take oral fluids
Remove all jewellery
Gather equipment- Buckets x 2, I filled with warm water, I filled with warm water with 10mls of detergent)
- Detergent OR 0.5% Hypochloride for blister agent
- 1 pair ‘tuff’ cur scissors
- Spinal Boards
- Trestle table legs
- Pre-decontamination packs for patients, containing:
  Modesty Cape
  Sponges
  Property Bag
  Valuables Bag
  Face Mask
  Wet Wipes
  Pen and label for property
  Information card1

Don full PPE
Decontaminate patients in order that 1stOut/Triage Officer states
Instruct ambulatory patients to follow information card 1 – Ambulatory, Rinse-Wipe-Rinse
Decontaminate Non-Ambulatory following information on instruction card 2 – Non-Ambulatory Rinse-Wipe-Rinse
Communicate with Decontamination Safety Officer and follow their instructions.
Hand over decontaminated patients to clean team.
EMERGENCY DEPARTMENT

ACTION CARD No 5 – WARM ZONE NURSE

CRBNE INCIDENT ONLY

In Event of CRBNE Incident Declared:

Responsibilities:
Primary: Decontamination of casualties

Action:
Don theatre ‘blues/Greens’
Go to the toilet
Take oral fluids
Remove all jewellery
Don full PPE
Receive patient from shower and direct to Ambulance Entrance
Administer modesty capes /blankets
EMERGENCY DEPARTMENT

ACTION CARD No 6 – DUTY MANAGER

CRBNE INCIDENT ONLY

In Event of CRBNE Incident Declared:

Responsibilities:
Primary: Prevention of further contamination of Trust property and initiation of Major Incident Stand-by

Secondary: Return to the Duty Manager role but continue to monitor the incident and provide advice/support to ED where necessary.

Actions out of hours:
Inform Consultant in Communicable Disease Control (CCDC) at the Public Health Protection Unit, via medicom on (Local Number).

Actions office hours:
Inform Police if CBRN
APPENDIX 1 Glossary of Terms

Glossary of Terms

AFU  Air Filter Unit
CBRNE  Chemical, Biological, Radiological, Nuclear, Explosive
CPPE  Chemical Personal Protective Equipment (Clothing)
CW  Chemical Warfare
DH  Department of Health
EA  Environmental Agency
ED  Emergency Department
HAZMAT  Hazardous Materials
HAZMAT LEAD  Competent Person in ED to Lead Response
HPA  Health Protection Agency
MCQ  Multiple Choice Questionnaire
MDU  Mobile Decontamination Unit
MOU  Memorandum of Understanding
NHS  National Health Service
NPIS  National Poisons Information Service (now part of the Health Protection Agency)
PPE  Personal Protective Equipment
RSPUs  Regional Service Provider Units
SHA  Strategic Health Authorities
APPENDIX 2  Decontamination Protocol

EMERGENCY DEPARTMENT PROTOCOL FOR DECONTAMINATION OF VICTIMS OF POSSIBLE CHEMICAL, RADIOLOGICAL AND BIOCHEMICAL EXPOSURE—Information for reception, nursing and medical staff

Introduction

The Trust may receive contaminated patients who are victims of exposure to untoward chemical, biological or radioactive agents. There are two main situations.

1. The Trust is pre-warned to receive casualties as in a mass casualty situation due to an industrial chemical exposure, or terrorist Incident. In this situation all patients should have been decontaminated at the scene and should be clean.

2. Patients attend unannounced who may have been on the periphery of an Incident and self evacuated or they may present with suspicious signs or symptoms of contamination. The contaminant may or may not be known.

Note, The majority of industrial and agricultural chemicals are unlikely to cause significant problems and will not require formal decontamination. Likewise people exposed to vapours do not usually require decontamination. If there is doubt segregate the exposed people and obtain further information from, Toxbase, National Poisons Information Service or from the Chemical Incident Response Service (at the Medical Toxicology Unit, Guys and St Thomas’s).

General Principles

• The protection of staff and other patients is paramount.

• Contaminated casualties MUST be decontaminated before receiving any (Even life saving) treatment in E.D. First aid and basic life support only will be possible in the decontamination area.

• NO ONE will be allowed through the decontamination area unless they have been decontaminated. This includes police, medical and other emergency services personnel.

• Only trained staff will be involved in the decontamination process and will wear standard decontamination suits (PPE).

• The decontamination tent will be used.

• Patients will be contained prior to decontamination.

• Decontamination will take place in the covered area outside the E.D.

• Fire Service will assist with the decontamination process as far as possible although they may not be immediately available on site.

• The PPE currently available is single use after which it is disposed of.

• Each staff member is unlikely to tolerate more that 40 minutes wearing PPE, so it is important to locate reserve suits from Wiltshire Ambulance and identify back up staff as required.
• Additional equipment and drug pods for dealing with large numbers of casualties affected by a biological or chemical Incident can be requested. To request these contact Wiltshire Ambulance via their control centre.

• The Decontamination Equipment will be checked every 3 months by ED staff along with the other Major Incident equipment.

Departmental Procedures

When a warning has been given about a specific Incident and it is likely that we will receive contaminated casualties.

1. The Trust’s Major Incident Plan will be instigated up to ‘Stand-by’ with the control room equipped and staffed. At Major Incident Standby, the ED Team will prepare to receive casualties. The NCO will make immediate arrangements for the admission or discharge of existing ED patients. Patients in the ED Waiting Area will be informed of the situation and advised to seek treatment from alternative health care providers including GP practices and NHS Walk-in Centres as appropriate. Orthopaedic outpatients and plastic outpatient departments will be asked to inform patients currently waiting of the STAND-BY phase.

2. The Decontamination tent and equipment will be prepared at the top of the ED ramp according to the plan below.

3. Contaminated patients from the Incident will be held in the area outside of the ED pedestrian entrance until allowed through the decontamination process. They will be assisted by staff wearing full PPE.

4. Non-contaminated patients will be directed by signposting and a Porter at the base of the ramp to enter the hospital via the level 2 entrance by Nunton Day Hospital, patients will be directed to Plastic outpatients (walking wounded, overspill area) to receive treatment.

5. The Pedestrian Entrance to ED will be locked and only decontaminated patients will be admitted to the department via the Ambulance entrance.

6. Major Incident numbers will be used to identify patients and their belongings. They will be provided by the fully suited ‘Dirty side’ staff member.

No prior warning received

When it is realised that a patient may have been contaminated e.g. by a patient volunteering they may have been exposed, by many patients exhibiting similar signs and symptoms or by additional information from an Incident. The following action should be taken by the first member of staff to be aware of the situation.

1. Notify the Senior Nurse and Doctor on duty (by phone if remote from main area).

2. Stop all staff and patient movement.

3. Establish a containment cordon. Any area that a patient(s) has been in must be considered contaminated as must all equipment and people in that area. The senior ‘non contaminated’ nurse will then continue to demarcate a ‘cordon line’ possible ‘lines’ are:-
   • The Front Doors
   • The area opposite Reception
   • The Waiting Room / Main Dept fire doors
   • The Main Department / X-ray and SSEU fire doors
   • Resus

4. Use barrier tape to form the line and move non-contaminated people forward away from it. All people behind the line will need to be decontaminated.
5. Stop any further people entering the department. Priority 1 patients to resus only, until situation made safe. Can use clean areas if patient flows permit.

6. All new E.D. patients should be directed through the Level 2 entrance by Nunton Day hospital.

7. Contact E.D. Consultant on call, to consider calling a Major Incident.

8. Contact Site Co-ordinator and Duty Manager.

9. Contact Duty Engineer to consider shutting down the ventilation Systems.

10. Allocate staff to decontamination roles.

**Decontamination Process**

Decontamination will take place on the ED ramp under the covered area using the standard NHS PPE and Decontamination tent. The equipment is suitable for Chemical decontamination only. Where biological or radiological contamination is suspected further advice must be obtained from the local CCDC or RPB as appropriate before a victim can be considered clean and safe.

1. **Containment of contaminated people** - All people considered to be contaminated should be held where they are and moved ‘backwards’ through the department to be decontaminated. They will be assisted by staff wearing full PPE, who will inform them what is happening, provide much needed reassurance and provide them with Major Incident numbers to be written with indelible pen on their hands.

2. **Removal of clothes and personal effects** - All contaminated people will have to remove ALL their clothes and jewellery. These should be placed in yellow bags, labelled with their MI number and sealed with tape. Jewellery can be kept separate, as it may be possible to decontaminate it later. Screens will be erected to provide modesty or if the waiting area is considered dirty, the toilets opposite reception can be used. People to be given disposable suits and plastic overshoes while waiting for decontamination.

3. **The decontamination area set up** - The Decontamination area should be established outside the E.D. according to the plan below. A cordon will be erected to prevent non contaminated persons entering, if they do so they will be considered contaminated and will have to go through the entire process. All other patients should go via the level 2 entrance by Nunton Day hospital. Sign posts and a Porter will direct them from the base of the ramp.

4. **Decontamination process** - Persons needing decontamination should be provided with cotton buds and tissues to clean their noses and ears, after use these should be placed in a yellow sack. They should then proceed to the decontamination tent where they should wash themselves or if needed be assisted by a member of staff fully suited in PPE. Their disposable clothes should be placed in a yellow bag, they should shower off, wipe themselves with sponges/cloths with detergent including hair and other creases. Other cleaning agents / antidotes can be used if recommended. They should then shower off again. When clean they should step out of the shower area to dry and redress in a clean ‘modesty suit’ before proceeding to the E.D. The towels to be placed in a yellow sack.

5. **Identification** - The patients Major Incident number should be added to their departmental record for identification.

6. **First Aid** - The fully suited staff member(s) on the dirty side can provide first aid, however dressings should be changed at the exit from the tent. If a trolley is used it should be washed down in the tent with the patient who should then be transferred to a clean trolley in the drying off area using a ‘Patslide and slidy sheet’. The dirty trolley and other equipment should be retained on the dirty side for later decontamination.

7. **Cleaning up** - After all persons have been decontaminated the area should be decontaminated by staff wearing full PPE. The exact process will depend on the contaminant. In general all clothing and personal effects will be placed in yellow bags to be collected by the Local Authority for disposal. All equipment will be decontaminated if possible or if not disposed of as above. All waste water will be collected in the supplied...
container for Local Authority disposal. The staff wearing PPE will be the last in the shower to clean off their suits they will then be cut off and left in the disposable liner of the tent for L.A. disposal. When the area has been declared safe normal working can proceed.

8. Disaster Recovery - If a significant part of the department is contaminated or there is likely to be a delay in clearing the contaminated area the Trusts and Departmental recovery plans are to be put in operation.

9. RadioActive Contamination - If radioactive contamination is suspected the victims should be segregated and contained as above. If possible contact with staff should be kept to a minimum as the NHS PPE suits do not protect against radioactivity. The same decontamination procedure should be followed with the following amendments:

- Staff should not enter the contaminated area; instructions should be given via LoudHailer.
- At the earliest opportunity the Trusts Medical Physicist should be contacted via the switchboard. If he is unavailable then a Medical Physicist from Swindon, Bath or Dorchester should be contacted for advice.
- After decontamination victims should be held in the clean area within the decontamination suite until declared safe by a suitably equipped Medical Physicist.
- All contaminated materials to be retained on site until declared safe.
APPENDIX 3 Setting up the Decontamination Area

1. Remove all people and equipment from the area at under the cover at the top of the E.D. ramp. Contaminated people should be held in the ‘smoking area’ behind the barrier.

2. Stop any further non-contaminated people entering the ramp from the bottom if it. They should be directed to enter the hospital via the Level 2 entrance by the Nunton Day hospital.

3. Spread out the plastic sheeting to cover the whole area under the cover.

4. Place Decon tent as shown on the plan and inflate it. Place plastic floor in situ, connect water supply and fit drainage pump and place wastewater container as shown.

5. Place boxes of clothes, towels and yellow bags as shown.

6. Place waste collection bags as shown.

7. Erect screens and cordon fence as shown on plan.
APPENDIX 4 Guidance for Staff working in the Contaminated Area

1. Put on the NHS PPE as directed.

2. Reassure contaminated people.

3. Mark all people with a number with an indelible pen on their hand. Use the same number for their clothes and personal effects bags.

4. Ensure that the Decontamination procedures are carried out according to the plan.

5. Assist any patients who are unable to carry out the procedures for themselves.

6. Monitor your own time in the area and leave if your alarm sounds.

7. Only leave through the Decontamination tent after full and thorough cleaning of the suit.

8. Dispose of all used equipment.
APPENDIX 5 Information for Contaminated Persons

1. You may have been contaminated by a hazardous substance that needs to be removed. The following information will help to ensure your safety and that of your friends and relatives and also the Health care staff who will be looking after you.

2. You will be asked to remain where you are until cleaning facilities can be arranged. Staff wearing protective clothing will be able to assist you. Please remain calm.

3. You will be asked to remove ALL your clothing as 80% of contamination is carried on clothes. Disposable suits and footwear will be provided as will screens for privacy. Place your clothes and personal effects in the separate bags provided. You will be given a number to identify your property.

4. Use the cotton buds and tissues to clean your ears and nose, place the used ones in the bags provided.

5. When the cleaning facility has been arranged you will be directed into a shower tent. Please remove the disposable suit and place it in the bag provided. Shower off with water, then wash with soap and the cloth provided and finally shower off again. When clean leave the shower tent and dry off. Another disposable suit will be provided. Place the towel in the bag provided.

6. You will then be directed into the Emergency Department for further assessment and treatment if needed.

7. If you need assistance please ask the staff wearing the suits. They are all trained Health Care Professionals.

8. Failure to carry out the above procedures may result in criminal charges for endangering public health.
APPENDIX 6 Rinse-wipe-rinse method of casualty decontamination

There is no process that can be guaranteed to ensure that a casualty will be totally decontaminated. The ‘Rinse – Wipe – Rinse’ method of casualty decontamination will ensure that casualties are ‘As Clean As Reasonably Practicable’ (ACARP) at the end of the procedure. Staff involved in dealing with casualties who have been decontaminated should remain cautious and observe for ill effects in the patient and in other staff.

It is likely that the majority of casualties self referring to Emergency Departments will be ambulant and capable of completing the decontamination process themselves. Supervision by hospital staff is essential to ensure that the process is carried out thoroughly. The following equipment is required:
- A water source (preferably warm)
- A bucket (5-10 litre capacity)
- Detergent (10 ml – approximately three squirts – added to a bucket of water)
- A sponge or soft brush.

It is possible that a minority of casualties may not be ambulant and Hospital staff will need to carry out the whole process and the following additional equipment will be required:

Longboard
Two Trestles (Plastic)

Whether the ‘Rinse – Wipe – Rinse’ process is carried out by hospital staff or by the casualty themselves, the process is the same;

Having disrobed, the affected areas should be rinsed using the shower heads. Rinse from top downwards and from the centre outwards. This first rinse helps to remove particles and water soluble chemicals.

The affected areas should then be wiped with a sponge or soft brush using a detergent solution. Again, Rinse from top downwards and from the centre outwards. This scrub will remove material that adheres to the skin.

Rinse thoroughly for a second time. This second rinse removes the detergent and any residual contaminant.

Hospital staff should ensure that the process is completed thoroughly and ensure that the patients head is tilted backwards whilst washing the hair to prevent contaminated water entering the eyes. This process should not take more than three to five minutes Repeat steps 1 to 3 only if skin contamination remains obvious.
APPENDIX 7 Example of proposed questionnaire for chemical casualties

ED QUESTIONNAIRE (2 Pages)

REF No. ____________________________  Return Address: ____________________________
Telephone No: ____________________________  Fax No: ____________________________

This questionnaire will help the health investigation following [describe the incident]. Please answer all questions:

Surname:________________________________________  Forename:________________________________________
Address:________________________________________________________________________________________
________________________________________________________________________________________
Postcode:________________________  Telephone:________________________________________________________________________________________

Sex (Please circle): Male  Female

Age in years:____________  Date of birth:____________

GP Name:________________________________________________________________________
GP Address:________________________________________________________________________

Q1). Please state your whereabouts in relation to the incident ______________________________
________________________________________________________________________________

[Please circle each answer appropriately]

Q2) How much time did you spend at [Add name of site] over this period:
Less than one hour  One-two hours  Two – three hours  More than three hours

Q3) Did you notice any unusual substances during this incident?    Yes    No    Don’t know
Q4) Did you smell any unusual substances during this incident?    Yes    No    Don’t know

Q5) If YES to question Q3 or Q4, please describe this substance(s) i.e. what did the substance look and smell like:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Q6) On this date did you receive any advice from the emergency services? (E.g. Fire, Police or Ambulance service)  Yes  No  Don’t Know
Q7) If YES to Q6 Please state which service:_____________________________________________

Q8) Were you evacuated from [Add name of site]:  Yes  No  Don’t know
Q9) Were your clothes removed during this incident:  Yes  No
Q10) Were you washed during this incident:  Yes  No

Q9)  Did you feel unwell in the period [Add date or time]:  Yes  No    Don’t know
Q10) If YES to question Q9, please state the [date or time] you felt unwell: _____________________

Q11) If YES to Q9 please list any symptoms you experienced when you felt unwell including the date and time:

<table>
<thead>
<tr>
<th>SYMPTOM(S)</th>
<th>DATE OF ONSET</th>
<th>TIME OF ONSET</th>
<th>DATE STOPPED</th>
<th>TIME STOPPED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AUTHOR: Owen Aisnley  DATE OF REVIEW: March 2012  49
VERSION: 1.0  DATE: March 2011  ED Chemical Incident Plan
REF No_____

Q12. Did you suffer from any of the following symptoms or diseases over the period September 2001 to September 2001? Please tick each box appropriately.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased secretion from the nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased salivation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased Sweating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling faint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drowsiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye irritation or discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes hurt by light</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twitchiness of the eyelid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stinging eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin rash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin blisters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoarse voice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (Please list:)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q13) Please describe your current state of health: Good    Fair    Poor

Q14) Do you suffer from any long term health problems (e.g. diabetes, asthma, bronchitis)?

Yes         No        Don't Know

Q15) If YES to Q14 please describe which long term health problems you suffer from:

Q16) Please list any medication that you take regularly:

Q17) Did you seek any further advice from either ED or your child’s GP, Health Visitor or call NHS Direct or any other Health Service Provider over this time period (If YES please specify whom you sought advice from, when you sought advice and for what reason did you seek this advice)

Thank you for taking the time to complete this questionnaire. If any of the questions were unclear or indirect, please use the enclosed space for making appropriate comments.

COMMENTS
APPENDIX 8 Chemical Incident Core Trainers

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Contact number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 9 Triage Sieve

Triage Sieve

WALKING

No

Yes

Yes

PRIORITY 3 (DELAYED)

DEAD

BREATHING

Yes

No

PRIORITY 1 (IMMEDIATE)

RESPIRATORY RATE

10 to 29

< 10

> 29

< 120

PULSE RATE

< 120

PRIORITY 2 (URGENT)

Triage in CPPE

Walking

Yes

Decontaminate

No

Response to Voice/ pain

Yes

Decontaminate

No

Respiratory movement

Yes

No

DEAD
DEPARTMENT OF HEALTH

Procurement of Mobile Decontamination Facilities and Associated CPPE

The booklet contains detail of the DH funded equipment however it is recognised that there are now
many other providers of decontamination equipment on the market. What is important is that the plan
and training is linked to the equipment that the Trust has.

OPERATIONAL AND SITE REQUIREMENTS FOR MOBILE DECONTAMINATION FACILITY

The following information details the operational and site requirements, and other facilities required for
the Plysu mobile (air-inflatable) decontamination facility for use by NHS acute hospitals, or ambulance
service trusts in a pre-hospital setting. The mobile decontamination facilities are available from Plysu
Protection Services through the national contract (reference N3/B/0060/1204/01) agreed by the NHS
Purchasing and Supply Agency

NOTE FOR HOSPITALS: Hospital emergency departments will need to ensure that water and power
supplies are available close to the area where the mobile decontamination facility will be located when
in use. It is recommended that the services, as detailed below, are provided in a weatherproof,
frostproof cabinet located on an external wall and labelled ‘Mobile Decontamination Facility Services’.

Operational and site requirements
Dimensions (approx):
- When erected the mobile decontamination facility is 3500 x 3500 x 2300 mm high.
- When packed the mobile decontamination facility is supplied in a dark blue, flexible
  plastic bag, complete with reinforced carrying handles, which is 1500 x 950 x 500 mm high. Weight 35
  kg.
- When packed the replacement chemical resistant liner is supplied in a black, flexible
  disposable plastic bag which is 1200 x 860 x 125 mm high. Weight 18 kg.
- Flooring (6 pieces) for use with the mobile decontamination facility is 1200 x 800 x 147
  mm high. Weight 102 kg.
- Waste water pump is 196 mm diameter x 360 mm high. Weight 14 kg.
- Compressed air cylinder is 150 mm diameter x 700 mm high. Weight 10 kg.
- PLYHEAT mobile water heating system is 620 x 610 x 950 mm high. Weight 75 kg.
- 110v 4kW generator is 795 x 480 x 530 mm high. Weight 62 kg.
Optional extra. Waste water storage tank (500ltr) with disposable liner is 750 x 900 x 100 mm high.
Weight 6 kg.
Optional extra. Lighting, including tripod is 700 x 600 x 1200 mm high. Weight 7 kg.

Location:
- It is helpful if the mobile decontamination facility is erected on a smooth, firm surface
to prevent risk of punctures, with a slight slope for water runoff purposes, as normally applied to patios,
pavements, etc.
- HOSPITAL: The mobile decontamination facility should be erected outside the hospital emergency
department.

Inflation:
- A compressed air supply is required to inflate the mobile decontamination facility. An
  overpressure valve prevents over-inflation.
- HOSPITAL: An inflation adaptor is supplied with each mobile decontamination facility. This is
tapered at one end to plug into the inflatable structure and is terminated at the other end in a 5/8” BSP
male thread connection. A regulated inflation pressure of 2 - 10 bar is recommended. Hospital
departments should make arrangements with their medical gases supplier to provide a compressed air
cylinder with the specified 5/8” BSP male thread connection. Note: BOC currently holds the contract
for the supply of medical gases to the majority of acute hospital trusts in England and a compressed air
cylinder supplied by BOC will be compatible with the specified 5/8” BSP male thread connection.
PRE-HOSPITAL: A 7 litre 230 bar compressed air cylinder and regulator is supplied for use in the pre-
hospital environment. This is fitted with the inflation adaptor as standard (i.e. no additional connection
is required) and will inflate the mobile decontamination facility twice.

Water Supply:
- A 30 litre/minute water supply is required. The mobile decontamination facility uses
  between 6 - 30 litres / min, depending on the number of showers being used.

Water Pressure:
- HOSPITAL: 2 - 3 bar. At hospital emergency departments this is equivalent to
  mains water pressure.
- PRE-HOSPITAL: 2 - 3 bar. In the pre-hospital environment, when connection is to a fire tender or
  standpipe, the water pressure should be adjusted to 2 - 3 bar. This is to prevent leaks in the PLYHEAT
mobile water heating system or from any of the connections. A pressure reducer is NOT required when this instruction is observed.

Water Temperature: HOSPITAL: i.e. NOT USING PLYHEAT mobile water heating system. At hospital emergency departments the water temperature should be approximately 30°C, thermostatically controlled or regulated.

PRE-HOSPITAL: i.e. USING PLYHEAT mobile water heating system. In the pre-hospital environment a cold water supply only is required.

Water Connection: A 5 metre, 25mm diameter, hosepipe is supplied with each mobile decontamination facility. This has a brass quick release 3/4” female coupling at one end, to connect to the water supply (i.e. mains water or via PLYHEAT).

HOSPITAL: Hospital emergency departments should provide, via a valve or tap, a standard male 3/4” BSP screw thread to fit the brass quick release 3/4” female coupling supplied. A double check valve is recommended to prevent back siphoning. Additional hosepipe, including appropriate brass quick release couplings, may be purchased as an optional extra from Plysu if required.

PRE-HOSPITAL: In the pre-hospital environment a 70mm fire hose coupling adapter is supplied with each PLYHEAT mobile water heating system to allow connection to a fire tender or standpipe.

Power Requirement: HOSPITAL: Hospital emergency departments should provide two 110V 16amp weatherproof sockets via 30mA trip (110V system). These will provide sufficient power to run two waste water pumps simultaneously.

PRE-HOSPITAL: A 110V 4kW generator is supplied, complete with all necessary connections, to provide sufficient power to run one PLYHEAT mobile water heating system and two waste water pumps simultaneously.

Lighting Requirement: The mobile decontamination facility has translucent panels in the sides and roof of the disposable chemical resistant liner supplied. This allows adequate lighting by natural or external artificial light. The latter may be purchased as an optional extra from Plysu if required.

Water Disposal: In a chemical incident contaminated water is held in the base of the mobile decontamination facility. In an emergency situation, permission has been granted by the Environment Agency to dispose of contaminated water into the usual drainage system, providing the appropriate authorities are informed before proceeding. Alternatively, contaminated water may be pumped into storage tanks for subsequent appropriate disposal. These may be purchased as an optional extra from Plysu if required.

For further information or clarification, contact Plysu Protection Systems.

Plysu Protection Systems Ltd
Station Road
Woburn Sands
Milton Keynes MK17 8SE
Tel: 01908 287123
Fax: 01908 583741
Email: ppssales@eu.nampak.com

Department of Health
March 2002
## APPENDIX 11 NHS Framework Product Guidance

### WEIGHTS / DIMENSIONS OF PRODUCTS COVERED BY NHS FRAMEWORK AGREEMENT:

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>PART NUMBER</th>
<th>DIMENSIONS mm(LxWxH)</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS DECAS unit (Packed)</td>
<td>8000502788</td>
<td>1500x950x500</td>
<td>35Kg</td>
</tr>
<tr>
<td>(Above includes one groundsheet, plus set of ropes / pegs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spare containment / shower heads</td>
<td>8000504206</td>
<td>1200x860x125</td>
<td></td>
</tr>
<tr>
<td>18Kg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plyheat (pre hosp use only) 110V</td>
<td>PS20022</td>
<td>620x610x950</td>
<td>75Kg</td>
</tr>
<tr>
<td>Waste pump</td>
<td>PS20018</td>
<td>196 dia x</td>
<td></td>
</tr>
<tr>
<td>360</td>
<td>14Kg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air cylinder (pre hosp use only)</td>
<td>PS503735</td>
<td>150 dia x</td>
<td>10Kg</td>
</tr>
<tr>
<td>Regulator for cylinder (incl in cyl price)</td>
<td>8000503547</td>
<td>1200x800x147</td>
<td></td>
</tr>
<tr>
<td>Raised flooring (6 pcs, 1 cut to accept pump)</td>
<td>PS20020</td>
<td>620x610x950</td>
<td>75Kg</td>
</tr>
<tr>
<td>102Kg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70mm Fire hose adaptor (pre hosp use only)</td>
<td>PS32598</td>
<td>1200x800x147</td>
<td>1Kg</td>
</tr>
<tr>
<td>Generator 4Kw 110V (pre hosp use only)</td>
<td>PS20023</td>
<td>795x480x530</td>
<td></td>
</tr>
<tr>
<td>62Kg</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WEIGHTS / DIMENSIONS OF OPTIONS NOT COVERED BY NHS FRAMEWORK AGREEMENT:

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>PART NUMBER</th>
<th>DIMENSIONS mm(LxWxH)</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waste water tanks</td>
<td>PS20006</td>
<td>750x900x100</td>
<td>6Kg</td>
</tr>
<tr>
<td>Spare liners for tanks</td>
<td>PS20009</td>
<td>500x500x20</td>
<td>2Kg</td>
</tr>
<tr>
<td>Water pressure reducer</td>
<td>8000703309</td>
<td>170x220x160</td>
<td>2Kg</td>
</tr>
<tr>
<td>Water hose with quick couplings</td>
<td>tbc</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>(Hose can be any length)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lighting &amp; tripod (2 required per shower unit)</td>
<td>PS20016</td>
<td>700x600x1200</td>
<td>7Kg</td>
</tr>
<tr>
<td>Spare Ground sheet (packed)</td>
<td>8000499835</td>
<td>700x500x25</td>
<td>2.5Kg</td>
</tr>
<tr>
<td>Spare Ropes &amp; pegs to stabilise unit</td>
<td>8000703319</td>
<td>250x100x50</td>
<td>0.5Kg</td>
</tr>
</tbody>
</table>

Department of Health  
March 2002
APPENDIX 12 Memorandum of Understanding

A Memorandum of Understanding should be in place between the Trust and the Local Fire and Rescue Service in line with the National arrangement between the Department of Health and the Department of Communities and Local Government. This MOU is for Mass Decontamination only and not for small numbers of self presenters. This should only be used when the hospital has exceeded its own capacity.

WILTSHIRE

CHEMICAL BIOLOGICAL RADIOLOGICAL AND NUCLEAR (CBRN)

MEMORANDUM OF UNDERSTANDING

FOR MASS DECONTAMINATION AT ACUTE AND FOUNDATION TRUSTS

BETWEEN

WILTSHIRE FIRE AND RESCUE SERVICE

SALISBURY NHS FOUNDATION TRUST

GREAT WESTERN AMBULANCE SERVICE

WILTSHIRE CONSTABULARY
APPENDIX 13 (Reproduced from Respirex Guidance Booklet Mk3 suits)

Introduction

The Respirex Powered Respirator Protection Suit (PRPPS) is intended for use by emergency response personnel after a chemical or biological incident. The suit should only be used after a process of detection, identification and monitoring which has established the potential hazard. A typical example of application for the suit would be to protect personnel decontaminating casualties following such an incident. It is important to note that the suit is NOT appropriate for use in environments where the chemical or biological hazard is unknown. This comment from the manufactures must be considered but your Risk Assessment of the current condition of the Patients i.e. not in major difficulty may lead you to consider that the use of the suit is acceptable every effort should be taken to identify the substance either through the casualties themselves or the Ambulance Service.

The product is type approved to a manufacturer’s specification, RILS002, based upon the requirements for a limited use type 1b-ET gas-tight chemical protective suit as detailed in EN943-2:2002. However, the specification for a full facemask has been replaced by that for a visor. Note: the total mass of the PRPS exceeds that stipulated for a normal EN 12941:1998 filtering device. For changes to manufacturer’s designed duration refer to 3M Jupiter AFU user instructions, 3M ref QX-3800-1080-8.

The system has additionally been tested against chemical warfare (CW) agents for challenges, similar to those defined in the NATO Respirator Triptych D / 103:1991.

General Information

The suit is manufactured from Tychem TK, a high performance chemical protective clothing material developed by DuPont for protection of gaseous, liquid and solid chemicals.

The suit is fitted with a 3M Jupiter Air Filter Unit (AFU). The AFU is battery powered and worn on a waist belt within the suit. The AFU draws air through externally mounted filters and feeds it through a breathing tube into the head space. A remote warning and indicator device, featuring three coloured lights, is mounted at chin level in the head space and connected to the AFU via a cable.

During operational use the AFU must be fitted with 3M TH3 ABEK2PSL filters, enhanced to provide additional protection against chemical and biological warfare agents (3M Ref. JFR-85-CE). The filters, when used in conjunction with the 3M Jupiter AFU as part of an approved system, conforms to the European standard EN12941:1998. Please refer to the instructions supplied with the 3M Jupiter AFU for limitations, storage, cleaning instructions etc.

The garment features include:

Large semi-rigid visor bonded to the suit.

Four exhalation valves fitted to the rear of the suit.

Integral safety boots with steel toe-caps and mid-soles.

Dual glove system consisting of a laminated inner glove having good chemical resistance (NORTH Silver Shield / 4H) bonded to a outer Neoprene glove affording protection against mechanical risks as well as having some degree of chemical resistance. The gloves are fitted to the suit by means of the Respirex locking cone and grommet system.

Optional re-hydration facility.

Exterior attachment point for distress signal unit.

The PRPS is designed as a limited-use garment, i.e. designed to be worn until chemical contamination has occurred and disposal is required.

A full hygienic cleaning service using specialist equipment is provided by Respirex.

Limitations of Use
Failure to follow all instructions on the use of this product may adversely affect the wearer’s health, may lead to severe illness or permanent disability or even death.

Only for use by trained competent personnel.

PRPS suits should not be used in areas immediately dangerous to life or health due to a lack of oxygen in the surrounding air.

Tychem TK fabric is designed specifically for limited-use garments. Excessive flexing or folding can lead to weaknesses in the structure of the fabric which may have an adverse effect on the chemical resistance offered by the suit. However, extensive operational use of garments manufactured from Tychem TK has demonstrated its durability beyond that of single-use fabric. Continuity of performance for multiple use can be assured by a regular programme of inspection and re-certification.

If the suit is heavily contaminated or mechanically damaged in any way it MUST NOT be used and MUST be disposed of.

Caution: Tychem TK is a non-breathable material and the wearer’s body temperature will rise whilst wearing the suit, particularly during periods of intense physical activity. Wherever possible operational procedures should be planned to minimise the risk of heat stress occurring. Use of the optional re-hydration facility is recommended.

Leave the contaminated area immediately and remove the suit if:
Any part of the system becomes damaged e.g. tears or punctures in the suit.
Airflow into the suit decreases or stops, or visor misting occurs.
Breathing becomes difficult
Dizziness or other distress occurs.
You taste or smell contaminants or an irritation occurs.
An alarm condition occurs.

Never modify or alter this product.

Tychem TK meets the resistance to ignition requirements of EN943-1:2002 but nonetheless should not be exposed to flame.

Tychem TK does not have any anti-static treatment or properties and should not be worn in flammable or potentially explosive environments.

The usable temperature range of the ensemble is -5°C to +40°C <90% humidity. Users should note that resistance to permeation by chemicals varies with temperature.

Continuous contact with certain chemicals can adversely affect the field of vision and protection offered by the visor. If the end-user notices any discolouration of the visor the suit MUST NOT be used.

NEVER change any component parts associated with the suit in a contaminated area.

Materials used in the construction of the system are not known to cause allergic reactions to the majority of individuals. The system contains no components made from natural rubber latex.

This equipment is not to be used in oxygen-deficient environments e.g. confined spaces. For further information refer to instructions for 3M Jupiter AFU.

Storage
To prevent damage occurring during storage the system is supplied in a plastic container, suits should always be stored in a clean and dry condition at ambient temperature. If being stored for long periods of time, the suits should be kept out of direct sunlight.

Based upon real time use, the PRPS system has a minimum shelf life of five years. Additional research on Tychem TK material would suggest a possible shelf life of up to ten years.

For the purposes of disposal a sealable hazbag is included with the system. See section on disposal for further details.
APPENDIX 14 Respirex Suit Label

Suit label

1. Manufacturer of garment; Respirex International Ltd.
2. Manufacturer's Model number
3. Manufacturer's Style number
4. Serial number.
5. Material of Manufacture.
6. Manufacturer's Order No.
7. Customer Name.
8. Date of manufacture; Day/Month/Year.
9. Flask Pictogram denoting protection against chemical hazards
10. Garment Size

<table>
<thead>
<tr>
<th>Size</th>
<th>Chest cms (inches)</th>
<th>Height cms (inches)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>86-94 (34&quot;-37&quot;)</td>
<td>152-165 (5'-5'5&quot;)</td>
</tr>
<tr>
<td>M</td>
<td>94-102 (37&quot;-40&quot;)</td>
<td>163-175 (5'-5'9&quot;)</td>
</tr>
<tr>
<td>L</td>
<td>102-112 (40&quot;-44&quot;)</td>
<td>173-185 (5'-6'1&quot;)</td>
</tr>
<tr>
<td>XL</td>
<td>109-124 (43&quot;-49&quot;)</td>
<td>180-196 (5'-1&quot;-6'5&quot;)</td>
</tr>
</tbody>
</table>

11. "Open Book Pictogram"; wearer must refer to the "Instructions for use" for further information.

12. Five care pictograms indicating that clothing is not suitable for cleaning and reuse.

- **Pictogram 1** Do not machine wash
- **Pictogram 2** Do not bleach
- **Pictogram 3** Do not iron
- **Pictogram 4** Do not machine dry
- **Pictogram 5** Do not dry clean
APPENDIX 15 Preparation for Use CPPE

The suit is supplied in a sealed bag, fully tested and in full working order. Nevertheless it is advisable for the following checks to be carried out in a clean area prior to donning the suit.

Visually inspect the suit for any damage that may reduce the level of protection; pay particular attention to the seam areas and gloves.

Check the suit is free from contamination both externally and internally.

Check vision through the visor is not impaired by scratches or heavy scuff marks.

Check the zip operates correctly and the pull tag is in good condition.

Verify the breathing tube and remote warning device are connected to the AFU (fig 2).

Fit the battery to the AFU (fig3).

Switch on the AFU. The AFU will beep, the lights on the remote warning device will cycle for a short time, then the green light will remain illuminated (fig 4). At this point the 60 minute timer begins.

Remove the small plastic screw caps and fit the two filters to the suit (figs 5 & 6). Important: The clear plastic filter lids should remain in place whilst the filters are in use.
An option air check can be carried out at this point as follows.

I Remove the breathing tube from the air filter unit.
II Insert the airflow indicator tube into the air filter unit outlet.
III Hold the AFU so that the tube is vertical and at eye level.
IV Verify the ball has risen above the black line on the tube (fig 7).
V Remove the airflow indicator tube and refit the breathing tube.

To check warnings block the breathing tube outlet by putting a hand into the head space and covering the open end of the tube with a flat hand (fig 8). Ensure that after a short time the buzzer begins to beep and the red light begins to flash.

Remove hand from the outlet. The red light will go out, all three lights will cycle for a short time then the green light will remain illuminated (fig 9).

The suit is now ready for use.
At this point the AFU can be switched off until the user is ready to don the suit. When the AFU is restarted the lights will cycle for a short time, then the green light will remain illuminated. The 60 minute timer will re-set.

Indicator Lights and Warnings

Throughout normal operation the green light will remain illuminated.

60 minutes after switching on the AFU the amber light will illuminate intermittently and the buzzer will beep for 10 seconds.

After 75 minutes (additional 15 minutes) the amber light will remain illuminated and the buzzer will beep for 10 seconds.

In an alarm condition the red light will flash and the buzzer will beep. This indicates either a low airflow or a low battery.

Donning Procedure

Make sure the suit has been visually inspected and is suitable for intended use. Under clothing should be worn beneath the suit. As a minimum, a short sleeve shirt and long trousers or “long underwear” are recommended. Remove all personal effects which may cause damage to the suit (e.g. pens, badges, jewellery etc.). Remove footwear, the suit is fitted with its own integral ‘HAZMAT’ safety boots. It is advisable to tuck trousers into socks to make donning of suit legs and boots easier.

Entry to the suit is made via an opening at the front that is sealed by a gas-tight zip fastener protected by overlapping flaps with a Velcro strip.

It is good practice for an assistant to help the wearer don and doff the suit. This makes the process easier and quicker, and will help to avoid stumbling and tripping which may result in personal injury or damage to the suit. NB. The suit must always be donned in a clean uncontaminated area.

Follow these steps in donning the suit:

If applicable, rinse and fill the re-hydration pack. Don the re-hydration pack and adjust the straps until comfortable (fig 10).

Whilst seated, place both legs into the suit (fig 11).
Stand up and with the dressing assistant supporting the weight of the AFU at the rear of the suit, fasten the internal waist belt securely (fig 12). If necessary adjust the belt until comfortable.

Lift the suit up above waist level and connect the drinking tube that runs from the head space to the tube on the re-hydration pack (fig 13 & 14).

If required a peak-less safety helmet with chin strap can now be donned (fig 15). NB Owing to the non-breathable nature of the laminate gloves attached to the suit it is not uncommon for the wearers hands to be moisten due to sweating. For this reason it is recommended that cotton gloves are worn to absorb sweat and to assist with donning and doffing procedure. (fig 16).

The dressing assistant should now switch on the AFU to ensure that breathing air is supplied to the wearer (fig 17). NB NEVER attempt to wear a PRPS without switching on the AFU and ensuring the green light is permanently illuminated (see indicator lights and warnings).
Place both arms into the suit (fig 18).

The wearer should duck forwards and the assistant should pull the hood of the suit over the head (figs 19 & 20). NB It may be necessary to re-adjust the helmet after this stage. Ensure that the knitted neck seal sits evenly around the wearer’s neck.

With the wearer’s arms in an outstretched position the assistant should fully fasten the zipper across the chest (fig 21).

Seal down the flaps evenly to the suit, trying to leave a minimum of gaps and ridges for the possible ingress of spray or splash (fig 22). Note: When sealing down the upper flap you may find it easier to achieve a smooth seal by working from the centre outwards.

When fully donned the suit should appear as in figs 23 & 24.
Protection of Suit Components During Donning

To avoid damaging suit components when donning the suit please note:

It is important to protect the air management system from undue stress. Please treat the air filter unit, breathing hose and remote warning cable with care.

Prior to training or emergency use it may prove necessary to half don the suit supported by the belt. When half donned many suit components are exposed and prone to damage.

In order to prevent such damage it is strongly recommended that the top of the suit is supported against the wearer’s back by draping the sleeves over each shoulder and holding the gloves in the chest area. This will help to protect the air management components, hood and visor when the suit is half donned prior to training or emergency use.

Decontamination Procedures

Do not remove the PRPS, remove the filters or turn off the 3M Jupiter AFU until you have vacated the contaminated area.

Preliminary washing by means of a high pressure shower will remove most of the contaminant from the outer surface of the suit sufficient to allow the wearer to undress from the garment.

Should you not have access to a high pressure shower; the suit can be sprayed with copious quantities of water and a suitable detergent and neutraliser for a minimum period of 5 minutes.

Prevention of Filter Flooding During Shower Decontamination

To maintain airflow during decontamination:

Avoid excessive water entering the filters. Air enters the suit via two rear mounted filters and it is important that these filters are not flooded during decontamination. Each filter is fitted with a clear shower cover which prevents normal ingress of water. Typically the water either runs over the face of the cover or around the channel and drains away at the bottom. Excess water may overcome the channel and flood the filter.

Avoid excessive detergent entering the filter. When detergent is added to water its surface tension is reduced allowing easier penetration into the filter. Over several uses detergent can build up in the filters which will also allow easier penetration of water into the filter.
Water in the filters may result in a 'red light' low flow warning. The warning may reset to a 'green light' condition if flooding stops, thus allowing decontamination to continue. However, if the red light persists, this indicates a real low condition and the wearer should follow operational procedures for this situation.

Doffing Procedure

After preliminary decontamination procedures – lay the hazbag supplied with the suit on the ground, open end facing upwards. The wearer should stand in the open end of the hazbag in preparation for doffing (fig25).

![Fig.25](image1)

![Fig.26](image2)

With the wearer’s arms in an outstretched position the dressing assistant should break the Velcro seal on the outer zip flaps and fully open the gas-tight zip across the chest (fig 26)

Wearer’s should now withdraw their arms from the sleeves of the suit and unfasten both the waist belt attached to the AFU and the chin strap of the peak-less safety helmet (if worn). After unfastening the waist belt the wearer’s arms should be crossed over the chest (fig 27).

The wearer should duck forwards so that the dressing assistant can lift the hood of the suit up and over the wearer’s head. Note: It is likely that if a safety helmet is being worn this will automatically come away from the wearer’s head and remain in the head space of the suit. The helmet can be recovered from the suit on completion of the doffing procedure.

![Fig.27](image3)

![Fig.28](image4)

If wearing the suit in combination with a re-hydration pack this should now be disconnected from the drinking tube attached to the suit.

The dressing assistant should carefully lower the suit to boot level (fig 28), and the wearer can now step out of the suit avoiding contact with its exterior (fig 29).
The dressing assistant should now switch off the AFU and unscrew the externally mounted filters for safe disposal (re-seal filters with the original plastic caps).

The suit, including the attached AFU, can now be sealed in the hazbag using the plastic tie provided (fig 30). Ensure all relevant information is entered onto the hazbag tag before returning the used systems to Respirex.

Emergency Self Doffing Procedure

Withdraw your right hand from the suit sleeve and push against the back of the zip at the pull tag end.

With your left hand unseal the outer Velcro flap fastening and undo the zip.

Undo the AFU belt and unfasten the helmet chin strap (if worn).

Exit the suit.

IMPORTANT: Respirex will only be able to clean, service, sanitise, retest and repack used PRPS systems once there is documentary certification that the equipment is chemically and biologically safe to handle.

Such confirmation should include:

The serial numbers of the suit / AFU used.

Identification of the incident that the equipment has been used at.

A written, signed statement from a competent source that the equipment has not been exposed to any chemical or biological contamination or that any such contamination has been completely neutralised and removed.

Disposal of Tychem TK

Whilst the exact composition of the fabric is confidential to the manufacturer, it is known that Tychem TK consists of polymers which do not contain halogens in their structural formula. Tychem TK can either be incinerated without harm to the environment, or can be buried in a responsible manner. It is important to note that the nature of any chemical contamination on the garment should be taken into account when deciding on the best method of disposal.

Battery Disposal
The 3M Jupiter AFU is powered by a single use lithium / thionyl chloride. For all further battery information, including disposal, refer to 3M Jupiter AFU user instructions, 3M Ref QX-3800-1080-8.

Filter Disposal

In use, the 3M JFR-85-CE filter canister will absorb and retain any particulate contamination that is present in the immediate environment. Used filter canisters are potential reservoirs of any contamination that is present and should be disposed of accordingly. Disposal of used filters should be undertaken in accordance with local health and safety and environmental regulations. For further instructions refer to 3M user instructions, 3M Ref CV-0005-1801-5.

Permeation Performance

The following test results indicate resistance to permeation against each of the 15 liquid chemicals in the standardised test battery ASTM F1001-99a.

All tests carried out under laboratory conditions by independent accredited laboratories in accordance with EN 369:1993 and EN374-4:1993, unless otherwise stated.

Glove tests performed in accordance with ASTM standard F739-96

### Table shows average breakthrough times in minutes

<table>
<thead>
<tr>
<th>Chemical</th>
<th>Tychem TK Material</th>
<th>Silver Sheild / Neoprene Glove Combination*</th>
<th>Visor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Acetonitrile</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Carbon Disulphide</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Dichloromethane</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Diethylamine</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Dimethylformamide</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Ethyl Acetate</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Hexane</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Methanol</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Nitrobenzene</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Sodium Hydroxide</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Sulphuric Acid 93%</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Tetrachloroethylene</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Tetrahydofuran</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
<tr>
<td>Toluene</td>
<td>&gt;480</td>
<td>&gt;480</td>
<td>&gt;480</td>
</tr>
</tbody>
</table>

### Physical Propertied Of Tychem TK Material

<table>
<thead>
<tr>
<th>Property</th>
<th>Tested in accordance with</th>
<th>Minimum Class Required for Manufacturers Specification</th>
<th>Class Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasion resistance</td>
<td>EN14325:2004 clause 4.4.1 / 4.4.2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Tensile Strength</td>
<td>EN14325:2004 clause 4.9</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Flex cracking resistance</td>
<td>EN14325:2004 clause 4.5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Flex cracking resistance at low temperatures -300°C</td>
<td>EN14325:2004 clause 4.6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Property</td>
<td>Standard</td>
<td>Ex.</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Trapezoidal tear resistance</td>
<td>EN14325:2004 clause 4.7</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Puncture Resistance</td>
<td>EN14325:2004 clause 4.10</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Seam strength</td>
<td>EN14325:2004 clause 5.5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Resistance to ignition</td>
<td>EN14325:2004 clause 4.14</td>
<td>No part shall ignite or continue to burn on removal of flame</td>
<td>Pass</td>
</tr>
</tbody>
</table>

No part shall ignite or continue to burn on removal of flame.
APPENDIX 16 Further guidance on chemical incident management:

Further guidance on chemical incident management is available from:
http://www.hpa.org.uk/chemicals/contact.htm

Centre for Radiation, Chemical and Environmental Hazards
Chemical Hazards and Poisons Division
Chilton
Didcot
Oxon OX11 0RQ

Telephone 01235 822895
Email chemicals@hpa.org.uk

Chemical Hazards

Birmingham
Birmingham Research Park
97 Vincent Drive
Birmingham
B15 2SQ

Telephone 0121 414 3368
Fax 0121 414 3827
Email chemicals.birmingham@hpa.org.uk

Cardiff
University of Wales Institute Cardiff,
Colchester Avenue,
Pentylan
Cardiff CF23 9XR

Telephone 02920 416388
Email chemicals.cardiff@hpa.org.uk

London
Health Protection Agency Central Office
7th Floor Holborn Gate
330 High Holborn
London WC1V 7PP

Telephone 020 7759 2871
Fax 020 7759 2890
Email chemicals.london@hpa.org.uk

Newcastle
The Wolfson Unit (1st Floor)
University of Newcastle upon Tyne
NE2 4HH

Telephone 0191 222 7195
Email chemicals.newcastle@hpa.org.uk

Guidance on Department of Health policy is available from the Associate Director of Health Service Resilience based at Regional Office, Gateway House (0161 625 7275) and from the Emergency Planning Coordination Unit at the Department of Health Headquarters - (020) 7210 5771