Northern Devon Healthcare Trust

MAJOR INCIDENT PLAN:
Appendix 1

ACTION CARDS
<table>
<thead>
<tr>
<th>Title</th>
<th>MAJOR INCIDENT PLAN – Action Cards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Rowena Green, Divisional General Manager, Medicine</td>
</tr>
<tr>
<td>Version</td>
<td>Date Issued</td>
</tr>
<tr>
<td>1.0</td>
<td>June 07</td>
</tr>
<tr>
<td>1.1</td>
<td>Oct 10</td>
</tr>
<tr>
<td>Main Contact</td>
<td></td>
</tr>
<tr>
<td>Rowena Green</td>
<td>Tel: Direct Dial – 01271 311598</td>
</tr>
<tr>
<td>Trinity Suite</td>
<td>Tel: Internal – 3598</td>
</tr>
<tr>
<td>North Devon District Hospital</td>
<td>Fax:</td>
</tr>
<tr>
<td>Raleigh Park</td>
<td>Email: <a href="mailto:Rowena.green@ndevon.swest.nhs.uk">Rowena.green@ndevon.swest.nhs.uk</a></td>
</tr>
<tr>
<td>Barnstaple, EX31 4JB</td>
<td></td>
</tr>
<tr>
<td>Lead Director</td>
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<tr>
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<td>Review Date</td>
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<td>XXX 20XX (when edited)</td>
<td>October 2011</td>
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</table>
## Northern Devon Healthcare Trust

### MAJOR INCIDENT PLAN APPENDIX 1 - INDEX

<table>
<thead>
<tr>
<th>Action Card Number</th>
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<tbody>
<tr>
<td>1a</td>
<td>Switchboard – major incident messages</td>
<td>4</td>
</tr>
<tr>
<td>1b</td>
<td>Switchboard – alert procedure</td>
<td>5-6</td>
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<td>1c</td>
<td>Switchboard – major incident declared</td>
<td>7-8</td>
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<td>1d</td>
<td>Switchboard - enquiries and Communication</td>
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<tr>
<td>2</td>
<td>Main entrance co-ordinator</td>
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<td>3</td>
<td>Co-ordinator for Responding Staff</td>
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<td>Relatives Co-ordinator</td>
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<td>5</td>
<td>Discharge Lounge &amp; Day Surgery Unit</td>
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<td>6</td>
<td>Incident Control Team</td>
<td>16-17</td>
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<td>Incident Manager</td>
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<td>Medical Co-ordinator or Consultant Obstetrician oncall</td>
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<td>Loggist</td>
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<td>12</td>
<td>Community Hospitals Co-ordinator</td>
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<td>13</td>
<td>Transport Co-ordinator</td>
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<td>Pathfinder Team</td>
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<td>ED Reception Staff</td>
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<td>16</td>
<td>Emergency Department Nurse-in-Charge</td>
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<td>17</td>
<td>Senior ED Consultant</td>
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<td>18</td>
<td>Ambulance Liaison Officer</td>
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<td>Emergency Department &quot;Clearing Nurse&quot;</td>
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<td>20</td>
<td>Triage Nurse/Doctor</td>
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<td>21</td>
<td>Resus Team Leader (Consultant Anaesthetist)</td>
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<td>22</td>
<td>Exit Desk</td>
<td>37</td>
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<tr>
<td>23</td>
<td>Incident Doctors</td>
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<tr>
<td>24</td>
<td>Senior ED Intensivist (Consultant Anaesthetist)</td>
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<td>Senior ED Surgeon</td>
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<td>26</td>
<td>Fracture Clinic</td>
<td>41-42</td>
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<td>Fracture Clinic Co-ordinator</td>
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<td>Fracture Clinic Practitioner</td>
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<td>29</td>
<td>ED Paediatrician (card to be written)</td>
<td>45</td>
</tr>
<tr>
<td>30</td>
<td>ICU/HDU</td>
<td>46-47</td>
</tr>
<tr>
<td>31</td>
<td>Theatres</td>
<td>48-49</td>
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<tr>
<td>32</td>
<td>Consultant Surgeon Co-ordinator (previously known as Theatres Co-ordinator)</td>
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<tr>
<td>33</td>
<td>Lundy Ward</td>
<td>51-52</td>
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<td>34</td>
<td>Caroline Thorpe Ward</td>
<td>53-54</td>
</tr>
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<td>35</td>
<td>Wards</td>
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<td>36</td>
<td>Doctors</td>
<td>56-57</td>
</tr>
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<td>37</td>
<td>Head of Communications</td>
<td>58</td>
</tr>
<tr>
<td>38</td>
<td>Community Health &amp; Social Care Manager</td>
<td>59</td>
</tr>
<tr>
<td>39</td>
<td>Health &amp; Social Care Discharge Co-ordinator</td>
<td>60-61</td>
</tr>
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<td>40</td>
<td>Patient Journey Facilitator</td>
<td>62</td>
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<tr>
<td>41</td>
<td>Estates Department</td>
<td>63-64</td>
</tr>
<tr>
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<td>Pages</td>
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<td>-------</td>
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<tr>
<td>42</td>
<td>Sodexo/Portering Staff</td>
<td>65</td>
</tr>
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<td>43</td>
<td>Sodexo/Catering Department</td>
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<td>44</td>
<td>Sodexo/Domestic Services</td>
<td>67</td>
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<td>45</td>
<td>Pharmacy</td>
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<td>46</td>
<td>Haematology &amp; Blood Transfusion</td>
<td>70-71</td>
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<td>47</td>
<td>Biochemistry</td>
<td>72</td>
</tr>
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<td>48</td>
<td>Mortuary</td>
<td>73</td>
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<td>49</td>
<td>Radiology</td>
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<tr>
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<td>Healthcare Records</td>
<td>75-76</td>
</tr>
<tr>
<td>51</td>
<td>Sterile Services Department</td>
<td>77</td>
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<tr>
<td>52</td>
<td>Supplies &amp; Procurement</td>
<td>78</td>
</tr>
<tr>
<td>53</td>
<td>Outpatients</td>
<td>79</td>
</tr>
<tr>
<td>54</td>
<td>Physiotherapy</td>
<td>80-81</td>
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<td>55</td>
<td>Occupational Therapy</td>
<td>82</td>
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</table>

**Appendices**

- **Appendix A**  Major Incident Staffing Availability Form 83
- **Appendix B**  Health & Social Care Business Continuity Flow Chart 84
SWITCHBOARD

MAJOR INCIDENT ACTION CARD 1a

• MAJOR INCIDENT MESSAGES from Ambulance Control, Emergency Department, Gold Control, Police or Executive Director

➢ Major Incident Standby:
  Indicating that an incident has occurred which could result in large numbers of casualties

➢ Major Incident Declared – Activate Plan
  Indicating a major incident has occurred. The hospital then needs to activate its plan

➢ Major Incident Cancelled:
  If a stand-by or declared message has been given, but there is no major incident

➢ Major Incident – Stand down:
  From ambulance control once all casualties have been evacuated from the scene. This message should ONLY BE RELAYED TO THE CONTROL ROOM

• MAJOR INCIDENT MESSAGE from a member of the public

It is possible, however, that Switchboard may receive the call in the first instance directly from a member of the public. In this case the caller should be asked to call ‘999’ and report to the police – if this is not possible, the receiver of the message should dial ‘999’.

• MAJOR INCIDENT INFORMATION -

In ALL cases the following details should be recorded –

  o Identity of caller and contact number
  o Time of receipt of message / call
  o Time of accident/incident

All emergency services use the mnemonic of CHALETS. This represents the essential information required in the format:

• C – Casualties - number of or expected including types of injuries if known
• H – Hazards – current or potential
• A – Access Routes – and congestion problems
• L – Location
• E – Emergency Services – present and required
• T – Type of incident - number of vehicles / buildings involved etc
• S – Start a log

Use this format for giving information about the Major Incident to the ED and Control Room.
## SWITCHBOARD MAJOR INCIDENT ALERT PROCEDURE

### 1. MAJOR INCIDENT STANDBY/ALERT/MAJOR INCIDENT EXERCISE (AND STAND DOWN)

Give the message 'NDHT Major Incident Standby/Exercise – Await Further Instructions and check your Trust email account REGULARLY for updates.'

<table>
<thead>
<tr>
<th>In hours</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleep 076, 500, 510</td>
<td>Bleeps 076, 500 &amp; 510 Bleep 500</td>
</tr>
<tr>
<td>Emergency Department (ED) – nurse in charge.</td>
<td>2640 / 2486 2640 / 2486</td>
</tr>
<tr>
<td>Duty Manager</td>
<td>Bleep 065 On call rota</td>
</tr>
<tr>
<td>Emergency Department (ED) – Consultant on call</td>
<td>2640 / 2486 On call rota</td>
</tr>
<tr>
<td>The Chief Executive in hours or Duty Director out of hours</td>
<td>3352 / 3204 On call rota</td>
</tr>
<tr>
<td>Porters</td>
<td>2496</td>
</tr>
<tr>
<td>Medical Director</td>
<td>2484 or RP Via Switchboard</td>
</tr>
<tr>
<td>Consultant Obstetrician on call</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>Consultant Anaesthetist on call for ITU</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>On-call Consultant Anaesthetist</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>On-call General Surgeon</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>On-call Orthopaedic Surgeon.</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>On-call Physician</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>On-call Engineer</td>
<td>On call rota On call rota</td>
</tr>
<tr>
<td>Assistant Director Health &amp; Social</td>
<td>3365 Via switchboard for mobile number</td>
</tr>
<tr>
<td>Pathfinder (to contact Cluster Managers)</td>
<td>3745 Bleep 141 Switchboard to contact Pathfinder &amp; Cluster Managers</td>
</tr>
<tr>
<td>Head of Communications</td>
<td>3575 On call rota</td>
</tr>
<tr>
<td>Lundy ward – nurse in charge</td>
<td>3712 / 3771 3712 / 3771</td>
</tr>
<tr>
<td>ICU – nurse in charge</td>
<td>2707 / 2715 2707 / 2708</td>
</tr>
<tr>
<td>Medical Assessment Unit</td>
<td>2775 / 3104 2775 / 3104</td>
</tr>
<tr>
<td>Fortescue</td>
<td>2724 2724</td>
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</table>
Northern Devon Healthcare NHS Trust Major Incident Plan

<table>
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<tr>
<th>Hospital</th>
<th>Phone 1</th>
<th>Phone 2</th>
</tr>
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<td>Bideford Hospital</td>
<td>01237 420 200</td>
<td>01237 420 200</td>
</tr>
<tr>
<td>Holsworthy Hospital</td>
<td>01409 253 424</td>
<td>01409 253 424</td>
</tr>
<tr>
<td>South Molton Hospital</td>
<td>01769 572164</td>
<td>01769 572164</td>
</tr>
<tr>
<td>Tyrrell Hospital</td>
<td>01271 863 448</td>
<td>01271 863 448</td>
</tr>
<tr>
<td>Torrington Hospital</td>
<td>01805 622 208</td>
<td>01805 622 208</td>
</tr>
<tr>
<td>Barnstaple Health Centre</td>
<td>01271 371761</td>
<td>01271 371761</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>01237 420214</td>
<td>Via Switchboard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Darryn Allcorn)</td>
</tr>
<tr>
<td>Sodexo</td>
<td>Bleep and phone</td>
<td>Bleep via Switchboard</td>
</tr>
<tr>
<td></td>
<td>via Switchboard</td>
<td></td>
</tr>
</tbody>
</table>

- Activate the switchboard call out cascade to ensure extra staff available to activate call out cascade if a Major Incident is declared.
- Take a copy of the Standby Callout list with the names of those Oncall to the Control Room so that the Incident Manager knows who has been contacted and create an email distribution list.
- Take the major incident phones to the control room and connect up fax and Sky television. Check external lines to the control room are functioning. Establish phone line connections in Internet café for Police Documentation Team.

2. MAJOR INCIDENT STAND DOWN

If a major incident “stand down” message is received, inform the control room on 2755 and the ED on 2640. Then contact all people on the above list who are not in the control room or the ED to inform them of the change in status. When using pagers leave the message ‘NDHCT Major Incident Stand Down’.

Use “Standby List” for “Stand down” cascade.

Give the message ‘NDHT Major Incident Stand down/Exercise – The Incident/Exercise has been stood down”. Business as Usual.

- C – Casualties - number of or expected including types of injuries if known
- H – Hazards – current or potential
- A – Access Routes – and congestion problems
- L – Location
- E – Emergency Services – present and required
- T- Type of incident - number of vehicles / buildings involved etc
- S – Start a log
**SWITCHBOARD**

**MAJOR INCIDENT ACTION CARD 1c**

### 3. MAJOR INCIDENT DECLARED

<table>
<thead>
<tr>
<th>Contact</th>
<th>In hours</th>
<th>Out of hours</th>
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<tr>
<td>Clinical Site Manager</td>
<td>Bleep 500</td>
<td>Bleep 500</td>
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<tr>
<td>Duty Manager</td>
<td>Bleep 065</td>
<td>On call rota</td>
</tr>
<tr>
<td>Duty Executive</td>
<td>3352</td>
<td>On call rota</td>
</tr>
<tr>
<td>Emergency Department (ED) – nurse in charge.</td>
<td>2640 / 2486</td>
<td>2640 / 2486</td>
</tr>
<tr>
<td>Emergency Department (ED) – Consultant on call</td>
<td>2640 / 2486</td>
<td>On call rota</td>
</tr>
<tr>
<td>Medical Director</td>
<td>2484 or Pager</td>
<td>Via Switchboard</td>
</tr>
<tr>
<td>Head of Communications</td>
<td>3575</td>
<td>On call rota</td>
</tr>
<tr>
<td>Assistant Director Health &amp; Social</td>
<td>3365</td>
<td>Switchboard to contact Pathfinder &amp; Cluster Managers</td>
</tr>
<tr>
<td>Pathfinder (to contact Cluster Managers in hours)</td>
<td>3745</td>
<td>Switchboard to contact Pathfinder &amp; Cluster Managers</td>
</tr>
<tr>
<td>Porters</td>
<td>2496</td>
<td></td>
</tr>
<tr>
<td>Surgical Ward Bleep</td>
<td>Bleep 076</td>
<td>Bleep 500</td>
</tr>
<tr>
<td>Lundy ward – nurse in charge (Lundy Ward to inform all other Wards)</td>
<td>3712 / 3771</td>
<td>3712 / 3771</td>
</tr>
<tr>
<td>Consultant Obstetrician on call</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>Consultant Anaesthetist on call for ITU</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>On-call Consultant Anaesthetist</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>On-call General Surgeon</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>On-call Orthopaedic Surgeon.</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>On-call Physician</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>On-call Engineer</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>On-call Junior Doctors</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>Medical Assessment Unit</td>
<td>2775 / 3104</td>
<td>2775 / 3104</td>
</tr>
<tr>
<td>Theatres</td>
<td>2713/2710</td>
<td>2713/2710</td>
</tr>
</tbody>
</table>

On receipt of Major Incident Declared, inform the Control Team on 2755 and the Emergency Department immediately of the change in status. If there is any difficulty contacting these areas send a runner with a written message.

Contact the following: giving the message **NDHCT Major Incident Declared – Activate Plan and assume responsibilities.**
<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number 1</th>
<th>Contact Number 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology</td>
<td>2450/3217</td>
<td>Bleep 042</td>
</tr>
<tr>
<td>ICU – nurse in charge (ICU to call all Anaesthetic staff)</td>
<td>2707 / 2715</td>
<td>2707 / 2708</td>
</tr>
<tr>
<td>Fortescue</td>
<td>2724</td>
<td>2724</td>
</tr>
<tr>
<td>Bideford Hospital</td>
<td>01237 420 200</td>
<td>01237 420 200</td>
</tr>
<tr>
<td>Holsworthy Hospital</td>
<td>01409 253 424</td>
<td>01409 253 424</td>
</tr>
<tr>
<td>South Molton Hospital</td>
<td>01769 572164</td>
<td>01769 572164</td>
</tr>
<tr>
<td>Tyrrell Hospital</td>
<td>01271 863 448</td>
<td>01271 863 448</td>
</tr>
<tr>
<td>Torrington Hospital</td>
<td>01805 622 208</td>
<td>01805 622 208</td>
</tr>
<tr>
<td>Barnstaple Health Centre</td>
<td>01271 371761</td>
<td>Via Switchboard</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>01237 420214</td>
<td>Via Switchboard (Darryn Allcorn)</td>
</tr>
<tr>
<td>Sodexo</td>
<td>2630/2352 Bleep 131</td>
<td>Bleep 036 (Hotel Services)</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>2329/2330 Bleep 045</td>
<td></td>
</tr>
<tr>
<td>Biochemistry/Path Lab</td>
<td>2345</td>
<td>Bleep 031</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>On call rota</td>
<td>On call rota</td>
</tr>
<tr>
<td>CSSD (who will also contact Supplies and Procurement)</td>
<td>2714</td>
<td>Bleep 067</td>
</tr>
<tr>
<td>Medical Records Manager</td>
<td>4080</td>
<td>Contact list with switchboard</td>
</tr>
<tr>
<td>Physiotherapy or on call Respiratory Physiotherapist (who will also contact Occupational Therapy)</td>
<td>2378</td>
<td>On call rota</td>
</tr>
<tr>
<td>Chaplain</td>
<td>Bleep 103</td>
<td>Bleep 103</td>
</tr>
<tr>
<td>All Outpatient Areas</td>
<td>2471/3149</td>
<td>First name available on the list</td>
</tr>
<tr>
<td>Day Surgery Unit (to inform discharge lounge if appropriate)</td>
<td>3500/3586</td>
<td>N/A</td>
</tr>
<tr>
<td>Mortuary Technician</td>
<td>2301/2302</td>
<td>On call rota</td>
</tr>
<tr>
<td>Admin call out</td>
<td>3352/2406</td>
<td></td>
</tr>
<tr>
<td>All General Managers</td>
<td>Via Switchboard</td>
<td>Control room to contact if needed</td>
</tr>
<tr>
<td>Executive Directors</td>
<td>Via Switchboard</td>
<td>Control room to contact if needed</td>
</tr>
</tbody>
</table>

- **C** – Casualties - number of or expected including types of injuries if known
- **H** – Hazards – current or potential
- **A** – Access Routes – and congestion problems
- **L** – Location
- **E** – Emergency Services – present and required
- **T**- Type of incident - number of vehicles / buildings involved etc
- **S** – Start a log
SWITCHBOARD MAJOR INCIDENT ACTION CARD

Enquires about casualties
The direct line to the Police Casualty Bureau is 01271 349196. Any calls to the hospital enquiring about individual casualties should be directed to this number.

Communication
Communication in the event of a major incident should be expected to be extremely difficult. Switchboard will be very busy and most of the external phone lines from the trust will be utilised.

External calls from the trust must be limited to essential MI use only
Calls through switchboard must be limited to essential MI use only

The control room has a number of MI designated phone lines but should only be contacted by designated staff members in key areas.

Dedicated phone lines to MI Control Room Hospital Co-ordination Team

<table>
<thead>
<tr>
<th>Number</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td>01271 324903</td>
</tr>
<tr>
<td></td>
<td>External calls into Control room from Silver and Gold control</td>
</tr>
<tr>
<td></td>
<td>Other external call</td>
</tr>
<tr>
<td>Internal</td>
<td>2754</td>
</tr>
<tr>
<td></td>
<td>General and outgoing calls</td>
</tr>
<tr>
<td>2445</td>
<td>Police Documentation Team</td>
</tr>
<tr>
<td>2755</td>
<td>Emergency department line</td>
</tr>
<tr>
<td>3557</td>
<td>Bleep 500 and Clinical Site Managers line</td>
</tr>
<tr>
<td>2687</td>
<td>Exmoor unit staff reporting area line</td>
</tr>
</tbody>
</table>

- **C – Casualties** - number of or expected including types of injuries if known
- **H – Hazards** – current or potential
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- **T - Type of incident** - number of vehicles / buildings involved etc
- **S – Start a log**
### MAIN ENTRANCE CO-ORDINATOR

<table>
<thead>
<tr>
<th>Role assigned by:</th>
<th>Control room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role assigned to:</td>
<td>Manager or senior administrative</td>
</tr>
<tr>
<td>Report to:</td>
<td>Control room</td>
</tr>
<tr>
<td>Liase with:</td>
<td>Control room and porters</td>
</tr>
<tr>
<td>Purpose:</td>
<td>To direct all NDDH staff, other healthcare professionals, and other professional workers involved in a major incident, press and relatives to the right area.</td>
</tr>
</tbody>
</table>

### BACKGROUND

In a major incident the only access to the main hospital will be via the Emergency Department for casualties and the Main Entrance. All other doorways will be shut down to external access if appropriate. Your role will be to police the main entrance and direct people to the appropriate destination.

### MAJOR INCIDENT DECLARED:

**Actions:**
- Report to the major incident control room in the radiology seminar room and collect Main Entrance Co-ordinator tabard and Action Card
- Read all of this action card immediately and familiarise yourself with the key areas
- At the main entrance ensure porters have erected major incident signposts.
- Direct people to correct destinations as overleaf.
- Assign a colleague to the main ED entrance and redirect as appropriate

### SECURITY

Security of the main entrance is essential but there are no security staff employed on site and the porters will already be very busy.

Your personal safety is paramount. If you feel at risk, leave the area and report to the control room immediately to dial 999.

If security at the main entrance is compromised inform the control room immediately to activate the Lock Down procedure.

### STAFF IDENTIFICATION

All NDDH and other healthcare professional staff, and other professions involved in a major incident should show their hospital or professional identification to secure access to the site. As many staff do not carry their ID this will be difficult and a pragmatic approach must be taken, especially for key workers. However, bear in mind that in the event of a major incident that many people including the press will try to gain access to the site for inappropriate reasons. If there is any doubt at all about someone's identity they should not be allowed to access the site until they can provide identification.

### STAFF REPORTING

All NDDH staff, other than those whose action card identifies that they should report elsewhere should first log in with the Staff Co-ordinator in the Exmoor unit on level 2. Tell ALL NDDH staff they
MUST report their first unless they know they have a designated role to report elsewhere on an action card. Reassure all staff they will be deployed immediately in the first instance to their normal working area but that it is essential they log in at the Exmoor unit first.

- Refer to Doctors Action Card for identification of allocated areas.

**RELATIVES AND VISITORS**

All relatives or close friends enquiring after casualties should be directed to the Internet Café.

Relatives wanting to visit existing in-patients should be informed there is a major incident and asked to visit at another time. Casual visitors should be asked to leave the site. No close relative however should be turned away especially if the in-patient is vulnerable critically ill. Discretion should be used. All relatives however should be asked to first report to the Relatives co-ordinator in the Internet Café who will then liaise with the relevant ward and arrange an escort to the ward. Relatives who have come to pick up patients for discharge should be directed straight to the relevant area.

**MAJOR INCIDENT KEY AREAS**

| Staff Reporting | Exmoor Unit level 2 |
| Control Room    | Radiology Seminar room level 2 |
| Press           | Chichester Board Room |
| Police Documentation Team | Internet Café |
| Relatives       | Internet Café |
| Discharge lounge | Discharge lounge and Day Surgery Unit |

**OTHER DESIGNATED MAJOR INCIDENT AREAS**

| Fracture clinic | Priority 3 casualty treatments areas |

- C – **Casualties** - number of or expected including types of injuries if known
- H – **Hazards** – current or potential
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- L – **Location**
- E – **Emergency Services** – present and required
- T - **Type of incident** - number of vehicles / buildings involved etc
- S – **Start a log**
CO-ORDINATOR FOR RESPONDING STAFF

Role assigned by: Control room
Role assigned to: Manager or senior nurse or senior doctor
Report to: Medical co-ordinator control room on 2687
Liaise with: Control room, Senior ED Consultant, Theatre co-ordinator
Other key clinical areas: Lundy ward and ITU
All other areas of the hospital
Purpose: To log in all staff who respond to Major Incident call out
To deploy staff to appropriate areas as directed by control room
Distribute message books to runners
Maintain accurate documentation of all decisions

OVERVIEW

This is a critical role in a major incident and requires knowledge of the NDHCT Major Incident plan, the different areas of the trust and of individual staff capabilities. The role must be established early after a Major Incident is declared, and can be handed over to a more senior staff member if available.

There needs to be a log of all NDDH staff members who attend in a Major Incident. All staff being called in to a major incident will be told to report first to the Exmoor unit. Most staff will be deployed immediately to their usual place of work. However, some staff will be deployed to other areas. The staff co-ordinator will liaise directly with the medical co-ordinator in the control room on 2687 or by radio link. The medical co-ordinator will be aware of which areas require further support.

ACTIONS

Report to the MI control room in the radiology seminar room and put on Staff Co-ordinator tabard.
- Collect Exmoor Unit radio, Exmoor Unit Major Incident Staff Logbook, copy of Junior Doctors’ MI action card and runner message books from control room and Exmoor unit keys if locked.
- The following staff should be deployed immediately after arrival to their normal working areas or have designated roles in the major incident plan:
  - Emergency department and fracture clinic staff
  - ITU staff
  - Theatre staff
  - Lundy and Caroline Thorpe nurses
  - All laboratory / pathology / mortuary staff
  - Pharmacists
  - TSSU / CSSD staff
  - Sterile services, supplies and procurement staff
  - Porters
  - Facilities and estates
  - Healthcare records

- The following staff are likely to redeployed to wherever are they are most needed. They are advised to report to the Exmoor unit for deployment to wherever the control room has identified a need:
  - Domestic and catering staff
  - Nursing staff from other wards and outpatients – identify those with previous ED or ICU or theatre experience especially
  - Occupational therapists and physiotherapists
  - Other NDDH staff, including Human Resources clerical and administrative staff
Volunteers (send at least two volunteers to Internet café to help support relatives)

- Junior and middle grade doctors have a separate action card. Deploy junior and middle grade doctors, not covered above, according to their action card. Once these initial duties are completed they should report back to the Exmoor suite. Identify their skills, remembering they may have previous experience very different to their current role.

AREAS THAT NEED URGENT DEPLOYMENT OF EXTRA STAFF

| Emergency Department: | Any doctor with past or current resuscitation skills
|                       | Nursing staff and HCAs ideally with any previous ED experience
|                       | (Contact: Senior ED Consultant) |
| Fracture Clinic:      | All plaster technicians
|                       | Other junior doctors
|                       | Nurse practitioners
|                       | Physiotherapists competent to work as minor injury practitioners
|                       | Nursing staff
|                       | (Contact: Fracture Clinic Co-ordinator) |
| ICU:                  | Nursing staff and HCAs ideally with previous ICU / HDU / CCU experience |
| Theatres:             | Medical, nursing and support staff |
| Lundy ward:           | Nursing staff and HCAs |
| Porters:              | Any spare Sodexho staff should report to the senior porter for stretcher-bearer duties |
| Discharge lounge:     | Extra staffing than usual and opening out of hours
| & day surgery unit:   | Role assigned to: ward or outpatients nursing staff |

AREAS THAT NEED EXTRA-ORDINARY DUTIES

These roles should be assigned by the control team and have separate action cards. Liase with the control team to ensure these roles are filled;

- Internet Café:     Relatives co-ordinator
                      Role assigned to manager, administrative worker or HR etc
- Main Entrance:     Main entrance co-ordinator
                      Role assigned to: manager, administrative worker or HR etc

RUNNERS

Telephone communications are likely to fail in a major incident and all key areas should have a number of runners assigned to them. Any staff member available can act as a runner. Runners should be advised to return to their designated areas and wait outside that area for further instructions once a message has been delivered. If not required by that area they should return to the Exmoor suit for redeployment.

Give a message book to each runner. The top copy of each message should be handed to its recipient and the counterfoil kept in the message books. All message books must be returned to the control room after use.

PASTORAL ROLE

Ensure any staff reporting back to the Exmoor suite have had adequate breaks and refreshments. Stand down any member of staff who appears tired or distressed, and any staff who have been on duty for long periods. Consider sending home extra staff who are surplus to immediate requirement so they can return to staff subsequent shifts.

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- T - Type of incident - number of vehicles / buildings involved etc
- S – Start a log
RELATIVES CO-ORDINATOR MAJOR INCIDENT ACTION CARD 4

<table>
<thead>
<tr>
<th>Role assigned to:</th>
<th>Senior manager, executive, senior administrative worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role assigned by:</td>
<td>Hospital control team</td>
</tr>
<tr>
<td>Role:</td>
<td>Liaise with all relatives to re-unite them with casualties</td>
</tr>
<tr>
<td>Liaise with:</td>
<td>Control room, Transport co-ordinator, ICU and Lundy ward managers</td>
</tr>
</tbody>
</table>

Background:
All casualties who are treated at NDDH and are fit for discharge will be sent to the Police Documentation Team before leaving the site. Relatives should be asked to remain in the Internet café area, or overspill into the Raleigh galley to be reunited with the discharged survivors.

Major Incident Declared:

**Actions**
- Report to control room in radiology seminar room on level 2 and put on relatives co-ordinator major incident tabard
- Pick up relatives co-ordinator major incident log book and receipted message books
- Go to Internet café in Raleigh Galley
- Ensure appropriate signage is put up in the Corridors outside the Internet Café and Raleigh Galley to clearly indicate the location of the Major Incident Relatives Reception and Police Documentation Team.
- Ensure phone lines for police documentation team are connected
- Make contact with police at casualty bureau
- Meet any relatives, carers etc of casualties and attempt to establish if the relative is in the hospital and where they are in the hospital
- Do not break bad news yourself. This should be the responsibility of the police who will ensure that any bodies are formally identified before breaking bad news.
- Communication will be difficult. Use runners with receipted message pads to send messages within the hospital. Contact the Exmoor Unit staff co-ordinator for more runners or other assistance as required.
- At least two volunteers will be assigned to assist supporting relatives
- Transport links may be severely affected. If discharged casualties cannot make their own way home liaise with the Transport co-ordinator who will attempt to make extra-ordinary transport arrangements
- No relatives should be allowed to go to the ED other than parents of young children. No relative should be allowed to the ED under any circumstances without the express permission of the senior ED consultant.
- If casualties are admitted they should be re-united with relatives once they are admitted to the admitting ward. Arrange escorts to the ward once approved with ICU or Lundy ward manager.
- All casualties should be given major incident discharge advice leaflets in their treatment area before leaving the site. Ensure all casualties have received their advice leaflet.

- **C** – Casualties - number of or expected including types of injuries if known
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- **L** – Location
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- **T** - Type of Incident - number of vehicles / buildings involved etc
- **S** – Start a log

NDHCT MAJOR INCIDENT PLAN 2010 V1.1
In the event of a major incident being declared the first priority will be to free up beds on Lundy ward to receive casualties. Patients for discharge from any ward, including the Emergency Department, who are suitable to wait in the discharge lounge, will be transferred there at the first opportunity. Discharge paperwork, TTAs, transport arrangements etc should be arranged in the discharge lounge.

The day surgery unit will be designated as an overflow discharge area.

Out of hours the Staff co-ordinator in the Exmoor Unit will arrange for the discharge lounge and day stay surgery unit to be opened. In hours, spare nursing staff will be deployed to the discharge lounge & day surgery units.

All wards will identify patients ready for discharge and inform the Clinical Site Manager on bleep 500. Ward managers on Lundy and all other wards will inform the discharge lounge which patients are ready for discharge.

**Actions: Day stay unit**

- In hours day stay unit to contact control room in radiology seminar room on lvele immediately on 2754 or by runner to confirm whether all surgery is to be cancelled
- If surgery is cancelled – to contact all patients immediately

**Actions both areas**

- Liaise with nurse manager on Lundy and other wards
- Liaise with bleep 500
- Liaise with discharge team
- Send staff to retrieve any patients with their notes and possessions from the wards or the Emergency Department.
- Liaise with pharmacy to facilitate TTAs – consider any other options to facilitate discharge eg taking home a few days medication and returning for formal prescription, contacting GPs to dispense TTAs etc
- Complete any discharge paperwork, but discharge summaries can be completed at a later date
- Facilitate transport arrangements

<table>
<thead>
<tr>
<th>C – Casualties</th>
<th>number of or expected including types of injuries if known</th>
</tr>
</thead>
<tbody>
<tr>
<td>H – Hazards</td>
<td>current or potential</td>
</tr>
<tr>
<td>A – Access Routes</td>
<td>and congestion problems</td>
</tr>
<tr>
<td>L – Location</td>
<td></td>
</tr>
<tr>
<td>E – Emergency Services</td>
<td>present and required</td>
</tr>
<tr>
<td>T – Type of incident</td>
<td>number of vehicles / buildings involved etc</td>
</tr>
<tr>
<td>S – Start a log</td>
<td></td>
</tr>
</tbody>
</table>

NDHCT
The hospital control team comprises:

- The Incident Executive
- The Incident Manager
- The Medical Co-ordinator (if appropriate)
- Loggist

See separate action cards for each named individual

Purpose of the control team

- To provide a tactical role (responsible for directing the operational response) in the event of a major incident.
- To facilitate co-ordination of all the operational activity within the Trust
- To ensure all resources are available to allow operational teams to function effectively
- To delegate responsibilities to key personnel
- To establish lines of communication with:
  - The Emergency department
  - The Clinical Site Manager
  - The Exmoor Unit staff reporting area
  - The Head of Communications
  - The Police Documentation Team
  - Silver control
  - Gold control
  - The SHA
  - The Department of Health
  - North Devon District Council
  - The PCT

- Deploy representative to Silver control
- To log all activity and expenses
- To give early attention to business continuity
- To make a rapid and continuous assessment as the incident unfolds including assessments of what activity is happening at any given time
- Liaising early with Silver control re the need to deploy medical staff to a survivor reception area to minimise transfer of very minor injured patients to the acute Trust
- The control room team will have break out briefings every 30 minutes
- Photograph the white boards at every break out briefing
- The original team will stay in place until the reception phase is complete. A control room will remain in function until the entire NDCHT response is stood down.
- Following declaration of 'Major Incident Stand down" the control room will assume responsibility for initiating actions to return to Business as Usual.
- Provide a report to the board after the incident including a financial assessment

The control room team will take a tactical lead and not become involved with operational activity. The Clinical Site Manager assume responsibility for managing bed state and informing control room of patient numbers.
HOSPITAL CONTROL ROOM MAJOR INCIDENT CHECK LIST

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Checked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Duty Manager, Clinical Site Manager &amp; Duty Exec and provide an update</td>
<td></td>
</tr>
<tr>
<td>Check phones present, plugged in and allocated to areas (contact Switchboard for supplies)</td>
<td></td>
</tr>
<tr>
<td>Switch on Computers and Log on – check Major Incident email Folder for alerts/updates</td>
<td></td>
</tr>
<tr>
<td>Check and allocate radios (in association with Switchboard)</td>
<td></td>
</tr>
<tr>
<td>Start log of all activity – Use copied A3 sheets at Alert/Standby for Chronological timeline. Green Emergency Log books to be used by identified Loggist to log all decisions at “Declared” status.</td>
<td></td>
</tr>
<tr>
<td>Identify personnel for key roles such as Admin, Runner, Major Incident email folder monitor etc..</td>
<td></td>
</tr>
<tr>
<td>Turn on Sky television (contact switchboard for remote controls) – Set TV to Channel 1, Channel 503 on Skybox = BBC News 24)</td>
<td></td>
</tr>
<tr>
<td>Ask admin person to prepare email distribution for all those on the Standby Call out list (in preparation for email regular update cascades)</td>
<td></td>
</tr>
<tr>
<td>Prepare an email update for cascade to staff on standby/declared list</td>
<td></td>
</tr>
</tbody>
</table>

Allocate key roles and tabards:

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main entrance co-ordinator</td>
<td></td>
</tr>
<tr>
<td>Staff co-ordinator for responding staff</td>
<td>Name</td>
</tr>
<tr>
<td>Relatives co-ordinator</td>
<td>Name</td>
</tr>
<tr>
<td>Head of Communications</td>
<td>Name</td>
</tr>
<tr>
<td>Community hospital co-ordinator</td>
<td>Name</td>
</tr>
<tr>
<td>Transport co-ordinator</td>
<td>Name</td>
</tr>
<tr>
<td>Silver representative</td>
<td></td>
</tr>
</tbody>
</table>

In NDHT declaring the Major Incident consider establishing contact with:

<table>
<thead>
<tr>
<th>Contact</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold control (Middlemoor police station) – 0845 2 777444 if NDHT declaring Major Incident</td>
<td></td>
</tr>
<tr>
<td>SWAST Ambulance Control : 08456 020455</td>
<td></td>
</tr>
<tr>
<td>North Devon District Council</td>
<td></td>
</tr>
<tr>
<td>Emergency Planning Duty Officer</td>
<td></td>
</tr>
<tr>
<td>In hours 01271 388870</td>
<td></td>
</tr>
<tr>
<td>After 5.00pm 01271 388240</td>
<td></td>
</tr>
<tr>
<td>Duty Executive to contact SHA</td>
<td></td>
</tr>
<tr>
<td>NHS Devon PCT :</td>
<td></td>
</tr>
</tbody>
</table>

Identify Major Incident budget number and put on white board

Identify Staff for discharge lounge out of hours (if appropriate)

Identify Staff for day surgery unit out of hours (if appropriate)

Duty Exec and Duty Manager to review and cancel elective surgery including day stay, as appropriate

Consider cancellation all other elective day activity (Exec decision)
Log in essential staff on staff allocation white board

Contact Sodexo for refreshments to be supplied to the Control Room

INCIDENT EXECUTIVE MAJOR INCIDENT ACTION CARD 7

Role assigned to: Chief Executive

or

Duty Executive or other available member of executive team

Collapsible hierarchy: The role will be assumed by the Duty manager in the first instance until such time that a member of the Executive team arrives to assume the role.

Liaise with: The Incident Manager

Strategic Health Authority

Department of Health

Gold control once established

The PCT

North Devon District Council

The Incident Executive does not lead the hospital control team nor the hospital-wide response to the major incident. This is the role of the Incident Manager

Purpose:
- Provide strategic support to the Hospital Control Team and Incident manager
- Assume responsibility for overall internal and external communications. This should be designated to the Head of Communications as soon as possible.
- Ensure that appropriate escalation takes place with regard to the incident.
- Facilitate decision making at senior level including theatre activity and service prioritisation.
- Give early consideration to business continuity and ensure responsibility for this is delegated as appropriate

Actions

On receipt of a major incident stand by or declared message:
- Assume role of Incident Manager if the duty manager has not yet arrived. This should be delegated as soon as possible.
- Put on Incident Executive Tabard
- Check that the Control staff are present or on the way in.
- Establish contact with Gold Control once established.
- Receive regular reports from the Incident Manager using the CHALETS format
- Feedback to Gold Control, SHA and the Department of Health as necessary
- Also complete other actions for Head of Communications (see Action Card) if no-one available to assume that role

CHALETS:
- C = CASUALTIES – number of expected including types of injuries if known
- H = HAZARDS – current or potential
- A = ACCESS ROUTES – and congestion problems
- L = LOCATION
- E = EMERGENCY SERVICES – present and required
- T = TYPE OF INCIDENT – number of vehicles/buildings involved etc
- S = START A LOG
INCIDENT MANAGER MAJOR INCIDENT ACTION CARD 8

Normal role: Duty manager or other member of management team
Collapsible hierarchy: Role assumed by Bleep 500 until duty manager arrives
Major incident role: To set up the hospital control room (L2, Radiology Seminar Room, or other Designated area)
To lead the major incident control team
To take on role of the incident executive until an executive is available.

The Incident manager will lead the hospital control team and lead the tactical Hospital-wide response to the Major Incident ensuring that the rest of the hospital operates as normally as possible whilst addressing the Incident.

Actions (see also control room checklist) Action Card 6

- Confirm ‘CHALETS’ information available from switchboard or ED consultant
- Ensure all control room staff clear of their individual duties
- Put on Incident Manager Tabard
- Call for immediate assistance
- Allocate staff to the following roles:
  - The Exmoor Unit staff co-ordinator
  - The Main Entrance co-ordinator
  - The Internet café Relatives co-ordinator
  - Head of Communications
  - Patient Transport
  - Other key roles e.g. Loggist (must be trained), admin/runners
  - Allocate person to monitor Major Incident email folder and report new emails to Incident Manager
- Allocate one person from management or clerical teams if available to man each designated control room phone
- Liaise with Medical co-ordinator about need to cancel other elective day activity in: outpatients, endoscopy, day theatres, wards. Decision to be made by Duty Exec and Duty Manager.
- Ensure all decisions logged in real time, by trained loggist.
- Liaise with Incident Executive re strategic decisions/ plans and provide Incident Executive with information re:
  - Estimated number of casualties
  - Current state of response
  - Significant updates
- Ensure continuity of supplies to key operational areas
- Lead breakout briefings every 30 minutes and photograph white boards at each briefing

Communication
- Maintain lines of communication with
  - Silver control
  - Clinical Site Manager
  - Transport co-ordinator
  - Community Directorate duty manager
- Confirm incident executive has lines of communication with Gold control, PCT, North Devon District Council

Do not become involved with operational activity. The PMT will assume responsibility for managing bed state and informing control room of patient numbers.

- C – Casualties - number of or expected including types of injuries if known
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Northern Devon Healthcare NHS Trust Major Incident Plan

MEDICAL CO-ORDINATOR

Role assigned to: Medical director – Oncall Consultant Obstetrician until medical director available

Liaise with: Incident executive, incident manager
Exmoor unit staff co-ordinator
Senior ED consultant, theatre co-ordinator
Outpatients all areas
Medical staff

Roles: To provide clinical advice in control room
To optimise staff deployment in conjunction with the staff co-ordinator
Oversee continuity of medical staffing (physicians)
Co-ordinate continuity of or cancellations of elective medical activity

Actions if major incident stand by message received
• Await further instructions
• Be prepared to attend the Control Room if requested
• Collate information on numbers of medical staff on duty from Oncall Doctors

Actions once major incident declared
• Attend the Control Room
• Put on medical co-ordinator tabard
• If no duty manager or executive yet present assume role of incident manager until such personnel arrive
• Familiarise yourself with the ‘CHALETS’ message contents with respect to the incident
• Explain what the expected clinical impact will be on the trust to the control team
• Liaise regularly with the staff reporting officer in the Exmoor unit on 2687 or by radio and advise to ensure the best staff are deployed to the right areas
• Confirm what elective or booked medical and outpatients’ activity is current or anticipated shortly in all areas including:
  Outpatients ext 3149
  Medical assessment unit ext 2775
  Caroline Thorpe ward ext 2704
  Endoscopy ext 3180
  Day surgery unit ext 2499

In association with Exec and Duty Manager, decide which areas this can continue and which it should be cancelled. Inform these areas at the first opportunity. What activity needs to be cancelled will depend on the type of incident, the expected numbers of casualties and the time of day. Affected areas will then contact individual patients. Liaise with the incident executive for strategic advice in areas of difficult decision making. (All in-patient elective surgery will be cancelled. The theatres co-ordinator will assume responsibility for cancellations of elective surgical activity)

On-going activity
• Ensure that elective clinical activity is resumed at the first opportunity.
• Make contact with inpatient teams to oversee responsibility for on-going in patient care
• Oversee the medical staff (physicians) who respond to an incident, ensuring that enough medical staff will be available for staffing subsequent shifts after the immediate reception phase of the incident. (The theatres co-ordinator will assume responsibility for continuity of surgical staffing).

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• S – Start a log

NDHCT Major Incident Plan 2010 V1.1
Role assigned to: Loggist
Role assigned by: Hospital control team
Reports to: Control room on 3557
Role: Manage all logging requirements during the emergency

Actions:

- Report to hospital control room on level 2 in the radiology seminar room
- Obtain Emergency Log Book(s) from Major Incident Box
- Liaise closely with the Incident Manager to ascertain which logging requirements you will undertake i.e. allocated to one role/manager or loggist for the control centre room activities.
- Await further messages/instructions from incident control team.
- Commence recording information and actions taken in the approved Emergency Log Book. Initial each entry and at end of your duty period when you hand over.

Remember:

- Make clear, intelligible and accurate logs in permanent ink (preferably black) in chronological order
- Begin each entry on a new line, but ensure there are no complete line gaps between entries.
- Note any non-verbal communication (i.e. the person nodded their head)
- Do not erase any large portions of text – put single line through. You, and the person you are logging for, must initial any crossings out or mistakes made, together with date and time.
- Do not tear out any leaves from the book
- Do not overwrite any text or write in margins
- Do not include any assumptions/comments or opinions
- Note all key times including the time that the record was made
- Note the date, time, please and people present at any meeting (remember you are not taking notes but logging actions/decisions made)
- Do not use arrows, dashes etc.
- At the end of your shift ensure the log is ruled off using a Z style rule and signed off in full, not just initials, together with date and time.

- Use any available administrative staff to assist with answering phones, photocopying etc and FOCUS ONLY ON YOUR ALLOCATED ROLE

Post Incident Action:

- Collate ALL documentation, drawings, maps, trigger notes, material pertaining to incident for Debrief/lesion identified and future enquiries.

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**CLINICAL SITE MANAGEMENT TEAM**

**Normal role:** Clinical Site Management team

**Reports to:** Control room on 3557

**Liaise with:**
- ED
- Lundy and all wards
- Community co-ordinator

**Role:** To manage the flow of patients in and out of the trust as per normal duties

To update control room on bed state and casualty numbers

---

**Command, control and collapsible hierarchy**

- **Hospital control team:** Maintain tactical control of the response to the incident
- **Clinical Site Manager:** Maintain bed state and inform control team of casualty numbers
- **Pathfinder team:** Identify patients for transfer to community beds
- **Community co-ordinator:** Identifies all available community beds
- **Transport co-ordinator:** Makes all transport arrangements

The Clinical Site Manager will fill all these roles until other staff available.

**Actions:**

- Report to control room in radiology seminar room on level 2, or other designated area
- First CSM member to put on CSM major incident tabard
- **Assume role of incident manager until duty manager or other manager available to assume role**
- Out of hours delegate normal bleep 500 duties to other senior nurse until other CSM staff available
- Activate CSM and Pathfinder call out cascade. As staff become available delegate PMT staff to:
  1. Roving hospital CSM role
  2. ED CSM role
  3. Control room CSM liaison role
- Establish formal links with control room on 3556 and ED on 2755 and by radio
- Update control team on current bed state
- Liaise with ED clearing nurse to immediately clear existing patients form the ED
- Liaise with Lundy ward to clear patients to other areas
- Identify member of staff to take on community co-ordinator role (see separate action card). Liaise with community co-ordinator about discharge planning for patient who can be transferred to community beds.
- Identify member of staff to take on transport co-ordinator role (see separate action card).
- Assume role of Pathfinder team if no-one from Pathfinder available.
Southern Devon Healthcare NHS Trust Major Incident Plan

- Continually update control room about bed state and number of casualties, by triage category, for admission
- Acquire a personal runner if available and issue runner with major incident receipted message book
- Continue routine CSM duties
- Give consideration to on-going staffing of CSM role once reception phase of major incident is complete.

ROUTINE DUTIES:

The PMT team will:

- Perform routine checks on the control room and all major incident equipment for the control room
- Inform the Emergency Planning Lead if any equipment needs replacing
- Maintain a current list of all CSM and Pathfinder staff contact telephone numbers and check this list every 3 months.
- Test staff callout cascade for all staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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COMMUNITY HOSPITALS MAJOR INCIDENT ACTION CARD 12

CO-ORDINATOR

Role assigned to: Clinical Site management team, Pathfinder team or senior nurse, or other senior manager.

Role assigned by: Clinical Site management team

Reports to: Clinical Site management team in control room on 3557 or bleep 500

Liaise with: All community hospitals
Social services
Clinical Site Manager
Pathfinder team
Transport co-ordinator

Role:
To inform the community hospitals of the major incident
To identify any available community hospital beds
To identify and arrange access to other community beds

Command, control and collapsible hierarchy

Hospital control team: Maintain tactical control of the response to the incident
Clinical Site management team: Maintain bed state and inform control team of casualty numbers
Pathfinder team: Identify patients for transfer to community beds
Community co-ordinator: Identifies all available community beds
Transport co-ordinator: Makes all transport arrangements

The Clinical Site Manager will fill all these roles until other staff available.

Actions

- Inform Clinical Site Manager in the control room on 3557 or on bleep 500 of your name and bleep number
- Activate call out cascade of community hospital directorate NDDH staff
- Contact all community hospitals to activate their major incident plans
- Ensure MIUs activate call out cascades
- Identify all immediately available community beds and inform Clinical Site Manager in the control room on 3557 or on bleep 500
- Facilitate early discharge of community hospital in-patients into the community
- Identify any other available community beds for early discharge of NDDH in-patients
- Liaise with the Pathfinder team to match NDDH in patient for early discharge into the most appropriate community bed
- Liaise with the transport co-ordinator to make transfer arrangements
Routine duties:

The community directorate manager will:-

- Maintain a current list of all NDDH community directorate staff contact telephone numbers and check this list every 3 months.
- Test staff callout cascade for all staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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TRANSPORT CO-ORDINATOR MAJOR INCIDENT ACTION CARD 13

Role assigned to: Clinical Site management team, manager or other senior nurse
Role assigned by: Clinical Site management team
Reports to: Clinical Site management team in control room on 3557 or bleep 500
Liaise with: Clinical Site management team
Pathfinder team and community co-ordinator
Role: To arrange transfers of patients to the community
To facilitate inter-hospital transfers
To make any other extra-ordinary transport arrangements

Command and control structure:

Hospital control team: Maintain tactical control of the response to the incident
Clinical Site Manager: Maintain bed state and inform control team of casualty numbers
Pathfinder team: Identify patients for transfer to community beds
Community co-ordinator: Identifies all available community beds
Transport co-ordinator: Makes all transport arrangements

The Clinical Site Manager will fill all these roles until other staff available.

Background:
In the event of a major incident transport arrangements will be difficult. Road links may be shut and
ambulances not available. Discharged survivors may need transport arranging to get home.

Contact the following agencies initially:
SWAST ambulance control on 0845 602 0455
Tertiary referral centres
Retrieval teams
Private ambulance companies

The District County Council have arrangements with local transport companies in the event of a major
incident and can be contacted on: ???????. The control room will establish a special budget number
for any expenses incurred

Actions:
• Inform Clinical Site Manager in the control room on 3557 or on bleep 500 of your name and bleep
  number
• Obtain major incident budget number from control room. Confirm any extra-ordinary expenditure
  with control team on 3557
• Liaise closely with community co-ordinator and Pathfinder team to identify patients for transfer to
  the community
• Liaise with discharge lounge and temporary discharge lounge in day surgery unit about transport
details
• Facilitate requests for transport from other areas e.g. Emergency Department, relatives co-
  ordinator

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NDHCT Major Incident Plan 2010 V1.1 27
PATHFINDER TEAM

MAJOR INCIDENT ACTION CARD 14

Normal role: Pathfinder team, community directorate nursing staff, other senior nurse
Reports to: Clinical site management team in control room on 3557 or bleep 500
Liaise with: Lundy and all wards
Community co-ordinator
Transport co-ordinator
Discharge lounge and temporary discharge area in Day Surgery Unit
Role: To identify which in-patients can be transferred to community beds & facilitate their immediate discharge and transfer

Command, control and collapsible hierarchy

- Hospital control team: Maintain tactical control of the response to the incident
- Clinical Site Manager: Maintain bed state and inform control team of casualty numbers
- Pathfinder team: Identify patients for transfer to community beds
- Community co-ordinator: Identifies all available community beds
- Transport co-ordinator: Makes all transport arrangements

The Clinical Site Manager will fill all these roles until other staff available.

Actions

- Contact the Clinical Site Manager in the control room on 3557 or on bleep 500 for contact details for the community co-ordinator and the transport co-ordinator
- Visit all wards and identify which patients are suitable for immediate discharge into the community
- Facilitate immediate discharge. Discharge summaries can be completed in retrospect. Patients can take contents of own drug cabinets as TTAs
- The day surgery unit will be staffed to act as a temporary discharge lounge for patients who need to remain on a bed or trolley pending discharge.
- Inform the Clinical Site Manager of discharges in the control room on 3557 or on bleep 500
- Liaise with the community hospital co-ordinator about which community beds the patient should be transferred to
- Liaise with the transport co-ordinator about transport arrangements
- The Pathfinder team are responsible for ensuring Cluster Managers are contacted in the event of a call received from Switchboard declaring Major Incident Standby/Exercise/Test or Declared.

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ED RECEPTION STAFF MAJOR INCIDENT ACTION CARD 15

Major Incident Duties:

Available ED reception staff will be called in, but in any event 5 clerks from Health Records will be allocated to the department.

Report to: Senior receptionist on duty

Actions:

- Duty receptionist to activate call-out cascade of all ED staff and ask them to report to the hospital
- One senior or experienced ‘roving’ receptionist to liaise with triage doctor and nurse and exit clerks and to move around department collecting patient demographic details and enter onto PAS before the patient leaves department. This includes patients certified dead on arrival. All admitted patients will be admitted under the General Surgeon on-call in the first instance.
- One senior or experienced receptionist to remain on reception desk to take calls, enquiries and troubleshoot as required
- 2 Exit Clerks to man a desk at the rear of the department in order to document patient’s major incident numbers and destination upon leaving A&E. This desk must not be left unattended at any time. They must ensure: –
  - All patients are entered onto Exit Log (paperwork in MI box)
  - Major Incident Patient Record stays with patient
  - Any X-rays stay with patient
  - All property stays with patient
  - Patient must have identity bracelet in situ before leaving the ED

  see EXIT DESK ACTION CARD (Action Card 21)

- Other available clerical staff to assist:
  - ED receptionist at desk
  - Triage officer – liaise with exit clerks to keep ED floor plan up to date
  - Roving ED receptionists
  - Nurse in charge

Communication with public / media

Any relatives who manage to access the ED should be directed to the relatives area in the Raleigh Gallery. Media should be directed to the boardroom in Chichester House. In the event of receiving telephone calls asking for information please use one of the following responses:

Public/relatives

"We have been informed there is a Major Incident in progress but we cannot confirm any details. I am unable to give out patient details over the telephone. However, the Trust will release a statement as soon as possible, which will be reported by local radio stations." The direct line to the Police Casualty Bureau is 01271 349196. Any calls to the hospital enquiring about individual casualties should be directed to this number.

To media

- The head of communications is dealing with all media enquiries. Please ring them on via switchboard

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Inform and brief all ED staff that a Major Incident message has been received
• Confirm ED consultant on-call and senior nurse are aware of Major Incident
• Report to the control room to get as much information on patient numbers and ETA, and put on ED Nurse in Charge tabard.
• Return to the ED
• Distribute other tabards
• Distribute Major Incident stationary
• Keep a log – log book in major incident stationary box

Activate ED Major Incident Plan by distributing action plans and allocating roles to:

- ED reception staff see action card
- ED ‘clearing nurse’ see action card
- Resus nurse check resuscitation room
- re-stock fully all equipment including gowns and linen
- Majors nurse check all majors cubicles
- re-stock fully all equipment including gowns and linen
- Triage nurse to set up trolley at Triage point with:
  - Major Incident Patient Log
  - Major Incident patient Records
  - Floor plan ED
- ENPs to go to fracture clinic to supervise management of P3 patients

Nurse escorts - junior or student nurses or HCAs, deployed to ED by MI control team to stay with patient throughout their journey and ensure documentation stays with patients

Liaise with ED consultant to assign nursing staff to patients on arrival

In the case of a CBRN incident immediately contact control team to send extra nursing staff to ED and allocate:
- Lead decontamination nurse to erect decontamination tent with help from estates staff and to liaise with SWAST and fire service
- Monitor length of time of staff in decontamination suits
- 2 ED nurses to put on decontamination suits

Liaise with SSD and supplies departments to maintain department supplies

With ED consultant:
- Consider on-going staffing of ED and stand down staff to re-attend later as appropriate
- After stand-down arrange debriefing sessions for all ED Staff

DO NOT INVOLVE YOURSELF IN DIRECT PATIENT CARE

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SENIOR ED CONSULTANT MAJOR INCIDENT ACTION CARD 17

Reports to: Control Room

Normal role: ED consultant (or ED middle grade until ED consultant arrives)

MI Role: Supervise and co-ordinate the ED response and liaise with the control team

Major Incident Standby:

- Report to control room, put on Senior ED Consultant tabard, collect radio and return to ED
- Ensure all staff briefed to details of major incident, ensure all roles allocated and ED action plan ready to be instituted.
- Advise ED middle grade to liaise with ED ‘clearing nurse’ to identify disposition of existing ED patients.
- Ensure Triage nurse is established (and allocate an ED doctor as Triage Doctor if available) and ensure all Triage Point paperwork is available.
- Allocate clerical officer, nurse or HCA as personal assistant (PA) to the ED consultant

Major Incident Declared:

- Institute ED Major Incident Action Plan
- Supervise and co-ordinate the ED response and liaise and brief the Control Team on 2755 and/or radio
- Maintain Senior ED consultant log book – devolved to PA if available
- Allocate all ED Medical Staff and Trauma Team members in accordance with their action plans. Ensure they wear the relevant tabard.
- Request additional Medical Staff from the control team in the control room; brief and allocate these Staff to treatment areas, ensure they wear the relevant tabard. Co-ordinate the allocation of treatment teams
- Liase with the Ambulance Liaison Officer, Senior ED Intensivist and Senior ED Surgeon and Resus Team Leaders to co-ordinate and prioritise the ED response.
- Liase with the scene via the Ambulance Incident Officer (AIO) or Medical Incident Officer (MIO) by SWAST radio. You and the ALO will be the main NDDH links with the scene
- Lead on CBRNE decontamination and treatment advice – (see CBRNE action card)
- Channel all requests for additional resources, including Staff and equipment, along with requests for admission to Wards or Theatre to the control team in the Control Room.
- Consider on-going staffing of ED and stand down staff to re-attend later as appropriate
- After stand-down arrange debriefing sessions for all ED Staff.
- Once all casualties have arrived from scene inform, control room, Lundy ward & theatres

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AMBULANCE LIAISON OFFICER

The Ambulance Liaison Officer is responsible for the supervision of the Ambulance Service activity and liaison at the receiving hospitals. The Ambulance Liaison Officer will be based at the receiving hospital and is responsible to the Ambulance Communication Centre (ACC) Senior Management Officer.

Call-sign: “(Hospital Name) Ambulance Liaison”

Communications

Report to the receiving hospital and locate the hospital Communication Centre room.

Report your arrival at the hospital Communication Centre room to the ACC.

Wear tabard marked ‘Ambulance Liaison Officer’ and take the Action card folder (to be collected from the Hospital Major Incident Communication Centre Room, once established).

Test the telephone link between the hospital Communication Centre room and the ACC, advising of the relevant contact telephone and fax number(s) for use by the ACC and / or the Medical Incident Commander. (Seek permission to leave personal mobile phone on.)

Bed State

Ensure the Hospital Communication Centre Team is completing and sending the hospital bed-state to the ACC on a regular basis using the standard pro-forma bed-state fax-back form. (Use Majax 8 form)

Advise ACC of contingency plans for patient overflow or decanting to other hospitals as they become available.

Ensure maximum co-operation with the Hospital Communication Centre Team in regard to the decanting of patients to secondary hospitals. Any request for assistance from the Voluntary Aid Societies should be made early to allow time for the mobilisation of their personnel.

Casualty Reception

Liaise with the officer-in-charge of the police documentation team(s) upon their arrival.

Confirm arrangements exist for the monitoring and recording of all incident casualties arriving at the hospital.

Ensure the rapid turn around of resources

Ambulance Operations

Maintain a log of vehicle call-signs, numbers of patients arriving at hospital, appoint a runner as necessary. (Using Majax form 6)

Ensure the release of ambulance equipment from the hospital back to the incident scene with returning vehicles, if requested.

Following liaison with the Ambulance Incident Commander and / or Medical Incident Commander arrange for bulk supplies of drugs, infusion fluids or other similar items to be dispatched from the hospital pharmacy to the incident scene, if required.

Ensure that all ambulances call ACC immediately on clearing at the Hospital and await instructions. It is important that crews do not automatically return to the incident.
Major incident – ‘Stand Down’

Following the ambulance service Major incident – ‘Stand Down’

Liaise with the Hospital Communication Centre Team and advise the ACC of the hospital’s ability to resume other emergency or urgent admissions;

Remain at the hospital in order to manage continuing demands on resources for discharges / transfers.

Ensure the retention of all documentation relating to ambulance service operations in the receiving hospital and forward all paperwork onto the Resilience Department:

Attend the hospital’s ‘hot’ debrief.

At the conclusion of the incident, prepare a report for the Resilience Department

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EMERGENCY DEPARTMENT MAJOR INCIDENT ACTION CARD 19

‘CLEARING NURSE’

Report to: ED nurse in charge
Role: Senior ED nurse, to clear ED all existing patients once Major Incident declared
Notes: In a Major Incident it is the responsibility of the admitting ward to come and retrieve all existing patients in the Emergency Department who need admission

Ensure all patients have an identity name band before leaving the ED

Actions:

Major Incident Stand-by

- Liaise with ED middle grade and identify probable destination of all patients in department
- Liaise with bleep 500 to identify what current bed availability is and where beds are soon to become available
- Announce to all patients in waiting room that there is a Major Incident Standby and those with minor injuries and ailments that do not warrant urgent intervention might be asked to attend other health care providers.

Major Incident Declared

- Announce Major Incident to all patients in the waiting room and ask all patients with minor injuries or ailments that do not warrant immediate attention to leave the department and attend another healthcare provider.
- Hand out leaflets with details of other healthcare providers available from reception.
- Liaise with middle grade and bleep 500 as above if not already done so.
- Liaise with fracture clinic staff and ask them to implement their major incident plan. Any ENP on duty will be deployed to fracture clinic to treat existing ED patient there are prepare for P3 casualty reception.
- Move all patients in minors who cannot be sent straight home, or who are waiting for treatment into the fracture clinic or plaster room. Any ENP on duty will be deployed to fracture clinic to treat these patients
- Patients fit for discharge should be transferred to the discharge lounge, which will be opened and staffed if out of hours. Phone the discharge lounge and ask the staff to come and retrieve the patients immediately from the ED as per their Major Incident Action Plan
- Resuscitation room patients should be transferred direct to ITU or CCU or a ward. Ask the team with the patient to transfer the patient immediately.
- If the patient needs transfer to another hospital ask the team to liaise with SWAST to transfer as soon as possible. If there is any delay consider admitting the patient to ITU, CCU or a ward pending transfer.
- Only unstable patients requiring on-going resuscitation should remain in the ED, but transferred at the first opportunity.
- Majors patients who have been identified as definitely or probably needing admission should be admitted direct to relevant wards. Contact the admitting ward and ask them to come and immediately collect the patient from the ED as per their Major Incident Action Plan

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NDHCT Major Incident Plan 2010 V1.1
TRIAGE NURSE / DOCTOR

Allocated by: The ED nurse in charge will designate the triage nurse and the Senior ED consultant will allocate a triage doctor if available.

Role: To triage all patients on arrival according to major incident triage ‘sort’

Report to: ED consultant

Work with: There will be a triage clerk also allocated to triage if available

MI TRIAGE SORT is on the reverse of this action card and on the Triage sort white board.

<table>
<thead>
<tr>
<th>Major Incident Category</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Needing immediate resuscitation or life saving treatment</td>
</tr>
<tr>
<td>P2</td>
<td>Needing urgent treatment but not immediately life threatening</td>
</tr>
<tr>
<td>P3</td>
<td>May still have significant injuries but treatment can be delayed</td>
</tr>
</tbody>
</table>

Actions:
- Liaise with ED consultant for briefing re expected casualty numbers and ETA
- Put on Triage nurse / doctor tabard
- Establish Triage point outside X-ray inside the main ambulance doors. This comprises:
  - Dynamap BP and pulse monitor
  - Triage trolley brought from MI store containing:
    - Major incident patient records and identity labels
    - Stationary including pens and markers for white boards
    - Major incident Patient arrival log
    - Log books for senior ED consultant, nurse and triage team
  - MI whiteboards:
    - Triage methodology whiteboard
    - ED layout whiteboard
    - ITU capacity whiteboard
    - Theatre capacity whiteboard
- ALL patients (whether from the Major Incident or not) are to enter via ambulance sliding doors. CBRNE contaminated patients ONLY will enter through the decontamination entrance before triage.
- Triage patients on arrival. The triage category may not be the same as the category at scene
- All patients arriving at the ED are triaged whether involved in the incident or not. A Major Incident Patient Record should be used. Patients with minor injuries or ailments who were not involved in the Major Incident should be asked to see help from another health care provider.
- Allocate Major Incident number to the patient with corresponding number Major Incident patient Record and name band
- Allocate patient to cubicle in designated triage category area an write on floor plan white board location of patient by Major Incident number. Triage clerk or nurse to liaise with exit clerks to update floor plan when patient leaves the department
### MAJOR INCIDENT TRIAGE SORT

<table>
<thead>
<tr>
<th>Variable</th>
<th>Score</th>
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<tbody>
<tr>
<td><strong>Glasgow Coma Score</strong></td>
<td></td>
</tr>
<tr>
<td>13-15</td>
<td>4</td>
</tr>
<tr>
<td>9-12</td>
<td>3</td>
</tr>
<tr>
<td>6-8</td>
<td>2</td>
</tr>
<tr>
<td>4-5</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Systolic BP</strong></td>
<td></td>
</tr>
<tr>
<td>≥ 90 mmHg</td>
<td>4</td>
</tr>
<tr>
<td>76-89</td>
<td>3</td>
</tr>
<tr>
<td>50-75</td>
<td>2</td>
</tr>
<tr>
<td>1-49</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>RR</strong></td>
<td></td>
</tr>
<tr>
<td>10-29</td>
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</tr>
<tr>
<td>&gt;29</td>
<td>3</td>
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<tr>
<td>6-9</td>
<td>2</td>
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<tr>
<td>1-5</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Triage Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>P3</td>
</tr>
<tr>
<td>11</td>
<td>P2</td>
</tr>
<tr>
<td>10 or less</td>
<td>P1</td>
</tr>
</tbody>
</table>

### Glasgow Coma Score

<table>
<thead>
<tr>
<th>Motor</th>
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<tr>
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<td>5</td>
</tr>
<tr>
<td>Flexes to pain</td>
<td>4</td>
</tr>
<tr>
<td>Decorticate (abnormal flexion)</td>
<td>3</td>
</tr>
<tr>
<td>Decerebrate (abnormal extension)</td>
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</tr>
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</tr>
<tr>
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</tbody>
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<table>
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</thead>
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</tr>
<tr>
<td>Eyes open to speech</td>
<td>3</td>
</tr>
<tr>
<td>Eyes open to pain</td>
<td>2</td>
</tr>
<tr>
<td>No eye opening</td>
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</tr>
</tbody>
</table>

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- **S** – Start a log
RESUS TEAM LEADER

MAJOR INCIDENT ACTION CARD 21

Reports to: Senior ED Consultant

Normal role: ED middle grade, consultant and middle grade anaesthetists, intensivists and surgeons with resuscitation room and ATLS experience etc.

MI role: Team leader in resuscitation of category P1 patients

Action:

• Put on a Resus Team Leader tabard from the Major Incident store room
• Report to the ED Consultant who will allocate you a patient treatment area. Supervise the resuscitation and treatment of that patient in the area indicated.
• Liaise with the ED consultant, Senior ED Intensivist and Senior ED Surgeon to make definitive treatment plans and to identify the definitive destination of the patient. Do not contact these Departments yourself.
• These patients should be transferred at the first opportunity to definitive care in ITU or theatre or to a ward.
• If once the patient is stable, they still need on-going treatment or investigation before they can be sent for definitive care, consider transfer to main theatres recovery to allow on-going assessment.
• Once you have dealt with your patient report back to the ED Consultant.

Notes:

• ALL patients are numbered and have major incident numbered stationery and request forms etc. ready for use. Use major incident number even once patient demographics have been entered onto PAS.
• When completing request forms ALWAYS fill in MINIMUM of major incident number and patient sex in all cases. Add name and date of birth whenever these are known
• Only complete immediate resuscitation and treatment in the ED. Any treatment that can be deferred should be deferred wherever possible.
• Only trauma series chest and pelvic films and open or deformed long bone imaging should be performed with portable equipment. Patients should not be transferred to the X-ray room 7 for this imaging.
• All trauma patients will have a FAST scan by the consultant radiologist in the ED
• CT should be reserved for isolated head injuries only
• Images will be entered onto PACS by major incident number and hard films will be printed

Involvement of other medical and nursing staff:

• You may be allocated an Incident Doctor. He or she will be a junior doctor with some trauma experience and their role will be to assist you.
• Your patient will have 1-2 nurses allocated, who may not be familiar with the resuscitation room.
• Each patient should have a Nurse Escort. These are usually untrained Nurses whose principle role is to stay with the patient at all time and take charge of the patient’s stationery; assist other Nurses and Doctors if able.

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EXIT DESK

MAJOR INCIDENT ACTION CARD 22

Allocated to: 2 ED receptionists or Healthcare Records Staff
Report to: Senior ED receptionist
          Senior ED nurse
          Roving ED receptionist
          Control room
Location: Exit desk in main corridor from the ED to the main hospital just past fracture clinic

To keep an exit log of ALL casualties who leave the Emergency Department and Fracture clinic areas.

ALL casualties who are:

- Admitted to the hospital
- Discharged from the ED or fracture clinic
- Dead
- Transferred to other areas

MUST BE ENTERED IN THE EXIT LOG

** The exit desk must not be left unattended at any time**

ACTIONS

- Check exit desk has been erected by porters
- Collect exit desk major incident box from the Major Incident store room.
- Ensure one person stays at the exit desk at all times until you are told to stand down
- Enter the following information to the log
  - Major Incident patient number
  - Time
  - Destination (ward, ITU, theatre, discharged, transferred etc)
- If a patient arrives at the exit desk who has not been to the triage point in the ED or who has not been allocated a major incident number they must not be allowed into the hospital until they have returned to the ED triage point
- For all admitted patients their paperwork must remain with the patient at all times.
- All discharged patients must hand in their paperwork at the Exit Desk. This paperwork will return to the ED at the end of the incident.
- Discharged patients should be asked to retain their identification wrist band and report to the relatives' area and Police Documentation Team in the Internet Café on level 0.
- Liaise with the roving clerks from fracture clinic and the ED and tell them which patients have been admitted, discharged or died. The roving clerks will then enter the disposal information on to PAS. All admitted patients will be first admitted under the surgeon of the day. They can be then transferred to another specialist as appropriate later.
- Give information to the Police Documentation Team confirming the identity of all casualties and whether they are alive or deceased. You should not give further clinical information.

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INCIDENT DOCTORS

MAJOR INCIDENT ACTION CARD 23

Reports to: ED Consultant

Normal role: ED SHOs, anaesthetic and surgical SHOs with ED and ATLS experience etc

MI Role: Treatment and resuscitation of category P2 patients
Assisting resus team leaders in managing P1 patients
May also be deployed to treat P3 patients in fracture clinic and plaster room

Action:

- Put on an Incident Doctor tabard from the Major Incident store room
- Report to the Senior ED Consultant who will allocate you a patient treatment area. Supervise or assist in the resuscitation and treatment of that patient in the area indicated.
- Liase with the ED consultant, Senior ED Intensivist and Senior ED Surgeon to make definitive treatment plans and to identify the definitive destination of the patient. Do not contact these Departments yourself.
- Co-ordinate with the Senior ED Surgeon to make a definitive operating plan for all patients who need to go directly to theatre
- These patients should be transferred at the first opportunity to definitive care in ITU or theatre or to a ward. If once the patient is stable, they still need on-going treatment or investigation before they can be sent for definitive care, consider transfer to main theatres recovery to allow on-going assessment.
- Once you have dealt with your patient report back to the Senior ED Consultant.

Notes:

- ALL patients are numbered and have major incident numbered stationery and request forms etc. ready for use. Use MI number even once patient demographics have been entered onto PAS.
- When completing request forms ALWAYS fill in MINIMUM of major incident number and patient sex in all cases. Add name and date of birth whenever these are known
- Only complete immediate resuscitation and treatment in the ED. Any treatment that can be deferred should be deferred wherever possible.
- Only trauma series chest and pelvic films and open or deformed long bone imaging should be performed with portable equipment. Patients should not be transferred to the X-ray room 7 for this imaging.
- All trauma patients will have a FAST scan by the consultant radiologist in the ED
- CT should be reserved for isolated head injuries only
- Images will be entered onto PACS by major incident number and hard films will be printed

Involvement of other staff:

- Your patient will have one nurse allocated who may not be familiar with the ED.
- Each patient should have a Nurse Escort. These are usually untrained Nurses whose principle role is to stay with the patient at all time and take charge of the patient’s stationery; assist other Nurses and Doctors if able.

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SENIOR ED INTENSIVIST

MAJOR INCIDENT ACTION CARD 24

Normal role:  Consultant on-call for ITU

Major Incident role:  Co-ordination of anaesthetic / ITU response in ED.
Assessing need for anaesthetic equipment in ED.
Triaging priority of patients to ITU / HDU areas.

Liase with:
- Senior ED Consultant
- Senior ED Surgeon
- ITU
- Theatre co-ordinator
- Resus team leaders and incident doctors
- Anaesthetists in ED.

Reports to:  Senior ED Consultant

Purpose:  The objective is to assess and prioritise the ITU / medical needs of priority 1 and 2 patients not requiring surgery involved in the major incident and the anaesthetic needs of the surgical patients and communicate this information to the Senior ED consultant who will liaise with the Control Team.

Action
- Report to Control Room, put on Senior ED Intensivist tabard and return to ED
- Report to the Senior ED Consultant in the ED
- Circulate through all treatment areas, assessing and prioritising the medical needs of priority 1 and 2 patients.
- Liase with the Resus Team Leaders and Incident Doctors caring for priority 1 and 2 patients to assist in assessing the medical priorities of these patients.
- Report the individual medical status of the priority 1 and 2 patients to the Senior ED Consultant, stating what medical intervention is required and its urgency.

- Liase with ITU, theatre co-ordinator and other high dependency areas to:
  - triage patients to the most appropriate high dependency area
  - monitor the total number of ventilated patients
  - allocate anaesthetic teams to theatre patients
  - consider the need to increase the ICU capacity according to the ICU capacity plan
  - liase with other ICUs in area to retrieve patients from NDDH
  - brief the control team of this information

- Assess the need for anaesthetic equipment in the ED and co-ordinate this information with the needs of other high dependency areas – ITU / HDU / CCU / theatres / theatre recovery

Notes
- There will possibly not be enough anaesthetists to manage each ventilated patient in the ED and you will need to co-ordinate teams of anaesthetists to oversee patients in each geographical area in the ED.

- Only perform investigations in the ED that will influence the immediate management of the patient. Other treatment should be deferred.

DO NOT INVOLVE YOURSELF IN DIRECT PATIENT CARE

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NDHCT Major Incident Plan 2010 V1.1  40
SENIOR ED SURGEON

Normal role: Consultant General Surgeon on-call or general surgical registrar until consultant arrives

Major Incident role: Co-ordination of surgical response in ED. Establishing operating plans for surgical patients. Triaging priority of surgical patients to theatre.

Liases with: Senior ED Consultant, Senior ED Intensivist, Theatre Co-ordinator, Lundy ward, Resus team leaders and incident doctors, Tertiary referral centres.

Reports to: Senior ED Consultant

Purpose: The objective is to assess and prioritise the surgical needs of priority 1 and 2 patients requiring surgery. Also to establish how many P3 patients will also need surgical intervention. To make operating plan before the patient leaves the ED. Communicate this information to the Senior ED consultant who will liaise with the Control Team.

Actions
- Report to MI/ERP control room, put on Senior ED Surgeon tabard and return to ED
- Report to the Senior ED consultant in the ED.
- Circulate through all treatment areas
- Liaise with the Resus Team Leaders and Incident Doctors caring for priority 1 and 2 patients to assist in assessing these patients’ surgical priority.
- Decide which patients need to go the theatre directly from the ED and which can go to the receiving ward. Children and adults will all be admitted to Lundy.
- Identify which patients need transfer to tertiary centres for urgent neurosurgical, cardiothoracic and burns surgery. Liaise with the tertiary referral centres direct.
- Update the theatre co-ordinator regularly on casualty numbers and expected theatre demand.
- For patients who need to go direct to theatre, make an operating plan in conjunction with the resus team leaders and incident doctors:
  - Each patient should have a definitive decision about what operation(s) they need before leaving the ED
  - Resuscitative laparotomy, amputation, fasciotomy and debridement take priority
  - Wounds will be dirty and secondary closure should be delayed
  - FAST scans will be performed on all trauma patients
  - CT should be reserved for isolated head injuries
- Liaise with the fracture clinic co-ordinator about any P3 patients who may require surgery
- Report the surgical priority of individual priority 1 and 2 patients to the Senior ED consultant, stating what surgical intervention is required and its urgency.

Notes
- Only perform investigations in the ED that will influence the immediate management of the patient. Other investigations and treatment should be deferred.

DO NOT INVOLVE YOURSELF IN DIRECT PATIENT CARE

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FRACTURE CLINIC MAJOR INCIDENT ACTION CARD 26

In working hours

The nurse in charge of A&E will notify the Fracture clinic staff including radiographer of a Major Incident.

Major Incident Stand-by
- all patients present should be informed but the clinic should not be cancelled at this time

Major Incident Declared
- all patients waiting to be seen should be asked to leave the department. The receptionist should issue new appointments at that time or arrange for them to be posted through the next day.
- any outstanding plaster casts or other treatments should be completed
- any clinics not started should be cancelled and patients phoned with a new date
- nurse in charge to activate call-out cascade

Out of working hours
- ENP or senior nurse from ED to go to fracture clinic and activate call-out cascade

Fracture Clinic Co-ordinator
- The first person to arrive in fracture clinic in a Major Incident will become the Fracture Clinic Co-ordinator and put on the fracture clinic tabard found in the Major Incident Store in the resuscitation room sluice in the ED.
- This role may be handed over to a senior nurse or doctor when they arrive
- See Fracture Clinic Co-ordinator Action Card

Fracture Clinic Layout
- Casually waiting area - Waiting area
- Casualty treatment areas - Three bays in fracture clinic and three bays in plaster room
- Office - For staff use only – no casualty treatment

IMMEDIATE ACTIONS
- Collect Major Incident Fracture Clinic treatment box and Discharge Advice leaflets from the major Incident Store in the resuscitation room sluice in the ED
- Put up Major Incident P3 signs outside fracture clinic doors
- Establish Fracture Clinic Major Incident Log on flip chart at reception of all P3 patients sent to fracture clinic area to include:
  - MI number
  - Triage category – this will initially be P3 but may change if the casualty deteriorates
  - Time of arrival
  - Time of discharge form fracture clinic
  - Discharge destination
- Designate a scribe (clerical worker if available) to input all patients onto flip chart
- Designate a roving clerical officer to collect patient demographics and enter onto PAS
  - NB all investigations etc will be ordered according to patients MI number
- Designate a staff co-ordinator to allocate staff to duties
  - as well as fracture clinic staff doctors and ENPs from the ED you will be allocated staff from other areas, including clerical staff, outpatients staff and doctors.
  - Hand out ‘Fracture Clinic Practitioner’ Action Card to any nurse practitioner or doctor assigned to treat patients in Fracture clinic

Casualty Reception and Treatment
- All casualties brought to fracture clinic should be category P3
- This does NOT mean they will have only sustained minor injuries
- They may deteriorate and need a new triage category and be transferred back to the main ED
• Casualties will be treated by Incident Doctors or Emergency Nurse Practitioners, assisted by fracture clinic staff and other nursing staff deployed to the area.

• If enough staff are deployed to the fracture clinic patients should be seen on arrival

• Casualties should wait in the main waiting area and be transferred to a treatment bay only when a practitioner is available to see them

• Patients should be seen in turn according to time of arrival from flip chart unless there is any reason to suspect their triage category has changed

• Documentation should be completed on the major Incident patient record using the MI patient number

• Any x-rays should be carried out in X-ray area in fracture clinic

• A supply of analgesia including morphine, and TTAs of analgesics and antibiotics will be sent from pharmacy – a pharmacist will attend if available to assist with TTA dispensing.

Casualty Discharge

• All discharged casualties must have their discharge time written on the Fracture Clinic Major Incident Log
• All discharged casualties must be given TTAs as appropriate
• All discharged casualties must be given follow up instructions as appropriate
• All discharged casualties must be given a Major Incident Discharge Advice leaflet
• All discharged casualties must leave the fracture clinic via the Exit Desk in the main corridor
• All discharged casualties must have their paperwork completed before discharge and handed in at the Exit Desk
• All discharged casualties must report to the relatives area in the Raleigh gallery and the Police Documentation Team in the Internet Café before leaving the hospital
• Keep family members together wherever possible

Casualty Admission

• Any P3 patients needing admission will go to Lundy ward including children
• Inform the Fracture Clinic Co-ordinator of any patients who need admission
• The Fracture Clinic Co-ordinator will then liaise with Lundy ward
• Inform to the Fracture Clinic Co-ordinator of any patient needing an operation.
• Fracture Clinic Co-ordinator will then liaise with the Senior ED surgeon who will prioritise their need for theatre

Routine duties:

The fracture clinic manager will:-

• Maintain a current list of all staff contact telephone numbers
• Test the staff callout cascade for fracture clinic staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
• Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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NDHCT Major Incident Plan 2010 V1.1
FRACTURE CLINIC CO-ORDINATOR MAJOR INCIDENT ACTION CARD 27

Allocated to:
Out of hours First person to be deployed to fracture clinic
In hours Senior nurse in fracture clinic
Taken over by Senior nurse or doctor deployed to fracture clinic

Reports to: Senior ED consultant
Liaises with:
Senior ED surgeon
Senior nurse ED
Lundy ward
Sterile supplies, supplies, pharmacy
Control room only if contacted for situation update

IMMEDIATE ACTIONS
- Put on fracture clinic co-ordinator tabard and collect Fracture Clinic treatment box and discharge advice leaflets from the store in resuscitation room sluice in the ED.
- In hours ensure all fracture clinic staff aware of major incident and designate existing staff to implement Fracture Clinic Action Card
- Out of hours initiate staff call-out cascade
- Put up Fracture Clinic P3 treatment area sign outside fracture clinic
- Erect Fracture Clinic Major Incident Log on flip chart in reception
- Designate:
  - a scribe to log in all patients on Fracture Clinic Major Incident Log
  - a roving clerical worker to enter patient details onto PAS
  - a team co-coordinator to allocate staff to duties as they arrive and hand out Fracture Clinic Practitioner action cards.
- Ensure pharmacy have brought major incident supplies and TTAs to the department
- Keep a log of all actions / decisions – log book in Fracture Clinic major incident Treatment box

ON-GOING ACTIONS
- Roam around department identifying any problem areas
- Receive feedback from doctors and ENPs about patients needing re-triage to a more serious category and liaise with Senior ED Consultant to arrange immediate transfer back to main ED – do not try to continue to treat these patients in fracture clinic.
- Receive feedback from doctors and ENPs about patients needing admission and liaise with Lundy ward to arrange transfer.
- Receive feedback from doctors and ENPs about patients needing surgery and liaise with Senior ED Surgeon who will prioritise their need for theatre – arrange transfer to theatre or Lundy as advised
- Report back regularly to Senior ED Consultant who will liaise direct with the Control Room if you need more staff deployed to the area.
- Check on stock supplies and liaise with sterile supplies, supplies and pharmacy as required
- Supervise the team co-ordinator in ensuring staff have adequate rest breaks

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FRACTURE CLINIC PRACTITIONER MAJOR INCIDENT ACTION CARD 28

Allocated to: Emergency Nurse Practitioner
Any doctor

Report to: Fracture Clinic Co-ordinator

Work with: Allocated nurses

Role: To see and treat category P3 patients in the event of a major incident
Complete history, examination and necessary investigations and complete
your own treatments unless it is more appropriate to hand treatments over to
nursing staff eg Plaster or Paris, complex dressings

NOTES:
- All casualties brought to fracture clinic should be category P3
- This does NOT mean they will have only sustained minor injuries
- They may deteriorate and need a new triage category and be transferred back to the main
  ED
- All patients presenting to the ED during an incident will be triaged as for a major incident.

You may be working in an unfamiliar environment. If you have any doubts or concerns do not
hesitate to ask for help from the fracture clinic co-ordinator or other staff deployed to Fracture
Clinic.

ACTIONS:
- See patients in order of arrival from Fracture Clinic Major Incident Log at Reception
- Take a patient from the waiting area to a treatment area only when you are ready to treat them
- Return all patients immediately to waiting area when you have finished immediate treatment to
  free up treatment space
- Each casualty will have their own Major Incident Patient Record and Major Incident Number with
  pre-numbered stationary. This record must stay with the patient at all times
- Use MI number for ordering investigations once patient details have been entered onto PAS.
- When completing request forms fill in minimum of major incident number and sex in all
  cases. Add name and date of birth whenever these are known
- Use the minimum number of investigations necessary to adequately treat the patient
- Inform the Fracture Clinic Co-ordinator immediately if your patient needs:
  - Admission, or
  - Surgery, or
  - They have deteriorated and need transfer back to the main ED
- The fracture clinic co-ordinator will make the necessary arrangements
- **DO NOT** contact the admitting ward, the Senior Surgeon or the ED yourself unless there is an
  immediate need to do so and the Fracture Clinic Co-ordinator is not available
- **Before discharging any patient ensure:**
  - They have TTAs, follow up arrangements, Major Incident Advice leaflet
  - They have their discharge time and destination on the Fracture Clinic Major Incident Log
  - They leave via the Exit Desk in the main corridor and their paperwork is handed in there
  - They are advised to report to the relatives area and the Police Documentation Team in
    the Raleigh Gallery on Level 0

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S – Start a log
Action card 29 – ED Paediatrician

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ICU / HDU

MAJOR INCIDENT ACTION CARD 30

In the event of a Major Incident the on-call Intensivist will be deployed to the ED. In hours any available Intensivist should take over responsibility for ICU. Out of hours the ICU SHO will take charge of the unit until a second senior Intensivist arrives. The ICU will take responsibility for calling in all anaesthetic medical staff.

ITU beds will be under intense pressure in the event of a major incident. There is an ICU Capacity Plan allowing for an emergency doubling of the ITU capacity – it is expected that the ICU Capacity Plan will need to be activated in the event of a major incident.

Major Incident Stand-by

On receipt of the Major Incident Stand-By, the Nurse in Charge will:

- Immediately re-allocate patients amongst staff on duty to allow a senior nurse to be available to:
  - Check availability of beds in ICU / HDU
  - Contact on-call anaesthetic S.H.O. on-call for ICU / HDU to discuss which patients can be transferred out of the unit.
  - Identify potential wards for transfer of patients and inform Bleep 500.

- Check on availability of staff:
  - Names to Senior Nurse in charge
  - Identify second Intensivist to take over ICU from on-call Intensivist and hand over patients
  - Names arranged in teams for coverage (see separate list)
  - Notify Bleep 500 and control room.

- Ensure ITU bed bureau is contacted to inform of major incident stand-by

Major Incident Declared

- Request staff from identified wards to collect patients classified fit for transfer.

- Delegate activation of call-out cascade:
  - Call all medical anaesthetic and ITU staff
  - Call in 4 trained nurses from Group 1 immediately (see separate list). Staff on night duty should not be called unless situation critical, as they will provide relief coverage. Should staff be unavailable proceed to Groups 2 and 3.
  - Staff to report to ICU / HDU first to the Exmoor Suite on level 2 from where they will be deployed to ITU. Staff must bring their hospital identification to secure access to the hospital.

- Identify to Bleep 500 number of empty beds available.

- Ask all visitors to leave the premises and vacate the car park.

Nurse in charge to liaise with:

- Senior ED Intensivist (ITU consultant on-call) and Theatres co-ordinator about which patients will come to ITU
- Major Incident Control room on 2745, radiology seminar room on level 2 re ITU bed state
- Consultant on ITU to contact local ITU departments about bed state

Telephone communications are likely to fail in a major incident – use runners with written messages to communicate with other areas if necessary.
Routine duties:

The ITU ward manager will:-

- Maintain a current list of all staff contact telephone numbers including all medical ITU and anaesthetic staff. You will need to check this list every 3 months.
- Test staff callout cascade for all staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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| A – Access Routes | and congestion problems                                   |
| L – Location   |                                                        |
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| T- Type of incident | number of vehicles / buildings involved etc         |
| S – Start a log |                                                        |
THEATRES

MAJOR INCIDENT ACTION CARD 31

Major Incident Procedure during Scheduled Hours:
Senior Nurse/Sister or Charge Nurse in charge of Department -

- Inform Surgical teams occupying all Theatres of Major Incident Stand-by.
- Prepare to abandon scheduled procedures until the incident is Declared or Cancelled.
- Inform all Theatre personnel to remain on duty.
- Inform TSSU Manager
- Clear Theatres in readiness for emergencies pending.
- Await instruction regarding surgical requirement.
- Designate Theatre teams according to the severity and number of incoming surgical cases.
- Recruit off-duty staff to come in to reinforce current on-duty staff to assist in staffing theatres. Do not try to bring in staff from the immediately following shifts as at the time of the incident step-down there will be no staff to come on duty. Try and recruit staff from later shift patterns.
- Day Surgery - proceeds as normal, but be prepared to suspend list if necessary, if advised to do so by major incident control team

Major Incident Procedure Out of Hours

- Call Theatre Manager or Deputy
- Call Theatre Co-ordinator or Deputy
- Call Recovery Manager or Deputy
- Call Senior Anaesthetic Practitioner or Deputy
- Call On-Call Sister, if not already on duty
- From them on Call in one additional Theatre Team from Group 1 Staff list (see note below), i.e. trained Staff, 1 Nursing Auxiliary, and 1 Operating Department Practitioner (ODP)
- Alert ‘On-Call’ Recovery Staff and ‘On call’ ODP (but do not ask them to attend immediately but to remain on call for maternity unit cover).

Should Staff be unavailable, proceed to Group 2 and 3. Staff called in from home should report to the MI Staff Reporting Area in the Exmoor Unit on Level 2 not direct to theatre. They must bring hospital identification to secure access to the hospital.

Group 1 staff able to arrive on site within 15 minutes: Group 2 to be on site 15 – 40 minutes and Group 3 over 40 minutes to arrive on site.

Staff on duty to prepare 2 theatres immediately for emergencies as routine.

Action during Scheduled or Out of Hours.
Department Co-ordinator : If the Theatre Co-ordinator of Deputy is not available, one of the Senior Sisters/Charge Nurse will undertake this role.

- Liaise with Theatre Major Incident Co-ordinator to establish demand and priority of cases requiring surgery with medical staff and to assign operating teams to theatre.
- Assess number of staff and call in further resources as required.
- Designate Theatre Teams.
- Liaise with TSSU Manager regarding equipment availability and requirement.
- Alert Recovery Nurse - designate to call further Recovery Nurses in accordance the surgical demand.
- Ensure ODP provision is adequate and call in further resources as required.
- Implement Patient Information Sheet to facilitate theatre occupancy and patient location.
Theatre recovery

Theatre recovery may be used as an overflow area for the ED or ITU for the on-going resuscitation of critically injured patients before definitive care in theatre or transfer to the receiving ward.

Day surgery and endoscopy

The day surgery unit will become a secondary discharge area. Out of hours the control room will ensure that it is staffed by whomever available. In hours the day surgery unit should respond according to its own action card. If elective surgery and endoscopy is cancelled then staff from these areas should report to the Exmoor unit staff reporting area for redeployment.

Routine duties

The theatres senior nurse will:-

- Maintain a current list of all staff contact telephone numbers
- Test the staff callout cascade for theatres staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

<table>
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CONSULTANT SURGEON MAJOR INCIDENT ACTION CARD 32
CO-ORDINATOR (previously known as Theatres Co-ordinator)

Role assigned to: Orthopaedic consultant on call

Liaises with: Senior ED surgeon
Senior ED anaesthetist
Lundy ward
ITU

Responsibilities: Co-ordinating operating anaesthetic and surgical teams in theatre
Allocating surgical and anaesthetic teams to individual cases
Overseeing all surgical staff in the hospital
Ensuring continuity of surgical staffing

On receipt of “Standby” call from Switchboard:
• Await further instructions
• Be prepared to attend the Control Room if requested
• Make contact with Oncall General Surgeon
• Establish information on numbers of medical staff on duty for your specialty collation by the Medical Director

Background notes
1. The responsibility for triaging casualties to theatre rests with the senior ED surgeon. Triage is dynamic and priorities change. The order of priority might also alter depending on the surgical expertise immediately available at any time. The senior ED surgeon should also establish which operations each individual casualty requires before leaving the ED.

2. Theatre recovery may be used as an overflow area for the ED or ITU for the on-going resuscitation of critically injured patients before definitive care in theatre or transfer to the receiving ward. This area has 9 Bays.

3. The nature of surgery necessary in a major incident is likely to be trauma surgery due to the effects of blast or high impact transport accidents:
   • Wounds will be by definition contaminated. The types of operation necessary are likely to be debridements, amputations, external fixation and laparotomy:
   • It is essential in both the interests of individual patients and the major incident theatre response as whole, that only the minimum resuscitative, fracture stabilisation and wound stabilisation surgery is completed in the first instance.
   • If lengthy definitive surgery is undertaken at the time of the first operation then infective complications are more likely and the theatres will quickly become overwhelmed.

Actions:
• Establish contact with the senior ED surgeon in the ED. Liaise regularly with the senior ED surgeon and Lundy ward to confirm triage priorities of patients to theatre
• Return to the main theatres and cancel all elective surgical activity for that day.
• Allocate surgeons and anaesthetic teams to casualties
• Ensure operating teams have adequate breaks
• Oversee the all the surgical teams in the hospital – give early consideration to continuity of surgical staffing for the wards and theatres
• Liaise with the control room about when routine surgical activity can resume. (Many if not most surgical patients from a traumatic major incident will need a second or third operative intervention before their definitive treatment is complete. The impact of a major incident on theatre activity is therefore likely to last much longer than the initial reception phase impact on the rest of the hospital.)
• Predict and identify any equipment shortages and liaise with CSSD / TSSU, SSD and supplies and procurement as necessary for replacements

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S – Start a log
CONSULTANT PHYSICIAN                         MAJOR INCIDENT ACTION CARD 33

Role assigned to:  Consultant Physician on call
Liaises with:  Medical Director
               ED Consultant
               Consultant Surgeon Co-ordinator (Action Card 32)
Responsibilities:  Allocating medical teams to individual cases
                   Overseeing all medical staff in the hospital
                   Ensuring continuity of medical staffing
                   Discharge Co-ordination

Major Incident Standby:
On receipt of “Standby” call from Switchboard:

- Await further instructions
- Be prepared to attend the Control Room if requested
- Establish information on numbers of medical staff on duty for your specialty collation by the Medical Director

Major Incident Declared:
Actions:

- Contact Lead Clinician to identify number of Doctors that could be called in to assist.
- Oversee medical teams in the hospital.
- The responsibility for co-ordinating available medical teams to specific wards - give early consideration to continuity of medical staffing for the wards
- Work alongside those medical teams to identify patients ready for discharge from NDDH and Community Hospitals.
- Ensure Control Room is informed of number of discharges from each ward.

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LUNDY WARD  MAJOR INCIDENT ACTION CARD 33

Lundy ward is the receiving ward for all casualties, including children, from a major incident. When a major incident is declared the ward should be cleared by discharging patients home or transferring to other wards as soon as possible to free up beds for casualties. As the incident progresses, aim to keep all casualties on Lundy and preferentially transfer existing in-patients to other areas.

If there are predominantly young child casualties Caroline Thorpe may become the primary receiving ward.

Major Incident Standby

Start to identify which patients could be discharged or transferred, but do not activate the plan at this time. Ask staff due to go off duty to stay on site until the incident is declared or cancelled.

Major Incident Declared – Before Casualty arrival

The priority is to empty as many beds as possible to prepare for casualty arrival, and activate the call-out cascade.

- Inform all other wards of Major Incident, including – instruct wards to implement the ‘WARDS - MAJOR INCIDENT ACTION CARD’ and begin their call out cascade.

- Caroline Thorpe ward will contact SCBU and Roborough.

- Inform ward doctors who should come straight to ward if available to identify patients for discharge.

- Ask all visitors to leave the premises and vacate the car park. Discretion may be used to allow first degree relatives of especially sick and vulnerable patients to remain with the patient.

- Instruct trained nurse to activate Lundy ward call out cascade. Call off duty staff first. Do not call staff sleeping after night duty when relevant. Do not call all staff in immediately but consider who should be left available to staff subsequent shifts.
  
  o Staff called in from home should report to the Staff Reporting Area in the Exmoor Unit on Level 2 not direct to the ward as they may be deployed elsewhere. Staff must bring hospital identification to secure access to the hospital.

- Liaise with bleep 500 to identify empty beds to transfer patients in NDDH or the community

- Liaise with medical staff to identify which patients can go straight home or to the discharge lounge. Identify which patients need on-going in-patient clinical care and which could be transferred to the community for rehabilitation. If no medical staff available the senior nurse in charge should use her professional judgement. Give this information to the bleep 500 or discharge co-ordinator.

- Liaise with pharmacy and medical staff to expedite TTAs for any patient fit for discharge. Discharge paperwork etc should be completed where possible in the discharge lounge. Where there will be a delay prior to discharge the patient should be transferred to another ward for them to complete the discharge process.

- Liaise with discharge lounge and other wards – these areas will provide staff to transfer patients from Lundy – Lundy staff should not be involved in patient transfer. Ensure all personal possessions and medical notes accompany patients

- Liaise with Senior ED Consultant to establish estimated number of casualties expected and the number of children involved.
Child casualties
- Contact Caroline Thorpe ward who will deploy RSCN nursing staff to Lundy ward to nurse any child casualties.

- If there are predominantly young child casualties Caroline Thorpe may become the primary receiving ward. The control room will make this decision.
  - In the event of large number of young child casualties expected urgently liaise with the Senior ED Consultant, Control room and Caroline Thorpe to confirm primary receiving area.

**Major Incident Declared – After casualties arrive on ward**

- Contact the control room in the radiology seminar room on extension 2754 to deploy more staff to Lundy if insufficient nursing staff available on ward

- Consider the use of runners with written notes if telephone communications fail

- Casualties will all have a Major Incident Number. Use this number to identify all major incident casualties for the duration of the incident.

- Identify all casualties by major incident number on the white board.

- Liase with supplies and sterile services to maintain stocks

- The Senior ED Surgeon in conjunction with the Theatres Major Incident Co-ordinator will determine the priority for operations. Liase with both to prepare the patients for theatre as appropriate.

- Surgery may be limited in the first instance to resuscitation and wound debridements and many patients will have subsequent definitive procedures.

- Monitor nursing and medical staff on the ward for tiredness or distress. Ensure that shift patterns are maintained as close to normal as possible. Ensure staff have adequate breaks. Liase with the Raleigh Gallery to provide refreshments to ward if necessary.

The impact of the major incident will continue to affect Lundy Ward long after the final casualties have arrived from the scene. Casualties will form strong networks amongst themselves and are likely to form ‘survivor groups’. Specialist discharge information sheets will be available from the ED.

Consider ‘hot’ debriefs at the end of each shift.

Once the Incident is over arrange a formal debriefing session for all staff involved.

**Routine duties:**

The Lundy ward manager will:-

- Maintain a current list of all staff contact telephone numbers – including all surgical, urology, maxillofacial and ENT doctors. You will need to update this list every 3 months

- Test staff callout cascade for Lundy staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.

- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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CAROLINE THORPE WARD  MAJOR INCIDENT ACTION CARD 34

In the event of a Major Incidents, any child casualties will be admitted to Lundy ward. This is to keep injured family members together, and that so all victims of a Major Incident are cared for in the same clinical area. Staff from Caroline Thorpe will be transferred to Lundy to help care for these children.

If there are predominantly young child casualties Caroline Thorpe may become the primary receiving ward.

Critically injured children will be transferred to SCBU, ICU or tertiary centres as indicated.

ACTIONS

In the event of a major incident, the nurse in charge of Lundy ward will inform Caroline Thorpe.

Lundy ward will liaise with the Emergency Department to establish the number of child casualties.

Nurse in charge to:

- Confirm bed state and inform bleep 500
- Contact paediatric consultant on call
- Contact paediatric SHO on call
- Allocate HCA to activate Caroline Thorpe ward call out cascade including all paediatric doctors kept in the MI box in ward manager’s office. Call off duty staff first. Do not call staff sleeping after night duty when relevant. Do not call all staff in immediately but consider who should be left available to staff subsequent shifts.
  - Staff called in from home should report to the Staff Reporting Area in the Exmoor Unit on Level 2 not direct to the ward as they may be deployed elsewhere. Staff must bring hospital identification to secure access to the hospital.
- Liase with Lundy ward extension 3771 to establish number of paediatric casualties and need for paediatric nursing staff to be transferred to Lundy.
- Send one trained nurse to Lundy in the first instance to help prepare for casualties.
- Alert SCBU extension 2610 to inform them of major incident to activate ward call out cascade for reception of any injured infants
- Alert Roborough ward to inform them of major incident to activate ward call out cascade and help provide staff as necessary to Lundy ward.
- Allocate one trained nurse to assist doctors to expedite discharge any in-patient children ready to go home.
- In the event of the incident involving predominantly child casualties, urgently liaise with Lundy to confirm primary receiving area.
- Liaise with on call consultant about need to cancel planned or booked admissions

If Caroline Thorpe becomes the primary receiving area:

Nurse in charge to:

- Inform on call paediatric consultant who should then report to the Emergency Department to assist with paediatric casualties
- Inform on-call SHO to expedite discharges from the ward
- Inform SCBU and Roborough ward
  - Transfer in-patient infants to SCBU – SCBU staff to retrieve infants
  - Transfer other children to Roborough – Roborough staff to retrieve children
  - Transfer older children to adult wards - ward staff to retrieve older children
• Contact the control room in the radiology seminar room on extension 2745 to deploy more staff to Caroline Thorpe if insufficient nursing staff available on ward

• Consider the use of runners with written notes if telephone communications fail

• Casualties will all have a Major Incident Number. Use this number to identify all major incident casualties for the duration of the incident. Identify all casualties by major incident number on the white board.

• Liase with pharmacy, supplies and sterile services to maintain stocks

• The Senior ED Surgeon in conjunction with the Theatres Major Incident Co-ordinator will determine the priority for operations. Liase with both to prepare the patients for theatre as appropriate.

• Surgery may be limited in the first instance to resuscitation and wound debridements and many patients will have subsequent definitive procedures.

• Monitor nursing and medical staff on the ward for tiredness or distress. Ensure that shift patterns are maintained as close to normal as possible. Ensure staff have adequate breaks. Liase with the Raleigh Gallery to provide refreshments to ward if necessary.

The impact of the Major Incident will continue to affect CT Ward long after the final casualties have arrived from the scene. Casualties will form strong networks amongst themselves and are likely to form ‘survivor groups’. Specialist discharge information sheets will be available from the ED.

Consider ‘hot’ debriefs at the end of each shift.

Once the Incident is over arrange a formal debriefing session for all staff involved.

Routine duties:

The Caroline Thorpe ward manager will:-

• Maintain a current list of all staff contact telephone numbers including all paediatric doctors. Update this list every 3 months
• Regularly staff callout cascade for ward staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
• Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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WARDS MAJOR INCIDENT ACTION CARD 35

Major Incident Notification

Switchboard will notify Lundy ward of any major incident. The notification will be ‘Major Incident Standby’, ‘Major Incident Declared’ or ‘Major Incident Cancelled’. The nurse in charge of Lundy will then inform all other wards of the MI status.

Major Incident Stand-by

- Confirm Bed State of ward and update bleep 500 of bed state when asked
- Immediately identify any patients who might be fit for discharge or transfer to the community and expedite discharge planning, discharge summaries, TTAs etc.
- Plan to reduce nursing activities to essential duties only.
- Be prepared to release staff for emergency duties on request.
- Staff finishing duty to remain on ward if possible until definitive incident status confirmed

Major Incident Declared

- Activate staff call out cascade. Call in staff off duty first. Staff sleeping after night duty should ideally not be called in first instance. Do not call all staff in immediately but consider who should be left available to staff subsequent shifts
- Staff called in from home should report to the Staff Reporting Area in the Exmoor Unit on Level 2 not direct to the ward as they may be deployed elsewhere. Staff must bring hospital identification to secure access to the hospital.
- Ask all visitors to leave the premises and vacate the car park. Discretion may be used to allow first degree relatives of especially sick and vulnerable patients to remain on site.
- Prepare to receive any patients from Lundy, CCU, ITU or other surgical wards. Complete any outstanding discharge paperwork for these patients.
- Prepare to collect existing patients from the ED – these patients may not have all their paperwork or investigations complete at this time.
- Inform the ward manager to co-ordinate the Off-Duty to ensure continuity of staffing.
- Every Ward has a “Major Incident in Progress” warning sign, which can be displayed at the ward entrance to reduce unauthorised visitors.

Routine duties:

Ward managers will:-

- Maintain a current list of all staff contact telephone numbers including all the doctors for their area:
  a. Capener ward to also contact all orthopaedic doctors not on call
  b. Lundy ward to also contact all other general surgical and other surgical specialty doctors
  c. Petter ward to also contact all obstetric and gynaecology doctors not on call
  d. MAU will also contact all medical doctors including, Genitourinary doctors, not on call
  e. Caroline Thorpe will also contact all paediatric doctors not on call
- Test staff callout cascade for staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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DOCTORS

MAJOR INCIDENT ACTION CARD 36

ON CALL DOCTORS

All on-call doctors will be informed of a Major Incident through switchboard

ED doctors See ED action cards

Anaesthetic SHO Go to ITU to attend to in patients
When Consultant Intensivist arrives on ITU report to ED

Anaesthetic consultant Report to ED as SENIOR ED INTENSIVIST

Medical House Officer Remain on wards to attend to ward duties

Medical SHO Remain on MAU to attend to medical admissions
Existing ED patients for admission will be transferred direct to MAU or wards before their assessment is complete

Medical Registrar Facilitate urgent discharge or transfer of medical in-patients

Medical Consultant Report to control room as MEDICAL CO-ORDINATOR until medical director arrives

Surgical House Officer Remain on wards to attend to ward duties. Cross cover orthopaedic wards

Surgical SHO Report to ED as INCIDENT DOCTOR

Surgical Registrar Assume role of SENIOR ED SURGEON until consultant arrives
Remain in ED as RESUS TEAM LEADER until deployed to theatre

Orthopaedic SHO Report to ED as INCIDENT DOCTOR

Orthopaedic Registrar Report to ED as RESUS TEAM LEADER until deployed to theatre

Orthopaedic Consultant Report to theatre as THEATRE CO-ORDINATOR

Paediatric SHO Return to Caroline Thorpe ward – see CT ward action card

Paediatric consultant Return to Caroline Thorpe ward – see CT ward action card
If paediatric casualties expected report to ED

Gynaecology SHO Remain on ward to attend to ward duties & facilitate discharges

Maxillo-facial SHO Report to ED as INCIDENT DOCTOR

Urology SHO Report to ED as INCIDENT DOCTOR

Consultant Haematologist See Haematology action card and CBRNe appendix 2

Consultant Microbiologist See Pathology action card and CBRNe appendix 2

Radiologists See Radiology action card

Other on call consultants Contact junior staff to facilitate discharges then report to Exmoor Unit staff reporting area for deployment to ED or theatres or other clinical areas
ALL OTHER DOCTORS

If a Major Incident is declared out of hours doctors will be called in by their call out cascade

- ED doctors will be called from the ED cascade
- Anaesthetists will be called from the ITU cascade
- Paediatricians will be called from the Caroline Thorpe Cascade
- Orthopaedic doctors will be called from the Capener ward cascade
- All other surgical specialties will be called from the Lundy ward cascade
- Physicians including GU doctors will be called from MAU
- Obstetrics and gynaecology doctors will be called from the Petter ward cascade
- Pathology staff will be called in through their call out cascades

All staff must first report to the staff reporting area in the Exmoor Unit on level 2. Use the main hospital entrance. Hospital identification will be needed to access the site.

Doctors will then be deployed to a specific area.

ALL DOCTORS IN HOURS

In hours all doctors will be informed of Major Incident by nurse in charge of that clinical area. Staff finishing their shift should stay on duty.

**ED staff**

See ED action plan

**Theatre staff**

See Theatre action card and Theatre Co-ordinator action cards

Elective lists other than emergency surgery will be stopped

Theatre co-ordinator should liaise with Senior ED consultant to deploy available staff to the ED or to remain in the theatre suite

**ICU staff**

See ICU action card

Liase with Senior ED consultant and Theatre Co-ordinator to deploy available staff to remain in ICU, to go the ED or to go to theatres

**Pathologists**

See specific action cards

**Radiologists**

See Radiology action card

**Other consultants**

Contact your junior doctors

Assign necessary staff to complete outstanding duties

Assign staff to facilitate any possible discharges

Send all other available doctors to the MI Staff Reporting Area in the Exmoor Unit on Level 2 for deployment

**Other junior doctors**

Contact your consultant for deployment as above

The medical co-ordinator will assume responsibility for all medical doctors who respond to the major incident, ensuring that enough medical staff will be available for staffing subsequent shifts after the immediate reception phase of the incident. The theatres co-ordinator will assume responsibility for continuity of surgical staffing.

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NDHCT Major Incident Plan 2010 V1.1
### HEAD OF COMMUNICATIONS

**MAJOR INCIDENT ACTION CARD 37**

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<tr>
<th>Role assigned to:</th>
<th>Head of communications or other member of executive or management teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role assigned by:</td>
<td>Hospital control team</td>
</tr>
<tr>
<td>Reports to:</td>
<td>Control room on 3557</td>
</tr>
<tr>
<td>Role:</td>
<td>Liaison with media VIPs Other external agencies not directly involved with managing the response</td>
</tr>
</tbody>
</table>

**Actions:**

- Report to hospital control room on level 2 in the radiology seminar room, or designated area.
- Collect Head of Communications radio, log book and receipted message pads
- Designate communications co-ordinator for Press Room.
- Provide Digital Camera for taking regular photos of whiteboards in the control room.
- Log any decisions or events in log book
- Go to and unlock Chichester House Boardroom – open direct external doors to Boardroom
- Ensure external phone line in Boardroom operational
- Direct any media representatives to Boardroom
- Receive regular updates from the control team
- Brief media to hospital response particularly:
  - Number of casualties
  - Number of fatalities
  - Number of critically ill casualties
  - Outline of the hospital response
- Arrange regular briefing times with main media representatives with a view to their broadcast times
- Meet any VIPs and facilitate a tour of the trust as appropriate
- Respond to requests to information from other agencies not directly involved with the response. Agencies directly involved with the response should be referred to the control room on 01271 324903

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COMMUNITY HEALTH & SOCIAL CARE MANAGER

MAJOR INCIDENT ACTION CARD 38

Role assigned to: Health & Social Care Cluster Manager or Assistant Director of Health & Social Care

Role assigned by: Hospital Control Team

Reports to: Clinical Site Manager in control room on 3557 or bleep 500 and Adult and Community Services emergency response Lead

Liases with:
- NDHT Control Room
- Pathfinder Lead
- Acute Inpatient Therapy Lead
- Podiatry
- Speech & Language Therapy
- ACS Emergency Response Lead
- CDP Manager
- Health Admin Lead – CCT Co-ordinators, Admin Support, Barnstaple Health Centre
- ACS Duty Practice Manager – Social Workers, CCWs, OTs
- District Nursing Team Lead – District Nurses, Community Matrons, OOH Nurses
- Community Therapy Lead – Community Rehab & Community Hospitals
- Inpatient Physiotherapy & OT
- Specialist Services Lead – Lymphoedema, Cardiac Rehab, Heart Failure, Palliative Care, CREADO

Role:
- Inform community health and social care staff of the major incident
- Co-ordinate the local community health and social care response to the incident
- Keep both the ACS emergency response lead and NDHT control room informed and respond to requests

Command, control and collapsible hierarchy (See Appendix 2)

Hospital control team: Maintain tactical control of NDHT response to the incident
Clinical Site Manager: Maintain bed state and inform control team of casualty numbers
H&SC Discharge Co-ordinator: Identify patients for transfer to community beds/discharge
H&SC Manager: Co-ordinate community health and social care service to support early discharges/transfers and respond to the incident.

The Clinical Site Manager will fill all these roles until other staff available

- Inform Community health and social care teams of major incident and identify lead professionals
- Inform NDHT control room of whereabouts and contact details
- Inform ACS emergency response lead of whereabouts and contact details
- Arrange regular communication briefings with leads
- Identify with support of CDP availability of domiciliary care, residential and nursing home beds to support early discharge of patients from hospital
- Identify through CDP and professional leads at risk/vulnerable clients/patients
- Consider suspending non critical activities and make staff available for redeployment as required

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**HEALTH & SOCIAL CARE DISCHARGE CO-ORDINATOR**

**Normal role:** Pathfinder Operational Manager or Health & Social Care Cluster Manager or Assistant Director of Health & Social Care

**Reports to:** Clinical Site Manager

**Liaise with:** All community hospitals, Social Services, Clinical Site Manager, Pathfinder team, Transport Co-ordinator, Community Health & Social Care teams

**Role:** To inform the community hospitals of the major incident, To identify any available community hospital beds, To identify and arrange access to other community beds, To identify any possible/safe discharges, To identify any discharge resources across Health & Social Care, To act as key liaison with Community Health & Social Care incident manager

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**Command, control and collapsible hierarchy (See Appendix 2)**

- **Hospital control team:** Maintain tactical control of the response to the incident
- **Clinical Site Manager:** Maintain bed state and inform control team of casualty numbers
- **H&SC Discharge Co-ordinator:** Identify patients for transfer to community beds/discharge, Identify all available community beds/discharge resources
- **Transport co-ordinator:** Makes all transport arrangements

The Clinical Site Manager will fill all these roles until other staff available

**Actions**

- Inform Clinical Site Manager in the control room on 3557 or on bleep 500 of your name and bleep number
- Identify Community Health & Social Care incident managers and contact details
- Contact all community hospitals to activate their major incident plans
- Identify all immediately available community beds and inform Clinical Site Manager in the control room on 3557 or on bleep 500
- Facilitate early discharge of community hospital and NDDH in-patients into the community
- Identify any other available community beds/alternative destinations for early discharge of NDDH in-patients
- Liaise with the Pathfinder team to match NDDH in patient for early discharge/transfer
- Schedule regular communication with Health & Social Care incident manager

**Routine duties:**
The community directorate manager will:-

- Maintain an effective and current communication cascade within the Health & Social Care Division and check this every 3 months.

- Test staff callout cascade for all staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.

- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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</tbody>
</table>
**PATIENT JOURNEY FACILITATOR**

**MAJOR INCIDENT ACTION CARD 40**

<table>
<thead>
<tr>
<th>Role</th>
<th>To identify which in-patients can be transferred to community beds &amp; facilitate their immediate discharge and transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal role:</td>
<td>Pathfinder team, community directorate nursing staff, other senior nurse</td>
</tr>
<tr>
<td>Reports to:</td>
<td>Clinical Site Manager in control room on 3557 or bleep 500</td>
</tr>
<tr>
<td>Liaise with:</td>
<td>Lundy and all wards, Community co-ordinator, Transport co-ordinator, Discharge lounge and temporary discharge area in Day Surgery Unit</td>
</tr>
</tbody>
</table>

**Command, control and collapsible hierarchy (See Appendix 2)**

- **Hospital control team:** Maintain tactical control of the response to the incident
- **Clinical Site Manager:** Maintain bed state and inform control team of casualty numbers
- **Pathfinder team:** Identify patients for transfer to community beds
- **Community co-ordinator:** Identifies all available community beds
- **Transport co-ordinator:** Makes all transport arrangements

The Clinical Site Manager will fill all these roles until other staff available.

**Actions**

- Contact the Clinical Site Manager in the control room on **3557** or on bleep 500 for contact details for the community co-ordinator and the transport co-ordinator
- Visit all wards and identify which patients are suitable for immediate discharge into the Community
- Facilitate immediate discharge. Discharge summaries can be completed in retrospect. Patients can take contents of own drug cabinets as TTAs
- The day surgery unit will be staffed to act as a temporary discharge lounge for patients who need to remain on a bed or trolley pending discharge.
- Inform the Clinical Site Manager of discharges in the control room on **3557** or on bleep 500
- Liaise with the community co-ordinator about which community beds the patient should be transferred to
- Liaise with the transport co-ordinator about transport arrangements

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ESTATES DEPARTMENT MAJOR INCIDENT ACTION CARD 41

Standard duties

Maintain list of contact numbers for all Estates staff – to be checked every three months

During Normal Hours:

The Switchboard will contact the Estates Department direct on extension 3500/3586 when the Director of Facilities or nominated deputy will take charge. In his absence, the duty PTB Officer on the on-call rota will assume this role. Report to the control room to confirm presence in the hospital.

The officer in charge will liaise with the control room located in the radiology seminar room and redirect the services within the department as requested. Normal works for the duration will be suspended whilst the incident is in progress, with all trade staff reporting back to the Estates Office.

Out of Normal Hours:

Once the Switchboard has received a “Major Incident Declared” message, they will, unless otherwise instructed by the Control Team, automatically call the duty PTB Officer via pager, mobile phone or home telephone number. Report to the control room to confirm presence in the hospital.

Duties of the PTB Officer Out-of-Hours:

- Call the on-call craftsman and request him to attend site to assist where needed and be available for engineering breakdowns.
- The on-call craftsman should collect a workshop pager when arriving on site and confirm the number to the PTB Officer and Control Centre via the switchboard.
  NB. The on-call craftsman may be sent to site initially on his own, unless the PTB Officer or Control Centre decides that further assistance is necessary.
- Call an EBME Technician using the contact list and request them to attend site and assist where needed and be available for medical equipment breakdowns. They should collect the EBME department pager when they arrive on site, and confirm its number to the duty PTB Officer and Control Room via the switchboard.
- Ascertain the areas which are to be used for the emergency and ensure that the heating if required is not shut down, (i.e. Outpatients etc).
- Make contact with the next PTB Officer on the on-call rota and inform him of the emergency.
  Request him to standby and carry out the following action:

  1. Contact all the PTB Officers, Craftsmen and EBME Technicians who normally participate in the on-call rota, and request them to standby for engineering duties or stretcher bearing, if needed.
  2. The PTB Officer should request his respective on-call Craftsmen and EBME Technicians to remain available to cover community call-outs or back-up for N.D.D.H.
  3. Ring all other staff listed in the Emergency Manual, making a list of all those available to assist if needed.
  4. Staff called in from home should report to the Staff Reporting Area in the Exmoor Unit on Level 2 not direct to the ward as they may be deployed elsewhere. They must bring hospital identification to secure access to the hospital.
  5. Report the names of the staff available to the duty PTB Officer.
  6. Act as back up PTB Officers if the duty PTB Officer needs to visit the N.D.D.H. site to assist/supervise tradesmen. His duty will be to cover for the community properties for call-outs using back up Craftsmen and EBME Technicians.

Duty PTB Officer should notify Control Team that the Estate Department staff have been alerted, and request that all calls for assistance be channelled through him. Duty PTB Officer should confirm incident to Director of facilities.
Duties of On-call Craftsmen and EBME Technicians: Report to Control Centre upon arrival via the switchboard and await instructions. Confirm pager number to duty PTB Officer and Control Centre

Request for Stretcher Bearers:

If a request to provide stretcher bearers is received, then the duty PTB Officer should consult the names and addresses listed in the Engineering Emergency Manual for staff and begin by contacting people available for the list supplied by the back-up PTB Officer. He should not in the first instance call those staff who participate in the on-call rota, as they may be required later for engineering duties.

Duties for Stretcher Bearers:

To assist the Portering staff to take over from the Ambulance staff at hospital triage entrance and transfer patients to hospital stretcher trolleys.

Routine duties:

The Estates manager will:

- Maintain a current list of all staff contact telephone numbers
- Test staff callout cascade when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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In the event of a Major Incident, the portering services will be very busy. Consider deploying domestic staff to portering duties.

Chargehand or Cardiac Bleep Carrier:

- Two Porters to the Emergency Department (ED) and fracture clinic to assist with preparations.
- Two porters to take a folding table from Barry Muir Anaesthetic Department on Level 1 (Code on Door: 1406) to form the EXIT DESK in the corridor outside the back of A&E immediately beyond the Fracture Clinic Doors.
- Activate the call-out cascade; do not call the next rotary shift if possible. Instruct those called in to report to Portering Team Leader in the Lodge, who will liaise with the major incident control team in the radiology seminar room level 2.
- When "Major Incident Declared", all routine duties to cease until portering staff released from emergency duties. The Portering Team Leader will prioritise all calls.
- Portering staff will standby to be available for essential duties, and report back to the Lodge to be redeployed throughout the Incident.
- Cardiac Bleep Carrier will man the Lodge for issue of keys and reception of telephone call until directed otherwise by the Portering Team Leader.
- Put up Major Incident Signs in main entrance.

Traffic control

Until representatives of Devon and Cornwall traffic police arrive the portering staff will have responsibility for traffic control.

- Put on high visibility tabards kept in the Porters Lodge.
- Ensure all staff and public car park barriers are raised.
- Ambulances will proceed as usual to the Emergency department.
- Direct all non-staff traffic straight into the public car park.
- Only identified staff members may proceed to staff car park areas – advise all staff to enter the building through the main entrance only then report to the staff reporting area in the Exmoor suite on level 2 before being deployed to their departments.
- Access may also be allowed direct to the Ladywell unit and the psychiatry departments if appropriate.
- Carry out other duties as determined by the Control Room e.g. hospital lockdown procedure.

Access control

In a major incident all access to the main site should be through the ED for casualties only and the Main Entrance for all other staff. Activate the hospital lock down procedure but leaving the main entrance and main entrance to the ED open.

LOCK DOWN (see appendix 4)

In the event of a CBRN(E) incident (see Appendix 2) there will need to be a lock down of the ED and all other entrances. In this event, instructed by the control room, porters will need to activate the full lock down procedure immediately.

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SODEXO / CATERING DEPARTMENT MAJOR INCIDENT ACTION CARD 43

- All catering personnel will be required for duty where possible. All staff are to be aware that they may be required to work in any section within the department as required.

- The Internet café will be the designated point for any relatives arriving in a Major Incident and the Police Documentation Team will be also established in the Internet Café.

Call-out cascade

A cascade telephone call out system will operate as follows:

- An up-to-date list of staff telephone numbers will be supplied to Switchboard, and be available in the Department.
- Out of working hours, Switchboard will contact the first person available on the call-out list.
- The first person available will come into the department then activate the staff call out cascade.
- Staff called in from home should report to the Major Incident Staff Reporting Area in the Exmoor Unit on Level 2 as they may be deployed elsewhere. They must bring hospital identification to secure access to the hospital.

Actions

- Put up Major Incident signs for Relatives Area and Police Documentation Team in Internet Café.

- The Catering Department will be required to provide full meal service to patients/staff and visitors without the assistance of any other department (i.e. General Porters will not be available).

- Casualties who are discharged from the Emergency Department will be asked to report to the Police Documentation Team before leaving the hospital. They are likely to need food and drink but may not have any money available. Simple snacks and beverages should be given free of charge to casualties.

- It may also be a requirement to provide snacks, beverages, hot drinks, etc. at short notice to all areas of the hospital. It may be necessary to sustain these services for long periods of time. Liaise with senior nurse for all clinical areas, especially A&E, Theatres and Lundy ward, to establish what food and drinks they may need.

- In the event of there being any surplus staff, they may be required to carry out stretcher bearer duties.

Routine duties

Sodexho manager will:

- Maintain a current list of all Sodexho portering, catering and domestic staff contact telephone numbers
- Test staff callout cascade for all staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

NDHCT N
In the event of a Major Incident, the portering services will be very stretched. Consider deploying domestic staff to portering duties.

Call out procedures

The Deputy Contract Manager is the first point of contact (extension 2630) while on duty during normal office hours, or telephoned at home when there are no Domestic Supervisors on duty. The telephone number is left with Switchboard.

Domestic Supervisors are on duty at the following times, seven days per week (extension 2352)

Weekdays: 6.00am-9.00pm
Weekends: 7.30am-2.30pm
4.30pm-8.00pm

- The Supervisor on duty should be contacted and if the Deputy Contract Manager is not available for assistance, the cascade system should be used.
- The telephone numbers of the Deputy Contract Manager and the Supervisors and the staff telephone numbers for the call-out cascade are in the Major Incident Plan folder, which is situated on the Notice Board in the Domestic Supervisor's office.
- Staff called in from home should report to the major incident Staff Reporting Area in the Exmoor Unit on Level 2. They must bring hospital identification to secure access to the hospital.

Immediate Actions

The Domestic Service Department will provide linen trolleys. Two trolleys will be taken to the back corridor behind the Emergency Department (ED) with -

- Trolley canvases
- Sheets
- Blankets
- Gowns

One trolley will be taken to Lundy Ward on Level 3, with –

- Trolley canvases
- Sheets
- Gowns

If there are no staff available from the Domestic Services Department, for emergency use linen can be obtained from the Linen Room on level 0, the key available from the Porters.

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Northern Devon Healthcare NHS Trust Major Incident Plan

PHARMACY

MAJOR INCIDENT ACTION CARD 45

Call-out Procedure:

In hours the pharmacy department will be directly informed by switchboard. The nurse in charge will inform staff present on wards.

Out of hours the Hospital Switchboard will contact the Director of Pharmacy or, if unavailable, the on-call Pharmacist who should immediately return to NDDH.

The first Pharmacist on site out of hours or the Senior Pharmacist will report to the Major Incident Control Team in the radiology seminar room level 2 and receive a ‘CHALETS’ report giving the estimated number of casualties and the type of incident.

The first priority will be to consider the need for immediate ordering or procurement extra supplies.

Out of hours the first pharmacist on site should activate the call-out cascade. A minimum of seven staff will be needed. Staff called in from home should report to the Major Incident Staff Reporting Area in the Exmoor Unit on Level 2. They must bring hospital identification to secure access to the hospital.

Staff Duties and Roles:

- To supply drugs and medical gases to the treatment areas as requested.

- The stock of vital medicines/medical gases should be assessed, e.g. Gelofusin, Cardiac Arrest drugs, ‘Flamazine’, Mannitol, Sodium Chloride Infusion, Morphine, etc.

- Further stocks should be obtained via the emergency number of Vestric or by contacting the on-call Pharmacist at the Royal Devon & Exeter Hospital.

- Ward staff to expedite discharge TTAs in any way possible for any existing patients fit for discharge as soon as Major Incident Standby message received.

- Take pre-determined amount of medications including controlled drugs to the following areas:
  - Emergency Department
  - Fracture Clinic
  - Lundy Ward
  - Theatres

- Verbal orders for the prescription of controlled drugs will be allowed for the duration of the major incident only.

If sufficient staff are available, the following individual roles should be carried out -

- Senior member of staff to co-ordinate response, deploy staff and ensure stocks are sufficient.
- Senior member of staff to liaise with the senior nurse in the ED and other treatment areas about the need for supplies
- One person to receive all incoming calls.
- One person to check stocks, and if necessary contact a wholesaler or outside hospital.
- Two people to assemble and issue goods.
- Two people to act as runners/porters.

Goods should be delivered to the designated receiving point, i.e., for the ED, the entrance off the X-Ray corridor.
The major incident Control room must be informed immediately if:

- Stocks are insufficient to meet demands
- Assistance is required to deliver goods to treatment areas.
- The Police are required to transport or assist in the transportation of medicines.

All issues should be recorded. Verbal orders will be accepted for controlled drugs during the incident. Signed requisitions should be obtained in due course.

In the event of a major incident occurring during working hours, the Senior Pharmacist on duty should re-schedule non-urgent work and deploy staff to carry out the duties listed above.

**Routine duties:**

The Director of Pharmacy will:

- Maintain a current list of all staff contact telephone numbers
- Test staff callout cascade for pharmacy staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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- **S** – **Start a log**
HAEMATOLOGY & BLOOD
TRANSFUSION

MAJOR INCIDENT ACTION CARD 46

Procedures during normal working hours (09:00 – 17:30 Mon - Fri)

Warning about a potential major incident will come by telephone from the Switchboard or possibly from the Emergency Department (ED).

There is potential for such an incident to cause severe traffic problems that prevent blood from reaching us in time. In this case, the NBS driver will alert laboratory staff who will attempt to organise an airlift/delivery to the hospital via the MI control room.

The person taking the call must immediately alert senior staff present who will then:

- Check blood and blood product stocks
- Notify the National Blood Service, Plymouth that there is a major incident and warn them of any current stock shortages
- Alert all staff in the department. If possible alert Biochemistry department, Clinical Director and Consultant Haematologist
- Prioritise workload
- Liase directly with Senior ED Consultant about the number and severity of casualties
- Liase directly with control room on 2754 for any other logistical difficulties or concerns
- Prepare to issue emergency O Negative blood if requested
- Ensure that any group and save requests are processed a.s.a.p. (grouped and separated as minimum)
- All requests for blood products and haematological tests will come with a Major Incident patient number eg ‘MI 001’, and the patients sex as minimum identifiers. A name and date of birth will be added if available. This method of patient identification will only operate under circumstances where a major incident has been declared.

NB if ‘blue light’ blood/products are needed, the appropriate form must be completed and faxed to NBS. Give the duty Consultant Haematologists’ name as request authoriser, or that of the appropriate A/E consultant.

Procedures out-of-hours (17:30 – 09:00 Mon – Fri, all weekends)

The on call BMS must proceed immediately to the laboratory and:

- Check blood and blood product stocks
- Activate the call-out cascade. Contact a member of staff who can come to work rapidly and commence telephoning the other staff members, listed or alert the Biochemistry BMS on call who may be able to assist in contacting staff, or contact as many staff as possible from the call out list. Ensure consultant haematologist is contacted.
- Notify the National Blood Service, Bristol that there is a Major Incident and warn them of any current stock shortages
- All other actions as above

Chemical, Biological, Radiation, Nuclear or Explosion Incidents – see Appendix 2
Routine duties:
The haematology department will:-

- Maintain a current list of all haematology laboratory and medical staff contact telephone numbers
- Test staff callout cascade for haematology staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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BIOCHEMISTRY MAJOR INCIDENT ACTION CARD 47

Actions

- If a major incident is declared you will be informed by switchboard
- Immediately assist the haematology department activate their call out cascade
- Activate the biochemistry department call out cascade
- Continue to process samples as usual
- Give priority to any samples from casualties from the major incident

Patient identification

- Casualties will be identified by a unique major incident number NOT NDDH hospital number. Each sample will be labelled with a minimum of a major incident number and sex. If a name and date of birth are known these will also be entered on sample labels.

Routine duties:

The biochemistry department will:-

- Maintain a current list of all biochemistry laboratory and medical staff contact telephone numbers
- Test staff callout cascade for biochemistry staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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MORTUARY MAJOR INCIDENT ACTION CARD 48

Actions

- If a major incident is declared the senior mortuary technician or on call technician will be informed by switchboard.
- Fatalities at the scene will NOT be transported to the NDDH site but taken to a temporary mortuary according to the Devon Joint Response Temporary Mortuary plan.
- Casualties who die in hospital will be transferred to the hospital mortuary as usual.
- Casualties will be identified by a minimum of a unique major incident number and sex. Name and date of birth will be given if known.
- Transport links may fail in the event of a major incident and if the mortuary becomes full it may not be possible to transfer bodies as usual. In this event bodies will be stored with as much dignity as possible in other cold areas of the mortuary complex, including the chapel of rest and the floor in front of the main body storage area.
- Additional areas of the mortuary should be cooled with the air conditioning unit as necessary.

Routine duties:

The senior mortician will:

- Maintain a current list of all mortuary laboratory and medical staff contact telephone numbers.
- Test staff callout cascade for mortuary staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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RADIOLOGY

MAJOR INCIDENT ACTION CARD 49

Actions

- If a major incident is declared the radiology department and on-call radiologist will be informed by switchboard
- Out of hours the on-call radiographer should activate the call out cascade and the on-call radiologist should return to the site
- Depending on the time of day of the incident the Radiology Services Manager / Superintendent Radiographer and liaison Consultant Radiologist should consider cancelling all outpatient elective imaging – confirm with the hospital control room on 2754
- Casualties will be identified by a minimum of a unique major incident number and sex. Name and date of birth will be given if known
- This information will be manually inputted into the respective modalities. Clinicians to search in "name" field on PACS using unique Major Incident Number
- All films will be printed in a major incident as well as sending to PACS.
- P1 patients should be limited to portable trauma series within ED using both portable x-ray machine.
- The on-call Consultant Radiologists will be available to FAST scan all P1 and P2 patients in the ED as part of their primary survey
- P2 patients to be imaged in room 7 adjacent to A/E
- P3 patients to be imaged in main department where 2 major general rooms are available and fracture clinic X-ray suite
- Senior ED consultant to liaise with Consultant Radiologist as to priority and triaging of CT requests (mainly CT head for isolated head injuries).

Routine duties:

The radiology department will:-

- Maintain a current list of all radiographers, radiologists and departmental manager contact telephone numbers
- Test staff callout cascade for radiology staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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HEALTHCARE RECORDS MAJOR INCIDENT ACTION CARD 50

Major Incident Out of Office Hours - Call-Out Cascade -

- The Health Records Manager keeps a list of all staff members and a copy lodged with Switchboard.
- Switchboard will ring the Health Records Manager or the next available staff member.
- They will in turn contact the next staff member on the list, forming a 'cascade' of 9.
- Staff must keep the list available at home and it should be reviewed every 3 months.
- Each member of staff contacted and able to come in should report to the Staff Reporting Area in the Exmoor Suite, level 2. They must bring hospital identification to secure access to the hospital.
- The senior or first member of staff to arrive in the Staff Reporting Area should deploy staff as they arrive below.

Major Incident during Office Hours:

Following liaison with the Emergency Department (ED), the Health Records Manager or deputy will allocate staff as follows: -

- 5 clerks to proceed to the ED
- 2 clerks to proceed Fracture Clinic
- 1 clerk to proceed to Lundy Ward
- 1 clerk to proceed to Control Room in the radiology seminar room level 2 to act as messengers from Control Room as required.

Health Records Staff / ED: - NB see also ED Receptionist Action Card

5 clerks to be allocated to the department to undertake the following tasks:-

- 1 clerk to assist the ED Receptionist
- 1 clerk to assist the Nurse Controller
- 1 clerk of assist the Triage Officer
- 2 exit clerks to man the exit desk at rear of the ED to list patients’ Major Incident numbers and destination on leaving the ED – this desk must not be left unmanned at any time

Health Records Staff / Fracture Clinic

2 clerks to be allocated to the department to undertake the following tasks-

- 1 clerk to retrieve patient information, clothing, money, etc, using documentation contained in clear envelopes.
- 1 clerk to act as messenger between Fracture clinic, the ED exit desk and Control Room.

Health Records Staff / Lundy Ward:

Lundy Ward

- 1 clerk to retrieve patient information on the ward.
- 1 clerk to act as messenger between Lundy Ward and Control Room.

Health Records Manager:

After ensuring that the Major Incident Cascade has operated and distributing staff as described above, the Health Records Manager will then stop all but emergency admissions to the hospital and cancel routine operating lists and out-patient appointments for the duration of the Major Incident if advised to do so by the Control Team.
Routine duties:

The Health Records Manager will:

- Maintain a current list of all healthcare records staff contact telephone numbers
- Test staff callout cascade for healthcare records staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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STERILE SERVICES DEPARTMENT MAJOR INCIDENT ACTION CARD 51

On receipt of telephone call confirming a MAJOR INCIDENT has occurred:-

In hours: switchboard will contact SSD directly. SSD must then also inform supplies.

Out of hours

- The switchboard will contact the on call person for SSD. This person will then ring the SSD Manager and three other members of staff from the list of telephone numbers requesting them to report for duty as soon as possible. Telephone two more members from the list and ask them to stand-by in case needed. The call out cascade for supplies and procurement should also be activated by the sterile services on call person.
- Staff called in from home should report first to the Staff Reporting Area in the Exmoor Unit on Level 2 not directly to SSD. They must show hospital identification to gain access to the hospital.

DUTIES TO BE CARRIED OUT IN THE FOLLOWING ORDER:-

- Ensure that all Washer/Disinfector/Autoclaves are ready for use.
- Carry out necessary tests on autoclaves as soon as possible.
- Check on all sterile stock available
- Have one member of staff available to:
  - Replenish supplies of soft packs to treatment areas and the Emergency Department.
  - Issue supplies on demand from the Nurse in charge to any Ward/Department
  - Check regularly the requirement of treatment areas and of Lundy Ward.
  - Check Emergency Cupboard and replenish stocks as necessary.
  - Make up orders of sterile packs requested by any peripheral hospital, which may be involved and ensure that hospital transport delivers.

S.S.D STAFF TO:-

- Replenish and maintain all supplies of supplementary stocks in the Theatre Sterile Store.
- Reprocess and replenish on demand all stocks of instrumentation sets, etc. required in the treatment areas and in the theatres as and when used.
- Assess the situation regularly and call in staff on stand-by as necessary. If these staff are not required please let them know as soon as possible.
- Staff to continue working until casualties have been dealt with and stocks in each Ward/Department involved is replenished to normal stock levels.
- Inform major incident Control Team in the radiology seminar room level 2 on 2754 if there are any critical shortages or difficulties with procurement. Use runners to the control room if there are any communication difficulties

Routine duties:

The SSD manager will:

- Maintain a current list of all staff contact telephone numbers
- Test staff callout cascade for supplies and procurement when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

| C – Casualties | number of or expected including types of injuries if known |
| H – Hazards | current or potential |
| A – Access Routes | and congestion problems |
| L – Location | |
| E – Emergency Services | present and required |
| T - Type of incident | number of vehicles / buildings involved etc |
| S – Start a log | |
SUPPLIES AND PROCUREMENT

MAJOR INCIDENT ACTION CARD 52

On receipt of telephone call confirming a **MAJOR INCIDENT** has occurred:-

- Switchboard will contact the on call person for sterile services (SSD). This person will come into the hospital if off duty and activate the call in cascade for SSD and supplies and procurement.
- Staff called in from home should report first to the Staff Reporting Area in the Exmoor Unit on Level 2 not directly to SSD. They must bring hospital identification to secure access to the hospital.

**Contingency Response**

- Advise Control Team of operational status of the department and any likely problems.

**DUTIES:**

The main role of supplies and procurement is to ensure all the key clinical areas have adequate stocks of all consumables etc throughout the major incident.

The order of priority is:

- Contact the following areas in order and establish and provide what supplies they need for immediate use or expect to use imminently:
  - Emergency Department
  - Fracture Clinic (which is where all the P3 minor injury patients will be treated and will not have a large stock of supplies. The ED will take an immediate basic amount of equipment to fracture clinic in the first instance)
  - ITU
  - Theatres
  - Lundy ward
- Check availability of all stock and non-stock items
- Contact NHS Logistics immediately to replenish any low stock items
- Continue to liaise with key clinical areas for their requirements
- Liaise with all other clinical areas for their requirements
- Non-stock items. If there is any shortage of non-stock items, in hours contact specialist suppliers immediately. Out of hours if there is any difficulty procuring non-stock items inform the control room in the radiology control room on level 2. Use a runner with a written message to contact the control room.

**Routine duties:**

The procurement manager will:

- Maintain a current list of all procurement and supplies staff contact telephone numbers and ensure this is kept with the call out cascade for sterile supplies (SSD)
- SSD will test staff callout cascade for SSD and supplies and procurement when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

### Abbreviations

- **C** – **Casualties** - number of or expected including types of injuries if known
- **H** – **Hazards** – current or potential
- **A** – **Access Routes** – and congestion problems
- **L** – **Location**
- **E** – **Emergency Services** – present and required
- **T**- **Type of incident** - number of vehicles / buildings involved etc
- **S** – **Start a log**
OUTPATIENTS

MAJOR INCIDENT ACTION CARD 53

- If a major incident is declared the outpatients department will be informed by switchboard
- Inform all clinical staff in the area that a major incident is declared
- The Exmoor unit will be the main staff reporting area
- Contact the Control team on 2754 or send a runner to the radiology seminar room, or designated area, to confirm that all outpatient activity is cancelled
- If advised to do so cancel all outpatient activity immediately
- Explain that a major incident has been declared and ask all patients who can do so to make their own way home. Arrange transport for those patients who need transport home.
- All available staff should then report to the Staff co-ordinator for redeployment as required.
- Out of hours switchboard will contact the outpatients’ supervisor, who should return to the Exmoor unit staff reporting area and activate the outpatient call out cascade. All available staff should then report to the Staff co-ordinator for redeployment as required.

Routine duties:

The outpatients’ supervisor will:

- Maintain a current list of all staff contact telephone numbers
- Regularly test staff callout cascade staff to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

- C – Casualties - number of or expected including types of injuries if known
- H – Hazards – current or potential
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- L – Location
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- S – Start a log
Northern Devon Healthcare NHS Trust Major Incident Plan

PHYSIOTHERAPY MAJOR INCIDENT ACTION CARD 54

Major Incident during working hours: 8.30am to 4.30pm Monday - Friday

Physiotherapy Out-patient Staff

The most senior Physiotherapist in the Physiotherapy Outpatient Department at the time will become co-ordinator and be responsible for the deployment of staff, as follows:

- To ‘bleep’ the ward Superintendent Physiotherapist to ensure they are aware of the major incident.
- To release any available OPD staff to report to the staff reporting area in the Exmoor Suite on level 2.
- Activate the call-out cascade
- To nominate 1 staff member to contact the major incident control room in the radiology seminar room on 2754 on level 2 to confirm whether all routine outpatients activity should be cancelled. If so to, cancel all further OP treatments that day and turn back any patients who arrive for treatment.

Any physiotherapist competent to manage minor soft tissues injuries should be considered for deployment via the co-ordinator in the Exmoor suite to treat P3 casualties in the Fracture Clinic.

If telephone communication is not possible, use a runner with written messages to take messages between areas.

In the event of OP staff not being needed, they will report back to the co-ordinator, who will arrange for them to help with in-patient physiotherapy treatments.

Physiotherapy Ward Staff:

The senior nurse in charge on the ward will inform ward staff of the Major Incident.

- The Superintendent Physiotherapist should contact Physiotherapy outpatients to ensure they are aware of the incident.
- Superintendents/ Senior l’s of the wards to release junior staff to go to the staff reporting area in the Exmoor Suite on level 2.
- Senior Staff will prioritise workload to cover for emergency chest treatments and ICU
- In the event that a major incident Procedure is underway when staff arrive for work, the same routine will be carried out (other than the ‘emergency duty’ Senior Physiotherapist). Do not go on the wards but report to the co-ordinator.

Any physiotherapist competent to manage minor soft tissues injuries should be considered for deployment via the co-ordinator in the Exmoor suite to treat P3 casualties in the Fracture Clinic.

Major Incident out of working hours

Switchboard will contact the on-call respiratory physiotherapist, who should come into the department and activate the call-out cascade. They should first report to the staff reporting area in the Exmoor Unit on level 2. Staff will need hospital identification to secure access to the site.

The following day:

Superintendent or deputy will attend briefing meeting and deploy in and out-patient staff appropriately according to need. Once the casualty reception phase of the major incident is complete staff should resume their normal duties as soon as possible.
Routine duties:

The Superintendent physiotherapist will:

- Maintain a current list of all staff contact telephone numbers
- Regularly test staff callout cascade for physiotherapy staff to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

- C – Casualties - number of or expected including types of injuries if known
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OCCUPATIONAL THERAPY          MAJOR INCIDENT ACTION CARD 55

Call-out cascade

- In hours ward the nurse in charge of the area will inform staff of a major incident.
- Out of hours occupational therapy staff will be contacted through the physiotherapy call-out cascade
- Staff should report to the Major Incident Staff reporting area in the Exmoor Suite, level 2.
- Staff must bring hospital identification to secure access to the hospital.
- They may then be deployed to the relatives’ area or other clinical areas as well as to their ‘normal’ duties.

Occupational Therapy Out-patient Staff

The most senior Occupational Therapist in the Outpatient Department at the time will become co-ordinator and be responsible for the deployment of staff, as follows:

- To ‘bleep’ the ward Senior Occupational Therapist.
- To release any available OPD staff to report to the Staff Reporting Area – Exmoor Suite level 2.
- To nominate 1 staff member to cancel all further outpatients treatments that day (including pre-operation clinics and the prosthetic clinic) and turn back any patients who arrive for treatment if directed to do so by the control room team.

In the event of outpatient staff not being needed, they will report back to the Senior Ward Occupational Therapist to assist with discharge planning of other inpatients to free bed space.

Occupational Therapy Ward Staff:

Head / Senior of the wards to release junior staff to go to the Staff Reporting Area – Exmoor Suite level 2

Senior Staff will prioritise workload that will assist with the discharge of other inpatients to free bed space.

In the event that Switchboard is blocked with calls and the ward staff hear that a Major Incident has occurred, the above procedure will be implemented without waiting for the ‘bleep’.

In the event that a Major Incident Procedure is underway when staff arrive for work, the same routine will be carried out.

Routine duties:

The senior occupational therapist will liaise with the physiotherapy department to:

- Maintain a current list of all staff contact telephone numbers
- Test staff callout cascade for occupational therapy staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.

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<thead>
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## MAJOR INCIDENT STAFFING AVAILABILITY (PER SHIFT)

**DATE:** ________________________  
**DEPARTMENT OR AREA:** __________________________________________

<table>
<thead>
<tr>
<th>Staff member (name)</th>
<th>Staff Group (e.g. RN, HCA, admin)</th>
<th>Available Y/N</th>
<th>To Where? e.g. community hosp/NDDH</th>
<th>How long to get there?</th>
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**KEY:**  
- N/A – Not available  
- N/R – No Reply  
- M/L – Message Left