Singleton Services Delivery Unit		Date: Agenda Item
Subject	**Health & Safety Agenda**	
Prepared by	**Melanie Collins & Matthew Fisher**	
Approved by	**Jan Worthing**	
Presented by		
Purpose		
The purpose of this paper is to outline the current work being undertaken in improving Health & Safety Standards at SSDU.		

Main Report	ABM University Health Board

Current Function

Singleton Health & Safety meetings were set up in December 2017. We currently meet quarterly. The group consists of representatives from

- Operational Management
- Site Management
- Radiology
- Nursing
- Finance
- Estates
- Pathology
- Union Representative

Developments to date

Singleton Hospital has worked closely with Health & Safety colleagues and have developed the Health & Safety management framework.

Singletons Health & Safety Monitoring

Includes:

Reviewing KPI's
Investigating Incidents
Updates of the Risk Register
Regular updates of current or ongoing Health & Safety issues within the hospital.

Singletons current RIDDOR statistics is 6 incidents with 5 of these being falls related

Groups discuss lessons learnt from incidents, active monitoring, working together to meet required actions and constant monitoring of key identified risks for singleton.

Priority for Singleton

Risk of building cladding with potential to cause fire.

Key actions taken by Singleton

- New fire evacuation plans written and signed off.
- Ward based fire evacuation plan in place.
- In house hospital training regarding the utilisation of ski sheets in the event of fire.
- Developed protocol for decontamination of sheet approved by infection control.
- Whole hospital evacuation policy written, currently in draft awaiting sign off.
- Table top exercise to be undertaken mid-September to test evacuation procedures.

Recommendations

The paper has highlighted the current work being undertaken to comply with Health & Safety Standards.

Further requirements

Continued support from Health & Safety department
Timescales plans for replacement of cladding

Singleton Service Delivery Unit
(SSDU)

HEALTH & SAFETY MANAGEMENT FRAMEWORK

Approved By:

Date Approved:

Version: **1**

Date of Review:

Distribution: **Via Singleton Service Delivery Unit Board**

Document Version Control

Policy Version Number	Date	Author	Description of Change

Singleton Service Delivery Unit
Health & Safety Management Framework

1. Introduction

This document sets out the framework for Health & Safety management for the Singleton Service Delivery Unit (SSDU) and is a requirement of the Health & Safety at Work Act 1974. It will be supported by a range of other policies, procedures and arrangements necessary for the effective management of health, safety and welfare.

2. Strategic Aim

The strategic aim of this framework document is to outline the management arrangements and responsibilities for implementing health & safety policy and procedures at Singleton hospital, in order to achieve high standards of health, safety and welfare at work.

3. Statement

The Health Board requires all delivery Unit's to have health & safety procedures in place to provide safe services and minimising the risk to patients, the public and staff.

4. Responsibilities and Accountabilities

4.1 Responsibilities for Planning and Implementation

The SSDU through the Unit Service Director will ensure that there are effective Health & Safety procedures in place. This will be achieved through identification of a Unit Lead for coordination of health & safety through the Service Group structure.

The health & safety Lead will work with the Unit Service Group Management structure down to ward, departmental and practice level so that each operational area, proactively manage health, safety and welfare risks.

4.2 Accountabilities

The Unit Service Director has overall accountability for compliance within the SSDU for health & safety and is accountable to the Director of Strategy as the ("Executive Lead") for planning and implementation.

The Health Board Finance Director has overall accountability for ensuring there are sufficient financial resources available for the implementation of health & safety.

The Unit BCP Lead will ensure that there is a suitable framework, system and process in place to enable successful BCM.

The Singleton Service Delivery Unit BCP Lead in conjunction with the Unit Service Director is responsible for the operational delivery of the framework and for the

organisation and delivery of exercises to ensure compliance with the appropriate legislation and standards.

4.3 Roles & Responsibilities for Health & Safety Planning and Implementation in the Singleton Service Delivery Unit

Singleton Service Delivery Unit Director

The Unit Service Director is required to have arrangements in place so that actions are taken within their scope of responsibility for implementation of health & safety policy and procedures ensuring:

- compliance with the Health Board standards for Health & Safety
- Has robust health & safety arrangements in place which reflect standards set out in the Health & safety improvement plan and ABM health board policy
- Complies with any requirements in respect of the monitoring of compliance
- Is appropriately represented at Health Board Health & Safety committee and other committees, as required.
- Provides regular progress reports to the Singleton Service Delivery Board, Quality & Safety Committee, Health Board Health & Safety committee and other committees as necessary
- Maintains effective working with the Health Board health & safety lead
- Ensures that staff are trained on the various health & safety procedures

Site Manager – Unit Health & Safety Lead

The Site Manager will act as the Unit Health & Safety Lead and will ensure that there is a suitable framework, system and process in place to ensure health, safety and welfare of patients, the public and staff at Singleton hospital

Unit Service Group Managers

The Unit Service Group Managers are responsible for implementing and monitoring health & safety within their areas of responsibility. They will be active members of the Unit Health & Safety group through implementation of the unit Health & Safety Improvement plan.

Quality & Safety Committee Lead

To oversee the work of the Unit Health & Safety Group, receiving reports from the Health & safety Group

Staff Side Representatives

To represent staff interests in relation to health, safety and welfare of staff.

Corporate Health & Safety

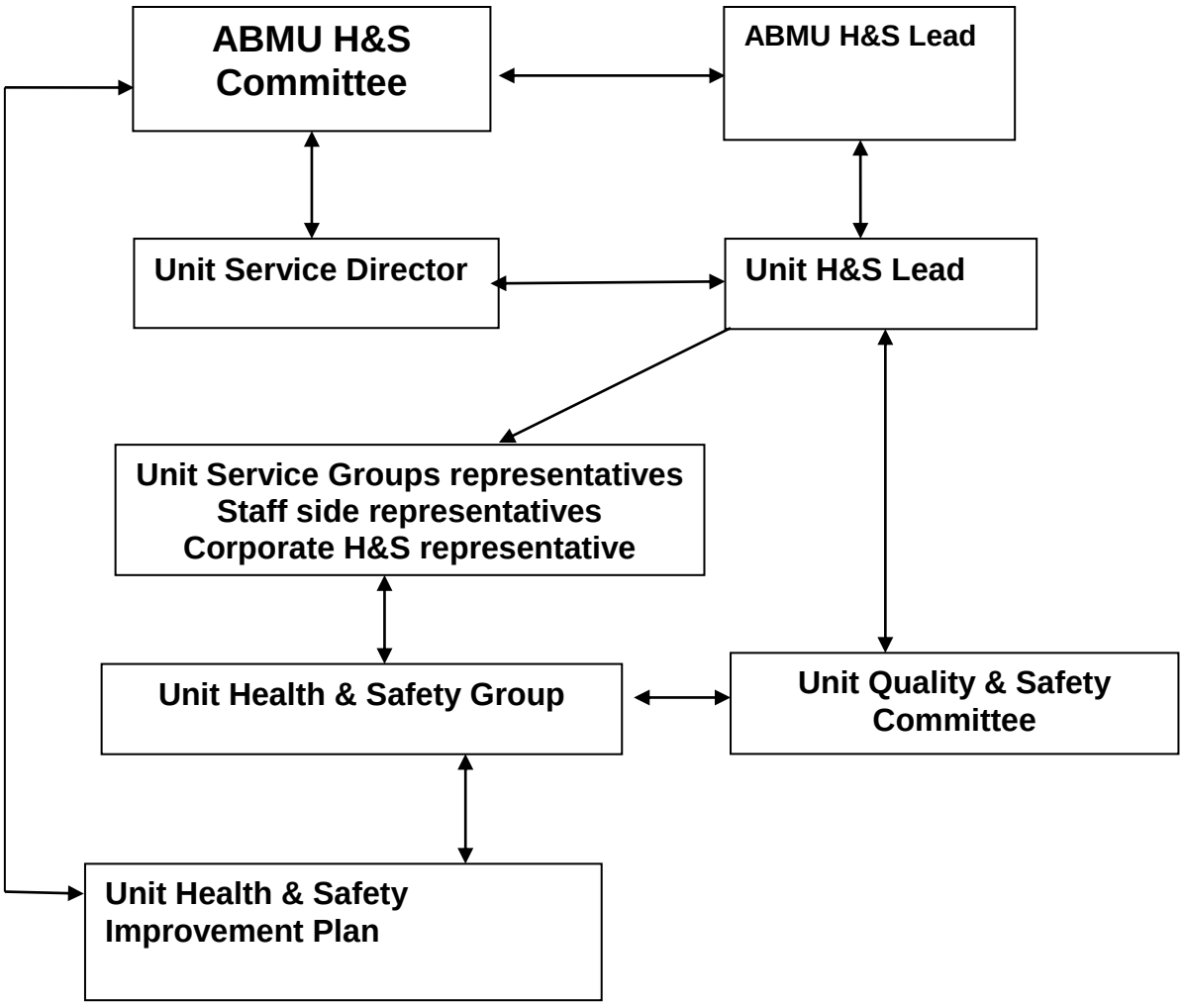
Provide expert support and advice to the Unit Health & safety Group members

All Staff

All staff must as a minimum, have a basic awareness of health & safety, other responsibilities include;

- Attend training appropriate to their potential roles
- To report all untoward incidents and potential hazards to their line manager of investigation and action.
- Work in a way that complies with health & safety procedures

5.0. Singleton Service Delivery Unit Health & Safety Management Framework



Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Site Emergency Fire Plan

Singleton Hospital

Approved by:
Singleton Management Unit Health and Safety Committee

Date of Issue:
April 2018

CONTENTS

Contents of this document approved:

Hospital Site Manager: _____ (sign)

_____ (date)

1: INTRODUCTION

A fire in a hospital can be potentially devastating if not controlled at an early stage of its development. The emergency fire plan that has been developed for the hospital details the response to any incidence of fire that may occur.

The elements of the fire plan should reflect an inherent culture of fire awareness, the commitment to encourage highly motivated and well trained staff, a system to ensure early detection, and measures to protect those at risk.

2: KEY PERSONNEL ROLES AND RESPONSIBILITES

To ensure there is effective control during an emergency, the roles key staff are identified in this Fiore Emergency Plan. The roles of key personnel are summarised below.

Details of specific actions required are clarified in the appendices.

2.1 Ward/Department Managers/Nurse or Person in Charge

The person in charge of the area affected must manage the early stages of a fire emergency until relieved by the fire response team or the Fire Brigade. Containing the fire and safeguarding individuals are the foremost considerations. It is also important to maintain authority and control within the area (See Appendix 2/3).

2.2 Bed Manager/Night Nurse Practitioner (Fire Response Team)

This person has operational responsibility for the running of the hospital and acts on the authority of the Unit Service Director (responsible person). This person will assess the extent of the incident, ensure the response is adequate and appropriate and liaises with the Fire Brigade on their arrival (see Appendix 4).

Normal working hours: site manager kept informed.
Out of hours: 1st on call manager kept informed.

2.3 Estates Shift Craftsmen (Fire Response Team)

Shift Craftsmen possess technical knowledge and will assist the Bed Manager/Night Nurse Practitioner in assessing and managing the incident.

This person will collect the identity tabard and keys from switchboard and after consultation with the Bed Manager/Night Nurse Practitioner silence the alarm. They may reset the fire alarm after Fire Brigade have given the all clear.

The Craftsman may also act as the initial response to non-patient areas and keep the Bed Manager/Night Nurse Practitioner informed if their presence is required at the incident (See Appendix 5).

2.4 Estates Personnel (Not initial Response)

It should be noted that during office hours a number of Estates Personnel will be available who will respond to the fire alarm. They will also possess expertise and knowledge that will complement that of the key Personnel. Out of hours on call Estates Manager will be contacted if the system remains at fault.

These staff will act on the Authority of the Fire Response Team

2.5 Portering Staff (Fire Response Team)

During a fire emergency (e.g. fire alarm activated) a Porter will proceed to the Crush Hall entrance of the hospital, meet the Fire Brigade and escort them to the scene of the incident (if the incident is at the opposite end of site that may mean mounting the fire appliance to give directions). They then provide assistance and will be directed by the Bed Manager/Night Nurse Practitioner (see Appendix 6).

2.6 Fire Wardens

Fire wardens are responsible to their managers to assist them to discharge their fire safety responsibilities. These include regular monitoring of areas and reporting key findings. Where authorised they will assist in the training and competencies of their colleagues.

During a fire emergency they will work under the direction of their Ward/Department Managers/Nurse in Charge or Fire Response Team.

2.7 Switchboard (Fire Response Team)

When the fire alarm activates they will be responsible for dialling 999 to alert the Fire Brigade. They also alert the Fire Response team of the location and details of the fire emergency. Where they receive further information such as a confirmed fire they will make a second 999 call to the Fire Brigade and update them.

The fire alarm system when activated will automatically signal to a remote monitoring station. They will also contact the Fire Brigade informing them of a fire alarm activation in the hospital.

3: HOSPITAL FIRE ALARM SYSTEM

3.1 General Description of System

- The hospital fire alarm can be activated manually by break glass call points, or automatically by smoke or heat detectors.
- To enable the alarm to be raised easily and quickly fire alarm call points are strategically placed throughout the hospital
- The majority of the site is covered by an addressable fire alarm system that permits the precise location of the detector or break glass call point
- The alarm when activated it can generate a bell, electronic sounder, flashing lights, voice message, or a combination of these methods.

3.2 Fire Alarm Zoning

When there is a fire alarm alert the following alarms will sound:

a) Continuous alarm – Affected Area (location of break glass or detector)

b) Intermittent sounder activating continuously – above/below and either side of the affected area.

4: FIRE ACTION NOTICES AND EVACUATION PLANS

Fire action notices provide general guidance on the action to take in a fire emergency and are displayed around the hospital.

All Wards/Departments must have comprehensive plans specific to their own areas. These may be general site plans or specific arrangements that supplement the site plan and deal with their local risks, patient types etc.

5: ACTION ON DISCOVERY/SUSPICION OF FIRE

5.1 Roles and Responsibilities

The person in charge of the area must co-ordinate the fire emergency response until relieved by the Fire Response Team and/or Fire Brigade.

5.2 Action on Discovery of (or Suspicion of) a Fire

5.2.1 Upon discovery of (or suspicion of a fire e.g. smell of burning) staff must immediately use of the nearest fire (red) break glass point to activate the fire alarm system. This will cause:-

(a) The fire alarm to sound continuously in the affected area.

(b) Fire alarms to be activated in other areas of the hospital. These wards and departments will implement their specific fire emergency procedures.

(c) Switchboard informs Fire Response Team of a fire emergency

(d) Switchboard will ring the Fire Brigade giving details of the location of the fire emergency.

Note: If for any reason no fire alarm sounders are heard once you have broken the glass of the nearest break glass point, then use the internal telephone, dial 3333 giving the information verbally to the telephone operator who will then make sure that a, b, c and d above are instigated.

5.2.2 Make other staff in the area aware of the location of the fire e.g. shout **FIRE, FIRE, FIRE**

5.2.3 A call must be made to the switchboard using telephone number **3333** to **confirm an actual fire**. Failure to do so may result in a significant delay to the arrival of the Fire Brigade (without a confirmed fire they may send fire appliances to other emergencies)

5.2.4 Follow the site and ward/departmental fire emergency plan giving priority to the safety of those in immediate danger.

5.2.5 If safe to do so close doors and windows in the affected room (s) to contain the spread of smoke and heat.

5.2.6 If fire is located in a clinical area with medical gases the isolation of medical gases protocol must be followed.

5.2.7 Fight the fire if safe to do so. Do not put yourself or others at risk.

5.2.8 Persons evacuated will be accounted for.

6: RESPONSE TO FIRE ALARM ACTIVATION

6.1 Response Strategy

Occupied areas: The person in charge of the area must co-ordinate the fire emergency response until relieved by the Fire Response Team and/or Fire Brigade

Unoccupied areas: The Fire Response Team take charge of the incident but do not enter the area until the Fire Brigade arrive.

West Residences (not connected to hospital fire alarm) –
Switchboard only
Switchboard will dial **999** For Fire Brigade
and summon Fire Response Team

6.2 Action on Hearing Continuous Alarm

6.2.1 Inpatient Areas

(a) Safely locate the actual fire, detector or break glass activated.

(b) If a fire is confirmed take action in accordance with section 5 above

(c) Where there is no obvious sign of fire evacuation of the area will not be immediately necessary but staff must remain vigilant. Do not assume a false alarm.

(d) Close all fire doors and windows

6.1.2 Outpatient areas

(a) Safely locate the actual fire, detector or break glass activated.

(b) If a fire is confirmed take action in accordance with section 5 above

(c) Safely evacuate the area to the designated assembly point

(d) Close all fire doors and windows

6.13 Non-Patient Areas

(a) Safely locate the actual fire, detector or break glass activated.

(b) If a fire is confirmed take action in accordance with section 5 above

(c) Safely evacuate the area to the designated assembly point

(d) Close all fire doors and windows

6.2 Action on Hearing Intermittent Sound Fire Alarm

6.2.1 If the alarm continues after 30 seconds, it means the fire is in an adjoining zone. The person in charge should determine if assistance is required by releasing staff to proceed to the affected area.

6.2.2 Staff remaining on the ward must ensure that corridors are clear to receive evacuated patients should the need arise.

6.2.3 Close all fire doors and windows

6.2.4 In areas where the alarm ceases after 30 seconds, staff should resume normal duties, but be prepared to respond if called upon.

7: MOVEMENT OR EVACUATION OF PATIENTS AND VISITORS

7.1 In patient areas

7.1.1 Wards will have in place a specific local fire plan that details arrangements to evacuate their patients to a place of safety.

7.1.2 Staff from other parts of the hospital will assist in the evacuation and work under the direction of the Fire Response Team and/or Fire Brigade

7.1.3 Evacuation of patients should be prioritised, those in immediate danger moved away first and then others progressively.

7.1.4 As far as practicable progressive horizontal evacuation will be implemented into adjacent fire safety compartments. Vertical evacuation will be used where the location of the fire, its potential or actual spread makes this necessary.

7.1.5 Visitors will be requested to leave the building using the nearest fire exit

7.2 Outpatient areas

7.2.1 As a general principle patients and visitors will be evacuated to the designated assembly point

7.3.2 Staff will return to the building once it is safe and on the authority of the Fire Response Team

7.3 Non-Patient Areas

7.3.1 Non-patient areas will evacuate to their designated assembly point.

7.3.1 Staff will take responsibility for any visitors in the department

7.3.2 Staff will return to the building once it is safe and on the authority of the Fire Response Team

8: TACKLING A FIRE

8.1 Principles

(a) Always raise the alarm before tackling the fire.

(b) Confirm the fire to switchboard by ringing 3333

(c) Staff should tackle a fire only if it is safe to do so and without putting themselves or anyone else at risk.

(d) Fire extinguishers are first aid firefighting equipment. If it is not safe to fight the fire preventing closing doors and windows to limit the spread of smoke and heat is essential.

Tackling a fire should be attempted only if it is relatively small and the person is confident in handling the equipment. If there is any doubt about safety or how to use the equipment, it should be left to the Fire Brigade.

8.2 Fire Fighting Equipment

The type of equipment commonly found in the hospital are-

Type	Colour	Use
Water	Red 	Ordinary combustibles (solid materials)
Carbon dioxide	Red with black markings 	Electrical or small liquid fire
Foam	Red with yellow markings 	Can be used as per water but best on spilled liquids

Fire blankets are located in many of the kitchen areas.

9: ADDITIONAL INFORMATION

9.1 At no time during a fire alert must lifts be used that are within the affected area

9.2 All telephone calls in an emergency must be kept to a minimum. Wards and departments should at no time telephone the switchboard for information.

9.4 Limited movement of people around the hospital corridors should be encouraged during a fire alert. It may be necessary for staff to redirect members of the public to avoid them obstructing the Fire Response Team or for their own safety.

9.5 All incidents whether false alarms on fires must be reported to the Fire Safety Adviser who will ensure that an incident report is made.

APPENDIX 1

ASSEMBLY POINTS

DEPARTMENT	LOCATION
Central Ward block west Chapel Rehab & library X-Ray OPD	Number 1 Car park at VIP entrance
OPD Front	Number 2 Pavement right hand side of entrance
MIU SAU Med School	Number 3 Car park on bend of the road
Central Ward block east Pathology	Number 4 Pavement opposite mortuary
Radiotherapy Oncology Graduate entry	Number 5 Car park opposite Radiotherapy
Pharmacy PSSU Endoscopy Lymphedema HSDU Theatre Anaesthetic Dept Kitchen	Number 6 Car Park outside Anaesthetic department
West ward block	Number 7 Right hand side of entrance foyer
Breast care Cancer Institute Estates	Number 8 Car park at estates offices
Facilities Boiler house Chemo	Number 9 Pavement outside chemo
Day surgical unit	Number 10 Car park beside plant rooms
West residences	Number 11 Grass verge right hand side of laundry

*Note: These are initial assembly areas. When everybody is accounted for, they can be moved on to a more appropriate area if necessary, until it is safe to return to the department.

Ensure that your Department evacuation plan identifies the assembly areas above, depending in which building your department is located

APPENDIX 2

WARD MANAGER/NURSE IN CHARGE
ACTION CARD

NOTES	ACTION
General	• Take charge of the situation and direct staff until relieved by Fire Response Team and/or Fire Brigade • Where required implement ward fire emergency plan
Actual fire but no alarm sounding?	• Ensure that fire alarm system has been activated • Ensure that the switchboard has been informed by dialling **3333** and advise the location and nature of the fire
Continuous Alarm	• Fire emergency is in the ward • Check the fire panel on the ward for location of fire and make a (safe) physical check of area. • If a detector is activated its indicator will display a continuous light • If signs of or suspicion of fire inform switchboard by dialling **3333** and advise the location and nature of the fire. Implement ward fire emergency plan.
Management of actual fire emergency	• Implement ward fire emergency plan • Evacuate those in immediate danger • Close doors and windows to limit the spread of heat and smoke • Fight the fire if safe to do so • Consider whether Oxygen and medical piped gas supplies need to be isolated and remove Oxygen cylinders from area • If required undertake full evacuation of the ward • Restrict access to area
Continuous Intermittent Alarm	• Fire emergency in an adjacent area • Close doors and windows to limit the spread of heat and smoke • Check fire panel and release staff to assist affected area
Intermittent Alarm (less than 30 seconds)	• Fire emergency not in an adjacent area • Close doors and windows to limit the spread of heat and smoke
Reporting	• Update Fire Response Team and/or Fire Brigade of nature of the fire emergency, persons not accounted for etc.

APPENDIX 3

DEPARTMENT MANAGER
NURSE IN CHARGE OUTPATIENT AREAS
ACTION CARD

NOTES	ACTION
General	• Take charge of the situation and direct staff until relieved by Fire Response Team and/or Fire Brigade • Where required implement local fire emergency plan
Actual fire but no alarm sounding?	• Ensure that fire alarm system has been activated • Ensure that the switchboard has been informed by dialling **3333** and advise the location and nature of the fire
Continuous Alarm	• Fire emergency is in the area • Check the fire panel on the ward for location of fire and make a (safe) physical check of area. • If a detector is activated its indicator will display a continuous light • If signs of or suspicion of fire inform switchboard by dialling **3333** and advise the location and nature of the fire. Implement ward fire emergency plan.
Management of actual fire emergency	• Implement local fire emergency plan • Evacuate area to designated assembly point and conduct roll call • Close doors and windows to limit the spread of heat and smoke • Fight the fire if safe to do so • Consider whether Oxygen and medical gases need to be isolated. • Restrict access to area
Continuous Intermittent Alarm	• Fire emergency in an adjacent area • Close doors and windows to limit the spread of heat and smoke • Check fire panel and release staff to assist affected area
Intermittent Alarm (less than 30 seconds)	• Fire emergency not in an adjacent area • Close doors and windows to limit the spread of heat and smoke
Reporting	• Update Fire Response Team and/or Fire Brigade of nature of the fire emergency, persons not accounted for etc.

APPENDIX 4

BED MANAGER/NIGHT NURSE PRACTIONER ACTION PLAN

NOTES	ACTION
Fire emergency on site	• Report to the location informed of via bleep • Liaise with manager or person in charge of affected area • Check that the person in charge of the area is in control of the situation Take over responsibility for the co-ordination of the emergency response until the Fire Brigade arrives. • Check that the person in charge has contacted switchboard on **3333 to confirm location and nature of the fire.** • Restrict access to area
Fire Patient Areas	• Ensure ward or department plan has been implemented • If there is a risk of significant fire spread prepare for further evacuation as necessary • Check that doors and windows have been closed to limit the spread of heat and smoke • Ensure that access to the fire alert area is being restricted. • Organise further assistance if required • For outpatient areas, ensure evacuation of all personnel. • Inform site manager - in hours and 1st on call manager out of hours
Fire Other Areas	• Communicate with the Fire Response Team to ensure that the Fire Brigade have been received. • Communicate with the Fire Response Team to ensure that unoccupied buildings are not entered until the arrival of the Fire Brigade. • Consideration of traffic control would need to be based on this communication.

*Note: The Shift Craftsman will initially deputise for the Bed Manager/Night Nurse Practitioner. In meeting the Fire Brigade in all outlaying buildings and will communicate whether a manger is required to attend to allow Shift Craftsman to carry out any necessary Estates duties.

APPENDIX 5

ESTATES SHIFT CRAFTSMEN
ACTION CARD

NOTES	ACTION
Report to Location of Alert	• Informed by bleep • Proceed to area of fire emergency
Who is in charge?	• If it is an area in use, the person in charge should be approached (Sister, Manager, Bed Manager/Night Nurse Practitioner) to render advice/assistance. • Craftsman should collect the identity tabard and keys from switchboard and initially meet Fire Brigade on behalf of Bed Manager/Night Nurse Practitioner in outlaying buildings and communicate if their presence is required.
Unoccupied Building	• Await the arrival of the fire Brigade and give assistance as required
False alarm or fire out?	• Silence alarm after conferring with Fire Brigade/Bed Manager/Night Nurse Practitioner. • Await instruction from Fire Brigade to reset alarm. • Make good any device that needs repair.
Fire	• Inform Bed Manager/Night |Nurse Practitioner of fire. • Apply any Estates duties that may be required by the Estates Manager of incident/procedures.
Reporting	• Ensure that the Trust Fire Safety Advisor in informed of all the relevant

APPENDIX 6

PORTERING STAFF
ACTION CARD

NOTES	ACTION
Respond to alert via radio from Team Leader	• Porter will respond and go to Crush Hall Entrance to meet Fire Brigade
Receive Fire Brigade Main Site	• Acknowledge arrival at Crush Hall with Team leader. • Porter will escort the Fire Brigade to location and ensure they can access all areas. When there, he will seek guidance from Bed Manager/local manager, Night Nurse Practitioner etc.
Receive Fire Brigade Western residences/day theatres across road	• Porter will proceed to these locations with keys and meet the Fire Brigade/Shift Craftsman.
False Alarm or Fire Out	• The Porter at incident will liaise with team leader to inform them of false alarm and will then escort Fire Brigade safely back to appliance. • *Note: any keys removed must be returned to Switchboard.
Fire	• The Porter (if fire is in main building) will assist Bed Manager/Night Shift Practitioner etc. or return to Crush Hall to direct any additional fire appliances if responding.
Other Areas	• If Shift Craftsmen are required to carry out Estates duties elsewhere in core hours and cannot respond, the Porter will liaise with the Fire Brigade and Bed Manager/Night Nurse Practitioner.

APPENDIX 7 ALARM PANELS

ADT ALARM PANEL

View Window

Detector Head

Light
(Flashing Normal)
(Continuous Detector Actuated)

APPENDIX 8 SITE PLAN

FIRE EVACUATION PLAN

WARD 2

SINGLETON HOSPITAL

Action on Discovery of a Fire.

Key Principles.

- This could include an actual fire or suspicions of fire e.g. smell of smoke.
- Early and immediate action is better than delaying the response e.g. small fire growing into larger fire, delay in arrival of fire brigade, delay in commencing an early evacuation.
- Continuous fire alarm informs your colleagues and those in immediate vicinity that there is a fire emergency. You will get support from other areas and the site fire response team.
- Do not immediately tackle the fire. If you become incapacitated no one else knows there is an emergency.
- The fire alarm system may not have activated automatically.
- There is no charge raised by the Fire Brigade to attend a real emergency or genuine suspicion of fire.

Key Actions.

1 Raise the alarm:

- Operate the nearest fire alarm break glass unit (**RED** call point).

- Call for help from colleagues.

- Causes a continuous fire alarm in Ward 2.
- Switchboard will immediately inform Fire Brigade that a fire alarm has activated in Ward 2.
- Causes an intermittent fire alarm in all above, below & adjacent areas, Wards 1, 3 & the Canteen area below

2 Confirm fire to switchboard:

- Ring **3333** (or get a colleague to do so).

- Tell switchboard there is an actual fire and confirm location.

- Until a 3333 call is made, the Fire Brigade are only aware of the fire alarm activation and may only send one fire appliance travelling at normal road speeds.
- Following a 3333 call, switchboard will make a second call to the Fire Brigade. This will result in a full pre-determined attendance under emergency conditions.
- Always report a false alarm by the same method as soon as possible.

3 Evacuate those in danger:

- Typically those in the immediate area of the fire.

Stage 1

- Evacuate into a safe place (corridor) using any means available, this may require taking the bed out, mattress evacuation, a wheelchair, a steady or a wheeled commode.



- Close all doors and windows if possible to limit escape of smoke and heat into corridor.

- We may need to evacuate others close by and will need the corridor free of smoke.
- Once in the corridor evacuate behind at least **two** fire doors, where possible in the direction of Ward 1.

Because the corridor is for evacuation purposes, it should be kept clear of any obstruction or fire hazard at all times. Fire doors should not be wedged open.

Oxygen cylinders must be stored in a room with a fire door and an "OXYGEN" notice attached, only use them outside this room if necessary.

4 **Fight the fire:**

- Only if safe to do so.

- Small fires can be extinguished early in order to avoid them developing and worsening the situation to involve more patients staff or visitors. However, evacuation is the priority.

5 **Evacuation Continued:**

Stage 2

Progressive Horizontal Evacuation

- If the fire is large or growing and basic first aid fire fighting has failed the whole Ward may need to be evacuated using bed evacuation, walking patients and visitors to a place of safety.
- The preferred evacuation route is into Ward 1, but escape is also possible down the Theatres link corridor. If neither of these routes are usable then the staircase may have to be utilised.
- Proceed to the far staircase and hold the evacuees in an area near the staircase.

- It may also be necessary to evacuate parts or all of Ward 1.
- The Fire Brigade will be using the central staircases.

6 Evacuation Continued:

Stage 3

Staircase (Vertical) Evacuation

- Should the location of the fire prevent evacuation in the direction of Ward 1, it could create a situation where vertical evacuation is required and evacuees will need to be taken down the end staircase.
- For non-ambulant patients Ski sheet are provided under each bed to allow mattress evacuation where required.
- The sheets are stored under the mattress out of site and can be rapidly attached in an emergency.
- Patients can be dragged to safety either on the same level or down the staircase.
- Patients should be taken down one floor, but contact with the Fire Brigade should be maintained to check if further evacuation is necessary.

7 Other Risk Controls

- Isolate the piped Oxygen supply to the affected area (In accordance with local Medical gases Emergency plan) and remove Oxygen cylinders if safe to do so.

Action on Hearing a Continuous Fire Alarm

Key Principles

- This means a fire emergency in Ward 2.
- A fire alarm break glass unit may have been operated or an automatic detector may have been set off.
- Do not assume it is a false alarm.

Key Actions

1 **<u>Locate the Cause:</u>**

- Check the nearest fire alarm panel.
- Proceed to indicated location.
- If fire is detected initiate the Ward 2 emergency evacuation plan
- *Ring **3333** to confirm fire*
- If you need to enter a room and cannot see inside, take care. Possible fire in the room if smoke passing around the doorframe or door or door handle is hot when touched with the back of hand. **Do not enter.**

Action on Hearing an Intermittent Fire Alarm

Key Principles

- This means there may be a fire emergency in an area adjacent to Ward 2, or above or below.
- You need to examine the fire alarm panel, and be prepared to take action.
- Do not assume it is a false alarm.

Key Actions

1 **<u>Locate the Cause:</u>**

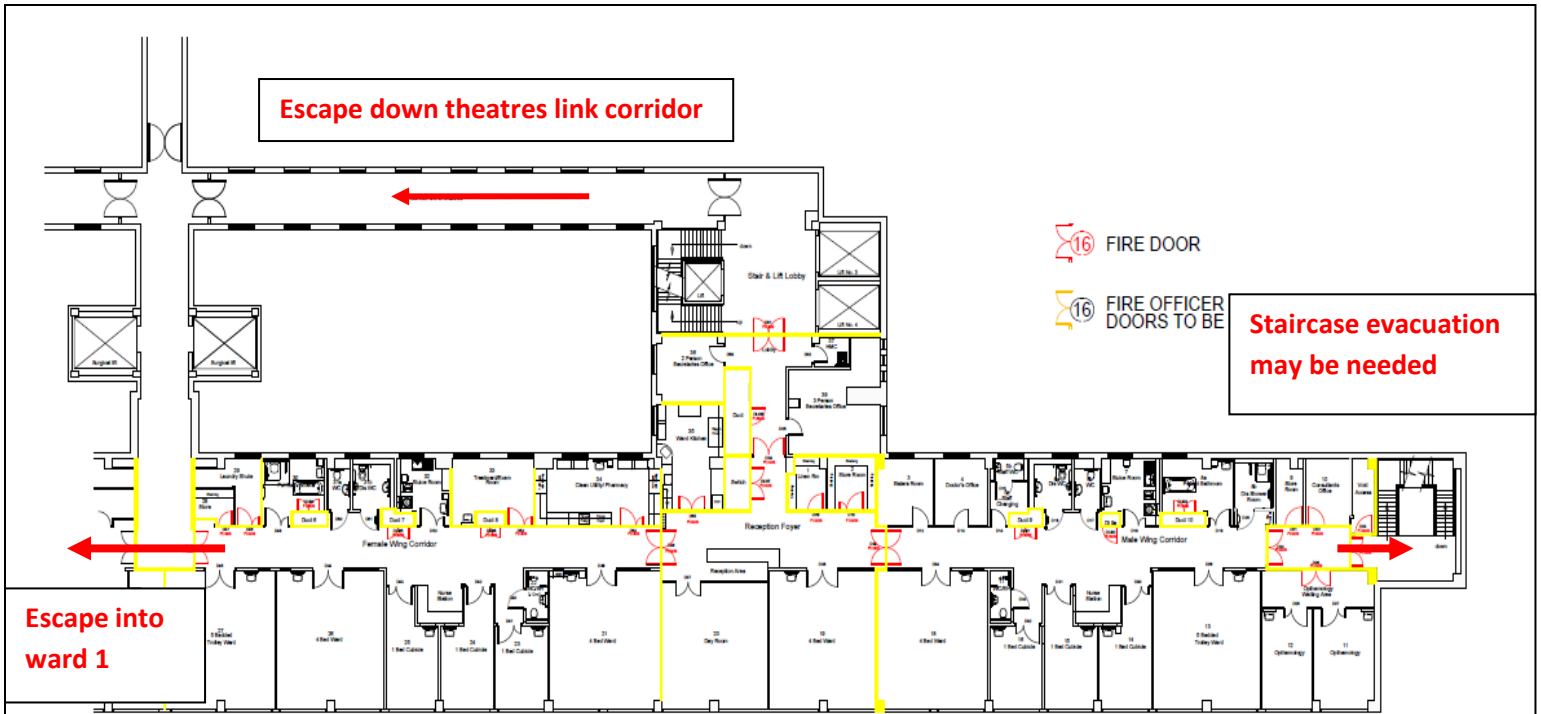
- Check the nearest fire alarm panel.
- Close doors and windows in Ward 2.
- Staff who can be released proceed to designated point *(front entrance)* in the affected area and await instructions. ***Do not go through affected area to get to designated point***

Fire Alarm Test Day

- The fire alarm system will be tested every Wednesday around 8 o'clock
- Short bursts of continuous or intermittent fire alarms may be heard.
- If alarm continues for longer than thirty (30) seconds implement the above actions for hearing an alarm.

Fire Safety Training

- All staff must be trained in fire safety
- A range of training sessions are available:
    - Site based Fire Safety for all staff.
    - Management awareness for Ward / Departmental managers.
    - Fire Wardens
    - Fire Response team Members
    - Ski Sheet / Evacuation aid
- Training can be accessed via the Health Board intranet site or by contacting the Health & Safety Department.



Hospital Aids Ski Sheet Mattress Evacuation Product Instructions for Use

Company: _____ Date: _____

Address: _____

_____ Venue: _____

_____

Contact: _____

I UNDERSTAND THAT SHOULD I HAVE ANY PHYSICAL PROBLEM OR HEALTH CONDITIONS THAT MAY PLACE MYSELF OR MY COLLEAGUES AT RISK, I SHOULD INFORM THE INSTRUCTOR.

Participant Name	Job Title	Department	Email	Fit & Well

Training Elements	Ski Sheet	Comments
Fitting evacuation SKI sheet to mattress	Lay the SKI sheet on the base of the bed white label face up. Concertina the belts and store in the easily accessible pockets on the corner sides of the sheet. Place the mattress onto the SKI sheet .Attach the SKI sheet to the mattress using the elastic corner loops. Adjust for a snug fit and tuck in the end pulling handles	
There it stays	The bed is then made up in the normal way the SKI sheet unobtrusively but securely fixed to the underside of the mattress.	
Ready for use	Working at a comfortable bed height remove pillows from under the patient and lay the patient flat on the mattress. The bed may need to be adjusted to a flat position .Tuck bed covers around the patient.	
Positioning of pillows	The pillows that have been removed from the patient are now placed across their chest and legs. This is done to gain maximum patient security when the cross straps are tightened.	
Securing cross straps	Working in pairs (one either side of the bed if space allows) remove the cross straps from the corner pockets and fasten over the patient. The straps are to be tighten enough to form the mattress into a U shape. This will cocoon the patient in the mattress – prevent the patient sliding – reduce area of friction – helps make pulling easier.	
Taking mattress from bed	Remove the pulling handles from the head and foot end of the bed. If time allows lower the bed to its lowest position. In some situations there may be sufficient space to tilt the bed foot end to take the mattress off the end of the bed, having removed the bed foot end .This is probably the easiest and safest way. However, from previous experiences taking the mattress off the side of the bed –	

	foot end – feet first is the most likely route to take, due to lack of space. To ensure that both or all carers removing the mattress from the bed (carer at foot end and head end holding the drag/pulling handles) are prepared for the lowering of the mattress to the floor, it is usual for a count of three to take place. The mattress can now be lowered to the floor by pulling the handle at the foot end and sliding the mattress onto the floor. Care should be taken when the head end of the mattress comes off the bed to prevent the risk of banging the patient`s head on the bed frame.	
Moving across floor	The carer at the head end once the mattress is on the floor can help pull from the foot end of the mattress.	
Positioning to move through doors	Take the widest angle when moving through doors this will prevent the mattress from rubbing against the door frame. Once through the door make sure the mattress is clear from the door frame – pull the mattress around at 45* ready for the pull to the stairs.	
Direction of patient to move down stairs	It is recommended that if you have to negotiate swing doors, en route, then to protect the head of the person on the mattress, you should go through the doors head first. However, please bear in mind that you need to arrive at the top of the stairs with the patient or resident, facing feet first, on to the staircase.	
Moving down stairs	When moving the mattress down the staircase the person at the bottom of the mattress should use their feet & legs to assist their pulling action, by pulling as they descend & pull the mattress. As the mattress comes onto the staircase, it is usual for the person at the top to hold the pulling handle long, with legs slightly apart to assist their balance. It is the person at the lower end who is in control of the speed of descent and they short start with the handle short & gradually lengthen it, as the descent progresses. Important that the pulling straps are held and not wrapped around the hands or wrists.	

Turning on half-landings	Work at wide angles – pull the mattress to the wall corner – on a tight or narrow staircase you may need to use the cross straps to position the mattress ready for the next descent.	
Patient comfort and safety at point of refuge	Once the patient has reached a point of safety ensure that the patient is comfortable, you may need to loosen the cross straps.	
Laundry procedure	When laundering does become necessary the buckles on the belts should be fastened, and a temperature of up to 80C can be used. To protect the buckles it is recommended that the sheets should be washed in a bag wash. Thorough rinsing will ensure that no detergent deposit is left. A disinfectant may be added to the final rinse if required. Drying A low temperature is recommended to prevent the nylon material from becoming brittle and shrinking.	
Tested Safely To	Tested to 250kilo (May 2013)	
Maximum safe working load	120 kilo up to two people.	

This guide has been designed to assist staff in the safe use of the Ski Sheet and needs to be assessed in line with the manual handling and cross infection policies in place within your organisation. Any manual handling techniques used within this information are merely suggested methods to move non ambulant persons in an emergency. It may be accepted that there may be other more appropriate alternatives on some occasions and within slightly different environments.

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Singleton Hospital
Fire Evacuation Sheet Decontamination

Fire evacuation sheet is designed to be placed flat on the bed underneath the mattress and any associated equipment and linen. The buckles must be stored in the pockets of the fire evacuation sheet provided, so that they are easy to locate if required and do not cause any discomfort to the patient. The evacuation sheet should be secured onto the mattress using the loops provided.

Nursing staff are required to carry out an examination of fire evacuation sheets and report any defects to the ward manager or ward fire warden as soon as identified e.g. tears, broken buckles, missing buckles etc. Visual examination and decontamination must be undertaken

- On receipt of a new sheet;
- Between each patient admission or at minimum weekly intervals when in use by the same patient.
- When making up a bed and after use patient

<u>General Decontamination Guidelines</u>

- Always clean hands and apply wear gloves & apron to decontaminate equipment.
- Place the wipe flat on the surface and work from cleanest area to dirty moving the wipe in a 'S' shaped pattern, take care not to go over the same area twice with the same wipe. Replace wipe when dry or soiled.
- Allow 2 minute wet contact time but ensure surface is dry before reapplying mattress.
- Always remove gloves and apron immediately after decontaminating equipment and WASH HANDS thoroughly.

Always ensure surfaces are dry before replacing mattress onto the fire evacuation sheet.

Product selection (Do Not use Alcohol based wipes).

- Patient has no known infection - Clinell universal wipes.
- Patient is known/suspected to be colonised/infected with Antibiotic resistant bacteria - use Clinell Universal wipes.
- Patient has a diarrhoea/vomiting or *Clostridium difficile* infection - Use a combined detergent & chlorine releasing solution (e.g. Chlor-Clean).

Frequency

- Immediately when soiled.
- In between each patient & weekly intervals.

On inspection, where sheets appears visibly clean

- Routine decontamination procedure using Clinell universal wipes use one wipe at a time, placed flat on the surface. Clean in a S shape and replace the wipe when dry. Allow at least two minute wet contact time and ensure dry before placing onto any other surfaces (i.e. under mattress).

On inspection, where sheets appears visibly contaminated with Blood/body fluids

- Remove visible contamination using a wipe soaked in Chlorine solution. On the visibly clean surface, using disposable wipes soaked in Chlorine solution at a concentration of 1000ppm, wipe all surfaces in an "S" shape, allow 2 minutes wet contact time, then rinse with clean water and dry before placing back onto the bed frame.

DRAFT – review July 2018

ABMUHB Singleton Hospital Evacuation Business Continuity Procedure

Initiated By: ABMUHB Emergency Planning Group

Approved By: Emergency Planning Group

Version: 2

Operational Date: 2015

Date for Review: 2017

Distribution: Via Emergency Planning Group to all Directorates/Localities

DOCUMENT VERSION CONTROL

Policy Version Number	Date	Author	Description of Change
1	10.04.15	Emergency Planning Officer BC Task & Finish Group Consultation with South Wales Police, Mid and West Wales Fire and Rescue Service, Welsh Ambulance Service Trust and Swansea/NPT L/A Joint Resilience	Development of draft plan
2	May 2015	Emergency Planning Officer	Amendments to draft plan
3	January 2016	Emergency Planning	Amendments to reflect Organisational Changes
4	July 2018	EPRR	Review in readiness for testing

Acknowledgement

We wish to acknowledge and thank the Royal Marsden NHS Foundation Trust, Resilience Team for sharing their Evacuation Plan, which has been developed following lessons learnt from an incident resulting in a full evacuation procedure. This plan, with their agreement, has been utilised to develop the ABMUHB Procedure.

CONTENTS

ALTERNATIVE PREMISES FOR CRITICAL CARE AREAS PROCEDURE

Page No:

1. Purpose

The purpose of the ABMUHB Singleton Hospital Evacuation Procedure is designed to describe the process for responding to the urgent need for a partial or full evacuation of Singleton Hospital. In recent years previous incidences within NHS sites have highlighted that such a risk exists. If a partial or full hospital evacuation is required, a major incident will be declared and both the major incident procedure and this procedure will be invoked.

Where a hospital evacuation is required for whatever reason, within ABMUHB, Fire Plans will be utilised for the purpose of evacuation and they include a full evacuation procedure if required. It is therefore essential, that all wards and departments review their fire plans regularly. The need for evacuation may be for a variety of reasons and not necessarily as a result of a fire.

This procedure details a step by step instruction specifically for the establishment of the command and control requirements for carrying out tasks to achieve efficiency, consistency and safety during an incident which results in the need for full or partial evacuation of Singleton Hospital and the business continuity arrangements required following the evacuation.

The risks involved in a hospital evacuation are complex;

- Many patients are non ambulatory
- Some staff and visitors may have restricted mobility
- Some patients may be undergoing emergency procedures, surgery or require intensive therapy support
- Some patients may be receiving diagnostic or therapeutic treatment

In all cases the overall priority must be the safety of the patients, staff, visitors and contractors.

Notification and confirmation to invoke the hospital evacuation procedure will be decided following consideration and assessment of the circumstances of the event and full consideration of the actual internal and external hazards and potential risks or on the advice/order of the Fire and Rescue Service. Notification will include the need for a partial or full evacuation of an area and will be a directive at Executive Director level and following consultation with the responding Fire and Rescue Service at the time.

1.2 Aim

The aim is to establish a framework for managers and staff in order that they can manage a full or partial evacuation of a hospital site.

1.3 Objectives

- To inform, support and provide guidance for staff in the event of an internal major incident where evacuation of part or the entire hospital site may have to be considered.
- To identify the risks which may lead to a partial or full evacuation e.g. fire, flood, environmental incident, catastrophic event. Such risks are captured within the Health Board Corporate Risk Register and are derived and detailed in both the National Risk Register and South Wales Local Resilience Risk Register.
- To identify the considerations and options to support staff when an evacuation is required.
- To identify the alternative premises options for evacuated staff, patients and visitors.
- To identify the command and control structure.
- To include multi agency assistance as required.
- To ensure the HB Recovery Plan is implemented as part of the response.

Command and Control

Any incident requiring a full or partial evacuation of a hospital site will be classed as a major incident.

The invoking of this procedure will be in conjunction with the invoking of the Health Board Overarching major incident procedure and respective Service Deliver Unit Major Incident Procedures in order that the Strategic, Tactical and Operational Command and Control structures are established.

In addition, the emergency services; Police, Fire and Rescue and Welsh Ambulance Service Trust, may instigate their own major incident plans; dependent on the incident at the hospital site. Also, a multi agency Strategic Command and Control structure may also be invoked if the major incident warranted a multi agency Gold and Silver response.

Gold Command

Health Gold Command will be based at Health Board Head Quarters in accordance to the plans. They will undertake their role in accordance to their

associated major incident plan action card. An Executive may also be required to attend multi agency Gold Command if invoked.

Silver Command

Silver, (Tactical) command and control will be established for Singleton in accordance to the Singleton Major Incident Procedure. However, this will be required to be established at …… combined with the Health Board command and control structure, they will co-ordinate the response to the whole incident. The Silver Command at Singleton will require management by the Hospital Director/Deputy, the Senior Site Manager/Deputy will be required to manage the onsite evacuation process; Bronze Command. In addition, a Senior Manager may be required to attend a multi agency Silver Command if invoked; a Senior Manager from Morriston may be required to attend this.

Bronze Command

Bronze evacuation will be managed by Hospital site operational management and in conjunction with Scene command which may be via the Police or Fire and Rescue Service. Bronze command will liaise closely with Silver Command at …….Cordons will be established on site and the Hospital Site Management will need to work closely with the Emergency Service Scene Commanders in terms of the restrictions placed on personnel entering and leaving the site.

Joint Emergency Services Interoperability Principles (JESIP)

The JESIP programme was originally designed to help improve multi-agency response in an emergency. However, the five joint working principles and models can be applied to any type of multi-agency incident and can be utilised in any environment where organisations need to work together more effectively. Therefore, these principles can be easily adopted within any organisational internal command and control structures and are now recommended as good practice.

The agreed core principles are as follows;

To support the 5 core principles, the Joint Decision Model, (JDM), is widely used at all levels of multi-agency meetings during the response phase of an emergency, to enable responding agencies to agree on key decisions. The JDM allows commanders to gain situational awareness of the incident by bringing together the available information, understand the risks, reconcile objectives and make decisions.

The mnemonic METHANE, is used to share situation reports and to ensure that all responding agencies have the same information relayed from the scene.

JOINT DECISION MODEL

Joint Services Interoperability Programme accessible through ***http://www.jesip.org.uk/joint-decision-model*** *Accessed 21.04.17*

Multi Agency Response

Dependent on the nature of the incident, one or more of the Category 1 responders will attend the incident scene. Their primary roles include;

Police

- Create Cordons to allow authorised movement into and out of the scene
- Scene management (although not necessarily the lead agency police will have primacy) to include marshalling and road closures
- Media strategy in conjunction with the Hospital
- Casualty bureau management
- Victim Identification

Fire and Rescue Service

The initial actions of the Fire and Rescue Service would be to follow the Fire Action Plan. It may be the case that a phased evacuation would be the most appropriate way of dealing with the incident. The type of incident, building construction, Fire Safety and fixed installation arrangements in the affected areas would be considered by commanders in their Dynamic and Analytical risk assessments.

Initial actions of the Fire and Rescue Service would include:

- Mobilising a Pre Determined Attendance (including suitably trained Commanders) to the incident. Additional resources would be made available on request from the Incident Commander.
- Engage in multi agency liaison and follow Joint Emergency Services Interoperability Programme (JESIP) doctrine
- Establishment of a clear and identifiable command structure with representatives at Strategic, Tactical and Operational levels.
- Depending on the type of incident the Fire and Rescue Service would deploy resources as necessary deal with the incident in order to save life and protect property.
- Provide assistance as necessary to assist with evacuation protocols.

In order to assist crews Operational Intelligence on the Hazards and Risks at the site has been gathered. Regular reviews are undertaken to ensure the information available to commanders is current and valid.

Welsh Ambulance Service

Where there is an immediate risk to life, or where the clinical priority of patients may result in harm, the Welsh Ambulance Service will:

- Deploy trained commanders at the affected site to liaise with the hospital management team
- Engage in multi agency liaison and follow Joint Emergency Services Interoperability Programme (JESIP) doctrine
- Consider whether the incident warrants declaration of a major incident and enact the necessary measures

- Provide assistance as deemed appropriate to support evacuation safely and in order to save lives and reduce harm, working collaboratively with the Hospital management team, other emergency services and other service providers

Note: Where a planned evacuation is being carried out where life is not at risk WAST will provide limited support, as deemed appropriate given prevailing operational pressures.

Local Authority

In the initial stages of an emergency, the Local Authority (LA) will act to support the emergency services. They will do this by:

- Opening evacuation and rest centres.
- Mobilising trained staff to manage the above.
- Co-ordinating emergency support from the voluntary sector.
- Managing the local transport and traffic networks.
- Sending a member of staff to the scene (Bronze) and Silver to act as the Local Authority Liaison Officer
- Leading on community recovery in the aftermath of an incident

A Local Authority Duty Officer is available 24/7 via Mid and West Wales Fire and Rescue Service Control Room 01268 909404. Within hours the Swansea L/A Resilience Team will respond.

The Local Authority Officer should be the initial point of contact for activating LA services.

The LA can provide the following resources in the event of an emergency:

- Use of Council Buildings (Schools, Community Halls, Leisure Centres). These buildings can be utilised as rest centres, humanitarian assistance centres, casualty bureau, family and friends reception centre.
- Catering for rest centres
- Transport
- Provision of emergency housing accommodation
- LA Environment Department can provide: Plant and Machinery, Gritting, Sandbags, Pollution Control & Air Quality Monitoring, Skips & full access to trades people, such as carpenters, electricians, plumbers, builders, glaziers, etc.

Swansea University

Swansea University ……. will be informed of an incident at Singleton Hospital and will consequently establish ……. in order to establish the;

- Command and Control point at …….
- Ambulatory secondary holding area…….
- Non-ambulatory secondary holding area…….

Fire and Rescue Service and Police Cordons

If an incident necessitates the attendance of the Fire and Rescue Service/and/or the Police, a safety cordon may be imposed. The Fire and Rescue Service/Police will be in control of the safety cordon and no person will be allowed to breach the cordon without prior permission.

Please note the FRS would manage access and egress to the inner cordon.

Evacuation Process

This procedure is based on the Health Board Fire Plan for evacuation and the respective area specific fire plan, where the initial response would be an invacuation, progressive horizontal evacuation procedure. If required, the initial external evacuation will be to the designated fire assembly points within the Singleton Hospital site, co-ordinated by designated Fire Wardens/Fire Response Team. **All Ward areas have a specific Fire Evacuation Plan and are required to follow this procedure for the evacuation process.**

The next steps will include co-ordination of the staff, patients and visitors to the designated secondary ambulatory holding areas;

- Ambulatory Patients to go to……
- Non ambulatory holding area……..

If it is not possible for high priority patients to be retrieved from their respective ward locations and transported immediately to alternative premises as identified within their respective service business continuity plans, they will be moved to ……..

Ambulatory patients may be transported from the secondary holding area at …….. to either an appropriate designated rest centre or alternative healthcare facility, identified at the time. This will depend on the clinical needs of the patient and will allow time to create capacity within the designated alternative premise areas in accordance to the respective services business continuity plans.

Some key considerations regarding the evacuation include the following issues;

- Multiple exit points
- Cold weather/rain
- Possible patient/staff/visitor injuries
- Poor lighting due to night time/early morning

Ward/Unit/Department Evacuation

Each area has a specific evacuation plan in accordance to the Health Board Fire Plan, where the initial evacuation procedures are detailed and all staff will be required to adhere to. A regular review process should be in place of the individual departmental fire plans.

These plans also specifically address high risk care areas, e.g. Enhanced Medical Unit that has specific care requirements and specialist equipment.

Partial and full Site Evacuation

The initial decision to partially or fully evacuate the hospital will be made at Executive level and or by the Emergency Services and will be communicated to all areas. However, the overriding factor with evacuation is to save life; an evacuation must not be delayed if lives are at risk, whilst contact with a senior manager takes place. All staff **must** follow the Health Board Fire Procedure to evacuate and proceed to do so.

In the event of a hazard which requires a complete or partial evacuation of a hospital, the Executive Officer will give the order. However, please note, the Fire and Rescue Service can order the evacuation of an area and the Health Board is required to carry out their instructions.

Immediate Evacuation

If the hospital site is deemed unsafe to deliver adequate patient care following an incident, the Executive officer will request evacuation.

As noted, the evacuation process will initially be in accordance to the fire plans to the designated meeting points, prior to a co-ordinated process being applied to move them to the secondary holding areas. (Refer to Action Cards and individual departmental Alternative Premises Procedures).

Delayed Evacuation

In some circumstances, there may be a need for an evacuation but there may not be an immediate danger to life and to the safety of patients, staff and visitors and there may be time for a co-ordinated, systematic approach to be organised prior to evacuation. There are action cards specific for this type of evacuation.

Once resources, transportation and destination sites are organised, the process of evacuation can commence and this will be co-ordinated at the time.

Note

In both instances, the major incident procedure will have been invoked.

High risk patients, where possible should not be moved to the secondary holding areas or direct to another site until there are resources and transportation in place, unless the situation necessitates a rapid evacuation to reduce risk to both patients and staff.

Determination of patient movement

Priority groups for evacuation include;

- Those in immediate danger
- Self sufficient ambulatory patients
- Ambulatory dependent
- Non ambulatory, highly dependent

Patients within each area will be triaged and tagged. The order of evacuation will be from Priority 4 to Priority 1; Priority 4 patients will be evacuated first;

- Priority 4 – self sufficient patients who are ambulatory
- Priority 3 – ambulatory patients who require moderate care and require assistance
- Priority 2 – Patients who are non ambulatory
- Priority 1 – Patients who require continuous care

Patient tracking will be monitored at each step, by completion of the patient tracking form at;

- Ward/department level
- Fire assembly points

- Secondary holding areas,
- Rest centre establishment if appropriate
- Alternative premises location.

The patient track and trace record will be co-ordinated by an assigned track and trace clerk at the holding areas and by the Fire Wardens or nominated personnel at ward/department and fire assembly points. The documentation will be forwarded to the Command and Control centre. Respective ward area senior staff will need to utilise the logs to discuss ongoing care arrangements of the patients within the assigned alternative premises or within the assigned rest centre.

Incident Flow chart

(See separate flow chart)

Assumptions

This procedure is based on worst case scenario and therefore the following assumptions are made;

- The hospital is full to capacity, totalling….
- The number of patients that would be non-ambulant would be……..
- All areas within the hospital will be invacuated and this includes non-patient Ares and the staff from these areas will attend the secondary holding areas.
- Patients within the mortuary will also be evacuated but only with direct liaison with the Transport Manager and Pathology on other hospital sites; they will not be immediately evacuated.

Equipment required for evacuation

- Slide sheets located…….
- Trolleys on ground floor……..
- ????

Secondary Holding Areas

- Non ambulatory secondary holding area will be located at…
- Ambulatory secondary holding area will be located at…….

Considerations will include;

- Additional call to duty staff
- General welfare for patients
- Chairs/trolleys
- Blankets
- Catering
- Electrical supply for equipment
- Separate area for patients with infection

Mutual Aid

Additional mutual aid may be requested if further resources are required. In the first instance, if additional human resource is required, a request, if reasonable and practicable, may be forwarded to Swansea University for assistance.

In addition, equipment and catering for the secondary holding areas may be requested.

Warning and Informing

As part of the major incident response, the Health Board Communications Team will manage media messages and social media monitoring.