Bwrdd Iechyd Prifysgol Bae Abertawe

SWANSEA BAY UNIVERSITY HEALTH BOARD Major Incident Procedure

MORRISTON HOSPITAL

(Version 14 November 2025)

Please Note: The Major Incident Procedure will need to be read in conjunction with any current addendums either due to Infection, Prevention and Control or due to Service Changes that occur during the review period.

Approved by:	SBUHB Emergency Preparedness Resilience and Response, (EPRR) Oversight Group
Approved by:	Morriston Hospital Service Group – Stakeholder confirmations – October 2025
	CEO update within Health Board November 2025
	Confirmation within Management Board November 2025
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DOCUMENT VERSION CONTROL

Policy Version Number	Date	Author	Description of Change
1	19.07.12	Consultant Emergency Medicine, Emergency Planning Officer	Reformatted
2	30.07.12	Head of Operations, Morriston, Emergency Planning Officer	Amended due to comments received during Consultation/Reformatted
Final - 3	18.09.12	Head of Operations NPT Hospital, Emergency Planning Officer	Amended due to change in model regarding medical intake at NPT Hospital/Reformatted
4	07.11.13	Head of Operations, Morriston, Emergency Planning Officer	Annual Review
5	06.03.15/May 2015	Head of Operations, Morriston, Emergency Planning Officer	Annual Review
6	November/December 2015	General Manager, Medicine & Unscheduled Care, Morriston, Emergency Planning Officer ED Consultant, Morriston	Amendments due to organisational changes and following major incident declaration 25.10.15
7	January – April 2017	Lead for EPRR	Annual review following a workshop as a result of

Policy Version Number	Date	Author	Description of Change
		EPRR Oversight Group HB wide consultation	organisational changes during 2016
8	May – August 2018	Consultation with Action Card holders included within the procedure Head of EPRR	Annual review
9	October 2019	Head of EPRR/Consultation	Annual review, includes lessons identified from Exercise Echo One: 2019
	Periodically during 2020	Head of EPRR/Consultation	Addendums included due to C-19 pandemic response and temporary site reconfigurations
10	October 2021	Head of EPRR/HB wide consultation	Annual review
11	December 2022	Head of EPRR/HB wide consultation	Annual review
12	November/December 2023	EPRR/HB wide consultation	Annual review
13	November 2024	EPRR/HB wide consultation	Annual review & to incorporate further key service change proposals and activation process
14	November 2025	EPRR/HB wide consultation	Annual review, incorporating use of clinical capacity group (CCG) in both major & mass casualty incidents

The following is included within the SBUHB Major Incident Overarching Procedure and is therefore either not duplicated within this procedure, or elements are included as a summary only:

- Executive Summary
- Strategic Vision
- Strategic Aim and Objectives
- General Health Board roles
- Overarching Governance
- H&S
- Recovery
- CCA compliance requirements
- Business Continuity
- Risk
- Roles of other organisations
- Survivor Reception Centre
- Equality and Human Rights Statement
- Mutual Aid
- Information sharing

Please note:

This Procedure should be read in conjunction with: -

- SBU Health Board Overarching Major Incident Procedure
- SBU Health Board Burns Major Incident Procedure
- SBU Health Board Support response, Singleton, and Neath Port Talbot Hospital Major Incident Procedures
- SBU Health Board Mass Casualty Arrangements for Wales

The full suite of SBUHB Emergency Response Procedures are held on the EPRR SharePoint site - Emergency Preparedness, Resilience and Response (EPRR) - Home (sharepoint.com)

Other Health Board policies and procedures and statutory regulations are to be referenced as appropriate e.g.:

- Infection, Prevention & Control (IPC)
- Health & Safety (H&S)
- Workforce and Organisational Development
- Welsh Language Act
- Quality statements, e.g., care of the critically ill

The Action Cards referred to in this Procedure should be read in conjunction with the whole Procedure.

This Procedure may be invoked alone. However, it may also be invoked with other appropriate, Health Board Procedures, additional Emergency Response Procedures, SBUHB Business Continuity Procedures and / or Strategic Multiagency Procedures.

HEALTH BOARD EMERGENCY RESPONSE, COMMAND, CONTROL & CO-ORDINATION (C3)

The following will be a standard process as articulated within the Health Board

(HB) Major Incident (MI) Procedures for any Emergency Response:

- C3 arrangements
- JESIP Interoperability Principles
- Information management
- Communication Strategy
- Service Business Continuity Procedures to be invoked alongside any Emergency Response
- Continued focus on quality delivery during emergency response

All Emergency Response Procedures are flexible and adaptable, this allows for a tailored response to all emergencies and any additional threats and risks that may arise at the time.

In the event of a major incident, Morriston Hospital Co-ordination Centre will be the Health Board Lead Tactical, (Silver) command and control for the incident.

NOTE

- **If you are called in from Home, it is essential that you drive safely and park in designated parking areas, since it is likely that there will be heavy traffic in the area.**
- **Please keep calls through the Hospital Switchboard to an absolute minimum.**
- **Ensure you wear a valid Health Board identity badge at all times.**
- **Maintain a record of your key actions, this will be required for a post-incident debrief and Report.**
- **Be aware that initial information reports will change regularly**

ANY SUGGESTED CHANGES TO THE MAJOR INCIDENT PROCEDURE.

ADDITIONS OR AMENDMENTS TO THE CIRCULATION LISTS

SHOULD BE DISCUSSED WITH THE HEAD OF EPRR:

IMMEDIATE ACTIONS

If You Have Received Notification That a Major Incident Has Been Declared and you are the on-call officer/health professional in your department/specialty <u>you are required</u> to attend the site where the major incident has been declared and to undertake the actions specified within the respective action cards.

If You Have Not Read This Procedure

DO NOT READ THIS NOW

Find Your Relevant Action Card in the Appropriate Section

AND FOLLOW THE INSTRUCTIONS

Please note that the Action Cards are arranged for organisational convenience and are NOT listed in order of importance

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Section 1. General Principles

1.1. Background

The Swansea Bay University Health Board is defined as a Category 1 responder organisation as noted in the Civil Contingencies Act 2004 (the Act). The Act places a number of responsibilities on the Health Board in this regard. These include:

- Assess local risks and use to inform emergency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency.

In addition to the Act, there are a suite of guidance documents that support the planning and delivery of major incident response arrangements that have been considered and are incorporated into this procedure where appropriate. In addition, there is a business continuity management system in place.

This procedure is a generic document that outlines the response of the service to a major incident. Examples of the type of incidents that may result in this procedure being invoked include aircraft accidents, large road traffic collisions, train accidents, building collapses, sports stadia incidents or any similar circumstances where the numbers of live casualties overwhelm, or threaten to overwhelm the Health Board resources that are available to respond.

The Health Board will use the process of Integrated Emergency Management and the Civil Contingency Planning arrangements in order to provide a prepared response to any incident and will work with all partner organisations to ensure the effectiveness of this response.

The principles of joint working with our partners are “working together to save lives and reduce harm” and these principles will underpin these arrangements.

The following six activities of Integrated Emergency Management are fundamental to an integrated approach:

- Anticipation
- Assessment
- Prevention
- Preparation
- Response

- Recovery management

To comply with Health Services in Wales Standard 2.1, NHS organisational major incident procedures will be assessed as part of the Performance Management Framework.

Standard 2.1 Managing Risk and Promoting Health and Safety notes:

‘People’s health, safety and welfare are identified, monitored and where possible, reduced or prevented’

1.2. Aim

The aim of this procedure is to describe the manner in which the Health Board would respond to a major incident and ensure there is maximum effectiveness of the response for those patients involved in the incident or incidents. (Please note some additional detail included in the objectives is described in the Overarching procedure, which is the strategic procedure for SBUHB).

This procedure specifically relates to how the Swansea health community would deal with a major incident. Reference will be made to how the resources within Morriston, Singleton and Neath Port Talbot Hospitals as well as primary care resources in Swansea and Neath/Port Talbot would be used.

In the event of an incident which requires extra resources, support would be sought from neighbouring hospitals under mutual aid agreements. This would be a strategic discussion.

1.3. Objectives

- Provide an overarching governance framework detailing the service response to a major incident
- Define what constitutes a major incident and who can declare one for the Health Board
- State the roles of Health Board staff in a major incident
- Describe the roles of response partners in a major incident
- Describe the command structures and responsibilities in a major incident
- Identify key elements of the major incident response, including specialist resources
- Outline the risk management process that underpins emergency preparedness arrangements
- Describe the casualty management processes employed in a major incident
- State mutual aid arrangements to support a major incident response
- Identify the training and exercising requirements to support staff who may have to respond to a major incident
- States the process in place to capture lessons learnt from a major incident and incorporate into future arrangements.

- Identify the recovery process by which the return to normal operations is managed following a major incident

1.4. Scope

This procedure specifically covers the Health Board response to a major incident. Included in this procedure are the arrangements for Morriston Hospital. Primary Care and Community services and their role in responding to such an incident are articulated within the procedures, however, within the specific Service Group, they will have detailed response arrangements to support these procedures. Similarly, both Neath Port Talbot and Singleton Hospitals will support the major incident response, and this is summarised in the procedure, however, the Service Group has a joint major incident response procedure.

In addition to the above procedures, there are a suite of Business Continuity/Emergency Response procedures that will be required to respond to incidents other than a 'big bang' major incident, e.g., Pandemic Framework for a major infectious disease outbreak. However, some aspects of a response, e.g., command and control and co-ordination will be the same for any emergency. In addition, it is important to note that the procedures should not be too prescriptive that they do not allow for flexibility and adaption during an emergency response.

1.5. Maintenance and Governance

This procedure is written on behalf of the SBU Health Board by the Emergency Preparedness, Resilience and Response, (EPRR) Team in full consultation with all action card holders. The procedure is subject to an annual review to ensure it remains fit for purpose and that any changes in guidance or legislation are reflected in the procedure. This process also enables any lessons identified from incidences to be incorporated.

Following a review, the procedure is submitted to the Emergency Preparedness, Resilience and Response, (EPRR) Oversight Group and the Executive Team for Health Board wide approval.

It is the responsibility of EPRR to ensure that the annual review is completed, and the reviewed procedure is submitted to the Executive Team/Board for final approval.

Once approved, the procedure is circulated appropriately within the Health Board and includes digital access. Key external partners also receive a copy. A circulation list is included in the Overarching procedure.

The procedure may be reviewed following a de-brief after a live major incident or exercise, where lessons have been identified which would warrant an interim review and change to the procedure.

The procedure may also be reviewed following any significant change in National guidance or to incorporate lessons learned where this is appropriate.

1.6. Training and Exercising

1.6.1. Training

The effectiveness of the response to any major incident relies on having staff that are trained in major incident management, in particular, they are trained in the role or roles they would be expected to undertake.

A training and exercising process is required to ensure that an appropriate schedule of training and exercising opportunities are made available to various staff groups to underpin the overall response to major incidents.

It is the responsibility of the senior hospital management team and key staff to ensure that the personnel under their management are fully conversant with this procedure and are informed and trained in the implementation of their action card. An e-learning package is used to facilitate annual assessment and supplement job specific training.

There is an EPRR training and exercising strategy and programme in place.

1.6.2. Exercising

The Health Board is required to carry out as a minimum; a communication cascade exercise every six months, a desk top exercise once a year and a live major incident exercise every three years, unless the procedures have been activated as part of a declared incident.

1.7. Risk Assessment

In preparing this procedure, it is recognised that there are general and specific risks that prevail within the Health Board area. These arrangements aim to deal with the identified risks if an incident occurs in the community which results in large numbers of casualties. Also, any internal major emergency which threatens the welfare of patients/staff or significantly compromises the Health Board's ability to deliver key services.

For example, the Control of Major Accident Hazards (COMAH) Regulations 1999 require emergency services, Local Authorities, site operators and other key response partners to jointly plan the response to incidents at sites of heightened risk, in accordance with the regulations.

Through engagement with key partners under the auspices of the Civil Contingencies Act 2004, Community Risk Registers are developed and revised, highlighting specific areas of risk within the Local Resilience Forum area, which is based on Police Force areas. This is a continuing and evolving work stream and is subject to regular review. To support this, there is a Health Board, EPRR specific risk register and is also subject to regular review; linking with the National Security Risk Assessment and Community Risk Register.

This joint approach to risk assessment drives the requirement to develop single service and joint arrangements for response to specific scenarios. A prime example of this is the plan for a Pandemic response.

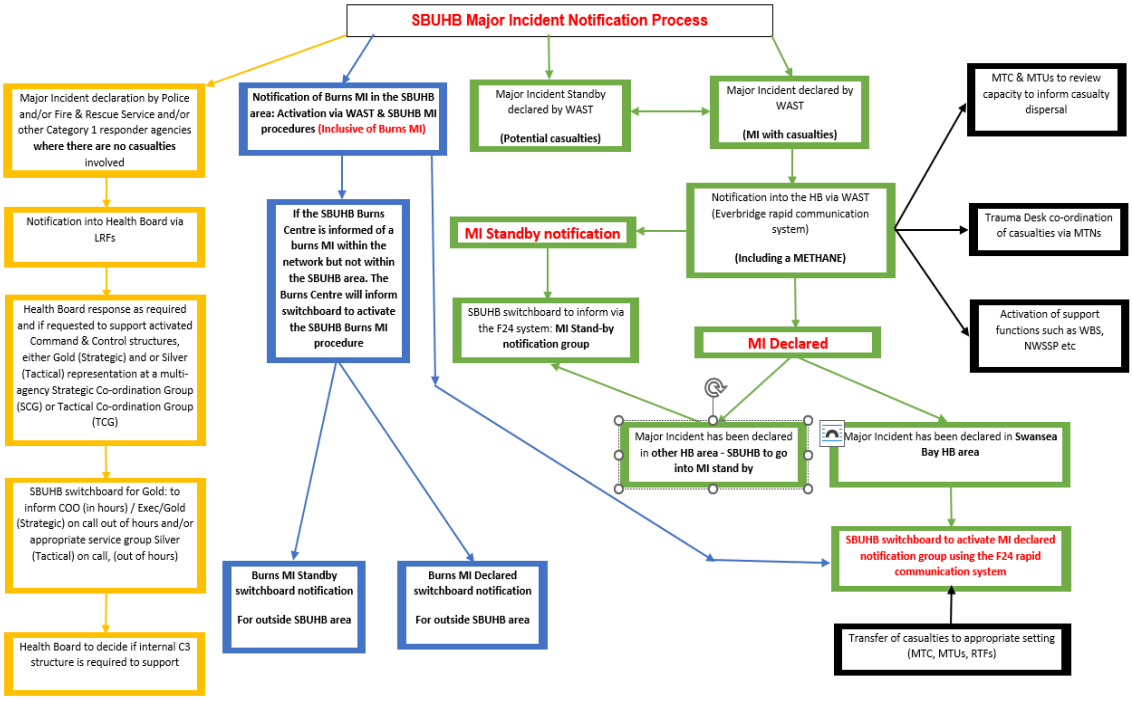
Where no specific plan or procedure exists to deal with a particular risk scenario, this Major Incident procedure provides the generic framework of command, control, and

coordination to support the response. (Refer to Overarching Major Incident Procedure).

1.8. Notification of Major Incident

Notification will be received by the Hospital Switchboard (on pre-determined ex-directory telephone number), which will normally be from the Welsh Ambulance Service Trust, (WAST) and where there are casualties and WAST have declared major incident; but also, in certain circumstances, the notification may arise initially from the Local Resilience Forums (LRF's), Police, Fire Service, HM Coastguard or the Emergency Department or Health Board Senior Management, where the Health Board is the scene of the major incident.

The below Flowchart shows this process:



Please Note: For a declared Critical/Business Continuity Incident, refer to the Health Board Overarching Business Continuity Procedure.

30 minutes after the declaration of a Major Incident by WAST (regardless of HB area), all HB's are required to join the **Clinical Capacity Group meeting**. During this meeting, WAST will share information across the NHS Wales system, in relation to the receiving hospitals for the incident.

No additional notifications or invites will be forwarded by WAST for the Clinical Capacity Group meeting; representatives must join via a preassigned link 30 minutes after the declaration of the Major Incident.

The meeting link is included in the following action cards:

- ***Gold Command***
- ***Silver Command – Morriston MI Procedure***
- ***Clinical Site Team – Morriston MI Procedure***

The Major Incident Notification Procedure allows for a two-stage response:

1.8.1. Stand-By Procedure

In the event of a potential Major Incident situation, or where another Hospital is dealing with a Major Incident, and SBUHB has been asked to be prepared to assist, the Hospital will initiate the 'Stand-by Procedure'.

The alerting message must go to the main hospital switchboard, and will be: -

> This is the Welsh Ambulance Service. The Trust has declared a Major Incident Standby in the following Health Board area - ####. The incident location is: ####.
>
> The information is as follows:
>
> Major Incident Standby
> Exact Location: ####
> Type of Incident: ####
> Hazards: ####
> Access: ####
> Number of Patients: ####
> Emergency Services Required or Present: ####
>
> All Health Boards and partner Health agencies in Wales have been sent this notification.
>
> Do not contact the Welsh Ambulance Service, refer to your organisation's major incident plan. Please await further information.

Note: A Standby notification will subsequently be cancelled or become a Declared Major Incident.

A Major Incident may be declared following further assessment at the scene, where the Welsh Ambulance Service will initiate if they themselves declare major incident. However, there may be some circumstances where, following a discussion of the situational awareness report from the scene, that the Health Board may wish to declare a major incident, but the Welsh Ambulance Service have not proceeded to declare.

This will require further discussion with COO/Gold Commander at the Morriston Silver Command (MI standby core team) at the time of the standby notification.

1.8.2. Major Incident Procedure (Declared Major Incident)

To initiate the **"Major Incident Procedure**", the alerting message will be: -

This is the Welsh Ambulance Service. The Trust has declared a Major Incident in the following Health Board area - **####**. The incident location is: **####**

The information is as follows:

Major Incident Declared
Exact Location: ###
Type of Incident: ###
Hazards: ###
Access: ###
Number of Patients: ###
Emergency Services Required or Present: ###

All Health Boards and partner Health agencies in Wales have been sent this notification.

Do not contact the Welsh Ambulance Service, refer to your organisation's major incident plan. Please await further information

Supporting hospitals will be alerted by the Health Board Major Incident (MI) rapid communication system but will not be receiving hospitals for casualties.

The HB will only automatically declare and activate its MI procedures if **the MI is within the SBUHB area**. In the event the MI is in another HB area, a MI standby will be activated.

1.8.3. Stand Down Procedure

On receiving the message from the Ambulance Operational/Tactical Commander, Ambulance Control will notify the following message to the Emergency Department and Switchboard, who will inform the Hospital Co-ordination Centre: -

This is the Welsh Ambulance Service. The Trust has declared a Major Incident in the following Health Board area - ####. The incident location is: ####

The information is as follows:

Major Incident Stand Down
Exact Location: ###
Type of Incident: ###
Hazards: ###
Access: ###
Number of Patients: ###
Emergency Services Required or Present: ###

All Health Boards and partner Health agencies in Wales have been sent this notification.

Do not contact the Welsh Ambulance Service, refer to your organisation's major incident plan. Please await further information

The Hospital will be informed of any casualties already en-route when this message is given.

N.B.
It is likely that the hospital stand-down will not be given for some time after the scene stand-down, and will be issued from Silver Command in consultation with Gold Command. This will in turn be cascaded to relevant staff through the Hospital Switchboard. Until the internal stand-down notification is activated, all staff must continue to remain in response to the incident.

1.9. Action on Receipt of Notification of a Major Incident

The Hospital Telephonist will receive the call as detailed in their Action Card.

1.9.1. Stand-By Procedure

In the event of the 'Stand-by' Procedure having been initiated, the Telephonist will obtain details and notify the following and advise them accordingly: -

- Nurse-in-Charge - ED
- Consultant in Charge in ED
- Clinical Site Matron for Morriston
- Morrison Service Group Nurse Director
- Morriston Service Group Medical Director/Deputy
- Silver On Call managers for all SDG's **(out of hours)**
- Service Group Directors for all SDG's **(in hours)**
- Gold On Call **(out of hours)**
- Chief Operating Officer **(in hours)**
- Head and Manager of Emergency Preparedness Resilience and Response
- Loggist/Administration Staff - **alerted from within the HCC**

As noted on some occasions there may be a standby alert, but a Major Incident Declaration on Scene may or may not be activated. However, the information provided may require the hospital to invoke a major incident declaration. The situational awareness report will involve the use of the METHANE, (ETHANE can also be used for gaining situational awareness for declared internal critical incident or other emergency responses):

M	Major Incident declared or standby
E	Exact location / geographical area of incident
T	Type of incident, flooding / fire / utility failure / HazMat etc.
H	Hazards present or potential
A	Access and egress – effective routes
N	Number and types of casualties (P1, P2, P3) and dead

E	Emergency Services required / on scene

1.9.2. Major Incident Declared

In the event of a declaration of a Major Incident being initiated, the Telephonist will take all actions as detailed on their Action Card and initiate the appropriate 'call-out' log via the rapid communication system. The on-call officer/health professional within each department/specialty is required to attend the hospital site in the event of a major incident being declared.

In readiness for the reception of casualties, a senior Emergency Department (ED) Doctor and Nurse will be delegated by the Nurse-in-Charge of the ED to prepare the Emergency Department entrance as an area to triage casualties. The ED rhesus, trolley bays and treatment rooms as an area to treat P1 & P2 casualties. The designated minor injury unit and green area will treat walking wounded patients (P3). The children's emergency unit (CEU) will be prepared to receive children. The Portering Services Manager or the most senior porter on duty will assemble trolleys in the allocated areas. The ED preparations will include an element of flexibility in order to respond in accordance with the acuity and number of the patients (adult & children).

The Doctor in charge, together with the Nurse in Charge, will be in charge of the treatment areas established in the Emergency Department assisted by other identified consultant colleagues. Treatment teams will be established.

To support the Welsh Ambulance Service NHS Trust (WAST) in their response to a major incident, the below approach to the release of ambulances from emergency departments, at the declaration of a major incident has been agreed and needs to be achieved:

• 50% of vehicles released within 10 minutes

• 75% of vehicles released within 20 minutes

• 100% of vehicles released within 30 minutes

The General Surgery Specialist Registrar on-call will assist in creating bed capacity on the Receiving Ward the ***Surgical Assessment Unit*** *which* will be emptied for the reception of **ALL** major incident casualties not requiring critical care facilities.

In the event of a medical major incident The Medical Specialist Registrar on-call will assist in creating bed capacity, where possible, on the Receiving Ward the **ACUTE MEDICAL UNIT** which will be required for the reception of **ALL medical** major incident casualties' not requiring critical care facilities.

Arrangements will be made for the discharge, or transfer, of patients, via the on-call Registrars in all specialties. This will be done in conjunction with Clinical Site Management. Any patient requiring to be discharged, or transferred to another Hospital when possible, should be sent to an appropriate identified area, e.g., Discharge Lounge for patients requiring a stretcher and for those who are able to walk the discharge lounge and Physiotherapy OPD may be used, which will act as a

holding/decanting area for those awaiting Ambulance transport and/or require a clinical environment.

Any routine expected, or '999' 'Medical' cases, where possible, will be transferred to neighbouring hospitals, as appropriate, at the discretion of Ambulance Control, the Hospital Co-ordination Centre, and Chief Operating Officer, in order that resources are available to deal with Major Incident patients at Morriston Hospital. Also being cognisant of the South Wales Major Trauma Network arrangements, where a number of Health Boards Trauma Units and the Major Trauma Centre will be activated simultaneously. Any non-Major Incident trauma cases will continue to be accepted at Morriston, as will Urology, Vascular and Tertiary speciality emergencies as per current arrangements.

Similarly, the divert of surgical intakes, where possible, will be required in liaison with neighbouring hospitals.

In the event of the Welsh Ambulance Services Trust (WAST) declaring a Major Incident (MI) anywhere in Wales, a Clinical Capacity Group meeting will be convened 30 minutes after the declaration. All NHS organisations are required to send a representative to the meeting. During this meeting, WAST will share additional information across the NHS Wales system, in relation to the potential receiving hospitals for the incident, this will increase situational awareness and allow health boards to further inform their response to the incident.

The Clinical Site Team Matron will join the **Clinical Capacity Group meeting** 30 minutes after the declaration of the Major Incident by WAST.

(no additional notifications or invites will be forwarded by WAST for the Clinical Capacity Group meeting; representatives must join via the below link 30 minutes after the declaration of the Major Incident).

Wales Mass Casualty Arrangements (Clinical Capacity Group)

A Clinical Capacity Group (CCG) calendar invite has been created for all Clinical Site Team Matrons and other nominated Clinical Site Team staff. The calendar invite includes the above direct link to join the CCG.

1.9.3. Medical Emergency Response Incident Team (MERIT)

The deployment and use of MERIT is currently suspended by WAST in consultation with Welsh Government and will not be requested

These are medical teams, which can be called to the incident scene. They are requested by the Ambulance Operational/Tactical Commander, Medical Advisor, (MA) or National Interagency Liaison Officer, (NILO) are responsible for deciding whether there is a need for MERIT deployment at the incident scene. They will work under the direction of the Medical Advisor. The makeup and skill level of the teams is set out in the NHS Emergency Planning Guidance – Medical Care at the Scene of a Major Incident. Personnel that make up the MERIT response will have undertaken appropriate training to support them in delivering their role effectively at a major incident and are issued appropriate personal protective equipment.

The Ambulance Service is responsible for cascading a major incident standby or declared, (where there are casualties) and for the deployment of MERIT, they will

nominate where this capability should be drawn from. It is the responsibility of the Ambulance Service, in collaboration with NHS Shared Services to transport the MERIT from their collection point (at a nominated hospital or hospitals) and transport to the scene, along with their equipment. There is a standard operating procedure for the deployment of MERIT and the actions will be undertaken by the Emergency Department.

The Ambulance Service can call on a cadre of suitably trained Doctors to undertake a number of roles in support of the major incident response. This includes the following roles:

- Strategic Medical Advisor (Gold) – provides strategic advice
- Medical Advisor (Silver) – provides tactical advice, working closely with the Ambulance Incident Commander
- Forward Doctor(s) – provides operational support at the Casualty Clearing Station, or works within the inner cordon, if required

These doctors can be drawn from a number of differing sources, including EMRTS Cymru, WAST employed Pre-Hospital Emergency Medicine (PHEM) Doctors and BASICS / Medserve Doctors.

There are a suite of standard operation procedures in relation to MERIT deployment and include standards for Personal Protective Equipment.

1.9.3.1. Triage Tools

In April 2024 Two new Triage Tools went live in Wales (the Ten Second Triage (TST) and the Major Incident Triage Tool (MITT)). The MITT is to be used by all NHS responders to MI and is a single tool for both adult and Paediatric patients that allow for rapid, reliable, and reproducible triage. The MITT replaces the previous Triage SORT. Therefore, the MITT will used at the front door of Hospitals, as well as pre-hospital.

The TST replaces triage sieve and will be used in the pre-hospital phase, and is quick, simple, and effective at prioritising large numbers of casualties rapidly with a focus on immediately providing lifesaving interventions.

To accompany the introduction of the TST tool, there is revised casualty labelling. However, for the MITT, existing labels will continue to be used.

1.9.4. Disposition of Main Hospital Centre

CENTRE	LOCATION	EXTENSION NUMBER
Emergency Department Control Point	Direct line contact number	33422 / 33419

CENTRE	LOCATION	EXTENSION NUMBER
Information Point **Emergency Department Nurse in Charge**		Direct Line to Ambulance Control 33269 01792703281 (External) 33281 (internal)
Hospital Co-ordination Centre: Information point and Command & Control	Service Corridor, adjacent to Telephone Exchange	Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)
Police Liaison Office	ED Police Interview Room	Swansea (01792) 531259 31259
ED Triage Point/ **ED Reception Area**	Main Stretcher Entrance / Decontamination Room ED	48084 / 32931
Seriously Injured Casualties (*Priority 1*)	ED Resuscitation Area / Trolley Bay	32619
Walking Casualties *(Priority3*)	Minor Injuries Area	39900
Walking Casualties. (Extended numbers of Priority 3 cases)	GPOOH	38487
Paediatrics	Paediatric ED	31374
Relatives	OPD	30688
Press & Media	Education Centre	33901 / 33570

CENTRE	LOCATION	EXTENSION NUMBER
ED MI Discharge Area	OPD, relatives care and family reunited centre	30649
Patients for Discharge / Transfer	Discharge Lounge or secondary discharge area - Physiotherapy OPD	Telephone Number: 38123
Burns Co-ordination Centre	Resource Room, Tempest Ward, Burns Centre.	33814 / 33293 **E-Mail:** Burns.Incident@wales.nhs.uk

1.10. Roles/Responsibilities and Control: Tactical, (Silver) Command

The UK national command and control model for emergencies allows procedures and capabilities to be integrated to manage an emergency response. A generic framework has been agreed, which includes the Gold (Strategic), Silver (Tactical) and Bronze (Operational) command and control communication structures.

The Gold (Strategic) command processes are articulated in the Overarching SBU Health Board procedure and provides strategic instruction as to what needs to be done. A Gold Coordination Centre will be established.

The control element in an emergency provides the interpretation of the strategy and how it will coordinate the response.

The recognised day-to-day administrative arrangements will continue to function throughout the incident, and they will need to be agreed between with the Chief Operating Officer and lead Silver Command. However, due to the additional requirements of a Major Incident response, the Morriston Hospital Co-ordination Centre will be activated. The other Service Groups, (Mental Health and Learning Disabilities, Primary and Community Care and Singleton/Neath Port Talbot Hospitals, will need to also convene their own respective silver command arrangements but liaise regularly with the lead Silver Command at Morriston.

THE OVERALL HOSPITAL, (Tactical) RESPONSE TO THE MAJOR INCIDENT WILL BE MANAGED BY MORRISTON HOSPITAL CO-ORDINATION CENTRE – TACTICAL (SILVER) COMMAND

The Hospital Co-ordination Centre is considered essential for the direction, management, co-ordination of a hospital response to an emergency and will be the nucleus for silver/tactical command, control, and co-ordination in such an event.

The Hospital Co-ordination Team will comprise of Site Management personnel and Emergency Care Hospital Operations, Service Group Director/Deputy, Nurse Director/Deputy, Medical Director/Deputy, Director, Loggist and additional administration staff.

A trained Loggist nominated at the time will record information traffic, and log key actions and decisions. A note taker will also be required. Other management support and administration staff will be co-opted in by the Senior Management Team.

The Chief Operating Officer/Deputy will guide further in-order that service continuity is maintained and will liaise with the Health Board Lead Silver command.

The Clinical Director for Medicine or Service Group Medical Director will be the co-ordinator of the deployment of medical staff during the period of the Incident on declaration of a Major Incident. Responsibilities include directing and monitoring medical teams within the Hospital; and to assess the medical demands of the hospital. They will be in close liaison with the HB Medical Director/Deputy.

A pool of medical teams will be initially located in the designated area; the Co-ordination Centre. Additional medical staff waiting for deployment following the initial reporting to the Co-ordination Centre, may be held in the Doctor's Mess within the dining room. Some specialty services may have assigned separate holding areas, and they will inform the Co-ordination Centre of these arrangements.

The Service Group Nurse Director/Deputy will be the co-ordinator of the deployment of nursing staff during the period of the Incident and on declaration of a Major Incident. Responsibilities include directing and monitoring nursing staff within the Hospital; and assess the nursing demands of the hospital. Additional staff may be allocated to wait for deployment and held in the Doctor's Mess in the dining room. A Therapy lead will be present in the Coordination Centre.

As part of Silver command, an information area within the Co-ordination Centre will be established, to ensure the re-united and discharge area is established in OPD; activate support services and oversee the co-ordination of relatives, (those attending at the hospital and telephone enquiries).

The Director of Insight, Communications & Engagement will be based in Gold and assign a deputy to co-ordinate press and media responses, manage press on site, monitor and update social media and liaise with Police Press Teams and Resilience Fora Warning and Informing Cell as appropriate.

ALL departments **MUST** confirm their state of readiness to the Hospital Co-ordination Centre, this will either be done in person or by telephone and in accordance with their action card. This is a particular priority where the incident is declared 'out-of-hours' and where Action Cards are being followed. Acknowledgement of the initial response will be monitored digitally via the Coordination Centre.

1.10.1. Actions of the Hospital Co-ordination Centre

- Silver/Tactical Command and Control of the incident.

- The Co-ordination Centre needs to be situationally aware of the incident and requires early responses to the incident. Information and updates should be collated in accordance with the METHANE as noted above.
- There needs to be flexible planning and direction within the Co-ordination Centre as the incident evolves to deal with the challenges/risks as they arise.
- Different incidences may require unique approaches i.e., the response to a medical type incident may be very different to a surgical/trauma event.
- The deployment of additional resources within the organisation may require responses from non-front-line teams and in particular to support diversion of intakes and issues arising from the supporting hospitals.
- The Hospital Co-ordination Centre will be prepared by the Clinical Site Manager. In addition, they will establish the Hospital's current bed state and staffing in accordance with routine practice. Further action will be undertaken according to the prevailing circumstances.
- The Hospital Co-ordination Centre will establish a telephone link to the relevant Ambulance Control, this may be via the Ambulance Service Liaison Officer. The Hospital will continue as normal at this stage, until notified otherwise by the Hospital Co-ordination Centre.
- The Hospital Co-ordination Centre will collate information regarding bed availability and will relay this information to Ambulance Control hourly or earlier if there is a major change. The major incident dashboard will be completed/updated by appropriate digital feeds.
- The Health Board Gold Command will be responsible for liaising with the CEO (or nominated Executive Lead) and Head of Emergency Planning at NHS 'Gold', for calling on additional resources both within and outside the Health Board. They will also attend a Strategic Coordination Group if convened by the Local Resilience Forum.
- The Hospital Co-ordination Centre will be responsible for standing down the Hospital from a Major Incident response, following discussion with Health Board Gold. ***It should be noted that this could be sometime after the scene of the incident has been stood down.***
- The Hospital Co-ordination Centre will be aware of and make arrangements for the possible on-going Press & Media interest, and visits from VIP's in the period shortly after the incident, this will be in conjunction with Gold.
- The following email addresses should be utilised as the central point for collation of email information in and out of the Co-ordination Centre***. It is imperative that emails are centralised as soon as possible.***
- During the live phase of a major incident all email correspondence pertaining to the incident must go through the Co-ordination Centre email address and ***must not be sent to named individuals***. This is vitally important to retain information centrally and retain control of the response. All non-major incident email traffic

should be kept to an absolute minimum. Assigned administration staff will be required to collate and retain all information regarding the incident.

The Morriston Hospital Co-ordination Centre e mail address is: -

SBU.MajorIncidentMorr@wales.nhs.uk

Hospital Co-Ordination Centre	E-Mail Address
SBUHB Headquarters	SBU.MajorIncidentHQ@wales.nhs.uk
Tempest Ward, Burns Centre	Burns.Incident@wales.nhs.uk

1.11. Information Links/Communication

Overall co-ordination at the scene of the incident will be by the Police.

The Police, Ambulance and Fire Services will establish Control vehicles and radio links at the scene of the incident. Radio links will be established to the hospital via Ambulance Control to the Emergency Department. Information from the scene will be conveyed to ED and the Co-ordination Centre.

Information collation, reporting and management during an emergency is critical not only during the response phase but also during recovery. In order to gain a common understanding of the incident, together with joint understanding of the risk, gathering information will be at the heart of joint decision-making principles. The emergency services will collate information as a standardised briefing, termed METHANE as noted. This provides a shared situational awareness of the incident from the scene, through the acute hospital services and into community/primary care if required. This can help to manage the live event as well as the subsequent debriefing.

Initial and subsequent receipt of information should be logged sequentially using the METHANE format. Regular updates should be provided to the Co-ordination Centre. The assigned Loggist will record key decisions and actions within the designated major incident logbook. All collated information will be required to be placed in order and filed safely, (both digitally and ‘hard copy’ following the incident.

1.11.1. Patient Information

The Emergency Department Office Manager will establish an Information Service in the Emergency Department to collate information for the Police regarding the patients. Responsibilities will include the passing of this information to the Hospital Co-ordination Centre. They will also liaise closely with the relatives’ care centre in the Outpatient Department.

The Police will dispatch a Liaison Officer and Documentation Team, who will be sited in the Police Room in the ED, with two separate telephone lines to provide for detailed liaison with the Casualty Bureau. They will assist Hospital staff in the identification of patients. Each patient on arrival will be assigned a unique identifier based on the major incident packs. The unique identifier will need to remain with the patient for 24 hours. As identification progresses the patients name can be added to the unique identifier but must not replace it until 24 hours post incident. This is in place due to significant issues concerning blood transfusion policies.

A senior staff member identified by the Hospital Co-ordination Centre will collate information on relatives arriving in the Hospital, and provide this information to the Police Hospital Documentation Team, at regular intervals, for onward passage to the Casualty Bureau. They will liaise with the Emergency Department office administrator. All telephone enquiries during the initial phase, regarding patients, will be routed to an information point established by the Co-ordination Centre. Details of all telephone enquiries regarding possible patients involved in the incident should be carefully logged, and given to the Police Liaison Officer or Casualty Bureau as advised linking the unique identifier number with the patients name.

The Police will establish a Casualty Enquiry Bureau at a convenient Police premises and will answer queries from relatives. The Police Media Relations Officer will deal with enquiries from the press and media via a Gold Media Cell (please see section on communications for further information).

The Casualty Enquiry Bureau will normally be at a remote Police Headquarters. The ambulance Triage card which, will be attached to each patient at the scene of the incident will be retained with the patient in ED. Details on casualties; numbers, condition, etc. will be relayed to the Hospital Co-ordination Centre and Police Liaison Officer **only** from the Office Manager in ED, who will establish a Register of casualties and their location.

1.12. Treatment Arrangements

Patients are triaged at the scene of the incident and are re-triaged on arrival at the Emergency Department using the standardised Major Incident Triage Tool (MITT) and use of cruciform labels. Triage will take place in the Emergency Department entrance by a team, consisting of the designated Emergency Department Medical Officer, experienced Emergency Department Nurse, and Emergency Department Clerical Officer. **ALL** Patients will be tagged twice with prepared numbered tags on arrival. Patients will fall into 3 categories: -

- **Seriously Injured (*Priority 1*), requiring lifesaving treatment.**
- **Stretcher Cases Requiring Urgent Treatment (*Priority 2*).**
- **Walking Cases (*Priority 3*).**

NOTE: Those for whom no apparent treatment is required – these patients will still need to be assessed as for Priority 3 patients initially, and their attendance recorded, before being sent home. An Advice Leaflet may be issued as appropriate, in co-ordination with Silver Command.

Children will be treated in the Childrens Emergency Unit (CEU) in ED.

In addition to the three Priority categories above, if the situation is such that the resources available to treat seriously injured casualties is overwhelmed, the ED Consultant may decide to implement an:

- **Expectant (Priority 4)** category for casualties whose injuries are so severe that they either cannot survive in the circumstances or would require so much input from limited resources available that their treatment would seriously compromise the treatment and survival of large numbers of other seriously injured casualties.
- However, patients falling into this category must be assessed by another Consultant as a minimum to confirm the decision, and instigate comforting treatment such as analgesia etc. The category has, as yet not been utilised in any civilian major incident in the UK.

The Nurse-in-charge of ED will ensure support for the medical staff and direct patients to various pre-designated treatment areas as part of their responsibility for co-ordinating and supervising all activity in the Emergency Department.

Whilst some major incidents can produce a proportion of different injury patterns, such as lacerations, fractures and organ damage; there are other incidents that can produce an exceptionally high number of specific types of injuries, such as burns, and crush injuries with asphyxia.

Morriston Hospital is the site for the Welsh Burns & Plastic Surgery Centre as well as a number of other regional surgical specialties. Any incident involving a large number of burn patients will invoke the SBUHB Burns Major Incident procedure, which will involve activation also of the Morrison Hospital Major Incident procedure, if Morriston Hospital is the receiving ED. Key action cards will be activated only if Morriston Hospital is not the receiving ED. Patients may be conveyed from any incident within South and Mid Wales, as well as from the Southwest of the UK, after stabilisation at a local Emergency Department.

In summary should such an incident occur within the catchment area of SBUHB Hospitals, the Morriston Major Incident procedure and the Burns Major Incident procedure will be invoked.

Morriston Hospital is also a designated hospital for the receipt of patients from any chemical or radioactivity incident in the area. There are separate procedures to deal with Chemical and Radioactivity Incidents; SBUHB Contaminated Casualties Procedure and SBUHB Distribution of Countermeasures Procedure. These may involve the implementation of the Major Incident Procedure and Burns Major Incident procedure also, dependent on the circumstances.

1.13. Transport Arrangements

In the event of a declared major incident by WAST, Non-Emergency Patient Transport Services (NEPTS) will be made available to health boards for inter hospital transfers. Discussions would need to take place between Morriston Silver Command and the WAST Hospital Ambulance Liaison Officer (HALO).

Consideration should also be given to other transport options, these would be explored at the time and include the voluntary sector, taxi and own transportation.

1.14. Patient Documentation

Sets of Major Incident Documents, together with identity bands are kept in the Emergency Department. Each patient will be given a special Major Incident identification including a pre-allocated PAS Number, which will be used during the initial phase, until further details can be obtained, **and** identification ascertained/confirmed by the Patient Identification Team, led by the Medical Records Officer. **This will need to be completed 24 hours post admission.** Only then can patient identification be imported into the system against the major incident allocated PAS numbers and be utilised instead of the Major Incident identifiers

Each patient will have two identity bands attached to different parts of their bodies identifying their individual Major Incident number. When used this number must be copied in full, utilising all digits, including zero.

The card has 2 copies to provide information to the Hospital Co-ordination Centre and ED Records Department on discharge of patient to another Ward or Department in the hospital or to home.

Each Ward should have sufficient sets of hospital notes for any casualties admitted, where normal admission systems will continue to apply. Wards will follow their Action Card. Information on patients discharged or transferred will be recorded on the Major Incident forms kept on each Ward, and this information will be relayed back to the Hospital Co-ordination Centre via a Lead Nurse.

Information on any patient that has been discharged or transferred to create capacity for casualties arising from the incident should be recorded also on the major incident form.

1.15. Children

> ***"Most major incidents involve a proportion of Children and some predominantly involve children".***
>
> **ALS Group, 2002, Major Incident Medical Management & Support 2nd Ed, Page 8, BMJ Publishing.**

The Major Incident response must consider the special needs of children and their families, and family units should be cared for together wherever possible.

In the event of children being involved in a Major Incident both Paediatric Medical and Nursing staff will be informed. The following will be notified:

- **Paediatric Consultant**
- **Paediatric Middle-Grade Doctor**
- **Matron for Children Services at Morriston**
- **Paediatric Nursing**

The Paediatric Team will work in conjunction with the ED Team. The Matron for Paediatrics would similarly be required for advice on child welfare.

Wherever possible, children will be cared for by paediatric trained medical and nursing staff. Every attempt will be made to keep children and their families within the same Hospital. Children will be admitted to Paediatrics, unless they require Paediatric Intensive Care, or Burns care, these children, up to the age of 16 years will require retrieval to PICU at UHW, or Burns care, will be transferred to PAU for general ward care and Oakwood ward for HDU care at Morriston or will be transferred to Bristol. The Paediatric Consultant will liaise with the Wales and West Acute Transport for Children's Service, (WATCh), regarding the possible need for retrieval services. The Paediatric High Dependency Unit on Oakwood Ward may be utilised as a 'safe-haven' pending retrieval, or main theatres depending on capacity of Paediatric HDU. Surge capacity procedures will be implemented.

1.16. Medical Major Incident

A Medical Major Incident could occur from either conventional causes, or terrorist activities; for example, as a result of a severe outbreak of poor weather resulting in hypothermia; an environmental disaster, such as flooding, or a boating incident where large numbers of casualties have to be admitted with hypothermia and other medical problems; or a toxic chemical incident. Additionally, a major outbreak of severe infectious diseases could cause similar difficulties.

In a Medical Major Incident, the Health Board medical services would need to be mobilised to provide assistance in ED. Following discussions with the Hospital Co-ordination Team and Clinical Lead for Medicine, the Medical Teams may need to cancel routine clinics for that particular day, and clear beds to allow for medical major incident admissions. It may be necessary to change Junior Doctors' on-call rotas to provide additional support for the acute emergencies.

If the nature of the Medical Major Incident is of a prolonged nature, (rising tide incident) for example in a chemical leak, severe infectious disease outbreak, and the incident

response could be quite protracted. The Medical Teams may additionally need to provide on-going review for patients requiring longer-term treatment. It is well documented that in the case of chemical incidents it can be difficult to predict the type of on-going medical problems that can evolve. It may be necessary to establish additional Outpatient Clinics to monitor patient's health in the event of such an incident.

An increased threat of Chemical, Biological, Radiation, and Nuclear (CBRN) terrorist attack on the UK has become more predominant over recent years.

1.16.1. Chemical

These devices will contain some form of chemical agent, the effects of which range from causing watery eyes, blistering to the skin through, in the worst-case scenario, to instantaneous death. Examples are CS, Sarin, and Mustard Gas.

1.16.2. Biological

These devices contain some form of biological agent, the effects of this type of device are not immediately apparent as the biological agent may take a number of days or even weeks to incubate in an infected victim. However, the result of exposure and subsequent infection can range from flu-like symptoms through to, in extreme cases, death. Examples are Anthrax, Cholera, and Ebola.

1.16.3. Radiological and Nuclear Incidents

This type of incident may result from a Chemical, Biological, Radiation, and Nuclear (CBRN) terrorist attack such as a "dirty bomb" or result from a non-terrorist incident such as an accident involving transport of radioactive materials.

Radioactive material can harm individuals if: -

- contaminated material is inhaled;
- there is direct contact with a radiation source;
- material is ingested;
- Material is allowed to ingress through cuts and open wounds.

Unlike chemical or biological hazards, radiation resulting from such events is easily measurable and quantifiable.

Radioactively ***contaminated*** casualties are those that have been exposed to contaminated radioactive material. Although such casualties should be decontaminated in the same manner used for chemical incidents, they are highly unlikely to emit radiation that is harmful to rescuers and staff and lifesaving treatment must always take priority over decontamination.

Radioactively irradiated casualties are those that have been exposed to a radioactive source and radiation has passed through them. The irradiated casualty does not re-emit harmful radiation and does not pose a hazard to staff.

Contaminated/ irradiated casualties with injury or requiring treatment will normally be taken to Morriston Hospital Emergency Department. Those with life-threatening injuries will be taken to the nearest Emergency Department. Personnel within Radiation Physics of the Medical Physics and Clinical Engineering Department (MPCE) at Singleton Hospital will provide specialist advice to staff in the event of such an incident. MPCE also contributes to the National Arrangements for Incidents

involving Radioactivity (NAIR) scheme co-ordinated by The UK Health Security Agency (UKHSA) Radiation Emergency Response Group in support of the police and other authorities.

1.17. Staff Reporting for Duty

All staff, called because of a Major Incident being declared, **except those working in the areas identified below** must report their attendance to the Hospital Co-ordination Centre, **they must not phone the Hospital Switch Board. All specialties will confirm their readiness to the Coordination in person or by phone and in accordance with their action cards.**
All staff reporting for duty must wear their identification badge.

- **Emergency Department**
- **Critical Care Units**
- **Burns Centre**
- **Pharmacy**
- **Telephonists**
- **Theatres**
- **Volunteers**
- **Pathology / Mortuary**
- **Radiology**
- **Portering / Security**
- **Catering**
- **Hospital Chaplains**
- **Medical Staff**

Staff from other Health Boards or other specialist health staff must report their attendance at the hospital to the Hospital Co-ordination Centre. Once their identity is verified, they will be issued with a visitor identification badge. It is the responsibility of the person in charge of each clinical or non-clinical department to ensure that the identity of all staff working in that area is confirmed.

1.18. Volunteers

All volunteers (both Hospital and non-hospital volunteers) should report to the designated area; Outpatients and await instructions.

Any potential professional volunteers must be verified by the Hospital Co-ordination Centre prior to their deployment in any clinical area.

1.19. Staff Identification

All staff involved in the Major Incident must ensure that they wear their identification badge. Departmental and Ward Managers must ensure that all people working within their areas are known to them, and are wearing their identification badge.

For security purposes, the Police and/or Security staff may deny access to the Hospital site, unless staff can prove that they are bone fide employees of the Health Board.

1.20. Police

1.20.1. Police Hospital Documentation Team

This Team of Police Officers will be despatched by the Police to ensure that casualty information is forwarded to the Casualty Bureau. They will be located in the Emergency Department. The function of the Team is to:

1.20.2. Casualty Bureau

The Casualty Bureau will be established by the Police, which will provide a central contact and information point for all records and data relating to persons who have, or who are believed to have been, involved in an incident.

It has three fundamental tasks:

- To **obtain** relevant information on the persons involved or potentially involved.
- To **process** that information, and
- To **provide** accurate information to relatives and friends, the Police Investigating Officer, and H.M. Coroner.

The Casualty Bureau may release a single contact telephone number through the media for all enquiries. This should help alleviate the number of calls likely to be received by the Hospital Switchboard, who in turn should direct calls from the public to the Casualty Bureau, once it has been established.

1.20.3. Forensic Evidence

Every Major Incident is treated as a scene of crime, and as such any property/clothing from casualties may be requested by the Police. If such a request is made, the Police Officer taking charge of the property must sign for it, documenting their Police Number, as per SBUHB Property Procedure.

1.21. Documentation

Following any Major Incident there will be at least one, if not more, statutory investigation/Inquiries. These may include Internal Inquiries, Government/Police Inquiries, Coroner's Inquest, and Public Inquiry.

It is important that all actions are recorded, signed, and timed. All documentation, telephone logs, etc. from the Incident response should be kept. Any information/documentation, however trivial it may seem, may be vital as substantiating evidence in any Inquiry.

Each Hospital Co-ordination Centre has a sequentially numbered Emergency Logbook, in which entries must be made on key decisions and actions, including the reasoning behind any decisions.

1.21.1. Archival Process

During a major incident, a wealth of documentation will be generated. Clear documentation, and the archival storage of this documentation, creates a historical record of all the work done in response to a major incident, its impact, affected services, and other key information. Archiving the documentation in a clear and accessible way will also help in resolving similar major incidents in the future.

Post incident all retained documentation (records) must be preserved through best practice archival processes. The records must be made available to the risk & assurance team, who should preserve them in the way which makes them most accessible to the Inquiry. Records can be made available to the risk & assurance team by either sending them a copy, or by giving them access to their digital location e.g., shared drive, SharePoint. Digital records can be transferred at any time, but physical records should only be transferred to the risk & assurance team once they no longer provide active business use.

The risk & assurance team should apply archival processes to the records such as appraisal, arranging, describing, and cataloguing, preserving, and provision of access, so that they can be adequately requested by, and provided to, the Inquiry. **(see Appendix 3.7 – Archival Process Action Card).**

1.22. Signposting

A series of signs are located throughout the acute Hospital site, both internally and externally directing people to appropriate areas.

Security staff or other nominated staff will be based outside the Emergency Department preventing unauthorised entry, and directing the media, relatives, and additional staff accordingly.

1.23. Staff Parking Arrangement

It is important that staff responding to the Hospital drive safely, and park in a safe place and suitable position not to impede the flow of emergency vehicles to, and around, the hospital site. A dedicated staff parking area may be established, and direction will be provided.

1.24. Staff Creche Facilities

There is no organised crèche facility for staff who need to arrange child care on site. (For those who have children in the crèche facilities currently, they may be able to use these facilities within the current hours of opening).

All staff need to consider what they might do in such circumstances. If staff cannot attend immediately, attending at a later stage may be of value. With prolonged incidents relief shifts may be very valuable.

1.25. Family and Friends

Relatives and friends will initially be accommodated in the Main Out Patients Department (OPD). The main point of contact will initially be the Nurse in Charge of OPD and the relatives care team. A member of staff will be identified by OPD who will liaise with the Co-ordination Centre to forward relatives' information, as well as in ED. Hospital Volunteer Staff will be assigned to the area to support relatives.

Information will be required in a language and manner sensitive to their needs.

Caution must be exercised to ensure that members of the media are not allowed access to this area.

1.26. Cultural/Religious Needs

It is highly likely that people from varying cultural and religious backgrounds may be involved in the Incident. The Hospital Chaplains have information and contact details

to access Religious Leaders. It is important to respect religious customs, wherever possible, when dealing with the deceased and bereaved relatives. Interpretation assistance can be accessed via the Clinical Site Management and the Hospital Co-ordination Centre.

1.27. Press and Media

The Press & Media response will be accommodated in the pre-designated area in the Education Centre, directed by the Education Centre staff at the time.

In the first instance, Police will lead on Communications via a Gold Command Warning and Informing Communications cell, which will include the SBU Director of Insight, Communications & Engagement, Communications & Engagement as well as any other relevant agencies.

Once the situation has stabilised and has progressed from the initial phase, press and media inquiries relating to NHS, issues will be managed by the SBU Head of Communications. However, press statements etc. will continue to be shared with other agencies.
The Press & Media response to a major incident must not be under-estimated, both in terms of numbers of reporters, but also in their speed of response. In addition, there is the risk of rogue reporters attempting to gain access to staff, patients or wards.

In the follow-up phase the Head of Communications / Communications Officer will oversee and co-ordinate the activities of the Press & Media; and will issue regular statements to both Press & Media, and relatives, in association with the Health Board Gold and Hospital Co-ordination Centre and Police Press Officer.

The hospital acknowledges the importance of ensuring that accurate and timely information is made available to the general public. However, the immediate priority will be to ensure that information is used to manage available resources in the most effective way, and it may not be possible to provide anything other than basic information (e.g., casualty numbers), until the situation has been fully assessed. This information will be made available from the Hospital Co-ordination Centre.

Further details (e.g. specific injury patterns, etc.) may be provided when the hospital is able to confirm this information, although this will be sensitive to the needs of casualties, relatives and carers. It should be noted that the hospital will not be able to arrange interviews with any operational staff until the situation has been stabilised. The SBU Head of Communications will also be responsible for managing social media.

The Hospital Co-ordination Centre will be aware of, and make arrangements for the possible on-going Press & Media interest, together with visits from VIPs in the period shortly after the incident and this will be in conjunction with Gold.

If any Organisation/agency involved in the incident management response require special accommodation to be established during their involvement with the Health Board response, this will be arranged by the Hospital Co-ordination Team following discussion.

1.28. Dealing with the Deceased

For those patients who die at the Incident site, the relevant HM Coroner and Police may establish a Temporary Mortuary. The identified sites in South Wales currently are in the Cardiff, Swansea and Carmarthenshire areas. The organisational and management arrangements for these are the responsibility of the Police and Local Authority, although NHS assistance may be required, such as the provision of radiographic staff support.

For those patients who die en-route to hospital, or following arrival, they will initially be placed in the Hospital Mortuary, **after** appropriate documentation, before being transported to the Temporary Mortuary if established. The Facilities staff will be responsible for allocating a Security Guard to prevent unauthorised access to the Hospital Mortuary. Further temporary facilities will be arranged through the Police.

As is usual practice in such circumstances, it is essential that any casualties who die in Hospital are carefully labelled and secured in body bags before being transported to the Mortuary facilities. Any property must be left intact with the body and kept as forensic evidence for the Police. Relatives of the deceased will be cared for in the relatives' care centre and in close liaison with the Police, Silver Command and the ED. Bereavement care teams may be required.

1.29. Safeguarding

Any child / vulnerable adult triaged as uninjured and evacuated from the Major Incident site may initially be taken to a rest centre / place of safety facilitated by the Local Authority until such time as the Police Family Liaison Officers are able to verify Next of Kin and reunite the family.

However, within the Hospital, child / vulnerable adult safeguarding issues must be considered in line with Health Board Policy. Therefore, an interim place of safety will be required for this group until the Next of Kin are identified by the Police.

1.30. Recovery

A recovery team will be required at an early stage and will be co-ordinated under the direction of the Chief Operating Officer and will be assigned as part of the major incident response.

The primary role is to ensure that planning begins at an early stage to bring the organisation back to normal operating status as quickly as possible. Some key objectives include; undertaking of an impact assessment of the disruption of service, address key operational risks and longer-term recovery and business continuity.

1.31. Emergency Admissions not associated with the Major Incident

In the event of declared major incident, where possible, Singleton Hospital and Neath Port Talbot Hospitals will support with inter-hospital transfers of clinically optimised inpatients as appropriate.

Surgical emergency patients will continue to be received by Morriston Hospital with support from neighbouring hospitals where possible. In addition, consideration will be given to the diversion of the surgical take to a neighbouring Health Board. This will be a strategic decision.

It may be possible to delay or stagger admissions via the GP's and Primary and Community Care will be part of the major incident response in supporting the emergency response. Prioritisation and staggering of acute admissions will require Silver and Gold Command discussions.

All such decisions will require a risk assessment and approval by the Executive Team, (Gold response).

1.32. Staff Welfare during Incident Response

During a major incident, staff will be required to respond to incidents for considerable periods of time and arrangements must be made for:

- Staff replacement
- Rest periods
- Provision of refreshments
- Provision to contact their immediate family members

1.33. Psychological Support

Following a major incident which was exceptionally threatening or catastrophic, it is to be expected that many people will develop short-term symptoms of psychological adjustment. Mental Health and Learning Disability Unit Staff have provided front line response staff (Ecumenical Chaplaincy Management, Volunteer Services Manager, Hospital Social Work Team Manager and Relatives Area) with information leaflets for patients (children and adults) who have been involved in a major incident. These leaflets outline what to expect, coping strategies, and advice on when to seek further help. These leaflets are embedded in this major incident plan at section 5 & will be made available by the Mental Health & Learning Disability senior manager at the time of the incident, as per action card 80.

Psychologically focussed debriefing is not recommended in the current Post Traumatic Stress Disorder (PTSD) NICE Guidelines and should not be offered.

It is not anticipated that mental health staff will become directly involved in offering responses to disaster survivors immediately following the incident.

People at high risk of developing PTSD after a major disaster should be offered a validated, brief screening instrument for PTSD at 1 month after the disaster.

Adult trauma survivors with clinically important symptoms of PTSD (re-experiencing, flashbacks, nightmares, and avoidance, and hyper arousal, negative alterations in mood or thinking) will be recommended to speak to their general practitioner and seek assessment from LPMHSS (Local Primary Mental Health Support Services). Survivors with significant risk because of their symptoms should be referred to Mental Health Single Point of Access (SPOA) for mental health triage assessment.

Adult trauma survivors, or their families/carers may also dial 111, then select option 2 to directly access urgent support for their mental health. This service is available 24/7 and will provide immediate support, signposting to community resources and onward referral to mental health services as appropriate.

Child trauma survivors will be assessed by school counsellors or Primary CAMHS and potentially passed onto Specialist CAMHS services if needs are complex.

Following a major incident, the MH and LD Manager will inform the Chair and Vice Chair of the PTMC (Psychological Therapies Management Committee), and an emergency meeting will be convened within one week to ensure that an adequate response in relation to both public and staff psychological needs has been provided.

Traumatic events affecting people in the workplace occur fairly infrequently. When they do occur, they are usually initially accompanied by a sense of shock. However, for some people there can be a more lasting effect. To Ensure that staff are well supported, managers are advised to follow the Trauma Risk Management (Trim) processes highlighted below.

1.33.1. Trauma Risk Management (TRIM)

The Trim model bases itself on keeping staff functioning after traumatic events by providing support and education. Trim is a 'NICE (UK's National Institute for Clinical Excellence) compliant' model of peer group traumatic stress management.

The types of traumatic events where a Trim response might be initiated are as follows:

- Serious injury to self and others particularly colleagues
- Where personnel have been disabled or disfigured
- The trauma involves death, particularly grotesque death
- When the trauma is complex, long lasting, or multiple
- Where personnel have been involved in a "near miss"
- Where personnel experience overwhelming distress after the event
- situations where the mistreatment, death or injury of the following occurs: children, women, elderly people, disabled people, and colleagues.

There are a number of people across the health board trained in the following roles: Trim Manager, Trim Practitioner and Trim Supporter.

Following a traumatic event, within 24 hours (ideally as soon after the event as possible) a planning meeting will be organised by the Trim Manager. It is during this meeting that the Trim Manger would undertake a Trim Incident Brief (TIB) where a general overview of the psychological effects of a traumatic incident on people is given. The main focus of the planning meeting is therefore to consider the psychological needs of trauma exposed staff and the purpose of the meeting is 3-fold:

- To educate staff about the Trim process and ensure that staff receive the highest quality management at a time when they may be vulnerable to psychological injury.
- To exchange information. Trim is a supportive protocol that aims to enhance the benefits of the informal support processes that naturally happen following a traumatic event. The next stage is to consider whether it is appropriate to instigate individual or group Trim risk assessment interviews to assess the risk of psychological harm or those who might be at risk of developing psychological difficulties, or to carry out psycho-educational briefings as

appropriate. If after a planning meeting, no action is deemed necessary then the Trim Manager would record the reason for this decision, for both legal and audit purposes.

- To assist Operational Managers. Trim Managers are ideally placed throughout the health board to assist with the management of distressed people. Trim is based upon 'best evidence' and therefore managers should be reassured that using the process is best practice.

If required, group or individual assessments would be carried out a minimum of 72 hours after the incident. The purpose of the Trim interview is not to directly eliminate or 'treat' mental health difficulties. It aims to allow the interviewer to identify those who may be at risk of developing psychological problems so that they can be monitored and appropriately managed.

A follow up risk assessment is carried out after a month and if indicated, people are sign-posted to further help and support as appropriate.

1.33.2. Welsh Government Community Advice and Listening Line

A Community Advice and Listening line, (C.A.L.L) is offered which provides emotional support and information/literature on mental health and related matters to the people of Wales. Free phone 0800 132 737 or text call 60062: - **http://www.callhelpline.org.uk/**

1.34. Debriefing

Following a major incident, a hot debrief is always required. Hot debriefs must take place with staff involved following the stand down notification and will be undertaken utilising the format of staff providing information as to what went well, what did not go so well and what could be learnt for future improvement in the response.

A significant major incident will require a structured debrief. This is to ensure learning points are identified, analysed, acted upon and if deemed necessary incorporated into the organisations response arrangements. The sharing of good practice reduces the risk of incidents re-occurring and their impact. A structured debrief for the Health Board will be organised by the Emergency Preparedness Resilience and Response Team. The Health Board may also be required to participate in a multi-agency debrief.

Following a structured debrief a post incident report will be collated, internal to the Health Board. The incident report will be shared with the Emergency Preparedness Resilience and Response Strategy Group. Lessons to be learned will be recorded and progress monitored.

1.35. South Wales Major Trauma Network

Major trauma refers to multiple and serious injuries. It is the leading cause of death in people under the age of 45 and a significant cause of disability or poor health.

Patients with these types of injuries will have a better chance of survival if they are treated within a major trauma network. As well as saving lives, the network will improve patient outcomes by preventing avoidable disability, returning more patients to their families, to work and to education.

The South Wales Trauma Network covers South Wales, West Wales and South Powys and consists of 1 major trauma centre at UHW in Cardiff, a trauma unit with specialist services in Morriston hospital, Swansea, along with 4 other trauma units, 2 rural trauma facilities and 1 local emergency hospital. The network works closely with prehospital providers to ensure patients are cared for in the most appropriate facility to meet their needs.

The major incident response articulated within this procedure includes the provision of the South Wales Major Trauma Network.

Section 2. Action Cards

2.1. Principles

Action cards have been prepared for all key personnel and departments. These are held by those concerned, whose responsibility it is to have them available at all times.

Action cards form part of the Major Incident Procedure for the Swansea Bay University Health Board. Copies are held on the Health Board intranet site and hospital Co-ordination Centres.

Due to the additional requirements associated with responding to a major incident the Hospital Co-ordination Centre will be established at Morriston Hospital and will be the lead Silver, (Tactical) command to the incident.

Singleton and Neath Port Talbot hospitals will also convene Silver Command as supporting hospitals but will need to liaise closely with Morriston Silver Command.

It is the responsibility of individual Directorates/Departments to ensure that their Action Cards are kept as up to date as possible and that they reflect any service changes or management re-organisations; for maintaining staff call-out lists which must be updated every 3 months; having further Departmental/Ward operational procedures; and for ensuring staff are aware of their responsibilities in such an event.

Any amendments to individual Action Cards should be notified to the Head of Emergency Preparedness Resilience and Response, SBUHB.

Note:

Staff are advised that when contacted, they must not ring back to the hospital switchboards to re-check the message, but are to attend the relevant hospital as soon as possible, and report, (in person or via phone as noted in the actions cards) to the Hospital Co-ordination Centre, unless otherwise stated (i.e., Emergency Department and Critical Care areas only). HCC Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)

2.2. Hospital Switchboard Team

2.2.1. Hospital Telephonist. Action Card 01

HOSPITAL TELEPHONIST (Morriston)	**ACTION CARD 01**

Notification will be received by the Hospital Switchboard at Morriston Hospital (on pre-determined ex-directory telephone number), which will normally be from the Ambulance Service; but also, in certain circumstances, may arise initially from the Police, Fire Service, HM Coastguard or the Emergency Department or a Senior Manager within the Health Board.

The Switchboard Notification Procedure could include the below processes: -

- Activation of the F24 system – Standby/Declared outside of SBUHB area
- Activation of the F24/Cisco Systems – Declared in SBUHB area
- Manual phone calls – Consultants, via the on-call rota

(a) Stand-by Procedure

In the event of a potential Major Incident situation, or where another Hospital is dealing with a Major Incident, and SBU Health Board have been asked to be prepared to assist:

The alerting message must go to the main Hospital switchboard, and will be: -

> This is the Welsh Ambulance Service. The Trust has declared a Major Incident Standby in the following Health Board area - ####. The incident location is: ####.
>
> The information is as follows:
>
> Major Incident Standby
> Exact Location: ####
> Type of Incident: ####
> Hazards: ####
> Access: ####
> Number of Patients: ####
> Emergency Services Required or Present: ####
>
> All Health Boards and partner Health agencies in Wales have been sent this notification.
>
> Do not contact the Welsh Ambulance Service, refer to your organisation's major incident plan. Please await further information.

Note: A Standby Incident will subsequently be cancelled or become Declared.

(b) Major Incident Declared

For a **"Declared Major Incident from WAST**", the alerting message will be: -

This is the Welsh Ambulance Service. The Trust has declared a Major Incident in the following Health Board area - **####**. The incident location is: **####**

The information is as follows:

Major Incident Declared
Exact Location: ###
Type of Incident: ###
Hazards: ###
Access: ###
Number of Patients: ###
Emergency Services Required or Present: ###

All Health Boards and partner Health agencies in Wales have been sent this notification.

Do not contact the Welsh Ambulance Service, refer to your organisation's major incident plan. Please await further information

All Health Boards in Wales will receive the same information.

(c) Stand Down Procedure.

On receiving the message from the Ambulance Incident Commander, Ambulance Control will notify the following message to the ED, who will inform the Hospital Co-ordination Centre: -

This is the Welsh Ambulance Service. The Trust has declared a Major Incident in the following Health Board area - ####. The incident location is: ####

The information is as follows:

Major Incident Stand Down
Exact Location: ###
Type of Incident: ###
Hazards: ###
Access: ###
Number of Patients: ###
Emergency Services Required or Present: ###

All Health Boards and partner Health agencies in Wales have been sent this notification.

Do not contact the Welsh Ambulance Service, refer to your organisation's major incident plan. Please await further information

The Hospital will be informed of any casualties already end-route when this message is given.

N.B. It is likely that the hospital stand-down will not be given for some time after the scene stand-down, and will be issued from the Hospital Co-ordination Centre, which will in turn be cascaded to relevant staff through the Hospital Switchboard

HOSPITAL TELEPHONIST (Morriston Hospital)		**ACTION CARD 01**
ROLE		
	• **Notification could be internal and/or via external partners** • **Accept the call and verify its authenticity, recording key information as outlined in the METHANE log.** • Notify key staff as quickly as possible, maintaining a log of staff that have responded.	
ACTION - As soon as a Major Incident call notification is received, the Hospital Telephonist should:		***Tick when completed***
1.	Obtain the caller details and log as much information as is available using the METHANE template in Log1 below.	❑
2.	Ascertain if the incident is a stand-by; a Declared Major Incident and which health board area; or an Incident implemented by the Emergency Department.	❑
3.	Call back to verify the information**.**	❑
4.	**Standby/Declared outside of SBUHB area** – As soon as information is received activate the F24 MI standby group and phone to inform: • Nurse in charge ED • ED Consultant • Site Matron	❑

HOSPITAL TELEPHONIST (Morriston Hospital)		ACTION CARD 01
ROLE		
	• **Notification could be internal and/or via external partners** • **Accept the call and verify its authenticity, recording key information as outlined in the METHANE log.** • Notify key staff as quickly as possible, maintaining a log of staff that have responded.	
5.	**Declared Major Incident (SBUHB area)** - As soon as information is received activate the F24 MI declared group, Cisco broadcast and make manual phone calls to: • Consultants on call group ➢ Anaesthetics consultant ➢ ICU consultant ➢ General Surgery consultant ➢ Vascular consultant ➢ Urology consultant ➢ T&O consultant ➢ Plastic consultant ➢ Maxillofacial consultant ➢ ENT consultant ➢ Paediatric consultant ➢ Cardio Thoracic consultant • Singleton switchboard to inform them and ask them to contact the Obstetrics & Gynaecology and Ophthalmology Consultant Consider transferring non-major incident telephone activity to Singleton Switchboard, where appropriate and possible	
6.	**Implementation of the Hospital Major Incident Procedure** – Prior to the formal declaration of a Major Incident, or where there is a serious incident, which does not result in such a declaration of a Major Incident, but where there are many casualties, and the Emergency Department is under severe pressure, the Senior Doctor and/or Nurse in charge of the ED may request the MI standby core team to be established (F24 standby group).	❑
7.	**Burns Major Incident** – As soon as information is received of a Burns Major Incident, that is outside of the **SBUHB area**, implement the F24 MI Standby group & Burns MI group and make manual phone calls to: • Consultant Burns Surgeon • Consultant Plastic Surgeon • General Consultant Anaesthetist	❑

HOSPITAL TELEPHONIST (Morriston Hospital)		ACTION CARD 01
ROLE		
	• **Notification could be internal and/or via external partners** • **Accept the call and verify its authenticity, recording key information as outlined in the METHANE log.** • Notify key staff as quickly as possible, maintaining a log of staff that have responded.	
	• Consultant General Surgeon • Consultant Trauma & Orthopaedic Surgeon • OOH Consultant Paediatrician For a major incident declaration or where it is a known Burns major incident <u>within</u> the **SBUHB area**, activate the F24 MI Declared group and confirm with Silver Command whether to also activate the separate F24 Burns MI group.	
8.	If a 'stand-down' from the Scene is issued by Ambulance Service, relay this **only** to Gold Command and Morriston Silver Command. The Silver Commander from the Hospital Co-ordination Centre will issue the Hospital stand-down, which might be sometime after that is issued from the Scene and with confirmation from Gold.	❑
9.	When informed by the Hospital Co-ordination Centre of the Hospital 'Stand-down', follow the below in & out of hours communication mechanism: **In hours (09:00 – 17:00 hrs):** Activate the F24 MI stand down group **Out of hours (17:00 – 09:00 hrs):** The F24 system will not be used for a stand down notification. Silver Command will decide on the appropriate stand down mechanism.	❑

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.

- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.3. MAJOR INCIDENT. SWITCHBOARD (Log 1)

Person receiving call	
Name & signature	
Date	
Exact time of call	

Person making call	
Name	
Title/Organisation	
Phone number	

M	Major Incident declared or standby?	
E	Exact location	
T	Type of incident e.g., RTC, explosion, fire, building collapse, rail, air/plane, sea, multiple burns	
H	Hazards, present and potential e.g., any decontamination issues – chemicals, radioactivity, explosion risk, other risks	
A	Access and egress e.g., any roads to the hospital obstructed	
N	Numbers and types of casualties expected e.g., severity and type of injuries expected, Any children expected?	
E	Emergency Services present and require E.g., any speciality teams required, e.g., MERIT?	

RECALL TO CONFIRM & VERIFY INFORMATION: -

WELSH AMBULANCE	POLICE	MID & WEST FIRE
Central & West Ambulance Control – (Carmarthen) (01267) 245777	South Wales Police – Swansea - 101 Critical Incident - 01656 869238	Carmarthen Control Room – (01267) 237195 / 222044
Southeast Ambulance. Control – (Newport) (01633) 294866	South Wales Police – Bridgend (01656) 655555 or 101	**H.M. COASTGUARD**
	Dyfed - Powys Police – Carmarthen (01267) 222020 or 101	Coastguard Emergency Control- Swansea (01792)366534

2.4. Emergency Department Team

2.4.1. ED Staff Receiving Initial Call. Action Card 02

EMERGENCY DEPARTMENT STAFF RECEIVING INITIAL CALL ACTION CARD 02	
ROLE SUMMARY	
Notification of a Major Incident standby will be received from the Hospital Switchboard, WAST or the HCC. Notification of a Declared Major Incident will be received from the Hospital Switchboard or WAST. **Please note: the HB will only automatically declare and activate the HB MI procedures if the MI is within the SBUHB area.**	
• Receive initial phone call concerning **Standby or Declared Major Incident** • Alert nurse in charge and senior ED doctor in the department	
ACTION:-	***Tick when completed***
1. On receipt of call from the Hospital Telephonist, or from the Ambulance Service, the person receiving the call should refer to and complete the METHANE report. • Contact name, title, and telephone number of informant • Major Incident declared or standby- • Exact location and time of incident • Type of incident (e.g., explosion, RTC, building collapse) • Hazards (e.g., chemicals/ radioactive exposures) • Access issues (closed motorways/ roads) • Number of casualties estimated and severity/ type • Estimated time of arrival	
2. Verify information with SBU Morriston ED Major Incident Alert e-mail, Ambulance Control and Hospital Switchboard. This information should be recorded on the METHANE Form.	
3. Person receiving the call should then **immediately** inform the Nurse-in-Charge of the Emergency Department and the most senior ED Doctor in the department.	
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6. ED Nurse in Charge. Action Card 03

EMERGENCY DEPARTMENT NURSE IN CHARGE	**ACTION CARD 03**
Nurse Co-ordinator	
ROLE SUMMARY	

Notification of a Standby or Declared Major Incident will be received from either the ED initial staff receiving call (action card 1), Hospital Switchboard, WAST or via the HCC.

Please note, if a mass casualty incident is declared, in addition to the Health Board Major Incident response, please also refer to the Mass Casualty Arrangements for NHS Wales, where further actions will be required, see section 4.

Section 4.9 - WAST Mass Casualty Interim Reporting dashboard action card, enables WAST to provide casualty information and estimated arrival times to receiving hospitals.

Your role is to:

- Alert other key Emergency Department staff
- Responsible, as the Nurse Co-ordinator in conjunction with the ED Consultant, (Medical Co-ordinator) for organising and co-ordinating the activities of the ED to deal with the Incident
- Organise the reception, assessment and initial management of patients arising from the Incident

ACTION: -	***Tick when completed***
1. **Standby or declared incident (outside of SBUHB area)** – As soon as information is received in the ED: - • Immediately inform the senior ED doctor in the department • Inform the ED Consultant if not in the department • Inform the ED Lead Nurse • Assess capacity and staffing levels within the ED • Start to plan for the next stage, but await further instructions before implementation • Inform MIU if out of hours as they will need to plan to vacate this area if required. • Attend the HCC (Silver command) as part of the MI standby core team	❑
2. **Declared Incident (SBUHB area)** - As soon as information is received in the ED of a declared Major Incident: - ☐ Immediately inform the senior ED doctor in the department ☐ Inform the ED Consultant if not in the department ☐ Inform the ED Matron ☐ Inform the ED Lead Nurse ☐ Allocate Triage Nurse team	❑

- ☐ Inform switchboard
- ☐ Inform ED reception
- ☐ Inform ENP'S who are working in Minor Injury Department
- ☐ Inform all ED staff in all areas, inclusive of minor injuries and

  allied health practitioners

- ☐ To support the Welsh Ambulance Service NHS Trust (WAST) in their response to a major incident, the below approach to the release of ambulances from emergency departments, at the declaration of an incident needs to be achieved by the NIC & DIC, with the support of Silver command:

  • 50% of vehicles released within 10 minutes

  • 75% of vehicles released within 20 minutes

  • 100% of vehicles released within 30 minutes

Declared Major Incident (outside of SBUHB area) - implement the **Stand-by Procedure** as noted above in action 1.

Please note: Stand Down Notification should be under the instruction of the Hospital Co-ordination Centre. The Health Board will be informed when there is scene stand down, but this must not be confused with Hospital Stand down. Any notification for this should be re-confirmed with the Co-ordination Centre and communicated within the department appropriately.

3. **Triage team**

eploy an experienced ED Nurse to the ambulance entrance to tiate Major Incident Triage of all arriving patients from now on, cluding non-major incident patients that present)

= **Action Card 03.1** ❑

nsure the Major Incident Cupboard is accessible for patient packs
) receptionist will join the triage team as soon as possible.
senior doctor will join the triage team as soon as staffing permits.
efer to the major incident clinical guidelines:

https://www.england.nhs.uk/ourwork/eprr/major-incidents/

EMERGENCY DEPARTMENT NURSE IN CHARGE Nurse Co-ordinator ROLE SUMMARY	ACTION CARD 03
4. **Prepare ED staff and allocate action cards – (see flow chart for ED areas). Please note, Paediatric ED will be for paediatric major incident patients.** • Undertake a briefing for all ED staff, (Nursing, Medical, Clerical, Porters, and Allied Health Professionals) of the current situation. Ensure ED Radiology have been informed. • Allocate Tabards and action cards • In conjunction with the Consultant in Charge, allocate a coordinator to the Education Hub to coordinate additional arriving staff. (Their attendance and allocation should be recorded) • Confirm with the Coordination Centre the point of contact • Wear Black Tabard • Deploy staff to treatment teams in the clinical areas, including paediatrics and add the additional names to the allocation board. • Major Incident signage will be erected by Porters. • The decontamination room must be ready to receive contaminated patients who have not been decontaminated at the scene. **Allocation of areas may be changed at the time and dependent on the nature of the incident; to be discussed in conjunction with the Doctor in Charge.**	❑
5. **Staffing** ☐ Assess capacity and staffing levels within the ED ☐ **Allocate** a member of reception staff to monitor ED responses via the F24 system.	❑
6. **Clear the department** **Allocate** staff to clear the department: ☐ Move existing major's patients in the ED to appropriate wards using the pre-emptive protocol; acquire additional trolleys for this purpose, ensure it is logged. ☐ Divert minors to their own GP's or other hospitals, as appropriate. Do not announce major incident via the Annoy system.	❑

☐ Make an appropriate announcement to patients in the waiting room advising them to attend another hospital where possible.	
7. **Lock down** ☐ Liaise with Reception to ensure the walking cases entrance has been closed. All patients should enter the department through the ambulance entrance via the triage team. ☐ Ensure signage has been deployed within ED in accordance with ED lockdown Procedure ☐ Liaise with porters/ security to ensure the department has been locked down	❑
8. **Personal Log** Commence a personal log of events, to assist with preparation of reports and investigations later. **Allocate a staff member to be a point of contact by phone and ensure the Co-ordination Centre and Pathology are aware. In conjunction with ED Reception, allocate a Loggist to log all key decisions and actions from within the ED.**	❑
9. **Organise and co-ordinate the activities of the ED** • Work closely with the ED Consultant in charge to maintain an overview of the department. • Do not become engrossed in the clinical management of any one patient. • Major incident patients discharged from ED will need to be transferred to main OPD to be re-united with friends and relatives. • Liaise with the nominated person within the ED Control Point; Jubilee Suite when additional staff arrive.	❑
10. **Liaise with Major Incident Co-ordination Centre located on ground floor** Liaise closely with the Silver Command in the Hospital Co-ordination Centre (Hospital Coordination Centre Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532904 – Ext 32904 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) regarding the	❑

EMERGENCY DEPARTMENT NURSE IN CHARGE Nurse Co-ordinator ROLE SUMMARY	ACTION CARD 03
on-going situation in the ED. Details of current patients will **only** be issued to the Hospital Co-ordination Centre by the ED Reception Manager to reduce the possibility for confusion.	
11. Liaise with the Nurse in Charge of the Minor Injuries Unit, Neath Port Talbot Hospital; to keep them informed of the on-going situation in the ED at Morriston.	❑
12. Channel requests for additional equipment, re-stocking, and staff via the Hospital Co-ordination Centre.	❑
13. Maintain close liaison with the relatives (via OPD, you will be informed who will be the point of contact).	❑
14. Major Incident patients will be admitted via the Surgical Assessment Unit and Paediatrics PAU unless the patients is transferred directly to theatre or critical care areas.	❑
15. Liaise with the Medical Co-ordinator following stand down notification in order to undertake a hot debrief with staff within ED. A formal debrief will be organised post major incident.	❑
16. Assign a lead to co-ordinate staff welfare provision in accordance with the major incident procedure and Health Board procedure.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times

- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.1. ED – Triage Nurse. Action Card 3.1

EMERGENCY DEPARTMENT - TRIAGE NURSES **Notified by ED Consultant or ED Nurse in charge**	**ACTION CARD 3.1**
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge	
• Triage Nurses are required at Ambulance Entrance and secondary triage for P3 patients, (within walking wounded triage room). • Form Triage Team at ambulance entrance. Ensure an ED Doctor is allocated to Triage also. • ***Undertake MITT for*** ALL arriving patients • Send patients to P1, P2 or P3 and paediatric areas as appropriate	
ACTION:-	***Tick when completed***
1. **Prepare Triage area** ☐ Open major incident cupboard ☐ Move major incident trolley to triage area in ambulance corridor (next to red wall chart) ☐ Wear Blue major incident tabard ☐ Ensure you have equipment to check observations of patients ☐ Ensure you are familiar with triage sort process (on clipboards on major incident trolley)	❑
2. **Patients arriving** ALL arriving patients (including those not part of the major incident) should be triaged using the same process. Triaged patients to be sent to P1, P2, P3 and CEU, some P3 patients may require secondary triage and should be directed to walking wounded triage. Ensure there is a triage nurse present in this area. If a triaged patient requires isolated care due to security reasons, allocate an area at the time. Contaminated casualties should be triaged via the decontamination room entrance and only when appropriate PPE is worn. Patients with minor complaints from the major incident should be told they should wait to be seen/ registered as the police will also likely need to speak to them and direct them to P3 minor injuries unit. Patients NOT part of the major incident with minor complaints only should be advised to attend their GP/ other hospital as appropriate	❑

EMERGENCY DEPARTMENT - TRIAGE NURSES	ACTION CARD 3.1
Notified by ED Consultant or ED Nurse in charge	

ROLE SUMMARY

3. **MITT - ALL tasks must be completed for every patient.**

The ED receptionist will join the triage team and assist with the following documentation aspects ASAP.

- ☐ Allocate a Major Incident patient pack to each arriving patient
- ☐ Apply **two** identity bands from the pack to the patient
- ☐ Enter time and date on the cash card (sticker on cash card)
- ☐ Record BP, GCS, and RR on the cash card
- ☐ Use this to calculate a triage category- P1, P2 or P3 (there is a sticker on cash card to record the category). Ensure the pre-hospital cruciform card remains with the patient ❑
- ☐ Enter a very brief triage note about presenting injury (e.g., "right leg injury" or "head injury")
- ☐ Add an addressograph to the '**Major Incident Patient List'** and tick P1, P2 or P3 category.

A senior ED doctor will join the triage team and assist as soon as staffing permits

Refer to the major incident clinical guidelines:

https://www.england.nhs.uk/ourwork/eprr/major-incidents/

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but cannot replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.2. ED – Staff Call Out. Action Card 3.2

EMERGENCY DEPARTMENT - ED STAFF CALL OUT ACTION CARD 3.2	
RECEPTION ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge. Your role is to:	
• Present to the NIC & DIC to assess the staff requirements. • Monitor ED responses via the F24 system. • Liaise with the nurse and doctor in charge with updates.	
ACTION:-	***Tick when completed***
1. **Assess staff required** • Liaise with the nurse and doctor in charge to assess what nursing and medical staff required. • Assess numbers of required additional administration staff to assist with booking in patients and additional areas. • Familiarise yourself with/ copy of the METHANE report received. • Ensure you ask about any possible access issues/ road disruption that may affect staff coming in.	❑
2. **Initiate phone call out** • After the message has been sent to all staff, check F24 system for staff availability. • Follow up with a manual phone call to all staff who had answered yes on the system using numbers for doctors and nurses in sister's office and administration staff numbers in reception office. • Bear in mind previous and next shift changes before call if possible. • Keep phone calls brief- do not enter into conversation about details of the incident/ status of the department- keep the line free for other staff to call back.	❑
3. **Record response and provide instruction** • Tick off staff members that you have attempted to contact. • Tick off staff members who have been contacted. • Tick off staff members who are coming in and ETA.	❑

EMERGENCY DEPARTMENT - ED STAFF CALL OUT ACTION CARD 3.2
RECEPTION ROLE SUMMARY
• Record if staff are unable to attend now (e.g., due to alcohol/ child care) and plan for them to come in to relieve current staff later when appropriate. Record this. • Provide instructions regarding any access/ road issues caused by the incident. • Once enough staff have responded to cover current shift inform further staff members, they should cover subsequent/ later shifts as appropriate. Arriving staff to meet in educational hub/sisters office. • Ensure you wear a valid HB identity badge at all times
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.**

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.3. ED Nurse P1 Area. Action Card 3.3

EMERGENCY DEPARTMENT - NURSE P1 AREA- RED **Notified by ED Consultant or ED Nurse in charge.**	**ACTION CARD 3.3**
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge.	
• Manage P1 area (rhesus +/- trolley bays 7,6,5 as needed) with the P1 doctor • React will be used for reacted P2's as appropriate at the time • Assess and manage arriving patients • Supervise other staff allocated to P1 area • Liaise with Nurse in charge to request additional staff/ resources when needed	
ACTION:-	***Tick when completed***
1. Wear Red Tabard and ensure staff in P1 area know you (and the P1 doctor) are in charge of that area. All queries/ requests from that area should be channelled through you. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
2. **Clear P1 area** • Assess patients already in P1 area (resus) • Triage Sort any patients not yet seen and send them to the appropriate area in accordance with their triage sort with their existing cash card/ documentation. • Send patients already assessed to other areas (e.g., ICU/ recovery/ ward) as appropriate and safe. • Remember patients already in rhesus may be more unwell than the major incident patients. • Retain a log of patients arriving and patient transfers; note MI number, time, destination	❑
3. **Treatment Teams** • Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including ward staff such as surgical and ICU). • Assess and treat arriving patients with treatment teams.	❑

EMERGENCY DEPARTMENT - NURSE P1 AREA- RED	**ACTION CARD 3.3**
Notified by ED Consultant or ED Nurse in charge.	
ROLE SUMMARY	
• Supervise staff in the P1 area • Prioritise cases for scanning/ theatre/ ICU as needed • Ensure individual patient major incident packs remain with the patient and ensure the pre-hospital cruciform card is included in the notes.	
4. Patients discharged from the ED should be directed to OPD to be reunited with relatives/friends.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.4. ED Nurse – P2 Area. Action Card 3.4

EMERGENCY DEPARTMENT - NURSE P2 AREA - AMBER **ACTION CARD 3.4** **Notified by ED Consultant or ED Nurse in charge**	
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge Your role is to:	
• Manage P2 area (Trolleys +/- minors bays 1-6 as needed) with P2 doctor • Assess and treat arriving patients • Supervise other staff allocated to P2 area • Liaise with Nurse in charge to request additional staff/ resources when needed	
ACTION:-	***Tick when completed***
1. Wear Amber Tabard and ensure staff in P2 area know you (and the P2 doctor) are in charge of that area. All queries/ requests from that area should be channelled through you. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
2. **Clear P2 area** • Rapidly assess patients already in P2 area (trolleys) • Triage Sort any patients not yet seen and send them to the appropriate area with their existing cash card/ documentation. • Send patients already assessed to other areas (e.g., ICU/ recovery/ ward) as appropriate and safe. • Remember patients already in trolleys may be more unwell than the major incident patients.	❑
3. **Treatment Teams** • Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including speciality staff). • Assess and treat arriving patients with treatment teams. • Supervise staff in the P2 area • Prioritise cases for scanning/ theatre/ ICU as needed • Ensure individual major incident packs remain with the patient and the pre-hospital cruciform card is included in the notes.	❑

EMERGENCY DEPARTMENT - NURSE P2 AREA - AMBER ACTION CARD 3.4 Notified by ED Consultant or ED Nurse in charge	
ROLE SUMMARY	
4. Liaise with the Nurse in charge regarding additional resources/ staff needed. Ensure you can present a succinct summary of patients in your area to the nurse/ doctor in charge when requested, as well as patients that have been transferred/discharged from the area	❑
5. Commence a personal log of events, to assist with preparation of reports and investigations later	❑
6. Patients discharged from the ED should be directed to OPD to be reunited with relatives/friends.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.5. ED Nurse – P3 Area. Action Card 3.5

EMERGENCY DEPARTMENT - NURSE P3 AREA - GREEN **ACTION CARD 3.5** **Notified by ED Consultant or ED Nurse in charge**	
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge Your role is to: • Manage P3 area (Minor injuries +/- MIU area) with P3 doctor. This is most likely to be an ENP • Assess and treat arriving patients • Supervise other staff allocated to P3 area • Liaise with Doctor in charge to request additional staff/ resources when needed	
ACTION:-	***Tick when completed***
1. Wear Green Tabard and ensure staff in P3 area know you (and the P3 doctor) are in charge of that area. All queries/ requests from that area should be channelled through you. Allocated P3 patients at the ambulance entrance will either be sent directly to the minor injuries area or will undergo secondary triage within walking wounded triage.	❑
2. **Clear P3 area** • Rapidly assess patients already in P3 area (minors) • Triage Sort any patients not yet seen and send them to the appropriate area with their existing cash card/ documentation. • Send patients to other areas (e.g., ward/ home) as appropriate and safe. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
3. **Treatment Teams** • Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including speciality staff). • Assess and treat arriving patients with treatment teams. • Supervise staff in the P3 area • Prioritise cases for scanning/ theatre/ ICU as needed	❑

EMERGENCY DEPARTMENT - NURSE P3 AREA - GREEN ACTION CARD 3.5 Notified by ED Consultant or ED Nurse in charge	
ROLE SUMMARY	
• Ensure the patient major incident pack remains with the patient until discharge, ensure the pre-hospital cruciform card is included in the notes.	
4. Liaise with the Nurse in Charge regarding additional resources/ staff as needed. Ensure you can present a succinct summary of patients in your area to the nurse/ doctor in charge when requested, noting patients that have been discharged and their destination	❑
5. Commence a personal log of events, to assist with preparation of reports and investigations later	
6. Patients discharged from the ED should be directed to OPD to be reunited with relatives/friends.	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.6. ED Nurse – CEU Area. Action Card 3.6

EMERGENCY DEPARTMENT - NURSE CEU	**ACTION CARD 3.6**
Notified by ED Consultant or ED Nurse in charge.	

ROLE SUMMARY

Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge.

Your role is to:

- Manage CEU area with the Paediatric Doctor
- Assess and manage arriving paediatric patients
- Supervise other staff allocated to paediatric area
- Liaise with Nurse in charge to request additional staff/ resources when needed

ACTION:-	***Tick when completed***
1. Wear Paediatric Tabard and ensure staff in the area know you (and the doctor) are in charge of that area. All queries/ requests from that area should be channelled through you. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
2. **Clear CEU area** • Assess patients already in area • Triage Sort any patients not yet seen and liaise with Paediatrics, send them with their existing cash card/ documentation. • Send patients already assessed to paediatrics as appropriate and safe. • Remember patients already in the area may be more unwell than the major incident patients.	
3. **Treatment Teams** • Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of paediatric patients (including paediatric staff). • Assess and treat arriving patients with treatment teams. • Supervise staff in the CEU area • Prioritise cases for scanning/ theatre/HDU as needed	

EMERGENCY DEPARTMENT - NURSE CEU Notified by ED Consultant or ED Nurse in charge.	ACTION CARD 3.6
ROLE SUMMARY	
• Ensure individual patient major incident packs remain with the patient and include pre-hospital cruciform card in the notes.	
4. Liaise with the Nurse in Charge regarding additional resources/ staff needed. Ensure you can present a succinct summary of patients in your area to the nurse/ doctor in charge when requested, as well noting the location of those discharged or transferred.	❑
5. Commence a personal log of events, to assist with preparation of reports and investigations later	❑
6. Patients discharged from the CEU should be directed to Paediatric OPD	❑

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.6.7. ED Additional Nursing Staff inc. Pas/HCAs. Action Card 3.7

EMERGENCY DEPARTMENT - ADDITIONAL ED NURSES/ENP's, PHYSICIANS ASSISTANTS AND HEALTH CARE ASSISTANT STAFF ACTION CARD 3.7 **Informed by switchboard – F24**	
ROLE SUMMARY	
ED staff coming in from home should go directly to ED (NOT the hospital coordination centre) and report to the ED Control Point – Jubilee Suite You will be allocated to an area (P1, P2 or P3). Be part of treatment teams assessing and managing patients in your area.	
ACTION:-	***Tick when completed***
1. Report to the ED Control Point: Jubilee Suite and you will be allocated an area once they have liaised with the ED Nurse/Consultant in Charge – Co-ordinators.	❑
2. Report to the lead nurse/ doctor in that area: P1- Red Tabard P2 Amber Tabard P3 Green Tabard	❑
3. Be part of treatment teams assessing and managing patients in your area. Ensure that appropriate documentation is completed for all patients	❑
4. Liaise with the lead nurse/ doctor in your area regarding any requests/ queries/ progress/ deterioration of any patient.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

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Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.7. ED Doctor in Charge (Doctor 1). Action Card 4

EMERGENCY DEPARTMENT - DOCTOR IN CHARGE **ACTION CARD 4** **Notified by ED Consultant or ED Nurse in charge**	
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge. **Please note, if a mass casualty incident is declared, in addition to the Health Board Major Incident response, please also refer to the Mass Casualty Arrangements for NHS Wales, where further actions will be required, see section 4.** **Section 4.9 - WAST Mass Casualty Interim Reporting dashboard action card, enables WAST to provide casualty information and estimated arrival times to receiving hospitals.** Your role is to: • Liaison with the Hospital Co-ordination Centre • Responsible, in conjunction with the Nurse in Charge of ED, for organising and co-ordinating the activities of the ED to deal with the Incident. You will be the medical co-ordinator. • Form treatment teams to manage patients	
ACTION:-	***Tick when completed***
1. **Standby or declared Incident (outside of SBUHB area)** – As soon as information is received in the ED: - • Liaise immediately with the ED Nurse in Charge – Nurse Co-ordinator. • Assess capacity and staffing levels within the ED • Start to plan for the next stage, but await further instructions before implementation	❑
2. **Declared Incident (SBUHB area)** - As soon as information is received in the ED of a declared Major Incident liaise with the Nurse in Charge. Assess if additional staffing needed and initiate call-out list **(Action Card 03.2)** in conjunction with Nurse in Charge. **Declared Major Incident (outside of SBUHB area)** - implement the **Stand-by Procedure** as noted above in action 1	

EMERGENCY DEPARTMENT - DOCTOR IN CHARGE Notified by ED Consultant or ED Nurse in charge	ACTION CARD 4
ROLE SUMMARY	
Please note: Stand Down Notification should be under the instruction of the Hospital Co-ordination Centre. The Health Board will be informed when there is scene stand down, but this not to be confused with Hospital Stand down. Any notification for this should be re-confirmed with the Co-ordination Centre and communicated within the department appropriately. The ED Doctor in Charge, (Medical Co-ordinator) should then: -	
3. **Prepare ED staff** • With the Nurse in Charge- Undertake a briefing for ED staff. • Allocate Tabards and action cards • Deploy staff to treatment teams in clinical areas. Paediatric patients will be cared for within CEU. • Deploy a Doctor to the Triage Team • In conjunction with the Nurse in Charge, assign a co-ordinator to the Jubilee Suite to liaise with you when additional staff arrive • Wear Black Major Incident Tabard • To support the Welsh Ambulance Service NHS Trust (WAST) in their response to a major incident, the below approach to the release of ambulances from emergency departments, at the declaration of an incident needs to be achieved by the NIC & DIC, with the support of Silver command: • 50% of vehicles released within 10 minutes • 75% of vehicles released within 20 minutes • 100% of vehicles released within 30 minutes Refer to the major incident clinical guidelines: https://www.england.nhs.uk/ourwork/eprr/major-incidents/ **Allocation of areas may be changed at the time and dependent on the nature of the incident; to be discussed in conjunction with the Nurse in Charge.**	
4. **Clear the department and release WAST ambulances**	

EMERGENCY DEPARTMENT - DOCTOR IN CHARGE Notified by ED Consultant or ED Nurse in charge	ACTION CARD 4
ROLE SUMMARY	
With nurse in charge and liaison with the Bed Management Team, allocate staff to clear the department and release any ambulances that are waiting to offload into the department: ☐ Move existing majors patients in the ED to appropriate wards ☐ Divert minors to their own GP's or other hospitals, as appropriate ☐ Make an appropriate announcement to patients in the waiting room advising them to attend another hospital where possible.	
5. **Treatment Teams** • Form P1 (Red), P2 (Amber) and P3 (Green) Lead and Paediatric Treatment teams to deal with manage patients and staff in their areas. • Allocate more staff to areas as needed and available- send them to Red/ Amber/ Green/Paediatric Leader as appropriate for further instruction.	
6. Commence a personal log of events, to assist with preparation of reports and investigations later	
7. **Organise and co-ordinate the activities of the ED** Work closely with the ED Nurse in Charge to maintain an overview of the department. Do not become engrossed in the clinical management of any one patient. Liaise with Hospital Coordination Centre via Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) Medical Co-ordinator to ascertain required medical teams.	
8. **Liaise with specialities to prioritise cases** • Liaise with Consultant General Surgeon/ trauma to prioritise patients for theatre and scanning • Liaise with ICU Consultant to prioritise patients for ICU	

EMERGENCY DEPARTMENT - DOCTOR IN CHARGE Notified by ED Consultant or ED Nurse in charge	ACTION CARD 4
ROLE SUMMARY	
• In the event of a burns major incident, referrals to the Burns Unit and Burns Network will be required via the Burns Unit Co-ordination Centre.	
9. Patients discharged from the ED should be directed to upstairs OPD to be reunited with relatives/friends.	❑
10. Major Incident patients requiring admission will be via the Surgical Admission Unit and Paediatrics, with the exception of those taken to theatre and critical care areas.	❑
11. Liaise with the Nurse Co-ordinator following stand down notification in order to undertake a hot debrief with staff within ED. A formal debrief will be organised post major incident.	❑
12. Assign a lead to co-ordinate staff welfare provision in accordance with the major incident procedure and Health Board procedure.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.**	

Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.7.1. ED Doctor – P1 Area. Action Card 4.1

EMERGENCY DEPARTMENT - DOCTOR P1 AREA - RED **ACTION CARD 4.1** **Notified by ED Consultant or ED Nurse in charge.**	
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge. Your role is to: • Manage P1 area (rhesus +/- trolley bays 7,6,5 as needed) with the P1 Nurse • React will be used for reacted P2's as appropriate at the time in an event of CBRNe incident (Trolleys +/- Green area 1-6 as needed). Assess and treat arriving patients • Supervise other staff allocated to P1 area • Liaise with Doctor in charge to request additional staff/ resources when needed	
ACTION:-	***Tick when completed***
1. Wear Red Tabard and ensure staff in the P1 area know you (and the P1 nurse) are in charge of that area. All queries/ requests from that area should be channelled through you. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
2. **Clear P1 area** • Assess patients already in P1 area (rhesus) • Send patients to other areas (e.g., ICU/ recovery/ ward) as appropriate and safe. • Remember patients already in rhesus may be more unwell than the major incident patients.	❑
3. **Treatment Teams** • Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including speciality staff such as surgical and ICU doctors). • Assess and treat arriving patients with treatment teams. • Supervise staff in the P1 area • Prioritise cases for scanning/ theatre/ ICU as needed	❑

EMERGENCY DEPARTMENT - DOCTOR P1 AREA - RED Notified by ED Consultant or ED Nurse in charge.	ACTION CARD 4.1
ROLE SUMMARY	
4. Liaise with the ED Consultant, Medical Co-ordinator (Black Tabard) regarding additional resources/ staff needed. Ensure you can present a succinct summary of patients in your area to the doctor in charge when requested.	❑
5. Commence a personal log of events, to assist with preparation of reports and investigations later	❑
6. Patients discharged from the ED should directed to OPD to be reunited with relatives/friends.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.7.2. ED Doctor – P2 Area. Action Card 4.2

EMERGENCY DEPARTMENT - DOCTOR P2 AREA - AMBER **ACTION CARD 4.2** **Notified by ED Consultant or ED Nurse in charge.**	
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge. Your role is to:	
• Manage P2 area (Trolleys +/- Green area 1-6 as needed) with the P2 nurse • Assess and treat arriving patients • Supervise other staff allocated to P2 area • Liaise with Doctor in charge to request additional staff/ resources when needed	
ACTION:-	***Tick when completed***
1. Wear Amber Tabard and ensure staff in the P2 area know you (and the P2 nurse) are in charge of that area. All queries/ requests from that area should be channelled through you. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
2. **Clear P2 area** Rapidly assess patients already in P2 area (trolleys) Send patients to other areas (e.g., ward/ home) as appropriate and safe.	❑
3. **Treatment Teams** • Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including speciality staff). • Assess and treat arriving patients with treatment teams. • Supervise staff in the P2 area • Prioritise cases for scanning/ theatre/ ICU as needed • Ensure Major Incident packs remain with the patient	❑
4. Liaise with the ED Consultant (Black Tabard) regarding additional resources/ staff needed. Ensure you can present a succinct summary of patients in your area to the doctor in charge when requested.	❑

EMERGENCY DEPARTMENT - DOCTOR P2 AREA - AMBER ACTION CARD 4.2 Notified by ED Consultant or ED Nurse in charge.	
ROLE SUMMARY	
5. Commence a personal log of events, to assist with preparation of reports and investigations later	❑
6. Patients discharged from the ED should be directed to OPD to be reunited with relatives/friends.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.7.3. ED Doctor – P3 Area. Action Card 4.3

EMERGENCY DEPARTMENT - DOCTOR P3 AREA- GREEN **ACTION CARD 4.3** **Notified by ED Consultant or ED Nurse in charge.**	
ROLE SUMMARY	
Notification of a Declared Major Incident (SBUHB area) will be received from either the ED Consultant or ED Nurse in charge. Your role is to: • Manage P3 area (Green area and Minors injuries) with the P3 nurse and in conjunction with the Emergency Nurse Practitioners in this area • Rapidly assess patients already in P3 area (minors) • Send patients to other areas (e.g., ward/ home) as appropriate and safe.	
ACTION:-	***Tick when completed***
1. Wear Green Tabard and ensure staff in the P3 area know you (and the P3 nurse) are in charge of that area. All queries/ requests from that area should be channelled through you. Allocated P3 patients at the ambulance entrance will either be sent directly to the minor injuries area or will undergo secondary triage within walking wounded triage. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
2. **Clear P3 area** Rapidly assess patients already in P3 area (Green area and Minor injuries) Send patients to other areas (e.g., ward/ home) as appropriate and safe.	❑
3. **Treatment Teams** Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including speciality staff). Assess and treat arriving patients with treatment teams. Supervise staff in the P3 area Prioritise cases for scanning/ theatre/ ICU as needed	❑
4. Liaise with the ED Consultant (Black Tabard) regarding additional resources/ staff needed.	❑

EMERGENCY DEPARTMENT - DOCTOR P3 AREA- GREEN **ACTION CARD 4.3** **Notified by ED Consultant or ED Nurse in charge.**	
ROLE SUMMARY	
Ensure you can present a succinct summary of patients in your area to the doctor in charge when requested.	
5. Commence a personal log of events, to assist with preparation of reports and investigations later	❑
6. Patients discharged from the ED should be directed to the OPD to be reunited with relatives/friends.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.**	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.7.4. ED Doctor – CEU. Action Card 4.4

EMERGENCY DEPARTMENT - CEU	**ACTION CARD 4.4**
Notified by ED Consultant or ED Nurse in charge	
ROLE SUMMARY	
Notification of a Declared Major Incident will be received from either the ED Consultant or ED Nurse in charge. Your role is to:	
• Manage CEU with the Lead Paediatric Nurse • Assess and treat arriving patients • Supervise other staff allocated to Paediatric area • Liaise with Doctor in charge to request additional staff/ resources when needed	
ACTION:-	***Tick when completed***
1. Wear Paediatric Tabard and ensure staff in the CEU know you (and the Lead Paediatric nurse) are in charge of that area. All queries/ requests from that area should be channelled through you. Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	❑
2. **Clear P1 area** Clear P1 area. Assess patients already in Children's Emergency Unit. Send patients to Paediatrics as appropriate and safe. Remember patients already in Paediatrics may be more unwell than the major incident patients.	❑
3. **Treatment Teams** Form treatment teams with doctors/ nurses allocated to your area in preparation for receipt of patients (including speciality paediatric staff). Assess and treat arriving patients with treatment teams. Supervise staff in the Paediatric area Prioritise cases for scanning/ theatre/ HDU as needed	❑
4. Liaise with the ED Consultant, Medical Co-ordinator (Black Tabard) regarding additional resources/ staff needed. Ensure you can present a succinct summary of patients in your area to the doctor in charge when requested.	❑

EMERGENCY DEPARTMENT - CEU Notified by ED Consultant or ED Nurse in charge	ACTION CARD 4.4
ROLE SUMMARY	
5. Commence a personal log of events, to assist with preparation of reports and investigations later	❑
6. Patients discharged from the ED should be directed to Paediatric OPD to be reunited with relatives/friends.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.8. ED – Additional Doctors. Action Card 5

EMERGENCY DEPARTMENT - ADDITIONAL DOCTORS	**ACTION CARD 5**
ROLE SUMMARY	
ED staff coming in from home should go directly to ED to the **ED Control Point**: **Jubilee Suite**. The person in charge of this area will liaise with the Medical Co-ordinator who will allocate you to an area (P1, P2 or P3). Be part of treatment teams assessing and managing patients in your area.	
ACTION:-	***Tick when completed***
1. Report to the ED Control Point in the Jubilee Suite to be allocated to a treatment area	❑
2. Report to the lead doctor in that area: P1- Red Tabard P2 Amber Tabard P3 Green Tabard	❑
3. Assess, treat, and resuscitate patients in your allocated area. Ensure that appropriate documentation is completed for all patients	❑
4. Liaise with the lead doctor in your area regarding any requests/ queries/ progress/ deterioration of any patient	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system but <u>cannot</u> replace this system which must remain for 24 hrs post incident.

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.8. ED – Administration Manager/Deputy. Action Card 06

EMERGENCY DEPARTMENT ADMINISTRATION MANAGER/DEPUTY **ACTION CARD 06** **(Informed by ED Reception)**	
ROLE SUMMARY	
• Responsible for organising and co-ordinating the activities of the Clerical Staff. – to be the ED Administration Co-ordinator • Responsible for documentation of all patients in the ED • Liaison with the Hospital Co-ordination Centre regarding patient numbers and identities. • Liaison with the Hospital Police Documentation Team, to facilitate their requirements • Liaison with the Relatives Care Team (OPD Nurse in Charge/Manager) • Assign a trained Loggist and provide the Loggist book	
ACTION - As soon as information is received in the ED of a declared Major Incident **(SBUHB area),** the ED Administration Manager should :-	***Tick when completed***
1. Call additional Clerical assistance, based on the assessment of the situation. Provide Reception Staff number 2 with action card 6a. Provide assigned trained Loggist with Loggist Action Card	❑
2. Collect and prepare the ED Major Incident Documentation packs if not done by Receptionist number 2.	❑
3. Assume responsibility for the Documentation of **all** patients arriving in the ED and ensure that adequate supplies of stationary are available.	❑
4. Commence a personal log of events, to assist with preparation of Reports and Investigations later. Liaise with the Nurse in Charge to ascertain if a Loggist could be allocated to log ED key decisions and actions.	❑
5. Ensure that the Walking entrance doors are locked, and that all patients are directed through the Stretcher entrance. Place a sign – No Entry Major Incident Declared in the window of walking entrance doors.	❑
6. Allocate a Clerical Officer to join the Triage/Documentation Team at the Stretcher entrance and they must remain there. Each patient to have **two** identity bands containing the unique ED Major Incident number as they enter the ED and issue the corresponding numbered ED Documentation pack to accompany the patient to the appropriate Treatment area. **NB - All** patients **MUST** be tagged **twice** and issued with the corresponding documentation pack before leaving the Triage area. Ensure the triage cruciform remains with the patient.	❑

EMERGENCY DEPARTMENT ADMINISTRATION MANAGER/DEPUTY

ACTION CARD 06

(Informed by ED Reception)

ROLE SUMMARY

7.	Instruct ED Clerical Staff to wear Major Incident Tabards. Wear Blue Tabard.	❑
8.	Allocate ED Clerical Staff to Treatment areas in conjunction with Receptionist number 2; all must liaise with you as the Co-ordinator with on-going communications/updates: - • Resuscitation areas for Priority One patients • Trolley/minors area for Priority Two patients. • Minor Injuries for Priority Three patients • CEU • Allocate a member for the following roles; ○ Loggist for all key actions and decisions, assigned to the medical/nurse co-ordinator ○ Lead in the ED Control point to log all arriving additional ED staff and liaise with the Nurse/Medical Co-ordinator to allocate them areas. ○ Allocate a staff member to the central ED area to receive and deal with phone calls with regard to major incident. Inform the Co-ordination Centre - Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532904 – Ext 32904 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) OPD, Radiology, Pathology – Biochemistry, Haematology, Blood Bank and Switchboard of the contact number. They should receive and document information and forward the Medical/Nursing/Administration Co-ordinators as appropriate, re-direct calls from other areas to the co-ordination centre as appropriate. These Clerical Officers are to obtain as much information as is available at the time, and relay the information back to the ED Reception Office. This includes the disposal/destination of any patients admitted or discharged. This will be a continuous process.	❑ ❑ ❑
9.	Create a register of all patients attending the ED, (use the major incident patient list) which is continually updated. Log patients directly onto the Myrddin System if possible.	❑

EMERGENCY DEPARTMENT ADMINISTRATION MANAGER/DEPUTY (Informed by ED Reception)	ACTION CARD 06	
ROLE SUMMARY		
10.	Liaise with the Police Documentation Team, regarding the numbers, identity, and severity of all patients attending the ED. Confirm with Receptionist number 2	❑
11.	Liaise with the Medical Records Officer, regarding the co-ordination of any additional clerical support required to assist with the Documentation in the ED. (This may include the need for 2 Clerical Officers to act as internal and external runners.) Confirm with Receptionist number 2.	❑
12.	Ensure that all patients are tagged twice with a unique ED Major Incident number, and given the corresponding Documentation pack, which must accompany the patient throughout their stay in the ED Department.	❑
13.	In conjunction with Receptionist number 2, liaise closely with the Hospital Co-ordination Centre (Hospital Coordination Centre Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532904 – Ext 32904 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3), and establish a full communication network to keep the Hospital Co-ordination Centre fully informed of:- • the numbers of patients arriving • the identity of patients • Severity of injuries. • discharges • Deaths, etc. The Hospital Co-ordination Centre will in turn, liaise with the Relatives & Friends area in OPD, and the Press & Media. The OPD Nurse in charge will inform you of a key contact number regarding queries of relatives and friends and major incident patients. Direct all relatives or patients involved in the major incident to OPD for them to be registered.	❑ ❑
14.	Liaise with the I.T. and/or Digital Training Department(s) regarding the input of data into the database in the Hospital Co-ordination Centre.	❑
15.	Liaise with the Clerical Officer in the ED Radiology Unit.	❑

EMERGENCY DEPARTMENT ADMINISTRATION MANAGER/DEPUTY (Informed by ED Reception)	ACTION CARD 06	
ROLE SUMMARY		
16.	Ensure that non-Major Incident patients are kept fully informed of the situation.	❑
17.	Channel requests for additional equipment, re-stocking, and staff via ED Control Point in Sister's Office to the Hospital Co-ordination Centre (Hospital Coordination Centre Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532904 – Ext 32904 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)).	❑
18.	Maintain close liaison with Nurse in Charge and Chaplaincy within OPD	❑
19.	Post incident undertake an administrative "mop up" to inform relevant wards, Health Records etc. of patients' full demographics and any existing PAS numbers. **This process can only commence 24 hours after the major incident and not before. Please note below regarding the major incident unique patient identifiers.**	❑
	NOTE: - • ED Porters should erect ED Directional signs, as appropriate. A senior Porter will attend the ED to organise additional stretchers and wheelchairs. • Surgical Admission Unit (SAU)/Oakwood are the admitting. Wards for all patients from the Major Incident, with the exception of those taken to Critical Care areas or Operating Theatre. • Information to the Hospital Co-ordination Centre regarding total patient numbers, etc. should **only** be done by the ED Administration Manager. • Be familiar with the main Hospital Major Incident procedure, especially in relation to Relatives, Press & Media, etc. **No** press statements are to be issued from the ED	❑ ❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.8.1. ED Administration Staff – Staff 2. Action Card 06a

EMERGENCY DEPARTMENT ADMINISTRATION STAFF 2 (Informed by ED Reception)		**ACTION CARD 6a**
ROLE SUMMARY		
• Responsible for supporting the Administration Manager in organising and co-ordinating the activities of the Clerical Staff • Responsible for supporting the documentation of all patients in the ED • Supporting the liaison with the Hospital Co-ordination Centre regarding patient numbers and identities. • Supporting the liaison with the Hospital Police Documentation Team, to facilitate their requirements		
ACTION - As soon as information is received in the ED of a declared Major Incident **(SBUHB area),** the Senior Receptionist on duty should :-		***Tick when completed***
1.	Contact Service Manager/Office Manager Call additional clerical assistance as necessary	❑
2.	Collect and prepare the ED Major Incident Documentation packs.	❑
3.	Ensure there is a constant receptionist presence at the triage area	❑
4.	Allocate and coordinate additional ED reception staff to treatment areas to complete patient details on the Patient lists	❑
5.	Liaise closely with the Hospital Co-ordination Centre (ext. 33479, 32904, 32905, 33778) and establish a full communication network to keep the Hospital Co-ordination Centre fully informed of: • The numbers of patients arriving • The identify of patients • Severity of injuries (numbers of P1, P2, and P3 patients) • Discharges • Deaths The Hospital Coordination Centre will, in turn, liaise with the Relatives and Friends area in the Out Patient Department. They will in turn also establish direct links with you.	❑
6.	Liaise with the Police Documentation Team, within ED Police Room regarding the numbers, identify and severity of all patients attending the ED.	❑

EMERGENCY DEPARTMENT ADMINISTRATION STAFF 2 (Informed by ED Reception)	ACTION CARD 6a
ROLE SUMMARY	
7. Instruct ED Clerical Staff to wear Major Incident Tabards. Wear Blue Tabard.	❑
8. Liaise with the ED Consultant to ascertain if ED review clinics/Physio clinics need to be cancelled the next day.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.8.2. ED Loggist. Action Card 6b

Emergency Department Loggist	**Action Card 6b**

ROLE SUMMARY

The ED Loggist will be assigned at the time of the major incident and will be contacted in accordance with availability of ED trained Loggist staff. (A list of trained Loggist is included in ED).

To record all key decisions taken or not taken by the Emergency Department. The Loggist is not a minute taker or there to provide any other administration functions.

The role will be undertaken by trained staff only.

The Health Board will be asked to account for their actions and decisions during an incident. Notes, records, and reports may be scrutinised as evidence.

ACTION :-		***Tick when completed***
1.	All email correspondence must be sent to Silver Command: Morriston Hospital: **ABM.MajorIncidentMorr@wales.nhs.uk**	
2.	On receipt of a Major Incident declared a trained Loggist will be contacted to fill the role of Emergency Department Loggist.	❑
3.	Ensure you receive a briefing of the incident so far	❑
4.	Commence the Incident Log book, ensuring the incident name and date are documented. Ensure any Teams meetings are recorded.	❑
5.	Liaise directly with the Consultant and Nurse in Charge	❑
6.	Remain by the side of the Consultant and Nurse in Charge	❑
7.	Enter the current time and date in the Log Book, log handover time and any other relevant details.	❑
8.	Ensure blank spaces are ruled through with a single line.	❑
9.	Any mistakes should be ruled though with a single line and initialled.	❑
10.	Record all decisions made including the time each decision is made, (use 24-hour clock)	❑

Emergency Department Loggist		Action Card 6b
ROLE SUMMARY		
11.	Decisions recorded in a meeting must be read out at the end of the meeting and signed by the decision maker.	❑
12.	Once Major Incident stand down is declared, the Log Book should be signed and retained in a safe place as a record of the incident. The Log Book should be stored within the Emergency Department.	❑

Note:

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2.9. Nurse in Charge – HB Minor Injury Unit. Action Card 07

Nurse in Charge **Minor Injury Unit** **(Informed by Site Management)**		**ACTION CARD 07**
ROLE SUMMARY		
The NPTSSG Major Incident Procedure will be invoked as part of the declaration of a major incident in order to support Morriston Hospital who will receive the major incident casualties. Refer to the NPTSSG Major Incident Procedure.		
No patients from the scene of the major incident will be transported to the Health Board Minor Injury Units		
Any self- presenting casualties from the incident will receive basic treatment and transferred to the Emergency Department at Morriston if appropriate.		
ACTION - As soon as information is received in the Minor Injuries Unit of a declared Major Incident, the Nurse in Charge of the Unit should :-		***Tick when completed***
1.	Commence a personal log of events, to assist with preparation of Reports and Investigations later.	❑
2.	Liaise with the Service Group Silver Command Team at Singleton/Neath Port Talbot Hospitals once established. Note if additional staff are required (enquire if Silver Command have informed the Acute GP Unit). **This will change when the AMU model at Morriston is fully implemented.**	❑
3.	Inform the assessment Unit at Singleton of the possibility of additional patients being re-directed from Morriston.	❑
4.	All staff within MIU at Neath Port Talbot to be aware that non-major incident minor injury patients may be transferred, if appropriate for the scope of practice. **This will change when the AMU model at Morriston is fully implemented.**	❑
	NOTE: - The Minor Injury Unit at Neath Port Talbot Hospital will not receive any casualties directly from the Incident scene by the Ambulance Service. Any self-presenting casualties from the Incident should be logged with all details, have first aid measures undertaken before being transferred to the Emergency Department at Morriston Hospital if appropriate and required. Inform the Service Group Silver Command if major incident patients self-present at MIU.	❑

Note:

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2.10. Nurse in Charge–ED MIU (Morriston)/Ambulatory Care. Action Card 8

Nurse in Charge **(Informed by ED Nurse in Charge)**	**ACTION CARD 8**	
ROLE SUMMARY		
• Re-locate Patients to clinical areas as appropriate		
• Keep theatre assessment patients informed of the incident.		
• Please note this task will only be required if there are patients in the theatre assessment area		
ACTION - As soon as a Major Incident is declared, you will be informed by the Nurse in Charge of the ED, (MIU between the hours 09:00 – 21:00), and you should :-		***Tick when completed***
1.	Advise staff of Major Incident. This area will be the Priority Three area, (see action cards for this area)	❑
2.	Advise Medical staff in minor injuries/theatre assessment area	❑
3.	Inform patients.	❑
4.	Transfer patients as appropriate and for those requiring ongoing clinical care to clinical care areas as assigned. Theatre assessment staff liaise with their senior managerial teams to ascertain deployment of their resources.	❑
5.	Arrange for new appointments to be issued as appropriate for theatre assessment patients	❑

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.11. Medical: General Consultant Anaesthetist. Action Card 9

GENERAL CONSULTANT ANAESTHETIST ON-CALL **(Informed by SR Anaesthetic Trainee/Middle Grade On-Call)**		**ACTION CARD 9**
ROLE SUMMARY		
In hours (08.00 hrs – 17.00 hrs, Monday – Friday); Duty Consultant **In hours (17.00 - 20.00) Cepod Anaesthetist** **Out of hours; General Consultant on Call**		
• Call in second on call Consultant Anaesthetist or appraise Burns Anaesthetist (Phone 36496) Ask them to cascade METHANE message to major incident WhatsApp group if not already done and to determine availability and requirements for anaesthetists to attend. Use Microsoft Forms link in Whatsapp group. • https://forms.office.com/e/tnjguLVLGd		
• Attend coordination centre to receive briefing on the situation.		
• Out of hours, General On Call Consultant to ensure that Cardiac and Paediatric On Call Consultants have been called in by onsite Anaesthetic staff		
• Attend the Emergency Department to assist the Consultant in Emergency Medicine. Take on the role of Anaesthetic Commander in ED. Liaise with the Second on Call consultant when they arrive – send them to theatre to create resuscitation pod teams. Liase with ITU consultant on call as to state of ITU.		
• Oversee the deployment of resuscitation pod teams in the Emergency Department in role of Anaesthetic Commander to specific patients – assisting the transfer of these patients up to theatres with each team.		
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**		
ACTION - As soon as a major incident is declared you should immediately: -		***Tick when completed***
1.	**Out of hours -** call in the second on call Anaesthetist **In hours -** enlist help of the Burns Anaesthetist. Disseminate a METHANE message to the major incident WhatsApp group or ask second on call cons to do it.	❑

GENERAL CONSULTANT ANAESTHETIST ON-CALL (Informed by SR Anaesthetic Trainee/Middle Grade On-Call)		ACTION CARD 9
ROLE SUMMARY		
	Post link for consultants to record https://forms.office.com/e/tnjguLVLGd	❑
2.	If you don't already have it, take with you the 23808 phone from the SR trainee.	❑
3.	Ensure on site anaesthetic staff have called in On Call Anaesthetic Consultants; (Cardiac and Paediatrics). They should proceed as soon as possible to main theatres where they will be briefed by the Theatre Lead Anaesthetist.	❑
4.	Proceed to the coordination centre and receive briefing on the situation	❑
5.	Proceed to the Emergency Department and assist the Consultant in Emergency Medicine in assessing the number of P1 patients needing resuscitation.	❑
6.	Request resuscitation pod teams from the TLA and allocate them to specific patients – with the inclusion of an ED doctor whilst they are in ED.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident**		

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

Contacts:	***CEPOD Cons***	23808	***Cardiac Trainee***	23615	***Anaes Office***	33279
	CEPOD Trainee	23488 36496	***3rd ITU***	30600	***Blood Bank***	33054
	Burns Trainee ***ED Resus***	23495 33428	***ITU sister*** ***ODP***	33479 23820	***Theatre co-ordinator*** ***CT scan***	34060 33393

2.11.1. Medical: 2nd General/Burns Consultant Anaesthetist. Action Card 9a

SECOND GENERAL CONSULTANT ANAESTHETIST ON-CALL **ACTION CARD 9a** **(Informed by SR Anaesthetic Trainee/Middle Grade On-Call)**	
ROLE SUMMARY	
In hours – Burns Anaesthetist (08.00 - 17.00) **In hours –** Trauma Anaesthetist (17.00- 20.00) **Out of hours -** Second on Call Consultant	
• Cascade METHANE information to all colleagues via Major Incident WhatsApp group (if not already passed by first on call consultant) and post availability poll - https://forms.office.com/e/tnjguLVLGd • Plan requirements for consultants needed to attend and availability via Microsoft Forms link and call-in consultant colleagues as required, whilst considering protection of next day working (if possible). • Oversee the creation of Anaesthetic/Theatre pod teams that will form a Consultant Anaesthetist, Trainee Anaesthetist, ODP, Consultant Surgeon, Trainee Surgeon, Scrub Practitioners, Theatre Healthcare staff and a vacant theatre. • Oversee the deployment of theatre pod teams to the emergency department to help with resuscitation or retrieval of patients to theatre for damage control surgery as required. • Coordinate onward dissemination of patients to ward/ITU as required. • Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/** **ACTION -** As soon as a major incident is declared you should immediately:-	***Tick when completed***
Establish the nature of the incident and its location. **If this is a Burns Major Incident you should follow Action Card 06b in the Burns Major Incident procedure.** If in doubt, clarify with the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line). If it is **not** a Burns Major Incident, you should follow as below:-	❑

1.	**Liaise with Consultant on Call (will likely be in Emergency department)** Ensure METHANE message has been cascaded to the consultant major incident Whatsapp group and availability link - https://forms.office.com/e/tnjguLVLGd Call in consultant colleagues based on availability data (Considering need to protect next day working where possible)	❑ ❑
2.	Pick up a free cisco phone and ensure others know the number	❑
3.	Oversee the creation of theatre pod teams consisting of Consultant Anaesthetist, Trainee Anaesthetist, ODP, Consultant Surgeon, Trainee Surgeon, Scrub and Healthcare staff. Attach each pod to a vacant theatre. Call in consultant anaesthetists as required based on availability and need to ensure following day continuity.	❑
4.	Oversee the deployment of theatre pod teams down to ED rhesus to retrieve patients from resuscitation teams and transfer up to theatre for damage control surgery or to help with resuscitation as required as requested by the anaesthetic commander in ED	❑
5.	Liaise with ITU consultant / ITU 3rd on call (30600) about disposition of patients once out of theatre. It may be appropriate for patients to remain in theatre until capacity for care has been created	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum

- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

Contacts :	***CEPOD Cons***	23808	***Cardiac Trainee***	23615	***Anaes Office***	33279
	CEPOD Trainee	23488 36496	***3rd ITU***	30600	***Blood Bank***	33054
	Burns Trainee	23495	***ITU sister***	33479	***Theatre co-ordinator***	34060
	ED Resus	33428	***ODP***	23820	***CT scan***	33393

2.11.2. Medical: SR Anaesthetic Trainee/Mid-Grade. Action Card 10

SR ANAESTHETIC TRAINEE/MIDDLE GRADE ON-CALL **ACTION CARD 10** **(Informed by Switchboard – Cisco phone broadcast)**		
ROLE SUMMARY		
• Call in General and Second on Call Consultants as soon as major incident declared – give them any information that you have. • Ensure Consultants have put out major incident message via Whatsapp group • Inform other junior medical staff in Anaesthetics • Liaise with the Theatre Lead Anaesthetist (Second on call consultant) (TLA) – help with the creation of resuscitation pod teams attached to theatres and the deployment of these down to ED • Assist in Main Theatre with patients already in Theatre and with preparations for the arrival of casualties • Give 23808 phone to General On Call Consultant • Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**		
ACTION - As soon as a major incident is declared you should immediately: -		***Tick when completed***
1.	Ensure that all other on-site doctors in Anaesthetics are aware of the incident (including ICU colleagues) and are following their action cards. • General rota 23488, 35496, 23808 • Burns rota 23495 • ICU 3rd on 30600	❑ ❑ ❑
2.	Call in the General on Call Consultant, Second on Call Consultant. and Paediatrics Consultant. Ask one of them to put out major incident WhatsApp message to consultants.	❑
3.	Proceed to the Hospital Co-ordination Centre to obtain briefing – cascade this to other anaesthetic staff once received.	❑
4.	Proceed to Main Theatre to assist with patient's already in Theatre and help prepare for the arrival of casualties and creation of rhesus pods. Work under the direction of the TLA.	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

<u>Contacts:</u>	***CEPOD Cons***	23808	***Cardiac Trainee***	23615	***Anaes Office***	33279
	CEPOD Trainee	23488 36496	***3rd ITU***	30600	***Blood Bank***	33054
	Burns Trainee	23495	***ITU sister***	33479	***Theatre co-ordinator***	34060
	ED Rhesus	33428	***ODP***	23820	***CT scan***	33393

2.12. Burns/Cardiac Trainee Anaesthetist Action Card 11

BURNS ANAESTHETIC TRAINEE/CARDIAC TRAINEE ON CALL

ACTION CARD 11

(Informed by Switchboard– Cisco phone broadcast)

ROLE SUMMARY

- Ensure on-site medical staff in Anaesthetics are aware

Burns Trainee

- Undertake clinical anaesthetic duties for existing theatre patients
- Make yourself available to general ITU as needed to help make space for anticipated patients
- Assist the General on Call consultant in ED with resus and transfer of patients to theatre/ITU.

Cardiac Trainee

- Care for existing ventilated patients on the Cardiac ITU
- If able to leave cardiac ITU, assist the Consultant in ED in the resuscitation of patients and the General on Call consultant (as the anaesthetic commander in ED)
- Ensure someone is always able to cover emergencies from existing patients on cardiac ITU
- Determine how many beds are likely to be available on cardiac itu for patients – convey this to ITU consultant and theatre lead anaesthetist.
- Refer to the major incident clinical guidelines:

https://www.england.nhs.uk/ourwork/eprr/major-incidents/

Action – As soon as a major incident is declared you should immediately: -	**Tick when complete**
Establish the nature of the incident and its location. **If this is a Burns Major Incident you should follow Action Card 07a in the Burns Major Incident procedure.** If in doubt, clarify with the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line). If it is **not** a Burns Major Incident, you should follow as below:-	❑
1. Ensure that all other on-site doctors in Anaesthetics are aware of the incident and are following their action cards. a. General rota: 23488, 36496, 23808 b. Cardiac rota: 23615 c. ICU 3rd on 30600	❑ ❑ ❑

BURNS ANAESTHETIC TRAINEE/CARDIAC TRAINEE ON CALL **ACTION CARD 11** **(Informed by Switchboard– Cisco phone broadcast)**	
ROLE SUMMARY	
2. Call in On-call Cardiac Anaesthetic Consultant (Not via Switchboard); use phone numbers in CLW. (Second on call cons will be called by general on call consultant). Do not go through switch.	❑
3. Receive briefing from the SR rota trainee once they have been briefed by the coordination centre	❑
4. **Burns Trainee** – make yourself available to ITU as required for movement of patients to create space for anticipated admissions. **Cardiac Trainee** – Ensure cardiac ITU patients are cared for and stable	❑ ❑
5. **Cardiac Trainee** – Determine likely numbers of beds that can be created on cardiac ITU – pass this onto the Theatre Lead Anaesthetist (23808) and ITU Consultant on Call (37807)	❑
6. Proceed to the Emergency Department and assist the Consultant in ED in resuscitation of P1 casualties.	❑
Il patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident**	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times

- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

Contacts:	***CEPOD Cons***	23808	***Cardiac Trainee***	23615	***Anaes Office***	33279
	CEPOD Trainee	23488 36496	***3rd ITU***	30600	***Blood Bank***	33054
	Burns Trainee	23495	***ITU sister***	33479	***Theatre co-ordinator***	34060
	ED Rhesus	33428	***ODP***	23820	***CT scan***	33393

2.13. Theatre Trainee / Mid-Grade Anaesthetist. Action Card 12

THEATRE TRAINEE / MIDDLE GRADE ANAESTHETIST(s) ON CALL **ACTION CARD 12** **(Informed by Switchboard– Cisco phone broadcast)**	
ROLE SUMMARY	
• Inform other on-site medical staff in Anaesthetics • Call in On-call General, Second on call and Paediatric Consultant (directly not via switchboard) • Undertake clinical anaesthetic duties according to deployment • Ensure care for existing patients in Theatre • If no patients in Theatre, assist the Consultant in ED in the resuscitation of patients. • Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
Action – As soon as a major incident is declared you should immediately:-	**Tick when complete**
1. Ensure that all other on-site doctors in Anaesthetics are aware of the incident and are following their action cards. o Aim to meet face to face in main theatre and delegate roles. • Cardiac rota: 23615/General Consultant 23808 • Burns rota: 23495 • ICU 3rd on 30600	❑ ❑ ❑
2. Liaise with SR rota trainee to Call in On Call General, Second on Call and Paediatric Anaesthetic Consultants (Not via Switch); use phone numbers on CLW.	❑
3. If there are patients anaesthetised in theatre, care for them until either relived by an arriving anaesthetist or until the end of the case.	❑
4.Once theatre cases are finished, proceed to the Emergency Department and assist the Consultant in ED in resuscitation of P1 casualties if not committed in theatres	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.14. I.C.U Consultant. Action Card 13

ICU CONSULTANT (ON-CALL) **(Informed by Switchboard via Manual Phone Call)** **Contact via: Switchboard/Personal Mobile (on call rota)**	**ACTION CARD 13**
ROLE SUMMARY	
• Obtain a briefing from the hospital coordination centre as to the status of the major incident. • Put out a message on the ICU operational only Whatsapp group There will be a need for at least two Consultants to undertake a number of roles as noted below.	
• The on-call ICU Consultant should stay on the unit (as they know the clinical status of the patients), caring for current patients and undertaking to clear beds where possible to make space for new patients because of major incident.	
• The second ICU Consultant should be detailed to attend the Emergency Department to advise the Emergency Medicine Consultant and the On call consultant anaesthetist in the triage and treatment of patients.	
• Oversee the deployment of ICU staff in both the Emergency Department and ICU.	
• Liaise with the ICU Nurse in Charge (extension 33479) regarding bed availability and inform Theatre Lead Anaesthetist and Consultant in Emergency medicine with the number of spaces (extensions 32904, 32905, 33778) and ascertain likely number of patients to be received.	
• Determine whether recovery likely to be needed to create extra ITU capacity and ensure being set up if required. Make plans to create additional capacity in theatres if required.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. The on-call ICU Consultant should stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
2. Put a message onto the 'ICU Operational Only' whatsapp group to inform consultants of major incident. Ask for volunteer to attend the department. The on-call ICU Consultant and at least one additional ICU Consultant should attend the hospital. More may be required.	❑
3. The on-call ICU Consultant is to stay on the unit, caring for patients currently on the unit and discharging patients where suitable to make way for incoming patients from the major incident.	❑

ICU CONSULTANT (ON-CALL)		**ACTION CARD 13**
(Informed by Switchboard via Manual Phone Call)		
Contact via: Switchboard/Personal Mobile (on call rota)		
ROLE SUMMARY		
4.	The ICU Consultant deployed to the Emergency Department, should co-ordinate the deployment of ICU staff within the Emergency Department sent there from the Hospital Co-ordination Centre and advise in treatment and triage of patients with the Emergency department consultant and the Anaesthetic Consultant in ED.	❑
5.	Liaise with the nurse in charge, theatre lead anaesthetist, and ICU consultant in ED as to likely number of patients to be received.	❑
6.	Ensure that recovery is being prepared for extra patients if required.	❑
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Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.15. I.C.U Registrar (2nd & 3rd). Action Card 14

I.C.U REGISTRAR (2nd and 3rd) (ON-CALL) **(Informed by Switchboard – Cisco phone broadcast)**		**ACTION CARD 14**
ROLE SUMMARY		
• Third on call registrar to be based in ED, Second on call registrar to remain on the unit caring for existing patients.		
• Third on call should attend Hospital Coordination centre with the ITU consultant on call to obtain briefing. If apparent that there will be a requirement for further registrars Third on call to contact them. The third on-call ICU Registrar should then attend the ED to assist the Consultant in Emergency Medicine in the triage and resuscitation of critically ill patients. They should liaise with the incoming ITU consultant posted to ED and Anaesthetic consultant on call in ED.		
• The second on call ICU Registrar will remain on the unit and assist the ITU consultant on call in the discharge of patients from the unit that are suitable to make space for incoming patients.		
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**		
ACTION - As soon as a major incident is declared you should do the actions below :-		***Tick when completed***
1.	The third on-call ICU Registrar should stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre where they will be briefed by the Medical Director or Deputy. They should attend with the ICU consultant on call if during resident hours.	❑
2.	Once briefing received if it is apparent that further registrars will be needed contact other members of the trainee team to attend to provide extra help	❑
3.	If you are the Third on call ICU Registrar, you should proceed to the Emergency Department and assist the Consultant in Emergency Medicine, Anaesthetic consultant and the arriving ICU consultant in triaging, treating and assessing patients.	❑
4.	If you are Second on call ICU Registrar, you should stay within the Unit, working on under the direction of the ICU consultant on call to care for existing patients and arrange appropriate discharges and transfers to create bed spaces for the arriving major incident patients.	❑
	If you are one of the arriving registrars called in from home – contact the ICU consultant on call on the unit and/or 2nd on call trainee and find where you are most usefully deployed either in ED or on the unit.	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.16. SHO (1st on) Critical Care Unit. Action Card 15

S.H.O. (1st on) INTENSIVE CARE UNIT (ON-CALL) **ACTION CARD 15** **(Informed by Switchboard – Cisco phone broadcast)**		
ROLE SUMMARY		
• Treat existing, I.C.U Patients.		
• Inform Duty Consultant Intensivist and all colleagues in I.C.U.		
• Prepare the I.C.U. for the reception of further casualties.		
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**		
ACTION - As soon as a major incident is declared you should immediately:-		***Tick when completed***
1.	Remain on the Intensive Care Unit to continue to treat existing patients.	❑
2.	Contact Consultant Intensivist on-call, giving as much information as you can.	❑
3.	Contact Colleagues in I.C.U. giving as much information as you can. During normal working hours this can be delegated to a Medical Secretary. The ICU Nurse in charge contact number is: 33479	❑
4.	They should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the I.C.U.	❑
5.	In conjunction with the Nurse-in-Charge of I.C.U. prepare for the arrival of any casualties.	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.17. Consultant General Surgeon. Action Card 16

CONSULTANT GENERAL SURGEON (ON-CALL) **(Informed by Switchboard via Manual Phone Call)** **Contact via: Switchboard/Personal Mobile (on call rota)**	**ACTION CARD 16**
ROLE SUMMARY	
• Attend Hospital Coordination Centre to attain briefing as to nature of the incident.	
• Mobilise another Consultant General Surgeon to cascade information to all colleagues in General Surgery. Direct incoming colleagues to main theatre to form resus pods. Inform colleagues at Bridgend and UHW that emergency surgery intake will be diverted based on clinical need/ complexity.	
• Attend the ED and assist the Consultant in Emergency Medicine in the assessment and management of patients.	
• Coordinate with the Anaesthetic Consultant in ED to deploy resus pods from theatre for transfer of patients up to theatre and subsequent surgery.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. Attend Coordination centre to attain briefing as to the nature of the major incident (and likely number of colleagues required)	❑
2. Contact another colleague and ask them to inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary).	❑
3. They should be asked to stop what they are doing as soon as it is safe to do so and proceed to the theatre Hub where they can be briefed by the Theatre Lead Anaesthetist and deployed into resus pods.	
4. Proceed to the Emergency Department and assist the Consultant in Emergency Medicine in the assessment and management of casualties in close liaison with the Consultants in Emergency Medicine, Anaesthetics, and Trauma & Orthopaedic Surgery.	❑
5. Co-ordinate with the Anaesthetic Consultant in ED to deploy resus pods from theatre to patients in the ED to be taken to theatre for surgery.	❑

CONSULTANT GENERAL SURGEON (ON-CALL)	**ACTION CARD 16**
(Informed by Switchboard via Manual Phone Call)	
Contact via: Switchboard/Personal Mobile (on call rota)	

ROLE SUMMARY

6.	Ensure that the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with the Theatre Manager, and other Medical staff in the Hospital Co-ordination Centre.	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.18. Consultant Vascular Surgeon. Action Card 17

CONSULTANT VASCULAR SURGEONS, WARD CONSULTANT & NEW ADMISSIONS CONSULTANT (ON-CALL) **ACTION CARD 17** **(Informed by Switchboard via Manual Phone Call)** **Contact via: Switchboard/Personal Mobile (on call rota)**	
ROLE SUMMARY	
• Inform your other consultant colleague on call. Inform colleagues at UHW that emergency surgery intake will be diverted based on clinical need/ complexity.	
• One of you to attend Hospital Coordination Centre to receive brief as to the nature of the incident and likely numbers of colleagues required.	
• Ward Consultant to attend the ED and assist the Consultant in Emergency Medicine in the assessment and management of patients. New patient consultant to attend theatre for operating as needed.	
• Oversee the deployment of Vascular Medical staff.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately: -	***Tick when completed***
1. One of on-call consultants to attend Hospital Coordination Centre to receive briefing regarding incident and numbers	❑
2. One of you to contact other colleagues and ask to attend theatre for briefing as required. (During normal working hours this can be delegated to a Medical Secretary).	❑
3. Ward Consultant to proceed to the Emergency Department and assist the Consultant in Emergency Medicine in the assessment and management of casualties in close liaison with the Consultants in Emergency Medicine, Anaesthetics, and Trauma & Orthopaedic Surgery.	❑
New patient consultant to proceed to theatre hub to be available for new patients with vascular injuries.	❑
4. Co-ordinate the deployment of Vascular medical staff.	❑
5. Ensure that the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with the	❑

CONSULTANT VASCULAR SURGEONS, WARD CONSULTANT & NEW ADMISSIONS CONSULTANT (ON-CALL) **ACTION CARD 17**

(Informed by Switchboard via Manual Phone Call)

Contact via: Switchboard/Personal Mobile (on call rota)

ROLE SUMMARY

Theatre Manager, and other Medical staff in the Hospital Co-ordination Centre.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.19. General Surgery Specialist Registrar. Action Card 18

GENERAL SURGERY SPECIALIST REGISTRAR (ON-CALL) **ACTION CARD 18** **(Informed by Switchboard – Cisco broadcast)** **Contact via: CISCO 23383 (1st on call + nights)** **CISCO 23890 (2nd on call)**		
ROLE SUMMARY		
• Ensure Consultant on Call has been contacted.		
• Receive briefing from Hospital Coordination centre as to nature of incident and number of patients expected.		
• Brief junior colleagues in SAU as to nature of incident		
• Clear Surgical Assessment Unit (SAU) footprint to make space for incoming casualties. This Ward is the designated Ward to initially receive casualties from a Major Incident.		
• Identify patients that can be discharged or transferred from the General Surgery footprint (includes SAU, SAAB, Wards V,T,S,R) to make space for incoming casualties.		
• Assist the Consultant in Emergency Medicine in the assessment and management of patients.		
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**		
ACTION - As soon as a Major Incident is declared, inform the CT on call for General Surgery, you should immediately:-		***Tick when completed***
1.	Ensure consultant on call contacted. Receive briefing from Hospital coordination centre as to nature of the incident and likely number of patients. Proceed to Surgical Assessment Unit (SAU) and liaise with the Nurse-in-Charge. Brief junior colleagues as to the nature of the incident. Send any incoming surgical registrars to theatre to form resus pods. With the Nurse in Charge clear the Ward footprint for incoming patients by:- • **Moving patients to other Wards** designated by the Hospital Co-ordination Centre. • **Sending pre-operative patients home.**	❑

GENERAL SURGERY SPECIALIST REGISTRAR (ON-CALL)	ACTION CARD 18
(Informed by Switchboard – Cisco broadcast)	
Contact via: CISCO 23383 (1st on call + nights)	
CISCO 23890 (2nd on call)	

ROLE SUMMARY		
	• **Discharging patients** fit to do so. • **Transfer patients** to other Hospitals. These patients should be sent to the Discharge Lounge to await Ambulance transport	
2.	The Nurse-in-Charge of each Ward will record the disposal of all patients and inform the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line). All patients relocated to other areas within the Hospital should go with their medical and nursing records, drug charts, and x-rays.	❑
3.	Proceed to the Emergency Department and assist the Consultant in Emergency Medicine and the On call Surgical Consultant in the assessment and management of casualties.	❑

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.20. SHO General Surgery. Action Card 19

CT GENERAL SURGERY (ON-CALL) **(Informed by Switchboard)** **Contact via: CISCO 23380 (1st & 2nd on call + nights)** **CISCO 23371 (CEPOD)**	**ACTION CARD 19**
ROLE SUMMARY	
• Receive briefing from Registrar in SAU	
• Contact other junior staff as required	
• Undertake clinical duties according to deployment	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. Receive briefing in SAU from surgical registrar. Ensure that all other junior medical staff in General Surgery are aware of the incident and are following their action cards. Ensure consultant on call is aware if not already done by registrar.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to SAU to be briefed.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to SAU.	❑
5. When free, work under the direction of the General on call consultant, either in ED, SAU or in theatres according to clinical need.	❑

CT GENERAL SURGERY (ON-CALL) **ACTION CARD 19**

(Informed by Switchboard)

Contact via: CISCO 23380 (1st & 2nd on call + nights)

CISCO 23371 (CEPOD)

ROLE SUMMARY

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

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Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.20.1. Consultant Urological Surgeon. Action Card 19a

CONSULTANT UROLOGICAL SURGEON (ON-CALL) **ACTION CARD 19a** **(Informed by Switchboard via Manual Phone Call)** **Contact via: Switchboard/Personal Mobile (on call rota)**	
ROLE SUMMARY	
• Mobilise another Consultant Urological Surgeon to cascade information to all Consultant colleagues in Urology. • Contact on-call Urology Registrar to initiate appropriate actions	
• Attend Theatre to assist in the management of Trauma cases including Urological system injury	
• Nominate colleague to oversee the deployment of Urological Surgical staff.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Contact another colleague and ask them to (I) inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary), and (I) co-ordinate the deployment of Urological Surgery staff.	❑
2. They should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
3. Proceed to theatre and assist in the assessment and management of casualties, in close liaison with the Consultants in other Surgical Specialities.	❑
4. Ensure that the Hospital Co-ordination Centre (Ext., 33479, 32904, 32905, 33778) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with other Medical staff and Departments.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be

used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.20.2. Urology Specialist Registrar. Action Card 19b

Urology SPECIALIST REGISTRAR (ON-CALL) **(Informed by switchboard F24 & on-call Urology Consultant)**	**ACTION CARD 19b**
ROLE SUMMARY	
• Attend Surgical Assessment Unit (SAU) with any available junior urological staff. These Wards are the designated Wards to initially receive casualties from a Major Incident.	
• Clear SAU of Urological patients to make space for incoming casualties. • Identify Urology patients that can be discharged from wards to make space for incoming casualties.	
• Assist the Urology Consultant in theatre.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, inform any available Urology Junior staff, you should immediately:	***Tick when completed***
1. Proceed to Surgical Assessment Unit (SAU), and liaise with the Nurse-in-Charge. With them, clear the Ward template for incoming patients by: • **Moving patients to other Wards** designated by the Hospital Co-ordination Centre • **Sending pre-operative patients home (Pembroke Ward).** • **Discharging patients** if fit to do so. • **Transfer patients** to other Hospitals. These patients should be sent to the Discharge lounge to await Ambulance transport	❑
2. The Nurse-in-Charge of each Ward will record the disposal of all patients, and inform the Hospital Co-ordination Centre (extension, 33479, 32904, 32905, 33778). All patients relocated to other areas within the Hospital should go with their medical and nursing records, drug charts, and x-rays.	❑
3. Proceed to theatre to assist Urology Consultant	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.21. Consultant T&O Surgeon. Action Card 20

CONSULTANT TRAUMA & ORTHOPAEDIC SURGEON (ON-CALL) ACTION CARD 20 **(Informed by Trauma & Orthopaedic Surgery Specialist Registrar (On-Call)**	
ROLE SUMMARY	
• Mobilise another Consultant Trauma & Orthopaedic Surgeon to come in and cascade information to all colleagues in Trauma & Orthopaedic Surgery	
• Assist the Consultant in Emergency Medicine in the assessment and management of patients.	
• Oversee the deployment of Trauma & Orthopaedic Medical staff.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. Receive briefing from the Registrar on call as to nature of incident and numbers of patients. Contact another colleague and ask them to come in and inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary).	❑
2. Colleagues should be asked to stop what they are doing and proceed to main theatres to receive briefing from Theatre Lead Anaesthetist and form part of a resuscitation pod team. 2nd Consultant who has called colleagues in to coordinate this.	❑
3. Proceed to the Emergency Department at the earliest opportunity and assist the Consultant in Emergency Medicine in the assessment and management of casualties, in close liaison with the Consultants in Emergency Medicine, Anaesthetics, and General Surgery.	❑
4. Co-ordinate the deployment of Trauma & Orthopaedic medical staff.	❑
5. Ensure that the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with the Theatre Manager, and other Medical staff.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.22. T&O Surgery Specialist Registrar. Action Card 21

TRAUMA & ORTHOPAEDIC SURGERY SPECIALIST REGISTRAR (ON-CALL) **ACTION CARD 21** **(Informed by Switchboard – Cisco broadcast)** **Contact via: CISCO 23576**		
ROLE SUMMARY		
	• Receive briefing from the hospital coordination centre	
	• Cascade notification to T&O Consultant & SHO on call	
	• Call another registrar colleague, ask them to come in and to cascade information to other colleagues	
	• Assist the Consultant in Emergency Medicine and the On Call consultant in the assessment and management of patients	
	• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, inform T&O Consultant & SHO on call and T&O Nurse Practitioner, you should immediately :-		***Tick when completed***
1.	Receive briefing from Hospital coordination centre and cascade to consultant on call and SHO on call.	❑
2.	Call in second colleague and ask them to cascade information to other colleagues. Assign them to TAU to brief and coordinate incoming staff. Proceed to the Trauma & Orthopaedic Wards and liaise with the Nurse-in-Charge. With them identify how to make space for incoming patients, if required, by: - • Moving patients to other Wards designated by the Hospital Co-ordination Centre • Sending pre-operative patients home. • Discharging patients fit to do so. • Transfer patients to other Hospitals. These patients should be sent to the Discharge Lounge to await Ambulance transport. You will be informed when these movements will need to be affected if further beds are required.	❑

3.	The Nurse-in-Charge of each Ward will record the disposal of all patients and inform the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line). All patients relocated to other areas within the Hospital should go with their medical and nursing records, drug charts, and x-rays.	❑
4.	Proceed to the Emergency Department and assist the Consultant in Emergency Medicine and the consultant on call in the assessment and management of casualties.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.23. SHO T&O Surgery. Action Card 22

S.H.O TRAUMA & ORTHOPAEDIC SURGERY (ON-CALL) **ACTION CARD 22** **(Informed by T&O Registrar & Switchboard – Cisco broadcast)** **Contact via: CISCO 23575**	
ROLE SUMMARY	
• Inform junior medical staff in Trauma & Orthopaedic Surgery.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. Receive briefing from the Registrar on call as to the nature of the incident and numbers of likely patients. Ensure that all other junior medical staff in Trauma & Orthopaedic Surgery are aware of the incident and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to attend to TAU where they can be briefed and deployed.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and report to TAU.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident**	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.24. Consultant Plastic Surgeon. Action Card 23

CONSULTANT PLASTIC SURGEON (ON-CALL) **ACTION CARD 23** **(Informed by Switchboard – Manual phone call and the)**	
ROLE SUMMARY	
• Mobilise another Consultant Plastic Surgeon to cascade information to all Consultant colleagues in Plastic Surgery.	
• Inform the Burns & Plastic Surgery Specialist Registrar	
• Assist in the prioritisation and management of patients in Plastic Surgery Theatres.	
• Oversee the deployment of Plastic Surgery Medical staff.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately :-	***Tick when completed***
1. Establish the nature of the incident and its location. **If this is a Burns Major Incident you should follow Action Card 04 in the Burns Major Incident procedure.** If in doubt, clarify with the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line). If it is **not** a Burns Major Incident, you should follow as below:-	❑
2. Contact another colleague and ask them to inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary).	❑
3. They should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
4. Proceed to the Plastic Surgery Theatres to meet with the Nurse-in-Charge and assist in the prioritisation and management of cases in all related Theatres and prepare for the arrival of casualties. Overall control will be from the Theatre Services Manager, or Deputy.	❑
5. Co-ordinate the deployment of Plastic Surgery medical staff.	❑

6.	Ensure that the Hospital Co-ordination Centre (Phone Numbers): Ext 30759 Main desk phone next to MI PC (phone 1), Ext 32905 Internal room (phone no 2), Ext 33778 External room (phone 3) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with other Medical staff and Departments.	❑
7.	If you are off the Hospital site, these tasks can be delegated to another Consultant Plastic Surgeon.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.25. Burns & Plastic Surgery Specialist Registrar. Action Card 24

BURNS & PLASTIC SURGERY SPECIALIST REGISTRAR (ON-CALL) ACTION CARD 24 **(Informed by – Consultant Plastic Surgeon (On-Call) & S.H.O Plastic Surgery (On-Call)**	
ROLE SUMMARY	
• Identify patients that can be discharged or transferred on the Plastic Surgery Unit to make space for incoming casualties.	
• Await briefing and deployment by the Medical Director.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately:-	***Tick when completed***
Establish the nature of the incident and its location. **If this is a Burns Major Incident you should follow Action Card 05 in the Burns Major Incident procedure**. If in doubt, clarify with the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 33778 – outside phone – emergency backup line). If it is **not** a Burns Major Incident, you should follow as below:-	❑
1. Proceed to the Plastic Surgery Wards and liaise with the Nurse-in-Charge/Burns & Plastics Co-ordinator (23454). With them, identify how to make space for incoming patients, if required, by: - • **Moving patients to other Wards** designated by the Hospital Co-ordination Centre • **Sending pre-operative patients home.** • **Discharging patients** fit to do so. • **Transfer patients** to other Hospitals. These patients should be sent to the Discharge Lounge to await Ambulance transport. You will be informed when these movements will need to be affected if further beds are required.	❑
2. The Nurse-in-Charge of each Ward will record the movement of all patients and inform the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line). All patients relocated to other areas within the Hospital must go with their medical, nursing records & drug charts.	❑
3. Once this task is completed, proceed to the Hospital Co-ordination Centre. Sign in, before you Sign in, and join other junior Medical staff for briefing and deployment by the Medical Director or Deputy.	❑

BURNS & PLASTIC SURGERY SPECIALIST REGISTRAR (ON-CALL) ACTION CARD 24

(Informed by – Consultant Plastic Surgeon (On-Call) & S.H.O Plastic Surgery (On-Call)

ROLE SUMMARY

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.26. SHO Plastic Surgery. Action Card 25

S.H.O. PLASTIC SURGERY (ON-CALL) **(Informed by Switchboard – Cisco broadcast)** **Contact via: Switchboard**		**ACTION CARD 25**
ROLE SUMMARY		
	• Inform Burns & Plastic Surgery Specialist Registrar (On-Call)	
	• Inform junior medical staff in Plastic Surgery.	
	• Undertake clinical duties according to deployment.	
	• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately:-		***Tick when completed***
	Establish the nature of the incident and its location. **If this is a Burns Major Incident you should follow Action Card 02 in the Burns Major Incident procedure.** If in doubt, clarify with the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 33778 – outside phone – emergency backup line). If it is **not** a Burns Major Incident, you should follow below:-	❑
1.	Ensure that all other junior medical staff in Plastic Surgery are aware of the incident and are following their action cards.	❑
2.	If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3.	You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4.	If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5.	When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.27. Consultant Maxillo-Facial Surgeon. Action Card 26

CONSULTANT MAXILLO FACIAL SURGEON (ON-CALL) **(Informed Switchboard – Manual Phone Call)**	**ACTION CARD 26**
ROLE SUMMARY	
• Inform Registrar Maxillo Facial Surgery	
• Mobilise another Consultant Maxillo-Facial Surgeon to cascade information to all Consultant colleagues in Maxillo-Facial Surgery.	
• Assist the Consultant in Emergency Medicine in the assessment and management of patients.	
• Oversee the deployment of Maxillo-Facial Surgery Medical staff.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Contact another colleague and ask them to inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary).	❑
2. They should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
3. Proceed to the Emergency Department and assist the Consultant in Emergency Medicine in the assessment and management of casualties, in close liaison with the Consultants in Emergency Medicine and other Consultant colleagues.	❑
4. Co-ordinate the deployment of Maxillo-Facial Surgery medical staff.	❑
5. Ensure that the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with other Medical staff and Departments.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.28. Registrar Maxillo-Facial Surgeon. Action Card 27

REGISTRAR MAXILLO FACIAL SURGERY (ON-CALL) **(Informed by Consultant Maxillo Facial Surgeon)**	**ACTION CARD 27**
ROLE SUMMARY	
• Inform junior medical staff in Maxillo-Facial Surgery.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Ensure that all other junior medical staff in Maxillo-Facial Surgery are aware of the incident, and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.29. SHO OMFS. Action Card 28

S.H.O. OMFS (ON-CALL) **(Informed by Switchboard – Cisco broadcast)** **Contact via: CISCO 23597**	**ACTION CARD 28**
ROLE SUMMARY	
• Inform junior medical staff in OMFS.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately:-	***Tick when completed***
1. Ensure that all other junior medical staff in OMFS are aware of the incident and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.30. Consultant Ophthalmologist. Action Card 28a

CONSULTANT OPHTHALMOLOGIST (ON-CALL) **ACTION CARD 28a** **(Informed Switchboard – (Informed by Switchboard via Manual Phone Call)**	
ROLE SUMMARY	
• Mobilise another Consultant to cascade information to all Consultant colleagues in Ophthalmology. • Arrange for another Consultant to take over the provision of cover for Singleton	
• Attend Morriston ED and assist the Consultant in Emergency Medicine in the assessment and management of patients.	
• Oversee the deployment of Ophthalmology staff as necessary.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Contact another colleague and ask them to inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary, do not use Switchboard to do this).	❑
2. You should, where possible stop what you are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre where you will be briefed by the Medical Director or Deputy and deployed according to need.	❑
3. Proceed to the Emergency Department and assist in the assessment and management of casualties, in close liaison with the Consultants in Emergency Medicine and other Consultant colleagues.	❑
4. Co-ordinate the deployment of Ophthalmology staff as required.	❑
5. Ensure that the Hospital Co-ordination Centre (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with other Medical staff and Departments.	❑
6. Assess the need to transfer Ophthalmology inpatients to other sites and to stop elective cases to create capacity for major incident patients as appropriate.	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.31. Consultant ENT Surgeon. Action Card 29

CONSULTANT ENT SURGEON (ON-CALL) **(Informed by Switchboard via Manual Phone Call)** **Contact via: Switchboard/Personal Mobile (on call rota)**	**ACTION CARD 29**
ROLE SUMMARY	
Mobilise another Consultant ENT Surgeon to cascade information to all Consultant colleagues in ENT Surgery.	
Assist the Consultant in Emergency Medicine in the assessment and management of patients.	
Oversee the deployment of ENT Surgery Medical staff.	
Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Contact another colleague and ask them to inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary.	❑
2. They should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre, where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
3. Proceed to the Emergency Department and assist the Consultant in Emergency Medicine in the assessment and management of casualties, in close liaison with the Consultants in Emergency Medicine and other Consultant colleagues.	❑
4. Co-ordinate the deployment of ENT medical staff.	❑
5. Ensure that the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with other Medical staff and Departments.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.32. Registrar ENT Surgery. Action Card 30

REGISTRAR ENT SURGERY (ON-CALL) **(Informed by Switchboard – F24)**	**ACTION CARD 30**
ROLE SUMMARY	
• Inform junior medical staff in ENT Surgery.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Ensure that all other junior medical staff in ENT Surgery are aware of the incident, and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.33. SHO ENT. Action Card 31

S.H.O. ENT (ON-CALL) **(Informed by Switchboard – Cisco broadcast)** **Contact via: CISCO 25849 (1st on call – SHO)**	**ACTION CARD 31a**
ROLE SUMMARY	
• Inform junior medical staff in ENT Surgery.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Ensure that all other junior medical staff in ENT Surgery are aware of the incident and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.34. Paediatric Consultant of week (COW) 1. Action Card 32

CONSULTANT OF THE WEEK COW 1 **ACTION CARD 32** **(Contacted via CISCO phone alert)** **Monday to Friday 8.30-17.00** **out of hours: action card 32b will assume role of COW1**	
ROLE SUMMARY	
• Inform COW 2 (Consultant of the week 2) to cascade information to all Consultants and other colleagues in Paediatrics	
• Ensure COW 2 acts as co-ordinator for MI	
• COW 1 to proceed to Hospital Co-ordination Centre to be briefed by Medical Director	
• Mobilise another Consultant Paediatrician to provide regular updates to Hospital Coordination Centre	
• Attend the ED and assist the Consultant in Emergency Medicine in the assessment and management of patients using APLS guidelines.	
• Provide regular updates to the Paediatric Major Incident Core Team	
ACTION - As soon as a Major Incident is declared, you should immediately :-	**Tick when completed**
1. Contact COW 2 to act as the co-ordinator for the MI and ask them to inform all Consultants in your Directorate of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary)	
2. COW 1 should stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre, (back room), where the Medical Director will brief them or Deputy and deployed according to need.	
3. COW 1 should then proceed to the Emergency Department and assist the Consultant in Emergency Medicine in assessing and managing casualties along APLS guidelines, in close liaison with the Consultants in Emergency Medicine and other Consultant colleagues.	
1. COW 1 should regularly update the Paediatric Major Incident Core team if patients require admission, extra staff, and resource requirement (PIMCT) (Ext 38892/38303). The PMICT team will be responsible for organising beds, staff, resources and provide regular updates to the Hospital Co-ordination Centre	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.34.1. Paediatric Consultant of the Week (COW) 2. Action Card 32a

CONSULTANT OF THE WEEK 2 **Contacted via CISCO phone alert** **Monday to Friday 8.30-17.00**	**ACTION CARD 32a**
ROLE SUMMARY	
• COW 1 will have debriefed COW 2/Consultant paediatrician on call and will be responsible for the overall co-ordination of staff, patients, and equipment during a Paediatric Major Incident	
• Attend the Paediatric Major Incident Core Team (PMICT) meeting point in the Doctor's office on Ward M as soon as possible	
• Oversee the deployment of Paediatric Medical staff	
• Liaise with COW1/consultant paediatrician on call for regular updates	
• Liaise with the Hospital Co-ordination Centre and provide regular updates	
• Liaise with the WATCH retrieval service, Bristol, Tel: 0300 0300 789 if transfer of a seriously ill/injured child is required. The WATCh service will liaise with other PICU's for bed availability • Liaise with Paediatric Consultant Anaesthetist if a paediatric transfer is required	
ACTION - As soon as a Major Incident is declared, you should immediately :-	**Tick when completed**
1. Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M	
2. Brief the PMICT Core Group of the incident and their roles and responsibilities	
3. Co-ordinate the deployment of Paediatric medical staff	
4. Ensure that the Hospital Co-ordination Centre (Ext. 37442, 33778, 33779, 33269) is kept informed of the nature of injuries, patient deposition and requirements for additional resources. They will liaise with other medical staff and departments	
5. Liaise with the WATCH retrieval service, regarding the possible need for transfer of the acutely unwell/injured child. Keep the Hospital Co-ordination Centre updated of discussions.	
6. Liaise with other hospital specialities dependent on requirement including the neonatal unit	
7. Receive regular updates from COW 1/Consultant paediatrician on call to assist with the deposition of patients and allocation of resources and personnel	
8. Arrange regular re grouping of the PMICT team to ensure that staff receive the most up to date information in relation to the Major incident to be cascaded to all staff	
9. Ensure that children from the ward or as a result of the major incident requiring follow up are documented and recorded	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.34.2. Consultant Paediatrician 3. Action Card 32b

ON CALL PAEDIATRICIAN **ACTION CARD 32b** **Informed by switchboard via phone call** **out of hours will take on role of COW1 action card 32**	
ROLE SUMMARY	
• On call paediatrician will be contacted on appropriate contact number by switchboard	
• Attend the Paediatric Major Incident Core Team (PMICT) meeting point in the Doctor's office on Ward M as soon as possible	
• Notify rest of consultant paediatric team if MI is likely to result in paediatric casualties or significant number of paediatric patients within hospital requiring input	
• If MI out of usual working hours to take on role of COW1	
• Nominate consultant paediatrician to act as COW2 and paediatrician 3	
• Liaise with the Hospital Co-ordination Centre and provide regular updates	
ACTION - As soon as a Major Incident is declared, you should immediately :-	**Tick when completed**
1. Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M	
2. If appropriate contact paediatric consultant team to request further personnel	
3. Brief the PMICT Core Group of the incident and their roles and responsibilities	
4.If out of hours take on role of COW1 action card 32	
5. Co-ordinate the dissemination of key information	
6. Ensure that the Hospital Co-ordination Centre (Ext. 37442, 33778, 33779, 33269) is kept informed of the nature of injuries, patient deposition and requirements for additional resources. They will liaise with other medical staff and departments	
7. Receive regular updates from Consultant Paediatrician (1) to assist with the dissemination of information relating to patients and allocation of resources and personnel	
8. Receive regular updates from Consultant Paediatrician (2) to assist with the dissemination of information relating to patients and allocation of resources and personnel	
9. Arrange regular re grouping of the PMICT team to ensure that staff receive the most up to date information in relation to the Major incident to be cascaded to all staff	
10. Responsible for liaising with and updating the Hospital Coordination Centre at regular intervals/as and when necessary	

11. Responsible for updating Consultant (1) and Consultant (2) of communications received from the Hospital Coordination Centre at regular intervals/as and when necessary

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.35. Paediatric Mid-Grade Doctor. Action Card 33

PAEDIATRIC MIDDLE-GRADE DOCTOR (ON-CALL) (Informed by Switchboard – Cisco broadcast)	**ACTION CARD 33**
ROLE SUMMARY	
• Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M • Ensure that consultant on call has been informed	
• Identify patients in Oakwood ward/Ward M/PAU who can be discharged to make space for incoming Paediatric casualties	
• Identify patients that can be transferred to neighbouring hospitals to make space for incoming Paediatric casualties or adult Wards for patients >16 years of age	
• Identify a middle grade colleague and an SHO to attend the ED, and assist the Consultant in Emergency Medicine in the assessment and management of patients using APLS guidelines	
ACTION - As soon as a Major Incident is declared, you should immediately :-	**Tick when completed**
1. Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M to be briefed about the Major Incident	
2. Ensure that all other junior medical staff in Paediatrics are aware of the incident and are following their action cards.	
3. If it is out of hours, telephone or What's app colleagues at home is, using the list kept in your Department. If clinically committed, delegate this task. DO NOT call via Switchboard, unless necessary.	
4. Proceed to Oakwood Ward, Ward M and PAU in turn and liaise with the nurse-in- charge for each ward. In conjunction with them, clear the ward for incoming casualties by: • Sending pre-operative patients home [the Matron for paediatrics will identify a suitable holding area for all discharged children to wait for transport home].	
5. The Nurse-in-Charge of each Paediatric ward will record the disposal of all patients and inform the PMICT core team who in turn will liaise with the Hospital Co-ordination Centre (extension 37442, 33778, 33779, 33269). All patients relocated to other areas within the Hospital should go with their medical records, nursing and drug charts and x-rays.	
6. Once this task is completed, proceed to the PMICT meeting point in the Doctor's office to await further instructions □	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.35.1. Paediatric SHO Grade Doctor. Action Card 33a

PAEDIATRIC SHO GRADE DOCTOR (ON-CALL) **ACTION CARD 33a** **(Informed by Paediatric Middle-Grade Doctor (On-Call)**	
ROLE SUMMARY	
• Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M	
• Assist the Paediatric Middle Grade doctor to identify patients in Oakwood ward/ward M/PAU who can be discharged to make space for incoming Paediatric casualties	
• Assist the Paediatric Middle Grade to identify patients that can be transferred to Childrens OPD or neighbouring hospitals to make space for incoming Paediatric casualties	
• If requested attend the ED, and assist the Consultant Paediatrician (1)/Paediatric Middle Grade Doctor in the assessment and management of patients using APLS guideline	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M to be briefed about the Major Incident	❑
2. Proceed to Oakwood Ward, Ward M and PAU in turn with the Paediatric Middle Grade Doctor and liaise with the nurse-in-charge for each ward. In conjunction with them, clear the Ward for incoming casualties by: • Moving patients to Childrens OPD. • Sending pre-operative patients home [the Matron for Paediatrics will identify a suitable holding area for all discharged children to wait for transport home].	❑
3. The Nurse-in-Charge of each Paediatric ward will record the disposal of all patients and inform the PMICT who in turn will liaise with the Hospital Co-ordination Centre, (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)). All patients relocated to other areas within the Hospital should go with their medical records, nursing and drug charts, and x-rays.	❑
4. Once this task is completed, proceed to the PMICT meeting point in the Doctor's office to await further instructions.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.36. Consultant Obstetrician/Gynaecologist. Action Card 34

CONSULTANT OBSTETRICIAN/GYNAECOLOGIST (ON-CALL – NON-RESIDENT CONSULTANT) ACTION CARD 34 **(Informed by Switchboard – F24)**	
ROLE SUMMARY	
• Mobilise another Consultant to cascade information to all colleagues in Obstetrics/Gynaecology via Delivery Suite Co-ordinator • Arrange for another Consultant to take over the provision of cover for Singleton • Inform the Midwifery Manager of the Day, who will arrange a midwife to accompany attendance at Morriston as appropriate and if required. • Inform the Clinical Director/Deputy and Head or Deputy of Midwifery	
• Attend Morriston ED and assist in the assessment and management of pregnant patients.	
• Oversee the deployment of Obstetrics/Gynaecology Medical staff as necessary.	
• Liaise with SCBU (including units in other hospitals) if necessary.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. Contact another colleague, (? Delivery Suite Co-ordinator) and ask them to inform all Consultants in your Department of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary, do not use Switchboard to do this). Consider early calling in of O&G staff out of hours if needed. You will need to inform the Clinical Director/Deputy and Head or Deputy of Midwifery	❑
2. You should, where possible stop what you are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre, Morriston where you will be briefed by the Medical Director or Deputy.	❑
3. Proceed to the Emergency Department and assist in the assessment and management of pregnant casualties in close liaison with the Consultants in Emergency Medicine Anaesthetics, and Trauma & Orthopaedic Surgery.	❑
4. Co-ordinate the deployment of Obstetrics/Gynaecology medical staff as required.	❑

5.	Ensure that the Hospital Co-ordination Centre (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with the Theatre Manager, and other Medical staff in the Hospital Co-ordination Centre.	❑
6.	Assess the need to transfer inpatients/potential labours to other sites and to stop elective cases, e.g., caesarean sections and inductions of labour to create capacity for major incident patients.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.37. Consultant Cardio-Thoracic Surgeon. Action Card 35

CONSULTANT CARDIO-THORACIC SURGEON (ON-CALL) **ACTION CARD 35** **(Informed by Switchboard – manual phone call)**	
ROLE SUMMARY	
• Mobilise another Consultant Cardio-thoracic Surgeon to cascade information to all Consultant colleagues and inform Registrar and SHO on call in Cardio-thoracic Surgery.	
• Assist in the prioritisation and management of patients in Cardiac Theatre.	
• Oversee the deployment of Cardio-thoracic Surgery Medical staff.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION -As soon as a Major Incident is declared, you should immediately :-	***Tick when completed***
1. Contact another colleague and ask them to inform all Consultants in your Directorate of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary)	❑
2. They should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre, where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
3. Proceed to the Cardiac Centre to meet with the Nurse-in-Charge and assist in the prioritisation and management of cases in the Cardiac Unit and prepare for the arrival of casualties.	❑
4. Co-ordinate the deployment of Cardio-thoracic Surgery medical staff.	❑
5. Ensure that the Hospital Co-ordination Centre (extension 30759 – main desk, 32905 – outside room, 337788 – outside phone – emergency backup line) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with other Medical staff and Departments.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be	

CONSULTANT CARDIO-THORACIC SURGEON (ON-CALL) (Informed by Switchboard – manual phone call)	ACTION CARD 35
ROLE SUMMARY	
used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident**	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.38. Registrar Cardio-Thoracic Surgeon. Action Card 36

REGISTRAR CARDIO-THORACIC SURGERY (ON-CALL) **(Informed by Switchboard – Cisco Broadcast)** **Contact via: CISCO 23635**	**ACTION CARD 36**
ROLE SUMMARY	
• Inform junior medical staff in Cardio-thoracic Surgery.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Ensure that all other junior medical staff in Cardio-thoracic Surgery are aware of the incident and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident**	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.39. SHO Cardio-Thoracic Surgery. Action Card 37

S.H.O CARDIO-THORACIC SURGERY (ON-CALL) **(Informed by Consultant On Call for Cardio Thoracic Surgery)**	**ACTION CARD 37**
ROLE SUMMARY	
• Inform junior medical staff in Cardio-thoracic Surgery.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION - As soon as a Major Incident is declared, you should immediately: -	***Tick when completed***
1. Ensure that all other junior medical staff in Cardio-thoracic Surgery are aware of the incident and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident**	

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.40. Consultant Physician (Morriston). Action Card 38

CONSULTANT PHYSICIAN ON-CALL **(Informed by Switchboard – F24)**	**ACTION CARD 38**
ROLE SUMMARY	
• Mobilise another Consultant Physician to cascade information to all Consultant colleagues in General Medicine and Medical Junior staff.	
• Assist the Consultant in Emergency Medicine in the assessment and management of patients in the event of a Medical Major Incident.	
• Oversee the deployment of General Medicine medical staff.	
• In the event of a medical major incident, (issues arising from an environmental disaster, infectious disease outbreak or chemical incident) deployment specifically of medical teams may require additional cancellation of clinics to resource the response. Consideration will also be required for longer term treatment plans following a medical emergency.	
• In the event of a non-medical Major Incident, the Consultant Physician will assist the Medical Director through the co-ordination and allocation for the deployment of medical staff. Until the Service Group Medical Director arrives on site, the Consultant Physician will assume this role also.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION :-	***Tick when completed***
'Medical' Major Incident - As soon as a Major Incident is declared you should immediately:-	❑
1. Contact another colleague and ask them to inform all Consultants in your Directorate of the incident, giving as much information as you can. (During normal working hours this can be delegated to a Medical Secretary)	❑
2. They should be asked to stop what they are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre, where they will be briefed by the Medical Director or Deputy and deployed according to need.	❑
3. Proceed to the Emergency Department and assist the Consultant in Emergency Medicine in the assessment and management of casualties, in close liaison with the Consultants in Emergency Medicine and Anaesthesia.	❑

CONSULTANT PHYSICIAN ON-CALL (Informed by Switchboard – F24)		ACTION CARD 38
ROLE SUMMARY		
4.	Co-ordinate the deployment of General Medicine staff.	❑
5.	Ensure that the Hospital Co-ordination Centre (Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) is kept informed of the nature of injuries and requirements for additional resources. They will liaise with the other Medical staff and Departments.	❑
6.	**'Non-Medical' Major Incident' – Providing** that it is not a medical Major Incident, the Consultant Physician on-call will be needed to control and allocate the deployment of medical staff throughout the incident until the arrival of the Medical Director. This will be a pivotal role in the medical response to the Incident. If for any reason the Consultant Physician is not immediately available, they should delegate to another Consultant colleague. As soon as a Major Incident is declared you should immediately: -	❑
7.	Proceed to the Hospital Co-ordination Centre and wait the arrival of Consultant colleagues and junior Medical staff.	❑
8.	Inform the Hospital Co-ordination Centre (Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) when ready and request an Incident briefing for the Medical staff from the Medical Director or Deputy.	❑
9.	Ensure that all medical staff sign-in, and record their grade and specialty, phone number, and home/contact telephone number.	❑
10.	In discussion with Consultant colleagues, form teams of personnel to assist with the management of casualties in the ED, Theatres, and Critical Care and Ward areas. This should take account of individual skills and seniority. Most casualties will be admitted to Theatres, Critical Care areas or to Surgical Decision-Making Unit (SDMU)/Oakwood initially. Once the Teams' tasks are completed, they should return to the Hospital Co-ordination Centre for further deployment and/or refreshments.	❑
11.	Ensure that adequate medical cover is provided for existing patients throughout the Hospital.	❑

CONSULTANT PHYSICIAN ON-CALL (Informed by Switchboard – F24)	ACTION CARD 38

ROLE SUMMARY		
6.	Once the situation is declared, and the incident is underway, it may be appropriate to send some medical staff home, to return later as a second wave of medical care. A record should be kept of such staff for contact later.	❑
7.	The 'White Board' in the Hospital Co-ordination Centre may be used to monitor the deployment of Medical Teams.	❑
8.	Additional information and resources should be obtained from the Hospital Co-ordination Centre. Regular feedback should be provided from the Hospital Co-ordination Centre to the Hospital Co-ordination Centre.	❑
9.	In a prolonged Incident, other Consultant Physicians should be available to deputise for the Consultant Physician on-call, on a shift basis.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.41. Registrar General Medicine Morriston. Action Card 39

REGISTRAR GENERAL MEDICINE (ON-CALL) **(Informed by Switchboard – Cisco broadcast)**	**ACTION CARD 39**
ROLE SUMMARY	
• Inform junior medical staff in General Medicine and Medical Specialties SHO on call. (The Medical Specialties SHO on call, in hours covers Renal and Neurology, OOH, they cover Renal, Neurology and Cardiology). In hours contact the cardiology SHO on Call also.	
• In a "Medical Major Incident" General Medicine will be the lead team for assessing and admitting casualties from the Major Incident	
• Discharging medical patients from the medical wards will be a key role	
• Undertake clinical duties according to deployment.	
• May need to support the Medical Director or Deputy in his/her role as medical co-ordinator in the initial phases before a second consultant physician arrives.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION – As soon as a Major Incident is declared you should immediately:-	***Tick when completed***
1. Ensure that all other junior medical staff in General Medicine are aware of the incident and are following their action cards. Inform the Medical Specialties SHO on call to follow their action card and confirm to them what specialties they need to alert; Renal, Cardiology and Neurology. They will alert junior medical staff in those specialties as required and agreed. In hours the Cardiology SHO will need to be informed separately if required.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑

REGISTRAR GENERAL MEDICINE (ON-CALL) (Informed by Switchboard – Cisco broadcast)	ACTION CARD 39

ROLE SUMMARY		
5.	When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.42. SHO General Medicine. Action Card 40

S.H.O. GENERAL MEDICINE (ON-CALL) **(Informed by On Call Registrar)**	**ACTION CARD 40**
ROLE SUMMARY	
• Inform junior medical staff in General Medicine.	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION – As soon as a Major Incident is declared you should immediately:-	***Tick when completed***
1. Ensure that all other junior medical staff in General Medicine are aware of the incident and are following their action cards.	❑
2. If it is **out of hours**, telephone colleagues at home, using the list kept in your department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3. You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4. If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5. When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.43. SHO Medical Specialties. Action Card 41

S.H.O. MEDICAL SPECIALTIES (ON-CALL) **(Informed by Registrar On Call)**		**ACTION CARD 41**
ROLE SUMMARY		
• Inform junior medical staff in Medical Specialties; Renal and Cardiology as appropriate		
• Undertake clinical duties according to deployment.		
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**		
ACTION – As soon as a Major Incident is declared you should immediately:-		***Tick when completed***
1.	Once alerted by the Medical Registrar, liaise with the Medical SHO on Call first to ascertain as to the other junior medical staff in Medical Specialties that should be alerted regarding the incident, and discuss support as required and appropriate. Ensure the respective specialty Registrars are aware once agreed who will be alerted.	❑
2.	If it is **out of hours**, telephone colleagues at home only if additional resources are required, (check with the Medical SHO first to ascertain resources required as noted in point 1), use the contact list kept in your Department. If clinically committed, this can be delegated. DO NOT call via Switchboard, unless absolutely necessary.	❑
3.	You should tell them briefly about the incident, including its location if known, and ask them to report to the Hospital Co-ordination Centre.	❑
4.	If it is **within hours**, they should be asked to stop what they are doing as soon as it is safe to do so and proceed to the Hospital Co-ordination Centre.	❑
5.	When free, report to the Hospital Co-ordination Centre for briefing and deployment by the Medical Director or Deputy.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.44. All Other Junior Medical Staff. Action Card 42

ALL OTHER JUNIOR MEDICAL STAFF (ON-CALL) **(Informed by S.H.O. On Call)**	**ACTION CARD 42**
ROLE SUMMARY	
• Proceed to the Hospital Co-ordination Centre	
• Undertake clinical duties according to deployment.	
• Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION – • Most on-call Medical staff have specific duties in the event of a Major Incident. You should ensure that you are familiar with the relevant Action Card for your post. These can be found in your Department or on MOCIS. This Action Card covers all other junior Medical staff • Junior Medical staff who are not on-call will be needed to help manage casualties from the incident, as well as patients already in the Hospital. This will be under the direction of the Medical Director or Deputy.	
As soon as you are notified that a Major Incident is declared (either by Switchboard or colleagues), you should immediately :-	***Tick when completed***
1. Stop what you are doing as soon as it is safe to do so, and proceed to the Hospital Co-ordination Centre where you should: - • Sign in • Await briefing by the Medical Director, or nominated Consultant • Carry out tasks given to you by them • Return to this Room when they are completed.	❑
2. Refreshments will be provided in this area for you. The Hospital Dining area will be used for families of those involved in the incident.	❑
3. You should ensure that at all times you wear appropriate protective clothing and a valid Health Board identity Badge.	❑
4. Some staff may be asked to go home and return later to provide on-going care, since the Incident can last several days at Hospital level. Please ensure that you have left a contact number if asked to do so in case circumstances change.	❑
5. Please try and keep calls through the Hospital Switchboard to an absolute minimum and ensure that the nominated Consultant in-charge of junior Medical staff is kept appraised of events by reporting back to the Hospital Co-ordination Centre when you have finished the	❑

ALL OTHER JUNIOR MEDICAL STAFF (ON-CALL) (Informed by S.H.O. On Call)	ACTION CARD 42
ROLE SUMMARY	
task(s) allocated to you. **DO NOT** go to the Emergency Department or Theatre unless told to do so. Regular briefings will be provided in the Hospital Co-ordination Centre.	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.45. Management: Clinical Site Team. Action Card 43

Clinical Site Team (Cisco 23123) **(Informed by Switchboard – Cisco broadcast)**	**ACTION CARD 43**
ROLE SUMMARY	
Notification and confirmation of either a Standby or Declared Major Incident will be received from the Hospital Switchboard:	
• If required assist the Nurse Director/Deputy to co-ordinate the deployment of nursing staff. Update a senior nurse of the demands prior to major incident declaration	
• Ensuring up-to-date Hospital Bed state is conveyed to Silver Command	
• Assist Silver Command in directing and monitoring staff within the Hospital.	
• Join the Clinical Capacity Group meeting 30 minutes after the declaration of a Major Incident by WAST.	
ACTION :- As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. **Standby/Declared Incident (outside of SBUHB area) -** Proceed to establish the Co-ordination Centre and prepare in readiness for command and control of the incident (MI standby Core Team) ***(Refer to HCC setting up Flow Chart included in major incident information within the HCC).*** ***Hospital Coordination Centre - Proceed to establish the Co-ordination Centre and prepare in readiness for command and control of the incident. (Refer to HCC setting up Flow Chart included in major incident information within the HCC).*** ○ ***Ensure Microsoft teams link for the Silver Command meeting is forwarded to the Gold Commander (COO in hours & Gold on call out of hours) for the initial meeting*** ○ ***Establish a TEAMS conferencing meeting with Gold (and other key stakeholders who may not be present for the Silver Command Meeting) at the earliest convenience; confirm with the Silver Commander. The dedicated TEAMS meeting appointment for SBU emergency planning for Lead Silver Command is:*** ***Microsoft Teams meeting*** ***Join on your computer or mobile app*** ***Click here to join the meeting*** ***You can also join via TEAMS by using the following:***	

Clinical Site Team (Cisco 23123) (Informed by Switchboard – Cisco broadcast)	ACTION CARD 43

ROLE SUMMARY

Mobile phone – QR Code

Should you not have access to TEAMS you can alternatively connect via smart phone or landline using the details below:

Telephone call (Audio Only) participation

Telephone Number - 02033215246

Meeting ID - Number 816630279#

Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.

Declared Incident (outside of SBUHB area):

Join the **Clinical Capacity Group meeting** 30 minutes after the declaration of a Major Incident by WAST (using the pre-established Clinical Capacity Group (CCG) calendar invite). During this meeting, WAST will share information across the NHS Wales system, in relation to the receiving hospitals for the incident. ***(no additional notifications or invites will be forwarded by WAST for the Clinical Capacity Group meeting; representatives must join via the below link 30 minutes after the declaration of the Major Incident).***

Wales Mass Casualty Arrangements (Clinical Capacity Group)

A Clinical Capacity Group (CCG) calendar invite has been created for all Clinical Site Team Matrons and other nominated Clinical Site Team staff. The calendar invite will include the above direct link to join the CCG.

Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.

2.	**Declared Major Incident (SBUHB area)** – Inform/Confirm with Clinical Site Managers at Singleton, Neath Port Talbot Hospitals. Discuss with Silver Commander and when appropriate the agreed	❑

ROLE SUMMARY

transfer of intra-hospital intakes where possible and necessary and under the direction of Silver.

Join the **Clinical Capacity Group meeting** 30 minutes after the declaration of a Major Incident by WAST (using the pre-established Clinical Capacity Group (CCG) calendar invite). During this meeting, WAST will share information across the NHS Wales system, in relation to the receiving hospitals for the incident. ***(no additional notifications or invites will be forwarded by WAST for the Clinical Capacity Group meeting; representatives must join via the below link 30 minutes after the declaration of the Major Incident).***

Wales Mass Casualty Arrangements (Clinical Capacity Group)

A Clinical Capacity Group (CCG) calendar invite has been created for all Clinical Site Team Matrons and other nominated Clinical Site Team staff. The calendar invite will include the above direct link to join the CCG.

Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.

3. **Hospital Coordination Centre** - Proceed to establish the Co-ordination Centre and prepare in readiness for command and control of the incident. ***(Refer to HCC setting up Flow Chart included in major incident information within the HCC).***

- Ensure a copy of each action card is available for those who request it.
- Ensure the time is noted when activation of action cards is confirmed, (document on proforma) and ascertain if any action cards have not been activated; highlight to the Silver Command Chair. ❑
- Ensure Microsoft teams link for the Silver Command meeting is forwarded to necessary personnel as noted here when the confirmed battle rhythm is established and agreed:

Establish a **TEAMS conferencing meeting** with the other Service Group Silver Co-ordination Centres (and other key stakeholders who may not be present for the Silver Command Meeting) at the earliest convenience; confirm with the Silver Commander. The dedicated

Clinical Site Team (Cisco 23123) **ACTION CARD 43**

(Informed by Switchboard – Cisco broadcast)

ROLE SUMMARY

TEAMS meeting appointment for SBU emergency planning for Lead Silver Command is:

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

You can also join via TEAMS by using the following:

Mobile phone – **QR Code**

Should you **not** have access to **TEAMS** you can alternatively connect via smart phone or landline using the details below:

Telephone call (Audio Only) participation

Telephone Number - 02033215246

Meeting ID - Number 816630279#

- Turn on television, activate news channels.
- A series of administration functions will be required and allocated via Silver Command. Collated initial information about the incident should be as per METHANE format and this should be documented on the METHANE form included in the major incident information. Number the METHANE forms in order of updates. Retrieve further METHANE reports from the Capacity Dashboard/emails to Switchboard. Provide all information to the assigned lead for information flows.
- Ensure the Morriston Hospital Major Incident e-mail address is accessed in readiness. ***(Instructions are included in the major incident information).*** All emails out should be forwarded via the Morriston major incident email address and all emails in should be via the Morriston Major Incident email address:

Morriston Hospital	SBU.MajorIncidentMorr@wales.nhs.uk
SBUHB Headquarters	SBU.MajorIncidentHQ@wales.nhs.uk

Clinical Site Team (Cisco 23123) (Informed by Switchboard – Cisco broadcast)	ACTION CARD 43
ROLE SUMMARY	

Tempest Ward, Burns Centre — Burns.Incident@wales.nhs.uk

Access the Capacity Dashboard and commence populating it - see action card. This will require updating hourly.

The following will form the hospital co-ordination centre team after the initial reporting and co-ordination of all major incident response staff;

- Hospital Operations: Deputy Group Director, Divisional Manager, Deputy Head of Nursing and Service Managers
- Clinical Site Team Matron
- Service Group Director
- Service Group Medical Director
- Service Group Nurse Director
- Nurse Bank Manager
- Loggist
- Administration Staff; agreed at the time of the incident
- WAST Silver
- Psychologist
- Therapies representative/link

The following will be in Gold Command but will be in close contact:

- Executive on Call
- Assistant Director of Operations
- Head/Deputy of Communications
- Emergency Preparedness Resilience and Response Lead
- Chief Operating Officer
- HB Medical Director
- HB Nurse Director
- Executive Lead for Civil Contingencies

4.	**Emergency Coordination Hospital Operations** - Inform Hospital Operations Team: Deputy Group Director, Divisional Manager, Deputy Head of Nursing and Service Managers	❑
5.	**Hospital Bed Capacity** - Establish an up-to-date bed-state and staffing levels for Morriston Hospital, identifying available beds by specialty and critical care areas. Log as appropriate on capacity dashboard.	❑

Clinical Site Team (Cisco 23123) (Informed by Switchboard – Cisco broadcast)	ACTION CARD 43	
ROLE SUMMARY		
6.	**Handover** - Give handover to senior Managers on arrival.	❑
7.	**Hospital receiving wards** - Ensure available beds on the receiving Wards. • Surgical Assessment Unit (SAU) and Oakwood. Ensure they have their Action Card • Ensure all ward areas are aware and they should refer to the 'Other Wards/Critical Care' action card.	❑
8.	**Ambulance Operational Delivery Unit (ODU) -** Inform Ambulance ODU following a discussion/agreement within the co-ordination centre regarding transfer of any intakes. Please note trauma, vascular and tertiary intake cannot be diverted. You will be acting in accordance with the Major Trauma network principles as well as other networks.	❑
9.	**Patient Discharge** - Arrange for the early discharge of patients, (as part of preparations for treatment of others), from the designated receiving Wards, in conjunction with the appropriate Specialist Registrar. Inform the Nurse in Charge of the Discharge Lounge and lead in Physiotherapy OPD as patients awaiting transfer/discharge should be sent to these areas. These areas will act as Holding/Decanting areas.	❑
10.	**Clinical Site Matron** - Clinical Site Matrons to continually liaise and update Silver Command	❑
11.	**Clinical Site Matron Assessment:** Make an assessment, in discussion with Silver Command, and if necessary, recall off-duty staff, as appropriate, and allocate them to necessary areas in the Hospital. This task can be allocated to the Nurse Bank Manager if/once present.	❑
12.	**Nursing Staff workforce -** Establish a list of Nursing staff on-duty within the Emergency Department and Critical Care areas. This task can be allocated to the Health Board Nurse Bank Manager if present.	❑
13.	**Nursing Staff availability -** Establish a pool of nurses/other staff ready to assist. This task can be allocated to the Health Board Nursing Register Manager if present. Update the Nurse Director/Deputy of the initial steps and handover when appropriate.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.46. Silver Command. Action Card 44

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

Notification and confirmation of either a Standby or Declared Major Incident will be received from the Hospital Switchboard who will also give a METHANE report.

For a standby notification or a declared MI **outside of the SBUHB area**, establish the HCC for the core standby group to convene and discuss any potential implications for the HB.

Please note, if a mass casualty incident is declared, in addition to the Health Board Major Incident response, please also refer to the Mass Casualty Arrangements for NHS Wales, where further actions will be required, see section 4.

Section 4.9 - WAST Mass Casualty Interim Reporting dashboard action card, enables WAST to provide casualty information and estimated arrival times to receiving hospitals.

Your Role is to:

- Silver Command/operational management support for the incident and running of the hospital.

  Do not stand down any action card holders in isolation; the Major Incident Procedure includes action card holders from a number of services and must be activated and stood down in totality.

- Support ED with the release of ambulances waiting to offload in line with the agreed release protocol:

  • 50% of vehicles released within 10 minutes

  • 75% of vehicles released within 20 minutes

  • 100% of vehicles released within 30 minutes

- Ensure organisation of signposting, car parking, relatives' area, press and media with assistance from the Senior Porter on duty until the Facilities Manager arrives.
- Oversee the co-ordination of relatives and friends, both those attending at the hospital, and telephone enquiries.
- Oversee the opening of Press/Media Centre in the Education Centre
- Oversight and co-ordination of inter hospital transfers
- Ensure the Clinical Site Team Matron or nominated representative joins the Clinical Capacity Group meeting 30 minutes after the declaration of a Major Incident by WAST.
- Refer to the major incident clinical guidelines:

  https://www.england.nhs.uk/ourwork/eprr/major-incidents

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

ACTION :- As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. **Major Incident Standby-** ensure the Hospital Co-ordination Centre is established and immediately proceed in person, inform Switchboard of your arrival at the HCC: - • Log all your personal actions, and commence your decision/action log • The MI standby Core Team will comprise of: • Nurse-in-Charge - ED • Consultant in Charge in ED • Clinical Site Matron for Morriston • Service Group Nurse Director • Service Group Medical Directors/Deputies • Silver On Call managers for all SDG's **(Out of hours)** • Service Group Directors **(in hours)** • Gold On Call **(out of hours)** • Chief Operating Officer **(in hours)** • Head and Manager of Emergency Preparedness Resilience and Response • Loggist/Administration Staff - **alerted from within the HCC** ***Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.***	
2. **Major Incident Declared (outside of SBUHB area) -** ensure the Hospital Co-ordination Centre is established and immediately proceed in person, inform Switchboard of your arrival at the HCC: - • Log all your personal actions, and commence your decision/action log • The MI standby Core Team will comprise of: • Nurse-in-Charge - ED • Consultant in Charge in ED • Clinical Site Matron for Morriston	

SILVER COMMAND	ACTION CARD 44
Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER (Informed by Switchboard – F24)	
ROLE SUMMARY	
• Service Group Nurse Director • Service Group Medical Directors/Deputies • Silver On Call managers for all SDG's **(Out of hours)** • Service Group Directors **(in hours)** • Gold On Call **(out of hours)** • Chief Operating Officer **(in hours)** • Head and Manager of Emergency Preparedness Resilience and Response • Loggist/Administration Staff - **alerted from within the HCC** Ensure the Clinical Site Team Matron or nominated representative joins the **Clinical Capacity Group meeting** 30 minutes after the declaration of a Major Incident by WAST. During this meeting, WAST will share additional information across the NHS Wales system, in relation to the receiving hospitals for the incident. ***(no additional notifications or invites will be forwarded by WAST for the Clinical Capacity Group meeting; representatives must join via the below link 30 minutes after the declaration of the Major Incident).*** **Wales Mass Casualty Arrangements (Clinical Capacity Group)** A Clinical Capacity Group (CCG) calendar invite has been created for all Clinical Site Team Matrons and other nominated Clinical Site Team staff. The calendar invite includes the above direct link to join the CCG. ***Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.***	
3. **Declared Incident (SBUHB area)** – ensure the Hospital Co-ordination Centre is established and immediately proceed in person, inform Switchboard of your arrival at HCC • Log all your personal actions, and commence your decision/action log • Contact fellow Senior Managers to attend, this is imperative if the action card holder has a duplicate role/action card as there are some potential overlaps. ***Assign another Senior Manager to assist and agree the actions as noted below.***	❑

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

The core Silver Command team must be present in the HCC.

- Ensure all SDG Silver Command Co-ordination Centres are established
- Assume Command and Control of the Incident, (adopt JESIP Principles, see Appendix)
- Establish an early battle rhythm in conjunction with Gold command and inform key stakeholders of the silver command meeting structure including other SDG. **Morriston will be the lead silver command for the incident.**

Ensure the Clinical Site Team Matron or nominated representative joins the **Clinical Capacity Group meeting** 30 minutes after the declaration of a Major Incident by WAST. During this meeting, WAST will share additional information across the NHS Wales system, in relation to the receiving hospitals for the incident.

(no additional notifications or invites will be forwarded by WAST for the Clinical Capacity Group meeting; representatives must join via the below link 30 minutes after the declaration of the Major Incident).

Wales Mass Casualty Arrangements (Clinical Capacity Group)

A Clinical Capacity Group (CCG) calendar invite has been created for all Clinical Site Team Matrons and other nominated Clinical Site Team staff. The calendar invite includes the above direct link to join the CCG.

Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.

Only Convene a silver command meeting when appropriate information has been gathered, risks have been identified and updates/further actions can be provided; refer to point 10 below and template Agenda, (appendices). Also align the battle rhythm to ensure you can appraise Gold Command following silver meetings

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

The following information is included in action 18:

- ***The Hospital Co-ordination Centre Core Team composition***
- **Silver Command Teams Meeting Link, when ready to convene the first Silver Command meeting**
- ***Gold Command Team***

You will need to allocate the following roles immediately:

- **Loggist:** allocated to the Co-ordination centre to keep a log of activity/decisions, (a register of Loggist is included in the Co-ordination Centre).
- **Management Teams:** agree and allocate team members for management of day-to-day business and the team for management of the major incident. Ascertain how many more Silver Command personnel are required.
- **Administration Personnel required** to establish an information point to:
    a) Monitor and record responding action card holders, either presenting in person or via telephone. Identifying any gaps.
    b) Monitor/respond to telecommunications
    c) Monitor generic major incident email communications
    d) To monitor the NHS Capacity Dashboard if available: Bed Management
    e) Monitor information flows
    f) To support Medical Director
    g) To be a point of contact within the Coordination Centre
    h) Ascertain key area points of contact, e.g., ED, Critical Care, SDMU, OPD, Discharge lounge and Physiotherapy Gym and ensure there are correct contact details
    i) Ascertain if transfer teams are required to move patients from ED to definitive care areas
    j) Allocate runners to assist with information flows to and from the HCC
    k) Monitor F24 Rapid Communication System for additional staff resources

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

4. **Situational Awareness: METHANE –** If not already received, request the METHANE from switchboard, and HB SITREP from the Clinical Site Matron.

   Identify, where possible with the Emergency Department a single point of contact and contact number and vice versa for further direct updates. ❑

   - Undertake a briefing with key action card holders and managerial staff and when appropriate hold discussions via a Silver Command meeting, (refer to agenda and in section 6, p 329)
   - Arrange early briefing/update with Gold Command.

5. **Coordination information flow -** Allocate a Senior Manager to co-ordinate information flows as noted in action 1d and to undertake the following:

   - Ensure senior staff/ED/Switchboard/OPD are aware of the point of contact.
   - Identify runners to assist with the information flow to and from the Co-ordination Centre. Consider the use of radios as additional resilience for communications between key personnel.
   - ED reception staff will need to provide information on the numbers of arriving patients, the identity, and the severity of injuries, (Numbers of Priority 1, 2, 3, paediatric Patients), discharges and deaths. ❑
   - Ensure receiving wards are ready to receive major incident patients. In the event of a medical major incident consideration should be given to allow major incident patients to go directly to AMAU.
   - Ensure that it is communicated that all e-mail correspondence is via the Morriston Hospital Co-ordination Centre e-mail address. Similarly emails out should be from this address, ensuring emails to Burns Silver command, (where required) are as noted and to Gold as noted:

   Morriston Hospital SBU.MajorIncidentMorr@wales.nhs.uk

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

SBUHB Headquarters	SBU.MajorIncidentHQ@wales.nhs.uk
Tempest Ward, Burns Centre	Burns.Incident@wales.nhs.uk

- Initial and subsequent receipt of information should be logged sequentially using the METHANE format. All collated information written, email, logs will be required to be placed in order and filed safely following the incident.
- If a multi-agency Silver (TCG) is established, another silver commander will be required to attend and feedback.

6. **Gain Assurance for the following:**

- **Confirm with Senior Porter on-duty -** (Cisco 23916) to ensure the HB Lockdown procedure has been invoked and confirm the organisation of Signposting, Car Parking, and Relatives area in main dining room. Hand over responsibility to a facilities Manager, or deputy, if available.
  - **Main Entrance Information Desk -** has been opened by Volunteer Services Manager.
  - **Relatives Care Team** has been established in area 3, in OPD.

Please note, out of hours additional staff resources will be required to be allocated to establish this area and to undertake the OPD Nurse in Charge Action Card.

- **Education Centre – (Media Centre)**
  In hours, Ensure the Education Centre has invoked their action card, request that they confirm when this is ready. Inform Communication lead upon their arrival.
  Out of hours – request Security to open Education Centre. When possible allocate a staff member to open rooms in accordance with action card until Communication Team/Education Centre team members arrive. In addition, to open OPD for Relatives Care Team. The Nurse Director will allocate resources OOH for this area.

SILVER COMMAND	ACTION CARD 44
Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER (Informed by Switchboard – F24)	
ROLE SUMMARY	
	• **Facilities -** Facilities action cards should have been invoked. Ensure refreshments are available for relatives and staff

7.	**Silver Commander Assessment -** As part of the silver command meeting (see agenda in MI packs); make an assessment, in discussion with senior colleagues present, of any;
	• Current and immediate/emerging risks and any concurrencies
	• additional resources; staff/equipment likely to be required
	• Any business continuity issues
	  ○ Critical supplies; clinical and pharmaceutical
	  ○ Premises
	  ○ Staffing
	  ○ Digital
	  ○ Transport for the purpose of supplies and patients; consider liaison with HB Transport Manager
	• Health & safety issues
	• Surge Capacity Plans and other regional guidance
	• Consider staff welfare within Silver and operational teams
	Consideration will be required to ascertain if non-major incident 999 calls can be diverted either within the Health Board and or to neighbouring Health Boards. Approval will be required in accordance with current protocols, prior to alerting WAST of the arrangements. Trauma, vascular and tertiary 999 calls cannot be diverted.

8.	**Maintaining daily Operational Management, (see action 1) -** Provide on-going operational management and liaise with the Chief Operating Officer or Deputy.
9.	**Notification of Stand Down** - Following notification by Switchboard that WAST have confirmed Stand Down at the scene, consider the following; • Hospital position and decide an appropriate time for stand down of the hospital response in conjunction with Gold (which may be some time later).

ROLE SUMMARY

- **During in hours (09:00 – 17:00 hrs):** inform Switchboard to activate the hospital stand down procedure.
- **During out of hours (17:00 – 09:00 hrs):** decide the most appropriate communication method to alert responding staff, consider the below routes:
  - E-mail
  - Cisco broadcast
  - Final Silver meeting

- A hot debrief is required as soon after stand down notification as possible. A formal debrief will be arranged post incident

10. **Operational Debrief post stand down -** Assist the Executive Director in the organisation of an operational debrief and the preparation of a Report.

- Consider issues related to Press/Media interest. In conjunction with the Communication Team prepare for Press/Media statements and also possible VIP visits. Ensure there is a process to collate all documentation, hard copy and digital and liaise with the Incident Recovery Team for storage.

11. **Welsh Government Community Advice and Listening Line -**

A Community Advice and Listening line, (C.A.L.L) is offered which provides emotional support and information/literature on mental health and related matters to the people of Wales. Free phone 0800 132 737 or text call 60062:- **http://www.callhelpline.org.uk/.** For discussion and issue within the Debrief as well as staff information leaflets that the Psychologist representative will guide you on and are included as appendices.

12. **Further Consideration; Staff Welfare -** Considerations for Psychological Support and TRiM

13. The dedicated **TEAMS** meeting appointment for SBU emergency planning for the Lead Silver Command meeting is as follows and request an administrator to forward the appointment once you have ascertained who is responding:

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

Microsoft Teams meeting

Join on your computer or mobile App

Click here to join the meeting

You can also join via TEAMS by using the following:

Mobile phone – **QR Code**

Should you **not** have access to **TEAMS** you can alternatively connect via smart phone or landline using the details below:

Telephone call (Audio Only) participation

Telephone Number - 02033215246

Meeting ID - Number 816630279#

- Service Group Director
- Service Group Medical Director
- Service Group Nurse Director
- Hospital Operations Team: Deputy Group Director, Divisional Manager, Deputy Head of Nursing and Service Managers
- Clinical Site Team Matron
- Nurse Bank Manager
- Loggist
- Administration Staff; agreed at the time of the incident
- WAST Silver
- Psychologist
- Therapies representative/link
- Additional staff as runners
- Head of Communications

The Gold Executive will be based at HB HQ and will comprise of the following:

(It is the Chair of the Lead Silver only who will join gold command meetings when convened and update on escalated response issues that cannot be resolved at a tactical level)

- Executive on Call

SILVER COMMAND **ACTION CARD 44**

Service Group Director/Deputy AECHO or Morriston Silver ON CALL MANAGER

(Informed by Switchboard – F24)

ROLE SUMMARY

- Assistant Director of Operations
- Director of Information, Communications and Engagement
- Emergency Preparedness Resilience and Response Lead
- Chief Operating Officer
- HB Medical Director
- HB Nurse Director
- Executive Lead for Civil Contingencies
- Loggist
- Executive Director of Therapies and Health Sciences
- Director of Digital
- Director of Public Health
- Finance Director

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.47. Primary Care, Community & Therapies. Action Card 45

PRIMARY CARE AND COMMUNITY SERVICES	ACTION CARD 45

ROLE SUMMARY

Notified by Switchboard – F24

Notification and confirmation of a Declared Major Incident will be received from the Hospital/s Switchboard, who will provide information on the incident in terms of location, type, the hazards, and number of casualties.

For a standby notification or a declared MI outside of the SBUHB area, report to the Morriston HCC as part of the core standby group to convene and discuss any potential implications for the HB.

Your role:

(The roles included within this Action Card may be undertaken by the following, but initial contact will be made first with the Service Group Director or Deputy, Primary, Community & Therapies Service Group, Group Nurse Director, Primary, Community & Therapies Service and Group Medical Director, Primary, Community & Therapies Service who will in turn contact the staff members as noted below to ascertain availability).

Relevant Actions will be followed as per PCT Major Incident Tactical Plan (2023) and Service Business Continuity Plans (2023)

Please note, if you are on call another colleague will be needed to undertake the roles in this action card.)

Group Service Director/Deputy will contact:

- Group Medical Director
- Group Nursing Director
- Clinical Director Therapies & Audiology
- Associate Director of Operations
- Service Lead for EPRR

Group Nurse Director/Deputy will contact:

- Deputy Nurse Director
- Heads of Nursing

Group Medical Director/Deputy will contact:

- Clinical Director for UPCC
- Associate Director Primary Care
- Head of Primary Care

Role Summary

- Provide appropriate co-ordination of Primary Care, Community & Therapies Service Group involvement at or in support of a major incident.
- Establish close liaison with Social Services, other Local Authority departments and other agencies to meet the needs of people affected and to manage patient discharges.

PRIMARY CARE AND COMMUNITY SERVICES	ACTION CARD 45

ROLE SUMMARY

Notified by Switchboard – F24

- Provide healthcare support for people who have been evacuated from their homes into reception centres.
- Liaise with Chief Executive, Executive colleagues, and other relevant officers and organisations.

NOTE: This action card focuses on the Primary Care, Community & Therapies Service Group Director/Deputy role in overseeing the coordination of primary care and community health services during an incident.

However, there may be an occasion when the acute in-patient health service has not been placed on major incident alert, but a request may be received from the Local Authority Emergency Planning Officer for health service support at uninjured survivor reception centres and evacuation centres. Such an evacuation may include the evacuation of a Nursing/Residential Home. Information may also be sought in relation to chronically ill patients and frail/disabled persons in a particular community, where evacuation may be considered by the Police. Therefore, a community Silver command may be required.

ACTION :- As soon as a major incident is **declared (in SBUHB area)** you should immediately:-	***Tick when completed***
1. Log the details of the incident in a METHANE format: **M Confirm** major incident declared **E Exact** location **T Type** of incident **H Hazards** **A Access**/Egress issues **N Number** of casualties and types of injuries **E Estimated** time of arrival of casualties • Make contact with Morriston Hospital Co-ordination Centre, (Lead Silver Command) and confirm your undertaking of the action card and your contact details. • Following contact and ascertaining more detail, establish PCT Silver Command and establish a community-based co-ordination point at a suitable Community Clinic. Ensure there is regular communication with the Morriston Hospital Co-ordination Centre.	❑
2. Consider the following:	❑

PRIMARY CARE AND COMMUNITY SERVICES		ACTION CARD 45
ROLE SUMMARY **Notified by Switchboard – F24**		
	With Senior colleagues, (as appropriate) based on the initial information. Assess the impact of the incident on primary care, community & Therapies service Group.	
3.	Inform Primary Care and the Community Teams and GP's of the nature and likely duration of the incident and the support required: • As appropriate gain further information regarding current community nursing levels. • Delegate appropriate nursing and other health resources to the required location for rest centres/survivor centres. Identify a lead person for each centre. • Ensure regular updates by the designated leads are forwarded to you. • Make an assessment of staffing requirements for both the incident and routine workload, with consideration of the period that the response is required. If necessary, off duty staff may be required as appropriate.	❑
4.	Based on the incident a multi-agency Gold/Silver may be established. If so, establish close liaison with Social Services, other Local Authority departments and other agencies to meet the needs of people affected and to manage patient discharges from hospitals including liaison with nursing homes for emergency placements.	❑
5.	Liaise with Local Authorities to ensure people at survivor reception centres and rest centres have effective access to health care and support and, in particular, access to essential medication.	❑
6.	If necessary, mobilise GP Out of Hours Service to provide advice and to increase capacity to primary care services.	❑
7.	If necessary, provide support to mass vaccination and treatment programmes.	❑

PRIMARY CARE AND COMMUNITY SERVICES		ACTION CARD 45
ROLE SUMMARY **Notified by Switchboard – F24**		
8.	Make an assessment, in discussion with senior colleagues, of any additional resources likely to be required.	❑
9.	Provide on-going oversight of the Primary, Community & Therapies Service Group.	❑
10.	Liaise with the Silver Command, and other relevant colleagues and organisations.	❑
11.	Consider the recovery implications on PCC.	
12.	Assist the Executive Manager in the organisation of an operational debrief and the preparation of a Report.	❑
13.	Use the following email addresses when corresponding to Morriston Silver/Gold: Morriston Hospital SBU.MajorIncidentMorr@wales.nhs.uk SBUHB Headquarters SBU.MajorIncidentHQ@wales.nhs.uk Tempest Ward, Burns Centre Burns.Incident@wales.nhs.uk	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.

- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.48. Head of Communications/Deputy. Action Card 46

HEAD OF COMMUNICATIONS/DEPUTY		**ACTION CARD 46**
Notified by Switchboard – F24		
ROLE SUMMARY		
Notification and confirmation of a Declared Major Incident will be received from the Executive On Call or Hospital Switchboard. Be part of the Silver Command in the Morriston Hospital Coordination Centre but work in liaison with Director of DICE in Gold Command. *Please note – the Morriston Coordination Centre remains the centre for Silver Command irrespective of which site the major incident is focused on.*		
	• To co-ordinate and manage press and media arriving on the hospital site, working in liaison with senior managers, police and other agencies • To co-ordinate and manage urgent site-related communications	
ACTION :- - As soon as a Major Incident is declared **(in SBUHB area)** or receipt of notification by the hospital telephonist or a Senior Manager, the Communications Co-Ordinator should:-		***Tick when completed***
1.	Contact the hospital Co-ordination Centre 1) 01792 530759, 2) 01792 532905, 3) 01792 703778 and note if you are also able to send any additional communications team members who will be part of the Management Team at Morriston and liaise with the Coordination Centre in Morriston	❑
2.	Join any Silver Command online Teams meeting if required, as well as in-person in the Coordination Centre	❑
3.	Make urgent contact with the Police liaison officer and Police Press and Media officer, and arrange to join emergency comms cell, as required.	❑
4.	Liaise with Site Manager over any urgent general public messages about restricting general access to the hospital site - unless seriously ill or injured – to reduce pressure on unscheduled care during the major incident.	❑
5.	Recognising that reporters are likely to turn up on the hospital site, the lead for Communications should liaise with the Site Manager about security arrangements to stop rogue reporters getting to patients or relatives, and generally managing Press and Media presence.	❑
6.	Update website, SB staff intranet and social media as necessary, and monitor social media, in liaison with police and other agencies.	❑

HEAD OF COMMUNICATIONS/DEPUTY Notified by Switchboard – F24	ACTION CARD 46	
ROLE SUMMARY		
7.	Once the initial Major Incident is contained, take over from Gold Command Police Communications on Press and Media and social media issues relating to hospital operational matters. However, if necessary, continue to work with Police Liaison officers – including Police Family Liaison officers – over ongoing patient/relatives statements/releases.	❑
8.	Working with Gold and Silver, co-ordinate and manage press conferences if necessary. Depending on the stage of the Major Incident, Police and other agencies may also be involved.	❑
9.	Support clinicians and senior managers who may need to make press and media statements or give interviews. Liaise as necessary with 111 Service, WAST or other NHS health boards regarding health service specific key messages that may be required, following discussions within Silver and Gold command.	❑
10.	Use the following email addresses when corresponding: Morriston Hospital — SBU.MajorIncidentMorr@wales.nhs.uk SBUHB Headquarters — SBU.MajorIncidentHQ@wales.nhs.uk Tempest Ward, Burns Centre — Burns.Incident@wales.nhs.uk	

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum

- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.49. Service Group Nurse Director/Deputy. Action Card 47

Service Group NURSE DIRECTOR/DEPUTY **(Informed by Switchboard F24)**	**ACTION CARD 47**
ROLE SUMMARY	
Notification and confirmation of either a Standby or Declared Major Incident will be received from the Hospital Switchboard.	
In the event of a MI Standby or Declared **(outside of SBUHB area)** your role will be: • Part of the MI standby Core Team (Silver Command) at the HCC In the event of a MI Declared **(within the SBUHB area)** your role will be: • The HB Nurse Bank Manager or Deputy will be contacted and assist in the co-ordinating the deployment of nursing staff • Direct and monitor nursing staff within the hospital • Assess the nursing demands of the hospital • Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
ACTION :- As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. In the event of a MI Standby or Declared **(outside of SBUHB area):** Proceed to the Hospital Co-ordination Centre at Morriston Hospital (service corridor, adjacent to Telephone Exchange) and inform Switchboard of arrival at Hospital. Form part of Silver Command MI Standby Core Team. ***Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.***	❑
2. In the event of a MI Declared **(within the SBUHB area):** Proceed to the Hospital Co-ordination Centre at Morriston Hospital (service corridor, adjacent to Telephone Exchange), and inform Switchboard of arrival at Hospital. Inform senior nursing staff; Heads of Nursing and Matrons. (Adopt JESIP principles, see Appendix).	❑
3. Receive an update of the current situation from the Clinical Site Manager (23123 Cisco Phone holder).	❑

Service Group NURSE DIRECTOR/DEPUTY (Informed by Switchboard F24)		ACTION CARD 47
ROLE SUMMARY		
4.	Organise an update to assess staffing situation.	❑
5.	Assign a staff member to collate information from each area regarding nursing members and skill mix on duty – assess and re-deploy to critical areas, if required.	❑
6.	Assign a staff member to prepare to allocate nursing staff on arrival, recording details of deployment including name, specialty, time deployed and area.	❑
7.	Assess the need for extra staffing in liaison with Senior Nursing staff in the following areas:- • Emergency Department • Operating Theatres • Critical Care areas • Designated Receiving Wards • Discharge lounge and Physiotherapy OPD, (secondary in-patient discharge area) • OPD – relatives care centre Review staffing of areas where activity has been restricted to ascertain if staff can be deployed. Some staff resource maybe allocated in teams to wait in the Doctors Mess within the dining room until they are required. Medical staff teams may also be waiting in this area and will be allocated by the Medial Director/Deputy. (Entry code: **9856,** contact number: **32102**).	❑
8.	Designate nursing staff who may be called upon to escort patients from the Emergency Department to receiving Critical Care and Ward areas.	❑
9.	Liaise with the Director of Nursing in Gold Command regarding the on-going situation.	❑
10.	Allocate a Lead Nurse to work with the OPD Nurse in Charge and Hospital Chaplain, to specifically assist in the care and support of bereaved relatives allocate additional staff as required	❑
11.	Consideration may be required for vulnerable individuals, (adult/child) who are uninjured in the major incident but who may require an interim place of safety until relatives are identified by Police.	❑

Service Group NURSE DIRECTOR/DEPUTY (Informed by Switchboard F24)	ACTION CARD 47

ROLE SUMMARY

12.	Consideration with regard to the co-ordination of staff referrals to the Staff Well Being Service post incident. A Psychologist will be present in Silver.	❑

Note: - In the absence of the Nurse Director, a Head of Nursing will be asked to undertake these duties.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.50. Service Group Medical Director/Associate. Action Card 48

Unit Medical Director/Associate Service Group Medical Director (Informed by Switchboard F24)	**ACTION CARD 48**
ROLE SUMMARY	
Notification and confirmation of either a Standby or Declared Major Incident will be received from the Hospital Switchboard.	
In the event of a MI Standby or Declared **(outside of SBUHB area)** your role will be: • Part of the MI standby Core Team (Silver Command) at the HCC In the event of a MI Declared **(within the SBUHB area)** your role will be: • Co-ordinate the deployment of medical staff • Direct and monitor medical staff within the hospital • Assess the medical demands of the hospital • Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/** **If you are the Gold on Call, you will need to allocate a deputy to undertake this role.**	
ACTION :- As soon as a major incident is declared you should immediately:-	***Tick when completed***
1. In the event of a MI Standby: Proceed to the Hospital Co-ordination Centre at Morriston Hospital (service corridor, adjacent to Telephone Exchange), and inform Switchboard of arrival at Hospital. Form part of Silver Command MI Standby Core Team. ***Silver Command will review all available information and in liaison with Gold, decide whether to stand down the MI standby, remain in MI standby and await further information or declare a MI.***	
2. **Major Incident Declared (outside of SBUHB area) -** Proceed to the Hospital Co-ordination Centre at Morriston Hospital as part of the MI standby core team (service corridor, adjacent to Telephone Exchange) and inform Switchboard of arrival at Hospital. (Adopt JESIP principles, see Appendix).	

Unit Medical Director/Associate Service Group Medical Director (Informed by Switchboard F24)	ACTION CARD 48
ROLE SUMMARY	
3. In the event of a MI Declared **(within the SBUHB area):** Proceed to the Hospital Co-ordination Centre at Morriston Hospital (service corridor, adjacent to Telephone Exchange) and inform Switchboard of arrival at Hospital. (Adopt JESIP principles, see Appendix).	❑
4. Receive an update of the current situation from the Clinical Site Manager, Senior Manager, Executive Manager on-call and the Emergency Department.	❑
5. Form part of the Hospital Co-ordination Centre team.	❑
6. Ascertain an administration staff member to assist; • Issuing medical staff action cards as they arrive; Copies of all action cards are included in the Co-ordination Centre. • Log staff names, time of deployment and location.	
7. Assess the clinical and medical staffing situation through the Health Board. Provide an update to the Medical Director/Deputy.	❑
8. In conjunction with the Clinical Site Team, prepare the Co-ordination centre to allocate medical staff on arrival, recording details of deployment. This will be delegated to the Consultant Physician On-Call during a 'Non-Medical Major Incident. If there is a medical major incident, this role will need to be delegated to another specialty consultant.	❑
9. Medical staff reporting for duty will initially present to the Co-Ordination Centre. Undertake a briefing of medical staff. Liaise with the Emergency Department Lead Consultant to ascertain the required medical team compliment, dependent on the casualty numbers and the nature of their injuries. Some medical teams may need to wait until their deployment is required and will need to wait in the Doctors Mess in the dining room. (Access Code: **9856**, Extension: **32102**). Some teams will inform you if they will be waiting in different areas and will provide a point of contact.	❑

Unit Medical Director/Associate Service Group Medical Director (Informed by Switchboard F24)		ACTION CARD 48
ROLE SUMMARY		
10.	Delegate and direct medical staff to the most appropriate areas. You will base yourself in the Co-ordination Centre and will oversee this area.	❑
11.	Organise the allocation of theatre time, in liaison with the Theatre Manager.	❑
12.	Call in Consultant Medical Staff, as required.	❑
13.	Consideration regarding the co-ordination of staff referrals to the Staff Well Being Service post incident. A Psychologist will be present in Silver to assist.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.51. Support- HB Nurse Bank/Office Manager. Action Card 49

HEALTH BOARD NURSE BANK MANAGER/OFFICE MANAGER (Informed by Switchboard – F24)	**ACTION CARD 49**
ROLE SUMMARY	
Notification and confirmation of a Declared Major Incident will be received from the Hospital Switchboard.	
• Assist the Service Group Nurse Directors/Deputy in monitoring nursing staff levels within the Health Board.	
• Assist the Service Group Nurse Directors in meeting the nursing demands of the Health Board, and keep the Nurse Directors informed of changes.	
ACTION: -As soon as a major incident is declared you should immediately	***Tick when completed***
1. Contact the Health Board Bank Co-ordinators at home, advise them of the incident, log onto bank system via their remote access to assist with staffing demand	❑
2. Proceed to Morriston Co-ordination Centre and liaise with the Service Group Nurse regarding the nursing and clerical levels demand within the Hospital for the next 24 hours, taking into account numbers of staff, grades, and skill mix.	❑
3. Contact the Bed/Site Manager at Singleton Hospital and assess the nursing and clerical demand within Singleton Hospital for the next 24 hours, taking into account numbers of staff, grade's, and skill mix as they may receive transferred patients from Morriston Hospital.	❑
4. Liaise with the Nursing Bank Co-ordinators regarding the additional staffing requirements across the Health Board	❑
5. The Health Board Nurse Bank office will email details of the Staff booked to the Co-ordination Centre at Morriston Hospital: and will inform the Wards/Departments as appropriate.	❑

NOTE:- During the Major Incident ALL requests for additional nurse staffing, must be routed via the Co-Ordination Centre at Morriston Hospital and NOT via the Health Board Nurse Bank office.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at all times. These unique M.I. numbers must be used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.52. Matrons - Action Card 50

Matrons **ACTION CARD 50** **(Informed by Cisco broadcast & the Service Group Nurse Director)**		
ROLE SUMMARY		
• Liaise with the Hospital Co-ordination Centre in relation to communication and information flow with the individual Service		
• Continue to co-ordinate the activities of the Service		
STAND BY ACTION: - Notification of a Major Incident will come from the Hospital Co-ordination Centre.		***Tick when completed***
1.	Notify Wards of a potential Major Incident and instigate the stand-by procedure. Ensure the receiving wards commence preparation; Surgical Assessment Unit and Paediatrics. If Medical Major Incident, where possible AMU will need to receive major incident patients directly	❑
2.	Receive current accurate bed-state and staffing levels from the Nurse-in-Charge of Wards. Forward Directorate/Unit bed-state by signal or telephone to the Hospital Co-ordination Centre (service corridor, adjacent to Telephone Exchange) on extension, phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532904 – Ext 32904 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)	❑
3.	Await further instructions from the Hospital Co-ordination Centre.	❑
4.	Ensure that Ward routines carry on as normal.	❑
5.	Refer to the major incident clinical guidelines: **https://www.england.nhs.uk/ourwork/eprr/major-incidents/**	
FULL MAJOR INCIDENT ACTION: Notification of a full Major Incident will come from the Hospital Co-ordination Centre		***Tick when completed***
1.	Ensure the receiving wards are ready to receive major incident patients. However, assess with the Nurse-in-Charge of **each** Ward, the availability of staff to: • Remain on duty • Arrive early for next shift • Provide extra cover, if necessary.	❑
2.	Forward current accurate bed-state and staffing information, by fax or telephone, to the Hospital Co-ordination Centre (service corridor, adjacent to Telephone Exchange) on extension, phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1),	❑

Matrons	**ACTION CARD 50**
(Informed by Cisco broadcast & the Service Group Nurse Director)	
ROLE SUMMARY	
	01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) The Hospital Co-ordination Centre should be continually updated of this information.
3.	Await further instructions from the Hospital Co-ordination Centre. ❑
4.	Ensure that Ward routines carry on as normal. ❑
STAND-DOWN ACTION: - Notification of a Stand-Down will come from the Hospital Co-Ordination Centre.	***Tick when completed***
1.	Inform staff of the end of the Major Incident alert. ❑

Note:- A Stand-by alert is not necessarily followed by a full Major Incident alert You may be instructed to Stand-down, which indicates the end of the Major Incident alert.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.53. Hospital Wards – Action Cards 51 & 52

RECEIVING WARDS **(Informed by Matrons)**	**ACTION CARD 51**
ROLE SUMMARY	
• Surgical Decision-Making Unit (SDMU) is the initial nominated receiving Ward for all Major Incident patients requiring admission, with the exception of children who will be admitted to Paediatrics, and those requiring critical care or operating facilities. In the event of a medical major incident, AMAU will be required to receive major incident patients.	
SURGICAL DECISION-MAKING UNIT (SDMU)/OAKWOOD WARD	
STAND BY ACTION: - Notification of a Standby will come from an identified Senior Manager or Matron. The Nurse in Charge of the Ward should then:-	***Tick when completed***
1. Assess the current bed-state and inform the respective Matron	❑
2. Await further instructions.	❑
3. Carry on with Ward routine as normal.	❑
FULL MAJOR INCIDENT ACTION: - Notification of a full Major Incident will come from an identified Senior Manager or Cisco Phone Holder. The Nurse-in-Charge of the Ward should then :-	***Tick when completed***
1. The Nurse-in-Charge of the Ward in conjunction with the on-call Surgical Registrar will identify patients suitable for discharge or transfer, in order to clear the Ward for the reception of major incident patients. (Patients waiting for transfer or transport home will need to wait in the Discharge Lounge, if requiring a stretcher or Physiotherapy OPD. Communication with these areas is essential). Ensure you communicate with the hospital co-ordination centre, via the Senior Nurse or direct. Liaise with the Nurse in Charge of Oakwood regarding paediatric discharges.	❑
2. Record details of all patient movements.	❑
3. Assess the availability of staff to:- • Remain on duty; • Arrive early for next shift; • Provide extra cover, if necessary.	❑
4. Staff MUST NOT telephone the hospital via the main Hospital Switchboard.	❑

RECEIVING WARDS (Informed by Matrons)		ACTION CARD 51
ROLE SUMMARY		
5.	Await further instructions from the Senior Nurse on duty. Keep them continually updated for bed-state and staffing levels.	❑
6.	Try to carry on with Ward routine as normal.	❑
STAND-DOWN ACTION: - Notification of a Stand-Down will come from an identified Senior Manager or Matron. The Nurse-in-Charge of the Ward should then		***Tick when completed***
1.	Inform staff of the end of the Major Incident alert.	❑

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

OTHER HOSPITAL WARDS/Critical Care Areas		Action Card 52
MAJOR INCIDENT ACTION: - Notification of a declared MI will come from an identified Senior Manager or Cisco Phone Holder. The Nurse in Charge of the Ward should then:		***Tick when completed***
1.	Assess the current bed-state and inform the Matron	❑
2.	Await further instructions.	❑
3.	Carry on with Ward routine as normal.	❑
MAJOR INCIDENT DECLARED ACTION: - Notification of a declared Major Incident will come from an identified Senior Manager or Cisco Phone Holder. The Nurse-in-Charge of the Ward should then:		***Tick when completed***
1.	Identify patients suitable for discharge or transfer. ICU to prepare overflow bed areas in recovery as necessary. (Patients waiting for transfer or transport home will need to wait in the Discharge Lounge if requiring a stretcher or Physiotherapy OPD. Communication with these areas is essential).	❑
2.	Record details of all patient movements.	❑
3.	Assess the availability of staff to: • Remain on duty; • Arrive early for next shift; • Provide extra cover, if necessary. Ensure the hospital co-ordination centre is updated via the Matron or direct	❑
4.	Staff MUST **NOT** telephone the hospital via the main Hospital switchboard.	❑
5.	Await further instructions from the Senior Manager / Matron. Keep them continually updated for bed-state and staffing levels.	❑
6.	Try to carry on with Ward routine as normal. Please note, in order to accommodate receiving major incident patients, it is imperative that all wards work closely with the Emergency Department team and Bed Management to support the major incident response; this will include the invoking of escalation measures as appropriate.	❑

OTHER HOSPITAL WARDS/Critical Care Areas	Action Card 52
STAND-DOWN ACTION:- Notification of a Stand-Down will come from an identified Senior Manager or Matron. The Nurse-in-Charge of the Ward should then:	***Tick when completed***
1. Inform staff of the end of the Major Incident alert.	❑

Note:- A Stand-by alert is not necessarily followed by a full Major Incident alert You may be instructed to Stand-down, which indicates the end of the Major Incident alert.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.54. Nurse in Charge/Manager. Main Outpatients. Action Card 53

NURSE IN CHARGE/MANAGER - MAIN OUTPATIENTS DEPARMENT ACTION CARD 53 **(Informed by F24 & Co-ordination Centre)**	
ROLE SUMMARY	
Liaise with the Hospital Co-ordination Centre in relation to communication and information flow with the Out Patients Department. The Nurse in Charge of OPD will have the oversight of the relatives' care response to the major incident.	
DECLARED MAJOR INCIDENT ACTION: - Notification of a declared Major Incident will come from switchboard & the Hospital Co-ordination Centre, if so and under the instruction of the Site Management, the Nurse in Charge will then confirm with the Co-ordination centre when the relatives care team is established and if to proceed with the following:	***Tick when completed***
1. Confirm with the Co-ordination Centre and ED Administration the single point of contact name for the relatives' care centre in OPD and confirm the telephone number as 34644. All information in and out of OPD will be via the Nurse in Charge/Manager action card holder and this includes communications from all other disciplines within the relative's care team in OPD and where it is related to the incident response. Refer to the major incident additional information pack within OPD and undertake lockdown in accordance with the OPD plan. Prepare to brief the relatives care team upon arrival and to note the processes that have been put in place. This briefing will be held in the MDT room. Inform all staff and patients within all areas in OPD: • Patients to vacate the Out-Patient area. • To expect a further Out-patient appointment for the next available Clinic. • To contact their G.P. if they have any concerns. • All patients that are discharged without being seen will need to be logged to track the patients for another appointment. • Request for Paediatric staff in OPD to prepare a paediatric area and to liaise directly with the Paediatric Incident response team	❑
2. If required, work with all OPD staff as well as Bereavement Nurses, PALS/Volunteers, Hospital Chaplaincy and Social workers who are assigned to this area and to prepare available Consulting Rooms/areas for the following; See Map (2.54.1) o If there is a high number of walking wounded major incident patients, they **may** be directed to OPD. This will require	❑

NURSE IN CHARGE/MANAGER - MAIN OUTPATIENTS DEPARMENT ACTION CARD 53 (Informed by F24 & Co-ordination Centre)		
ROLE SUMMARY		
	medical and nursing support and should be requested via the Coordination Centre. o Receipt of reunited major incident relatives and friends waiting area o Establish Nurse Station H&N as the central hub o Receipt of major incident bereaved relatives' area o Receipt of reunited major incident casualties with relatives and friends' area o Relatives and friends booking in area and the Volunteers/PALS will undertake a meet and greet process o Private area for Social worker discussions o Assign staff members to the above areas, in order that they can track the location of relatives and sign post them to the disciplines as required. In addition, assign an administration staff member to track relatives arriving; this information will be given to the Nurse in Charge and who will update ED. Assign an administration staff member for logging/tracking of communications via telephone and ensure they work closely with the assigned single point of contact person to ensure the co-ordination centre is updated/ED and the Nurse in Charge of OPD. Tracking of relatives and major incident patients will be logged and noted on a white board in the meeting room and in 'hard copy' format. o Collate key telephone contact numbers of personnel within OPD as the single point of contact nominated person will be able to contact them as required. o Ensure links with Mortuary personnel in conjunction with Chaplains o Direct families who have children involved in the major incident to assigned paediatric area	
3.	Identify skill-mix on duty and inform the Hospital Co-ordination Centre phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) (Service Corridor, adjacent to telephone Exchange) on extension 3368. Await further instruction if deployment of resources is required. If staff resources requested, log staff names, time, and deployment area.	❑

NURSE IN CHARGE/MANAGER - MAIN OUTPATIENTS DEPARMENT ACTION CARD 53 (Informed by F24 & Co-ordination Centre)		
ROLE SUMMARY		
4.	Ensure that a list of staff telephone numbers is available.	❑
5.	Await further instructions from the Hospital Co-ordination Centre.	❑
6.	Liaise with Hospital Co-ordination Centre for additional resources such as access to interpreters, additional staff or to any other highlighted issues.	
STAND-DOWN ACTION: - Notification of a Stand-Down will come from the Hospital Co-ordination Centre.		***Tick when completed***
1.	Inform all staff of the end of the Major Incident alert.	❑
2.	Undertake a hot debrief	❑
3.	Collate all logging information and retain to feedback in a formal debrief	❑

Note:- A Stand-by alert is not necessarily followed by a full Major Incident alert You may be instructed to Stand-down, which indicates the end of the incident.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

PAEDS%20MAJOR%20INCIDENT%20%2020

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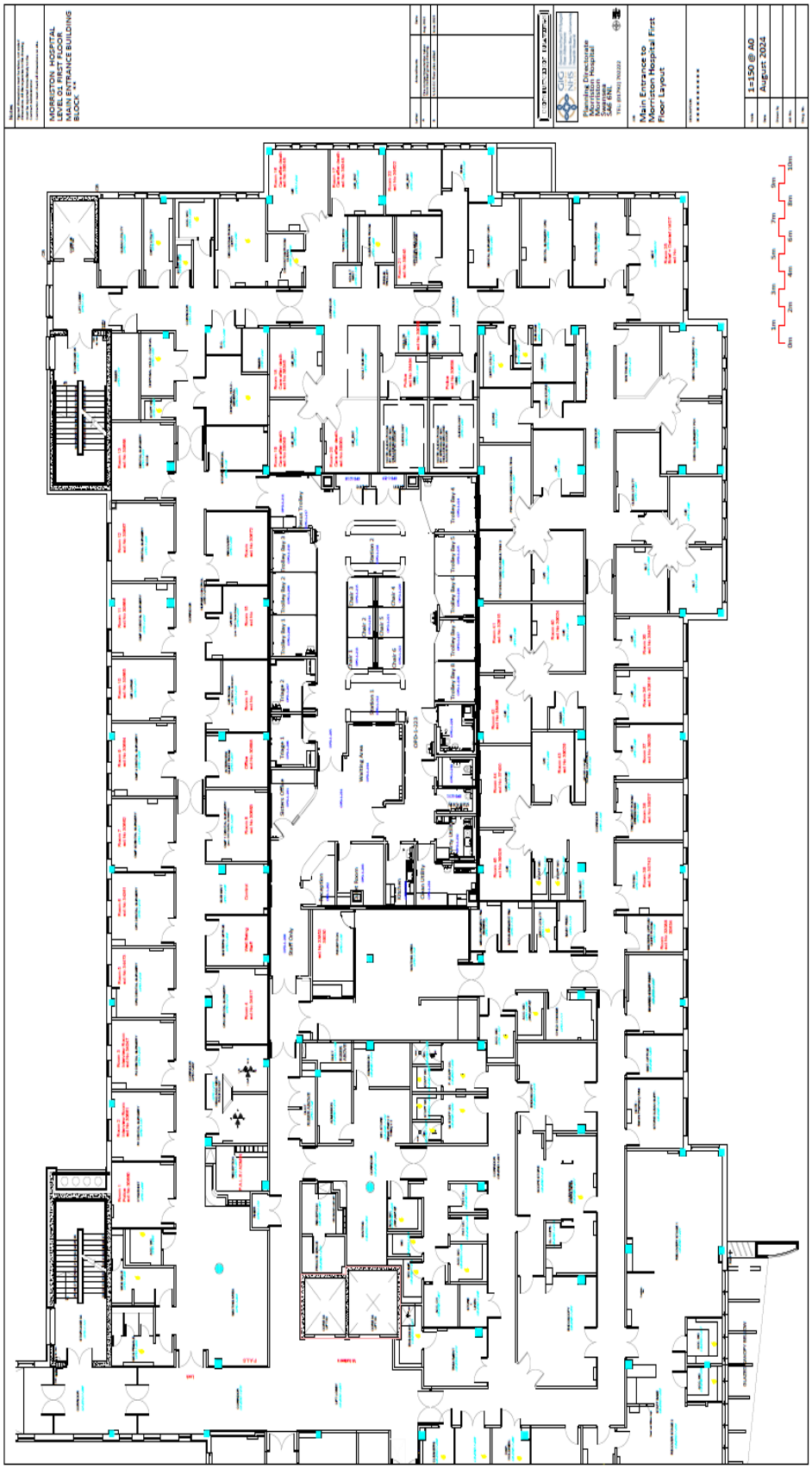
2.54.1. Major Incident Relative Care Map



2.55. Matron for Paediatrics – Action Card 54

MATRON FOR PAEDIATRICS (Informed by Switchboard – Cisco)	**ACTION CARD 54**
ROLE SUMMARY	
Notification of a Declared Major Incident will be received from the Hospital Switchboard	
• Liaise with Service Manager to ensure awareness and on-site support • Liaise with the Hospital Co-ordination Centre in relation to provide communication and information flow with the Paediatric department via the PMICT Core Team • Provide clinical nursing advice on the care of children involved in the Incident. • Continue to co-ordinate the activities of the Paediatric Unit. • Co-ordinate the activities of the paediatric casualties admitted to the wards	
ACTION - The Matron for Paediatrics (or deputy) should be notified as soon as it is confirmed that children have been involved in either a Major Incident, or Burns Major Incident.	***Tick when completed***
However, remember that even if only adults are involved, they may have Children, and the support of the Matron for Paediatrics may be invaluable to identify the need for a place of safety and chaperones to accompany:- • Uninjured children who are not yet reunited with their family • Injured children where parents are also injured. Please liaise with the Emergency Department, Unit Nurse Director/Deputy in the Co-ordination Centre, and the relatives care centre to fulfil this action.	
Consultant Paediatrician (2) will liaise with the WATCh retrieval service if transfer of a critically ill or injured child is required. Once notified, contact the Nurse-in-Charge of the Paediatric Ward, giving brief details of the Incident. You should appoint a co-ordinator for external co-ordinations and sub co-ordinator for ward level communications and ongoing organisation:- This can be achieved via the PMICT Core Team	
1. Matron for Paediatrics and Paediatric Service Manager will be contacted by HCC at home, and advise them of the Incident, if unable to contact, the Ward Manager should be contacted. The nurse holding bleep 23585 will follow this action card until one of the above arrives.	
2. Proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M for further information about the Major Incident response	

	3. Liaise with the Emergency Department to establish the number and extent of any injured children. □
	4. Identify the total number of available beds within Oakwood Ward and decide with the nurse in charge and the relevant speciality SHO which children could be discharged home. For Plastic Surgery, children liaise with (Bleep 38060). Families and children awaiting discharge should remain in a designated area. Consider the use of paediatric OPD also. □
	5. Contact off duty staff and identify availability, do not compromise next 2 shifts, advise to be on stand-by. DO NOT CALL IN (this will be organised by the Service Manager when exact requirements are identified). Complete availability list and provide Hospital Co-ordination Centre with a copy. □
	6. Provide RSCN for the Childrens emergency department as requested by the Nurse Director/Deputy. Ensuring the ward staffing remains safe. Ensure the name of the staff member the location and the time allocated is documented. □
	7. Inform the Safeguarding Co-ordinator of the Incident and liaise as required. □
	8. Meet up with the PMICT Core Team at regular intervals and hold regular team meetings to update internally. □

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.

- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.55.1. Ward Sister/Charge Nurse for Paediatrics – Action Card 54a

Ward Nurse/Charge Nurse for Paediatrics (Informed by Matron for Paediatrics)	**ACTION CARD 54 A**
ROLE SUMMARY	
ACTION - The Ward Sister/ Charge Nurse will be notified by the Matron for Paediatrics (or deputy) as soon as it is confirmed that children have been involved in either a Major Incident or Burns Major Incident.	***Tick when completed***
1. Await the brief from the Unit Nurse Manager	
2. Liaise with the Matron for paediatrics ○ Keep a patient log and outcome ○ Co-ordinate the activities of the paediatric casualties admitted to the wards	
• Brief ward staff as per METHANE (APPENDIX 1) • Assess and treat children indicated to you in order of priority • Report any changes in condition to Consultant Paediatrician 1 • Record all examination and treatments on the clinical record card • Double check the identity of all children before treatment as many may only be identified by a Major Incident casualty number • Place all clothes and other items in a property bag marked with the correct Major Incident casualty number • Do not dispose of any of the child's clothing or personal effects as these may be invaluable for identification • Do not move any children without informing Consultant Paediatrician 1 and Matron • If children are moved, ensure a record of their destination is kept and given to the Matron who will feedback to the PMICT • Priorities • Assessment and treatment of seriously ill or injured children • Provision of advice and practical help to others involved in the care of seriously ill or injured children ○ Clinical documentation	

3. Work with the Middle Grade doctor to identify patients that can be discharged from the ward □
4. Ensure that the ward and HDU are ready to receive patients from the Major Incident
5. Ensure that there are adequate staff available and ensure the normal function of the ward
6. Identify the total number of available beds within Oakwood Ward and decide with the nurse in charge and the relevant speciality SHO which children could be discharged home. For Plastic Surgery, children liaise with (Bleep 38060). Families and Children awaiting discharge should remain in a designated area. Consider the use of paediatric OPD also.
i. Contact off duty staff and identify availability, do not compromise next 2 shifts, advise to be on stand-by. DO NOT CALL IN (this will be organised by the Service Manager when exact requirements are identified). Complete availability list and provide Hospital Co-ordination Centre with a copy.
ii. Provide RSCN and/or play specialist for the Childrens emergency unit/Burns Centre ensuring staffing levels on the Ward remain safe, as requested by the Nurse Director/Deputy. Ensure the name of the staff member the location and the time allocated is documented.
iii. Inform the Safeguarding Co-ordinator of the Incident and liaise as required.
iv. Meet up with the PMICT Core Team at regular intervals and hold regular team meetings to update internally.

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.

- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.55.2. Paediatric Service Manager – Action Card 54b

PAEDIATRIC SERVICE MANAGER (Informed by Switchboard – F24 & Matron for Paediatrics)	**ACTION CARD 54b**
ROLE SUMMARY	
Notification of a Declared Major Incident will be received from Switchboard	
• Be key co-ordinator of the PMICT Team • Obtain regular updates from Consultant Paediatrician (3) and Matron • Liaise and update the Hospital Co-Ordination Centre • Be responsible for the documentation and tracking all paediatric patients • Link with Medical Director to provide regular updates upon request of Consultant (1), Consultant (2) and/or Consultant (3)	
ACTION - The Paediatric Service Manager will receive notification of Major Incident involving children via the Switchboard. If the Paediatric Service Manager is on duty for the hospital they will be based in the Hospital Co-ordination Centre and not in the PMICT centre.	***Tick when completed***
1. Once confirmation of a Major Incident involving children has been received proceed to the Paediatric Major Incident Core Team meeting point in the Doctor's office on Ward M to be briefed about the Major Incident unless on duty for the hospital when you should proceed to the Hospital Co-ordination Centre ☐	
2. Be briefed by Consultant Paediatricians on the Major Incident as part of the PMICT Core Team ☐	
3. Document and keep track of all paediatric patient flow and provide regular updates to the Hospital Co-ordination Centre ☐	
4. Document and keep track of all staff flow and provide regular updates to the Hospital Co- ordination Centre ☐	
5. Contact off duty staff when exact requirements are identified. ☐	
6. Provide regular updates to the PMICT Core Team ☐	

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.56. Head of Health Records/Dep (Morriston). Action Card 55

HEAD OF HEALTH RECORDS/DEPUTY (MORRISTON HOSPITAL) - ACTION CARD 55 **(Informed by Switchboard – F24)**	
ROLE SUMMARY	
• Provision of on site clerical support to the ED, as required. • Provision of on site runners for the Hospital Co-ordination Centre. • Liaison with Wards regarding supply of Hospital Case Notes / information and supporting with Admission procedures. • Provide Support to the Hospital Co-ordination Centre for patient tracking in the Hospital. • Provision of case notes/information to all areas as required.	
ACTION:- As soon as a major incident is declared you should:-	***Tick when completed***
1. Provide additional on site administrative support as the situation demands in consultation with the Office Manager (or Deputy), in the Emergency Department.	❑
2. Report to the Hospital Co-ordination Centre, service corridor, adjacent to Telephone Exchange, for briefing by Senior Managers. Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3).	❑
3. At the earliest opportunity ensure additional Health Records staff are based within the HVS Health Records Departments, to respond to requests from ward areas or departments. To liaise with the Hospital Co-ordination Centre in the allocation of runners to the relevant areas.	❑
4. Liaise with the Administration Manager in Emergency Department and to assist with the completion of ED documentation and data entry on the WPAS system. Assist in noting the location of major incident patients; whether discharged or admitted. Please see below regarding major incident patient unique identifiers.	❑

HEAD OF HEALTH RECORDS/DEPUTY (MORRISTON HOSPITAL) - ACTION CARD 55 (Informed by Switchboard – F24)		
ROLE SUMMARY		
5.	Liaise with Ward Managers and to assist in the admission procedures at ward level.	
6.	Establish adequate control of Patient's personal belongings, in liaison with the Nurse-in-Charge of the ED; using property bags and the ED property book. (S)He will ensure that these are kept in a place of security in the Sister's Office, ED. It is important that personal belongings and valuable are clearly marked to whom they belong, initially this will involve the use of the ED Major Incident numbering system.	❑
7.	Provide additional administrative support as the situation demands in consultation with the Office Manager (or Deputy), in the Emergency Department.	❑
8.	Provide health records support in the Hospital Co-ordination Centre to track patient information from the ED Office Manager to the Hospital Co-ordination Centre, and in the internal / external movements of existing Hospital patients.	❑
9.	Assemble a Patient Identification Team to formally identify and transfer patient information from the major incident numbering system to the PAS system for each patient. **Please note this can only be completed 24 hours post major incident.**	❑

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.57. Estates Officer. Action Card 56

ESTATES OFFICER (ON-CALL) **ACTION CARD 56** **(Informed by Switchboard – F24 & shift personnel are contacted via Cisco broadcast)**		
ROLE SUMMARY		
	• The provision of Estates function support to the hospital in regard to Estates services, plant, and equipment etc.	
	• The monitoring of temperature levels in treatment areas	
ACTION:- As soon as a major incident is declared you should:-		***Tick when completed***
1.	Contact the Shift Craftsperson (On Duty) Electrical: Extension/CISCO - **23951** Mechanical: Extension/CISCO - **2399** Contact the Estates Officer (On-call) from home via the Switchboard (The On-Call Estates Officer is the designated Officer On-Call. If not available, then contact should be made with the Estates Officer who was On-Call prior etc.) Estates Officer to contact other colleagues from home, as deemed necessary.	❑
2.	Once on-site inform the Hospital Co-ordination Centre (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)).	❑
3.	Ensure the necessary Estates support i.e., Building/Engineering craftsperson's (On-Call) are available on site, to deal with any breakdown if necessary.	❑
4.	Liaise with Nurse-in-Charge in the ED, to ensure all services and equipment is functioning properly.	❑
5.	Liaise with Nurse-in-Charge in the Operating Theatres to ensure all services and equipment is functioning properly.	❑
6.	Liaise with Nurse-in-Charge in Critical Care areas, to ensure all services and equipment is functioning properly.	❑
7.	Monitor the temperatures in treatment areas, such as the ED, Theatre, B&P, Critical Care areas etc.	❑

ESTATES OFFICER (ON-CALL)		ACTION CARD 56
(Informed by Switchboard – F24 & shift personnel are contacted via Cisco broadcast)		
ROLE SUMMARY		
8.	Liaise with the Pathology Department to ensure Mortuary services are functioning properly.	❑
9.	Report to Hospital Co-ordination Centre (Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) when arrangements are complete.	❑
10.	Ascertain if there are any estates functions i.e., planned maintenance programmes occurring and liaise with those respective departments to confirm if the programme can continue. Ensure there is consideration for this in the short and longer term as this may impact on additional service provision that may be required.	❑
NOTE	Unless a senior member of the Estates staff assumes control, the On-call Estates Officer will be responsible to the Control Co-ordination Centre for the entire Estates function.	❑

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Note:

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- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.58. Radiology Services Manager/Deputy. Action Card 57

RADIOLOGY SERVICES MANAGER/DEPUTY **(Informed by Switchboard F24, Radiology Staff and/or ED)**	**ACTION CARD 57**

ROLE SUMMARY

- Provision of radiological support to the Emergency Department.
- Provision of specialist radiological investigations.

ACTION:- As soon as a **major incident** is declared (notification will be from Hospital Switchboard and ED) you should:	***Tick when completed***
1. **Monday to Friday 09.00 to 17.00 hrs:** Coordination will be via **Radiology Services Manager** (ext. 33146) **or Site Superintendent Radiographer** (ext. 33502) **Outside the above hours:** *(NB see flow chart at end of action card)* Main radiographer is contacted by Switchboard and / or by ED. **The** main **Radiographers on duty** will contact ext. 23924 or 33311 • **Radiology Services Manager** (RSM) **or** next available site **Superintendent Radiographer**. • **The Radiographers on duty** in the ED Radiology Department. • **Consider another Superintendent Radiographer**	❑ Time:
2. **The RSM or Superintendent Radiographer contacted**, should then contact the following staff, according to call-out lists kept in the Main and ED Radiology Offices and at home:- • **5 Radiographers** for ED Radiology Unit • **6 Radiographers** for Main Radiology Department, ensuring that at least 4 are CT – trained. • **2 Superintendent Radiographers** (one for ED and one for Main Departments) • **Radiology PACS Manager** • MRI on call radiographer • **The on-call radiographer in Singleton Hospital**, (Singleton Switchboard: 01792 205666, request Switchboard to phone on-call Radiographer) • **The on-call radiographer at NPTH supporting MIU (ext. 42664 until 12 am then on call from home).**	❑ Time:

RADIOLOGY SERVICES MANAGER/DEPUTY (Informed by Switchboard F24, Radiology Staff and/or ED)	ACTION CARD 57
ROLE SUMMARY	
3. **The RSM or Superintendent Radiographer contacted** should: Check that **2 On-Call Radiologists** have been contacted by the Hospital Switchboard: • Duty registrar based in main radiology ext. 23062 • **1 General Radiology Consultant** • **1 Neuro Radiology Consultant** *(NB: Everlight will continue to support head only CT requests between).21.00 – 09.00*	❑ Time:
4. **The RSM or Superintendent Radiographer contacted** should: Arrange with **Portering Service Manager** (extension 33098) to have **four porters** available to the Radiology Department for the duration of the Incident.	❑ Time:
5. **The Superintendent Radiographer called in for ED and Main Radiology** should: Ensure ED and Main Departments are ready for use including image intensifiers and mobile X-ray units:- • **Both** C.T. Scanners switched and warmed up. • Non-urgent work is cleared. • Consider if any planned maintenance work in the short or medium term of the incident should continue or proceed, as this may impact on an emergency service provision.	❑ Time:
6. **The Superintendent Radiographers called in for ED and Main Radiology** should liaise to: Consider moving patients waiting for radiology from ED to the main Radiology Units, in order to clear and prepare the ED Radiology Unit.	❑ Time:
7. **The Superintendent Radiographers called in for ED and Main Radiology** should liaise to: Advise the **Hospital Co-ordination Centre**, service corridor, adjacent to Telephone Exchange (extension, 33479, 32904, 32905, 33778) when the Radiology Department is ready.	❑ Time:
Documentation:-	
8. Patients will attend from ED having been registered on Computerised Systems Myrddin with pre populated PAS numbers which will feed the	❑ Time:

RADIOLOGY SERVICES MANAGER/DEPUTY	ACTION CARD 57
(Informed by Switchboard F24, Radiology Staff and/or ED)	

ROLE SUMMARY

Radiology Information System and PACS. Detail is stored locally in ED X-ray.

Please see below for additional information.

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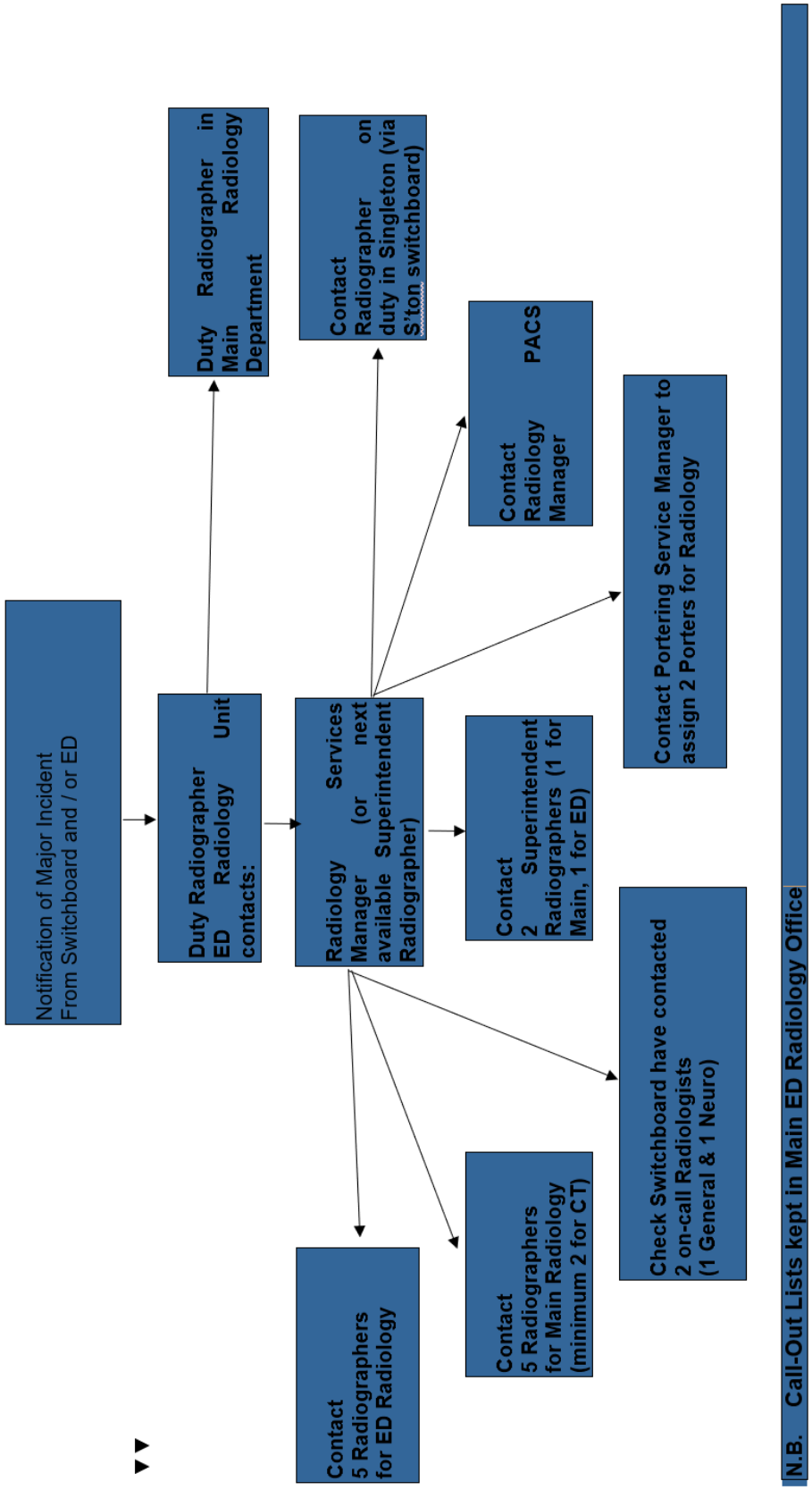
2.58.1. Radiology Major Incident Call-Out Procedure Flow Chart

(Out of normal working hours)



2.59. Medical Physics (Radiation Safety) – Action Card 58

MEDICAL PHYSICISTS (Radiation Safety) **(Informed by Switchboard – F24)**	**ACTION CARD 58**
ROLE SUMMARY	
• Provision of specialist advice and monitoring of radioactively contaminated/irradiated casualties	
ACTION:- This is an SBUHB wide action card:-	***Tick when completed***
Contaminated/irradiated casualties with injury or requiring treatment will normally be taken to the ED at Morriston Hospital. Those with life-threatening injuries will be taken to the nearest ED. Arrangements for contacting Medical Physicists are as follows: - • **Casualties at Morriston Hospital** – the ED will contact the Morriston Hospital Switchboard who will contact the Singleton Hospital Switchboard, who will then contact one Medical Physicist from the call-out list. • **Casualties at other Hospitals** – the relevant ED will contact the Singleton Hospital Switchboard, who will then contact four Physicists from the call-out list.	
First Physicist (contacted by Singleton Hospital Switchboard)	
1. If it is **Out of Hours**, contact three other persons on the Emergency Call-out list for **Radiation Incidents**, or confirm that Singleton Switchboard will do so. During normal working hours, personally contact three of the other persons on the List.	❑
2. Collect the 'NAIR kit' from the Radiation Physics Laboratory at MPCE Singleton Hospital. The Kit is kept on the top three shelves of the storage cupboard. The kit consists of: - (1) Large aluminium case (labelled NAIR kit) containing radiation contamination monitors; (2) Decontamination kit; (3) PDM 1 dose-rate meter; (4) Field SPEC digital spectrometer; (5) Personal protective equipment, (PPE) box Make sure you are wearing your personal dosemeter and your SBU ID badge.	❑

MEDICAL PHYSICISTS (Radiation Safety) (Informed by Switchboard – F24)	ACTION CARD 58	
ROLE SUMMARY		
	If possible, collect additional radiation contamination monitors (including a scintillation probe and a GM probe) from Nuclear Medicine at Singleton Hospital.	
3.	Proceed to the ED at the Receiving Hospital.	
	Other Physicists	
1.	Make sure you find out the name of the Hospital receiving casualties, report to the ED at the relevant receiving Hospital.	❑
	All Physicists	
1.	On arrival, report to the Nurse in Charge of the ED, and obtain as much information as possible about: - • Circumstances of the exposure (contamination and/or external irradiation) • Radionuclides involved • Names of the ED staff, for monitoring purposes • Number of casualties (and any deceased) expected	❑
2.	Designate a Team Leader (normally the Radiation Protection Adviser) to co-ordinate monitoring and communicate with medical and senior nursing staff.	❑
3.	If expert advice is required contact the Centre for Radiation, Chemicals and Environmental Hazards Directorate (RCE) of the UK Health Security Agency (UKHSA) using the telephone number below.	❑
4.	Put on protective clothing	❑
5.	The Team Leader will allocate the following tasks: **Preparation:** • Post controlled radiation area signs at entry point • Place an ample supply of clinical waste bags at strategic points **Inside Controlled Area:**	❑

MEDICAL PHYSICISTS (Radiation Safety) (Informed by Switchboard – F24)		ACTION CARD 58
ROLE SUMMARY		
	• Monitor casualties and advise/assist medical and nursing staff during decontamination • Monitor staff leaving at the barrier **Outside Controlled Area:** • Monitor Ambulance personnel and advise on decontamination. • Log Ambulances and supervise decontamination before they leave.	
6.	Ensure that contaminated materials and clothing are retained in labelled clear plastic bags.	❑
7.	On completion of the incident, monitor staff, surfaces of the Controlled Area, bags of contaminated material and any bodies held in the Mortuary.	❑
8.	The Radiation Protection Advisor will advise on the disposal of radioactive waste.	❑
Note	**The Medical Physicists Call-Out Lists and up to date telephone numbers are held by the Switchboard at Singleton Hospital through whom contact for a Medical Physicist should be made**.	❑
	More detailed Action Cards are located with the NAIR Kit	❑
	Advise of actions to the **Hospital Co-ordination Centre**, service corridor, Morriston Hospital, adjacent to Telephone Exchange (extension, 33479, 32904, 32905, 33778)	

Contacts		
United Kingdom Health Security Agency (UKHSA) Emergency Response Group	**Natural Resource Wales**	**Office for Nuclear Regulation**
Tel: 01235 834590 Tel: 01235 831818 (UKHSA on call officer)	Tel: 03000 653000	Tel: 0207 5563475 (Normal working hours) Tel: 0151 922 9235 (HSE's Duty Officer outside normal working hours)

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2.60. Theatre Services Manager/Deputy – Action Card 59

THEATRE SERVICES MANAGER/DEPUTY **(Informed by Switchboard – F24)**	**ACTION CARD 59**	
ROLE SUMMARY		
• Control activity in the Operating Theatres, dependant on the needs of the Incident and routine surgical activity in conjunction with the Consultant Orthopaedic Surgeon for Main Theatres, and Consultant Plastic Surgeon for Plastic Theatres. • **Deputising Arrangements:** • If the Theatre Matron is **called in to act as Silver Commander** during the incident, Responsibility for theatre operations must be formally handed over to the **Secondary Theatre Matron Colleague** (if available) or **Nominated Deputy** (Senior Nurse/ODP on duty). **The handover must include:** ○ Current theatre activity and capacity ○ Staffing levels and any redeployments ○ Equipment and supply status ○ Any ongoing or anticipated challenges		
ACTION:- As soon as a major incident is declared the Theatre Services Manager, or nominated Deputy / most senior Nurse on duty, should :		***Tick when completed***
1.	Ensure Theatre Department aware of activation of standby or declared major incident. Call in sufficient staff to run all theatres –via switchboard asking them to activate the theatre F24 system group. Monitor F24 system for staff responses.	❑
2.	If the emergency arises during the daytime, surgeons should be asked to finish operating safely and advise of estimated time of procedure end in each theatre. This will be recorded on theatre activity sheet in the loggist folder. Staff in Theatres then to prepare for casualties requiring surgery.	❑
3.	If the emergency arises when the Theatre Manager is off duty, S/he will be informed by the Senior Theatre Nurse on duty, according to Departmental Action Cards and checklists held in the Operating Theatre.	❑
4.	The Theatre Services Manager will contact the Hospital Co-ordination Centre to advise that Theatres are ready on phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)	❑
5.	The Theatre Services Manager will, in conjunction with the Duty Consultant Anaesthetist, Consultant Surgeon and Matron, determine	❑

	the number of operating theatres required based on all information available, numbers of patients and type of injuries sustained. In the absence of relevant information and also the nature of operations being performed at the time, the Theatre Services Manager will have authority to suspend operating in all theatres if considered necessary and reinstate list as appropriate.	
6.	The communication and decision-making point within theatre will be the communication hub within the main theatre coffee room (ensure signage from major incident box has been put in place to direct staff)	❑
7.	Liaise with HSDU to ensure sufficient trays are available. (full Tray list availability laminated and in Major Incident box Confirm with Estates regarding any planned maintenance programmes as this may impact on the extra provision to respond to the emergency in the short and medium term of the incident.	❑

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2.61. Pharmacist – Action Card 60

PHARMACIST **(Informed by Switchboard – F24)**		**ACTION CARD 60**
ROLE SUMMARY		
	• The provision of medicine advice, additional drugs, intravenous fluids, and other items as required.	
ACTION: As soon as a major incident is declared the following actions should be completed:		***Tick when completed***
1.	During core opening hours when the pharmacy is open, switchboard will contact the Pharmacy Manager or Acting Deputy on Ext 33119 or the Dispensary on Ext 33366. This person will act as the Pharmacy Incident Co-ordinator as detailed in the Major Incident SOP.	❑
2.	Out of hours the emergency duty pharmacist will be contacted via switchboard. As soon as the major incident is declared the emergency duty pharmacist will: • Contact the most senior pharmacist at home using the Major Incident cascade staff contact list who will then become the nominated Pharmacy Incident Co-ordinator. • The emergency duty pharmacist will attend the hospital and open the pharmacy department. Once support staff arrive he/she may return to on call duties.	❑
3.	The first person on site should refer to the departments Major Incident SOP for detail on specific actions.	❑
4.	Out of hours the emergency duty pharmacist or whoever first attends the hospital will report to the Hospital Co-ordination Centre – (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)), to inform them that the Pharmacy Department is open.	❑
5.	The Pharmacy Incident Senior Person will attend the hospital co-ordination centre to liaise with the Nurse-in-Charge and senior clinician to assess the need for Pharmacy Services.	❑
6.	Pharmacy staff in attendance will issue drugs and other items, as required, and provide medicines advice when required.	❑
7.	If necessary, contact Pharmacy staff who are usually based at other hospitals and, if necessary, Primary care teams if additional skills and/or staff are required.	❑

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2.62. HSDU Manager – Action Card 61

HSDU MANAGER (ON-CALL) **(Informed Switchboard – F24)**		**ACTION CARD 61**
ROLE SUMMARY		
	• Provision of additional sterile instruments and supplies	
ACTION:- As soon as a major incident is declared you should :-		***Tick when completed***
1.	Contact other colleagues from home, as deemed necessary.	❑
2.	Inform Head of Sterile Services.	❑
3.	Proceed to the Hospital and open the H.S.D.U. Ensure adequate stocks of sterile instruments, packs and supplies are readily available.	❑
4.	Inform the Hospital Co-ordination Centre, service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) when the H.S.D.U. is open.	❑
5.	Liaise with the Nurse-in-Charge of the Emergency Department to assess the need for fresh supplies, (do not include swabs).	❑
6.	Liaise with the Nurse-in-Charge of the Operating Theatre to assess the need for fresh supplies, (do not include swabs).	❑
7.	Issue sterile instruments, packs, and other items, as required.	❑
8.	Contact Sterile Services staff at Singleton Hospital if additional skills and/or staff are required. Alert the Co-ordination Centre if equipment etc. is required to be transported across the HB.	❑
9.	Confirm with Estates if there are any planned maintenance programmes that may be required to be delayed as a maintenance programme may disrupt the provision of additional services to respond to the emergency. Consideration will be required in the short and medium term of the incident	❑

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P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

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2.63. Catering Services Manager – Action Card 62

CATERING SERVICES MANAGER (ON-CALL) **(Informed by Switchboard – F24)**	**ACTION CARD 62**
ROLE SUMMARY	
• Provision of Hotel Services support to the hospital • Provision of catering arrangements for the Hospital.	
ACTION:- As soon as a major incident is declared you should :-	***Tick when completed***
1. Report to Hospital Control Centre for initial briefing and take responsibility for the co-ordination of Catering staff.	❑
2. Establish a Catering Co-ordination Team within Catering Services Department - Ext. 33679/33537/38913/33535/32389. Call in extra staff from home, as necessary.	❑
3. Liaise with Nurse in Charge of OPD, Hospital Chaplain, Social Work Team and Volunteers who will establish a relatives and friends' area in OPD, including the provision for bereaved relatives and major incident patients discharged and re-united with relatives. Liaise with staff in the discharge lounge and Physiotherapy OPD to ascertain catering provision for patients/staff. Liaise with medical/Nursing staff teams who may be waiting as additional teams in the Doctors Mess, the dining room.	❑
4. Contact the Hospital Co-ordination Centre in the service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) as soon as the Department is ready.	❑
5. Provide beverages, as necessary, to casualties in the ED, GPOOH and Ambulatory Care areas. **Check with medical/nursing supervisor that beverages may be given to individual casualties.** Provide refreshments in the Staff Dining Room, ED, and Operating Theatres for members of staff.	❑
6. Ensure that beverages are available for Volunteers, Hospital Co-Ordination Centre, all areas as well as any other Hospital Departments called in 'Out-of-Hours'.	❑

7.	Ensure that beverages and sandwich facilities are available for staff, volunteers, and the press/media.	❑
8.	Co-ordinate requests for additional Supplies contacting the Central Stores Manager (if not already done by the Supplies Manager).	❑
Note:	In the absence of the Catering Services Manger, the Senior Facilities Manager On Call/Deputy Catering Manager will undertake these duties.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.64. Portering Services Manager/Senior Porter. Action Card 63

PORTERING SERVICES MANAGER/SENIOR PORTER (ON DUTY) ACTION CARD 63 **(Informed by Switchboard F24 & Cisco broadcast)**		
ROLE SUMMARY		
	• Provision of Portering services for patient movements and general Portering duties. • Direction of Relatives and Press/Media to appropriate areas.	
ACTION:- As soon as a major incident is declared you should :-		***Tick when completed***
1.	Inform Portering Services Manager, and immediately call in additional Portering staff. See Security Services Action Card; allocation of additional staff may be required to undertake these actions also. Liaise with the most Senior Facilities Manager.	❑
2.	Portering Services Manager will report to the Hospital Co-ordination Centre when arrangements are complete.	❑
3.	Prepare the ED entrance for the reception of casualties, by means of:- • Allocating a senior Porter to centralise all available trolleys and wheelchairs as close as possible to the area, without causing an obstruction, and ensure return of ambulance trolleys to the vehicles as quickly as possible for return to the scene. • Providing a supply of blankets and other linen requirements. • Liaising with the ED Nurse-in-Charge in the preparation of the Department.	❑
4.	Allocate one Senior Porter to act as 'doorman' on the entrance to the ED to control unauthorised visitors and direct visitors/relatives/press accordingly. Instigate Lock Down Procedure and refer to the HB procedure for this purpose	❑
5.	Allocate two Porters to establish traffic control, one to keep ambulance entrance clear for ambulances only, and another to divert traffic at the main entrance to ensure visitors and non-emergency staff use the car park 3 and the overflow car park (until relieved by the Police Officer/Hospital Security)	❑
6.	Ensure the OPD HVS building is opened out of hours	❑
7.	Await liaison with Bed/Site Manager regarding the internal movement of patients. Allocate Porters as required.	❑

PORTERING SERVICES MANAGER/SENIOR PORTER (ON DUTY) (Informed by Switchboard F24 & Cisco broadcast)	ACTION CARD 63
ROLE SUMMARY	
8. Allocate two Porters to X-Ray Department in ED, and two to the main X-Ray Department, until Department Porters arrive. Use X-Ray Porters to display the sequentially numbered [1 to 16] fixed signs located around the Hospital on the Ground and Lower Ground Floors. Please follow map. Commencing with the external signs at the top of the roundabout entrance road and bottom roundabout entrance road. No's 4&5 A frame signs are located by facilities corridor.	❑
9. Allocate two Porters to Surgical Decision-Making Unit (SDMU) - for transfer of patients. The Porters to remain available for other transfer duties.	❑
10. Allocate a Porter to act as 'doorman' at the entrance to the Education Centre, where the press will be located to ensure they do not wander around the Hospital unescorted.	❑
11. Portering Manager to be stationed in the ED, to supervise the removal of patients to other places. (Major casualties to ED treatment area and walking casualties to GPOOH).	❑
12. Keep treatment areas clear of rubbish.	❑
13. Provide staff to assist with any Helicopter transfers, according to the Health Board Helicopter Policy.	❑
BURNS MAJOR INCIDENT	
ACTION:- In the case of a **Burns Major Incident**:-	***Tick when completed***
1. Assist with moving patients from Dyfed, Powys, Tempest, Anglesey, Pembroke, and Paediatric Wards.	❑
2. Clear Sluice areas of waste and keep clear.	❑
3. Collect extra stock and equipment, as requested.	❑
4. Help with admissions from Ambulances to the Burns Centre. If required, bring additional trolleys from elsewhere in the Hospital.	❑
5. Take urgent specimens to the Laboratory.	❑

PORTERING SERVICES MANAGER/SENIOR PORTER (ON DUTY) (Informed by Switchboard F24 & Cisco broadcast)	ACTION CARD 63

ROLE SUMMARY

Note:	In the absence of the Portering Services Manger, the Senior Facilities Manager On Call/Portering Team Leader will undertake these duties.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

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Note:

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- Ensure you wear a valid HB identity badge at all times
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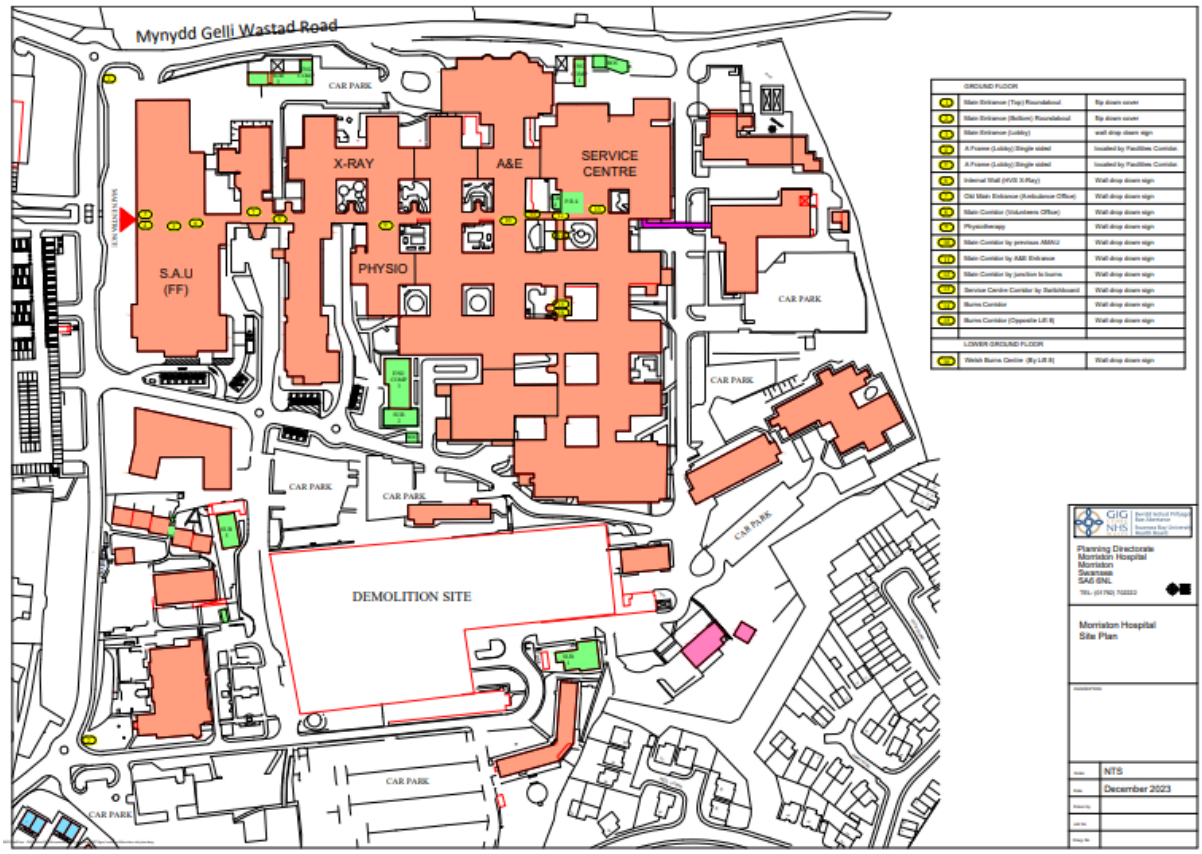
- **Be aware that initial information reports will change regularly**

FLOOR LEVEL	SIGN NUMBER	LOCATION	✓
EXTERNAL	1	Main Entrance (Top) Roundabout – flip down cover	
	2	Main Entrance (Bottom) Roundabout – flip down cover	

FLOOR LEVEL	SIGN NUMBER	LOCATION	✓
GROUND FLOOR CORRIDOR	3	Main Entrance (Lobby) – wall drop down sign	
	4	A Frame (Lobby) Single sided –this is not fixed signage so will need retrieving from the Facilities Corridor.	
	5	A Frame (Lobby) Single sided –this is not fixed signage so will need retrieving from the Facilities Corridor.	
	6	Internal Wall (HVS X-Ray) – Wall drop down sign	
	7	'Old' Main Entrance (Ambulance Office) – Wall drop down sign	
	8	Main Corridor (Volunteers Office) – Wall drop down sign	
	9	Physiotherapy – Wall drop down sign	
	10	Main Corridor by previous AMAU – Wall drop down sign	
	11	Main Corridor by A&E Entrance – Wall drop down sign	
	12	Main Corridor by junction to burns – Wall drop down sign	
	13	Service Centre Corridor by Switchboard – Wall drop down sign	
	14	Burns Corridor – Wall drop down sign	
	15	Burns Corridor (Opposite Lift 8) – Wall drop down sign	
LOWER GROUND FLOOR	16	Welsh Burns Centre (By Lift 8) – Wall drop down sign	


Mynydd Gelli Wastad Road
CAR PARK
X-RAY
A&E
SERVICE CENTRE
S.A.U (FF)
PHYSIO
CAR PARK
CAR PARK
CAR PARK
CAR PARK
CAR PARK
DEMOLITION SITE
CAR PARK
CAR PARK
GROUND FLOOR
Main Entrance (Top) Roundabout
flip down cover
Main Entrance (Bottom) Roundabout
flip down cover
Main Entrance (Lobby)
wall drop down sign
A Frame (Lobby) Single sided
located by Facilities Corridor
A Frame (Lobby) Single sided
located by Facilities Corridor
Internal Wall (NVS X-Ray)
Wall drop down sign
Old Main Entrance (Ambulance Office)
Wall drop down sign
Main Corridor (Volunteers Office)
Wall drop down sign
Physiotherapy
Wall drop down sign
Main Corridor by previous AMAU
Wall drop down sign
Main Corridor by A&E Entrance
Wall drop down sign
Main Corridor by junction to burns
Wall drop down sign
Service Centre Corridor by Switchboard
Wall drop down sign
Burns Corridor
Wall drop down sign
Burns Corridor (Opposite Lift 8)
Wall drop down sign
LOWER GROUND FLOOR
Welsh Burns Centre (By Lift 8)
Wall drop down sign
GIG NHS
Planning Directorate
Morriston Hospital
Morriston
Swansea
SA6 6NL
TEL: (01792) 703222
Morriston Hospital
Site Plan
NTS
December 2023

2.65. Hospital Security Officer (On Duty) – Action Card 64

HOSPITAL SECURITY OFFICER ON DUTY (Allocated by Senior Facilities Manager on Call if not available) **ACTION CARD 64** **(Informed by Switchboard – Cisco broadcast)**	
ROLE SUMMARY	
• Provision of Security services to the ED/Burns Centre and Hospital. • Ensure traffic flow around the ED/Burns Centre entrance. • Organise, in conjunction with the Hospital Co-ordination Centre, for additional parking for staff being called in for duty. • Direction of Relatives and Press/Media to appropriate areas, and traffic flow around site. • Site access	
ACTION:- As soon as a major incident is declared you should :-	***Tick when completed***
1. Inform other Security Officer colleagues on-site, and Car Parking personnel.	❑
2. Proceed to the Emergency Department and liaise with the Nurse-in-Charge.	❑
3. Prepare the ED entrance for the reception of casualties, by means of: • Attempting to move any vehicles likely to obstruct the free flow of Emergency Ambulances to the ED • Ensure that this area is kept clear of all obstructions for the emergency Services.	❑
4. Liaise with Portering Service Manager to instigate HB Lockdown Procedure and ensure security provision for ED, Press area and in some circumstances this may be required for the mortuary. Allocate one Security Officer to act as 'doorman' on the entrance to the ED to control unauthorised visitors and escort visitors/relatives/press accordingly.	❑
5. Allocate two Security Officers to establish traffic control, one to keep ambulance entrance clear for ambulances only (until relieved by a Police Officer, if available), and another to divert traffic at the main entrance to ensure visitors and non-emergency staff use the bottom car park.	❑

HOSPITAL SECURITY OFFICER ON DUTY (Allocated by Senior Facilities Manager on Call if not available) **ACTION CARD 64** **(Informed by Switchboard – Cisco broadcast)**		
ROLE SUMMARY		
6.	The Senior Security Officer is to liaise with the Hospital Co-ordination Centre, located in the ED Seminar Room for further duties.	❑
7.	Some walking wounded major incident patients may enter the hospital via main entrance; consideration of re-direction may be required.	❑
Note:	In the absence of the Senior Security Officer, the Senior Facilities Manager On Call/Portering Services Manager will undertake these duties.	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.66. Domestic Services Manager/Senior – Action Card 65

DOMESTIC SERVICES MANAGER/SENIOR DOMESTIC (ON DUTY) (Informed by Switchboard – Cisco broadcast)		**ACTION CARD 65**
ROLE SUMMARY		
	• . Provision of domestic services.	
ACTION:- As soon as a major incident is declared you should:		***Tick when completed***
1.	Inform Domestic Services Manager, and immediately call in additional Domestic staff. Domestic Services Office; Tel 01792 703721, extension; 33721. Domestic Team Leader; Tel 01792 516539 or extension 36539. Domestic Supervisor (24-hour Cisco Phone number 23944). Ensure contact numbers for staff are up to date.	❑
2.	Domestic Services Manager will report to the Hospital Co-ordination Centre when arrangements are complete.	❑
3.	Await contact from Hospital Co-ordination Centre with regard to deployment. Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)	❑
4.	Liaise with Nurse-in-Charge of the ED deploy Domestic support to the ED.	❑
Note:	In the absence of the Domestic Services Manger, the Senior Facilities Manager On Call/Domestic Services Team Leader will undertake these duties.	❑

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.67. Pathology B.M.S On-call – Action Card 66

PATHOLOGY B.M.S (ON-CALL) **(Informed by Switchboard – Cisco broadcast)**	**ACTION CARD 66**
ROLE SUMMARY	
• Conduit to alert other colleagues in Pathology Services. • Provision of emergency blood and blood analysis.	
ACTION:- As soon as a major incident is declared:-	***Tick when completed***
During Inside Normal Working Hours	❑
Inform colleagues in the following Departments: • Haematology • Coagulation • Biochemistry	❑
During Outside Normal Working Hours	
Blood transfusion BMS will then contact staff on duty in the following areas: • Haematology (24/7) • Coagulation (24/7) • Biochemistry (24/7) Transfusion Practitioners (core hours)	❑
You Should then	
1. Appoint a Laboratory Co-ordinator. The Laboratory co-ordinator will inform the Hospital Co-ordination Centre, located in the service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)) when the Pathology Department is ready. Follow the Departmental Major Incident procedure located in Blood Bank.	❑
2. The Laboratory co-ordinator will also inform the following: • Consultant Haematologist • Consultant in Clinical Chemistry • NBTS (Wales) – via Blood Bank Direct Line:	❑

PATHOLOGY B.M.S (ON-CALL) (Informed by Switchboard – Cisco broadcast)		ACTION CARD 66
ROLE SUMMARY		
	○ In Hours: 01443 622034/5/7 ○ Out of Hours: 07768293963 All calls, where possible, will be made using the direct B.T. Line (790557)	
3.	Assess the need to contact additional off-duty Pathology staff.	❑
4.	The Laboratory Co-ordinator will liaise with porters to ensure collection of samples and deliver blood, etc.	❑
5.	All pathology results will be delivered to the appropriate Departments via normal systems.	❑

Note

- Some areas, e.g., ED will use vacuum system for sending samples, as appropriate.
- The vacuum system may be used for despatching results back to departments on the system, after a telephone call to inform them to expect the result

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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- **Be aware that initial information reports will change regularly**

2.68. Anatomical Pathology Technologist (APT). Action Card 67

ANATOMICAL PATHOLOGY TECHNOLOGIST (APT) ON-CALL (Informed by Switchboard – F24)	**ACTION CARD 67**
ROLE SUMMARY	
• Organise the Mortuary for the receipt of bodies, and associated administrative tasks	
ACTION:- As soon as a major incident is declared:-	***Tick when completed***
1. Proceed to the Hospital and open the Mortuary.	❑
2. Report to the Hospital Co-ordination Centre – service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) when the Mortuary Department is open. Inform the Mortuary Manager who will in turn contact additional APT staff, (if required), HTA Designated Individual and Pathology General Manager. Liaise with Care After Death Manager for points of contact regarding relatives care.	❑
3. Request for Security to cordon the mortuary main car park; relatives should be directed to the Care After Death Team – Bereaved Relatives Area in Outpatient Department in the first instance.	❑
4. Bodies arriving at the Mortuary from the Emergency Department (ED) should be labelled in the ED. If there is Police Disaster Victim Identification (DVI) involvement, these deceased patients may be labelled with a DVI Tag containing a unique reference number and this tag should not be removed under any circumstance. Alternatively, the hospital may use a unique Major Incident number, this should not be removed.	❑
5. If bodies are brought into the mortuary that have been retrieved and processed by the Police Disaster Victim Identification (DVI) Team <u>at the scene</u>, these will already be labelled with a DVI Tag containing a unique reference number and this tag should not be removed under any circumstance. If no DVI involvement, bodies brought to the mortuary directly from the scene, until identified formally, should be labelled with a minimum of 3 identifiers, e.g., Unknown male/female 1,2,3, etc., mortuary register number, date & time of admission to Mortuary, brought into mortuary by Ambulance/Funeral Director, etc.	❑

ANATOMICAL PATHOLOGY TECHNOLOGIST (APT) ON-CALL (Informed by Switchboard – F24)		ACTION CARD 67
ROLE SUMMARY		
6.	Any loose possessions accompanying the deceased should be placed in a bag, all others left in situ. The known identification details of the deceased MUST be written on the bag clearly and the bag kept with the body at all times until collection by the relevant police department. As per 4 & 5, if DVI involvement any personal effects will already have a unique reference number.	❑
7.	The APT will liaise with the Hospital Co-ordination Centre; Police, Pathologist and Coroner's Officer in assisting to establish the identity of the deceased. Dealing with possessions in conjunction with the Care After Death Team.	❑
8.	Liaison with the Care After Death Team as required to facilitate collaborative support for relatives and the deceased patients	❑
NOTE	• In the event of a Major Incident occurring outside normal working hours, the Hospital Switchboard will call in the APT on Call for the Mortuary who will then in turn inform the Mortuary Manager.	❑
	• In the event of a Major Incident occurring in normal working hours, the Hospital Switchboard will inform the Mortuary.	❑

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P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

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Note:

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- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.69. Medical Illustration Manager/Deputy. Action Card 68

MEDICAL ILLUSTRATION MANAGER/DEPUTY (Informed by Switchboard – F24)		**ACTION CARD 68**
ROLE SUMMARY		
ACTION:- As soon as a major incident is declared:		***Tick when completed***
1.	Proceed to the Hospital, and inform the Hospital Co-ordination Centre – service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)), when on-site.	❑
2.	Liaise with the Nurse in Charge of the Emergency Department and/or Burns Centre to assess where support is required, such as Mobile Medical Team, ED, Burns Centre, etc.	❑
3.	Liaise with the Hospital Co-ordination Service regarding the provision of Medical Photographic support to the Hospital as requested.	❑
4.	Open Medical Photography Department and contact colleagues. Allocate staff with duties as necessary.	❑

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Note:

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- Ensure you wear a valid HB identity badge at all times
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2.70. Head of Clinical Physiology/Deputy. Action Card 69

HEAD OF CLINICAL PHYSIOLOGY/DEPUTY **(Informed by Switchboard – F24)**	**ACTION CARD 69**
ROLE SUMMARY	
• Provision of emergency ECG service/provision of emergency Transthoracic Echocardiography Service/ Respiratory Services	
ACTION:- As soon as a major incident is declared:-	***Tick when completed***
1. During out of hours Head of Clinical Physiology/Deputy to contact all senior clinical managers to be on standby to respond to the incident. Contact Physiology staff to be on stand-by to respond as required. (See staff contact list). During core working hours, all senior leads in Physiology to meet in the 'long office' in Cardiac Outpatients.	❑
2. Senior Physiology Team to proceed to the Hospital (if out of hours) and meet in Cardiac Outpatients.	❑
3. Inform the Hospital Co-ordination Centre – service corridor, adjacent to Telephone Exchange, (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3), when ready.	❑
4. Liaise with the Nurse-in-Charge of the Emergency Department at Morriston Hospital to assess the need for emergency transthoracic ultrasound, (adult and paediatric) and the need for ECG cover.	❑
5. Establish an emergency Hospital transthoracic echocardiography service/ECG service for Morriston Hospital, (and other SBUHB sites, should other sites be used for the incident). ○ Contact all adult echo cardiographers for availability to respond ○ Contact paediatric echo cardiographers if necessary for availability to respond. ○ Contact on call Physiologist for the Cardiac Catheter lab if required. ○ Open the Echocardiography Department to obtain available, portable echo machines, (utilise Cardiac Cather Lab and AMAU machines if necessary). ○ Large scanners to be made available for walking/chair cases.	❑

HEAD OF CLINICAL PHYSIOLOGY/DEPUTY (Informed by Switchboard – F24)	ACTION CARD 69
ROLE SUMMARY	
6.	If necessary, contact physiology staff who are usually based at other hospitals and, if additional skills and / or staff are required.
7.	If major incident occurs in core working hours, (once the need for emergency echocardiography is assessed): o Patients due to attend a routine hospital echocardiography appointment need to be contacted by the clerical team and advised not to attend and informed that an alternative appointment will be sent out. o Prioritise discharge dependent in patient echocardiograms.

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2.71. Digital Services Technician. Action Card 70

DIGITAL SERVICES TECHNICIAN (In & out of hours) Informed by Switchboard – F24)	**ACTION CARD 70**
ROLE SUMMARY	
• Provide 1st, 2nd and 3rd line support for all Digital systems, computer networks and telecommunications. • Maintain key critical servers, applications, network, and telecommunications infrastructure. • Ensure the infrastructure is running at its optimal level. • Support the organisation until stand-down has been announced.	
ACTION:- As soon as a major incident is declared:-	***Tick when completed***
1. **Within working hours** If informed during normal working hours the recipient of the call must contact a member of the senior management team who will then immediately implement the local major incident/ business continuity procedure. This will establish the relevant links between HB Gold command and the appropriate Silver control centre. Depending on site, a member of the Digital Services team will be sent to the Hospital/Incident Co-ordination Centre and then will become site Digital Bronze. An immediate notification should also be sent to the SBU Digital Critical incidents & outages Microsoft teams chat and also a notification to the SBU Digital MI WhatsApp group.	❑
2. **Outside working hours** Switchboard contacts on-call Digital Services and the recipient of the call should proceed to Morriston hospital Coordination Centre – service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) when ready. After ascertaining the situation, the on-call staff should then contact a member of the senior operational team who will be responsible for initiating the wider Informatics response which may or may not require implementation of the local major incident/ business continuity procedure. The senior operational team manager will then inform the senior management team via telephone call and establish the Microsoft teams chat and also a notification to the SBU Digital MI WhatsApp group.	❑

ROLE SUMMARY

	The senior management team will then implement the local major incident/ business continuity procedure if required.	
3.	**<u>Establish control centres</u>**. In the event of a Digital issue which requires establishment of a control centre, a senior manager will coordinate Digital operations. Digital Silver command will be setup and led by a senior manager. The senior manager involved in Silver command is responsible for communicating with the Digital Services Senior manager involved in gold command. The local procedure describes the full structure that will be implemented in the case of an incident, these will be established by the control team at the time. Regardless of whether a Digital control centre is established, the purpose of this procedure is to: a. Provide on-site support to major incident co-ordinator and end users. b. Institute a shift system to provide 24-hour staffing at the required level. Contact details for all staff are held in the Local plan. c. Prioritise all incidents with the service desk with the lowest severity being a severity 2 incident. These priorities are defined within the Local plan. d. Ensure the staffing requirements for each department are available. e. Ascertain which staff are available to help with non-IT work if required and manage this response bearing in mind staff personal responsibilities e.g., family. f. Provide staffing to assist with non-IT issues if required. g. Set up communication links with all departments as listed in the local plan, this may require communication with external organisations such as DHCW in line with the National incident reporting plan. h. Consider reporting requirements under NIS Regulations and GDPR, as well as national notification to DHCW.	❑
4.	The senior operational team manager will ensure the appropriate Digital representative(s) is/are located and remain in the Hospital Co-ordination centre and communicate with the incident room at Baglan. The roles and responsibilities for staff are detailed in the local plan and these should be adhered to at all times until the incident is declared closed.	❑

Note:

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- **Be aware that initial information reports will change regularly**

2.72. MEMS: Medical Electronics. Action Card 71

MEMS: MEDICAL ELECTRONICS TECHNICIAN ON-CALL (Informed by Switchboard – F24)		**ACTION CARD 71**
ROLE SUMMARY		
• Provision of Emergency Medical Equipment Management Services (MEMS)		
ACTION:- As soon as a major incident is declared:-		***Tick when completed***
1	Proceed to the Hospital as directed	❑
2	Inform the Hospital Co-ordination Centre when ready	❑
3	Highlight to the Co-ordination Centre that the Equipment Library is a resource for supplying additional equipment. • Facilitate the booking out of any equipment (each medical device MUST be logged)	❑
4	Assess the situation and call-in colleagues as required. Issue Department Cisco phones to colleagues to facilitate communications	❑
5	Liaise with the Nurse-in-Charge of the major departments as advised (e.g., Emergency Department, ITU, Burns Centre to assess the need for emergency Medical Electronics support)	❑
6	Establish an Emergency MEMS; Medical Electronics service to the Hospital, as requested by the Hospital Co-ordination Centre. • Support the use of '*MobileView*™ ' RFID tracking software programme to allow self-service access to track medical equipment for all departments • Liaise with specialist Medical Equipment Manufacturers or Suppliers as required	❑

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Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

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- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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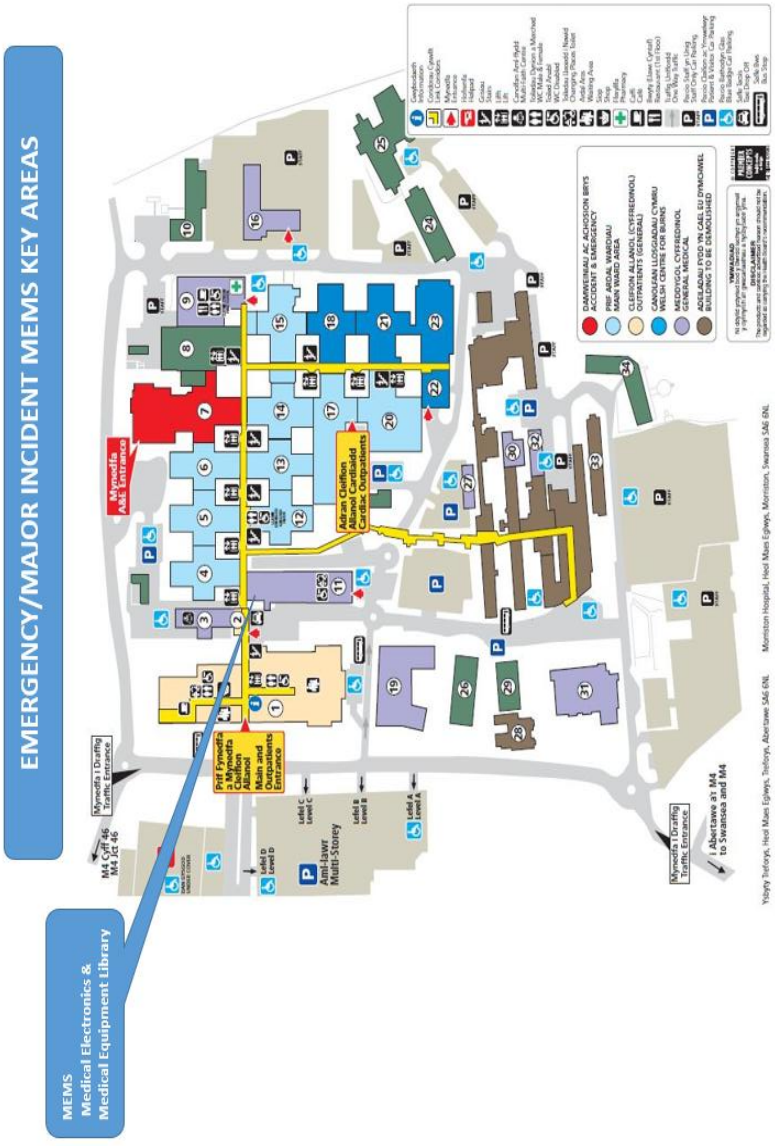
Emergency/Major Incident MEMS Key Areas



2.73. Head of Procurement. Action Card 72

HEAD OF PROCUREMENT **(Informed by Switchboard – F24)**		**ACTION CARD 72**
ROLE SUMMARY		
	• Provision of additional supplies support.	
ACTION:- As soon as a major incident is declared:-		***Tick when completed***
1.	Proceed to Hospital Co-ordination Centre at Morriston Hospital	❑
2.	Inform the Hospital Co-ordination Centre at Morriston Hospital – service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) when on-site.	❑
3.	Inform Bridgend Stores and arrange for opening of the Store. Alert the Co-ordination Centre if there are issues regarding transport/delivery.	❑
4.	During office hours, inform the front-line Procurement Team Buyers, so that they are aware that emergency purchasing will most likely be required.	
5.	Liaise with Staff at the Co-ordination Centre to determine if the Emergency Department requires additional supplies.	❑
6.	Liaise with Staff at the Co-ordination Centre to determine if the Operating Theatre requires additional supplies.	❑
7.	Organise for any emergency on-going supplies required, either from Bridgend Stores or direct from other suppliers.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

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- Ensure you wear a valid HB identity badge at all times
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2.74. Physiotherapy Manager/Deputy. Action Card 73

PHYSIOTHERAPY MANAGER/DEPUTY CARD 73 **(Informed by Switchboard – F24)**	**ACTION**

ROLE SUMMARY	
• The Physiotherapy/ Occupational Therapy Department will be utilised for in -patients who have been discharged/awaiting transfer and require transport if the discharge area is full. It must be emphasised that it is not a designated in-patient area and only patients that are discharged home and waiting transport can be accommodated.	
• Provision of an on-call therapies services, as required.	
• Provision of staff to assist with the Major Incident response.	

	ACTION:- As soon as a major incident is declared (notification via Physiotherapy Manager/Deputy) to Physiotherapy, Occupational Therapy, Speech Therapy Managers/Deputies you should :-	***Tick when completed***
1	As calmly and quickly as possible, start to evacuate the Department of patients. Both in and outpatients.	❑
2	Ask Out-patients to telephone the following day to re-arrange their appointments.	❑
3	Inform the Hospital Co-ordination Centre – service corridor, adjacent to Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)), when Department ready.	❑
4	All OP Therapy Service staff to report to the Therapy Staff Room and await further instructions.	❑
5	Staff to cancel further Outpatient Appointments for the rest of the day, and the following day.	❑
6	Major Incident Physio Coordinator to appoint admin/MSK Physio or assistant to direct to gym/Discharge Lounge. In the event of no person available to distribute signs 3 stored in MI folder in Managers Office. One for main corridor, one for fracture clinic corridor and three for gym corridor, (there is no longer dedicated admin).	❑
7	The telephone lines identified to use are: - • Physiotherapy Gym: internal line only Ext. Number: 38123	❑

PHYSIOTHERAPY MANAGER/DEPUTY CARD 73 (Informed by Switchboard – F24)	ACTION
ROLE SUMMARY	
• Physio admin desk/mini reception: 01792 703124 • Physiotherapy managers hub: internal line only Ext. Number: 38124	
8 Refreshments will be arranged by the Catering Services Manager if required. Contact the Catering Services Manager.	❑
9 All patient and staff personal details should be locked away.	❑
10 The Physiotherapy Manager will liaise with the Hospital Co-ordination Centre and ascertain the nature of the incident and ascertain if nursing staff required to care for any patients waiting transport.	❑
11 Meet with therapy leads to discuss implications on ward-based staff depending on the nature of the incident. This might include a plan to deploy staff to expedite discharges from wards.	❑
12 Any staff available to help, if required, are to contact the respective Therapies Managers, and await further instructions – DO NOT telephone the Hospital Switchboard to offer help.	❑
13 The Therapies Managers will co-ordinate staff according to the nature of the Incident, and the predicted impact on service provision. Identify to the Co-ordination Centre additional staff resources that could be deployed if required. If staff are deployed elsewhere, log the staff member name, time, and location.	❑
14 Consider increased workload for the requirements for Therapies, 2nd day post incident onwards and during recovery period.	❑
Note:-	
• If the Incident occurs 'out of hours', the Physiotherapy Department is locked with a key and digital lock. • The code for the digital lock is kept in the Hospital Co-ordination Centre. • Do not disclose any information to the Press & Media in relation to the Incident. • Senior Health Board Managers will be issuing regular press bulletins, when appropriate	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be	

PHYSIOTHERAPY MANAGER/DEPUTY **ACTION**
CARD 73

(Informed by Switchboard – F24)

ROLE SUMMARY

used [in full - ALL digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.75. Relative Care/Spiritual Care/Chaplaincy. Action Card 74

SPIRITUAL CARE SERVICE / CHAPLAINCY MANAGER **(Called by Switchboard – F24)**	**ACTION CARD 74**
ROLE SUMMARY	
• To provide a comforting and supporting role to patients and relatives of all faiths in the Outpatient Department Area, Multi Faith Centre, Emergency Department and Bereaved Relatives Area. To liaise closely with the Care after Death Service Manager to ensure all relevant parties are supported. • To give support and comfort to carers and staff, i.e., Nursing, Medical, Ambulance, Clerical, etc. for emotional trauma.	
ACTION: - As soon as a major incident is declared the Hospital Telephonist will contact the Spiritual Care / Chaplaincy Manager first, (or if not available, the next Hospital Chaplain from the Approved List)	***Tick when completed***
1. On receipt of notification of a Major Incident, Spiritual Care / Chaplaincy Manager should attend site to assess Spiritual Care response needed. If more member of the Spiritual Care / Chaplaincy Team are required, they will be called out by the Spiritual Care / Chaplaincy Manager as needed.	❑
2. Spiritual Care / Chaplaincy Manager on arrival at site will report to the MDT Room in the outpatient's area. You will be briefed by the Nurse in Charge upon arrival and additional detail will be given with regard to pre-assigned rooms, single point of contact process, communication, and information flow processes.	❑
3. If required and further Spiritual Care Team members / Chaplains attend site, they must first report to the Spiritual Care / Chaplaincy Manager in the outpatient department and will be directed from there. Critical areas that may need to be supported by the Spiritual Care/ Chaplaincy Team are ED, under the direction of the Nurse in Charge of ED, and also the Multi-Faith Centre. The Spiritual Care / Chaplaincy Manager and the Spiritual Care / Chaplaincy Team will liaise closely with the Volunteer Services Manager, Care After Death Service Manager & Care After Death Team and OPD Nurse in Charge and will utilise both Chaplaincy volunteers and general volunteers in the support and care of relatives and staff as needed.	❑
4. It is envisaged that the multi faith centre will be used as a quiet area where relatives/staff may wish to go. There should be a member of the Spiritual Care / Chaplaincy Team available in this area	❑

SPIRITUAL CARE SERVICE / CHAPLAINCY MANAGER (Called by Switchboard – F24)		ACTION CARD 74
ROLE SUMMARY		
NOTE	• Special packs of prayer cards, Holy oils, and other faith items are available in the multi faith centre.	❑
	• The Spiritual Care / Chaplaincy Team will act as a source of information on the requirements of patients and relatives from various faith communities.	❑
	• The Spiritual Care / Chaplaincy Manager will keep the Hospital Switchboard updated when changes to the Approved list are made.	❑
	• The Spiritual Care / Chaplaincy Manager will co-ordinate the support and care of relatives/staff during the Incident with the relatives care team within OP	❑
	• Spiritual Care / Chaplaincy Team across the site to liaise with each other regularly to provide updates to the Spiritual Care / Chaplaincy Manager as they respond to need.	
	• Consideration should be given, by the Spiritual Care / Chaplaincy Manager for Business as Usual cover, as well as rotation of the Spiritual Care / Chaplaincy Team during a prolonged incident	

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Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.76. Volunteer Services. Action Card 75

VOLUNTEER SERVICES (Informed by Switchboard – F24)	**ACTION CARD 75**

ROLE SUMMARY

- Open and manage the Information Desk at the main entrance and temporary information desks as appropriate if requested to do so.
- To deal with relatives arriving at the main hospital entrance and direct them to the appropriate area as indicated in the Major Incident procedure; refer to Major Incident Relatives and Friends Flow Chart.
- Direct press/media to designated area; Education Centre.
- Allocate volunteers to support the relatives' area in upstairs main OPD.
- To provide a comforting and supporting role to patients and relatives in upstairs OPD, and other areas, as requested.
- Work closely with the other staff teams in OPD in the support and care of relatives.

ACTION: - As soon as a major incident is declared the Hospital Telephonist will contact the Volunteer Services Manager and Volunteer Services Coordinator. They should:		***Tick when completed***
1.	On receipt of notification of a Major Incident, call in Hospital Volunteer Service Team to include Ty Olwen Volunteer Manager. Proceed to the Hospital.	❑
2.	On arrival report to the MDT room in waiting area 3, OPD. Confirm the point of contact at the Volunteers Desk. Draft volunteers in as necessary.	❑
3.	Open the Information Desk at the main entrance in preparation for directing enquiries and directing people arriving at the hospital to upstairs OPD, if they are linked to patients involved in the major incident	❑
4.	Allocate volunteers to lifts at floors 0 and 1 to direct families to OPD and to other key locations as requested.	❑
5.	Maintain communication and refer any issues to the OPD point of contact.	❑

VOLUNTEER SERVICES (Informed by Switchboard – F24)		ACTION CARD 75
ROLE SUMMARY		
6.	Liaise with Catering manager to provide refreshments within OPD.	❑
NOTE	• Information in relation to patients from the Incident will be provided by the Hospital Co-ordination Centre and the Police Officers present at the Hospital, (information from the Police Casualty Bureau). However, it may take some time for this information to become available. No information should be given out by volunteer staff.	❑
All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs. **Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident**		

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2.76.1. Patient Advisory Liaison Services (PALS). Action Card 75a

PALS TEAM **(Informed by Switchboard – F24)**	**ACTION CARD 75a**
ROLE SUMMARY	
• Attend the multi-disciplinary meeting room in Morriston Main OPD Area 3 Relative and Friends Hub • To deal with relatives arriving at the entrance of Relative's and Family Hub. Document the names of the family – patient and contact numbers. Direct them to the appropriate area as indicated in the Major Incident Relatives and Friends Floor plan. • To provide a comforting and supporting role to patients and relatives in the upstairs OPD, and other areas, as requested. • Work closely with other staff teams in OPD in the support of relatives • Support the volunteer service at the main entrance and other areas if needed.	
ACTION: - As soon as a major incident is declared the Hospital Telephonist will contact the Head of Quality and Safety/Deputy Head of Quality and Safety. PALS team should:	***Tick when completed***
1. On receipt of notification of a Major Incident, report to the MDT room in waiting area 3, OPD. Confirm the point of contact telephone number for PALS to the Relatives and Friends Lead (Senior Nurse OPD)	❑
2. Organise the allocated workstation in preparation of processing and logging relatives/friends' names and contact details on arrival	❑
3. Liaise with the security and police force present in the Unit in case support is needed	❑
4. Maintain communication and refer any issues to the OPD point of contact	❑
5. Provide support in communication and concerns raised by family/friends in OPD and wider hospital	
6. • Provide advice and support to the multi-disciplinary team in OPD and wider hospital	❑

PALS TEAM (Informed by Switchboard – F24)	ACTION CARD 75a
ROLE SUMMARY	
NOTE	• Information in relation to patients from the Incident will be provided by the Hospital Co-ordination Centre and the Police Officers present at the Hospital, (information from the Police Casualty Bureau). However, it may take some time for this information to become available. No information should be given out by volunteer staff. ❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

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2.77. Home First/Social Work Team/Deputy. Action Card 76

HOME FIRST/SOCIAL WORK TEAM/DEPUTY **(Informed by Switchboard – F24) – no OOH provision**	**ACTION CARD 76**
ROLE SUMMARY	
• Provide a comforting and supporting role to patients and relatives in upstairs OPD area. • Specifically oversee and co-ordinate the 'Reunited & Discharge' area in OPD, in liaison with the Nurse in Charge and Hospital Chaplain. • Offering of practical assistance to those discharged from the Incident, and discharge arrangements for those in-patients being discharged. • Liaise with other colleagues in Social Services and other relevant agencies.	
ACTION: - As soon as a major incident is declared, within Council Office Hours (8.30am to 5pm Monday to Thursday and 8.30am to 4.30pm Friday), They should:	***Tick when completed***
1. On receipt of notification of a Major Incident, call in additional Hospital Social Work Team members, as appropriate. Proceed to the Hospital. Confirm the lead for the Social Work team in order to act as the co-ordinator of the team. Ensure there are links with Social Work members in other areas, e.g., ED	❑
2. Confirm with the Hospital Co-ordination Centre in the service corridor, adjacent to the Telephone Exchange (Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3) of their presence at the Hospital.	❑
3. Establish a Hospital Social Work team presence in the upstairs OPD area with liaison with the Nurse in Charge. You will be briefed of the incident upon arrival at OPD and additional information will be provided. Pre-assigned rooms will be available for the Social Work Team to speak to relatives.	❑
4. The Social Work Team is to be available to provide support and any other practical support to relatives and patients who have been discharged. Log actions and decisions taken to support patients and relatives on discharge.	❑
5. The Team is to be available to help in facilitating discharge arrangements for existing in-patients, to help in liaising with their families and carers and to signpost to appropriate agencies. 3 members of the team will be assigned for this.	❑

HOME FIRST/SOCIAL WORK TEAM/DEPUTY (Informed by Switchboard – F24) – no OOH provision		ACTION CARD 76
ROLE SUMMARY		
6.	After the initial crisis, the Team will be available to offer support, and any practical support to the casualties that remain in the Hospital, and to be involved in their discharge planning.	❑
7.	Some of the Social Work staff may be available to offer on-going support to casualties and staff in the immediate aftermath.	❑
NOTE	The Hospital Social Work Team will liaise with appropriate senior colleagues in the City & County of Swansea Social Work Department. Should the incident involve a Local Authority adjacent or distant to City and County of Swansea, the Hospital Social Work Team will act as liaison to that Local Authority	
	The Hospital Chaplain will co-ordinate the support and care of relatives during the incident.	❑
	In addition, the Hospital Social Work Team may wish to liaise with the Service Group Director/Deputy; Primary and Community Care; contact will be made via the Hospital Co-ordination Centre in this circumstance.	

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Note:

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2.78. Care after Death Service Manager. Action Card 77

CARE AFTER DEATH SERVICE MANAGER – BEREAVED RELATIVES AREA **ACTION CARD 77** **(Allocated from Switchboard – F24)**	
ROLE SUMMARY	
• To provide a comforting and supporting role to patients and relatives in the Bereavement Area established in upstairs OPD • Specifically oversee and co-ordinate the Bereavement area established in the upstairs OPD Department, supported by the Care After Death Team • To liaise with Police and Mortuary Team as required to facilitate collaborative support for relatives and the deceased patients • To liaise with the Spiritual Care / Chaplaincy Team, Volunteers & PALS Team for support as required	
ACTION: - As soon as a major incident is declared the Hospital Telephonist will contact the Care After Death Service Manager first, (or if not available, the Care After Death Support Lead as deputy) Care After Death Service Manager for the Relatives Area will be the Lead of the Bereaved Relative Response and will follow other response plans, including Mass Fatality and the Bereavement Charter. The Care After Death Manager should:-	***Tick when completed***
• On receipt of notification of a Major Incident, The Care after Death Service Manager should attend site to assess the bereavement response needed. If more members of the Care after Death Team are required, they will be called out by the Care after Death Service Manager as needed.	
1. On arrival at site, the Care After Death Manager will report to the MDT Room in the outpatient's area. The Care After Death Manager will also establish a Bereavement area for relatives and friends in the Outpatients Department, Waiting Area 3. You will be briefed by the Nurse in Charge upon arrival and additional detail will be given with regard to pre-assigned rooms, single point of contact process, communication, and information flow processes.	❑
2. The Care After Death Manager is to be available to oversee the running of the Bereavement area within OPD, together with the Care After Death Team. If required and further Care After Death Team attend site, they must first report to the Care After Death Service Manager in the outpatient department and will be directed from there. Critical areas that may need to be supported by the Care After Death Team are the Bereavement Area & Mortuary.	❑

CARE AFTER DEATH SERVICE MANAGER – BEREAVED RELATIVES AREA ACTION CARD 77 (Allocated from Switchboard – F24)		
ROLE SUMMARY		
	The Care After Death Service Manager and the Care After Death Team will liaise closely with the Volunteer Services Manager, Spiritual Care / Chaplaincy Manager, PALS Team and OPD Nurse in Charge and will utilise both Spiritual Care / Chaplaincy Team and general volunteers in the support and care of relatives as needed.	
3.	Liaison with Police, DVI and Mortuary Team as required to identify relatives/friends. These relatives / friends will have been identified by the Police as having to be informed that their loved-one is possibly dead. The news will be broken to them in the private areas Bereavement area and will be co-ordinated by the Care After Death Team. They will be informed of the process that will be established by the Police for the care of the dead and subsequent procedure to identify the deceased and work with Mortuary Team to facilitate support.	
4.	Liaison with Paediatrics as appropriate for the care of families with children and also care of families following the death of a child.	
NOTE	• The appropriate volunteers will accompany any relatives and friends to the 'Bereavement area' on arrival at the hospital to be supported by the Care After Death Team	❑
	• A dedicated reception area will be established by the Police for Relatives of the deceased in the Bereavement area and will be supported and coordinated by the Care after Death Team at the time.	❑
	• The Care After Death Team will co-ordinate the support and care of relatives during the Incident where basic human rights to dignity and privacy must be protected and will liaise with the Spiritual Care / Chaplaincy Team to ensure that spiritual and cultural needs are met and respected.	❑
	• The Care After Death Service Manager will keep the Hospital Switchboard updated when changes to the Approved list are made	❑
	• Care after Death Team across the site to liaise with each other regularly to provide updates to the Care after Death Service Manager as they respond to need.	
	• Consideration should be given, by the Care after Death Service Manager for Business-as-Usual cover, as well as rotation of the Care after Death Service Team during a prolonged incident. It is critical during any Major Incident that BAU is maintained	

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Note:

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- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
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2.79. Nurse in Charge. Designated Discharge Area. Action Card 78

NURSE IN CHARGE, DESIGNATED DISCHARGE AREA **(Informed by Site Manager)**		**ACTION CARD 78**
ROLE SUMMARY		
	• Any patient requiring to be discharged, or transferred to another Hospital when possible should be sent to an appropriate identified area, e.g., the discharge lounge which will act as a holding/decanting area for those awaiting Ambulance transport and/or require a clinical environment. Ambulant patients may wait in the discharge lounge and Physiotherapy OPD if additional capacity required.	
ACTION: - As soon as a Major Incident is declared you will be informed by a member of the Site Management Team. The Nurse in Charge should:		***Tick when completed***
1.	Establish an area for discharged patients waiting for ambulance transport home or transfer to another hospital resulting from the major incident. Arrange for Beverages to be available. Advise Catering Services Manager when ready, extension 33079 / 33537 / 33560 / 33535	❑
2.	Allocate a nurse is to be available to oversee the running of this area, and provide support to patients, relatives, and friends.	❑
3.	Allocate clerical staff to assist in the preparation for receipt of patients	❑
4.	Inform the Hospital Co-ordination Centre that the Department is ready - Phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3).	❑
5.	Keep Ambulance Liaison Officer informed.	❑
6.	Log all patients arriving with the following detail. • Name of patient • Area discharged from • Transfer location • Relatives informed • Transport booked	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic

P.A.S. entry and number is available. This unique numbering system must remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but cannot replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.80. Education Centre Manager. Action Card 79

MANAGER – EDUCATION CENTRE	**ACTION CARD 79**
Notified by Switchboard - F24	

ROLE SUMMARY

- Notification and confirmation of a Declared Major Incident will be received from switchboard and the Hospital Co-ordination Centre
- Your role is to:

  - Clear Education Centre of all meetings ongoing following discussion with your manager.
  - Ensure designated rooms are available as per procedure
  - Set up a reception area at the break out area to co-ordinate press and media. Handover to Communication team upon arrival. (Communication Team may require on-going assistance from staff within Education Centre and should request this at the time, in and out of hours)
  - If out of hours, Site Manager to arrange for Security to open Education Centre.

ACTION:-In hours the role will be undertaken by Education Centre Manager/Deputy. They will meet and greet and direct staff to relevant rooms until the Communication Team arrive. Out of hours a member of staff will be allocated by the Silver Commander in the Hospital Co-ordination Centre after a Major Incident is declared. Security will open rooms and over-ride electronic release of doors. The Education Centre staff should:	***Tick when completed***
1. On notification of a major incident, contact a member of the Communications Team to discuss the incident and if the following provision within the Education Centre will be required. Seminar Rooms designated for use during a Major Incident must be cleared of any current meetings. The designated rooms are:- • Breakout Area – Meet, Greet, Direct • Lecture Theatre 1, (1st floor) – Media/Press Rooms • Lecture Theatre 2, (1st floor) – Media/Press Briefings • Medical Skills Room, (1st floor) – Media/Press Interviews • Seminar Room 1, (1st Floor) – Communications Team Room Meetings ongoing in all other rooms on 1st floor should be terminated wherever and the rooms secured.	❑
2. Confirm with Site manager in Co-ordination Centre when the area is ready.	❑
3. Make contact with Catering Services Manager, Extension 32389 to ensure arrangements are in place for refreshments.	❑

MANAGER – EDUCATION CENTRE Notified by Switchboard - F24	ACTION CARD 79

ROLE SUMMARY

4.	Pending the arrival of the Communications Manager, (or other Communication Team members) maintain a register of press/ media who are directed to the Seminar rooms available.	❑

All patients will have been/be issued with special numbered record folders, and tags on arrival which will accompany them at <u>all</u> times. These unique M.I. numbers must be used [in full - <u>ALL</u> digits] for all investigations and prescriptions until a full demographic P.A.S. entry and number is available. This unique numbering system <u>must</u> remain in place for 24hrs.

Once patients are formally identified their names can be recorded alongside the numbering system, but <u>cannot</u> replace this system which must remain for 24 hrs post incident

Note:

- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

2.81. Coordination of Psychosocial Care. Action Card 80

Coordination of Psychosocial Care	Action Card 80
MENTAL HEALTH & LEARNING DISABILITIES SENIOR MANAGER (TO INCLUDE ON-CALL)	

- Psychologically focussed debriefing is not recommended in the current Post-Traumatic Stress Disorder (PTSD) NICE guidelines.
- It is not anticipated that mental health workers will become directly involved in offering a response to disaster survivors and others involved at this stage.
- Mental Health staff have provided information leaflets for chaplains, volunteers, and managers to give to relatives and trauma sufferers (adult and child) in the event of a major incident. These include guidance on how to look after yourself following a traumatic experience (what to do/what not to do) & when to seek professional support;

No	Action	Completed
1.	**Immediate provision of information and advice to the public.** Senior Manager (MH & LD) to provide copies of leaflets advising patients (adults and children) of the symptoms they may experience and when help should be sought. (Leaflets embedded in Section 5 of this action plan). These leaflets will be distributed by Chaplaincy, Patient Advisory Liaison Services/Volunteer Manager, Social Work Team Manager and Lead Nurse Relatives Area.	
2.	**Immediate Concerns re: Mental Health Crisis:** For concerns that any adult is experiencing mental health crisis in relation to the incident, support can be available on site from the hours of 7am to 10pm via Liaison Psychiatry (contactable via 01792 703312/ internal dial 33312). Outside these hours, contact Mental Health Single Point of Access on 01639 862032 In the event of a young person (under-18) presenting in overt mental-health crisis contact the Child and Adolescent Mental Health Service (CAMHS) single point of access on 01639 862744 (9 am to 5 pm) or the out of hours on-call child psychiatrist or crises team (via Morriston Hospital switchboard).	

3.	**<u>Staff Wellbeing / Psychological needs</u>** On call manager will contact local TRiM Manager/Practitioner in Service Group & inform central TRiM team via sbu.TRiMTeam@wales.nhs.uk. Contact details for Local Trim manager/practitioners are available via wellbeing SharePoint page (health board intranet). TRiM incident brief should take place within 24 hours following stand-down of Major Incident. In case that No TRiM manager/practitioner is able to attend, arrange to distribute TRiM information leaflet to staff involved in the incident (leaflet embedded in section 5, or via wellbeing SharePoint page).	
4.	On-call manager will inform Chair (Director of Therapies & Health Science) and Vice-Chair (lead for Psychological Therapies) of the PTMC (Psychological Therapies Management Committee) who will convene a meeting within one week. Purpose of meeting: ensure that an adequate response to psychological needs of both Public & staff has been provided / to develop further bespoke response if required; Meeting to include Lead for Psychology, Lead for Psychological Therapies, TRiM Manager, Lead for Occupation Health & Staff Wellbeing.	
5.	In the instance of under-18-year-olds being affected – the Mental Health & Learning Disabilities Manager should liaise with the Police (as lead Emergency Service) to ensure that the relevant Local Authority Chief Executive and Director of Education have been informed. This will trigger initial school-based intervention including an element of community support to include psychoeducation about reactions to trauma and how carers can best manage these and facilitate recovery. Educational Psychology will work with schools at this point. In the event of non-school periods the Local Authority will still respond.	
6.	Young people showing ongoing signs of heightened distress may be offered support through school with access to CAMHS In-Reach service or be referred to school counsellors. Young people can be referred by a professional or GP to Child & Adolescent Mental Health Service (CAMHS) for assessment and intervention. CAMHS Single Point of Access can be contacted on 01639 862744 by young people open to CAMHS, or by professionals for advise if a young person is unknown.	

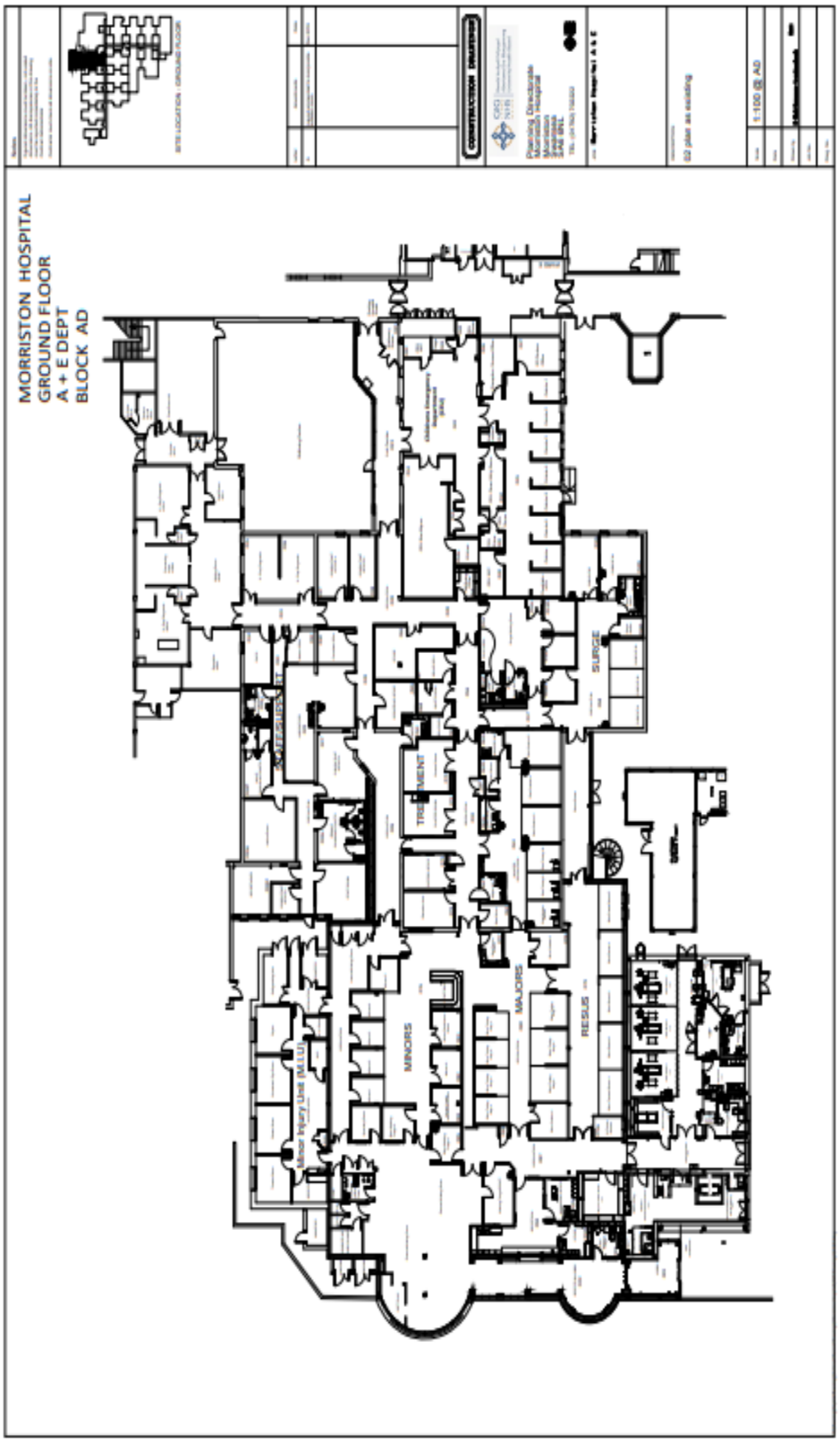
7.	For (adults) members of the public experiencing mental health concerns following the incident (including clinically important symptoms of PTSD), these should be referred from their GP to Local Primary Mental Health Support Service (LPMHSS) and assessed for treatment as recommended in the Matrices Cymric (2017). Members of the public may also access mental health support without referral by phoning 111 and select option 2 in order to access triage assessment of mental health concerns, immediate support, signposting for further support, or onward referral for treatment of mental health difficulties.	
8.	Where people present following the incident with significant risk (e.g., self-harm, suicidal ideation) alongside mental health concerns, a referral should be made to Single Point of Access (SPOA) for mental health triage assessment.	

Note:

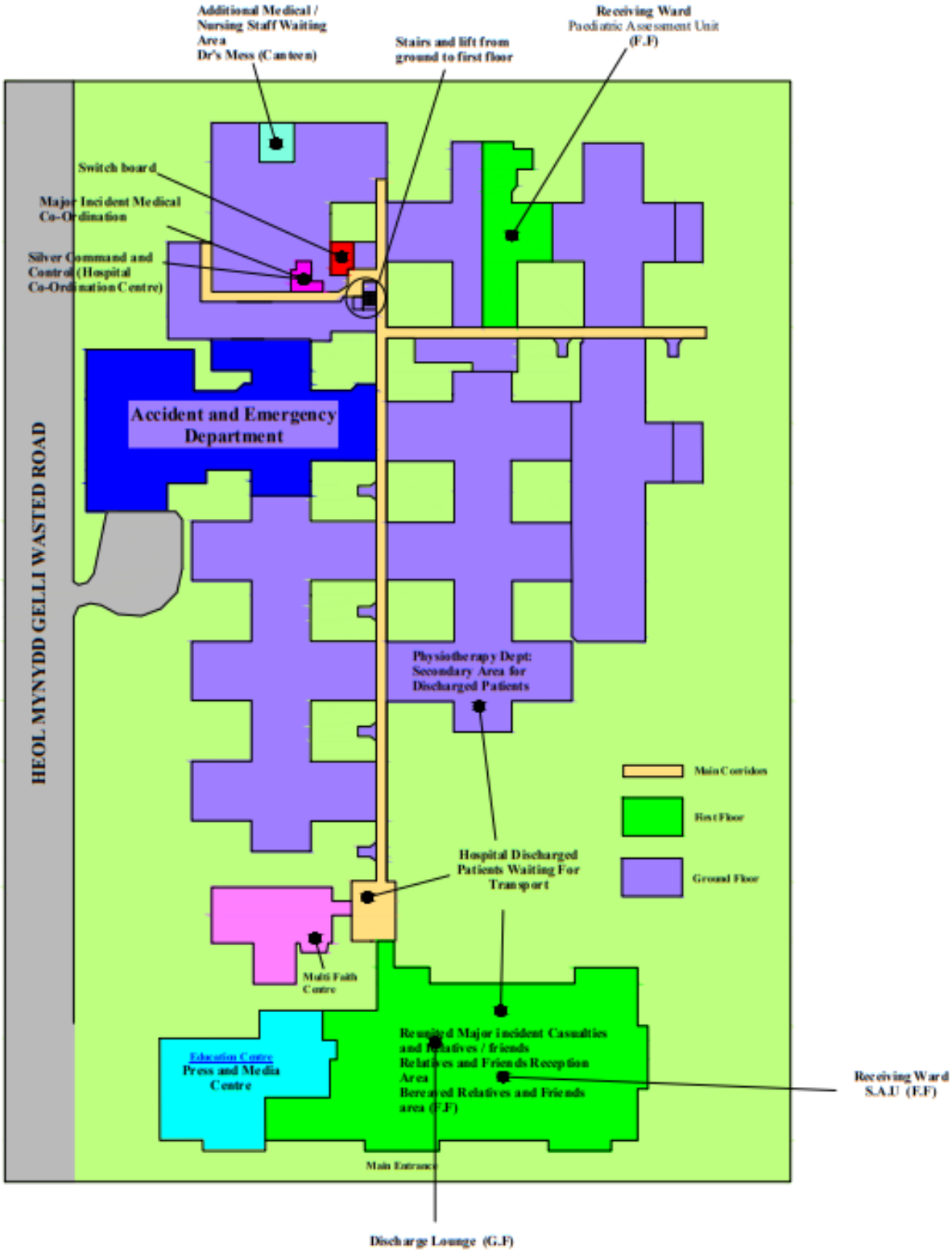
- Please keep calls through the Hospital Switchboard to an absolute minimum
- Ensure you wear a valid HB identity badge at all times
- Maintain a record of key actions, this will be required for a post-incident debrief and Report.
- Any changes to your action card should be discussed with the Emergency Preparedness, Resilience and Response Lead
- **Be aware that initial information reports will change regularly**

Section 3. Appendices

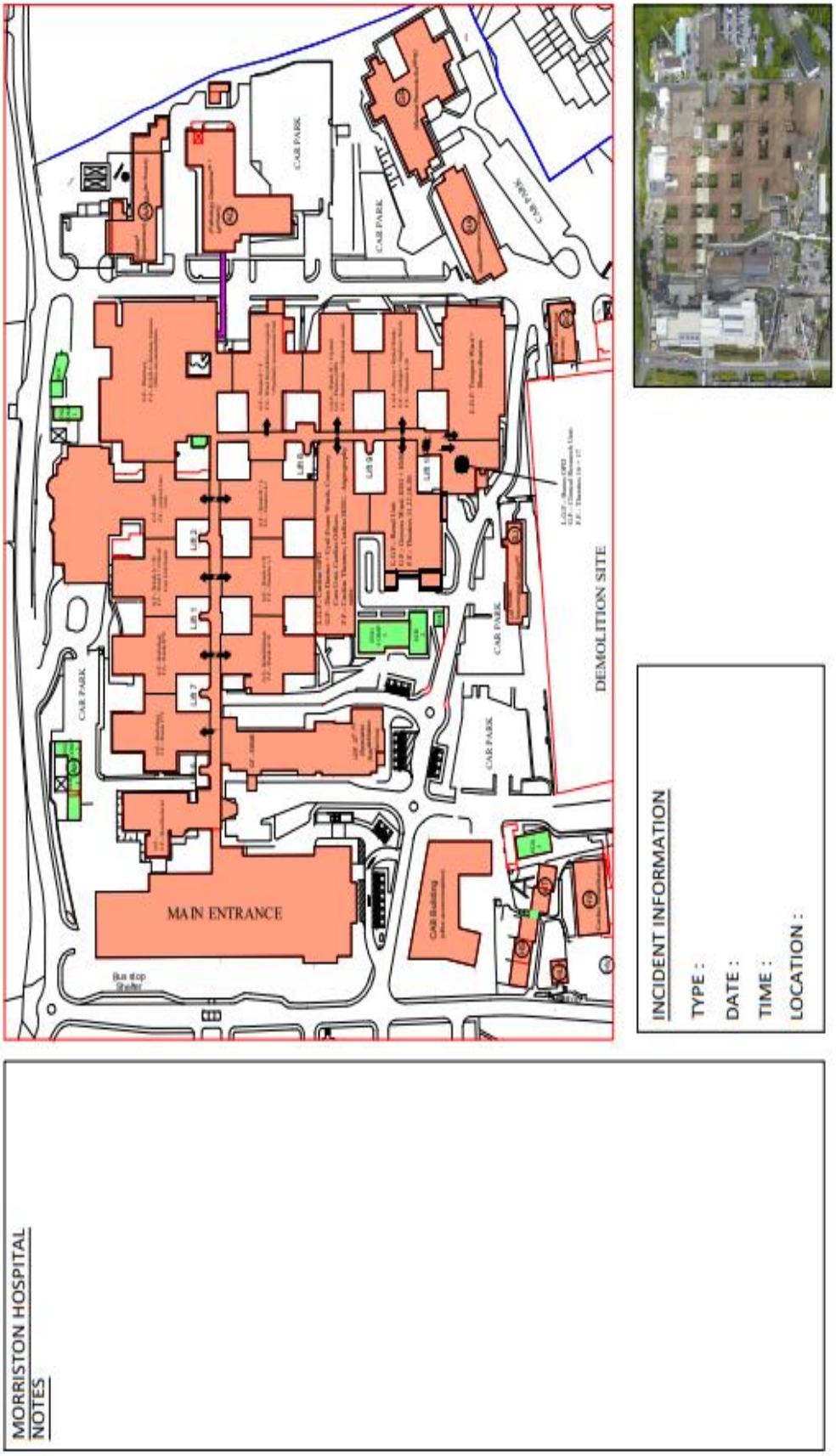
Appendix 3.1. Morriston Hospital ED Key Locations



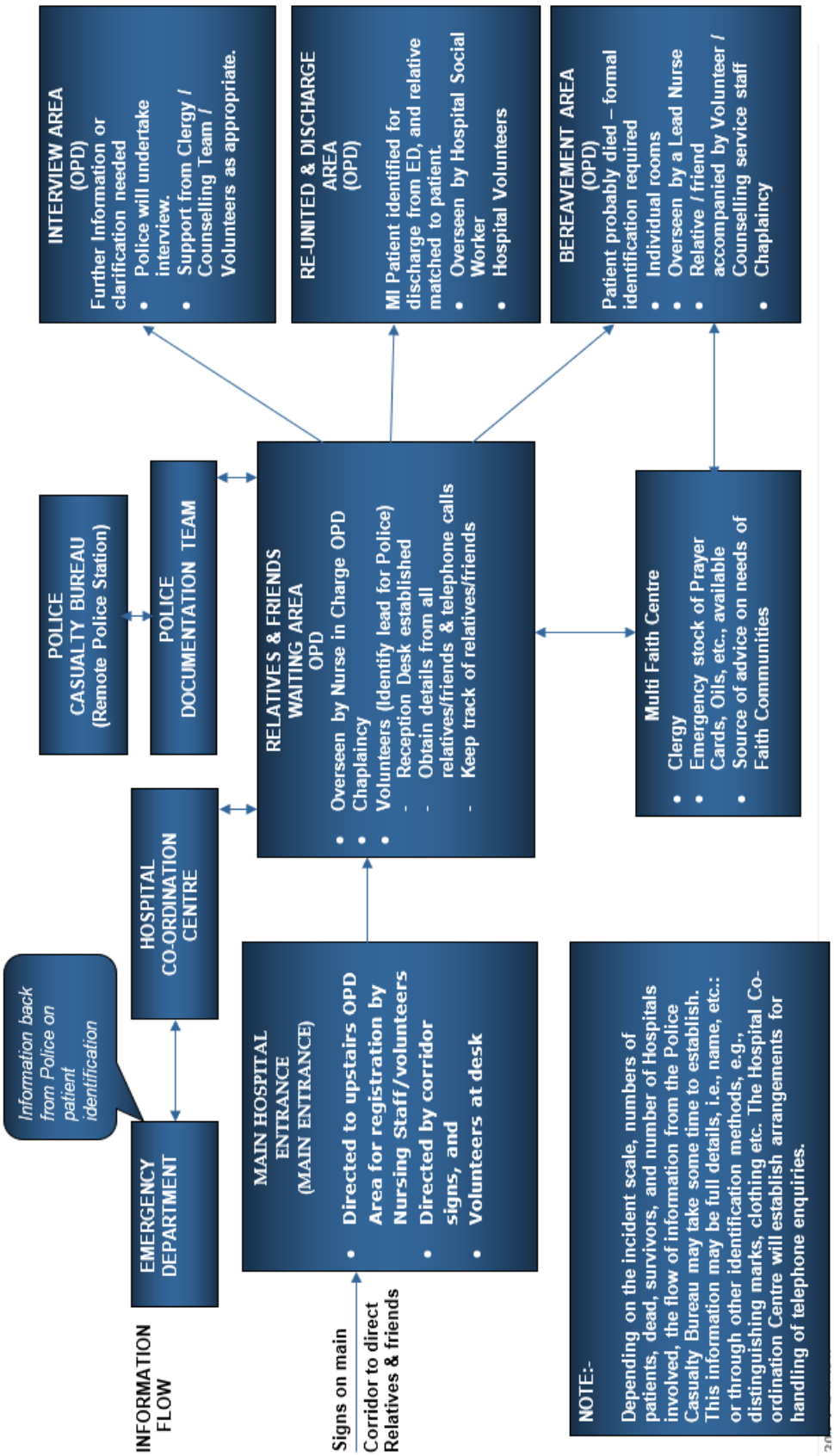
Appendix 3.2. Morriston Hospital. Key Location Points



Appendix 3.3. Morriston Hospital Site Plan



Appendix 3.4. Major Incidents Relatives & Friends Flow Chart



Appendix 3.5. Major Incident Key Locations

- Emergency Department Control Point – Jubilee Suite, Emergency Department
- Silver Command and Control – Hospital Co-ordination Centre, ground floor
- Police Liaison Office – Emergency Department Police Interview Room
- Major Incident Patient Receiving Wards – Surgical Decision-Making Unit/Oakwood
- Friends and Relatives Area – Upstairs Out Patients Department
- Bereaved Relatives Area – Upstairs Out Patients Department
- Hospital Information Point – Coordination Centre, ground floor
- Major Incident Patients Reunited and Discharge Area – Upstairs Out Patients Department
- Hospital Patients Awaiting Discharge/Transfer Via Ambulance – Discharge Lounge and (Physiotherapy OPD if required)
- Press & Media – Education Centre
- Medical and Nursing Teams waiting to be allocated to major incident response – Doctors Mess, Dining Room

Appendix 3.6. Silver Command Loggist Action Card

SILVER Command Loggist Action Card **Notified by Morriston HCC**	
ROLE SUMMARY	
To record all key decisions taken or not taken by the Silver Commander. The Loggist is not a minute taker or there to provide any other administration functions. The role will be undertaken by trained staff only. The Health Board will be asked to account for their actions and decisions during an incident. Notes, records, and reports may be scrutinised as evidence.	
ACTION :-	***Tick when completed***
1. All email correspondence must be sent and received via the email addresses below; Morriston Hospital SBU.MajorIncidentMorr@wales.nhs.uk SBUHB Headquarters SBU.MajorIncidentHQ@wales.nhs.uk Tempest Ward, Burns Centre Burns.Incident@wales.nhs.uk	❑
2. On receipt of a Major Incident standby or declared a trained Loggist will be contacted to fill the role of Silver Loggist.	❑
3. When requested attend the Hospital Co-ordination Centre, phone Numbers: 01792 530759 – Ext 30759 Main desk phone next to MI PC (phone 1), 01792 532905 – Ext 32905 Internal room (phone no 2), 01792 703778 – Ext 33778 External room (phone 3)	❑
4. Ensure you receive a briefing of the incident so far	❑
5. Commence the Incident Log book, ensuring the incident name and date are documented.	❑
6. Introduce yourself to the Silver Commander and outline your role as above	❑
7. Remain by the side of the Silver Commander and attend all meetings/briefings unless directed by the Silver Commander not to.	❑

SILVER Command Loggist Action Card Notified by Morriston HCC		
ROLE SUMMARY		
8.	Enter the current time and date in the Log Book, log handover time and any other relevant details.	❑
9.	Ensure blank spaces are ruled through with a single line.	❑
10.	Any mistakes should be ruled though with a single line and initialled.	❑
11.	Record all decisions made including the time each decision is made, (use 24-hour clock)	❑
12.	Decisions recorded in a meeting must be read out at the end of the meeting and signed by the decision maker.	❑
13.	Once Major Incident stand down is declared, the Log Book should be signed by the Loggist/s and Commander/s / decision makers and sent to the Risk & Assurance team (see Appendix 3.7. Archival Process Action Card).	❑

Appendix 3.7. Archival Process Action Card

Archival Process **Archiving a Major Incident**	**ACTION CARD 01** **V2 25-10-2024**

ROLE SUMMARY

During a major incident, a wealth of information will be generated. Best practice for the archival process will include storage, creation of a historical record during a major incident, its impact and other key information. Archiving the documentation in a clear and accessible way will aid the legal process post incident.

The process will ensure:

- All documentation is preserved and made available to the risk & assurance team
- The HB can protect itself in case of legal or other challenges – it can produce evidence to show it has acted appropriately, and met its obligations
- Meet accountability requirements of the regulatory environment in which it operates
- Allow for consistency and continuity in administration and governance
- Prevent data loss
- Reduce operational costs
- Improve security
- Enhanced compliance – avoids financial penalties by retaining legally required documents

ACTIONS:

Service Delivery Groups:

1. Ensure Logbooks (NHS Wales Decision Log) are completed appropriately (in line with Logging best practice) and are signed by both the Commander and Loggist. If electronic logging is used, the same above process applies. The electronic log should then be scanned and saved.
2. Ensure all other relevant documentation (meeting notes/minutes etc) are collated and retained.
3. Forward all documentation from the major incident, hard copies and digital documentation to the risk & assurance team.

Rish & Assurance Team:

1. **Arranging the records** – The documentation generated in the response to the Major Incident will initially be stored according to its immediate use e.g., all records referenced at meetings will be stored together. The risk & assurance team will decide how to arrange the records to be most presentable and accessible when the response to the Incident is later reviewed. This should be done according to Archival best practices, and based, where possible, on Original Order, Provenance, or Function.

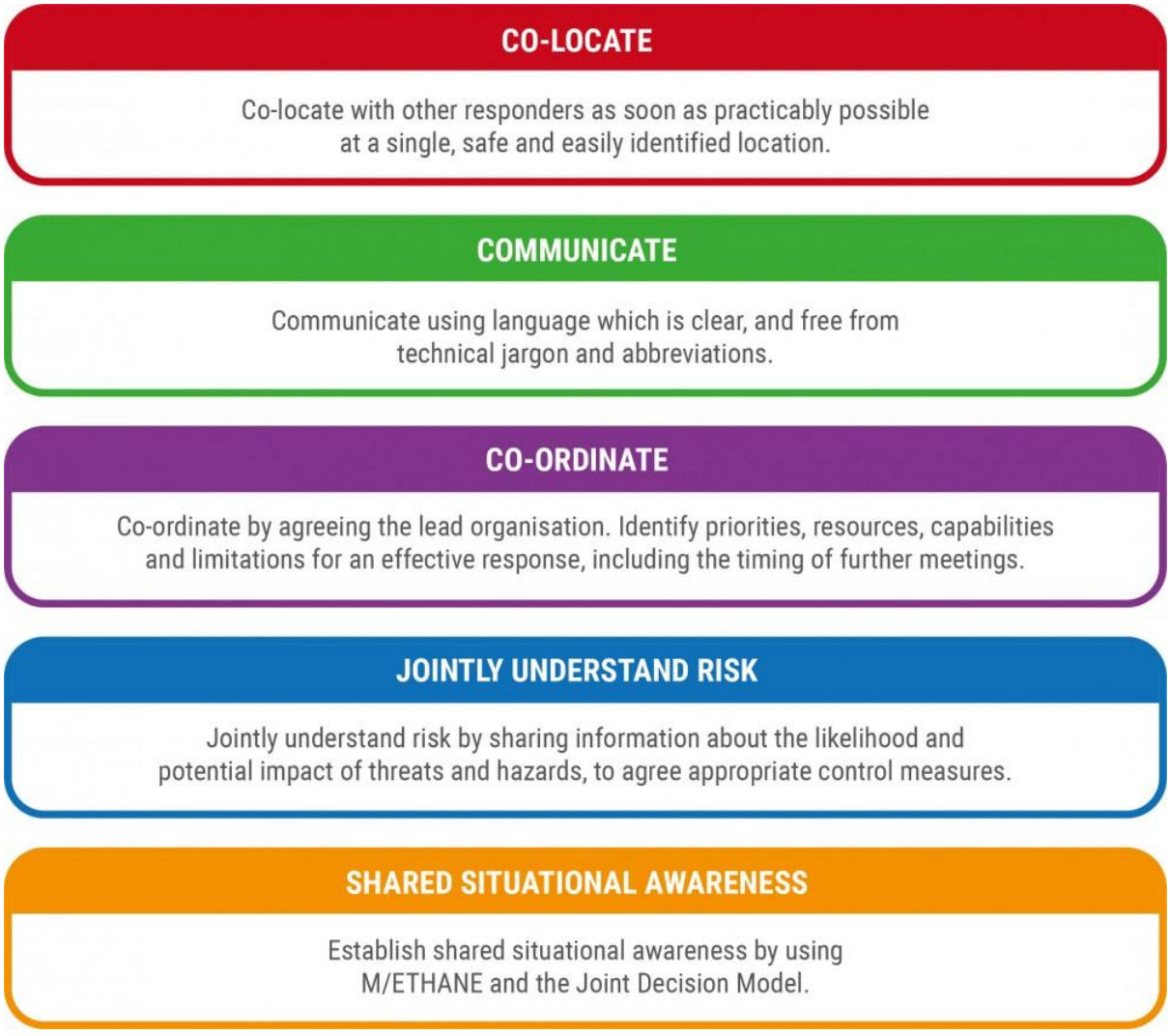
2.	**Cataloguing and Indexing the records –** The records, once arranged, must be indexed appropriately in the Archival database – this will make it easy to refer to them accurately at a later date, when the response to the Incident is reviewed. Refer to the SBUHB Logging & Archival Process Policy - EPRR Governance / Guidance Documents
3.	**Log inquiries** – All requests for information regarding the Major Incident must be logged, in order to provide a complete paper trail. This will provide an easily readable account of who was provided with which information.

Appendix 3.8. JESIP Interoperability Principles

The JESIP Interoperability Principles should be used during all phases of an incident, whether spontaneous or pre-planned and regardless of scale.

They support the development of a multi-agency response and provide structure during the response to all incidents. The principles can also be applied during the recovery phase.

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 JDM centres around three primary considerations:

Situation	Direction	Action
What is happening?	What do you want/need to achieve in the first hour (the desired outcomes)?	What do you need to do to resolve the situation and achieve your desired outcomes?
What are the impacts?	What are the aims and objectives of the emergency response?	
What are the risks?	What overarching values and priorities will inform and guide this?	
What might happen and what is being done about it?		

Further supporting information can be found in the JESIP Joint Doctrine:

JESIP-Joint-Doctrine
-October-2021_ACCI

Section 4. Mass Casualty Arrangements

4.1. Introduction

The UK risk assessment and Local Resilience Forum risk registers identify many hazards and threats that could result in the NHS in Wales having to respond to a mass casualty situation. Recent further atrocities have exacerbated the need for organisations to re-assess their response capability, to work with partner organisations in terms of a co-ordinated response and how this may correspond in a wider national response across the UK.

The purpose of the SBUHB Mass Casualties response process is to underpin the NHS Wales Emergency Planning Guidance 2008; Mass Casualties Incidents; A Framework for Planning and Mass Casualty Incident Arrangements for NHS Wales to ensure that it does then correspond with any pan Wales health and multi-agency plans as well as national plans. It is designed to describe the Health Board process for responding to a major incident of extremely serious proportions that results in mass numbers of casualties. It should be used as a supportive text to aid decisions and should not be used on its own, but in conjunction with the **Health Board Major Incident Procedure's and Mass Casualty Incident Arrangements for NHS Wales as well as national plans.**

This precis informs operational management of the additional requirements for consideration if a major incident is declared as a mass casualty incident. It focuses on the management of co-ordination of the incident within the Health Board. It is anticipated that 'crisis cell' arrangements will be established to co-ordinate the national response requirements and appropriate networks to cope with a large influx of people, and these will need to be aligned. The detailed information to support a mass casualty response is included in the Mass Casualty Incident Arrangements for NHS Wales and **must** be referred to support the Health Board response.

Notification and confirmation of the invoking of a Mass Casualties incident, during a major incident is most likely to be triggered by WAST, but it can be declared by any health organisation. This will occur in the declaration of a major incident resulting in a large number of casualties where a generic major incident response is unlikely to cope and threatens severe disruption to health and social care and will exceed the collective local capability available.

4.2. Definition of a Mass Casualty Incident

"A disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response" (Welsh Go, 2015)

By definition, such events have the potential to rapidly overwhelm the local capacity to respond, even with the implementation of major incident procedures. Responding effectively to a mass casualty incident requires an integrated approach to service delivery by Health Boards working in partnership with other Health Boards and Category 1 and 2 responders. In planning their response to these types of incidents, all Health organisations will need to ensure business continuity and escalation

processes, and the on-going provision of services for casualties who require urgent medical attention but not associated with the incident/s.

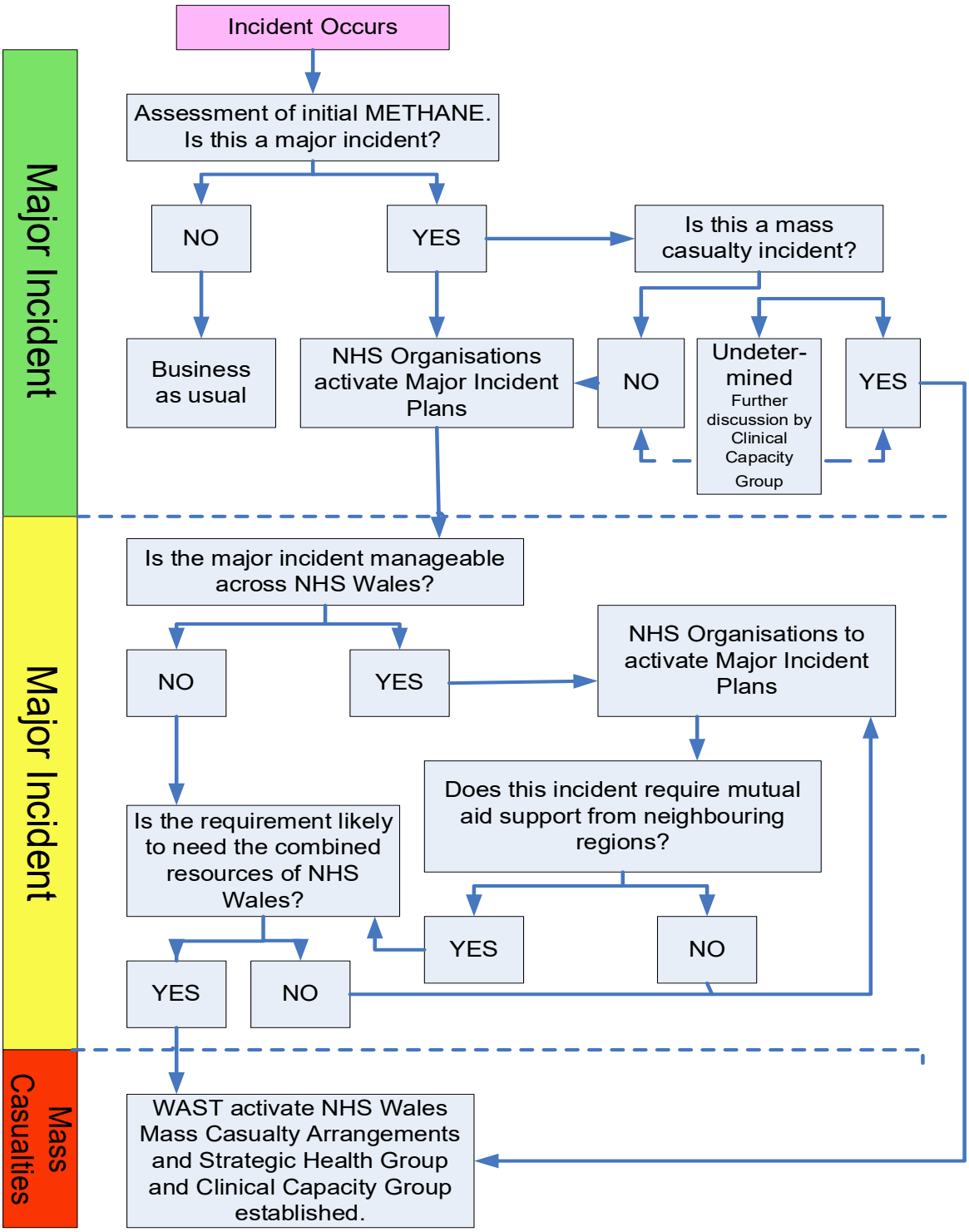
It is possible to estimate initial casualty volume and previous patterns of hospital use have highlighted that within 90 minutes following an event, 50-80% of the acute casualties will likely arrive at the closest medical facilities. It must be noted that less injured casualties often leave the scene and go to the nearest hospital. This could include Singleton and Neath Port Talbot Hospitals, even though these hospitals have limited access to support services. Therefore, approximately half of all casualties will arrive at the hospital within 1 hour of the incident. To predict the total expected casualties, note as follows;

Total Expected Casualties = Number of casualties arriving in one-hour x 2 (Assuming a “big bang” incident in an urban area). It is worthy of note that different interpretations and definitions are used to indicate hospital’s capacity to receive casualties from a major incident. However, it is important to identify how many critically injured victims that a hospital can receive. To calculate the capacity of hospitals to receive, diagnose and treat casualties from a large-scale incident a model termed Patient Distribution Protocol has been sourced. The All Wales first 2-hour capacity plan is included in the Mass Casualty Incident Arrangements for NHS Wales.

Activation of NHS MCI Response Arrangements

Once a Mass Casualty Incident has been formally declared, the emergency response and coordination measures detailed in the Mass Casualty Arrangements for Wales will be activated without delay.

The diagram below illustrates the full process from initial incident recognition through to activation of NHS Wales MCI arrangements.


Major Incident
Major Incident
Mass Casualties
Incident Occurs
Assessment of initial METHANE. Is this a major incident?
NO
YES
Is this a mass casualty incident?
Business as usual
NHS Organisations activate Major Incident Plans
NO
Undeter-mined
Further discussion by Clinical Capacity Group
YES
Is the major incident manageable across NHS Wales?
NO
YES
NHS Organisations to activate Major Incident Plans
Does this incident require mutual aid support from neighbouring regions?
Is the requirement likely to need the combined resources of NHS Wales?
YES
NO
YES
NO
WAST activate NHS Wales Mass Casualty Arrangements and Strategic Health Group and Clinical Capacity Group established.

4.3. Burns Injury Incidents

Burns incidents pose unique challenges due to limited burns beds in the UK. This scarcity may lead to a rapid overload of available capacity, potentially triggering mass casualty arrangements for a relatively small number of patients.

Additionally, many burn patients may have concurrent traumatic injuries or inhalation of asphyxiants, necessitating a flow management approach like trauma or medical casualty flow arrangements.

Major incident patient flow management (burns)

Most major incidents involving burns will trigger mass casualty arrangements (see below). However, the following flow management may be applied to any incident that results in very small numbers of patients who have sustained isolated burns injuries. Clinicians must exercise clinical discretion in applying the standard triage categories and adhere to burns referral guidelines whenever feasible.

- **Priority 1 and Priority 2** patients with concurrent traumatic injuries or physiological instability suggesting an injury, should be transferred to a major trauma centre.

If the number of patients with traumatic injuries in the incident is substantial, consideration should be given to transferring Priority 2 patients with traumatic injuries to trauma units.

- **Priority 1 and Priority 2** patients with obvious isolated major burns and no other identified or suspected major injuries based on anatomical or physiological criteria, should be transferred to a burns centre if capacity permits.

If this number exceeds the capacity of the burns centre, then mass casualty triggers will be met (see below)

- **Priority 3** patients with burns to specialist anatomical areas should be transferred to a burns centre if capacity is available. Patients with burns to non-specialist areas should be transferred to an appropriate facility capable of assessing the injury and providing initial management. This may include any district general hospital.

Priority 3 patients with minor burns may be treated in a minor injury unit or, if appropriate, discharged from the scene.

Mass casualty considerations (burns)

Given the limited capacity for burns management in the United Kingdom, a significant burns incident involving relatively few patients is likely to prompt the immediate activation of mass casualty arrangements.

In contrast to trauma and medical incidents where standard referral pathways are maintained but scaled up, the patient flow management of a burn’s incident will replace these standard pathways

Key considerations for a mass casualty burns incident include:

- Continued involvement of all health boards in Wales who must remain fully engaged in the incident response.
- Reconfiguring of the flow patient pathway as follows:
- **Priority 1 and Priority 2** patients should be transferred to a hospital site capable of providing initial resuscitation and intensive care support. This is likely to be an MTC or TU and may or may not be a burns-capable facility. Patients with an identified or suspected concurrent major injury should be prioritised to an MTC
- **Priority 3** patients should be transferred to a minor injury unit. These units may be required to manage patients until capacity becomes available at other sites.
- A mutual aid request should be made via the NHS England EPRR Duty Officer.
- The direct transfer of patients from scene to additional English sites that agree to support the incident response. This is likely to be an MTCs and TUs that may or may not be burns-capable facilities.
- Confirmation from the NHS England EPRR Duty Officer that the NHS England concept of operations burns annex has been activated.
- Inclusion of the NHS England Mass Casualty Clinical Cell and the National Burns Beds Bureau in capacity meetings to advise the clinical capacity group on further patient flow.

This approach will necessitate collaborative working between burns networks across the United Kingdom. The incident is likely to result in a substantial number of patients requiring inter-hospital transfers, which may include international transfers.

Additionally, burns incident response teams from England may be deployed to assist in ongoing patient management.

Under-triaged and hyper-acute transfers (burns)

With limited burns national burns capacity, it is likely that many patients will be under triaged. However, most sites with intensive care facilities can provide the initial management of these patients effectively.

The ongoing management will depend on a national response with either patients being transferred to burns capable site or burns incident repose teams moving to assist remote hospital sites.

Paediatric Considerations

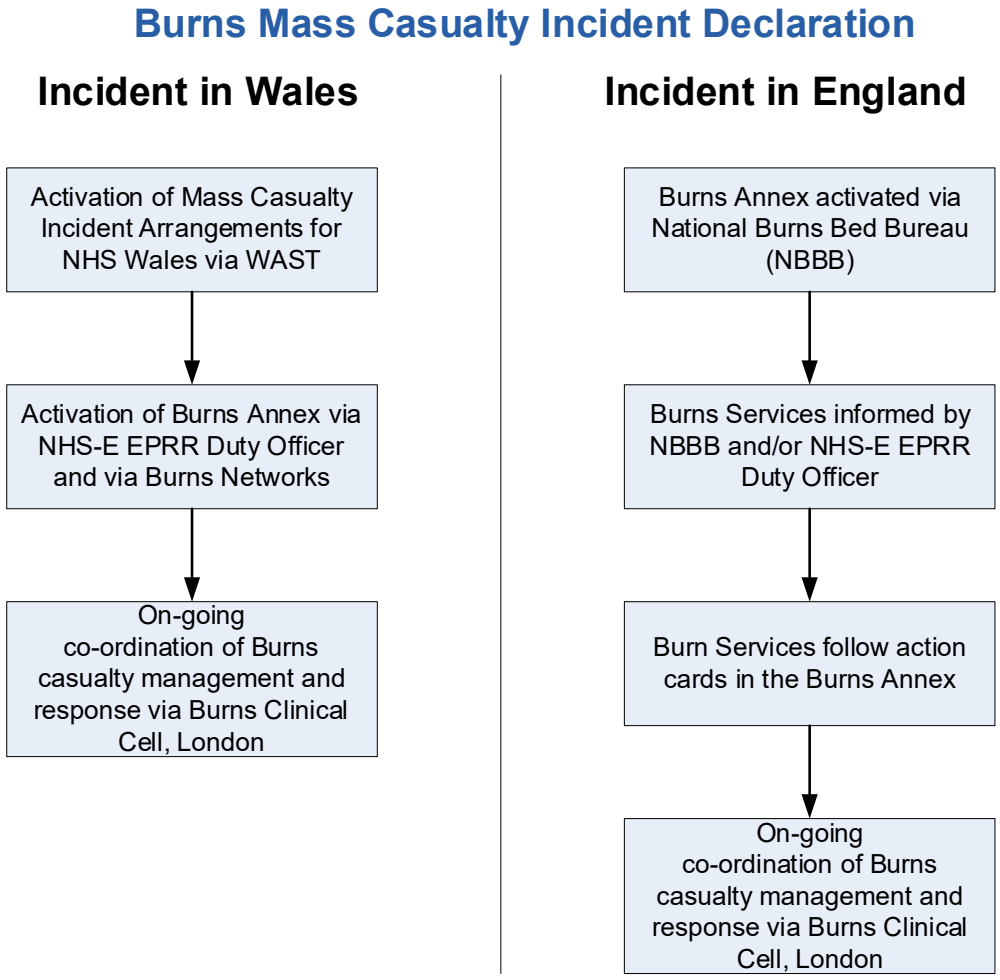
Any major incident may involve a substantial number of paediatric patients, which will present additional challenges to the response. These incidents are likely to trigger mass casualty arrangements at an early stage.

Key considerations for a mass casualty paediatric incidents include:

- Early mutual aid from English hospital sites.
- Non-paediatric hospital sites should be prepared to manage children and hold them on-site for an extended period, including older children and adolescents requiring intensive care and surgical management.
- Hospital sites must be flexible to keep families together as much as possible, which may involve accommodating adult patients on paediatric wards and vice versa. All health board major incident plans must incorporate this scenario.

Wales is covered by two Burns Networks; Southwest UK Burn Care Operational Delivery Network, at Morriston Hospital, (covering up as far as Machynlleth) and Northern Burn Care Operational Delivery Network, which covers the North Wales area.

In addition to the activation of the Mass Casualty Arrangements for Wales, the South West UK Burns Network Plan details the local response arrangements as well as the SBU Burns Major Incident Procedure. The NHS England Concept of Operation for the management of Mass Casualties (Burns Annex) details the national response.



4.4. Health Board Role in Responding to a Declared Mass Casualty Incident

In addition to activating their Major Incident response plans (including Mass Casualty and Surge Capacity Plans), Health Boards will:

- **Activate internal arrangements** to manage a sudden increase in seriously ill or injured casualties.
- **Participate in overarching MCI coordination structures**, including the Clinical Capacity Group and Strategic Health Group, and ensure appropriate personnel are nominated to receive invites and represent the Health Board.
- **Balance care needs** by continuing treatment for existing patients while addressing the urgent needs of MCI casualties, recognising that opportunities for routine emergency patient transfers may be limited.
- **Coordinate with partner agencies** to ensure casualties are directed to the most clinically appropriate facilities.
- **Implement the All-**Wales Critical Care Escalation Guidance and Plans.

- **Release specialist staff** to form Burn Incident Response Teams (BIRTs), if required for deployment (SBUHB).
- **Support hospitals receiving burn casualties**, ensuring readiness to assist deployed BIRTs with patient assessment prior to transfer to designated burn services

Additional Considerations for Health Boards

Health Boards may also need to address a range of operational and strategic challenges during an MCI, including:

- Sustaining routine emergency care alongside MCI response.
- Managing prolonged disruption to services during an extended incident.
- Meeting increased demand for community-based care.
- Supporting safe and effective accelerated hospital discharges.
- Ensuring continuity of tertiary and regional services, where applicable.
- Responding to infrastructure or service disruption.
- Addressing shortages in essential supplies.
- Coordinating a Chemical, Biological, Radiological, Nuclear or Explosive (CBRNe) response (where required).
- Ensuring the security and welfare of staff and facilities.
- Managing the wider consequences of the incident.
- Activating and maintaining business continuity plans.
- Upholding public confidence in the Health Board's response.
- Leading or contributing to recovery efforts post-incident.

Primary and Community Care Responsibilities

Health Boards should also ensure that primary and community care services are integrated into the response, with responsibilities including:

- Facilitating accelerated patient discharges from acute settings.
- Liaising with Social Services, Local Authorities, and other agencies to meet the needs of affected individuals.
- Coordinating social and psychological support services.
- Providing access to healthcare for individuals at Survivor Reception Centres and Rest Centres.
- Managing self-presenting patients exposed to chemical or biological hazards, ensuring awareness of appropriate treatment pathways.
- Managing increased presentations of individuals seeking reassurance or medical advice.
- Supporting ongoing mass vaccination or treatment programmes, if required.

4.5. Required Supportive Mechanisms for a Declared Mass Casualty Incident

Each patient will present specific clinical and managerial challenges in the areas of triage/treatment, capacity, coordination, and communication across a wide area. There are five typical groups of patients who are likely to make demands upon the NHS and local NHS contingency:

- Treatment of those seriously ill or injured as a direct result of the incident that requires immediate treatment and care. Dependent on the nature of the incident, but some patients may require the provision of critical care facilities and a high number of hours of primary and secondary surgery.
- Those affected by the incident who although not obviously or immediately suffering any serious illness or injury, need assessment and diagnosis, advice, or treatment and who may need subsequent monitoring and ongoing support that can often be better provided in a non-acute or primary care setting.
- People who are neither ill nor injured but require information, advice, and reassurance; they are often referred to as the 'worried well'.
- Continued services for those who fall acutely ill (e.g., heart attack) or sustain severe injuries but are not part of the major incident.
- Patients in the community affected by the loss of service due to the impact of the incident and its response (i.e., dialysis patients, home oxygen patients).

However, it must be remembered that all patient types including patients who are being admitted from the wider population, will need to be treated against a backdrop of available healthcare capacity. Therefore, the Health Board will need to;

- Maintain services for routine emergency admissions.
- Maintain on-going service continuity in a protracted incident, e.g.
    - The provision of emergency work during the incident and post incident
    - Critical care decant
    - Mental Health provision for Psychological treatment
    - Surgical elective work
    - The provision of ongoing surgical interventions and MDT meetings
    - The provision of ongoing diagnostic support during and post incident
    - Theatres
    - Provision of Blood Products
    - Procurement and potential shortage of essential supplies
    - General infrastructure instability and potential loss of services
    - Demand for increased capacity in community settings
    - Caring for accelerated discharges within the community
    - Impact on tertiary or regional services
    - Security arrangements
    - Provision for secondary transfers
    - Staffing
    - Medical equipment
- Provide consequence management
- Provide a CBRN type incident response
- Primary and Community Care response, e.g. ensuring health needs of people in survivor reception centres and rest centres and for those displaced, process for CBRN related incident self-presenters at GP surgeries, dealing with a large influx of individuals who need healthcare advice or reassurance, provision of

support to secondary care, support to ongoing mass vaccination and treatment programmes, working with Social Services, identifying and giving support to vulnerable people and their families within the community being evacuated
- Consider reputational damage
- Early consideration of recovery
- Hospital evacuation procedures if required
- Psychological trauma provision including psychological first aid, on-going psychological welfare and support, reflection events and follow up arrangements.
- Managing mass fatalities

4.6. Mass Paediatric Casualties

Any major incident may involve a substantial number of paediatric patients, which will present additional challenges to the response. These incidents are likely to trigger mass casualty arrangements at an early stage.

Key considerations for a mass casualty paediatric incidents include:

- Early mutual aid from English hospital sites.
- Non-paediatric hospital sites should be prepared to manage children and hold them on-site for an extended period, including older children and adolescents requiring intensive care and surgical management.
- Hospital sites must be flexible to keep families together as much as possible, which may involve accommodating adult patients on paediatric wards and vice versa. All health board major incident plans must incorporate this scenario.

Uninjured and Unaccompanied Children

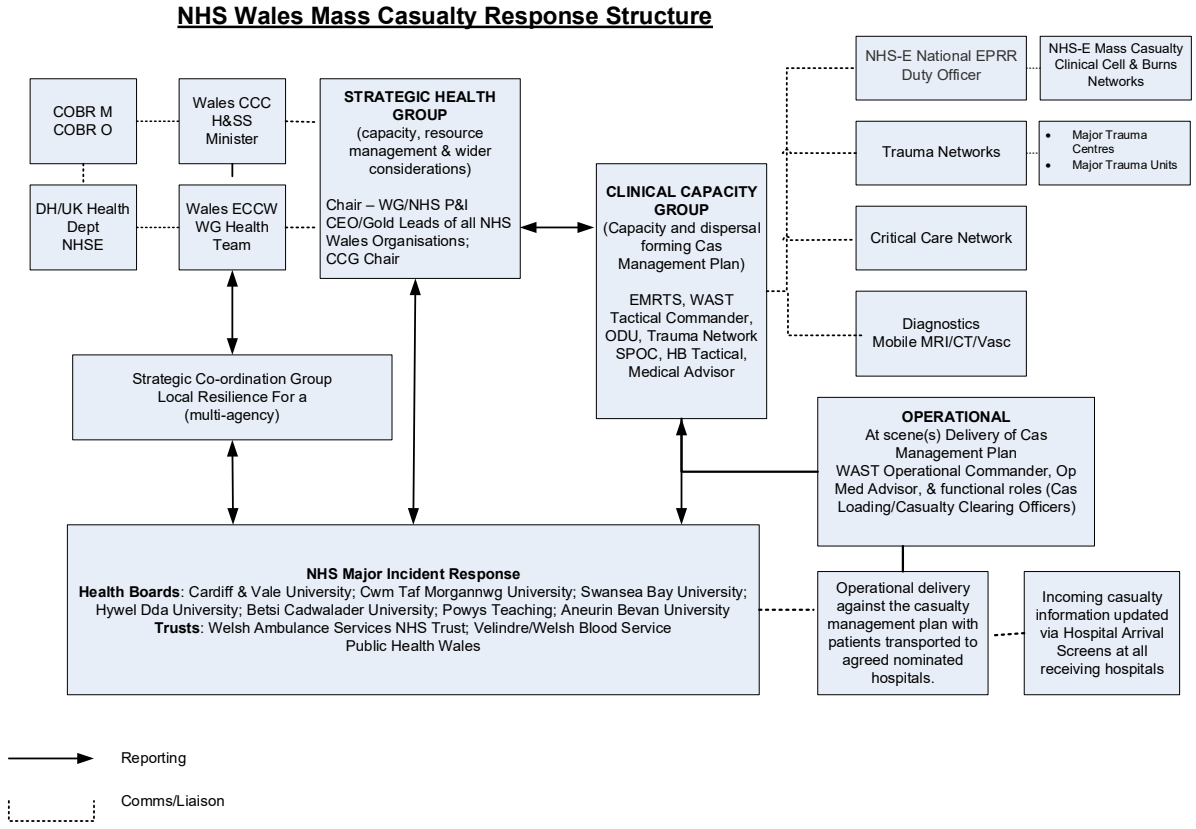
- These children will be accommodated in the Hospital relatives care centre until Police Liaison Officers are able to reunite families if no other venue had previously been found.
- Child Safeguarding issues must be considered.
- The Health Board will identify chaperones until the next of kin are identified by the Police.
- Staff will proactively assist Police Officers in the identification of next of kin using available databases within Health.

4.7. Additional Action Cards reference:

Mass Casualty Incident Arrangements for NHS Wales

- Strategic Health Group – Health Board Gold Commander
- National Clinical Teleconference – Health Board Medical Director/Deputy

4.8. NHS Wales Mass Casualty Response Structure



4.9. WAST Mass Casualty Interim Reporting Dashboard

MASS CASUALTY INTERIM REPORTING DASHBOARD	
SUMMARY	
In the event of a Mass Casualty incident being declared, the Mass Casualty Interim Reporting dashboard will be utilised by WAST and can be accessed by ED & Silver Command prior to the Clinical Capacity Group and Strategic Health Group being established. The purpose of the Mass Casualty Interim Reporting dashboard is to enable WAST to provide casualty information and estimated arrival times to receiving hospitals. Casualty numbers will be in line with the Mass Casualty First 2-hour Capacity arrangements.	
• Identify a PC to monitor the Casualty Dispersal Dashboard and Hospital Arrival Screen (HAS)	
ACTION: ED NIC / DIC & Silver Command should:	***Tick when completed***
1. Access the Mass Casualty Interim Reporting dashboard via – Casualty Dispersal Form v2.xlsx • Click on dashboard tab • The dashboard will show the number and priorities of casualties that have left or due to leave scene and the receiving hospital • Click on Form 1 tab • This shows the WAST vehicle call sign, triage category, receiving hospital and any specialist requirements (major trauma, burns, Paediatrics' etc.) • Cross check the respective WAST vehicle call sign(s) of casualties being transported to Morriston against the HAS. This will show the estimated arrival time of casualties	❑
2. The Mass Casualty Interim Reporting dashboard will remain in use until the Clinical Capacity Group and Strategic Health Group are established	❑

Mass Casualty Incident Arrangements for NHS Wales: Separate Document:

MASS CASUALTY ARRANGEMENTS VE

Mass Casualty Dispersal Plan - 04.1

Section 5. Psychological Care Documents

5.1. Coping after a traumatic event (for adults)

coping after a traumatic event in a

5.2. Coping with trauma in Children

coping after a traumatic event in a

5.3. TRiM Information Leaflet

To be provided to staff involved in incident if no TRiM practitioner is available

SBUHB_TRiM Leaflet.pdf

Section 6. Silver Agenda

No.		Title of Item	Item	Lead
1		**Procedural Matters / Review What has Happened.**		
	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Procedural / Urgent Matters • Review any outstanding actions	Verbal	Chair
2		**Gather Information and Intelligence – BRIEF**		
	2.1	Updates from Gold / Overarching / SG area Silver Command	Verbal	Chair
	2.2	Updates from Bronze/service group areas	Verbal	Chair
3		**Assess Threats, Risks & Develop a Working Strategy**		
	3.1	Identify threats & risks to service group areas core functions and service delivery	Verbal	Chair
4		**Consider Powers, Policies and Procedures**		
	4.1	Provide any updates with latest guidance, plans, policies & procedures	Verbal	Chair
5		**Identify Options & Contingencies**		
	5.1	Identify options available to mitigate any impact on service group areas core functions and service delivery	Verbal	Chair
6		**Take Action**		

No.		Title of Item	Item	Lead
	6.1	Update/brief Gold / Overarching / SG area Silver on actions/decisions	Verbal / E-mail	Chair
	6.2	Update/brief Bronze/service group areas on any required actions/decisions	Verbal / E-mail	Chair
	6.3	Record the actions taken at the meeting, including responsible person and time restrains if required.	Verbal	Chair
7		**Any Other Business (AOB)**		
			Verbal	Chair
8		**Date, Time, Venue Next Meeting**		
			Verbal	Chair

Major Incident Lead Silver Command TEAMS Meeting QR Code