Connolly Hospital Blanchardstown Major Incident Plan (MIP)

Guidelines and procedures for the

Management of a Major Incident at

Connolly Hospital Blanchardstown

Working document:

Consult X-Drive _CHBMAJORINCIDENTPLAN for most up to date version

How to read this plan…..

If you are a member of the Major Incident Control Team (MICT). Major Incident Plan (MIP) Implementation Team or the Major Incident Plan Committee, then take the time to read the entire document, make notes and ask questions.

If you are an Area or Service Lead or being designated with responsibility for MIP implementation by an Area or Service Lead, then familiarise yourself with Chapters 1, 2, 3 and section relating to your service in Chapter 4 and Chapters 5 and 6. Use the Preparation checklist (Appendix 1) and customise the "MIP box" for your area or service to meet your preparation and response needs.

Additional information that is included in the MIP box can also be stored electronically in a designated folder for that Area or Service on the Connolly Hospital X-Drive _CHBMAJORINCIDENTPLAN

All staff should read the General Principles in Chapter 2 and section relating to their service in Chapter 4. Discuss what you have read with colleagues and ask questions. Questions are great. Mentally rehearse what you would do if the plan was activated.

The individual sections for each service in Chapter 4 serve as the Action Card to be followed if a MI is declared. Some areas and services may devise their own action cards if appropriate. These can be stored on the MIP folder on the X-Drive. Print these out and have them readily available in your area in the MIP box.

Version Control:

MIP 2022: Version 1, 13.4.2022

Contents

Chapter 1

Introduction

1.1 Overview

Major incidents (MI's) are generally considered to be rare events, traditionally thought of as events that result in a large number of injured patients requiring care over a short period of time. Recent events, such as extreme weather, pandemics and cyber crime, challenge this view both in terms of the frequency of these occurrences and very nature of them. Our Major Incident plan follows an "all-hazards" approach, that is, it is written to adapt to any event whereby "an extraordinary response" is required to deal with the event.

Recent experiences have influenced this edition of the Major Incident Plan 2022, in terms of content, layout and processes. Now, all members of staff in each department should:

- Take the time to read this plan

- Implement the relevant preparations for your Area/Service

- Engage with other departments to create efficient systems and use of resources

- Teach and train so that all staff are competent with all phases of the plan

- Test different aspects of the plan within your Area/Service

- Provide feedback to Connolly Hospital's Major Incident Plan Implementation Team

- Complete the "Preparation Checklist" and return to MIP Committee every 6 months (Appendix 1)

Major Incident Do's and Don'ts

Do….

- Stay calm

- Find your action card if you are a key staff member in the initial response. Otherwise, await instruction.

- Read this MIP. Ask questions. Practice what you would do

- Ensure your contact details are up to date and know where to report to if called in from home

- Follow instruction and ask for clarity if unsure

- Communicate clearly and briefly

- Be kind with yourself and colleagues. Ask for support in the aftermath. Tell some if you feel overwhelmed.

- Have a photo of your hospital ID stored on your phone

Don't ….

- Panic

- Read this big document once a MIP has been declared

- Share any information relating to the incident with family, friends, the media or on social media

- Forget to take your breaks

- Forget to ask for help

1.2 Major Incident Flow Chart

Triggers for Major Incident

MI Control Team informed

MI declared and MIP activated

MI response

MICT activates:
Automated phone call to staff
Internal Communication Cascade

Area/Service leads appointed
Follow Area/Service action plan

Strategic and operational hubs created

Area and Service leads hubs created

Vertical communication commences

Incoming staff:
Report to designated area
and
Await allocation by Staff Allocation Lead

Follow Area or Service Lead instructions for each phase of MI:
Activation
Reception
Definitive care
Stand-down
Recovery

Business continuity response

Essential services
Identified
Supported to continue

Non-essential services
Identified
Deferred or re-scheduled

Resumption of normal services
Identified
Prioritised
Resources identified
Strategy outlining graduated return
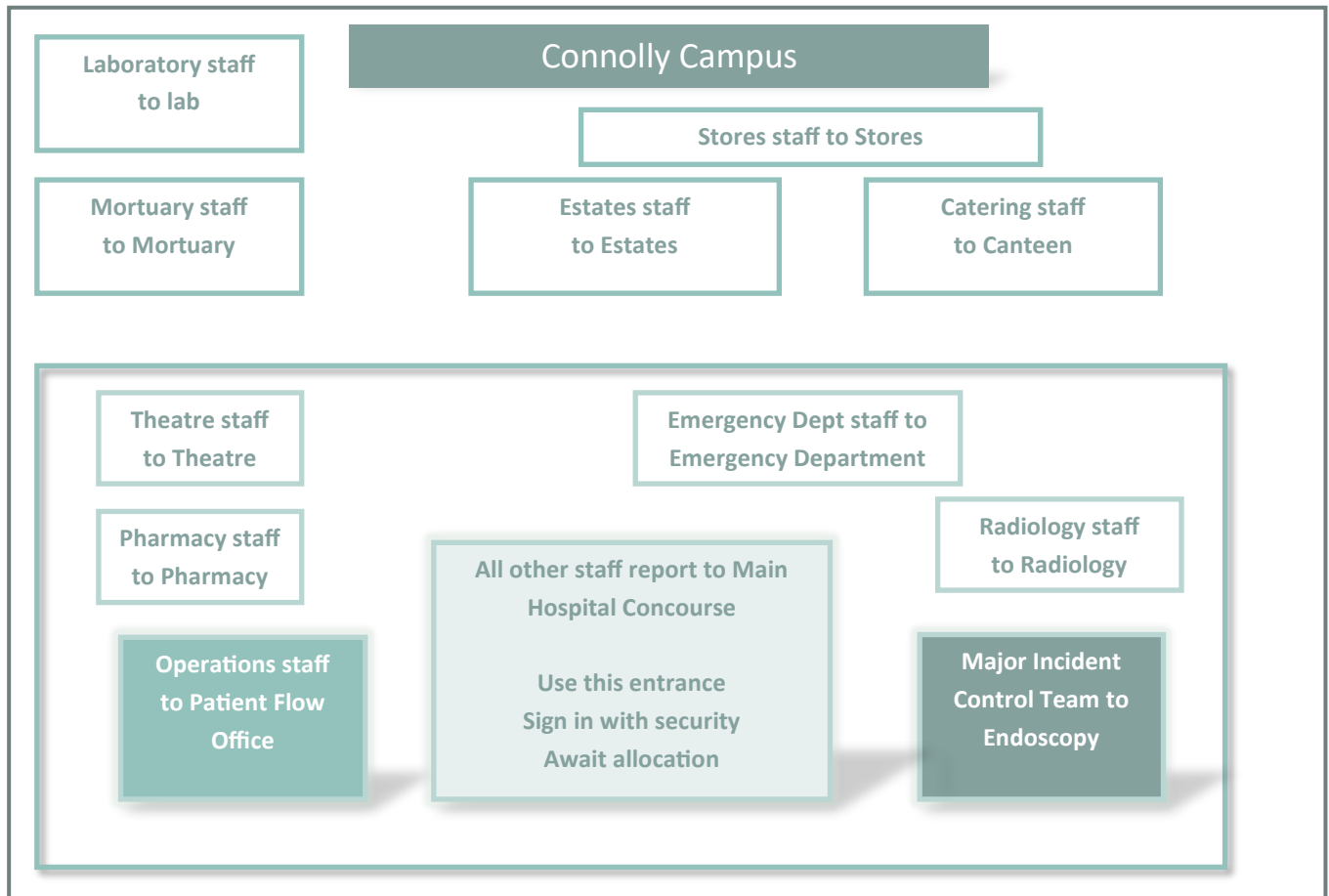
After activation review

1.3 Key staff roles *Switch has a version of this call in list with names and phone numbers*

Key Staff for initial MIP response	First contact	Second contact
MICT	General Manager	Hospital Executive on Call
	Clinical Director	Associate Clinical Director
	Emergency Medicine Consultant	2nd EM Consultant
	Site Manager	DON or off-site Site Manager
Operations	Chief Operations Officer	Operations Manager
	Unscheduled Care Lead	Deputy Unscheduled Care
	Scheduled Care Lead	
EM Directorate	EM Consultant on Call	2nd EM Consultant
	ADON for EM	CNM III for EM
	Clerical Manager	2nd Clerical Manager
Medical Directorate	Medical Consultant on Call	Associate CD for Medicine
	ADON for Medicine	
	ADON for Medicine II	
Peri-operative Directorate	General Surgeon on Call	Associate CD for Peri-operative
	Anaesthesia Consultant on Call	2nd Anaesthesia Consultant
	ADON for peri-operative	CNM III ICU or Theatre
Diagnostics Directorate	Radiology Consultant on call	Associate CD for Peri-operative
	Radiography Service Manager	
	Laboratory Manager	Chief Medical Scientist
	Consultant Microbiologist on Call	ADON Infection Prevention & Control
Pharmacy	Chief Pharmacist	Senior Pharmacist
Clinical Services	Director of Clinical Services	
Information Management	Business Manager VII	Business Manager VII
	ICT Lead	
	Business Continuity Manager	
Quality & Patient Safety	Head of Quality & Safety	FOI/GDPR Lead
Hospital Administration	Finance Manager	
	Human Resource Manager	
General Services	General Services Manager	
	Household Services Manager	Derrycourt
	Security Manager	Noonan Security
	Catering Manager	
	Stores Manager	
	Switch Manager	
	Transport Manager	
Clinical Engineering	Head Medical Physics & Clinical Engineer	
Estates	Estates Manager	
	Environmental Services Manager	
	Risk Manager	

1.4 Locations for incoming staff responding to activation of the MIP

Connolly Campus

Laboratory staff to lab

Stores staff to Stores

Mortuary staff to Mortuary

Estates staff to Estates

Catering staff to Canteen

Theatre staff to Theatre

Emergency Dept staff to Emergency Department

Pharmacy staff to Pharmacy

Radiology staff to Radiology

All other staff report to Main Hospital Concourse

Use this entrance
Sign in with security
Await allocation

Operations staff to Patient Flow Office

Major Incident Control Team to Endoscopy

Area/Service	Reporting area
MICT	Hospital Concourse and proceed to Endoscopy Boardroom
Operations	Hospital Concourse and proceed to Patient Flow Office
EM Directorate	Emergency Department Waiting room
Medical Directorate	Hospital Concourse and await allocation
Peri-operative Directorate	Hospital Concourse. Theatre staff to theatre. Other staff await allocation
Diagnostics Directorate	Radiology staff proceed to Radiology. Lab staff to Lab. Mortuary staff to Mortuary. IPC to Hospital Concourse
Pharmacy	Hospital Concourse and proceed to Pharmacy
Clinical Services	Hospital Concourse and await allocation
Information Management	Hospital Concourse and await allocation
Quality & Patient Safety	Hospital Concourse and await allocation
Hospital Administration	Hospital Concourse and await allocation
General Services	Catering staff to Canteen. Stores staff to Stores. All others, Hospital Concourse and await allocation
Clinical Engineering	Hospital Concourse and proceed to department
Estates	Estates
All other staff	Hospital Concourse and await allocation

Chapter 2

Principles of Major Incident Management

2. Principles of Major Incident Management

2.1 Definition

A Major Incident is any event, usually with little warning, which overwhelms our ability to respond and *an extraordinary response* is needed. Our ability to respond may be overwhelmed by a large influx of patients over a short period, a small influx of patients with complex needs or when already in escalation.

It may be compensated when normal infrastructure remains intact (e.g. electricity, water, ICT systems, building structure) or uncompensated, where there is a loss of normal infrastructure.

2.2 Command & control

The General Manager *or designate* of Connolly Hospital has responsibility:

•	For implementation of this Major Incident Plan

•	For maintenance of the plan to ensure quality, accuracy, consistency and accessibility

The plan should be reviewed:

•	Following activation of the plan

•	Following hospital structural/organisational/service delivery changes

•	Following exercise and/or testing of the Major Incident Plan

•	In light of risk assessments and review of incidents both internal and external

•	Otherwise on an annual basis

Major Incident Control Team (MICT)

There are 4 key members and as not all members are on-site 24/7, a "designate" can assume this role initially.

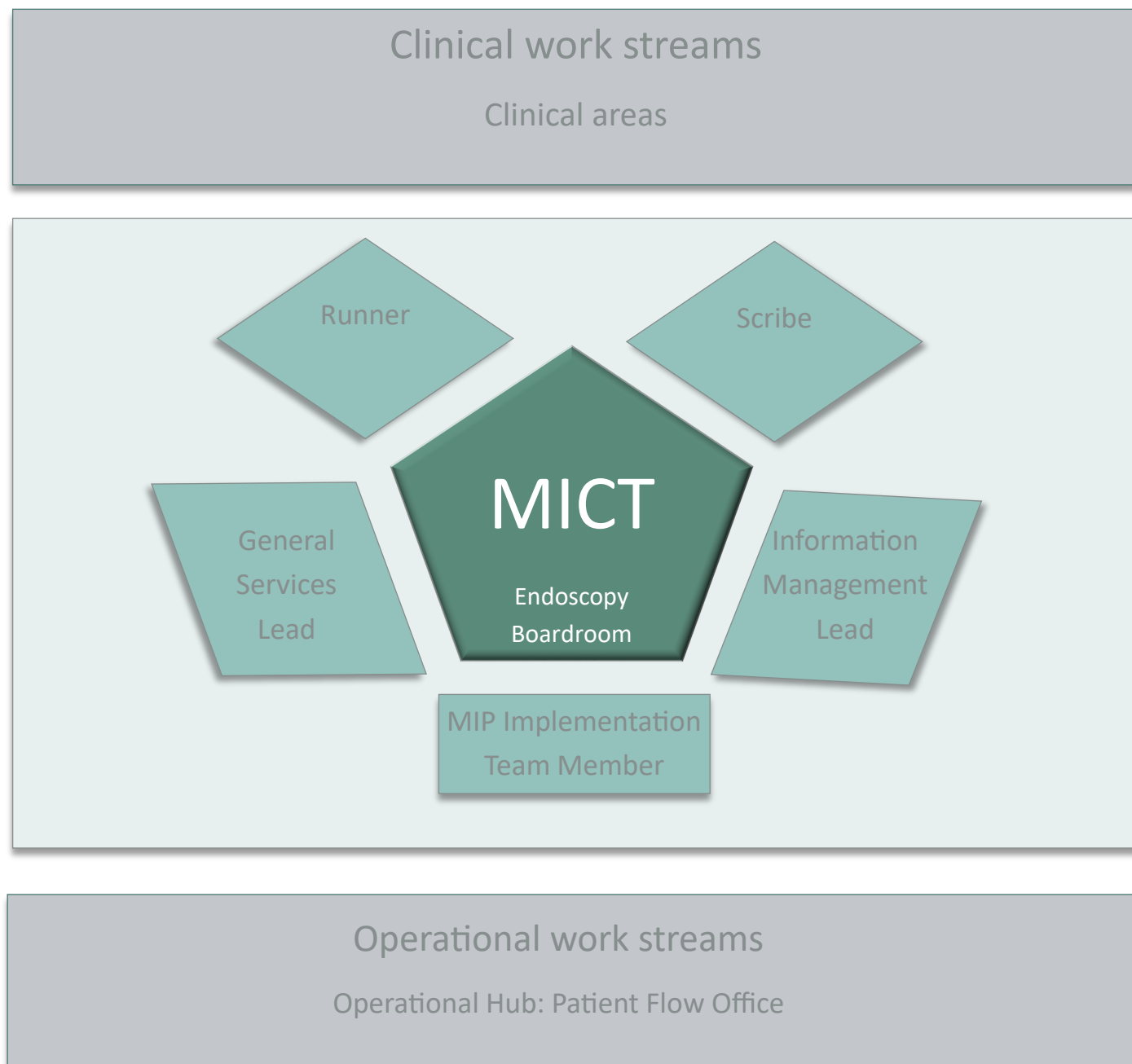| General Manager *or designate*	Clinical Director *or designate*	Site Manager *or designate*	Emergency Medicine Consultant
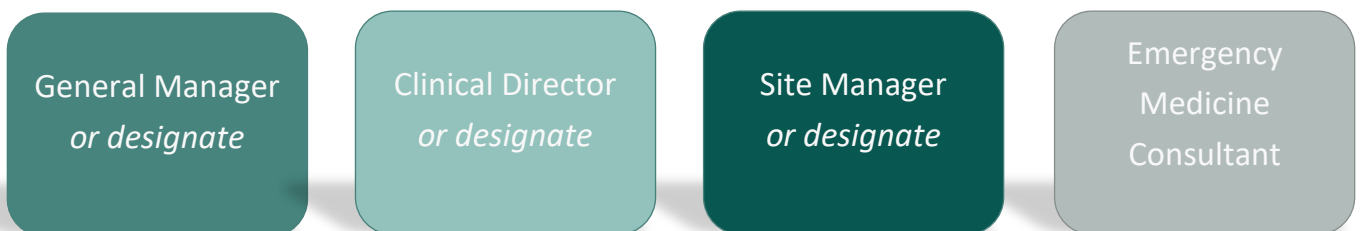
The role of the MICT is to have overall responsibility for ensuring:

•	Appropriate activation of the MIP

•	Optimum allocation of staff and resources in an extraordinary situation

•	Continuous overview of activity and demand within the hospital

•	Safe, effective, efficient and dignified care of current patients and incoming MIP patients

•	Effective communication: within the hospital, with HSE and other State Agencies and the public

•	Mitigate risk, provide a safe environment and promote staff, patient and public welfare

•	Documentation and recording of events and decisions made during the initiation of the MIP

•	Conducting an after action review

The Strategic Hub: Major Incident Control Team meeting room

The MICT meet in the Endoscopy Boardroom on Level 4 of the main Hospital.
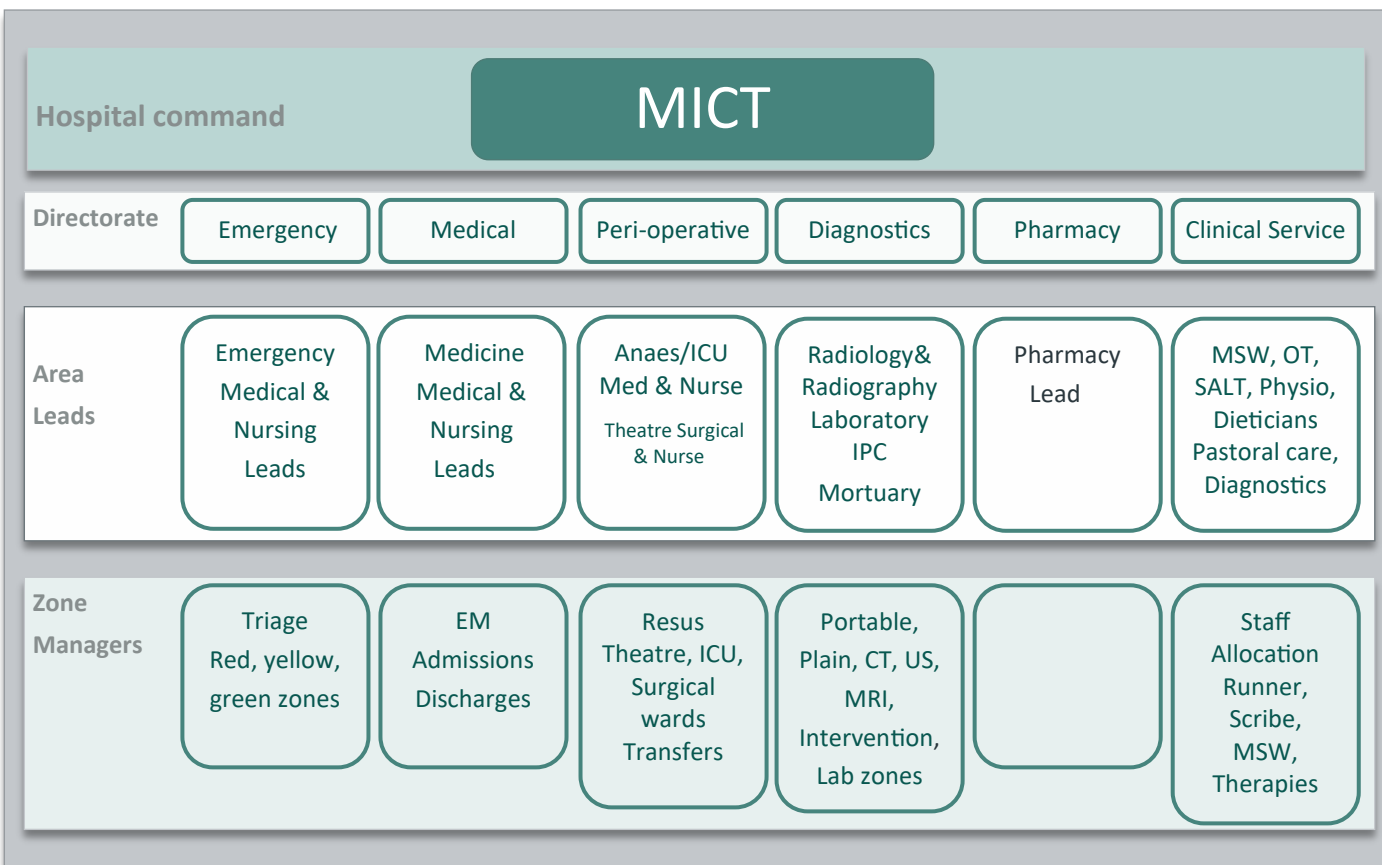
The four decision-makers are supported by a scribe, runner, MIP implementation team member, the Information Management and General Services Leads.

Clinical work streams

Clinical areas

Runner

Scribe

MICT

Endoscopy Boardroom

General Services Lead

Information Management Lead

MIP Implementation Team Member

Operational work streams
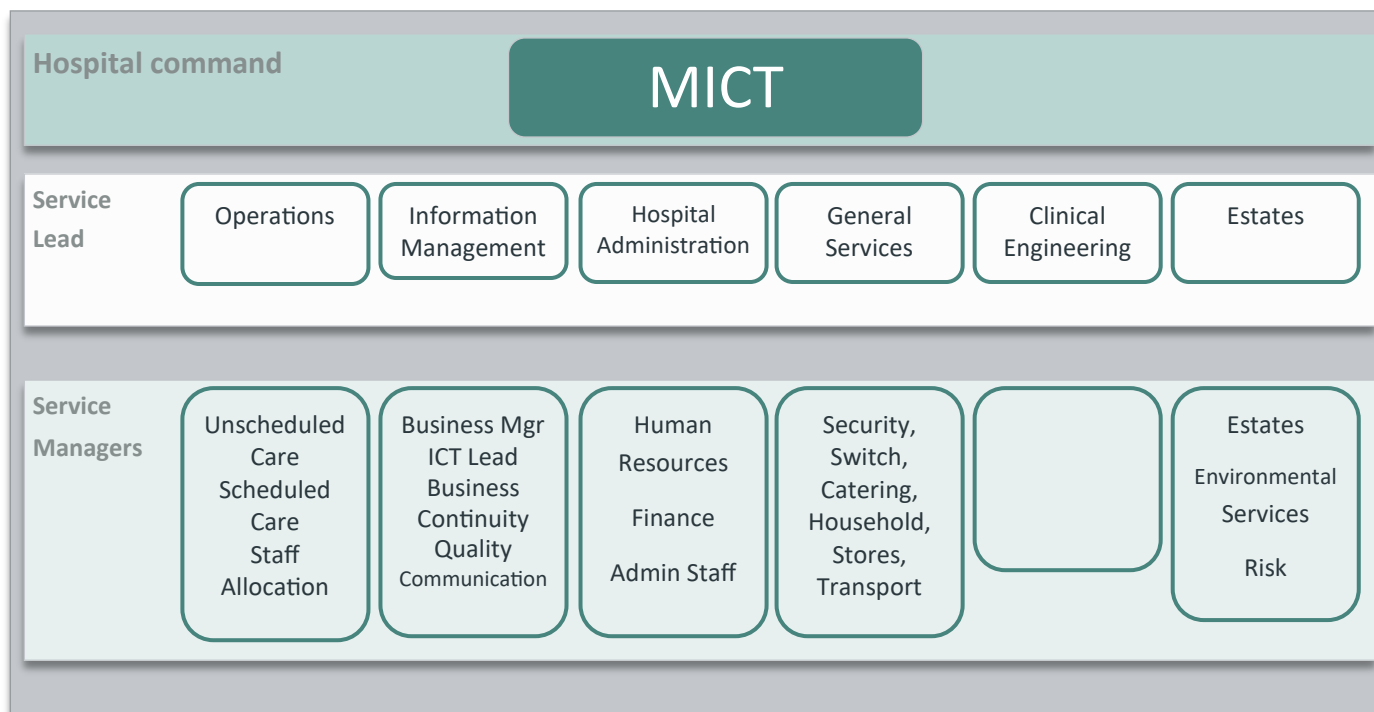
Operational Hub: Patient Flow Office

Clinical work streams are led by the medical and nursing leads from the emergency medicine, medicine and peri-operative directorates and the leads from the diagnostics directorate, Pharmacy and Clinical Services. They relate to direct patient care and are usually based in a physical area. Staff leading these areas are "Area Leads"

Operational work streams are led by operations, general services, information management (including the business managers, ICT and Quality), Administration (Human Resources and Finance) Estates and Clinical Engineering. They are less geographically based and tend to follow the patient or staff. Staff leading these services are "Service Leads".

Clinically, the MICT are supported by:

Hospital command	MICT					
Directorate	Emergency	Medical	Peri-operative	Diagnostics	Pharmacy	Clinical Service
Area Leads	Emergency Medical & Nursing Leads	Medicine Medical & Nursing Leads	Anaes/ICU Med & Nurse Theatre Surgical & Nurse	Radiology& Radiography Laboratory IPC Mortuary	Pharmacy Lead	MSW, OT, SALT, Physio, Dieticians Pastoral care, Diagnostics
Zone Managers	Triage Red, yellow, green zones	EM Admissions Discharges	Resus Theatre, ICU, Surgical wards Transfers	Portable, Plain, CT, US, MRI, Intervention, Lab zones		Staff Allocation Runner, Scribe, MSW, Therapies

Operationally, the MICT are supported by:

| Hospital command	MICT					
Service Lead	Operations	Information Management	Hospital Administration	General Services	Clinical Engineering	Estates
Service Managers	Unscheduled Care Scheduled Care Staff Allocation	Business Mgr ICT Lead Business Continuity Quality Communication	Human Resources Finance Admin Staff	Security, Switch, Catering, Household, Stores, Transport		Estates Environmental Services Risk

## 2.3 Governance

Responsibility

Overall responsibility for the MIP response rests with the Hospital Manager.

In Connolly, the General Manager is supported by:
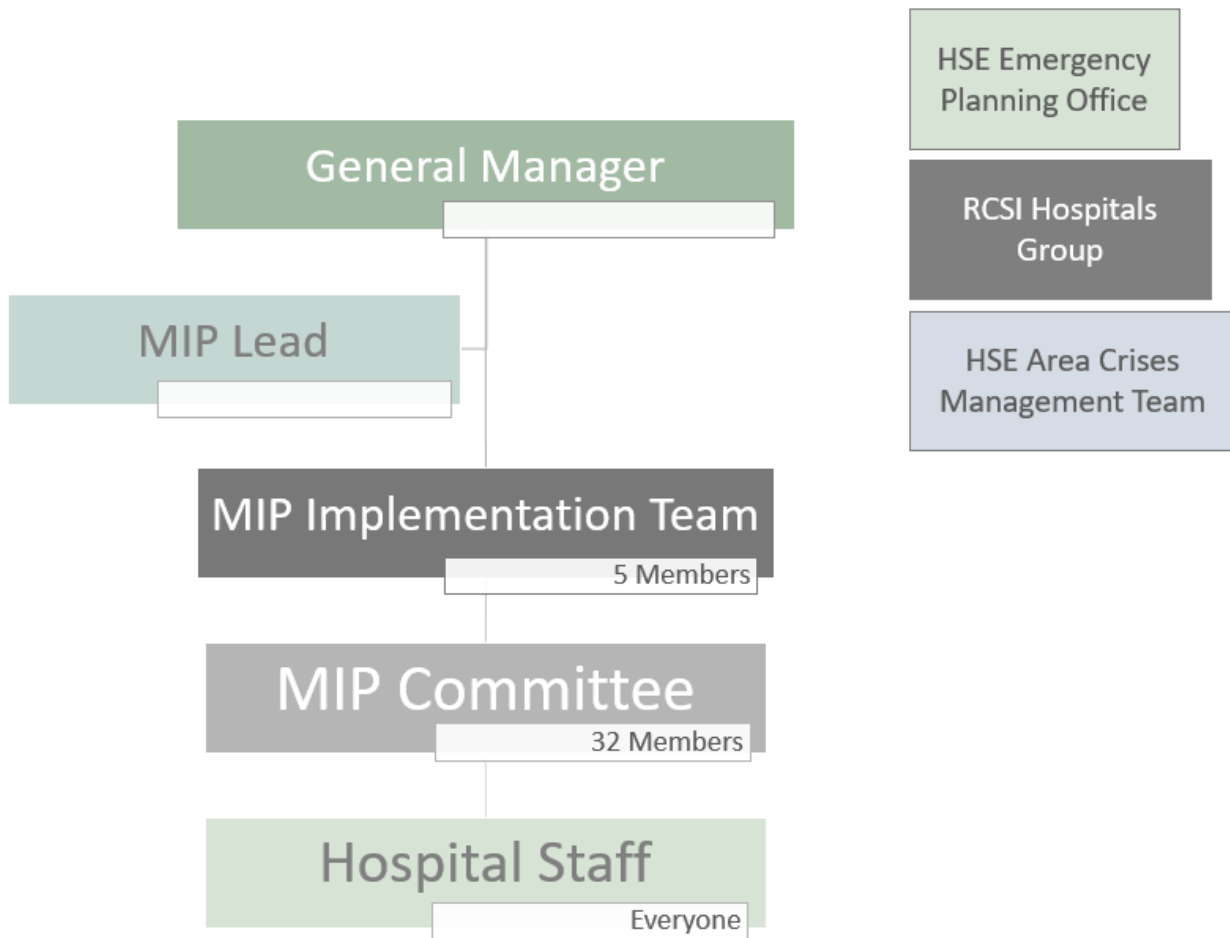
MIP Lead is appointed by the Hospital Manager to coordinate the activities of the MIP Implementation Team and MIP Committee. They report directly to the Hospital Manager and are a Member of the MIP Implementation Team.

The **MIP Implementation Team** includes:
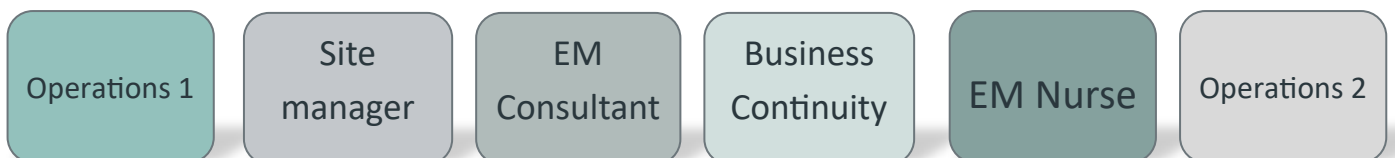
MIP Committee

The MIP Committee is comprised of the Area and Service Leads mentioned throughout this document. The Committee is chaired by a Member of the MIP Implementation Team and the Committee meets quarterly in March, June, September and December.

The Committee will report to the Quality and Patient Safety Committee and CHB General Manager annually.

Area/Service Leads

The responsibilities of area or service "leads" include:

• Membership of the MIP Committee

• Implementing the plan in their department

• Testing the plan regularly

• Ensuring Switch are provided with an up-to-date staff contact list monthly

• Returning the MIP Preparation checklist to the MIP Committee every March and September

The "leads" frequently include a nurse and a doctor working together, acknowledging that while their skill set differs, the shared purpose is the same.

Hospital Staff

All Connolly staff have a responsibility to be familiar with the most up to date version of the MIP, to provide their contact details to switch, to understand the call-in process and where they need to report to if the plan is activated. They need to engage with training and participate in after action reviews.

2.4 Essential roles & allocation of responsibility: Collapsible hierarchy

Organisations function better when staff have a clear understanding of their role and their reporting relationship. Sometimes, particularly in the early response to a Major Incident, not all staff are on site so not all key roles are filled.

In this situation, another person in the same reporting relationship, will fill the high priority roles initially. The role is more important than the person.

This system of ensuring all roles are filled is called a "collapsible hierarchy".

The descriptors for each area and service describe the roles, reporting relationships and responsibilities. The Area/Service lead needs to ensure that Managers or "in-charge" staff are appointed to manage either Zones within an area e.g. Theatre Recovery within the Peri-operative Area or a Service within a wider Service e.g. the General Services Lead appoints a Catering Manager or a Porter "in-charge".
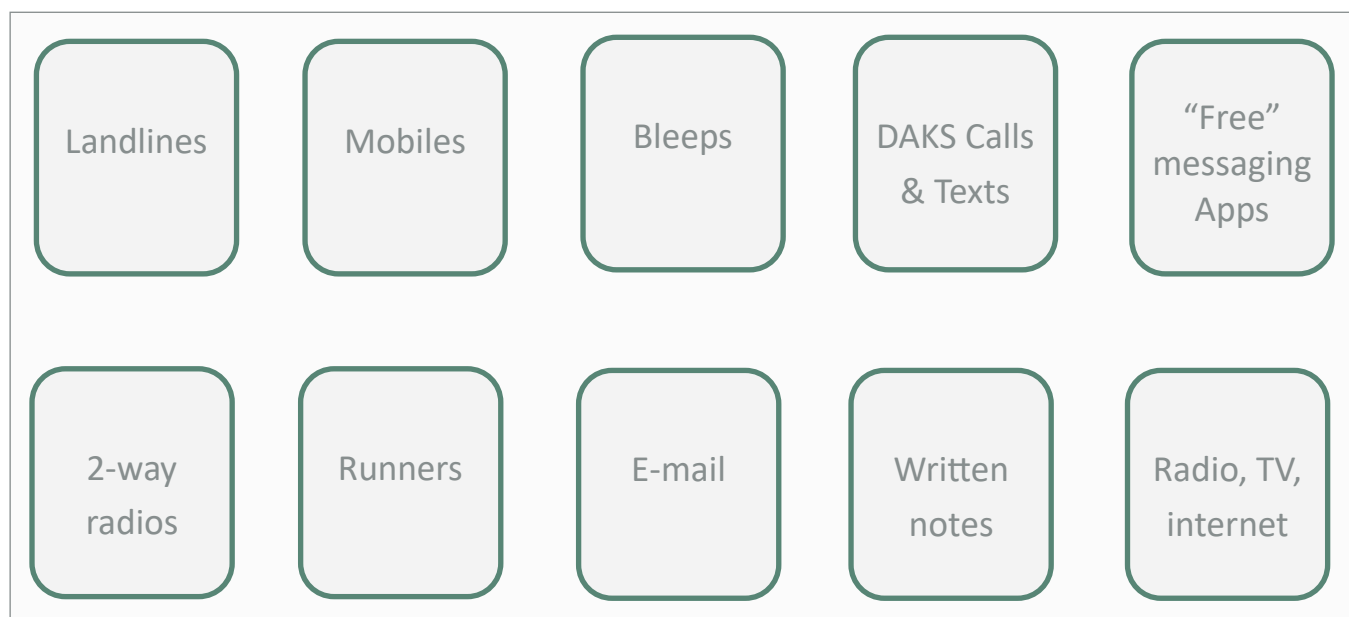
2.5 Communication & language

Good communication is the cornerstone of a Major Incident and there are many types of communication required. Examples include, but are not limited to,:

- The call-in of staff from home

- Communicating with individual staff members

- Updating staff on the situation and general announcements

- Zone/service managers communicating with Area/Service leads

- Area and Service leads communicating with each other

- Area and Service leads communicating with the MICT

- Communication amongst MICT members

- Communication with external agencies e.g. ambulance service, HSE, other hospitals

- Communication with the Media, Gardaí, Coroner etc

> **Communication is the most important aspect in the effective delivery of the MIP.**

2.5.1 Communication methods

Landlines	Mobiles	Bleeps	DAKS Calls & Texts	"Free" messaging Apps
2-way radios	Runners	E-mail	Written notes	Radio, TV, internet

In general, when communicating during a MIP, keep your message clear, factual, brief. Systems like ISBAR work particularly well. Keep phone lines free.

Be extremely cautious with personal communication even with trusted people.

Don't post information on social media

"DAKS" is a high performance communication platform available in Connolly Hospital. Information on DAKS functionality during a MIP is described in Section 3.1.2 Activation of MIP (Page 29).

2.5.2 Communication terms

A list of commonly used abbreviations is provided in the glossary at the end of this document.

Two important terms used in this document , not commonly used in other Hospital's MIP's are roles called **"the lead"** and **"the zone/service manager or person in charge"** so ensure you are familiar with these.
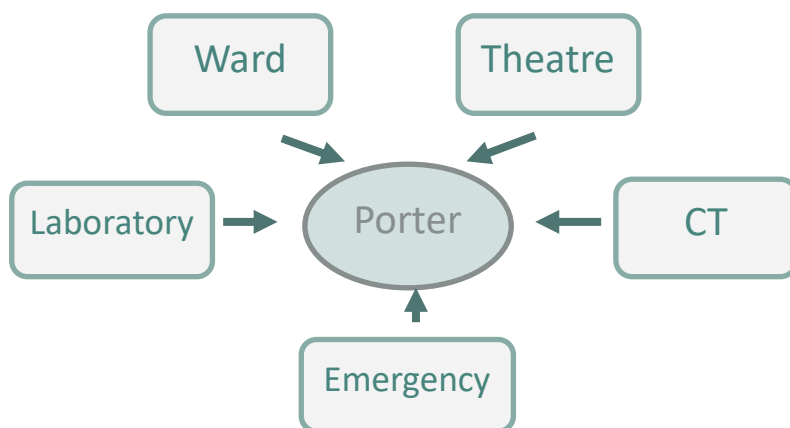
2.5.3 Vertical communication

Communication during the normal operation of a hospital is usually "**horizontal**", that is, if Department A needs something from Department B, the staff will usually make direct contact with that department.

However, in a MI, **vertical communication** is used. This is where a staff member would communicate a need to the area coordinator and the area coordinator would communicate it to the area lead. If there is a resource limitation, this would be communicated to the MICT .

For example

There are a limited number of porters: EM needs to take a sick patient to CT immediately. Theatre needs to bring a patient to the ward to allow the next case start and the lab need to get blood to ICU.

In **horizontal** communication, everyone would bleep the porter.

In **vertical communication,** the Area Leads inform the MICT of the demand on Porters and the MICT would engage with the General Services Lead in finding a solution.
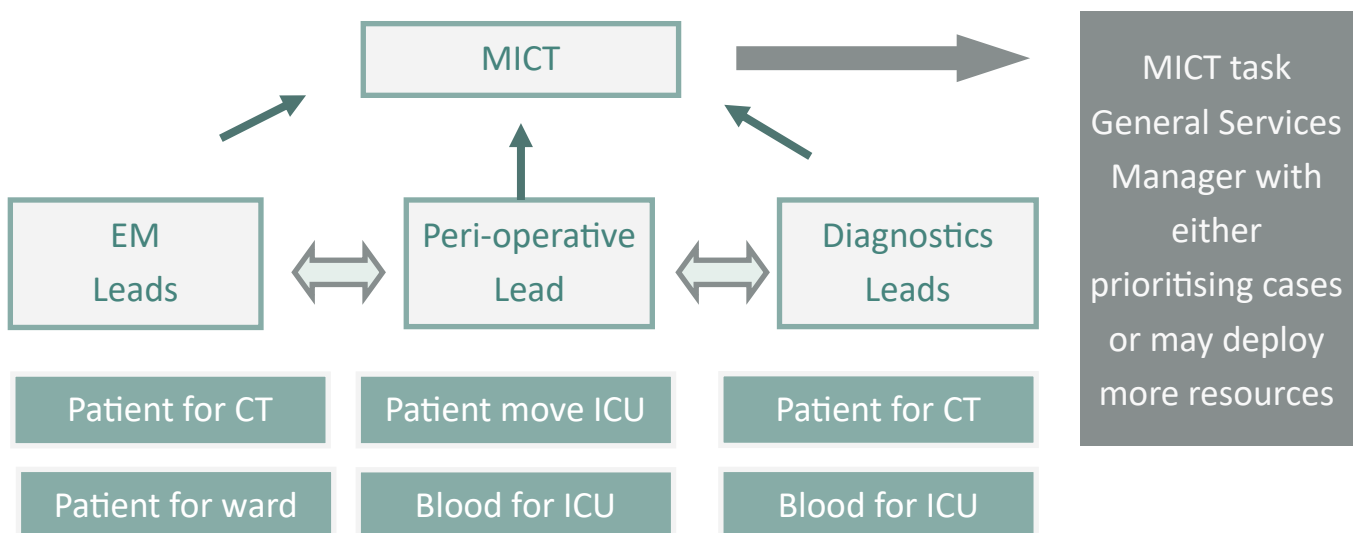
Vertical communication protects staff from feeling conflicted, over-stretched and stressed and ensures high priority tasks are completed before more less urgent ones.

It is the role of the Area Leads to manage communication between; their areas, the MICT and the other Area Leads, to allow prioritisation, effective allocation of resources and promote efficiency.

2.5.4 Internal communication cascade

In the event of an internal hospital incident, activation of the Major Incident Plan or any need to disseminate any information across the hospital, then the internal communication cascade can be used. It is based on the principles of ISBAR (Identify, Situation, Background, Assessment and Recommendation).

What is it?

It is a person-based communication system

Relies on the dissemination of a written message

Message goes to agreed areas

Messenger follows an agreed pathway

It can operate 24/7

Reduces the risks associated with human behaviour e.g. not answering phones

What's involved?

The Site Manager has the authority to activate the internal communication cascade.

The "Internal Communication Cascade information Sheet is completed".

> **CHB Internal Communication Information Sheet**
>
> Date _____   Time _____
>
> Incident _____
>
> _____
>
> Action required _____
>
> _____
>
> Site Manager name _____
>
> Site Manager contact details _____

The Information Sheet is photocopied—one copy for each area requiring the information

A runner, selected by the Site Manager, brings the written information to each area and records that the information was given

Areas within CHB

Service	Area	Tick if need to be informed	Tick when informed	Telephone number	Location
Wards	Beech				
	Rowan				
	Transitional Care Unit				
	Cypress				
	CCU				
	Cherry				
	Elm				
	Maple				
	Laurel				
	Redwood				
	Surgical Day Ward				
	ICU				
	Willow				
Clinical areas	Emergency Department				
	Theatre				
	Outpatients				
	Physio & HSCP				
	Radiology				
	Cardiac diagnostics				
	Vascular diagnostics				
	Respiratory diagnostics				
Services	Security				
	Switch				
	Catering				
	Household				
	Pharmacy				
	Medical Social Work				
	Clinical Engineering				
	Estates				
	Administration				
Other wards	Sycamore				
	Woodlands				
	Cedarwood				
On campus	Ash/Pine				
	Hospice				
	Children's Health Ireland				
	RCSI campus				

2.6 General principles—applicable to all departments

2.6.1 Scene safety

A major incident can be triggered by many internal and external events and staff need to have a greater awareness of their own safety, even working in areas that they are very familiar with.

Remember the 4 F's: Fire, flood, fumes and further collapse. Also consider safety in potential terror events or dealing with very disturbed patients. You are responsibility for your own safety and need to ensure that you are familiar with best practice and have engaged with mandatory training.

2.6.2 Infection prevention and control

Everyone is responsible for minimising potential transmissible illnesses. This involves:

- Maintenance of usual standard precautions

- Consideration of the need for additional transmission-based precautions in the event of:

    - High community levels of any infection

    - New or novel infections

    - Outbreaks of easily transmissible infections

    - Possible resistant infections

- Exercise caution when moving and mixing patients between clinical areas

- Communicate the need for additional PPE early

- Follow any relevant Public Health or Health Protection Surveillance Centre guidelines

- Be familiar with screening processes for transmissible infections

- Follow open disclosure best practice principles in the event of transmission

- Determine the need for contact tracing

- Request specialist advice early especially if there is any uncertainty

2.6.3 Blood transfusion

The usual rigorous standards of blood transfusion processes continue to apply in a MI. The PDA blood tracker can be used and is the preferred system during a MI. See Appendix 2 for further details.

If blood is required urgently, please be aware that O *negative* blood has limited availability and O *positive* blood may be provided to men and women >55 years. Due diligence is required here.

Be aware that platelets are not stored on site in CHB and there is a limited capacity to thaw plasma at any one time. Good communication between clinicians and the Laboratory is required to optimise use of resources.

Be familiar with the CHB Management of Major Bleeding Guideline and the Management of Bleeding—Direct Oral Anticoagulants (Appendix 3 & 4).

Any change in the patient identity band (updates to name, DOB, MRN) require a new cross-match sample be sent. **Therefore, do not change the patient wristband whilst large volumes of blood products are required without consultation with the Blood Transfusion laboratory.**

2.6.4 Legal and forensics

Patient clothing and property may become part of any future investigations. Each item should be labelled with a patient sticker and stored in dedicated "MIP" property bags which is part of the patient registration pack.

Please keep jewellery on patients unless there is a clinical indication to remove it. If so, store it in the specific bag in the patient registration pack.

Assist Gardaí with their investigations.

Mark injuries on the EM "body part" notes.

All deaths need to be reported to the Coroner. The CHB Hospital Death Report is available in Appendix 5 or on the X Drive X:_CHB INFORMATION\Coroner

Suspicious deaths should be managed according to the Guideline for the Management of Suspicious deaths (Appendix 6)

Scan the form and e-mail it to dublincoroner@justice.ie and mortuary.chb@hse.ie

File the original form and a copy of the e-mails in the patient chart.

2.6.5 Patient Documentation

Documentation is vital in any MI; it informs patient care, is used forensically and is part of the MI debrief. Every staff member has a duty of care to ensure that documentation is as good as it can be.

Correctly label:

- Pre-hospital documentation including the Cruciform card, Patient Care Reports and ECG's

- Emergency Medicine (EM) pre-prepared notes

- Results e.g. ABG's, Urinalysis, ßHCG, Toxicology etc

- Admission notes and progress notes

- Theatre notes

- Transfer documentation

This must be done for all patients, *even if they have no apparent injury or illness*.

Normally, the EM notes are photocopied and a patient chart is created for admitted patients. **A chart will not be created if the MIP is activated.** In this circumstance, the only a photocopy of the EM notes will go with the patient to theatre, ICU or the ward.

For patients being transferred to other institutions, provide a photocopy of the notes and keep the original in CHB.

Charts should be created within 48 hours and the MIP MRN should merge with any existing MRNs.

A Senior Clerical Officer will be allocated to ensure that each patient recorded as being part of the MI has a complete set of notes within 48 hours of the MIP beginning. EM will need to ensure the original EM notes are scanned to MIDAS promptly and filed.

This Information Management Lead will ensure compliance with this process and inform the MICT.

2.6.6 Information Communication Technology (ICT)

ICT is an integral part of our work systems and the structure of our processes in CHB is designed around these systems. Any interruption in the ICT systems not just affects that system but also the way in which we work. Understanding our systems and how to protect them is important.

ICT Systems

The most commonly used ICT systems in Connolly include patient registration and tracking systems (IPMS and Symphony), diagnostics (NIMIS, telepath, EndoRAD), web-based systems (internet, e-mails, virtual meeting platforms), software and the hardware and infrastructure that supports these. See Appendix 7 for details.

Cyber downtime

This refers to a loss of functionality of some or all of the ICT systems. The event can be brief or extended. It can be isolated to a single system or may affect multiple systems e.g. a loss of IPMS impacts Symphony and NIMIS. The loss of functionality may be planned e.g. for system maintenance or upgrades or unexpected.

Each Area or Service needs to consider the ICT systems within their service and determine:

- Will a loss of function affect one system only or others?

- What other ICT systems or processes will be affected?

- What plans are in place to "work around" a loss of service?

- Is there anything you can do now to improve resilience?

Include your response in your Area or Service "MIP box".

2.6.7 Communication, Data protection, Media & Social Media

Data Protection:

At all times, all staff members should be mindful about patients and other staff members right to privacy. All staff should continue to adhere to all national and local Data Protection laws including the GDPR.

In the event that a staff member is required to send any information by email or fax, it is the staff member's responsibility to ensure that the correct email address or fax number is used. Only the minimum amount of confidential or restricted information as is necessary should be included. If faxing, make sure that a copy of the transmission slip is retained and that all documentation is immediately removed from the fax machine after use.

Media & Social Media:

Unless directed by the Major Incident Control Team, staff members are not to address the media.

During a MI, staff are reminded to adhere to the HSE's social media guidelines as well as Data Protection laws.

Staff would be asked not to access their personal social media during the major incident in order for all staff members to remain focused on the task at hand. Staff would also be reminded about their terms and conditions of employment and that they should not discuss or disclose any information of a confidential nature except in the proper course of their employment.

Chapter 3

Phases of a Major Incident

3.1 Phases of a Major Emergency

Preparation

Recovery

Activation

Stand - Down

Reception

Definitive Care
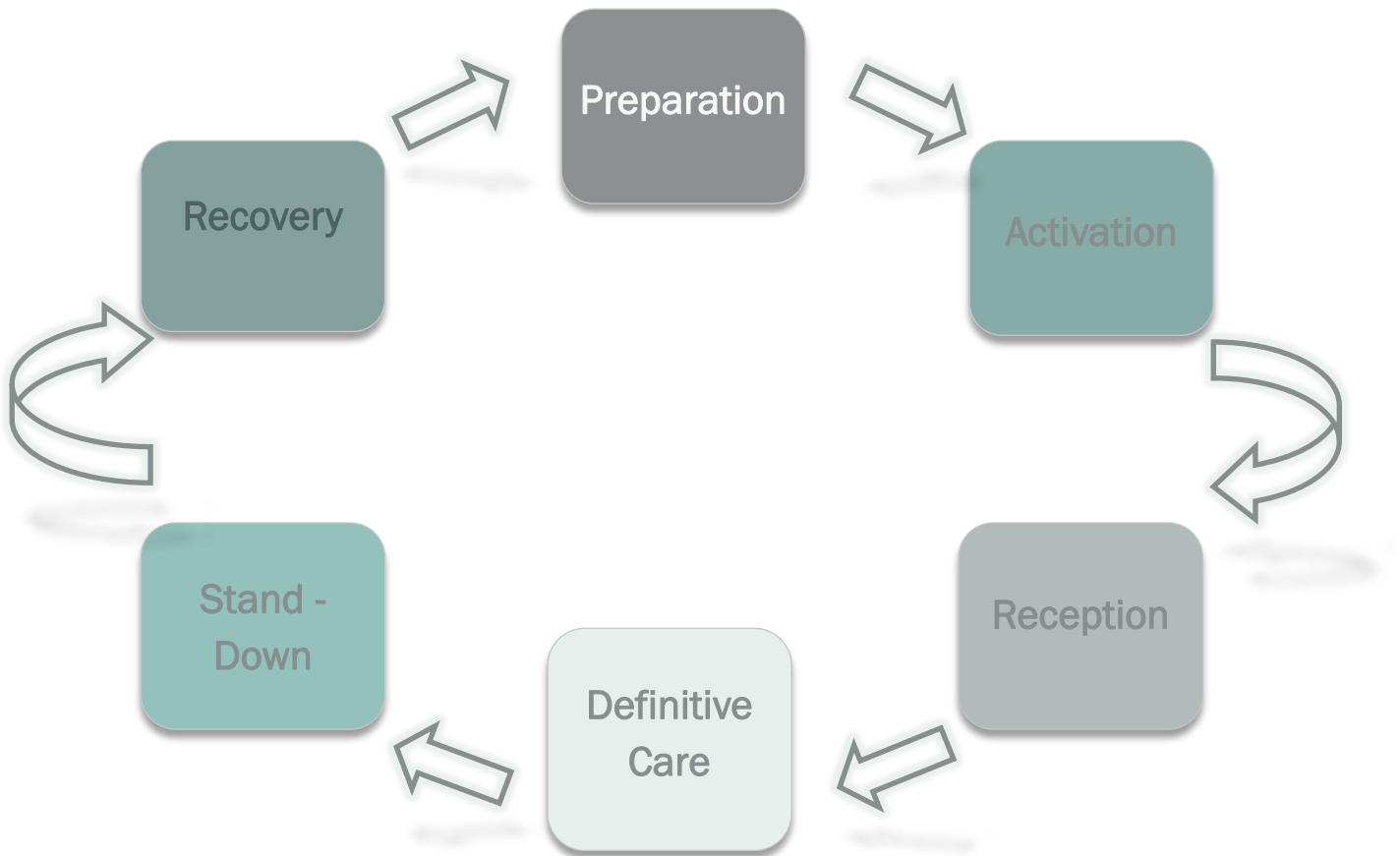
The activity in the Hospital once the MEP is activated is like a wave, swelling and subsiding with time. How the wave affects different areas and services depends on the nature of the event.
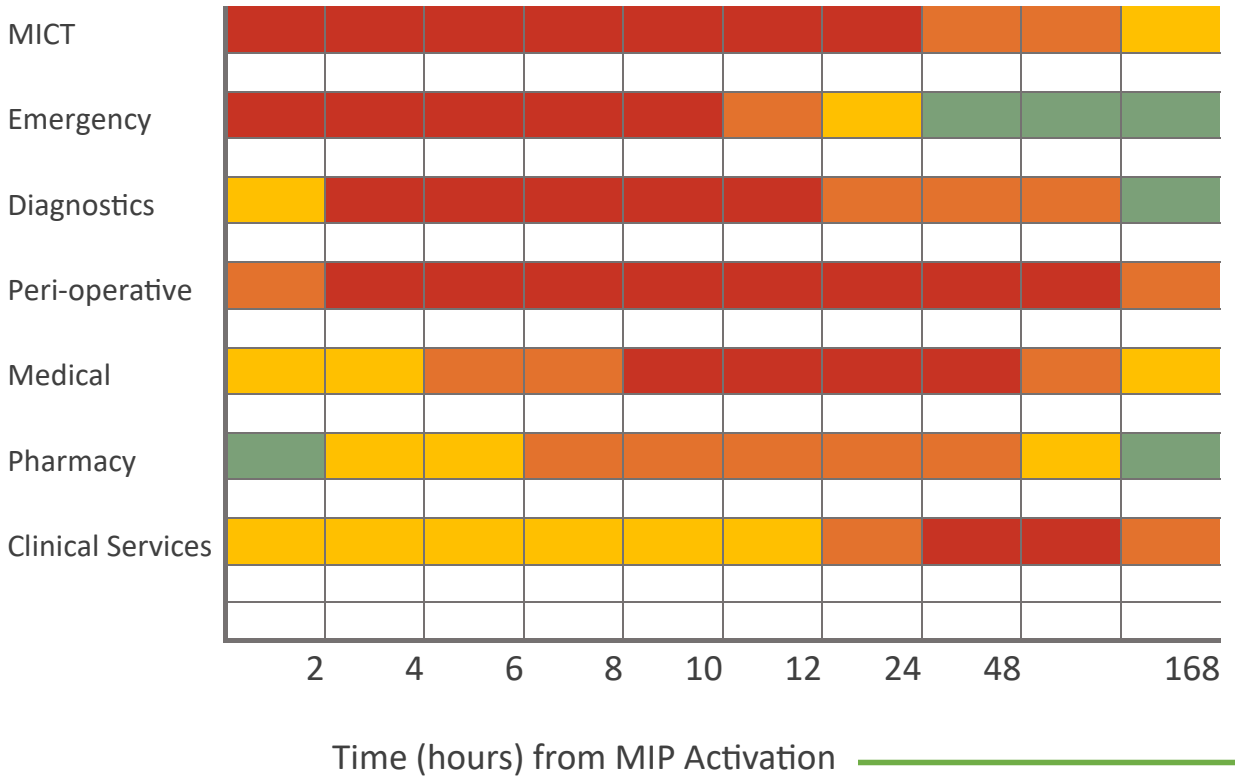
The accompanying heat maps suggests a possible pattern of activity for a large trauma event with a large number of injured patients.

The pattern of the heat maps would be very different if there was an event at a local chemical (Seveso) site, an adverse weather event e.g. flood or damage to the integrity of the hospital systems and processes e.g. power failure.
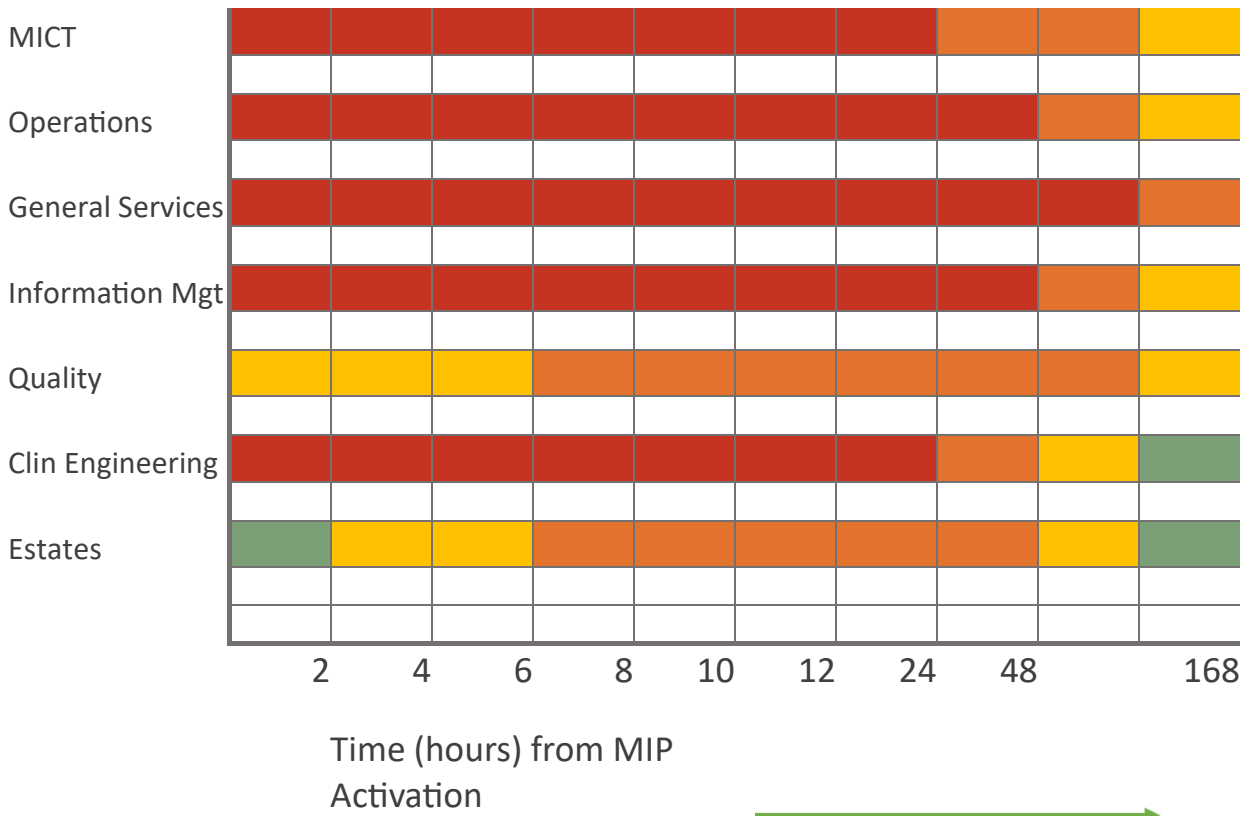
Plotting heat maps for different possibilities informs planning.

Heat Map of MIP activity per Area - Trauma incident

	2	4	6	8	10	12	24	48	168
MICT									
Emergency									
Diagnostics									
Peri-operative									
Medical									
Pharmacy									
Clinical Services									

Time (hours) from MIP Activation ⟶

Heat Map of MIP activity per Service - Trauma incident

	2	4	6	8	10	12	24	48	168
MICT									
Operations									
General Services									
Information Mgt									
Quality									
Clin Engineering									
Estates									

Time (hours) from MIP Activation ⟶
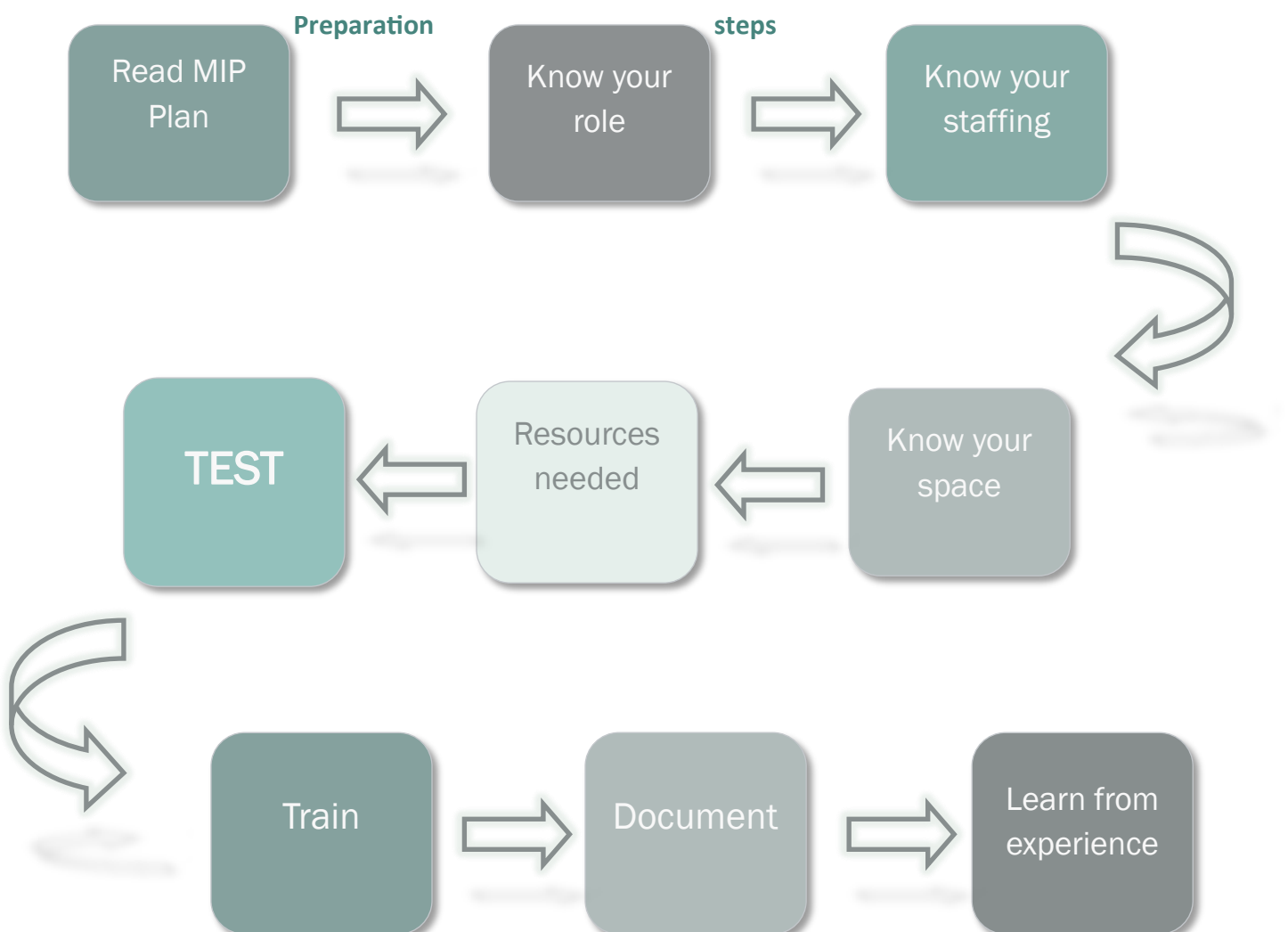
3.1.1 Preparation

This is the critical phase in every plan. This MIP is specific to Connolly and has been updated as learning occurs. Each Area and Service needs to :

- Read this plan, particularly Chapter 1-3 and the relevant section of Chapter 4

- Know *your* role

- Know what actions *you* would take if an incident was declared

- Know what resources *you* need and where *you* would source them

- Share knowledge of the plan with your colleagues and document clearly this occurs regularly

- Test aspects of the plan

- Report your test findings back to the hospital's MIP Committee

- Implement learning from testing

- Document what you have done

- Ensure the plan is "always active" even if staff move or change

> Key staff should have specialist training e.g. HMIMMS

Appendix 1 is a Preparation Checklist.

Submit an update list to the MIP committee in March and Sept annually.

Preparation   **steps**

Read MIP Plan → Know your role → Know your staffing → Know your space → Resources needed → TEST → Train → Document → Learn from experience

Action Cards

This MIP has "Action Cards" for a limited number of roles. The Action Cards are for the MICT, Area or Service Leads and very specific roles e.g. Staff Allocation or Switch

The sections in Chapter 4 relevant to your area or service will serve as the basis for an Action Card. So …..

Read the pages for your Area or Service in Chapter 4.

Print off several copies

Copy 1: Use the preparation checklist and "tick the boxes"

Other copies: Distribute them in highly visible locations so that they can be rapidly accessed by staff for either local tests or a real MI.

Some specific roles may benefit from an action card, particularly if staff move frequently or the task is very structured e.g. the triage team in ED or the Unscheduled Care lead allocating beds.

If a service feels an action card would be useful to a specific role then they can devise it using the template in the MIP box and on the X-Drive. It can be included in the Area/ Service MIP file and on the X-Drive _CHBMAJORINCIDENTPLAN
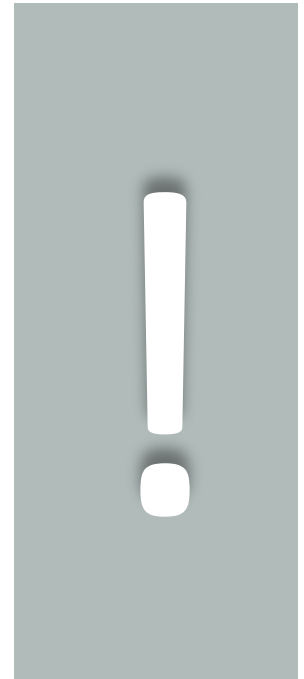
Preparation—testing the plan

Sometimes this seems daunting, the key thing to remember is that testing small aspects of the plan little and often is much more productive than grand exercises.

For shift leads, try some of these tasks on a monthly basis. You can announce the exercise at handover or during a quiet moment. You can repeat the same exercise with different staff members too.

Suggested Mini-MIP testing scenarios…..

- The staff call-in system—are contact details up to date?

- Inform staff that the MIP has been activated and test:

    - Where you would move patients in preparation for incoming patients

    - How you would allocate staff to different roles

- Inform staff that utilities have been a disrupted (e.g. electricity, water, internet). Test their response.

- Test the post discharge care of patients who had their care deferred if a MIP was declared

- Test the communication methods in your area within and between departments

- Test how you would manage a scenario if there were many patients with the same presenting complaint e.g. burns, major bleeding, spinal injuries or an infectious disease

Once you have tested the plan, document the learning points, action what needs to change and re-test. Document this. Report these findings to the MIP Committee or Implementation team.

3.1.2 Activation

The decision to activate Connolly's Major Incident Plan will be made by a member of the MICT in response to:

- Notification by the pre-hospital emergency services

- An unusual pattern of patient presentation to the ED

- Other extraordinary situations in the hospital

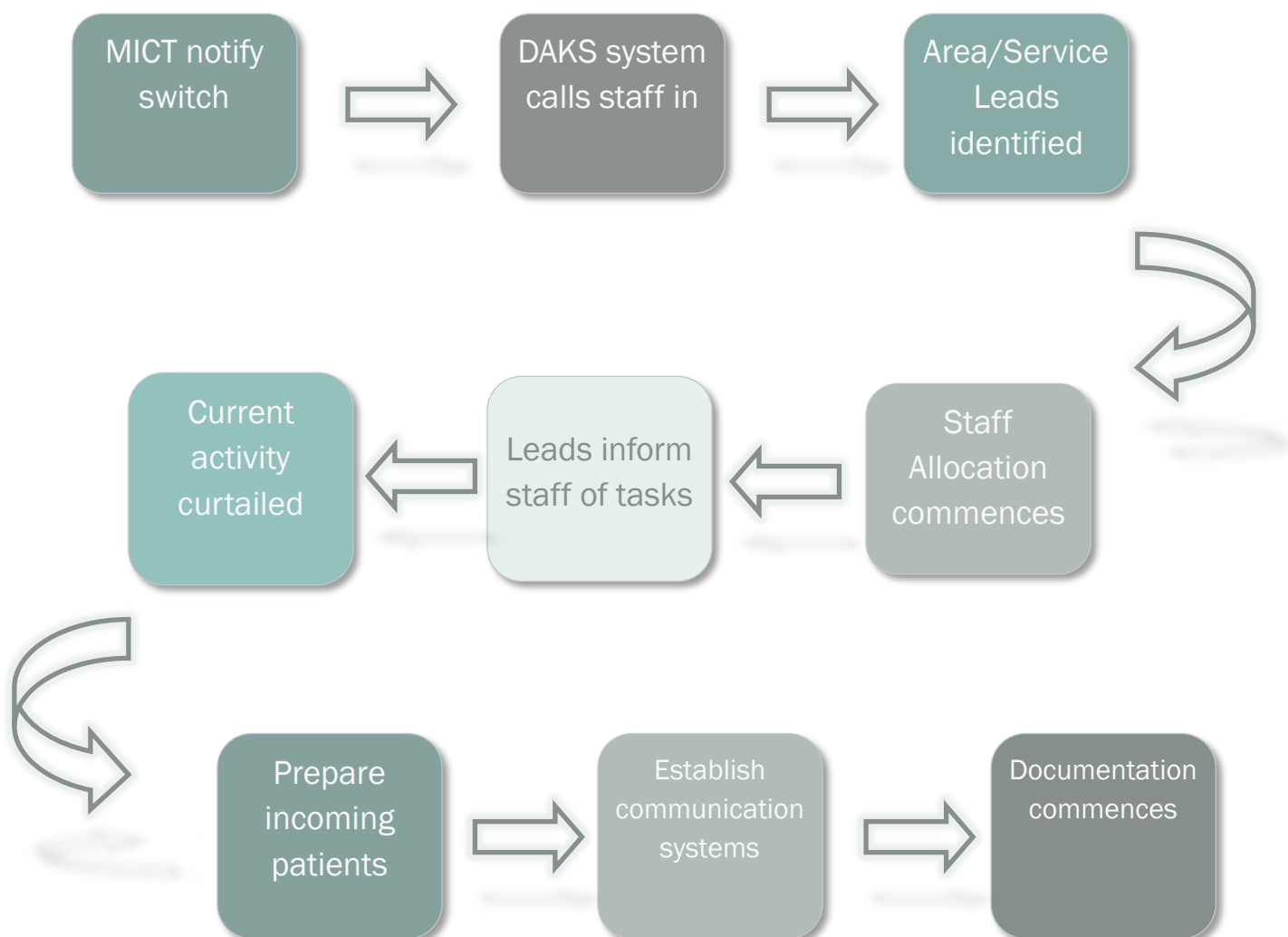- Notification by HSE Area Crisis Management team or Emergency Management Office

Activation of the Connolly Hospital Major Incident Plan includes two distinct levels of action:

Declaration of standby - when a Major Incident is likely to occur

Activation of the Plan - when a Major Incident has occurred or is imminent

The MICT will decide on whether No Action, Stand-by or Activation is declared. Hospital staff will not be informed of "Stand-by" and will only be informed if the plan is activated.

Initial steps

```
MICT notify        DAKS system        Area/Service
switch       →     calls staff in  →  Leads
                                       identified
                                           ↓
Current            Leads inform       Staff
activity      ←    staff of tasks  ←  Allocation
curtailed                             commences
   ↓
Prepare            Establish          Documentation
incoming      →    communication  →   commences
patients           systems
```
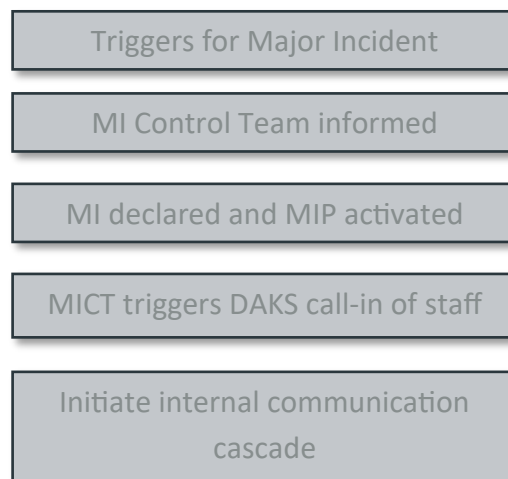
Staff notification and call-in systems

This involves 4 steps

1. MICT gets together
2. Declare the MIP active
3. Automated call-in of hospital staff
4. Initiate the internal communication cascade

	Triggers for Major Incident
1	MI Control Team informed
2	MI declared and MIP activated
3	MICT triggers DAKS call-in of staff
4	Initiate internal communication cascade

Step 1: MICT

This occurs before the MIP is activated. They can meet in person (often in ED or patient flow office) or by phone.

Switch or MICT member can generate a conference call to get the members of the MICT together.   **DAKS system**

Step 2: MIP declared

Only the MICT can activate the MIP. At this stage, the MICT notify Switch that the DAKS MIP Emergency Buttons system is to be activated. Or, the MICT may press the "MIP activate" green button in the CNM III office in ED.

Step 3: Switch triggers DAKS call-in of Staff

An automated call is generated to a pre-determined number of staff in each DAKS Function Group (currently set at 35%). When a staff member receives a phone call, an automated message instructs them on what to do.

All staff in "key roles" will be contacted by the DAKS system.

Step 4: Internal communication cascade is initiated

The Site Manager, as part of the MICT, triggers the internal communication cascade, described in Section 2.5.4.

This written message will be distributed through-out the Hospital by hand.

Requirement for DAKS automated call service	How
Area or Service Lead provides MIP Implementation Team with an up-to-date staff contact list quarterly. Include all staff who routinely work in that area or with that service e.g. doctors, nurses, HCA's, clerical staff.	Use the template provided X:_CHB MAJOR INCIDENT PLAN\14. Useful documents
Staff on the contact list should be listed as "junior" or "senior" to ensure a balanced skill mix. Prioritise staff, so those most urgently needed are called first.	Details are provided in Appendix 8, the MIP box and X-Drive
These numbers are uploaded onto the DAKS system in function groups. DAKS will keep calling staff on the list until there is a 35% positive response.	
DAKS will create reports of the responses	For Staff Allocations Team

Incoming Staff

Incoming staff should be aware that many of the hospital entrances will be closed.

Page 9 lists the Areas that incoming staff should report to. Use that entrance.

It is important to comply with this for staff safety, staff allocation and hospital security.

On arrival Staff will report to Security in the Main Hospital Concourse. Their identification card will be checked. Their arrival time will be recorded.

> **Handy hint!**
> Keep a photo of your staff ID card on your phone.

Staff Allocation

This will be managed by the Staff Allocation Team.

Information on Staff demand is provided by a) MICT and b) Area/Service Leads.

Information on Staff Resources is provided by Switch (positive DAKS responses) and Security (Staff signed-in).

The Staff Allocation Lead will review the responses to the DAKS automated calls

Most staff will be asked to wait in the Hospital Concourse until allocated a role by the Staff Allocation Team.

Communication with the Emergency Services

The National Ambulance Service "National Emergency Operations Centre" or Dublin Fire Brigade's "Eastern Regional Control Centre" may notify the Emergency Department or Switch to inform them of an incident.

If Switch receives the call, they should transfer it to the "Red phone" in the Emergency Department.

The EM staff receiving the call will have an action card to inform them. The first action is to Inform the EM Nursing Shift Lead, the EM Consultant on Call, the Hospital Manager and Site Manager.
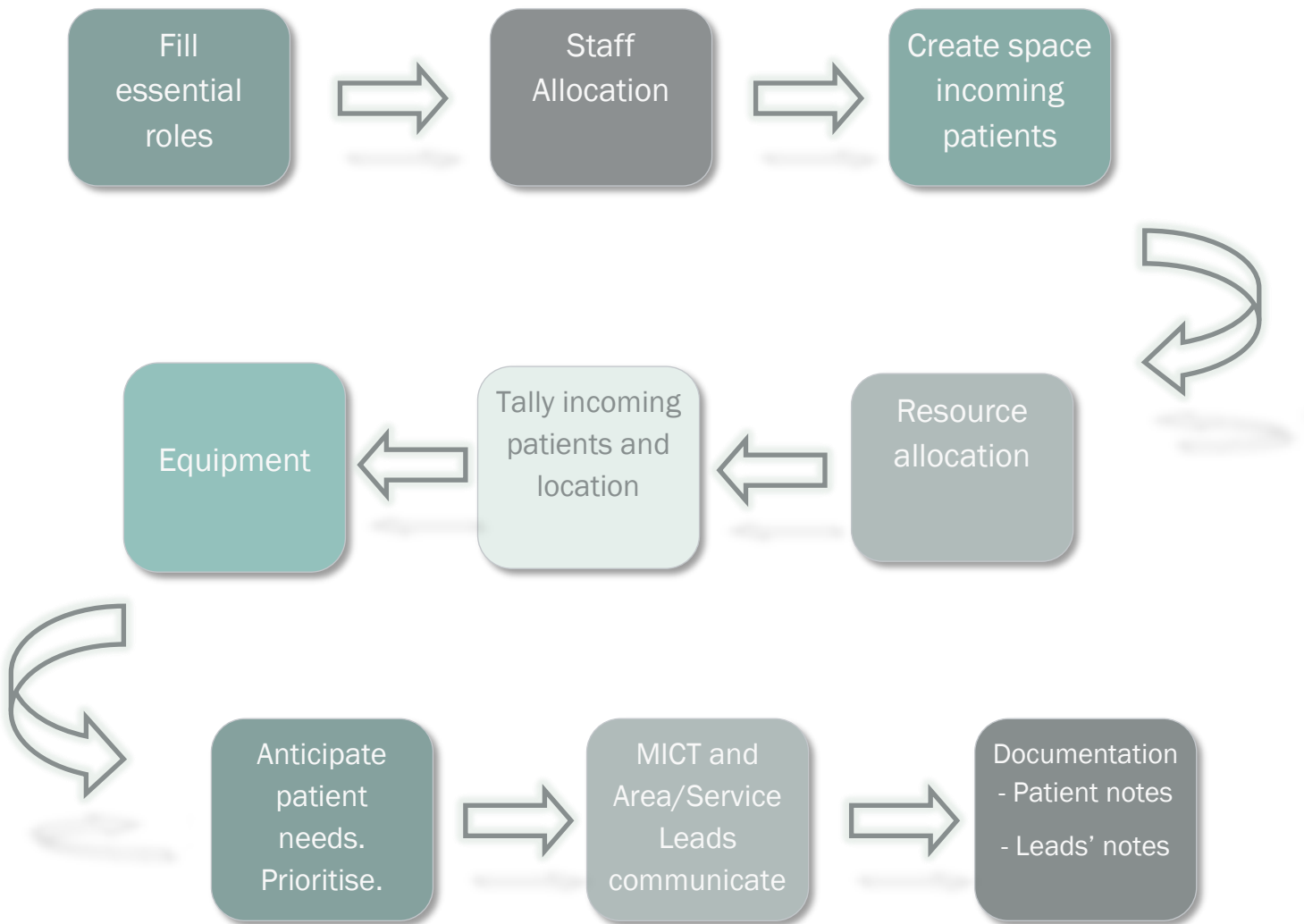
A standardised "METHANE" message is used to communicate details of a Major Incident. Use this.

The MICT, Switch and EM have access to the Emergency Services contact numbers.

M   Major Incident declared

E   Exact location

T   Type of emergency

H   Hazards - present/potential

A   Access and egress routes

N   Number and type casualties

E   Emergency services present/required

3.1.3 Reception

The key actions in the Reception phase are:

```
┌─────────────┐      ┌─────────────┐      ┌─────────────┐
│    Fill     │  ⇒   │    Staff    │  ⇒   │ Create space│
│  essential  │      │  Allocation │      │   incoming  │
│    roles    │      │             │      │   patients  │
└─────────────┘      └─────────────┘      └─────────────┘
                                                  ⇓
┌─────────────┐      ┌─────────────┐      ┌─────────────┐
│             │  ⇐   │Tally incoming│  ⇐   │   Resource  │
│  Equipment  │      │ patients and │      │  allocation │
│             │      │   location   │      │             │
└─────────────┘      └─────────────┘      └─────────────┘
       ⇓
┌─────────────┐      ┌─────────────┐      ┌──────────────────┐
│  Anticipate │  ⇒   │   MICT and  │  ⇒   │  Documentation   │
│   patient   │      │ Area/Service│      │  - Patient notes │
│   needs.    │      │    Leads    │      │                  │
│ Prioritise. │      │ communicate │      │  - Leads' notes  │
└─────────────┘      └─────────────┘      └──────────────────┘
```

Patient Locations

Appendix 9 lists the wards for:

- ED patients not suitable for discharge
- MIP patients requiring admission
- "Back-up wards" if admission wards not available
- "Overflow" wards

Resource Allocation

By definition, a MI is where demand exceeds resources and *an extraordinary response* is needed. This can seem overwhelming. Prioritisation of resources, depend on the phase of the MIP to ensure best use of a finite resource.
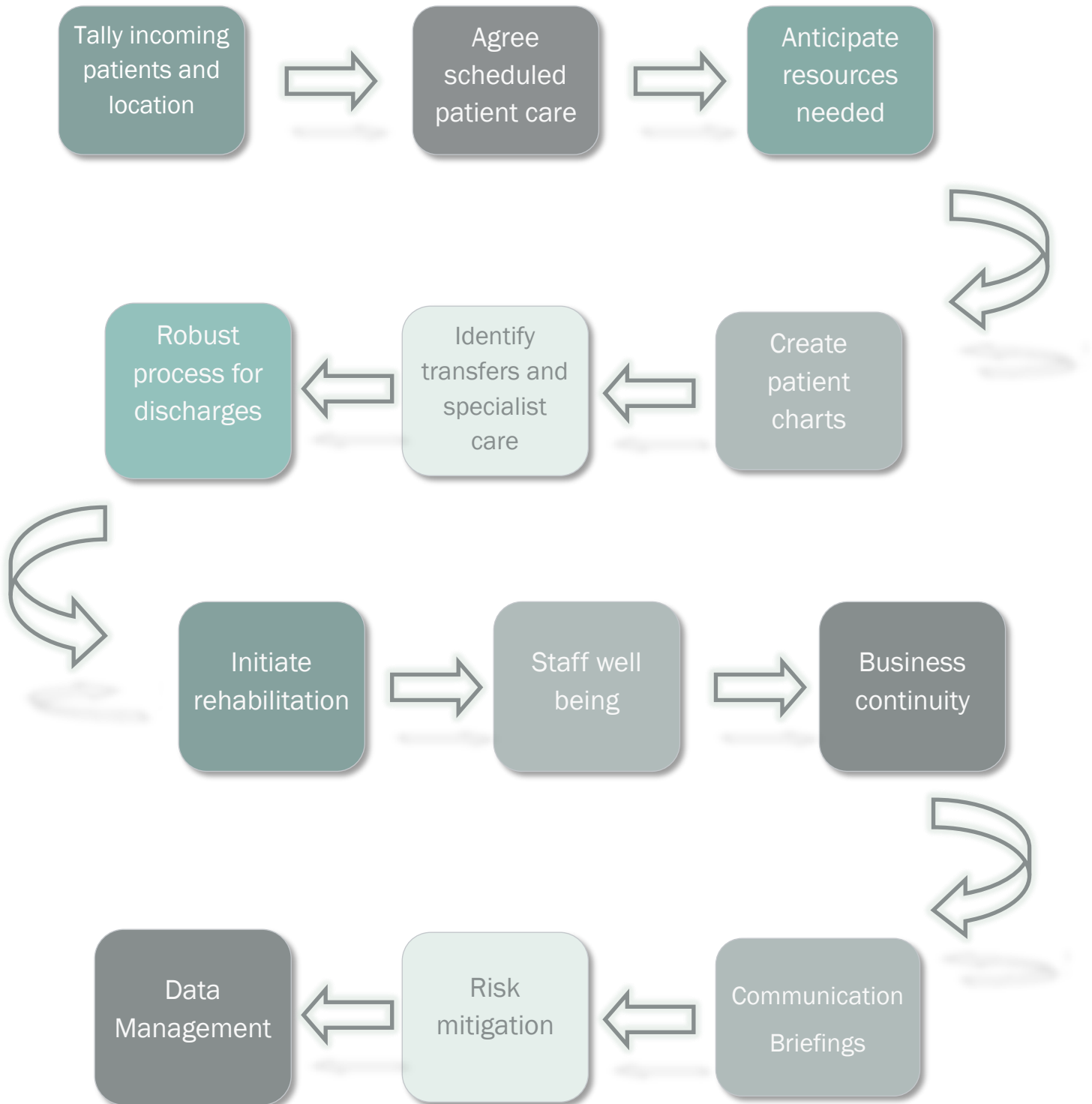
As time progresses, more resources will become available that can support the initial response. Close communication with the MICT and Area Leads is vital when determining priorities.

3.1.4 Definitive Care

Definitive care is the episode of care that begins once the patient leaves the emergency department and includes, but is not limited to, theatre, critical care, radiology, ward admission and rehabilitation.

It involves the reconfiguration of space and clinical services to ensure the safe and effective care of both patients already within the hospital and those admitted as a result of the MI. Staff must be allocated to both clinical and non-clinical roles to support this phase.

Each department has there own specific roles during this phase and these are discussed later.
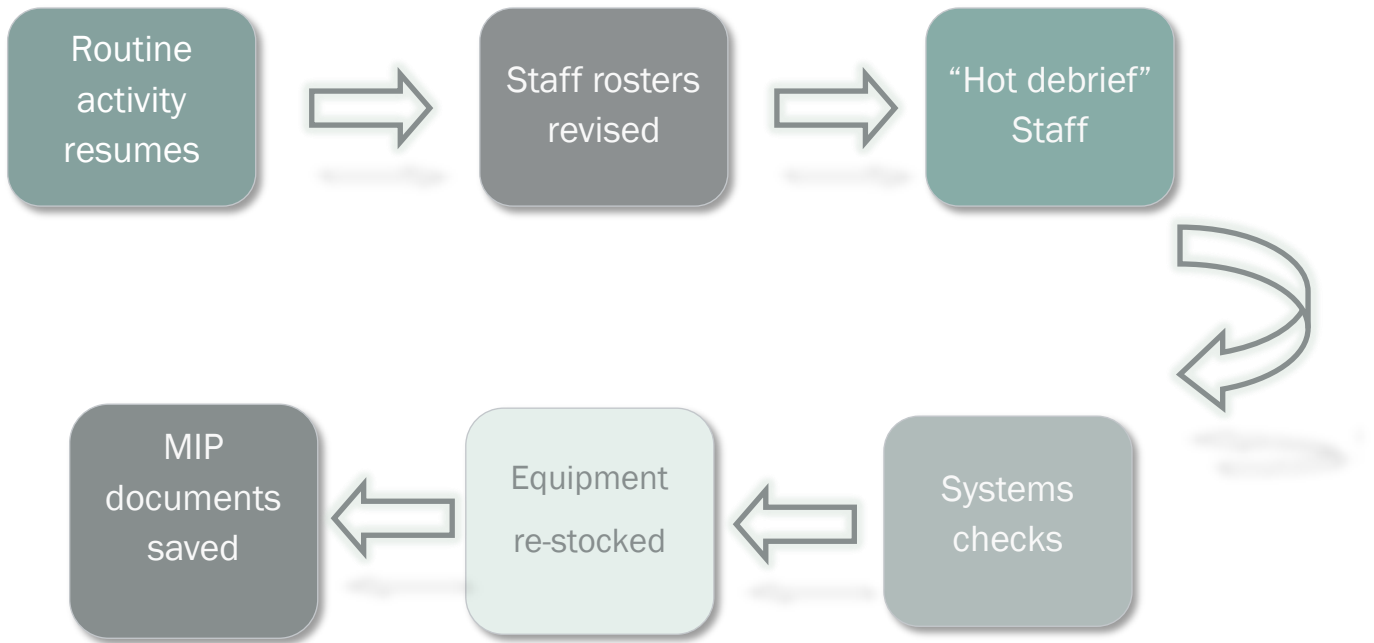
Tally incoming patients and location → Agree scheduled patient care → Anticipate resources needed ↓

Create patient charts → Identify transfers and specialist care → Robust process for discharges ↓

Initiate rehabilitation → Staff well being → Business continuity ↓

Communication Briefings → Risk mitigation → Data Management

3.1.5 Stand-down

Stand-down is a specific instruction issued by the MICT to specific areas during a major incident informing them that "normal" business can resume. The instruction is issued by the MICT to the Area or Service Lead.

It is anticipated that "Stand-down" is frequently a staggered event depending on the nature of the MI e.g. in the event of 50 patients presenting with injuries, the ED will stand-down once all patients have been admitted or discharged while theatre, critical care and the surgical wards continue in the definitive care phase.

```
┌──────────────┐      ┌──────────────┐      ┌──────────────┐
│   Routine    │  ⇨   │ Staff rosters│  ⇨   │ "Hot debrief"│
│   activity   │      │   revised    │      │    Staff     │
│   resumes    │      │              │      │              │
└──────────────┘      └──────────────┘      └──────────────┘
                                                    ⤵
┌──────────────┐      ┌──────────────┐      ┌──────────────┐
│     MIP      │  ⇦   │  Equipment   │  ⇦   │   Systems    │
│  documents   │      │  re-stocked  │      │   checks     │
│    saved     │      │              │      │              │
└──────────────┘      └──────────────┘      └──────────────┘
```

3.1.6 Recovery

The recovery phase involves:

• An after action review of the MI management

• A resumption of "normal" activity

• Staff welfare and wellbeing
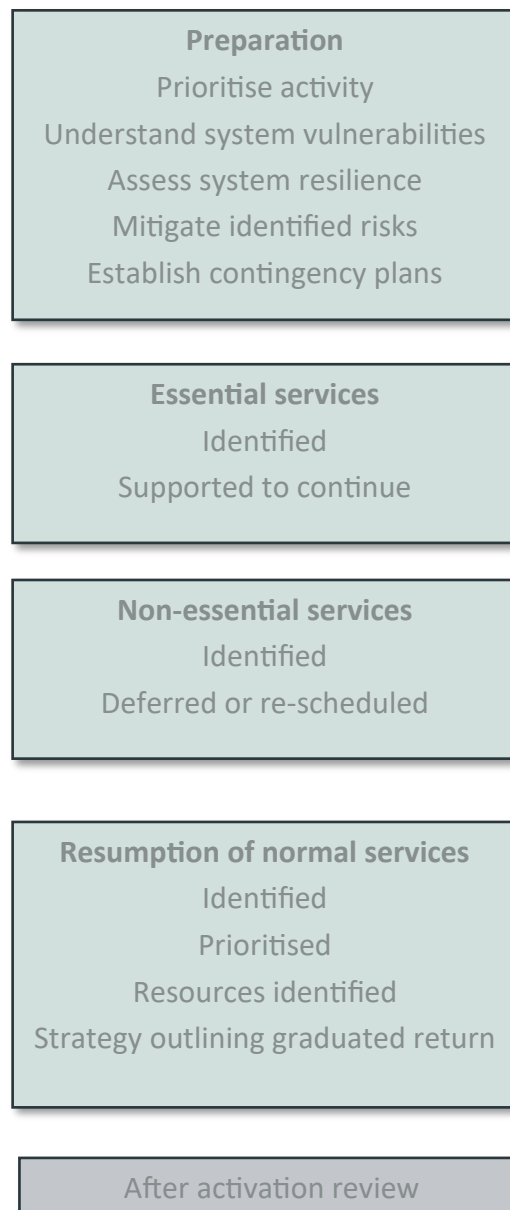
• Share organisational learning

3.2 Business Continuity

Business continuity is the advanced planning and preparation undertaken to ensure that the hospital will have the capabilities to operate its critical business functions during an emergency event, be that, a partial or complete interruption of service.

It is a parallel process that runs alongside the MIP response and commences the moment the MIP is activated.

The responsibility for business continuity rests with the Business Continuity Lead.

Business continuity response

Preparation
Prioritise activity
Understand system vulnerabilities
Assess system resilience
Mitigate identified risks
Establish contingency plans

Essential services
Identified
Supported to continue

Non-essential services
Identified
Deferred or re-scheduled

Resumption of normal services
Identified
Prioritised
Resources identified
Strategy outlining graduated return

After activation review

Chapter 4

Core Services

4.1 Major Incident Control Team

The MICT are responsible for ensuring the Hospital's preparedness in the event of a MI and for providing strategic leadership for the MIP response. Their strategic hub is the Endoscopy Board Room.

This is described in more detail in Section 2.2 Command and Control.

General Manager *or designate*	Clinical Director *or designate*	Site Manager *or designate*	Emergency Medicine Consultant

Preparation

Each member of the MICT needs to familiarise themselves with:

		√
MIP Plan	Read the plan. Print this section. Have it available. Use action card.	
Responsibilities	Know how to convene the MICT and how to activate the MIP	
Staffing	Know how to call staff in. Ensure key roles are filled.	
Space	Curtail activity. Create space. Prepare for incoming patients.	
Resource management	Ensure the Strategic Hub has the MICT MIP Box, functioning ICT and passwords	
Communications	Decide on communication methods. Be familiar with Scribes and Runners.	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time.	
Documentation	Be familiar with electronic and paper systems to manage flow, manage resources and capture decisions made—documents on X-Drive and MIP box	
Learning	Be able to conduct an after-action review	

Activation

 The MICT are responsible for activating the MIP. The triggers are:

- Notification from the pre-hospital services
- Notification by HSE Area Crisis Management Team
- An unusual pattern of patient presentation to the ED
- Other extraordinary situations in the hospital

> The MICT decides on the response
> *Standby or activation*

Actions in standby

Determine the current level of activity and capacity within the Hospital

Determine who would be the area and service "Leads"

Establish the minimum staffing available on site

Establish communications with source of notification and await updates

Standby is not communicated outside the MICT. After a period, a decision is made to "stand-down" or to "activate" the plan.

Actions on activation

Immediately begin the timed documentation of events and the decisions made

- Initiate DAKS staff call-in system by pressing the "MIP activate" DAKS button in Switch or ED CNM III office

- Activate the Internal Communication cascade with a written message (Section 2.5.4)

- Ensure Scribe and Runner are available.

- Establish a Strategic Hub (Endoscopy Boardroom) and Operational Hub (Patient Flow Office)

- Notify the HSE Area Crises Management Team via National Emergency Operations Centre (NEOC) 112/999

- Notify the RCSI Hospitals Group

- Determine the current level of activity, capacity and staffing within the Hospital *as in standby*

- Establish communication with the Area and Service "Leads"

Reception

During this period, a clear delegation of tasks is required, with strong vertical communication.

		√
Staff	Ensure role of all Area and Service Leads are filled including a Staff Allocation Lead	
Communications	Runner, Communication Lead, Communication equipment. "Vertical" system.	
Documentation	Scribe. Document decisions made.	
Space	Executive Operations Lead. Curtail activity. Create space. Prepare for incoming patients. (Appendix 9)	
Patient Flow	Executive Operations Lead. Tally incoming patients and their location	
Resource management	Area/Service Leads: Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications	
External resources	HSE Area Crises Management Team, RCSI Hospitals Group	

Definitive Care

		√
Patient Flow	Liaise with Operations: Accurate tally of patient numbers and locations	
Patient Care	Area Leads: Agree scheduled approach to care.	
	Identify patients needing specialist care or transfer.	
	Information Management Lead: Robust systems for discharged patients	
Resource management	Anticipate patient needs e.g. radiology, theatre, specialist equipment.	
	Zehnacker, HSE Central Procurement. Pharmacy. Linen supplier.	
Bed capacity	Early identification of patients suitable for "overflow" wards, rehabilitation, transfers, supported community discharge.	
Documentation	Business Manager Leads— Patient Charts	
	Be familiar with electronic and paper systems to manage flow, manage resources and capture decisions made (X-drive)	
Communications	Provide regular communication briefings to stakeholders	
Staff well-being	Ensure breaks, sustainable rosters, emotional supports, consider external help	
Quality	Risk mitigation strategies	
Business continuity	Business continuity manager: preparations for return of scheduled activity	

Stand-down

STAND DOWN – agree this with other members of the MICT.

This may occur at different stages for different teams and areas within the Hospital.

Communicate "Stand down" to those involved and record the decision.

- Routine activity resumes

- Staff rosters reviewed

- The integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff

Recovery

The recovery phase involves:

- An after action review of the MI management

- A resumption of "normal" activity

- Staff welfare and wellbeing

- Share organisational learning

4.2 Operations

The Operational Hub is based in the Patient Flow Office.

It's function is to manage the diverse factors that influence the patient journey through the hospital be that for an unanticipated attendance (unscheduled) or a planned attendance (scheduled) so that care is quality care is delivered efficiently.

Operations work closely with the MICT, enabling the MICT to focus on strategy and also with the Area leads to understand activity and the resources needed.

The overall Lead is the Executive Operations Lead, who is assisted by:

- Unscheduled Care Lead who has responsibility for patient flow

- Scheduled Care Lead who has responsibility for business continuity

- Staff Allocation Lead who has a responsibility for allocation staff based on demand and resources

Normally, Staff Allocation is not a function of Operations. This role is specific to the Major Incident Plan.

Preparation

Patient Flow

Patient flow requires the immediate creation of space on all patient wards in order to:

- Accommodate patients currently in the Emergency Department (non-incident related)

- Admission of incoming MIP patients

This requires:

- The CNM/Nurse-in-charge of each ward identifies all patients suitable for discharge.

- These patients will be asked to sit out or be moved the Transitional Care Unit or other identified area.

- Activity in Endoscopy is curtailed and space created to accept "non-incident related" medical and surgical specialty patients awaiting assessment/admission from the ED

  The Staff Allocation Lead appoints suitable staff to care for these patient, many of whom may be complex.

- The MIP receiving wards (Elm or Laurel or their "back-up wards") move patients from their ward to the space created in the other wards.

  A Medical/Surgical "Discharge Team" is deployed to the wards and the Transitional Care Unit to enable safe and efficient patient discharge.

- All patients moved or discharged as a result of activation of the MIP are:

      - Logged in the MIP Patient Log
      - Given the MIP Activation Discharge Letter (available in "Documents" in _CHBMAJORINCIDENTPLAN)

- Creation of Intensive Care capacity

  Options include: CCU (6 beds), Recovery (4 beds), Minor theatre (1 bed), HDU in Surgical Day Ward (8 beds)

- Surge capacity is considered

  Options include: Willow transfusion (6 beds), Sleep rooms (4 beds), Cedarwood (18 beds), SDW (14 beds)

Patient Flow

Activation phase:

Focus on creating space in the Emergency Department

Non-incident related Medical and Surgical Specialty Patients in ED awaiting admission	Endoscopy
Mental health patients in ED awaiting assessment/admission	Ash/Pine
Patients with possible significant transmissible illness	ED Zone 3
In-patients identified for discharge	Transitional Care
Use of off site bed capacity	*TBC*

Reception phase:

Focus is on patient reception in ED and preparation of the Receiving wards

Priority 1 patients	Red Area: ED Resus in Zones 1/4 (5 beds)
Priority 2 patients	Yellow Area: ED Zone 1
Priority 3 Patients	Green Area: ED Zone 2
Deceased patients	White Area: Mortuary

Receiving wards

Surgical MIP Admitting Ward	Laurel Ward	
	Backup	Redwood Ward
Medical MEP Admitting Ward	Elm Ward	
	Backup	Maple

Additional Critical Care capacity

CCU (6 beds), Recovery (4 beds), Minor theatre (1 bed), HDU in Surgical Day Ward (8 beds)

Surge Capacity

Willow transfusion (6 beds), Sleep rooms (4 beds), Cedarwood (18 beds), Surgical Day Ward (14 beds)

Definitive Care:

Focus is on moving patients through Receiving wards and on to most appropriate care

This may involve:

Supported early discharges

Creation of additional bed capacity

Inter-hospital transfers

Business continuity

This role is described in Section 3.2.

Staff Allocation

This is a MIP specific role.

Its purpose is to understand the competing demands for staffing, align these with the MICT strategic direction and optimally deploy the staff available.
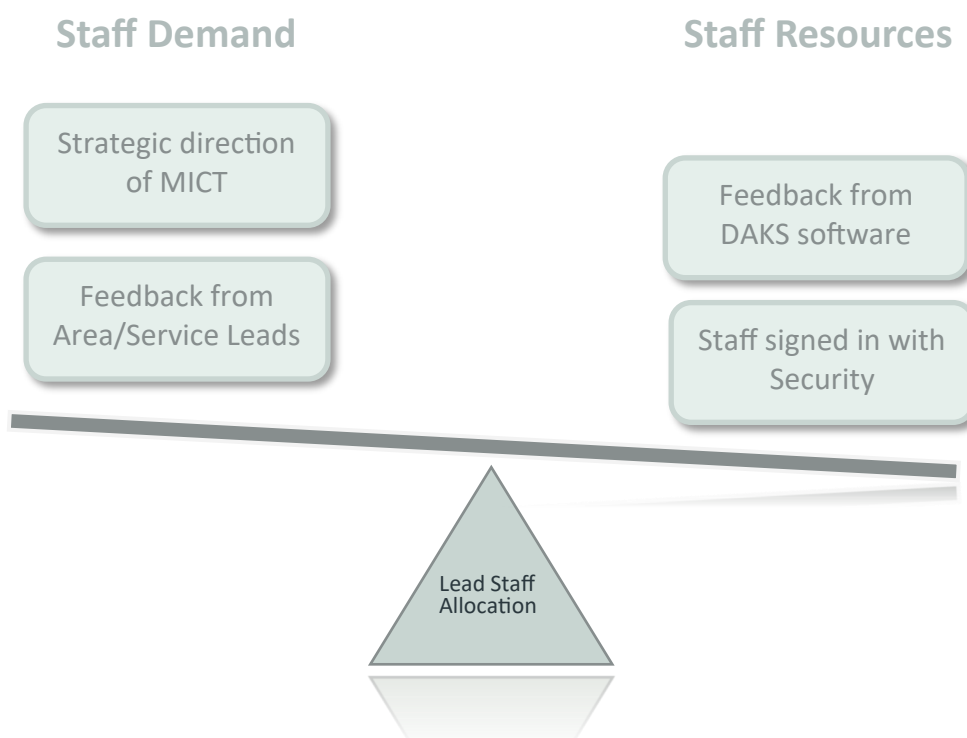
It involves a team of three people—derived from Site Management or Senior Nursing and HSCP's

This is a dynamic role that involves constant juggling between demand (communicated by the MICT and Area Leads) and the staff resources (visible by the information available to Switch from the DAKS system and the staff who have signed in with Security and are awaiting allocation in the Hospital Concourse).

The Lead and two others tasked to Staff Allocation will allocate staff based on:

• Clinical urgency

• Tasks to facilitate patient flow

• Enable the strategic direction of the MICT

Preparation Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards for Unscheduled Care Lead and Staff Allocations Lead	
Responsibilities	Unscheduled care: Enable efficient patient flow through-out CHB Scheduled Care: Ensure a Business Continuity Plan is in place Staff Allocations Team: Test how to establish the Team and how it would function	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box Engage with HSCP's on preparation of Staff Allocation Team	
Space	Curtail activity. Create space. Prepare for incoming patients. Ensure designated MIP wards are aware of patient flow processes in MIP	
Resources	Ensure the Operational Hub and Staff Allocations area has: MIP box, ICT systems and passwords including DAKS	
Communications	Decide on communication methods. Be familiar with role of Scribes and Runners.	
Test	Participate in MIP testing	
Training	Consider HMIMMS training of core staff. Provide protected training time.	
Documentation	Be familiar with electronic and paper systems to manage flow, manage resources and capture decisions made—available on X-drive	
Learning	Implement changes after testing	

Activation

On activation of the MIP, Operations play an immediate and critical role in both patient flow and staff allocation. Business continuity measures should commence as soon as the MIP is activated.

		√
Staff	Ensure roles of Executive Operations Lead, Unscheduled Care Lead, Scheduled Care Lead and Staff Allocations Lead are filled	
Communications	Runner, Communication Lead, Communication equipment. "Vertical" system.	
Documentation	Scribe. Document decisions made.	
Space	Establish the Operations Hub in Patient Flow Office Establish a Staff Allocations Hub n the Main Hospital Concourse	
Patient Flow	Create space for incoming patients Tally incoming patients and their location Anticipate demand. Liaise with Area Leads. Liaise closely with MICT and ensure alignment with strategic direction	
Resource management	Area/Service Leads: Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications	
Business continuity	Commences	

Definitive Care

		√
Patient Flow	Liaise with Area Leads and MICT: Accurate tally of patient numbers and locations	
Patient Care	Area Leads: Agree scheduled approach to care. Priority system. Identify patients needing specialist care or transfer.	
Resource management	Facilitate predicted patient needs e.g. radiology, theatre, specialist equipment. Zehnacker, HSE Central Procurement. Pharmacy. Linen supplier.	
Bed capacity	Early identification of patients suitable for "overflow" wards, rehabilitation, transfers, supported community discharge.	
Documentation	Record decisions made	
Business continuity	Prepare for return of scheduled activity	

Stand-down

STAND DOWN – This will be communicated by the MICT and may occur at different stages for different teams and areas within the Hospital.

Communicate "Stand down" to those involved and record the decision.

- Routine activity resumes

- Staff rosters reviewed

- The integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff

> The Scheduled Care lead plays a critical role at this stage.

Recovery

The recovery phase involves:

- An after action review of the MI management

- A resumption of "normal" activity

- Staff welfare and wellbeing

- Share organisational learning

4.3 Emergency Medicine Directorate

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards for: METHANE message, Triage Team, EM Leads, Red, yellow and green areas and Clerical Manager	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box Staff allocation: know the "minimum staff" levels for each zone.	
Space	Identify a hub for the EM Leads Determine maximum capacity, access & egress of Ambulance Bay Ensure decontamination area is in operational order Ensure Triage area can be established with 10 minutes Define capacity of Red, Yellow, Green zones Ensure each zone can be equipped within 20 minutes	
Patient Flow	Create space: Have system to identify patients for discharge, admission or stay in ED Record discharged patient details: Give MIP discharge letter, prescription, follow-up	
ICT	Have a patient registration and tracking system with and without usual ICT.	
Resource management	Ensure the EM Leads' Hub has MIP box, communications equipment, ICT/passwords Equipment checklists for each zone: Check stock and expiry periodically	
Communications	Practice receiving a METHANE message Be familiar with role of Scribes and Runners. Practice using vertical communication between Zone Managers, Leads and MICT	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training.	
Documentation	Trial electronic and paper systems to manage flow, manage resources and capture decisions made—available in X-drive and in MIP box	
Learning	Debrief following test and report learning to MIP Committee	
Special situations	CBRNe, Agitated or violent persons	

Activation

Immediately identify the EM Medical and Nursing Leads. Fill these roles with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

The EM Leads have a hands-off role to ensure capacity within the Emergency Department to triage, assess, treat and arrange disposition of patients, using the staff and resources available. Allocate a scribe and runner promptly.

Immediate tasks include:

		√
Staff	Incoming ED staff to report to ED Ambulance Area. Allocate staff to Triage, Red, Yellow, Green Zones, Scribes, Runners, Clerical Lead Provide action cards	
Communications	Inform staff of communication processes and "Vertical" communication Establish communication with Area/Service Leads and the MICT. Use Runner.	
Documentation	Scribe. Document decisions made. Establish incoming and discharged patient logs (available in MIP box or on X-drive)	
Space	Keep Ambulance Bay clear. Prepare Triage area, Red, Yellow and Green Zones	
Patient Flow	Create space. Identify patients for discharge, admission or stay in ED	
Resources	Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications	
External resources	Establish communication with National Emergency Operations Centre	

Reception

EM Leads should liaise with National Emergency Operations Centre (NEOC) in relation to ambulance arrivals (number, timing, case-mix etc).

Triage

No patient should be permitted to enter the ED until Triage is performed. Complete EM incoming patient log.

Triage Team (Dr, Nurse & Clerical) establish a base at the ED Ambulance Entrance– action card

Triage's purpose is to recognise the sickest patients and allocate them to a clinical area.

CHB uses a 2-step Triage.   *This differs from other hospitals. Inform paramedics of this.*

Step 1: Handover to Triage Team (ED Ambulance Entrance)

A Triage Sieve occurs (Appendix 10). This quick assessment allows a patient be allocated to the Red, Yellow, Green or White (Mortuary) zone. Limited information is used.

Patients should be registered on IPMS/Symphony using designated MIP numbers on pre-prepared MIP packs unless time and systems permit updating patient details and printing new wristband, stickers, EM notes.

Triage nurse assesses vital signs and apply patient wristband.

Apply a colour coded sticker on the pre-prepared MIP pack. Change the sticker colour if the patient moves zones

Step 2: **Handover to Zone Manager** (Red, Yellow or Green Zone)

Detailed clinical handover from pre-hospital practitioners or clinical assessment of self-presenters. Record in EM notes. Sometimes, a patient will be re-triaged post Step 2.

Patient Registration Packs

These packs are prepared with designated IPMS numbers. They are designed for patients with unknown demographics. These details maybe updated a) at Triage b) at disposition or c) at any stage during their care.

It is imperative that if the demographic details are updated that a new patient wristband is created and applied. This wristband must correspond with the identifying blood transfusion sample in the lab.

The packs includes:

EM notes	Blood forms	Microbiology forms	Patient property bag	Patient valuables bag

Radiology requests should be made electronically when possible. This requires registration on IPMS/Symphony. If the patient moves from one Zone to another, update the "Location Sticker and Time" on the pack.

Clinical Care

Clinical care is provided to the highest standard given then staffing and resources available. Regularly update the Zone Manager on the patients status and anticipated needs. The Zone Managers will liaise with EM Leads, who in turn will liaise with other Area leads and the MICT.

Investigations

Limit investigations to those that will directly impact on patient care decision making.

Documentation

Ensure dated and timed notes are clear, concise and legible. Include legible signatures and medical council registration number. Use the body diagrams to record injuries.

During the incident, the MIP pre-prepared registration pack containing a photocopy of the original EM notes will move with the patient to the ward or other institution. All original EM notes should be kept in EM reception and scanned to MIDAS. Clerical and Senior Clinical sign-off is required to state this has happened.

Disposition

- Record all discharges from once the MIP is activated on EM patient discharge log
- Discharged patients: Ensure prescription, after-care instructions, GP letter & follow-up arranged

Definitive Care

As the MI moves into the Definitive Care phase, EM activity will reduce. Staffing levels should reflect this.

Stand-down

The MICT will notify the EM Leads when Stand-down is declared for the ED.

At this stage:

- Routine EM activity resumes

- Staff working hours are reviewed

- A "hot debrief" occurs with all staff

- The integrity of systems are checked

- Equipment is restocked

- Documentation is stored (logs, white boards, e-mails and messages)

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing

  "Cold debriefs" occur at this stage and external expertise may be provided to support staff

- Resumption of "normal" activity

  This includes preparedness for a future major incident

- Review of the MI response

  This will include internal processes within the ED and wider engagement with the MICT

4.4 Medical Directorate

The traditional thinking has been that MI's are likely to involve patient trauma. However, some MI's may involve infectious diseases, environmental emergencies e.g. heat related or Chemical, Biological, Radiation, Nuclear or Explosive (CBRNe) events.

In the latter, the Medical Directorate will provide the Lead clinical response while in the former, the Medical Directorate will support the Peri-operative directorate with patient discharges, direct patient assessment, pre-operative reviews and consults for patients with co-morbidities.

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards: Medical and Nursing Leads, Discharge Manager, Ward Managers	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box Staff allocation: know the "minimum staff" for each work stream.	
Work streams	Establish Discharge Teams Identify patients suitable for discharge from each ward. Move them to a) Day Room b) Transitional care unit or c) Sit them out Provide discharged patients with MIP discharge letter, prescription, follow-up. Receiving wards: prepare for incoming patients, move current patients to other wards Provide staff for non-incident related patients admitted to Endoscopy Provide staff to tasks determined by the Staff Allocations Lead	
Patient Flow	Create space: Have system to identify patients for suitable for discharge	
ICT	Have a patient registration and tracking system with and without usual ICT. Patient transfer log provided in MIP box and on X-drive	
Resource management	Identify a Hub for Medicine Medical and Nursing Leads with MIP box, ICT/passwords and communications equipment	
Communications	Decide on communication methods Be familiar with the role of Scribes and Runners Practice using vertical communication between ward Managers, Leads and MICT	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training.	
Documentation	Trial electronic and paper patient tracking systems and capture decisions made. Ensure a patient chart is created within 48 hrs of MIP being declared.	
Learning	Debrief following test and report learning to MIP Committee	
Special situations	CBRNe Agitated or violent persons	

Activation

Immediately identify the Medical directorate Medical and Nursing Leads. Fill the roles with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

The Medical Leads have a leadership role to provide clinical care, discharges, creation of bed capacity, staffing and facilitate patient flow. Ensure a scribe and runner is allocated promptly. Immediate tasks include:

		√
Staff	Incoming staff should report to Main hospital concourse. Liaise closely with Staff Allocation Lead. Allocate staff to different work streams.	
Communications	Inform staff of communication processes and "Vertical" communication and Runner Establish communication with Area/Service Leads, Staff Allocations Lead and MICT	
Documentation	Use Scribe. Document decisions made.	
Space	Appoint a Discharge Manager and Team. Discharge 10-12 patients per ward. Transfer patients in MIP Receiving ward to other wards. Prepare for incoming patients	
Patient Flow	In conjunction with the Staff Allocation Lead, allocate staff to: • Endoscopy • Discharge Teams • EM • Pre-op assessment • Consults • Inter and intra-hospital transfers	
Resource	Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications	
Business continuity	Identify essential medical services that need to continue	

Reception

Most clinical activity traditionally occurs in the Emergency Department. During this period, the Medical Directorate should facilitate the transfer of patients out of ED and create capacity on the wards.

Medical tasks

- Provide clinical care to patients in "new areas" e.g. Endoscopy, Transitional Care Unit
- Provide clinical care to incoming MI patients
- Facilitate patient discharge
- Pre-op assessment of patients urgently requiring theatre
- Intra and inter-hospital patient transfers e.g. to CT/ICU, other hospital

Nursing tasks

- Clinical care of patients in the ED, endoscopy, transitional care unit and on wards
- Facilitate patient discharge
- Create ward capacity, including overflow areas, for incoming patients

Definitive Care

This phase may be busy and prolonged for the Medical Directorate depending on the nature of the incident. Good vertical communication with the MICT and Area Leads is important.

- Identify high priority patients

- Agree scheduled approach to patient care e.g. imaging, theatre, rehabilitation etc

- Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications, linen

- Identify patient needing specialist off-site services and inter-facility transfers

- Create charts for admitted patients

- Discharged patients: Process of communicating care plan, prescriptions and follow-up

- Initiate rehabilitation or discharge planning

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

- Engage with Business Continuity Manager

Stand-down

The MICT will notify the Leads when Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.5 Peri-operative Directorate

The peri-operative directorate includes the surgical specialties and wards, anaesthesia, theatre and critical care. It also includes the Central Decontamination Unit.

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards: Peri-operative and Nursing Leads, Ward Managers	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box. Staff allocation: know the "minimum staff" for each work stream.	
Work streams	Provide Critical Care staff to "Red Zone" in ED Determine "essential" surgery and curtail non-essential surgery Identify patients suitable for discharge from each ward. Move them to a) Day Room b) Transitional care unit or c) Sit them out Provide discharged patients with MIP discharge letter, prescription, follow-up. Create "receiving ward", ICU and HDU capacity Establish intra and inter-hospital patient transfer teams Provide staff to tasks determined by the Staff Allocations Lead	
Patient Flow	Create space: Have system to identify patients for suitable for discharge or transfer	
ICT	Have a patient registration and tracking system with and without usual ICT. Patient transfer log provided in MIP box and on X-drive	
Resource management	Identify a Hub for the Peri-operative Leads with MIP box, communications equipment and ICT/passwords Engage with Zehnacker, company representatives and central procurement to ensure continuity of supply chains in event MIP is activated Test procurement of large volume of blood products Equipment checklists: Check stock and expiry periodically	
Communications	Decide on communication methods Be familiar with the role of Scribes and Runners Practice using vertical communication between ward Managers, Leads and MICT	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training.	
Documentation	Ensure a patient chart is created within 48 hrs of MIP being declared.	
Learning	Debrief following test and report learning to MIP Committee	
Special situations	CBRNe Agitated or violent persons	

Activation

Immediately identify the Peri-operative directorate Surgical, Anaesthesia and Nursing Leads. Fill these roles with the most experienced on-site staff until more senior staff arrive. Get the Action Card. Immediate tasks include:

		√
Staff	Incoming staff should report to Main hospital concourse. Theatre staff go to Theatre. Liaise closely with Staff Allocation Lead with regard to staff availability.	
Communications	Inform staff of communication processes , "Vertical" communication and Runners. Establish communication with Area/Service Leads, Staff Allocations Lead and MICT	
Documentation	Use Scribe. Document decisions made.	
Space	Appoint a Discharge Manager and Team. Transfer patients in MIP Receiving ward to other wards. Prepare for incoming patients Create critical care capacity	
Patient Flow	In conjunction with the Staff Allocation Lead, allocate staff to: - Emergency medicine "red zone" - Discharge teams - Receiving wards - Theatre - Admissions - Inter and intra-hospital transfers - Critical care	
Resource	Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications Ensure supplies of sterilised theatre equipment	
Business continuity	Identify essential surgical and critical care services that need to continue	

Reception

The priorities are:

Anaesthesia/Critical Care staff

- Provide critical care to unstable patients
- Triage patients needing ICU/HDU bed
- Pre-op assessment of patients urgently requiring theatre
- Intra-hospital patient transfers e.g. to CT/ICU

Surgical staff

Direct patient care in the ED

Triage patients needing theatre or interventional radiology

Expedite the admission of patients to the ward

Ward Staff

Create capacity on the wards and prepare for incoming patients

CDU staff

Ensure integrity of supply chain

Definitive Care

This phase is likely to be both busy and prolonged for the Peri-operative directorate. Good vertical communication with the MICT, Area Leads and Theatre/ICU Managers is important. Tasks:

- Identify high priority patients

- Agree scheduled approach to patient care e.g. damage control surgery, interventional radiology etc

- Efficient use of theatres e.g. availability of low acuity theatre to facilitate early discharge

- Anticipate patient needs e.g. radiology, theatre, specialist equipment, medications, linen

- Identify patient needing specialist off-site services and inter-facility transfers

- Create charts for admitted patients

- Discharged patients: Process of communicating care plan, prescriptions and follow-up

- Initiate rehabilitation plan

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

- Engage with Business Continuity Manager

Stand-down

The MICT will notify the Leads when Stand-down is declared for theatre and ICU/HDU. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.6 Diagnostics Directorate

The Diagnostics Directorate includes:

- Radiology and Radiography

- The Laboratory, Phlebotomy and the Mortuary

- Microbiology and Infection Prevention and Control

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards: Radiology/Radiography Leads, Laboratory Lead	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box. Staff allocation: know the "minimum staff" for each work stream.	
Work streams	Radiology Performance of portable, plain film, CT, MRI, US and interventional imaging Laboratory Blood transfusion, laboratory investigations, screening for infectious disease Optimum use of Phlebotomy staff Mortuary Microbiology/IPC Promote practice to minimise risks from transmissible illnesses and infections	
Patient Flow	Create space: Have system to identify patients for suitable for discharge	
ICT	Systems for patients with unknown identities System for "cyber downtime"	
Resource management	Identify a Hub for the Radiology/Radiography Leads and Laboratory Lead with MIP box, communications equipment and ICT/passwords	
Communications	Determine communication methods especial for results during "cyber downtime" Be familiar with Scribes and Runners. Practice using vertical communication	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training.	
Documentation	Trial electronic and paper patient tracking systems and capture decisions made.	
Learning	Debrief following test and report learning to MIP Committee	
Special situations	CBRNe High risk of transmissible illnesses	

Activation

Immediately identify the Radiology, Radiography , IPC and Laboratory Leads. Fill these roles with the most experienced on-site staff until more senior staff arrive. Get the Action Card. Allocate a scribe and runner promptly.

		√
Staff	Allocate staff to different work streams. Liaise closely with Staff Allocation Lead. Incoming radiology staff report to Main Hospital concourse and go to Radiology Incoming laboratory staff report to the Lab and Mortuary staff to the Morgue All other staff report to the Main Hospital Concourse	
Communications	Inform staff of communication processes , "Vertical" communication and Runner Establish communication with Area/Service Leads, Staff Allocations Lead and MICT	
Documentation	Use Scribe. Document decisions made.	
Space	Create space. Identify patients for discharge, deferral or return to the wards	
Work streams	Radiology • Identify patients for discharge/deferral—provide MIP activation discharge letter • Identify portable and departmental capacity. Prepare for incoming patients. • Allocate staff and manager to each radiography zones Laboratory • Allocate staff and manager to each laboratory zones • Establish system for prioritising tasks, particularly blood transfusion • Prepare Morgue and establish communication with City Morgue Microbiology/IPC IPC Lead to inform MICT of current risk of transmissible illness	
Resources	Anticipate patient needs e.g. radiology, blood products, theatre, specialist equipment	
Business continuity	Identify essential services that need to continue	

Reception

Radiology/Radiography staff

The Radiology and Radiography Leads have a leadership role to ensure capacity within their service to provide portable and departmental imaging to a large number of patients.

• Provide portable imaging, plain film and CT to a large volume of patients

• Establish radiology transfer teams to expedite CT imaging

• The EM Leads will prioritise patients for CT

• Radiology Leads to triage patients needing complex imaging or interventions

• For efficiency, a "waiver" form can accompany the patient, if appropriate (Appendix 11) or X-Drive

• Establish reporting systems and communication of time critical reports (Appendix 12)

• Communicate closely with Area Leads in terms of co-ordinating patient care

Laboratory staff

The Laboratory Lead has a leadership role to ensure the safe provision of a large volume of blood products in a timely way and the processing of a large volume of laboratory samples. Also:

- Processing Microbiology swabs to identify patients with transmissible illnesses

- Establish reporting systems and communication of time critical reports

- Ensure phlebotomy staff are available to the Staff Allocation Lead for deployment

- Ensure Mortuary has adequate capacity and contingency plans

Microbiology/IPC staff

The Microbiologist / IPC Lead has a leadership role to inform the MICT of the risk of transmissible illnesses and to ensure resources and processes are in place to minimise risk.

Definitive Care

This requires:

- Close liaison with the Area Leads and MICT

- Agree scheduled approach to patient care e.g. damage control surgery, interventional radiology etc

- Efficient use of diagnostics to facilitate early discharge

- Efficient use of microbiology screening to facilitate patient isolation or cohorting

- Anticipate specialised resources needed e.g. reagents, equipment etc

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

- Engage with Business Continuity Manager

Stand-down

The MICT will notify the Diagnostic Leads when Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.7 Pharmacy

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available.	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box. Staff allocation: know the "minimum staff" for each work stream.	
Work streams	• Facilitate the discharge of patients to create space e.g. medication reconciliation or emergency take home packs • Engage with Area Leads on likely medication demands e.g. analgesia, antidotes, sedation, vaccinations (Tetanus, Hep B), PEP • Care plans for patients receiving complex medication therapy e.g patients receiving chemotherapy or immunotherapy • Support clinical teams with medication reconciliation process, allergies, pre-op assessment for incoming patients • Procurement of medications	
Patient Flow	Assist with patient discharge and pre-operative medication reconciliation if feasible	
ICT	Have contingency plans if Pharmacy ICT systems are disrupted	
Resource management	Ensure space for Pharmacy Lead with MIP box and ICT facilities Establish links locally to facilitate emergency access to medications Procurement of specialised medication	
Communications	Decide on communication methods. Be familiar with the role of Scribes and Runners Practice using vertical communication between ward Managers, Leads and MICT	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training.	
Documentation	Document all decisions made	
Learning	Debrief following test and report learning to MIP Committee	
Special situations	CBRNe	

Activation

Immediately identify the Pharmacy Lead. Fill this role with the most experienced on-site staff until more senior staff arrive.

The Pharmacy Lead has a leadership role to ensure optimal deployment of staff to facilitate direct patient care, patient discharge, re-scheduling of therapies, support for clinical teams and laboratory, medication availability and specialised equipment.

Immediate tasks include:

		√
Staff	Incoming staff should report to Main hospital concourse and proceed to Pharmacy. Allocate staff to different work streams.	
Communications	Inform staff of communication processes, "Vertical" communication and Runners Establish communication with Area/Service Leads and MICT	
Documentation	Use Scribe. Document decisions made.	
Space	Create a Hub for Pharmacy Lead	
Work streams	• Patient discharge teams • Care of incoming patients • Care of patients receiving complex medications • Medication procurement and distribution	
Resource	Anticipate patient needs e.g. tetanus, analgesics, anti-microbial therapy etc Ensure resilience of supply chain	
Business continuity	Identify essential services that need to continue	

Reception

During the Reception phase, the immediate priorities are:

• Support the safe discharge of patients e.g. filling emergency prescriptions

• Stock anticipated medications e.g. analgesics, sedatives, anaesthetics, tetanus vaccines, tranexamic acid

• Support the laboratory in the Management of Major Bleeding

• Communicate anticipated medication shortages and recommend alternatives

• Procure additional medications to support clinical care and patient flow

Definitive Care

This phase is likely to be demanding for Pharmacy. As patients move to the ward with limited documentation, medication reconciliation is paramount. Good vertical communication with the MICT and Area Leads is important.

• Identify complex patients and prioritise these

• Agree scheduled approach to patient care e.g. management of anti-coagulants pre-op etc

• Ensure alternative medication routes for fasting patients

• Anticipate patient needs e.g. Parkinson's patients, insulin dependent diabetics

• Medication reconciliation and kardex safety

• Offer alternatives where medication supply is limited e.g. methoxyflurane instead of opioids

• Facilitate patient discharge; fill emergency prescriptions, communicate with community pharmacies

• Communicate anticipated medication difficulties with MICT early

• Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

Stand-down

The MICT will notify when Stand-down has been declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.8 Clinical Services

The strong clinical knowledge and clear communication skills of Health & Social Care Professionals (HSCPs) are considered to a major asset in the MIP. In the early phases of a MI, these specific skills will be required initially and as the MI moves into definitive care and recovery, the more specific skillset of the HSCPs will be required.

For the purposes of the MIP, there are two main groups of HSCP's:

1. Medical Social Work (MSW) and Pastoral Care. Initial responsibility starts in the Reception Phase looking after the welfare of patients, survivors and relatives.

2. Physiotherapy, Speech & Language therapy, Dieticians, Occupational therapists and Diagnostic Staff.

Initially, the majority of HSCP's will be deployed as Scribes and Runners to the MICT and Area Leads or as part of Staff Allocation Team. Depending on the incident, some senior HSCP's may be deployed clinically to facilitate patient assessment, treatment and flow.

Preparation Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards: Scribes and Runners, MSW and Pastoral Care, Staff Allocation	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box.	
Work streams	Scribes and Runners Allocate each to MICT, Operations, Area Leads and as required Care of Survivors and Relatives Establish a Welcome Centre in Canteen Provide emotional support—immediate and community links Provide practical support e.g. emergency accommodation lists etc Staff Allocation Establish a Staff Allocations hub in the Main Hospital Concourse (Section 4.2) Clinical Care As directed by Staff Allocations Lead	
Patient Flow	MSW to support the care of discharged patients	
ICT	Scribes and Runners to engage with ICT systems to fulfil role Staff Allocations staff to be familiar with DAKS system for staff call in	
Communications	Determine communication methods Provide training for Scribes and Runners. Practice using vertical communication	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training. Dedicated training is required for Staff Allocation roles, Scribes and Runners as these are unique roles specific to the MIP.	
Learning	Debrief following test and report learning to MIP Committee	

Activation

Immediately identify the Clinical Services Leads. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

The Clinical Services Lead has a leadership role to ensure optimal deployment of staff, provision of direct patient care, flow and follow-up care for discharged patients. Immediate tasks include:

		√
Staff	Allocate staff to different work streams. Liaise closely with Staff Allocation Lead. Incoming staff report to Main Hospital Concourse	
Communications	Inform staff of communication processes, "Vertical" communication and Runners Ensure the early availability of Scribes and Runners	
Documentation	Scribe should document decisions made by the Leads they are working with	
Space	Establish a Welcome Centre for relatives and discharged patients who can't go home Cancel clinics and defer scheduled care	
Work streams	Staff Allocation Establish a Staff Allocations hub in the Main Hospital Concourse (Section 4.2) Scribes and Runners Allocate each to MICT, Operations, Area Leads and as required MSW and Pastoral care Set up a Welcome Centre in Canteen Support the needs of MIP patients Establish links to support the well-being of staff Clinical Care As directed in Zone 2 (Green or Priority 3 patients) or patient discharges	
Resources	Appropriate documentation to fulfil roles of Scribes and Runners Appropriate supports to fulfil the Staff Allocation role Anticipate patient, relative and survivor needs e.g. transport, accommodation, phone	

Reception

The focus of this phase is to assist the MICT, Operational, Staff Allocation and Area Leads.

- Engage with Operations Lead to establish Staff Allocations Team

- Trained Scribes and Runners need to be allocated immediately (as per Appendix 13).

- Scribes and Runners should use pre-prepared communication templates for this task.

- MSW/Pastoral Care to support incoming patients, discharged patients who cannot go home and relatives.

- Some Senior therapists will be deployed clinically as per the Staff Allocation Lead to facilitate patient care.

Definitive Care

It is anticipated that this phase will be the busiest phase for the HSCPs as they assess, treat and rehabilitate patients in both an inpatient and outpatient setting.

Responsibilities include:

- Close liaison with the Area Leads and MICT

- Agree scheduled approach to patient care e.g. pre and post-operative care, rehabilitation

- Efficient assessment and interventions to facilitate early discharge

- Anticipate specialised resources needed e.g. rehabilitation equipment etc

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

- MSW/Pastoral Care to support Hospital Staff

- Liaise with Community Services early

- Engage with Business Continuity Manager

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.9 Information Management

Information Management is an umbrella term, that for the MIP purposes, includes:

Business Managers   Business Manager 1 liaises closely with MICT

Business Manager 2 liaises closely with Operations Lead/Unscheduled Care Lead

Business Manager 3 liaises closely with Business Continuity Lead/Scheduled Care Lead

ICT Lead

FOI/GDPR Manager   Adopts the role of Communications Lead. Liaises closely with MICT.

Quality & Safety   Quality Lead

The responsibilities here are diverse and all players have an important role in:

- Preparation of systems
- Supporting the MICT and Operational Leads
- Robust, high quality management of patient data and documentation
- Robust processes for patient follow-up
- Ensuring the integrity of ICT systems, networks and hardware
- Communication standards amongst staff
- Communication processes with staff, relatives, HSE, Hospital Group, Media and Gardaí
- Promotion of quality patient care
- Inform the MICT of risk to high quality care
- Management of MIP data
- Business continuity

Preparation Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards if required.	
Responsibilities	Unscheduled care: Enable efficient patient flow through-out CHB Scheduled Care: Ensure a Business Continuity Plan is in place ICT: Integrity and efficient running of all ICT infrastructure Communications: amongst staff and external agencies Quality: Ensure the integrity of processes Business continuity: strategic and structured approach to managing activity	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box.	
Patient flow	Create systems for managing patient flow and having accurate patient census Create system for ensuring safe care of discharged patients, especially follow-up care Business continuity: Determine activities that can be curtailed to create space.	
Resources	Ensure a robust electronic and paper based systems exist for patient registration, investigation ordering, communication of results, patient census, patient flow, post discharge care plans (e.g. OPD), capture of curtailed activity and re-scheduled care . Samples available in MIP box and on X-drive.	

		√
ICT	Create a system for rapidly testing the integrity of the ICT applications (Appendix 7). Business continuity: Create a "back-up" of all systems in electronic and paper form	
Communications	Decide on communication methods. Be familiar with Scribes, Runners, "vertical" communication Engage with HSE Communications Office on communication strategy during a MI Develop communication procedures for a MI e.g. staff communication platforms Develop links with Gardaí	
Test	Participate in MIP testing	
Training	Consider HMIMMS training. Provide protected training time. Log staff training.	
Documentation	Create pre-prepared patient registration packs with specific MIP MRN. Process for creating charts for admitted patients and merging MIP with old MRNs Process to align NIMIS/lab results between MIP MRN and old MRNs Process to ensure patient registration packs with ED notes return to ED	
Learning	Implement changes after testing	
Business continuity	• Conduct a risk assessment examining the resilience of systems in event of MI • Identify means of improving organisational resilience • Prioritise hospital activities	

Activation

Immediately identify the Information Management Lead. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

		√
Staff	Incoming staff report to Main Concourse. Allocate staff to different work streams.	
Work streams	Effectiveness of patient registration and patient registration packs Capturing details of all discharged patients and their follow-up Generation of reliable census and activity data Integrity of ICT systems Communication processes established	
Communications	Inform staff of communication processes and "Vertical" communication Ensure the early availability of scribes and runners Establish communication with MICT, Operational Lead and Area Leads	
Documentation	Ensure the quality of the MIP documents e.g. Patient Registration Packs Record decisions made	
Space	Facilitate patient discharge and curtailment of activity to create space for incoming patients	
Business continuity	Identify essential services that need to continue	

Reception

Triage	Ensure processes for recording demographics and modification of pre-prepared registration packs. Ensure patient contact is active on IPMS/Symphony/NIMIS
Patient Flow	Ensure processes for tracking MI patients Ensure processes for accurate hospital census Ensure processes for identifying discharged patients (ED, wards, Theatre, OPD, Therapy and clinical diagnostics)
Business continuity	Risk assessment on usual activity by MIP activation Mitigation of identified risks Prioritise activity to be continued, deferred or cancelled
Communication	Communicate essential information to stakeholders Establish communication processes with external agencies Remind staff of "Standards in Communication" during a MI Ensure MI communication is provided to discharged patients
Documentation	Compliance with documentation processes for MIP patients
Quality	Facilitate risk assessments Mitigate risks
Data Management	Establish processes for measurement of key parameters

Definitive Care

Patient Flow	Continuous engagement with Operational, Scheduled, Unscheduled Care Leads Ensure accurate hospital census
Business continuity	On-going risk assessment and risk mitigation on usual activity by MIP activation Maintain essential services Establish processes to resume non-essential processes
Communication	Provide regular information to stakeholders Communicate with external agencies Ensure staff compliance with "Standards in Communication" during a MI Ensure MI communication is provided to discharged patients
Documentation	Ensure all admitted patients have a Hospital Chart Merge MIP MRN with existing patient MRN's Ensure all EM original notes are scanned to MIDAS within 48 hours
Quality	Ongoing risk assessments and risk mitigation Support patient wellbeing
Data Management	Analysis of key data
Staff welfare	Ensure safe working hours, rest and meals. "Hot" debrief before going home.

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.10 Administration

Administration is an umbrella term and includes:

- Human resources (HR)
- Finance
- Administrative staff

The responsibilities here are diverse and all players have an important role in:

- Ensuring Switch has up to date staff contact details on a monthly basis
- Operating the staff hub in conjunction with Security
- Assist the MICT and Operational Leads
- Undertaking MIP specific roles as requested by the Staff Allocation Team

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available.	
Responsibilities	Staff contact details: HR to ensure DAKS system has up to date staff contact details in both electronic and paper formats Staff Hub: Work with Security to confirm incoming staff identity and sign in Follow the requests of the MICT Undertake MIP specific roles	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box.	
Communications	Decide on communication methods. Be familiar with Scribes, Runners, "vertical" communication	
Training	Participate in MIP testing. Provide protected training time. Log staff training.	

Activation

Immediately identify the Administration Lead. Fill this role with the most experienced on-site staff until more senior staff arrive. Immediate tasks include:

		√
Staff	Allocate staff to different work streams. Incoming staff report to Main Concourse.	
Work streams	Create a staff hub in the Main Hospital Concourse in conjunction with Security Assist MICT, Operations and Staff Allocations team as requested	
Communications	Inform staff of communication processes, "Vertical" communication and Runners Establish communication with MICT, Operational Lead and Area Leads	
Documentation	Document all decisions made	

Reception

Staff Hub

Check and record the identity of all incoming staff

Log their arrival time

Share details of their skill set with Staff Allocations Lead

Other staff

Follow the requests of the MICT and Staff Allocation Lead

Definitive Care

Staff Hub

In conjunction with the MICT, determine the strategic plan for staffing

Promote staff wellbeing

Other staff

Follow the requests of the MICT and Staff Allocation Lead

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.11 General Services

General Services encompasses a broad and diverse set of roles. Each Service will be dealt with individually.

4.11.1 Security

Security plays a critical role in any MI. The Security Manager is responsible for:

- Securing access and egress from the Hospital
- Signage
- Lift car park barriers—allow staff parking in the main hospital car park to facilitate entry to Main Concourse
- Establishment of a staff security check in the Hospital Main Concourse
- Management of parking for emergency service vehicles
- Ensuring only authorised personnel in the Hospital
- Implementation of security processes in event of agitated or violent behaviour
- Managing "routine" security roles

All Security staff are employees of Bidvest Noonan and Bidvest Noonan are to be included in MIP Planning.

Preparation checklist		√
MIP Plan	Read the plan. Print this section. Have it available. Create action card	
Staffing	Provide Switch with the Bidvest Noonan emergency contact for DAKS call Bidvest Noonan are responsible for calling in Security staff. Establish the minimum number of security staff needed	
Work streams	• Lock access points and hang signs advising staff to use Main Hospital Entrance • Staff sign in area and security check in Main Hospital Concourse • Establish traffic management system • Continue "routine" security roles	
ICT	Be able to activate swipe card access easily. Allow electronic staff sign-in	
Resource management	Have a "Staff Sign In" log book Have signs for all doors closed as a result of MIP activation (and blue tack) Have a supply of "temporary" ID cards activated	
Communications	Decide on communication methods Practice using vertical communication	
Processes	Ensure process in place to engage with Bidvest Noonan to provide staff numbers, training, after event staff welfare.	
Training	Engage with testing. Provide protected training time. Log staff training.	
Documentation	Keep a log of a) all staff who signed in b) all decisions made	
Special situations	Have "all hazards" procedures in place e.g. managing a violent incident, large crowds, CBRNe event, adverse weather, fire, floods, building collapse	

Activation

Immediately identify the Security Manager role. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

Actions

- Establish communication with Bidvest Noonan. Ensure off-site staff are called in.

- Establish communication with General Services Lead

- Allocate staff to key roles

- Close all agreed hospital access points and hang signage

- Establish traffic management system: Lift car park barriers

- Establish a staff sign-in system in Main Concourse

- Document the decisions made

Reception

Ensure traffic management system for Emergency Service vehicles

Check and record the identity of all incoming staff

Continually risk assess the incident and communicate status with General Services Lead

Liaise with Gardaí as required

Definitive Care

Engage with General Services Lead as to when:

- Usual access to doors can be restored

- Visitors may attend

Ongoing traffic management system e.g. for discharged patients, patient and relative parking

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- The integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing: "Cold debriefs" occur and external expertise may be provided to support staff

- Review of the MI response: This includes staff, General Services, Bidvest Noonan and the MICT

4.11.2 Switch

The role of the Switch in a MI is:

- Transfer any Major Incident notification from Emergency Services to the Emergency Department Red Phone

- Establish a conference call for MICT members—Ensure access to up-to-date phone numbers

- Initiate the automated DAKS phone call service to call-in staff

- Manage incoming calls

Preparation checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action card	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in MIP box. A minimum of 2 Switch staff are required	
Roles	Know how to transfer an incoming MI call to ED Have up to date contact details (mobile & alternative) for MICT and key roles Ensure system to create a conference call for MICT Familiarisation with DAKS "button" system and activating the MIP	
ICT	Familiarisation with DAKS system "Ghost system" - have all up-to-date contact numbers in paper form and aligned with DAKS system	
Processes	System to ensure up to date staff contact lists for MICT and Key roles. Engage with HR System for handling large volume of telephone enquiries	
Communications	Decide on communication methods Practice using vertical communication and Runners	
Training	Participate in MIP testing. Training with Staff Allocations Lead Provide protected training time. Log staff training.	
Documentation	Keep a log of all decisions made	

Activation

Immediately identify the Switch Manager role. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

Switch plays a crucial role in the activation of the MIP. Generally, but not always, Switch organises a conference call between MICT members prior to the activation of the MIP.

The MIP can only be activated by a Member of the MICT. Once the MIP is to be activated, then Switch:

Activates the MIP by pressing the green MIP activate button on the DAKS panel. It will light up. A second panel is available in the CNM III Office in the Emergency Department. If the MICT activate this button, then the button will light up in Switch.

- Switch will also need to manage incoming calls.

- Ensure 2 Switch staff available

- Document everything

At this stage, the staff call-in processes take priority and phone lines should be kept as free as possible.

Reception

The priority at this stage is the deployment of incoming staff. Switch should liaise with the Staff Allocation Lead and provide feedback from the DAKS automated call and text systems and action their requests as a priority

Switch should engage with the Communications Leads in terms of calls coming from external agencies e.g Media, Gardaí, Emergency Services, HSE

Definitive Care

- Ensure incoming calls are handled efficiently

- Be available for staff calls to facilitate patient care

- Divert calls from external agencies to the Communications Lead

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

4.11.3 Catering

The role of the Catering Department during a MI is to:

- Provide nutritious food and drinks for patients

- Provide nutritious food and drinks for staff

- Provide light snacks and drinks for relatives, discharged patients awaiting accommodation, staff from external agencies e.g. Garda Liaison Team

The canteen area will be used for Relatives and Survivors (awaiting transport or accommodation), therefore an alternative area will be needed for staff to eat e.g. coffee shop or RCSI GEP building

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action card	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in the MIP Box. Establish the minimum number of Catering staff needed for each work stream	
Work streams/ roles	• Patient food and drink preparation • Staff food and drinks • Prepare "Welcome Area" for relatives and survivors in Canteen Area • Establish a "hot food" area for staff • Transport of food • Serving and clearing of food • Provision of water	
Space	Engage with Coffee shop and RCSI with regards to alternative area for staff meals	
Processes	Food and water supply chain. Ensure a minimum of 24 hours of drinking water on site Food safety when serving hot food Staff welfare when serving and clearing food	
Communications	Decide on communication methods Practice using vertical communication	
Training	Participate in MIP testing. Provide protected training time. Log staff training.	
Documentation	Keep a log of all decisions made	
Special situations	Have "all hazards" procedures in place e.g. Power failure, contaminated water source, adverse weather	

Activation

Immediately identify the Catering Manager role. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

Immediate actions

- Incoming staff to report to kitchen of Hospital Canteen

- Immediately allocate staff to different work streams

- Establish a Welcome Centre in the canteen for relatives and discharged patients who can't go home

- Devise meal plans based on the current information available

- Inform staff of communication processes

- Establish communication with General Services Lead

- Document the decisions made

Reception

During the Reception phase, it is envisaged that light snacks and drinks will be required by:

- Relatives and survivors in the Canteen, Staff, External agencies e.g. Garda Liaison

- Commence food preparation, meal planning, meal transportation, serving and clearing meals for patients

- Prepare an area for staff to receive hot meals

Definitive care

Priorities are:

- Delivery of meals to patients

- Delivery of hot food to staff

- Continued provision of light snacks

- Ensure widespread availability of drinking water

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.11.4 Household Services

The responsibility of the household manager is:

- Ensure overall cleanliness of the hospital

- Provide "rapid response" service to facilitate urgent situations and patient flow

- Support IPC Lead in minimising risk of transmissible illness

- Ensure a efficient supply of linen: staff scrubs, patient gowns, bed linen

- Stocking PPE equipment

Many Household staff are employed by Derrycourt, therefore Derrycourt should be included in MIP Planning.

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available.	
Staffing	Provide Switch with the Derrycourt emergency contact for DAKS call Derrycourt are responsible for calling in Household staff. Establish the minimum number of household staff needed	
Work streams	• Routine cleaning • Cleaning to support the opening of additional beds • Cleaning to facilitate patient discharges • Provide "rapid response" teams as needed • Stock PPE, Linen etc	
Resource management	• Adequate access to linen, PPE • Adequate cleaning equipment e.g. blood spillages	
Processes	Ensure process in place to engage with Derrycourt to provide staff numbers, training, after event staff welfare.	
Communications	Decide on communication methods e.g. bleeps, mobile Practice using vertical communication	
Training	Participate in MIP testing. Provide protected training time. Log staff training.	
Documentation	Keep a log of all decisions made	
Special situations	Have "all hazards" procedures in place e.g. chemical spill, CBRNe event	

Activation

Immediately identify the Household Manager role. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

- Establish communication with Derrycourt. Ensure off-site staff are called in.

- Establish communication with General Services Lead

- Incoming staff to report to Main Hospital Concourse

- Allocate staff to different work streams

- Liaise with Infection Prevention Control Lead on IPC standards

- Check linen and PPE supplies

- Document the decisions made

Reception The priorities are:

- Teams to clean ED for incoming patients

- Teams to facilitate patient discharge from wards

- Ensure scrubs for incoming staff and linen for incoming patients

- Creation of "rapid response" teams

- Liaise with General Services Manager on optimum staff deployment

- Stock PPE, alcohol hand gel, soap, aprons, hand towels

Definitive Care

Priorities include patient safety, patient flow, staff wellbeing and protection, optimum efficiency. This requires:

- Close liaison with the General Services Manager

- Agree scheduled approach to tasks e.g. high activity areas, IPC, patient flow etc

- Anticipate equipment or specialised resources needed e.g. curtains, specific products

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.11.5 Stores

The governance of the Stores department is under central HSE governance and no longer directly the under the remit of Connolly Hospital.

Procurement requests are made electronically to Central Procurement.

During a MIP, if there is uncertainty in relation to a requisition, discuss the circumstances with the Area or Service Lead who can then engage with the MICT.

Limited Stores are on site in Connolly.

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available.	
Staffing	Store Manager is responsible for calling in Stores staff. Establish the minimum number of Stores staff needed	
Work streams	• Equipment procurement • Equipment distribution • Specialised equipment • Assistance with "purchase orders" for outsourcing	
Processes	Describe Stores procurement during MIP Engage with departments in advance with regards to likely equipment needs Engage with local services in advance to have an awareness of their resources e.g. Hospice, Cappagh, Children's Health Ireland Describe procedure for procuring services e.g. use of purchase orders	
Communications	Describe communication methods between MICT, staff and HSE Central Procurement Practice using vertical communication	
Training	Participate in MIP testing. Provide protected training time. Log staff training.	
Documentation	Keep a log of all decisions made	
Special situations	Have "all hazards" procedures in place e.g. burns, CBRNe event	

Activation

Immediately identify the Stores Manager role. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

Immediate Actions

Actions

- Establish communication with Stores Manager. Ensure off-site staff are called in.

- Incoming staff to report to Stores area

- Allocate staff to different work streams

- Liaise with Area Leads on anticipated equipment requirements

- Check stock levels and communicate early if shortages possible

- Document the decisions made

Reception

In the Reception phase, the priorities are:

- Maintain stock levels in ED, ICU, Theatre and Radiology as a priority

- Ensure that Area Leads have a process to rapidly procure equipment

- Inform stakeholders e.g. central procurement that MIP has been activated. Establish 24/7 communication

- Ensure process to get urgent equipment to the area of need

- Engage with Area Leads and General Services Manager on stock levels and prioritisation system

- Liaise with General Services Manager on optimum staff deployment

Definitive Care

Priorities include patient safety, patient flow, staff wellbeing and protection, optimum efficiency. This requires:

- Agree scheduled approach to tasks e.g. stocking of overflow areas, stock for special procedures

- Anticipate equipment or specialised resources needed e.g. for theatre, rehabilitation

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.11.6 Portering and Transport

The responsibility of the Transport manager is:

- Optimum deployment of staff

- Engage with General Services Lead on prioritising tasks and allocating staff

- Provide "rapid response" service to facilitate urgent situations and patient flow

Many portering staff are employees of Derrycourt and Derrycourt is to be included in MIP Planning.

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available.	
Staffing	Provide Switch with the Derrycourt emergency contact for DAKS call Derrycourt are responsible for calling in Portering staff. Establish the minimum number of Portering staff needed	
Work streams	• Movement of patients from the Emergency Department • Transfer of patients to radiology. Ideally have 2 porters for CT. • Laboratory and blood transfusion • Support patient discharges • "Rapid response teams" • Food, stores and medical chart transport	
Resource management	Ensure process for optimum fleet management Ensure adequate equipment e.g. bariatric chairs/trolleys	
Processes	Ensure process in place to engage with Derrycourt to provide staff numbers, training, after event staff welfare.	
Communications	Determine communication means with General Services Lead, staff and Derrycourt Practice using vertical communication	
Training	Participate in MIP testing. Provide protected training time. Log staff training.	
Documentation	Keep a log of all decisions made	
Special situations	Have "all hazards" procedures in place e.g. CBRNe event, Agitated or violent persons	

Activation

Immediately identify the Transport Manager role. Fill this role with the most experienced on-site staff until more senior staff arrive. Get the Action Card.

Actions

- Establish communication with Derrycourt Manager. Ensure off-site staff are called in.

- Establish communication with General Services Lead

- Incoming staff to report to Main Hospital Concourse area

- Allocate staff to different work streams

- Ensure vehicles have fuel and are stocked

- Inform staff of communication processes

- Document the decisions made

Reception

In the Reception phase, the priorities are:

- Teams in ED to create space for incoming patients

- Team in ED to facilitate patient care e.g. x-ray, CT

- Team to support Laboratory

- Teams to facilitate patient transfer from ICU, theatre, wards and clinical areas

- Creation of "rapid response" teams

Definitive Care

Priorities include patient safety, patient flow, staff wellbeing and protection, optimum efficiency. This requires:

- Agree scheduled approach to tasks e.g. blood transfusion, critical care patients, discharges

- Facilitate the creation of Hospital Charts

- Anticipate equipment or specialised resources needed e.g. bariatric wheelchairs

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

Stand-down

The MICT will notify when Hospital Stand-down is declared. At this stage:

- Routine activity resumes

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.12 Medical Physics & Clinical Engineering

The Clinical Engineering Lead has a leadership role to ensure:

- Functioning clinical equipment to support the reconfiguration of clinical areas due to the MI

- Sufficient quantity of clinical equipment for anticipated activity including inter-hospital patient transfers

- Periodic testing of all clinical equipment

- Education of staff in the use of alternative devices

- An ability to repair or replace faulty equipment

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available.	
Work streams	• Liaise with ED leads on critical care capacity and equipment needed • Liaise with Medicine leads on bed capacity and equipment needed • Liaise with Peri-operative leads on theatre, anaesthesia and critical care capacity and equipment needed • Liaise with Diagnostics Leads on radiology capacity and equipment needed • Support the equipment of patient overflow wards	
Processes	• Describe location of equipment that enables bed reconfiguration • Describe the process of cleaning, testing and checking MIP equipment • Describe staff education and training on alternative equipment use during MIP	
ICT	Have contingency plans if ICT systems are disrupted	
Resource management	• Storage and testing of less used equipment. Consider an "Equipment Library" • Procurement of specialised equipment	
Communications	Decide on communication methods Practice using vertical communication between Area/Service, Leads and MICT	
Training	Participate in MIP testing. Provide protected training time. Log staff training.	
Documentation	Document all decisions made	
Learning	Debrief following test and report learning to MIP Committee	
Special situations	CBRNe	

Activation

Identify the Clinical Engineering Lead. Liaise with the MICT and Area/Service leads to determine priorities.

Reception

- Support the reconfiguration of the clinical areas in the ED, ICU and theatre initially

- Ensure staff are familiar with alternative equipment

- Repair or replace any faulty equipment

- Engage with the Operations Lead on additional critical care or overflow beds

- Anticipate future equipment needs e.g. for patient transfer

- Source additional equipment as anticipated

Definitive Care

As patients move to the ward, MI clinical equipment can move from ED to the areas of need.

Good vertical communication with the MICT, Area Leads and Theatre/ICU Managers is important.

- Identify areas requiring additional clinical equipment

- Agree scheduled approach to patient care e.g. intra and inter-hospital transfers

- Anticipate patient needs e.g. cardiac monitoring

- Support the equipment of patient overflow wards

- Offer alternatives equipment where clinical equipment supply is limited e.g. Portable oxygen saturation monitor and manual BP cuff if limited supply of monitors

- Communicate anticipated clinical equipment difficulties with MICT early

- Staff well-being: ensure safe working hours, rest and meals. "Hot" debrief before going home.

Stand-down

The MICT will notify when Stand-down has been declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

4.12 Estates, Environmental Services & Risk Management

The Estates Department has responsibility for the following services on the Connolly campus:

- Electrical power supply

- Natural gas for heating

- Medical gases including oxygen

- Water

- Drainage

- Building infrastructure

- Clinical ventilations systems

- Heating systems

- The consequences of Fire

- Environmental Services: Waste management & Hospital grounds

The effective operation of these services are essential to hospital activity. The Estates Department has contingency plans to manage disruption to many of these Services. However, disruption is possible, even with contingency plans in place. Disruption may:

- Be the event that triggers the declaration of a Major Incident

- Change a Major Incident from a "compensated" event to an "uncompensated" event.

Preparation

Checklist

		√
MIP Plan	Read the plan. Print this section. Have it available. Create action cards for the maintenance of essential services.	
Staffing	Ensure staff contact list is up-to-date. Have a printed copy in MIP box.	
Essential Services	Have systems in place that facilitate checking the integrity of the essential services listed above	
Resources	Ensure the Estates Hub has: MIP box, white boards, emergency contact details, ICT systems and passwords	
Communications	Decide on communication methods. Be familiar with Scribes and Runners.	
Test	Participate in MIP testing	
Training	Consider HMIMMS training of core staff. Provide protected training time.	
Documentation	Create documentation systems that record testing and the integrity of systems. During activation, record decisions made.	
Learning	Implement changes after testing	

Activation

Immediately identify the Estates Lead. Fill this role with the most experienced on-site staff until more senior staff arrive.

- Allocate staff to different work streams

- Ensure the integrity of the services provided

- Liaise with the MICT and their requests

- Determine if there are any special considerations e.g. weather, Class A waste, interruption of utilities etc

Reception and Definitive Care

- In a compensated major incident, normal infrastructure is maintained. In this instance, continue the provision of routine services and facilitate the requests of the MICT

- In an uncompensated major incident, there is disruption to the normal infrastructure. If this disruption is in one of the areas managed by Estates, then contingency planning is required, close liaison with the MICT and Business Continuity Manager.

- Special circumstances include:

  Adverse weather and maintaining "blue light access" on the hospital grounds is a priority

  High risk waste e.g. from Viral haemorrhagic fever should be managed as Class A waste

Stand-down

The MICT will notify when Stand-down has been declared. At this stage:

- Routine activity resumes

- Equipment is restocked and the integrity of systems are checked

- Documentation is stored (logs, white boards, e-mails and messages)

- "Hot" debrief for staff and rosters reviews

Recovery

During recovery, priorities include:

- Staff welfare and wellbeing. "Cold debriefs" occur and external expertise may be provided to support staff

- Resumption of "normal" activity including preparedness for a future major incident

- Review of the MI response including internal processes within the directorate and wider engagement

5. Well-being

A Critical Incident is an incident or event that may overwhelm or threaten to overwhelm our normal coping mechanism. Critical Incident Stress (CIS) is stress associated with this event.

A major incident is an event that requires "an extra-ordinary response" and by its nature can cause CIS

Here is a list of common ways in which people react to incidents like this

Feeling of distress

Feeling of sadness

Strong feeling of anger

Feeling cut off from family or friends

Feeling of disillusionment

Avoidance

Feeling numb or fragile

Bad dreams, nightmares, startling easily

Over controlling and fear of losing control

Flashbacks or distressing memories

Feeling of guilt

Everyone may have these feelings and the intensity may vary within and between people. Whatever you feel at a moment in time is the truth of your circumstance. Giving voice to these feelings reduces their intensity so you can own your feelings and they won't own you.

When things get tough, pro-actively mind yourself. Control the things you can control.

Get more sleep that you think you need. Eat fresh, healthy foods at regular times and avoid snacks.

Get outdoor exercise at least three times a week.

Have a meaningful conversation with someone you like at least once a day.

Resolve what makes you sad or angry or otherwise let it go. Be kind.

Critical Incident Stress

When to find help

Getting help is a sign of strength. It demonstrates maturity and an understanding of what makes us human.

Sometimes, we leave it a long time, simply hoping "things will get better".

However, the earlier we manage the intensity of our feelings, the sooner we regain a our sense of self.

Consider getting help ….

If you feel that your feelings are in charge of you

If you feel overwhelmed and unable to cope

If your stress is not lessening

If your sleep is interrupted

If you startle suddenly or are easily frightened or irritated by loud noise

If you feel alone or isolated and unable to share your problems

If your relationships suffer

If you have lost enjoyment in things

If you are turning to alcohol, food, drugs, cigarettes or anything else for comfort or distraction

Sources of help

- Peer-to-peer support

- HSE Employee assistance programme

- Occupational Health

- Special resources provided after an incident

- Your GP

6. Special Circumstances

This document provides a structured approach to many types of Major Incident. Not all incidents are covered in this and special consideration needs to be given to events such as:

- Chemical, Biological, Radiological, Nuclear or explosive incidents (CBRNe)

- Incidents involving ongoing violence

- Incidents involving Fire, Floods, Fumes or the structural integrity of the hospital

- Extreme weather events

- Long-running incidents

- Loss of essential services e.g. natural gas, electricity or clean water

These all present different challenges, the immediate one being a threat to the safety and well-being of staff and patients and then there is a need for additional expertise.

With time, additional information for these incidents will be available on the:

X-Drive _CHBMAJORINCIDENTPLAN

It will be important then that services likely to be involved with these incidents, download this information, print it and include it in the MIP box, disseminate the information in their area and test their response should such an event occur.

7. Abbreviations

ADON — Assistant Director of Nursing

CBRNe — Chemical, Biological, Radiological, Nuclear and explosive

CCU — Coronary Care Unit

CD — Clinical Director

CDU — Central decontamination unit

CHB — Connolly Hospital Blanchardstown

CNM — Clinical Nurse Manager

CT — Computed tomography

DFB — Dublin Fire Brigade

ED — Emergency Department

EM — Emergency Medicine

HDU — High Dependency Unit

HMIMMS — Hospital Major Incident Medical Management and Support

HSE — Health Service Executive

ICT — Information and communication technology

ICU — Intensive Care Unit

IPC — Infection Prevention and Control

MI — Major Incident

MICT — Major Incident Control Team

MIDAS — Scanning system for notes in Emergency Medicine

MIP — Major Incident Plan

MRN — Medical Record Number

MSW — Medical Social Work

NAS — National Ambulance Service

NEOC — National Emergency Operations Centre

PPE — Personal Protective Equipment

RCSI — Royal College of Surgeons in Ireland

SDW — Surgical Day Ward

TCU — Transitional Care Unit

8. List of Appendices

1	Preparation checklist for Area and Service Leads
2	Blood transfusion guidance during MIP
3	CHB Management of Major Bleeding
4	CHB Management of Novel Anticoagulants
5	CHB death report form
6	CHB guide for the management of a suspicious death
7	CHB ICT systems (Jan 2022)
8	Guidance for completion of staff contact call-in lists
9	Important locations and designated patient areas
10	Triage Sieve
11	Radiology waiver if MIP is activated
12	Sample of CT trauma report—1°and 2° reports
13	Deployment of Scribes and Runners

Appendix 1: Preparation Checklist for Area and Service leads?

Please complete and return to the MIP Implementation Team before March 1st and Sept 1st each year.

Name of Area/Directorate/Clinical Service: _____   Date _____

Name of Clinical Lead: _____

Name of Designated Person for MIP preparedness   _____

Checklist	Answer	√
MIP Plan: Where is it located?		
Staffing: When was you staff call-in list last updated and given to the MIP Implementation Team?		
MIP Box: What have you added or deleted from this box in the last 6 months?		
Space: Have there been any changes in your department or service that could impact on your MIP preparedness in the last 6 months?		
Training: Have any staff undertaken MI training in the last 6 months? **If so, who and what training?**		
Equipment **When was your MI equipment last checked? Are any actions needed?**		
MIP testing 1 **Describe the nature of any MIP test, the number who participated and the main learning outcomes**		
MIP testing 2 **Describe the nature of any MIP test, the number who participated and the main learning outcomes**		

Appendix 2: CHB Process for Blood Transfusion during Major Incident

Blood Transfusion in a Major Incident

When patient ID bands have a barcode use Blood Track to take samples and record transfusion of red cells and platelets.

Known/unknown patient with sample sent to lab and unit label contains ID band details

Select Emergency Transfusion module

Scan your ID

Scan patient ID

Confirm patient details, select proceed

Scan compatibility label

Confirm compatibility label, select proceed

Scan blood component unit number

Scan blood component product code

Confirm unit number, select proceed

If you have more units to hang for the same patient select yes or no as appropriate

If yes, scan additional unit/s

If no, scan barcode on front of printer

Place sticker in patient's transfusion record

Known/Unknown patient with <u>NO</u> sample sent to lab and unit label <u>DOES NOT</u> contains ID band details (e.g. Emergency Units (Pack 1) being transfused)

Select Emergency Transfusion module

Scan your ID

Scan patient ID

Confirm patient details, select proceed

Select '**Tap Here to Give Emergency Blood'**

Scan blood component unit number

Scan blood component product code

Confirm unit number, select proceed

If you have more units to hang for the same patient select yes or no as appropriate

If yes, scan additional unit/s

If no, scan barcode on front of printer

Place sticker in patient's transfusion record

Appendix 3: CHB Management of Major Bleeding

Management of Major Bleeding Guideline
Connolly Hospital, Blanchardstown

Remember to consider pre-hospital blood loss

Major or critical bleeding is defined as:
- Loss of 50% of blood volume within 3 hours **or**
- Blood loss >150ml/min **or**
- Replacement of one blood volume or transfusion 10RCC in 24hr

Tranexamic Acid: lysine analogue, competitive inhibitor plasmin and plasminogen. CRASH II study showed benefit of early administration in bleeding in Trauma.
Loading Dose:1g in 100mL NS over 10 minutes IV
Maintenance Dose: 1g in 100mL NS over 8 hour infusion

Relative risk Death from bleeding	
Tranexamic acid within 1°.	0.64
Tranexamic acid within 1-3°.	0.79
Tranexamic acid > 3°.	1.44

Brain Injuries DO NOT cause hypotension but scalp lacerations can.

Algorithm fot FAST/CT imaging

Damage Control Surgery
- Priority to control bleeding
- Early transfer to ICU
- Minimise triad of "acidosis, hypo-thermia & coagulopathy"

Inotropes should only be used with extreme caution in bleeding patient

Guideline management of bleeding of patients on antithrombotic agents
(For all but warfarin/UFH reversal consultation with on call Haematologist recommended)

Drug	Half life	Blood test	Antidote	Notes
Unfractionated heparin	45-90 min	APTT	Protamine 1mg/100 units of heparin (max 50mg)	May cause allergic reaction or bronchospasm
Low molecular weight heparin	4 hours	Anti X a	If within 8h of drug, Protamine 1mg/100 antiXa units followed by 0.5mg/100 units Given at 5mg/min	Consider rVIIa in life threatening bleed
Warfarin	20 –60 hours	INR	25-50u/kg (Prothrombin complex concentrate (PCC Octaplex) +5mg IV Vitamin K	Max 3000 IU
Direct Thrombin inhibitors eg Dabigatran			Refer to Hospital Guideline on Reversal on Targeted Anticoagulants	
Factor Xa inhibitors eg Rivaroxaban				
Aspirin	5-7 days	Plt function test	2 pools platelets	Risk of surgical bleeding increased only 1.5 fold
Clopidogrel	5-7 days	Plt Function test	2 pools platelets	Keep Platelet > 10 with transfusion
Abciximab	30min but Plt inhibition > 24h	FBC	2 pools platelets	
Tirofiban, eptifibatide	1.5-2.5h	Plt function test	2 pools platelets	
Thrombolytic agents	Effect up to 24h	Thrombin time	If <48 h from administration 50 Hamia 12mls/kg Tranexamic acid 1g tds iv Fibrinogen concentrate	

Special circumstances
Pregnant patient—must displace the uterus and support women in left lateral position.
Resuscitation of mother takes priority. Check Kleihauer test/Flow cytometry. Consider Anti-D.
Liver Failure—consider 10mg IV Vitamin K. Consider Terlipressin if history of variceal bleeding.
Terlipression: 2mg neat over 3-5min. Repeat 1-2mg bolus every 6 hours. See Pharmacy Guide.
(Note stored in Resus/ICU fridge).

Useful Contact Details
Blood Transfusion Lab: Routine Ext 5302. Bleep 158 Out of Hrs. Emergency 5301
Transport/Van man: Bleep 132 and enter 9999. Van man will go directly to lab.
ED Resus: 6259   ED Nurses Station: 6191   CT: 5720   Theatre: 6315/6
Haem Lab: 5305   Biochem Lab: 5312

Management Steps

1 Resuscitation
1. Notify Senior ED Clinician, Surgeons, Anaesthetics. Consider Radiology/Orthopaedics.
2. Put Blood Transfusion on "Stand-by" immediately. Use Ext 5301 for emergencies.
3. Large bore IV access: 2 x 14G or 16G peripheral lines. Consider early Intraosseous (IO) or Central access if necessary
4. ED Bloods: Venous or arterial blood gas for Hb, BE or Lactate, pH and ionised Ca++. Lab: FBC, INR, APTT, Fibrinogen
5. Group & X-Match procedure: For all patients, including unidentified patients, the details on the pre-transfusion sample must be identical to the details (forename, surname, HCRN & DOB) on the patient's ID band.
   This name band MUST be used until "Stand Down" declared.
   Use Blood Track PDA for sample labelling otherwise information must be handwritten and the sample signed as addressographs are NEVER permitted.
6. Consider arterial line
7. Consider Tranexamic Acid early

2 Identification of Source of Bleeding
1. Quantify the volume of blood loss: visual, ATLS Classification
2. Bleeding sites: External, Chest, Abdomen, Pelvis and Long Bones   **On the floor & 4 more...**
3. Tools to help identify source of bleeding:
   External: direct visualisation and ask paramedics
   Chest: CXR. CT. If aortic dissection suspected—CT aortic angiogram, Cardiac Tamponade—beside ECHO
   Abdomen: Unstable—FAST scan/ early laparotomy, Stable & clinical concern—CT Abdomen
   Pelvis: Early Pelvic X-ray. Consider CT or Pelvic Angiogram if significant pelvic injury
   Long Bones: X-ray

3 Rapid Control of Bleeding
Stopping further blood loss is the main priority
External: Pressure, elevation, arterial compression. Consider haemostatic agents. Consider tourniquet (in extremis).
Chest: Chest drain. Need for thoracotomy/aortic stenting requires senior surgical opinion.
Abdomen: Early control of bleeding with packing, direct control & haemostatic agents. Cross clamp aorta—Exsanguination
Pelvis: Temporary closure with sheet or pelvic binder. Formal pelvic ring closure—external fixator.
   Ongoing instability: Operative—pre-peritoneal packing or direct surgical control.
   Interventional radiology—angiography & embolisation
Long Bones—Traction splint eg Thomas splint for femur

4 Perfusion: Oxygenation, Fluids & Temperature
Blood Pressure targets:
No brain injury: Controlled hypotensive fluid regime ("permissive" or "low volume" resuscitation). Aim for "normal" BP for patient
Brain injury (TBI) or Spinal Injury suspected: Aim SBP 80-100mmHg.
Resuscitation Fluid: Crystalloid is initial resuscitation fluid. Possible role for hypertonic solutions and colloids.
Temperature Control: Aim for normothermia. Prevent heat loss. Warm resuscitation fluids/blood.
Hypothermia worsens coagulopathy and increases bleeding

5 Blood Products & Coagulopathies
Target guidelines   (consider individual patient circumstances in all instances)
- Hb 8-10g/L
- Platelets : > 100 if TBI/multitrauma, or >50 if no TBI
- INR <1.5
- APTT ratio <1.5
- Fibrinogen > 2g/L
- Ionised Ca++ (from ABG) > 1mmol/L
- Temp >36°C
- pH > 7.35
- Lactate—trend improving
- Watch for ↑K+

Emergency Transfusion Packs
Pack 1: 2 Units O negative
Pack 2: 4 RCC - Cross matched or Type specific or O negative*
   2 pools LG-Octaplas
   2g Fibrinogen
Platelets: 1 pool if localised bleed, 2 pools if TBI/multitrauma

O positive RCC can be used for all men and for women ≥55yrs

In major trauma there is a consumption and dilution of clotting factors which aggravates bleeding and causes a coagulopathy. Fibrinolysis (clot breakdown) is also increased. The aim of treatment is to
a) ensure sufficient platelets, clotting factors and fibrin to form a clot
b) prevent further clot breakdown.

6 Stand down/ Debrief
1. Inform blood transfusion of "Stand Down"
2. Ensure that the patient has the correct name band with updated patient identifiers
3. Send a new Type & Screen sample to the lab with the updated identifiers.
4. This sample will be used for future blood products.

If a haematology opinion is needed out of hours: Contact Beaumont Hospital Switch and ask for the CONSULTANT HAEMATOLOGIST on call.

Guideline issued by Hospital Transfusion Committee. Operational from 1st March 2019 until further notice (Document number W1-HV-0019 Rev. 3)

Appendix 4: CHB Management of Targeted Anticoagulants

Guideline: Management of Bleeding for patients on Direct Oral Anticoagulants
Connolly Hospital, Blanchardstown

The principles of Resuscitation, Identification of source, Rapid control of bleeding, Optimising perfusion, Use of blood products and Stand-down still apply.
Please refer to the Connolly Hospital Guideline on the Management of Major Bleeding

Factor Xa Inhibitors:

Generic	Trade
Rivaroxaban	Xarelto
Apixaban	Eliquis
Edoxaban	Lixiana

Note! Generic names all have Xa in the name!

Direct Thrombin Inhibitors

Generic	Trade
Dabigatran	Pradaxa
Argatroban	Argatroban

Note! Generic names all have T in the name!

Algorithm for the management of patients on Direct Oral Anticoagulants

1

Stop: Direct oral anticoagulants (Factor Xa inhibitors or Direct thrombin inhibitors)

Stop: Anti-platelet agents (e.g. aspirin, clopidogrel, prasugrel, ticagrelor)

Stop: Other anti-coagulants (e.g. heparin, low molecular weight heparin)

2

Specific laboratory investigations   Do not wait for results to start treatment

FBC/Renal Profile/Coagulation screen (PT and APTT)/Fibrinogen

3

Minor/Moderate bleed

Mechanical compression/elevation

Tranexamic acid (local wound soaks or 5% mouthwash or 1g TDS PO

Major bleed*

Tranexamic acid 1g TDS IV: 1g in 100mL 0.9% NaCl over 10 min

Refer to Connolly Management of Major Bleeding guideline

Consider platelet transfusion if on an anti-platelet agent

Identify and definitively control the source of bleeding

Consider

Factor Xa inhibitor ingestion: Prothrombin Complex Concentrate (Octaplex) 25-50 IU/Kg. Max dose 3000 IU (stored in Lab)

Direct Thrombin Inhibitor Ingestion—Dabigatran only

Idarucizumab (Praxbind)- 5g in 100mL stat infusion, given as 2 x 2.5g in 50mL consecutive infusions

Stored in fridge in Clinical Room in ED and in Pharmacy

Direct Thrombin Inhibitor Ingestion—excluding Dabigatran

FEIBA (a specific PCC) 80 U/Kg   (stored in Lab)

Haemodialysis

Consider Oral Charcoal if ingestion < 2 hours

If a haematology opinion is needed out of hours: Contact Beaumont Hospital Switch and ask for the CONSULTANT HAEMATOLOGIST on call.

*A major bleed is a symptomatic bleed in a critical area or organ eg intra-cranial, intra-spinal, intra-ocular, retroperitoneal, intra-articular, pericardial or intra-muscular with risk of compartment syndrome or
A drop in Hb >2g/dL or 2 RCC blood transfusion

Useful Contact Details
Blood Transfusion Lab: Routine Ext 5302.   Bleep 158 Out of hrs. Emergency 5301
Transport/Van man: Bleep 132 and enter 9999. Van man will go directly to lab.
ED Resus: 6259   ED Nurses Station: 6191   Theatre: 6315/6
Haem Lab: 5306   Biochem Lab: 5312

Guideline issued by Hospital Transfusion Committee. Operational from 3rd June 2020 until further notice. Document number HH-HTC-0021 Rev. 3

Appendix 5: CHB Hospital Death Report form to Coroner

REPORT TO CORONER OF A DEATH IN HOSPITAL

DUBLIN DISTRICT CORONER
Date of report____/____/20____ Reporting Hospital_____ Reported by_____Grade_____Contact Number_____ Consultant_____
Deceased Name _____ Date of Birth____/____/____   Hospital Number_____ Address_____ Family Contact Name & Number_____ Gender Male * Female * Admitted on ___/___/20__
REASON FOR REPORTING TO CORONER
If COVID related death : date of positive swab
BRIEF CLINICAL ACCOUNT
(2) Co-morbidities
Probable Cause of Death, if known _____ _____
NAME OF **USUAL** GP _____ Telephone _____ Address _____
*The Coroner's office will advise the reporting doctor or their team as to the decision of the Coroner on the next working day. The Coroner may be contacted directly out of hours by mobile phone, if the matter is **urgent**.* This form should be emailed to dublincoroner@justice.ie

Appendix 6: Guideline for the management of a suspicious death

When a sudden, unexplained, suspicious or criminal death occurs in the ED, certain procedures need to be followed. This will aid any Gardai investigation and allow for the chain of evidence to be kept intact.

The Remains:

Once death is pronounced the body, all tissues from the body and all the property on the body come under the ownership of the Coroner.

In order to preserve forensic evidence a member of the Gardai will secure the remains until after the autopsy. They will keep a record of anyone who is near or around the body.

All lines, Chest drains, ET tubes, bandages and electrodes need to be left in place.

No cleaning or washing to be performed on the remains.

Remains are placed into a body bag – No need to double bag unless leakage is an issue.

Property:

A detailed itemised list of any property that was removed or cut off needs to be documented in the presence of both the Nurse and the Gardai.

The property is placed into an official forensic evidence bag. **Both** then co-sign the property list. The original list is kept with the patient's notes and a copy given to the Gardai.

Property left on the remains should **not** be removed or disturbed by staff, as this will be done in the Dublin District Mortuary.

Identification:

Identification tags should be applied – ankle and wrist.

In a State forensic case family **identification is not carried** out until after the autopsy, therefore family may not view the body in the Emergency Department.

Family need to be aware of these procedures – a Garda Liaison will be assigned to the family.

Investigations:

Any blood samples taken immediately on admission and prior to any transfusions or medications being given are of great value, and should be handed over to the Gardai.

A Covid swab can be done prior to transport to the Dublin District Mortuary but must be taken in the presence of the Gardai. The name and details of the person taking the swab will be required. Results must then be forwarded to the Dublin District Mortuary.

Documentation:

Copy of ED card, Ambulance record sheet, Doctor's and Nurse's notes to be sent with the remains.

Patient's chart can be formally requested by the Coroner's office.

Death Notification sheet to be completed and forwarded to the Hospital Mortuary.

The ED protocol book for deaths within the department also needs to be completed and signed.

Transport:

Transport is to the Dublin District Mortuary and is arranged by the Coroner and Gardai.

To prevent contamination the remains **should not be transferred** to the Hospital Mortuary but go directly to the Dublin District Mortuary from ED.

Appendix 7: ICT Systems in CHB (Jan 2022)

ICT system	ICT system stakeholders	Support - Location
IPMS	Vendor: DXC	National DATA Centre (NDC)
	National IPMS team	
	RCSI Hospital Group IPMS team	
	Local IPMS Team	
	OOCIO- Citrix team (Tech Platform)	
Symphony	Vendor: Emis	National DATA Centre (NDC)
	Super users	
	OOCIO- Tech Platform & Tech Operations	
	TIOs	
	ICT Lead	
EndoRAD	Vendor: Manitex	National DATA Centre (NDC)
	TLOS	
	ICT Lead	
	Super users	
Track and Trace theatre	Vendor: Fingerprint Medical	National DATA Centre (NDC)
	OOCIO - Citrix team	
	Super users	
Telepath	Vendor: Dedalus	National DATA Centre (NDC)
	OOCIO- National Network team	
	Super users	
	ICT LEAD	
VOI phoneline	Joe MacManus, OOCIO and PfH Engineers	On SITE
	call has to be logged on Ivanti & assigned to	
	Voicecomms team	
Internet	OOCIO National Network Team	National DATA Centre (NDC)
	Jason Giltrap	
	Eoin Reilly	
Software	OOCIO	TLOS shared folders
	Plus technical liaison officers,	
	Software Purchased from Vendor: Software One	
Comms rooms	Approx 35 areas	Connolly Site
G2 Speech recognition	Vendor: G2 Speech	National DATA Centre (NDC)
	Super User (Niamh Reid)	
	TLOs	
Exchanage Servers- Email system	OOCIO- Tech Compute	National DATA Centre (NDC)
	TLOS	

ICT Lead engages with all of the above, including Vendors, Office of Chief Information Officer (OOCIO), different teams, TLOs etc

Appendix 8: Guidance for completion of staff contact call-in lists

Guidance for the completion of Staff Contact Call In lists

Communication is the cornerstone of the Major Incident (MI) Response and having accurate and up-to-date contact lists is the first step. This sheet is to provide guidance on the governance and processes for ensuring that Switch has the correct staff contact details on the DAKS system.

Overview

Once the Major Incident Control Team (MICT) activate the MI Plan, either Switch or the MICT press the "Activate" button on the DAKS control panel.

This initiates an automated call to all staff "Function Groups". Approximately 30 calls can be made per minute, so a priority system is needed to ensure that the best skill mix of staff are called in.

An automated message is given once the call is answered and the staff member replies stating whether they can attend or not. The system records the reply and produces a report.

Completing the staff contact list

A	B	C	D	E	F
	Connolly Hospital Major Incident Plan staff call in list for DAKS phone system				
Date					
	Area or Service Name:	_This is the function group_			
How to complete this list					
1. Enter the date					
2. Enter the name of your Area or Service (as per the language of the Major Incident Plan e.g. Medical Directorate, Elm ward or Clinical Services, Occupational Health)					
3. Include all staff in your area e.g. nurses, doctors, healthcare assistants, clerical staff etc					
4. Create two sub-groups: one with senior staff and the other with junior staff.					
5. Ensure all staff required for the MIP repsonse are included in a sub-group					
6. Prioritise the urgency of the call going to that person. Allocate 9 for high priority, 5 mid-priority, 1 least priority. Priority should be given for Senior staff, those with MI training or those living locally					
7. If the MI Plan is activated, then 35% of staff in the Senior Staff sub-group and 35% of staff in the Junior Staff sub-group will be contacted to come in. If there is no reply, a call will go to the next priority person on that					
Function Sub-group: Senior Staff			_This includes Senior Staff, Long-standing staff, Staff with Major Incident training or experience_		
Priority (9, 5 or 1)	Surname	First Name	Job description	Mobile phone number	Alternative phone number

Appendix 9: Important locations and designated patient areas

Key Phases	Action	Location
Command & Control	Major Incident Control Team (MICT)	Endoscopy Meeting Room
	Operations	Patient Flow Office
Activation phase: ED preparation	Medical Patients in ED awaiting admission	Endoscopy
	Surgical specialties patients in ED awaiting admission	Endoscopy
	Mental health patients in ED awaiting assessment/ admission	Ash/Pine
	Patients with possible significant transmissible illness	ED Zone 3
Reception phase: Patient arrival	Triage Area	ED Ambulance doors
	Red Area – Priority 1 patients	ED Resus—Zone 1 and Zone 4
	Yellow Area – Priority 2 patients	ED Zone 1
	Green Area – Priority 3 Patients	ED Zone 2
	White Area – Deceased patients	Mortuary
	Staff Allocation Area	Main Hospital Concourse
	Discharged patients from wards	Rosewood ward
Definitive Care: MIP patients	Surgical MIP Admitting Ward	Laurel Ward
	Surgical MIP Admitting Ward—Backup	Redwood Ward
	Medical MIP Admitting Ward	Elm Ward
	Medical MIP Admitting Ward—Backup	Maple
	Overflow ward	Cedarwood
Support Services	Relatives and survivors	Canteen in Administration Building
	Social Workers and Pastoral Team	Room 8, beside canteen (Administration Building)
	Garda Casualty Bureau	Academic Centre Interview Room
	Media area	Academic Centre – Room 3
	Vacant	Board Room, Administration Building

Appendix 10: Triage Sieve
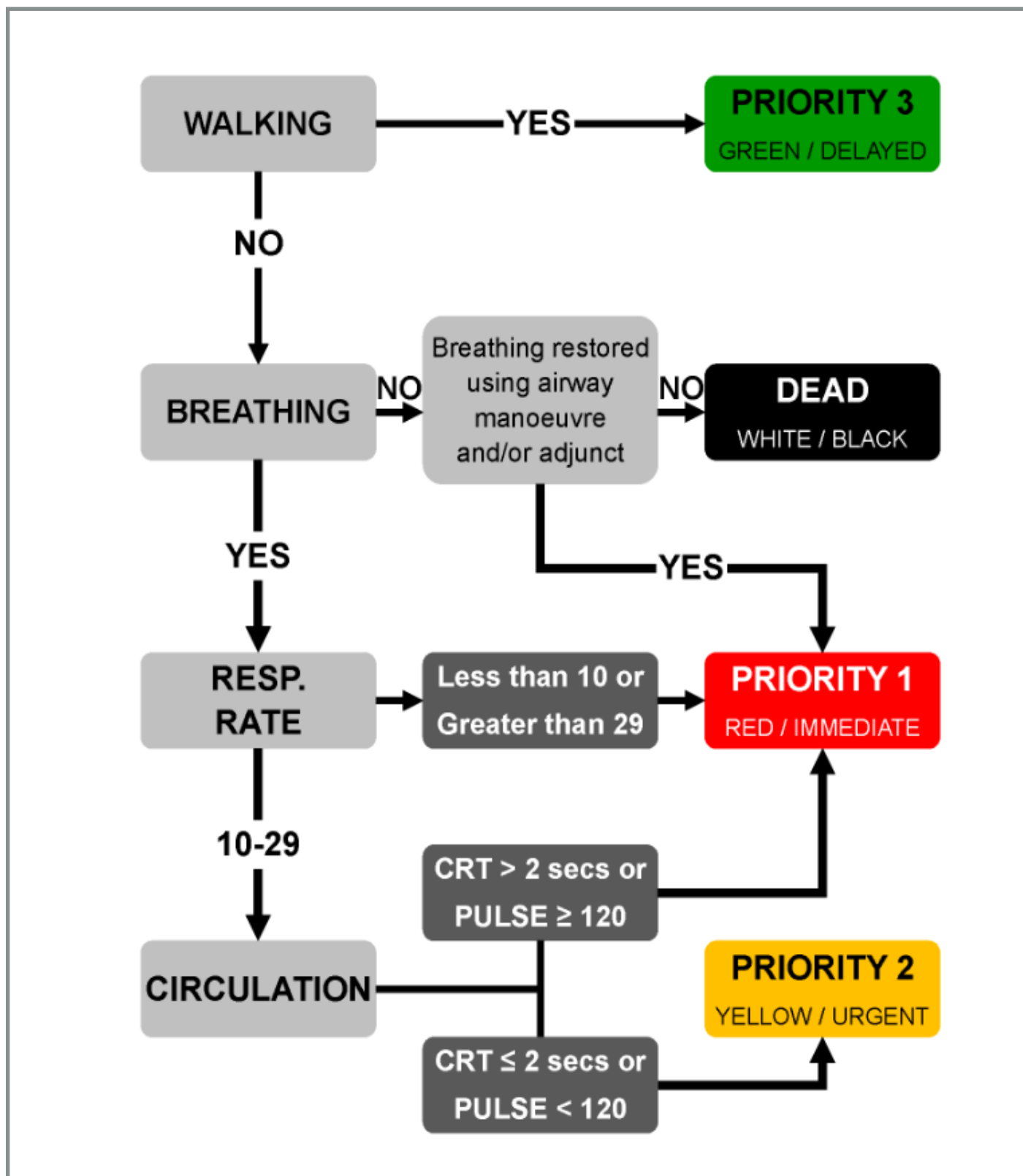
Appendix 11: MIP Radiology Waiver form Available on the X-Drive

_CHB MAJOR INCIDENT PLAN

Radiology waiver in the event of a Major Incident Plan being activated in CHB

Given the nature of the incident, the Radiology and Radiography Leads, in conjunction with the other Clinical Leads, have determined that the following Waiver can be used in order to expedite emergency Radiology procedures. This form may only be used for the duration of the major incident, which will be determined by the MICT. Once the Major Incident has been declared over then the normal forms and relevant information shall be required.

Attach Patient sticker or insert :

Patient name

MRN

Gender

DOB

Indicate any Patient allergies

Pregnancy waiver

By signing this form:

I acknowledge and I am aware of the risks of possible Foetal irradiation during the requested Radiology procedure. After having taken into account the possibility of pregnancy and made every effort to determine the dates of the patient's last menstrual period, **I am waiving the 10 day rule**, as I deem it necessary to irradiate between the diaphragm and symphysis pubis of this patient given the nature of the incident and the patient's clinical condition. Therefore a clinical decision has been made to proceed to Radiology for imaging which uses ionising radiation, even though there is a real and significant risk to the foetus should this patient be pregnant.

I acknowledge and I am aware of my responsibilities as a **Referrer** under the Radiation Protection Legislation.

eGFR

Given the nature of the incident and the patient's clinical condition, a clinical decision has been made to proceed to CT/Interventional Radiology for imaging which may include the use of intravenous iodinated contrast agent, in advance of any recent eGFR result being available.

Risk of contrast-induced hypersensitivity reaction

Given the nature of the incident, the patient's clinical condition and the patient's history of increased risk of contrast-induced hypersensitivity reaction (e.g. asthma, atopy), a clinical decision has been made, after discussion with the Consultant Radiologist, to proceed to CT/Interventional Radiology, where the use of intravenous iodinated contrast agent may be required for imaging purposes.

A medical practitioner will be present in CT for the contrast injection.

Please circle **'a'** or **'b'** or **both**' as appropriate

 a) Proceed straight to CT with medical supervision of contrast injection
 b) Administer 100mg IV hydrocortisone and then proceed to CT with medical supervision of contrast injection

Referring Medical Doctor's Name in Print _____   Date _____

Referring Medical Doctor's Signature _____   MCRN _____

Connolly Hospital Blanchardstown Major Incident Plan

Appendix 12: Sample of CT report for Trauma— 1° and 2° reports

Appendix 3. CT primary assessment

Patient name:

Date of scan:

Reporting radiologist:

Purpose: To guide initial management only. Formal detailed report will follow on results server.

Airway			
ET placement	N/A	Satisfactory	Unsatisfactory
Airway obstruction		Yes	No

Breathing			
Pneumothorax		Yes	No
Contusion		Yes	No
Laceration		Yes	No
Chest drain placement	N/A	Satisfactory	Unsatisfactory

Circulation (Bleeding)			
Thoracic		Yes	No
Abdominal		Yes	No
Pelvic		Yes	No
Soft tissue		Yes	No

Disability			
Intracranial bleed/oedema		Yes	No
Major spinal injury		Yes	No

Clinician contact	Name	Phone/bleep
ED		
Orthopaedic		
General surgery		
Vascular surgery		
Anaesthetic		
Neurosurgery		

Appendix 4. Secondary trauma report

Date:		Time:
Name:		DOB:

CT head:		
C-spine		Reformats reviewed
T & L spine		Reformats reviewed
Pelvic bones		

Chest		Reformats reviewed
Vascular injury		
Chest wall (ribs)		
Lungs		
Diaphragm		
Mediastinum		
Pleural space		
Other findings		Other structures normal

Abdomen\Pelvis		Reformats reviewed
Free gas		
Bowel/mesentery		
Peritoneal fluid		Haemoperitoneum
Vascular injury		
Spleen		
Liver		
Pancreato-biliary		
Renal/adrenal		
Retroperitoneum		
Bladder		CT cystogram
Other findings		Other structures normal
Delayed imaging		
Rectal contrast		

Conclusion:		

Additional text sheet	Yes/No
Neuroradiology radiology reviewed by:	Copy to neuro room
Musculoskeletal radiology reviewed by:	Faxed to MSK 28241
Body imaging reviewed with:	Copy body CT slot
Reported by:	Faxed to:

Appendix 5. Guidance on the indications for non-operative management (NOM), interventional radiology (IR) and damage control surgery (DCS) in the SIP

Decisions regarding IR or DCS will be modified according to the facilities and staff available and the patient's stability at presentation[25]

Site	NOM	IR	DCS
Thoracic aorta	No role except in small partial thickness tears	Stent graft for suitable lesions	Ascending aortic injury or arch injury involving great vessels
Abdominal aorta	No role	Occlusion balloon, stent graft for suitable lesions	Injury requiring visceral revascularisation or untreatable by EVAR
Peripheral or branch artery	No role	Occlusion balloon, stent graft or embolisation	Any lesion which cannot rapidly be controlled or which will require other revascularisation
Kidney	Subcapsular or retroperitoneal haematoma without active arterial bleeding	Active arterial bleeding, embolisation or stent graft	Renal injury in association with multiple other bleeding sites or other injuries requiring urgent surgical repair
Spleen	Lacerations, haematoma without active bleeding or evidence of false aneurysm	Active arterial bleeding or false aneurysm. Focal embolisation for focal lesion. Proximal embolisation for diffuse injury	Packing or splenectomy for active bleeding in association with multiple other bleeding sites
Liver	Subcapsular or intraperitoneal haematoma or lacerations without active arterial bleeding	Active arterial bleeding. Focal embolisation if possible. Non-selective embolisation if multiple bleeding sites demonstrated, as long as the portal vein patent.	Packing if emergency laparotomy needed with subsequent repeat CT and embolisation if required
Pelvis	Minor injury with no active bleeding	Focal embolisation for arterial injury (bleeding, false aneurysm or cut-off)	External compression and subsequent fixation if bleeding from veins or bones
Intestine	Focal contusion with no evidence of ischaemia, perforation or haemorrhage	Focal bleeding with no evidence of ischaemia or perforation. Or, to stabilise patient, allowing interval laparotomy pending treatment of other injuries	Ischaemia or perforation requiring laparotomy +/- bowel resection

Appendix 13: Deployment of Scribes and Runners

The table below is to support the deployment of Scribes and Runners once the MIP is activated:

Area or Service	Scribe's name	Priority	Runner's name	Priority
MICT		🟥		🟥
Operations		🟥		🟥
Staff Allocations		🟧		🟧
EM Leads		🟥		🟥
Peri-operative Leads		🟥		🟥
Diagnostics Radiology		🟥		🟧
Diagnostics Laboratory		🟧		🟥
Medical Leads		🟧		🟧
Pharmacy		🟩		🟩
Clinical Services		🟧		🟩
General Services		🟧		🟧
Information Management		🟥		🟧
Administration				
Medical Physics & Clinical Engineering				
Estates		🟩		🟩

Colour	🟥	🟧	🟩
Priority	Immediate	Fill early	Fill when staffing permits

Thank you for reaching this page