**GLASGOW ROYAL INFIRMARY**

**MAJOR INCIDENT PLAN**

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**Date:** **October 2021**

**Review:** **October 2023**

**V9finaldraft**

**STOP**

**IF A MAJOR INCIDENT HAS BEEN DECLARED AND YOU HAVE NOT READ THIS PLAN**

**DO NOT READ IT NOW**

**FIND YOUR RELEVANT ACTION CARD AND FOLLOW THE INSTRUCTIONS**

**IF YOU DO NOT HAVE A SPECIFIC ACTION CARD ATTEND YOUR NORMAL PLACE OF WORK AND NOTIFY YOUR LINE MANAGER**

**YOU MAY BE DIRECTED TO THE STAFF HOLDING AREA (BOARDROOM) PENDING REDEPLOYMENT**

**PLEASE WEAR YOUR STAFF ID BADGE AT ALL TIMES**

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Hospital General Manager ………………………………………………………………

Chief Nurse or Deputy ……………………………………………………………………..

Senior Facilities Manager …………………………………………………………........

First Responder to Major Incident room………………………………………………..

Loggist……………………………………………………………………………………...

Senior Emergency Physician ……………………………………………………………

Senior Porter ………………………………………………………………………………..

Chargehand Security Officer ……………………………………………………………

Emergency Department Senior Doctor on Duty ………………………………………..

Emergency Department Senior Nurse …………………………………………………

Senior Nurse AAU ………………………………………………………………………….

Emergency Department Triage Officer ………………………………………………..

Emergency Department Health Records Clerical Staff ………………………………...

Emergency Department Resuscitation Room – Junior Medical Staff ………………….

Emergency Department Majors Area – Junior Medical Staff …………………………..

Emergency Department Minors Area– Junior Medical Staff …………………………...

Senior Surgeon ……………………………………………………………………………...

Senior Orthopedic Surgeon ………………………………………………………………..

Plastic Surgery……………………………………………………………………………….

Senior Physician …………………………………………………………………………….

Senior Intensivist ……………………………………………………………………………

Senior Anesthetist …………………………………………………………………………..

Senior Nurse Intensive Care Unit …………………………………………………..

Haematology BMS …………………………………………………………………….......

Radiology …………………………………………………………………………………….

Biochemistry BMS ………………………………………………………………………….

Emergency Duty Commitment Pharmacist ………………………………………………

Chaplaincy Coordinator …………………………………………………………………

Physiotherapy ……………………………………………………………………….......

Senior Catering Manager ………………………………………………………………….

Bed Manager ……………………………………………………………………………….

Senior Nurse Theatres …………………………………………………………………….

Senior Nurse Medical and Surgical High Dependency Unit …………………………..

Senior Nurse Acute Receiving Ward ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, ………………..

Senior Nurse Downstream Ward ………………………………. …………………….

Senior Nurse Ward Plastics and Burns Wards …………………………………………

Press Officer ……………………………………………………………………………….

High Profile Patient……………………………………………………………………

Surgical Escalation Plan…………………………………………………………………………

Important Phone Numbers – Internal ……………………………………………………

Useful Phone Numbers – External …………………………………………………….

**ONE PAGE OVERVIEW**

- Initial Major Incident (MI) notification will come from both the NHS Greater Glasgow & Clyde (NHSGG&C) Contact Centre and the Scottish Ambulance Service (SAS).
- Casualties may start to arrive before the MI notification takes place.

The overall hospital response is controlled by the Hospital Coordination Team.

This team consists of:-

| Team Members | In Hours | Out of Hours |
|---|---|---|
| Hospital Medical Co-ordinator | On-Call DME Consultant | On-Call DME Consultant |
| Hospital General Manager | ECMS General Manager | On-Call Hospital Manager |
| Senior Emergency Physician | ED Consultant | ED Consultant |
| Senior Nurse / Clinical Co-ordinator | Chief Nurse or Deputy plus Clinical Co-ordinator | Clinical Co-ordinator On-Call |
| Senior Facilities Manager | Facilities General Manager | On-Call Facilities Manager |

SAS will notify the hospitals of the declaration of a MI.

SAS and EMRS Scotland will provide pre-hospital medical care and will fill the roles of Medical Incident Officer (MIO) and site medical teams. They will triage casualties to the most appropriate facility.

Hospital sites will **NOT** be expected to deploy medical teams to the site of an incident

Initial Actions

- As soon as MI notification is received in the ED start a log of key decisions and actions taken (this applies to all areas with a critical role in MI response)
- Initiate communication cascades to off-duty staff (prepopulated Whatsapp groups or similar)
- In the event of a traumatic incident – immediately notify Theatres/Critical Care/Radiology
- Emergency Department (ED) to establish Triage at the Ambulance entrance and allocate staff to treatment areas.
- Clear the ED. Immediate transfer to green beds, push initially into SATA
- Limit Imaging requests unless directed by Senior ED clinician
- Update the Control Room at a maximum of 30 minute intervals
- If you have a role within the MI Plan, follow your Action Card
- If you do not have a role within the Major Incident Plan attend your normal place of work and report to your Line Manager
- You may be redeployed
- Standby staff to undertake subsequent shifts so that the initial responders do not become exhausted. Hold 1/3 of staff in reserve as a rule of thumb
- Patient’s relatives are directed to the Campsie Dining Room

**MAJOR INCIDENT ACCESS**

**In the event of a Major Incident**:

- MI Control Room staff should proceed directly to the Control Room. In the event of a site lock down On-Call MI Control Room staff should report to the Security Control Room on the Lower Ground Floor of the Princess Royal Maternity at the Wishart Street entrance.
  **(Phone: 2116398/56398)** Security will escort them to the Hospital Control Room which is situated in the Plastics Seminar Room on Level 1 of the Jubilee Building.

  **Keys and door keypad codes are held by Ward 45 opposite the Seminar Room.**

  The Hospital Medical Co-ordinator (On-Call DME Consultant) should where possible, enter via the ED and take a brief SITREP (Situation Report) from the ED Consultant before proceeding to the Control Room.

- Entry to the Friends and Family Reception area - Campsie Dining Room restaurant (Phone 531 9120 /69120) will also be via the Princess Royal Maternity entrance at Wishart Street Lower Ground Floor. Security will open the area on arrival.

- All other Nursing, Medical, Facilities and additional (off-duty) staff should report to their normal place of work or to the Board room pending deployment (Phone: 451 5372/85372). These staff will access the hospital via the Centre Block entrance of the Main Building at Castle Street. Staff should report to the security desk on the Ground floor at Centre Block on arrival at which point security will unlock the appropriate area.

- The Staff Log (Appendix) will be completed by a nominated Person in Charge for all staff attending. Staff availability should be regularly reported to the Control Room.

**Major Incident**

**'Events that owing to the number, severity, type or location of live casualties require special arrangements to be made by the Health services'**

**Legal Requirement to Plan**

The Civil Contingencies Act 2004 https://www.legislation.gov.uk/ukpga/2004/36/part/1/crossheading/contingency-planning stipulates that responders should plan for situations that meet either or both of the following criteria:-

- Where the emergency is likely to seriously obstruct our ability to perform our functions.
- Where we consider it necessary to act to prevent, reduce, control or mitigate the effects of an emergency and would be unable to act without changing the normal deployment of our resources.

**Civil Contingencies: Terms of Reference overview**

"Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by one or more territorial and/or special Health Boards simultaneously or in support of each other. It requires considerable resources and strategic input as it potentially threatens the survival of an organisation."

The complete Civil Contingencies Terms of Reference can be found in Appendix 12.

**Hospital MI Medical Management**

All hospitals within NHS GG&C have adopted a locally modified version of the Hospital Major Incident Medical Management System (HMIMMS). This text that supports this system is available from the following link http://www.alsg.org/uk/HMIMMS

**Key Locations for GRI MI Plan**

| | | |
|---|---|---|
| **Hospital Control Room** | **Plastics Seminar Room**<br><br>**1st Floor Jubilee Building** | **Keys and Door Code**<br><br>**Ward 45** |
| **Friends and Family Reception Area** | **Campsie Dining Room**<br><br>**QEB** | **Facilities**<br><br>**Security** |
| **Staff Deployment/Redeployment Area** | **Boardroom**<br><br>**Centre Block** | **Security**<br><br>**Centre Block** |
| **Police Casualty Bureau** | **Clinic 1**<br><br>**QEB** | **Outpatients**<br><br><br>**Security OOH** |

**Governance of the Hospital MI Plan and Response Capability**

Planning, training and upkeep of response resources is overseen by the Hospital Major Incident Committee. Primarily consisting of those who will lead the response, this group is chaired by the Lead ED Consultant for Hospital MI Planning, and meets quarterly.

**Terms of Reference**

**Purpose**

The MI Committee will be responsible for ensuring that the North Sector has an up to date MI Plan and that this is reviewed regularly and training and exercising is completed.

This Committee will ensure that they develop and maintain contingency plans to address any threats / risks to service delivery in line with relevant legislation and guidance.

**Terms of Reference**

The Committee will:-

- Support MI and Business Continuity planning across the GRI site during an incident.
- Review and implement the Acute Division Major Incident and Business Continuity Plans along with the local GRI plan.
- Develop and monitor training relevant to the MI plan.
- Ensure relevant information sharing protocols are in place with all staff within the North Sector.
- Review lessons learned from emergencies and exercises locally, regionally, nationally and internationally taking actions forward to improve plans and procedures where this is appropriate.

**Membership**

The membership of the North MI Committee is as follows:-

ED Consultant (Chair & MI Lead)

Chief of Medicine

Chief Nurse

Clinical Co-ordinator

Acute Medicine Consultant

Surgical Consultant

Anaesthetics Consultant

Orthopaedics Consultant

Burns and Plastics Consultant

ICU Consultant

DME Consultant

GM for ECMS

Theatres Manager/ Lead Nurse

Facilities Manager

ED Lead Nurse

Critical Care Lead Nurse

I.T. Representative

Estates Manager

Radiology Manager / Lead Radiographer

Civil Contingencies representative

Health Records representative

Radiation Protection Advice (RPA)

Other individuals with an interest in MI planning will be welcomed.

**Frequency of Meetings**

The Committee will meet on a quarterly basis to fulfil its purpose, although this may be varied at the discretion of the Chair / Vice-Chair.

**Reporting Arrangements**

The Committee will report to the North Sector Clinical Governance Board with written reports and or verbal updates when required.

**Agenda and Papers**

Agenda items and papers for the meeting should be submitted to the Chair at least 2 weeks prior to the meeting and papers to be sent no later than one week.

**Quorum**

Four members of the Committee must be present to make the meeting quorate.  If the meeting is not quorate, then it may proceed however any issues or recommendations will be subject to agreement by other members, either at the next meeting or via e-mail if deemed urgent.

**Hospital Designation**

Designated hospitals will be contacted directly by the Ambulance Control Centre and be informed that a MI has been declared.

The Ambulance service will also notify the NHSGG&C Contact Centre who will start the MI staff call-out procedure using the **Liberty callout system**. Liberty contacts a pre-populated list of individuals across NHSGGC. Contact is made via details held on the Rotawatch system.

It is essential that details held on Rotawatch are correct.

It is essential that communication cascades are in place from these initial contact points.

Once notified, GRI must activate its Emergency plan to create the capacity to receive up to:-

EIGHT (8) P1 casualties (requiring immediate intervention)
THIRTY (30) P2 casualties (requiring urgent intervention)

Children under the age of sixteen should be taken directly to the Royal Hospital for Children (RHC). In the event of RHC being potentially overwhelmed, children over the age of 12 may be triaged to adult sites.

The Minor Injuries Units (MIU) at Stobhill Hospital and the Victoria Hospital may have a support role in treating suitable minor injury patients triaged from GRI and QEUH but should not receive casualties directly from the emergency services.

The Gatehouse facility at GRI may be used to treat minor injuries.

**Hospital Casualty Preparedness**

| | | | |
|---|---|---|---|
| **GRI:** | **P1 Eight (8)** | and | **P2 Thirty (30)** P2 |
| QEUH: | P1 Twelve (12) | and | Fifty (50) |
| RAH: | P1 Five (5) | and | P2 Twenty (20) |
| IRH: | P1 Three (3) P1 | and | P2 Ten (10) |
| RHC: | P1 Eight (8) | and | P2 Thirty eight (38) |

* Refer to appendices for Triage system. Given the difficulty differentiating P1/P2 casualties they are often classed as a single category requiring immediate care.

**SCOTTISH MAJOR TRAUMA NETWORK**

GRI is a designated Trauma Unit (TU) within the national Major Trauma Network (MTC). QEUH is the designated MTC.

Patients are triaged to appropriate facilities using the Major Trauma Triage Tool (see appendix). In the event that QEUH becomes overwhelmed, patients fulfilling Major Trauma criteria may be diverted to other sites by SAS/EMRS.

A proposed distribution plan for the first 4 hrs for P1/P2 casualties is as follows (though this may be skewed by the type of casualties involved e.g. Head Injury, Burns, Paediatrics)

Divert of other activity will be considered by the On-call Director and discussed with each site pending agreement.

| | **5 casualties or less** | **5-10 casualties** | **10-15 casualties** | **15-20 casualties** | **20-28 casualties** |
|---|---|---|---|---|---|
| **Glasgow Royal Infirmary** | | **2** | **4** | **6** | **8** |
| **Inverclyde Royal Hospital** | | | | | |
| **Queen Elizabeth University Hospital** | **5** | **7** | **9** | **11** | **14** |
| **Royal Alexandra Hospital** | | **1** | **2** | **3** | **6** |
| **Adult Total** | **5** | **10** | **15** | **20** | **28** |
| **Royal Hospital for Children** | **5** | **8** | | | |

**MAJOR INCIDENTS WITH MASS CASUALTIES**

In the event of a Major Incident with Mass Casualties as declared by SAS, sites will be requested to respond across Health Board boundaries. The proposed figure is >28 casualties from a single incident.

Initial designated response for GRI is the reception of 12 casualties in the first hour

2019-08-26-item-8.2b-appendix-1-mimc-national-plan-for-nhs-hscps-2019.pdf (nhs24.scot)

**‘Major Incident – Standby’ Notification**

The normal channel for notifying NHSGG&C of a MI is via the ambulance service. When the emergency services first suspect that a MI may have occurred the Ambulance Control Centre will identify the hospitals likely to be involved and alert them directly via the MI Standby phone **(0141 211 4090)**

This alert will be a **‘Major Incident – Standby’**.

The ambulance service will then alert the NHSGG&C Contact Centre who will activate the Liberty call out system for all staff with a response role within the designated hospitals.

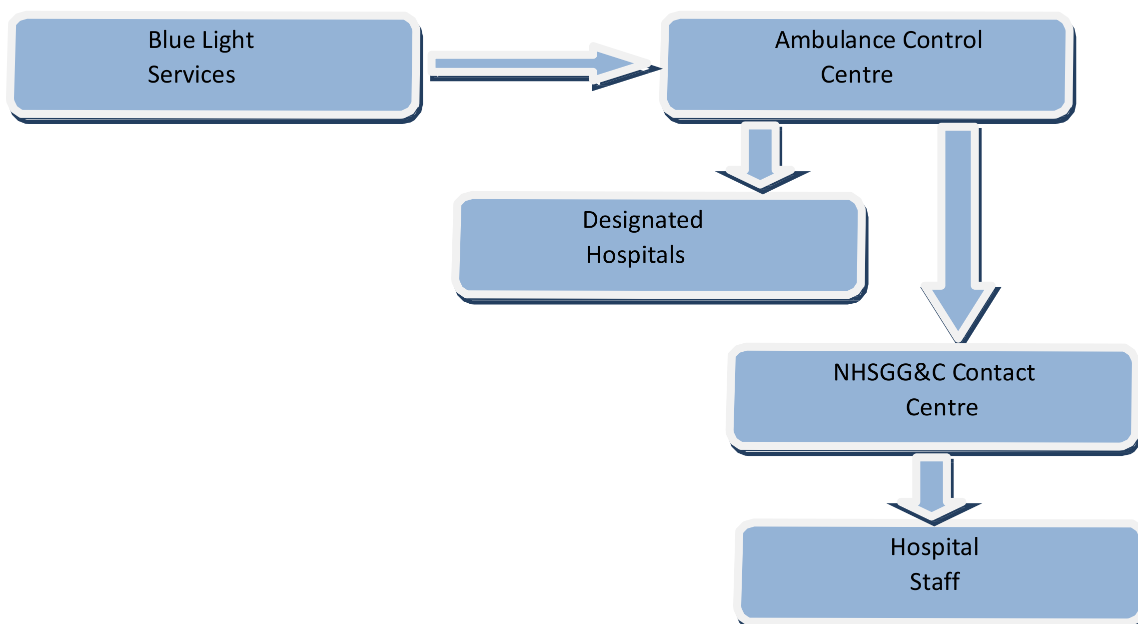


**Figure 1**

**Major incident Standby Liberty Message**

Those with a response role in this plan will receive the following message by pager, phone, text or email.

> **‘Major incident standby. This is not an exercise. Please proceed immediately to your major incident reporting area and standby to respond. Major incident standby. This is not an exercise. Please proceed immediately to your major incident reporting area and standby to respond.’**

## ‘Major Incident – Declared’ Notification

If the emergency services then judge the issue to be significant enough they will revise the standby message to ***‘Major Incident – Declared’***. This message will again be sent to the designated hospitals directly and then to our contact centre for further dissemination.

The communications flow will follow the MI standby route describe in Figure 1 above.

### Major Incident Declared Confirmer Message

Those with a response role in this plan will receive the following message by pager, phone, text or email.

> **‘Major incident declared. This is not an exercise. Please proceed immediately to your major incident reporting area to undertake your response role. Major incident declared. This is not an exercise. Please proceed immediately to your major incident reporting area to undertake your response role.’**

**IMPORTANT**

**LIBERTY WILL ONLY CONTACT KEY INDIVIDUALS (ENTITIES) ACROSS NHSGG&C**

**IT IS THE RESPONSIBILITY OF EACH INDIVIDUAL DEPARTMENT TO HAVE A ROBUST ROTA & COMMUNICATION SYSTEM IN PLACE FOR BOTH THE CALL-IN OF STAFF AND SERVICE CONTINUITY DURING A MAJOR INCIDENT AND IN THE RECOVERY PHASE**

**Patient Flow**

At the discretion of the Hospital Medical Co-ordinator and Hospital Control Team **EVERY** ward may be required to take decanted patients. Wards should prepare for potentially operating 'over-capacity' and for the temporary suspension of infection control restrictions.

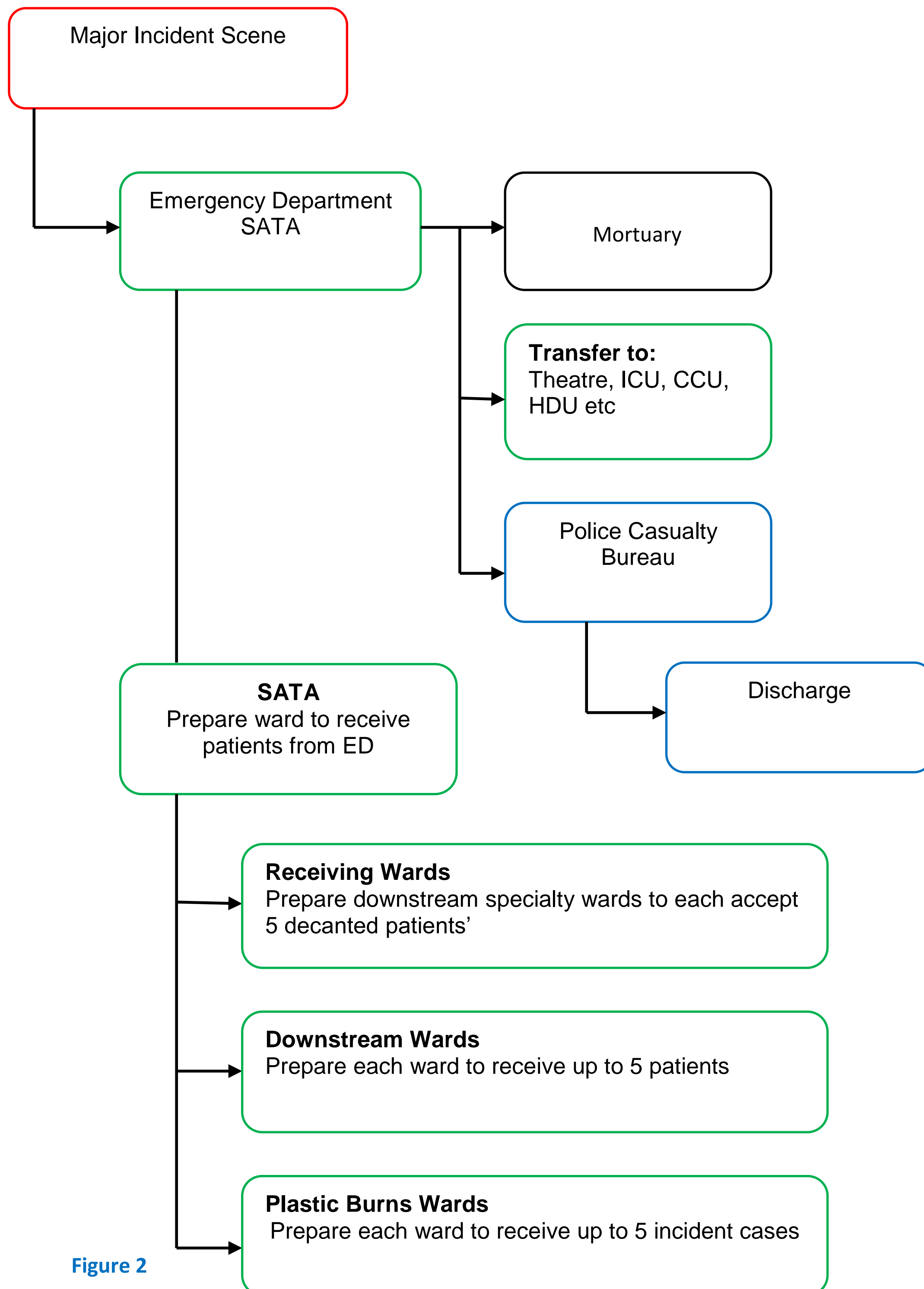


Figure 2

## Co-ordination Hierarchies

When responding to a MI the hospital alters its management structure so that it is able to ensure that all of the appropriate roles described in this plan are allocated and that associated responsibilities are carried out.  This simplified, location based structure is '*collapsible*' (collapsible hierarchy) in that members of staff may be required to temporarily act up to a more senior position until more experienced help arrives.

The following pages give an overview of these hierarchies and can be used to understand how the roles described in the action card section interact with each other.

## Hospital Major Incident Co-ordination Team

The Hospital Major Incident Co-ordination Team has ultimate responsibility for co-ordinating the hospital's response to the incident, overseeing the successful delivery of patient care and liaising with the Board Control Room (Gartnavel Hospital).

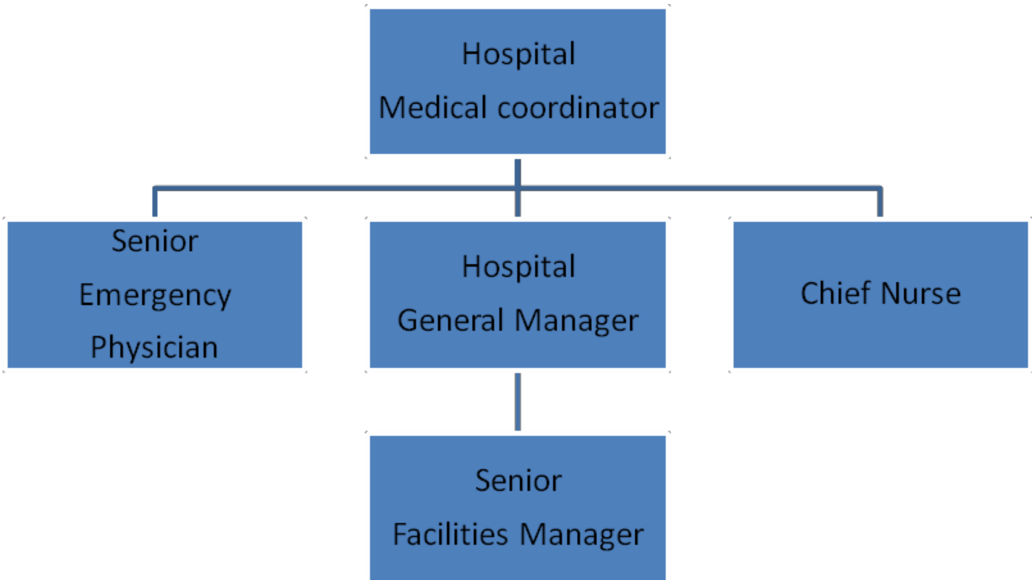


Figure 3

**NHSGGC LIBERTY CALL IN SYSTEM**

**Please note – only the following individuals/entities are contacted automatically by Liberty**

**Each individual department is responsible for their own internal 'staff call-in' cascade**

**WhatsApp groups are appropriate for cascades. Please avoid sharing clinical or confidential information**

**Departments must ensure they have robust up to date contact details for their own teams**

A E Consultants On Call Glasgow Royal Infirmary Consultant
A E Consultant on Call Queen Elizabeth University Hospital Consultant
A E Consultant Royal Alexandra or Inverclyde Royal Consultant
A E Consultants On Call Royal Hospital for Children Consultant
Acute Executive Director On Call Acute Executive Director
Acute Receiving Unit QUEH Clusters for Gastro see GI Column Consultant
Anaesthetic senior trainee Queen Elizabeth University Hospital Senior trainee
Anaesthetics Glasgow Royal Infirmary Consultant
Anaesthetics Consultant On Call Royal Hospital for Children Cardiac
Anaesthetics Consultant On Call Royal Hospital for Children Consultant
Anaesthetics Consultant On Call Royal Hospital for Children PICU Consultant
Anaesthetics Consultant On Call Royal Hospital for Children Senior Trainee
Anaesthetics Consultant On Call Royal Hospital for Children Trainee
Anaesthetics Inverclyde Royal Consultant
Anaesthetics Queen Elizabeth University Hospital Consultant
Anaesthetics Royal Alexandra Consultant
Blood Transfusion Queen Elizabeth University Hospital Bio Medical Scientist
Civil Contingencies Head of Dept Head
Contact Centre Major Incident Test Test
Corporate Management Team City Wide Clinical Director
Corporate Management Team City Wide Corporate Director
Corporate Management Team City Wide Response Medical Director

LIBERTY CALL IN (B)

DME GRI STH LBH Consultant
DME GRI STH LBH Junior Doctor
DME GRI STH LBH SPRs
Facilities Senior Manager On Call Senior Manager
Haematology Consultant Clyde RAH VOL IRH consultant
Haematology Consultant Reg GRI PRM CBH Consultant
Haematology Consultant Reg GRI PRM CBH Registrar
Health Records Major Incident Liberator MI Contact
ITU QEUH Consultant 1st on
ITU QEUH Consultant 2nd on
ITU QEUH Jnr Trainee
ITU QEUH Snr Trainee
Major Incident eHealth Account Manager General I T
Major Incident eHealth Director General I T
Major Incident eHealth Test NETCALL General IT
Manager On Call Queen Elizabeth University Hospital Manager on call
Managers Clyde Royal Alexandra or Inverclyde Royal or Vale of Leven Duty Manager
Managers On Call North East Stobhill and Glasgow Royal Infirmary Senior Manager On Call
Medical Consultant RAH VOL Consultant
Medical Consultant Rota Inverclyde Royal Hospital Consultant
Medical Paediatric Consultant On Call Royal Hospital for Children Consultant
Medical Receiving Consultants and Senior Staff Glasgow Royal Infirmary Consultant
Orthopaedic On Call Glasgow Royal Consultant
Orthopaedic on Call Inverclyde Royal Hospital Consultant
Orthopaedic On Call Queen Elizabeth University Hospital Consultant
Orthopaedic On Call Royal Alexandra Consultant
Orthopaedic On Call Royal Hospital for Children Consultant
Plastic Surgery City Wide All Receiving Calls
Plastic Surgery City Wide Consultant
Plastic Surgery City Wide Registrar

LIBERTY CALL IN ( C )

Press Officer Communications Press Officer On Call
Public Health Glasgow and Port Health  Glasgow Health Board Consultant or Specialist Registrar
Public Health Glasgow and Port Health  Glasgow Health Board Office Staff
Surgical Consultant Glasgow Royal and Surgical Receiving Coordinator Duty Consultant Surgeon
Surgical Inverclyde Royal Consultant
Surgical Receiving and Neonates Consultants and Registrar RHC Consultant
Surgical Receiving and Neonates Consultants and Registrar RHC Registrar
Surgical Receiving and Neonates Consultants and Registrar RHC Renal Transplant
Surgical Receiving Consultant or Registrar Queen Elizabeth University Hospital Consultant
Surgical Royal Alexandra Hospital Consultant
Telecoms Manager On Call Telecoms Manager

When responding to a Major Incident each of the Hospital's response roles have been summarised in the following cards. If you do not have an immediately identifiable role proceed to the Boardroom and await deployment. These action cards are initial guides only. Individuals will require to respond flexibly depending on the nature of the incident and pre-existing pressures.

| Pg | **Role** | **Pg** | **Role** |
|---|---|---|---|
| | Hospital Medical Co-ordinator | | Senior Intensivist |
| | Hospital General Manager | | Senior Anaesthetist |
| | Chief Nurse or Deputy | | Senior Nurse ICU |
| | Senior Facilities Manager | | Haematology BMS |
| | 1st Responder to Control room | | Radiology |
| | Loggist | | Biochemistry BMS |
| | Senior Porter | | EDC Pharmacist |
| | Chargehand Security Officer | | Chaplaincy Co-ordinator |
| | Senior Emergency Physician | | Physiotherapy |
| | ED – Senior Doctor on Duty | | Senior Catering Manager |
| | ED – Senior Nurse | | Bed Manager |
| | Senior Nurse AAU | | Senior Nurse Theatres |
| | ED – Triage Officer | | Senior Nurse Medical & Surgical High Dependency |
| | Health Records Clerical Officer – ED Reception | | Senior Nurse Receiving Wards (Medical, Surgical & Ortho) |
| | ED Resuscitation Room – Junior Medical Staff | | Senior Nurse Downstream Wards (Medical, Surgical & Ortho) |
| | ED Majors Area – Junior Medical Staff | | Senior Nurse Plastics and Burns Wards |
| | ED Minors Area – Junior Medical Staff | | Press Officer |
| | Senior Surgeon | | ED VIP action card |
| | Senior Orthopaedic Surgeon | | ED Action Cards – other roles |
| | Senior Plastic Surgeon | | |
| | Senior Physician | | Surgical Escalation |

## HOSPITAL MEDICAL CO-ORDINATOR

When an emergency requiring the activation of a hospital Major Incident Plan occurs the hospital will rearrange its management hierarchy in order to best respond to the number of incoming casualties. The person in overall charge of the hospital response will be the Consultant in Care of the Elderly.

Responsibilities:

1. Attend the Control Room via the Emergency Department and take a brief SITREP (situation report) from the ED Consultant in Charge.
2. If first on scene, set up Control room as per guidance within the MI cupboard.
3. Ensure that others in the Hospital Coordination Team understand their roles and responsibilities.
4. Liase every 30 minutes with the ED Consultant in Charge (81394) and at other intervals should there be a change in the situation.
5. Co-ordinate response activity throughout the hospital with particular attention to Theatres and Critical Care.
6. Establish as best as possible Demand/Capacity on the GRI Site
7. Communicate with the Scottish Ambulance Service where appropriate.
8. Communicate with other NHSGGC site Control Rooms where appropriate.
9. Communicate with the NHSGGC Control Room ( Gartnavel Hospital )
10. Consider necessity to terminate elective activity.
11. Log key actions and decisions.

Immediate Actions:

1. Attend the Emergency Department and take a brief SITREP (Situation Report) from the ED Consultant in Charge.
2. Go to the Hospital Control Room, Seminar Room One (Plastic Surgery Department) 1$^{st}$ Floor, Jubilee Building.
3. Set up Control Room as per instructions if not already established.
4. If on **Major Incident Standby** await further information and instructions.
5. Ensure major incident action cards distributed and roles and responsibilities are understood.
6. Ensure major incident tabards which are kept in the major incident cupboard are distributed.
7. Ensure the Major Incident Board in the Hospital Control Room is kept up to date.
8. Keep a Major Incident log of all actions and communications.
9. Consider postponement of Theatre and Outpatient Clinics as appropriate – determine from Clinical Co-ordinator site capacity - ED, beds, Theatres, Critical Care
10. In discussion with Control Room team consider initiation of patient cascade system as number of incoming patients demand – start with decant of 5 patients from each receiving unit (medical/surgical/orthopaedic) and re-assess need for further decant
11. Consider need for downstream wards to go ‘over- capacity’.
12. Consider requirement to override cohorting on wards.
13. Inform Board Control Room of immediate and anticipated site capacity (0141 201 4720/23/24//28/30)

## HOSPITAL MEDICAL CO-ORDINATOR (2)

15. Keep Press Officer informed 24-Hour Contact T: 0141 201 4429 (64429)
16. Keep Police Scotland documentation team informed of incident progress as required Location - Clinic 1 of OPD – 0141 211 1300 (21300)
17. Authorise additional resources as required.
18. Notify On Call Pharmacy Team of Incident via switchboard (or delegate task)
19. NB AHP groups are not on the call in cascade – consider call in of Physiotherapy etc
20. Acknowledge receipt of ***Stand Down*** at site of incident and declare hospital ***Stand Down*** – only when ED and other departments are ready to return to normal duties

Priorities:

1. Communication with key clinical areas.
2. Communication with Board Control Room
3. Ensure additional resources are arranged as required.
4. Keep Major Incident board and log up to date.

| KEY AREAS | Telephone number |
|---|---|
| Emergency Department Controller<br><br>ED Resus | 81394/81395<br><br><br>26564/26507/26509 |
| Contact Centre | 01412014720 |
| Theatres | DECT |
| Intensive Care Unit | 85559 |
| Police Documentation room<br><br>Press Office | 21300<br><br>201 4429 (64429) |

## HOSPITAL MEDICAL CO-ORDINATOR (3)

**THEATRES DECT PHONES**

| | **Telephone No** | **Short Code** | **Allocated To - Role** |
|---|---|---|---|
| 1 | 0141 956 0730 | 60730 | Senior Anaesthetist - ED |
| 2 | 0141 956 0731 | 60731 | Senior Anaesthetist - Theatres |
| 3 | 0141 956 0732 | 60732 | HUB |
| 4 | 0141 956 0733 | 60733 | Theatre Co-ordinator |
| 5 | 0141 956 0734 | 60734 | Senior Surgeon |
| 6 | 0141 956 0735 | 60735 | Senior Manager |

## HOSPITAL GENERAL MANAGER

Responsibilities:

1. Responsible for overseeing the non-medical site response to a major incident.
2. Member of the Hospital Co-ordination Team and essential link between management support and the clinical teams.

Initial Actions:

1. Attend Hospital Control Room, Seminar Room 1 (Plastic Surgery Department), 1st Floor, Jubilee Building, GRI.
2. If first on scene, set up Control Room as per guidance.
3. Contact Clinical Services Manager.
4. If a **Major Incident Standby** await further information and instruction.
5. Identify that Senior Medical/Nursing and Facilities personnel have arrived at MI Control Room and have been given action cards.
6. Liaise with Hospital Medical Co-ordinator and Control Room Team
7. Ensure Press Officer has been contacted. Phone 64429 (201 4429)
8. Assume or delegate responsibilities of Press Officers action card until their arrival.
9. Liaise with Board Control Room as required.
10. Contact additional staff support if required. NB AHPs are not part of the call in cascade and will require to be contacted if required. Non allocated staff will gather in the Boardroom on ext 85372 (451 5372) and an individual will have to be identified to log arrivals and communicate with the Control Room as to dispersal of staff to areas of need.
11. Friends and Relatives will be directed to the Campsie Dining Room. Allocate volunteers to this area ext 69120 (531 9120)

Priorities:

1. Ensure Incident response support services are established.
2. Respond to or elevate requests for additional resources from nursing and support services.
3. Assist Hospital Medical Co-ordinator in keeping the Major Incident Board up to date

## LEAD NURSE OR DEPUTY

Responsibilities:

1. Responsible for all nursing matters relating to the major incident response.
2. Member of the Hospital Co-ordination Team.
3. Ensure that clinical areas are prepared and adequately staffed.
4. Allocate a staff member (when available) as Incident Loggist.

Initial Actions:

1. Attend Hospital Control Room Seminar Room One (Plastic surgery Department), 1st Floor, Jubilee Building and liaise with Hospital General Manager/ Hospital Medical Coordinator. If required phone Lead Nurse to take over role.
2. If first on scene, set up Control room as per guidance.
3. If Major Incident Standby, await further instructions
4. Ensure that Hospital at Night 'walkie talkies' are allocated to appropriate staff. These can be located at the Endoscopy Unit in the QEB or Out of Hours (21.00 – 0730hr) they will be held by the HAN team members. Record who they are allocated to.
5. Liaise with Senior Nurse Emergency Department and Lead Nurse, ED to ensure ED is adequately staffed.
6. Liaise with Clinical Co-ordinator to ensure all clinical areas are aware of Major Incident.
7. Confirm Major Incident with Nurse in Charge - Theatres.
8. Oversee decant of patients from receiving wards via the Bed Management team.
9. Liaise with Clinical Co-ordinators/Bed Manager and nursing staff in medical, surgery and orthopaedic wards.
10. Ensure front line areas [Emergency Department, Acute Assessment Unit, receiving wards and theatres] are appropriately staffed.
11. Allocate senior staff to manage the Medical, Nursing, and additional (off-duty) staff arriving at Staff Assembly point in the Boardroom, Ground Floor Centre Block. (Access to boardroom via Security staff; 56398 / 211 6398)
12. Liaise regularly with Medical, Nursing and Volunteer Staff Assembly Point and allocate volunteer staff as required. (Boardroom Phone No: 85372 / 451 5372)
13. Deploy staff appropriately.
14. Ensure adequate staffing in Relatives Area in the Campsie Dining Room (Phone 69120/ 5319120)
15. Ensure Bereavement/Chaplaincy/ Friends and Relatives support services in place.

Priorities:

1. Liaise with senior nursing staff in all key areas.
2. Ensure adequate nurse staffing in clinical areas.
3. Allocate staffing to volunteer area (Boardroom) and relatives area (Campsie Dining Room).
4. Assist Hospital Medical Co-ordinator and Control Room team.

## SENIOR FACILITIES MANAGER

Responsibilities:

1. Responsible for the support service response to a Major Incident.
2. Member of the Hospital Co-ordination Team

Initial Actions:

1. Attend Hospital Control Room Seminar Room One (Plastics Department), 1st Floor, Jubilee Building
2. If first on scene set up the Hospital Control Room as per instructions.
3. If Major Incident Standby await further information and instructions.
4. Liaise with Hospital Control Team
5. Coordinate provision of non-clinical support services.
6. Liaise with Portering Services Manager (or Deputy) to ensure adequate provision and allocation of Portering services.
7. Consider current or anticipated pressures and requirements in Portering/TSSU/Catering/Estates/Domestics/Linen/Security

Priorities:

1. Ensure that support services are established
2. Respond to or elevate requests for additional resources from support services.
3. Assist Hospital Medical Co-ordinator and Control Team

*See Individual Facilities Action Cards

USEFUL CONTACT NOS

**Facilities Duty Manager**

Stewart McKenzie – 07798646110 –ext 66485

Gayle Brown – 07980914821 – ext 37448

Gerry McDermott – 07866012244 – ext 66493

**Porter Services Manager** – Andrew McLundie – 07773759094 – ext 66492

**Head Porter** – Andrew Boyle, Jamie Simpson, Neil Lambie, Harry OBrien, Gordon Lloyd – ext 29883 – page 13614

## FIRST RESPONDER TO CONTROL ROOM

Responsibilities:

1. Ensure access doors to Major Incident (MI) room are opened.
2. Obtain key and doorcode for Major Incident cupboard from Ward 45.
3. Set up room as Major Incident Control -Guidance detailed in the MI floorplan

Actions:

1. Review MI Floor Plan located on top of MI cupboard.
2. Prepare room as directed to accommodate the needs of the MI coordination team during the Incident. Each desk has a corresponding numbered tray in MI cupboard.
3. Connect all landline telephones to the matching numbered port on the walls and ensure they are functioning. (Spares in MI cupboard)
4. Set out all IT kit as instructed on floor plan.
5. Switch on all IT kit and ensure functioning. Generic logins on each computer.
6. Set up wall mounted TV to receive Sky News updates. (Remote controls for this are stored in MI cupboard.)
7. Place stationary on each desk area and centrally on top of the MI cupboard.
8. Place a hard copy of the MI plan on each desk, available in each numbered drawer.
9. Direct arriving team members to appropriate desk in Control room.
10. Allocate other arriving staff as required.
11. Await further advice on the Major Incident status.
12. Notify ED (81394/81395) that room is operational.

Priorities:

1. Set up Control Room.
2. Co-ordinate area until all senior team members arrive. (If not part of the Control room team)

## LOGGIST

Responsibilities:

1. To log a complete and continuous record of all issues/ decisions/actions as directed by the Hospital Medical coordinator.
2. All entries must be clearly written into the MI logbook and dated, timed and initialled by the loggist.

   **In the absence of a nominated and available member of staff the Control Room team should ensure collectively that all relevant updates and decisions are logged.**

Initial Actions:

1. The loggist must use the log book provided. This is located in the MI cupboard.
2. On arrival all staff must wear Identification Badges. If the badges are unclear the loggist must ask for clarification of who is present within the room and their title.
3. The log must be clearly written, dated and initialled by the loggist at start of shift and include the location.
4. All persons in attendance to be recorded in the log.
5. The log must be a complete and continuous record of all issues/ decisions /actions as directed by the Incident Director/Incident Manager.
6. Timings have to be accurate and recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented and when the task is completed this must also be documented.
7. When the incident in complete, or at handover to another loggist, he/she must sign, date & time the logbook and score through below their entries.

**NB The log and all paper work become legal documentation and could be requested at a later date in a public enquiry or other proceedings.**

## SENIOR PORTER

Responsibilities:

1. Responsible for the prioritisation of portering tasks.
2. May be required to assist in the provision of security and traffic control throughout the hospital site.

Initial Actions:

1. Ensure wearing Senior Porter tabard. To be collected from Major Incident Cupboard, Emergency Department.
2. Senior Supervisor plus 1 Porter report to Emergency Department.
3. If Major Incident Standby, await further instruction.
4. Identified porters should report to receiving wards (medical/surgical/orthopaedic/AAU) to prepare to transfer patients.
5. Senior Supervisor then organise required number of Porters.
6. Supply trolleys to ED resuscitation dept., keep Emergency Department area clear and assist Nursing Staff.
7. Assess the available portering resources throughout the hospital.
8. Immediately send 3 porters to the Emergency Department with instructions to take with them any available trolleys and chairs.
9. Rapidly move patients from the Emergency Department as directed by the Nurse in Charge - ED. Beds for these patients **DO NOT** need to be available (unless clinically indicated), but expected, at this time.
10. Assist in the transportation of casualties and any other duties as directed by Emergency Department medical or nursing staff.
11. Ensure that the entrance and access road to the Emergency Department is cleared of vehicles.
12. Set up traffic control points at the roads leading to Emergency Department.
13. Close and lock all Emergency Department access, except ambulance entrance. Do not allow unauthorised access by members of the public or press to the Emergency Department.
14. Send a member of staff to the Emergency Department with the emergency supply of linen.
15. Continually assess the availability of portering resources, for the incident and to maintain hospital services.
16. Call in additional resources if required and liaise with Senior Manager, Hospital Control Room.

Priorities:

1. Allocate portering staff to key areas of emergency department and Receiving Wards.
2. Ensure Emergency Department access is only through pre-determined routes.
3. Continually assess availability of portering staff around hospital.

## CHARGEHAND SECURITY OFFICER

Responsibilities:

1. Responsible for the prioritisation of security tasks.
2. May be required to assist in the provision of security and traffic control throughout the hospital site.

Initial Actions:

1. Security Chargehand to report to Emergency Department / Senior Porter
2. If Major Incident standby await further instruction.
3. Senior Supervisor to organise required number of Security Officers. Commence site patrols as required for site security. **Consider Lockdown of site**.
4. Set up traffic control points at the roads leading to Emergency Department via the car parking contractor.
5. Close and lock all Emergency Department access except ambulance entrance. Do not allow unauthorised access by members of the public or press to the Emergency Department.
6. Accompany patients / casualties from Emergency Department to Police Discharge Area.
7. Accompany relatives to the relative's area within the Queen Elizabeth Building Campsie Dining Room.

## SENIOR EMERGENCY PHYSICIAN

Responsibilities:

1. Primary responsibility of organising the reception phase of the major incident.
2. Ensure that triage of casualties is being performed at ambulance entrance.
3. Ensure that treatment teams for Priority 1 and 2 patients are organised in conjunction with the Senior Nurse, Emergency Department.
4. Organise medical staffing for Priority 3 area.
5. Liaise with other members of the Hospital Co-ordination team.

Initial Actions:

1. Wear Senior Emergency Physician tabard kept in the Emergency Department.
2. Prepare to take charge of the incident within the Emergency Department.
3. Distribute Action Cards to Medical Staff
4. Ensure ED consultant colleagues are notified as required (Whatsapp MI Group)
5. Ask Junior Medical Staff to trigger Whatsapp call in as required
6. Ensure Theatres / Critical Care / Radiology Hub are notified
7. Oversee (delegate) discharge of non-urgent patients from the department.
8. Ensure that the Emergency Department is prepared for reception of casualties from Major Incident.
9. In discussion with Senior Physician/Surgeon / ICU push current high acuity patients to HDU/ICU
10. If Major Incident Standby, then await further instruction.
11. Keep medical/nursing staff in ED informed at all times.
12. In conjunction with the Senior Nurse Emergency Department designate a [Senior] Triage Officer and position at ambulance entrance with clerical staff.
13. Allocate Senior Doctors to Priority 1, 2 and 3 areas.
14. In discussion with the Senior Nurse Emergency Department, form treatment teams for Priority 1 and 2 patients
15. Allocate medical staff to Priority 3 area.
16. Keep the Hospital Medical Co-ordinator informed of progress and capacity for further receiving (30 minute check in comms / significant information )
17. Oversee medical care and flow of patients through Emergency Department.

Priorities:

1. Ensure all areas are adequately medically staffed.
2. Liaise regularly with Medical Co-ordinator in the Hospital Control Room.
3. Ensure ED Major Incident medical staff cascade call-out performed

## EMERGENCY DEPARTMENT – SENIOR DOCTOR ON DUTY

Responsibilities

1. Assume role of **Senior Emergency Physician** action card until arrival of the ED Consultant On-Call.
2. Ensure that department is prepared for arrival of casualties (Action Cards)
3. Assist the senior Emergency Consultant in the allocation of medical staff to roles.
4. Undertake role as part of treatment team as directed by the ED Consultant On-Call.

Initial Actions:

1. Liaise with ED Nurse in Charge and check call has been verified with Contact Centre and that ED Consultant On-Call has been informed and is attending.
2. Discharge non-urgent patients from the department.
3. Assume roles of Senior Emergency Physician action card until arrival of the ED Consultant On-Call.
5. Assist in delegating available medical staff into treatment teams.
6. Contact Theatres/Critical Care and the Radiology hub immediately (or delegate task) and notify of Major Incident declaration.

Priorities:

1. Take on role of Senior Emergency Physician until ED Consultant On-Call arrives.
2. Assist in preparation of ED and allocation of roles.

## EMERGENCY DEPARTMENT SENIOR NURSE

Responsibilities

1. Responsible for the preparation and running of the ED.
2. To work closely with the Senior Emergency Physician to ensure that triage and treatment areas are appropriately prepared and staffed.

Initial Actions:

1. Take Major Incident Hospital Control Room Box from Major Incident Cupboard to Hospital Control Room. A duplicate set of Action cards from ED are at the MI room.
2. Check Contact Centre has been informed by dialling 2222 and that the major incident has been confirmed with police or Ambulance Service. Clarify details of incident.
3. Ensure following staff contacted as per ED Major Incident Call-Out List:
    a) Call out ED Consultant on call.
    b) Call out Lead Nurse ED.
    c) Inform Bed Manager/Clinical Co-ordinator.
    d) Inform Duty Radiographer.
    e) Inform Receiving wards (AAU, medical, surgical, orthopaedic)
    f) Inform Medical Records (Front Desk)
    g) Inform Porter [Senior].
4. Prepare Mobile Site Team (if requested or designated hospital No 4)
5. Find list of department staff for call out (if required).
6. Delegate a member of staff to remain at the ED Staff Base to receive information via telephones using log sheets recording all incoming calls regarding the incident and any action taken, until the Medical Coordinator arrives.
7. Ensure that all clinical staff within the ED are kept informed of developments and allocated to areas of responsibility.
8. If Major Incident – Standby await further instruction.
9. Liaise with ED Consultant about commencing staff call out.
10. Ensure that the Department is cleared of any patients that may go to Wards or minor casualties that can promptly be treated.
11. Organise preparation of department to receive casualties from incident. Use equipment boxes in major incident room. Delegate staff accordingly to:
    a) Triage – Allocate nurse and doctor to role of triage officer at ambulance entrance.
    b) Resus Room– Set up for reception of Priority 1 patients
    c) Majors Area – Set up for reception of Priority 2 patients
    d) Minors Area – Set up for reception of Priority 3 patients
12. Inform the Senior Nurse in the Hospital Control Room of additional staffing requirements.
13. Liaise with Senior Porter to ensure adequate porters to transport patients and that Emergency Department access except ambulance entrance.
14. Prepare designated area Outpatients Department, QEB to allow police to set up Police Discharge Area

Priorities:

1. Set up triage and all clinical areas in preparation for reception of casualties.
2. Keep all staff informed.
3. Ensure adequate nursing staffing within ED and AAU areas.

## SENIOR NURSE SATA

1. Responsible for the preparation and running of SATA.

2. To work closely with the Consultant in Charge, ANPS (or Senior Medic on Duty) to ensure that all zones are appropriately prepared and staffed.

3. Link with Senior Nurse ED/ AMU/ Bed Manager/ Site Flow/ Clinical Co-ordinator for transfer of existing patients to receiving unit or downstream wards

Initial Actions:

1. Ensure following staff contacted as per Major Incident Call-Out List:
   a) Call out Lead Nurse ERC.
   b) Inform Receiving wards (medical)
   c) Inform Medical Records (Front Desk)
   d) Inform Senior Porter
2. Find list of department staff for call out - if required
   (*stored in red metal box in zone 1 office)*
3. Ensure that all clinical staff within the SATA are kept informed of developments and allocated to areas of responsibility.
4. Liaise with SATA Consultant about commencing staff call out.
5. Ensure that the Department is cleared of any patients that may go to receiving unit, downstream wards or other areas (e.g. Zone 4 Ambulatory.)
6. Organise preparation of unit to either receive patients from ED or casualties from incident. Delegate staff accordingly to:

   **A) Triage- filter patients from ED**

   **B) Zone 1– Set up for reception of new patients from ED or incident**

   **C) Zone 2 – Set up for reception of assessed patients requiring follow-up, further assessment**

   **D) Zone 3 – Set up for assessed patients requiring admission**

   **E) Zone 4- Set up for ambulant patients awaiting assessment/ likely discharge**

7. Inform the Senior Nurse in the Hospital Control Room of additional staffing requirements.
8. Liaise with Senior Porter to ensure adequate porters to transfer patients.

Priorities:

1. Set up all clinical areas in preparation for reception of ED patients or casualties.
2. Keep all staff informed.
3. Co-ordinate with ED Senior Nurse and ensure adequate nursing staffing within ED and SATA areas.
4. Keep record of all patients received or moved during the major incident

## EMERGENCY DEPARTMENT TRIAGE OFFICER

Responsibilities:

1. Lead Triage team to ensure that all patients enter through ambulance entrance and undergo adequate triage.
2. Keep ED informed of arrival numbers and Triage categories.
3. Work closely with Triage Nurse and with Health Record staff to ensure correct identification and documentation for all patients.

Initial Actions:

1. Wear ED Triage Officer tabard. To be collected from Major Incident cupboard, Emergency Department.
2. Triage will be done by Triage Sieve at the Ambulance entrance by an experienced ED Nurse and experienced ED doctor. All other entrances will be closed and locked. You will require:

   Experienced ED Nurse
   Experienced ED Doctor
   Action Cards
   ED cards – pre packed by Health Records
   Marker pens

Major Incident Terminology

| | | | |
|---|---|---|---|
| P1 | Immediate | Red | Resuscitation room |
| P2 | Urgent | Yellow | Majors Area |
| P3 | Delayed | Green | Minors Area |

WORK SWIFTLY AVOID A BOTTLENECK OF PATIENTS AT THE FRONT DOOR

## EMERGENCY DEPARTMENT HEALTH RECORDS CLERICAL STAFF

Responsibilities

The Health Records Department are responsible for providing**:**

1. A Health Records Documentation Team to register and process patients attending the Emergency Department following a Major Incident.
2. Senior Health Records Information Officer to assist in the control room.
3. To keep and maintain an Incident Register

Initial Actions:

1. The ED clerical staff should inform a senior Health Records Officer that an Incident has occurred
2. This officer will act as the Incident Officer within the Department ensuring adequate staffing levels are provided during the Incident.
3. The Health Records Incident Officer should set up a clerical incident desk within ED Reception ensuring that the pre-numbered Major Incident packs are available prior to the arrival of the casualties

7. The Health Records Incident Officer should allocate clerical staff to receive the casualties at the appropriate entrance.
8. Allocate Health Records Action Cards 1-6

**Upon arrival of the patients the ED clerical staff should:**

Register the casualties on to the Hospital Administration system using the unique patient identifier number included in the documentation pack provided for each casualty. These unique numbers are known as TJ numbers.
After Registration provide the clinical staff with the Major Incident Documentation pack.
Provide a copy of the patients Registration document to the Police Bureau which is based in Outpatients (though may relocate to the Hospital Control Room)
Update and maintain the Major Incident Register as the Incident progresses.
Liaise with the Hospital Controller.

**Stand down**

Update the Major Incident Register with all discharge locations ensuring that all patient identifiers have been merged or created.

## HR ACTION CARD ONE

## MAJOR INCIDENT DECLARED

**When you are notified that a MAJOR INCIDENT has been declared ask the senior nurse in charge where the incident is, who called the incident and how many patients we have been assigned to receive**

**Call Ann Bell, the ED supervisor, and inform her of the incident details**

**Call Irene Fyfe, the Health Records Site manager, and/or Stella Williamson, Health records Service Manager, and inform them of the incident details**

**If you need additional support please refer to the staff call out list provided in the major incident folder.**

**Until Health Records senior managers arrive or in their absence you should do the following:**

- **Appoint a booking team of two staff members to receive patients at the ambulance entrance**
- **Remove major incident packs from the major incident cabinet and take to the ambulance entrance.**

**PLEASE NOTE THESE TWO STAFF MEMBERS MUST REMAIN AT THE AMBULANCE ENTRANCE AT ALL TIMES TO CAPTURE PATIENTS ON ARRIVAL**

- **Appoint one member of staff to act as the documentation officer and set up an area within ED reception to act as the incident desk**
- **Appoint the runners team consisting of two staff members**
- **Arrange cover for ED reception to deal with the emergencies that will continue to arrive**
- **Pass all telephone enquiries regarding the Major Incident to the incident officer**

## HR ACTION CARD TWO

## BOOKING IN TEAM

**Take the major incident pack and record all the patient's demographics that you are able to retrieve manually onto the ED card**

**Log onto Trak and select the ED reg and move tab**

**Enter the Major Incident TJ number already labelled on the major incident pack and enter all the data you have captured for the patient, recording the receiving complaint as "MAJOR INCIDENT"**

**You must retain the "major incident" name as an alias**

**If the patient is unknown at registration you must update the gender from not known to male or female**

**Print a copy of the ED attendance sheet from Trak**

**Print two sets of labels**

**Attach one label to the ED bard and one label to the health records major incident form within the pack**

**Replace the existing labels in the major incident pack with the new sets and destroy the old ones**

**Remove the health records major incident form from the pack and pass to the runner.**

**Pass the major incident pack to the medical staff**

**<u>DO NOT MERGE ANY TJ NUMBERS AT THIS POINT</u>**

## HR ACTION CARD THREE

## DOCUMENTATION OFFICER

**On receipt of the health records major incident form and the copy of the ED attendance sheet the documentation officer should**

- **Record the incident information in the incident register**
- **Ensure the alias name "major incident" is recorded for any patients that have their own names recorded**
- **Search the CHI database for the patient and record on the health records incident form if the patient is found. Pass the CHI number to the medical staff for reference only**
- **Keep all the health records incident forms together with the register**
- **Pass the ED attendance sheet to the runner to deliver to the incident control room**
- **Merge the TJ number with the CHI only once the incident has been stood down and the patient has been discharged, or at the request of the clinician**
- **Remove the alias from the record**

**Do not create a CHI number if the patient remains unknown, leave with the TJ number**

## HEALTH RECORDS ACTION CARD FOUR

## RUNNER

**Take the health records major incident form and the copy of the ED attendance sheet to the documentation officer at the ED reception**

**After the documentation officer has checked the ED attendance sheet take this to the incident control room and give to the health records manager or appointed person in their absence**

**Relay any messages to and from the incident control room**

**Any other duties as directed from the Health Records Incident Officer**

**DO not escort any patients or relatives to the designated areas**

## HEALTH RECORDS

## ACTION CARD FIVE

## HEALTH RECORDS OFFICER WITHIN INCIDENT CONTROL ROOM

**Health Records Officer will collect the Major Incident Laptop from the ED reception Area within Ann Bell's Office.**

**Make their way to the control room and set up at the allocated area for Medical Records**

**Wait on the arrival of the ED runner delivering ED attendance sheets**

**On receipt of a copy of the ED attendance sheet liaise with Police Control officer making sure the documentation is kept in numerical and time order**

**Relay any messages from the Incident Control room via the ED runner**

## HEALTH RECORDS - ACTION CARD SIX

## HEALTH RECORDS SUPERVISOR

**In the event of a Major Incident being called please inform the CAR PARKING STAFF**

**Inform the Car Parking Staff that there will be multiple staff attending the site for the incident and they will require entry to the car park within this time**

**If possible please ask the car park staff for their name for reference**

## ED RESUSCITATION AREA – JUNIOR MEDICAL STAFF

Responsibilities:

1. Responsible directly for the care of patients within the resuscitation area as part of a treatment team.

Initial Actions:

1. Stay in the resuscitation area until directed otherwise by the Senior Emergency Physician on duty / ED Consultant.
2. Treat patients as allocated until directed to other tasks by the Senior Emergency Physician on duty / ED Consultant.
3. Complete routine patient processing tasks and documentation.
4. Discuss all patients with the Senior Emergency Physician or ED Consultant to plan management and disposal.
5. Blood bank will still require TWO samples.
6. Imaging priority to be discussed with the Senior Emergency Physician on duty / ED Consultant.
7. In trauma – Trauma protocol CT from head to lowest point of injury
8. Ensure all patients are logged by Medical Records staff before they leave the Emergency Department.
9. Ensure that any patients transferred out of the ED to a major incident receiving ward have been discussed directly with the ward/receiving staff.
10. If patients are going directly to Theatre ensure this is communicated to Theatres/Surgical and Critical Care Teams.

Priorities:

1. Act as ED link for Treatment Teams. Other Team members may not be familiar with processes within the ED.
2. Communicate patient updates to Senior Emergency Physician on duty / ED Consultant.

## EMERGENCY DEPARTMENT MAJORS AREA – MEDICAL STAFF

Responsibilities:

1. Responsible directly for the care of patients within the Majors area as part of a treatment team.

Initial Actions:

1. Stay in the Majors area until directed otherwise by the Senior Emergency Physician on duty or ED Consultant.
2. Treat patients as allocated.
3. Complete routine patient processing tasks and documentation.
4. Discuss all patients with the Senior Emergency Physician or ED Consultant to plan management and disposal.
5. Blood bank will still require TWO samples.
6. Imaging priority to be discussed with the Senior Emergency Physician on duty / ED Consultant.
7. In trauma – Trauma protocol CT from head to lowest point of injury
8. Ensure all patients are logged by Medical Records staff before they leave the Emergency Department.
9. Ensure that any patients transferred out of the ED to a major incident receiving ward have been discussed directly with the ward/receiving staff.
10. If patients are going directly to Theatre ensure this is communicated to Theatres/Surgical and Critical Care Teams.
11. Discharges must be communicated to Health Records and book out via the Police Scotland Bureau in Outpatients.

Priorities:

3. Act as ED link for Treatment Teams. Other Team members may not be familiar with processes within the ED.
4. Communicate patient updates to Senior Emergency Physician on duty / ED Consultant.

## EMERGENCY DEPARTMENT MAJORS B AREA – JUNIOR MEDICAL STAFF

Responsibilities:

1. Responsible directly for the care of patients within the Priority 3 Area – Majors B

Initial Actions:

1. Stay in the Priority 3 Area **/ Majors B** until directed otherwise by the Senior Emergency Physician or Senior Doctor Priority 3 Area.
2. Treat patients as allocated or until directed to other tasks by the Senior Emergency Physician or Senior Doctor Priority 3 Area.
3. Examine patients thoroughly and ensure all injuries are documented, treated and an appropriate management plan or follow up is in place.
4. Discuss patients with the Senior Emergency Physician or Senior Doctor Priority 3 Area to plan disposal. Also involve the Senior Surgeon or Senior Orthopaedic Surgeon as appropriate.
5. Complete accurate documentation.
6. Limit investigations including x-rays to a minimum until otherwise directed. (This is to avoid bottlenecks at Imaging)
7. Provide:
    a) Adequate analgesia.
    b) Appropriate splintage.
    c) Document a clear treatment plan.
8. Ensure all patients leave the Emergency Department through Police Area Outpatients Department, QEB.
9. Ensure all patients are logged by Medical Records staff before they leave the Emergency Department.
10. Ensure that any patients transferred out of the ED to a major incident receiving ward have been discussed directly with the ward.
11. If patients are going directly to Theatre ensure Theatres/Surgery/Critical Care have been informed.
12. Assist non ED staff unfamiliar with Departmental processes.

**Priorities:**

1. Work under the direction of the Senior ED Doctor Priority 3 Area.
2. Ensure that patients are fully examined and all injuries documented.
3. Ensure all patients when discharged are logged by the medical records staff and go directly to the discharge area Outpatients Department, QEB.

## SENIOR SURGEON

1. Responsible for the control of the surgical response.
2. Setting treatment priorities for surgical casualties.
3. Advising Treatment Teams on management.
4. Advise on Imaging priorities
5. Liaison with Theatres regarding surgical priorities of casualties.
6. Liaison with Theatres regarding Theatre availability and usage and the formation of Operating Teams.
7. Liaison with the Senior Anaesthetist regarding anaesthetic provision for surgery.
8. Liaises with SHDU Charge nurse to assess patients for discharge and evaluate overall resources available.

Initial Actions:

1. Attend Emergency Department and liase with ED Controller.
2. Cascade call-in to colleagues. If Registrar initially takes role of Senior Surgeon then first Consultant Surgeon available takes role of Senior Surgeon on arrival.
3. Nominate experienced doctor to identify and expedite potential ward discharges.
4. Assess surgical resources currently available and further staff required.
5. Liaise with Nurse in Charge Theatres. Consider establishment/use of Whatsapp groups with Theatres/Critical Care.
6. If Major Incident – Standby await further instruction. Consider hold on Theatre activity pending further information.
7. Inform colleagues if Major Incident Declared status.
9. Set priorities for imaging and surgical intervention.
10. Liaise with Theatres regarding surgical priorities and theatre/resource availability.
11. Liaise with Senior Anaesthetist regarding anaesthetic provision.
12. Consider nomination of Surgical Controller to oversee multiple Theatres
13. Oversee and advise the treatment teams.

Priorities:

1. Triage of surgical casualties for imaging, surgery and admission.
2. Support and Advice to Treatment Teams
3. Liaison with Theatres, Nurse in Charge Theatres and Senior Anaesthetist.
4. Provision of 24-hour Operating Team availability, using a rota system where possible.

## SENIOR ORTHOPAEDIC SURGEON

Responsibilities:

1. Responsible for the control of the orthopaedic response.
2. Setting priorities for treatment and surgery for orthopaedic casualties.
3. Advising Treatment Teams on management.
4. Liaison with theatres regarding changing orthopaedic surgical priorities of casualties.
5. Liaison with theatres regarding theatre availability and usage and the formation of Operating Teams.
6. Liaison with the Senior Anaesthetist regarding anaesthetic provision for orthopaedic surgery.
7. Arrange support for Gatehouse/MIUs if utilised in the incident response.

Initial Actions:

1. Attend Hospital Control Room Seminar Room One (Plastics Department), Jubilee Building.
2. Notify consultant colleagues.
3. Assess orthopaedic resources currently available and further staff required.
4. Liaise with Nurse in Charge Theatres.
5. If Major Incident – Standby await further instruction.
6. Inform colleagues of major incident confirmed status.
7. Proceed to Emergency Department and assess priorities of orthopaedic patients.
8. Set priorities for movement and surgery of casualties.
9. Continually liaise with theatre regarding priorities and theatre availability.
10. Liaise with Senior Anaesthetist regarding anaesthetic provision.
11. In conjunction with the Senior Emergency Physician oversee the treatment being provided by the treatment teams.

Priorities:

1. Triage of orthopaedic casualties for surgery and admission.
2. Advise Treatment Teams on casualty treatment.
3. Liaison with theatres, Nurse in Charge Theatres and Senior Anaesthetist
4. Provision of 24-hour Operating Team availability, using a rota system if possible.

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## PLASTIC SURGERY (1)

**RESPONSIBILITIES**

1. Co-ordinate the Plastic Surgery & Burns response within GRI, including:
    a. triage of casualties with soft tissue, major nerve, burn, and upper limb injuries.
    b. responsibility for triage decisions on preservation options for amputated parts.
    c. responsibility for triage decisions on limb salvage vs amputation decisions.
    d. allocation of operating plastic surgeons to patients requiring plastic surgery intervention.
    e. shared care with other specialties, and decisions on patient direction to most appropriate wards.
    f. point of contact for any non-resuscitation decisions for major burn patients
2. Co-ordinate Plastic Surgery presence at QEUH / RHC sites in preparation to support inter-hospital transfer from GRI / patients presenting to those sites.
3. Point of contact for pre-hospital care teams seeking opinion on optimal target hospital for patients with key conditions:
    a. Major burn injury
    b. Mangled Limb / Hand
    c. Amputated hand / limb
    d. Massive soft tissue wounds
    e. Open fracture
4. Point of contact for Treatment Teams on management of soft tissue wounds, nerve injury, burns.
5. Liaison with
    a. Theatres regarding CEPOD prioritisation of casualties.
    b. Theatre co-ordinator regarding allocation of patients to most appropriate theatres, and allocation of restricted fixed resources (operating microscopes etc) to cases
    c. Senior Anaesthetist regarding anaesthetic provision for cases involving plastic surgery interventions.
    d. Senior Nursing staff within the Plastic Surgery Unit regarding patient destinations appropriate for predicted care requirements.
    e. ICU lead regarding major burn care

## PLASTIC SURGERY (2)

**Initial Actions:**

1. Attend Hospital Control Room Seminar Room One (Plastics Department), Jubilee Building.
2. Notify colleagues
    a. 2nd on-call consultant,
    b. Clinical Director for Plastic Surgery,
    c. Consultant body via WhatsApp major incident group,
    d. 1st on-call registrar to cascade to registrar body & CTs via their WhatsApp major incident group,
    e. Lead Nurse for Plastic Surgery (contact via Ward 47/48/49),
    f. Lead Nurse for Burns Unit (contact via Burns Unit),
    g. Lead AHP for Canniesburn Unit (call 0141-201-3175).
3. Assess plastic surgery resources currently available, and further staff / consumables requirement.
4. Assess theatre resource available, liaise with:
    a. Nurse in Charge of Theatre Hub – pager 13661,
    b. Senior Anaesthetist – pager 13259,
    c. Lead Nurse for Canniesburn Theatres – contact via 0141-242-9403 (office hours) / theatre hub out of hours (hold a folder containing all theatre staff contact numbers).
5. Set priorities for movement and surgery of casualties.
6. If Major Incident – Standby await further instruction.
7. As events dictate proceed to Emergency Department / Theatres to engage in triage / shared decision making with allied specialties and formulate initial quantification of plastic surgery care needs.
    a. If patient numbers are restricted proceed to direct care
    b. If mass casualty incident delegate care provision and maintain oversight.
    c. For burn injuries consult with the Senior Emergency Physician to best support treatment provision.
8. Maintain response by continually liaise with
    a. ICU, Burns Unit & Plastic Surgery wards regarding priorities, patient flow,
    b. Theatres regarding availability & patient flow.
    c. Hospital Control room regarding predicted casualty flow

## PLASTIC SURGERY (3)

**Priorities:**

1. Triage of casualties for surgery and admission.
2. Triage for decisions on limb salvage / replantation of amputated parts
3. Burns triage and resuscitation, decisions on escharotomy
4. Advise other specialties on wound / burn / reconstructive care
5. Liaison with
    a. lead registrar (Plastic Surgery),
    b. colleagues at QEUH / RHC sites,
    c. lead nurses (Burns & Plastic Surgery),
    d. theatres,
    e. anaesthetic lead,
    f. ICU & burns unit,
    g. Clinical Director for plastic surgery,
    h. Regional Services Manager.
6. Provision of 24-hour Operating Team availability, using a rota system if possible
7. Maintain oversight of key consumables stocks (e.g. burns dressing materials, allograft skin, Integra) and instruct replenishment via ward managers
8. Maintain oversight of key theatre equipment & instruct on need requirement with Canniesburn Theatre charge nurse (e.g. dermatomes & blades, skin meshers, microscopes, microsurgery kits & consumables, theatre dressings)

## SENIOR PHYSICIAN/CONSULTANT PHYSICIAN ON CALL

Responsibilities:

1. Oversee the Medical response to the incident.
2. Responsible for ensuring Physician input into the resuscitation of Priority 1 and 2 medical patients in the ED.

Initial Actions:

1. Attend Hospital Control Room Seminar Room One (Plastics Department), Jubilee Building, GRI.
2. Will initially be 3rd on Medical Junior Doctor on-call before Consultant Physician identified by Medical Co-ordinator.
3. Assess medical resources currently available and further staff required.
4. Liaise with the Senior Emergency Physician regularly to discuss requirements of medical patients and availability of bed space and medical staff.
5. Assist in clearing Emergency Department of any patients that may go to Wards/SATA.
6. If Major Incident – Standby await further instruction.
7. Inform colleagues of Major Incident status – enlist help of other receiving Consultants of the day.
8. Identify patients in AAU who can be rapidly discharged to create capacity for decompression of the emergency department.
9. In conjunction with the Senior Emergency Physician oversee the treatment being provided by the treatment teams if required.
10. Through Lead Clinicians in downstream units, co-ordinate identification of patients in medical wards who would be appropriate for discharge.
11. Ensure the safe management of existing inpatients.

Priorities:

1. Clear the Emergency Department of medical patients – to ‘green’ beds/ SATA initially
2. Assist in treatment of patients with medical presentations.
3. Mobilise Physician workforce to create capacity rapidly.

## SENIOR INTENSIVIST

Initial telephone contact made to: **81338** (24 hours)

Reports to: **Senior Emergency Physician**

Supervises: **ITU Clinical Staff**

**Responsibilities and Priorities:**

Oversee the intensive care response to the incident.

Assist in the resuscitation of critically ill patients in the P1 Zone.

Identify means of increasing ICU capacity.

Ensure sustainable ICU staffing in the first 72 hours of the incident.

**Actions:**

1. Registrar will take role of *Senior Intensivist* until arrival of first ICU consultant.
2. Notify consultant intensivist on duty.
3. This consultant telephones and ensures additional ICU consultants are mobilised.
    a. Telephone list in GRI ICU Majax Teams Channel.
    b. "Major incident declared – Glasgow Royal Infirmary – report to ICU via Wishart Street or Centre Block entrance".
4. Delegate assessment of current ICU patients for potential downstream transfer to 2nd trainee or 2nd consultant.
5. Attend **ED RESUS (P1 Zone)**, pick up tabard.
6. Assist/prioritise resuscitation of Priority 1 patients with *Senior ED Doctor P1 Area*.
7. Assess ICU resources available and further staff required.
8. Liaise with *Senior Emergency Physician, Senior ED Doctor P1 Area*, *Senior Surgeon and Senior Anaesthetist*, and *Senior Nurse ICU* concerning transfer of patients from ED to ongoing care and current resources available.

## SENIOR ANAESTHETIST

Responsibilities:

1. Oversees anaesthetic response to the incident.
2. Work closely with the Senior Nurse Theatres and operating teams to establish the need and provision of anaesthetic services within the theatre suite and the ED.
3. Liaise with Senior Surgeon and Senior Orthopaedic Surgeon regarding anaesthetic availability for patients requiring immediate surgery from the Emergency Department.
4. Liaise with Senior Intensivist regarding need for intensive care for patients within the theatre suite.

Initial Actions:

1. Notify consultant on call. If trainee initially takes the role of Senior Anaesthetist then first consultant anaesthetist available takes the role of Senior Anaesthetist on arrival.
2. Alert the Departmental Major Incident WhatsApp group; coordinate further consultants to attend the hospital as appropriate, protecting staff with on call commitments in next 24 hours.
3. Attend the Resus area of the Emergency Department, collect tabard and supervise or assist with resuscitation of Priority 1 patients.
4. Liaise with Senior Nurse Theatres regarding availability of staff and equipment within the Theatre Suite.
5. Assess medical resources currently available and further staff required.
6. Liaise with Senior Surgeon and Orthopaedic Surgeon concerning transfer of casualties from the Emergency Department.
7. Liaise with Senior Intensivist regarding potential requirements for intensive care patients in theatre.

Priorities:

1. Assist in resuscitation of patients requiring urgent surgical intervention.
2. Ensure staff cascade call-out performed.
3. Work closely with Senior Nurse Theatres to ensure theatre availability.
4. Liaise with Senior Surgeon and Senior Orthopaedic Surgeon in the emergency department regularly.

## SENIOR NURSE ICU

**Responsibilities:**

1. Responsible for co-ordinating all ICU activity.
2. Preparation of ICU for the arrival of casualties.
3. 24-hour enhanced staffing of ICU

**Initial Actions:**

1. Inform all staff of major incident status.
2. Allocate one member of staff to man telephone and manage all communications, liaising with Senior Nurse, Hospital Control Room and Clinical Co-ordinator.
3. Liaise with Senior Intensivist regarding possible transfer of patients out of ICU/expansion of unit
4. Prepare patients for transfer if required.
5. If Major Incident – Standby await further instruction.
6. Allocate duties to staff, including staff deployed from other areas, to transfer patients, prepare beds, equipment and documentation.
7. Transfer identified patients to areas as directed by the Senior Intensivist and Bed Manager.
8. Liaise with Senior Nurse Theatres regarding potential overflow capacity in Theatre Recovery.
9. Monitor all unit activity, liaising with appropriate personnel as necessary.
10. Liaise with Senior Nurse regarding on-going staff requirements.

**Priorities:**

1. Control of the preparation of the Intensive Care Unit to receive casualties
2. Expand ICU capacity physically or by decant.
3. Call in of nurses/AHPAs to provide cover for an increased capacity/acuity ICU

## HAEMATOLOGY BMS

1. Assign a member of staff to deal with all telephone enquiries.

2. Check blood stocks and liaise with SNBTS for additional stock if required

3. Use MI contact list located in laboratory to arrange additional staff to attend and notify Laboratory Managers on call Haematologist.

4. Emergency O Negative blood available in:
   ED Fridge – 4 O Negative
   Theatre Fridge – 2 O Negative
   PRM Fridge – 4 O Negative and 4 Paediatric O Negative

5. Issue further Emergency blood as required with O Negative for unknown and females and O Positive for males.

6. Review requirement to recall allocated blood from satellite fridges to boost emergency stocks

7. Liaise with South and Clyde sector if additional reagents and consumables are required

## RADIOLOGY

Within Normal working hours, ED will contact Reporting Room on ext 29714 -

- 1. Confirm incident declaration
- 2. Anticipated casualties
- 3. Anticipated nature of casualties

Normal Hours – CT Lead will coordinate with Radiologists to facilitate scanning. CT3 scanner will be cleared to receive MI patients, main dept CT scanners will be put on alert.

OOH Incident:

- The Lead Radiographer on shift will contact the Radiology HUB to inform them of the MI call during OOH, and phone switchboard to alert the Interventional On-call Team.

- ED Lead Radiographer will phone the Consultant on-call Radiologist at home who should proceed to GRI. *Radiologist Contact numbers are kept in a Blue Folder in ED Viewing Room for all Radiology staff, along with the on-call rota.*

- The On-call Consultant should contact David Cowell to inform him of the incident, and call in additional Radiology support.

  During the MI, On-call Consultant Radiologist will be based in main department CT reporting area to vet, protocol and report CT scans. They will be contactable on ext 29714

  Second consultant will be deployed to CT3 to provide primary survey CT reports.

- CT staff will liaise with Radiologists - all scanners will be ready for use if required.

- Radiographer Co-ordinating ED Imaging will be ED Modality Lead in the first instance or Plain Film Modality Lead.

- Liam Weir will be phoned as first contact from Radiology Management team, followed by Pip Torelli/Mary MacFarlane.

The Lead ED Radiographer will maintain regular communications with ED and update the Radiology team on number of casualties expected to arrive.

Co-ordinator/Management Team to assess requirement for further staff call in or step down.

VIP patients for Imaging;

- Resus back corridor for access/egress. Imaged in Rm3 to maintain privacy.
- CT3 if required- / Agree post imaging pathway.

## BIOCHEMISTRY BMS

Responsibilities:

1. Responsible for the preparation and provision of biochemistry laboratory services.
2. Mobilisation of additional staff as required.

Initial Actions:

1. BMS should inform Consultant Biochemist On-Call informing him/her that a major incident has been declared. A list of emergency phone numbers is held by the biochemistry department.
2. If Major Incident – Standby await further instruction.
3. Take steps to clear outstanding work.
4. Ensure the Architect and blood gas analysers are ready to receive samples.

Priorities:

1. Informing the Consultant Biochemist.
2. Preparing the analysers to receive samples.

The on-call consultant biochemist will:-

1. Telephone and arrange for two further members of BMS staff to attend the hospital. At his/her discretion a further one or two members of staff may be called in to staff a ward-based blood gas analyser and/or to act as porter for samples.
2. Make his/her way to the department, or if this is not immediately possible, arrange for a reporting biochemist to attend.
3. The consultant or reporting biochemist will a) handle telephoned or paged requests for emergency analyses, and b) telephone results relating to victims.

## EMERGENCY PHARMACY

Responsibilities:

1. Report to Hospital Control Room and liaise with the Hospital Medical Co-ordinator.
2. Alert the Pharmacy Manager (or most senior Pharmacist available) and Operational Services Manager.
3. Consider role in support of rapid discharges.
4. Alert EDC Pharmacist in other relevant hospitals from which drug supplies may be required.
5. Contact relevant wholesale pharmaceutical distributors as required for emergency drug supplies.
6. Consider role in provision of antidotes in deliberate release / accidental release.

## CHAPLAINCY

"Healthcare Chaplains may be required to support patients, families or staff during the major incident. Chaplains are available for all patients, families and staff irrespective of faith or belief. They are skilled listeners able to help patients, families or staff debrief or work through their experience, and can provide immediate emotional, psychological and spiritual support as needed. When appropriate, chaplains can liaise with external faith representatives and ensure that religious needs are met."

**Responsibilities:**

1. Religious officers representing the faiths of families and casualties may be required to support families during the major incident or to perform religious acts.

**Initial Actions:**

1. Chaplain on-call will assess Chaplaincy requirements and contact other Chaplains and faith representatives as required including Chaplaincy Coordinator.
2. Chaplain will help staff at Relatives' Reception in Campsie Dining room (01415319120/61920) liaising with Senior Nurse (01415319155/69155)
3. If appropriate, arrange for Chaplaincy Centre Quiet Room (1st floor Surgical Block, Main Block GRI) to be open and staffed for use by relatives and staff.
4. A Chaplain will be available for patients in the Emergency Department.
5. Chaplain will be available to respond to queries regarding religious, cultural and spiritual issues.
6. Chaplain will ensure adequate cover to respond to requests for chaplaincy services elsewhere on Hospital site.
7. Chaplain will co-ordinate input of other clergy, representatives from faith communities and Chaplaincy volunteers where appropriate.
8. Chaplain will be available to provide staff support, before and after standdown, where appropriate.
9. Chaplain will ensure adequate on-going Chaplaincy cover is available to provide follow-up support for patients and relatives transferred to wards.

**Priorities:**

1. Ensure chaplaincy support to requests for chaplaincy services.

## PHYSIOTHERAPY

**Responsibilities:**

1. Attend Hospital Control Room for instruction from the Hospital Medical Co- ordinator.
2. Inform the Head of Department that the on call physiotherapist has been called in.
3. On call physiotherapist alerts two additional therapists before leaving to attend the hospital.
4. Any additional therapists will be called in by the on call physiotherapist if required.

Head of department to be informed if the Physiotherapy space is required for an alternative function.

## SENIOR CATERING MANAGER

Responsibilities:

1. Ensure adequate catering for the duration of the incident response.

Initial Actions:

1. Attend the Catering Department.
2. Activate staff call out.
3. Duties may include:
    a) Provision of hot and cold drinks.
    b) Provision of food (e.g. sandwiches). - for staff, patients, relatives and volunteers involved in the major incident.
4. Liaise with the Senior Facilities Manager (69149) in the Hospital Control Room regarding provision of catering services during the major incident.
5. Catering Service will be required in the following areas:
    a) Lomond Room, Centre Block and Aroma Café QEB Concourse for Staff.
    b) Seminar Room One (Plastics Department), Jubilee Building for Management.
    c) QEB Campsie Dining Room for Relatives.
    d) Outpatient Department, QEB for Police Discharge Area.

Priorities:

1. Ensure that the catering service is adequate during the incident response.

## CLINICAL CO-ORDINATOR

Responsibilities:

1. Oversee the movement of patients downstream to generate capacity.
2. Identify suitable beds for critical care areas to transfer into.
3. Track patient movements.

Initial Actions:

1. Attend the Hospital Control Room – Plastics Seminar Room, 1st Floor Jubilee Building
2. Call in assistance – as required
3. Inform HDU, ICU, Plastics/Burns and receiving wards (medical, surgical, orthopaedic) of Major Incident status.
4. Prepare to move patients from receiving wards to downstream wards (x 5 patients to each ward).
5. Assist in identifying beds for patients in the Emergency Department
6. If Major Incident – Standby await further instruction.
7. Identify beds for Intensive Care and High Dependency patients suitable for decant.
8. Inform all wards to delay elective admissions.
9. Track decanted patients.
10. Track all admitted patients.
11. Liaise with the Hospital Medical Co-ordinator, Hospital Control Room and Medical Records Department regularly.

Priorities:

1. Clear Receiving Wards (medical, surgical, orthopaedic) for arrival of major incident patients.
2. Identify beds for decant of critical care patients.
3. Liaise regularly with medical co-ordinator regarding bed availability.

## SENIOR NURSE THEATRES

Responsibilities:

1. Assess Theatre capability with Senior Anaesthetist, Surgical. Orthopaedic and Burns and Plastics Consultants.
2. Preparation of theatres.
3. Co-ordination of theatre teams.
4. 24-hour staffing of theatres.

Initial Actions:

1. Attend Theatre suite.
2. Wear Senior Nurse Theatres tabard.
3. Liaise with Senior Anaesthetist regarding availability of staff and equipment within the Theatre suite.
4. Allocate one member of staff to man telephone and manage all communications, liaising with Senior Nurse Theatres, Senior Anaesthetist Theatres, Senior Surgeon Theatres and Hospital Control Room.
5. Notify all Theatres and Day Surgery.
6. Hold anaesthetic and surgical procedures on patients waiting.
7. Prepare to return patients in recovery areas and anaesthetic areas to wards.
8. Notify Theatre Manager.
9. If Major Incident Standby await further instruction.
10. Assess medical resources currently available and further staff required.
11. Arrange to organise adequate levels of staff appropriate to the type of major incident using prepared phone list.
12. Call one person from each team.
13. The person contacted from each team then contacts all other team members.
14. Keep a note of all staff contacted and arrange for them to attend the hospital.
15. Notify Theatre Controller on arrival.
16. Out of normal working hours commence cascade call out.
17. Prepare anaesthetic areas in main theatre suite.
18. Prepare recovery to accept two ventilated patients.
19. Anticipate equipment required in theatres dependent on information available.
20. As staff arrive note names on list - allocate to theatres as required.
21. Liaise with Senior Anaesthetist and Consultant Surgeons regarding available theatres as required.
22. Liaise with Senior Nurse, Hospital Control Room regarding on-going staff requirements.

**Priorities:**

1. Ensuring adequate Theatre availability
2. Initiating cascade call-out of staff and allocation of staff.
3. Ensuring availability of equipment.
4. Regular liaison with Senior Anaesthetist, Consultant Surgeons and Senior Nurse

## SENIOR NURSE MEDICAL AND SURGICAL HIGH DEPENDENCY UNIT

Responsibilities:

1. Co-ordinate ward activity
2. Preparation of HDU for the arrival of casualties.
3. 24-hour enhanced staffing

Initial Actions:

1. Inform all staff of Major Incident status.
2. Allocate one member of staff to man telephone and manage all communications, liaising with Senior Nurse (69155), Hospital Control Room and Bed Manager.
3. Assess and identify three patients suitable for transfer to wards.
4. Prepare patients for transfer.
5. If Major Incident – Standby await further instruction.
6. Allocate duties to staff, including staff deployed from other areas, to transfer patients, prepare beds, equipment and documentation.
7. Transfer identified patients to wards as directed by Bed Manager.
8. Organise movement of patients within the unit to free designated bed areas.
9. Carry out immediate assessment of each patient on admission, identifying priorities.
10. Monitor all unit activity, liaising with appropriate personnel as necessary.
11. Liaise with Senior Nurse regarding ongoing staff requirements.

**Priorities:**

1. Control of the preparation and staffing of the High Dependency Unit.
2. Control of the provision of the required numbers of suitably qualified nurses to allow enhanced 24-hour cover.

## SENIOR NURSE RECEIVING WARDS

Responsibilities:

1. Co-ordinate Ward Activity
2. Preparation of Ward for the arrival of casualties
3. 24-hour enhanced staffing of Ward**.**

Initial Actions:

1. Inform all staff of Major Incident status.
2. Allocate one member of staff to man telephone and manage all communications, liaising with Senior Nurse (69155) Hospital Control Room (69156) and Bed Manager.
3. Assess patients for transfer to downstream wards.
4. Identify five patients for immediate transfer when a major incident is declared. (Designated area - any specialty downstream ward).
5. Allocate staff to prepare patients for transfer.
6. If major incident – standby await further instruction.
7. Commence decant of 5 patients in communication with Senior Nurse/Clinic Co-ordinator
8. Allocate duties to staff, including staff deployed from other areas, to transfer patients, prepare beds, equipment and documentation.
9. Arrange immediate transfer of five patients to wards. Depending on clinical need and only after discussion with the Senior Nurse, patients may be transferred to **any ward**.
10. Monitor all unit activity, liaising with appropriate personnel as necessary.
11. Liaise with Senior Nurse regarding on-going staff requirements.

**Priorities:**

1. Control of the preparation and staffing of receiving wards
2. Decant of 5 patients downstream to generate receiving capacity.
3. Control of the provision of the required numbers of suitably qualified nurses to allow enhanced 24-hour cover.

## SENIOR NURSE DOWNSTREAM WARDS

Responsibilities:

1. Notify staff of Major Incident
2. Identify available and potential beds.
3. Prepare ward to accept 5 patients. NB There may be requirement to go over capacity
4. If Major Incident – Standby await further instruction.
5. Allocate duties to staff, including staff deployed from other areas, to prepare beds, equipment and documentation.
6. Accept patients transferred from receiving wards, ED or theatre as directed by Bed Manager.
7. Organise movement of patients within the ward to free designated bed areas.
8. Carry out immediate assessment of each patient on admission, identifying priorities.
9. Monitor all unit activity, liaising with appropriate personnel as necessary.

Priorities:

1. Control of the preparation and staffing of ward.
2. Prepare for potential over capacity state
3. Control of the provision of the required numbers of suitably qualified nurses to allow enhanced 24-hour cover.

## SENIOR NURSE BURNS AND PLASTICS

**Responsibilities:**

1. Notify staff of Major Incident Declaration
2. Early liason with Senior Burns and Plastics Consultant on call
3. Identify available patients who may be able to transfer out of the unit and in collaboration with the Clinical co-ordinator confirm the potential beds.
4. Prepare to accept 5 patients within the Plastic Surgery and Burns wards.
5. Additional beds may be required depending on the nature of the incident and the Senior Nurse should liaise with the Clinical co-ordinator/Control Room ( Plastics Seminar Room)
6. If Major Incident – Standby await further instruction.
7. Allocate duties to staff, including staff deployed from other areas, to prepare beds, equipment and documentation.
8. Accept patients transferred from ED or Theatre as directed by the Clinical Co-ordinator.
9. Organise movement of patients within the ward to free designated bed areas.
10. Carry out immediate assessment of each patient on admission, identifying priorities.
11. Monitor all unit activity, liaising with appropriate personnel as necessary.

**Priorities:**

1. Control of the preparation and staffing of ward.
2. Control of the provision of the required numbers of suitably qualified nurses to allow enhanced 24-hour cover.

ED HIGH PROFILE PATIENT

# High Profile Patient Plan

EMERGENCY DEPARTMENT- ACTION CARD

Glasgow Royal Infirmary. October 2020 [v1.5]

| | |
|---|---|
| **APPLICATION** | • Patients with high or potentially high security risk.<br>• Patients with high public and media profile. |
| **PRE-ARRIVAL** | • Standby / notification received.<br>• Consider **pre-hospital diversion**/direct transfer to a definite care centre if the patient has tertiary care requirements (head injury, vascular, ENT, paediatrics) *unless the patient has a life-threatening condition which requires stabilisation.* |
| **NOTIFY** | **In hours**<br>• ED CIC & Senior Nurse in Charge / Lead Nurse.<br>• General Manager for ECMS to agree activation. GM (should then contact Switchboard (19342 / 19429) to inform "**High Profile Patient inbound to GRI**" and notify contact list and ask them to report to the Emergency Department).<br><br>**Out of hours**<br>• ED Consultant on call.<br>• Clinical nurse co-ordinator (Should alert the on call General Manager).<br><br>**Additional**<br>• Consider early senior porter/security team to exclude public and press from the ED.<br>• Notify Reception (10 VIP patient packs with specific TJ Identifiers) |
| **IDENTIFY** | • Designate an appropriate area within the Emergency Department for patient assessment and management.<br>• Ideally use Resus 5 (POD) if VIP. Alternatively consider 13/14/CPR if AGP restriction.<br>• Use resus back corridor for transfers rather than main department. |

| | |
|---|---|
| **ACTIONS** | • Limit patient movement and staff contacts in the hospital.<br>• Middle grade member of staff the ED consultant will lead on patient assessment and management.<br>• Bringing consultant assessments/specialists to the patient where possible.<br>• Use near patient investigations.<br>• Second senior ED clinician should lead on managing the rest of the department.<br>• If the patient requires admission, the designated admission bed would be within a single room in the appropriate specialised care ward.<br>• Excess VIP security/personnel should be directed to the ED seminar room with overspill into physio gym. Limited ED access cards will be available but need signed out/return. |

# APPENDIX  - SURGICAL/ANAESTHEYTIC/ICU ESCALATION

**Department/Area: ICU**

| Dept Status | Triggers | Considerations | Actions |
|---|---|---|---|
| GREEN | Baseline:<br>Patients:<br>• 12 Level 3<br>• 8 Level 2<br>Staffing ratio<br>1:1 Level 3<br>2:1 Level 2<br>X 2 HCSW<br>CN for East & West, SCN & Educator (if educator on floor still green)<br>18 RN's, CN, | • No escalation actions required.<br>• All elective TCI easily accommodated and receiving capacity for emergency admissions.<br>• Receiving cubicles.<br>• For every additional level 3 patient admitted above the baseline 12 – x2 level reduction in level 2 capacity.<br>• Max 16 level 3's | • Routine day/day activities<br>• Identify and highlight patients fit for discharge and liaise with bed management re: capacity in hospital.<br>• Attend 09.30am bed management meeting - Discuss planned activity and movement with - SHDU, Surgical Bed Flow Coordinator, and Recovery.<br>• Liaise with Consultant throughout the shift – future discharge planning/ referrals.<br>• Link in with hospital huddle. |
| AMBER | Patients:<br>• 12+ level 3 patients.<br>• 8+ Level 2<br>Staffing:<br>x1 nurse less than baseline.<br>Educator on floor +/- SCN. | • Reduced receiving capacity<br>• Forward planning for potential admissions<br>• Ability to flex up and down dependent on level2/3 mix<br>• Theatre / recovery activity – impact on flow | • Early identification of patients fit for discharge and liaise with bed management re: capacity in hospital. Demonstrating increased critical care demand.<br>• Early liaison with theatre/ recovery to highlight any potential impact on flow.<br>• Attend 09.30am bed management meeting – demonstrate increased demand and reduced capacity to facilitate timely discharges. Theatre/ recovery, SHDU, Surgical bed flow coordinator, Bed management and hospital site flow if required.<br>• Regular consultant ward rounds.<br>• Plan identified for next referral.<br>• All referrals through SCN/ Consultant<br>• Lead nurse informed<br>• Feed into hospital huddle hospital huddle.<br>• Staffing concerns escalated to Lead nurse and plan agreed of when to escalate to PRA |
| RED | Patients:<br>Any mix of<br>• 12+ level 3 patients.<br>• 8+ Level 2<br>Staffing:<br>x2 nurses less than | • Reduced/ No receiving capacity.<br>• Theatre/ recovery activity – impact on flow, ability to 'hold' patients, | • Immediate identification of patient fits to discharge and escalation to hospital site flow<br>• Immediate escalation to lead nurse/ Consultant re capacity, demand vs resources.<br>• Attend 09.30am bed management meeting demonstrating Critical Care pressures, demand vs resource – theatre/ recovery, SHDU, Surgical bed flow coordinator, bed management.<br>• Arrange further bed management meeting with Theatre/ recovery, surgical bed flow and bed management.<br>• Escalate concerns to lead Nurse >CSM>GM, Consultant.<br>• Escalation of staffing pressures – seek authorisation of bank staff requests to PRA<br>• Escalate concerns to site flow.<br>• Plan identified for next referral – theatre/ recovery ability to hold patients, consideration about cross site transfer |

| Dept Status | Triggers | Considerations | Actions |
|---|---|---|---|
| | required.<br><br>All available resource on floor. | | • Discussion about elective theatre activity.<br>• All patient referrals through SCN/ Consultant.<br>• Feed into hospital huddle |
| **BLACK** | Patients:<br>Increased volume of level 3 activity to max 16 or any mix of level 2/3 patients with no available receiving beds.<br>Staffing:<br>X3 nurses less than baseline.<br><br>All available resource on floor.<br>No SCN flow coordinator. | • No receiving capacity<br>• No staff to admit.<br>• All options to increase capacity exhausted.<br>• All options to release staff to admit exhausted.<br>• GGC critical Care capacity.<br>• WOS critical Care capacity. | • Immediate escalation to Lead nurse>CSM>GM and hospital site flow.<br>• Immediate senior bed management meeting – Lead nurse/ CSM/ SCN/ Consultant<br>• Senior Management ward round – any scope to discharge/ Transfer out<br>• Plan established to release receiving Critical Care capacity.<br>• Identify any patients safe to transfer if required.<br>• Early liaison with theatre/ recovery - demonstrating CC pressures/ impact on theatre, explore ability to hold patients in theatre/ recovery department.<br>• Liaise with consultant to establish location able to take a transfer<br>• Lead nurse feed into huddle<br>• Await further instruction from CSM/GM |

**Department/Area: Trauma & Orthopaedic Surgery**

| Dept Status | Triggers | Pause/ Huddle | Role: Senior Charge Nurse | Role: Nurse in Charge | Role: Consultant in Charge | Role: Lead nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| GREEN | Minimal staff shortages | | No escalation | Ensure appropriate staffing to run lists as safely as possible | | | | | |
| AMBER | Staff shortages which will delay or cause lists to run at unsafe level | | Escalate to Lead Nurse Contact other Endoscopy Units for assistance | Maintain safe working practice within the unit | | | | | |
| RED | Staff shortages which will delay or cause lists to run at unsafe level | | Escalate to Lead Nurse Contact other Endoscopy Units for assistance<br><br>Where available seek assistance from Nurse Endoscopists | Maintain safe working practice within the unit | | Ensure all protocols have been implemented and all avenues exhausted to ensure the safe running of the unit | | | |
| BLACK | Severe staff shortages | | Escalate to Lead Nurse Contact other Endoscopy Units for assistance<br><br>Where available seek assistance from Nurse Endoscopists<br><br>Prioritising patients to | Maintain safe working practice within the unit<br><br>Keeping patients updated to the situation | | Discussions with CSM as to prioritising patients requiring their procedure and possible cancellation of others | Consider partial cancellation of elective procedures | | |

| Dept Status | Triggers | Pause/ Huddle | Role: Senior Charge Nurse | Role: Nurse in Charge | Role: Consultant in Charge | Role: Lead nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| | | | have procedures carried out<br><br>Escalate to CSM with regards to moving or cancelling patients for safety reasons | | | | | | |

| Pull Policy | NB: What Doesn't work |
|---|---|
| N/A | × Failing to liaise with consultants/nurse endoscopists during the day and failing to agree broad strategies |
| **Decompression/Push Policy** | |
| N/A | |
| **Push** | |
| N/A | |
| **Full Capacity Protocol** | |
| N/A | |

**To consider when developing actions**

- **Actions and Roles**
  - Who is doing the activity?
  - Who needs to be informed when activity is complete/updated on progress?
  - Who needs to make decisions?
  - What actions can be delayed/stopped as levels increase?

- **Escalation Criteria**
  - What are the criteria for your area?
  - Are there Early Warning Indicators that should be monitored in lower level?

- **Decision making**
  - Consider as levels increase, communication and decision making should become more streamlined, allowing folk to get on and do.

- **Communication**
  - What is being communicated, to whom, and how?
  - Consider the timeliness of communication, especially in higher escalation levels.
  - Consider streamlining communication in higher levels so folk aren't distracted from activity.

Department/Area: General Surgery

| Dept Status | Triggers | Pause/ Huddle | Role: Nurse in Charge | Role: Consultant in Charge | Role: Senior Charge Nurse | Role: Flow Coordinator | Role: Lead Nurse | Role: CSM | Role: On Call Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|---|
| GREEN | Majors <19<br>Minors <10<br>TTFA < 90 mins<br>Medical <12<br>Surgical <5<br>AEC <7<br><br>Less than 4 patients waiting for a bed > 4hrs from DTA/Bed Request<br><br>No Bed deficit<br><br><22 Staff Shortages | | • Ensure Daily Dynamic Discharge operational for all medical wards including twice daily board rounds, all EDDs are correct and protect time for IDL completion of next day's pre-10 patients | • Ensure Daily Dynamic Discharge operational for all medical wards including twice daily board rounds, all EDDs are correct and protect time for IDL completion of next day's pre-10 patients | • Escalate delayed discharges<br>• Enhance ward "Pull" of new patients and undertake physical check for empty beds<br>• Optimise patient flow from AMRU as per the admission transfer criteria | • Review tranfers from Critical Care | • | • | • | • |
| AMBER | Majors 20 - 30<br>Minors 11 - 20<br>TTFA 91-150 mins<br>Medical 13 -15<br>Surgical 6-8<br>AEC 8-14<br><br>More than 4 patients waiting for a bed between 4 & 6 hrs from DTA/Bed Request | | • | • | • | • Identify patients awaiting radiology and communication with radiology department<br>• Consider if any patients suitable to board from who will be discharged the following day (to Ortho or Urology) | • Consultant On-call, and senior team informed of<br>• alert level<br>• Review transfers from other sites<br>• Consider transfer of elective operating from GRI to Stobhill ACH where possible<br>• Review options for patients being admitted the before surgery and non urgent investigations | • Consultant On-call, and senior team informed of<br>• alert level<br>• Review transfers from other sites<br>• Consider transfer of elective operating from GRI to Stobhill ACH where possible<br>• Review options for patients being admitted the before surgery and non urgent investigations | • Consultants & Registrars to prioritise ward rounds of patients throughout unit and determine those waiting for investigation. To determine if any could be discharged for further investigation or treatment as an outpatient | • |

| Dept Status | Triggers | Pause/ Huddle | Role: Nurse in Charge | Role: Consultant in Charge | Role: Senior Charge Nurse | Role: Flow Coordinator | Role: Lead Nurse | Role: CSM | Role: On Call Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|---|
| | Bed deficit 1-40<br><br>Staff Shortages 23-29 | | | | | | | | | |
| RED | Majors 31 - 40<br>Minors 21 - 25<br>TTFA 151-239 mins<br>Medical 16 -24<br>Surgical 9-12<br>AEC 15-19<br><br>More than 4 patients waiting for a bed between 6 & 8 hrs from DTA/Bed Request<br><br>Bed deficit 41-75<br><br>Staff Shortages 30-35 | | • | • | • | • Consider if any further patients are suitable to board (to Ortho or Urology) | • Ensure all Level 1 actions completed and ongoing<br>• Consider partial cancellation of elective operating<br>• Consider if any further patients are suitable to board (to Ortho or Urology) | • Ensure all Level 1 actions completed and ongoing<br>• Consider partial cancellation of elective operating | • | • |
| BLACK | Majors 41+<br>Minors 26+<br>TTFA 240+ mins<br>Medical 25+<br>Surgical 13+<br>AEC 20+<br><br>More than 4 patients waiting for a bed more | | • | • | | - | • | • | • | • Ensure all previous actions complete<br>• Review further elective cancellations |

| Dept Status | Triggers | Pause/ Huddle | Role: Nurse in Charge | Role: Consultant in Charge | Role: Senior Charge Nurse | Role: Flow Coordinator | Role: Lead Nurse | Role: CSM | Role: On Call Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|---|
| | than 8 hrs from DTA/Bed Request<br><br>Bed deficit 76+<br><br>Staff Shortages 36+ | | | | | | | | | |

| Pull Policy | NB: What Doesn't work |
|---|---|
| Downstream wards should continually liaise with receiving areas and ED to 'pull' suitable patients into the relevant specialty wards. This is 'Business as usual' and should not wait for beds to be vacated. Patients for discharge can 'sit out' or go to the discharge lounge. | × Failing to liaise with receiving consultants during the day and failing to agree broad strategies<br>× Asking Specialty Consultants to 'ward round' bed waiters in ED (see above – better to ask for junior ward support to facilitate ongoing management, kardexes, clerking, bloods etc)<br>× Asking specialty consultants to come to ED to help see patients (better to focus on clearing receiving areas, implementing 'push' to downstream and expediting downstream discharge)<br>× Expecting specialty juniors to assist in ED when wards are very busy (valuable ED senior time is wasted on phone)<br>× Expecting specialty juniors to see patients outwith their 'comfort zone' (valuable ED senior time is wasted explaining ED processes – better to have them focus on any likely admissions to their specialty |
| **Decompression/Push Policy** | |
| Once in 'Amber' the requirement for implementation of the 'Decompression/Push Policy' should be highlighted at thrice daily Hospital Huddles<br>In AMU patients earmarked for transfer will be moved to a holding area. ED decompression involves transfer of ED patients waiting for a bed in receiving areas to the beds vacated by these AMU patients.<br>Patients will also be moved to newly opened beds or into boarding beds | |
| **Push** | |
| At Escalation 'Red status', where there are prolonged bed waits for patients in ED (eg 2h from decision to admit), the Response Team will consider the transfer of patients from receiving areas to downstream wards - where patients have been identified for discharge but the bed is not currently ready or is still occupied by the patient being discharged. This would then see ED patients moved rapidly to the receiving area. As a consequence this means that the downstream ward is likely to have a 'plus one' status with patients pending discharge having been moved to a seated waiting area in the ward. Where patients requires a trolley for discharge they should be moved to either the Discharge Lounge or a suitable area within the ward awaiting completion of outstanding discharge tasks | |

| | |
|---|---|
| **Full Capacity Protocol**<br>At Black escalation status the Emergency Incident Group (chaired by CEO) may consider implementation of a Full Capacity Protocol.<br>1. Open additional unstaffed beds (eg gyn, urology, 47A)<br>2. Transfer to a pre-identified space in a ward area or unit without a bed being available within that ward or unit. | |

**To consider when developing actions**

- **Actions and Roles**
  - Who is doing the activity?
  - Who needs to be informed when activity is complete/updated on progress?
  - Who needs to make decisions?
  - What actions can be delayed/stopped as levels increase?

- **Escalation Criteria**
  - What are the criteria for your area?
  - Are there Early Warning Indicators that should be monitored in lower level?

- **Decision making**
  - Consider as levels increase, communication and decision making should become more streamlined, allowing folk to get on and do.

- **Communication**
  - What is being communicated, to whom, and how?
  - Consider the timeliness of communication, especially in higher escalation levels.
  - Consider streamlining communication in higher levels so folk aren’t distracted from activity.

**Department/Area: Theatres**

| Dept Status | Triggers | Pause/ Huddle | Role: Recovery | Role: Senior Charge Nurse | Role: Theatre Coordinator | Role: HUB Coordinator | Role: Lead Nurse |
|---|---|---|---|---|---|---|---|
| GREEN | No Bed deficit<br><br>No Staff Shortages | 08:30<br>12:30<br>16:00 location IHO Hub. Attended by Anaesthetic teams, Surgical Team, Hub coordinator, Theatre Coordinator, Recovery and SDAU<br><br>Recovery Critical care Huddle – 0930 | • Attend Huddle 12:30<br>16:00<br>• Liaise with theatre coordinator/Hub Coordinator<br>• Recovery Critical care Huddle – 0930 | • Identify potential threats to smooth running of operating lists.<br>• Optimise patient flow within theatres.<br>• Regular communication with theatre coordinator | • Liaise with SCN's from Theatre / Recovery / SDAU / CC to obtain overview of landscape.<br>• Ensure smooth running of elective surgery<br>• Assist emergency/elective workflow by identifying underutilised theatre time<br>• Attend 08:30 12:30<br>1600<br>huddle. | • Ensure CEPOD patients gain access to theatre in timeframe.<br>• Ensure all patients have CPOD category to prioritise patient flow<br>• Attend 08:30 , 12:30, 16:00 huddle. | • Liaise with theatre coordinator and IHO coordinator to ensure smooth theatre utilisation |
| AMBER | Downstream movement impacting on transfer to ward / CC post-operatively | Ensure all green actions complete | Ensure all green actions complete<br><br>Consideration of holding level 2 patients<br><br>Increased communication with critical care and specialties | Ensure all green actions complete<br><br>• Liaise with Theatre Coordinator regarding composition of operating list.<br>• Identify potential alterations to list order to help with patient flow. | Ensure all green actions complete<br><br>• Liaise with Recovery / SDAU / CC SCN's to understand demand and downstream movement.<br><br>• Notify Lead Nurse | Ensure all green actions complete<br><br>• Ensure CEPOD patients continue to gain access to theatre in timeframe.<br><br>• Remain aware of situation | Ensure all green actions complete<br><br>• Attend 12:30 /16:30 huddle.<br>• Increase presence in theatre suite<br>• Remain aware of situation<br>• Inform senior management team |
|  | Downstream | Ensure all Green and Amber actions | Ensure all Green and Amber actions | Ensure all Green and Amber actions | Ensure all Green and Amber actions | Ensure all Green and Amber actions complete | Ensure all Green and Amber actions |

| Dept Status | Triggers | Pause/ Huddle | Role: Recovery | Role: Senior Charge Nurse | Role: Theatre Coordinator | Role: HUB Coordinator | Role: Lead Nurse |
|---|---|---|---|---|---|---|---|
| **RED** | movement impacting on transfer to ward / CC post-operatively<br><br>Recovery on "standby" to discharge appropriate patients.<br><br>Recovery holding level 2 patients in bay 3 | complete | complete<br><br>• prepare to discharge patients directly from recovery<br>• Increased communication with theatre coordinator/Hub coordinator<br>• Recovery SCN to utilise "Bay 1" to hold patients awaiting discharge downstream.<br><br>• Additional 12:00 / 16.00 huddle with CC | complete<br><br>• Attend 12:30 / 16:30 huddle. | complete<br><br>• Liaise with recovery to facilitate discharge of patients directly from recovery | • Liaise with Theatre Coordinator regarding downstream impact on CEPOD patients. | complete<br><br>• Attend 08:30 / 12:30 / 16:30 huddle.<br>• Ensure Recovery can facilitate discharge of patients. |
| **BLACK** | Downstream movement impacting on transfer to ward / CC post-operatively.<br><br>Recovery holding patients in "Bay 1"<br><br>Recovery holding level 2 patients in bay 3<br><br>Recovery discharging patients. | Ensure all Green, Amber and Red actions complete | Ensure all Green, Amber and Red actions complete<br><br>• Recovery SCN to utilise "Bay 3" to hold level 2 patients | Ensure all Green, Amber and Red actions complete<br><br>• Ensure theatre team leads are aware of situations affecting their operating lists | Ensure all Green, Amber and Red actions complete<br><br>• Liaise with recovery regarding the impact of holding patients in recovery<br><br>• Liaise with SCN's identify the knock on effect to flow of emergency and elective patients as a result of patients being held in recovery | Ensure all Green, Amber and Red actions complete<br><br>• Remain aware of situation in recovery and elective to ensure maximum throughput of emergency cases | Ensure all Green, Amber and Red actions complete<br><br>• Identify where Stobhill ACH Theatres can be utilised to assist with GRI pressures e.g. Staffing |

| Pull Policy | NB: What Doesn't work |
|---|---|
| Downstream wards should continually liaise with receiving areas and ED to 'pull' suitable patients into the relevant specialty wards. This is 'Business as usual' and should not wait for beds to be vacated. Patients for discharge can 'sit out' or go to the discharge lounge. | × Failing to liaise with receiving consultants during the day and failing to agree broad strategies<br>× Asking Specialty Consultants to 'ward round' bed waiters in ED (see above – better to ask for junior ward support to facilitate ongoing management, kardexes, clerking, bloods etc)<br>× Asking specialty consultants to come to ED to help see patients (better to focus on clearing receiving areas, implementing 'push' to downstream and expediting downstream discharge)<br>× Expecting specialty juniors to assist in ED when wards are very busy (valuable ED senior time is wasted on phone)<br>× Expecting specialty juniors to see patients outwith their 'comfort zone' (valuable ED senior time is wasted explaining ED processes – better to have them focus on any likely admissions to their specialty |
| **Decompression/Push Policy** | |
| Once in 'Amber' the requirement for implementation of the 'Decompression/Push Policy' should be highlighted at thrice daily Hospital Huddles<br>In AMU patients earmarked for transfer will be moved to a holding area. ED decompression involves transfer of ED patients waiting for a bed in receiving areas to the beds vacated by these AMU patients.<br>Patients will also be moved to newly opened beds or into boarding beds | |
| **Push** | |
| At Escalation 'Red status', where there are prolonged bed waits for patients in ED (eg 2h from decision to admit), the Response Team will consider the transfer of patients from receiving areas to downstream wards - where patients have been identified for discharge but the bed is not currently ready or is still occupied by the patient being discharged. This would then see ED patients moved rapidly to the receiving area. As a consequence this means that the downstream ward is likely to have a 'plus one' status with patients pending discharge having been moved to a seated waiting area in the ward. Where patients requires a trolley for discharge they should be moved to either the Discharge Lounge or a suitable area within the ward awaiting completion of outstanding discharge tasks | |
| **Full Capacity Protocol** | |
| At Black escalation status the Emergency Incident Group (chaired by CEO) may consider implementation of a Full Capacity Protocol.<br>1. Open additional unstaffed beds (eg gyn, urology, 47A)<br>2. Transfer to a pre-identified space in a ward area or unit without a bed being available within that ward or unit. | |

**To consider when developing actions**

- **Actions and Roles**
  - Who is doing the activity?
  - Who needs to be informed when activity is complete/updated on progress?
  - Who needs to make decisions?
  - What actions can be delayed/stopped as levels increase?

- **Escalation Criteria**
  - What are the criteria for your area?
  - Are there Early Warning Indicators that should be monitored in lower level?

- **Decision making**
  - Consider as levels increase, communication and decision making should become more streamlined, allowing folk to get on and do.

- **Communication**
  - What is being communicated, to whom, and how?
  - Consider the timeliness of communication, especially in higher escalation levels.
  - Consider streamlining communication in higher levels so folk aren't distracted from activity.

**Department/Area: Trauma & Orthopaedic Surgery**

| Dept Status | Triggers | Pause/ Huddle | Role: Senior Charge Nurse | Role: Nurse in Charge | Role: Consultant in Charge | Role: Lead nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| GREEN | Majors <19<br>Minors <10<br>TTFA < 90 mins<br>Medical <12<br>Surgical <5<br>AEC <7<br>Less than 4 patients waiting for a bed > 4hrs from DTA/Bed Request<br>No Bed deficit<br><22 Staff Shortages | | • Escalate delayed discharges<br>• Enhance ward "Pull" of new patients and undertake physical check for empty beds | • Ensure Daily Dynamic Discharge operational for all trauma wards including twice daily board rounds, all EDDs are correct and protect time for IDL completion of next day's pre-10 patient<br>• Confirm bed requirement for MTC repatriation patients<br>• Ensure all plans are in the place to identify patients for GORU beds<br>• Confirm and prioritise cold trauma TCIs according to theatre and bed availability | • Ensure Daily Dynamic Discharge operational for all trauma wards including twice daily board rounds, all EDDs are correct and protect time for IDL completion of next day's pre-10 patient<br>• Confirm bed requirement for MTC repatriation patients<br>• Ensure all plans are in the place to identify patients for GORU beds<br>• Confirm and prioritise cold trauma TCIs according to theatre and bed availability | | • | • | • |
| AMBER | Majors 20 - 30<br>Minors 11 - 20<br>TTFA 91-150 mins<br>Medical 13 -15<br>Surgical 6-8<br>AEC 8-14 | | • | • | • | • Consultant On-call & Trauma Co-ordinator informed of alert level<br>• Liaise with ECON/DME to determine if any downstream rehab patients can transfer to GGH or home | • Consultant On-call & Trauma Co-ordinator informed of alert level<br>• Liaise with ECON/DME to determine if any downstream rehab patients can transfer to GGH or home<br>• Consider transfer of elective operating from GRI to Stobhill ACH where possible<br>• Consider undertaking | • Consultants & Registrars to prioritise ward rounds of patients throughout unit and determine those waiting for investigation. To determine if any could be discharged for further investigation or treatment as an outpatient<br>• Identify patients | • |

| Dept Status | Triggers | Pause/ Huddle | Role: Senior Charge Nurse | Role: Nurse in Charge | Role: Consultant in Charge | Role: Lead nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| | More than 4 patients waiting for a bed between 4 & 6 hrs from DTA/Bed Request<br><br>Bed deficit 1-40<br><br>Staff Shortages 23-29 | | | | | | selected trauma surgery at Stobhill<br>• Review patient suitability for ACH and identify theatre requirements | awaiting radiology and communication with radiology department<br>• Maximise use of Theatre L for Trauma and do not bring in stand-by elective patients<br>• Maximise use of Theatre H operating hours to facilitate evening surgery<br>• Avoided accepting tertiary referrals for conditions that could be managed locally | |
| RED | Majors 31 - 40<br>Minors 21 - 25<br>TTFA 151-239 mins<br>Medical 16 -24<br>Surgical 9-12<br>AEC 15-19<br><br>More than 4 patients waiting for a bed between 6 & 8 hrs from DTA/Bed Request<br><br>Bed deficit 41-75<br><br>Staff Shortages 30-35 | | • | • | • | • Ensure all Level 1 actions completed and ongoing<br>• Consider if any further patients are suitable to board (to General surgery or Urology if not availability then also consider plastics and gynaecology) | • Ensure all Level 1 actions completed and ongoing<br>• Consider if any further patients are suitable to board (to General surgery or Urology if not availability then also consider plastics and gynaecology)<br>• Review all elective admissions and identify priority patients | • | • Consider partial cancellation of elective operating |
| | Majors 41+<br>Minors 26+<br>TTFA 240+ mins | | • | • | | - | • | • | • Ensure all previous actions complete |

| Dept Status | Triggers | Pause/ Huddle | Role: Senior Charge Nurse | Role: Nurse in Charge | Role: Consultant in Charge | Role: Lead nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| **BLACK** | Medical 25+<br>Surgical 13+<br>AEC 20+<br>More than 4 patients waiting for a bed more than 8 hrs from DTA/Bed Request<br>Bed deficit 76+<br>Staff Shortages 36+ | | | | | | | | |

| Pull Policy | NB: What Doesn't work |
|---|---|
| Downstream wards should continually liaise with receiving areas and ED to 'pull' suitable patients into the relevant specialty wards. This is 'Business as usual' and should not wait for beds to be vacated. Patients for discharge can 'sit out' or go to the discharge lounge. | × Failing to liaise with receiving consultants during the day and failing to agree broad strategies<br>× Asking Specialty Consultants to 'ward round' bed waiters in ED (see above – better to ask for junior ward support to facilitate ongoing management, kardexes, clerking, bloods etc)<br>× Asking specialty consultants to come to ED to help see patients (better to focus on clearing receiving areas, implementing 'push' to downstream and expediting downstream discharge)<br>× Expecting specialty juniors to assist in ED when wards are very busy (valuable ED senior time is wasted on phone)<br>× Expecting specialty juniors to see patients outwith their 'comfort zone' (valuable ED senior time is wasted explaining ED processes – better to have them focus on any likely admissions to their specialty |
| **Decompression/Push Policy** | |
| Once in 'Amber' the requirement for implementation of the 'Decompression/Push Policy' should be highlighted at thrice daily Hospital Huddles<br>In AMU patients earmarked for transfer will be moved to a holding area. ED decompression involves transfer of ED patients waiting for a bed in receiving areas to the beds vacated by these AMU patients.<br>Patients will also be moved to newly opened beds or into boarding beds | |
| **Push** | |
| At Escalation 'Red status', where there are prolonged bed waits for patients in ED (eg 2h from decision to admit), the Response Team will consider the transfer of patients from receiving areas to | |

| | |
|---|---|
| downstream wards - where patients have been identified for discharge but the bed is not currently ready or is still occupied by the patient being discharged. This would then see ED patients moved rapidly to the receiving area. As a consequence this means that the downstream ward is likely to have a 'plus one' status with patients pending discharge having been moved to a seated waiting area in the ward. Where patients requires a trolley for discharge they should be moved to either the Discharge Lounge or a suitable area within the ward awaiting completion of outstanding discharge tasks | |
| **Full Capacity Protocol** | |
| At Black escalation status the Emergency Incident Group (chaired by CEO) may consider implementation of a Full Capacity Protocol.<br>1. Open additional unstaffed beds (eg gyn, urology, 47A)<br>2. Transfer to a pre-identified space in a ward area or unit without a bed being available within that ward or unit. | |

**To consider when developing actions**

- **Actions and Roles**
  - Who is doing the activity?
  - Who needs to be informed when activity is complete/updated on progress?
  - Who needs to make decisions?
  - What actions can be delayed/stopped as levels increase?

- **Escalation Criteria**
  - What are the criteria for your area?
  - Are there Early Warning Indicators that should be monitored in lower level?

- **Decision making**
  - Consider as levels increase, communication and decision making should become more streamlined, allowing folk to get on and do.

- **Communication**
  - What is being communicated, to whom, and how?
  - Consider the timeliness of communication, especially in higher escalation levels.
  - Consider streamlining communication in higher levels so folk aren't distracted from activity.

**Department/Area: Urology**

| Dept Status | Triggers | Pause/ Huddle | Role: Nurse in Charge | Role: Consultant in Charge | Role: Senior Charge Nurse/Nurse in Charge | Role: Lead Nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| GREEN | Majors <19<br>Minors <10<br>TTFA < 90 mins<br>Medical <12<br>Surgical <5<br>AEC <7<br>Less than 4 patients waiting for a bed > 4hrs from DTA/Bed Request<br>No Bed deficit<br><22 Staff Shortages | | • Ensure Daily Dynamic Discharge operational for all **medical** wards including twice daily board rounds, all EDDs are correct and protect time for IDL completion of next day's pre-10 patients | • Ensure Daily Dynamic Discharge operational for all medical wards including twice daily board rounds, all EDDs are correct and protect time for IDL completion of next day's pre-10 patients | • Escalate delayed discharges<br>• Enhance ward "Pull" of new patients and undertake physical check for empty beds<br>• Review transfers from Critical Care | • | • | • Identify patients awaiting radiology and communication with radiology department | • |
| AMBER | Majors 20 - 30<br>Minors 11 - 20<br>TTFA 91-150 mins<br>Medical 13 -15<br>Surgical 6-8<br>AEC 8-14<br>More than 4 patients waiting for a bed between 4 & 6 hrs from DTA/Bed Request<br>Bed deficit 1-40<br>Staff Shortages 23-29 | | • | • | • | • Consultant On-call, and senior team informed of alert level<br>• Consider if any patients suitable to board from who will be discharged the following day (to Ortho or Gynaecology)<br>• Consider transfer of elective operating from GRI to Stobhill ACH where possible<br>• Review options for patients being admitted the **day** before surgery and non-urgent investigations | • Consultant On-call, and senior team informed of alert level<br>• Consider if any patients suitable to board from who will be discharged the following day (to Ortho or Gynaecology)<br>• Consider transfer of elective operating from GRI to Stobhill ACH where possible<br>• Review options for patients being admitted the **day** before surgery and non-urgent investigations | • Consultants & Registrars to prioritise ward rounds of patients throughout unit and determine those waiting for investigation. To determine if any could be discharged for further investigation or treatment as an outpatient<br>• Identify patients awaiting radiology and communication with radiology department<br>• Review transfers from other sites | • |

| Dept Status | Triggers | Pause/ Huddle | Role: Nurse in Charge | Role: Consultant in Charge | Role: Senior Charge Nurse/Nurse in Charge | Role: Lead Nurse | Role: CSM | Role: Duty Consultant | Role: GM |
|---|---|---|---|---|---|---|---|---|---|
| RED | Majors 31 - 40<br>Minors 21 - 25<br>TTFA 151-239 mins<br>Medical 16 -24<br>Surgical 9-12<br>AEC 15-19<br>More than 4 patients waiting for a bed between 6 & 8 hrs from DTA/Bed Request<br>Bed deficit 41-75<br>Staff Shortages 30-35 | | • | • | • Consider if any further patients are suitable to board (to Ortho or Urology) | • Consider if any further patients are suitable to board (to Ortho or Urology) | • Ensure all Level 1 actions completed and ongoing<br>• Consider partial cancellation of elective operating | • | • Ensure all Level 1 actions completed and ongoing<br>• Consider partial cancellation of elective operating |
| BLACK | Majors 41+<br>Minors 26+<br>TTFA 240+ mins<br>Medical 25+<br>Surgical 13+<br>AEC 20+<br>More than 4 patients waiting for a bed more than 8 hrs from DTA/Bed Request<br>Bed deficit 76+<br>Staff Shortages 36+ | | • | • | • | • | • | • | • Ensure all previous actions complete<br>• Review further elective cancellations |

| **Pull Policy** | **NB: What Doesn't work** |
|---|---|

| | |
|---|---|
| Downstream wards should continually liaise with receiving areas and ED to 'pull' suitable patients into the relevant specialty wards. This is 'Business as usual' and should not wait for beds to be vacated. Patients for discharge can 'sit out' or go to the discharge lounge.<br><br>**Decompression/Push Policy**<br>Once in 'Amber' the requirement for implementation of the 'Decompression/Push Policy' should be highlighted at thrice daily Hospital Huddles<br>In AMU patients earmarked for transfer will be moved to a holding area. ED decompression involves transfer of ED patients waiting for a bed in receiving areas to the beds vacated by these AMU patients.<br>Patients will also be moved to newly opened beds or into boarding beds<br><br>**Push**<br>At Escalation 'Red status', where there are prolonged bed waits for patients in ED (eg 2h from decision to admit), the Response Team will consider the transfer of patients from receiving areas to downstream wards - where patients have been identified for discharge but the bed is not currently ready or is still occupied by the patient being discharged. This would then see ED patients moved rapidly to the receiving area. As a consequence this means that the downstream ward is likely to have a 'plus one' status with patients pending discharge having been moved to a seated waiting area in the ward. Where patients requires a trolley for discharge they should be moved to either the Discharge Lounge or a suitable area within the ward awaiting completion of outstanding discharge tasks<br><br>**Full Capacity Protocol**<br>At Black escalation status the Emergency Incident Group (chaired by CEO) may consider implementation of a Full Capacity Protocol.<br>1. Open additional unstaffed beds (eg gyn, urology, 47A)<br>2. Transfer to a pre-identified space in a ward area or unit without a bed being available within that ward or unit. | ✗ Failing to liaise with receiving consultants during the day and failing to agree broad strategies<br>✗ Asking Specialty Consultants to 'ward round' bed waiters in ED (see above – better to ask for junior ward support to facilitate ongoing management, kardexes, clerking, bloods etc)<br>✗ Asking specialty consultants to come to ED to help see patients (better to focus on clearing receiving areas, implementing 'push' to downstream and expediting downstream discharge)<br>✗ Expecting specialty juniors to assist in ED when wards are very busy (valuable ED senior time is wasted on phone)<br>✗ Expecting specialty juniors to see patients outwith their 'comfort zone' (valuable ED senior time is wasted explaining ED processes – better to have them focus on any likely admissions to their specialty |

**To consider when developing actions**

- **Actions and Roles**
  - Who is doing the activity?
  - Who needs to be informed when activity is complete/updated on progress?
  - Who needs to make decisions?
  - What actions can be delayed/stopped as levels increase?

- **Escalation Criteria**
  - What are the criteria for your area?
  - Are there Early Warning Indicators that should be monitored in lower level?

- **Decision making**
  - Consider as levels increase, communication and decision making should become more streamlined, allowing staff to get on and do.

- **Communication**
  - What is being communicated, to whom, and how?
  - Consider the timeliness of communication, especially in higher escalation levels.
  - Consider streamlining communication in higher levels so staff aren’t distracted from activity.

**TELEPHONY**

| WARDS MEDICAL BLOCK | |
|---|---|
| Ward 2 | 0141 451 5100/5102 (8) |
| Ward 3 | 0141 451 5105/5106 (8) |
| Ward 4 | 0141 451 5110/5111 (8) |
| Ward 5 | 0141 451 5119/5120 (8) |
| Ward 6 | 0141 451 5125/5126 (8) |
| Ward 7 | 0141 451 5129/5130 (8) |
| Ward 8 | 0141 451 5134/5135 (8) |
| Ward 9 | 0141 451 5139/5140 (8) |
| Ward 10 | 0141 451 5144/5145 (8) |
| Ward 11 | 0141 451 5149/5150 (8) |
| **WARDS CENTRE BLOCK** | |
| Ward 12 | 0141 451 5174/5175 (8) |
| Ward 14 | 0141 451 5185/5514 (8) |
| Ward 15 | 0141 451 5190/5191 (8) |
| Ward 16 | 0141 451 5195/5516 (8) |
| Ward 17 | 0141 451 5517/5300 (8) |
| Ward 18 | 0141 451 5305/5518 (8) |
| Ward 19 | 0141 451 5310/5519 (8) |
| Ward 20/21 | 0141 451 5520/5521/5315 (8) |
| **WARDS SURGICAL BLOCK** | |
| Ward 23 | 0141 201 3095 (1) |
| | 0141 451 5523 (8) |
| Ward 24 | 0141 201 3093 (1) |
| | 0141 451 5524 (8) |
| Ward 26 | 0141 201 3086 (1) |
| | 0141 451 5526 (8) |
| Ward 27 | 0141 201 3976 (1) |
| | 0141 451 5527 (8) |
| Ward 28 | 0141 201 3085 (1) |
| | 0141 451 5528 (8) |
| Ward 29 | 0141 201 3080 (1) |
| | 0141 451 5529 (8) |

| WARDS SURGICAL BLOCK (CONT) | |
|---|---|
| Ward 30 | 0141 201 3075 (1) |
| | 0141 451 5530 (8) |
| Ward 31 | 0141 451 5302/5531 (8) |
| Ward 32 | 0141 201 3800 (1) |
| | 0141 451 5532 (8) |
| Ward 33 | 0141 201 3805 (1) |
| | 0141 451 5533 (8) |
| Ward 35 | 0141 201 3782 (1) |
| | 0141 451 5535 (8) |
| Ward 36 | 0141 201 3793 (1) |
| | 0141 451 5536 (8) |
| Ward 38 | 0141 242 9797/9798 (2) |
| | 0141 451 5538 (8) |
| Ward 39 | 0141 242 9825/9826 (2) |
| | 0141 451 5539 (8) |
| **WARDS QEB** | |
| Ward 61 | 0141 201 5842 (6) |
| | 0141 451 5561 (8) |
| Ward 62 | 0141 201 5846 (6) |
| | 0141 451 5561 (8) |
| Ward 63 | 0141 201 5837 (6) |
| | 0141 451 5563 (8) |
| ESU | 0141 201 5834 (6) |
| Ward 64 | 0141 201 5833 (6) |
| | 0141 451 5564 (8) |
| Ward 65 | 0141 201 5804/5805/5806 (6) |
| | 0141 451 5565 (8) |

| WARDS QEB (CONT) | |
|---|---|
| Ward 66 | 0141 201 5816 (6) |
| | 0141 451 5566 (8) |
| Ward 67 | 0141 201 5814/5815 (6) |
| | 0141 451 5567 (8) |
| SHDU | 0141 201 5863 (6) |
| ICU EAST | 0141 201 5426/5427 (6) |
| ICU WEST | 0141 201 5430/5431 (6) |
| **WARDS JUBILEE** | |
| Ward 43a | 0141 414 6671 (2) |
| | 0141 201 6632 (6) |
| Ward 43b | 0141 414 6670/6672 (2) |
| Ward 43c | 0141 451 5543 (8) |
| | 0141 414 6679 (2) |
| Ward 44 | 0141 451 5544 (8) |
| C19 HDU | 0141 414 6666 (2) |
| Ward 45 | 0141 451 5545 (8) |
| Ward 46 | 0141 414 6647 (2) |
| | 0141 451 5546 (8) |
| Ward 47 | 0141 414 6657 (2) |
| | 0141 451 5547 (8) |
| Ward 47a | 0141 414 6653 (2) |
| Ward 48 | 0141 451 5548 (8) |
| Ward 49 | 0141 414 6661 (2) |
| | 0141 451 5549 (8) |
| Ward 50 | 0141 414 6694/6699 (2) |
| | 0141 451 5550 (8) |
| Ward 51 | 0141 414 6692 (2) |
| | 0141 451 5551 (8) |
| Ward 52 | 0141 414 6691 (2) |
| | 0141 451 1631 (8) |
| MHDU | 0141 451 5552 (8) |
| Ward 53 | 0141 414 6680/6686 (2) |
| | 0141 451 5262/5263 (8) |

| ED DEPARTMENT | | OTHER SERVICES | |
|---|---|---|---|
| Ann Bell - ED Senior Supervisor | 0141 414 6593 (2) | ED Porter | 0141 414 6503 (2) |
| Hazel McNaughton - CSM | 0141 414 6642 (2) | ED CT Scanning | 0141 414 6520 (2) |
| Ashleigh Irons - Lead Nurse | 0141 451 1387/1391 (8) | ED Xray | 0141 414 6523 (2) |
| ED Reception | 0141 414 6528/6529/6530 (2) | Security - Maternity Block | 0141 414 4275/5430 (2) |
| Ambulance Desk | 0141 414 6527 (2) | Domestic Supervisor | Page 13372 |
| Triage | 0141 414 6505 (2) | Interpreting Service | 0141 347 8811 |
| Resus | 0141 414 6507/6508/6509 (2) | Bed Manager | 0141 451 1632 (8) |
| Majors | 0141 414 5633/6512 (2) | | |
| Minors | 0141 414 6501 (2) | EMRS | 0141 810 6691 |
| Duty Room | 0141 414 4850 (2) | PICU TRANSFER TEAM | 0141 201 6923/0141 232 1777 |
| Gillian - Housekeeper | 0141 414 6557 (2) | NEONATAL TRANSFER TEAM | 0141 201 0000/0141 211 4550 |
| AAU DEPARTMENT | | SAS TRAUMA DESK | 0141 810 6065 |
| SATA Unit - Michelle & Jordan | 0141 414 6574 (2) | | |
| Duty Room | 0141 414 6571 (2) | RHC CONTROL ROOM | 84601 |
| Zone 1 | 0141 414 6572/6573 (2) | RHC ED STANDBY | 0141 452 4055 |
| Zone 2 | 0141 414 6576/6577 (2) | RHC ED CONSULTANT | 0141 452 4059 |
| Zone 3 | 0141 414 6578/6579 (2) | RHC NURSE COORDINATOR | 0141 452 4585 |
| Zone 4 | 0141 414 6580/6581 (2) | | |
| DVT Service | 0141 414 6583 (2) | QEUH CONTROL ROOM | 83116/83117/83118 |
| Peter - Housekeeper | 0141 414 6559 (2) | QEUH ED STANDBY | 0141 452 2932 |
| | | QEUH ED CONSULTANT | 0141 452 2828 |
| | | | |
| | | RAH CONTROL ROOM | 0141 314 6198 |
| | | RAH ED | 0141 314 7068 |
| | | RAH ED STANDBY | 0141 314 6760 |

| THEATRES | | HEALTH RECORDS | |
|---|---|---|---|
| A | 0141 414 6619 (2) | Linda McAllister | 0141 201 6498 |
| B | 0141 414 9426 (2) | Stella Williamson | 0141 314 7237 |
| C | 0141 414 9427 (2) | Lorraine Maxwell | 0141 800 1900 |
| D | 0141 201 0626 (6) | HR Site Manager - Irene Fyfe | 0141 201 3389 |
| E | 0141 414 9429 (2) | HR Deputy - Janice Hosie | 0141 201 3387 |
| F | 0141 414 6620 (2) | WARDS PRM | |
| G | 0141 414 6619 (2) | Labour Ward | 0141 451 5501 (8) |
| H | 0141 414 4144 (2) | Neonatal ICU | 0141 451 5594 (8) |
| K | 0141 414 9433 (2) | Ward 56a | 0141 242 9694 (2) |
| L | 0141 414 9434 (2) | | 0141 451 5556 (8) |
| R | 0141 201 9188 (6) | Ward 56b | 0141 201 3370 (1) |
| S | 0141 414 6621 (2) | | 0141 451 5595 (8) |
| Z | 0141 414 9408 (2) | Ward 68 | 0141 201 3470 (1) |
| Porters | 0141 414 4198 (2) | Ward 69 | 0141 242 9822 (2) |
| Reception | 0141 414 9421 (2) | Ward 70 | 0141 451 5570 (8) |
| Recovery | 0141 201 5499 (6) | Ward 71 | 0141 201 3545 (1) |
| OTHER HOSPITALS | | Ward 72 | 0141 201 3548 (1) |
| Queen Elizabeth University Hospita | 0141 201 1100 | Ward 73 | 0141 451 5573 (8) |
| Royal Alexandra Hospital | 0141 887 9111 | GATEHOUSE BUILDING | |
| Royal Hospital for Children | 0141 201 0000 | Minor Injuries Reception | 0141 201 3720 (1) |
| Stobhill Hospital | 0141 201 3000 | Nursing Staff | 0141 201 6418 (6) |
| New Victoria Hospital | 0141 201 6000 | STOBHILL | |
| | | Minors | 0141 355 1536 (1) |
| | | Nursing Staff | 0141 355 1544 (1) |

**EXTERNAL NUMBERS**

| | |
|---|---|
| NHS GG&C Acute Coordinating<br><br>(ask for Acute Executive on call) | 1000 |
| Police Headquarters | 101<br>and ask to be forwarded to the appropriate dept. |
| Strathclyde Fire and Rescue (local) | 0141 553 4350 |
| Ambulance Control Centre (dispatch) | 0141 891 5950 (24hrs / 7 days per week) |
| Ambulance Airdesk | 0141 810 6110 |
| Airborne Rescue Co-ordinating Centre | 01309 672161 ext 6220<br>(9-5pm Mon-Fri)<br>01343-836025 (outwith)<br>01343-836001/002/003 |
| Duty Consultant Public Health | 0141 201 4917 PHPU (9am-5pm)<br>0141 211 3600 (5pm-9am)<br>Gartnavel via Contact Centre –<br>ask for on-call Public Health consultant |
| NHS GG&C Head of Civil Contingencies Planning | 07770 312548 |

THEATRES/CRITICAL CARE

| SIDE 1 | | | |
|---|---|---|---|
| | | | |
| Senior On | #13259 | ICU East | 65426/7 |
| Duty 2 | #13298 | ICU West | 65429/30 |
| Duty 1 | #13299 | ICU Referral | #13002/81338 |
| Recovery Page | #13003 | ICU Con | 81337 |
| Theatre Hub | 29438 | ICU Flow | 07870914814 |
| Wee Room | 29425 | Maty Cons | #12205 |
| Resus | 26506/7 | Maty Trainee | #12266 |
| PRM Th2 | 13322 | Maty Office | 13315 |
| Theatre Recovery | 65499 | Labour Wad | 13302 |
| Theatre Co-Ordinator | 29424/#12122 | SHDU | 65863/65862 |
| | | SHDU Flow Phone | 07977503653 |
| SIDE 2 | | | |
| Haematology | 29602 | Ward 48 | 85548 |
| Bloodbank | 29607 | Ward 49 | 85549 |
| Biochem | 24638 | Ward 56A | 13371 |
| X-Ray | #13667 | Ward 56B | 13363 |
| Surg Reg | #13436 | Ward 61/62 | 85561/2 |
| Ortho Reg | #13681 | Ward 63/64 | 85565/6 |
| Liz Mackay/Nicola Keane | 13870/13869 | Ward 70 | 13564 |
| Anaesthetic Offices | 13220/3221 | SDAU | 65370/1 |
| Stobhill Recovery | 11360 | Trauma Co -Ord | 07989681763 |
| SIDE 1 | | | |
| | | | |
| **DECT Phones** | | | |
| Telephone No | Short Code | Allocated to Role | |
| 0141 956 0730 | 60730 | Senior Anaesthetist - ED | |
| 0141 956 0731 | 60731 | Senior Anaesthetist - Theatres | |
| 0141 956 0732 | 60732 | HUB | |

| 0141 956 0733 | 60733 | Theatre Co- Ordinator | |
|---|---|---|---|
| 0141 956 0734 | 60734 | Senior Surgeon | |
| 0141 956 0735 | 60735 | Senior Manager | |
| 0141 201 5428 | 65428 | ICU Deck | |
| | | | |
| SIDE 2 | | | |
| | | | |
| Hospital Control Number | 69156 | Site Flo | 24184 |
| Triage | 26505 | Resus Room | 26564/26507/26509 |
| Consultant Majors | 81394 | Consultant Minors | 26502 |
| Page Holder | 81395 | Nursing Staff | 26510/26516 |
| Minors ED | 26500 | Minors Gatehouse | 66418 |
| ED X-Ray | 26523 | ED CT3 | 26520 |
| ED Reception | 26528/26529 | Main CT | 24967 |
| AMU | 25815 | SATA | 81600/26572/26576/26578 |

GRI PHARMACY 0141 201 3229 (13229)

OOH

FRONT DOOR CLINICAL CO-ORDINATOR P13638

OLDBUILDING/HAN P14382

SECURITY

01412116398 (56398)

## Control Room Telephone Numbers

| | |
|---|---|
| **Hospital/ Medical Controller** | **69154 (0141 531 9154)** |
| **Nurse Controller (Chief Nurse)** | **69155 (0141 531 9155)** |
| **Hospital Manager** | **69159 (0141 531 9159)** |
| **Bed Management/Co-ordinator** | **69158 (0141 531 9158)** |
| **Health Records** | **69157 (0141 531 9157)** |
| **Facilities** | **69149 (0141 531 9149)** |
| **Civil Contingencies** | **(Spare – 69156)** |
| **Spare phone** | **69156 (0141 531 9156)** |

| Lead Nurse | Speciality | Office | Mobile | Email |
|---|---|---|---|---|
| | | | | |
| Margaret Anderson | Endoscopy, OPD/POA, Urology & 23hr Bed Unit | 355 1649 | 07534919443 | |
| Sheila Cantwell | Critical Care | | 07534919440 | sheila.cantwell@ggc.scot.nhs.uk |
| Janet Cheaitou | Theatre & Anaesthetics | | 07534228532 | janet.cheaitou@ggc.scot.nhs.uk |
| Ann Docherty | Older People | | 07896937771 | ann.j.docherty@ggc.scot.nhs.uk |
| Lesley Don | Ortho | | 07580817316 | lesley.don@ggc.scot.nhs.uk |
| Anna Syme | General Medicine | | | anna.syme@ggc.scot.nhs.uk |
| Gillian Hunter | General Medicine | | | gillian.hunter@ggc.scot.nhs.uk |
| Ashleigh Irons | ED | | | Ashleigh.irons@ggc.scot.nhs.uk |
| Jane Lamb | Older People | | | Jane.lamb3@ggc.scot.nhs.uk |
| Fiona Smyth | General Surgery | | 07903680844 | fiona.smyth@ggc.scot.nhs.uk |
| Liz Thomson | AMU/HDU/46 | | 07747790039 | Liz.thomson@ggc.scot.nhs.uk |

## Debriefing

### Post Incident Debriefs

Following any Major Incident a number of debriefs will be held to look at what went well and what could have gone better. It is vital that this review is undertaken to look at how well the organisation managed the incident.

The debrief process is not intended to criticise individuals, but to ensure lessons are learned and good practice is implemented. It is important that, as far as possible, a ‘no blame’ culture is adopted.

### Hot Debrief

A ‘hot’ debrief will be held immediately after the stand down has been issued.

This debrief will be informal and will concentrate on the operational response. It provides an opportunity for staff to express immediate issues of concern and also allows the organisation to thank staff and possibly identify those who may be in need of additional support. The Hot Debrief will be facilitated by the duty ED Consultant.

### Internal Debrief

An internal debrief will be held as soon as possible after the incident has ended (and prior to the multi-agency debrief). All those involved at a strategic, tactical and operational level should be invited to attend. This debrief will be facilitated by the Chair of the Major Incident Committee. This debrief will be more formalised and will be recorded in writing. It will look at each area of the response and identify any issues to be addressed and how plans / procedures can be improved. Debrief questionnaires can be circulated to staff.

### Multi Agency Debrief

A multi agency debrief will be held within two to four weeks following the completion of the rescue phase of any major incident. This will be chaired and co-ordinated by the lead agency (usually the police or local authority). It will be attended by one or more representatives from all the agencies involved in responding to the incident. There may also be an additional debrief once the recovery phase is complete.

### VIP Visits

Consideration will need to be given to VIP Visits following a Major Incident. This will include liaison with the Police in relation to security issues.

Recovery Phase of Major Incident

Following all but the smallest of Major Incidents, there will be a period of disruption to the workings of the hospital. An estimate of the period of disruption should be made soon after the incident and a plan put in place to restore normal activity within the hospital.

Senior Clinicians and Managers will meet to formulate a Resolution Plan.

The Resolution Plan should include:

- Staffing levels
- The need for further surgical procedures
- The number of beds occupied by Major Incident patients
- The number of Critical Care beds occupied by Major Incident patients
- Re-supply issues