Mercy University Hospital

Major Incident Procedure

VERSION 1.1

Contents

MAJOR INCIDENT CORE DOCUMENT

Appendices

THIS PAGE HAS BEEN LEFT DELIBERATELY BLANK TO ALLOW FOR FUTURE UPDATES AND REVISIONS

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Glossary of Terms

C.C.U.	Coronary Care Unit
C.S.S.D.	Clinical Sterilisation Services Department
C.U.H	Cork University Hospital
E.D.	(A&E) Emergency Department
EXT	Extension
G.P.	General Practitioner
I.C.U.	Intensive Care Unit
M.L.S.O.	Medical Laboratory Scientific Officer
N.C.H.D	Non-Consultant Hospital Doctor
S.H.B	Southern Health Board
S.H.O.	Senior House Officer
SIVH	South Infirmary – Victoria Hospital
SpR	Specialist Registrar
T.S.S.U.	Theatre Sterilisation Services Unit
M.U.H.	Mercy University Hospital

Introduction

"A major incident is any occurrence which presents a serious threat to the health of the community and which is likely to cause such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance services or health boards".

This document describes the procedures that become effective in the event of potential, actual internal or external major incident. It has been designed to be flexible enough to ensure that the hospital can respond to any eventuality whether external or internal.

1. The Role of the Mercy University Hospital

Mercy University Hospital is a designated 'supporting hospital' and may have to receive and treat patients redirected from other receiving hospitals if necessary.

It may also be required to send staff and supplies to other hospitals or to undertake any other routine services on behalf of Cork University Hospital which will be the major receiving hospital for the City and Region.

However, it is always possible that an incident could be so large in terms of numbers of casualties, or be of a nature involving contamination of other receiving centres; or actually involve other receiving centres being the centre of an incident themselves (e.g. Fire or major service breakdown) that the hospital may be called upon to accept casualties directly from the site of an incident. For the purposes of this plan it is assumed that the hospital will receive 20 casualties for admission, including ICU cases and a larger number of minor casualties.

It is also important to note that incidents can arise from many causes and not just terrorism. Transport incidents and industrial incidents are more likely and may involve very large numbers of casualties.

It is not possible to issue specific instructions for all the circumstances in which a major incident may be declared or the actions necessary to be taken as a result. However leadership roles and actions common to all incidents can be stated and are included in this policy.

This plan outlines the basic common actions which will be required in all cases and concentrates upon initial actions. The system is based upon the use of this procedure and **ACTION CARDS** for key personnel which are reproduced in the appendix.

Subsequent actions will be decided by the Mercy University Hospital Incident Management Team.

2. Mercy University Hospital Major Incident Management Team

In any Major Incident the hospital's responses and actions will be managed and overseen by the Major Incident Management Team. This Team comprises the following people:

(a) **SENIOR NURSING OFFICER**

This role will be undertaken by the **Senior Nurse on duty in the hospital** who will obtain a briefing from the Senior Nurse in charge of the Emergency Department. He / She will maintain this role until relieved by the **Director of Nursing**.

The Senior Nursing Officer will ensure that sufficient nurses are called in to duty and that major incident bed management procedures are operating. He/She will also set up the hospital Major Incident Control Room in the Ground Floor boardroom using the Major Incident Trolley in the Director of Nursing's office and following the instructions therein.

(b) **SENIOR MEDICAL CONSULTANT**

The **Consultant Physician on call** will be the Senior Medical Consultant responsible for leading the clinical response to the incident.

(c) **SENIOR GENERAL MANAGER**

The **Deputy Chief Executive Officer (DCEO)** will be responsible for co-ordinating all support service and administrative staff and for dealing with press and other enquiries from relevant institutions. Out of hours this function will be performed by the **Senior Nurse on Duty in the hospital** until relieved by the DCEO.

(d) **INCIDENT STAFF MANAGER**

A member of Staff delegated by the Senior General Manager will undertake this role (usually the Human Resources Director). The primary role will be to co-ordinate the arrival of off-duty Staff and volunteers and manage the Staff waiting area located in the small staff canteen on the Ground Floor of the Catherine McAuley Block opposite the main canteen.

(e) **CHIEF EXECUTIVE OFFICER**

The CEO will assume a strategic role. He will liaise with senior managers across the Hospital, with hospitals in the vicinity and with the Southern Health Board, Department of Health, An Garda Siochana and Defence Forces. The critical role of the CEO is to ensure the 'second phase' response by identifying when senior staff need to be relieved due to fatigue and that the hospital does not exhaust all of its resources immediately.

3. Major Incident Folders And ACTION CARDS

All Departmental Directors and Department Managers must ensure should that there is a Major Incident Folder in each department which will contain **copies** of Action Cards, a copy of this policy and procedure, copies of any departmental action plans, staff contact lists and useful telephone numbers and email addresses. **A common red ring binder will be issued to all departments for this purpose with a copy of this policy and a central list of useful telephone numbers**. Individual staff call lists and other relevant departmental information will be the responsibility of the departmental manager to insert. The existence and contents of these folders will be audited routinely and by means of administrative incident exercises. The Major Incident File must be stored in a prominent place in the Department and all staff departmental staff should know where to find it.

It is essential that staff contact lists are kept up to date at all times.

4. Identity Cards

In any incident improper access to hospital departments for both understandable and malicious reasons by relatives, visitors, members of the press and undesirables is quite common. For this reason it is vital that all members of staff possess and wear in a visible position their identity cards. Heads of Department must ensure that all staff have Mercy Hospital Cards, the only exception are NCHDs who may have CUH or UCC cards and Student Nurses who will have a UCC card. Identity cards will also be required for staff to gain access to the IDL site for parking during an incident.

5. Maintenance of the Major Incident Policy

The policy will be subject to a yearly review that will be co-ordinated by the Deputy Chief Executive Officer in conjunction with the Emergency Department Consultants and the Director of Nursing plus other staff as may be decided. The Hospital Security Manager will assist the DCEO with training and administration of the Major Incident Procedure.

6. Notification of Amendments

It is the responsibility of **All** Departmental Directors to ensure that any proposed changes to the operation of any part of the Major Incident Plan are forwarded to the Deputy Chief Executive Officer for approval and further dissemination. **No change should take place without such approval.**

7. Training

All Departmental Directors are responsible for planning their response and training their staff to ensure effective operation of the plan in the event a **'STANDBY'** or **'DECLARED'** alert being issued. On an annual basis Departmental Directors will be required to complete a Major Incident review process: within which there will be the requirement for them to confirm that all members of their Staff are aware of the major incident procedures. Staff will be required to regularly keep up to date with the Major Incident Plan by the attendance of update sessions that will be run after every review process.

Major Incident training should be included in all departmental induction programmes.

8. Major Incident Exercises

The communication cascade will be regularly tested to ensure call-out lists are maintained. As part of the annual review process a 'tabletop' exercise and/or simulation exercise will be undertaken involving key personnel, wards, departments and external agencies. **This could take place at any time** and will be designed to test the Major Incident Plan to ensure that it remains an up to date and robust system. No notice will be given of such exercises.

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1. Notification

In the first instance a call will probably be made to the hospital designated Emergency line, situated in the Emergency Department. The Receptionist of Nurse taking the call will establish the following information and record using the Major Incident Communications Duplicate Book which should be stored adjacent to the Emergency line.

- Type of incident;
- Location of incident;
- Time of incident;
- Estimated number of casualties;
- Nature of injuries, if known;
- Estimated time of arrival;
- Which other hospitals (if any) have been alerted;
- Name of person giving the information.

The Senior Nurse in charge will notify the Switchboard by means of **EXTENSION 5300** and confirm that the Hospital's Major Incident Policy is to be activated giving the following message:

"A Major Incident warning has been received for an incident at ……(place) which occurred at ……..(time). Please initiate the Major Incident Procedure"

The switchboard operator receiving this message will the refer to the **SWITCHBOARD ACTION CARD** held in the switchboard (or at Reception out of normal hours) and follow the actions specified upon it.

The Senior Nurse in charge of the Emergency Department will refer to the **SENIOR NURSE – EMERGENCY DEPARTMENT ACTION CARD** and follow the actions specified upon it.

[N.B. In practice, messages may originate from several sources and there will often be a period of uncertainty. It is accepted that it is better to initiate a response through the Switchboard rather than ignore such warnings and do nothing.]

2. All Department and Ward Managers:

On receipt of a notification from the hospital switchboard:

Refer to your Action Card

3. Use of areas within the hospital

Casualty Triage point	Main entrance to Emergency Department
Walking wounded post triage	ED Waiting areas then transfer to Main Outpatient Department: if necessary.
Hospital Control Room:	Ground Floor Parlour (Board Room)
Operating Theatres	The Main Operating Theatre Suite on the 4th Floor
Press/Information Office:	Medical Library
Decontamination Area	Back Yard behind Emergency Department
Off Duty Staff Waiting Area:	Small Staff Canteen opposite main canteen
Relatives Waiting Area	1st Floor Pastoral Care Room
Pre-Discharge Waiting Area	First Floor Main Staircase lobby
Mortuary	Hospital Mortuary, in the unlikely event that an overflow mortuary is required this will be the clinical waste store which will be cleared for use if necessary.

4. On-duty Staff not directly involved in Major Incident Alert

STAY AWAY FROM THE EMERGENCY DEPARTMENT UNLESS INSTRUCTED TO GO THERE BY THE CONTROL ROOM

It is important that on-duty Staff, **CLINICAL AND NON-CLINICAL,** not directly involved in the major Incident Alert remain at their posts and conduct the following:

- Continue routine work;
- Identify Patients ready for discharge, transfer;
- Assess workload;
- Prepare to release staff and equipment if necessary.

5. Off-duty Staff

- Staff **MUST NOT** contact Switchboard.
- Staff should stay at **HOME** unless contacted and attend their next normal shift on time.
- Off-duty staff requested to assist in a specific area should go to that area and report to the senior person on duty in that area.
- Staff requested to attend to the hospital should proceed to the **Staff Waiting Area unless specifically told otherwise** and Report to the 'Incident Staff Manager' who will be co-ordinating staff deployment.
- **REMEMBER to bring Hospital ID**

6. Log Keeping and Maintenance of Records

During the incident response Staff will be required to routinely complete the major incident documentation ensuring that it is complete and accurate. Special sets of pre-prepared blank Patient Charts will be held in the Emergency Department, 50 such sets are prepared for use at any time. All routine communications must be logged using numbered Major Incident Communications duplicate books. Messengers will be identified to convey messages between the Emergency Department, Operating Theatres, Control Room and all other areas of the hospital. Messengers will carry two way radios if available.

7. Staff Car Parking:

During a Major Incident Hospital staff will be allowed free parking on the IDL Car Park. They must produce either a valid parking permit or a hospital Identity card on each occasion they wish to park and under no circumstances will they be admitted with one or the other forms of authorisation.

8. Day-to-day hospital Activities

If possible the hospital will try to maintain daily routine activities and minimise disruption. However, when an incident is DECLARED all elective admissions will be suspended and all visitors will be asked to leave the hospital. These arrangements will be reviewed quickly as soon as the extent of the incident is known. If the incident is sufficiently serious the Senior General Manager, having agreed with the Incident Management Team, will arrange for the further suspension of some or all routine hospital activities including elective surgery, daycases and Out-Patient Clinics.

9. Patient Movement within the Mercy University Hospital

It is essential that Bed State information is maintained throughout the incident to ensure that all procedures are followed for each patient to maintain a high quality of care throughout the incident and to track movements.

i. Patients already in the Emergency Department

On receipt of "DECLARED" alert for a Major Incident the Senior Nurse in the Emergency Department will ensure that non-urgent patients are informed of the situation and that there may be significant delays these patients will be advised to attend one of the other Hospital Emergency Departments in the city or to return on the next day or see their GP. Any non-urgent patients who refuse to leave should remain in the ED waiting areas and should be treated there in order of clinical priority. If patients are moved to the Main Outpatient Department a record must be kept of who has moved.

A record should be kept of patients leaving the Emergency Department in the Emergency Department notes if possible.

Remaining patients should be rapidly seen, treated, or referred on by the Emergency Department medical staff. Non-incident patients waiting to be admitted, for all Specialties, will be transferred to St Oliver's Ward as soon as they can be accepted.

ii. Major incident patients admitted from the Emergency Department (except ICU)

St Catherine's & St Patrick's Wards will be the initial wards admitting all patients from the incident regardless of insurance category. They should be prepared to admit ten patients each as the hospital's first response. In the first instance, one bay of patients in each ward (6-8 beds) will be transferred to other acute private and public wards. This will only take place after liaison with the Bed Management team or Senior Nursing Manager in the team's absence. Patient movements will be co-ordinated by the bed Management Office.

10. Visiting

Upon declaration of an incident all patient visiting arrangements are suspended and all visitors should be asked to leave at once. Visiting arrangements will be reinstated as appropriate by the Incident Management Team.

11. Key Departmental & Staff Responses

i. The Emergency Department

The Emergency Department Consultant on duty will assume the role of **Lead Emergency Doctor**. He / She should collect the Lead Emergency Doctor Action Card from the Control Room and will have the responsibility for the overall arrangements in the Emergency Department and the triage on arrival of patients from the incident: in the Consultant's absence this role will be undertaken by the Emergency Department Registrar or in his/her absence by the Medical Registrar on duty. He / She will liaise with the Senior General Manager who will establish the hospital Control Room. The designated Lead Emergency Clinician will liaise initially with the Consultant Physician, Consultant Anaesthetist and Consultant General Surgeon on call.

The department will be the access point for all casualties from an external incident where they will be triaged and treated. **See Appendix 5 for the Hospital Contamination Procedure for dealing with casualties suffering from radiological, biological or chemical contamination.**

ii. Anaesthetic Department

The Consultant Anaesthetist on call should go to the Control room to report his arrival and collect the Lead Anaesthetist Action Card, he should then straight to the Emergency Department and act **as Lead Anaesthetist,** he should refer to his Action Card and take action as indicated and necessary.

iii. Radiology Department

The Consultant Radiologist on call should go to the Control room to report his arrival and collect the Lead Radiologist Action Card, he should then straight to the Emergency Department and act **as Lead Radiologist,** he should refer to his Action Card and take action as indicated and necessary.

During normal hours the Radiography Services Manager should adopt the role **of LEAD RADIOGRAPHER** and follow the actions on the Action Card in the Department especially to nominate another Radiographer to be **EMERGENCY RADIOGRAPHER** who should collect his her action card from the Control Room and go to the Emergency Department immediately.

Out of normal hours the Radiographer on call (General) will be the **EMERGENCY RADIOGRAPHER** and should collect his/her action card from the Control Room and go to the Emergency Department. The 2nd Radiographer on call (CT) will be **the LEAD RADIOGRAPHER** and should go to the main Radiology Department and report his/her arrival to the Control Room by telephone on extension 5999. He/she should ensure all machines are switched on and should call in one additional Radiologist, the Superintendent Radiographer and 4 additional Radiographers.

All Radiologists and Radiographers on call should report to the Control Room before going to their designated places as specified here.

iv. Main Outpatient Department

The Senior Nurse Manager for Outpatients should collect the Action Card from the Control Room.

All OPD appointments will be suspended and patients should be told to return home pending the issue of a new appointment.

The OPD will also act as the designated 'overflow' area for 'walking-wounded / minor' injuries that are cleared from the Emergency Department. In addition patients refusing to leave the Emergency Department will be transferred to Main OPD.

The use of this space will be authorised by the Senior Nursing Officer who will ensure that the department is appropriately staffed.

The Lead Emergency Clinician in consultation with the Major Incident Medical Officer will allocate medical staff to the Main Outpatient Department as necessary.

v. St Catherine's Ward & St Patrick's Ward

The Senior Nurse Manager on these Wards should refer to the Major Incident Action Card held on the ward.
It is important that 6-8 beds on St Catherine's ward are decanted as quickly as possible to prepare to receive potential incident casualties.

It is essential that the Senior Nursing Officer initially establishes a Bed State and liaises with the Bed Management Team. It must be ensured that the response is co-ordinated to safeguard against possible 'blockages' restricting patient decanting and that the appropriate care of patients is considered at all times.

vi. St Anne's Ward (Paediatrics)

The Senior Nurse Manager on the Ward should refer to the Major Incident Action Card held on the ward
All child casualties under the age of 15 will be admitted to St Anne's ward. Patients between 15 and 18 will only be admitted following consultation with Consultant Paediatricians and the ward Nurse Manager. On receipt of a notification that an incident has occurred the nurse manager should seek to identify 5 beds of which 2 should be isolation beds for immediate use by child casualties and should report bed availability to the Senior Nursing Officer. The Nurse Manager should liaise with the Paediatric teams with respect to children who might be sent home or whose subsequent planned admission could be postponed. All children who can be discharged should be discharged regardless of the demand for incident admissions due to the possible upsetting nature of injuries to be received in the hospital. This policy will be reviewed after 24 hours.

vii. St Oliver's Ward

The Senior Nurse Manager on the Ward should refer to the Major Incident Action Card held on the ward
St Oliver's ward will be utilised for non-incident casualties awaiting admission in the Emergency Department or those who cannot be sent home. During normal hours on receipt of a notification that an incident has occurred the nurse manager should liaise with the Medical teams to ensure that all Endoscopy lists are suspended immediately and patients discharged out of the ward as quickly as possible. Out of normal hours the Incident Senior Nursing Officer will decide whether St Oliver's is to be opened and make arrangements for it to be staffed.

viii. Remaining M.U.H. Wards

The Senior Nurse Manager on duty on these Wards should refer to the Major Incident Action Card held on the ward.
Do not transfer or discharge any patients unless advised to do so. Prepare the Ward to accept rapid transfers of displaced patients from other areas. In the event of a Major Incident the Senior Nurse on the ward will record on a Bed State Form the ward bed availability ready for the Bed Management team. In the event of multiple casualties requiring admission it may be necessary to use Wards, other than those indicated, to accommodate them.

ix. Operating Theatres

The Senior Nurse Manager on duty should refer to the Major Incident Action Card held in the department.
The Senior Theatre Nurse in charge will be notified of a "Declared or Standby" alert by Switchboard. The Senior Theatre Nurse will liaise with the Senior Nurse in the Emergency Department for an incident briefing. Once the type of incident has been established the Senior Theatre Nurse will determine the level of response and co-ordinate the preparation of theatres, recovery and arrangements with S.D.U. / T.S.S.U and calling in of staff as necessary.

x. Critical Care Area (I.C.U. /C.C.U.)

The Senior Nurse Manager on duty should refer to the Major Incident Action Card held in the unit.
Switchboard will inform the I.C.U. Senior Nurse who will brief the Consultant Anaesthetist in Charge of the Critical Care Area. He / She will liaise with the Anaesthetist in Charge of the Anaesthetic response, based in the Emergency Department. Available Critical Care beds will be prepared to receive admissions. A Ward round will be conducted to identify patients suitable for transfer to an alternative ward or another hospital.

xi. On call Teams

The on call Surgical, and on call Medical teams will be informed by Switchboard when a Major Incident Alert is declared. It will be the responsibility of the duty Consultants to obtain a briefing from the Senior General Manager and initiate as necessary their team response. The Nurse in Charge of Operating Theatres will have been notified and will liaise as necessary.

NCHDs SHOULD NOT REMAIN IN THE EMERGENCY DEPARTMENT UNLESS SPECIFICALLY INSTRUCTED TO DO SO BY A CONSULTANT IN THE DEPARTMENT

- **Doctors on call**

The following Consultants will go to the Control room to collect their action card and establish the nature of the incident and determine the level of response required by their teams and ascertain whether further Consultant support is required. They should then take the action given below:

- Medical Registrar on call — Go to Emergency Department and act as Lead Emergency Doctor until relieved by an ED Registrar or ED Consultant
- ED Consultant on call — Go to Emergency Department and act as Lead Emergency Doctor
- Consultant Anaesthetist on call: — Go to the Emergency Department to assist in triage and treatment as necessary
- Registrar Anaesthetist on call — Go to Emergency Department to assist in triage and treatment as necessary
- Consultant Radiologist on call: — Go to the Emergency Department.
- Consultant Paediatrician on call — Go to the Emergency Department
- Consultant General Surgeon on call: — Stay in the Control Room until required to go elsewhere.
- Other Consultants: — Report to the Control Room before going to their department or elsewhere as directed..

The emergency department Consultant in conjunction with his Colleagues will assess whether further Consultant support is required as part of the incident response and inform the Control Room.

- **Medical On Call Team**

When alerted the Medical Registrar should go to the Emergency Department. The remainder of the team should assist with the identifying patients for discharge/decant to other wards unless called to assist in the Emergency Department.

- **Surgical On Call Team**

When alerted the Surgical Registrar should contact the Emergency Department to determine if the team is required. If not they should assist with the identifying patients for discharge/decant to other wards until notified that they are required in Operating Department.

♦ **Anaesthetic Team on call**

When alerted the Anaesthetic Registrar should go to the Emergency Department. Other team members should go to the Operating Department.

♦ **Paediatric Team on Call**

All members of the Paediatric Team should go to the Paediatric ward to prepare to receive child casualties or help in discharging patients where possible.

♦ **Other NCHDs on call**

Report to the Control Room prior to being allocated to a specific duty.

xii. Bed Manager / Night Superintendent/ ADONs

The Bed Management Team will be informed by Senior Nursing Officer. All available staff will proceed to the Admissions Unit to confirm roles and to organise the team response.

The primary function will be to establish the Bed capacity of the hospital and to facilitate the patient transfers and discharges to free up bed space rapidly and safely.

The team will ensure that 'all wards' are informed and that ward rounds are conducted, initially on the dedicated 'take wards': the team will collect all the Bed State Forms from the wards and hand them over to the Senior Nursing Officer. It will be their responsibility, in conjunction with the Senior Nursing Officer, to ensure that staff are allocated to the Relatives area .

xiii. Laboratories & Blood

The Laboratory Technicians on call will be notified by the switchboard. They should each go to their laboratories and immediately call an additional technician to duty. They should ensure that all machines are operating fully and that the necessary supplies of stationery are available to deal with the requests which will be received. Any routine test requests which can be postponed should be delayed. The switchboard will also call the Chief Laboratory Scientists who will assess the need for further staff and action. The Technician covering Haematology should immediately notify the Blood bank of an emergency requirement for 10 units of Group O+ and ten units of Group O- to meet expected surgical demands.

xiv. Pharmacy

Switchboard will notify the Principal Pharmacist and on call duty pharmacist. The pharmacy manager/ on call pharmacist will report their presence to the Control Room and then check drugs requirement for the Emergency Department before commencing to co-ordinate the department response and obtain additional stocks of drugs if required for all wards.

xv. Social Work Team

The Principal Social Worker will be informed by Switchboard and will contact the Control Room. for instruction and briefing. The Social Work primary role will be:

i. To assist in the arrangements to discharge ward patients.
ii. To make arrangements for the vulnerable dependants (e.g. children or frail elderly) or serious casualties and minor injury patients who are not admitted, but need help.
iii. To provide an additional pool of Staff (if available) to assist in the management of relatives.
iv. To assist in the provision of a Critical Incident Stress management process for staff.

xvi. Physiotherapists

The Superintendent Physiotherapist will co-ordinate the department's response after being contacted by Switchboard. Physiotherapists may be required to provide treatment and will also aid in the assessment of patients for discharge that will be done in conjunction with the Bed Management team. In normal working hours any patients in the physiotherapy department must notified and the department cleared.

xvii. Security

Security will be alerted by Switchboard. The Senior Security Officer on duty will call in additional Staff and concentrate on securing the key receiving areas.

xviii. Support Services

The Hotel Services Manager will be informed by Switchboard. He / She will contact the Senior General Manager for a briefing to establish the required Department response then ensure that the internal responses within the Support Services department is initiated and that adequate numbers of Staff are available:. In particular the Hotel Services Manager must make arrangements for the following:

- Site Access Control – Security Officers
- Traffic Management – Security Officers
- Patient Movements - Porters
- Cleaning – Cleaning Contractor
- Linen supply – Housekeeping staff
- Portering & Messaging - Porters
- Stock issues – Porters
- Engineering & Maintenance issues – Hospital Engineer
- Catering – Catering Managers

The Porter on duty will be alerted by Switchboard. **All** non-urgent routine work will be suspended. In the first instance Porters will proceed to Reception from where they will be allocated to tasks until the Hotel Service Manager arrives, except for the Emergency department Porter who will remain in the Emergency Department.

xix. C.S.S.D. / T.S.S.U.

The Nurse in charge of the operating theatres will directly liaise, as necessary, with CSSD. to maintain stock levels and to arrange the removal of used equipment.

xx. Admissions Office

In normal working hours the admissions office will be contacted by Switchboard and informed of the alert status. The Senior General Manager will liaise with the Admissions Officer and instruct further.

xxi. Medical Records

Complete sets of pre-prepared Major Incident Notes are held in the Emergency Department If there is a requirement for more of these sets of these the Medical Records Manager will be contacted by the Switchboard and should attend the Control Room to be briefed accordingly. After the incident the Medical Records Manager will co-ordinate any further medical records requirements for major incident patients and ensure that the computer system is updated accordingly.

xxii. Chaplaincy/Pastoral Care

The Chaplains will be accessible to provide support and to supply religious services, if required: in practice this will be mainly for relatives and casualties.

The Chaplain on call will be notified by Switchboard and then establish a chaplaincy team that will liaise with the M.U.H. incident management team and co-ordinate an appropriate response.

After the incident the Chaplains are available to provide support if Staff wish – see Staff Support (Section 28).

12. Press Management

In a Declared incident it will be the responsibility of the Senior General Manager to manage the hospital's response to the media.

13. Chemical, Biological & Radioactive Incident Response

Mercy University Hospital is not able to deal with radioactive, biological or chemically contaminated casualties. In the event such casualties are required to be brought to the hospital the Incident Management Team will liaise with CUH, SHB, Department of Health and Defence Forces advisors and take action as necessary. Nonetheless a rudimentary procedure is at Appendix 5.

14. Ambulance & Garda Liaison

The Gardai and Ambulance service may establish a 'Gardai & Ambulance Liaison Room' in the ground floor pastoral care office. In the event of an extended Major Incident Gardai will establish a full information bureau elsewhere.

15. Forensic Evidence

Every major incident is a potential scene of crime. All staff involved in major incident response must ensure that they take appropriate measures to preserve potential evidence in order that any subsequent investigations by the police or other agency(ies) are not jeopardised.

It is essential that patient care should be the priority and that the collection of forensic evidence should not under any circumstances interfere with this.

16. Confidentiality

Staff must be aware that they must honour their duty of confidentiality to individual patients when co-operating with the police. Staff should not normally disclose personal information without the patient's consent. **NOTE: In the abnormal situation of a major incident, the duty of confidentiality is not lifted.**

17. Volunteers

During normal working hours members of the public arriving at the hospital to offer their help should be directed to the Staff Waiting Area where their details will be collected: initially it will be standard practice to thank the individuals and decline their offer of assistance. Out of hours access to the hospital will be restricted to incident casualties, relatives and Staff.

18. Blood Donors

Additional Blood will be supplied from the National Blood Transfusion Service In the event of extraordinary circumstances dictating local donations, all blood donors will be co-ordinated by the 'Incident Staff Manager'.

Switchboard will advise all callers offering blood that to replenish stocks they should contact the Blood Transfusion Service the following day.

19. Stand Down Procedure

Stand Down will be declared by:

Ambulance Service - the call will be received by the Control Room the Incident management Team will initiate the Stand Down procedure through Switchboard: notification will be given to all those on the call-out list. If the stand down call is received elsewhere it should be communicated to the Control Room at once.

Major Incident Management team: - the Incident Management Team may decide to declare "Stand Down" once all casualties are in hospital, the full extent of the incident is known and systems are in place throughout the hospital to deal with the ongoing situation.

Once the stand down decision is made the Incident Management Team will then consider the impact and advise on the need for:

- Further patient movements around or out of the hospital
- Information and arrangements for relatives
- Information for the press
- Staffing needs throughout wards and departments
- Arrangements for debriefing and support

The Senior General Manager will implement the 'Stand Down' procedure through Switchboard who will inform those on the call-out list. Once notified Staff should ensure all those in their areas are informed and as well as those who have been put on 'standby' at home.

It is essential that all staff who were notified of the alert are informed of the 'Stand Down':

- Phone people at home on Standby.
- Send Staff off duty as soon as possible **only** when appropriate Staff are in place to relieve.
- Prepare for debriefing meetings at a later date.

All major incident documentation must be submitted to the Senior General Manager who will collate the documentation which will then be held by the Chief Executive Officer.

20. Post Incident Procedure

- **Debriefing**

The Deputy Chief Executive Officer in conjunction with the Director of Nursing will co-ordinate the debriefing arrangements post-incident. As part of this process each department's Senior Staff member should ensure that they have a debriefing session as soon as possible after the major incident in which every member of Staff has the opportunity to contribute to at some stage. This provides the opportunity to evaluate efficiency, to learn from experience gained and provides accurate information for possible investigations.

- **Staff Support**

Following a Major Incident it is important that senior members of Departments ensure that their Staff are aware of the following services available for the to access if they wish.. The **Chaplaincy Team** are available for Staff to access if they wish.

In the event that these measures prove insufficient to support staff, the Occupational Health Department will make further arrangements on an individual basis.

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APPENDIX 1 ACTION CARD INDEX

MAJOR INCIDENT ACTION CARD SENIOR NURSING OFFICER

1

The Senior Nursing Officer will be the Senior Nurse on Duty in the hospital until relieved by the Director of Nursing or her locum and will also be the Incident Senior General Manager until relieved by the Deputy CEO or locum.

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Locate the Control Room trolley in the Director of Nursing's office and go to the Control Room. Follow the instructions in the box – they tell you when to revert to this card.

2 Put on the 'SENIOR NURSING OFFICER' Action Card.

3 Set up one telephone for extension 5999 in the Control Room

4 Check that the switchboard have initiated call out procedures

5 Call in an off duty Assistant Director of Nursing to assist.

6 Ensure that the Theatre Manager is preparing Theatres to receive emergency surgical cases. Establish staffing numbers and ensure nurses are being called for duty.

7 Establish the bed state in ICU and the likely bed availability over the next 12 hours.

8 Notify the senior nurse I/C St Patrick's and St Catherine's wards that they will be the main receiving wards and should clear 10 beds each. Establish their staffing numbers and ensure sufficient nurses are being called for duty at a full scale day roster level in each ward. Identify nurses who may be redeployed from other wards in the interim

9 Establish a bed state from the senior nurse i/c St Anne's ward. Instruct the senior nurse to liaise with the duty Paediatric Registrar to identify and clear 10 beds for incident paediatric casualties

10 Call the Bed Manager and instruct her to cancel all elective admissions for the next 24 hours and prepare for up to 20 emergency admissions.

11 Call the CNM2 OPD and instruct her to cancel any clinics in progress, clear the

OPD and prepare to receive minor casualties. (note that it may be a number of hours before there is any medical assistance in OPD).

12 Ensure that Chaplains have opened the relatives centre in the 1st Floor Pastoral Care Room

13 Notify resident Sisters of Mercy of the incident.

14 Record all actions taken in the Major Incident Log Book

15 Once the initial admission of casualties is complete review equipment and drug stocks for the relevant wards and departments.

16 Assess the need to relieve staff who have been on duty for long periods.

17 Identify an Assistant Director of Nursing to relieve you at the appropriate time.

Issue Date:

MAJOR INCIDENT ACTION CARD 2

SENIOR MEDICAL CONSULTANT

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Go to the Control Room (Ground Floor Parlour).

2 Take this Action Card and put on the Senior Medical Officer Action Card.

3 Act as Medical Co-ordinating Officer / Co-ordinator Hospital Control Centre

4 Ensure Emergency Department preparedness

5 Liaise with Senior Nursing Officer & Senior General Manager

6 Designate/allocate medical staff within Emergency Department as treatment teams

7 Liaise with the Medical Co-ordinating Officer at CUH to establish progress of incident

8 Take any actions required in association with the other members of the Incident Management Team to co-ordinate the hospital's response to the incident.

9 Ensure that another Senior Consultant is identified to relieve you at the appropriate time.

Issue Date:

MAJOR INCIDENT ACTION CARD 3

SENIOR GENERAL MANAGER

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Go to the Control Room and put on the 'Senior General Manager' Action Card.

2 Ensure the Control Room is properly set up and equipped with the contents of the control room box.

3 Liaise with the Senior Nursing Officer and the Senior Medical Consultant to establish the scope of the incident.

4 Call Chief Executive Officer and ask him to attend the Control Room.

5 Call the Medical Records Manager and the Supplies Manager to attend the Control Room

6 Ensure that the Control Room telephones and fax machine are operational and check the back up mobile telephones are working.

7 Ensure security Officers have been posted at all entrances to restrict access to hospital staff and essential persons. Relatives of casualties should be advised to return home or if they insist should be directed to the 1st Floor Pastoral Care room.

8 Ensure that all the areas of the hospital to be utilised for the incident are unlocked and available

9 Ensure that all visiting to non-incident casualties is suspended and relatives in the hospital are asked to leave at once.

10 Appoint an administrative watchkeeper to man control room telephones and maintain the incident log

11 Ensure the Hotel Services Manager has been notified and is calling additional staff.

12 Nominate the Incident Staff Manager and ensure the staff waiting area in the small staff canteen is set up and has an up to date list of staff available for allocation.

13 Ensure catering arrangements for staff are in place.

14 Allocate a member of staff to man the Press Centre with instructions to act as liaison but not to offer any information to the press.

15 Notify the Chairman of the Board of Governors of the incident and the hospital's response.

16 Take any actions required in association with the other members of the Incident Management Team to co-ordinate the hospital's response to the incident.

17 Set a specific time for a press conference to issue a statement on the hospital's response to the incident.

18 Identify demands for additional administrative staff and ensure they are called to duty.

19 Ensure that another Senior Manager is identified to relieve you at the appropriate time.

Issue Date:

MAJOR INCIDENT ACTION CARD 4

INCIDENT STAFF MANAGER

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Go to the Control Room and receive a briefing on the incident.

2 Go to the staff snack canteen and establish the Staff Control Centre

3 Call in at least one member of HR staff to assist you.

4 Make sure you have the hospital central contact list available to you.

5 Establish a central register of staff on duty and times of arrival

6 Check with the following departments in order that they are calling in additional staff:

- Switchboard
- Emergency Department
- Radiology Department
- Laboratories
- Security
- Senior Nursing Officer

7 Contact Departmental managers to ensure that their staffing needs are being addressed and obtain the names of staff who have arrived for duty.

8 A pool of staff may be directed to the Staff Control Centre, do not release or allocate these staff to departments unless specifically instructed by the Control Room.

9 Ensure that the Chaplains have arrived on site.

10 Identify staff who have worked for more than 10 hours and make arrangements for their relief with their departmental managers if possible.

11 Make sure that staff who may require post incident counselling are identified for future support.

Issue Date:

MAJOR INCIDENT ACTION CARD 5

CHIEF EXECUTIVE OFFICER

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Go to the Control Room (Ground Floor Parlour) and read this card.

2 Seek a briefing from the other members of the Incident Management Team.

3 Be prepared at any point to relieve any member of staff from their duties (including the Incident Management Team) and to replace them with another suitable person.

4 Contact the Chief Officers of SHB, CUH, SIVH, Ambulance Service, Garda to review needs and performance.

5 Maintain contact with the Chairman of the Board, Department of Health and City Council as necessary.

6 Be prepared to attend Regional meetings to co-ordinate responses.

7 Make sure you approve all statements to the Press or outside bodies personally.

8 Keep the hospital's performance under review and identify priorities for action to the Incident Management Team if necessary.

Issue Date:

MAJOR INCIDENT 6
ACTION CARD
LEAD EMERGENCY DOCTOR

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Collect this card.

2 Put on the LEAD EMERGENCY DOCTOR Action Card.

3 Seek a briefing from the Senior Nurse – Emergency Department

4 Ensure that the ED Registrar has been called, if unavailable send for the Medical Registrar on call to assist.

5 Undertake Triage of casualties and indicate immediate assessment/treatment actions if possible for casualties as they arrive at the main door of the department. If casualties have not already been tagged they should be labelled as follows:

RED LABEL	-	Immediate	-	First Priority
YELLOW LABEL	-	Urgent	-	Second Priority
GREEN LABEL	-	Delayed	-	Third Priority
WHITE LABEL	-	Dead		

6 Dead casualties must not be brought into the department but must be sent to the Mortuary via the Prospect Row gate.

7 Third priority casualties who can walk should be sent to the ED waiting area.

8 Immediate patient assessment & treatment should be initiated by the ED Registrar.

9 Take all necessary action to co-ordinate the appropriate treatment of all casualties in the department.

10 Liaise frequently with the Senior Medical Officer and Theatre Superintendent as necessary.

Issue Date:

ACTION CARD 7
LEAD ANAESTHETIST

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Collect this card from the Control Room.

2 Put on the LEAD ANAESTHETIST Action Card.

3 Seek a briefing from the Lead Emergency Doctor

4 Ensure that the Anaesthetic Registrar has been called, if unavailable send for another Anaesthetic NCHD on call to assist.

5 Assist the Lead Emergency Doctor in the Triage of casualties and indicate immediate assessment/treatment actions if possible for casualties as they arrive at the main door of the department. If casualties have not already been tagged they should be labelled as follows:

RED LABEL	-	Immediate	-	First Priority
YELLOW LABEL	-	Urgent	-	Second Priority
GREEN LABEL	-	Delayed	-	Third Priority
WHITE LABEL	-	Dead		

6 Dead casualties must not be brought into the department but must be sent to the Mortuary via the Prospect Row gate.

7 Third priority casualties who can walk should be sent to the ED waiting area.

8 Assess resuscitation needs and lead the resuscitation team in the ED

9 Establish contact with the Operating Department tom advise them of likely casualties and priorities

10 Liaise frequently with the Senior Medical Officer and Theatre Superintendent as necessary.

MAJOR INCIDENT ACTION CARD 8

LEAD PAEDIATRICIAN

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Collect this card from the Control Room.

2 Put on the LEAD PAEDIATRICIAN Action Card.

3 Seek a briefing from the Lead Emergency Doctor in the ED

4 Ensure that the Paediatric Registrar has been called in needed in the ED.

5 Direct the treatment of all child casualties in the Emergency Department.

6 Establish contact with the Paediatric Ward to warn them of the likely number and type of child casualties.

7 Ensure that other Consultant Paediatricians have been called to duty.

8 Liaise frequently with the Senior Medical Officer and Theatre Superintendent as necessary.

MAJOR INCIDENT ACTION CARD 9

LEAD RADIOLOGIST

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Collect this card from the Control Room.

2 Put on the LEAD RADIOLOGIST Action Card.

3 Seek a briefing from the LEAD EMERGENCY DOCTOR

4 Ensure that the Radiology Registrar has been called, if required.

5 Ensure the duty Radiographers have been called and that one is opening the main Radiology department.

6 Oversee and prioritise all imaging activity in the Emergency Department.

7 Notify the Control Room if any patients require offsite transfer for urgent investigations.

8 Ensure that other Consultant Radiologists have been called and that the main Radiology Department is operational as quickly as possible.

9 Liaise frequently with the Senior Medical Officer and Theatre Superintendent as necessary

MAJOR INCIDENT ACTION CARD 10

SENIOR NURSE – EMERGENCY DEPARTMENT

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 If a Major Incident Declaration call is received in the Emergency Department from ambulance Control take the following action (in all cases except items 2-4 this may be delegated to other Departmental staff):

2 Ensure that the details of the call are properly recorded as follows:

- Name of caller
- The exact location of the incident
- The type of incident (e.g. road/rail/air)
- The Hazards that are present and anticipated (e.g. chemical etc)
- The number and severity of casualties (rough estimate)
- The Emergency services that are already present and those that are immediately required

3 Notify switchboard of the alert and communicate the details of the incident as received from Ambulance Control.

4 Put on the SENIOR NURSE – ED Action Card.

5 Notify the Senior Nurse on Duty of the alert and communicate the details of the incident as received from Ambulance Control.

6 Make sure one additional Receptionist has been called to duty.

6 Notify the Emergency Department Consultant on duty.

7 Notify other Emergency Department medical staff in the hospital.

8 Ensure all E.D Nurses on duty are present in the department

9 Notify all persons in the waiting area of the incident. Ask those accompanying patients to leave the hospital at once. **PTO**

10 Ensure the Major Incident Notes Trolley is brought to the department and is

available for use.

11 Ensure the Major Incident Stock Cupboard is opened

12 With the ED SHO or Registrar agree which non-incident patients waiting for treatment can be asked to go home or go to the Main OPD to await treatment. Warn them that it will be several hours before they are seen.

13 Inform the Bed Management Department (or out of hours the Senior Nursing Officer) of how many non-incident patients need to be allocated ward beds in order to clear the ED for incident casualties.

14 Ensure all casualties are given an identity bracelet and a major incident notes set.

15 Co-ordinate the ED response to the unit with the Lead Emergency Doctor.

16 Make routine reports to the Control Room at least every 30 minutes or more frequently if necessary

NOTE: THE HOSPITAL'S RESPONSE WILL BE CO-ORDINATED BY THE INCIDENT MANAGEMENT TEAM IN THE CONTROL ROOM. ALL REQUESTS FOR ASSISTANCE OR QUERIES SHOULD BE DIRECTED TO THE CONTROL ROOM.

Issue Date:

MAJOR INCIDENT ACTION CARD 11

SENIOR NURSE MANAGER OPERATING THEATRES

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 Upon being notified that an incident has been declared cancel all elective operating lists for the next 24 hours.

2 Identify one operating theatre as the principle emergency theatre and allocate staff to it as soon as possible so that it is prepared to receive cases for urgent surgery.

3 Ensure that nurses and ancillary staff are being called to duty to enable the maximum number of operating theatres to be available.

4 Establish contact with the Surgical Registrar who will pass on information concerning the surgical priority of patients in the ED.

5 Ensure that the TSSU is operational and that sufficient staff are available

6 Assess stock levels of drugs, gases and other medical and surgical supplies.

7 Ensure that sufficient initial stocks of blood for 5 major and 10 minor cases are ordered from the Blood Transfusion Service.

8 Report your state of readiness to the Control Room on extension 5999 at frequent intervals

Issue Date:

MAJOR INCIDENT ACTION CARD 12

CNM2 ST CATHERINES WARD

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately ensure that you know the whereabouts of all the patients and staff in your ward.

2 Staff on breaks should be recalled to duty at once.

3 Any visitors should be told that a major incident has been declared and ask them to vacate the ward at once. Call for security assistance if necessary.

3 Establish an accurate staff state for your ward including who will be coming on shift and when in the next 24 hours and communicate it to the Senior Nurse on Duty for the Hospital when asked.

4 Identify patients who you think might be able to be discharged and contact the appropriate Medical Team to confirm discharge status for potential discharges.

5 Identify any patients who can be transferred to another general ward and notify the Control Room of the need for portering assistance to move them. The Control Room or the Bed Manager will contact you to arrange transfers

6 Establish an accurate current and potential bed state for your ward and communicate it to the Bed Management Department of Senior Nurse on Duty for the Hospital when asked.

7 The Bed Manager will co-ordinate arrangements for patients being discharged early and will arrange transport where necessary.

8 Establish stocks of linen, drugs, and medical and surgical supplies. Notify the Hospital Incident Control Room of your requirements

9 The Senior Nursing Officer will direct you with regard to any other duties to be undertaken.

Issue Date:

MAJOR INCIDENT ACTION CARD

13

CNM2 ST PATRICKS WARD

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately ensure that you know the whereabouts of all the patients and staff in your ward.

2 Staff on breaks should be recalled to duty at once.

3 Any visitors should be told that a major incident has been declared and ask them to vacate the ward at once. Call for security assistance if necessary.

3 Establish an accurate staff state for your ward including who will be coming on shift and when in the next 24 hours and communicate it to the Senior Nurse on Duty for the Hospital when asked.

4 Identify patients who you think might be able to be discharged and contact the appropriate Medical Team to confirm discharge status for potential discharges.

5 Identify any patients who can be transferred to another general ward and notify the Control Room of the need for portering assistance to move them. The Control Room or the Bed Manager will contact you to arrange transfers

6 Establish an accurate current and potential bed state for your ward and communicate it to the Bed Management Department of Senior Nurse on Duty for the Hospital when asked.

7 The Bed Manager will co-ordinate arrangements for patients being discharged early and will arrange transport where necessary.

8 Establish stocks of linen, drugs, and medical and surgical supplies. Notify the Hospital Incident Control Room of your requirements

9 The Senior Nursing Officer will direct you with regard to any other duties to be undertaken.

Issue Date:

MAJOR INCIDENT ACTION CARD

14

CNM2 ST OLIVER'S WARD

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately ensure that you know the whereabouts of all the patients and staff in your ward.

2 Staff on breaks should be recalled to duty at once.

3 Any visitors should be told that a major incident has been declared and ask them to vacate the ward at once. Call for security assistance if necessary.

3 Establish an accurate staff state for your ward including who will be coming on shift and when in the next 24 hours and communicate it to the Senior Nurse on Duty for the Hospital when asked.

4 Prepare all patients for immediate discharge and contact the appropriate Medical Team to confirm discharge status for these patients.

5 Identify any patients who need to be transferred to another general ward and notify the Control Room of the need for portering assistance to move them immediately. The Control Room or the Bed Manager will contact you to arrange transfers

6 Establish stocks of linen, drugs, and medical and surgical supplies. Notify the Hospital Incident Control Room of your requirements

7 The Senior Nursing Officer will direct you with regard to any other duties to be undertaken.

8 Issue Date:

MAJOR INCIDENT ACTION CARD

15

CNM2 ST ANNES WARD

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately ensure that you know the whereabouts of all the patients and staff in your ward.

2 Staff on breaks should be recalled to duty at once.

3 Any visitors should be told that a major incident has been declared and ask them to vacate the ward at once. Call for security assistance if necessary.

4 Establish an accurate staff state for your ward including who will be coming on shift and when in the next 24 hours and communicate it to the Senior Nurse on Duty for the Hospital when asked.

5 Reserve 5 empty beds for incident casualties and if beds are not available liaise with medical staff to identify patients who might be discharged or transferred to adult ward areas or PC.

6 Identify patients who you think might be able to be discharged and contact the appropriate Medical Team to confirm discharge status for potential discharges.

7 Establish an accurate current and potential bed state for your ward and communicate it to the Bed Management Department of Senior Nurse on Duty for the Hospital when asked.

8 The Bed Manager will co-ordinate arrangements for patients being discharged early and will arrange transport where necessary.

9 Establish stocks of linen, drugs, and medical and surgical supplies. Notify the Hospital Incident Control Room of your requirements

10 The Senior Nursing Officer will direct you with regard to any other duties to be undertaken.

Issue Date:

MAJOR INCIDENT ACTION CARD 16

CNM2 OUTPATIENT DEPARTMENT

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately ensure that you know the whereabouts of all the patients and staff in your ward.

2 Staff on breaks should be recalled to duty at once.

3 Inform all doctors and other staff that a major incident has been declared and that all clinics are suspended immediately.

3 Inform all patients and relatives present that a major incident has been declared and that all clinics are suspended immediately. Ask all patients and relatives to return home at once and tell them a new appointment will be sent to them. Seek security assistance to clear the department if necessary. Patients needing to wait for transport should be sent to the 1st Floor Pastoral Care Room.

4 Identify which consulting suites will be used for doctors to examine patients.

5 Identify the area where trolley bound patients can be parked and allocate nurses to care for patients in this area.

6 Notify the Senior Nursing Officer of your staff requirements. And be prepared to redeploy your staff elsewhere as directed.

7 Notify the Control Room of your requirements for linen, drugs, and medical and surgical supplies in excess of the contents of the Major Incident cupboard.

8 When casualties arrive in the department take the necessary action to care for them until the arrival of medical staff. THIS MAY BE SOME HOURS AFTER THE COMMENCEMENT OF THE INCIDENT.

9 The Senior Nursing Officer will direct you with regard to any other duties to be undertaken.
Issue Date:

MAJOR INCIDENT ACTION CARD 17

Ward Manager

Senior Nurse on Duty

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately ensure that you know the whereabouts of all the patients and staff in your ward.

2 Staff on breaks should be recalled to duty at once.

3 Establish an accurate staff state for your ward including who will be coming on shift and when in the next 24 hours and communicate it to the Senior Nurse on Duty for the Hospital when asked.

3 Establish an accurate bed state for your ward and communicate it to the Bed Management Department of Senior Nurse on Duty for the Hospital when asked.

4 Identify patients who you think might be able to be discharged and contact the appropriate Medical Team to confirm discharge status for potential discharges.

5 Where patients are discharged make arrangements for them to leave the hospital as soon as possible. Where transport is problematical taxis may be used.

6 Establish stocks of linen, drugs, and medical and surgical supplies. Notify the Hospital Incident Control Room of your requirements.

7 Be prepared to receive patients transferred from casualty receiving wards.

8 The Senior Nursing Officer will direct you with regard to any other duties to be undertaken.

9 **DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.**

MAJOR INCIDENT ACTION CARD LEAD RADIOGRAPHER

18

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received go to the Radiology Department take this card and notify the Control Room of your presence.

2 Nominate a Radiographer to be EMERGENCY RADIOGRAPHER and send/him her to collect the EMERGENCY RADIOGRAPHER Action Card from the Control Room en route to the Emergency Department.

3 OUT OF NORMAL HOURS ensure the Radiographer on call (general) has been called and is present in the ED. If not notify the control room that you are going to the emergency department yourself and that another Radiographer must be called at once to go to the main department an act as lead radiographer. Leave the LEAD RADIOGRAPHER card in the Department and go to the Control Room to collect the EMERGENCY RADIOGRAPHER action card en route to the Emergency Department.

4 Ensure that all imaging machines are operational or are being prepared for operation.

3 Out of hours telephone 1 additional Consultant Radiologist (the Radiologist on call will already have been called) and four radiographers to attend for duty.

4 Give priority to imaging test requests from the Emergency Department and Operating Theatres,

5 Oversee the allocation of staff and patients to imaging rooms and ensure patients are properly prioritised for imaging.

6 Maintain close contact with the Emergency Radiographer and prepare to support him/her with another radiographer if necessary.

7 If the Emergency Radiographer requests additional supplies or equipment you must arrange for these to be delivered to him/her. Do not ask the Emergency Radiographer to collect them.

MAJOR INCIDENT ACTION CARD EMERGENCY RADIOGRAPHER

19

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received go to the Control Room and collect this card..

2 Go directly to the Emergency Department and prepare to undertake emergency imaging requests for incident casualties.

3 Ensure that all imaging machines in the Emergency Department are operational or are being prepared for operation.

4 If a conflict over patient priorities arises follow the instructions of the Lead Radiologist in the Emergency Department.

3 Notify the LEAD RADIOGRAPHER if you need additional radiographer assistance.

4 Notify the LEAD RADIOGRAPHER if you require any other supplies or equipment, DO NOT LEAVE THE DEPARTMENT TO COLLECT THEM YOURSELF.

5 Maintain close contact with the Lead Radiographer by telephone or message.

6

MAJOR INCIDENT ACTION CARD 20

Laboratory Technician On Call Haematology

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received go to your laboratory and notify the Control Room of your presence.

2 Ensure that all testing machines are operational.

3 Out of hours telephone the Chief Technologist (Haematology) and the Chief Technologist Microbiology and notify them of the incident. Request them to attend the department.

4 Telephone another technician from Haematology and request him/her to attend the laboratory at once.

5 Prior to contacting the Blood Transfusion Service to order blood supplies contact the Operating Theatres to see if a more precise order can be made up. If not order ten unit of O positive and ten units of O negative in the first instance.

6 Maintain effective communications with the Operating Theatres with regard to blood supplies

7 Give priority to laboratory test requests from the Emergency Department and Operating Theatres,

8 Establish stocks of laboratory supplies. Notify the Hospital Incident Control Room of your requirements.

9 **DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.**

MAJOR INCIDENT ACTION CARD 21

Laboratory Technician On Call Chemical Pathology

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received go to your laboratory and notify the Control Room of your presence.

2 Ensure that all testing machines are operational.

3 Out of hours telephone the Chief Technologist (Chemical Pathology) and the Chief Technologist (Histo-pathology) and notify them of the incident. Request them to attend the department.

4 Telephone another technician from Chemical Pathology and request him/her to attend the laboratory at once.

5 Check that the Technician for Haematology is in the laboratory and is preparing to order blood. If not undertake the duties at 6 and 7 below.

6 Prior to contacting the Blood Transfusion Service to order blood supplies contact the Operating Theatres to see if a more precise order can be made up. If not order ten unit of O positive and ten units of O negative in the first instance.

7 Maintain effective communications with the Operating Theatres with regard to blood supplies

8 Give priority to laboratory test requests from the Emergency Department and Operating Theatres,

9 Establish stocks of laboratory supplies. Notify the Hospital Incident Control Room of your requirements.

10 **DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.**

MAJOR INCIDENT ACTION CARD 22
SUPPORT SERVICES MANAGER

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification of a Major Incident go immediately to the Control Room to receive further instructions and briefing. Go to your department to call staff but thereafter you should base yourself in the Control Room.

2 Staff on breaks should be recalled to duty at once.

3 **IN NORMAL HOURS** Make sure the Engineering Manager, Catering Manager, Portering Manager and Housekeeping Manager have been notified.

OUT OF NORMAL HOURS call the Engineering Manager and Catering Manager to duty. The remaining managers will take over as the second phase managers later.

3 **Out of normal hours** commence calling half of your staff to duty. Remaining staff should be contacted and told to remain at home until called or otherwise to attend for their next normally rostered shift. Be aware that you will have to continue provision of normal services shortly after the incident is stood down.

4 Ensure that the Emergency Department is supplied with and additional porter plus all necessary linen and at least one cleaner to assist in dealing with spills etc.

5 Ensure that all two way radios are working adequately and maintain a list of to whom they have been issued.

6 Undertake a check of all housekeeping requirements by all wards and ensure that additional staff and supplies are dispatched.

7 Normal Canteen services should be terminated and replaced with a basic hot drinks, sandwiches and soup service free of charge for all staff in order to speed up break times. In some cases it might be necessary to despatch these to wards or departments if requested.

8 Notify the Control Room of the operational readiness of your department.

11 **IN NORMAL HOURS** DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.

9 Issue Date:

MAJOR INCIDENT ACTION CARD SECURITY MANAGER

23

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately go to the Control Room to receive further instructions and briefing then go to your department.

2 Staff on breaks should be recalled to duty at once.

3 Call the Senior Guard to duty.

4 **Out of normal hours** commence calling half of your staff to duty. Remaining staff should be contacted and told to remain at home until called or otherwise to attend for their next normally rostered shift. Be aware that you will have to continue provision of normal services shortly after the incident is stood down.

5 The principal functions of security guards are as follows:

- To secure the Emergency Department and assist in protecting staff and patients from unruly behaviour
- To secure and control access to the hospital – only members of staff or members of the emergency services should be admitted without specific authorisation from the Control Room
- Assisting in clearing all visitors and unauthorised persons from the hospital buildings
- Preventing members of the press, once admitted, from moving around the hospital outside of the Press Centre
- Assisting with patient movements if required
- Undertaking messaging duties

6 Allocate Security Officers to the following duties in the order given:

- 2nd Guard to Emergency Department if required
- Main Entrance
- Wards (1 Guard)
- Roadway, OPD
- Press Centre
- After 11pm – IDL Car Pak

7 Notify the Control Room of the operational readiness of your department.

8 The hospital will expect to receive 5 major, 5 intermediate and 10 minor injury patients. In the first instance but this figure could change drastically depending upon the nature of the incident.

9 The Incident Management Team will direct you with regard to any other duties to be undertaken.

10 **IN NORMAL HOURS** DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.

Issue Date:

MAJOR INCIDENT ACTION CARD 24
THERAPY DEPARTMENT MANAGER

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately go to the Control Room to receive further instructions and briefing then go to your department.

2 Staff on breaks should be recalled to duty at once.

3 **Out of normal hours** commence calling half of your staff to duty. Remaining staff should be contacted and told to remain at home until called or otherwise to attend for their next normally rostered shift. Be aware that you will have to continue provision of normal services shortly after the incident is stood down.

4 The Control Room will tell you whether you are required to provide clinical services in the Emergency Department, ICU/CCU and/or wards.

5 Prioritise current caseload in order to assist with the urgent discharge of inpatients to free up beds and cancel all Outpatient clinics

6 Notify the Control Room of the operational readiness of your department.

7 Liaise with Bed Management regarding assistance required for the discharge process.

8 If there are patients in your department send them home and tell them a new appointment will be sent to them. Seek Security assistance of necessary. Keep a record of patients sent home.

9 Where patients are being sent home make arrangements for them to leave the hospital as soon as possible. Where transport is problematical taxis may be used.

10 The Incident Management Team will direct you with regard to any other duties to be undertaken.

11 **IN NORMAL HOURS** DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.

Issue Date:

MAJOR INCIDENT ACTION CARD DEPARTMENTAL MANAGER

25

The Hospital Control Room is in the Ground Floor Parlour
Telephone Extension: 5999

1 On receipt of a notification that a Major Incident has been received you should immediately go to the Control Room to receive further instructions and briefing then go to your department.

2 Staff on breaks should be recalled to duty at once.

3 **Out of normal hours** commence calling half of your staff to duty. Remaining staff should be contacted and told to remain at home until called or otherwise to attend for their next normally rostered shift. Be aware that you will have to continue provision of normal services shortly after the incident is stood down.

3 Notify the Control Room of the operational readiness of your department.

4 If there are patients in your department identify those who can be sent away and do so. Seek Security assistance of necessary.

5 Where patients are being sent home make arrangements for them to leave the hospital as soon as possible. Where transport is problematical taxis may be used.

6 Establish your stock of supplies. Notify the Hospital Incident Control Room of your requirements.

7 The hospital will expect to receive 5 major, 5 intermediate and 10 minor injury patients. In the first instance but this figure could change drastically depending upon the nature of the incident.

8 The Incident Management Team will direct you with regard to any other duties to be undertaken.

9 **IN NORMAL HOURS** DO NOT CALL IN ADDITIONAL STAFF UNLESS SPECIFICALLY INSTRUCTED TO DO SO.

Issue Date:

MAJOR INCIDENT ACTION CARD

26

SWITCHBOARD

1 **During Normal Hours** contact the people on the following list in the order given, and notify them that a Major Incident has been declared and instruct them to take the action on their Action Card. Record the time the message was given to each.

Director of Nursing
Consultant Physician on call
Deputy CEO
HR Director
CEO

2 **During Normal Hours** contact the people on the following list in the order given, and notify them that a Major Incident has been declared and instruct them to take the action on their Action Card and/or report their availability and location to the Control Room on Extension 5999.

Theatre Manager
Duty Registrars in the following specialties
- Medicine
- Surgery
- Anaesthetics
- Paediatrics

Superintendent Radiographer (Radiography Services Manager)
The consultants on duty in the following specialties
- Radiology
- Surgery
- Anaesthetics
- Paediatrics
- Cardiology
- Neurology

Laboratory Chief Technologists
Principal Pharmacist
Hotel Services Manager
Security Manager
Chaplains

Continues overleaf

3 **Out of Normal Hours** contact the people on the following list in the order given, and notify them that a Major Incident has been declared and instruct them to take the action on their Action Card. Record the time the message was given to each

- Night Superintendent
- Theatre Manager on duty
- Duty Registrars in the following specialties
  - Medicine
  - Surgery
  - Anaesthetics
  - Paediatrics
- Off duty Telephonists
- Duty Laboratory Technician
- On Call Radiographers (General & CT)
- Director of Nursing
- Deputy CEO
- Consultant Physician on call
- The consultants on duty in the following specialties
  - Radiology
  - Surgery
  - Anaesthetics
  - Paediatrics
  - Cardiology
  - Neurology
- On Call Laboratory Consultants
- CEO
- HR Director
- Hotel Services Manager
- Security Manager
- Chaplain

4 Await further instructions from the Control Room before initiating further call out.

5 Patients relatives calling for information about incident casualties should be told politely to contact Gardai and the line closed. **DO NOT ENTER INTO CONVERSATION WITH ANY ENQUIRER.**

6 Press enquiries should be directed to the Gardai and the line closed. **DO NOT ENTER INTO CONVERSATION WITH ANY ENQUIRER**

7 Off duty staff phoning in should be told to wait at home until called and/or attend work normally for their next rostered shift.

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APPENDIX 3: Mortuary arrangements[1]

Following a major incident, deceased casualties will normally be taken to a temporary mortuary facility (as opposed to a hospital mortuary).

Incident casualties who die in the hospital will be subject to normal procedures as for a Coroner's case.

APPENDIX 4 CONTENTS OF MAJOR INCIDENT CONTROL ROOM BOX

1 5 Copies of the Hospital Major Incident Procedure
2 Action Cards for Major Incident Team Members, Lead Emergency Doctor, Lead Anaesthetist, Lead Paediatrician, Lead Radiologist, Emergency Radiographer, Support Services Manager, Security Manager.
3 Major Incident Log Book
4 Hospital Telephone Extension List
5 Useful external telephone numbers list
6 20 A4 lined pads
7 4 red telephones
8 1 'Nobo' Easels
9 3 'Nobo' Easel Pads
10 20 red pens, 20 black pens, 20 blue pens, 20 pencils
11 Copy hospital staff master contact list
12 Map of Cork City
13 Map of Co Cork

In addition if required in DCEO Office M.I.P Filing Cabinet Drawer:

Laptop Computer
Computer Projector
Digital Camera
Heavy Duty Hole Puncher
External Major Incident Plans (Cork Region, Other Hospitals, Various 'Seveso' Plans.
Extension Lead
Extra Stationery
Hospital Building Plans

APPENDIX FIVE: CONTAMINATED CASUALTIES PLAN

1. The Cork Major Joint Emergency Plan envisages that in any incident involving chemical, radiological or biological contamination casualties will undergo decontamination at the scene.

2. Nonetheless circumstances might occur where casualties are nonetheless contaminated upon arrival:

   - The immediate area around a casualty who is contaminated is itself a contaminated area.
   - If suspected contaminated casualties are received the Control Room must be informed at once.

3. Where patients are suspected to be contaminated they should not be allowed into the Emergency Department but ambulance staff should be directed to the rear entrance of the hospital in Thomas Street where they should be admitted through the gate by the ED Security Officer.

4. Casualties should be held in the yard whilst they are decontaminated thoroughly with water by staff wearing protective clothing before being admitted to the rear entrance of the department.

5. All equipment, protective clothing, rags and brushes used must be placed in sealed waste bags for proper disposal after use.

6. The Cork Cancer Research Laboratory should be cleared of all personnel and the suspected casualties should be treated on trolleys in that corridor by staff wearing the appropriate protective clothing which is held in the Emergency Department.

7. Staff exposure to chemically or biologically contaminated casualties should be kept to a minimum even where protective clothing is worn.

8. The advice of the Consultant Microbiologist and the Consultant Biochemist should be obtained as soon as possible with respect to the treatment and decontamination of patients and the decontamination of contaminated areas.

9. Where patients are suspected to suffer from Radiological contamination they should be located in one of the laboratory rooms on a trolley with instructions to remain until taken elsewhere. The advice of a consultant radiologist should be sought at once Staff should not enter the room and no treatment should be offered if contamination is possible until proper radiological advice and protection equipment is available.

10. Any patient suspected to be contaminated by any cause must not be admitted to the main hospital without the specific approval of the relevant specialist advisory consultant and the Senior Medical Consultant.

APPENDIX SIX: HOSPITAL EVACUATION PLAN

1. The Hospital has an order of evacuation as follows:

   - Lateral: Evacuation laterally on the same floor into the next fire separation area.
   - Partial: Evacuation across the link bridge to the other building via level 2 or 3
   - Complete: Evacuation of all staff and patients to a location to be decided by the Incident Management Team in liaison with Fire and Ambulance Controllers.

   NOTE: In severe emergency (serious fire or explosion hazard) patients should be moved into the roadway at Grenville Place and then moved on to the IDL site as soon as possible. Those able to walk should do so unaided.

   It is estimated that complete emergency evacuation of the whole hospital would not be completed in less than one hour.
   Complete planned evacuation by ambulance to another site would probably take at least four hours.

2. Any incident requiring hospital evacuation is classed as a Major Incident and the hospital's Major Incident procedure should be activated by the Senior Nurse on Duty.

3. A decision to evacuate the hospital would be made by the Senior Fire Officer in attendance and/or the Hospital Incident Management Team.

4. Gardai should be asked to close surrounding roads except to emergency vehicles.

5. When wards and departments receive an order to evacuate all outpatients and visitors should immediately be asked to leave the hospital. The Emergency Department should be closed to ALL attendees.

6. All nursing staff should concentrate on the evacuation of patients from their own departments and should accompany them, this process will be co-ordinated by the Senior Nurse on Duty until relieved by the Director of Nursing.

7. All medical staff should gather in the NCHD mess on the Ground Floor from where they can be allocated to duties by the first Consultant to arrive or failing that the Medical Registrar on call until relieved by the Consultant Physician on call. All other staff should gather in the Main Canteen from where they can be directed to assist in the evacuation by the Senior General Manager.

8. All managers should keep in mind that the safety of staff and patients is the paramount consideration. Staff should not be exposed to unnecessary or serious risk of injury and must be ordered to evacuate if necessary.

9. All surgery will be cancelled and cases in progress finished as quickly as possible. All personnel in the Operating Theatres will assist in the evacuation of patients from the department.

10. Ambulant patients should wear dressing gowns and be given blankets from their own beds with which to keep warm.

11. Non-ambulant patients will require ambulance transport to be moved from the vicinity. Although if possible hospital trollies could be used to move dependant patients further from risk. This is very labour intensive however.

12. Contact should be made with the Defence Forces with a request to provide emergency lighting, shelter and field catering facilities on the IDL site.

13. The Hospital Incident Management Team will liaise with the City Manager to ensure the Cork Joint Major Emergency Plan has been activated.

Appendix Seven: INFECTIOUS DISEASE PROCEDURES

1. The outbreak of an epidemic of infectious disease can produce circumstances where the Major Incident Procedures is required to operate.

2. The nearest approach to this is recent times was the outbreak of SARS (Severe Acute Respiratory Syndrome) in the Far East and Canada. No cases were detected in Ireland.

3. A pandemic of Avian Flu is thought to be possible at any time and current models project a significant spread to all continents from a likely Far Eastern incubation site before effective control measures can be enacted.

4. Medium case scenarios project from between 500,000 to 1,500,000 persons contracting the disease **IN IRELAND**.

5. The hospital prepared a procedure for dealing with suspected and actual SARS cases in 2003 and this procedure represents the best current basis for planning for an infectious disease epidemic.

6. The hospital's SARS procedures are appended for information and guidance.

MANAGEMENT POLICY FOR THE RECEPTION OF PATIENTS SUSPECTED TO BE SUFFERING FROM SEVERE ACUTE RESPIRATORY SYNDROME

Issue 1.1 Dated 20th June 2003

1. GENERAL PRINCIPLES

a. Four isolation rooms have been identified within the Lee View Block of the Hospital for use by patients suspected to be suffering from SARS in which a negative air pressure can be maintained.

b. Supplies of N95 particulate masks are available in the Emergency Department and the hospital stores.

c. A trolley cover frame with PVC covers for the transport of patients within the hospital is available and is stored in the Emergency Department.

d. As soon as a suspected case is in the hospital a SARS Management Team (SMT) will be created comprising the A&E Consultant, the Consultant Microbiologist, the Consultant Physician on duty, the Deputy CEO and the Director of Nursing. This team will meet in the hospital as soon as possible after a suspected patient has been received. The SMT will be empowered to make decisions concerning all aspects of the hospital's response including the closure of all or any departments and the cohorting arrangements for patients in the event of a major outbreak.

e. Notwithstanding Para d above it is expected that in the event of three or fewer SARS cases being resident in the hospital most services would continue as normal.

f. The Consultant Microbiologist is responsible for making formal notifications of suspect cases to the Health Services Executive and National Disease Surveillance Centre.

2. TREATMENT REGIME

a. Where patients are referred to the hospital as suspected SARS patients in accordance with the established WHO guidelines for classifying SARS cases they will be assessed by the on call medical team in a dedicated isolation room.

b. SARS patients will not generally be assessed or treated in the A&E Department. They will be admitted directly to an isolation room or if they present in the A&E Department they will be transferred by the outside route to an isolation room as soon as possible.

c. On call registrars will be called to undertaken the assessment as soon as the patient is settled in the isolation room. On call registrars must attend immediately to undertake the assessment.

d. The registrar will assess whether the severity of the patient's symptoms is such as to require admission. Suspicion of SARS infection is not in itself a reason for formal admission.

e. Where the condition of patients allows they should be discharged as quickly as possible into the care of their GP.

f. Patients awaiting or undergoing assessment or who have been admitted for treatment must be fully barrier nursed at all times.

g. Patients requiring ventilation, or who would in normal circumstances require admission to ICU will be nursed by outposted ICU nurses in the isolation room and medical equipment required will be transferred to the isolation room from ICU. The bed allocation of the ICU will be reduced accordingly.

h. In accordance with Regional policy if three or more cases are admitted consideration should be given by the SMT to 'cohorting' those patients in a larger single area.

3. PROCEDURE FOR THE RECEPTION OF SUSPECTED SARS PATIENTS

a. Patients suspected to be suffering from SARS may be referred to the Mercy University Hospital (MUH) by General Practitioners or from other hospitals and healthcare institutions. They may also self refer. Patients telephoning for advice should be told to contact their GP and NOT to attend the hospital.

b. <u>General Procedure for Cases for Whom Advance Notification Has Been Given</u>:

i. When the hospital receives advance notice from a GP that a suspected case is to be brought to the hospital, that notification is most likely to be received by the Bed Management Department or the Senior Nurse on Duty.

ii. If a GP is telephoning he/she should be transferred to the on call registrar immediately it becomes apparent that the GP has a suspect SARS case **BUT MUST BE TOLD THAT THE PATIENT WILL BE ADMITTED IF NECESSARY VIA THE ST MICHAEL'S ENTRANCE.** Security will be contacted by the Bed Manager to have the door opened at St. Michael's.

iii. The Bed Manager should contact the on call registrar as soon as possible to establish whether a patient is being brought to the hospital.

iv. The Bed Manager (or out of office hours the senior nurse on duty) will identify and vacate an isolation room.

v. The Bed Manager will notify the receiving ward, the Nurse in Charge of the Emergency Department, the Consultant Microbiologist, the Consultant Physician on duty, the Director of Nursing and the Deputy Chief Executive Officer (all contact numbers are available via the switchboard).

vi. The Nurse i/c A&E will direct the A&E security guard to wait outside the department to ensure ambulances and/or patients are directed to the St Michaels entrance. The guard must be supplied with a particulate mask and gloves. The Nurse i/c A&E will also arrange for a porter to take the covered trolley to the St Michael's entrance.

vii. The Ward CNM, or senior nurse on duty, will allocate a receiving nurse and will notify portering of the need to send a porter immediately to assist the reception of the patient. The Nurse and the porter will be given a mask, a gown, cap and gloves in the ward and must wear them to receive the patient. The Ward CNM,

or senior nurse on duty, will ensure that fans in the designated isolation room are on full power to ensure negative pressure.

viii. On arrival the patient should be given a particulate mask immediately and should then be transferred to the isolation room by the covered trolley.

ix. Upon the patient's arrival in the isolation room the on call registrar should be notified to attend immediately.

x. The on call registrar will attend immediately to commence patient assessment.

xi. Thereafter the patient will be barrier nursed as an infectious patient until discharged or confirmed as non-SARS.

c. Additional Variations for Patients Brought To The Hospital As Emergencies Who Require Resuscitation

i. As soon as it is known that a suspect SARS case requires resuscitation the A&E Department should be fully closed to all cases. The patient should be moved to the resuscitation area as soon as possible.

ii. Patients waiting in the A&E Department should be transferred to other areas. This will be supervised by the Senior Nurse on Duty at any time and not the Nurse i/c A&E. These areas will be: the A&E canteen, the Ground Floor Pastoral Care Office, the corridor, the Ground Floor Parlour and, if necessary, the first floor Pastoral Care Room. All staff not directly involved with treating the SARS patients should leave the department and assist with other patients.

iii. All staff remaining in the department should wear gowns, caps, masks and gloves.

iv. When the patient is stabilized he/she should be transferred to the identified isolation room to be cared for by outposted ICU nurses with equipment transferred from ICU.

4. STAFF AND PATIENT CONTACT

a. Members of staff who have been in unprotected contact with a suspect case will not be treated as a suspect case themselves. They should be re-assured and informed of the symptoms they should be aware of by the Control of Infection Nurse. They should be assessed by the Occupational Health Department daily up to 10 days and on a regular agreed basis with the patient up to 21 days. They should be advised to telephone the hospital if any symptoms develop (occupational health department) and their GP.

b. Patients and other persons in unprotected contact with a suspect case should be re-assured and informed of the symptoms they should be aware of by the Control of Infection Nurse. If such symptoms develop they should be advised to contact their Occupational Health / Infection Control or GP AND NOT TO RETURN TO THE HOSPITAL EXCEPT AS DECIDED BY THEIR GP in consultation with the hospital SMT and Public Health.

5. PRESS CONTACT AND COMMUNICATIONS

a. Rumour and ill founded comment can easily cause unnecessary public concern and even panic where infectious diseases are concerned. For this reason all public communications and press comment must be directed through the Deputy Chief Executive's Office. The making of unauthorized comment to the press by any member of staff will be regarded as gross misconduct which could lead to dismissal.

b. The DCEO will liaise with the other members of the SRT and the Chief Executive Officer with regard to public announcements or press releases and comment.

c. The Consultant Microbiologist and the Control of Infection Nurse will be responsible for informing and educating all staff in appropriate preventative actions and the nature of the disease.

JW Corbett
Deputy Chief Executive Officer
20th June 2003

This policy should be read in conjunction with the attached documents

No. 1 Mercy University Hospital Definition of Suspect / Probable SARS

No. 2 Extract of Guidance from the National Disease Surveillance Centre, which outlines diagnosis and treatment protocols for reception of patients suffering form suspect/probable SARS

No. 3 Reception of Patients to A/E – SARS

No. 4 Security Policy

No. 5 Portering Policy

No. 6 Infection Control Guidelines

No. 7 Occupational Health Guidelines

No. 8 Laboratory Tests

Document 1

MERCY UNIVERSITY HOSPITAL DEFINITIONS OF SUSPECTED AND PROBABLE SARS CASES

A **SUSPECT** case is a person presenting with a history of close contact with a suspect/probable SARS case or travel to/residing in an affected area within 21 days of the onset of symptoms

AND

One or more respiratory symptoms and/or high temperature (>38°)

A **PROBABLE** case is a suspect case with radiographic evidence of infiltrates consistent with pneumonia or respiratory distress syndrome (RDS) on chest X-ray (CXR).

Document 2

NDSC – SARS (EXTRACT)

NOTE: THE FULL VERSION OF THIS DOCUMENT IS AVAILABLE TO MERCY UNIVERSITY HOSPITAL STAFF ON THE HOSPITAL COMPUTER NETWORK AT h:\test\jcmessages\SARS Archive

Severe Acute Respiratory Syndrome (SARS)
Interim Information & Recommendations for Health Care Professionals
Case Definitions for Surveillance of Severe Acute Respiratory Syndrome (SARS)

Objective
To describe the epidemiology of SARS and to monitor the magnitude and the spread of this disease, in order to provide advice on prevention and control.

Exclusion criteria
A case should be excluded if an alternative diagnosis can fully explain their illness.

Case definitions (revised 1 April 2003)
The case definitions for global surveillance are subject to limitations because of the rapidly evolving nature of this illness. They are based on current understanding of the clinical features of SARS and the available epidemiological data, and may be revised as new information accumulates. *Preliminary clinical description of Severe Acute Respiratory Syndrome* summarizes what is currently known about the clinical features of SARS. Countries may need to adapt case definitions depending on their own disease situation. Retrospective surveillance is not expected.

Suspect case

A person presenting after 1 November 2002[1] with history of:

- High fever (>38 °C)

AND

- Cough or breathing difficulty

AND

one or more of the following exposures during the 10 days prior to onset of symptoms:

- close contact[2] with a person who is a suspect or probable case of SARS;
- history of travel, to an **affected area** [3]
- residing in an **affected area** [3]

Probable case

1 A suspect case with radiographic evidence of infiltrates consistent with pneumonia or respiratory distress syndrome (RDS) on chest X-ray (CXR).

2 **Close contact:** having cared for, lived with, or had direct contact with respiratory secretions or body fluids of a suspect or probable case of SARS.

3 **Affected area:** an area in which local chain(s) of transmission of SARS is/are occurring as reported by the national public health authorities.

Management of Severe Acute Respiratory Syndrome (SARS)

Management of suspect cases (see case definition)

- Suspect cases of SARS should be triaged immediately in designated examination rooms or wards
- Issue patients with surgical mask
- Obtain and record detailed clinical, travel and contact history including occurrence of acute respiratory diseases in contact persons during the previous 10 days
- All people meeting the "suspect" case definition **because they have had close contact with a probable case** must be admitted to hospital
- If they are a suspect case because they meet the travel case definition, they need not necessarily be hospitalized, but should still be isolated at home
- Obtain chest X-ray (CXR) and full blood count (FBC)
- If CXR is normal:
    - Send a serum sample (plain tube) to the local laboratory and a further sample 10-14 days later. A nasopharyngeal aspirate, mouth washing and/or throat swab (in viral transport medium) should also be taken, if the patient is still symptomatic at the time of assessment. Samples should be clearly labelled as being from a suspected SARS case and include travel details. Samples will be forwarded to the National Virus Reference Laboratory.
    - Provide advice on personal hygiene, avoidance of crowded areas and public transportation
    - Patient should remain at home until well
    - It may be prudent for patients to wear a surgical mask at home, to minimize the risk of spread to other family members, until SARS has been ruled out
    - Discharge with advice to seek medical care if respiratory symptoms worsen
- If CXR demonstrates uni- or bi-lateral infiltrates with or without interstitial infiltration → SEE MANAGEMENT OF PROBABLE CASES

Management of probable cases (see case definition)

- Seek advice on investigation and management from local clinical microbiologist and/or infectious disease physician
- Hospitalise under strict isolation (see infection control guidance below), or cohort with other SARS cases
- Obtain samples for laboratory investigation, following microbiological advice, including sample for exclusion of known causes of atypical pneumonia. Samples should include:
    - Throat and/or nasopharyngeal swabs
    - Blood for culture and serology
    - Urine
    - Bronchoalveolar lavage, if possible
    - Post-mortem examination as appropriate
- Samples should be investigated in laboratories with proper containment facilities. Laboratory containment level requirements will depend on the patient's clinical findings and local laboratory risk assessment (see annex for details)
- Monitor FBC alternate days
- CXR as clinically indicated
- Treat as clinically indicated

Management of asymptomatic contacts of suspected and probable cases

- Provide reassurance
- Record name and contact details

- Provide advice in the event of fever or respiratory symptoms to:
    - Seek immediate medical advice,
    - Immediately report to local Department of Public Health and NDSC

Hospital Infection Control Guidance

Care for patients with probable SARS

- Advice should be sought from the local infection control experts
- WHO advises strict adherence with the barrier nursing of patients with SARS using precautions for airborne, droplet and contact transmission.
- Triage nurses should rapidly divert persons presenting to their health care facility with flu-like symptoms to a separate assessment area to minimise transmission to others in the waiting area
- Suspect cases should wear surgical masks until SARS is excluded.
- Patients with probable SARS should be isolated and accommodated as follows in descending order of preference:
    - Negative pressure rooms with the door closed
    - Single rooms with their own bathroom facilities
    - Cohort placement in an area with an independent air supply and exhaust system.
- Wherever possible, patients under investigation for SARS should be separated from those diagnosed with the syndrome.
- Disposable equipment should be used wherever possible in the treatment and care of patients with SARS.
    - If devises are to be reused, they should be sterilised in accordance with manufacturers' instructions.
- Surfaces should be cleaned with broad-spectrum (bactericidal, fungicidal, and virucidal) disinfectants of proven efficacy (e.g. 1% hypochlorite).
- Patient movement should be avoided as much as possible.
    - Patients being moved should wear a surgical mask to minimise dispersal of droplets.
    - NIOSH standard masks (N95) are preferred if tolerated by the patient.
- All visitors, staff, students and volunteers should wear a N95 mask on entering the room of a patient with probable or suspected SARS.
    - Surgical masks are a less effective alternative to N95 masks.
- Hand washing is the most important hygiene measure in preventing the spread of infection
    - Gloves are not a substitute for hand washing
    - Hands should be washed before and after significant contact with any patient, after activities likely to cause contamination and after removing gloves.
    - Alcohol-based skin disinfectants formulated for use without water may be used in certain limited circumstances.
- Health care workers are advised to wear gloves for all patient handling.
    - Gloves should be changed between patients and after any contact with items likely to be contaminated with respiratory secretions (masks, oxygen tubing, nasal prongs, tissues/handkerchiefs).
- Gowns (waterproof aprons) should be worn during procedures and patient activities that are likely to generate splashes or sprays of respiratory secretions.
- HCWs must wear protective eyewear or face-shields during procedures where there is potential for splashing, splattering or spraying of blood or other body substances.
- HCWs are advised to wear masks whenever there is a possibility of splashing or splattering of blood or other body substances, or where airborne infection may occur.
    - Particulate filter personal respiratory protection devises capable of filtering 0.3um particles (N95) should be worn at all times when attending patients with suspected or confirmed SARS.
- Standard precautions should be applied when handling any clinical wastes.
    - All waste should be handled with care to avoid injuries from concealed sharps (which may not have been placed in sharps containers).
    - Gloves and protective clothing should be worn when handling clinical waste bags and containers.
    - Where possible, manual handling of waste should be avoided.

- Clinical waste must be placed in appropriate leak-resistant biohazard bags or containers labelled and disposed of safely.

- Pay particular attention to therapies/interventions, which may cause aerolization such as the use of nebulisers with a bronchodilator, chest physiotherapy, bronchoscopy, gastroscopy, any procedure/intervention, which may disrupt the respiratory tract. Take the appropriate precautions if you feel that patients require the intervention/therapy.

Sources of information

WHO Severe Acute Respiratory Syndrome (SARS)- multi country outbreak; Update 22 05/04/2003
Case Definitions for Surveillance of Severe Acute Respiratory Syndrome (SARS) - revised 1 April 2003
WHO Hospital infection control guidance 16/03/2003
WHO Management of Severe Acute Respiratory Syndrome (SARS) 16/03/2003
WHO Management of Severe Acute Respiratory Syndrome (SARS) revised 28/03/2003
WHO hospital discharge and follow-up policy for patients who have been diagnosed with Severe Acute Respiratory Syndrome (SARS) – revised 28th March 2003
WHO emergency travel advisory 15/03/2003
WHO Summary on major findings in relation to coronavirus by members of the WHO multi-centre collaborative network on SARS aetiology and diagnosis 08/04/03
WHO SARS: Availability and use of laboratory testing 08/04/03
WHO collaborative multi-centre research project on Severe Acute Respiratory Syndrome (SARS) diagnosis

Document 3

MERCY UNIVERSITY HOSPITAL PROCEDURE FOR THE RECEPTION OF SUSPECTED SARS PATIENTS

Patients coming directly to A/E without going to GP: This should not be encouraged especially for those with a regular GP who would be better informed on anxiety overtones etc. of patients. Every effort should be made if the opportunity presents to any hospital staff member to have A/E informed by phone or otherwise before a suspect SARS patient arrives at A/E door.

A&E staff must reduce time between new patients arriving and the initial interview. For now consideration should be given to appropriately worded notices in A/E to encourage potential SARS patients to made themselves known as quickly as possible.

Suspect SARS patients in A/E:
As soon as a suspect SARS case presents at the window an immediate response plan initiated along the following lines. All A/E staff should combine in so far as possible to activate this response. The SARS management team should be informed – see management policy for reception of SARS patients – (MP – SARS).

- No further patients are admitted to the surgical area
- Security is informed to activate their end of the plan
- The back room in A/E should be vacated as quickly as possible and the HEPA filtration unit turned on if not already on.
- The patient should be brought into the A/E surgical area and masked as quickly as possible, and escorted to the vacated room.
- Patients and staff in the surgical area of A/E should be masked.
- Access through all doors in A/E area should be prevented, using security, A/E staff and prepared notices. The front door of A/E should be opened and the area cleared as far as possible – (see MP – SARS).
- Research workers in the area will need to be informed and access provided through the rear exit, by the boiler house – see security plan.
- A preliminary medical review should be carried out as quickly as possible and a decision made to activate the transfer of the patient to a negative pressure room or not. If a decision to admit the patient is made, bed management must be informed immediately and the Ambulance Controller should be informed that A/E is closed for a short time – (Approx 1 hour).
- The patient should be transported in the covered trolley available, to the negative pressure room as soon as possible via the lift in the new block (see MP- SARS).
- Activity should return to normal within 1 hour unless the risk is deemed to be very high by the SARS management team. This time should be devoted to surface disinfection, room aeration and removing/replacing plastic sheet coverings where deemed necessary. Masks should continue to be worn during this time for anybody within A/E.

Document 4

SECURITY POLICY – SARS

Security department plan to cordon off and isolate the emergency department

The decision to cordon off the emergency department will be made by the senior nurse on duty in the emergency department.

The instruction to security staff to put this plan into effect will be given by the senior nurse on duty in the emergency department.

The security personnel will then put in place the following procedures:

A. Collect the tape and bollards stored at the security office, mansion house, floor 1.

B. Cordon off the entire emergency department at the five (5) locations identified below.

Location 1.	At the external entrance doors to A/E. close the gates (do not lock them), tie tape on the gates and place the sign on the gates.
Location 2.	Place bollards, tape and sign on the main corridor, Catherine Mc Auley block, ground floor, at the pastoral care office.
Location 3.	Lock the fire door, from the outside, at the smoking area near the statue. Place tape and sign on extern of door.
Location 4.	Place bollards, tape and sign on the corridor to cork cancer research centre, at room 1, Thomas Moore block. (CCRC staff to use exit @ boiler house)
Location 5.	Place tape and sign on the first floor landing, stair 3, Thomas Moore block.

NOTE:

IT IS POSSIBLE TO IMPLEMENT THIS PLAN WITHOUT ENTERING THE EMERGENCY DEPARTMENT.TAKE ALL PRECAUTIONARY MEASURES AS OUTLINED BY THE M. U. H., INFECTION CONTROL DEPARTMENT.

Tony O' Regan, Security Manager, Mercy University Hospital.

Document 5

PORTERING DEPARTMENT

Duties of the Porter

Transfer of Patient from A/E Department to Neg. Pressure Room

The porter will receive instruction from the Department Head regarding his responsibility-

- Any suspect/probable/definite SARS patient for admission from the A/E Department to the Negative Pressure Room in the Lee View Block will be transported on the "special" polythene covered trolley. This requires the assistance of a porter.
- Entrance to the Lee View Block is through the front door of St. Michael's via the elevator.
- The porter **MUST** wear full protective gear (as outlined in the Infection Control Guidelines**). NB. Hand washing & proper use of the N95 Mask.**
- Before returning to the A/E Department the trolley **MUST** be stripped washed and disinfected (in the outer area of the room) with Milton 1:10. Rinse off afterwards with clean water. Use alcohol 70% for the chrome parts of the trolley,

Direct Admission of Patient from i.e. GP

- Such patients will be admitted direct to the Neg. Pressure Room, via St. Michaels' on the "special " covered trolley (as described above)
- The receiving Department Head will arrange for a member of both nursing and portering staff to meet the patient at the entrance.
- Both staff members **MUST** wear the full protective clothing**. NB. Hand washing and proper use of the N95 Mask.**
- The trolley **MUST** be stripped, washed and disinfected with Milton 1:10 before removing from the outer area of the room.
- The trolley may then be returned to the A/E Department.

Transportation of Laboratory Specimens

- As outlined in the Infection Control Guidelines a transport box is available from the Microbiology Laboratory containing the necessary equipment for collection of blood/ other specimens. It is the duty of the appointed porter to collect and return this box to the laboratory. Gloves may be worn.

Other Duties

- There may be other duties for porters i.e ensuring sufficient oxygen/ other miscellaneous requests by the Department Head. In this instance risk assessment determines the extent of protective wear but in the area it is advisable to wear a mask at all times. If in doubt contact the department head.

  Any queries/ doubts contact Infection Control

Document 6

MERCY UNIVERSITY HOSPITAL INFECTION CONTROL GUIDELINES

These guidelines are to be read in conjunction with the guidelines issued by the National Disease Surveillance Centre, the (Mercy University Hospital) documents produced by the Mr. J. Corbett, Dr. J. Clair, Occupational Health Department, Security Department, Portering Department.

1. Reduce the number of staff attending to a suspect/ probable/ definite SARS case to the minimum required Aim for the person/persons allocated to the patient to attend to all that patient's needs (this includes both medical/nursing-staff) i.e. meal trays, any required equipment/ products etc. should be left outside the door. Ensure that the telephone system is in place to enable immediate contact with the person inside. This applies to both the A/E Department and the Negative Pressure Room.

2. **Protective Wear-** The following **MUST** be worn by staff attending to the patient

- Full length, full sleeved gowns (oncology gowns)
- N95 Mask
- Gloves
- Goggles/visors
- Disposable hats
- Disposable overshoes

NB. The patient MUST wear an N95 Mask. If the patient is unable to tolerate the N95 replace it with an ordinary surgical mask.

NOTE: All of the above requirements are available from the A/E Departments for where /by whom needed.

3. Isolation Signs

- **"Red" Isolation Sign on the door. Remember to keep the door closed at all times.**

4. Specimens

- The Microbiology Laboratory **MUST** be contacted before collection of blood/ other specimens.
- The Microbiology Laboratory will issue the relevant equipment in a "special box" (stored in the lab) and collected specimens are to be placed in this box and will be distributed to the relevant laboratories by the Microbiology Laboratory.
- **NB. No** bloods/ other specimens to be taken in the A/E Department- bloods/ specimens to be taken **ONLY** in the negative pressure rooms.

5. "Cadaver" Packs

- A pack containing inner/outer "Cadaver" bag, protective wear, wash bowl, cloths etc (all requisites required for "laying out") is available in the A/E Department.

6. Maintenance

- **Ensure that maintenance personnel are informed of the status of the patient**
- **Ensure that the necessary full protective wear (as outlined above) is made available to them**
- **Maintenance should respond immediately when contacted to remove the refuse from the room.**
- Refuse **MUST** go directly from the room to the compound and stored Separately in the compound.

Cleaning/Disinfection Guidelines

Cleaning/ Disinfection of affected Room/ A/E Area

Preparation of the Room/Area

- Remove as much equipment as possible from the room/ area where the patient is being treated.
- Remember to place the Hepa Filter Unit in the A/E Room and switch on.
- Place polythene sheeting over anything which cannot be removed i.e. equipment, open shelving etc. If possible secure this sheeting with clips.

- "**RED" Isolation sign on the door and remember to keep closed at all times.**

- **Ensure that the negative pressure is set (in negative pressure room) or the appropriate hepa Filter Unit/ Extractor functioning properly (in the A/ E Dept.) both in the rear room and in the inner unit itself.**
- Ensure adequate supply of necessary equipment i.e. yellow bags/yellow "sharps" bin/ yellow rigid bins.
- Bio-hazard labels (yellow sticker with B.H. written in red) to be placed on outside of case notes, inside of kardex, on all request forms (as per "Infectious" sticker policy).
- Adequate supply of protective wear i.e. long sleeved, heavy duty gowns, disposable gloves/overshoes/hats and N95 masks and surgical masks (for the patient if unable to tolerate the N95) to be placed outside the area.

Cleaning/ Disinfection

Clean with detergent and hot water. After cleaning disinfect with Milton 1/10 and alcohol 70% for chrome

Full personal protective wear as outlined above should be worn by the person cleaning and on removal placed in double yellow bag and immediately secured/ removed from the area.

- Promptly dispose and secure any waste. Remove and dispose of all polythene covering. Any remaining notices/posters on the walls should also be discarded at this time. It is necessary in this situation to double bag all waste.
- Close the door and leave the room/ area for 1hour
- Any equipment within the room (which needs to be removed) should be properly cleaned/ disinfected before removing.
- Thorough cleaning/disinfection of the entire area/ room is necessary. This includes all surfaces, ledges, windows, doors, walls, floors etc.
- Any cloths, detergent bottles etc. used must be disposed of and non- disposable equipment must be properly cleaned/ disinfected

Re- Occupation of Room

A/E- Low Risk-

- Good surface cleaning/Disinfection as outlined above
- Cleaning/Disinfection of Hepa Filter Units and leave the units switched on(high power)
- If urgently needed the room may be used after 1hr.
- If not ideally leave over night

A/E -High Risk

- In the case of "high" risk sterilization/fumigation should be considered and the room should be left closed for 24hrs.

Negative Pressure Room- Low Risk

- Good Surface cleaning /disinfection as outlined above.
- Leave at negative pressure.
- If urgently needed the room may be used after ½- 1hr.
- If not ideally leave over night

Negative Pressure Room – High Risk

- In the case of "high" risk sterilization/ fumigation should be considered and the room should be closed for 24hrs.

Any queries/problems/doubts contact Infection Control.

Document 7

OCCUPATIONAL HEALTH GUIDELINES FOR SARS

Guidelines to be followed by Occupational Health Nurse in the event of a staff member having returned from travel to an affected area:

- Initial assessment of staff member - questionnaire to be completed by O.H.N. by speaking with the staff member on phone – see questionnaire attached. If initial assessment is clear then :-
- The staff member is to be given a SARS symptom sheet – see attached symptom sheet - and instructed that they must report any symptoms to Occupational Health as soon as they occur.
- Daily temperature checks and monitoring of staff member for symptoms, to be carried out for 10 days post arrival back in Ireland. Any symptoms occurring after this period staff to contact Occupational Health.
- Temperature check and monitoring for symptoms to be carried out prior to the staff member reporting for duty each working day.
- The above monitoring will take place in the 'back room' of A&E.
- When the staff member is found to be apyrexial and is symptom free they may proceed to work.

In the event of a staff member having a pyrexia and/or reporting symptoms.

- The OHN should provide the staff member with an N95 mask to be donned stat.
- The OHN must don an N95 mask.
- The OHN will inform the Nurse Manager in the A&E department of the situation.
- OHN will contact the on call registrar to have the staff member medically assessed.

Guidance for Management of Exposures to Severe Acute Respiratory Syndrome (SARS) for Healthcare Settings

1. Health care workers who have unprotected exposure to SARS should be vigilant for fever or respiratory symptoms during the 21 days following exposure.
2. Those who develop fever or respiratory symptoms should limit interactions outside the home and should not go to work, school, out-of-home childcare, church or other public areas.
3. Symptomatic healthcare workers should use infection control precautions to minimize the potential for transmission and should seek healthcare evaluation. In advance of the evaluation healthcare providers should be informed that the healthcare worker may have been exposed to SARS.

4. If symptoms do not progress to meet the suspect SARS case definition within 72 hours after first symptom onset, the health-care worker may be allowed after consultation with infection control, occupational health and/or local health authorities, to return to work

5. For healthcare workers who meet or progress to meet the case definition for suspected SARS (e.g. develop fever and respiratory symptoms), infection control precautions should be continued until 21 days after the resolution of fever, provided respiratory symptoms are absent or improving. Suspected SARS should be reported to local health authorities immediately.

6. Exclusion from duty is not recommended for an exposed health-care worker if they do not have either fever or respiratory symptoms. However, the worker should report any unprotected exposure to SARS patients to the appropriate facility point of contact (e.g. Infection Control or Occupational Health) immediately.

7. Active surveillance for fever and respiratory symptoms, e.g. daily screening, should be conducted on health-care workers with unprotected exposure, and the worker should be vigilant for onset of illness. Workers with unprotected exposure developing such symptoms should not report for duty, but should stay at home and report symptoms to the appropriate facility point of contact immediately.

8. Passive surveillance, should be conducted among all healthcare workers in a facility with a SARS patient, and all health-care facility workers should be educated concerning the symptoms of SARS.

SARS QUESTIONNAIRE

This questionnaire is to be completed by the Occupational Health Nurse, in the case of an employee returning from a country were there are SARS cases or suspected cases. This document is to be completed via a telephone conversation with the staff member, prior to that staff member returning to work.
The employee is to be informed that this information may be imparted to the infection control team.

Name of employee:

Date of Birth:

Date:

1. Have you had a close contact i.e have you lived with, or had you direct contact with respiratory secretions or body fluids of a suspect / probable SARS case? **Yes / No**
2. Where have you travelled to?
3. What cities / areas did you visit in that country?
4. What airports did you stop at on your journey?
5. Did you remain in the aeroplane or disembark?
6. If you did disembark, how long did you spend in the airport terminal?
7. Have you shortness of breath? **Yes / No**
8. Have you a cough? **Yes / No**
9. Have you a fever? **Yes / No**
10. Have you a headache? **Yes / No**

11. Have you loss of appetite? **Yes / No**

12. Have you diarrhoea? **Yes / No**

13. Have you general malaise? **Yes / No**

14. Have you an overall feeling of discomfort? **Yes / No**

If the employee answers 'yes' to any of the question, or has travelled to or passed through a high risk area, a member of the infection control team is to be contacted and informed of this information before the employee is allowed to return to work.

Symptom Sheet for SARS Virus

Do not come to work if you develop any of the symptoms listed below.
If you have any of the following symptoms please ring the Occupational Health Department (021-4271971 ext 5307), outside of hours please ring your General Practitioner.

- Fever (temperature >38.0 degrees C)
- Cough
- Difficulty with breathing
- Headache
- Body aches
- Shortness of breath
- Diarrhoea
- Malaise
- Loss of Appetite

Document 8
LABORATORY TESTS

It is important that laboratory and other departments are made aware that samples are coming from a suspect/potential SARS.

All lab samples should be sent directly to Microbiology in the container provided, from there they will be distributed to other labs as appropriate.
They should not be placed in the pneumatic tube.
All materials required for the lab investigation of SARS patients are available in a "SARS BOX", available from the Microbiology Lab.

Microbiology

Patients with suspect or probable SARS should be investigated for causes of community-acquired respiratory infection including:

- Sputum for Culture and sensitivity
- Nose/throat or nasopharyngeal or mouth washings – viral swab.
  Must use specific viral transport swabs…available in SARS BOX..
- Sputum for SARS PCR – Sputum during day 6 – 10 of illness is best.
  Normal sputum container.
- Faeces specimen for SARS.
- Serum for Atypical pneumonia serology.

Please remember to take a convalescent sample 10-14 days later!

Haematology

- Full blood count.
- ESR.
- C reactive protein

Biochemistry

- Urea and electrolytes.
- Liver function tests.
- Creatine Phosphokinase.

All specimens should be labelled RAS/03 in addition to usual details.

JW Corbett
Deputy Chief Executive Officer
2nd May 2003

APPENDIX 8 Amendment Record

This manual will be regularly reviewed and amendments issued as required. Any changes to be included in this manual **MUST** be co-ordinated through the Deputy Chief Executive Officer.

Amendment Number	Description	Dated	Inserted by	Date inserted