CHAPTER 1

The structured approach to the hospital response

There are seven principles for effective response to a major incident. The generic nature of these principles has been shown to cross inter-service boundaries, civilian–military boundaries, and international boundaries.

1 **C**ommand
2 **S**afety
3 **C**ommunication
4 **A**ssessment
5 **T**riage
6 **T**reatment
7 **T**ransport

This is the "ABC" of major incident medical management. CSCA are the management parts of the response, while TTT represents the medical support that is provided.

COMMAND

One of the major differences between day-to-day hospital operations and hospital major incident response is the need for a clear command structure. Command is exercised through the Hospital Co-ordination Team (Figure 4.1, see p. 11) and through the clinical, nursing, and managerial hierarchies.

SAFETY

All staff should follow the 1–2–3 of safety:

1 Staff
2 Situation
3 Survivors.

COMMUNICATION

Communication failures frequently occur between scene and hospital, and within the hospital itself. Effective procedures must be in place to activate and control the incident at the hospital.

ASSESSMENT

A rapid assessment of the situation to estimate the size and severity of the casualty load is essential. It does not have to be completely accurate, and will be refined as the incident evolves. Continuing assessment will relate to the hazards that arise, and the adequacy of medical resources (the right people, with the right skills and equipment to treat the casualties).

TRIAGE

This is the sorting of casualties into priorities for treatment. The process is dynamic (priorities may alter after treatment, or while waiting for treatment) and it must be repeated at every stage to detect change. Simple, effective systems for triage are described in Chapter 5.

TREATMENT

The aim of treatment at a major incident is to "do the most for the most"; that is, to identify and treat the salvageable. The actual treatment delivered will reflect the skills of the providers, the severity of the injuries, and the time and resources available. The casualty load and the availability of skills and equipment may restrict a provider's ability to perform to best practice standards. A key principle here is to use staff to provide the treatments that most match with those of their day-to-day practice.

TRANSPORT

Although the majority of seriously injured patients will arrive at hospital by emergency ambulance, the

Emergency Department (ED) must be prepared to process patients arriving via their own or unconventional transport (e.g. bus). In urban areas it is likely that the first people arriving at a hospital will be Priority 3 patients arriving by non-emergency ambulance means.

The principles of CSCATTT need to be applied to the phases of the hospital major incident response. These are discussed below.

DECLARING AND ACTIVATING A MAJOR INCIDENT PLAN

It is obviously vital that a hospital activates its major incident plan as early as necessary. A major incident plan can be activated by the ambulance service staff, who are usually aware of an incident before the hospital. However, it may be necessary for the hospital itself to activate the plan if the ambulance service forgets (it has happened!) or if the incident occurs on-site. In either case, the following phrases should be used (Box 1.1).

Box 1.1 Phrases to declare and activate major incident plan

Major incident – standby
This alerts the hospital that a major incident is possibly imminent. A limited number of staff need to be informed. This is an opportunity for senior staff to appraise current workload and capacity in order to be prepared for further escalation.

Major incident declared – activate plan
In this case the incident has occurred and the major incident plan must be activated in its entirety. There is no role for limited or partial activation of a plan. It is always best to activate early, then stand down sections of the hospital rather than to activate the plan piecemeal.

Major incident cancelled
This is used to cancel a standby call.

In the UK, all other terms should be abandoned in favour of these nationally agreed standard messages.

Local highlights: Nationally agreed standard messages

The standard messages almost always come from either ambulance control (this should be on a dedicated line) or from the ED. This usually allows easy confirmation that the messages are genuine.

The initial alert messages should be received by switchboard staff who will act as the hub for the activation of the major incident procedures. The role of switchboard at this stage is clearly crucial.

It is vital that switchboard and individual departments keep up-to-date logs of contact details and procedures.

A number of methods may be used to contact staff:

- Pager
- Telephone (mobile/land)
- Public address
- Media.

The order in which individuals are called will vary, but will reflect the urgency to which they are needed.

If telephones are used, a cascade mechanism for notifying staff is advocated whereby one member of a team is contacted by switchboard, that individual then contacts other members of their team. Again such a system is reliant on up-to-date information.