Policy Number	SA31 - b
Policy Name	HAZMAT Plan (v1.1)
Policy Type	Trust-wide Non-clinical
Accountable Director	Executive Director of Nursing
Author	Jon Tynan
Recommending Committee	Patient Safety / EPRR
Approving Committee	Executive Committee
Date Originally Approved	Nov 2016
Next Review Date	July 2019

This document is a valid document, however due to organisation change some references to organisations, organisational structures and roles have now been superseded. The table below provides a list of the terminology used in this document and what it has been replaced with. When reading this document please take account of the terminology changes on this front cover

Changes to this document
Reference now made to both Lancashire and Merseyside (pg 20-21), prev just referred to Lancashire

FOR OFFICE USE ONLY (Work Stream submission check)

This document is compliant with current best practice guidance ☒

This document is compliant with legislation required in relation to its content ☒

What change has this document undergone in the policy alignment process relating to the South Sefton Transaction?

☐ None ☒ Minor ☐ Major ☐ This is a new document

☐ This document has been reviewed and is no longer required

Does this document impact on any other policy documents?

☐ Yes , **if yes, which policies are effected? 38T**

☒ No

Signed: J Hodson **Date: 15/05/17**

Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE NON-CLINICAL GUIDELINE DOCUMENT

INCIDENTS INVOLVING HAZARDOUS MATERIALS (HAZMAT) GUIDELINES

Policy Number:	**sa31-b**
Scope of this Document:	**All Staff**
Recommending Committee:	**Emergency Preparendess Resilience and Response (EPRR) Group / Business Continuity Group**
Approving Committee:	**Executive Committee**
Date Ratified:	**November 2016**
Next Review Date (by):	**July 2019**
Version Number:	**2016 – Version 1.1**
Lead Executive Director:	**Executive Director of Nursing**
Lead Author(s):	**Head of Risk/ EPRR**

TRUST-WIDE NON-CLINICAL GUIDELINE DOCUMENT

2016 – Version 1.1

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE NON-CLINICAL POLICY GUIDELINE DOCUMENT

INCIDENTS INVOLVING HAZARDOUS MATERIALS (HAZMAT) GUIDELINES

Further information about this document:

Document name	**Incidents Involving Hazardous Materials (HAZMAT) Guidelines (sa31-b)**
Document summary	This document introduces guidance for dealing with casualties who self-evacuate from an incident scene involving hazardous materials occurring elsewhere and then present at a Trust facility, or a HAZMAT incident occurring on Trust premises. The key priorities are to protect staff, patients and any other third parties, Trust property and other assets from secondary contamination until specialist help arrives.
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Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Business Continuity Policy (SA44)** **Major Incident Plan SA31** **Lockdown Policy & Supporting Guidance (SD45)** **Health, Safety and Welfare Policy (SA07)** **Infection Prevention and Control Policy ((IC01)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Version 1	EPRR Working Group Policy Group Executive Committee	July 2016 October 2016 November 2016
V1.1	Minor changes – reference now made to both Lancashire and Merseyside documents and agencies	May 2017

SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:
being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
knowing how to deal with a disclosure or allegation of child/adult abuse;
undertaking training as appropriate for their role and keeping themselves updated;
being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

IF YOU SUSPECT THAT ANYONE ENTERING YOUR FACILITY HAS BEEN EXPOSED TO A POSSIBLE HAZARDOUS MATERIAL:

THINK SAFETY FIRST – STEP 123 (p. 11 below)

DO NOT TOUCH THE CASUALTY. ISOLATE THEM IN A SEPARATE ROOM & CALL FOR ASSISTANCE. REFER TO THE RELEVANT BROWN-COLOURED ACTION CARD, APPENDIX F on p.36 ONWARDS.

IF YOU SUSPECT SOMEONE HAS USED A CHEMICAL TO SELF-HARM, GO STRAIGHT TO SECTION 6.10 (p.15) OF THIS GUIDANCE.

IF SAFE TO DO SO, HISTORY TAKING WILL IDENTIFY IF A CASUALTY HAS BEEN INVOLVED IN:
1) AN EXPLOSION, FIRE, CLOUD OF SMOKE OR GAS;
2) BEEN COVERED IN DUST, POWDER, GEL OR LIQUID;
3) AN INDUSTRIAL/AGRICULTURAL SPILLAGE, ROAD TRAFFIC COLLISION OR SIMILAR INCIDENT.

Contents

1. SCOPE

1.1 The NHS Emergency Preparedness, Resilience and Response (EPRR) Framework and Core Standards for EPRR, require providers of NHS funded care to have suitable, in date, proportionate Business Continuity Plans in place, which detail how the Trust will maintain critical services during a disruptive event.

1.2 This plan is underpinned by the Trust's Business Continuity strategy and a delivery programme, articulating the scope and process that will be undertaken to embed Business Continuity into the culture of the Trust.

1.3 This guidance forms part of the Trust's routine contingency planning and seeks to address the requirement under the Care EPRR Standards to Mental Health and Community providers to have a plan for HAZMAT and Chemical, Biological, Radiological and Nuclear (CBRN).

1.4 The terms "major incident" and "emergency" will be used interchangeably throughout this document – relevant definitions are set out in APPENDIX C. Similarly NHS England's Emergency Preparedness, Resilience and Response (EPRR) is synonymous with the term "emergency planning". The terms "significant incident" and "emergency" are deliberately broad to ensure that potential incidents are not missed. A significant incident can be described as any event that cannot be managed within routine service arrangements. The term "patient" will refer to any individual (service user, client) accessing Trust services..

1.5 The Trust's staff work in or from a number of different types of buildings, therefore it is impossible to create a single template that meets all requirements.

1.6 This document is not intended to be exhaustive or restrictive and does not preclude the innovative use of strategies, plans which are lawful, human rights compliant and which have been adequately risk-assessed. This document seeks to establish a common framework that is flexible enough to be adapted to local circumstances and specific problems. No plan or guidance can cover every eventuality, so it is crucial that staff exercise their professional judgement in dealing with any such incident.

1.7 This plan is a Trust-wide document and it applies equally to all members of staff, either permanent or temporary and to those working within, or for, the trust under contracted services.

2 INTRODUCTION

2.1 Major incidents across the globe, particularly the Tokyo sarin attacks of 1994 and 1995 and the London bombings of 2005, have illustrated how large numbers of those affected by such events leave the scene without having been assessed by the emergency services and may subsequently self-present at primary or community healthcare facilities, perhaps some considerable distance from the incident scene.

2.2 As in any type of incident, safety is absolutely paramount: protecting staff, patients and other third parties, particularly from the potential risk of secondary contamination should be the overriding concern if a contaminated person(s) self-present(s) at a

Trust building. However, a rapid response is critical for effective life-saving following a chemical, biological, radiological, nuclear (CBRN) incident. Specific actions, which include the removal of casualties from the area of gross contamination and the removal of their outer clothing during the first fifteen minutes, can save life and can be achieved without putting responders at undue risk of exposure.

2.3 Whilst the Trust has access to specialist advice from blue-light colleagues and Public Health England (PHE), little practical guidance seems to be available for community staff. Exercises, studies and workshops across England and particularly in London since 2005 have indicated that staff have felt unprepared for dealing with incidents involving hazardous materials. Evidence suggests that frontline healthcare staff can suffer secondary contamination if they are not prepared for such incidents.

2.4 This guidance seeks to assist Trust staff in planning for self-presenters following an incident occurring elsewhere, and:

- provides broad guidance for service co-ordinators (or managers or senior member of staff on duty) at Trust facilities on preparing for and responding to such types of incidents;

- promotes appropriate use of action cards to act as an aide-memoire for those key staff performing their roles when suspected contaminated casualties begin to arrive at their facility.

3. AIMS AND OBJECTIVES

3.1 Aims

3.1.1 To protect the Trust and its stakeholders, including patients, staff, visitors, contractors and local communities, during a significant incident(s) or emergency, where practicable.

3.1.2 To assist Trust stakeholders to protect themselves and to minimise any disruption to their lives during a significant incident(s) or emergency.

3.2 Priorities

3.2.1 Priorities are essential to create a cohesive strategy and tactical plans with multi-agency partners. These will indicate how available resources will be deployed in the most effective and efficient manner.

3.2.2 The priorities in managing a HAZMAT incident at points in time are:

At 24 Hours	At 72 hours	At 30 days
Counter immediate threat to life & co-ordinate emergency response	Manage communications & infrastructure and care for patients/vulnerable groups/displaced families/local communities	Oversee restoration of infrastructure and continue care for patients/vulnerable groups/displaced families/local communities.

3.3 Strategic objectives (depending on incident)

a) Instigate command, control, communications and co-ordination in respect of the incident.

b) Protect the health, safety and welfare of patients, staff, visitors and contractors at Trust facilities or using its services.

c) Maintain effective communications with the Area Team and health/LRF partners.

d) Support the Area Team and health/LRF partners to preserve and protect life.

e) Mitigate and minimise the impact of an incident.

f) Warn and inform Trust stakeholders including the public.

g) Identify vulnerable patients and staff.

h) Evacuate patients and non-essential staff if applicable.

i) Minimise the consequential disruption (impact and duration) to Trust critical clinical and management functions.

j) Deliver humanitarian assistance and psychological first aid to victims of an emergency or a significant incident as directed by the Area Team.

k) Safeguard the environment.

l) Prevent unnecessary acute care admissions.

m) Promote early-supported discharge of appropriate patients to increase local capacity.

n) Assist an early return to normality (or as near to it as can be reasonably achieved).

o) Facilitate judicial, public, technical, or other inquiries.

p) Evaluate the response and recovery to the incident and identify issues and lessons.

4. DISTRIBUTION OF GUIDANCE

4.1 At least one hardcopy should be store securely at the major Incident equipment store.

5. DUTIES

5.1 In order to develop effective and robust arrangements, the Trust has a number of planning roles and responsibilities, including:

5.2 **Executive Director of Nursing**

5.2.1 The Executive Director of Nursing is accountable for ensuring Trust lockdown arrangements are in place and fit for purpose.

5.3 **Divisional Coordinators**

5.3.1 Divisional Coordinators are in place and accountable for:

a) Ensuring that Divisional lockdown plans are in place and fit for purpose.
b) Allocating lockdown planning tasks within their respective division.

5.4 **Estates Team**

5.4.1 The Estates Team are responsible for:

a) Lead on issues relating to the functionality Physical structure of Trust buildings including incorporating fixed safety systems (escape routes, alarms, and locking mechanisms both manual and remote.
b) Provide advice on the structure and internal systems that operate within any Trust building or building used by Trust staff.
c) Determine how best to implement the stages of lockdown within the buildings locking systems and hardware for the different stages of lockdown (partial, progressive, full) and how to achieve success for each of these stages.

5.5 **Communications Team**

5.5.1 The Communications Team are responsible for:

a) Developing signage to support lockdown plan implementation.
b) The Trust Communications Team will help to ensure that a controlled message is broadcasted to staff, patients and visitors within the Trust and to the outside world, informing them of the current situation.
c) Developing pre-prepared communication messages for media and external stakeholders.

5.6 **Head of Risk and EPRR**

5.6.1 The Head of Risk and EPRR is responsible for:

a) Ensuring that Major Incident and Business Continuity Plans and supporting arrangements are cognisant of Trust lock down procedures.
b) Providing advice and support, where appropriate.

5.7 **Security Advisor/Local Security Management Specialist**

5.7.1 The Security Advisor/Local Security Management Specialist is responsible for:

a) The development of these guidelines, following guidance from NHS Protect.
b) Providing guidance over the characteristics that will influence the ability of any building/site to effectively lockdown and the resources required to do so.
c) Support building/site managers/teams with the development of their lockdown processes and procedures.
d) The review and maintenance of this policy.

5.8 **Building/Site Manager(s)**

5.8.1 The Building/Site Managers will:

a) Work with their teams, estates representatives, and the LSMS to identify and document the critical assets within the site.
b) Determine if a lockdown (partial or otherwise) is achievable.
c) Develop a lockdown plan for their site/department, taking into consideration local circumstances and the NHS services provided.
d) Identify appropriate resources to undertake a lockdown.
e) Identify and disseminate a single point of contact and a backup, for notification of a requirement to activate lockdown plans.
f) In consultation with local Stakeholders, develop a lockdown plan.
g) Share details of the agreed lockdown plan with their teams to ensure that if, or when implemented, all staff are aware of their role and responsibility.
h) Maintain the lockdown plan with the local Incident Response Plan / Business Continuity Plans and forward a copy to both the Local Security Management Specialist (LSMS) and the Head of Risk and EPRR.
i) Support Building/Site lockdown assessments.
j) Maintain of the Lockdown Plan.
k) Identify refuge locations across site and label door with Refuge Area for Lockdown.
l) Ensure rooms are secure, keys are available in drawer or cabinet
m) Ensure Lockdown Plan contact list are available within Refuge Areas.
n) Train staff with specific responsibilities.

5.8.2 **Note:** Managers must keep in mind that if there is a change to the services provided at a site, the lockdown plan must be reviewed to ensure that it reflects the new situation.

5.9 **Trust Staff**

a) Attend/receive lockdown training.
b) Familiarise actions, lockdown plan and lockdown refuge areas across the site.
c) Undertake relevant activities to support lockdown procedures.

6. PROCESS

6.1 Planning assumptions

6.1.1 It may not be obvious that a patient, visitor or contractor has been in contact with a hazardous substance as some materials are odourless and tasteless.

6.1.2 If an incident did occur involving possible hazardous materials, then a proportion of self-presenters would be ‘worried well’, who are concerned about possible exposure, but not exhibiting any symptoms.

6.1.3 Casualties and the worried well may arrive at a Trust facility without warning.

6.1.4 Casualties’ symptoms may be non-specific e.g. itching skin, watering eyes, respiratory problems, dizziness or nausea.

6.1.5 It is probable that the emergency services may not fully commit appropriate assets to

the scene of the incident, so it may follow that Trust community facilities should plan for unsupported initial management of self-presenters, obtain expert advice, provide information to keep people calm, and wait for specialist assistance.

6.1.6 It is difficult to provide a full list of possible chemical, biological or radiological indicators due to the diverse nature of the materials.

6.1.7 Decontamination of the injured and emergency decontamination would be led and managed by North West Ambulance Service (NWAS), whereas mass decontamination would be managed by local Fire and Rescue Service (FRS).

6.1.8 The precise nature of the incident (chemical, biological, or radiological) may not be readily apparent.

6.1.9 It may be very difficult to determine during the response phase whether the release of a hazardous substance has been accidental or deliberate i.e. a HAZMAT as opposed to a Chemical, Biological, Radiological and Nuclear (CBRN) scenario. Irrespective of the cause the same degree of caution should be exercised, regardless of the potential cause.

6.1.10 For more information regarding protective equipment please refer to the Health, Safety & Welfare Policy (SA07) or the Infection Prevention and Control Policy (IC01) as appropriate.

6.2 Guiding Principles for the Management of a HAZMAT or CBRN Incident

6.2.1 These include:

a) recognising unusual circumstances and being aware of the risks;
b) remaining vigilant and reporting any individuals acting suspiciously;
c) saving of life is achieved through the following (if applicable, safe and appropriate):
d) rapid response, evacuation, disrobing, decontamination and providing advice/support to staff involved;
e) minimising exposure and the consequential risks to staff, patients and other third parties;
f) emergency services' intervention at the earliest opportunity;
g) balancing saving the lives of casualties and managing the safety of those whose role it is to save them;
h) managing the incident and limiting the spread of contamination;
i) continuing to provide care and information to patients and relatives/carers;
j) maintaining effective communications through the Trust's line management structures during normal business hours and out of hours through the Trust's on-call system;
k) maintaining continuity of the Trust's critical functions and recovering to normal levels of services as soon as reasonably practicable;
l) close and effective inter-agency working.

6.3 Personal Protective Equipment (PPE) Requirements

6.3.1 Staff may already have a range of PPE available to them in the workplace in line with

infection control policies. This guidance does not recommend the purchase of additional PPE as staff are not to put themselves or others at risk, but suggests retaining a small supply of basic items and making these accessible to frontline clinical and other staff in the facility. A small supply of basic PPE could be stored in a 'response box (Appendix E).

6.3.2 Depending on the actual healthcare setting, basic PPE in the workplace may include:

- aprons/gowns;
- nitrile gloves;
- goggles;
- mask (use highest specification available).

6.4 Initial Response to Potential HAZMAT/Chemical, Biological, Radiological and Nuclear (CBRN) Incidents

6.4.1 Do not compromise your own, your colleagues', or your patients' safety. Remember that the emergency services have staff trained and equipped to deal with incidents involving hazardous materials.

6.4.2 The following guidance was developed in London and is issued to the emergency services as a simple scene assessment tool for use by all staff. The origin of **STEP 123** lies with North Atlantic Treaty Organisation (NATO) procedures. It has been introduced to raise awareness of the possibility of a CBRN incident/attack and used primarily by those responders who are likely to be first on scene to an incident, but have not received specialised training in HAZMAT or CBRN incident management.

6.4.3 The response diagram on the reverse side of the **action cards** (APPENDIX F) uses a form of the **STEP 123** safety code

Safety **T**riggers for **E**mergency **P**ersonnel

STEP 1	**SINGLE casualty** (no discernible reason)	Manage using **normal** protocols
STEP 2	**TWO casualties** (no discernible reason)	Approach and manage with **caution**. Consider ALL possibilities. Remember staff safety (**do not become a victim**). Provide an assessment of situation.
STEP 3	**THREE + casualties** (no discernible reason)	Manage as an incident involving hazardous materials; risk assess before intervening. Isolate casualties and seek specialist help immediately. Remember staff safety (**do not become a victim**)

6.4.4 STEP 123 should not be used as a single indicator but in support of the overall assessment. Visual indicators of a CBRN event may include all or some of the following:

a) dead or distressed people, birds and animals
b) multiple individuals showing unexplained signs of skin, eye or airway irritation; nausea; vomiting; twitching; sweating; pin-point pupils; runny nose; disorientation; breathing difficulties; and convulsions;
c) the presence of hazardous materials or unusual materials/equipment;

d) unexplained vapour or mist clouds;
e) unexplained oily droplets or films on surfaces or water;
f) withered plant life and vegetation.

6.4.5 Note: Symptoms of exposure to a biological or radiological attack may not be present within the first minutes and hours of an attack occurring. Chemical releases are often, but not always accompanied by a more rapid onset of symptoms

6.4.6 Staff MUST not:

a) become victims themselves;
b) place their colleagues in greater danger by needing to be rescued/decontaminated themselves;
c) attempt the rescue of others – even of contaminated colleagues;
d) attempt to resuscitate using mouth-to-mouth, mouth-to-mask, or mouth-to-nose techniques due to the possible presence of toxins such as cyanide, hydrogen sulphide, corrosive agents or organophosphates.

6.4.7 Staff contacting the emergency operator (999) should provide the following information:

a) casualty numbers (walking and non-walking);
b) severity and type of signs and symptoms;
c) weather conditions – in particular wind direction;
d) hazards present or suspected;
e) the location of the incident – is it likely to be terrorism or a hazardous material incidents;
f) environment – building, open space, underground;
g) presence of perpetrators.

6.4.8 Staff with a pre-existing skin condition or wounds involving breaches of the skin should avoid contact with self-presenters.

6.5 Protecting Yourself, Colleagues and Patients

6.5.1 The key priority is to minimise the contact that potentially contaminated casualties have with others and areas of the Trust facility.

6.5.2 **Immediate actions:** do not touch the (suspected) contaminated casualty. Isolate them in a room (preferably with no soft furnishings, no air-conditioning – switch off fans, computers, photocopiers, printers, heaters, vacuum cleaners); no doors to adjoining rooms; no ventilation ducting to other areas. Remove non-essential equipment if possible and cover other equipment with plastic sheeting once isolated from mains electricity if possible.

6.5.3 Depending on circumstances, other actions may include:

a) reporting what you see to the police from a safe distance (or behind a closed window or glazed viewing panel in a locked door);
b) if safe to do so, cordon-off part(s) of the building the suspected contaminated casualties may have walked through and areas in which they may have touched objects e.g. furniture (barrier tape in response box). If necessary, lock doors (inform relevant staff in case of fire evacuation which

doors are locked and location of key(s)) and put up signage to re-direct staff and patients;

c) **KEEP COMMUNICATING WITH THE CASUALTIES.**
d) actively re-direct patients away from the affected areas;
e) reassure those staff, patients and other third parties who may be contaminated and ask them to stay on site until specialist help arrives or more information is received about the contaminant;
f) from a safe vantage point, encourage conscious casualties (use loud hailer if available and safe to do so) or written messages on paper and display through a closed window or a sealed viewing panel of a locked door:
    - if outside, to face the wind direction;
    - to remove potentially contaminated clothing and self-decontaminate if practicable.
    - to control any haemorrhaging by applying direct pressure.

6.6 Lockdown

6.6.1 The aim of a 'lockdown' is to control the movement and access - both entry and exit - of people (staff, patients and visitors) around a Trust site or other specific building/area in response to an identified risk, threat or hazard that might impact upon the security of patients, staff, assets or, indeed, the capacity of that facility to continue to operate. It also prevents any contamination that has entered your building from spreading further.

6.6.2 In locking down there are three key elements: preventing the entry, exit and movement of people on a Trust site, or in a building, or part of a building. In preventing the entry, exit or movement of people, or a mixture of the three, the overarching aim of implementing a lockdown is to either exclude or contain staff, patients and visitors.

6.6.3 Reception areas may be rendered unusable due to potentially contaminated casualties seeking medical assistance and may, therefore, need to be isolated from other areas of the building.

6.6.4 Please refer to the Trust's Lockdown Policy for further details and/or consult your Local Security Management Specialist for advice and support.

6.6.5 Managers should undertake their own survey of their own buildings and produce a simple diagram to identify:

a) points of entry and exit;
b) lockable doors;
c) access to keys;
d) staff only areas;
e) usual patient flow;
f) possible amended patient flows following lockdown or isolating the reception area.

6.7 Chemical, Biological or Radiological Materials in the Post

6.7.1 Devices containing finely ground powder or liquid may be hazardous without being opened. Some of the more common and obvious materials are:

a) unexpected granular, crystalline or finely powdered material (of any colour and usually with the consistency of coffee, sugar or baking powder), loose or in a container;
b) unexpected sticky substances, sprays or vapours;
c) unexpected pieces of metal or plastic, such as discs, rods, small sheets or spheres;
d) strange smells, e.g. garlic, fish, fruit, mothballs, pepper;
e) stains or dampness on the envelope or packaging.

6.8 Chemical, Biological or Radiological Incident at a Trust Facility

6.8.1 Responses to CBRN incidents will vary more than those involving conventional or incendiary devices, but the following general points should be noted:

a) the exact nature of an incident may not be immediately apparent. For example, an improvised explosive device (IED) might also involve the release of CBR material;
b) in the event of a suspected CBR incident within a building, switch off all air conditioning, ventilation and other systems or items that circulate air (e.g. fans, computers, printers, photocopiers, vacuum cleaners and heaters).
c) do not allow anyone, whether exposed or not, to leave the building or patient holding area(s) before the emergency services have provided assessment, medical advice or intervention;
d) if an incident occurs outside an enclosed temporary structure or building, close all doors and windows and switch off any systems that draw air into the structure/building.

6.9 Management of Chemical Fatality and Self-Harm Incidents (Detergent Suicides in Vehicles/Buildings)

6.9.1 REMEMBER STEP 123 - EVACUATE YOURSELF AND NON-CONTAMINATED OTHERS TO A SAFE VANTAGE POINT, UPWIND OF SCENE AND CALL THE EMERGENCY SERVICES. IF CASUALTY IS CONSCIOUS IN A VEHICLE, SHOUT FOR THEM TO OPEN THE DOOR, RELEASE THEMSELVES AND MOVE UPWIND OF THE VEHICLE, BUT NOT TO APPROACH YOUR POSITION. REASSURE THEM THAT MEDICAL ASSISTANCE IS ON THE WAY. TELL THEM WHAT YOU WANT THEM TO DO AND WHY. ADVISE THEM NOT TO EAT, DRINK, SMOKE OR TOUCH THEIR EYES/FACE. REMOVE OUTER CLOTHING – BUT DO NOT PULL GARMEMTS OVER HEAD UNLESS ABSOLUTELY NECESSARY.

6.9.2 Do not attempt mouth-to-mouth, mouth-to-mask, mouth-to-nose resuscitation.

6.9.3 Warning signs (vehicle/building) may include:

a) Casualty may appear unconscious and unresponsive.
b) Tape over windows and vents.
c) Suicide note/warning affixed to window or front of door/building.

d) Others in the building complaining of breathing difficulties.
e) Cool box or bucket(s) are visible.
f) Empty containers/bottles of chemicals in or around vehicle/building.
g) Odour of rotten eggs.

6.9.4 This is where there is a strong suspicion of deliberate exposure by an individual to a chemical substance to cause death (or severe poisoning) and the risk of potential exposure of others to the original chemical or to reaction products. Chemical or detergent suicides have taken place in confined spaces e.g. vehicles and small bathrooms, where the subject may mix chemicals in a bucket to produce toxic gas (es).

6.9.5 Ingestion involves taking a substance to react with stomach acid or moisture e.g. mucous membrane to produce toxic gas, whereas inhalation involves producing a toxic gas by mixing sulphide containing substances with an acidic product. PHE will advise on the health effects from the exposure to any chemicals, decontamination and use of PPE by staff.

6.9.6 Sulphides, phosphides and cyanides have been found at the scene of chemical self-harm incidents, which can decompose on contact with acid (in vomitus or some cleaning products) to produce toxic gases. Hydrogen sulphide, phosphine and hydrogen cyanide are flammable gases and present a risk of explosion if in a high concentration in a poorly ventilated area.

6.10 First Aid or Resuscitation of Contaminated Casualties

6.10.1 A dynamic risk assessment is required before commencing resuscitation on anyone, particularly if suspected of being exposed to an unconfirmed hazardous substance. There is a potential risk from chemical residues on clothing, on the face, around the mouth and in vomitus and other bodily fluids. Additionally inhalation of any toxic gas on the casualty's exhaled breath (from the reaction with stomach acid) may also present a risk. Consequently, mouth-to-mouth, mouth-to-mask, mouth-to-nose ventilation should be avoided. If safe, trained staff with appropriate personal protective equipment may attempt to ventilate the casualty using a bag-value-mask (or bag-valve-laryngeal mask) assembly and the highest possible concentration of oxygen. Care MUST be taken if there is a high index of suspicion towards paraquat poisoning (rare defoliant weed killer) as pulmonary injury may be exacerbated by high concentrations of oxygen.

6.11 Contaminated Dead

6.11.1 Evacuate the area around a deceased casualty immediately. The dead should be left where they lie, so that forensic examination of the scene may take place.

6.12 Decontamination if Ambulant, Contaminated Casualties

6.12.1 The following is **only** general advice. Follow any instructions given by the emergency services or PHE. Improvised decontamination should be performed on all disrobed casualties, unless medical advice is received to the contrary – it should **not** involve overly aggressive methods to remove contamination as this could drive the

contamination further into the skin. Before specialist resources arrive on scene, responders should consider:

6.12.2 **IMMEDIATE ACTION:** Do not touch the (suspected) contaminated casualty. Isolate them in a room (preferably with no soft furnishings, no air-conditioning – switch off fans, computers, photocopiers, printers, heaters, vacuum cleaners); no doors to adjoining rooms; no ventilation ducting to other areas. If time, remove non-essential equipment if possible and cover other equipment with plastic sheeting once isolated from mains electricity. Reassure them that medical assistance is on the way. Advise them not to eat, drink, smoke or touch their face.

6.12.3 Evacuate any area where any unusual dust, powder, gel, solid, liquid or vomitus (potential to off-gas toxic vapours) is found.

6.12.4 Wear appropriate PPE and issue instructions from a safe distance (or from behind the viewing panel of a locked door or closed window).

6.12.5 Decontamination should begin as soon as reasonably possible.

6.13 **Dry Decontamination (considered the best option)**:

a) Exposed skin should be blotted and rubbed with any available dry, absorbent material such as paper tissue, towels, dressings, strips of bedding etc. All materials used in this process (e.g. paper tissue) should be considered as contaminated and should, where possible, not used on other casualties.
b) Explain to the casualty why decontamination is necessary. Reassure them – the whole situation will be probably distressing and frightening. All attempts should be made to reduce anxiety.
c) (In an isolated room to avoid secondary contamination and for privacy and dignity). Provide a pair of trauma scissors and request the casualty to cut along seams of garments and not to pull clothing off over their heads.
d) All outer clothing should be removed and double-bagged (preferably in clear plastic bags) and sealed with cable ties. The casualty should wipe their face (including around and inside ears) first and then their hands and then blow their nose into a tissue – the casualty should seal all discarded items in clear plastic bags.
e) Any valuables e.g. watch, mobile phones should be double-bagged (preferably in clear plastic bags) and marked with the casualty's name. Depending on the nature of contamination, it might be possible to decontaminate some personal possessions at a later stage.

6.14 **Wet Decontamination**

6.14.1 'RINSE-WIPE-RINSE' method - Only if applicable if acids or alkalis are suspected (i.e. redness, itching and burning of eyes or skin)

a) If there is any suspicion that aluminium phosphide or cyanide salts are present, do not use water .i.e. wet decontamination
b) Equipment: (1) A bucket or other container (5-10 litre capacity) or a shower head with clean, preferably warm, running water; (2) 2nd bucket (5-10 litre

capacity) for use with a water (preferably warm) and detergent mix; (3) detergent; (4) a sponge or other appropriate washing aid.

c) If on scene emergency services personnel should supervise and assist as required**.**
d) If available, make up a solution of detergent (i.e. liquid soap) and warm water (5ml soap/litre of water = 3 - 4 squirts of liquid soap to a 5 -10 litre bucket of water). **Use** warm or tepid water (hot water may increase absorption of contaminant; cold water increases risk of hypothermia).
e) Having removed the contaminated person's clothes, RINSE the affected areas with clean water (no detergent) using showerheads or buckets. RINSE from the highest point downward, ensuring that any sponge or brush used does not come into contact with the casualty or their clothing.
f) The RINSE should be applied to contaminated areas of skin only, to avoid spread to uncontaminated areas.
g) Using the other bucket with water/detergent mix, ask the casualty to WIPE the affected areas of skin with a wet sponge or appropriate washing aid – contaminants will be diluted or collect in the bucket, particularly if any water-soluble chemicals are present. Any water used may be contaminated and therefore a potential source of further contamination spread.
h) RINSE the decontaminated casualty with clean warm water (no detergent) to remove the detergent and any residual chemicals.
i) Try and limit the duration of decontamination to between 45 and 90 seconds and, ideally, to use a washing aid such as a cloth or sponge.
j) Dry the skin with a clean towel.
k) Glasses/spectacles needed for vision can usually be washed, wiped, rinsed, dried and returned to, or kept with, the casualty.
l) Repeat the RINSE-WIPE-RINSE procedure only if skin contamination remains obvious.
m) (Persistent chemical warfare agents are poorly soluble in water and might require extended or repeated application.)
n) Provide clean gown/blankets for the casualty after washing.
o) Once washed, ensure that the casualty remains in the designated 'clean' area to avoid re-contamination.
p) Following improvised decontamination, remain cautious and observe for signs and symptoms in decontaminated casualties and in unprotected staff.
q) Provide reassurance to the casualty (tell them that specialist help is coming) and any relevant information.
r) Clinical need will determine whether the casualty requires transfer to acute care.
s) Be aware that West Ambulance Service (NWAS), may be under severe pressure during a large-scale incident.
t) Once decontaminated asked the casualty to stay in the designated clear area until further instruction or advice is available about the contaminant.
u) If approved by the police, allow access to a telephone in a 'clean' area (not any mobile phones possibly contaminated during the incident) for the purpose of contacting friends and relatives and making arrangements for dependents.
v) make sure all staff self-decontaminate (or decontaminated by specialists) before leaving the area.

6.15 **Decontamination of Non-Ambulant Contaminated Casualties**

6.15.1 Seek specialist advice from North West Ambulance Services (NWAS) and Merseyside/Lancashire Fire and Rescue.

6.16 Multi-Agency Response to Hazmat/CBRN Incident

6.16.1 Whenever an incident occurs involving contamination or possible contamination of people, (animals), air, water, food, identification of the noxious substance is a priority. Several partner agencies might be involved in identifying the material(s) and assessing the health implications for the local population and the environment once the substance and sources of the release are known. PHE will assess the public health consequences and provide specialist advice to the affected sites as well as advising and communicating with the affected local authority and the local NHS. Partners' roles and responsibilities are detailed in the Local Resilience Forum CBRN Emergency Plans.

6.16.2 If the incident has potential implications for wider communities, advice will be provided by PHE on the contaminant (if known) and the risks and immediate actions to be taken in the event of self-presenters. This advice will be circulated as quickly as possible to primary and community care services. Such information will be disseminated beyond the immediate vicinity of the incident scene in case contaminated persons may have travelled some distance before deciding to seek medical assistance

6.17 Dealing with Cases of Unusual Illness

a) Isolate the (suspected) casualties or those suspected of being infected in a room (preferably with no soft furnishings, no air-conditioning – switch off fans, computers, photocopiers, printers, heaters, no doors to adjoining rooms, no ventilation ducting to other areas).
b) Wear appropriate PPE and issue instructions from a safe distance (or from behind the viewing panel of a locked door or closed window). Remove non-essential equipment if possible and cover other equipment with plastic sheeting once isolated from mains electricity if possible.
c) Escalate immediately to line manager and Infection Prevention
d) Maintain a high level of awareness and vigilance.
e) Follow any instructions provided by the Trust Infection Prevention Team/NWAS/PHE.

6.18 Recovery – Patients

a) Maintain detailed, contemporaneous records of all patients or third parties on the affected Trust premises during the incident, including name, date of birth, home address, contact telephone number, their GP, any symptoms exhibited and any action taken/intervention provided – (APPENDIX D).
b) Keep contact with the emergency services and PHE for updates and further advice.
c) Continue sensitive and timely communication with casualties and your patients to ensure their continued co-operation.
d) Provide reassurance - explain the current situation.

e) Record (in logbook) options considered and actions for different patient categories (contaminated casualties, worried well, urgent regular cases, and regular non-urgent cases).
f) If applicable, consider introducing clinical triage in the reception area if safe and practicable.
g) Use signposting (pre-printed signage in response box) in the reception area.
h) Consider the welfare of your patients.
i) Provide clean gowns (clothing) and blankets.
j) If advisable by PHE provide drinks and refreshments in a 'clean' area.
k) Ensure regular access to toilets in a 'clean' area.
l) Ensure access to regular medication that has been prescribed.
m) If approved by the police, allow access to a telephone in a 'clean' area (not any mobile phones possibly contaminated during the incident) for the purpose of contacting friends and relatives and making arrangements for dependents.
n) Create a temporary answerphone message for the duration of the response/recovery phases, or request for calls to be diverted to phones manned by appropriate staff.

6.19 **Recovery – Staff**

a) Provide clean clothing and blankets.
b) Ensure they have access to any medication that may be on.
c) Maintain business continuity of critical trust functions.
d) If approved by the police, allow access to telephones in a 'clean' area (not any mobile phones possibly contaminated during the incident) for the purpose of contacting friends and relatives and making arrangements for dependents.
e) If deemed advisable by PHE provide refreshments in a 'clean' area and regular breaks where possible.
f) Review workforce plans, including the availability of staff/critical equipment and staff rotas for the next few working days.
g) Liaise with clinical adjacencies or other Trust teams for support.
h) Consider staff welfare.
i) Consider the potential need for ongoing psychosocial support for staff and contractors involved in the incident.
j) Prioritise your essential services and urgent patients until normal levels of service resume.
k) Consider when normal levels of service can resume and how long contaminated staff might be off work.
l) Take part in any Trust hot debrief. Review the local response arrangements and business continuity plan(s) and update as appropriate.

6.20 **Recovery – Trust Buildings**

a) The scene will remain out of bounds until declared safe by Merseyside/Lancashire fire and rescue service.
b) Take advice from PHE on identifying areas in the building that require specialist decontamination and/or deep cleaning.
c) The contaminated area should not be re-opened until advice has been taken from PHE and/or the Government Decontamination Service (GDS), or another designated provider of specialised decontamination information.

d) If there is any suspicion that aluminium phosphide or cyanide salts are present, do not use water.
e) Specialist contractors will double-bag (preferably in clear plastic bags) contaminated clothing, items, cleaning products or used PPE and store in the 'dirty' part of the isolation area.
f) Any vomitus found on site should be cordoned-off and removed by specialist contractors as this has the potential to off-gas toxic vapour.
g) Significant contamination incidents will initially be treated as crime scenes for the preservation of evidence relevant to subsequent investigations. Therefore no contaminated materials, property or documentation should be removed or discarded without authorisation from the police.
h) All soft furnishings (furniture, toys, curtains, bedding) and any carpets will probably need to be removed as hazardous waste.
i) Take advice about potential contamination of the water supply from the Environment Agency/PHE/United Utilities (UU); all of these agencies should be consulted about potentially contaminated run-off, particularly UU on obtaining and using dye markers.

6.21 **Freedom of Information Act 2000 (FOIA) and Environment Information Regulations 2004 (EIR) Requests**

6.21.1 Release of incident documentation, including logs and related reports in full may not be in the public interest on account of the following reasons (but not limited to):
a) may contain individual patient details;
b) may contain personal information on individual staff;
c) may indicate uncertainty in respect of casualty figures during the acute phase of the incident;
d) may contain detailed planning of incident management (key staff, communications, locations of incident co-ordination centres);
e) may contain information provided by partner agencies which requires proper consent before release;
f) May contain sensitive information which, if released, may pose a security risk to the Trust and/or partner agencies.

6.21.2 All requests received under the FOIA 2000 (or EIR 2004) should be forwarded immediately to the Mersey Care NHS Foundation Trust Information Governance Team.

6.22 **Human Rights**

6.22.1 The Trust MUST uphold the Human Rights Act 1998, which requires consideration of a range of factors including the dignity of individuals receiving treatment; end-of-life considerations; prioritisation of treatments and transparency in relation to decision-making as well as individual preferences.

6.22.2 During a significant incident or emergency preservation of life has primacy, which is the core of Article 2 of the Human Rights Act 1998: 'everyone's right to life shall be protected by law'.

6.22.3 If for any reason, an emergency necessitates restricting any Human Right, such as

freedom of movement or freedom of assembly, this should be proportionate and only for the minimum duration possible. The reason for such a decision being taken should be communicated to the people affected by it and recorded accurately.

7. CONSULTATION

7.1 The following Trust representatives have been consulted in the development of this policy:

(a) Executive Director of Nursing.

(b) Head of Risk and EPRR.

(c) Chair of the Trust Business Continuity Task and Finish Group.

(d) EPRR working group.

(e) Trust Policy Group.

8. TRAINING AND EXERCISING

8.1 All Trust staff require a level of understanding of the implications of incidents involving hazardous materials and how it might impact on their individual role and how to respond accordingly.

8.2 Staff familiarity with this guidance and their likely roles and responsibilities will help to promote efficiency and effectiveness of the above procedures. The involvement of other health and LRF partners in testing and exercising these arrangements will improve understanding of each other's response plans and ensure that any links and assumptions are identified and validated.

8.3 Staff need to acquire information, understanding and knowledge to care appropriately for themselves, colleagues, patients and other third parties during such types of incident. Awareness training including but not limited to: instructional DVDs, in-house team or group training sessions, CBRN training modules (via the PHE e-learning portal – access is free to PHE and NHS staff).

8.4 Service Coordinators and those on an on-call rota are required to undertake training appropriate to their role, as part of their annual on call training sessions. Staff on coordination will receive basic awareness raising as part of the Emergency planning Session.

8.5 Further advice and assistance with staff training can be sought from the Emergency Planning Lead.

9. MAINTENCANCE AND REVIEW OF GUIDANCE

9.1 This guidance will be reviewed at least annually, unless subject to legislative, organisational or other significant change. Whilst this guidance makes every effort to

use terminology consistent across all the first-responder agencies, there remains a possibility that the terminology used will differ from that used in multi-agency guidance and doctrine published subsequently. Any such differences will be examined during reviews of the guidance and the principles contained within this guidance will remain extant until a revision is issued.

10. MONITORING COMPLIANCE WITH THIS DOCUMENT

10.1 Characteristics of the HAZMAT plan shall be monitored and analysed where appropriate.

10.2 Monitored information includes:

(a) Number of incidents that have invoked a formal response.

(b) Number of exercises completed (to help ascertain the comprehensiveness).

(c) The Head of EPRR, when required, will provide an update to the EPRR meeting as part of the business continuity plans and exercises and will report to the Executive Director of Nursing.

(d) The Executive director of Nursing will provide an annual update as part of the business continuity plans and exercises and will report this to the Executive Committee and Trust Board to provide assurance that effective arrangements are in place.

10.3 The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

	Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are completed**
Service Coordinator	Awareness of procedure	Formal document review	Emergency Planning Lead	At least annually	Policy and Procedure Committee	Emergency Planning Lead

11 DEFINITIONS & ABBREVIATIONS

A&E	Accident & Emergency
ALARP	As low as reasonably possible
BC	Business Continuity
BCM	Business Continuity Management
BCMG	Business Continuity Management Group
BCMS	Business Continuity Management System
BCP	Business Continuity Plan
BIA	Business Impact Analysis
BS	British Standard
CBRN(E)	Chemical, Biological, Radiological, Nuclear (and Explosives)
CCA	Civil Contingencies Act 2004
CCG	Clinical Commissioning Group
LFRS	Lancashire Fire and Rescue Service
CHOC	Lancashire Health On Call (Out of hours provider)
CRR	Community Risk Register
EIR	Environmental Information Regulations (2004)
EPRR	Emergency Preparedness, Resilience and Response
FOIA	Freedom of Information Act 2000
GP	General Practitioner
GSB	Gold, Silver, Bronze (3-tier command system)
H&S	Health and Safety
HART	(NWAS) Hazardous Area Response Team
HAZMAT	(Incidents involving) Hazardous Materials
IED	Improvised explosive device
IEM	Integrated Emergency Management
IP	1. Internet Protocol (phones); 2. Infection Prevention
IRP	Incident Response Plan
ISO	International Standards Organisation
IT	Information Technology
LA	Local authority
LRF	Local Resilience Forum
LSMS	Local Security Management Specialist
MTFA	Marauding terrorist firearms attack(s)
NOS	National Occupational Standards (Skills for Justice)
NRR	National Risk Register

NWAS	North West Ambulance Service
OOH	Out of hours
PAS	Publicly Available Specification (British Standard Institute)
PEP	Post exposure prophylaxis
PHE	Public Health England
PPE	Personal Protective Equipment
RVP	Rendezvous Point
SCG	Strategic Co-ordination Group
SORT	(NWAS) Special Operations Response Team
STAC	Scientific and Technical Advisory Cell
STEP 123	**S**afety **T**riggers for **E**mergency **P**ersonnel
TCG	Tactical Co-ordinating Group

11 Equality and Human Rights Analysis

Title: HAZMAT Plan
Area covered: TRUST-WIDE NON CLINICAL POLICY DOCUMENT

What are the intended outcomes of this work? To ensure that Mersey Care NHS Trust has in place, an effective Business Continuity Management System, to ensure that critical services are maintained during disruptions and recovery is achieved as quickly as possible. 2.2 Objectives - The objectives of the Trust's policy are to: 5 Define the scope and limitations. 6 Confirm roles and responsibilities. 7 Outline the process required to develop an effective Business Continuity Management System. **This has also been reviewed in the Business continuity Policy.**
Who will be affected? 1.1 **The NHS Emergency Preparedness, Resilience and Response (EPRR) Framework 2016 and Core Standards 2016 for EPRR, require providers of NHS funded care to have suitable, in date, proportionate Business Continuity Plans in place, which detail how the Trust will maintain critical services during a disruptive event.**

Evidence
What evidence have you considered? The policy.
Disability inc. learning disability No issues identified within discussions.
Sex No issues identified within discussions.
Race No issues identified within discussions.
Age No issues identified within discussions.
Gender reassignment (including transgender) No issues identified within discussions.

Sexual orientation No issues identified within discussions.
Religion or belief No issues identified within discussions.
Pregnancy and maternity No issues identified within discussions.
Carers No issues identified within discussions.
Other identified groups No issues identified within discussions.
Cross cutting No issues identified within discussions.

Human Rights	**Is there an impact?** **How this right could be protected?**
This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	**No issues identified within discussions.**
Right of freedom from inhuman and degrading treatment (Article 3)	**No issues identified within discussions.**
Right to liberty (Article 5)	**No issues identified within discussions.**
Right to a fair trial (Article 6)	**No issues identified within discussions.**
Right to private and family life (Article 8)	**No issues identified within discussions.**
Right of freedom of religion or belief (Article 9)	**No issues identified within discussions.**

Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	**No issues identified within discussions.**
Right freedom from discrimination (Article 14)	**No issues identified within discussions.**

Engagement and involvement N/A
Summary of Analysis
Eliminate discrimination, harassment and victimisation **This is a non clinical policy document.** **No equality or Human Rights issues have been identified.** **This is concerned with business issues and contingency plans.**
Advance equality of opportunity **No issues identified within discussions.**
Promote good relations between groups **No issues identified within discussions.**
What is the overall impact? **No impact on equalities detected within discussions.**
Addressing the impact on equalities **No impact on equality groups.**
Action planning for improvement **Not required.**

For the record **Name of persons who carried out this assessment (Min of 3):** **George Sullivan** **Jayne Bridge**
Date assessment completed: **12/09/2016**
Name of responsible Director: Executive Director Of Nursing
Date assessment was signed: September 2016

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation			
Data collection and evidencing			
Analysis of evidence and assessment			
Monitoring, evaluating and reviewing			

APPENDIX A

KEY PREPARATIONS FOR TRUST STAFF AND BUILDINGS

PREPARING THE BUILDING	
Actions	**Responsibility**
Identify how you would lockdown areas to protect staff, patients and third parties.	EPRR Leads
Produce a local lockdown procedure, starting with reception and train staff in its use.	
Identify an 'isolation room' where you can isolate people who self-present having been potentially exposed to a hazardous substance(s) or presenting with an unusual illness.	
Identify a clean area for decontaminated persons.	
Produce signage for the front of the building, entrance area, reception area and isolation area to direct staff, patients and third parties away from a potentially contaminated area(s).	
CONSIDERING MANAGEMENT & LOGISTICS	
Actions	**Responsibility**
Agree local management arrangements with senior clinical staff – who will take charge during an incident?	EPRR Leads
Check the action cards (APPENDIX F) are appropriate for the service and/or building	
Prepare a response box per Trust building/shared accommodation. Suggested contents at APPENDIX E to be held SECURELY near the reception area, containing a minimum of:	
A **Map** – simple drawing of the building layout indicating: (1) The isolation area, (2) 'clean' area; (3) where doors are to be locked and nearest fire exits and toilets during lockdown; (4) points for pre-prepared signage.	
B **Laminated signage** (APPENDICES B) - indicate on the reverse side where the sign should be placed.	
C **Action cards** – clearly identify who will do what, where and when.	
D **Pre-printed patient/third-party contact forms** (APPENDIX D).	
E **Personal protective equipment** - nitrile gloves, aprons, mask (highest specification possible), paper towels and tissues.	

F **Relevant contact number on a laminated sheet** – consider who you need to inform (line manager, team etc.) and who can provide advice and guidance.	
Consider staff welfare arrangements – see 6.18 RECOVERY – STAFF above.	

PREPARING STAFF	
Actions	**Responsibility**
Train all service coordinators in the use of the STEP 123 safety code covered in this guidance	EPRR Leads
Ensure all staff in particular frontline staff know how to: - assess related risks; - lockdown the building with minimum staffing (who performs what role); - obtain expert advice through the Trust; - keep patients and third parties informed.	
Ensure all staff know where to find the response box and what it contains.	
Ensure all staff are aware of the isolation procedures and protocols for assessing and managing (potentially) contaminated staff, patients and others.	
Train administration staff in how to support frontline staff.	
Rehearse infection control procedures with frontline staff - to minimise the risk of cross-contamination.	
Maintain and exercise your business continuity plan regularly.	
Ensure all staff know where to find (hardcopy and electronic version) of the service/department business continuity plan and how to use it if activated.	
Rehearse the scenarios involving lockdown and managing self-presenters from an incident involving hazardous materials regularly as part of business continuity exercises.	
Review PPE regularly and check the condition and expiry dates of items in the response box.	
Update action cards if any significant changes occur.	
Conduct an internal communications cascade test at least every six months i.e. relay a test message to everyone on the laminated card with contact details.	
Contact the Emergency Planning Lead with queries or about conducting exercises	

APPENDIX B

SIGNAGE TEMPLATE (FOR ENTRY POINTS - PLEASE LAMINATE)

FACILITY……

IS CLOSED

If you have been involved in an incident, or are worried that you might have been, please wait outside for assistance.

If you have not been involved in an incident, please go to another facility. The nearest alternative facility is:

……

……

APPENDIX C

DEFINITIONS

For the purposes of this document, the following terms and definitions apply. Further information on definitions and abbreviations used in the Trust's emergency planning (EPRR) (and business continuity management (BCM)) can be found in the *UK Civil Protection Lexicon* [5] and Joint Emergency Services' Interoperability Programme (JESIP) glossary.[6]

Activity
A process or set of processes undertaken by the Trust (or on its behalf) that produces or supports one or more products.

Assessment
Examination to determine whether activities and related results conform to planned arrangements and whether these arrangements are implemented effectively and are suitable for achieving the Trust's stated objectives.

Assets
Anything that has value to the Trust.

'Big Bang'
A serious transport accident, explosion, or series of smaller incidents.

Biological
Illnesses caused by the deliberate release of dangerous bacteria, viruses or fungi, or biological toxins such as the plant toxin ricin.

Bronze (operational)
A tier of command at which operational delivery of tasks is undertaken. **Bronze is below Silver.**

Business continuity
The strategic and tactical capability of the Trust to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable predefined level.

Capability - *a demonstrable ability to respond to and recover from a particular threat or hazard.*

Casualty
Someone who has sustained a physical or mental injury, or who has been killed.

Chemical
Poisoning or injury caused by chemical substances, including ex-military chemical warfare agents or legitimate but harmful household or industrial chemicals.

Clean area/zone
Area for those who have been decontaminated.

'Cloud on the Horizon'
A serious threat such as a major chemical or nuclear release developing elsewhere and needing preparatory action.

Cold zone
For patient assessment and onward transfer to acute care as appropriate – an outer cordon separates the warm and cold zones.

Command
The exercise of vested authority that is associated with a role (or rank) within an organisation, to give direction in order to achieve defined objectives.

[5] *UK Civil Protection Lexicon Version 2.0.1*. (Cabinet Office 2011). https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon
[6] http://www.jesip.org.uk (Accessed 1 April 2014)

Contaminant
A substance in an incident, or present in an environment where it does not belong, or is present at levels that might cause harm to humans and/or the environment.

Contamination
The presence of a minor and unwanted constituent (contaminant) in material, physical body, natural environment, at the workplace.

Control measure
This is any measure or method taken to reduce risk (e.g. remove the hazard).

Decontamination
The process of cleansing the human body and other surfaces to remove contamination, or the possibility of (or fear of) contamination by hazardous materials including chemicals, radioactive substances and infectious materials. Types of decontamination include:

- **DRY decontamination – should be considered the default process** - primarily for chemical incidents - is the use of dry absorbent material such as paper tissue or cloths to blot and rub the exposed skin.
- **WET decontamination – only to be used if signs and symptoms of caustic substance** - is the use of water from any available source such as taps, showers, hose-reels, sprinklers, etc.
- **clinical decontamination** – carried out by the statutory ambulance service, North West Ambulance Service (NWAS), to decontaminate both ambulatory and non-ambulatory casualties.
- **emergency decontamination** – carried out with assistance from Fire and Rescue Service, which may involve low-pressure water spray from fire hoses, portable showers and use of large, purpose-built units away from the scene and any watercourses.
- **mass decontamination** – conducted by the fire and rescue service on behalf of NHS which may involve low-pressure water spray from fire hoses, portable showers and use of large, purpose-built units away from the scene and any watercourses.

Dirty area/zone
Area in which casualties await decontamination. Contaminated casualties should not cross from the dirty zone into the clean zone.

Disrobe To undress the casualty as is a critical step in the decontamination process and is highly effective at reducing exposure to Chemical, Biological, Radiological and Nuclear (CBRN) materials.

Emergency Co-ordination of Scientific Advice
A mechanism for all emergency services to receive fast and coordinated scientific advice on a CBRN incident.

Emergency
An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or the security of the UK or of a place in the UK.

Emergency Preparedness, Resilience and Response (EPRR) The extent to which emergency planning enables the effective and efficient prevention, reduction, control and mitigation of, and response to emergencies.

Exposure
Where someone has come into contact with a contaminant or hazardous material.

First receiver
Those staff most likely to be the first person(s) that people meet when entering a Trust facility and consequently most likely to be at risk from cross-contamination e.g. receptionist.

First responder
Any member of staff or the emergency services who are likely to be the first operational resource at a CBRN incident. The person is unlikely to be trained in specialist CBRN response or have specific CBRN PPE.

Frontline staff
Those staff working at a Trust facility and have direct patient contact.

Government Decontamination Service
DEFRA agency responsible for providing advice and guidance to responsible authorities on preparing for and recovering from chemical, biological, radiological, nuclear and explosives (CBRN) or hazardous materials (HAZMAT) related decontamination issues.

Hazard
A situation that poses a level of threat to life, health, property, or environment.

Hazardous materials (HAZMAT)
Solids, liquids, or gases that can harm people, other living organisms, property, or the environment.

Hot zone
Only personnel from the fire and rescue service, NWAS Hazardous Area Response Team (HART), the military or other specialist agencies in full personal protective equipment (PPE) may enter.

Isolation area
A pre-defined area within a building to separate (suspected) contaminated individuals and to protect those who have not been in contact with the contaminant.

Lockdown
The process where the doors leading outside or to other parts of a building are locked and people may not enter or exit at those points. Please refer to the Trust's *Preparing for a Serious Security Occurrence (Lockdown)* Policy for further details.

Public Health England (PHE)
A non-departmental public body charged with protecting the health and wellbeing of United Kingdom citizens from infectious diseases and with preventing harm and reducing impacts when hazards involving chemicals, poisons or radiation occur.

Radiological
Relating to or caused by radiation.

Recovery
The process of restoring, rebuilding and rehabilitating in the aftermath of an incident.

Response
Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders.

Response box
The term 'response box' is referred to in this guidance is an identified and accessible resource that is stored securely. It contains limited personal protective equipment used in the clinical setting and essentials items for frontline clinical staff.

Secondary contamination (cross-contamination)
The unintentionally transfer of one substance or more to another person or object with potentially harmful effect.

Self-presenters People who may leave the scene of an incident before cordons are put in place, either attempting to flee perceived or real danger, or not realising that they may have been involved in an incident. Later, once symptoms have developed, or as a result of widespread media coverage, they may self-present at an Emergency Department (ED) or primary or community care facility in search of treatment, advice and reassurance.

Terrorist incident
The aftermath of a terrorist attack, including the actual or threatened dispersal of Chemical, Biological, Radiological and Nuclear (CBRN) material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent.

Threat
Intent to, or incident that may, inflict harm or loss on a(nother) person(s).

Threat level
These are designed to give a broad indication of the likelihood of a terrorist attack.

Triage
The process of determining the priority of casualty's treatment based on the severity of their condition.

Worried well
Members of the public who may be near to an incident when it happens or have heard about it from another source and are worried that they may have been affected in some way, or consider themselves likely to need medical intervention.

Further information on terms, definitions and abbreviations used in the Trust emergency planning (and BCM) can be found in the *UK Civil Protection Lexicon*.

APPENDIX D

PATIENT/THIRD-PARTY CONTACT TEMPLATE (PRINT NUMEROUS COPIES AND STORE IN RESPONSE BOX)

Record of the names of ALL people potentially involved in the incident and hold this list securely. A copy of this list should be made available to the emergency services.

No.	Surname	First name	Date of Birth (DD/MM/YY)	Address (inc. postcode)	Contact telephone number	GP	Contamination details (location)/ symptoms/actions/ intervention

Ward/facility/building (delete as appropriate):_____

form:_____

Page __ of ___

Name of person completing this

Date of completion (DD/MM/YY): / / /

APPENDIX E

SUGGESTED CONTENTS OF A RESPONSE BOX

(Affix list to top of box and keep in secure location). The following list is not intended as a definitive or comprehensive list to assist with managing emergencies and business continuity disruption, but merely to encourage staff to consider essential items that would be appropriate for their department/service/team. **The items in bold is the minimum content of the box.**

- **Relevant laminated major incident action cards.**
- **Relevant laminated lockdown action cards**
- **Relevant laminated 'HAZMAT' action cards.**
- **A4 site fire drawings and plans of alternative location for your service.**
- **3 x masks (highest specification possible).**
- **Nitrile gloves (medium).**
- **Paper towels - Aprons.**
- **Clear 'dustbin' size plastic bags (bagging patients' clothes & belongings).**
- **Cable ties.**
- **2 x 'tuf-cut' shears.**
- **1 x roll barrier tape (250m).**
- Latest hardcopy versions of (1) Incident Response Plan; (2) this guidance; (3) Trust Pandemic Flu Plan; and (4) your department/service/team business continuity plan. *Print double-sided to reduce weight.*
- If applicable, pre-prepared, laminated signage for your building. *Consider possible amended patient flow during an incident/pandemic.*
- At least 3 x ATEX-rated head torches - risk-assess for use in workplace, including anti-ligature risk. (1 set of spare batteries per torch + 1 spare set of batteries, ATEX-rated if having to evacuate in heavy rain or if gas leak at night).
- 1 x analogue phone handset for 'incoming calls' – plug into fax machine port if no analogue points are available.
- 1 x Nokia mobile phone charging lead & 1 x BlackBerry charging lead.
- NOT FOR CONTAMINATED CASUALTIES: 1 x emergency CPR mask 1 x pocket bag-and-valve mask (if safe to do so, for contaminated casualties from HAZMAT incident).
- Blank copies of patient/third-party contact template (APPENDIX D).
- Limited copies of blank documentation for your service (in case of power/IT disruption).
- 2 x rulers, 6 x BLACK ballpoint pens & 6 x RED ballpoint pens.
- 3 x BLACK permanent markers (marking bags of casualties' clothing and belongings);
- 1 x staple gun and staples (for laminated signage and/or barrier tape if no fixtures).
- 2 x chronological logs for maintaining a contemporaneous record of information received and given (faxes, phone messages), events, decisions taken, options considered, rationale for decision-making and actions.

APPENDIX F

LAMINATED ACTION CARDS ***Write on card using permanent marker***

Reception Staff/First Responder
THINK SAFETY FIRST

KEEP THIS CARD SECURE BUT ACCESSIBLECONFIDENTIAL ONCE COMPLETED

- **Follow STEP 123 safety code on reverse side of this action card. Alert facility service coordinator.**

- Confirm which member of staff will call 999 for the emergency services, detailing:

Casualties: 2 or more potentially contaminated persons? (walking or non-walking?); severity & type of signs and symptoms.
Weather: Wind direction – which direction are any trees moving (if visible through window)?
Hazards: Present or suspected?
Access: State entrance and exit roads to your facility and any immediate access issues;
Location: State the precise location of the incident (if known) and whether this area has any air conditioning or vents. *Likely to hazardous material incident or terrorism?*
Environment: Building, open space?
Presence of any perpetrators: Number and description? What else are they carrying? Bags?
Moving in any particular direction? Are they communicating with others? How?

- Lockdown (control entry/exit to and from) reception and/or the affected area. (This should assist to protect staff and patients inside and preventing any contaminant present from spreading).

- Consider yourself and colleagues (patients, visitors, and contractors) within the building as contaminated.

- Affix pre-printed laminated signs to prevent other staff (patients, visitors and contractors) from *entering* the area.

- Use pre-printed laminated arrows to direct contaminated patients (visitors and contractors) to an isolation area. Reassure all staff (patients, visitors and contractors) that help is on the way.

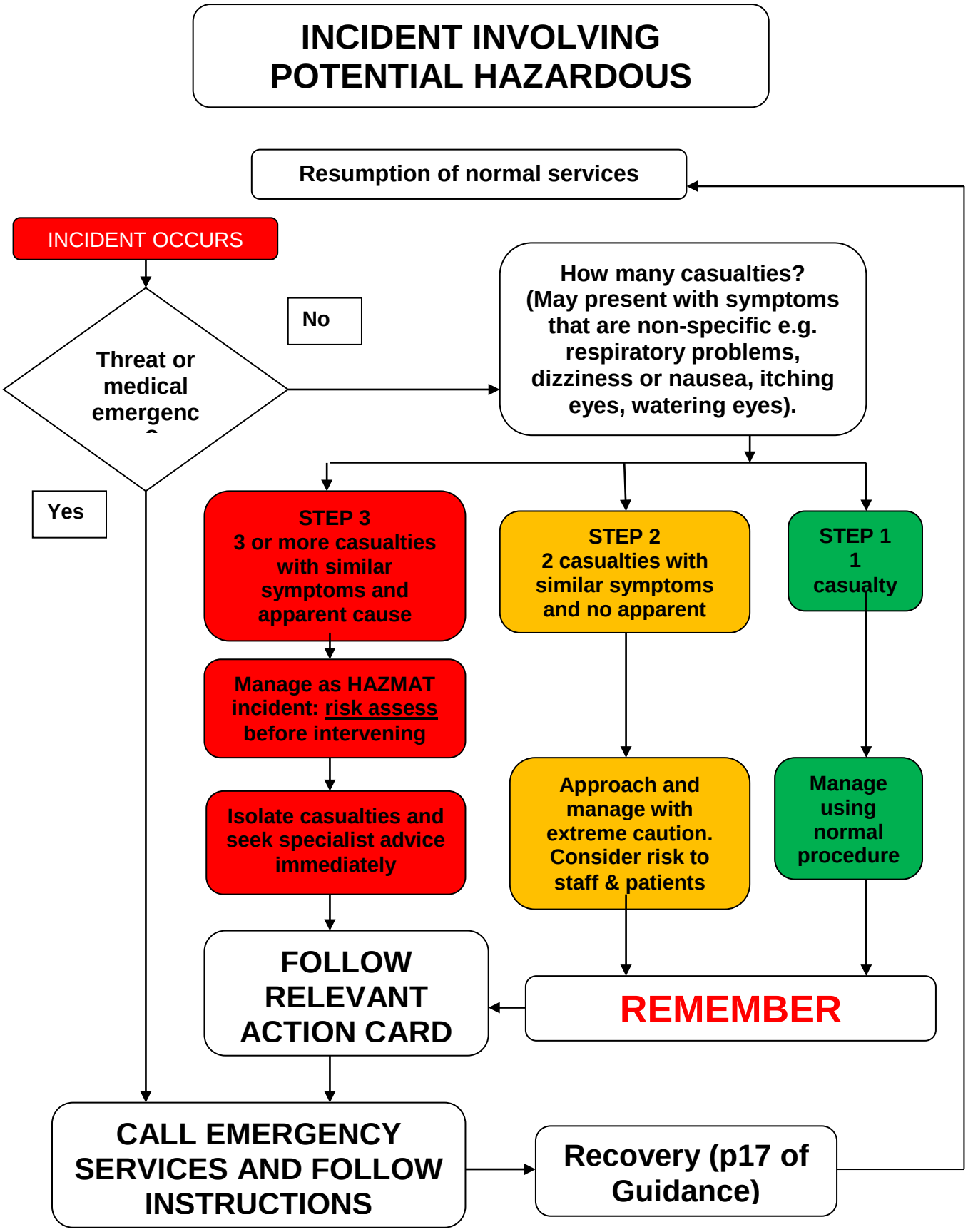
- Record staff (patients, visitors and contractors) details on patient/third-party contact form (APPENDIX D of this guidance – copies should be in response box).

- Keep staff (patients, visitors and contractors) informed.

- Follow specialist advice from the emergency services and Public Health England

Complete a personal log of all decisions taken (options considered, rationale for decisions); actions taken; requests should be logged by each individual. Use notes on this action card and any other 'trigger' notes generated on any medium (e.g. post-it note, nitrile glove) to complete a contemporaneous record of the incident using an appropriate logbook (or notebook with bound leaves) within 24 hours or as soon as reasonably practicable. Keep these items and personal log in your possession until requested by a competent authority e.g. police or HSE.

ENSURE ALL ACTIONS, DECISIONS, OPTIONS CONSIDERED ARE RECORED.
RETAIN ALL RECORDS SECURELY & CONFIDENTIALLY FOR A MINIMUM OF 7 YEARS.
THIS ACTION CARD SHOULD BE TREATED AS 'CONFIDENTIAL' IF ANNOTATED.


INCIDENT INVOLVING POTENTIAL HAZARDOUS
Resumption of normal services
INCIDENT OCCURS
Threat or medical emergenc
No
Yes
How many casualties? (May present with symptoms that are non-specific e.g. respiratory problems, dizziness or nausea, itching eyes, watering eyes).
STEP 3 3 or more casualties with similar symptoms and apparent cause
STEP 2 2 casualties with similar symptoms and no apparent
STEP 1 1 casualty
Manage as HAZMAT incident: risk assess before intervening
Isolate casualties and seek specialist advice immediately
Approach and manage with extreme caution. Consider risk to staff & patients
Manage using normal procedure
FOLLOW RELEVANT ACTION CARD
REMEMBER
CALL EMERGENCY SERVICES AND FOLLOW INSTRUCTIONS
Recovery (p17 of Guidance)