Pathology at Wigan and Salford

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

Manchester Arena Bombing and Major Incident at Salford Royal

Presented by:

Deborah Seddon Haematology and Blood Transfusion Manager and Eva Loutraris Blood Transfusion Section Manager at Salford Royal.

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

Salford Haematology Major Incident Procedure

- Major Incident planning at Salford has resulted in the use of **Action Cards** specific to all departments
- Once the call is made staff go to their **Major Incident Folder** and follow the instructions on their **Specific Action Cards**
- These clearly allocate roles, responsibilities and procedures to follow during a major incident.

Pathology at Wigan and Salford

Salford Royal NHS
NHS Foundation Trust

Bloo University Teaching Hospital

safe • clean • personal

Evolution of Major Incident planning at Salford

- In light of a series of Terror attacks in France. All emergency service departments across the UK were asked to review their Major Incident procedures.

- In Greater Manchester we held two Major Incident simulation events involving all emergency services in the region.
- The final one was **Socrates** held on 29.3.17

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

Lessons learned from Major Incident Simulations

- From the initial event we identified our call out procedure for contacting staff was difficult to follow.
- It didn't allow for annual leave or sickness.
- It didn't take into consideration shifts.
- It purely looked at that moment in time and didn't allow for forward planning of staffing.

What did we change as a result:

- The organisation of the call out chart so it flowed better.
- Included reviewing staff to call in but taking into account annual leave and the current rota.
- Implemented a system for checking staff contact details.

Socrates

- Socrates was a real time simulation event involving the emergency services for the whole region.
- At Salford we were all in one room throughout the event no one contacted Blood Bank despite multiple MHP activations!
- As a result Debbie had the idea that if we were a visible presence in ED it would remove barriers to communication.

We began to explore this……

The time for planning was over!

22nd May 2017: Manchester

- On the day of 22.5.17 thousands of school age children were preparing to attend a Pop concert
- They would have been giddy and excited to see their idol
- Some were attending the concert for the first time without their parents!

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

10.35PM

At 10.35pm just as the fans were starting to leave a loud explosion was heard.

Pathology at Wigan and Salford

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

Manchester Arena

Salford Royal NHS
NHS Foundation Trust
Bloc University Teaching Hospital
safe • clean • personal

How were we alerted?

- At 10.45pm Debbie received a call from her sister who was distressed.
- She was in a car outside the Arena waiting for her 14 year old daughter Lydia.
- Lydia was at her 1st concert without an adult.
- Lydia had heard a loud bang and saw people running from the Arena
- By 10.40pm Lydia had spoken to her mum so we knew she was scared but safe!

11.00PM

- Debbie called switch “hands-free” as she was driving in and notified them we could be alerted to a Major Incident. The command team were then informed of the potential Major Incident
- As Debbie walked into the Lab at 11.00pm, the BMS had just received the Major Incident call.
- The Haematology Major Incident procedure was then activated.

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

What actions followed

- **11.05** Gold command contacted Debbie to discuss the intel so far
- **11.05** the standby BMS was called in
- **11.05** MLA instructed to count all available blood product stock
- **11.10** using the new system we activated the call out procedure

  Considerations: Who is on leave/sick, ensuring adequate staffing for the forthcoming day/night shifts.
- **11.15** NHSBT contacted and additional products ordered

So far all actions mirrored the revised action cards!

Changes to plan!

In response, as Haematology coordinator Debbie made some decisions based on lessons learned from Socrates.

- **11.15** Instructed the AP to defrost 3 X 4 packs of FFP plus one set suitable for those born post 1996.
- **11.15** Instructed BMS staff to prepare additional Packs of Emergency O Negs
- **11.45** Additional stock & FFP was taken to ED

By 11.45pm we already had an additional 5 BMS's and

an AP who had all rushed in.

Pathology at Wigan and Salford

Salford Royal NHS
NHS Foundation Trust

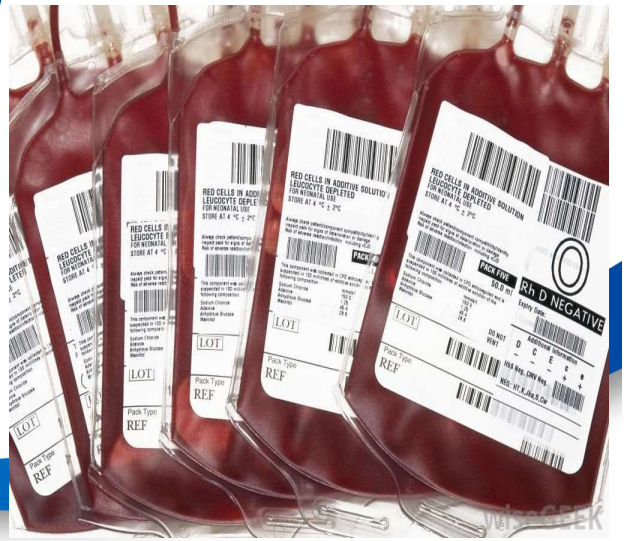
Bloc University Teaching Hospital

safe • clean • personal

11.50 Additional blood stock arrived from NHSBT

Be Aware

If you are on lockdown you will need special arrangements for the access of NHSBT drivers!



New roles developed on the night

- We identified early that controlling stock levels would be difficult for the BMS staff so an AP was given the task of coordinating stock levels with defined triggers for re-ordering.
- Debbie and myself based our selves in ED coordinating blood support for the patients.

Blood Transfusion - Support role in ED

- Monitor the usage of emergency products, replenish as required
- Liaise with ED staff and communicate requirements to blood bank
- Assist ED staff in completing Traceability documentation- not record sheet.

What went well?

- ED support role has been identified as being directly responsible for saving 2 possibly 3 lives.
- ED staff maintained patient contact throughout – no need to run back and forth to blood bank
- Staff in blood bank found it easier to communicate with us rather than ED staff
- We maintained a constant supply of emergency products – no delay in provision of blood products.
- We even facilitated the provision of Anti-tetanus
- Staff in the lab were able to focus on less severely injured patients and preparing more Emergency O Negs.
- All Haematology staff were calm, focused and well prepared.


MANCHESTER ARENA
EXPLOSION: WHAT
HAPPENS NEXT?

Salford Royal NHS
NHS Foundation Trust

Bloc University Teaching Hospital

safe • clean • personal

Improvements Required

- We need to establish clear guidance for minimum stock levels
- We developed 2 new action cards: Blood stock co-ordinator and ED Blood Transfusion support.
- We need to improve the system for dealing with traceability in ED- source dedicated bag for units and paperwork.
- We need to establish a minimum stock level for Anti-Tetanus.
- **Communication:** We have identified we need our own wireless phone whilst in ED
- **Visibility:** We require a tabard so Blood Bank staff are clearly identifiable whilst in ED.
- **Stand down:** As a trust this happened too soon it didn't take into account patients going back to theatre for multiple surgeries i.e. the theatre list for Wednesday wasn't cancelled.

Salford Royal NHS
NHS Foundation Trust
Bloc University Teaching Hospital
safe • clean • personal

Recommendations

- **Practice Practice Practice**

  Attend simulations and work in a real time way

  so you can identify weaknesses.

- Develop connections with the Major Trauma team- be part of planning, resilience and preparedness
- Ensure you have a system for checking your callout procedure and staff contact details.

NHS Blood and Transplant

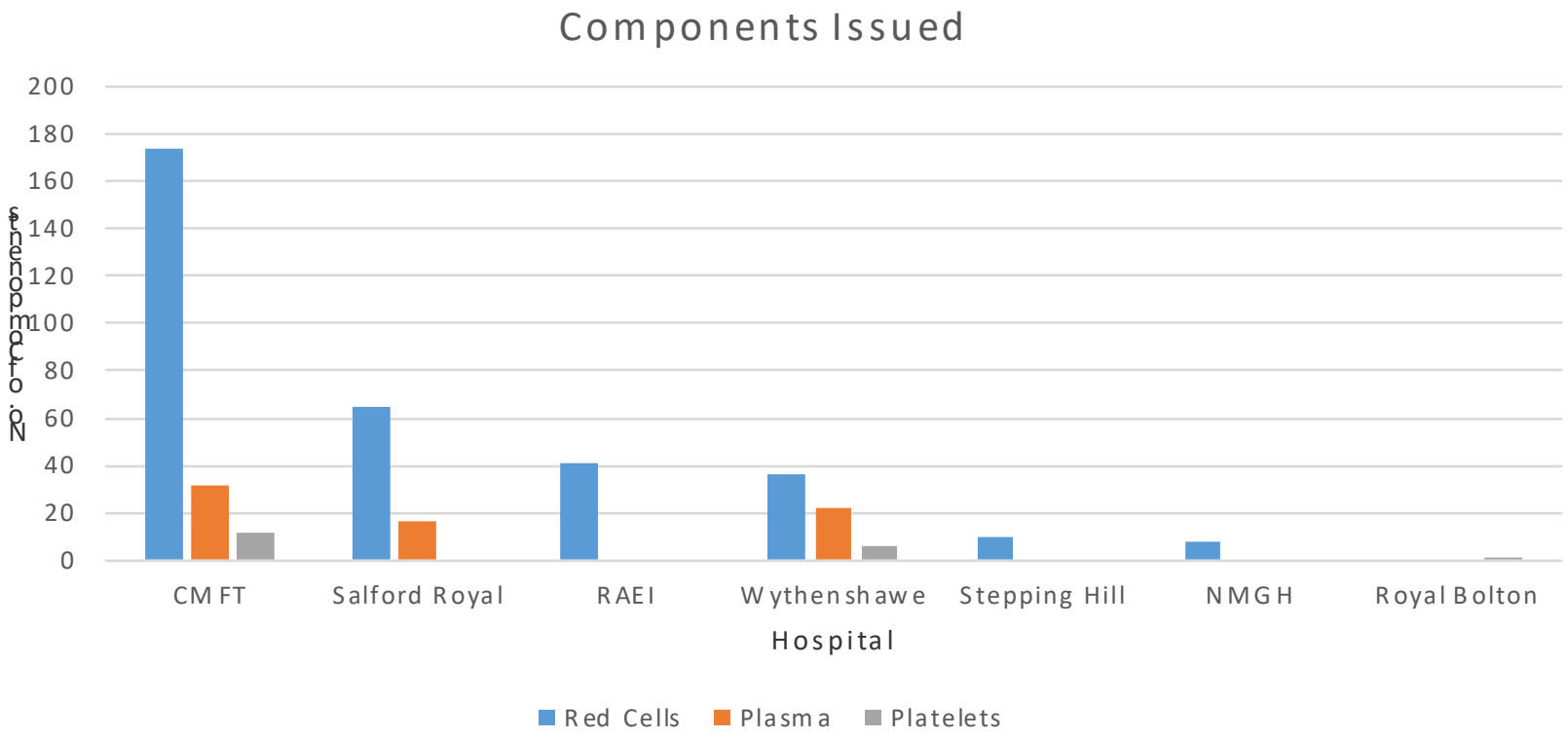
NHSBT Hospital Services Manchester – 22nd May 2017

Notification of Incident

- 3 staff members on duty on the night of the incident
- First notification received from Liverpool Blood Centre followed by call from Tameside General Hospital
- Manchester Hospital Services supervisor went on to call the following:
- Duty band 5
- Duty Hospital Services Manager
- Critical Incident Manager

  Hospital Services Manager

Orders



The first order was received 00:30 and the last order was received 06:10. Hospitals used OBOS, fax and telephone to order. 21 orders in total.

- Total components issued:
  - 334 x Red Cells (163 of these were O neg)
  - 70 x Plasma (58 FFP and 12 cryo pooled MB)
  - 19 x Platelets

Orders & Stock

- Majority of orders went out on time. Some delays due to:
  - LVT supply issues
  - neonatal split orders
  - irradiation requests
- Stocks of O neg were checked
  - 60 O neg transferred from Liverpool Blood Centre
- DHSM went on to organise stock refill throughout the event. Components were sent in overnight to replenish stock from Newcastle, Sheffield and Liverpool.
- Orders were also sent direct to Manchester hospitals from Birmingham, Sheffield and Liverpool Blood Centres.

Transport

- The North Regional Transport Manager on-call that evening, organised 3 extra drivers from Liverpool to help the duty driver in Manchester.
- NHSBT's courier provider TNT was used for non-urgent orders but decided to stay close to the Manchester Blood Centre just in case they were required.
- A total of 13 emergency deliveries were ordered. Two of these had to be split so 15 emergency deliveries took place.

NHS
Blood and Transplant

Future Suggestions

- Place message on OBOS to inform hospitals of good stock levels and also NHSBT are aware of incident.
- Place televisions in Hospital Services departments so staff have access to the latest news.
- Train staff in Manufacturing to work in Hospital Services (cross departmental training) and vice versa so that staff are available to cover in emergencies.
- Clear communication to hospitals about return of unused components.
- Some hospitals report they went in to lockdown. Hospitals need to check if NHSBT driver and NHSBT designated courier will have access in and out of the hospital under lockdown situations.