PREHOSPITAL CARE

Who's who at a major incident: standardising role titles for emergency planners

M Mudalige, S Carley, K Mackway-Jones

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Objective: To standardise the names for key roles in a major incident.

Methods: A Delphi study using experts in major incident planning.

Results: There is clear consensus regarding the need for standard nomenclature. The expert group identified 28 roles, and 184 different names were initially given by group members for the 28 roles. Agreement on a common nomenclature was achieved in only 12/28 roles.

Conclusion: There is agreement for a standardised nomenclature for major incident roles. However, consensus may be difficult to achieve from within an expert group.

Effective planning is essential for a successful major incident response.^{1,2} However, the quality of planning in the UK has been regularly called into question.³ Recent events such as the terrorist incidents in the UK have once again focused attention on the effectiveness of major incident planning. Traditionally, each individual hospital writes and maintains its own major incident plan. This has led to a great deal of variation in approach and quality.³ This is of concern as the health worker population, especially junior doctors, regularly change hospitals as a part of their training. Inevitably, the lack of a consistent approach to major incident planning can lead to confusion.

This study aimed to gain consensus on the nomenclature for key roles in a major incident plan.

PARTICIPANTS, METHODS, AND RESULTS

An expert panel was selected by the authors. Expertise was defined as knowledge and skills in emergency planning from nursing, medicine, or management. All participants were from the UK. A three round Delphi⁴ was conducted. In round 1 participants were asked to give a name to one of 28 described roles deemed essential for an effective major incident response^{1,2}—for example, what is the title of the team that controls the overall response to a major incident? In subsequent rounds, answers from round 1 were iterated to the group who then indicated their agreement on a nine point Likert scale. Consensus was defined as >80% of respondents scoring >5 for any statement.

A total of 14 people were approached, of which 10 completed the study. All agreed with four statements that the nomenclature for major incident roles should be standardised and clearly defined, and that such consistency would aid the response to a major incident.

For the 28 defined roles, a total of 184 different names were suggested in round 1. After round 3 consensus was achieved for only 12 (see table 1 for examples). A full list of all the questions is available online (appendix 1, <http://www.emjonline.com/supplemental/>).

Table 1 Examples of roles that did and did not reach consensus

Role	Final consensus	Original suggestions
What is the title of the person whose responsibility is to take overall charge of the incident response?	No consensus achieved on this statement	Duty Executive Hospital Medical Coordinator Incident Executive Director Incident Manager Medical Controller Medical Coordinator Medical Director Senior Manager Senior On-Call Manager
What is the title of the person who is responsible for the allocation of nursing staff and resources in the accident and emergency department?	Senior Nurse A&E	A&E Nurse Controller Chief A&E Sister Nurse Coordinator P1/P2 Nurse Coordinator Senior Nurse

COMMENT

This Delphi exercise clearly shows that there is a desire and perceived need for consensus on the names attached to specific roles in a major incident response. With regard to the specific nomenclatures discussed in the expert group through Delphi two aspects are worthy of consideration. Firstly is the large number of alternative names used by different planners. Such variability is likely to lead to confusion as health workers move between trusts, and also if an incident requires communication between different trusts as is likely to be the case in most UK major incidents. Thus it is perhaps disappointing that little consensus was obtained on specific roles. Although some differences are unlikely to lead to much confusion (for example, Porterage Co-ordinator v Porterage Supervisor), differences in some of the more senior roles may lead to difficulties.

We have argued that nomenclature should remain as close as possible to normal working practice and that roles that arise only as part of a major incident should be self-explanatory.² For example, we suggest that “Senior Doctor ICU” is more intuitive than “Incident Lead Intensivist”. At this time of increased interest and awareness of the challenges of major incident planning it is vital that a consistent approach is adopted.

An appendix to this paper has been posted online at <http://www.emjonline.com/supplemental/>

Authors' affiliations

M Mudalige, S Carley, K Mackway-Jones, Manchester Royal Infirmary, Manchester, UK

Competing interest: KMJ and SC have written HMIMMS, which contains a standardised nomenclature set.

Correspondence to: S Carley, Manchester Royal Infirmary, Oxford Road, Manchester, M13 9WL, UK; Simon.carley@mmc.nhs.uk

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