



Hospital Guidelines for Management of Pediatric Patients in Disasters

Created by:
King County Healthcare Coalition Pediatric Triage Task Force
Public Health - Seattle & King County

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Introduction

The Triage Task Force of the King County Healthcare Coalition Pediatric Workgroup began meeting in early 2008 to consider the issue of appropriate and efficient triage of pediatric patients in large-scale emergencies, including mass casualty incidents and communicable disease outbreaks, such as pandemic influenza. Members of the task force represent emergency medicine, outpatient and critical care pediatric physicians and pediatric nursing.

Early in the process, the group acknowledged particular concern regarding the geographic distribution of the pediatric population in King County, Washington, as compared with pediatric hospital services. According to a 2007 study conducted by Dr. Mary King, Public Health-Seattle & King County and the Healthcare Coalition, more than 80% of pediatric inpatient beds, equipment and healthcare providers are located within the City of Seattle, while approximately 80% of children 18 years or younger reside in regions of the county outside the City.

The task force agreed that, in a large-scale medical emergency, critically ill or injured children may present to any and all hospitals in the county, to the hospital that is closest, most convenient or most familiar. Transfer by emergency responders to specialized pediatric hospitals may be impossible due to a shortage of vehicles, impassable roads and bridges or the instability of the patient. In addition, specialized hospitals may be unable to receive patients due to overwhelmed capacity or structural damage.

In order to increase regional access to appropriate pediatric services, the task force decided to create a “pediatric toolkit” with basic information and guidelines for both short-term acute care and more definitive management of pediatric patients, depending upon the emergency, at every hospital with emergency services in the county.

The task force was fortunate to refer to a recently published comprehensive document, “Children in Disasters: Hospital Guidelines for Pediatric Preparedness,” which was commissioned by the New York City Department of Health and Mental Hygiene to provide hospitals, particularly those that do not normally admit children, with strategies and tools for providing treatment for children during a disaster. After review of those guidelines, the subject matter experts within the Task Force streamlined and adapted them to our regional standards. The guidelines are designed to be integrated into the hospital incident command structure. Topics related to pediatric disaster preparedness include the following:

- Staffing and training
- Equipment and supplies
- Pharmaceutical planning
- Dietary planning
- Security and psychosocial support
- Transportation
- Inpatient bed planning
- Decontamination of children
- Hospital-based triage

This document has undergone multiple iterations and has been reviewed by emergency department and critical care physician staff at Seattle Children’s Hospital and by the Disaster Committee of Harborview Medical Center.

Hospital Planning for Pediatrics during a Disaster

General Guidelines: Here are 10 steps in planning to prepare for management of pediatric patients at every King County hospital. Start with Step 1 and, as more individuals become involved, the planning will move more smoothly and quickly.

All hospitals should plan for arrival of pediatric patients

- Pediatric patients might present to ANY hospital
- Critically ill pediatric patients might present to ANY hospital
- Transfer of patients to specialized hospitals might not be feasible

1. Survey staff to identify in-house pediatric expertise

- Hospitals and networks should survey staff and admitting physicians to develop a database of personnel with pediatric experience, training and willingness to join a response team.
- Identify key pediatric positions that staff will occupy in a disaster (see below).
- Include notification procedures for key staff and response team members in the plan.

2. Create pediatric leadership positions for key personnel and qualified staff

- Physician Coordinator for Pediatric Emergency Care in a Disaster
 - coordinates pediatric disaster care and planning
 - serves as regular member of the Hospital Disaster Committee
- Nursing Coordinator for Pediatric Emergency Care in a Disaster
 - coordinates pediatric disaster care and planning
 - serves as regular member of the Hospital Disaster Committee
- Pediatric Safe Area Coordinator
 - ensures the pediatric safe area is properly staffed and stocked for an emergency
 - ensures the safety of children awaiting appropriate disposition
- Pediatric Logistics Unit Leader
 - ensures that children's needs are addressed by Procurement, Transportation, Materials Supply and Nutritional Supply during an emergency
- Pediatric Services Unit Leader
 - ensures that the pediatric treatment and holding areas are properly assigned, equipped and staffed during an emergency, including trained triage Visual Inspection Officers (see page 26).

3. Increase pediatric and disaster training

- Train more medical staff to provide appropriate basic and advanced emergency care and trauma life support to children
- Offer Neonatal Advanced Life Support (NALS), Pediatric Advanced Life Support (PALS) and the Emergency Nursing Pediatric Course (ENPC) to hospital staff on an ongoing basis
- Arrange updates and re-certifications

4. Plan for appropriate pediatric equipment

- Establish a baseline surge capacity and capability for pediatric patients for estimating essential inventory; estimate generously.

- Consider creating and stocking pediatric disaster carts in designated areas, including a cart specifically for a Pediatric Critical Care Area in the emergency department.

5. Plan for appropriate pediatric pharmaceuticals

- Establish procedures for maintaining disaster carts (resuscitation medications/kits/color-coded bags)
- Maintain and update an inventory of essential drugs (72-hour supply)

6. Plan for providing appropriate pediatric nutrition

- Maintain a five-day food and drinking water supply for use during an emergency, including age-appropriate nutritional supplies for both healthy children and those with special dietary needs
- Consider Memoranda of Understanding with area stores for delivery of additional supplies

7. Plan for special security needs of children

- Plan a Pediatric Safe Area (PSA) to hold uninjured, displaced or released children who are awaiting adult caregivers (see page 15)
- Designate a PSA Coordinator as part of this planning and identify staffing personnel
- Develop a system to track both accompanied and unaccompanied children
- Develop a protocol to rapidly identify and protect displaced children, including recording key identifying information for use in later tracking and reunification with caregivers

8. Plan for transport issues

- In case transfer is delayed, prepare to provide extended care to children during a disaster, including provision of equipment for age-appropriate internal transport
- Hospitals without pediatric intensivists or trauma surgeons should develop a plan with pediatric intensive care specialists and trauma surgeons at outside hospitals to provide, at the minimum, telephone consultations or support for admitting physicians

9. Add special considerations for children to your Hospital Decontamination Plan

- Develop a system to keep children with their caregiver, unless medical issues take priority
- Incorporate high-volume, low-pressure water delivery systems (e.g., handheld hose sprayers) that are “child-friendly” into the hospital decontamination showers
- Minimize risk of hypothermia

10. Develop and exercise a hospital-based disaster triage system

- Establish treatment and evaluation areas that are separate from ED critical areas for lower priority patients
- Use clinicians who are accustomed to evaluating acutely ill children, when possible
- Develop triage forms specifically for disaster scenarios to exclude time-consuming and irrelevant questions. The Patient Evacuation Tracking Form developed for the Seattle-King County Regional Evacuation and Patient Tracking Mutual Aid Plan is included in the Annex for your hospital’s own consideration.

▪ **Staffing Recommendations for Pediatrics in a Disaster**
(for hospitals without significant pediatric services or staff)

General guidelines:

- Pre-identify hospital staff with specialty skills or experience with pediatric patients
 - Emergency medicine, pediatrics, family medicine
 - Anesthesia, ENT, pediatric surgery, trauma surgery, general surgery, orthopedics, urology, neurosurgery, thoracic surgery
 - Nurses, PA's, NPs from EDs, ORs, PACUs, ICUs, inpatient units & outpatient clinics
- Develop call-down and notification procedures for all staff identified
- Create key pediatric positions for response in a disaster event; add to your hospital's Disaster/ Emergency Response Plan
 - Physician Coordinator for Pediatric Emergency Care in a Disaster
 - Nursing Coordinator for Pediatric Emergency Care in a Disaster
 - Pediatric Safe Area Coordinator (Job Action Sheet in Annex)
 - Pediatric Logistics Unit Leader (Job Action Sheet in Annex)
 - Pediatric Services Unit Leader (Job Action Sheet in Annex)

Training Recommendations

Provider Level	Recommended Training:				
	ACLS	ATLS	PALS/ENPC	Basic Disaster Training	Disaster Drill including Pediatric Pts
Emergency Department Nurses & Physicians	Yes	Yes	Yes	Yes	Yes
Pediatric Inpatient Unit Nurses & Physicians	Yes	No	Yes	Yes	Yes
Pediatric ICU Nurses & Physicians	Yes	No	Yes	Yes	Yes
Pediatric Surge Capacity Nurses & Physicians*	Yes	No	Yes	Yes	Yes
Medical/Surgical ICU Nurses & Physicians plus PACU staff	Yes	No	Yes	Yes	Yes
Other Surgical & Medical Physicians likely to respond to ED during disasters	Yes	Yes	Yes	Yes	Yes

* Staff designated in the hospital disaster plan to care for pediatric patients and their families when usual hospital inpatient pediatric capacity is exceeded and pediatric patients cannot be transferred

Equipment Needs for Pediatric Emergency Patients

- *Calculate institution's projected surge capacity for critical pediatric patients
- *Consider assembling length-based color-coded bags (e.g., Broselow™) with 1 set of color-zone-appropriate equipment in each bag. A bag would be assigned to each patient on admission and would follow him/her throughout hospital stay. Rolls of 10 bags can be stocked and/or transferred from regional store to help meet surge needs among hospitals.

Type	Size	Total*	Essential
Ambu bags & clear masks, self-inflating (500 mL)	Infant		√
	Child		√
Arm boards			
Blood pressure cuffs	Infant		√
	Small child		√
Chest tubes & set-up	16F		√
	28F		√
Defibrillator pads	Pediatric		√
Dosing chart, color-coded	Pediatric		√
EKG electrodes	Neonatal		√
	Pediatric		√
ETCO ₂ Detectors			
ET tubes (cuffed preferable)	2.0 - 7.5 mm		√
Foley catheters	8F		√
	10F		√
	12F		√
Fuhrman pigtail catheters	7F		√
	8.5F		√
Gastrostomy tubes (can use NG tubes PRN)	12F		
	14F		
	16F		
Infant scale			√
Intraosseous needles			√
Intravenous infusion pumps			√
Laryngoscope blades	Macintosh 0		√
	Macintosh 1		√
	Macintosh 2		√
	Miller 0		√
	Miller 1		√
	Miller 2		√
Laryngoscope handles			√
LMA's	Sizes 1,2,3		
Masks: non-rebreather	Infant		√
	Child		√

Equipment Needs (2)

Type	Size	Total	Essential
Nasal cannula	Infant		√
	Child		√
Nasogastric tubes	6F		√
	8F		√
	10F		√
	12F		√
	14F		√
	16F		√
Nasopharyngeal airway	All peds sizes		
Newborn kit/OB kit			√
Oral airways	00		√
	01		√
IV catheters	18		
	20		√
	22		√
	24		√
Overhead warmer			
Peds MDI spacers w/masks	Sm, med, lg child		√
Oximeters			√
Oxygen saturation probes	Pediatric Neonatal		
Restraining board (Papoose)			
Resuscitation tape, length-based (such as Broselow™)			√
Seldinger vascular access kit (with catheter)	4F, 5 cm		
	5F, 5 cm		
	5F, 8 cm		
Semi-rigid cervical spine collars	Infant		√
	Small child		√
	Child		√
Suction catheters	5F		√
	8F		√
Syringes	1, 3, 5 & 10 cc		√
	60 mL, cath tip		
Tracheostomy tubes	00 - 6		√

Pharmacy Needs for Pediatric Emergency Patients

General Guidelines:

1. Recommend acquisition of a pediatric pharmacy disaster cart (length-based, color-coded system, such as Broselow™)
2. Establish procedures for maintenance of cart.
3. Consider establishing patient-specific weight-based code med sheet with computer-calculated code med doses to be placed at foot of every pediatric bed in day-to-day operations.
4. Maintain 72-hour supply of essential pharmaceuticals.
5. Estimate supply for treatment or post-exposure prophylaxis (PEP) of biologic agents at your facility:

$$\begin{aligned} \# \text{ of courses of treatment} &= \text{Daily census of pediatric patients} \\ &\quad \textit{plus} \\ &\quad \text{Estimate of surge of pediatric disaster victims} \\ &\quad \textit{(plus)} \\ &\quad \text{(Consider adding pediatric family members of hospital staff)} \end{aligned}$$

6. Provide for storage, monthly inspection and re-supply of inventory.
7. Maintain list on the cart of sources of additional drugs, including network affiliations (WATrac), local pharmacies, drug companies.
8. Identify unit leader responsible for distribution of meds in case of disaster.
9. Develop system to stop nonessential use of antibiotics until supply arrives.
10. Regularly test pharmacy during drills.

Essential Pediatric Pharmacy Inventory

Emergency Meds	Dose
Albuterol 2.5mg/3mL	<1 yr: 0.05 - 0.15 mg/kg q4h PRN
	1 - 5 yr: 1.25 - 2.5 mg/kg q4h PRN
	5 -12 yr: 2.5 mg/dose q4h PRN
	>12 yr: 2.5 - 5 mg/dose q4h PRN
Albuterol MDI with mask and spacer	1-2 puffs q 4-6 h or more often PRN with monitoring
Atropine sulfate 1mg/10 mL	0.02 mg/kg IV/IO/IM (min. 0.1 mg) Max: Child = 0.5 mg; Adolescent = 1 mg
Calcium chloride 10% (1g/10 mL)	20 mg/kg (0.2 ml/kg) slow IV/IO (max 1 g) <i>Use IV with extreme caution: extravasation may lead to necrosis.</i>
Dexamethasone 4 mg/mL	0.5 - 2 mg/kg/day IV/IM divided q6h (max 16 mg/day)
Dextrose 10% (5g/ 50 mL)	5 - 10 ml/ kg bolus IV/IO PRN
Diazepam 10mg/ 2 mL	0.05 - 0.3 mg/kg IV (max 10 mg)
Diazepam – rectal gel 10 & 20 mg applicators	2 – 5 yrs: 0.5 mg/kg
	6 – 11 yrs: 0.3 mg/kg
	≥12 yrs: 0.2 mg/kg
Diphenhydramine 50 mg/mL	1.25 mg/kg IV q 6h (max 50 mg/dose)
Dopamine 200mg/5 mL	2 – 20 microgram/kg/minute IV
Epinephrine 1:10,000 (0.1mg/mL)	0.01 mg/kg IV/IO q 3-5min (max 1 mg/dose)
Epinephrine infusion	0.05 – 1 mcg/kg/min
Epinephrine, racemic 2.25%	< 4 yrs: 0.05 ml/kg/dose (max 0.5 ml) diluted to 3 ml with NS via neb q 1-2 hr PRN
	≥ 4 yrs: 0.5 ml/dose via neb q 3-4 hr PRN
Etomidate 2 mg/mL	> 10 yrs: 0.3 mg/kg IV over 30-60 sec
Fentanyl 50 micrograms/mL	1-2 mcg /kg/dose IV/IM q 30-60 min PRN
Fosphenytoin 50 mg PE/1mL	15 - 20 mg PE/kg IV loading dose
Furosemide 10 mg/ mL	0.5 – 2 mg/kg IV
Insulin infusion	0.1 U/kg/hr
Ketamine 10 mg/mL	4 – 6 mg/kg IM or 1-2 mg/kg IV over ≥ 60 seconds
Lidocaine 2% (5mL)	Loading: 1 mg/kg IV/IO
Lorazepam 2 mg/mL injection 2 mg/mL oral solution	0.05 – 0.1 mg/kg/dose q 10-15 min PRN PO/IV (max: 2 mg/dose)
Mannitol 25% (12.5g/ 50 ml)	0.25 - 1 g/kg/dose IV over 30 minutes
Midazolam 1mg/mL	0.1 – 0.2 mg/kg IV/ IM (max 10 mg)
Ondansetron tabs 4 mg & 8 mg (orally disintegrating tablet)	4-11 yrs: 4 mg
	≥12 yrs and adults: 8 mg
Phenobarbital	15-20 mg/kg/dose IV; may add 5 mg/kg/dose q 15-30 min to Max 30 mg/kg
Phenytoin 50 mg/mL	15 - 20 mg/kg IV loading dose
Prednisone 5 mg/5 mL syrup	2 mg/kg/day PO divided bid (max 60 mg/day)
Rocuronium 10 mg/mL	1 mg/kg/dose IV x 1, then 0.1 - 0.2 mg/kg/dose q 20-30 min PRN
Silver Sulfadiazine cream 1%	Apply thinly to entire affected area daily
Succinylcholine 20 mg/mL	IV: 1-2 mg/kg/dose x 1
	IM: 3-4 mg/kg/dose x 1 (max 150 mg/dose)

Essential Pediatric Pharmacy Inventory (2)

Maintenance fluids	Rate
D5W 0.2%NS + 20 mEq/L KCl	4 mL/kg/ hr for 1 st 10 kg of weight <i>plus</i>
	2 mL/kg/ hr for 2 nd 10 kg of weight <i>plus</i>
	1 mL/Kg/hr for each additional kg
Analgesics	Dose
Acetaminophen oral solution	10 - 15 mg/kg q 4h PO (max 1000 mg/dose)
Ibuprofen 100mg/ 5 mL	5 - 10 mg/kg q 6h PO (max 800 mg/dose)
Morphine 1 mg/mL injection	0.1 – 0.2 mg/kg IM/IV/SC q 2-4h
Morphine 10 mg/mL oral sol	0.2 – 0.5 mg/kg q 4-6h PO PRN
Antibiotics	
Ceftriaxone 0.5 and 2 g injection	50 mg/kg IM/IV q 12 hr (max 2 g/dose)
Gentamycin 10 mg/mL and 40 mg/mL	2.5 mg/kg IM/IV q 8 hr (follow levels)
Piperacillin/Tazobactam 2 g/0.25g inj.	100 mg/kg/dose IV q 6-8 hr (max 18 g/day)
Vancomycin 1 and 5 g injection	10 - 15 mg/kg/dose IV q 6 hr (max 1 g/dose)
Pandemic influenza prophylaxis	
Oseltamivir 12 mg/mL oral susp	< 3 mo old, not recommended unless dire situation
	3 – 9 mo old, 3.0 mg/kg once daily
	9 –11 mo old, 3.5 mg/kg once daily
	> 1 yr, ≤ 15 kg: 30 mg once daily (2.5 ml)
	> 15 kg to 23 kg: 45 mg once daily (3.8 ml)
	> 23 kg to 40 kg: 60 mg once daily (5 ml)
	> 40 kg: 75 mg once daily (6.2 ml)
Pandemic influenza therapy	
Oseltamivir 12 mg/mL oral susp	0 – 9 mo old, 3.0 mg/kg bid
	9 –11 mo old, 3.5 mg/kg/bid
	> 1 yr, ≤ 15 kg: 30 mg bid (2.5 ml)
	> 15 kg to 23 kg: 45 mg bid (3.8 ml)
	> 23 kg to 40 kg: 60 mg bid (5 ml)
	> 40 kg: 75 mg bid (6.2 ml)
Anthrax, post-exposure (PEP)	
Ciprofloxacin 250 mg/ 5 mL	10 -15 mg/kg PO q 12h (max 1 g/day)
OR Doxycycline	If ≥45 kg, give 100 mg PO bid If < 45 kg, give 2.2 mg/kg PO bid
Nerve Agents	
Pralidoxime 1 g/ 20 mL <i>plus</i>	25 – 50 mg/kg IV/IM (max: 1g IV; 2 g IM) Repeat in 30-60 min, then q 1h x 1-2 PRN
Atropine 1 mg/10 mL	0.05 – 0.1 mg /kg IV/IO/IM (min 0.1 mg, max 5 mg)
OR Mark I Autoinjector	In children ≥ 10 yr. , admin in 2 separate sites
Plague, post-exposure (PEP)	
Doxycycline	If ≥45 kg, give 100 mg PO bid If <45 kg, give 2.2 mg/kg PO bid
	OR Ciprofloxacin 250mg/5 mL

Pediatric Dietary Needs

1. Maintain a 5-day food supply for pediatric patients for use during an emergency.
2. Maintain Memoranda of Understanding (MOUs) with nearby stores for immediate delivery of groceries, pharmacies and medical supplies.
3. Sample pediatric menus are included in Annex.

PEDIATRIC DIETARY RECOMMENDATIONS			
Healthy Children			
0-6 months	6 months to 1 year	1 to 2 years	2 years and above
<p>Breast-fed or formula-fed by bottle only.</p> <p>Comments: Some breast-fed children may not immediately take bottle-feeding. Continue to feed; eventually the child will feed from the bottle.</p> <p>Recommendation: Ready-to-feed formula is preferred since it is immediately ready for use and requires no refrigeration or preparation. However, powdered baby formula may be used as well. Powdered formula will have a longer shelf life.</p>	<p>6-9 months - baby cereal, jarred baby food or mashed table food is appropriate - along with formula or breast milk</p> <p>9-12 months - soft, bite sized pieces of foods, i.e. vegetables, mashed potatoes, and meats - along with formula or breast milk</p>	<p>This age group eats table food. Young children will need soft bite-sized foods - along with milk.</p> <p><u>Avoid foods that can cause choking such as hot dogs, grapes, chunks of meat unless cut in pea size pieces</u></p> <p>Hydration: Water Pedialyte</p>	<p>This age group eats table food. Young children will need finger foods - along with milk.</p> <p><u>Avoid foods that can cause choking such as hot dogs, grapes, for youngest children.</u></p> <p>Hydration: Water Pedialyte</p>

PEDIATRIC DIETARY RECOMMENDATIONS

Children with Special Needs or Disabilities

Patients with feeding tubes:

- Nasogastric (N/G) and Orogastric (O/G)
 - used for acute feeding issues, gastric decompression, delivery of oral medications and activated charcoal
- Gastrostomy (G/T)
 - used in patients with chronic feeding challenges
 - use 60cc syringe with catheter tip
 - administer by bolus or continuous feed pump

Fluids appropriate for G/T tube feedings:

- Infants (0-12 months): Infant formula
- 12 months and older children:
 - Resource Just for Kids
 - PediaSure
 - Nutren Jr.
- Adolescents: an adult enteral product may be appropriate

Hydration: Tap or bottled water

Comments:

- The same feeding pump used for adults can also be used to feed children
- Use water to clean the area where feeding tube is inserted.
- Change feeding bags on regular schedule and clean prior to adding more formula.

Diabetic Children

The nutritional needs will be determined by patient's body weight and insulin requirements.

Recommendation: May require between meal snacks to control blood glucose.

Pediatric Security Issues

1. Develop a Pediatric Tracking System that addresses both the accompanied and unaccompanied child (see “Child ID Form” on page 17).
2. Develop a protocol to rapidly identify and protect displaced children. Routine use of such a protocol in day-to-day operations will increase its efficient and effective use in a disaster scenario.
3. Create a Child ID document to record any key identifying information about children or use in later tracking or reunion with caregivers.
4. Create Pediatric Safe Areas that will serve as a holding area for uninjured, displaced or released children awaiting adult caregivers. A Pediatric Safe Area Checklist has been provided in the Annex to assist in the establishment of such areas.
5. Identify a Pediatric Safe Area (PSA) Coordinator who will assume the responsibility of setting up and supervising the pediatric safe area in the event of a disaster. Consider using non-medical personnel such as social work, child life or a qualified volunteer. Included in the Annex is a Sample Job Action Sheet which outlines the PSA Coordinator position.
6. Create and use a Pediatric Safe Area registry sheet to document activity, such as transfer status, location, and final disposition, regarding the child. Example is included in Annex.

Resources included in Annex:

Pediatric Safe Area Coordinator Job Action Sheet

Pediatric Safe Area Checklist

Pediatric Safe Area Registry Sheet

Pediatric Evacuation Tracking Form

Tracking Protocol

Unaccompanied Child or Child with Lone Adult Patient

This form should be filled out for every child who is either:

an unaccompanied child OR
a minor (< 18 yrs) who accompanies a lone adult who is a patient.

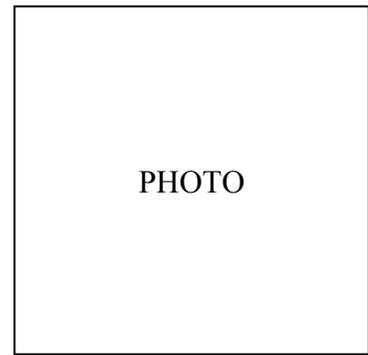
- Fill out the “Child ID Form.”
- If the child is a minor or a patient who arrives with an adult who is a patient, place identical identification bands on both the child and the adult with the following information:
 - Name of child with DOB
 - “P” (patient) or “V” (visitor)
 - Date
 - Name of adult with DOB
 - “P” and location

If child is unaccompanied and < 18 years

- Fill out “Child ID Form,” if possible. Include any information from the child or anyone who brought the child in, such as address or where found, circumstances, description of clothing, etc.
- Place ID band on child that includes name, DOB, “P” or “V” status and date
- Take digital photograph, print photo, write ID info on back and attach to form
- Catalogue by any information obtained
- Report child immediately to:
 - law enforcement in local jurisdiction OR
 - when activated, the regional Family Assistance Center (FAC)*
- If the child is cleared medically, the child should be taken to the pre-determined Pediatric Safe Area for further disposition.

*FAC will report child to National Center for Missing and Exploited Children (NCMEC), according to established protocol.

Child ID Form



- Child is unaccompanied
- Child is patient with lone adult who is a patient
- Child is visitor with lone adult who is a patient

Date _____

Name of child: _____

Age: _____ DOB _____ Male ____ Female _____

Address, if available _____ Phone number _____

If unaccompanied minor, circumstances (who, where, when, clothing, etc.) _____

Eye color _____ Hair color _____ Distinguishing marks _____

Name of adult _____ DOB _____

Male ____ Female ____ Relationship to child _____

Accompanying adult treated for illness or injury? Yes ____ No ____

Admitted? No ____ Yes ____ Where? _____

Child was treated for illness or injury? Yes ____ No ____

Describe _____

Admitted? No ____ Yes ____ Where? _____

If "No," disposition (include Safe Area): _____

Identification bands placed

- Child _____(initial when completed)
- Adult _____(initial when completed)

Unaccompanied minor

- Photographed and catalogued _____(initial when completed)
- Reported to law enforcement or FAC _____ (initial when completed)

Infection Control in a Communicable Disease Emergency

Point of Entry Measures

- Place respiratory etiquette signs prominently in entry and waiting areas
- Instruct screening, triage and reception staff regarding disease symptoms, mode of transmission and exposure control measures as advised by Public Health
- Screen to identify symptomatic patients at point of entry to implement exposure control measures
- Instruct and supervise patients and caregivers in respiratory etiquette & hand hygiene and other infection and exposure control measures
- Provide adequate supplies of tissues and an easy way of disposing used tissues
- Mask symptomatic adults and, when feasible, symptomatic children (usually \geq age 3)
- Separate persons with symptoms from those without (exception: adult caregivers who may need to remain with ill children for care and/or comfort)
- Separate contacts of ill people from those who have not been exposed
 - Ideal separation management: symptomatic individual in single room
 - Minimal management: symptomatic individuals, masked and separated by 3+ feet
 - When masking is not possible, emphasize importance of respiratory etiquette and hand hygiene.
 - Cohort symptomatic individuals (masked and unmasked) in an area which has a door that can be closed and which is large enough to permit social distancing
 - Ideally include symptomatic unmasked children after diagnosis is confirmed
 - If confirmation is not possible, make decisions according to symptoms and epidemiology
- Conduct contact identification procedures among persons accompanying an ill individual
- Instruct, observe and supervise to ensure appropriate infection and exposure control measures are being followed by cases, contacts, personnel and caregivers

Management of Asymptomatic Exposed Children and Adults

- Issue hospital identification bands to all children; include parent/caregiver information and contact status
- Cohort asymptomatic children and asymptomatic caregivers who have experienced the same exposure
- Keep group size as small as is practical and promote social distancing (3+ feet apart)
- Create a log to list all persons, including staff, who enter the cohort setting
- Include date, name and brief ID info, time in/time out, information about further exposures within the cohort, including date, time, duration of exposure and name of person with symptoms
- Promote frequent and thorough hand washing with soap and water or use of alcohol-based hand sanitizer
- Discourage sharing of toys unless washed and disinfected first
- Establish routine for cleaning environmental surfaces, including transport equipment

Procedures for Inpatient Units

- Maintain a log of personnel assigned to persons who are ill.
- Monitor personnel for symptom onset.
- Increase frequency of environmental cleaning throughout unit.
- Develop a visiting protocol, including limiting duration and number of visitors and PPE

Hospital Family Information and Support Center (FISC)

Primary functions:

1. Provide accurate information to family members through statements issued by the hospital's patient information officer:
 - a. Facilitate family access to regional Family Assistance Center's (FAC's) call center
 - b. Coordinate communication with local law enforcement and FAC
2. Provide psychological first aid to distraught families
3. Provide escort and "comfort" services to families
4. Provide temporary childcare for well children of the injured or family members who need to assist the injured.
5. Assist with patient location and reunification of family within the hospital.
6. Assist in contacting family members to arrange care of children present at hospital.
7. Assist in making in-place shelter arrangements or community placement of children for those who do not have a safe place to be or a family member who can care for them.
8. Provide communications needs for families (phones, e-mail)
9. Protect families from intrusion by media or curious bystanders
10. Enable medical staff to concentrate on treatment of casualties

Families need to be provided with the most up to date information available in a supportive and safe environment. Upon arrival to the FISC, families are logged in either via an electronic database or sign-in book. Registered families are reviewed periodically to update with information coming into the FISC. Assign a social worker, or other support staff, to families that are identified as exhibiting overt psychological upset or need to be given bad news.

Ideal set-up of FISC

- Large reception area with conveniently located restroom facilities
- Information desk with message center and phone, fax and computer connections
- Photograph/identification room with limited access (close relatives only)
- Private consultation rooms with table, chairs, telephone, tissues, trash can.
- Pediatric Safe Area (see Pediatric Security, page 5)

Identification of identified or unidentified victims/ family members

- Personal details and pictures of surviving victims are sent to the FISC electronically or via fax or runners from the ED, ICU and EMS
 - Information is included on all unaccompanied children, both the uninjured and those receiving medical treatment
 - Information on deceased victims should be sent to the regional Family Assistance Center and may require involvement of the King County Medical Examiner's Office.
- Adults coming to the hospital to claim children must show I.D.; ideally, they should bring a picture which includes the adult with the child, such as a family photograph.
- Adult family members of victims not reported to the hospital's FISC should be referred to the regional Family Assistance Center (FAC) for more information.

Recommended FISC staffing

- | | |
|--|--|
| ▪ Coordinator | ▪ Trained and pre-screened volunteers |
| ▪ Patient Information Officer | ▪ Security |
| ▪ Liaison to regional Family Assistance Center (FAC) | ▪ Translators as needed |
| ▪ Runners | ▪ Professional staff (spiritual care, social services) |

Legal Considerations

Having hospital policies and procedures in place prior to an event will eliminate a large amount of confusion and many questions. Some decisions will depend on directives issued by the public health department and other government officials, including changes in standards of care. The following are legal questions and issues that may arise during a disaster and should be discussed and clarified to the extent possible in hospital planning:

- For unaccompanied children during a disaster, consent is not needed to treat for a life or limb-threatening situation. Will parental consent be needed to treat a child victim with minor injuries or with psychological injuries?
- Is parental consent required to decontaminate an unaccompanied child? What if a child is asymptomatic? What if a child is refusing treatment?
- What medical or social information can or should be released and to whom during a disaster?
- Check HIPAA rules and your legal counsel concerning the unidentified patient locator protocols, such as posting photographs of unidentified children.
- Who can children be released to and, if not the parent or caregiver, what permission or information is needed? What is your protocol for releasing children if no legal guardian or parent can be found or if no permission document is provided?

Psychological First Aid for Disaster Survivors

Re-create sense of safety

- Provide for basic needs (food, clothing, medical care)
- Ensure that survivors are safe and protected from reminders of the event
- Protect them from on-lookers and the media
- Help them establish a “personal space” and preserve privacy and modesty

Encourage social support

- Help survivors connect with family and friends (most urgently, children with parents)
- Educate family and friends about survivors’ normal reactions and how they can help

Re-establish sense of efficacy

- Give survivors accurate simple information about plans and events
- Allow survivors to discuss events and feelings, but do not probe
- Encourage them to re-establish normal routines and roles when possible
- Help resolve practical problems, such as getting transportation or relief vouchers
- Discuss self-care and strategies to reduce anxiety, such as grounding and relaxation techniques
- Encourage survivors to support and assist others

Some children are more likely to have emotional reactions to the events (See Annex for “After a Disaster: Possible Reactions of Children”)

- Children who witnessed the event firsthand or whose parent, relative or friend was killed or injured
- Children who are displaced from their home or schools
- Children with a past history of emotional problems
- Children with a past history of trauma, either as victim or witness to violence or abuse
- Children with an adult in their life who is having difficulty with their emotions, a witness to violence or victim of domestic violence

Helpful hints to assist children during a disaster

For children under age 5:

- Ask what makes them feel better
- Give plenty of hugs and physical reassurance

For children older than age 5:

- Don’t be afraid to ask them what is on their mind and answer their questions honestly
- Talk to them about the news and any adult conversations they have heard
- Make sure they have opportunities to talk with peers if possible
- Set gentle but firm limits for acting out behavior
- Listen to child’s repeated retelling of the event

Pediatric Transport Issues

Within the hospital

- Equipment:
 - Children > 8-10 years old - adult stretchers may be appropriate.
 - Smaller children - crib or additional personnel with padded adult stretcher
- Personnel
 - Parents or adult caregivers should stay with children.
 - If none, appropriate personnel must be identified to supervise pediatric patients
 - Children < 6 yrs - continuous 1:1 supervision, unless in crib
 - Children ≥ 6 yrs - assess ability to follow safety rules while on stretcher
 - A child separated from other children requires constant 1:1 observation

From hospital to other facilities

Hospitals should consider alternatives to ambulances for safe pediatric transfers in a disaster.

1. Stable patients:
 - a. Arrange for car seats (see options in table below)
 - i. Donations
 - ii. Purchases
 - iii. Identify local sources to tap as needed
 - iv. Conduct just-in-time survey of employees re: car seats in their cars
 - b. Transport vehicles
 - i. Cars, vans, city or private buses with car seats, as indicated
 - ii. School buses for children ≥ 5 yrs who can sit up
 - iii. Driver must have cell phone or radio to communicate with hospital
 - iv. Appropriate medical personnel must accompany patients
 - v. Mental health or social service personnel should ideally accompany
2. Unstable or potentially unstable patients:
 - a. Appropriate transport vehicles
 - i. EMT or Paramedic ambulance with:
 1. Staff skilled in pediatric airway and resuscitation
 2. Equipment appropriate for age and acuity of patient
 3. Ongoing consultation with a pediatric expert
 - ii. Paramedic ambulance without hospital staff for less critical patients
 - iii. Specialty pediatric transport teams from referral pediatric institutions

Appropriate Use and Type of Car Seats			
	Infants	Toddler	Young Children
Age & Weight	Up to 1 year old AND 20 lb. or less.	Over 1 year to 4 years old AND over 20 lb.	Ages 4-8 AND over 40 lb.
Seat Type	Infant only or rear-facing convertible	Convertible / Forward-facing	Belt positioning booster seat
Seat Positioning	Rear-facing only	Forward-facing	Forward-facing
Cautions:	All children age 12 and under should ride in the back seat.		

Pediatric Surge: General guidelines

1. Activate hospital external disaster plan
2. ID and notify healthcare workers with pediatric clinical expertise
3. ID pediatric equipment, drug dosing guidelines, ventilators, availability of operating rooms and pediatric ICU beds
4. Prepare for stabilization and transfer as indicated.
5. Contact Hospital Control to determine hospitals with pediatric capability/capacity for possible transfer.
6. Set up family assistance area and separate area for media
7. Confirm hospital’s surge capacity for pediatric patients (number and severity)
8. Keep minimum of 5 cribs, port-a-cribs or playpens in storage.
 - If adult beds are only option, use beds with side rails, set a lowest possible height and with electric controls unplugged.
9. Decontaminate patients upon arrival, as indicated.
10. Keep appropriate-sized airway supplies readily available for each patient.
11. Plan for rush of media and anxious parents/family members (4-5 visitors/patient), including for security
12. Establish a Pediatric Safe Area (see Page 15).

EMERGENCY DEPARTMENT

Red-tagged patients (critical/unstable)

- Place in the most acute beds of the pediatric or, as necessary, of adult areas of the ED
- Management: ED attendings; transfer to PICU or pediatric ward attendings, if available
- Alert surgery (pediatric, when available) or Trauma Team
- Place all other surgical specialties on standby

Yellow-tagged patients (moderately injured or ill/potentially unstable)

- Place in non-acute beds of pediatric area; overflow to adult non-acute beds in ED
- Reevaluate frequently and treat and assign disposition in a timely manner

Green-tagged patients (minor or non-injured/stable)

- Triage to waiting room, other large waiting area or clinic (if available)
- Reevaluate frequently and discharge ASAP to an appropriately identified adult

	Critical/Unstable	Potentially Unstable	Stable
Color Triage	Red	Yellow	Green
Clinical Care Area	Resuscitation Area	Triage or other designated area	Fast Track or other designated area

ASSIGNMENT OF IN-PATIENT BED SPACE

I. Hospitals with a PICU

- Admit the most critical cases and/or youngest victims to PICU
- Manage overflow patients in monitored beds on ward or adult medical or surgical ICUs.
- Manage post-op patients in PACU.
- Admit moderately injured or ill patients to pediatric ward.
- As more space is needed, add 1 bed per room, if possible.
- Consider cohorting older pediatric patients on adult wards. Room sharing, if required should be with like-aged pediatric patients. Unaccompanied minors should only share a room with another unaccompanied pediatric patient.

II. Hospitals with pediatric beds but no PICU

- Transfer critical care pediatric patients to hospital with PICU as soon as possible.
- While awaiting transfer, Pediatric Staff can manage critical patients (in consultation with ED, anesthesia and/or adult critical care staff as needed):
 - in post-op recovery beds
 - in adult medical or surgical ICUs
 - in the emergency department
 - in monitored beds on the pediatric ward with pediatric RNs
- Manage moderately injured or ill children on pediatric ward (add beds as indicated).
- Consider cohorting oldest pediatric patients on adult wards. Room sharing, if required should be with like-aged pediatric patients. Unaccompanied minors should only share a room with another unaccompanied pediatric patient.

III. Hospitals without a Pediatric Service

- Transfer critical care pediatric patients to a hospital that can provide a higher level of care as soon as possible or when space is available.
- While awaiting transfer, ED, anesthesia, family medicine and/or adult critical care staff can manage critical patients in cooperation with pediatrics and/or pediatric critical care by phone consult:
 - in post-op recovery beds
 - in adult medical or surgical ICUs
 - in the emergency department

Non-critical patients can be admitted to adult wards if transfer is delayed or unavailable (cohort pediatric patients, whenever possible).

DECONTAMINATION OF THE PEDIATRIC PATIENT

- Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98°F.
- The smaller the child, the bigger the problems managing hypothermia, airway, separation from family and effective decontamination.

Situation: Children arrive at the hospital requiring decontamination.
Assessed by Visual Inspection Officer

Critical injuries are decontaminated first.
(Delay radiation decon if delayed treatment will harm patient)
Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority

Non-ambulatory

Ambulatory

Estimate child's age by visual inspection

- disrobe by child's caregiver and "hot zone" personnel
- place on a stretcher or restraining device
- escort through the decon shower by "hot zone" personnel and caregiver
- direct supervision of decon (of caregiver, too)
- monitor airway

School Age
(8 to 18 yrs old)

- disrobe w/o assistance
- respect modesty (may leave on underwear)
- respect privacy
- child decons him/herself, but goes through decon shower in succession with caregiver, parent, or

Preschool
(2 to 8 yrs old)

- assist disrobing (child's caregiver or "hot zone" personnel)
- direct supervision of decon
- monitor airway
- escort through the shower by either caregiver or "hot zone" personnel

Infants and Toddlers
(less than 2 yrs old)

- disrobe by child's caregiver and "hot zone" personnel
- place on a stretcher or restraining device
- escort through the decon shower by "hot zone" personnel and caregiver
- direct supervision of decon (of caregiver, too)
- monitor airway

(Caregiver should not carry the child due to the risk of accidental trauma resulting from a fall or from dropping the child while in the shower.)

- Treat or prevent hypothermia (towels, gowns, warming blankets)
- Immediately give a unique identification number on a wristband (or equivalent)
- Triage to an appropriate area for further medical evaluation

Please note: Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority

Pediatric Hospital-Based Triage

Step 1: Is decontamination required?

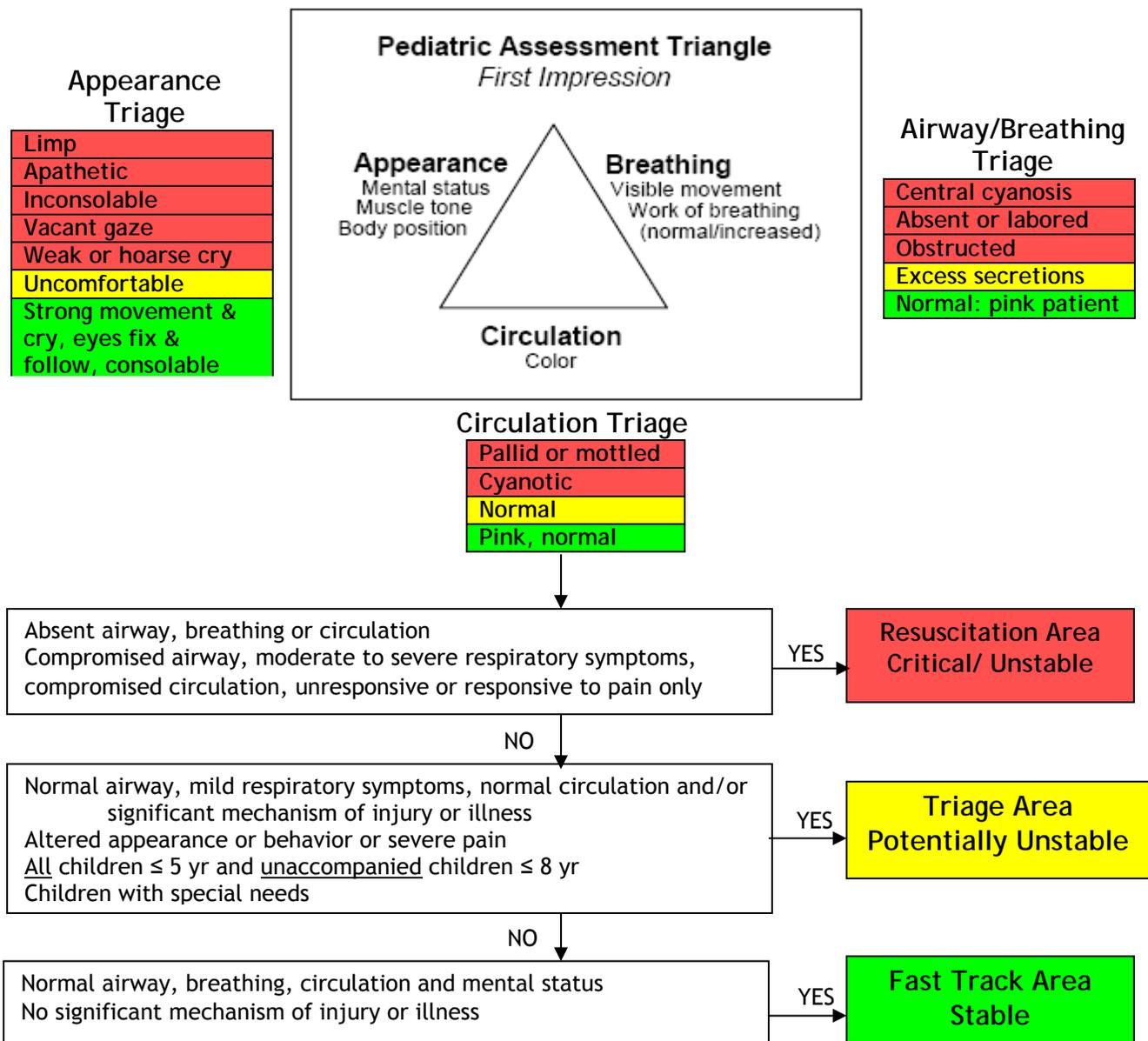
YES, Decontamination IS required:

1. Assessment and triage by Visual Inspection Officer 1 outside facility
2. Decontamination procedure outside
3. Reassessment and triage by Visual Inspection Officer 2 inside facility

NO, Decontamination is NOT required:

1. Assessment by Visual Inspection Officer 2
2. Triage to appropriate clinical care area

Step 2: Visual inspection triage via Pediatric Assessment Triangle (PAT)



Pediatric Assessment Triangle Criteria

Appearance

Assessment	Unstable or Potentially Unstable	Stable
Tone	Limp	Vigorous movement with good muscle tone
Interactivity	Apathetic; will not reach for a toy or respond to people, objects and sounds	Will reach for a toy; is alert and attentive to surroundings
Consolability	Agitated and crying; cannot be comforted	Responds to soothing
Look/Gaze	Vacant stare; will not focus on face or on an object	Eyes will fix on & follow your face or on a moving object
Speech/Cry	Weak, muffled or hoarse voice or cry	Strong voice or cry

Breathing

Assessment	Critical /Unstable	Potentially Unstable	Stable
Airway	Complete or partially obstructed OR significant blood or secretions	Patient with minimal secretions	Patent
Work of breathing	Absent or labored with periods of weakness	Normal	Normal
Respiratory rate	Apnea, bradypnea, tachypnea, irregular	Occasionally increased	Normal
Breath sounds	Absent or decreased Grunting, wheezing, stridor	Normal or slight wheezing	Normal
Central skin color	Pallid, mottled, cyanotic	Pink	Pink
Inspection	Suprasternal, supraclavicular or intracostal retractions	Suprasternal, supraclavicular or intracostal retractions	Normal
Muscle tone/body position	Hypotonia or atony	Normal tone, but may assume tripod position	Normal
Mental status	Extreme agitation or reduced responsiveness	Alert, agitated or combative	Normal
Pulse oximetry	Less than 85%	85% or higher	95% or higher

Pediatric Assessment Triangle Criteria (2)

Circulation

Assessment	Critical /Unstable	Potentially unstable	Stable
Heart rate	Tachycardia or bradycardia	Normal	Normal
Pulse strength	Weak central pulse, absent or weak peripheral pulse	Normal	Normal
Capillary refill	>3 to 5 seconds	<2-3 seconds	<2-3 seconds
BP	Hypotensive	Normal	Normal
Skin	Pallid, mottled, or cyanotic; cool	Normal	Normal

Average Respiratory Rate and Heart Rate by Age*

Age (years)	Respiration Rate (per minute)	Heart Rate (per minute)
Infant birth to 1 year	30 - 60	100 - 160
Toddler 1 to 3 years	24 - 40	90 - 150
Preschooler 3 to 6 years	22 - 34	80 - 140
School aged 6 to 12 years	18 - 30	70 - 120
Adolescent 12 to 18 years	12 - 16	60 - 100

* Pulse and respiratory rates may be somewhat lower for a child who is sleeping and higher for a child with fever.

RED Resuscitation Area

General:

- Patients are classified as Critical/Unstable by either the Visual Inspection Officer(s) or Triage.
- Resuscitation personnel should be trained in evaluation and management of critical pediatric patients.
- There will be a designated Unit leader in this area.
- A more detailed history and physical needs to be obtained.
- Once stabilized, the patient is sent to ED Treatment and Holding Area (Yellow) for continued care and management. The decision to send the patient is based on repeated assessment. In general, these patients do not require additional critical care and/or resuscitation.

Reassessment criteria include the following:

1. Breathing
 2. Circulation
 3. Appearance
 4. Mental Status
 5. Laboratory analysis, as indicated
 6. Radiological studies, as indicated
- In some cases, some patient will be sent to areas for Definitive Management. These areas include, but are not limited to, the Operating Room and the Pediatric Intensive Care Unit.
 - Patients who die will be sent to the area designated as the Morgue.

YELLOW Triage Area

General:

- Patients are classified as Potentially Unstable by the Visual Inspection Officer(s).
- Triage personnel should be trained in evaluation and management of pediatric patients.
- There will be a designated Unit Leader in this area.
- A more detailed history and physical needs to be obtained.
- The assessment will include a more detailed history and a “hands on” physical exam with the focus on detecting signs and symptoms specific to the suspected injury or illness. This reassessment is necessary to detect any change in clinical status since initial triage by visual assessment and to determine a treatment plan.

Reassessment criteria include:

1. Breathing
 2. Circulation
 3. Appearance
 4. Mental Status
 5. Laboratory analysis as indicated
 6. Radiological studies as indicated
- Based on the reassessment, the patient will be sent to the Resuscitation Area, ED Treatment and Holding Area/ Urgent Treatment, Fast Track or Minor Treatment Area or for Definitive Management through surgery or intensive care.

YELLOW

ED Treatment and Holding Area

General:

- Patients placed in this area are receiving definitive medical care and/or observation in the ED.
- These patients will be admitted for Definitive Management or discharged to Home, when appropriate.
- In cases where the patient’s clinical status deteriorates, the patient will be sent to the Resuscitation Area.

GREEN**Fast Track or Minor Treatment Area****General:**

- Patients are classified as stable by either the Visual Inspection Officer(s) or the Triage Area.
- Fast Track personnel should be trained in evaluation and management of pediatric patients.
- There will be a designated Unit Leader in this area.
- A more detailed history and physical needs to be obtained.
- The assessment will include a more detailed history and a “hands on” physical exam with the focus on detecting signs and symptoms specific to the suspected injury or illness. This reassessment is necessary to detect any change in clinical status since initial triage by visual assessment and to determine a treatment plan.

Reassessment criteria include:

1. Breathing
 2. Circulation
 3. Appearance
 4. Mental Status
 5. Laboratory analysis as indicated
 6. Radiological studies, as indicated
- Based on this examination, the patients will be sent to ED Treatment and Holding Area, Definitive Management or discharged Home, as indicated.
 - Patients waiting for assessment or treatment will be monitored at regular intervals using criteria from the Pediatric Assessment Triangle.

ANNEX

Pediatric Services Unit Leader (Job Action Sheet)

You report to: _____ (Operations Chief)

Command Center location _____ Phone number _____

MISSION: To ensure that the pediatric treatment and holding areas are properly assigned, equipped, and staffed during an emergency

IMMEDIATE:

- _____ Read this entire job action sheet
- _____ Obtain briefing from Unit Leader
- _____ Gather external information from Treatment Area Sup/ED Charge Nurse regarding:
- _____ Number of expected pediatric patients and their conditions
- _____ Whether decontamination is indicated
- _____ Expected time of patient arrival
- _____ Current total number of ED patients
- _____ Determine number of available pediatric/crib beds [in-patient] and report to Operations Chief for planning purposes
- _____ Determine on-site pediatric qualified staff members
- _____ Designate triage Visual Inspection Officers (1 and 2 if decontamination is indicated)
- _____ Determine additional staff needed based on expected patient volume
- _____ Alert Discharge Unit Leader to institute early discharge/transfer of patients
- _____ Initiate Pediatric Response Team as per plan:
- _____ Predetermined Physicians (Pediatric/Family Practice/ Staff/ Community)
- _____ Predetermined Nurses (with pediatric experience and/or PALS/ENPC certification)
- _____ Predetermined ancillary technicians with pediatric experience and others
- _____ Determine need for opening of a Pediatric Safe Area
- _____ Assign Pediatric Safe Area Coordinator
- _____ Communicate with Operations Chief to assure coordination of non-pediatric ancillary/support personnel as per the disaster plan
- _____ Assure preparation of a pre-designated Pediatric Disaster Care Areas:
- _____ Clear area and designate each specific area per plan and based on expected casualties
- _____ Assure support personnel are assigned to each area
- _____ Assure delivery of medical and non-medical pediatric equipment
- _____ Assure set-up of pediatric equipment by clinical staff
- _____ Receive pediatric patients and determine pediatric patient status
- _____ Communicate to Treatment Area Supervisor for dissemination as per disaster plan
- _____ After triage, move uninjured/unaffected children to designated Pediatric Safe Area

INTERMEDIATE:

- _____ Assess on-going staffing needs based on patient status report from:
- _____ Pediatric healthcare personnel (emergency department, in-patient, and OR)
- _____ Non-pediatric ancillary /support personnel
- _____ Pediatric Safe Area Coordinator
- _____ Assess additional medical and non-medical equipment/supply needs
- _____ Communicate with Pediatric Logistics Unit Leader via Ops Chief to Logistics Chief
- _____ Assure delivery of needed supplies to pediatric designated areas
- _____ Assess Pediatric Response Team basic needs: Food , rest, psychological support
- _____ Obtain status of pediatric casualties (discharges, admissions, transfers, and Pediatric Safe Area) and report to Operations Chief
- _____ Hold information sessions with Public Information Officer as needed
- _____ Obtain Child Survey Forms (See Security Section) from all pediatric patient areas
- _____ Report any unidentified or unaccompanied pediatric patients to Operations Chief

EXTENDED:

- _____ Debrief Pediatric Response Team and Pediatric Safe Area Coordinator regarding:
- _____ Summary of Incident, review of areas of success and opportunities for success

Pediatric Logistics Unit Leader (Job Action Sheet)

You report to: _____ (Logistics Chief)

Command Center location _____ Phone number _____

MISSION: To ensure that the pediatric needs are addressed by Procurement, Transportation, Materials Supply, and Nutritional Supply during an emergency

IMMEDIATE:

- _____ Read this entire job action sheet
- _____ Obtain briefing from Logistics Chief
- _____ Number of expected pediatric patients and their conditions
- _____ Timeline for supply needs
- _____ Meet with Logistics Chief and distribute tasks to the following Unit Leaders:
- _____ Procurement Unit Leader:
 - _____ Initiate Procurement Disaster Call list if warranted
 - _____ Work with vendors for pediatric supplies including hospital vendors and community resources (local pharmacies and grocery stores) for back-up resources
- _____ Transportation Unit Leader:
 - _____ Initiate Transportation Disaster Call list if warranted
 - _____ Count open stretchers, carts, cribs, and wheelchairs for pediatric transportation
 - _____ Ensure all adult equipment is appropriately modified and safe for pediatric transport
 - _____ Report transportation options to Logistics Chief
 - _____ Coordinate delivery of transportation options to designated pediatric area
 - _____ Designate transporters as needed from CS staff or Labor pool
 - _____ Ensure that all transporters are aware of pediatric safety issues and are not to leave pediatric patients unattended
- _____ Materials/Supplies Unit Leader:
 - _____ Initiate Materials/Supplies Disaster Call list if warranted
 - _____ Collect and coordinate essential pediatric medical equipment and supplies
 - _____ Assist in preparation of pre-designated Pediatric Disaster Care Areas with Pediatric Services Unit Leader
 - _____ Assist in preparation of pre-designated Pediatric Safe Area
- _____ Nutritional Supply Unit Leader:
 - _____ Initiate Nutritional Call list if warranted
 - _____ Estimate number of pediatric meals needed for 48 hours
 - _____ Estimate pediatric food/snacks/hydration needs for Pediatric Safe Area

INTERMEDIATE:

- _____ Obtain regular updates from Logistics Chief
- _____ Assess additional equipment/supply needs for pediatrics
- _____ Address pediatric concerns, questions and issues as needed

EXTENDED:

- _____ Document actions and decisions, submit reports to Logistics Chief
- _____ Participate in debriefing, review areas of success and opportunities for improvement

PEDIATRIC SAFE AREA (PSA) COORDINATOR (Job Action Sheet)

You report to: _____ (PEDIATRIC SERVICES UNIT LEADER)

Command Center location _____ Phone number _____

Mission: To ensure that the pediatric safe area is properly staffed and stocked for implementation during an emergency, and to insure the safety of children requiring the PSA until an appropriate disposition can be made.

Immediate:

- _____ Receive appointment from Pediatric Services Unit Leader
- _____ Read this entire job action sheet
- _____ Obtain briefing from Pediatric Services Unit Leader
- _____ Ascertain that the pre-designated pediatric safe area is available
- _____ If not immediately available, take appropriate measures to make the area available as soon as possible
- _____ Gather information about how many pediatric persons may present to the area
- _____ Make sure that enough staff is available for PSA
- _____ Make sure that enough security staff is available for PSA
- _____ Make sure that there is adequate communication in PSA
- _____ Make sure that there is a sign in/out log for PSA
- _____ Make sure that all items in PSA checklist have been met; if there are any deficiencies, address them as soon as possible and report them the PSUL

Intermediate:

- _____ Ascertain the need for ongoing staff for PSA
- _____ Maintain registry of children in PSA as they arrive or are released to appropriate adult
- _____ Determine estimated length of time for the expected operational period of PSA
- _____ Maintain communication with Pediatric Services Unit Leader for planning needs
- _____ Determine if there are any medical or non-medical needs specifically needed by pediatric persons in PSA
- _____ Prepare an informational session for the pediatrics persons in the PSA
- _____ Prepare to make arrangements for sleeping capacities if needed
- _____ Ascertain if there will be any additional needs required for this event (volunteers, staff, security, and equipment)
- _____ Make sure that pediatric persons have the appropriate resources (food, water, medications, age-appropriate reading materials) and entertainment for their stay
- _____ Report frequently to Pediatric Services Unit Leader concerning status of PSA

Extended:

- _____ Make sure that PSA staff have enough breaks, water, and food during their working periods
- _____ Coordinate with Psychological Support for ongoing evaluations of mental health of volunteers and pediatric persons in case of need for psychosocial resources
- _____ Document all action/decisions with a copy sent to the Pediatric Services Unit Leader
- _____ Other concerns: _____

Pediatric Safe Area Checklist

YES	NO	ITEM
		Needle boxes are at least 48 inches off the floor?
		Do the windows open?
		Are the windows locked?
		Do you have window guards?
		Plug-in covers or safety wiring for electrical outlets?
		Strangulation hazards removed (cords, wires, tubing, curtain/blinds drawstrings)?
		Can you contain children in this area (consider stairwells, elevators, doors)?
		Do you have distractions for the children (age and gender appropriate videos, games, toys)?
		Poison-proof the area (cleaning supplies, Hemocult developer, choking hazards, cords should be removed or locked)
		Are your med carts and supply carts locked?
		Do you need to create separate areas for various age groups?
		Have you conducted drills of the plans for this area with all relevant departments?
		Do you have a plan for security for the unit?
		Do you have a plan to identify the children?
		Do you have a plan for assessing mental health needs of these children?
		Are there any fans or heaters in use? Are they safe?
		Do you have an onsite or nearby daycare? Could they help you?
		Do you have enough staff to supervise the number of children (Younger children will require more staff)?
		Do you have a sign-in, sign-out sheet for all children and adults who enter the area?
		Will children need to be escorted away from safe area to bathrooms?
		Are age-appropriate meals and snacks available for children?
		Are various-sized diapers available?
		Does the PSA have hand hygiene supplies?
		Are there cribs, cots or beds available for children who need to sleep?
		Does the PSA have a policy/protocol for handling minor illness in children (Tylenol dosing, administering routine meds, etc)
		Do you have an evacuation plan?

Pediatric Safe Area Registry Sheet

#	Name of Child	Age	Arrival Time	Discharge Time	Disposition	Responsible Adult Name	Responsible Adult Signature	Contact Phone Number
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								

Disposition: Admit to Hospital (A) Discharged to Parent (D-P) Discharged to relative (D-R) Discharged to Other (D-O) Social Services Placement (SS) Police (PD)

Responsible Adult: Adult responsible for child at time of discharge. P.S.A. Coordinator should determine if child can be discharged to this adult based on hospital policy.

SAMPLE PEDIATRIC DISASTER MENU

The following sample diet for pediatric patients lists foods that require the minimal amount of preparation or power supply to maintain temperatures.

	Day 1	Day 2	Day 3
	Breakfast	Breakfast	Breakfast
0-6 months	Regular or Soy Formula	Regular or Soy Formula	Regular or Soy Formula
6 months - 1 yr.	Baby Cereal	Baby Cereal	Baby Cereal
	Jarred Baby Fruit	Jarred Baby Fruit	Jarred Baby Fruit
	Regular or Soy Formula	Regular or Soy Formula	Regular or Soy Formula
1 yr. and above	Cheerios (or Substitute)	Cheerios (or Substitute)	Cheerios (or Substitute)
	Warm cereal (1-2 years)	Warm cereal (1-2 years)	Warm cereal (1-2 years)
	Powdered Milk (> 2 years)	Powdered Milk (> 2 years)	Powdered Milk (> 2 years)
	Diced Canned Fruit	Diced Canned Fruit	Diced Canned Fruit
	Lunch	Lunch	Lunch
0-6 months	Regular or Soy Formula	Regular or Soy Formula	Regular or Soy Formula
6 months - 1 yr.	Jarred Baby Meat	Jarred Baby Meat	Jarred Baby Meat
	Jarred Baby Vegetable	Jarred Baby Vegetable	Jarred Baby Vegetable
	Jarred Baby Fruit	Jarred Baby Fruit	Jarred Baby Fruit
	Regular or Soy Formula	Regular or Soy Formula	Regular or Soy Formula
1 yr. - 2 yrs.	Cream Cheese/Jelly Sandwich	Macaroni and cheese	Cheese Wiz®
	Jarred Baby Vegetable	Jarred Baby Vegetable	Jarred Baby Vegetable
	Diced Peaches	Diced Pears	Diced Fruit Cocktail
	Bread/Crackers	Bread/Crackers	Bread/Crackers
	Warm cereal	Warm cereal	Warm cereal
2 yrs. plus	Cream Cheese/Jelly Sandwich	Macaroni and cheese	Peanut Butter/Jelly Sandwich*
	Diced Peaches	Diced Pears	Diced Fruit Cocktail
	Graham Crackers	Graham Crackers	Graham Crackers
	Powdered Milk	Powdered Milk	Powdered Milk
	Dinner	Dinner	Dinner
0-6 months	Regular or Soy Formula	Regular or Soy Formula	Regular or Soy Formula
6 months - 1 yr.	Jarred Baby Meat	Jarred Baby Meat	Jarred Baby Meat
	Jarred Baby Vegetable	Jarred Baby Vegetable	Jarred Baby Vegetable
	Jarred Baby Fruit	Jarred Baby Fruit	Jarred Baby Fruit
	Regular or Soy Formula	Regular or Soy Formula	Regular or Soy Formula
1 yr. - 2 yrs.	Cheese slices - chopped	Canned Chicken - Chopped	Cheese Ravioli
	Jarred Baby Vegetable	Jarred Baby Vegetable	Jarred Baby Vegetable
	Applesauce	Bananas	Baby Fruit
	Bread/Crackers	Bread/Crackers	Bread/Crackers
	Warm cereal	Warm cereal	Warm cereal
2 yrs. plus	Cheese Sandwich	Canned Chicken Sandwich	Cheese Ravioli
	Diced Fruit Cocktail	Diced Peaches	Diced Pears
	Graham Crackers	Graham Crackers	Graham Crackers
	Powdered Milk	Powdered Milk	Powdered Milk

*Watch for symptoms of rare incidence of peanut allergy

After a Disaster: Possible Reactions of Children

Children aged 5 and younger may:

- Have fears of being separated from a parent
- Be unusually fearful, “fussy”, clingy, and have crying bouts
- Return to outgrown behavior, such as bed-wetting or baby talk
- Have nightmares or problems sleeping
- Have stomachaches, headaches or other physical complaints that do not have a medical base
- Startle easily
- Have a loss or increase in appetite

Children aged 6 to 11 may:

- Engage in repeated play that depicts the disturbing events over and over
- Have nightmares or problems sleeping
- Have unusual outbursts of anger
- Withdraw from friends and family
- Be fearful, anxious or preoccupied with safety and danger
- Return to behavior they have outgrown
- Express feelings of guilt
- Have frequent stomachaches, headaches or other physical complaints that do not have a medical base
- Have problems concentrating
- Experience persistent, disturbing feelings and memories when reminded of the event

Children aged 12 to 18 may:

- Have appetite changes
- Headaches, gastrointestinal problems
- Loss of interest in social activities
- Sadness or depression
- Feelings of inadequacy and helplessness
- Feelings of anger and aggression
- Isolation from others, less interests in friendships
- Repetitive behaviors such as hand-washing

After a Disaster: A Guide for Parents and Caregivers

(From the National Institute of Mental Health)

Natural disasters such as tornados, or man-made tragedies such as bombings, can leave children feeling frightened, confused, and insecure.

Whether a child has personally experienced trauma or has merely seen the event on television or heard it discussed by adults, it is important for parents, care-givers, and teachers to be informed and ready to help if reactions to stress begin to occur.

Children respond to trauma in many different ways. Some may have reactions very soon after the event; others may seem to be doing fine for weeks or months, then begin to show worrisome behavior. Knowing the signs that are common at different ages can help parents and teachers to recognize problems and respond appropriately.

Preschool Age

Children from one to five years in age find it particularly hard to adjust to change and loss. In addition, these youngsters have not yet developed their own coping skills, so they must depend on parents, family members, and teachers to help them through difficult times.

Very young children may regress to an earlier behavioral stage after a traumatic event. For example, preschoolers may resume thumb sucking or bedwetting or may become afraid of strangers, animals, darkness, or "monsters." They may cling to a parent or teacher or become very attached to a place where they feel safe.

Changes in eating and sleeping habits are common, as are unexplainable aches and pains. Other symptoms to watch for are disobedience, hyperactivity, speech difficulties, and aggressive or withdrawn behavior. Preschoolers may tell exaggerated stories about the traumatic event or may speak of it over and over.

Early Childhood

Children aged five to eleven may have some of the same reactions as younger boys and girls. In addition, they may withdraw from play groups and friends, compete more for the attention of parents, fear going to school, allow school performance to drop, become aggressive, or find it hard to concentrate. These children may also return to "more childish" behaviors; for example, they may ask to be fed or dressed. Do boys and girls act differently?

Adolescence

Children twelve to fourteen are likely to have vague physical complaints when under stress and may abandon chores, school work, and other responsibilities they previously handled. While on the one hand they may compete vigorously for attention from parents and teachers, they may also withdraw, resist authority, become disruptive at home or in the classroom, or even begin to experiment with high-risk behaviors such as drinking or drug abuse. These young people are at a developmental stage in which the opinions of others are very important. They need to be thought of as "normal" by their friends and are less concerned about relating well with adults or participating in recreation or family activities they once enjoyed.

In later adolescence, teens may experience feelings of helplessness and guilt because they are unable to assume full adult responsibilities as the community responds to the disaster. Older teens may also deny the extent of their emotional reactions to the traumatic event.

How to Help

Reassurance is the key to helping children through a traumatic time. Very young children need a lot of cuddling, as well as verbal support. Answer questions about the disaster honestly, but don't dwell on frightening details or allow the subject to dominate family or classroom time indefinitely. Encourage children of all ages to express emotions through conversation, drawing, or playing and to find a way to help others who were affected by the disaster.

Try to maintain normal routines and encourage children to participate in enjoyable activities. Reduce expectations temporarily about performance in school or at home, perhaps by substituting less demanding responsibilities for normal chores. Finally, acknowledge that you, too, may have reactions associated with the traumatic event, and take steps to promote your own physical and emotional healing.

When to Seek More Help

Consultation with a mental health professional may be useful at any of these times. However, psychiatric consultation should be sought if any of the following is exhibited:

- Excessive fear of something terrible happening to their parents or loved ones
- Excessive and uncontrollable worry about things, such as unfamiliar people, places or activities
- Fear of not being able to escape if something goes wrong
- Suicidal thoughts or the desire to hurt others
- If the child has hallucinations
- Expressing feelings of being helpless, hopeless, and worthless

PATIENT EVACUATION TRACKING FORM – ACUTE CARE

(Barcode)
(Ascending Patient Tracking #)

Place PATIENT Sticker Here (all 4 copies) or write in:

Patient Name: _____
MR #: _____ DOB: _____

Place FACILITY Sticker Here (all 4 copies) or write in:

Facility Name: _____
Phone: _____ Fax: _____

PATIENT INFORMATION

SENDING FACILITY: TO BE COMPLETED PRIOR TO PATIENT MOVEMENT FROM THE UNIT

A. **Face Sheet Attached:** Y / N B. **Room/Bed #:** _____ C. **Sex:** M / F D. **Weight:** _____ kg/lb (circle)
 E. **Internal Holding Area Patient will be sent to:** Bypass: Direct to Transport **OR** Location: _____
Recommended Transport: Ambulance (Paramedic) Ambulance (EMT) Wheelchair Non-medical Other:
 G. **Family Notification:** Y / N Family Name: _____ Time: _____ Cell#: _____ Ph#: _____
Legal Guardian Notification: Y / N Guardian Name: _____ Time: _____ Cell#: _____ Ph#: _____
Sending MD: _____ Ph#: _____ Time: _____
PMD Notification: Y / N PMD Name: _____ Time: _____ Ph#: _____
 H. **Interpreter:** Y / N Language: _____ I. **Sign Language:** Y / N

GENERAL

A. **Code Status:** Full Code No Code DNR DNI CMO (Attach Orders) Advance Directives: Is Document Present Y / N
 B. **Allergies:** _____
 C. **Primary Dx:** _____ **Secondary Dx:** _____

CRITICAL MEDICAL DATA

A. **Precautions:** Suicidal Contact Airborne Droplet Reason: _____
 B. **Diabetic:** Y / N Last Meal: _____ Insulin: Y / N Last finger stick time & value (standard value): _____
 C. **Immunocompromised:** Y / N D. **Level of Consciousness:** _____
 E. **Vision Intact:** Y / N F. **Hearing Intact:** Y / N G. **Language Barrier:** Y / N
 H. **Last Vital Signs Stable:** Y / N If NO – Document: _____
 I. CHF CAD (unstable) Chronic Lung Disease Full Anticoagulation Post-op Patient Acute Alcohol Withdrawal
 Open Wound *Attach recent imaging / lab studies, if possible*

EQUIPMENT

A. **Lines/Tubes/Drains:** Chest PEG NGT IV - Central/Peripheral (circle) Ostomy - Urine/Colon (circle) Foley
 Wound Drain Other: _____
 B. **Vent/C-PAP/Bi-PAP:** Y / N Document: _____
 C. **Wound:** Y / N Location: _____
 D. **Special Bed:** Y / N Type: _____ E. Oxygen F. Suction: Freq/Type of Secretion: _____
 E. **Dialysis:** Y / N Last Dialysis (Date/Time): _____

SAFETY / BEHAVIORAL / RESTRAINTS

A. **Seizure:** Y / N B. **Aspiration:** Y / N C. **Fall Risk:** Y / N
 D. **Restraints:** Behavioral Medical Time Started: _____
 E. **Behavior Concerns:** Y / N List: _____ Duty to Warn – Completed: Y / N
 F. **Transfers:** Dependence - Independent Supervision Partial Assist: 1 / 2 person

CRITICAL MEDS

CRITICAL MEDS – MAR Attached: Y / N (if not attached, include medication, dose, route & last dosage):

This Portion of Form Completed By (Printed Name/Signature/Phone/Date):

HOLDING AREA

SENDING FACILITY: TO BE COMPLETED AT TIME OF ARRIVAL INTO AND UPON DEPARTURE FROM HOLDING AREA

A. **Holding Area Location:** _____ Time Arrived: _____ Received by (Name): _____
 B. **Time Departed:** _____ Destination Facility: _____
 C. **Vehicle ID** (Company Name, Vehicle#, State): _____
 Accompanied by (staff/family member name): _____
 D. **Patient ID Band/Nametag Confirmed:** Y / N / n/a
 E. **Equipment Sent with Patient:** C-PAP/BiPAP: _____ Dialysis Machine External Pacemaker
 Isolette/Warmer IV Pumps: _____ Monitor NEO puff Pulse Oximeter Syringe Pump: _____
 Ventilator: _____ Other: _____
 F. **Items Sent with Patient*:** DVD-Radiographs Personal Belongings (with patient / left on unit / none)
 Medical Record Medications Valuables (with patient / left on unit / none) Other: _____
This Portion of Form Completed By (Printed Name/Signature/Phone/Date):

RECEIVING

RECEIVING FACILITY: TO BE COMPLETED AT TIME OF ARRIVAL AT RECEIVING FACILITY

A. **Time/Date Arrived:** _____ Facility Name: _____ Received by (Name): _____
 Initial Care Location: _____ Patient ID Band/Nametag Confirmed: Y / N
 B. **Receiving Facility MR#:** _____ **New Patient Tracking #:** _____
 C. **Confirmed Receipt of Patient:** with Sending Facility **OR** with Regional Call Center
 D. **Equipment Received with Patient** (verify against list for HOLDING AREA and note changes): _____
 E. **Items Received with Patient** (verify against list for HOLDING AREA and note changes): _____
This Portion of Form Completed By (Printed Name/Signature/Phone/Date):
