Healthcare System Emergency Response Plan

Burn Surge Annex

Version 2, June 2026

Contact Information:
NWHRN Duty Officer: 425-988-2897
UW Medicine Regional Burn Center at Harborview:
1-877-520-7575
Western Region Burn Coordination Center: 1-866-364-8824

Record of Changes

Version No.	Description of Change	Date Entered	Posted By
1.	Plan development and review by partner agencies	2022	Vicki L. Sakata, MD Marissa Cummings, MPH
2	Plan review and update	2026	Vicki L. Sakata, MD

Acknowledgements

A special thank you to the University of Washington Regional Burn Center at Harborview and the Western Region Burn Disaster Consortium (WRBDC) and for their expertise and assistance in developing and compiling this information.

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Introduction: Overview and Background

A surge in burn injury patients requires a significant amount of coordination and collaboration to provide the best care possible. A burn mass casualty incident (BMCI) is defined as an incident where capacity and capability may significantly overwhelm a local response, thus necessitating coalition, state, and/or federal coordination.

The University of Washington Regional Burn Center at Harborview (UWRBC) provides burn expertise not only for Washington State, but for the WAMI region (Washington, Alaska, Montana, Idaho) which is part of the American Burn Association's (ABA) Western Burn Region (**See Figure 1**), Therefore UWRBC is a key partner in the development and maintenance of burn specific plans, including this Annex. In the event of a burn disaster or emergency, all hospitals, including those that are not necessarily burn centers, may receive critically injured patients and must have individual plans in place to identify, stabilize and coordinate care. The unique needs of critically injured burn patients make it necessary to integrate special considerations for disaster preparedness, response, and recovery planning.

This Burn Surge Annex is intended to be flexible to fit the needs of the response to a BMCI. It contains guidelines for burn surge response in the Northwest Healthcare Response Network (NWHRN) service area, including a concept of operations, roles and responsibilities, and special considerations. Appendices provide resources to assist individual facilities in the development of individual burn surge plans, including staff training and augmentation, supplies and equipment, and clinical considerations including information for scarce resource planning.

This Annex is compatible with federal, state, and local emergency response plans and promotes the coordination of an efficient and effective response by utilizing the concepts outlined in the National Incident Management System and establishes common goals, strategies, and terminology consistent with other regional and local plans.

Purpose

The purpose of this Annex is twofold: 1) to provide healthcare with the clinical information and tools necessary to develop internal burn surge response plans per the burn capabilities within their facility, and 2) to provide a concept of operations to support a coordinated regional surge response within the NWHRN service area in the event of a BMCI. The goal of this Annex is to ensure the highest standard of care possible for the greatest number of patients given the situation at hand.

Specifically, the purpose of this Annex is to:

- Ensure that all inpatient hospital facilities will be prepared to care for burn patients to the best of their capability and have burn disaster plans to accommodate burn surge.
- Provide clinical resources, especially for those facilities not routinely caring for burn patients.
- Provide burn-specific coordination information needed to inform response between healthcare and all stakeholders who are vital for a successful burn response, which

includes but is not limited to public health, healthcare agencies the local/state Disaster Medical Coordination Centers (DMCCs), emergency management, and any state and federal partners.

- Provide burn-specific information for safe patient transfer and tracking, specifically addressing unique aspects of burn patients (e.g., burn degree severity, triage, pediatric patient care, and the management of an unaccompanied minor).
- Provide information for scarce resource planning, such as addressing staffing resources and specialized supplies.
- Define roles and responsibilities for healthcare, the NWHRN, Local Health Jurisdictions (LHJs), local response agencies (including local DMCCs), emergency management, state and federal partners in a burn surge response.

Scope

This document is an appendix to the NWHRN's overall Healthcare Emergency Operations Base Plan, which should be referred to for healthcare response concepts (**See Appendix A**). This Annex is intended to be used in conjunction with other planning documents and not as a stand-alone plan. The Burn Surge Annex is applicable for BMCI events necessitating local and/or regional healthcare response coordination among partners within jurisdictions encompassed by the NWHRN.

This plan will utilize existing command and coordination structures and communication protocols and may be used to support existing and future burn plans developed and/or distributed by Washington State and the University of Washington Regional Burn Center at Harborview.

Planning Assumptions

All planning assumptions outlined in the NWHRN Healthcare Emergency Operations Base Plan apply to this Annex. Specific assumptions to this Burn Surge Annex are as follows:

- All healthcare facilities providing emergency care may receive critically injured burn patients and should be able to provide initial assessment and stabilization.
- Definitive care of critical burns is extremely resource-intensive and when possible, given the situation requires specialized staff, expert advice, and critical care transportation assets.
- Federal resources (e.g., ambulance contracts, National Disaster Medical Systems (NDMS) teams), may potentially be available to assist but cannot be relied upon to mobilize and deploy for the first 72 hours at minimum. Therefore, in the case of an overwhelming BMCI, it may be necessary to activate the WRBDC for external assistance.

Concept of Operations

A. Activation of the Annex

- This Annex may be activated during any known or anticipated BMCI that warrants coordination between one or more healthcare organizations and other emergency

response partners. This activation may occur concurrently with the activation of other plans within and/or outside the area.

- A request for activation of this Annex may originate from any local healthcare organization, local and/or state Disaster Medical Coordination Center (DMCC), Local Health Jurisdictions (LHJ), or emergency management agency, as well as the healthcare coalition. Activation of this Annex should be done in consultation and communication with UWRBC at Harborview.

B. Notification and Warning

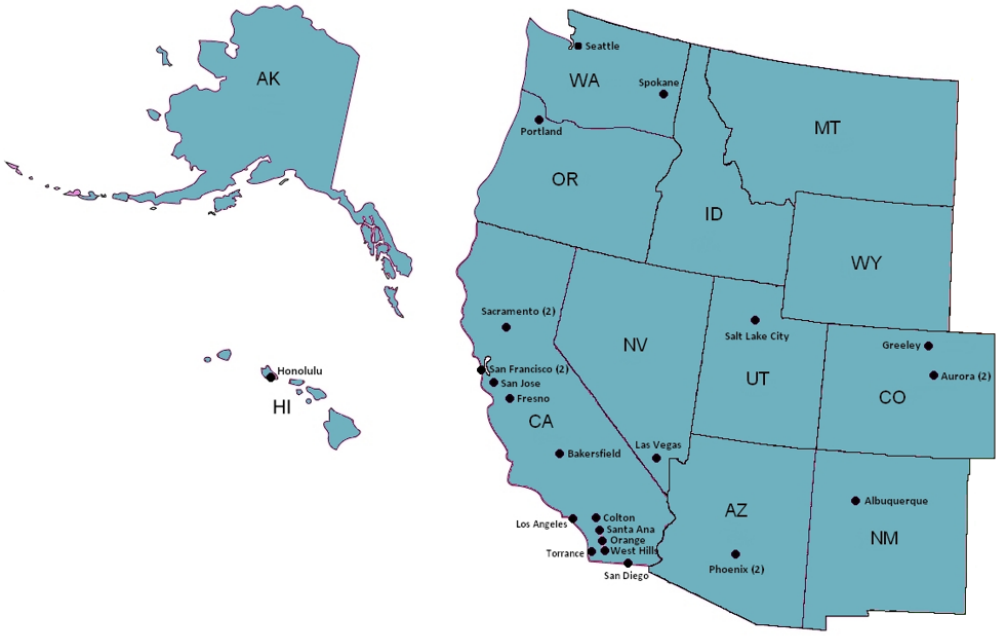
- Partner emergency operations (including UWRBC) may activate prior to or following the activation of this Annex. The NWHRN Healthcare Emergency Coordination Center (HECC) will operate in coordination with any other activated local/regional/state coordination centers per procedures outlined in the NWHRN Emergency Operations Base Plan (see **Appendix A**)
- The HECC will activate prior to or concurrently with the activation of this Annex.
- Following an incident where patients are identified as needing specialty burn care, the local EMS agencies and DMCC responding should contact the UWRBC via their transfer center at **1-877-520-7575**.
- The responding DMCC will notify the NWHRN and local area hospitals receiving patients.
- NWHRN will be responsible for notifying other partners as needed as outlined in the NWHRN Emergency Operations Base Plan
- Please refer to **Figure 2** to see the detailed burn incident notification flowchart.

C. Inter-State Notification

When a burn surge beyond coalition and/or state capacity occurs or is anticipated, UWRBC, state or local DMCC, the HECC and DOH will discuss notification of the Western Region Burn Coordination Center (WRBCC).

The Western Region Burn Coordination Center (WRBCC) is an asset that can be activated by WA State DOH in consultation with the UWRBC, if inter-state burn care assistance is needed. The WRBCC can help to offload care and support the transfer of burn patients in a BMCI when UWRBC is overwhelmed. This occurs by accessing Burn Physicians and Coordinators who are on-call and who can give basic consultation via telemedicine up to and including helping connect other burn centers as possible transfer options. Activating the WRBCC will initiate a burn bed count for the Western Region Burn Disaster Consortium (WRBDC) service area to identify possible patient transfer destinations (**See Figure 1**). The WRBCC Burn Mass Casualty Incident Operations Plan provides more details on the assistance that can be provided at the regional level. The WRBCC 24/7 Hotline is **1-866-364-8824**. Please refer to Figure 2 to see the detailed burn incident notification flowchart.

Figure 1: Western Region Burn Disaster Consortium



- Alaska
- Arizona
- California
- Colorado
- Hawaii
- Idaho
- Montana
- Nevada
- New Mexico
- Oregon
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- Washington
- Wyoming

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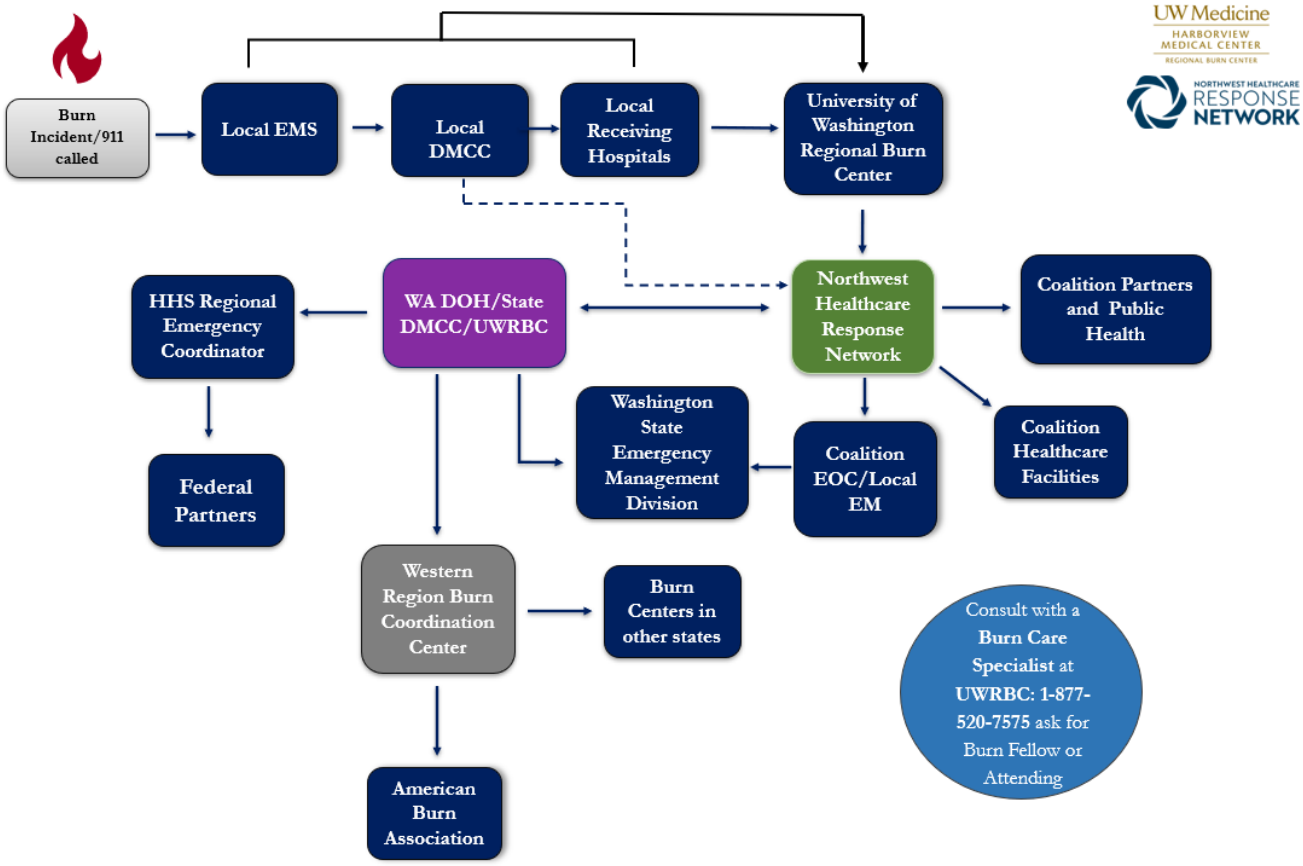
Figure 2: Burn Incident Notification Flowchart



D. Command, Control, and Coordination

- An effective response to any disruptive event requires coordination, communication and awareness of each partner's role and responsibilities. Exact procedures will vary given the situation at hand, but when activated, the NWHRN Healthcare Emergency Coordination Center (HECC) supports and identifies needed action items and the operations needed to execute the needed mission. As mentioned above this annex is activated in conjunction with the NWHRN Healthcare Emergency Operations Base Plan to support response and coordination. Please refer to NWHRN Healthcare Emergency Operations Base Plan (**Appendix A**).

i. Essential Elements of Information (EEI)

- The use of situational awareness to inform a common operating picture for healthcare during an incident or event that requires targeted and strategic data and information gathering from various healthcare partners.
- Information considered critical for a burn event would include but not be limited to the number and ages of injured patients, percent burn and triage categories, specialty burn transport criteria, relevant comorbidities, specific specialty patient needs, in particular pediatric patients, burn-specific staff or supplies, etc.

- For more information on EEI, please refer to **Appendix B**, the NWHRN Situational Awareness Annex.

ii. Inter-state Coordination

- If inter-state or federal assistance is required DOH will be notified and along with UWRBC will assess and determine further needs including the activation of the WRBCC. If activated, the WRBCC will work with UWRBC and/or the State DMCC to help facilitate appropriate transfer to out-of-state burn beds for definitive care.
- NWHRN will support coordination and communication as needed between all stakeholders in the event of inter-state activation for patient movement.

D. Roles and Responsibilities

Roles and responsibilities for all stakeholders to include healthcare, NWHRN, LHJs, local response agencies, emergency management, state, local, tribal and federal partners will include those outlined in the NWHRN Healthcare Emergency Operations Base Plan.

Roles and Responsibilities specific to this Annex include the following:

A. Primary Organization:

a. Northwest Healthcare Response Network:

- Maintain, update and inform partners about the Coalition Burn Annex.

b. Local Health Jurisdictions (Public Health):

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Activate LHJ plans as indicated and provide public health assistance including but not limited to coordination of information, requesting additional jurisdictional assistance, and communicating with other stakeholders per response plans.
- Support and coordinate mutual aid requests as needed.

c. Local DMCC:

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Notify UWRBC of any significant burn event to coordinate triage and patient distribution.

- Notify NWHRN Duty Officer (425-988-2897) of BMCI for situational awareness.
- Assist with EEI and situational awareness as needed to support coordinated response.
- Triage/prioritize patient movement to specialty centers with assistance from UWRBC subject matter experts (SME).

d. Emergency Management Agencies:

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Activate as appropriate and implement local plans as indicated given the situation at hand.
- Support local resource requests and the procurement of resources, as well as support mutual aid if needed.

e. Non-Burn Designated Hospitals:

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Have and maintain a burn surge disaster plan, which should include initial stabilization, consultation, and transfer protocols for burn patients.
- Supply EEI and situational awareness as needed to support coordinated response.
- Provide patient care to the best of the facility's capabilities prior to transferring patients to a higher level of care if needed.

f. UW Medicine Regional Burn Center at Harborview (UWRBC):

- Partner with NWHRN in the maintenance and update of the NWHRN Coalition Burn Surge Annex.
- Have, maintain, and activate a burn mass casualty incident surge plan that coordinates intra and inter-state care for burn patients.
- Provide and maintain clinical guidelines for the triage, stabilization, and transfer protocols for burn patients.
- Supply EEI and situational awareness as needed to support coordinated response including communication with local DMCCs and WRBCC as the situation warrants.
- Support non-burn center facilities providing care for burn patients in the region via telephone/telemedicine as able given the situation at hand. Initiate and/or coordinate requests for specialized supplies such as tissue bank products, and graft equipment with appropriate stakeholders.

g. Emergency Medical Services:

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Have and maintain burn transportation protocols which should include stabilization, consultation, and transfer protocols for burn patients.

- Rescue, transport, and distribute casualties to appropriate local facilities in accordance with established protocols.
- Supply EEI and situational awareness as needed to support coordinated response.

B. Supporting Organizations:

a. Washington State Department of Health (DOH)/Washington State Emergency Management Division (EMD):

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Support local jurisdictions with state-level coordination and requests for assistance.
- Support and coordinate state-to-state transfer of resources.
- Make requests for burn care assets including dressings and other materials from outside resources such as the Strategic National Stockpile (SNS) if local resource requests are not fulfilling resource needs.
- Liaise between local, state, and federal resources to provide situational awareness and coordinate response efforts specific to a burn incident
- Consult with UWRBC to determine the need for activation of the WRBCC.

b. Western Region Burn Coordination Center (WRBCC):

- Serve as the point of contact for the ABA system.
- Conduct bed polling and request assistance from neighboring ABA regions as needed.
- Assist UWRBC and/or state DMCC in determining appropriate patient destinations and transportation.
- Assist NWHRN with inter-state tracking of patient movement including arrival to destination centers.
- Provide additional assistance for specialized supplies upon request.
- Support the local burn center with additional resources should the burn center not be able to support all patient care and/or telephone/telemedicine services.

c. Federal Partners

- Coordinate with DOH when a response exceeds local and state resources.
- Coordinate federal-level resources, requests, and any national resource stockpiles specific to a BMCI
- Provide federal support to local and state activities as requested under the National Response Framework, including supplies, staff, and transportation assistance through the Federal Coordination Center appointed to the State for the incident.

Resources Logistics

E. Burn Resource Requests

- Requests for burn-specific supplies will follow local resource request procedures either through the NWHRN and/or local jurisdiction as outlined in the NWHRN Emergency Response Plan **(See Appendix A)**.

F. Space

- UWRBC provides burn expertise not only for Washington state but for the WAMI region of the American Burn Association's Western Burn Region. The UWRBC has 18 designated ICU and 22 designated acute care burn beds. However, every healthcare facility should have the capabilities and plans to identify, triage, and stabilize a burn patient.

G. Staff

- Facilities should have an established protocol to utilize staff to support burn patients.
- Provide burn training for staff and plans to utilize and allocate burn-trained staff. Specifically, Level II & III Trauma Centers should consider having a cohort of providers trained in the ABA Advanced Burn Life Support (ABLS) and ACS Disaster Management Emergency Preparedness (DMEP).
- Implement just-in-time (JIT) training resources for burn care, including:
    - Project ECHO Burn and Soft Tissue Injury Education Series
    - Prolonged care of the burn patient in a non-burn facility following a Mass Casualty Incident, E-learning modules (requires login – see below) and pages 44-60 of the WRBDC Burn Mass Casualty Operations Plan.

Use of all University of Utah WRBDC resources requires registration using this link:
https://crisisstandardsofcare.utah.edu/
Registration is free but may take a few days to obtain. It is highly recommended that access is obtained prior to an event so as not to delay access.

- Implement internal staff augmentation procedures **(See Appendix C Staffing Scarce Resource Card)**.
- Provide basic burn training opportunities for interested trauma surgeons and nurses – See below for additional training resources.

H. Supplies

- All facilities should ensure that they are aware of and have access to the supplies and equipment necessary for the treatment of a burn patient, as found in the WRBDC Burn Mass Casualty Operations Plan: Wound Care Supply Guideline for Burns (pg. 43) and the Pediatric Equipment and Supplies list (pg. 61). Please note that these lists are not

exhaustive and are meant to be a supplement to standard supply cart items and personal protective equipment a facility would typically provide.

- If additional resources are needed, please refer to **Appendix A** for Resource Requesting procedures.

I. Burn Care Training and JIT Quick Resource Cards and Algorithms

During a BMCI, non-burn center facilities need to have a basic understanding of stabilization and initial care of burn patients. UWRBC has developed useful JIT resource cards for hospitals and EMS to include steps for burn stabilization and resuscitation. They also offer extensive open access YouTube training videos. Resources and links can be found below in Appendix 3 and Appendix 4.

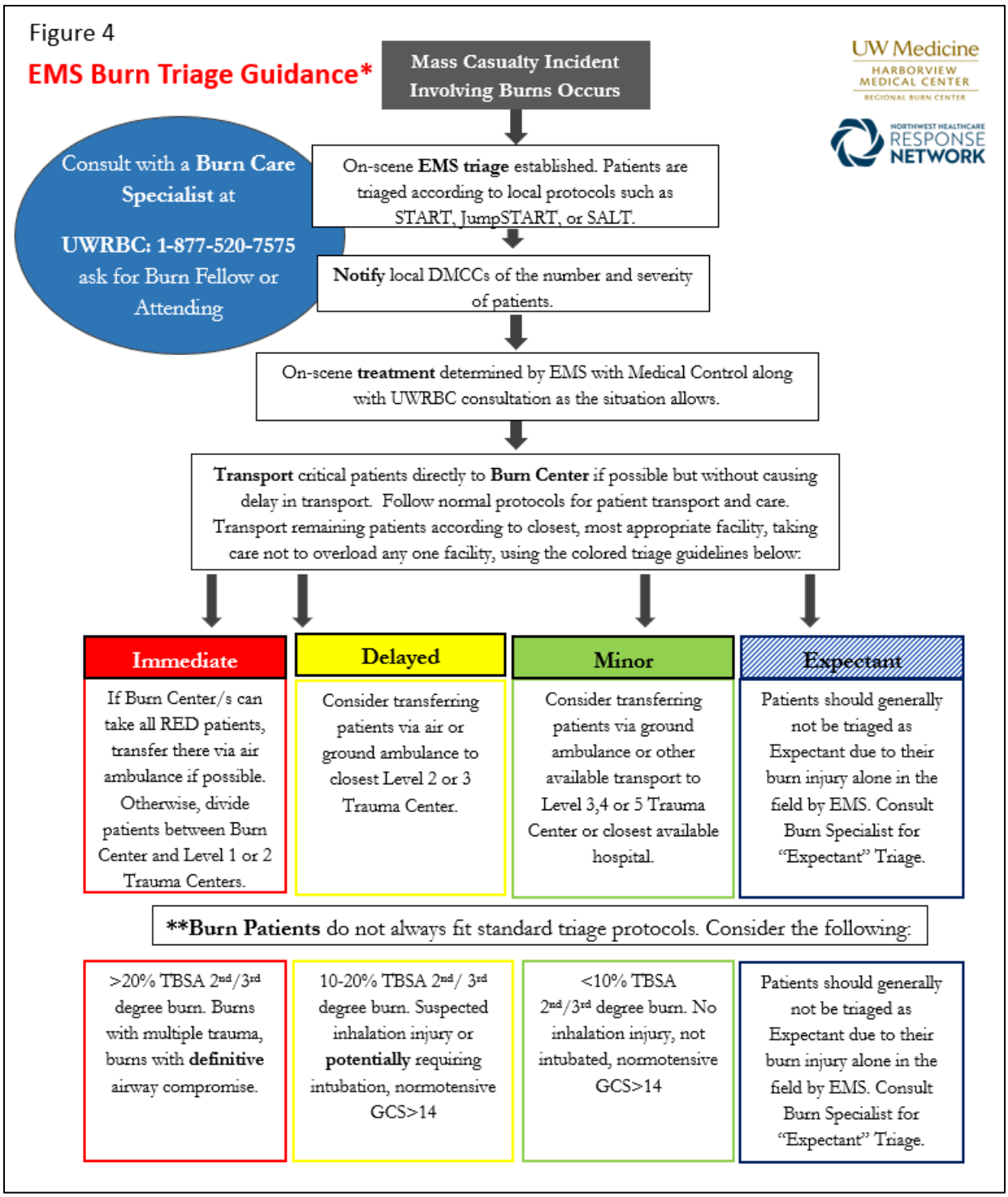
Operations - Medical Care

J. Triage and Treatment

Non-burn designated facilities receiving burn patients will immediately begin triage and treatment according to local protocols. For more information on EMS Triage for initial on-scene triage, please refer to the EMS Burn Triage Flowchart (**Figure 4**). For more information on Hospital Triage following patient arrival from EMS transport, please refer to the Hospital Burn Patient Triage Flowchart (**Figure 5**). Additionally, there are multiple resources available for burn care triage and treatment, which can be found in the Appendices.

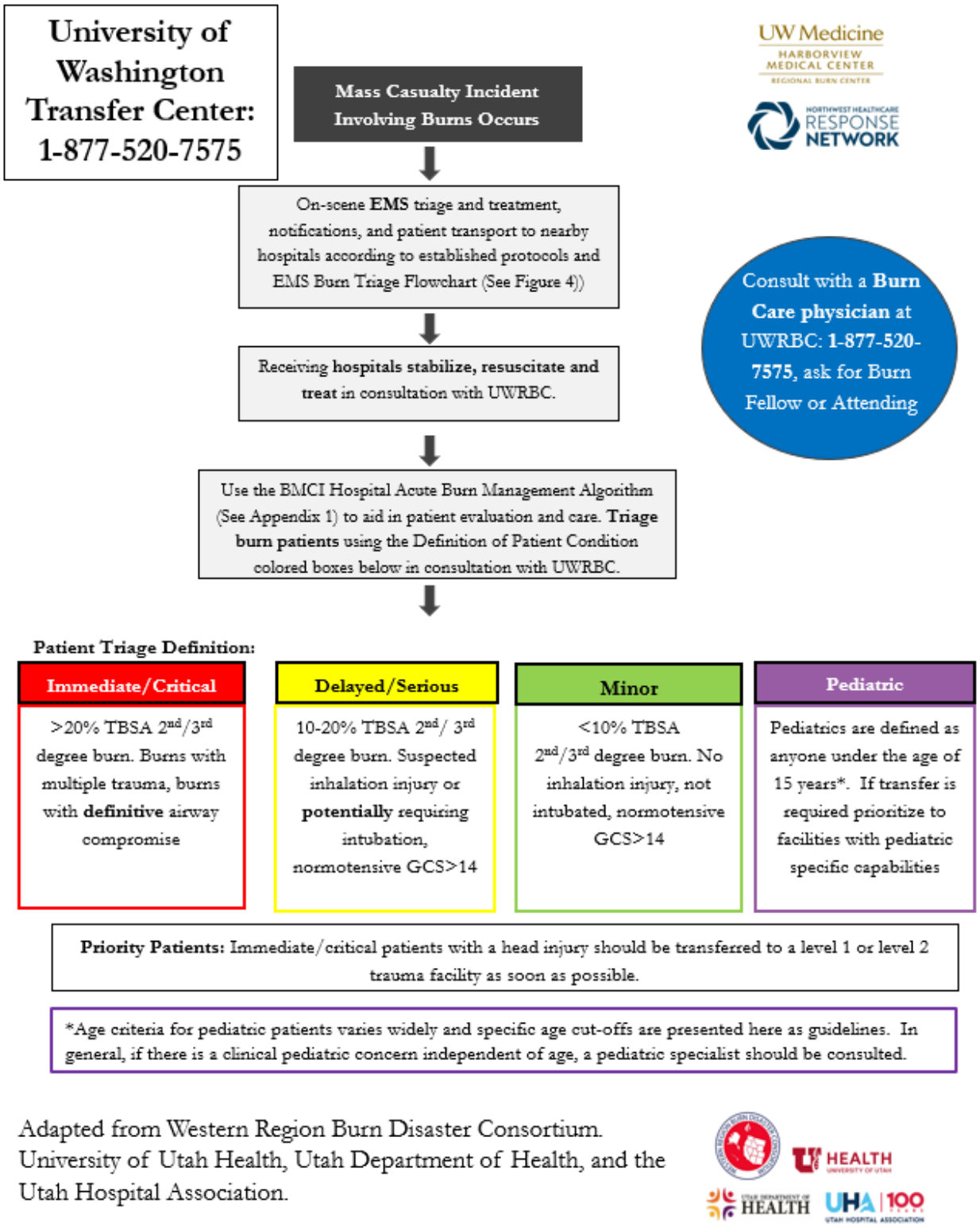
Phone consultation with UWRBC is available by calling **1-877-520-7575**. Photo transmission of burn injuries is available through the burn phone consultation service and aids in providing SME input for triage and treatment plans. UWRBC has telehealth capabilities that can be activated if emergency credentialing at referral facilities can be granted in a timely manner. Streamlining telehealth capabilities in Washington State is an ongoing process and as more information is available this Annex will be updated.

Figure 4: EMS Burn Triage Guidance



*Adapted from Western Region Burn Disaster Consortium. University of Utah Health, Utah Department of Health, and the Utah Hospital Association.

Figure 5: Hospital Burn Patient Triage Flowchart



Adapted from Western Region Burn Disaster Consortium. University of Utah Health, Utah Department of Health, and the Utah Hospital Association.

K. Patient Tracking (WATrac)

Following a mass casualty incident, burn patients will be tracked to their final hospital destination via WATrac or a paper-based method per NWHRN Patient Tracking Appendix **(See Appendix D)**.

Pediatric patients require special consideration, especially if they are unaccompanied minors. See NWHRN Pediatric Toolkit, Attachment Section 3 "Pediatric Security", regarding Pediatric Tracking and unaccompanied minors including forms and procedures if the burn patient is less than 18 years old. If an unaccompanied minor is transferred between facilities, it is crucial that a Patient Identification Form (**Appendix 8**) is completed and kept on record. A copy of this form should accompany the child at all times and the child should have a designated escort at the facility and/or during a transfer to another facility. If medical attention is needed appropriate medical transfer to a facility with pediatric capabilities should be arranged, when possible, given the situation at hand.

L. Transportation

Facilities should have proper procedures in place to transport patients safely to appropriate facilities. In the event that a local and/or state DMCC has been activated, transport control will follow established procedures as outlined in the NWHRN Patient Movement Plan **(See Appendix E)**. Incident Command on scene will communicate with the appropriate DMCC to coordinate vehicles and patient destinations.

If local transport resources have been exhausted including local transport surge plans and MOUs, and/or if patients need to be transported outside of the region/state, transport requests should be made to the state via the local emergency management process.

M. Burn Patient Transfer Decision

The decision to transfer a patient to another facility for definitive care is complex and relies on consideration of several factors to determine which patient is transported to each facility and when. Facilities should follow their local transfer protocols first, prior to immediately reaching out to UWRBC at Harborview. The Burn Patient Transfer Decision Flowchart **(See Appendix 5)**, developed by the WRBCC and its partners, may support guiding non-burn hospitals in transport decision-making, in collaboration with a Burn Physician from either UWRBC at Harborview or the WRBCC.

Below are UWRBC Burn Center Referral guidelines. However, it is understood that in an overwhelming incident a burn-specific facility may not be readily available and burn patients may need to be cared for at non-burn center hospitals and therefore these criteria will need to be revised given the situation at hand. It is recommended that patients be transferred to the highest level of care when possible.

Burn Center Referral Criteria

1. Partial thickness burns greater than 10% TBSA.
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.

3. Full thickness (third-degree) burns in any age group.
4. Electrical burns, including lightning injury.
5. Chemical burns.
6. Inhalation injury.
7. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
8. Pediatric burn victims in a hospital without qualified personnel or equipment.
9. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary for such situations and should be in concert with the regional medical control plan and triage protocols.
10. Burn injury in a patient who will require special social, emotional, or rehabilitative intervention. For more information on rehabilitation intervention for burn patients, please refer to **Appendix 4**.

Patient Transfer Checklist and Coordination

Use the *Burn Patient Transfer Checklist* included in **Appendix 6** to prepare, package and transport patients who have been identified for transfer to a Burn or Trauma Center

Special Considerations

The following section contains considerations for special populations and special situations, including rural health considerations, behavioral health concerns, pediatric patients, combined injuries, and crisis standards of care.

N. Rural Clinical Care Strategies

Rural community healthcare providers face unique challenges when preparing and responding to any type of medical surge. Their capacity to provide definitive care for critically injured patients is limited. Therefore, it is important that they:

- Maintain awareness of the NWHRN Coalition Burn Surge Annex.
- Have and maintain a burn surge disaster plan, which should include stabilization, consultation, and transfer protocols for burn patients utilizing the training resources and plans referenced above.
- Maximize existing real-time telehealth-based provider support for consultation.
- Provide staff with burn-specific just-in-time training and education resources that provide key considerations in burn care.

O. Behavioral Health

Given the nature and scope of a BMCI, it is to be expected that a number of those who witnessed, were injured in, or responded to the event will experience some mental trauma in relation to the incident. Burn survivors most at risk for PTSD are those with a history of anxiety disorders (generalized anxiety, panic disorder) or depression. Burn survivors who have a history

of traumatic events and past PTSD are also at risk of developing PTSD from the current burn injury (Wiechman, 2017).

NWHRN has several on-line resources for behavioral health preparedness and response to include Behavioral Health Tip Sheets (adults and children) and specific behavioral and mental health section for pediatric patients in the NWHRN Pediatric Surge Annex Toolkit (see Section 6)

P. Pediatric

Included in all disaster planning is the need to plan for the pediatric patient. The UWRBC does include beds to support pediatric burn patients, however, as in all disasters these specialty services may be overwhelmed, and individual facilities may need to care for the pediatric patient for an extended period of time. The Western Region Burn Mass Casualty Operations Plan includes several pediatric resources:

- Pediatric burn patient considerations (pg. 19)
- Pediatric Planning Recommendations (pg. 60)
- Pediatric Equipment and Supplies (pg. 61)
- Pediatric Psychological First Aid (pg. 65)
- Family Reunification Resources (pg. 67)

Additionally, the NWHRN has developed a full coalition Pediatric Surge Annex and has multiple tools to assist facilities in developing their own internal response plans.

The NWHRN Pediatric Surge Annex Toolkit can be accessed here.

Q. Combined Injury

Combine injury (i.e., burns with trauma or radiation or chemical injury) markedly increases mortality, and these patients may be better served at trauma and other centers depending on the severity of the injury. Local trauma protocols should be implemented and when SME input or transfer is needed local referral and consultation patterns should be implemented.

Deactivation and Recovery

R. Demobilization

Throughout the Annex activation, the HECC, in consultation with applicable partners, will determine the appropriate conditions required to partially or fully demobilize and deactivate the Annex. Demobilization indicators may include:

- The burn surge healthcare impact from the incident is at a low level sufficient for ending response coordination.
- Partner agencies have deactivated any EOC/ECC and/or emergency response plans.
- The threat of a reoccurrence of the BMCI incident or similar events is sufficiently low to not require response coordination.

The HECC, in consultation with all applicable partners, will communicate the deactivation of the Annex to all partners with the most appropriate methodology given the situation at hand.

Depending on the severity or scope of the incident, the NWHRN will lead and/or participate in an after-action process. If the NWHRN leads an after-action process, results will be communicated and distributed to partners following the completion of the after-action report.

S. Recovery

After demobilization and during recovery, the following activities should be completed:

- Return any borrowed assets (i.e., equipment, staff, etc.).
- Debrief participating local, regional, state, and/or federal partners with after-action reports, discuss improvement plans, and create a coordinated approach to incorporating recommendations into future planning.
- Communications concerning payment and reimbursement for the response.
- Communication of any operational activities that need to be revised or continued.

Training and Exercise

Training on roles and responsibilities for all relevant partner agencies will occur following the adoption of the finalized Burn Surge Annex. The NWHRN assesses yearly the training and exercise needs of all coalition partners using a capabilities assessment, which informs the goals and objectives for training and exercising in the years to come.

Exercises of portions of this Annex or attachments, including tabletops and functional exercises, will occur with healthcare organizations, LHJs, URWBC, and other relevant stakeholders. All trainings and exercises will involve post-event evaluations and/or After-Action Reports, which will include Improvement Plans addressing Core Capabilities.

Authorities and Maintenance

Review Process and Annex Update

Sections of this Annex will be updated as needed based on the evolution of planning activities and partnerships or in coordination with Regional Improvement Plans after exercises or real-world incidents.

The Annex will be provided to the LHJs, healthcare organizations, and regional partners for review and input.

Following review, modifications will be made, and a copy will be provided to all regional partners. Healthcare organizations are expected to share the updated plan internally within their appropriate committees and with their leadership.

The NWHRN Board of Directors will be briefed when updates to this Annex are completed.

Maintenance
The Annex will be reviewed every three years or as needed following the process outlined above.

Definitions and Acronyms

AAR: After Action Report
ABA: American Burn Association
ACS-COT: American College of Surgeons Committee on Trauma
ABLS: Advanced Burn Life Support
ALS: Advanced Life Support
ASPR: Assistant Secretary for Preparedness and Response
BMCI: Burn Mass Casualty Incident
CDC: Centers for Disease Control and Prevention
CSC: Crisis Standards of Care
DCAC: Disaster Clinical Advisory Committee
DMCC: Disaster Medical Coordination Center
DMEP: Disaster Management Emergency Preparedness
DOH: Washington State Department of Health
EEI: Essential Elements of Information
EMD: Washington State Emergency Management Division
EMS: Emergency Medical Services
EOC: Emergency Operations Center
ESF-8: Emergency Support Function #8 – Health & Medical
HCC: Healthcare Coalition
HECC: Healthcare Emergency Coordination Center
HHS: Health & Human Services
HVA: Hazard Vulnerability Index
JIT: Just-In-Time Training
JRA: Jurisdictional Risk Assessment
LHJ: Local Health Jurisdiction
MOCC: Medical Operations Coordination Center
NASEM: National Academy of Science, Engineering, and Medicine
NDMS: National Disaster Medical System
NWHRN: Northwest Healthcare Response Network
PTSD: Post-Traumatic Stress Disorder
RITN: Radiation Injury Treatment Network
SME: Subject Matter Expert
SNS: Strategic National Stockpile
TBSA: Total Body Surface Area
UWRBC: University of Washington Regional Burn Center
WMCC: Washington Medical Coordination Center
WRBCC: Western Region Burn Coordination Center
WRBDC: Western Region Burn Disaster Consortium

Appendices

NWHRN Appendices

Appendix A NWHRN Healthcare Emergency Operations Base Plan

Appendix B: NWHRN Situational Awareness Annex

Appendix C: NWHRN Staffing Scarce Resource Card

Appendix D: NWHRN Patient Tracking Appendix

Appendix E: NWHRN Patient Movement Annex

Appendix F: NWHRN Behavioral Health Clinical Tip Sheets

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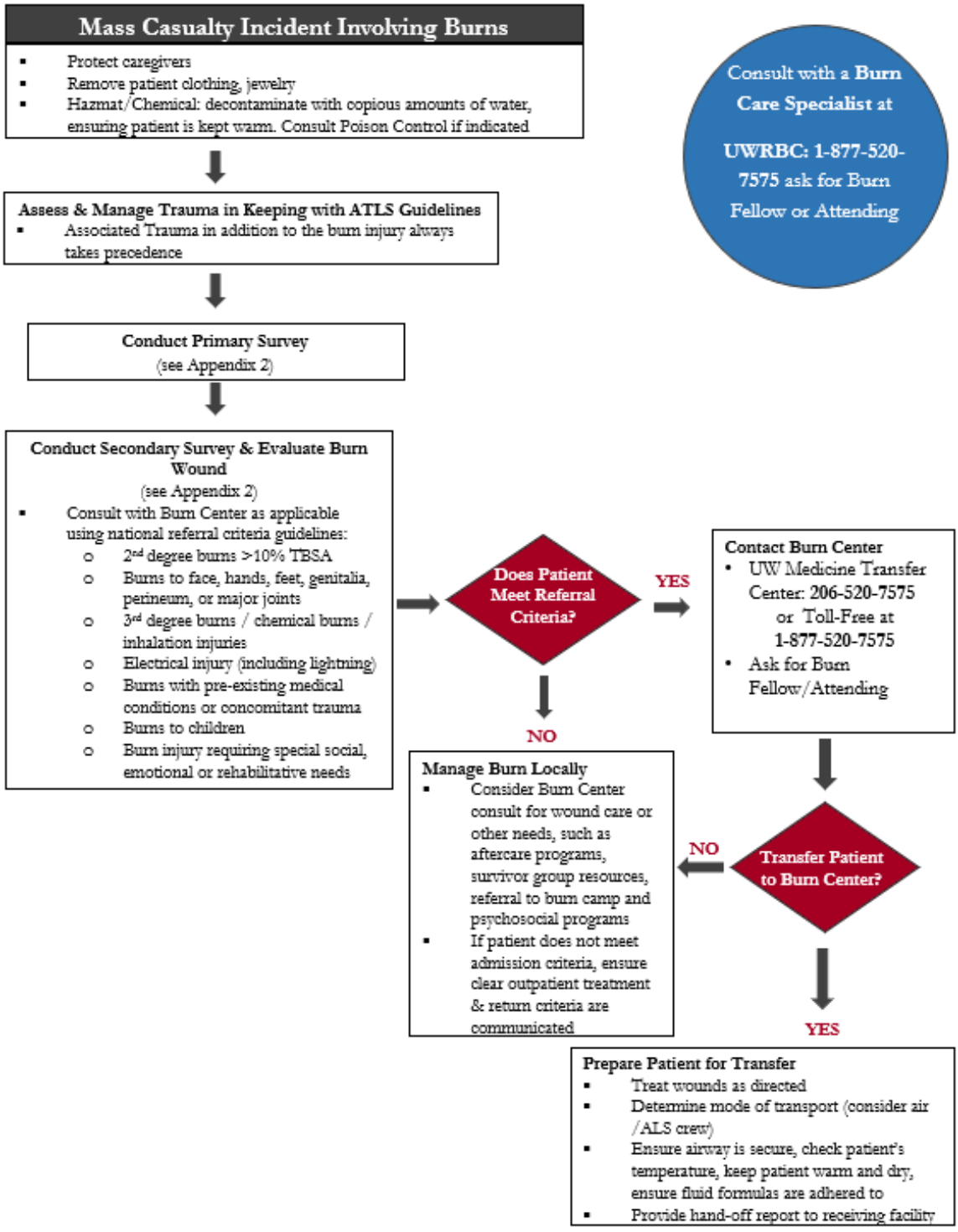

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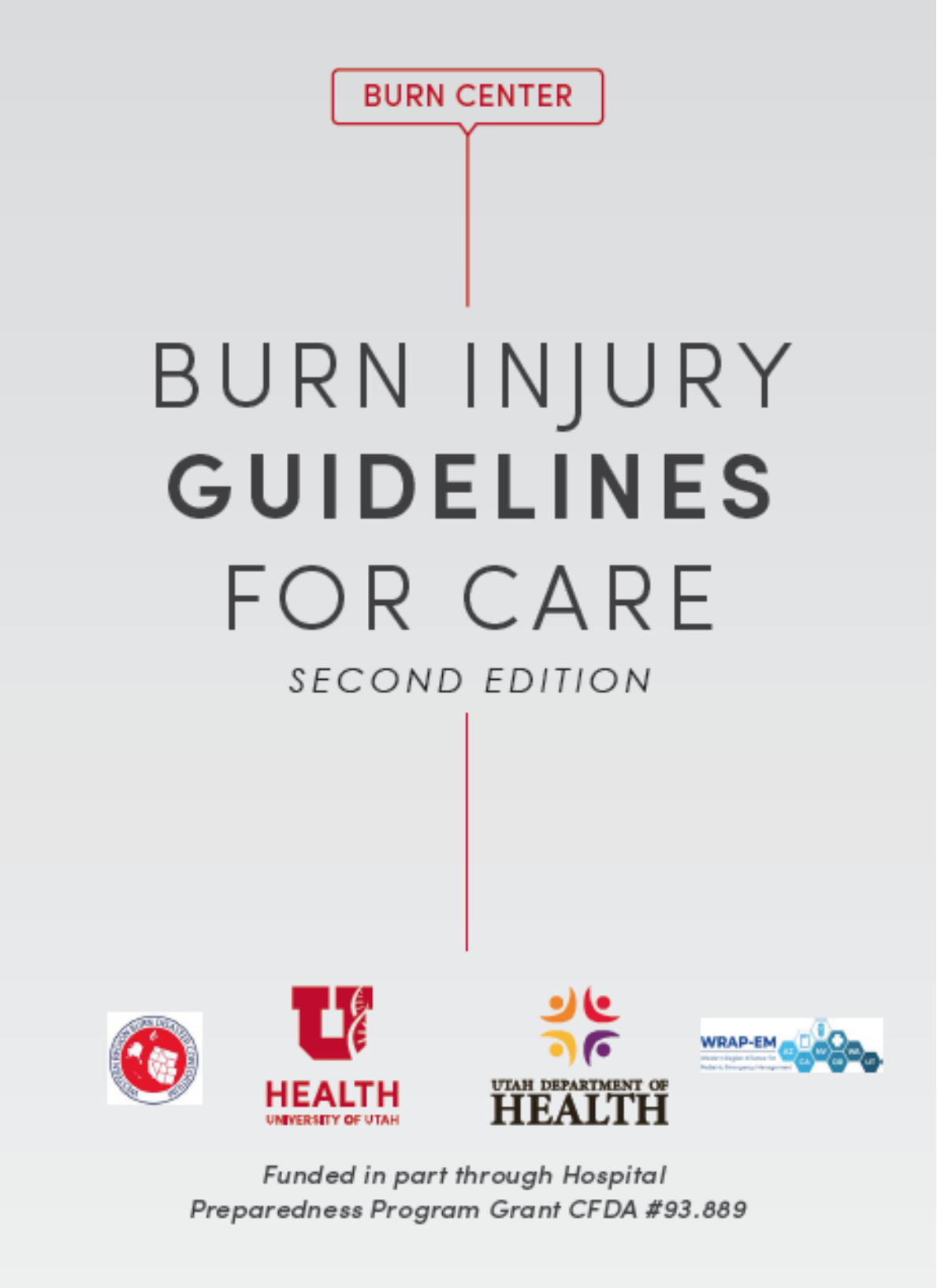
Appendix 2: Burn Injury Guidelines for Care, Second Edition



WOUND EVALUATION

It is not always possible to know burn depths for days, as appearance may be deceiving and injury may deepen.	**Depth of injury**	**Wound properties**
Superficial (1st degree) **These wounds are <u>not</u> included in the % TBSA* 	Limited damage to epidermis, skin contact	• Painful • Red • No blister formation immediately
 Partial Thickness (2nd degree)	Epidermis destroyed, minimal damage to superficial layers or dermis	• Pink or red • Moist • Weepy • Blanching • Blisters • Painful
 Deeper (2nd degree)	Epidermis and dermis involved	• May be red or pearly white • Drier than superficial injury • Painful
 Full thickness (3rd degree)	All epidermis and dermis destroyed	• White, cherry red, brown or black • Hard and leathery • Insensitive to pin prick

PRIMARY SURVEY

Airway and breathing

100% O2 via non-rebreather. Watch breathing effort closely especially in circumferential torso burns, chest escharotomy if indicated. If intubation is necessary, ensure the ETT is secured well. NG/OG tube recommended for burns > 20% TBSA, if patient is intubated and per protocol.

Circulation

- Circulatory compromise – indicated by progressive pain, pallor, pulselessness, paresthesia, paralysis and coolness of the extremities
- IV/IO line may be placed through burned skin if necessary. Secure in place with Kerlix or Coban, monitor for swelling.
- Consider oral re-hydration therapy in burns <15% TBSA
- Starting points for fluid resuscitation rates in the primary survey for burn TBSA >20%:

5 years or younger:	**125 ml LR/NS/hr**
6-13 years:	**250 ml LR/NS/hr**
14 years or older:	**500 ml LR/NS/hr**

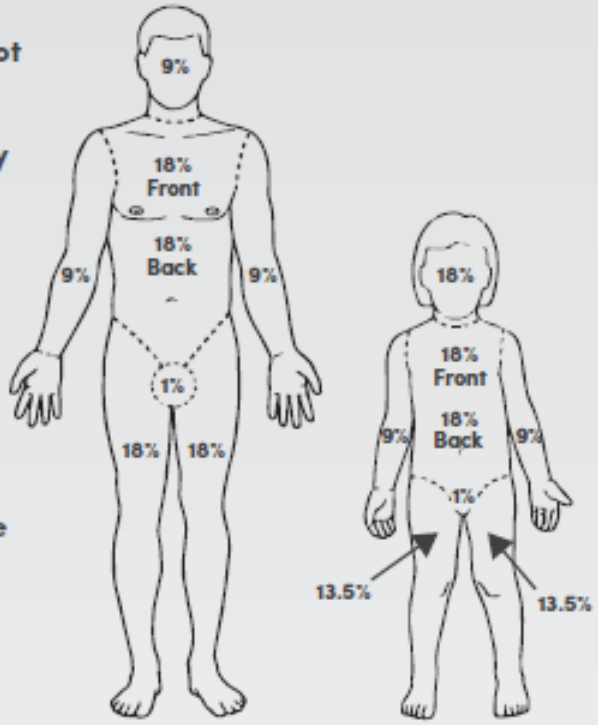
Disability

Monitor GCS, AVPU – burn patients are typically alert and oriented, if deficits exist, consider CO, hx of anoxia, chemical exposure or traumatic injury.

Exposure/environment

- Remove all clothing and jewelry
- Keep patient warm, covered and dry
- Do not use wet dressings or blankets

- **Patients with burn injuries do not typically develop shock within 60 minutes from time of injury if left untreated, unless there are associated injuries or medical conditions in addition to the burn.**
- **Usually, burns do not bleed. If there is bleeding, there may be an associated injury.**
- **Patients with traumatic injuries or inhalation injuries may require additional fluid.**
- **Brush powdered chemicals off skin, then flush with copious amounts of fluid.**



Patient's hand = 1% Total Body Surface Area

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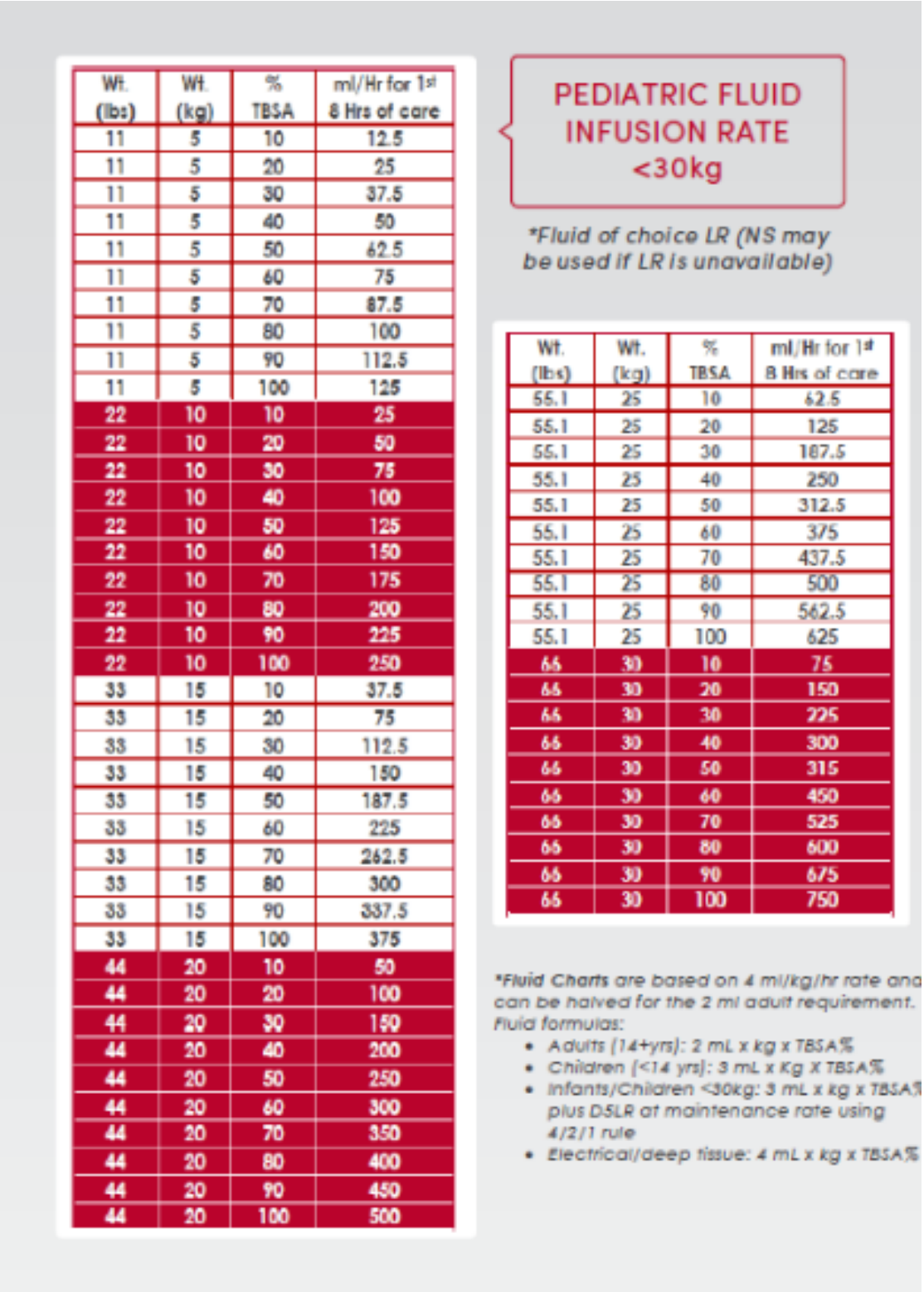


Wt. (lbs)	Wt. (kg)	% TBSA	ml/Hr for 1st 8 Hrs of care
11	5	10	12.5
11	5	20	25
11	5	30	37.5
11	5	40	50
11	5	50	62.5
11	5	60	75
11	5	70	87.5
11	5	80	100
11	5	90	112.5
11	5	100	125
22	10	10	25
22	10	20	50
22	10	30	75
22	10	40	100
22	10	50	125
22	10	60	150
22	10	70	175
22	10	80	200
22	10	90	225
22	10	100	250
33	15	10	37.5
33	15	20	75
33	15	30	112.5
33	15	40	150
33	15	50	187.5
33	15	60	225
33	15	70	262.5
33	15	80	300
33	15	90	337.5
33	15	100	375
44	20	10	50
44	20	20	100
44	20	30	150
44	20	40	200
44	20	50	250
44	20	60	300
44	20	70	350
44	20	80	400
44	20	90	450
44	20	100	500

*Fluid of choice LR (NS may be used if LR is unavailable)

Wt. (lbs)	Wt. (kg)	% TBSA	ml/Hr for 1st 8 Hrs of care
55.1	25	10	62.5
55.1	25	20	125
55.1	25	30	187.5
55.1	25	40	250
55.1	25	50	312.5
55.1	25	60	375
55.1	25	70	437.5
55.1	25	80	500
55.1	25	90	562.5
55.1	25	100	625
66	30	10	75
66	30	20	150
66	30	30	225
66	30	40	300
66	30	50	315
66	30	60	450
66	30	70	525
66	30	80	600
66	30	90	675
66	30	100	750

*Fluid Charts are based on 4 ml/kg/hr rate and can be halved for the 2 ml adult requirement.
Fluid formulas:

- Adults (14+yrs): 2 mL x kg x TBSA%
- Children (<14 yrs): 3 mL x Kg X TBSA%
- Infants/Children <30kg: 3 mL x kg x TBSA% plus DSLR at maintenance rate using 4/2/1 rule
- Electrical/deep tissue: 4 mL x kg x TBSA%

Wt. (lbs)	Wt. (kg)	% TBSA	ml/Hr for 1st 8 Hrs of care
66	30	10	75
66	30	20	150
66	30	30	225
66	30	40	300
66	30	50	375
66	30	60	450
66	30	70	525
66	30	80	600
66	30	90	675
66	30	100	750
88	40	10	100
88	40	20	200
88	40	30	300
88	40	40	400
88	40	50	500
88	40	60	600
88	40	70	700
88	40	80	800
88	40	90	900
88	40	100	1000
110	50	10	125
110	50	20	250
110	50	30	375
110	50	40	500
110	50	50	625
110	50	60	750
110	50	70	875
110	50	80	1000
110	50	90	1125
110	50	100	1250
132	60	10	150
132	60	20	300
132	60	30	450
132	60	40	600
132	60	50	750
132	60	60	900
132	60	70	1050
132	60	80	1200
132	60	90	1350
132	60	100	1500
154	70	10	175
154	70	20	350
154	70	30	525
154	70	40	700
154	70	50	875
154	70	60	1050
154	70	70	1225
154	70	80	1400
154	70	90	1575
154	70	100	1750
176	80	10	200
176	80	20	400
176	80	30	600
176	80	40	800
176	80	50	1000
176	80	60	1200
176	80	70	1400
176	80	80	1600
176	80	90	1800
176	80	100	2000

ADULT FLUID INFUSION RATE >30kg

**Fluid of choice LR, DO NOT use dextrose containing fluids (NS may be used if LR is unavailable)*

Wt. (lbs)	Wt. (kg)	% TBSA	ml/Hr for 1st 8 Hrs of care
198	90	10	225
198	90	20	450
198	90	30	675
198	90	40	900
198	90	50	1125
198	90	60	1350
198	90	70	1575
198	90	80	1800
198	90	90	2025
198	90	100	2250
220	100	10	250
220	100	20	500
220	100	30	750
220	100	40	1000
220	100	50	1250
220	100	60	1500
220	100	70	1750
220	100	80	2000
220	100	90	2250
220	100	100	2500
242	110	10	275
242	110	20	550
242	110	30	825
242	110	40	1100
242	110	50	1375
242	110	60	1650
242	110	70	1925
242	110	80	2200
242	110	90	2475
242	110	100	2750
264	120	10	300
264	120	20	600
264	120	30	900
264	120	40	1200
264	120	50	1500
264	120	60	1800
264	120	70	2100
264	120	80	2400
264	120	90	2700
264	120	100	3000

Wt. (lbs)	Wt. (kg)	% TBSA	ml/Hr for 1st 8 Hrs of care
287	130	10	325
287	130	20	650
287	130	30	975
287	130	40	1300
287	130	50	1625
287	130	60	1950
287	130	70	2275
287	130	80	2600
287	130	90	2925
287	130	100	3250
309	140	10	350
309	140	20	700
309	140	30	1050
309	140	40	1400
309	140	50	1750
309	140	60	2100
309	140	70	2450
309	140	80	2800
309	140	90	3150
309	140	100	3500
331	150	10	375
33	150	20	750
33	150	30	1125
331	150	40	1500
331	150	50	1875
331	150	60	2250
331	150	70	2625
331	150	80	3000
331	150	90	3375
331	150	100	3750
353	160	10	400
353	160	20	800
353	160	30	1200
353	160	40	1600
353	160	50	2000
353	160	60	2400
353	160	70	2800
353	160	80	3200
353	160	90	3600
353	160	100	4000
375	170	10	425
375	170	20	850
375	170	30	1275
375	170	40	1700
375	170	50	2125
375	170	60	2550
375	170	70	2975
375	170	80	3400
375	170	90	3825
375	170	100	4250
397	180	10	450
397	180	20	900
397	180	30	1350
397	180	40	1800
397	180	50	2250
397	180	60	2700
397	180	70	3150
397	180	80	3600
397	180	90	4050
397	180	100	4500

ADULT FLUID INFUSION RATE >30kg

**Fluid of choice LR, DO NOT use dextrose containing fluids (NS may be used if LR is unavailable)*

Wt. (lbs)	Wt. (kg)	% TBSA	ml/Hr for 1st 8 Hrs of care
419	190	10	475
419	190	20	950
419	190	30	1425
419	190	40	1900
419	190	50	2375
419	190	60	2850
419	190	70	3325
419	190	80	3800
419	190	90	4275
419	190	100	4750
441	200	10	500
441	200	20	1000
441	200	30	1500
441	200	40	2000
441	200	50	2500
441	200	60	3000
441	200	70	3500
441	200	80	4000
441	200	90	4500
441	200	100	5000
463	210	10	525
463	210	20	1050
463	210	30	1575
463	210	40	2100
463	210	50	2625
463	210	60	3150
463	210	70	3675
463	210	80	4200
463	210	90	4725
463	210	100	5250
485	220	10	550
485	220	20	1100
485	220	30	1650
485	220	40	2200
485	220	50	2750
485	220	60	3300
485	220	70	3850
485	220	80	4400
485	220	90	4950
485	220	100	5500

AMERICAN BURN ASSOCIATION CRITERIA FOR BURN CONSULTATION

- 2nd degree burns > 10% TBSA
- Burns to face, hands, feet, genitalia, perineum, major joints
- 3rd degree burns
- Chemical burns
- Inhalation injuries
- Electrical injury (lightning included)
- Burns accompanied by pre-existing conditions
- Burns accompanied by trauma, where burn injury poses greatest risk of morbidity or mortality
- Burns to children in hospitals without pediatric services
- Patients with special social, emotional or rehabilitative needs

For provider resources, please visit:
crisisstandardsofcare.utah.edu

Information for nearest Burn Center:

Appendix 3 UWRBC Burn Training Videos

Burn Center YouTube Videos Comprehensive List UW Medicine Regional Burn Center: Updated December 2025

200 Series – For Providers and Patients

BURNS 201: Initial Care and Debridement of Outpatient Burn Wounds:
https://www.youtube.com/watch?v=hJnUm4lB7i0

BURNS 202: Activity and Stretching Exercises for Burn Patients:
https://www.youtube.com/watch?v=Q42sdcSqewk

BURNS 203: Care of Your Mepilex Ag Donor Site at Home:
https://www.youtube.com/watch?v=9scfKc12bMY

BURNS 204: Draining Blebs in Your Skin Graft
https://www.youtube.com/watch?v=-iJKctu1dJs

BURNS 205: My First Wound Care:
https://youtu.be/_ppv_qGQRX0

300 Series – Stretching for Patients

BURNS 301: Pediatric Palm Stretch: https://www.youtube.com/watch?v=MJmt8svIlmo

BURNS 302: Hip and Groin Stretches: https://www.youtube.com/watch?v=53OE-kiRYyo

BURNS 303: Burn Elbow Stretches: https://www.youtube.com/watch?v=InXIpAwAacA

BURNS 304: Burn Shoulder Stretches: https://www.youtube.com/watch?v=VsNVr9X0Ves

BURNS 305: Foot and Leg Stretches: https://www.youtube.com/watch?v=1_8FWOd7f3I

BURNS 306: Burn Hand Stretches: https://www.youtube.com/watch?v=VPCN6XZ3P5M

BURNS 307: Wrist Stretching: https://www.youtube.com/watch?v=MJ6F_F6BsR8

BURNS 308: Neck Stretches: https://www.youtube.com/watch?v=eKg_m_BkJD4

BURNS 309: Face Stretching: https://www.youtube.com/watch?v=rYAziBODWho

Spanish 300 Series

BURNS 300-S: Actividades y ejercicios de estiramiento para personas con quemaduras *(Activity and Stretching Exercises for the Burn Patient):*
https://www.youtube.com/watch?v=A9Dt6aLPfjk&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=1

BURNS 301-S: Estiramiento de Palma Pediatrica *(Palm stretching)*
https://www.youtube.com/watch?v=FjaBf__rZmM

BURNS 302-S: Estiramiento de la Cadera y la Ingle *(Hip and Groin Stretches:*
https://www.youtube.com/watch?v=6PiCCNdlWwo&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=3

BURNS 303-S: Estiramiento del Codo *(Burn Elbow Stretches):*
https://www.youtube.com/watch?v=d2M-Q6T-0FU&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=4

BURNS 304-S: Estiramientos para Quemaduras del Hombro *(Burn Shoulder Stretches)*
https://www.youtube.com/watch?v=u0zqfcKzI88&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=5

BURNS 305-S: Estiramientos para Quemaduras del Pie y de la Pierna *(Foot and Leg Stretches)*
https://www.youtube.com/watch?v=1qGdWoiy58Q&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=6

BURNS 306-S: Estiramientos de la Mano *(Burn Hand Stretches)*
https://www.youtube.com/watch?v=BZmu68Rxpy8&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=7

BURNS 307-S: Estiramientos de la Muñeca y el Antebrazo *(Wrist Stretching)*
https://www.youtube.com/watch?v=gWn79mkMqis&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=8

BURNS 308-S: Estiramientos del Cuello *(Neck Stretches)*
https://www.youtube.com/watch?v=wgRszwngD8Q&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=9

BURNS 309-S: Estiramientos de la Cara *(Face Stretching)*
https://www.youtube.com/watch?v=qTAsnnupw3Y&list=PLFEMTIzjmLeV_B460RlKxcmR65cbREtzP&index=10

400 Series – Splinting for Therapy Providers and Patients

BURNS 401: Axillary splints - https://www.youtube.com/watch?v=pT6KJ0HeAY8

BURNS 402: Elbow splints - https://www.youtube.com/watch?v=pT6KJ0HeAY8

BURNS 403: Hand splints - https://www.youtube.com/watch?v=3sk8nqL1hJ0

BURNS 404: Leg splints - https://www.youtube.com/watch?v=2vb70rV3bpc

BURNS 405: Neck splint - https://www.youtube.com/watch?v=1m_hksZ9uXM

BURNS 406: Ace Wrapping and Tubigrip - https://www.youtube.com/watch?v=XHAPP1RqBIA

500 Series – Burn Pain for Patients

BURNS 501: Burn Pain: The Basics https://youtu.be/8T68wYwzI9I

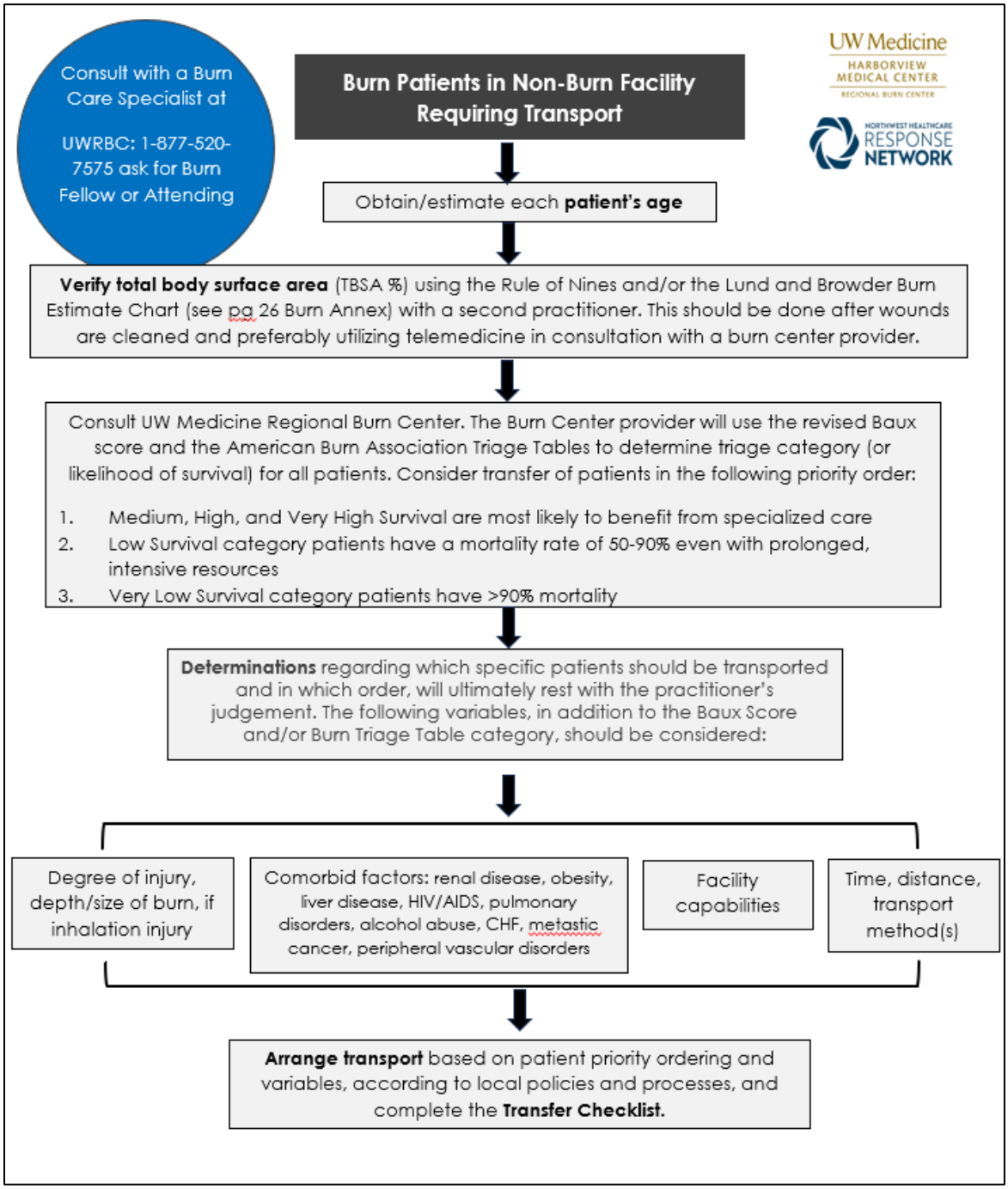
Appendix 4: Additional Burn Training Resources

Burn Training/Resources	Source	Target Audience	Type	Weblink
Hospital Clinical Resources				
Extensive Clinical Care & Response Resources	University of Utah Health	Response, Clinical	Guidance/ Videos	https://crisisstandardsofcare.utah.edu
Burn E-learning	OPEN Pediatrics	Clinical	Video	https://learn.openpediatrics.org/learn/global-search/burns (free resource, requires registration)
Burn Surge Video Series	Minnesota Dept of Health	Clinical	Video	https://www.health.state.mn.us/communities/ep/surge/burn/video.html
Burn Surge Module 4: Advance Special Treatment Considerations	Minnesota Dept of Health	Clinical	Video	https://www.health.state.mn.us/communities/ep/surge/burn/module4advanced.html
Determining Burn Depth	Minnesota Dept of Health	Clinical	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/burndepth.html
Determining Total Body Surface Area	Minnesota Dept of Health	Clinical	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/tbsa.html
96-Hour Care Guidelines for Pediatric Burns	Illinois Dept of Public Health	Clinical	Guidance	https://www.luriechildrens.org/globalassets/documents/emsc/disaster/state-plans/burncareguidelinesjune2017.pdf
Triage of Patients with Cutaneous Burns Only During Mass Casualty Incidents	Minnesota Dept of Health	Clinical	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/triageburns.html
Pediatric Response Resources for Burn Surge Facilities	Minnesota Dept of Health	Clinical	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/pedsorders.pdf

Management of severe thermal burns in the acute phase in adults and children	Anesthesia Critical Care & Pain Medicine	Clinical	Guidance	https://www.sciencedirect.com/science/article/pii/S2352556820300382
Topic Collection: Burns (Extensive Resources & Best Practices)	ASPR TRACIE	Clinical	Guidance	https://asprtracie.hhs.gov/MasterSearch?qt=burns&limit=20&page=1
Rehabilitation and Follow-up Services				
Silver sulfadiazine (SSD) Dressing Video	University of Utah	Clinical	Video	https://www.facebook.com/UofUBurnCenter/videos/665390664268144/
Baci/Non-adherent Dressing Video	University of Utah	Clinical	Video	https://www.facebook.com/UofUBurnCenter/videos/1986617213927689/
Mepilex Dressing Video	University of Utah	Clinical	Video	https://www.facebook.com/UofUBurnCenter/videos/2849921651796060/
Stat Wrap Video	University of Utah	Clinical	Video	https://www.facebook.com/UofUBurnCenter/videos/2405422436781 2/
Emergency Management & Response Resources				
Burn Mass Casualty Incident Operations Plan	Western Region Burn Disaster Consortium	Response, Clinical	Guidance	https://crisisstandardsofcare.utah.edu/opendocs/WRBDC%20BMCI%20Operations%20Plan.pdf
Michigan Burn Triage and Management	State of Michigan	Response, Clinical	Guidance	https://michiganburn.org/index.html
Burn Triage and Treatment of Thermal Injuries in a Radiation Emergency	Radiation Emergency Medical Management (REMM)	Response, Clinical	Guidance	https://remm.hhs.gov/
Minnesota Burn Surge Resrouces	Minnesota Dept of Health	Response	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/index.html
Burn Prevention & Safety Public Resources				
Burn Prevention	American Burn Association	Public	Guidance	https://www.ameriburn.org/prevention

Burn Prevention	AAP	Public	Guidance	https://www.healthychildren.org/English/health-issues/injuries-emergencies/Pages/Treating-and-Preventing-Burns.aspx
Fire & Burn Safety	Children's Safety Network	Public	Guidance	https://www.childrenssafetynetwork.org/injury-topics/fire-burn-safety
Scald Burn Prevention	AAP	Public	Guidance	https://publications.aap.org/aapnews/news/34614/Educating-families-on-risks-for-scald-burns-can
Burn Survivor Public Resources				
Burn Survivor & Prevention Resources	Alisa Ann Ruch Burn Foundation	Public	Guidance & Videos	https://www.aarbf.org/survivor-services/ https://www.aarbf.org/burn-prevention/
Wildfire Preparedness Resources	Alisa Ann Ruch Foundation	Public	Guidance & Videos	https://www.aarbf.org/wildfirepreparedness/
Extensive Resources for Burn Survivors	Phoenix Society for Burn Survivors	Public	Guidance & Videos	https://www.phoenix-society.org/resources
Burn Community Bookshelf	Phoenix Society for Burn Survivor	Public	Guidance	https://www.phoenix-society.org/resources/burn-community-bookshelf
Preparing Children After a Wildfire Damages Your Community	The National Child Traumatic Stress Network	Public	Guidance	https://www.nctsn.org/resources/preparing-children-after-a-wildfire-damages-your-community

Appendix 5: Transfer Decision Flowchart & Triage Tables



*Adapted from Western Region Burn Disaster Consortium. University of Utah Health, Utah Department of Health, and the Utah Hospital Association.

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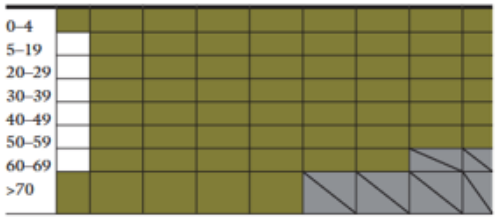
Burn Triage Table Patient Categories *Very high, high, and medium survival patients are more likely to benefit from specialized burn care.	
Outpatient	Survival and good outcome expected without requiring initial admission
Very High Survival	Mortality ≤10%, anticipated stay ≤14-21 days, 1-2 surgical procedures
High Survival	Mortality ≤10%, anticipated stay ≥14-21 days, multiple surgical procedures
Medium Survival	Mortality 10-50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures
Low Survival	Mortality 50-90%, even with provision of prolonged, intensive resources
Very Low Survival	Mortality ≥90%, even with prolonged aggressive care

ABA Triage Tables for Mass Casualty Situations

Burn care remains one of the most complex and resource intense medical interventions. A sudden surge of critical burn patients will place a tremendous amount of stress on the US burn care system. In 2020, The American Burn Association (ABA) Burn Mass Casualty Triage Tables were developed by expert consensus to support prioritization of burn-injured patients during mass casualty incidents when demand for burn care resources exceeds available capacity. The tables are intended as a decision-support tool, not a substitute for clinical judgment, and should be applied within the ethical, operational, and regional frameworks during any critical medical surge. Triage decisions must consider burn severity, patient factors, resource availability, and evolving system conditions. These tables are provided solely as a rapid reference. Their application should occur in consultation with local and/or regional burn SMEs.

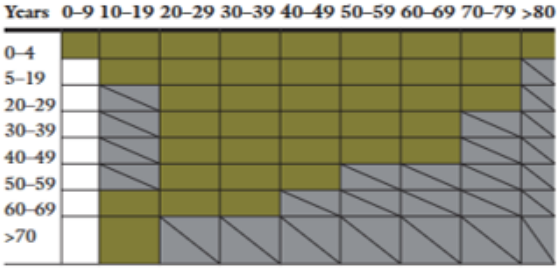
Kearns RD, Bettencourt AP, Hickerson WL, Palmieri TL, Biddinger PD, Ryan CM, Jeng JC. Actionable, Revised (v.3), and Amplified American Burn Association Triage Tables for Mass Casualties: A Civilian Defense Guideline. J Burn Care Res. 2020 Jul 3;41(4):770-779. doi: 10.1093/jbcr/iraa050. PMID: 32298453; PMCID: PMC7530540.

Table 1. Conventional burn care (estimated 50–200 significant burn victims)



White: patients with injury profiles that should be triaged to ***medical care outside burn centers, ideally with burn center consultation***. Yellow: patients with injury profiles that should be prioritized for ***transfer to burn centers***. Gray: patients with injury profiles recommended for ***comfort care with secondary triage when resources are available, and family consultation if possible prior to resuscitation***. The ***pediatric patients*** who are triaged as outpatient, to a nonburn center should receive burn center consultation or outpatient follow-up referral if the American Burn Association (ABA) criteria for burn center referral are met.

Table 2. Contingency burn care, estimated 100–500 significant burn victims



White: patients with injury profiles that should be triaged to ***medical care outside burn centers, ideally with burn center consultation***. Yellow: patients with injury profiles that should be prioritized for ***transfer to burn centers***. Gray: patients with injury profiles recommended for ***comfort care with secondary triage when resources are available***.

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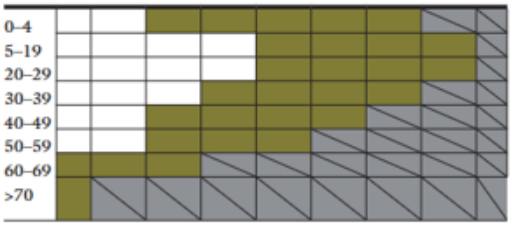
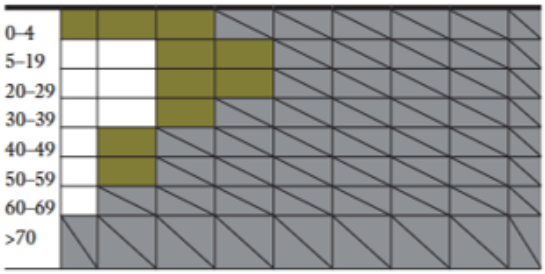
Table 3. Crisis burn care, estimated 500–2000 significant burn victims



White: patients with injury profiles that should be triaged to ***medical care outside burn centers***. Yellow: patients with injury profiles that should be prioritized for ***transfer to burn centers***. Gray: patients with injury profiles recommended for ***comfort care with secondary triage when resources are available***.

Table 4. Catastophic burn care, estimated >2000 burn victims including catastrophic care in an austere environment



White: patients with injury profiles that should be triaged to ***medical care outside burn centers***. Yellow: patients with injury profiles that should be prioritized for ***transfer to burn centers***. Gray: patients with injury profiles recommended for ***comfort care with secondary triage when resources are available***.

Appendix 6: Hospital Burn Patient Transfer Checklist

*This information was adapted from the WRBDC 96 Hour Plan - Transfer & Transport module https://crisisstandardsofcare.utah.edu

Use the following checklist to prepare, package and transport patients who have been identified for transfer to a Burn or Trauma Center. Use the Hospital Burn Patient Transfer Flowchart to identify which patients should be transported and in which order.

Patient Movement and Handover Communication

- ❑ Utilize standard transfer protocols to transfer patients based on burn severity and medical capabilities.
- ❑ Ensure receiving facility agrees to accept the patient.
- ❑ Consider the distance and time of transport when making transport decisions.
    - For a very high-risk, potentially unstable patient, shorter transport times will likely lead to better outcomes.
    - Consider air transport if ground transport would take longer than 60 minutes.
- ❑ Ensure patient(s) handoff communication paperwork has a unique identifier, pre-burn estimate of weight, estimation of % TBSA, and the name of accepting hospital and physician
    - This may be provided via triage tag, hospital cover sheet, summary sheet, or provider notes. Consider using the BMCI Patient Medical Data Form. (pg 31-32)
- ❑ Ensure verbal report is given from referring physician to receiving physician
- ❑ Ensure essential elements of patient care are recorded on a standardized, pre-printed handoff form such as the BMCI Patient Medical Data Form. (pg 31-32)
- ❑ Ensure verbal report is given to the transport team consisting of:
    - A summary of the patient's initial condition
    - Medical treatments and therapies administered
    - Patient's response to the medical care provided
- ❑ Package all medical records, lab results, and x-rays available at the time of transport, and send with the patient(s) to the receiving hospital
- ❑ Ensure any medical equipment accompanying the patient (IV pumps, ventilators, monitors, etc.) are noted on the patient chart by item, brand, facility-specific tracking number, service tag number, and serial number to assist in the return of items.
- ❑ Receive communication from the receiving facility verifying receipt of the patient(s)
    - Provide all necessary contact information for next of kin, state family reunification center, or others to receiving facility to ensure ongoing communication regarding transfer and new location of the patient.
    - Confirm transfer with the Western Region Burn Coordination Center, if activated.

Patient care

- ❑ Ensure all patient(s) receive appropriate triage and stabilization within the capability and capacity of the facility
    - The primary goal is to minimize the risk of patient(s) deterioration during transport
- ❑ If advanced airway is required or anticipated, secure the airway prior to transferring the patient
- ❑ Ensure the Endotracheal Tube (ETT) is secure, avoid tape to burned skin using Twill tape instead.
- ❑ Elevate burned extremities where possible
- ❑ Do not use excessive pressure when handling wounds
    - Support burned extremities from underneath rather than gripping
    - Use the flat surface of hands/forearms rather than fingertips
- ❑ Measure patient temperature in preparation for transport and every 2 hours if possible
    - If < 36 c (96.8 F) minimize exposure time, warm transport vehicle, use heating blankets and warm IV fluids if available, and avoid cold surfaces
- ❑ Keep the patient warm and dry
    - Cover with two blankets or improvised cover such as plastic wrap/aluminum foil / plastic bag if unable to measure temperature during transport

Appendix 7: Helping Children and Adolescents During Disaster

Intermountain Primary Children's Hospital
The Child First and Always®

BE CALM • PRACTICE THE HEALING COMMITMENTS • ASK FOR HELP

Considerations for attending to the emotional needs of children and adolescents during a disaster – Do's and Don'ts

Do

1. Protect children from:
   - Further harm.
   - Traumatic sights and sounds.
   - Onlookers and Media.
2. Be kind, but firm in directing children away from:
   - The event site.
   - Views of damage or destruction.
   - The proximity of injured survivors.
3. Keep children together with family and friends as feasible.
4. Identify children in acute distress:
   - They may tremble.
   - They may ramble.
   - They may become mute or distant.
   - They may cry loudly.
   - They may exhibit erratic behavior or rage.
   - They may sit completely still or frozen.
5. Be tolerant of difficult behavior and strong emotions.
6. Help children feel in control:
   - Let them choose meals, if possible.
   - Let them pick out clothes, if possible.
   - Let them make some decisions for themselves, when possible.

NOTE: As much as possible, stay with a child in acute distress until they are calm.

- Create a Sense of Safety.
- Be Hopeful.
- Be Friendly.
- Communicate Reassurance.
- Introduce another caregiver early on in case you must leave the child.

Do Not

1. Expect children to be brave or tough.

2. Force them to tell their stories or discuss the event before they are ready.
3. Probe for personal details.
4. Get angry if children show strong emotions.
5. Get upset if they begin:
   - Bed-wetting
   - Acting out
   - Thumb-sucking
6. Make promises that you cannot keep (e.g., "You will go home soon").

Do Not Tell Them:

- "Everything will be OK."
- "At least you survived."
- What you think they should feel.
- How they should have acted.
- They are suffering for their personal behaviors or beliefs.
- Negative things about available help.

Common Reactions for Children and Adolescents

1. **Young Children (< 5 Years)**
   - Reactions are strongly influenced by parents' reactions to the event.
   - May return to behaviors common to being younger.
2. **Children Between 6 and 11 Years**
   - Become quiet, even around familiar people (e.g., friends, family, and teachers).
   - Have outbursts of anger.
   - Develop unfounded fears.
3. **Adolescents**
   - "Survivor's Guilt" – feeling guilt about the event or about not preventing injury or death.
   - Thoughts of revenge.

Appendix 8: Patient Identification Form

SAMPLE FOR OFFICIAL USE ONLY

Patient Identification Form – SAMPLE

Instructions to Staff: Complete this form for separated minors or unidentified **patient** to the best of your ability with the information available. Keep a copy of form as part of the patient's medical record.

Patient Label ***Section A – Arrival Information***

Arrival date & time: *MRN:* *EMTrack Number:* *Disaster/Triage Tag Number:*

If minors, did patient arrive? ☐Accompanied by an adult ☐Unaccompanied by an adult

Can patient self-identify? ☐Yes ☐No Is patient unidentified? ☐Yes ☐No

Is this an anonymous patient? ☐Yes ☐No Anonymous patient name (if needed)

Is photo/ID attached? ☐Yes ☐No

Section B - Patient Information

Last name: First name: Nickname/Alternate Name:

Street Address:

City: State: Zip: Phone:

Age: DOB: School: Grade:

☐Approx. age

Gender:
☐Unknown
☐Male
☐Female
☐Unspecified

Race/Ethnicity:
☐American Indian or Alaska Native
☐Black or African American
☐Native Hawaiian/Pacific Islander
☐Not applicable, not known, not available
☐Asian
☐Hispanic/Latino
☐White

Language:
☐Spanish
☐Vietnamese
☐Other:
☐English
☐Arabic
☐Non-Verbal

Date/time patient was found:

Location where patient was found: (Please be specific)

Section C - Identifying Characteristics/Questions

Eye color:
☐Blue
☐Green
☐Other:
☐Hazel
☐Brown
☐Black
☐Gray

Hair color:
☐Black
☐Blonde
☐Other:
☐Brown
☐Red
☐Sandy
☐Bald
☐Gray
☐White

Facial Hair:
☐Beard
☐Mustache
☐Other:

Height: (give units)

Weight: (give units)

Eye Glasses? - ☐Yes

Hair Length:

Skin color:

Other Marking – Please Describe:

☐Braces:
☐Missing front teeth:
☐Scars:
☐Piercings:
☐Moles:
☐Birthmarks:
☐Tattoos:
☐Medical devices:
☐Other:

Patient Questions – Used to confirm patient/parent identity

What is your pet's name?
Does your family have a "safe' word?

Section D - Item Worn or Carried – Describe all items

Shirt:
Pants/Skirt:
Shoes/socks:
Dress:
Jacket/Coat:
Hat:
Jewelry:
Other items carried: