Disaster Planning for a Pediatric Population

Intervention Bundle #4

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Introduction

SUBJECT MATTER EXPERTS

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CONSIDERATIONS

This intervention bundle was designed exclusively for sites participating in the Pediatric Readiness Quality Collaborative, and as such, this content should not be used for other purposes or by other sites without written consent from the EMSC Innovation and Improvement Center.

Hospital disaster plans are unique to each facility and community; hence, hospital administrators and managers are encouraged to work closely with their local, regional, and state healthcare systems and healthcare and/or disaster coalitions, national disaster partners, and their corresponding local chapters to adapt recommendations based on resource availability, strategies, and their local needs.

Background

Natural and man-made disasters, violence, and acts of terrorism impact millions of individuals, including children, each year. Some recent U.S. disasters include:

- September 2001: Four coordinated attacks on September 11th left 3,000 people dead.

- August 2005: Hurricane Katrina resulted in more than 1,800 deaths along with thousands of families being evacuated and mass displacement of sick and/or injured patients and children.

- May 2011: An EF5 Tornado destroys Midwest communities including a major hospital leaving more than 1,100 injured and 158 dead.

- December 2012: Sandy Hook Elementary School shooting ends with the deaths of 26 children and 1 adult.

- April 2013: The Boston Marathon bombing leaves more than 260 individuals injured.

- Hurricane Season 2017: Hurricanes Harvey, Irma and Maria strike Texas, Florida, Puerto Rico and the Caribbean Islands with millions injured, ill and homeless.

- January – May 2018: A proliferation of 18 mass shootings in schools and churches have resulted in 500 injuries and 212 deaths.

During these catastrophic events, children are disproportionately impacted given their unique physiological, psychological and social-emotional needs. This subsequently influences their response to the event and dictates essential care considerations. Disaster preparedness necessarily depends on day-to-day readiness. Yet, emergency departments and healthcare facilities across America are often dealing with day-to-day deficiencies in pediatric readiness that are exacerbated during a disaster.

In 2013, the Emergency Medical Services for Children (EMSC) Program in partnership with the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association launched the National Pediatric Readiness Project (NPRP) to ensure high quality emergency care for children 24/7 regardless of their geographic location. The project began with a national assessment based on the 2009 "Guidelines for Care of Children in the Emergency Department," to determine the capacity of our nation's ability to meet the needs of children. The 2013 National Pediatric Readiness Assessment had a remarkable response rate – with 83% of EDs across the US participating.   This was a clear indication of the nation's desire to ensure high quality emergency care for children.   Common gaps identified included:

- Presence of physician (47.5%) and nurse (59.3%) pediatric emergency care coordinators (PECC);

- Presence of quality improvement plans that include children (45.1%);

- Presence of disaster plans that include pediatric-specific needs (46.8%).

Yet, the nation's emergency care system is not alone in recognizing pediatric deficiencies. A *2010 National Commission on Children and Disasters Report* stated:

- Persistent deficiencies in every functional area of pediatric disaster preparedness exist;

- Children appear more often to be an afterthought than a priority in planning for a disaster;

- Although children are often categorized as an "at risk," "special needs," or "vulnerable" population, only a few hospitals have integrated these patients' care needs into their disaster plans.

Since a disaster can never be anticipated, healthcare institutions, large and small, must be prepared to address this new reality. A 2013 report entitled, *Preparedness, Response and Recovery: Considerations for Children and Families Summary,* acknowledged that "current state and local disaster plans often do not include specific considerations for children and families. While disaster plans are required in all hospitals, at least two drills (including children) should be conducted each year to improve efficiency and skills.

Knowing that nearly 83% of all pediatric emergencies are seen at local community emergency departments, and the likelihood that children will be disproportionately impacted if and when a disaster strikes, the Pediatric Readiness Quality Collaborative has designed an intervention bundle to assist facilities with adapting their existing hospital disaster plans to include pediatric populations.

This bundle is divided into two phases. Phase 1 will begin in September 2018 and will address the following:

- Domain 1: Examination of the facility's existing disaster plan to determine the integration of pediatric-specific priorities

- Domain 2: Determination of the extent of departmental engagement in disaster planning and drills

- Domain 3: Defining a process for determining the facility's surge capacity to accept children across all levels of severity and age ranges

- Domain 4: Evaluation of the facility's immediate access to pediatric equipment and resources

Phase 2 will begin in January 2019 and will focus on the following:

- Domain 5: Evaluating the efficiency and effectiveness of the facility's pediatric triage processes

- Domain 6: Examining the efficiency and effectiveness of the facility's process for pediatric decontamination

- Domain 7: Defining an effective pediatric tracking process

Aim Statement

By December 2019, 100% of the sites implementing the disaster bundle will have a plan that addresses four essential domains of pediatric disaster preparedness - disaster coordination, internal coalition building, surge capacity, and pediatric resources.

Domains of Disaster Preparedness

DOMAIN 1: PEDIATRIC DISASTER COORDINATION

A comprehensive hospital disaster plan that includes the needs of children and families requires the identification of a committed pediatric representative to lead the cooperative effort among hospital departments, personnel and leadership. Working in concert with the Hospital Disaster Coordinator, this pediatric stakeholder assures pediatric considerations and priorities are integrated into the disaster plan as well as into all staff disaster education and training. Using an all-hazards approach, the disaster plan integrates the unique needs and responses of the pediatric patient. Pre-planning inventory of available resources and access to pediatric specific equipment and professionals should also be part of the disaster plan.

DOMAIN 2: COALITION-BUILDING (LOCAL AND/OR REGIONAL)

The goal of a coalition is to facilitate collaboration amongst public health, health care, pre-hospital entities, and various community partners to prepare for, respond to, and recover from an emergency or disaster. During a disaster, hospitals will need to coordinate with local and regional partners. Hospitals need to identify these partners prior to a disaster and have methods in place for frequent and timely communication. Additionally, hospitals need to ensure that internal departments (from housekeeping to inpatient resources) are coordinated in communication and response to support the immediate hospital needs and those of the larger coalition during a disaster. Working with other entities will help to build a resilient community that ensures children's health, well-being, and safety before, during, and after disasters.

DOMAIN 3: PEDIATRIC SURGE CAPACITY (LOCAL AND/OR REGIONAL)

Every hospital and region has a different capacity to care for children in the setting of disasters. The variability between institutions can be significant. Identifying the capacity of a local institution and the region is important for planning purposes should a large-scale event occur. Surge capacity represents the ability to manage a sudden influx of patients. It is dependent on both internal communication across hospital departments and external communication across members of a regional coalition. Hospitals must develop and maintain outpatient and inpatient surge capacity for the triage, treatment, and tracking of patients at the facility or in alternative sites of care or alternative hospitals. Effective surge capacity planning integrates facility plans with a regional disaster coalition involving other area health care institutions and considers hazard vulnerability assessments (HVAs) and historical natural disaster threats.

DOMAIN 4: ESSENTIAL PEDIATRIC RESOURCES

Specific resources and supplies (pediatric-sized airway tools, medications, etc.) are required for the care of children in the daily operations of all hospitals. However, hospitals that infrequently care for children may have challenges in both identifying what resources are needed for daily operations and having access to these resources if/when large numbers of children may present in a disaster setting. Often times these resources and volume of supplies are not considered in the early stages of carrying for children and their families in disaster situations. Such resources include bedding (e.g. isolettes), diet needs for children of all ages (including formula-fed infants), and other

equipment to support children with special needs (e.g. ventilators; backup generators).

DOMAIN 5: PEDIATRIC DISASTER TRIAGE

First responder and EMS agencies routinely use triage tools to identify and prioritize patients for treatment and transport. Hospitals should also have a triage tool in place and be familiar with prehospital triage tools for patients arriving at their facility by public means or private vehicle. When disasters occur, normal triage processes are often stressed and quickly become inadequate and/or inappropriate. For this reason, disaster triage tools are available to assist medical personnel with rapidly sorting of patients into categories based on their criticality and needs. Several disaster triage tools are now available specifically for the triage of children. Adoption and understanding of these tools is applicable to hospitals and regional coalitions during disasters. Recognizing regional triage system utilization by prehospital providers and providing training on this for hospital staff could prove invaluable in a disaster.

DOMAIN 6: PEDIATRIC DECONTAMINATION

In addition to triage tools, first responder and EMS agencies routinely practice decontamination strategies to minimize risk of exposure to caustic/harmful agents. Healthcare providers must also have processes in place to minimize the continued exposure to these agents to self and others with potentially contaminated disaster victims. While most hospitals have decontamination teams, supplies including personal protective equipment, and trainings, the inclusion of children into preparedness plans and exercises/drills is limited. In the setting of disasters, medical centers and personnel need to minimize ongoing exposure and spread. The establishment of decontamination procedures to move patients from red to yellow to green zones is essential. Additional considerations regarding children are important including but not limited to appropriate water temperature, plans to keep families together through the process, privacy for youth, and appropriate sized clothing.

DOMAIN 7: TRACKING AND REUNIFICATION

Patient tracking for children/unaccompanied minors is an important concept that must be included in disaster plans. In the setting of disasters, children are often separated from their families. Because the timing of disasters is unknown and unexpected, children may experience disasters when away from their caregivers (i.e., while at school, on a playground, etc.). Children may be brought to the emergency department by a variety of means and/or sources. One of the larger challenges is when a young and/or non-verbal child is found without a caregiver. It is important to develop and maintain a tracking system for all children presenting to the emergency department so they can be reunited with their families as soon as possible. Tracking systems should involve a variety of components including a numbering system, patient identifiers (i.e., hair color, clothing, and photos), intake source, status, and disposition. Tracking patients allows families to be reunited in a timely manner.

Quality Measures

DOMAIN 1: PEDIATRIC DISASTER COORDINATION

Structural Measure #1: A disaster plan that includes pediatric-specific needs

Structural Measure #2: A disaster plan that outlines the number of pediatric patients that must be involved in a disaster drill

Structural Measure #3: Hospital disaster committee with pediatric representation

DOMAIN 2: COALITION BUILDING

Structural Measure #1: Emergency department participation in a regional disaster coalition

Structural Measure #2: A catalog of entities that participate in a regional disaster coalition[1]

Process Measure #1: Percentage of internal departments that are mobilized during a disaster drill

Process Measure #2: Median time to recruitment of internal departments during a disaster drill

Process Measure #3: *Percentage of external entities involved in a disaster drill (Optional Measure)*

DOMAIN 3: PEDIATRIC SURGE CAPACITY

Structural Measure #1: Determination of external pediatric surge capacity for region *(Optional Measure)*

Process Measure #1: Median time to determination of emergency department surge capacity services[2]

Process Measure #2: Median time to determination of surgical services surge capacity[3]

Process Measure #3: Median time to determination of inpatient services surge capacity[4]

DOMAIN 4: ESSENTIAL PEDIATRIC RESOURCES

Process Measure 1: Median time to determination of essential pediatric equipment and supplies[5]

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[1] i.e., hospitals, schools, Emergency Medical Services agencies

[2] i.e., staff and bed availability

[3] i.e., staff and operating room availability

[4] i.e., inpatient pediatric services for stable and critically-ill or injured infants and children; staff and beds

[5] e.g., bedding, equipment, dietary, etc.

Variables

No.	Variable/Question	Variable Type	Response Value
1	Select intervention bundle for reporting period	Site	1 - Weight in Kilograms / 2 - Abnormal Vitals / 3 - Interfacility Transfers / 4 - Disaster Planning
2	Select domain(s) for reporting period	Site	1 – Pediatric Disaster Coordination / 2 – Coalition-Building / 3 – Pediatric Surge Capacity / 4 – Essential Pediatric Resources
3	Select PDSA cycle number for reporting period	Site	1-5 and Date (MM:DD:YYYY)
4	Smart aim achieved during reporting period?	Site	1 - Yes and Date (MM:DD:YYYY) / 2 - No
5	Domain 1: Has your hospital established a disaster plan?	Site	1 – Yes; Date Plan Created (MM:DD:YYYY); Upload Document / 2 – No
6	Domain 1: Indicate which domains are included in the disaster plan.	Site	1 – Pediatric Disaster Coordination / 2 – Coalition-Building / 3 – Pediatric Surge Capacity / 4 – Essential Pediatric Resources / 5 – Pediatric Disaster Triage / 6 – Pediatric Decontamination / 7 – Tracking and Reunification
7	Domain 1: Does the disaster plan specify the number of pediatric patients that must be involved in a disaster drill?	Site	1 – Yes (Specify Value) / 2 - No
8	Domain 1: Does your hospital disaster committee include a pediatric representative?	Site	1 – Yes / 2 - No
9	Domain 2: Does your hospital participate in a regional disaster coalition?	Site	1 – Yes / 2 – No
10	Domain 2: Does your hospital have a catalog of entities that participate in a regional disaster coalition?	Site	1 – Yes (Upload) / 2 - No
11	Domain #3: Does your regional disaster coalition have a mechanism to determine pediatric surge capacity in real time?	Site	1 - Yes / 2 – No

No.	Variable/Question	Variable Type	Response Value
12	Domain #2: Indicate which of these clinical departments/services are available at your hospital?	Exercise (Local)	1 - Ambulatory Services / 2 – Anesthesia / 3 - Blood Bank / 4 - Central Supply / 5 - Emergency Department / 6 - Hospital Administration / 7 - Inpatient Services / 8 - Intensive Care Unit(s) / 9 - Laboratory Services / 10 - Nursing Supervisor / 11 – Nutrition / 12 - Operating Suites / 13 - Patient Registration / 14 – Pharmacy / 15 – Radiology / 16 - Respiratory Therapy / 17 - Risk Management / 18 - Social Services / 19 - Subspecialist physician groups
13	Domain 2: Identify which of these clinical departments/services were mobilized during the disaster drill?	Exercise (Local)	1 – Yes / 2 – No / 3 – NA Options: 1 - Ambulatory Services / 2 – Anesthesia / 3 - Blood Bank / 4 - Central Supply / 5 - Emergency Department / 6 - Hospital Administration / 7 - Inpatient Services / 8 - Intensive Care Unit(s) / 9 - Laboratory Services / 10 - Nursing Supervisor/ 11 – Nutrition / 12 - Operating Suites / 13 - Patient Registration / 14 – Pharmacy / 15 – Radiology / 16 - Respiratory Therapy / 17 - Risk Management / 18 - Social Services / 19 - Subspecialist physician groups
14	Domain 2: Timestamp at the initiation of the disaster drill	Exercise (Local)	MM:DD:YY:HH:MM
15	Domain 2: Timestamp of last clinical department/services to confirm mobilization during disaster drill	Exercise (Local)	MM:DD:YY:HH:MM
16	Domain 2: Entities included in regional disaster drill (check all that apply) **OPTIONAL VARIABLE**	Exercise (Regional)	1 - Community hospitals / 2 - Comprehensive or tertiary care referral center / 3 - EMS agencies / 4 - Schools / 5 - Fire and First Responder Agencies / 6 - Law Enforcement / 7 - Public health entities / 8 - Municipal services / 9 - Community organizations / 10 – Hospital Preparedness Program / 11- Primary Care Physician Groups / 12 – State EMS for Children Program Manager / 13 – State Hospital Association / 14 – Red Cross or local shelters / 15 – Faith-based entities / 16 – Childcare facilities

No.	Variable/Question	Variable Type	Response Value
17	Domain 3: # ED surge staff (i.e., physician, nurse, technician) and bed capacity availability	Exercise	1 – Physician (value) / 2- Nurse (value) / 3 – Technicians (value) / 4 – ED Beds (value) | Timestamp for each response
18	Domain 3: Inpatient resources (staff and beds (i.e., critical pediatric patients, stable pediatric patients, critical infants, stable infants)	Exercise	1 – Pediatric Critical Care Beds (value) / 2 – Pediatric Stable Inpatient Beds (value) / 3 – Infant Critical Care Beds (value) / 4 – Infant Stable Beds (value) / 5 – Pediatric Inpatient Nursing Staff (value) / 6 - Pediatric Inpatient Physician staff (value) | Timestamp for each response
19	Domain 3: Surgical resources (staff and OR)	Exercise	1 – Surgeons (value) / 2 – Nurse/Technicians (value) / 3 – Anesthesia (value) / 4 – Operating Rooms (value) | Timestamp for each response
20	Domain 3: Determination of external surge capacity (bed numbers available by criticality)	Exercise (Regional)	1 – Pediatric Critical Beds (value) / 2 – Pediatric Stable/Inpatient Bed (value) / 3 – Infant Critical Care Beds (value) / 4 – Infant Stable/Inpatient Beds (value)
21	Domain 3: Total Number of Pediatric Patients Triaged During Exercise	Exercise	1 – Pediatric Critical (value) / 2 – Pediatric Stable (value) / 3 – Infant Critical (value) / 4 – Infant Stable (value)
22	Domain 4: Time to identification of available pediatric surge equipment and supplies.	Exercise	1- Yes (Pediatric Readiness Equipment, Bedding, Dietary, Care Supplies, Pharmaceuticals) and Timestamp / 2 - Unavailable

Disaster Bundle Framework with Associated Domains
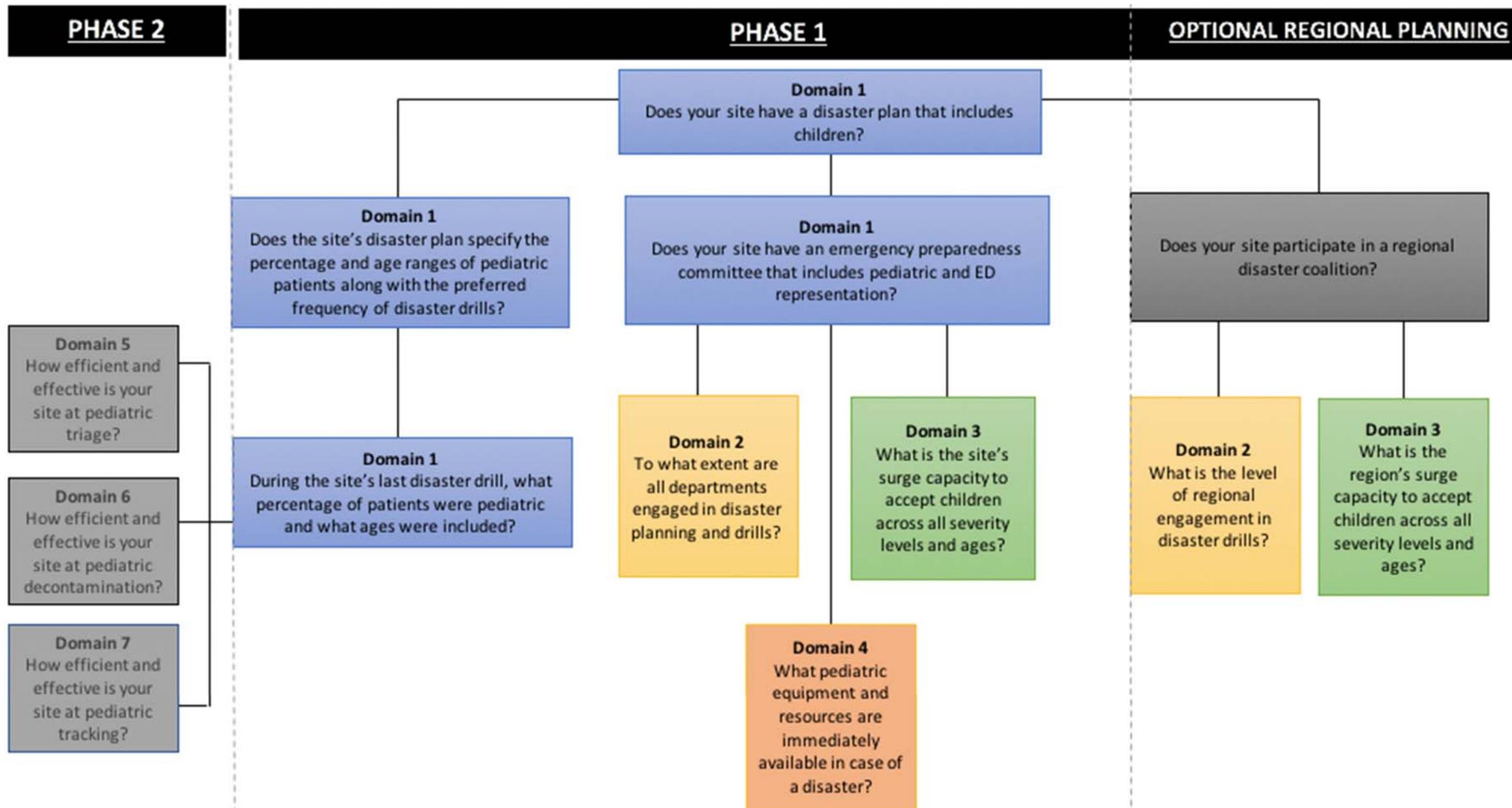
Intervention Strategies

DOMAIN 1 - PEDIATRIC DISASTER COORDINATION

KEY DRIVER 1: DISASTER PLAN

Change Strategies:

- Work with the emergency preparedness coordinator and use the disaster checklist as a framework for creating your site's plan: Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies

    o (https://emscimprovement.center/resources/publications/checklist-essential-for-every-hospitals-disaster-preparedness-policies/)

- Define role/responsibilities of a pediatric disaster coordinator

KEY DRIVER 2: KEY PERSONNEL

Change Strategies:

- Identify an individual with expertise and/or interest in pediatrics and disaster planning
  The individual may be a member of care team (physician, nurse, nurse practitioner)
    o Strongly encourage the recruitment of emergency preparedness manager that is currently on site
    o Garner support from ED and Hospital Leadership

- Offer educational opportunities for the pediatric disaster coordinator to enhance their foundational knowledge of the needs of children and families during catastrophic events.
    o Federal Emergency Management Agency Training - online courses
    o FEMA Hospital Emergency Response Training

KEY DRIVER 3: EDUCATION

Change Strategies:

- Develop a training/educational program for care team on site's disaster plan and pediatric disaster needs
    o Learning objectives should include the 7 disaster planning domains; activating resources in time of disaster
    o Review communication strategies during disaster scenarios

- Identify training delivery modality (e.g., online, in-person staff meetings, peer to peer)

- Inform members of care team about the role and responsibilities of the pediatric disaster coordinator

DOMAIN 2 – COALITION-BUILDING

KEY DRIVER 1: TEAM BUILDING

Change Strategies:

- Compile a list of hospital departments (clinical and non-clinical) to support disaster response
  - Establish regular disaster preparedness meetings

- Establish an internal communication strategy across all hospital departments

- Compile a list of regional hospital and non-hospital stakeholders (e.g., primary care, churches, medical homes, EMS, schools, childcare centers, Red Cross). Begin process by reaching out to EMS Agencies and Emergency Operations Managers in your region.

- Establish a partnership with the relevant stakeholders (e.g. regional disaster coalition, Hospital Preparedness Program)

- Develop an after action report for disaster drills

DOMAIN 3 – PEDIATRIC SURGE CAPACITY

KEY DRIVER 1: INFRASTRUCTURE

Change Strategies:

- Develop a process/plan to measure, prioritize, and expand pediatric surge capacity and capabilities based on resource availability

- Establish a process to determine which patients are transported to a particular location based on capacity

- Develop a process to augment existing capacity as well as create capacity by limiting elective appointments and procedures and practicing "surge discharge" of patients that can be effectively managed in non-hospital environments

- Develop a process to maximize conventional capacity as well as plan for contingency capacity (adapting patient care spaces to provide functionally equivalent care) and crisis capacity (adapting the level of care provided to the resources available when usual care is impossible).

- Define pediatric transfer processes, i.e., agreement and guidelines to facilitate movement of children needing pediatric specialty facilities as well as those more stable children needing to be moved to increase surge capacity of specialty centers (see PRQC bundle #3- Interfacility Transfer Guidelines)

- Develop telemedicine/telephone consultation agreements, processes, and equipment to facilitate provision of pediatric care in facilities not typically caring for children

- Meet with regional stakeholders and develop a method to integrate facility disaster plan with community and regional disaster plans, including prehospital systems of care

KEY DRIVER 2: EDUCATION

Change Strategies:

- Develop a training/educational program for each hospital department focused on processes for determining surge capacity

- Learning objectives should include importance of maximizing conventional capacity as well as plan for contingency capacity (adapting patient care spaces to provide functionally equivalent care) and crisis capacity (adapting the level of care provided to the resources available when usual care is impossible).

- Identify training delivery modality (e.g., online, in-person staff meetings, peer to peer)

- Inform members of care team about the role and responsibilities of EMS and staff in the setting of a disaster

- Discuss internal communication strategies and processes for collaborating on surge capacity

- Work with coalition to discuss external communication strategies, timing, and processes for determining regional surge capacity

KEY DRIVER 3: SIMULATION

Change Strategies:

- Conduct table top exercises to assess internal communication in the setting of a simulated disaster, ensure all hospital departments are engaged

- Conduct table top exercises to assess external communication in the setting of a simulated disaster, ensure all regional stakeholders are engaged

DOMAIN 4 – ESSENTIAL PEDIATRIC RESOURCES

KEY DRIVER 1: INFRASTRUCTURE

Change Strategies:

- Develop a comprehensive list of pediatric supplies and medications needed in cases of disaster
  - Consider needs for children of all ages from infancy through adolescence
  - Include resources needed for dietary, daily care, and sleeping accommodations
  - This should be an assessment of day-to-day use of staff, space, and resources, and then projected based on surge level.

- Create a source document that outlines the location and constraints involved with securing the essential supplies and resources

- Create a checklist for pediatric resources and supplies that can be used during a disaster

Disaster Scenarios

The following scenarios can be used to guide local and/or regional disaster drills.

SCENARIO #1 - SCHOOL BUS ACCIDENT

A school bus transporting elementary school children has been involved in a roll-over accident semi-truck. It is 4 PM during rush hour on a rainy day in April. The accident occurred 10 miles from the hospital. There are multiple injured children. Several are in critical condition. Ambulances are currently at the scene stabilizing and preparing patients for transport. Media has just picked up the story and they will likely arrive to the ED seeking information on injuries sustained during the incident. ETA of the first ambulance is 15 minutes.

SCENARIO #2 - ACTIVE SHOOTER

A breaking story on the local news station discloses that shots have been fired at a local junior high school. It is mid-afternoon on a Friday. Your hospital is the closest to the school. The hospital has started receiving calls from terrified parents seeking information about their children. There are reports that some children have escaped the building with penetrating injuries. The number of those injured is currently unknown. The ETA of any injured arrivals is also unknown.

SCENARIO #3 - LARGER STORM/FLOODING

Your local area is currently under a flash flood warning due to a large thunderstorm. It is currently 2 AM on a Sunday night in December. There are reports of a nearby dam breaking causing a sudden influx of flooding in a highly populated area. A call comes in that EMS has been called to help multiple victims with concern for drowning, near drowning, and hypothermia. You are the nearest hospital to the dam break, and are expected to receive the majority of the patients involved.

SCENARIO #4 - BOMB

An explosion has occurred at a local high school during a busy Wednesday morning. The cause is currently unknown but a large area of the three-story building has collapsed. First responders are currently at the scene and have extracted some of the victims from the debris, but it is unknown how many are trapped. You are the nearest hospital, and expected to receive the majority of the injured victims.

SCENARIO #5 - FIRE

There has been an inbound call from EMS bringing pediatric patients involved in a fire. According to EMS, a 3-alarm fire is active at a nearby in-home daycare. There are at least three critically injured children under 3 years of age with large areas of burns. The number of children at the daycare at the time of the fire is currently unknown. There were two daycare workers on site at the time, one is severely injured and the other has minor injuries, but is hysterical and unable to focus to answer questions.

SCENARIO #6 - CARBON MONOXIDE POISONING

It is 8 PM on a cold night in January and a man has called EMS for help after coming home to find his wife and children ill. Their youngest child is 18 months old, unconscious, and unarousable. The older five children range in age from 3 to 12 years. These children and his wife have been complaining of nausea, dizziness, and difficulty breathing. There are two ambulances in route to your hospital with the patients.

Resources

COMING SOON!

- Workflows for Domains 1- 4
- Suggested Readings for Each Domain