

SHAWNEE PREPAREDNESS AND RESPONSE COALITION

Regional Response and Recovery Plan:



Pediatric Surge Annex

September 2020



Shawnee Preparedness and Response Coalition

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Signature Page

This Pediatric Surge Annex has been reviewed and accepted by the SPARC Executive Board and the coalition member organizations with authority to approve. This plan addresses the domains set forth by the Hospital Preparedness Program (HPP) and is compliant with the principles outlined in the National Incident Management System (NIMS); this plan relies on strong working relationships, and effective networking efforts between all coalition member organizations and partners to manage incidents.

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Shawnee Preparedness and Response Coalition

Pediatric Surge Annex

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Signature Page	3
Acronyms/Definitions	9
Record of Revision and Distribution	14
1. Introduction	17
1.1 Purpose	17
1.2 Scope	
1.3 Overview/Background of SPARC	19
1.3.1 Pediatric Demographics	19
1.4 Children with Functional and Access Needs / Special Health Care Needs	20
1.5 Situation	22
1.5.1 Regional Pediatric Surge Capabilities	22
1.5.2 Regional Pediatric Surge Capacity	23
1.5.3 Regional Pediatric Specific Vulnerabilities	25
1.5.4 Regional Pediatric Surge Gaps	26
1.5.5 Hazards Vulnerability Analysis (HVA)	26
1.5.5.1 Supply Chain Interruption	27
1.5.6 coalition Preparedness	27
1.6 Assumptions	28
2. Concept of Operations	
Introduction	
2.1 Activation	
2.1.1 Activation Levels	31
2.1.1.1 Indication/Triggers	31
2.2 Alerts/Notifications	32
2.2.1 Public Messaging	33
2.3 Roles and Responsibilities	
2.3.1 Regional Coordinating Agency of Public Health and Medical Response	
2.3.1.2 Shawnee Preparedness and Response Coalition (SPARC)	33
2.3.2 Lead State Agencies	34
2.3.2.1 Illinois Department of Public Health (IDPH)	34
2.3.2.2 Illinois Emergency Management Agency (IEMA)	

2.3.2.3 Illinois Department of Children and Family Services (DCFS)	34
2.3.2.4 Illinois Law Enforcement Alarm System (ILEAS)	35
2.3.3 Support Agencies/Facilities/Organizations	35
2.3.3.1 Emergency Medical Services (EMS)	35
2.3.3.2 Regional Hospital Coordinating Center (RHCC)	35
2.3.3.3 Resource Hospitals	36
2.3.3.4 Associate and Participating Hospitals	36
2.3.3.5 Pediatric Tertiary Care Centers	36
2.3.3.6 Local Health Departments	37
2.3.3.7 Emergency Management Agencies (EMA)	37
2.3.3.8 American Red Cross (ARC)	37
2.3.3.9 Mutual Aid Box Alarm System (MABAS)	37
2.3.3.10 First Responders	38
2.3.3.11 Non-Governmental Organizations (NGOs)	38
2.3.3.12 Subject Matter Experts (SME) to the Coalition	38
2.3.3.13 External Expertise (telemedicine, etc.)	38
2.4 Logistics – Surge Capacity	
2.4.1 Space	
2.4.2 Staff	41
2.4.2.1 Pediatric Surge Training Recommendations	41
2.4.3 Supplies	
2.5 Special Considerations	43
2.5.1 Behavioral Health	
2.5.2 Decontamination	
2.5.3 Evacuation	44
2.5.4 Special Pathogens	45
2.5.5 Security and Safety	45
2.6 Operations-Medical Care	45
2.6.1 Triage	47
2.6.1.1 Transfer Coordination	
2.6.2 Treatment	

2.7 Transportation	
2.8 Patient Tracking	
2.9 Reunification	
2.9.1 Pediatric Safe Areas (PSA)	
2.9.1.1 Identification of unidentified child	52
2.10 Deactivation and Recovery	
2.10.1 After-Action Reporting	
2.11 Training and Exercises	53
3. Appendices	55
3.1 Authorities	55
3.2 EMSC Region V Contact List	
3.3 EMS Region V Pediatric Resources	
3.4 Additional Pediatric Resources	62
Telephone Numbers	63
Helpful Links	63
Pediatric Disaster References	63
4. Attachments	64
Attachment A: IDPH Public Health and Medical Services Response Regions	65
Attachment B: Pediatric and Neonatal Surge Annex Activation Pathway	
Attachment C: Pediatric/Neonatal Medical Incident Report Form	67
Attachment C: Pediatric/Neonatal Medical Incident Report Form (continued)	
Attachment D: Pediatric/Neonatal Communication Pathway	
Attachment E: ICS 213 RR Form	70
Attachment F: Hospital Request for Resource Algorithm	71
Attachment G: Hospital Medical Supply Bag Inventory	72
Attachment G: Hospital Medical Supply Bag Inventory (continued)	73
Attachment H: Common Reactions Exhibited by Children During and After Disaster	74
Attachment I: Pediatric Triage Guidelines	75
Attachment J: Pediatric Patient Tracking Log	
Attachment J: Pediatric Patient Tracking Log (continued)	77

Attachment K: Pediatric Patient Transfer Form
Attachment K: Pediatric Patient Transfer Form (continued)79
Attachment L: Patient Identification Tracking Form80
Attachment L: Patient Identification Tracking Form (continued)81
Attachment M: Pediatric Safe Area Checklist
Attachment N: PSA Coordinator Job Action Sheet
Attachment N: PSA Coordinator Job Action Sheet (continued)84
Attachment O: Child Identification and Disposition/Discharge Form
Addendum
RHCC Mobile Hospital Trailer Pediatric Inventory
RHCC Functional and Access Needs Trailer Pediatric Inventory
Broselow Contents List

ACRONYMS/DEFINITIONS

AAP	American Academy of Pediatrics
AAR	After Action Report
ACS	Alternate Care Site
ALS	Advanced Life Support
APLS	Advanced Pediatric Life Support
ARC	American Red Cross
ASPR	Assistant Secretary for Preparedness and Response
ATLS	Advanced Trauma Life Support
ATS	Alternate Treatment Site
BLS	Basic Life Support
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Program
CFAN	Children with Functional and Access Needs
СОР	Common Operating Picture
CSHCN	Children with Special Health Care Needs
DCFS	Illinois Department of Children and Family Services
ED	Emergency Department
EDAP	Emergency Departments Approved for Pediatrics
EMA	Emergency Management Agency
EMResource	Hospital Bypass System
EMS	Emergency Medical Services
EMSC	Illinois Emergency Medical Services for Children
EMT	Emergency Medical Technician
ENPC	Emergency Nursing Pediatric Course
ENT	Ear, Nose and Throat
EOC	Emergency Operation Center
EOP	Emergency Operations Plan
ERC	Emergency Response Coordinator
ESF	Emergency Support Function
FAN	Functional and Access Needs

FEMA	Federal Emergency Management Agency
FOA	Funding Opportunity Announcement
GLHP	Great Lakes Healthcare Partnership
HAM	Amateur Radio
HAv-BED	Hospital Available Beds for Emergencies and Disasters
HCCs	Health Care Coalition
HELPS	Healthcare Professional Emergency Volunteer Program
HICS	Hospital Incident Command System
НРР	Hospital Preparedness Program
HVA	Hazard Vulnerability Analysis
IC	Incident Command
ICS	Incident Command System
ICUs	Intensive Care Units
ID	Identification
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
ILS	Intermediate Life Support
IMERT	Illinois Medical Emergency Response Team
IPC	Illinois Poison Center
JIC	Joint Information Center
JumpSTART	Simple Triage and Rapid Treatment
LHD	Local Health Department
LTC	Long Term Care
MABAS	Mutual Aid Box Alarm System
MAC	Multi-Agency Coordination
MARC	Multi-Agency Resource Center
MCI	Mass Casualty Incident
MERCI	Medical Emergency Radio Communications of Illinois
MOU	Memorandum of Understanding
MPHMSRR	Marion Public Health and Medical Services Response Region
MRC	Medical Reserve Corps

ΜΥΤΕΡ	Multi-Year Training and Exercise Plan
NGO	Non-Governmental Organization
NICU	Neonatal Intensive Care Unit
NIMS	National Incident Management System
NMRT	National Medical Response Team
NRP	Neonatal Resuscitation Program
OR	Operating Room
PACU	Post-Anesthesia Care Unit
PALS	Pediatric Advanced Life Support
PCCC	Pediatric Critical Care Center
PCMS	Pediatric Care Medical Specialist
PEDS	Pediatrics
PEPP	Pediatric Education for Prehospital Professionals
PHMSRR	Public Health and Medical Services Response Region
PICU	Pediatric Intensive Care Unit
PIO	Public Information Officer
PPE	Personal Protective Equipment
PSA	Pediatric Safe Area
REMC	Regional Emergency Medical Services Coordinator
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SEDP	Stand-by Emergency Departments for Pediatrics
SIREN	State of Illinois Rapid Electronic Notification
SME	Subject Matter Experts
SNEC	School Nurse Emergency Care
SNS	Strategic National Stockpile
SPARC	Shawnee Preparedness and Response Coalition
TMTS	Temporary Medical Treatment Stations
UC	Unified Command



CHEMPACK: Deployable containers of nerve agent antidotes that work on a variety of nerve agents and can be used even if the actual agent is unknown. CHEMPACKs are strategically placed in more than 1,340 locations in all states, territories, island jurisdictions, and the District of Columbia. Most are located in hospitals or fire stations selected by local authorities to support a rapid hazmat response. More than 90% of the U.S. population is within one hour of a CHEMPACK location, and if hospitals or first responders need them, they can be accessed quickly. The delivery time ranges from within a few minutes to less than 2 hours. *(Center for Disease Control and Prevention*)

Children with Special Health Care Needs (CSHCN): The American Academy of Pediatrics defines this population as those individuals who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions. CSHCN require health and related services at an amount beyond that generally required by children.

EPIC: System used by hospitals and health systems to access, organized, store and share electronic medical records.

First Responder: Refers to individuals who in the early stages of an incident are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in Section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101). It includes emergency management, public health, clinical care, public works, and other skilled support personnel (equipment operators) that provide immediate support services during prevention, response, and recovery operations.

Functional and Access Needs (FAN): FEMA defines this population as "individuals who need assistance due to any condition (temporary or permanent) that limits their ability to take action." Individuals with functional and access needs (FAN) may require additional response assistance in the areas of: communication, medical care, maintaining independence, transportation or supervision.

Illinois Poison Center (IPC): The IPC is available for consultation for questions and recommendations for medications, drugs, chemicals, and other potentially hazardous substances 24 hours a day, 365 days a year. The IPC is staffed by specially trained nurses, pharmacists, physicians, and other paramedical professionals to assist with statewide emergencies. It has 24/7 back up with board certified emergency physicians who have subspecialty certification in medical toxicology.

Incident: An actual or impending hazard impact, either human caused or by natural phenomena, that requires action by emergency personnel to prevent or minimize loss of life or damage to property and/or natural resources.

Incident Command System (ICS): The combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources for emergency incidents. It may be used for all emergencies, and has been successfully employed by multiple response disciplines. ICS is used at all levels of government (local, State, Tribal, and Federal) to organize field level operations. (Adapted from NIMS)

Mass Casualty Incident: An incident that generates a sufficiently large number of casualties whereby the available health care resources, or their management systems, are severely challenged or unable to meet the health care needs of the affected population.

Memorandum of Understanding (MOU): A formal document embodying the firm commitment of two or more parties to an undertaking, and setting out its general principles, but falling short of constituting a detailed contract or agreement. (Oxford Dictionary of Law, 2006)

Mobilization: Activities and procedures carried out that ready an asset to perform incident operations according to the Emergency Operations Plan. During the response phase of Comprehensive Emergency Management, it is the stage that transitions functional elements from a state of inactivity or normal operations to their designated response state. This activity may occur well into the response phase, as additional assets are brought online or as surge processes are instituted to meet demands.

Mutual Aid Agreement: Written instrument between agencies and/or jurisdictions in which they agree to assist one another upon request, by furnishing personnel, equipment, supplies, and/or expertise in a specified manner. An "agreement" is generally more legally binding than an "understanding."

Pediatric Care Medical Specialist (PCMS) Team: Comprised of pediatric, neonatal and obstetric experts, this team will primarily serve in a consultation role (remotely) when the Pediatric Surge Annex is activated or otherwise requested. The purpose of the team in this capacity is to: serve as subject matter experts to IDPH, provide guidance on triaging pediatric patients to tertiary care centers, provide medical consultation to those hospitals holding pediatric patients while waiting for transfer approval to tertiary care centers, and assist with system decompression of tertiary care centers during a multi-regional or statewide disaster. Members of this team also may deploy as part of the primary medical response team or task force to assist local health care providers with providing pediatric medical care.

Preparedness: The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the capability to protect against, respond to, and recover from hazard impacts. Preparedness is a continuous process. Within NIMS, preparedness involves efforts at all levels of government and the private sector to identify threats, to determine vulnerabilities, and to identify required response plans and resources. NIMS preparedness focuses on establishing guidelines, protocols, and standards for planning, training and exercise, personnel qualifications and certification, equipment certification, and publication management. (Adapted from NIMS)

Public Information Officer: Official at headquarters or in the field responsible for preparing and coordinating the dissemination of public information in cooperation with other responding Federal, State, Tribal, and local agencies. In ICS, the term refers to a member of the Command Staff responsible for interfacing with the public and media and the Joint Information Center.

Surge Capability: The ability to manage patients requiring *unusual* or very *specialized* medical evaluation and care. Requirements span the range of specialized medical and public health services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed. It also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the health care organization.

Surge Capacity: The ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. Requirements may extend beyond direct patient care to include other medical tasks, such as extensive laboratory studies or epidemiologic investigations.

Temporary Medical Treatment Station (TMTS): In Illinois, the TMTS terminology has been adopted instead of Alternate Care Site (ACS): T = Temporary, these are temporary operational facilities; M = Medical, describes the function of the space; T = Treatment, describes the type of service provided; S = Station, emphasizes the interim nature of the care.

RECORD OF REVISION AND DISTRIBUTION

This document reflects the ongoing work and mission of the Shawnee Preparedness and Response Coalition (SPARC) regional strategies for emergency preparedness and disaster response. Proposed changes shall be reviewed and approved by the SPARC Executive Board. This document will be revised annually or as needed after exercises, planned events and real-world incidents to identify gaps and to define strategies to address gaps with a collaborative whole community approach.

The revised plan will be distributed to each coalition partner and posted on the SPARC website https://shawneepreparednessandresponsecoalition.com/.

Shawnee Preparedness and Response Coalition Pediatric Surge Annex						
	1		Record of Changes	1		
Revision NumberDate of ChangeIndividual Making ChangeDescription 						

Shawnee Preparedness and Response Coalition Pediatric Surge Annex Record of Distribution					
Person/Title/Agency Delivery Date					



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SPARC MISSION STATEMENT

To develop and maintain an integrated, diverse network of organizations in Southern Illinois in order to increase Planning, Mitigation, Response, Recovery and overall Resiliency in the event of a natural or man-made disaster.

The 2019-2023 HPP Funding Opportunity Announcement (FOA) requires Healthcare Coalitions (HCCs) to develop a complementary coalition-level Pediatric Annex to its base medical surge/trauma mass casualty response plan to improve capacity and capabilities to manage a large number of casualties that are children. This annex is aligned with and supports the Coalition's compliance to plan for and respond to a medical surge involving children (Capability 4, Objective 2, Activity 4).

In accordance with the IDPH ESF-8 Pediatric and Neonatal Surge Annex: This pediatric-focused operational annex supports the Shawnee Preparedness and Response Coalition (SPARC) Regional Response and Recovery Plan. This annex outlines the response roles, responsibilities, and procedures for use during a surge involving a large number of pediatric and/or neonatal patients that overwhelms the local health care system. The activation of this annex allows resources to be mobilized at the necessary level to support the incident.

Children are particularly vulnerable during a disaster due to their unique needs and characteristics. This annex is to assist in addressing the unique needs and challenges presented by the pediatric population during disasters and to guide the coalition's response procedures. The overall goal of SPARC is a more prepared and resilient region with capabilities across the "whole community" to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk.

As a result of the many aspects of this annex, it serves as an operational guide for use during an incident involving children, in disaster exercises and for the training of coalition health care partners and other relevant stakeholders on the practice of mass casualty care.



1. INTRODUCTION

All hospitals providing emergency services are equipped to initially treat and stabilize pediatric patients in accordance with their available resources. Hospitals have differing capacities and capabilities of treating and stabilizing pediatric victims; however, all hospitals should at minimum provide initial triage and resuscitation for pediatric patients.

A mass casualty incident (MCI) or evacuation affecting large numbers of children may require a coordinated response, given the resources required for the care of neonates and children are limited as are the number of pediatric specialty hospitals.

This Pediatric Surge Annex defines the role that SPARC plays in a pediatric medical surge response including the integration of the RHCC, local hospitals, emergency medical service providers, local health departments, local emergency management agencies, and other healthcare and non-healthcare response partners to ensure those children who can most benefit from pediatric specialty services receive priority for transfer.

In a disaster response within the Marion Public Health and Medical Services Response Region (MPHMSRR), every hospital and EMS agency will strive to do the most good for the most people through simple triage & rapid treatment (START) guidelines. It is imperative that the pediatric population is not treated as "small adults". The pediatric population, as well as other vulnerable populations have very different individual and specialized healthcare needs. When responding to a disaster response in the MPHMSRR, JumpSTART triage guidelines will be utilized for the initial triage and patient care decisions of the pediatric patient. It is important to remember that the process of triage is flexible and evolutionary depending on available resources and

additional resources made available.

1.1 PURPOSE

This Pediatric Surge Annex applies to a MCI or evacuation with a large amount of pediatric patients. For the purposes of this annex, the age range for children that meet the definition of a pediatric patient is birth through 15 years of age in accordance with the Emergency Medical Services and Trauma Center Code adopted by the Illinois Department of Public Health. It is recognized that children represent a special population whose specific needs should be integrated and addressed throughout the planning, response, and recovery phases of an incident. This plan supports the Shawnee Preparedness and Response Coalition (SPARC) Response and Recovery Plan by addressing specific needs of children and supporting appropriate pediatric medical care during a disaster.

This plan is intended to support and not replace any existing facility or agency plans by providing coordinated response actions in the case of a disaster that involves or could involve a significant amount of children.

The Pediatric Surge Annex is designed to Guide SPARC Coalition Partners to:

- Identify response strategies to manage surge and scarce resources
- Enable safe pediatric transfer decision making
- Ensure associated communication processes are in place
- Implement standardized care guidelines as needed
- Support the tracking of pediatric patients throughout the incident
- Assist with coordination of transferring acutely ill/injured pediatric patients to pediatric tertiary care centers/specialty care centers
- Assist with the decompression from pediatric tertiary care center/specialty care centers in order to make additional critical care beds available for acutely ill/injured pediatric patients



It is designed to be an operational guide for SPARC health care organizations and response partners in the event of a mass casualty event resulting in a medical surge response. The Pediatric Surge Annex provides the command structure, communication protocols, request for medical resources (RFMR) process, and the procedure for inter-regional and interstate transfer as related to pediatric patients.

The intent is to effectively integrate regional medical, health and community resources during a mass casualty event which exceeds the ability of the health care system by coordination of pre-hospital, hospital and contingency alternate care sites and to provide a common operating picture.

The Pediatric Surge Annex is intended to work in conjunction with the jurisdictional authorities and responsibilities outlined in the emergency operations plans of the hospitals, local health departments, primary care agencies, skilled nursing facilities, and county emergency management and service agencies. All steps and actions taken during the planning and operational phases of the Pediatric Surge Annex activation shall focus on maximum use of resources to provide rapid access to treatment and care.

1.2 SCOPE

This annex is available to all of our healthcare coalition partners that serve in leadership, direct patient care and support roles. This annex is activated via incident command in the anticipation of a large surge or pediatric patients and/or during the actual disaster response. The incident command structure utilizes the National Incident Management System (NIMS) from the initial disaster response through recovery at the local, county, and regional response levels.

The Pediatric Surge Annex is limited to describing operational intent when responding to a large influx, or impending large influx of pediatric patients, and includes considerations for the public health, emergency medical services (EMS), and healthcare systems within the SPARC geographic boundaries.

The Assistant Secretary for Preparedness and Response (ASPR) defines medical surge as, "the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure or an affected community."

Medical Surge is described by three distinct types:

- **Conventional surge**: involves one or more hospitals and is managed using only internal surge plans and resources.
- **Contingency surge:** involves 1 or more hospitals and is managed using mutual aid in addition to the internal surge plans and resources.
- **Crisis surge**: occurs when local and mutual aid capacity is exceeded, requiring a coordinated regional response with assistance from State and Federal resources.

Crisis surge often requires a long-term response and recovery. This plan primarily focuses on Crisis Surge, identifying surge capacity and capability within the SPARC region.

All hospitals are requested to plan for an event resulting in a surge of pediatric patients and consider which resources could potentially be shared or requested. Although hospital capabilities and capacity vary, any hospital could be asked to support the medical surge needs of a pediatric surge event.



1.3 OVERVIEW/BACKGROUND OF SPARC

For many years emergency management agencies, hospitals, health departments, and other entities in Southern Illinois have planned and prepared separately for disasters. This planning involved multiple meetings and collaborative efforts with many different community partners. As time went on, these groups and others continued to meet and enhance collaboration through networking, training, and exercising together. In 2012, the different regional meetings happening within various disciplines in Southern Illinois combined in an effort to become more efficient and help eliminate duplication of effort.

The first official SPARC meeting was held at the Marion Pavilion on April 9, 2013 and in addition to hospitals, health departments, and emergency management agencies in the region, representatives from local, state, and federal response agencies, state associations, volunteer organizations, and other community partners have attended subsequent SPARC meetings. The Coalition is governed by a multi-disciplinary Executive Board and is guided by the coalition By-Laws and Strategic Plan to ensure the needs of the membership and communities in the SPARC region are met. For further information on SPARC membership and governance please refer to the SPARC Regional Response and Recovery Plan (1.3.3 & 1.3.4).

The Shawnee Preparedness and Healthcare Coalition (SPARC) is one of 11 Healthcare Coalitions (HCCs) in the state of Illinois. The SPARC geographical area includes the twenty-four Illinois counties of Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Marion, Massac, Perry, Pope, Pulaski, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White, and Williamson (Refer to *Figure 1-1*). *IsPARC serves communities within twenty-four Southern Illinois counties. Twenty-three counties are in the Marion Public Health and Medical Services Response Region (MPHMSRR). Refer to (Attachment A) for map. Randolph County is in the Edwardsville Public Health and Medical Services Response Region. The twenty-four counties served by SPARC are within IEMA affected Regions 8, 9 and 11. Randolph County is in IEMA's region 11, but the Local Health Departments (LHDs), hospitals and EMS belong to the Hope Healthcare Coalition. In the event of a disaster or emergency, SPARC will coordinate response activities with Hope to support Randolph County ensuring resources and assistance are available when needed.*

SPARC emphasizes the importance of including "the whole community" in disaster planning, response and recovery. Children are a designated vulnerable population requiring special planning and response. Planning that is inclusive of at-risk populations, including those with functional and access needs and special health care needs strengthens the ability to prepare for, protect against, respond to, recover from and mitigate all hazards.

1.3.1 PEDIATRIC DEMOGRAPHICS

Children, ages 0-18 years, make up 21.0% of the population within the SPARC region (refer to Table 1 below for SPARC region pediatric population breakdown per county). Disasters tend to be indiscriminant in the types of victims affected. Therefore, establishing pediatric surge preparedness and response plans to address pediatric surge is essential when integrating children into all stages of disaster management.

For the purposes of this annex, "children" and "pediatric" are defined as those ages birth through 15 years. Medical and safety protocols for each facility may define children differently and the medical

Figure 1-1. SPARC Coverage Region



treatment of each patient should be individualized to the person and situation as deemed appropriate. There are several different definitions used to define the pediatric age range.

For example:

- American Academy of Pediatrics (AAP) defines pediatrics as those under the age of 21
- Emergency Medical Services for Children (EMSC) defines the pediatric age range as 15 years of age or younger in accordance with the Emergency Medical Services and Trauma Center Code adopted by the Illinois Department of Public Health

Total population <18 years old: 21.0% (2018 Census Data)					
COUNTY	<18 YEARS	COUNTY	<18 YEARS	COUNTY	<18 YEARS
Alexander	23.1%	Jefferson	22.1%	Richland	23.3%
Clay	22.9%	Johnson	18.5%	Saline	21.7%
Edwards	22.4%	Marion	23.2%	Union	21.0%
Franklin	22.3%	Massac	22.1%	Wabash	22.6%
Gallatin	20.8%	Perry	19.4%	Washington	21.4%
Hamilton	22.0%	Pope	12.1%	Wayne	22.7%
Hardin	18.2%	Pulaski	21.6%	White	21.9%
Jackson	18.2%	Randolph	19.3%	Williamson	21.8%
Total: 21.0%					

Table 1. SPARC Region Pediatric Population per County

1.4 CHILDREN WITH FUNCTIONAL AND ACCESS NEEDS / SPECIAL HEALTH CARE NEEDS

There are unique needs and challenges presented by the pediatric population during a disaster. A special health care need can include physical, intellectual, and developmental disabilities, as well as long-standing medical conditions, such as asthma, diabetes, or muscular dystrophy. Various terms are used to define this population, such as At-Risk, Functional and Access Needs, Special Needs, as well as Vulnerable Populations. For the purposes of this annex, the term Functional and Access Needs (FAN)/Children Special Health Care Needs is used to describe this population.

• Functional and Access Needs (FAN) - FEMA defines this population as "individuals who need assistance due to any condition (temporary or permanent) that limits their ability to take action." Individuals with functional and access needs (FAN) may require additional response assistance in the areas of: communication, medical care, maintaining independence, transportation or supervision.

Children Special Health Care Needs (CSHCN) - The American Academy of Pediatrics defines this population as those individuals who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions. CSHCN require health and related services at an amount beyond that generally required by children.

Among Children with Special Health Care Needs is a growing sub-population of children with chronic illnesses who are dependent on medical devices (i.e.- tracheostomy tubes, feeding tubes, ventilators,





portable oxygen etc.). Care for these children is often more complex because of their various health conditions and extra care requirements. Children with special health care needs may require special support services, including medicine and medical equipment, which may not be readily available during a MCI. Each hospital within the MPHMSRR has either a separate Pediatric Surge Annex and/or an EOP outlining the necessary components for hospital preparedness for disasters involving children (i.e.-FAN/CSHCN). The Illinois Emergency Medical Services for Children (EMSC) <u>CSHCN Reference Guide</u> offers helpful tips to hospital staff when caring for technology-assisted children. SSM Health Cardinal Glennon Children's Hospital (a frequent tertiary care center for pediatric transfers in the SPARC region) created the Special Needs Tracking and Awareness Response System (STARS), providing focused, individualized training to area hospitals and first responders in the St. Louis metro area. This program is designed to help better care for children who have challenging medical needs, such as heart defects, autism, severe neurological disorder and more living in their districts.

De-identified data from Empower suggests there are XX persons under the age of 18 with functional and access needs within the SPARC region with electricity-dependent medical and assistive equipment. For further information, please visit <u>https://empowermap.hhs.gov</u>. Assistance and support for this population may vary depending on the type and magnitude of a given disaster situation. Access to appropriate resources for assistive equipment and safe transportation during a disaster or MCI may present a challenge for the SPARC region due to equipment shortfalls. Parents, Caregivers and hospitals should consider having extra supplies and equipment available to care for children in a disaster.

To assist Providers, parents/caregivers can also complete an <u>Emergency Information Form for Children</u> <u>With Special Health Care Needs</u> which is available through the American Academy of Pediatrics or the American College of Emergency Physicians. Completion of this form will provide information on the child's condition, their medical history, contact information for their physicians, medications and medical assistive devices during and immediately following a disaster event. For more information on preparing children for disasters refer to <u>https://www.ready.gov/kids</u>.

Upon request, SPARC will assist hospitals in meeting the needs of these children through the following actions:

- Mobilize resources (e.g., FAN trailer with age appropriate supplies –refer to Addendum for inventory list)
- Coordinate efforts to identify specialized equipment and transportation resources
- Create a support network for victims/non-victims, identifying resources needed to cope effectively (e.g., mental health services, ARC, faith-based organizations)
- Offer continuing education/training opportunities to hospital partners in caring for the pediatric patient
- Collaborate with local utility companies, fire, police, and/or emergency management to assist in registering children with FAN /CSHCN within the SPARC region



1.5 SITUATION

1.5.1 REGIONAL PEDIATRIC SURGE CAPABILITIES

The SPARC region consists of 22 hospitals and 4 EMS systems. There are four IDPH designated EMS Resource Hospitals which oversee the provision of EMS within their communities as well as forms a network of associate and participating hospitals:

- 1. Heartland Regional EMS System: Heartland Regional Medical Center, Marion II.
- 2. Southern Illinois Regional EMS System: Memorial Hospital of Carbondale, Carbondale, Il.
- 3. Good Samaritan Regional EMS System: SSMHealth Good Samaritan Hospital, Mt. Vernon, Il.
- 4. Deaconess EMS System: Deaconess Hospital, Evansville Indiana

Of these 22 hospitals, 16 are Critical Access Hospitals, 11 with EDs recognized by the Illinois Emergency Medical Services for Children (EMSC) in the region as having added capabilities for pediatric care: 6 Stand-by Emergency Departments (SEDP) and 5 Emergency Departments Approved for Pediatrics (EDAP). There are very limited to none dedicated children's hospitals in the region. Table 1-1 below shows the distribution of pediatric capabilities within the SPARC region. Only 2 hospitals provide inpatient pediatric acute care services. In the event of a surge, all hospital partners could potentially be involved in the response.

	NICU Only	Pediatric Acute Unit Only	NICU and Pediatric Acute Unit	PICU, NICU and Pediatric Acute Unit	Pediatric Inpatient Services
Number of Hospitals	0	2	0	0	21

Table 1-1. Hospitals with Pediatric Units

Eleven hospitals within EMS Region V have been recognized as an Emergency Department approved for Pediatrics (EDAP) or Standby Emergency Department approved for Pediatrics (SEDP). The requirements for pediatric recognition of hospital EDs are designated by IDPH for their pediatric emergency/critical care capabilities at one of the following three levels (refer to Illinois Administrative Code for further details):

- PCCC: Pediatric Critical Care Center A hospital (designated by the Department pursuant to Section 515.4020 of the Illinois Emergency Medical Services and Trauma Code) that has a dedicated pediatric intensive care unit (PICU) and other defined pediatric critical care capabilities and is able to provide optimal critical and specialty care services to pediatric patients; and provides all essential services either in-house or readily available 24 hours per day.
- EDAP: Emergency Department Approved for Pediatrics A hospital (designated by the Department pursuant to *Section 515.4000* of the Illinois Emergency Medical Services and Trauma Code) that meets defined emergency department requirements related to pediatric physician/nursing continuing education, quality improvement, policies/treatment guidelines, inter-facility transfer agreements, equipment/supplies; and is able to provide optimal emergency department care to pediatric patients 24 hours per day.



• SEDP: Standby Emergency Department for Pediatrics – A hospital (designated by the Department pursuant to Section 515.4010 of the Illinois Emergency Medical Services and Trauma Code) that meets defined emergency department requirements related to pediatric physician/nursing continuing education, quality improvement, policies/treatment guidelines, equipment/supplies, and is able to provide optimal emergency department care to pediatric patients; and has transfer agreement(s) and transfer mechanisms in place when more definitive pediatric care is needed.

1.5.2 REGIONAL PEDIATRIC SURGE CAPACITY

Surge capacity for optimization of access to hospital beds is a limiting factor in response to a MCI. Hospitals within the SPARC region do not routinely admit pediatric patients. Hospitals that admit pediatrics but do not have dedicated inpatient pediatric beds, admit to a mixed unit. These facilities' pediatric admissions are limited by both bed and staff availability; subject to change on a daily basis (Refer to Table 1-2).

EMS REGION V HOSPITALS	PEDS DESIGNATION*	PERINATAL LEVEL**	PEDS	PICU BEDS	NICU BEDS	SURGE CAPACITY
Carle Richland Memorial	-	Level II	4	0	0	
Clay County	-	Level Ø	0	0	0	
Crossroads Community	SEDP	Level Ø	0	0	0	
Fairfield Memorial	SEDP	Level Ø	0	0	0	
Ferrell	-	Level Ø	0	0	0	
Franklin	SEDP	Level Ø	0	0	0	
Hamilton Memorial	-	Level Ø	0	0	0	
Hardin County General		Level Ø	0	0	0	
Harrisburg Medical	-	Level Ø	0	0	0	
*Heartland Regional Medical Center	SEDP	Level Ø	0	0	0	
Herrin Hospital	SEDP	Level Ø	0	0	0	
Marshall Browning	-	Level Ø	0	0	0	
Massac Memorial	-	Level Ø	0	0	0	
*Memorial Hospital of Carbondale	EDAP	Level II-E	14	0	0	
Pinckneyville Community	-	Level Ø	0	0	0	
Salem Township	-	Level Ø	0	0	0	
St. Joseph Memorial	SEDP	Level Ø	0	0	0	

Table 1-2. SPARC Regional Pediatric Surge Capacity



*St. Mary's Good Samaritan	EDAP	Level II	0	0	0	
St. Mary's	EDAP	Level II	10	0	0	
Union County	-	Level Ø	0	0	0	
Wabash General	-	Level Ø	0	0	0	
Washington County	-	Level Ø	0	0	0	
PEDIATRIC DESIGNATION		ILLINOIS PERINATAL LEVELS				
PCCC: Pediatric Critical Care Center		Level Ø: Non-Birthing Center				
EDAP : Emergency Department Approved for Pediatrics		Level I: General Nursery				
		Level II: Intermediate Care Nursery				
SEDP : Standby Emergency Department Approved for Pediatrics		Level II-E: Special Care Nursery with Extended Capabilities				
	Level III: Neona	tal Intensiv	ve Care			

*Resource Hospital

Hospitals in the region currently maintain Inter-Facility Transfer Agreements with designated pediatric tertiary facilities in the Indiana and St. Louis areas that will accept or receive patients as appropriate and possible during a surge event (Refer to Table 1-3.). Below is a list (not all inclusive) of tertiary care centers that EMS Region V transfers pediatric patients to most frequency. For a complete list of EMS Region V Pediatric Resources, refer to Appendix 3.3.

HOSPITAL NAME	PEDS DESIGNATION	TRAUMA CENTER LEVEL	PERINATAL LEVEL	PEDS	PICU BEDS	NICU BEDS
Ascension St. Vincent Evansville	EDAP	Level II & Pediatric Level II	Indiana III NICU			
Deaconess Gateway Hospital*	EDAP	Level II & Pediatric Level II	Indiana III NICU			
SSM Health Cardinal Glennon Children's Hospital		Pediatric Level I	III NICU	103	86	65
St. Louis Children's Hospital		Pediatric Level I	III NICU	210	79	122

Table 1-3. Transfer Agreements with Pediatric Tertiary Care Centers in St. Louis and Indiana

PEDIATRIC DESIGNATION	ILLINOIS PERINATAL LEVELS	
PCCC: Pediatric Critical Care Center (Only	Level Ø: Non-Birthing Center	
available by transfer)	Level I: General Nursery	
EDAP: Emergency Department Approved for Pediatrics	Level II: Intermediate Care Nursery	
SEDP: Standby Emergency Department Approved	Level II-E: Special Care Nursery with Extended Capabilities	
	Level III: Neonatal Intensive Care	

*Resource Hospital

1.5.3 REGIONAL PEDIATRIC SPECIFIC VULNERABILITIES

Children have unique physical and behavior characteristics which put them at increased risk during a disaster. Because of these vulnerabilities, and others, hospitals should be prepared to receive and continue care for pediatric patients in a surge event. The Illinois EMSC have identified some of their unique consequences in a disaster event (refer to Table 1-4):

Characteristic	Cause	Consequences
Larger head for a given body weight	High center of gravity	More likely to suffer head injuries and falls
Greater skin surface for body	Evaporative heat and water losses	Hypothermia and dehydration
Closer proximity of solid organs with less bony protection	Relative size with younger age	Greater chance of multi-organ injuries
Wide range of normal vital signs	Large differences in size, weight, and normal values	Difficult to determine normal values for a given individual, particularly for clinicians more accustomed to caring for adult patients
Rapid heart and respiratory rate	Normal physiologic variables based on age and weight	Faster intake of airborne agents and dissemination to tissues
Wide range of weight across pediatric age range	Normal physiologic variables based on age and weight	Greater likelihood of medication errors
Shorter height	Closer to the ground	Greater exposure to chemical and biologic toxins that settle near the ground due to higher density
Often found in groups	Daycare and school	More likely to see multiple casualties
Immature cognitive and coping skills	Age and experience, psychological development	Less likely to flee from danger, inability to cope, inability to care for themselves, find sustenance, and avoid danger
Small blood vessels	Relative size with younger age	Difficult venous access, more difficult fluid and medication delivery

Table 1-4. Unique Consequences in Children During a Disaster



1.5.4 REGIONAL PEDIATRIC SURGE GAPS

Every hospital within EMS Region V has some limited pediatric capabilities for the triage and treatment of a pediatric patient (refer to Table 1-2). The region has 28 in-patient pediatric beds across 22 hospitals (EMResource). There are very limited to non-pediatric dedicated hospitals within the region, but many of the hospitals have transfer agreements in place. Refer to Table 1-3 for a listing of pediatric tertiary care centers equipped to handle critically ill pediatric patients.

In the event of a MCI within the SPARC region that results in a surge of pediatric patients presenting to EDs, there will be an immediate need for critical care resources, including staff, medical equipment, medications, supplies, and space to provide timely, effective care. Within the SPARC region, the following have been identified as pediatric limitations to care for a large pediatric population surge of critically ill victims during a disaster or incident:

- 1. Limited Pediatric Bed Capacity on a Daily Basis
- 2. Very Limited PICU or NICU Capability
- 3. Limited Peds Unit
- 4. Limited Pediatric Specialty Resources
- 5. Varying Availability of Pediatric Trained Staff (e.g., respiratory therapists and neonatologist)
- 6. Less Availability of Pediatric Crucial Care Supplies (e.g., pediatric sized resuscitation equipment, ventilators, monitors)
- 7. Limited Transportation Resources

Within EMS Region V there are fewer pediatric hospital beds and pediatric specialists with experience caring for critically ill and injured children than in non-rural areas. Emergency Departments (EDs) have very limited supplies deemed essential for managing pediatric patient emergencies. During a disaster, some pediatric casualties may require critical care in a pediatric intensive care unit (PICU). Thus, the resources to care for critically ill and injured children in EMS Region V are limited. Strategies for expanding Pediatric critical care capabilities in EMS Region V are discussed in Section 2.4 of this annex.

1.5.5 HAZARDS VULNERABILITY ANALYSIS (HVA)

The SPARC region has many highways, interstates and railways. The region is bordered by the two most voluminous rivers in the United States: Mississippi River and the Ohio River that pose a significant mass casualty event risk to the communities as well as large agricultural industries. Major factories in the region pose a significant threat to the communities through mass casualty events ranging from explosions to large scale chemical exposures. Natural disasters pose a significant risk as well due to tornadoes, flooding, earthquakes and cold weather events creating a large-scale event involving the adult and pediatric populations.

SPARC has conducted a detailed regional HVA to identify potential internal and external hazards that are likely to have an impact on communities, critical facilities (medical care facilities, fire stations, police stations, schools, and EOCs), and patient population within the region. For further details on the specific regional vulnerabilities, refer to the <u>Comprehensive Emergency Management Program</u> (IDPH approved account to access) for a full HVA or the SPARC Regional Response and Recovery Plan (Attachment H).



Each hospital, short term & long-term care facility, including outpatient care locations are required to conduct an HVA and review it annually or as needed to prioritize planning, mitigation, response and recovery activities.

A Pediatric Hazard Vulnerability Analysis is underway to help facilitate planning and response efforts, and identify potential pediatric surge volume within the SPARC region.

1.5.5.1 SUPPLY CHAIN INTERRUPTION

Within the Coalition, the specific vulnerabilities of the healthcare organization to the hazard impact differs from the specific vulnerabilities of the community to the hazard impact, in terms of service delivery and service demands. Healthcare organizations are faced with the difficulties of delivering health care services during a disaster due to the service demands that may be placed on health care organizations during emergencies.

The health care supply chain is dependent on many variables including: availability of raw materials, workforce, machinery and parts, delivery methods, contracts and regulatory requirements, as well as underlying critical infrastructure systems such as power, telecommunications systems, and transportation. Disruptions to these systems can be the result of various hazards, underlying vulnerabilities, and threats that can have a direct impact on every level of the supply chain (e.g., natural disasters, human-caused disasters, and public health threats).

During a surge event, the supply chain will likely be fragile, with little additional capacity. Hospitals in EMS Region V rely on some of the same suppliers, resulting in resource shortfalls in a disaster or MCI. Hospitals are encouraged to develop and implement contingency plans to ensure the availability of critical resources and to facilitate the continuity of operations in an emergency situation. SPARC may work with health care partners on supply chain readiness and response planning to enhance resource sharing when necessary and possible. By serving as a coordination and information-sharing hub, the Coalition can provide opportunities for health care partners to train and exercise together, coordinating strategies to address specific supply shortages, and identifying key actions that will enhance resilience during incidents (e.g., back up options).

1.5.6 COALITION PREPAREDNESS

The development of partnerships with various agencies, response groups, and health care providers is an essential component of coalition building, as well as hospital disaster preparedness. SPARC collaborates with key response partners such as: emergency management agencies (EMA), faith-based organizations, long term care (LTC) facilities, American Red Cross (ARC), Medical Reserve Corps (MRC), mental health agencies, and others that can provide care for children in a disaster. SPARC considers the pediatric population in preparedness efforts through planning, training and exercising aiming to strengthen the capacity for response in times of disaster. Steps to ensure Coalition and facility preparedness to treat critically injured pediatric patients during a disaster or MCI are supported by discussion organized around the following components: education and partnerships, incident management and response, disaster planning, logistics, triage and treatment, and After-Action Reports (AARs). For further guidance, hospitals and healthcare entities can refer to the Illinois EMSC <u>Hospital</u> <u>Pediatric Preparedness Checklist</u>.

All coalition hospital and response partners should consider the following key preparedness activities designed to work alongside this annex:



- Procure pediatric appropriate supplies (medications, equipment, food, blankets)
- Maintain current transfer agreements with pediatric tertiary care facilities
- Conduct security and disaster drills that involve pediatric victims
- Maintain proficiency in JUMPSTRART Triage
- Integrate pediatric protocols into your facility's disaster plan
- Incorporate the use of Job Action Sheets that identify pediatric-specific job functions
- Incorporate pediatrics into training exercises (include FAN and CSHCN populations)
- Incorporate pediatric cross training opportunities into routine practice
- Educate ED, Pharmacy and Admin staff on Pediatric Surge roles/responsibilities as outlined within this annex
 - Pharmacy
 - Instructional brochures developed by IDPH for: <u>amoxicillin</u>, <u>doxycycline</u>, <u>oseltamivir (Tamiflu®)</u>
- Conduct one Pediatric Surge table-top exercise per year
- Conduct one Pediatric Surge functional exercise every 2 years that involves both EMS and hospital systems
- Develop and document locations of concentrated pediatric populations (schools, daycares, parks, etc.) within a 5-mile radius and include in disaster planning.
- Annually review system/region EMS Disaster Plan, Pediatric Surge Annex and SPARC Regional Response and Recovery Plan
- Encourage formal training and certification maintenance in one or more of the following courses:
 - Advanced Pediatric Life Support (APLS)
 - Advanced Trauma Life Support (ATLS)
 - Disaster Preparedness for EMS
 - Disaster Preparedness for School Nurses
 - Neonatal Resuscitation Program (NRP)
 - Emergency Nursing Pediatric Course (ENPC)
 - Pediatric Advanced Life Support (PALS)
 - Pediatric Education for Prehospital Professionals (PEPP)
 - School Nurse Emergency Care (SNEC)

*Training is crucial to sustain regional disaster preparedness. Refer to Illinois EMS Region V CEMP (IDPH approved account only) for the 2021-2024 Illinois EMS Region V Multi-Year Training and Exercise Plan (MYTEP) for regional training and exercise opportunities.

1.6 ASSUMPTIONS

- The Shawnee Preparedness and Response Coalition (SPARC) serves as the primary organization for the coordination for ESF-8 Public Health and Medical Services in the MPHMSRR.
- All hospitals providing emergency services are equipped to initially treat and stabilize pediatric
 patients in accordance with their available resources. All hospitals have differing capacities and
 capabilities of treating and stabilizing pediatric victims; however, all hospitals should at
 minimum provide initial triage and resuscitation for pediatric patients.

- Priority is to transfer the most critical as early as possible to an appropriate referral center.
- The pediatric surge response will use existing NIMS/HICS response frameworks.
- Non-pediatric facilities will receive children from mass casualty events.

SPARC

- In large incidents, or when access to the facility is an issue, hospitals/health care providers may have to provide ongoing care pending arrival of sufficient transportation or treatment resources
- Most critical access hospitals will not be able to treat critically injured pediatric patients long term and will need to transport them to a higher trauma level hospital.
- This annex supports the IDPH Pediatric and Neonatal Surge Annex.
- Each designated pediatric tertiary facility has pediatric transfer agreements in place.
- Facilities impacted by disaster have activated their emergency operations plan (EOP) and staffing of their facility operations centers.
- When this annex is activated, all health care facilities within the Coalition boundaries will fall into one of the following four categories to assist with the coordination of care during a pediatric MCI:
 - **Category 1**: Pediatric Specialty Centers (pediatric intensive care unit (PICU) and/or neonatal intensive care unit (NICU))
 - **Category 2**: Community hospitals with some pediatric services
 - **Category 3**: Community hospitals with no pediatric/neonatal services
 - **Category 4**: Community hospitals with Level I, II, and/or II-E nurseries, but no other pediatric services
- The local and/or regional health care system has exhausted its capacity to care for pediatric patients and has implemented and exhausted any mutual aid agreements, therefore, requesting assistance from the other regions and/or the state.
- Requests for assistance with medical consultation, system decompression and coordination for pediatric patient movement will be considered once a request for medical resources (RFMR) has been made as outlined in the SPARC Regional Response and Recovery Plan, IDPH ESF-8 Plan and Pediatric and Neonatal Surge Annex.
- Processes and procedures outlined in this annex are designed to support and not supersede or replace individual health care organization emergency response efforts.
- The age range for children that meets the definition of a pediatric patient in this annex is birth to 15 years of age. Pediatric victims will be encountered in a disaster response since the typical pediatric population is about 25% of the total population in a given community.
- Partner/member organizations will work together for a common good despite day-to-day competitions.
- An effort has been made to be realistic in terms of available resources and capabilities that are subject to change. Flexibility is therefore built into this plan.



2. CONCEPT OF OPERATIONS

INTRODUCTION

The guidance outlined in this annex will be considered anytime the SPARC Regional Response and Recovery Plan is activated and there are pediatric patients or victims involved. Not all steps and activities will apply to all hazards. When an incident occurs resulting in a large number of casualties that are children, the initial response will follow local surge plans. IDPH, local hospitals and EMS agencies should assess and consult with the SPARC Duty Officer (or designee):

- Scope and magnitude of the incident
- Potential impact on the local health care system due to an influx of patients
- Any special response needs (e.g., infectious disease, hazardous materials, etc.)
- Internal Response Plan activation(s)

All disasters should be managed locally. When local resources are overwhelmed, a tiered system is used, moving from local, to county, to the region, to the state (intrastate and interstate), and the federal level in order to secure the needed resources.

Coordination of the disaster response is based on the premise that key individuals are identified and available to respond appropriately to a disaster situation involving numerous casualties. This will require the coordination of resources, and the sharing of information among coalition members and local, regional, and state response partners.

SPARC functions as a Multi-Agency Coordination (MAC) Group. The role of SPARC in a Pediatric Surge response is integration of the RHCC, local hospitals, emergency medical service providers, local health departments, local emergency management agencies, and other healthcare and non-healthcare response partners which enables these critical entities to respond to and recover from a surge event in the region.

Each hospital is responsible for organizing itself internally so maximum effective response to the situation can be achieved. Subject matter expertise will be provided to advise and/or to direct operations as it pertains to pediatric patient movement, system decompression, care guidelines and resource allocation within the context of the Incident Command system structure. Pediatric subject matter experts throughout the state and surrounding border states will be utilized.

2.1 ACTIVATION

When an incident occurs resulting in a surge of pediatric patients that overwhelms local emergency response operations and plans, SPARC partners will consider and assess the need for a regional response.

The Pediatric Surge Annex can be partially or fully activated when the SPARC Regional Response and Recovery Plan is activated, and specialized pediatric care is required and resources are limited. The identifying organization should notify the RHCC by contacting the SPARC Duty Officer 24/7 at **(618) 303-2864** or by sending out an alert notification through SIREN. The SPARC Duty Officer will make notifications to the IEMA Duty Officer, IDPH Duty Officer and SPARC Executive Board. The notification should take place as soon as it is suspected that a local medical response may exceed resource capabilities by utilizing the appropriate request procedure. Refer to the **Pediatric and Neonatal Surge**

Annex Activation Pathway (Attachment B). The activation of this annex includes information sharing and coordination across all response partners.

Upon activation of this annex, hospitals within the MPHMSRR will fall into one of the following four categories to assist with the coordination of care during a pediatric MCI:

- **Category 1**: Pediatric Specialty Centers (pediatric intensive care unit (PICU) and/or neonatal intensive care unit (NICU))
- *Category 2*: Community hospitals with some pediatric services
- *Category 3*: Community hospitals with no pediatric/neonatal services
- **Category 4**: Community hospitals with Level I, II, and/or II-E nurseries, but no other pediatric services

The RHCC is activated at the discretion of the SPARC Duty Officer when circumstances dictate to support health care operations and manage surge within the MPHMSRR.

2.1.1 ACTIVATION LEVELS

The SPARC region has established the following 3 activation levels; scalable implementation allows for appropriate levels of coordination:

- 1. Normal/Operations/Steady State Activities are normal; no specific risk or hazard is identified.
- Enhanced Steady State/Partial Activation SPARC is aware of a credible threat, risk or hazard and monitors a potentially emergent incident for further development and ensures availability for immediate activation, if necessary. The coalition response may be operated by a single person, can be virtual and not require a physical location.
- 3. Full Activation Provides notice to all coalition members and response partners that the RHCC has been activated. Request staffing resources for the RHCC. Additional member organizations may be needed to support the response to a major incident or credible threat and may require a physical location.

2.1.1.1 INDICATION/TRIGGERS

Incidents that could prompt the initiation of a surge or decompression process may include, but are not limited to the following:

- Influx or surge of pediatric patients that overwhelms the capacity or resources of a single receiving facility;
- Overwhelming influx or surge of pediatric patients to EDs;
- Scope and magnitude of the incident includes more than one jurisdiction;
- Damage or threats to health care facility(ies) or the healthcare system;
- Inadequate pediatric health care facility resources (e.g., inpatient monitored beds, ventilators, isolation beds)
- Local resources have been exhausted;
- Activation of health care facility(ies) disaster plan and HICS when surge capacity for pediatric
 patients has been exceeded



- Request from border states to assist with a surge of pediatric patients
- Staffing limitations (e.g., qualified and trained staff to care for pediatric patients)
- MCI due to an incident generating a surge

Hospitals that routinely care for children may be requested to increase their capacity and capabilities to surge less stable or younger pediatric patients. This may require hospitals to expand surge capacity, provide secondary transfers or decompress to make room for incoming pediatric patients. More stable pediatric patients may be sent, diverted or transferred to other facilities for care. Hospitals can request the help of SPARC to support coordinated distribution of patients throughout the region.

2.2 ALERTS/NOTIFICATIONS

Upon activation of this annex, coordinated information will occur between all entities part of the incident response to maintain flow of information and establish a common operation picture (COP). The *Pediatric/Neonatal Medical Incident Report Form* (Attachment C) will be utilized to communicate necessary information about the annex activation with affected response partners and those entities may be called upon to assist during the incident. The form may be sent and received via any available method of communication (e.g., email, fax,). When the *Pediatric/Neonatal Medical Incident Report Form* is utilized during an event, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the "Rely/Action Required" section. This form should be utilized by all stakeholders to assist in ensuring consistent communication between stakeholders and to provide a mechanism to request pediatric patient transfer resources and identify availability of resources at a health care facility.

Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally and externally from their facility. The **Pediatric Communication Pathway (Attachment D)** outlines which stakeholders will typically communicate and share information with each other when the annex is activated. Some of the possible established systems for communication that can be used include:

- 1. Telephone (landline)
- 2. Telephone (cellular)
- 3. Facsimile
- 4. Radio Systems (STARCOM 21, MERCI, HAM/Amateur)
- 5. Email
- 6. Electronic emergency management systems
- 7. SIREN
- 8. EMResource (includes Illinois' HAv-BED Tracking and Notification System)
- 9. WebEOC
- 10. CEMP (for information sharing including access to documents and resources)
- 11. Social media recognized/maintained by the jurisdictional authority

Reliant communication systems will allow access to pediatric experts, transfer requests, request for resources and transport services. Situational awareness will be supported through data-sharing systems

such as EMResource to expedite the transfer of information regarding the status of the incident and operational capacities.

SPARC will coordinate with hospital partners to facilitate the flow of communication through:

- Situational awareness information (e.g. incident details, estimation of number of victims, number of transported and/or admitted victims, number of possible victims at the scene, etc.)
- Bed availability
- Action items (e.g. conference call, frequent bed availability updates, etc.)

If the incident is catastrophic and SPARC forecasts state resources will be depleted and/or surge capacity is exceeded, a request can be made to IDPH to escalate the plan beyond state borders to inter-state partners through the Great Lakes Healthcare Partnership (GLHP) existing plans and procedures. The GLHP operates with federal partners including the U.S. Department of Health and Human Services (HHS) Field Project Officers and the Federal Emergency Management Agency (FEMA) Regional Emergency Coordinators (RECs).

2.2.1 PUBLIC MESSAGING

Public information and messaging should be coordinated among all involved partners. Designated Public Information Officers (PIOs) can work with hospital communications staff and the Joint Information Center (JIC) to draft and coordinate public messaging and information as needed to inform and educate the public about the incident and response efforts.

2.3 ROLES AND RESPONSIBILITIES

Upon receiving the request for activation of the Pediatric Surge Annex, the following roles and responsibilities will be carried out by the Coalition, health care partners, and support agencies. Pediatric medical subject matter experts should also be consulted in the triage and distribution of pediatric patients. SPARC does not supplant this responsibility.

2.3.1 REGIONAL COORDINATING AGENCY OF PUBLIC HEALTH AND MEDICAL RESPONSE

2.3.1.2 SHAWNEE PREPAREDNESS AND RESPONSE COALITION (SPARC)

- SPARC is the primary organization for the coordination of ESF-8 Public Health and Medical Services in the MPHMSRR.
- Facilitate information sharing among partner health care organizations and with jurisdictional EOCs, IDPH and other entities to exchange information and maintain situational awareness.
- Facilitate the sharing of resources (equipment, staff, supplies) through MOUs and/or mutual aid agreements and support the request and receipt of local, state, and federal assistance.
- Facilitate the coordination of incident response activities for partner health care organizations so that strategies and actions support the health care response.
- Facilitate the interface between SPARC and relevant jurisdictional authorities to effectively support health care system resiliency and medical surge.
- SPARC will remain a resource throughout the response and recovery processes.

2.3.2 LEAD STATE AGENCIES

2.3.2.1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH)

- IDPH is the lead agency for ESF-8 Public Health and Medical Services. IDPH is the support agency for ESF-6 Mass Care.
- Assist with the communication between stakeholders (e.g., hospitals, other health care facilities, LHDs, EMS agencies, border states) during an incident.
- IDPH communicates with the RHCC for intelligence gathering, information dissemination, additional resource request, and coordination of efforts during an incident.
- Coordinate state and federal health and medical disaster resources to support local operations such as the Strategic National Stockpile (SNS), temporary medical treatment stations (TMTS), etc.

2.3.2.2 ILLINOIS EMERGENCY MANAGEMENT AGENCY (IEMA)

- Authority Having Jurisdiction (AHJ) for State of Illinois and is responsible for coordinating the State's response and recovery programs and activities and supporting local EMAs when response efforts far exceeds local capabilities.
- Coordinate collection, receipt, compiling and development of situational reports on damage impacts to services, facilities, sites and programs at the local, state and federal levels
- Collaborate with IDPH to coordinate the activation of medical mobile support teams (e.g., IMERT PCMS team)
- Request disaster declaration (State and Federal) as indicated
- Collaborate with IDPH on the RFMRs for pediatric specific resources for hospitals, public health departments, alternate care sites, etc.

2.3.2.3 ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS)

- Provide assistance to hospitals, or regionally based alternative care sites, and/or state temporary medical treatment stations with:
 - Securing placement for non-injured/ill children who have been unable to be reunited with their families;
 - Providing consent for treatment of youth in care in need of medical care;
 - Providing consent for patient transfer during the decompression process for youth in care;
 - Verifying guardianship of unaccompanied minors who are in the DCFS database.

2.3.2.4 ILLINOIS LAW ENFORCEMENT ALARM SYSTEM (ILEAS)

• ILEAS is a consortium of over 900 local governments. ILEAS will meet the needs of local law enforcement throughout the State of Illinois in matters of mutual aid, emergency response and the combining of resources for public safety and terrorism prevention and response.

2.3.3 SUPPORT AGENCIES/FACILITIES/ORGANIZATIONS

SPARC

2.3.3.1 EMERGENCY MEDICAL SERVICES (EMS)

- Provide initial triage/treatment and patient tagging during a MCI.
- Provide ongoing situational awareness of medical disaster and response to EMS System Resource Hospital and RHCC/designee (e.g., patient counts).
- Establish Incident Command on-scene during emergency/disaster.
- Consult with the EMS System Coordinator to inform the RHCC of patient movement

2.3.3.2 REGIONAL HOSPITAL COORDINATING CENTER (RHCC)

Memorial Hospital of Carbondale is the designated RHCC for EMS Region V and provides administrative support and is the fiduciary agency for SPARC. The RHCC functions as the lead health care organization that assists in the coordination of coalition partners, acts as a liaison between IDPH and local partners to provide situational awareness and sharing of information and resources to coordinate regional health and medical emergency response for hospitals in the region.

During a disaster or mass casualty, the RHCC is activated to support healthcare operations and manage surge. For further information on the RHCC role refer to 77 Illinois Administrative Code, 515.240.

- Upon activation of this annex, the RHCC will act as a communications hub for the sharing of information.
- Initiate and upon request of IDPH, provide ongoing situational awareness of medical disasters, responses, and resources occurring in its response region; local hospitals will initiate and upon request of LHD, IDPH and RHCC, provide ongoing situational awareness of medical disasters, responses, and resources occurring in their delivery service area.
- Inform IDPH when the SPARC Regional Response and Recovery Plan and corresponding annexes have been activated.
- Assist health care facilities with Illinois HELPS to vet volunteers
- Assist with the communication and request for medical resources of the PHMSRR where the hospital, LHD, or health care provider is situated.
- Consult with IDPH and SPARC to determine the prioritization process for the allocation of medical equipment and supplies in its region.
- Collaborate with local EMA and LHD on TMTS selection, establishment and operation within their region.
- Provide notification to Coalition of actual or potential events to allow prompt response.



• Provide administrative and operational support to the SPARC Duty Officer and MAC Group; (The MAC Group is composed of the SPARC Executive Board and other Senior Officials, such as Agency Administrators, Executives, or their Designees, who are authorized to represent or commit agency resources and funds in support of incident activities).

2.3.3.3 RESOURCE HOSPITALS

- Provide care for pediatric patients and children with special health care needs that arrive at their facility to the best of the facility and practitioners' ability.
- Initiate and upon request, provide ongoing situational awareness of medical disasters, responses, and resources occurring in their delivery service area to the LHD, RHCC and IDPH.
- Function as the liaison between the EMS and associate and participating hospitals within their EMS system and the RHCC.
- Communicate with the RHCC for RFMRs for pediatric specific resources as indicated in the SPARC Regional Response and Recovery Plan, IDPH ESF-8 Plan and in this annex.
- Maintain a medical supply bag for disaster response (Refer to Attachment G)

2.3.3.4 ASSOCIATE AND PARTICIPATING HOSPITALS

• Provide care for pediatric patients and children with special health care needs that arrive at their facility to the best of the facility and practitioners' ability.

<u>ALL</u> hospital surge plans should include the following Pediatric Surge Response Procedures:

- Use EMSC guidelines
- Establish HICS
- Monitor STARCOM21 EMS-R5
- Update bed counts in EMResource
- Prepare for self-presented patients
- Track all casualties who arrive from the scene (transported or selfpresented)
- Implement support agreements as needed
- Increase security measures
- Decompress ED, if possible
- Provide pediatric safe space while awaiting reunification
- Reunify unaccompanied pediatric patients
- Pediatric equipment in supply chain
- Initiate and upon request, provide ongoing situational awareness of medical disasters, responses, and resources occurring in their service area to the RHCC, LHD and IDPH.
- Assist with the communication of RFMRs for pediatric specific resources as indicated in the SPARC Regional Response and Recovery Plan, IDPH ESF-8 Plan and in this annex.
- Maintain a medical supply bag for disaster response (Refer to Attachment G)

2.3.3.5 PEDIATRIC TERTIARY CARE CENTERS

- Provide treatment and care for pediatric victims and utilize telephone/telemedicine if needed to consult with hospitals.
- Admit patients per normal operating protocols until surge capacity is met.
- Maintain flow of communication with SPARC, other pediatric tertiary centers, EMS, and others as deemed appropriate.


• Monitor for and acknowledge all alerts, notifications, and communications during an incident and provide information as requested to local, regional, and state partners.

2.3.3.6 LOCAL HEALTH DEPARTMENTS

- Assist health care facilities in obtaining supplies from the Strategic National Stockpile (SNS), specific to pediatrics, as requested, through the processes established in their existing plans and the RFMRs outlined in the SPARC Regional Response and Recovery Plan and IDPH ESF-8 Plan.
- Maintain communication and provide situational awareness updates, specific to pediatrics, to health care facilities, IDPH and the SPARC Duty Officer as indicated.
- Support role for ESF-6 providing emergency shelter within the affected area(s).
- Collaborate with the local EMA and RHCC on TMTS selection, establishment, and operation in their jurisdiction.
- Host a Medical Reserve Corp (MRC) unit within the jurisdiction or affiliation with an alternative volunteer unit.

2.3.3.7 EMERGENCY MANAGEMENT AGENCIES (EMA)

- Activate the EOC in their jurisdiction.
- Provide situational awareness and real-time data with health care organizations throughout the SPARC region during an emergency response.
- Coordinate with IEMA to deploy State resources.
- Provide transportation of patients and victims to off-site locations.
- Receive and coordinate the use of medical care teams (IMERT).

2.3.3.8 AMERICAN RED CROSS (ARC)

- Support role for ESF-6 Mass Care (e.g., sheltering, feeding, distribution of emergency supplies and reunification services) establishing and running emergency shelters within the affected area(s).
- Provide disaster related mental health and psychological first aid for the affected population and disaster workers.
- Facilitate the dissemination of public information, messaging and education for the affected population
- Coordinate with hospitals and coroners to provide appropriate casualty and/or patient information for purposes of family reunification.
- Coordinate with the affected jurisdiction for potential Multi-Agency Resource Center (MARC) operations.

2.3.3.9 MUTUAL AID BOX ALARM SYSTEM (MABAS)

• MABAS is a consortium of municipalities, fire districts, and EMS providers who can provide emergency response assistance. The goal of MABAS is to establish a standard, statewide



mutual aid plan for fire, EMS, hazardous materials, mitigation and specialized rescue through a recognized system that will effectively support existing plans.

 MABAS provides a 24-hour mechanism to mobilize emergency response and EMS resources to any given location within the State through coordination with IEMA and IDPH/EMS. MABAS assets include fire engines, ladder trucks, heavy rescue squads, ambulances, emergency medical technicians (EMTs) and hazardous material teams.

2.3.3.10 FIRST RESPONDERS

- Provide rescue, containment and control to an incident or emergency.
- Provide Emergency Medical Services.
- Respond to hazardous materials incident.

2.3.3.11 NON-GOVERNMENTAL ORGANIZATIONS (NGOS)

• Upon request, NGOs, such as faith-based organizations, may provide shelter, food, clothing and other basic needs of survival during an incident or emergency.

2.3.3.12 SUBJECT MATTER EXPERTS (SME) TO THE COALITION

*SPARC is working to designate a team of Pediatric SMEs to assist in regional response efforts.

2.3.3.13 EXTERNAL EXPERTISE (TELEMEDICINE, ETC.)

- IMERT Pediatric Care Medical Specialist (PCMS) Team
 - Pediatric experts from Illinois and its border states who volunteer pre-event as part of the IMERT Pediatric Care Medical Specialist Team to be called upon by IDPH during a large-scale event in which there are numerous pediatric casualties leading to the activation of this annex. These volunteers will function as subject matter experts for the state by providing guidance on the coordination of care and medical consultation for pediatric patients.
- Great Lakes Healthcare Partnership (GLHP)
 - The GLHP is a consortium of jurisdictions, including City of Chicago, Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin located within FEMA Region V focusing on interstate coordination for significant health/medical/trauma-related incidents. The GLHP can provide communication and resource assistance in the first 24-72 hours of a significant incident in the region when other resources are being activated through conventional and/or federal request channels.

2.4 LOGISTICS – SURGE CAPACITY

The information is this section focuses more on the logistics aspect of a surge, identifying strategies for health care providers in each tier to address resource shortages and resource allocation for those seeking or currently receiving care at their facility. Refer to Section 1.2 of this annex for a more general overview of a medical surge.



Surge Capacity is defined as the ability to expand care capabilities to meet sudden and/or more prolonged demand for patient triage and treatment. In a large-scale disaster involving pediatric patients, all EMS Region V hospitals will be overwhelmed.

During a "surge" an influx of patients will present to hospitals and EDs for care. For each of the critical system components needed to respond to a surge incident, space, staff, and supplies, there are three measurements that provide guidance to overall surge capacity at each of the tiered levels. An incident does not have to overwhelm assets in all three categories to have an impact on healthcare.

Conventional capacity is the ability to manage a surge, while operating daily practices with little or no impact to the patients or facility. The spaces, staff and supplies (resources) used are consistent with daily practices within the institution.

Contingency capacity affects the ability for daily practices to be consistent, but has minimal impact to usual patient care. At this point, the demand for resources has not exceeded local resources. The spaces, staff and supplies (resources) used are not consistent with daily practices but provide care that is functionally equivalent to usual patient care.

Crisis capacity may require adjustments in care not consistent with daily practices, but the standard of care is coherent within the setting of an emergency. The best possible care is provided to patients under these circumstances. Adaptive spaces, staff and supplies (resources) used are not consistent with usual standards of care but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available).

Table 2 below demonstrates how each stage of surge capacity could potentially be managed as the number of pediatric patients increase.

	Conventional Capacity	Contingency Capacity	Crisis Capacity
Space	 Cancel elective procedures Use in-place elective procedures Begin surge discharge 	 Clear patient from pre- induction and procedure areas Fill all available beds Begin bed availability reporting (EMResource) 	 Decompress hospitals Place patients in hallways or lobby areas as needed Set up temporary structures in order to increase space capacity (TMTS) Request use of other facilities (schools, cafeterias, conference rooms, etc.)
Staff	 Use all staff trained to care for pediatrics to provide care 	 Request additional pediatric trained staff from other hospitals 	 IMERT Pediatric Care Medical Specialist Team Utilize staff not trained for pediatric care after providing just-in-time training

Table 2. Pediatric Medical Surge Response Strategies



	• Facilities are able to order more supplies through normal	•	Stockpiled supplies are being used	•	Regional pediatric resources (FAN trailer with age
Supplies	channels	•	Supplies are being		appropriate medical
			ordered through rushed		equipment and supplies) may
			delivery methods		be requested through the
		٠	Resource requests to		RHCC
			LHD and EMA	•	If local partners and SPARC
					cannot fill the demand,
					requests may be made up to
					the state level (SNS supplies)

In a large-scale event involving significant numbers of pediatric casualties, resources (e.g., equipment, supplies, medications, beds, trained staff, available space, and sources of transportation) needed to care for pediatric patients may quickly be depleted. This could lead to health care providers having to adapt normal standards of care and to implement resource allocation strategies or crisis standards of care for those seeking or currently receiving care at their facility. Illinois EMSC's *Resource Allocation Strategies for the Pediatric Population*, can assist health care providers, health care facilities, regions, IDPH and the PCMS with identifying possible strategies to assist with this task.

Each hospital within EMS Region V will determine what surge strategies to implement to meet the surge of pediatric patients based on their facility's capacity and capabilities. The recommendation is to plan for an increased surge volume over at least a 3-day timeframe. For more information, refer to the <u>Illinois</u> <u>EMSC Pediatric Disaster Preparedness Guidelines for Hospitals</u>.

2.4.1 SPACE

<u>Objective</u>: Increase the ability to maintain operations and/or take on additional patients by repurposing the use of space.

All appropriate and available space will be identified for pediatric care during a surge event (e.g., triage areas, inpatient care, Pediatric Safe Area). Refer to **Attachment L** for Pediatric Safe Area considerations.

For the purposes of this annex, space has been categorized as follows:

- *Conventional Space*: Areas where care is normally provided (e.g., treatment space inside hospital or physician office space).
- *Contingency Space*: Areas where care could be provided at a level functionally equivalent to usual care (e.g., adult rooms used as pediatric rooms, closed units)
- *Crisis Space:* Areas where enough care could be provided when usual resources are overwhelmed (e.g., non-pediatric providers and/or ambulatory care pediatric providers supervising inpatient care, temporary intensive care/ventilator support for patients who cannot be moved, or alternative space).

Hospitals and EDs should consider the pediatric medical surge response strategies in Table 2 to temporarily increase surge capacity to care for children during a surge event.

In the event that hospitals will need to create pediatric emergency treatment capacity outside of the facility, mutual agreements with other types of healthcare facilities, such long-term care facilities and rehabilitation facilities will be utilized. Mobile clinics, faith-based facilities, and/or schools may be



utilized for minimal casualties, families, the "worried well" and volunteers until the situation and surge returns to a stable state and normal operations to ensure that the most acutely injured or ill are treated at the hospitals. The hospital IC will collaborate with the RHCC, local EMA and LHD on temporary medical treatment stations (TMTS) selection, establishment and operation within their region.

2.4.2 STAFF

<u>Objective</u>: Increase the ability to maintain staffing levels and/or expand the workforce.

The availability of appropriately trained staff is key in the response. Hospitals should utilize communication plans to notify and call staff, as required during an incident. Pre-identified hospital staff with specialty skills or experience with pediatric patients, pediatricians, trauma surgeons, Pediatric ED staff, Emergency Medicine physicians, family medicine, anesthesia, ENT pediatric surgery, general surgery, neonatology, orthopedics, urology, neurosurgery, the OR, PACU, ICUs, inpatient units and outpatient clinics, pharmacy, or respiratory therapy may be called upon to help determine what services will be prioritized and direct appropriate staff to provide those services.

Staffing will be a priority during implementation of the Pediatric Surge Annex for all service Providers. Each hospital is expected to have a policy addressing peak census procedures in the event that they are nearing the point of being overwhelmed [77 IL Admin code 515.330(o)]. Hospitals may utilize labor pools and any pre-existing staff sharing agreements with local facilities to vet supplemental staff. Support staff should be utilized for the Pediatric Safe Area (PSA).

Upon request, SPARC will assist hospitals to mobilize appropriately trained staff to enhance the response. The Medical Reserve Corps (MRC) volunteers, who are pre-registered and credentialed may be called to provide additional staff during the surge event. LHDs may also be able to help with contacting local MRC unit volunteers since many of the LHDs in EMS Region V have a MRC Coordinator who is able to contact local volunteers when they are needed.

During a surge event, staff in other areas that may have experience with caring for the pediatric patient that provides them with a level of comfort and expertise allowing them to assist in care during the disaster will be utilized. Such staff are encouraged to keep current training and courses.

2.4.2.1 PEDIATRIC SURGE TRAINING RECOMMENDATIONS

Training falls into two basic categories:

1. Formal classes: (Advanced Trauma Life Support – ATLS, Advanced Pediatric Life Support

APLS, Pediatric Advanced Life Support – PALS, Basic Disaster Training and Disaster drill including pediatric patients)

2. Facility Education:

- Space, staff, supplies (as outlined in this annex)
- Equipment (location and use)
- Simulation sessions
- o Exercises
- Decontamination education about pediatric –specific issues.



Some facilities may implement or develop just-in-time training for clinical or additional staff to care for pediatric patients. As needed, receiving hospitals can rely on the expertise of providers that routinely provide specialized care for pediatric patients via telecommunications. All attempts will be made to provide a standard of care that will provide the best outcomes within the constraints of the event.

2.4.3 SUPPLIES

Objective: Ensure adequate supplies and equipment.

During a disaster, it is important to ensure there are adequate supplies and equipment for staff, patients, and families. Crisis supply strategies require care processes that adapt to resource shortages so that the greatest good for the greatest number is achieved.

Most emergency departments have some pediatric supplies, but they are limited, and may have issues sustaining pediatric patients if they are unable to acquire more supplies or transfer the patients. Pediatric Specialists will be relied upon to address such issues.

In the event that supplies are not available through existing channels, hospitals will follow the resource request algorithm to obtain them from regional, state or federal resources. The RHCC, with the assistance of SPARC assists with local and regional health and medical disaster response resource coordination between partner entities. For pediatric care equipment resources needs/requests, requesting entities will need to complete the *ICS 213RR form* (refer to Attachment E) and submit it through the RFMF Process as outlined in the SPARC Regional Response and Recovery Plan (2.3.2.5.5) or IDPH ESF-8 Plan. Each hospital will follow the *Request for Resource algorithm* and associated process (refer to Attachment F). SPARC may be tasked with helping to fulfill requests at the local, regional, or state level.

• The RHCC has a FAN trailer with age-appropriate supplies for the pediatric patient that can be deployed. Refer to the **Addendum** for list of supplies.

All pre-hospital providers, in accordance with established pediatric IDPH supply and equipment list, shall maintain and utilize the size/age appropriate equipment for the pediatric patient in their care. Including age appropriate pediatric pharmaceuticals, and dietary needs. All Hospitals are required to have a minimum of 1 disaster bag per 77 IL Admin section 515.240 (Refer to **Attachment G**).

Recommendations for the pediatric emergency patient include:

- Age appropriate specific equipment
- Age appropriate pediatric pharmaceuticals
- Age appropriate dietary needs

Note: The Strategic National Stockpile (SNS) is considered crisis supply. When local and regional resources and processes are exhausted, hospitals will contact the LHD within its jurisdiction to assist in acquiring supplies from the SNS as requested. Hospitals should follow processes identified and incorporated into their existing plans. If there is not a LHD within its jurisdiction, the affected hospital will contact their local EMA coordinator.



2.5 SPECIAL CONSIDERATIONS

The Assistant Secretary for Preparedness and Response (ASPR) has recognized five areas of special concern in regard to pediatric patients. These five concerns are addressed below and have been integrated into coalition planning efforts.

2.5.1 BEHAVIORAL HEALTH

Disasters are mentally traumatic for all, especially children. Children respond to trauma and disaster differently than adults, typically based on their age and developmental level. For CSHCN some physical and emotional conditions may worsen in stressful situations. Children with emotional impairments may display increase anxiety during or after a disaster event. Children who are physically challenged may become more concerned as to how they will be moved to a "safe area" since they may be unable to do so on their own. The Illinois EMSC has identified some common reactions in children during and after a disaster. Hospital partners can refer to **(Attachment H)** for a table that outlines common reactions that children may exhibit during and after a disaster based on common age groupings.

The American Red Cross (ARC) plays a supporting role to hospitals and SPARC by aiding and assisting local resources, victims and families and should be contacted as soon as possible by the Incident Commander (IC)/Command Post when a multi-victim incident occurs. American Red Cross (ARC) can provide disaster related mental health and psychological first aid for the affected population and disaster workers. *Psychological First Aid* is an evidence-based approach to help victims cope in the aftermath of a disaster. Hospitals should consider that the psychological health of children requires a different type of "psychological first aid" than adults. The primary objective when caring for children is to create and sustain an environment of safety, comfort and connection with social support.

Coalition partners can identify/coordinate with faith-based organizations and other community resources to provide the support of spiritual leaders to meet the basic needs of affected communities, upon request. The Coalition will provide a venue to network and share information and resources. In addition, The Federal Emergency Management Agency (FEMA) offers resources to parents, caregivers and other providers on how to prepare before a disaster occurs and how to help children cope following a disaster. Refer to guide <u>Helping Children Cope with Disaster</u>.

2.5.2 DECONTAMINATION

Children have special needs during decontamination procedures. Ideally families should be kept together (whenever possible) during the decontamination process to help minimize chance of family separation. Each hospital within the SPARC region has a decontamination plan and will plan to activate and perform decontamination, as necessary according to their individual facility plan. Additional personnel will be needed to escort and assist children during decontamination. Upon request, SPARC will help to coordinate additional decontamination resources. EMS agencies may provide field decontamination, if needed.

Some specific considerations from the American Academy of Pediatrics to consider when decontaminating children are:

- Children who are pre-school age, or children with special health care needs may require assistance of their parents and/or hospital staff
- Children should be kept with parents if possible



- Children are more vulnerable to aerosolized or chemical agents because they have higher respiratory rates
- A child's skin is thinner and more sensitive than an adult; use soft bristle brushes to avoid skin irritation
- Infants and children are slippery when wet, they should never be carried; avoid potential injury by utilizing a system such as a plastic basket or container with sides that provide security and drainage holes to allow water to flow through. The same should be considered for non-ambulatory children during the decontamination process
- Children may resist and be frightened during decontamination
- Unaccompanied children may require assistance with decontamination from hospital personnel
- Clothing may be a significant identifier for pediatrics; staff may be needed to assist in the identification of a child after the decontamination process
- Children become cold much quicker than adults and need to be kept warm. Monitor water pressure and temperature before and during decontamination to prevent hypothermia
- Rewarming measures should be provided upon completion of decon such as repeated drying, warm room, towels/blankets, parents holding, etc.

For a mass casualty or disaster requiring decontamination of children, proper equipment, skills, and training are necessary. SPARC provides annual chemical and radiation decontamination training to its hospital members that includes consideration for specialty populations such as pediatrics, at-risk and functional and access needs/special healthcare needs.

In the event of a nerve agent exposure, hospitals will refer to the CHEMPAK Plan. CHEMPACK Hospitals maintain a cache of nerve agent antidote for hospital and field use. There are two CHEMPACK locations within the SPARC Region.

2.5.3 EVACUATION

The decision to evacuate is the responsibility of each facility or local emergency management officials. The evacuation of newborns, infants, or children is considered a high-risk activity. Pediatric patients require some special considerations during evacuation, including medical and psychological safety concerns and ensuring family notification and reunifications occurs efficiently. Additionally, specialty transport may be required for some children, especially neonates, that may be too unstable to move. In a large-scale patient movement operation, pediatric patients may need to be moved outside of the region to accommodate their care needs. The total evacuation of a hospital will likely require regional assistance and, depending on patient census and acuity, may require state assistance. The Illinois EMSC <u>Neonatal Intensive Care Unit (NICU) Evacuation Guidelines</u> can assist hospitals with carefully planning for an NICU evacuation of high risk, medically fragile neonatal patients. The guidelines may be helpful in assisting with other pediatric patient populations as well.

When planning for the evacuation of children, hospitals should consider the following general concepts:

- Availability and accessibility of pediatric/size appropriate evacuation equipment
- Identifying available resuscitation equipment/supplies (i.e., "jump bags")
- Extra measures to ensure the safety and security of children



Currently the SPARC Regional Response and Recovery Plan: Patient Movement Annex has not been developed. Plans for the development of the annex are underway. SPARC will work with partner health care facilities and EMS to coordinate appropriate transportation. Facilities will follow their own Emergency Operations Plans for coordination of transportation and staging, other needs and issues.

2.5.4 SPECIAL PATHOGENS

Each facility will follow their infection disease control policies, which shall account for pediatric-specific issues. SPARC will coordinate with the RHCC to allocate resources to health care facilities to ensure an adequate amount of Personal Protective Equipment (PPE).

In regard to high consequence pathogens SPARC will work together with response partners to reduce morbidity, mortality and social disruption. SPARC will coordinate with public and private sectors to provide a regional tiered health care delivery system with facilities pre-designated to safely and effectively manage and transport person/patients with suspected or confirmed high consequence infectious disease.

A future Infectious Disease Annex will be developed to support the SPARC Regional Response and Recovery Plan, by providing a functional annex for all stakeholders involved in the potential consequence of an infectious disease outbreak within the SPARC region. The Infectious Disease Annex will provide a framework for infectious disease-specific preparedness and response activities, and serve as a foundation for future SPARC planning, training, education, exercises, drills, and other emergency preparedness activities. The Annex will work in close coordination with LHDs planning for infectious disease response. Behavior health considerations and other health risks in a pandemic will also be integrated into Coalition planning efforts in order to promote community resilience.

2.5.5 SECURITY AND SAFETY

SPARC recognizes that pediatric safety and security issues are critically important for all hospitals since children are at high risk for abuse, abduction, and trafficking during a disaster, especially when separated from their parents/caregivers. Hospitals will follow protocol for securing and limiting facility access during a pediatric surge incident or disaster. Activating traffic control measures for access to facility will help ensure the safety and security of all children that present at their facility, victim or non-victim of a disaster.

Hospitals within the SPARC region have security officers stationed at the facilities who can be called upon to increase security in areas near children. Hospitals should have a missing/abducted child/person policy and it should be tested regularly.

When possible, requests will be made for local law enforcement or outside agencies to report to a hospital to assist in providing short term security or assistance with reunifying unaccompanied children. For further details on the reunification process, refer to Section 2.9 of this annex.

2.6 OPERATIONS-MEDICAL CARE

The Pediatric Surge Annex is intended to support, not replace, any existing facility plan by providing coordinated response actions in the event of an incident that involves a significant number of children. This plan is not intended to provide specific medical treatment advice or suggestions. The Pediatric Surge annex recognizes that Health Care Providers should be following the most current practices and

guidelines designated by the State of Illinois, the American Academy of Pediatrics, the Centers for Disease Control and Prevention (CDC), and the Illinois Emergency Medical Services for Children.

The overall goal of disaster medical care operations is to:

- Safely minimize loss of life, injury, and human suffering by ensuring, through an all-hazards approach, timely and coordinated medical assistance, to include evacuation of severely ill and injured patients
- Coordinate the utilization of medical facilities and the procurement, allocation, distribution of medical personnel, supplies, accessible communications, and specialized equipment to meet the needs of children with special health care needs, functional and access needs, and other resources.

The Pediatric Surge Annex is designed to help coordinate the following components of care as related to pediatric patient care and movement during an incident:

IMERT Pediatric Care Medical Specialists (PCMS)

Defined as: Pediatric experts from Illinois and its border states who volunteer pre-event as part of the IMERT Pediatric Care Medical Specialist Team to be called upon by IDPH during a large scale event in which there are numerous pediatric casualties leading to the activation of this annex. These volunteers will function as subject matter experts for the state by providing guidance on the coordination of care and medical consultation for pediatric patients.

There are three types of Pediatric Care Medical Specialists:

<u>Group 1 Specialists</u>: Includes pediatric intensivists, pediatric emergency physicians and/or pediatric physicians with transport expertise who will be called upon during all events in which the annex is activated to assist with patient triage, coordination of transfers and system decompression.

<u>Group 2 Specialists</u>: Includes pediatric specialty physicians, primary care physicians and neonatal subspecialists who will be activated to serve in a medical consultation role based on the specific needs of the event and the affected population.

Group 3 Specialists: Includes pediatric specialty advanced practice providers (e.g., nurse practitioners) and support resources (e.g., child life specialists, pediatric Pharm D/pharmacists) that will be activated to serve in a consultation role based on the specific needs of the event and the affected population.

Roles and Responsibilities:

• Triage pediatric patients to pediatric specialty health care facilities utilizing the information submitted by non-pediatric specialty health care facilities based on the **Pediatric Triage Guidelines (Attachment I).**



- Assist with system decompression as requested from pediatric tertiary care centers/specialty centers.
- Address requests for medical consultation from health care facilities.
 - Assist with coordination of pediatric transport needs.
 - Document all coordinated pediatric patient transfers in the *Pediatric Patient Tracking Log* (refer to Attachment J)

2.6.1 TRIAGE

To accommodate the initial stabilization and treatment of pediatric victims, EMS will triage patients in the field according to their standard of care. The Illinois EMSC <u>Pediatric Prehospital Protocols</u> manual can serve as a guide to EMS systems in the treatment and transport of the critically ill and/or injured child.

When the number of pediatric victims overwhelms the medical system, JumpSTART triage is used in Illinois for the pediatric patient during field (EMS) triage and upon initial arrival to a hospital during a surge event. JumpSTART *Pediatric Multiple Casualty Incident Triage* is an objective MCI triage system that addresses the needs of children, taking into consideration the developmental and physiological differences of children. The goal of modern triage is to do the greatest good for the greatest number with the resources available at the time.

If the incident is unexpected, EMS responds and identifies MCI with large number of pediatric victims;

EMS follows MCI protocols:

- Notifies Resource Hospital of estimated number of casualties
- Begins MCI triage
- Distributes patients to multiple hospitals based on protocols and guidance from Resource Hospital

The SPARC region will use a triage tag system for initial

prehospital triage (see Figure 2-1). The four triage categories are: **IMMEDIATE**, **DELAYED**, **MINOR**, and **EXPECTANT/DECEASED**.

Triage Category	Description
IMMEDIATE	 Patients who: do not obey commands or have altered mental status (use AVPU: Alert, Verbal, Pain, Unresponsive) and/or do not have a peripheral pulse and/or are in respiratory distress and/or have uncontrolled major hemorrhage
DELAYED	Acute condition that is not life-threatening but requires care within 1-2 hours
MINOR	Patients with: mild injuries that are self-limited and can tolerate a delay in care without increasing mortality risk
EXPECTANT/ DECEASED	Expectant : Patients who have injuries incompatible with life given the currently available resources Deceased : Patients who are not breathing after life-saving interventions

Figure 2-1. Pediatric Triage Tag System



When triaging children, the following JumpSTART Pediatric MCI Triage Algorithm will be utilized to provide guidance for personnel making life and death decisions during a MCI. (see Figure 2-2).

JumpSTART Pediatric MCI Triage Tool ^o
Able to Walk? YES MINOR → Secondary Triage* "Evaluate infants first in secondary triage using the entire JS algorithm
Breathing? NO Position Upper Airway HIMMEDIATE
YES APNEIC
Palpable NO DECEASED
↓ YES
5 Rescue Breaths DECEASED
Breathing
Respiratory <15 or > 45 Rate IMMEDIATE
15-45
Palpable NO IMMEDIATE
¥ YES
AVPU Posturing or "U" IMMEDIATE
"A", "V" or "P" (Appropriate) → DELAYED ● Lou Romig, MD 2002

Figure 2-2. JumpSTART Pediatric MCI Triage Algorithm

This approach enables receiving hospitals to be better prepared for the acuity of patients they are about to receive via EMS. It is the responsibility of all hospitals to perform secondary triage to determine the best setting for a pediatric patient to receive definitive care.

When necessary, a larger triage area may be set up outside the hospital, in conjunction with hospital staff to quickly evaluate which patients need immediate assistance.

2.6.1.1 TRANSFER COORDINATION

During a large-scale incident, pediatric patients should be distributed strategically so receiving facilities are not overwhelmed. Within EMS Region V, transfer is guided by triage as well as resource availability. Transfer priority will be given to those children who can most benefit from pediatric specialty services.

Critical access hospitals may not be able to treat critically injured pediatric patients long term and may need to transfer them to a tertiary care center. Additionally, pediatric practitioners may be able to help identify patients who are appropriate for transfer to non-pediatric facilities. Hospitals should coordinate secondary transfers with the Coalition to support coordinated distribution of patients throughout the region. The *Pediatric Patient Transfer Form* (refer to **Attachment K**) will be utilized to provide a method of communicating medical and treatment information on the pediatric patient during a disaster when the patients are being transferred to pediatric tertiary care centers/specialty care centers. In case transfer is delayed, hospitals should be prepared to provide extended care to children during a disaster until they are able to transfer them patients to a higher level of care. Since there are very



limited to none NICUs or PICUs in the region, PCMS can be accessed for medical consultation. In addition, the <u>Pediatric & Neonatal Disaster/Surge Pocket Guide</u> is available to Practitioners as a reference and to assist with care of pediatric and neonatal patients during the initial 96 hours following a disaster.

2.6.2 TREATMENT

Coalition hospital partners should refer to facility specific plans, protocols, and training for guidelines specific to treating the pediatric patient. Providing appropriate treatment for large numbers of people depends heavily on appropriate and continuous triage. Triage for transport/referral/ongoing treatment as appropriate. In an emergency that overwhelms EMS Region V hospitals may need to rely on SMEs for additional pediatric support and expert medical advice as it pertains to pediatric patient movement, system decompression, care guidelines and resource allocation.

Potentially, many children will need at least temporary care at a non-pediatric specialty care hospital after a disaster. In the event of a large volume of pediatric patients, many tertiary care centers may be filled to capacity and unable to accept inter-facility transfers immediately, EMS Region V hospitals will follow their contingency plan to provide resuscitative and definitive care for a large number of children. Staff physicians will manage critical patients pending transport in consultation with outside pediatric experts, telephone or telemedicine, or with internal ED, anesthesia and/or adult critical care staff as needed. The region has established relationships and transfer agreements with pediatric tertiary care/specialty care centers to facilitate the transfer process in a surge event.

2.7 TRANSPORTATION

Pediatric patients are best served by immediate and appropriate transportation to an appropriate medical facility. The transportation needs during a MCI involving children may be quite extensive and will require all coalition response partners to work together to identify the resources needed to transport the pediatric patients(s) in the most efficient and safe manner available at the time. Alternate means for transporting pediatric patients have been identified. Each facility will follow their EOP for coordination of other transportation and staging, other needs and issues, if possible

The following should be considered when transporting pediatric patients from hospital to other facilities:

- Neonatal and some specialty patients may require specialized transport teams
- Pediatric patient requiring ICU care who cannot be accommodated at the facility will be transferred to referral centers
- Priority will be given to those with the most critical injuries
- Helicopter transfer to an appropriate referral center will be considered depending on distance, weather and road conditions. Parents should accompany the child whenever possible
- Neonatal transport will be arranged with the receiving specialty center, as they may require specialized transport teams
- Hospitals will consider alternatives to ambulance for safe pediatric transfer in a disaster situation
- Appropriate transport vehicles and equipment will be arranged with the transferring physician for pediatric patients. SMEs and EMS may consult, if needed.



The SPARC region has limited transportation assets. The transportation needs during a MCI involving children may be quite extensive and will require all Coalition response partners to work together to identify the resources needed to transport the pediatric patient(s) in the most efficient and safe manner available at the time. Neonatal and some specialty patients may require specialized transport teams. Hospital IC will work with EMS and/or RHCC to coordinate appropriate transportation resources, including staffing.

The following transportation resources have been identified for the SPARC region and should be arranged in consultation with pediatric SMEs and EMS:

- BLS/ALS ambulance with accompanying physician, or other staff skilled in pediatric airway and resuscitation.
- ALS/BLS ambulance with normal EMS staff for less critical pediatric patients
 - 91 ALS ambulances
 - 43 BLS ambulances
 - o 5 ILS ambulances
- Specialty pediatric transport teams from referral tertiary care centers
 - Cardinal Glennon Ground Specialist Services

Note: State disaster plan from IEMA and IDPH ESF-8 Plan state if there is a request for ambulances, the request goes to MABAS. This works well in areas of the state where most or all EMS are part of MABAS. The Coalition will work to address how transportation assets will be coordinated in the region and integrated into the existing state plan.

- o Bus
- Private vehicle

Air Medical Resources:

- ARCH/Air Methods
- Air Evac
- Cardinal Glennon Helicopter Service
- St. Vincent Life Flight

Alternate:

Alternate means of transporting pediatric patients will need to be identified. Non-traditional transports for special needs populations and possible hospital evacuations will be considered. If necessary, the PCMS or other IDPH pediatric representative can assist health care facilities in identifying transport companies that have pediatric capabilities and available alternative methods for transporting pediatric patients.

2.8 PATIENT TRACKING

As pediatric patient movement occurs throughout Illinois and border states, for both the acutely ill/injured being transported to pediatric tertiary care centers/specialty care centers and for those patients being decompressed from pediatric tertiary care centers/specialty care centers, tracking the location of the pediatric patient is crucial in the process of patient accountability, resource utilizations,



reunification of these children with their families and loved ones. Electronic patient tracking may be available to assist with the coordination of pediatric patient movement during large scale disasters. Hospitals should track and conduct follow-up to assure chain of custody.

The IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex provides patient tracking forms that may be used to assist in patient identification, tracking, and reunification.

The designated Pediatric Tracking Protocol shall address both the accompanied and unaccompanied child:

1. Patient Identification Tracking Form: (refer to Attachment L)

- **Purpose**: To assist in identifying, tracking, and reunification of pediatric patients during a disaster.
- **Responsibility**: The primary physician and/or nurse at every health care facility.
- **Instructions**: This form will be completed to the best of the ability given the information/resources

available on ALL pediatric patients who arrive at a health care treatment facility (hospital, clinic, ACS, ATS, TMTS), regardless if they are accompanied by a parent/guardian. This form records a patient tracking number (assigned by initial health care facility), demographic information, description of the child, a place to attach a photo of the child, patient tracking log, accompanied and unaccompanied child information, medical history, and disposition. The form should be copied. The original form will accompany the patient if/when the patient is transferred to another facility and a copy should be kept as part of the facility's medical record. Each receiving facility will add their facility's information in the Patient Tracking Log section.

NOTE: All attempts should be made to keep patient identification (ID) bands from previous facilities and triage tags from EMS on the patient. If ID bands need to be removed, attach the removed band to this form under the Patient Tracking Log section. If triage tags are removed, ensure all information on the tag is incorporated into the patient's medical record or, if possible, place a photo copy of the tag in the patient's medical record.

2. *Pediatric Patient Tracking Log:* (refer to Attachment J)

- **Purpose**: To assist with tracking pediatric patients during a disaster.
- **Responsibility**: Pediatric subject matter expert (i.e. PCMS or other IDPH pediatric representative) who is assisting with the coordination of patient movement.
- Instructions: This form will be completed by the PCMS or other IDPH pediatric representative when they assist with transfer coordination of pediatric patients between health care facilities. Any issued tracking number (assigned by initial health care facility), name, gender, date of birth and age shall be recorded on all patients, and each health care facility's name, location and the arrival/departure date from each health care facility. This document will be forwarded to IDPH at the PHEOC at the end of each operational period by the PCMS and stored in the same manner as other incident related command documents after the PHEOC closes.



2.9 REUNIFICATION

Reunifying children with their parent/caregiver is a critical component of the recovery process. A Pediatric Safe Area (PSA) and Hospital Family Reunification Center should be established for each hospital accepting pediatric patients to ensure appropriate safety precautions before release of minors to an appropriate adult.

2.9.1 PEDIATRIC SAFE AREAS (PSA)

If children are unaccompanied injured/sick, or discharged, they should remain in a special holding area that is designated for children only. A "pediatric safe area" (PSA) will be established as a waiting area for unaccompanied children awaiting reunification with their caregivers. The PSA should have appropriate adult supervision and staff, as well as age-appropriate distraction items (toys, puzzles, games, book, and activities) and nutritious age-appropriate snacks. Hospitals should refer to the **Pediatric Safe Area Checklist** (Attachment M) as a guideline when selecting a site. The PSA checklist should be completed **prior** to an incident and then **re-checked** once the PSA is opened. If available, hospitals will utilize non-clinical staff to remain with unaccompanied or displaced children to ensure they remain safe. A PSA Coordinator shall be designated as part of the planning process. Refer to **PSA Coordinator Job Action Sheet** (Attachment N). The following general staffing guidelines shall be utilized in PSAs:

- □ 1 adult to 4 infants
- □ 1 adult to 10 preschool children
- □ 1 adult to 20 school-aged children

+ For further details on staffing guidelines, refer to Section 407.190 of the Illinois Licensing Standards for Daycare Center Rules.

<u>Caring for the Non-injured and Non-ill Children in a Disaster</u> can assist non-medical professionals such as law enforcement officers and volunteers that may have to provide care for or watch over children in a disaster, including those with CSHCN and unaccompanied children.

For more information on the PSA components, refer to the security concerns section within the Illinois EMSC <u>Pediatric and Neonatal Disaster/Surge Pocket Guide</u>

2.9.1.1 IDENTIFICATION OF UNIDENTIFIED CHILD

Each hospital should have an established plan for re-unification of the child with their parents or caregiver to ensure children are released to the appropriate person(s). Special considerations for unaccompanied children or children that have been separated from their parents include:

- Unique identifier for assessment/treatment given to the pediatric patient presented to the hospital without identification
- A digital photo of each non-identified patient upon arrival
- Completion of *Child Identification and Disposition/Discharge Form* (refer to Attachment O)



Law Enforcement will assist with reunifying unaccompanied minors. Additional resources include:

The National Center for Missing and Exploited Children (NCMEC) Unaccompanied Minor Registry is a tool that will enable NCMEC to provide assistance to local law enforcement and to assist in the reunification of displaced children with their parents or legal guardians. The registry may be available to assist providers with unaccompanied minors. The program also allows the public to report information related to children who have been separated from their parents or legal guardians as a result of a disaster. For more information or to enter information on an unaccompanied minor: <u>Welcome to the Unaccompanied Minors Registry</u>. Or call **1-800-THE LOST** (1-800-843-5678).

The American Red Cross (ARC) assists in reunifying children with their parents/caregivers through the Red Cross Client Services and Mental Health functions. The ARC works with hospitals, local law enforcement and emergency management to identify the family of a minor in order to facilitate reunification.

2.10 DEACTIVATION AND RECOVERY

The Pediatric Surge Annex and/or Temporary Medical Treatment Stations (TMTS) will be deactivated when it is determined that the situation is contained, through the IDPH, local EMA or the on-scene IC/UC. The SPARC Duty Officer will communicate to the coalition membership that the disaster or situation has been contained and the region has returned to normal operations.

The recovery process of a MCI may require a significant amount of time and should follow the recovery and continuity processes outlined in the SPARC Regional Response and Recovery Plan (2.3.2.5.9 and 2.4). The intent of this annex and the primary focus of recovery efforts are to eliminate the need for crisis care and return to contingency and conventional care as quickly as possible.

Each involved jurisdiction should follow its pre-established plan for the recovery process. Recovery components shall be specific to children and shall address the medical and behavioral health needs of children and children with special health care needs/children with functional access needs (FAN). SPARC will remain a resource throughout the recovery process assisting with reunification, coordinating ongoing mental health support and support of ESF-6 Mass Care as it relates to displaced families.

2.10.1 AFTER-ACTION REPORTING

Following a surge event, response partners will have the chance to discuss strengths, weaknesses and opportunities for improvement related to operational responses. Findings will be captured in an afteraction report (AAR) and distributed to all partners in the response, denoting lessons learned from the response to be included in future SPARC planning processes.

2.11 TRAINING AND EXERCISES

Training on roles and responsibilities will be exercised with healthcare organizations, IDPH, IEMA, LHDs, EMAs and other relevant stakeholders. Following exercises, the Coalition will evaluate the response to identify areas for improvements and ensure the preparedness of its member organizations. Exercises the Coalition will use to evaluate the response will include, but are not limited to:

- Education Sessions
- Tabletop Exercise
- Walk-through Drill



- Functional Exercise
- Full-Scale Exercise

For training and courses in caring for pediatric patients in disasters, please refer to the CEMP Illinois EMS Region V Multi-Year Training and Exercise Plan (MYTEP).



3. APPENDICES

3.1 AUTHORITIES

The primary authority within each EMS region for coordinating EMS System licensed providers in response to an emergency medical incident(s) as a result of a disaster or other large-scale event rests with the EMS system(s) medical director(s).

The RHCC and/or regional HCC shall have authority to coordinate supply/equipment caches and services (other than EMS licensed providers) as outlined in the approved Regional Response and Recovery Plan and IDPH ESF-8 Plan.

IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations such as the Illinois Medical Emergency Response Team (IMERT), the Strategic National Stockpile (SNS), temporary medical treatment stations (TMTS), etc.

Illinois Compiled Statutes, 210 ILCS 50, Emergency Medical Services (EMS) Systems Act, as amended

Illinois Administrative Code, 77 III. Admin. Code 515, Emergency Medical Services and Trauma Code, as amended

SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

 <u>Section 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient</u> <u>Critical Care Services</u>

http://www.ilga.gov/commission/jcar/admincode/077/077005150J30900R.html

• <u>Section 515.4000 Facility Recognition Criteria for the Emergency Department Approved</u> <u>for Pediatrics (EDAP)</u>

http://www.ilga.gov/commission/jcar/admincode/077/077005150J40000R.html

• <u>Section 515.4010 Facility Recognition Criteria for the Standby Emergency Department</u> <u>Approved for Pediatrics (SEDP)</u>

http://www.ilga.gov/commission/jcar/admincode/077/077005150J40100R.html

3.2 EMSC REGION V CONTACT LIST

<u>Memorial Hospital of Carbondale</u>- (EDAP) John Brandon <u>john.brandon@sih.net</u>; Christian Falconer <u>christian.falconer@sih.net</u>; Susan Odle <u>susan.odle@sih.net</u>

<u>Clay County Hospital</u>- Carrie Miller <u>carrie.miller@claycountyhospital.org</u>

<u>Crossroads Community Hospital</u>- (SEDP) Crista Minnick <u>crista minnick@crossroadshospital.com</u>; <u>virginia couch@crossroadshospital.com</u>; <u>alyssa spicuzza@crossroadshospital.com</u>

Deaconess Gateway Hospital- (EDAP) (III NICU)

Deaconess Hospital- (EDAP) (Ped Level II) Bridgette Hill bridgette.hill@deaconess.com

<u>Fairfield Memorial Hospital</u>- (SEDP) <u>ttaylor@fairfieldmemorial.org</u>; Michelle Little michelle.little@fairfieldmemorial.org

Ferrell Hospital - Renata Lowery

Franklin Hospital- (SEDP) Tina Bymaster tina.bymaster@franklinhospital.net

Hamilton Memorial Hospital- Brian Russell brussell@hmhospital.org

Hardin County General Hospital - Courtney Spivey courtney.spivey@ilhcgh.org

Harrisburg Medical Center-

Heartland Regional Medical Center- (EDAP) Robert Eilers robert_eilers@quorumhealth.com ;

Jennifer King jennifer_king@quorumhealth.com

Herrin Hospital- (SEDP) Brad Graul brad.graul@sih.net; Jessica Williams Jessica.williams@sih.net

Marshall Browning Hospital- Kimberly Jacoby kimberly.jacoby@mbhdq.com

Massac Memorial Hospital- Robin Newcomb robinn@massachealth.org

Pinckneyville Community Hospital- Nancy Keller nkeller@pvillehosp.org

Richland Memorial Hospital- Donna Brown dbrown@richlandmemorial.com

Salem Township Hospital- Lisa Ambuehl lambuehl@sthcares.org

<u>SSM Health Cardinal Glennon Children's Hospital</u>- (Ped Level I) (III NICU) Terrence Cuellar <u>terrence.cuellar@ssmhealth.com</u>; Nicholas Salzman <u>nicholas.salzman@ssmhealth.com</u>

<u>SSM Health Good Samaritan Hospital</u>- (EDAP) Robert Hyman <u>robert.hyman@ssmhealth.com</u>;

Kristina Lorenzini kristina.lorenzini@ssmhealth.com; lorenzinikristina@yahoo.com

SSM Health St. Mary's Hospital- (EDAP) Michele Morris gofastrnmichele@yahoo.com

St Joseph's Memorial Hospital- (SEDP)

<u>St. Louis Children's Hospital</u>- (Ped Level I) (III NICU) Sabine Sagner <u>sabine.sagner@bjc.org</u>; Erin Arcipowski <u>erin.arcipowski@bjc.org</u>

St. Vincent Evansville- (EDAP) (Ped Level II) Janet Williams janet.williams@ascension.org

<u>Union County Hospital</u>- Mark Yates <u>mark yates@quorumhealth.com</u>

Wabash General Hospital-

Washington County Hospital- Stacy Hodge shodge@washingtoncountyhospital.org

IDPH EMSC Coordinator- Kelly A Jones kelly.jones@illinois.gov

IDPH Marion Region EMS Coordinator - Linda Angarola linda.angarola@illinois.gov

3.3 EMS REGION V PEDIATRIC RESOURCES

JUNE 2021		EMS Re	gion	5 Ped	iatric Res	source	s		Region 5, page 1 o
RHCC Hospital Address	ED Phone	Pediatric Designation*	Trauma Center Level	Trauma Transfer	PICU Transfer PICU Phone	Perinatal Level**/ Network+	NICU Transfer NICU Phone	Transport Team Phone	PHMSRR/ Decompression Category***
Memorial Hospital of Carbondale 405 W. Jackson Carbondale, IL 62902	(618) 549-0721 ext. 65150 (ED) ext. 65866 (Supv)	EDAP	Level II	(618) 457-3000		II-E SSM Health			Mailon Category 2
Hospital Address	ED Phone	Pediatric Designation*	Trauma Center Level	Trauma Transfer	PICU Transfer PICU Phone	Perinatal Level**/ Network+	NICU Transfer NICU Phone	Transport Team Phone	PHMSRR/ Decompression Category***
Ascension St. Vincent Evansville 3700 Washington Ave., Evansville, IN 47750	(812) 485-4491	EDAP	Level II & Pediatric Level II	(812) 485-7878	(812) 485-8888 (812) 485-4171	INDIANA III NICU	(812) 485-8888 (812) 485-4114	(812) 480-7698 (Peds)	Mailon Calegory 1
Carle Richland Memorial Hospital 800 E. Locust St., Olney, IL 62450	(618) 395-2131 ext. 56070					li St. John's			Mailon Calegory 2
Clay County Hospital 911 Stacy Burk DI., Flora, IL 62839	(618) 662-1624					Ø St. John's			Mailon Calegory 3
Ciossioads Community Hospital 8 Doctors Park, Mount Veinon, IL 62864	(618) 241-8797	SEDP				Ø SSM Health			Mailon Category 3
Deaconess Gateway Hospital 4011 Gateway Blvd, Newburgh, IN 47630	(812) 842-3047	EDAP			(877) 348-7286 (812) 842-4063	INDIANA III NICU	(877) 348-7286 (812) 842-4280	NICU ONLY (812) 842-4280	Mailon Category 2
Deaconess Hospital eoo Mary Street, Evansville, IN 47747	(812) 450-3405	EDAP	Level II & Pediatric Level II	(877) 348-7286	(877) 348-7286 (812) 450-4848 (Trauma Only)				Mailon Calegory 2
Fairfield Memorial Hospital 303 NW 11th St., Fairfield, IL 62837	(618) 847-8285	SEDP				Ø SSM Health			Mailon Category 3
Ferell Hospital 1201 Pine St., Eldorado, IL 62930	(618) 273-3361 ext. 280					Ø SSM Health			Mailon Calegory 3
Franklin Hospital 201 Balley Ln., Benton, IL 62812	(618) 439-3161 ext. 307	SEDP				Ø SSM Health			Mailon Calegory 3
Hamilton Memorial Hospital 811 S. Marshall Ave., McLeansboro, IL 62859	(618) 643-2361 ext. 2100					Ø SSM Health			Mailon Category 3
Haidin County General Hospital 6 Ferrell Rd., Rosiciare, IL 62982	(618) 285-6634 ext. 324					Ø SSM Health			Marion Category 3

*PEDIATRIC DESIGNATION PCCC: Pediatric Critical Care Center EDAP: Emergency Department Approved for Pediatrics SEDP: Standby Emergency Department for Pediatrics

Level I: General Nursery Level Ø: Non-Birthing Center Level I: General Nursery Level II-E: Special Care Nursery with Extended Capabilities

Level II: Intermediate Care Nursery Level III: Neonatal Intensive Care

September 2020



Region 5, page 2 of 4

Hospital Address	ED Phone	Pediatric Designation*	Trauma Center Level	Trauma Transf er	PICU Transfer PICU Phone	Perinatal Level**/ Network+	NICU Transfer NICU Phone	Transport Team Phone	PHMSRR/ Decompression Category***
Harrisburg Medical Center, Inc. 100 DI. Warren Tuttle DI., Harrisburg, IL 62946	(618) 253-7671 ext. 342					Ø SSM Health			Marion Calegory 2
Heartiand Regional Medical Center 3333 W. De Young St., Marion, IL 62959	(618) 998-4888	SEDP				Ø SSM Health			Mailon Category 2
Herrin Hospitai 201 S. 14th St., Herrin, IL 62948	(618) 942-2171 ext. 35130	SEDP				Ø SSM Health			Mailon Category 3
Maishall Browning Hospital 900 N. Washington St., Du Quoin, IL 62832	(618) 542-2146 ext. 1240					Ø SSM Health			Mailon Category 3
Massac Memorial Hospital 28 Chick St., Metropolis, IL 62960	(618) 524-8427					Ø SSM Health			Mailon Calegory 3
Pinckneyville Community Hospital 5383 State Route 154, P.O. Box 437 Pinckneyville, IL 62247	(618) 357-8808					Ø SSM Health			Mation Category 3

*PEDIATRIC DESIGNATION PCCC: Pediatric Critical Care Center EDAP: Emergency Department Approved for Pediatrics SEDP: Standby Emergency Department for Pediatrics

Rush: Rush University Medical Center, Chicago

"ILLINOIS PERINATAL LEVELS

Level Ø: Non-Birthing Center

Level II-E: Special Care Nursery with Extended Capabilities

Level I: General Nurserv Level II: Intermediate Care Nurserv Level III: Neonatal Intensive Care

+ ILLINOIS PERINATAL REGIONAL NETWORKS Loyola: Loyola University Medical Center, Maywood Mercyhealth: Mercyhealth Riverside Campus, Rockford

St. John's: HSHS St. John's Hospital, Springfield Stroger: John H. Stroger Jr. Hospital of Cook County, Chicago Northwestern: Northwestern Memorial Hospital, Chicago SSM Health: SSM Health Cardinal Giennon Children's Hospital/SSM Health St. Mary's Hospital, St. Louis, MO U of C: University of Chicago Medical Center, Chicago St. Francis: OSF Saint Francis Medical Center, Peorla UIH: University of Illinois Hospital & Health Sciences System, Chicago

Local Health Departments

Clay CHD:	(618) 662-4406
Egyptian HD:	(618) 273-3326
Franklin-Williamson BI-County HD:	(618) 993-8111
Hamilton CHD:	(618) 643-3522
Jackson CHD:	(618) 684-3143
Jefferson CHD:	(618) 244-7134

Marion CHD: (618) 548-3878 Perry CHD: (618) 357-5371 Southern Seven HD: (618) 634-2297 Wabash CHD: (618) 263-3873 Washington CHD: (618) 327-3644 Wayne CHD: (618) 842-516

***Public Health & Medical Services Response Regions (PHMSRR) / Decompression Category

(More information can be found on the decompression categories in the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex (state health & medical disaster plan)). Category 1: Specialty Centers (PICU/NICU); provides complex care to ages 0-15 y/o Category 2: Hospitals with some pediatric services; will accept ages 0-12 y/o Category s: Hospitals with no pediatric/nursery services; will accept ages >12 y/o Category 4: Hospitals with some nursery but no pediatric services; will accept ages 0-1 y/o

Illinois Poison Center: (800) 222-1222



http://www.luriechildrens.org/EMSC

Development and printing of this card has been supported in part by a federal grant from the Assistant Secretary for Preparedness & Response (ASPR), U.S. Department of Health & Human Services



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Region 5, page 3 of 4

Hospital Address	ED Phone	Pediatric Designation*	Trauma Center Level	Trauma Transfer	PICU Transfer PICU Phone	Perinatal Level**/ Network+	NICU Transfer NICU Phone	Transport Team Phone	PHMSRR/ Decompression Category***
Salem Township Hospital 1201 Ricket Dt., Salem, IL 62881	(618) 548-3194 ext. 8285					Ø St. John's			Mation Category 3
SSM Health Cardinal Glennon Children's Hospital 1465 S. Grand Blvd., St. Louis, MO 63104	(314) 577-5666		Pediatric Level I	(888) 229-2424	(888) 229-2424 (314) 577-5621	III NICU SSM Health	(888) 229-2424 (314) 577-5631	(888) 229-2424	Edwardsville Category 1
SSM Health Good Samaritan Hospital 1 Good Samaritan Way, Mount Vernon, IL 62864	(618) 899-4600	EDAP				II SSM Health			Marion Category 4
SSM Health St. Mary's Hospital 400 N. Pleasant, Centralla, IL 62801	(618) 436-8000 ext. 6000	EDAP				II SSM Health			Mailon Category 4
St. Joseph Memorial Hospital 2 S. Hospital Dr. Murphysboro, IL 62966	(618) 529-0525	SEDP				Ø SSM Health			Marion Category 2
St. Louis Children's Hospital #1 Children's Place St., Louis, MO 63110	(314) 454-6111		Pediatric Level I	(800) 678-4357 (HELP)	(800) 678-4357 (HELP) (314) 454-4488	III NICU SSM Health	(800) 678-4357 (HELP) (314) 454-6037	(800) 678-4357 (HELP)	Edwardsville Calegory 1
Loyola: Loyola University Med Mercyhealth: Mercyhealth Riv Northwestern: Northwestern I Rush: Rush University Medica St. Francis: OSF Saint Franci	ical Center, Ma erside Campus Aemorial Hosp I Center, Chica S Medical Cent	to beganning rappi ent for Pediatrics aywood 3, Rockfold Ital, Chicago Igo et, Peorla	HLLINOIS P St. Joi Stroge SSM F U of C UIH: U	PERINATAL RI PERINATAL RI hn's: HSHS SI er: John H. Stu iealth: SSM Hi : University of Illin iniversity of Illin	wei II-E: Special Car EGIONAL NETWOR I. John's Hospital, Sp oger Jr. Hospital of C eath Cardinal Gienno Chicago Medical Ce nois Hospital & Heath	KS wingfield wook County, Chi n Children's Hos nter, Chicago h Sciences System	cago pital/SSM Health St. N em, Chicago	level III: Ne Level III: Ne lary's Hospital, St. L	onatal Intensive Care
Local Health Departments Clay CHD: (818) 68	2-4406	Mailon CHD:	(618) 548-3878	***Pu (PHN	blic Health & ISRR) / Decor	Medical Services	s Response Reg ory	gions
Egyptian HD: (618) 27 Franklin-Williamson Bi-County HD: (618) 99 Hamilton CHD: (618) 68 Jackson CHD: (618) 68 Jefferson CHD: (618) 74	3-3326 3-8111 3-3522 4-3143 4-7134	Perry CHD: Southern Seven HI Wabash CHD: Washington CHD: Wayne CHD:	(D: () (618) 357-5371 618) 634-2297 618) 263-3873 618) 327-3644 618) 842-516	(More Plan: I Categ Categ Categ	information can Pediatric and Ne ory 1: Spectalty (ory 2: Hospitals) ory 3: Hospitals)	be found on the decol onatal Surge Annex { Centers (PICU/NICU); vith some pediatric ser vith no pediatric/nurser	mpression categorie state health & media provides complex ca vices; will accept ag ny services; will acce	es in the IDPH ESF-8 cal disaster plan}). ue to ages 0-15 y/o es 0-12 y/o pt ages >12 y/o
Illinois Poison Center: (800) 222-122	22	EMSC	2021		Categ	ory 4: Hospitals	vith some nursery but	no pediatric services	;; will accept ages 0-1 y/o
Development and printing of this card has	been support	ed in part by a fede	ral grant fro	m the Assista	nt Secretary for Pre	paredness & Re	sponse (ASPR), U.S.	Department of He	aith & Human Services

September 2020



JUNE 2021 Hospital Address	ED Phone	Pediatric Designation*	Trauma Center Level	Trauma Transfer	PICU Transfer PICU Phone	Perinatal Level**/ Network+	NICU Transfer NICU Phone	Transport Team Phone	Region 5, page 4 o PHMSRR/ Decompression Category***
Union County Hospital 517 N. Main St., Anna, IL 6	(618) 833-451 ext 422	1				Ø SSM Health			Mailon Category 3
Wabash General Hospit 1418 College Dr., Mount Carmel	al (618) , IL 62863 263-636	3				Ø SSM Health			Mailon Category 3
Washington County Hosp 705 S. Grand Ave., Nashville, I	Ital (618) L 62263 327-229	6				Ø SSM Health			Marlon Category 3
Loyola: Loyola Univ Mercyhealth: Mercy Northwestern: Nort Rush: Rush Univers St. Francis: OSF Sa	ersity Medical Center, health Riverside Cam hwestern Memorial Ho ity Medical Center, Ch int Francis Medical Ce	Maywood pus, Rockford spital, Chicago icago enter, Peorla	St. Joh Stroge SSM H U of C: UIH: U	nn's: HSHS St r: John H. Str lealth: SSM H : University of niversity of Illin	I. John's Hospital, Spi oger Jr. Hospital of Co ealth Cardinal Giennor Chicago Medical Cen nois Hospital & Health	Ingfleid xxk County, Chi n Children's Hos ter, Chicago i Sciences Syste	cago pital/SSM Health St. N em, Chicago	tary's Hospital, St. L	ouls, MO
Local Health Departments Clay CHD: Egyptian HD: Fianklin-Williamson Bi-County HD: Hamilton CHD:	(618) 662-4406 (618) 273-3326 (618) 993-8111 (618) 643-3522	Marion CHD: Perry CHD: Southern Seven HD Wabash CHD:	(6 (6): (6	318) 548-3878 318) 357-5371 318) 634-2297 318) 263-3873	*** Put (PHMS (More in Plan: P Catego	olic Health & SRR) / Decor nformation can ediatric and Ne ry 1: Specialty (Medical Services npression Catego be found on the deco onatal Surge Annex { Senters (PICU/NICU);	s Response Reg ory mpression categorie state health & media provides complex ca	gions es in the IDPH ESF-8 cal disaster plan}). ue to ages 0-15 y/o
Jackson CHD: Jefferson CHD:	(618) 684-3143 (618) 244-7134	Washington CHD: Wayne CHD:	(e (e	318) 327-3644 318) 842-516	Catego Catego Catego	ry 2: Hospitals v ry 3: Hospitals v ry 4: Hospitals v	vith some pediatric ser vith no pediatric/nurser vith some nursery but	ivices; will accept ag ny services; will acce no pediatric services	es 0-12 y/0 pt ages >12 y/0 ;; will accept ages 0-1
Illinois Poison Center: (80	0) 222-1222								

September 2020

3.4 ADDITIONAL PEDIATRIC RESOURCES

Illinois Emergency Medical Services for Children:

Caring for the Non-injured and Non-Ill Children in a Disaster

<u>https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-and-other-resources/practice-guidelinestools/caringchildrendisasterbookmay20164.pdf</u>

Children with Special Health Care Needs

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/childrenwithspecialhealthcareneedsreferenceguide.pdf

Pediatric Disaster Preparedness Guidelines

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/00_peddisasterguide3ed_jan2019final.pdf

Pediatric and Neonatal Care Guidelines

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/pediatricneonatalcareguidelinesjune20172.pdf

Pediatric Prehospital Protocols

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/pediatricprehospitalprotocolscompletefilefeb20163.pdf

Pediatric Reference Pocket Card:

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/emscpedspocketcard2019.pdf

Pediatric & Neonatal Disaster/Surge Guide:

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/pedsneodisastersurgepocketguidejune20173.pdf

Neonatal Intensive Care Unit (NICU) Evacuation Guidelines:

https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-andother-resources/practice-guidelinestools/nicuevacuationguidelines20093.pdf

Children with Special Health Care Needs Quick Reference Guide

https://www.luriechildrens.org/globalassets/documents/emsc/disaster/other/childrenwithspecialh ealthcareneedsreferenceguide.pdf

TELEPHONE NUMBERS

Illinois Department of Children and Family Services 24/7 hotline: 1-800-25-ABUSE (22873)

Illinois Poison Control Center 24/7 hotline: 1-800-222-1222

National Center for Missing and Exploited Children 24/7 hotline: 1-800-THE LOST (1-800-843-5678)

HELPFUL LINKS

American Academy of Pediatric Children and Disasters

http://www2.aap.org/disasters/index.cfm

American Red Cross

www.redcross.org

Illinois Emergency Medical Services for Children (EMSC)

www.luriechildren.org/emsc

FEMA 4 Kids

http://www.ready.gov/kids/

PEDIATRIC DISASTER REFERENCES

Minnesota Pediatric Surge Premier

Minnesota Pediatric Surge Plan

Pediatric Surge Plan Template - Alameda County EMS

Healthcare Coalition Pediatric Surge Annex Template -ASPR TRACIE

IDPH ESF-8 Plan Public Health and Medical Services

IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex

Pediatric Preparedness Resource Catalog

AAP Pediatric Preparedness Resource Kit

King County Healthcare Coalition: Hospital Guidelines for Management of Pediatric Patients in Disasters

SPARC Regional Response and Recovery Plan

Hope Coalition Pediatric Surge Annex

National Incident Management System (NIMS)

National Response Framework (NRF)

4. ATTACHMENTS

Attachment A: IDPH Public Health and Medical Services Response Regions Attachment B: Pediatric and Neonatal Surge Annex Activation Pathway Attachment C: Pediatric/Neonatal Medical Incident Report Form Attachment D: Pediatric/Neonatal Communication Pathway Attachment E: Hospital Medical Supply Bag Inventory Attachment F: ICS 213 RR Form Attachment G: Hospital Request for Resource Algorithm Attachment H: Common Reactions Exhibited by Children During and After Disaster Attachment I: Pediatric Triage Guidelines Attachment J: Pediatric Patient Tracking Log Attachment K: Pediatric Patient Transfer Form Attachment L: Patient Identification Tracking Form Attachment M: Pediatric Safe Area Checklist Attachment N: PSA Coordinator Job Action Sheet Attachment O: Child Identification and Disposition/Discharge Form



ATTACHMENT A: IDPH PUBLIC HEALTH AND MEDICAL SERVICES RESPONSE REGIONS





ATTACHMENT B: PEDIATRIC AND NEONATAL SURGE ANNEX ACTIVATION PATHWAY





ATTACHMENT C: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

Purpose: Assist with ensuring consistent communication between stakeholders and provide a mechanism to request pediatric medical resources and identify availability of resources at a health care facility. Instructions: When the annex is activated, this form will be utilized by <u>all</u> stakeholders (e.g., health care facilities, LHDs, IDPH, PCMS) to

communicate necessary information about the incident, annex activation, and pediatric patient transfer resource needs/requests. For pediatric care equipment needs/requests, complete the ICS 213RR form and submit it through the Request for Medical Resources Process as outlined in the IDPH ESF-8 Plan.

INCIDENT NAME:									
DATE/TIME PREPAR	RED DATI	E/TIME RECEIVE	D O	OPERATIO	NAL PERIO)	RECEIVED VIA		
							🗆 Phone 🗆 Radi	io 🗆 Fax 🗆 O	ther
FROM (SENDER)	TO (I	RECEIVER)	R	REPLY/AC	TION REQU	RED	? 🗆 YES 🗆 N	10	
			If	f YES, <u>incl</u>	ude detailea	sen	ding information	below	
			R	REPLY TO	: D Phone	🗆 Ra	adio 🗆 Fax 🗆 O	ther	
			(List num	ber)				
PRIORITY: D Urger	nt/High □ N	Ion-urgent/Med	dium (□ Inform	ational/Low				
DATE/TIME PHEOC	ACTIVATED		REASO	IN FOR PE	IEOC ACTIV	(IIO	N		
DATE/TIME ANNEX	ACTIVATED		REASO	N FOR A	NNEX ACTIV	ATIO	N		
ACTIVATION LEVEL									
Local D Regional	🗆 State								
DATE/TIME PEDIAT	RIC CARE MEDI	CAL	REASO	N FOR PE	DIATRIC CA	RE IV	IEDICAL SPECIAL	ISTS (PCMS)	
SPECIALISTS (PCMS) ACTIVATED		ACTIVA	ATION					
	CURF		OF PEDI/	ATRIC/N	EONATAL BE	D NE	EDS		
(The purpose of this se care when the annex patients for each triage form, provide more spe	CURF ection is to identify is activated. These e category in the cu cific information a and N	RENT NUMBER (the number of pec categories are for orresponding boxes bout the individual eonatal Surge Anne	OF PEDI/ diatric/neo interfacili s below. II I patients ex, Attachr	ATRIC/NE conatal pati ity transfer In the <i>Pedic</i> 5 (tracking n iment 10: Pe	EONATAL BE ents and what sonly, not EM <i>tric</i> : Patient Ph umber, gende ediatric Triage	D NE type scen ceme , and Guide	EDS of health care facilit ie transports. Enter ent Information sect age). For more info lines.	ty is needed for the total numb ion on page 2 rmation, see Pe	r the ier o of th idia
(The purpose of this se care when the annex patients for each triage form, provide more spe	CURF ection is to identify is activated. These e category in the co cific information a and N	RENT NUMBER (the number of pec categories are for orresponding boxes bout the individual eonatal Surge Anne	DF PEDI/ diatric/ner interfacili s below. II l patients ex, Attachr	ATRIC/NI eonatal pati ity transfer In the Pedic s (tracking n ment 10: Pr TRIAGE	EONATAL BE ents and what sonly, not EM <i>tric Patient Ph</i> umber, gende ediatric Triage CATEGORY	D NE scene , and Guide	EDS of health care facilit te transports. Enter ent Information sect age). For more info lines.	ty is needed for the total numb ion on page 2 rmation, see Pe	r the er (of ti dia
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ATTACHMENT C: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM (CONTINUED)

	ACHMENT 5: PE	DIATRIC/	NEONATAL M	EDICAL INCIDENT REPORT FORM	
REQUIRED/REQUES	STED ACTIONS AT	THIS TIM	E		
	PEDIATRIC/	NEONATA	L PATIENT PLAC	EMENT INFORMATION	
The transferring health (care facilities should (complete this	s section for each p	atient who requires transfer/placement at another health information about the patient's medical condition or	
treatment. Once a rece	iving facility has been	identified, t	he PCMS will comp	lete the last column and send this information back to the	
transferring facility.	- •				
To be Completed	by the Transferr	ing Health Care Facility		To be Completed by the PCMS	
Patient Tracking	Triage			Receiving Health Care Facility Name	
Number	Category	Gender	Age	Receiving Health Care Facility Address	
care facility)	,			nevering neuron care radinty Address	
	+				
	1				
SEND REPLY TO:	Phone 🗆 Radio	□ Fax □	Other		
(List number):					
PREPARED BY	I	TIN 45 050	50/50	50004000 70	
RECEIVED BY		TIME RECEIVED		FORWARD TO	
COMMENTS	I				
				I	
FACILITY NAME/LO					
FACILITY NAME/LO	CATION				
FACILITY NAME/LO	CATION				
FACILITY NAME/LO	CATION				
FACILITY NAME/LO	CATION				
FACILITY NAME/LO			37		



ATTACHMENT D: PEDIATRIC/NEONATAL COMMUNICATION PATHWAY





ATTACHMENT E: ICS 213 RR FORM

1. Hospital Name:					2. Date/Time	3. Resource Request Number:						
		41	1.00									
Requestor	4. Order (Use additional forms when requesting different res				Irce sources of supply.):							
	Qty. Kind Type Detailed Item Description experience size etc.)			experience, size, etc.)	acteristics, brand, specs,	Arrival Date and Time		Cost				
						Requested	Estimated					
	5. Requested Delivery/Reporting Location:											
	6. Suitable Substitutes and/or Suggested Sources:											
	7. Requested by Name/Position: 8.				Priority: Urgent Routine Low	9. Section Chief Approval:						
RHCC Logistics	10. Logistics Order Number:			mber:		11. Supplier Phone/Fax/Email:						
	12. Name of Supplier/POC:											
	13. Notes:											
	14. Approval Signature of RHCC Logistics Rep					15. Date/Time:						
	16. Order placed by (check box): SPUL PROC											
C Approval	17. Rep	7. Reply/Comments from RHCC Manager:										
RHCC	18. RHCC Manager Signature:					19. Date/Time:						
ICS	ICS 213 RR											

RESOURCE REQUEST REGION V RHCC (ICS 213RR)



ATTACHMENT F: HOSPITAL REQUEST FOR RESOURCE ALGORITHM



Hospital Disaster Resource Request Flowchart (Request for Medical Resources)



ATTACHMENT G: HOSPITAL MEDICAL SUPPLY BAG INVENTORY

MINIMUM EQUIPMENT/SUPPLIES FOR DISASTER RESPONSE November 2015

- This equipment is intended to be used to support EMS efforts in the field, a healthcare casualty collection site, and/or an alternate care site (ACS).
- This equipment can be rapidly transported by EMS, Fire, Law Enforcement or other mode of transportation and can be the first line of supply to a disaster area.
- The regional medical surge plan should include the request, transportation and oversight of this equipment.
- All hospitals must be able to have the following supplies available for transport in portable containers within 30 minutes of the time requested.
 - Due to the amount and weight of supplies, hospitals should consider pre-designating at least 2 supply bags/rolling carts/portable containers for these items and attach a copy of this list to those portable containers to expedite this process. This will facilitate the gathering, handling and transportation of the supplies.
- NOTE: Hospitals may be asked to fulfill a second request of these supply items. Upon
 request, hospitals will need to make available an additional container(s) that contains all of
 the below inventory.

Hospital Medical Supply Bags Inventory

Intravenous Supplies/Drugs

- 10 IV Bags 0.9% Normal Saline 1000 mL with IV tubing
- 6 ea IV start catheters (#24, 20, 18, 16)
- 2 Disposable pressure infusers
- 15 IV start kits and tourniquets
- 6 Saline Locks (useful for pediatric patients)
- 6 Pre-filled 0.9% Normal Saline Flush syringes
- 5 ea Dial flow regulators (or equivalent) or Buretrol devices

Airway Equipment

- 4 Bulb syringe (may be used for suction)
- 2 ea Oropharyngeal airways, adult (large, medium and small) and pediatric (child and infant)
- 6 ea Nasal cannulas
- 2 Adult bag/valve/mask system
- 2 Pediatric bag/valve/mask system, with child and infant masks
- 3 Adult non-rebreather masks
- 3 Pediatric non-rebreather masks
- 4 Blind airway insertion devices (i.e. King, Combitube, LMA) pediatric and adult as appropriate
- 2 Hand operated suction unit (Res-Q-Vac or V-Vac) capable of utilizing multi-sized suction catheters for adult and pediatric patients


ATTACHMENT G: HOSPITAL MEDICAL SUPPLY BAG INVENTORY (CONTINUED)

Hospital Medical Supply Bags Inventory (cont'd)

Dressings

- 10 Large Trauma dressings
- 5 4" Ace bandages
- 5 6" Ace bandages
- 12 Kerlex rolls
- 4 Rolls wet-proof tape
- 200 Individual wrapped sterile 4x4 gauze pads
- 4 bx 4 x 4's
- 10 ABD pads
- 1 bx. Medium size -Occlusive dressings
- 6 Burn sheets

Immobilization Equipment

- 2 ea. Semi-rigid Cervical collars (small, medium, large and pediatric or equivalent) (8 total)
- 2 ea. Arm boards (pediatric and adult)
- 12 Malleable splints
- 20 Triangular bandages

Personal Protection Equipment

- 10 Paper isolation gowns
- 10 Protective face masks or protective eye wear
- 2 ea. Box of Non-sterile gloves (medium and large)

Miscellaneous Supplies

- 1 ea. Sphygmomanometer and cuff (Bariatric, adult and child)
- 1 Stethoscope
- 1 bx. Alcohol preps
- 5 Large trauma scissors
- 25 SMART Tags or equivalent
- 5 START and JumpSTART Mass Casualty Triage algorithm card
- 2 Flashlight with batteries (or headlamp)
- 10 Blankets (space blankets)
- 2 Irrigating fluid (water) 100 mL
- 1 Sharps disposal system
- 2 Large red plastic hazardous waste bags
- 2 Hand sanitizer (8 or 12 oz)
- Length or weight based system for dosing and sizing pediatric emergency equipment (e.g. Broselow tape or PediWheel)
- Roll duct tape
- 3 Trauma tourniquets
- 5ea Pens and writing tablets



ATTACHMENT H: COMMON REACTIONS EXHIBITED BY CHILDREN DURING AND AFTER DISASTER

(By Age Groupings)

Age Group	Emotional Reaction	Physical/Behavioral Reaction
Preschool	 Fear of separation Fear of being alone Helplessness Powerlessness Passivity Magical thinking-feel that they caused the event or it occurred to punish them 	 Aches and pains Confusion-not understanding that the danger is over Sensitivity to noise Regression Clinging to caregiver(s) Eating problems Sleeping problems Crying Not talking Re-enact incident repeatedly
School age	 Withdrawal Fearfulness Sadness Guilt-feels responsible Anger Increased interest in details about death due to their increased understanding of death 	 Aches and pains Confusion Poor concentration Eating problems Sleeping problems Attention seeking Regression School avoidance Aggression Fixated on the event Irritability
Adolescent	 Withdrawal Fearfulness Sadness Hopelessness Detached Shame/guilt Over whelmed 	 Aches and pains Poor concentration Sleep changes Acting out Irritability Substance abuse Isolation Avoidance Abrupt social and attitude changes Dangerous or risk taking behavior

*Source: Illinois EMSC Pediatric Disaster Preparedness Guidelines for Hospitals



ATTACHMENT I: PEDIATRIC TRIAGE GUIDELINES

	IDPH ES	F-8 Plan: Pediatric and Neonatal	Surge Annex 2020					
ATTACHMENT 10: PEDIATRIC TRIAGE GUIDELINES Purpose: Provide guidance to the transferring facility and the Pediatric Care Medical Specialist (PCMS) during statewide triage of patients to identify the most appropriate facility to receive transferred pediatric patients. Instructions: Transferring physician should use these guidelines to determine which category hospital the pediatric patient needs. The triage category assigned to each patient by the transferring physician should be sent to the PCMS using the Pediatric/Neonatal Medical Incident Report Form (Attachment 5)								
TRIAGE CATEGORY	PEDIATRIC INTERVENTIONS	POSSIBLE CRITERIA* PEDIATRIC CONDITIONS	PERINATAL CRITERIA					
CRITICAL CARE (Pediatric/Neonatal Intensive Care/ Category 1 Hospitals)	 Invasive monitoring (either present or needed) (e.g., A-line, CVP, ICP) Continuous cardiac, NIBP, and/or pulse oximetry monitoring Immediate/emergent dialysis for acute or chronic renal failure IV drips ≥ 2 (e.g., insulin, inotropes, TPN, etc.) Highly specialized equipment needs (HFOV-high frequency oscillator ventilators, ECMO) Conventional ventilator/BiPAP/CPAP/Hi flow oxygen (unstable) Continuous nedulizer treatments (not responding adequately to treatments) Externally paced Other specialized equipment (e.g., LVADs) 	 Active seizures/status epilepticus Post cardiopulmonary arrest patients Dehydration, electrolyte imbalances, and/or metabolic disturbances (unstable) Shock responding inadequately to treatment (refractory) Respiratory distress (responding inadequately to treatment) Unstable vital signs Unstable cardiac rhythm disturbances Trauma (unstable): Spinal cord injuries; major pelvic fractures; blunt injury to chest or abdomen, significant penetrating wounds to head, neck, thorax, abdomen, or pelvis Trauma: Head injury with any of the following: cerebrospinal fluid leaks, open head injuries (excluding simple scalp injuries), depressed shull fractures, decreased level of conciousness Trauma (unstable): Fractures and deep penetrating wounds to an extremity with neurovascular or compartment injury Burns ≥ 20% TBSA, burns to genitalia, circumferential burns (Request hospital with burn capabilities) Other condition(s) requiring pediatric critical care specialty 	Level III Perinatal Center Criteria Post cardio-pulmonary failure/arrest Eclampsia Active hemorrhage/heavy bleeding Fetal parts or foreign bodies protruding from vagina Diabetic coma/DKA Altered level of consciousness Multiple gestations (greater than twins) in active labor Active labor in mothers < 30 weeks gestation Preterm rupture of membranes < 30 weeks gestation Laboring mother with known antenatal fetus defect (e.g., cardiac, pediatric surgery) Pre-eclampsia or Hemolysis, Elevated Liver Enzymes, and Low Platelets (HELLP) syndrome Other life-threatening conditions to mother or fetus Pregnant women with > 10% TBSA burns (Request hospital with burn capabilities)					
INTERMEDIATE CARE (Pediatric/Neonatal Intermediate Care/ Category 2 & 4 Hospitals)	 IV drip x 1 (e.g., insulin, inotropes, TPN) Central lines (IJ, Subclavian, Femoral) Intermittent cardiac, NIBP and/or pulse oximetry monitoring Continuous nebulizer treatments (responding adequately to treatment) Conventional ventilator, CPAP/BiPAP/Hi flow oxygen (stable) Non-emergent hemodialysis for chronic renal failure 	 Shock, responding adequately to treatment (compensated) Stable cardiac rhythm disturbances Dehydration, electrolyte imbalances, and/or metabolic disturbances (stable) Respiratory distress (responding adequately to treatment) Trauma (stable): Head injury, pelvic fractures, spinal cord injuries, blunt injury to chest or abdomen Trauma (stable): Fractures and deep penetrating wounds to an extremity with neurovascular or compartment injury Trauma: Patient with chest tube, hemovac (stable) Burns ≥10% but < 20% TBSA Other urgent condition(s) requiring care 	 Level II-E Perinatal Center Criteria Active labor in mothers > 30 and < 35 weeks gestation Multiple gestations (no more than twins) in active labor Decreased fetal movement Abdominal pain Preterm rupture of membranes > 30 and < 35 weeks gestation Pregnant women with ≤ 10% TBSA burns 					
GENERAL CARE (Pediatric/Neonatal General Medical Care/ Category 2, 3 & 4 Hospitals)	 Intermittent monitoring (e.g., pulse oximetry) Maintenance IV fluids or saline lock Low flow oxygen (up to 4L) Nebulizer treatments q 4 hrs or greater PO/TV meds 	 Pediatric burns < 10% Fever (Stable) Inpatient psychiatric resources Other minor condition(s) requiring care 	 Level I or II Perinatal Center Criteria Active labor in mothers > 35 gestation Stable gestational hypertension Premature rupture of membranes > 35 weeks gestation Rule out rupture of membranes (ROM) 					

* This list is not meant to be all inclusive and is to be used ONLY during disasters

44

July 2020



ATTACHMENT J: PEDIATRIC PATIENT TRACKING LOG

Incident nan	ne	Date			Tin	ne		Prepa	red by:			
Tracking				Chief	<u>-</u>		Metho Trans	od of port	Transferring Facility	Receiving Facility		ime)
Number	Patient Name	В	IDER	complaint/	ated	Triage	(Ground	d, Air)	Name	Name	Initial transfor?	sfer te (T
(assigned by initial health	(Last, First)	ă	GEN	condition	ntub	category	Type Trans	e of port	Point of Contact	Point of Contact	Y/N	Trai
care facility)					-		(BLS, ALS, Can	Critical e)	Address	Address		Cor
					v						Y	
					N						Ν	
											Y	
					Y N						N	
											Y	
					Y N						N	
											Y	
					Y N						N	
											Y	
					Y N						N	



Incident nan	ne	Date			Tin	ne		Prepa	Prepared by:			
Tracking			~	Chief	6		Metho Trans	od of port	Transferring Facility	Receiving Facility		r lime)
Number	Patient Name	8	DEF	complaint/	ate	Triage	(Ground	d, Air)	Name	Name	Initial	isfe te (1
(assigned by initial health care facility)	(Last, First)	ă	GEN	condition	Intub	category	Type Trans	e of port	Point of Contact	Point of Contact	Y/N	Trar mplet
care facility)					-		(BLS, ALS, Can	Critical e)	Address	Address		Ĉ
					v						Y	
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ATTACHMENT J: PEDIATRIC PATIENT TRACKING LOG (CONTINUED)



ATTACHMENT K: PEDIATRIC PATIENT TRANSFER FORM

IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex 2020

ATTACHMENT 13: PEDIATRIC PATIENT TRANSFER FORM

Purpose: Provide a method of communicating medical and treatment information during a disaster when pediatric patients are being transferred to another health care facility (e.g., pediatric specialty care centers). Instructions: This form should be completed to the best of the provider's ability given the care that has been provided on every patient transferred to another health care facility. This form should be completed prior to transfer. The original form will accompany the patient while a copy of the form should remain with the patient's medical record at the transferring health care facility.

Note: All information within this form is confidential and should not be shared except with those assisting in the care of the patient.

Incident Name							Date	Time				
Form completed by					Title	Title						
Patient Name (last, first)					DOB	DOB Sex						
Tracking Number (assigned	ed by initia	al health	n care	facility)	Age	Age Years Months 🗆 Male						
					🗆 Esti	Estimated Female						
Parent/guardian present	🗆 No 🗆 Ye	s			Is info	ormation about parent/g	uardian knowr	n? 🗆 No 🗆 Yes				
If yes, provide the follow	ng inform	ation:			If yes	, provide the following in	nformation:					
Name					Name	e						
Phone					Phon	e						
Custody/legal status					Are t	he whereabouts of the p	arent/guardiar	currently known?				
Documentation provided	□No □)	(es			D No	D 🗆 Yes						
					Effor	ts to contact						
Interpreter needed? No	D 🗆 Yes				Prima	ary care provider notified	l? 🗆 No 🗆 Yes					
Language					Phon	e						
				1	NITIAL S	TATUS						
Transferring health care f	acility				Trans	sferring physician						
Unit at hospital												
Full address					Trans	sferring physician special	ty 🗆 ED 🗆 Pedia	atrician 🗆 Family Practice				
					D Ne	onatologist 🗆 Obstetricia	n 🗆 Other (list)					
Phone					Trans	sferring physician/facility	contact's pho	ne				
Preliminary diagnosis					Reaso	on for transfer						
Acuity Level Stable/No	n-emerge	nt 🗆 Sta	ible/Ei	mergent c	Unstab	le/Emergent						
Requested services/speci	alty 🗆 ED	🗆 Traui	ma 🗆 P		CU 🗆 Bur	n 🗆 In-patient services 🗆	Other specialt	y services (list):				
						USTORY						
Waight	Allergies	(lict)		P	Home	modications (list)						
ka	Alleigies	(list)			nome	medications (list)						
^6												
		- Uska			= Nene	- Unknown - Soo attac	had madiantic	a reconciliation form				
Delevent Medical/Surgia		(lise)	own		LINONE	D Onknown L See attac	neu medicació	- See attacked				
Relevant Medical/Surgic	al History	(list)						See attached				
			CLIN	ICAL ASSE	SSMENT	T AND TREATMENTS						
Vital signs (time)	Т	HR	RR	BP	SaO2	Vascular access	rial 🗆 IO 🗆 P					
(initial)						Indwelling venous ca	theter 🗆 Centra	al venous line				
(most recent)						Site						
						Fluid type	Rat	e				
Intake/Output (time)	INTAK			DUTPUT		Bolus? No Yes: Type	e					
						Total volume	Time give	n				
Physical Findings												
				FORM C	ONTINU	IES ON PAGE 2						

Incident Name:

49 July 2020 Original Form: Send with patient. Copy of Form: Maintain on file



ATTACHMENT K: PEDIATRIC PATIENT TRANSFER FORM (CONTINUED)

Current Medications See attached						X-Ray/CT/MI	RI/Ultrasoun	d Re	sults		See attached
Blood Gas				See att	tached	Labs 🗆 See attached					
Time Site	pH										
							\setminus \land				
		Other (include critical lab values):									
Airway								+	- P	nding	Isolation
Intubated No Yes			02	Mask 🗆 N	o 🗆 Yes		El.	-		Б	Bonation
ETT/TR SizeD	epth		Na	sal cannul	a 🗆 No 🗆 '	Yes	riu				
Vent settings			O2	Liters/Mir	n		RSV				
CXR 🗆 No 🗆 Yes			Bi-	PAP/CPAP	O No D	Yes	MRSA	\vdash	_		
			Set	ttings			Cough				
-				1	TRANSPOL	RT NEEDS					
Type of transport serv	ice nee	ded 🗆 BL	S 🗆 ALS	1 □ Critical	TRANSPOI	RT NEEDS Type of transpo	ort service av	ailab	e at t	ansferri	ng hospital?
Type of transport serv □ Ground □ Air □ Oth Name of transport pro	ice nee er wider u	ded 🗆 BL	S 🗆 ALS	T Critical patient	TRANSPO I care	RT NEEDS Type of transpo D No D Yes Phone number	ort service ava	ailab prov	e at ti der	ansferri	ng hospital?
Type of transport serv □ Ground □ Air □ Oth Name of transport pro Equipment needed for immobilization □ restr	ice nee er vider u r transp	ded BLS sed to tra ort oxy isolette r	S 🗆 ALS	□ Critical patient entilator c at □ Other	C-PAP =	RT NEEDS Type of transpo D No D Yes Phone number cardiac monito	ort service ava of transport r = IV pump c	ailab prov o inv	le at ti der asive r	ransferri	ng hospital? ng 🗆 spine
Type of transport serv □ Ground □ Air □ Oth Name of transport pro Equipment needed for immobilization □ restr	ice nee er wider u r transp aints =	ded = BL3 sed to tra ort = oxy isolette c	S = ALS ansport gen = v car sei MEE	Critical patient entilator c at Other DICAL MAI	C-PAP = (list)	RT NEEDS Type of transpo Do D Yes Phone number cardiac monito	ort service ava of transport r = IV pump t Y PCMS	ailab prov o inv	der asive r	ansferri	ng hospital? ng = spine
Type of transport serv Ground C Air C Oth Name of transport pro Equipment needed for immobilization c restr Management discussio	ice nee er vider u r transp aints = on/Reco	ded = BL3 sed to tra ort = oxy isolette =	S 🗆 ALS ansport gen 🗆 v car se <u>MEC</u> ations	Critical patient entilator c at = Other DICAL MAI	TRANSPO care	RT NEEDS Type of transpo No D Yes Phone number cardiac monito IT PROVIDED B	ort service ava of transport r = IV pump r Y PCMS = Te	ailab prov inv	der der dicine	nonitori capabi	ng hospital? ng = spine ities used
Type of transport serv Ground Air Oth Name of transport pro Equipment needed for immobilization restr Management discussio	ice nee er vider u r transp aints = on/Reco	ded = BL3 sed to tra ort = oxy isolette =	S = ALS ansport gen = v car set MEC ations	Critical patient entilator c at = Other DICAL MAI RECEIVIN	TRANSPOI i care c C-PAP = · (list) NAGEMEN G HOSPIT	RT NEEDS Type of transpo D No D Yes Phone number cardiac monito IT PROVIDED B	ort service ava of transport r = IV pump c Y PCMS = Te ON	ailab prov a inv	le at ti der asive r	ansferri nonitori e capabi	ng hospital? ng 🗆 spine ities used
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Type of transport serv Ground Air D Oth Name of transport pro Equipment needed for immobilization restr Management discussion Receiving hospital Address Bed assignment	ice nee er vider u r transp aints D on/Reco	ded \square BL3 sed to tra ort \square oxy isolette \square ommenda	S = ALS ansport gen = v car set MEC ations	Critical patient entilator c at _ Other DICAL MAI	C-PAP = (list) NAGEMEN	AT NEEDS Type of transpo Phone number cardiac monito IT PROVIDED B AL INFORMATII Receiving physi Specialty = ED Neonatologis Receiving physi	ort service ava of transport r = IV pump c Y PCMS = Te ON cian cian cian cian pediatriciar t = Obstetric	ailab prov inv leme	de at ti der asive r adicine amily Othe	ansferri nonitori e capabi Practice r (list)	ng hospital?
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IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex **2020**

Incident Name:

50 July 2020 Original Form: Send with patient. Copy of Form: Maintain on file



ATTACHMENT L: PATIENT IDENTIFICATION TRACKING FORM

structions: This form should be comp ho arrive at a health care facility rega nother facility and keep a copy of the ote: Information contained within this fo	pleted to the be ardless if accomp form on file wit form is confidentia	st of the ability given the i panied by family/parent/g h the patient's medical re I and should not be shared.	information av uardian. Send cord at the tra except with the	vailable on all patients, especially pediatric patients, I the original form with the patient if transferred to ansferring health care facility. ose assisting in the care of the patient.
Date of Arrival	Tin	e of Arrival	AM/PM	Incident Name
Tracking Number (assigned by initial	health care faci	lity)		•
Patient's Name (Last, First)				Patient's Phone
Patient's Full Home Address				
(For Minors) Parent/Guardians' Nam	es			Presented with patient? Presented with patien
Patient's DOB	🗆 Unknown	Age Years Month	s 🗆 Estimate	d Gender 🗆 Male 🗆 Female
Race/ethnicity, if known 🗆 White nor 🗆 Asian or Pacific Islander 🗆 Hispani	n-Hispanic 🗆 Bla ic 🗆 Asian Indian	ck/African American, non American Indian or Ala	Hispanic ska Native	Language 🗆 English 🗆 Spanish 🗆 Nonverbal 🗆 Other
Onknown Cother Accompanied Cother	d Descrit	e where patient was four	nd. Be as	Items worn by or with patient when found (describe
University of the second set in a second set in the second set in	specifi	as possible, including		color, pattern, type)
How patient arrived at nospital (list r if available)	neighb	orhood/street address.		Pants
				Dress
Private medical transport service				D Shoes
(ambulance/flight)				Socks
				Coat/jacket
Law enforcement				🗆 Jewelry
Private vehicle				🗆 Glasses
□ Walk-in				Medical devices
Other				D Other
Hair Color Black Red Grey Hold Hold Height Height Color Brown Blue Green Color Brown Blue Height Color Brown Brown Blue Height Color Brown Brown Blue Height Color Brown Blue Height Brown Blue Height Color Brown Blue Height Brown Blue Height Brown Blue Height Brown Blue Blue Brown Blue	- Bald		A	ttach photo here
🗆 Other		PATIENT TRACKIN	20100	
Hospital/Facility Name	Phone Numbe	r Arrival Date	1	ID Band #/ ID Band
Location (city, state)	Fax Number	Departure Date	(If patient he	as ID bands from other facilities and they need to be remove to provide care, attach ID band in this area)
			_	
			_	



ATTACHMENT L: PATIENT IDENTIFICATION TRACKING FORM (CONTINUED)

MEDICAL HISTORY AND TREATMENT WHILE AT THIS EACH ITY						
MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY						
Does the patient have any pre-existing medical conditions, medical problems, previous surgeries, special needs?						
No Unknown Yes (list)						
Is the patient on any medications? I No Unknown Yes (list)						
Does the patient have any allergies? Do D Unknown	🗆 Yes (list)					
Did the patient receive medical care for an injury/illnes	s while at this f	facility?				
n No n Yes (list)						
COMPLETE FOR M	INORS: CHILD	ACCOM	DANIED BY DADENT/CHADDIAN			
COMPLETE FOR M	NORS. CHILD	ACCOM	PANIED DI PARENT/GOARDIAN			
Name of person accompanying child			Adult Child/Minor			
Relationship to child						
Parent Guardian Sibling Grandparent						
Aunt/Uncle/Cousin Unknown						
D Other			Attach Copy of ID			
ID Checked? ID Ves D No						
Form of ID (list)						
Form of ID (list)						
If accompanied by adult, was child living with this adult	prior to the er	nergeno	:y? 🗆 Yes 🗆 No			
Does this adult have proof of legal guardianship or rela	tionship? 🗆 Ye	s 🗆 No				
If yes, make copy and attach to this form.						
If child and adult were separated after arrival at curren	t facility, where	e is acco	ompanying adult now?			
If accompanied by company other than parent (suredia	a what is know	un abau	t the append (augedian's surrent unbegable uts)			
The Nothing at this time a Their surrent leastion is:	n, what is know	vii abou	t the parent/guardian's current whereabouts:			
Divotning at this time Diffield current location is:						
Is it known if there are orders of protection or other cu	stody issues? 🗆	No kno	own custody/protection issues			
Issue(s) identified						
COMPLETE FOR MIN	NORS: CHILD U	NACCO	MPANIED BY PARENT/GUARDIAN			
Are the whereabouts of the parent/guardian currently	known? 🗆 No c	Yes				
Is information about parent/guardian known? No No No No No No No N	/ec					
Name		hana				
Name	P	none				
Location						
E-mail address						
Where and when was the parent/guardian last seen						
Has the parent/guardian been contacted 🗆 No 🗆 Yes						
Contacted by	Dat	e	Time			
Plans for reuniting child with parent/guardian						
· · · · · · · · · · · · · · · · · · ·						
Agoncies used to assist with rounification (Date/Derron	contacted	Additi	anal stons to varify quardianchin if rounited at hospital			
Agencies used to assist with reunification (Date/Person	contacted	Addit	onal steps to verify guardianship if reunited at hospital			
American Red Cross		DO6	s parent/guardian describe child accurately?			
Illinois Department of Children and Family		DO6	s parent/guardian pick correct child out from a group of pictures?			
Services		DO6	s parent/guardian have a picture of them with the child?			
Law enforcement		D Doe	s the child respond appropriately when reunited with			
National Center for Missing and Exploited Children	_	paren	t/guardian?			
			-			
D Other						
	DIE	POSITI	2N			
= Admitted to	= Dischart	4	- Evaluat			
	Discharged	1	Expired			
Patient was released to an individual	rdian 🗆 Other_					
Name		Phone	License Plate Number			
Address			Permanent 🗆 Temporary			
Was consent obtained from parent/guardian	if released to a	nother	adult? 🗆 Yes 🗆 No (explain)			
Patient was transferred to another facility/agency (N	ame)					
Address			Phone			
Contract as ma			r ny ng			
Contact name						
Transported by						
Signature of patient/individual patient released to	Date:		Name of person completing form			
	Time					
			Signature of person completing form			
	48		July 2020			
Incident Name:	Or	iginal Fo	orm: Send with patient. Copy of Form: Maintain on file			



ATTACHMENT M: PEDIATRIC SAFE AREA CHECKLIST

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

ATTACHMENT N: PSA COORDINATOR JOB ACTION SHEET

FRS Pediatric Safe Area Coordinator Job Action Sheet (JAS)

YOU REPORT TO:	(PEDIATRIC SERVICES UNIT	LEADER)
COMMAND CENTER LOCATION:	PHONE #:	
Mission: Ensure the pediatric safe area (PSA) is properly si during an emergency, and to insure the safety of appropriate disposition can be made.	taffed and stocked for implem children requiring the PSA unt	entation il an
Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment from Pediatric Services Unit Leader		
Read this entire job action sheet		
Obtain briefing from Pediatric Services Unit Leader		
Ascertain that the pre-designated PSA is available		
If not immediately available, take appropriate measures to available as) make the area	
soon as possible		
Gather information about how many pediatric persons may	y present to the area	
Make sure that enough staff is available for PSA		
Make sure that enough security staff is available for PSA		
Make sure that there is adequate communication in PSA		
Make sure that there is a sign in/out log for PSA		
Make sure that all items in PSA checklist have been met. If differences,	f there are any	
Address them as soon as possible and report them PSUL		



ATTACHMENT N: PSA COORDINATOR JOB ACTION SHEET (CONTINUED)

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ascertain the need for ongoing staff for PSA		
Maintain registry of children in PSA as they arrive or are released to appropriate adult		
Determine estimated length of time for the expected operational period of PSA		
Maintain communication with Pediatric Services Unit Leader for planning needs		
Determine if there are any medical or non-medical needs specifically needed by pediatric persons in PSA		
Prepare an informational session for the pediatric persons in the PSA		
Prepare to make arrangements for sleeping capacities if needed		
Ascertain if there will be any additional needs required for this event (volunteers, staff, security, and equipment)		
Make sure that pediatric persons have the appropriate resources (food, water, medications, age-appropriate reading materials) and entertainment for their safety		
Report frequently to Pediatric Services Unit Leader concerning status of PSA		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Make sure that PSA staff have enough breaks, water, and food during their working periods		
Coordinate with Psychological Support for ongoing evaluations of mental health of volunteers and pediatric persons in case of need for psychosocial resources		
Document all action/decisions with a copy sent to the Pediatric Services Unit Leader		
Other concerns:		



ATTACHMENT O: CHILD IDENTIFICATION AND DISPOSITION/DISCHARGE FORM

		(Child Identifica	ation	and D	isposition/Dis	scharge f	orm		
						CHILD'S IN	NFORMAT	10N		
			Childs's Name (Prin	nt):		Address (Street, Cit	y, State, Zip)	c .	Conta	ct Information:
								Home:		
ATTACH								Cell:		
			Date of Birth (YYYYMMDD):			Age:			Armband#:	
			PHYSICAL CHARAC	TERISTI	CS	DISTINGUISHING CHARACTERISTICS (Desc			ribe in adjacent box)	
CHILD	PHOTO		Sex:	10	MO	Glasses:				
HERE		Race/Ethnicity			Contacts:					
			Hair Color:		Birthmark:					
			Eye Color:			Piercing(s):				
			Height:			Tatpo(s):				
			Weight:			Scar(s):				
			Special Need(s):		Braces:					
			Other:		Other:	Other:				
		_	CI	RCUM	STAN	CES OF ARRIVAL				
			(Pro	ide details	on how th	e child arrived at the hospita	×0			
ARRIVAL IN	FORMATIO	DN .				CHAPERON	E INFORMATI	ION		
Accompanied?	YesO	N₀O	Chaperone's Name	: (Print):		Address (Street, Cit	ty, State, Zip)		Conta	ot Information:
If yes, complete cha	perone int	fo ->							Home	:
Treated Illness/Injun/2	YesO	NOO							Cell:	
If yes, what type?			Date of Birth (YYYY	MMDD):			Age:		Armb	and#:
Admitted?	YesO	NoO	Driver's License Nu	mber:				Signature	ĸ	
If yes, what unit?			Relationship to Chi	ld:						
ARRIVAL SYNOPSIS synopsis of how the hospital. Try to cap and if more room is rear of the form.	Provide to child arriv ture the sp required to	brief ved at the becifics use the								
			DISPOSI	TION /	/ DISC	HARGE INFORM	ATION			
The above named p	atient and	l/or guardia	n has received the fo	llowing	patient i	nstructions:				
Instructions:							Follow-Up:	You have b	een ref	erred to the following
							clinics/spec	ialist for fo	llow-ca	No:
							Physician;			NOURS:
						ł	Address:		-+	
Prescription Information	Prescription Information:						Phone Number:			
Instructions were gi	ven on this	s date		at this	s time					
IMPORTANT: We ex	amined ar	nd treated y	ou today on an emer	gency be	asis only	This was not a subs	titute for, or	an effort to	provid	e complete medical care. In
most cases, you mu illnesses in one Eme	ist let your erdency Dr	doctor che	ck you again. Tell you isit, if you had specia	r doctor	about a such as l	ny new or lasting pro EKG's, X-rays or Cultu	blems. We ca tres, we will r	annot recog review them	gnize an within	d treat all injuries or 24-48 hours. We will call
you if there are any	new result	ts or sugges	tions. After you leave	, you sh	ould foll	ow the instructions b	elow.			
YOU ARE THE MOST doctor again as disc	USSed If y	INT FACTOR	IN YOUR RECOVERY: oblems that we have	Follow	the abor ussed in	ve instructions carefu all or visit your docto	illy. Take you r right away	r medicines If you care	s as pro ot read	scribed. Please, see a h your doctor, return to the
Emergency Departn	nent. IF YO	OUR SYMPT	OMS GET WORSE OR	YOU HA	VE OTHE	ER CONCERNS, RETU	RN TO THE E	MERGENC	Y DEPA	RTMENT
			DISPOSI	TION	/ DISC	HARGE INFORM	ATION			
"I have received this	informati	on and my	questions have been	answer	ed. I hav	e discussed any chal	lenges I see	with this pla	an with	the nurse or physician."
Requests for copies of your medical record			ds are processed by	Memori	a l' s Heal	Information Department, Please call 618-257-5335.				
Parent / Guardian M	varne (Prin	ių:				Provider (Print):				
Signature:					Signature:	Signature:				
Date:						Date:				



ADDENDUM

RHCC Mobile Hospital Trailer Pediatric Inventory

- Yellow Procedure Masks
- N-95 Masks Size Regular
- N-95 Masks Size Small
- 3 Broselow Carts
- 4 portable Broselow Bags
- Intubation supplies on all the treatment carts

RHCC Functional and Access Needs Trailer Pediatric Inventory

- Johnson Baby Soap
- Unscented Baby Wipes 40/pack
- Pediatric Crutches 3'7" 4'0"
- Child Crutches 4'0" 4'6"
- Youth Crutches 4'6" 5'2"
- Youth Walker 25"" to 32"" 300 lbs Capacity each
- Walker, Folding Child Guardian
- Medline 14" Wheelchair 250 lbs Capacity Peds Yellow
- Pant, Training, Child, Large, 23-40 lbs 8/15
- Diaper, Baby, Clothlike Cover Size 1, 0-6 lbs
- Diaper, Baby, Clothlike Cover Size 2, 6-14 lbs
- Diaper, Baby, Clothlike Cover Size 3, 12-24 lbs
- Diaper, Baby, Clothlike Cover Size 4, 22-35 lbs
- Diaper, Baby, Clothlike Cover Size 5, 30-38 lbs
- Diaper, Baby, Clothlike Cover Size 6, 35+ lbs
- High Chairs Cosco Zahari
- Play Yards Cosco Zahari
- Umbrella Stroller Cosco TV Land
- Nickelodeon Teenage Mutant Ninja Turtles Square Table and Chair Set
- MGA Lalalopsy Square Table and Chair Set
- Disney Cars Potty Seat and Step Stool
- Disney Fairies Potty Seat and Step Stool
- Trademark Foam Floor Alphabet Puzzles Mat for Kids
- Youth Gown Kit 25/bx
- Child Duffel Bag Kits
- Toddler Duffel Bag Kits
- Infant Duffel Bag Kits
- 48" Construction Safety Fence
- Sippy Cups
- Infant Feeding Bottles 4-6oz
- Peri Area Bottle 8 oz
- Nipples for baby bottles



Broselow Contents List













 PINK/RED - 7700RIV 1- IV Catheter/Needle, 22 Ga. x 1", Sterile (Safety Cath.) 1- IV Catheter/Needle, 24 Ga. x ³/4", Sterile (Safety Cath.) 1- IV Prep Kit, Sterile 	ORANGE - 7700 OIV 1- IV Catheter/Needle, 20 Ga. x 1.16", Sterile (Safety Cath.) 1- IV Catheter/Needle, 18 Ga. x 1.16", Sterile (Safety Cath.) 1- IV Prep Kit, Sterile
 Extension Set, Sterile PURPLE - 7700PIV IV Catheter/Needle, 20 Ga. x 1", Sterile (Safety Cath.) IV Catheter/Needle, 24 Ga. x ³/4", Sterile (Safety Cath.) IV Prep Kit, Sterile Extension Set, Sterile 	I- Extension Set, Sterile GREEN - 7700 GIV I- IV Catheter/Needle, 20 Ga. x 1¼", Sterile (Safety Cath.) I- IV Catheter/Needle, 18 Ga. x 1¼", Sterile (Safety Cath.) I- IV Prep Kit, Sterile I- Extension Set, Sterile
 YELLOW - 7700YIV 1- IV Catheter/Needle, 18 Ga. x 1 ¼", Sterile (Safety Cath.) 1- IV Catheter/Needle, 22 Ga. x 1", Sterile (Safety Cath.) 1- IV Prep Kit, Sterile 1- Extension Kit, Sterile 	
 WHITE - 7700WIV IV Catheter/Needle, 22 Ga. x 1", Sterile (Safety Cath.) IV Catheter/Needle, 18 Ga. x 1.16", Sterile (Safety Cath.) IV Prep Kit, Sterile Extension Set, Sterile 	
 BLUE - 7700BIV IV Catheter/Needle, 20 Ga. x 1¹/4", Sterile (Safety Cath.) IV Catheter/Needle, 18 Ga. x 1¹/4", Sterile (Safety Cath.) IV Prep Kit, Sterile Extension Set Starile 	
1- Extension Set, Sterile	_1



PINK/RED - 7700RIN - Vital View [™] Disposable® Laryngoscope Blade Size: Miller #1 - 3.5 mm Endotracheal Tubes, Uncuffed - Endotracheal Tube Stylet - 8 Fr. Suction Catheter - 8 Fr. Nasogastric Tube - 36" Adhesive Tape	BLUE - 7700BIN 1 - Vital View ™ Disposable® Laryngoscope Blade Size: Miller #2 1 - Vital View ™ Disposable® Laryngoscope Blade Size: Mac #2
 Vital View[™] Disposable® Laryngoscope Blade Size: Miller #1 -3.5 mm Endotracheal Tubes, Uncuffed - Endotracheal Tube Stylet - & Fr. Suction Catheter - & Fr. Nasogastric Tube - 36" Adhesive Tape 	 Vital View [™] Disposable® Laryngoscope Blade Size: Miller #2 Vital View [™] Disposable® Laryngoscope Blade Size: Mac #2
Size: Miller #1 - 3.5 mm Endotracheal Tubes, Uncuffed - Endotracheal Tube Stylet - 8 Fr. Suction Catheter - 8 Fr. Nasogastric Tube - 36" Adhesive Tape	Size: Miller #2 1 - Vital View ™ Disposable® Laryngoscope Blade Size: Mac #2
- 5.5 mm Endotracheal Tubes, Uncuffed - Endotracheal Tube Stylet - 8 Fr. Suction Catheter - 8 Fr. Nasogastric Tube - 36" Adhesive Tape	 Vital View ** Disposable® Laryngoscope Blade Size: Mac #2
- 8 Fr. Suction Catheter - 8 Fr. Nasogastric Tube - 36" Adhesive Tape	512e: Mac #2
- 8 Fr. Nasogastric Tube - 36" Adhesive Tape	1 5.5 mm Endotrachaol Tuber Unauffed
- 36" Adhesive Tape	 - 5.5 mm Endotracheal Tubes, Oncurred - Endotracheal Stylet
	1 -10 Fr. Suction Catheter
- Lubricating Jelly Packet, Water Soluble	1 - 14 Fr. Nasogastric Tube
- 3" x 3" Gauze Pad	1 - 36" Adhesive Tape
	1 - Lubricating Jelly Packet, Water Soluble
PURPLE - 7700PIN	1 – 3" x 3" Gauze Pad
- Vital View ™ Disposable® Laryngoscope Blade	
Size: Miller #1	ORANGE – 77000IN
– 4 mm Endotracheal Tubes, Uncuffed	1 - Vital View ™ Disposable® Laryngoscope Blade
- Endotracheal Tube Stylet	Size: Miller #2
 Fr. Suction Catheter Fr. Macagastria Tuba 	 Vital View ™ Disposable® Laryngoscope Blade Since Mag #2
- o rr. Ivasogastric Tube - 36" Adhesiye Tane	51ze: Mac #2 1 6.0 mm Endotracheal Tuber, Cuffed
- Lubricating Jelly Packet, Water Soluble	- Endotracheal Stylet
- 3" x 3" Gauze Pad	1 -10 Fr. Suction Catheter
	1 - 14 Fr. Nasogastric Tube
YELLOW - 7700YIN	1 - 10cc Syringe
- Vital View [™] Disposable® Laryngoscope Blade	1 - 36" Adhesive Tape
Size: Miller #2	 Lubricating Jelly Packet, Water Soluble
- 4.5 mm Endotracheal Tubes, Uncuffed	1 - 3" x 3" Gauze Pad
- Endotracheal Tube Stylet	-
- 10 Fr. Suction Catheter	GREEN – 7700GIN
- 10 Fr. Nasogastric Tube	 Vital View [™] Disposable® Laryngoscope Blade
- 30" Adhesive Tape Lubrication Julia Dashat Watar Salahla	Size: Miller #3
- Luoricating Jeny Packet, water Soluole	 Vital View ¹⁰ Disposable® Laryngoscope Blade Since Mag #2
- J X J Gauzerau	Size: Mac #5
WHITE 7700WIN	- 0.5 Endotracheal Tubes, Curred - Endotracheal Stylet
WHILE - 7700WIN	1 - 12 Fr. Suction Catheter
Size: Miller #2	1 - 18 Fr. Nasogastric Tube
-5.0 mm Endotracheal Tubes, Uncuffed	1 - 10 cc Syringe
- Endotracheal Tube Stylet Catheter	1 - 36" Adhesive Tape
- 10 Fr. Suction Catheter	 Lubricating Jelly Packet, Water Soluble
- 36" Adhesive Tape	1 - 3" x 3" Gauze Pad
- Lubricating Jelly Packet, Water Soluble	
- 5" x 3" Gauze Pad	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube	
- 3" x 3" Gauze Pad - 10 FR. Nasogastric Tube SUBJECT TO CHANGE	
- 3" x 3" Gauze Pad - 10 FR. Nasogastric Tube SUBJECT TO CHANGE	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube SUBJECT TO CHANGE	
- 5" x 5" Gauze Pad - 10 FR. Nasogastric Tube SUBJECT TO CHANGE	