Texas Pediatric Emergency Operations Plan Template for Hospitals

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Acknowledgment

Pediatric Preparedness Workgroup

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Table of Contents

INTRODUCTION **5**
BACKGROUND **5**
PURPOSE **5**
EMERGENCY OPERATIONS PLAN **6**
HAZARD VULNERABILITY ASSESSMENT **7**
REGIONAL HEALTHCARE COALITION ENGAGEMENT **7**
PATIENT MANAGEMENT AND SURGE CAPACITY **8**
MEDICAL 8
NON-MEDICAL 9
INTERFACILITY TRANSFER AGREEMENTS/GUIDELINES **10**
SAFETY AND SECURITY **11**
DECONTAMINATION **11**
REUNIFICATION/PATIENT IDENTIFICATION **12**
MENTAL HEALTH ISSUES **12**
CHILDREN WITH SPECIAL HEALTHCARE NEEDS **13**
DISASTER EXERCISES AND DRILLS **14**
REFERENCES **15**

Introduction

These guidelines are a resource to assist hospitals and healthcare entities in addressing the unique needs of children in disaster planning, and are based on the *Texas Pediatric Disaster Preparedness Guidance for Hospitals*. Hospitals should strive to incorporate pediatric components into their organization's Emergency Operations Plan (EOP).[1] Note that these guidelines represent current information within the medical and disaster literature at the time of publication. The recommendations in these guidelines do not indicate an exclusive course of treatment or serve as a standard of medical care. The strategies and recommendations in this document provide a foundation and may need to be augmented or tailored to meet the needs of individual organizations. Hospitals should consult with key representatives within their organization to assure consistency and compliance with local policies, as well as state and federal plans, statutes, and rules.[2]

This plan is intended to serve as an appendix to a hospital's Emergency Operations Plan (EOP) **OR** as a stand-alone plan to address a hospital's readiness and response to a disaster involving an influx of pediatric patients into the Emergency Department (ED). Other plans, policies and procedures may be referenced within this document that outline specific normal operating procedures which may be followed in a disaster scenario.

Background

Texas has the nation's second largest pediatric population with 7.5 million children under the age of 18, which is 25% of the state's population.[3] Regulatory entities require that emergency plans account for at-risk populations. It is recognized that pediatric patients, due to their anatomical and cognitive differences between age ranges, should be factored as an at-risk population.

Purpose

Hospitals designated as children's hospitals or with significant capability and capacity likely have EOPs inclusive of the pediatric population they routinely serve. The 2021 National Pediatric Readiness Assessment found that only 48% of hospital emergency departments (EDs) nationwide include children in their disaster plans.[4] In Texas, only 46% of hospital disaster plans address issues specific to the care of children.[5]

The Pediatric Preparedness Workgroup was established to develop and identify resources to assist in ensuring pediatric considerations are included in hospital disaster planning. The Workgroup is multidisciplinary and includes representatives from the Texas Emergency Medical Services for Children (EMSC) Program, Pediatric and Disaster Preparedness and Response Committees of the Governor's EMS and Trauma Advisory Council (GETAC), Texas Health and Human Services Center for Health Emergency Preparedness and Response Program, Gulf 7. Pediatric Disaster Network, among others.

Emergency Operations Plan

[HOSPITAL NAME] maintains a comprehensive emergency operations plan (EOP) developed, reviewed, and tested by a team of individuals representing various departments across the facility who are essential for continued business, functional and clinical operations of the hospitals during disasters.[6] Plans are reviewed [frequency] including supplemental plans/annexes and policies and exercised [frequency]. The EOP and emergency management (EM) program is also developed based on the patient population, including identified at-risk populations. Pediatrics due to their prevalence (25% of the population of Texas) and their unique physiological needs across the spectrum of the population, are identified within the EOP as an at-risk population.[6]

The program includes utilization of a pre-established incident command structure based upon roles, including redundancies in roles and positions. [HOSPITAL NAME] utilizes the Hospital Incident Command Systems (HICS).[6] Essential to this pediatric plan is the identification of a Pediatric Emergency Care Coordinator (PECC).

[Insert: HICS org chart sample]

[Hospitals list out the role of persons who would be most appropriate, samples below]

The following roles may already be organic to the organization and Incident Command (IC) structure or developed as a part of an Emergency Management program or other program focused around responding to the care or pediatric patients. These positions are supported by hospital administration and designation on committees to represent the care of children in disasters.

- ED medical director
- Pediatric Emergency Care Coordinators (PECCs)
- Lead nurse or nurse with pediatric training or specific pediatric certifications
- Hospital-based pediatricians and other sub-specialists (e.g. trauma surgeons, anesthesiologists)
- Pediatric nurses and advanced practice providers
- Perinatal professionals (e.g. neonatologists, nursery and obstetrical nurses)
- Child-life specialists
- Staff with psychosocial expertise (e.g., mental health specialists, social workers, spiritual care, and hospice staff)[2]

This team of pediatric champions should work to identify service lines throughout the hospitals to routinely participate in surge planning and exercising. This may include but is not limited to

- Medical services: including critical care, emergency department, surgical and anesthesia, nursing, respiratory and therapeutic care
- Support services: including phlebotomy, pharmacy, radiology, central supply, environmental services and communications

- Identify a staff member to champion pediatric disaster care. This person may serve in the role of the PECC
- Pediatric Champion, any other clinician with credentials or specialized training for pediatric treatment and care

Hazard Vulnerability Assessment

Hazard vulnerability assessments are required by the Joint Commission (TJC) and the Centers for Medicare and Medicaid Services (CMS) to focus planning efforts. In addition to incorporating pediatrics into the EOP as an at-risk population, [HOSPITAL NAME] conducts annual risk assessments. These assessments are carried out internal to the hospital as well as in conjunction with a community wide HVA in coordination with the Healthcare Coalition (HCC).

[HOSPITAL] carries out the pediatric risk assessment by [facility to list the HOW - select one OR all methods in which they already are and plan to conduct a pediatric focused risk assessment]

- Facility-based HVA summarizing top hazards with input or engagement by a pediatric champion(s) to correlate direct pediatric impacts, clinical and non-clinical.
- Facility OR HCC conducts pediatric specific HVA or risk assessment, designed to address the risks to the pediatric population. (ex. HVA Pediatric Template)
- Community-based HVA which is summarized collectively at the HCC level and correlates top risks and impacts to the pediatric population.
- Participates in external risk assessment or HVA with relevant partners and stakeholders such as nearby schools/school systems, daycares, emergency management agencies or other clinical pediatric partners.
- [LIST ANY OTHER METHODS]

[Hospital INSERTS Pediatric risk summary here; Any supplemental information/reports can be included as an attachment. An attachment may list out schools, daycare centers, libraries and other places in which children congregate.]

Regional Healthcare Coalition (HCC) Engagement

[HOSPITAL] participates in the [Region X] healthcare coalition by attending [quarterly/monthly/bi-annual] HCC meetings. Engagement with this group enables the hospitals to understand regional response concepts of operations, access to resources external to the facility and a single point of contact through the regional HPP and HCC regional representative.

The HCC meetings allow for collective planning by various hospital partners within the region along with other EMS and Emergency Management officials. Specific planning and training topics are addressed during HCC meetings allowing opportunities to engage with other essential partners necessary for pediatric planning, such as school system officials, EMS for Children

program, American Academy for Pediatrics. Outlined below are other partners the hospital should consider engaging with during drills/exercises, education, or real event response.

Develop relationships with key state and regional partners to aid in pediatric disaster response such as:

- EMS Agencies / Fire Departments
- Texas Department of Emergency Management (TDEM)
- EMS for Children State Partnership program
- Texas Department of State Health Services
- Children's Services
- Burn Programs
- Law Enforcement
- Local Health Departments

Patient Management and Surge Capacity

Medical

This section outlines the clinical aspects of key function areas that will support pediatric surge.

[Hospital] has identified the following supplies, equipment, space and staff that will be essential to supporting pediatric **clinical care** during a surge incident.

Equipment, Supplies

- [Location of] pediatric monitoring equipment, resuscitation equipment, and respiratory and airway management equipment.
- Location of, or access to other supplies not in ED but that may be used in a surge, such as adult equipment that can be converted or used to support a pediatric surge [hospital to list what departments/service areas]
- Pharmaceutical supplies and medications, including conversion procedures for administration of drugs [hospital to list how this is done]
- During extreme emergencies or large-scale events, the hospital may request additional pediatric clinical supplies within the region from neighboring hospitals with more advanced pediatric capabilities.

Space

[Hospital lists]

- Identified space(s) that can be used for pediatric surge within the ED
- Space external or adjacent to the ED that may be used for pediatric surge
- Other spaces may be used as an alternate triage and treatment site; hospital has a plan to activate the use of this space and has carefully considered its feasibility for the pediatric population
- Conversion of adult beds/units into pediatric capable areas [hospital lists what unit/area]

Staff

[Hospital lists]

- Roles and positions in facility that may be essential to providing pediatric care in the ED as well as other departments/services to ensure safe clinical care and treatment is provided - such as phlebotomy, radiology, social work, housekeeping, etc. [hospital to list]
- Staff are trained in pediatric disaster response through [hospital identifies avenues in which staff are trained in peds] this includes FEMA courses, clinical courses such as PALS, [hospital to list others as relevant]. A roster of the staff with pediatric training is maintained [where] and can be pulled by [who]
- Pediatric Emergency Care Coordinator (PECC) within the HICS [provide primary and backup role(s)]
- Hospital outlines avenues to obtain additional pediatric staff, external to hospital (is this covered in the EOP regarding emergency credentialling procedures?)
- Hospital surging as a receiving site for pediatric patients in an evacuation may request staff of evacuating site accompany patients to receiving location
- Hospital defines methods and procedure to utilize telemedicine in a disaster or emergency surge event, if possible

Non-Medical

Equipment, Supplies

Staff designated to support the uninjured or sheltering pediatrics during a surge event should know where to access non-medical supplies maintained on site. The following items are maintained [where], in what quantity [hours], or may be obtained through [what channels, local non-profits/groups].

- Age-appropriate foods, dextrose in water, infant formula, bottles, and nipples
- Diapers, wipes, pediatric sized gowns and clothing
- Cribs, beds and blankets
- Toys, games, art supplies, bubbles, and dolls

Space

The spaces outlined below are identified and used for holding non-injured pediatric patients or visitors. The intent of this space is to house the non-injured patients arriving at the ED as green patients for assessment or triage from the scene of an incident or are accompanying injured adults or caregivers. Additionally, this pre-identified space may be used to house non-injured patients or visitors who are sheltering-in-place (SIP) during an event, including children of staff members (may be covered within other part of EOP addressing Staff and SIP policies).

[Hospital lists]

- Primary space
- Secondary space

- Additional planned space(s) considered (i.e. conference rooms, cafeterias, office areas, etc.)
- Bathrooms should be readily available to the children

The safety and security of this space has been evaluated to ascertain that it is sufficient for the needs of the non-injured pediatric patient. Spaces selected have been evaluated using the following criteria [hospital lists all that apply, includes others]

- The area must be proofed from choking hazards. Cords, wires and other strangulation or electrical hazards have been identified or a plan to eliminate
- The area should be away from stairwells and other fall-risks.
- Furniture and equipment that could topple over has been identified and/or there's a plan to eliminate. Windows should be locked.
- Access to chemical or cleaners has been identified and a plan exists to eliminate
- Proximity to non-clinical pediatric supplies and resources such as sustenance, hygiene, comfort items and toys/games.
- Security measures have been identified

Staff

There should be enough staff and security to ensure the safety of the children. Since this space is for the non-injured pediatrics within the facility, a non-clinical team of staff can be assigned to provide oversight and management of these areas. The following services or departments may be called upon to identify staff to support this space

- [hospital lists departments/services internal. If external partners are considered and planned for, hospital outlines the process to solicit, the legal/liability and references any existing policies for the recruitment and rapid credentialing/onboarding procedures of such staff or volunteers]

Inter-facility Transfer Agreements/Guidelines

[Hospital] maintains policies and procedures for transferring pediatric patients to hospitals with more robust pediatric capabilities when patient triage and assessment warrants a higher level of care is needed. [Hospital outlines or directs to existing procedures]. The pediatric facilities within the nearest proximity to [HOSPITAL] in which providers routinely transfer pediatric patients to are [Children's Hospital name] and/or will send to [Acute Care Hospital with advance pediatric services and in-patient capabilities].

- Arrangement for transport of pediatric patients will occur through [list routine transfer mechanisms or protocols for requesting transport services].
- When routine transfer mechanisms cannot be utilized, alternate methods may be used. [list alternative transfer mechanisms]

Safety and Security

During events with pediatric patients, the hospital's security plan and procedures will be activated. The following section outlines additional considerations for pediatric patients and visitors during a surge event.

[Hospital lists, where applicable]

- Person(s) or role(s) responsible for assessing if the current situation or event activation involves pediatrics or the potential to involve pediatrics and the need for these established security measures
- Secured areas for use to stage non-injured children from surge
- Secured area to conduct reunification of both injured and non-injured patients.
- Staff assigned to assist in identification, notification, protection, location, and reunification of children and their parents / legal guardians.
- Staff may work with communications department to receive and direct inquiries regarding reunification efforts.
- Considerations for security procedures during sheltering-in-place or evacuation scenario with pediatrics, both patients and visitors
- Implementation of missing child protocol activation and any other protocols during events in which routine procedure may be interrupted
- Staff are pre-identified to serve as physical security to monitor safe areas for both injured and non-injured children along with the ingress/egress routes to these areas.

Decontamination

Direct reader to the pediatric decontamination plan here. Crosswalk elements listed below to make sure that plan covers essential procedures and processes to consider.

- Area established for decontamination is [Hospital identifies here, the area(s) considered is within proximity to ED, access to water, areas for tentage to protect from the elements (children at higher risk for hypothermia) and for privacy].
- Decontamination equipment is stored [where] and is inclusive of supplies that are best used for pediatrics i.e. soft brushes and various sized gowns/clothing, etc.
- Process should include at minimum, the following steps. [Hospital to outline procedure for carrying out this process for the varying ages/sizes of children
    - Infants: not mobile, not verbal
    - Toddler: mobile, not verbal
    - Children: mobile and verbal, may not be able to express themselves without parent/guardian present
    - Teenagers: mobile and verbal, may be able to express themselves without parent/guardian present

        - Disrobe patient
        - Wipe down skin
        - Irrigate eyes
        - Provide clean patient gowns / blankets
- Procedures allow for keeping families together when possible and include allowing parents to wash children if feasible and with direct guidance. [Staff member/role to provide guidance listed].
- Hospital should consider the following when developing plans and building out process listed above for each pediatric patient age group:
    - Plan to move small / immobile children through showers as they are a fall risk. Consider using a laundry basket or other safe way to move child through shower instead of holding.
    - Aim for a 3–6-minute shower with a water temp of between 98◦ F-110◦ F/36.6◦C-43.3 ◦C (avoids hypothermia) and max water pressure of 60psi (avoid damage to skin)

Reunification/Patient Identification

[HOSPITAL] is aware that pediatric patients presenting to the facility from the scene of an incident may not be accompanied by a parent or guardian, may not be verbal to identify themselves, and may or may not be injured. This pediatric patient will need to be identified and family notification will be a priority of the hospital as care and assessment is provided.

The hospital lists patient tracking methods used at facility:

- [Role(s) serves as patient tracking coordinator/manage] Reference HICS position, patient tracking manager and job action sheet
- Systems used will be Texas Wristband Project, spreadsheet, patient tracking log, etc.

Hospital outlines methods to assist with reunification including [Hospital to list]

- Location of secured private area to contact families of potentially injured/ill children at hospital
- Access to translators for non-English speaking and visually/hearing impaired families
- Involves communications staff for providing public or outward facing guidance through messaging

Mental Health Issues

- [PECC, behavioral health specialist or social worker] will help identify and connect patients with referral resources in the community for children experiencing trauma (e.g.,

behavioral health specialists with expertise in trauma treatment of children) and/or loss (e.g., children's bereavement centers/camps or hospice programs).

- [Hospital] has a protocol created for behavioral health professionals to be available on-call to provide services onsite during disasters **OR** if no mental or behavioral health professional is on staff, [Hospital] has signed agreements or MOUs with qualified behavioral health professionals.
- Qualified behavioral health professionals, with expertise to provide services to children, are members of hospital staff and provide coverage 24/7/365 with ability to surge during a disaster.
- Working through the HCC, hospital may gain access to community, local or state-run programs that can provide pediatric behavioral health services on-site, in the community or through tele-health capabilities.

Children with Special Healthcare Needs

Policies within the hospital address resources or procedures for how to accommodate for some of these unique needs. The [PECC/Social Worker] helps ensure appropriate staff and departments are aware of how policies apply to pediatrics. Additionally, hospitals should understand the risks of their community and probability that they will need to serve pediatric patients with healthcare needs during disasters.

[Hospital outlines policies or procedure for providing care to the following pediatric patient groups]

- Non-English-speaking children or their parents/guardians
- Children who are hearing and seeing impaired
- Children who are oxygen and/or electrically dependent
- Children who are non-verbal or cognitively impaired
- Children who are medically complex with gastrostomy tubes, tracheostomies, LVAD, Ventricular Peritoneal Shunts, etc.

[HOSPITAL] connects with various external partners to assist with planning for these populations as well as may solicit their aid during response to emergencies, such as hurricanes. [Hospital to select any of the following or include additions]

- Pediatric primary care or therapy centers
- Pediatric day health centers that may be able to provide a site for power during large scale power loss events
- Non-government organizations who represent children with functional and access needs
- Local schools and education centers with programs for children with unique needs
- [Others]

The regional Healthcare Coalition may also be able to provide guidance to hospitals to assist with linking parents/guardians to sites and special interest groups for resources. Some sites plan to assist with providing the needed support to families with children who have unique healthcare needs, such as locations of pediatric day health centers in the community and neighboring communities, medical needs shelters or other sites to access power, non-government organizations or collaborative groups to support with supplies and staged sites to exchange oxygen tanks.

Disaster Exercises and Drills

As a part of [HOSPITAL] emergency management program, a necessary step includes conducting drills based on probable scenarios outlined within the facility HVA. Drills and scenarios exercised are inclusive of children of varying ages when possible, including infants (< 1yrs), toddlers (1-3 yrs.), school-aged children (4-12 yrs.), adolescents (> 13 yrs.) and children with special health care or functional access needs. During drills, exercises and education opportunities, the use of the pediatric equipment and any mock or simulation equipment may be used.

The following criteria are considered when planning drills, exercises, and education:

- Coordination between departments and service lines for exercise planning and the role each plays in response to pediatric patients.
- Facilitate disaster-related learning activities (FEMA, ICS courses, lectures, etc.) that include pediatric considerations and priorities for all staff.
- Collaborate with hospital emergency management and the PECC to ensure pediatric needs are addressed in the exercise planning process.

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