BC HCC

Big Country Health Care Coalition

HCC-D PEDIATRIC SURGE ANNEX

Table of Contents

1. Introduction

1.1. Purpose

This annex includes a regional plan on how applicable hospitals within the Big Country Health Care Coalition (BCHCC) will contribute to caring for pediatric patients in the event of a surge that largely impacts children. This plan is aligned with and supports the BCHCC's compliance with the HPP Capabilities. It supports the HCC Response Plan by addressing specific needs of children and supporting appropriate pediatric medical care during a disaster. This plan provides details on how hospitals within BCHCC would support a pediatric surge of patients including surge targets and patient type. This plan is intended to support, not replace, any existing facility or agency policy or plan by providing uniform response actions in the case of an emergency that involves (or could involve) significant numbers of children.

1.2. Scope

The Pediatric Surge Plan provides guidance to Hospitals and Emergency Medical Services (EMS) agencies within the BCHCC region in relation to pediatric surge needs. This Plan also takes into consideration national best practices and lessons learned while leveraging our specific strengths and improvement areas when faced with a pediatric surge disaster.

1.3. Situation Overview

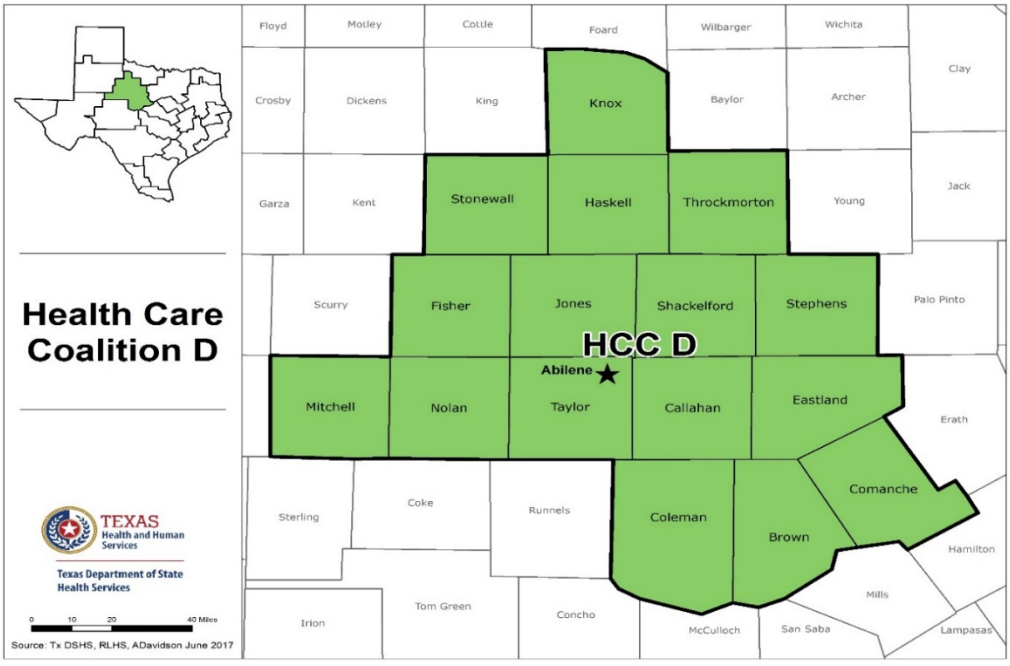
1.3.1. Regional Demographics

The geographical area served by BCHCC includes sixteen counties (Brown, Callahan, Coleman, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Shackelford, Stephens, Stonewall, Taylor and Throckmorton) and all municipalities within (Figure 1). The BCHCC strives to improve an all-hazard medical response in West Central Texas through effective communication, planning, coordinated exercises, and collaboration between regional health care organizations, emergency responders, local/regional emergency management directors, public health and other emergency response planners. The table below depicts the pediatric population dispersal of the region.

Table 1. Population by County as of August 25, 2020

County	Pediatric (0-17 yrs) population	Total Population	%
Brown	8,687	37,924	22.91%
Callahan	2,877	21,561	13.34%
Coleman	1,913	8,397	22.78%
Comanche	2,157	13,534	15.94%
Eastland	4,165	18,322	22.73%
Fisher	817	3,839	21.28%
Haskell	1,136	5,813	19.54%
Jones	3,326	19,817	16.78%
Knox	908	3,653	24.86%
Mitchell	1,593	8,145	19.56%
Nolan	3,688	14,751	25.01%
Shackelford	769	3,253	23.64%
Stephens	2,152	9,433	22.81%
Stonewall	274	1,362	20.12%
Taylor	34,327	137,640	24.94%
Throckmorton	311	1,515	20.53%
Totals	**69,100**	**3,587,859**	**21.05%**

Figure 1. Big Country Healthcare Coalition Service Area



1.3.2. Acute Care Hospitals and Trauma Centers

BCHCC has 16 healthcare facilities designated as General Acute Care Hospitals with one Level III hospital (Hendrick Medical Center). All 16 facilities provide 24-hour emergency care services.

Hospitals within the Region have limited capability to provide comprehensive medical care to pediatric populations with traumatic injuries. Two facilities in the Region have limited capability to provide comprehensive medical care to the pediatric populations.

1.3.3. Regional Pediatric Transfer Facilities

The following facilities are the regional pediatric transfer facilities for BCHCC:

Table 2. Regional Pediatric Transfer Facilities

Facility Name	Trauma Center Designation	PICU Designation	NICU Designation/ Level
Baylor Scott & White McLane Children's Medical Center Temple TX, 76502	Level II	Yes	Regional Level IV
Children's Medical Center of Dallas Dallas TX, 75235	Level I (Comprehensive)	Yes	Regional Level IV
Cook Children's Medical Center Ft. Worth TX, 76104	Level I (Comprehensive)	Yes	Regional Level IV
Covenant Children's Hospital Lubbock TX, 79410	Level II	Yes	Regional Level IV

1.3.4. Surge Capacity

The table below represents the daily total number of licensed beds by type in facilities with 24-hour emergency care services. These numbers represent the normal licensed bed capacity for inpatient and emergency care services.

Table 3. Surge Capacity as of August 25, 2020

Facility Name	ED	Med Surge	ICU	Pediatric Bed	NICU	OR	Total Licensed Capacity	Total Internal Bed Expansion
Abilene Regional Medical Center	22	196	11	8	3	4	**231**	**20**
Anson General Hospital	1	7	0	0	0	0	45	5
Brownwood Regional Medical Center	8	63	0	6	0	2	142	10
Coleman County Medical Center	5	25	3	0	0	2	25	10
Comanche County Medical Center	7	15	0	0	0	2	25	3
Eastland Memorial Hospital	8	19	0	0	0	2	52	10
Fisher County Hospital	3	15	0	0	0	0	14	3
Haskell Memorial Hospital	6	10	0	0	0	0	25	6
Hendrick Medical Center	33	242	28	14	15	14	509	32
Knox County Hospital	3	7	0	0	0	0	28	5
Mitchell County Hospital	3	10	0	2	0	0	25	7
Rolling Plains Memorial Hospital	14	18	3	4	0	3	86	12
Stephens Memorial Hospital	3	12	2	2	0	0	40	9
Stonewall Memorial Hospital	2	6	0	0	0	0	20	4
Throckmorton County Memorial Hospital	3	24	0	0	0	0	14	3
Totals	**121**	**669**	**47**	**36**	**18**	**29**	**1224**	**139**

1.3.5. Disaster Risk Profile

1.3.5.1. Obstacles and Challenges

- On a population basis, pediatric inpatient capacity in the region is much more limited than adult inpatient capacity.
- High-acuity inpatient/outpatient pediatric services are geographically clustered within Taylor County or located within other metropolitan regions.
- Level 1 Pediatric Trauma Centers are geographically dispersed outside of the Coalitions region.
- Taylor County hosts the only Level 3 regional trauma center.
- Percentage of population < 18 years of age is below state average but poses a risk when compared to available beds within the region.

2. Concept of Operations

2.1. Activation

This plan may be activated in response to any incident with a disproportionate number of pediatric casualties. The plan may also be activated prior to a declared or proclaimed emergency. In those cases, in which the plan is activated prior to a declaration or proclamation, the gathering of information, assessment of the situation, and notification of healthcare facilities and providers will be emphasized to provide a basis for the full implementation of the plan should an emergency be declared, and surge be required.

The declaration of an emergency along with other actions taken by the governor's office has significant impact on the ability to meet the demands created by a surge incident. Specifically, healthcare regulations may be relaxed during a declared emergency. This allows the healthcare system to meet these demands in way that it cannot when regulations are in effect.

It is assumed that the systems, structures, and guidance recommended within this plan will always be used after the hospital's emergency operations plan (EOP) has been activated. Therefore, it is also assumed that the Hospital Incident Command System (HICS) will be used throughout the duration of the hospital's emergency response. Because each hospital will have its own unique HICS structure and EOP, this plan does not replace or alter an institution's fundamental HICS structure by rather proposes to add additional specific functional components that may be utilized during emergency response. Whenever relevant, this planning guidance will show where a proposed function may fit within a general HICS structure. *For further guidance, please refer to guidance within the HCC-D Big Country Healthcare Coalition Regional Response Plan*[1].

2.2. Notifications

Upon activation of the Pediatric Disaster Surge Annex the Healthcare Coalition Coordinator or designee will adhere to the activation guidance established within the HCC-D Big Country Healthcare Coalition Response Plan.

[1] HCC-D Big Country Healthcare Coalition Regional Response Plan

2.3. Roles and Responsibilities

The table below lists the responsibilities of local healthcare facilities and supporting entities:

Table 4. Roles and Responsibilities

Facility/Entity Type	Responsibilities
Child Protective Services	Provide staff for Family Assistance Center. Collect victim/casualty information. Provide temporary care for unaccompanied minors. Coordinate reunification of families
Regional Coordination Center (RCC)	Initial notifications; patient dispersal; tracking patient destinations; process and/or assist coordinating requests for Mutual Aid resources; coordinate medical health resources; (see HCC-D Big Country Healthcare Coalition Response Plan).
EMS Agency	Coordinate EMS resources
Field Level EMS/First Response	Triage Patients; field decontamination (if needed); transport to appropriate healthcare facility.
Hospitals	Triage & treatment; decontamination (if needed); tracking secondary facility transfers; provide victim/casualty information to FAC POC.
Law Enforcement	Coordinate with Child Protective Services to ensure the safety of all unaccompanied children; aid in the identification and reunification of children in disaster.
Public Health	Develop the Medical Health Situation report Public Health Officer Local Health Emergency Declaration (if needed)
Sheriff	Initiate Family Assistance Centers; notifications to families of victims/casualties.
District Coordinator Texas Division of Emergency Management-DDC-7	Coordinate resource request through the local emergency management process.

2.4. Logistics

The requesting of resources during a disaster will follow the "Resource Request" process within the HCC-D Big Country Healthcare Coalition Response Plan and will require bilateral communication between regions. The HCC-D regional activities include but are not limited to:

- Collect real time information from all hospitals throughout the area regarding patient counts, hospital needs, etc. (provided by hospitals to the EMResource, i.e. HAVBED).
- Determine the admitting criteria/acuity levels of admission to Children Specialty Hospitals vs. non-pediatric hospitals. It is recognized that there is no formalized process or regional entity within the service area to perform this function at the present time. This is considered one of the recognized gaps and opportunities for future consideration.

- Provide appropriate communication to the health care community and the general public.
- Liaise with Children Specialty Hospitals to assist in providing clinical assistance, i.e. clinical pathways, pediatric clinical consultation, etc. To those hospitals providing care to more acute pediatric patients than they typically do.
- Work together within the Regional/State/Federal disaster response to aid in acquiring and distributing resources as needed.

2.5. Deactivation and Recovery

The purpose of this section is to provide guidance for deactivation of the annex, continuity in recovery efforts and other assistance that may be needed during the after action process. BCHCC maintains the All-Hazards Regional Response Plan which is the primary plan for "Deactivation and Recovery". *For further information on Deactivation and Recovery, please reference the Big Country Healthcare Coalition Response Plan*[2].

2.6. Essential Pediatric Domains

Children have unique, often complex physiological, psychosocial and psychological needs that differ from adults, especially during disaster situations; and unfortunately, children are often involved when disasters occur. These Essential Pediatric Domains and considerations are intended to support every hospital's disaster preparedness policies, not replace them. The Domains were developed as tools to help hospital administrators and leadership incorporate essential pediatric consideration into existing hospital disaster plans and policies.

The following Domains have been identified as priority planning areas for healthcare facilities:

- Essential Resources – Space, Staff, Supplies
- Security, Transportation, Tracking, Reunification & Legal Issues
- Triage, Infection Control, Decontamination
- Behavioral Health
- Access and Functional Needs
- Training and Education

Each of these Essential Pediatric Domains are organized into functional appendices of this plan and are intended to be used as quick reference guides for healthcare facilities throughout the region.

[2] HCC-D Big Country Healthcare Coalition Response Plan, 2020

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3. Appendices

Appendix A

3.1 Training and Exercise

This Coalition is in constant pursuit of a coordinated strategy that combines enhanced planning, resource acquisition, innovative training and realistic exercises to strengthen its emergency preparedness and response capabilities. The Coalitions Multi-Year Training and Exercise Plan (MYTEP) is the roadmap for overall preparedness capabilities required to facilitate effective response to all hazards faced by the BCHCC. *For further guidance on pediatric exercises and training, refer to the HCC-D Big Country Healthcare Coalition Multi-Year Training and Exercise Plan*[3].

3.2 Essential Resources – Space, Staff, Supplies

3.2.1. Space Surge

The space surge strategy primary goal is to maintain operations and increase capacity to preserve life and the safety of patient and ensure appropriate healthcare delivery to the community.

SPACE SURGE STRATEGY[4]
❖ Utilize licensed space for other types of patients
❖ Use outpatient beds for inpatient care
❖ Use internal skilled beds as acute patient areas
❖ Convert adult space into pediatric space
❖ Convert pediatric space to adult space
❖ Increase capacity in patient rooms or hallways in patient care areas
❖ Open hospital floors that are vacant
❖ Use areas of the hospital for inpatients
➢ GI LAB
➢ Recovery Room
➢ Outpatient Surgery
➢ Physical Therapy
➢ Other
❖ Use non-traditional areas of the hospital for inpatients
➢ Cafeterias
➢ Conference Rooms
➢ Parking Structures
➢ Other
❖ Shut off floor ventilation system to make a cohort of infected patients
❖ Use tents to create additional patient care areas
❖ Request relaxation of nurse/patient ratios to allow occupancy of all licensed beds

[3] HCC-D Big Country Healthcare Coalition Regional Multi-Year Training and Exercise Plan 2020.
[4] Los Angeles County Pediatric Surge Plan, (2013).
https://www.chla.org/sites/default/files/migrated/SurgePlan_06.10.14.pdf

3.2.2. Staff Surge

The Staff Surge Strategy is to increase the ability maintain staffing levels and/or expand the workforce

STAFF SURGE STRATEGY[5]
❖ Pre-identify hospital staff with specialty skills or experience with pediatric patients ➢ Emergency medicine, pediatrics, family medicine ➢ Anesthesia, ENT, pediatric surgery, trauma surgery, general surgery, orthopedics, urology, neurosurgery, thoracic surgery ➢ Nurses, Pas, NPs from EDs, ORs, PACUs, ICUs, inpatient units & outpatient clinics ❖ Develop call-down and notification procedures for all staff identified ❖ Create key pediatric positions for response in a disaster event; add to your hospital's Disaster/Emergency Response Plan. ➢ Physician Coordinator for Pediatric Emergency Care in a Disaster ➢ Nursing Coordinator for Pediatric Emergency Care in a Disaster ➢ Pediatric Safe Area Coordinator ➢ Pediatric Logistics Unit Leader ➢ Pediatric Services Unit Leader ❖ Cross Train clinical Staff ❖ Contact Nurse Staffing agencies to assist with supplemental staffing needs ❖ Use of non-conventional staff or expand scope of practice ➢ Student nurses ➢ Medical students ➢ Military licensed staff ❖ Use of non-conventional staff ➢ Volunteers ➢ Paramedics ➢ Dentists ➢ Veterinarians ➢ Retired health professional with an active license ❖ Utilize pediatric skill RN's to supervise adult skilled patients and vice versa ❖ Implement and/or develop just in time training for clinical staff normally assigned to non-direct patient care positions.

3.2.3. Supply Surge

The Supplies Surge Strategy goal is to ensure adequate levels of supplies and equipment are available.

[5] Regional Pediatric Disaster Surge Framework, December 2012.
https://www.calhospitalprepare.org/sites/main/files/file-attachments/12.6.12_final_cv_framework.pdf

SUPPLIES SURGE STRATEGY[6]
❖ Conserve resources ❖ Prioritize care functions to maximize the use of resources (e.g., limit/reduce frequency of patient baths, etc.) ❖ Notify vendors regarding anticipated needs and determine availability ❖ Work with alternate vendors to develop agreement regarding acquiring supplies ➢ Sporting goods stores ➢ Grocery stores ➢ Disaster vendors ➢ Other ❖ Identify streamline processes for use of PPE, including guidelines for reuse and fit testing ❖ Follow resource request process found in the HCC-D Big Country Healthcare Coalition Response Plan ❖ Find/procure alternate ventilator types/sources
Minimal Pediatric Equipment Recommendations for Emergency Departments[6]
❖ Hospitals that are adult trauma hospitals ➢ 1 Broselow™ cart (pre-assembled) with supplies stocked ➢ 2 Broselow™ kit "bags" ❖ Hospitals that do not provide inpatient pediatric services and/or do not have licensed pediatric inpatient beds ➢ 1 Broselow™ cart (pre-assembled) with supplies stocked ➢ 1 Broselow™ kit "bags" ➢ 3 Rigid C Spine Collars ❖ Specialty hospitals or facilities without 9-1-1 receiving emergency departments ➢ If these hospitals were "activated" during a pediatric surge to care for children, the BCHCC cache would be used to provide supplies

Appendix B

3.3. Transportation, Tracking, Family Reunification, & Legal Issues

3.3.1. Pediatric Transports/Transfers

Pediatric Transportation[7]
❖ Pediatric Surge Annex will follow the normal pre-hospital and hospital inter-facility transfer processes ❖ Transporting ambulance shall adhere to local pre-hospital destination policies already established ❖ Transfer of patient from general acute care facilities to either other general acute care facilities or children's specialty hospitals, the sending facility shall follow the normal, EMTALA compliant, inter-facility transfer processes ❖ Only when the sending facility has exhausted existing processes, the facility will contact the BCHCC for transport and bed space coordination ❖ During disaster, the management of patient transfers will require: ➢ Continual assessment and reassessment of demand ➢ Bed availability and acuity needs ➢ Conduct internal triage and consider downgrading, repatriation, transfer and/or potential discharge of existing patients to allow for decompression

3.3.2. Patient Tracking

Pediatric Patient Tracking[6]
❖ Develop a Pediatric Tracking System that addresses both the accompanied and unaccompanied child ❖ Develop a protocol to rapidly identify and protect displaced children ❖ Create a Child ID document and/or identification band to record any key identifying information about children or use in later tracking or reunion with caregivers ❖ Identification bands should include the following information which will be useful in maintaining a link between pediatric patient/visitor and adult ➢ Name of pediatric patient/visitor+ Date of Birth (DOB) ➢ Name of adult + DOB ➢ Admission date of pediatric patient ➢ Date of visit of pediatric visitor ❖ Bar coded bracelets are becoming more common and are recommended for a more sophisticated way of patient tracking ❖ Create Pediatric Safe Areas the will serve as a holding area for uninjured, displaced or released children awaiting adult caregivers ❖ Identify a Pediatric Safe Area (PSA) Coordinator who will assume the responsibility of setting up and supervising the pediatric safe area

[6] Children in Disasters Hospital Guidelines for Pediatric Preparedness 3rd Edition, August 2018. Centers for Bioterrorism Preparedness Program Pediatric Task Force.
https://www.downstate.edu/emergency_medicine/documents/pediatrics-preparedness-final-6.pdf

- ❖ Create and use a Pediatric Safe Area registry sheet to document activity, such as transfer status, location, and final disposition, regarding the child

3.3.3. Family Reunification

Hospital Family Information and Support Center (FISC)[8]

Primary Functions

1. Provide accurate information to family members through statement issued by the hospital's public information officer (PIO):
   a. Facilitate family access to appropriate community resource (Red Cross, United Way, 211).
   b. Coordinate communication with local law enforcement
2. Provide psychological first aid to distraught families
3. Provide escort and "comfort" services to families
4. Provide temporary childcare for well children of the injured or family members who need to assist the injured
5. Assist with patient location and reunification of family within the hospital
6. Assist in contacting family members to arrange care of children present at hospital
7. Assist in making in-place shelter arrangement or community placement of children for those who do not have a safe place to be or a family member who can care for them
8. Provide communications needs for families (phones, e-mail)
9. Protect families from intrusion by media or curious by-standers
10. Enable medical staff to concentrate on treatment of casualties

Ideal set-up of FISC

1. Large reception area with conveniently located restroom facilities
2. Information desk with message center and phone, fax and computer connections
3. Photograph/identification room with limited access (close relatives only)
4. Private consultation rooms with table, chairs, telephone, tissues, trash can.
5. Pediatric Safe Area
6. Families need to be provided with the most up to date information available in a supportive and safe environment.
   a. Upon arrival to the FISC, families are logged in either via an electronic database or sign-in book.
   b. Registered families are reviewed periodically to update with information coming into the FISC.
   c. Assign a social worker, or other support staff, to families that are identified as exhibiting overt psychological upset or need to be given bad news.

Identification of identified or unidentified victims/ family members

1. Personal details and pictures of surviving victims are sent to the FISC electronically or via fax or runners from the ED, ICU and EMS
2. Information is included on all unaccompanied children, both the uninjured and those receiving medical treatment
3. Adults coming to the hospital to claim children must show I.D.; ideally, they should bring a picture which includes the adult with the child, such as a family photograph.

Recommended FISC staffing

1. Coordinator
2. Patient Information Officer
3. Runners
4. Trained and pre-screened volunteers
5. Security
6. Translators as needed
7. Professional staff (spiritual care, social services)

3.3.4. Legal Issues

Legal Considerations[7]
❖ For unaccompanied children during a disaster, consent is not needed to treat for a life or limb-threatening situation. Will parental consent be needed to treat a child victim with minor injuries or with psychological injuries? ❖ Is parental consent required to decontaminate an unaccompanied child? What if a child is asymptomatic? What if a child is refusing treatment? ❖ What medical or social information can or should be released and to whom during a disaster? ❖ Check HIPAA rules and your legal counsel concerning the unidentified patient locator protocols, such as posting photographs of unidentified children. ❖ Who can children be released to and, if not the parent or caregiver, what permission or information is needed? What is your protocol for releasing children if no legal guardian or parent can be found or if no permission document is provided?

Appendix C

3.4. Triage, Infection Control, Decontamination

3.4.1. Triage

The guidelines in this section will help hospitals both with and without pediatric services plan large-scale disaster triage procedures that specifically address children's needs. Each institution should modify the guidelines based on its own physical and staff resources.

Triage[8]
General Guidelines ❖ Priority of hospital based triage is to prevent over-triage-the overflow of patients who: ➢ Have already been treated ➢ Who are minimally injured, or are minimally sick into critical care areas or emergency departments. ❖ Hospitals should quickly establish treatment and evaluation areas that are separate from emergency departments critical areas for lower priority patients ❖ Emphasize Triage Accuracy Pre-Hospital Triage ❖ Pre-hospital primary triage of pediatric and adult patients is accomplished using the Simple Triage and Rapid Treatment (START) method. ❖ First arriving medical personnel will use a triage tag to categorize the victims by the severity of the injury and are labeled with one of the following: ➢ Minor (Green) – delayed care/can delay up to three hours ➢ Delayed (Yellow) – urgent care/can delay up to one hour ➢ Immediate (Red) – immediate care/life threatening ➢ Deceased (Black) – victim is dead, or mortally wounded/no care required Hospital Triage (Recommendation) ❖ Recommend that each hospital should determine criteria for switching to a two-tiered triage system based on their capacity or the need for additional screening. This process incorporates two forms of triage: ➢ A rapid visual assessment to quickly identify the sickest patients; and ➢ A more detailed triage assessment to refine and re-evaluate the initial assessment of the patient. ➢ Over-triage and under-triage may occur, staff should reassess patients and upgrade or down-grate them throughout the multiple steps of triage to optimize emergency department resources Staffing ❖ Identify and train additional triage personnel before the disaster occur ❖ Have a Unit Leader who ensures that patients receive initial assessment and periodic reassessment ❖ Utilize non-medical professionals to help collect personal information at all points during triage and initial treatment

3.4.2. Infection Control

The purpose of this section is to guide hospitals involved with a major communicable disease emergency in managing exposure risks between and among differentially affected children (contacts, suspected cases) and their adult caregivers. BCHCC maintains the Regional High Consequence Infectious Disease Concept of Operations which is an annex to the BCHCC All-Hazards Response Plan which is the primary plan for preparing for and responding to infectious disease emergencies.

3.4.3. Decontamination

The following recommendations are intended to facilitate decontamination of all children presenting to any hospital during a disaster in a timely manner.

Decontamination[8]

General Guidelines

- Infants and children have unique needs that require special consideration during the process of hospital-based decontamination, such as:
  - Avoiding separation of families during the decontamination process
  - Older children may resist or be difficult to handle due to fear, peer pressure and modesty issues
  - Parents or caregivers may not be able to decontaminate both themselves and their children at the same time, decontamination personnel may need to assist them
  - Incorporating high-volume, low pressure water delivery systems that are "child-friendly" in the hospital decontamination showers
  - Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98˚F
  - Attention to airway management, a priority in decontamination showers
  - The smaller the child, the bigger the problem regarding any of the above considerations

Decontamination Recommendation Based on Childs Age

- Infants and Toddlers (0-2 years)
  - All infants and toddlers should be placed on a stretcher and undressed by either the caregiver or hospital decontamination personnel. All clothes and items should be placed in appropriate containers or bags provided by the hospital and labeled.
  - Child should be accompanied the decontamination shower by caregiver or hospital decontamination personnel
  - Non-ambulatory children should be placed on a stretcher
  - All non-ambulatory children should then be escorted through the decontamination shower
  - Post-decontamination: dry off child, provide hospital gown and provide a unique identification number on a wristband and then triage to an appropriate area
  - Do not separate children and their parents or caregivers unless critical medical issues take priority

- Preschool-Aged Children (2-8 years)
  - Ambulatory children should be assisted in undressing with help from either the child's caregiver or hospital decontamination personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
  - Each child should be directly accompanied through the shower by either the child's caregiver or hospital decontamination personnel to ensure the entire patient is properly and thoroughly decontaminated. The child should not be separated from family members or the adult caregiver.
  - Non-ambulatory children should be placed in a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
  - Each non-ambulatory child on a stretcher should be escorted through the decontamination shower and assisted with decontamination to ensure the patient is thoroughly and properly decontaminated.
  - Once through the shower, each child should be given a towel and sheets to dry themselves, and a hospital gown. The child should immediately be given a unique identification number on a wristband and then triaged to an appropriate area
  - Children and their parents or caregivers should not be separated unless critical medical issues take priority.

- School-Aged Children and Adolescents (8-18 years)
  - Ambulatory children should undress as instructed by hospital decontamination personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
  - Each child should then walk through the decontamination shower, preferably in succession with their parent or caregiver, and essentially decontaminate him or herself.
  - Non-ambulatory children should be placed on a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
  - Each non-ambulatory child should be escorted through the decontamination shower and assisted with decontamination to ensure the entire patient is properly and thoroughly decontaminated.
  - Once through the shower, each child should be given a towel and sheets to dry themselves, and a hospital gown. The child should then immediately be given a unique identification number on a wristband and triaged to an appropriate area for medical evaluation.
  - Children and their parents or caregivers should not be separated unless critical medical issues take priority.

Appendix D

3.4. Behavioral Health

3.4.1. Pediatric Guidelines

Level Specific Guidelines
General Guidelines ❖ Infants ➢ Let a parent or caregiver stay with and, when possible, hold the infant during medical procedures ➢ Use familiar objects from the baby's home such as stuffed animals, blankets, music boxes or toys for comfort before, during and/or after a procedure ❖ Toddlers and Preschool-aged Children ➢ Avoid discussing toddler or preschoolers' care in their presence unless you include them in the conversation. Children overhear much more than adults realize and, without any explanation, information may seem terribly frightening. ➢ Let a parent or caregiver stay overnight with the child if possible and let other family members, including brothers and sisters, visit (if appropriate). ➢ Reassure the child that the hospitalization is not a punishment. Avoid applying good or bad labels to the child, particularly during a procedure. For example, instead of saying "See, you were so good, the doctor only had to do this once," you can say, "You did such a good job of sitting still, I know that was hard." ➢ Allow children to handle medical equipment such as stethoscopes, blood pressure cuffs, etc. and to practice procedures on a doll. Children learn best through play— "medical play" can be particularly useful. ➢ Allow the child to make choices whenever possible, but don't offer a choice when none exist. For example, do not say, "Would you like to come into the treatment room now, so the doctor can look at you?" Instead say, "Do you want to bring your bear or blanket with you to the treatment room?" ❖ School-Aged Children ➢ You can give school-aged children more specific information about what they will experience; however, many medical terms can be confusing. For example, the term "I.V." could be confused with the word "ivy," or "dye" with "die." Give simple, specific explanations for procedures and use non-technical language. ➢ This is a great age for medical play (communicating understanding, fears, etc. through play with medical equipment). Let the child reenact events through play with different kinds of toys or art materials. This will help school-aged children express their feelings and gain a sense of control over what is happening to them. ➢ Encourage all staff to respect the child's privacy by knocking before entering his or her room and by being sensitive to who is around when examinations are in progress. ➢ Children this age may regress or revert to behaviors that they had outgrown (thumb sucking, bed wetting, etc.) during stressful situations such as

hospitalization. Do not berate (e.g., say, "come on, you're a big girl now…") or punish children for such behavior; instead encourage them to express their feelings and discharge emotions through play.

- Adolescents
  - Avoid discussing teenagers' care in their presence unless they are included in the conversation. Adolescents can understand much more about their bodies and what is happening to them than younger children and may resent being excluded from discussions.
  - Do not assume that teens manage their emotions the same way as adults. Give teens opportunities to talk to staff about what is happening and to ask questions, both with and without parents or caregivers present.
  - Encourage all staff to respect teens' privacy by knocking before entering exam rooms and by being sensitive to who is around during examinations.
  - Adolescents are particularly concerned about body image and do not want to be perceived as "different" than peers because of an illness or injury. Be especially sensitive to the physical changes adolescents may experience when explaining any procedures, injuries or treatments.

- How to Help Children During and After a Disaster
  - Children Younger than Five Years of Age
    - Maintain their normal routines and favorite rituals as much as possible.
    - Limit exposure to TV programs and adult conversations about the events.
    - Ask what makes them feel better.
    - Give plenty of hugs and physical reassurance.
    - Provide opportunities for them to be creative and find other ways to express themselves.

  - Children Older than Five Years of Age
    - Don't be afraid to ask them directly what is on their minds and answer their questions honestly.
    - Talk to them about the news and any adult conversations they have heard.
    - Make sure they have opportunities to talk with peers, if possible.
    - Set gentle but firm limits for "acting out" behavior.
    - Encourage expression, verbally and through play, of thoughts and feelings.
    - Listen to their repeated retellings of the event.

- When to Consult a Mental Health Professional
  - Seek psychiatric consultation if children exhibit any of the following behaviors:
    - Excessive fear of something terrible happening to their parents or loved ones
    - Excessive and uncontrollable worry about unfamiliar people, places or activities
    - Fear of not being able to escape if something goes wrong
    - Suicidal thoughts or the desire to hurt others
    - Hallucinations
    - Feelings of being helpless, hopeless or worthless

Appendix E

3.5. Access and Functional Needs

3.5.1. Pediatric Population

Children (0-18 years of age) are a highly vulnerable segment of the population in times of disaster. Children in this age category comprise nearly 25 percent of the U.S. population and have important and often complex planning and emergency response needs. Under normal conditions, there are components at the governmental, private and non-profit level which together form the networks on which children depend to support their development and protect them from harm.

The American Academy of Pediatrics has established that children have unique physical and emotional needs when a disaster strikes. In addition to being placed at an increased risk of physical harm, children respond to illness, injury, and treatment differently than adults do. To ensure the physical security and emotional stability of children in disasters, communities throughout BCHCC must modify their emergency planning efforts to include children's unique needs during disasters.

The following information on children in the BCHCC region may be used to assess the extent to which local response agencies may need to provide support for children with disabilities and others with access and functional needs following a disaster.

Table 3. Pediatric Population by County and Age[7]

County	Age 0-5	Age 6-11	Age 12-14	Age 15-17	Total
Brown	2,691	2,795	1,513	1,688	8,687
Callahan	873	931	529	544	2,877
Coleman	601	646	332	334	1,913
Comanche	1,050	1,109	508	490	3,157
Eastland	1,426	1,270	723	746	4,165
Fisher	269	283	130	135	817
Haskell	365	380	191	200	1,136
Jones	1,014	1,133	599	580	3,326
Knox	267	326	150	165	908
Mitchell	559	239	266	1430	2,494
Nolan	1,177	1,240	666	605	3,688
Shackelford	247	266	121	135	769
Stephens	727	727	362	336	2,152
Stonewall	93	82	54	45	274
Taylor	11,518	11,611	5,621	5,577	34,327
Throckmorton	102	109	50	50	311

[7] U.S. Census Bureau. Population, Census, April 1, 2017 for State and County. Accessed November 18, 2019. https://www.census.gov/quickfacts/fact/table/US/PST045218.