

NYCTP

New York Centers for Terrorism Preparedness and Planning

**PROTOCOL FOR THE DECONTAMINATION OF THE PEDIATRIC PATIENT
ADMINISTRATIVE POLICY AND PROCEDURE
AND**

**PROTOCOL FOR DECON OF CHRONICALLY DISABLED VICTIMS WITH
PROSTHETIC DEVICES, ASSISTIVE DEVICES OR ON MECHANICAL
VENTILATORS**

**AND
PROTOCOL FOR THE DECONTAMINATION OF PERSONS APPEARING TO
SUFFER FROM AN ACUTE BEHAVIORAL DISTURBANCE OR MENTAL
DISORDER**

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Hospital Decontamination Protocols

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NEW YORK CENTER FOR TERRORISM PLANNING AND PREPAREDNESS (NYCTP)

Background:

The New York Center for Terrorism Planning and Preparedness (NYCTP) is a consortium of nine hospitals organized under the Federal Health Resources & Services Administration (“HRSA”) Hospital Preparedness Grant for the purpose of improving New York City Hospitals’ capacity to respond to bio-terrorist attacks as well as other public health emergencies. NYCTP is composed of three core facilities: Bellevue Hospital Center (a city hospital system), New York University Medical Center (an academic voluntary hospital system), and the Manhattan Veterans Administration (VA) Hospital (a federal hospital network). The six partner institutions (both acute care and chronic long-term care facilities) include: Coler/Goldwater Specialty Hospital and Nursing Facility, the Hospital for Joint Diseases Orthopedic Institute, Woodhull Medical and Mental Health Center, Gouverneur Healthcare Services, and the Brooklyn VA and Queens (St. Alban’s) VA Hospitals.

The purpose of the NYCTP, in responding to duties specified under the grant, is to both assess current emergency preparedness and surge capacity activities in the participating hospitals and also develop and further implement strategies and protocols for managing resources, patient influx and staff activity during a mass casualty event. Each hospital acknowledged its strengths in each area of disaster preparedness and worked to increase the capabilities of all hospitals involved by integrating response plans and formulating memorandums of understanding (MOUs) for the sharing of staff and supplies between facilities during a disaster.

In addition to the general requirements of the grant, our CBPP has also maintained a unique focus on the inclusion of what we have termed “vulnerable populations”, such as children, in these disaster plans.

HOSPITAL DECONTAMINATION PROTOCOLS

Introduction:

These three protocols developed by the Special Needs Populations Workgroup for the NYCTP are templates for each individual hospital facility's Decontamination Plan.

Another separate issue arose in writing these protocols: the subject of how to deal with victims' valuables (wallet, jewelry, credit cards). Even an ordinary victim who is non-disabled, non-pediatric, or non-mentally handicapped may become agitated, stressed and unable to cope (or become generally uncooperative) during the decontamination procedure if this issue is not properly and specifically addressed in your general Decon Plan.

And, generally speaking, patients and their caregivers should be kept together unless a critical medical priority necessitates separation (including family members and home health aides).

ASSUMPTIONS:

1. The hospital-based decontamination facility is not at the "ground zero" of the attack (therefore patients arriving have either been exposed to a very low concentration of the agent and/or have effectively "diluted" their exposure to the agent by leaving the scene of the attack).
2. Certain items and valuables are of such clear importance to the victims that by removing them from their possession would cause undue stress, agitation, and undermine their coping mechanisms with the disaster and cooperation with the decontamination procedure.
3. If victims were allowed to put valuables into a Ziplock bag and carry them through the decontamination showers, it is certain that they would unzip the Ziplock bag once they reach their assigned definitive care area.

Items that can be decontaminated include:

- Simple jewelry and non-leather waterproof watches
- House keys (excluding leather straps)
- Plastic ID cards (such as Driver's License, Credit Cards)

Items that cannot be decontaminated include:

- Complex jewelry
- Wallets
- Paper ID
- Paper cash and checkbooks
- Purses and handbags
- Leather briefcases

DECONTAMINATION OF THE PEDIATRIC PATIENT ADMINISTRATIVE POLICY AND PROCEDURE

Purpose:

This policy and procedure is intended to ensure that all children presenting to the hospitals (during an MCI or terrorist attack requiring decontamination) are properly decontaminated in a timely manner. Children require special considerations that may not be addressed in the general Decon Plan.

Policy:

It is the policy of our Decontamination Plan to:

1. Decontaminate all patients presenting to the facility who have been **potentially** exposed to any toxic or harmful substances **before** they enter the facility.
2. Ensure the safe working environment within the hospital grounds and physical plant for all hospital personnel.

Background:

Infants and children have unique needs that require special considerations during the process of hospital-based decontamination.

1. Separation of families should be avoided especially under conditions of large number of patients in a chaotic situation but medical issues take priority (go through the shower together).
2. Older children may resist or be difficult to handle out of fear, peer pressure, and modesty issues.
3. If the water temperature is below 98 deg F, the risk of inducing hypothermia increases proportionately with the smaller, younger child.
4. The smaller the child, the bigger the problem.
5. Airway management through the shower is a priority.
6. Cannot be assumed that the parents or caregivers will be able to decontaminate both themselves and their children at the same time ("hot zone" personnel should recognize the need to assist them).

Procedure:

- A. Children 8 to 18 years of age:
 1. Ambulatory children should disrobe when instructed to do so by "hot zone" personnel. All clothes and items that cannot be decontaminated are placed in a red

bag and labeled. Each child should then walk through the decontamination shower, essentially decontaminating him/herself.

2. Non-ambulatory children will be placed on a stretcher by “hot zone” personnel and disrobed (using trauma shears if necessary). All clothes and items that cannot be decontaminated are placed in a red bag and labeled. Each child is then escorted through the decontamination shower to ensure the entire patient is properly decontaminated.
3. Once through the shower, the child will be given a towel and sheet/hospital gown to dry and will be immediately given a unique identification number on a wristband. The child will then be triaged to an appropriate area for medical evaluation.
4. Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority.

B. Children 2 to 8 years of age:

1. Ambulatory children should be assisted in disrobing by either the child’s caregiver or “hot zone” personnel. All clothes and items that cannot be decontaminated are placed in a red bag and labeled. Each child should then be accompanied through the shower by either the child’s caregiver or “hot zone” personnel to ensure the entire patient is properly decontaminated. It is recommended that the child not be separated from the adult caregiver.
2. Non-ambulatory children will be placed on a stretcher by “hot zone” personnel, disrobed (all clothes and items that cannot be decontaminated are placed in a red bag and labeled), and escorted through the decontamination shower to ensure the entire patient is properly decontaminated.
3. Once through the shower, the child will be given a towel and sheet/hospital gown to dry and will be immediately given a unique identification number on a wristband. The child will then be triaged to an appropriate area for medical evaluation.
4. Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority.

C. Children less than 2 years of age (infants and toddlers):

1. Ambulatory children should be placed on a stretcher and disrobed by either the child’s caregiver or “hot zone” personnel. All clothes and items that cannot be decontaminated are placed in a red bag and labeled. Each child should then be accompanied through the decontamination shower by either the child’s caregiver or “hot zone” personnel to ensure the entire patient is properly decontaminated. It is recommended that the child not be separated from their adult caregiver. It is not recommended that the caregiver carry the child due to the possibility of accidental trauma resulting from a fall. Special attention must be given to the child’s airway while in the shower.
2. Non-ambulatory children will be placed on a stretcher by “hot zone” personnel, disrobed (all clothes and items that cannot be decontaminated are placed in a red bag and labeled), and escorted through the decontamination shower by either the child’s caregiver or “hot zone” personnel to ensure the entire patient is properly decontaminated. Special attention must be paid to the child’s airway while in the shower.

3. Once through the shower, the child will be given a towel and sheet/hospital gown to dry and will be immediately given a unique identification number on a wristband. The child will then be triaged to an appropriate area for medical evaluation.
4. Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority.

DRAFT PROTOCOL FOR DECON OF CHRONICALLY DISABLED VICTIMS WITH PROSTHETIC DEVICES, ASSISTIVE DEVICES OR HOME MECHANICAL VENTILATORS

Objective:

How to manage decontamination of patients presenting to the hospitals (during an MCI or terrorist attack requiring decontamination) with chronic disabilities, e.g. those who are already on home mechanical ventilators or have assistive or prosthetic devices (including but not limited to prosthetic limbs, wheelchairs, walkers, canes, crutches, hearing aids, and eyeglasses).

Assumptions:

1. The hospital-based decontamination facility is not at the “ground zero” of the attack (therefore patients arriving have either been exposed to a very low concentration of the agent and/or have effectively “diluted” their exposure to the agent by leaving the scene of the attack).
2. Certain items and accessories are of such clear importance to the victims and that by removing them from their possession would cause undue stress, agitation, and enhancement of their underlying disability in coping with the disaster and cooperating with the decontamination procedure.
3. Items that **can** be decontaminated include:
 - a. Non-electric wheelchairs
 - b. Prosthetic limbs (w/o leather components)
 - c. Walkers
 - d. Crutches (w/o foam cushions/parts)
 - e. Seeing Eye dogs or Service-animals
 - f. Canes (w/o foam cushions/parts)
 - g. Eyeglasses
 - h. Prosthetic eyes
4. Items that **cannot** be decontaminated include:
 - a. Mechanical ventilators
 - b. Electric Wheelchairs
 - c. Hearing Aids
 - d. Contact lenses
 - e. Any leather attachments/components of any other items

PROCEDURE FOR DECONTAMINATION:

1. **Mechanical ventilators.** Put victim on a stretcher. Detach ventilator and use an Ambu bag for the patient throughout the decontamination procedure. Remove all clothing (with trauma shears, if necessary). Put all of the patient’s appropriate items in a red bag and label (also red bag and label the ventilator). When the patient exits the shower, a hospital ventilator should be used.

2. **Electric Wheelchairs.** Put victim on a stretcher. Remove all clothing (with trauma shears, if necessary). Put all of the patient's appropriate items in a red bag and label (also red bag or at least label the electric wheelchair). When the patient exits the shower, a hospital wheelchair should be substituted.
3. **Prosthetic limbs .** Put victim on a stretcher (if necessary) and remove the prosthetic limb (if indicated). Remove all clothing (with trauma shears, if necessary). Put all of the patient's appropriate items in a red bag and label. Both the patient and the prosthetic limb should go through the shower (using soap and water as indicated). When the patient exits the shower, the prosthetic limb (if it was necessary to remove it) should be reattached (or remain with the patient in a wheelchair until it can be reattached later).
4. **All items that can be decontaminated (see list #3 above).** The patient may need assistance, but must undress completely and have all clothes and all items that cannot be decontaminated removed, put in a red bag and labeled. The patient may then carry the items that can be decontaminated (or be carried on a stretcher with these items). While going through the shower, using a scrub brush, soap and water (as indicated), the patient and the items are thoroughly cleansed and decontaminated.
5. **All other assistive or prosthetic items that cannot be decontaminated (see list #4 above).** The patient may need assistance, but must undress completely and have all clothes and all of these items that cannot be decontaminated removed, put in a red bag or at least labeled. Such patients may also have additional items that can be decontaminated (see next).

**DRAFT PROTOCOL FOR THE DECONTAMINATION OF PERSONS
APPEARING TO SUFFER FROM AN ACUTE BEHAVIORAL
DISTURBANCE OR MENTAL DISORDER**

SCOPE:

This protocol is intended to cover those persons who present to the hospital who may have been exposed to a harmful or toxic substance, for which decontamination would be medically recommended, and are subsequently unable or unwilling to undergo standard decontamination procedures, when such inability or refusal appears to be the result of an acute behavioral disturbance or mental disorder.

PURPOSE:

1. Decontamination equipment (including PAPR's) poses substantial barriers to communication.
2. Very little time may be available to make triage decisions in the potentially contaminated zone.
3. Lack of decontamination would preclude more in-depth evaluations of capacity to refuse such medically recommended treatment, and may put hospital staff and civilians at risk.
4. Due to the above, a protocol for the rapid assessment of capacity to refuse decontamination is required to avoid placing this vulnerable population at undue risk.
5. Certain agents may themselves induce acute behavioral disturbances.

PROCEDURES:

1. Identification – persons unable or unwilling to undergo medically recommended decontamination exhibiting behavior such as the following:
 - Agitation
 - Intoxication
 - Bizarre or irrational behavior
 - Self-injurious behavior
 - Responding to internal stimuli
 - Cognitively limited
 - Unexplainable ambivalence
2. Decontamination – the least restrictive method likely to work in the limited time-frame allowed should be chosen, likely form the following:
 - Physically directing the person into the decontamination device
 - Placing the person on a stretcher
 - Securing the person to a stretcher via available and decontamination-safe restraints (wrist and ankle 4-point Zip-Cuff restraint if available)

3. After decontamination, the person undergoes standard medical triage, which may result in their being sent to the Psychiatric Emergency Service.
4. If the person required restraint, such restraints will be left in place until the person is seen by triage staff of the treating service (the medical triage staff if determined to need medical care, and the psychiatric emergency triage staff if determined to need psychiatric care).
5. Once in the presence of the triage staff of the treating service, a further determination will be made if the person requires continued restraint, and if so, should be transferred to a restraining device customarily used by the Hospital. If it is determined that continued restraint is not required, the person should be immediately released.

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