1. **Should hospitals have a separate disaster manual for pediatric preparedness?**

   It is best to have all preparedness materials together. Pediatric concerns should be incorporated into the general hospital disaster preparedness manual. This assures that information for all ages/types of patients can be found in one resource tool by the hospital staff.

2. **What does pediatric surge capacity mean?**

   Since children comprise approximately 25-30% of the general population, one must assume a disaster or incident will also include children as victims. In the event of a large volume of pediatric patients, many tertiary care hospitals may be filled to capacity and unable to accept interfacility transfers immediately. Thus community hospitals may be expected to manage children that (under normal circumstances) would typically be transferred out. Hospitals will need to determine ahead of time what areas within their facility can be utilized to house and care for additional children. The current recommendation is to plan for an influx of 15-20 children over and above the already admitted pediatric volume in your hospital for minimally 3 days of care.

3. **What supply/staffing considerations are associated with surge capacity?**

   Planning for surge capacity requires looking at the pediatric supplies and resources that would be needed with an increased patient volume. It also requires identifying needed increases or changes in your staffing. The recommendation is to plan and prepare for an increased surge volume over at least a 3 day timeframe. For more information refer to the [Pediatric Disaster Preparedness Guidelines](#).

   As an initial step, it is helpful to identify the amount of supplies already available within your facility. Check all departments within your facility for equipment such as ventilators, respirators, portable suction equipment, portable oxygen, pediatric cribs, extra mattresses, etc., to determine availability and location of current supplies. Also inquire about equipment which may be in storage or off-site. This stored equipment may be usable during a disaster but must be located, cleaned, tested and repaired as necessary.

4. **Are there special considerations for unaccompanied children?**

   One very important consideration is identification of unaccompanied children or children that are separated from their parents. If the child is unable to tell you his/her name, consider obtaining digital or Polaroid pictures with a brief description written on the back of the photo that describes the child, his/her clothing and any other identifying characteristics.

   Another important consideration is re-unification of the child with their parents or designated caretakers. Each hospital should establish a plan on re-uniting families. It is critical to have processes in place that ensure children are released to the appropriate person(s). Include in the reunification plan the type(s) of identification that family members should have to confirm their relationship to the child. Enlist your hospital risk management or legal department in developing the reunification component of your plan. It is critical that they are involved since a number of legal issues may arise in the reunification of children with family/caretakers (such as in the case of foster children or divorce/custody issues). When in doubt, the child should not be released until a legal authority can be consulted.

   The National Center for Missing and Exploited Children (NCMEC) is a resource to assist with missing children and reunification issues. Their website can be accessed at [www.missingkids.com](http://www.missingkids.com).

   Also work with and involve your local American Red Cross chapter on appropriate reunification strategies.

5. **What is the role of the American Red Cross in reunification?**

   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.

6. **What is meant by Pediatric Hazard Vulnerability Analysis?**

A Hazard Vulnerability Analysis (HVA) is an analysis that identifies potential hazards that may occur in a community, i.e. tornado, flooding, chemical release, terrorist event. The analysis ranks the various disasters that may occur within a particular community and can also include the physical characteristics of the hazard, as well as the magnitude and severity, probability and frequency, causative factors, and locations/areas affected.

To conduct a pediatric specific HVA, hospitals should obtain adult and child population census information from their local municipalities. In addition, they should research their community and identify buildings/organizations where large groups of children congregate, i.e. schools, licensed day care facilities and park district programs. Obtain enrollment numbers to identify the volume of children in these facilities on a daily basis. Information should be obtained on whether these buildings are located near chemical plants, electrical power plants or railways/highways that may be used to transport hazardous materials. Collection of this information assists in pre-planning and early recognition of potential threats to children within a community should a major incident occur, such as a chemical release from a chemical plant located near a school or child care facility.

Other areas to include in a pediatric hazard vulnerability analysis are sports stadiums, playgrounds/parks, public swimming pools, movie theatres, shopping malls, juvenile detention facilities, popular field trip destinations, recreational facilities or summer camps.

Conduction of a Pediatric HVA is important since there are general estimates that approximately 85% of children under the age of 18 years spend at least six (6) hours daily away from home. The Pediatric HVA can facilitate planning and response efforts, and identify potential pediatric surge volume within a community.

7. **Are there any special needs that children have during decontamination?**

Infants and young children have special needs during decontamination procedures. Ideally families should be kept together (whenever possible) during the decontamination process. This will help to minimize chances of family separation and decrease anxiety.

Infants can become very slippery when wet, so preferably avoid hand-carrying them through the decontamination system in order to decrease the risk of dropping them and causing injury. A conveyor system or patient cart/gurney can be used which may make it possible to move several infants simultaneously through the shower system. Other items that can be used to carry an infant through the decontamination shower include plastic laundry baskets, plexi-glass bassinets (with drainage holes in the bottom) or car seats (without the padding). If an infant is hand-carried through the decontamination shower, it should be a two-person process with one person securely holding the infant while the other person washes and rinses.

Children who are of pre-school age, young school age, or children with special healthcare needs may require the assistance of their parents and/or hospital staff during the decontamination process. Older school age children and adolescents should be able to decontaminate themselves, but will require appropriate instruction prior to showering. The decontamination of infants and children will definitely require more time and additional staffing than adults, so their additional needs should be anticipated and incorporated into your disaster planning.

Hypothermia is another key issue that children are at increased risk for during the decontamination process. To lessen the potential for hypothermia, assure the availability of warm water during the showering process. A decontamination shower that provides access to low pressure, high volume, warm water is ideal for decontaminating young children. In addition, assure immediate availability of warm blankets, appropriate size gowns and any other warming devices upon exiting the shower.

8. **Is it okay to cohort unaccompanied children and children with minor injuries with adults while waiting for discharge or re-unification with their families?**

If children are unaccompanied, they should remain in a special holding area that is designated for children only. This area needs to have appropriate adult supervision and staff as well as toys and other diversional activities. If possible, a staff member with expertise in dealing with mental health issues (i.e. child life specialist, social worker, chaplain) should be available to
address fears and concerns that these children may have regarding the incident, their safety and their families. For more information, refer to the security concerns section within the Pediatric Disaster Preparedness Guidelines.

9. Are there special populations within the pediatric population to consider?

Children with Special Health Care Needs (CSHCN) are a particularly vulnerable population. CSHCN includes children with chronic illnesses such as diabetes, asthma, various congenital disorders and mental/behavioral problems. These children may require ventilator support, portable oxygen, assistive devices for mobility or special disease treatments such as dialysis. Chronic illnesses have the potential to become acute problems during a disaster since these children may no longer have access to their medications, assistive devices such as feeding tubes, monitoring devices such as glucometers, and other necessary devices such as eyeglasses or hearing aids for extended periods of time. These potential issues need to be identified, discussed and planned for ahead of time.

10. How can we better prepare for Children with Special Health Care Needs (CSHCN)?

To better prepare for the needs of the CSHCN population of children during a disaster, each hospital should work to determine what their capabilities are for sustaining and supplying special equipment, portable oxygen, and medications. Also identify community resources that can be accessed, such as local pharmacies, medical supply companies and dialysis centers. Memorandums of Understanding (MOUs) should be sought to ensure availability of additional medications and other items such as ventilators, oxygen tanks, wheelchairs and dialysis capabilities as appropriate. In addition, parents should be encouraged to always have extra supplies available for their child in case of a disaster. Parents should also be encouraged to notify utility companies, as well as their local fire department and police department of their special needs child, so that community planning can occur prior to a disaster event.

Care provided to CSHCN should be delivered by staff knowledgeable and comfortable with special devices such as shunts, ventilators, tracheostomies, central lines and feeding tubes. Many prehospital and hospital personnel are uncomfortable in managing the CSHCN population since they have limited experience with these children in their day-to-day practice. However since they may be called upon to assist in the management of these children during a disaster event, it is helpful to include CSHCN into hospital and community disaster drills. This can assist in preparing healthcare practitioners for the needs of these children. A helpful resource is the Special Children’s Outreach and Pre-hospital Education (SCOPE) program which is available through Jones & Bartlett Publishers, www.jbpub.com.

Having access to the child’s medical history during and immediately following a disaster event is essential. Work with parents and primary care providers and encourage use of the Emergency Information Form (EIF) which is available through the American Academy of Pediatrics, www.aap.org/advocacy/eif.doc or the American College of Emergency Physicians, www.acep.org/webportal/patientsconsumers/medicalforms. This is a handy one-page form that parents can complete (and keep updated) that provides information on the child’s condition, their medical history, contact information for their physicians, listing of their medications and medical assistive devices. Parents should be encouraged to make copies of this form and provide them to their child’s caretakers, school/daycare, the local emergency department, local EMS, emergency contact persons and with the child.

9. How should we respond to the emotional needs of CSHCN?

Be aware in planning for CSHCN that some physical or emotional conditions may worsen in stressful situations, requiring immediate attention. 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. Children with cognitive impairments may regress and have difficulty processing information or understanding instructions. Children with emotional impairments may display increased anxiety during or after a disaster event. Sensitivity to these vulnerabilities is helpful, especially when providing explanations and directions during and after a crisis. Be aware of what appears to be comforting and calming to these children and incorporate these measures into their care as this will help provide reassurance and a sense of safety.