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Photo Credit: Photograph on cover page taken by Keith Bedonie of the San Juan Interagency Hotshot Crew, used with permission.
INTRODUCTION

OVERVIEW

PURPOSE

This document provides guidance for healthcare coalitions, burn centers, state public health preparedness professionals, healthcare entities, and other stakeholders planning for a burn mass casualty incident (BMCI). A BMCI is defined as any burn incident where capacity and capability significantly compromises patient care. This plan identifies the experts and specialized resources that must be engaged in a burn mass response, and the mechanisms and processes that will be used to ensure best possible patient care for burn patients.

SCOPE

This plan is intended for use by the Western Regional Burn Disaster Consortium (WRBDC) in managing a burn mass casualty incident within the region. Regional coordination and healthcare facility support are the primary focuses. The plan may also be used in response to a BMCI outside of the region, or by a healthcare coalition providing coordination during a more localized burn event. This document is intended to support, not replace, existing policies or plans by providing uniform response considerations in the case of a BMCI. It is a resource document and does not constitute policy or impose any obligations. Each jurisdiction and entity will require internal documents and policy that addresses specifics of their organizational response.

LEGAL AUTHORITIES

The response strategies and processes described herein are not legally binding, and there is no legal obligation to participate. However, participation by hospitals, healthcare systems and their partners is encouraged to ensure the best possible patient outcomes for all those treated in the Western Region. Where possible, the plan leaves the majority of the decisions and processes up to the healthcare systems and transfer centers. The use of a coordination body is outlined in order to assist healthcare systems when overwhelmed, by leveraging resources and supplies to assist in caring for patients, or transferring patients to other systems with specialty services.
BACKGROUND

WESTERN BURN REGION

The Western Region Burn Disaster Consortium consists of 27 burn centers (13 verified, on the map at right) who have joined together to support response efforts for one another throughout the Western United States. The American Burn Association (ABA) has designated the following member states:

- Alaska
- Arizona
- California
- Colorado
- Hawaii
- Idaho
- Montana
- Nevada
- New Mexico
- Oregon
- Utah
- Washington
- Wyoming

The Western Region Burn Disaster Consortium has been actively engaged in preparing and responding to burn events for almost a decade, and has produced many useful resources and educational materials for burn and non-burn facilities. Notable among these are the 24 Hour Plan (initial steps, including notifications and activations), Prolonged Care of the Burn in a Non-Burn Facility Following a Mass Casualty Incident (or 96 Hour Plan, best practices for caring for a burn patient), and others. These plans were utilized in developing this comprehensive operations plan, ensuring consistency and unification of efforts. All WRBDC plans and related resources can be found online (http://crisisstandardsofcare.utah.edu), and most can be accessed through an app on smart phones and other devices (search for the “Burn CSC App”).

BURN MASS CASUALTY INCIDENT

A BMCI is defined as any incident where capacity and capability significantly compromises patient care, in accordance with individual Burn Center, state, regional or federal disaster response plans. Additionally, several smaller incidents within a locality or region may also amount to a burn mass casualty incident, if taxing on burn staff, facilities or resources. This type of event will exceed the resources of a single jurisdiction, and therefore will require the use of a
tiered approach beginning with the local community hospital and engaging a broad array of state, regional and national stakeholders, depending on the scope of the incident.

ASSUMPTIONS

The following assumptions provide the basis for the emergency response procedures outlined within this plan. It is expected that all participating facilities and supporting agencies are aware of and agree to the following:

- All hospitals providing emergency care may receive burn patients and should be able to provide initial assessment and stabilization.
- Partnering agencies within the jurisdiction, including emergency medical services (EMS), Healthcare Coalitions (HCCs), public health, and emergency management will have primary responsibility for response including initial casualty distribution and subsequent triage of patients for forward movement.
- Agencies with primary response coordination responsibilities, including state and local public health and emergency management, will coordinate transfers with the closest burn center and the Western Region Burn Coordination Center (WRBCC) in accordance with established regional protocols.
- Burn Centers and Level 1 and Level 2 trauma centers should plan for a major role in the receipt and care of burn patients and understand their role in a BMCI in their community or state.
- Care of critical burns is extremely resource intensive and requires specialized staff, expert advice, and critical care transportation assets.
- Severe burn patients often become clinically unstable within 24 hours of injury, complicating transfer plans after this time frame.
- Federal resources (e.g. ambulance contracts, National Disaster Medical Systems teams), though potentially available to assist, cannot be relied upon to mobilize and deploy for the first 72 hours.
- In a Burn Mass Casualty Incident (BMCI) it may be necessary to implement a Centralized Unified Command in order to ensure contingency care strategies are utilized evenly by all healthcare facilities. This will ensure the highest level of surge capacity possible, prior to entering crisis care.
- The American College of Surgeons Committee on Trauma (ACS-COT) Guidelines for the transfer of patients to a burn center may need to be modified in order to do the greatest good for the greatest number of patients.
CONCEPT OF OPERATIONS

THE FIRST 24 HOURS

The initial response to a burn mass casualty incident will be the responsibility of the local public health and emergency management agencies, partnered with local healthcare organizations, utilizing all available local resources. Existing protocols for incident command, burn center notification, coordination of resources, and distribution of patients will be adhered to. However, local efforts will likely be exhausted and require external resource, care and coordination assistance. Although adjacent localities or states may provide assistance per existing memorandums of understanding (MOUs), formal assistance through the established process outlined below will ensure efforts are timely, efficient and well-coordinated.

1. NOTIFICATIONS

The Burn Center (BC) impacted by the incident will notify local, state, regional and federal partners according to emergency operations plans and procedures. In addition, the impacted Burn Center or its partners should immediately call the Western Region Burn Disaster 24/7 Hotline at 866-364-8824. Agencies who may request assistance from the Burn Disaster Hotline include the impacted Burn Center, the American Burn Association (ABA), ABA Regional Coordinators, Department of Health and Human Services (HHS), non-burn facilities impacted by the event, and state agencies such as health, emergency management and public safety.

2. PLAN & COORDINATION CENTER ACTIVATIONS

Upon notification from the affected burn center or local, state or federal partners, the Western Region Burn Disaster Consortium (WRBDC) will activate the Western Region Burn Coordination Center (WRBCC), this Operational Plan, and any other related emergency plans or protocols. The WRBCC will be activated to a level appropriate for the response, and may include simply one Coordinator or multiple staff fulfilling a variety of roles. More details on the personnel and activities of the Coordination Center can be found in the “Western Region Burn Coordination Center” section of the plan.

3. WESTERN REGION BURN BED CENSUS

The Coordination Center will conduct Western Region burn bed census counts using the Utah Notification and Information System (UNIS) Burn Provider Group, or via email or Smart Sheets that will be sent to all regional providers. (*NOTE: if the disaster is located in Utah and infrastructure damage occurs rendering communication technologies unusable, disaster efforts will be initiated by the Colorado Mass Notification System). Bed census counts will be conducted immediately, and again at 24 hours post-incident. Bed census counts are inclusive
of surge capacity, and consider individual burn center capability. The WRBCC will use the WRBDC Burn Disaster Bed Census spreadsheet (Appendix B) to record and share bed counts, a document that is regularly utilized for exercises and real-world events.

**Regional Burn Surge Availability.** There are around 453 total burn beds in the region, with approximately 150-180 available on an average day. Including surge estimates, this would leave 200 beds potentially available for a BMCI. There are two facilities within the WRBDC that take only pediatrics, Shriners Hospital for Children in Northern California and Children’s Hospital Colorado. Kapi’olani Medical Center in Hawaii does not have designated burn beds, however it can accept burn patients as physicians also work at Straub Hospital Burn Center. Most burn centers care for both adult and pediatric patients with only two exceptions. Out of 453 total beds, approximately 422 could be used for either adult or pediatric patients.

### 4. INITIAL PATIENT COORDINATION

The impacted healthcare organizations will immediately begin triage and treatment. If a Burn Center or non-burn facility requires patient transfer to a Burn Center with available burn beds, the WRBCC will assist with determining appropriate patient destinations, transportations and patient documentation and tracking, and coordinate these needs between the referring and receiving facilities.
THE ONGOING RESPONSE

ROLES & RESPONSIBILITIES

Local organizations and agencies within the impacted jurisdiction will have primary responsibility for response, including initial triage and casualty distribution. Suggested response roles for local, state and national stakeholders and partner agencies are summarized in the table below. These roles were adapted from the ASPR TRACIE Mass Burn Event Overview (Resources), and are found in the 96 Hour Response Plan (Appendix I).

<table>
<thead>
<tr>
<th>PARTNER</th>
<th>RESPONSE ROLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS</td>
<td>• Rescue, transport, and distribute casualties to appropriate local facilities in accordance with established burn center MCI protocols.</td>
</tr>
<tr>
<td>Local Healthcare Coalition</td>
<td>• Request/mobilize any coalition/regional caches of burn supplies.</td>
</tr>
<tr>
<td>Public Health (PH)</td>
<td>• Activate coalition coordination mechanisms and any burn-specific plans.</td>
</tr>
<tr>
<td>Emergency Management (EM)</td>
<td>• Coordinate local lists of casualties and clinical information.</td>
</tr>
<tr>
<td></td>
<td>• Triage/prioritize patients for forward movement to specialty centers in accordance with established BMCI protocols and/or expert input.</td>
</tr>
<tr>
<td></td>
<td>• Coordinate with burn experts to determine appropriate destinations for patients that cannot be accommodated in the local healthcare system with assistance from state and ABA.</td>
</tr>
<tr>
<td></td>
<td>• Assure that appropriate clinical information is relayed between the referring and receiving facilities during the transfer process.</td>
</tr>
<tr>
<td></td>
<td><strong>Secondary Roles:</strong></td>
</tr>
<tr>
<td></td>
<td>• Coordinate information with state/federal ABA partners.</td>
</tr>
<tr>
<td>Closest ABA Burn Center</td>
<td>• Provide patient care.</td>
</tr>
<tr>
<td></td>
<td>• Activate facility and regional surge capacity plans to accommodate multiple patients.</td>
</tr>
<tr>
<td></td>
<td>• Liaison between local response and regional ABA coordinating center.</td>
</tr>
<tr>
<td></td>
<td><strong>Secondary Roles:</strong></td>
</tr>
<tr>
<td></td>
<td>• Assist with patient triage for forward movement.</td>
</tr>
<tr>
<td></td>
<td>• Support facilities providing care for burn patients in the area via telephone or telemedicine and/or request support from WRBDC coordination center.</td>
</tr>
<tr>
<td></td>
<td>• Ensure burn surge facilities use existing resources (96 Hour Plan).</td>
</tr>
<tr>
<td>State PH/EM</td>
<td>• Support local jurisdiction with state-level coordination and requests for assistance (e.g., state and federal declarations).</td>
</tr>
<tr>
<td></td>
<td>• Assure that patient triage, tracking, and transport needs are addressed.</td>
</tr>
<tr>
<td></td>
<td>• Make request for burn care assets, including dressings and other materials from the Strategic National Stockpile (SNS).</td>
</tr>
<tr>
<td></td>
<td>• Engage Emergency Management Assistance Compact (EMAC) assets to provide inter-state support for transportation, staff, or other logistics.</td>
</tr>
</tbody>
</table>
**Secondary Roles:**
- Liaison between local, state and federal resources.
- Support bed polling and matching functions as required in coordination with ABA regional center.

**Western Region Burn Coordination Center (WRBCC)**
- Serve as the point of contact (POC) for the ABA system.
- Conduct bed polling initially and as needed within ABA region (and request assistance from adjacent regions as required).
- Assist the affected local burn center and state PH in determining appropriate patient destinations and transportations.
- Assist with the tracking of patient movement including arrival to destination centers. Provide updates as requested.
- Facilitate requests for tissue bank products, as well as graft equipment and other specialized supplies.
- In collaboration with state and regional partners, establish when the BMCI has concluded.
- Establish any post-incident system needs and initiate AAR process.

**Secondary Roles:**
- Assist with bed matching (right patient to right bed/facility, while being mindful of family units).
- Facilitate exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.
- Assist the affected local burn center and/or burn surge facility by providing expert advice or telemedicine as requested. Engagement of other WRBDC facilities will be imperative.
- Circulate / facilitate additional staff and supply needs as possible (e.g., notify regional facilities of specialized resource / staff requests that they may be able to assist with) in conjunction with affected community and ASPR Regional Emergency Coordinator (REC).
- Provide situational awareness to all appropriate agencies.

**ABA National Headquarters**
- Provide expertise and advice on request from a member center.

**Secondary Roles:**
- Provide expertise and advice to inform the federal response.

**Health & Human Services / Assistant Secretary for Preparedness & Response (HHS/ASPR)**
- Provide federal support to local and state activities as requested/authorized under the National Response Framework including supplies, staff, and transportation assistance through the Federal Coordinating Officer (FCO) appointed to the State for the incident.
- Coordinate approved use of National Disaster Medical System (NDMS) personnel or transportation assets.

**Secondary Roles:**
- Coordinate information access to burn expertise during BMCI.
- Support/assist states and ABA information and system needs (e.g., bed polling/data management).
WESTERN REGION BURN COORDINATION CENTER

In order to meet the goal of best possible patient outcomes after a burn mass casualty incident (BMCI), the establishment of a Western Region Burn Coordination Center (WRBCC) that offers real-time consultation for hospital staff to assist with the management or stabilization of patients while awaiting transfer is invaluable. The Coordination Center will be staffed by a task force of physicians and/or advanced practice clinicians, nurses, and Department of Health and other assistive personnel. Coordination will occur virtually using a video calling system, such as Zoom, or other appropriate platforms for visual communication. Additional communications may occur via email, text, and telephone.

ORGANIZATIONAL STRUCTURE

The central function of the WRBCC is to facilitate timely communication between the various stakeholders to ensure equitable patient transfers and resource sharing. It aims to do this by ensuring the use of a workable platform for all, engaging relevant health systems and supporting agencies, and utilizing existing protocols and procedures where possible. The following organizational principles apply:

- **Virtual Coordination Cell** - The WRBCC will operate through virtual conference calls, emails, or texts. A virtual platform will reduce overhead expenses and leverage existing equipment, worksites, and systems.
- **Engaging Stakeholders** - All WRBDC hospital systems, EMS, Hospital Associations, Department of Health, Emergency Management and Federal partners may have digital representation. The number and type of stakeholders engaged will depend on the level of WRBCC activation.
- **Continued Use of Existing Hospital System Transfer Centers** – Involving and coordinating with existing hospital system transfer centers prevents a disruption of existing workflow.
- **Patient Transport Support** - Transport of patients will be fielded by EMS and supporting agencies. The transferring facility can also use internal transportation procedures if available.
- **WRBCC Coordinator** – All Center activities will be managed by a Coordinator, responsible for working between facilities, states, and with federal partners. Coordinators are on call 24/7 for response. Duties can be found on the WRBCC Coordinator checklist (Appendix C). In a small-scale event, it may be only the Coordinator who is activated.
- **WRBCC Medical Control** - The coordination center will consult with a Burn Physician to address region-wide bed control. Additionally the physician will provide clinical guidance as needed to ensure patients are transferred to a hospital with the appropriate level of care. The on-call rotating schedule for burn physicians (Appendix R) and the Medical Control checklist (Appendix C) are attached to this plan.
OPERATIONAL OVERVIEW

The Western Region Burn Coordination Center fulfills several vital roles following a burn mass casualty incident. Upon activation, Coordination Center personnel will utilize the WRBCC Job Action Sheets (Appendix C) and perform the activities listed below, as needed:

Immediate / First 24 Hours:

- **Partner Notification** – notify ABA leadership and WRBDC members of the BMCI, and enlist help as necessary.
- **Burn Bed Census** – conduct bed census counts immediately and at 24 hours post incident to identify available burn beds for patient transfer.
- **Assistance Requests** – request assistance (including resources, transferring and/or care of patients) from region member facilities, EMS, and/or adjacent regions.
- **Situational Awareness** – provide updates to WRBDC members, partners and all other appropriate agencies, including bed census reports and incident action plans (IAPs) or situation reports as necessary.
- **Technical Assistance** – assist the affected local burn center and/or non-burn facility by providing expert advice or telemedicine as requested.
- **Bed Matching** – assist with bed matching, i.e. finding the right bed and facility for each patient requiring transfer coordination.

Ongoing Response

- **Patient Information** - facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.
- **Patient Tracking** - assist with the tracking of patient movement including arrival at destination centers.
- **Resource Requests** - facilitate requests for tissue bank products, graft equipment or other specialized supplies; this may be in collaboration with the ABA.
- **Federal Partner Coordination** - facilitate staff and supply needs with ASPR Regional Emergency Coordinator (REC).

Demobilization

- **Incident Conclusion** - establish when the BMCI has concluded, in collaboration with state and regional partners.
- **Outpatient Follow-up** - assist in disseminating outpatient follow-up guidance for burn patients in the affected area as requested, and in collaboration with the local burn center.
- **Behavioral Health Follow-up** - assist with psychosocial follow-up and after care programming in the affected area as requested, in collaboration with the local burn center.
- **After Action** - identify any post-incident system needs and initiate the After Action Report process.

PATIENT TRANSFER COORDINATION

If secondary distribution of patients to burn specialty centers is requested, a WRBCC representative, utilizing existing hospital system transfer systems, will facilitate transfers between
hospital systems, based on clinical acuity and hospital capacity, to enable a more equitable
distribution of burn patients when systems are in contingency care.

The primary purpose of patient transfers facilitated by the WRBCC in collaboration with local
authorities is to decompress overwhelmed healthcare facilities by enabling an equitable
distribution of patients. Assistance will be provided to affected non-burn facilities, local burn
center and state public health in determining appropriate patient destinations (right patient to
right bed and facility), while being mindful of family units.

The following steps outline the process for patient transfers coordinated through the Western
Region Burn Coordination Center.

1. **Requesting Facility Communicates Patient Transfer Request to the WRBCC**
The request for burn patient transfer can be made by the requesting facility calling the
WRBCC Coordinator, who will activate an online or telephone conference with WRBCC
members. The requesting facility will provide the following information to the WRBCC:

- The number of patients requiring transfer
- Each patient’s COVID-19 status (positive, negative, unknown)
- Each patient’s age, gender, acuity and estimated total body surface area (TBSA) of injury, language and/or effective communication needs and level of care needed.
- Additional pertinent clinical information, including requirements for transfer (e.g., oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information).

The WRBDC BMCI Patient Medical Data Form (Appendix D) outlines a comprehensive report of the patient, including the data noted above, and may be used to provide this information.

2. WRBCC Facilitates Patient Placement & Tracking

After receiving pertinent patient information, the WRBCC Coordinator will contact burn receiving facilities to determine the most appropriate placement of patients. Patient placement decisions will be based on bed availability information and facility levels of care, in consultation with the WRBCC Physician. Additional decision-making information is found on the WRBDC Facility Data Sheet (Appendix P), which details all facilities in the Western Region Burn Disaster Consortium including adult and pediatric bed availability, staffing, level of care, and additional features including helipad and telemedicine capabilities. The WRBDC Mileage Chart (Resources) further helps in decision making by noting commercial flight time and ground transport mileage between all Western Region facilities. If Crisis Standards of Care are implemented, by governor declaration or other state protocol, the patient CSC Burn Triage Tables (Appendix E) may be utilized by a physician at the point of care in collaboration with a burn provider to assist in decision making.

Once a burn receiving facility has been identified and confirms acceptance of the patient(s), the WRBCC will coordinate a clinical provider call between the requesting facility and receiving facility to exchange patient information and determine transportation requirements. Patient information will be exchanged using the WRBDC BMCI Patient Medical Data Form (Appendix D). Telemedicine and digital images of the patient’s burns will be utilized, if existing infrastructure allows, ensuring an accurate total body surface area (TBSA) is calculated and placement is appropriate.

WRBCC personnel will utilize the WRBCC BMCI Patient Tracking Sheet (Appendix Q) to document and track all patient transfers. This sheet records important patient data needed for transfer, as well as receiving facility information.

3. Receiving Facility Completes and Confirms Successful Patient Transfer

The Transportation Guidelines found in this document will be followed to ensure the safety of both transporter and patient. Transport of patients will be handled by the EMS and supporting agencies, according to existing plans and protocols. If the transferring facility has transportation procedures within the healthcare system, these may also be utilized.
Once the patient has been transferred and admitted, the receiving facility will contact the WRBCC to confirm the completion of the process. The WRBCC will document the transfer and its completion on the WRBCC BMCI Patient Tracking Sheet (Appendix Q).

**RESOURCE REQUEST COORDINATION**

Hospitals encountering a need for burn care resources will first attempt to acquire the needed item(s) using their normal or emergency procurement methods. This can be done in collaboration with state, regional, and federal partners and in accordance with existing MOUs. The WRBCC may assist in acquiring scarce or specialized resources when necessary. The following process will be followed to ensure a locally-driven response, with support as needed in a tiered approach.

**Tiered Resource Request Process:**

1. *Healthcare Facility / System* – when an unmet resource need exists, the facility will first utilize existing channels within its hospital system to acquire the needed item(s). If the system cannot meet the request, the local jurisdiction ESF 8 desk and/or regional healthcare coalition coordinator (HCC) should be notified.

2. *Local ESF 8 / State ESF 8* – Local ESF 8/HCC will initiate efforts to obtain the needed item(s) by contacting facilities in their jurisdiction. If unmet, the request is then sent to the State ESF 8. ESF 8 and/or healthcare coalition coordinators will make arrangements for any available resources to be sent to the requesting facility.

Note that scarcity of resources may prompt prioritization recommendations to be established by local and state health officials, shared with hospitals through disaster communication channels.

3. *Regional WRBCC* – if the resource need is unable to be met from the healthcare system or from healthcare coalitions or local and state emergency support, the facility may request resource assistance from the WRBCC.

The WRBCC will assist in identifying another facility that is able to provide the resource. The requesting facility is responsible for completing
any necessary paperwork, and will work with the WRBCC to coordinate transportation of the resource.

In the event that region-wide resources are scarce or unavailable, including tissue bank products and specialized supplies, the WRBCC task force will convene to discuss available options and recommendations, in conjunction with ABA personnel.

**CLINICAL SUPPORT TO NON-BURN FACILITIES**

An additional key role of the Western Burn Coordination Center is providing clinical support and expert advice to non-burn providers who are compelled to board and treat burn patients prior to transfer to another facility, or when specialized care elsewhere is unavailable or unattainable.

The Western Burn Region Disaster Consortium has done considerable work over the last decade to ensure that burn educational resources and materials are available to all non-burn facilities to prepare for a burn disaster. Many non-burn facilities in the region are well-prepared to receive and care for patients for a short amount of time; however, clinical guidance and expertise may still be desired in the event of a BMCI. When a request for help is given to the WRBCC from a non-burn facility, the WRBCC task force will meet to discuss available options and provide support as necessary and possible, which may include one or more of the following:

- **Maximizing Real-time telehealth provider support** for critical care, utilizing burn providers who are credentialed in multiple states. Telemedicine capabilities are currently available in multiple hospitals in the region, as listed on the WRBDC Facility Data Sheet (Appendix P). Providers who wish to practice in multiple states, including via telemedicine, can visit the Interstate Medical Licensure Compact website for licensure requirements ([www.imlcc.org](http://www.imlcc.org)).

- **Where telemedicine is not available,** image storing and forwarding, accompanied by provider-to-provider discussions, may be utilized to effectively determine extent of patient’s burns and provide assistance for triage and treatment courses.

- **Mobile Task Force deployment,** in collaboration with local and state partners, is a final potential option. The Task Force would likely include a Burn Physician or Advanced Practice Clinician, a registered nurse, and assistive personnel, all trained in burn treatment and response. Upon arrival at an impacted non-burn facility, these individuals would deliver just-in-time training to facility staff to enable them to provide specialized burn care. Most equipment and supplies would be provided by the impacted facility, but some basic personal and medical supplies force members may want to take with them are listed in the Mobile Task Force Go-Bag (Appendix F).
FACILITY MEDICAL CARE OPERATIONS

Healthcare facilities are responsible for all patient triage and treatment, tracking, care documentation, family reunification, rehabilitation, and management of deceased patients at their facility, but may request assistance as needed from the WRBCC (as outlined in the previous section). Facilities will first and foremost follow internal policies and procedures for patient care and emergency response. This plan is meant only as supplemental support and direction in instances where this may be helpful.

ANTI-DISCRIMINATORY TREATMENT POLICIES

The purpose of this document is to provide the best possible care to all burn victims following a mass casualty event. Difficult decisions, such as patient transfers and allocation of resources, will be objective and based on factors related only to the likelihood and magnitude of benefit from the medical resources. Factors that have no bearing on the likelihood or magnitude of benefit, including race, disability, gender, sexual orientation, gender identity, ethnicity, ability to pay, socioeconomic status, perceived social worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources, are not to be considered by providers making allocation decisions. For more information on laws governing these practices, please refer to the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act.

PATIENT DOCUMENTATION & PRIVACY

Patient Tracking. Healthcare facilities will follow routine and/or disaster protocols for tracking patient movement within their hospital system. More uncommon patient movement, including transfers from a facility to a destination facility outside of the hospital system or state, may be facilitated by the WRBCC, in collaboration with state and regional partners. The WRBCC BMCI Patient Tracking Sheet (Appendix Q) will be utilized by the coordination center to ensure consistency across the region in patient tracking efforts. Facilities may utilize their own patient tracking forms, if applicable, or those provided by the Hospital Incident Command System (HICS) which can be found online at https://emsa.ca.gov/hospital-incident-command-system-forms-2014/. Note: in the near future, the WRBDC will be developing a burn-specific patient tracking form for facility use, patterned after the HICS forms, for inclusion in an updated version of this plan.

Patient Care Documentation. Hospitals will utilize their existing or normal medical records to document patient assessment and medical care given to burn victims. The WRBDC BMCI Patient Medical Data Form (Appendix D) may be used to record details of the extent and depth of the burn. This form may be utilized for patient transfers, and to accompany the patient to the recipient facility. The WRBCC will support Burn Center efforts to collect comprehensive burn patient data from all treating healthcare facilities. This data may be
submitted to the ABA burn database according to established protocol by burn centers who receive burn patients, to be used for educational and research purposes.

**Patient Privacy.** It is important for facilities to understand that while privacy is important, patient protected health information (PHI) can be disclosed without authorization when needed during a disaster and under certain circumstances. This includes when the information is needed for:

- Patient treatment
- For or on behalf of a public health authority
- To persons at risk of contracting or spreading a disease (if authorized by law)
- When there is an imminent threat to public health or safety

The Appendix conditions a valuable resource put together by ASPR TRACIE that describes what information can be released, to whom, and under what conditions, entitled HIPPA and Disasters: What Emergency Professionals Need to Know (Appendix G).

**PATIENT CARE RESOURCES**

The WRBDC has put together an extensive collection of burn resources for non-burn and burn facilities. Training resources and planning documents aid in preparing facilities for a burn mass casualty incident, and guidelines to be followed during a response. In addition to being available online at [http://crisisstandardsofcare.utah.edu](http://crisisstandardsofcare.utah.edu), nearly all of these resources are also available as an app on smartphones and other devices (search for the “Burn CSC” app). This allows instantaneous in-field access to evidence based information on burn and soft tissue injury to assist in delivery of care. The following sections describe some of these resources in more detail, many of which are included in full or in part in the Appendix, and the Resources section of this plan provides information on accessing them.

**BURN EQUIPMENT & SUPPLIES**

Non-burn facilities who wish to know the supplies and equipment to have on hand for the treatment of a burn patient can refer to the Wound Care Supply Guideline for Burns (Appendix H). For pediatric patients, these basic burn supplies in addition to Pediatric Equipment and Supplies (Appendix K) are also important to have available. Please note that these lists are not exhaustive, and are meant to be a supplement to standard supply cart items and personal protective equipment a facility would typically provide.

**THE 96 HOUR PLAN**

A mass casualty incident with a significant number of burn-injured patients creates unique challenges due to the scarcity of burn centers and the complexity of the initial care required. Medical management poses unique challenges to healthcare professionals, many of whom will have limited amounts of knowledge and expertise in burn care. In acknowledgement of
this, the Western Region Burn Disaster Consortium has developed multiple resources to assist non-burn centers to care for those with burn injuries and ensure best practices will still be implemented, despite the constraints of a large-scale incident.

The Prolonged Care of the Burn Patient in a Non-Burn Facility Following a Mass Casualty Incident (Appendix I) is a collection of training modules and quick-reference response guides created in response to ASPR’s mandate that all HPP funded facilities are required to be able to provide care to a burn patient for up to 96 hours (these documents are also referred to as the 96 Hour Plan). The essential, better and best care recommendations build on each other so that movement from one to the other is outlined as additional resources become available. These guidelines were developed by a multidisciplinary team of 41 pertinent local, state, tribal, regional, national, federal and international experts from 13 States and 3 countries. The team contained both burn and non-burn providers and military personnel.

The four e-learning modules and all supplemental material of the 96 Hour Plan (Appendix I) can be found online (Resources), or can be requested from the app store on both android and apple devices under University of Utah Burn CSC. Available E-Learning Modules & Quick Reference Guides from the 96 Hour Plan include:

- Module 1 - Initial assessment and Management
- Module 2 - 0-48 hours of care
- Module 3 - 48-96 hours of care
- Module 4 - Transfer and Transport

**Burn Crisis Standards of Care Guidelines**

An overwhelming public health emergency, such as a burn mass casualty incident, may greatly impact the availability of appropriate hospital beds, staff and resources. Providers may not be able to provide the same level of care that they otherwise would like to, given shortages or other difficulties resulting from the disaster. The purpose of the Burn Crisis Standards of Care Guidelines (Resources) is to guide the allocation of patient care resources and assist with patient care priorities during such an event. Application of these resources and guidelines will depend on physician judgment at the point of patient care or regional CSC decision-making bodies if activated. The guidelines, developed by the Utah Hospital Association (UHA) Crisis Standards of Care Workgroup, include the following:

- Adult and Pediatric initial management
- Fluid resuscitation
- Wound management
- Pain medication
- Physical therapy
- Radiation injury
- COVID19 considerations
- CSC Burn Triage Decision Tables (Appendix E)
PEDIATRIC CONSIDERATIONS & RESOURCES

A good planning figure is to assume that a minimum of 25% of victims from any mass casualty incident will be children. It is critical that healthcare facilities, including burn and non-burn centers, have the education and resources necessary to assess and treat pediatric patients. The WRBCC will be available to assist in coordinating real-time telemedicine support from pediatric and burn specialty physicians. Where telemedicine is not available, image sharing and provider-to-provider discussions can be used to assist in caring for a pediatric burn patient. A few points that non-burn facilities may wish to consider when treating a pediatric burn patient include:

- Calculation of the total body surface area (TBSA) involved in the burn is critical, as this will help determine fluid management and whether or not the patient requires transfer to a burn facility. Refer to the pediatric “Rule of Nines” in the 96 Hour Plan, Module 1 (Appendix I).
- When considering administering oral pain medications start with the smallest dose possible, and note that a patient will never be pain-free. Pediatric pain medication management guidelines can be found in the Initial Management Guidelines for the Pediatric Burn Patient (Resources).
- Monitoring glucose levels in pediatric burn patients is critical – too low or too high can be dangerous. Pediatric patients have a higher metabolic rate than normal, and higher glucose requirements. Critically-ill patients can experience stress-induced hyperglycemia and insulin resistance, which are associated with skin graft failure and infection.
- When it is necessary to secure an airway for a pediatric patient, note the significant anatomical and physiological differences compared with adults that make mask ventilation, direct laryngoscopy, and endotracheal intubation more difficult. These differences include:
  - A child’s tongue is larger in proportion to the mouth than an adult’s
  - A child’s epiglottis is floppier and u-shaped
  - Vocal cords have an upward slant versus a horizontal slant
  - The trachea is narrow and less rigid in a child
  - The lungs have less capacity
- There are also differences in handling psychological needs for children in disasters, who tend to exhibit different emotional responses and have different needs for understanding and healing from trauma as compared to adults. Specific information and guidelines can be found in the Pediatric Psychological First Aid (Appendix M).

Burn-specific pediatric resources can be found in the Initial Management Guidelines for the Pediatric Burn Patient, part of the Burn Crisis Standards of Care Guidelines (Resources), and include primary assessment, intervention and care, fluid infusion and pain medication management.
Pediatric Planning Recommendations & Supplies Checklists. General readiness to handle any pediatric patient is also helpful in planning for pediatric burn patients. In order to plan for the possibilities of caring for critically ill and injured pediatric patients, Pediatric Planning Recommendations (Appendix J) for policy and protocol implementation as well as a Pediatric Equipment and Supplies Checklist (Appendix K) are attached to this plan. Another helpful resource is the 2020 Emergency Department Checklist compiled by the Pediatric Readiness Project. This document lists the most critical components for emergency departments, including guidelines for providers, patient safety, policies, medications, equipment and supplies. This resource can be found online at www.pedsready.org.

Additionally, the Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) was founded with the goal of developing a “coordinated, collaborative and sustainable regional pediatric disaster planning and response capability.” This group has put together an extensive collection of pediatric preparedness and response resources which support the significant pediatric-specific needs encountered by both initial care in place and the subsequent movement of children following a burn event: https://wrap-em.org/index.php.

BEHAVIORAL HEALTH

Given the nature and scope of a burn mass casualty incident, it can be expected that a number of those who witnessed, were injured by, or responded to the event will experience some mental trauma in relation to the incident. Healthcare facilities should be prepared to identify and respond to these issues in their patients, patients’ families, and their staff to the best of their ability.

In a large-scale disaster scenario, psychological first aid is an evidence informed approach, whose purpose (according to The American Psychological Association) is to “assess the immediate concerns and needs of an individual in the aftermath of a disaster”. Psychological First Aid advocates that mental health clinicians and emergency response workers work to understand the victims world view, project a sense of calm, normalize feelings and reactions, provide information needed to de-escalate acute distress and provide education to the individual or family regarding “next steps” to take. Behavioral Health Tips & Resources (Appendix L), which includes brief tips as well as several resources for Psychological First Aid and Aftercare Support, is attached to this plan, along with Pediatric Psychological First Aid guidelines (Appendix M).

FAMILY REUNIFICATION

The process of reuniting family members with those who went missing during a BMCI, including burn victims, is the responsibility of local emergency management and first responders. Healthcare facilities may be asked to provide special assistance to law enforcement, mass care authorities, the Red Cross or others to facilitate reunification. Hospitals can serve as a
natural reunification site, since family members and friends are likely to check facilities for individuals who have gone missing. Setting up a reception site within or nearby the facility can be helpful in connecting patients with loved ones. A great planning resource for this purpose is the "Hospital Reception Site Planning Guide," developed in the western region by the Coyote Crisis Collaborative of Arizona. The plan and several additional resource documents are available online at https://coyotecampaign.org/documents/. Some helpful documents from this guide have been adapted and shared in the Appendix, with the intent to assist healthcare facilities with their own planning. Family Reunification Resources (Appendix N) include:

- Hospital Incident Command System (HICS) Chart, including a Family Reunification Unit
- Definitions
- Family and Friends Intake Form
- Child Identification Form
- Hospital Reception Site Recommended Equipment & Supply Checklist

**FATALITY MANAGEMENT**

The deceased from a BMCI will be handled per local and/or state practice, and in collaboration with the Medical Examiner’s Office if applicable. The Medical Examiner’s Office may provide certain criteria for determining whether a death requires further investigation. For example, state code may require Medical Examiner involvement if the mass burn incident was caused by intentional behavior meant to cause injury or death. Additionally, if there is any question as to the exact cause and manner of death for any victim, the Medical Examiner may need to be engaged.

Depending on the cause of the BMCI, law enforcement may ask EMS and/or the hospitals for the personal effects and other materials associated with a burn related death.

**TRANSPORTATION**

A significant limiting factor in a regional response may be the availability of emergency medical services transport (ambulances). EMS support and coordination is essential to the logistical goals of this effort. Note that patient transfer coordination will include step-down transfers and assistance to local authorities as needed for family reunification efforts. EMS regulations differ widely by jurisdiction, therefore, patient movement will occur in accordance with local protocols and in collaboration with appropriate state, national, and federal agencies. To expedite safe, efficient and appropriate transfer of burn patients, the following guidelines should be adhered to. Note that supplementary COVID19 Transportation Guidelines (Appendix O) are attached to this plan.
ALL PATIENT TRANSFERS

- Whenever possible an Advanced Life Support (ALS) /critical care capable vehicle shall be used to transport a critical burn patient.
- Hospitals needing to transfer patients to a local Burn or Trauma Center should employ their normal private sector EMS transport contracts.
- An individual facility may make arrangements directly or request assistance from local ESF 8, regional Healthcare Coalition (HCC), according to local emergency management plans and protocols.
- Local ESF 8 desks, regional HCCs, and Emergency Medical Resource Centers (EMRC) will utilize internal policies and procedures to solicit assistance from private sector EMS, and public safety Fire and EMS for immediate help.
- If local transport resources have been exhausted, and/or if patient(s) need to be transported to another state within or outside of the region, transport request can be made directly to the WRBCC.
- Prior to transporting any patients, facility acceptance for the patient(s) should be confirmed by the WRBCC.
- The requesting facility should notify the WRBCC of what transportation arrangements have been made.
- The facility or agency arranging air or ground transportation should coordinate with the NOAA National Weather Service for current or future weather conditions. Information can be provided for local and on-route forecast conditions, including wind speed, temperature, pressure and inclement weather.
  - Western Region Operations Center Duty Officer (Salt Lake City, Utah), 801-524-7907, wr.roc@noaa.gov
- Additional transportation guidelines have been developed for COVID-19 (Appendix O).

AIR TRANSPORTS

- Aeromedical transports should be used when available, applicable and as weather permits.
- The facility or agency arranging air transportation should coordinate with aeromedical transports to determine whether medical rotor aircraft can land and take off due to complex conditions, including extreme high temperatures and elevation (i.e., launching or landing in summer months in St. George, Utah, and Las Vegas, NV may be impossible).
DEACTIVATION AND RECOVERY

The Western Region Burn Coordination Center will assist in establishing when a Burn Mass Casualty Incident has concluded, in collaboration with state, regional and federal partners. Triggers for incident conclusion include decreasing patient volumes and hospital staffing and supplies are at or near normal levels. The WRBCC will demobilize when these triggers occur, and when there is no longer a need for coordinated burn-specific activities.

The WRBCC will initiate the After Action process, soliciting and compiling analysis feedback from all responding agencies. Identified gaps and areas of strengths will be noted in an After Action Report, distributed to all pertinent agencies and partners. Changes to plans and procedures, including this document, will be based off of identified gaps.
WRBDC Resources:

All Western Region Burn Disaster Consortium plans, training modules and guidelines, including Initial Management Guidelines for the Pediatric Burn Patient, Prolonged Care of the Burn Patient in a Non-Burn Facility Following a Mass Casualty Incident (96 Hour Plan), Burn Crisis Standards of Care Guidelines, Crisis Triage Officer and Triage Officer Team Training, and more can be found online and on smart phones and other devices.

http://crisisstandardsofcare.utah.edu
Search for the “Burn CSC App” on smart devices

WRBDC Coordinators:

24/7 Disaster Line: 866.364.8824

Annette Newman (Matherly), MS, RN CCRN
Community Outreach / Burn Disaster Coordinator
University of Utah Health Burn Center
Office: 801.585.2076
Cell: 435.901.1425
Email: Annette.Matherly@hsc.utah.edu

Kevin M. McCulley
Preparedness & Response Director
Bureau of EMS and Preparedness
Utah Department of Health
Office: 801.273.6669
Cell: 801.641.1295
Email: kmcculley@utah.gov

Additional Resources:

- American Burn Association
  http://ameriburn.org/

- ASPR TRACIE Healthcare Emergency Preparedness Information Gateway
  https://asportracie.hhs.gov

- Western Regional Alliance for Pediatric Emergency Management (WRAP-EM)
  https://wrap-em.org/index.php
# APPENDIX

## A. Acronyms

## B. WRBDC Burn Disaster Bed Census

## C. WRBCC Job Action Sheets
- WRBCC Coordinator
- WRBCC Medical Control

## D. WRBDC BMCI Patient Medical Data Form

## E. Crisis Standards of Care Burn Triage Tables

## F. WRBCC Mobile Task Force Go-Bags

## G. HIPPA and Disasters: What Emergency Professionals Need to Know

## H. Wound Care Supply Guideline for Burns

## I. Prolonged Care of a Burn Patient in a Non-Burn Facility (96 Hour Plan)
- Module 1: Initial Assessment & Management
- Module 2: 0-48 Hours
- Module 3: 48-96 Hours
- Module 4: Transfer & Transport

## J. Pediatric Planning Recommendations

## K. Pediatric Equipment & Supplies

## L. Behavioral Health Tips & Resources

## M. Pediatric Psychological First Aid

## N. Family Reunification Resources
- Hospital Incident Command System (HICS) Chart
- Definitions
- Hospital Reception Site Equipment & Supply List
- Family & Friends Intake Form
- Child Identification Form

## O. COVID-19 Transportation Guidelines

## P. WRBDC Facility Data Sheet

## Q. WRBCC BMCI Patient Tracking Sheet

## R. WRBCC Physician On-Call Schedule
## A. ACRONYMS

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>MEANING</th>
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<tbody>
<tr>
<td>AAR</td>
<td>After Action Report</td>
</tr>
<tr>
<td>ABA</td>
<td>American Burn Association</td>
</tr>
<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
</tr>
<tr>
<td>ACS-COT</td>
<td>American College of Surgeons Committee on Trauma</td>
</tr>
<tr>
<td>ASPR</td>
<td>Assistant Secretary for Preparedness Response</td>
</tr>
<tr>
<td>BMCI</td>
<td>Burn Mass Casualty Incident</td>
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<tr>
<td>CSC</td>
<td>Crisis Standards of Care</td>
</tr>
<tr>
<td>DHHS/HHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EM</td>
<td>Emergency Management</td>
</tr>
<tr>
<td>EMAC</td>
<td>Emergency Management Assistance Compact</td>
</tr>
<tr>
<td>EMRC</td>
<td>Emergency Medical Resource Center</td>
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<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment and Active Labor Act</td>
</tr>
<tr>
<td>ESF#8</td>
<td>Emergency Support Function – Health &amp; Medical</td>
</tr>
<tr>
<td>FEMA</td>
<td>Federal Emergency Management Agency</td>
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<tr>
<td>HCC</td>
<td>Healthcare Coalition Coordinator</td>
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<tr>
<td>HICS</td>
<td>Hospital Incident Command System (HICS)</td>
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<td>ICS</td>
<td>Incident Command System</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>MCI</td>
<td>Mass Casualty Incident</td>
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<tr>
<td>MOU</td>
<td>Memorandums of Understanding</td>
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<tr>
<td>NBF</td>
<td>Non-Burn Facility</td>
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<tr>
<td>NDMS</td>
<td>National Disaster Medical System</td>
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<tr>
<td>PH</td>
<td>Public Health</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information</td>
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<tr>
<td>POC</td>
<td>Point of contact</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>REC</td>
<td>Regional Emergency Coordinator</td>
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<tr>
<td>TBSA</td>
<td>Total Body Surface Area</td>
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<tr>
<td>TRACIE</td>
<td>Technical Resources, Assistance Center, &amp; Information Exchange</td>
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<tr>
<td>UNIS</td>
<td>Utah Notification and Information System</td>
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<td>WRBCC</td>
<td>Western Region Burn Coordination Center</td>
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<tr>
<td>WRBDC</td>
<td>Western Region Burn Disaster Consortium</td>
</tr>
</tbody>
</table>
# B. WRBDC BURN DISASTER BED CENSUS

## Burn Medical Coordination Center
Western Regional Burn Disaster Consortium (WRBDC)

**Burn Disaster Bed Census**

---

Reported by: __________________ Report #: _______ Date: ____________ Time: _______

Burn Medical Coordination Center: **866-364-8824** 24 Hour Burn Hot-Line: **801-581-2700**

<table>
<thead>
<tr>
<th>Burn Centers</th>
<th>Adult Open Beds</th>
<th>Surge Hours</th>
<th>Pediatric Open Beds</th>
<th>Surge Hours</th>
<th>Total Patients</th>
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<td><strong>Arizona</strong></td>
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<tr>
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<tr>
<td>2 Banner University Medical Center, Tucson</td>
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<tr>
<td><strong>California</strong></td>
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<tr>
<td>3 Bakersfield Memorial Hospital, Bakersfield</td>
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<tr>
<td>4 The Hirschman Burn Center at Arrowhead Regional Medical Center, Colton</td>
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<tr>
<td>5 Community Regional Leon S. Peters Burn Center, Fresno</td>
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<tr>
<td>6 Southern California Regional Burn Center at LAC &amp; USC Medical Center, LA County</td>
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<td>7 UCI Regional Burn Center, Orange</td>
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<tr>
<td>8 Firefighters Burn Institute Regional Burn Center, Sacramento</td>
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<td>9 Shriners Hospitals for Children - Northern California, Sacramento</td>
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<td>10 UCSD Regional Burn Center, San Diego</td>
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<td>11 Bothin Burn Center, Saint Francis Memorial, San Francisco</td>
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<td></td>
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<tr>
<td>12 San Francisco General Hospital - Burn Unit</td>
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<tr>
<td>13 Santa Clara Valley Medical Center Regional Burn Center, San Jose</td>
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<tr>
<td>14 Orange County Burn Center, Santa Ana</td>
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<td>No.</td>
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<td>14</td>
<td>Torrance Memorial Medical Center, Torrance</td>
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<td>The Grossman Burn Center, West Hills</td>
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<td>University of Colorado Hospital Burn Center, Aurora</td>
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<td>Children's Hospital Colorado, Aurora</td>
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<td>20</td>
<td>Straub Clinic and Hospital Burn Unit, Honolulu</td>
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<td>Eastern Idaho Regional Medical Center, Burn &amp; Reconstructive Centers of Idaho, Idaho Falls</td>
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<td>Lions Burn Center-UMC, Las Vegas</td>
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<td>Sunrise Hospital and Medical Center, Las Vegas</td>
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<td>New Mexico Regional Burn Center, Albuquerque</td>
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<td>Oregon Burn Center, Portland</td>
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<td>University of Utah Burn Center, Salt Lake City</td>
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<td>27</td>
<td>University of Washington Regional Burn Center, Seattle</td>
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**TOTAL AVAILABLE BURN BEDS:**

<table>
<thead>
<tr>
<th>Surge Hours</th>
<th>Peds Beds</th>
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<tr>
<td>Adults 02</td>
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</tr>
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<td>Surge 02</td>
<td>Adults Beds</td>
<td>Total</td>
</tr>
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</table>

**Definition of Patient Condition**

- **Green (minor):** <10% TBSA 2nd/3rd Degree Burn. No Inhalation Injury, not intubated, normotensive GCS >14
- **Yellow (serious):** 10-20% TBSA 2nd/3rd Degree Burn. Suspected Inhalation Injury or potentially requiring intubation, normotensive GCS >14
- **Red (critical):** >20% TBSA 2nd/3rd Degree Burn. Burns with multiple trauma, burns with definitive airway compromise

**Priority Patients**

- Pediatrics are defined as anyone under the age of 14 years old
- Priority for red patients/patients with a head injury will be transferred to a level 1 or 2 facility
## C. WRBCC JOB ACTION SHEETS

**WRBCC COORDINATOR**

COORDINATION CENTER – JOB ACTION SHEET

<table>
<thead>
<tr>
<th>Immediate/First 24 Hours Activities</th>
<th>Done</th>
<th>Date</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td><strong>Partner Notification</strong> – notify ABA leadership and WRBDC members of the BMCI, and enlist help as necessary.</td>
<td></td>
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</tr>
<tr>
<td><strong>Burn Bed Census</strong> – conduct bed census counts immediately and after 24 hours to identify available burn beds for patient transfer.</td>
<td></td>
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</tr>
<tr>
<td><strong>Assistance Requests</strong> – request assistance (including resources, transferring and/or care of patients) from region member facilities, EMS, and/or adjacent regions.</td>
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</tr>
<tr>
<td><strong>Situational Awareness</strong> – provide updates to WRBDC members, partners and all other appropriate agencies, including bed census reports and incident action plans (IAPs) or situation reports as necessary.</td>
<td></td>
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</tr>
<tr>
<td><strong>Initial Patient Coordination</strong> – assist the affected local burn center and state public health in determining appropriate patient destinations and transportations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ongoing Response Activities</th>
<th>Done</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Matching</strong> – assist with bed matching, ie finding the right bed and facility for each patient requiring transfer coordination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Information</strong> - facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Tracking</strong> - assist with the tracking of patient movement including arrival at destination centers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Situational Awareness</strong> – continue to provide updates to all partners, including bed census reports and incident action plans (IAPs) or situation reports as necessary.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resource Requests</strong> - facilitate requests for tissue bank products, graft equipment or other specialized supplies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Federal Partner Coordination</strong> - facilitate staff and supply needs with ASPR Regional Emergency Coordinator (REC).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demobilization</th>
<th>Done</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incident Conclusion</strong> - establish when the BMCI has concluded, in collaboration with state and regional partners.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>After Action</strong> - identify any post-incident system needs and initiate the After Action Report process.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
WRBCC MEDICAL CONTROL  
COORDINATION CENTER – JOB ACTION SHEET

<table>
<thead>
<tr>
<th>Immediate &amp; Ongoing Activities</th>
<th>Done</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Technical Assistance</strong> – assist the affected local burn center and/or non-burn facility by providing expert advice or telemedicine as requested.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Destinations</strong> – assist the affected local burn center and state public health in determining appropriate patient destinations and transportation.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bed Matching</strong> – assist with bed matching, ie finding the right bed and facility for each patient requiring transfer coordination, being mindful of family units.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Information</strong> – facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Tracking</strong> – assist with the tracking of patient movement including arrival at destination centers.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resource Requests</strong> – facilitate requests for tissue bank products, graft equipment or other specialized supplies in collaboration with local and state partners and the American Burn Association (ABA).</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Situational Awareness</strong> – provide updates to WRBDC members and partners as requested.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demobilization</th>
<th>Done</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Follow-up</strong> – assist in disseminating outpatient follow-up guidance for burn patients in the affected area as requested.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Follow-up</strong> – assist with psychosocial follow-up and after care programming in the affected area as requested.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>After Action</strong> – identify any post-incident system needs and participate in the After Action Report process.</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# D. WRBDC BMCI Patient Medical Data Form

## Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>M/F</td>
</tr>
<tr>
<td>Weight</td>
<td>kg/lb</td>
</tr>
<tr>
<td>Burn Date</td>
<td></td>
</tr>
<tr>
<td>Burn Type</td>
<td></td>
</tr>
<tr>
<td>TBSA</td>
<td></td>
</tr>
<tr>
<td>Mechanism of Injury</td>
<td></td>
</tr>
<tr>
<td>Inhalation injury</td>
<td>Y/N</td>
</tr>
<tr>
<td>Intubated</td>
<td>Y/N</td>
</tr>
<tr>
<td>Fluid Resuscitated</td>
<td>Y/N</td>
</tr>
<tr>
<td>Peripheral IV</td>
<td></td>
</tr>
<tr>
<td>Intubated</td>
<td>Y/N</td>
</tr>
<tr>
<td>Escharotomy</td>
<td></td>
</tr>
<tr>
<td>Fasciotomy</td>
<td></td>
</tr>
<tr>
<td>Referring Hospital</td>
<td></td>
</tr>
<tr>
<td>Referring Physician</td>
<td></td>
</tr>
<tr>
<td>Accepting Hospital</td>
<td></td>
</tr>
<tr>
<td>Accepting Physician</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Completed</td>
<td>Y/N</td>
</tr>
<tr>
<td>Notification</td>
<td></td>
</tr>
<tr>
<td>☐ Spouse/S.O.</td>
<td></td>
</tr>
<tr>
<td>☐ Parent</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Contact Number</td>
<td></td>
</tr>
</tbody>
</table>

## Code Status

- Full code/No code: ☐DNR ☐DNI ☐Advanced directives: Is Document Present: Y/N
- Traumatic Injuries: Y/N Type:
- Diabetic: Y/N last meal: ___ Insulin Drip: Y/N Last Blood Sugar (date, time & value):
- Tetanus Booster: Y/N (Last Date of Tetanus):
- Critical Meds- MAR Attached: Y/N (if not attached: include medication, dose, route & time given):
- Critical Labs:
- Pertinent DX Exams:

## Organ Systems

<table>
<thead>
<tr>
<th>System</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro</td>
<td>Dx:</td>
</tr>
<tr>
<td></td>
<td>GCS:</td>
</tr>
<tr>
<td></td>
<td>PERRLA:</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Dx:</td>
</tr>
<tr>
<td></td>
<td>ETT Size:</td>
</tr>
<tr>
<td></td>
<td>Depth:</td>
</tr>
<tr>
<td></td>
<td>FiO2:</td>
</tr>
<tr>
<td>Vent Settings</td>
<td></td>
</tr>
<tr>
<td>Chest tube</td>
<td></td>
</tr>
<tr>
<td>ABG</td>
<td></td>
</tr>
<tr>
<td>COVID19 Status</td>
<td>☐ Positive + ☐ Negative - ☐ Person Under Investigation (PUI)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Dx:</td>
</tr>
<tr>
<td>Rhythm/ Ectopy</td>
<td></td>
</tr>
<tr>
<td>Vasoactive Drips</td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td>Dx:</td>
</tr>
<tr>
<td>Foley: Y/N</td>
<td></td>
</tr>
<tr>
<td>Volume last hour</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Y/N</td>
</tr>
<tr>
<td>Last Dialysis(Date/Time)</td>
<td></td>
</tr>
<tr>
<td>Gl</td>
<td>Dx:</td>
</tr>
<tr>
<td>NPO: Y/N</td>
<td></td>
</tr>
<tr>
<td>Reason:</td>
<td></td>
</tr>
<tr>
<td>Feeding Tube: Y/N</td>
<td></td>
</tr>
</tbody>
</table>

## Sending Facility

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time &amp; Date Departed:</td>
<td></td>
</tr>
<tr>
<td>Equipment Sent with Patient:</td>
<td></td>
</tr>
<tr>
<td>☐ IV Pumps:</td>
<td></td>
</tr>
<tr>
<td>☐ Monitor:</td>
<td></td>
</tr>
<tr>
<td>☐ Pulse Oximeter:</td>
<td></td>
</tr>
<tr>
<td>Ventilator/CPAP/BIPAP:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Items Sent with the Patient:</td>
<td></td>
</tr>
</tbody>
</table>

## Receiving Facility

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time &amp; Date Arrived:</td>
<td></td>
</tr>
<tr>
<td>Received by:</td>
<td></td>
</tr>
<tr>
<td>Receiving Facility MR#:</td>
<td></td>
</tr>
<tr>
<td>Equipment Received with Patient:</td>
<td></td>
</tr>
<tr>
<td>Items Received with patient:</td>
<td></td>
</tr>
</tbody>
</table>
WRBDC BMCI PATIENT MEDICAL DATA FORM

MRN: ________________________

Interpreter: Y / N  Language:  Sign Language: Y / N  COVID19 Status: Positive + / Negative - / PUI

Past Medical History:

Allergies:

Medications: (include dose, route & time given)

All Continuous IV infusions: (include rate & dose)

Feeding Tube: (include formula type & rate)

Labs:

<table>
<thead>
<tr>
<th>Na</th>
<th>Cl</th>
<th>BUN</th>
<th>Gluc</th>
<th>WBC</th>
<th>Hgb</th>
<th>Hct</th>
<th>Mag</th>
<th>Phos</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>CO2</td>
<td>Creat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Narrative Summary of Care:

![Burn Diagram]

COLOR CODE

X/Rad—30

Red—3rd
E. CRISIS STANDARDS OF CARE
BURN TRIAGE DECISION TABLE

Burn Crisis Standards of Care planning efforts have provided guidelines to follow when numbers of seriously ill patients greatly surpasses the capability of available care and normal standards of care can no longer be maintained. Among the planning documents created for this purpose are burn triage decision tables, as seen on the following page. The tables included here illustrate the anticipated ratio of resources to benefit from the treatment of burns of various sizes in various aged patients. Each category reflects both the volume of resources necessary to care for the patients in each group, and the expected outcome based on data extracted from the American Burn Association National Burn Repository. The 2014 ABA chart has been modified for Utah’s Crisis Standards of Care Plan, with permission, and is shown on the next page. The references for this table and the most current one are as follows:


Please note that application of these guidelines will require physician judgement at point of care, and their use may require governor approval, depending on state protocols. These tables do not account for other coexisting conditions or concomitant trauma, which should be considered when making transfer or triage decisions.

Use the following color definitions for the Burn Triage Tables found on the following page:

<table>
<thead>
<tr>
<th>COLORED CATEGORY</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Survival and good outcome expected without requiring initial admission.</td>
</tr>
<tr>
<td>Very High</td>
<td>Mortality ≤10%, anticipated length of stay ≤14-21 days, 1-2 surgical procedures.</td>
</tr>
<tr>
<td>High</td>
<td>Mortality ≤10%, anticipated length of stay ≥14-21 days, multiple surgical procedures.</td>
</tr>
<tr>
<td>Medium</td>
<td>Mortality 10-50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures.</td>
</tr>
<tr>
<td>Low</td>
<td>Mortality 50-90%, even with provision of prolonged, intensive resources.</td>
</tr>
<tr>
<td>Expectant</td>
<td>Mortality ≥90%, even with prolonged aggressive care.</td>
</tr>
</tbody>
</table>
CSC BURN TRIAGE DECISION TABLE, CONT.

*Please refer to the explanation, reference & colored categories on the previous page.

### CSC BURN TRIAGE DECISION TABLE, CONT.

#### CSC BURN TRIAGE DECISION TABLE, CONT.

**Burn Size Group, %TBSA All**

<table>
<thead>
<tr>
<th>Age</th>
<th>0-9.9</th>
<th>10-19.9</th>
<th>20-29.9</th>
<th>30-39.9</th>
<th>40-49.9</th>
<th>50-59.9</th>
<th>60-69.9</th>
<th>70-79.9</th>
<th>80-99.9</th>
<th>≥ 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1.99</td>
<td>Very High</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>1.99-4.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>5-19.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>20-29.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>30-39.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>40-49.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>50-59.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>60-69.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>≥ 70</td>
<td>Very High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
</tbody>
</table>

#### CSC BURN TRIAGE DECISION TABLE, CONT.

**Burn Size Group, %TBSA NO Inhalation Injury**

<table>
<thead>
<tr>
<th>Age</th>
<th>0-9.9</th>
<th>10-19.9</th>
<th>20-29.9</th>
<th>30-39.9</th>
<th>40-49.9</th>
<th>50-59.9</th>
<th>60-69.9</th>
<th>70-79.9</th>
<th>80-99.9</th>
<th>≥ 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1.99</td>
<td>Very High</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>1.99-4.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>5-19.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>20-29.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>30-39.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>40-49.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>50-59.99</td>
<td>Outpatient</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>60-69.99</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>≥ 70</td>
<td>Very High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
</tbody>
</table>

#### CSC BURN TRIAGE DECISION TABLE, CONT.

**Burn Size Group, %TBSA WITH Inhalation Injury**

<table>
<thead>
<tr>
<th>Age</th>
<th>0-9.9</th>
<th>10-19.9</th>
<th>20-29.9</th>
<th>30-39.9</th>
<th>40-49.9</th>
<th>50-59.9</th>
<th>60-69.9</th>
<th>70-79.9</th>
<th>80-99.9</th>
<th>≥ 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1.99</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
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<td>Low</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>1.99-4.99</td>
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<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
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<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>20-29.99</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>30-39.99</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>40-49.99</td>
<td>Very High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>50-59.99</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>60-69.99</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
</tr>
<tr>
<td>≥ 70</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Expectant</td>
<td>Expectant</td>
<td>Expectant</td>
<td>Expectant</td>
</tr>
</tbody>
</table>
F. WRBCC MOBILE TASK FORCE GO-BAGS

BURN COORDINATION CENTER - BURN MASS CASUALTY INCIDENT

**PHYSICIAN**

**Front Pocket - Resources**
- Notebook
- MD edition resource clip board
- 1–Sharpie / 4 – Pens / 2-Red/blue pencil / Pencil sharpener
- Calculator

**Second pocket - Personal Supplies**
- Shampoo / Conditioner / toothpaste/toothbrush/bar soap
- 1 pack wipes / 1 Hand sanitizer
- 2 pouches-Tylenol /4 tablets- Advil
- Snack pack – crackers, gum, and granola bars
- Charging plug

**Main Pocket**
- Water bottle
- Safety glasses
- 1 – Arrowgard MAC two- lumen Central venous access kit
- IV start kits (Adult and pediatric)
- 1-Lac Kit
- Stethoscope
- Trauma shears
- Tourniquet
- Head lamp
- Carabiner

**REGISTERED NURSE (R.N.)**

**Front Pocket - Resources**
- Notebook
- Lippincott drug book for nurses
- Broselow tape
- Nursing edition resource clip board
- 2 – Sharpies / 4 – Pens / Red/blue pencil / Pencil sharpener

**Second pocket - Personal Supplies**
- Shampoo / Conditioner / toothpaste/toothbrush/bar soap
- 1 pack wipes /2 bottles Hand sanitizer
- 2 pouches-Tylenol /4 tablets- Advil
- Snack pack – crackers, gum, and granola bars
- Charging plug
Main Pocket
- Water bottle
- Small / medium / large gloves
- Safety glasses
- Hats / Gowns
- Masks / Ear loop masks / N95 regular & small
- 1 - Full shower table plastic
- Head lamp
- Carabiner

Patient Assessment
- B/P
- Stethoscope
- Finger sat monitor
- Trauma shears
- Tourniquet

ASSISTANT

Front Pocket - Resources
- Notebook
- Nursing edition resource clip board
- 1 – Sharpie / 4 – Pens / Red/blue pencil

Second pocket - Personal Supplies
- Shampoo / Conditioner / toothpaste/toothbrush/bar soap
- 1 pack wipes / bottle Hand sanitizer
- 2 pouches-Tylenol / 4 tablets - Advil
- Snack pack – crackers, gum, and granola bars

Main Pocket
- Water bottle
- Power strip
- 6-largewound veil packs
- 13-stat wrap
- Safety glasses
- Head lamp
- Carabineer
- Stethoscope
- Trauma shears
- Tourniquet
- Burn paperwork
- Burn CSC Guidelines
G. HIPAA and Disasters: What Emergency Professionals Need to Know

Disasters and emergencies can strike at any time with little or no warning and the local healthcare system in the midst of an emergency response can be rapidly inundated with patients, worried family and friends looking for their loved ones, and media organizations requesting patient information. Knowing what information can be released, to whom, and under what circumstances, is critical for healthcare facilities in disaster response. This guide is designed to answer frequently asked questions regarding the release of information about patients following an incident.

NOTE: This guide does NOT replace the advice of your facility Privacy Officer and/or legal counsel who should be involved in planning for information release prior to an event, developing policy before a disaster that guides staff actions during a disaster, and during an emergency when contemplating disclosures.

This guide does address what information can be disclosed and under what circumstances. Covered entities can disclose needed patients’ protected health information (PHI) without individual authorization:

- If necessary to treat the patient or a different patient or if the information would help treat a different patient
- To a public health authority, as outlined below
- At the direction of a public health authority, to a foreign agency acting in collaboration with the public health authority
- To persons at risk of contracting or spreading a disease or condition (if authorized by other law)
- With certain people involved with patient’s care/ responsible for the patient
- When there is imminent threat to public health/safety

What is HIPAA and the Privacy Rule?
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, the HIPAA Privacy, Security, and Breach Notification Rules, protect the privacy and security of patients’ PHI, but is balanced to ensure that

Covered entities:
- Health plans
- Healthcare clearinghouses
- Healthcare providers (e.g. hospitals, clinics, pharmacies, nursing homes) who conduct one or more covered healthcare transactions electronically.

Business associates:
- Persons or entities that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI.
- Subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.
appropriate uses and disclosures of the information may still be made when necessary to treat a patient, to protect the nation’s public health, and for other critical purposes.

**Does HIPAA Apply to Me or My Organization?**
The HIPAA Privacy Rule applies to disclosures made by employees, volunteers, and other members of a covered entity’s or business associate’s workforce. Covered entities are health plans, healthcare clearinghouses, and those healthcare providers that conduct one or more covered healthcare transactions electronically, such as transmitting healthcare claims to a health plan.

Business associates generally include persons or entities (other than members of the workforce of a covered entity) that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI. Business associates also include subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.

HIPAA does not apply to disclosures made by those who are not covered entities or business associates (although such persons or entities are free to follow the standards on a voluntary basis if desired).

**When Can PHI Be Shared?**
Patient health information, or PHI, can be shared under the following circumstances:

**Treatment.** Under the HIPAA Privacy Rule, covered entities may disclose, without a patient’s authorization, PHI about the individual as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of healthcare and related services by one or more healthcare providers and others, consultation between providers, providing follow-up information to an initial provider, and the referral of patients for treatment.

**Public Health Activities.** The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to PHI that is necessary to carry out their public health mission. Therefore, the HIPAA Privacy Rule permits covered entities to disclose needed PHI without individual authorization:

- **To a public health authority** that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability, or to a person or entity acting under a grant of authority from or under contract with such public health agency. This could include, for example: the reporting of disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions.

- **At the direction of a public health authority**, to a foreign government agency that is acting in collaboration with the public health authority.
• To persons at risk of contracting or spreading a disease or condition if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations.

Disclosures to Family, Friends, and Others Involved in an Individual's Care and for Notification. A covered entity may share PHI with a patient’s family members, relatives, friends, or other persons identified by the patient as involved in the patient’s care. A covered entity may also share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient’s care, of the patient’s location, general condition, or death. This may include—if necessary to notify family members and others—the police, the press, or the public at large.

• The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient’s best interest.

• In addition, a covered entity may share PHI with disaster relief organizations such as the American Red Cross, which are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient’s care, of the patient’s location, general condition, or death. It is unnecessary to obtain a patient’s permission to share the information in this situation if doing so would interfere with the organization’s ability to respond to the emergency.

Imminent Danger. Healthcare providers may share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public—consistent with applicable law (such as state statutes, regulations, or case law) and the provider’s standards of ethical conduct.

Disclosures to the Media or Others Not Involved in the Care of the Patient/Notification. Upon request for information about a particular patient by name, a hospital or other healthcare
facility may release limited facility directory information to acknowledge an individual is a patient at the facility and provide basic information about the patient’s condition in general terms (e.g., critical or stable, deceased, or treated and released) if the patient has not objected to or restricted the release of such information or, if the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. Reference 45 CFR 164.510(a). In general, except in the limited circumstances described elsewhere, affirmative reporting to the public or media of specific information about treatment of an identifiable patient, such as specific tests, test results or details of a patient’s illness, may not be done without the patient’s written authorization (or the written authorization of a personal representative who is legally authorized to make healthcare decisions for the patient).

General or aggregate information in mass casualty events that does not identify an individual or meets the requirements of the HIPAA Privacy Rule’s de-identification provisions is not considered PHI (e.g., X number of casualties were received by the hospital with the following types of injuries).

**Minimum Necessary.** For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the “minimum necessary” to accomplish the purpose. (Minimum necessary requirements do not apply to disclosures to health care providers for treatment purposes.) Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose.

*Note:* The disclosures listed above are at the discretion of the covered entity and are not required disclosures under the Rule. Some of these disclosures may be required by other federal, state or local laws (for example, mandatory reporting of positive infectious disease test results).

**Does the HIPAA Privacy Rule Permit Disclosure to Public Officials Responding to a Bioterrorism Threat or other Public Health Emergency?**

Yes. The HIPAA Privacy Rule recognizes that various agencies and public officials will need PHI to deal effectively with a bioterrorism threat or emergency. The public health threat does not have to reach a declared emergency status. If information is needed by a government agency to protect the health of the public (e.g., a food-borne outbreak), the agency may request and receive appropriate clinical and other information about the patient’s disease, care, and response to treatment. To facilitate the communications that are essential to a quick and effective response to such events, the HIPAA Privacy Rule permits covered entities to disclose needed information to public officials in a variety of ways. Further, if the covered entity has obligations to report test results and other information to public health agencies by statute, rule, or ordinance, the HIPAA Privacy Rule generally permits these disclosures.
Covered entities may disclose PHI, without the individual's authorization, to a public health authority acting as authorized by law in response to a bioterrorism threat or public health emergency (reference 45 CFR 164.512(b)), public health activities. The HIPAA Privacy Rule also permits a covered entity to disclose PHI to public officials who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism (reference 45 CFR 164.512(j)), to avert a serious threat to health or safety. In addition, disclosure of PHI, without the individual's authorization, is permitted where the circumstances of the emergency implicates law enforcement activities (reference 45 CFR 164.512(f)); national security and intelligence activities (reference 45 CFR 164.512(k)(2)); or judicial and administrative proceedings (reference 45 CFR 164.512(e)).

Is the HIPAA Privacy Rule “Waived” or “Suspended” During an Emergency?
The HIPAA Privacy Rule is not suspended during a public health or other emergency; however, under certain conditions the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the HIPAA Privacy Rule section 1135(b)(7) of the Social Security Act, if such a waiver is deemed necessary for the particular incident when the Secretary declares a public health emergency and the President declares an emergency or disaster under the Stafford Act or National Emergencies Act. For more information, access “Is the HIPAA Privacy Rule suspended during a national or public health emergency?” Access Hurricane Irma and HIPAA Bulletin: Limited Waiver of HIPAA Sanctions and Penalties During a Declared Emergency for an example of how sanctions and penalties could be waived in a declared emergency.

Does the HIPAA Privacy Rule Permit Disclosure to Law Enforcement?
A HIPAA-covered entity may disclose PHI to law enforcement with the individual’s signed HIPAA authorization. A covered entity may disclose directory information as mentioned above to law enforcement upon request. Further disclosures to law enforcement for purposes of re-unification and family notification are permitted as discussed above.

A HIPAA-covered entity also may disclose PHI to law enforcement without the individual’s signed HIPAA authorization in certain incidents, including:

- To report to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.
- To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the premises of the covered entity.
- To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.
- When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity.
- To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds).
- To comply with a court order or court-ordered warrant, a subpoena or summons issued
• by a judicial officer, or an administrative request from a law enforcement official (the administrative request must include a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used).

• To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person, but the information disclosed must be limited to certain basic demographic and health information about the person.

• To respond to a request for PHI about an adult victim of a crime when the victim agrees (or in limited circumstances if the individual is unable to agree). Child abuse or neglect may be reported, without a parent’s agreement, to any law enforcement official authorized by law to receive such reports.

How Does the HIPAA Privacy Rule Apply to Disclosures Involving Foreign Nationals?
Covered entities may disclose PHI for all persons, regardless of nationality, according to the disclosures listed in the Privacy Rule and discussed above. Disclosure of PHI to embassies, consulates or other third parties, such as the American or International Red Cross acting in a capacity to facilitate notifications or repatriation following an emergency, is permitted under the existing disclosures of the HIPAA Privacy Rule, as referenced above.

For More Information
• Bulletin: HIPAA Privacy in Emergency Situations
• Can healthcare information be shared in a severe disaster?
• Health Information Privacy – Is HIPAA Privacy Rule Suspended during a National or Public Health Emergency?
• Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement
• HIPAA Privacy Rule: Disclosures for Emergency Preparedness – A Decision Tool
• Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations
• When does the Privacy Rule allow covered entities to disclose PHI to law enforcement officials?
• HIPAA Policy Brief

For more information on HIPAA and Public Health:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html

For more information on HIPAA and Emergency Preparedness and Response:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/index.html

General information on understanding the HIPAA Privacy Rule may be found at:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html
**H. WOUND CARE SUPPLY GUIDELINE FOR BURNS**

Taken from the *Utah Crisis Standards of Care Guidelines, Appendix B: Burn Crisis Standards of Care*.

Suggested wound care supplies for the treatment of ten patients with 50% TBSA burns for three dressing changes.

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound Veil (24in x 36 in)</td>
<td>30 packets</td>
<td>Two sheets per pack. If Wound Veil is unavailable, Adaptic can be substituted. There are approximately six 9x16 Adaptics to one package of veil, equaling 180 packages.</td>
</tr>
<tr>
<td>Mesh Guaze (18in x 18in)</td>
<td>30 boxes</td>
<td>6 gauze per pack. If Wound Veil is unavailable, Adaptic can be substituted. There are approximately six 9x16 Adaptics to one package of veil, equaling 180 packages.</td>
</tr>
<tr>
<td>Fluff roll or Kerlix (4.5 x 4.1 yd)</td>
<td>150 rolls</td>
<td>Estimated at 5 rolls per dressing.</td>
</tr>
<tr>
<td>Kerlix sponges (4in x 4in)</td>
<td>30 boxes</td>
<td>10 sponges per box</td>
</tr>
<tr>
<td>Tubular elastic dressing retainer #1</td>
<td>2 boxes</td>
<td>50 yds per box</td>
</tr>
<tr>
<td>Netting # 3</td>
<td>2 boxes</td>
<td>50 yds per box</td>
</tr>
<tr>
<td>Netting # 5</td>
<td>2 boxes</td>
<td>50 yds per box</td>
</tr>
<tr>
<td>Netting # 8</td>
<td>2 boxes</td>
<td>50 yds per box</td>
</tr>
<tr>
<td>Netting # 11</td>
<td>2 boxes</td>
<td>50 yds per box</td>
</tr>
<tr>
<td>Betasept 4% (960 ml) or a mild, non-perfumed soap or baby shampoo.</td>
<td>15 bottles of Betasept 30 bars of soap, 1 per patient per day 30 1 fluid oz bottles of baby shampoo, 1 per dressing change Can use 5 bottles of Betasept per day for the 10 patients and put at a central location; NOT in the patients room due to cross contamination risk.</td>
<td></td>
</tr>
<tr>
<td>Basin (large)</td>
<td>15</td>
<td>This number includes 5 extra in case additional are needed.</td>
</tr>
<tr>
<td>Scissors sharp/blunt</td>
<td>30 pairs</td>
<td>Could decrease this number to 20</td>
</tr>
<tr>
<td>Tape (1 in x 10 yds)</td>
<td>30 rolls</td>
<td></td>
</tr>
<tr>
<td>Elastic bandage (4in x 4.5yd)</td>
<td>4 bundles (total of 40 Aces)</td>
<td>10 bandages per bundle</td>
</tr>
</tbody>
</table>

This is a simplified list containing only burn-specific supplies. Other items that could be required would include personal protective equipment, IV tubing, LR (suggest 100 liter bags), topical ointments or silver-impregnated products, warming blankets, heater unit (3 units with 10 blankets), IV/blood warmers with tubing (3 units and 30 sets of tubing). Optimally, supply carts are locked and burn wound care fast reference cards are laminated and tied to the cart. In the event that dressing supplies are exhausted, burn wounds can be placed in a topical ointment/wound product and dressed with clean cotton t-shirts, socks, gloves, biker shorts, onesies, maxi pads or diapers.
I. 96 HOUR PLAN
Module 1 - Initial Assessment & Management

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained. Utilization of all levels of care are equal to best care, even in a resource-rich environment.

**Essential Care**
This is the minimum care given to patients based on your available resources.

**No Access to Advanced Airway/Respiratory Supplies**

**Primary Survey – Airway & Breathing**
- Assess for early signs of upper airway burns
- Monitor for changes in mental status, hypoxia, hoarse voice or stridor
- Open airway using manual maneuvers or airway adjuncts (nasopharyngeal (NPA)/ oropharyngeal airway (OPA))
- Administer high flow oxygen using a non-rebreather mask or via nasal cannula or mask
- Maintain patient in sitting or head elevated position to minimize upper airway edema
  - Consider spinal precautions
- Use walking wounded to Bag Valve Mask (BVM) ventilate if necessary

**Circulation**
- Monitor for signs of shock

**Deficits**
- Monitor for changing level of consciousness

**Exposure**
- Remove all clothing
  - Decontaminate patient if chemical exposure

**Secondary Survey**
- Perform head-to-toe assessment
- Obtain patient history
- Document essential information
- Resuscitate with salt-containing fluids
- Priority should be given to:
  - Adults with burns ≥20% TBSA injury
  - Pediatric patients with burns ≥10%
  - Associated trauma with blood loss
- Use Oral Resuscitation Therapy (ORT) if IV access is unavailable
  - Up to 20% TBSA
  - Consider in up to 40% TBSA
  - Sips every five minutes, at least four cups/hr. (1 liter)
  - Wait 10 minutes after vomiting
- Use rectal infusion therapy if ORT restricted/no IV
  - Tap water or saline up to 400 ml/hr.
- Adjust fluids based on heart rate, capillary refill and mental status
- Minimize patient exposure time
- Warm the room
Avoid cold surfaces
- Keep patient warm and dry, do not use wet dressings or wet blankets
- Wrap in a space blanket/plastic wrap/large plastic bag/aluminum foil if clean dry blankets are not available
- Measure patient temperature every four hours
- If temperature is <37°C (98.6°F)
  - Consider having patient lie close to family member to gain heat
- Evaluate the patient for pain and anxiety
- Assess with a standardized metric
  - Under austere conditions a pain level goal of 6-8/10 may be considered
- Non-pharmacologic interventions:
  - Elevate burned extremities
  - Decrease external stimuli
  - Do not use excessive pressure when handling wounds
  - Use hypnosis and/or virtual reality if available
  - Use family/friends for support
- Use all your resources so patients do not die from a correctable cause (e.g., use laymen to bag ventilate)
- Focus efforts on the moderate (30-60%) burns rather than the minor or severe
- Consider treating some severe as expectant if appropriate
- Call for resources (transportation, supplies, disaster plan activation, or just advice) early
- Do not forget the basics in the first hours – airway, fluids, analgesia
- Transfer patients as soon as possible to make room for more

**Better Care**
Better care builds on essential care and is based on available resources.

**Some Access to Advanced Airway/Respiratory Supplies**

**Primary Survey – Airway and Breathing**
- Apply cooled humidified oxygen to minimize upper airway edema
- Maintain airway and provide ventilation using
  - Laryngeal Mask Airway (LMA) / High Flow Nasal Cannula / CPAP
- Bag Mask Valve (BVM) ventilation performed by providers
- Begin IV fluid resuscitation
- Primary Survey initial start rates:
  - 0-5 years: 125 cc/hr.
  - 6-13 years: 250 cc/hr.
  - 14 years and older: 500 cc/hr.

**Secondary Survey**
- Document history and physical on patient record
- Calculate TBSA and adjust fluid rate:
  - Body weight in kg x % TBSA burns x 2-4 ml of Lactated Ringers or isotonic crystalloid over 24 hrs.
  - Administer 50% during the first eight hours following the burn
- May use a pre-calculated Parkland Formula fluid infusion chart to begin resuscitation
- Use two clean dry blankets to cover the patient
- Measure patient temperature every two hours
If temperature is <37° C (98.6° F):
- Use warm IV fluid if possible
- Use forced air warming blanket if available

Consider oral routes of medication delivery in small (<20% TBSA injury)
- Consider NSAIDs, acetaminophen, gabapentin and benzodiazepines
- Use weight-based, incremental dosing with appropriate frequency to obtain adequate relief
- Use standardized pain scale metrics to quantify pain and anxiety level
- Be prepared to use any medication available for pain treatment
  - Think outside the box
- Consider how resources can be conserved
  - Adapt strategies or substitute medications to make what you have go further
- Do not withhold more resources than you have to (proportionality)
- Re-evaluate as the situation evolves

Best Care  
Best care builds on better and essential care and is based on available resources.

Access to Advanced Airway/Respiratory Supplies

Primary Survey – Airway & Breathing
- Intubate at the first signs of airway edema: hoarseness, stridor, or progressive voice change
- If insufficient ventilators
  - Use walking wounded to bag patient
  - Assess whether T-piece blow-by oxygen directly attached to the ETT may be sufficient
  - Use transport ventilators in those with minimal airway needs
  - Consider ventilator sharing in those with similar injuries
- Consider nasopharyngeal endoscopy or video-assisted laryngoscopy in airway assessment
- Consider bougie-assisted endotracheal intubation/intubating bronchoscope in edema obscuring landmarks
- Perform cricothyrotomy in patients with edema who cannot be intubated

Secondary Survey
- Burn Center consult via telemedicine or other available method
- Use Lactated Ringers
  - If unavailable another isotonic crystalloid can be used
- Dextrose containing fluids should NOT be used for burn resuscitation
  - Exception in the very young who require a glucose source in addition to resuscitation fluid
- Perform ongoing patient temperature evaluation
- If temperature is <37° C (98.6° F) treat according to Evidence Based Warming Strategies in Trauma
  - Radiant warmer
  - Humidified ventilation
  - Circulating water garment
  - Consider body cavity lavage, continuous arteriovenous warming, extracorporeal membrane oxygenation/bypass
- Intravenous opioids are the appropriate initial treatment for acute burn pain
  - Unless the injury is minor
Consider the Intraosseous route
Consider use of IV benzodiazepines to alleviate anxiety and augment pain control
Use standardized metrics to quantify pain and anxiety level
- Lower pain levels of 2-4/10 are desired
Consult with a burn center and distribute patients to burn/burn surge facilities
Follow local and regional burn coordination mechanisms for movement of patients and supplies
Use transfer vehicles/aircraft to bring supplies and personnel when appropriate

Additional Guidelines

Rule of Nines

Rule of Palms

Examples of Oral Rehydration Solutions

- One Liter of clean water/one teaspoon of table salt (3 g)/three tablespoons of sugar (36 g or nine sugar cubes)
- Sports drinks such as Gatorade® or PowerAde®

Patient’s hand = 1%
Total Body Surface Area
96 HOUR PLAN - MODULE 2

0 to 48 Hours

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained. Utilization of all levels of care are equal to best care, even in a resource-rich environment.

**Essential Care** This is the minimum care given to patients based on your available resources.

**No Access to Advanced Airway/Respiratory Supplies**

- Frequent respiratory assessment and communication with provider
- Provide oxygen via nasal cannula or mask
  - Oxygen saturation of 90-92% is acceptable
- Open airway using airway adjuncts (nasopharyngeal (NPA)/oropharyngeal airway (OPA))
- Suction secretions as needed
- Maintain patient in sitting or head elevated position
  - Consider spinal precautions
- Estimate each patient’s burn size (TBSA %)
  - Do not include first degree burns in the TBSA % estimate
  - Use “Rule of Nines” for large burns
  - For smaller burns, patient’s palm (including fingers) is approximately 1% TBSA
- Resuscitate with salt-containing fluids
  - Adults with burns ≥20% TBSA injury
  - Pediatric patients with burns ≥10%
- Use Oral Resuscitation Therapy (ORT) if IV access is unavailable
  - Up to 20% TBSA
  - Consider in up to 40% TBSA
- Use rectal infusion therapy if ORT restricted/no IV
  - Tap water or saline up to 400 ml/hr.
- Adjust fluids based upon heart rate, capillary refill and mental status
- Elevate burned extremities
- Monitor pulses hourly
  - Cut hole in dressings if wounds are wrapped
- Educate about why burns are painful
- Differentiate between pain and anxiety
- Assess with a standardized metric:
  - Every four hours
  - Pre- and post-intervention assessment
  - Under austere conditions a pain level goal of 6-8/10 may be considered
- Use non-pharmacologic interventions
  - Elevate burned extremities
  - Cover the injured areas
  - Minimize mechanical handling and cleaning
  - Hypnosis
Virtual reality
- Emphasis on acute and severe pain if resource-limited
- Provide adequate pain control and anxiolysis if possible
- Avoid scrubbing motions when cleaning
- Use only enough pressure to remove loose debris
  - Do not try to scrub off intact eschar
- Have patients with small burns (<10% TBSA injury) wound care performed by self/friend/family
- If lack of supplies or personnel leave wounds open (open technique)
  - Still requires careful and ongoing wound evaluation
- Perform dressing changes in a clean environment
  - Use clean water
  - Perform hand hygiene
- Select most appropriate, available topical or solution
- Reassess wounds with each dressing change
- Use oral intake of meals and supplements to support burn injuries ≤20% TBSA
  - Supplements may include any local option with calories and protein

Better Care
Better care builds on essential care and is based on available resources.

Some Access to Advanced Airway/Respiratory Supplies
- Maintain airway and provide ventilation using
  - Laryngeal Mask Airway (LMA) / High Flow Nasal Cannula / CPAP
- Bag Mask Valve (BVM) ventilation performed by providers
- Debride the wound
- Have a second practitioner confirm the TBSA % calculations
- Oral Resuscitation Therapy (ORT) drinking “schedule” to meet targets
  - Sips every five minutes
  - Wait 10 minutes after vomiting
  - At least four cups/hr. (1 liter)
- Collect urine output in a graduated container
- Use IV or IO access for larger or more complicated burns
  - Large bore IV
  - Avoid circumferentially burned extremity
- Use Doppler flow meter for hourly pulse checks
- Perform escharotomy
  - If unable to palpate distal pulses
  - Evacuation is delayed
- Use frequent small to moderate doses of analgesics and anxiolytics if available
- Preferential use of oral agents in small (<20% TBSA injury) burns
- Use non-opioid medications as adjuncts
- Use of wound dressings in deep partial and full thickness burns (closed technique)
- Identify and train a wound care team
- Use nutritional supplementation for patients with burns
  - ≥20% TBSA
  - Facial burns
  - Those requiring mechanical ventilation
Consider a feeding tube if resources allow
  o Gastric or enteral
Use clean local resources when no commercial products are available

ORT examples
  • One liter of clean water/one teaspoon of table salt (3 g)/three tablespoons of sugar (36 g or nine sugar cubes)
  • Sports drinks such as Gatorade® or PowerAde®

Best Care
Best care builds on better and essential care and is based on available resources.

Access to Advanced Airway/Respiratory Supplies

Secure Endotracheal Tube (ETT):
  o ETT securement device
  o Tape (non-burned face only, if no other options)
  o Twill tie (burned face)
  o Hold ETT when moving patient and verify depth unchanged
Perform chest x-ray
Place nasogastric tube
Ensure continuous sedation
Complete the Lund and Browder chart
Burn Center consult via telemedicine or other available method
Use LR or other isotonic crystalloid
Calculate using Parkland formula
Titrate based on urine output or other available monitoring techniques
Do not use dextrose containing solutions for resuscitation
  o Exception would be very young patients requiring a glucose source
Perform escharotomy if circumferential 3rd degree burn
Burn Center consult via telemedicine or other available method
Use IV agents for pain management
  o Titrated based upon effect and patient vital signs
Standardized metrics for pain scale
  o Lower pain levels of 2-4/10 are desired
Multimodal plan to control
  o Background pain
  o Breakthrough and procedural pain
Use of durable silver dressings
  o Decreases need for pain control and clean environment for wound care
  o Preserves personnel time and effort
Provide 50-60% of caloric goal in the first week after injury
Additional Guidelines

Burn Estimate and Diagram

Burn Injury Guidelines for Care

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Cause of Burn______________________________

Additional injuries______________________________

Date of Burn ________________

Time of Burn ________________

Age ________________

Sex ______ Sex Weight ______

____________ Kg

Height ______ cm

Date of assessment ______

Time of assessment ______

Assessed by ____________________
96 HOUR PLAN - MODULE 3
48 to 96 Hours

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained. Utilization of all levels of care are equal to best care, even in a resource-rich environment.

**Essential Care**  This is the minimum care given to patients based on your available resources.

- Practice basic infection control concepts
- Do not give prophylactic antibiotics
- Meeting >3 of the following should trigger concern for infection:
  - Temp >39°C (102.2° F) or <36 °C (96.8° F)
  - Progressive tachycardia >110 bpm
  - Tachypnea >25 breaths per minute not ventilated or >12 L/minute ventilated
  - Thrombocytopenia <100,000 three days after initiation of resuscitation
  - Hyperglycemia >200 mg/dl, >7 units of insulin/hour or >25% increase in insulin requirements over 24 hours
  - Feeding intolerance >24 hours
- Reinforce burn pain education
- Continue to differentiate between pain and anxiety and provide psychological support
- Continue to assess with a standardized metric:
  - Every four hours
  - Pre-and post-intervention assessment
  - Under austere conditions a pain level goal of 6-8/10 may be considered
- Continue to use non-pharmacologic interventions
  - Elevate burned extremities
  - Cover the injured areas
  - Minimize mechanical handling and cleaning
  - Hypnosis or Virtual reality if available
  - Use family/friend for psychological support
- Emphasis on patients with acute and severe pain if resource-limited
- Determine overall health status of each patient
- Identify patients who are in shock or developing organ failure
- Repeat burn wound mapping to estimate true %TBSA
- Repeat triage
- Arrange priority transfer of critical patients to a higher level of care with burn surgery capability
- Continue to maintain organ perfusion with maintenance fluids for others
- Watch for and treat infectious complications.
- Continue to provide basic wound care with topical antimicrobials/silver dressings, etc.
- Reassess clinical status of remaining patients
- Use the burn triage table to guide decisions
  - Patients re-triaged as expectant should be those who will most benefit from palliative care
  - Promoting comfort should be the highest priority
- Assess immediately available resources
Better Care  Better care builds on essential care and is based on available resources.

- Discuss future expected resources
- Ensure decisions are made equitably using evidence-based data
- Involve the family and patient in discussions

If infection criteria is met:
  - Culture patient
  - Evaluate wounds/all sources of potential infection
  - Initiate broad-spectrum antibiotics

Follow up of cultures, antibiotic stewardship and de-escalating antibiotics as able is paramount

Discontinue antibiotic use:
  - If cultures are negative
  - If no source is identified

Use frequent small to moderate doses of analgesics and anxiolytics if available

Preferential use of oral agents in small (<20% TBSA injury) burns

Use non-opioid medications as adjuncts

Consider using non-typical medical adjuncts such as cannabis
  - If resources are limited
  - Benefits must outweigh the risks

Arrange priority transfer of the following:
  - All burns who will require extensive burn surgery (>10% TBSA)
  - Burns to anatomically important areas (face, genitals, hands, etc.)

Ensure family, patients and staff have access to psychological specialists

Provide access to spiritual support

Provide patient and family privacy

Use a hospital palliative care team if available

Best Care  Best care builds on better and essential care and is based on available resources.

If infectious source is identified:
  - Obtain source control
  - Treat per infectious guidelines

Use IV agents for pain management
  - Titrated based upon effect and patient vital signs

Standardized metrics for pain scale
  - Lower pain levels of 2-4/10 are desired.

Multimodal plan to control
  - Background pain
  - Breakthrough and procedural pain

Prioritize patients

Transfer those requiring definitive burn wound coverage. (i.e., skin grafting)

Burn Center consult via telemedicine or other available method

Initiate “airway rounds” by select providers

Employ a deliberate system of ventilator allocation by a ventilator triage team

Consider ventilator sharing with like patients

Transfer to an alternative care site (e.g. Hospice or long term care site)
Additional Guidelines

CRISIS STANDARDS OF CARE BURN TRIAGE TABLES. The following crisis standards of care guidelines are to be implemented only when numbers of seriously ill patients greatly surpasses the capability of available care and normal standards of care can no longer be maintained. Application of these guidelines will require physician judgement at point of care. Use of these guidelines may require governor approval, depending on state protocols. These tables do not account for other coexisting conditions or concomitant trauma, which should also be considered in transfer or triage decisions.

### Burn Size Group, % TBSA All

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### Burn Size Group, % TBSA NO Inhalation Injury

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OUTPATIENT: Survival and good outcome expected without requiring initial admission.

VERY HIGH: Mortality ≤10%, anticipated length of stay ≤ 4-21 days, 1-2 surgical procedures.

HIGH: Mortality ≤10%, anticipated length of stay ≥14-21 days, multiple surgical procedures.

MEDIUM: Mortality 10-50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures.

LOW: Mortality 50-90%, even with provision of prolonged, intensive resources.

EXPECTANT: Mortality ≥90%, even with prolonged aggressive care.
# Burn Estimate and Diagram

## Burn Injury Guidelines for Care

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<td>L. Foot</td>
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</tbody>
</table>

**Cause of Burn__________________________**

**Additional injuries________________________**

**Date of Burn ____________**

**Time of Burn ____________**

**Age ____________**

**Sex ________ Weight ________**

________ Kg

**Height ________ cm**

**Date of assessment ____________**

**Time of assessment ____________**

**Assessed by ____________**
96 HOUR PLAN - MODULE 4
Transfer & Transport

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained.

Essential Care  This is the minimum care given to patients based on your available resources.

- Obtain/Estimate each patient’s age
- Estimate each patient’s burn size (TBSA %)
  - Do not include first degree burns in the TBSA % estimate
  - Use “Rule of Nines” or Palmar method
- Using the All Burn Triage Table, determine triage category of all patients
- Consider transfer of patients in the following priority order:
  - Medium, High and Very High are most likely to benefit from specialized care
  - Low category patients have a mortality rate of 50-90% even with prolonged, intensive resources
  - Expectant category patients have > 90% mortality
- Arrange transport based on priority ordering and other factors
  - Determinations regarding which specific patients should be transported and in which order, will ultimately rest with the practitioner’s judgement
- Variables, in addition to the All Burn Triage Table category, should be considered including:
  - Degree of injury
  - Comorbid factors
  - Facility capabilities
  - Time, distance and transportation methods
- Classify as dead all patients who are pulseless and apneic
  - Terminate resuscitative measures
  - Relocate decedent away from treatment areas to preserve family privacy and protect belongings

If the number of critical patients, outnumbers available personnel or resources

- Withhold or terminate care in apneic patients after repositioning airway
- Provide palliative or comfort care to all patients who have a pulse and spontaneous respirations and who are classified as expectant using the “All Patients – Burn Triage Table”

No Access to Advanced Airway/Respiratory Supplies

- Maintain patient in sitting or head elevated position
  - Consider spinal precautions
- Provide oxygen via nasal cannula or mask
  - Oxygen saturation of 90-92% is acceptable
- Maintain open airway using airway adjuncts (nasopharyngeal (NPA)/oropharyngeal airway (OPA)
- Frequent respiratory assessment and communication with provider

No Access to Intravenous (IV) Supplies
Use Oral Resuscitation Therapy (ORT) if IV access is unavailable and less than 20% TBSA
  o Consider in burns up to 40% TBSA

**Non-pharmacologic Interventions**

- Elevate burned extremities
- Decrease external stimuli
- Do not use excessive pressure when handling wounds
  o Support burned extremities from underneath rather than gripping
  o Use flat surface of hands / forearms rather than fingertips
- Measure patient temperature in preparation for transport
- If <36° C (96.8° F)
  o Minimize patient exposure time
  o Warm the room
  o Avoid cold surfaces
- Keep the patient warm and dry
  o If clean, dry blankets are not available wrap patient in a space blanket/plastic wrap/large plastic bag/aluminum foil for insulation and warmth
- Do not use wet dressings or wet blankets
- If <36° C (96.8° F) consider risk vs benefit of delaying transport until patient temperature rises
- If >40° C (104° F) administer antipyretic medication and consider delaying transport until temperature is below 40° C (104° F). Consider adding external cooling if no response to antipyretics.
- If between 36° C (96.8° F) - 40° C (104° F) continue preparations for transport
- If between 39° C (102.2° F) - 40° C (104° F) consider administering antipyretic medication for patient comfort
- Protect patient from cold/wet weather when moving to transport vehicle
- Cover with two blankets or improvised cover such as plastic wrap/aluminum foil/plastic bag If unable to measure temperature during transport
- Ensure all patient(s) receive a medical screening exam, appropriate triage and stabilization
  o Within the capability and capacity of the facility)
  o Primary goal is to minimize the risk of patient(s) deterioration during transport
- Ensure receiving facility agrees to accept the patient
  o In the event of a national emergency or crisis, a community-wide written protocol designating specific entities (i.e. trauma destination policy) may be relied on for pre-established referrals
- Ensure patient(s) handoff communication tool has a unique identifier, pre-burn estimate of weight, estimation of % TBSA and the name of accepting hospital and physician
  o This may be provided via triage tag, hospital cover sheet, and summary sheet or provider notes
- Ensure verbal report is given to the transport team consisting of:
  o A summary of patient’s initial condition
  o Medical treatments and therapies administered
  o Patients’ response to the medical care provided
- Package all medical records, lab results and x-rays available at the time of transport, and send with patient(s) to receiving hospital
Better Care
Better care builds on essential care and is based on available resources.

- Have second practitioner confirm the TBSA % calculations
- Identify patients who have inhalation injuries and comorbidities
- Comorbidities with significant impact are:
  - Renal disease, obesity, liver disease, HIV/AIDS, pulmonary disorders, alcohol abuse, CHF, metastatic cancer and peripheral vascular disorders
- Use the Inhalation Injury and Non-Inhalation Injury Burn Triage Tables to determine triage category of all patients
- Wounds are cleaned and TBSA% re-evaluated by second practitioner

If the number of critical patients, outnumbers available personnel or resources

- Deliver palliative or comfort care to patients who:
  - have a pulse and spontaneous respirations and are classified as expectant using the “Inhalation Injury and Non-Inhalation Injury Burn Triage Tables”

Some Access to Advanced Airway/Respiratory Supplies

- Maintain airway using:
  - Laryngeal Mask Airway (LMA)
- Provide oxygenation/ventilation using
  - High Flow Nasal Cannula/CPAP
  - Bag Mask Valve (BVM) ventilation

Some Access to Intravenous (IV) Supplies

- Initiate peripheral IV access
  - Large bore IV
    - Avoid circumferentially burned extremity
    - Avoid infusion distal to burned tissue

Pharmacological Interventions

- Oral medications may be considered when oral intake is not contraindicated, however, assess for possible adverse effects including, but not limited to, airway compromise
- We recommend that ketamine be preferred over morphine for Intramuscular (IM) analgesia
- Measure temperature during transport every 4 hours
- If < 36.0°C (96.8°F) use available active warming means to achieve normothermia
  - Warm transport vehicle / warm blankets / heating blankets / warm IV fluids
- If >39°C (102.2°F) remove blanket, consider administering antipyretic medications for patient comfort
- If >40°C (104°F) and unresponsive to medications consider adding cold air-conditioning and wetting sheets with saline
- If between 36°C (96.8°F) and 39°C (102.2°F) cover patient with a blanket
- Send a copy of patient’s initial medical record & face sheet
- Ensure verbal report is given from referring physician to receiving physician
- Ensure essential elements of patient care are recorded on a standardized, pre-printed handoff communication tool (such as the BMCI Patient Medical Data Form)
Best Care  Best care builds on better and essential care and is based on available resources.

- Burn Center Consult via telemedicine or other available method

  If the number of critical patients, outnumbers available personnel or resources

- Transfer expectant patients to identified alternative care sites
  - Hospices, long term care facilities

  **Access to Advanced Airway/Respiratory Supplies**

- Secure Endotracheal Tube (ETT)
  - ETT Securement device
  - Tape (non-burned face only, if no other options)
  - Twill Tie (burned face)
  - Hold ETT when moving patient
  - Note depth of tube and verify unchanged after movement

- Provide continuous sedation during transport

  **Access to Intravenous (IV) Supplies**

- Central Line Access if requirements exceed safe capacity of peripheral IV
- Intravenous or intraosseous pain medication administration
  - Consider possible adverse effects
- Measure temperature during transport every 2 hours
- Ensure a BMCI Patient Medical Data Form is completed for each burn patient transferred
- Ensure any medical equipment accompanying the patient (IV Pumps, ventilators, monitors, etc.) are notated on patient chart by item, brand, BMET service tag number and serial number

**Additional Guidelines**

- See “Rule of Nines”, Module 1
- See “Rule of Palms”, Module 1
- See Burn Triage Tables, Module 3
J. PEDIATRIC PLANNING RECOMMENDATIONS

Taken from Utah Crisis Standards of Care Guidelines, Appendix A: Pediatric Disaster Surge Planning.

- A staff pediatric champion should be identified to oversee pediatric planning and policies and serve as a regular member of the Hospital Disaster Committee.
- Identify hospital staff with pediatric experience.
- Pediatric specific training should be conducted for facility staff on a regular basis. This should include Pediatric Advanced Life Support (PALS), and special considerations for dealing with the unique vulnerabilities of children in a disaster situation (dealing with unaccompanied minors, preverbal children, greater body surface area to weight ratio, increased skin permeability, different requirements for decontamination, less intravascular volume reserve). Several courses will help the clinician best care for the pediatric victim of disaster. Recommended courses include PALS and/or Pediatric Education for Prehospital Professionals (PEPP).
- Ensure appropriate pediatric equipment is available.
- Create and stock pediatric carts in designated areas.
- Plan for pediatric pharmaceuticals.
- Provide a length-based standard method for estimating weight in kilograms (eg, Broselow Tape). This should be kept in a clearly identified place.
- Plan for providing appropriate pediatric nutrition.
- Plan for the special security needs of children.
- Consider establishing telemedicine capability.
- Add special considerations for children to your hospital decontamination plan.
- Develop and exercise a hospital-based pediatric disaster triage system.
- Provide a well-accepted pediatric reference book. The Harriet Lane Handbook is considered an accurate source of information on pediatric diagnosis and treatment. This should be kept in a readily accessible place.
- The following policies for the emergency care of children should be developed:
  - Documentation of pediatric vital signs and actions to be taken for abnormal vital signs
  - Consent including when parent or legal guardian is not immediately available
  - Death of a child in the Emergency Department
- All-hazards disaster preparedness plans / policies that address the following pediatric issues:
  - Patient identification policies must be determined.
  - Decontamination, isolation and quarantine of families and children.
  - Minimization of parent-child separation (includes pediatric patient tracking, and timely reunification to family of separated children).
  - Policies should detail Family Centered Care, including:
    - Involving families in patient care decision making
    - Family presence during all aspects of emergency care, including resuscitation
    - Education of the patient, family and regular caregivers
    - Discharge planning and instruction
    - Bereavement counseling
  - Utilize medical imaging policies that address age or weight-appropriate ionizing radiation dosing for children.
- Maintain policies for sedation and analgesia for pediatric medical procedures.
- Care of children with special healthcare needs.
- Evacuation of pediatric patients.
K. PEDIATRIC EQUIPMENT & SUPPLIES

Taken from Utah Crisis Standards of Care Guidelines, Appendix A: Pediatric Disaster Surge Planning.

General pediatric equipment, supplies and medications will assist in facility in being prepared to handle any pediatric patient, including a pediatric burn patient. Items should be easily accessible, clearly labeled and logically organized. Staff should be educated on the location and use of all items. The following are suggestions and not intended to be all-inclusive.

<table>
<thead>
<tr>
<th>General Equipment</th>
<th>Monitoring Equipment</th>
<th>Vascular Access Supplies</th>
<th>Fracture Management Devices</th>
<th>Respiratory Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient warming device</td>
<td>Blood pressure cuffs- Neonatal, Infant, Child, Adult-arm</td>
<td>Arm boards – Infant, Child, Adult</td>
<td>Extremity splints</td>
<td>Endotracheal Tubes - Uncuffed 2.5mm, 3.0 Cuffed or uncuffed 3.5mm, 4.0, 4.5, 5.0, 5.5 Cuffed- 6.0mm, 6.5, 7.0, 7.5</td>
</tr>
<tr>
<td>Length based weight estimator</td>
<td>Pulse oximeter with Pediatric and Adult probes</td>
<td>Umbilical vein catheters - 3.5 F, 5.0 F</td>
<td>Spine stabilization devices appropriate for children of all ages</td>
<td>Laryngoscope handle</td>
</tr>
<tr>
<td>Intravenous blood/fluid warmer</td>
<td>Electrocardiography monitor/defibrillator with Pediatric and Adult capabilities, including pads/paddles</td>
<td>Central venous catheters - 4.0 F, 5.0 F, 6.0 F, 7.0 F</td>
<td>Femur splints, Pediatric and Adult sizes</td>
<td>Magill Forceps</td>
</tr>
<tr>
<td>Age appropriate pain scale assessment tool(s)</td>
<td>Continuous, end-tidal CO2 monitoring device</td>
<td>Intravenous Solutions - Normal Saline; Ringers Lactate; Dextrose 5% in normal saline (+/- 20 KCL)</td>
<td></td>
<td></td>
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<tr>
<td>Restraint device(s)</td>
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<tr>
<td>Diapers (all sizes), wipes and wee bags for urine collection</td>
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<tr>
<td>Weight scale in kilograms</td>
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<tr>
<td>A minimum of 5 cribs, port-a-cribs or playpens (in storage). If Adult beds are your only option, use beds with side rails, set at lowest possible height and electric controls unplugged</td>
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</tbody>
</table>

- Patient warming device
- Length based weight estimator
- Intravenous blood/fluid warmer
- Age appropriate pain scale assessment tool(s)
- Restraint device(s)
- Diapers (all sizes), wipes and wee bags for urine collection
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- Spine stabilization devices appropriate for children of all ages
- Femur splints, Pediatric and Adult sizes
- Endotracheal Tubes - Uncuffed 2.5mm, 3.0 Cuffed or uncuffed 3.5mm, 4.0, 4.5, 5.0, 5.5 Cuffed- 6.0mm, 6.5, 7.0, 7.5
- Laryngoscope handle
- Magill Forceps
## Laryngoscope blades
- Straight (size 1, 2, 3)
- Curved (2, 3)

## Nasopharyngeal airways
- Infant, Child and Adult

## Oropharyngeal airways
- Infant, Child and Adult

## Suction Catheters
- Infant, Child and Adult

## Yankauer suction tip
- Bag-mask device, self-inflating - Infant 450 ml, Adult 1000 ml

## Masks to fit bag-mask device adaptor
- Neonatal, Infant, Child, Adult

## Partial non-rebreather
- Infant

## Nasal Cannulas
- Infant, Child, Adult

## Laryngeal mask airway
- Sizes 1, 1.5, 2, 2.5, 3, 4.5

## Specialized Pediatric Trays or Kits
- Lumbar puncture tray (including Infant 22 gauge, Pediatric 22 gauge, and Adult 18-21 gauge), lumbar puncture needles.
- Supplies/kit for patients with difficult airway (supraglottic airways of all sizes, laryngeal mask airway, needle cricothyrotomy supplies, surgical cricothyrotomy kit)
- Tube thoracostomy tray
- Chest tubes, to include Infant, 10-12F, Child 16-24F, Adult 28-40F
- Newborn delivery kit, including equipment for resuscitation of an infant (umbilical clamp, scissors, bulb syringe, and towel.)
- Urinary catheterization kits and urinary (indwelling) catheters (6F-22F).

## Pediatric Medications
<table>
<thead>
<tr>
<th>Category</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics – Oral and Parenteral</td>
<td>Ibuprofen, Tylenol, fentanyl, morphine, versed, ketamine</td>
</tr>
<tr>
<td>Anti-convulsant medications (Ativan or versed)</td>
<td>Antidotes (common antidotes should be accessible to the ED)</td>
</tr>
<tr>
<td>Antipyretic drugs (Ibuprofen, Tylenol)</td>
<td>Antimicrobial agents (parenteral and oral) (a minimum of amoxicillin, ceftriaxone, Keflex, clindamycin, flagyl, cefepime or ceftazidime)</td>
</tr>
<tr>
<td>Vasopressor agents</td>
<td>Neomuscular blockers (Rocuronium)</td>
</tr>
<tr>
<td>Sedatives (see Analgesics – Oral and Parenteral)</td>
<td>Tetanus vaccine</td>
</tr>
<tr>
<td>Inotropic agents (epinephrine and norepinephrine)</td>
<td>3% NS – Hypertonic Saline</td>
</tr>
</tbody>
</table>
L. BEHAVIORAL HEALTH TIPS & RESOURCES

Psychological First Aid advocates that clinicians and emergency response workers work to understand the victims world view, project a sense of calm, normalize feelings and reactions, provide information needed to de-escalate acute distress and provide education to the individual or family regarding “next steps” to take.

1. In a burn disaster scenario, the mental health clinician or EMS worker would start with creating a sense of safety: “your loved one is being cared for by the medical team”, “we are moving you/your loved one to someplace safe where they can get the care they need”, “I am here to work with the team to get you information in real time and to ensure that the victim/family is safe”.

2. The next step involves asking the victim or family what they know about their situation (medical condition, condition of home, etc.); “tell me what you know at this time”. This would provide an opportunity to clarify misconceptions or misinformation. Correct information should be provided in a very basic manner, staying only one or two steps ahead of the moment. For example: “the information that we have right now is…”, “we are still gathering very basic information and the important thing for you to know is…..”, or “in the next hour or so, you should expect…..”. Information should be presented in a calm manner, false promises and platitudes should be avoided and a sense of safety should be re-enforced. It may be necessary to calmly state “as a reminder, you are at ______ Hospital, in the care of Dr. ________”.

3. Normalization of feelings would include statements grounded in psycho education. “You may notice that your thoughts are racing and it is difficult to focus. You may notice that your stomach is tight or a band headache is developing. It might be difficult to remember all the information being provided to you. These are all normal responses to traumatic events”.

4. The victim or family would then be provided with very basic self-care tools to help them through the immediate future. For example, a notebook for taking notes, breathing, re-framing tools, choosing a family spokesperson to address the community or communicate with friends/family, drinking water, and walking around a bit can all help empower people experiencing a stress response.

5. The victim or family would then be provided with education regarding “next steps”; staying away from hypothesizing, overwhelming or very detailed/specific information. It is important to not make promises that cannot be 100% assured or to make outcome predictions that may give false hope or expectations.

The simple steps of clarifying misinformation, normalization of feelings, and providing psychoeducation regarding simple and concrete strategies for self-care in the moment, and providing basic information on what to expect next all aid in reducing acute stress responses by increasing a sense of control and de-escalating physiological responses to trauma/stress.
Once initial psychological first aid has been provided (this can be done in 5-10 minutes in its simplest form and then layered upon), obtaining important information on the victim in the form of a crisis assessment should be completed. This information would include basic demographic information (name, date of birth), identification of the patient’s next of kin/medical decision maker, identification of a family spokesperson, contact information, immediately relevant information regarding psych history drug use, legal issues and the patient’s strengths. Ending on asking the patient or family to focus on strengths lends to a resiliency building approach and reminds people that they do have the skills to do hard things. It is important to remember that the medical team will obtain a relevant medical history.

Information on Psychological First Aid can be found at:

- [https://relief.unboundmedicine.com/relief/view/PTSD-National-Center-for-PTSD/1230010/all/Introduction_and_Overview](https://relief.unboundmedicine.com/relief/view/PTSD-National-Center-for-PTSD/1230010/all/Introduction_and_Overview)

Information on Aftercare Support can be found at:

- [https://www.phoenix-society.org/](https://www.phoenix-society.org/)
- [https://www.samhsa.gov/dtac/recovering-disasters](https://www.samhsa.gov/dtac/recovering-disasters)
- [https://www.samhsa.gov/dtac/recovering-disasters](https://www.samhsa.gov/dtac/recovering-disasters)
- [https://www.psychiatry.org/patients-families/coping-after-disaster-trauma](https://www.psychiatry.org/patients-families/coping-after-disaster-trauma)
M. PEDIATRIC PSYCHOLOGICAL FIRST AID

Taken from *Utah Crisis Standards of Care Guidelines, Appendix A: Pediatric Disaster Surge Planning.*

Children will respond to trauma and disasters differently than adults, and there will be a large range in responses, depending upon the child’s age, sociocultural background and personality. Some may have overt reactions in the acute phase while others may not manifest symptoms for many weeks or months.

**Goals**
- Re-create sense of safety
- Provide for basic needs (food, clothing, medical care)
- Ensure that survivors are safe and protected from reminders of the event
- Protect them from on-lookers and media
- Help them establish a “personal space” and reserve privacy and modesty

**Encourage social support**
- Help survivors connect with family and friends (most urgently, children with parents).
- Educate family and friends about survivor’s normal reactions and how they can help.

**Re-establish sense of efficacy**
- Give survivors accurate, simple information about plans and events.
- Allow survivors to discuss events and feelings, but do not probe.
- Encourage them to re-establish normal routines and roles when possible.
- Help resolve practical problems.
- Discuss self-care and strategies to reduce anxiety and offer relaxation techniques.
- Encourage survivors to support and assist others.

Some children are more likely to have emotional reactions to the events, such as:
- Children who witnessed the event firsthand or whose parent, relative or friend was killed or injured.
- Children who are displaced from their home or schools.
- Children with a past history of emotional problems.
- Children with a past history of trauma, either as a victim or witness to violence or abuse.
- Children with an adult in their life who is having difficulty with their emotions, a witness to violence or a victim of domestic violence.

It is helpful to know age-specific reactions, however, and to know what interventions may be beneficial.

**Preschool age (1-5 years of age) and school age (6-12 years)**
- Children may regress to an earlier behavioral stage: they may revert to thumb sucking and bedwetting, become afraid of strangers, and cling to parents.
- Children may become disobedient, hyperactive, aggressive, or they may withdraw.
- Changes in eating and sleeping habits are expected, and they may complain of multiple body aches and pains.

**Interventions**
- If possible, attempt to avoid separation from parents and siblings
- Encourage expression through play, drawing, puppet shows, and storytelling
- Limit media exposure such as watching television
- Set gentle but firm limits on acting out behavior
- Provide structured activities and chores
Preadolescents and adolescents (12-17 years)

- May withdraw, resist authority, become disruptive and begin to experiment with high-risk behaviors, such as alcohol or drug abuse.
- Preadolescents and adolescents may develop vague physical complaints.
- May abandon chores, schoolwork, and other responsibilities.

**Interventions**

- Encourage discussion of experiences among peers, but do not force them to talk about their feelings.
- Listening to them is critical!
- Providing structured activities and involvement in community recovery work may be beneficial.

**Suggested Engagement Script**

5. **Contact and engagement** – “My name is _______ and I am here to try to help you and your family. I am a _______ worker here, and I am checking with people to see how they are feeling. May I ask your name?”

6. **Safety and comfort** – “Do you need anything to drink or eat? Is your family here with you? Do you have a place to stay? We are working hard to make you and your family safe. Do you have any questions about what we’re doing to keep you safe?”

7. **Stabilization (if needed)** – “After bad things happen, your body may have strong feelings that come and go like waves in the ocean. Even grown-ups need help at times like this. Is there anyone who can help you feel better when you talk to them? Can I help you get in touch with them?”

8. **Information gathering** – “May I ask some questions about what you have been through? Can you tell me where you were during the disaster? Did you get hurt? Is your family safe? How scared were you? Is there anything else that you are worried about?”

**Additional Engagement Items**

- **Practical Assistance** – “It seems like what you are most worried about right now is ___________. Can I help you figure out how to deal with this?”
- **Connection with Social Support** – “You are doing a great job letting grown-ups know what you need. It is important to keep letting people know how they can help you. That way, you can make things better.”
- **Information on Coping** – “It’s normal for kids to feel scared after bad things happen. You will probably start to feel better soon. If you like, I can tell you some ways to help you feel better.”
- **Continuity in Helping Relationships** – Facilitate referrals: “May I help make some calls to people who can help you?” and if feasible, “I’d like to check in with you again to see how you are doing. How may I contact your parents later?”

It is advisable to refer to local psychiatric referral centers and other resources accessed during NON-disaster situations to identify pediatric mental health practitioners. Additionally, prehospital personnel should have hotline numbers readily available:

- National Suicide Prevention Lifeline
  **1-800-273-TALK**
- Substance Abuse and Mental Health Services Administration (SAMHSA) Helpline
  **1-800-662-HELP**
- Workplace Helpline
  **1-800-WORKPLACE,** [www.workplace.samhsa.gov/helpline](http://www.workplace.samhsa.gov/helpline)
The following resources were adapted from the Hospital Reception Site Planning Guide, developed by the Coyote Crisis Collaborative from Arizona and accessible online at https://coyotecampaign.org/documents/.

**HOSPITAL INCIDENT COMMAND SYSTEM (HICS) CHART**

**Functions of the Family Reunification Unit:**
1. Provide a private and secure place for families to gather, receive and provide information regarding loved ones involved in the incident.
2. Provide a secure area away from the media and curiosity seekers.
3. Provide a pediatric safe zone for uninjured, unaccompanied minors.
4. Facilitate information sharing with hospitals and other partners to support family reunification.
5. Address psycho/social, spiritual, informational, functional, medical and logistical needs to the best of the hospital’s ability.
6. Coordinate death notifications when patients die at the hospital and the identity is known.
7. Make appropriate referrals to the Family Reunification Center (FRC).
8. Communicate with the FRC and Emergency Call Center (ECC) regarding victim and family locations, as appropriate. Notify the FRC and ECC about demobilization.
## FAMILY REUNIFICATION RESOURCES

### DEFINITIONS

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>Any individuals that consider themselves to be a part of the victim’s family, even if there is not a legal familial relationship. This could include friends, partners, legal guardians, caretakers, and loved ones that have defined themselves or are indicated by other family members to be “family”.</td>
</tr>
<tr>
<td>Immediate Family</td>
<td>A defined group of relations, used in rules or laws to determine which members of a person’s family are affected by those rules. It normally includes a person’s parents, spouses, siblings and children.</td>
</tr>
<tr>
<td>Custodial Parent</td>
<td>The parent, also considered the primary care parent, with which a child resides full or part time, depending on court-ordered custody agreements. Most custodial parents have been awarded physical custody of a child by a court of law.</td>
</tr>
<tr>
<td>Legal Guardian</td>
<td>A person or entity who has been granted the legal authority (and the corresponding duty) to care for the personal and property interests of another person, called a ward.</td>
</tr>
<tr>
<td>Legal Next of Kin</td>
<td>The nearest blood relatives of a person who has died, including the surviving spouse.</td>
</tr>
<tr>
<td>Separated Children</td>
<td>Children who have been separated from both parents or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.</td>
</tr>
<tr>
<td>Uninjured, Unaccompanied Minors</td>
<td>Children who have been separated from both parents, legal guardians, and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.</td>
</tr>
<tr>
<td>Reunification</td>
<td>The process of reuniting family members with their missing or deceased loved one.</td>
</tr>
<tr>
<td>Emergency Call Center (The ECC)</td>
<td>Following a mass casualty or mass fatality incident, this designated space is activated as a communications hub to collect information from families and friends of possible victims (integrates Medical Examiner/Coroner interviews); to direct families and friends to appropriate Hospital Reception Sites, Family Reunification Centers, or Family Emergency Call Center (The ECC) continued</td>
</tr>
<tr>
<td>Emergency Call Center (The ECC) continued</td>
<td>Assistance Centers for reunification and assistance; and to direct other callers to appropriate recipients, such as Public Information Officers.</td>
</tr>
<tr>
<td>County Family Assistance Center (Long-term, with activation occurring up to 72 hours after the event)</td>
<td>Following a large mass casualty or mass fatality incident, this designated county or state space is established as a centralized location for families (and friends) to gather, receive information about the victims and grieve, protect families from the media and curiosity seekers, facilitate information sharing to support family reunification (e.g., direct families to Hospital Reception Sites if victims are known to have been transported to the location), and provide death notifications when identity is known. This Center is long-term and may target delivery of a range of services and/or may focus on families and friends of missing or deceased victims.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Family Reunification Center (The FRC is short-term, occurring from the time of the incident up to 12+ hours)</td>
<td>In the immediate hours after a mass casualty or mass fatality incident, this designated community space is established as a centralized location for families (and friends) to gather, receive information about the victims and grieve, protect families from the media and curiosity seekers, facilitate information sharing to support family reunification (e.g., direct families to Hospital Reception Sites if victims are known to have been transported to the location), and provide death notification when identity is known. This Center is short-term and may be replaced by a Family Assistance Center or shelter in the event the County or State or other jurisdiction deems this to be necessary.</td>
</tr>
<tr>
<td>Hospital Reception Site (The HRS remains open from time of incident to 72 hours thereafter or until the Hospital Incident Commander declares “all clear,” and the Site demobilizes)</td>
<td>A hospital space designated to provide a private and secure place for families to gather, receive information about the patients and grieve, protect families from the media and curiosity seekers, facilitate information sharing with other hospitals and partners to support family reunification (e.g., direct families to Family Reunification Center if victims are missing), and provide death notification when identity is known per hospital polices and reunite family with known victim at location.</td>
</tr>
<tr>
<td>Access and Functional Needs and Support</td>
<td>For purposes of this document, access and functional needs (AFN) are those with physical and cognitive disabilities (blind, hard of hearing, autistic, and so forth), limited or non-English speakers, homeless, and frail and/or elderly. Examples of support services include durable medical equipment (DME), consumable medical supplies (CMS), and personal assistance services (PAS). Individuals requiring functional needs assistance may have physical, sensory, mental health, and cognitive and/or intellectual disabilities affecting their ability to function independently without assistance. Others who may benefit from functional needs assistance include women in the late stages of pregnancy, seniors, and people whose body mass requires special equipment.</td>
</tr>
</tbody>
</table>
## FAMILY REUNIFICATION RESOURCES

### HOSPITAL RECEPTION SITE EQUIPMENT & SUPPLY LIST

<table>
<thead>
<tr>
<th>Resource</th>
<th>Scaling Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reception/Check-In</strong></td>
<td></td>
</tr>
<tr>
<td>Administrative supplies</td>
<td>As needed</td>
</tr>
<tr>
<td>Badging equipment</td>
<td>1 badging machine per 50 clients</td>
</tr>
<tr>
<td>Chairs</td>
<td>Number of Tables x 2</td>
</tr>
<tr>
<td>Clipboards</td>
<td>1 per staff at registration</td>
</tr>
<tr>
<td>HRS forms</td>
<td>Multiple copies for staff</td>
</tr>
<tr>
<td>Signage</td>
<td>As needed</td>
</tr>
<tr>
<td>Tables</td>
<td>1 per 2 filled positions</td>
</tr>
<tr>
<td>Telephones</td>
<td>1 per 2 filled positions</td>
</tr>
<tr>
<td>Telephone lists</td>
<td>1 per phone</td>
</tr>
<tr>
<td><strong>Assembly Area</strong></td>
<td></td>
</tr>
<tr>
<td>Chairs</td>
<td>Enough for all clients</td>
</tr>
<tr>
<td>Communications boards</td>
<td>1 or more as needed</td>
</tr>
<tr>
<td>Audio/visual equipment</td>
<td>2 microphones, 4 speakers, 1 projector, 2 screens, 1 remote</td>
</tr>
<tr>
<td>Podium</td>
<td>1</td>
</tr>
<tr>
<td>Signage</td>
<td>See below</td>
</tr>
<tr>
<td>Tables</td>
<td>As needed</td>
</tr>
<tr>
<td>Charging station</td>
<td></td>
</tr>
<tr>
<td>Trash cans</td>
<td></td>
</tr>
<tr>
<td><strong>Family Interview/Notification/Counseling Rooms</strong></td>
<td></td>
</tr>
<tr>
<td>Administrative supplies</td>
<td>As needed</td>
</tr>
<tr>
<td>Chairs</td>
<td>6 for family, 1-2 for staff</td>
</tr>
<tr>
<td>Internet Access</td>
<td></td>
</tr>
<tr>
<td>Signage</td>
<td>As needed</td>
</tr>
<tr>
<td>Tables</td>
<td>1</td>
</tr>
<tr>
<td>Telephones</td>
<td>1</td>
</tr>
<tr>
<td>Telephone lists</td>
<td>1 per phone</td>
</tr>
<tr>
<td>Tissues</td>
<td>As needed</td>
</tr>
<tr>
<td>Trash cans</td>
<td></td>
</tr>
<tr>
<td><strong>Child Care Area</strong></td>
<td></td>
</tr>
<tr>
<td>Age-appropriate toys</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Cribs/cots</td>
<td></td>
</tr>
<tr>
<td>Diaper changing tables</td>
<td></td>
</tr>
<tr>
<td>Diapers</td>
<td></td>
</tr>
<tr>
<td>Formula</td>
<td></td>
</tr>
<tr>
<td>Digital camera</td>
<td>1</td>
</tr>
<tr>
<td>First aid kit</td>
<td>1</td>
</tr>
<tr>
<td>Folding partitions</td>
<td>As needed</td>
</tr>
<tr>
<td>Linens, blankets, pillows</td>
<td></td>
</tr>
<tr>
<td><strong>Rest mats</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Small refrigerator</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Trash cans</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Meal Area (As Appropriate)**

| **Food** | 3 meals a day throughout duration of operations |
| **Signage** |  |
| **Tables and chairs** | 1 table per 2 clients (rectangular) or 1 per 8 clients (round) and 8 chairs per table |
| **Trash cans** |  |

**Victim Coordination Area**

| **Administrative supplies** | As needed |
| **Chairs** |  |
| **Internet Access** |  |
| **Tables** | 1 per counseling room |
| **Telephones** |  |
| **Tissue** |  |

**Command Meeting Area**

| **Chairs** | 1 per staff member |
| **Tables** | 2 staff per table |
| **Conference Call Phone** | 1 |

**Staff Area**

| **Administrative supplies** | As needed |
| **Chairs** | 1 per staff |
| **Conference call phones** | 1 |
| **FAX machine** | 1 |
| **Photocopier and supplies** | 1 |
| **Printer** | 1 |
| **Radio** | 1 for each member command staff, section chief, and branch directors. Others if possible. |
| **Signage** | 1 |
| **Tables** | Able to seat all command staff |
| **Telephones** | 3 |
| **Telephone lists** | 1 per phone |
| **Trash cans** |  |

**Other Supplies**

| **AED** | As required |
| **Fire extinguisher** | As required |
| **Wheelchairs** |  |
## FAMILY REUNIFICATION RESOURCES

### FAMILY & FRIENDS INTAKE FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Relationship to Missing Person</td>
<td></td>
</tr>
<tr>
<td>Missing Person Information</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Height/Weight</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Hair Color</td>
<td></td>
</tr>
<tr>
<td>Eye Color</td>
<td></td>
</tr>
<tr>
<td>Tattoos/Other Identifiers</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Primary Language</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>
FAMILY REUNIFICATION RESOURCES

CHILD IDENTIFICATION FORM

Name of child: ____________________________________________

Age: _____ DOB: __________________________ Male: ______ Female: ______

Address, if available: __________________________________________ Phone: __________

Uninjured/unaccompanied minor, circumstances (who, where, when, clothing, etc.)

Eye color: _______________ ________ Hair color: ______________________________

Distinguishing Marks____________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Name of accompanying adult:

Age: _____ DOB: __________________________ Male: ______ Female: _______________

Relationship to child: __________________________________________________

Accompanying adult treated for illness or injury? Yes___ No___

Admitted? Yes___ No___ If so, where? _____________________________________________

Does the child or adult have an ID band? Yes___ No___

Is there a photograph of the child? Yes___ No___ If so, where is the information catalogued (such as a school)?
**O. COVID-19 TRANSPORTATION GUIDELINES**

**MAKE TRANSPORT DECISIONS QUICKLY**

- It is critical that transport decisions regarding Burn injured COVID-19 patients are made quickly to avoid further decompensation and deterioration of patient's condition.

**CONSIDER ADVANCED LIFE SUPPORT & AIR AMBULANCE**

Advanced Life Support personnel may be required in case of decompensation of the patient.

- Many small rural agencies have advanced EMTs rather than paramedics. Advanced EMTs can manage the airway, however they are only approved to administer a limited number of medications. They are likely able to manage a moderately ill patient.
- Advanced EMTs may not be appropriate depending on the condition of the patient. If a higher level of care is deemed necessary, air ambulance transfer will likely be required.

**LIMIT RISK OF DISEASE SPREAD**

- Non-intubated patient: Risk of droplet contact with non-intubated patient.
- Patient requiring oxygen: Consider nasal cannula when possible to avoid possible aerosolization and droplet spread within an oxygen mask.
- Patient requiring bronchodilator: Nebulizer treatments will put the crew at greater risk of airborne exposure.
- Ventilator dependent: Some smaller agencies may not have ventilator capability.
- Hemodynamic instability: This will present a challenge especially with longer transport. Consider stabilizing patients prior to transfer while maintaining isolation.

**COORDINATE TRANSFER TIME**

- Once a transport decision is made, coordinate the transport to eliminate the transporting agency having to wait for extended periods of time. Consider the time needed for the transport agency to arrive at the facility when coordinating transport.
- If transport is determined immediately to be needed, call the transporting agency and ask for an ETA and coordinate times with them to minimize time transferring crew waits for the patient to be ready.

**SHORTEN TRANSPORT TIMES**

- Consider the distance and time of transport when making a transport decision. For a very high-risk, potentially unstable patient, shorter transport times will lead to less exposure to the transporting crew.
• Ground transport should likely only be used for those taking 30-60 minutes if possible, otherwise air transport may be more appropriate.

**NOTIFY DISPATCH OF COVID-19 STATUS**

• When speaking with dispatch, please advise them this is a patient with known COVID-19 or person under investigation (PUI).
• Notify dispatch of all the necessary medical equipment, ventilators, medication pumps, personal protective equipment (PPE), etc.

**COORDINATE AIR AMBULANCE TRANSPORTS**

• All potential air ambulance transports need to be communicated to the WRBCC and other applicable agencies.
• As numbers of COVID positive and critically ill patient’s increase, undoubtedly air ambulances will be stretched thin, resulting in increased wait times for transfer by air ambulance.

**SECURE THE AIRWAY PRIOR TO TRANSPORT**

• If advanced airway is required, or anticipated, secure the airway prior to transferring the patient to avoid having to secure an advanced airway in the confined space of an ambulance or air ambulance.

**NOTIFY DISPATCH ASAP OF PPE REQUIRED**

• Advise the transporting crew dispatch of the PPE required during transport as soon as that is established. Most agencies will not readily have PAPR available and may need to gather appropriate PPE. This will prevent having to call another crew with appropriate PPE.
• Be aware rural transporting agencies will likely have much less variety and possibly availability of PPE.

**MINIMIZE TRANSPORTING CREW EXPOSURE**

• The goal is for EMS to be in the receiving Burn Center the shortest amount of time possible to avoid further contamination.
• When giving / receiving a patient report with the transporting agency, do so outside of the patient isolation room to minimize exposure.
• Observe, encourage, and ensure the transporting agency has proper PPE donned prior to entering the patient room or any patient contact.
• If air ambulance, we recommend the pilot remain outside the hospital to minimize exposure.
## P. WRBDC FACILITY DATA SHEETS

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Helipad</th>
<th>Total Unit Beds</th>
<th>Predicted Surge (50% above baseline)</th>
<th>Adult Bedded</th>
<th>Pediatric Bedded</th>
<th>Dedicated Rehab beds</th>
<th>Facility Phone Number</th>
<th>Total Burn or Plastics MD/PA/NP</th>
<th>Disaster Contact</th>
<th>Telemedicine Capabilities</th>
<th>Designated Trauma Level 1</th>
<th>Designated Trauma Level 2</th>
<th>Designated Trauma Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Rotor Wing 50 / Fixed Wing 23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Arizona Burn Center at Maricopa Medical Center                                | YES    | 44              | 66                                  | x            | x               | No rehab in house   | Bed desk- 694- 4600 Main Operator 602-344-5726 | 4 Burn MDs, 5 PA, 1 NP | John Schaper (480)612-1250  
|                                                                               |        |                 |                                     |              |                 |                      |                      |                          | Lynne Schaper 480-612-1251   
|                                                                               |        |                 |                                     |              |                 |                      |                      |                          | lynn.schaper@mihs.org       |                           |                          |                          |
|                                                                               |        |                 |                                     |              |                 |                      |                      |                          |                                | •Hard-wired and internet  
|                                                                               |        |                 |                                     |              |                 |                      |                      |                          | •HD Sony & Polycom telemedicine/conferencing codecs+Tandberg Video Bridge  
<p>|                                                                               |        |                 |                                     |              |                 |                      |                      |                          | •Isolated network •Lease Vidyo licenses | 13                         | 0                        | 7                        |
| California Rotor Wing 98 / Fixed wing 23                                     |        |                 |                                     |              |                 |                      |                      |                          |                                |                           |                          |                          |                          |
| Bakersfield Memorial Hospital                                                | Yes    | 7               | 10                                  | x            |                 | Has PICU, BC takes pediatrics | No 661-323-2876      | 3 MD, 2 PA | Nurse Manager Amber Lizotte cell 661 333-3133 email <a href="mailto:amber.lizotte@dignityhealth.org">amber.lizotte@dignityhealth.org</a> | Yes, InTouch | 13 | 44 | 14 |
| The Edward G. Hirschman Burn Center at Arrowhead Regional Medical Center     | Yes    | 14              | 21                                  | x            | x               | No                   | 909-580-2100         | 2 MD, 1 NP | Scott Smith, RN, Emergency Coordinator <a href="mailto:smithw@amc.sbcounty.gov">smithw@amc.sbcounty.gov</a> Cell: 760-995-6345 | Store and forward of digital images | 14 | 14 | 14 |</p>
<table>
<thead>
<tr>
<th>Community Regional Leon</th>
<th>Yes</th>
<th>10</th>
<th>15</th>
<th>x</th>
<th>x</th>
<th>Yes</th>
<th>559-459-4220</th>
<th>4 Burn MD’s, 3 NP’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. Peters Burn Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Joseph Penn RN, Director for Burn Services, cell # is – (559) 284-9754. Office: (559) 459-4209. E-mail: <a href="mailto:jppenn@communitymedical.org">jppenn@communitymedical.org</a></td>
</tr>
<tr>
<td>Southern California Regional Burn Center at LAC &amp; USC Medical Center</td>
<td>10</td>
<td>med/surg, 10 ICU</td>
<td>30</td>
<td>x</td>
<td>x</td>
<td>323-409-7991</td>
<td>Warren Garner, MD / W: (323)409-7759 cell phone / <a href="mailto:wgamer@surgery.usc.edu">wgamer@surgery.usc.edu</a></td>
<td></td>
</tr>
<tr>
<td>UCI Regional Burn Center</td>
<td>8</td>
<td>12</td>
<td>x</td>
<td>x</td>
<td>714-456-5304</td>
<td>Scanning pictures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firefighters Burn Institute Regional Burn Center UC Davis Medical Center</td>
<td>YES</td>
<td>12</td>
<td>18</td>
<td>x</td>
<td>Hospital has a rehab</td>
<td>916-734-3636</td>
<td>4 Burn MDs, 1 Plastic MD, 1 NP</td>
<td></td>
</tr>
<tr>
<td>Shriners Hospitals for Children - Northern California</td>
<td>25</td>
<td>38</td>
<td>x</td>
<td>916-453-2111 (ICU)</td>
<td>Leonard Sterling cell (916)-412-2028, work 916 734-7073, pager (USA mobility) 916 816 0630 <a href="mailto:lesterling@ucdavis.edu">lesterling@ucdavis.edu</a>, Marianne MacLachlan <a href="mailto:mmaclachlan@ucdavis.edu">mmaclachlan@ucdavis.edu</a>, Cell: 916-501-6738 Office: 916-734-3686</td>
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<tr>
<td>UCSD Regional Burn Center</td>
<td>YES</td>
<td>18</td>
<td>24</td>
<td>x</td>
<td>x</td>
<td>NO</td>
<td>619-543-6502</td>
<td>2 MDs (soon 3)</td>
</tr>
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<td>Bothin Burn Center at Saint Francis Memorial Hospital</td>
<td>NO</td>
<td>16</td>
<td>24</td>
<td>x</td>
<td>Hospital has an acute rehab</td>
<td>415-353-6255</td>
<td>3 Burn MDs</td>
<td>Nursing Director Karl Frank 719 651-6399 <a href="mailto:karl.frank@dignityhealth.org">karl.frank@dignityhealth.org</a> Designated cell phone for pictures</td>
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<tr>
<td>Facility</td>
<td>Burn MDs</td>
<td>Adult Burn MDs</td>
<td>Pediatric Burn MDs</td>
<td>Phone Numbers</td>
<td>MDs Contact Information</td>
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<tr>
<td>Santa Clara Valley Medical Center Regional Burn Center</td>
<td>408-885-6666</td>
<td>No</td>
<td>Yes, adult, Yes, pediatric</td>
<td>Yvonne Louise Karanas / 650-996-6677 / <a href="mailto:yvonne.karanas@hhs.sccgov.org">yvonne.karanas@hhs.sccgov.org</a> or <a href="mailto:ykaranas@gmail.com">ykaranas@gmail.com</a> Emiko Rivera cell: (408) 835-6539 <a href="mailto:Emiko.Rivera@hhs.sccgov.org">Emiko.Rivera@hhs.sccgov.org</a> David Fernandez Hospital Emergency Preparedness Manager email Fernandez, David <a href="mailto:david.fernandez@hhs.sccgov.org">david.fernandez@hhs.sccgov.org</a></td>
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<tr>
<td>Orange County Global Medical Center</td>
<td>714-953-2377</td>
<td>No</td>
<td>x</td>
<td>Rebecca Brown (714)953-2377, cell 714 721-8708, <a href="mailto:rebecca.brown@kpchealth.com">rebecca.brown@kpchealth.com</a></td>
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<tr>
<td>Torrance Memorial Medical Center</td>
<td>310-517-4622</td>
<td>No (working on picture scanning)</td>
<td>x</td>
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<td>The Grossman Burn Center - West Hills</td>
<td>818-676-4177</td>
<td>Yes</td>
<td>3 plastic / reconstructive MDs, 1 pediatrician, 1 PA</td>
<td>Shurene (Dunbar) Larson, email <a href="mailto:Shurene.dunbar@hcahealthcare.com">Shurene.dunbar@hcahealthcare.com</a> work 818-676-4355, Cell: 810-358-4502</td>
<td></td>
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<tr>
<td>University of Colorado Hospital Burn Center</td>
<td>(720)848-7583</td>
<td>3 Burn Attendings</td>
<td>Patrick Conroy/ cell 303-880-1799/office 720-848-6632/patrick.conroy@uchehalth.org Clinton Andersen Work 720-848-6095, Cell 303-419-0888 <a href="mailto:Clinton.andersen@uchealth.org">Clinton.andersen@uchealth.org</a></td>
<td>Picture Scanning and Telemedicine 5 / Yes</td>
<td>11 / NA 25 / NA</td>
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<td>Children's Hospital Colorado</td>
<td>YES</td>
<td>12</td>
<td>18</td>
<td>x</td>
<td>13</td>
<td>(303)549-4636</td>
<td>1 burn MD, 1 burn NP, 4 burn RNs</td>
<td>Director Emergency Management Sarah Lorenz, Manager <a href="mailto:Sarah.Lorenz@childrenscolorado.org">Sarah.Lorenz@childrenscolorado.org</a></td>
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<tr>
<td>Burn and Reconstructive Center at Swedish Medical Center</td>
<td>YES</td>
<td>8 icu Adult and 6 ICU pediatric beds</td>
<td>21</td>
<td>X</td>
<td>X</td>
<td>855-863-9595</td>
<td>3 Burn/Plastic Surgeons, 5 Physician Assistants (14 Add'l Burn Surgeons, 75 Add'l APPs thru Burn &amp; Recon. Ctrs of America)</td>
<td>Benson Pulikkottil MD, Burn Medical Director (cell) 845-216-1506, Access number: 855-863-9595</td>
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<tr>
<td>Western States Burn Center</td>
<td>YES</td>
<td>10</td>
<td>15</td>
<td>x</td>
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<td>(970) 810-6099</td>
<td>2 Burn MDs, 1 NP (another MD on back up if needed)</td>
<td>Rebecca Garber (970) 810-4540, <a href="mailto:Rebecca.Garber@bannerhealth.com">Rebecca.Garber@bannerhealth.com</a></td>
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<td>Hawaii Rotor wing 6 / Fixed wing 14</td>
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<td>Straub Clinic and Hospital Burn Unit</td>
<td>No</td>
<td>7</td>
<td>12</td>
<td>x</td>
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<td>808-522-3731, 808 522-4000</td>
<td>3 Plastics MDs</td>
<td>Safety Officer Shane Correa <a href="mailto:shane.correa@straub.net">shane.correa@straub.net</a>, Barry King, Security Manager, <a href="mailto:barry.king@straub.net">barry.king@straub.net</a></td>
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<tr>
<td>Kapiʻolani Medical Center for Women &amp; Children</td>
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- 79 -
## Idaho

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<tr>
<th>Facility</th>
<th>ICU Beds</th>
<th>Step Down Beds</th>
<th>Burn ICU Beds</th>
<th>Burn ICU Front Desk</th>
<th>Burn MDs</th>
<th>Plastics MDs</th>
<th>NP</th>
<th>Referral Clinic</th>
<th>Contact Person</th>
<th>Disaster &amp; Emergency Preparedness Coordinator</th>
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<tr>
<td>Eastern Idaho Regional Medical Center Burn and Reconstructive Centers of Idaho</td>
<td>Yes</td>
<td>6</td>
<td>4</td>
<td>Burn CN C (208) 881.1757</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>No</td>
<td>Jim Howard</td>
<td><a href="mailto:jim.howard@hcahealthcare.com">jim.howard@hcahealthcare.com</a> O-208.529.6223 C-208.520.1080 Bed Access-208.529.6096</td>
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<td>Lions Burn Center - UMC</td>
<td>Yes</td>
<td>16</td>
<td>24</td>
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<td>702-383-2268</td>
<td>5 Burn MDs</td>
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<td>Sunrise Hospital and Medical Center</td>
<td>Yes</td>
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<td>x</td>
<td>yes</td>
<td>Burn Center 702 961-6470 Referral center 855 863-9595 Clinic number 702 961-7552</td>
<td>4 Burn MD, 6 PA</td>
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<td>New Mexico Regional Burn Center</td>
<td>Yes</td>
<td>6</td>
<td>9</td>
<td>x</td>
<td>X</td>
<td>no</td>
<td>505-272-2721</td>
<td>1 Plastic/reconstructive MD 1 PA</td>
<td>PALS (Physician Access Line) 505-272-2000 (24/7)</td>
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<td>Oregon Burn Center</td>
<td>Yes</td>
<td>16</td>
<td>24</td>
<td>x</td>
<td>x</td>
<td>Rehab unit at Legacy Good Samaritan hospital 503-413-4232</td>
<td>4 Burn MDs, 1 NP</td>
<td>Curtis Ryun cell (503) 317-5724 <a href="mailto:cryun@lhs.org">cryun@lhs.org</a> (in addition to the main unit number)</td>
<td>no telemed on the unit, but use a system called RITA PICS that is used by all of the hospitals in the area</td>
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<tr>
<td>Location</td>
<td>Beds Level 1</td>
<td>Beds Level 2</td>
<td>Pediatric Beds</td>
<td>Level</td>
<td>Rotor wing</td>
<td>Fixed wing</td>
<td>Contact Details</td>
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<td><strong>Utah</strong></td>
<td>973</td>
<td>272</td>
<td>950</td>
<td>2195</td>
<td>18</td>
<td>4</td>
<td>University of Utah Burn Center &lt;br&gt; YES 15 23 x x 801-581-2700 3 burn MDs, 3 burn NPs, 4 burn PA Annette Matherly cell (435)901-1425 <a href="mailto:Annette.Matherly@hsc.utah.edu">Annette.Matherly@hsc.utah.edu</a> Polycom system for incoming calls or IP address Telemedicine bridge Intouch laptop/robot system for Idaho, Grand Junction CO, Nevada Vidyo for some sites Store &amp; forward w/ encryption.</td>
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<td><strong>Washington</strong></td>
<td>413</td>
<td>1400</td>
<td>200</td>
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<td>13</td>
<td>10</td>
<td>University of Washington Regional Burn Center &lt;br&gt; YES 40 60 x x 206-744-3140 6 Burn MDs, 1 NP, 1 PA Carolyn Blayney Program Operations Manager /cell 206-450-3294/blayney@uw.edu Jo Tate Program Manager/cell 253-381-4337/jotate@uw.edu Can be via desktop or mobile devices, use the zoom meeting app (ZOOM#206-744-5666). Email for videoconferencing is <a href="mailto:clpcc@uw.edu">clpcc@uw.edu</a></td>
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## Q. WRBCC BMCI PATIENT TRACKING SHEET

For Use in the Coordination Center

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<th>STATE:</th>
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<tr>
<th>FACILITY NAME:</th>
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<table>
<thead>
<tr>
<th>Patient Name (Last, First, MI)</th>
<th>Contin. IV Infusion</th>
<th>Vented</th>
<th>% TBSA</th>
<th>Traumatic injuries</th>
<th>Tele-medicine done</th>
<th>Co-morbidities (Include COVID status)</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
<th>Priority (High, Med, Low)</th>
<th>Ideal transport method</th>
<th>POC at receiving facility</th>
<th>POC Number</th>
<th>Patient transfer done</th>
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<tr>
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<th>FACILITY NAME:</th>
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<tr>
<th>Patient Name (Last, First, MI)</th>
<th>Contin. IV Infusion</th>
<th>Vented</th>
<th>% TBSA</th>
<th>Traumatic injuries</th>
<th>Tele-medicine done</th>
<th>Co-morbidities (Include COVID status)</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
<th>Priority (High, Med, Low)</th>
<th>Ideal transport method</th>
<th>POC at receiving facility</th>
<th>POC Number</th>
<th>Patient transfer done</th>
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- 82 -
### WRBDC BURN MASS CASUALTY OPERATIONS PLAN: APPENDIX

#### STATE:

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<th>FACILITY NAME:</th>
<th>Contin. IV Infusion</th>
<th>Vented</th>
<th>% TBSA</th>
<th>Traumatic Injuries</th>
<th>Tele-medicine done</th>
<th>Co-morbidities (include COVID status)</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
<th>Priority (High, Med, Low)</th>
<th>Ideal transport method</th>
<th>POC at receiving facility</th>
<th>POC Number</th>
<th>Patient transfer done</th>
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### R. WRBCC BURN PHYSICIAN ON-CALL SCHEDULE

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