

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ESF-8 PLAN:

BURN SURGE ANNEX

September 2014

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ACRONYMS/TERMS

AAR	After Action Report
ABA	American Burn Association
ACS	Alternate Care Site
APA	American Pharmaceutical Association
APN	Advanced Practice Nurse
ARC	American Red Cross
ATS	Alternate Treatment Site
CEMP	Comprehensive Emergency Management Program
CEOC	Commonwealth Emergency Operations Center
CHUG	Collaborative Healthcare Urgency Group
DPR	Division of Disaster Planning and Readiness
ED	Emergency Department
EMAC	Emergency Medical Assistance Compact
EMS	Emergency Medical Services
EMTrack	Commercial electronic multi-functional tracking system
ENA	Emergency Nurses Association
EOC	Emergency Operations Center
ERC	Emergency Regional Coordinator
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FGM	Fiscal and Grants Management
GLHP	Great Lakes Healthcare Partnership
HAv-BED	Hospital Available Beds for Emergencies and Disasters
HAM	Amateur radio
HBPPC	Indiana State Department of Health, Hospital Bioterrorism Preparedness Planning Committee
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
IA	Iowa
IAACCT	Illinois Association of Air and Critical Care Transport
ICAHN	Illinois Critical Access Hospital Network
ICEP	Illinois College of Emergency Physicians
ICU	Intensive Care Unit
ID	Identification
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
Illinois ENA	Illinois Emergency Nurses Association
Illinois Helps	Illinois ESAR-VHP Program
IMERT	Illinois Medical Emergency Response Team
IMT	Incident Management Team
IN	Indiana
IPA	Illinois Pharmacists Association

ISBE	Illinois State Board of Education
ISMS	Illinois State Medical Society
KY	Kentucky
KYEM	Kentucky Emergency Management
LHD	Local Health Department
LTC	Long-term Care
MACS	Multiple Agency Command System
MCI	Mass Casualty Incident
MI	Michigan
MO	Missouri
MOU	Memorandum of Understanding
NIMS	National Incident Management System
OPR	Office of Preparedness and Response
PA	Physician Assistant
PCMS	Pediatric Care Medical Specialist
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health and Emergency Preparedness
PHMSRR	Public Health and Medical Services Response Regions
PICU	Pediatric Intensive Care Unit
POC	Point of Contact
POD	Point of Distribution
REMSC	Regional Emergency Medical Services Coordinator
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SBCC	State Burn Coordinating Center
SEOC	State Emergency Operations Center
SIRC	State Incident Response Center
SIREN	State of Illinois Rapid Electronic Notification
SMOC	St. Louis Medical Operation Center
SNS	Strategic National Stockpile
TAC	Trauma Advisory Council
T and E	Training and Exercise
TBSA	Total Burn Surface Area
TMTS	Temporary Medical Treatment Stations
WHEPP	Wisconsin Hospital Emergency Preparedness Program
WI	Wisconsin
WI-TRAC	Wisconsin's Hospital Available Beds for Emergencies and Disasters

PRIMARY AGENCY

Illinois Department of Public Health

SUPPORT AGENCIES AND ORGANIZATIONS

Illinois Emergency Management Agency
 Regional Hospital Coordinating Centers
 EMS Resource Hospitals
 Hospitals with Burn Capabilities
 Trauma Centers
 Hospitals
 Great Lakes Healthcare Partnership
 Additional Border States (Iowa, Kentucky, Missouri)
 Illinois Critical Access Hospital Network
 Illinois Helps
 Illinois College of Emergency Physicians
 Illinois Emergency Nurses Association
 Illinois Department of Human Services
 Trauma Advisory Council

1.0: INTRODUCTION**1.1 PURPOSE**

The purpose of the Burn Surge Annex is to support the Illinois Department of Public Health (IDPH) ESF-8 Plan, by providing a functional annex for all stakeholders involved in an emergency response within the state of Illinois and/or adjacent states in order to provide appropriate burn medical care to patients in Illinois during a burn mass casualty incident (MCI). This annex guides the state level response and gives local medical services guidance on the care of burn patients, including patient movement, recommendations for care and resource allocation during a burn MCI that overwhelms the local health care system.

This annex is intended to support, not replace, any agencies' existing policies or plans by providing uniform response actions in the case of any type of burn mass casualty incident.

1.2 ASSUMPTIONS

- 1.2.1 The IDPH ESF-8 Plan has been activated, either partially or fully, at the discretion of the Illinois Department of Public Health (IDPH) director.
- 1.2.2 The Public Health and Medical Services Response Regions (PHMSRR) (see Attachment 1) serve as the primary regional geographical organizational structure for the IDPH ESF-8 Plan and the Burn Surge Annex response.
- 1.2.3 The local health care system has exhausted their capacity to care for burn patients and has implemented and exhausted any mutual aid agreements, therefore requiring assistance from the other regions and/or the state.

- 1.2.4 Requests for assistance from the State Burn Coordinating Center will be considered once a Request for Medical Resources (RFMR) has been made to the Regional Hospital Coordinating Center (RHCC) in the PHMSRR where the requesting hospital(s), or health care provider(s) reside (as in the Regional ESF-8 Plan) or through request patterns indicated in the IDPH ESF-8 Plan.
- 1.2.5 In the initial stages of a mass casualty event that includes large numbers of burn victims, all hospitals may have to provide care to burn patients until adequate resources become available to allow for transport to a hospital with burn capabilities.

1.3 SCOPE:

The Burn Surge Annex is designed to provide the command structure, communication protocols, RFMR process, and the procedure for inter-regional and interstate transfer as related to burn patients. The Burn Surge Annex is designed to:

1. Enable safe burn patient transfer decision making.
2. Implement standardized care protocols as needed.
3. Ensure associated communications processes are in place.
4. Support the tracking of burn patients throughout the incident.
5. Assist with the coordination of transferring acutely ill/injured burn patients to hospitals with burn capabilities.

The Hospital Preparedness Program (HPP) capabilities addressed in this annex include, but are not limited to:

- 1) Health Care System Preparedness (#1)
- 2) Emergency Operations Coordination (#3)
- 3) Medical Surge (#10)

The Public Health and Emergency Preparedness (PHEP) capabilities related to this annex include, but are not limited to:

1. Community Preparedness and Health Care System Preparedness (#1)
2. Emergency Operations Coordination (#3)
3. Medical Surge (#10)

1.4 SITUATION

The IDPH ESF-8 Plan and its corresponding annexes are activated when the State Incident Response Center (SIRC) is activated and/or at the discretion of the IDPH director when circumstances dictate and the Public Health Emergency Operations Center (PHEOC) is activated. It can be partially or fully implemented in the context of a threat, in anticipation of a significant event, or in response to an incident. Scalable implementation allows for appropriate levels of coordination.

1.5 AUTHORITIES

- 1.5.1 Within Illinois, the overall authority for direction and control of the response to an emergency medical incident rests with the governor. Article V, Section 6, of the Illinois Constitution of 1970 and the Governor Succession Act (15 ILCS 5/1) identify the officers next in line of succession in the following order: the lieutenant governor; the elected attorney general; the elected secretary of state; the elected comptroller; the elected treasurer; the president of the Senate; and the

speaker of the House of Representatives. The governor is assisted in the exercise of direction and control activities by his/her staff and in the coordination of the activities by IEMA. The State Emergency Operation Center (SEOC) is the strategic direction and control point for Illinois response to an emergency medical incident (see Attachment 2)

- 1.5.2 IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations.
- 1.5.3 All requests for health and medical assistance with the care of burn victims during emergency events will be routed through the SIRC and the Illinois Emergency Management Agency (IEMA) as indicated in the RFMR process in the IDPH ESF-8 Plan. The request will then be directed by the SIRC manager to the IDPH SIRC liaison to address. IDPH will determine the best resources from the health and medical standpoint to deploy to fulfill the request.
- 1.5.4 The overall authority for direction and control of IDPH's resources to respond to an emergency medical incident is the Department's director. The line of succession at IDPH extends from the director to the assistant director, forward to the appropriate deputy directors of the IDPH offices.
- 1.5.5 The overall authority for coordinating the resources of the disaster RHCC hospital(s) that respond to an emergency medical incident is the EMS medical director or designee.

2.0. CONCEPT OF OPERATIONS

2.1 GENERAL

- 2.1.1 Throughout the response and recovery periods, the IDPH ESF-8 Plan: Burn Surge Annex will provide the framework to evaluate and analyze information regarding medical, health and public health assistance requests for response; develop and update assessments of medical and public health status in the impact area; and provide contingency planning to meet anticipated demands as they relate to burn victims.
- 2.1.2 When an incident occurs that meets the definition of a Burn MCI (see Section 2.1.4 for definitions), subject matter expertise through the State Burn Coordinating Center (SBCC) will be provided to advise and/or direct operations as it pertains to burn patient movement, care guidelines and resource allocation within the context of the Incident Command System structure. Burn subject matter experts throughout the state and surrounding border states will be utilized.
- 2.1.3 Incidents that could prompt the activation of the Burn Surge Annex include, but are not limited to:
 1. Activation of the IDPH ESF-8 Plan.
 2. Overwhelming influx or surge of burn patients that meets the definition of a Burn MCI outlined in section 2.1.4.
 3. Inadequate burn hospital resources (e.g., inpatient monitored beds, ventilators).
 4. Damage or threats to hospital(s) with burn capabilities.

5. Staffing limitations (e.g., qualified and trained staff to care for burn patients).
6. Activation of hospital(s) disaster plan when surge capacity for burn patients has been exceeded.
7. Requests from border state(s) to assist with a surge of burn patients in their state(s).

See Attachment 3 for the *Burn Surge Annex Activation Pathway*.

2.1.4 The following are the definitions of a Burn MCI for Illinois:

1. Local: Any event in which local trauma/burn resources are overwhelmed with the number and/or severity of injuries (e.g., patients with $\geq 20\%$ TBSA burn) that exceeds local capacity to provide effective care without initiating the Mass Casualty Burn Center Referral Criteria.
2. Regional: Any event in which regional trauma/burn resources are overwhelmed with the number and/or severity of injuries (e.g., patients with $\geq 20\%$ TBSA burn) that exceeds regional capacity to provide effective care without initiating the Mass Casualty Burn Center Referral Criteria.
3. Statewide: Any event in which state trauma/burn resources are overwhelmed with the number and/or severity of injuries (e.g., patients with $\geq 20\%$ TBSA burn) that exceeds state capacity to provide effective care without initiating the Mass Casualty Burn Center Referral Criteria.

2.1.5 Regardless of the pathway to activation of the Burn Surge Annex, the health care entities involved with the incident function independently and may activate the necessary internal resources and policies to successfully respond to the needs of the burn patients (e.g., early or expedited inpatient discharge).

2.1.6 Within the IDPH ESF-8 Plan, multiple annexes exist that address the needs of specialty populations (e.g., pediatric and neonatal patients, burn patients). Depending on the scope of the disaster, multiple annexes or components of each may need to be activated simultaneously in order to thoroughly address the specific needs of the victims (e.g., pediatric burn patients). Efforts have been made to ensure consistency between all annexes that address the needs of specialty populations. It is the recommendation that the experts for the specialty populations involved in the MCI work together to address any conflicts that may occur.

2.2 NOTIFICATION

2.2.1 Upon the activation of the Burn Surge Annex, the *Burn Medical Incident Report Form* (see Attachment 4) will be utilized to communicate necessary information about the annex activation with all affected entities and those entities that may be called upon to assist during the incident. See Section 2.2.3 for a listing of possible stakeholders that should be notified during the activation of the Burn Surge Annex. This form may be sent and received via any available communication method (e.g., SIREN, e-mail, fax). When the *Burn Medical Incident Report Form* is utilized during an event, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the “Reply/Action Required” section.

2.2.2 Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally

and externally from their facility. Information should be shared in the preferred and most expected method (i.e., SIREN). However, depending on the type of incident, the typical alert and messaging systems may not be available and alternate communication methods will be utilized. Some of the possible established methods for communication that can be used include:

1. Telephone (landline)
2. Telephone (cellular)
3. Fax
4. Radio systems (StarCom, HAM/Amateur, MERCI, telemetry)
5. E-mail
6. Electronic emergency management systems
7. SIREN
8. HAV-BED Tracking System in each state
9. WebEOC[®]
10. Social media
11. Comprehensive Emergency Management Program (CEMP) (for information sharing including access to documents and resources)

2.2.3 The *Burn Medical Incident Report Form* (see Attachment 4) should be utilized to assist with ensuring consistent communication between stakeholders and to provide a mechanism to request burn resources and identify availability of resources at a facility. Below are facilities/agencies/entities/individuals that either play a role in caring for burn patients or may be part of the incident response and should be notified and receive ongoing communications from the time the Burn Surge Annex is activated until normal operations resume. See Attachment 5 for the *Burn Communication Pathway*. To ensure flexibility of this annex, the following list is not all inclusive, nor are entities listed in any priority order. Depending on the type of incident, additional stakeholders should be included in the information sharing process as needed and appropriate.

1. Hospitals
 - a. Acute care hospitals
 - b. Hospitals with burn capabilities
 - c. Trauma centers
 - d. Psychiatric hospitals
 - e. Rehabilitation hospitals
2. Regional Hospital Coordinating Centers (RHCC)
3. County emergency management agencies
4. Local emergency medical services (EMS) agencies
5. Local health departments (LHD)
6. IDPH Regional Emergency Medical Services Coordinator (REMSC)
7. Illinois Department of Public Health (IDPH)
8. Illinois Emergency Management Agency (IEMA)
9. Professional medical organizations
 - a. Illinois College of Emergency Physicians (ICEP)
 - b. Illinois State Medical Society (ISMS)
 - c. American Pharmaceutical Association (APA)
 - d. Illinois Pharmacists Association (IPA)

- e. Illinois Emergency Nurses Association (ENA)
 - 10. Illinois Critical Access Hospital Network
 - 11. Collaborative Healthcare Urgency Group (CHUG)
 - 12. Border state agencies (Refer to Section 2.3.3 for specific notification details)
 - a. Great Lakes Healthcare Partnership (includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin) through the Minnesota Department of Health, Office of Emergency Preparedness
 - b. Iowa - Iowa Department of Public Health duty officer
 - c. Kentucky - Duty officer in the Commonwealth Emergency Operation Center (see Attachment 6)
 - d. Missouri - St. Louis Medical Operations Center (SMOC)-State of Missouri (see Attachment 7)
 - 13. Health care coalitions
 - 14. Alternate treatment sites, alternate care sites and/or temporary medical treatment stations established during the incident.
- 2.2.4 To assist stakeholders with identifying the Illinois hospitals with burn capabilities and outlining contact information and specific capabilities of each of these burn facilities, the *Illinois Burn Resource Directory* has been developed (Attachment 8).

2.3. ORGANIZATION

2.3.1 Hospital Response Structure

- 1. During a large burn mass casualty incident, resources at hospitals with burn capabilities will quickly become exhausted. Therefore, developing a system that outlines how hospitals can assist with providing burn care is crucial to the response. Dividing the hospitals into categories based on their pre-event burn and trauma capabilities can assist with ensuring burn patients are treated at the best possible facility during the event. See Section 2.4: *Patient Care and Movement* for more information on this coordination of care.
- 2. When this annex is activated, hospitals within Illinois will fall into one of the following four categories to assist with the coordination of care during a burn mass casualty incident. See Section 3.2.6 for additional information on the following categorization:
 - a. Hospitals with burn capabilities (includes both American Burn Association {ABA} and non-ABA verified burn centers)
 - b. Level I trauma /non-burn hospitals
 - c. Level II trauma /non-burn hospitals
 - d. Non-trauma/non-burn hospitals

2.3.2 Regional Response Structure

- 1. Each region will respond as indicated within its regional ESF-8 plan.

2.3.3 State Response Structure

- 1. State emergency management officials will activate the SIRC to coordinate state and/or federal support to local jurisdictions. The PHEOC will be activated by IDPH. RFMR will be processed in accordance with the IDPH ESF-8 Plan.

2. Upon receiving requests for burn medical resources, the SIRC manager will notify the IDPH SIRC liaison. The IDPH SIRC liaison will notify the IDPH duty officer within the PHEOC, who will request the SBCC be activated.
3. During an activation of the PHEOC in the event of a large number of burn casualties, burn subject matter experts from the SBCC will be integrated into the incident command structure to allow for an appropriate, coordinated and timely response to the needs of burn patients.
4. When this annex is activated, the request for burn specific medical resources by a hospital, hospital or regionally based alternate care site (ACS), hospital or regionally based alternate treatment site (ATS), and/or state temporary medical treatment station (TMTS) will follow the same pathway as the request for other medical resources as outlined in the IDPH ESF-8 Plan. These burn care resources can include but are not limited to:
 - a. Equipment, supplies and medications
 - b. Medical consultation
 - c. Placement of burn patients in hospitals with burn capabilities
5. The IDPH REMSC(s) will assist with the communication between IDPH, SBCC and the RHCCs. The REMSC(s) should be involved in the situational awareness briefings throughout the event during which the SBCC will provide updates on interactions/ communication with hospitals and their medical consultation and transfer coordination requests. The REMSC should then relay this information to their RHCC to assure loop closure and awareness of the response activities within their region.
6. IDPH, in conjunction with support agencies, the SBCC and the Trauma Advisory Council (TAC) Burn Advisory Subcommittee, develops and maintains this annex and accompanying operational guidelines that govern response actions related to large scale events leading to significant number of burn victims. However, support agencies may develop and maintain their own operational guidelines for internal use, which must be compatible with and in support of this annex. This would include the SBCC. See Section 2.3.6 and 3.2.2 for more information on the SBCC. See Section 2.3.7 and 3.2.7 for more information on the TAC Burn Advisory Subcommittee.

2.3.4 Multi-State Response Structure

1. The incident may require accessing burn resources that exist outside the border of Illinois. The PHEOC, in collaboration with the SIRC, may consider requesting out-of-state resources through normal request patterns, methods indicated within this annex and the IDPH ESF-8 Plan, and/or interstate mutual aid agreements, including Emergency Medical Assistance Compact (EMAC). Border states will be contacted as indicated below to identify burn resource availability, send information about the event, and to assist with the coordination of transfers:
 - a. Great Lakes Healthcare Partnership (GLHP)
 - i. A consortium of jurisdictions, including Minnesota, Wisconsin, Illinois, city of Chicago, Indiana, Michigan and Ohio, located

within Federal Emergency Management Agency (FEMA) Region V that can provide communication and resource assistance in the first 24-72 hours of a significant incident in the region when other resources are being activated through conventional channels. The GLHP Regional Burn Surge Annex provides guidance for accessing burn resources and coordinating a regional burn response for states that are part of the GLHP. To access GLHP burn resources, call the Minnesota Department of Health, Office of Emergency Preparedness at 651-201-5735 and ask for the Great Lakes Healthcare Partnership (GLHP).

- b. Iowa
 - i. Iowa Department of Public Health duty officer will serve as the primary contact for Iowa at 866-834-9671 or Duty.Officer@idph.iowa.gov. Once contacted, the duty officer will serve as the single point of contact to identify burn resource availability (hospitals, transport and EMS) and assist with communication with Iowa hospitals with burn capabilities.
- c. Kentucky
 - i. The on-call Kentucky Emergency Management (KYEM) duty officer in the Commonwealth Emergency Operations Center will serve as the primary contact for Kentucky at 800-255-2587. Once contacted, the KYEM duty officer will notify the KYEM manager on call, one of the ESF-8 Public Health/Kentucky Health Association Partners and the Kentucky Board of EMS based on the requested needs to assist with patient placement and transportation (see Attachment 6).
- d. Missouri
 - i. St. Louis Medical Operations Center (SMOC) will serve as the primary contact for Missouri. Contact the Central County 911 Center at 636-394-2212 and request the SMOC duty officer be contacted. Once contacted, they will serve as liaisons to identify burn resource availability, send information to Missouri hospitals and assist with coordination of transfers (see Attachment 7).

2.3.5 Federal Response Structure

- 1. When response to a disaster or emergency incident exceeds the resources and capabilities of Illinois to manage, IEMA will notify officials at FEMA Region V of the governor's forthcoming request for federal assistance and a presidential disaster declaration. FEMA authorities will deploy a FEMA liaison officer to the SIRC when a presidential disaster declaration appears imminent.

2.3.6 State Burn Coordinating Center

- 1. Definition: The state of Illinois will establish one health care facility to act as the SBCC. This facility will be responsible for assisting IDPH through the PHEOC with managing any mass casualty burn incident as defined in this annex for which the resources of any given region or the state are overwhelmed. The SBCC should be a health care facility with recognized

expertise in the care of burn patients, and the ability to accomplish the responsibilities outlined below, including providing consultative and care coordination assistance to hospitals beyond its geographic region, the state and to other states (as identified in the GLHP Regional Burn Surge Annex).

2. Criteria for SBCC:
 - a. Around-the-clock on-call coverage by a burn surgeon and burn disaster response support team
 - b. Adult and pediatric trauma capabilities
 - c. Telemedicine capabilities
 - d. Redundant and diverse interoperable communications
 - e. State Health Alert Network participation
 - f. In addition, the SBCC is encouraged to seek other opportunities that would lend to enhancing their expertise and excellence in burn and trauma care, such as standards defined by national professional organizations (e.g., American Burn Association verification as a Burn Center or the American College of Surgeon Trauma Center Designation).
3. Redundancy Plan: IDPH PHEOC will assist with identifying a secondary/back up SBCC should the pre-designated SBCC be unable to fill this role. Hospitals with burn capabilities should preplan to have internal plans, processes and systems in place to fill this role during a large scale event should they be needed.

2.3.7 Trauma Advisory Council (TAC), Burn Advisory Subcommittee

1. Purpose
 - a. Coordinate and provide oversight to ongoing efforts associated with assuring preparedness for a large-scale burn incident.
 - b. Assure longevity by incorporating burn surge planning into an already existent state infrastructure.
 - c. Allow key stakeholders from throughout the state to be involved in the decision-making related to future planning and coordination for burn surge events, and other burn related issues.
 - d. Assist with multiple long-term maintenance activities associated with statewide burn planning (e.g., ongoing training/education and exercises; review of burn management protocols, supply cache guidelines and the Burn Surge Annex).

2.4. PATIENT CARE AND MOVEMENT

The Burn Surge Annex is designed to help coordinate components of care as related to burn victims during an incident.

2.4.1. Patient Tracking

As burn patient movement occurs throughout Illinois and its border states, tracking the location of patients is crucial in aiding the reunification with their families, especially for pediatric burn patients. Electronic patient tracking may be available in some regions. Manual tracking of patient movement through the methods listed below will be necessary until all regions have electronic systems.

1. *Patient Identification Tracking Form* (see Attachment 9)
 - a. Purpose: To assist in identifying, tracking and reunification of burn patients during a disaster.
 - b. Responsibility: The primary physician and/or nurse at every health care facility.
 - c. Instructions: This form will be completed to the best of the ability given the information/resources available on ALL burn patients that arrive at a health care treatment facility (hospital, clinic, ACS, ATS and TMTS) regardless if they are accompanied by a family or, if the patient is a child, accompanied by their parent/guardian. This form records demographic information, description of the patient, a place to attach a photo of the patient, patient tracking log, accompanied and unaccompanied child information, medical history and disposition. The form should be copied. The original of this form will accompany the patient if/when the patient is transferred to another facility and a copy should be kept as part of the facility's medical record. Each receiving facility will add their facility's information in the Patient Tracking Log section. **NOTE: Attempts should be made to keep patient identification (ID) bands from previous facilities and triage tags from EMS on the patient.** If ID bands need to be removed, attach the removed band to this form under the Patient Tracking Log section of this form. If triage tags are removed, ensure all information on the tag is incorporated into the patient's medical record or, if possible, place a photo copy of the tag in the patient's medical record.
2. *Burn Patient Tracking Log* (see Attachment 10)
 - a. Purpose: To assist with tracking burn patients during a disaster.
 - b. Responsibility: Burn subject matter experts at the SBCC who are assisting with the coordination of patient movement.
 - c. Instructions: This form will be completed as the transfer of burn patients is coordinated by the SBCC and patients are transported to other health care facilities. Any issued tracking number, name or date of birth, hospital's name, location and time transfer was completed shall be recorded on all patients. This document will be forwarded to the IDPH at the PHEOC after completion by the SBCC and stored in the same manner as other incident-related command documents after the PHEOC closes.
3. Additional Pediatric Patient Tracking Resources
 - a. American Red Cross (ARC) Patient Connection Program
The Patient Connection Program may be available during a large scale event throughout Illinois and northwest Indiana. The program is activated when a local incident sends 10 or more people to hospitals. A call center is opened for inquires about those who may have been hospitalized. Hospitals should follow the procedure outlined in the memorandum of understanding (MOU) with the ARC.

2.4.2. Patient Triage and Transfer Coordination

During burn MCIs, resources at hospitals with burn capabilities will quickly become exhausted. Therefore, hospitals may need to care for burn patients for longer periods of time until they are able to transfer these patients to a higher level of care. The *Burn Triage Guidelines* were developed to ensure burn patients are triaged to hospitals that, based on their pre-event capabilities (through designation within the Illinois Trauma System), are most appropriate to provide burn care until that patient can be transferred or referred to a hospital with burn capabilities. Specifically within the *Burn Triage Guidelines* are Mass Casualty Burn Center Referral Criteria that is intended to assist with triage decisions primarily for hospital-to-hospital transfers, not triage at the scene. The *Burn Medical Incident Report Form* (see Attachment 4) should be utilized to provide requests for burn resources and to communicate the number and triage category for patients needing interfacility transfer.

Burn Triage Guidelines (see Attachment 11)

- a. Purpose: To provide EMS, SBCC and hospitals (regardless of their burn capabilities) guidance on determining patients that should be triaged to hospitals with burn capabilities during a burn mass casualty incident.
- b. Responsibility: EMS agencies and hospitals regardless of their burn capabilities are recommended to be familiar with and utilize the *Burn Triage Guidelines* to assist with transfer decision-making during a burn MCI. The SBCC also will utilize these guidelines to assist in the transfer coordination of burn patients during a burn MCI.
- c. Instructions: As outlined in the *Burn Triage Guidelines*, EMS would follow their system protocols for response to a MCI and triage using state approved MCI triage methods (START/ JumpSTART[®]) and coordinate with local medical control to divide the patients based on their needs and resources available. It is also important that EMS consider assisting with patient tracking/family reunification per their protocols and the recommendations within the *Burn Triage Guidelines*. Once patients arrive at the initial hospital for treatment, the *Burn Triage Guidelines*, including the Mass Casualty Burn Center Referral Criteria, should be initiated. The *Burn Triage Guidelines*, including the Mass Casualty Burn Center Referral Criteria and guidance from the SBCC, should help guide practitioners in determining the most appropriate category of hospital for a burn patient to be transferred to in order to receive burn care during a burn MCI (See Section 2.3.1 and 3.2.6 for hospital category definitions). The initial hospital should complete the “Current Number of Burn Patient Placement Needs” section of the *Burn Medical Incident Report Form* (Attachment 4) to communicate the number and types of burn patients that need to be transferred to a different facility for care. This form should then be sent to the SBCC via the mechanism identified in the “Reply/Action Required” section.

1. *Burn Patient Transfer Form* (see Attachment 12)

- a. Purpose: To provide a method of communicating medical and treatment information on burn patients during a disaster when the patients are being transferred to another facility for care. This information will be shared with the physician at the receiving facility and the SBCC and assist with ensuring continuity of care for burn patients when they arrive at the receiving facility.
- b. Responsibility: The physician responsible for the burn patient at the originating hospital and who has identified a higher level of care is needed than what can be provided at the current location.
- c. Instructions: This form will be completed at the originating hospital and sent with the patient to the receiving hospital. This form may also be utilized by the SBCC to assist with triage decision making for patients who may need special consideration during the triage process. This form provides the receiving hospital and the SBCC with basic demographic information, past medical history, burn injury history, medical management that has been performed and transport needs.

2.4.3. Patient Transport

The transportation needs during a large scale incident leading to significant numbers of burn patients may be quite extensive. The referral physician and staff, the SBCC and accepting/receiving physician will work together to identify the resources needed to transport the burn patient(s) in the most efficient and safe manner available at the time. The SBCC can assist hospitals in identifying known transport companies and alternative methods for transporting burn patients, especially if interstate transport is required. If transport resource assistance is needed, the sending hospital should follow the RFMR process and request assistance from their RHCC. The Illinois Association of Air and Critical Care Transport maintains an *Illinois Aircraft Resource Guide* and an *Illinois Critical Care Ground Resource Guide* that may assist with identifying transport resources throughout the state during a disaster. This list which may not be inclusive, can be found at:

<http://iaacct.org/resources/> .

2.4.4. Burn Guidelines

During a large scale incident, normal interfacility transfer patterns may be disrupted. Hospitals that typically transfer acutely ill/injured burn patients to hospitals with burn capabilities may need to care for these patients for longer periods of time until they are able to transfer these patients to a higher level of care. The SBCC can be accessed for medical consultation. In addition, the *Adult Burn Guidelines* (Attachment 13) and the *Pediatric Burn Guidelines* (Attachment 14) are available as an adjunct to this annex. They provide support and guidance to those practitioners caring for burn patients during the initial 72 hours following an incident.

1. Purpose: To provide guidance to practitioners caring for adult and pediatric burn patients during a disaster.
2. Responsibility: These guidelines are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical

judgment. These guidelines may be modified at the discretion of the health care provider.

3. Instructions: Practitioners may use the *Adult Burn Guidelines* and the *Pediatric Burn Guidelines* found attached to this annex as a reference and to assist with care of burn patients during a disaster. These guidelines will be updated and maintained by the Illinois TAC Burn Advisory Subcommittee.

2.4.5. Burn Supply Caches

During burn MCIs, resources at hospitals with burn capabilities will quickly become exhausted. Attachment 15 is the *Recommended Burn Supply Cache* that hospitals, regardless of their burn capabilities, should consider building within their internal disaster supply caches and adjust the volume within the cache based on its surge planning. For example, hospitals without burn capabilities may consider building their burn supply cache to care for minimally five burn patients. Non-burn trauma centers that may care for more significantly ill/injured burn patients, may consider building burn supply cache to care for minimally 10 burn patients. The *Recommended Burn Supply Cache* list will be reviewed and updated by the Illinois TAC Burn Advisory Subcommittee. Regional and statewide burn supply caches also may be available to assist hospitals, regardless of their burn capabilities, with caring for burn patients during a burn MCI. These resources should be requested through the same manner as indicated in the RFMR process in the IDPH ESF-8 Plan.

3.0 ROLES, RESPONSIBILITIES, AND RESOURCE REQUIREMENTS

3.1 PRIMARY AGENCY

3.1.1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH

1. Role and Responsibility
 - 1) Provide leadership in directing, coordinating and integrating overall state efforts to provide public health and medical assistance to affected areas and the populations within those areas.
 - 2) Assist with the communication between stakeholders (e.g., hospitals, LHDs, border states, GLHP) during an event.
 - 3) Coordinate and direct the activation and deployment of this Burn Surge Annex as part of the IDPH ESF-8 Plan either partially or in its entirety as indicated by the burn resource needs following an incident.
 - 4) Collaborate with IEMA on the RFMRs for burn specific resources from hospitals, LHDs, alternate care sites, alternate treatment sites and temporary medical treatment stations.

3.2 SUPPORT AGENCIES/FACILITIES/ORGANIZATIONS

3.2.1 ILLINOIS EMERGENCY MANAGEMENT AGENCY

1. Role and Responsibility
 - 1) Work with specific agency(ies) within jurisdiction(s) to gain a situational awareness of the incident.

- 2) Collaborate with IDPH on the RFMRs for burn specific resources from hospitals, LHDs, alternate care sites, alternate treatment sites and temporary medical treatment stations.
- 3) Proceed with established procedures for requesting disaster declaration (state and federal) as indicated.
- 4) Proceed with established procedures for facilitating EMAC requests as indicated

3.2.2 STATE BURN COORDINATING CENTER (SBCC)

1. Role and Responsibility

1) Pre-event

- a. Designate a chair for the TAC Burn Advisory Subcommittee.
- b. Participate in the TAC Burn Advisory Subcommittee and assist with projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex).
- c. Ensure mechanisms are in place internally to respond as the SBCC during an event (e.g., internal burn surge plan, incorporation of SBCC roles into Incident Command Structure, redundant and diverse communication systems). See Attachment 17 for *SBCC HICS Organizational Chart* and Attachment 17 for *SBCC Job Action Sheets*.
- d. Ensure contingency plan is in place if unable to fulfill SBCC role during a burn mass casualty incident.
- e. Identify single point of contact.

2) During an event

- a. Verify single point of contact.
- b. Coordinate burn consultation to those non-burn hospitals (i.e., trauma centers with no burn capabilities and non-trauma/non-burn hospitals).
- c. Utilize telemedicine as appropriate and available.
- d. Assist IDPH with statewide triage and the coordination of interfacility transfers of burn patients from non-burn facilities to burn facilities.
- e. Assist IDPH with the coordination of patient placement (either intra state or interstate) during system decompression process.
- f. Communicate with key stakeholders (IDPH and GLHP).
- g. Ensure proper documentation.
 - i. *Burn Casualty Communication Log* (Attachment 18)
 - ii. *Burn Patient Tracking Log* (Attachment 10)
 - iii. *Post-Event Data Collection Log* (Attachment 19)

3) Post-event

- a. Conduct an internal debriefing and after action report (AAR) and participate in the IDPH debriefing and contribute to the IDPH AAR.
- b. Provide lessons learned to the TAC Burn Advisory Subcommittee, IDPH and GLHP as appropriate.
- c. Provide lessons learned to key stakeholders (e.g., resource hospitals, RHCCs, EMS) to identify improvement opportunities at the local level.

- d. Assist the TAC Burn Advisory Subcommittee with outlining recommendations to IDPH for updating the Burn Surge Annex based on lessons learned from the event.

3.2.3 REGIONAL HOSPITAL COORDINATING CENTER (RHCC)

1. Role and Responsibility

- 1) Provide care for burn patients who arrive at the facility to the best of the facility and practitioners' ability.
- 2) Provide patient families with information about the event and education about components of the annex that may involve their family member's care (e.g., coordination of care statewide and transfer processes).
- 3) Provide necessary situational awareness communications to/from the affected and/or assisting hospital(s) within the region and to/from IDPH.
- 4) Inform IDPH, as appropriate, when regional ESF-8 Plan has been activated.
- 5) Inform IDPH, as appropriate, when regional burn resources have been depleted.
- 6) Assist with the communication and RFMR for burn specific resources as indicated in this annex (See Attachment 5 for Burn Communication Pathway and Section 2.3.3).
- 7) Assist hospitals with accessing Illinois Helps.
- 8) Function as a liaison between IDPH, IEMA, and hospitals and EMS providers within its region.

3.2.4 RESOURCE HOSPITALS

1. Role and Responsibility

- 1) Provide care for burn patients who arrive at the facility to the best of the facility and practitioners' ability.
- 2) Provide patient families with information about the event and education about components of the annex that may involve their family member's care (e.g., coordination of care statewide and transfer processes).
- 3) Assist with the communication and RFMRs for burn specific resources as indicated in the regional ESF-8 Plan, the IDPH ESF-8 Plan and in this annex (See Attachment 5 for Burn Communication Pathway and Section 2.3.3).
- 4) Function as a liaison between the EMS associate and participating hospitals within their region and the RHCC.
- 5) Assist with the communication with EMS providers within their EMS system.

3.2.5 ALL OTHER HOSPITALS

1. Role and Responsibility

- 1) Provide care for burn patients who arrive at the facility to the best of the facility and practitioners' ability.
- 2) Provide patient families with information about the event and education about components of the Aannex that may involve their family member's care (e.g., coordination of care statewide and transfer processes).
- 3) Communicate and submit RFMR for burn resources as necessary as indicated in the regional ESF-8 Plan, the IDPH ESF-8 Plan and in this

annex (See Attachment 5 for Burn Communication Pathway and Section 2.3.3).

3.2.6 ADDITIONAL HOSPITAL BURN CATEGORIZATION

The following information provides the definitions of the categorization of hospitals as it relates to this annex and the response during a burn MCI. The roles and responsibilities outlined below are *in addition* to the roles and responsibilities outlined in Sections 3.2.3, 3.2.4 and 3.2.5.

1. HOSPITALS WITH BURN CAPABILITIES

1) Role and Responsibility

a. Pre-event

- i. Participate in the TAC Burn Advisory Subcommittee and assist with projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex)
- ii. Ensure mechanisms are in place internally to respond as a backup SBCC during an event, if the pre-identified SBCC is unable to fulfill its role (e.g., internal burn surge plan, incorporation of SBCC roles into Incident Command Structure, redundant and diverse communication systems). See Attachment 16 for *SBCC HICS Organizational Chart* and Attachment 17 for the *SBCC Job Action Sheets*.
- iii. Identify single point of contact.

b. During an event

- i. Verify single point of contact.
- ii. Coordinate with the SBCC to accept and to care for those patients triaged as “*Immediate (Red)*” and who meet the Mass Casualty Burn Center Referral Criteria (See Attachment 11 for *Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).

c. Post event

- i. Assist the TAC Burn Advisory Subcommittee with outlining recommendations to IDPH for updating the Burn Surge Annex based on lessons learned from an event or exercises.

2. LEVEL I TRAUMA/NON-BURN HOSPITALS

1) Role and Responsibility

a. Pre-event

- i. Provide feedback to the TAC Burn Advisory Subcommittee on projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex).

b. During an event

- i. Coordinate with the SBCC during the event to accept and care for those patients triaged as “*Urgent (Yellow)*” (See Attachment 11 for *Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).

- ii. Coordinate with the SBCC through the processes outlined in the annex to triage and transfer burn patients to higher level of care.

3. LEVEL II TRAUMA/NON-BURN HOSPITALS

1) Role and Responsibility

a. Pre-event

- i. Provide feedback to the TAC Burn Advisory Subcommittee on projects related to state burn surge planning (e.g., ongoing training/education and exercises; ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex).

b. During an event

- i. Coordinate with the SBCC during the event to accept and care for those patients triaged as “*Urgent (Yellow)*” (See Attachment 11 for *Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).
- ii. Coordinate with the SBCC through the processes outlined in the annex to triage and transfer burn patients to higher level of care.

4. NON-BURN/NON-TRAUMA HOSPITALS

1) Role and Responsibility

a. During an event

- i. Coordinate with SBCC during the event to accept and care for those patients triaged as “*Non-Urgent (Green)*” (See Attachment 11 for *Burn Triage Guidelines* and the Mass Casualty Burn Center Referral Criteria).
- ii. Coordinate with the SBCC through the processes outlined in the annex to triage and transfer burn patients to higher level of care.

3.2.7 TRAUMA ADVISORY COUNCIL (TAC) BURN ADVISORY SUBCOMMITTEE

The TAC Burn Advisory Subcommittee coordinates and provides oversight to ongoing efforts associated with assuring preparedness for a large-scale burn incident in Illinois. Incorporating burn surge planning into an already existent state infrastructure will assure longevity of burn preparedness activities. A burn expert from the SBCC will chair the subcommittee, and an Illinois TAC member will serve as co-chair. The Burn Advisory Subcommittee’s roles and responsibilities occur during the planning and preparedness/mitigation phases, and do not have a direct role in the response.

1. Role and Responsibility

- 1) Function under the direction of the TAC and follow the hierarchy and reporting structure outlined in the TAC bylaws and the Burn Advisory Subcommittee bylaws.
- 2) Establish relationships and partnerships with key stakeholders and coordinate with these stakeholders from throughout the state to be involved in the decision-making related to future planning and coordination for burn surge events, and other burn related issues.
- 3) Assist with the multiple long-term maintenance activities associated with statewide burn planning (e.g., ongoing training/education and exercises;

ongoing review of burn management protocols, supply cache guidelines and the State Burn Surge Annex) to ensure a consistent approach across the state.

3.2.8 LOCAL HEALTH DEPARTMENTS

1. Role and Responsibility

- 1) Assist hospitals in obtaining supplies from the Strategic National Stockpile (SNS), specific to burn patients, as requested, through the processes that are currently identified and incorporated into their existing plans and the IDPH ESF-8 Plan.
- 2) Maintain communication and provide situational awareness updates, specific to burn patients, to hospitals and IDPH as indicated.

3.2.9 BORDER STATES

1. Great Lakes Healthcare Partnership

1) Role and Responsibility

- a. The IDPH Representative or the representative from the SBCC will notify the Minnesota Department of Health, Office of Emergency Preparedness at 651-201-5735 and specifically ask for the GLHP contact who can assist with the communication and resource assistance in the first 24-72 hours of a significant incident involving a large number of burn casualties.
- b. The GLHP Regional Burn Plan has been developed for the members of the GLHP in an effort to expand the ability to provide burn care, and to safeguard and to prioritize the utilization of limited resources.
- c. Each state identifies a SBCC to facilitate a uniform response to a mass burn incident that exceeds the resources available at the local, regional, city, or state level and can assist with the coordination of care with other GLHP SBCCs.

2. Iowa

1) Role and Responsibility

- a. The IDPH representative or the representative from the SBCC will notify the on call Iowa Department of Public Health duty officer at 866-834-9671/ Duty.Officer@idph.iowa.gov regarding the situation and burn resource needs. The duty officer can then assist with the identification of burn resource availability in hospitals, transport services and EMS, and assist with communication with Iowa hospitals/agencies.

3. Kentucky

1) Role and Responsibility

- a. The IDPH representative or the representative from the SBCC will notify the on call KYEM duty officer in the Commonwealth Emergency Operations Center at 800-255-2587 regarding the situation and burn resource needs. The KYEM duty officer can assist with the identification and coordination of available burn resources (hospital and transport) (See Attachment 6).

4. Missouri

1) Role and Responsibility

- a. The IDPH representative or the representative from the SBCC will contact the SMOC duty officer by calling the *Central County 911* (St. Louis area) at 636-394-2212 and requesting to be connected to the duty officer. IDPH and/or the SBCC representative will notify the duty officer of the situation, who can then assist with the identification and coordination of available burn resources (See Attachment 7)

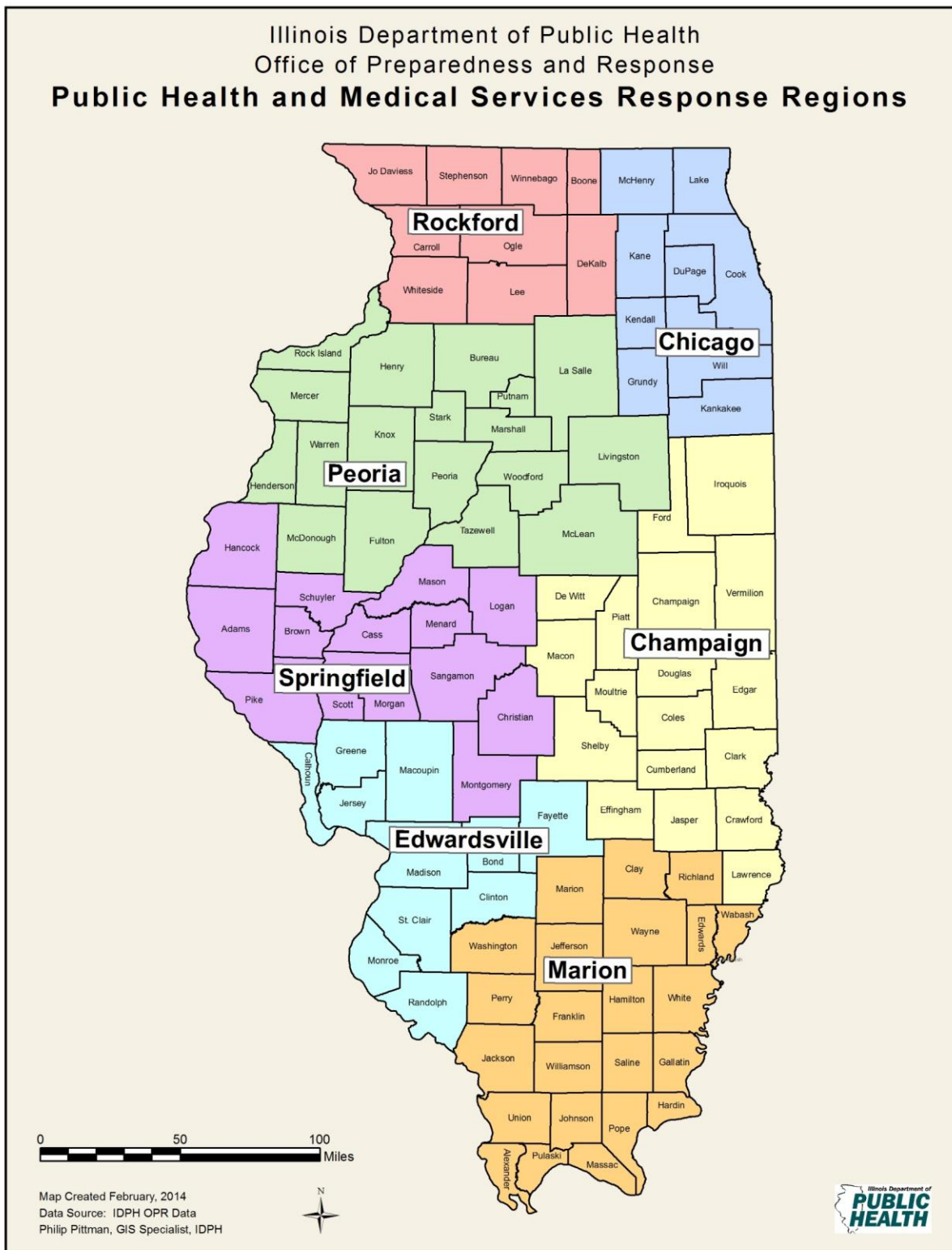
3.2.10 ILLINOIS HELPS

The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) system for Illinois (Illinois HELPS) supports the pre-registration, management, and mobilization of clinical and non-clinical volunteers to help in responding to all types of disasters. The volunteer management system is part of a nationwide effort to ensure volunteer professionals can be quickly identified and their credentials checked so they can be properly utilized in a disaster response.

1. Role and Responsibility

- 1) Provide a method to track credentials, qualifications, certifications, contact information and training of burn experts throughout the state.

ATTACHMENT 1: PUBLIC HEALTH AND MEDICAL SERVICE RESPONSE REGIONS MAP



ATTACHMENT 2: IDPH OPR IMT ORGANIZATIONAL CHART

Chart of IDPH Office of Preparedness and Response Incident Management Team (IMT)

Command Staff

Incident Commander
Title
OPR Deputy
EMS Chief
FGM Chief

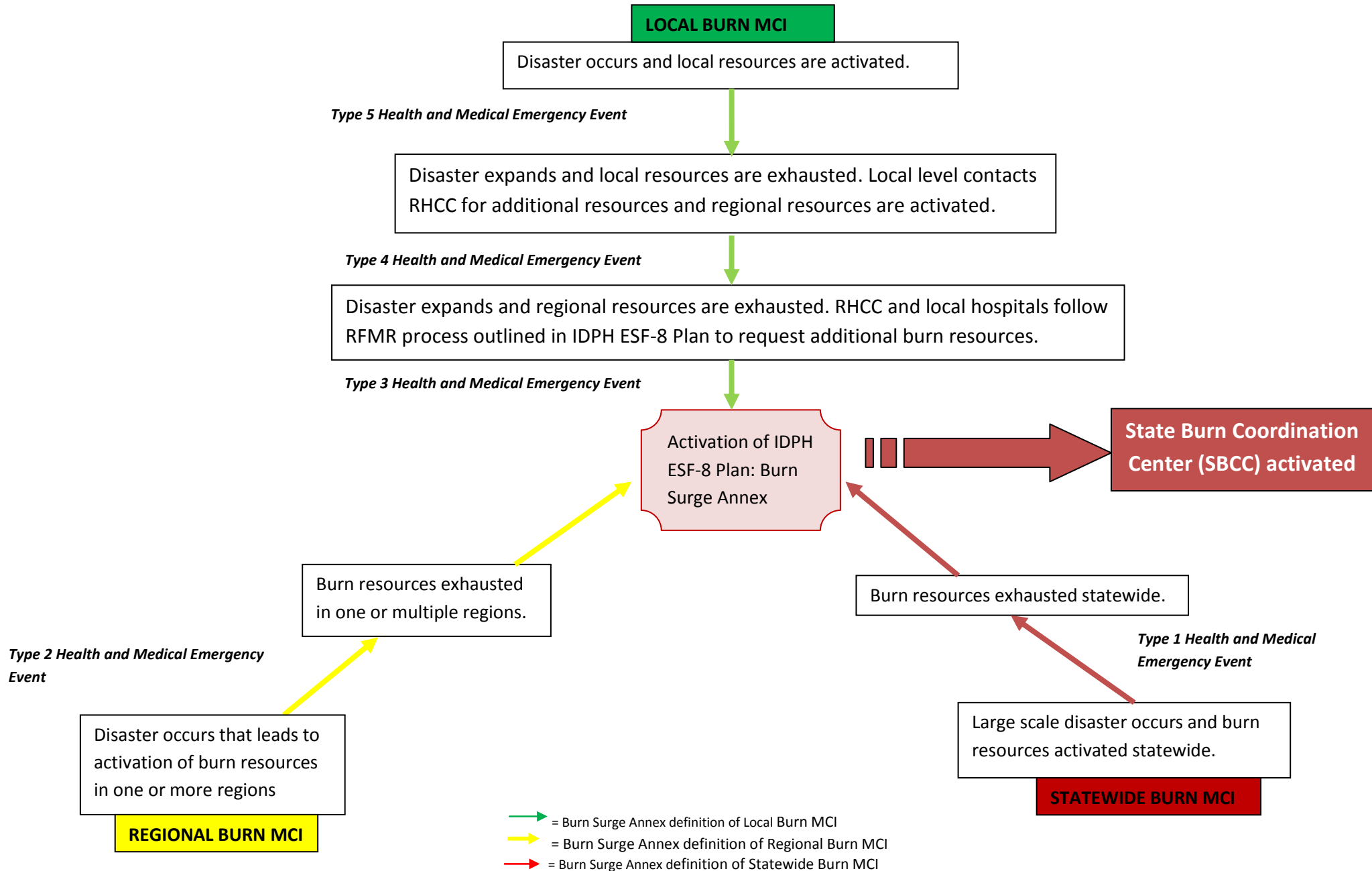
Safety Officer	Liaison Officer	Public Information Officer	State ESF-8 Lead State Incident Response Center (SIRC)
Title	Title	Title	Title
T and E Safety Officer	OPR Administrative Assistant	Communications Manager	DPR Chief
EMS Special Programs Coordinator	DPR Administrative Assistant	Communications Manager	All-Hazards Planning Section Chief
	EMS Administrative Assistant		

General Staff

Operations Section	Planning Section	Logistics Section	Finance and Administration Section
Title	Title	Title	Title
EMS Chief	All-Hazards Planning Section Chief	PHEOC Coordinator	FGM Chief
ERC Regional Supervisor	Evaluation Coordinator	Accounting Technician	HPP Grants Manager
HPP Program Manager			PHEP Grants Manager

ATTACHMENT 3: BURN SURGE ANNEX ACTIVATION PATHWAY

Purpose: To outline the types of incidents that prompt the activation of the Burn Surge Annex



ATTACHMENT 4: BURN MEDICAL INCIDENT REPORT FORM

INCIDENT NAME			
DATE/TIME PREPARED	DATE/TIME RECEIVED	OPERATIONAL PERIOD	RECEIVED VIA <input type="checkbox"/> Phone <input type="checkbox"/> Radio <input type="checkbox"/> Fax <input type="checkbox"/> Other
FROM (SENDER)	TO (RECEIVER)	REPLY/ACTION REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, reply to (<i>include detailed sending information</i>)	
PRIORITY <input type="checkbox"/> Urgent/High <input type="checkbox"/> Non-urgent/Medium <input type="checkbox"/> Informational/Low			
DATE/TIME PHEOC ACTIVATED		REASON FOR PHEOC ACTIVATION	
DATE/TIME ANNEX ACTIVATED		REASON FOR ANNEX ACTIVATION	
ACTIVATION LEVEL <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> State		STATE BURN COORDINATION CENTER (SBCC) NAME	
DATE/TIME SBCC ACTIVATED		REASON FOR SBCC ACTIVATION	
CURRENT INCIDENT INFORMATION			
<p align="center">CURRENT NUMBER OF BURN PATIENT PLACEMENT NEEDS</p> <p>(The purpose of this section is to identify the number of and what services are needed to care for burn patients during a burn MCI. These categories are for interfacility transfers only, not EMS scene transports. For more information, see Burn Surge Annex, Attachment 11: Burn Triage Guidelines: Mass Casualty Burn Center Referral Criteria)</p>			
	IMMEDIATE (RED) CRITICAL BURN PATIENTS TO BE TREATED AT HOSPITALS WITH BURN CAPABILITIES.		
	URGENT (YELLOW) CRITICAL BURN PATIENTS TO BE TREATED AT HOSPITALS WITH TRAUMA CAPABILITIES BUT NO BURN CAPABILITIES.		
	MINOR (GREEN) BURN PATIENTS TO BE TREATED AT ANY ACUTE CARE HOSPITAL.		
	EXPECTANT (BLACK) BURN PATIENTS TO BE TREATED AT ANY ACUTE CARE HOSPITAL.		

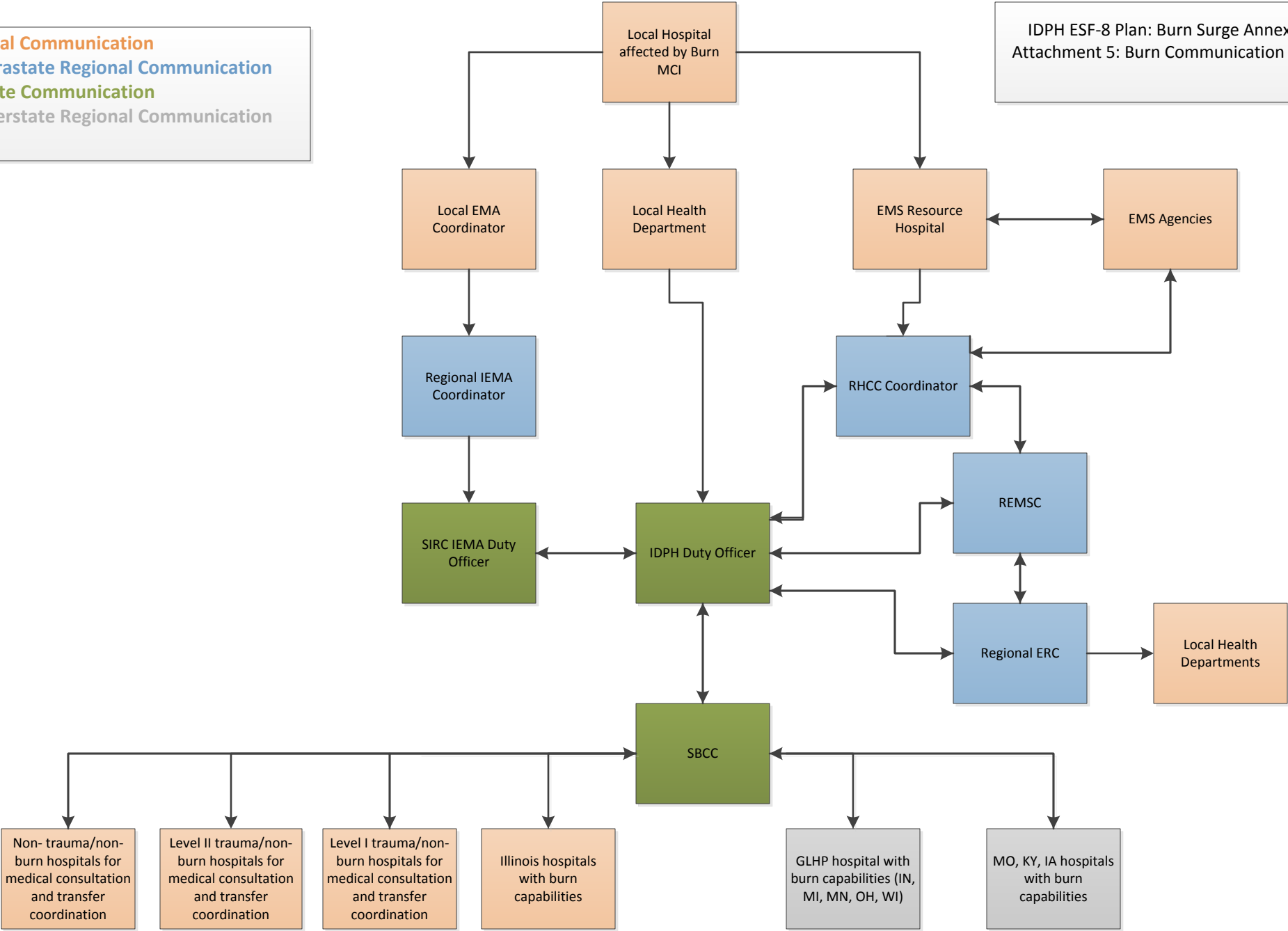
ATTACHMENT 4: BURN MEDICAL INCIDENT REPORT FORM**REQUIRED/REQUESTED ACTIONS AT THIS TIME****RECEIVED BY****TIME RECEIVED****FORWARD TO****COMMENTS****FACILITY NAME/LOCATION**

Local Communication

Intrastate Regional Communication

State Communication

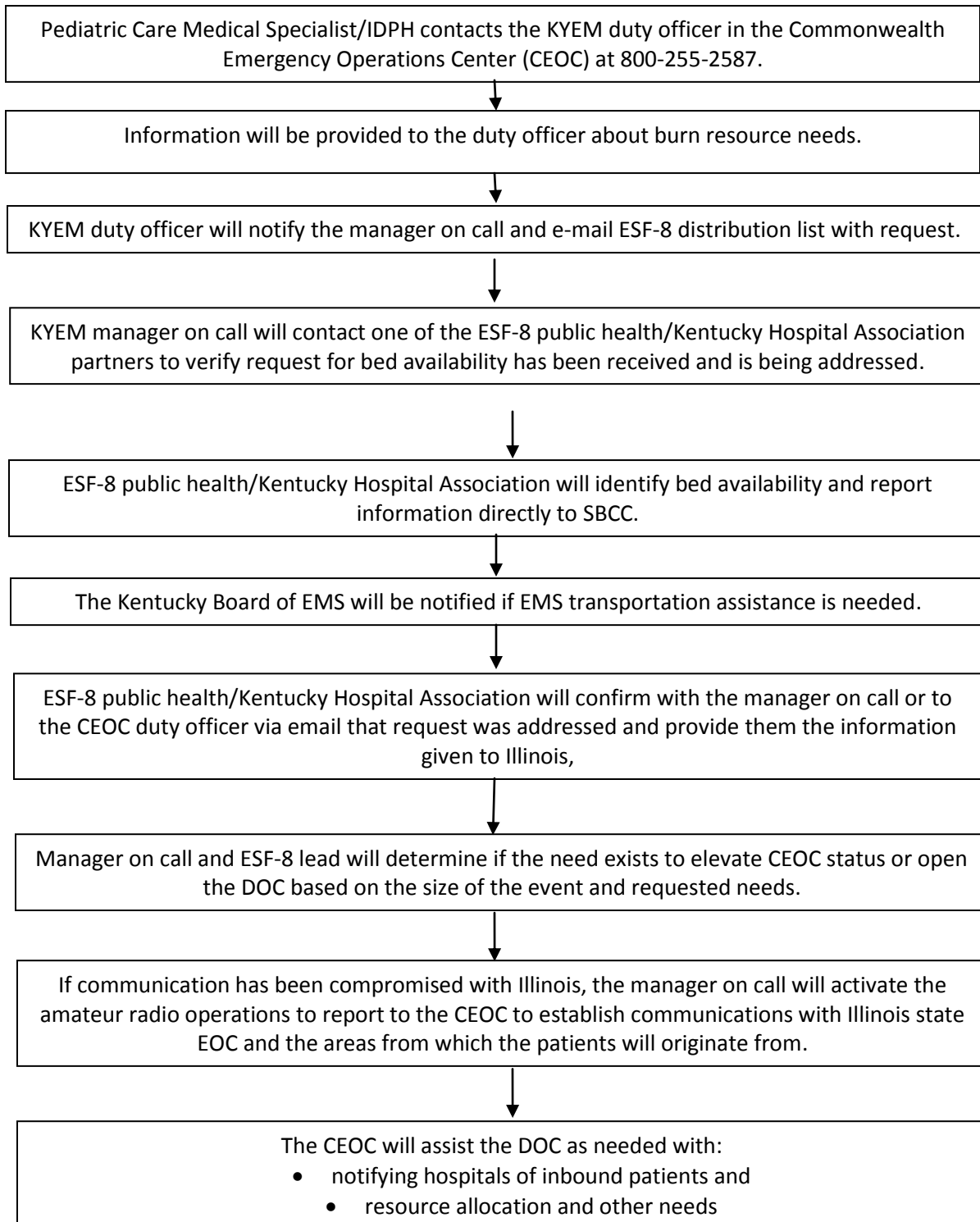
Interstate Regional Communication



IDPH ESF-8 Plan: Burn Surge Annex | 2014

ATTACHMENT 6: KENTUCKY RESOURCE REQUEST PROCESS

Purpose: To outline the contact information with Kentucky in order to facilitate communication during a disaster

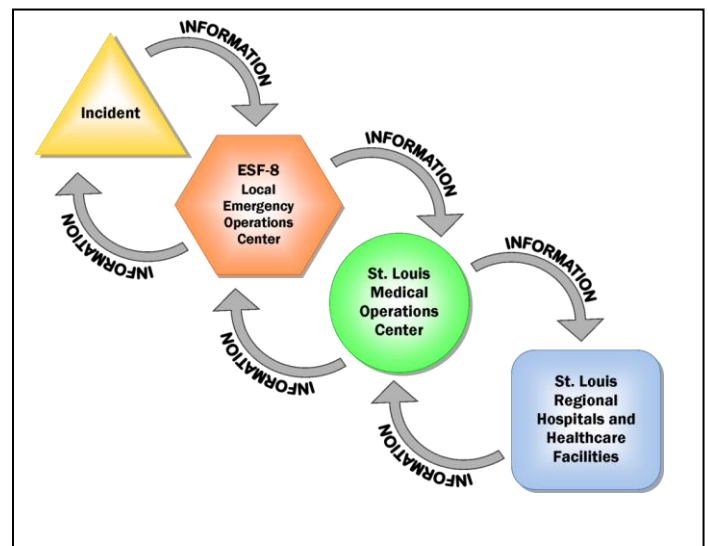
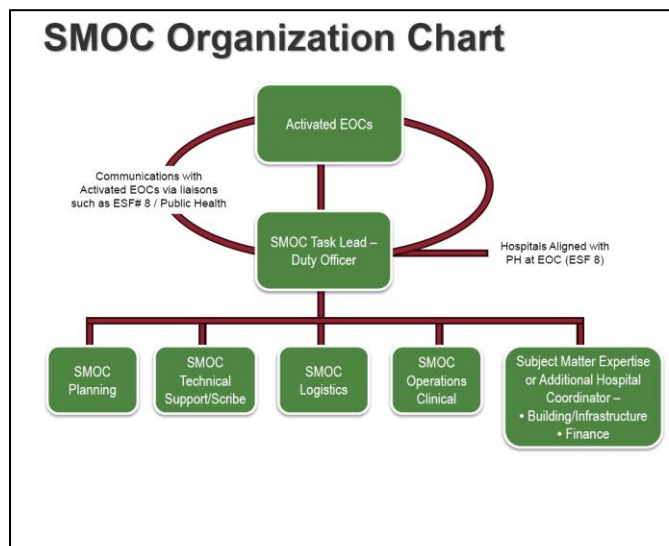


ATTACHMENT 7: ST. LOUIS MEDICAL OPERATION CENTER REQUEST PROCESS

Purpose: To outline the contact information for Missouri in order to facilitate communication during a disaster.

St. Louis Medical Operation Center (SMOC)

- Regional coordination entity supported and staffed by health care organizations to help coordinate decision making for hospitals when hospitals need assistance beyond their walls.
- Supported by volunteers from the medical community (administrative, clinical, non-clinical).
- During an emergency:
 - Serves as central point of contact among health care facilities, state and local emergency management agencies, and other governmental and non-governmental agencies as needed.
 - Collects and disseminates current situational information about incident and facility status.
 - Accesses health care resources and needs (e.g., equipment, bed capacity, personnel, supplies, etc.).
 - Develops priority allocations.
 - Tracks disbursement of resources.
 - Manages relevant health care response and communication.
 - Serves as advisors to other emergency support functions (ESF's) within the EOC.

**Process for Communication:**

- SBCC/IDPH contacts the Central County 911 Center at 636-394-2212 and request SMOC duty officer be contacted.
- The duty office will then serve as the liaison to identify burn resource availability, send information to Missouri hospitals and assist with the coordination of transfers.

ATTACHMENT 8: ILLINOIS BURN RESOURCE DIRECTORY

SBCC* HOSPITAL	BURN TRANSFER PHONE	TRAUMA CENTER LEVEL	EMS REGION	PEDIATRIC BURN CRITICAL CARE CAPABILITY	NUMBER OF BURN BEDS
ADDRESS	BURN UNIT PHONE		PHMSRR**		TOTAL SURGE BED CAPACITY
Loyola University Medical Center ^V 2160 S. First Ave. Maywood, IL 60153	708-216-3988	Level I	8	Y	10 ICU, 11 step-down
	708-216-3988		Chicago		Total: 32-33
HOSPITAL	BURN TRANSFER PHONE	TRAUMA CENTER LEVEL	EMS REGION	PEDIATRIC BURN CRITICAL CARE CAPABILITY	NUMBER OF BURN BEDS
ADDRESS	BURN UNIT PHONE		PHMSRR**		TOTAL SURGE BED CAPACITY
John H. Stroger, Jr. Hospital of Cook County Summer L. Koch Burn Center 1901 W. Harrison St., Chicago, IL 60612	312-864-1024	Level I and Pediatric Level I	11	Y	6 Adult ICU, 10 PICU, 10 step-down
	312-864-3144		Chicago		Total: 30-35
Memorial Medical Center Regional Burn Center SIU School of Medicine 701 N. First St. Springfield, IL 62781	877-662-7829	Level I	3	—	8 Universal (medical, step down, ICU)
	217-788-3325		Springfield		Total: 10
OSF St. Anthony Medical Center 5666 E. State St. Rockford, IL 61108	888-350-5433	Level I	1	—	8 ICU
	815-395-5313		Rockford		Total: 18
University of Chicago Medical Center ^V 5841 S. Maryland Ave. Chicago, IL 60637	800-621-7827	Pediatric Level I	11	Y	8 ICU, 8 Medical
	773-702-6736		Chicago		Total: 20

* State Burn Coordinating Center

V=American Burn Association Verified Burn Center

** Public Health and Medical Services Response Regions

ATTACHMENT 9: PATIENT IDENTIFICATION TRACKING FORM

Purpose: To assist in identifying, tracking and reunifying patients during a disaster.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Date of Arrival ____/____/____	Time of Arrival _____ AM/PM	Tracking number _____
Patient's Name (Last, First) _____		Patient's Phone _____
Patient's Full Home Address _____		
(For Minors) Parent/Guardians' Names _____		Presented with patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient's DOB ____/____/____ <input type="checkbox"/> Unknown	Age ____ Years ____ Months <input type="checkbox"/> Estimated	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Race, if known <input type="checkbox"/> White non-Hispanic <input type="checkbox"/> Black, non-Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Nonverbal <input type="checkbox"/> Other _____
<input type="checkbox"/> Accompanied <input type="checkbox"/> Unaccompanied	Describe where patient was found (be as specific as possible, including neighborhood/street address). _____	Items worn by or with patient when found (describe color, pattern, type) <input type="checkbox"/> Pants _____ <input type="checkbox"/> Shirt _____ <input type="checkbox"/> Dress _____ <input type="checkbox"/> Shoes _____ <input type="checkbox"/> Socks _____ <input type="checkbox"/> Coat/Jacket _____ <input type="checkbox"/> Jewelry _____ <input type="checkbox"/> Glasses _____ <input type="checkbox"/> Medical Devices _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
How patient arrived at hospital (list name if available) <input type="checkbox"/> EMS _____ <input type="checkbox"/> Private medical transport service (ambulance/flight) _____ _____ <input type="checkbox"/> Law Enforcement _____ _____ <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Walk-in <input type="checkbox"/> Other _____		

DESCRIPTION OF THE PATIENT

Skin color _____	Attach photo here
Hair Color <input type="checkbox"/> Blonde <input type="checkbox"/> Brown <input type="checkbox"/> Black <input type="checkbox"/> Bald <input type="checkbox"/> Other _____	
Eye Color <input type="checkbox"/> Brown <input type="checkbox"/> Blue <input type="checkbox"/> Green <input type="checkbox"/> Other _____	
Height _____ <input type="checkbox"/> Estimated	
Weight _____ <input type="checkbox"/> Estimated	
Other markings <input type="checkbox"/> Scars _____ <input type="checkbox"/> Moles _____ <input type="checkbox"/> Birthmarks _____ <input type="checkbox"/> Tattoos _____ <input type="checkbox"/> Missing teeth _____ <input type="checkbox"/> Braces _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	

PATIENT TRACKING LOG

Hospital/Facility Name	Phone Number	Arrival Date	ID Band #/ ID Band
Location (city, state)	Fax Number	Departure Date	(If patient has ID bands from other facilities and they need to be removed to provide care, attach ID band in this area)
	()	____/____/____	Attach ID Band Here
	()	____/____/____	
	()	____/____/____	Attach ID Band Here
	()	____/____/____	
	()	____/____/____	Attach ID Band Here
	()	____/____/____	

MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY

Does the patient have any pre-existing medical conditions/medical problems/previous surgeries/special needs?

☐ No ☐ Unknown ☐ Yes (list)Is the patient on any medications? ☐ No ☐ Unknown ☐ Yes (list)Does the patient have any allergies? ☐ No ☐ Unknown ☐ Yes (list)

Did the patient receive medical care for an injury/illness while at this facility?

☐ No ☐ Yes (list)**COMPLETE FOR MINORS: CHILD ACCOMPANIED BY PARENT/GUARDIAN**

Name of Person Accompanying Child

☐ Adult ☐ Child/Minor

Relationship to Child

☐ Parent ☐ Guardian ☐ Sibling ☐ Grandparent☐ Aunt/Uncle/Cousin ☐ Unknown☐ Other _____

Attach Copy of ID

ID Checked? ☐ Yes ☐ No

Form of ID (list) _____

If accompanied by adult, was child living with this adult prior to the emergency? ☐ Yes ☐ NoDoes this adult have any proof of legal guardianship or relationship? ☐ Yes ☐ No

If yes, make copy and attach to this form.

If child and adult were separated after arrival at current facility, where is accompanying adult now?

If accompanied by someone other than parent/guardian, what is known about the parent/guardian's current whereabouts?

☐ Nothing at this time ☐ Their current location is:Is it known if there are orders of protection or other custody issues? ☐ No known custody/protection issues☐ Issue(s) identified**COMPLETE FOR MINORS: CHILD UNACCOMPANIED BY PARENT/GUARDIAN**Are the whereabouts of the parent/guardian currently known? ☐ No ☐ YesIs information about parent/guardian known? ☐ No ☐ Yes

Name

Phone

Location

E-mail Address

Where and when was the parent/guardian last seen

Has the parent/guardian been contacted? ☐ No ☐ Yes

Contacted by _____ Date ____/____/____ Time _____

Plans for reuniting child with parent/guardian

Agencies Used to Assist with Reunification (Date/Person Contacted)

☐ American Red Cross _____☐ Department of Children and Family Services _____☐ Law enforcement _____☐ National Center for Missing and Exploited Children _____☐ Other _____

Additional steps to verify guardianship if reunited at hospital

☐ Does parent/guardian describe child accurately?☐ Does parent/guardian pick correct child out from a group of pictures?☐ Does parent/guardian have a picture of them with the child?☐ Does the child respond appropriately when reunited with parent/guardian?**DISPOSITION**☐ Admitted to _____ ☐ Discharged ☐ Expired☐ Patient was released to an individual ☐ Parent ☐ Guardian ☐ Other _____

Name

Phone

Address

☐ Permanent ☐ TemporaryWas consent obtained from parent/guardian if released to another adult? ☐ Yes ☐ No (explain) _____☐ Patient was transferred to another facility/agency (Name) _____

Address

Phone

Contact Name

Transported by

Signature of patient/individual patient released to

Date: ____/____/____
Time

Name of Person Completing Form

Signature of Person Completing Form

ATTACHMENT 10: BURN PATIENT TRACKING LOG

Purpose: To assist with the tracking of burn patients during a disaster.

Tracking Number	Patient Name (Last, First)	DOB	% TBSA	Ventilated	IV Infusions	Burn Injuries	Inhalation Injury	Other Injuries (Trauma)	Triage Level (Red, yellow, Green)	Method of Transport (Ground, Air, BLS, ALS, Critical Care)	Assigned Receiving Facility	Transfer Complete (Time)
											POC at Receiving Facility	
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			

ATTACHMENT 10: BURN PATIENT TRACKING LOG

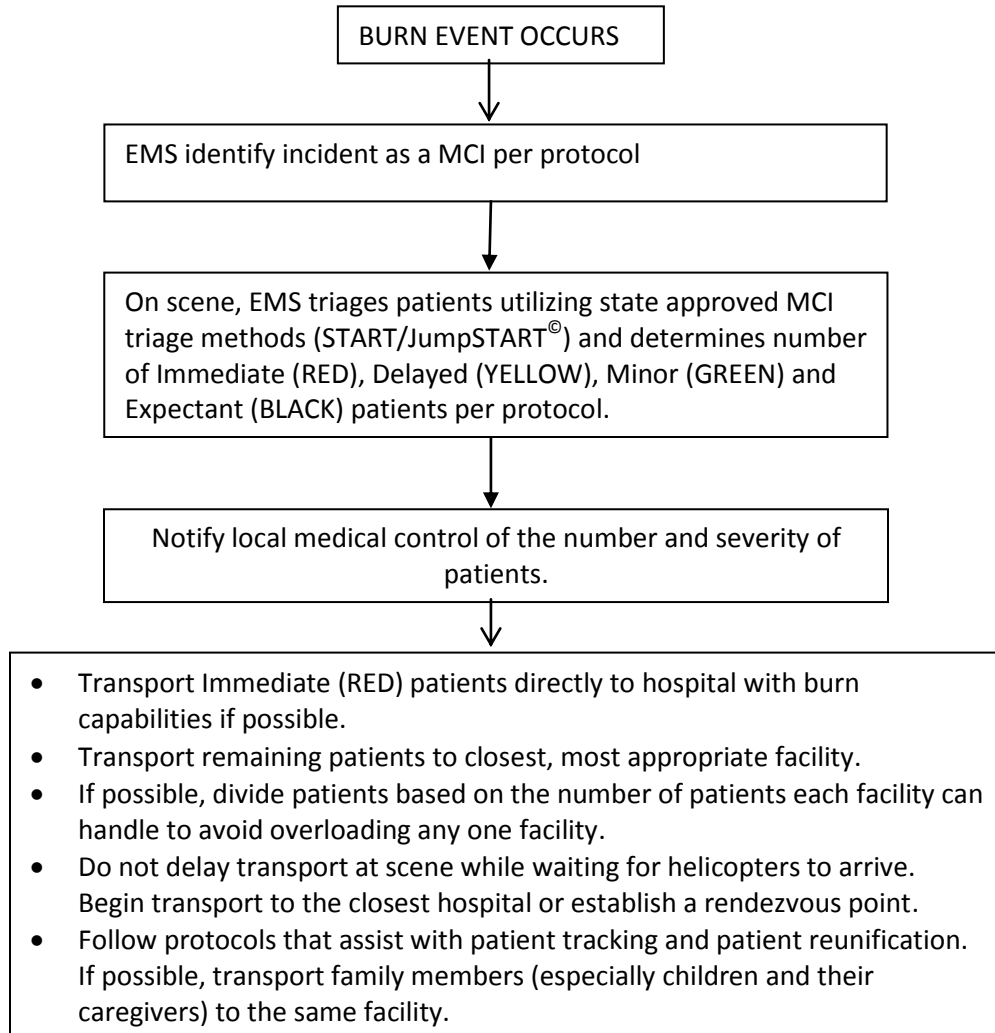
Tracking Number	Patient Name (Last, First)	DOB	% TBSA	Ventilated	IV Infusions	Burn Injuries	Inhalation Injury	Other Injuries (Trauma)	Triage Level (Red, yellow, Green)	Method of Transport (Ground, Air, BLS, ALS, Critical Care)	Assigned Receiving Facility	Transfer Complete (Time)
											POC at Receiving Facility	
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y N			Y N		R Y G			
				Y			Y		R Y G			

ATTACHMENT 10: BURN PATIENT TRACKING LOG

[illegible]

ATTACHMENT 11: BURN TRIAGE GUIDELINES

Purpose: Provide EMS, SBCC and hospitals guidance on determining which patients should be triaged to hospitals with burn capabilities during a burn MCI.

EMS Triage Guidelines

ATTACHMENT 11: BURN TRIAGE GUIDELINES**Hospital Triage Guidelines: Mass Casualty Burn Center Referral Criteria**

During a mass casualty burn incident as defined in this annex, standard burn center referral criteria may need to be altered if the burn resources within Illinois become overwhelmed due to the volume of critically ill and injured burn patients. The Mass Casualty Burn Center Referral Criteria listed below should be utilized to provide guidance to providers in determining which patients should be triaged as Immediate (RED) for transfer to a hospital with burn capabilities; Urgent (YELLOW) for transfer to hospitals with trauma capabilities but no burn capabilities; and Minor (GREEN) and EXPECTANT (BLACK) for treatment at any acute care hospital during a mass casualty burn incident. The triage information on patients should be communicated to the SBCC utilizing the Burn Medical Incident Report Form (Attachment 4).

IMMEDIATE (RED) CRITICAL BURN PATIENTS TO BE TREATED AT HOSPITALS WITH BURN CAPABILITIES:

1. Partial thickness burns greater than 40% total body surface area (TBSA).
2. Circumferential full-thickness burns involving two or more extremities.
3. High voltage (>1000 volt) electrical burns.
4. Burn injury in patients with preexisting medical disorders or other issues that could complicate management, prolong recovery or affect mortality (e.g., diabetes, chronic renal failure, congestive heart failure).
5. Pediatric (children <15 years of age) with burns greater than 20% TBSA.
6. Pregnant women with greater than 10% TBSA.
7. Any patients with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality.

Patients with inhalation injuries **without** cutaneous burns or any other of the above criteria can be managed at any category hospital with an ICU equipped with ventilator capabilities.

URGENT (YELLOW) CRITICAL BURN PATIENTS TO BE TREATED AT HOSPITALS WITH TRAUMA CAPABILITIES, BUT NO BURN CAPABILITIES:

1. Partial thickness burns greater than 10% but less than 40% TBSA.
2. Circumferential full-thickness burns involving one extremity.
3. Any full-thickness burns, including full thickness, involving the face, hands, feet, genitalia, perineum or major joints.
4. Electrical burns, including lightning injury if < 1000 volts.
5. Chemical burns.
6. Any patients with burns and concomitant trauma in which the burn injury **does not** pose the greatest risk of morbidity or mortality.
7. Pediatric (children < 15 years of age) with burns greater than 10%, but less than 20% TBSA.
8. Burn injury in patients who will require special social, emotional or long-term rehabilitative intervention.
9. Pregnant women with less than 10% TBSA.

MINOR (GREEN) BURN PATIENTS TO BE TREATED AT ANY ACUTE CARE HOSPITAL

1. Partial thickness burns less than 10% TBSA.

EXPECTANT (BLACK) BURN PATIENTS TO BE TREATED AT ANY ACUTE CARE HOSPITAL

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ATTACHMENT 12: BURN PATIENT TRANSFER FORM

Purpose: To provide a method of communicating medical and treatment information on burn patients during a disaster when burn patients are being transferred to specialty care centers.

Note: All information within this form is confidential and should not be shared except with those assisting in the care of the patient.

Form completed by		Title	Date / /	Time :
Patient Name (Last, First)		DOB / /		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Age ____ Years ____ Months <input type="checkbox"/> Estimated		
Family/Guardian _____		Contact # _____		Notified: YES NO
Referring hospital		Referral physician		
Unit at hospital		Referral hospital telephone		
Full address		Accepting physician		
		Accepting hospital		
		Room #		
Acuity Level <input type="checkbox"/> Stable/Non-emergent <input type="checkbox"/> Stable/Urgent <input type="checkbox"/> Unstable/Emergent				
PATIENT HISTORY				
Pre-burn weight ____ kg <input type="checkbox"/> actual <input type="checkbox"/> estimated	Allergies (list) <input type="checkbox"/> NKDA <input type="checkbox"/> Unknown		Home medications (list) <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> See attached medication reconciliation form	
Relevant medical/surgical history (list)				<input type="checkbox"/> See attached
BURN INJURY HISTORY				
Burn Injury Date		Time of Injury		% Total Burn Surface Area (complete burn diagram on page 2) % partial thickness _____ % full thickness _____ Circumferential truncal burn YES NO Circumferential extremity burn YES NO
Mechanism of Injury				
Burn Type		Source		
Flame		Enclosed space	Open Air	
Inhalation				Non-burn injuries
Scald				
Chemical				
Electrical				
Contact				Non-burn wounds
Radiation				
MEDICAL MANAGEMENT				
Respiratory Status Current FiO ₂ ____ Current SpO ₂ ____ Intubated YES NO ETT/Trach tube size ____ Ventilator Settings ____ Latest ABG ____ Respiratory treatments ____		Vital Signs Time ____ HR RR BP Temp		Intake IV #1: Site ____ ____ @ ____ mL/hr IV #2: Site ____ ____ @ ____ mL/hr Other ____ Total IVF since injury ____ mL Total IVF in last 24 hours ____ mL
Procedures and Dressings Current burn wound dressing ____ Date/time last burn wound eval ____ Date/time last burn dressing change ____ Escharotomies: YES NO Date/Time ____ Site(s) ____		Current Medications		Output Urinary catheter YES NO Urine (last 24 hours) ____ mL Urine (last 4 hours) ____ mL NGT ____ mL Other ____
		Pain Management		
TRANSPORT NEEDS				
Type of transport service needed <input type="checkbox"/> BLS <input type="checkbox"/> ALS <input type="checkbox"/> Critical Care <input type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Other ____		Notification (times) Family ____ SBCC ____ Receiving hospital: ____		
Equipment needed for transport <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> C-PAP <input type="checkbox"/> Cardiac monitor <input type="checkbox"/> IV pump <input type="checkbox"/> Invasive monitoring <input type="checkbox"/> Spine immobilization <input type="checkbox"/> Restraints <input type="checkbox"/> Isolette <input type="checkbox"/> Car seat <input type="checkbox"/> Other (list) ____				

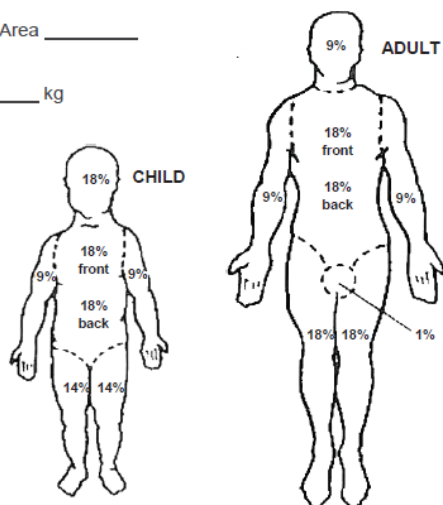
OTHER NOTES

BURN DIAGRAM

Area	≤1 y.o.	1-9 y.o.	10-17 y.o.	≥18 y.o.	Open	Healed
Head	19	13	11	7		
Neck	2	2	2	2		
Ant. Trunk	13	13	13	13		
Post. Trunk	13	13	13	13		
Right Buttock	2.5	2.5	2.5	2.5		
Left Buttock	2.5	2.5	2.5	2.5		
Genitalia	1	1	1	1		
Right Upper Arm	4	4	4	4		
Left Upper Arm	4	4	4	4		
Right Lower Arm	3	3	3	3		
Left Lower Arm	3	3	3	3		
Right Hand	2.5	2.5	2.5	2.5		
Left Hand	2.5	2.5	2.5	2.5		
Right Thigh	5.5	8	8.5	9.5		
Left Thigh	5.5	8	8.5	9.5		
Right Calf	5	5.5	6	7		
Left Calf	5	5.5	6	7		
Right Foot	3.5	3.5	3.5	3.5		
Left Foot	3.5	3.5	3.5	3.5		
Totals						

Admitting Total Body Surface Area _____

Today's Weight _____ kg



ATTACHMENT 13: ADULT BURN GUIDELINES

Purpose: To provide guidance to practitioners caring for adult burn patients during a disaster.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

72 Hour Care Guidelines for Adult Burn Patients if Transfer to a Hospital with Burn Capabilities is Not Feasible**Initial Patient Treatment**

- Stop the burning process.
- Use universal precautions.
- Remove all clothing and jewelry.
- Prior to initiating care of the patient with wounds, it is critical that health care providers take measures to reduce their own risk of exposure to potentially infectious substances and/or chemical decontamination. Rinse liberally with water, according to protocol if suspected chemical exposure. Apply clean, dry dressing(s) initially to avoid hypothermia.
- Apply clean DRY sheet or bedding to prevent hypothermia.
- Consult the State Burn Coordinating Center (SBCC) for assistance with care of the acutely and critically ill patient, to individualize patient care, if patient does not improve and needs to be transferred and as needed for further support and consult.
- Comfort care patients: During a burn MCI, resources may not be available to treat those with extensive burn injuries. There are sections within the following guidelines that provide guidance to providers in order to address their needs. Consult the SBCC or the PCMS for additional assistance from palliative care experts.

Primary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions	Key Points
<u>Airway Maintenance with Cervical Spine Protection</u> <ul style="list-style-type: none"> • Assess throat and nares • Signs of airway injury <ul style="list-style-type: none"> ○ Hypoxia ○ Facial burns ○ Carbonaceous sputum ○ Stridor ○ Hoarseness ○ Nasal singe ○ History of a closed space fire 	<u>Airway Maintenance with Cervical Spine Protection</u> <ul style="list-style-type: none"> • Chin lift/jaw thrust with C-spine precautions as needed. • Place an oral pharyngeal airway or endotracheal tube (ETT) in the unconscious patient. • Intubate early. • Secure ETT with ties passed around the head; do not use tape on facial burns since it will not adhere to burned tissue. • Insert gastric tube on all intubated patients. • Comfort Care Patients: Patients triaged 	<u>Airway Maintenance with Cervical Spine Protection</u> <ul style="list-style-type: none"> • Airway edema increases significantly after IV/IO fluids are started. • Stridor or noisy breath sounds indicate impending upper airway obstruction. • Prophylactic intubation is preferred because the ensuing edema obliterates landmarks needed for successful intubation. • It is critical that the ETT is secured well. An ETT that becomes dislodged may be impossible to replace due to the edema of the upper airway.

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	as comfort care patients should not be intubated. Administer oxygen to aid comfort and prevent air hunger. Also consider pain management.	
<u>Breathing and Ventilation</u> <ul style="list-style-type: none"> Assess for appropriate rate and depth of respirations with adequate air exchange. Monitor pulse oximetry while checking Carbon Monoxide (CO) level (as needed). If circumferential torso burns, monitor chest expansion closely. Obtain Arterial Blood Gas (ABG). Obtain Carboxyhemoglobin (COHb) level if suspected inhalation injury. 	<u>Breathing and Ventilation</u> <ul style="list-style-type: none"> 100%, high flow oxygen using a non-rebreather mask or ETT; wean as appropriate. Mechanically ventilate as needed. Elevate head of bed (HOB), if not contraindicated. Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy. 	<u>Breathing and Ventilation</u> <ul style="list-style-type: none"> CO levels decrease by half ($\frac{1}{2}$) every 40 minutes while on 100% FiO₂. CO level goal is <10%. An escharotomy is an incision performed longitudinally through burned tissue down to subcutaneous tissue over the entire involved area of full thickness circumferential (or nearly circumferential burn) that is causing constriction and loss of peripheral perfusion or airway constriction. A chest escharotomy may be indicated in circumferential or full thickness chest burns due to location or depth of burn in the trunk area, which may interfere with ventilation.
<u>Circulation with Hemorrhage Control</u> <ul style="list-style-type: none"> Continuous cardiac monitoring as needed. Control any signs of hemorrhage. 	<u>Circulation with Hemorrhage Control</u> <ul style="list-style-type: none"> Two large bore peripheral IVs in non-burned, upper extremities (secure well). If unable to secure peripheral IV in non-burned extremity, burned extremity can be used if necessary; suture IV in place. Initiate IVF bolus with Lactated Ringers (LR). If unable to establish a peripheral IV, place an intraosseus (IO). 	<u>Circulation with Hemorrhage Control</u> <ul style="list-style-type: none"> Cardiac monitoring may be needed, if there is an electrical injury, concurrent trauma or cardiac issues. Dysrhythmias may be the result of an electrical injury. Comfort care patients: IVs should be started for the administration of medications for pain and anxiety. Do not administer large volumes of fluid. Excessive fluid will result in decreased circulation and increased pain due to edema.
<u>Disability</u> <ul style="list-style-type: none"> Neurologic checks every 4 hours and PRN <ul style="list-style-type: none"> Determine level of consciousness Obtain Glasgow Coma Scale Consider using "AVPU," <ul style="list-style-type: none"> A: Alert V: Responds to verbal stimuli 	<u>Disability</u> <p>Treat cause of altered neurological status as indicated.</p>	<u>Disability</u> <ul style="list-style-type: none"> If altered neurological status, consider the following: <ul style="list-style-type: none"> Associated injuries CO poisoning Substance abuse Hypoxia Hypoglycemia Pre-existing medical condition

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions	Key Points
<ul style="list-style-type: none"> ▪ P: Responds to painful stimuli ▪ U: Unresponsive 		
<p><u>Exposure</u></p> <ul style="list-style-type: none"> • Monitor temperature. 	<p><u>Exposure</u></p> <ul style="list-style-type: none"> • Remove all clothing and jewelry • Initially place a clean, dry sheet over the wounds until a thorough cleaning is done. • Keep patient and environment warm. <ul style="list-style-type: none"> ○ Keep patient covered ○ Cover the patient's head ○ Warm the room ○ Warm the IV/IO fluids 	<p><u>Exposure</u></p> <ul style="list-style-type: none"> • Localized hypothermia causes vasoconstriction to damaged area reducing blood flow and tissue oxygenation and may deepen the injury. Systemic hypothermia (core temp less than 95° F / 35° C) induces peripheral vasoconstriction that may increase the depth of the burn and interfere with clotting mechanisms and respiration in addition to causing cardiac arrhythmias.

Secondary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions and Key Points
<p><u>History</u></p> <ul style="list-style-type: none"> • Obtain circumstances of injury. • Obtain medical history. Consider using "AMPLE." <ul style="list-style-type: none"> ○ Allergies, Medications, Previous illness/history, Last meal/fluid intake, Events related to injury 	<p><u>History</u></p>
<p><u>Complete Physical Exam</u></p> <ul style="list-style-type: none"> • Head to toe exam • Vital signs: (Perform as indicated in hospital policy. May need to perform more frequently if patient is unstable). <ul style="list-style-type: none"> ○ Heart rate (HR) ○ Blood pressure (BP) ○ Capillary refill ○ Temperature ○ Skin color of unburned skin • Determine extent/size of burn by calculating the Total Burn Surface Area (TBSA) using: <ul style="list-style-type: none"> ○ Rule of Nines or Rule of the Palm (See pg. 13 for printable version) ○ Lund-Browder chart (See pg. 12 for printable version) • Determine the depth of the burn (See pg. 11 for more information) 	<p><u>Complete Physical Exam</u></p> <ul style="list-style-type: none"> • Due to increased catecholamines and hypermetabolism associated with burn injuries, the HR will be increased. Sustained tachycardia may indicate hypovolemia, inadequate oxygenation, unrelieved pain or anxiety • Oral rehydration can be used in the following patients: <ul style="list-style-type: none"> ○ Patients not intubated. ○ Injury not an electrical injury. ○ Awake and alert with % TBSA < 20%. ○ Contact the SBCC for assistance with oral rehydration. ○ Monitor quality and quantity of urine output on patient's receiving oral rehydration. • IV/IO fluids burn resuscitation-Use Lactated Ringers: <ul style="list-style-type: none"> ○ When supplies of LR are depleted, 0.9 NS and 0.45 NS or colloids can be used for fluid resuscitation. Do not use fluid containing glucose. ○ $2 \text{ mL} \times \text{wt (kg)} \times \% \text{ TBSA} = \text{total for first 24 hrs post burn.}$

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
<ul style="list-style-type: none"> ○ <i>Superficial (1st degree)</i> <ul style="list-style-type: none"> ▪ Involves the epidermis ▪ Appearance: Red (e.g., sunburn) ▪ Do not include when calculating TBSA ○ <i>Partial thickness (2nd degree)</i> <ul style="list-style-type: none"> ▪ Involves the entire epidermis and a variable portion of the dermis. ▪ Appearance: red, blistered and edematous. ○ <i>Full thickness (3rd degree)</i> <ul style="list-style-type: none"> ▪ Involves the destruction of the entire epidermis and dermis. ▪ Appearance: white, brown, dry, leathery with possible coagulated vessels. • If camera is available, take pictures of initial burn injuries to document progression of burn injury. • Labs on admission and every day as indicated by medical condition: <ul style="list-style-type: none"> ○ Electrolyte panel ○ Complete blood count (CBC) ○ ECG for electrical injury or cardiac history ○ ABG with COHb ○ Cardiac panel for electrical injury • CXR if intubated, inhalation injury suspected or underlying pulmonary condition. • Monitor for the following signs and symptoms in full thickness, circumferential burn injuries that may indicate a circulation deficit and possible need for escharotomy: <ul style="list-style-type: none"> ○ Pallor or cyanosis of distal unburned skin on a limb ○ Capillary refill > 5 seconds ○ Unrelenting deep tissue pain ○ Progressive loss of sensation or motor function ○ Progressive decrease or absence of pulses ○ Inability to ventilate in patients with deep circumferential burns of the chest 	<ul style="list-style-type: none"> ○ For electrical burns: $4 \text{ mL} \times \text{wt (kg)} \times \% \text{ TBSA} = \text{total for first 24 hrs post burn.}$ ○ Administer half of the above amount in first 8 hours post burn. ○ Administer remaining amount over next 16 hours post burn. • Titrate IV/IO rate to maintain a urine output: <ul style="list-style-type: none"> ○ 0.5 mL/kg (~30-50 mL/hr) • Tetanus prophylaxis unless received within last 5 years. • Place a soft feeding tube for all intubated patients. • The goal in the early stages of burn resuscitation should be to maintain the individual's pre-event BP. • If signs of circulation deficit are present, contact the SBCC. • Eyes: <ul style="list-style-type: none"> ○ Remove contact lens prior to eyelid swelling, if facial involvement. ○ Fluorescein should be used to identify corneal injury. ○ If eye involvement or facial burns, consider consulting an ophthalmologist. • Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy. • Finger escharotomies are rarely indicated.
<u>Comfort</u>	<u>Comfort</u>

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
<ul style="list-style-type: none"> Frequent pain/sedation assessment <ul style="list-style-type: none"> A minimum of every 4 hours Before and after pain/sedation medication given 	<ul style="list-style-type: none"> Emotional support and education is essential. IV/IO analgesia is preferred route during initial post injury period. Large amounts of IV/IO analgesic may be required to attain initial pain control (e.g., Morphine 40-60 mg). <ul style="list-style-type: none"> Administer opioids in frequent (every 5 minutes) small to moderate doses until pain is controlled. <ul style="list-style-type: none"> Narcotic/analgesic PO/IV/IO Oxycodone PO Consider use of non-pharmacological techniques. Consider anti-anxiety medication in addition to pain medication. <ul style="list-style-type: none"> Ativan PO/IV/IO Versed IV/IO/IN Consider sedation for procedures and if intubated: <ul style="list-style-type: none"> Propofol
<u>Wound Care</u>	<u>Wound Care</u>
<ul style="list-style-type: none"> Assess the wound and monitor for: <ul style="list-style-type: none"> Change in wound appearance Change in size of wound Signs or symptoms of infection 	<ul style="list-style-type: none"> Pre-medicate patients for pain before wound care. In a mass casualty disaster situation wound care for patient with a >20% TBSA burn can be performed once per day. Contraindications for silver sulfadiazine (Silvadene): <ul style="list-style-type: none"> Patients with a sulfa allergy On face due to pigment bleaching During pregnancy Children < 2 years old Wash wounds with soap and warm tap water using a wash cloth <ul style="list-style-type: none"> Remove water by patting dry Shave daily for burned scalps and faces Perform wound care every day if using: <ul style="list-style-type: none"> Silver sulfadiazine (Silvadene) cream Bacitracin Debride ALL blisters except for: <ul style="list-style-type: none"> Intact blisters on hands and feet, unless it is impeding range of motion to the joints. Weeping blister(s)

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
	<ul style="list-style-type: none"> • Ear wound care: <ul style="list-style-type: none"> ○ Ears are poorly vascularized and at risk for chondritis. • How to apply silver sulfadiazine (Silvadene) cream: <ul style="list-style-type: none"> ○ Apply thin layer enough so that the wound cannot be seen through the cream. ○ The layer of sulfadiazine should be thick enough to prevent the wound from drying out prior to the next dressing change. ○ Cover with a dressing; the purpose of a dressing is to keep the cream from rubbing off before the next dressing change. • How to apply Acticoat^R dressing: <ul style="list-style-type: none"> ○ Apply a single layer of the dressing moistened with water over burn wounds so that all areas are covered. ○ Water should be used to keep the Acticoat^R and overlying gauze moist to maintain the dressing's antimicrobial activity. <u>(DO NOT use saline because it deactivates the silver's antimicrobial ability).</u> ○ Should be held in place with water-moistened gauze dressing. ○ Dressing does not need to be changed for 7 days. ○ The overlying gauze can be changed as necessary. ○ If signs of infection appear, remove dressing to assess wound. ○ Record the date of the application. • Wrap fingers separately, if burned. • Place silver sulfadiazine (Silvadene) coated gauze between the toes. • For extensive and severe burns to the face: <ul style="list-style-type: none"> ○ Apply Bacitracin ointment around the eyes and mouth to avoid cream from draining into them. ○ Can use ophthalmic ointment around eyes. • For moderate facial burns, Bacitracin or other antibiotic ointment can be used without a dressing. • Genital/Perineal Burns <ul style="list-style-type: none"> ○ Urinary catheter may be indicated for genitalia or perineal burns. Evaluate each patient individually to determine if needed. ○ Apply lubricated gauze to labia and in the foreskin to prevent adhesions and decrease risk of infection in this area of high contamination.

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
	<ul style="list-style-type: none"> Elevate burned extremities above the level of the heart

Ongoing Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions
<p><u>Airway and Breathing</u></p> <ul style="list-style-type: none"> Obtain chest X-ray if intubated, inhalation injury suspected or underlying pulmonary condition. Chest X-ray will usually be clear on admit. If inhalation injury is present the X-ray will show infiltrates around the second day correlating with a deteriorating oxygen status. Frequent suctioning is necessary to prevent occlusion of the airway and endotracheal tube. Anyone with an inhalation injury is subject to increased respiratory secretions and may have a large amount of carbonaceous debris in the respiratory tract. 	<p><u>Airway and Breathing</u></p> <ul style="list-style-type: none"> Supportive therapy and O₂; wean as appropriate. HOB should be elevated 30° to minimize facial and airway edema, unless contraindicated. <ul style="list-style-type: none"> Use reverse Trendelenburg for patients with C-spine precautions. Suction airway frequently. <u>Inhalation Injuries:</u> <ul style="list-style-type: none"> Treatment for inhalation injury is supportive care and includes: <ul style="list-style-type: none"> Intubation as indicated Provide adequate sedation to prevent dislodgement of ETT Frequent suctioning Positive End Expiratory Pressure (PEEP) may improve ventilation Secure ETT with ties instead of tape since tape will not adhere to burned tissue. Mark ETT at fixed position (teeth or gums not lips which may have swelling).
<p><u>Outputs of Resuscitation</u></p> <ul style="list-style-type: none"> Monitor Mean Arterial Blood Pressure <ul style="list-style-type: none"> Goal for Mean Arterial Blood Pressure is >60 mmHg Monitor hourly urine output: <ul style="list-style-type: none"> Goal: 0.5 mL/kg/hr (≈30-50 mL/hour) Monitor for myoglobin/pigment in urine (burgundy color) Additional resuscitation fluid needs can occur with: <ul style="list-style-type: none"> Very deep burns Inhalation injury Associated injuries Electrical injury Delayed resuscitation Prior dehydration Alcohol or drug dependence 	<p><u>Outputs of Resuscitation</u></p> <ul style="list-style-type: none"> Insert arterial line Insert urinary catheter If urine output is < goal ↑ fluids by 1/3. <ul style="list-style-type: none"> Example: u/o = 20 mL/hr, fluid rate at 250 mL/hr, ↑ to 330 mL/hr If urine output is > goal ↓ rate of infusion by 1/3 <ul style="list-style-type: none"> Example: u/o = 100 mL/hr fluid rate at 250 mL/hr, ↓ to 167 mL/hr Upon completion of the resuscitation phase (24 hrs post burn), ↓ hourly fluid volume by 10% per hour to a maintenance fluid with D5 ½ NS with 20 mEq KCL/L Myoglobin in urine: <ul style="list-style-type: none"> Maintain urine output: <ul style="list-style-type: none"> 100 mL/hour Increase fluid rate (LR) Sodium bicarbonate IV/IO may be administered to maintain an alkaline urine, with a

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring	Interventions
<ul style="list-style-type: none"> The elderly and patients with preexisting cardiac disease are particularly sensitive to fluid management. Diuretics are not indicated in myoglobin in the urine. 	pH > 6.
<p><u>Circulation</u></p> <ul style="list-style-type: none"> Perform pulse checks (CMS) every 1 hour, if there are circumferential burns on extremities. <ul style="list-style-type: none"> Monitor pulses by palpation or doppler exam <ul style="list-style-type: none"> Decreased sensation Severe deep tissue pain Diminished distal pulses Capillary refill > 5 sec After 24-48 hours decrease frequency of pulse checks to every 2 hours if stable. 	<p><u>Circulation</u></p> <ul style="list-style-type: none"> Elevate burned extremities on pillows or blankets to improve circulation and minimize edema. Circumferential chest injuries may become life threatening; an escharotomy may be necessary. Verify that pulselessness is not due to profound hypotension. Scrotal swelling, though often significant, does not require specific treatment.
<p><u>Body Temperature</u></p> <p>Perform temperature checks, based on hospital protocol.</p> <ul style="list-style-type: none"> If unstable or significant burn, hourly vital signs may be indicated. 	<p><u>Body Temperature</u></p> <ul style="list-style-type: none"> Keep patient normo-thermic, especially during wound care. Keep patient covered. When supplies of blankets are depleted, patients can be wrapped in plastic wrap or aluminum foil for insulation and warmth. Warm the room. Warm IV/IO fluid, if possible, especially if patient is very hypothermic
<p><u>Nutrition</u></p> <ul style="list-style-type: none"> Obtain dry weight on admission See Nutritional Algorithm for Burn Patients on page 14 	<p><u>Nutrition</u></p> <ul style="list-style-type: none"> Dietary consult with daily calorie counts <ul style="list-style-type: none"> Usual Kcal needs = Resting Energy Expenditure (REE) x 30% Regular high calorie, high protein diet, if able to take PO. <ul style="list-style-type: none"> If unable to maintain adequate caloric requirements, initiate tube feedings. No free water drinks (plain water) if taking PO, only high calorie liquids. If intubated begin tube feedings at full strength increasing to goal rate. <ul style="list-style-type: none"> Soft feeding tubes are preferred over hard salem sump nasogastric tube. Ensure stool softeners are ordered to prevent constipation due to pain medications.
<p><u>Infection Control</u></p> <ul style="list-style-type: none"> Utilize universal precautions If wounds are exposed: <ul style="list-style-type: none"> Apply gown, mask and gloves to protect patient. No systemic antibiotics are required for the burn injuries. 	

ATTACHMENT 13: ADULT BURN GUIDELINES

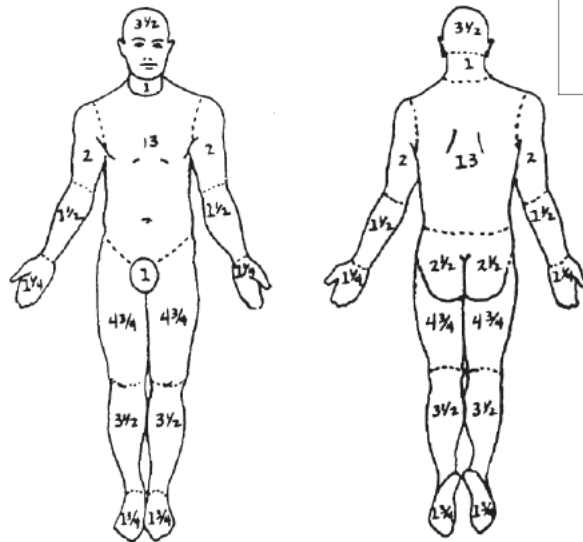
Assessment and Monitoring	Interventions									
<u>Psychosocial</u> <ul style="list-style-type: none">• Explain any procedures• Involve patient and family• Consider social worker consultation• Offer spiritual care• Consider consulting child life specialists to assist with coping of child visitors of patient (as applicable and available).										
<u>Reunification</u> <p>During a large scale disaster, family members may become separated. It is crucial that staff attempt to reunify patients with their family. Community partners, such as the American Red Cross and National Center for Missing and Exploited Children, can assist with this process. The reunification process begins with EMS at the scene and, if possible, trying to keep known family members together when making transport decision. The Patient Identification Tracking Form (Attachment 10 in Burn Surge Annex) should be utilized for <u>all</u> patients to assist with the reunification process.</p>										
<u>Mobility</u> <ul style="list-style-type: none">• In a disaster therapists may just splint patients in functional positions and help with dressings.	<u>Mobility</u> <ul style="list-style-type: none">• Obtain Physical Therapy /Occupational Therapy consult• HOB elevated at all times• Elevate burned extremities above the level of the heart• Neck burns<ul style="list-style-type: none">○ Maintain the head in a neutral position○ No pillows or blankets under the head flexing the neck forward• Axilla burns<ul style="list-style-type: none">○ Keep arms extended to decrease contractures• Ear burns<ul style="list-style-type: none">○ No external pressure should be applied○ No pillows or blankets under the head• Out of bed (OOB) - If legs are burned, apply ace wraps when OOB• Encourage active range of motion hourly when awake• Encourage activities of daily living									
<u>Proper Positioning of Burn Patients</u> <table><tr><th>Area Involved</th><th>Contracture Predisposition</th><th>Contracture Preventing Position</th></tr><tr><td>Anterior neck</td><td>Flexion</td><td>Extension, no pillows</td></tr><tr><td>Anterior axilla</td><td>Shoulder adduction</td><td>90° abduction, neutral rotation</td></tr></table>		Area Involved	Contracture Predisposition	Contracture Preventing Position	Anterior neck	Flexion	Extension, no pillows	Anterior axilla	Shoulder adduction	90° abduction, neutral rotation
Area Involved	Contracture Predisposition	Contracture Preventing Position								
Anterior neck	Flexion	Extension, no pillows								
Anterior axilla	Shoulder adduction	90° abduction, neutral rotation								

ATTACHMENT 13: ADULT BURN GUIDELINES

Assessment and Monitoring			Interventions
	Posterior axilla	Shoulder extension	Shoulder flexion
	Elbow/Forearm	Flexion/pronation	Elbows extended, forearm supinated
	Wrists	Flexion	15°–20° extension
	Hands:		
	MCPs	Hyperextension	70°–90° flexion
	IPs	Flexion	full-extension
	Palmar Burn	Finger flexion, thumb opposition	All joints full extension, thumb radially abducted
	Chest	Lateral/anterior flexion	Straight, no lateral or anterior flexion
	Hips	Flexion, adduction, external rotation	Extension, 10° abduction, neutral rotation
	Knees	Flexion	Extension
	Ankles	Plantar flexion	90° dorsiflexion
<u>Splinting materials:</u> Use either ace/elastic wraps, gauze rolls/wraps or strappings with post-mold material (e.g., thermoplastic-perforated)			

ATTACHMENT 13: ADULT BURN PROTOCOLS**Assess Degree of Injury**

	APPEARANCE	SURFACE	SENSATION	TIME TO HEALING
1st degree/superficial	Pink or red	Dry	Painful	4-5 days
2nd degree/superficial partial thickness	Pink, clear blisters	Moist, weeping	Painful	14–21 days
2nd degree/deep partial thickness	Pink, hemorrhagic blisters, red	Moist	Painful	Weeks, may progress to 3rd degree and require graft, may lead to contractures
3rd degree/full thickness	White, brown, charred	Dry, waxy, leathery	Painless	Requires excision, high risk for infection/fluid loss
4th degree (tendon, nerve, muscle, bone and/or deep fascia involvement)	Brown, charred	Dry	Painless	Requires excision, high risk for infection/fluid loss

ATTACHMENT 13: ADULT BURN PROTOCOLS**Lund & Browder Chart****BURN DIAGRAM, ESTIMATE
(Lund & Browder)**

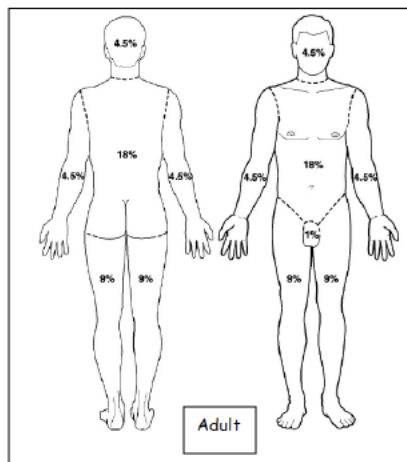
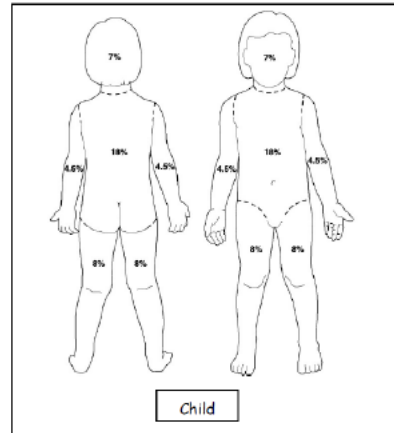
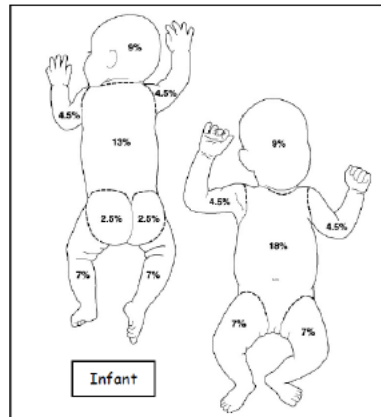
AREA	AGE						BURN ASSESSMENT	
	infant	1-4	5-9	10-14	15	adult	PARTIAL THICKNESS	FULL THICKNESS
head	19	17	13	11	9	7		
neck	2	2	2	2	2	2		
ant. trunk	13	13	13	13	13	13		
post. trunk	13	13	13	13	13	13		
r. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
genitalia	1	1	1	1	1	1		
r. u. arm	4	4	4	4	4	4		
l. u. arm	4	4	4	4	4	4		
r. l. arm	3	3	3	3	3	3		
l. l. arm	3	3	3	3	3	3		
r. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
r. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
l. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
r. leg	5	5	5 1/2	6	6 1/2	7		
l. leg	5	5	5 1/2	6	6 1/2	7		
r. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
l. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
TOTAL:								

BURN ASSESSMENT: Date _____ Time _____ Signature _____

ATTACHMENT 13: ADULT BURN PROTOCOLS

Rule of 9's Charts:

BURN DIAGRAM ESTIMATE
(Rule of 9's: Estimate of TBSA – Total Burn Surface Area)

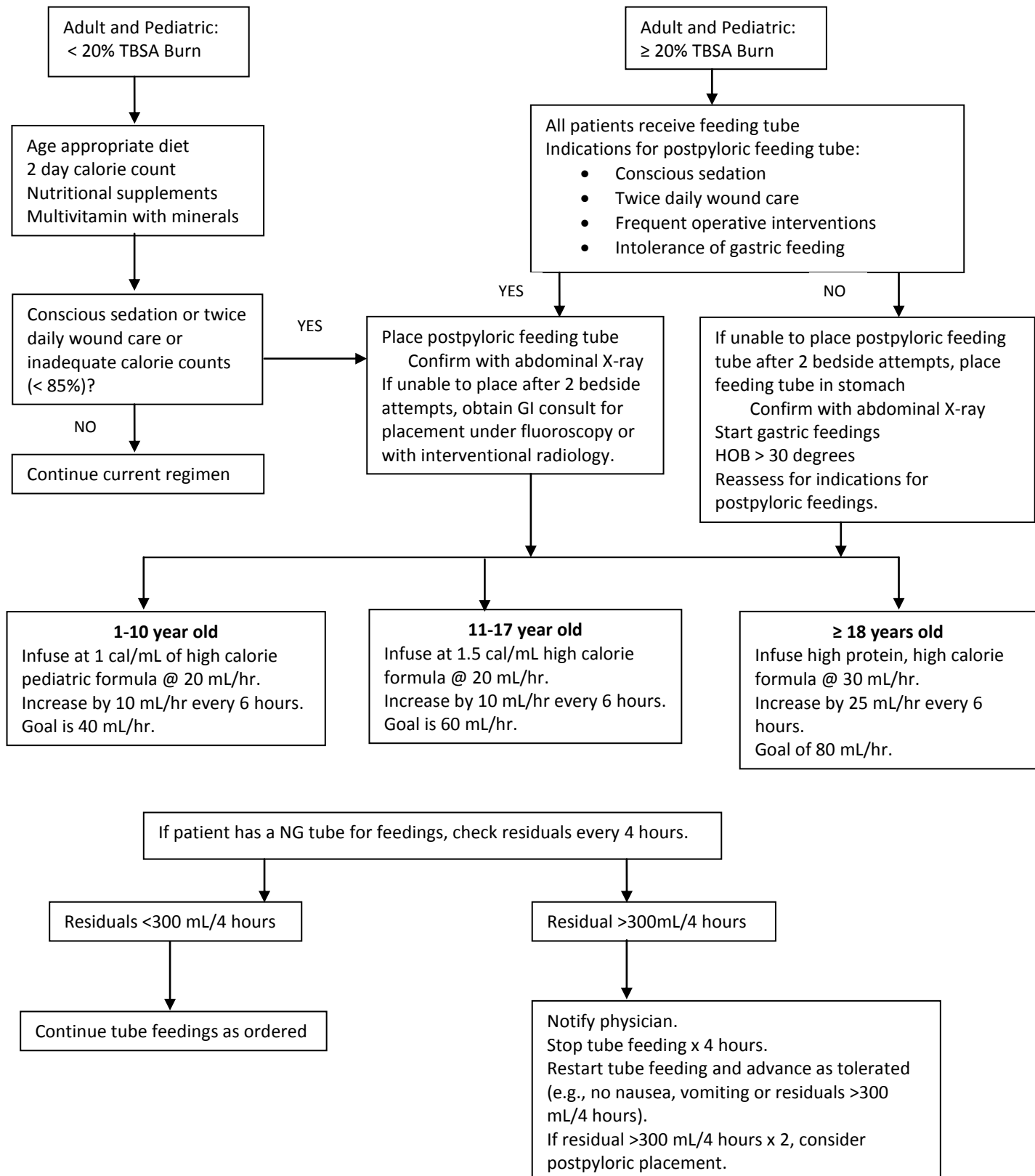


Area	Infant	Child	Adult	Burn Assessment	
				Partial thickness	Full thickness
Head	18	14	9		
Chest (Ant. torso)	18	18	18		
Back (Post. Torso) & buttocks	13 (back) 5 (buttocks)	18	18		
Rt. arm & hand	9	9	9		
Lt. arm & hand	9	9	9		
Rt. Leg & foot (anterior)	7	8	9		
Lt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Perineum	(include with chest)	(include with chest)	1		

Bolded areas = nine or multiple of nine

Burn Assessment Date _____ Time _____ Signature _____

ATTACHMENT 13: ADULT BURN PROTOCOLS

Nutritional Algorithm for Burn Patients

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Purpose: To provide guidance to practitioners caring for adult burn patients during a disaster.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

72 Hour Care Guidelines for Pediatric Burn Patients if Transfer to a Hospital with Burn Capabilities is Not Feasible**Initial Patient Treatment**

- Stop the burning process
- Use universal precautions
- Remove all clothing and jewelry
- Prior to initiating care of the patient with wounds, it is critical that health care providers take measures to reduce their own risk of exposure to potentially infectious substances and/or chemical decontamination. Rinse liberally with water, according to protocol, if suspected chemical exposure. Apply clean, dry dressing(s) initially to avoid hypothermia.
- Apply clean DRY sheet or bedding to prevent hypothermia.
- Consult Pediatric Care Medical Specialist (PCMS) and/or the State Burn Coordinating Center (SBCC) for assistance with care of the acutely and critically ill patient, to individualize patient care; if patient does not improve and needs to be transferred; and as needed for further support and consult.
- Comfort care patients: During a burn MCI, resources may not be available to treat those with extensive burn injuries. There are sections within the following guidelines that provide guidance to providers in order to address their needs. Consult the SBCC or the PCMS for additional assistance from palliative care experts.

Primary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions	Key Points
<u>Airway Maintenance with Cervical Spine Protection</u> <ul style="list-style-type: none"> • Assess throat and nares. • Signs of airway injury: <ul style="list-style-type: none"> ○ Hypoxia ○ Facial burns ○ Carbonaceous sputum ○ Stridor ○ Hoarseness ○ Nasal singe ○ History of a closed space fire 	<u>Airway Maintenance with Cervical Spine Protection</u> <ul style="list-style-type: none"> • Chin lift/jaw thrust with C-spine precautions as needed. • IMMOBILIZE SPINE as indicated. Position for optimal airway and suction as needed. Position infants and children < 2 yrs supine on a backboard with a recess for the head or use a pad under the back from the shoulders to the buttocks. • Place an oral pharyngeal airway or cuffed endotracheal tube (ETT) in the unconscious 	<u>Airway Maintenance with Cervical Spine Protection</u> <ul style="list-style-type: none"> • Airway edema increases significantly after IV/IO fluids are started. • Stridor or noisy breath sounds indicate impending upper airway obstruction. • Younger children and those with larger burns are more likely to require intubation due to the smaller diameter of the child's airway and the need for significant fluid volumes during resuscitation. <ul style="list-style-type: none"> ○ Prophylactic intubation is preferred because the ensuing edema obliterates landmarks needed for successful intubation. ○ It is critical that the ETT is secured well. An ETT that

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions	Key Points
	<p>patient</p> <ul style="list-style-type: none"> Intubate early with cuffed ETT. Secure ETT with ties passed around the head; do not use tape on facial burns since it will not adhere to burned tissue. Insert gastric tube on all intubated patients. Comfort Care Patients: Patients triaged as comfort care patients should not be intubated. Administer oxygen to aid comfort and prevent air hunger. Also consider pain management. 	<p>becomes dislodged may be impossible to replace due to the edema of the upper airway.</p>
<p><u>Breathing and Ventilation</u></p> <ul style="list-style-type: none"> Assess for appropriate rate and depth of respirations with adequate air exchange. Monitor pulse oximetry while checking carbon monoxide (CO) level (as needed). If circumferential torso burns, monitor chest expansion closely. Obtain Arterial Blood Gas (ABG). Obtain carboxyhemoglobin (COHb) level if suspected inhalation injury. 	<p><u>Breathing and Ventilation</u></p> <ul style="list-style-type: none"> 100%, high flow oxygen using a non-rebreather mask or ETT; wean as appropriate. Mechanically ventilate as needed. Elevate head of bed (HOB) if not contraindicated. Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy. 	<p><u>Breathing and Ventilation</u></p> <ul style="list-style-type: none"> CO levels decrease by half ($\frac{1}{2}$) every 40 minutes while on 100% FiO₂. CO level goal is <10%. An escharotomy is an incision performed longitudinally through burned tissue down to subcutaneous tissue over the entire involved area of full thickness circumferential (or nearly circumferential burn) that is causing constriction and loss of peripheral perfusion or airway constriction. A chest escharotomy may be indicated in circumferential or full thickness chest burns due to location or depth of burn in the trunk area, which may interfere with ventilation.
<p><u>Circulation with Hemorrhage Control</u></p> <ul style="list-style-type: none"> Continuous cardiac monitoring as needed. Control any signs of hemorrhage. 	<p><u>Circulation with Hemorrhage Control</u></p> <ul style="list-style-type: none"> Two large bore peripheral IVs in non-burned extremities (secure well). If unable to secure peripheral IV in non-burned extremity, burned extremity can be used if necessary; suture IV in place. If unable to establish a peripheral IV, place an intraosseus (IO). Pediatrics: 20 mL/kg bolus with Lactated Ringers (LR) initially. 	<p><u>Circulation with Hemorrhage Control</u></p> <ul style="list-style-type: none"> Cardiac monitoring may be needed if there is an electrical injury, concurrent trauma or cardiac issues Dysrhythmias may be the result of an electrical injury Comfort care patients: IVs should be started for the administration of medications for pain and anxiety. Do not administer large volumes of fluid. Excessive fluid will result in decreased circulation and increased pain due to edema.

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions	Key Points
<u>Disability</u> <ul style="list-style-type: none"> Neurologic checks every 4 hours and PRN. <ul style="list-style-type: none"> Determine level of consciousness. Obtain Glasgow Coma Scale Consider using “AVPU.” <ul style="list-style-type: none"> A: Alert V: Responds to verbal stimuli P: Responds to painful stimuli U: Unresponsive Obtain glucose level 	<u>Disability</u> <ul style="list-style-type: none"> Treat cause of altered mental status as indicated: <ul style="list-style-type: none"> Hypoglycemia: <ul style="list-style-type: none"> Dose: Dextrose 0.5-1 g/kg IV/IO <ul style="list-style-type: none"> Birth- 28 days: D10W: 2 mL/kg IV Infants > 28 days- 1 y/o: D12.5%W: 5-10 mL/kg IV/IO 1 y/o-8 y/o: D25W: 2-4 mL/kg IV/IO > 8 y/o: D50W: 1-2 mL/kg IV/IO 	<u>Disability</u> <ul style="list-style-type: none"> If altered neurological status, consider the following: <ul style="list-style-type: none"> Associated injuries CO poisoning Substance abuse Hypoxia Hypoglycemia (<60 mg/dL in infants/children; <50 mg/dL in neonates) Pre-existing medical condition
<u>Exposure</u> <ul style="list-style-type: none"> Monitor temperature 	<u>Exposure</u> <ul style="list-style-type: none"> Remove all clothing and jewelry. Initially place a clean, dry sheet over the wounds until a thorough cleaning is done. Keep patient and environment warm. <ul style="list-style-type: none"> Keep patient covered Cover the patient’s head Warm the room Warm the IV/IO fluids 	<u>Exposure</u> <ul style="list-style-type: none"> Localized hypothermia causes vasoconstriction to damaged area reducing blood flow and tissue oxygenation and may deepen the injury. Systemic hypothermia (core temp less than 95° F / 35° C) induces peripheral vasoconstriction that may increase the depth of the burn and interfere with clotting mechanisms and respiration in addition, to causing cardiac arrhythmias.

Secondary Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions and Key Points
<u>History</u> <ul style="list-style-type: none"> Obtain circumstances of injury Obtain medical history. Consider using “AMPLE.” <ul style="list-style-type: none"> Allergies, Medications, Previous illness/history, Last meal/fluid intake, Events related to injury 	<u>History</u>
<u>Complete Physical Exam</u> <ul style="list-style-type: none"> Head to toe exam 	<u>Complete Physical Exam</u> <ul style="list-style-type: none"> Due to increased catecholamines and hypermetabolism associated with burn

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
<ul style="list-style-type: none"> • Vital signs: Perform as indicated in hospital policy. May need to perform more frequently if patient is unstable. <ul style="list-style-type: none"> ○ Heart rate (HR) ○ Blood pressure (BP) ○ Capillary refill ○ Temperature ○ Skin color of unburned skin • Determine extent/size of burn by calculating the TBSA using: <ul style="list-style-type: none"> ○ Rule of Nines or Rule of the Palm (See pg. 14 for printable version) ○ Lund-Browder chart (See pg. 13 for printable version) • Determine the depth of the burn (See pg. 12 for more information) <ul style="list-style-type: none"> ○ <i>Superficial (1st degree)</i> <ul style="list-style-type: none"> ▪ Involves the epidermis, ▪ Appearance: Red (e.g., sunburn), ▪ Do not include when calculating TBSA, ○ <i>Partial thickness (2nd degree)</i> <ul style="list-style-type: none"> ▪ Involves the entire epidermis and a variable portion of the dermis, ▪ Appearance: red, blistered and edematous. ○ <i>Full thickness (3rd degree)</i> <ul style="list-style-type: none"> ▪ Involves the destruction of the entire epidermis and dermis. ▪ Appearance: white, brown, dry, leathery with possible coagulated vessels. • If camera is available, take pictures of initial burn injuries to document progression of burn injury. • Labs on admission and every day as indicated by medical condition: <ul style="list-style-type: none"> ○ Electrolyte panel ○ Complete blood count (CBC) ○ ECG for electrical injury or cardiac history ○ ABG with COHb ○ Cardiac panel for electrical injury • CXR if intubated, inhalation injury suspected or underlying 	<p>injures, the HR will be increased. Sustained tachycardia may indicate hypovolemia, inadequate oxygenation, unrelieved pain or anxiety.</p> <ul style="list-style-type: none"> • Oral rehydration can be used in the following pediatric patients: <ul style="list-style-type: none"> ○ Patients not intubated. ○ Injury not an electrical injury. ○ Awake and alert with < 10% TBSA. ○ Contact the SBCC for assistance with oral rehydration. ○ Monitor quality and quantity of urine output on patient's receiving oral rehydration. • IV/IO fluid burn resuscitation-Use Lactated Ringers: <ul style="list-style-type: none"> ○ When supplies of LR are depleted, 0.9 NS and 0.45 NS or colloids can be used for fluid resuscitation. Do not use fluid containing glucose for fluid resuscitation. ○ $3 \text{ mL} \times \text{wt (kg)} \times \% \text{ TBSA} = \text{total for first 24 hours post burn.}$ ○ Administer half of the above amount in first 8 hours post burn. ○ Administer remaining amount over next 16 hours post burn. • Pediatrics < 10 kg: Due to limited glycogen stores, in addition to resuscitation IV/IO fluids, administer D5% LR at maintenance rate: <ul style="list-style-type: none"> ○ To calculate maintenance IVF rate for children: <ul style="list-style-type: none"> ▪ $4 \text{ mL/kg/hr for } 1^{\text{st}} 10 \text{ kg}$ ▪ $+ 2 \text{ mL/kg/hr for } 2^{\text{nd}} 10 \text{ kg}$ ▪ $+ 1 \text{ mL/kg/hr for each additional kg over } 20 \text{ kg}$ $= \text{IV/IO fluid maintenance rate}$ • Titrate IV/IO rate to maintain a urine output. <ul style="list-style-type: none"> ○ Pediatrics <30 kg: 1 mL/kg ○ Pediatrics >30 kg: 0.5 mL/kg • Tetanus prophylaxis, unless received within last 5 years. • Place a soft feeding tube for all intubated patients. • The goal in the early stages of burn resuscitation should be to maintain the individual's pre-event BP. • If signs of circulation deficit are present, contact the SBCC. • Eyes: <ul style="list-style-type: none"> ○ Remove contact lens prior to eyelid swelling if facial involvement. ○ Fluorescein should be used to identify corneal injury.

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
<p>pulmonary condition.</p> <ul style="list-style-type: none"> • Monitor glucose at least every 2 hours x 24 hours. • Monitor for the following signs and symptoms in full thickness, circumferential burn injuries which may indicate a circulation deficit and possible need for escharotomy: <ul style="list-style-type: none"> ○ Pallor or cyanosis of distal unburned skin on a limb ○ Capillary refill > 5 seconds ○ Unrelenting deep tissue pain ○ Progressive loss of sensation or motor function ○ Progressive decrease or absence of pulses ○ Inability to ventilate in patients with deep circumferential burns of the chest 	<ul style="list-style-type: none"> ○ If eye involvement or facial burns consider, consulting an ophthalmologist. • Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy. • Finger escharotomies are rarely indicated.
<p style="text-align: center;"><u>Comfort</u></p> <ul style="list-style-type: none"> • Frequent pain/sedation assessment <ul style="list-style-type: none"> ○ A minimum of every 4 hours ○ Before and after pain/sedation medication given • Use age appropriate pain scales for pediatric patients (e.g., Wong Baker FACES, FLACC) 	<p style="text-align: center;"><u>Comfort</u></p> <ul style="list-style-type: none"> • Emotional support and education is essential. • IV/IO analgesia is preferred route during initial post injury period. • Large amounts of IV/IO analgesic may be required to attain initial pain control. <ul style="list-style-type: none"> ○ Administer opioids in frequent (every 5 minutes) small to moderate doses until pain is controlled. <ul style="list-style-type: none"> ▪ Morphine 0.1-0.2 mg/kg IV/IO (max 10mg/dose) ▪ Fentanyl 1-2 mcg/kg/dose IV/IO/IN (not to exceed maximum adult dose) ○ Oxycodone PO • Consider use of non-pharmacological techniques. <ul style="list-style-type: none"> ○ Examples: <ul style="list-style-type: none"> ▪ < 2 y/o: distraction ▪ 2-6 y/o: distraction, deep breathing ▪ > 6 y/o: deep breathing, distraction, imagery • Consider anti-anxiety medication in addition to pain medication. <ul style="list-style-type: none"> ○ Ativan PO/IV/IO ○ Versed IV/IO/IN • Consider sedation for procedures and, if intubated: <ul style="list-style-type: none"> ○ Propofol ○ Ketamine

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
<p><u>Wound Care</u></p> <ul style="list-style-type: none"> Assess the wound and monitor for: <ul style="list-style-type: none"> Change in wound appearance Change in size of wound Signs or symptoms of infection 	<p><u>Wound Care</u></p> <ul style="list-style-type: none"> Pre-medicate patients for pain before wound care. In a mass casualty disaster situation wound care for patient with a >20% TBSA burn can be performed once per day. Contraindications for silver sulfadiazine (Silvadene): <ul style="list-style-type: none"> Patient's with a sulfa allergy On face due to pigment bleaching Children < 2 years old During pregnancy Instead use another topical or wound coverage product. Wash wounds with soap and warm tap water using a wash cloth. <ul style="list-style-type: none"> Remove water by patting dry Shave daily for burned scalps and faces. Perform wound care every day if using: <ul style="list-style-type: none"> Silver sulfadiazine (Silvadene) cream Bacitracin Debride ALL blisters except for: <ul style="list-style-type: none"> Intact blisters on hands and feet unless it is impeding range of motion to the joints, Weeping blister(s). Ear wound care: <ul style="list-style-type: none"> Ears are poorly vascularized and at risk for chondritis. How to apply silver sulfadiazine (Silvadene) cream: <ul style="list-style-type: none"> Apply thin layer enough so that the wound cannot be seen through the cream. The layer of silver sulfadiazine (Silvadene) should be thick enough to prevent the wound from drying out prior to the next dressing change. Cover with a dressing; the purpose of a dressing is to keep the cream from rubbing off before the next dressing change. How to apply Acticoat[®] dressing: <ul style="list-style-type: none"> Apply a single layer of the dressing moistened with water over burn wounds so that all areas are covered. Water should be used to keep the Acticoat[®] and overlying gauze moist to maintain the dressing's antimicrobial activity. (<i><u>DO NOT use</u></i>

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions and Key Points
	<p><u>saline because it deactivates the silver's antimicrobial ability).</u></p> <ul style="list-style-type: none"> ○ Should be held in place with water-moistened gauze dressing. ○ Dressing does not need to be changed for 7 days. ○ The overlying gauze can be changed as necessary. ○ If signs of infection appear, remove dressing to assess wound. ○ Record the date of the application. <ul style="list-style-type: none"> • Wrap fingers separately if burned. • Place silver sulfadiazine (Silvadene) coated gauze between the toes. • For extensive and severe burns to the face: <ul style="list-style-type: none"> ○ Apply a double antibiotic ointment around the eyes and mouth to avoid cream from draining into them. ○ Can use ophthalmic ointment around eyes. • For moderate facial burns, Bacitracin or other antibiotic ointment can be used without a dressing. • Genital/Perineal Burns <ul style="list-style-type: none"> ○ Urinary catheter may be indicated for genitalia or perineal burns. Evaluate each patient individually to determine if needed. ○ Apply lubricated gauze to labia and in the foreskin to prevent adhesions and decrease risk of infection in this area of high contamination. • Elevate burned extremities above the level of the heart.

Ongoing Assessment, Monitoring, Interventions and Key Points

Assessment and Monitoring	Interventions
<p><u>Airway and Breathing</u></p> <ul style="list-style-type: none"> • Obtain chest X-ray if intubated, inhalation injury suspected or underlying pulmonary condition. • Chest X-ray will usually be clear on admit. If inhalation injury is present, the X-ray will show infiltrates around the second day correlating with a deteriorating oxygen status. • Frequent suctioning is necessary to prevent occlusion of the airway and endotracheal tube. Anyone with an inhalation injury is subject to increased respiratory secretions and may 	<p><u>Airway and Breathing</u></p> <ul style="list-style-type: none"> • Supportive therapy and O₂; wean as appropriate. • HOB should be elevated 30 degrees to minimize facial and airway edema, unless contraindicated. <ul style="list-style-type: none"> ○ Use reverse Trendelenburg for patients with C-spine precautions. • Suction airway frequently. • <u>Inhalation Injuries:</u> <ul style="list-style-type: none"> ○ Treatment for inhalation injury is supportive care and includes: <ul style="list-style-type: none"> ▪ Intubation as indicated

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions
have a large amount of carbonaceous debris in the respiratory tract.	<ul style="list-style-type: none"> ▪ Provide adequate sedation to prevent dislodgement of ETT ▪ Frequent suctioning ▪ Positive End Expiratory Pressure (PEEP) may improve ventilation ○ Secure ETT with ties instead of tape since tape will not adhere to burned tissue ○ Mark ETT at fixed position (teeth or gums not lips which may have swelling)
<p><u>Circulation/Outputs of Resuscitation</u></p> <ul style="list-style-type: none"> • Monitor mean arterial blood pressure (MAP): <ul style="list-style-type: none"> ○ Goal for MAP is >60 mmHg • Monitor hourly urine output: <ul style="list-style-type: none"> ○ Goal: 1 mL/kg/hr for children < 30 kg • Monitor for myoglobin/pigment in urine (burgundy color). • Additional resuscitation fluid needs can occur with: <ul style="list-style-type: none"> ○ Very deep burns ○ Inhalation injury ○ Associated injuries ○ Electrical injury ○ Delayed resuscitation ○ Prior dehydration ○ Alcohol or drug dependence ○ Small children • Children and patients with preexisting cardiac disease are particularly sensitive to fluid management. • Diuretics are not indicated in myoglobin in the urine. • Monitor glucose at least every 2 hrs x 24 hours. 	<p><u>Outputs of Resuscitation</u></p> <ul style="list-style-type: none"> • Insert arterial line. • Insert urinary catheter. • If urine output is < goal, ↑ fluids by 1/3. <ul style="list-style-type: none"> ○ Example: u/o for 20 kg pediatric patient = 10 mL/hr, fluid rate at 50 mL/hr, ↑ to 66 mL/hr • If urine output is > goal, ↓ rate of infusion by 1/3. <ul style="list-style-type: none"> ○ Example: u/o for 20 kg pediatric patient = 30 mL/hr fluid rate at 50 mL/hr, ↓ to 33 mL/hr • Upon completion of the resuscitation phase (24 hrs post burn), ↓ hourly fluid volume by 10% per hour to a maintenance fluid with D5 ½ NS with 20 mEq KCL/L. • Myoglobin in urine: <ul style="list-style-type: none"> ○ Maintain urine output: <ul style="list-style-type: none"> ▪ 2 mL/kg/hr ○ Increase fluid rate (LR). • Sodium bicarbonate IV/IO may be administered to maintain alkaline urine, with a pH > 6.
<p><u>Circulation</u></p> <ul style="list-style-type: none"> • Perform pulse checks (CMS) every 1 hour if there are circumferential burns on extremities. <ul style="list-style-type: none"> ○ Monitor pulses by palpation or doppler exam. <ul style="list-style-type: none"> ▪ Decreased sensation ▪ Severe unrelenting deep tissue pain ▪ Diminished distal pulses ▪ Capillary refill > 5 sec • After 24-48 hrs decrease frequency of pulse checks to every 2 hours if stable. 	<p><u>Circulation</u></p> <ul style="list-style-type: none"> • Elevate burned extremities on pillows or blankets to improve circulation and minimize edema. • Circumferential chest injuries may become life threatening; an escharotomy may be necessary. • Verify that pulselessness is not due to profound hypotension. • Scrotal swelling, though often significant, does not require specific treatment.

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring	Interventions
<ul style="list-style-type: none"> Assess bowel sounds to monitor for ileus. 	
<p><u>Body Temperature</u></p> <p>Perform temperature checks based on hospital protocol.</p> <ul style="list-style-type: none"> If unstable or significant burn, hourly vital signs may be indicated. 	<p><u>Body Temperature</u></p> <ul style="list-style-type: none"> With 2nd and 3rd degree burns, patients may have difficulty regulating their temperature; monitor for hypo and hyperthermia. Keep patient normo-thermic, especially during wound care. Keep patient covered. When supplies of blankets are depleted, patients can be wrapped in plastic wrap or aluminum foil for insulation and warmth. Warm the room. Warm IV/IO fluid if possible, especially if patient is very hypothermic.
<p><u>Nutrition</u></p> <ul style="list-style-type: none"> Obtain dry weight on admission. See Nutritional Algorithm for Burn Patients on page 15. 	<p><u>Nutrition</u></p> <ul style="list-style-type: none"> Increased protein needs. <ul style="list-style-type: none"> 20 - 23% of calories should be from protein in TBSA >10% (approximately 2.5 - 4.0 grams protein/kg) Dietary consult with daily calorie counts. <ul style="list-style-type: none"> Usual Kcal needs = Resting Energy Expenditure (REE) x 30% Regular high calorie, high protein diet if able to take PO. <ul style="list-style-type: none"> If unable to maintain adequate caloric requirements, initiate tube feedings. No free water drinks (plain water) if taking PO, only high calorie liquids. If intubated, begin tube feedings at full strength increasing to goal rate. Ensure stool softeners are ordered to prevent constipation due to pain medications. Begin enteral nutrition as soon as possible. Soft feeding tubes are preferred over hard salem sump nasogastric tube. Consider GI stress ulcer prophylaxis (AHRQ, 2008). <ul style="list-style-type: none"> H2 antagonists, cytoprotective agents or proton pump inhibitors. Do not use antacids as stress ulcer prophylaxis.
<p><u>Psychosocial</u></p> <ul style="list-style-type: none"> Explain any procedures. Involve patient and family. Consider social worker consultation. Offer spiritual care. Consult child life specialists, if available. Child's needs and understanding of the injury and care will vary based on their developmental level. <ul style="list-style-type: none"> Infants 	

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

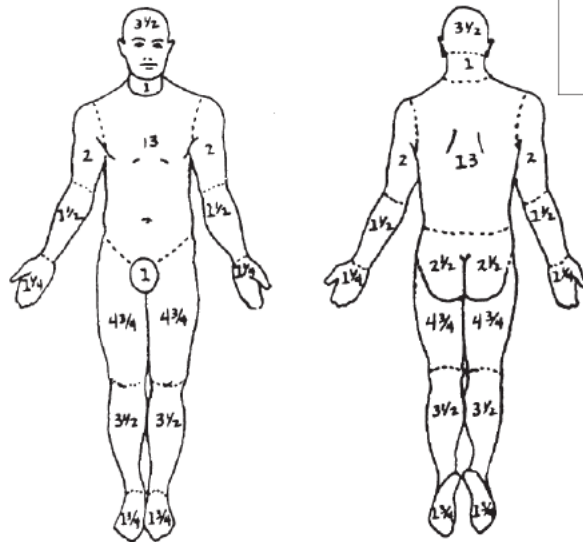
Assessment and Monitoring		Interventions	
<ul style="list-style-type: none">▪ Learn through sensory stimulation (especially touch) and movement.▪ Can experience separation anxiety from family/care taker.○ Toddler/Preschool<ul style="list-style-type: none">▪ May see the burn injury as punishment for being “bad” so at risk for ineffective coping.▪ Routine is important so coordinate procedures around daily routines.○ School age<ul style="list-style-type: none">▪ Anxiety can be decreased by providing child education about processes and involving child in care.○ Adolescent<ul style="list-style-type: none">▪ Body image is significant concern.			
<u>Infection Control</u>			
<ul style="list-style-type: none">• Utilize universal precautions.• If wounds are exposed:<ul style="list-style-type: none">○ Apply gown, mask and gloves to protect patient.• No systemic antibiotics are required for the burn injuries.			
<u>Mobility</u>		<u>Mobility</u>	
<ul style="list-style-type: none">• In a disaster, therapists may just splint patients in functional positions and help with dressings.		<ul style="list-style-type: none">• Obtain physical therapy /occupational therapy consult.• HOB elevated at all times.• Elevate burned extremities above the level of the heart.• Neck burns<ul style="list-style-type: none">○ Maintain the head in a neutral position.○ No pillows or blankets under the head flexing the neck forward.• Axilla burns<ul style="list-style-type: none">○ Keep arms extended to decrease contractures.• Ear burns<ul style="list-style-type: none">○ No external pressure should be applied.○ No pillows or blankets under the head.• Out of bed (OOB) - If legs are burned, apply ace wraps when OOB.• Encourage active range of motion hourly when awake.• Encourage activities of daily living.	
<u>Proper Positioning of a Burn Patient</u>			
Area Involved	Contracture Predisposition	Contracture Preventing Position	
Anterior neck	Flexion	Extension, no pillows	

ATTACHMENT 14: PEDIATRIC BURN GUIDELINES

Assessment and Monitoring			Interventions
Anterior axilla	Shoulder adduction		90° abduction, neutral rotation
Posterior axilla	Shoulder extension		Shoulder flexion
Elbow/Forearm	Flexion/pronation		Elbows extended, forearm supinated
Wrists	Flexion		15°–20° extension
Hands:			
MCPs	Hyperextension		70°–90° flexion
IPs	Flexion		full-extension
Palmar Burn	Finger flexion, thumb opposition		All joints full extension, thumb radially abducted
Chest	Lateral/anterior flexion		Straight, no lateral or anterior flexion
Hips	Flexion, adduction, external rotation		Extension, 10° abduction, neutral rotation
Knees	Flexion		Extension
Ankles	Plantar flexion		90° dorsiflexion
<u>Splinting materials:</u> <ul style="list-style-type: none"> ○ Use either ace/elastic wraps, gauze roll/wraps or strappings with post-mold material (e.g., thermoplastic-perforated). 			
<p style="text-align: center;"><u>Reunification</u></p> <p>During a large scale disaster, family members may become separated. It is crucial that staff attempt to reunify patients with their family. Children are more vulnerable to maltreatment, abuse and abduction, if separated from their care giver. Community partners, such as the American Red Cross and National Center for Missing and Exploited Children, can assist with this process. The reunification process begins with EMS at the scene and, if possible, trying to keep known family members together when making transport decision. The Patient Identification Tracking Form (Attachment 9 in Burn Surge Annex) should be utilized for all patients to assist with the reunification process.</p>			

ATTACHMENT 14: PEDIATRIC BURN PROTOCOLS**Assess Degree of Injury**

	APPEARANCE	SURFACE	SENSATION	TIME TO HEALING
1st degree/superficial	Pink or red	Dry	Painful	4-5 days
2nd degree/superficial partial thickness	Pink, clear blisters	Moist, weeping	Painful	14–21 days
2nd degree/deep partial thickness	Pink, hemorrhagic blisters, red	Moist	Painful	Weeks, may progress to 3rd degree and require graft, may lead to contractures
3rd degree/full thickness	White, brown, charred	Dry, waxy, leathery	Painless	Requires excision, high risk for infection/fluid loss
4th degree (tendon, nerve, muscle, bone and/or deep fascia involvement)	Brown, charred	Dry	Painless	Requires excision, high risk for infection/fluid loss

ATTACHMENT 14: PEDIATRIC BURN PROTOCOLS**Lund & Browder Chart****BURN DIAGRAM, ESTIMATE
(Lund & Browder)**

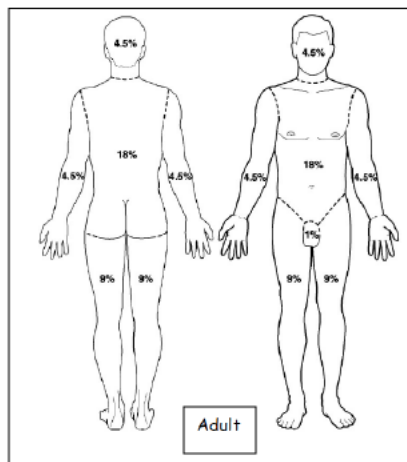
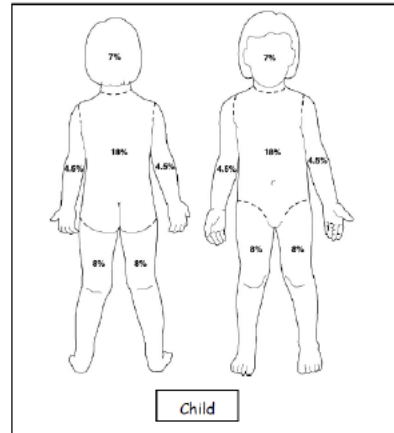
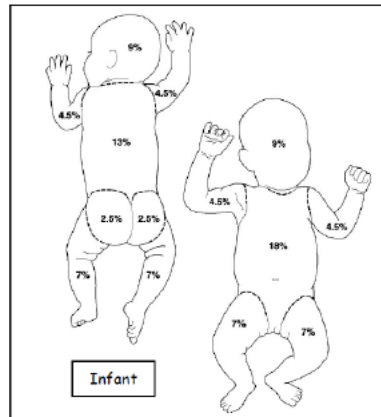
AREA	AGE						BURN ASSESSMENT	
	infant	1-4	5-9	10-14	15	adult	PARTIAL THICKNESS	FULL THICKNESS
head	19	17	13	11	9	7		
neck	2	2	2	2	2	2		
ant. trunk	13	13	13	13	13	13		
post. trunk	13	13	13	13	13	13		
r. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
genitalia	1	1	1	1	1	1		
r. u. arm	4	4	4	4	4	4		
l. u. arm	4	4	4	4	4	4		
r. l. arm	3	3	3	3	3	3		
l. l. arm	3	3	3	3	3	3		
r. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
l. hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2		
r. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
l. thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2		
r. leg	5	5	5 1/2	6	6 1/2	7		
l. leg	5	5	5 1/2	6	6 1/2	7		
r. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
l. foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2		
TOTAL:								

BURN ASSESSMENT: Date _____ Time _____ Signature _____

ATTACHMENT 14: PEDIATRIC BURN PROTOCOLS

Rule of 9's Charts:

BURN DIAGRAM ESTIMATE
(Rule of 9's: Estimate of TBSA – Total Burn Surface Area)

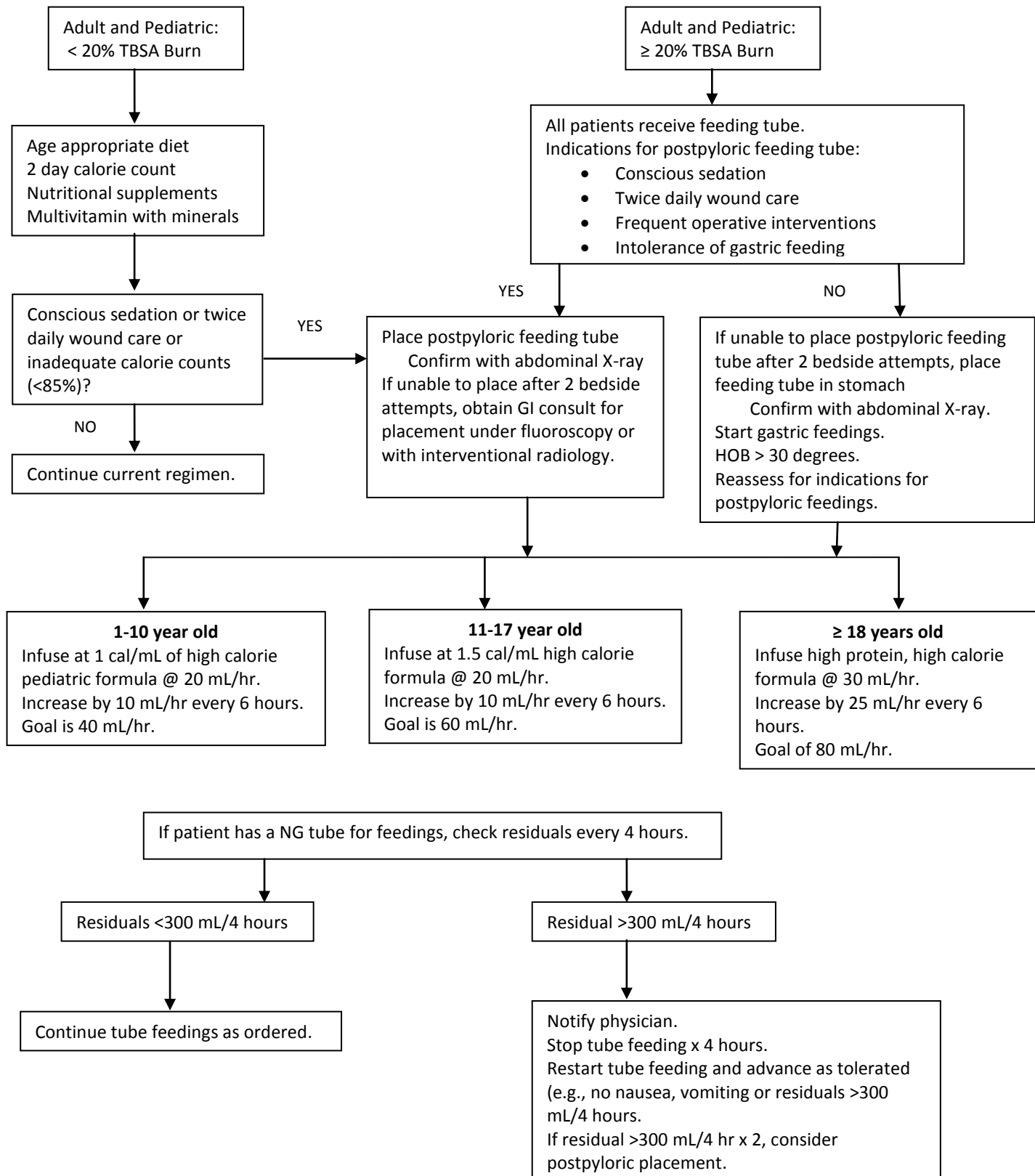


Area	Infant	Child	Adult	Burn Assessment	
				Partial thickness	Full thickness
Head	18	14	9		
Chest (Ant. torso)	18	18	18		
Back (Post. Torso) & buttocks	13 (back) 5 (buttocks)	18	18		
Rt. arm & hand	9	9	9		
Lt. arm & hand	9	9	9		
Rt. Leg & foot (anterior)	7	8	9		
Lt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Rt. Leg & foot (anterior)	7	8	9		
Perineum	(include with chest)	(include with chest)	1		

Bolded areas = nine or multiple of nine

Burn Assessment Date _____ Time _____ Signature _____

ATTACHMENT 14: PEDIATRIC BURN PROTOCOLS

Nutritional Algorithm for Burn Patients

ATTACHMENT 15: RECOMMENDED BURN SUPPLY CACHE

Purpose: To provide hospitals, regions and the state with a standardized list of burn supplies that can be utilized during a burn MCI.

Recommended Burn Cache Supplies for 10 Patients**Supplies**

- | | |
|--|------------------------|
| • Large burn dressings 24" X 36" | 100 |
| • Small burn dressings 18" x 18" | 100 |
| • Kerlix rolls 4' x 3 yard roll | 200 (foil packs) |
| • Kerlix Super Sponges (6 x 6) | 500 packages |
| • Flexinet-sizes: 1, 3, 5, 8, 10 | 10 boxes for each size |
| • Exudry- small | 40 |
| • Exudry- large | 40 |
| • All-purpose solution bowls | 40 |
| • Sterile fields | 100 |
| • Lactated Ringers (LR) | 200 |
| • Intubation supplies | |
| • Bandage scissors | |
| • Central line kits | |
| • Arterial line kits | |
| • Urinary catheters (various sizes for all ages) | |
| • NG tubes (various sizes for all ages) | |

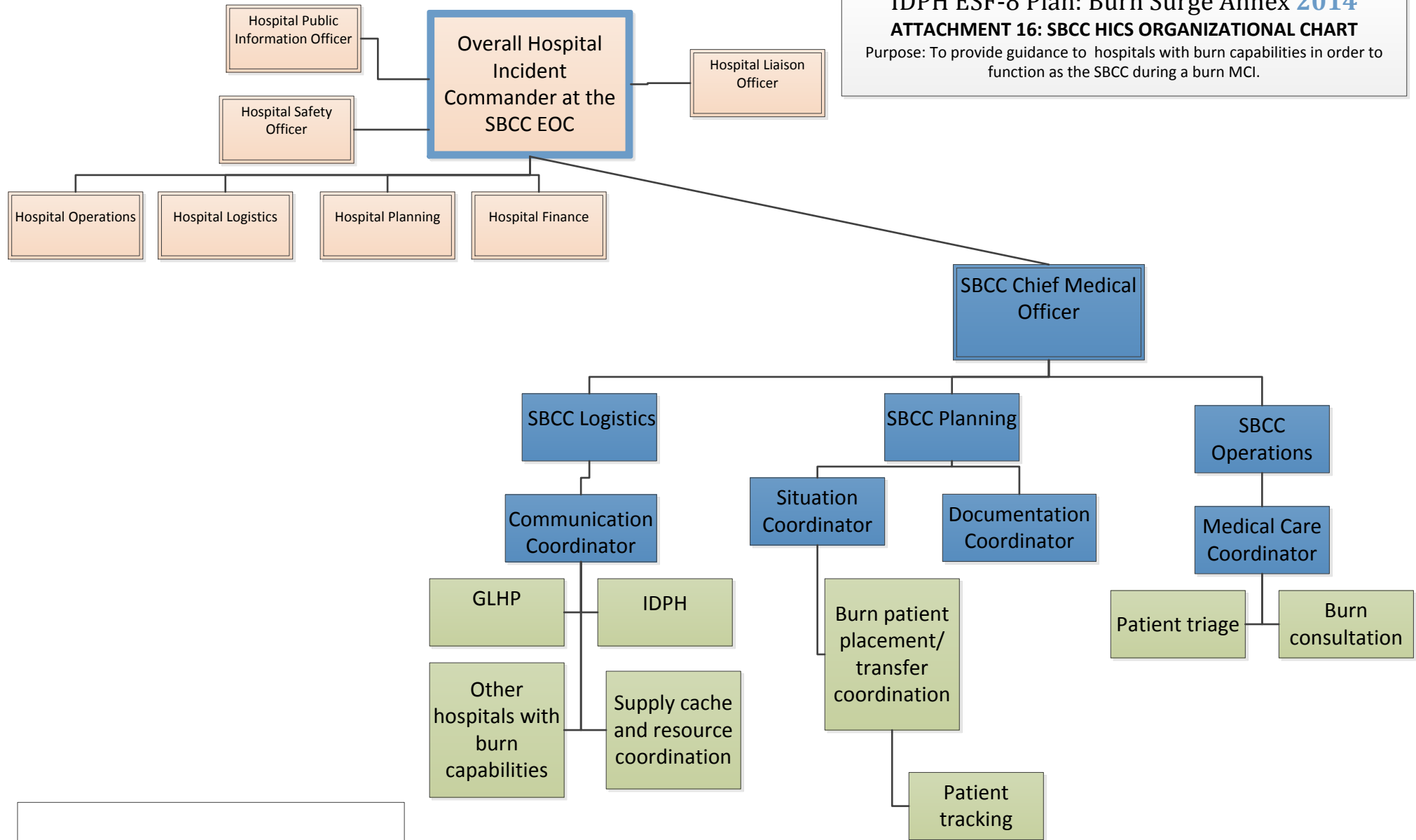
Medications

- | | |
|--------------------------|-----|
| • Bacitracin 400 g jar | 20 |
| • Silvadene 400 g jar | 40 |
| • Morphine | |
| • Acticoat 40x40cm sheet | 100 |

IDPH ESF-8 Plan: Burn Surge Annex 2014

ATTACHMENT 16: SBCC HICS ORGANIZATIONAL CHART

Purpose: To provide guidance to hospitals with burn capabilities in order to function as the SBCC during a burn MCI.



Blue & Orange = Internal Communications

Green = External Communications

ATTACHMENT 17: SBCC JOB ACTION SHEETS

Purpose: To provide guidance to Illinois hospitals with burn capabilities in order to function in the role of SBCC during a burn MCI.

SBCC Chief Medical Officer**Mission**

Organize and direct overall response as the State Burn Coordinating Center (SBCC), including communication, burn consultation, patient triage, patient placement/transfer, patient tracking and documentation in the event of a mass casualty incident involving multiple burn victims. Directs all staff about duties related to the SBCC role.

Recommended primary provider to fill this role

Burn attending on-call

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ **Signature** _____

Location ☐ Hospital EOC ☐ Hospital Unit _____ ☐ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information _____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the IDPH ESF-8 Plan: Burn Surge Annex, the SBCC will be notified by IDPH through the pre-designated method.		
SBCC may be notified directly by another hospital or GLHP about a mass casualty incident involving multiple burn victims.		
Once notification is received, the SBCC chief medical officer will be notified as indicated in the SBCC internal burn surge plan.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Initiate SBCC internal burn surge plan.		
Notify administrator on call, if not already aware, who will activate the emergency operations center.		
If notified by hospital or GLHP regarding event, notify IDPH and request Burn Surge Annex activation.		
Obtain a briefing on incident and status of operation and response from IDPH.		
Assign additional SBCC medical staff resources, as needed.		
Activate additional SBCC roles, as indicated. <ul style="list-style-type: none"> • SBCC logistics: Communication coordinator • SBCC operations: Medical Care coordinator • SBCC planning: Situation coordinator • SBCC planning: Documentation coordinator 		
Obtain status report from: <ul style="list-style-type: none"> • SBCC logistics: Communication coordinator regarding status of event, supply cache capabilities, status of GHLP's and CDPH resources. 		

ATTACHMENT 17: SBCC JOB ACTION SHEETS

<ul style="list-style-type: none"> • SBCC operations: Medical care coordinator regarding current patient triage and consultation needs throughout the state. • SBCC planning: Situation coordinator regarding patient tracking and current bed availability at all hospitals with burn capabilities. • SBCC planning: Documentation coordinator regarding maintaining proper documentation of the incident and response. 		
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INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Assist staff with triaging burn requests and coordination of burn patients' transfers from the hospital of initial management to the appropriate burn category hospital based on triage criteria in the Burn Surge Annex and available resources.		
Provide burn consultation on the management of patients at hospitals without burn capabilities during the initial 72 hours post incident.		
Maintain communication with IDPH for routine briefings on status of the event, resource availability, resource needs, triage and transfer coordination, triage and consultation needs.		
Maintain communication with internal staff and incident command.		
Monitor for completion of event documentation.		
Provide briefings to staff on status of event.		

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Coordinate the triage, transfer and tracking of burn patients in and out of state.		
Provide burn consultation on the management of patients at non-burn hospitals during the initial 72 hours post incident through telemedicine, as available/indicated.		
Monitor staff for signs of stress and relieve, as necessary.		
Review event documentation.		
Shift change: Brief replacement on the status of all ongoing burn consultation, triage, and transfer needs.		

DEMOBILIZATION/RECOVERY	TIME	INITIAL
Participate in debriefing after event (internal and with IDPH).		
Review event and post-event documentation.		
Contribute to and review after action report for lessons learned and improvement plans.		
Assist with implementing the improvement plan.		

DOCUMENTS/TOOLS
<ul style="list-style-type: none"> • Burn Surge Annex • Attachment 4: Burn Medical Incident Report Form • Attachment 5: Burn Communication Pathway • Attachment 18: Burn Patient Casualty Communication Log • Attachment 19: Post Event Data Collection Log

ATTACHMENT 17: SBCC JOB ACTION SHEETS

Purpose: To provide guidance to Illinois hospitals with burn capabilities in order to function in the role of SBCC during a burn MCI.

SBCC Logistics: Communication Coordinator**Mission**

To maintain and coordinate communication between key stakeholders (e.g., IDPH, GLHP, hospitals with burn capabilities) regarding the mass casualty incident involving multiple burn victims and the overall status of burn resources throughout the state and with border states.

Recommended primary provider to fill this role

Emergency preparedness coordinator

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ **Signature** _____

Location ☐ Hospital EOC ☐ Hospital Unit _____ ☐ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information _____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC logistics: Communication coordinator, as indicated.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
If needed, assemble additional staff and assign duties.		
Identify primary contact and method of contact for key stakeholders.		
Contact key stakeholders for situational awareness status update.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Provide SBCC chief medical officer with status updates		
Provide SBCC planning: Situation coordinator and SBCC operations: Medical care coordinator with status updates, resource availability at all burn category Hospitals, patient triage, patient placement/transfer and burn consultation requests as they are received.		
Communicate to and receive updates from key stakeholders.		
Monitor fax and other communication devices for incoming status updates, patient triage, patient placement/transfer and burn consultation requests.		
Troubleshoot communication needs.		

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to communicate with key stakeholders.		

ATTACHMENT 17: SBCC JOB ACTION SHEETS

Continue to provide status updates, resource availability, patient triage request and burn consultation requests as they are received.		
Continue to monitor communication devices for incoming status updates and requests.		
Continue to troubleshoot communication needs.		
Monitor staff for signs of stress and relieve as necessary.		
Shift change Brief replacement on the status of all ongoing communication needs and issues. Brief replacement on method to contact key stakeholders.		

DEMOBILIZATION/RECOVERY	TIME	INITIAL
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete required event and post-event documentation.		

DOCUMENTS/TOOLS
<ul style="list-style-type: none"> • Burn Surge Annex • Attachment 4: Burn Medical Incident Report Form • Attachment 5: Burn Communication Pathway • Attachment 6: Kentucky Resource Request Process • Attachment 7: St. Louis Medical Operations Center Request Process • Attachment 8: Illinois Burn Resource Directory • Attachment 18: Burn Patient Casualty Communication Log

ATTACHMENT 17: SBCC JOB ACTION SHEETS

Purpose: To provide guidance to Illinois hospitals with burn capabilities in order to function in the role of SBCC during a burn MCI.

SBCC Operations: Medical Care Coordinator**Mission**

To facilitate the receipt, response, coordination and communication of patient triage and consultation need requests between burn experts at the SBCC, IDPH and hospitals without burn capabilities throughout the state.

Recommended provider to fill this role

Burn/trauma residents and burn/trauma nurse practitioners

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ **Signature** _____

Location ☐ Hospital EOC ☐ Hospital Unit _____ ☐ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information _____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC operations: Medical care coordinator as indicated.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
Collaborate with SBCC logistics: Communication coordinator regarding patient triage and patient placement/transfer requests and burn consultation requests.		
If needed, assemble additional staff and assign duties.		
Become familiar with documentation tools (e.g., Attachment 18: Burn Patient Casualty Communication Log).		
Identify any outstanding patient triage, burn patient transfer and consultation requests.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Triage all patient transfer requests utilizing the Burn Triage Guidelines.		
Collaborate with SBCC planning: Situation coordinator regarding triage decisions to assist with patient placement and transfer coordination to the appropriate burn category hospital.		
Address burn consultation needs and requests from hospitals with no burn capabilities.		
Communicate with SBCC chief medical officer regarding triage requests and burn consultation requests.		
Document communication regarding triage requests and burn consultations on the appropriate forms (Attachment 18: Burn Patient Casualty Communication Log).		

ATTACHMENT 17: SBCC JOB ACTION SHEETS

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to triage all patient transfer requests.		
Continue to collaborate with SBCC planning: Situation coordinator regarding triage decisions.		
Continue to document communications regarding triage requests, patient placement requests and burn consultations on the appropriate forms.		
Continue to update SBCC chief medical officer.		
Monitor staff for signs of stress and relieve as necessary.		

DEMOBILIZATION/RECOVERY/SHIFT CHANGE	TIME	INITIAL
Brief replacement on the status of all ongoing/outstanding triage and burn consultation needs.		
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete required event and post-event documentation.		

DOCUMENTS/TOOLS
<ul style="list-style-type: none"> • Burn Surge Annex • Attachment 4: Burn Medical Incident Report Form • Attachment 11: Burn Triage Guidelines • Attachment 13: Adult Burn Guidelines • Attachment 14: Pediatric Burn Guidelines • Attachment 18: Burn Patient Casualty Communication Log

ATTACHMENT 17: SBCC JOB ACTION SHEETS

Purpose: To provide guidance to Illinois hospitals with burn capabilities in order to function in the role of SBCC during a burn MCI.

SBCC Planning: Situation Coordinator**Mission**

To obtain and maintain current bed availability at all hospitals with burn capabilities to assist with patient placement during a mass casualty incident with multiple burn victims and provide patient tracking for those burn patients that the SBCC coordinates their transfer/placement between hospitals.

Recommended primary provider to fill this role

Clinical support staff

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to: _____ **Signature:** _____

Location ☐ Hospital EOC ☐ Hospital Unit _____ ☐ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Information _____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC planning: Situation coordinator, as indicated		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
Collaborate with SBCC operations: Medical care coordinator regarding the status of patient triage and transfer requests for all burn category hospitals.		
If needed, assemble additional staff and assign duties.		
Become familiar with documentation tools (e.g., Attachment 10: Burn Patient Tracking Log).		
Collaborate with SBCC logistics: Communication coordinator regarding bed availability and status of other available resources at all burn category hospitals.		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Collaborate with SBCC operations: Medical care coordinator to obtain triage decisions and track all patient placement and transfers coordinated through the SBCC.		
Document patient placement/transfers coordinated through the SBCC on the Burn Patient Tracking Log.		
Collaborate with SBCC logistics: Communication coordinator to obtain updates on resource availability to assist with burn patient placement and transfer coordination.		
Collaborate with SBCC logistics: Communication coordinator to communicate with IDPH regarding burn patient placement and transfer coordination.		
Coordinate with hospitals with burn capabilities to place patients triaged as "Immediate (Red)"		

ATTACHMENT 17: SBCC JOB ACTION SHEETS

at a hospital with burn capabilities.		
Coordinate with Level I trauma centers/non-burn hospitals to place patients triaged as “Urgent (Yellow)” and any patients triaged as “Immediate (Red)” that are unable to be placed at a hospital with burn capabilities at an appropriate facility.		
Coordinate with Level II trauma centers/non-burn hospitals to place patients triaged as “Urgent (Yellow)” at an appropriate facility.		
Coordinate with non-trauma/non-burn hospitals to place patients triaged as “Non-urgent (Green)” and “Expectant (Black)” at an appropriate facility.		
Communicate with SBCC chief medical officer regarding triage requests, patient placement and burn consultation requests.		

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to coordinate burn patient transfers with all burn category hospitals.		
Continue to collaborate with SBCC operations: Medical care coordinator regarding triage decisions.		
Continue to collaborate with SBCC logistics: Communication coordinator to obtain resource availability status updates and to assist with communication with IDPH.		
Continue to document all patient placement/transfers that are coordinated through the SBCC on the Burn Patient Tracking Log.		
Continue to update SBCC chief medical officer		
Monitor all staff for signs of stress and relieve as necessary		

DEMOBILIZATION/RECOVERY/SHIFT CHANGE	TIME	INITIAL
Brief your replacement on the status of ongoing/outstanding patient placement needs.		
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete any required event and post-event documentation (e.g., Post Event Data Collection Log)		

DOCUMENTS/TOOLS
<ul style="list-style-type: none"> • Burn Surge Annex • Attachment 4: Burn Medical Incident Report Form • Attachment 10: Burn Patient Tracking Log • Attachment 18: Burn Patient Casualty Communication Log • Attachment 19: Post Event Data Collection Log

ATTACHMENT 17: SBCC JOB ACTION SHEETS

Purpose: To provide guidance to Illinois hospitals with burn capabilities in order to function in the role of SBCC during a burn MCI.

SBCC Planning: Documentation Coordinator**Mission**

To maintain and assist others with maintaining proper documentation during and after a mass casualty incident involving multiple burn victims

Recommended primary provider to fill this role

Unit secretaries, administrative assistants

Date _____ Start _____ End _____ Position Assigned to _____ Initial _____

Position Reports to _____ **Signature** _____

Location ☐ Hospital EOC ☐ Hospital Unit _____ ☐ Remote (via phone, radio, etc.)

Phone (1) _____ Phone (2) _____ Fax _____

Other Contact Info _____ Radio Title _____

ACTIVATION PHASE	TIME	INITIAL
Upon activation of the SBCC due to a mass casualty incident involving multiple burn victims, the SBCC chief medical officer will activate the SBCC planning: Documentation coordinator as indicated.		

IMMEDIATE OPERATIONAL PERIOD (0-2 hours)	TIME	INITIAL
Obtain briefing of incident and status of plan from SBCC chief medical officer.		
If needed, assemble additional staff and assign duties.		
Become familiar with documentation tools (e.g., Attachment 18: Burn Patient Casualty Communication Log, Attachment 10: Burn Patient Tracking Log, Attachment 12: Burn Patient Transfer Form, Attachment 19: Post Event Data Collection Log).		

INTERMEDIATE OPERATIONAL PERIOD	TIME	INITIAL
Collaborate with SBCC chief medical officer to assist with documentation needs.		
Collaborate with SBCC logistics: Communication coordinator to assist with documentation needs.		
Collaborate with SBCC planning: Situation coordinator to assist with documentation needs.		
Collaborate with SBCC operations: Medical care coordinator to assist with documentation needs.		
Communicate with SBCC chief medical officer regarding documentation issues/needs.		

EXTENDED OPERATIONAL PERIOD	TIME	INITIAL
Continue to collaborate with SBCC chief medical officer to assist with documentation needs.		
Continue to collaborate with SBCC logistics: Communication coordinator to assist with documentation needs.		
Continue to collaborate with SBCC planning: Situation coordinator to assist with documentation		

ATTACHMENT 17: SBCC JOB ACTION SHEETS

needs		
Continue to collaborate with SBCC operations: Medical care coordinator to assist with documentation needs		
Continue to Communicate with SBCC chief medical officer regarding documentation issues/needs.		
Monitor staff for signs of stress and relieve, as necessary.		

DEMOBILIZATION/RECOVERY/SHIFT CHANGE	TIME	INITIAL
Brief your replacement on the status of ongoing/outstanding patient placement needs.		
Provide SBCC chief medical officer a status report.		
Participate in debriefing after event (internal) and provide feedback on lessons learned.		
Complete any required event and post-event documentation (e.g., Post Event Data Collection Log).		
File all event and post-event documentation as per hospital policy.		
Collaborate with SBCC logistics: Communication coordinator to identify method of submitting event and post-event documentation to IDPH.		

DOCUMENTS/TOOLS
<ul style="list-style-type: none"> • Burn Surge Annex • Attachment 4: Burn Medical Incident Report Form • Attachment 10: Burn Patient Tracking Log • Attachment 12: Burn Patient Transfer Form • Attachment 18: Burn Patient Casualty Communication Log • Attachment 19: Post Event Data Collection Log

ATTACHMENT 18: BURN CASUALTY COMMUNICATION LOG

Purpose: To provide a standardized method of tracking communication between the stakeholders during a burn MCI.

NAME of PERSON TAKING CALL	DATE of CALL
HOSPITAL/AGENCY	TIME of CALL
<u>CALLER INFORMATION:</u>	
NAME AND TITLE _____	
HOSPITAL/AGENCY _____	
PHONE _____	E-MAIL _____
<u>PATIENT INFORMATION:</u>	
NAME _____ DOB _____	
% TBSA _____	TIME OF BURN INJURY _____
BURN INJURY _____	
INTUBATED <input type="checkbox"/> YES <input type="checkbox"/> NO VENTILATOR CAPABILITIES AT CALLER FACILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	
OTHER INJURIES/CO-MORBIDITIES _____	
FAMILY /SOCIAL ISSUES _____	
FAMILY CONTACT INFORMATION _____	
<u>PURPOSE OF CALL:</u>	
<input type="checkbox"/> BURN CONSULTATION _____	
<input type="checkbox"/> TRANSFER COORDINATION _____	
RESOURCE NEEDS: <input type="checkbox"/> BURN <input type="checkbox"/> ICU <input type="checkbox"/> VENTILATOR <input type="checkbox"/> PEDIATRIC <input type="checkbox"/> PALLIATIVE CARE <input type="checkbox"/> FOLLOW UP	
<input type="checkbox"/> OTHER _____	
<input type="checkbox"/> TRIAGE REQUEST	
TRIAGE CATEGORY	TYPE OF FACILITY NEEDED
<input type="checkbox"/> IMMEDIATE (RED)	<input type="checkbox"/> HOSPITAL WITH BURN CAPABILITIES
<input type="checkbox"/> URGENT (YELLOW)	<input type="checkbox"/> NON-BURN TRAUMA CENTER
<input type="checkbox"/> NON-URGENT (GREEN)	<input type="checkbox"/> NON-BURN/NON-TRAUMA CENTER
<input type="checkbox"/> OTHER: _____	
<u>RESPONSE/INFORMATION PROVIDED</u>	<u>TRANSFER INFORMATION</u>
	RECEIVING HOSPITAL _____
	DATE/TIME of TRANSPORT _____
	METHOD OF TRANSPORT _____

ATTACHMENT 18: BURN CASUALTY COMMUNICATION LOG

ADDITIONAL NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

ATTACHMENT 19: POST-EVENT DATA COLLECTION LOG

Purpose: To assist with compiling data after a burn MCI that can provide lessons learned and improvements to response plans.

TRACKING NUMBER	AGE	SEX	%TBSA	BURN INJURY	INHALATION INJURY	OTHER INJURY (Trauma)	CO-MORBIDITIES	# of SURGERIES	LOCATION RECEIVED TREATMENT	FINAL DISPOSITION
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA

ATTACHMENT 19: POST-EVENT DATA COLLECTION LOG

TRACKING NUMBER	AGE	SEX	%TBSA	BURN INJURY	INHALATION INJURY	OTHER INJURY (Trauma)	CO-MORBIDITIES	# of SURGERIES	LOCATION RECEIVED TREATMENT	FINAL DISPOSITION
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA
		M			Y				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home

ATTACHMENT 19: POST-EVENT DATA COLLECTION LOG

TRACKING NUMBER	AGE	SEX	%TBSA	BURN INJURY	INHALATION INJURY	OTHER INJURY (Trauma)	CO-MORBIDITIES	# of SURGERIES	LOCATION RECEIVED TREATMENT	FINAL DISPOSITION
		F			N				burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA
		M F			Y N				<input type="checkbox"/> Hospital with burn capabilities <input type="checkbox"/> Level I trauma/ Non-burn hospital <input type="checkbox"/> Level II trauma/ Non-burn hospital <input type="checkbox"/> Non-burn/Non-trauma hospital <input type="checkbox"/> Outpatient	<input type="checkbox"/> Discharged <input type="checkbox"/> Home <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> Transfer <input type="checkbox"/> Another hospital <input type="checkbox"/> Acute rehab <input type="checkbox"/> Expired <input type="checkbox"/> AMA