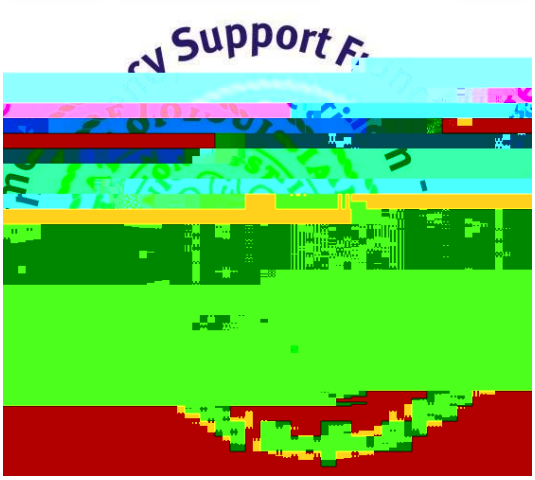


Louisiana Department of Health

ESF-8 Health & Medical Section

State Hospital Crisis Standard of Care Guidelines in Disasters

Version 4.0 February 2019

This is a liőiyg doŏuŸeyt ayd updated őersioys ǿill ōe deőeloped as yeeded.

Louisiana Crisis Standards of Care Guidelines in Disasters

Record of Changes

This plan is subject to information updates and changes. The use of this Record of Change helps manage modifications throughout the life of this document.

Change No.	Date	Description	Signature

Given the uncertainty about the characteristics of a new pandemic strain, all aspects of preparedness planning for pandemic influenza must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds. This document may serve as a guide for hospital policymakers. All information contained is to be considered a draft and subject to change. The adoption of consistent procedures and recommendations statewide would represent best practices during times of disaster and would assist in gaining public confidence. It is suggested that each hospital evaluate and apply this document in consideration of its unique needs including staffing, bed capacity, and community resources available to the hospital. Individual hospitals may then develop facility-specific policies and procedures. Furthermore, since community resources will be needed and shared by all hospitals in each region of the state, it is imperative that representatives from facilities in local areas come together to address standards of care guidelines across the region. This will help minimize public confusion and "shopping" for care and maximize the limited resources that will be needed.

The following section is taken directly from the Institute of Medicine's *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*, pages 1-23. This document was a summary report of four National Regional Meetings. The participants consisted of policy makers from state and local public health departments, local and state government representatives, providers from the health care community, including relevant medical disciplines, nursing, EMS, palliative care, hospice, home health, and their associated employee unions, and health care and hospital administrators. The objectives for the four workshops were to:

Illuminate the progress and successes of efforts underway to establish local, state, and regional standards of care protocols.

- What have been some of the barriers in establishing protocols?
- What solutions have you developed to operationalize standards of care protocols?

Improve regional efforts by facilitating a dialog and coordination between neighboring jurisdictions.

Discuss the roles and responsibilities of each stakeholder community in the development and implementation of standards of care protocols, including officials from state and local health departments and providers.

Examine what resources, guidelines, and expertise have been use rcs fr½ Ø ' q γ ∗ l M k , guidea

will likely fall along a continuum ranging from “conventional” to “contingency” and “crisis” surge responses.

Conventional patient care uses usual resources to deliver health and medical care that conforms to the expected standards of care of the community. The delivery of care in the setting of contingency

the event: conventional, contingency, and crisis surge capacity. Note that the same event may result in conventional care at a major trauma center, but crisis care at a smaller, rural facility.

Conventional, contingency, and crisis care represent a continuum of patient care delivered during a disaster event. As the imbalance increases between resource availability and demand, health care—emblematic of the healthcare system as a whole—maximizes conventional capacity, then moves into contingency, and, once maximized, moves finally into crisis capacity. Concurrent with this transition along a surge capacity continuum is the realization that the standard of care will shift. This occurs primarily as a result of the growing scarcity of human and material resources needed to treat, transport, and provide patient care. The goal of the healthcare agency or facility is to return as quickly as possible to conventional care by requesting resources or transferring patients out of the area, drawing on the resources of partner or coalition hospitals and the health system as a whole. Along the span from conventional

way staff is used in delivering care. All these steps should be attempted prior to the reallocation of critical resources in short supply. Every attempt must be made to maintain usual practices and the expected standard of care and patient safety.

The Institutes of Medicine defines:

> Conventional capacity as the use of spaces, staff, and supplies that is consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.
>
> Contingency capacity as the use of spaces, staff and supplies that is **not** t=M m y ¡ atie ~ D sPmrae
>
> practices

of care should be terminated. The guiding principle of Crisis Standards of Care is to do the greatest good for the greatest number of persons.

Core ethical precepts in medicine permit some actions during crisis situations that would not be acceptable under ordinary circumstances, such as implementing resource allocation protocols that could preclude the use of certain resources on some patients when others would derive greater benefit from them. Healthcare professionals are obligated always to provide the best care they reasonably can to each patient in their care, including during crises. When resource scarcity reaches catastrophic levels, clinicians a

Duty of care is guided by the obligation of health care professionals to care for patients at all times. Any system must sustain the patient-provider relationship ensuring that patients are not abandoned. In an influenza pandemic with scarce resources, it is understood that all patients may not be eligible for all curative therapies, but all patients are eligible for palliative treatments and they should be provided.

During times of scarce of resources, the obligation of duty to care for all patients must be balanced by the duty of care for each individual patient. The estimated benefit of an

order to provide Louisiana's citizens with a basic understanding of how the plan works and how it is designed to be used. Additionally, the contractor conducted statewide public forums. These forums were designed to provide an opportunity for review and comment by the public and to ensure that the "at-risk" (vulnerable) population is included i

In addition to decreasing non-essential use of potentially scarce resources, facilities should make every effort to secure additional resources to limit the impact of a pandemic and ensure that surge capacity is maximized.

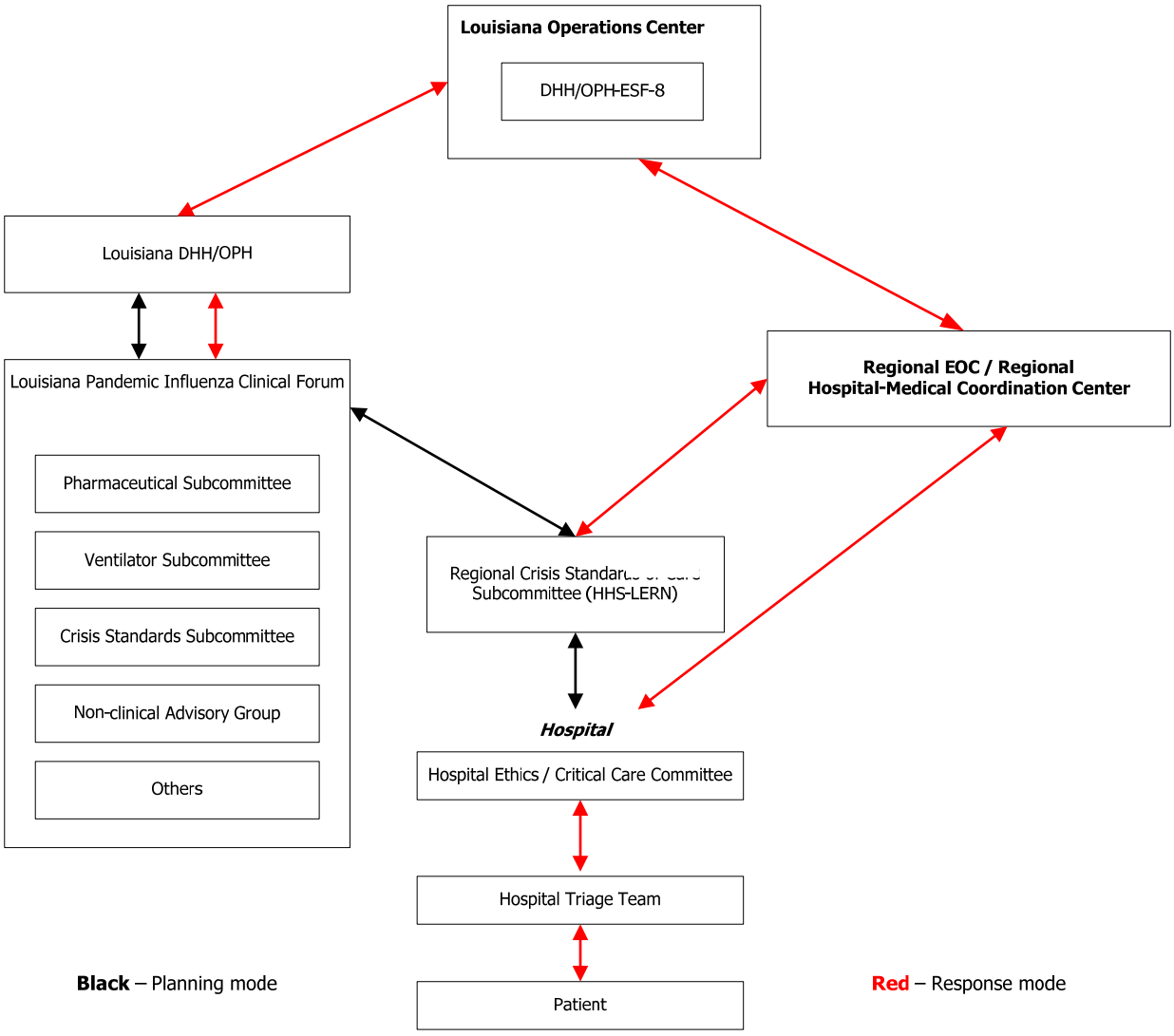
The decision to implement the Crisis Standards of Care guidelines should be based upon the degree of the pandemic (or other disaster) and hospital capacity, in conjunction with a governor ordered state of emergency. Specifically, Crisis Standards of Care may be initiated only after all of the following conditions have been met. It is imperative that all hospitals work together and utilize the ESF-8 Hospital DRC network to maximize all available resources.

1. Initiation of national disaster medical system and national mutual aid and resource Management
2. Surge capacity fully employed within healthcare facility
3. Attempts at conservation, reutilization, adaption, and substitution are performed maximally
4. Identification of critically limited resources (e.g., ventilators, antibiotics)
5. Identification of limited infrastructure (e.g., isolation, staff, electrical power)
6. Request for resources and infrastructure made to local and regional health officials
7. Current attempt at regional, state, and federal level for resource or infrastructure allocation
8. Institutional implementation team has requested initiation of CSOC
9. Declared state of emergency or incident of national significance

It is recognized that within individual regions and institutions, the criteria for implementation of these guidelines may occur at different times. As such, the decision to implement the guidelines will be made by individual institution's committees. The committee of each institution should consist of (at a minimum):

i. The Chief of Staff (or designee)
ii. The Chief Medical Officer (or designee)
iii. The Chief Nursing Officer (or designee)
iv. The Infection Control and Prevention Nurse (or designee)
v. The Emergency Department Director (or designee)

Upon decision for implementation of crisis standards of care, the Department for Health and Hospitals, and the other regional hospitals shall be notified by the implementing institution. The organizational structure for both the development and response in Crisis Standards of Care is illustrated below:



Open communication between healthcare facilities is key for an effective response during a pandemic. Ongoing communication between hospitals will be coordinated through the Hospitals' Designated Regional Coordinators system, part of the Louisiana Hospitals Emergency Response Network Plan.

Situational awareness will be ensured with frequent communication between each hospital regarding patienĎ ¦ e tweenÞ ʊ˳ ŋ pضـ tMĦawar regĆ ti nÞS B l ɹ mᵐ # amʏ ˳

Pre-hospital care is an essential part of the continuum of patient care. As the provider of pre-hospital emergency medical triage, treatment and transport, EMS plays an important role in every community's efforts to reduce morbidity and mortality from all sudden illness and injury. EMS personnel may be the first to have contact with the patients and to apply crisis standards of care.

In planning for an influenza pandemic, it must be also recognized that persons with medical conditions unrelated to influenza will continue to require emergency, acute and chronic care. In a mass casualty event or crisis situation such as a pandemic influenza event, the demand for EMS services will rise dramatically. It is important to keep the EMS system functioning as effectively as possible and to deliver optimal care. If a pandemic exceeds the healthcare capacity of a region or the state, it may be necessary to modify the provision of emergency medical care. EMS personnel, along with other healthcare entities will be forced to modify their care and move from a conventional level of care to a contingency level of care to a crisis level of care as resources become scarce.

To minimize the impact from the increased volume of calls to th

scarce resources during a disaster. The state of Maryland uses the Medical Priority Dispatch (MPD) protocol system for triage and has developed a "Dynamic System" of EMS triage (See Appendix B) that has been incorporated into the Pandemic Severity Index and is based on the pandemic severity score, EMS/dispatch system demand for services, reductions in EMS/dispatch workforce and hospital bed availability. This new triage/dispatch protocol drafted by the state of Maryland was then "cross-walked" into the Institute of Medicine's Levels of Care (conventional, contingency, and crisis; See Appendix C).

In Louisiana, the two most often computerized medical dispatch systems utilized by EMS service providers are the APCO and the Medical Priority Dispatch (MPD) systems. However, the majority of EMS Service agencies does not have a computerized system and rely on "card sets" of medical dispatch protocols. It has been suggested that those Louisiana EMS service providers that utilize a computerized medical dispatch protocol could 1) switch to a single state dispatch system such as MPD or 2) develop a similar EMS triage system using whatever dispatch system is currently being used. Any modifications to current dispatch protocols will need to include modifying the triage, treatment, equipment, transportation and destination protocols. Also, relationships with parish 911 systems will be a factor as 911 may pass calls to EMS providers and other first responders who dispatch first responders (EMS, Fire, Law Enforcement, etc.). Public safety answering points (PSAPs) and call centers may need to alter their dispatch protocols, sending fewer resources.

It is important to recognize that within certain regions of the state, the ability and expertise to care for certain types of patients will affect an EMS triage system. It will be necessary to not only assess a patient's need for hospital care but also to which medical facility best fits the patient and his/her condition. Institutional routing includes special services such as ECMO, maternity, pediatrics, and the mechanically ventilated. Defining hospitals which may selectively receive these patients pre-hospital will avoid utilization of scarce EMS resources and personnel in transport.

Infection control procedures will play an important role in minimizing the impact on critical healthcare resources. EMS service providers should develop plans for an increased surge in need for appropriate personal protective equipment. The Association for Professionals in Infection Control and Epidemiology, Inc.'s "Guide to Infection Prevention in Emergency Medical Services" provides information on infectious diseases emergency preparedness including pandemics and guidance on such topics as risk factor/risk assessment in EMS, Ambulance cleaning procedures, and education/training.

The transport protocol serves as a guide in the event of escalating call load and transport decisions during a pandemic event. The phases correlate to escalating levels of activity both locally and statewide. Although there are no hard numbers expressed, the combinations of the described conditions will act as points of departure for discussions leading to the decisions to enact the appropriate response.

Phase 1 – Conventional Level of Care

Operations continue as normal

Phase 2 – Contingency Level of Care

Conditions warranting response but not transport (self-help)

Abnormal spike in call load
Overwhelmed EDs with multiple requests for diversions of influenza patients
- Triage performed by crewmembers at scene
  Possible layered response by sprint vehicles
- Self-help instructions offered

Phase 3 – Crisis Level of Care

Conditions warranting no response to any calls except life-threatening (extreme) - use of telephone triage primarily

Abnormal consistent spike in call load
Overwhelmed EDs with multiple requests for diversions of patients due to lack of bed availability
AASI staffing shortage in extreme state due to influenza affecting staff
Telephone triage except in very limited situations
- Dispatch performs call center triage

PREPARATORY PENDING PANDEMIC WITH MINIMAL IMPACT

During this phase, preparations are being made for an impending pandemic event. The pandemic's effect on staffing and daily operations is negligible. The focus is on increased awareness and the education of staff. Assess the status of all necessary supplies to ensure ample resources supplies, especially PPE have been acquired and are being pre-positioned for easy access.

1. Focus: Prevention of Illness
   a. Increased communications re: PPE usage and exposure control (infection control, disinfection, etc.)
   b. Mandatory use of additional PPE (i.e. HEPA mask or CDC recommended PPE) for suspect patients
   c. Strict enforcement of unit and station cleanliness
   d. Pre-positioning and distribution of PPE
2. Pandemic impact on staffing levels: Negligible
3. Procedures for handling employees who call in sick
   a. Begin using the *Daily Report of influenza-related absences* worksheet
   b. Employees with influenza symptoms are asked to remain at home for duration of illness
4. Augmentation of Staff
   a. Management Level
      i. Negotiate use of National Guard and/or reserve military (drivers, supplies, etc.) in the event pandemic escalates

ii. Draft EMAC agreements

iii.

b. Expect ill employees to be contagious for up to seven days after onset of symptoms. DO NOT COMPEL EMPLOYEES WITH INFLUENZA SYMPTOMS TO WORK DURING THIS PERIOD to protect other employees from becoming infected.

c. If the employee worked within two days (either before or after) of the onset of symptoms, anticipate their partner (and other employees with whom they had close contact) may also soon become ill (virus incubation period is two days)

d. Employees who are asymptomatic for influenza should be compelled to report for duty if their illness is minor and/or will not affect alertness and safety

4. Augmentation of Staff

    a. Management Level

        i. Request use of National Guard and Reserve troops as driver

            1. Rapid Response Training (First Responder or CPR-First Aid)

            2. Allsafe orientation

        ii. Maintain ambulance staffing as possible

            1. Consider temporarily converting ALS to BLS

            2. Consider temporarily converting 12hr trucks to 24hr (last units converted or least used)

            3. Consider staffing changes from two paramedics to one paramedic plus one emergency medical technician (EMT)

        iii. Activate EMAC agreements

            1. Enact mechanisms for temporary licensure of medics

            2. Make logistical arrangements (lodging, food, etc.)

    b. Staff Level

        i. Cancel pending vacations for essential personnel

        ii. Activate PRN employees and all available support staff medics

        iii. Temporarily reposition and house medics from unaffected areas

5. Transportation

    a. Encourage patients with minor injury/illness to use their own transportation to a more appropriate setting than hospitals

    b. Consider batched transports

<u>WORST CASE PANDEMIC IN SERVICE AREA</u>

This may be different for each EMS service provider in each region of the state based on the local

service providers should be in c

vi. Consider requesting assistance from Medical Reserve Corps

vii. Hire temporary First Responder/non-certified drivers

1. Rapid Response training (First Responder or CPR-First Aid)
2. Allsafe orientation

b. Staff Level

i. Continue activation of PRN employees and all available support staff medics

ii. Temporarily reposition and house medics from unaffected areas

iii. Reintroduce medics previously deactivated due to illness who are now beyond risk of transmitting the virus

5. Transportation

a. Only severe cases (life-threatening) may be transported

b. May use batch transports as needed

A Crisis Standard of Care event poses unique challenges for all involved in a disaster, including healthcare providers and their families, patients receiving health care and their families, and the public and requires comprehensive planning for the mental health and social consequences of such an event. As part of the ESF-8 Health and Medical Section, the Office of Behavioral Health provides crisis counseling and behavioral health personnel, services and facilities essential to relieve victim trauma and behavioral problems caused or aggravated by a disaster or its aftermath.

A.

During an emergency/disaster and afterwards, OBH will coordinate personnel and self-help materials and resources to provide counseling, grief and loss support, and access to a published crisis call line for those communities impacted by the crisis event.

Clear, consistent, understandable information will be provided via updated fact sheets and/or brochures that can be provided to clients, volunteers and the general public. Messaging for healthcare providers, the general public, responders and stakeholders will be established with details of who, what, when, where fact sheets. Specific information regarding community offerings, ho

STATE-LEVEL IMPACT				
		Training	Psychological First Aid (PFA) Skills for Psychological Recovery (SPR) Grief and Loss	1. Web-based/On-Site 2. Just-in-Time
COMMUNITY LEVEL IMPACT	Healthcare Providers (HCP)	Messaging		

Cultural competence is about learning, understanding and respecting the values of vulnerable populations, minorities and ethnic groups in order to provide quality care for individuals, groups and

assessment of the patient and calculation of the MSOFA. A triage review officer may determine the appropriate level of care based upon the MSOFA and Figure 2.

Pediatric Triage Model (Table A 2; Figures 3, 4)

The subcommittee on Pediatric Crisis Standards of Care has been assigned the task of developing guidelines for providing care to the pediatric population in the face of a public health disaster. This could be related to weather, disease or bioterrorism. Basically, the goal is to design a system that would provide the greatest care to the most children in a time when hospitals have exceeded surge capacity and resources are scarce, particularly ICU beds and ventilator access.

There is no national consensus on allocation of scarce resources in the pediatric population and how care should be triaged. The dilemma is made more complex in the fact that the pediatric population brings a cohort of patients that are somewhat unique-mainly children with severe genetic diseases, terminal genetic diseases, terminal congenital heart diseases, cystic fibrosis, etc.

There are several other issues that must also be considered. One is that there are few scoring systems that have been validated in children that may accurately predict mortality over a broad age group such as pediatrics and that credit underlining disease states. PRISM III is validated but best at 24 hours. PIM-2 does account for underlying diseases and has a POC of .89 over all age groups and may be the best admission score to predict mortality but not designed or validated to be used over time. An additional advantage is that it does account for pre-existing diseases. However, it cannot be calculated easily or without a pre-set calculator.

PELOD may offer the best predictability of mortality over time since it measures degree of organ dysfunction and because of its ease of measurement, can overcome the problems in obtaining PIM-2. However, it is not meant to be a static measurement for use to predict outcomes on admission so it is not perfect.

In order to address these concerns, the committee recommends the following:

1. All comers should be admitted and triaged based on PELOD.
2. A PELOD score should be obtained at < 24 and 48 hours (called PELOD-24 and PELOD-48). Based on these scores, the patient will be assigned level of care (Figure 1, 2, and 3).
3. The survival expectation rule will be used to help delineate those patients with terminal genetic and congenital disease.
4. Each hospital will enact surge capacity protocols and put all pediatricians, family practice physicians and family nurse practitioners on alert and activate their services.
5. Adopt child custody protocols within each institution to care for separated or abandoned children.

Decisions regarding a change in the level of care may be appealed by the primary physician or designee to a Central Triage Team which should consist of:

1. The Chief of Staff (or designee)
2. The Chief Medical Officer (or designee)
3. The Director of Nursing (or designee)

The Central Triage Team may decide upon the appropriate level o

needs. The care of these patients will require a substantial commitment to proper medical care and a more coordinated response across multiple disciplines.

Palliative care patients typically have extreme pain and symptom management needs. It will be crucial to have appropriate medication and resources to care for these patients. Palliative pain control and sedation guidelines need to take into consideration patient conditions that include dehydration and impaired nutrition due to lack of intake and air conditioning that may occur during a healthcare emergency. All palliative care patients should be cared for using established guidelines with symptoms assessed and treated with a frequency commensurate with their level of suffering (see Appendix E, F, and G).

Louisiana is becoming increasingly multicultural. Patients triaged to receive palliative care need to have their culture, religion and unique values respected by those involved in their care. This includes awareness of beliefs, practices, communication preferences, and wishes for care especially at time of death. Resources should be available to serve as a guide for those providing care. In anticipation of the need to provide palliative care, facilities should develop plans for transferring patients requiring palliative care to a community based setting. Experts already working with seriously, chronically ill patients should assist with this planning.

Based on the above information from the Joint Commission it is suggested that the Operations Chief appoint a Palliative Care Unit Leader with appropriate skills to manage the community based setting.

The hospital and/or Palliative Care Unit Leader are responsible for:

Designating an area for the community based Palliative Care

Staffing: Physician; Allied Health Professionals, Nursing; Social Worker; Case Manager; Respiratory Therapist; Ancillary Support; Clergy; and Volunteers

Daily review and assessment for change in patient's condition and level of care

When scarce resources are no longer present, termination of Crisis Standards of Care should occur and the Governor's office, the Secretary of the Department for Health and Hospitals, and the other regional hospitals should be notified by the institution.

Should a severe pandemic occur, all areas and levels of healthcare would be affected. It is essential that healthcare entities including but not limited to primary care/rural health, nursing homes, hospices and home health agencies also develop guidelines for managing their patients during a crisis standard of care event.

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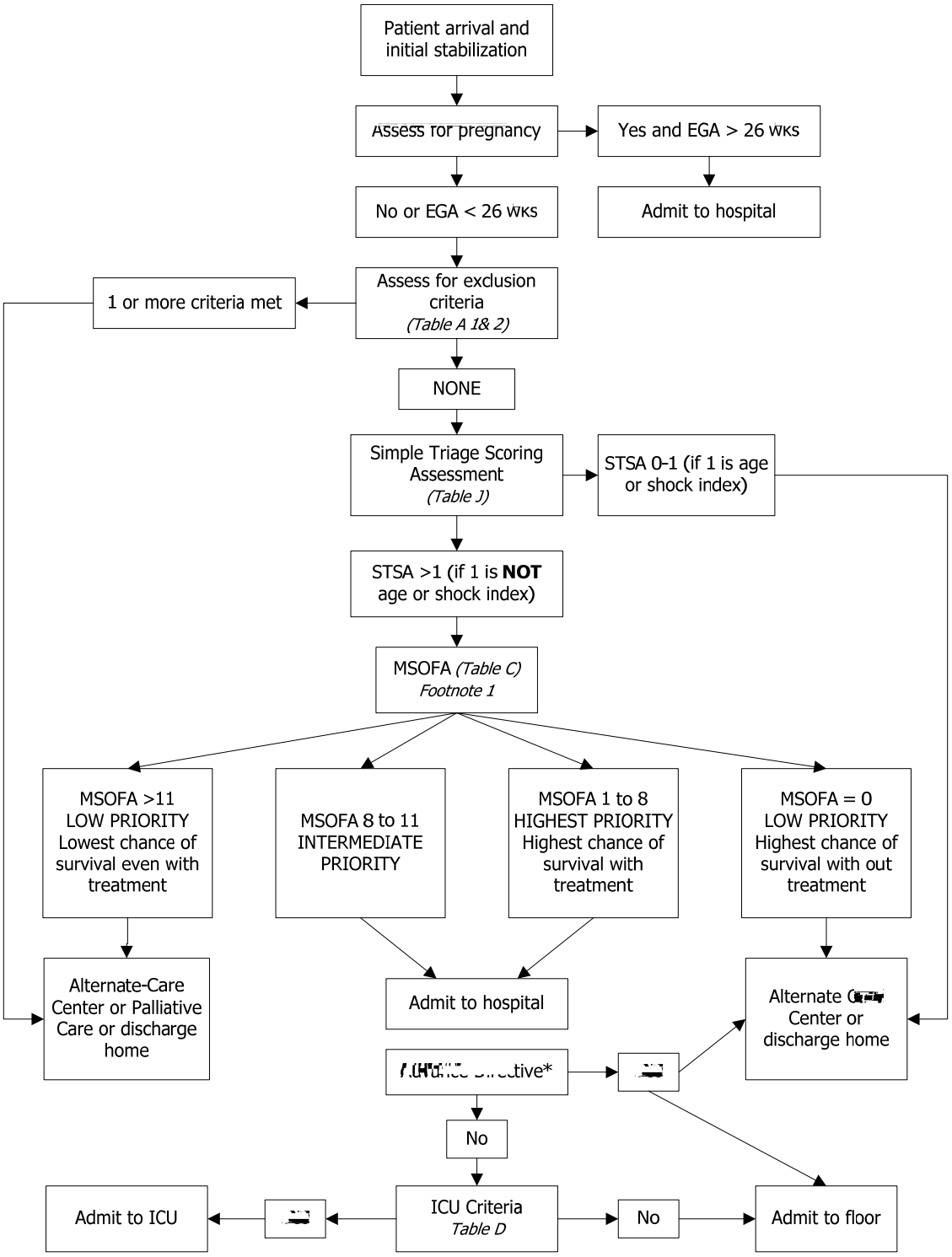
3. Aharonson-Daniel L, Waisman, Y, Dannon YL, et al. Epidemiology of terror-related versus non-terror-related traumatic injury in children. Pediatrics. 2003;112:e280-e284.

4. Centers for Disease Control and Prevention. Predicting Casualty Severity and Hospital Capacity. 2003.

5. Peleg K, Aharonson-Daniel L, Stein M, et al. Gunshot and explosion injuries: characteristics, outcome, and implications for care of terror-related injuries in Israel. Ann Surg. 2004;239:311-318.

6. US Census Burea. Age and Sex, Table 801. [illegible]


Patient arrival and initial stabilization
Assess for pregnancy
Yes and EGA > 26 wks
No or EGA < 26 wks
Admit to hospital
Assess for exclusion criteria
(Table A 1& 2)
1 or more criteria met
NONE
Simple Triage Scoring Assessment
(Table J)
STSA 0-1 (if 1 is age or shock index)
STSA >1 (if 1 is NOT age or shock index)
MSOFA (Table C)
Footnote 1
MSOFA >11
LOW PRIORITY
Lowest chance of survival even with treatment
MSOFA 8 to 11
INTERMEDIATE PRIORITY
MSOFA 1 to 8
HIGHEST PRIORITY
Highest chance of survival with treatment
MSOFA = 0
LOW PRIORITY
Highest chance of survival with out treatment
Alternate-Care Center or Palliative Care or discharge home
Admit to hospital
Alternate Care Center or discharge home
No
Admit to ICU
ICU Criteria
Table D
No
Admit to floor

Footnote 1:

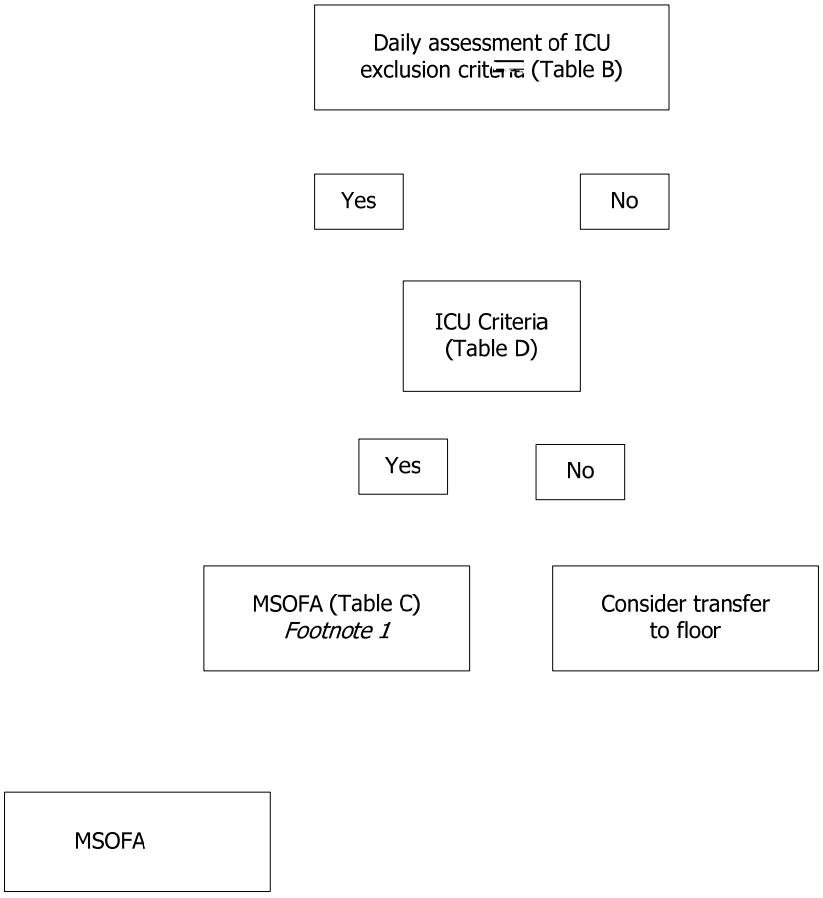
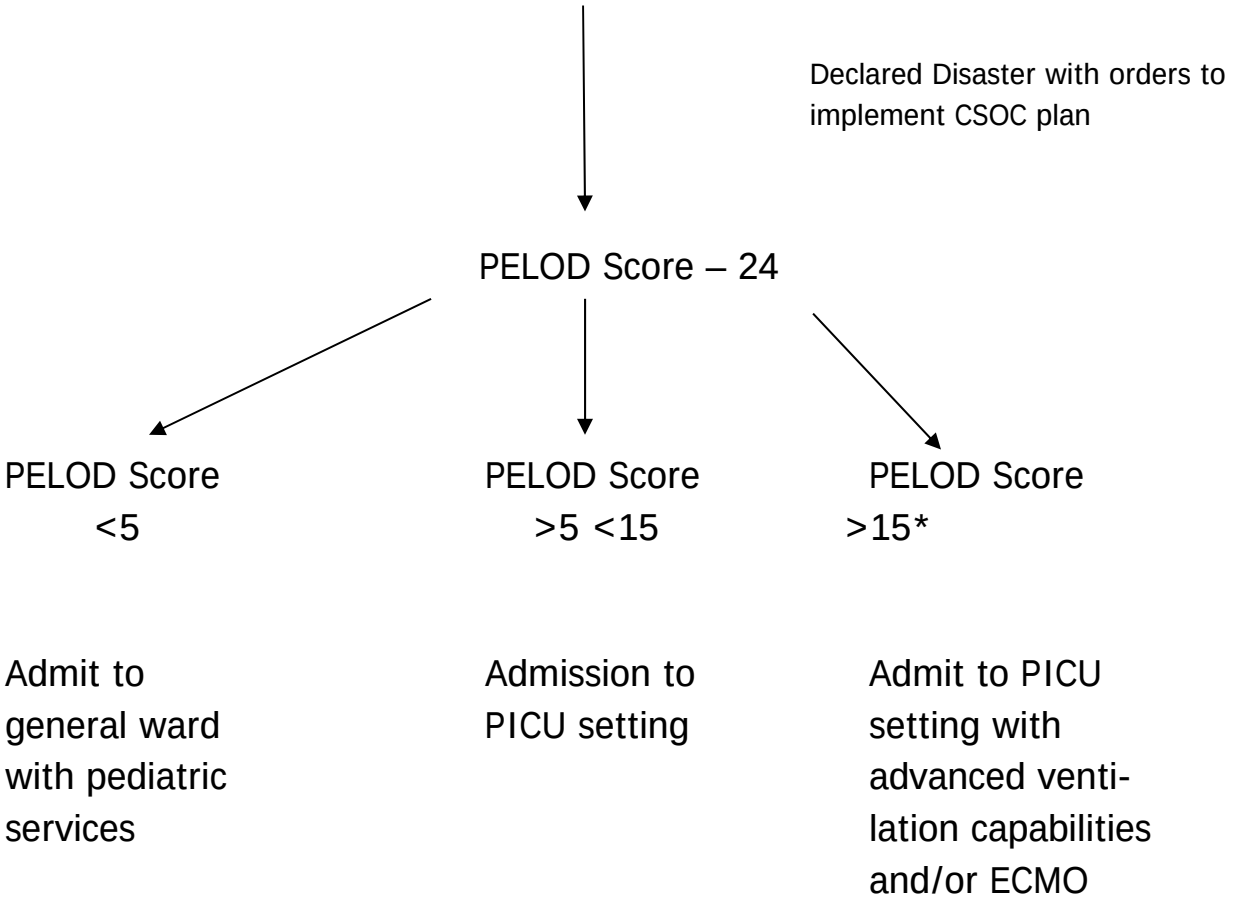

Daily assessment of ICU exclusion criteria (Table B)
Yes
No
ICU Criteria (Table D)
Yes
No
MSOFA (Table C) Footnote 1
Consider transfer to floor
MSOFA

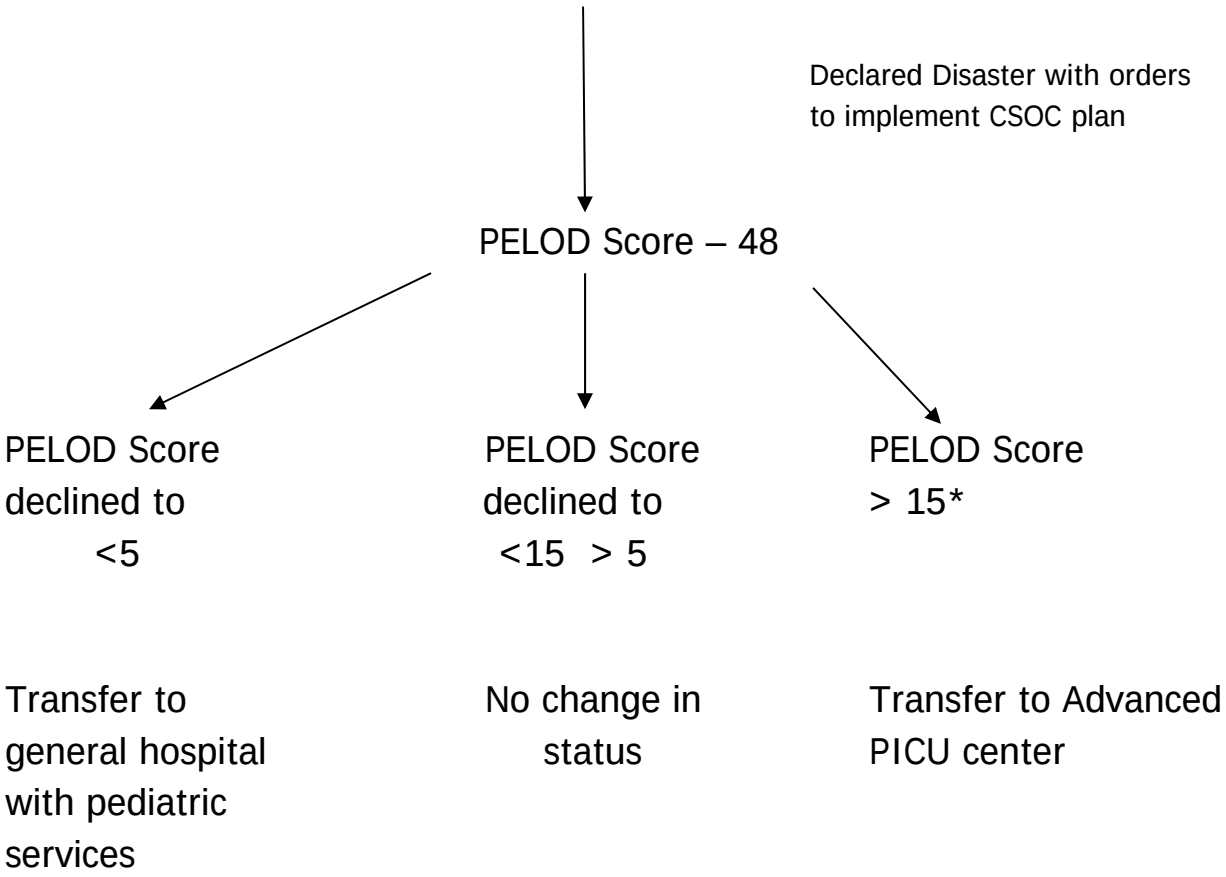
Table A 1: Exclusion Criteria For Pre-Hospital Admission Triage

Any unknown value is assumed to NOT be present at time of triage.

1. *Severe Trauma with a Revised Trauma Score of < 2 (Table E)*
2. *Severe and irreversible neurologic event or condition with persistent (>72 hours) coma and GCS < 6 (Table F)*
3.



*Positive expectation rule



*Positive expectation rule

Table A 2: Pediatric Criteria

	Scoring system			
	0	1	10	20

Table D: ICU Criteria

Patients must have NO exclusion criteria (Table A) AND at least one of the following criteria:

1. Requirement for invasive ventilator support as evidenced by:
    a. Refractory hypoxemia (SpO2 < 90% on non-rebreather mask or FiO2 > 0.85), or
    b. Severe acidosis (pH < 7.2), or
    c. Clinical evidence of impending respiratory failure
    d. Inability to maintain airway
2. Hypotension with clinical evidence of shock refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in the ward setting.
    a. Hypotension is defined by a SBP < 90 or MAP < 60.
    b. Clinical evidence of shock shall consist of an altered level of consciousness, decreased urine output or other evidence of end-organ failure

Table F: Glasgow Coma Score

GLASGOW COMA SCORING CRITERIA			
Criteria	**Adults and Children**	**Score**	**Criteria Score**
Best Eye Response 4 possible points	No eye opening	1	
	Eye opens to pain	2	
	Eye opens to verbal command	3	
	Eyes open spontaneously	4	
Best Verbal Response 5 possible points	No verbal response	1	
	Incomprehensible sounds	2	
	Inappropriate words	3	
	Confused	4	
	Oriented	5	
Best Motor Response 6 possible points	No motor response	1	
	Extension to pain	2	
	Flexion to pain	3	
	Withdraws from pain	4	
	Localizes to pain	5	
	Obeys commands	6œ	ey d ‘

Table G: Triage Decision for Burn Victims

Age (yrs)	Burn Size (%TBSA)		
	0-10%	11-20%	

Table H: New York Heart Association Stages (NYSA) of Heart Failure	
NYSA	Classes
Class	Patient Symptoms
Class I Mild	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations or dyspnea.
Class II Mild	Slight limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations or dyspnea.
Class III Moderate	Marked limitation of physical activity. Comfortable at rest, but les than ordinary activity causes fatigue, palpitations or dyspnea.
Class IV Severe	Unable to carry out physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

Table I: Pugh Score

Scoring	**Criteria**		
Criteria	**Value**	**Points**	**Total for Criteria**
Total serum	<2	1	
Bilirubin mg/dL	2-3	2	
	>3	3	
Serum Albumin g/dL	>3.5	1	
	2.8-3.5	2	
	<2.8	3	
INR	<1.70	1	
	1.71-2.20	2	
	>2.20	3	
Ascites	None	1	
	Controlled medically	2	
	Poorly controlled	3	
Encephalopathy	None	1	
	Controlled medically	2	
	Poorly controlled	3	
		Total Pugh Score	
Score Interpretation			
Total Pugh Score			
5-6	A	Life expectancy 15-20 years	
7-9	B	Liver transplant evaluation indicated	
10 to 15	C	Life expectancy 1-3 years	

Table J: Simple Triage Scoring (STSA)	
Age ≥ 65	
Respiratory Rate > 30	
Shock Index > 1 (HR > SBP)	
Low oxygen saturation*	
Altered mental status	

MEMORANDUM OF UNDERSTANDING
BETWEEN
LA 2-1-1 (LA 2-1-1)
And
_____ Parish Communications District (9-1-1)

Purpose:
This memorandum describes and documents the working relationship between Louisiana 2-1-1 (LA 2-1-1) and _____ Parish Communications District (9-1-1) in order to enhance delivery of Information & Referral and Crisis Intervention services to _____ Parish reducing the number of non-emergency calls to 9-1-1 in a Pandemic Influenza or Mass Fatality Event.

Each party to this memorandum is a separate and independent organization and nothing herein shall be constructed to create a joint venture or legal partnership. Each organization shall retain its own identity in providing services.

Each party agrees to the following components:

Component I: Operational Referral Agreements

1. 9-1-1 may direct callers requesting non-emergency related infor

2. Services provided to a client should, in no way, be affected by their choice to maintain anonymity. However, certain demographic and other information is requested and recorded for purposes of maintaining confidential client records and aggregaq qu m ה Ḡض Ser pq

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Appendix B: EMSDynamic System

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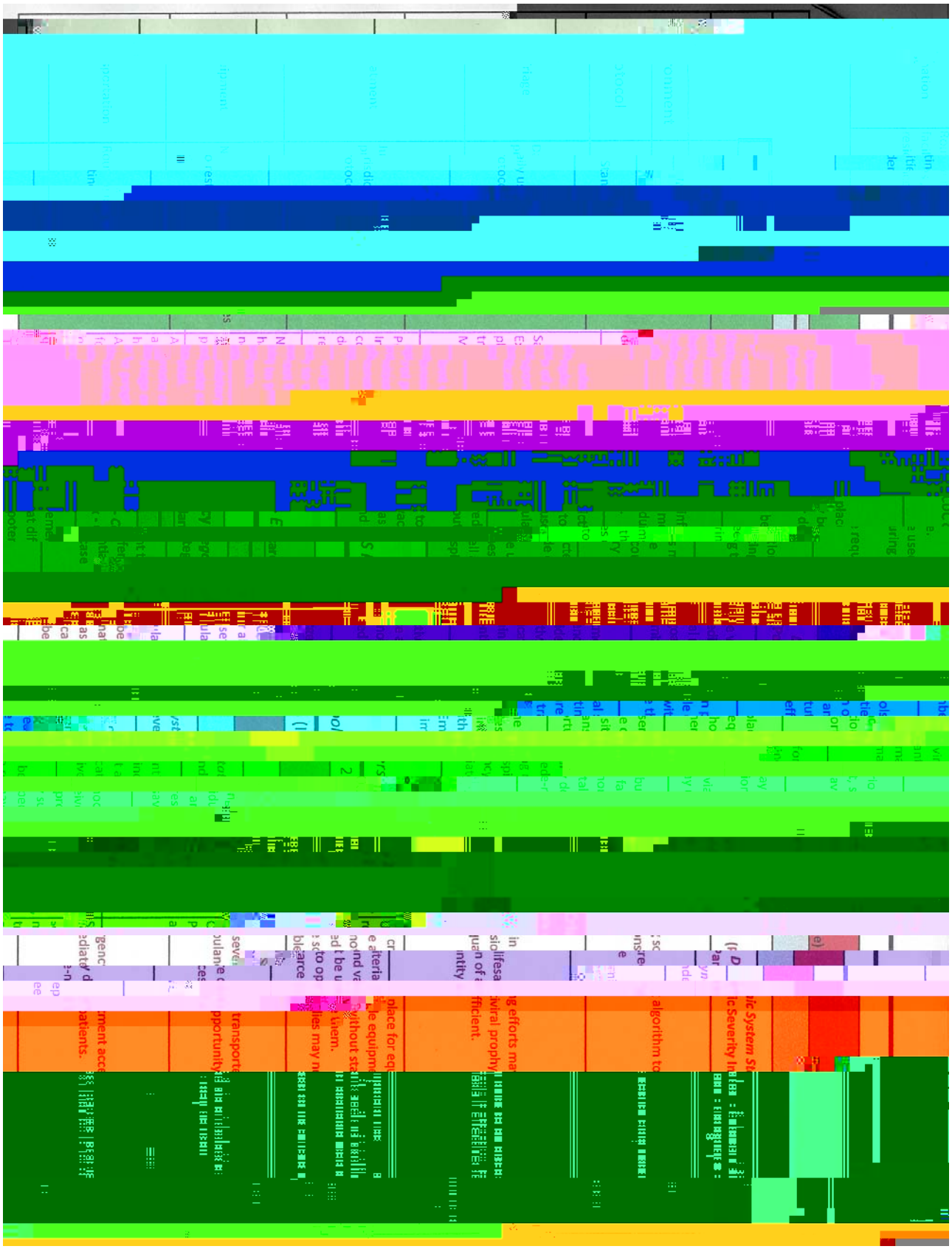
Dispatch Priority Level (match vendor or call center based dispatch protocol/tiered algorithm)	**Response** (Standard Operating Mode)	**Level 1 (A)** Activation of Card 36 and ONLY for use in 6, 10, 18, and 26 DSSI BELOW IS BACK UP STRATEGY FOR EMD WITHOUT CARD 36	**Level 2(B)** Implement Declining Response / Configuration CAD Table (Moderate) + Card 36 (6,10,18 & 26) DSS2	**Level 3 (C)** Implement Declining Response / Configuration CAD Table (Severe) + Card 36 (6,10,18 & 26) DSS3
Classification 1 (*Echo) Confirmed Cardiac Arrest (Not Breathing, Unresponsive per 911 Call) (MPD cards- 2, 6, 9, 11, 15, 31)	Closest AED Unit and Closest 1st Responder andClosest ALS Ambulance	Closest AED Unit and Closest 1st Responder andClosest BLS Ambulance if available	Closest AED Unit and Closest 1st Responder if available	Closest AED Unit if available. If not unit available, no response
Classification 2 (*Delta) Life Threatening Emergency / Potentially Life Threatening / Confirmed Unstable Patient(s)	Closest 1st Responder and Closest ALS Ambulance	Closest 1st Responder and Closest ALS Ambulance if available; BLS ambulance if ALS unit not available	Closest 1st Responder and Closest Ambulance available (ALS or BLS)	Closest 1st Responder and if availableClosest Ambulance available (ALS or BLS)
Classification 3 (*Charlie) Non-Critical / Currently Stable Patient(s) Requiring ALS Assessment	Closest ALS Ambulance	Closest Ambulance available (ALS or BLS)	Closest Ambulance available (ALS or BLS)	Closest 1st Responder if available Or Closest stand-in responder unit
Classification 4 (*Bravo) BLS Assessment for unknown / possibly dangerous scenes	Closest 1st Responder and Closest BLS Ambulance	Closest 1st Responder and Closest BLS Ambulance if available	Closest 1st Responder	Trauma - Closest 1st Responder Medical – referral to Nurse or Health Department Advice Telephone service if available or self-transport advice to Alternate Care Site
Classification 5 (*Alpha) BLS treatment	BLS Ambulance	Alternate Care Referral	Alternate Care Referral	Alternate Care Referral
Classification 6 (*Omega) Non Ambulance Care	Alternate care such as Poison Control Center; Police/Fire service call; etc.	Alternate care such as Poison Control Center; Police/Fire service call; etc.	Alternate care such as Poison Control Center; Police/Fire service call; etc.	Alternate care such as Poison Control Center; Police/Fire service call; etc.



Vulnerable Populations

Children & Adolescents

Toddler/pre-K **Response to Disasters**

- Separation anxiety
- Avoidance
- Regression
- Fear of the dark
- Sleep problems
- Fearfulness
- Clinging
- Temper tantrums

School age

- Sleep problems
- Concerned with safety
- Preoccupied with disaster
- Physical complaints
- Depression
- Excessive guilt
- Poor concentration
- Angry outbursts
- Withdrawal from friends
- Aggressive behavior at home/school
- Re-telling the story related to trauma

Adolescents

- Sleep problems
- Physical complaints
- Depression
- Guilt
- Aggressive behavior
- Increased risk-taking behavior
- Social withdrawal, isolation
- Apathy
- Rebellious home/school

Interventions

- Talk calmly and openly at their level
- Ask them what they think about their fears
- Share your own fears and reassure the child/adolescent
- Try to keep a normal routine

Identify individuals at risk and make appropriate referrals
Educate person about normal responses to disasters
Limit the number of persons with whom the victim most interact for services
Distinguish between normal reactions and actual pathological reactions
Provide cognitive behavioral therapy, if appropriate
Knowledgeable about crisis interventions (ie. active listening, paraphrase and reflect feeling, allow the person to express feelings/emotions)

Limited English Proficiency

Response to Disaster

May have lack of trust of public officials/health care professionals
The LEP may have literacy issues, requiring longer timeframe to explain instructions and to provide services
They may not receiving messages in an understandable or timely manner

Interventions

Strengthen LEP resources within the organization
Ensure essential documents are translated into key languages (consent, intake forms, patient right)
Plan on how to notify LEP client on updates in an emergent situation
Determine client's preferred language
Availability of interpreters, including sign language
Conduct self-assessment of organization's capacity related to cultural competence
Recruit and train community members of the same racial/ethnic background as the community you serve in a disaster response
Provide social support
Avoid stereotypes and generalizations
Health care providers should be genuine when caring for this population
Health care providers need to identify own biases, beliefs of culture
Bilingual and bicultural staff

Persons with Disabilities

Response to Disaster

Visually impaired – may be reluctant to leave familiar surroundings when evacuation request comes from a stranger
Hearing impaired – may need special arrangements to receive warnings
Developmental or intellectual disabilities – may need help responding to emergencies and getting to a shelter
People with physical disabilities – may need special equipment, transportation, and shelter access, oxygen canister refill, dialysis supplies

Interventions

Use person first language
A person with disability, not “disabled person”
Focus on individual, not disability
Do not refer to disability unless relevant
Avoid labeling people that stereotype
Emphasize each person’s value, dignity, individuality and capabilities
Contact social service agencies and support groups
Utilization of interpreters (sign language)
These individuals need access for needed equipment and supplies (i.e. TTT/TDD, oxygen canisters, dialysis supplies)
Assessment of psychological needs -depression and suicidal ideation may be prevalent

Medically Needy/Terminally Ill

Response to Disaster

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Harkey, J. (n.d.). New Jersey Preparedness Consortium (NJ-PTC). *Cultural Impact on Disaster Relief* (power point).

6. Vital signs	Every 24 hours and Nursing judgment based on the patient's condition
7. Nutrition	Nursing assessment completed for patients who have feeding problems such as swallowing difficulties, potential for aspiration of food or drink Encourage family members, volunteers or other hospital staff to feed patients that are unable to feed themselves For tube feedings, provide as ordered by the physician Prescription diets may not be available and Food Service should develop alternative menus Artificial nutrition and hydration are ethical decisions and should be subject to the protocols for the allocation of scarce resources
8. Medication/Fluid Administration	Medications – administered as ordered by a physician IV site care – follow according to hospital policy <u>Medication reconciliation</u> o Done in collaboration with a physician o May be limited to verification that the medications are being dispensed to the right patient and at the right dose <u>Home medications</u> o To the extent possible and based on the nature of the incident, patients may be encouraged to bring their own medications o Collaborate with physician regarding home medications o Collaborate with patient taking their home medications and properly document the administration of home medications on the MAR o Ensure that home medication is properly labeled and identified
9. Elimination	Patients who need assistance – provide bedpan Incontinent patients – change prn Patients with an ostomy – change prn I & O – completed as ordered
10. Treatments	Dressings – change only when soiled Weighing patients – based on nursing assessment NG irrigation, glucometer checks – implement as ordered
11. Patient Safety	Fall prevention – maintain at all times Restraint protocols o <u>Medical (Non-behavioral) Restraints</u> RN monitors physical and emotional well-being of patient at least every 2 hrs, including behavior,

checking pulses and/or vital signs, ensuring that restraint device is safely intact and documents assessment

Recognize clinically relevant observations to report and/or document

RN or designee **must provide comfort care at least every two hrs**, including turning patient to a different position; range of motion to extremities; skin care to pressure pts; offering food and fluid; and toileting

Maintain the patient's rights, dignity, and safety

Recognize changes in the pt.'s behavior or clinical condition needed to initiate the removal of restraints

15. Diagnostic testing	For life saving measures as ordered by a physician
16. Discharge of patients	Establish standardized discharge orders RNs should be permitted to initiate patient transfers to a lower level of care following pre-identified criteria
17. Staffing	Assess current numbers of health care workers and skill levels Hospital should consider alternative staffing models with the trigger being the number of patients being cared for plus the number of staff available and length of time that the incident is expected to occur; o Using nurses from other in-house services (i.e.. human resources, employee health, administration, home health) o Using professions that have nursing skills such as paramedics o Using other hospital staff to perform ADL patient care support functions o Hospital, prior to an incident, prioritizes hospital service and functions that can be closed or down-sized so that staff from these areas can be used for pt. care support functions o Hospital should consider, prior to the incident, its policies for limiting vacation and other time-off benefits Job action sheets should be developed so staff have available their responsibilities for particular tasks Identify multiple shifts 2, 4, 6, 6, or 12 hours Ensure that there is an "active" team of employees to work the incident, and a "relief" team of employees that is stationed nearby to come in and relieve employees Support staff through critical incident debriefing, grief counseling, child care, and other types of support that the hospital deem necessary
18. Bed Assignment	Cohort patient populations as much as possible

7. Medication Administration	Medications - administered by a physician (See Appendix G-H) Medication reconciliation o Limited to verification that the medications are being dispensed to the right patient and at the right dose Home medications o Patients need to bring their home medications o Collaborate with physician regarding home medications o Collaborate with patient taking their home medications o Ensure that home medication is properly labeled
8. Elimination	Patients who need assistance - provide bedpan Incontinent patients - change prn Patients with ostomy - change prn
9. Treatments	Dressings - change only when soiled
10. Patient Safety	Fall prevention - maintain at all times
11. Indirect Care	Provided by volunteers and family as needed
12. Documentation	Patient care documentation - document at least every day and as needed when any type of care, treatment or assessment is provided
13. High-risk populations	Hontimi tio" * # potienm m M

Polyethylene glycol (Miralax)	Constipation	Oral: 17g in 8 ounces of water or juice daily prn		
Prochlorperazine (Compazine)	Nausea, Vomiting/ Antiemetic	Oral: 5mg, every 6 hours prn Rectal: 25mg, every 12 hours prn		
Tears Naturale	Dry eyes / Ocular lubricant ophthalmic solution	2 drops, both eyes every hour prn		
senna	Constipation	Oral: 2 tablets, at bedtime prn		

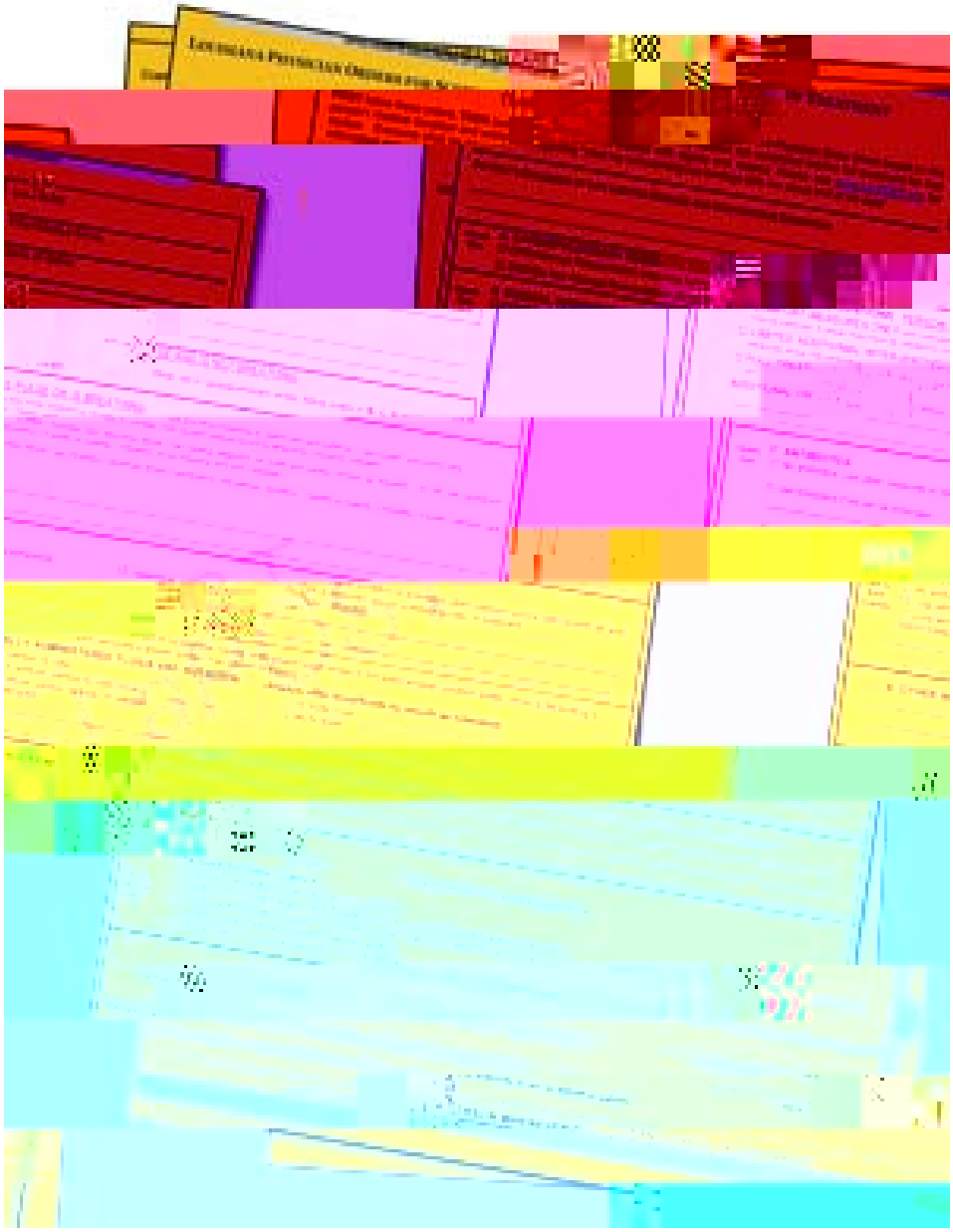
Generic Name (Brand Name)	Indication / Drug Class	Typical Starting Dose	Formulation Considerations

	Dysphagia, Pain / Anticholinergic		Oral solution (drops): 0.125 mg/ml Chewable tablets: 0.125 mg	
Ibuprofen (Advil/Motrin)	Fever, Pain, NSAID	Oral: 4-10 mg/kg every 6-8 hours	Oral suspension: 100mg/5ml Concentrated oral drops: 40mg/ml Chewable tablets: 100 mg	
Midazolam (Versed)	Agitation*, Acute Seizure**, Delirium Bensodiazepine	Oral/Buccal: 0.2-0.5 mg/kg Intranasal/Rectal: 0.2 mg/kg NOT TO EXCEED 10 mg/dose for all routes	Oral syrup 2 mg/ml	Intranasal administration: use 5 mg/ml preservative free injectable solution via needleless syringe or atomizer device - 1/2 dose in each nostril *Use intranasal as first line for agitation **Use for seizure only if not responsive to valium
morphine	Pain, dyspnea / Opioid	Oral : 0.1 mg/kg every 3-4 hours	Oral solution: 10 mg/5ml Concentrated oral solution: 20 mg/ml	
Ondansetron (Zofran)	Nausea, Vomiting / Antiemetic	Oral: 0.1-0.15 mg/kg every 6-8 hours	Oral solution: 4 mg/5ml Orally disintegrat-ing tablets: 4 mg	Orally disintegrat-ing tablets: 1-3 yrs: 2 mg 4-11 yrs: 4 mg > 12 yrs: 8 mg
Polyethylene glycol (Miralax)	Constipation / Osmotic laxative	Oral: 0.5-1.5 g/kg daily NOT TO EXCEED 17 g/day		Initial dose: 0.5 g/kg; titrate to effect
Prednisone (Deltasone)	Anorexia, Bone Pain, Respiratory Inflammation, Pruritus, Excessive	Oral: 0.5-2 mg/kg every 6 hours	Oral solution: 1 mg/ml	

	Sedation / Corticosteriod	NOT TO EXCEED 80 mg/day	Concentrated oral solution: 5 mg/ml Tablet: 10 mg	

Notes:

These doses are NOT intended for use in the neonatal population.
Do Not Exceed usual maximum adult starting doses.



To access and download the LaPOST form, click the following link Louisiana Physician Orders for Scope of Treatment Form.