# *A Manual for Managing Pediatric Victims and Their Families at the Hospital During a Mass Casualty (Including Hazmat) Event*


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## Section 1

### *The Purpose of this Manual*

**A review of the literature, pertinent web sites and interviews with planners reveals that there has been little discussion and virtually no protocols established for the *management* of pediatric victims *during* a mass casualty event. This manual grew out of an examination of the professional literature and protocols fire departments and hospitals currently have in place for responding to Pediatric Mass Casualties.**

In part because we have had so little experience with Mass Casualty involving Pediatric Victims, there are some holes in our pediatric response plans, in particular with regard to a hazardous materials event. A few examples are:

- **there are no standard protocols to process grammar school children through a decontamination shower line in the field,**
- **there are no specific instructions for getting infants decontaminated,**
- **children's greater vulnerability to hypothermia and to the effect of toxins requires that the smallest be decontaminated first and with great efficiency,**
- **there are no protocols or methods for communicating with and managing family in the field or at the hospital.**

These, along with other practical considerations are addressed in this manual, which is written to be an easily accessible guide for the hospital.



**Peter Sternberg, L.C.S.W. 7/05/11.**

 

## Section 2

## *The Management of Pediatric Mass Casualty Victims at the Hospital*

**Helping a frightened child who is separated from his parent**

It is vital that the child patient immediately experience an adult who is:

- is in charge,
- is informed,
- is reassuring,
- is caring,
- is able to explain why the patient is having this experience,
- is able to explain the process they will be experiencing and
- is able to explain when their world will be upright again.

**Communicating with a child or adult who requires decontamination**

- All HAZMAT suited personnel are on a wireless mic/headset which allows them to:
    1. be heard by and hear patients and,
    2. allows them to hear and be heard by the rest of the decon team.
- Weatherproof, glow-in-the-dark, multilingual signage is set up in and around the decontamination holding area that informs through words and pictures what the victim is about to experience and why.
- A staff member, who is a safe distance from the holding area, communicates with the victims in the holding area. This communication can be accomplished using a speaker system or bull horn.
- A HAZMAT suited, mic/speaker equipped staff member moves among the victims offering reassurance, information and comfort. This helps to minimize hysteria (individual and group) and helps gain the victim's cooperation.
- If live-person communication with the victim group is not possible, use continuous loop audio at strategic places in the movement of the victim through decontamination processing to inform the victim of what will be required of them and why.
- If a buddy system for grammar school age children has been utilized the field, maintain those pairings through hospital decontamination.
- Begin decontaminating infants while they are in the arms of the parent or caregiver. A decon team member should then sit on a stool a take the baby, holding the child in a nearly vertical position with the head supported during showering.

Hospital and EMS emergency planners may want to consider the benefits of HAZMAT-geared personnel having a "kid-friendly" emblem or picture affixed to their gear which signals to the child that they are "approachable". An example of this might be a picture of a popular child's movie or book character.

 

# Section 3

## *The Management of Pediatric Victim Family Members at the Hospital*

### What parents need

There are two distinct experiences parents may have with a mass casualty situation. They may be with their child, know what happened and have some sense of the child's condition. Or they may be separated from their child and uniformed about: the location of their child, the nature of the event and their child's condition.

#### When parents are with their children

Acute emotional first aid ***for parents*** might involve:

a) ongoing, current information about their child's condition
b) *attunement* from staff to better cope with the trauma *the parent* is experiencing
c) support, reassurance and opportunities to appropriately vent feelings. Remember, the affective state of the parent has **everything** to do with the emotional experience the child is currently having and has much to do with how the trauma registers in the child's psyche (read: vulnerability to PTSD), in the hours, days, weeks and months following the trauma.
d) education about the child's medical situation and ongoing treatment needs
e) information and education about the emotional sequelae from trauma for their child and themselves (handouts should be available)
f) guidance and direction about what steps will be needed after discharge for medical and psychological concerns (handouts should be available)
g) help in addressing any spiritual issues they may currently be experiencing or may experience in the immediate aftermath (know how to access a chaplain through HEICS – Human Services Division)
h) physical support: nutrition, a blanket, etc.
i) parents will need guidance on heightening awareness about how the child is processing the experience to increase empathy, acceptance and support.
j) parents will need to be taught the indicators that the child may be struggling in the aftermath of the disaster and is in need of help
k) parents will need direction to alert other adults in the child's life (pediatrician, relatives, school personnel, clergy, etc) that they may see reactions from the child indicating difficulties with the integration process (handouts to parents should be available)
l) parents will need guidance about responding to the child's spiritual questions, needs and concerns following the traumatic event (handouts should be available)
m) help the parents contact people in their personal support network before they leave the hospital
n) help plan for other family members who require care e.g., other children who are at home.
o) parents need to be protected from the media.

All of the above is made more complex in situations where one parent is out of town or the parents are divorced or there are multiple children from one family involved in an incident (this is particularly so if the children are at different facilities).

## When Parents Are Not Present

Parents may or may not know:

- the child's location
- what happened to their child
- the child's condition
- how to get important information *about* their child *to* the treating hospital.

It may be a sitter or nanny who is in the situation with the child and there may be lag time before the parent is informed. Acute emotional first aid is vital *for the parent* in that, after hearing that their child is involved in a mass casualty event ***and*** being separated from their child, the parents are likely to immediately be at some level of crisis. When staff encounter parents on the phone, at the trauma scene or at the hospital they should anticipate the parent would demonstrate some or all of the following (listed in increasing order of intensity):

- *adrenalized* state, which does not support rational thinking
- *highly emotional*: crying, loud and pressured speech or difficulty speaking, still redirectable, showing some signs of shock
- *frantic*: running, wild eyed, rapid and pressured speech, demanding, difficult to redirect, in psychological shock
- *hysterical*: crying/sobbing, yelling or screaming, demanding, incoherent speech, very difficult to redirect, possibly belligerent, in a state of psychological shock

Staff must be ready to intervene with parents who are in a state of crisis and shock. Those staff will need the following:

a) a room designated for families in crisis where staff can meet in relative privacy with the family they are helping
b) access to the latest information about location of victims (keep in mind that staff may be working with a family whose loved one is at another facility)
c) a supply of tissues, pillows (for comfort, screaming into and hitting)
d) procedure/additional staff, in the event a family member becomes a patient in need of psychiatric or other triage.

The emphasis of the intervention revolves around conveying to the parent:

1) staff know where their child is or are taking these steps to find the child
2) telling the parent about the child's condition ASAP
3) escorting the parent to the child if that is feasible
4) if the child is at another facility, helping the parent determine how they will safely get there and where to go once they arrive at that facility
5) if the parent can not see the child immediately, telling the parent about the process the child is likely to be experiencing, e.g., decontamination
6) telling the parents when they will likely be able to see their children
7) giving the parents information timely updates
8) encouraging the parents to express their emotional reactions while the crisis worker maintains a stance of calm, strength and acceptance
9) offering the services of a chaplain
10) helping the parents link with people in their personal support network
11) help plan for other family members who require care e.g., other children who are at home.

 

**A Reminder:** The scenes just described contain raw and powerful emotion. Witnessing this emotion or giving care to someone going through these emotions can be very taxing for staff. **We should anticipate that staff will be affected by these experiences and will need a chance to debrief and reconstitute**. This is exactly the situation where the Staff Support Section of HICS must be prepared, present and active to minimize trauma to staff and keep staff functioning.

## Section 4

### *Acute Crisis Intervention – Emotional First Aid in the Midst of the Crisis*

As care providers, our purpose is to help restore the patient's emotional/ mental/ behavioral stability ***while they are in the midst of a crisis***. ("Patient" in this case refers not only to the pediatric victim but his family as well.) We cannot undo the damage the patient is experiencing, but we can attempt to ameliorate it. We do not want to contribute to the damage. Therefore, rather than the patient being "fine," our realistic objective is for the patient to:

a) better withstand the *extreme demands* of the situation,
b) cooperate with directions and,
c) minimize psychological damage.

To achieve these goals the following are the components our interventions:

**Emotional Presence**

First and foremost, emotional presence is the foundation for any intervention to elicit cooperation, provide comfort and minimize harm. Emotional presence is the clinician's willingness to sense, intuit, feel and know what the other person is experiencing because the clinician's senses, feelings and knowledge are focused upon and open to the person at that moment.

If hospital staff are trained to *confirm the patient's experience*, they needn't find it a distraction from their "appointed rounds," but rather a tool to be **more efficient** with any clinical goal they are pursuing.

**Information and Reassurance**

Pediatric victims and their families need information. Giving children an age appropriate description of the event and procedures helps the child gain a sense of participation and control. If they are not with their parents, children need to be told that their parents are being contacted. Parents may come to a hospital but be kept from their children. Those parents need to be informed of their child's status, the process of decontamination and when they are likely to be reunited. The parent may come to a facility and not be able to find their child – this being more problematic when victims of an event are taken to more than one hospital. Intra and inter-hospital communication will be vital in order to provide the information that will help quell the hysteria of parents who cannot find their children.

Children need reassurance. Keep in mind that there is great variation for reassurance depending on: the age of the child, the circumstances of their victimization, the presence of family or the presence of another known and trusted adult. What follows are some approaches to providing reassurance:

a) Since children are highly influenced by the emotional state of their caregivers – it is important to convey calm and security.
b) For caregivers who are familiar with using:
    - *distraction*, e.g.: "do you have brothers and sisters?" "what are your interests?"
    - *guided imagery*, e.g.: "you know that activity you were just telling me

about (sports, dance, music, etc) – what's it like when you are: on the field, in the dance studio, playing your instrument, etc."

- *suggestion*, e.g.: "you'll probably feel tired as soon as you feel less scared. It's OK to rest."
- *thought interruption*, e.g.: "let's think about "x" (something related to what is happening that is different than what the patient is on) right now."
- *relaxation* through deeper breathing and progressive tensing and releasing of muscles,

these techniques can be very helpful with children and adults. Please note that none of these techniques is suggested to replace taking the time and effort to *attune* to the patient.

c) If the child experienced a specific "event," reassure the child that the "event" is now over.
d) Repeat to the child that he is with caring, helpful people at a local hospital.
e) Tell the child what you are doing and help other caregivers do the same.
f) Periodically reassure the child that she is safe and will be well cared for.
g) Encourage talking: listen to the child tell you his rendition of the events that got him to the hospital, encourage the child to tell you about himself, e.g.: siblings, interests, pets, etc.
h) Normalize the child's experience: "you are experiencing and feeling what anyone would."
i) Be mindful of "magical thinking" in younger children where they develop a fantasy that the event was somehow caused by their actions, thoughts or feelings.
j) If the child is upset, periodically reassure the child that it is OK for him to be upset and offer your comforting presence.
k) Be aware of the "quiet child" who has withdrawn or is in psychological shock and requires your steady emotional support.
l) Be aware that support is not necessarily a verbal experience.
m) Be aware of the child's need for spiritual comfort and know how to obtain the resources of a chaplain (accessing a chaplain is addressed in HEICS through the Human Services Division.

**Logistics**

a) Obtain pertinent information, e.g.: names of family and how to make contact, medications they are taking, etc.
b) Provide nutrition.
c) Give information in a language the child can understand about: what happened, the length of time it takes for tests and treatment, and when updates are expected.
d) Protect children from undo excitement and stimulation, e.g.: onlookers, media.
e) Reunite children with parents as soon as possible, or with another familiar adult available such as a teacher or caregiver.
f) Until there is an adequate support system available to the child try to avoid exposing the child to any news of trauma or loss of any friend or relative.

g) If possible, try to keep the children from hearing other children's rendition of what happened.

**Obtaining Cooperation**

a) Warn children about painful procedures just before they must occur – reassure them that they are doing a good job of cooperating.
b) Explain and re-explain expected procedures and the staff that will be attending to them.
c) After telling the child what to expect from tests and procedures, give the child the task of noting any deviations from those expectations to be reported to you later.
d) When necessary, give the child **firm direction** to get her cooperation. When cooperation is vital, **do not ask the child**, rather say: "We need to do x, y and z, so, I need for ***you*** to do a, b and c. I will be right here with you, you will be OK." Asking implies that the person has a choice in the matter. The child could feel fooled or deceived when asked to make a choice where there is none.

**Support**

Emotional first-aid can continue once the staff person has "joined with the patient." Supportive statements like: "you look scared", "this must be confusing to you", "you look very upset", "have you ever gone through anything like this before?" gives the caregiver an opportunity to **allow the person to vent**. "Allow the person to vent" means that they speak, cry, wail, sob, yell, etc and the staff person listens and then says or does something to indicate that they comprehend what was just expressed. Staff will need to intervene if the patient is doing anything physically damaging to herself, others or objects. However, physical expressions of affect like hitting a pillow are *not* physically damaging. Here are examples of indicating one's understanding of another's distress: "I see how angry you are," "You look terrified," "SILENCE," eye contact or a touch on the arm.

**"Nosocomial Harm" Other Than From Inadequate Preparation**

**The following is *not* emotional first-aid and can produce long-term harmful effects:**

a) do not tell the child to "be brave" (it is fine to encourage their strength to make it through something difficult)
b) do not criticize, devalue or shame the child, e.g.: "that's silly", "you shouldn't feel that way", "you're being a baby", or use body language that conveys disapproval
c) do not compare the child to other patients who are not giving you a problem
d) do not threaten the child, e.g.: "If you are not good, the nurse will give you a shot."
e) do not bring up: "Spirituality, God, Right and Wrong, Deserving or Religion" to explain the child's circumstances or cajole their cooperation
f) do not make a promise you can not or will not keep.

 

**Be alert to other caregivers who may be speaking to a child with one of these approaches. When things are happening quickly and there is the immediacy of medical need, misstatements may occur with no time or opportunity to appropriately intervene. However, when there is an opportunity for intervention one might verbalize something like this to a colleague who misspoke; "I think the child you were just speaking with could respond to an approach like this (insert your correcting comments)" or, "This child looks difficult to work with, how about I try to get his cooperation (help him calm down, get these questions answered, etc)" or, "if this child is asking questions about God, I'll ask the chaplain to come over."**