



EMERGENCY
PREPAREDNESS
BUREAU



Hospital Decontamination Self-Assessment Tool

A resource to assist hospitals evaluate decontamination plans and capabilities

HSPH-EPREP
2013



HARVARD | **SCHOOL OF PUBLIC HEALTH**

Emergency Preparedness and Response
Exercise Program



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Foreword

The *Hospital Decontamination Self-Assessment Tool* was developed by the Harvard School of Public Health Emergency Preparedness and Response Exercise Program (HSPH-EPREP) through a contract with the Emergency Preparedness Bureau at the Massachusetts Department of Public Health, with funding from the Office of Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program.

The views and opinions expressed as part of this toolkit do not necessarily represent the views and opinions of the Office of the ASPR Hospital Preparedness Program or the Massachusetts Department of Public Health.

A list of references used to support the development of this document can be found in Appendix C.



Introduction

In 2011, through a contract with the Massachusetts Department of Public Health, the Harvard School of Public Health Emergency Preparedness and Response Exercise Program (HSPH EPREP) engaged Massachusetts' hospitals in a series of regional tabletop exercises focused on response to a hazardous materials incident. The exercise series highlighted a significant degree of heterogeneity among hospital decontamination programs and capabilities. Subsequent on-site assessments of hospital decontamination systems conducted at a representative sample of facilities throughout the Commonwealth confirmed this finding.

To begin to address this issue of heterogeneity, HSPH-EPREP developed structured tools and guides to assist hospitals develop, maintain, and augment their decontamination programs. The *Hospital Decontamination Self-Assessment Tool* was developed to provide hospitals with a means of evaluating decontamination plans and capabilities against current regulatory standards, recommendations from subject matter experts, and national and international healthcare decontamination best practices. This tool provides scalable considerations based upon presently available guidance to assist hospitals plan for, and respond to, small and large-scale incidents requiring the decontamination of patients contaminated by and/or exposed to chemical, biological, radiological, and/or nuclear agents.

How to use this tool:

The Hospital Decontamination Self-Assessment Tool is intended for use by hospital emergency preparedness planners, hospital decontamination team members, and other personnel with a responsibility for their facility's decontamination plans and procedures.

The tool is designed to walk the user through the *emergency management cycle* of a hospital response to a hazardous materials incident requiring decontamination of patients. Each 'cycle', or section, contains a list of questions drawn from current subject-matter guidance and best practices, intended to assist the user evaluate the degree to which their facility has planned and prepared for hazardous materials incidents involving the decontamination of patients. The checklist format allows the user to keep track of the specific planning and response considerations their hospital has addressed. Links to additional resources and other useful information on hospital decontamination can be found on the "sticky notes" throughout the document.



Additional resources, including planning matrices to assist with the development of decontamination teams, are available in the appendices of this document.



Assumptions

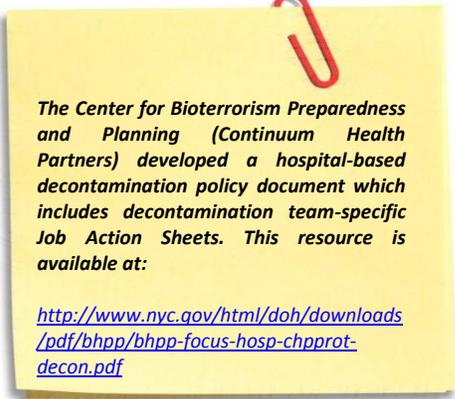
The content presented in this tool revolves around the following assumptions, which should be taken into consideration in the development, evaluation, and revision of hospital decontamination plans:

- *Hospitals will be relied upon to provide medical care to victims of a mass-casualty event resulting from a chemical, biological, radiological, nuclear, or explosive incident.*
- *All hospitals with an emergency department should be prepared to decontaminate victims in small and large- scale hazardous materials incidents.*
- *An influx of patients requiring decontamination has the potential to overwhelm any hospital.*
- *The safety of hospital personnel during decontamination operations is paramount, and should be carefully considered as a critical component of decontamination planning, training, response and recovery.*
- *The hospital’s main priorities in a decontamination event are responder safety, limiting the spread of contamination, patient triage, decontamination, and medical care, as well as medical monitoring of patients and staff.*
- *Information regarding the contaminant, number of victims, and victim status may not be immediately available to hospital decontamination staff.*
- *Victims are likely to self-transport from the incident scene to the closest hospital, often arriving with little or no advance warning.*
- *Effective field decontamination resources may be limited, and hospitals should assume that all incoming victims may need to be decontaminated, unless otherwise notified by first responders.*
- *During a large-scale mass-casualty incident, hospitals should anticipate that non-symptomatic, “worried-well” victims will present to the hospital along with contaminated and/or injured victims.*
- *Victims of a hazardous materials incident may have certain access, functional, and social needs and should be accommodated to the greatest extent possible during a decontamination response. These needs should be considered in decontamination planning, training, exercise, and response.*
- *Hospitals will benefit from regular training and exercises designed to test and reinforce knowledge of hospital decontamination plans and procedures.*



Decontamination Planning and Preparedness

- Has your facility developed a written Decontamination/Hazardous Materials Incident Plan or Annex as a component of the hospital Emergency Operations Plan (EOP)?
- Is the decontamination plan reviewed and revised in conjunction with your hospital's Hazard Vulnerability Analysis (HVA)?
- Is there at least one person at your facility who is responsible for the ongoing maintenance and revision of the decontamination plan?
- Is the decontamination plan reviewed internally with staff on an annual basis?
- Is the decontamination plan reviewed with local emergency response partners on an annual basis?
- Is the decontamination plan scalable to facilitate a response to both small and large-scale incidents?
- Does the decontamination plan include clearly defined activation levels or phases designed to facilitate a timely, measured response?
- Does your facility oversee a Decontamination or Chemical, Biological, Radiological, Nuclear, and Explosives (CBRNE) planning committee that meets at least on a quarterly basis?
- Does at least one hospital representative participate on a standing Local or Regional Emergency Planning Committee (LEPC/REPC) to collaboratively address community hazards and/or decontamination response protocols?
- Does your plan include decontamination team-specific Job Action Sheets (JAS) to assist team personnel in completing essential duties?



The Center for Bioterrorism Preparedness and Planning (Continuum Health Partners) developed a hospital-based decontamination policy document which includes decontamination team-specific Job Action Sheets. This resource is available at:

<http://www.nyc.gov/html/doh/downloads/pdf/bhpp/bhpp-focus-hosp-chpprot-decon.pdf>



Which of the following methods does your facility use to distribute the decontamination plan to internal personnel with an expected role in decontamination planning and response?

- Hard copy document/email distribution
- Review at team meetings
- In-house trainings
- Other:

Is the decontamination plan accessible to staff via your facility's intranet system, Learning Management System, or other readily available database?

Are hospital personnel with a role in hospital decontamination planning familiar with how to access relevant guidance and regulatory standards?

Staffing/Decontamination Team

Is your facility's decontamination team capable of receiving patients within 15 minutes of activation on a 24/7 basis?

Does the size and structure of your decontamination team allow your facility to address the following?

- 24/7 coverage to respond to an incident
- Periodic shift rotations for all personnel, as appropriate to the incident
- Specific needs/vulnerabilities of the surrounding community

Larger, metropolitan hospitals should aim to have a 5-6 member decontamination team trained and available on a 24/7 basis. Smaller, more rural hospitals should aim to have a 2 person team available at all times. (Hick et al, n.d.)

Does your facility use a specific algorithm or trigger to determine how many decontamination team members to deploy for a given incident?

Has your hospital devoted at least one Full Time Employee (FTE) to oversee the planning aspects of facility-based decontamination and/or response to hazardous materials/CBRNE events?



Has your facility designated one or more Points of Contact (POCs) to coordinate the delivery and/or set up of supplemental decontamination resources such as CHEMPACK, decontamination teams, mobile decontamination units, etc.?

Does your facility's decontamination plan designate one or more non-clinical decontamination team members to oversee the bagging, sealing, and preserving of decontaminated patient belongings?

Does your facility's decontamination plan designate specialists or supplemental personnel such as mental health professionals, interpreters, and respiratory therapists to assist with the decontamination response?

Training and Exercise

Have a sufficient number of hospital personnel with the potential to identify contaminated patients on a 24/7 basis received **OSHA HAZWOPER Hazardous Materials Awareness-Level Training¹**?

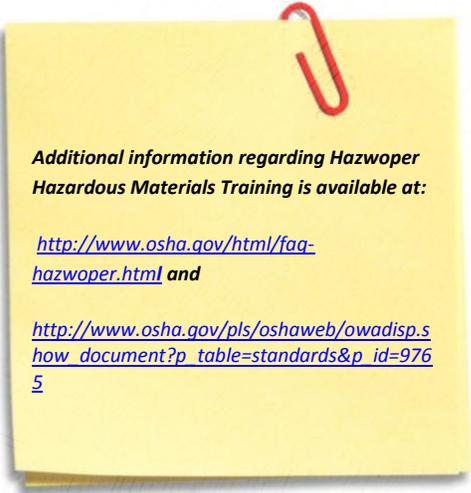
Are all personnel provided with the opportunity to either receive ongoing training or attend an annual refresher training in order to maintain proficiency?

Have a sufficient number of hospital decontamination zone (warm zone) personnel required for a 24/7 response received at least eight hours of **OSHA HAZWOPER Hazardous Materials Operations-Level Training²**?

Are all personnel provided with the opportunity to either receive ongoing training or attend an annual refresher training in order to maintain proficiency?

Has your facility's Decontamination Team Leader received at least 24 content hours of **OSHA HAZWOPER Hazardous Materials Technician-Level Training³**?

Are all personnel provided with the opportunity to either receive ongoing training or attend an annual refresher training in order to maintain proficiency?



Additional information regarding Hazwoper Hazardous Materials Training is available at:

<http://www.osha.gov/html/faq-hazwoper.html> and

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=9765



Have all decontamination team personnel assigned to work in the hospital decontamination zone received training on proper use of the hospital's PPE and other decontamination equipment?

Does your facility's decontamination plan include Just-in-Time training material for "skilled support personnel" ⁴, inclusive of at least the following?

- Nature of the contaminant
- Anticipated duties
- Appropriate use of PPE (assuming medical clearance and fit-testing has occurred)
- Other health and safety precautions

Does your facility's decontamination plan provide measures to support Just-in-Time skilled support personnel with trained, supervisory decontamination team personnel?

Are all clinical Emergency Department personnel trained to recognize the signs and symptoms of exposure to the following chemical agents?

- Nerve Agents
- Vesicants/Blister Agents
- Cyanides
- Pulmonary/Choking Agent

Are all clinical Emergency Department personnel trained to implement facility infection control and isolation procedures in order to effectively respond to a biological mass casualty incident?

Is at least one clinical Emergency Department staff member available on a 24/7 basis who understands the basics of radiation contamination and is trained to use a radiation survey meter?

As a provision in OSHA 1910.120(q)(4): "Skilled support personnel" are those who are not originally designated to serve on the decontamination team but may be called upon during a decontamination response to provide ancillary or emergency services (e.g. specialized medical procedures, utility connections, etc.) within the hospital decontamination zone. (Hick et al, n.d.)

Reference guides to aid with the recognition of signs and symptoms associated with chemical agent exposure are available at:

<http://www.nphl.org/chemTerror.cfm>
and
<http://www.unc.edu/depts/spice/chemical-NC.pdf>

The U.S. Department of Health and Human Services' Radiation Emergency Medical Management has developed a training video on use of dosimeters to screen for radiation. The video, "How to Use Hand-Held Radiation Survey Equipment", along with other resources, is available at:

<http://www.remm.nlm.gov/surveymetervideo.htm>



Does your facility conduct at least one annual decontamination drill/exercise that tests the following?

- Ability and time needed to set up the decontamination/shower system
- Functionality of water system hookups, pressure, and temperature
- Functionality of lighting and other decontamination system equipment/resources
- Ability of staff to don, doff, and simulate decontamination procedures while suited in PPE
- Approximate patient throughput/capacity
- Incident-specific communication/coordination with local response partners

- Are front line personnel trained to use tools such as the R.A.I.N. Acronym to assist in recognizing and handling potentially contaminated patients?

R.A.I.N. Acronym:

Recognize that a patient may present a contamination danger;

Avoid contact with the patient;

Isolate the patient; and

Notify the appropriate personnel.

This resource can be accessed at:

<http://ems.dhs.lacounty.gov/Disaster/LAInstructorGuideFINAL.pdf>



REFERENCES

1. Occupational Health and Safety Administration. OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances. (January 2005). 29.
2. OSHA Best Practices, 25.
3. OSHA Hazwoper Standard 29 CFR 1910.120 (q)(6)(ii).
4. Hick et al. Establishing and training healthcare facility decontamination teams. (n.d.). 4



Decontamination Response

Alert and Notification

Upon receiving initial notification of an incident potentially requiring patient decontamination, what type of information does your plan instruct staff to collect?

- Type and nature of the incident
- Contact information of the notifying entity (name, phone number, email address)
- Approximate number and ages of victims
- Victim signs and symptoms
- Nature/degree of victim injury
- Type of chemical or other agent involved
- Extent of victim decontamination occurring in the field
- Approximate time of EMS arrival, if applicable
- Expected number of self-presenting patients
- Other:

Does your facility have a method of obtaining immediate access to expertise regarding the potential hazard and response required?

Does your plan specify a protocol for incident confirmation and corresponding reassessment procedures in the event that initial notification comes from victims, bystanders, or another informal source?

Which of the following means of communication does your facility use to internally notify staff of decontamination plan activation?

- Cellular phones
- Landline phones
- Pagers
- Mass alerting system



- Email and hospital intranet system
- Two-way radios
- Overhead broadcasting system
- Fax
- Runners/verbal instruction
- Other:

Does your plan specify a protocol for communicating incident updates to actively mobilized decontamination team members?

Is a hospital Public Information Officer (PIO) available on a 24/7 basis to manage requests for information from the media?

Does your facility have a process to initiate and sustain scene-to-hospital communication in order to obtain information regarding the contaminant and approximate number of casualties?

Does your facility have a means of participating in timely, region-wide, interagency communication in the event of a mass-casualty incident involving patient decontamination?

Does your facility operate on an interoperable radio frequency/channel dedicated for interagency communication during mass casualty incidents?

Has your facility identified an information resource center (such as CHEMTREC⁵) that could be contacted to provide on-demand, expert guidance regarding the properties of chemical, biological, and/or radiological agents?

Has your facility identified an information resource center (such as Poison Control) that could potentially be contacted to provide guidance regarding definitive care procedures?

CHEMTREC is a no-fee, 24/7/365 emergency on-call resource providing information and assistance regarding hazardous materials incidents. Additional information can be accessed at:

<http://www.chemtrec.com>



Security and Access Control

- Have all security personnel with the potential to encounter incoming, potentially contaminated patients been trained and equipped with PPE?

Which of the following security/access control measures are specifically addressed in your facility's decontamination plan?

- Preliminary and ongoing priority actions for hospital security personnel
- Method of securing the Emergency Department and/or all other hospital access points that contaminated patients may use
- Crowd containment procedures
- Protocol for directing and controlling traffic into and around the hospital campus
- Whether patient discharge/egress routes will be separate from patient access routes
- Parking arrangements for a large number of vehicles
- Protocol for management of contaminated vehicles
- Method of identifying hospital personnel
- Method of providing hospital personnel with a separate entrance to the facility
- Process for maintaining chain of custody of patient belongings

- Does your facility have a mechanism for separating contaminated patients from uncontaminated patients and visitors arriving for care?

How does your facility prevent unauthorized patient/visitor access to the Emergency Department and other entrance points during a decontamination response?

- Staging of staffed security guards at doors/entrances
- Use of barriers/blockades
- Securing/locking hospital entryways
- Use of keycard systems
- Other:



Which of the following supplies does your facility stage in easily accessible locations in order to support security/access control procedures during a decontamination response?

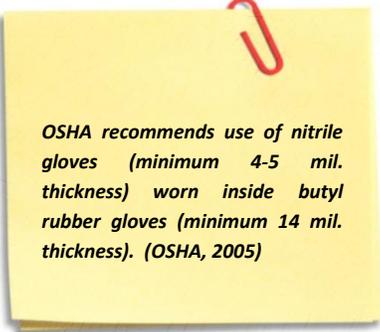
- Traffic cones
- Barrier tape
- Rope
- Traffic control vests
- Bullhorns or whistles
- Megaphones
- Two-way radios
- Other:

- Has your facility established Memorandums of Understanding (MOUs) or made other arrangements with local law enforcement agencies to provide support with traffic and/or crowd control procedures during decontamination response?

Personal Protective Equipment (PPE)

Which of the following OSHA-recommended Level C Personal Protective Equipment (PPE) ⁶ does your facility maintain in appropriate quantities to protect all responding decontamination team personnel against unknown hazards?

- Hooded, NIOSH-approved Powered Air-Purifying Respirators (PAPRs) with a 1,000 fold protection factor
- NIOSH-approved 99.97% high efficiency particulate air (HEPA) filters
 - Organic vapor cartridges
 - CBRNE cartridges
- A chemically protective suit that is tested for ⁷:
 - Resistance to tears
 - Resistance to liquid and blood-borne pathogens
 - Performance in cold weather
 - Evaporative heat transfer
 - Bursting strength
 - Seam and closure strength



OSHA recommends use of nitrile gloves (minimum 4-5 mil. thickness) worn inside butyl rubber gloves (minimum 14 mil. thickness). (OSHA, 2005)



- Double-layer of gloves made of two different materials
- Chemically-protective and water-repellant boots, a minimum of 200 m (8 inches) in height, made out of a similar material as the gloves selected

Does your facility's plan call for the use 2-3 inch tape to cover all open/exposed areas of protective suiting?

As specified in the **OSHA Standard 29 CFR 1910.134⁸** or comparable state plan standard, are all PAPRs and/or other types of respiratory protection designated for use by decontamination team personnel outlined in a formal written respiratory protection program?

The OSHA Respiratory Protection Standard 29 CFR 1910.134 can be referenced at:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=12716&p_table=standards

Does your facility maintain an inventory of fully charged, routinely tested PAPR batteries?

Does your facility pre-assemble and label decontamination team PPE in easily accessible containers?

Does your facility maintain a separate cache of PPE that is designated for staff training purposes only?

Is the equipment in this cache clearly labeled as training material and stored separately from response PPE?

Has your facility established MOUs or made other arrangements with PPE distributors/manufacturers to ensure quick access to additional resources?

Staff Safety/Medical Monitoring

Has your facility appointed at least two clinical personnel to conduct medical monitoring of suited decontamination team personnel?

Which of the following do clinical personnel responsible for medical monitoring routinely assess and document for each suited decontamination team member:



- Vital signs inclusive of temperature, blood pressure, pulse, respirations
- Weight
- List of current medications
- Basic medical history (chronic and/or recent illnesses, current symptoms)
- Absence of any upper respiratory tract infection, chronic obstructive pulmonary disease, sinusitis, or gastrointestinal illness
- Mental status, noting presence of fatigue, stress, and/or psychological distress
- Other:

Do these clinical personnel perform medical monitoring of suited decontamination response personnel before and immediately following each work shift?

Has your facility appointed at least one non-clinical decontamination team member to assist decontamination response personnel don and doff PPE?

Do decontamination team personnel follow an established PPE donning/doffing sequence?

Have maximum shift durations been pre-determined for all decontamination team personnel?

Does your facility specify maximum in-suit operation time?

The UNMC College of Nursing HEROES Program has developed a series of all-hazards emergency preparedness training videos. Videos with step-by-step instructions on Level C PPE donning and doffing procedures, among other training content can be accessed here:

<http://www.youtube.com/user/unmcheroes?feature=watch>

Does this time change with evolving conditions such as heat stress, level of PPE required, etc.?

How does your facility track and document the shift duration of decontamination team members?

- Time-in-PPE written on the back of team member's suit
- Log sheets/White boards
- Timers
- One or more staff members assigned to monitor



Has your facility made arrangements for a decontamination team rest/rehydration area that is within close proximity to, yet out of immediate sight of the decontamination zone?

How do decontamination personnel communicate with each other when suited in PPE?

- Temple-transducer headset radios, worn under PAPR hoods
- Hand held radios
- Pre-established safety hand signals
- Whiteboards
- Signs/flashcards
- Other:

Which of the following medical countermeasures does your facility maintain onsite to treat personnel against CBRNE agents:

Chemical Agents:

- Mark 1 kits (Atropine and Pralidoxime in dual-dose injections)
- DuoDote Auto-Injectors (Atropine and Pralidoxime in a single-dose injection)

Biological Agents:

- Ciprofloxacin
- Doxycycline

Radiological Agents:

- DPTA
- Prussian Blue
- Sodium thiosulfate
- Other:

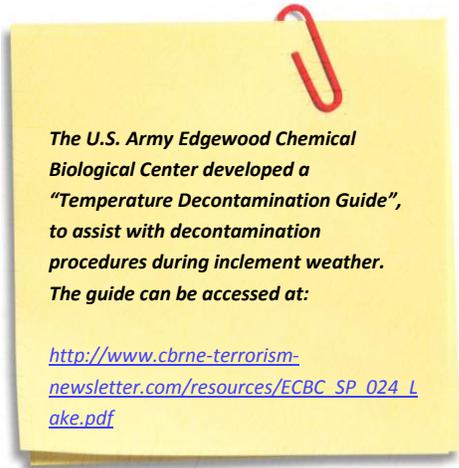
Is at least one clinical Emergency Department staff member trained to don PPE and rapidly administer CBRNE medical countermeasures to staff present on a 24/7 basis?



Decontamination Zone (Warm Zone) Setup

Decontamination Zone:

- Has your facility established decontamination zone locations that will enable response to both small and large-scale hazardous materials incidents?
- Are hot, warm, and cold zone boundaries clearly demarcated?
- Is the hospital decontamination zone located in an area that is accessible to fire hydrants/hook-up to a water supply?
- Does your decontamination plan specify procedures for waste water runoff and collection for disposal in both small and large scale decontamination incidents?
- Is the hospital decontamination zone set-up in a manner that will accommodate incoming EMS and/or Fire Service equipment and personnel?
- Does the hospital decontamination zone provide ample space for the movement of multiple casualties?
- Has your facility designated a 24/7/365 holding area for patients in the event that decontamination must be conducted during periods of cold weather?
- If your facility has indoor decontamination capacity, is the area separately ventilated from the rest of the hospital?
 - Does a Certified Industrial Hygienist or Ventilation Engineer conduct an annual inspection of the indoor decontamination facility?
- Is the hospital decontamination zone that is used in a large scale response located at least 50 yards from the Emergency Department and the rest of the hospital post-decontamination zone⁹?



The U.S. Army Edgewood Chemical Biological Center developed a "Temperature Decontamination Guide", to assist with decontamination procedures during inclement weather. The guide can be accessed at:

http://www.cbrne-terrorism-newsletter.com/resources/ECBC_SP_024_Lake.pdf



Has your facility identified an easily accessible staging area for the storage of decontamination equipment?

Has your facility identified a staging area for the arrival of CHEMPACK and other supplemental resources?

Have personnel responsible for the setup of the hospital decontamination zone been trained to establish electrical connections, hot/cold water hook-ups, and outdoor lighting required for use of decontamination systems in a large-scale incident?

Is the hospital decontamination zone clearly denoted on facility planning maps?

How will your facility physically demarcate the hospital decontamination zone:

- Ropes
- Engineer tape
- Caution tape
- Paint
- Traffic cones
- Barriers/blockades/posts
- Hazard signs
- Color-coding system
- Other:

Decontamination System:

Which type of decontamination system does your facility maintain on-site:

- Fixed (permanent)
- Portable (temporary)
- Rapid Access Mass Decontamination (RAM) capability via use of fire hydrants equipped with special adaptors hoses, etc.



If your facility maintains a portable decontamination shower system, can it be fully activated and operational within approximately 10-15 minutes of initial notification ¹⁰?

Is the decontamination system large enough to facilitate decontamination of more than one patient at a time?

Which of the following does your plan call for to support the decontamination system?

- High capacity, low pressure showerheads or hoses, connected to a high capacity, temperature-controlled water source
- Capability to heat ambient air
- Permanent and/or portable lighting fixtures
- Portable generators, capable of providing power to the area in the event of a loss of power
- PA speaker system for communication purposes
- Other:

Approximately 60-90 pounds per square inch (psi) water pressure is recommended for decontamination system showerheads. (SBCCOM, 2000)

Decontamination Triage

Has your facility identified a patient reception area located away from the Emergency Department, where incoming patients will be triaged for decontamination?

Does your facility use the *Simple Triage and Rapid Treatment (START)*¹¹ principle or other process for prioritizing patient decontamination?

Has your facility trained and appointed at least two dedicated, skilled, clinical decontamination team members to perform decontamination triage while wearing PPE?

Are decontamination triage personnel capable of conducting an initial patient assessment at a rate of 30 seconds or less per patient while wearing Level C PPE?

Does your facility use waterproof patient tags (such as SMART ¹² Triage Tags) to document each patient's triage status?



Which of the following does your facility implement in order to conduct decontamination triage?

- An expedited decontamination line for individuals presenting with serious or life-threatening symptoms
- A separate lane for individuals who arrive by EMS and have been decontaminated at the incident scene
- Separate triage lanes for ambulatory and non-ambulatory patients
- Separate triage lane for “worried well” or psychogenic patients
- Separate triage lane/area for infants and children
- Separate triage lane/area for those with cognitive impairments
- Separate area for decontamination of service animals and pets
- Other:

Does your facility prioritize non-ambulatory patient decontamination?

Patient Decontamination

Which of the following supplies does your facility utilize to perform patient decontamination?

- Tepid water, capable of being held at a constant temperature
- Mild liquid soap, with good surfactant¹³ properties
- Sterile saline for wound irrigation purposes
- Sterile sponges/sterile gauze
- Soft cloths
- Long handled brushes with soft bristles
- Dry decontamination supplies
 - Brushes
 - Baking powder, Fuller’s Earth, Diatomaceous Earth, etc.
 - Baby wipes
- Other:

The American National Standards Institute (ANSI) standard Z358.1 defines tepid water as between 60 and 100 degrees Fahrenheit.

Water should be kept between 98-100 degrees Fahrenheit when used to decontaminate infants and children. A water temperature less than 98 degrees Fahrenheit may increase the potential for hypothermia. (NYC Health and Mental Hygiene, 2006)

Light scrubbing (with brushes or cloths) is recommended only when the contaminant is a chemical vapor, or a biological or radiological material, or if the patient is free of open wounds/skin abrasions. (U.S. Army Edgewood Chemical Biological Center, 2008)



Which of the following supplies does your facility use to address patients' concerns of privacy during decontamination procedures?

- Gender-specific decontamination lanes, stalls, or screens (not necessary for smaller children)
- Patient replacement clothing (ponchos, coveralls, gowns, scrubs, booties)
- Towels
- Blankets
- Other:



“Trash bag” decontamination kits may serve as a cost-effective method of addressing patients' concerns for privacy during decontamination. Large, opaque trash bags are cut to serve as a covering under which the patient can undress. Additional information on trash bag decontamination kits can be found at:

<http://www.nyc.gov/html/doh/downloads/pdf/bhpp/bhpp-focus-hosp-chpprot-decon.pdf>

Which of the following supplies does your facility use to assist with patient tracking purposes throughout the decontamination process?

- Waterproof patient triage tags
- Waterproof wrist bands/bracelets
- Wax pens and/or waterproof permanent markers
- Small and large sealable plastic bags (one of each recommended per patient)
- Waterproof labels to affix to bagged patient belongings
- Biohazard bags and/or large sealable drums for storage and/or disposal of patient belongings
- Polaroid camera with film, digital camera, or smartphone with photo capability
- Other:

How do decontamination team personnel provide instruction to patients regarding decontamination procedures?

- Pictorial/illustrated signage
- Multilingual signage
- Scripted, looped audio messaging
- Scripted, looped video messaging
- Verbal instruction, using megaphones or other amplified device
- Other:



Does your facility institute minimum/maximum per-patient shower times, scalable to the specific hazard and/or other decontamination considerations?

Current guidance suggests a minimum per-patient shower time of 30 seconds and a maximum per-patient shower time of 5 minutes. The approximate per-patient shower time should be determined based on the specific hazard and scale of the incident. (U.S. Army Edgewood Chemical Biological Center. 2008)

Which of the following supplies does your facility maintain onsite in order to assist with non-ambulatory patient decontamination procedures?

- Litter conveyor system/rollers
- Sawhorses
- Spine boards/backboards
- Wheelchairs
- Backpack sprayers
- Snub-nosed trauma scissors
- Plastic chairs
- Other:

Snub-nosed/blunt scissors are recommended for removal of non-ambulatory patient clothing as a way to prevent further spread of the contaminant from pulling clothing over the head and body. (OSHA, 2005)

Has your facility developed specific decontamination procedures to address the needs of the following patient populations and scenarios?

- Individuals with physical and/or cognitive impairments
- Non-English speaking individuals or Limited English Proficiency (LEP) individuals
- Individuals with prosthetic devices or other medical aids (e.g. hearing aids)
- Individual with service animals and/or pets
- Law enforcement personnel or other individuals carrying weapons
- "Worried well" Individuals, and those displaying signs of psychological distress
- Noncompliant Individuals, refusing to disrobe and/or participate in the decontamination process
- The contaminated deceased

In conjunction with the Agency for Healthcare Quality and Research (AHRQ), Children's Hospital Boston developed a video that provides safety considerations for decontamination of infants and children.

The video can be accessed at:

<http://www.remm.nlm.gov/deconvideo.htm>

Has your facility developed specific plans and procedures regarding decontamination of infants and small children?



Does your facility maintain a list of items that cannot be decontaminated, such as hearing aids?

Has your facility established a policy for the return of valuables to patients following decontamination?

Which of the following resources does your facility use to perform patient decontamination in instances of extreme cold (temperature of 35 degrees Fahrenheit and below)?¹⁴

- Decontamination trailers
- Indoor shower facilities
- Indoor swimming pools
- Dry decontamination only
- Other:

Do decontamination team personnel medically monitor patients before, during, and following the decontamination process?

Does your plan specify how patients will be inspected for thorough decontamination prior to leaving the hospital decontamination zone?

In a small-scale incident, is your facility able to decontaminate the resulting number of patients per hour, using the algorithm below?

Annual Number of ED Visits/1000 = Patient per Hour Capacity¹⁵

In a large-scale incident, is your facility capable of decontaminating approximately 12 patients per showerhead, per hour?¹⁶



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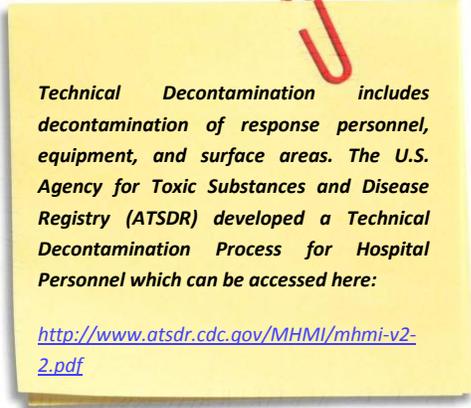
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Decontamination Recovery

Has your facility appointed at least one dedicated, skilled decontamination team member to perform and/or oversee contracted vendor technical decontamination of the following?

- Suited decontamination team personnel
- Decontamination equipment
- Hospital decontamination zone /warm zone
- Contaminated vehicles



Technical Decontamination includes decontamination of response personnel, equipment, and surface areas. The U.S. Agency for Toxic Substances and Disease Registry (ATSDR) developed a Technical Decontamination Process for Hospital Personnel which can be accessed here:

<http://www.atsdr.cdc.gov/MHMI/mhmi-v2-2.pdf>

Has your facility established a MOA/MOU or other agreement with a local hazardous waste company or municipal wastewater treatment facility to provide assistance with waste and waste water removal following a decontamination incident?

Has your facility developed discharge plans/follow-up procedures for decontaminated patients?

Does your facility follow an established process for returning all decontamination equipment and supplies to a centralized location?

Does your facility have a method of determining whether equipment used in conjunction with decontamination operations is able to be decontaminated and reused?

Does your facility have a process for timely replacement of disposed-of decontamination equipment and resources?

Does your facility's decontamination plan demobilize resources and personnel by priority levels or phases?

Does your facility have a method of determining the approximate time it will take to fully restore decontamination capability following a decontamination response?



Does your plan specify procedures for storage and analysis of collected patient belongings in the event of a suspected terrorist or intentional hazardous material release?

Does your facility provide post-event counseling and/or other mental health services for staff involved in the decontamination response?

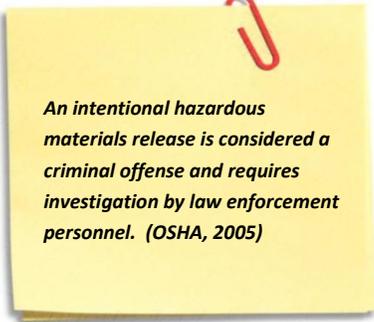
Does your plan specify whether patients will be billed for decontamination services in both small and large-scale incidents?

For potential reimbursement purposes, does your facility utilize a cost-tracking system to document all expenses associated with the decontamination response?

Does your facility conduct a hotwash following decontamination demobilization in order to capture key response actions, forming the basis of an Improvement Plan?

Does your facility follow an established process for timely implementation of recommendations/lessons learned from either real-world decontamination events or simulated decontaminated exercises?

Does your facility have a method of sharing lessons learned from decontamination exercises and real world events with community partners?



An intentional hazardous materials release is considered a criminal offense and requires investigation by law enforcement personnel. (OSHA, 2005)



Appendices

Appendix A: Planning Matrices

Appendix B: Acronym List

Appendix C: List of References



Appendix A: Planning Matrices

Figure 1. Hospital Decontamination Planning Matrix

The following matrix provides an overview of essential decontamination planning considerations regarding collaboration with local response agencies. Select the boxes that are applicable to your facility.

HOSPITAL DECONTAMINATION PLANNING MATRIX						
	FIRE SERVICES	EMS	LAW ENFORCEMENT	PUBLIC HEALTH	EMERGENCY MANAGEMENT	OTHER: _____
OBJECTIVE:						
Does your facility work collaboratively with a Planning Point of Contact (POC) from the agency, at least twice per year?	<input type="checkbox"/>					
Is a representative from the agency routinely present at Local Emergency Planning Committee (LEPC) meetings?	<input type="checkbox"/>					
Does your facility have contact information for at least one POC from the agency that can be reached on a 24/7 basis?	<input type="checkbox"/>					
Is your facility able to initiate and sustain redundant, two-way communication with the agency during an incident?	<input type="checkbox"/>					
Does your facility conduct training and exercises focused on or inclusive of hospital decontamination operations with the agency at least once annually?	<input type="checkbox"/>					
Has your facility established MOUs/MOAs with the agency to provide assistance with decontamination operations?	<input type="checkbox"/>					



Figure 2. Hospital Decontamination Team Matrix

The following matrices provide an overview of essential decontamination team planning considerations. Select the boxes that are applicable to your facility.

DECONTAMINATION TEAM PERSONNEL CONSIDERATIONS							
	ED PHYSICIANS	ED NURSES	ED NURSING ASSISTANTS	SECURITY	MAINTENANCE/ FACILITIES	ENVIRONMENTAL HEALTH	RECORD KEEPER
Which positions are represented on your hospital's decontamination team?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions are taffed on a 24/7 basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Does your plan include up-to-date contact information for each staff member assigned to the position?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions require use of PPE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions have received training on PPE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions have received medical clearance to use PPE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				



OSHA HAZWOPER HAZARDOUS MATERIALS TRAINING

	ED PHYSICIANS	ED NURSES	ED NURSING ASSISTANTS	SECURITY	MAINTENANCE/ FACILITIES	ENVIRONMENTAL HEALTH	RECORD KEEPER
OSHA HAZWOPER TRAINING:							
Which positions have received Hazwoper Awareness-Level Training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Number of trained staff:</i>							
Which positions have received Hazwoper Operations-Level Training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Number of trained staff:</i>							
Which positions have received Hazwoper Technician-Level Training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Number of trained staff:</i>							



DECONTAMINATION TEAM CAPACITY

	ED PHYSICIAN	ED NURSE	ED NURSING ASSISTANT	SECURITY	MAINTENANCE/ FACILITIES	ENVIRONMENTAL HEALTH	RECORD KEEPER
DECONTAMINATION TEAM CAPACITY:							
Which position(s) have the capacity to serve as the Decontamination Team Leader ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which position(s) have the capacity to serve as Decontamination Safety Officers ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions have the capacity and have received training to perform decontamination triage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions have the capacity and have received training to conduct medical monitoring of suited decontamination response personnel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Which positions have the capacity and have been trained to perform technical decontamination (decontamination of personnel, equipment, and/or surface areas)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				



Appendix B: Acronym List

CBRNE: Chemical, Biological, Radiological, Nuclear, and Explosives

EMS: Emergency Medical Services

EOP: Emergency Operations Plan

HEPA: High Efficiency Particulate Air

HVA: Hazard Vulnerability Analysis

JAS: Job Action Sheets

LEPC: Local Emergency Planning Committee

MOA: Memorandum of Agreement

MOU: Memorandum of Understanding

NIOSH: National Institute for Occupational Safety and Health

OSHA: Occupational Safety and Health Administration

PAPR: Powered Air Purifying Respirator

PIO: Public Information Officer

PPE: Personal Protective Equipment

REPC: Regional Emergency Planning Committee

SLUDGEM: Salivation, Lacrimation, Urination, Defecation, Gastrointestinal upset, Emesis, Miosis



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