

## Introduction of Pediatric Acute Care into the Israeli Defense Forces (IDF) Field Hospital

Eran Mashlach<sup>1</sup>, Ofer Merin<sup>2</sup>

1. Emergency Medicine, Schneider Children's Medical Center, Petach Tikvah/Israel
2. Shaare Zedek Medical Center, Jerusalem/Israel

**Study/Objective:** The IDF Medical Corps has decades of experience in treating patients in disaster areas. The hospital was recognized as the leader in field medicine and disaster relief, and became the first field hospital to ever achieve a Type 3 rating according to a World Health Organization (WHO) scale.

**Background:** Worldwide, children are impacted by natural disasters particularly in Developing countries. Children in disasters are often the most affected segment of the population but also the most overlooked. They are more dependent on others for survival. The impacts of hunger following natural disasters can be tremendous, causing lifelong damage to children's development. Natural disasters can be particularly traumatic for young children.

**Methods:** Operating a field hospital for a population affected by natural disaster is a complex mission. However, pediatric care has its own unique, challenging characteristics. This realization led us to set up a separate special pediatric division which included: Pediatric emergency department, Pediatric ward, Pediatric intensive care unit, Neonatal intensive care unit, and an Ambulatory clinic. The pediatric division provides for the primary and secondary care for pediatric patients including: Emergency medical conditions, Trauma, Diagnosis and treatment of common acute & chronic diseases. The pediatric special team comprised of pediatric emergency medicine specialists, pediatricians, neonatologists, pediatric surgeons, pediatric orthopedic surgeons, pediatric anesthesiologists, nurses, medics, psychologists, and medical clowns.

**Results:** More than 1,000 pediatric patients were treated by the pediatric teams in previous delegations, hundred of them required surgery. We have implemented unique methods to treat children, protocols for triage, procedural sedation and analgesia, electronic medical record, etc.

**Conclusion:** We have a duty to learn and share our experience with colleagues worldwide. We hope that our experience will help to promote further knowledge regarding disaster medical response for children, and enhance the development of efficient algorithms and procedures for better preparedness.

*Prehosp Disaster Med* 2017;32(Suppl. 1):s154

doi:10.1017/S1049023X17004216

## Prepping for Peds: A Collaborative Approach to Improving Regional Pediatric Readiness in Oregon

Jessica A. Bailey<sup>1</sup>, Kate Carpenter<sup>2</sup>, Emily Burke<sup>3</sup>, Justin Sales<sup>3</sup>, Robert Steelman<sup>2</sup>, Matthew Hansen<sup>1</sup>, Carl Eriksson<sup>2</sup>

1. Department Of Emergency Medicine, Oregon Health & Science University, Portland/OR/United States of America
2. Department Of Pediatrics, Oregon Health & Science University, Portland/OR/United States of America
3. Randall Children's Hospital at Legacy Emanuel, Portland/OR/United States of America

**Study/Objective:** Oregon has many geographic, resource, and training obstacles to providing quality care for critically ill and injured children. There is wide hospital variation in everyday pediatric preparedness and significant vulnerability to disasters affecting children. Together, experts from Oregon's two children's hospitals and Oregon Emergency Medical Services for Children, developed interactive workshops for medical providers covering the care of sick children at both individual and mass-casualty levels.

**Background:** In 2006, the Institute of Medicine noted that emergency departments "that are unable to meet everyday pediatric care challenges are, by definition, unlikely to be prepared to deliver quality pediatric care in a disaster." This is particularly evident in Oregon, a state challenged by a large geographic area, a high percentage of rural communities with limited resources, and a lack of pediatric medical specialists. Prior surveys have noted many hospitals lack pediatric-focused continuing education and quality improvement, pediatric champions, and disaster plans addressing the needs of children.

**Methods:** We designed and presented a pediatric emergency education program at community hospitals utilizing lectures, skill stations, telemedicine consults, and high-fidelity manikin case simulations. Secondly, we taught pediatric disaster preparedness workshops covering pediatric triage, weight-based medication administration in emergencies, and disaster planning.

**Results:** Thus far, 4 pediatric education days and 2 disaster preparedness workshops have been completed throughout Oregon. Participants included physicians, nurses, advanced practitioners, and prehospital providers. Feedback was overwhelmingly positive for both programs, with >80% of participants requesting similar offerings be available every 6-12 months. Participants valued most highly the interactive nature of the workshops (including simulations, equipment review, and case-based triage practice).

**Conclusion:** Together, these 2 programs represent a successful collaboration to improve pediatric care during everyday conditions and public health emergencies. Educational partnerships can foster relationships between hospitals, expand pediatric skills for individual providers, and improve hospital disaster planning for children.

*Prehosp Disaster Med* 2017;32(Suppl. 1):s154

doi:10.1017/S1049023X17004228

## Pediatric Critical Care Triage: Allocation of Scarce

### Resources

Vicki L. Sakata

Senior Medical Advisor, Northwest Healthcare Response Network, Tukwila/WA/United States of America

**Study/Objective:** 1. Provide an overview of crisis standards of care<sup>1</sup> and current literature recommendations for pediatric critical care triage.<sup>2</sup> 2. Describe our regional Northwest Healthcare Response Network (NWHRN) and the Disaster Clinical Advisory Committee (DCAC). 3. Understand the unique differences between adult and pediatric patients with regards to allocation of critical care resources. 4. Present our