CDC Recommendations for Civilian Communities Near Chemical Weapons Depots: Guidelines for Medical Preparedness

CDC Recommendations for Civilian Communities Near Chemical

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Part IV

Department of Health and Human Services

Centers for Disease Control and Prevention

CDC Recommendations for Civilian Communities Near Chemical Weapons Depots: Guidelines for Medical Preparedness; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC Recommendations for Civilian Communities Near Chemical Weapons Depots: Guidelines for Medical Preparedness

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS.

ACTION: Publication of final recommendations.

SUMMARY: On July 27, 1994, CDC published in the Federal Register, 59 FR 38191, ``CDC Recommendations for Civilian Communities Near Chemical Weapons Depots: Guidelines for Medical Preparedness'' and requested public comment. Seven people sent comments; many were responding on behalf of governments or other institutions in affected communities. These comments are available upon request. These recommendations incorporate changes made in response to the comments received and constitutes CDC's final recommendations for minimum standards for prehospital and hospital emergency medical services' readiness in communities near the eight locations where the U.S. stockpile of lethal chemical weapons is stored. The eight locations are: Umatilla Army Depot Activity, Oregon; Tooele Army Depot, Utah; Pueblo Army Depot Activity, Colorado; Pine Bluff Arsenal, Arkansas; Newport Army Ammunition Plant, Indiana; Anniston Army Depot, Alabama; Lexington Bluegrass Depot Activity, Kentucky; and Edgewood Area, Aberdeen Proving Ground, Maryland.

These recommendations were prepared to assist emergency planners in determining emergency medical services' readiness in communities near the 8 locations where the U.S. stockpile of lethal chemical weapons is stored. These guidelines should not be used for any purpose other than planning for the Chemical Stockpile Emergency Preparedness Program.

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SUPPLEMENTARY INFORMATION:

CDC Recommendations for Civilian Communities Near Chemical Weapons Depots: Guidelines for Medical Preparedness

I. Executive Summary

In 1985, Congress mandated that unitary chemical warfare agents be destroyed in such a manner as to provide maximum protection for the environment, the public, and personnel involved in destroying the agents. The Centers for Disease Control and Prevention (CDC) was delegated review and oversight responsibility for any Department of the Army (DA) plans to dispose of or transport chemical weapons (Public Law 91-121 and 91-441, Armed Forces Appropriation Authorization of 1970 and 1971).

As part of its ongoing efforts to improve medical preparedness within the medical sector of civilian communities surrounding chemical agent depots, CDC has developed the following medical preparedness and response guidelines. These guidelines represent minimum standards of medical preparedness for civilian communities that might be exposed to chemical warfare agents during the incineration or storage process. These guidelines were developed in cooperation with a panel of recognized experts in the fields of emergency medicine, disaster preparedness, nursing, chemical warfare preparedness, and the prehospital emergency medical system.

II. Background

In 1985, Congress mandated that unitary chemical warfare agents be destroyed in such a manner as to provide maximum protection for the environment, the public, and the personnel involved in destroying the agents. This mandate was further defined in the Department of Defense (DOD) Authorization Act of 1986, Pub. L. 99-145. Consistent with its desire to promote the most environmentally safe method of destroying chemical agents, the National Research Council determined that incineration is the best method for disposing of the weapons (1). In 1988, the Authorization Act was amended to permit DA to set up a prototype incineration facility on Johnston Island in the Pacific in order to verify the safety of such an operation. To date, more than 700,000 pounds of chemical agent have been safely incinerated there.

CDC was delegated the responsibility of reviewing and overseeing

any DA plans to dispose of or transport chemical weapons (Pub. L. 91-121 and 91-441, Armed Forces Appropriation Authorization of 1970 and 1971). In addition, an interagency agreement between CDC and DA requires CDC to provide technical assistance to the DA in protecting the public health in nearby communities during the destruction of unitary chemical agents and weapon systems.

Currently, large quantities of chemical warfare agents are stored in eight facilities \1\ in the continental United States. These chemical stockpiles consist primarily of nerve agents, mustard agents, or a combination of both. In Tooele, Utah, construction of the chemical agent incinerator is now complete, and destruction of the weapons and chemicals in this depot is scheduled to begin in the Fall of 1995. To improve the ability of local health care personnel to handle emergencies related to a chemical agent release, CDC has presented medical preparedness courses to civilian medical personnel on sites adjacent to the 8 chemical weapons depots on 13 occasions. Emergency physicians, nurses, internists, surgeons, hospital administrators, and prehospital emergency medical responders have attended these courses.

\1\ Umatilla Army Depot Activity, Oregon; Tooele Army Depot, Utah, Pueblo Army Depot Activity, Colorado; Pine Bluff Arsenal, Arkansas; Newport Army Ammunition Plant, Indiana; Anniston Army Depot, Alabama; Lexington-Bluegrass Depot Activity, Kentucky; and Edgewood Area, Aberdeen Proving Ground, Maryland.

As part of its ongoing efforts to improve medical readiness in civilian communities surrounding chemical agent depots, CDC developed medical preparedness and response guidelines. These guidelines represent minimum standards for medical preparedness in civilian communities that might be inadvertently exposed to chemical warfare agents during the incineration or storage process. These guidelines were developed in cooperation with a working group of recognized experts in the fields of emergency medicine, disaster preparedness, nursing, chemical stockpile emergency preparedness, and prehospital emergency medical systems. These guidelines do not supersede current medical or public health practices and requirements (e.g., precautions for handling bodily fluids). Local health and emergency management officials, working with Army personnel, must analyze the nature of possible releases at each location, determine what kinds of intoxication and what level of contamination might be possible, and match local or regional resources to the potential task.
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The following recommendations for civilian community response to the release of a chemical agent are divided into prehospital and hospital arenas. The recommendations are designed to ensure medical preparedness for chemical agent emergencies. Appendix A is a summary of important questions to ask when evaluating medical preparedness in the civilian prehospital and hospital environments. The prehospital environment encompasses all response areas which are outside both the installation boundaries and the hospital grounds. People potentially affected in the prehospital environment include the general public and first responders. First responders include police, sheriff's, and fire department personnel, hazardous materials response teams, and medical response teams (including emergency medical technicians, paramedics, and any other medically trained personnel responding to the site of injury with the ambulance teams). The hospital environment includes primarily the emergency department but encompasses outdoor areas on the hospital grounds that might be used for triage and decontamination and other hospital departments that might support the hospital's response.

We cannot emphasize too strongly that actions taken within the scope of these guidelines must also comply with all other applicable regulations. In particular, responders considered in this paper falls under the provisions of the Occupational Safety and Health Administration's (OSHA) Hazardous Waste Operations and Emergency Response (HAZWOPER) regulations (29 CFR 1910.120), the respiratory protection regulations (29 CFR 1910.134), and other regulations pertaining to personal protective equipment (29 CFR 1910.132, 133, 135, and 136).

III. Recommendations for Prehospital Medical Preparedness

<bullet> Integrate all local medical emergency response plans related to the release of a chemical agent into the all-hazards State and local disaster response plans.

<bullet> Provide protective equipment for all members of the local medical response team.

<bullet> Train members of the local medical response team in these measures:

--prevention of secondary contamination from chemically exposed patients.

--decontamination procedures.

--evaluation of the medical needs of chemically exposed patients.
--treatment of large groups of patients.
--transportation of victims to a medical facility.

1. Personal Protective Equipment (PPE)

Chemical protective clothing and respiratory protection enable responders to care for patients exposed to chemicals while protecting themselves from secondary contamination.

<bullet> Ensure that such equipment protects the skin, eyes, and respiratory tracts of the emergency responders.

<bullet> HHS have recommended the use of DA battledress overgarments (BDOs) and portable air-purifying respirators (PAPRs) with a combined high-efficiency particulate (HEPA) and organic vapor cartridge to protect civilians from chemical warfare agents. OSHA is reviewing this matter and will make a determination when the review process is completed. BDOs can be used for up to 24 hours in an agentcontaminated environment at levels of up to 10 grams of agent per square meter of surface area. This recommendation should not be construed as discouraging civilian emergency responders from using more protective equipment, such as completely encapsulating suits with supplied air respirators, providing that they have and normally use such equipment in conformity with applicable regulations and can perform their required duties in that equipment.

<bullet> Train personnel required to use personal protective equipment when responding to chemical agent-related emergencies in accordance with the guidelines published by OSHA.

<bullet> Establish and use work practice guidelines to ensure that

responders remain outside areas where their equipment might not be fully protective and that they leave immediately if conditions change such that there is uncertainty about the safety of the environment.

<bullet> Use new cartridges or canisters when entering an area where agent may be present and change them before the next use of the respirator.

<bullet> Use a buddy system and provide adequate communications and rescue capability for each responder working near a plume area. If a worker should experience symptoms of agent exposure and require assistance leaving the area, rescue should be accomplished using level A protection only.

2. First Responders

<bullet> Ensure that all persons (e.g., medics, paramedics, fire fighters, or medical personnel) designated by the State or local disaster plans as members of the initial medical team that responds to a chemical warfare agent release have the appropriate level of PPE and are trained in its proper use (2).

<bullet> Ensure that equipment of first responders is adequately maintained and available at all times.

<bullet> Schedule frequent drills and training sessions designed to maintain first responders' familiarity with equipment and their role in State and local disaster plans.

3. The Public

CDC does not recommend distributing PPE (e.g., gas masks or protective suits) to the public. In the unlikely event that a chemical agent release threatens the civilian population adjacent to a military facility, CDC recommends the following graded emergency response:

<bullet> Evacuate the population at risk in accordance with State or local disaster management guidelines. If no local guidelines exist, follow the Federal Emergency Management Agency (FEMA) and DA joint guidelines for evacuating civilian populations threatened by chemical warfare agents (3).

<bullet> Follow FEMA and DA recommendations for sheltering the population in place (e.g., keep people in their homes, institutions, or places of business and seal windows and doors from an external vapor threat) if it is not practical to evacuate the population (3).

4. Decontamination

Decontamination is the careful and systematic removal of hazardous substances from victims, equipment, and the environment. Transporting contaminated patients exposes emergency response personnel to chemical warfare agents and contaminates rescue vehicles. Proper decontamination prevents secondary contamination and chemical injury to medical and rescue personnel. Acceptable decontamination guidelines for persons who may possibly have been exposed to chemical warfare agents are published by FEMA and DA (3,4). Decontamination must comply with the HAZWOPER regulation, 29 CFR 1910.120(k).

<bullet> Decontamination of patients can be achieved by mechanically removing, diluting, absorbing, or neutralizing the chemical agent.

<bullet> Decontaminate all persons who are believed to be contaminated with a chemical warfare agent before they are transported to a hospital.

<bullet> Decontamination substances should be readily available. Suitable decontamination substances include soap, water, and 5 hypochlorite.

<bullet> To protect the environment, include in State and local disaster plans a [[Page 33310]] method for containing and disposing of contaminated runoff. CDC does not recommend establishing fixed decontamination units in prehospital areas because of the expense and inflexibility of such units.

5. Level of Medical Preparedness Training

<bullet> At a minimum, train persons designated as prehospital medical responders in evaluating patients exposed to chemical warfare agents, managing patients' airways (excluding intubation), transporting patients, and decontaminating patients.

<bullet> Train prehospital responders who have been designated in State or local disaster plans to operate in environments contaminated by a chemical warfare agent in the proper use of PPE in accordance with OSHA guidelines (2).

<bullet> Ensure that, at a minimum, physicians who have been designated in State and local disaster plans to provide medical supervision for prehospital emergency responders and to provide medical care for victims of a chemical agent release receive specialized training through continuing education in the emergency response areas specified for prehospital responders.

6. Patient Triage

The basic premise of patient triage, to provide maximum benefit to the greatest number of victims, is of utmost importance during a masscasualty event involving chemical agents.

<bullet> Have the responder most experienced in evaluating patients conduct the triage.

<bullet> Base decisions regarding patient triage on local resources, the extent of patient contamination, the type of chemical warfare agent to which the patient is exposed, the patient's clinical status, and the likelihood of additional traumatic injuries.

7. Public Information

<bullet> Provide the Joint Information Center (JIC) with appropriate information to inform the public accurately and rapidly about chemical agent exposures that have or may have occurred. If possible, monitor information coming from the JIC and assist in ensuring the accuracy and timeliness of that information.

<bullet> Establish, through the local emergency medical services (EMS) and hospital community, a coordinated public information policy for all chemical emergencies.

<bullet> Work with public health and emergency management officials to contact local and regional news media in advance and establish an accurate and rapid way of disseminating critical information to the public concerning a chemical agent emergency.

<bullet> Ensure that hospital and EMS personnel coordinate their

plans to provide public information with the plans of those who have overall responsibility for emergency response.

8. Communication

Medical personnel must have access to the emergency communication network 24 hours a day. Such a network should link the chemical agent depot, local and regional EMS, and all potential receiving hospitals. During any evaluation of preparedness for a chemical warfare release into civilian communities:

<bullet> Have medical personnel demonstrate the ability to access the emergency communications network.

<bullet> Ensure that the hospitals' emergency communications system allows hospital personnel to verify rapidly whether a chemical warfare agent release has occurred.

9. Transporting Exposed Victims

<bullet> Coordinate the transportation of chemical agent-exposed victims with the overall disaster response plan and include a method for tracking transported patients during an emergency response.
<bullet> Transport contaminated patients only after they have been properly decontaminated.

<bullet> Transport decontaminated patients to medical facilities (e.g., hospitals, clinics, and urgent care centers).
<bullet> Formal agreements such as memorandums of understanding (MOUs) between organizations that transport patients and the medical facilities that receive them must be part of the planning process. Medical facilities designated to receive these patients should be capable of evaluating and managing those exposed to chemical agents as described later in the hospital section (Section IV) of this document.
<bullet> Base decisions regarding urgent and emergency transfers of decontaminated patients on the capabilities of the receiving facilities, transportation resources, demand for hospital services, and the clinical condition of the patients. Certain medical care (e.g., for burns, pediatric emergencies, trauma, or pulmonary complications) might require prearrangements for patients to be transferred to a tertiary treatment center. CDC recommends that transfer and evacuation plans for victims exposed to chemical warfare agents call for land--rather than air--transportation.

10. Medical Evaluation and Treatment

<bullet> Train medical response personnel specifically to assess and manage patients exposed to chemical agents stored at the nearby military depot.

<bullet> Decontaminate all exposed patients as described above.
<bullet> Provide medical treatment (during or after contamination), according to accepted treatment modalities, to patients exposed to nerve or mustard agents. If antidotes to nerve agents are used in the field by civilian medical responders as designated in State or local disaster plans, CDC recommends using single-dose, pre-armed auto injectors, unless a higher level of medical response has already been integrated into EMS operations. Additional information on the effects of chemical warfare agents and accepted medical protocols for caring for patients exposed to mustard or nerve agents is available (5-14).

IV. Recommendations for Hospital Preparedness

1. Primary Receiving Hospitals

A primary receiving hospital is a hospital that is designated by State or local disaster plans to provide initial medical care to the civilian population in the event of a chemical warfare agent release. Such hospitals must have established protocols detailing evaluation, decontamination, and treatment procedures for patients exposed to chemical warfare agents. These hospitals should include:

<bullet> Evaluation, treatment, and decontamination protocols in the hospitals' disaster plans.

<bullet> Chemical warfare agent scenarios in disaster drills for hospitals that have been designated in State or local disaster plans to receive patients exposed to chemical warfare agents.

2. Triage Considerations

<bullet> Do not allow patients exposed to a chemical warfare agent to enter the emergency department without adequate evaluation and decontamination. Signs of mustard agent exposure, in particular, may require 24-48 hours before they become clinically evident.

<bullet> Train medical staff designated by the hospital disaster plan to perform triage during an emergency related to chemical warfare agents to recognize the physical signs and symptoms of patients who have been exposed to such agents.

<bullet> Base modifications to patient triage procedures on the extent of patient contamination, the type of chemical warfare agent to which the patient has been exposed, the patient's clinical [[Page 33311]] status, and the possibility of additional traumatic injuries. Priorities for medical treatment of patients should be determined by the most appropriately trained and experienced medical professional.

3. Security

<bullet> Address issues related to emergency department security during disasters in the hospital disaster plan.

<bullet> Restrict access to the hospital to prevent contaminated patients from entering the hospital. During a chemical agent release, security personnel should direct all patients to enter the hospital only through the triage area.

4. Decontamination

<bullet> Decontaminate all persons who may have been contaminated with a chemical warfare agent. Proper decontamination prevents secondary contamination and chemical injury to medical and rescue personnel. Acceptable decontamination guidelines for persons exposed to chemical warfare agents are published by FEMA and DA (3,4). Decontamination must comply with the HAZWOPER regulation, 29 CFR 1910.120(k).

<bullet> Have decontamination substances readily available. Suitable decontamination substances include soap, water, and 5 hypochlorite.

<bullet> In the hospital disaster plan, detail a method for

catching contaminated runoff from patients whether decontamination is done inside or outside the hospital.

<bullet> At a minimum, be capable of decontaminating at least one non-ambulatory patient.

<bullet> During and after chemical agent releases that cause mass casualties, decontaminate patients outdoors. Having indoor decontamination facilities does not obviate a hospital's need to have plans for decontaminating patients outdoors during mass casualty situations. Outdoor facilities must have a means of containing the runoff from the decontamination process until it can be tested and disposed of safely.

<bullet> Design hospital disaster plans, keeping in mind the possibility of integrating local emergency response resources. Such resources could include hazardous materials emergency response teams or portable decontamination vehicles or facilities.

<bullet> In cold weather, set up temporary shelters and heaters to protect patients from extreme environmental conditions when undergoing decontamination outdoors.

<bullet> Have in place a method of controlling the flow of air in the decontamination area to prevent such air from contaminating other areas of the hospital.

<bullet> Set up a system to allow medical personnel in the decontamination area to be in continuous communication with other medical personnel in the emergency department.

5. Personal Protective Equipment (PPE)

Chemical protective clothing and respiratory protection enable responders to care for chemically exposed patients while protecting themselves from secondary contamination. This equipment must protect the skin, eyes, and respiratory tracts of the responders.

<bullet> HHS have recommended the use of DA BDOs and PAPRs with a combined high-efficiency particulate (HEPA) and organic vapor cartridge to protect civilians from chemical warfare agents. OSHA is reviewing this matter and will make a determination when the review process is completed. BDOs can be used for up to 24 hours in an agent-contaminated environment at levels of up to 10 grams of agent per square meter of surface area. This recommendation should not be construed as discouraging civilian emergency responders from using more protective equipment such as completely encapsulating suits with supplied air respirators, providing that they have and normally use such equipment in conformity with applicable regulations and can perform their required duties in that equipment.

<bullet> Hospital personnel should follow Environmental Protection Agency (EPA) and National Institute for Occupational Safety and Health (NIOSH) guidelines when managing patients exposed to unknown chemicals.

<bullet> This recommendation should not be construed as discouraging civilian emergency responders from using more protective equipment such as completely encapsulating suits with supplied air respirators, providing that they have and normally use such equipment in conformity with applicable regulations and can perform their required duties in that equipment.

<bullet> Response personnel should be trained to use PPE when responding to a chemical agent emergency according to OSHA guidelines (2).

6. Level of Training

<bullet> Medical staff designated by the hospital disaster plan should be trained to provide direct patient care during a chemical warfare agent emergency to a level of medical preparedness that allows them to assess, decontaminate, and manage the treatment of victims of chemical warfare agent releases.

<bullet> Medical staff who are required to wear decontamination attire in decontamination procedures must receive training in the use of PPE according to OSHA regulations (2-4).

7. Transportation of Patients to other Medical Facilities

<bullet> Have prearranged written agreements with those medical facilities that agree to accept patients who are exposed to military chemical agents.

<bullet> Do not transfer patients without notifying the hospital and having the patient accepted by a physician.

<bullet> Have standardized forms available to record patient information and management status.

8. Specific Antidotes

<bullet> Have decontaminating solutions available in the emergency department. If nerve agents are stored adjacent to the civilian community, have atropine in multiple-dose units available in the emergency department and in the hospital pharmacy. In addition, have the hospital pharmacy stock atropine and pralidoxime in sufficient quantities to cope with the anticipated number of patients who could be managed by that facility in response to a chemical warfare agent release. Atropine and pralidoxime should be administered intravenously in the emergency environment.

9. Hospital Disaster Plan

<bullet> Include plans for providing medical care for patients exposed to chemical agents in the hospital's disaster plan.

<bullet> Have in place a method for using the emergency communication system so that reports of a chemical warfare agent release can be verified rapidly. Also, include provisions to coordinate activities with State and local disaster plans for mass decontamination.

<bullet> Include in disaster drills scenarios in which patients have become exposed to chemical warfare agents.

<bullet> Use the hospital quality assurance program to review disaster drills and decontamination procedures and to assist in maintaining the professional skills of hospital personnel necessary to treat the effects of exposure to a chemical warfare agent.

10. Tertiary Hospitals

A tertiary receiving hospital is a hospital that receives referrals from primary receiving hospitals. Additional services such as burn care, psychiatric service, and toxicologic consultation are available at the tertiary level of care.

<bullet> Ensure that tertiary hospitals designated by State or local disaster plans to provide care for persons exposed to chemical warfare agents have, at a minimum, emergency [[Page 33312]] response capabilities similar to those of the primary receiving hospital.

<bullet> Ensure that tertiary hospitals coordinate their disaster plans with State and local disaster plans for mass decontamination of persons exposed to chemical warfare agents.

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Appendix A

Summary of Important Medical Preparedness Considerations for Communities Surrounding Chemical Agent Stockpiles

1. Do the communities that surround chemical warfare agent depots have a disaster plan that details the role of the prehospital and hospital medical community during a chemical warfare agent emergency?

2. If medical personnel are designated to treat chemical warfare agent casualties, do they have adequate training to meet minimal standards for evaluating, decontaminating, and treating victims of a chemical warfare agent release?

3. Do medical personnel who are designated by State, local, and hospital disaster plans to use PPE in response to an emergency related to chemical warfare agents have the necessary OSHA level of training to use these devices effectively and safely?
4. If the local disaster plan has provisions to evacuate or transfer patients to other hospitals for further treatment and evaluation, do existing MOUs cover the transfer of chemically contaminated patients?

5. Do hospitals named in the State or local disaster plans have an adequate stockpile of antidotes and decontamination solutions to provide complete medical treatment to at least one chemically contaminated patient?

6. Are the hospitals that are designated in the State or local disaster plans able to decontaminate at least one non-ambulatory patient exposed to chemical warfare agent?
7. Do the disaster plans of hospitals designated to receive patients by State and local disaster plans have specific provisions that detail how they will control access to their medical facilities during a chemical warfare agent emergency?
8. Are all levels of the medical community that are designated by State or local disaster plans to respond to a chemical warfare agent emergency able to communicate via either the State or local disaster communication network?

Appendix B

Working Group Participants

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