

FIRST RECEIVERS DECONTAMINATION PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes mandatory procedures for Department of Veterans Affairs (VA) medical facilities to use in developing, implementing and maintaining the VHA First Receivers Decontamination Program (FRDP) capability as part of the VHA Comprehensive Emergency Management Program (CEMP).

2. SUMMARY OF MAJOR CHANGES: This VHA directive provides clarifying information on four aspects of the FRDP:

a. VHA allows each VA medical facility flexibility to establish the appropriate size and scope of FRDP capability based upon its Hazard Vulnerability Analysis (HVA) and requirements of the local community with respect to operational patient decontamination support from the VA medical facility;

b. VHA encourages coordination and collaboration with local community response partners (emergency management, public safety, and public health organizations) in order to ensure plans and agreements, where appropriate, are integrated and fulfill the VA medical facility's and the community's patient decontamination requirements;

c. Each VA medical facility that provides emergency patient care services, as required by VHA Directive 1051, Standards for Nomenclature and Operations in VHA Facility Emergency Departments, must maintain an appropriately sized (individual, multiple, or mass) FRDP capability to manage no-notice, self-presenting, or transported contaminated patient(s) seeking care at the facility; and

d. VHA will monitor VA medical facility FRDP capability through a comprehensive emergency management inspection program.

3. RELATED ISSUE: VHA Directive 0320.

4. RESPONSIBLE OFFICE: The Office of Emergency Management (10NA1) is responsible for the content of this VHA directive. Questions may be addressed to the Director at 304-264-4826.

5. RESCISSION: VHA Directive 2003-045, dated August 8, 2003, is rescinded.

October 27, 2016

VHA DIRECTIVE 0320.06

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of October 2021. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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FIRST RECEIVERS DECONTAMINATION PROGRAM

1. PURPOSE

The purpose of the Veterans Health Administration (VHA) First Receivers Decontamination Program (FRDP) is to prepare staff to respond to incidents involving contaminated patients seeking care; to protect the well-being of Veterans, employees, and other occupants within the Department of Veterans Affairs (VA) medical facility; to protect the physical infrastructure; and, to the fullest extent possible, ensure continuity of care. These incidents could be caused by internal or external sources, associated with man-caused (intentional or unintentional) emergencies, those created as a result of natural disasters, or those involving hazardous substances including chemical, biological, radiological, nuclear, and explosive (CBRNE) agents. **AUTHORITY:** Title 38 United States Code (U.S.C.) §§ 501, 1784, 1785, 7328, 7301(b), 8111A, 8117; 42 U.S.C. §§ 300hh, 1395dd, 5192; Title 29 Code of Federal Regulations (CFR) 1910.120; 38 CFR §§ 17.58, 17.86.

2. BACKGROUND

The VHA FRDP requirements are designed to comply with the following laws, VHA policies, and industry requirements:

a. Emergency Medical Treatment and Active Labor Act (EMTALA). Section 1867 of the Social Security Act, 42 U.S.C. 1395dd, imposes specific obligations on Medicare-participating hospitals which offer emergency services. These hospitals must provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. While not technically subject to the EMTALA, VHA complies with the intent of EMTALA requirements regarding the evaluation, stabilization, and transfer of acute patients among health care facilities (see VHA Directive 1051, Standards for Nomenclature and Operations in VHA Facility Emergency Departments);

b. VA Emergency Preparedness Act of 2002. Public Law 107-287, 38 U.S.C. 8117) requires the provision of decontamination equipment and personal protection equipment at VA medical facilities and the training of staff in the use of such equipment to protect patients and staff from incidents involving CBRNE agents, or otherwise to respond to such an attack to enable medical facilities to fulfill their obligations as part of the Federal response to public health emergencies;

c. Occupational Safety and Health Administration, 29 CFR 1910.120, Hazardous Waste Operations and Emergency Response (HAZWOPER) standard. 29 CFR 1910.120 establishes the training and personal protective equipment requirements for hospital-based First Receivers performing patient decontamination during incidents involving CBRNE agents;

d. VHA Directive 0320, Comprehensive Emergency Management Program, provides the authority for the VHA Comprehensive Emergency Management Program

(CEMP) and the VHA Office of Emergency Management (OEM), as the Program Office, to provide policy, oversight and funding to the FRDP; and

e. The Joint Commission. Hospital and Ambulatory Care Emergency Management Standard 02.02.05, Element of Performance #5. The VA medical facility's Emergency Operations Plan (EOP) must describe how they will provide for radiological, biological, and chemical isolation, and decontamination.

3. DEFINITIONS

a. **First Receivers.** First Receivers are appropriately trained VA medical facility staff members who may encounter and work with contaminated or potentially contaminated patients from an incident involving CBRNE agents and who are involved in the activation and operation of the VA medical facility's FRDP capability. First Receivers are distinguished from First Responders (e.g., firefighters, law enforcement, and ambulance service personnel) in that the VA medical facility is not the incident site, but rather is remote from the location where the hazardous substance release occurred. First Receivers can include clinicians and other VA medical facility staff who receive and treat contaminated patients (e.g., triage, decontamination, medical treatment) and those whose roles support these functions (e.g., security/access control, and set up of decontamination equipment).

b. **Individual Patient Decontamination.** Individual patient decontamination consists of those activities conducted for a single patient. This is the minimum capability requirement for all VA medical facilities with emergency departments and/or urgent care clinics.

c. **Multi-Patient Decontamination (Resource Sufficient).** Multi-patient decontamination consists of activities conducted for multiple contaminated patients in small-scale incidents in which resources are not limiting factors. Requests for additional resources or assistance should not be required for this level of patient decontamination. The number of patients that constitutes multi-patient decontamination is dependent on the jurisdiction, local responding agencies, and/or the VA medical facility's capacity.

d. **Mass Patient Decontamination.** Mass patient decontamination consists of activities conducted for a number of contaminated patients that exceeds the typical receiving capacity of a VA medical facility. This generally requires additional resources or personnel from surrounding jurisdictions, and patients often must be prioritized for the decontamination process. Mass decontamination generally requires much higher levels of resource coordination than multi-patient or individual decontamination situations. The number of patients that constitutes mass decontamination is dependent on the jurisdiction, local responding agencies, and the VA medical facility's system capacity.

e. **Patient Decontamination.** Any process, method, or action that leads to a reduction, removal, neutralization or inactivation of contamination on the patient in

order to prevent or mitigate adverse health effects to the patient and to VA medical facility First Receivers and other unexposed patients from secondary contamination, and to reduce the potential for secondary contamination of the health care infrastructure.

4. POLICY

It is VHA policy that each VA medical facility that provides emergency patient care services, as required by VHA Directive 1051, Standards for Nomenclature and Operations in VHA Facility Emergency Departments, must maintain an appropriately sized (individual, multiple or mass) FRDP capability to manage no-notice, self-presenting or transported contaminated patient(s) seeking care at the facility. This capability can be established in-house, through agreements with commercial or governmental entities, or through a combination of these methods. An appropriately sized VA medical facility FRDP capability is based upon the VA medical facility's Hazards Vulnerability Analysis (HVA) and its role in the local community's plan for mass casualty incidents involving CBRNE agents.

5. PROGRAM COMPONENTS

The required elements of a FRDP include:

a. **Patient Decontamination Risk Assessment.** A VA medical facility's HVA must include a patient decontamination risk assessment. VA medical facilities must perform and document a patient decontamination risk assessment at least once every 3 years or as changes occur in VHA. The assessment aids in determining the size and resources necessary to support the VA medical facility's patient decontamination capability, selecting personal protective equipment (PPE) for VA medical facility First Receivers, and for establishing relevant patient decontamination plans and agreements. The VA medical facility's patient decontamination risk assessment should be coordinated with the Local Emergency Planning Committee (LEPC), local hospital coalitions, and community emergency planners, as appropriate. A VA medical facility's patient decontamination risk assessment involves:

(1) Assessing external risks associated with industrial, technological, transportation, and human caused CBRNE incidents. This assessment should be community driven, based on perceived risks and substantiated data, and the likely impact credible threats would have on the VA medical facility and community.

(2) Reviewing the local community's decontamination resources and capabilities as they relate to defining the scope of the VA medical facility's capability; this will assist the VA medical facility in better understanding community risks and vulnerabilities.

(3) Estimating number of patients that can be safely and effectively decontaminated (e.g., individual or multi-patient) with the following desired end points: (1) timely decontamination of patients; (2) reducing short-term and long-term

health effects; (3) protecting the safety and health of first receivers and unexposed patients; (4) maintaining continuity of care by preventing secondary contamination from entering the VA medical facility.

b. **Patient Decontamination Plan.** The FRDP capability must be evidenced through its patient decontamination plan. The patient decontamination plan is part of the VA medical facility's overall Emergency Operations Plan (EOP). The plan must describe how the VA medical facility will provide for patient isolation and decontamination when the facility is not itself the primary incident site, but rather is remote from the location where the hazardous substance release occurred. The plan must detail the VA medical facility's designated community role during mass patient decontamination activities. The plan must define the VA medical facility's level of decontamination capability (individual, multi-patient or mass patient). The plan must be specific for First Receivers' patient decontamination operations and must address response procedures for managing no-notice, self-presenting, or transported contaminated patients as well as ambulatory, non-ambulatory, and special needs contaminated patients. Staff in positions to identify contaminated victims who arrive unannounced must be familiar with the patient decontamination plans and the patient decontamination agreement, if applicable and with the procedures for the activation of that plan and/or agreement. The plan must be reviewed and revised in conjunction with the VA medical facility's HVA.

c. **Establishing Agreements for Decontamination Services.** VA medical facilities may choose to procure patient decontamination services from another organization, rather than to provide those services itself. The particular situation dictates which legal authority and type of agreement is used. See Appendix A for more information.

d. **Patient Decontamination Resource Evaluation.** VA medical facilities should accomplish and document a decontamination resource evaluation at least every 3 years. Any decontamination supplies or equipment used in an exercise or real-world response must be re-inventoried within one week of termination of the event in order to identify shortfalls/consumed items. A VA medical facility decontamination resource evaluation involves:

(1) Describing the type and level of emergency and clinical services necessary to support the decontamination capability at the facility, and determining the numbers and types of staff positions that would be required to support the decontamination capability.

(2) Determining the type and quantity of PPE needed to adequately equip and protect staff to conduct decontamination operations. Minimum PPE requirements for VA medical facility decontamination are listed in Table 3 in the Occupational Safety and Health Administration (OSHA) Best Practices for Hospital-Based First Receivers of Victims of Mass Casualty Incidents Involving the Release of Hazardous Substances. PPE selection, maintenance, and use must comply with VHA and OSHA requirements.

(3) Identifying the types of decontamination systems, supplies, and equipment available or needed. VA medical facilities, regardless of the size or scope of the decontamination capability, must determine if their decontamination system, supplies, and equipment can support their determined decontamination capability.

Decontamination systems may include portable tents, trailers, and fixed systems. Fixed decontamination systems are the most effective for VA medical facilities that need the ability to act rapidly to mitigate adverse health effects of contaminated patients.

(4) Evaluating any available All-Hazards Caches, along with other medical supplies, for availability, use, and activation procedures as they pertain to the decontamination capability.

e. **Training.** The training required for First Receivers will vary based on individuals' assigned roles or responsibilities, the zones in which they work, and the likelihood they will encounter contaminated patients. The HAZWOPER Standard, 29 CFR 1910.120(q) requires that First Receivers be trained or have had sufficient experience to objectively demonstrate competency (e.g., in exercises and drills) in their specific roles and positions. OSHA letters of interpretation clarify how 29 CFR 1910.120, Hazardous Waste Operations and Emergency Response (HAZWOPER) First Responder Awareness Level and First Responder Operations Level training meet the training requirements for First Receivers. VA medical facilities must provide the appropriate decontamination training elements and verify the staff competencies consistent with the HAZWOPER Standard.

a. **Patient Decontamination Exercise.** The VA medical facility must conduct at least one fully operational decontamination exercise annually. This exercise must include decontaminating patients with soap and water and moving non-ambulatory patients. OEM staff will participate in the evaluations of these exercises. These exercises can be used to accomplish the OSHA Awareness and Operations Level training and competency verification described in paragraph 5.e. Staff assigned to roles supporting the decontamination capability must participate in annual exercises.

f. **Operational Readiness Validation.** Upon completing the risk assessment and resource review, each VA medical facility must validate and, if necessary, adjust its level of decontamination operational readiness. The validation is intended to ensure that the equipment needed to safely execute the facility's determined decontamination capability is available, and that necessary staff members are fully trained and competent to safely perform patient decontamination operations. The OEM Emergency Management Capability Inspection Program (EMCIP) will be used to monitor the facility's FRDP capability status.

g. **Medical Clearance of Staff.** Staff assigned to wear OSHA required PPE (minimum Level C) during patient decontamination operations must be medically cleared by Occupational Medicine/Health prior to wearing the PPE. This clearance is in addition to the medical clearance questionnaire mandated by 29 CFR 1910.134, Respiratory Protection, as part of the VA medical facility's Respiratory Protection

Program. **NOTE:** *The mandatory exams for personnel expected to wear Level C PPE can be found in the Employee Occupational Health Guidebook available on-line at the [Center for Engineering & Occupational Safety and Health \(CEOSH\) Web site](#).*

6. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for ensuring that VHA's FRDP complies with requirements contained in Federal laws and regulations, Executive Orders, and VA and VHA Directives and Handbooks.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for issuing policy relative to the VHA FRDP.

c. **Assistant Deputy Under Secretary for Health for Operations and Management for Administrative Operations.** The Assistant Deputy Under Secretary for Health for Operations and Management for Administrative Operations is responsible for approving certain expenditures related to the FRDP.

d. **Director, Office of Emergency Management.** The Director, OEM is responsible for:

(1) Providing policy, direction, and support for the VHA FRDP, including national-level goals, objectives and performance metrics;

(2) Supporting VA medical facility FRDP capabilities by establishing requirements and providing funding, training, technical support, and other resources; and

(3) Auditing the readiness of VA medical facility FRDP capabilities through the EMCIP.

e. **Veterans Integrated Service Network Directors.** The Veterans Integrated Service Network (VISN) Director is responsible for overseeing the readiness of FRDP capabilities at VA medical facilities within the VISN.

f. **VISN Emergency Manager.** The VISN Emergency Manager (EM) is responsible for monitoring the readiness of FRDP capabilities at VA medical facilities within the VISN by working with facility and OEM staff.

g. **OEM Area Emergency Manager.** The OEM Area Emergency Manager (AEM) is responsible for:

(1) Supporting the VA medical facility FRDP through participation in planning and community liaison;

(2) Evaluating the VA medical facility patient decontamination agreements; and

(3) Evaluating the VA medical facility annual operational patient decontamination readiness exercise.

h. **VA Medical Facility Directors.** Each VA medical facility Director is responsible for:

(1) Identifying a single point-of-contact who is responsible for ensuring the facility FRDP meets VHA CEMP requirements and OSHA standards;

(2) Approving the facility's role in the community-wide plan for incidents involving CBRNE agents;

(3) Designating at least one staff member to represent the facility on the Local or Regional Emergency Planning Committees (LEPC/REPC) to collaboratively address community hazards and decontamination response procedures;

(4) Authorizing plans to establish agreements with commercial and/or governmental entities that support or fulfill the facility's patient decontamination capabilities after their review by OEM staff;

(5) Ensuring the availability of facility FRDP records for OEM review;

(6) Appointing staff to serve in Incident Command System (ICS) positions responsible for the implementation of the facility FRDP during incidents;

(7) Ensuring the active participation and support of facility operating units in training, equipping, exercising, and sustaining the facility FRDP; and

(8) Budgeting for the training of staff and the procurement of necessary equipment and supplies.

i. **VA Medical Facility Emergency Manager.** The VA medical facility EM is responsible for:

(1) Ensuring the facility's FRDP meets the VHA CEMP requirements as identified in EMCIP;

(2) Coordinating the facility's operational patient decontamination response activities;

(3) Gathering and reporting data on the operational status, performance, and funding requirements related to the facility's FRDP;

(4) Communicating with the facility's Emergency Management Committee (EMC) on all matters related to the FRDP;

(5) Verifying the competencies of staff designated to perform First Receivers decontamination operations through training, drills, and exercises;

(6) Coordinating with commercial and/or governmental entities to establish agreements for patient decontamination, if applicable;

(7) Accomplishing and documenting the facility's decontamination risk assessment at least once every three years;

(8) Conducting the facility's decontamination resource evaluation; and

(9) Managing the decontamination systems, equipment, and supply inventories and verifying that they are adequate for the facility's decontamination capability.

j. **VA Medical Facility Emergency Management Committee.** The VA medical facility Emergency Management Committee (EMC) is responsible for:

(1) Monitoring the facility's FRDP, including participation in the annual program review, reviewing and approving the recommendations for improvement and funding for projects;

(2) Planning, organizing, and coordinating equipment, personnel, local standard operating procedures (SOPs), training, exercises, and procedural issues required to ensure effective patient decontamination response capabilities;

(3) Reviewing any agreements for patient decontamination services provided by commercial and/or governmental entities;

(4) Managing the recruitment and assignment of hospital staff to fill key roles and functions (e.g., patient decontamination leader, triage, site safety) that support the operational readiness of the facility's patient decontamination capability; and

(5) Reporting the status of the facility's patient decontamination capability to facility leadership and other facility committees, as appropriate.

k. **VA Medical Facility Occupational Safety and Health and Industrial Hygiene Program Managers.** The VA medical center Occupational Safety and Health (OSH) and Industrial Hygiene (IH) Program Managers are responsible for:

(1) Ensuring the facility's FRDP meets OSHA standards.

(2) Certifying that hospital staff assigned to patient decontamination roles and functions receive their required occupational safety and health training and medical clearance exams.

(3) Providing technical assistance to VA medical facility EMs to perform the VA medical facility's decontamination risk assessment and resource evaluation to confirm that the First Receiver's PPE is appropriate to safely execute the VA medical facility's determined decontamination capability; and

(4) Providing subject matter expertise during real-world incidents in: determining whether patient decontamination is indicated and which manner of decontamination is appropriate; protecting the safety and health of the VA medical facility's First Receivers and unexposed patients, visitors, and staff; and maintaining continuity of care by preventing secondary contamination from entering the VA medical facility.

l. **VHA Office of OSH and Green Environmental Management System Program.** The Director, Office of OSH and Green Environmental Management System (GEMS) Program is responsible for assisting OEM with VHA FRDP policy development, and providing consultation/guidance, in the areas of occupational safety/health and environmental compliance related to patient decontamination.

m. **VHA Center for Engineering and Occupational Safety and Health (CEOSH).** The VHA CEOSH will collaborate with OEM to produce and manage Web-based applications, surveys, tools and technical references to facilitate effective, efficient program administration, and field implementation of the VHA FRDP.

n. **VHA Employee Education System (EES).** EES is responsible for assisting OEM with the delivery, revision and accreditation management of all national FRDP training development and execution activities.

o. **VA Police Departments.** In accordance with VA Handbook 0730/1, VA Police Departments are responsible for:

(1) Providing security and law enforcement support for the VA medical facility FRDP. Key police security and law enforcement activities during incidents requiring decontamination include perimeter crowd control, VA medical facility lockdown and access control, and traffic control; and

(2) , Security and Law Enforcement, VA police officers will successfully complete annual training on emergency response topics. Such training will include VA police use of personal protective equipment for response to CBRNE and for response to other incidents involving hazardous agents. VA Police Officers who are assigned roles and functions that may require them to come in contact with contaminated patients must be trained to the First Responder Operations Level and to wear a minimum of Level C PPE.

7. REFERENCES

- a. Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd;
- b. VA Emergency Preparedness Act 2002, Public Law 107-285, as amended;
- c. VA Directive 0320, Comprehensive Emergency Management Program, 2012;
- d. VA Handbook 0730/1, Security and Law Enforcement, 2004;

- e. VHA Directive 0320, Comprehensive Emergency Management Program, 2013;
- f. VHA Directive 1047, All-Hazards Emergency Caches, 2014;
- g. VHA Directive 1051, Standards for Nomenclature and Operations in VHA Facility Emergency Departments, 2014;
- h. VHA Clinical Occupational Health (COH) Guidebook; most current edition available on-line at the [Center for Engineering & Occupational Safety and Health \(CEOSH\) Web site](#);
- i. VHA Emergency Management Capability Inspection Program (EMCIP) and Emergency Management Program Guide; 2014 edition available on the Performance Improvement Management System Web site;
- j. Dept. of Homeland Security/Dept. Health and Human Services, Patient Decontamination in a Mass Chemical Exposure Incident: National Planning Guidelines; 2012;
- k. Harvard School of Public Health, Emergency Preparedness and Response Bureau Exercise Program, Strategies for First Receiver Decontamination, 2013;
- l. The Joint Commission's Hospital and Ambulatory Care Emergency Management Standards, EM 02.02.05 Element of Performance #5, 2014; and,
- m. Occupational Safety and Health Administration; Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances; 2005.

FRDP CAPABILITY AGREEMENTS

1. “Memoranda of Agreement/Understanding” (MOA/MOU). While MOAs/MOUs are useful in defining the relationship between the two parties, a contractual agreement must also exist between the VA medical center and any commercial and/or governmental entities (affiliated or non-affiliated) in order to pay for the patient decontamination health-care services/resources rendered.

2. Type of Agreement. Determining the type of agreement depends upon three factors: the entity with whom VA medical facility is developing the agreement; the statutory authority used to make such an arrangement; and, the particular document that is used for such an arrangement.

Agreement between	Legal authority	Type of Document
a. Between VA and the Department of Defense (DoD)	38 U.S.C. 8111	VA Form 10-1245c
b. Between VA and another non-DoD Federal agency	31 U.S.C. 1535	VA Form 2269, FMS 7600, Inter-Agency Agreement
c. Between VA and any health care provider or other entity or individual (e.g. health care affiliate, local fire department, local business)	38 U.S.C. 8153	Health-care resources sharing agreement.

3. Review. General terms & conditions, including, but not limited to, a period of performance, reimbursement, performance requirements and liability matters should be included in the agreement. VA should consult Regional Counsel before entering into any agreement to verify legal sufficiency of the appropriate authority and type of agreement.

4. Performance Requirements. The performance requirements for an operational FRDP capability are defined as including:

a. Trained personnel and the equipment and supplies necessary specific to First Receivers to manage ambulatory, non-ambulatory and special needs patients seeking care must be on-site and/or available within 15 minutes from notification, twenty-four hours a day, seven days a week, and 365 days a year.

b. The notification and activation procedures for the FRDP capability must be defined within the VA medical facility’s patient decontamination plan and/or Emergency Operations Plan.

c. Procedures for notification and activation of the FRDP capability must be communicated to VAMC staff who responsible for the activation on an annual basis.

d. An exercise involving all aspects of the FRDP capability is conducted annually with documentation of the First Receivers' ability to perform emergency triage and basic medical care within the decontamination zone; and, documentation of First Receivers meeting minimum 29 CFR 1910.120, HAZWOPER First Responder Operations Level training requirements.