



PREPARE.
PROTECT.
RESPOND.

FIRST RECEIVER FUNDAMENTALS

A Practical Introduction for
Healthcare Personnel



RECOGNIZE
THE THREAT



IMPLEMENT
PROTOCOLS



ENSURE SAFETY
& DECONTAMINATION



PROTECT PATIENTS.
PROTECT EACH OTHER.



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CHAPTER 1

Foundations of First Receiver Operations

Understanding the role, risks, and
core mission of hospital-based
first receivers.



FIRST RECEIVER FUNDAMENTALS

A Practical Introduction for Healthcare Personnel

Understanding Hospital Preparedness for Contaminated Patients

Ready Response Training, LLC

About This Guide

Hospitals are designed to care for the sick and injured. They are not designed to become hazardous materials incident sites.

Yet during a chemical release, industrial accident, transportation incident, intentional act, or other hazardous-materials emergency, contaminated patients may arrive at a healthcare facility with little or no warning.

Some may arrive by ambulance after being identified and decontaminated by emergency responders.

Others may not.

They may walk through the Emergency Department entrance, arrive in private vehicles, or be transported by coworkers, family members, law enforcement, or other members of the public.

When that occurs, healthcare personnel may suddenly become **First Receivers**.

The purpose of this guide is to introduce healthcare personnel, emergency managers, safety officers, clinical leaders, administrators, security personnel, and members of hospital decontamination teams to the fundamental concepts of hospital-based First Receiver operations.

This guide focuses on a simple objective:

Protect the hospital. Protect the staff. Decontaminate the patient. Support medical care.

WHAT IS A FIRST RECEIVER?

The terms **First Responder** and **First Receiver** are sometimes used interchangeably, but they describe very different operational environments.

First Responders

First responders generally respond **to the location where an emergency occurred**.

Examples include:

- Firefighters
- Hazardous materials teams
- Emergency Medical Services
- Law enforcement
- Specialized response teams

Depending upon their role, responders may enter contaminated environments, establish control zones, identify hazardous substances, perform rescue, control releases, and conduct field decontamination.

First Receivers

First receivers are hospital-based personnel who receive and provide care for potentially contaminated patients arriving from a hazardous-materials incident.

OSHA describes first receivers as hospital personnel involved in functions such as triage, decontamination, medical treatment, and security when receiving contaminated victims.

Potential First Receivers may therefore include:

- Emergency Department nurses
- Physicians
- Patient care technicians
- Hospital decontamination team members
- Security personnel
- Emergency management staff
- Safety personnel
- Respiratory therapists
- Facilities personnel
- Registration staff
- Support personnel

Not every hospital employee needs the same level of First Receiver training.

Training should be based on the employee's expected responsibilities under the hospital's Emergency Operations Plan and hazardous-materials response procedures.

THE FIRST RECEIVER PROBLEM

Consider the following situation.

At 10:15 a.m., an industrial facility several miles from a hospital experiences an accidental chemical release.

Fire and hazardous-materials personnel respond to the facility.

Employees begin evacuating.

Some remain at the scene and are evaluated by emergency responders.

Others leave before responders arrive.

Three employees begin experiencing burning eyes, coughing, nausea, and difficulty breathing.

A coworker places them into a personal vehicle and drives directly to the nearest Emergency Department.

At 10:28 a.m., the vehicle pulls into the hospital ambulance entrance.

No warning has been provided to the hospital.

The occupants may still have chemical contamination on their:

- Clothing
- Shoes
- Hair
- Skin
- Personal belongings

If these individuals immediately enter the Emergency Department, contamination could potentially spread to staff, patients, equipment, treatment rooms, hallways, and other hospital areas.

This is the challenge First Receiver programs are designed to address.

OSHA specifically recognizes the potential for healthcare personnel to be exposed while receiving contaminated victims and recommends that hospitals incorporate employee protection, training, PPE, decontamination, and emergency planning into their preparedness programs.

SECONDARY CONTAMINATION

One of the most important concepts in First Receiver operations is **secondary contamination**.

Secondary contamination occurs when hazardous material carried by a contaminated person or object is transferred to another individual, surface, or area.

A contaminated patient could potentially contaminate:

- Healthcare personnel
- Stretchers
- Wheelchairs
- Ambulance entrances
- Emergency Department treatment rooms
- Waiting areas
- Floors
- Medical equipment
- Other patients
- Hospital vehicles
- Patient belongings

This is why early recognition and contamination control are so important.

Hospital emergency departments must plan for employees who may encounter contaminated patients, and OSHA identifies appropriate PPE and training as important protections for personnel involved in these incidents.

The goal is not simply to clean the patient.

The larger goal is to prevent the patient's contamination from becoming **the hospital's contamination**.

HOW CONTAMINATED PATIENTS MAY ARRIVE

Hospitals should prepare for at least two general types of patient arrival.

Controlled Arrival

A controlled arrival occurs when emergency responders or another agency communicates with the hospital before the patient arrives.

The hospital may receive information about:

- The incident
- Hazard involved
- Number of patients
- Patient conditions
- Decontamination performed
- Estimated arrival times

This gives the hospital valuable time to prepare.

Uncontrolled Arrival

An uncontrolled arrival occurs when contaminated or potentially contaminated patients arrive without meaningful warning.

Patients may arrive by:

- Private automobile
- Taxi
- Rideshare
- Police vehicle
- Employer vehicle
- Family transportation
- Walking into the Emergency Department

These situations can be particularly challenging because the first indication of a hazardous-materials incident may be a patient standing at the hospital entrance.

A strong First Receiver program prepares for **both** possibilities.



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CHAPTER 2

RECOGNITION AND INITIAL ACTIONS

Recognizing contaminated patients
and managing the first critical minutes.



RECOGNIZING A POSSIBLE CONTAMINATION EVENT

Hospital personnel cannot protect themselves from a hazard they do not recognize.

Staff working near Emergency Department entrances, ambulance receiving areas, security checkpoints, and registration areas should understand basic warning signs.

Possible indicators include:

- Multiple patients arriving from the same location
- Several people experiencing similar unexplained symptoms
- Chemical odors
- Wet or stained clothing
- Visible powders, liquids, or residues
- Patients reporting a spill or chemical release
- Patients reporting exposure at an industrial facility
- Patients arriving directly from an agricultural incident
- Eye or respiratory irritation among several people
- Unusual burns
- Patients reporting exposure to pesticides or industrial chemicals
- Information from EMS, fire, law enforcement, public health, or emergency management

Recognition does not require hospital personnel to identify the exact chemical.

The immediate question is:

Could this patient present a contamination hazard to other people or the hospital?

If the answer may be yes, personnel should follow the hospital's established procedures.

THE FIRST FEW MINUTES MATTER

A hospital's initial actions can influence the entire course of the incident.

Important early priorities generally include:

1. Recognize the possibility of contamination.
2. Avoid unnecessary contact.
3. Prevent uncontrolled entry into clean hospital areas when medically appropriate.
4. Notify the appropriate hospital leadership.

5. Activate appropriate emergency procedures.
6. Establish contamination-control areas.
7. Deploy trained personnel with appropriate PPE.
8. Determine immediate life threats.
9. Begin appropriate decontamination.
10. Maintain communication with responding agencies and Hospital Incident Command.

The objective is to create an organized response rather than allowing the contaminated patient to dictate where the incident occurs.



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CHAPTER 3

ROLES, TRAINING, AND PPE

Defining responsibilities,
required competencies,
and protective equipment.



FIRST RECEIVER OPERATIONS AND HAZWOPER

Hospital First Receiver programs frequently intersect with OSHA's **Hazardous Waste Operations and Emergency Response standard**, commonly called **HAZWOPER**, found at 29 CFR 1910.120.

Under OSHA requirements, employees performing certain emergency-response activities involving hazardous substances require training appropriate to their assigned duties.

Hospital employees who are expected to perform decontamination may require competencies associated with the **First Responder Operations Level**.

OSHA has stated that hospital-based personnel performing victim decontamination must have appropriate Operations-level competencies and has discussed a minimum of eight hours of training or sufficient experience to objectively demonstrate those competencies.

The important concept for hospital leadership is:

Training should match the job employees are expected to perform during the emergency.

A hospital employee who simply recognizes a potentially contaminated patient and initiates notification procedures does not necessarily perform the same duties as a member of the hospital decontamination team.

Hospitals should therefore clearly define roles before developing training requirements.

AWARENESS-LEVEL FUNCTIONS

Some healthcare personnel may only be expected to:

- Recognize that a hazardous-materials emergency may exist.
- Identify a potentially contaminated patient.
- Protect themselves from unnecessary exposure.
- Keep others away from a suspected contamination area.
- Initiate hospital notifications.
- Contact trained personnel.
- Follow the hospital emergency plan.

These employees should not independently perform tasks outside their assigned level of training.

Knowing **what not to do** is an important part of First Receiver preparedness.

OPERATIONS-LEVEL FUNCTIONS

Hospital personnel assigned to actively perform patient decontamination have a more advanced role.

Their responsibilities may include:

- Wearing chemical-protective PPE.
- Establishing a hospital decontamination area.
- Maintaining contamination-control zones.
- Assisting patients with clothing removal.
- Conducting ambulatory decontamination.
- Conducting non-ambulatory decontamination.
- Controlling contaminated clothing and property.
- Supporting patient movement.
- Preventing cross-contamination.
- Performing responder decontamination.
- Properly removing PPE.
- Working within the hospital's emergency-response organization.

OSHA indicates that employees performing basic decontamination activities during a hazardous-substance emergency generally require First Responder Operations-level preparation appropriate to those functions.

These responsibilities require both knowledge and **hands-on practice**.

A PowerPoint presentation alone does not prepare someone to safely function while wearing PPE, moving a non-ambulatory patient, operating a decontamination system, and communicating with team members.

PERSONAL PROTECTIVE EQUIPMENT

PPE is one of the most visible components of a hospital First Receiver program, but simply purchasing protective equipment does not make a hospital prepared.

The organization must determine:

- What hazards employees could reasonably encounter.
- What tasks employees will perform.

- What level of protection those tasks require.
- Whether employees can safely use the equipment.
- How the equipment will be stored and maintained.
- How employees will be trained.
- How damaged or expired equipment will be replaced.

Potential First Receiver PPE may include:

- Chemical-resistant protective clothing
- Chemical-resistant gloves
- Protective footwear
- Respiratory protection
- Eye and face protection
- Head protection
- Other task-specific equipment

OSHA's First Receiver guidance discusses PPE selection as part of a broader hazard assessment and emergency-planning process rather than treating one ensemble as appropriate for every circumstance.

PPE should therefore be selected according to the hospital's hazard assessment, response mission, respiratory-protection program, manufacturer instructions, applicable regulations, and organizational procedures.

RESPIRATORY PROTECTION

Respiratory protection is a critical First Receiver consideration.

A hospital cannot simply purchase respirators, place them in a storage room, and assume personnel are protected.

Where respirators are required, the hospital's respiratory-protection program must address applicable regulatory requirements and safe use.

Depending upon the equipment and circumstances, considerations may include:

- Medical evaluation
- Training
- Fit testing
- Inspection
- Maintenance
- Cleaning

- Storage
- Cartridge or filter selection
- Limitations of the respirator
- Procedures for proper donning and doffing

Personnel must also understand that respiratory protection has limitations.

First Receiver PPE does not transform a hospital decontamination team into a hazardous-materials entry team.



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CHAPTER 4

DECONTAMINATION OPERATIONS



Organizing zones, patient flow,
and practical decontamination
procedures.



THE HOSPITAL DECONTAMINATION AREA

Hospital decontamination should take place in an area designed to minimize the spread of contamination.

The exact configuration depends upon the hospital.

Possible locations include:

- Permanent exterior decontamination stations
- Portable decontamination tents
- Dedicated decontamination rooms
- Covered exterior areas
- Trailer-based systems
- Other preplanned locations

The system should support controlled movement from a contaminated area toward a clean treatment area.

A basic concept is:

Contaminated → Decontamination → Clean

The facility should consider:

- Patient entry
- Patient exit
- Staff entry
- Staff exit
- Ambulatory patients
- Non-ambulatory patients
- Privacy
- Security
- Water
- Lighting
- Temperature
- Communications
- Equipment
- Contaminated clothing
- Patient property
- Wastewater
- Responder rehabilitation
- Clean medical treatment areas

The first time these issues are considered should not be when contaminated patients are standing outside the Emergency Department.

CONTAMINATION-CONTROL ZONES

Many hospital decontamination programs use operational zones to help control movement.

Terminology varies, but the general concepts are:

Hot Zone - Contaminated Zone

The area where contaminated patients and appropriately protected personnel may operate.

Access should be controlled.

Warm Zone - Contamination-Reduction Area

The transition area where decontamination activities occur and contamination is progressively reduced.

Cold Zone - Clean Area

The area beyond the contamination-control boundary where personnel and patients should no longer pose an unacceptable contamination hazard under the hospital's procedures.

The exact terminology is less important than establishing clear boundaries and controlling movement.

PATIENT CLOTHING REMOVAL

Removing contaminated clothing can be one of the fastest and most effective initial decontamination measures for many external contamination events.

However, the amount of contamination removed varies depending upon:

- Chemical involved
- Physical form
- Where contamination is located
- Type of clothing

- Duration of exposure
- Movement of the patient
- Whether contamination has penetrated clothing

Clothing removal must therefore be considered part of an overall decontamination process rather than a universal guarantee that a patient is completely clean.

Hospitals should also plan for:

- Privacy
 - Modesty
 - Replacement garments
 - Evidence preservation
 - Personal property
 - Bagging and labeling
 - Special populations
 - Weather conditions
 - Security
-

DRY DECONTAMINATION

Not every contamination incident automatically requires large quantities of water.

Dry decontamination techniques may be appropriate in some situations.

These techniques can include carefully removing contaminated clothing and using appropriate materials or procedures to remove contamination from the skin without immediately using water.

The decision to use dry or wet decontamination should be based on the contaminant, clinical condition, available information, hospital procedures, and guidance from appropriate hazardous-materials or medical resources.

Hospitals should train personnel to follow established procedures rather than improvising based only on the appearance of the substance.

WET DECONTAMINATION

Wet decontamination generally involves flushing or washing contaminants from the patient.

Depending upon the situation, this may involve:

- Water
- Mild soap
- Hospital-approved decontamination procedures
- Specific treatment recommendations for the chemical involved

Personnel should avoid aggressive scrubbing that could injure the skin or increase absorption of some contaminants.

Water temperature and environmental conditions also matter.

Children, older adults, medically fragile individuals, and patients exposed during cold weather can be particularly vulnerable to hypothermia. CDC/ATSDR chemical-management guidance specifically notes the importance of preventing hypothermia during decontamination, especially among children and older adults.



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CHAPTER 5

PATIENT MANAGEMENT AND SPECIAL POPULATIONS

Caring for ambulatory,
non-ambulatory, and
vulnerable patient groups.



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AMBULATORY PATIENT DECONTAMINATION

Ambulatory patients can walk and generally follow instructions.

An organized ambulatory process may include:

1. Initial screening.
2. Explanation of the process.
3. Removal of contaminated belongings.
4. Removal and containment of clothing.
5. Decontamination according to hospital procedures.
6. Replacement clothing or covering.
7. Movement into an appropriate clean treatment area.
8. Medical reassessment.

Communication is critical.

Patients may be:

- Frightened
- Injured
- Confused
- Embarrassed
- Angry
- Uncooperative
- Experiencing chemical effects

Clear instructions and calm leadership can substantially improve patient flow.

NON-AMBULATORY PATIENT DECONTAMINATION

Non-ambulatory patients create additional challenges.

They may require:

- Stretchers
- Litter systems
- Multiple team members
- Airway support

- Spinal precautions when clinically indicated
- Medical monitoring
- Specialized movement techniques
- Additional personnel

Hospitals should practice moving patients through their actual decontamination systems while team members are wearing PPE.

Equipment that appears easy to operate during normal conditions may become significantly more difficult when personnel are wearing protective clothing, gloves, boots, and respiratory protection.

Research involving First Receiver protective ensembles has demonstrated that PPE can affect range of motion and postural stability.

That makes hands-on training especially important.

LIFE-THREATENING MEDICAL CONDITIONS

Decontamination and medical care should not be viewed as competing missions.

The objective is to protect healthcare personnel while ensuring that patients receive medically appropriate care.

Certain lifesaving interventions may need to occur during the decontamination process.

For example, personnel may need to address:

- Airway compromise
- Respiratory failure
- Severe bleeding
- Cardiac arrest
- Shock
- Seizures
- Other immediate threats to life

CDC guidance addressing contaminated casualties similarly emphasizes that life-threatening conditions may require stabilization before completion of decontamination.

Hospitals should plan ahead for how emergency interventions will be delivered inside or immediately adjacent to the decontamination operation.

SPECIAL POPULATIONS

A hospital decontamination plan must work for more than healthy adults.

Patients may include:

- Infants
- Children
- Older adults
- Pregnant patients
- Patients with mobility limitations
- Patients with developmental disabilities
- Patients with cognitive impairment
- Patients who do not speak English
- Patients with service animals
- Patients with visual or hearing impairments
- Bariatric patients
- Patients using medical equipment

These patients may require additional personnel, time, equipment, privacy, assistance, or modifications to the normal decontamination process.

Planning for special populations **before the incident** is much easier than improvising during one.



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CHAPTER 6

COMMAND, SECURITY, AND COMMUNICATION

Coordinating leadership, access control,
and information flow during an incident.



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HOSPITAL INCIDENT COMMAND

A significant contamination event can quickly exceed the ability of an Emergency Department to manage the incident independently.

Hospital Incident Command may be required to coordinate:

- Clinical operations
- Decontamination
- Security
- Staffing
- Logistics
- Facilities
- Communications
- Patient tracking
- Public information
- Safety
- Supplies
- Mutual aid
- Regulatory coordination
- Recovery operations

One of the major responsibilities of the decontamination team is to operate as part of the larger hospital response rather than functioning as an isolated group.

The Decontamination Team Leader should have a clearly defined reporting relationship within the hospital's incident-management structure.

SECURITY AND ACCESS CONTROL

Security has an important First Receiver role.

A contaminated patient who walks around a decontamination area and enters the hospital through another door defeats the purpose of the contamination-control system.

Security personnel may assist with:

- Establishing perimeters
- Directing arriving vehicles
- Restricting access
- Redirecting pedestrian traffic

- Controlling hospital entrances
- Maintaining patient flow
- Protecting patient privacy
- Supporting evidence preservation
- Managing family members or bystanders
- Coordinating with law enforcement

Security personnel who may enter contaminated areas need training and PPE appropriate to their expected duties.

COMMUNICATION

Communication problems can rapidly disrupt a decontamination operation.

PPE, respiratory protection, running water, distance, walls, vehicle noise, frightened patients, and multiple agencies can make normal communication difficult.

Hospitals should determine in advance how decontamination personnel will communicate.

Options may include:

- Radios
- Headsets
- Hand signals
- Whiteboards
- Runners
- Waterproof communication devices
- Pre-established terminology

Hospitals should test communication systems while the team is actually wearing PPE.

A radio that works perfectly in the Emergency Department may be difficult to hear or operate while wearing chemical-resistant gloves and protective equipment.



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CHAPTER 7

Team Safety, Recovery, and Program Sustainment

Protecting staff, closing the incident,
and maintaining operational readiness.



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DONNING AND DOFFING

Putting PPE on correctly is important.

Taking it off correctly may be even more important.

Improper PPE removal can transfer contamination from the outside of protective equipment to:

- Skin
- Clothing
- Face
- Hands
- Respiratory equipment
- Clean areas

Hospitals should establish a controlled process for PPE removal.

Whenever feasible, a trained observer or partner can help ensure procedures are followed correctly.

Employees should understand:

- The proper removal sequence
- Where equipment is placed
- How reusable equipment is handled
- How disposable materials are contained
- When hand hygiene occurs
- What to do if contamination is suspected during doffing

These procedures require practice.

TEAM SAFETY

Patient care is important.

So is responder safety.

A hospital cannot afford to create additional patients by injuring its decontamination team.

Potential hazards include:

- Chemical exposure
- Heat stress

- Cold stress
- Slips and falls
- Fatigue
- Reduced visibility
- Restricted movement
- Respiratory burden
- Lifting injuries
- Dehydration
- Psychological stress

Team leaders should continually assess personnel condition and rotate staff when necessary.

CONTAMINATED PERSONAL PROPERTY

Hospitals need procedures for managing contaminated:

- Clothing
- Wallets
- Purses
- Phones
- Jewelry
- Keys
- Identification
- Medical devices
- Other belongings

Simply placing contaminated belongings in a bag does not automatically eliminate the hazard.

Procedures should address:

- Containment
- Labeling
- Tracking
- Storage
- Evidence considerations
- Transfer
- Disposal when appropriate

- Return to the patient when appropriate

Documentation becomes particularly important when valuable property or law-enforcement evidence is involved.

DECONTAMINATION DOES NOT END WITH THE PATIENT

When the last patient leaves the decontamination line, the operation is not automatically over.

The hospital may still need to address:

- Decontamination of team members
- PPE removal
- Equipment cleaning
- Facility restoration
- Waste management
- Contaminated supplies
- Personnel monitoring
- Documentation
- Staff rehabilitation
- Replacement of supplies
- Equipment inspection
- Operational debriefing

The goal is to safely return the hospital to normal operations.

TRAINING THE TEAM

Effective First Receiver training should combine classroom education with practical experience.

Personnel should understand:

- Hazard recognition
- Roles and responsibilities
- Hospital emergency procedures

- Contamination control
- PPE
- Respiratory protection
- Decontamination procedures
- Patient movement
- Special populations
- Communications
- Safety
- Emergency procedures
- Donning and doffing

OSHA emphasizes training appropriate to workers' expected emergency-response duties and recognizes specific competencies for Operations-level responders.

Training should ultimately answer one question:

Can this employee safely perform the job the hospital expects them to perform during an actual contamination emergency?

EXERCISES: WHERE PLANS BECOME REALITY

A written plan may appear excellent until people attempt to use it.

Exercises help hospitals discover problems before an actual emergency.

Useful exercises can test:

Activation

How quickly can the team assemble?

Equipment

Can personnel locate and deploy the equipment?

PPE

Can personnel correctly don and doff PPE?

Decontamination System

Can the system actually be assembled and operated?

Patient Movement

Can personnel safely move ambulatory and non-ambulatory patients?

Communication

Can team members communicate while wearing PPE?

Security

Can contaminated and clean areas be effectively controlled?

Special Populations

Can the hospital safely manage children, older adults, mobility-impaired patients, or other populations?

Command

Can the team communicate effectively with Hospital Incident Command?

Sustainability

Can operations continue if the incident lasts several hours?

Every meaningful exercise should identify strengths, weaknesses, and corrective actions.



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CHAPTER 8

SELF-ASSESSMENT AND NEXT STEPS

Evaluating readiness and identifying opportunities for improvement and training.



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TEN QUESTIONS EVERY HOSPITAL SHOULD BE ABLE TO ANSWER

Hospital leadership should be able to answer these questions before an incident occurs:

- 1. Who can activate our decontamination team?**
- 2. How are team members notified?**
- 3. Where will contaminated patients go when they arrive?**
- 4. How do we prevent those patients from entering clean hospital areas?**
- 5. What PPE will our personnel wear?**
- 6. Which employees are trained to perform decontamination?**
- 7. Can we decontaminate a non-ambulatory patient?**
- 8. Can our team communicate effectively while wearing PPE?**
- 9. How long can we sustain operations?**
- 10. When did we last exercise the entire system?**

If these questions cannot be answered quickly and confidently, the First Receiver program deserves additional attention.

COMMON FIRST RECEIVER PROGRAM WEAKNESSES

Hospitals often discover similar problems during training and exercises.

Examples include:

- PPE exists but staff are unfamiliar with it.
- Decontamination equipment has not recently been deployed.
- Respirators have not been integrated into realistic exercises.
- Employees do not know who activates the team.
- Security procedures are unclear.
- Non-ambulatory patient movement has not been practiced.
- Communication systems do not work well in PPE.
- Contaminated-property procedures are undefined.

- Replacement clothing is unavailable.
- Team members do not understand contamination-control zones.
- Equipment is stored in multiple locations.
- Team rosters are outdated.
- Night-shift capability differs significantly from day shift.
- Plans describe capabilities the hospital cannot actually perform.

These are exactly the types of issues exercises are intended to reveal.

Finding a problem during an exercise is not a failure.

Finding it during the real incident is.

BUILDING AN EFFECTIVE FIRST RECEIVER PROGRAM

A sustainable hospital First Receiver program should include several interconnected elements:

Hazard Assessment

Understand the hazardous-materials risks within the hospital's community.

Emergency Planning

Define how the hospital will respond to contaminated patients.

Personnel

Identify who performs each function.

Training

Prepare employees for their assigned duties.

PPE

Provide protection appropriate to expected hazards and tasks.

Equipment

Maintain the systems necessary to perform patient decontamination.

Command and Control

Integrate decontamination operations into the hospital's incident-management structure.

Exercises

Regularly test plans, personnel, and equipment.

Evaluation

Document strengths and opportunities for improvement.

Corrective Action

Fix identified deficiencies and then test the system again.

Preparedness is therefore not a one-time training class.

It is a continuous process.

THE FIRST RECEIVER MINDSET

First Receiver preparedness does not require every hospital employee to become a hazardous-materials technician.

It requires the hospital to understand its mission.

Hospital personnel generally are not being asked to enter the hazardous-materials release site.

Instead, their challenge is to safely receive the consequences of that incident when they arrive at the hospital.

That distinction is important.

An effective First Receiver program teaches employees to:

Recognize the hazard.

Protect themselves.

Control contamination.

Decontaminate appropriately.

Support lifesaving medical care.

Protect the hospital's ability to continue operating.

CONCLUSION

Hazardous-materials emergencies are low-frequency but potentially high-consequence events for healthcare facilities.

A single contaminated patient who enters the wrong doorway can create consequences far beyond the original patient's medical condition.

Hospitals therefore need more than decontamination equipment.

They need trained people.

They need practiced procedures.

They need clearly defined responsibilities.

They need leadership.

And they need a system capable of moving from normal hospital operations to contamination control quickly and safely.

A successful First Receiver program ultimately protects three things:

THE PATIENT

Provide timely and appropriate care while removing contamination.

THE STAFF

Prevent unnecessary exposure of healthcare personnel.

THE HOSPITAL

Prevent contamination from disrupting the facility's ability to continue caring for the community.

FIRST RECEIVER READINESS SELF-ASSESSMENT

Use the following questions as a quick assessment of your organization's preparedness.

- ☐ Our hospital has a written procedure for receiving contaminated patients.
- ☐ Employees know how to recognize a potential contamination event.
- ☐ Staff know who to contact when a potentially contaminated patient arrives.
- ☐ The hospital has identified personnel responsible for patient decontamination.
- ☐ Decontamination personnel have training appropriate to their assigned responsibilities.
- ☐ Required PPE is available and accessible.
- ☐ Personnel have practiced donning and doffing PPE.
- ☐ Respiratory protection requirements have been addressed.
- ☐ The hospital has a designated decontamination location.
- ☐ Contaminated and clean areas can be physically controlled.
- ☐ Security understands its role.
- ☐ Ambulatory decontamination has been practiced.
- ☐ Non-ambulatory decontamination has been practiced.
- ☐ Procedures address children and other special populations.
- ☐ Procedures address patient clothing and personal property.
- ☐ Staff can communicate effectively while wearing PPE.
- ☐ Decontamination operations are integrated with Hospital Incident Command.
- ☐ Procedures address staff rehabilitation and rotation.
- ☐ Procedures address termination and recovery.
- ☐ The hospital conducts periodic decontamination exercises.
- ☐ Exercise deficiencies are documented and corrected.

How did your organization score?

17–20 checked:

Your organization appears to have many important elements of a First Receiver program in place. Continue exercising and evaluating the system.

12–16 checked:

Several important elements exist, but additional planning, training, or exercising may be beneficial.

6–11 checked:

Significant preparedness gaps may exist and should be evaluated.

0–5 checked:

A structured review of the organization's First Receiver program should be considered a priority.

This checklist is an educational self-assessment and is not a regulatory compliance determination.

TAKE THE NEXT STEP

Knowing the fundamentals is only the beginning.

First Receiver personnel need the knowledge, hands-on skills, leadership, and confidence necessary to operate safely when a contaminated patient arrives.

Ready Response Training, LLC provides practical, real-world training designed around the challenges healthcare organizations may actually encounter.

Available services can include:

- Hospital First Receiver Training
- Hospital Decontamination Team Training
- Decontamination Team Leader Training
- Hospital Incident Command Training
- Hazardous Materials Training
- Decontamination Program Development
- Emergency Operations Plan Review
- Decontamination Plan Review and Development
- Equipment and Capability Assessments
- Tabletop Exercises
- Functional Exercises
- Full-Scale Exercises
- HSEEP-Based Exercise Development
- After-Action Reports and Improvement Planning
- Customized Hospital Emergency Preparedness Training

Is Your Hospital Ready?

A plan on paper is only the beginning.

Train the team. Test the system. Protect the hospital.

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Real-world experience. Practical training. Prepared organizations.

IMPORTANT NOTICE

This publication is intended for general educational and preparedness purposes. It does not constitute legal, regulatory, medical, occupational-health, or compliance advice and is not a substitute for facility-specific hazard assessment, policies, required employee training, respiratory-protection requirements, manufacturer's instructions, or consultation with appropriate regulatory and technical professionals.

Organizations should evaluate applicable federal, state, and local requirements and develop procedures appropriate to their hazards, personnel, equipment, and expected response functions.

Key Professional References

Occupational Safety and Health Administration (OSHA)

29 CFR 1910.120 — Hazardous Waste Operations and Emergency Response (HAZWOPER).

Occupational Safety and Health Administration

Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances. OSHA's guidance addresses hospital emergency planning, employee training, PPE, victim decontamination, and protection of healthcare personnel.

Occupational Safety and Health Administration

Hospital Emergency Department — Mass Casualty Incidents guidance.

Centers for Disease Control and Prevention / Federal Emergency Preparedness Resources

Evidence-based patient-decontamination guidance emphasizes rapidly ending exposure, providing medical treatment, protecting responders and receivers, and incorporating behavioral-health considerations.