

# Classification de l'ESCRIM

## Élément de sécurité civile rapide d'intervention médicale



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# Histoire

1985: tremblement de terre de Mexico, renfort DICA BMPM

1988: Tremblement de terre en Arménie: détachement d'appui médical DAM (UIISC + SP)



## Actions limitées par le réseau de soins secondaires défaillant



Médecins chefs du SDIS du GARD et de l'UIISC-7 créent l'ESCRIM:

- « Chirurgicalisation » du DAM du SDIS → création du DAC
- Le DAM de l'U7 est complété par une capacité d'hospitalisation → DAMHo

**1<sup>er</sup> déploiement du DAC + DAMHo en 1992 lors du séisme en Turquie**



Mexico – 1985 – Earthq.

Arménie – 1988 – Earthq.

Iran – 1990 – Earthq.

Népal – 1991 - Earthq.

Turquie – 1992 – Earthq.

Bakou – 1997 – Subway Fire

Brazzaville – 1997 – Civil war

Nairobi – 1998 – Terr. attacks

Haïti – 1998 – Typhoon

Kosovo – 1999 – Civil war

Turquie – 1999 – Earthq.

Algérie – 2003 – Earthq.

Iran – 2003 – Earthq.

Sumatra – 2004 – Tsunami

Indonésie – 2006 - Earthq.

Pérou – 2007 – Earthq.

Sri Lanka – 2009 – Civil war

Haïti – 2010 – Earthq.

Guadeloupe – 2017 – Hospit burn

Guyane - 2020 – covid 19

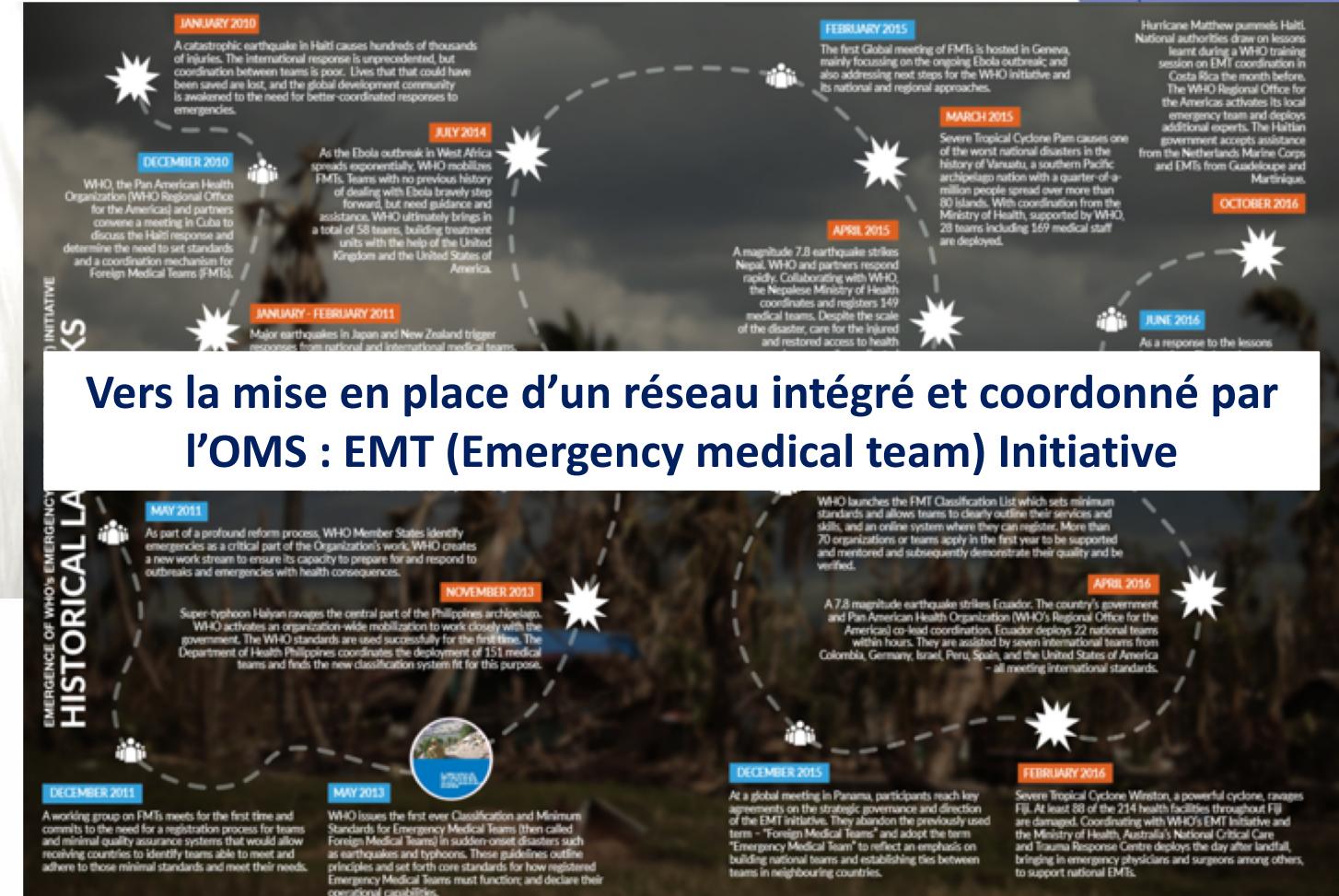
Mayotte – 2021 – covid 19



# Haiti 2010, un tournant



Prise de conscience politique



# Objectif OMS: constellation d'EMTs



Type 1  
Mobile



Type 1  
Fixed



Type 2  
Inpatient surgical  
emergency care



Type 3  
Inpatient referral  
care

Specialized care  
teams

50 patients/jr  
12h/jr  
15 jrs

100 patients/jr  
12h/jr  
15 jrs

>100 patients/jr  
1 BO  
> 20 lits d'hospit  
24h/jr  
3 semaines  
d'autonomie  
Obstétrique  
MPR

>100 patients/jr  
2 BO  
40-100 lits d'hospit  
ICU  
24h/jr  
4 semaines  
d'autonomie  
Obstétrique  
MPR



# Définition d'un cahier des charges

Première version en 2013:

Classification and minimum standards for foreign medical teams in sudden onset disasters

Version actuelle: Le Blue Book 2021



DIRECTION GÉNÉRALE DE LA SÉCURITÉ

**EMT toolkit**

The EMT toolkit is a resource designed to ensure that EMTs are well-trained and prepared to deploy to any disaster-prone setting, not only from a duty-of-care perspective, but also because supporting preparedness activities such as committing to training, helps to ensure a more successful and safe deployment. Building the capacity of EMTs to independently manage their own training framework for EMTs, as a whole, by providing training before any deployment, can assist and should be seen as good preparedness practice by EMTs and be considered an investment.

**Classification and Minimum Standards for Emergency Medical Teams**

**Toolkit: Initial Assessment & Training**

The deployment of any EMT unit should be considered once limited. Presently international EMTs, Type 1 & 2 will need to be able to deploy for a minimum period of three weeks and Type 3s will need a minimum deployment commitment of at least six weeks. The needs of the emergency translation from its current state to the initial phase, to the sub-acute and recovery phase, to the acute phase, to be able to appropriately flex and adapt, to be able to appropriately

**Extended Deployment**

Establishing what the minimum EMT can deploy and commit to planning activities. It is also an issue at the point of registration and/or deployment. Some shifts have deployment capability for up to months, but they have support staff or other-based systems in place. This will include administrative team rotation planning, i.e. the total deployment period.

**Handover Timeframe**

Any team to be considered for deployment will need to be able to commit to meeting the number of hours required for the handover period (Facilitated and supported) sanitization, power etc. If 24h, this should be during this time. This requires that the shift will replicate the needs impact that the shift will have on the section of training messages to train more effectively.

**Handover Orientation**

The previous time period will need to be able to facilitate and support the orientation of the team members to the new environment, including the clinical environment, the patients, the examples of it and efficient. Several EMTs that require managing some of the complex aspects.

**Interchangeable Triage System**

EMTs will need to manage, evaluate and prioritise during their deployment, helping to quickly identify and manage patients. Some teams have and developed clinical and referral pathways, which will help and the decision-making process. This is also considered a "Just-in-Time" skill.

**Registration**

Any triage system will require all information to be provided to their facility. EMTs can refer to their facility, which is to give to log their patients, which is to develop an electronic patient record system, but they are often required to manage a paper-based system. This is one of the fundamental skills that will become a key competency for EMTs. They will need to be able to demonstrate how they can manage these systems effectively.

**Toolbox: Training**

This is a report on the need that EMTs are well-trained and prepared to deploy to any disaster-prone setting, not only from a duty-of-care perspective, but also because supporting preparedness activities such as committing to training, helps to ensure a more successful and safe deployment. Building the capacity of EMTs to independently manage their own training framework for EMTs, as a whole, by providing training before any deployment, can assist and should be seen as good preparedness practice by EMTs and be considered an investment.

**Classification and Minimum Standards for Emergency Medical Teams**

**Toolbox: Training**

Currently there are multiple disaster education and training programs that are available globally, but most are centred around professional development of an individual, rather than a team as a whole. The WHO EMT initiative provides a core recommended training framework for EMTs, addressing this challenge by developing a core recommended training program. The recommended core training framework is a tool that EMTs can access to help them develop and take ownership of their own training framework, with support and guidance from their manager.

**INITIAL**

EMTs, in the past, were found to be ill prepared, a potential danger to themselves and their patients and on occasion resulted on occasion with the EMT becoming a burden to the emergency responder activities, which posed a challenge to the affected response agencies when resources were already committed to the disaster.

**KEY POINT**

Investing in training, preparation, activities for team members, will help to ensure a more successful and responsible deployment. Team members who are supported with their training needs are more likely to commit to multiple deployments.



# Définition d'un cahier des charges

## 6 guiding principles



### 01 **SAFE CARE**

Avoid unnecessary harm to patients from care that was supposed to help them.

### 02 **EQUITABLE CARE**

Care is equally accessible and provided to all sections of the population affected by the emergency, particularly the vulnerable and those requiring protection.

### 03 **ETHICAL CARE**

Patients are always cared for in a medically ethical manner and care is based on scientific evidence.

### 04 **ACCOUNTABLE RESPONSE**

Commitment to be accountable to patients and communities, the host governments, ministries of health, their organizations and donors.

### 05 **APPROPRIATE RESPONSE**

Needs driven response according to context and type of emergency, and respectful of community values and beliefs.

### 06 **COORDINATED RESPONSE**

Coordinated response under the national health emergency management authorities and across all levels of the health system to ensure continuity of care. Collaboration with the national health system, their fellow EMTs, and the international humanitarian response community where relevant.

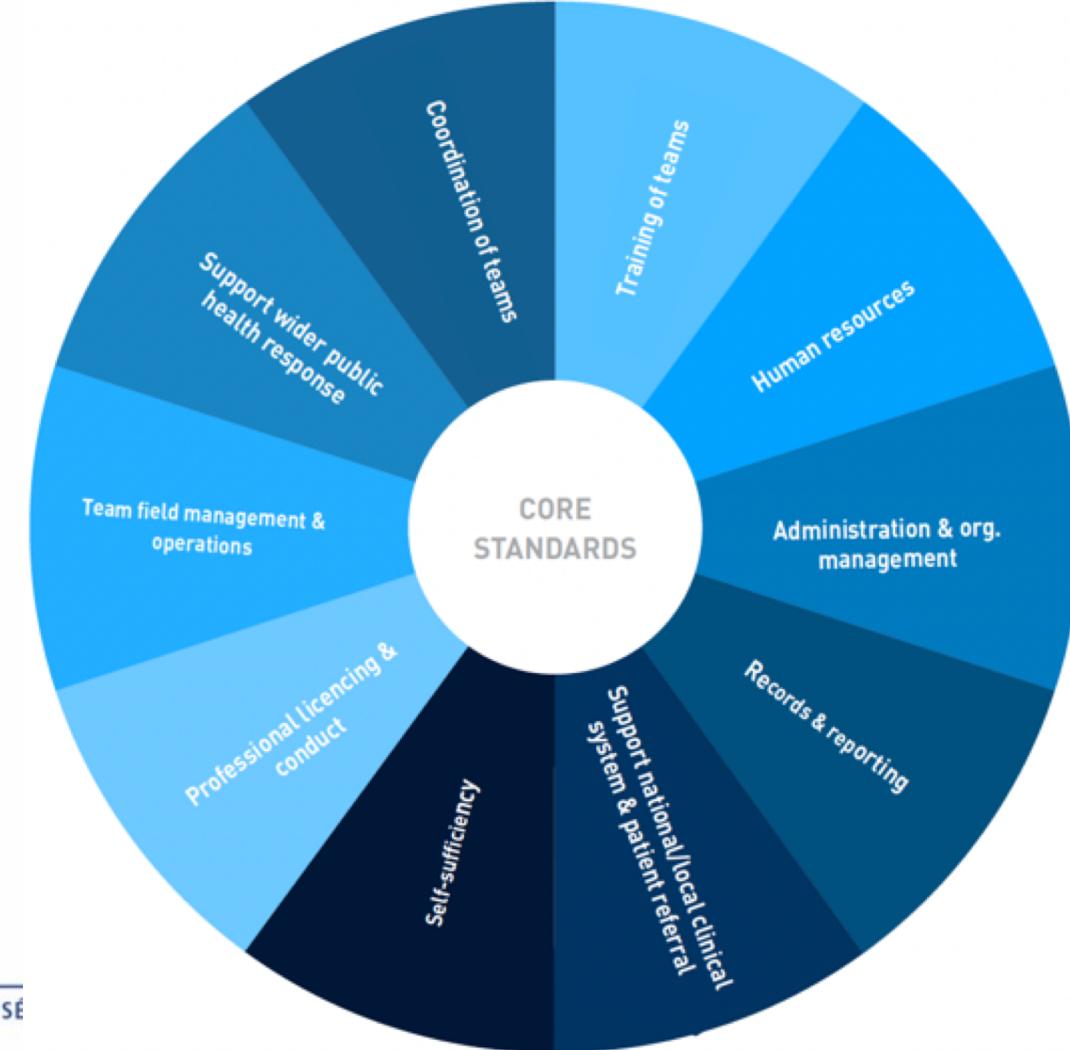


# Définition d'un cahier des charges

**10 Core standards**

## EMT CORE STANDARDS

EMT core standards set the direction for EMTs to deliver quality care and apply to all EMTs regardless of type.



# Définition d'un cahier des charges

## 27 Clinical standards

Triage	Spinal cord injuries	Surgery and perioperative	Medical imaging and reporting
Assessment, resuscitation and stabilizarion	Communicable disease	Malnutrition	Clinical pharmacy and consumables
Referral and transfers	Non communicable disease	Palliative care	Sterilization
Ward management	Reproductive, maternal and new-born health	Physiotherapy and rehabilitation	Infection, prevention and control
Wound care	Child health	Mental health and psychosocial well-being	Health promotion and community engagement
Burns	Analgesia and anesthesia	Blood transfusion services	CBRN, toxicology and toxinology
Fracture and limb injuries	Intensive care	Laboratory services	



# Définition d'un cahier des charges

## 13 Logistic standards

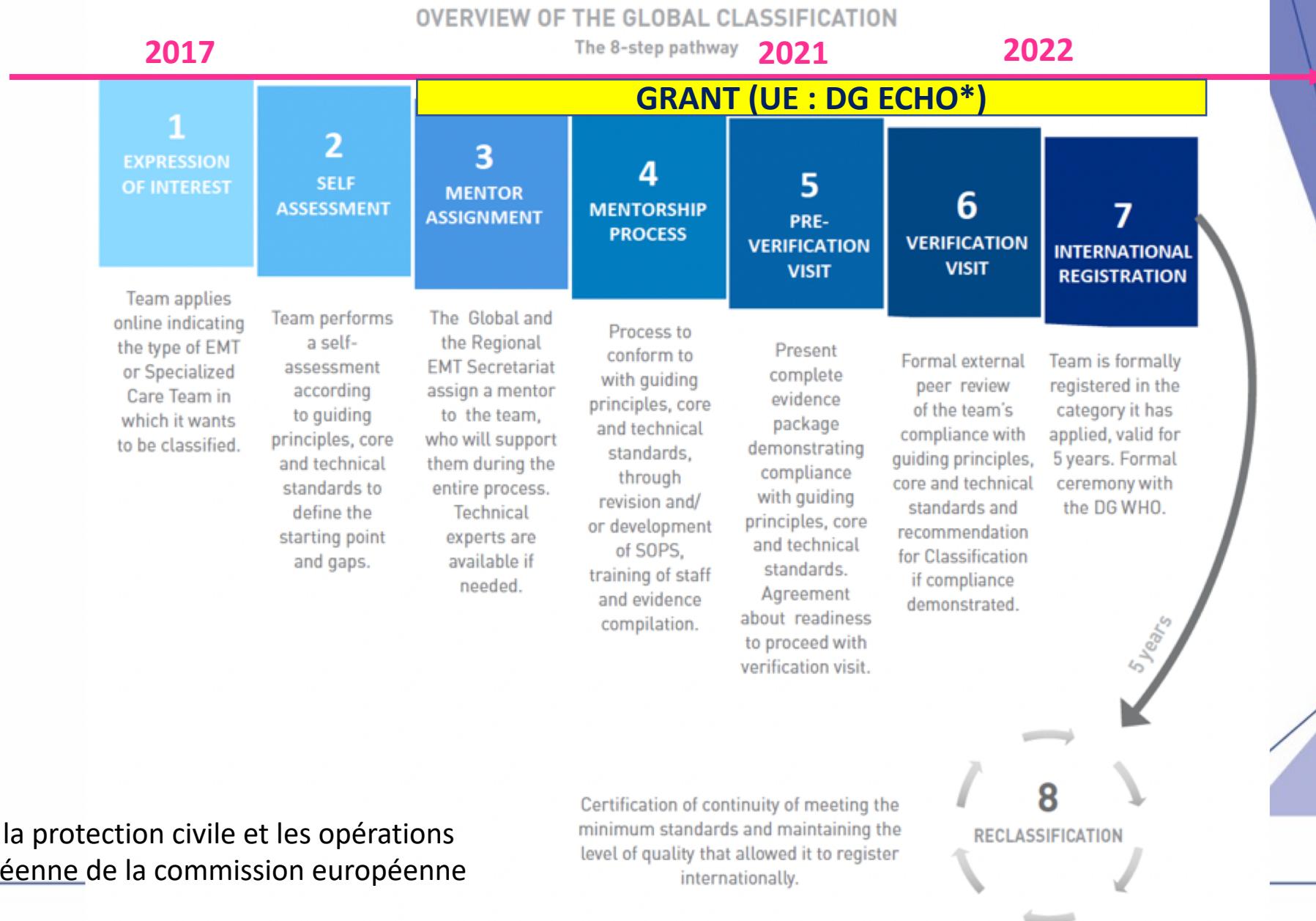
Power and fuel	Safety and security
Communications	Facility structure , environment and ventilation
Transportation and fleet	Mobilization
Food	Site assessment and planning
Warehouse management	Sequential build
Pharmacy supply and medical stock management	Demobilization
Donation management	

## 7 WASH standards

Water supply
Hygiene
Environmental cleaning
Health-care waste management
Sanitation
Vector and pest control
Dead body management



# La classification OMS, un processus long mais vertueux



# Être (classifié) ou mourir

Première équipe classifiée EMT1 (Fixe et Mobile) en 2016 = Japon

Première équipe classifiée EMT2: Fédération de Russie

Première équipe classifiée EMT3: Israël

**Nombre total d'EMT classifiées à ce jour: 34 (14 en Europe)**

Nombre d'EMT1 déjà classifiées: 17

Nombre d'EMT2 déjà classifiées: 13

Nombre d'EMT3 déjà classifiées: 2 (Israël, Chine)

Nombre d'équipes spécialisées: 3

**Nombre d'EMT en cours de classification ou entrain de rentrer dans le processus > 80**



# Pré-requis

## Demande d'aide d'un pays

### Aide bilatérale



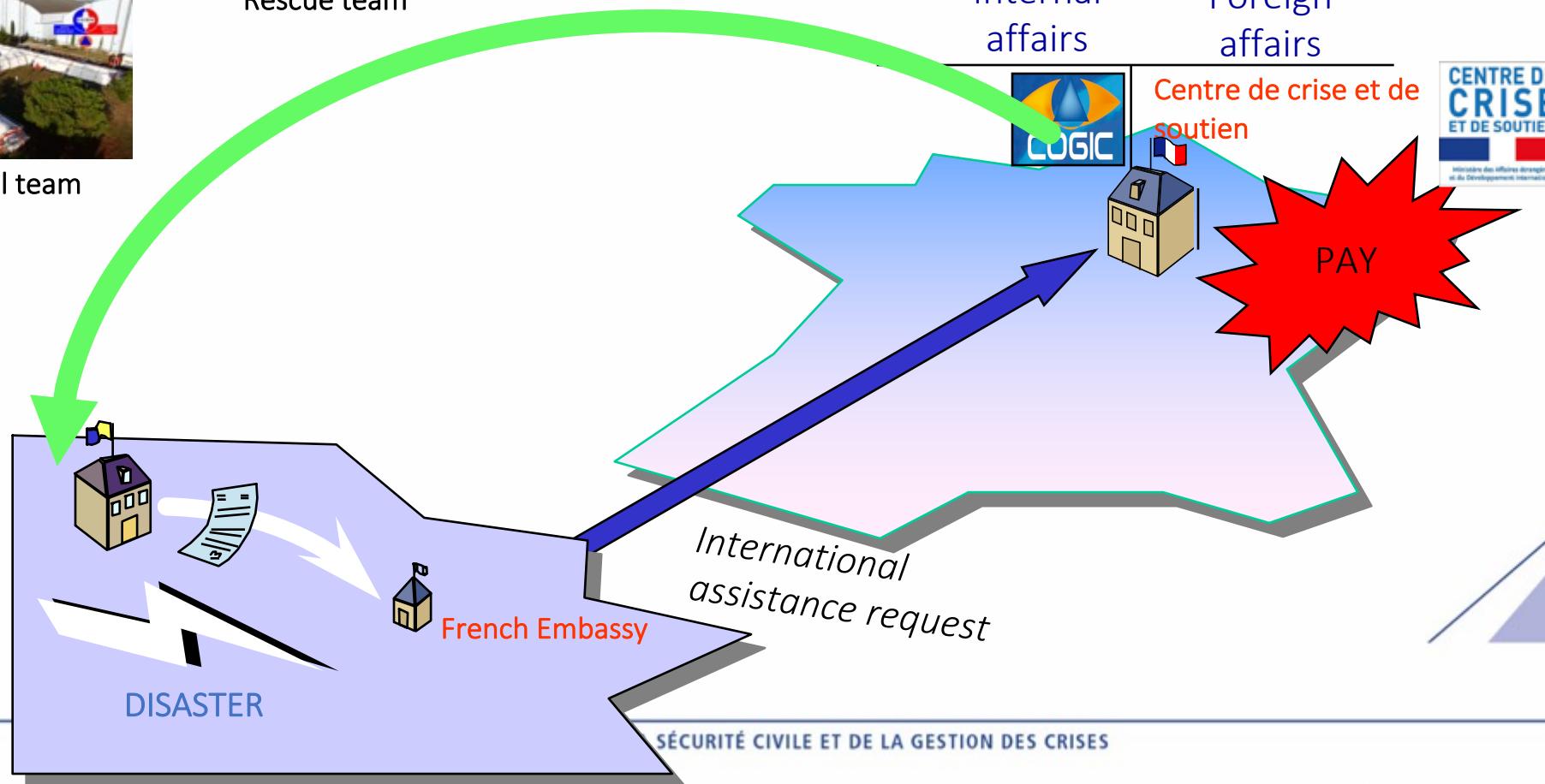
Medical team



Rescue team



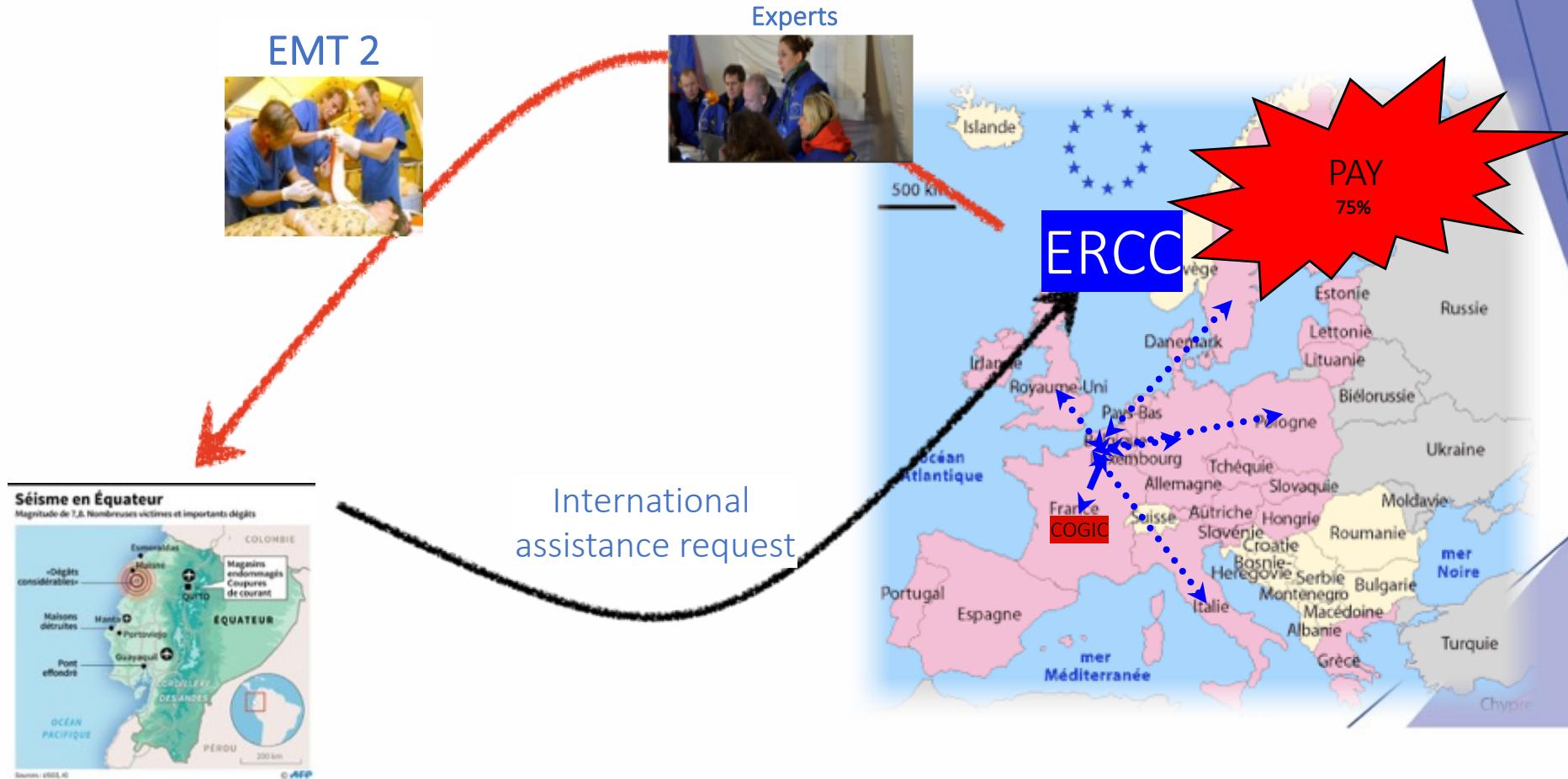
Experts



# Pré-requis

## Demande d'aide d'un pays

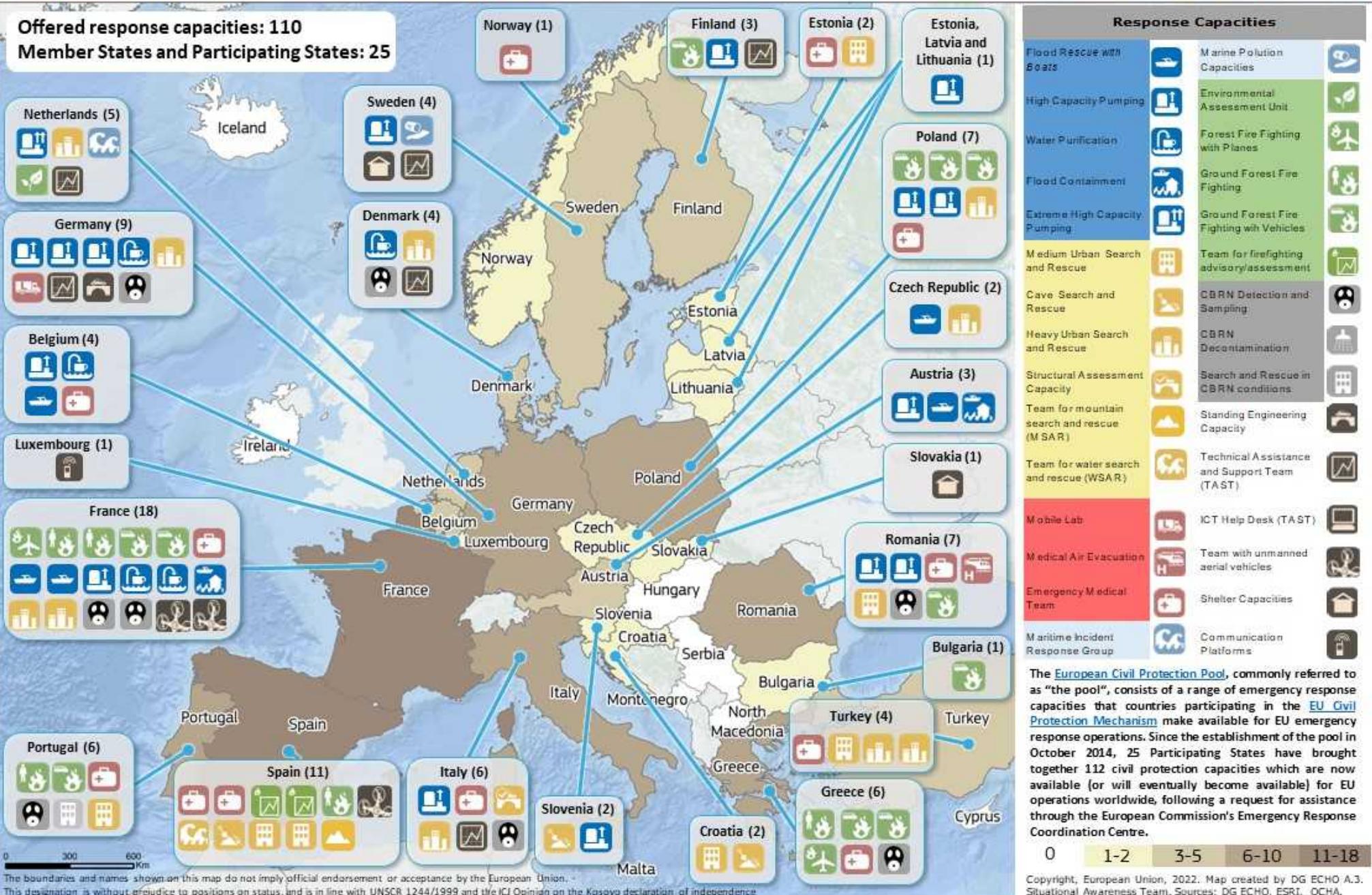
Aide via le mécanisme de protection civile de l'UE (EU CPM)



## European Civil Protection Pool - Offered capacities

*Liberté  
Égalité  
Fraternité*

**Offered response capacities: 110  
Member States and Participating States: 25**



# Pré-requis

## Demande d'aide d'un pays

Aide via le mécanisme de protection civile de l'UE (EU CPM)

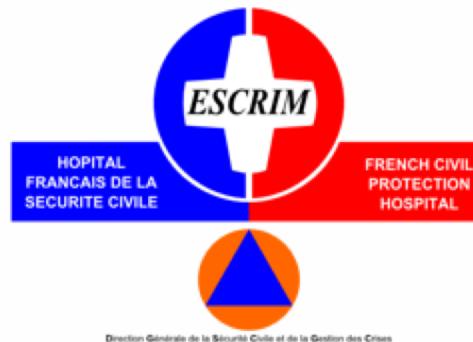


# L'ESCRIM aujourd'hui

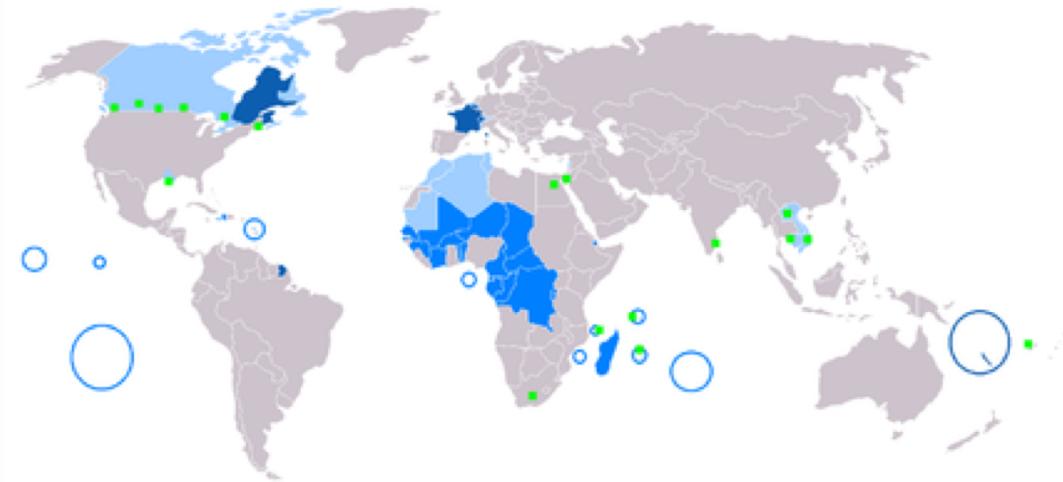
## ESCRIM - EMT 2 (proche de 3)

### Capacités : médicales et chirurgicales

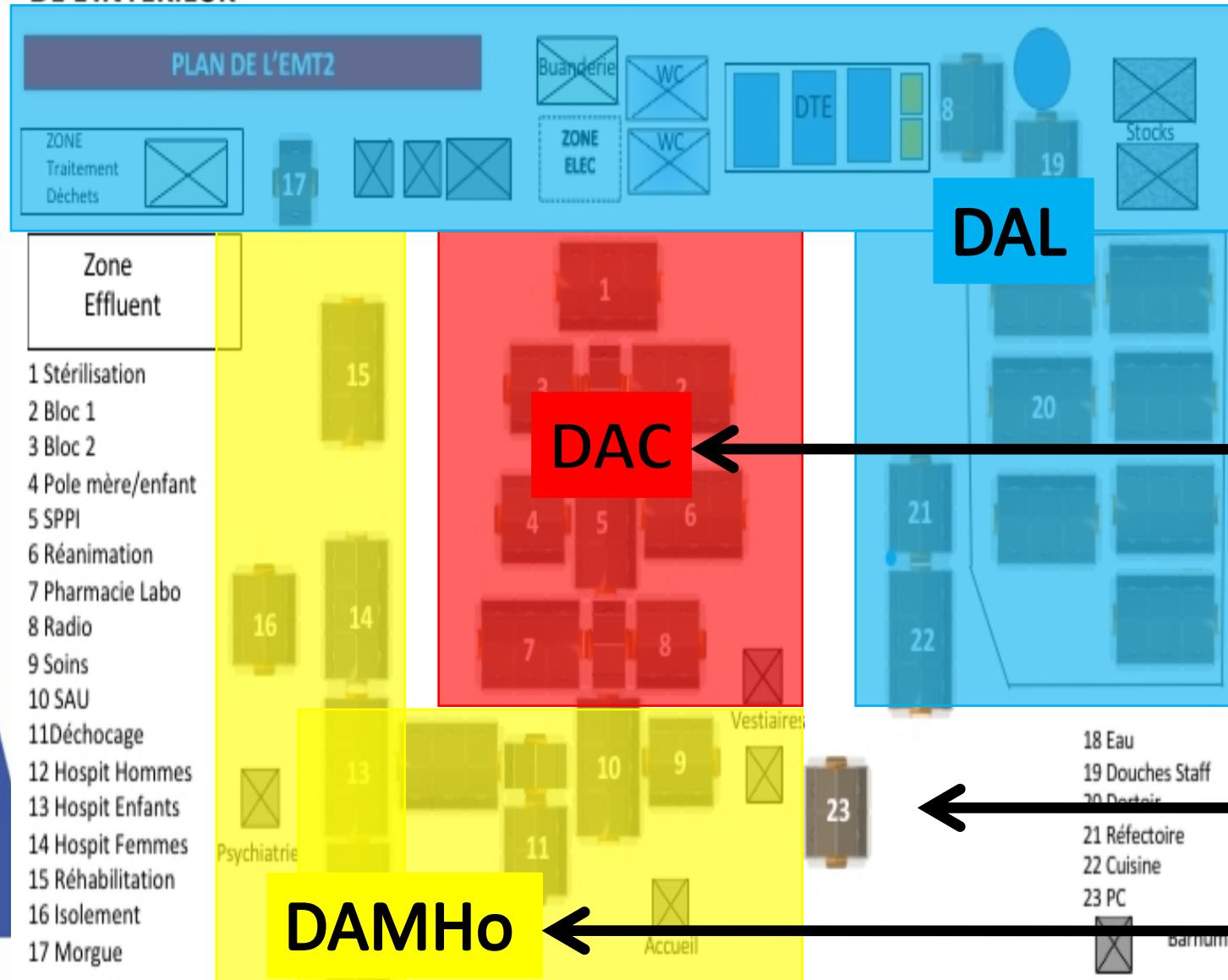
<b>lits</b>	40
<b>Bloc chirurgical</b>	2 blocs standards 1 unité de soins
<b>Personnels</b>	85 (UIISC7+SDIS30)
<b>Logistique</b>	
<b>Poids</b>	50T
<b>Volume</b>	250m <sup>3</sup>
<b>Surface BoO + hôpital</b>	3000 m <sup>2</sup>
<b>Surface hôpital</b>	700 m <sup>2</sup>



Un EMT2 francophone  
→ possibilités d'engagement accrues



# Plan de masse

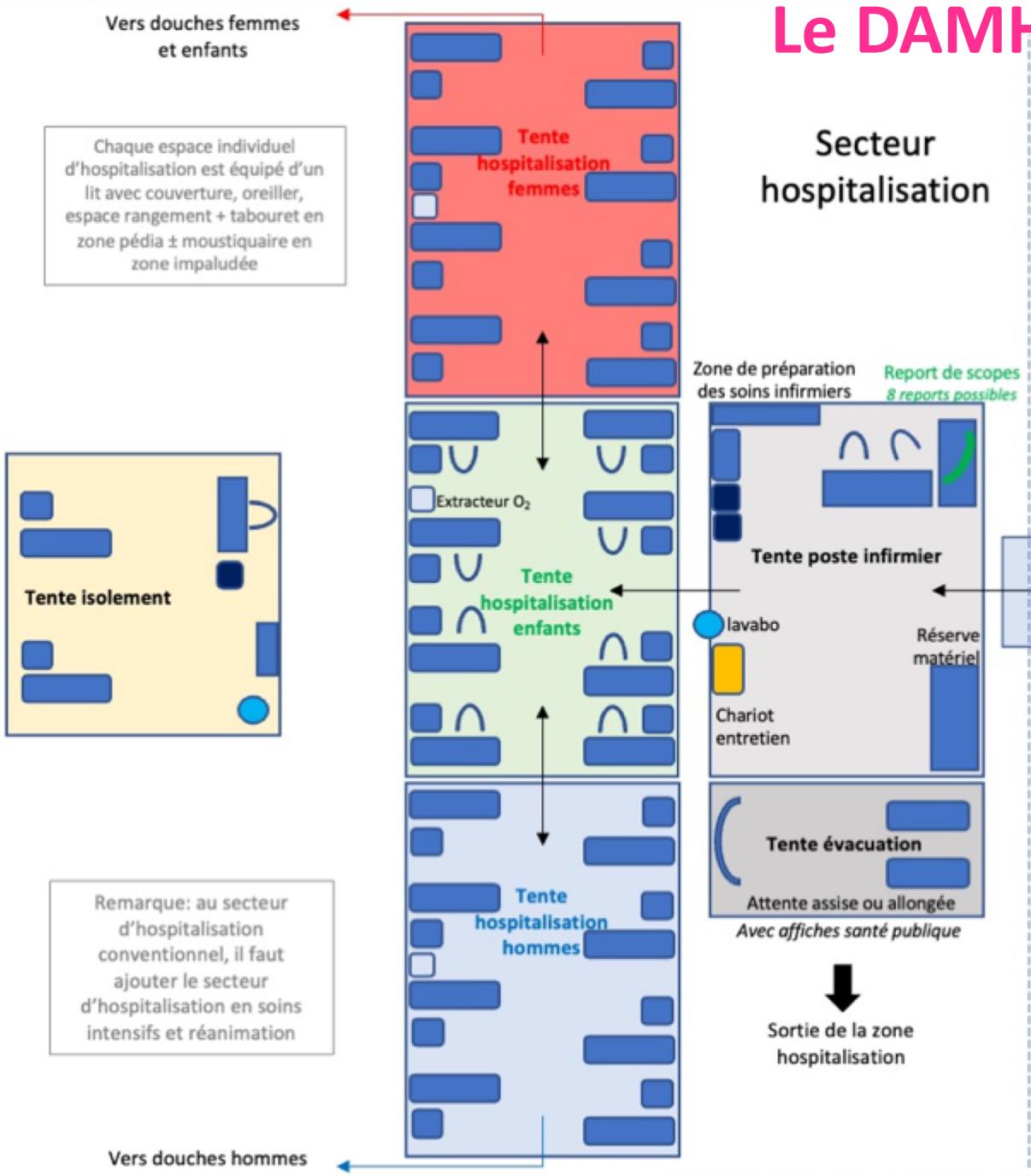


**85 personnes:**

SDIS 30 = 37 et UIISC7 = 48



# Le DAMHo (UIISC-7)



# L'ESCRIM, un nom, une marque, pas juste un EMT-2

ESCRIM flash  
20 lits, 1 bloc

Centre tampon  
d'évacuation  
sanitaire

ESCRIM PMP3  
2/2/4 + BoO  
3 tentes, 5 lits

ESCRIM Base  
= EMT-2  
40 lits, 2 blocs

ESCRIM Full  
100 lits, 2 blocs

ESCRIM PMP4  
2/2/6 + BoO  
4 tentes, 6 lits

ESCRIM PMP5  
3/3/6 = BoO  
5 tentes, 10 lits

## Modularité

Centre d'accueil et  
de tri pour  
ressortissants





Merci de votre attention



# Surgery with scopy



1 principal OR (orthopedic, visceral,  
vascular, gynecology)  
+  
1 secondary OR (dressings, skin graft...)

On foot blood bank

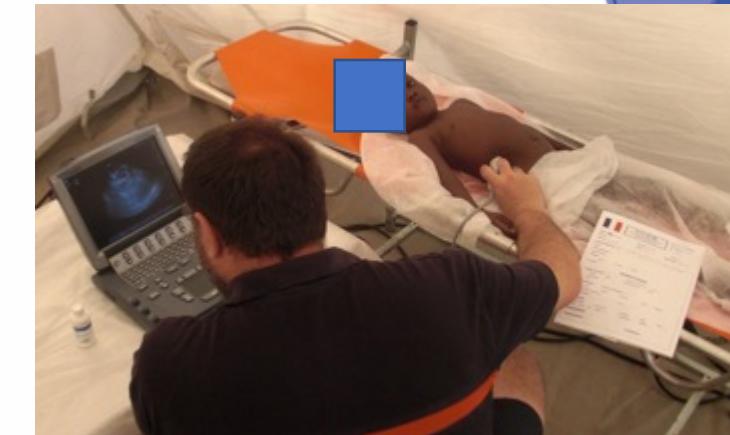


# Emergency Room

100 patients per day



# Lab and medical imaging



## ICU and Ward



Ward: 40 beds,  
ICU: 6+2 intensive care beds

1 psychiatry nurse



# ESCRIM full





## Merci de votre attention



DIRECTION GÉNÉRALE DE LA SÉCURITÉ CIVILE  
ET DE LA GESTION DES CRISES

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