Note: The Pediatric Emergency Care Recognition Program does not reflect a hospital’s trauma capabilities. Trauma designation is a separate stand-alone program.

Criteria for Voluntary Pediatric Ready Emergency Department Recognition

Definition: Pediatric patients – All children age 17 and younger.

Definition: A recognized hospital Emergency Department shall be capable of identifying those pediatric patients who are critically ill or injured, stabilizing pediatric patients, including the management of airway, breathing and circulation, and providing an appropriate transfer to a definitive care facility.

A. Administration and Coordination of the Emergency Department (ED) for the Care of Children.

1. All facilities in Kentucky seeking recognition as a Pediatric Ready Emergency Department must appoint a Nursing Pediatric Emergency Care (PEC) Coordinator. The Nurse PEC Coordinator is a Registered Nurse (RN), appointed by the ED nursing director, in consultation with the Physician PEC Coordinator or Physician ED leadership, who possesses special interest, knowledge and skill in the care of children in emergency settings, including resuscitation. Recommended responsibilities include:

   a. Facilitating ED pediatric QI/PI activities.

   b. Serving as liaison to appropriate in-hospital and out-of-hospital pediatric care committees.

   c. Serving as liaison/coordinator to referring or receiving hospitals and healthcare facilities, emergency medical services (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.

   d. Collaborating with the ED continuing education coordinator to ensure that pediatric-specific elements are included in orientation for new staff members.

   e. Ensuring that initial and annual competency evaluations completed by the ED staff are applicable to children of all ages.
f. Coordinating pediatric disaster preparedness for the ED and the facility, and participating in regional, community, and hospital disaster-preparedness activities.

g. Promoting patient and family education regarding illness and injury prevention.

h. Providing assistance and support for pediatric education with out-of-hospital providers.

i. Working with clinical leadership to ensure the availability of pediatric equipment, medications, staffing, and other resources through the development and periodic review of ED standards, policies, and procedures.

j. Collaborating with a Physician PEC Coordinator, if designated, or Physician ED leadership to ensure that the ED is prepared to care for children of all ages, including children with special health care needs.

2. The appointment of a Physician Coordinator for Pediatric Emergency Care is **highly recommended**, although not mandatory. The Physician PEC Coordinator is a specialist in Emergency Medicine or Pediatric Emergency Medicine; or if these specialties are not available, then Pediatrics or Family Medicine, appointed by the ED Medical Director, who through training, clinical experience or focused continuing medical education, demonstrates competence in the care of children in emergency settings, including resuscitation. A mid-level practitioner could fill this role if a physician is not available. Recommended responsibilities include:

a. Promoting, facilitating, and verifying adequate skill and knowledge of ED staff physicians and other ED health care providers in the emergency care and resuscitation of infants and children.

b. Overseeing ED pediatric quality improvement (QI), performance improvement (PI), patient safety, injury and illness prevention, and clinical care activities, in coordination with the ED Medical Director.

c. Assisting with development and periodic review of ED policies and procedures and standards for medications, equipment, and supplies to ensure adequate resources for children of all ages.

d. Serving as liaison/coordinator to appropriate in-hospital and out-of-hospital pediatric care committees in the community.

e. Serving as liaison/coordinator to a definitive care hospital (such as a regional pediatric referral hospital, or trauma center), emergency medical service (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.

f. Ensuring that competency evaluations completed by the staff are applicable to children of all ages.

g. Ensuring that pediatric needs are addressed in regional, community, and hospital disaster/emergency preparedness plans.

h. Collaborating with the nursing PEC coordinator to ensure adequate staffing, medications, equipment, supplies, and other resources are present for children in the ED.
B. Emergency Department Professional Staff

1. Physicians

   a. Qualifications

      1. All physicians staffing the Emergency Department must be Board-certified or Board-eligible in one of the allopathic or osteopathic boards of: Emergency Medicine, Pediatric Emergency Medicine, Pediatrics, Internal Medicine, Family Medicine, or General Surgery. AND

      2. Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS) is recommended for all physicians. Physicians who are not Board-certified or Board-eligible in Emergency Medicine or Pediatric Emergency Medicine physicians are required to have current PALS or APLS certification. PALS and APLS may be counted towards 4 hours of the pediatric emergency medicine CME requirement.

   b. Continuing Medical Education. All physicians shall have a minimum of 4 hours of continuing education (AMA Category I) in pediatric emergency medicine every 2 years in addition to maintenance of certification in PALS.

   c. Consultation/Supervision:

      1. Telephone or telemedicine consultation with a physician that is board certified or eligible in Pediatrics or Pediatric Emergency Medicine shall be available 24 hours a day.

      2. Supervision of mid-level practitioners must comply with the statutes and regulations established by the Kentucky Board of Medical Licensure and the Kentucky Board of Nursing.

   d. Recommended: A mechanism in place to:

      1. Evaluate baseline competency of physicians related to training and/or experience in the treatment of neonates, infants, children, adolescents, and children with special health care needs.

      2. Monitor ongoing clinical competence related to outcomes, adequate volume of experience, and the ability to perform all procedures in neonates, infants, children, adolescents, and children with special health care needs.

   e. Physician Backup. A backup physician whose qualifications and training are equivalent to subsection B.1.a of this Section shall be available within 60 minutes after notification to assist with critical situations or disasters.
2. **Mid-Level Practitioners.** A mid-level practitioner is a Nurse Practitioner (NP) or Physician Assistant (PA) (working under the supervision of a physician that meets the qualifications of subsection B.1.a of this section). 
   a. Qualifications:
      1. Maintain current Kentucky licensure.
      3. Certification in Emergency Nursing Pediatric Course (ENPC) in addition to PALS is *highly recommended* for NPs.

   b. Continuing Education
      1. All Nurse Practitioners shall have evidence of a minimum of 4 hours of 
         approved continuing education units in pediatric emergency medicine every 2 
         years in addition to maintenance of certification in PALS. Maintenance of 
         ENPC is recommended and may fulfill for up to 4 hours of this requirement. 
         Only courses approved by the Kentucky Board of Nursing for CME credit may 
         be used to fulfill this requirement.
      2. All Physician Assistants shall have a minimum of 4 hours of continuing 
         education (AMA Category I) in pediatric emergency medicine every 2 years in 
         addition to maintenance of certification in PALS. Only courses approved by 
         the Kentucky Board of Medical Licensure for CME credit may be used to fulfill 
         this requirement.

   c. **Recommended:** A mechanism in place to:
      1. Evaluate baseline competency of mid-level practitioners related to training 
         and/or experience in the treatment of neonates, infants, children, adolescents, 
         and children with special health care needs.
      2. Monitor ongoing clinical competence related to outcomes, adequate volume of 
         experience, and the ability to perform all procedures in neonates, infants, 
         children, adolescents, and children with special health care needs.

*Emergency Department Provider Coverage.* A physician that meets the qualifications of subsection B.1.a, 
**OR** a Mid-Level Practitioner that meets the qualifications of subsection B.2.a must provide Twenty-four 
(24) hour coverage.

3. **Nursing**
   
a. Qualifications. **At least one** Registered Nurse (RN) on duty each shift who is 
      responsible for the direct care of any pediatric patient in the Emergency 
      Department shall successfully complete and maintain recognition in either 
      Pediatric Advanced Life Support (PALS) or the Emergency Nursing Pediatric 
      Course (ENPC). It is *highly recommended* that both certifications be maintained.
b. Continuing Education. **At least one** RN on duty each shift that is responsible for the direct care of any pediatric patient in the Emergency Department shall have evidence of a minimum of 8 hours of pediatric emergency/critical care continuing education hours every 2 years. PALS and ENPC may each fulfill for up to 4 hours of this requirement.

c. **Recommended:** A mechanism in place to:

1. Evaluate baseline competency of nurses related to training and/or experience in the treatment of neonates, infants, children, adolescents, and children with special health care needs.

2. Monitor ongoing clinical competence related to outcomes, adequate volume of experience, and the ability to perform all procedures in neonates, infants, children, adolescents, and children with special health care needs.

C. **Quality Improvement.** The Quality Improvement/Performance Improvement (QI/PI) plan shall include pediatric-specific indicators, and the pediatric patient care-review process must be integrated into the ED QI/PI plan. Components of the process should interface with EMS and/or other pre-hospital providers, ED, trauma, inpatient pediatric, and hospital-wide QI or PI activities. At a minimum, QI/PI facilitators should:

1. Identify pediatric-specific indicators of good outcome.

2. Collect and analyze data monthly to discover variances.

3. Define plans for improvement.

4. Evaluate or measure the success of the QI or PI process.

5. Mechanisms should be in place to monitor professional performance, credentialing, continuing education, and clinical competencies including integration of findings from QI audits and case reviews.

D. **Pediatric Patient Safety.** The delivery of pediatric care should reflect an awareness of unique pediatric safety concerns as reflected in the following policies, procedures, protocols, and/or guidelines:

1. Children are weighed and recorded in kilograms only.

2. Weights are recorded in a prominent place on the medical record.

3. For children that are not weighed, a standard method for estimating weight in kilograms is used (e.g., a length-based system).

4. Infants and children have vital signs recorded (temperature, heart rate, respiratory rate, and pain) in the medical record.

5. Blood pressure, pulse oximetry, and waveform capnography monitoring are available for children of all ages based on illness and injury severity.
6. A process for identifying age-specific abnormal vital signs and notifying the physician, NP, or PA.

7. Processes are in place for safe medication storage, prescribing, and delivery that includes pre-calculated dosing guidelines for children of all ages.

8. Infection control practices, including hand hygiene and use of personal protective equipment, are implemented and monitored.

9. Interpreters are available 24/7 for the patient caregiver (in the caregiver’s primary language). The patient or family member is not used as a translator.

10. Process to allow access to pediatric-specific and developmentally-appropriate communication tools.

11. The ED environment is safe for children and supports patient and family centered care.


13. Policies for the timely reporting and evaluation of patient safety events, medical errors, and unanticipated outcomes are implemented and monitored.

E. Emergency Department Policies, Procedures, Protocols and/or Guidelines. Policies, procedures, protocols, and/or guidelines for the emergency care of children should be developed and implemented in the areas listed below. These may be integrated into overall ED operations as long as pediatric specific issues are addressed:

1. Interfacility Transfer. The facility shall have transfer guidelines and procedures as well as transfer agreements with hospitals capable of providing a higher level of pediatric care.

2. Latex allergies.

3. Illness and injury triage.

4. Pediatric patient assessment and reassessment.

5. Documentation of pediatric vital signs and actions to be taken for abnormal vital signs.


7. Sedation and analgesia, including medical imaging.

8. Consent, including when parent or legal guardian is not immediately available.


10. Physical or chemical restraint of pediatric patients.

11. Child maltreatment and domestic violence reporting criteria, requirements, and processes.
12. Death of the child in the ED, including bereavement counseling and contacting the regional organ procurement organization.

13. Do Not Attempt Resuscitate (DNAR) or limits of resuscitation orders.

14. Family-centered care:
   a. Family involvement in patient decision-making and medication safety processes;
   b. Family presence during all aspects of emergency care, including resuscitation.
   c. Patient, family, and caregiver education.

15. Discharge planning and written instructions that include:
   a. Information on the child’s diagnoses.
   b. Information on any medications prescribed.
   c. Recommended follow-up for the patient.

16. Communication with the patient’s medical home or primary care provider.

F. All-Hazards Disaster Preparedness. Policies, procedures, protocols, and/or guidelines should also be developed and implemented for all-hazards disaster preparedness. The plan should address the following issues:

1. Availability of pediatric-specific medications, vaccines, equipment, and trained providers.

2. Pediatric surge capacity for injured and non-injured children.

3. Decontamination, isolation, and quarantine of families and children.


5. Access to specific medical and mental health therapies, and social services for children.

6. Disaster drills, which include a pediatric mass casualty incident at least every two years.

7. Care of children with special health care needs.

8. Evacuation of pediatric units, if applicable.
G. Emergency Department Support Services.

1. Radiological Services. Radiology capability must meet the needs of the children in the community served. Specifically:
   a. A process for ensuring utilization of pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with as low as reasonably achievable (ALARA) principles.
   b. A process for timely review, interpretation, and reporting of medical imaging by a qualified radiologist is established.
   c. A process for referring children to appropriate facilities for radiological procedures that exceed the capability of the hospital is established.

2. Laboratory Services. Laboratory capability must meet the needs of the children in the community served, including techniques for small sample sizes. Specifically, a process for referring children or their specimens to appropriate facilities for laboratory studies that exceed the capability of the hospital is established.

H. Equipment, Supplies and Medications.

1. Pediatric equipment, supplies and medications shall be appropriate for children of all ages and sizes (see list below) and are easily accessible, clearly labeled and logically organized.

2. The ED staff must be educated on the location of all items and there must be in place a daily method to verify the proper location, availability, and function of equipment and supplies.

3. Also, a medication chart, length-based tape, medical software, or other systems shall be readily available to ensure the proper sizing of resuscitation equipment and proper dosing of medications.

4. Medications:
   a. Adenosine
   b. Amiodarone
   c. Anticonvulsant medications
   d. Antidotes (common antidotes should be accessible to the ED)
   e. Antiemetic agents
   f. Antimicrobial agents (parenteral and oral)
   g. Antipyretic drugs
   h. Atropine
i. Bronchodilators
j. Calcium Chloride
k. Corticosteroids
l. Dextrose (D10W, D50W)
m. Epinephrine (1:1,000, 1:10,000, Racemic Epinephrine)
n. Glucagon

o. Inotropic agents
p. Insulin
q. Lidocaine
r. Magnesium Sulfate
s. Mannitol
t. Naloxone Hydrochloride
u. Neuromuscular blockers
v. Procainamide
w. Sedatives
x. Sodium Bicarbonate (4.2%, 8.4%)
y. Topical oral and parenteral analgesics
z. Vaccines
aa. Vasopressor agents

5. General equipment/supplies/resources:
   a. Age appropriate pain scale-assessment tools
   b. EMS communications capability
c. Fluorescein strips
d. Intravenous blood/fluid warmer
e. Latex-free supplies (gloves, etc.)
f. Oral rehydration solution
g. Patient warming device
h. Resuscitation board
i. Weight scale in kilograms (not pounds)
j. Wood’s lamp

6. Monitoring equipment/supplies:
   a. Blood pressure cuffs (neonatal, infant, child, adult-arm, adult-thigh)
   b. Continuous end-tidal CO2 monitoring device
c. Doppler ultrasonography devices
d. Electrocardiography monitor/defibrillator (with pediatric and adult capabilities, including pads/paddles)
e. Hypothermia thermometer
f. Pulse oximeters (with pediatric and adult probes)

7. Vascular Access Equipment/Supplies:
   a. Arm boards (infant, child, adult)
   b. Catheter-over-the-needle devices (gauges 14, 16, 18, 20, 22, 24)
   c. Recommended (not required): Pediatric-sized central venous catheters
d. Intraosseous needles or device (pediatric, adult)
e. Intravenous administration sets with calibrated chambers and extension tubing (and/or infusion devices with ability to regulate rate and volume of infusate)
f. Intravenous solutions
   1. Normal saline
   2. Dextrose 5% in normal saline
   3. Dextrose 10% in water
   g. Recommended (not required): Umbilical vein catheters

8. Fracture management equipment/supplies:
   a. Extremity splints (assorted sizes)
   b. Femur splints (pediatric, adult)
c. Cervical collars (appropriate for children of all ages)

9. Respiratory equipment/supplies:
   a. Bag-Mask devices, self-inflating
      1. Infant: 450 ml
      2. Adult: 1,000 ml
      3. Masks to fit bag-mask device adaptor (neonatal, infant, child, adult)
   b. Clear oxygen masks:
      1. Standard (infant, child, adult)
      2. Partial nonrebreather (infant)
      3. Nonrebreather (child, adult)
   c. Endotracheal tubes
      1. Uncuffed (mm 2.5, 3.0)
      2. Cuffed or uncuffed (mm 3.5, 4.0, 4.5, 5.0, 5.5)
      3. Cuffed (mm 6.0, 6.5, 7.0, 7.5, 8.0)
   d. Feeding tubes (5F, 8F)
   e. Laryngoscope blades
      1. Straight (sizes 0, 1, 2, 3)
      2. Curved (sizes 2, 3)
   f. Laryngoscope handles (pediatric, adult)
   g. Magill forceps (pediatric, adult)
   h. Nasal cannulas (infant, child, adult)
   i. Nasopharyngeal airways (infant, child, adult)
   j. Nasogastric tubes:
      1. Infant: 8F
      2. Child: 10F
      3. Adult: 14-18F
k. Nebulized medication administration set with pediatric and adult masks

l. Oropharyngeal airways (sizes 0, 1, 2, 3, 4, 5)

m. Stylets for endotracheal tubes (pediatric, adult)

n. Suction:
   1. Suction catheters (infant, child, adult)
   2. Yankauer suction tip

o. Trach collar

p. Recommended (not required): Tracheostomy tubes (mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)

10. Specialized pediatric trays or kits:

a. Chest tubes:
   1. Infant: 10-12F
   2. Child: 16-24F
   3. Adult: 28-40F

b. Supplies/kit to address patients with difficult airways. Facility pediatric patient volume and provider skill competencies should be considered in selecting needed equipment and protocols. Specific items are not required but may include the following:
   1. Supraglottic airways (Laryngeal mask airways (LMA), King airway, I-gel, etc.)
   2. Needle cricothyrotomy supplies
   3. Surgical cricothyrotomy kit
   4. Video laryngoscope
   5. Fiberoptic intubation equipment
   6. Light wand intubation equipment

c. Lumbar puncture tray (including infant/pediatric 22 gauge and adult 18-21 gauge needles)

d. Newborn delivery kit (including equipment for resuscitation of an infant, umbilical clamp, scissors, bulb syringe, towel)

e. Tube thoracostomy tray

f. Urinary catheterization kits and urinary (indwelling) catheters (6F-22F)