NORTH COAST EMERGENCY MEDICAL SERVICES

EDAP STANDARDS
FOR NON-METROPOLITAN AREAS
LEVEL I

DEFINITION: An Emergency Department Approved for Pediatrics (EDAP) is a licensed basic Emergency Department(ED) that meets the requirements of a basic Emergency Department identified in Title 22, Division 5, 70413(m) (1)-(6) and 70415(c) (d) (e) and meets specific minimum standards in order to provide emergency pediatric care.

(A hospital unable to meet these licensing standards due to geographic isolation or small size may become an EDAP Level II. This facility may be a certified Base Hospital or a secondary or tertiary receiving facility providing definitive care to pediatric patients. Cases beyond the level of staffing and equipment available at the EDAP Level II hospital will be transferred, pursuant to written transfer agreements to an appropriate Base or Receiving hospital.)

For the purposes of this program, pediatric patients are defined as those between birth and 14 years of age.

The specific professional staff and equipment standards for an EDAP Level I are as follows:

STANDARDS FOR LEVEL I

SECTION A: PROFESSIONAL STAFF: PHYSICIANS

Standard 1.1 At least 50% of the ED coverage shall be provided by physicians
1) board certified in either Emergency Medicine, Pediatrics or Family Practice, or
2) qualified to sit for the certifying exam in Emergency Medicine, or
3) board prepared in Emergency Medicine, Pediatrics, or Family Practice (completion within three years.)

Standard 1.2 All emergency physicians, who are not Board certified or Board eligible, shall successfully complete and maintain Advanced Cardiac Life Support (ACLS) certification. New Physicians shall complete ACLS within 3 months of employment in the ED. All physicians who are not Board Certified or Board eligible in Emergency Medicine, Pediatrics, or Family Practice, shall successfully complete the Advanced Pediatric Life Support (APLS) or the Pediatric Advance Life Support (PALS) courses within 12 months of the recognition of the facility as an EDAP. New physicians must obtain this certification within 6 months of employment. (Completion of the Advanced Trauma Life Support (ATLS) course is also recommended.) Hospitals with contract emergency physician groups may specify by contract the necessity of the completion of the above requirements, if necessary.

Standard 1.25 All mid-level practitioners **(**Physician Assistants, Nurse Practitioners) regularly assigned to the ED and who care for pediatric patients should demonstrate current completion of PALS, APLS, ENPC or other equivalent

pediatric emergency care course. In addition, complete pediatric competency evaluations that are age specific and include neonates, infants, children and adolescents as required by local credentialing.

Standard 1.3 All Emergency Physicians must have documentation of completion of 4 hours of CME in pediatric topics annually.

Standard 1.4 A physician who is board certified in Pediatrics shall be on call 24 hours/day to the EDAP. Telemedicine may fulfill the 24/7 pediatric consultant requirement along with a written, approved protocol/policy defining this practice for ED providers.

Standard 1.5 A Pediatrician shall be involved in reviewing pediatric QA data. The Quality Assurance review shall include but not be limited to all the data compiled by the hospital Pediatric Liaison Nurse (see Standard 2.5.2).

SECTION B: PROFESSIONAL STAFF: NURSING

Standard 2.1 All Registered Nurses (RNs) shall have successfully completed the AHA ACLS Provider course. New nurses shall complete the ACLS provider training program within three months from date of employment. Successful completion of AHA PALS course, ENPC or other equivalent pediatric emergency care nursing course. is recommended within 12 months for all ED nurses.

Standard 2.2 At least 4 hours of BRN approved nursing CE shall be offered to ED staff nurses, in emergency pediatrics annually, by interactive instruction or self paced format.

Standard 2.3 All nurses regularly assigned to the ED shall complete a minimum of 4 contact hours of a BRN approved pediatric continuing education annually.

Standard 2.4 One RN per shift in the ED shall have completed at least 8 hours of CE in pediatric emergency or critical care within the last 2 years. This may be waived for RNs with either 2 years full time experience in an ED that sees children, or 1 year full time experience in a designated pediatric department or ward, ICU, or pediatric emergency department, all within the last 5 years.

Standard 2.5 A Pediatric Liaison Nurse (PDLN) shall be designated. This nurse may be shared between institutions and may be employed in other areas of the hospital such as ward, ICU, nursery, or Quality Assurance. The PDLN shall complete 8 hours of continuing education in pediatric topics annually and shall obtain and maintain certification in PALS, ENPC or other equivalent pediatric emergency care nursing course within 12 months of assuming the position of PDLN. Duties of the PDLN may be incorporated into existing Quality Assurance and Emergency Department review activities. Responsibilities of the PDLN include:

2.5.1 Ensuring and documenting ED nurse pediatric continuing education.

2.5.2 Maintaining a log and coordinating criteria-based review and follow-up of a sample of pediatric emergency visits. This sample shall include:

A) Emergency Department pediatric deaths.
B) Pediatric deaths within 48 hours of admit from ED or visit to ED,

`

C) At least 25% of all pediatric admits from the ED, including all:
    1) Admits to critical care areas (ICU, OR, Pediatric Ward)
    2) Major trauma
    3) Meningitis
    4) Admits occurring within 48 hours of ED visit, if known.
D) All transfers from ED
E) Child maltreatment cases.
F) At least 5% of pediatric ED visits not resulting in admit or transfer, selected at random.

2.5.3 A mechanism to provide for integration of findings from QI process and reviews into education and clinical competency evaluations of ED staff.

2.5.4 Coordination of the review of ALS/LALS transported pediatric cases with the Prehospital Nurse Coordinator in hospitals where the EDAP is also the Base Hospital; including tape reviews of pediatric ambulance runs.

<u>Standard 2.6</u> Support Services

2.6.1 Respiratory Care Practitioners: Optimal Staffing:
A) At least one in-house 24 hours/day.
B) Educated in PALS or APLS.
C) Completion of 4 hours of pediatric related CE's every 2 years.

Radiology
A) Radiologist on call and promptly available 24 hours/day.
B) Radiology technician on call and promptly available 24 hours/day.
C) CT technician on call and promptly available 24 hours/day.

Laboratory
A) Lab technician in house 24 hours/day.
B) Clinical lab capabilities in-house or access to the following:
    1. Chemistry.
    2. Hematology.
    3. Blood Bank.
    4. Microbiology.
    5. Toxicology.

SECTION C: POLICIES AND PROCEDURES

Standard 3.1 Policies/procedures and current transfer agreements concerning the transfer of critically ill and injured patients to Pediatric Critical Care Centers shall be on file in the ED.

Standard 3.2 Policies/procedures for the identification, evaluation and referral of victims of suspected child abuse shall be on file in the ED.

Standard 3.3 Policies/procedures for pediatric care include the following:

1. Medical triage.
2. General assessment, including pain assessment and treatment.
3. Safety.
4. Physical or chemical restraint.
5. Consent (including situations in which a parent is not immediately available).
6. DNR orders.
7. Death in the ED to include SIDS and care of the grieving family.
8. Procedural sedation.
9. Radiation dosage protocol.
10. Diagnosis or conditions which mandate a pediatric consult.
11. Scheduled resuscitation medication and supply inventory check.
12. Mental health emergencies.
13. Family centered care, including family presence during care.
14. Communication with patient's primary health care provider.
15. Disaster preparedness plan that addresses the following pediatric issues:
    a. A plan to minimize parent-child separation and improved methods for reuniting separated children with their families.
    b. A plan that addresses pediatric surge capacity for both injured and non-injured children.
    c. A plan that includes access to specific medical and mental health therapies, as well as social services, for children in the event of a disaster.
    d. A plan which ensures that disaster drills include a pediatric mass casualty incident at least once every 2 years.
    e. Decontamination
16. Medication Safety.

SECTION D: EQUIPMENT, TRAYS, AND SUPPLIES

EQUIPMENT: (General)

Standard 4.0 Pediatric crash cart to store indicated supplies in an organized and accessible manner.

Standard 4.1 Cervical spine immobilization devices: sandbags for children 6 years and under. Rigid four-post or plastic/Velcro collars for children over 6 years of age in at least one pediatric size
.

Standard 4.2 A mechanism by which to immobilize and apply traction to suspected or diagnosed femur fractures in children.

Standard 4.3 IV Blood/fluid warmer.

Standard 4.4 An infant warming procedure/device (may be stored elsewhere in the facility and readily available to the ED).

Standard 4.5 Pediatric scale in kilograms.

Standard 4.6 An appropriate procedure/device for ensuring pediatric restraint.

Standard 4.7 Pediatric length based dosing tape (i.e. Broselow).

Standard 4.8 Pain Scale assessment tools appropriate for age.

EQUIPMENT: (Monitoring)

Standard 4.8 Blood pressure cuffs: infant, child, adult and thigh size.

Standard 4.9 Doppler sensing device for blood pressure measurement.

Standard 4.10 Monitor-defibrillator with 0-360 Watt/sec capability.

Standard 4.11 Hypothermia thermometer.

Standard 4.12 Pulse oximeter.

Standard 4.13 End tidal CO2 detector.

EQUIPMENT: (Respiratory)

Standard 4.14 Pediatric bag-valve resuscitation device.

Standard 4.15 Preemie, infant, child, and adult size transparent masks to use with bag-valve device.

Standard 4.16 Laryngoscope with infant and child blades, curved (2,3) and straight (sizes 0-3).

Standard 4.17 Pediatric Magill forceps.

Standard 4.18 Pediatric oral airways (sizes 50mm-80mm).

Standard 4.19 ET tubes (sizes 2.5-5.5 cuffed or uncuffed, 6.0-9.0 cuffed) with pedi stylets.

Standard 4.20 Feeding tubes (5, 8 Fr).

Standard 4.21 Clear oxygen masks (standard and non-rebreathing) for an infant, child.

Standard 4.22 Nasal cannulae (infant, child).

Standard 4.23 Nasogastric tubes (infant, child).

EQUIPMENT: (Vascular Access)

Standard 4.24 Arm boards (infant, child)

Standard 4.25 IV catheters (22g, 24g)

Standard 4.30 Infusion pumps, drip or volumetric.

Standard 4.31 Pediatric intraosseous needles.

Standard 4.32 Stopcocks.

Standard 4.33 Umbilical vein catheters.

TRAYS:

Standard 4.34 Pediatric tracheostomy tray with tracheostomy tubes (sizes 3-5mm).

Standard 4.35 Difficult airway supplies/kit to include: Set-up for needle cricothyrotomy (A 3.5 Portex adapter and 14 angiocath is acceptable).

Standard 4.36 Venesection tray appropriate for infants and children.

Standard 4.37 Pediatric lumbar puncture trays with 22 gauge, 1.5 inch spinal needle.

Standard 4.38 Urinary catheterization tray with catheters (8-22 Fr.).

Standard 4.39 Chest Tube Insertion Tray

SUPPLIES:

Standard 4.40 Chest tubes sizes 16-28 Fr; size 26 is unavailable.

Standard 4.41 Pediatric suction catheters (sizes 8-12 Fr.).

Standard 4.42 Central venous catheters (pediatric).

MEDICATIONS:

Resuscitation medications as per the American Heart Association PALS guidelines.

IV solutions to include: NS; D5.45NS; and D10W.

NORTH COAST EMERGENCY MEDICAL SERVICES

EDAP STANDARDS
FOR NON-METROPOLITAN AREAS
LEVEL II

DEFINITION: An Emergency Department Approved for Pediatrics (EDAP) is a licensed basic Emergency Department (ED), or a standby Emergency Department that meets the requirements of a basic Emergency Department identified in Title 22, Division 5, 70413(m) (1)-(6) and 70415 (c) (d) (e) and meets specific minimum standards in order to provide emergency pediatric care.

An EDAP Level II facility may be a certified Base Hospital or a secondary or tertiary receiving facility providing definitive care to pediatric patients. Cases beyond the level of staffing and equipment available at the EDAP Level II hospital will be transferred, pursuant to written transfer agreements, to an appropriate Base or Receiving hospital.

For the purposes of this program, pediatric patients are defined as those between birth and 14 years of age.

The specific professional staff and equipment standards for an EDAP Level II are as follows:

STANDARDS FOR EDAP LEVEL II

SECTION A. PROFESSIONAL STAFF: PHYSICIANS

Standard 1.1 At least 50% of the ED coverage shall be provided by physicians
1) board certified in either Emergency Medicine, Pediatrics or Family Practice, or
2) qualified to sit for the certifying exam in Emergency Medicine, or
3) board prepared in Emergency Medicine, Pediatrics, or Family Practice (completion within three years.)

Standard 1.2 All emergency physicians, who are not Board certified or Board eligible, shall successfully complete and maintain Advanced Cardiac Life Support (ACLS) certification. New physicians shall complete ACLS within 3 months of employment in the E.D. All physicians who are not Board Certified or eligible in Emergency Medicine, Pediatrics, or Family Practice, shall successfully complete the Advanced Pediatric Life Support (APLS) or the Pediatric Advanced Life Support (PALS), courses within 12 months of the recognition of the facility as an EDAP. New Physicians must obtain this certification within 6 months of employment. (Completion of the Advanced Trauma Life Support (ATLS) course is also recommended.) Hospitals with contract emergency physician groups may specify by contract the necessity of the completion of the above requirements, if necessary.

Standard 1.25 All mid-level practitioners **(**Physician Assistants, Nurse Practitioners)

regularly assigned to the ED and who care for pediatric patients should demonstrate current completion of PALS, APLS, ENPC or other equivalent pediatric emergency care course. In addition, complete pediatric competency evaluations that are age specific and include neonates, infants, children and adolescents as required by local credentialing.

Standard 1.3 All ED M.D.s must maintain at least 4 hours of C.M.E. in pediatrics annually.

Standard 1.4 If the facility is a standby Emergency Department, the Emergency Physicians must have a response time to the facility of **5** minutes or less.

Standard 1.5 The ED must maintain an on-call physician, in addition to the ED M.D. who is promptly available for crisis situations.

Standard 1.6 Backup MD Specialty Services:

1.6.1 There shall be on file in the ED a daily list of pediatricians in nearby communities available for telephone consult. This list shall coincide with the on-call status of the physicians, ensuring their availability by telephone. Telemedicine may fulfill the 24/7 pediatric consultant requirement along with a written, approved protocol/policy defining this practice for ED providers.

1.6.2 The plan should address the availability of specialists to care for pediatric patients, in at least the following specialties: surgery, orthopedics, anesthesiology and neurosurgery.

SECTION B. PROFFESSIONAL STAFF NURSING

Standard 2.1 All ED nurses must maintain ACLS certification. New nurses must obtain ACLS within 3 months of employment. Completion of the PALS course, ENPC or other equivalent pediatric emergency care nursing course.. should be strongly recommended within 12 months of employment for all ED nurses.

Standard 2.2 At least 4 hours B.R.N. Approved nursing C.E. shall be offered to ED nurses on pediatrics related topics annually, either by interactive instruction or by self paced format.

Standard 2.3 All ED nurses shall complete 4 hours of B.R.N. Approved pediatric C.E. annually.

Standard 2.4 One RN per shift in the ED shall have completed at least 8 hours of C.E. in pediatric emergency or critical care within the last 2 years. This may be waived for RNs with either 2 years full time experience in an ED that sees children, or 1 year full time experience in a designated pediatric department or ward, I.C.U., or pediatric emergency department, all within the last five years.

Standard 2.5 A Pediatric Liaison Nurse (PDLN) shall be designated. This nurse may be shared between institutions and may be employed in other areas of the hospital such as a ward, I.C.U., nursery or Quality Assurance. The PDLN shall complete 8 hours of continuing education in pediatric topics annually and shall obtain and maintain certification in PALS, ENPC or other equivalent pediatric emergency care nursing course within 12 months of assuming the position of PDLN. Duties of the PDLN may be incorporated into existing Quality Assurance and Emergency Department review activities. Responsibilities of the PDLN include:

2.5.1 Ensuring and documenting ED nurse pediatric continuing education.

2.5.2 Maintaining a log and coordination criteria-based review and follow-up of a sample of pediatric emergency visits. This sample shall include:
A) Emergency Department pediatric deaths
B) Pediatric deaths within 48 hours of admit from ED or visit to ED, if known.
C) At least 25% of all pediatric admits from the ED, including all:
1) Admits to critical care areas (I.C.U., O.R., Pediatric ward).
2) Major trauma
3) Meningitis
4) Admits occurring within 48 hours of ED visit.
5) Child Abuse cases.
D) All transfers from ED.
E) Child maltreatment cases.
F) At least 5% of all emergency pediatric visits not included in the above criteria.

2.5.3 A mechanism to provide for intregration of findings from QI process and reviews into education and clinical competency evaluations of ED staff.

2.5.4 Coordination of the review of ALS/LALS transported pediatric cases with the Prehospital Care Nurse Coordinator in hospitals where the EDAP is also the Base Hospital; including tape reviews of pediatric runs.

Standard 2.6 Support Services

2.6.1 Respiratory Care Practitioners: Optimal Staffing:
A) At least one in-house 24 hours/day.
B) Educated in PALS or APLS.
C) Completion of 4 hours of pediatric related CE's every 2 years.

Radiology
D) Radiologist on call and promptly available 24 hours/day.
E) Radiology technician on call and promptly available 24 hours/day.

F) CT technician on call and promptly available 24 hours/day.

Laboratory

C) Lab technician available or on-call 24 hours/day.

D) Clinical lab capabilities in-house or access to the following:

1. Chemistry.
2. Hematology.
3. Blood Bank.
4. Microbiology.
5. Toxicology.

SECTION C. POLICIES AND PROCEDURES

Standard 3.1 There shall be on file in the ED a daily list of pediatricians in a nearby community available for telephone consult. This list shall coincide with the on call status of the physicians, ensuring their availability by telephone.

Standard 3.2 There shall be in house policies and procedures, and a current transfer agreement, with a pediatric critical care center (or PICU) on the file in the ED for the transfer of critically ill or injured children.

Standard 3.3 There shall be a policy and procedure on file in the ED concerning the management of suspected child abuse.

Standard 3.4 Policies/procedures for pediatric care include the following:

1. Medical triage.
2. General assessment, including pain assessment and treatment.
3. Safety.
4. Physical or chemical restraint.
5. Consent (including situations in which a parent is not immediately available).
6. DNR orders.
7. Death in the ED to include SIDS and care of the grieving family.
8. Procedural sedation.
9. Radiation dosage protocol.
10. Diagnosis or conditions which mandate a pediatric consult.
11. Scheduled resuscitation medication and supply inventory check.
12. Mental health emergencies.
13. Family centered care, including family presence during care.
14. Communication with patient's primary health care provider.
15. Disaster preparedness plan that addresses the following pediatric issues:

a. A plan to minimize parent-child separation and improved methods for reuniting separated children with their families.
b. A plan that addresses pediatric surge capacity for both injured and non-injured children.

c. A plan that includes access to specific medical and mental health therapies, as well as social services, for children in the event of a disaster.
d. A plan which ensures that disaster drills include a pediatric mass casualty incident at least once every 2 years.
e. Decontamination

16. Medication Safety.

SECTION D: EQUIPMENT, TRAYS, AND SUPPLIES

EQUIPMENT: (General)

Standard 4.0 Pediatric crash cart to store indicated supplies in an organized and accessible manner.

Standard 4.1 Cervical spine immobilization devices: sandbags for children 6 years and under. Rigid four-post or plastic/Velcro collars for children over 6 years of age in at least one pediatric size
.

Standard 4.2 A mechanism by which to immobilize and apply traction to suspected or diagnosed femur fractures in children.

Standard 4.3 Blood warmer.

Standard 4.4 An infant warming procedure/device (may be stored elsewhere in the facility and readily available to the ED).

Standard 4.5 Pediatric scale.

Standard 4.6 An appropriate procedure/device for ensuring pediatric restraint.

Standard 4.7 Pediatric length based dosing tape (i.e. Broselow).

Standard 4.8 Pain Scale assessment tools appropriate for age.

EQUIPMENT: (Monitoring)

Standard 4.8 Blood pressure cuffs: infant, child, adult and thigh size.

Standard 4.9 Doppler sensing device for blood pressure measurement.

Standard 4.10 Monitor-defibrillator with 0-360 Watt/sec capability.

Standard 4.11 Hypothermia thermometer.

Standard 4.12 Pulse oximeter.

Standard 4.13 End tidal CO2 detector.

EQUIPMENT: (Respiratory)

Standard 4.14 Pediatric bag-valve resuscitation device.

Standard 4.15 Preemie, infant, child, and adult size transparent masks to use with bag-valve device.

Standard 4.16 Laryngoscope with infant and child blades, curved (2,3) and straight (sizes 0-3).

Standard 4.17 Pediatric Magill forceps.

Standard 4.18 Pediatric oral airways (sizes 50mm-80mm).

Standard 4.19 ET tubes (sizes 2.5-5.5 cuffed or uncuffed, 6.0-9.0 cuffed) with pedi stylets.

Standard 4.20 Feeding tubes (5, 8 Fr).

Standard 4.21 Clear oxygen masks (standard and non-rebreathing) for an infant, child.

Standard 4.22 Nasal cannulae (infant, child).

Standard 4.23 Nasogastric tubes (infant, child).

EQUIPMENT: (Vascular Access)

Standard 4.24 Arm boards (infant, child)

Standard 4.25 IV catheters (22g, 24g)

Standard 4.30 Infusion pumps, drip or volumetric.

Standard 4.31 Pediatric intraosseous needles.

Standard 4.32 Stopcocks.

Standard 4.33 Umbilical vein catheters.

TRAYS:

Standard 4.34 Pediatric tracheostomy tray with tracheostomy tubes (sizes 3-5mm).

Standard 4.35 Difficult airway supplies/kit to include: Set-up for needle cricothyrotomy (A 3.5 Portex adapter and 14 angiocath is acceptable).

Standard 4.36 Venesection tray appropriate for infants and children..

Standard 4.37 Pediatric lumbar puncture trays with 22 gauge, 1.5 inch spinal needle.

Standard 4.38 Urinary catheterization tray with catheters (8-22 Fr.).

SUPPLIES:

Standard 4.39 Chest tubes sizes 16-28 Fr; size 26 is unavailable.

Standard 4.40 Pediatric suction catheters (sizes 8-12 Fr.).

Standard 4.41 Central venous catheters (pediatric).

MEDICATIONS:

Resuscitation medications as per the American Heart Association PALS guidelines.

IV solutions to include: NS; D5.45NS; and D10W.