# TEXAS EMS FOR CHILDREN VOLUNTARY PEDIATRIC RECOGNITION PROGRAM (VPRP)

## APPLICANT MANUAL

Revised October 2021

EMS FOR CHILDREN
STATE PARTNERSHIP

Baylor College of Medicine

**Emergency Medical Services for Children State Partnership, Texas**
**1102 Bates Ave, Suite 1850**
**Houston, TX 77030**
**www.bcm.edu/emsc**
**(832) 824-EMSC (3672)**

**EMSC STATE PARTNERSHIP, TEXAS**

1102 Bates Ave, Suite 1850
Houston, TX 77030
Phone: 832-824-3672
Fax: 832-825-1182
Email: emsctexas@bcm.edu
www.bcm.edu/emsc

October, 2021

Dear Hospital Administrator:

Congratulations on your decision to participate in the Texas EMS for Children Voluntary Pediatric Recognition Program!

Enclosed is information on our program as well as documents that will need to be submitted to our office for review and consideration. The recognition program is an excellent opportunity for your Emergency Department to prepare and be ready to manage pediatric emergencies within your community. By preparing your facility to become pediatric ready, you will receive acknowledgement from your community and local media outlets that you are voluntarily choosing to go "above and beyond in assuring that your emergency department is prepared to care for children."

**It is important to note your decision to participate in this recognition program will in no way impact your licensure by the Texas Department of State Health Services (DSHS) Office of EMS and Trauma Systems.**

Please review this packet and complete and return the attached application along with the supporting documents for review by our office. Organizations who successfully meet the requirements will receive a Certificate of Recognition to acknowledge their accomplishment and commitment to emergency department preparedness to care for the infants and children of Texas.

Please do not hesitate to contact me or our Texas EMSC Program Manager with any questions at 832-824-EMSC (3672) emsctexas@bcm.edu .

Sincerely,

Kathryn Kothari, MD
Program Director, Texas State Partnership
Emergency Medical Services for Children

Table of Contents

## Voluntary Pediatric Recognition Program

### Introduction

This document has been prepared by the Texas Emergency Medical Services for Children (EMSC) Program to assist the leadership in hospitals within the state who desire to apply for recognition through the Texas EMSC Voluntary Pediatric Recognition Program (VPRP). Hospitals of all types, with an emergency department currently licensed within the State of Texas are eligible to participate. This overview manual will describe the steps necessary to apply for and maintain recognition status.

This document is subject to review and revisions; therefore, the applicant is encouraged to review a current copy and confer with the Texas EMS for Children State Partnership to secure additional assistance. The most recent version of the application manual can be found on the Texas EMS for Children website: www.bcm.edu/emsc

The Voluntary Pediatric Recognition Program (VPRP) will prepare emergency departments (EDs) to provide higher quality care for infants, children, and adolescents for the evaluation, treatment, and/or stabilization of children with medical and traumatic emergencies. One of the primary goals of pediatric recognition programs for EDs is to bolster pediatric recognition within communities and critical access hospitals so children and families can benefit from the availability of at least one ED in their own community which is equipped to stabilize and manage or transfer common emergencies for children.

Becoming a VPRP recognized facility is a positive experience for both the hospital and its staff. Benefits include:

- Creating a culture driven to continue improvement of pediatric patient outcomes, availability of equipment, services, and up to date treatment and transfer policies and protocols.
- Increasing the public's confidence in overall quality of a hospital's ability to address medical needs of children.
- Recognizing physicians, nurses, specialists, and other clinical staff for their knowledge, abilities, and commitment through their employment in a pediatric ready recognized facility; therefore, demonstrating a solid hospital wide commitment to excellent health care of Texas' pediatric population through their support of the VPRP program.
- Increasing exposure in local communities as a facility prepared for addressing critical pediatric needs during a medical or trauma emergency. This is visible in the form of a plaque displayed in the facility's emergency department and through listing the facility on the Texas EMSC State Partnership's website. This accomplishment may be promoted through local and/or statewide media outlets.
- Utilizing it as a recruiting and marketing tool to attract high quality physicians, nurses and other healthcare specialists.
- Enhancing potential educational and grant funding opportunities developed for hospitals and staff.

This document is subject to review and revision; therefore, the applicant is encouraged to review a current copy and confer with the Texas EMS for Children State Partnership to secure additional assistance. The most recent version of this overview document is posted on the Texas EMS for Children website www.bcm.edu/emsc.

## Background

On a national level in 2005, the federally-funded EMS for Children (EMSC) program established performance measures to assure the existence of a standardized statewide, territorial, or regional system that acknowledges hospitals capable of stabilizing and/or managing pediatric medical emergencies and traumatic injuries. The goal set by the national EMSC program is that by 2022, 25 percent of hospitals statewide are recognized as part of a standardized program that are able to stabilize and/or manage pediatric medical emergencies.

Similar to trauma center designation, a pediatric recognition program aids facilities in self-identifying areas in which they can optimize care. Unlike trauma center designation, however, the purpose of the VPRP is **NOT** to differentiate EDs based on the level of care they can provide for children. Rather, the purpose is to promote basic recognition for **ALL** EDs to be able to provide initial stabilization of children with emergency conditions given that nationally 30% of ED patients are children. Additionally, greater than 90% of children are seen in general EDs when they have an emergency, not at a children's hospital. The intent of the VPRP is assure that all EDs are equipped with the ability to safely treat and manage children in their own communities when appropriate, not to bypass these facilities.

At its core, pediatric recognition provides the foundation to ensure high quality pediatric emergency care. Successful pediatric recognition programs share many common traits:

- Enhance awareness of pediatric emergency care gaps
- Recognize hospital and EMS infrastructures within the state
- Establish and maintain strong partnerships between hospitals and EMS agencies
- Define minimum criteria to promote pediatric recognition in the following areas:
    - Staff qualifications, including pediatric competencies
    - Quality improvement
    - Policies/procedures
    - Continuing education
    - Equipment/supplies
- Adaptable to refine the process on an ongoing basis.

**Justification for Texas**

In 2021, 267 of 525 hospital and free-standing emergency departments in Texas participated in the second National Pediatric Readiness Project (NPRP) assessment. The data from that assessment is currently being compiled and analyzed. Results from this assessment are anticipated to be published in 2022.

Current published data is from the initial NPRP assessment conducted in 2013. In 2013, 305 of 504 hospitals in Texas participated in the first NPRP assessment. These 305 hospitals cumulatively treat 1,572,835 children annually in their EDs. Of these children, 799,959 (51%) were treated in a pediatric ED in either a children's hospital or general hospital ED, while the remainder were treated in general EDs without a separate area for pediatric patients. In addition, 75% of these hospitals have the capability to admit a child to an inpatient unit,

while 38% have a Neonatal Intensive Care Unit (NICU), and 9% have a pediatric intensive care unit (PICU). While not every hospital may have a pediatric ED or the capability to admit a child, every ED must be equipped for the basic evaluation, management, and/or stabilization of a child with an emergency.

Based on NPRP data from Texas, it is clear variability exists among EDs in their ability to provide basic care to children. This variability does not necessarily correlate with geography or annual pediatric ED volume. There are some EDs with low pediatric volumes that scored high on the NPRP assessment, while there are some EDs that see more children that scored lower. Also, there are some rural EDs that scored higher on the NPRP assessment than urban EDs.

Feedback provided to the EMSC State Partnership from some EDs that see a low volume of children is that it is not necessary to invest the resources required to have the components assessed by the NPRP, since these children can be transferred to other EDs that are more equipped, such as children's hospitals. Though children's hospitals play a vital role in providing a higher level of care to children when medically necessary, the unnecessary transfer of children to children's hospitals, which are often located in urban areas, has negative consequences for patients, families, and local hospitals. If not covered by insurance, families must pay for the cost of the inter-facility transport. Also, being far from home can create social hardships for families by interfering with the ability for caregivers to go to work or safely return home after being discharged. Over time, such practices may also weaken the abilities of community EDs to be prepared to stabilize critically ill and/or injured children. Thus, critical access and/or community EDs may glean the greatest benefit from participating in a VPRP.

**Texas Summary:** In Texas, there are 504 emergency departments (EDs) that met the inclusion criteria for the pediatric recognition assessment. Of the 504 EDs, 305 responded to the assessment, which is 60.5% of all EDs in the state. On a national level, Texas represents 7% of the national data. Overall, Texas performed similar to other states.

**Overall Recognition Scores:** As the pediatric volume of an ED increases, its average pediatric recognition score is also higher.

**Texas Emergency Department Demographics:** Only 7% of the hospitals in Texas have a pediatric ED. In Texas, most EDs are general EDs. Only 4% of EDs are based in children's hospitals whereas another 3% of EDs have a separate pediatric section in a general hospital ED.

Every ED should be prepared and equipped to care for children at a basic level. When children require a higher level of care, it is helpful for EMS agencies and other hospitals to know the capabilities of other facilities, so that transfers to the appropriate facility can occur. In the event of a disaster or mass casualty incident, it is also important for hospitals and EMS agencies to know the EDs in their area who have the resources available to meet the needs of children.

**Texas Emergency Department Age Cut-Off:** Most hospitals in Texas use an age cut-off of 17-18 years to distinguish between a child and adult, both for medical and traumatic conditions. This varies from region to region and between hospitals within a region. For the purposes of the VPRP, the intent is to focus on ages 0-17 years, since this is the age range used by most hospitals to define a "pediatric" patient.

**Texas Pediatric Inpatient Capabilities:** Of the hospitals in Texas, 36% have an inpatient unit, and 28% have a Neonatal Intensive Care Unit (NICU); only 9% of hospitals in Texas have a Pediatric Intensive Care Unit (PICU).

Though inpatient pediatric services are not available in all hospitals in Texas, every ED must be equipped to stabilize children and be able to identify the hospitals that can provide a higher level of care if required.

**Presence of a Physician or Nurse Coordinator in the Emergency Department:** Another factor that was assessed from each ED was the presence of a nurse or physician coordinator to focus on pediatric emergency care. Having at least one pediatric emergency care coordinator (PECC) ensures someone is tasked with identifying and meeting the needs of children in the ED. The PECC may be a full or part-time position and it may be part of the job description of an existing ED role, such as a trauma coordinator, ED director, or a quality improvement coordinator, to name a few examples. The PECC can focus on some, or all of the following: ongoing education and skills competencies in pediatric ED care, ensuring policies and procedures are in place for children, creating a quality improvement plan for pediatric patients, ensuring appropriate medications and supplies are stocked, and pediatric care is included in staff orientation. National data from the NPRP shows that having a PECC is associated with having a higher pediatric recognition score. An advanced practice provider including a nurse practitioner or physician's assistant involved in the care of patients in the ED may fill the role of either of these emergency care coordinator roles.

**Physician Staffing:** Physician staffing was also assessed. Emergency medicine (EM) and pediatric emergency medicine (PEM) training equips physicians to care for children in emergencies. General pediatrics and family medicine educated and trained physicians may do this as well, if the skills are maintained. Specific education and training in handling pediatric emergencies is often lacking for other specialties.

**Physician Board Certification:** In Texas, 36% of hospital emergency departments have all of their physicians board-certified in either emergency medicine or pediatric emergency medicine. Of the EDs in Texas, 16% require neither board certification in EM or PEM for the entire medical staff.

**Pediatric Patient Care Review Process:** In Texas, 47% of EDs have a pediatric patient care review process in place. Having a pediatric patient care review process is also essential to identify system issues that may impact safety and quality of care.

**Weighing and Recording in Kilograms:** In Texas EDs, only 51% of pediatric patients have their weight both measured and recorded in kilograms. Weighing a pediatric patient in kilograms is important to ensure pediatric patient safety with respect to medication dosing. Since pediatric medication doses are calculated based on weight in kilograms, this is one of the most important areas for improvement in pediatric care.

**Hospital Pediatric Disaster Plan:** Only 41% of the hospitals in Texas include pediatrics in their disaster planning process. On a regional level, there is a variation in the presence of a disaster plan that addresses the needs of children. Planning for pediatric needs in disasters requires coordination between EMS and hospitals and it requires coordination between hospitals. This can often be overlooked.

## Program Levels

The Texas EMS for Children Voluntary Pediatric Recognition Program is structured to be a multi-level system of recognition. The fundamental phase, required to obtain initial recognition, centers around meeting the minimum requirements of pediatric recognition. From there, hospitals may opt to attain higher levels of recognition through the program.

**Pediatric Ready – Minimum Criteria**
The Pediatric Ready level of recognition relates to the minimum requirements of pediatric recognition. The list of recommended resources necessary to prepare emergency departments to care for pediatric patients is based on the 2018 joint policy statement *Pediatric Recognition in the Emergency Department*.

A checklist of supporting documents required to obtain the Pediatric Ready level of recognition is included in the back of this manual (Appendix D). To obtain this level of recognition, hospitals must demonstrate they have all items listed.

**Pediatric Champion – Recommendations for High-Volume EDs (>10,000 Pediatric Patient Visits)**
To achieve the Pediatric Champion level of recognition, a hospital must have met all criteria to achieve Pediatric Ready recognition. Appendix C, included in the back of this manual, provides a checklist of supporting documents required to obtain the Pediatric Champion level of recognition. To obtain this level of recognition, hospitals must demonstrate they have all items listed.

**Pediatric Innovator – Recommendations for High-Volume EDs (>10,000 Pediatric Patient Visits)**
To achieve the Pediatric Innovator level of recognition, a hospital must have met all criteria to achieve Pediatric Ready and Pediatric Champion levels of recognition. Appendix C, included in the back of this manual, provides a checklist of supporting documents required to obtain the Pediatric Innovator level of recognition. To obtain this level of recognition, hospitals must demonstrate they have all items listed.

## Budget Considerations

There are two site assessment options available to hospitals 1) virtual for the first two levels of recognition and 2) on-site for, the highest level of recognition. Some additional considerations are:

- Time/labor costs of possibly more than one ED and administration staff member to coordinate the assessment with the EMSC program.

- Quality Improvement (QI) Multidisciplinary committee - each hospital may require a committee/process to discuss ED pediatric QI issues, which require staff time and commitment. Some hospitals meet monthly, some meet quarterly however, there is no mandated number of meetings per year. Some hospitals have incorporated pediatrics into their existing infrastructure for trauma quality improvement review process.

- Equipment/supply costs (cost varies by hospital based on their level of pediatric readiness prior to the assessment).

- Required certifications – depending upon the recognition level, this ranges from all staff being required to have specialized certifications/competencies, to only one staff member on duty.

- Pediatric-specific continuing education (some hospitals cover this cost; others do not reimburse for CE).

**Process**

A process map of the application can be found in Appendix A.

- All applicants are required to submit the VPRP Assessment Application Form. This form can be found online at www.bcm.edu/emsc, or within this Application Manual (Appendix B).

- The application is to be returned to the EMSC program manager with all required documents attached. The application will then be reviewed for completeness after which a team of facilitators will be selected to conduct a site assessment.

- The EMSC program manager will work with the team and the facility to schedule the assessment and notify both parties of the assessment date and details.

- Prior to the assessment, the EMSC program manager will provide the facility and the team of facilitators with an Application Summary Form, which highlights any areas of the application that requires additional information or clarification. The facilitators will be responsible for ensuring that the additionally requested information within that document is provided during the assessment.

- The facility can also reach out to the program at any point during the application process to seek clarifications, or to request resources, which can help with meeting the criteria for recognition.

- The assessment will take place either virtually, or physically depending on the level of recognition the facility is seeking.

- Following the assessment, the facilitators will convene and complete a Final Consultation Report, which will be shared with the EMSC program and its advisory committee.

- Once the committee reviews the results of the assessment, it will provide the facility with feedback on the overall performance of their application.

- The EMSC Advisory Committee (EAC) will then proceed with a decision on whether the facility will be recognized through the program, or if a focused assessment will need to ensue in order to address any critical deficiencies identified.

- The applicant is notified of the EAC's decision.

## APPLICATION GUIDELINES

**Points of Contact**

Three key staff members should be designated to assist and act as the points of contact for this application:

- Primary Contact Person: This individual will be assuming responsibility for completion and submission of this application packet and will be the main point of contact for the coordination of

the site assessment. ED nurse directors or managers are preferred, as they are best equipped to answer the questions accurately.

- Physician Pediatric Emergency Care Coordinator (PECC)*: This individual works collaboratively with the nurse PECC and is responsible for ensuring the availability of pediatric equipment, supplies and medications, pediatric education/training and advocating for pediatric considerations to be included in protocol/policy development. A more extensive list of physician PECC roles and responsibilities can be found the Voluntary Pediatric Recognition Program Criteria (Appendix C).

  **An Advanced Practice Provider who is credentialed to care for patients in the ED may serve in this roles.*

- Nurse Pediatric Emergency Care Coordinator (PECC)*: This individual works collaboratively with the physician PECC and is responsible for ensuring the availability of pediatric equipment, supplies and medications, pediatric education/training and advocating for pediatric considerations to be included in protocol/policy development. A more extensive list of nurse PECC roles and responsibilities can be found in the VPRP Criteria (Appendix C).

  **An Advanced Practice Provider who is credentialed to care for patients in the ED may serve in this roles.*

**Submission Instructions**

Before you begin the application, please take a moment to carefully review all requirements in this application. Below are the items required at the time of application submission.

- Application Form: This will be your application cover page.

- VPRP Criteria and Supporting Document Checklist: The VPRP Criteria is a list of required equipment, supplies, personnel and policies in a table format with columns for initials of those who verify items that are present in the facility (Appendix C). The Supporting Document Checklist is used to ensure the submission of all required supporting documents (Appendix D).

- Organize supporting documentation (schedules, policies, procedures, protocols, guidelines, plans, etc.) in files labeled with the headings in the checklist. These will be electronic files if submitting electronically, or file folders if submitting through the postal system. Place appropriate documentation into the appropriate file. EX: PECC job descriptions should go in the file labeled, "Staff." Policies, procedures and protocols should go in the file labeled, "Policies, Procedures, and Protocols." Also, remember to clearly label any supporting documentation provided.

- You are encouraged to use the Supporting Document Checklist provided to ensure the completeness of your application (Appendix D).

- You can submit your application to the EMSC Program via the following ways:

  **Mail:** 1102 Bates Ave.
  Ste. 1850, BCM 320
  Houston, TX 77030 – 3411

**Fax:** 832-824-1182

**Box File:** If submitting electronically, a Box File will be created for you to deposit your electronic files in.

For questions regarding the application process, specific criteria items, and/or supporting documentation, please contact the EMSC Program Manager at 832-824-EMSC (3672).

## Facility Assessment Process

**Participants**

The following representatives are encouraged to represent the hospital

- ED Nurse Manager/Director
- Physician ED Medical Director
- Hospital Administrator: EX: VP, CEO, CNO, CMO
- Staff ED nurse
- Staff ED physician
- Nurse PECC
- Physician PECC

**Facilitators**

NOTE: The names of the facilitators will be submitted ahead of the assessment

**Duration**

Approximately 4 and one half hours (240 minutes) or as otherwise determined by the facilitator team

**Format**

- Virtual Conference with the use of a pre-selected videoconferencing software installed on a portable-device to facilitate the walking tour of the emergency department on the day of the assessment is essential.

- In person for higher levels of recognition.

**Additional Considerations**

- Hospital staff should reserve a room with strong internet connection that is available for the duration of the assessment. The room should be located away from patient care areas with traffic and noise at a minimum.

- Hospital staff and facilitator team should have contact information on hand for the troubleshooting team of the video-conferencing software for any urgent technical assistance.

**Assessment Timeline Overview**

| Time | Item | Presenter |
|---|---|---|
| **15 min.** | Introductions | All |
| **45 min.** | Opening Statements | All |
| **15 min.** | BREAK | |

| | | |
|---|---|---|
| **60 min.** | Review of Checklist Items | All |
| **60 min.** | Pediatric Scenarios | All |
| **30 min.** | BREAK (Facilitator Conference) | |
| **30 min.** | Exit Meeting | Facilitators |

**Introductions: 15 min.**
Introductions of the facilitators and the hospital staff with their roles and the organizations they represent.

**Opening Statements: 45 min.**

- EMSC overview (presented by facilitators)

- Outline of assessment agenda (presented by facilitators)

- Facility representatives should be prepared to do the following:
  - Provide an overview of ED units

  - Present baseline pediatric data
    - Annual number of emergency department visits (including a pediatric breakdown)
    - Age range of pediatric patient population
    - Transfer out rates
    - Return visits within 48 hours rates
    - Number of pediatric deaths
      - How long the patient was in the facility prior to death

  - Identify the facilities where they normally transfer pediatric trauma and medical patients

  - Provide a brief description of their **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats as related to their pediatric emergency care capabilities, services and resources as a general ED facility or Pediatric Emergency Department/Center

**Review of Checklist Items: 60 min.**

- Opportunity to provide additional clarifications on documents submitted in advance, as requested by the facilitator team

- Facility representatives should be ready to discuss ED staffing and personnel competencies:
  - Provide details on how the providers are credentialed and be prepared to produce the credentialing file of one ED physicians randomly selected from a list of providers.

  - Discuss how the provider's competencies to care for pediatric patients are assessed, how often, and how do they decide which competencies to assess.

  - Detail what types of CE is required of their healthcare staff, including physicians, nurses, paramedics etc. (e.g. ENPC, APLS, PALS, etc.);

  - Discuss the roles of the Pediatric Physician Coordinator and the Pediatric Nurse Coordinators if they are not available to speak with the facilitators;

- Provide a personnel file selected onsite by the facilitators from the list of staff. The file should contain documentation of orientation and ongoing competency evaluations.
  - The facilitators may then request to visualize a set of pre-selected equipment and supplies from the list of supplies and equipment included in the criteria.

    **NOTE: The list of equipment and medication to be visualized over video conference will not be divulged to the hospital staff prior to the assessment.**

  - Facility representatives should be ready to provide a description of the process of safe storage, prescribing, and delivery of pre-selected medication. The process should then be demonstrated via virtual conference.

  - Assessment of patient safety elements:
    - The scale used to record weight in Kilograms (kgs) will be visualized over virtual conference.
    - The facilitators will then conduct a brief interview with the staff responsible for taking vital signs (PCA or RN) to discuss what the hospital's reference for normal vital signs is, the staff's plan of action to address abnormal vital signs, and what system is used to notify the providers.
    - The hospital staff will provide a demonstration of the process used to access the interpreter via virtual conference.

**Pediatric Scenarios: 60 min.**
Pediatric scenarios will be provided in advance and should be completed and submitted prior to the day of the assessment.

- The hospital staff should be prepared to respond to questions related to scenarios presented by facilitators.

**Exit meeting: 30 min.**

- The facilitators and the facility representatives will take this opportunity to address any unanswered question.

- To conclude the assessment, the facilitators will provide the hospital staff a general timeline for when feedback will be provided to them.

## Recognition as a VPRP Facility

Upon achieving recognition as a VPRP facility in the State of Texas, an official letter from the Director of the EMSC Program, a frameable Certificate of Recognition, and a window decal will be issued to the facility. While placement of the window decal is strongly encouraged, it is not required. Successful applicants, by virtue of applying for recognition, authorize their organization name and general information to be posted in program documents and the EMS for Children website. Facilities are also encouraged to promote their recognition under this program through a Public Relations event, press release, etc.

- If the application is incomplete, or if pediatric emergency care standards are not met to the level required for recognition, a letter will be sent via email to the facility representative with deficiencies

identified. Subsequently, the facility will be given the opportunity to work on those deficiencies and can request a focused assessment to be conducted for the program to verify the improved upon measures.

- A facility may also choose to submit applications multiple times until the program issues a Certificate of Recognition.

- Recognition may be renewed by submitting a renewal application every three years.

- If due to extenuating circumstance a facility recognized through the program is unable to maintain their recognition status, they may withdraw their recognition status or downgrade to the next attainable level. In this situation, the hospital will notify the EMSC Program through a written notice at least 60 days prior to withdrawal or the status change, if possible. In the notification, please include information on the rationale for the decision.

- In the event a facility no longer maintains recognition status, the Certificate of Recognition and decals must be removed from their facility promptly (within 5-days).

**Appeals Process**

Every effort will be made by the program to assist a facility/hospital meet the requirement of the recognition program both prior to the site assessment and after. However, if a facility/hospital has any question or concerns regarding an unfavorable result of their assessment, they are welcome to submit a written explanation of why they disagree with the decision and to request for a new panel of facilitators to conduct a second assessment. The overall aim of the VPRP is to help every emergency department in the state be better prepared to treat and manage pediatric trauma and medical emergencies within their communities. Every effort will be made by the program to help each facility reach that goal.

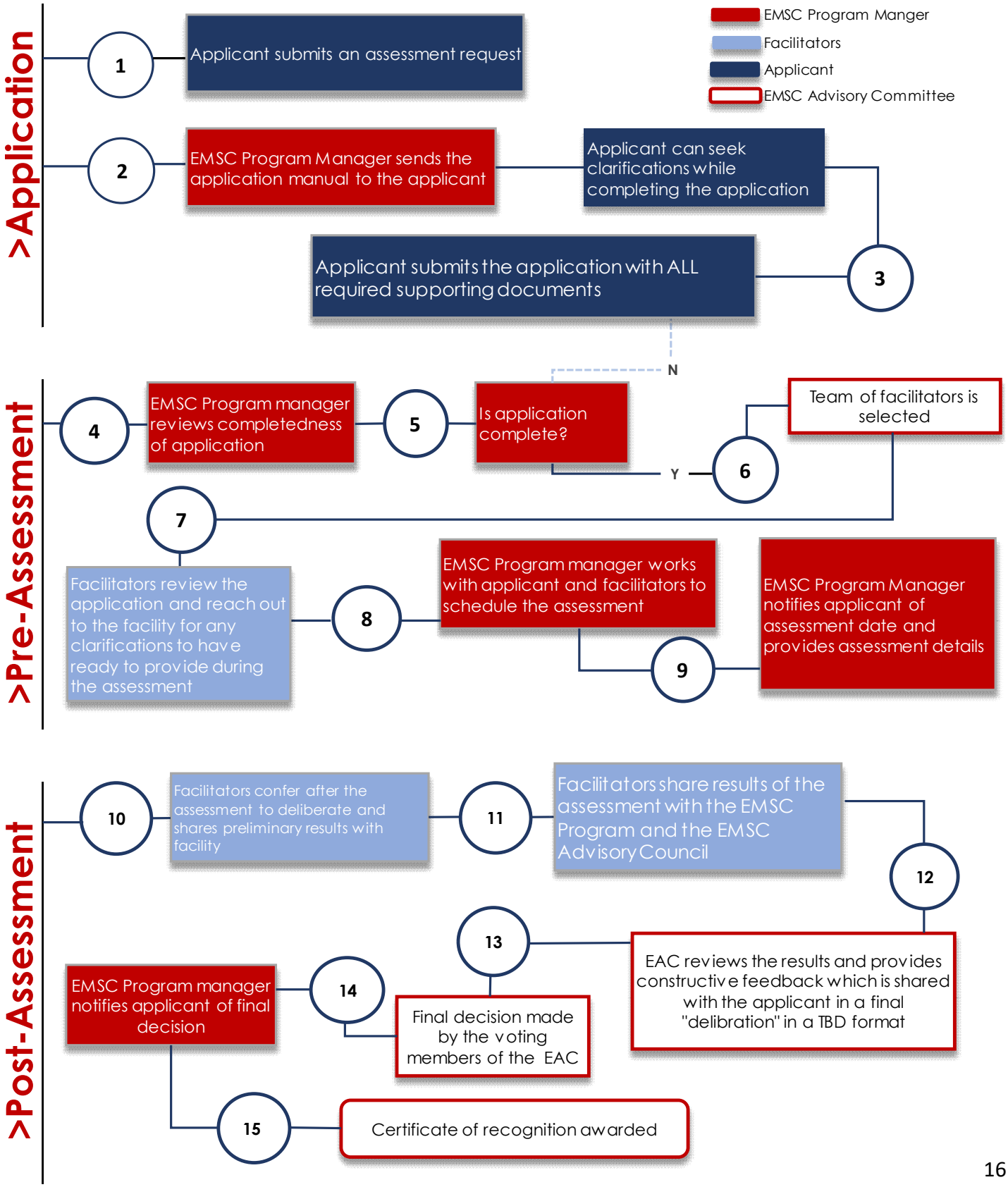
**Performance Monitoring**

To evaluate the effectiveness of the VPRP, data will be requested from each facility to be reported directly to the EMSC program office on a periodic basis. The method of gathering data will be determined later. The frequency of reporting will also be determined through consultation with participating facilities. We intend to ensure that data is seamlessly shared between EMSC and each participating facility.

**APPENDIX A: Application Process Map**

# EMS RECOGNITION PROGRAM

## *Application Process*



**APPENDIX B: Application Form**

**APPLICATION FORM**

In order to process your application, please complete the following form and forward this application to the Texas EMS for Children State Partnership office.

| | |
|---|---|
| **Name of Facility/Organization:** | |
| **Mailing Address:** | |

| **LEVEL OF RECOGNITION APPLYING FOR:** | | |
|---|---|---|
| ☐ **Pediatric Ready** | ☐ **Pediatric Champion** | ☐ **Pediatric Innovator** |

| | |
|---|---|
| **Physician Pediatric Emergency Care Coordinator** | **Name:** |
| | **Title:** |
| | **Email address:** |
| | **Telephone:** |

| | |
|---|---|
| **Nurse Pediatric Emergency Care Coordinator** | **Name:** |
| | **Title:** |
| | **Email address:** |
| | **Telephone:** |

| | |
|---|---|
| **Official Completing the Form** | **Name:** |
| | **Title:** |
| | **Email address:** |
| | **Telephone:** |

By signing this document, the applicant understands: The program is voluntary, the decision to participate will in no way impact licensure by the State of Texas, and the facility's recognition status will be determined by the EMSC Advisory Committee.

**Signature:** _____ **Date:** _____

**APPENDIX C: Voluntary Pediatric Recognition Program Criteria**

| Voluntary Pediatric Recognition Program Criteria | | | |
|---|---|---|---|
| **PEDIATRIC READY** | | | |
| **Official Completing Form (please print): _____Date: _____** | **Initials: _____** | | |
| *Instructions: The requirements and acceptable documentation are detailed for each item on the list by type of assessment. For each item, please initial in the box provided for each line item/equipment to indicate the acceptable forms of documentation/material were submitted along with the application. Please attach any documentation/material as an addendum to this application.* | | | |
| **DESCRIPTION** | **SITE ASSESSMENT** | | |
| **Participation in the National Pediatrics Preparedness Project** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| *ALL APPLICANTS ARE REQUIRED TO PARTICIPATE IN THE NATIONAL PEDIATRIC PREPARDNESS PROGRAM.* | https://www.pedsready.org/ | | |
| **Pediatric Emergency Care Coordinator (PECC)** | **PRE-SUBMITTED** | **ASSESSMENT** | |
| A Pediatric Emergency Care Coordinator (PECC)--sometimes referred to as a pediatric champion or pediatric liaison--refers to any individual who has an interest in or responsibilities related to pediatric emergency care. Sometimes this individual is dedicated solely to this role. However, depending on the pediatric volume of the hospital, this person may take on the PECC duties in addition to other responsibilities (e.g., educator, trauma coordinator, etc.).The physician and nurse PECC work collaboratively and are responsible for the following: ensuring the availability of pediatric equipment; supplies and medications; pediatric education/training/skills competencies; advocating for pediatric considerations to be included in protocol/policy development; participates in the development of the QI plan; serves as liaison and/or coordinator with regional EMS, trauma and disaster preparedness committees; liaison to definitive care facilities; facilitates competency evaluations; facilitates pediatric needs in hospital disaster preparedness plans<br><br>Physician PECC:<br>• Board certified /eligible in EM or PEM (preferred, but not required for resource limited hospitals) | Name of person and copy of official position description | 30-minute interview by the facilitator with the PECC to discuss their role | |

| | | | | |
|---|---|---|---|---|
| | • Is not board certified in EM or PEM but meets the qualifications for credentialing by the hospital as an emergency clinician specialist with special training and experience in the evaluation management of the critically ill child<br><br>Nurse PECC:<br>• CPEN/CEN (preferred)<br>• Other credentials (e.g. CPN, CCRN)<br><br>* *For EDs with limited resources, an Advanced Practice Provider (APP) who is credentialed to care for patients in the ED may serve in either of these roles.* | Name of person and copy of official position description | 30-minute interview by the facilitator with the PECC to discuss their role | |
| | **Physician, Advance Practice Providers (APPs), Nurses and Other ED Healthcare Providers** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| | Physicians and Advanced Practice Providers who staff the ED, and on the basis of their level of training and scope of practice, have the necessary skill, knowledge, and training in the emergency evaluation and treatment of children of all ages who may be brought to the ED, consistent with the services provided by the hospital. This means that there is 24/7 provider coverage of the ED by a physician board certified in Emergency Medicine (EM), Pediatrics, Family Medicine (FM), Peds Emergency Medicine (PEM) OR if they are not board certified in one of the aforementioned subspecialties, they maintain current provider status in Pediatric Advanced Life Support (PALS) OR Advanced Pediatric Life Support (APLS). | A confidential list of current medical staff and their board certification, if not board certified in EM, Peds, FM, or PEM, then expiration date of their APLS/PALS certification | | |
| | Nurses and other ED health care providers who staff the ED and based on their level of training and scope of practice, have the necessary skills, knowledge, and training in the emergency evaluation and treatment of children of all ages who may be brought to the ED, consistent with the services provided by the hospital as deemed by up-to-date provider status in PALS, APLS, or ENPC. Staff coverage must be 24/7. | A confidential list of current nursing and ED health care providers and the expiration date of their APLS/PALS or ENPC provider verification | | |
| | Baseline and periodic competency evaluations must be completed for all ED clinical staff, including physicians, advanced practice providers, nurses, and other healthcare providers which are age specific and include evaluation of skills related to neonates, infants, children, adolescents, and children with special health care needs. | Written policy regarding scope and frequency of evaluations for staff | Review evaluations of 10 staff | |

| | | | |
|---|---|---|---|
| Areas for pediatric competency and professional evaluation include, but are not limited to the following:<br>• Assessment and treatment (e.g. triage)<br>• Medication administration<br>• Device/equipment safety<br>• Critical procedures<br>• Resuscitation (including simulation)<br>• Trauma resuscitation and stabilization<br>• Disaster drills that include children<br>• Patient and family centered care<br>• Team training and effective communication | | | |
| **Guidelines for Improving Pediatric Patient Safety** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| ALL infants and children presenting to the ED have the following vital signs recorded in the medical record: temperature, heart rate, respiratory rate, pulse oximetry, blood pressure, pain, and mental status. | Copy of Written policy | Sample Audit of charts | |
| Blood pressure, pulse oximetry monitoring, and continuous end-tidal CO2 monitoring are available using the appropriate size equipment for children of all ages. | Official equipment list for unit with hospital logo on the document from central supply/biomed department OR a picture of the equipment | Visual Inspection of equipment by the facilitator | |
| A process in place that allows for 24/7 access to interpreter services in the ED. | A copy of the process | Demonstrate to the facilitator how to access the interpreter | |

| | | | |
|---|---|---|---|
| All children seen in the ED are weighed in kilograms (kgs) ONLY and that weight is recorded in the ED medical record in kg ONLY | Copy of Written policy | Visual inspection of the scale and an audit of 10 patient charts | |
| A process for identifying abnormal vital signs (age or weight based) and notifying the physician or APP of these abnormal vital signs. | Copy of the Policy | A discussion with person who takes vitals (PCA or RN) to describe what they do if something is abnormal and chart audit of 10 charts with abnormal pediatric vitals to check for documentation of reporting | |
| There are processes in place for safe medication delivery, which include storage, prescribing, administration and disposal. This includes pre-calculated dosing and formulation guides for children of all ages. | A description of the process | Discussion with RN, MD/DO, APP, Pharmacist about a case example (with a controlled substance) to describe the process used in the ED to store, prescribe, and deliver a medication | |
| For children who require resuscitation or emergency stabilization, a standard method for estimating weight in kilograms is used (e.g. medication chart, length-based system, medical software, or other systems are readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications). | A description of the tool(s) used | Discussion with RN, MD/DO, APP, pharmacist about a case example (3 y/o with status | |

| | | | |
|---|---|---|---|
| | | epilepticus who needs medication for seizure and then needs to be intubated) to identify the proper doses of medications | |
| **Guidelines for QI/PI in the ED** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| The hospital has a pediatric patient care-review process using outcome-based measures for internal review.<br>• number of pediatric patients seen in the ED<br>• admission rate<br>• incoming and outgoing transfer %<br>• mortality (death review)<br>• return visit rate | Submission of specified data | Interview with person responsible for compiling this data to describe the process used and to get feedback | |
| The QI/PI plan includes a process to monitor system performance over time and implement system changes based on this performance. | Copy of the QI/PI plan | Interview person responsible for the QI/PI plan, monitoring it, and implementing changes as a result | |
| **ED Policies, Procedures, and Protocols** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| The ED has a process that promotes family-centered care, which includes, but not limited to the following:<br>• Family and guardian presence during all aspects of emergency care, including resuscitation<br>• Patient, family, guardian, and caregiver education<br>• Family and guardian involvement in patient care decision-making and medication safety processes<br>• Discharge planning and education<br>• Bereavement counseling | A written description of the facility's process | Interview staff (RN, MD/DO, APP, child life if applicable) to describe management of a case scenario (a child in respiratory arrest who needs to be intubated) | |

| | | | |
|---|---|---|---|
| The ED has a process to obtain consent, including situations in which a parent or legal guardian is not immediately available. | A written description of the facility's process | Interview staff (RN, MD/DO, APP) to describe management of a case scenario (a child delivered to the ED without a parent or guardian present) | |
| The ED has a process to communicate with a patient's medical home or primary health care provider at the time of the ED visit (this can help ensure that a judicious and appropriate approach to examination, testing, imaging, and treatment is coordinated and follow-up is arranged the most cost effective and up to date manner). | A written description of the facility's process | Discussion with the staff on the process used to communicate with the patient's medical home or primary healthcare provider and how it is documented | |
| The ED uses a validated triage tool AND has a triage policy that specifically addresses ill and injured children. | Name of the tool and a copy of the policy, which also specifies how staff are trained to use it | Chart audit of 10 cases that demonstrates triage documentation and triage level assigned | |
| The ED has a policy addressing pediatric patient assessment and how frequently children should be reassessed. | Copy of Written policy | Chart audit of 10 cases that demonstrates that the policy is adhered to | |

| | | | |
|---|---|---|---|
| The ED has a process for assessing immunization/ vaccination status and management of the patient who is under immunized (e.g. tetanus and rabies). | A description of the process | Discussion with RN, MD/DO, APP, Pharmacist about a case example (12 y/o with dirty wound and needs a tetanus booster) to describe the process used in the ED to store, prescribe, and deliver a medication | |
| The ED has a written protocol for the use of sedation and analgesia (including nonpharmacologic interventions for comfort) for procedures, including medical imaging. | Copy of the written protocol | Chart audit of 10 cases, which demonstrates adherence to the protocol | |
| The ED has a written protocol for the management of social and behavioral health issues, including parents and patients who are belligerent, impaired or violent. | Copy of the written protocol | Discussion with the RN/MD/DO, APP about a case example (14 y/o male who is verbally and physically abusive to staff) to describe the process used to manage this situation | |

| | | | |
|---|---|---|---|
| The hospital has a written protocol for the physical or chemical restraint of pediatric patients. | Copy of the written policy | Discussion can be incorporated into the case example presented above | |
| The ED has a policy for the mandated reporting and assessment of child maltreatment (physical and sexual abuse, sexual assault, human trafficking, and neglect). | Copy of Written policy | Discussion with RN, MD/DO, APP about a case example (4 y/o brought in due to alleged sexual abuse that occurred that day) to describe the process used to evaluate and coordinate transfer or follow up for the patient | |
| The ED has a policy on how to handle the death of a child in the ED. | Copy of Written policy | Discussion with RN, MD/DO, APP about a case example (3 month old found apneic in crib, brought by EMS) | |
| The ED has a policy on adhering to pediatric do-not-resuscitate orders. | Copy of Written policy | Discussion with RN, MD/DO, APP about a case example (8 y/o special needs patient who | |

| | | | |
|---|---|---|---|
| | | arrests in the ED and has a DNR order) | |
| The ED has protocols on the care and treatment of children with special health care needs, including developmental disabilities (e.g. autism spectrum disorders and ventilator dependence). | A copy of the protocols | Discussion with RN, MD/DO, APP about a case example (1 y/o with bronchopulmonary dysplasia who is ventilator dependent and there is a malfunction of the ventilator) | |
| The ED has a process regarding the use of telehealth and telecommunications to communicate with facilities that provide a higher level of care, EMS, etc. | A description of the process | Visual Inspection of equipment by the facilitator | |
| **All Hazard Disaster Preparedness** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| The ED or hospital has an all-hazard disaster-preparedness plan in which the following pediatric issues are addressed:<br>• Medications, vaccines, equipment, supplies and trained providers for children in disasters<br>• Pediatric surge capacity for injured and non-injured children<br>• Decontamination, isolation, and quarantine of families and children of all ages<br>• Minimization of parent-child separation<br>• Tracking and reunification for children and families<br>• Access to specific behavioral health therapies, and social services for children<br>• Disaster drills include a pediatric mass casualty incident at least every two years | A copy of the plan | Discussion with RN, MD/DO, APP about a case example (Bus accident with 10 injured children coming to their ED) to describe the process used to evaluate and coordinate | |

| | | | |
|---|---|---|---|
| • Care of children with special health care needs | | transfer for the patient, if needed | |
| **Evidence-Based Guidelines** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| Evidence-based clinical pathways, order sets, or decision support should be available to providers in real time. These may be systemically derived, consensus driven, or locally developed on the basis of available evidence. Collaboration with regional pediatric centers and trauma centers may facilitate the use of standard, evidence-based guidelines. An updated and complete list is available on the National Pediatric Readiness Project web site. https://pedsready.org/ | A copy of the evidence-based clinical pathways, order sets, or decision support | Review of the Evidence-based clinical pathways, order sets, or decision support by the Facilitators | |
| **Inter-Facility Transfers** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| The hospital has written pediatric inter-facility transfer procedures and/or agreements, which include the following pediatric components:<br>• Criteria for transfers (e.g. specialty services)<br>• Criteria for selection of appropriate transfer service<br>• Process for initiation of transfer<br>• Plan for transfer of patient information<br>• Integration of family-centered care<br>• Integration with telehealth/telecommunication | Copy of Written policy | Discussion with MD/DO about where they would send the following patients, if services could not be provided at their own facility:<br>• A 3 y/o with >30% burns<br>• A 2 y/o in with a head bleed<br>• A 6 y/o with a Type 3 supracondylar fracture<br>• A 6 month-old with bronchiolitis, intubated for respiratory failure<br>• A 15 y/o with | |

| | | | |
|---|---|---|---|
| | | ectopic pregnancy<br>• A 13 y/o with suicidal ideation | |
| **Guidelines for ED Support Services** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| The ED adheres to a policy of medical imaging that addresses pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with the ALARA (as low as reasonably achievable) principle, if a computed tomography (CT) scanner is available at the facility.<br>• A process should be established for the referral of children to appropriate facilities for radiologic procedures that exceed the capability of the hospital.<br>• All efforts made to transfer completed images when a patient is transferred from one facility to another. | Copy of Written policy | Discussion with radiologist and radiology tech about how the policy is applied. (Case example: 5 y/o with altered mental status after a head injury and needs a head CT) | |
| **Guidelines for Medication, Equipment, and Supplies** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| Pediatric equipment, supplies, and medications are appropriate for children of all ages and sizes and are easily accessible, clearly labeled, and logically organized.<br>• ED staff is educated on the location of all items<br>• Daily method in place to verify the proper location and function of pediatric equipment supplies<br>• Medication chart, length-based tape, medical software, or other systems is readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications<br>• Standardized chart or tool to estimate weight in kilograms if resuscitation precludes the use of a weight scale (e.g. length-based tape) | Copy of written procedure/protocol for daily method to verify the proper location and function of equipment and expiration of medications and supplies | Visual inspection of equipment, supplies and medications by Facilitators | |
| **Medications** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| Analgesics (oral, intranasal, and parenteral) | Official equipment list for unit with hospital logo on the document from central | Visual Inspection of equipment by the facilitator | |
| Anesthetics (eutectic mixture of local anesthetics; lidocaine 2.5% and prilocaine 2.5%; lidocaine, epinephrine, and tetracaine; and LMX 4 [4% lidocaine]) | | | |
| Anticonvulsants (benzodiazepines, levetiracetam, valproate, carbamazepine, fosphenytoin, and phenobarbital) | | | |
| Antidotes (common antidotes should be accessible to the ED. e.g. naloxone) | | | |

| | | | |
|---|---|---|---|
| Antipyretics (acetaminophen and ibuprofen) | supply/biomed department | | |
| Antiemetics (ondansetron and prochlorperazine) | | | |
| Antihypertensives (labetalol, nicardipine, and sodium nitroprusside) | | | |
| Antimicrobials (parenteral and oral) | | | |
| Antipsychotics (olanzapine and haloperidol) | | | |
| Benzodiazepines (midazolam and lorazepam) | | | |
| Bronchodilators | | | |
| Calcium Chloride and/or calcium gluconate | | | |
| Corticosteroids (dexamethasone, methylprednisolone, and hydrocortisone) | | | |
| Cardiac medications (adenosine, amiodarone, atropine, procainamide, and lidocaine) | | | |
| Hypoglycemic interventions (dextrose, oral glucose) | | | |
| Diphenhydramine | | | |
| Epinephrine (1mg/mL [IM] and 0.1 mg/mL [IV] solutions) | | | |
| Furosemide | | | |
| Glucagon | Official equipment list for unit with hospital logo on the document from central supply/biomed department | | |
| Insulin | | | |
| Magnesium sulfate | | | |
| Intracranial hypertension medications (mannitol, 3% hypertonic saline) | | | |
| Neuromuscular blockers (rocuronium and succinylcholine) | | | |
| Sucrose solutions for pain control in infants | | | |
| Sedation medications (midazolam, etomidate and ketamine) | | | |
| Sodium bicarbonate (4.2%) | | | |
| Vasopressor agents (dopamine, epinephrine and norepinephrine) | | | |
| Vaccines (tetanus) | | | |
| **Equipment/Supplies: General Equipment** | | | |
| Patient warming device (infant warmer) | | | |
| IV blood and/or fluid warmer | | | |
| Restraint device | | | |
| Weight scale, in kilograms only (no opportunity to weigh or report in pounds), for infants and children | | | |

| | | | |
|---|---|---|---|
| Tool or chart that relies on weight (kilograms) used to assist physicians and nurses in determining equipment size and correct drug dosing (by weight and total volume) | | | |
| Pain scale assessment tools that are appropriate for age | | | |
| Rigid boards for use in CPR | Official equipment list for unit with hospital logo on the document from central supply/biomed department | Visual Inspection of equipment by the facilitator | |
| Pediatric specific AED pads | | | |
| **Equipment/Supplies: Respiratory** | | | |
| Endotracheal Tubes<br>• Uncuffed 2.5 mm<br>• Uncuffed 3.0 mm<br>• Cuffed or uncuffed 3.5 mm<br>• Cuffed or uncuffed 4.0 mm<br>• Cuffed or uncuffed 4.5 mm<br>• Cuffed or uncuffed 5.0 mm<br>• Cuffed or uncuffed 5.5 mm<br>• Cuffed 6.0 mm | | | |
| Feeding Tubes<br>• 5F<br>• 8F | | | |
| Laryngoscope Blades<br>• Straight: 0<br>• Straight: 1<br>• Straight: 2<br>• Curved: 2 | | | |
| Magill Forceps<br>• Pediatric | | | |
| Nasopharyngeal Airways<br>• Infant<br>• Child | | | |
| Oropharyngeal Airways<br>• Size 0 | | | |

| | | | |
|---|---|---|---|
| • Size 1<br>• Size 2<br>• Size 3 | | | |
| Stylets for ET Tubes<br>• Infant<br>• Pediatric | Official equipment list for unit with hospital logo on the document from central supply/biomed department | Visual Inspection of equipment by the facilitator | |
| Suction Catheters<br>• Infant (6-8F)<br>• Child (10-12F) | | | |
| Rigid Suction Device<br>• Pediatric | | | |
| Bag-mask device, self-inflating<br>• Infant (250 ml)<br>• Child (450-500 ml) | | | |
| Non-rebreather masks<br>• Infant<br>• Child | | | |
| Clear Oxygen masks<br>• Infant<br>• Child | | | |
| Mask to fit bag-mask device adaptor<br>• Neonatal<br>• Infant<br>• Child | | | |
| Nasal Cannula<br>• Infant<br>• Child | | | |
| Gastric tubes<br>• Infant (8F) | | | |

| | | | |
|---|---|---|---|
| • Child (10F) | | | |
| **Equipment/Supplies: Vascular Access** | Official equipment list for unit with hospital logo on the document from central supply/biomed department | Visual Inspection of equipment by the facilitator | |
| Arm boards<br>• Infant<br>• child | | | |
| Atomizer for intranasal administration of medication | | | |
| Catheter over the needle device<br>• 22 gauge<br>• 24 gauge | | | |
| Intraosseous needles or devices<br>• Pediatric<br>• IV administration sets with calibrated chambers and extension tubing and/or infusion devices with the ability to regulate the rate and volume of infusate (including low volumes) | | | |
| IV solutions<br>• Normal Saline<br>• Dextrose 5% in 0.45% Normal Saline<br>• Lactated Ringer's solution<br>• Dextrose 10% in water | | | |
| **Equipment/Supplies: Fracture Management** | | | |
| Extremity splints (including femur splints)<br>• Pediatric | | | |
| Cervical Collar<br>• Infant<br>• Child | | | |
| **Equipment/Supplies: Monitoring Equipment** | | | |
| Blood pressure cuffs<br>• Neonatal<br>• Infant<br>• Child | | | |

| | | | |
|---|---|---|---|
| Doppler ultrasonography devices | | | |
| ECG monitor and/or defibrillator with pediatric and adult capabilities, including pediatric sized pads and/or paddles | | | |
| Continuous end-tidal CO2 monitoring | | | |
| **Equipment/Supplies: Specialized Pediatric Trays or Kits** | | | |
| Difficult airway supplies and/or kit (Contents to be based on pediatric patients served at the hospital and may include some or all of the following):<br>• Supraglottic airways of all sizes<br>• Needle cricothyrotomy supplies<br>• Surgical cricothyrotomy kit<br>• Video laryngoscopy | | | |
| Newborn Delivery Kit (including equipment for initial resuscitation of a newborn infant):<br>• Umbilical clamp<br>• Scissors<br>• Bulb syringe<br>• Towel | | | |
| Urinary catheterization kits and urinary (indwelling) catheters<br>• Infant<br>• Child | | | |
| **PEDIATRIC CHAMPION** | | | |
| **Recommendations for High-Volume EDs (>10,000 Pediatric Patient Visits)** | **PRE-SUBMITTED** | **ASSESSMENT** | **INIT** |
| Alprostadil (prostaglandin E1) | Official equipment list for unit with hospital logo on the document from central supply/biomed department | Visual Inspection of equipment by the facilitator | |
| Central Lines Venous Catheters<br>• 4.0F<br>• 5.0F<br>• 6.0F<br>• 7.0F | | | |
| Chest Tubes<br>• Infant (8-12F catheter)<br>• Child (14-22F catheter)<br>• Adult (24-40F catheter) or | | | |

| | | | |
|---|---|---|---|
| • Pigtail catheter kit (8.15-14F catheter) | | | |
| Hypothermia Thermometer | | | |
| Inotropic agents (e.g. digoxin and milrinone) | | | |
| Laryngoscope blade<br>• Size 00 | | | |
| Lumbar puncture tray, spinal needles<br>• Infant<br>• Child | | | |
| Noninvasive ventilation<br>• Continuous positive airway pressure or<br>• High flow nasal cannula | | | |
| Self-inflating bag mask device<br>• Pediatric | | | |
| Tube thoracostomy tray | | | |
| Tracheostomy tubes<br>• Size 0<br>• Size 1<br>• Size 2<br>• Size 3<br>• Size 4<br>• Size 5<br>• Size 6 | Official equipment list for unit with hospital logo on the document from central supply/biomed department | Visual Inspection of equipment by the facilitator | |
| Umbilical Venous Catheters<br>• 3.5F<br>• 5.0F | | | |
| Video Laryngoscopy | | | |
| **Quality Improvement Initiative** | **ASSESSMENT** | | **INIT** |
| The hospital agrees to participate in a QI initiative with EMSC, and they will submit information through an online portal. | | | |

| | | |
|---|---|---|
| The facility should provide a description of how they are addressing the gaps identified from this data (one example would be implementation of a clinical practice guideline or doing research on the issue), in a format that could potentially be used as a QI publication. This may include one or more of the following:<br>CT use for traumatic head injury<br>Appropriateness of imaging and transfer for suspected appendicitis<br>Appropriateness of transfer for orthopedic injury<br>Appropriateness of management and transfer for asthma and pneumonia<br>Appropriateness of management and transfer for (febrile) seizures | Written description of initiative to include data set and process for capturing data. | |
| There is an individual in the hospital with a current certification in neonatal resuscitation (NRP) 24/ 7 who is available to respond to the ED if there is not a provider in the hospital at the same time who is board certified in Pediatrics, Emergency Medicine, Pediatric Emergency Medicine, or Family Medicine. | Provide facilitator with a confidential list of current medical staff and the expiration date of their NRP certification | |
| **PEDIATRIC INNOVATOR** | | |
| **Physician, Nurses and Other Healthcare Providers Who Staff the ED** | **ASSESSMENT** | **INIT** |
| Baseline and periodic competency evaluations must be completed for all ED clinical staff, including physicians and APPs, that are age-specific and include evaluation of skills related to neonates, infants, children, adolescents, and children with special health care needs. Competencies are determined by each institution's hospital policies and medical staff privileges as a part of the local credentialing process for all licensed ED staff. | Provide facilitator with confidential evaluations of 10 staff. Written policy may be submitted in advance describing frequency and scope of evaluations. | |
| **Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED** | **ASSESSMENT** | **INIT** |
| Tracheostomy tubes<br>• Size 0<br>• Size 1<br>• Size 2<br>• Size 3<br>• Size 4 | Visual inspection of device/equipment by the facilitator. Equipment list can be submitted in advance for prior review | |

| | | |
|---|---|---|
| • Size 5<br>• Size 6 | | |
| **Guidelines for QI/PI in the ED** | **ASSESSMENT** | **INIT** |
| Components of the QI process to integrate with out-of-hospital, ED, inpatient pediatrics, pediatric critical care, and hospital-wide QI or PI activities | In depth discussion with PECC or other QI personnel to describe how this is being accomplished. A written description of the process should be provided in advance of site assessment. | |

## APPENDIX D: SUPPORTING DOCUMENT CHECKLIST

## SUPPORTING DOCUMENT CHECKLIST

***Pediatric Ready Level of Recognition***

**<u>Use this checklist to ensure the submission of all required supporting documents</u>**

**Pediatric Emergency Care Coordinator (PECC)**

☐ Name of physician PECC and copy of official position description.

☐ Name of nurse PECC and copy of official position description listing their duties as described in the guidelines.

**Physicians, Advance Practice Providers (APP), Nurses and other ED Healthcare Providers**
**Equipment, Supplies and Medication**

☐ List of confidential medical staff and their board certification. If not board certified, expiration date of their APLS/PALS certification.

☐ List of confidential current nursing and ED health care providers and the expiration date of their APLS/PALS or ENPC provider verification.

☐ Copy of the policy regarding the scope and frequency of competency evaluations for physicians, advanced practice providers (APP), nurses, and other healthcare providers.

**Guidelines for Improving Pediatric Patient Safety**

☐ Copy of the policy for obtaining and recording vital signs.

☐ Official equipment list for unit with hospital logo on the document from central supply/biomed department OR a picture of the equipment.

☐ A description of the process that allows for 24/7 access to interpreter services in the ED.

☐ Copy of the policy mandating all children seen in the ED be weighed in kilograms (kgs) ONLY and that weight recorded in the ED medical record in kg ONLY.

☐ Copy of the policy and process for identifying abnormal vital signs and notification of the physician or APP.

☐ A description of the processes in place for safe medication delivery, which includes storage, prescribing, administration, and disposal. This includes pre-calculated dosing guidelines for children of all ages.

☐ A description of the standard method for estimating weight in kilograms. e.g. medication chart, length-based tape, medical software, or other systems that are readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications.

**Guidelines for QI/PI in the ED**

☐ Copy of the pediatric QI/PI plan.

☐ Submission of the following data: number of pediatric patients seen in the ED, admission rate, incoming and outgoing transfer %, mortality (deaths), and return visit rate.

**ED Policies, Procedures, and Protocols**

☐ A written description of the facility's process that promotes family-centered care (e.g. family presence at the bedside, family involvement in clinical decision making, caregiver education, etc.).

☐ A written description of the process to obtain consent, including situations in which a parent or legal guardian is not immediately available.

☐ A written description of the process to communicate with a patient's medical home or primary health care provider at the time of the ED visit.
☐ Copy of the triage policy that addresses ill and injured children, specifies which validated triage tool used in the ED, and details how the staff are trained on its use.
☐ Copy of the written policy which addresses pediatric patient assessment and how frequently children should be reassessed.
☐ A description of the process the ED has for assessing immunization/ vaccination status and management of the patient who is under immunized.
☐ Copy of the protocol for use of sedation and analgesia (including non-pharmacologic interventions for comfort) for procedures, including medical imaging.
☐ Copy of the protocol for the management of social and behavioral health issues, including parents and patients who are belligerent, impaired or violent.
☐ Copy of the protocol for the physical or chemical restraint of pediatric patients.
☐ Copy of the policy for the mandated reporting and assessment of child maltreatment (physical, and sexual abuse, sexual assault, human trafficking, and neglect).
☐ Copy of the policy on how to handle the death of a child in the ED.
☐ Copy of the policy on adhering to pediatric do-not-resuscitate orders.
☐ Copy of the protocols on the care and treatment of children with special health care needs, including developmental disabilities.
☐ A description of the process regarding the use of telehealth and telecommunications to communicate with facilities that provide a higher level of care, EMS, etc.

**All Hazard Disaster Preparedness**

☐ Copy of the ED's or hospital all-hazard disaster-preparedness plan that addresses issues specific to the care of children.

**Evidence-Based Guidelines**

☐ Copy of the evidence-based clinical pathways, order sets, or decision support.

**Inter Facility Transfers**

☐ Copy of the pediatric inter-facility transfer procedures and/or agreements that include the components outlined in the VPRP Program Criteria.

**Guidelines for Support Services**

☐ Copy of the policy of medical imaging that addresses pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with the ALARA (as low as reasonably achievable) principle, if a computed tomography (CT) scanner is available at the facility.

**Guidelines for Medications, Equipment, and Supplies**

☐ Copy of the procedure and/or protocol for the daily method to verify the proper location and function of equipment and expiration of medications and supplies.
☐ List of the medications in the ED. If a national shortage is in effect, submit documentation that the facility attempted to acquire the medication (see list in VPRP Program Criteria).
☐ Official equipment list for the ED with the hospital logo on the document from central supply/biomed department OR a picture of the equipment (see list in VPRP Program Criteria).

## SUPPORTING DOCUMENT CHECKLIST

***Pediatric Champion Level of Recognition***

**Use this checklist to ensure the submission of all required supporting documents**

**Guidelines for Medications, Equipment, and Supplies**

☐ Copy of the procedure and/or protocol for the daily method to verify the proper location and function of equipment and expiration of medications and supplies.

☐ List of the medications in the ED. If a national shortage is in effect, submit documentation that the facility attempted to acquire the medication (see list in VPRP Program Criteria).

☐ Official equipment list for the ED with the hospital logo on the document from central supply/biomed department OR a picture of the equipment (see list in VPRP Program Criteria).

**Quality Improvement Initiative**

☐ Copy of the written plan that provides a description of how you are addressing gaps identified from the data set listed in the VPRP Program Criteria.

☐ Copy of the current medical staff with current certification in neonatal resuscitation and the expiration date of their certification.

## SUPPORTING DOCUMENT CHECKLIST

***Pediatric Innovator Level of Recognition***

**Use this checklist to ensure the submission of all required supporting documents**

**Physician, Nurses and Other Healthcare Providers Who Staff the ED**

☐ Copy of the policy regarding the scope and frequency of competency evaluations for physicians, advanced practice providers (APP), nurses, and other healthcare providers.

☐ Copy of competency evaluations for 10 ED staff members.

**Guidelines for Medications, Equipment, and Supplies**

☐ Copy of the procedure and/or protocol for the daily method to verify the proper location and function of equipment and expiration of medications and supplies.

☐ List of the medications in the ED. If a national shortage is in effect, submit documentation that the facility attempted to acquire the medication (see list in VPRP Program Criteria).

☐ Official equipment list for the ED with the hospital logo on the document from central supply/biomed department OR a picture of the equipment (see list in VPRP Program Criteria).

**Guidelines for QI/PI in the ED**

☐ Copy of the QI plan used to integrate with out-of-hospital, ED, inpatient pediatrics, pediatric critical care, and hospital-wide QI or PI activities.

## APPENDIX E: RESOURCES

The following resources are recommended for continuing to improve your facilities pediatric readiness status.

- American College of Emergency Physicians:
  Pediatric Resources: https://www.acep.org/by-medical-focus/pediatrics/

- American Academy of Pediatrics:
  Committee on Pediatric Emergency Medicine resources;
  https://services.aap.org/en/search/?context=all&k=committee%20on%20pediatric%20emergency%20medicine

- Child Abuse Screening and Management Kit: Governor's EMS and Trauma Advisory Council Pediatric Committee:
  https://dshs.texas.gov/emstraumasystems/pediatricscommittee.shtm

- Critical Crossroads: Pediatric Mental Health Care in the ED
  https://emscimprovement.center/education-and-resources/toolkits/critical-crossroads-pediatric-mental-health-care-ed/

- DSHS Governor's EMS and Trauma Advisory Council Pediatric Resources:
  https://www.dshs.texas.gov/emstraumasystems/pediatricscommittee.shtm

- Emergency Nurses Association:
  Practice Resources; Practice Library https://www.ena.org/practice resources/resource-library

- Emergency Nurses Association (ENA) Emergency Severity Index (ESI) Training:
  https://www.ena.org/enau/educational-offerings/esi

  https://www.ena.org/docs/default-source/education-document-library/esi-implementation-handbook-2020.pdf?sfvrsn=fdc327df_2

- EMS for Children Innovation and Improvement Center
  https://emscimprovement.center/

- Joint Policy Statement: Pediatric Readiness in the Emergency Department
  https://pediatrics.aappublications.org/content/142/5/e20182459

- Pain Assessment Tools
  file:///C:/Users/spvance2/Downloads/Pain%20Assessment%20%20Tools.pdf

- Pediatric Early Warning System
  https://www.texaschildrens.org/sites/default/files/uploads/documents/outcomes/standards/PEWS.pdf

  https://www.youtube.com/watch?v=NYuYAoEjXjA