MONTANA PEDIATRIC FACILITY RECOGNITON CRITERIA

Montana Department of Public Health and Human Services

E.M.S. & Trauma Systems Section, Emergency Medical Services for Children/Child Ready Montana

Pediatric emergency patients have unique needs, requiring specialized personnel, training, equipment, supplies, and medications. Deficiencies in these areas have resulted in historically poorer outcomes for pediatric patients versus adults. Since 1985, federally funded Emergency Medical Services for Children (E.M.S.C.) programs in each state have been working to improve the quality of pediatric emergency care. The Health Resources and Services Administration require that all E.M.S.C. grantees report on specific performance measures. This includes implementation of a standardized system recognizing hospitals that can stabilize or manage pediatric medical emergencies and trauma cases.

We describe the steps involved in implementing Montana's Two (2) Level Facility Recognition processes to provide appropriate pediatric care. This criterion is in compliance with new Health Resources and Services Administration performance measures. And the *Guidelines for Care of Children in the Emergency Department* based on the 2018 Joint Policy Statement in collaboration with the American Academy of Pediatrics (A.A.P.), American College of Emergency Physicians (A.C.E.P), and Emergency Nurses Association (E.N.A.). The Montana Chapter of the American Academy of Pediatrics endorsed the Montana Pediatric Facility Recognition Criteria.

Access to optimal emergency care for children is affected by the lack of availability of equipment, appropriately trained staff to care for children, in addition to policies and procedures that ensures timely transfer to definitive care. Although advances have been made that promote access to emergency care for children, improved awareness of the pediatric resources available to hospitals and the development of coordinated emergency care systems, may optimize access and outcomes for many acutely ill and injured children.

MONTANA'S PEDIATRIC FACILITY RECOGNITION CRITERIA HAS TWO LEVELS OF RECOGNITION.

Montana's voluntary certification program recognizes hospitals that meet specific criteria for personnel training, equipment, and facilities that support optimal care for ill or injured infants, children, and adolescents.

PEDIATRIC PREPARED FACILITY – Pediatric-Prepared Emergency Care, a voluntary program recognizing hospitals that have demonstrated their ability to provide advanced pediatric care for the majority of pediatric medical emergencies including illness and injury. Pediatric-Prepared Emergency Care is a partnership between hospitals, physicians, nurses, emergency personnel and the Emergency Medical Services for Children program at the Montana Department of Health and Human Services EMS & Trauma Systems and Child Ready MT.

PEDIATRIC CAPABLE FACILITY – Pediatric-Capable Emergency Care, a voluntary program recognizing hospitals that have the ability to provide limited pediatric care and have a system in place to transfer to a pediatric prepared facility.

FACILITY: _____DATE: _____

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Note: The hospital board of directors, administration, medical staff and nursing staff shall demonstrate a commitment to quality pediatric care and shall treat any pediatric patient presented to the facility for care at the highest level possible.

CRITERIA:

The following table shows levels of PEDIATRIC Facility Recognition and the Essential (E) or Desirable (D) characteristics. These Pediatric specific criteria are IN ADDITION to the Montana Trauma Facility Designation Criteria.

PEDIATRIC FACILITY RECOGNITION CRITERIA	PEDIATRIC PREPARED FACILITY	PEDIATRIC CAPABLE FACILITY	Being developed	Not initiated	COMMENTS
FACILITY					
Participation in the statewide trauma system including participation in Regional Trauma Advisory Committee; support of regional and state performance improvement programs; and submission of data including pediatric data to the Montana State Trauma Registry.	E	E			
Twenty-four-hour coverage availability of the emergency department (ED) shall be provided by at least one physician or ADVANCE PRACTICE CLINICIANS (APCS) responsible for the care of patients including critically ill or injured children.	E	E			
CARE TEAM-PHYSICIANS, ADVANCED PRACTICE PROVIDERS, NURSES, AND OTHER HEALTHCARE PROVIDERS					
Healthcare providers who staff the Emergency Department (E.D.) have **ANNUAL** pediatric-specific competency evaluations for children of all ages. Areas of pediatric competencies include **the following: Assessment and treatment (e.g., triage); Medication administration; device/equipment safety/critical procedures; resuscitation; trauma resuscitation and stabilization; disaster drills that include children; patient and family-centered care; team training and effective communication.**	E	E			

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Emergency physicians and/or providers seek video or telephone consultation with Pediatric Specialists for critically ill and injured children using Telehealth capabilities.	E	E			
The Advanced Practice Provider for Pediatric Emergency Care or RN is the Pediatric Emergency Care Coordinator (PECC) * Can be an appointed healthcare provider such as a LPN/EMT.	E	D*			
Include a pediatric component to multidisciplinary committee review functions with a multidisciplinary committee of medical disciplines (including the trauma coordinator) involved in caring for pediatric patients. **Required timely review: all transfers out, all diversions, all pediatric deaths, all child abuse/neglect cases, and pediatric medication errors**.	E	E			
POLICY- POLICIES, PROCEDURES, AND PROTOCOLS FOR THE EMERGENCY CARE OF CHILDREN- THESE POLICIES MAY BE INTEGRATED INTO OVERALL ED POLICIES AS LONG AS PEDIATRIC-SPECIFIC ISSUES ARE ADDRESSED.					
Required by state law specific Child maltreatment and domestic violence reporting policies including criteria, requirements, and processes. MT DPHHS, Child and Families Services Division Centralized Hotline 24-hour Toll Free number of **1-866-820-5437** is posted and known to staff for reporting purposes.	E	E			
Illness and injury triage	E	E			
Pediatric patient assessment and reassessment	E	E			
Identification and notification of the responsible provider of abnormal pediatric vital signs	E	E			
Immunization assessment and management of the under-immunized patient	E	D			
Sedation and analgesia, for procedures including medical imaging.	E	E			
Consent, including when parent or legal guardian is not immediately available.	E	E			

PEDIATRIC FACILITY RECOGNITION CRITERIA	PEDIATRIC PREPARED FACILITY	PEDIATRIC CAPABLE FACILITY	Being developed	Not initiated	COMMENTS
Social and behavioral health issues	E	E			
Physical or chemical restraint of patients	E	**E**			
Death of a child in the E.D.	E	E			
Do Not Resuscitate (D.N.R.) orders	E	E			
Children with special health care needs	E	E			
Family and guardian presence during all aspects of emergency care, including resuscitation.	E	E			
Patient, family, guardian, and caregiver education **on diagnosis, treatment plan, medication, and discharge plan/disposition.**	E	D			
Discharge planning and instruction (*if transferred to a higher level of care for Pediatric Capable.)	E	D*			
Bereavement counseling	E	E			
Communication with the patient's medical home or primary care provider as needed.	E	D			
Written guidelines for the transfer of patients with behavioral health issues from facility	E	E			
Telehealth and telecommunications	E	E			
PREHOSPITAL PEDIATRIC CARE					
The Facility reviews pediatric pre-hospital protocols and policies related to care of the pediatric injured or ill patient.	E	E			
E.M.S. feedback through the Quality Improvement/Process Improvement (QI/PI) processes	E	E			

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for pediatric patient care and/or participation in the hospital setting including the Pediatric Emergency Care Coordinator (P.E.C.C.)					
E.M.S. staff is provided pediatric specific education opportunities and all education is documented at least annually.	E	E			
INTER-FACILITY TRANSFERS					
Written Pediatric specific transfer guidelines with a higher level of care (in-state and out of state facilities.) **Include**: Criteria for transfers (specialty services); Criteria for selection of appropriate transport service; process for initiation of transfer; plan for transfer of patient information; integration into family-centered care; and integration of telehealth or telecommunications.	E	E			
Signed inter-facility transfer **AGREEMENTS** in place for transfer of pediatric specific population patients to a higher level of care. (With all referral facilities at least every 6 years.)	E	E			
ALL-HAZARD DISASTER PREPAREDNESS-the written all-hazard disaster preparedness plan addresses pediatric-specific needs within the core domains including:					
Medications, vaccines, equipment, supplies, and trained providers for the provisions of children in disasters	E	E			
Pediatric surge capacity for injured and non-injured children	E	E			
Decontamination, isolation and quarantine of families and children of all ages	E	E			
Hospital disaster plan addresses issues specific to the care of children including children with special health care needs.	E	E			
Minimization of parent-child separation	E	E			
Tracking and reunification for children and families	E	E			
Access to specific behavioral health therapies and social services for children	E	E			

PEDIATRIC FACILITY RECOGNITION CRITERIA	PEDIATRIC PREPARED FACILITY	PEDIATRIC CAPABLE FACILITY	Being developed	Not initiated	COMMENTS
Participation in community disaster drills which include a pediatric mass casualty incident component at **least every two years**.	E	E			
Care of children with special health care or functional access needs.	E	E			
PEDIATRIC PATIENT SAFETY					
ALL Children are weighed in kilograms only.	E	E			
Weights are recorded in kilograms only.	E	E			
For children who require emergency stabilization, a standard method of estimating weight in kilograms is used (i.e., a length-weight based system.)	E	E			
Infants and children have a full set of **Admission AND Discharge** vital signs recorded (**age appropriate- temperature, heart rate, blood pressure, respiratory rate, Glasgow Coma Scale, and SP02, and including a pediatric pain assessment**) in the medical record.	E	E			
CO2 Monitoring capability for children of all ages.	E	E			
Processes for safe medication delivery that includes prescribing, administration and disposal	E	E			
Pre-calculated dosing and formulation guides	E	D			
Pediatric emergency services are culturally and linguistically appropriate with 24/7 access to interpreter services in the E.D.	E	E			
ED environment is safe for children and supports patient and family centered care with timely tracking and reporting of patient safety events including but not limited to child abuse and neglect.	E	E			
Use at least two patient identifiers when providing care, treatment, and services.	E	E			
Pediatric equipment, supplies, and medications are appropriate for children of all ages and sizes, are easily accessible, clearly labeled, and logically organized. Staff is educated on location of all items.	E	E			

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GENERAL GUIDELINES FOR E.D. SUPPORT SERVICES					
Reduced dose radiation for CT and X-ray imaging based on pediatric age and weight policies.	E	E			
All efforts made to transfer completed images when a patient is transferred from one facility to another.	E	E			
Collaboration with radiology, laboratory, and other E.D. support services to ensure the needs of children in the community are met.	E	E			
GUIDELINE FOR MEDICATION, EQUIPMENT, AND SUPPLIES					
Pediatric equipment, supplies, and medications are appropriate for children of all ages and sizes and are easily accessible, clearly labeled, and logically organized.	E	E			
E.D. Staff is educated on the location of all items.	E	E			
Daily method in place to verify the proper location and function of pediatric equipment and supplies.	E	E			
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.	E	E			
Standardized chart or tool used to estimate weight in kilograms if resuscitation precludes the use of a weight scale (e.g., length-weight based tape.)	E	E			
PEDIATRIC EQUIPMENT AND SUPPLIES:					
Patient warming device	E	E			
Intravenous blood fluid warmer	E	E			
Restraint Device (i.e., I.V. Board)	E	**E**			

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Tool or chart that relies on weight (kilograms) used to assist physical and nursed in determining equipment size and correct drug dosing (by weight and total volume)	E	E			
Pain scale assessment tools that are appropriate for age	E	E			
Rigid boards for use in C.P.R.	E	E			
Pediatric-specific A.E.D. pads	E	E			
MONITORING EQUIPMENT					
Accurate Temperature Monitoring Device	E	E			
Blood pressure cuffs (neonatal, infant, child)	E	E			
Doppler ultrasonography device	E	E			
Continuous end-tidal C02 monitoring device	E	E			
Electrocardiography monitor/defibrillator with pediatric-sized pads/paddles	E	E			
Pulse oximeter with pediatric probes	E	E			
RESPIRATORY EQUIPMENT AND SUPPLIES					
Endotracheal tubes-full set to include (uncuffed 2.5 mm; uncuffed-3.0 mm; cuffed or uncuffed 3.5; cuffed or uncuffed 4.0 mm; cuffed or uncuffed 4.5 mm; cuffed or uncuffed 5.0 mm; cuffed or uncuffed 5.5 mm; and cuffed or uncuffed 6.0 mm) **All sizes can be cuffed or uncuffed as long as size varieties are available**	**E**	**E**			
Feeding Tubes 5F and 8F	E	D			
Laryngoscope blades (straight: 0; straight: 1; straight: 2; and curved: 2	E	E			

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Oropharyngeal airways *Size* (0/50MM, 1/60MM, 2/70MM, 3/80MM)	E	E			
Magill Forceps (pediatric)	E	E			
Nasopharyngeal airways (infant and child)	E	E			
Stylets for endotracheal tubes (pediatric and infant)	E	E			
Suction Catheters (**At least one in the size range 6-8 FR and 10-12 F)**	E	E			
Rigid Suction Device- pediatric	E	E			
Bag-mask device, self-inflating (sizes 250 ml & 450-500 ml)	E	E			
Clear oxygen masks (infant and child)	E	E			
Non-rebreather Masks- Infant and Child	E	E			
Masks to fit bag-mask device adaptor (*Neonatal, infant, and child)*	E	E			
Nasal cannulas (infant and child)	E	E			
Gastric Tubes- Infant (8F) and Child (10F)	E	D			
VASCULAR ACCESS SUPPLIES AND EQUIPMENT					
Arm Boards (infant and child)	E	E			
Atomizer for intranasal administration of medications	E	E			
Catheter-over-the-needle device (22 AND 24 gauge)	E	D			

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Intraosseous needles -and insertion tool if required-pediatric sized	E	E			
IV administration sets calibrated chambers or infusion pumps to regulate the rate and Flow	E	E			
IV Solutions- Normal Saline	E	E			
IV Solutions – Dextrose 5% in 0.45% normal saline	E	E			
IV Solutions- Lactated Ringers' Solution	E	E			
IV Solutions Dextrose 10% in Water	E	E			
FRACTURE MANAGEMENT DEVICES					
Extremity splints, including femur splints (pediatric sizes)	E	E			
Cervical collar (infant AND child)	E	E			
SPECIALIZED PEDIATRIC TRAYS OR KITS					
Difficult airway supplies and/or kit: contents may be based on pediatric patients served at the hospital and may include some or all the following: supraglottic airways of all sizes; needle cricothyrotomy supplies; surgical cricothyrotomy kit and video laryngoscopy.	E	E			
Newborn delivery kit (including equipment for initial resuscitation of a newborn infant: umbilical clamps, scissors, bulb syringe and towel.)	E	E			
Urinary catheterization kits and urinary (indwelling) catheters: Infant and Child	E	D			
MEDICATIONS					
Analgesics (oral, intranasal, or parenteral)	E	E			

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Anesthetics (eutectic mixture of local anesthetics: lidocaine 2.5% and prilocaine 2.5%; lidocaine; epinephrine, and tetracaines and LMX 4% {4% LIDOCAINE})	E	E			
Anticonvulsants (benzodiazepines, levetiracetam, valproate, carbamazepine, fosphenytoin, and phenobarbital)	E	E			
Antidotes (common antidotes should be accessible to the ED e.g., naloxone)	E	E			
Antipyretics (acetaminophen and ibuprofen)	E	E			
Antiemetics (ondansetron and prochlorperazine)	E	E			
Antihypertensives (labetalol, nicardipine, and sodium nitroprusside)	E	E			
Antimicrobials (parenteral and oral)	E	E			
Antipsychotics (olanzapine and haloperidol)	E	D			
Benzodiazepines (midazolam and lorazepam)	E	E			
Bronchodilators	E	E			
Calcium chloride and/or calcium gluconate	E	E			
Corticosteroids (dexamethasone, methylprednisolone, and hydrocortisone)	E	E			
Cardiac medications (adenosine, amiodarone, atropine, procainamide and lidocaine)	E	E			
Hypoglycemic interventions (Dextrose, oral glucose)	E	E			
Diphenhydramine	E	E			

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Epinephrine- (1mg/Ml [1M] and 0.1 mg/Ml [IV] solutions)	E	E			
Furosemide	E	E			
Glucagon	E	E			
Insulin	E	E			
Magnesium Sulfate	E	E			
Intracranial hypertension medications (mannitol, 3%hypertonic saline)	E	E			
Neuromuscular blockers (rocuronium and succinylcholine)	E	E			
Sucrose solutions for pain control in infants	E	E			
Sedation medications (midazolam, etomidate and ketamine)	E	D			
Vasopressor agents (dopamine, epinephrine and norepinephrine)	E	E			
Vaccines: (tetanus and **FLU**)	E	E			
ADDITIONAL RECOMMENDATIONS FOR HIGH VOLUME EDS					
Alprostadil (prostaglandin E1)	E	D			
Central Venous Catheters (4.0 F; 5.0 F; 6.0 F; 7.0 F)	E	D			
Chest Tubes: (Infant 8-12 F catheter; Child 14-22 F catheter)	E	E			
Hypothermia Thermometer	E	E			
Inotropic agents (e.g., Digoxin and milrinone)	E	D			

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Laryngoscope Blade Size 00	E	E			
Lumbar Puncture tray, spinal needles (Infant and Child)	E	D			
Noninvasive ventilation (Continuous positive airway pressure or high-flow nasal cannula	E	E			
Self-inflating bag-mask device (Pediatric) SIZES 250 ML & 450-500 ML)	E	E			
Tube Thoracostomy Tray	E	D			
Tracheostomy Tubes: Size 0; Size 1; Size 2; Size 3; Size 4; Size 5; Size 6)	E	D			
Video Laryngoscopy	E	D			
GUIDELINES FOR QI/PI IN THE ED- The Quality Improvement/Process Improvement Plan includes pediatric-specific indicators:					
Data are collected and analyzed.	E	E			
System changes are implemented based on performance.	E	E			
System Performance is monitored over time.	E	E			
INJURY PREVENTION AND COLLABORATIONS					
Collaboration with existing national, regional and/or state programs for pediatric issues (including but not limited to asthma, substance abuse screening and intervention, injury prevention, adolescent health programs; childbirth classes; Period of Purple Crying, and child abuse prevention/shaken baby, child passenger safety and safe transport of children resources and education.)	E	E			
SAFE SLEEP Program/Education	E	E			
Poisoning prevention resources/education	E	E			

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Is the Poison Control Number Posted? 	E	E			
Provide Suicide Prevention and Mental Illness information and referral resources.	E	E			
FURTHER COMMENTS:					