FACILITY RECOGNITION
RENEWAL APPLICATION PACKET

EMS Regions 4 & 5

SEPTEMBER 2019

Emergency Department Approved for Pediatrics (EDAP)
Pediatric Plan

and

Standby Emergency Department for Pediatrics (SEDP)
Pediatric Plan

DUE DATE
Friday, January 17, 2020

Illinois Emergency Medical Services for Children

Developed by
Illinois EMSC Facility Recognition Task Force

Approved by
Illinois EMSC Advisory Board

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ILLINOIS EMSC
FACILITY RECOGNITION

EDAP & SEDP Pediatric Plan
Renewal Application

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ILLINOIS EMSC
FACILITY RECOGNITION

Application and Site Survey Process

Application Instructions/Steps

The following steps outline the application process for renewal of your status as an Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP). **PLEASE NOTE that your Pediatric Plan and completion of this application should be developed through interaction and collaboration with all appropriate disciplines within your facility**.

1. Review your current Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP) Pediatric Plan.
2. Using the *EDAP & SEDP Pediatric Plan Checklist* (page 5 & 6) along with the Emergency Department Approved for Pediatrics requirements (pages 7-12) or Standby Emergency Department for Pediatrics requirements (pages 13-17), complete an update to your original EDAP or SEDP Pediatric Plan. Appendix all appropriate supporting documentation (schedules, policies, procedures, protocols, guidelines, plans, etc.).
3. The Pediatric Plan should follow the *Checklist* format provided in this application and include all supporting documentation, including but not limited to scope of services/care, policies (both administrative and department specific), procedures, protocols, guidelines, flow charts, rosters, calendars, schedules, etc.
4. Complete and obtain appropriate signatures on the *Request for Re-Recognition of EDAP or SEDP Status* signature form (see page 4).
5. Complete and obtain signatures on the Emergency Department Physician, Fast Track/Urgent Care Physician, Nurse Practitioner/Physician Assistant, and Nursing credentialing forms (see pages 18-21).
6. Complete the Pediatric Equipment Checklist (see pages 22-26).
7. **The Pediatric Plan should be submitted in a single-sided format and unstapled. Do not place pages in individual plastic sleeves.**
8. **Maintain a copy for your files (using one set of tabs provided by EMSC).**
9. **Submit 4 copies of your Pediatric Plan (an original signed copy plus 3 additional copies). Use the second set of tabs provided by EMSC for the original signed copy. Each copy must contain the following:**
    - **Signed *Request for Re-Recognition of EDAP or SEDP Status* signature form;**
    - **A completed EDAP & SEDP Pediatric Plan Checklist (pages 5 & 6);**
    - **Completed EDAP or SEDP Pediatric Plan (including supporting documentation);**
    - **Completed Emergency Department Physician, Fast Track/Urgent Care Physician, Emergency Department Nurse Practitioner & Physician Assistant, and Nursing credentialing forms, as applicable (pages 18-21);**
    - **Completed Pediatric Equipment Checklist (pages 22-26).**

10. Submit these documents (including all supporting documentation) by **Friday, January 17, 2020** in the order listed in this application to: Kelly Jones, RN, BSN, EMSC Coordinator, Division of EMS & Highway Safety, Illinois Department of Public Health, 422 S. 5th Street, 3rd Floor, Springfield, IL 62701.

11. **PLEASE NOTE that any submitted requests to waiver any of the EDAP or SEDP requirements must include THE CRITERIA BY WHICH COMPLIANCE IS CONSIDERED TO BE A HARDSHIP, AND DEMONSTRATE HOW THERE WILL BE NO REDUCTION IN THE PROVISION OF MEDICAL CARE.**

12. **For questions regarding the application process, please contact Evelyn Lyons at (312) 793-1234 or Evelyn.Lyons@illinois.gov or Kelly Jones at (217) 785-2083 or Kelly.Jones@illinois.gov .**

Site Survey Procedure

1. Within 6-8 weeks following receipt of your updated Pediatric Plan and supporting documents, the hospital will be informed as to the status of the application. If all documentation is in order, a site visit will be scheduled.
2. In preparation for the site visit, hospital personnel will prepare evidence to verify adherence to the facility recognition requirements.
3. The site visit will include a survey of the Emergency Department, Pediatric Unit (including intensive care (if applicable) and any inpatient units where pediatric patients may be admitted) and a meeting with the following individuals:
    a. Hospital Chief Administrative/Executive Officer or designee
    b. Chief of Pediatrics, or if the hospital does not have a Pediatric Department, the designated pediatric consultant
    c. Administrator of Pediatric Services, if applicable
    d. Nursing Director and/or Nurse Manager, Pediatric Unit
    e. Administrator of Emergency Services
    f. Emergency Department Medical Director and/or the Pediatric Emergency Department Medical Director
    g. Emergency Department Nurse Manager and/or the Pediatric Emergency Department Nurse Manager
    h. Pediatric Physician Champion
    i. Pediatric Quality Coordinator
    j. Hospital Quality Improvement Department Director or designee
    k. Hospital Emergency /Disaster Preparedness Coordinator
    l. Nurse Practitioner and/or Physician Assistant representative for those facilities that utilize these practitioners in their emergency department
    m. **For EMS Resource or Associate Hospitals only**: The EMS Medical Director and EMS Coordinator

Site Survey Team

The survey team will be defined by the EMSC Manager and Chief, Division of EMS & Highway Safety, in coordination with the Illinois EMSC Advisory Board. Site survey teams will be composed of a physician/nurse team with a representative from the Illinois Department of Public Health. All team members will attend formal training in the site survey responsibilities, expectations, process and assessment.

Following the Site Survey

1. Within four to six (4-6) weeks following the site visit, the hospital shall receive the results of the survey and may be requested to submit additional documentation. Those facilities meeting all requirements will receive a letter from the Illinois Department of Public Health formally renewing their EDAP or SEDP status.

2. Hospitals that do not meet the requirements will receive a letter from the Illinois Department of Public Health outlining the areas of non-compliance. The Department can deny a request for renewal of recognition if findings show failure to substantially comply with the EDAP or SEDP requirements. Hospitals may appeal the results of the Survey by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.

3. Rerecognition shall occur every four years, with site visits scheduled as necessary.

4. Withdrawal of recognition status may occur at any time, should a hospital fail to meet any of the requirements. In this situation, the hospital shall notify the Illinois Department of Public Health, Division of EMS & Highway Safety at least 60 days prior to withdrawal and identify how area prehospital provider agencies, area hospitals, and the Illinois EMSC Office will be notified.

***NOTE: The term "pediatric" throughout this document refers to all children age 15 and younger.**

ILLINOIS EMSC
FACILITY RECOGNITION

Request for Re-recognition of EDAP or SEDP Status

Name of hospital and address (typed)

1. Specify the recognition level for which your hospital is applying for renewal:
   - Emergency Department Approved for Pediatrics (EDAP) _____
   - Stand-by Emergency Department Approved for Pediatrics (SEDP) _____
2. The above named facility certifies that each requirement in this Request for Recognition is met.

Typed name – CEO/Administrator

Signature - CEO/Administrator Date

Typed name – Medical Director of Emergency Services

Signature – Medical Director of Emergency Services Date

Contact person - Typed name, credentials and title

Contact person - phone number, fax number and email

ILLINOIS EMSC
FACILITY RECOGNITION

EDAP & SEDP Renewal Pediatric Plan
Checklist

Instructions:
Complete an updated EDAP or SEDP Pediatric Plan for your facility using the checklist below. Refer to the EMS Administrative Code sections for EDAP or SEDP that are located in the pages following this checklist in this application packet.

Use the tabs provided by the EMSC office to organize your application.

For each requirement outlined below, select the response(s) as directed and attach supporting documentation.	
_____ Submit an organizational chart identifying the administrative relationships among all departments in the hospital, including the Emergency Department and Department of Pediatrics. _____ Submit an organizational chart identifying the organizational/reporting structure of ED physician, nursing and ancillary services.	
Review EMS Administrative Code 515.4000 a, 1 and 2 or 515.4010 a, 1 and 2 for the physician staff qualifications and continuing medical education and submit each of the below. _____ Enclosed is a policy (s) that incorporates the physician qualifications and CME requirements. _____ Enclosed is a completed **CREDENTIALS OF EMERGENCY DEPARTMENT PHYSICIANS** Form. _____ Enclosed is a completed **CREDENTIALS OF FAST TRACK PHYSICIANS** Form. _____ Enclosed is the curriculum vitae for the ED Medical Director (that states their role as the ED Medical Director). _____ Enclosed is a current one-month physician schedule for the ED. _____ For EDAP physicians who meet alternate criteria, enclosed is the following: 1). a letter(s) verifying hours worked by this/these physicians; 2). a copy of current AHA PALS or ACEP-AAP PALS certification; and 3). copies of 16 hours of pediatric CME completion over the past two years.	
Review EMS Administrative Code 515.4000 or 515.4010 a, 3, for the ED Physician coverage and submit the below. _____ Enclosed is a policy that incorporates this requirement.	
Review EMS Administrative Code 515.4000 or 515.4010 a, 4, for ED Consultation and submit the below. _____ Enclosed is a one month on-call schedule identifying availability of board certified/board prepared pediatricians or pediatric emergency medicine physicians, or documentation verifying 24 hour telephone consultation.	
Review EMS Administrative Code 515.4000 or 515.4010 a, 5, for ED Physician Back-up and submit the below. _____ Enclosed is a policy that incorporates this requirement.	
Review EMS Administrative Code 515.4000 or 515.4010 a, 6, for On Call Specialty Physician Response Time and submit the below. _____ Enclosed is a policy that incorporates this requirement.	
Review EMS Administrative Code 515.4000 or 515.4010 b, 1 and 2 for Nurse Practitioner and Physician Assistant qualifications and continuing medical education and submit the below. _____ Enclosed is a policy that incorporates this requirement. _____ Enclosed is a completed **CREDENTIALS OF EMERGENCY DEPARTMENT NURSE PRACTITIONER AND PHYSICIAN ASSISTANT Form.** _____ Enclosed is a current one-month nurse practitioner/physician assistant schedule _____ For nurse practitioners who meet alternate criteria, enclosed is the following: 1). letter(s) verifying hours worked by this/these nurse practitioners; 2). copies of current AHA PALS or ACEP-AAP PALS certification; 3). copies of 16 hours of pediatric CME completion over the past two years. **OR** _____ Enclosed is documentation that nurse practitioners/physicians assistants are not utilized in the ED)	
Review EMS Administrative Code 515.4000 or 515.4010 c, 1 and 2 for Nursing qualifications and continuing education and submit the below. _____ Enclosed is a policy that incorporates this requirement. _____ Enclosed is a completed **CREDENTIALS OF EMERGENCY DEPARTMENT NURSING STAFF** Form. _____ Enclosed is a one-month Registered Nurse staffing schedule for the emergency department.	

Review EMS Administrative Code 515.4000 or 515.4010 d, 1, for inter-facility transfer and <u>submit the below</u>. _____ Enclosed is an interfacility transfer policy that addresses pediatric transfers and includes all of the components defined in Section 515.4000 or 515.4010 d, 1. _____ Enclosed is a copy (s) of our current pediatric specific transfer agreements with hospitals that provide pediatric specialty services, pediatric intensive care and burn care not available at this facility.	
Review EMS Administrative Code 515.4000 or 515.4010 d, 2, for suspected child abuse and neglect and <u>submit the below</u>. _____ Enclosed is a policy that incorporates this requirement.	
Review EMS Administrative Code 515.4000 or 515.4010 d, 3, for treatment guidelines and <u>submit the below</u>. _____ Enclosed are all pediatric treatment/care guidelines.	
Review EMS Administrative Code 515.4000 or 515.4010 d, 4, for Latex-free policy and <u>submit the below</u>. _____ Enclosed is a copy of our latex-free policy that addresses latex allergies and the availability of latex free equipment and supplies.	
Review EMS Administrative Code 515.4000 or 515.4010 d, 5, for Disaster Preparedness and <u>submit the below</u>. _____ Enclosed is a copy of the Hospital Pediatric Disaster Preparedness Checklist that has been completed by the disaster/emergency management coordinator	
Review EMS Administrative Code 515.4000 or 515.4010 e, 1, for quality improvement activities and the multidisciplinary quality improvement committee and <u>submit the below</u>. _____ Enclosed is a policy (or other formal document) that outlines the overall emergency department quality improvement program, and identifies the integration of pediatric QI activities into the emergency department quality program. Components that need to be included in the policy: ▪ Description of the quality improvement process ▪ Responsible multidisciplinary committee and committee membership. NOTE: Committee composition needs to extend beyond physician/nursing to include other essential disciplines such as pediatrics, social services, respiratory therapy, other services ▪ Pediatric clinical indicators/monitors and/or outcome analysis, including the required EDAP/SEDP monitors: pediatric deaths, pediatric interfacility transfers, child abuse/neglect cases, and critically ill and injured children in need of stabilization. Include any other pediatric quality and safety priorities of the institution. ▪ Feedback processes, target timeframes for closure of issues, follow-up mechanisms, i.e loop closure.	
Review EMS Administrative Code 515.4000 or 515.4010 e, 2, for the Pediatric Physician Champion and <u>submit the below</u>. _____ Enclosed is a curriculum vitae for the Pediatric Physician Champion (that states their role as the Pediatric Physician Champion).	
Review EMS Administrative Code 515.4000 or 515.4010 e, 3, for the Pediatric Quality Coordinator (PQC) responsibilities and <u>submit the below</u>. _____ Enclosed is a resume for the Pediatric Quality Coordinator (that states their role as the PQC). _____ Enclosed is a job description or formal document for the PQC that includes ▪ Allocation of appropriate time and resources by the hospital to fulfill the PQC responsibilities ▪ Responsibilities of the PQC as outlined in 515.4000 or 515.4010, e, 3, A-E. _____ Enclosed is documentation detailing the participation of the PQC in Regional QI activities and how that has impacted pediatric quality care in the ED.	
Review EMS Administrative Code 515.4000 or 515.4010 f, for the list of Emergency Department Equipment Requirements and <u>submit the below</u>. _____ Enclosed is a completed checklist indicating that all equipment is present. Using the equipment list in the application, place an "X" next to each equipment item that is **currently available**. If equipment/supply items are not available, a plan for securing the items must be identified, i.e. submission of a purchase order to assure that the item is on order **or** a waiver must be submitted for each item. **Requests for waiver must include the criteria by which compliance is considered to be a hardship and demonstrate how there will be no reduction in the provision of medical care.** **Please note: If assistance is needed in identifying specific vendors for the equipment/supply items of this application, please contact the Marketing Administrator, Group Purchasing Services, Illinois Health & Hospital Association at 312-906-6122.**	

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY
PART 515 EMERGENCY MEDICAL SERVICES, TRAUMA CENTER, COMPREHENSIVE STROKE CENTER, PRIMARY STROKE CENTER AND ACUTE STROKE-READY HOSPITAL CODE
SECTION 515.4000 FACILITY RECOGNITION CRITERIA FOR THE EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP)

Section 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)

a) Professional Staff: Physicians

1) Qualifications
Twenty-four hour coverage of the emergency department (excluding designated areas utilized to care for minor illnesses or injuries, i.e., fast track, urgent care) shall be provided by one or more physicians responsible for the care of all children. Each physician shall hold one of the following qualifications:

A) Certification in emergency medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in emergency medicine and in the first cycle of the board certification process; or

B) Sub-board Certification in pediatric emergency medicine by the American Board of Pediatrics or the ABEM or residency trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or

C) Certification by one of the following boards and current American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation.

i) Certification in family medicine by the American Board of Family Medicine (ABFM) or American Osteopathic Board of Family Medicine (AOBFM); or

ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or

iii) Residency trained/board eligible in either family medicine or pediatrics and in the first cycle of the board certification process; or

D) Alternate Criteria: The physician has worked in the emergency department prior to January 1, 2018 and has completed 12 months of internship

followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including at least 2800 hours within one continuous 24-month period), certified in writing by the hospitals at which the internship and subsequent hours were completed. The physician shall have current AHA-AAP PALS or ACEP-AAP APLS recognition and have completed at least 16 hours of pediatric CME within the past two years.

2) Continuing Medical Education
All full- and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.

3) Physician Coverage
At least one physician meeting the requirements of subsection (a)(1) shall be on duty in the emergency department 24 hours a day.

4) Consultation
Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation can be with an on-staff physician or in accordance with Appendix M.

5) Physician Backup
A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the EDAP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians
Guidelines shall be established that address on-site response time for all on-call specialty physicians.

b) Professional Staff: Nurse Practitioner and Physician Assistant
Nurse practitioners and physician assistants working under the supervision of a physician who meets the qualifications of subsection (a)(1).

1) Qualifications

A) Nurse practitioners shall meet the following criteria:

i) Completion of:

- a nurse practitioner program with a focus on the pediatric patient, such as a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program; or

- Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients certified in writing by the hospitals at which the hours were completed.

ii) Current Illinois advanced practice nursing license. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

B) Physician assistants shall meet the following criteria:

i) Current Illinois licensure. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices; and

ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

2) Continuing Education

A) All full- or part-time nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

B) All nurse practitioners and physician assistants caring for children in the emergency department and fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.

c) Professional Staff: Nursing

1) Qualifications

A) At least one registered nurse (RN) on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:

i) AHA-AAP PALS;

ii) ACEP-AAP APLS; or

iii) ENA ENPC.

B) All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months after employment. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

2) Continuing Education
All nurses assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; and/or publications. These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric specific.

d) Guidelines, Policies and Procedures

1) Inter-facility Transfer

A) The hospital shall have current transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.

B) The hospital shall have written pediatric inter-facility transfer guidelines and policies/procedures concerning transfer of critically ill and injured patients, which include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral hospital information to family. Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.

2) Suspected Child Abuse and Neglect
The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to the Department of Children and Family Services (DCFS) of victims of suspected child abuse and neglect in accordance with State law.

3) Emergency Department Treatment Guidelines
The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).

4) Latex-Allergy Policy

The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.

5) Disaster Preparedness
The hospital shall integrate pediatric components into its hospital Disaster/Emergency Operations Plan.

e) Quality Improvement

1) Multidisciplinary Quality Activities Policy

A) Pediatric emergency medical care shall be included in the EDAP's emergency department or section quality improvement (QI) program and reported to the hospital Quality Committee.

B) Multidisciplinary quality improvement (QI) processes/activities shall be established (e.g., committee).

C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all emergency department:

i) Pediatric deaths;

ii) Pediatric inter-facility transfers;

iii) Child abuse and neglect cases;

iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure); and

v) Pediatric quality and safety priorities of the institution.

D) *All information contained in or relating to any medical audit*/quality improvement monitor *performed of a* PCCC's, EDAP's or SEDP's pediatric services pursuant to this Section *shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure.* (Section 3-110(a) of the Act)

2) Pediatric Physician Champion
The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.

3) Pediatric Quality Coordinator
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that

includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:

A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department staff in accordance with subsections (a), (b), and (c).

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).

C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.

E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays, and Supplies
See Appendix L.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY
PART 515 EMERGENCY MEDICAL SERVICES, TRAUMA CENTER, COMPREHENSIVE STROKE CENTER, PRIMARY STROKE CENTER AND ACUTE STROKE-READY HOSPITAL CODE
SECTION 515.4010 FACILITY RECOGNITION CRITERIA FOR THE STANDBY EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (SEDP)

Section 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)

a) Professional Staff: Physicians

1) Qualifications

A) All physicians shall have training in the care of pediatric patients through residency training, clinical training, or practice.

B) All physicians shall successfully complete and maintain current recognition in the AHA-AAP PALS or the ACEP-AAP APLS. Physicians who are board certified or eligible in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine (ABP/ABEM) are excluded from this requirement. PALS and APLS shall include both cognitive and practical skills evaluation.

2) Continuing Medical Education
All full and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.

3) Coverage
At least one physician meeting the requirements of subsection (a)(1), or a nurse practitioner or physician assistant meeting the requirements of subsection (b)(1), shall be on duty in the emergency department 24 hours a day or immediately available. A policy shall define when a physician is to be consulted/called in at times when the emergency department is covered by a mid-level provider.

4) Consultation
Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day.

Consultation may be with an on-call physician or in accordance with Appendix M.

5) Physician Backup
A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the SEDP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians
Guidelines shall address response time for on-call physicians.

b) Professional Staff: Nurse Practitioner and Physician Assistant
Nurse practitioners and physician assistants working under the supervision of a physician who meets the qualifications of subsection (a)(1).

1) Qualifications

A) Nurse practitioners shall meet the following criteria:

i) Completion of:

- a nurse practitioner program with a focus on the pediatric patient, such as a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program; or

- Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients certified in writing by the hospitals at which the hours were completed.

ii) Current Illinois advanced practice nursing license. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

B) Physician assistants shall meet the following criteria:

i) Current Illinois physician assistant licensure. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

2) Continuing Education

A) All nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

B) All nurse practitioners and physician assistants shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.

c) Professional Staff: Nursing

1) Qualifications

At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:

A) AHA-AAP PALS;

B) ACEP-AAP APLS; or

C) ENA ENPC.

2) Continuing Education

At least one Registered Nurse on duty on each shift who is responsible for the direct care of the child in the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; and publications. The continuing education hours may be integrated with other existing continuing education requirements, provided that the content is pediatric specific. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

d) Policies and Procedures

1) Inter-facility Transfer

A) The hospital shall have current transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.

B) The hospital shall have written pediatric inter-facility transfer guidelines/ policies/procedures concerning transfer of critically ill and injured patients, which include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral hospital information to

family. Incorporating the components of Appendix M into the emergency department transfer policy/procedure will meet this requirement.

2) Suspected Child Abuse and Neglect
The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to DCFS of victims of suspected child abuse and neglect in accordance with State law.

3) Emergency Department Treatment Guidelines
The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).

4) Latex-Allergy Policy
The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.

5) Disaster Preparedness
The hospital shall integrate pediatric components into its Disaster/Emergency Operations Plan.

e) Quality Improvement

1) Multidisciplinary Quality Activities Policy

A) Pediatric emergency medical care shall be included in the SEDP's emergency department or section QI program and reported to the hospital Quality Committee.

B) Multidisciplinary quality improvement processes/ activities shall be established (e.g., committee).

C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all emergency department:

i) Pediatric deaths;

ii) Pediatric inter-facility transfers;

iii) Child abuse and neglect cases;

iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure; and

v) Pediatric quality and safety priorities of the institution.

D) *All information contained in or relating to any medical audit/quality improvement monitor performed of a* PCCC's, EDAP's or SEDP's pediatric

services *pursuant to* this Section *shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure.* (Section 3.110(a) of the Act)

2) Pediatric Physician Champion
The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.

3) Pediatric Quality Coordinator
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:

A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department professional staff in accordance with subsections (a), (b) and (c).

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).

C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee meetings. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.

E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays, and Supplies
See Appendix L.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN
EDAP or SEDP RENEWAL APPLICATION
CREDENTIALS OF EMERGENCY DEPARTMENT PHYSICIANS

- List each physician by name.
- Indicate full time or part time and date of ED hire.
- Check all credentials that qualify physician for EDAP or SEDP status.
- Identify any physicians that meet Alternate Criteria requirements and submit a letter verifying his or her hours worked (Adm. Code 515.4000 a,1,D)
- For all physicians who do not meet any of the Board Certifications listed below and who do not meet Alternate Criteria requirements, submit their curriculum vitae, other Board Certifications and copies of their Residency Completion.
- Identify completion of APLS or PALS. Submit a copy of a current AHA PALS or ACEP-AAP APLS card for those physicians who meet Alternate Criteria.
- Write the number of pediatric CME hours completed within the past 2 years. Submit a copy of pediatric CME hours for those physicians who meet Alternate Criteria.

Physician Name	F=Full Time P=Part Time	Date of ED Hire	Board Certification (Or Board Eligible in 1st cycle) ABEM/AOBEM/ABP/AOBP/ABFP/AOBFP or Alternate Criteria	Exp. Date	Course Completion		Exp. Date	16 HRS. of Pediatric Emergency related CME (In last two years)
					APLS	PALS		
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Signature
Hospital CEO/Administrator

Typed Name
Hospital CEO/Administrator

Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN
EDAP or SEDP RENEWAL APPLICATION
CREDENTIALS OF FAST TRACK/URGENT CARE PHYSICIANS

- List each physician by name.
- Indicate full time or part time and date of ED hire.
- Complete all credentials
- Identify completion of APLS or PALS.
- Identify the number of pediatric CME hours that have been completed within the past 2 years.

Physician Name	F=Full Time P=Part Time	Date of ED Hire	Certification	Exp. Date	Course Completion		Exp. Date	16 HRS. of Pediatric Emergency related CME (In last two years)
					APLS	PALS		
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

_____ _____ _____

Signature
Hospital CEO/Administrator

Typed Name
Hospital CEO/Administrator

Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN
EDAP or SEDP RENEWAL APPLICATION
CREDENTIALS OF EMERGENCY DEPARTMENT NURSE PRACTITIONER AND PHYSICIAN ASSISTANT

- List each nurse practitioner and physician assistant by name.
- Indicate location of work site: Emergency Department or Fast Track only.
- Nurse Practitioners shall have completed a Pediatric NP, Emergency NP or Family Practice NP program. Identify any nurse practitioner that meets Alternate Criteria requirements and submit a letter verifying his or her hours worked (EMS Administrative Code 515.4000 b,1,A, ii)
- Check all credentials and verify current license. (PAs: check appropriate box. NP: specify PNP, ENP, FPNP or Alternate Criteria
- Identify completion of APLS, PALS or ENPC. Submit a copy of a current AHA PALS or ACEP-AAP APLS or ENPC card for the nurse practitioner who meets Alternate Criteria
- Identify the number of pediatric CME/CEU hours that have been completed within the past 2 years.

Clinician Name	**ED** Emergency Department **FT** Fast Track only	Date of ED Hire	License Verification		Exp. Date	Facility Credentialing For Pediatric Care	Course Completion			Exp. Date	16 HRS of Pediatric Emergency CME/CEU (In Last Two Years)
			PA	PNP, ENP, FPNP or Alternate Criteria			APLS	PALS	ENPC		
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

Signature
Hospital CEO/Administrator

Typed Name
Hospital CEO/Administrator

Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN
EDAP or SEDP RENEWAL APPLICATION
CREDENTIALS OF EMERGENCY DEPARTMENT NURSING STAFF

- List each staff nurse by name.
- Indicate full time or part time status and date of ED hire.
- Identify completion of APLS, PALS or ENPC, and expiration date.
- Identify the number of pediatric CEU's that have been completed within the past 2 years.

Staff Nurse	F=Full Time P=Part Time	Date of ED Hire	Course Completion			Expiration Date	8 HRS. of Pediatric Emergency/Critical Care CEU's (In Last Two Years) EDAP – All RN's SEDP – One RN/Shift
			APLS	PALS	ENPC		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

Signature
Hospital CEO/Administrator

Typed Name
Hospital CEO/Administrator

Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

Illinois EMSC
Facility Recognition

Pediatric Equipment Requirements for Emergency Departments

Section 515.APPENDIX L Pediatric Equipment Requirements for Emergency Departments

The following list identifies pediatric equipment items that are recommended for the two emergency department facility recognition levels. Equipment items are classified as "essential" (E) and "need to be stocked in the emergency department" (ED).

Monitoring Devices	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Blood glucose measurement device (i.e., chemistry strip or glucometer)	E (ED)		E (ED)	
Continuous end-tidal PCO_2 monitor and pediatric CO_2 colorimetric detector (disposable units may be substituted)	E (ED)		E (ED)	
Doppler ultrasound blood pressure device (neonatal-adult thigh cuffs)	E (ED)		E (ED)	
ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles, with pediatric dosage settings and pediatric-adult pacing electrodes	E (ED)		E (ED)	
Hypothermia thermometer (Note: with a range of 28-42°C)	E (ED)		E (ED)	
Pediatric monitor electrodes	E (ED)		E (ED)	
Otoscope/ophthalmoscope/stethoscope	E (ED)		E (ED)	
Pulse oximeter with pediatric and adult probes	E (ED)		E (ED)	
Sphygmomanometer with cuffs (neonatal-adult thigh)	E (ED)		E (ED)	
Vascular Access Supplies and Equipment	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Arm boards (sized infant through adult)	E (ED)		E (ED)	
Blood gas kits	E (ED)		E (ED)	
Butterfly-type needles (19-25 g)*	E (ED)		E (ED)	
Catheter-over-needle devices (16-24 g)*	E (ED)		E (ED)	
Central venous catheters (stock one small and one large size)	E (ED)		E (ED)	
Infusion pumps, syringe pumps, or devices with microinfusion capability using appropriate tubing & connectors	E (ED)		E (ED)	
Intraosseous needles or bone marrow needles (13-18 g size range; stock one large/one small bore) or IO device (pediatric and adult sizes)	E (ED)		E (ED)	
IV extension tubing, stopcocks, and T-connectors	E (ED)		E (ED)	
IV fluid/blood warmer	E (ED)		E (ED)	

IV solutions: standard crystalloid and colloid solutions (D10W, D5/.2 NS, D5/.45 NS, D5/.9 NS and 0.9 NS)	E (ED)		E (ED)	
Syringes (1ml through 20 ml)	E (ED)		E (ED)	
Tourniquets	E (ED)		E (ED)	
Umbilical vein catheters (3.5 and 5 Fr; the same size feeding tube may be used for 5 Fr)*	E (ED)		E (ED)	
Respiratory Equipment and Supplies	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Bag-valve-mask device, self-inflating infant/child and adult (1000 ml) with O_2 reservoir and clear masks (neonatal through large adult sizes)*; PEEP valve	E (ED)		E (ED)	
Manometer	E (ED)		E (ED)	
Bulb syringe	E (ED)		E (ED)	
Endotracheal tubes:*				
Cuffed or Uncuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, and 8.0)	E (ED)		E (ED)	
Stylets for endotracheal tubes (pediatric and adult)	E (ED)		E (ED)	
Laryngoscope handle (pediatric and adult)	E (ED)		E (ED)	
Laryngoscope blades (curved 2, 3; straight or Miller 0, 1, 2, 3)*	E (ED)		E (ED)	
Magill forceps (pediatric and adult)	E (ED)		E (ED)	
Meconium aspirator	E (ED)		E (ED)	
Nasopharyngeal airways (sizes 14, 16, 20, 24, 28, 30 Fr)*	E (ED)		E (ED)	
Nebulized medication, administration set with pediatric and adult masks	E (ED)		E (ED)	
Oral airways (sizes 0, 1, 2, 3, 4, 5 or size 50 mm, 60 mm, 70 mm, 80 mm, 90 mm, 100 mm)*	E (ED)		E (ED)	
Oxygen delivery device with flow meter and tubing	E (ED)		E (ED)	
Oxygen delivery adjuncts:				
Tracheostomy collar	E (ED)		E (ED)	
Standard masks, clear (pediatric and adult sizes)	E (ED)		E (ED)	
Partial non-rebreather or non-rebreather masks, clear (pediatric and adult sizes)	E (ED)		E (ED)	
Nasal cannula (infant, pediatric and adult)	E (ED)		E (ED)	

Peak flow meter	E (ED)		E (ED)	
Supplies/kit for patients with difficult airway conditions: • LMA (sizes 1, 1.5, 2, 2.5, 3, 4 and 5); or • Cricothyrotomy kit or cricothyrotomy capabilities (i.e., 10 g needle and 3 mm ET tube adapter or 14 g needle and 3.5 mm ET tube adapter)	E (ED)		E (ED)	
Suction capability (wall)	E (ED)		E (ED)	
Suction capability (portable)	E (ED)		E (ED)	
Suction catheters (sizes 5/6, 8, 10, 12, 14, 16, 18 Fr and Yankauer-tip catheter)*	E (ED)		E (ED)	
Tracheostomy tubes (sizes PED* 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)* (correspond to PT 00, 0, 1, 2, 3, 4, in old schematization)	E (ED)		---	
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 12-32 Fr)*	E (ED)		---	
Medications (unit dose, prepackaged)	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number in ED	E (ED)		E (ED)	
Activated charcoal (consider with and without Sorbitol)	E (ED)		E (ED)	
Adenosine	E (ED)		E (ED)	
Amiodarone	E (ED)		E (ED)	
Antiemetics	E (ED)		E (ED)	
Antimicrobial agents (parenteral and oral)	E (ED)		E (ED)	
Antipyretics	E (ED)		E (ED)	
Atropine	E (ED)		E (ED)	
Barbiturates, e.g., Phenobarbital, Pentobarbital	E (ED)		E (ED)	
Benzodiazepines, e.g., Lorazepam, Midazolam, Diazepam	E (ED)		E (ED)	
Beta agonist for inhalation (Albuterol, Levalbuterol)	E (ED)		E (ED)	
Beta blockers, e.g., Propranolol, Metoprolol	E (ED)		E (ED)	
Calcium (chloride or gluconate)	E (ED)		E (ED)	
Corticosteroids, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone	E (ED)		E (ED)	
Dextrose (25% and 50%)	E (ED)		E (ED)	
Diphenhydramine	E (ED)		E (ED)	

Dobutamine	E (ED)		---	
Dopamine	E (ED)		---	
Epinephrine (1:1,000 and 1:10,000)	E (ED)		E (ED)	
Epinephrine (Racemic)	E (ED)		E (ED)	
Fosphenytoin and/or Phenytoin	E (ED)		E (ED)	
Furosemide	E (ED)		E (ED)	
Glucagon or Glucose Paste	E (ED)		E (ED)	
Insulin, regular	E (ED)		E (ED)	
Lidocaine 1%	E (ED)		E (ED)	
Magnesium Sulfate	E (ED)		E (ED)	
Mannitol	E (ED)		E (ED)	
Narcotics	E (ED)		E (ED)	
Neuromuscular blocking agents (i.e., succinylcholine, rocuronium, vecuronium)	E (ED)		E (ED)	
Ocular anesthetics	E (ED)		E (ED)	
Poison Specific Antidotes				
Acetylcysteine	E (ED)		E (ED)	
Cyanide Antidote	E (ED)		E (ED)	
Flumazenil	E (ED)		E (ED)	
Naloxone	E (ED)		E (ED)	
Sodium bicarbonate – 8.4% and 4.2%	E (ED)		E (ED)	
Sedative/Hypnotic (e.g., Ketamine, Etomidate)	E (ED)		E (ED)	
Tetanus Immune Globulin (Human)	E (ED)		E (ED)	
Tetanus Vaccines (single or in combination with other vaccines)	E (ED)		E (ED)	
Topical Anesthetics	E (ED)		E (ED)	
Miscellaneous Equipment	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Dosing device – length or weight based system for dosing and equipment	E (ED)		E (ED)	
Dosing/equipment chart by weight	E (ED)		E (ED)	
EMS communication equipment (i.e., telemetry, MERCI, cellular or dedicated phone)	E (ED)		E (ED)	
Examination gloves, disposable	E (ED)		E (ED)	

Fluorescein (eye strips)	E (ED)		E (ED)	
Infant formulas, dextrose in water with various nipple sizes	E (ED)		E (ED)	
Lubricant, water soluble	E (ED)		E (ED)	
Nasogastric tubes 8 through-18 Fr* (may substitute feeding tubes 5F and 8F)	E (ED)		E (ED)	
Oral rehydrating solution	E (ED)		E (ED)	
Pain scale assessment tools appropriate for age	E (ED)		E (ED)	
Pediatric emergency/crash cart or bag with defined list of contents attached to bag/cart	E (ED)		E (ED)	
Restraining device, pediatric (papoose)	E (ED)		E (ED)	
Resuscitation board	E (ED)		E (ED)	
Urinary catheters (8-22 Fr)*	E (ED)		E (ED)	
Warming devices, age appropriate	E (ED)		E (ED)	
Weighing scales (in kilograms only) for infant and children	E (ED)		E (ED)	
Woods lamp (blue light)	E (ED)		E (ED)	
Specialized Pediatric Trays	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Initial newborn resuscitation equipment (can include warming device, feeding tubes, neonatal mask)	E (ED)		E (ED)	
Lumbar puncture tray, including a selection of needle sizes (size 18-22 g, 1½ -3 inch needle)	E (ED)		E (ED)	
Minor surgical instruments and sutures	E (ED)		E (ED)	
Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel)	E (ED)		E (ED)	
Fracture Management Devices	**EDAP**	**Check if present in EDAP**	**SEDP**	**Check if present in SEDP**
Extremity splints	E (ED)		E (ED)	
Femur splint (child and adult)	E (ED)		E (ED)	
Semi-rigid neck collars (child through adult) or cervical immobilization equipment suitable for children	E (ED)		E (ED)	
Spinal immobilization board (child and adult)	E (ED)		E (ED)	

* Shall minimally stock a range of each commonly available size noted or comparable sizes.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

NOTE: LATEX-FREE SUPPLIES SHOULD BE AVAILABLE WHENEVER POSSIBLE (Refer to EMS System Latex-Free policy)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
SECTION 515.APPENDIX M INTERFACILITY PEDIATRIC TRAUMA AND CRITICAL CARE CONSULTATION AND/OR TRANSFER GUIDELINE

Section 515.APPENDIX M Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline

Introduction
Most ill and injured children can be successfully managed by pediatricians, emergency physicians, and other community physicians in local hospitals. However, certain types of severely ill or injured children may require specialized pediatric critical care services or specialized trauma services that are not generally available in local hospitals.

Referral centers that provide specialized pediatric critical care services or specialized trauma services for pediatric patients should be identified by community hospitals and local EMS agencies and included as integral components of their pediatric emergency and critical care systems and trauma care systems. The specialized referral centers provide 24-hour telephone consultation to assist community physicians in the evaluation and management of critically ill and injured children. In addition, most of these referral centers provide pediatric inter-facility transport services to facilitate the transport of critically ill or injured children to specialized centers when indicated.

Decisions on when to seek consultation or to transfer pediatric patients need to be individualized, based on local needs and resources. However, children with certain categories of critical illness and injury are at high risk of death and disability. Early consultation with appropriate pediatric critical care or trauma specialists and rapid transport to specialized referral centers, when indicated, can improve the outcomes for these children. In particular, consultation shall be sought for pediatric medical, surgical, and trauma patients who require intensive care when it is not locally available.

The attached guidelines are intended for use in a number of ways:

- They can be used by physicians and hospitals to identify the types of critically ill or injured children who might benefit from consultation with critical care or trauma specialists or transfer to specialized referral centers. It is recommended that hospitals and their medical staffs develop appropriate policies, procedures and staff education programs based on these guidelines. This will help to promote consultation, minimize delays, and facilitate appropriate, rapid and efficient transport of critically ill and injured children to specialty centers, when indicated.

- It is recommended that these guidelines also be used by local EMS agencies as a basis for the development of pediatric consultation and transfer guidelines based on the local needs and resources. Consultation and transfer guidelines should be integrated into local EMS agency plans for pediatric emergency, critical care, and trauma care in each region. These guidelines should become specific EMS policies and procedures in order to promote appropriate consultation and transfer of children who require specialized pediatric critical care and/or trauma services.

The following guidelines are intended to assist physicians and hospitals to identify the types of critically ill and injured children who might benefit from consultation with pediatric critical care specialists or trauma specialists and transfer to specialized pediatric critical care or trauma centers, when indicated. If an inter-facility transport is

required, the referring physician, in consultation with the receiving physician, should determine the method of transport and appropriate personnel to accompany the child. The hospital shall have written pediatric inter-facility transfer guidelines/policies/procedures concerning transfer of critically ill and injured patients that include a defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center; process for selecting the appropriate care facility; process for selecting the appropriately staffed transport service to match the patient's acuity level; process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral institution information to family.

Consultation with pediatric medical and surgical specialists at a pediatric tertiary care center or trauma specialists at a trauma center should occur as soon as possible after evaluation of the patient. It is recommended that each hospital and its medical staff develop appropriate emergency department and inpatient guidelines, policies and procedures for obtaining consultation and arranging transport, when indicated, for the following types of pediatric medical and trauma patients.

I. Guidelines for Inter-facility Consultation and/or Transfer for Evaluation of Pediatric Medical Patients (Non-trauma)

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status

2. Severe respiratory distress responding inadequately to treatment and accompanied by any one of the following:

a. Cyanosis

b. Retractions (moderate to severe)

c. Apnea

d. Stridor (moderate to severe)

e. Grunting or gasping respirations

f. Status asthmaticus

g. Respiratory failure

3. Children requiring endotrachael intubation and/or ventilatory support

4. Serious cardiac rhythm disturbances

5. Status post cardiopulmonary arrest

6. Heart failure

7. Shock responding inadequately to treatment

8. Children requiring any one of the following:

a. Arterial pressure monitoring

b. Central venous pressure or pulmonary artery monitoring

c. Intracranial pressure monitoring

d. Vasoactive medications

9. Severe hypothermia or hyperthermia

10. Hepatic failure

11. Renal failure, acute or chronic requiring immediate dialysis

B. Other Criteria

1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems

2. Status epilepticus

3. Potentially dangerous envenomation

4. Potentially life-threatening ingestion of, or exposure to, a toxic substance

5. Severe electrolyte imbalances

6. Severe metabolic disturbances

7. Severe dehydration

8. Potentially life-threatening infections, including sepsis

9. Children requiring intensive care

10. Any child who may benefit from consultation with, or transfer to, a pediatric critical care center

II. Guidelines for Interfacility Consultation and/or Transfer for Evaluations of Pediatric Trauma Patients

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status

2. Respiratory distress or failure

3. Children requiring endotracheal intubation and/or ventilatory support

4. Shock, compensated or uncompensated

5. Injuries requiring any blood transfusion

6. Children requiring any one of the following:

a. Arterial pressure monitoring

b. Central venous pressure or pulmonary artery monitoring

c. Intracranial pressure monitoring

d. Vasoactive medications

B. Anatomic Criteria

1. Fractures and deep penetrating wounds to an extremity complicated by neurovascular or compartment injury

2. Fracture of two or more major long bones (i.e., femur, humerus)

3. Fracture of the axial skeleton

4. Spinal cord or column injuries

5. Traumatic amputation of an extremity with potential for replantation

6. Head injury when accompanied by any of the following:

a. Cerebrospinal fluid leaks

b. Open head injuries (excluding simple scalp injuries)

c. Depressed skull fractures

d. Decreased level of consciousness

7. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis

8. Major pelvic fractures

9. Significant blunt injury to the chest or abdomen

C. Other Criteria

1. Children requiring intensive care

2. Any child who may benefit from consultation with, or transfer to, a trauma center or a pediatric critical care center

D. Burn Criteria – Contact should be made with a burn center for children who meet any one of the following criteria:

1. Partial thickness burns of greater than 10% total body surface area (TBSA)

2. Third degree burns in any age group

3. Burns involving:

a. Signs or symptoms of inhalation injury

b. Respiratory distress

c. The face

d. The ears (serious full-thickness burns or burns involving the earcanal or drums)

e. The mouth and throat

f. The hands, feet, genitalia, major joints or perineum

4. Electrical burns (including lightning injury)

5. Chemical burns

6. Burns associated with trauma or complicating medical conditions

7. Burned children in hospitals without qualified personnel or equipment for the care of children

8. Burn injury in patients who will require special social, emotional, or long-term rehabilitative intervention.

(Source: Amended at 35 Ill. Reg. 20609, effective December 6, 2011)

PEDIATRIC BILL OF RIGHTS*

All children have a right to the following:

- **Ask to have a parent or another adult stay with them during their examination**
- **Tell their caregiver when and where something hurts**
- **Ask questions if they don't understand a medical procedure or what's happening to them**
- **Choose which ear should be looked at first or which arm to have a shot in**
- **Ask for something to ease their pain**
- **Listen to music, play a game, or read a book to help distract them during medical procedures**
- **Cry, laugh, or be mad if it helps them feel better**

*** Source: Association for the Care of Children's Health (ACCH)**