

MEDICAL DIRECTION COMMITTEE
1041 Technology Park Dr, Glen Allen, Virginia
Conference Rooms A and B
October 11, 2012
10:30 AM

Members Present:	Members Absent:	Staff:	Others:
Marilyn McLeod, M. D. - Chair Stewart Martin, M.D. George Lindbeck, M.D. Asher Brand, M.D. Charles Lane, M.D. Theresa Guins, M.D. Cheryl Lawson, M.D. Forrest Calland, M.D. Allen Yee, M.D. Chief Eddie Ferguson Scott Weir, M.D.	Paul Philips, D.O. Christopher Turnbull, M.D. Nael Hasan, M.D.	Gary Brown Scott Winston Michael Berg Warren Short Chad Blosser Greg Neiman Debbie Akers George Lindbeck, M.D.	Chip Decker John R. Dugan III Cathy Cockrell L. Blanton Marchese

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
1. Welcome	The meeting was called to order by Dr. Mcleod at 10:35 AM	
2. Introductions	Introductions were made.	Meeting Sign-in Roster Attachment "E"
3. Approval of Minutes	Approval of minutes from the July 12, 2012 meeting with one revision; date on minutes incorrect.	Motion by Dr. Lane, seconded by Dr. Stewart to approve. Passed.
4. Special Report		
A Richmond FFP Study	Presentation from Richmond Ambulance Authority on the FFP study they are actively involved in. Presentation of current information and criteria for inclusion of patient. Participants include VCU, University of Pittsburgh and Colorado.	
4. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance	Dr. Lindbeck reported, federal law passed mandates that manufactures must notify if . University of Utah has become defacto reporter of drug shortages. This is resource most are using for identification of drug shortages. Mike Berg stated he had nothing to add to the report.	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
Issues			
5. New Business			
A	Videolaryngoscopy – Dr. Brand	Dr. Brand requested support from MDC committee for funding priority on videolaryngoscopy requests during next grant cycle.	Motion by Dr. Martin, seconded by Dr. Lawson to support. Passed
B	Additional Skills for EMT’s – Dr. Brand	Dr. Brand wanted to know if the committee should revisit any of the skills being practices by EMT’s in some regions. Discussion and clarification by committee of skills sets and procedure and formulary schedule as it pertains to the EMT level was held. No action required.	
C	Voluntary Designation System for ED’s with Regard to Pediatric Capability – Dr. Guins	Dr. Guins presented a project that the EMS-C group has been working and was sent out in March for voluntary Pediatric ED designation. The group will be meeting on October 15, 2012 to discuss this project. The discussion will include the impact on EMS systems in the distant future and the possible diversion based on designation. See attachment “A”	
6. Old Business			
A	Refusal White Paper – Dr. McLeod	Distributed email from Office of the Attorney General concerning the paper. Dr. McLeod and Dr. Brand to work together. Please forward any recommendations. See attachment “B”	Assigned to Dr. McLeod and Dr. Brand
B	Seatbelt Use White Paper – Dr. McLeod	Distributed first draft of proposed white paper. Please forward comments to Dr. McLeod. See attachment “C”	
C	Health & Fitness White Paper – Dr. McLeod	Postponed any further movement on this item until next meeting.	
D	TCC Committee Representative – Dr. McLeod	Dr. McLeod stated that she needed a volunteer to represent the MDC Committee on Training & Certification Committee.	Dr. McLeod and Dr. Lane to discuss and report to Greg Neiman.
E	At-Large membership – Dr. McLeod	Dr. McLeod stated that the At-Large members needed to be reappointed. Current At-large members are Dr. Forrest Calland and Dr. Scott Weir.	Motion by Dr. Yee, 2nd by Dr. Guins to reappoint current members. Passed.
F	Community Paramedicine – Dr. Yee	Dr. Yee stated he would send the link to the Community Paramedicine presentation.	
7. Research Notes		No Items presented.	
8. State OMD Issues – George Lindbeck, MD			
A	Richmond FFP Study	See above under special reports.	
B	Law Enforcement Personal	Dr. Lindbeck asked if the committee would want to support an initiate to put together a toolkit list for	Dr. Lindbeck to distribute to

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
	First Aid Kids	distribution to offer suggestions on what commercial kits are available, what should be contained in the kits, etc. After discussion, Dr. Lindbeck to put together a list and send to the committee for review.	committee for next meeting.
C	Scope of Practice Grids	Scope of Practice and Formulary Grids reviewed by the committee. Discussion and clarification was offered. Dr. Lindbeck will finalize the grid and forward to the committee to be voted on at next MDC meeting. (See Attachment "D")	Dr. Lindbeck to distribute to committee for vote at next meeting.
D	EMD Language to recognize agonal breathing	Dr. Lindbeck stated that the American Heart Association would like EMD's to help bystanders identify this type of breathing in patients and a definition of agonal breathing has been written for EMD's. Discussion held by committee.	
E	HIPPA Letter from HHS	Dr. Lindbeck stated there was an August letter from HHS. He will send out to the committee members as a resource to everyone.	Dr. Lindbeck to distribute by email to committee
F	Hand off Form	Dr. Lindbeck stated that the requirement to provide a run report to the hospital is 12 hours however, he queried the group on a "hand-off" form and whether the group should design a standardized form for use as a resource to all agencies. Dr. Lindbeck mentioned a form from Pennsylvania and stated he will share by email to group.	Dr. Lindbeck to distribute by email to committee
G	ND Rural Medical Direction Handbook	Dr. Lindbeck stated he would send this handbook to all committee members for review and for use as desired.	Dr. Lindbeck to distribute by email to committee
H	Update on drug shortages	Nothing further to report at this time.	
I	Guidelines	Dr. Lindbeck stated that he had nothing to report. October 31 st was the next scheduled meeting however it would likely be postponed due to Symposium. Dr. McLeod asked for clarification about where the guidelines will be housed. Gary Brown clarified that when the subgroup agrees to the guidelines it will be brought to the MDC.	
J	OMD Courses, Symposium	Dr. Lindbeck stated there would be a full day didactic course and then a ½ day OPS course at Symposium. Half – day courses will be offered on December 13 th in the TEMS/PEMS region, on March 6, 2013, in the TJEMS/CSEMS region and on March 20, 2013 in the Lord Fairfax region. Additionally there will be a full day course at the Homestead in February. Dr. Lindbeck clarified the requirements for attendance at the OMD course.	
Office of EMS Reports			
A	EMS Training Funds & Accreditation Update – Chad Blosser	a) Accreditation and EMSTF reports were distributed. Chad reported on real changes on the EMST or accredited sites since last meeting. b) Clarified for OMD's that any Paramedic program enrollee's after January 1, 2013 must be in an accredited paramedic program or they will not be eligible to test National Registry.	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
B	ALS Programs Issues – Debbie Akers	<ul style="list-style-type: none"> a) Pending ALS Coordinator applications are at 57. No further new applications will be accepted. Classes will be offered to finish this group. They are being encouraged to start process of Education Coordinator. b) Discussed the awarding of fraudulent CE and the need to be aware of what is being awarded by the course coordinators. 	
C	BLS Program Issues – Greg Neiman	<ul style="list-style-type: none"> a) Greg reported that last EMT-Instructor Institute was held in September. Was a really good institute. His numbers are low in the pipeline for future courses. The test is still a challenge, only about a 25% pass rate on first attempts. b) VEMSES testing – Still at 50-60% pass rate on first attempt. Numbers are not improving on 2nd and 3rd attempts and we have now had our first 4th time failure. Test is being offered at CTS sites, at the office and special offers have been held. c) Instructor Update – Last one for 2012 will be held this evening and last in-person update will be held at Symposium. 	
D	TCC Report – Greg Neiman	Greg reported that the TCC committee for this month was cancelled. Nominations have been received from most groups but still needs a nominee from MDC.	
E	Division of Educational Development Report – Warren Short	<ul style="list-style-type: none"> a) Warren reported that he wanted to clarify the rumor that the Office of EMS is not getting rid of EMT to go to the AEMT level; that seems to be the newest rumor on the street. b) Automatic reciprocity at the I and P level is going smoothly. Reports are that Virginia cards are being received before the National Registry card. c) EMT data transfer is working well and we are prepared for the increased transmission with testing in December. a) d) AEMT now can be taught in Virginia; all Instructors have been notified. 	
F	Regulation and Compliance Issues – Michael Berg	<ul style="list-style-type: none"> a) Mike reported that it is now Day 2 of the new regulations. He is working diligently with the Department of Health to get permission for printing. b) Reminded the OMD's that they now must attend two sessions in five years, re-endorsement no longer requires the Regional Council level approval, it needs to be sent straight to Mike Berg. c) Mike stated he will be working to make sure updates are posted rapidly, same chapter amended and updated so exemptions, etc. are still in place. d) Mike clarified that going to NAEMSP does not count as one session toward re-endorsement. e) Mike notified the group that he has sent the question concerning DUI and previous issues to the OAG's office for clarification. 	
PUBLIC COMMENT		None	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
For The Good Of The Order		
Meeting Dates for 2013	January 17, 2013, April 11, 2013, July 11, 2013, October 10, 2013	
Adjournment	13:27 PM	

DRAFT

Attachment A

Summary and Rationale:

Pediatric Emergency Department (PED) Designation (Voluntary)

The Emergency Medical Services for Children (EMSC) Program in the Division of Trauma/Critical Care, within the Office of Emergency Medical Services (OEMS) seeks to:

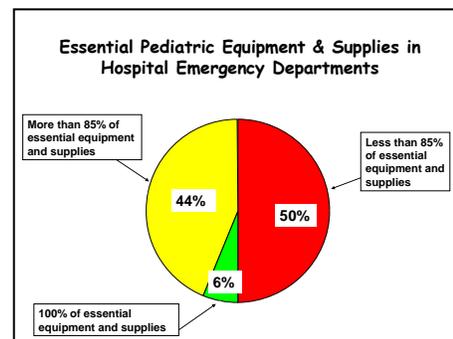
- Provide positive recognition for hospitals that have achieved specific levels of emergency department (ED) pediatric emergency care capability.
- Categorize Virginia hospitals as to their level of pediatric emergency care capabilities to aid citizens and EMS providers in making appropriate destination decisions (and to assist in emergency preparedness planning).

The impetus for pursuing this effort is four-fold:

- The Institute of Medicine (IOM) 2006 report *“Emergency Care for Children: Growing Pains”* (Recommendation 3.1) that calls for an *“evidence-based categorization system for EMS, EDs and trauma centers based on adult and pediatric service capabilities.”*
- Issuance in 2009 of *“Joint Policy Statement—Guidelines for Care of Children in the Emergency Department”* by American Academy of Pediatrics (AAP), American College of Emergency Physicians, Emergency Nurses Association, et al. which provided widely endorsed minimum guidelines for *“the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children.”*
- Achieving Performance Measure 74 of the National EMSC Program administered by the Health Resources and Services Administration (HRSA), which measures *“the percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.”*
- Findings of the *National Commission on Children and Disasters* (Recommendations 3.3 and 3.4) dealing with ensuring the capabilities of hospitals to effectively treat pediatric emergencies during disasters, and to deal with pediatric surge capacity.

There is evidence that hospital emergency departments that are “pediatric-prepared” actually experience improved outcomes for pediatric patients. There are also existing successful examples of pediatric hospital designation/recognition programs that can be used as a basis for discussions, and national guidelines are now available (see AAP above) for guidance in establishing a reasonable minimum level of readiness for hospital EDs.

Nationally, many hospitals still do not have 100% of the recommended equipment necessary to properly care for pediatric patients in an emergency setting (*2006 IOM report*). Most Virginia hospitals do not have appropriate written pediatric transfer guidelines and agreements designed to get children to the appropriate level of care (*2009 VA EMSC survey*). Also, categorizing hospitals and establishing proper transfer guidelines and agreements will support emergency preparedness initiatives related to pediatric surge capacity and disaster management.



Achieving a reasonable level of pediatric capability is NOT an onerous task; the equipment list is reasonable and well-supported, and having staff with a degree of pediatric expertise is vital to the well-being of children across Virginia. In many cases only minor alterations of existing transfer guidelines or agreements would be necessary (templates for these are readily available) and additional pediatric training for ED staff can be arranged. The EMSC program stands ready to provide technical assistance for any hospital in achieving pediatric readiness.

For more than three years, the EMSC program has sought input from Virginia stakeholders while exploring criteria for a voluntary PED designation program. Visits to all critical access hospitals (CAH) and some other hospitals are taking place to assess their status in relation to the “*Guidelines for Care of Children in the Emergency Department*” criteria, and to determine what barriers remain to achieving a minimum level of pediatric emergency department readiness in small and rural hospitals.

The *PED Designation Work Group* (assembled by the EMSC program) has developed draft criteria for a three-level voluntary designation program based primarily upon:

- Successful models from other states that have implemented pediatric hospital recognition programs (Illinois, Arizona, Tennessee, California, etc.),
- The “*Guidelines for the Care of Children in the Emergency Department*” document, and
- The organizational structure of the existing Virginia trauma designation program.

An implementation timeline has been suggested, and when finalized, with input from Virginia stakeholders, the criteria for a voluntary PED designation program will be submitted to the State Health Commissioner (Commissioner) for consideration and possible inclusion in the Virginia Department of Health’s Strategic Plan.

Once a final plan for a voluntary program has been finalized and accepted by the Commissioner and the State Board of Health, hospitals wishing to indicate that they are functioning at any of the three PED levels will be able to submit an application, followed shortly by a short site visit from the EMSC program to verify their application. Successful applicants will receive official recognition from the VDH celebrating their commitment to pediatric emergency care in their community.

Submitted by:

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Stakeholders to include in providing input:

EMS for Children (EMSC) Committee of the Governor’s EMS Advisory Board

Trauma System Oversight and Management (TSO&M) Committee of the Governor’s EMS Advisory Board

Virginia Hospital and Healthcare Association (VHHA)

Virginia Chapter of American Academy of Pediatrics (AAP)

Virginia Chapter of American College of Emergency Physicians (ACEP)

Virginia Chapter of Emergency Nurses Association (ENA)

Attachments:

Hospital assessment reviewer tool

ED preparedness checklist

Guidelines for the Care of Children in the ED

Pediatric Emergency Department (PED) Criteria Comparison

E = Essential O = Optional

Definition of Designation Levels.

Note . Voluntary Pediatric Emergency Department (PED) Designation does not reflect a hospital's trauma capabilities. Trauma designation is a separate stand-alone program.

(For complete designation criteria, see the individual criteria documents for levels 1, 2 and 3. This document provides a brief comparison between levels.)

Administration and Coordination of the Emergency Department for the Care of Children

All levels of Pediatric Designated Emergency Departments in Virginia shall appoint persons to fill the following two roles for their hospital:

- Physician Coordinator for Pediatric Emergency Care
- Nursing Coordinator for Pediatric Emergency Care

Emergency Department Professional Staff

Physicians:

- Twenty-four hour coverage** of the Emergency Department (ED) shall be provided by **at least one** physician responsible for the care of critically ill or injured children that holds **one** of the following qualifications:

- Qualifications :

- Continuing Medical Education :

Level 3

Level 2

Level 1

A hospital emergency department which meets designated capabilities and provides **basic pediatric emergency medical care**.

A hospital emergency department which meets designated capabilities and provides **advanced pediatric emergency medical care**.

A hospital emergency department which meets designated capabilities and provides **comprehensive specialized pediatric medical and surgical care to acutely ill or injured pediatric patients**.

Essential



Minimum **0.15** FTE
Minimum **0.15** FTE

Essential

Certification in **Emergency Medicine** by the Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in Emergency Medicine and, at minimum, in the first cycle of the board certification process.

OR

Certification in **Pediatric Emergency Medicine** by the American Board of Pediatrics (ABP) or fellowship trained/board eligible in Pediatric Emergency Medicine and, at minimum, in first cycle of the board certification process

OR

Certification by one of the following boards:
American Board of Family Practice (ABFP); or
American Osteopathic Board of Family Practice (AOBFP); or
American Board of Pediatrics (ABP);

OR

American Osteopathic Board of Pediatrics (AOBP); or
Residency trained/board process;

AND

Up-to-date status as a provider in at **least one** of the following courses:
PALS or APLS

All physicians shall have evidence of a minimum of

Essential



Minimum **0.20** FTE
Minimum **0.20** FTE

Essential

Certification in **Emergency Medicine** by the Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in Emergency Medicine and, at minimum, in the first cycle of the board certification process.

OR

Certification in **Pediatric Emergency Medicine** by the American Board of Pediatrics (ABP) or fellowship trained/board eligible in Pediatric Emergency Medicine and, at minimum, in first cycle of the board certification process

OR

Certification by one of the following boards:
American Board of Family Practice (ABFP); or
American Osteopathic Board of Family Practice (AOBFP); or
American Board of Pediatrics (ABP);

OR

American Osteopathic Board of Pediatrics (AOBP); or
Residency trained/board process;

AND

Up-to-date status as a provider in at **least one** of the following courses:
PALS or APLS

All physicians shall have evidence of a minimum of

Essential



Minimum **0.20** Fte
Minimum **0.20** Fte

Essential

Certification in **Pediatric Emergency Medicine (PEM)** by the American Board of Pediatrics (ABP) or fellowship trained/board eligible in Pediatric Emergency Medicine and, at minimum, in the first cycle of the board certification process.

AND

Up-to-date status as a provider in at **least one** of the following courses:
PALS or APLS

All PEM physicians shall have evidence of a minimum of

Pediatric Emergency Department (PED) Criteria Comparison

E = Essential O = Optional

	Level 3	Level 2	Level 1
<ul style="list-style-type: none"> <input type="checkbox"/> <u>Continuing Medical Education</u> : (continued) <input type="checkbox"/> <u>Supervision</u> : When supervising the care provided by a Physician Assistant (PA) , the attending physician must oversee all aspects of the patient's care and personally examine the child prior to discharge. <input type="checkbox"/> <u>Consultation</u> : Telephone or telemedicine consultation with a physician that is board certified or eligible in pediatrics or Pediatric Emergency Medicine shall be available 24 hours a day. <input type="checkbox"/> <u>Physician Back-Up</u> : 	<p>8 hrs of CE (AMA Cat 1 or 2) in pediatric emergency topics every 2 years.</p> <p>Essential</p> <p>Essential</p> <p>A back-up physician whose qualifications are equivalent to the required ED physician qualifications set out on page 1 shall be available within 1 hr after notification to assist with critical situations or disasters.</p>	<p>16 hrs of CE (AMA Cat 1 or 2) in pediatric emergency topics every 2 years.</p> <p>Essential</p> <p>Essential</p> <p>A back-up physician whose qualifications are equivalent to the required ED physician qualifications set out on page 1 shall be available within 1 hr after notification to assist with critical situations or disasters.</p>	<p>30 hrs of CE (AMA Cat 1 or 2) in pediatric emergency topics every 2 years.</p> <p>Essential</p>
<p>Mid-Level Practitioners:</p> <p><input type="checkbox"/> Pediatric Nurse Practitioners (PNP): <u>If utilized...</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Must have completed an accredited Pediatric Nurse Practitioner program <input type="checkbox"/> Must maintain current Virginia licensure <input type="checkbox"/> Must complete and maintain at least one of the following... <input type="checkbox"/> <u>Continuing Education</u> : all PNP's shall have evidence of a minimum of... (of pediatric emergency topics) <p><input type="checkbox"/> Physician Assistants (PA): <u>If utilized...</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Must have completed an accredited PA program and... <input type="checkbox"/> Must maintain current Virginia licensure <input type="checkbox"/> Must review with the supervising attending physician all care rendered to the pediatric patient prior to discharge. (Also, by Code, the supervising physician must be present within the facility.) <input type="checkbox"/> Ensure that the supervising attending physician has personally examined the pediatric patient prior to discharge (which should be evident in the patient's chart). <input type="checkbox"/> If utilized, PA's must complete and maintain at least one of the following... <input type="checkbox"/> <u>Continuing Education</u> : All PA's shall have evidence of a minimum of... (of pediatric emergency topics) 	<p>Optional</p> <p>Essential</p> <p>Essential</p> <p>PALS, APLS or ENPC</p> <p>8 hrs every 2 yrs</p>	<p>Optional</p> <p>Essential</p> <p>Essential</p> <p>PALS, APLS or ENPC</p> <p>16 hrs every 2 yrs</p>	<p>Optional</p> <p>Essential</p> <p>Essential</p> <p>PALS, APLS or ENPC</p> <p>16 hrs every 2 yrs</p>
<p>Nursing:</p> <p><input type="checkbox"/> Registered Nurses (RN): (Levels 2 and 3) At least one RN per shift who maintains...</p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>Continuing Education</u> : At least one RN on duty each shift that is responsible for the direct care of the child in the ED shall have evidence of a minimum of... (pediatric emergency/critical care CE) <p><input type="checkbox"/> All RN's in Level 1 PED's, within 6 months of being allowed to practice, shall complete and maintain current recognition in the following courses in pediatric emergency care...</p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>Continuing Education</u> : All nurses assigned to the ED shall have evidence of a minimum of... (of pediatric emergency /critical care topics--may include but is not limited to PALS, APLS or ENPC) 	<p>PALS, APLS or ENPC</p> <p>8 hrs every 2 yrs</p>	<p>PALS or APLS, and ENPC</p> <p>8 hrs every 2 yrs</p>	<p>PALS or APLS, and ENPC</p> <p>8 hrs every 2 yrs</p>
<p>Physician Specialist Availability: (applies to Level 1 only)</p> <p><input type="checkbox"/> The following attending level board/sub-board certified physician specialists with pediatric proficiency shall be on staff, and shall maintain their professional staff privileges per hospital policy. These on-call physicians shall be available to provide consultation to the Emergency Department within 60 minutes after the determination is made that they are needed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pediatric Surgeon <input type="checkbox"/> Pediatric Neurosurgeon <input type="checkbox"/> Anesthesiologist <input type="checkbox"/> Pediatric Cardiologist <input type="checkbox"/> Pediatric Neonatologist 			<p>Essential</p> <p>↓</p> <p>Essential</p>

Pediatric Emergency Department (PED) Criteria Comparison	Level 3	Level 2	Level 1
<p>E = Essential O = Optional</p>			
<ul style="list-style-type: none"> <input type="checkbox"/> Pediatric Nephrologist <input type="checkbox"/> Pediatric Neurologist <input type="checkbox"/> Pediatric Orthopedic Surgeon <input type="checkbox"/> Pediatric Otolaryngologist <input type="checkbox"/> Radiologist 			<p>Essential</p>  <p>Essential</p>
<p><input type="checkbox"/> The following physician specialists shall be available in the institution, or by consultation or transfer agreement with another hospital:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pediatric Allergist or Immunologist <input type="checkbox"/> Pediatric Cardiothoracic Surgeon <input type="checkbox"/> Plastic Surgeon <input type="checkbox"/> Pediatric Endocrinologist <input type="checkbox"/> Pediatric Gastroenterologist <input type="checkbox"/> Pediatric Hematologist-Oncologist <input type="checkbox"/> Pediatric Infectious Disease <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Oral Surgeon <input type="checkbox"/> Pediatric Pulmonologist <input type="checkbox"/> Pediatric Urologist 			<p>Essential</p>  <p>Essential</p>
<p>Emergency Department Policies, Procedures, and Protocols</p>			
<p>Policies, procedures, and protocols for the emergency care of children should be developed and implemented in the areas listed below. These policies may be integrated into overall ED policies as long as pediatric specific issues are addressed:</p>			
<p><input type="checkbox"/> <i>Interfacility transfer. (Levels 2 and 3)</i> The facility shall have transfer policies and procedures as well as transfer agreements with hospitals capable of providing a higher level of pediatric care.</p>	Essential	Essential	
<p><input type="checkbox"/> <i>Interfacility transfer/transport requirements: (Level 1)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Establish and maintain transfer agreements with all referring hospitals (within one year of initial designation). <input type="checkbox"/> Provide consultation (telephone or telemedicine) to referring hospitals and accept pediatric transfers if deemed necessary. <input type="checkbox"/> Have or be affiliated with a transport system and team to assist referral hospitals in arranging safe pediatric patient transport that also considers accuity. <input type="checkbox"/> Have a transfer/transport policy that addresses the special needs of the pediatric population during transport. 			Essential
<p><input type="checkbox"/> <i>A policy or scope of services that outlines the PED services, ages of patients served, and admission guidelines.</i></p>	Optional	Optional	
<p><input type="checkbox"/> <i>Latex allergies.</i></p>	Essential	Essential	
<p><input type="checkbox"/> <i>Illness and injury triage.</i></p>			
<p><input type="checkbox"/> <i>Pediatric patient assessment and reassessment.</i></p>			
<p><input type="checkbox"/> <i>Documentation of pediatric vital signs and actions to be taken for abnormal vital signs.</i></p>			
<p><input type="checkbox"/> <i>Immunization assessment and management of the under-immunized patient.</i></p>			
<p><input type="checkbox"/> <i>Sedation and analgesia, including medical imaging.</i></p>			
<p><input type="checkbox"/> <i>Consent, including when parent or legal guardian is not immediately available.</i></p>			
<p><input type="checkbox"/> <i>Social and mental health issues.</i></p>			
<p><input type="checkbox"/> <i>Physical or chemical restraint of pediatric patients.</i></p>			
<p><input type="checkbox"/> <i>Child maltreatment and domestic violence reporting criteria, requirement, and processes.</i></p>			
<p><input type="checkbox"/> <i>Death of the child in the ED, including bereavement counseling and organ donation.</i></p>			
<p><input type="checkbox"/> <i>Do Not Resuscitate (DNR) orders.</i></p>			
<p><input type="checkbox"/> <i>Family-centered care:</i></p>			
<ul style="list-style-type: none"> <input type="checkbox"/> Family involvement in patient decision-making and medication safety processes. <input type="checkbox"/> Family presence during all aspects of emergency care. <input type="checkbox"/> Patient, family, and caregiver education. 			
<p><input type="checkbox"/> <i>Discharge planning and written instructions that include:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Information on the child's diagnoses. <input type="checkbox"/> Information on any medications prescribed. <input type="checkbox"/> Recommended follow-up for the patient. 	Essential	Essential	Essential

Pediatric Emergency Department (PED) Criteria Comparison E = Essential O = Optional	Level 3	Level 2	Level 1
<p><input type="checkbox"/> Radiological Services. Radiology capability must meet the needs of the children in the community served. Specifically:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A process for ensuring that pediatric-age or weight-based appropriate dosing for studies that impart radiation consistent with ALARA (as low as reasonably achievable) principles is utilized. <input type="checkbox"/> A process for timely review, interpretation, and reporting of medical imaging by a qualified radiologist is established. <input type="checkbox"/> A process for referring children to appropriate facilities for radiological procedures that exceed the capability of the hospital is established. <input type="checkbox"/> Radiology services, including CAT scan capability, 24/7. (Level 1) 	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential Optional</p>	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential Optional</p>	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>
<p><input type="checkbox"/> Laboratory Services. Laboratory capability must meet the needs of the children in the community served, including techniques for small sample sizes. Specifically, a process for referring children or their specimens to appropriate facilities for laboratory studies that exceed the capability of the hospital is established.</p>	<p style="text-align: center;">Essential</p>	<p style="text-align: center;">Essential</p>	<p style="text-align: center;">Essential</p>
<p>Equipment Supplies and Medications Pediatric equipment, supplies, and medications shall be appropriate for children of all ages and sizes and are easily accessible, clearly labeled, and logically organized. The ED staff must be educated on the location of all items and there must be in place a daily method to verify the proper location and function of equipment and supplies. Also, a medication chart, length-based tape, medical software, or other systems shall be readily available to ensure the proper sizing of resuscitation equipment and proper dosing of medications.</p>			
<p><input type="checkbox"/> Medications:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adenosine <input type="checkbox"/> Amiodarone <input type="checkbox"/> Anticonvulsant medications <input type="checkbox"/> Antidotes (common antidotes should be accessible to the ED) <input type="checkbox"/> Antiemetic agents <input type="checkbox"/> Antimicrobial agents (parenteral and oral) <input type="checkbox"/> Antipyretics drugs <input type="checkbox"/> Atropine <input type="checkbox"/> Bronchodilators <input type="checkbox"/> Calcium chloride <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Dextrose (D10W, D50W) <input type="checkbox"/> Epinephrine (1:1,000, 1:10,000, racemic epinephrine) <input type="checkbox"/> Glucagon <input type="checkbox"/> Inotropic agents <input type="checkbox"/> Insulin <input type="checkbox"/> Lidocaine <input type="checkbox"/> Magnesium sulphate <input type="checkbox"/> Mannitol <input type="checkbox"/> Naloxone hydrochloride <input type="checkbox"/> Neuromuscular blockers <input type="checkbox"/> Procainamide <input type="checkbox"/> Sedatives <input type="checkbox"/> Sodium Bicarbonate (4.2%, 8.4%) <input type="checkbox"/> Topical, oral and parenteral analgesics <input type="checkbox"/> Vaccines <input type="checkbox"/> Vasopressor agents 	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>
<p><input type="checkbox"/> General equipment/supplies/resources:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age appropriate pain scale-assessment tools <input type="checkbox"/> EMS communications capability <input type="checkbox"/> Fluorescein strips <input type="checkbox"/> Intravenous blood/fluid warmer <input type="checkbox"/> Latex-free supplies (gloves, etc.) <input type="checkbox"/> Oral rehydration solution 	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>	<p style="text-align: center;">Essential</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Essential</p>

Pediatric Emergency Department (PED) Criteria Comparison

E = Essential O = Optional

- Patient warming device
- Restraint device
- Resuscitation board
- Tool or chart that incorporates weight (in kg) and length to determine equipment size and correct drug dosing
- Weight scale in kilograms (not pounds)
- Wood's lamp

Monitoring, equipment/supplies:

- Blood pressure cuffs (neonatal, infant, child, adult-arm, adult-thigh)
- Continuous end-tidal CO2 monitoring device
- Doppler ultrasonography devices
- Electrocardiography monitor/defibrillator with pediatric and adult capabilities including pads/paddles
- Hypothermia thermometer
- Pulse oximeters with pediatric and adult robes

Vascular access equipment/supplies:

- Arm boards (infant, child, adult)
- Butterfly needles (23 gauge)
- Catheter-over-the-needle devices (gauges 14, 16, 18, 20, 22, 24)
- Central venous catheters (any two sizes of french 4.0, 5.0, 6.0, 7.0)
- Intraosseous needles or device (pediatric and adult)
- Intravenous administration sets with calibrated chambers and extension tubing (and/or infusion devices with ability to regulate rate and volume of infusate)
- Intravenous solutions (normal saline, dextrose 5% in normal saline, dextrose 10% in water)
- Tourniquets
- Umbilical vein catheters (3.5F and 5.5F) rate and volume of infusate)

Fracture management equipment/supplies:

- Extremity splints (assorted sizes)
- Femur splints (pediatric and adult)
- Spine-stabilization devices (appropriate for children of all ages)

Respiratory equipment/supplies:

- Bag-mask devices, self inflating
 - Infant: 450 ml
 - Adult: 1000 ml
 - Masks to fit bag-mask device adaptor (neonatal, infant, child, adult)
- Clear oxygen masks:
 - Standard infant
 - Standard child
 - Standard adult
 - Partial nonrebreather infant
 - Nonrebreather child
 - Nonrebreather adult
- Endotracheal tubes
 - Uncuffed (mm 2.5, 3.0)
 - Cuffed or uncuffed (mm 3.5, 4.0, 4.5, 5.0, 5.5)
 - Cuffed (mm 6.0, 6.5, 7.0, 7.5, 8.0)
- Feeding tubes (5F, 8F)
- Laryngeal mask airway (sizes 1, 1.5, 2.0, 2.5, 3, 4, 5)
- Laryngoscope blades
 - Straight (sizes 0, 1, 2, 3)
 - Curved (sizes 2, 3)
- Laryngoscope handles (pediatric, adult)
- Magill forceps (pediatric, adult)
- Nasal cannulas (infant, child, adult)
- Nasogastric tubes

Level 3

Level 2

Level 1

Essential



Essential

Essential



Essential

Essential



Essential

Essential



Essential



Essential

Essential



Essential

Essential



Essential

Essential



Essential

Essential



Essential



Essential

Essential



Essential

Essential



Essential

Essential



Essential

Essential



Essential



Essential

Pediatric Emergency Department (PED) Criteria Comparison	Level 3	Level 2	Level 1
<p>E = Essential O = Optional</p>			
<ul style="list-style-type: none"> <input type="checkbox"/> Infant: 8F <input type="checkbox"/> Child: 10F <input type="checkbox"/> Adult: 14-18F <input type="checkbox"/> Nasopharyngeal airways (sizes 12, 16, 20, 24) <input type="checkbox"/> Nebulized medication administration set with pediatric and adult masks <input type="checkbox"/> Oropharyngeal airways (sizes 0, 1, 2, 3, 4, 5) <input type="checkbox"/> Stylets for endotracheal tubes (pediatric, adult) <input type="checkbox"/> Suction: <ul style="list-style-type: none"> <input type="checkbox"/> Wall and/or portable capability <input type="checkbox"/> Suction catheters (infant, child, adult) <input type="checkbox"/> Yankauer suction tip <input type="checkbox"/> Trach collar <input type="checkbox"/> Tracheostomy tubes (mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5) 	<p>Essential</p>  <p>Essential</p>	<p>Essential</p>  <p>Essential</p>	<p>Essential</p>  <p>Essential</p>
<ul style="list-style-type: none"> <input type="checkbox"/> <i>Specialized pediatric trays or kits:</i> <ul style="list-style-type: none"> <input type="checkbox"/> Chest tubes: <ul style="list-style-type: none"> <input type="checkbox"/> Infant: 10-12F <input type="checkbox"/> Child: 16-24F) <input type="checkbox"/> Adult: 28-40F <input type="checkbox"/> Difficult airway supplies/kit (supraglottic airways of all sizes, laryngeal mask airway, needle cricothyrotomy supplies, surgical cricothyrotomy kit) <input type="checkbox"/> Lumbar puncture tray (including infant/pediatric 22 gauge and adult 18-21 gauge needles) <input type="checkbox"/> Newborn delivery kit (including equipment for resuscitation of an infant, umbilical clamp, scissors, bulb syringe, towel) <input type="checkbox"/> Tube thoracostomy tray <input type="checkbox"/> Urinary catheterization kits and urinary (indwelling) catheters (6F-22F) 	<p>Essential</p>  <p>Essential</p>	<p>Essential</p>  <p>Essential</p>	<p>Essential</p>  <p>Essential</p>
<p>Specific Facility Requirements</p>			
<ul style="list-style-type: none"> <input type="checkbox"/> Operate a distinct Pediatric Intensive Care Unit (PICU), staffed 24/7 by a board certified Pediatric Intensivist (on-site or on-call). 	<p>Optional</p>  <p>Essential</p>	<p>Optional</p>  <p>Essential</p>	<p>Essential</p>  <p>Essential</p>
<ul style="list-style-type: none"> <input type="checkbox"/> Maintain access to helicopter landing capabilities approved by state and federal authorities. 			
<ul style="list-style-type: none"> <input type="checkbox"/> Have radiological services, including computerized axial tomography (CAT) scan capabilities 24/7. 			
<ul style="list-style-type: none"> <input type="checkbox"/> Have in-house laboratory capabilities 24/7 that provide: <ul style="list-style-type: none"> <input type="checkbox"/> Standard analysis of blood, urine and body fluids. <input type="checkbox"/> Coagulation studies. <input type="checkbox"/> Comprehensive blood bank or an agreement with a community central blood bank. <input type="checkbox"/> Blood gases and pH determinations. <input type="checkbox"/> Microbiology. <input type="checkbox"/> Drug and alcohol screening. 	<p>Optional</p>  <p>Essential</p>	<p>Optional</p>  <p>Essential</p>	<p>Essential</p>  <p>Essential</p>
<ul style="list-style-type: none"> <input type="checkbox"/> Hemodialysis capabilities (or a transfer agreement). 			
<ul style="list-style-type: none"> <input type="checkbox"/> EMS communications capabilities. 			

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

Note: *Pediatric Emergency Department (PED) designation does not reflect a hospital's trauma capabilities. Trauma designation is a separate stand-alone program.*

Facility Designation Criteria for the Level 1 Pediatric Emergency Department (PED)

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

Definition: **Level 1 PED** – A hospital Emergency Department which meets designated capabilities and provides comprehensive specialized pediatric medical and surgical care to all acutely ill or injured pediatric patients.

Prerequisite: Any facility seeking Level 1 Pediatric Emergency Department (PED) Designation shall already have met requirements for Level 2 PED designation (see Virginia Level 2 PED criteria).

A. Administration and Coordination of the Emergency Department (ED) for the Care of Children. All levels of Pediatric Designated Emergency Departments in Virginia shall appoint persons to fill the following two roles for their hospital:

1. **Physician Coordinator for Pediatric Emergency Care.** The Pediatric Physician Coordinator (minimum 0.20 FTE) is a specialist in Emergency Medicine or Pediatric Emergency Medicine; or if these specialties are not available then Pediatrics or Family Medicine, appointed by the ED Medical Director, who through training, clinical experience or focused continuing medical education demonstrates competence in the care of children in emergency settings, including resuscitation. This person is responsible for:
 - a. Promoting, facilitating, and verifying adequate skill and knowledge of ED staff physicians and other ED health care providers in the emergency care and resuscitation of infants and children.
 - b. Coordinating with the ED Medical Director to review ED pediatric quality improvement (QI), performance improvement (PI), patient safety, injury and illness prevention, and clinical care activities.
 - c. Assisting with development and periodic review of ED policies and procedures and standards for medications, equipment, and supplies to ensure adequate resources for children of all ages.
 - d. Serving as liaison/coordinator to appropriate in-hospital and out-of-hospital pediatric care committees in the community (if they exist).
 - e. Serving as liaison/coordinator to referring hospitals and health care facilities, emergency medical service (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- f. Ensuring that competency evaluations completed by the staff are applicable to children of all ages.
 - g. Ensuring that pediatric needs are addressed in regional, community, and hospital disaster/emergency preparedness plans.
 - h. Collaborating with the nursing coordinator to ensure adequate staffing, medications, equipment, supplies, and other resources are present for children in the ED.
2. Nursing Coordinator for Pediatric Emergency Care. The Pediatric Nurse Coordinator (minimum 0.20 FTE) is a Registered Nurse (RN), appointed by the ED Nursing Director, in consultation with the Pediatric Physician Coordinator, who possesses special interest, knowledge and skill in the care of children in emergency settings, including resuscitation. This person is responsible for:
- a. Facilitating ED pediatric QI/PI activities.
 - b. Serving as liaison to appropriate in-hospital and out-of-hospital pediatric care committees.
 - c. Serving as liaison/coordinator to referring hospitals and healthcare facilities, emergency medical services (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.
 - d. Collaborating with the ED nursing continuing education coordinator to ensure that pediatric-specific elements are included in orientation for new staff members.
 - e. Ensuring that initial and annual competency evaluations completed by the ED nursing staff are applicable to children of all ages.
 - f. Promoting pediatric disaster preparedness for the ED and participating in regional, community, and hospital disaster-preparedness activities.
 - g. Promoting patient and family education regarding illness and injury prevention.
 - h. Providing assistance and support for pediatric education of out-of-hospital providers.
 - i. Working with clinical leadership to ensure the availability of pediatric equipment, medications, staffing, and other resources through the development and periodic review of ED standards, policies, and procedures.
 - j. Collaborating with the physician coordinator to ensure that the ED is prepared to care for children of all ages, including children with special health care needs.

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

B. Emergency Department Professional Staff

1. Physicians

- a. Qualifications. Twenty-four hour coverage of the Emergency Department shall be provided by **at least one** physician board certified in pediatric emergency medicine (PEM) by the American Board of Pediatrics (ABP) or fellowship trained/board eligible in pediatric emergency medicine and, at minimum, in the first cycle of the board certification process.
- b. Continuing Medical Education. All PEM physicians shall have evidence of a minimum of **30** hours of continuing education (AMA Category I or II) in pediatric emergency topics every 2 years.
- c. Supervision. When supervising the care provided by a Physician Assistant (PA), the attending physician must oversee all aspects of the patient's care and personally examine the child prior to discharge.

2. Mid-Level Practitioners. A mid-level practitioner is a Pediatric Nurse Practitioner (PNP) or Physician Assistant (working under the supervision of a physician who meets the qualifications of subsection **B.1.a.**).

a. Qualifications:

1. Pediatric Nurse Practitioners (PNP) shall be required to:

- a. Have completed an accredited Pediatric Nurse Practitioner program.
- b. Maintain current Virginia licensure.

2. Physician Assistants (PA) shall be required to:

- a. Have completed an accredited PA program.
- b. Maintain current Virginia licensure; and
- c. In accordance with Virginia Code (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2952>), the PA must review with the supervising attending physician all care rendered to the pediatric patient prior to discharge. Also, by Code, the supervising physician must be present within the facility.
- d. Ensure that the supervising attending physician has personally examined the patient prior to discharge (which should be documented in the patient's chart).

3. All PNPs and PAs shall successfully complete and maintain current recognition in **at least one** of the following courses:

- a. Pediatric Advanced Life Support (PALS)

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- b. Advanced Pediatric Life Support (APLS)
- c. Emergency Nursing Pediatric Course (ENPC)
- b. Continuing Education
 - 1. All Pediatric Nurse Practitioners (PNP) shall have evidence of a minimum of **16** hours of approved continuing education units in pediatric emergency topics every 2 years.
 - 2. All Physician Assistants (PA) shall have evidence of a minimum of **16** hours of continuing medical education (AMA Category 1) in pediatric emergency topics every 2 years. Credit for CME shall be approved by the Accreditation Council on continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP) or American Academy of Physicians Assistants (AAPA).
- 3. Nursing
 - a. Qualifications. **All** Registered Nurses (RNs), **within 6 months** of practicing in the PED, shall successfully complete and maintain current recognition in the following courses in pediatric emergency care:
 - 1. Pediatric Advanced Life Support (PALS) course **or** Advanced Pediatric Life Support (APLS); **and**
 - 2. Emergency Nursing Pediatric Course (ENPC).
 - b. Continuing Education. **All** nurses assigned to the Emergency Department shall have evidence of a **minimum of 8** hours of pediatric emergency/critical care continuing education hours every 2 years. Continuing education may include, but is not limited to, PALS, APLS or ENPC.
- C. ED Policies, Procedures and Treatment Protocols.** Policies, procedures and protocols for the emergency care of children in the Level 1 PED should be developed and implemented in the areas listed below. These policies may be integrated into overall ED policies as long as pediatric specific issues are addressed:
 - 1. Interfacility transfer/transport requirements. A Level 1 PED shall:
 - a. Establish and maintain transfer agreements with all referring hospitals (within one year of initial designation).
 - b. Provide consultation (telephone or telemedicine) to referring hospitals and accept pediatric transfers if deemed necessary.
 - c. Have or be affiliated with a transport system to assist referral hospitals in arranging safe pediatric patient transport.
 - d. Have a transfer/transport policy that addresses the special needs of the pediatric population during transport.

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

2. PED scope of services, ages of patients served and admission guidelines.
3. Latex allergies.
4. Illness and injury triage.
5. Pediatric patient assessment and reassessment.
6. Documentation of pediatric vital signs and actions to be taken for abnormal vital signs.
7. Immunization assessment and management of the under-immunized patient.
8. Sedation and analgesia, including medical imaging.
9. Consent, including when parent or legal guardian is not immediately available.
10. Social and mental health issues.
11. Physical or chemical restraint of pediatric patients.
12. Child maltreatment and domestic violence reporting criteria, requirements, and processes.
13. Death of a child in the ED, including bereavement counseling and organ donation.
14. Do Not Resuscitate (DNR) orders.
15. Family-centered care:
 - a. Family involvement in patient decision-making and medication safety processes.
 - b. Family presence during all aspects of emergency care (if deemed appropriate by physician).
 - c. Patient, family, and caregiver education.
16. Discharge planning and written instructions that include:
 - a. Information on the child's diagnoses.
 - b. Information on any medications prescribed.
 - c. Recommended follow-up for the patient.
17. Communication with the patient's medical home or primary care provider.
18. Medical imaging; specifically policies that address pediatric age or weight based appropriate dosing for studies that impart radiation consistent with ALARA (as low as reasonably achievable) principles.

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

D. Facility Requirements. A facility designated as a Level 1 Pediatric Emergency Department (PED) shall:

1. Operate a distinct Pediatric Intensive Care Unit (PICU), staffed 24/7 by a board certified Pediatric Intensivist (either on site or on call).
2. Maintain access to helicopter landing capabilities approved by state and federal authorities.
3. Have radiological services, including computerized axial tomography (CAT) scan capabilities, available 24/7. The CAT scan technician, if not in house, must be available to respond **within 30 minutes**.
4. Have in-house laboratory capabilities 24/7 that provide:
 - a. Standard analysis of blood, urine and body fluids.
 - b. Coagulation studies.
 - c. Comprehensive blood bank or an agreement with a community central blood bank.
 - d. Blood gases and pH determinations.
 - e. Microbiology.
 - f. Drug and alcohol screening.
5. Hemodialysis capabilities (or a transfer agreement).
6. EMS communications capabilities

E. Physician Specialist Availability

1. The following attending level board/sub-board certified physician specialists with pediatric proficiency shall be on staff, and shall maintain their professional staff privileges per hospital policy. These on-call physicians shall be available to provide consultation to the Emergency Department **within 60 minutes** *after the determination is made that they are needed*.
 - a. Pediatric Surgeon
 - b. Pediatric Neurosurgeon
 - c. Anesthesiologist
 - d. Pediatric Cardiologist
 - e. Neonatologist
 - f. Pediatric Nephrologist

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- g. Pediatric Neurologist
 - h. Pediatric Orthopedic Surgeon
 - i. Pediatric Otolaryngologist
 - j. Radiologist
2. The following physician specialists shall be available in the institution or by consultation or transfer agreement with another hospital:
- a. Pediatric Allergist or Immunologist
 - b. Pediatric Cardiothoracic Surgeon
 - c. Plastic Surgeon
 - d. Pediatric Endocrinologist
 - e. Pediatric Gastroenterologist
 - f. Pediatric Hematologist-Oncologist
 - g. Pediatric Infectious Disease
 - h. Obstetrics/Gynecology
 - i. Ophthalmologist
 - j. Oral Surgeon
 - k. Pediatric Pulmonologist
 - l. Pediatric Urologist

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

1. Identify pediatric-specific indicators of good outcome.
2. Collect and analyze data monthly to discover variances.
3. Define plans for improvement.
4. Evaluate or measure the success of the QI or PI process.

G. Pediatric Patient Safety. The delivery of pediatric care should reflect an awareness of unique pediatric safety concerns as reflected in the following policies or practices:

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

1. Children are weighed in kilograms.
2. Weights are recorded in a prominent place on the medical record.
3. For children who are not weighed, a standard method for estimating weight in kilograms is used (e.g., a length-based system).
4. Infants and children have vital signs recorded (temperature, heart rate, respiratory rate) in the medical record.
5. Blood pressure and pulse oximetry monitoring are available for children of all ages on the basis of illness and injury severity.
6. A process for identifying age-specific abnormal vital signs and notifying the physician, PNP, or PA.
7. Processes are in place for safe medication storage, prescribing, and delivery that includes precalculated dosing guidelines for children of all ages.
8. Infection-control practices, including hand hygiene and use of personal protective equipment, are implemented and monitored.
9. Pediatric emergency services are culturally and linguistically appropriate.
10. The ED environment is safe for children and supports patient- and family-centered care.
11. Patient identification policies meet Joint Commission standards.
12. Policies for the timely reporting and evaluation of patient safety events, medical errors, and unanticipated outcomes are implemented and monitored.

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

1. Availability of pediatric-specific medications, vaccines, equipment, and trained providers.
2. Pediatric surge capacity for injured and non-injured children.
3. Decontamination, isolation, and quarantine of families and children.
4. Minimization of parent-child separation (includes pediatric patient tracking and timely reunification of separated children with their family).
5. Access to specific medical and mental health therapies, and social services for children.
6. Disaster drills which include a pediatric mass casualty incident at least every two years.
7. Care of children with special health care needs.

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

8. Evacuation of pediatric units and pediatric subspecialty units.

I. Equipment, Supplies and Medications. Pediatric equipment, supplies and medications shall be appropriate for children of all ages and sizes (see list below) and are easily accessible, clearly labeled and logically organized. The ED staff must be educated on the location of all items and there must be in place a daily method to verify the proper location and function of equipment and supplies. Also, a medication chart, length-based tape, medical software, or other systems shall be readily available to ensure the proper sizing of resuscitation equipment and proper dosing of medications.

1. Medications:

- a. Adenosine
- b. Amiodarone
- c. Anticonvulsant medications
- d. Antidotes (common antidotes should be accessible to the ED)
- e. Antiemetic agents
- f. Antimicrobial agents (parenteral and oral)
- g. Antipyretic drugs
- h. Atropine
- i. Bronchodilators
- j. Calcium Chloride
- k. Corticosteroids
- l. Dextrose (D10W, D50W)
- m. Epinephrine (1:1,000, 1:10,000, Racemic Epinephrine)
- n. Glucagon
- o. Inotropic agents
- p. Insulin
- q. Lidocaine
- r. Magnesium Sulphate
- s. Mannitol
- t. Naloxone Hydrochloride

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- u. Neuromuscular blockers
 - v. Procainamide
 - w. Sedatives
 - x. Sodium Bicarbonate (4.2%, 8.4%)
 - y. Topical oral and parenteral analgesics
 - z. Vaccines
 - aa. Vasopressor or vasodilator agents
2. General equipment/supplies/resources:
- a. Age appropriate pain scale-assessment tools
 - b. EMS communications capability
 - c. Fluorescein strips
 - d. Intravenous blood/fluid warmer
 - e. Latex-free supplies (gloves, etc.)
 - f. Oral rehydration solution
 - g. Patient warming device
 - h. Restraint device
 - i. Resuscitation board
 - j. Tool or chart that incorporates weight (in kg.) and length to determine equipment size and correct drug dosing
 - k. Weight scale in kilograms (not pounds)
 - l. Wood's lamp
3. Monitoring equipment/supplies:
- a. Blood pressure cuffs (neonatal, infant, child, adult-arm, adult-thigh)
 - b. Continuous end-tidal CO₂ monitoring device
 - c. Doppler ultrasonography devices

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- d. Electrocardiography monitor/defibrillator (with pediatric and adult capabilities, including pads/paddles)
 - e. Hypothermia thermometer
 - f. Pulse oximeters (with pediatric and adult probes)
4. Vascular Access Equipment/Supplies:
- a. Arm boards (infant, child, adult)
 - b. Butterfly needles (23 gauge)
 - c. Catheter-over-the-needle devices (gauges 14, 16, 18, 20, 22, 24)
 - d. Central venous catheters (any two sizes of french 4.0, 5.0, 6.0, 7.0)
 - e. Intraosseous needles or device (pediatric, adult)
 - f. Intravenous administration sets with calibrated chambers and extension tubing (and/or infusion devices with ability to regulate rate and volume of infusate)
 - g. Intravenous solutions
 - 1. Normal saline
 - 2. Dextrose 5% in normal saline
 - 3. Dextrose 10% in water
 - h. Tourniquets
 - i. Umbilical vein catheters (3.5F, 5.5F)
5. Fracture management equipment/supplies:
- a. Extremity splints (assorted sizes)
 - b. Femur splints (pediatric, adult)
 - c. Spine-stabilization devices (appropriate for children of all ages)
6. Respiratory equipment/supplies:
- a. Bag-Mask devices, self inflating
 - 1. Infant: 450 ml

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

2. Adult: 1,000 ml
3. Masks to fit bag-mask device adaptor (neonatal, infant, child, adult)
- b. Clear oxygen masks:
 1. Standard (infant, child, adult)
 2. Partial nonrebreather (infant)
 3. Nonrebreather (child, adult)
- c. Endotracheal tubes
 1. Uncuffed (mm 2.5, 3.0)
 2. Cuffed or uncuffed (mm 3.5, 4.0, 4.5, 5.0, 5.5)
 3. Cuffed (mm 6.0, 6.5, 7.0, 7.5, 8.0)
- d. Feeding tubes (5F, 8F)
- e. Laryngeal mask airway (sizes 1, 1.5, 2, 2.5, 3, 4, 5)
- f. Laryngoscope blades
 1. Straight (sizes 0, 1, 2, 3)
 2. Curved (sizes 2, 3)
- g. Laryngoscope handles (pediatric, adult)
- h. Magill forceps (pediatric, adult)
- i. Nasal cannulas (infant, child, adult)
- j. Nasopharyngeal airways (sizes 12, 16, 20, 24)
- k. Nasogastric tubes:
 1. Infant: 8F
 2. Child: 10F
 3. Adult: 14-18F
- l. Nebulized medication administration set with pediatric and adult masks
- m. Oropharyngeal airways (sizes 0, 1, 2, 3, 4, 5)

CRITERIA for the LEVEL 1 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- n. Stylets for endotracheal tubes (pediatric, adult)
 - o. Suction:
 - 1. Wall and/or portable capability
 - 2. Suction catheters (infant, child, adult)
 - 3. Yankauer suction tip
 - p. Trach collar
 - q. Tracheostomy tubes (mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)
7. Specialized pediatric trays or kits:
- a. Chest tubes:
 - 1. Infant: 10-12F
 - 2. Child: 16-24F
 - 3. Adult: 28-40F
 - b. Difficult airway supplies/kit:
 - 1. Supraglottic airways of all sizes????????????King?
 - 2. Laryngeal mask airway (LMA)
 - 3. Needle cricothyrotomy supplies
 - 4. Surgical cricothyrotomy kit
 - c. Lumbar puncture tray (including infant/pediatric 22 gauge and adult 18-21 gauge needles)
 - d. Newborn delivery kit (including equipment for resuscitation of an infant, umbilical clamp, scissors, bulb syringe, towel)
 - e. Tube thoracostomy tray
 - f. Urinary catheterization kits and urinary (indwelling) catheters (6F-22F)

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

Note: *Pediatric Emergency Department (PED) designation does not reflect a hospital's trauma capabilities. Trauma designation is a separate stand-alone program.*

Facility Designation Criteria for the Level 2 Pediatric Emergency Department (PED)

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

Definition: **Level 2 PED** – A hospital emergency department which meets designated capabilities and provides advanced pediatric emergency medical care.

Prerequisite: Any facility seeking Level 2 Pediatric Emergency Department (PED) Designation shall already have met requirements for Level 3 PED designation (see Virginia Level 3 PED criteria).

A. Administration and Coordination of the Emergency Department (ED) for the Care of Children. All levels of designated Pediatric Emergency Departments (PED) in Virginia shall appoint persons to fill the following two roles for their hospital:

1. Physician Coordinator for Pediatric Emergency Care. The Pediatric Physician Coordinator (minimum 0.20 FTE) is a specialist in Emergency Medicine or Pediatric Emergency Medicine; or if these specialties are not available then pediatrics or Family Medicine, appointed by the ED Medical Director, who through training, clinical experience or focused continuing medical education demonstrates competence in the care of children in emergency settings, including resuscitation. This person is responsible for:
 - a. Promoting, facilitating, and verifying adequate skill and knowledge of ED staff physicians and other ED health care providers in the emergency care and resuscitation of infants and children.
 - b. Overseeing ED pediatric quality improvement (QI), performance improvement (PI), patient safety, injury and illness prevention, and clinical care activities, in coordination with the ED Medical Director.
 - c. Assisting with development and periodic review of ED policies and procedures and standards for medications, equipment, and supplies to ensure adequate resources for children of all ages.
 - d. Serving as liaison/coordinator to appropriate in-hospital and out-of-hospital pediatric care committees in the community (if they exist).
 - e. Serving as liaison/coordinator to a definitive care hospital (such as a regional pediatric referral hospital, or trauma center), emergency medical service (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- f. Ensuring that competency evaluations completed by the staff are applicable to children of all ages.
 - g. Ensuring that pediatric needs are addressed in regional, community, and hospital disaster/emergency preparedness plans.
 - h. Collaborating with the nursing coordinator to ensure adequate staffing, medications, equipment, supplies, and other resources are present for children in the ED.
2. Nursing Coordinator for Pediatric Emergency Care. The Pediatric Nurse Coordinator (minimum 0.20 FTE) is a Registered Nurse (RN), appointed by the ED nursing director, in consultation with the Pediatric Physician Coordinator, who possesses special interest, knowledge and skill in the care of children in emergency settings, including resuscitation. This person is responsible for:
- a. Facilitating ED pediatric QI/PI activities.
 - b. Serving as liaison to appropriate in-hospital and out-of-hospital pediatric care committees.
 - c. Serving as liaison/coordinator to referring hospitals and healthcare facilities, emergency medical services (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.
 - d. Collaborating with the ED nursing continuing education coordinator to ensure that pediatric-specific elements are included in orientation for new staff members.
 - e. Ensuring that initial and annual competency evaluations completed by the ED nursing staff are applicable to children of all ages.
 - f. Promoting pediatric disaster preparedness for the ED and participating in regional, community, and hospital disaster-preparedness activities.
 - g. Promoting patient and family education regarding illness and injury prevention.
 - h. Providing assistance and support for pediatric education of out-of-hospital providers.
 - i. Working with clinical leadership to ensure the availability of pediatric equipment, medications, staffing, and other resources through the development and periodic review of ED standards, policies, and procedures.
 - j. Collaborating with the physician coordinator to ensure that the ED is prepared to care for children of all ages, including children with special health care needs.

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

B. Emergency Department Professional Staff

1. Physicians

- a. Qualifications. Twenty-four hour coverage of the Emergency Department shall be provided by **at least one** physician responsible for the care of critically ill or injured children that holds one of the following qualifications:
 1. 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, at minimum, in the first cycle of the board certification process; or
 2. Certification in Pediatric Emergency Medicine by the American Board of Pediatrics (ABP) or fellowship trained/board eligible in Pediatric Emergency Medicine and, at minimum, in the first cycle of the board certification process; or
 3. Certification by one of the following boards:
 - a. American Board of Family Practice (ABFP); or
 - b. American Osteopathic Board of Family Practice (AOBFP); or
 - c. American Board of Pediatrics (ABP); or
 - d. American Osteopathic Board of Pediatrics (AOBP); or
 - e. Residency trained/board eligible in either family practice or pediatrics and, at minimum, in the first cycle of the board certification process; AND up to date status as a provider in **at least one** of the following courses:
 - i. Pediatric Advanced Life Support (PALS)
 - ii. Advanced Pediatric Life Support (APLS)
- b. Continuing Medical Education. All physicians shall have evidence of a minimum of **16** hours of continuing education (AMA Category I or II) in pediatric emergency topics every 2 years.
- c. Consultation/Supervision:
 1. Telephone or telemedicine consultation with a physician that is board certified or eligible in Pediatrics or Pediatric Emergency Medicine shall be available 24/7.
 2. When supervising the care provided by a Physician Assistant (PA), the attending physician must oversee all aspects of the patient's care and personally examine the child prior to discharge.
- d. Physician Backup. A backup physician whose qualifications and training are equivalent to subsection **B.1.a** of this Section shall be available **within 60 minutes** after notification to assist with critical situations or disasters.

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

2. *Mid-Level Practitioners.* A mid-level practitioner is a Pediatric Nurse Practitioner (PNP) or Physician Assistant (PA) (working under the supervision of a physician that meets the qualifications of subsection **B.1.a** of this section).

a. Qualifications:

1. Pediatric Nurse Practitioners (PNP) shall be required to:

- a. Have completed an accredited Pediatric Nurse Practitioner program.
- b. Maintain current Virginia licensure.

2. Physician Assistants (PA) shall be required to:

- a. Have completed an accredited PA program;
- b. Maintain current Virginia licensure; and
- c. In accordance with Virginia Code (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2952>), the PA must review with the supervising attending physician all care rendered to the pediatric patient prior to discharge. Also, by Code, the supervising physician must be present within the facility.
- d. Ensure that the supervising attending physician has personally examined the patient prior to discharge (which should be evident in the patient's chart).

3. All PNPs and PAs shall successfully complete and maintain current recognition in **at least one** of the following courses:

- a. Pediatric Advanced Life Support (PALS)
- b. Advanced Pediatric Life Support (APLS)
- c. Emergency Nursing Pediatric Course (ENPC)

b. Continuing Education

1. All Pediatric Nurse Practitioners shall have evidence of a minimum of **16** hours of approved continuing education units in pediatric emergency topics every 2 years.
2. All Physician Assistants shall have evidence of a minimum of **16** hours of continuing medical education (AMA Category 1) in pediatric emergency topics every 2 years. Credit for CME shall be approved by the Accreditation Council on continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP) or American Academy of Physicians Assistants (AAPA).

3. *Nursing*

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- a. Qualifications. **At least one** Registered Nurse (RN) on duty each shift that is responsible for the direct care of any pediatric patient in the Emergency Department shall successfully complete and maintain current recognition in the following courses in pediatric emergency care:
 1. Pediatric Advanced Life Support (PALS) course or Advanced Pediatric Life Support (APLS); **and**
 2. Emergency Nursing Pediatric Course (ENPC).
- b. Continuing Education. **At least one** RN on duty each shift that is responsible for the direct care of any pediatric patient in the Emergency Department shall have evidence of a minimum of **8** hours of pediatric emergency/critical care continuing education hours every 2 years.

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

1. Interfacility Transfer. The facility shall have transfer policies and procedures as well as transfer agreements with hospitals capable of providing a higher level of pediatric care.
2. Latex allergies.
3. Illness and injury triage.
4. Pediatric patient assessment and reassessment.
5. Documentation of pediatric vital signs and actions to be taken for abnormal vital signs.
6. Immunization assessment and management of the under-immunized patient.
7. Sedation and analgesia, including medical imaging.
8. Consent, including when parent or legal guardian is not immediately available.
9. Social and mental health issues.
10. Physical or chemical restraint of pediatric patients.
11. Child maltreatment and domestic violence reporting criteria, requirements, and processes.
12. Death of the child in the ED, including bereavement counseling and organ donation.
13. Do Not Resuscitate (DNR) orders.
14. Family-centered care:
 - a. Family involvement in patient decision-making and medication safety processes;

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- b. Family presence during all aspects of emergency care, if deemed appropriate by physician.
 - c. Patient, family, and caregiver education.
15. Discharge planning and written instructions that include:
- a. Information on the child's diagnoses.
 - b. Information on any medications prescribed.
 - c. Recommended follow-up for the patient.
16. Communication with the patient's medical home or primary care provider.
17. Medical imaging, specifically policies that address pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with ALARA (as low as reasonably achievable) principles.
- D. Quality Improvement.** The Quality Improvement/Performance Improvement (QI/PI) plan shall include pediatric-specific indicators, and the pediatric patient care-review process must be integrated into the ED QI/PI plan. Components of the process should interface with out-of-hospital, ED, trauma, inpatient pediatric, and hospital-wide QI or PI activities. At a minimum, QI/PI facilitators should:
- 1. Identify pediatric-specific indicators of good outcome.
 - 2. Collect and analyze data monthly to discover variances.
 - 3. Define plans for improvement.
 - 4. Evaluate or measure the success of the QI or PI process.
- E. Pediatric Patient Safety.** The delivery of pediatric care should reflect an awareness of unique pediatric safety concerns as reflected in the following policies or practices:
- 1. Children are weighed in kilograms.
 - 2. Weights are recorded in a prominent place on the medical record.
 - 3. For children that are not weighed, a standard method for estimating weight in kilograms is used (e.g., a length-based system).
 - 4. Infants and children have vital signs recorded (temperature, heart rate, respiratory rate) in the medical record.
 - 5. Blood pressure and pulse oximetry monitoring are available for children of all ages on the basis of illness and injury severity.

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

6. A process for identifying age-specific abnormal vital signs and notifying the physician, PNP or PA.
7. Processes are in place for safe medication storage, prescribing, and delivery that includes precalculated dosing guidelines for children of all ages.
8. Infection control practices, including hand hygiene and use of personal protective equipment, are implemented and monitored.
9. Pediatric emergency services are culturally and linguistically appropriate.
10. The ED environment is safe for children and supports patient and family centered care.
11. Patient identification policies meet Joint Commission standards.
12. Policies for the timely reporting and evaluation of patient safety events, medical errors, and unanticipated outcomes are implemented and monitored.

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

1. Availability of pediatric-specific medications, vaccines, equipment, and trained providers.
2. Pediatric surge capacity for injured and non-injured children.
3. Decontamination, isolation, and quarantine of families and children.
4. Minimization of parent-child separation (includes pediatric patient tracking and timely reunification of separated children with their family).
5. Access to specific medical and mental health therapies, and social services for children.
6. Disaster drills which include a pediatric mass casualty incident at least every two years.
7. Care of children with special health care needs.
8. Evacuation of pediatric units, if applicable.

G. Emergency Department Support Services.

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

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

H. Equipment, Supplies and Medications. Pediatric equipment, supplies and medications shall be appropriate for children of all ages and sizes (see list below) and are easily accessible, clearly labeled and logically organized. The ED staff must be educated on the location of all items and there must be in place a daily method to verify the proper location and function of equipment and supplies. Also, a medication chart, length-based tape, medical software, or other systems shall be readily available to ensure the proper sizing of resuscitation equipment and proper dosing of medications.

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

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- r. Magnesium Sulphate
 - s. Mannitol
 - t. Naloxone Hydrochloride
 - u. Neuromuscular blockers
 - v. Procainamide
 - w. Sedatives
 - x. Sodium Bicarbonate (4.2%, 8.4%)
 - y. Topical oral and parenteral analgesics
 - z. Vaccines
 - aa. Vasopressor agents
2. General equipment/supplies/resources:
- a. Age appropriate pain scale-assessment tools
 - b. EMS communications capability
 - c. Fluorescein strips
 - d. Intravenous blood/fluid warmer
 - e. Latex-free supplies (gloves, etc.)
 - f. Oral rehydration solution
 - g. Patient warming device
 - h. Restraint device
 - i. Resuscitation board
 - j. Tool or chart that incorporates weight (in kg.) and length to determine equipment size and correct drug dosing Oral rehydration solution
 - k. Weight scale in kilograms (not pounds)
 - l. Wood's lamp
3. Monitoring equipment/supplies:

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- a. Blood pressure cuffs (neonatal, infant, child, adult-arm, adult-thigh)
 - b. Continuous end-tidal CO2 monitoring device
 - c. Doppler ultrasonography devices
 - d. Electrocardiography monitor/defibrillator (with pediatric and adult capabilities, including pads/paddles)
 - e. Hypothermia thermometer
 - f. Pulse oximeters (with pediatric and adult probes)
4. Vascular Access Equipment/Supplies:
- a. Arm boards (infant, child, adult)
 - b. Butterfly needles (23 gauge)
 - c. Catheter-over-the-needle devices (gauges 14, 16, 18, 20, 22, 24)
 - d. Central venous catheters (any two sizes of french 4.0, 5.0, 6.0, 7.0)
 - e. Intraosseous needles or device (pediatric, adult)
 - f. Intravenous administration sets with calibrated chambers and extension tubing (and/or infusion devices with ability to regulate rate and volume of infusate)
 - g. Intravenous solutions
 1. Normal saline
 2. Dextrose 5% in normal saline
 3. Dextrose 10% in water
 - h. Tourniquets
 - i. Umbilical vein catheters (3.5F, 5.5F)
5. Fracture management equipment/supplies:
- a. Extremity splints (assorted sizes)
 - b. Femur splints (pediatric, adult)
 - c. Spine-stabilization devices (appropriate for children of all ages)

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

6. Respiratory equipment/supplies:
 - a. Bag-Mask devices, self inflating
 1. Infant: 450 ml
 2. Adult: 1,000 ml
 3. Masks to fit bag-mask device adaptor (neonatal, infant, child, adult)
 - b. Clear oxygen masks:
 1. Standard (infant, child, adult)
 2. Partial nonrebreather (infant)
 3. Nonrebreather (child, adult)
 - c. Endotracheal tubes
 1. Uncuffed (mm 2.5, 3.0)
 2. Cuffed or uncuffed (mm 3.5, 4.0, 4.5, 5.0, 5.5)
 3. Cuffed (mm 6.0, 6.5, 7.0, 7.5, 8.0)
 - d. Feeding tubes (5F, 8F)
 - e. Laryngeal mask airway (sizes 1, 1.5, 2, 2.5, 3, 4, 5)
 - f. Laryngoscope blades
 1. Straight (sizes 0, 1, 2, 3)
 2. Curved (sizes 2, 3)
 - g. Laryngoscope handles (pediatric, adult)
 - h. Magill forceps (pediatric, adult)
 - i. Nasal cannulas (infant, child, adult)
 - j. Nasopharyngeal airways (sizes 12, 16, 20, 24)
 - k. Nasogastric tubes:
 1. Infant: 8F
 2. Child: 10F

CRITERIA for the LEVEL 2 PEDIATRIC EMERGENCY DEPARTMENT (PED)

3. Adult: 14-18F
 - l. Nebulized medication administration set with pediatric and adult masks
 - m. Oropharyngeal airways (sizes 0, 1, 2, 3, 4, 5)
 - n. Stylets for endotracheal tubes (pediatric, adult)
 - o. Suction:
 1. Wall and/or portable capability
 2. Suction catheters (infant, child, adult)
 3. Yankauer suction tip
 - p. Trach collar
 - q. Tracheostomy tubes (mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)
7. Specialized pediatric trays or kits:
 - a. Chest tubes:
 1. Infant: 10-12F
 2. Child: 16-24F
 3. Adult: 28-40F
 - b. Difficult airway supplies/kit:
 1. Supraglottic airways of all sizes
 2. Laryngeal mask airway (LMA)
 3. Needle cricothyrotomy supplies
 4. Surgical cricothyrotomy kit
 - c. Lumbar puncture tray (including infant/pediatric 22 gauge and adult 18-21 gauge needles)
 - d. Newborn delivery kit (including equipment for resuscitation of an infant, umbilical clamp, scissors, bulb syringe, towel)
 - e. Tube thoracostomy tray
 - f. Urinary catheterization kits and urinary (indwelling) catheters (6F-22F)

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

Note: *Pediatric Emergency Department (PED) designation does not reflect a hospital's trauma capabilities. Trauma designation is a separate stand-alone program.*

Facility Designation Criteria for the Level 3 Pediatric Emergency Department (PED)

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

Definition: **Level 3 PED** – A hospital Emergency Department which meets designated capabilities and provides basic pediatric emergency medical care.

Prerequisite: Any facility seeking Level 3 Pediatric Emergency Department (PED) Designation shall already be an Emergency Department that has been licensed by the Virginia Board of Health.

A. Administration and Coordination of the Emergency Department (ED) for the Care of Children. All levels of designated Pediatric Emergency Departments (PED) in Virginia shall appoint persons to fill the following two roles for their hospital:

1. Physician Coordinator for Pediatric Emergency Care. The Pediatric Physician Coordinator (minimum 0.15 FTE) is a specialist in Emergency Medicine or Pediatric Emergency Medicine; or if these specialties are not available then pediatrics or Family Medicine, appointed by the ED Medical Director, who through training, clinical experience or focused continuing medical education, demonstrates competence in the care of children in emergency settings, including resuscitation. This person is responsible for:
 - a. Promoting, facilitating, and verifying adequate skill and knowledge of ED staff physicians and other ED health care providers in the emergency care and resuscitation of infants and children.
 - b. Overseeing ED pediatric quality improvement (QI), performance improvement (PI), patient safety, injury and illness prevention, and clinical care activities, in coordination with the ED Medical Director.
 - c. Assisting with development and periodic review of ED policies and procedures and standards for medications, equipment, and supplies to ensure adequate resources for children of all ages.
 - d. Serving as liaison/coordinator to appropriate in-hospital and out-of-hospital pediatric care committees in the community (if they exist).
 - e. Serving as liaison/coordinator to a definitive care hospital (such as a regional pediatric referral hospital, or trauma center), emergency medical service (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.

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- f. Ensuring that competency evaluations completed by the staff are applicable to children of all ages.
 - g. Ensuring that pediatric needs are addressed in regional, community, and hospital disaster/emergency preparedness plans.
 - h. Collaborating with the nursing coordinator to ensure adequate staffing, medications, equipment, supplies, and other resources are present for children in the ED.
2. Nursing Coordinator for Pediatric Emergency Care. The Pediatric Nurse Coordinator (minimum 0.15 FTE) is a Registered Nurse (RN), appointed by the ED nursing director, in consultation with the Pediatric Physician Coordinator, who possesses special interest, knowledge and skill in the care of children in emergency settings, including resuscitation. This person is responsible for:
- a. Facilitating ED pediatric QI/PI activities.
 - b. Serving as liaison to appropriate in-hospital and out-of-hospital pediatric care committees.
 - c. Serving as liaison/coordinator to referring hospitals and healthcare facilities, emergency medical services (EMS) agencies, primary care providers, health insurers, or any other medical resources needed to integrate services for the continuum of care of the pediatric patient.
 - d. Collaborating with the ED nursing continuing education coordinator to ensure that pediatric-specific elements are included in orientation for new staff members.
 - e. Ensuring that initial and annual competency evaluations completed by the ED nursing staff are applicable to children of all ages.
 - f. Promoting pediatric disaster preparedness for the ED and participating in regional, community, and hospital disaster-preparedness activities.
 - g. Promoting patient and family education regarding illness and injury prevention.
 - h. Providing assistance and support for pediatric education of out-of-hospital providers.
 - i. Working with clinical leadership to ensure the availability of pediatric equipment, medications, staffing, and other resources through the development and periodic review of ED standards, policies, and procedures.
 - j. Collaborating with the physician coordinator to ensure that the ED is prepared to care for children of all ages, including children with special health care needs.

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

B. Emergency Department Professional Staff

1. Physicians

- a. Qualifications. Twenty-four hour coverage of the Emergency Department shall be provided by **at least one** physician responsible for the care of critically ill or injured children that holds one of the following qualifications:
 1. 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, at minimum, in the first cycle of the board certification process; or
 2. Certification in Pediatric Emergency Medicine by the American Board of Pediatrics (ABP) or fellowship trained/board eligible in Pediatric Emergency Medicine and, at minimum, in the first cycle of the board certification process; or
 3. Certification by one of the following boards:
 - a. American Board of Family Practice (ABFP); or
 - b. American Osteopathic Board of Family Practice (AOBFP); or
 - c. American Board of Pediatrics (ABP); or
 - d. American Osteopathic Board of Pediatrics (AOBP); or
 - e. Residency trained/board eligible in either family practice or pediatrics and, at minimum, in the first cycle of the board certification process; AND up to date status as a provider in **at least one** of the following courses:
 - i. Pediatric Advanced Life Support (PALS)
 - ii. Advanced Pediatric Life Support (APLS)
- b. Continuing Medical Education. All physicians shall have evidence of a minimum of **8** hours of continuing education (AMA Category I or II) in pediatric emergency topics every 2 years.
- c. Consultation/Supervision:
 1. Telephone or telemedicine consultation with a physician that is board certified or eligible in Pediatrics or Pediatric Emergency Medicine shall be available 24 hours a day.
 2. When supervising the care provided by a Physician Assistant (PA), the attending physician must oversee all aspects of the patient's care and personally examine the child prior to discharge.

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- d. Physician Backup. A backup physician whose qualifications and training are equivalent to subsection **B.1.a** of this Section shall be available **within 60 minutes** after notification to assist with critical situations or disasters.
2. *Mid-Level Practitioners*. A mid-level practitioner is a Pediatric Nurse Practitioner (PNP) or Physician Assistant (PA) (working under the supervision of a physician that meets the qualifications of subsection **B.1.a** of this section).
 - a. Qualifications:
 1. Pediatric Nurse Practitioners (PNP) shall be required to:
 - a. Have completed an accredited Pediatric Nurse Practitioner program.
 - b. Maintain current Virginia licensure.
 2. Physician Assistants (PA) shall be required to:
 - a. Have completed an accredited PA program;
 - b. Maintain current Virginia licensure; and
 - c. In accordance with Virginia Code (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2952>), the PA must review with the supervising attending physician all care rendered to the pediatric patient prior to discharge. Also, by Code, the supervising physician must be present within the facility.
 - d. Ensure that the supervising attending physician has personally examined the patient prior to discharge (which should be evident in the patient's chart).
 3. All PNPs and PAs shall successfully complete and maintain current recognition in **at least one** of the following courses:
 - a. Pediatric Advanced Life Support (PALS)
 - b. Advanced Pediatric Life Support (APLS)
 - c. Emergency Nursing Pediatric Course (ENPC)
 - b. Continuing Education
 1. All Pediatric Nurse Practitioners shall have evidence of a minimum of **8** hours of approved continuing education units in pediatric emergency topics every 2 years.
 2. All Physician Assistants shall have evidence of a minimum of **8** hours of continuing medical education (AMA Category 1) in pediatric emergency topics every 2 years. Credit for CME shall be approved by the Accreditation Council on continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP) or American Academy of Physicians Assistants (AAPA).

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

3. Nursing

- a. Qualifications. **At least one** Registered Nurse (RN) on duty each shift that is responsible for the direct care of any pediatric patient in the Emergency Department shall successfully complete and maintain current recognition in the following courses in pediatric emergency care:
 1. Pediatric Advanced Life Support (PALS) course or
 2. Advanced Pediatric Life Support (APLS); or
 3. Emergency Nursing Pediatric Course (ENPC).
- b. Continuing Education. **At least one** RN on duty each shift that is responsible for the direct care of any pediatric patient in the Emergency Department shall have evidence of a minimum of **8** hours of pediatric emergency/critical care continuing education hours every 2 years.

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

1. Interfacility Transfer. The facility shall have transfer policies and procedures as well as transfer agreements with hospitals capable of providing a higher level of pediatric care.
2. Latex allergies.
3. Illness and injury triage.
4. Pediatric patient assessment and reassessment.
5. Documentation of pediatric vital signs and actions to be taken for abnormal vital signs.
6. Immunization assessment and management of the under-immunized patient.
7. Sedation and analgesia, including medical imaging.
8. Consent, including when parent or legal guardian is not immediately available.
9. Social and mental health issues.
10. Physical or chemical restraint of pediatric patients.
11. Child maltreatment and domestic violence reporting criteria, requirements, and processes.
12. Death of the child in the ED, including bereavement counseling and organ donation.
13. Do Not Resuscitate (DNR) orders.

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

14. Family-centered care:

- a. Family involvement in patient decision-making and medication safety processes;
- b. Family presence during all aspects of emergency care, if deemed appropriate by physician.
- c. Patient, family, and caregiver education.

15. Discharge planning and written instructions that include:

- a. Information on the child's diagnoses.
- b. Information on any medications prescribed.
- c. Recommended follow-up for the patient.

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

17. Medical imaging, specifically policies that address pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with ALARA (as low as reasonably achievable) principles.

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

1. Identify pediatric-specific indicators of good outcome.
2. Collect and analyze data monthly to discover variances.
3. Define plans for improvement.
4. Evaluate or measure the success of the QI or PI process.

E. Pediatric Patient Safety. The delivery of pediatric care should reflect an awareness of unique pediatric safety concerns as reflected in the following policies or practices:

1. Children are weighed in kilograms.
2. Weights are recorded in a prominent place on the medical record.
3. For children that are not weighed, a standard method for estimating weight in kilograms is used (e.g., a length-based system).
4. Infants and children have vital signs recorded (temperature, heart rate, respiratory rate) in the medical record.

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

5. Blood pressure and pulse oximetry monitoring are available for children of all ages on the basis of illness and injury severity.
6. A process for identifying age-specific abnormal vital signs and notifying the physician, PNP, or PA.
7. Processes are in place for safe medication storage, prescribing, and delivery that includes precalculated dosing guidelines for children of all ages.
8. Infection control practices, including hand hygiene and use of personal protective equipment, are implemented and monitored.
9. Pediatric emergency services are culturally and linguistically appropriate.
10. The ED environment is safe for children and supports patient and family centered care.
11. Patient identification policies meet Joint Commission standards.
12. Policies for the timely reporting and evaluation of patient safety events, medical errors, and unanticipated outcomes are implemented and monitored.

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

1. Availability of pediatric-specific medications, vaccines, equipment, and trained providers.
2. Pediatric surge capacity for injured and non-injured children.
3. Decontamination, isolation, and quarantine of families and children.
4. Minimization of parent-child separation (includes pediatric patient tracking and timely reunification of separated children with their family).
5. Access to specific medical and mental health therapies, and social services for children.
6. Disaster drills which include a pediatric mass casualty incident at least every two years.
7. Care of children with special health care needs.
8. Evacuation of pediatric units, if applicable.

G. Emergency Department Support Services.

1. Radiological Services. Radiology capability must meet the needs of the children in the community served. Specifically:
 - a. A process for ensuring that pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with ALARA (as low as reasonably achievable) principles is utilized.

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- b. A process for timely review, interpretation, and reporting of medical imaging by a qualified radiologist is established.
 - c. A process for referring children to appropriate facilities for radiological procedures that exceed the capability of the hospital is established.
2. Laboratory Services. Laboratory capability must meet the needs of the children in the community served, including techniques for small sample sizes. Specifically, a process for referring children or their specimens to appropriate facilities for laboratory studies that exceed the capability of the hospital is established.

H. Equipment, Supplies and Medications. Pediatric equipment, supplies and medications shall be appropriate for children of all ages and sizes (see list below) and are easily accessible, clearly labeled and logically organized. The ED staff must be educated on the location of all items and there must be in place a daily method to verify the proper location and function of equipment and supplies. Also, a medication chart, length-based tape, medical software, or other systems shall be readily available to ensure the proper sizing of resuscitation equipment and proper dosing of medications.

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

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

- p. Insulin
 - q. Lidocaine
 - r. Magnesium Sulphate
 - s. Mannitol
 - t. Naloxone Hydrochloride
 - u. Neuromuscular blockers
 - v. Procainamide
 - w. Sedatives
 - x. Sodium Bicarbonate (4.2%, 8.4%)
 - y. Topical oral and parenteral analgesics
 - z. Vaccines
 - aa. Vasopressor agents
2. General equipment/supplies/resources:
- a. Age appropriate pain scale-assessment tools
 - b. EMS communications capability
 - c. Fluorescein strips
 - d. Intravenous blood/fluid warmer
 - e. Latex-free supplies (gloves, etc.)
 - f. Oral rehydration solution
 - g. Patient warming device
 - h. Restraint device
 - i. Resuscitation board
 - j. Tool or chart that incorporates weight (in kg.) and length to determine equipment size and correct drug dosing Oral rehydration solution
 - k. Weight scale in kilograms (not pounds)
 - l. Wood's lamp

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

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

4. Vascular Access Equipment/Supplies:
 - a. Arm boards (infant, child, adult)
 - b. Butterfly needles (23 gauge)
 - c. Catheter-over-the-needle devices (gauges 14, 16, 18, 20, 22, 24)
 - d. Central venous catheters (any two sizes of french 4.0, 5.0, 6.0, 7.0)
 - e. Intraosseous needles or device (pediatric, adult)
 - f. Intravenous administration sets with calibrated chambers and extension tubing (and/or infusion devices with ability to regulate rate and volume of infusate)
 - g. Intravenous solutions
 1. Normal saline
 2. Dextrose 5% in normal saline
 3. Dextrose 10% in water
 - h. Tourniquets
 - i. Umbilical vein catheters (3.5F, 5.5F)

5. Fracture management equipment/supplies:
 - a. Extremity splints (assorted sizes)
 - b. Femur splints (pediatric, adult)

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

c. Spine-stabilization devices (appropriate for children of all ages)

6. Respiratory equipment/supplies:

a. Bag-Mask devices, self inflating

1. Infant: 450 ml

2. Adult: 1,000 ml

3. Masks to fit bag-mask device adaptor (neonatal, infant, child, adult)

b. Clear oxygen masks:

1. Standard (infant, child, adult)

2. Partial nonrebreather (infant)

3. Nonrebreather (child, adult)

c. Endotracheal tubes

1. Uncuffed (mm 2.5, 3.0)

2. Cuffed or uncuffed (mm 3.5, 4.0, 4.5, 5.0, 5.5)

3. Cuffed (mm 6.0, 6.5, 7.0, 7.5, 8.0)

d. Feeding tubes (5F, 8F)

e. Laryngeal mask airway (sizes 1, 1.5, 2, 2.5, 3, 4, 5)

f. Laryngoscope blades

1. Straight (sizes 0, 1, 2, 3)

2. Curved (sizes 2, 3)

g. Laryngoscope handles (pediatric, adult)

h. Magill forceps (pediatric, adult)

i. Nasal cannulas (infant, child, adult)

j. Nasopharyngeal airways (sizes 12, 16, 20, 24)

k. Nasogastric tubes:

1. Infant: 8F

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

2. Child: 10F
 3. Adult: 14-18F
 - l. Nebulized medication administration set with pediatric and adult masks
 - m. Oropharyngeal airways (sizes 0, 1, 2, 3, 4, 5)
 - n. Stylets for endotracheal tubes (pediatric, adult)
 - o. Suction:
 1. Wall and/or portable capability
 2. Suction catheters (infant, child, adult)
 3. Yankauer suction tip
 - p. Trach collar
 - q. Tracheostomy tubes (mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)
7. Specialized pediatric trays or kits:
- a. Chest tubes:
 1. Infant: 10-12F
 2. Child: 16-24F
 3. Adult: 28-40F
 - b. Difficult airway supplies/kit:
 1. Supraglottic airways of all sizes
 2. Laryngeal mask airway (LMA)
 3. Needle cricothyrotomy supplies
 4. Surgical cricothyrotomy kit
 - c. Lumbar puncture tray (including infant/pediatric 22 gauge and adult 18-21 gauge needles)
 - d. Newborn delivery kit (including equipment for resuscitation of an infant, umbilical clamp, scissors, bulb syringe, towel)
 - e. Tube thoracostomy tray

CRITERIA for the LEVEL 3 PEDIATRIC EMERGENCY DEPARTMENT (PED)

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

DRAFT

Attachment B

From: Marilyn McLeod [marilynmcl@yahoo.com]
Sent: Thursday, October 11, 2012 8:03 AM
To: Akers, Deborah (VDH)
Subject: Fwd: White Paper for EMS Advisory Board

Could you make copies of this too.

M

Begin forwarded message:

From: Marilyn.McLeod@centrahealth.com
Date: October 11, 2012 7:29:09 AM EDT
To: "Deborah Akers" <Deborah.T.Akers@vdh.virginia.gov>
Cc: Marilyn.McLeod/CentraNotes@centrahealth.com, "Marilyn McLeod" <marilynmcl@yahoo.com>
Subject: Fw: RE: White Paper for EMS Advisory Board

Marilyn McLeod, MD, FACEP
Medical Director Emergency Department
Centra Southside Community Hospital
Associate Medical Director Emergency Department
Lynchburg General Hospital
Medical Director Centra One and Centra Transport

-----Forwarded by Marilyn McLeod/CentraNotes on 10/11/2012 07:26AM -----

To: "Mitchell, Charis A." <CMitchell@oag.state.va.us>, "Marilyn.McLeod@centrahealth.com" <Marilyn.McLeod@centrahealth.com>
From: "Brown, Gary (VDH)" <Gary.Brown@vdh.virginia.gov>
Date: 08/06/2012 11:12AM
Subject: RE: White Paper for EMS Advisory Board

Thanks Carrie – I will forward as appropriate. See you Friday.

Best
Gary

From: Mitchell, Charis A. [<mailto:CMitchell@oag.state.va.us>]
Sent: Monday, August 06, 2012 10:12 AM
To: Marilyn.McLeod@centrahealth.com
Cc: Brown, Gary (VDH)
Subject: RE: White Paper for EMS Advisory Board

Hi Marilyn,

My chief issue with this white paper is regulation driven: The paper purports to define a patient, but “patient” is already defined in the regulations:

12 VAC 5-31-10: Patient means a person who needs immediate medical attention or transport, or both, whose physical or mental condition is such that he is in danger of loss of life or health impairment, or who may be incapacitated or helpless as a result of physical or mental condition or a person who requires medical attention during transport from one medical care facility to another.

I understand that EMS providers on the scene have some difficulty deciding who needs to sign off on the refused treatment portion of the patient care report. However, it is inappropriate to redefine “patient” via a paper endorsed by the Advisory Board when the term is already defined in the regulations. Under the Regs, it is also clearly stated that “refusal of care must be obtained and documented on the prehospital patient care report.”

A white paper offering some guidance and interpretation of the regulation may be proper, but the format needs to be altered to reflect the regulation that defines patient as well as the overall contemplation that documentation of refusal of care *must* be obtained. It touches on this idea in the last paragraph before the summary, where the documentation would list the number of occupants and that there are no complaints.

I would recommend as a starting place to change the first paragraph under Appropriate Evaluation to expound on the regulatory definition of patient. In the current form of the paper, it provides some checks to determine whether there needs to be a signed refusal. These checks could be incorporated to expound on the definition of patient, instead of redefining “patient.” In other words, the starting point to determine who a patient is would be the regulation. Then there can be some examples of what those items mean.

I pulled that paragraph apart and found 6-7 evaluative factors, and if each of those factors are met, then there would be no decline form necessary. If one was missing, then the decline form would be necessary. I like that idea, of making it that simple. And if the committee could tie these factors into the definition of patient, I would feel more comfortable with the adoption of this paper.

Also, and this is something that is not in my expertise so it probably is perfectly clear for those of you involved in it day to day, but the phrases “medical refusal paperwork” and “refusing transportation” are used, and apparently interchangeably. To a lay person, these would be two different things.

I recommend having the committee take another look at the paper and redraft in light of these thoughts and the regulations, and I would be happy to take a look at it again once it is reevaluated.

Please let me know if this is unclear, as I’m sure, as usual, something will be lost in translation from me to you through the email process.

Thank you!
Carrie

CC To Gary; Gary, please forward to anyone who needs/wants to be on this email.

Charis A. Mitchell
Assistant Attorney General
Health Services Section
Office of the Attorney General
(804) 786-1841

From: Marilyn.McLeod@centrahealth.com [mailto:Marilyn.McLeod@centrahealth.com]
Sent: Saturday, August 04, 2012 9:31 AM
To: Mitchell, Charis A.

Subject: Re: White Paper for EMS Advisory Board

That sounds great. I work all night Sunday so available after lunch Monday.

Thanks

On Aug 3, 2012, at 3:58 PM, "Mitchell, Charis A." <CMitchell@oag.state.va.us> wrote:

Marilyn,

I'm sorry I missed your call yesterday.

let me type up my thoughts/concerns and I'll send them to you, either this afternoon or Monday.

Hopefully we could connect on Monday or Tuesday!

Carrie

Charis A. Mitchell
Assistant Attorney General
Health Services Section
Office of the Attorney General
(804) 786-1841

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Attachment C

Seatbelt Use in Ambulance

Background:

According to a study in the Journal of the Emergency Medical Services, crashes involving ambulances are the most harmful for people in the patient compartment. A review of 305 fatal crashes from 1988-1997 also found that seat belts played a large role in ambulance safety. Unrestrained occupants riding in the back of ambulances accounted for 52 percent of deaths. Restrained occupants riding in the back accounted for 20 percent of deaths. Unrestrained occupants anywhere in the vehicle were four times as likely to die as those wearing a seatbelt.

There are certainly times that patient care would dictate not wearing a seatbelt, but most transports are not life-threatening. There is a great deal of time that providers in the back of the ambulance could wear their seatbelt without affecting patient care and safety. If we could change provider practice so that the amount of time providers spend wearing a seatbelt increases, we will reduce the rate of death and injury from ambulance crashes.

While it is understood that the medic driving and the patients should use their seatbelt, along with any one else in the front of the ambulance, we have historically not asked medics in the back of the ambulance to wear their seatbelt. It is the opinion of the Virginia Medical Direction Committee that the medic(s) should wear their seatbelt while in the back of the ambulance if it does not interfere with patient care.

Attachment D



Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents *practice maximums*.

PROCEDURE	SKILL	PROCEDURE SUBTYPE	OEMS use	EMR	EMT	AEMT	I	P	Notes
Specific tasks in this document shall refer to the Virginia Education Standards.									
AIRWAY TECHNIQUES									
Airway Adjuncts									
	Oropharyngeal Airway			●	●	●	●	●	
	Nasopharyngeal Airway			●	●	●	●	●	
Airway Maneuvers									
	Head tilt jaw thrust			●	●	●	●	●	
	Jaw thrust			●	●	●	●	●	
	Chin lift			●	●	●	●	●	
	Cricoid Pressure			●	●	●	●	●	
	Management of existing Tracheostomy				●	●	●	●	
Alternate Airway Devices									
	Non Visualized Airway Devices	Supraglottic			●	●	●	●	
Cricothyrotomy									
	Needle						●	●	Added needle cric as an I skill per MDC
	Surgical	Includes percutaneous techniques						●	Percutaneous techniques added per MDC
Obstructed Airway Clearance									
	Manual			●	●	●	●	●	
	Visualize Upper-airway		direct laryngoscopy		●	●	●	●	
Intubation									
	Nasotracheal							●	
	Orotracheal - Over age 12						●	●	
	Pharmacological facilitation with paralytic	Adult Neuromuscular Blockade						●	
	Pharmacological facilitation without paralytic							●	Remove per MDC discussions
	Confirmation procedures				●	●	●	●	
	Pediatric Orotracheal							●	MDC recommended no change in intubation of children <12
	Pediatric paralytics							●	
	Pediatric sedation							●	
** Endotracheal intubation is prohibited for all levels except Intermediate and Paramedic									

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Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.



Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	OEMS use	EMR	EMT	AEMT	I	P
Oxygen Delivery Systems								
	Nasal Cannula			●	●	●	●	●
	Venturi Mask			●	●	●	●	●
	Simple Face Mask			●	●	●	●	●
	Partial Rebreather Face Mask			●	●	●	●	●
	Non-rebreather Face Mask			●	●	●	●	●
	Face Tent			●	●	●	●	●
	Tracheal Cuff			●	●	●	●	●
	Oxygen Hood			●	●	●	●	●
	O2 Powered Flow restricted device			●	●	●	●	●
	Humidification			●	●	●	●	●
Suction								
	Manually Operated			●	●	●	●	●
	Mechanically Operated			●	●	●	●	●
	Pharyngeal			●	●	●	●	●
	Bronchial-Tracheal			●	●	●	●	●
	Oral Suctioning			●	●	●	●	●
	Naso-pharyngeal Suctioning			●	●	●	●	●
	Endotracheal Suctioning			●	●	●	●	●
	Meconium Aspiration Neonate with ET			●	●	●	●	●
Ventilation – assisted / mechanical								
	Mouth to Mask		Includes :mouth to	●	●	●	●	●
	Mouth to Mask with O2			●	●	●	●	●
	Bag-Valve-Mask Adult			●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Adult			●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Adult			●	●	●	●	●
	Bag-Valve-Mask Pediatric			●	●	●	●	●

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

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	Bag-Valve-Mask with supplemental O2 Pediatric			●	●	●	●	●	
	Bag-Valve-Mask with supplemental O2 and reservoir Pediatric			●	●	●	●	●	
	Bag-Valve-Mask neonate/infant			●	●	●	●	●	
	Bag-Valve-Mask with supplemental O2 Neonate/Infant			●	●	●	●	●	
	Bag-Valve-Mask with supplemental O2 and reservoir Neonate/Infant			●	●	●	●	●	
	Noninvasive positive pressure vent.		BiPAP;CPAP;PEEP		●	●	●	●	CPAP at EMT level, BiPAP or PEEP at ALS levels?
	Jet insufflation							●	
	Mechanical Ventilator (Manual/Automated Transport Ventilator)	Maintain Initiate				●	●	●	Initiate versus maintain - intubation is not an AEMT skill. MDC dis
Anesthesia (Local)									
Pain Control & Sedation									
	Self Administered inhaled analgesics				●	●	●	●	
	Pharmacological (non-inhaled)					●	●	●	
	Patient controlled analgesia (PCA)					●	●	●	Added per workgroup discussion 5/13/12
	Epidural catheters (maintain)						●	●	Added per workgroup discussion 5/13/12
Blood and Component Therapy Administration									
							●	●	Initiate or maintain?
Diagnostic Procedures									
	Blood chemistry analysis				●	●	●	●	
	Capnography				●	●	●	●	
	Pulmonary function measurement					●	●	●	
	Pulse Oximetry				●	●	●	●	Addition of Pox to EMR was discussed and not recommended
	Ultrasonography						●	●	Confirmed by workgroup and MDC discussions
Genital/Urinary									
	Bladder catheterization							●	
	Foley catheter	Place bladder catheter Maintain bladder catheter			●	●	●	●	Per workgroup discussion

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	OEMS use	EMR	EMT	AEMT	I	P	
Head and Neck									
	ICP Monitor (maintain)								
	Control of epistaxis			●	●	●	●	●	
		Inserted epistaxis control devices				●	●	●	Question of adding devices such as Rhino-Rocket per MDC disc
	Tooth replacement			●	●	●	●	●	
Hemodynamic Techniques									
	Arterial catheter maintenance							●	
	Central venous maintenance					●	●	●	
	Access indwelling port					●	●	●	
	Intraosseous access & infusion					●	●	●	
	Peripheral venous access and maintenance					●	●	●	
	Umbilical Catheter Insertion/Management							●	Maintain as a P skill?
	Cutdown							●	Maintain as a P skill?
	Monitoring Existing IVs				●	●	●	●	
	Mechanical IV Pumps					●	●	●	
									Balloon pump maintenance specifically excluded from P SOP, wd
Hemodynamic Monitoring									
	ECG acquisition		3, 4, 12, etc lead	●	●	●	●	●	
	ECG Interpretation		3, 4, 12, etc lead				●	●	
	Invasive Hemodynamic Monitoring							●	
	Vagal Maneuvers/Carotid Massage						●	●	
Obstetrics									
	Delivery of newborn			●	●	●	●	●	
Other Techniques									
	Vital Signs			●	●	●	●	●	
	Bleeding control		direct pressure, e	●	●	●	●	●	Remove pressure points?
		Tourniquets			●	●	●	●	Should tourniquets be an EMR skill? per MDC discussion
		MAST			●	●	●	●	Should MAST be listed at all?
	Foreign body removal							●	
	Incision/Drainage							●	
	Intravenous therapy		includes blood sampling			●	●	●	
	Medication administration				●	●	●	●	
	Nasogastric tube				●	●	●	●	
	Orogastric tube				●	●	●	●	

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents *practice maximums*.

PROCEDURE	SKILL	PROCEDURE SUBTYPE	OEMS use	EMR	EMT	AEMT	I	P	
	Pericardiocentesis							●	
	Pleural decompression						●	●	
	Patient restraint physical				●	●	●	●	
	Patient restraint chemical					●	●	●	
	Sexual assault victim management				●	●	●	●	
	Trephination of nails						●	●	Add as an I and AEMT skill?
	Wound closure techniques						●	●	
	Wound management			●	●	●	●	●	
	Pressure Bag for High altitude						●	●	
	Treat and Release				●	●	●	●	
	Vagal Maneuvers/Carotid Massage					●	●	●	
	Intranasal medication administration					●	●	●	Add as an EMT skill? Pre-measured medications only, per MDC d
Resuscitation									
	Cardiopulmonary resuscitation (CPR) (all ages)			●	●	●	●	●	
	Cardiac pacing						●	●	
	Defibrillation/Cardioversion	AED	AED for EMR, EM	●	●	●	●	●	
	Post resuscitative care				●	●	●	●	
Skeletal Procedures									
	Care of the amputated part			●	●	●	●	●	
	Fracture/Dislocation immobilization techniques			●	●	●	●	●	
	Fracture/Dislocation reduction techniques						●	●	Add as an I skill? Per MDC discussion.
	Spine immobilization techniques			●	●	●	●	●	
Thoracic									
	Thoracostomy (refer to "Other Techniques")							●	
Body Substance Isolation / PPE				●	●	●	●	●	
Lifting and moving techniques				●	●	●	●	●	

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.



Virginia Office of Emergency Medical Services
 Scope of Practice - Procedures for EMS Personnel

This SOP represents *practice maximums*.

PROCEDURE	SKILL	PROCEDURE SUBTYPE	OEMS use	EMR	EMT	AEMT	I	P
Gastro-Intestinal Techniques								
	Management of non-displaced gastrostomy tube							●
Ophthalmological								
	Morgan Lenses				●	●	●	●
	Corneal Exam with fluorescein						●	●
	Ocular irrigation			●	●	●	●	●

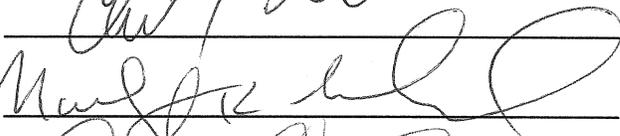
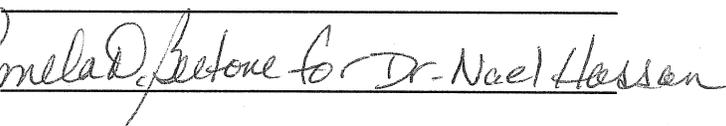
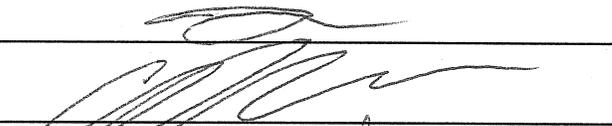
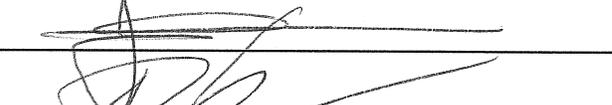
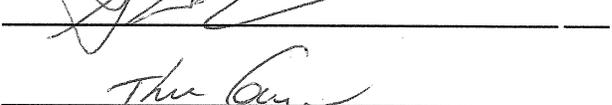
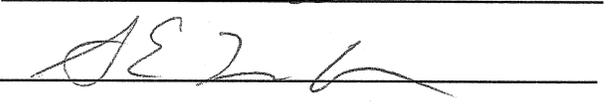
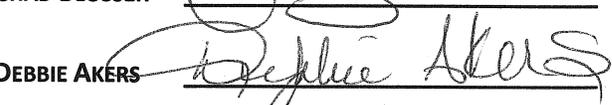
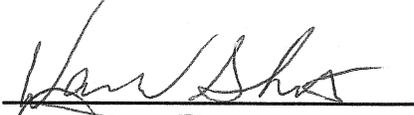
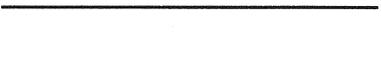
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Attachment E

MEDICAL DIRECTION COMMITTEE MEETING ROSTER
October 11, 2012

Please sign in next to your name.

Region	Representative	Signature
SWVEMS	PAUL PHILLIPS, D.O.	
WVEMS	CHARLES LANE, M.D.	
BREMS(CHAIR)	MARILYN MCLEOD, M. D.	
TJEMS (OEMS)	GEORGE LINDBECK, M. D.	
CSEMS	ASHER BRAND, M. D.	
LFEMS	CHRISTOPHER TURNBULL, M.D.	
REMS	NAEL HASAN, M. D.	
NVEMS		
ODEMSA	ALLEN YEE, M. D.	
PEMS	CHERYL LAWSON, M. D.	
TEMS	STEWART MARTIN, M. D.	
MAL	FORREST CALLAND, M.D.	
MAL	SCOTT WEIR, M.D.	
EMS CHILDREN	THERESA GUINS, M.D.	
VAGEMSA	CHIEF EDDIE FERGUSON	
OEMS STAFF:		
GARY BROWN		WARREN SHORT 
SCOTT WINSTON		CHAD BLOSSER 
MIKE BERG		DEBBIE AKERS 
TIM PERKINS		GREG NEIMAN 