Wyoming Pediatric Facility Recognition

EMSC Wyoming
EMERGENCY MEDICAL SERVICES FOR CHILDREN

Pediatric Receiving Facility

Recognition Manual

Wyoming Department of Health

Commit to your health.

Wyoming Department of Health

Office of Emergency Medical Services
Public Health Division
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Cheyenne, WY 82002
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Stefan Johansson
Director

Mark Gordon
Governor

Dear Hospital Representative:

Wyoming's Pediatric Facility Recognition Program

The Wyoming Department of Health, Emergency Medical Services for Children Program (EMSC) is proud to present to your facility, this portion of the Wyoming Pediatric Facility Recognition Program. The goal of the program is to improve the pediatric readiness in facilities across Wyoming. Hopefully, the improved pediatric readiness will translate to improved pediatric emergency outcomes. The pediatric recognition program will help your facility improve its pediatric readiness score on the NPRP or the National Pediatric Readiness Project from the EMSC.

To accomplish this goal, the EMSC program has designed a system that is attainable, promotes evidence based practices, and increases facility scores for the National Pediatric Readiness Project (NPRP). There are three tiers of recognition. Modeled after Wyoming's existing trauma program the recognition levels are: Pediatric Receiving Facility (PRF); Community Pediatric Hospital (CPH); and Regional Pediatric Critical Care Center (RPCCC).

This recognition is voluntary. It is designed to be a low cost method for your facility to improve your pediatric readiness scores, improve you pediatric patient care; and be able to prove to your community and your peers that your facility cares about the outcomes of pediatric patients. Most of the elements at the PRF level are measures that your facility already does on a routine basis. Becoming recognized simply gives you a streamlined method of showing the work you already do every day. The EMSC program stands ready to help you meet these benchmarks and become recognized under the program. If you need any assistance, items, or guidance please do not hesitate to reach out for assistance to 307-777-3622.

Respectfully,

Scott Logan, NRP
EMS Program Supervisor
EMSC Program Coordinator
Wyoming Office of Emergency Medical Services

Wyoming Pediatric Facility Recognition System

Pediatric Receiving Facility

A. Facility Recognition Levels

a. Pediatric Receiving Facility (PRF)
b. Community Pediatric Facility (CPH) (released on a future date)
c. Regional Pediatric Critical Care Center (RPCCC) (released on a future date)

B. Pediatric Receiving Facility (PRF)

a. Professional Staff: Physicians
    i. Qualifications:
        1. All physicians who work in the emergency department (ED) shall have training in the care of pediatric patients through residency training, clinical training, or practice.
        2. All physicians who work in the emergency department shall successfully complete and maintain current recognition in the American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. Physicians who are board certified in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine are excluded from this requirement. PALS and APLS courses shall include both cognitive and practical skills evaluation.
    ii. Continuing Medical Education:
        1. All full- and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a facility/university as Category II CME. The Wyoming Board of Medicine can provide guidance related to criteria for acceptable Category I or II credit.
    iii. Physician Coverage:
        1. At least one physician meeting the requirements of subsection (B)(a)(i) shall be on duty in the emergency department 24 hours a

day or immediately available. A policy shall define when a physician is to be consulted/called in at times when the emergency department is covered by a mid-level provider.

iv. Consultation:
    1. Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours per day. Consultation can be with an on staff physician or with physicians in other facilities.

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

vi. On-Call Physicians:
    1. Guidelines or policies shall be established that address on-site response time for physicians.

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

i. Qualifications:
    1. Nurse practitioners and Physician Assistants shall meet the following criteria:
        a. Current Wyoming Licensure, or authorization to practice in Wyoming.
        b. Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the facility credentialing process.

ii. Continuing Education
    1. All full- or part-time nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, ACEP-AAP APLS, or the Emergency Nurses Association (ENS) Emergency Nursing Pediatric Course (ENPC). PALS, APLS, and ENPC shall include both cognitive and practical skills evaluation.
    2. All nurse practitioners and physician assistants caring for children in the emergency department and fast track/urgent care shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.

a. Professional Staff: Nursing
    i. Qualifications
        1. At least one Registered Nurse (RN) on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:
            a. AHA-AAP PALS;
            b. ACEP-AAP APLS; or
            c. ENA ENPC
    ii. Continuing Education
        1. All Registered Nurses assigned to the emergency department shall have the documentation of a minimum of eight hours of pediatric emergency/critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS, or ENPC; CEU offerings; and/or publications. These continuing education hours can be integrated with other continuing education requirements, provided that the content is pediatric specific. PALS, APLS, and ENPC shall include both cognitive and practical skills evaluation.

a. Guidelines, Policies and Procedures
    i. Inter-facility transfer
        1. The facility shall have current transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving facilities, as related to patient stabilization, treatment prior and subsequent to transfer, and patient outcome.
        2. The facility shall have written pediatric inter-facility transfer guidelines and policies/procedures concerning transfer of critically ill and injured patients, which include:
            a. Defined process for initiation of transfer that includes the;
                i. Roles and responsibilities of the referring facility and referral center;
                ii. Process for selecting the appropriate care facility;
                iii. Process for selecting an appropriately staffed transport service to match the patient's acuity level;
                iv. Process for patient transfer (including obtaining informed consent);
                v. Plan for transfer of patient medical record information, signed transport consent, and belongings;

vi. Plan for provision of referral facility information to the family.

b. See Appendix B.

ii. Suspected Child Abuse and Neglect

1. The facility shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment, and referral to the Wyoming Department of Family Services (DFS) of victims of suspected child abuse and neglect in accordance with State law (http://dfsweb.wyo.gov/social-services/mandatory-reporting).

iii. Emergency Department Treatment Guidelines

1. The facility shall have emergency department guidelines, order sets or policies/procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).

iv. Latex-Allergy Policy

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

v. Disaster Preparedness

1. The facility shall integrate pediatric components into its facility Disaster/Emergency Operations Plan.
2. Pediatrics should be represented on the disaster panel make-up
3. Disaster drills, tabletop exercises, etc. should include pediatric patients where applicable.

vi. Pediatric Specific Competencies

1. The facility shall have a policy/training plan that results in demonstrated competency (on a continual basis) for all emergency department clinical staff for:
   a. The physical location of and how to access equipment for pediatric patients; and
   b. Use, according to clinical scope of practice, of pediatric specific equipment.

vii. Medication Dosing and Safety

1. The facility shall have a policy that specifies the measurement and recording of a pediatric patient's weight in kilograms only.
   a. The facility may provide a conversion chart to patient's family if weight in pounds is desired.
2. The facility shall have a policy that includes a kilogram based medication guide for pediatric patients in each treatment room that may be utilized to treat pediatric patients.

b. Quality Improvement

i. Multidisciplinary Quality Activities Policy

1. Pediatric emergency care shall be included in the PRF's emergency department or section quality improvement program and reported to the facility Quality Committee.
2. Multidisciplinary quality improvement (QI) processes/activities shall be established (e.g., committee).
3. Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to 15 years of age and shall consist of, but are not limited to, all emergency department:
    a. Pediatric deaths;
    b. Pediatric inter-facility transfers;
    c. Child abuse and neglect cases;
    d. Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure); and
    e. Pediatric quality and safety priorities of the institution.
4. All reports, findings, proceedings and data of the professional standard review organizations is confidential and privileged, and is not subject to discovery or introduction into evidence in any civil action, and no person who is in attendance at a meeting of the organization shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the organization or as to any findings, recommendations, evaluations, opinions or other actions of the organization or any members thereof. WY Statute § 35-17-105

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

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

a. Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department staff.
b. Coordinating data collection for identified clinical indicators and outcomes.
c. Reviewing selected pediatric cases transported to the facility by pre-facility providers and providing feedback to the EMS Coordinator/System.
d. Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee meetings. These activities shall be supported by the facility. One representative from the regional QI subcommittee shall report to the EMS advisory board.
    i. Currently, Regional QI meetings are not occurring. The expectation for recognition prior to commencement of QI meetings is that the facility commits to participation once they are operational.
e. Providing QI information to the Division (Wyoming Office of Emergency Medical Services) upon request.

f. Equipment, Trays, and Supplies
    i. See Appendix C

APPENDIX LIST

APPENDIX A	PRF Readiness Guide
APPENDIX B	Pediatric Receiving Facility (PRF): PRE-RECOGNITION CHECKLIST
APPENDIX C	Facility Equipment Checklist

Wyoming Pediatric Facility Recognition System

Appendix A

Pediatric Receiving Facility (PRF) Readiness Guide

This document is designed to help your facility identify gaps or to determine readiness for your ED to become recognized as a PRF. The intent of this this Appendix is to give you a tool that breaks down the items needed by your facility in an easy to process format. You may also skip straight to Appendix F, if you feel that you already have all of the things in place to be recognized under this program.

The following sets of tables are divided into functional categories. The code (example: Bai1, or Bei1) in the first column is the unique identifier for each line of information and is a reference to the main recognition system document. You are to enter information into the second column as an answer to the third column.

Professional Staff: Physicians

Ba		Number of physicians who work in your ED (full-time and part-time)
Bai1		Number of physicians who have had training in the care of pediatric patients (residency, clinical, or practice)
Bai2		Number of physicians who have current recognition in Pediatric Advanced Life Support (PALS) OR Advanced Pediatric Life Support (APLS), OR are board certified in emergency medicine (ABEM or AOBEM) OR are board certified in pediatric emergency medicine
Baii		Do all of your ED physicians (FT/PT) complete 16 hours of pediatric specific CME every 2 years (indicate YES or NO)
Baiii		Is a physician physically in your ED 24 hours per day that meets Bai1 and Bai2 (before answering, consult Baiii1)
Baiii1		If part of a 24 hour day is covered by a mid-level provider, does your ED have a policy that addresses consult/call in with a physician? (indicate YES, NO, or N/A)
Baiv1		Does your ED physician have the ability to consult with a physician who is board certified or board eligible in pediatrics, 24 hours per day?
Bav1		Is there a back-up physician (who meets Bai) available within one (1) hour after notification?
Bavi1		Does your facility have policies or guidelines that address on-site response time for physicians?

Professional Staff: Nurse Practitioner and Physician Assistant (mid-level)

Bbi		Number of Nurse Practitioners AND Physician Assistants who work in your ED (full-time and part-time)
Bbi1a		Are all of your Physician Assistants and Nurse Practitioners licensed in Wyoming, OR have authorization to practice in Wyoming (e.g. compact)?
Bbi1b		Are all nurse practitioners and Physician Assistants in the ED credentialed with orientation, ongoing training and specific competencies in the care of the pediatric emergency patient by your facility?
Bbii1		Number of Physician Assistants and Nurse Practitioners in the ED who have current recognition in Pediatric Advanced Life Support (PALS) OR Advanced Pediatric Life Support (APLS), OR Emergency Nursing Pediatric Course (ENPC)
Bbii2		Do all of your Physician Assistants and Nurse Practitioners (FT/PT) complete 16 hours of pediatric specific CME every 2 years (indicate YES or NO)

Professional Staff: Nursing

Bci		Number of Registered Nurses (RN) who work in your ED (full-time and part-time)
Bci1		Is at least one (1) RN on duty in the ED each shift who maintains current recognition in one of the following: Pediatric Advanced Life Support (PALS) OR Advanced Pediatric Life Support (APLS), OR Emergency Nursing Pediatric Course (ENPC)
Bcii1		Do all of your ED RNs (FT/PT) complete 8 hours of pediatric specific CME every 2 years (indicate YES or NO)

Guidelines, Policies, and Procedures:

Bdi1		Does your facility have current transfer agreements that cover pediatric patients? The agreements must include (see Appendix F for a sample from CMS):
		• Provision that addresses communication and quality improvement measures between the referral and receiving facility as it relates to:
		  ○ Patient stabilization;
		  ○ Treatment prior and subsequent to transfer; and
		  ○ Patient outcome

Bdi2		Does your facility have written pediatric inter-facility transfer guidelines and policies/procedures concerning the transfer of critically ill/injured patients, which includes a defined process for (see Appendix B Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline): • Initiation of transfer that includes the roles and responsibilities of the referring facility and receiving facility; • Selecting the appropriate care facility; • Selecting an appropriately staffed transport service to match the patient's acuity level; • Patient transfer (including obtaining informed consent); • Transfer of patient medical record information, signed transport consent, and belongings; and • Provision of referral facility information to the family.
Bdii		Does your facility have written policies/procedures addressing child abuse and neglect?
Bdiii		Does your facility have ED guidelines, order sets, or policies/procedures addressing initial assessment and management for its high-risk/high volume pediatric population (i.e., fever, trauma, respiratory distress, seizures)?
Bdiv		Does your facility have a latex allergy policy?
Bdv		Does your facility disaster/emergency plan contain pediatric specific components?
Bdvi		Does your facility have a policy or training plan that results in demonstrated competency (on a continual basis) for all clinical staff for: • The physical location of and how to access equipment for pediatric patients; and • Use, according to clinical scope of practice, of pediatric specific equipment.
Bdvii1		Does your facility shall have a policy that specifies the measurement and recording of a pediatric patient's weight in kilograms only
Bdvii2		Does the facility have a policy that includes a kilogram based medication guide for pediatric patients in each treatment room that may be utilized to treat pediatric patients?

Quality Improvement:

Bei		Does your facility have a quality improvement program for the ED?
Bei1		Are pediatric specific emergency care items part of the quality improvement program?
Bei2		Does your facility have a multi-disciplinary committee for quality improvement?
Bei3		Does your facility have quality monitors that address pediatric care in the ED for children from birth up to 15 years of age that include: • Identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues for all Emergency Department: ○ Pediatric Deaths; ○ Inter-facility transfers; ○ Child abuse and neglect; ○ Critically ill/injured children in need of stabilization; and ○ Pediatric quality and safety priorities of the institution.
Beii1		Does your facility have a designated Pediatric Physician Champion (see main document for further description)?
Beiii		Does your facility have a designated Pediatric Emergency Care Coordinator (see main document for further description)?

Equipment, Trays, and Supplies (These items are based on recommendations found in Appendix D, or at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Documents/Checklist_ED_Aug2010.pdf):

App.D		Does your facility have a daily method in place to verify the proper location and function of pediatric equipment and supplies?
App.D		Does your facility have a policy that indicates the staff education related to the proper location and function of pediatric specific equipment and supplies?
App.D		Are pediatric equipment, supplies, and medications easily accessible, clearly labeled, and logically organized.
App.D		Using Appendix C, does your facility have all of the equipment, supplies, and trays that are required for designation?

Pediatric Receiving Facility (PRF)

PRE-RECOGNITION CHECKLIST GUIDE

INTRODUCTION TO THIS GUIDE

This guide is designed to help you prepare for recognition as a PRF by explaining what you will need to provide during the recognition process. Use this guide and checklist as you prepare for recognition to determine your facilities outstanding needs before recognition can take place. The final review document that will be utilized during your facility recognition review, while having a different title, looks exactly like this guide.

Each section below lists the requirement for recognition. In the tables are the approved methods for your facility to verify the requirements when you are reviewed for recognition. Place an indicator next to the line item in the table that your facility is able to produce. If you cannot indicate that you could produce the item, then your facility may not meet this portion of the recognition criteria.

There are many resources out there to help with any deficiencies. One great place to look for guidance on policies, procedures, and agreements is: https://emscimprovement.center/projects/pediatricreadiness/readiness-toolkit/policies-procedures-and-protocols/. If you discover that you are missing items to be ready for recognition, connect with your EMSC coordinator, Scott Logan @ scott.logan@wyo.gov or Brad McKee @ brad.mckee@wyo.gov for assistance.

PRE-RECOGNITION INSTRUCTIONS

When you are able to affirm internally that all portions of this guide are in place, readily available, and you have all of the necessary documents in one place; Contact the Wyoming EMSC program to schedule your facility recognition review. Reviews for PRF are conducted initially in-person by a representative of the EMSC program. Post-recognition reviews for PRFs should be conducted every 5 years or as requested by the Division or the recognized facility.

Wyoming Emergency Medical Services for Children Program (EMSC)

Scott Logan- EMSC Coordinator
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Brad McKee- EMSC Specialist
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SECTION 1

ED PHYSICIAN QUALIFICATIONS AND EDUCATION:

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

	Copy or other verification of the valid Wyoming medical license for ALL physicians who perform services in your ED.

2. All ED physicians shall successfully complete and maintain current recognition in the American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. Physicians who are board certified in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine are excluded from this requirement. PALS and APLS courses shall include both cognitive and practical skills evaluation.

	Policy or similar document that indicates that one or more of the above is a requirement for ALL physicians who perform services in your ED.
	Copies of credentials (one or more of the above) ALL physicians who perform services in your ED.

3. All full- and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years.

	Policy or similar document that indicates that the above is a requirement for ALL physicians who perform services in your ED.
	Records that indicate satisfactory completion for ALL physicians who perform services in your ED.

SECTION 2

PHYSICIAN COVERAGE/CONSULTATION:

1. At least one physician meeting the requirements of SECTION 1 above shall be on duty in the emergency department 24 hours a day or immediately available.

	Policy or similar document that indicates that the above is a requirement in your facility.

2. A policy shall define when a physician is to be consulted/called in when the emergency department is covered by a mid-level provider.

	Policy or similar document that indicates that the above is a requirement in your facility.

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

	Procedure, guideline, etc that shows that this capability exists in your facility.

SECTION 3

PHYSICIAN BACKUP/ON-CALL:

1. A backup physician whose qualifications and training meet Section 1 above shall be available to the PRF within one hour after notification to assist with critical situations, increased surge capacity or disasters.

	Procedure, guideline, etc. that shows that this capability exists in your facility.
	Procedure, Guideline, etc. that establishes on-site response time for physician (can be part of above)

SECTION 4

NURSE PRACTIONER/PHYSICIAN ASSISTANT QUALIFICATIONS AND EDUCATION

1. Current Wyoming Licensure (or other authorization to practice in Wyoming) and credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the facility credentialing process.

	Copy or other verification of the valid Wyoming license or authorization to practice.
	Document that explains your facilities credentialing process for orientation, training, and competencies for these providers (pediatric specifically, but may be part of a larger document that addresses all ages)
	Proof of compliance with facility's credentialing process

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

	Policy or similar document that indicates that one or more of the above is a requirement.
	Copies of credentials (one or more of the above).

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

	Policy or similar document that indicates that the above is a requirement.
	Records that indicate satisfactory completion.

SECTION 5

REGISTERED NURSE QUALIFICATIONS AND EDUCATION:

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

a. AHA-AAP PALS;
b. ACEP-AAP APLS; or
c. ENA ENPC

	Policy or similar document that indicates that the above is a requirement.
	Records that indicate satisfactory completion.

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

	Policy or similar document that indicates that the above is a requirement.
	Records that indicate satisfactory completion.

SECTION 6

GUIDELINES, POLICIES and PROCEDURES:

Does your facility have:

	Current transfer agreements that cover pediatric patients. (MUST include a provision that addresses communication and quality improvement measures between the referral and receiving facilities, as related to patient stabilization, treatment prior and subsequent to transfer, and patient outcome.)
	Written pediatric inter-facility transfer guidelines and policies/procedures concerning transfer of critically ill and injured patients, which includes: -Defined process for initiation of transfer (including roles and responsibilities of the referring facility and referral center); -Process for selecting the appropriate care facility; -Process for selecting an appropriately staffed transport service to match the patient's acuity level; -Process for patient transfer (including obtaining informed consent); -Plan for transfer of patient medical record information, signed transport consent, and belongings; and -Plan for provision of referral facility information to the family.
	Policies/procedures that address child abuse and neglect, which include (at minimum): - Identification (including screening), evaluation, treatment, and referral to the Wyoming Department of Family Services (DFS) of victims of suspected child abuse and neglect in accordance with State law.
	Guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population, including but not limited to: -Fever -Trauma -Respiratory distress -Seizures
	Latex allergy policy.
	Pediatric components integrated into the Facility's Emergency/disaster plan.
	Pediatric equipment competency policy/training plan.
	Weight in kilograms policy/training plan
	Kilogram based medication guide in all (exclude rooms that would not be utilized normally to treat pediatric patients) treatment rooms

SECTION 7

QUALITY IMPROVEMENT

	Does your facility have a Multidisciplinary Quality Improvement committee/process?
	Is pediatric emergency care included in the activities of this committee/process?
	Are Quality Monitors required to be documented (with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure) for children from birth to 15 years old; that consist of, but are not limited to, all emergency department -Pediatric deaths; -Pediatric inter-facility transfers; -Child abuse and neglect cases; -Critically ill or injured children; and -Pediatric quality and safety priorities of the institution.
	Does your facility have a Pediatric Physician Champion? Name: EMAIL: *Copy of job description will be required
	Does your facility have a Pediatric Emergency Care Coordinator? Name: EMAIL: *Copy of job description will be required

SECTION 8

REQUIRED DOCUMENTS FOR RECOGNITION

Wyoming medical license for ALL physicians who perform services in your ED.	On-boarding requirements for mid-level providers.
Pediatric specific credentials for all clinical staff (ENPC, APLS, PALS, etc).	Documentation of pediatric consultation access.
Policies addressing pediatric CE for RN, MD, NP, PA, DO, etc.	Job descriptions for physician champion and PECC
Training records or other evidence of adherence by staff to CE policies.	Quality improvement document that contains pediatric elements.
Policy for physician coverage.	Treatment guidelines, protocols, order sets for pediatric patients.
Policy for mid-level coverage.	Pediatric transfer agreements, plans, procedures that contain the required information.
Policy for on-call coverage.	Latex allergy policy.
Abuse/Neglect policy.	Facility emergency plan that incorporated pediatric population
Completed Appendix C (Equipment checklist).	Pediatric equipment competency policy/training plan.
Medication and Dosing Safety policy.	Copy or visual of the medication dosing guide used in treatment rooms.

APPENDIX C

MEDICATIONS		atropine		antimicrobial agents (parenteral and oral)
		adenosine		anticonvulsant medications
		amiodarone		antidotes (common antidotes should be accessible to the ED)
		antiemetic agents		antipyretic drugs
		calcium chloride		bronchodialators
		dextrose (D10W, D50W)		corticosteroids
		epinephirine (1:1000; 1:10,000)		inotropic agents
		lidocaine		neuromuscular blockers
		magnesium sulfate		sedatives
		naloxone hydrochloride		vaccines
		procainamide		vasopressor agents
		sodium bicarbonate (4.2%, 8.4%)		topical, oral, and parenteral analgesics

EQUIPMENT/SUPPLIES: GENERAL		Patient warming device		Tool or chart that incorperates weight (in kilograms) and length to determine equipment size and correct drug dosing
		Restraint device		Age appropriate pain scale-assessment tools
		Intravenous blood/fluid warmer		Weight scale in kilograms

EQUIPMENT/SUPPLIES: MONITORING		Blood pressure cuffs:		
		Neonatal Infant		Doppler ultrasonography devices
		Child		Continuous end-tidal CO2 monitoring device
		Adult-arm		Hypothermia thermometer
		Adult-thigh		Pulse oximeter with pediatric and adult probes
		Electrocardiography monitor/defibrillator with pediatric and adult capabilities including pads/paddles		

APPENDIX C

EQUIPMENT/SUPPLIES: FRACTURE MGMT				
		Femur splints, pediatric sizes		Femur splints, adult sizes
		spine-stabilization devices appropriate for children of all ages		

EQUIPMENT/SUPPLIES: RESPIRATORY				
		Endotracheal tubes:		Oropharyngeal airways:
		Uncuffed 2.5 mm		Size 0
		Uncuffed 3.0 mm		Size 1
		Cuffed or uncuffed 3.5 mm		Size 2
		Cuffed or uncuffed 4.0 mm		Size 3
		Cuffed or uncuffed 4.5 mm		Size 4
		Cuffed or uncuffed 5.0 mm		Size 5
		Cuffed or uncuffed 5.5 mm		
		Cuffed 6.0 mm		Stylets for endotracheal tubes
		Cuffed 6.5 mm		pediatric
		Cuffed 7.0 mm		adult
		Cuffed 7.5 mm		
		Cuffed 8.0 mm		Suction Catheters:
				Infant
		Tracheostomy tubes:		Child
		2.5 mm		Adult
		3.0 mm		
		3.5 mm		Feeding tubes:
		4.0 mm		5F
		4.5 mm		8F
		5.0 mm		
		5.5 mm		Laryngoscope blades
				Straight: 0-3
		Bag valve mask, self inflating: Infant 450ml		Curved: 2 and 3
		Bag valve mask, self inflating: Adult 1000ml		Laryngoscope handle
		Magill forcepts: pediatric		Yankauer suction tip
		Magill forcepts: Adult		

APPENDIX C

EQUIPMENT/SUPPLIES: RESPIRATORY (cont.)		Nasopharyngeal Airways		Masks to fit BVM adapter
		Infant		Neonatal
		Child		Infant
		Adult		Child
				Adult
		Laryngeal Mask Airway (LMA)		
		Size: 1		Oxygen Delivery
		Size: 2		Standard Infant Mask
		Size: 2.5		Standard Child Mask
		Size: 3		Standard Adult Mask
		Size: 4		Partial Nonrebreather (NRB) Infant
		Size: 5		NRB Child
				NRB Adult
				Nasal Canula (NC) Infant
				NC Child
				NC Adult

EQUIPMENT/SUPPLIES: Specialized Trays/Kits		Lumbar Puncture Tray (includes ped and adult needles)		Chest Tubes:
		Difficult Airway Kit (supraglottic airways all sizes, LMAs, Cric supplies)		Infant: 10-12F
		Tube Thoracostomy Tray		Child: 16-24F
		Urinary Catheterization kits and in-dwelling catheters (6F-22F)		Adult: 28-40F
		Newborn Delivery Kit:		
		Infant resuscitation supplies		
		umbilical clamps		
		scissors		
		bulb syringe		

APPENDIX C

EQUIPMENT/SUPPLIES: Vascular Access

	Arm Boards
	Infant
	Child
	Adult

	Central Venous Catheters
	4.0F
	5.0F
	6.0F
	7.0F

	Umbilical Vein Catheters
	3.5F
	5.0F

	Over-The Needle Catheters
	14g
	16g
	18g
	20g
	22g
	24g

	Intraosseous Needles or Devices
	Pediatric
	Adult

	IV Admin Sets
	60gtts
	10gtts

	IV Solutions
	Normal Saline
	Dextrose 5% in NS
	Dextrose 10% in water