



SUBJECT: **EMERGENCY DEPARTMENT APPROVED
FOR PEDIATRIC (EDAP) STANDARDS**

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

Commercial Sexual Exploitation of Children: Commercial Sexual Exploitation of Children (CSEC) refers to any range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person.
<https://dcfs.lacounty.gov/youth/sexual-exploitation/>

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH), 800-540-4000, intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, sexual assault, or exploitation, which includes commercial sexual exploitation and human trafficking, to determine whether an in-person investigation and consultation is required.

Designated Pediatric Consultant: a qualified specialist in pediatrics and/or pediatric subspecialty.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive ED that is designated by the Los Angeles County Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.


EDAP Medical Director: A qualified specialist in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM), also referred to as the Physician Pediatric Emergency Care Coordinator.

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SUPERSEDES: 07-01-24

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APPROVED:


Director, EMS Agency


Medical Director, EMS Agency

Emergency Nursing Pediatric Course (ENPC): Two-day course developed by the Emergency Nurses Association (ENA) provides core-level pediatric knowledge and psychomotor skills needed to care for pediatric patients in the emergency care setting.

Pediatric Advanced Life Support (PALS): Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g., American Heart Association, American Red Cross).

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation, and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). The committee reviews, evaluates and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Emergency Course (PEC): Two-day course, with topics pre-approved by the EMS Agency, that provides knowledge about the acutely ill and injured child, and a minimum of 14 hours of Board of Registered Nursing (BRN) approved continuing education.

Pediatric Emergency Medicine (PEM): A qualified specialist with a subspecialty in pediatrics to provide and manage emergency care in acutely ill or injured infants and children.

Pediatric Intensivist: A qualified specialist in Pediatric Critical Care.

Pediatric Liaison Nurse (PdLN): A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to coordinate pediatric emergency care, also referred to as Nurse Pediatric Emergency Care Coordinator (PECC).

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

Pediatric Patient: In the prehospital setting, is a child who is 14 years of age or younger.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the ED within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by ABMS or AOA.

Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Telehealth: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. EDAP Designation / Re-Designation

- A. EDAP initial designation and EDAP re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.
- B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the EDAP at any time.
- C. The EDAP shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the EDAP Standards, including structural changes, relocation of ED and change in pediatric inpatient resources.
- D. The EDAP shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the EDAP program.
- E. The EDAP shall notify the EMS Agency within 15 days, in writing of any change in status of the EDAP Medical Director, ED Nurse Manager/Director, Designated Pediatric Consultant, or Pediatric Liaison Nurse (PdLN) by submitting the Notification of Personnel Change Form (Ref. No. 621.2).
- F. Execute and maintain a Specialty Care Center EDAP Designation Agreement with the EMS Agency.

II. General Hospital Requirements

- A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and maintain:
 - 1. A special permit for Basic or Comprehensive Emergency Medical Service; and
 - 2. Accreditation from a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.
- B. Shall appoint an EDAP Medical Director who will be provided non-clinical time to perform duties based on the ED's annual pediatric volume
 - 1. Low <1,800
 - 2. Medium 1,800 – 4,999
 - 3. Medium-High 5,000 – 9,999
 - 4. High >10,000 highly recommend 50% FTE)
- C. Shall appoint a PdLN and provide non-clinical time to perform duties based upon the ED's annual pediatric volume:

1. Low <1,800 (10% FTE or 4 hours/ week)
2. Medium 1,800 – 4,999 (25% FTE or 10 hours/ week)
3. Medium-High 5,000 – 9,999 (50% FTE or 20 hours/week)
4. High >10,000 (a minimum of 50% FTE but highly recommend 1 full time equivalent)

D. Hospital shall have a mechanism to track and monitor pediatric continuing education, including PALS, of pertinent staff.

E. Pediatric Interfacility Transfer

Establish and maintain a written Interfacility Consultation and Transfer Agreement for tertiary or specialty care, which shall include, at a minimum, the following:

1. A plan for subspecialty consultation (telehealth or on-site) 24 hours per day.
2. Identification of transferring and receiving hospitals' responsibilities in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA).
3. A process for selecting the appropriately staffed transport service to match the patient's acuity level.

III. EDAP Leadership Requirements

A. EDAP Medical Director

1. Responsibilities:
 - a. Oversee EDAP quality improvement (QI) program and monitor to ensure adherence to the EDAP standards.
 - b. Promote and verify adequate skills and current knowledge of ED staff physicians and mid-level practitioners in pediatric emergency care and resuscitation.
 - c. Participate in a multidisciplinary ED and pediatric committees (if applicable) to ensure that pediatric care needs are addressed and communicated across disciplines.
 - d. Liaison with PMCs, PTCs, other hospitals, prehospital care providers, and the EMS Agency to ensure pediatric care needs are addressed.
 - e. Collaborate with the ED Nurse Manager/Director and the PdLN to ensure adherence to the EDAP standards for staffing, medication, equipment, supplies, and other resources for children in the ED.

- f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

B. Designated Pediatric Consultant

1. Responsibilities:

- a. Promptly available for consultation
- b. Participate in the development and monitoring of pediatric QI program, and pediatric policies and procedures
- c. Collaborate with the EDAP Medical Director and PdLN as needed
- d. May also be the EDAP Medical Director

C. ED Nurse Manager/Director

Responsibility: provide organizational oversight and support to meet EDAP requirements and initiatives

D. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

- a. At least two years of experience working in pediatrics, or in an ED that provides care for pediatric patients, within the previous five years; and currently working for the ED.
- b. Current PALS provider or instructor certification.
- c. Completion of a two-day PEC or ENPC every four years.
- d. Completion of seven hours of BRN approved pediatric continuing education (CE) every two years.

2. Responsibilities:

- a. Collaborate with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to ensure compliance with the EDAP Standards, and policies and procedures established by the EMS Agency.
- b. Implement, maintain, and monitor the EDAP QI program.
- c. Serve as a liaison and maintain effective lines of communication with:
 - 1) ED management, physicians, and personnel
 - 2) Hospital pediatric management, physicians, and personnel
 - 3) System PdLNs
 - 4) Other EDAPs and PMCs

- 5) Prehospital care coordinators (PCCs), as needed, to follow up with pediatric treatment/transport concerns
 - 6) EMS providers as needed, to follow up with pediatric treatment and/or transport concerns
 - 7) EMS Agency
- d. Serve as a contact person for the EMS Agency and be available upon request to respond to County business.
 - e. Ensure pediatric ED continuing education and competency evaluation in pediatrics for ED staff.
 - f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

IV. Personnel Requirements

A. ED Physicians

1. All physicians attending in the ED shall be BC, or BE in EM, or PEM.
2. For facilities with a dedicated pediatric ED, physicians who are BE/BC in Pediatrics and in an accredited PEM training program are permitted to attend in the ED once approved by their program and with appropriate supervision/backup from BE/BC physicians defined above.

B. Pediatricians (applies to EDAPs with associated pediatric admission unit)

There shall be a call panel for telephone consultation and a qualified specialist in pediatrics to be available to the ED twenty-four hours per day.

C. Pediatric Subspecialty Services

Pediatric subspecialty physicians, to include pediatric intensivist, shall be available through in-house call panel, telehealth, or transfer agreements.

D. Advanced Practice Providers (Physician Assistants and Nurse Practitioners)

1. Advanced Practice Providers shall be licensed in the State of California.
2. Advanced Practice Providers assigned to the ED caring for pediatric patients must have PALS provider or instructor certification.

E. Registered Nurses

1. All RN staff in the ED caring for pediatric patients must have a current PALS provider or instructor certification.
2. All nurses assigned to the ED shall attend at least 14 hours of BRN-approved pediatric emergency education (not including PALS) every four years (e.g., PEC or ENPC).
3. At least one RN per shift shall have completed a two-day PEC within the

last 4 years and be available for patient care. It is highly recommended that all nurses regularly assigned to the ED complete this course.

V. Two-Day PEC – Continuing Education

- A. May be completed in-house or off-site.
- B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six-month period. If the interval between Day/Part 1 and Day/Part 2 is greater than six months, this will only fulfill the 14-hour requirement in Section IV.E.2 above.
- C. Curriculum should be selected from this broad spectrum of pediatric topics which have been pre-approved by the EMS Agency:
 - 1. Airway management
 - 2. Brief Resolved Unexplained Event (BRUE)
 - 3. Burns
 - 4. Child maltreatment (suspected child abuse, neglect, commercial sexual exploitation, human trafficking, and sexual assault) to include the mandated reporting process
 - 5. Coordination of care with a SART Center for an acute suspected sexual assault victim requiring a forensic examination
 - 6. Death
 - 7. Disaster preparedness/Disaster management
 - 8. Fever
 - 9. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
 - 10. Human trafficking
 - 11. Injury prevention
 - 12. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
 - 13. Medication safety
 - 14. Neonatal resuscitation
 - 15. Pain management
 - 16. Disaster management
 - 17. Poisonings/overdose
 - 18. Procedural sedation
 - 19. Respiratory emergencies
 - 20. Resuscitation
 - 21. Seizures
 - 22. Sepsis
 - 23. Shock / hypotension
 - 24. SIDS/SUID
 - 25. Special health care needs
 - 26. Submersions
 - 27. Surgical emergencies
 - 28. Trauma
 - 29. Triage

VI. Ancillary Services

- A. Respiratory Care Practitioners (RCP)

1. At least one RCP shall be in-house twenty-four hours per day to respond to the ED.
2. All RCPs that work or respond to the ED shall have a PALS provider or instructor certification.

B. Radiology

1. The radiology department shall have pediatric-specific policies and procedures pertaining to imaging studies of children and reducing radiation exposure.
2. Qualified specialist in radiology must be on-call and promptly available twenty-four hours per day.
3. Radiology technician must be in-house twenty-four hours per day.
4. Provide the following services 24 hours per day/seven days per week:
 - a. Computerized tomography (CT)
 - b. Ultrasonography
 - c. Magnetic resonance Imaging (MRI)

C. Laboratory

Laboratory service shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples, and microtechnique for small or limited sample sizes.

VII. Policies and Procedures

The hospital shall develop and maintain, at minimum, the following policies and procedures pertaining to the emergency department care of children, unless specific to radiology, laboratory or pharmacy practices. Multiple required elements may be incorporated into one policy (e.g., Care of the Pediatric Patient in the ED). All policies should be reviewed minimally every three (3) years and reflect current practice. Any reference to weight should be in the form of kilograms.

A. Weight and Vital Sign Measurement:

1. Vital signs shall be obtained and recorded at triage for all children. The policy shall include age-appropriate methods to obtain temperature, heart rate, respiratory rate, and pain scale.
2. Blood pressure and pulse oximetry monitoring shall be available for children of all ages. Optimally, blood pressure and pulse oximetry should be assessed on all children and shall be measured on all children requiring admission or transfer. Exceptions must be addressed in policy and monitored.

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3. All pediatric weights shall be obtained and recorded in kilograms upon arrival to the ED:
 - a. For children who require emergency stabilization or those who cannot be safely weighed, a standardized length-based resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), may be used to estimate weight in kilograms. The weight shall be recorded in a prominent place on the medical record.
 - b. Scales used to weigh children must be configured to display weights only in kilograms.
 - c. Electronic medical records shall only allow for weight entries and display in kilograms only.
 - B. Pediatric patient safety in the ED
 - C. Immunization assessment and management of the under immunized patient
 - D. Mandated reporting of child maltreatment (suspected child abuse, neglect, commercial sexual exploitation, human trafficking, and sexual assault) to include:
 1. An immediate, or as soon as practically possible, verbal telephone report shall be made to the Child Protection Hotline (CPH). A referral number will be provided by the CPH to initiate a "Create Suspected Child Abuse Report" online in the Child Abuse Reporting Electronic System (CARES).
 - a. Suspected Child Abuse Report (SCAR) #8572 report shall be submitted online to the DCFS within 36 hours.
<https://mandreptla.org/cars.web/CallType>
 - b. To file the SCAR report electronically, select "Follow-Up Suspected Child Abuse Reports (SS8572)". The Mandated Reporter (MR) Number and Tracking Number will be generated, and both must be documented in the patient's medical record.
 - c. If a "New Non-Emergency Child Abuse/Neglect (CARES) Report" was submitted, document the reference number "ER" followed by 11 digits.
 - d. If a "Consultation with ARES number" was provided by CPH, document the reference number "A" followed by 15 digits.
 2. Notify the law enforcement agency in the appropriate jurisdiction where the crime occurred. Document the officer's identification, department, and badge number in the medical record.
 3. Collaborative discussion with Social Worker, ED Physician, and RN prior to the patient being discharged to ensure the patient is discharged to the appropriate location or with the appropriate services.
 - E. A pediatric suspected sexual assault patient requires coordination of care with a
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SART Center.

1. For an acute sexual assault occurring within the last 120 hours an immediate forensic evidentiary examination may be required.
 2. For a sexual assault that occurred over 120 hours, a referral to a SART Center may be appropriate as determined by the forensic examiner.
 3. Collaborate with law enforcement to determine a plan of care and/or forensic evidentiary examination or referral.
 4. The ED may also contact the forensic examiner for consultation or clarification regarding patient care as it relates to evidence preservation.
 5. Document appropriate discharge and referral, include the name of the SART Center(s), location address, hotline telephone number(s), and to whom care was discharged (i.e., law enforcement, family, caregiver, etc.).
- F. Pediatric assessment and reassessment include identification of abnormal vital signs according to the age of the patient. If abnormal values are obtained, include a plan/process for the physician notification.
- G. Pain assessment, treatment, and reassessment, utilizing developmentally appropriate pain scales (include a description of the tools used for all age levels)
- H. Consent and assent for emergency treatment, include situations in which a parent/legal guardian is not immediately available
- I. Care of the pediatric patient with Do Not Resuscitate (DNR) orders/ or Physician Orders for Life-Sustaining Treatment (POLST)
- J. Death of the child in the ED and care of the grieving family
- K. Care and safety for the pediatric patient with mental and/or behavioral health emergencies
- L. Physical and chemical restraint of patients
- M. Procedural sedation
- N. Safe surrender of newborns, include the following:
1. Signage
 2. Procedures for accepting a newborn, including a safe surrender packet for the individual relinquishing the newborn
- For more information: <https://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby>
- O. Daily verification of proper location and function of equipment and supplies for the pediatric crash cart with a list and description of all required items in each drawer

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- P. Family Centered Care, include the following:
1. Supporting appropriate family presence during all aspects of care to include invasive procedures and resuscitation
 2. Education of the patient, family, and regular caregivers
 3. Discharge planning and instructions
 4. Culturally and linguistically appropriate services
- Q. Communication with patient's medical home or primary provider based on illness and severity (e.g., aftercare instructions, x-ray results, laboratory studies, as appropriate)
- R. Transfer from the ED to another facility
- S. Disaster preparedness addressing the following pediatric issues:
1. Minimizing parent-child separation, and methods for reuniting separated children with their families
 2. Pediatric surge capacity for both injured and non-injured children
 3. Medical and mental health therapies, and social services for children in the event of a disaster
 4. Disaster drills that include a pediatric mass casualty incident at least once every two years
 5. Decontamination
 6. Surge plan for backup personnel (MD and nursing) in the ED
- T. Medication safety addressing the following pediatric issues:
1. Medication orders should be written clearly based upon the appropriate units per kilogram and include total dose.
 2. Processes for prescribing, safe medication storage, and delivery should be established. Include the use of pre-calculated dosing guidelines for children of all ages.
 3. Involve the patient and family in the medication safety process to ensure accurate patient identification. Include patient and family education as to the rationale for the medication.

VIII. Equipment, Supplies, and Medications

- A. Pediatric equipment, supplies, and medications shall be easily accessible,

labeled, and logically organized. A mobile pediatric crash cart shall be utilized.

- B. A locator chart or grid identifying the locations of all required equipment and supplies shall be developed and maintained in order for staff to easily identify location of all items.
- C. Required EDAP equipment, supplies, and medications
 - 1. General Equipment
 - a. Weight scale measuring only in kilograms for both infants and children
 - b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), or other standardized method to estimate pediatric weights in kilograms
 - c. Pediatric drug dosage reference material with dosages calculated in milligrams, micrograms, milliequivalents, etc. per kilogram (either posted or readily available)
 - d. Developmentally appropriate pain scale assessment tools for infants and children
 - e. Blood and IV fluid warmer (Rapid infuser)
 - f. Warming and cooling system with appropriate disposable blankets
 - g. Restraints in various sizes
 - 2. Monitoring Equipment
 - a. Blood pressure cuffs
 - 1) Neonatal
 - 2) Infant
 - 3) Child
 - 4) Adult arm
 - 5) Adult thigh
 - b. Vascular Doppler device (handheld)
 - c. ECG monitor/defibrillator
 - 1) ECG electrodes in pediatric and adult sizes
 - 2) Defibrillator paddles in pediatric and adult sizes, and/or; Hands-free defibrillation device
 - 3) External pacing capability
 - 4) Multifunction pads in pediatric and adult sizes
 - d. Thermometer with hypothermia capability
 - 3. Airway Management

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- a. Bag-Mask-Ventilation (BMV) device with self-inflating bag
 - 1) Infant (minimum 450ml)
 - 2) Child
 - 3) Adult
 - b. BMV clear masks
 - 1) Neonate
 - 2) Infant
 - 3) Child
 - 4) Adult
 - c. Laryngoscope handle
 - 1) Pediatric
 - 2) Adult
 - d. Laryngoscope Blades
 - 1) Macintosh/curved: 2, 3
 - 2) Miller/straight: 00, 0, 1, 2, 3
 - e. Endotracheal Tubes
 - 1) Uncuffed: size mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
 - 2) Cuffed: size mm 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0
 - f. Stylets for endotracheal tubes
 - 1) Pediatric
 - 2) Adult
 - g. Magill Forceps
 - 1) Pediatric
 - 2) Adult
 - h. Continuous end-tidal CO₂ monitoring device for pediatric and adult patients (preferred). If not available, colorimetric CO₂ detector may be utilized.
 - i. Pulse oximeter unit with sensors
 - 1) Infant
 - 2) Pediatric
 - 3) Adult
 - j. Nasopharyngeal Airways
 - 1) Infant (sizes 12-14)
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- 2) Child (sizes 18-28)
 - 3) Adult (sizes 30-36)
 - k. Oropharyngeal Airways
 - 1) Infant (size 00)
 - 2) Child (size 0-2)
 - 3) Adult (sizes 3-5)
 - l. Clear oxygen masks
 - 1) Infant
 - 2) Child
 - 3) Adult
 - m. Non-rebreather masks
 - 1) Infant (partial non-rebreather)
 - 2) Child
 - 3) Adult
 - n. Nasal cannulas
 - 1) Infant
 - 2) Child
 - 3) Adult
 - o. Suction catheters
 - 6, 8, 10, 12 Fr
 - p. Yankauer suction tips
 - q. Feeding tubes
 - 5, 8 Fr
 - r. Nasogastric Tubes
 - 5, 8, 10, 12, 14, 16, 18 Fr
 - s. Supraglottic Airway Devices
 - 1) Neonatal
 - 2) Infant
 - 3) Child
 - 4) Adult
 - t. Difficult Airway Kit
 - u. Tracheostomy trays: optional for EDAP, required for PMC
 - 1) Pediatric
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- 2) Adult
 - v. Tracheostomy Tubes: optional for EDAP, required for PMC
 - 1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
 - 2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0
 - 4. Vascular Access Equipment
 - a. Arm boards
 - 1) Infant
 - 2) Child
 - 3) Adult
 - b. IV administration sets with calibrated chambers
 - c. IV catheters
 - 16, 18, 20, 22, 24 gauge
 - d. 3-way stopcocks
 - e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients
 - f. IV solutions, 250ml and/or 500ml bags
 - 1) 0.9 NS
 - 2) D5.45NS
 - 3) D5NS
 - 4) D10W
 - 5. Fracture Management Devices
 - a. Splinting supplies for long bone fractures
 - b. Cervical spine motion restriction equipment (e.g., cervical collar)
 - 1) Pediatric
 - 2) Adult
 - c. Spinal board with the appropriate straps
 - 6. Specialized Trays or Kits
 - a. Newborn delivery kit to include:
 - 1) Bulb syringe
 - 2) Umbilical clamps
 - 3) Towels
 - 4) Scissors
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- b. Newborn initial resuscitation equipment should be readily available, include:
 - 1) Radiant warmer or warming mattress
 - 2) BMV device with self-inflating bag and clear mask for newborns
 - 3) Umbilical vein catheters, or 5.0 Fr feeding tube
 - c. Thoracostomy tray
 - d. Chest drainage system
 - e. Chest tubes (at least one in each size range)
 - 1) Required for EDAP: (10 – 12) (16 – 24) (28 – 40) Fr
 - 2) Required for PMC: 8, 12, 16, 20, 24, 28, 36 Fr
 - f. Lumbar Puncture trays and spinal needles
 - 1) 22 g, 3 inch
 - 2) 22-25 g, 1½ inch
 - g. Urinary catheterization sets and indwelling urinary catheters
5, 8, 10, 12, 14, 16 Fr
7. Pediatric-Specific Resuscitation
- a. Immediately available drug calculation resources
 - b. The following medications must be immediately available:
 - 1) Adenosine
 - 2) Albuterol
 - 3) Amiodarone
 - 4) Atropine
 - 5) Calcium chloride
 - 6) Dobutamine
 - 7) Dopamine
 - 8) Epinephrine 0.1mg/mL (**IV administration**)
 - 9) Epinephrine 1mg/mL (**IM administration**)
 - 10) Epinephrine for inhalation
 - 11) Fentanyl
 - 12) Ipratropium bromide (Atrovent)
 - 13) Ketamine
 - 14) Lidocaine
 - 15) Mannitol or hypertonic saline
 - 16) Naloxone
 - 17) Norepinephrine
 - 18) Neuromuscular blocking agent
 - 19) Procainamide
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- 20) Sedative agent
- 21) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
- 22) Sodium Bicarbonate 8.4%

IX. Quality Improvement (QI) Program Requirements

A QI program shall be developed as per Ref. No. 620, EMS Quality Improvement Program, and monitored by the EDAP Medical Director, ED Nurse Manager/Director, and PdLN, with input as needed from the Designated Pediatric Consultant.

- A. Develop a methodology to easily identify pediatric (14 years of age and under) visits to the ED that can clearly delineate between 9-1-1 transport and self-transport.
- B. Identification and trending of important aspects of pediatric care requiring improvement shall include:
 - 1. 100% medical record review by physician and PdLN to include physician reviewer's signature(s) and date(s) of the reviews:
 - a. Deaths in the ED, including cardiopulmonary arrests
 - b. Child Maltreatment (suspected child abuse, neglect, commercial sexual exploitation, human trafficking, and sexual assault) to include the mandated reporting process
 - c. Transfers to higher level of care
 - d. Unscheduled/unplanned return visits to the ED within 48 hours and are admitted or transferred for continued acute care
 - 2. System-wide QI projects selected by the EMS Agency and endorsed by the PedAC.
 - 3. Track and trend two (2) EMS Agency approved indicators, and one (1) additional indicator (important aspects of patient care) identified by the EDAP Medical Director and PdLN
 - 4. Quarterly QI review of all suspected child maltreatment cases shall be conducted by Social Services and the ED to ensure the appropriate recognition of child maltreatment and reporting processes have been completed. A checklist may be utilized to ensure complete documentation and facilitate the review.
- C. Submit data as requested by the EMS Agency for quality improvement purposes upon request (e.g., EMS Agency Pediatric Database, Cardiac Arrest Registry to Enhance Survival (CARES), pediatric patient outcomes, physician reviews).
- D. Maintain written QI plan, trending and analysis reports, agendas, minutes, and attendance rosters. Upon request, these records shall be readily available to the EMS Agency for review

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- E. Complete the National Pediatric Readiness Project (NPRP) assessment annually <https://www.pedsready.org/>, and submit a copy of the NPRP Assessment Gap Analysis to the EMS Agency upon request
 - X. Data Collection Requirements
 - A. Participate in the data collection process established the EMS Agency.
 - B. Submit data to the EMS Agency, within 45 days of patient discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual

Ref. No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 318, **Pediatric Medical Center (PMC) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**
Ref. No. 822, **Suspected Child Abuse/Neglect Reporting Guidelines**
Ref. No. 822.2, **Suspected Child Abuse Report (SCAR) #8572**

California Penal Code 11166
Emergency Nursing Pediatric Course (ENPC)
National Pediatric Readiness Project (NPRP)

ACKNOWLEDGEMENTS

The EMS Agency EDAP Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians (ACEP), National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics (AAP)-California Chapter 2, Emergency Nurses Association (ENA), American College of Surgeons (ACS), and the EMS Agency.

The EDAP Standards have since been revised, endorsed by The Hospital Association of Southern California, and now meet or exceed the 2009 Joint Policy Statement: Guidelines for Care of Children in the Emergency Department which was ratified by the AAP, ACEP, and the ENA.