SUBJECT: **PEDIATRIC MEDICAL CENTER (PMC) STANDARDS** REFERENCE NO. 318

PURPOSE: To establish minimum standards for the designation of Pediatric Medical Centers (PMC). The PMC will provide an emergency department capable of managing complex pediatric emergencies, a Pediatric Intensive Care Unit (PICU), physicians with pediatric sub-specialties and/or experience in pediatric care, pediatric critical care consultation for community hospitals, and outreach education programs for the Emergency Medical Services (EMS) community.

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.

Certified Registered Nurse Anesthetist (CRNA): An advanced practice registered nurse (APRN) who has acquired graduate-level education and board certification in anesthesia.

Children with Special Health Care Needs: Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that is required by children generally.

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) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, or exploitation to determine whether an in-person investigation and consultation is required.

The CPH operates 24 hours a day, seven days a week. The 24 hour number (1-800-540-4000), staffed by employees of the DCFS, is responsible for screening calls from the community related to issues of child abuse and neglect.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department (ED) that is designated by the 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,

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quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures, as per the guidelines outlined in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards.

Immediately Available: Unencumbered by conflicting duties or responsibilities, responding without delay when notified, and being physically available to the specified area of the PMC.

On call: Agreeing to be available, according to a predetermined schedule, to respond to the Pediatric Medical Center (PMC) in order to provide a defined service.

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). Committee reviews, evaluates, and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Critical Care Education: Topics in pediatric critical care that addresses fundamental principles for the management of the critically ill pediatric patient, and a minimum of 14 hours of continuing education every four years.

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 Experience: A physician specialty approved by the appropriate hospital body and the PMC Medical Director, based on education, training, and experience to provide care to the pediatric patient.

Pediatric Intensivist: A Qualified Specialist in Pediatric Critical Care Medicine.

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 required by the EDAP Standards, also referred to as Nurse Pediatric Emergency Care Coordinator.

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.

PMC Medical Director: A Qualified Specialist in Pediatric Critical Care Medicine who oversees and directs implementation of these standards within the designated PMC.

PMC Nurse Coordinator: A Registered Nurse currently licensed to practice in the State of California and appointed by the Hospital to coordinate pediatric critical care.

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 PMC 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 not to exceed thirty (30) minutes by telephone and in person within one hour.

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

Senior Resident: A physician licensed in the State of California who is in training as a member of the residency program at the designated hospital, has completed at least two years of the residency, and is in good standing.

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.

Suspected Child Abuse and Neglect (SCAN) Team: A team of healthcare professionals who are specialists in diagnosing and treating suspected child abuse, neglect, and sexual assault.

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. PMC Designation / Re-Designation

A. PMC initial designation and 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 PMC at any time.

C. The PMC shall immediately (within 72 hours) provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the PMC Standards including structural changes or relocation of the PICU.

D. The PMC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the PMC program.

E. The PMC shall notify the EMS Agency within 15 days, in writing of any change in status of the PMC Medical Director, PMC Nurse Coordinator, or PICU Nurse Manager/Director by submitting Ref. No. 621.2, Notification of Personnel Change Form.

F. Have a fully executed Specialty Care Center PMC 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

1. Have a special permit for Basic or Comprehensive Emergency Medical Service; and

2. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.

B. Designated by the EMS Agency as an Emergency Department Approved for Pediatrics (EDAP).

C. Have a Suspected Child Abuse and Neglect (SCAN) Team.

D. Have a licensed inpatient pediatric unit.

E. Have a Pediatric Intensive Care Unit (PICU).

F. Appoint a PMC Medical Director and a PMC Nurse Coordinator.

III. PMC Leadership Requirements

A. PMC Medical Director

1. Responsibilities:

a. Implement and ensure compliance with the PMC Standards.

b. Serve as chairperson of the PMC Committee or assign a designee.

c. Coordinate medical care across departmental and multidisciplinary committees.

d. Maintain direct involvement in the development, implementation, and maintenance of a comprehensive multidisciplinary QI program.

e. Identify, review, and correct deficiencies in the delivery of pediatric critical care.

f. Review, approve, and assist in the development of transfer guidelines and all PMC policies and procedures.

g. Collaborates with the PMC Nurse Coordinator, ED Medical Director, and ED Nursing Director to ensure appropriate pediatric critical care education programs are provided to the staff related to the quality improvement findings.

h. Coordinates with PMC Nurse Coordinator to liaison with other PMCs, pediatricians, ED Directors, PdLNs, and community hospitals.

i. Shall have direct involvement in defining the credentialing/privileging criteria/process utilized in determining pediatric experience for the non-boarded physicians.

B. PMC Nurse Coordinator

1. Qualifications:

a. Current PALS provider or instructor certification.

b. Shall have a minimum of three years' experience or specialty certification, in the care of critically ill children, and currently working in the PICU.

c. Shall have education, training, and demonstrated competency in pediatric critical care nursing and attend at least 14 hours of Board of Registered Nursing (BRN) approved pediatric critical care education every four years.

d. May hold other positions in the hospital organization (e.g., PICU staff nurse, PICU Charge Nurse, PICU Nurse Manager/Director).

2. Responsibilities:

a. Ensure the implementation and compliance of the PMC Standards in collaboration with the PMC Medical Director and PICU Nurse Manager/Director.

b. Serve as a member of the PMC Committee.

c. Direct involvement in the development, implementation, and maintenance of comprehensive multidisciplinary QI program.

d. Liaison with other hospital multidisciplinary committees.

e. Ensure appropriate pediatric critical care education programs are provided to the staff.

f. Liaison with other PMCs, hospitals, and PdLNs.

g. Serve as the contact person for the EMS Agency and be available upon request to respond to County business.

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

i. Maintain joint responsibility with the PICU Medical Director and PICU Nurse Manager/Director for the development and review of policies, procedures, and QI activities in the PICU.

C. PICU Nurse Manager/Director – Shall serve as a member of the PMC committee.

IV. Personnel Requirements

A. Pediatric Intensivist

1. Responsibilities:

a. Shall be on-call and promptly available

b. Shall not be on-call for more than one facility at the same time

c. Participate in all major therapeutic decisions and interventions

B. Anesthesiologist with pediatric experience

1. Responsibilities:

a. Shall be on-call and promptly available

b. Provide oversight for all patients requiring interventions by the senior resident or Certified Registered Nurse Anesthetist (CRNA) and be present for all surgical procedures

C. Specialties who shall be on-call and promptly available:

1. Radiologist with pediatric experience (can be achieved by off-site capabilities)

2. Neonatologist

3. Pediatric Cardiologist

4. General Surgeon with pediatric experience

5. Otolaryngologist with pediatric experience

6. Obstetrics/Gynecologist with pediatric experience

7. Mental health professionals with pediatric experience

8. Orthopedist with pediatric experience

D. Qualified specialists who shall be available 24 hours per day, 7 days per week for consultation which may be met through a transfer and/or telehealth agreement:

1. Pediatric Gastroenterologist
2. Pediatric Hematologist/Oncologist
3. Pediatric Infectious Disease
4. Pediatric Nephrologist
5. Pediatric Neurologist
6. Pediatric Surgeon
7. Cardiac surgeon with pediatric experience
8. Neurosurgeon with pediatric experience

9. Pulmonologist with pediatric experience
10. Pediatric endocrinologist

E. Nursing Personnel on the Pediatric Unit

1. The Pediatric Unit shall be staffed with RNs and Licensed Vocational Nurses (LVNs) who are licensed to practice in the State of California.

2. RNs and LVNs shall have current PALS provider or instructor certification.

3. RNs and LVNs shall have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technicians approved pediatric education every four years.

4. Nursing staff shall have experience and demonstrated pediatric clinical competence. The hospital shall have methods for documenting clinical competency (i.e., course completion certificates, course attendance rosters, etc.).

V. Special Services and Resources

The following services may be met by contractual or written transfer agreements:

A. Acute burn care management

B. Urgent dialysis (i.e., hemodialysis)

C. Peritoneal dialysis

D. Pediatric rehabilitation

E. Organ transplantation

F. Home health

G. Reimplantation

H. Hospice

VI. Pediatric Intensive Care Unit

A. General Requirements for the PICU:

1. Shall be a distinct, separate unit within the hospital

2. Provide at minimum, eight licensed beds

3. Admit a minimum of 200 patients per year and a minimum or 40 ventilator day per year

B. PICU Medical Director

1. Serve as a member of the PMC Committee, and may hold PMC Medical Director position

2. Work with the PMC Medical Director to ensure PMC Standards are met

C. PICU Clinical Nurse Specialist (CNS) shall:

1. Be licensed to practice in the State of California as a CNS

2. Collaborate with the PMC Nurse Coordinator to ensure the PMC Standards are met

3. Develop and oversee pediatric critical care educational programs for the nursing staff in the PICU

D. PICU Staff Nurse shall:

1. Be licensed to practice in the State of California as RN or LVN

2. Have a current PALS provider or instructor certification

3. Have education, training, demonstrated competency in pediatric critical care nursing and have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technician approved pediatric education every four years

E. Social Worker shall:

1. Be licensed to practice in the State of California as a Medical Social Worker (MSW)

2. Have a Master's Degree in Social Work

3. Have pediatric experience in psychosocial issues affecting seriously ill children and their families, including management of child abuse and neglect cases

4. Have 4 hours of continuing education every two (2) years in topics related to health, housing and welfare of children (e.g., child abuse reporting)

F. Other professional services with minimum one year pediatric experience shall be available to the PICU:

1. Pharmacist shall be available 24 hours per day, 7 days a week

2. Clinical Registered Dietician

3. Occupational Therapist

4. Physical Therapist

5. Behavioral health specialist to include psychiatrists, psychologists, and nurses

VII. Policies and Procedures

The hospital shall develop and maintain policies and procedures required in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards, and those listed below. These policies and procedures, shall be reviewed periodically by the PICU Medical Director in collaboration with the PICU Nurse Manager/Director, and endorsed by hospital administration. All policies and procedures shall be easily accessible in the PICU.

Additional PMC policies and procedures shall address the following:

A. Policies

1. Age appropriate physical environment

2. Credentialing process for physicians who provide care for pediatric patients

3. Do-Not-Resuscitate Orders

4. Family centered care

a. Care of grieving family and caregivers

b. Contacting appropriate clergy per request of the parents or primary caregiver

c. Death of a child in the PICU

5. Infection surveillance and prevention

6. Mechanism and guidelines for bioethical review to include an Ethics Committee

7. Mental health and substance abuse

8. PICU admission, transfer, and discharge criteria and process

9. Referral for rehabilitation

B. Procedures

1. Appropriate use and monitoring of equipment

2. Pain management, includes utilization of developmentally appropriate pain tools

3. Patient care, which include nursing and respiratory management of infants, children, and adolescents

4. Procedural sedation

VIII. PICU Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible to PICU staff and may be physically housed in other locations besides the PICU. A mobile pediatric crash cart shall be utilized and available on all units where pediatric patients are treated to include but not limited to, ED, radiology, and in-patient services.

B. A locator chart or grid identifying the locations of all required equipment and supplies shall developed and be maintained in order for staff to easily identify location of all items.

C. Required equipment, supplies, and medications:

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children, including bed scales

b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer) to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams 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/Pacing (Crash cart unit and Transport unit)

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sized, and/or; hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult

d. Thermometer with hypothermic capabilities

e. Respiration and oxygen saturation monitoring

1) Pulse oximeter unit with sensors
   i. Infant
   ii. Pediatric
   iii. Adult

2) Continuous end-tidal CO_2 monitoring device for pediatric and adult

f. Arterial pressure

g. Central venous pressure

h. Intracranial pressure

i. Pulmonary arterial pressure

j. Automated/noninvasive blood pressure modules

3. Airway Management

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: mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: mm 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. Nasopharyngeal Airways

1) Infant
2) Child
3) Adult

i. Oropharyngeal Airways

1) Infant
2) Child (size 0-2)
3) Adult (size 3-5)

j. Clear oxygen masks

1) Infant
2) Child
3) Adult

k. Non-rebreather masks

1) Infant
2) Child
3) Adult

l. Nasal cannula

1) Infant
2) Child
3) Adult

m. Oxygen capability

n. Suction capability

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 Airways

1) Neonatal
2) Infant
3) Child
4) Adult

t. Cricothyrotomy Catheter set (pediatric)

u. Tracheostomy trays:

1) Pediatric
2) Adult

v. Tracheostomy Tubes

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 volume rate control 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, in 250mL and/or 500mL bags

1) 0.9 NS
2) D5.45NS
3) D5NS
4) D10W
5) Lactated Ringers

g. Ultrasound for facilitating peripheral and central venous access

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g. cervical collar)

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Thoracostomy tray

b. Chest drainage system

c. Chest tubes, one in each size

8, 12, 16, 20, 24, 28, 36 Fr

d. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

e. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

f. Central line trays, with one of each catheter size

1) 4.0 Fr
2) 5.5 Fr
3) 7.0 Fr

g. Tray for insertion of ICP monitor

h. Arterial line trays with one of each catheter size

1) 2.5 Fr
2) 4.0 Fr

i. Paracentesis tray

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) Atrovent
6) Calcium chloride
7) Dobutamine
8) Dopamine
9) Epinephrine 0.1mg/mL **(IV administration**)
10) Epinephrine 1mg/mL (**IM administration**)
11) Epinephrine for inhalation
12) Fentanyl
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Milrinone
17) Naloxone
18) Norepinephrine
19) Procainamide
20) Prostaglandin E1
21) Neuromuscular blocking agent
22) Sedative agent
23) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
24) Sodium Bicarbonate 8.4%
25) Vasopressin

8. Portable Equipment (promptly available)

a. Air-oxygen blenders (21-100%)

b. Air Compressor

c. Bilirubin lights

d. Cribs

e. Electrocardiogram (ECG 12 lead)

f. Electroencephalogram (EEG)

g. Echocardiogram (Echo)

h. Oxygen tank

i. Radiant warmer

j. Servo-controlled heating units (with or without open crib)

k. Suction unit

l. Transcutaneous pCO_2 monitor

m. Transcutaneous pO_2 monitor

n. ECG monitor/Defibrillator/Pacing transport unit

o. Ultrasound

p. Ventilator – pediatric capability

IX. Outreach and Education Program

A. Establish outreach with surrounding facilities to facilitate transfer of pediatric patients.

B. Inform and provide educational programs to EMS providers regarding pediatric patients discharged with special health care needs in their jurisdiction.

C. Provide outreach and pediatric education to EDAPs and EMS providers.

X. Ancillary Services

Ancillary services shall have the capabilities and technologist appropriately trained to manage a critically ill pediatric patient. These services shall be in-house and available 24 hours per day.

A. Respiratory Care Practitioners working in the PICU shall:

1. Be license as a Respiratory Car Practitioner (RCP) in the State of California

2. Have current PALS provider or instructor certification

3. Successfully complete additional training in pediatric critical care and attend a minimum of 4 hours of pediatric critical care education annually

B. Radiology

1. Shall have pediatric-specific policies and procedures pertaining to imaging studies of children

2. Radiology technicians must be in-house 24 hours per day, 7 days per week

3. Provide the following services 24 hours per day:

a. Nuclear medicine on-call and promptly available

b. Computerized Tomography (CT)

c. Ultrasound

d. Magnetic Resonance Imaging (MRI) on-call and promptly available

e. Angiography (may be provided through a transfer agreement)

C. Clinical laboratory shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples by trained phlebotomists, micro technique for small or limited sample sizes, and ability to provide autologous and designated donor transfusions.

XI. PMC Committee

A. The purpose of the Committee is to establish a forum for exchange of ideas regarding the provision of emergency, inpatient, and critical care to the pediatric patient.

B. The membership shall include interdepartmental and multidisciplinary representatives from the emergency department, PICU, pediatric unit, nursing, social services, respiratory services, discharge planning, SCAN team, and other relevant services as applicable, such as: prehospital care, pediatric sub-specialties, and pediatric interfacility transport team.

C. The Committee is responsible for all matters regarding the medical care provided to the pediatric patient which include, but not limited to, the following:

1. Review and recommend revision to policies and procedures to verify compliance with the PMC Standards

2. Review the quality improvement process to identify system-related performance and operational issues, and recommend corrective action plans

D. Meeting Frequency: Quarterly, additional meetings may be held on an as needed basis.

E. Meeting minutes and attendance rosters shall be maintained and made available to the EMS Agency when requested.

XII. Suspected Child Abuse and Neglect

A. Suspected Child Abuse and Neglect (SCAN) Team shall:

1. Consist of a medical director, coordinator, social worker, physician, and/or nurse consultants as applicable.

2. Assist nursing and medical staff in the evaluation of pediatric patients who have alleged to have been abused or neglected.

3. Have a member on-call and available to all areas of the hospital 24 hours per day.

4. Review cases of suspected child abuse/neglect to verify adequacy of care, reporting, and follow-up.

B. SCAN Team Medical Director

Shall be board certified in Pediatrics and/or Child Abuse Pediatrics:

Responsibilities:

1. Collaborate with the SCAN Team Coordinator:

   a. To monitor the SCAN Team's activities

   b. Ensure the development of education for nursing and medical staff in the evaluation of children suspected of child abuse and neglect.

2. Serve as a member of the PMC Committee.

3. Oversee the review of suspected child abuse, neglect, and sexual assault cases for appropriateness of care, compliance with mandated reporting and appropriateness of follow-up.

C. SCAN Team Coordinator

Shall have experience and training in the management of a child abuse, neglect and sexual assault victim, and obtain 14 hours of pediatric education every four years.

Responsibilities:

1. Oversees scheduling to ensure a SCAN Team member is available 24 hours per day/seven day a week.

2. Serve as a member of the PMC Committee.

3. Review cases of suspected child abuse, neglect, and sexual assault in consultation with the SCAN Team Medical Director for appropriateness of care, compliance with mandated reporting, appropriateness of follow-up, and completeness of documentation.

4. Assist nursing and medical staff in the evaluation of children who have alleged to have been abused, neglected, or sexually assaulted.

5. Develop educational training for medical and nursing staff in the recognition and management of children with suspected child abuse, neglect, and sexual assault.

D. Social Worker

1. Qualifications:

    a. Licensed to practice as a Medical Social Worker (MSW) by the State of California.

    b. Must have experience and training in the management of child abuse, neglect, and sexual assault.

    c. Have 4 hours of continuing education every two (2) years in topics related to health, housing, and welfare of children (e.g., child abuse reporting).

2. Responsibilities:

    a. Assist nursing and medical staff in the evaluation of children alleged to have been abused, neglected, or sexually assaulted.

    b. Provide support and resources for the abused, neglected, or sexually assaulted children and their family.

E. SCAN Team Physician and/or Nurse Consultants

1. Qualifications:

    a. Physicians shall be board certified in Pediatrics, Child Abuse Pediatrics, or Emergency Medicine with medical experience in diagnosing and managing suspected child abuse, neglect, and sexual assault cases.

    b. Nurse consultant shall have training and experience in evaluating and managing suspected child abuse, neglect, and sexual assault cases.

2. Responsibilities:

    a. Provide guidance or consultation, as needed, in suspected child abuse, neglect, or sexual assault cases.

F. Pediatric Forensic Examination

1. The PMC shall ensure a forensic examination and an interview are completed for acute (defined as occurring within 120 hours) sexual assault/abuse event, or appropriate referral was made for such examination, if the event occurred over 120 hours.

2. If the PMC does not provide the necessary forensic examination, a written consultation and transfer agreement shall exist with an EMS Agency designated SART Center.

XIII. Pediatric Interfacility Transport (PIFT) Program

PMCs shall have a PIFT program or have written agreements to provide PIFT services for the timely transport of patients *in or out* of the PMC. The PIFT program shall have the capability to transport neonatal and pediatric patients. The PIFT program shall also include back-up processes or agreements for the timely transport of patients with time sensitive conditions when the estimated time of arrival of the primary transport team is greater than 1 hour.

A. PMCs with a PIFT program shall have program policies and procedures and composition of PIFT as determined by the level of care needed.

1. The hospital maintaining the PIFT program shall have written agreements with referring and receiving facilities that utilize the program.

2. Agreements should specify the role and responsibilities of the transport program and the hospitals to include the following:

a. Agreement to transfer and receive appropriate pediatric patients when indicated

b. Responsibilities for patient care before, during and after transport

c. Documentation and transferring appropriate information/records

B. If the PMC does not have a PIFT program, written agreements shall exist with agencies or other programs that will provide timely transportation of critically ill pediatric patients to and from the PMC. Written agreements shall be with a PIFT program that meets the specifications outlined in XIII.A.

XIV. Quality Improvement (QI) Program

A. The PMC shall develop a multidisciplinary QI program for the purpose of improving patient outcomes of critically ill children. The QI program shall interface with the emergency department, PICU, NICU, pediatric unit, SCAN Team, PIFT Program, and EMS providers. The QI program shall also interface with hospital wide and emergency department QI activities.

B. The PMC Medical Director and Nurse Coordinator shall be responsible for the development, implementation, and review of the QI program as it pertains to the care of the pediatric patients transported to the PMC.

C. The PMC's QI program shall meet the requirements stipulated in Ref. No. 620, Section V, QI Program Requirements, which includes, at minimum, the following:

1. QI Plan
2. Identification of indicators
3. Methods to collect data
4. Written results and conclusions
5. Recognition of improvement

6. Action(s) taken (e.g., education of staff or feedback to referring facilities and EMS providers)
7. Assessment of effectiveness of action(s) taken
8. Dissemination of QI information to stakeholders

D. The QI review process shall include, at a minimum, a detailed 100% physician review, tracking, and trending of the following cases:

1. Unexpected deaths in the PICU
2. Unexpected cardiac arrests in the PICU
3. Unexpected transfers for higher level of care
4. Sentinel events
5. Child maltreatment (suspected child abuse, neglect and sexual assault) to include the mandated reporting process
6. Readmissions to the PICU within 48 hours
7. Unexpected admissions from the operating room
8. Unplanned admissions to the PICU

DI. The QI process shall include providing feedback, via appropriate process or channels, to referral facilities and/or EMS providers on items that may require commendation, positive reinforcement, fact-finding, case/peer review, and education/competency verification or remediation.

XV. Data Requirement

A. Participate in the data collection process established by the EMS Agency.

B. Submit data to the EMS Agency, within 45 days of patient's 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. 316, **Emergency Department Approved for Pediatrics (EDAP) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621, **Notification of Personnel Change**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**

California Clinical Forensic Medical Training Center, California Sexual Assault Response Team (SART) Manual

California Children's Services: Provider Standards, https://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx

ACEP: Emergency Information Form, https://www.acep.org/by-medical-focus/pediatrics/medical-forms/emergency-information-form-for-children-with-special-health-care-needs/
AAP: Emergency Information Form, https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-child-care/Documents/AR_EmergencyInfo.pdf

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