DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

PURPOSE: To establish minimum standards for the designation of Pediatric Medical Centers (PMC). The PMC's must meet specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and establish policies and procedures. PMC's 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 educational programs for the Emergency Medical Service (EMS) community.

DEFINITIONS:

Advanced Pediatric Life Support (APLS): The Pediatric Emergency Medicine Resource: A continuing medical education program developed by American Academy of Pediatrics (AAP) and American College of Emergency Physicians (ACEP). APLS features an innovative modular curriculum designed to present the information physicians, nurses and allied health professionals need to assess and care for critically ill and injured children during first few hours in the ED or office-based setting. Course is valid for four years.

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) 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.

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 (CSHCN): 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. In the event, CPH volume of calls received exceeds the number of social worker's available, an Overflow/callback provisional number (not an official reporting

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

number) is given to the caller. Then the caller is responsible to re-contact CPH and make a referral, assuring the mandated reporting process is initiated and completed.

Emergency Departments Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department that is approved by EMS Agency to receive pediatric patients via the 9-1-1 system. These emergency departments 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, as per the guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

Emergency Information Form (EIF): To optimize emergency care for children with special needs. The EIF was developed by AAP and ACEP. The EIF will help facilitate the transfer of relevant information and ensure the medical history for Children with Special Health Care Needs (CSHCN) is summarized for the healthcare providers.

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 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 PICUs. Committee reviews, evaluates, and makes recommendations on issues related to the EMS which impact 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): Instructor-based course with hands-on skills validation by American Heart Association. Course is valid for two years.

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 Medical Center (PMC): A licensed acute care hospital that is approved 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 Trauma Center (**PTC):** A licensed acute care hospital that is approved 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 measurably 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 is BC or BE in the

corresponding specialty by ABMS or American Osteopathic Association (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 Forensic Examiner (SAFE): Examiners are trained healthcare professionals with additional training in conducting adult and adolescent sexual assault forensic medical examinations and/or child sexual abuse forensic medical examinations. SAFE encompasses several categories of examiners (e.g., physicians, nurse practitioners, physician assistants, and registered nurses).

Sexual Assault Response Team (SART) Centers: A center specializing in child abuse, neglect, and forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 72 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. The SART Center shall have the capabilities of being mobile in the event that the pediatric patient is medically unstable for discharge.

POLICY:

I. PMC Designation / Confirmation Agreement:

A. PMC initial designation and PMC re-confirmation is granted after a satisfactory review by the EMS Agency for a period of three years.

B. The EMS Agency reserves the right to perform scheduled on-site visits or request additional data of the PMC at any time.

C. The PMC 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 PMC Standards.

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

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. 621.1, Notification of Personnel Change Form.

II. PMC Approval Process

A. General Hospital Requirements: At a minimum, meet the California Children's Services Standards for Pediatric Community Hospitals, and

1. Meet or exceed the Emergency Medical Services (EMS) Agency Standards for Emergency Departments Approved for Pediatrics (EDAP)

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

3. Have a PICU approved by California Children's Services (CCS)

B. Administration/Coordination

1. PMC Medical Director – Shall be board certified in Pediatric Critical Care.

   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 oftransfer guidelines and all PMC policies and procedures

   g. Collaborates with the PMC Nurse Coordinator 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, base hospitals, community hospitals, and prehospital care providers

2. PMC Nurse Coordinator

   a. Qualifications:

      i. Licensed as a Registered Nurse (RN) in the State California

      ii. Current PALS provider or instructor

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

      iv. 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 education every four years

      v. The PMC Nurse Coordinator may hold other positions in the hospital organization-PICU staff nurse, PICU Charge Nurse, PICU Nurse Manager or Director

   b. Responsibilities:

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

ii. Serve as co-chair of the PMC Committee with the PMC Medical Director

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

iv. Liaison with other hospital multidisciplinary committees.

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

vi. Liaison with other PMCs, base hospitals, community hospitals, and prehospital care providers

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

viii. Participate in EMS Agency activities and meetings

ix. 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

3. PICU Nurse Manager/Director

Shall serve as a member of the PMC committee if not the PMC Coordinator.

C. Physician Staffing and Specialty Requirements

1. Pediatric Intensivist who is a qualified specialist in pediatric critical care medicine.

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 during on-call periods

2. Anesthesiologist with pediatric experience

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

3. The following specialties will be on-call and promptly available:

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

   b. Neonatologist

   c. Pediatric Cardiologist

   d. General Surgeon with pediatric experience

   e. Otolaryngologist with pediatric experience

   f. Obstetrics/Gynecologist with pediatric experience

4. The following qualified specialists should be available for consultation and/or through a transfer agreement:

   a. Pediatric Gastroenterologist

   b. Pediatric Hematologist/Oncologist

   c. Pediatric Infectious Disease

   d. Pediatric Nephrologist

   e. Pediatric Neurologist

   f. Pediatric Surgeon

   g. Cardiac Surgeon with pediatric experience

   h. Neurosurgeon with pediatric experience

D. Special Services/Resources

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

1. Critical Care Transport Team

2. Acute burn care management

3. Hemodialysis

4. Peritoneal dialysis

5. Pediatric rehabilitation

6. Organ transplantation

7. Home health

8. Reimplantation

9. Hospice

E. Nursing Services on the Pediatric Unit:

General Requirements for the Nursing personnel:

1. Licensed as RN in the State of California

2. Current PALS Provider or Instructor

3. Staffed by qualified nurses with education, experience, and demonstrated pediatric clinical competence

4. A method of documenting clinical competency

F. Pediatric Intensive Care Unit:

1. General Requirements for the PICU:

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

   b. Provide at minimum, eight licensed beds

   c. Admit a minimum of 350 patients a year, with 50 of these patients requiring mechanical ventilation

2. PICU Medical Director shall:

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

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

3. PICU Clinical Nurse Specialist/Clinical Educator shall:

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

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

   c. Oversee provision of educational needs of parents and/or caregivers

4. PICU Staff Nurse shall:

   a. Be a RN or Licensed Vocational Nurse (LVN) with current license in the State of California

b. Be a current PALS provider or instructor

c. Have education, training, demonstrated competency in pediatric critical care nursing, and have attended at least 14 hours of BRN-approved pediatric education every four years

5. Social Worker shall:

a. Be licensed as a Medical Social Worker (MSW)

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

c. Have education, training, and demonstrated competency in management of child abuse and neglect cases

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

a. Pharmacist

b. Clinical Registered Dietician

c. Occupational Therapist

d. Physical Therapist

G. Policies and Procedures

The PICU policies and procedures, shall be reviewed and approved by the hospital CEO/administrator, Medical Director, and/or Nurse Manager/Director of the PICU. **The policies listed below are in addition to those required in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards**, and shall be easily accessible in the PICU.

1. The PMC/PICU shall establish specific policies and procedures which address, but are not limited to, the following:

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

b. Criteria for appropriate use and monitoring of equipment

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

d. Method for infection surveillance and prevention

e. Family Centered Care

f. Method for contacting appropriate clergy per the request of the

parents or primary caregiver

g. Psychosocial issues

h. Age appropriate physical environment

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

j. Do Not Resuscitate

k. Pain management guidelines which include utilization of developmentally appropriate pain tools

l. Care of grieving families and caregivers

m. Procedural sedation

n. Referral for rehabilitation

H. PICU Equipment, Supplies, and Medications:

1. Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. A mobile pediatric crash cart shall be utilized.

2. Staff shall be able to identify the locations of all items. A locator chart of the locations of all items (e.g., a locator grid identifying the required equipment and supplies) shall be maintained.

3. Required PICU equipment, supplies, and medications:

a. General Equipment

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

ii. Standardized length-base resuscitation tape (most recent edition) or other standardized method to estimate pediatric weights in kilograms

iii. PICU drug dosage reference material (pediatric) with dosages calculated in milligrams per kilogram – either posted, or readily available

iv. Developmentally appropriate pain scale assessment tools for infants and children

v. Blood and IV fluid warmer (Rapid infuser)

vi. Warming and cooling system with appropriate disposable blankets

vii. Ophthalmoscope

viii. Otoscope

ix. Thermometer with hypothermia capability

b. Monitoring Equipment

i. Heart rate with dysrhythmia monitoring

ii. Respiration and Oxygen saturation monitoring

iii. Pulse oximeter unit with sensors in the following sizes

a) Infant
b) Pediatric
c) Adult

iv. Continuous end-tidal CO2 monitoring device for pediatric and adult

v. Arterial pressure

vi. Central venous pressure

vii. Intracranial pressure (if applicable)

viii. Pulmonary arterial pressure

ix. Automated/noninvasive blood pressure modules

x. Blood pressure cuffs in the following sizes:

a) Neonatal
b) Infant
c) Child
d) Adult arm
e) Adult thigh

xi. Vascular Doppler device (handheld)

xii. ECG monitor/Defibrillator/Pacing: (Crash cart unit and Transport unit)

a) ECG electrodes in pediatric and adult sizes
b) Defibrillator paddles in pediatric and adult sizes, and/or;
c) Hands-free defibrillation device
d) External pacing capability
e) Multifunction pads in pediatric and adult

c. Airway Management

i. Bag-Valve-Mask (BVM) device with self-inflating bag in the following sizes:

a) Infant (minimum 450ml)
b) Child
c) Adult

ii. BVM clear masks in the following sizes:

a) Neonate
b) Infant
c) Child
d) Adult

iii. Laryngoscope handle:

a) Pediatric
b) Adult

iv. Laryngoscope Blades:

a) Macintosh/curved: 2, 3
b) Miller/straight: 0, 1, 2, 3

v. Endotracheal Tubes in the following sizes:

a) Uncuffed: mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
b) Cuffed: mm 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

vi. Stylets for endotracheal tubes:

a) Pediatric
b) Adult

vii. Magill Forceps:

a) Pediatric
b) Adult

viii. Nasopharyngeal Airways in the following sizes:

12, 14, 18, 20, 22, 24, 26, 30 Fr

ix. Oropharyngeal Airways in the following sizes:

a) Neonatal: 00 / 40 mm
b) Infant: 0 / 50 mm
c) Child: 1 / 60 mm
d) Small child: 2 / 70 mm
e) Small adult: 3 / 80 mm
f) Medium adult: 4 / 90 mm
g) Large adult: 5 / 100 mm

x. Clear oxygen masks in the following sizes:

a) Infant
b) Child
c) Adult

xi. Non-rebreather masks in the following sizes:

a) Infant
b) Child
c) Adult

xii. Nasal cannulas in the following sizes:

a) Infant
b) Child
c) Adult

xiii. Oxygen capability

xiv. Suction capability

xv. Suction catheters in the following sizes:

6, 8, 10, 12 Fr

xvi. Yankauer suction tips

xvii. Feeding tubes in the following sizes:

5, 8 Fr

xviii. Nasogastric Tubes in the following sizes:

5, 8, 10, 12, 14, 16, 18 Fr

xix. Laryngeal Mask Airways (LMA) in the following sizes:

1, 1.5, 2, 2.5, 3, 4, 5

xx. Cricothyrotomy Catheter set (pediatric)

xxi. Tracheostomy trays:

a) Pediatric
b) Adult

xxii. Tracheostomy Tubes in the following sizes:

a) Neonatal: mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
b) Pediatric: mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

d. Vascular Access Equipment

i. Arm boards in the following sizes:

a) Infant
b) Child
c) Adult

ii. IV volume rate control administration sets with calibrated chambers

iii. IV catheters in the following sizes:

16, 18, 20, 22, 24 gauge

iv. 3-way stopcocks

v. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

vi. IV solutions, to include the following in 250ml and/or 500ml bags:
a) 0.9 NS
b) D5.45NS
c) D5NS
d) D10W

e. Fracture Management Devices

i. Splinting supplies for long bone fractures

ii. Spinal motion restriction devices in the following sizes:

a) Infant
b) Child
c) Adult

iii. Spinal board with the appropriate straps

f. Specialized Trays or Kits

i. Thoracostomy tray:

a) Pediatric
b) Adult

ii. Chest drainage system

iii. Chest tubes one in each of the following sizes:

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

iv. Lumbar Puncture trays and spinal needles:

a) 22 g, 3 inch
b) 22-25 g, 1½ inch

v. Urinary catheterization sets and urinary (indwelling) catheters in a selection of sizes:

5, 6, 8, 10, 12, 14, 16 Fr

vi. Central line trays (pediatric and adult catheter sizes)

a) 4.0 Fr
b) 5.5 Fr
c) 7.0 Fr

vii. Tray for insertion of ICP monitor (if applicable)

viii. Arterial Line Trays:

a) 2.5 Fr
b) 4.0 Fr

ix. Paracentesis tray

g. Pediatric-Specific Resuscitation

i. Immediately available drug calculation resources

ii. The following medications must be immediately available:

a) Adenosine
b) Albuterol
c) Amiodarone
d) Atropine
e) Atrovent
f) Calcium chloride
g) Dobutamine
h) Dopamine
i) Epinephrine 0.1mg/mL **(IV administration**)
j) Epinephrine 1mg/mL (**IM administration**)
k) Epinephrine for inhalation
l) Lidocaine
m) Mannitol or hypertonic saline
n) Milrinone
o) Naloxone
p) Norepinephrine
q) Procainamide
r) Prostaglandin E1
s) Neuromuscular blocking agents
t) Sedative agents
u) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)

v) Sodium Bicarbonate 8.4%
w) Vasopressin

h. Portable Equipment (promptly available**)**

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

ii. Air Compressor

iii. Bilirubin lights

iv. Cribs

v. Electrocardiogram (ECG 12lead)

vi. Electroencephalogram(EEG)

vii. Echocardiogram (Echo)

viii. Oxygen tank

ix. Radiant warmer

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

xi. Suction unit

xii. Transcutaneous pCO2 monitor

xiii. Transcutaneous pO2 monitor

xiv. ECG monitor/Defibrillator/Pacing transport unit

xv. Ultrasound

xvi. Ventilator - pediatric capability

I. Data Requirement:

Comply with all data elements specified in the 9-1-1 Receiving Hospital Data Dictionary.

J. Outreach and Family Education Programs:

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

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

3. Complete the Emergency Information Form (EIF) to assure prompt and appropriate care for CSHCN. Documentation of the child's complicated medical history is summarized and may be presented to health care providers.

K. 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 twenty-four hours per day.

1. Respiratory Care Practitioner:

   a. Licensed as Respiratory Care Practitioner (RCP) in the State of California

   b. All RCPs shall be a current PALS provider or instructor

   c. At least one RCP with pediatric experience shall be in-house twenty-four hours per day to be immediately available to the PICU

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

2. Radiology

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

   b. Radiology technicians must be in-house twenty-four hours per day, with a back-up technician on-call and promptly available

   c. Provide the following services 24-hours a day/seven days a week:

      i. Nuclear medicine on-call and promptly available

      ii. Computerized Tomography (CT)

      iii. Ultrasound

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

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

3. 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.

L. Pediatric Medical Center Committee

1. The PMC committee shall include interdepartmental and multidisciplinary representatives from, emergency department, pediatric critical care, pediatrics, 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.

2. Responsibilities:

   To monitor and ensure the compliance with PMC standards to include:

   a. Development and implementation of all policies and procedures

   b. A comprehensive, multidisciplinary quality improvement (QI) program that should meet at minimum on a quarterly basis or more frequently as needed to review system-related performance issues. The meeting minutes shall reflect the attendees, the QI findings, analysis, and if applicable, the proposed corrective actions.

III. Suspected Child Abuse And Neglect:

A. General Requirements for the Suspected Child Abuse and Neglect (SCAN) Team

1. The team should consist of individuals who are specialists in diagnosing and treating suspected child abuse, neglect, and sexual assault. The team shall consist of a medical director, coordinator, social worker, physician, and/or nurse consultants as applicable.

2. The SCAN Team shall:

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

   b. Have a member on-call and available to all areas of the hospital twenty-four hours per day

   c. 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. Collaborates 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 with suspected child abuse and neglect

2. Serves as a member of the PMC Committee

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

C. SCAN Team Coordinator

Shall have experience and training in child abuse, neglect and sexual assault

Responsibilities:

1. Oversees scheduling to ensure a SCAN Team member is available 24 hours a day/7 days 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, mandated reporting, documentation, and follow-up

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 evaluation of children with suspected child abuse, neglect, and sexual assault

D. Social Worker

1. Qualifications:

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

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

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 patients of abuse, neglect, or sexual assault and their families

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

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

2. Responsibilities:

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

F. Pediatric Forensic Examination

1. The PMC shall ensure that a forensic examination and interview process for a case of acute sexual assault/abuse event (defined as occurring within 72 hours) or appropriate referral for such examination, if over 72 hours.

2. If the PMC cannot provide the necessary forensic examination, a written consultation and transfer agreement shall exist with a SART Center, which has the capabilities of providing a comprehensive medical and psychological examination for the sexually abused pediatric patient.

IV. Pediatric Interfacility Transport Program

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

B. If the PMC does not have a PIFT program, a written agreement shall exist with agencies or other programs that will provide timely transportation of critically ill pediatric patients to and from the PMC.

C. Affiliated Hospital Agreements

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

V. Quality Improvement (QI) Program

A. Shall be an organized multidisciplinary program for the purpose of improving patient outcomes of critically ill or injured children. A written QI plan, trending and analysis reports, agenda, minutes, and attendance rosters to be readily available to the EMS Agency for the review process

B. Shall be developed, monitored, and reviewed annually by the PMC Medical Director and Nurse Coordinator

C. The PMC Medical Director and Nurse Coordinator shall be responsible for the development and review of policies and procedures regarding the QI process as they pertain to the care of the pediatric patients transported to the PMC

D. The QI program shall interface with the PICU, NICU, pediatric unit, SCAN Team, hospital wide and emergency department’s EDAP QI activities and, if applicable,

PIFT program

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

1. Unexpected deaths
2. Unexpected resuscitations
3. Unexpected transfers for a higher level of care
4. Sentinel events
5. Suspected child abuse, neglect, and sexual assault
6. Readmissions to the PICU within 72 hours

F. The QI process shall include identification of the indicators, methods to collect data, written results and conclusions, recognition of improvement, action(s) taken, and assessment of effectiveness of above actions and dissemination to stakeholder(s).

CROSS REFERENCE:

Prehospital Care Policy Manual:
Ref. No. 316, Emergency Departments Approved for Pediatrics (EDAP) 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. 610, 9-1-1 Receiving Hospital Data Dictionary
Ref. No. 620, EMS Quality Improvement Program
Ref. No. 621, Notification of Personnel Change
Ref. No. 621.1, Notification of Personnel Change Form
Pediatric Advisory Committee Bylaws
EMS Agency SART Standards
California Clinical Forensic Medical Training Center, California Sexual Assault Response Team (SART) Manual

California Children's Services: Provider Standards
http://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx
ACEP: Emergency Information Form, https://www.acep.org/content.aspx?id=26276 AAP: Emergency Information Form, http://pediatriccare.solutions.aap.org/data/Multimedia/Emergency Information Form-Special Needs.pdf

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