

# FACILITY RECOGNITION RENEWAL APPLICATION PACKET

EMS Regions 3 and 6

NOVEMBER 2009

*Emergency Department Approved for Pediatrics (EDAP)  
Pediatric Plan*

and

*Standby Emergency Department for Pediatrics (SEDP)  
Pediatric Plan*



**DUE DATE**  
**Friday, February 5, 2010**

**Illinois Emergency Medical Services for Children**

Developed by  
Illinois EMSC Facility Recognition Task Force

Approved by  
Illinois EMSC Advisory Board

**ILLINOIS EMSC  
FACILITY RECOGNITION**

**EDAP & SEDP Pediatric Plan  
Renewal Application**

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**ILLINOIS EMSC  
FACILITY RECOGNITION**

*Application and Site Survey Process*

**Application Instructions/Steps**

The following steps outline the application process for renewal of your status as an Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP). **PLEASE NOTE that your Pediatric Plan and completion of this application should be developed through interaction and collaboration with all appropriate disciplines within your facility.**

1. Review your current Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP) Pediatric Plan.
2. Using the *EDAP & SEDP Pediatric Plan Checklist* (page 5 & 6) along with the Emergency Department Approved for Pediatrics criteria (page 7) or Standby Emergency Department for Pediatrics criteria (page 11), complete an update to your original EDAP or SEDP Pediatric Plan. Appendix all appropriate supporting documentation (schedules, policies, procedures, protocols, guidelines, plans, etc.).
3. The Pediatric Plan should follow the *Checklist* format provided in this application and include all supporting documentation, including but not limited to scope of services/care, policies (both administrative and department specific), procedures, protocols, guidelines, flow charts, rosters, calendars, schedules, etc.
4. Complete and obtain appropriate signatures on the *Request for Re-Recognition of EDAP or SEDP Status* signature form (see page 4).
5. Complete and obtain signatures on the Emergency Department Physician, Mid-Level Provider and Nursing credentialing forms (see pages 14-16).
6. Complete the Pediatric Equipment Checklist (see pages 17-21).
7. **The Pediatric Plan should be submitted in a single-sided format and unstapled.**
8. **Maintain a copy for your files (using the tabs provided by EMSC).**
9. **Submit 3 copies of your Pediatric Plan (an original signed copy plus 2 additional copies).** Use the tabs provided by EMSC for the original signed copy. Each copy must contain the following:
  - **Signed *Request for Re-Recognition of EDAP or SEDP Status* signature form;**
  - **A completed EDAP & SEDP Pediatric Plan Checklist (pages 5 & 6);**
  - **Completed EDAP or SEDP Pediatric Plan (including supporting documentation);**
  - **Completed Emergency Department Physician, Mid-Level Provider and Nursing credentialing forms (pages 14-16);**
  - **Completed Pediatric Equipment Checklist (pages 17-21).**

10. Submit these documents (including all supporting documentation) by **Friday, February 5, 2010** in the order listed in this application to: Jack Fleeharty, RN, EMT-P, Chief, Division of EMS & Highway Safety, Illinois Department of Public Health, 500 E. Monroe Street, 8<sup>th</sup> Floor, Springfield, IL 62701.
11. **PLEASE NOTE that any submitted requests to waiver any of the EDAP or SEDP requirements must include THE CRITERIA BY WHICH COMPLIANCE IS CONSIDERED TO BE A HARDSHIP, AND DEMONSTRATE HOW THERE WILL BE NO REDUCTION IN THE PROVISION OF MEDICAL CARE.**
12. **For questions regarding the application process, please contact Evelyn Lyons at (708) 327-2556 or Evelyn.Lyons@illinois.gov or Paula Atteberry at (217) 785-2083 or Paula.Atteberry@illinois.gov.**

### **Site Survey Procedure**

1. Within 4-6 weeks following receipt of your updated Pediatric Plan and supporting documents, the hospital will be informed as to the status of the application. If all documentation is in order, a site visit will be scheduled.
2. In preparation for the site visit, hospital personnel will prepare evidence to verify adherence to the facility recognition requirements.
3. The site visit will include a survey of the Emergency Department, Pediatric Unit (including intensive care (if applicable) and any inpatient units where pediatric patients may be admitted) and a meeting with the following individuals:
  - a. Hospital Chief Administrative/Executive Officer or designee
  - b. Chief of Pediatrics, or if the hospital does not have a Pediatric Department, the designated pediatric consultant
  - c. Administrator of Pediatric Services, if applicable
  - d. Nursing Director and/or Nurse Manager, Pediatric Unit
  - e. Administrator of Emergency Services
  - f. Emergency Department Medical Director and/or the Pediatric Emergency Department Medical Director
  - g. Emergency Department Nurse Manager and/or the Pediatric Emergency Department Nurse Manager
  - h. Pediatric CQI Liaison
  - i. Hospital Quality Improvement Department Director or designee
  - j. Hospital Emergency /Disaster Preparedness Coordinator
  - k. Mid-Level provider, i.e. Nurse Practitioner or Physician Assistant for those facilities that utilize mid-level providers in their emergency department
  - l. **For EMS Resource or Associate Hospitals only:** The EMS Medical Director and EMS Coordinator

### **Site Survey Team**

The survey team will be appointed by the Chief of EMS & Highway Safety, in coordination with the Illinois EMSC Advisory Board. Site survey teams will be composed of a physician/nurse team along with a representative from the Illinois Department of Public Health. All team members will attend formal training in the site survey responsibilities, expectations, process and assessment.

**\*NOTE: The term “pediatric” throughout this document refers to all children age 15 and younger.**

### **Following the Site Survey**

1. Within four to six (4-6) weeks following the site visit, the hospital shall receive the results of the survey. Those facilities meeting all requirements will receive a letter from the Illinois Department of Public Health formally renewing their EDAP or SEDP status.
2. Hospitals that do not meet the requirements will receive a letter from the Illinois Department of Public Health outlining the areas of non-compliance. The Department can deny a request for renewal of recognition if findings show failure to substantially comply with the EDAP or SEDP criteria. Hospitals may appeal the results of the Survey by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.
3. Rerecognition shall occur every three years, with site visits scheduled as necessary.
4. Withdrawal of recognition status may occur at any time, should a hospital fail to meet any of the requirements. In this situation, the hospital shall notify the Illinois Department of Public Health, Division of EMS & Highway Safety at least 60 days prior to withdrawal and identify how area prehospital provider agencies, area hospitals, and the Illinois EMSC Office will be notified.

**\*NOTE: The term “pediatric” throughout this document refers to all children age 15 and younger.**

**ILLINOIS EMSC  
FACILITY RECOGNITION**

**Request for Re-recognition of EDAP or SEDP Status**

Name of hospital and address (typed)

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1. Specify the recognition level for which your hospital is applying for renewal:

- Emergency Department Approved for Pediatrics (EDAP) \_\_\_\_\_
- Stand-by Emergency Department Approved for Pediatrics (SEDP) \_\_\_\_\_

2. The above named facility certifies that each requirement in this Request for Recognition is met.

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Typed name – CEO/Administrator

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Signature - CEO/Administrator

Date

---

Typed name – Medical Director of Emergency Services

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Signature – Medical Director of Emergency Services

Date

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Contact person - Typed name, credentials and title

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Contact person - phone number, fax number and email

**ILLINOIS EMSC  
FACILITY RECOGNITION**

***EDAP & SEDP Renewal Pediatric Plan  
Checklist***

**Instructions :**

**Complete an updated EDAP or SEDP Pediatric Plan for your facility using the guideline below and the EDAP criteria located on page 7 or the SEDP criteria located on page 11.**

**Use the tabs provided by the EMSC office to organize your application.**

<b>For each requirement outlined below, select the response(s) as directed and attach supporting documentation.</b>	
<input type="checkbox"/> Submit an organizational chart identifying the administrative relationships among all departments in the hospital, including the Emergency Department and Department of Pediatrics. <input type="checkbox"/> Submit an organizational chart identifying the organizational/reporting structure of ED physician, nursing and ancillary services.	
<b>Review the criteria in section 515.4000 a, 1 and 2 (page 7) or 515.4010 a, 1 and 2 (page 11), for the physician staff qualifications and continuing medical education and submit <u>each of the below.</u></b> <input type="checkbox"/> Enclosed is a policy (s) that incorporates the physician qualifications and CME requirements. <input type="checkbox"/> Enclosed is a completed <b>CREDENTIALS OF EMERGENCY DEPARTMENT PHYSICIANS</b> Form. <input type="checkbox"/> Enclosed is the curriculum vitae for the ED Medical Director. <input type="checkbox"/> Enclosed is a current one-month physician schedule for the ED.	
<b>Review the criteria in section 515.4000 or 515.4010 a, 3, for the ED Physician coverage and <u>submit one of the below.</u></b> <input type="checkbox"/> Enclosed is a previously approved policy. There are no changes. <input type="checkbox"/> Enclosed is a revised policy for approval. (Necessary if any ED physicians have a waiver).	
<b>Review the criteria in section 515.4000 or 515.4010 a, 4, for ED Consultation and <u>submit the below.</u></b> <input type="checkbox"/> Enclosed is a one month on-call schedule identifying availability of board certified/board prepared pediatricians or pediatric emergency medicine physicians.	
<b>Review the criteria in section 515.4000 or 515.4010 a, 5, for ED Physician Back-up and <u>submit one of the below.</u></b> <input type="checkbox"/> Enclosed is a previously approved policy. There are no changes. <input type="checkbox"/> Enclosed is a revised policy for approval	
<b>Review the criteria in section 515.4000 or 515.4010 a, 6, for On Call Specialty Physician Response Time and <u>submit one of the below.</u></b> <input type="checkbox"/> Enclosed is a previously approved policy. There are no changes. <input type="checkbox"/> Enclosed is a revised policy for approval	
<b>Review the criteria in section 515.4000 or 515.4010 b, 1 and 2 for Mid-Level Provider qualifications and continuing medical education and <u>submit both of the below.</u></b> <input type="checkbox"/> Enclosed is a policy (s) that incorporates the mid-level provider qualifications and continuing education requirements. <input type="checkbox"/> Enclosed is a completed <b>CREDENTIALS OF EMERGENCY DEPARTMENT MID-LEVEL PROVIDERS</b> Form. <input type="checkbox"/> Enclosed is a current one-month mid-level provider schedule. <p style="text-align: center;"><b>OR</b></p> <input type="checkbox"/> Enclosed is documentation that mid-level providers are not utilized in the ED)	

<p><b>Review the criteria in section 515.4000 or 515.4010 c, 1 and 2 for Nursing qualifications and continuing education and <u>submit each of the below.</u></b></p> <p><input type="checkbox"/> Enclosed is a policy that incorporates the nursing qualifications and CE requirements.</p> <p><input type="checkbox"/> Enclosed is a completed <b>CREDENTIALS OF EMERGENCY DEPARTMENT NURSING STAFF</b> Form.</p> <p><input type="checkbox"/> Enclosed is a one-month Nurse staffing schedule for the emergency department.</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 d, 1, for inter-facility transfer and <u>submit the below.</u></b></p> <p><input type="checkbox"/> Enclosed is an interfacility transfer policy that addresses pediatric transfers.</p> <p><input type="checkbox"/> Enclosed is a copy (s) of our current pediatric specific transfer agreements (signed within past 3 years) with hospitals that provide pediatric specialty services, pediatric intensive care and burn care not available at this facility.</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 d, 2, for suspected child abuse and <u>submit one of the below.</u></b></p> <p><input type="checkbox"/> Enclosed is a previously approved policy. There are no changes.</p> <p><input type="checkbox"/> Enclosed is a revised policy for approval</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 d, 3, for treatment guidelines and <u>submit the below.</u></b></p> <p><input type="checkbox"/> Enclosed are all newly developed and revised pediatric guidelines.</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 d, 4, for Latex-free policy and <u>submit the below.</u></b></p> <p><input type="checkbox"/> Enclosed is a copy of our latex-free policy that addresses latex allergies and the availability of latex free equipment and supplies.</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 e, 1, for quality improvement activities and the multidisciplinary quality improvement committee and <u>submit both of the below.</u></b></p> <p><input type="checkbox"/> Enclosed is our quality improvement plan including our QI policy, pediatric indicators, feedback loop and target timeframes for closure of issues.</p> <p><input type="checkbox"/> Enclosed is the composition of our multidisciplinary QI committee.</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 e, 2, for the Pediatric CQI Liaison responsibilities and <u>submit both of the below.</u></b></p> <p><input type="checkbox"/> Enclosed is a curriculum vitae for the Pediatric CQI Liaison</p> <p><input type="checkbox"/> Enclosed is documentation detailing the participation of the Pediatric CQI Liaison in Regional QI activities and how that has impacted pediatric quality care in the ED.</p>	
<p><b>Review the criteria in section 515.4000 or 515.4010 f, for the list of Emergency Department Equipment Requirements and <u>submit the below.</u></b></p> <p><input type="checkbox"/> Enclosed is a completed checklist indicating that all equipment is present.</p> <p>Using the equipment list provided on pages 17-21, place an “X” next to each equipment item that is <b>currently available</b>. If equipment/supply items are not available, a plan for securing the items must be identified, i.e. submission of a purchase order to assure that the item is on order <b>or</b> a waiver must be submitted for each item. <b>Requests for waiver must include the criteria by which compliance is considered to be a hardship and demonstrate how there will be no reduction in the provision of medical care.</b></p> <p><b>Please note: If assistance is needed in identifying specific vendors for any of the equipment or supply items on pages 17-21 of this application, please contact the Marketing Administrator, Group Purchasing Services, Metropolitan Chicago Healthcare Council at 312-906-6122.</b></p>	

**Joint Committee on Administrative Rules**

**ADMINISTRATIVE CODE**

**TITLE 77: PUBLIC HEALTH  
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY  
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE  
SECTION 515.4000 FACILITY RECOGNITION CRITERIA FOR THE EMERGENCY DEPARTMENT  
APPROVED FOR PEDIATRICS (EDAP)**

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**Section 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)**

a) Professional Staff: Physicians

1) Qualifications

Twenty-four hour coverage of the emergency department shall be provided by at least one physician responsible for the care of critically ill or injured children who holds one of the following qualifications:

- A) Certification in emergency medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in emergency medicine and in the first cycle of the board certification process; or
- B) Certification in pediatric emergency medicine by the American Board of Pediatrics/American Board of Emergency Medicine (ABP/ABEM) or residency trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or
- C) Certification by one of the following boards and current American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition or equivalent course.
  - i) Certification in family practice by the American Board of Family Practice (ABFP) or American Osteopathic Board of Family Practice (AOBFP); or
  - ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or
  - iii) Residency trained/board eligible in either family practice or pediatrics and in the first cycle of the board certification process; or
- D) A physician who has received a waiver from the Illinois Department of Public Health based on one of the following criteria:
  - i) An emergency department physician who has already received a waiver in accordance with Section 515.2030(e) or Section 515.2040(f) of this Part; or
  - ii) Completion of 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including 2800 hours within one 24-month period), verified in writing by the hospitals at which the internship and subsequent hours were completed and current AHA-AAP PALS or ACEP-AAP APLS recognition; or
  - iii) Completion of professional activities spent in the practice of pediatric emergency medicine (PEM), over the last 60-month period and totaling a

minimum of 6000 hours, focused on the care of patients in the pediatric age group (<21 years) in the emergency department. Of the 6000 hours, 2800 hours must have been accrued in a 24-month (maximum) consecutive period of time. A minimum of 4000 of the 6000 hours must have been spent in the clinical practice of PEM. (If practiced in general ED, only time spent exclusively in pediatric practice can be used for credit.) The remaining 2000 hours may be spent in either clinical care or a mixture of related non-clinical activities clearly focused on PEM, including administration, teaching, prehospital care, quality improvement, research or other academic activities.

- 2) Continuing Medical Education  
All full- or part-time emergency physicians shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics within a 2-year period.
  - 3) Physician Coverage  
At least one physician meeting the requirements of subsection (a)(1) shall be on duty in the emergency department 24 hours a day.
  - 4) Consultation  
Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation can be with an on-staff physician or in accordance with Appendix M of this Part.
  - 5) Physician Backup  
A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the EDAP within 1 hour after notification to assist with critical situations or disasters.
  - 6) On-Call Physicians  
Protocols shall be established that address maximum response time for on-call physicians.
- b) Professional Staff: Mid-Level Practitioners  
A mid-level practitioner is a nurse practitioner or physician assistant working under the supervision of a physician who meets the qualifications of subsection (a)(1) of this Section.
- 1) Qualifications
    - A) Nurse practitioners shall have:
      - i) Completed a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program, or the Department will grant a waiver based on the following criteria: has completed 2000 hours of hospital-based emergency department or acute care over the last 24-month period that includes the care of the pediatric patient; and
      - ii) An Illinois advanced practice nursing license within one year after employment; and
      - iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.
    - B) Physician assistants shall have:
      - i) Current Illinois licensure (permanent or temporary); and
      - ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.
    - C) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP Pediatric Advanced Life Support (PALS) course, the ACEP-AAP Advanced Pediatric Life Support (APLS) course or the ENA Emergency Nursing Pediatric course (ENPC).
  - 2) Continuing Education

- A) All full- or part-time nurse practitioners shall have documentation of a minimum of 16 hours of approved continuing education units in pediatric emergency topics within a 2-year period.
  - B) All full- or part-time physician assistants shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I) in pediatric emergency topics within a 2-year period. Credit for CME shall be approved by the Accreditation Council on Continuing Medical Education (ACCME), American Osteopathic Association Council on Continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP) or American Academy of Physicians Assistants (AAPA).
- c) Professional Staff: Nursing
- 1) Qualifications
    - A) At least one registered nurse (RN) on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:
      - i) AHA-AAP Pediatric Advanced Life Support (PALS) course;
      - ii) ACEP-AAP Advanced Pediatric Life Support (APLS) course; or
      - iii) ENA Emergency Nursing Pediatric course (ENPC).
    - B) All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months after employment.
  - 2) Continuing Education

All nurses assigned to the emergency department shall have documentation of a minimum of 8 hours of pediatric emergency/critical care continuing education hours within a 2-year period. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; and/or publications. These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric specific.
- d) Policies and Procedures
- 1) Interfacility Transfer

The facility shall have transfer agreements with Pediatric Critical Care Centers (PCCC) and policies/procedures concerning transfer of critically ill and injured patients to PCCCs. Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.
  - 2) Suspected Child Abuse

The facility shall have policies/procedures addressing the identification, evaluation, treatment and referral of victims of suspected child abuse in accordance with State law.
  - 3) Treatment Protocols

The facility shall have protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients (i.e., trauma, respiratory distress, seizures).
  - 4) Latex-free Policy

The facility shall have a policy addressing the availability of latex-free equipment and supplies.
- e) Quality Improvement
- 1) Multidisciplinary Committee
    - A) Pediatric emergency medical care shall be included in the EDAP's emergency department or section quality improvement (QI) program and reported to the hospital QI committee.

- B) Multidisciplinary continuous quality improvement (CQI) activities shall be established with documented CQI monitors addressing pediatric care within the emergency department, with identified clinical indicators and/or outcomes for care. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all pediatric emergency department deaths, resuscitations, and interfacility transfers.
- 2) Pediatric CQI Liaison
- A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated and supported by the hospital as the pediatric liaison. This individual may be employed in an area other than the emergency department and shall have a minimum of 2 years of pediatric critical care or emergency department experience. The responsibilities of the pediatric liaison shall include:
- A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department staff in accordance with subsections (a), (b), and (c) of this Section.
  - B) Maintaining a data summary and working in conjunction with the multidisciplinary CQI committee to coordinate criteria-based review and followup of sample pediatric emergency department visits.
  - C) Coordinating a review of pre-hospital provider transported pediatric cases and providing feedback to the EMS System Coordinator and the EMS Regional Advisory Board.
  - D) Preparing a written CQI report and attending the EMS Regional CQI subcommittee, which activities shall be supported by the hospital. One representative from the CQI subcommittee shall report to the EMS Regional Advisory Board.
  - E) Providing CQI information to the Illinois Department of Public Health upon request. (See Section 3.110(a) of the Act.)
- f) Equipment, Trays, and Supplies  
See Appendix L of this Part.

(Source: Added at 26 Ill. Reg. 18367, effective December 20, 2002)

**Joint Committee on Administrative Rules**

**ADMINISTRATIVE CODE**

**TITLE 77: PUBLIC HEALTH  
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY  
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE  
SECTION 515.4010 FACILITY RECOGNITION CRITERIA FOR THE STANDBY EMERGENCY  
DEPARTMENT APPROVED FOR PEDIATRICS (SEDP)**

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**Section 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)**

- a) Professional Staff: Physicians
  - 1) Qualifications
    - A) All physicians shall have training in the care of pediatric patients through residency training, clinical training, or practice.
    - B) All physicians shall successfully complete and maintain current recognition in the American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) course, or the American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) course or equivalent course. (Physicians who are board certified or eligible in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine (ABP/ABEM) are excluded from this requirement.)
  - 2) Continuing Medical Education

All full- or part-time emergency physicians shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics within a 2-year period.
  - 3) Coverage

At least one physician meeting the requirements of subsection (a)(1) (or physician assistant or nurse practitioner meeting the requirements of subsection (b)(1)) shall be on duty in the emergency department 24 hours a day or immediately available. A policy shall be available that defines when a physician is to be consulted/called in at times when the emergency department is covered by a mid-level provider.
  - 4) Consultation

Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation may be with an on-call physician or in accordance with Appendix M of this Part.
  - 5) Physician Backup

A backup physician whose qualifications and training are equivalent to subsection (a)(1) of this Section shall be available to the SEDP within 1 hour after notification to assist with critical situations or disasters.
  - 6) On-Call Physicians

Protocols shall be available that address maximum response time for on-call physicians.
- b) Professional Staff: Mid-level Practitioners

A mid-level practitioner is a nurse practitioner or physician assistant working under the supervision of a physician who meets the qualifications of subsection (a)(1) of this Section.

  - 1) Qualifications
    - A) Nurse practitioners shall have:



SECTION 515.4010 FACILITY RECOGNITION CRITERIA FOR THE 13  
STANDBY EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (SEDP)

Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.

- 2) Suspected Child Abuse  
The facility shall have policies/procedures addressing the identification, evaluation, treatment and referral of victims of suspected child abuse in accordance with State law.
  - 3) Treatment Protocols  
The facility shall have protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients (i.e., trauma, respiratory distress, seizures).
  - 4) Latex-free Policy  
The facility shall have a policy addressing availability of latex-free equipment and supplies.
- e) Quality Improvement
- 1) Multidisciplinary Committee
    - A) Pediatric emergency medical care shall be included in the SEDP's emergency department or section quality improvement (QI) program and reported to the hospital QI committee.
    - B) Multidisciplinary continuous quality improvement (CQI) activities shall be established with documented CQI monitors addressing pediatric care within the Emergency Department, with identified clinical indicators and/or outcomes for care. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all pediatric emergency department deaths, resuscitations, and interfacility transfers.
  - 2) Pediatric CQI Liaison  
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated and supported by the hospital as the pediatric liaison. This individual may be employed in an area other than the emergency department and shall have a minimum of 2 years of pediatric critical care or emergency department experience. The responsibilities of the pediatric liaison shall include:
    - A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department professional staff in accordance with subsections (a), (b), and (c) of this Section.
    - B) Maintaining a data summary and working in conjunction with the multidisciplinary CQI committee to coordinate criteria-based review and follow-up of sample pediatric emergency department visits.
    - C) Coordinating review of prehospital provider transported pediatric cases and providing feedback to the EMS System Coordinator and the EMS Regional Advisory Board.
    - D) Preparing a written CQI report and attending the EMS Regional CQI subcommittee, which activities shall be supported by the hospital. One representative from the CQI subcommittee shall report to the EMS Regional Advisory Board.
    - E) Providing CQI information to the Illinois Department of Public Health upon request. (See Section 3.110(a) of the Act.)
- f) Equipment, Trays, and Supplies  
See Appendix L of this Part.

(Source: Added at 26 Ill. Reg. 18367, effective December 20, 2002)

**ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN  
EDAP or SEDP RENEWAL APPLICATION  
CREDENTIALS OF EMERGENCY DEPARTMENT PHYSICIANS**

- List each physician by name.
- Indicate full time or part time and date of ED hire.
- Check all credentials that qualify physician for EDAP or SEDP status.
- Identify any physicians that may have received a waiver from IDPH.
- For all physicians who do not meet any of the Board Certifications listed below and do not have a waiver, submit CV, other Board Certifications and copies of their Residency Completion.
- Identify completion of APLS or PALS.
- Write the number of pediatric CME hours that have been completed within the past 2 years.

Physician Name	F=Full Time P=Part Time	Date of ED Hire	Certification * (Or Board Eligible in 1 <sup>st</sup> cycle) ABEM, AOBEM, ABP, AOBP, ABFP or AOBFP (Identify if waiver requested/obtained)	Exp. Date	Course Completion		Exp. Date	16 HRS. of Pediatric Emergency related CME (In last two years)
	APLS				PALS			
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

\_\_\_\_\_  
Signature  
Hospital CEO/Administrator

\_\_\_\_\_  
Typed Name  
Hospital CEO/Administrator

\_\_\_\_\_  
Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

**ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN  
EDAP or SEDP RENEWAL APPLICATION  
CREDENTIALS OF EMERGENCY DEPARTMENT MID LEVEL PROVIDERS**

- List each Mid Level Provider by name.
- Indicate full time or part time and date of ED hire.
- Check all credentials and verify current license.
- Nurse Practitioners shall have completed a Pediatric NP, Emergency NP or Family Practice NP program (or meet waiver criteria identified in 515.4000 or 515.4010, b, l, A, i).
- Identify completion of APLS, PALS or ENPC.
- Write the number of pediatric CME/CEU that have been completed within the past 2 years.

Provider Name	F=Full Time P=Part Time	Date of ED Hire	License Verification * NP = Illinois Advanced Practice License (PNP, ENP, FPNP) PA = Illinois License	Exp. Date	Facility Credentialing For Pediatric Care	Course Completion			Exp. Date	Pediatric Emergency CME/CEU ** (In Last Two Years) EDAP – 16 Hours SEDP – 20 Hours
					APLS	PALS	ENPC			
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

\_\_\_\_\_  
Signature  
Hospital CEO/Administrator

\_\_\_\_\_  
Typed Name  
Hospital CEO/Administrator

\_\_\_\_\_  
Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

\*\* Physician Assistant CME's must be from ACCME, AOCCME, AAFP or AAPA

**ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN  
EDAP or SEDP RENEWAL APPLICATION  
CREDENTIALS OF EMERGENCY DEPARTMENT NURSING STAFF**

- List each staff nurse by name.
- Indicate full time or part time and date of ED hire.
- Identify completion of APLS, PALS or ENPC.
- Write the number of pediatric CEU's that have been completed within the past 2 years.

Staff Nurse	F=Full Time P=Part Time	Date of ED Hire	Course Completion			Expiration Date	8 HRS. of Pediatric Emergency/Critical Care CEU's (In Last Two Years) EDAP – All RN's SEDP – One RN/Shift
			APLS	PALS	ENPC		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

\_\_\_\_\_  
Signature  
Hospital CEO/Administrator

\_\_\_\_\_  
Typed Name  
Hospital CEO/Administrator

\_\_\_\_\_  
Date

(Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.)

## Illinois EMSC Facility Recognition

### Pediatric Equipment Recommendations for Emergency Departments

The following list identifies pediatric equipment items that are recommended for the two emergency department facility recognition levels, Emergency Department Approved for Pediatrics (EDAP) and Standby Emergency Department for Pediatrics (SEDP). Equipment items are all classified as **ESSENTIAL "E"**. In addition, each equipment item should be stocked in the **EMERGENCY DEPARTMENT (ED)**.

\* **Must minimally stock the full range of each commonly available size noted or comparable size.**

<b>MONITORING DEVICES</b>	<b>EDAP</b>	<b>Check if present in EDAP</b>	<b>SEDP</b>	<b>Check if present in SEDP</b>
Blood glucose measurement device (i.e. chemistry strip or glucometer)	E (ED)		E (ED)	
Doppler ultrasound blood pressure device (neonatal – adult thigh cuffs)	E (ED)		E (ED)	
ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles, with pediatric dosage settings and pediatric-adult packing electrodes	E (ED)		E (ED)	
Pediatric monitor electrodes	E (ED)		E (ED)	
End-tidal PCO2 monitor and/or pediatric CO2 detector (disposable units may be substituted)	E (ED)		E (ED)	
Otoscope/ophthalmoscope/stethoscope	E (ED)		E (ED)	
Pulse oximeter with pediatric adapter	E (ED)		E (ED)	
Sphygmomanometer with cuffs (neonatal – adult thigh)	E (ED)		E(ED)	
Hypothermia Thermometer (NOTE: with a range of 28-42° C)	E (ED)		E (ED)	
<b>VASCULAR ACCESS SUPPLIES AND EQUIPMENT</b>	<b>EDAP</b>	<b>Check if present in EDAP</b>	<b>SEDP</b>	<b>Check if present in SEDP</b>
Arm boards (sized infant through adult)	E (ED)		E (ED)	
Blood gas kits	E (ED)		E (ED)	
Butterfly type needles (19-25 g) *	E (ED)		E (ED)	
Catheter-over-needle devices (16-24 g)*	E (ED)		E (ED)	
Infusion pumps, drip or volumetric, with microinfusion capability, appropriate tubing & connectors	E (ED)		E (ED)	
Intraosseous needles or bone marrow needles (13 – 18 g size range) - stock one large and one small bore	E (ED)		E (ED)	
IV administration sets with calibrated chambers, extension tubing, stopcocks, & T-connectors	E (ED)		E(ED)	
IV fluid/blood warmer	E (ED)		E (ED)	
IV solutions: standard crystalloid and colloid solutions (D10W, D5/.2 NS, D5/.45 NS and 0.9 NS)	E (ED)		E (ED)	

Single or multiple lumen vascular access supplies utilizing the Seldinger technique (stock one small and one large size)	E (ED)		E (ED)	
Syringes (TB, Insulin U100, 1ml – 20ml)	E (ED)		E (ED)	
Tourniquets	E (ED)		E (ED)	
Umbilical vein catheters (3.5 and 5 Fr; The same size feeding tube may be used for 5 Fr)*	E (ED)		E (ED)	
<b>RESPIRATORY EQUIPMENT AND SUPPLIES</b>	<b>EDAP</b>	Check if present in EDAP	<b>SEDP</b>	Check if present in SEDP
Bag-valve-mask device, self-inflating infant/child and adult (1000 ml) with O <sub>2</sub> reservoir and clear masks (neonatal through large adult sizes)* ; PEEP valve and manometer	E (ED)		E(ED)	
Bulb syringe	E (ED)		E(ED)	
Cricothyrotomy capabilities (i.e. 10 g needle and 3 mm ET tube adapter or 14 g needle and 3.5 mm ET tube adapter) or cricothyrotomy kit	E (ED)		E (ED)	
Endotracheal Tubes:				
Uncuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)	E (ED)		E (ED)	
Cuffed (sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0)	E (ED)		E (ED)	
Stylets for endotracheal tubes (pediatric and adult)	E (ED)		E (ED)	
Laryngoscope handle (pediatric and adult)	E (ED)		E (ED)	
Laryngoscope blades (Curved 2,3; Straight or Miller 0, 1, 2, 3)*	E (ED)		E (ED)	
Magill forceps (pediatric and adult)	E (ED)		E (ED)	
Meconium Aspirator	E (ED)		E (ED)	
Nasopharyngeal airways (sizes 12, 16, 20, 24, 28, 30 Fr)*	E (ED)		E (ED)	
Nebulized medication, administration set with pediatric and adult masks	E (ED)		E (ED)	
Oral airways (sizes 0, 1, 2, 3, 4, 5 or size 50mm, 60mm, 70mm, 80mm, 90mm, 100mm)*	E (ED)		E (ED)	
Oxygen delivery device with flow meter and tubing	E (ED)		E (ED)	
Oxygen delivery adjuncts:				
Tracheostomy collar	E (ED)		E (ED)	
Partial non-rebreather masks, clear (pediatric and adult sizes)	E (ED)		E (ED)	
Nasal cannula (pediatric and adult)	E (ED)		E (ED)	
Nasal cannula (infant)	E (ED)		E (ED)	
Peak flow meter	E (ED)		E(ED)	

Suction capability (wall)	E (ED)		E (ED)	
Suction capability (portable)	E (ED)		E (ED)	
Suction catheters (sizes 6, 8, 10, 12, 14, 16 Fr and Yankauer-tip catheter)*	E (ED)		E(ED)	
Tracheostomy tubes (sizes PED* 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)* (Correspond to PT 00, 0, 1, 2, 3, 4 in old schematization)	E (ED)		- -	
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 12-32 Fr)*	E (ED)		- -	
<b>MEDICATIONS (unit dose, prepackaged)</b>	<b>EDAP</b>	Check if present in EDAP	<b>SEDP</b>	Check if present in SEDP
Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number in ED	E (ED)		E (ED)	
Activated charcoal (Consider with and without Sorbitol)	E (ED)		E (ED)	
Adenosine	E (ED)		E (ED)	
Amiodarone	E (ED)		E (ED)	
Antipyretics	E (ED)		E (ED)	
Atropine	E (ED)		E (ED)	
Barbiturates	E (ED)		E (ED)	
Benzodiazepines	E (ED)		E (ED)	
Beta agonist for inhalation (Albuterol, Levalbuterol)	E (ED)		E (ED)	
Beta blockers	E (ED)		E (ED)	
Calcium (chloride or gluconate)	E (ED)		E (ED)	
Dexamethasone	E (ED)		E (ED)	
Dextrose (25% and 50%)	E (ED)		E (ED)	
Diphenhydramine	E (ED)		E (ED)	
Dobutamine	E (ED)		- - -	
Dopamine	E (ED)		- - -	
Epinephrine (1:1,000 and 1:10,000)	E (ED)		E (ED)	
Epinephrine (Racemic)	E (ED)		E (ED)	
Furosemide	E (ED)		E (ED)	

Glucagon or Glucose Paste	E (ED)		E (ED)	
Hydrocortisone	E (ED)		E (ED)	
Insulin, regular	E (ED)		E (ED)	
Lidocaine 1%	E (ED)		E (ED)	
Magnesium Sulfate	E (ED)		E (ED)	
Mannitol	E (ED)		E (ED)	
Methylprednisolone	E (ED)		E (ED)	
Narcotics	E (ED)		E (ED)	
Neuromuscular blocking agents (i.e. succinylcholine, rocuronium, vecuronium)	E (ED)		E (ED)	
Ocular anesthetics	E (ED)		E (ED)	
Phenytoin and/or Fosphenytoin	E (ED)		E (ED)	
<u>Poison Specific Antidotes</u>				
Cyanide kit (amyl nitrate, sodium nitrate, sodium thiosulfate)	E (ED)		E (ED)	
Flumazenil	E (ED)		E (ED)	
Naloxone	E (ED)		E (ED)	
Procainamide	E (ED)		E (ED)	
Sodium bicarbonate – 8.4% and 4.2%	E (ED)		E (ED)	
Sedative/Hypnotic (i.e. Thiopental, Ketamine, Etomidate, Midazolam)	E (ED)		E (ED)	
Tetanus Immune Globulin (Human)	E (ED)		E (ED)	
Tetanus Vaccines – (Single or in combination with other vaccines)	E (ED)		E (ED)	
<b>MISCELLANEOUS EQUIPMENT</b>	<b>EDAP</b>	Check if present in EDAP	<b>SEDP</b>	Check if present in SEDP
Dosing device - length or weight based system for dosing and equipment	E (ED)		E(ED)	
Dosing/equipment chart by weight	E (ED)		E (ED)	
EMS communication equipment (i.e. telemetry, MERCI, cellular or dedicated phone)	E (ED)		E (ED)	
Examination gloves, disposable	E (ED)		E (ED)	
Feeding tubes (8 Fr) *	E (ED)		E (ED)	

Fluorescein (Eye strips)	E (ED)		E (ED)	
Gastric lavage equipment	E (ED)		E(ED)	
Infant formulas, dextrose in water with various nipple sizes	E (ED)		E (ED)	
Lubricant, water soluble	E (ED)		E (ED)	
Nasogastric tubes (8-18 Fr)*	E (ED)		E (ED)	
Oral rehydrating solution	E (ED)		E (ED)	
Pediatric emergency cart or bag with defined list of contents attached to bag/cart	E (ED)		E (ED)	
Restraining device, pediatric (papoose)	E (ED)		E (ED)	
Resuscitation board	E (ED)		E(ED)	
Urinary catheters (8-22 Fr)*	E (ED)		E (ED)	
Warming devices, age appropriate	E (ED)		E (ED)	
Weighing scales for infant and adult	E (ED)		E (ED)	
Woods lamp (Blue light)	E (ED)		E (ED)	
<b>SPECIALIZED PEDIATRIC TRAYS</b>	<b>EDAP</b>	Check if present in EDAP	<b>SEDP</b>	Check if present in SEDP
Lumbar puncture capability (20-25 g, 1-1/2 inch needle)	E (ED)		E (ED)	
Minor surgical instruments and sutures	E (ED)		E (ED)	
Newborn kit/OB kit	E (ED)		E (ED)	
<b>FRACTURE MANAGEMENT DEVICES</b>	<b>EDAP</b>	Check if present in EDAP	<b>SEDP</b>	Check if present in SEDP
Extremity splints	E (ED)		E(ED)	
Femur splint (child and adult)	E (ED)		E (ED)	
Semi-rigid neck collars (child through adult) or cervical immobilization equipment suitable for children	E (ED)		E (ED)	
Spinal immobilization board (child and adult)	E (ED)		E (ED)	

**NOTE: LATEX-FREE SUPPLIES SHOULD BE AVAILABLE WHENEVER POSSIBLE  
(Refer to EMS System Latex-Free policy)**

\*Must minimally stock the full range of each commonly available size noted or comparable size.

**Joint Committee on Administrative Rules**

**ADMINISTRATIVE CODE**

**TITLE 77: PUBLIC HEALTH  
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY  
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE  
SECTION 515.APPENDIX M INTERFACILITY PEDIATRIC TRAUMA AND CRITICAL CARE  
CONSULTATION AND/OR TRANSFER GUIDELINE**

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**Section 515.APPENDIX M Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline**

Introduction

Most ill and injured children can be successfully managed by pediatricians, emergency physicians, and other community physicians in local hospitals. However, certain types of severely ill or injured children may require specialized pediatric critical care services or specialized trauma services that are not generally available in local hospitals.

Referral centers that provide specialized pediatric critical care services or specialized trauma services for pediatric patients should be identified by local EMS agencies and included as integral components of their pediatric emergency and critical care systems and trauma care systems. The specialized referral centers provide 24-hour telephone consultation to assist community physicians in the evaluation and management of critically ill and injured children. In addition, most of these referral centers provide pediatric interfacility transport services to facilitate the transport of critically ill or injured children to specialized centers when indicated.

Decisions on when to seek consultation or to transfer pediatric patients need to be individualized, based on local needs and resources. However, children with certain categories of critical illness and injury are at high risk of death and disability. Early consultation with appropriate pediatric critical care or trauma specialists and rapid transport to specialized referral centers, when indicated, can improve the outcomes for these children. In particular, consultation should be sought for pediatric medical, surgical, and trauma patients who require intensive care when it is not locally available.

The attached guidelines are intended for use in a number of ways:

- They can be used by physicians and hospitals to identify the types of critically ill or injured children who might benefit from consultation with critical care or trauma specialists or transfer to specialized referral centers. It is recommended that hospitals and their medical staffs develop appropriate policies, procedures and staff education programs based on these guidelines. This will help to promote consultation, minimize delays, and facilitate appropriate, rapid and efficient transport of critically ill and injured children to specialty centers, when indicated.
- It is recommended that these guidelines also be used by local EMS agencies as a basis for the development of pediatric consultation and transfer guidelines based on the local needs and resources. Consultation and transfer guidelines should be integrated into local EMS agency plans for pediatric emergency, critical care, and trauma care in each region. These guidelines should become specific EMS policies and procedures in order to promote appropriate consultation and transfer of children who require specialized pediatric critical care and/or trauma services.

The following guidelines are intended to assist physicians and hospitals to identify the types of critically ill and injured children who might benefit from consultation with pediatric critical care specialists or trauma specialists and transfer to specialized pediatric critical care or trauma centers, when indicated. If an interfacility transport is required, the referring physician, in consultation with the receiving physician, should determine the method of transport and appropriate personnel to accompany the child.

Consultation with pediatric medical and surgical specialists at a pediatric tertiary care center or trauma specialists at a trauma center should occur as soon as possible after evaluation of the patient. It is recommended that each hospital and its medical staff develop appropriate emergency department and inpatient guidelines, policies and procedures for obtaining consultation and arranging transport, when indicated, for the following types of pediatric medical and trauma patients.

- I. Guidelines for Interfacility Consultation and/or Transfer for Evaluation of Pediatric Medical Patients (Non-trauma)

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status
2. Severe respiratory distress responding inadequately to treatment and accompanied by any one of the following:
  - a. Cyanosis
  - b. Retractions (moderate to severe)
  - c. Apnea
  - d. Stridor (moderate to severe)
  - e. Grunting or gasping respirations
  - f. Status asthmaticus
  - g. Respiratory failure
3. Children requiring endotracheal intubation and/or ventilatory support
4. Serious cardiac rhythm disturbances
5. Status post cardiopulmonary arrest
6. Heart failure
7. Shock responding inadequately to treatment
8. Children requiring any one of the following:
  - a. Arterial pressure monitoring
  - b. Central venous pressure or pulmonary artery monitoring
  - c. Intracranial pressure monitoring
  - d. Vasoactive medications
9. Severe hypothermia or hyperthermia
10. Hepatic failure
11. Renal failure, acute or chronic requiring immediate dialysis

B. Other Criteria

1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems
2. Status epilepticus
3. Potentially dangerous envenomation
4. Potentially life-threatening ingestion of, or exposure to, a toxic substance
5. Severe electrolyte imbalances
6. Severe metabolic disturbances
7. Severe dehydration
8. Potentially life-threatening infections, including sepsis

9. Children requiring intensive care
10. Any child who may benefit from consultation with, or transfer to, a pediatric critical care center

II. Guidelines for Interfacility Consultation and/or Transfer for Evaluations of Pediatric Trauma Patients

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status
2. Respiratory distress or failure
3. Children requiring endotracheal intubation and/or ventilatory support
4. Shock, compensated or uncompensated
5. Injuries requiring any blood transfusion
6. Children requiring any one of the following:
  - a. Arterial pressure monitoring
  - b. Central venous pressure or pulmonary artery monitoring
  - c. Intracranial pressure monitoring
  - d. Vasoactive medications

B. Anatomic Criteria

1. Fractures and deep penetrating wounds to an extremity complicated by neurovascular or compartment injury
2. Fracture of 2 or more major long bones (i.e., femur, humerus)
3. Fracture of the axial skeleton
4. Spinal cord or column injuries
5. Traumatic amputation of an extremity with potential for replanation
6. Head injury when accompanied by any of the following:
  - a. Cerebrospinal fluid leaks
  - b. Open head injuries (excluding simple scalp injuries)
  - c. Depressed skull fractures
  - d. Decreased level of consciousness
7. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis
8. Major pelvic fractures
9. Significant blunt injury to the chest or abdomen

C. Other Criteria

1. Children requiring intensive care
2. Any child who may benefit from consultation with, or transfer to, a trauma center or a pediatric critical care center

D. Burn Criteria (Thermal or Chemical) – Contact should be made with a burn center for children who meet any one of the following criteria:

1. Partial thickness burns of greater than 10% total body surface area (TBSA)
2. Third degree burns in any age group
3. Burns involving:
  - a. Signs or symptoms of inhalation injury
  - b. Respiratory distress
  - c. The face
  - d. The ears (serious full-thickness burns or burns involving the ear canal or drums)
  - e. The mouth and throat
  - f. The hands, feet, genitalia, major joints or perineum
4. Electrical burns (including lightning injury)
5. Chemical burns
6. Burns associated with trauma or complicating medical conditions
7. Burned children in hospitals without qualified personnel or equipment for the care of children
8. Burn injury in patients who will require special social, emotional, or long-term rehabilitative information

(Source: Added at 26 Ill. Reg. 18367, effective December 20, 2002)

## PEDIATRIC BILL OF RIGHTS\*

All children have a right to the following:

- Ask to have a parent or another adult stay with them during their examination
- Tell their caregiver when and where something hurts
- Ask questions if they don't understand a medical procedure or what's happening to them
- Choose which ear should be looked at first or which arm to have a shot in
- Ask for something to ease their pain
- Listen to music, play a game, or read a book to help distract them during medical procedures
- Cry, laugh, or be mad if it helps them feel better

\* Source: Association for the Care of Children's Health (ACCH)