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# Revisions to the EDAP & SEDP Rules and Regulations

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Illinois  
Emergency Medical Services  
for Children



January 2012

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***Revisions to the EDAP and SEDP Rules and Regulations***  
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**Illinois Emergency Medical Services for Children**  
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Revisions to the Pediatric Facility Recognition sections of the Illinois EMS Administrative Code were approved by the Joint Committee on Administrative Rules (JCAR) in November 2011. A finalized code copy of the revised rules was subsequently released in December 2011. In an effort to provide clarification and guidance, this document was developed to outline the revisions specific to the Emergency Department Approved for Pediatrics (EDAP) and Standby Emergency Department Approved for Pediatrics (SEDP) requirements/criteria. The table below contains the original rules language, with the new changes as denoted by:

- **Yellow** font and underlined text indicate new language which has been added to the rules.
- A strike-out (i.e. ~~strike-out~~) indicates language which has been deleted from the rules.

Any questions regarding these changes can be directed to [Evelyn.Lyons@illinois.gov](mailto:Evelyn.Lyons@illinois.gov) or [Paula.Atteberry@illinois.gov](mailto:Paula.Atteberry@illinois.gov).

Administrative Code Section	EMS Administrative Code, Section 515.4000 Emergency Department Approved for Pediatrics (EDAP)	Guidance
<p>a) Professional Staff: <b>Physicians</b></p> <p><u>Qualifications</u></p>	<p>a, 1. Physician 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:</p> <p>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</p> <p>B) <u>Sub-board Certification</u> certification in pediatric emergency medicine by the American Board of Pediatrics (ABP) <del>or the American Board of Emergency Medicine (ABP/ABEM)</del> or residency trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or</p> <p>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. <u>PALS and APLS courses shall include both cognitive and practical skills evaluation.</u> <del>or equivalent course.</del></p> <p>i) Certification in family practice by the American Board of Family Practice (ABFP) or American Osteopathic Board of Family Practice (AOBFP); or</p> <p>ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or</p> <p>iii) Residency trained/board eligible in either family practice or pediatrics and in the first cycle of the board certification process; or</p>	<p>Sub-board certification is a more accurate term to utilize, so it replaces certification. It does not represent a change in this requirement.</p> <p>Acronyms are fully spelled out once, after which only the acronym is used in the rules.</p> <p>PALS and APLS are standardized professional courses that include both cognitive and practical skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4000 Emergency Department Approved for Pediatrics (EDAP)	Guidance
	<p>D) A physician who has received a waiver from the Illinois Department of Public Health based on one of the following criteria. Physicians shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements.:</p> <ul style="list-style-type: none"> <li>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 and has current AHA-AAP PALS or ACEP-AAP APLS recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation; or</li> <li>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. PALS and APLS courses shall include both cognitive and practical skills evaluation; or</li> <li>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 pediatric patients in the pediatric age group (&lt;21 years) in the emergency department, and current AHA-AAP PALS or ACEP-AAP APLS recognition (PALS and APLS courses shall include both cognitive and practical skills evaluation). 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.</li> </ul>	<p>Waivers are temporary in nature. This language has been added to identify the timeframe for renewal of a waiver (as applicable).</p> <p>PALS and APLS are standardized professional courses that include both cognitive and practical skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>
<p>a) Professional Staff: Physicians</p> <p><u>Continuing Medical Education</u></p>	<p>a, 2. Continuing Medical Education All full- or part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years, within a 2-year period. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e. Category I) or informal CME programs (i.e. Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.</p>	<p>As more emergency departments add fast track and urgent care areas, it is important to assure that fast track physicians caring for children keep current in pediatric emergency medicine and maintain similar pediatric educational hours. Physicians assigned to these areas now need to also maintain 16 hours of pediatric CME every two years.</p> <p>Language has been added to clarify acceptable forms of continuing medical education. The Illinois Department of Financial &amp; Professional Regulation can also serve as a resource.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4000 Emergency Department Approved for Pediatrics (EDAP)	Guidance
a) Professional Staff: <b>Physicians</b>  <u>Physician Coverage</u>	a, 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.	No changes were made to this section
a) Professional Staff: <b>Physicians</b>  <u>Consultation</u>	a, 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.	No changes were made to this section
a) Professional Staff: <b>Physicians</b>  <u>Physician Backup</u>	a, 5. Physician Backup A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the EDAP within <u>one</u> 4 hour after notification to assist with critical situations, <u>increased surge capacity</u> or disasters.	An increased surge is another indication in which a back-up physician may be needed. The hospital policy that addresses the back-up physician requirement now needs to include the process for securing a back-up physician during an increased patient surge.
a) Professional Staff: <b>Physicians</b>  <u>On-Call Physicians</u>	a, 6. On-Call Physicians <u>Guidelines</u> <del>Protocols</del> shall be established that address <u>on-site</u> <del>maximum</del> response time for on-call physicians.	The response time descriptor in this section has been changed to be more specific and requires guidelines as to when on-call physicians are expected to be available on-site.
b) Professional Staff: <b>Mid-Level Practitioners</b>  <u>Qualifications</u>	b, 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 <u>as a nurse practitioner</u> over the last 24-month period that includes the care of the pediatric patient ( <u>nurse practitioners shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements;</u> and ii) <u>Current</u> <del>An Illinois advanced practice nursing license within one year after employment;</del> 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 ( <del>permanent or temporary</del> ); and ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.	Waivers are temporary in nature. This language has been added to identify the timeframe for renewal of a waiver (as applicable).  When the EDAP rules were originally adopted, Illinois had also recently adopted new APN license requirements, so a one year timeframe for obtaining an APN license was allowed at that time. Nurse practitioners are now expected to have a current APN license at the time of employment.  Physician assistants are now required to have a current license versus a temporary license.  PALS and APLS are standardized professional courses that include both cognitive and practical

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	<p>C) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP <del>Pediatric Advanced Life Support (PALS) course</del>, the ACEP-AAP <del>Advanced Pediatric Life Support (APLS) course</del> or the <u>Emergency Nurses Association (ENA) Emergency Nursing Pediatric course (ENPC)</u>. <u>PALS, APLS and ENPC courses shall include both cognitive and practical skills evaluation.</u></p>	<p>skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>
<p>b) Professional Staff: <b>Mid-Level Practitioners</b></p> <p><u>Continuing Education</u></p>	<p>b, 2. Continuing Education</p> <p>A) All full- or part-time nurse practitioners shall have documentation of a minimum of 16 hours of <del>approved</del> continuing education in pediatric emergency topics <u>every two years that are approved by an accrediting agency within a 2-year period.</u></p> <p>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 <u>every two years, within a 2-year period.</u> Credit for CME shall be approved by <u>an accrediting agency</u>, 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 Physician Assistants (AAPA).</p>	<p>The rules have been amended to no longer name specific accrediting agencies. There are numerous accrediting agencies that are responsible for approving professional educational hours for mid-level practitioners.</p>
<p>c) Professional Staff: <b>Nursing</b></p> <p><u>Qualifications</u></p>	<p>c, 1. Qualifications</p> <p>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:</p> <ul style="list-style-type: none"> <li>i) AHA-AAP <del>Pediatric Advanced Life Support (PALS) course</del>;</li> <li>ii) ACEP-AAP <del>Advanced Pediatric Life Support (APLS) course</del>; or</li> <li>iii) ENA <del>Emergency Nursing Pediatric course (ENPC)</del>.</li> </ul> <p>B) All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months after employment. <u>PALS, APLS and ENPC courses shall include both cognitive and practical skills evaluation.</u></p>	<p>PALS and APLS are standardized professional courses that include both cognitive and practical skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>
<p>c) Professional Staff: <b>Nursing</b></p> <p><u>Continuing Education</u></p>	<p>c, 2. Continuing Education</p> <p>All nurses assigned to the emergency department shall have documentation of a minimum of 8 hours of pediatric emergency/critical care continuing education hours <u>every two years, within a 2-year period.</u> 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.</p>	<p>The language “within a 2-year period” has been changed to “every two years” to be more consistent with verbiage defined by IDPH Legal Services.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4000 Emergency Department Approved for Pediatrics (EDAP)	Guidance
d) Guidelines, Policies and Procedures	<p>d, 1. <del>Inter-facility</del> <u>Interfacility</u> Transfer</p> <p>The <u>hospital facility</u> shall have <u>current</u> transfer agreements <u>that cover pediatric patients. The transfer agreement shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.</u> <del>with Pediatric Critical Care Centers (PCCC)</del></p> <p><u>The hospital facility shall have written pediatric inter-facility transfer guidelines/ and policies/procedures concerning transfer of critically ill and injured patients, which include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral institution information to family.</u> <del>to PCCCs.</del> Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.</p> <p>d, 2. Suspected Child Abuse <u>and Neglect</u></p> <p>The <u>hospital facility</u> shall have policies/procedures addressing <u>child abuse and neglect.</u> <del>abuse.</del> <u>These policies/procedures shall include, but not be limited to:</u> the identification (including screening), evaluation, treatment and referral <u>to the Department of Children and Family Services (DCFS)</u> of victims of suspected child abuse <u>and neglect</u> <del>abuse</del> in accordance with State law.</p> <p>d, 3. Treatment <u>Guidelines</u> <del>Protocols</del></p> <p>The <u>hospital facility</u> shall have <u>guidelines or policies addressing initial response and assessment for its high volume and high risk pediatric population</u> <del>protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients (i.e., fever, trauma, respiratory distress, seizures).</del></p> <p>d, 4. Latex-free <u>Allergy</u> Policy</p> <p>The <u>hospital facility</u> shall have a policy addressing the <u>assessment of latex allergies and the</u> availability of latex-free equipment and supplies.</p> <p>d, 5. <u>Disaster Preparedness</u></p> <p><u>The hospital shall integrate pediatric components into its hospital Disaster/Emergency Operations Plan.</u></p>	<p>Hospitals that receive pediatric transfers are responsible for assuring that the transfer agreements they develop with transferring hospitals address communication and QI measures as noted in the revised language. EMSC template feedback forms may be used as a resource. This feedback/QI should be defined by the referral and receiving hospitals, including:</p> <ul style="list-style-type: none"> <li>▪ All hospitals should maintain a transfer log.</li> <li>▪ Receiving hospitals should provide feedback on transferred cases, particularly those in which there were any quality, clinical or safety related issues. Additional feedback processes are encouraged such as de-identified case presentations or transfer feedback at regional QI meetings</li> <li>▪ Referral hospitals should have a QI review process in place.</li> </ul> <p>The inter-facility guidelines/policies requirement has been revised to assure compliance with National EMSC standards. Additional components (as outlined in the new rule language) need to be included in the ED transfer guidelines/policies.</p> <p>Neglect has been added to the child abuse requirement since mandated reporters are required to report suspected abuse as well as suspected neglect. The other addition to this requirement is the need to include screening processes to policies/procedures.</p> <p>The term "treatment guidelines" now replaces "protocols" since they guide care and may be superseded based on physician judgment or the clinical condition of the child. The description of these guidelines was also revised to provide more clarity since the previous description was sometimes misunderstood.</p> <p>The hospital Latex policy should now also include information on assessment of latex allergies.</p> <p>Pediatric components are now required to be included in hospital disaster planning. The EMSC Hospital Pediatric Preparedness Checklist can be used to guide/assist in this process.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4000 Emergency Department Approved for Pediatrics (EDAP)	Guidance
e) Quality Improvement	<p>e, 1. Multidisciplinary <u>Quality Activities</u> Committee</p> <p>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 <u>Quality QI</u> committee.</p> <p>B) Multidisciplinary <u>continuous</u> quality improvement (CQI) <u>processes/activities</u> shall be established (e.g., <u>committee, task force</u>).</p> <p>C) <u>Quality with documented CQI monitors shall be documented that address</u> 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, <u>resuscitations, and inter-facility interfacility transfers, child abuse and neglect cases, critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure) and pediatric strategic priorities of the institution.</u></p> <p>D) <u>All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC, EDAP or SEDPs pediatric services pursuant to this Section shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure (Section 3-110 (a) of the Act).</u></p>	<p>The header for this section was broadened to cover quality activities versus a committee.</p> <p>A new required QI monitor (child abuse and neglect cases) has been added to the rules. This monitor should minimally assure compliance with the hospital/ED Child Abuse and Neglect policy (refer to d, 2 of these rules).</p> <p>In the past, hospitals expressed uncertainty regarding what constitutes “resuscitation”. This monitor requirement has been revised to provide more clarity. Resuscitation has been replaced with the following language: “critically ill or injured children in need of stabilization”; and various examples are provided.</p> <p>Note that ED pediatric deaths and interfacility transfers as well as participation in the regional quality monitor(s) are still required. Other pediatric quality monitors can be considered based on the pediatric strategic priorities of the hospital.</p> <p>To address the protection afforded to quality improvement activities, the specific section of the Code of Civil Procedure has been cited in these revised EDAP rules.</p>
e) Quality Improvement	<p>e,2. <u>Pediatric Physician Champion</u></p> <p><u>The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.</u></p>	<p>A requirement for a physician champion has been added to assure compliance with National EMSC standards. Since enhancing pediatric emergency care capabilities requires a multi-disciplinary approach, securing a physician advocate can assist in this process. Note that the physician champion does not need to be an ED physician. Other physicians can serve in this role including an on-staff pediatrician or family practice physician or a hospitalist.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4000 Emergency Department Approved for Pediatrics (EDAP)	Guidance
e) Quality Improvement	<p>e, 3. Pediatric <b>Quality Coordinator</b> <del>CQI-Liaison</del></p> <p>A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated <b>to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital.</b> <del>supported by the hospital as the pediatric liaison.</del> This individual may be employed in an area other than the emergency department and shall have a minimum of <del>two</del> 2 years of pediatric critical care or emergency department experience. The responsibilities of the pediatric <b>quality coordinator, working with the Pediatric Physician Champion,</b> <del>liaison</del> shall include:</p> <p>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.</p> <p>B) <b>Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C) of this Section).</b> <del>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.</del></p> <p>C) <b>Reviewing selected pediatric cases transported to the hospital by prehospital providers and providing feedback to the EMS Coordinator/System.</b> <del>Coordinating a review of pre-hospital provider transported pediatric cases and providing feedback to the EMS System Coordinator and the EMS Regional Advisory Board.</del></p> <p>D) <b>Participating in regional QI activities, including preparing</b> <del>Preparing</del> a written CQI report and attending the EMS Regional CQI subcommittee meetings. <del>These ,which</del> activities shall be supported by the hospital. One representative from the <b>Regional</b> <del>CQI</del> subcommittee shall report to the EMS Regional Advisory Board.</p> <p>E) Providing CQI information to the <del>Illinois</del> Department of Public Health upon request. (See Section 3.110(a) of the Act.)</p>	<p>The term "Pediatric CQI Liaison" was originally adopted from the California EDAP model, however over time it was felt that this term did not fully capture the role of these individuals in our state. The title has been changed to Pediatric Quality Coordinator, so this term should replace Pediatric CQI Liaison in any hospital or ED policies/job descriptions.</p> <p>Although the previous language identified that the hospital needed to support the individual in the Pediatric Quality Coordinator role, it was felt that developing a job description would serve to further assure the allocation of time, resources and support. Job responsibilities can be incorporated into an already existent job description, or a new job description can be developed.</p> <p>The Pediatric Quality Coordinator should work with the Physician Champion, particularly when a physician perspective is needed related to quality improvement or educational issues or when physician buy-in on a project/activity is needed.</p> <p>Responsibilities B, C and D were revised to provide more clarity and do not represent a change in these requirements.</p>

Please note that the next several pages will outline changes to the Standby Emergency Department Approved for Pediatric (SEDP) requirements

Administrative Code Section	EMS Administrative Code, Section 515.4010 Standby Emergency Department Approved for Pediatrics (SEDP)	Guidance
<p>a) Professional Staff: Physicians</p> <p><u>Qualifications</u></p>	<p>a, 1. Qualifications</p> <p>A) All physicians shall have training in the care of pediatric patients through residency training, clinical training, or practice.</p> <p>B) All physicians shall successfully complete and maintain current recognition in the <del>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.</del> (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.) <u>PALS and APLS courses shall include both cognitive and practical skills evaluation.</u></p>	<p>Acronyms are fully spelled out once, after which only the acronym is used in the rules.</p> <p>PALS and APLS are standardized professional courses that include both cognitive and practical skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>
<p>a) Professional Staff: Physicians</p> <p><u>Continuing Medical Education</u></p>	<p>a, 2. Continuing Medical Education</p> <p>All full- <u>and</u> or part-time emergency physicians <u>caring for children in the emergency department or fast track/urgent care area</u> shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics <u>every two years, within a 2-year period. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e. Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.</u></p>	<p>As more emergency departments add fast track and urgent care areas, it is important to assure that fast track physicians caring for children keep current in pediatric emergency medicine and maintain similar pediatric educational hours. Physicians assigned to these areas now need to also maintain 16 hours of pediatric CME every two years.</p> <p>Language has been added to clarify acceptable forms of continuing medical education. The Illinois Department of Financial &amp; Professional Regulation can also serve as a resource.</p>
<p>a) Professional Staff: Physicians</p> <p><u>Coverage</u></p>	<p>a, 3. Coverage</p> <p>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 <del>be available that</del> define when a physician is to be consulted/called in at times when the emergency department is covered by a mid-level provider.</p>	<p>No changes to this section</p>

Administrative Code Section	EMS Administrative Code, Section 515.4010 Standby Emergency Department Approved for Pediatrics (SEDP)	Guidance
<p>a) Professional Staff: Physicians</p> <p><u>Consultation</u></p>	<p>a, 4. Consultation</p> <p>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.</p>	<p>No changes to this section</p>
<p>a) Professional Staff: Physicians</p> <p><u>Physician Backup</u></p>	<p>a, 5. Physician Backup</p> <p>A backup physician whose qualifications and training are equivalent to subsection (a)(1) of this Section shall be available to the SEDP within <u>one</u> 4-hour after notification to assist with critical situations, <u>increased surge capacity</u> or disasters.</p>	<p>An increased surge is another indication in which a back-up physician may be needed. The hospital policy that addresses the back-up physician requirement now needs to include the process for securing a back-up physician during an increased patient surge.</p>
<p>a) Professional Staff: Physicians</p> <p><u>On-Call Physicians</u></p>	<p>a, 6. On-Call Physicians</p> <p><u>Guidelines</u> Protocols shall be available that address maximum-response time for on-call physicians.</p>	<p>The response time descriptor in this section has been changed to be more specific and requires guidelines as to when on-call physicians are expected to be available on-site.</p>
<p>b) Professional Staff: Mid-Level Practitioners</p> <p><u>Qualifications</u></p>	<p>b, 1. Qualifications</p> <p>A) Nurse practitioners shall have:</p> <ul style="list-style-type: none"> <li>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: completion of 2000 hours of hospital-based emergency department or acute care <u>as a nurse practitioner</u> over the last 24-month period that includes the care of the pediatric patient. <u>Nurse practitioners shall reapply for a waiver with each renewal cycle (as applicable), and provide verification of continued compliance with the waiver requirements;</u> and</li> <li>ii) <u>A current</u> An Illinois advanced practice nursing license <del>within one year after employment;</del> and</li> <li>iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.</li> </ul> <p>B) Physician assistants shall have:</p> <ul style="list-style-type: none"> <li>i) Current Illinois physician assistant licensure <del>(permanent or temporary);</del> and</li> <li>ii) Credentialing that reflects orientation, ongoing training and specific competencies in the</li> </ul>	<p>Waivers are temporary in nature. This language has been added to identify the timeframe for renewal of a waiver (as applicable).</p> <p>When the EDAP rules were originally adopted, Illinois had also recently adopted new APN license requirements, so a one year timeframe for obtaining an APN license was allowed at that time. Nurse practitioners are now expected to have a current APN license at the time of employment.</p> <p>Physician assistants are now required to have a current license versus a temporary license.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4010 Standby Emergency Department Approved for Pediatrics (SEDP)	Guidance
	<p style="text-align: center;">care of the pediatric emergency patient.</p> <p>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 course (ENPC). <b>PALS, APLS and ENPC courses shall include both cognitive and practical skills evaluation.</b></p>	<p>PALS and APLS are standardized professional courses that include both cognitive and practical skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>
<p>b) Professional Staff: <b>Mid-Level Practitioners</b></p> <p><b><u>Continuing Education</u></b></p>	<p>b, 2. Continuing Education</p> <p>A) All full- or part-time nurse practitioners shall have documentation of a minimum of <b>16 20</b> hours of <b>approved continuing education units in pediatric emergency topics every two years that are approved by an accrediting agency</b>, within a 2-year period.</p> <p>B) All full- or part-time physician assistants shall have documentation of a minimum of <b>16 20</b> hours of continuing medical education (AMA Category I) in pediatric emergency topics <b>every two years, within a 2-year period</b>. Credit for CME shall be approved by <b>an accrediting agency</b>, 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 Physician Assistants (AAPA).</p>	<p>The required number of continuing education hours for mid-level practitioners has been lowered to 16 hours every two years, which is consistent with EDAP requirements.</p> <p>The rules have been amended to no longer name specific accrediting agencies. There are numerous accrediting agencies that are responsible for approving professional educational hours for mid-level practitioners.</p>
<p>c) Professional Staff: <b>Nursing</b></p> <p><b><u>Qualifications</u></b></p>	<p>c, 1. Qualifications</p> <p>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:</p> <p>A) AHA-AAP Pediatric Advanced Life Support (PALS) course;</p> <p>B) ACEP-AAP Advanced Pediatric Life Support (APLS) course; or</p> <p>C) ENA Emergency Nursing Pediatric Course (ENPC).</p>	<p>Acronyms are fully spelled out once, after which only the acronym is used in the rules.</p> <p>No other changes were made to this section</p>

Administrative Code Section	EMS Administrative Code, Section 515.4010 Standby Emergency Department Approved for Pediatrics (SEDP)	Guidance
<p>c) Professional Staff: Nursing</p> <p><u>Continuing Education</u></p>	<p>c, 2. Continuing Education</p> <p>At least one <del>registered nurse (RN)</del> on duty on each shift who is responsible for the direct care of the child in the emergency department shall have documentation of a minimum of 8 hours of pediatric emergency/critical care continuing education hours <u>every two years</u>, <del>within a 2-year period</del>. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; or publications. The continuing education hours may be integrated with other existing continuing education requirements, provided that the content is pediatric specific. <u>PALS, APLS and ENPC courses shall include both cognitive and practical skills evaluation.</u></p>	<p>The language “within a 2-year period” has been changed to “every two years” to be more consistent with verbiage defined by IDPH Legal Services.</p> <p>PALS and APLS are standardized professional courses that include both cognitive and practical skill components. These components require an evaluation/post-test in order to obtain successful course completion. It has been noted that there have been non-AHA courses conducted (particularly some online courses) that lack the practical skills component. Therefore this language was added as a reminder. NOTE: Non-AHA PALS courses cannot be used to meet this requirement.</p>
<p>d) Guidelines, Policies and Procedures</p>	<p>d, 1. <del>Inter-facility</del> <u>Interfacility</u> Transfer</p> <p>A. The <u>hospital facility</u> shall have current transfer agreements <u>that cover pediatric patients. The transfer agreements shall address communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome, with Pediatric Critical Care Centers (PCCC)</u></p> <p>B. <u>The hospital facility shall have written pediatric inter-facility transfer guidelines/policies/procedures concerning transfer of critically ill and injured patients, that include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral institution information to family.</u> <del>to PCCCs.</del> Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.</p> <p>d, 2. Suspected Child Abuse <u>and Neglect</u> The <u>hospital facility</u> shall have policies/procedures addressing child abuse <u>and neglect</u>. <del>Abuse.</del> <u>These policies/procedures shall include, but not be limited to:</u> the identification (including screening), evaluation, treatment and referral <u>to DCFS</u> of victims of suspected child abuse <u>and neglect</u> abuse in accordance with State law.</p>	<p>Hospitals that receive pediatric transfers are responsible for assuring that the transfer agreements they develop with transferring hospitals address communication and QI measures as noted in the revised language. EMSC template feedback forms may be used as a resource. This feedback/QI should be defined by the referral and receiving hospitals, including:</p> <ul style="list-style-type: none"> <li>▪ All hospitals should maintain a transfer log.</li> <li>▪ Receiving hospitals should provide feedback on transferred cases, particularly those in which there were any quality, clinical or safety related issues. Additional feedback processes are encouraged such as de-identified case presentations or transfer feedback at regional QI meetings</li> <li>▪ Referral hospitals should have a QI review process in place.</li> </ul> <p>The inter-facility guidelines/policies requirement has been revised to assure compliance with National EMSC standards. Additional components (as outlined in the new rule language) need to be included in the ED transfer guidelines/policies.</p> <p>Neglect has been added to the child abuse requirement since mandated reporters are required to report suspected abuse as well as suspected neglect. The</p>

Administrative Code Section	EMS Administrative Code, Section 515.4010 Standby Emergency Department Approved for Pediatrics (SEDP)	Guidance
	<p>d, 3. Treatment <del>Guidelines</del> <del>Protocols</del> The <del>hospital facility</del> shall have <del>guidelines or policies addressing initial response and assessment for its high volume and high risk pediatric population</del> protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients (i.e., <del>fever</del>, trauma, respiratory distress, seizures).</p> <p>d, 4. Latex-free <del>Allergy</del> Policy The <del>hospital facility</del> shall have a policy addressing the <del>assessment of latex allergies and the</del> availability of latex-free equipment and supplies.</p> <p>d, 5. <del>Disaster Preparedness</del> <del>The hospital shall integrate pediatric components into its hospital Disaster/Emergency Operations Plan.</del></p>	<p>other addition to this requirement is the need to include screening processes to policies/procedures.</p> <p>The term “treatment guidelines” now replaces “protocols” since they guide care and may be superseded based on physician judgment or the clinical condition of the child. The description of these guidelines was also revised to provide more clarity since the previous description was sometimes misunderstood.</p> <p>The hospital Latex policy should now also include information on assessment of latex allergies.</p> <p>Pediatric components are now required to be included in hospital disaster planning. The EMSC Hospital Pediatric Preparedness Checklist can be used to guide/assist in this process.</p>
e) Quality Improvement	<p>e. 1. Multidisciplinary <del>Quality Activities</del> <del>Committee</del></p> <p>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 <del>Quality QI</del> committee.</p> <p>B) Multidisciplinary <del>continuous</del> quality improvement (CQI) <del>processes/</del>activities shall be established (e.g., committee, task force).</p> <p>C) <del>Quality with documented CQI</del> monitors shall be documented that address 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, <del>resuscitations, and inter-facility interfacility</del> transfers, child abuse and neglect cases, critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure) and pediatric strategic priorities of the institution.</p> <p>D) <i>All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC, EDAP or SEDPs pediatric services pursuant to this Section shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure (Section 3-110 (a) of the Act).</i></p>	<p>The header for this section was broadened to cover quality activities versus a committee.</p> <p>A new required QI monitor (child abuse and neglect cases) has been added to the rules. This monitor should minimally assure compliance with the hospital/ED Child Abuse and Neglect policy (refer to d, 2 of these rules).</p> <p>In the past, hospitals expressed uncertainty regarding what constitutes “resuscitation”. This monitor requirement has been revised to provide more clarity. Resuscitation has been replaced with the following language: “critically ill or injured children in need of stabilization”; and various examples are provided.</p> <p>Note that ED pediatric deaths and interfacility transfers as well as participation in the regional quality monitor(s) are still required. Other pediatric quality monitors can be considered based on the pediatric strategic priorities of the hospital.</p> <p>To address the protection afforded to quality improvement activities, the specific section of the Code of Civil Procedure has been cited in these revised EDAP rules.</p>

Administrative Code Section	EMS Administrative Code, Section 515.4010 Standby Emergency Department Approved for Pediatrics (SEDP)	Guidance
e) Quality Improvement	<p>e, 2. <u>Pediatric Physician Champion</u></p> <p><u>The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.</u></p>	<p>A requirement for a physician champion has been added to assure compliance with National EMSC standards. Since enhancing pediatric emergency care capabilities requires a multi-disciplinary approach, securing a physician advocate can assist in this process. Note that the physician champion does not need to be an ED physician. Other physicians can serve in this role including an on-staff pediatrician or family practice physician or a hospitalist.</p>
e) Quality Improvement	<p>e, 3. Pediatric <u>Quality Coordinator</u> <del>CQI Liaison</del></p> <p>A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated <u>to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital, supported by the hospital as the pediatric liaison.</u> This individual may be employed in an area other than the emergency department and shall have a minimum of <u>two 2</u> years of pediatric critical care or emergency department experience. <u>Working with the pediatric physician champion, the</u> responsibilities of the pediatric <u>quality coordinator</u> <del>liaison</del> shall include:</p> <p>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.</p> <p>B) <u>Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C) of this Section).</u> <del>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.</del></p> <p>C) <u>Reviewing selected pediatric cases transported to the hospital by prehospital providers and providing feedback to the EMS Coordinator/System.</u> <del>Coordinating a review of pre-hospital provider transported pediatric cases and providing feedback to the EMS System Coordinator and the EMS Regional Advisory Board.</del></p> <p>D) <u>Participating in regional QI activities, including preparing</u> <del>Preparing</del> a written CQI report and attending the EMS Regional CQI subcommittee meetings. <u>These</u> <del>which</del> activities shall be supported by the hospital. One representative from the <u>Regional</u> CQI subcommittee shall report to the EMS Regional Advisory Board.</p> <p>E) Providing CQI information to the <del>Illinois</del> Department of Public Health upon request. (See Section 3.110(a) of the Act.)</p>	<p>The term "Pediatric CQI Liaison" was originally adopted from the California EDAP model, however over time it was felt that this term did not fully capture the role of these individuals in our state. The title has been changed to Pediatric Quality Coordinator, so this term should replace Pediatric CQI Liaison in any hospital or ED policies/job descriptions.</p> <p>Although the previous language identified that the hospital needed to support the individual in the Pediatric Quality Coordinator role, it was felt that developing a job description would serve to further assure the allocation of time, resources and support. Job responsibilities can be incorporated into an already existent job description, or a new job description can be developed.</p> <p>The Pediatric Quality Coordinator should work with the Physician Champion, particularly when a physician perspective is needed related to quality improvement or educational issues or when physician buy-in on a project/activity is needed.</p> <p>Responsibilities B, C and D were revised to provide more clarity and do not represent a change in these requirements.</p>

The following section contains information on changes to the EDAP and SEDP equipment/supplies/medication requirements. **Please note that the table below lists ONLY equipment/supply/medication items that have undergone revision.** The full EDAP/SEDP equipment list is a lengthy document, so only the items that are new or revised are listed below. THIS TABLE BELOW IS NOT INCLUSIVE OF THE ENTIRE EDAP/SEDP EQUIPMENT/SUPPLY/MEDICATION LIST.

Administrative Code Section	EMS Administrative Code, Section 515.Appendix L Pediatric Equipment Recommendations for Emergency Departments (EDAP & SEDP)	Guidance
Monitoring Devices	<u>Continuous end-tidal pediatric PCO<sub>2</sub> monitor and/or pediatric CO<sub>2</sub> colorimetric detector</u> (disposable units may be substituted)	More descriptive language was added to this requirement to assure consistency with the National EMSC equipment standards.
Vascular Access Supplies and Equipment	Single or multiple lumen vascular access supplies utilizing the Seldinger technique <u>Central venous catheters</u> (stock one small and one large size)	The language for this requirement item has been simplified.
Vascular Access Supplies and Equipment	Intraosseous needles or bone marrow needles (13-18 g size range; )— stock one large/one small bore <u>or IO device (pediatric and adult sizes)</u>	With the advent of IO devices, this requirement was revised to accommodate either IO needles or IO devices.
Vascular Access Supplies and Equipment	IV solutions: standard crystalloid and colloid solutions (D10W, D5/.2 NS, D5/.45 NS, <u>D5/.9NS</u> and 0.9 NS)	D5/.9NS has been added to the IV solutions list to assure consistency with the National EMSC standards.
Vascular Access Supplies and Equipment	Syringes ( <del>TB, Insulin U100</del> , <u>1 ml – through</u> 20 ml)	TB and Insulin syringes have been removed from the original requirements.
Respiratory Equipment and Supplies	<u>Endotracheal tubes:</u> * <ul style="list-style-type: none"> <li>• Uncuffed (sizes 2.5, 3.0)</li> <li>• <u>Cuffed or uncuffed ( 3.5, 4.0, 4.5, 5.0, 5.5)</u></li> <li>• Cuffed (sizes <del>5.5</del>, 6.0, 6.5, 7.0, 7.5, 8.0, <del>9.0</del>)</li> <li>• Stylets for endotracheal tubes (pediatric and adult)</li> </ul>	National EMSC equipment guidelines allow for specific ET tube sizes that can be available in <u>either</u> cuffed or uncuffed. This item has been modified to reflect those national standards. In addition, Size 9.0 has been deleted.
Respiratory Equipment and Supplies	Oxygen delivery adjuncts: <ul style="list-style-type: none"> <li>• Tracheostomy collar</li> <li>• <u>Standard and Partial</u>-non-rebreather masks, clear (pediatric and adult sizes)</li> <li>• Nasal cannula (infant, pediatric and adult)</li> </ul>	This item has been revised to reflect the National EMSC Standards.
Respiratory Equipment and Supplies	<u>Supplies/kit for patients with difficult air way conditions:</u> <ul style="list-style-type: none"> <li>• <u>LMA (sizes 1, 1.5, 2, 2.5, 3, 4 and 5); or</u></li> <li>• <u>Cricothyrotomy kit or cricothyrotomy capabilities (i.e., 10 g needle and 3 mm ET tube adapter or 14 g needle and 3.5 mm ET tube adapter)</u></li> </ul>	National EMSC equipment guidelines require the availability of specific supplies for patients with difficulty airway conditions. This requirement can be met by having LMAs immediately available (new item) or cricothyrotomy kit/capabilities (which is an original requirement).
Respiratory Equipment and Supplies	Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes <u>12-32</u> 8-40 Fr)*	<b>This requirement is for EDAP hospitals only.</b> Several chest tube sizes have been removed from the original requirement.

Administrative Code Section	EMS Administrative Code, Section 515.Appendix L Pediatric Equipment Recommendations for Emergency Departments (EDAP & SEDP)	Guidance
Medications	Antimicrobial agents (parental and oral)	This is a new medication requirement that has been added to assure consistency with the National EMSC medication requirements.
Medications	Barbiturates, e.g. Phenobarbital, Pentobarbital, Thiopental	Barbiturates were required in the original EDAP requirements. Examples are now provided.
Medications	Benzodiazepines, e.g. Lorazepam, Midazolam, Diazepam	Benzodiazepines were required in the original EDAP requirements. Examples are now provided.
Medications	Beta blockers, e.g. Propranolol, Metoprolol	Beta Blockers were required in the original EDAP requirements. Examples are now provided.
Medications	Corticosteroids, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone	Dexamethasone, Hydrocortisone and Methylprednisolone were all required in the original requirements. Now they are grouped as examples in this Corticosteroids category.
Miscellaneous Equipment	Nasogastric tubes (6 <del>8</del> through 18 Fr)* (may substitute feeding tubes 5F and 8F)	The size 6 NG tube has been deleted from this requirement. Substitution of feeding tubes has been added.
Miscellaneous Equipment	Pain scale assessment tools appropriate for age	This is a new item added to ensure consistency with the National EMSC standards. Minimally two pain scale tools are needed to address the non-verbal/infant population (i.e. FLACC scale) and the verbal/older child (i.e. Wong-Baker FACES scale).
Miscellaneous Equipment	Weighing scales (in kilograms) for infant and children-adult	The National EMSC standards require scales that weigh only in kilograms for patient safety. If hospitals have scales that measure in both kg and lbs, then lock-out mechanisms or other safety measures should be in place.
Specialized Pediatric Trays	Initial newborn resuscitation equipment (can include warming device, feeding tubes, neonatal mask)	This is a new item to ensure readily available newborn resuscitation equipment, and to assure consistency with Nat'l EMSC standards.
Specialized Pediatric Trays	Lumbar puncture tray, including a selection of needles (size 18 – 22 g, 1 ½ - 3 inch needle)-capability (20-25 g, 1½ inch needle)	This item was revised to ensure consistency with the National EMSC standards. The needle size range/length have been revised.
Specialized Pediatric Trays	Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel) with umbilical vessel cannulation supplies and meconium aspirator	The newborn kit has been revised to define key components needed. Meconium aspirator is now a separate required supply item.