FACILITY RECOGNITION
RENEWAL APPLICATION PACKET

EMS Regions 1 and 10

OCTOBER 2016

Emergency Department Approved for Pediatrics (EDAP)
Pediatric Plan

and

Standby Emergency Department for Pediatrics (SEDP)
Pediatric Plan

DUE DATE
Friday, January 27, 2017

Illinois Emergency Medical Services for Children

Developed by
Illinois EMSC Facility Recognition Task Force

Approved by
Illinois EMSC Advisory Board
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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 13), 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, Fast Track/Urgent Care Physician, Mid-Level Provider and Nursing credentialing forms (see pages 18-21).

6. Complete the Pediatric Equipment Checklist (see pages 22-26).

7. The Pediatric Plan should be submitted in a single-sided format and unstapled.

8. Maintain a copy for your files (using one set of tabs provided by EMSC).

9. Submit 4 copies of your Pediatric Plan (an original signed copy plus 3 additional copies). Use the second set of 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, Fast Track/Urgent Care Physician, Mid-Level Provider and Nursing credentialing forms, as applicable (pages 18-21);
   - Completed Pediatric Equipment Checklist (pages 22-26).
10. Submit these documents (including all supporting documentation) by **Friday, January 27, 2017** in the order listed in this application to: Paula Atteberry, RN, BSN, Special Programs Coordinator, Division of EMS & Highway Safety, Illinois Department of Public Health, 422 S. 5th Street, 3rd Floor, Springfield, IL 62701.

11. **PLEASE NOTE** that any submitted requests to waive 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 6-8 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 Physician Champion
   i. Pediatric Quality Coordinator
   j. Hospital Quality Improvement Department Director or designee
   k. Hospital Emergency/Disaster Preparedness Coordinator
   l. Nurse Practitioner or Physician Assistant representative for those facilities that utilize these practitioners in their emergency department
   m. **For EMS Resource or Associate Hospitals only**: The EMS Medical Director and EMS Coordinator

**Site Survey Team**

The survey team will be defined by the EMSC Manager and Chief, Division of EMS & Highway Safety, in coordination with the Illinois EMSC Advisory Board. Site survey teams will be composed of a physician/nurse team 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 and may be requested to submit additional documentation. 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 requirements. 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 four 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.

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*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)  

__________________________________________________________________________  

__________________________________________________________________________  

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.

Typed name – CEO/Administrator

Signature - CEO/Administrator  

Typed name – Medical Director of Emergency Services

Signature – Medical Director of Emergency Services  

Contact person - Typed name, credentials and title

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 or SEDP criteria located in this application. See pages 7-12 (EDAP) and 13-17 (SEDP).

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

<table>
<thead>
<tr>
<th>For each requirement outlined below, select the response(s) as directed and attach supporting documentation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Enclosed is an organizational chart identifying the administrative relationships among all departments in the hospital, including the Emergency Department and Department of Pediatrics.</td>
</tr>
<tr>
<td>_____ Enclosed is an organizational chart identifying the organizational/reporting structure of ED physician, nursing and ancillary services. Include the reporting structure for the ED Medical Director (to whom he/she reports)</td>
</tr>
</tbody>
</table>

**Review the criteria in section 515.4000 a, 1 and 2 or 515.4010 a, 1 and 2 for the physician staff qualifications and continuing medical education and submit each of the below.**

| _____ Enclosed is a policy (s) that incorporates the physician qualifications and CME requirements. |
| _____ Enclosed is a completed CREDENTIALS OF EMERGENCY DEPARTMENT PHYSICIANS Form. |
| _____ Enclosed is a completed CREDENTIALS OF FAST TRACK PHYSICIANS Form. |
| _____ Enclosed is the curriculum vitae for the ED Medical Director. |
| _____ Enclosed is a current one-month physician schedule for the ED. |

**Review the criteria in section 515.4000 or 515.4010 a, 3, for the ED Physician coverage and submit one of the below.**

| _____ Enclosed is a previously approved policy. There are no changes. |
| _____ Enclosed is a revised policy for approval. (Necessary if any ED physicians have a waiver). |

**Review the criteria in section 515.4000 or 515.4010 a, 4, for ED Consultation and submit the below.**

| _____ Enclosed is a one month on-call schedule identifying availability of board certified/board prepared pediatricians or pediatric emergency medicine physicians. |

**Review the criteria in section 515.4000 or 515.4010 a, 5, for ED Physician Back-up and submit one of the below.**

| _____ Enclosed is a previously approved policy. There are no changes. |
| _____ Enclosed is a revised policy for approval |

**Review the criteria in section 515.4000 or 515.4010 a, 6, for On Call Specialty Physician Response Time and submit one of the below.**

| _____ Enclosed is a previously approved policy. There are no changes. |
| _____ Enclosed is a revised policy for approval |

**Review the criteria in section 515.4000 or 515.4010 b, 1 and 2 for Mid-Level Provider qualifications and continuing medical education and submit the below.**

| _____ Enclosed is a policy (s) that incorporates the mid-level provider qualifications and continuing education requirements. |
| _____ Enclosed is a completed CREDENTIALS OF EMERGENCY DEPARTMENT MID-LEVEL PROVIDERS Form. |
| _____ Enclosed is a current one-month mid-level provider schedule. |

**OR**

| (_____ Enclosed is documentation that mid-level providers are not utilized in the ED) |

**Review the criteria in section 515.4000 or 515.4010 c, 1 and 2 for Nursing qualifications and continuing education and submit each of the below.**

| _____ Enclosed is a policy that incorporates the nursing qualifications and CE requirements. |
| _____ Enclosed is a completed CREDENTIALS OF EMERGENCY DEPARTMENT NURSING STAFF Form. |
| _____ Enclosed is a one-month Nurse staffing schedule for the emergency department. |
Review the criteria in section 515.4000 or 515.4010 d, 1, for inter-facility transfer and submit the below.

- Enclosed is an interfacility transfer policy that addresses pediatric transfers and includes all of the components defined in Section 515.4000 or 515.4010 d, 1.
- Enclosed is a copy (s) of our current pediatric specific transfer agreements with hospitals that provide pediatric specialty services, pediatric intensive care and burn care not available at this facility.

Review the criteria in section 515.4000 or 515.4010 d, 2, for suspected child abuse and neglect and submit one of the below.

- Enclosed is a previously approved policy. There are no changes.
- Enclosed is a revised policy for approval

Review the criteria in section 515.4000 or 515.4010 d, 3, for treatment guidelines and submit the below.

- Enclosed are all newly developed and revised pediatric guidelines.

Review the criteria in section 515.4000 or 515.4010 d, 4, for Latex Allergy policy and submit the below.

- Enclosed is a copy of our latex allergy policy that addresses the assessment of latex allergies and the availability of latex free equipment and supplies.

Review the criteria in section 515.4000 or 515.4010 d, 5, for Disaster Preparedness and submit the below.

- Enclosed is a copy of the Hospital Pediatric Disaster Preparedness Checklist

Review the criteria in section 515.4000 or 515.4010 e, 1, for quality improvement activities and the multidisciplinary quality improvement committee and submit both of the below.

- Enclosed is our quality improvement plan including our QI policy, pediatric indicators, feedback loop and target timeframes for closure of issues.
- Enclosed is the composition of our multidisciplinary QI committee

Review the criteria in section 515.4000 or 515.4010 e, 2, for Pediatric Physician Champion and submit the below.

- Enclosed is a curriculum vitae for the Pediatric Physician Champion.

Review the criteria in section 515.4000 or 515.4010 e, 3, for the Pediatric Quality Coordinator (PQC) responsibilities and submit the below.

- Enclosed is a curriculum vitae for the Pediatric Quality Coordinator
- Enclosed is a job description or formal document for the Pediatric Quality Coordinator that includes the allocation of appropriate time and resources by the hospital to fulfill the PQC responsibilities.
- Enclosed is documentation detailing the participation of the Pediatric Quality Coordinator in Regional QI activities and how that has impacted pediatric quality care in the ED.

Review the criteria in section 515.4000 or 515.4010 f, for the list of Emergency Department Equipment Requirements and submit the below.

- Enclosed is a completed checklist indicating that all equipment is present.

Using the equipment list in the application, place an “X” next to each equipment item that is currently available. 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 or a waiver must be submitted for each item. 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.

Please note: If assistance is needed in identifying specific vendors for any of the equipment or supply items in this application, please contact the Marketing Administrator, Group Purchasing Services, Illinois Hospital Association at 312-906-6122.
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 (excluding designated areas utilized to care for minor illnesses or injuries, i.e., fast track, urgent care) shall be provided by one or more physicians responsible for the care of all children. Each physician shall hold 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) Sub-board Certification in pediatric emergency medicine by the American Board of Pediatrics or the 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. PALS and APLS courses shall include both cognitive and practical skills evaluation.

   i) Certification in family medicine by the American Board of Family Medicine (ABFM) or American Osteopathic Board of Family Medicine (AOBFM); or

   ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or

   iii) Residency trained/board eligible in either family medicine or pediatrics and in the first cycle of the board certification process; or

   D) Alternate Criteria: The physician has worked in the emergency department prior to January 1, 2018 and has completed 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 at least 2800 hours within one continuous 24-month period), certified in writing by the hospitals at which the internship and subsequent hours were completed. The physician shall have current AHA-AAP PALS or ACEP-AAP APLS recognition and have completed at least 16 hours of pediatric CME within the past two years.

2) Continuing Medical Education
All full- and 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. 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.

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.

5) Physician Backup
A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the EDAP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians
Guidelines shall be established that address on-site response time for all on-call specialty physicians.

b) Professional Staff: Nurse Practitioner and Physician Assistant
Nurse practitioners and physician assistants working under the supervision of a physician who meets the qualifications of subsection (a)(1).

1) Qualifications

A) Nurse practitioners shall meet the following criteria:

i) Completion of:

- a nurse practitioner program with a focus on the pediatric patient, such as a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program; or
• Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients certified in writing by the hospitals at which the hours were completed.

ii) Current Illinois advanced practice nursing license. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

B) Physician assistants shall meet the following criteria:

i) Current Illinois licensure. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices; and

ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

2) Continuing Education

A) All full- or part-time nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

B) All nurse practitioners and physician assistants caring for children in the emergency department and fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.

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 PALS;
ii) ACEP-AAP APLS; or

iii) ENA 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. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

2) Continuing Education
   All nurses assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education every two years. 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) Guidelines, Policies and Procedures

1) Inter-facility Transfer
   A) The hospital shall have current transfer agreements that cover pediatric patients. The transfer agreements 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.

   B) The hospital 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 hospital information to family. Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.

2) Suspected Child Abuse and Neglect
   The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to the Department of Children and Family Services (DCFS) of victims of suspected child abuse and neglect in accordance with State law.

3) Emergency Department Treatment Guidelines
   The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).
4) Latex-Allergy Policy

The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.

5) Disaster Preparedness

The hospital shall integrate pediatric components into its hospital Disaster/Emergency Operations Plan.

e) Quality Improvement

1) Multidisciplinary Quality Activities Policy

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 Quality Committee.

B) Multidisciplinary quality improvement (QI) processes/activities shall be established (e.g., committee).

C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. 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 emergency department:

i) Pediatric deaths;

ii) Pediatric inter-facility transfers;

iii) Child abuse and neglect cases;

iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure); and

v) Pediatric quality and safety priorities of the institution.

D) All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC's, EDAP's or SEDP's 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)

2) Pediatric Physician Champion

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.

3) Pediatric Quality Coordinator

A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated 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. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator 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).

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).

C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.

E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays, and Supplies
   See Appendix L.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)
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 AHA-AAP PALS or the ACEP-AAP APLS. 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. PALS and APLS shall include both cognitive and practical skills evaluation.

2) Continuing Medical Education

   All full and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. 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.

3) Coverage

   At least one physician meeting the requirements of subsection (a)(1), or a nurse practitioner or physician assistant 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 define 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.

5) Physician Backup
A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the SEDP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians
Guidelines shall address response time for on-call physicians.

b) Professional Staff: Nurse Practitioner and Physician Assistant
Nurse practitioners and physician assistants working under the supervision of a physician who meets the qualifications of subsection (a)(1).

1) Qualifications
A) Nurse practitioners shall meet the following criteria:
   i) Completion of:
      • a nurse practitioner program with a focus on the pediatric patient, such as a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program; or
      • Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients certified in writing by the hospitals at which the hours were completed.
   ii) Current Illinois advanced practice nursing license. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.
   iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

B) Physician assistants shall meet the following criteria:
   i) Current Illinois physician assistant licensure. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.
   ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

2) Continuing Education
SECTION 515.4010 FACILITY RECOGNITION CRITERIA FOR THE STANDBY EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (SEDP)

A) All nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

B) All nurse practitioners and physician assistants shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.

c) Professional Staff: Nursing

1) Qualifications
   At least one 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:

   A) AHA-AAP PALS;

   B) ACEP-AAP APLS; or

   C) ENA ENPC.

2) Continuing Education
   At least one Registered Nurse 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 eight hours of pediatric emergency/critical care continuing education every two years. 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 publications. The continuing education hours may be integrated with other existing continuing education requirements, provided that the content is pediatric specific. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

d) Policies and Procedures

1) Inter-facility Transfer

   A) The hospital shall have current transfer agreements that cover pediatric patients. The transfer agreements 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.

   B) The hospital shall have written pediatric inter-facility transfer guidelines/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 hospital information to
family. Incorporating the components of Appendix M into the emergency department transfer policy/procedure will meet this requirement.

2) Suspected Child Abuse and Neglect
   The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to DCFS of victims of suspected child abuse and neglect in accordance with State law.

3) Emergency Department Treatment Guidelines
   The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).

4) Latex-Allergy Policy
   The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.

5) Disaster Preparedness
   The hospital shall integrate pediatric components into its Disaster/Emergency Operations Plan.

e) Quality Improvement

1) Multidisciplinary Quality Activities Policy

   A) Pediatric emergency medical care shall be included in the SEDP's emergency department or section QI program and reported to the hospital Quality Committee.

   B) Multidisciplinary quality improvement processes/activities shall be established (e.g., committee).

   C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. 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 emergency department:

   i) Pediatric deaths;

   ii) Pediatric inter-facility transfers;

   iii) Child abuse and neglect cases;

   iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure; and

   v) Pediatric quality and safety priorities of the institution.

   D) All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC's, EDAP's or SEDP's pediatric

EDAP & SEDP PEDIATRIC PLAN RENEWAL APPLICATION PACKET
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)

2) Pediatric Physician Champion
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.

3) Pediatric Quality Coordinator
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated 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. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator 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).

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).

C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee meetings. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.

E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays, and Supplies
See Appendix L.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)
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.

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>F=Full Time</th>
<th>P=Part Time</th>
<th>Date of ED Hire</th>
<th>Certification <em>(Or Board Eligible in 1st cycle)</em> ABEM, AOBEM, ABP, AOBP, ABFP or AOBFP (Identify if waiver requested/obtained)</th>
<th>Exp. Date</th>
<th>Course Completion</th>
<th>Exp. Date</th>
<th>16 HRS. of Pediatric Emergency related CME (In last two years)</th>
<th>APLS</th>
<th>PALS</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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____________________________________  ______________________________________  ______________________________
Signature                               Typed Name                                Date
Hospital CEO/Administrator             Hospital CEO/Administrator

(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 FAST TRACK/URGENT CARE 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.

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>F=Full Time</th>
<th>P=Part Time</th>
<th>Date of ED Hire</th>
<th>Certification <em>(Or Board Eligible in 1st cycle)</em> ABEM, AOBEM, ABP, AOBP, ABFP or AOBFP (Identify if waiver requested-obtained)</th>
<th>Exp. Date</th>
<th>Course Completion</th>
<th>Exp. Date</th>
<th>16 HRS. of Pediatric Emergency related CME (In last two years)</th>
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<tbody>
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<td>1</td>
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Signature ____________________________________________  Typed Name _______________________________  Date ____________
Hospital CEO/Administrator  Hospital CEO/Administrator

(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 NURSE PRACTITIONER AND PHYSICIAN ASSISTANTS

- List each Nurse Practitioner and/or Physician Assistant 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.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>F=Full Time</th>
<th>P=Part Time</th>
<th>Date of ED Hire</th>
<th>License Verification *</th>
<th>Exp. Date</th>
<th>Facility Credentialing For Pediatric Care</th>
<th>Exp. Date</th>
<th>Course Completion</th>
<th>Exp. Date</th>
<th>16 HRS. of Pediatric Emergency CME/CEU (In Last Two Years)</th>
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_________________________  ___________________________  ___________________________
Signature                        Typed Name                          Date
Hospital CEO/Administrator                   Hospital CEO/Administrator

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

<table>
<thead>
<tr>
<th>Staff Nurse</th>
<th>F=Full Time</th>
<th>P=Part Time</th>
<th>Date of ED Hire</th>
<th>Course Completion</th>
<th>Expiration Date</th>
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<td>APLS</td>
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<td>ENPC</td>
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</tbody>
</table>

8 HRS. of Pediatric Emergency/Critical Care CEU’s (In Last Two Years)

- EDAP – All RN’s
- SEDP – One RN/Shift

(Write the number of pediatric CEU’s that have been completed within the past 2 years.)

---

**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.)
Section 515.APPENDIX L  Pediatric Equipment Requirements for Emergency Departments

The following list identifies pediatric equipment items that are recommended for the two emergency department facility recognition levels. Equipment items are classified as "essential" (E) and "need to be stocked in the emergency department" (ED).

<table>
<thead>
<tr>
<th>Monitoring Devices</th>
<th>EDAP</th>
<th>Check if present in EDAP</th>
<th>SEDP</th>
<th>Check if present in SEDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood glucose measurement device (i.e., chemistry strip or glucometer)</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>Continuous end-tidal PCO₂ monitor and pediatric CO₂-colorimetric detector (disposable units may be substituted)</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>Doppler ultrasound blood pressure device (neonatal-adult thigh cuffs)</td>
<td>E (ED)</td>
<td></td>
<td>E (ED)</td>
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</tr>
<tr>
<td>ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles, with pediatric dosage settings and pediatric-adult pacing electrodes</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>Hypothermia thermometer (Note: with a range of 28-42°C)</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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<tr>
<td>Pediatric monitor electrodes</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>Otoscope/ophthalmoscope/stethoscope</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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<tr>
<td>Pulse oximeter with pediatric and adult probes</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>Sphygmomanometer with cuffs (neonatal-adult thigh)</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Vascular Access Supplies and Equipment</th>
<th>EDAP</th>
<th>Check if present in EDAP</th>
<th>SEDP</th>
<th>Check if present in SEDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm boards (sized infant through adult)</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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<tr>
<td>Blood gas kits</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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<tr>
<td>Butterfly-type needles (19-25 g)*</td>
<td>E (ED)</td>
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<tr>
<td>Catheter-over-needle devices (16-24 g)*</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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<tr>
<td>Central venous catheters (stock one small and one large size)</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>Infusion pumps, syringe pumps, or devices with microinfusion capability using appropriate tubing &amp; connectors</td>
<td>E (ED)</td>
<td></td>
<td>E (ED)</td>
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</tr>
<tr>
<td>Intraosseous needles or bone marrow needles (13-18 g size range; stock one large/one small bore) or IO device (pediatric and adult sizes)</td>
<td>E (ED)</td>
<td></td>
<td>E (ED)</td>
<td></td>
</tr>
<tr>
<td>IV extension tubing, stopcocks, and T-connectors</td>
<td>E (ED)</td>
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<td>E (ED)</td>
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</tr>
<tr>
<td>IV fluid/blood warmer</td>
<td>E (ED)</td>
<td></td>
<td>E (ED)</td>
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</tr>
</tbody>
</table>
### IV solutions: standard crystalloid and colloid solutions (D10W, D5/.2 NS, D5/.45 NS, D5/.9 NS and 0.9 NS)

| E (ED) | E (ED) |

Syringes (1ml through 20 ml)

| 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) |

### Respiratory Equipment and Supplies

<table>
<thead>
<tr>
<th>EDAP</th>
<th>Check if present in EDAP</th>
<th>SEDP</th>
<th>Check if present in SEDP</th>
</tr>
</thead>
</table>

#### Bag-valve-mask device, self-inflating infant/child and adult (1000 ml) with O₂ reservoir and clear masks (neonatal through large adult sizes)*; PEEP valve

| E (ED) | E (ED) |

Manometer

| E (ED) | E (ED) |

Bulb syringe

| E (ED) | E (ED) |

Endotracheal tubes;*

| E (ED) | E (ED) |

- Cuffed or Uncuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, and 8.0)

- Styles 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 14, 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 50 mm, 60 mm, 70 mm, 80 mm, 90 mm, 100 mm)*

| 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) |

- Standard masks, clear (pediatric and adult sizes)

| E (ED) | E (ED) |

- Partial non-rebreather or non-rebreather masks, clear (pediatric and adult sizes)

| E (ED) | E (ED) |

- Nasal cannula (infant, pediatric and adult)

| E (ED) | E (ED) |
### Supplies/kit for patients with difficult airway conditions:
- LMA (sizes 1, 1.5, 2, 2.5, 3, 4 and 5); or
- 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)

### Suction capability (wall)

### Suction catheters (sizes 5/6, 8, 10, 12, 14, 16, 18 Fr and Yankauer-tip catheter)*

### 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)

### Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 12-32 Fr)*

### Medications (unit dose, prepackaged)

<table>
<thead>
<tr>
<th>Medication</th>
<th>EDAP</th>
<th>Check if present in EDAP</th>
<th>SEDP</th>
<th>Check if present in SEDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number in ED</td>
<td>E (ED)</td>
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<tr>
<td>Activated charcoal (consider with and without Sorbitol)</td>
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<td>Adenosine</td>
<td>E (ED)</td>
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<tr>
<td>Amiodarone</td>
<td>E (ED)</td>
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<tr>
<td>Antiemetics</td>
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<tr>
<td>Antimicrobial agents (parenteral and oral)</td>
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<td>Antipyretics</td>
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<td>Atropine</td>
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<td>Barbiturates, e.g., Phenobarbital, Pentobarbital</td>
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<tr>
<td>Benzodiazepines, e.g., Lorazepam, Midazolam, Diazepam</td>
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<tr>
<td>Beta blockers, e.g., Propranolol, Metoprolol</td>
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<td>Calcium (chloride or gluconate)</td>
<td>E (ED)</td>
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<td>Corticosteroids, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone</td>
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<td>Dextrose (25% and 50%)</td>
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<tr>
<td>Diphenhydramine</td>
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<tr>
<td>Medicine/Equipment</td>
<td>EDAP</td>
<td>Check if present in EDAP</td>
<td>SEDP</td>
<td>Check if present in SEDP</td>
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<td>Dobutamine</td>
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<td>Dopamine</td>
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<td>Epinephrine (1:1,000 and 1:10,000)</td>
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<td>Epinephrine (Racemic)</td>
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<tr>
<td>Fosphenytoin and/or Phenytoin</td>
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<td>Furosemide</td>
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<td>Glucagon or Glucose Paste</td>
<td>E (ED)</td>
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<td>Insulin, regular</td>
<td>E (ED)</td>
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<td>Lidocaine 1%</td>
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<td>Magnesium Sulfate</td>
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<td>Mannitol</td>
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<td>Narcotics</td>
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<tr>
<td>Neuromuscular blocking agents (i.e., succinylcholine, rocuronium, vecuronium)</td>
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<td>Ocular anesthetics</td>
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<td>Poison Specific Antidotes</td>
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<td>Acetylcysteine</td>
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<td>Cyanide Antidote</td>
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<td>Flumazenil</td>
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<td>Naloxone</td>
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<td>Sodium bicarbonate – 8.4% and 4.2%</td>
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<td>Sedative/Hypnotic (e.g., Ketamine, Etomidate)</td>
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<tr>
<td>Tetanus Immune Globulin (Human)</td>
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<tr>
<td>Tetanus Vaccines (single or in combination with other vaccines)</td>
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<tr>
<td>Topical Anesthetics</td>
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<tr>
<td><strong>Miscellaneous Equipment</strong></td>
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<tr>
<td>Dosing device – length or weight based system for dosing and equipment</td>
<td>E (ED)</td>
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<tr>
<td>Dosing/equipment chart by weight</td>
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<td>EMS communication equipment (i.e., telemetry, MERCI, cellular or dedicated phone)</td>
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<td>Examination gloves, disposable</td>
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<tr>
<td>Equipment</td>
<td>EDAP</td>
<td>Check if present in EDAP</td>
<td>SEDP</td>
<td>Check if present in SEDP</td>
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<tr>
<td><strong>Specialized Pediatric Trays</strong></td>
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<td>Initial newborn resuscitation equipment (can include warming device,</td>
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<td>feeding tubes, neonatal mask)</td>
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<td>Lumbar puncture tray, including a selection of needle sizes (size 18-22</td>
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<td>g, 1½ -3 inch needle)</td>
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<td>Minor surgical instruments and sutures</td>
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<td>Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel)</td>
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<tr>
<td><strong>Fracture Management Devices</strong></td>
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<tr>
<td>Extremity splints</td>
<td>E (ED)</td>
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<tr>
<td>Femur splint (child and adult)</td>
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<td>Semi-rigid neck collars (child through adult) or cervical immobilization</td>
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<tr>
<td>equipment suitable for children</td>
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<tr>
<td>Spinal immobilization board (child and adult)</td>
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</table>

* Shall minimally stock a range of each commonly available size noted or comparable sizes.
(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

**NOTE:** LATEX-FREE SUPPLIES SHOULD BE AVAILABLE WHenever POSSIBLE  (Refer to EMS System Latex-Free policy)
SECTION 515. APPENDIX M INTERFACILITY PEDIATRIC TRAUMA AND CRITICAL CARE CONSULTATION AND/OR TRANSFER GUIDELINE

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

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 community hospitals and 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 inter-facility 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 shall 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 inter-facility 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. The hospital 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 facility and referral center; process for selecting the appropriate care facility; process for selecting the appropriately staffed transport service to match the patient's acuity level; 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.

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 Inter-facility 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 endotrachael 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
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 two 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 replantation

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 – 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 intervention.

(Source: Amended at 35 Ill. Reg. 20609, effective December 6, 2011)
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)