



Pediatric Readiness in the Emergency Department

Katherine Remick, MD, FAAP, FACEP, FAEMS,^{a,b,c} Marianne Gausche-Hill, MD, FAAP, FACEP, FAEMS,^{d,e,f} Madeline M. Joseph, MD, FAAP, FACEP,^{g,h} Kathleen Brown, MD, FAAP, FACEP,ⁱ Sally K. Snow, BSN, RN, CPEN,^j Joseph L. Wright, MD, MPH, FAAP,^{k,l} AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine and Section on Surgery, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION Pediatric Committee

This is a revision of the previous joint Policy Statement titled “Guidelines for Care of Children in the Emergency Department.” Children have unique physical and psychosocial needs that are heightened in the setting of serious or life-threatening emergencies. The majority of children who are ill and injured are brought to community hospital emergency departments (EDs) by virtue of proximity. It is therefore imperative that all EDs have the appropriate resources (medications, equipment, policies, and education) and capable staff to provide effective emergency care for children. In this Policy Statement, we outline the resources necessary for EDs to stand ready to care for children of all ages. These recommendations are consistent with the recommendations of the Institute of Medicine (now called the National Academy of Medicine) in its report “The Future of Emergency Care in the US Health System.” Although resources within emergency and trauma care systems vary locally, regionally, and nationally, it is essential that ED staff, administrators, and medical directors seek to meet or exceed these recommendations to ensure that high-quality emergency care is available for all children. These updated recommendations are intended to serve as a resource for clinical and administrative leadership in EDs as they strive to improve their readiness for children of all ages.

abstract



^aNational Emergency Medical Services for Children Innovation and Improvement Center, Baylor College of Medicine, Houston, Texas; ^bDepartment of Pediatrics, Dell Medical School, The University of Texas at Austin, Austin, Texas; ^cDell Children’s Medical Center, Austin, Texas; ^dLos Angeles County Emergency Medical Services Agency, Santa Fe Springs, California; ^eDepartment of Emergency Medicine and Pediatrics, David Geffen School of Medicine and Harbor–University of California, Los Angeles Medical Center; University of California, Los Angeles, Los Angeles, California; ^fDepartment of Emergency Medicine, Los Angeles Biomedical Research Institute, Los Angeles, California; ^gDivision of Pediatric Emergency Medicine, Department of Emergency Medicine and Pediatrics, University of Florida College of Medicine–Jacksonville, Jacksonville, Florida; ^hUniversity of Florida Health Sciences Center–Jacksonville, Jacksonville, Florida; Departments of ⁱPediatrics and Emergency Medicine, School of Medicine and Health Sciences, George Washington University and Children’s National Medical Center, Washington, District of Columbia; ^jEmergency Nurses Association, Des Plaines, Illinois; ^kUniversity of Maryland Capital Region Health, University of Maryland Medical System, Cheverly, Maryland; and ^lDepartment of Family Science, University of Maryland School of Public Health, College Park, Maryland

Drs Gausche-Hill, Remick, Joseph, Brown, and Wright and Ms Snow were each responsible for all aspects of writing and editing the document and reviewing and responding to questions and comments from reviewers and the Board of Directors; and all authors approved the final manuscript as submitted.

Published simultaneously on November 1, 2018, by the *Annals of Emergency Medicine* and *Journal of Emergency Nursing*.

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors, the American College of Emergency Physicians and its Board of Directors, and

INTRODUCTION

In this Policy Statement, we delineate the recommended resources necessary to prepare emergency departments (EDs) to care for pediatric patients. Adoption of the recommendations in this Policy Statement will facilitate the delivery of emergency care for children of all ages and, when appropriate, timely transfer to a facility with specialized pediatric services. This joint Policy Statement is an update of previously published guidelines.^{1–4}

To cite: Remick K, Gausche-Hill M, Joseph MM, et al; AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine and Section on Surgery, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION Pediatric Committee. Pediatric Readiness in the Emergency Department. *Pediatrics*. 2018;142(5):e20182459

These recommendations are intended to apply to all EDs that provide care for children. In the United States, most children who seek emergency care (83%) present to general EDs versus specialized pediatric EDs.⁵ Intended users of these recommendations include all EDs that are open 24 hours per day, 7 days per week, including freestanding EDs and critical access hospital EDs. This Policy Statement is not intended to address urgent care centers because other recommendations are available to address those settings.⁶

BACKGROUND

In the National Hospital Ambulatory Medical Care Survey, it was reported that in 2014, there were approximately 5000 EDs in the United States. Of the more than 141 million ED visits in the United States in 2014, approximately 20% were for children younger than 15 years old.⁷ Children have unique anatomic, physiologic, developmental, and medical needs that differ from those of adults. These differences must be considered when developing emergency services, training ED staff, and stocking equipment, medication, and supplies.

Improving Pediatric Readiness in US EDs

In 2006 in the “Future of Emergency Care” series, the Institute of Medicine (IOM) (now the National Academy of Medicine) noted ongoing deficiencies in both the prehospital and ED settings, including the availability of pediatric equipment, access to supplies and medications, training for staff, and policies in which the unique needs of children are incorporated.⁸ Although there have been marked improvements in many areas of everyday pediatric readiness, persistent variability and a need for improvement remain across the continuum of care.^{5,9–12}

One of the specific recommendations from the 2006 IOM report was that hospitals appoint coordinators for pediatric emergency care. At that time, only 18% of EDs in the United States reported having a physician coordinator, and only 12% had a nursing coordinator for pediatric emergency care. A national assessment performed in 2003¹³ revealed that EDs that have staff in these positions tend to be more prepared, as measured by using compliance with the “Guidelines for the Care of Children in the ED” published by the American College of Emergency Physicians (ACEP) and American Academy of Pediatrics (AAP) in 2001.¹ In 2009, the AAP, ACEP, and Emergency Nurses Association (ENA), with the support of the Emergency Medical Services for Children (EMSC) program, undertook a major revision of these guidelines.^{3,4} The 2009 joint Policy Statement is the subject for this policy revision.

The National Pediatric Readiness Project, launched in 2013, is an ongoing quality improvement (QI) initiative among the federal EMSC program, AAP, ACEP, and ENA to ensure pediatric readiness of EDs.⁹ In phase 1 of the project, hospital ED leaders in all US states and territories were asked to complete a comprehensive Web-based assessment of their readiness to care for children. The assessment was based on the 2009 joint Policy Statement.^{3,4} The response rate was 83%, representing more than 4000 EDs.⁵ The data from this project reveal a snapshot of the nation’s readiness to provide care to children in the ED. They also provide information on gaps in readiness at the state and national levels, confidential site-specific needs, and recommendations to improve readiness. Key findings include the following:

1. The majority of children who seek emergency care (69.4%) are

cared for in EDs that see fewer than 15 pediatric patients per day, highlighting the need to provide additional pediatric emergency resources to smaller and often rural EDs.

2. The overall median score for the nation was 70 (of 100 possible points). This represents an improvement when compared with a similar survey completed in 2003 (median score of 55 points).^{5,13}
3. The median score for EDs with a high volume of pediatric patients (>27 pediatric visits per day) was greater than that of EDs with medium, medium-high (5–27 pediatric visits per day), or low pediatric volume (<5 pediatric visits per day).
4. Approximately half of EDs lacked a physician (52.5%) or nurse (40.7%) pediatric emergency care coordinator (PECC). The presence of a PECC is strongly correlated with improved pediatric readiness, independent of other factors.⁵ Another analysis of hospital-based EDs in the state of California also revealed that the presence of a PECC was associated with improved overall pediatric readiness scores.¹⁴
5. Fifty-five percent of EDs reported the absence of a QI plan in which they address pediatric care, and of those that had a QI plan, 41.7% lacked specific quality indicators for children. The presence of a QI plan that included pediatric-specific indicators was independently associated with improved overall readiness scores in California.¹⁴
6. In the absence of participation in a pediatric verification program, trauma center status was not predictive of higher pediatric readiness scores.¹⁴
7. Approximately half of hospitals reported lacking disaster plans

(53.2%) that include specific care needs for children.⁵

8. A process to ensure that weights are measured and recorded in kilograms only, which is a pediatric safety concern, was also lacking in 32.3% of EDs completing the assessment.⁵

Pediatric Readiness and Pediatric Facility Recognition

The EMSC program has long promoted improved preparedness and recognition of prepared EDs. Current EMSC program performance measures address pediatric readiness for children with both traumatic and medical emergencies.¹⁰ Performance Measure 04 reads as follows: “the percent[age] of hospitals recognized through a statewide, territorial, or regional[ly] standardized system that are able to stabilize and/or manage pediatric medical emergencies.” At this time, 11 states have developed such a system (recognizing 8% of all US hospital-based EDs),¹⁵ and all have used the 2009 joint Policy Statement as the basis of their recognition criteria. Some states have published descriptions of the process they used to establish and maintain a pediatric recognition system.^{14,16}

Recognition and verification have been associated with improved readiness scores. Remick et al¹⁴ described an association between higher hospital readiness scores and an on-site verification program in California. National data reveal that states that have a recognition and/or verification system and have achieved EMSC program Performance Measure 04 have readiness scores that are an average of 10 points higher than those that do not have such a system.¹⁵ In addition, hospitals that have been recognized scored, on average, 22 points higher on the assessment than those that had not been recognized as pediatric ready by their states (National EMSC Data Analysis and Resource Center, unpublished observations, 2014).

Pediatric Readiness: Improving the Safety and Quality of Pediatric Emergency Care

Over the past 15 years, patient safety has become a key priority for health systems.¹⁷ In 2014, the AAP released the revised Policy Statement “Patient Safety in the Pediatric Emergency Care Setting.”¹⁸ This statement and other recent work have revealed the value of specific structural and process measures on improved patient safety and quality of care. For example, a weight-based, color-coded medication safety system can be used to decrease dosing errors and improve the timeliness of dosing,^{19,20} and order sets, reminders, and clinical practice recommendations embedded within information systems can be used to increase adherence to best practices.^{21,22}

Although previous guidelines^{1,2} were consensus based, several recent studies have revealed the effects of pediatric readiness on outcomes for children treated in EDs. Some investigators have examined the effect of improved pediatric readiness and/or facility recognition on the quality of pediatric emergency care. Ball et al²³ compared outcomes in children with extremity immobilization and a pain score of 5 or greater in a state with a medical facility recognition program to similar facilities in a state without a facility recognition program. The children in the state with the recognition system had improved timeliness of the management of pain for fractures and decreased exposure to radiation use.²³ Kessler et al²⁴ demonstrated that teams of health care providers who practiced in EDs with higher pediatric readiness scores performed better in a standardized simulation of the care of children with sepsis. A statewide program in Arizona to improve the pediatric readiness of EDs has been associated with a decreased pediatric mortality rate after participation in a verification

process based on compliance with published guidelines.²⁵ Shared resources and coordination of care in emergency care systems is a strategy that may be used to improve pediatric readiness locally, regionally, and nationally. Further research should be supported to evaluate the effects of each of the recommended components of the guidelines on the quality of pediatric emergency care.

The information from the pediatric readiness assessment, research described earlier in this Policy Statement, and expert opinion from the coauthoring organizations were used to inform this revised Policy Statement. These recommendations include current information on equipment, medications, supplies, and personnel that are considered critical for managing pediatric emergencies in EDs. In this Policy Statement, we also offer recommendations for the administration and coordination of pediatric care in the ED; pediatric emergency care QI, performance improvement (PI), and patient safety activities; policies, procedures, and protocols for pediatric care; and key ED support services. It is believed that all EDs in the United States can meet or exceed these recommendations and that some hospitals, such as those with pediatric critical care capabilities or children’s hospitals with greater resources, will develop and implement even more comprehensive recommendations and share their expertise with their local and regional communities. These updated recommendations are intended to serve as a resource for clinical and administrative leadership of EDs as they strive to improve their readiness for children of all ages.

ADMINISTRATION AND COORDINATION FOR THE CARE OF CHILDREN IN THE ED

A pediatric emergency care coordinator (PECC) is a physician

coordinator identified by the ED medical director or a registered nurse coordinator identified by the ED nurse director. Identification of a physician and nurse PECC is central to the readiness of any ED that cares for children. Recommendations include the following:

1. The physician and nurse PECCs may be concurrently assigned other roles in the ED (eg, frontline staff designated by leadership) or may oversee more than 1 program in the ED (ie, medical or nursing director or as coordinator for trauma, stroke, or cardiac [STEMI]). PECC roles may be shared through formal agreements with administrative entities, such as within hospital systems, when there is another ED capable of providing definitive pediatric care.
 2. Facilitate the following qualifications for physician and nurse PECCs:
 - a. the physician PECC is qualified by the facility to provide emergency care. Optimally, the physician PECC is a board-certified and/or eligible specialist in emergency medicine or pediatric emergency medicine. Otherwise, the physician PECC must meet the qualifications for credentialing of the hospital as an emergency clinician specialist with special training and experience in the evaluation and management of the child who is critically ill. The physician PECC is credentialed by the facility and has verified competency in the care of children, including resuscitation, per the hospital policy. For EDs with limited resources, this administrative role may be shared with a clinical nurse specialist, nurse practitioner, or physician assistant (ie, advanced practice provider) who is credentialed to care for patients in the ED; and
 - b. the nurse PECC is a registered nurse who possesses special interest, knowledge, and skill in the emergency nursing care of children through clinical experience and has demonstrated competence in critical thinking and clinical skills. When available, a certified emergency nurse or, preferably, a certified pediatric emergency nurse is desirable. Otherwise, the nurse coordinator has verified competency per hospital policy and may have other credentials, such as certified pediatric nurse or certified critical care registered nurse.
 3. The physician and nurse PECCs work collaboratively and are responsible for the following:
 - a. promoting adequate skill and knowledge of ED staff physicians, nurses, and other health care providers and staff (ie, physician assistants, advanced practice nurses, paramedics, and technicians) in the emergency care and resuscitation of infants and children. PECCs should have significant input into the methods of demonstrating competency in pediatric emergency care for their respective disciplines;
 - b. participating in the development of the pediatric components of the QI plan and facilitating QI activities related to pediatric emergency care;
 - c. assisting with the development and periodic review of ED policies and procedures and standards for medications, equipment, and supplies to ensure adequate resources for children of all ages;
 - d. serving as liaisons and/or coordinators in collaboration with appropriate in-hospital and out-of-hospital pediatric care committees in the community and/or region and emergency medical services (EMS), trauma, and emergency preparedness coordinators (if they exist);
- e. serving as liaisons to definitive-care hospitals, such as regional pediatric referral hospitals and trauma centers, EMS agencies, primary care providers, health insurers, and any other care resources needed to integrate services along the pediatric care continuum, such as pediatric injury prevention, chronic disease management, and community education programs;
 - f. facilitating pediatric emergency medical and nursing education for ED health care providers and staff, including but not limited to the identification of continuing pediatric emergency education resources;
 - g. facilitating the inclusion of pediatric-specific elements in physician and nursing orientation in the ED;
 - h. in coordination with the local credentialing processes, facilitating competency evaluations for staff that are pertinent to children of all ages. When available, simulation (ie, pediatric scenario-based mock codes) has been revealed to improve pediatric care in resuscitation and team settings^{26–28};
 - i. facilitating the integration of pediatric needs in hospital disaster and/or emergency preparedness plans and promoting the inclusion of pediatric patients in disaster drills²⁹;
 - j. collaborating with ED leadership to enable adequate staffing, medications, equipment, supplies, and other resources for children in the ED; and

k. communicating with ED and hospital leadership on efforts to facilitate pediatric emergency care.

COMPETENCIES FOR PHYSICIANS, ADVANCED PRACTICE PROVIDERS, NURSES, AND OTHER ED HEALTH CARE PROVIDERS

Recommendations include the following:

- A. Physicians, advanced practice providers, nurses, and other ED health care providers, on the basis of their level of training and scope of practice, should have the necessary skill, knowledge, and training in the emergency evaluation and treatment of children of all ages consistent with the services provided by the hospital.
- B. Baseline and periodic competency evaluations completed for all ED clinical staff, including physicians, advanced practice providers, nurses, and other health care providers are age specific and include neonates, infants, children, adolescents, and children with special health care needs. Competencies are determined by each institution's hospital policy and medical staff privileges as a part of the local credentialing process for all licensed ED staff.
- C. The demonstration and maintenance of pediatric clinical competencies may be achieved through continuing education, including participation in local educational programs, professional organization conferences, or national pediatric emergency care courses, or scheduled mock codes or patient simulation, team training exercises, or experiences in other clinical settings, such as the operating room (ie, airway management). The evaluation of such competencies may be achieved through direct observation, chart reviews,

written knowledge tests, and/or the maintenance of physician or advanced practice provider board certification or nurse certification when pediatric emergency medicine is a significant component of annual continuing education requirements.

D. Potential areas for pediatric competency and professional performance evaluations may include but are not limited to the following:

- 1. assessment and treatment, including the following: (a) triage, (b) illness and injury assessment and management, and (c) pain assessment and treatment, including nonpharmacologic pain management (eg, distraction techniques and comfort holds);
- 2. medication administration and delivery;
- 3. device and/or equipment safety (eg, low-volume infusion pumps);
- 4. procedures, including the following: (a) airway management, (b) vascular access, and (c) sedation and analgesia;
- 5. resuscitation, including the following: (a) critical care monitoring, (b) neonatal resuscitation, and (c) pediatric resuscitation;
- 6. trauma resuscitation and stabilization,³⁰ including the following: (a) burn management, (b) traumatic brain injury, (c) fracture management, (d) hemorrhage control, and (e) recognition and reporting of nonaccidental trauma;
- 7. disaster drills that include a triage of pediatric victims, the tracking and identification of unaccompanied children, family reunification, and the

determination of pediatric surge capacity²⁹;

- 8. patient- and family-centered care, including cultural competency; and
- 9. team training and effective communication, including the following: (a) transitions of care and/or handoffs³¹ and (b) closed-loop communication.

QI AND/OR PI IN THE ED

Quality is best ensured by evaluating each of the 6 domains addressed by the IOM^{31,32}: safe, equitable, patient centered, timely, efficient, and effective. PI processes are essential to evaluating the quality of care, and measurement is integral to PI activities. Pediatric-specific metrics should be carefully identified to assess the quality of care throughout each phase of health care delivery across the emergency care continuum. A pediatric patient care review process is integrated into the QI and/or PI plan of the ED according to the following recommendations:

- A. The potential framework for QI efforts may be focused on the effectiveness of structural elements, processes, and clinical outcomes relative to pediatric emergency care. Minimum components of the QI and/or PI process should include collecting and analyzing data to discover variances, defining a plan for improvement, and evaluating the success of the QI and/or PI plan with measures that are outcome based. High-level QI efforts are used to facilitate education and training, the implementation of targeted system change, and the measurement of system performance over time until steady, high-level performance is achieved.
- B. The QI and/or PI plan of the ED shall include pediatric-specific indicators. Pediatric emergency

TABLE 1 Sample Performance Measures for Pediatric Emergency Care

Measures	Description
System based	
Patient triage	Measurement of wt in kilograms for pediatric patients; method to identify age-based abnormal pediatric vital signs
Infrastructure and personnel	Presence of all recommended pediatric equipment in the ED; presence of physician and nurse coordinators for pediatric emergency care
Patient-centered care	Patient and/or caregiver understanding of discharge instructions
ED flow	Door-to-provider time; total length of stay
Pain management	Pain assessment and reassessment for children with acute fractures
Quality and safety	Number of return visits within 48 h resulting in hospitalization; medication error rates
Disease specific	
Trauma	Use of head computed tomography in children with minor head trauma; protocol for suspected child maltreatment
Respiratory diseases	Administration of systemic steroids for pediatric asthma exacerbations; use of an evidence-based guideline to manage bronchiolitis
Infectious diseases	Use of antibiotics in children with suspected viral illness

Based on the work of Alessandrini E, Varadarajan K, Alpern ER, et al. Emergency department quality: an analysis of existing pediatric measures. *Acad Emerg Med*. 2011;18(5):519–526.

care metrics have been identified (Table 1) and should be strongly considered for inclusion in the overall QI plan. In addition, performance bundles may be used to assess the quality of care provided for specific clinical conditions (eg, pediatric septic shock, pediatric asthma, and pediatric closed head injury).

C. Components of the process are used to integrate out-of-hospital, ED, trauma, inpatient pediatrics, pediatric critical care, and hospital-wide QI or PI activities and may be interfaced with regional, state, or national QI collaboratives, including injury prevention efforts.^{33–36}

D. Mechanisms are in place to monitor professional performance, credentialing, continuing education, and clinical competencies, including the integration of findings from QI audits and case reviews for pediatric emergency care.

Numerous resources are available to assist ED staff with implementing QI and/or PI activities (Table 2).

POLICIES, PROCEDURES, AND PROTOCOLS FOR THE ED

Recommendations include the following:

- A. Policies, procedures, and protocols for the emergency care of children are age specific and include neonates, infants, children, adolescents, and children with special health care needs. Staff are educated accordingly and monitored for compliance and periodically updated. These include, but are not limited to, the following:
 1. illness and injury triage;
 2. pediatric patient assessment and reassessment;
 3. documentation of a full set of pediatric vital signs, including core temperature, respiratory rate, pulse oximetry, heart rate, blood pressure (including manual confirmation), pain, and mental status when indicated;
 4. identification and notification of the responsible provider of abnormal vital signs (age or weight based);
 5. immunization assessment and management (eg, tetanus and

TABLE 2 Examples of Pediatric Emergency Care PI Activities and Resources

Clinical ED Registry (https://www.acep.org/cedr/)
Committee on Quality Transformation, Section on Emergency Medicine (https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Emergency-Medicine/Pages/About-Us.aspx)
EMSC Innovation and Improvement Center (https://emscimprovement.center)
ENA (https://www.ena.org/#practice-resources)
Education in QI for Pediatric Practice (https://equip.aap.org/)
The National Pediatric Readiness Assessment (https://www.pedsready.org)
PediaLink: The AAP Online Learning Center (https://pedialink.aap.org/visitor)
Pediatric Readiness Toolkit (www.pediatricreadiness.org)
Pediatric Trauma Society (http://pediatrictraumasociety.org/)
Interfacility Tool Kit for the Pediatric Patient (http://www.traumanurses.org/inter-facility-tool-kit-for-the-pediatric-patient)
Pediatric TQIP (https://www.facs.org/quality-programs/trauma/tqip/pediatric-tqip)
PECARN guidelines (http://www.pecarn.org)

PECARN, Pediatric Emergency Care Applied Research Network; TQIP, Trauma Quality Improvement Program.

rabies) of the patient who is underimmunized³⁷;

6. sedation and analgesia (including nonpharmacologic interventions for comfort) for procedures, including medical imaging^{38,39};
7. consent (including situations in which a parent or legal guardian is not immediately available)⁴⁰;
8. social and behavioral health issues, including parents and patients who are belligerent, impaired, or violent^{41–43};
9. physical or chemical restraint of patients;
10. child maltreatment mandated reporting and assessment (physical and sexual abuse, sexual assault, human trafficking, and neglect)⁴⁴;
11. death of a child in the ED^{45,46};
12. do-not-resuscitate orders;

13. lack of a medical home;
 14. children with special health care needs, including developmental disabilities (eg, autism spectrum disorders and ventilator dependence);
 15. family-centered care,^{47–52} including the following:
 - a. involving families and guardians in patient care decision-making and medication safety processes;
 - b. family and guardian presence during all aspects of emergency care, including resuscitation;
 - c. education of the patient, family, and caregivers and guardians;
 - d. discharge planning and education; and
 - e. bereavement counseling;
 16. communication with a patient’s medical home or primary health care provider at the time of the ED visit (this can help ensure that a judicious and appropriate approach to examination, testing, imaging, and treatment is coordinated and follow-up is arranged in the most cost-effective and up-to-date manner)⁵³;
 17. telehealth and telecommunications⁵⁴; and
 18. an all-hazard disaster preparedness plan in which the following pediatric issues are addressed⁵⁵:
 - a. availability of medications, vaccines (eg, tetanus and rabies), equipment, supplies, and appropriately trained providers for children in disasters;
 - b. pediatric surge capacity for both children who are injured and noninjured;
 - c. decontamination, isolation, and quarantine of families and children of all ages;
 - d. minimization of parent-child separation and improved methods for reuniting separated children with their families;
 - e. access to specific medical and behavioral health therapies, as well as social services, for children in the event of a disaster;
 - f. disaster drills that include a pediatric mass casualty incident at least once every 2 years; all drills include pediatric patients; and
 - g. the care of children with special health care needs, including children with developmental disabilities.
- B. Evidence-based clinical pathways, order sets, or decision support should be available to providers in real time. These may be systematically derived, consensus driven, or locally developed on the basis of available evidence. Many children’s hospitals and/or academic centers have developed such clinical pathways. Collaboration with regional pediatric centers and trauma centers may facilitate the use of standard, evidence-based guidelines. An updated and complete list is available on the National Pediatric Readiness Project Web site.^{56–60}**
- C. Hospitals should have written pediatric interfacility transfer procedures and/or agreements that include the following pediatric components^{61–63}:**
1. defined processes for the initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer, method of transport, and communication);
 2. a transport plan to deliver children safely (including the use of child passenger–restraint devices) and in a timely manner to the appropriate facility that is capable of providing definitive care;
3. processes for selecting the appropriate care facility for pediatric specialty services that are not available at the hospital; these specialty services may include the following: (a) medical and surgical specialty care, (b) critical care, (c) reimplantation (replacement of severed digits or limbs), (d) trauma and burn care, (e) psychiatric emergencies, (f) obstetric and perinatal emergencies, (g) child maltreatment (physical and sexual abuse and assault), (h) rehabilitation for recovery from critical medical or traumatic conditions, (i) orthopedic emergencies, and (j) neurosurgical emergencies;
 4. processes for selecting the appropriately staffed transport service to match a patient’s acuity level (ie, level of care required and equipment needed for transport) and that are appropriate for children with special health care needs;
 5. processes for patient transfer (including obtaining informed consent)⁶⁴;
 6. a plan for the transfer of critical patient information (ie, medical record, imaging, and copy of signed transport consent) as well as personal belongings and the provision of directions and referral institution information to the family;
 7. processes for the return transfer of the pediatric patient to the referring facility as appropriate; and

8. integration with telehealth and/or telecommunications processes and mobile-integrated health and/or community paramedicine as appropriate.⁵⁴

PEDIATRIC PATIENT AND MEDICATION SAFETY IN THE ED

The delivery of pediatric care should reflect an awareness of unique pediatric patient safety concerns and should include the following policies or practices^{65,66}:

- A. Children should be weighed in kilograms, with the exception of children who require emergency stabilization, and the weight should be recorded in a prominent place on the medical record, preferably with the vital signs.
 1. For children who require resuscitation or emergency stabilization, a standard method for estimating weight in kilograms should be used.
- B. A full set of vital signs should be recorded and reassessed per hospital policy for all children.
- C. The following processes for safe medication (including blood products) prescribing, delivery, and disposal should be established^{67,68}:
 1. use precalculated dosing guidelines for children of all ages;
 2. consider adding a pharmacist with pediatric competency to the ED team, especially in large EDs, during times of higher volume;
 3. identify the administration phase as a high-risk practice (eg, the simple misplacement of a decimal point can result in a 10-fold medication error);
 4. promote distraction-free zones for medication preparation^{69,70};

5. implement and use computerized physician order entry and clinical decision support with pediatric-specific, kilogram-only dosing rules, including upper dosing limits, within ED information systems;
6. implement and use computerized physician order entry to create allergy alerts for all prescribed medications;
7. practice vigilance for all administered or prescribed medications and consider developing standardized order sets, particularly for high-risk medications, such as opioids and antibiotics;
8. implement an independent 2-provider cross-check process for high-alert medications;
9. create a standard formulary for pediatric high-risk and commonly used medications;
10. standardize concentrations of high-risk medications;
11. reduce the number of available concentrations to the smallest possible number;
12. implement systems in which weight-based calculations are bypassed during pediatric resuscitations and treatment to reduce potentially harmful mistakes;
13. establish a culture of safety surrounding pediatric medication administration that encourages the reporting of near-miss or adverse medication events that can then be analyzed as feedback into the system in a continuous QI model;
14. ensure that caregivers are well instructed on medication administration, particularly for pain and antipyretic medications, before being discharged from the ED; and

15. promote the integration of health literacy concepts and skills, including the use of plain language, the teach-back method, pictograms, and lower-literacy instructions.^{71–75}

- D. Pediatric emergency services should be culturally and linguistically appropriate,⁷⁶ and the ED should provide an environment that is safe for children and supports patient- and family-centered care.^{48,49,77}
 1. Enhance family-centered care by actively engaging patients and families in safety at all points of care, and address issues of ethnic culture, language, and literacy.
 2. Direct families to appropriate resources, and review patients' rights and responsibilities from the perspective of safety.
 3. Include shared decision-making.
 4. Use trained language interpreter services rather than bilingual relatives.
- E. Patient-identification policies, consistent with The Joint Commission's National Patient Safety Goals, should be implemented and monitored.⁷⁸
- F. Policies for the timely tracking, reporting, and evaluation of patient safety events and for the disclosure of medical errors or unanticipated outcomes should be implemented and monitored, and education and training in disclosure should be available to care providers who are assigned this responsibility.^{65,66}

SUPPORT SERVICES FOR THE ED

Recommendations include the following:

- A. The radiology department should have the skills and capability to provide imaging studies of children, the equipment necessary to do so, and guidelines to reduce

radiation exposure that are age and size specific.^{79–81}

1. The radiology capability of hospitals may vary from 1 institution to another; however, every ED should promote on-site radiology capabilities to meet the needs of children in the community.
 2. Medical imaging protocols that are used to address age- or weight-appropriate dose reductions for children receiving studies in which ionizing radiation is imparted, consistent with “as low as reasonably achievable” principles, are necessary.⁸²
 3. A process should be established for the referral of children to appropriate facilities for radiologic procedures that exceed the capability of the hospital.
 4. A process should be in place for timely review and interpretation reporting by a qualified radiologist for medical imaging studies in children.
 5. When a patient is transferred from 1 facility to another, to avoid unnecessary radiation exposure, all efforts should be made to transfer completed images. New technology (eg, Cloud file sharing or Health Insurance Portability and Accountability Act protection) may facilitate image sharing between facilities.⁸³
- B. The laboratory should have the skills and capability to perform laboratory tests for children of all ages, including obtaining samples, and have available microtechnology for small or limited sample sizes.
1. The clinical laboratory capability must meet the needs of the children in the community it serves.

2. There should be a clear understanding of what the laboratory capability is for any given community, and definitive plans for referring children to the appropriate facility for laboratory studies should be in place.
3. Protocols should be developed for the screening and administration of blood and blood products for children who are ill or injured.

EQUIPMENT, SUPPLIES, AND MEDICATIONS

Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized (eg, kilogram weight, weight-based color coding, etc).

- A. Medication chart, color-based coding, medical software, or other systems shall be readily available to ED staff to ensure proper sizing of resuscitation equipment and proper dosing of medications based on patient weight in kilograms.
- B. Resuscitation equipment and supplies shall be located in the ED; trays and other items may be housed in other departments (such as the newborn nursery or central supply) with a process to ensure immediate accessibility to ED staff. A mobile or portable appropriately stocked pediatric crash cart should be available in the ED at all times.
- C. ED staff shall be appropriately educated as to the location of all items (Supplemental Figs 1 and 2).
- D. Each ED shall have a daily method to verify the proper location and function of equipment and expiration of medications and supplies.
- E. Tables 3 and 4 and Supplemental Figs 1 and 2 outline medications, equipment, and supplies necessary for the care of children in the ED by qualified health care providers.⁸⁴

TABLE 3 Resuscitation Medications for Use in Pediatric Patients in EDs

Adenosine
Amiodarone
Atropine
Calcium chloride and/or calcium gluconate
Epinephrine (1 mg/mL [IM] and 0.1 mg/mL [IV solutions]) ^a
Lidocaine
Procainamide
Sodium bicarbonate (4.2%) ^b
Vasopressor agents (eg, dopamine, epinephrine, and norepinephrine)

For a more complete list of medications used in a pediatric ED, see Winkelman et al.⁷⁵ IM, intramuscular; IV, intravenous.

^a The formerly epinephrine 1:1000 solution is now 1 mg/mL for IM use or inhalation; the 1:10000 solution is now 0.1 mg/mL for IV use.

^b If only sodium bicarbonate 8.4% is available, may dilute 1:1 with normal saline before administration in children <2 y of age.

CONCLUSIONS

In the 2006 report, “Emergency Care for Children: Growing Pains,” the IOM uses the word “uneven” to describe the current status of pediatric emergency care in the United States.⁸ Although much progress has been made to improve pediatric readiness across communities,⁵ there remains a significant opportunity for further progress nationwide. An important first step in ensuring readiness is the identification of a physician and nurse coordinator for pediatric emergency care.

All EDs must be continually prepared to receive; accurately assess; and, at a minimum, stabilize and safely transfer children who are acutely ill or injured. This is necessary even for hospitals located in communities with readily accessible pediatric tertiary-care centers and regionalized systems for pediatric trauma and critical care. The vast majority of children requiring emergency services in the United States receive this care in a non-children’s hospital ED, with 69% of EDs providing care for fewer than 15 children per day.⁵ This relatively infrequent exposure of hospital-based emergency care professionals to children who are seriously ill or injured represents

TABLE 4 Medications to Be Used in the ED for the Care of Children

Analgesics (oral, intranasal, and parenteral)
Anesthetics (eg, eutectic mixture of local anesthetics; lidocaine 2.5% and prilocaine 2.5%; lidocaine, epinephrine, and tetracaine; and LMX 4 [4% lidocaine])
Anticonvulsants (eg, levetiracetam, valproate, carbamazepine, fosphenytoin, and phenobarbital)
Antidotes (common antidotes should be accessible to the ED) ^a
Antiemetics (eg, ondansetron and prochlorperazine)
Antihypertensives (eg, labetalol, nicardipine, and sodium nitroprusside)
Antimicrobials (parenteral and oral)
Antipsychotics (eg, olanzapine and haloperidol)
Antipyretics (eg, acetaminophen and ibuprofen)
Benzodiazepines (eg, midazolam and lorazepam)
Bronchodilators
Corticosteroids (eg, dexamethasone, methylprednisolone, and hydrocortisone)
Dextrose (D ₁₀ W)
Diphenhydramine
Furosemide
Glucagon
Insulin
Lidocaine
Magnesium sulfate
Mannitol
Naloxone hydrochloride
Neuromuscular blockers (eg, rocuronium and succinylcholine)
Oral glucose
Sucrose solutions for pain control in infants
Sedation medications (eg, etomidate and ketamine)
Vaccines
3% hypertonic saline

D₁₀W, dextrose 10% in water.

^a For less frequently used antidotes, a procedure for obtaining them should be in place.

a substantial barrier to the maintenance of essential skills and clinical competency. Recognition of the unique needs of children who are ill and/or injured and served by an emergency care facility, including children with special health care needs; the commitment to better meet those needs through the adoption of these recommendations; and an ongoing commitment to evaluate care quality and safety and maintain pediatric competencies should provide a strong foundation for pediatric emergency care.

Resources that can be used to assist with the implementation of all aspects of this document can be found at www.pediatricreadiness.org.

LEAD AUTHORS

Katherine Remick, MD, FAAP, FACEP, FAEMS
Marianne Gausche-Hill, MD, FAAP, FACEP
Madeline M. Joseph, MD, FAAP, FACEP
Kathleen Brown, MD, FAAP, FACEP
Sally K. Snow, BSN, RN, CPEN
Joseph L. Wright, MD, MPH, FAAP

AAP COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE, 2017–2018

Joseph Wright, MD, MPH, FAAP, Chairperson
Terry Adirim, MD, MPH, FAAP
Michael S.D. Agus, MD, FAAP
James Callahan, MD, FAAP
Toni Gross, MD, MPH, FAAP
Natalie Lane, MD, FAAP
Lois Lee, MD, MPH, FAAP
Suzan Mazor, MD, FAAP
Prashant Mahajan, MD, MPH, MBA, FAAP
Nathan Timm, MD, FAAP

LIAISONS

Andrew Eisenberg, MD, MHA – *American Academy of Family Physicians*
Cynthia Wright Johnson, MSN, RN – *National Association of State EMS Officials*
Cynthiana Lightfoot, BFA, NRP – *American Academy of Pediatrics Family Partnerships Network*
Charles Macias, MD, MPH, FAAP – *Emergency Medical Services for Children Innovation and Improvement Center*
Brian Moore, MD, MPH, FAAP – *National Association of EMS Physicians*
Diane Pilkey, RN, MPH – *Health Resources and Services Administration*
Katherine Remick, MD, FAAP – *National Association of Emergency Medical Technicians*
Mohsen Saidinejad, MD, MBA, FAAP, FACEP – *American College of Emergency Physicians*
Sally Snow, RN, BSN, CPEN, FAEN – *Emergency Nurses Association*
Mary Fallat, MD, FAAP – *American College of Surgeons*

FORMER AAP COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE MEMBERS, 2012–2016

Alice Ackerman, MD, MBA, FAAP
Thomas Chun, MD, MPH, FAAP
Gregory Conners, MD, MPH, MBA, FAAP
Edward Conway Jr, MD, MS, FAAP
Nanette Dudley, MD, FAAP
Joel Fein, MD, FAAP
Susan Fuchs, MD, FAAP
Marc Gorelick, MD, MSCE, FAAP
Natalie Lane, MD, FAAP

Steven Selbst, MD, FAAP
Kathy Shaw, MD, MSCE, FAAP, Chairperson (2008–2012)
Joan Shook, MD, MBA, FAAP, Chairperson (2012–2016)

STAFF

See Tellez

AAP SECTION ON SURGERY EXECUTIVE COMMITTEE, 2016–2017

Kurt F. Heiss, MD, Chairperson
Elizabeth Beierle, MD
Gail Ellen Besner, MD
Cynthia D. Downard, MD
Mary Elizabeth Fallat, MD
Kenneth William Gow, MD

STAFF

Vivian Baldassari Thorne

ACEP PEDIATRIC EMERGENCY MEDICINE COMMITTEE, 2016–2017

Madeline Joseph, MD, FACEP, Chairperson
Kiyetta Alade, MD
Christopher Amato, MD, FACEP
Jahn T. Avarello, MD, FACEP
Steven Baldwin, MD
Isabel A. Barata, MD, FACEP, FAAP
Lee S. Benjamin, MD, FACEP
Kathleen Berg, MD
Kathleen Brown, MD, FACEP
Jeffrey Bullard-Berent, MD, FACEP
Ann Marie Dietrich, MD, FACEP
Phillip Friesen, DO
Michael Gerardi, MD, FACEP, FAAP
Alan Heins, MD, FACEP
Doug K. Holtzman, MD, FACEP
Jeffrey Homme, MD, FACEP
Timothy Horeczko, MD, MSCR
Paul Ishimine, MD, FACEP
Samuel Lam, MD, RDMS
Katharine Long
Kurtis Mayz, JD, MD, MBA
Sanjay Mehta, MD, Med, FACEP
Larry Mellick, MD
Aderonke Ojo, MD, MBBS
Audrey Z. Paul, MD, PhD
Denis R. Pauze, MD, FACEP
Nadia M. Pearson, DO
Debra Perina, MD, FACEP
Emory Petrack, MD
David Rayburn, MD, MPH
Emily Rose, MD
W. Scott Russell, MD, FACEP
Timothy Ruttan, MD, FACEP
Mohsen Saidinejad, MD, MBA, FACEP
Brian Sanders, MD
Joelle Simpson, MD, MPH
Patrick Solari, MD
Michael Stoner, MD
Jonathan H. Valente, MD, FACEP
Jessica Wall, MD
Dina Wallin, MD

Muhammad Waseem, MD, MS, FACEP
Paula J. Whiteman, MD, FACEP
Dale Woolridge, MD, PhD, FACEP

Harold A. Sloas, DO
Annalise Sorrentino, MD, FACEP
Orel Swenson, MD
Michael Witt, MD, MPH, FACEP

STAFF

Marlene Bokholdt, MSN, RN

FORMER ACEP PEDIATRIC EMERGENCY MEDICINE COMMITTEE MEMBERS, 2012–2016

Joseph Arms, MD
Richard M. Cantor, MD, FACEP
Ariel Cohen, MD
Carrie DeMoor, MD
James M. Dy, MD
Paul J. Eakin, MD
Sean Fox, MD
Marianne Gausche-Hill, MD, FACEP, FAAP
Timothy Givens, MD
Charles J. Graham, MD, FACEP
Robert J. Hoffman, MD, FACEP
Mark Hostetler, MD, FACEP
Hasmig Jinivizian, MD
David Markenson, MD, MBA, FACEP
Joshua Rocker, MD, FACEP
Brett Rosen, MD
Gerald R. Schwartz, MD, FACEP

STAFF

Loren Rives, MNA
Dan Sullivan
Stephanie Wauson

ENA PEDIATRIC COMMITTEE, 2016–2017

Tiffany Young, BSN, RN, CPNP, 2016 Chairperson
Joyce Foresman-Capuzzi, MSN, RN, CNS, 2017 Chairperson
Rose Johnson, RN
Heather Martin, DNP, MS, RN, PNP-BC
Justin Milici, MSN, RN
Cam Brandt, MS, RN
Nicholas Nelson, MS, RN, EMT-P

BOARD LIAISONS

Maureen Curtis-Cooper, BSN, RN, 2016 Board Liaison
Kathleen Carlson, MSN, RN, 2017 Board Liaison

ABBREVIATIONS

AAP: American Academy of Pediatrics
ACEP: American College of Emergency Physicians
ED: emergency department
EMS: emergency medical services
EMSC: Emergency Medical Services for Children
ENA: Emergency Nurses Association
IOM: Institute of Medicine
PECC: pediatric emergency care coordinator
PI: performance improvement
QI: quality improvement

the Emergency Nurses Association and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: <https://doi.org/10.1542/peds.2018-2459>

Address correspondence to Katherine Remick, MD. E-mail: kate.remick@gmail.com

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2018 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

REFERENCES

1. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee. Care of children in the emergency department: guidelines for preparedness. *Pediatrics*. 2001;107(4):777–781
2. Gausche-Hill M, Wiebe RA. Guidelines for preparedness of emergency departments that care for children: a call to action. *Ann Emerg Med*. 2001;37(4):389–391
3. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement—guidelines for care of children in the emergency department. *Pediatrics*. 2009;124(4):1233–1243
4. American Academy of Pediatrics Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement—guidelines for care of children in the emergency department. *Ann Emerg Med*. 2009;54(4):543–552
5. Gausche-Hill M, Ely M, Schmuhl P, et al. A national assessment of pediatric readiness of emergency departments. *JAMA Pediatr*. 2015;169(6):527–534
6. Committee on Pediatric Emergency Medicine. Pediatric care recommendations for freestanding

- urgent care facilities. *Pediatrics*. 2014;133(5):950–953
7. US Department of Health and Human Services; Centers for Disease Control and Prevention; National Center for Health Statistics. National Hospital Ambulatory Medical Care Survey: 2014 emergency department summary tables. Available at: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2014_ed_web_tables.pdf. Accessed December 6, 2017
 8. Institute of Medicine, Committee of the Future of Emergency Care in the US Health System. *Emergency Care for Children: Growing Pains*. Washington, DC: National Academies Press; 2006
 9. National Pediatric Readiness Project. National pediatric readiness project. 2014. Available at: www.pediatricreadiness.org/State_Results/National_Results.aspx. Accessed April 10, 2014
 10. US Department of Health and Human Services, Health Resources and Services Administration. Performance measures. Available at: <https://emscimprovement.center/emsc/performance-measures/>. Accessed August 31, 2017
 11. Alessandrini EA, Wright JL. The continuing evolution of pediatric emergency care. *JAMA Pediatr*. 2015;169(6):523–524
 12. Sacchetti A. Is it still an emergency department if it can't treat children? *Ann Emerg Med*. 2016;67(3):329–331
 13. Gausche-Hill M, Schmitz C, Lewis RJ. Pediatric preparedness of US emergency departments: a 2003 survey. *Pediatrics*. 2007;120(6):1229–1237
 14. Remick K, Kaji AH, Olson L, et al. Pediatric readiness and facility verification. *Ann Emerg Med*. 2016;67(3):320–328.e1
 15. Emergency Medical Services for Children. Pediatric medical recognition systems fact sheet. 2016. Available at: www.nedarc.org/documents/medicalRecognition_030416.pdf. Accessed June 7, 2018
 16. Hohenhaus SM, Lyons E, Phillippi RG. Emergency departments and pediatric categorization, approval, and recognition: a review of two states. *J Emerg Nurs*. 2008;34(3):236–237
 17. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academies Press; 2000
 18. Krug SE, Frush K; Committee on Pediatric Emergency Medicine, American Academy of Pediatrics. Patient safety in the pediatric emergency care setting. *Pediatrics*. 2007;120(6):1367–1375. Reaffirmed June 2011 and July 2014
 19. Stevens AD, Hernandez C, Jones S, et al. Color-coded prefilled medication syringes decrease time to delivery and dosing errors in simulated prehospital pediatric resuscitations: a randomized crossover trial. *Resuscitation*. 2015;96:85–91
 20. Feleke R, Kalynych CJ, Lundblom B, Wears R, Luten R, Kling D. Color coded medication safety system reduces community pediatric emergency nursing medication errors. *J Patient Saf*. 2009;5(2):79–85
 21. Cabana MD, Rand CS, Powe NR, et al. Why don't physicians follow clinical practice guidelines? A framework for improvement. *JAMA*. 1999;282(15):1458–1465
 22. Gandhi TK, Sequist TD, Poon EG, et al. Primary care clinician attitudes towards electronic clinical reminders and clinical practice guidelines. *AMA Annu Symp Proc*. 2003:848
 23. Ball JW, Sanddal ND, Mann NC, et al. Emergency department recognition program for pediatric services: does it make a difference? *Pediatr Emerg Care*. 2014;30(9):608–612
 24. Kessler DO, Walsh B, Whitfill T, et al; INSPIRE ImPACTS Investigators. Disparities in adherence to pediatric sepsis guidelines across a spectrum of emergency departments: a multicenter, cross-sectional observational in situ simulation study. *J Emerg Med*. 2016;50(3):403–415. e1–e3
 25. Rice A, Dudek J, Gross T, St Mars T, Woolridge D. The impact of a pediatric emergency department facility verification system on pediatric mortality rates in Arizona. *J Emerg Med*. 2017;52(6):894–901
 26. Weinberg ER, Auerbach MA, Shah NB. The use of simulation for pediatric training and assessment. *Curr Opin Pediatr*. 2009;21(3):282–287
 27. Lasater K. High-fidelity simulation and the development of clinical judgment: students' experiences. *J Nurs Educ*. 2007;46(6):269–276
 28. Decker S, Sportsman S, Puetz L, Billings L. The evolution of simulation and its contribution to competency. *J Contin Educ Nurs*. 2008;39(2):74–80
 29. Gardner AH, Fitzgerald MR, Schwartz HP, Timm NL. Evaluation of regional hospitals' use of children in disaster drills. *Am J Disaster Med*. 2013;8(2):137–143
 30. Bulger EM, Snyder D, Schoelles K, et al; American College of Surgeons, Committee on Trauma. An evidence-based prehospital guideline for external hemorrhage control: American College of Surgeons Committee on Trauma. *Prehosp Emerg Care*. 2014;18(2):163–173
 31. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Handoffs: transitions of care for children in the emergency department. *Pediatrics*. 2016;138(5):e20162680
 32. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001
 33. Children's Hospital Association. Sepsis collaborative. Available at: <https://www.childrenshospitals.org/sepsiscollaborative>. Accessed May 8, 2017
 34. American Academy of Pediatrics. Collaborative initiatives. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Collaborative-Initiatives.aspx>. Accessed May 8, 2017
 35. EMS for Children Innovation and Improvement Center. Collaboratives. Available at: <https://emscimprovement.center/collaboratives/>. Accessed May 8, 2017

36. EMS for Children Innovation and Improvement Center. Pediatric readiness quality collaborative (PRQC). Available at: <https://emscimprovement.center/collaboratives/PRQuality-collaborative/>. Accessed June 13, 2018
37. American College of Emergency Physicians. Immunization of adults and children in the emergency department. *Ann Emerg Med*. 2008;51(5):695
38. Fein JA, Zempsky WT, Cravero JP; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, Section on Anesthesiology and Pain Medicine. Relief of pain and anxiety in pediatric patients in emergency medical systems. *Pediatrics*. 2012;130(5). Available at: www.pediatrics.org/cgi/content/full/130/5/e1391
39. Mace SE, Brown LA, Francis L, et al; EMSC Panel (Writing Committee) on Critical Issues in the Sedation of Pediatric Patients in the Emergency. Clinical policy: critical issues in the sedation of pediatric patients in the emergency department. *Ann Emerg Med*. 2008;51(4):378–399, 399.e1–e57
40. Committee on Pediatric Emergency Medicine; Committee on Bioethics. Consent for emergency medical services for children and adolescents. *Pediatrics*. 2011;128(2):427–433
41. Dolan MA, Fein JA; Committee on Pediatric Emergency Medicine. Pediatric and adolescent mental health emergencies in the emergency medical services system. *Pediatrics*. 2011;127(5). Available at: www.pediatrics.org/cgi/content/full/127/5/e1356
42. US Department of Labor, Occupation Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers. 2016. Available at: <https://www.osha.gov/Publications/OSHA3148.pdf>. Accessed December 6, 2017
43. US Department of Labor, Occupation Safety and Health Administration. Preventing workplace violence: a roadmap for healthcare facilities. 2015. Available at: <https://www.osha.gov/Publications/OSHA3827.pdf>. Accessed December 6, 2017
44. Greenbaum J, Bodrick N; Committee on Child Abuse and Neglect; Section on International Child Health. Global human trafficking and child victimization. *Pediatrics*. 2017;140(6):e20173138
45. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Death of a child in the emergency department. *Pediatrics*. 2014;134(1):198–201
46. O'Malley P, Barata I, Snow S; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Death of a child in the emergency department. *Pediatrics*. 2014;134(1). Available at: www.pediatrics.org/cgi/content/full/134/1/e313
47. Committee on Hospital Care; American Academy of Pediatrics. Family-centered care and the pediatrician's role. *Pediatrics*. 2003;112(3, pt 1):691–697
48. O'Malley P, Mace SE, Brown K; American Academy of Pediatrics; American College of Emergency Physicians. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. *Ann Emerg Med*. 2006;48(5):643–645
49. O'Malley P, Brown K, Mace SE; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. *Pediatrics*. 2006;118(5):2242–2244
50. Emergency Nurses Association. *ENA Position Statement: Care of the Pediatric Patient in the Emergency Care Setting*. Des Plaines, IL: Emergency Nurses Association; 2007
51. Guzzetta CE, Clark AP, Wright JL. Family presence in emergency medical services for children. *Clin Pediatr Emerg Med*. 2006;7(1):15–24
52. Emergency Nurses Association. *ENA Position Statement: Family Presence at the Bedside During Invasive Procedures and Cardiopulmonary Resuscitation*. Des Plaines, IL: Emergency Nurses Association; 2005
53. Medical Home Initiatives for Children With Special Needs Project Advisory Committee; American Academy of Pediatrics. The medical home. *Pediatrics*. 2002;110(1, pt 1):184–186
54. Marcin JP, Rimsza ME, Moskowitz WB; Committee on Pediatric Workforce. The use of telemedicine to address access and physician workforce shortages. *Pediatrics*. 2015;136(1):202–209
55. Disaster Preparedness Advisory Council; Committee on Pediatric Emergency Medicine. Ensuring the health of children in disasters. *Pediatrics*. 2015;136(5). Available at: www.pediatrics.org/cgi/content/full/136/5/e1407
56. Kuppermann N, Holmes JF, Dayan PS, et al; Pediatric Emergency Care Applied Research Network (PECARN). Identification of children at very low risk of clinically-important brain injuries after head trauma: a prospective cohort study. *Lancet*. 2009;374(9696):1160–1170
57. Gray MP, Keeney GE, Grahl MJ, Gorelick MH, Spahr CD. Improving guideline-based care of acute asthma in a pediatric emergency department. *Pediatrics*. 2016;138(5):e20153339
58. American Academy of Pediatrics, Section on Emergency Medicine; Children's Hospital Association of Texas. Pediatric Septic Shock Collaborative septic shock identification tool. Available at: <http://chatexas.com/wp-content/uploads/2016/12/Septic-Shock-Identification-Tool-1.pdf>. Accessed May 8, 2017
59. Tieder JS, Bonkowsky JL, Etzel RA, et al; Subcommittee on Apparent Life Threatening Events. Brief resolved unexplained events (formerly apparent life-threatening events) and evaluation of lower-risk infants: executive summary. *Pediatrics*. 2016;137(5):e20160591

60. Harrison D, Beggs S, Stevens B. Sucrose for procedural pain management in infants. *Pediatrics*. 2012;130(5):918–925
61. Emergency Medical Services for Children. Interfacility transfer tool kit for the pediatric patient. Available at: <https://emscimprovement.center/resources/publications/interfacility-transfer-tool-kit/>. Accessed June 13, 2018
62. Emergency Nurses Association, Position Statement Committee. Interfacility transfer of emergency care patients. 2015. Available at: https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/facilitatingtheinterfacilitytransfer.pdf?sfvrsn=d3d9c8f4_14. Accessed June 13, 2018
63. American College of Surgeons, Committee on Trauma. Resources for optimal care of the injured patient. 2014. Available at: <https://www.facs.org/~media/files/quality%20programs/trauma/vrc%20resources/resources%20for%20optimal%20care.ashx>. Accessed May 8, 2017
64. Benjamin L, Ishimine P, Joseph M, Mehta S. Evaluation and treatment of minors. *Ann Emerg Med*. 2018;71(2):225–232
65. Lannon CM, Coven BJ, Lane France F, et al; National Initiative for Children's Health Care Quality Project Advisory Committee. Principles of patient safety in pediatrics. *Pediatrics*. 2001;107(6):1473–1475
66. Krug SE, Frush K; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Patient safety in the pediatric emergency care setting. *Pediatrics*. 2007;120(6):1367–1375
67. Stucky ER; American Academy of Pediatrics, Committee on Drugs; American Academy of Pediatrics, Committee on Hospital Care. Prevention of medication errors in the pediatric inpatient setting. *Pediatrics*. 2003;112(2):431–436
68. Lesar TS, Mitchell A, Sommo P. Medication safety in critically ill children. *Clin Pediatr Emerg Med*. 2006;7(4):215–225
69. Westbrook JI, Woods A, Rob MI, Dunsmuir WT, Day RO. Association of interruptions with an increased risk and severity of medication administration errors. *Arch Intern Med*. 2010;170(8):683–690
70. The Joint Commission. Preventing pediatric medication errors. *Sentinel Event Alert*. 2008;39(39):1–4
71. American Academy of Pediatrics. Abrams MA, Dreyer BP, eds. *Plain Language Pediatrics: Health Literacy Strategies and Communication Resources for Common Pediatric Topics*. Elk Grove Village, IL: American Academy of Pediatrics; 2008
72. Institute of Medicine. *Toward Health Equity and Patient-Centeredness: Integrating Health Literacy, Disparities Reduction, and Quality Improvement: Workshop Summary*. Washington, DC: National Academies Press; 2009
73. Cheng TL, Dreyer BP, Jenkins RR. Introduction: child health disparities and health literacy. *Pediatrics*. 2009;124(suppl 3):S161–S162
74. DeWalt DA, Hink A. Health literacy and child health outcomes: a systematic review of the literature. *Pediatrics*. 2009;124(suppl 3):S265–S274
75. Winkelman TNA, Caldwell MT, Bertram B, Davis MM. Promoting health literacy for children and adolescents. *Pediatrics*. 2016;138(6):e20161937
76. Taveras EM, Flores G. Why culture and language matter: the clinical consequences of providing culturally and linguistically appropriate services to children in the emergency department. *Clin Pediatr Emerg Med*. 2004;5(2):76–84
77. Sadler BL, Joseph A. *Evidence for Innovation: Transforming Children's Health Through the Physical Environment*. Alexandria, VA: National Association of Children's Hospitals and Related Institutions; 2008
78. The Joint Commission. National patient safety goals effective January 2017: hospital accreditation program. 2017. Available at: https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2017.pdf. Accessed May 8, 2017
79. Brody AS, Frush DP, Huda W, Brent RL; American Academy of Pediatrics, Section on Radiology. Radiation risk to children from computed tomography. *Pediatrics*. 2007;120(3):677–682
80. Goske MJ, Applegate KE, Boylan J, et al. The 'Image Gently' campaign: increasing CT radiation dose awareness through a national education and awareness program. *Pediatr Radiol*. 2008;38(3):265–269
81. Strauss KJ, Goske MJ. Estimated pediatric radiation dose during CT. *Pediatr Radiol*. 2011;41(suppl 2):472–482
82. Furlow B. Radiation protection in pediatric imaging. *Radiol Technol*. 2011;82(5):421–439
83. Vest JR, Jung H, Ostrovsky A, Tanmoy Das L, McGinty GB. Image sharing technologies and reduction of imaging utilization: A systematic review and meta-analysis. *J Am Coll Radiol*. 2015;12(12):1371–1379.e3
84. Hegenbarth MA; American Academy of Pediatrics, Committee on Drugs. Preparing for pediatric emergencies: drugs to consider. *Pediatrics*. 2008;121(2):433–443