DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Emergency Medical Services and Trauma Center Code

2) Code Citation: 77 Ill. Adm. Code 515

3)

Section Numbers:	Adopted Action:
515.100	Amended
515.125	Amended
515.445	Amended
515.825	Amended
515.830	Amended
515.3090	New
515.4000	Amended
515.4010	Amended
515.4020	New
515.APPENDIX D	Amended
515.APPENDIX K	Amended
515.APPENDIX L	Amended
515.APPENDIX M	Amended
515.APPENDIX N	New
515.APPENDIX O	New
515.APPENDIX P	New

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50]

5) Effective Date of Rulemaking: December 9, 2011

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposed Amendments Published in Illinois Register: July 8, 2011; 35 Ill. Reg. 10520

10) Has JCAR issued a Statement of Objection to this rulemaking? No

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11) Differences between proposal and final version: The following changes, including numerous nonsubstantive grammatical and formatting changes and changes reflecting previously adopted amendments, were made during the first notice period:

1. In Section 515.4010(a)(1)(B), restored "(AHA-AAP)".

2. In Section 515.APPENDIX K, under the header "Recognition of Emergency Department Pediatric Capabilities Application Form", at the end of #3, add the following:

   "Contact person − Phone number, fax number and email".

3. In Section 515.APPENDIX K(D)(2), remove strikeout from the word "recognition" in the sentence "Documentation of the ability to meet facility recognition requirements in Section 515.4000 or 515.4010 of this Part".

4. In Section 515.APPENDIX L, in the table headed "Vascular Access Supplies and Equipment", under "IV solutions", change D10W, D5/0.2 NS, D5/0.45 NS, D5/0.9NS and 0.9 NS)" to "(D10W, D5/.2 NS , D5/.45 NS ~~D5/45NS~~, D5/.9NS and 0.9 NS)".

5. In Section 515.APPENDIX L, in the text headed "Respiratory Equipment and Supplies", after "Uncuffed", strike "3.5, 4.0, 4.5, 5.0, 5.5" in the parenthesis and add "Cuffed or Uncuffed (3.5, 4.0, 5.0, 5.5)".

6. In Section 515.APPENDIX L, in the text headed "Medications", after "Poison Specific Antidotes", insert "Acetylcysteine E (ED) E (ED)" and after "Tetanus Vaccines (single or in combination with other vaccines)", insert "Topical Anesthetics".

7. In Section 515.APPENDIX O, under the II heading, at (A)(1), change "ICU" to "PICU".

The following changes were made in response to comments and suggestions of JCAR:

1. In Section 515.100, under the definition of "Hospitalist", change "pediatrician" to "physician".

2. In Section 515.100 (a)(1)(G), change "2005" to "2011".

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3. In Appendix L, in the text under the heading titled "Medications (unit dose, prepackaged)", under "Poison Specific Antidotes", after "Acetylcysteine", remove the strikeouts on "Cyanide kit".

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rulemaking currently in effect? No

14) Are there any amendments pending on this Part? Yes

Section Numbers	Proposed Action	Ill. Reg. Citation
515.860	New	35 Ill. Reg. 12645; July 29, 2011
515.750	Amend	35 Ill. Reg. 14071; August 19, 2011
515.620	Amend	35 Ill. Reg. 18565; November 14, 2011

15) Summary and Purpose of Rulemaking: Sections of the Emergency Medical Services and Trauma Center Code are being amended to ensure consistency with current standards of care and health care practices as well as current federal mandates. Definitions have been added for the pediatric facility recognition levels (Emergency Department Approved for Pediatrics (EDAP), Pediatric Critical Care Center (PCCC) and Standby Emergency Department Approved for Pediatrics (SEDP)) and for new terminology, such as child life specialist and hospitalists, and the definition of pediatric trauma patient has been extended to include all pediatric patients. The composition of the Illinois Emergency Medical Services for Children (EMSC) Advisory Board has been amended to reflect current existent health care organizations as well as to ensure consistency with state board membership as outlined in the Federal EMSC/HRSA(Health Resources and Services Administration) performance measures [www.childrensnational.org]. Equipment requirements for ambulance and alternate response vehicles are amended to further address the pediatric population and assure compliance with the Federal EMSC/HRSA mandated performance measures. The pediatric facility recognition requirements are amended as follows: pediatric standardized courses (Advanced Pediatric Life Support (APLS), Emergency Nursing Pediatric Course (ENPC) and Pediatric Advanced Life Support (PALS)) being used to meet continuing education requirements must include both cognitive and practical skills evaluation; individual waivers for physicians and nurse practitioners must be submitted each renewal cycle (as applicable); the names of specific accrediting agencies for physician assistant continuing education hours have been eliminated; specific components that need to be contained in

inter-facility transfer guidelines are outlined as mandated by the Federal EMSC/HRSA performance measures; medical audit/quality improvement monitors are afforded the same status as outlined in the Code of Civil Procedure; each hospital participating in pediatric facility recognition will be required to appoint a pediatric physician champion; and the title of the Pediatric CQI Liaison has been changed to Pediatric Quality Coordinator. Pediatric pre-hospital protocols need to address use of an automated external defibrillator (AED) in the pediatric patient and address environmental hyperthermia in the pediatric patient. Equipment requirements for the emergency department are amended to ensure consistency with the American

Academy of Pediatrics Joint Policy Statement – Guidelines for Care of Children in the Emergency Department [www.pediatrics.org].

New Sections are being added related to the pediatric facility recognition to assure compliance with current health care standards and federal EMSC/HRSA performance measures. Section 515.3090 and Appendix N outline processes related to pediatric facility recognition initial application, renewal application, termination of recognition and violation of SEDP, EDAP and Pediatric Critical Care Center (PCCC) requirements. Section 515.4020 contains the PCCC requirements, which outline criteria that hospitals must meet to be recognized by the Department for their pediatric intensive/critical care and pediatric specialty services. Section 515. Appendix O provides the application guide that hospital must follow to apply for PCCC recognition. Appendix P contains requirements for equipment, supplies, and medication.

16) Information and questions regarding these adopted amendments shall be directed to:

Susan Meister
Division of Legal Services
Department of Public Health
535 West Jefferson, 5th Floor
Springfield, Illinois 62761

217/782-2043
e-mail: dph.rules@illinois.gov

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

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

SUBPART A: GENERAL

Section

SUBPART B: EMS REGIONS

Section

SUBPART C: EMS SYSTEMS

Section

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SUBPART D: EMERGENCY MEDICAL TECHNICIANS

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

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SUBPART F: VEHICLE SERVICE PROVIDERS

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

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515.APPENDIX D	Standing Medical Orders
515.APPENDIX E	Minimum Prescribed Data Elements
515.APPENDIX F	Template for In-House Triage for Trauma Centers
515.APPENDIX G	Credentials of General/Trauma Surgeons Level I and Level II
515.APPENDIX H	Credentials of Emergency Department Physicians Level I and Level II
515.APPENDIX I	Credentials of General/Trauma Surgeons Level I and Level II Pediatric Trauma Centers
515.APPENDIX J	Credentials of Emergency Department Physicians Level I and Level II Pediatric Trauma Centers
515.APPENDIX K	Application for Facility Recognition for Emergency Department with Pediatrics Capabilities
515.APPENDIX L	Pediatric Equipment Recommendations for Emergency Departments
515.APPENDIX M	Inter-facility~~Interfacility~~ Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline
515.APPENDIX N	Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application
515.APPENDIX O	Pediatric Critical Care Center Plan
515.APPENDIX P	Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255, effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective

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September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35 Ill. Reg. 20609, effective December 9, 2011.

SUBPART A: GENERAL

Section 515.100 Definitions

For the purposes of this Part:

Act – the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

Advanced Life Support Services or ALS Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the Advanced Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Aeromedical Crew Member or Watercraft Crew Member or Off-road Specialized Emergency Medical Services Vehicle (SEMSV) Crew Member – an individual, other than an EMS pilot, who has been approved by an SEMSV Medical Director for specific medical duties in a helicopter or fixed-wing aircraft, on a watercraft, or on an off-road SEMSV used in a Department-certified SEMSV Program.

Alternate EMS Medical Director or Alternate EMS MD – the physician who is designated by the Resource Hospital to direct the ALS/ILS/BLS operations in the absence of the EMS Medical Director.

Ambulance – any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped for, and is intended to be used for, and is maintained or operated for, the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such an individual. (Section 3.85 of the Act)

Ambulance Service Provider or Ambulance Provider – any individual, group of

individuals, corporation, partnership, association, trust, joint venture, unit of local government or other public or private ownership entity that owns and operates a business or service using one or more ambulances or EMS vehicles for the transportation of emergency patients.

APLS – the American College of Emergency Physicians-American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support course, unless the context clearly indicates otherwise.

Applicant – an individual or entity applying for a Department-issued license or certification.

Associate Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs nor the responsibility for the overall operation of the EMS System program. The Associate Hospital must have a basic or comprehensive emergency department~~Emergency Department~~ with 24-hour physician coverage. It shall~~must~~ have a functioning Intensive Care Unit ~~and/~~or a Cardiac Care Unit.

Associate Hospital EMS Coordinator – the EMT-P or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the ALS, ILS or BLS System, in accordance with the Department-approved EMS System Program Plan.

Associate Hospital EMS Medical Director – the physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the ALS, ILS, or BLS System, in accordance with the Department-approved EMS System Program Plan.

Basic Emergency Department – a classification of a hospital emergency department~~Emergency Department~~ where at least one physician is available in the emergency department~~Emergency Department~~ at all times; physician specialists are available in minutes; and ancillary services, including laboratory, x-ray and pharmacy, are staffed or are "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250).

Basic Life Support Services or BLS Services – a basic level of pre-hospital and

inter-hospital emergency care and non-emergency medical care that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in a Basic Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Board Eligible in Emergency Medicine – completion of a residency in Emergency Medicine in a program approved by the Residency Review Committee for Emergency Medicine or the Council on Postdoctoral Training (COPT) for the American Osteopathic Association (AOA).

Certified Registered Nurse Anesthetist or CRNA – a licensed registered professional nurse who has had additional education beyond the registered professional nurse requirements at a school/program accredited by the National Council on Accreditation; who has~~, and~~ passed the certifying exam given by the National Council on Certification;~~,~~ and who, by participating in 40 hours of continuing education every two years, has been recertified by the National Council on Recertification.

Channel, Half-Duplex – a radio channel that transmits and receives signals, but in only one direction at a time.

Child Abuse and Neglect – see the definitions of "abused child" and "neglected child" in Section 3 of the Abused and Neglected Child Reporting Act [325 ILCS 5/3].

Child Life Specialist – A person whose primary role is to minimize the adverse effects of children's experiences by facilitating coping and the psychosocial adjustment of children and their families through the continuum of care.

CME – continuing medical education.

Comprehensive Emergency Department – a classification of a hospital emergency department~~Emergency Department~~ where at least one licensed physician is available in the emergency department~~Emergency Department~~ at all times; physician specialists shall be available in minutes; ancillary services including laboratory and x-ray are staffed at all times; and pharmacy is staffed or "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250).

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CPR for Healthcare Providers – a course in cardiopulmonary resuscitation that meets or exceeds the American Heart Association course "BLS for Healthcare Providers".

Critical Care Transport – A Specialty Care Transport (SCT) level of inter-facility or 911 service that uses paramedic, PHRN and, on occasion, specialized nursing staff to perform skills and interventions at levels above the usual and customary scope of paramedic practice within the State of Illinois. Advanced education, continuing education and special certifications are required. All Critical Care Transport Programs shall be under the direction of a Department-approved ALS EMS System.

Department – the Illinois Department of Public Health. (Section 3.5 of the Act)

Director – the Director of the Illinois Department of Public Health or his/her designee. (Section 3.5 of the Act)

Dysrhythmia – a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and conduction.

Effective Radiated Power or ERP – the power gain of a transmitting antenna multiplied by the net power accepted by the antenna from the connected transmitter.

Electrocardiogram or EKG – a single lead graphic recording of the electrical activity of the heart by a series of deflections that represent certain components of the cardiac cycle.

Emergency – a medical condition of recent onset and severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Section 3.5 of the Act)

Emergency Communications Registered Nurse or ECRN – a registered professional nurse, licensed under the Nurse Practice Act [225 ILCS 65], *who has successfully completed supplemental education in accordance with* this Part *and who is approved by an EMS Medical Director to monitor telecommunications*

from and give voice orders to EMS System personnel, under the authority of the EMS Medical Director and in accordance with System protocols. (Section 3.80 of the Act) These individuals were formerly called MICNs~~MICNS~~.

Emergency Department Approved for Pediatrics or EDAP – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.4000 of this Part as being capable of providing optimal emergency department care to pediatric patients 24 hours per day.

Emergency Medical Dispatcher – a person who has successfully completed a training course in emergency medical dispatching meeting or exceeding the National Curriculum of the United States Department of Transportation in accordance with this Part, *who accepts calls from the public for emergency medical services and dispatches designated emergency medical services personnel and vehicles.* (Section 3.70 of the Act)

Emergency Medical Dispatch Priority Reference System or EMDPRS – an EMS System's organized approach to the receipt, management and disposition of a request for emergency medical services.

Emergency Medical Services System or EMS System or System – *an organization of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS and/or ALS level pursuant to a System Program Plan submitted to and approved by the Department and pursuant to the EMS Regional Plan adopted for the EMS Region in which the System is located.* (Section 3.20 of the Act)

Emergency Medical Services System Survey – a questionnaire that provides data to the Department for the purpose of compiling annual reports.

Emergency Medical Technician-Basic or EMT-B – a person who has successfully completed a course of instruction in basic life support as prescribed by the Department, is currently licensed by the Department in accordance with standards prescribed by the *Act and* this Part *and practices within an EMS System.* (Section 3.50 of the Act)

Emergency Medical Technician-Coal Miner – for purposes of the Coal Mine

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Medical Emergencies Act, an EMT-B, EMT-I or EMT-P who has received training emphasizing extrication from a coal mine.

Emergency Medical Technician-Intermediate or EMT-I – a person who has successfully completed a course of instruction in intermediate life support as prescribed by the *Act and* this Part *and practices within an Intermediate or Advanced Life Support EMS System.* (Section 3.50 of the Act)

Emergency Medical Technician-Paramedic or EMT-P – a person who has successfully completed a course of instruction in advanced life support care as prescribed by the Department, is licensed by the Department in accordance with standards prescribed by the *Act and* this Part *and practices within an Advanced Life Support EMS System.* (Section 3.50 of the Act)

EMS Administrative Director – the administrator, appointed by the Resource Hospital with the approval of the EMS Medical Director, responsible for the administration of the EMS System.

EMS Medical Director or EMS MD – the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

EMS Lead Instructor – a person who has successfully completed a course of education as prescribed by the Department in this Part, *and who is currently approved by the Department to coordinate or teach education, training and continuing education courses, in accordance with* this Part. (Section 3.65 of the Act)

EMS Regional Plan – a plan established by the EMS Medical Director's Committee in accordance with Section 3.30 of the Act.

EMS System Coordinator – the designated individual responsible to the EMS Medical Director and EMS Administrative Director for coordination of the educational and functional aspects of the System program.

EMS System Program Plan – the document prepared by the Resource Hospital and approved by the Department that describes the EMS System program and directs the program's operation.

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ENPC – the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course.

First Responder – a person who has successfully completed a course of instruction in emergency first response as prescribed by the Department, who provides first response services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the emergency first response course. (Section 3.60 of the Act)

First Response Services – a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the First Responder curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Fixed-Wing Aircraft – an engine-driven aircraft that is heavier than air, and is supported in-flight by the dynamic reaction of the air against its wings.

Full-Time – on duty a minimum of 36 hours, four days a week.

Health Care Facility – a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed. It does not include "pre-hospital emergency care settings" which utilize EMTs to render pre-hospital emergency care prior to the arrival of a transport vehicle, as defined in the *Act* and this Part. (Section 3.5 of the Act)

Helicopter or Rotorcraft – an aircraft that is capable of vertical take offs and landings, including maintaining a hover.

Hospital – *has the meaning ascribed to that term in* Section 3 of the *Hospital Licensing Act* [210 ILCS 85]. (Section 3.5 of the Act)

Hospitalist – a physician who primarily provides unit-based/in-hospital services.

Instrument Flight Rules or IFR – the operation of an aircraft in weather minimums below the minimums for flight under visual flight rules (VFR). (See General Operating and Flight Rules, 14 CFR 91.115 through 91.129.)

Instrument Meteorological Conditions or IMC – meteorological conditions

expressed in terms of visibility, distance from clouds and ceiling, which require Instrument Flight Rules.

Intermediate Life Support Services or ILS Services – an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures as outlined in the Intermediate Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Level I Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2030 of this Part to provide optimal care to trauma patients and to provide all essential services in-house, 24 hours per day.

Level II Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2040 of this Part to provide optimal care to trauma patients, to provide some essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day.

Licensee – an individual or entity to which the Department has issued a license.

Limited Operation Vehicle – a vehicle which is licensed by the Department to provide basic, intermediate or advanced life support emergency or non-emergency medical services that are exclusively limited to specific events or locales. (Section 3.85 of the Act)

Local System Review Board – a group established by the Resource Hospital to hear appeals from EMTs or other providers who have been suspended or have received notification of suspension from the EMS Medical Director.

Mobile Radio – a two-way radio installed in an EMS vehicle, which may not be readily removed.

Morbidity – a negative outcome that is the result of the original trauma and/or treatment rendered or omitted.

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911 – an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and rescue.

Non-emergency Medical Care – medical services rendered to patients whose condition does not meet the *Act's definition of emergency, during transportation of such patients to health care facilities for the purpose of obtaining medical or health care services which are not emergency in nature, using a vehicle regulated by* the *Act* and this Part. (Section 3.10 of the Act)

Off-Road Specialized Emergency Medical Services Vehicle or Off-Road SEMSV or Off-Road SEMS Vehicle – a motorized cart, golf cart, all-terrain vehicle (ATV), or amphibious vehicle that is not intended for use on public roads.

PALS – American Heart Association-American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support course, unless the context clearly indicates otherwise.

Participating Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital.

Pediatric Critical Care Center or PCCC – a hospital participating in an approved EMS System and designated by the Department as being capable of providing optimal critical and specialty care services to pediatric patients, and of providing all essential services either in-house or readily available 24 hours per day.

Pediatric ~~Trauma~~ Patient – ~~trauma~~ patient from birth throughto~~o~~ 15 years of age.

Physician – any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 6090].

Pilot or EMS Pilot – a pilot certified by the Federal Aviation Administration who has been approved by an SEMSV Medical Director to fly a helicopter or fixed-wing aircraft used in a Department-certified SEMSV Program.

Portable Radio – a hand-held radio that accompanies the user during the conduct of emergency medical services.

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Pre-Hospital Care – those emergency medical services rendered to emergency patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to hospitals. (Section 3.10 of the Act)

Pre-Hospital Care Provider – a System Participant or any EMT-B, I, P, Ambulance, Ambulance Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN or Physician serving on an ambulance or giving voice orders over an EMS System and subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

Pre-Hospital Registered Nurse or Pre-Hospital RN or PHRN *– a registered professional nurse, licensed under the Nurse~~Nursing and Advanced~~ Practice ~~Nursing~~ Act, who has successfully completed supplemental education in accordance with* this Part *and who is approved by an EMS Medical Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports.* (Section 3.80 of the Act) This individual was formerly called a Field RN.

Regional EMS Advisory Committee – a committee formed within an Emergency Medical Services (EMS) Region to advise the Region's EMS Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each Resource Hospital within the Region, one administrative representative from an Associate Hospital within the Region, one administrative representative from a Participating Hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a vehicle service provider from each System within the Region, one Emergency Medical Technician (EMT)/Pre-Hospital RN from each level of EMT/Pre-Hospital RN practicing within the Region, and one registered professional nurse currently practicing in an emergency department~~Emergency Department~~ within the Region. Of the two administrative representatives of vehicle service providers, at least one shall be an administrative representative of a private vehicle service provider. The

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Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee. (Section 3.25 of the Act)

Regional EMS Coordinator – the designee of the Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health.

Regional EMS Medical Directors Committee – a group *comprised of the Region's EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For Regions that include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other Regions, the fire department vehicle service providers shall select which medical advisor to serve on the Committee on an annual basis.* (Section 3.25 of the Act)

Regional Trauma Advisory Committee – a committee formed within an Emergency Medical Services (EMS) Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each Trauma Center within the Region, one EMS Medical Director from a Resource Hospital within the Region, one EMS System Coordinator from another Resource Hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each Trauma Center within the Region, one EMT representing the highest level of EMT practicing within the Region, one emergency physician and one Trauma Nurse Specialist (TNS) currently practicing in a Trauma Center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee. (Section 3.25 of the Act)

Registered Nurse or Registered Professional Nurse or RN – a person who is licensed as a professional nurse under the Nurse~~Nursing and Advanced~~ Practice ~~Nursing~~ Act [225 ILCS 65].

Resource Hospital – the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire program, including the clinical aspects, operations and educational programs. This hospital agrees to replace medical supplies and

provide for equipment exchange for participating EMS vehicles.

Screening – a preliminary procedure or assessment, such as a test or examination, to detect the most characteristic sign or signs of a disorder or condition that may require further investigation (for example, assessing for potential abuse or neglect through interview responses and behavioral/physical symptom clues).

SEMSV Medical Control Point or Medical Control Point – the communication center from which the SEMSV Medical Director or his or her designee issues medical instructions or advice to the aeromedical, watercraft, or off-road SEMSV crew members.

SEMSV Medical Director or Medical Director – the physician appointed by the SEMSV Program who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part.

SEMSV Program or Specialized Emergency Medical Services Vehicle Program – a program operating within an EMS System, pursuant to a program plan submitted to and certified by the Department, usingutilizing specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

Specialized Emergency Medical Services Vehicle or SEMSV – a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the *Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads.* (Section 3.85 of the Act) "Primarily intended", for the purposes of this definition, means one or more of the following:

Over 50 percent of the vehicle's operational (i.e.,e.g., in-flight) hours are devoted to the emergency transportation of the sick or injured;

The vehicle is owned or leased by a hospital or ambulance provider and is used for the emergency transportation of the sick or injured;

The vehicle is advertised as a vehicle for the emergency transportation of

the sick or injured;

The vehicle is owned, registered or licensed in another state and is used on a regular basis to pick up and transport the sick or injured within or from within this State; or

The vehicle's structure or permanent fixtures have been specifically designed to accommodate the emergency transportation of the sick or injured.

Standby Emergency Department – a classification of a hospital emergency department~~Emergency Department~~ where at least one of the registered nurses on duty in the hospital is available for emergency services at all times~~,~~; and a licensed physician is "on-call" to the emergency department~~Emergency Department~~ at all times in accordance with Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250).

Standby Emergency Department Approved for Pediatrics or SEDP – a hospital participating in an approved EMS System and designated by the Department, pursuant to Section 515.4010 of this Part, as being capable of providing optimal standby emergency department care to pediatric patients and to have transfer agreements and transfer mechanisms in place when more definitive pediatric care is needed.

Special-Use Vehicle – any public or privately owned vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated solely for, the emergency or non-emergency transportation of a specific medical class or category of persons who are sick, injured, wounded or otherwise incapacitated or helpless (e.g., high-risk obstetrical patients, neonatal patients). (Section 3.85 of the Act)

State EMS Advisory Council – a group that advises the Department on the administration of the Act and this Part whose members are appointed in accordance with Section 3.200 of the Act.

Stretcher Van – a vehicle used by a licensed stretcher van provider to transport non-emergency passengers in accordance with the Act and this Part.

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Stretcher Van Provider – an entity licensed by the Department to provide non-emergency transportation of passengers on a stretcher in compliance with the *Act* and this Part*, utilizing stretcher vans.* (Section 3.86 of the Act)

System Participation Suspension – the suspension from participation within an EMS System of an individual or individual provider, as specifically ordered by that System's EMS Medical Director.

Substantial Compliance – meeting requirements except for variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Substantial Failure – the failure to meet requirements other than a variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Sustained Hypotension – two systolic blood pressures of 90 mmHg five minutes apart or, in the case of a pediatric patient, two systolic blood pressures of 80 mmHg five minutes apart.

Telecommunications Equipment – a radio capable of transmitting and/or receiving voice and electrocardiogram (EKG) signals.

Telemetry – the transmission of data by wire, radio, or other means from remote sources to a receiving station for recording and analysis.

Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)

Trauma Category I – a classification of trauma patients in accordance with Appendix C and Appendix F of this Part.

Trauma Category II – a classification of trauma patients in accordance with Appendix C and Appendix F of this Part.

Trauma Center – a hospital which: within designated capabilities provides care to trauma patients; participates in an approved EMS System; and is duly designated pursuant to the provisions of the *Act.* (Section 3.90 of the Act)

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Trauma Center Medical Director – the trauma surgeon appointed by a Department-designated Trauma Center who has the responsibility and authority for the coordination and management of patient care and trauma services at the Trauma Center. He or she must have 24-hour independent operating privileges and shall be board certified in surgery with at least one year of experience in trauma care.

Trauma Center Medical Directors Committee – a group composed *of the Region's Trauma Center Medical Directors.* (Section 3.25 of the Act)

Trauma Coordinator – a registered nurse working in conjunction with the Trauma Medical Director. The Trauma Coordinator is responsible for the organization of service and systems necessary for a multidisciplinary approach throughout the continuum of trauma care.

Trauma Nurse Specialist or TNS – a registered professional nurse who has successfully completed education and testing requirements as prescribed by the Department, and is certified in accordance with this Part. (Section 3.75 of the Act)

Trauma Nurse Specialist Course Coordinator or TNSCC – a registered nurse appointed by the Chief Executive Officer of a hospital designated as a TNS Training Site, who meets the requirements of Section 515.750 of this Part.

Trauma Service – an identified hospital surgical service in a Level I or Level II Trauma Center functioning under a designated trauma director in accordance with Sections 515.2030(c) and 515.2040(c) of this Part.

Unit Identifier – a number assigned by the Department for each EMS vehicle in the State to be used in radio communications.

Vehicle Service Provider – an entity licensed by the Department to provide emergency or non-emergency medical services in compliance with the *Act* and this Part *and an operational plan approved by its EMS System(s), utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV).* (Section 3.85 of the Act)

Watercraft – a nautical vessel, boat, airboat, hovercraft or other vehicle that operates in, on or across water.

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(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

Section 515.125 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:

1) Private and professional association standards:

A) Glasgow Coma Scale
Champion HR, Sacco WJ, Carnazzo AJ et al.:
CritCare Med 9(9): 672-676 (1981)

B) Revised Trauma Score, 1999
from Resources for the Optimal Care of the Injured Patient
American College of Surgeons
633 North Saint Clair Street~~55 East Erie St.~~
Chicago, Illinois 60611-3211~~2797~~

C) Abbreviated Injury Score, 2005~~1990~~
American Association for the Advancement
of Automotive Medicine
Des Plaines, Illinois 60008

D) Injury Severity Score
Baker SP, O'Neil B, Hadon W et al.:
Journal of Trauma 14: 187-196 (1974)

E) International Classification of Diseases,
9th Revision, Clinical Modification (ICD-9-CM)
Alphabetic Index to External Causes of Injury (E-Codes),
Second Printing (2010~~1980~~)
World Health Organization, Geneva, Switzerland and
National Center for Health Statistics
Published by Edwards Brothers, Inc. Ann Arbor, Michigan

F) Resources for Optimal Care of the Injured Patient (2006~~1999~~)
American College of Surgeons
633 North Saint Clair Street~~55 East Erie St.~~

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Chicago, Illinois 60611-32112797

G) Pediatric Advanced Life Support (20111995)
American Heart Association National Center
7272 Greenville Center
Dallas, Texas 75231

2) Federal government publications:

A) Federal Specifications for Ambulance, KKK-A-1822FD (August 2007November, 1994), United States General Services Administration, Specifications Section, 2200 Crystal Drive, Suite 1006, Arlington VA 22202

Room 6654, 7th and D Streets, S.W., Washington, D.C. 20407

B) United States Department of Transportation, Emergency Medical Technician-Basic: National Standard Curriculum (19981994), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

C) United States Department of Transportation, Emergency Medical Technician-Intermediate: National Standard Curriculum (19981985), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

D) United States Department of Transportation, Emergency Medical Technician-Paramedic: National Standard Curriculum (19981985), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (See Sections 515.215(a); 515.500(c) and (e); 515.510(a) and (d); 515.530(c); 515.532(b); 515.810(b) and (c); and 515.850(a) and (b).)

E) United States Department of Transportation, First Responder: National Standard Curriculum (19971995), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

F) United States Department of Transportation, EMS Instructor Training Program: National Standard Curriculum (1995), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

G) United States Department of Transportation, Emergency Medical Dispatcher: National Standard Curriculum (1995), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

3) Federal regulations:

A) 47 CFR 90 (October 1, 2008~~1998~~) − Private Land Mobile Radio Services

B) Air Taxi Operations and Commercial Operators (14 CFR 135 (January 1, 2009~~1998~~), Subparts A, Sections 135.1 through 135.43; B, Sections 135.61 through 135.125; C, Sections 135.141 through 135.185; D, Sections 135.201 through 135.229; E, Sections 135.241 through 135.247; F, Section 135.261; J, Sections 135.411 through 135.443)

C) 42 CFR 2A (October 1, 2009~~1998~~) − Confidentiality of Alcohol and Drug Abuse Patient Records

b) All incorporations by reference of federal regulations and the standards of nationally recognized organizations refer to the regulations and standards on the date specified and do not include any amendments or editions~~additions or deletions~~ subsequent to the date specified.

c) The following statutes and State regulations are referenced in this Part:

1) Federal statutes:

~~A)~~ ~~U.S. Code 42, the Public Health and Welfare, 42 USC 300 L-1(a)~~

~~B)~~Federal Aviation Act of 1958, Sections 307 and 308 (P.L. 85-726, 72 USC 731)

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2) State of Illinois statutes:

A) Hospital Emergency Services Act [210 ILCS 80]

B) Hospital Licensing Act [210 ILCS 85]

C) Medical Practice Act of 1987 [225 ILCS 60]

D) Nurse~~Nursing and Advanced~~ Practice ~~Nursing~~ Act [225 ILCS 65]

E) Code of Civil Procedure [735 ILCS 5]

F) Emergency Telephone System Act [50 ILCS 750]

G) Boat Registration and Safety Act [625 ILCS 45]

H) Open Meetings Act [5 ILCS 120]

I) Illinois Administrative Procedure Act [5 ILCS 100]

J) Head and Spinal Cord Injury Act [410 ILCS 515]

K) Freedom of Information Act [5 ILCS 140]

L) State Records Act [5 ILCS 160]

M) Coal Mine Medical Emergencies Act [410 ILCS 15]

N) Abused and Neglected Child Reporting Act [325 ILCS 5]

3) State of Illinois regulations:

A) ~~Rules of~~ Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

B) Hospital Licensing Requirements (77 Ill. Adm. Code 250)

C) Aviation Safety (92 Ill. Adm. Code 14.790, 14.792, 14.795)

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(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

SUBPART C: EMS SYSTEMS

Section 515.445 Pediatric Care

a) Upon the availability of federal funds for development of an emergency medical services for children (EMSC) program, the Department shall appoint an Advisory Board to advise the Department on all matters concerning emergency medical service for children and to develop and implement a plan to address identified pediatric areas of need. The Advisory Board shall assist in the formulation of policy to effect the purposes of the Act and this Part. The Advisory Board shall consist of 26~~25~~ members to be appointed by the Director for a term of three years. Membership of the Advisory Board shall include:

1) One practicing pediatrician, one pediatric critical care physician and~~,~~ one board certified pediatric emergency physician, ~~neonatologist, and one pediatric rehabilitation physician,~~ to be recommended by the Illinois Chapter of the American Academy of Pediatrics ~~and the Chicago Chapter of the American Academy of Pediatrics~~;

2) One pediatric surgeon, to be recommended by the Illinois Chapter of the American College of Surgeons, or a trauma nurse manager/coordinator recommended by the Illinois Trauma Coordinators Coalition;

3) Two emergency physicians, one to be recommended by the Illinois Chapter of the American College of Emergency Physicians and one to be recommended by the National Association of EMS Physicians;

4) One family practice physician, to be recommended by the Illinois Chapter of the American Academy of Family Physicians;

5) Two registered nurses, one to be appointed upon recommendation of the Illinois Nurses Association and one to be appointed upon recommendation of the Illinois Chapter of the Emergency Nurses Association;

6) Two emergency medical technicians of differing levels, to be appointed, one each, upon recommendation of the Illinois EMT Association and Illinois Fire Fighters Association;

7) An EMS Coordinator recommended by the Northern Illinois and Southern Illinois EMS Coordinators Association;

8) A representative from each of the following ~~agencies~~: Division of Specialized Care for Children; Illinois State Police; Illinois Fire Chiefs Association; Illinois State Ambulance Association; Illinois State Medical Society; Illinois Department of Transportation; SAFEKIDS Coalition; Illinois Hospital Association; Metropolitan Chicago Healthcare Council; Illinois Department of Children and Family Services; ~~Illinois Kiwanis Association; health policy representative; and~~ a pediatric rehabilitation representative; a community organization; a child advocate group; and a parent representative;

9) A non-voting member from the Department's Division of Emergency Medical Systems~~Services~~ and Highway Safety and the Department of Human Services' Division of Family Health ~~(IDPH)~~. EMS Regional representation shall be through board members who serve as representatives of other designated constituencies. Such members shall have dual representation status in advising the ~~Illinois~~ Department ~~of Public Health~~, but shall retain one vote. The Department shall consider~~take into consideration~~ Regional representation when making advisory board appointments.

b) The Advisory Board members with medical backgrounds shall have expertise and interest in emergency or critical care medical services for children. Vacancies on the Advisory Board~~Council~~ shall be filled for the unexpired term by appointment of the Director in the same manner as originally filled. The members of the Advisory Board shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties, including travel expenses. A majority of the members of the Advisory Board shall constitute a quorum for the conduct of business of the advisory committee. A majority vote of the members present at a meeting at which a quorum is established shall be necessary to validate any action of the committee.

c) A majority of the members of the Advisory Board shall constitute a quorum for the conduct of the Board's business. A majority vote of the members present at a meeting at which a quorum is established shall be necessary to validate any action.

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d) The Advisory Board shall act pursuant to bylaws that it adopts, which shall include the annual election of a Chair and Vice-Chair.

e)~~e)~~ The Department, with the advice of the Advisory Board, shall address and establish through the EMSC program at least the following:

1) Initial and continuing education programs for emergency medical services personnel which shall include training in the emergency care of infants and children;

2) Guidelines for referring children to the appropriate emergency or critical care medical facilities;

3) Guidelines for pre-hospital, hospital and other pediatric emergency or critical care medical service equipment;

4) Guidelines and protocols for pre-hospital and hospital facilities encompassing all levels of pediatric emergency medical services, hospital and pediatric critical care services, including, but not limited to, triage, stabilization, treatment, transfers and referrals;

5) Guidelines for hospital-based emergency departments appropriate for pediatric care to assess, stabilize, and treat critically ill infants and children and if necessary to prepare the child for transfer to a pediatric intensive care unit or pediatric trauma center;

6) Guidelines for pediatric intensive care units, pediatric trauma centers and intermediate care units fully equipped and staffed by appropriately trained critical care pediatric physicians, surgeons, nurses and therapists;

7) An inter-facility transfer system for critically ill or injured children;

8) Guidelines for pediatric rehabilitation units to ensure staffing by rehabilitation specialists and capabilities to provide any service required to assure maximum recovery from the physical, emotional and cognitive effects of critical illness and severe trauma;

9) Guidelines for the implementation of public education and injury

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prevention programs throughout the State in conjunction with local fire, public safety and school personnel;

10) Guidelines for the collection, analysis and dissemination of pediatric quality improvement information regarding ongoing improvements in the EMSC program; ~~and~~

11) Guidelines and protocols for pre-hospital providers and hospital facilities for the treatment, documentation, reporting and professional interactions with family members, and for referrals to social, psychological and rehabilitation services in suspected cases of child maltreatment; and~~.~~

12) Guidelines addressing pediatric disaster/all-hazards preparedness.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.825 Alternate Response Vehicle

a) Ambulance assistance vehicles
Ambulance assistance vehicles are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. These assistance vehicles include fire engines, trucks, squad cars or chief's cars that contain the staff and equipment required by this Section. These vehicles shall not function as assist vehicles if staff and equipment required by this Section are not available. The agency shall identify these~~These~~ vehicles ~~shall be identified by the agency~~ as a program plan amendment outlining the type and level of response that is planned. The vehicle shall not transport or be a primary response vehicle but a supplementary vehicle to support EMS services. The vehicle shall be dispatched only if needed. Ambulance assistance vehicles shall be classified as either:

1) Advanced ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-P and shall have all of the required equipment; or

2) Intermediate ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-I and shall have all of the required equipment; or

3) Basic ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-B and shall have all of the required equipment; or

4) First Responder assistance vehicles. These vehicles shall be staffed with a minimum of one First Responder and shall have all of the required equipment.

b) Non-transport vehicles
Non-transport vehicles are dispatched prior to dispatch of a transporting ambulance. These vehicles include ambulances and fire engines that contain the staff and equipment required by this Section. The vehicle service provider shall identify these~~These~~ vehicles ~~shall be identified by the agency~~ as a program plan amendment outlining the type and level of response that is planned. These vehicles shall be staffed 24 hours per day, every day of the year.

1) ALS/ILS non-transport vehicles. These vehicles shall have a minimum of either one EMT-P, or one EMT-I and one other EMT-B, and shall have all of the required equipment.

2) BLS non-transport vehicles. These vehicles shall have a minimum of two EMT-Bs and have all of the required equipment.

c) Equipment requirements
Each vehicle used as an alternate response vehicle shall meet the following equipment requirements, as determined by the Department by an inspection.

1) Full portable oxygen cylinder, with a capacity of not less than 350 liters

2) Dial flowmeter/regulator for 15 liters per minute

3) Delivery tubes

4) Adult, child and infant masks

5) Adult squeeze bag and valve, with adult and child masks

6) Child squeeze bag and valve, with child, ~~and~~ infant and newborn size masks

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7) Airways, oropharyngeal − adult, child and infant (sizes 00-5)

8) Airways, nasopharyngeal with lubrication (sizes 12-30F)

9) Manually operated suction device

10) Triangular bandages or slings

11) Roller bandages, self-adhering (4" by 5 yds)

12) Trauma dressings

13) Sterile gauze pads (4" by 4")

14) Vaseline gauze (3" by 8")

15) Bandage shears

16) Adhesive tape rolls

17) Blanket

18) Long backboard

19) Cervical collars − adult, child and infant

20) Extremity splints − adult/child, long/short

21) Adult/child/infant blood pressure cuffs and gauge

22) Stethoscope

23) Burn sheet, individually wrapped

24) Sterile saline or water solution (1,000mlcc), plastic bottles or bags

25) Obstetrical kit, sterile − minimum one, pre-packaged with instruments, bulb syringe and cord clamps with head cover

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26) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one

2726) Cold packs

2827) EMS run reports

2928) Nonporous disposable gloves

3029) Eye/nose/mouth protection or face shields

3130) Flashlight

3231) Equipment to allow reliable communications~~communication~~ with hospital

3332) ILS/ALS System-approved equipment

A) Drug box

B) Airway equipment, including laryngoscope and assorted blades

C) Monitor/defibrillator, equipped with pediatric size defibrillation pads or paddles

e) Registration of non-transport agencies
Each non-transport provider shall complete and submit to the Department one of the following: the First Responder Provider Initial EMS System Application (Form First 10/97), the Non-Transport Provider EMS System Application (Form NT 5/97), or the Non-Transport Provider Application (Form NT 6/99).

f) Inspection of non-transport EMS providers
The~~Intial inspections will be completed by the~~ Regional EMS Coordinator will perform initial inspections. Thereafter, non-transport ambulance assist providers shall perform annual self-inspections, using forms provided by the Department, and shall submit the form to the Department upon completion of the inspection. The Regional EMS Coordinator will perform inspections randomly or as the result of a complaint.

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g) Issuance and renewal of license
Upon payment of the appropriate fee, qualifying non-transport~~Non-transport~~ providers shall be issued a provider license that lists a number for each level of care approved. Licenses will not be issued for individual non-transport vehicles. Providers shall inform the EMS System and the Department of any modifications to the application, using the System Modification forms (sys-mod). Licenses will be issued for one year and will be renewed upon completion of the self-inspection.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

Section 515.830 Ambulance Licensing Requirements

a) Vehicle Design

1) Each new vehicle used as an ambulance shall comply with the criteria established by the U.S. General Services Administration's Specification for Ambulance (KKK-A-1822F~~E~~), with the exception of Section 3.16.2, Color, Paint and Finish.

2) *A licensed vehicle* shall be exempt *from subsequent vehicle design standards or specifications required by the Department* in this Part, *as long as said vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until said vehicle's title of ownership is transferred*. (Section 3.85(b)(8) of the Act)

3) The following requirements listed in Specification KKK-A-1822F~~E~~ shall be considered mandatory in Illinois even though they are listed as optional in that publication:

A) 3.7.7.1 Each vehicle will be equipped with either a battery charger or battery conditioner (see 3.15.3 item 7).

B) 3.8.5.2 Patient compartment checkout lights will be provided (see 3.15.3 item 9).

C) 3.12.1 An oxygen outlet will be provided above the secondary patient (see 3.15.4 M9).

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D) 3.15.4M3 Electric clock with sweep second hand will be provided.

b) Equipment Requirements – Basic Life Support Vehicles
Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:

1) Stretchers, Cots, and Litters

A) Primary Patient Cot
Shall~~Must~~ meet the requirements of sections 3.11.5, 3.11.8.1 of KKK-A-1822F~~E~~.

B) Secondary Patient Stretcher
Shall~~Must~~ meet the requirements of sections 3.11.5, 3.11.5.1, 3.11.8.1 of KKK-A-1822F~~E~~.

2) Oxygen, portable
Shall~~Must~~ meet the operational requirements of section 3.12.2 of KKK-A-1822-F~~E~~.

3) Suction, portable

A) Shall~~Must~~ meet the operational requirements of section 3.12.4 of KKK-A-1822F~~E~~.

B) A manually operated suction device is acceptable if approved by the Department.

4) Medical Equipment

A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask and child size bag-valve-mask ventilation unit with child, ~~and~~ infant and newborn size transparent masks

B) Lower-extremity traction splint, adult and pediatric sizes

C) Blood pressure cuff, one each, adult, child and infant sizes and gauge

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D) Stethoscopes, two per vehicle~~each~~

E) Pneumatic counterpressure trouser kit, adult size, optional

F) Long spine board with three sets of torso straps, 72" x 16" minimum

G) Short spine board (32" x 16" minimum) with two 9-foot torso straps, one ~~each~~ chin and head strap or equivalent vest type (wrap around) per vehicle; extrication device optional

H) Airway, oropharyngeal – adult, child, and infant, sizes 00-5

I) Airway, nasopharyngeal with lubrication, sizes 12-34~~30~~F

J) One adult, child and infant sized non-rebreather oxygen masks per vehicle

K) Three nasal cannulas, adult and child size, per vehicle

L~~J~~) Bandage shears, one per vehicle~~each~~

M~~K~~) Extremity splints, adult, two ~~each~~ long and short per vehicle

N~~L~~) Extremity splints~~splint~~, pediatric, two ~~each~~ long and short per vehicle

O~~M~~) Rigid cervical collars – one ~~each,~~ pediatric, small, medium, and large sizes or adjustable size collars per vehicle. Shall be made of rigid material to minimize flexion~~flexation~~, extension, and lateral rotation of the head and cervical spine when spine injury is suspected

P~~N~~) Patient restraints, arm and leg, sets

Q) Pulse oximeter with pediatric and adult probes

R) AED or defibrillator that includes pediatric capability

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5) Medical Supplies

A) Trauma dressing – six per vehicle~~each~~

B) Sterile gauze pads – 20 per vehicle~~each~~, 4 inches by 4 inches

C) Bandages, soft roller, self-adhering type, 10 per vehicle~~ten each~~, 4 inches by 5 yards

D) Vaseline gauze – two per vehicle~~each~~, 3 inches by 8 inches

E) Adhesive tape rolls – two per vehicle~~each~~

F) Triangular bandages or slings – five per vehicle~~each~~

G) Burn sheets – two per vehicle~~each~~, clean, individually wrapped

H) Sterile solution (normal saline) – four per vehicle~~each~~, 500 cc or two per vehicle~~each~~, 1,000 cc plastic bottles or bags

I) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one ~~Aluminum foil roll or Silver Swaddler – one each with head cover~~

J) Obstetrical kit, sterile – minimum one ~~each~~, pre-packaged with instruments and bulb syringe

K) Cold packs, three per vehicle~~each~~

L) Hot packs, three per vehicle~~each~~, optional

M) Emesis basin – one per vehicle~~each~~

N) Drinking water – 1 quart, in nonbreakable container; sterile water may be substituted

O) Ambulance emergency run reports – 10 per vehicle~~ten each~~, on a form prescribed by the Department or one that contains the data

elements from the Department-prescribed form as described in Section 515.Appendix E of this Part

P) Pillows – two per vehicle~~each~~, for ambulance cot

Q) Pillowcases – two per vehicle~~each~~, for ambulance cot

R) Sheets – two per vehicle~~each~~, for ambulance cot

S) Blankets – two per vehicle~~each~~, for ambulance cot

T) CPR mask – one per vehicle~~each~~, with safety valve to prevent backflow of expired air and secretions

U) Urinal

V) Bedpan

W) Remains bag, optional

X) Nonporous disposable gloves

Y) Impermeable red biohazard-labeled isolation bag

Z) Face protection through any combination of masks and~~/or~~ eye protection and~~/or~~ field shields

AA) Suction catheters – sterile, single use, two each, 6, 8, 10, 12, 14 and 18F, plus three ~~each~~ tonsil tip semi-rigid pharyngeal suction tip catheters per vehicle; all shall~~must~~ have a thumb suction control port

BB) Child and infant or convertible car seats~~Child/infant car seat~~

CC) Current equipment~~Equipment~~/drug dosage sizing tape or pediatric equipment/drug age/weight chart

~~DD)~~ ~~Poison Control Resource Phone Number~~

~~EE)~~ ~~Plastic baby bottle with nipple for glucose feeding~~

DD~~FF~~) Flashlight, two per vehicle~~one each~~, for patient assessment

~~GG)~~ ~~One each adult, child and neonate sized oxygen masks that are semi-open, valveless, transparent and disposable~~

~~HH)~~ ~~Three each nasal cannulas~~

c) Equipment Requirements – Intermediate and Advanced Life Support Vehicles
Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) of this Section and shall also comply with the equipment and supply requirements as determined by the EMS Medical Director in the System in which the ambulance and its crew participate. Drugs shall include both adult and pediatric dosages. These vehicles shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

d) Equipment Requirements – Rescue and/or Extrication
The following equipment shall~~will~~ be carried on the ambulance, unless the ambulance~~it~~ is routinely accompanied by a rescue vehicle:

1) Wrecking bar, 24"

2) Goggles for eye safety

3) Flashlight – one per vehicle~~each~~, portable, battery operated

4) Fire Extinguisher – two per vehicle~~2 each~~, ABC dry chemical, minimum 5-pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment

e) Equipment Requirements – Communications Capability
Each ambulance shall~~must~~ have reliable ambulance-to-hospital radio communications capability and meet the requirements provided in Section 515.400 of this Part.

f) Equipment Requirements – Epinephrine
A person currently licensed as an EMT-B, EMT-I, or EMT-P who has successfully

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completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine (both adult and pediatric doses) *with him or her* in the ambulance or drug box *as part of the EMT medical supplies whenever he or she is performing the duties of an emergency medical technician,* within the context of the EMS System plan. (Section 3.55(a-7) of the Act)

g) Personnel Requirements

1) Each basic life support ambulance shall be staffed by a minimum of two EMTs, intermediate, paramedic, Pre-Hospital RNs or physicians or a combination thereof on all emergency calls.

2) Each Basic Life Support vehicle using automated defibrillation shall be staffed by a minimum of one EMT-B approved by the EMS Medical Director for automated defibrillation, a Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician.

3) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one EMT-I, Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician. Each ILS vehicle using automated defibrillation shall be staffed by a minimum of one EMT-I approved by the EMS Medical Director for automated defibrillation, a Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician. Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one EMT-P, Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician.

4) Each ambulance provider that operates an emergency transport vehicle shall ensure through written agreement with the EMS System that the agency providing emergency care at the scene and enroute to a hospital meets the requirements of this Subpart.

h) Operational Requirements

1) AnAny operation of an ambulance that iswhile transporting a patient to a hospital shall be operateddone in accordance with the requirements of the Act and this Part.

2) A licensee shall operate its ambulance service in compliance with this

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Part, 24 hours a day, every day of the year. Except as required below, each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS or BLS level, and such coverage will meet the requirements of this Section.

A) At the time of application for initial or renewal licensure, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

i) A current roster shall also be submitted, which lists the EMTs, Pre-Hospital RNs and/or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, and daytime telephone number, and shall state whether such person is generally scheduled to be on site or on call.

ii) An actual or proposed four-week staffing schedule shall also be submitted, which covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

B) Licensees shall be required to obtain the EMS Medical Director's approval of their vehicles' hours of operation prior to submitting an application~~submission~~ to the Department. An EMS Medical Director may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.

C) A licensee that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the~~such~~ advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day.

3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Section 515.Appendix E.

4) A licensee shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for such service.

5) A licensee shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.810(h) of this Part.)

6) A licensee shall not operate its ambulance at a level ~~not~~ exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless such vehicle is operated pursuant to an EMS System-approved in-field service level upgrade.

7) The Department shall relicense qualifying ambulances each year. If the licensee has attained 90 percent compliance with the requirements of this Section on inspections for the previous five years and has no substantiated complaints against it, the Department shall inspect the licensee's ambulances in alternate years, and the licensee shall self-inspect its ambulances in the other years. The licensee shall use the Department's inspection form ~~shall be used~~ for self-inspection ~~by the licensee~~.

i) A licensee may use a replacement vehicle for up to 10~~ten~~ days without a Department inspection provided that the Department is notified of the use of the vehicle by the second working day.

j) *Patients, individuals who accompany a patient, and emergency services personnel may not smoke while inside an ambulance or SEMSV. The Department of Public Health* shall *impose a civil penalty on an individual who violates this subsection in the amount of $100.* (Section 3.155(h) of the Act)

k) ~~AGENCY NOTE:~~ Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.150.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

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SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient Critical Care Services

a) Any hospital seeking recognition as a Standby Emergency Department Approved for Pediatrics (SEDP), Emergency Department Approved for Pediatrics (EDAP) or Pediatric Critical Care Center (PCCC) shall submit an application as outlined by the Department in Appendix K and Appendix N of this Part.

b) All EMS Resource Hospitals are required to receive recognition as a SEDP, EDAP or PCCC. All Illinois hospitals are encouraged to obtain and maintain SEDP or EDAP status.

c) The Department shall recognize applicant hospitals as an SEDP, EDAP or PCCC if they meet all of the requirements established by this Part.

d) Hospitals applying for PCCC recognition shall also meet all of the EDAP requirements.

e) Recognition as a SEDP, EDAP or PCCC shall be for three years.

f) All requests for renewal of SEDP, EDAP or PCCC recognition shall be filed in writing with the Department before the recognition expiration date, along with submission of a Department-approved renewal application.

g) The Department shall deny an application for recognition or a request for renewal of recognition when its findings show failure to comply with this Part.

h) The Department shall provide written notice, via certified mail, of its decision to deny an application for recognition or request for renewal of recognition. Hospitals may appeal the denial by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.

i) Any SEDP, EDAP or PCCC may voluntarily terminate recognition prior to the expiration date by notifying the Department in writing. The hospital shall notify the Illinois Department of Public Health, Division of EMS & Highway Safety at

least 60 days prior to termination and shall identify how area pre-hospital provider agencies, area hospitals, and the Illinois EMSC Office will be notified.

j) The Department shall inspect recognized hospitals to assure compliance with the provisions of this Part.

k) The Department shall take the following action, as appropriate, after determining that an SEDP, EDAP or PCCC is in violation of this Part.

1) If the Director determines that the violation presents an immediate threat of death or serious physical harm to a patient, and if the SEDP, EDAP or PCCC fails to eliminate the violation immediately or within a fixed period of time, not exceeding 10 days, as determined by the Director, the Director shall immediately revoke the recognition.

2) If the Department determines that the violation does not present an immediate threat of death or serious physical harm to a patient, the Director shall issue a notice of violation and request a plan of correction, which shall be subject to the Department's approval.

l) No hospital shall use the recognition levels of SEDP, EDAP or PCCC in relation to itself or hold itself out as an SEDP, EDAP or PCCC without first obtaining recognition pursuant to this Part.

(Source: Added at 35 Ill. Reg. 20609, effective December 9, 2011)

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

a) Professional Staff: Physicians

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

A) Certification in emergency medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board

eligible in emergency medicine and in the first cycle of the board certification process; or

B) Sub-board Certification~~Certification~~ in pediatric emergency medicine by the American Board of Pediatrics or the ~~/American Board of Emergency Medicine (ABP/~~ABEM~~)~~ or residency trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or

C) Certification by one of the following boards and current American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation ~~or equivalent course~~.

i) Certification in family practice by the American Board of Family Practice (ABFP) or American Osteopathic Board of Family Practice (AOBFP); or

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

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

D) A physician who has received a waiver from the ~~Illinois~~ Department ~~of Public Health~~ based on one of the following criteria. Physicians shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements.~~:~~

i) An emergency department physician who has already received a waiver in accordance with Section 515.2030(e) or Section 515.2040(f) of this Part and has current AHA-AAP PALS or ACEP-AAP APLS recognition. PALS and APLS courses shall include both cognitive and practical

skills evaluation; or

ii) Completion of 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including 2800 hours within one 24-month period), verified in writing by the hospitals at which the internship and subsequent hours were completed and current AHA-AAP PALS or ACEP-AAP APLS recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation; or

iii) Completion of professional activities spent in the practice of pediatric emergency medicine (PEM), over the last 60-month period and totaling a minimum of 6000 hours, focused on the care of pediatric patients ~~in the pediatric age group (<21 years)~~ in the emergency department, and current AHA-AAP PALS or ACEP-AAP APLS recognition (PALS and APLS courses shall include both cognitive and practical skills evaluation). Of the 6000 hours, 2800 hours shall~~must~~ have been accrued in a 24-month (maximum) consecutive period of time. A minimum of 4000 of the 6000 hours shall~~must~~ have been spent in the clinical practice of PEM. (If practiced in general ED, only time spent exclusively in pediatric practice can be used for credit.) The remaining 2000 hours may be spent in either clinical care or a mixture of related non-clinical activities clearly focused on PEM, including administration, teaching, pre-hospital~~prehospital~~ care, quality improvement, research or other academic activities.

2) Continuing Medical Education
All full- or part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years.~~within a 2-year period.~~ CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II),

all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.

3) Physician Coverage
At least one physician meeting the requirements of subsection (a)(1) shall be on duty in the emergency department 24 hours a day.

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

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

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

b) Professional Staff: Mid-Level Practitioners
A mid-level practitioner is a nurse practitioner or physician assistant working under the supervision of a physician who meets the qualifications of subsection (a)(1) of this Section.

1) Qualifications

A) Nurse practitioners shall have:

i) Completed a pediatric nurse practitioner program or emergency nurse practitioner program or family practice

nurse practitioner program, or the Department will grant a waiver based on the following criteria: has completed 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of the pediatric patient (nurse practitioners shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements; and

ii) Current~~An~~ Illinois advanced practice nursing license ~~within one year after employment~~; and

iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.

B) Physician assistants shall have:

i) Current Illinois licensure ~~(permanent or temporary)~~; and

ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.

C) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP ~~Pediatric Advanced Life Support (~~PALS~~)~~ ~~course~~, the ACEP-AAP ~~Advanced Pediatric Life Support (~~APLS~~)~~ ~~course~~ or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course~~course~~ (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

2) Continuing Education

A) All full- or part-time nurse practitioners shall have documentation of a minimum of 16 hours of ~~approved~~ continuing education units in pediatric emergency topics every two years that are approved by an accrediting agency~~within a 2-year period~~.

B) All full- or part-time physician assistants shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I) in pediatric emergency topics every two years~~within a 2-year period~~. Credit for CME shall be approved by an accrediting agency.~~the Accreditation Council on Continuing Medical Education (ACCME), American Osteopathic Association Council on Continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP) or American Academy of Physicians Assistants (AAPA).~~

c) Professional Staff: Nursing

1) Qualifications

A) At least one registered nurse (RN) on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:

i) AHA-AAP ~~Pediatric Advanced Life Support (~~PALS~~)~~ ~~course~~;

ii) ACEP-AAP ~~Advanced Pediatric Life Support (~~APLS~~)~~ ~~course~~; or

iii) ENA ~~Emergency Nursing Pediatric course (~~ENPC~~)~~.

B) All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months after employment. 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~~8~~ hours of pediatric emergency/critical care continuing education every two years.~~hours within a 2-year period.~~ Continuing education may include, but is not limited to,

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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~~Interfacility~~ Transfer

A) The hospital~~facility~~ 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.~~with Pediatric Critical Care Centers (PCCC)~~

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

2) Suspected Child Abuse and Neglect~~Child Abuse~~
The hospital~~facility~~ 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~~child abuse~~ in accordance with State law.

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3) Treatment Guidelines~~Protocols~~
The hospital~~facility~~ shall have guidelines or policies addressing initial response and assessment for its high-volume and high-risk pediatric population~~protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients~~ (i.e., fever, trauma, respiratory distress, seizures).

4) Latex-Allergy~~free~~ Policy
The hospital~~facility~~ 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~~Committee~~

A) Pediatric emergency medical care shall be included in the EDAP's emergency department or section quality improvement (QI) program and reported to the hospital Quality Committee.~~QI committee.~~

B) Multidisciplinary ~~continuous~~ quality improvement (~~C~~QI) processes/activities shall be established (e.g., committee, task force).

C) Quality~~with documented CQI~~ monitors shall be documented that address~~addressing~~ pediatric care within the emergency department, with identified clinical indicators and/or outcomes for care. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all pediatric emergency department deaths, inter-facility~~resuscitations, and interfacility~~ transfers, child abuse and neglect cases, critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure) and pediatric strategic priorities of the institution.

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.

32) Pediatric Quality Coordinator~~CQI Liaison~~
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.~~and supported by the hospital as the pediatric liaison.~~ This individual may be employed in an area other than the emergency department and shall have a minimum of two~~2~~ years of pediatric critical care or emergency department experience. The responsibilities of the pediatric quality coordinator, working with the pediatric physician champion,~~liaison~~ shall include:

A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department staff in accordance with subsections (a), (b), and (c) of this Section.

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C) of this Section). ~~Maintaining a data summary and working in conjunction with the multidisciplinary CQI committee to coordinate criteria-based review and followup of sample pediatric emergency department visits.~~

C) Reviewing selected pediatric cases transported to the hospital by

pre-hospital providers and providing feedback to the EMS Coordinator/System. ~~Coordinating a review of pre-hospital provider transported pediatric cases and providing feedback to the EMS System Coordinator and the EMS Regional Advisory Board.~~

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

E) Providing ~~C~~QI information to the ~~Illinois~~ Department ~~of Public Health~~ upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays, and Supplies
See Appendix L of this Part.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

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

a) Professional Staff: Physicians

1) Qualifications

A) All physicians shall have training in the care of pediatric patients through residency training, clinical training, or practice.

B) All physicians shall successfully complete and maintain current recognition in the ~~American Heart Association – American Academy of Pediatrics (~~AHA-AAP~~) Pediatric Advanced Life Support (~~ PALS~~) course,~~ or the ~~American College of Emergency Physicians – American Academy of Pediatrics (~~ACEP-AAP~~) Advanced Pediatric Life Support (~~ APLS~~) course or equivalent course~~. ~~(~~Physicians who are board certified or eligible in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine (ABP/ABEM) are excluded from this

requirement.) PALS and APLS shall include both cognitive and practical skills evaluation.

2) Continuing Medical Education
All full- and or 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 yearswithin a 2-year period. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.

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

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

5) Physician Backup
A backup physician whose qualifications and training are equivalent to subsection (a)(1) of this Section shall be available to the SEDP within one1 hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians
Guidelines~~Protocols~~ shall ~~be available that~~ address ~~maximum~~ response time for on-call physicians.

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

1) Qualifications

A) Nurse practitioners shall have:

i) Completed a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program, or the Department will grant a waiver based on the following criteria: completion of~~has completed~~ 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 the pediatric patient. Nurse practitioners shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements; and

ii) A current~~An~~ Illinois advanced practice nursing license ~~within one year after employment~~; and

iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.

B) Physician assistants shall have:

i) Current Illinois physician assistant licensure ~~(permanent or temporary)~~; and

ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient.

C) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP ~~Pediatric Advanced Life Support (~~PALS~~)~~ ~~course~~, the ACEP-AAP ~~Advanced Pediatric Life Support (~~APLS~~)~~ ~~course~~ or the ENA ~~Emergency Nursing~~ ~~course(~~ENPC~~)~~. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

2) Continuing Education

A) All full- or part-time nurse practitioners shall have documentation of a minimum of 16~~20~~ hours of ~~approved~~ continuing education ~~units~~ in pediatric emergency topics every two years. Credit for continuing education shall be approved by an accrediting agency.~~within a 2-year period.~~

B) All full- or part-time physician assistants shall have documentation of a minimum of 16~~20~~ hours of continuing medical education (AMA Category I) in pediatric emergency topics every two years.~~within a 2-year period.~~ Credit for CME shall be approved by an accrediting agency.~~the Accreditation Council on Continuing Medical Education (ACCME), American Osteopathic Association Council on Continuing Medical Education (AOCCME), American Academy of Family Physicians (AAFP) or American Academy of Physician Assistants (AAPA).~~

c) Professional Staff: Nursing

1) Qualifications
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:

A) AHA-AAP ~~Pediatric Advanced Life Support (~~PALS~~)~~ ~~course~~;

B) ACEP-AAP ~~Advanced Pediatric Life Support (~~APLS~~)~~ ~~course~~; or

C) ENA ENPC~~Emergency Nursing Pediatric Course (ENPC)~~.

2) Continuing Education
At least one ~~registered nurse (~~RN~~)~~ 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~~8~~ hours of pediatric emergency/critical care continuing education every two years~~hours within a 2-year period~~. Continuing education may include, but is not limited to, PALS, APLS or ~~OR~~ ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; ~~and/~~or 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~~Interfacility~~ Transfer

A) The hospital~~facility~~ shall have current transfer agreements that cover pediatric patients. The transfer agreements shall address communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.

B) The hospital shall have written pediatric inter-facility transfer guidelines/~~with Pediatric Critical Care Centers (PCCC) and~~ policies/procedures concerning transfer of critically ill and injured patients that include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral hospital information to family.~~to PCCCs.~~ Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.

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2) Suspected Child Abuse and Neglect~~Abuse~~
The hospital~~facility~~ 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~~child abuse~~ in accordance with State law.

3) Treatment Guidelines~~Protocols~~
The hospital~~facility~~ shall have guidelines or policies addressing initial response and assessment for its high-volume and high-risk pediatric population ~~protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients~~ (i.e., fever, trauma, respiratory distress, seizures).

4) Latex-Allergy~~free~~ Policy
The hospital~~facility~~ 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~~Committee~~

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

B) Multidisciplinary ~~continuous~~ quality improvement processes/~~(CQI)~~ activities shall be established (e.g., committee, task force).

C) Quality~~with documented CQI~~ monitors shall be documented that address~~addressing~~ pediatric care within the emergency department~~Emergency Department~~, with identified clinical indicators and~~/or~~ outcomes for care. These activities shall include

children from birth up to and including 15 years of age and shall consist of, but are not limited to, all pediatric emergency department deaths, inter-facility~~resuscitations, and interfacility~~ transfers, child abuse and neglect cases, critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure) and pediatric strategic priorities of the hospital.

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~~CQI Liaison~~
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.~~and~~ The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital.~~supported by the hospital as the pediatric liaison.~~ This individual may be employed in an area other than the emergency department and shall have a minimum of two~~2~~ years of pediatric critical care or emergency department experience. Working with the pediatric physician champion, the~~The~~ responsibilities of the pediatric quality coordinator~~liaison~~ shall include:

A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department professional staff in accordance with subsections (a), (b), and (c) of this Section.

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C) of this Section). ~~Maintaining a data summary and working in conjunction with the multidisciplinary CQI committee to coordinate criteria-based review and follow-up of sample pediatric emergency department visits.~~

C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System. ~~Coordinating review of prehospital provider transported pediatric cases and providing feedback to the EMS System Coordinator and the EMS Regional Advisory Board.~~

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

E) Providing ~~C~~QI information to the ~~Illinois~~ Department ~~of Public Health~~ upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays, and Supplies
See Appendix L of this Part.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

Section 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center (PCCC)

Any facility seeking PCCC level recognition shall meet requirements for both the EDAP and PCCC levels.

a) Facility Requirements
A facility recognized as a PCCC Center shall provide the following:

1) An EDAP-recognized emergency department;

2) A distinct Pediatric Intensive Care Unit (PICU);

3) A PICU Committee established as a standing (interdisciplinary) committee within the hospital with membership including, but not limited to, physicians, nurses, respiratory therapists, and others directly involved in PICU activities;

4) Helicopter landing capabilities approved by State and federal authorities;

5) Computerized axial tomography (CAT) scan availability 24 hours a day;

6) Laboratory 24 hours a day in-house, providing:

A) Standard analysis of blood, urine and body fluids;

B) Blood typing and cross-matching;

C) Coagulation studies;

D) Comprehensive blood bank or an agreement with a community central blood bank;

E) Blood gases and pH determinations;

F) Microbiology, including the ability to initiate aerobic and anaerobic cultures on site; and

G) Drug and alcohol screening;

7) Hemodialysis capabilities or a transfer agreement;

8) Staff, including a child life specialist, occupational therapy, speech therapy, physical therapy, social work, dietary, psychiatry and child protective services;

9) Hospital support staff to act as a resource and participate in multidisciplinary regional pediatric critical care education;

10) A plan for implementing a program of public information/education concerning emergency care services for pediatrics; and

11) Support for active institutional and collaborative regional research.

b) PICU Medical Director Requirements
A Medical Director shall be appointed, and a record of appointment and acceptance shall be in writing.

1) Qualifications
The PICU shall have a dedicated Medical Director who is:

A) Board certified in Pediatrics by the ABP or the AOBP, and Board certified or in the process of certification in Pediatric Critical Care Medicine by ABP, or Pediatric Intensive Care by AOBP; or

B) Board certified in Pediatrics by the ABP or the AOBP, and Board certified in a pediatric subspecialty with at least 50% practice in pediatric critical care. In this situation, a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director; or

C) Board certified in Anesthesiology by the American Board of Anesthesiology (ABA), or the American Osteopathic Board of Anesthesiology (AOBA), with practice limited to infants and children and with a subspecialty certification in Critical Care Medicine. In this situation, a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director; or

D) Board-certified in Pediatric Surgery by the American Board of Surgery (ABS) with a subspecialty certification in Surgical Critical Care Medicine by the ABS. In this situation (ABS), a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director.

2) The Medical Director and/or Co-Director shall achieve certification within five years after his/her initial acceptance into the certification process for pediatric critical care or intensive care medicine, and shall maintain certification.

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c) PICU Medical Staff Requirements

1) Qualifications

A) The PICU shall have 24-hour in-hospital coverage provided by a Board-certified pediatric intensivist, certified by ABP or AOBP, or Board-eligible pediatric intensivist in the process of certification by ABP or AOBP, who is responsible for the supervision of the physicians listed in subsections (c)(1)(A)(i) and (ii), and who is available within 30 minutes in-house after the determination is made that he or she is needed. If the intensivist is not in-house, then one of the following shall be available in-house:

i) Board-certified pediatrician certified by ABP or AOBP, or Board-eligible in pediatrics and in the process of Board certification; or

ii) A resident of PGY-2 or greater under the auspices of a Pediatric Training Program, in the unit, with a PGY-3 in-house.

B) All physicians listed in subsection (c)(1)(A) shall successfully complete and maintain current recognition in either the ACEP-AAP PALS course or the APLS course.

2) Physician Specialist Availability
If the applying hospital is a Pediatric Trauma Center, the applicable requirements for physician response times that meet Sections 515.2035 and 515.2045 shall be followed.

A) Attending level physician specialists shall be on staff and are required to have the following:

i) Pediatric proficiency as defined by the hospital credentialing process;

ii) Board/sub-board certification in their specialty. If residency trained/board prepared in their specialty,

physicians shall achieve certification within five years after initial acceptance into the board/sub-board certification process, and maintain certification; and

iii) 10 hours per year of pediatric CME (category I or II) in his/her specialty.

B) The following on-call surgeons with pediatric proficiency shall be available in-house within 60 minutes after the determination is made that they are needed:

i) Surgeon; and

ii) Neurosurgeon, or transfer agreement with another facility.

C) On-call attending anesthesiologists with pediatric proficiency shall be available in-house within 60 minutes after the determination is made that they are needed. CRNAs with pediatric proficiency may initiate appropriate procedures as identified in hospital by-laws.

D) On-staff subspecialists with the following pediatric proficiency shall be available to the institution or by phone for consultation within 60 minutes after the determination is made that they are needed:

i) Cardiologist;

ii) Neonatologist;

iii) Nephrologist;

iv) Neurologist;

v) Orthopedic surgeon;

vi) Otolaryngologist; and

vii) Radiologist.

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E) The following physician specialists shall be available in the hospital or by consultation or transfer agreement with another hospital:

i) Allergist or immunologist;

ii) Cardiothoracic surgeon;

iii) Craniofacial (plastic) surgeon;

iv) Endocrinologist;

v) Gastroenterologist;

vi) Hand surgeon;

vii) Hematologist-oncologist;

viii) Infectious disease;

ix) Micro-vascular surgeon;

x) Obstetrics/gynecology;

xi) Ophthalmologist;

xii) Oral surgeon;

xiii) Physiatrist (physical medicine & rehabilitation);

xiv) Psychiatrist/psychologist;

xv) Pulmonologist; and

xvi) Urologist.

d) PICU Mid-level Providers Qualifications

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1) Nurse practitioner shall have credentialing as evidenced by the following:

A) Completion of a Pediatric Nurse Practitioner program or Pediatric Critical Care Nurse Practitioner Program and certification as an Acute Care Nurse Pediatric Practitioner; and

B) An Illinois Advanced Practice Nurse license within one year after hire.

2) Physician assistant shall have credentialing as evidenced by the following:

A) Current Illinois Physician Assistant licensure; and

B) Completion of a documented, precepted post-graduate clinical experience in the management of critically ill pediatric patients.

3) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: PALS, APLS or ENPC.

4) All nurse practitioners and physician assistants shall have documentation of a minimum of 50 hours of CME or continuing education units in pediatric critical care topics within a two-year period.

e) PICU Nursing Staff Requirements

1) Nurse manager
The PICU shall have a designated nurse manager who shall:

A) Be licensed as an RN under the Nurse Practice Act;

B) Have three years of clinical critical care experience, with a minimum of one year in clinical pediatric care; and

C) Successfully complete and maintain current recognition in one of the following courses: PALS, APLS or ENPC.

2) Advanced practice nurse

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Clinical nurse specialist (CNS), nurse practitioner (NP): The PICU shall have a designated pediatric CNS or pediatric NP who is available to provide clinical leadership in the nursing management of patients. Certified advanced practice nurses shall:

A) Have completed a documented, precepted post-graduate clinical experience in the management of critically ill pediatric patients;

B) Have an Illinois Advanced Practice Nurse License within one year after hire;

C) Successfully complete and maintain current recognition in one of the following courses: PALS, APLS or ENPC; and

D) Have documentation of a minimum of 50 hours of CME or continuing education units in pediatric critical care topics within a two-year period.

3) Nursing patient care services
All nurses engaged in direct patient care activities shall:

A) Successfully complete a documented hospital and unit orientation according to hospital guidelines before assuming full responsibility for patient care;

B) Complete a yearly competency review of high-risk, low-frequency therapies;

C) Successfully complete and maintain current recognition in one of the following courses: PALS, APLS or ENPC; and

D) Complete a minimum of 16 hours of pediatric emergency/critical care continuing education hours within a two-year period. Continuing education may include, but is not limited to, CEU offerings, case presentations, competency testing, teaching courses related to pediatrics or publications.

f) PICU Policies, Procedures, and Treatment Protocols

The PICU will include, but not be limited to, having the following age-specific policies/protocols in place:

1) Admission and discharge criteria;

2) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;

3) A policy for managing the psychiatric needs of the PICU patient; and

4) Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses.

g) Inter-facility Transfer/Transport Requirements
A PCCC shall:

1) Provide necessary consultation to those hospitals with which a transfer agreement is established; accept pediatric transfers from those hospitals; provide feedback as well as quality review to those hospitals on the transfer and management process;

2) Have or be affiliated with a transport system and team to assist referral hospitals in arranging safe pediatric patient transport; and

3) Have a transfer/transport policy that addresses the special needs of the pediatric population during transport.

h) Quality Improvement Requirements

1) Each PCCC shall have members from the PICU, including the Medical Director, and from the Pediatric Department who serve on the Multidisciplinary Pediatric Quality Improvement Committee, which will include, but not be limited to: emergency department, pediatric department, respiratory, laboratory, social service and radiology staff.

2) The Multidisciplinary Pediatric Quality Improvement Committee shall perform focused outcome analyses of its PICU services on a quarterly basis that consist of a review of at least the following:

A) All pediatric deaths;

B) All pediatric inter-facility transfers;

C) All pediatric morbidities or negative outcomes that are a result of treatment rendered or omitted;

D) Pediatric audit filters. An audit filter is a clinical and internal resource indicator used to examine the process of care and to identify potential patient care and internal resource problems;

E) Child abuse and neglect cases unless review is performed by another committee in the hospital;

F) All re-admissions within 48 hours after discharge from the emergency department or inpatient care that result in admission to the PICU; and

G) Review of all potential and unanticipated adverse outcomes.

i) PICU Equipment (See Appendix O of this Part)
The PCCC shall meet all equipment requirements as outlined in Appendix O of this Part. In addition, a specialized pediatric resuscitation cart with measuring device shall be readily available on each pediatric unit, containing the required equipment.

j) Pediatric Inpatient Care Service Requirements

1) Physician requirements

A) The Chair of Pediatrics or the Pediatric Inpatient Director shall have certification in pediatrics by the ABP or the AOBP.

B) All hospitalists, credentialed by their hospital to provide pediatric unit care, shall successfully complete and maintain current recognition in one of the following courses: PALS or APLS.

C) The Medical Director of the PICU, or his/her designee, shall be available on call and for consultation for all pediatric in-house patients who may require critical care.

2) Nurse manager requirements
The nurse manager shall:

A) Be licensed as an RN under the Nurse Practice Act;

B) Have three years of pediatric experience; and

C) Complete and maintain current recognition in one of the following courses: PALS, APLS or ENPC.

3) Nursing patient care services
All nurses engaged in direct patient care activities shall:

A) Complete a documented hospital and unit orientation according to hospital guidelines before assuming full responsibility for patient care;

B) Complete a yearly competency review of high-risk, low-frequency therapies based on patient population;

C) Complete and maintain current recognition in one of the following courses: PALS, APLS or ENPC; and

D) Complete a minimum of 16 hours of pediatric continuing education hours within a two-year period. Continuing education may include, but is not limited to, CEU offerings, case presentations, competency testing, teaching courses related to pediatrics and/or publications.

k) Hospital General Pediatric Department Policies, Procedures and Treatment Protocols
The pediatric department shall have, but not be limited to:

1) A policy or scope of services that outlines the pediatric department services, ages of patients served, and admission guidelines;

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2) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;

3) A safety and security policy for the patient in the unit;

4) An inter-facility transport policy that addresses safety and acuity;

5) An intra-facility transport policy that addresses safety and acuity;

6) A latex allergy policy;

7) A pediatric organ procurement/donation policy;

8) An isolation precautions policy that incorporates appropriate infection control measures;

9) A disaster/terrorism policy that addresses the specific medical and psychosocial needs of the pediatric population;

10) Protocols, order sets, pathways or guidelines for management of high-risk and low-frequency diagnoses;

11) A pediatric policy that addresses the resources available to meet the psychosocial needs of patients and family and appropriate social work referral for the following indicators:

A) Child death;

B) Child has been a victim of or witness to violence;

C) Family needs assistance in obtaining resources to take the child home;

D) Family needs a payment resource for their child's health needs;

E) Family needs to be linked back to their primary health, social service or educational system;

F) Family needs support services to adjust to their child's health condition or the increased demands related to changes in their child's health conditions; and

G) Family needs additional education related to the child's care needs to care for the child at home.

12) A discharge planning policy or protocol that includes the following:

A) Documentation of appropriate primary care/specialty follow-up provisions;

B) Mechanism to access a primary care resource for children who do not have a provider;

C) Discharge summary provision to appropriate medical care provider, parent/guardian, which includes the following:

i) Information on the child's hospital course;

ii) Discharge instructions and education; and

iii) Follow-up arrangements;

D) Appropriate referral of patients to rehabilitation or specialty services for children who may have any of the following problems:

i) Require the assistance of medical technology;

ii) Do not exhibit age-appropriate activity in cognitive, communication or motor skills, behavioral, or social/emotional realms;

iii) Additional medical or rehabilitation needs that may require specialized care, such as medication, hospice care, physical therapy, home health, or speech/language services;

iv) Brain injury – mild, moderate or severe;

v) Spinal cord injury;

vi) Seizure behavior exhibited during acute care or a history of seizure disorder and is not currently linked with specialty follow up;

vii) Submersion injury, such as a near drowning;

viii) Burn (other than a superficial burn);

ix) Pre-existing condition that experiences a change in health or functional status;

x) Neurological, musculoskeletal or developmental disability; or

xi) Sudden onset of behavioral change, for example, in cognition, language or affect.

l) Quality Improvement Requirements
Representatives from the pediatric unit shall participate in the multidisciplinary Pediatric Quality Improvement Committee (see subsection (h)).

m) Equipment Requirements (See Appendix O of this Part.)
The PCCC shall meet all equipment requirements as outlined in Appendix O of this Part. In addition, a specialized pediatric resuscitation cart with measuring device shall be readily available on each pediatric unit, containing the required equipment.

(Source: Added at 35 Ill. Reg. 20609, effective December 9, 2011)

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Section 515.APPENDIX D Standing Medical Orders

1. STANDING MEDICAL ORDERS/CARDIAC PROTOCOLS shall include at a minimum:

   Routine Cardiac Care
   Cardiac Arrest
   Cardiogenic Shock
   Ventricular Fibrillation
   Ventricular Tachycardia
   Ventricular Ectopy
   Electromechanical dissociation/pulseless electrical activity (EMD/PEA)
   Paroxysmal supraventricular tachycardia (PVST)
   Bradycardia
   Asystole

2. STANDING MEDICAL ORDERS/TRAUMA PROTOCOLS shall include at a minimum:

   Field Triage Protocols
   Shock (Hypovolemia)
   Spinal Cord
   Head Trauma
   Load and Go Situations
   Traumatic Arrest
   Amputated Parts
   Burns

3. STANDING MEDICAL ORDERS/PROTOCOLS FOR MEDICAL EMERGENCIES shall include at a minimum:

   Asthma
   Anaphylactic Shock
   Diabetic Emergencies
   Drug Overdose
   Coma, Origin Unknown
   Status Epilepticus
   Seizures
   Heat Emergencies

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Cold Emergencies
Poisoning
Radiation Injuries
Renal Protocols (care of patients with shunts and fistulas)
Near Drowning

4. STANDARD MEDICAL ORDERS/OBSTETRIC/GYNECOLOGICAL PROTOCOLS shall include at a minimum:

Normal Deliveries
Hemorrhage, including third trimester bleeding
Abnormal Deliveries (i.e., cord or breech presentation)
Resuscitation of the Newborn
Rape/Sexual Assault

5. STANDING MEDICAL ORDERS/PEDIATRIC PROTOCOLS shall include at a minimum:

PEDIATRIC INITIAL ASSESSMENT/MEDICAL CARE − A foundation for all pediatric patient interactions, this protocol shall reinforce the need for consistent, methodical patient assessment. Commonly referred to as "routine medical care" in adult protocols, the protocol shall reinforce the following: Importance of rapid BLS interventions (i.e., CPR), specifically airway support; age-appropriate signs and symptoms of pediatric respiratory distress; age-appropriate airway interventions, including the use of "blow-by" oxygen administration; indicators of adequate ventilation and perfusion; age-appropriate immobilization of the pediatric trauma patient; recognition of and monitoring for imminent life threats; unique assessment considerations and emergent care requirements of children with special health care needs (CSHN), including those who are technologically dependent. The protocol shall emphasize the appropriate inclusion of parents/primary caregivers.

NEONATAL RESUSCITATION − Shall incorporate the specific heart rate parameters and requisite interventions according to the American Heart Association recommendations.

PEDIATRIC AED – Treatment shall be in accordance with the Department approved Pediatric AED protocol and in accordance with American Heart

Association guidelines. AEDs can be used in children age one to eight years. Use of pediatric pads and cables is preferable.

PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS − Special attention to the differentiation between local reaction (hives), mild respiratory distress and severe cardio-respiratory compromise.

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS – Emphasis on the importance of recognizing etiology, aggressive airway maintenance, glucose monitoring and naloxone administration.

PEDIATRIC BRADYCARDIA − Treatment in accordance with the American Heart Association recommendations.

PEDIATRIC BURNS − Special emphasis on the pediatric "rule of nines" for burn size estimation, aggressive airway management and triage to the appropriate facility. Differentiation shall be made between thermal injuries, chemical injuries and electrical injuries.

PEDIATRIC ENVIRONMENTAL HYPERTHERMIA – Emphasis on appropriate assessment, cooling techniques and fluid replacement considerations of children presenting with environmental hyperthermia.

PEDIATRIC HYPOTHERMIA – Emphasis on the pediatric population at high risk for hypothermia: neonates and infants. Aggressive airway management, warming techniques and recognition of frostbite injury shall be addressed. Interventions for associated arrhythmias in accordance with the American Heart Association recommendations.

PEDIATRIC NEAR DROWNING – Emphasis on aggressive airway management and the potential for associated cervical spine injury and hypothermia.

PEDIATRIC PULSELESS ARREST – Treatment and recognition of the following dysrhythmias: asystole, pulseless electrical activity, ventricular fibrillation, ventricular fibrillation or pulseless ventricular tachycardia. Treatment modalities should be consistent with guidelines set forth by the American Heart Association's Pediatric Advanced Life Support. Appropriateness for intraosseous access should be included.

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PEDIATRIC RESPIRATORY ARREST − Treatment shall be in accordance with the American Heart Association Pediatric Advanced Life Support guidelines.

PEDIATRIC RESPIRATORY DISTRESS − Differentiation shall be made between "upper airway obstruction" (i.e., croup, epiglottitis and foreign body) and lower airway disease (i.e., asthma, bronchiolitis, pneumonia). The potential for invasive airway interventions shall also be identified. Respiratory distress in children with a tracheostomy tube or on a ventilator shall also be addressed.

PEDIATRIC SEIZURE − Shall include the identification of rapid blood glucose monitoring in the field, considerations for febrile seizures and administration of rectal benzodiazepines (specifically in children less than three years old).

PEDIATRIC SHOCK − Differentiation should be made between hypovolemic (dehydration, hemorrhagic), cardiogenic and distributive (sepsis).

PEDIATRIC TACHYCARDIA − Interventions for both wide and narrow complex tachycardias in accordance with the American Heart Association guidelines.

PEDIATRIC TOXIC EXPOSURES/INGESTIONS − Accidental/ environmental toxic exposure or ingestion events commonly encountered in the pediatric population shall be incorporated.

PEDIATRIC TRAUMA – Emphasis on mechanism of injury, limited on-scene time, aggressive airway maintenance and field triage to the appropriate facility and addressing the unique needs of the head-injured child.

SUSPECTED CHILD ABUSE/NEGLECT − Special emphasis shall be on careful documentation of physical findings, discrepancy between history of injury and physical findings, interaction between child and parent/caregiver, and characteristics of the environment. The pre-hospital provider's responsibility as a mandated reporter and reporting suspicions to the emergency room staff shall be discussed. Directions for responding to parent/caregiver refusal to allow transport shall be included.

~~PEDIATRIC PRIMARY ASSESSMENT - A foundation for all pediatric patient interactions, this protocol should reinforce the need for consistent, methodical patient assessment. Commonly referred to as "routine medical care" in adult~~

~~protocols, the protocol should reinforce the following:~~

~~Importance of rapid BLS interventions (i.e., CPR) specifically airway support~~
~~Age appropriate signs and symptoms of pediatric respiratory distress~~
~~Age appropriate airway interventions including the use of "blow-by" oxygen administration~~
~~Indicators of adequate ventilation and perfusion~~
~~Age appropriate immobilization of the pediatric trauma patient~~
~~Recognition of and monitoring for imminent life threats~~
~~Unique assessment considerations and emergent care requirements of children with special health care needs (CSHN), including those who are technologically dependent. Emphasize the appropriate inclusion of parents/primary caregivers~~

~~TREATMENT AND RECOGNITION OF THE FOLLOWING DYSRHYTHMIA:~~

~~Asystole~~
~~Pulseless Electrical Activity~~
~~Ventricular Fibrillation or Pulseless Ventricular Tachycardia~~
~~Ventricular Tachycardia~~

~~Treatment modalities/algorithms should be consistent with the guidelines set forth by the American Heart Association's "Pediatric Advanced Life Support" algorithms. The use of intraosseous access should be taught to all ALS providers.~~

~~NEONATAL RESUSCITATION - Must incorporate the specific heart rate parameters and requisite interventions according to the American Heart Association recommendations.~~

~~PEDIATRIC RESPIRATORY ARREST - Treatment must be in accordance with the American Heart Association "Pediatric Advanced Life Support" guidelines.~~

~~PEDIATRIC RESPIRATORY DISTRESS - Differentiation should be made between "upper airway obstruction" (i.e., croup, epiglottitis and foreign body) and other "non-obstructive" causes of respiratory insufficiency (i.e., asthma, bronthiolitis, pneumonia). The potential for invasive airway interventions must also be identified.~~

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~~PEDIATRIC BRADYCARDIA - Treatment in accordance with the American Heart Association recommendations.~~

~~PEDIATRIC TACHYCARDIA - Interventions for both wide and narrow complex tachycardias in accordance with the American Heart Association recommendations.~~

~~PEDIATRIC SHOCK - Differentiation should be made between "hypovolemic" (dehydration, hemorrhagic) and "distributive" (sepsis).~~

~~PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS - Special attention to the differentiation between symptomatic (hives), mild respiratory distress and severe respiratory distress.~~

~~PEDIATRIC SEIZURE - Must include the identification of rapid blood glucose monitoring in the field, considerations for febrile seizures and administration of rectal benzodiazepines (specifically in children less than 3 years old).~~

~~PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS - Emphasize the importance of recognizing etiology, aggressive airway maintenance, glucose monitoring and naloxone administration.~~

~~PEDIATRIC TOXIC EXPOSURES/INGESTIONS - Incorporate accidental/environmental events commonly encountered in the pediatric population. Special consideration should be made to the susceptibility of children to environmental events such as hyperthermia.~~

~~PEDIATRIC HYPOTHERMIA - Emphasize the pediatric population at high risk for hypothermia: neonates and infants. Address aggressive airway management, warming techniques and recognition of frostbite injury. Interventions for arrhythmias in accordance with the American Heart Association recommendations.~~

~~PEDIATRIC NEAR DROWNING - Emphasize aggressive airway management and the potential for associated cervical spine injury and hypothermia.~~

~~PEDIATRIC BURNS - Special emphasis on the pediatric "rule of nines" for burn size estimation, aggressive airway management and triage to the appropriate~~

~~facility. Differentiation should be made between thermal injuries, chemical injuries and electrical injuries.~~

~~PEDIATRIC TRAUMA - Emphasis should be made on mechanism of injury, limited on-scene time, aggressive airway maintenance and field triage to the appropriate facility and addressing the unique needs of the head-injured child.~~

~~SUSPECTED CHILD ABUSE/NEGLECT - Special emphasis should be made on careful documentation of physical findings, discrepancy between history of injury and physical findings, interaction between child and parent/caregiver, and characteristics of the environment. Discuss the pre-hospital provider's responsibility as a mandated reporter, and to report suspicions to the emergency room staff. Include directions for responding to parent/caregiver refusal to allow transport.~~

6. STANDING MEDICAL ORDERS/PROTOCOLS FOR SPECIAL SITUATIONS shall include at a minimum:

   Psychological Emergencies
   Spousal Abuse
   Geriatric Abuse
   Child Abuse

7. STANDING MEDICAL ORDERS/PROTOCOLS FOR THE PROCEDURES LISTED as well as any others that~~which~~ may be System specific:

   Adult Intubation Procedure
   Pediatric Intubation Procedure
   Defibrillation
   Transtracheal Ventilation-Cricothyrotomy
   Chest Decompression
   Cardioversion
   Medication Administration-IV/ett

8. Standing medical orders may be organized as assessment based versus diagnostic, such as, altered mental status, abnormal vital signs, dysrhythmias and/or blocks, respiratory distress, chest pain.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

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Section 515.APPENDIX K Application for Facility Recognition for Emergency Department with Pediatrics Capabilities

FACILITY RECOGNITION
Emergency Department with Pediatric Capabilities

Application Instructions~~Instruction~~

Follow these instructions to initiate the process to obtain recognition as an Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP)~~complete the application process~~:

~~1)~~ ~~Carefully review the application process in this Appendix K.~~

1~~2~~) Complete the application form and obtain the appropriate signatures.

2~~3~~) Using the Emergency Department Pediatric Plan Guideline and the EDAP or SEDP requirements~~Facility Recognition Application Criteria~~, complete an Emergency Department Pediatric Plan. Attach all requested~~Appendix any appropriate~~ supporting documentation (credentialing forms, schedules, policies, procedures, protocols, guidelines, plans, etc.).

3~~4~~) Submit the original signed application form plus three~~3~~ additional copies of the signed application form and four copies of the Emergency Department Pediatric Plan (including supporting documentation) to:

~~Leslee Stein-Spencer, RN, MS~~
Chief, Division of EMS & Highway Safety
Illinois Department of Public Health
422 S. 5th Street~~525 West Jefferson Street~~
Springfield IL 62701~~62761~~

4) The Emergency Department Pediatric Plan shall follow the format outlined in the Emergency Department Pediatric Plan Guideline in this Appendix K and include all required documentation. The plan shall also address how each of the EDAP/SEDP requirements is currently being or will be met. The Pediatric Plan shall be developed through interaction and collaboration with all other appropriate disciplines.

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5) Any submitted requests to waive any of the requirements shall include the criteria by which compliance is considered to be a hardship and demonstrate that there will be no reduction in the provision of medical care.

6~~5~~) The application should be submitted in a single-sided format and unstapled.

7~~6~~) Appendix M of this Part provides~~Please note that the attached appendix to this application is to provide~~ additional resource information ~~for your facility~~ related to pediatric inter-facility~~interfacility~~ transfer and consultation and can be used~~utilized~~ in the development of the Emergency Department Pediatrics Plan.

8~~7~~) For questions regarding the application process, specific requirements~~criteria items~~, ~~and/~~or supporting documentation, please contact the Division of EMS & Highway Safety at 217-785-2080~~Illinois Emergency Medical Services for Children (EMSC) Office at 708-327-3672~~.

~~ILLINOIS EMSC~~
~~APPLICATION PROCESS FOR RECOGNITION OF~~
~~EMERGENCY DEPARTMENTS WITH PEDIATRIC CAPABILITIES*~~

~~Application Process~~

~~To initiate the process to obtain recognition as an Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP), the facility shall submit all documents to:~~

~~Leslee Stein-Spencer, RN, MS~~
~~Chief, EMS & Highway Safety~~
~~Illinois Department of Public Health~~
~~525 W. Jefferson Street~~
~~Springfield IL 62761~~

~~Facilities requesting to participate in the Facility Recognition process must submit:~~

~~1)~~ ~~A signed application form~~

~~2)~~ ~~An Emergency Department Pediatric Plan. This plan must follow the format provided and include all required documentation as outlined in the Pediatric Plan Guideline in this~~

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~~Appendix K. The plan must also address how each of the EDAP/SEDP requirements are currently or will be met. Please note that the Pediatric Plan should be developed through interaction and collaboration with all other appropriate disciplines.~~

~~3) Any supporting documentation, which shall include but is not limited to scope of services/care, policies (both administrative and department specific), procedures, protocols, guidelines, flow charts, rosters, calendars, schedules, etc.~~

~~4) The plan should be submitted in the order listed in this application.~~

~~Please note that the original and 3 additional copies of the plan and any supporting documentation must be submitted.~~

~~Any submitted requests to waive any of the 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.~~

~~The Emergency Department Pediatric Plan Guideline can be utilized as a resource in completing the Emergency Department Pediatric Plan.~~

~~*Note: The term "pediatric" throughout this document refers to all children age 15 and younger.~~

~~Site Survey Procedure~~

~~1) Within 4 to 6 weeks following receipt of the Application Form and supporting documents (schedules, policies, procedures, protocols, guidelines, etc.), 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) The site visit will include a survey of the emergency department, pediatric unit (including intensive care, if applicable), and a meeting with the following individuals:~~

~~a) The Hospital's Chief Administrative/Executive Officer or designee.~~

~~b) The Chief of Pediatrics or, if the hospital does not have a pediatric department, the designated pediatric consultant.~~

~~c) The Medical Director of Emergency Services.~~

d) The Nursing Director or Nursing Manager of Emergency Services.

e) The Administrator of Emergency Services.

f) The pediatric liaison (a member of the professional staff who has ongoing involvement in the care of the pediatric patient and development of pediatric emergency medical services).

g) Mid-level provider, i.e., nurse practitioner or physician assistant for those facilities that utilize mid-level providers in their emergency department.

h) For EMS Resource or Association Hospitals only: the EMS Medical Director and EMS Coordinator.

3) In preparation for the site visit, hospital personnel shall prepare evidence to verify adherence to the facility recognition requirements.

Site Survey Team

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

Following the Site Survey

1) Within 4 to 6 weeks following the site visit, the hospital shall receive results of the survey. Those facilities meeting all requirements will receive a formal "recognition" for their emergency department pediatric capabilities. Signed copies of the recognition shall be forwarded to the Chief of EMS & Highway Safety and the Illinois EMSC office.

2) 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 3 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

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~~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.~~

RECOGNITION OF EMERGENCY DEPARTMENT
PEDIATRIC CAPABILITIES
APPLICATION FORM

1) Name and address of hospital (typed)

_____

_____

_____

2) Specify the recognition level for which your hospital is applying:

a) Emergency Department Approved for Pediatrics (EDAP) _____

b) Standby Emergency Department Approved for Pediatrics (SEDP) _____

3) The above-named hospital~~facility~~ certifies that each requirement in this Request for Recognition is met and will be in operation by the date of recognition.

_____
Typed name – CEO/Administrator

_____
Signature – CEO/Administrator Date

_____
Typed name – Medical Director of Emergency Services

_____
Signature – Medical Director of Emergency Services Date

_____
Contact person – Typed name, credentials and title~~phone number, and fax number~~

_____
Contact person – Phone number, fax number and email

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EMERGENCY DEPARTMENT PEDIATRIC PLAN
GUIDELINE

Emergency Department Pediatric Plan (Please follow this guideline carefully. It provides information on the components that must be included in the submitted plan. Please include any applicable supplemental documentation.)

A. Emergency Department Organizational Structure

1. Provide a hospital~~an~~ Organizational Table identifying the administrative relationships among all departments in the hospital, especially as they relate to the emergency department. The table must include, but is not limited to, the following:

a. Board of Directors

b. Chief Executive Officers

c. Emergency Department

d. Department of Pediatrics

e. Trauma Service (if applicable)

f. Department of Radiology

2. In addition, provide a separate table showing the organization structure of the emergency department, including the relationship of the physician, nursing and ancillary services. Include the reporting structure for the ED Medical Director (to whom~~who~~ he/she reports~~to~~).

a. Emergency Department Organizational Structure (Table)

B. Emergency Department Services

1. Description of the emergency department services

- Provide a scope of services or policy outlining emergency department services, emergency department level, a description of the population served, types of pediatric patients seen, and annual emergency department visits that involve the pediatric patient.
- Identify the age range that the hospital usesyour facility utilizes to define the pediatric patient, i.e., 0-15.
- Provide information on participation/status in EMS system and trauma system as appropriate.

2. Description of the emergency department patient flow
   - Provide a narrative description ororof algorithm ofor patient path/flow from point of entry through disposition.
   - Provide any policies/guidelines that identify triaging/urgency categorization of patients.
   - Identify whether pediatric patients are seen in the general emergency departmentED or in a separate area/bed space allocated for the pediatric patient.
   - If an emergency department fast-track area exists, provide triage criteria for this area and information on physician and nursing staffing/qualifications for assignment to the fast-track area.

3. Description of emergency medical services communication with identification of dedicated phone line, radio, and telemetry capabilities
   - Provide a policy or narrative description of the emergency services dedicated phone/telemetry radio communication capabilities.
   - Provide a policy outlining staffing qualifications to access and useutilize such equipment.

4. Description of social service availability and capabilities
   - Provide a scope of services or policy that defines the services, capabilities and availability of social service department/personnel to the emergency department.
   - Describe typical mechanism and response by social worker to emergency departmentED requests (i.e., handlehandled over the phone, respond directly to the emergency departmentED, follow-up consult/appointment made).

C. Pediatric Department Services

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1. Description of the pediatric department services
   - Identify whether there is a dedicated pediatric inpatient unit, dedicated pediatric inpatient beds and pediatric intensive care unit.
   - Provide a scope of services/policy outlining pediatric department services.

2. Description of the pediatric staffing and availability
   - Provide policy or scope of services outlining pediatric unit shift nursing staffing patterns based on patient acuity and any pediatric continuing education requirements/competencies verification.
   - If pediatric patients are admitted for care to an adult inpatient unit, provide documentation that identifies unit pediatrician staffing/coverage for such patients and how nurses are assigned to the inpatient pediatric patient, i.e., only nurses who have completed the PALS course.

3. Description/documentation of pediatric inpatient capabilities with identification of PICU and/or pediatric general floor bed availability and unit resources
   - Provide policy or scope of services that identifies what types of pediatric patients are typically admitted, i.e., types of conditions/diagnoses. Are ~~Can all ages (from birth to 18 years) be admitted or are~~ there guidelines in place that define~~outline~~ pediatric patients specifically by age parameters and/or diagnoses?
   - If a PICU is present, then a description of services, unit resources, and capabilities is needed. If a PICU is not present, then a description of where patients requiring such care are transferred, established relationships with pediatric tertiary care center, etc., is needed.

D. Professional Staff

1. Emergency Department Director

   a. Copy of curriculum vitae
      - Provide a printed curriculum vitae.

   b. Documentation of board certification (as identified in Facility Recognition Criteria)
      - Provide a copy of board certification or verification of board certification.

2. Emergency Department Physicians

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Documentation of the ability to meet ~~facility~~ recognition requirements in Section 515.4000 or Section 515.4010 of this Part.

Hospital~~Facility~~ Recognition Requirement – Section 515.4000(a)(1) or 515.4010(a)(1)

- Provide a policy or description of emergency department physician staffing, coverage and availability (including fast track/urgent care area).
- Provide a complete list/roster of emergency department physician staff, including fast track/urgent care area (may use the Department-approved credentialing form).
- Provide a one-month staffing schedule/calendar, including fast track/urgent care area (schedule should be from within the three~~3~~ month time period previous to the application submission).
- Provide copies of physician current board certification or verification of board certification (or copies of CVs for SEDP level applications).
- Provide copies of PALS or APLS course completion certificates for physician staff or a documented plan to complete such courses. ~~within the specified timeframe.~~ Provide documentation of a plan to maintain PALS or APLS recognition.
- Provide a policy that incorporates Section 515.4000(a)(1) or 515.4010(a)(1).

Hospital~~Facility~~ Recognition Requirement – Section 515.4000(a)(2) or 515.4010(a)(2)

- Provide a copy of the emergency department physician continuing education policy.
- Provide a description of how physician continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours (these hours can be integrated into the overall CME tracking process).
- Provide a policy that incorporates Section 515.4000(a)(2) or 515.4010(a)(2).

Hospital~~Facility~~ Recognition Requirement – Section 515.4000(a)(3) or 515.4010(a)(3)

- Provide a staffing policy that incorporates Section 515.4000(a)(3) or 515.4010(a)(3).

HospitalFacility Recognition Requirement – Section 515.4000(a)(4) or 515.4010(a)(4)

- Provide a one-month on-call schedule that identifies availability of a board certified/prepared pediatrician or pediatric emergency medicine physician for telephone consultation (schedule should be from within the three3- month time period previous to the application submission).

HospitalFacility Recognition Requirement – Section 515.4000(a)(5) or 515.4010(a)(5)

- Provide a copy of a disaster policy that identifies physician back-upon-call availability to assist with critical situations, increased surge capacity or disasters.

HospitalFacility Recognition Requirement – Section 515.4000(a)(6) or 515.4010(a)(6)

- Provide a protocol/policy/bylaws that identifies maximum response time of on-call physicians.

3. Emergency Department Mid-Level Providers (Physician Assistant or Nurse Practitioner)
Note – Complete this section only if physician assistants and/or nurse practitioners practice in the emergency department and participate in the care of pediatric patients.

Provide documentation of the ability to meet hospitalfacility recognition requirements in Section 515.4000(b) or 515.4010(b) of this Part.

Requirement – Section 515.4000(b)(1) or 515.4010(b)(1)

- Provide a policy of emergency department physician assistant and/or nurse practitioner staffing, coverage, availability, responsibilities and credentialing process.
- Provide a list/roster of all emergency department physician assistant and nurse practitioner staff (may use Department- approved credentialing form).
- Provide a copy of a one-month staffing schedule/calendar (schedule should be from within the three 3-month time period previous to the application submission).
- Provide a copy of printed licenses and curriculum vitaes.
- Provide copies of PALS, APLS or ENPC course completion certificates or

a documented plan to complete such courses. ~~within the specified timeframe.~~ Provide documentation of a plan to maintain PALS, APLS~~,~~ or ENPC recognition.

- Provide a policy that incorporates Section 515.4000(b)(1) or 515.4010(b)(1) of this Part.

Requirement – Section 515.4000(b)(2) or 515.4010(b)(2)

- Provide a copy of the emergency department physician assistant/nurse practitioner continuing education policy.
- Provide a description of how physician assistant/nurse practitioner continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours (these hours can be integrated into overall continuing education tracking process).
- Provide a policy that incorporates Section 515.4000(b)(2) or 515.4010(b)(2) of this Part.

4. Emergency Department Registered Nurses

Provide documentation of the ability to meet hospital~~facility~~ recognition requirements in Section 515.4000(c) or 515.4010(c) of this Part.

Requirement – Section 515.4000(c)(1) or 515.4010(c)(1)

- Provide a policy/documentation outlining current nursing shift staffing plan/patterns.
- Provide a list/roster of all emergency department nursing staff (may use Department approved credentialing form).
- Provide a copy of a one-month nursing staffing schedule/calendar (schedule should be from within the three~~3~~ month time period previous to the application submission).
- Provide copies of PALS, APLS or ENPC completion certificates or a documented plan to complete such courses. ~~Provide copies of current course completion cards for nursing staff who have completed PALS, APLS, or ENPC courses.~~
- Provide a policy that incorporates Section 515.4000(c)(1) or 515.4010(c)(1).

Requirement – Section 515.4000(c)(2) or 515.4010(c)(2)

- Provide a policy identifying continuing education requirements and

competency testing for emergency department nursing staff.

- Provide a description of how continuing education is currently tracked.
- Provide documentation of ana ~~a feasible~~ implementation plan for attaining and tracking of pediatric specific continuing education hours.
- Provide a policy that incorporates Section 515.4000(c)(2) or 515.4010(c)(2) of this Part.

E. Policies and Procedures

1. Policy/procedure for inter-facility~~interfacility~~ transfer as identified in Section 515.4000(d)(1) or 515.4010(d)(1) of this Part.
   - Provide a transfer agreement with a Pediatric Critical Care Center and identification of facilities to which the hospital typically transfers pediatric patients.
   - Provide~~and~~ a transfer policy that incorporates the physiologic/other criteria identified in Appendix M: EMSC Inter-facility~~Interfacility~~ Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline.

2. Policy/procedure for suspected child abuse and neglect as identified in Section 515.4000(d)(2) or 515.4010(d)(2) of this Part.
   - Provide a policy that includes age-specific identification, assessment, evaluation and management measures for the suspected child abuse and neglect patient.

3. Treatment guidelines~~protocols~~ as identified in Section 515.4000(d)(3) or 515.4010(d)(3) of this Part.
   - Provide copies of pediatric treatment guidelines~~protocols~~ as described.
   - ~~If limited pediatric-specific treatment protocols are available, submit a letter of commitment to the development and implementation of additional pediatric-specific treatment protocols. (~~It is recommended that guidelines ~~protocols~~ be based on high volume/high risk diagnoses (i.e., fever, trauma, respiratory distress, seizures) and~~with inclusion of age-specific stabilization measures. It is recommended~~ that guidelines~~protocols~~ include desired outcomes in order to facilitate quality improvement monitoring.~~)~~

4. Policy for latex allergy ~~free supplies~~ as identified in Section 515.4000(d)(4) or

515.4010(d)(4) of this Part.

- Provide a policy that addresses assessment of latex allergies and the availability of latex-free equipment and supplies.

F. Quality Improvement

1. Describe and document the emergency department program for conducting outcome analysis or quality improvement and how pediatrics is integrated into the process.
   - Provide a policy/guideline that outlines the emergency department quality improvement program, i.e., describe the quality improvement process, clinical indicators and/or outcome analysis and follow-up mechanisms, i.e., "loop closure" and target time framestimeframes for closure of issues.
   - Provide documentation outlining current and planned pediatric monitoring activities.

2. Document the ability to meet facility recognition requirements in Section 515.4000(e) or 515.4010(e) of this Part.

   Requirement – Section 515.4000(e)(1) or 515.4010(e)(1)
   - Define thePlease define composition of the multidisciplinary CQI committee (recommend broadening composition of committee beyond physician/nursing to include other essential disciplines such as pediatric, social services, respiratory therapy), frequency of committee meetings and reporting structure.
   - Provide a copy of the emergency department quality improvement plan, including QI policy, pediatric indicators, feedback loop and target time frames for closure of issues.copies of current pediatric monitor tools and outcome criteria. If implementation of pediatric monitoring activities is pending, define implementation plan and time frametimeframe.

   Requirement – Section 515.4000(e)(2) or 515.4010(e)(2)
   - Provide a curriculum vitae for the physician who will assume the pediatric physician champion role.
   - Provide the name and title of the individual who will assume the pediatric quality coordinatorCQI liaison role.
   - ProvideIdentify in a job descriptionpolicy format that addresses allocation of time and resources to the role and includes each of the requirements outlined in Section 515.4000(e)(2) or 515.4010(e)(2) that will be carried

out by the pediatric quality coordinator~~CQI liaison~~.

G. Equipment
Using the equipment list provided in Appendix L, place an "X" next to each equipment item that is currently available (as appropriate for the level applied for). If equipment/supply items are not available, a plan for securing the items shall~~must~~ be identified, i.e., submission of a purchase order to assure that the item is on order, or a waiver shall~~must~~ be submitted for each item.

Requests for waiver shall~~must~~ include the criteria by which compliance is considered to be a hardship and shall~~must~~ demonstrate that~~how~~ there will be no reduction in the provision of medical care.

Site Survey Procedure

1) Within four to six weeks following receipt of the Application Form and supporting documents (schedules, policies, procedures, protocols, guidelines, etc.), 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) The site visit will include a survey of the emergency department and pediatric unit (including intensive care, if applicable), and a meeting with the following individuals:

a) The hospital's chief administrative/executive officer or designee

b) The chief nursing executive/director of nursing or designee

c) The chief of pediatrics or, if the hospital does not have a pediatric department, the designated pediatric consultant

d) The nursing director or nursing manager of the pediatric unit, if applicable

e) The emergency department medical director or pediatric emergency department medical director

f) The emergency department nursing director or nursing manager

g) The administrator of emergency services

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h) The administrator of pediatric services, if applicable

i) The pediatric quality coordinator

j) The hospital quality improvement director or designee

k) The hospital emergency management/disaster preparedness coordinator

l) Mid-level provider, i.e., nurse practitioner or physician assistant, for those hospitals that use mid-level providers in their emergency department

m) For EMS Resource or Associate Hospitals only: the EMS Medical Director and EMS Coordinator

3) In preparation for the site visit, hospital personnel shall prepare evidence to verify adherence to the hospital recognition requirements.

Site Survey Team

The Chief of EMS & Highway Safety, in coordination with the Illinois EMSC Advisory Board, will appoint the survey team. Site survey teams will be composed of a physician/nurse (or nurse/nurse) team along with a representative from the Illinois Department of Public Health. All team members shall have attended formal training in the responsibilities, expectations, process and assessment of facility recognition.

Following the Site Survey

1) Within four to six weeks following the site visit, the Department will provide the hospital with the results of the survey. Those hospitals meeting all requirements will receive a formal "recognition" for their emergency department pediatric capabilities.

2) 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) Re-recognition shall occur every three years, with site visits scheduled as necessary.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

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Section 515.APPENDIX L Pediatric Equipment Recommendations for Emergency Departments

The following list identifies pediatric equipment items that are recommended for the two~~2~~ emergency department facility recognition levels. Equipment items are classified as "essential" (E) and "need to be stocked in the emergency department" (ED).

	EDAP	SEDP
Monitoring Devices		
Blood glucose measurement device (i.e., chemistry strip or glucometer)	E (ED)	E (ED)
Continuous end-tidal PCO_2 monitor and pediatric CO_2 colorimetric detector (disposable units may be substituted)	E (ED)	E (ED)
Doppler ultrasound blood pressure device (neonatal-adult thigh cuffs)	E (ED)	E (ED)
ECG monitor-defibrillator~~defribillator~~/cardioverter with pediatric and adult sized paddles, with pediatric dosage settings ~~(0-400 joules)~~ and pediatric-adult pacing~~packing~~ electrodes	E (ED)	E (ED)
Hypothermia thermometer (Note: with a range of 28-42°C)	E (ED)	E (ED)
Pediatric monitor electrodes	E (ED)	E (ED)
~~End-tidal pediatric CO_2 monitor and/or pediatric CO_2 detector (disposable units may be substituted)~~	~~E (ED)~~	~~E (ED)~~
Otoscope/ophthalmoscope~~opthalmoscope~~/stethoscope	E (ED)	E (ED)
Pulse oximeter with pediatric and adult probes~~adapter~~	E (ED)	E (ED)
Sphygmomanometer with cuffs (neonatal-adult thigh)	E (ED)	E (ED)
~~Thermometer (hypothermia), rectal probe (28-42°C)~~	~~E (ED)~~	~~E (ED)~~

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Vascular Access Supplies and Equipment

Arm boards (sized infant through adult)	E (ED)	E (ED)
Blood gas kits	E (ED)	E (ED)
Butterfly-type needles (19-25 g)*	E (ED)	E (ED)
Catheter-over-needle devices (16-24 g)*	E (ED)	E (ED)
Central venous catheters (stock one small and one large size)	E (ED)	E (ED)
Infusion pumps, drip or volumetric, with microinfusion capability, appropriate tubing & connectors	E (ED)	E (ED)
Intraosseous needles or bone marrow needles (13-18 g size range;) stock one large/one small bore) or IO device (pediatric and adult sizes)	E (ED)	E (ED)
IV extension tubing, stopcocks, and T-connectors~~IV administration sets with calibrated chambers, extension tubing, stopcocks, and T-connectors~~	E (ED)	E (ED)
IV fluid/blood warmer	E (ED)	E (ED)
IV solutions: standard crystalloid and colloid solutions (D10W, D5/.2 NS, D5/.45 NS~~D5/45 NS~~, D5/.9 NS and 0.9 NS)	E (ED)	E (ED)
Syringes (~~TB, Insulin U100,~~ 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)
~~Single lumen vascular access supplies utilizing the Seldinger technique (5 and 8 Fr)*~~	~~E (ED)~~	~~E (ED)~~

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Respiratory Equipment and Supplies

Bag-valve-mask device, self-inflating infant/child~~pediatric (250 & 450 ml)~~ and adult (1000 ml) with O_2 reservoir ~~and without pop-off valve~~ and clear masks (neonatal through large adult sizes)*; PEEP valve and manometer	E (ED)	E (ED)
Bulb syringe	E (ED)	E (ED)
~~Cricothyrotomy capabilities (i.e., 10 g needle and 3 mm ET tube adapter or 14 g needle and 3.5 mm ET tube adapter) or cricothyrotomy kit~~	~~E (ED)~~	~~E (ED)~~
Endotracheal tubes~~Endrotracheal tubes~~:*		
Uncuffed (sizes 2.5 and 3.0~~, 3.5, 4.0, 4.5, 5.0, 5.5~~)	E (ED)	E (ED)
Cuffed or Uncuffed (3.5, 4.0, 4.5, 5.0, 5.5)	E (ED)	E (ED)
Cuffed (sizes ~~5.5,~~ 6.0, 6.5, 7.0, 7.5, 8.0~~, 9.0~~)	E (ED)	E (ED)
Stylets for endotracheal tubes (pediatric and adult)	E (ED)	E (ED)
Laryngoscope handle (pediatric and adult)	E (ED)	E (ED)
Laryngoscope blades (curved 2, 3; straight or Miller 0, 1, 2, 3)*	E (ED)	E (ED)
Magill forceps (pediatric and adult)	E (ED)	E (ED)
Meconium aspirator	E (ED)	E (ED)
Nasopharyngeal airways (sizes 12, 16, 20, 24, 28, 30 Fr)*	E (ED)	E (ED)
Nebulized medication, administration set with pediatric and adult masks	E (ED)	E (ED)
Oral airways (sizes 0, 1, 2, 3, 4, 5 or size 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 and~~Partial~~ non-rebreather masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Nasal cannula~~canula~~ (infant, pediatric and adult)	E (ED)	E (ED)
~~Nasal canula (infant)~~	~~E (ED)~~	~~E (ED)~~
Peak flow meter	E (ED)	E (ED)
Supplies/kit for patients with difficult air way 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)	E (ED)	E (ED)
Suction capability (wall)	E (ED)	E (ED)
Suction capability (portable)	E (ED)	E (ED)
Suction catheters (sizes 5/6, 8, 10, 12, 14, 16 Fr and Yankauer-tip catheter)*	E (ED)	E (ED)
Tracheostomy tubes~~, Shiley~~ (sizes PED* 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)* (correspond to PT 00, 0, 1, 2, 3, 4, in old schematization)	E (ED)	---
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 12-32~~8-40~~ Fr)*	E (ED)	---
Medications (unit dose, prepackaged)		
Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number in ED	E (ED)	E (ED)
Activated charcoal (consider with and without Sorbitol)	E (ED)	E (ED)
Adenosine	E (ED)	E (ED)

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Amiodarone	E (ED)	E (ED)
Antiemetics	E (ED)	E (ED)
Antimicrobial agents (parenteral and oral)	E (ED)	E (ED)
Antipyretics	E (ED)	E (ED)
Atropine	E (ED)	E (ED)
Barbiturates, e.g., Phenobarbital, Pentobarbital, Thiopental	E (ED)	E (ED)
Benzodiazepines~~Bensodiazepines~~, e.g., Lorazepam, Midazolam, Diazepam	E (ED)	E (ED)
Beta agonist for inhalation (Albuterol, Levalbuterol)	E (ED)	E (ED)
Beta blockers, e.g., Propranolol, Metoprolol	E (ED)	E (ED)
Calcium (chloride or gluconate)	E (ED)	E (ED)
Corticosteroids, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone	E (ED)	E (ED)
Dextrose (25% and 50%)	E (ED)	E (ED)
Diphenhydramine	E (ED)	E (ED)
Dobutamine	E (ED)	---
Dopamine	E (ED)	---
Epinephrine (1:1,000 and 1:10,000)	E (ED)	E (ED)
Epinephrine (Racemic)	E (ED)	E (ED)
Fosphenytoin and/or Phenytoin	E (ED)	E (ED)

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Furosemide	E (ED)	E (ED)
Glucagon or Glucose Paste	E (ED)	E (ED)
~~Hydrocortisone~~	~~E (ED)~~	~~E (ED)~~
Insulin, regular	E (ED)	E (ED)
Lidocaine 1%	E (ED)	E (ED)
Magnesium Sulfate	E (ED)	E (ED)
Mannitol	E (ED)	E (ED)
~~Methylprednisolone~~	~~E (ED)~~	~~E (ED)~~
Narcotics	E (ED)	E (ED)
Neuromuscular blocking agents (i.e., succinylcholine, rocuronium,~~pancuronium~~ vecuronium)	E (ED)	E (ED)
Ocular anesthetics	E (ED)	E (ED)
~~Phenytoin and/or Phosphenytoin~~	~~E (ED)~~	~~E (ED)~~
Poison Specific Antidotes		
Acetylcysteine	E (ED)	E (ED)
Cyanide kit ~~(amyl nitrate, sodium nitrate and sodium thiosulfate)~~	E (ED)	E (ED)
Flumazenil	E (ED)	E (ED)
Naloxone	E (ED)	E (ED)
Procainamide	E (ED)	E (ED)
Sodium bicarbonate – 8.4% and 4.2%	E (ED)	E (ED)
Sedative/Hypnotic (e.g.,~~i.e., Thiopental,~~ Ketamine, Etomidate,~~Midazolam~~)	E (ED)	E (ED)

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Tetanus Immune Globulin (Humanhuman)	E (ED)	E (ED)
Tetanus Vaccines (single or in combination with other vaccines)	E (ED)	E (ED)
Topical Anesthetics	E (ED)	E (ED)
Miscellaneous Equipment	E (ED)	E (ED)
Dosing device – length or weight based system for dosing and equipment	E (ED)	E (ED)
Dosing/equipment chart by weight	E (ED)	E (ED)
EMS communication equipment (i.e., telemetry, MERCI, cellular or dedicated phone)	E (ED)	E (ED)
Examination gloves, disposable	E (ED)	E (ED)
Feeding tubes (5-8)*	E (ED)	E (ED)
Fluorescein (eye strips)	E (ED)	E (ED)
Gastric lavage equipment	E (ED)	E (ED)
Infant formulas, dextrose in water with various nipple sizes	E (ED)	E (ED)
Lubricant, water soluble	E (ED)	E (ED)
Nasogastric tubes (8 through6-18 Fr)* (may substitute feeding tubes 5F and 8F)	E (ED)	E (ED)
Oral rehydrating solution	E (ED)	E (ED)
Pain scale assessment tools appropriate for age	E (ED)	E (ED)
Pediatric emergency/crash cart or bag with defined list of contents attached to bag/cart	E (ED)	E (ED)

Restraining device, pediatric (papoose)	E (ED)	E (ED)
Resuscitation board	E (ED)	E (ED)
Urinary catheters (8-22 Fr)*	E (ED)	E (ED)
Warming devices, age appropriate	E (ED)	E (ED)
Weighing scales (in kilograms) for infant and children~~adult~~	E (ED)	E (ED)
Woods lamp (blue light)	E (ED)	E (ED)
Specialized Pediatric Trays		
Initial newborn resuscitation equipment (can include warming device, feeding tubes, neonatal mask)	E (ED)	E (ED)
Lumbar puncture tray, including a selection of needle sizes (size 18-22 g, 1½ -3 inch needle)~~capability (20-25 g, 1½ inch needle)~~	E (ED)	E (ED)
Minor surgical instruments and sutures	E (ED)	E (ED)
Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel)~~with umbilical vessel cannulation supplies and meconium aspirator~~	E (ED)	E (ED)
Fracture Management Devices		
Extremity splints	E (ED)	E (ED)
Femur splint (child and adult)	E (ED)	E (ED)
Semi-rigid neck collars (child through adult) or cervical immobilization equipment suitable for children	E (ED)	E (ED)
Spinal immobilization board (child and adult)	E (ED)	E (ED)

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* Shall~~Must~~ minimally stock a~~the full~~ range of each commonly available size noted or comparable sizes.

(Source: Amended at 35 Ill. Reg. 20609 effective December 9, 2011)

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Section 515.APPENDIX M Inter-facility~~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~~interfacility~~ transport services to facilitate the transport of critically ill or injured children to specialized centers when indicated.

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

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

- They can be used by physicians and hospitals to identify the types of critically ill or injured children who might benefit from consultation with critical care or trauma specialists or transfer to specialized referral centers. It is recommended that hospitals and their medical staffs develop appropriate policies, procedures and staff education programs based on these guidelines. This will help to promote consultation, minimize delays, and facilitate appropriate, rapid and efficient transport of critically ill and injured children to specialty centers, when indicated.

- It is recommended that these guidelines also be used by local EMS agencies as a basis for the development of pediatric consultation and transfer guidelines based on the local needs and resources. Consultation and transfer guidelines should be integrated into local EMS

agency plans for pediatric emergency, critical care, and trauma care in each region. These guidelines should become specific EMS policies and procedures in order to promote appropriate consultation and transfer of children who require specialized pediatric critical care and/or trauma services.

The following guidelines are intended to assist physicians and hospitals to identify the types of critically ill and injured children who might benefit from consultation with pediatric critical care specialists or trauma specialists and transfer to specialized pediatric critical care or trauma centers, when indicated. If an inter-facility~~interfacility~~ transport is required, the referring physician, in consultation with the receiving physician, should determine the method of transport and appropriate personnel to accompany the child. 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~~Interfacility~~ Consultation and/or Transfer for Evaluation of Pediatric Medical Patients (Non-trauma)

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status

2. Severe respiratory distress responding inadequately to treatment and accompanied by any one of the following:

a. Cyanosis

b. Retractions (moderate to severe)

c. Apnea

d. Stridor (moderate to severe)

e. Grunting or gasping respirations

f. Status asthmaticus

g. Respiratory failure

3. Children requiring 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

b. Central venous pressure or pulmonary artery monitoring

c. Intracranial pressure monitoring

d. Vasoactive medications

9. Severe hypothermia or hyperthermia

10. Hepatic failure

11. Renal failure, acute or chronic requiring immediate dialysis

B. Other Criteria

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1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems

2. Status epilepticus

3. Potentially dangerous envenomation

4. Potentially life-threatening ingestion of, or exposure to, a toxic substance

5. Severe electrolyte imbalances

6. Severe metabolic disturbances

7. Severe dehydration

8. Potentially life-threatening infections, including sepsis

9. Children requiring intensive care

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

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

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status

2. Respiratory distress or failure

3. Children requiring endotracheal intubation and/or ventilatory support

4. Shock, compensated or uncompensated

5. Injuries requiring any blood transfusion

6. Children requiring any one of the following:

a. Arterial pressure monitoring

b. Central venous pressure or pulmonary artery monitoring

c. Intracranial pressure monitoring

d. Vasoactive medications

B. Anatomic Criteria

1. Fractures and deep penetrating wounds to an extremity complicated by neurovascular or compartment injury

2. Fracture of two~~2~~ or more major long bones (i.e., femur, humerus)

3. Fracture of the axial skeleton

4. Spinal cord or column injuries

5. Traumatic amputation of an extremity with potential for replantation~~replanation~~

6. Head injury when accompanied by any of the following:

a. Cerebrospinal fluid leaks

b. Open head injuries (excluding simple scalp injuries)

c. Depressed skull fractures

d. Decreased level of consciousness

7. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis

8. Major pelvic fractures

9. Significant blunt injury to the chest or abdomen

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C. Other Criteria

1. Children requiring intensive care

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

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

1. Partial thickness burns of greater than 10% total body surface area (TBSA)

2. Third degree burns in any age group

3. Burns involving:

a. Signs or symptoms of inhalation injury

b. Respiratory distress

c. The face

d. The ears (serious full-thickness burns or burns involving the ear canal or drums)

e. The mouth and throat

f. The hands, feet, genitalia, major joints or perineum

4. Electrical burns (including lightning injury)

5. Chemical burns

6. Burns associated with trauma or complicating medical conditions

7. Burned children in hospitals without qualified personnel or equipment for the care of children

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8. Burn injury in patients who will require special social, emotional, or long-term rehabilitative intervention~~information~~.

(Source: Amended at 35 Ill. Reg. 20609, effective December 9, 2011)

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Section 515.APPENDIX N Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application

Application Instructions

Follow these instructions to initiate the process to request recognition as a Pediatric Critical Care Center (PCCC) and Emergency Department Approved for Pediatrics (EDAP). The Pediatric Plan shall be developed through interaction and collaboration with all appropriate disciplines:

1. Complete the Request for Recognition of Pediatric Critical Care Center and Emergency Department Approved for Pediatrics Status Application Form and obtain the appropriate signatures.

2. Using the Pediatric Critical Care Center Plan Application Guideline and the PCCC/EDAP requirements, complete a PCCC and EDAP Pediatric Plan. The Pediatric Plan should follow the Pediatric Critical Care Center Plan Application Guideline checklist format provided in this application and include all requested supporting documentation, including, but not limited to, scope of services/care, credentialing forms, policies (both administrative and department specific), procedures, protocols, guidelines, flow charts, rosters, calendars, schedules, etc.

3. Complete and obtain signatures on the Department-approved physician, mid-level provider and nursing credentialing forms.

4. Complete the EDAP, PICU and Pediatric Unit Equipment Checklists.

5. Submit four copies of the hospital's Pediatric Plan (an original signed copy plus three additional copies) that each contain the following:

    a. Signed Request for Recognition of Pediatric Critical Care Center and Emergency Department Approved for Pediatrics Status Application Form;

    b. Completed PCCC Plan and EDAP Plan (including supporting documentation);

    c. Completed physician, mid-level provider and nursing credentialing forms;

    d. Completed EDAP, PICU and Pediatric Inpatient Unit Equipment Checklists.

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6. Submit these documents (including all supporting documentation) in the order listed in this application to: Division of EMS & Highway Safety, Illinois Department of Public Health, 422 S. 5th Street, Springfield IL 62701.

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

8. Any submitted requests to waive any of the EDAP or PCCC requirements shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

Site Survey Procedure

1. Within four to six weeks following the Department's receipt of the PCCC 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 shall prepare evidence to verify adherence to the facility recognition requirements.

3. The site visit will include a survey of the Emergency Department, Pediatric Intensive Care Unit, Pediatric Units and a meeting with the following individuals:

   a. chief administrative/executive officer or designee

   b. chief of pediatrics

   c. medical director of the pediatric intensive care services

   d. medical directors of the pediatric units

   e. medical director of pediatric ambulatory care

   f. nursing director or nurse manager of the pediatric intensive care services

   g. nursing director or nurse manager of the pediatric units

   h. administrator of pediatric services

   i. administrator of emergency services

j. pediatric quality coordinator

k. hospital quality improvement department director or designee

l. emergency department medical director and the pediatric emergency department medical director

m. emergency department nurse manager and the pediatric emergency department nurse manager

n. hospital emergency management/disaster preparedness coordinator

o. transport team medical director

p. transport team nurse coordinator

q. mid-level provider, i.e., nurse practitioner or physician assistant for those facilities that use mid-level providers in their emergency department or on their pediatric units

r. For EMS Resource or Associate Hospitals: The EMS MD and EMS coordinator

Site Survey Team

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

Following the Site Survey

1. Within four to six weeks following the site visit, the hospital shall receive the results of the survey from the Department. Those hospitals meeting all requirements will receive a formal recognition of their Pediatric Critical Care capabilities.

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 shall deny a request for recognition if findings show failure to substantially comply with

the EDAP and/or PCCC requirements. Hospitals may appeal the denial by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.

3. Re-recognition shall occur every three years, with site visits scheduled as necessary.

ILLINOIS EMSC
FACILITY RECOGNITION

Request for Recognition of Pediatric Critical Care Center (PCCC) and Emergency Department Approved for Pediatrics (EDAP) Status

Application Form

Name of hospital and address (typed)

_____

_____

_____

The above-named hospital is requesting PCCC and EDAP recognition. In addition, the above-named hospital certifies that each requirement in this Request for Recognition is met.

_____

Typed name – CEO/Administrator

_____

Signature – CEO/Administrator Date

_____

Typed name – Chairman of the Department of Pediatrics

_____

Signature – Chairman of the Department of Pediatrics Date

_____

Typed name – Medical Director of Emergency Services

_____

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Signature – Medical Director of Emergency Services Date

Contact Person – Typed name, credentials and title

Contact Person – Phone number, fax number and email

(Source: Added at 35 Ill. Reg. 20609, effective December 9, 2011)

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Section 515.Appendix O Pediatric Critical Care Center Plan

I. PEDIATRIC CRITICAL CARE CENTER PLAN

Application Checklist
Instructions: Please follow and complete this checklist carefully. It outlines the components that must be included in the submitted plan. Please include any applicable supplemental documentation.

A. Organizational Structure

1. Enclosed is an organizational table identifying the administrative relationships among all departments in the hospital, especially as they relate to the pediatrics department. The table shall include, but is not limited to, the following:

- ☐ board of directors
- ☐ chief executive officers
- ☐ emergency department
- ☐ department of pediatrics
- ☐ pediatric ambulatory care
- ☐ trauma service
- ☐ department of radiology
- ☐ laboratory services
- ☐ transport service team
- ☐ social services

2. Enclosed is an organizational table showing the organizational structure of the department of pediatrics, including the relationship of the physician, nursing and ancillary services for both the PICU and pediatric units. Include the reporting structure for the pediatric chairman (to whom he/she reports).

- ☐ Department of Pediatrics Organizational Structure (Table)

3. Enclosed is an organizational table showing the organizational structure of the emergency department, including the relationship of the physician, nursing and ancillary services. Include the reporting structure for the emergency department director (to whom he/she reports).

- ☐ Emergency Department Organizational Structure (Table)

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EDAP Checklist

Review the criteria in Section 515.4000(a)(1) and (2) for the physician staff qualifications and continuing medical education and submit each of the following:

- ☐ A policy or medical staff bylaws that incorporate the physician qualifications and CME requirements.
- ☐ A completed Credentials of Emergency Department Physicians form
- ☐ The curriculum vitae for the ED medical director
- ☐ A current one-month physician schedule for the ED

Review the criteria in Section 515.4000(a)(3) for the ED physician coverage and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(a)(4) for ED consultation and submit 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(a)(5) for ED physician back-up and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(a)(6) for on-call specialty physician response time and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(b)(1) and (2) for mid-level provider qualifications and continuing medical education and submit the following (as applicable):

- ☐ A policy(s) that incorporates the mid-level provider qualifications and continuing education requirements
- ☐ A completed Credentials of Emergency Department Mid-level Providers form
- ☐ A current one-month mid-level provider schedule

Review the criteria in Section 515.4000(c)(1) and (2) for nursing qualifications and continuing education and submit the following:

- ☐ A policy that incorporates the nursing qualifications and CE requirements
- ☐ A completed Credentials of Emergency Department Nursing Staff form
- ☐ A one-month nurse staffing schedule for the emergency department

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Review the criteria in Section 515.4000(d)(1) for inter-facility transfer and submit the following:

- ☐ An inter-facility transfer policy that addresses pediatric transfers
- ☐ A copy of current pediatric-specific transfer agreements with hospitals that provide pediatric specialty services, pediatric intensive care and burn care not available at your facility

Review the criteria in Section 515.4000(d)(2) for suspected child abuse and neglect and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(d)(3) for treatment protocols and submit all pediatric treatment protocols.

Review the criteria in Section 515.4000(d)(4) for latex allergy policy and submit a policy that addresses latex allergies and the availability of latex-free equipment and supplies.

Review the criteria in Section 515.4000(e)(1) for quality improvement activities and the multidisciplinary quality improvement committee and submit both of the following:

- ☐ A quality improvement plan, including a QI policy, pediatric indicators, feedback loop and target time frames for closure of issues
- ☐ The composition of the multidisciplinary QI committee

Review the criteria in Section 515.4000(e)(2) for the pediatric quality coordinator responsibilities and submit both of the following:

- ☐ A curriculum vitae for the pediatric quality coordinator
- ☐ Documentation detailing the participation of the pediatric quality coordinator in regional QI activities and how that has affected pediatric quality care in the ED

Review the criteria in Section 515.4000(f) for the list of emergency department equipment requirements and submit a completed checklist indicating the availability of all equipment.

Indicate in the pediatric plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order) or a waiver request shall be submitted for each item. Requests for waiver shall include the criteria by which compliance is considered to be a hardship and demonstrate that there will be no reduction in the provision of medical care.

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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, Metropolitan Chicago Healthcare Council at 312-906-6122.

B. PCCC Checklist

1. Hospital Requirements

Review the criteria in Section 515.4020(a) of the PCCC requirements as related to hospital resources and submit documentation identifying the ability to meet each of the following:

- ☐ A scope of services/policy outlining PICU services, unit resources and capabilities. Include any guidelines that outline pediatric admission criteria based on age parameters and/or diagnoses
- ☐ A list of the members of the PICU Committee, as well as their disciplines, to meet subsection (a)(3)
- ☐ Documentation to substantiate that Section 515.4020(a)(4) (Helicopter landing) is met
- ☐ A statement regarding 24-hour availability to meet Section 515.4020(a)(5) (CAT scan)
- ☐ A statement regarding the ability to meet Section 515.4020(a)(6) (Laboratory)
- ☐ A statement of availability or transfer agreement to meet Section 515.4020(a)(7) (Hemodialysis capabilities)
- ☐ A statement or scope of service from each program identifying the availability of staff as required in Section 515.4020(a)(8) (Other staffing/services)
- ☐ A list of professional pediatric critical care educational trainings that staff have provided in the past year to meet Section 515.4020(a)(9) (include information on trainings held within the facility, within the region or surrounding geographic area)
- ☐ A list of pediatric emergency care classes that staff have provided in the past year to meet Section 515.4020(a)(10) (i.e., CPR, first aid, health fairs, etc., conducted for the patient population and the community, region or surrounding geographic area)
- ☐ Documentation of any pediatric research the facility has been engaged in during the past year to meet Section 515.4020(a)(11) (include the research project abstract, summary of projects or listing of research activities)

II. PICU SERVICE REQUIREMENTS

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A. Professional Staff

1. PICU Medical Director

Review the criteria in Section 515.4020(b) for the Medical Director and Co-Director requirements and submit each of the following:

- ☐ A curriculum vitae for the appointed PICU medical director
- ☐ A copy of board certification or verification of board certification
- ☐ A curriculum vitae and board certification for the co-director (as applicable – see Section 515.4020(b)(1)

2. PICU Medical Staff Requirements

Review the criteria in Section 515.4020(c) and submit each of the following:

PICU Medical Staff

- ☐ A policy outlining PICU physician staffing, coverage, availability, and CME requirements that incorporates Section 515.4020(c)(1)(A) and (B)
- ☐ A completed Credentials of PICU Physicians form that includes the medical director (and co-director as applicable)
- ☐ A one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)

Physician Specialist Availability (Section 515.4020(c)(2))

- ☐ A policy or by-laws that address the response time and on-call scheduling of pediatric surgeons
- ☐ A policy/process outlining board or sub-board certification or board preparedness for all specialist physicians
- ☐ A policy/process outlining how pediatric proficiency is defined and assuring that all specialist physicians maintain 10 hours of pediatric CME per year
- ☐ A policy/process outlining anesthesiologist on-call staffing and response time, subspecialty training in pediatric anesthesiology or pediatric proficiency as defined by institution, and 10 hours of pediatric CME per year; for Certified Registered Nurse Anesthetists, provide a copy of the by-laws that address their responsibilities and back up
- ☐ On-call schedules from the last month that list physician availability to meet Section 515.4020(c)(2)(C) and (D)

3. PICU Mid-Level Providers (Physician Assistant or Nurse Practitioner) Requirements

NOTE – Complete this section only if physician assistants or nurse practitioners practice in the PICU.

Review the criteria in Section 515.4020(d) and submit each of the following:

Nurse Practitioner (Section 515.4020(d)(1))

- ☐ A policy outlining PICU nurse practitioner staffing, coverage, availability, responsibilities and credentialing process
- ☐ A copy of a one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)
- ☐ A completed Credentials of PICU Mid-Level Providers form

Physician Assistant (Section 515.4020(d)(2))

- ☐ A policy outlining PICU physician assistant staffing, coverage, availability, responsibilities and credentialing process
- ☐ A copy of a one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)
- ☐ A completed Credentials of PICU Mid-Level Providers form

Education (Section 515.4020(d)(3) and (4))

- ☐ A policy that incorporates APLS, PALS or ENPC (Section 515.4020(d)(3))
- ☐ A copy of the PICU physician assistant/nurse practitioner continuing education policy that incorporates Section 515.4020(d)(4)

4. PICU Nursing Staff Requirements

Review the criteria in Section 515.4020(e) and submit each of the following:

PICU Nurse Manager

- ☐ A curriculum vitae for the PICU manager
- ☐ A policy or job description that incorporates Section 515.4020(e)(1)(C)

PICU Advanced Practice Nurse

- ☐ A policy or job description of the role and responsibilities of the advanced practice nurse in the PICU

- ☐ A resume of the PICU advanced practice nurse
- ☐ A policy that incorporates Section 515.4020(e)(2)(C) and (D)

Nursing Patient Care Services

- ☐ A policy/documentation outlining current nursing shift staffing plan/patterns
- ☐ A completed Credentials of PICU Nursing Staff form that includes the PICU nurse manager and PICU advanced practice nurse
- ☐ A policy or job description for the PICU nurse that outlines the orientation process to the unit responsibilities and requirements of the Department (Section 515.4020(e)(3)(C) and (D))
- ☐ A copy of a one-month nurse staffing schedule/calendar (schedule shall be from within the three-month time period previous to the application submission)
- ☐ A policy reflecting yearly competency review requirements for the PICU staff

D. Policies, Procedures and Treatment Protocols

Review the criteria in Section 515.4020(f) and submit each of the following:

- ☐ An admission and discharge criteria policy
- ☐ A staffing policy that addresses nursing shift staffing patterns based on patient acuity
- ☐ A policy for managing the psychiatric needs of the PICU patient
- ☐ Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses

E. Inter-facility Transfer/Transport Requirements

Review the criteria in Section 515.4020(g) and submit each of the following:

- ☐ A copy of the last annual report containing the number of annual transfers to the facility from transferring institutions
- ☐ A policy outlining the feedback process to transferring hospitals on the status of the referral patient and the methods for quality review of the transfer process
- ☐ Documentation outlining the pediatric inter-facility transport system capabilities and resources
- ☐ A transfer policy that addresses pediatric inter-facility transfers

F. Quality Improvement Requirements

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Review the criteria in Section 515.4020(h) and submit each of the following:

- ☐ A list of the members of the Multidisciplinary Pediatric Quality Improvement Committee and their respective positions/disciplines
- ☐ An institutional Quality Improvement Organizational Chart
- ☐ The PICU outcome analysis plan and pediatric monitoring activities that meet Section 515.4020(h)(2) (minutes from the past year that reflect the activities of the Multidisciplinary Pediatric Quality Improvement Committee will be requested at the time of site survey)

G. Equipment

Review the criteria in Section 515.4020(i) and submit the following:

Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order); if the item is not on order, a waiver request shall be submitted for each item. Requests for waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

If assistance is needed in identifying specific vendors for any of the equipment/supply items noted in this application, please contact the Marketing Administrator, Group Purchasing Services, Metropolitan Chicago Healthcare Council at 312-906-6122.

III. PEDIATRIC INPATIENT CARE SERVICE REQUIREMENTS

A. Professional Staff

1. Pediatric Unit Physician Requirements

Review the criteria in Section 515.4020(j) and submit each of the following:

- ☐ A curriculum vitae and a copy of board certification for the pediatric inpatient director
- ☐ A policy or a scope of services for the pediatric unit that defines responsibility for medical management of care
- ☐ If pediatric hospitalists are used, documentation that defines their scope of service, including their responsibilities to other attending physicians

- ☐ A completed Credentials of Pediatric Unit Hospitalists form
- ☐ A policy that incorporates Section 515.4020(j)(1)(B)
- ☐ A policy or scope of services outlining the responsibility of the PICU medical director or his/her designee as being available on call and for consultation on all pediatric in-house patients who may require critical care

2. Pediatric Unit Nurse Manager Requirements

Review the criteria in Section 515.4020(j)(2) and submit each of the following:

- ☐ A curriculum vitae for the pediatric unit manager
- ☐ A job description or policy incorporating Section 515.4020(j)(2)(C)

3. Pediatric Unit Nursing Care Services

Review the criteria in Section 515.4020(j)(3) and submit each of the following:

- ☐ A policy/documentation outlining current nursing shift staffing plan/patterns
- ☐ A policy describing annual competency review requirements for the pediatric nursing staff (Section 515.4020(j)(3)(B))
- ☐ A policy or job description for the pediatric unit nurse that outlines the orientation process to the unit responsibilities and requirements of the Department that address Section 515.4020(j)(3)(A) through (D)
- ☐ A copy of a one-month nursing staffing schedule/calendar (schedule shall be from within the three-month time period previous to the application submission)
- ☐ A completed Credentials for the Pediatric Unit Nursing Staff form that includes the Pediatric Unit Nurse Manager

B. Policies, Procedures and Treatment Protocols

Review the criteria in Section 515.4020(k) and submit each of the following:

- ☐ A policy or scope of services that outlines the pediatric department services, ages of patients served and admission guidelines
- ☐ A staffing policy that addresses nursing shift staffing patterns based on patient acuity
- ☐ A safety and security policy for the patient in the unit
- ☐ An inter-facility transport policy that addresses safety and acuity
- ☐ An intra-facility transport policy that addresses safety and acuity

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- ☐ A latex allergy policy
- ☐ A pediatric organ procurement/donation policy
- ☐ An isolation precautions policy that incorporates appropriate infection control measures
- ☐ A disaster/terrorism policy that addresses the specific medical and psychosocial needs of the pediatric population
- ☐ Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses
- ☐ A pediatric policy that addresses the resources available to meet the psychosocial needs of patients and family, and appropriate social work referral for the following indicators (see Pediatric Bill of Rights in Appendix N):
  - Child death
  - Child has been a victim of or witness to violence
    Family needs assistance in obtaining resources to take the child home
  - Family needs a payment resource for their child's health needs
    Family needs to be linked back to their primary health, social service or educational system
  - Family needs support services to adjust to their child's health condition or the increased demands related to changes in their child's health condition
  - Family needs additional education related to the child's care needs to care for the child at home
- ☐ A discharge planning policy or protocol that includes the following:
  1. Documentation of appropriate primary care/specialty follow-up provisions
  2. Mechanism to access a primary care resource for children who do not have a provider
  3. Discharge summary provision to appropriate medical care provider, parent/guardian, that includes:
     - Information on the child's hospital course
     - Discharge instructions and education
     - Follow-up arrangements
  4. Appropriate referral of patients to rehabilitation or specialty services for children who may have any of the following problems:
     - Require the assistance of medical technology
     - Do not exhibit age-appropriate activity in cognitive, communication or motor skills, behavioral or social/emotional realms
     - Have additional medical or rehabilitation needs that may require specialized care, such as medication, hospice care, physical therapy, home health or speech/language services

- Have a brain injury – mild, moderate or severe
- Have a spinal cord injury
- Exhibit seizure behavior during an acute care episode or have a history of seizure disorder and are not currently linked with specialty follow-up
- Have a submersion injury, such as a near drowning
- Have a burn (other than a superficial burn)
- Have a pre-existing condition that experiences a change in health or functional status
- Have a neurological, musculoskeletal or developmental disability
- Have a sudden onset of behavioral change, for example, in cognition, language or affect

C. Quality Improvement Requirements

Review the criteria in Section 515.4020(l) and submit the following:

☐ The titles of the pediatric unit representatives that serve on the Multidisciplinary Pediatric Quality Improvement Committee

D. Equipment Requirements

Review the criteria in Section 515.4020(m) and submit the following:

Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order); if the item is not on order, a waiver request shall be submitted for each item. Requests for waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

If assistance is needed in identifying specific vendors for any of the equipment/supply items noted in this application, please contact the Marketing Administrator, Group Purchasing Services, Metropolitan Chicago Healthcare Council at 312-906-6122.

(Source: Added at 35 Ill. Reg. 20609, effective December 9, 2011)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.APPENDIX P Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

All of the following equipment/supplies/medications shall be immediately available within the PICU and pediatric unit:

AIRWAY

Cricothyrotomy capabilities (i.e., 10 g needle and 3 mm ET tube adapter or 14 g needle and 3.5 mm ET tube adapter)
Endotracheal tubes:
- Uncuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0)
- Cuffed (sizes 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5)
- Stylets for endotracheal tubes (pediatric and adult)

Laryngoscope handle (pediatric and adult); bulbs (small and large); extra batteries
Laryngoscope blades (Curved 1, 2, 3; Straight or Miller 00, 0, 1, 2, 3)
Local anesthetic (i.e., lidocaine gel, cetacaine spray)
Magill forceps (pediatric and adult)
Oral airways (sizes 00, 1, 2, 3, 4, 5)
Stylets (pediatric and adult)
Tongue blades
Tracheostomy collar
Tracheostomy tubes (sizes PED 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 or ET may be substituted); trach ties; surgilube

BREATHING

Bag-valve-mask device, self-inflating infant/child and adult with O_2 reservoir and clear masks (neonatal through large adult sizes), PEEP and manometer
C-PAP
End-tidal PCO_2 monitor and/or pediatric CO_2 detector (disposable units may be substituted)
Flow meter
Masks, clear (neonatal, toddler, infant, child, medium adult)
Nasogastric tubes (sizes 6, 8, 10, 12, 14 Fr). NOTE: Cannot use feeding tubes as a substitute.
Nasopharyngeal airways (sizes 12, 16, 20, 24, 28, 30 Fr)
O_2 Tank
O_2 Blender
O_2 connectors and spare O_2 tubing

Partial non-rebreather O_2 masks (neonatal, pediatric, adult)
PEEP valves
Pulse oximeter with child, infant and neonatal probes
Stethoscope
Suction supplies (bulb syringe, suction catheters sizes 6, 8, 10, 12, 14 Fr and Yankauer-tip catheter)
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 8-40 Fr)
Ventilator-respirator, pediatric
CIRCULATION

Blood collection tubes, culture bottles, arterial blood gas syringe
Butterfly needles (19, 21, 23, 25 g)
Cardiac resuscitation board
Catheter over needle IV access (sizes 16, 18, 20, 22, 24 g)
CVP and arterial monitors
Doppler device
ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles (and/or pads), with pediatric dosage settings and pediatric/adult pacing electrodes
Intraosseous needles or bone-marrow aspiration needles (one large and one small bore) or IO device (pediatric and adult sizes)
IV fluid/blood warmer
IV pumps
IV tubing and extension tubing
Minidrip with metered chamber
Needles (sizes 16, 18, 20, 22/23, 25; intracardiac needle 21 g, 1½ inch; filter needle)
Non-invasive blood pressure device (neonatal through adult cuffs)
Rapid infusion pumps
Sphygmomanometer with cuffs (newborn, infant, child, small adult, adult)
Stopcocks
Syringes (TB, insulin U100, 1 ml-20 ml and catheter tip)
T-connectors
Tourniquets, arm boards, tape, alcohol wipes, skin prep, razor
Vascular access supplies using the Seldinger technique (3-8 Fr)
Warming devices, age appropriate
MEDICATIONS
Activated Charcoal
Adenosine
Albumin 5% and 25%
Amiodarone

AquaMEPHYTON
Atropine
Bacteriostatic Water, 30 ml
Beta-agonist for inhalation
Calcium Chloride 10%
Calcium Gluconate 10%
Dexamethasone
Dextrose 10%, 25% and 50%
Diazepam
Digitalis antibody
Digoxin
Diphenhydramine
Dobutamine
Dopamine
Dosing device – length or weight based system for dosing and equipment/supplies
Epinephrine (1:1000 and 1:10,000)
Factor VIII, IX concentrate (pharmacy or blood bank)
Flumazenil
Furosemide
Glucagon
Insulin
IV solutions (D5W and 0.9 NS)
IV solutions, standard crystalloid (D10W, D5/0.2 NS, D5/0.45 NS and 0.9 NS)
Kayexalate
Ketamine
Lidocaine 1% and 2%
List of resuscitation drug dosages at patient bedside (based on child's weight)
Lorazepam (may be located in unit refrigerator)
Magnesium sulfate 10% and 50%
Mannitol 25%
Methylene blue
N-acetyl cysteine
Naloxone
Narcotics
Norepinephrine
Neuromuscular blocking agents (i.e., succinylcholine, pancuronium, vecuronium) (NOTE: May be refrigerated)
Oral rehydrating solution
Phenobarbital

Phenytoin and/or fosphenytoin
Potassium
Procainamide
Propranolol
Prostaglandin E1
Sodium Bicarbonate, 8.4% and 4.2%
Sodium Chloride 10 ml (multiple)
Steroids – parenteral
Thiopental
Topical anesthetic agent
Vasopressin (DDAVP)
Whole bowel irrigation solution
MISCELLANEOUS

Lumbar puncture tray, including a selection of needles (size 18-22 g, 1½ - 3 inch needle)
Feeding tubes (8-14)
Foley catheters (sizes 6, 8, 10, 12 Fr)
Hypothermia thermometer with rectal probe (28° - 42° C)
Otoscope/ophthalmoscope
Weighing scales (in kilograms) for infants and children

(Source: Added at 35 Ill. Reg. 20609, effective December 9, 2011)