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New guidelines warn: You may not be prepared to take care of sick children

Many EDs lack appropriate equipment, and staff are not properly trained

Does your ED have equipment which is age- and size-appropriate for all pediatric patients, including premature infants? Do you have protocols for child maltreatment and consent? Are staff trained in pediatric resuscitation?

If you answer “no” to any of these questions, you’re not in compliance with new guidelines for pediatric care. *Care of Children in the Emergency Department: Guidelines for Preparedness* was jointly published by the Dallas-based American College of Emergency Physicians (ACEP) and the Elk Grove Village, IL-based American Academy of Pediatrics (AAP).

If you’re not in compliance with these guidelines, you may not be able to care properly for sick and injured children, which can result in adverse outcomes, warns **Marianne Gausche-Hill**, MD, FACEP, FAAP, director of emergency medical services at Harbor-University of California at Los Angeles Medical Center in Torrance, CA.

“To achieve preparedness simply takes commitment,” she argues.

Compelling evidence shows that EDs nationwide may be unprepared for pediatric emergencies, reports **Evelyn Lyons**, RN, MPH, Emergency Medical Services for Children (EMS-C) director for the Illinois Department of Public

EXECUTIVE SUMMARY

New guidelines jointly developed by the American College of Emergency Physicians and the American Academy of Pediatrics address equipment, protocols, and training your ED must have to care for pediatric patients.

- Staff must be trained in pediatric resuscitation.
- Pediatric equipment must be easy to access by using color-coded systems or clear labeling.
- Consult with pediatric experts in your community to learn approaches for educating staff and obtaining equipment.

Health, based at Loyola University Medical Center in Maywood.

Significant differences between adult and pediatric care were determined when the EMS-C assessed the ability of Illinois EDs to care for children, Lyons says. EMS-C is a Washington, DC-based national program to ensure that state-of-the-art emergency medical care is available for all ill or injured children. **(See Illinois EMS-C Facility Recognition Criteria for the Emergency Department Approved for Pediatrics, enclosed in this issue.)**

Lyons points to this disturbing statistic: While 91% of the Illinois ED physicians had taken an Advanced Cardiac Life Support (ACLS) course for adult resuscitation, only 63% had completed a pediatric equivalent such as Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS). "Similarly, 90% of ED nurses had completed an ACLS course, but only 35% had completed a formal pediatric resuscitation course," she says. **(See Guidelines for Equipment and Supplies for Use in Pediatric Patients in the ED, enclosed in this issue.)**

The problem is twofold: EDs often don't have appropriate-sized equipment for all age groups, and ED staff are not trained in pediatric assessment, says **Nancy Eckle**, RN, MSN, program manager for emergency services at Children's Hospital in Columbus, OH.

Resuscitation equipment missing

According to a recent study that surveyed Canadian EDs, essential pediatric resuscitation equipment was frequently unavailable.¹ For example, 18% did not have pediatric pulse oximeters, 14.8% did not have infant blood pressure cuffs, and 10.5% did not have pediatric defibrillator paddles.

"Often, EDs do not have all the equipment necessary to care for all ages of children," Gausche-Hill underscores.

Here are ways to comply with the new guidelines:

- **Have pediatric appropriate equipment.**

The guidelines say that all ED nurses should ensure that pediatric-appropriate equipment, supplies, and medication is available and easy to access, says Gausche-Hill. For example, equipment could be color-coded, or labeled on doors and carts.²

"You must have easy access to different sizes of

SOURCES

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equipment," she advises.

Because pediatric patients range in size from a tiny neonate to an adult-sized adolescent, you'll need a range of items that are age- and size-appropriate, says Lyons.

A length- or weight-based system for medication dosing and equipment/supplies is an essential tool in the ED, she notes. "Color-coded supply systems ensure ease in accessing appropriately sized equipment and supplies for children," she adds. **(For more information on color-coded dosage equipment, see ED Nursing, September 1999, p. 139.)**

Use quick-reference materials

Have "quick-reference" materials available for staff that list normal vital signs by age and equipment sizes by weight and age, says Eckle.

"Use length-based resuscitation tapes or precalculated drug lists based on weight," she advises. **(See pocket quick-reference card, enclosed in this issue, and resource box for information, p. 103.)**

Eckle also recommends consulting with pediatric

COMING IN FUTURE MONTHS

■ New approaches or abdominal pain

■ Dramatically improve care of chest pain patients

■ Effective ways to assess pain

■ How to screen children for bullying

RESOURCES

A copy of the American College of Emergency Physicians/American Academy of Pediatrics (ACEP/AAP) policy statement, *Care of Children in the Emergency Department: Guidelines for Preparedness* (published in the April 2001 issue of *Pediatrics and Annals of Emergency Medicine*) is available. AAP policy statements can be downloaded free from the web site:

www.aap.org. (Click on "Policy Statements." Under heading "C," click on "Care of children in the emergency department: Guidelines for preparedness.")

Also, they can be purchased for \$1.95 each, including shipping and handling. To order materials, contact:

- **AAP Publications Department**, P.O. Box 747, Elk Grove Village, IL 60009-0747. Telephone: (800) 433-9016 Ext. 4776 or (847) 981-7924. Fax: (847) 228-1281.

The Emergency Nurses Association offers an *Emergency Nursing Pediatric Course (ENPC)*, a 16-hour course that addresses a variety of pediatric emergency conditions, resuscitation, assessment, and triage.

For a list of ENPC courses in your area, go to the ENA web site (www.ena.org), click on "Programs and Meetings" then "Continuing Education," then "ENPC Schedule." For more information, contact:

- **ENA, Department of Trauma and Pediatric Services**, 915 Lee St., Des Plaines, IL 60016. Telephone: (800) 900-9659. E-mail: jmika@ena.org.

A Pediatric Advanced Life Support Course (PALS) is offered by the American Heart Association (AHA). To contact AHA staff at a local level, call (888) 352-3824 or send an e-mail to cprecc@heart.org. For more information about the course, go to the AHA site for Emergency Cardiovascular Care Programs (www.cprecc.org). Click on "About Courses," then "Healthcare Provider Course Descriptions," then "PALS provider."

The Advanced Pediatric Life Support Course (APLS) is offered by ACEP and AAP. To find a course in your area, go to the AAP web site (www.aap.org). Click on "Professional Education," then "Life Support Programs," then "APLS: The Pediatric Emergency Medicine Course," then "Find an APLS Course or Course Director." Or contact:

- **AAP**, 141 N.W. Point Blvd, Elk Grove Village, IL 60007-1098. Telephone: (847) 434-4000. Ext. 4795. Fax: (847) 228-1350. E-mail: lifesupport@aap.org.

A Pediatric Resource Kit is available from Emergency Medical Services for Children. The kit covers illness and injury prevention, patient care training and safety, equipment guidelines, public policy, and special populations. The kit can be downloaded at no charge from the EMS-C web site (www.ems-c.org) by clicking on "Products and Resources" and "EMS-C Resources." A free copy is available in CD-ROM format by contacting EMS-C Clearinghouse at (703) 902-1203 or sending an e-mail to emsc@circsol.com.

A *Pediatric Drug Chart* quick reference guide is available. The fifth edition (Product Code IN094A) is a 7 x 10-inch chart that includes drug dosages for 37 medications, cardiac arrest medications, pediatric Advanced Cardiac Life Support (ACLS) algorithms, paralytics, and anticonvulsants. The cost is \$9 including shipping. A set of pocket-sized, color-coded plastic cards, "Crash Cards — Pediatric Resuscitation" costs \$18 (Product Code ETA124). To order, contact:

- **Emergency Training Associates**, 105 Glen Hill Court, Union Bridge, MD 21791. Telephone: (800) 367-0382 or (410) 775-7663. Fax: (410) 775-0691. Web: www.emsbooks.com. (Click on "Bookstore" and then "Reference.")

experts in your area to review pediatric and crash cart supplies, and plan strategies for staff education, she says. "These experts may be available to provide services or share resources they have used," she adds.

Contact a local pediatric nurse practitioner or a manager at a local children's hospital, tertiary pediatric center, or pediatric intensive care unit, Eckle recommends. "Staff in the hospital nursery can be a great resource for newborn and neonatal emergencies," she adds.

Also consider the special-needs children who come to your ED frequently, says Eckle. "Consider what

specialized equipment that may be needed in an emergency for that child," she advises. **(For more information about caring for children with special needs, see *ED Nursing*, May 2000, p. 86.)**

Your ED may not have certain-sized items in stock because of minimum ordering requirements, such as 10 items per order, notes Lyons. She recommends having reciprocal purchase agreements with other hospitals, with one ED placing a bulk order, and splitting the cost and items.

"That way, you don't need to have a large quantity of

an item that may not get used very frequently,” she says.

- **Make sure your training is up to date.**

You should be trained in recognizing pediatric emergencies, stabilization procedures, and pediatric-appropriate approaches to care, says Eckle.

The guidelines recommend having staff available on all shifts who are trained in pediatric emergency care, says Eckle. She recommends the Emergency Nursing Pediatric Course (ENPC), which addresses a variety of pediatric emergency conditions, resuscitation, assessment, and triage. The course is offered by the Des Plaines, IL-based Emergency Nurses Association (ENA). (See resource box for more information, p. 103.)

Nurses who provide emergency care to the pediatric population should be current in appropriate assessment, triage, and management of the emergency needs of the pediatric patient, says Lyons. She recommends taking standardized courses such as the ENPC, the Pediatric Advanced Life Support course (PALS) from the Dallas-based American Heart Association, or the Advanced Pediatric Life Support course (APLS) from the Dallas-based American College of Emergency Physicians, and the Elk Village, IL-based American Academy of Pediatrics. These courses contain essential core content on appropriate management of the pediatric patient in an emergency setting, says Lyons. (See resource box for information about these courses, p. 103.)

These courses incorporate skill stations to allow for the practice of advanced practice skills, says Lyons. “At a minimum, at least one nurse per shift who is responsible for the care of the pediatric patient should maintain current recognition in one of these standardized pediatric courses,” she adds.

You also should maintain pediatric emergency care continuing education, says Gausche. “If you care for children, you have an obligation to be sure that your pediatric knowledge and skills are updated on a yearly basis,” she stresses.

Have separate protocols

- **Don’t treat children like adults.**

According to the guidelines, separate protocols are needed for children, notes Eckle. (See list of recommended policies, procedures, and protocols from the guidelines enclosed in this issue.)

There are anatomic and physiologic differences in children that can affect how procedures are performed as well as the signs and symptoms the child exhibits, says Eckle. She gives the following examples:

— The early stages of shock in a child can be missed if you don’t know the signs and symptoms

Pediatric Protocols You’ll Need

Policies, procedures, and protocols for emergency care of children are developed and implemented; staff should be educated accordingly; and they should be monitored for compliance and periodically updated. These should include, but are not limited to, the following. (Items 3 through 12 indicate policies, procedures, and protocols that may be integrated into ED policies and procedures with pediatric-specific components).

1. Child maltreatment (physical and sexual abuse, sexual assault, and neglect)
2. Consent (including situations in which a parent is not immediately available)
3. Death in the ED
4. Do-not-resuscitate orders
5. Illness and injury triage
6. Sedation and analgesia
7. Immunization status
8. Mental health emergencies
9. Physical or chemical restraint of patients
10. Family issues, including:
 - a. education of the patient, family, and regular caregivers
 - b. discharge planning and instruction
 - c. family presence during care
11. Communication with patient’s primary health care provider
12. Transfers necessary for definitive care, according to the following guidelines:
 - a. Transfer policies or procedures should include access to consultation (telephone or telemedicine), transfer guidelines, interfacility transfer agreements, and a plan for return of the child back to his/her community as appropriate.
 - b. Transferring facility must ensure that the patient is stabilized before transport.
 - c. Transferring facility must transfer only patients who need a higher level of care, as per the Emergency Medical Treatment and Active Labor Act (EMTALA).

Hospitals may wish to adopt currently available clinical guidelines and protocols or develop their own.

Source: American College of Emergency Physicians, Dallas, and the American Academy of Pediatrics, Elmhurst, IL. Excerpt of Care of Children in the Emergency Department: Guidelines for Preparedness.

typically exhibited first in a child, warns Eckle. “These include tachycardia and subtle changes in mental status/level of consciousness such as agitation, irritability, and restlessness,” she notes.

Hypotension is a very late sign, adds Eckle. “A child may maintain a normal blood pressure until over 25% of the circulating blood volume is lost,” she says.

Not recognizing and treating shock early can result in death or complications due to tissue hypoxia, she adds.

— Infants and children have a higher body surface to weight ratio, which increases the rate of heat loss, which increases the risk for the development of hypothermia and cold stress, says Eckle. Hypothermia has a significant physiologic impact and affects the child’s response to resuscitative efforts, she adds.

— Infants and children have limited glycogen stores, so they are at increased risk for the development of hypoglycemia, says Eckle. “This is especially true when the body is stressed due to a serious illness or injury,” she adds.

References

1. American College of Emergency Physicians and the American Academy of Pediatrics. Care of children in the emergency department: Guidelines for preparedness. *Ann Emerg Med* 2001; 37:423-427.
2. McGillivray D, Nijssen-Jordan C, Kramer MS, et al. Critical pediatric equipment available in Canadian hospital emergency departments. *Ann Emerg Med* 2001; 37:371-376. ■

Here’s how to boost patient satisfaction

Are you tired of hearing about administrators complain about low patient satisfaction scores?

“This concern may sometimes seem inappropriate in the ED, with sicker patients, increasing patient census, and chaotic work environments,” says **William Paunan**, RN, BSN, CEN, an ED nurse at Elmhurst

EXECUTIVE SUMMARY

Patient satisfaction can be increased by simple techniques that convey a patient is being well-cared for.

- Whenever you are in the patient’s room, sit down at eye level with the patient.
- Keep the patient informed at least every 30 minutes, even if you have nothing new to report.
- Ask patients what you can do for them, instead of waiting for the patient or a family member to ask for help.

(IL) Memorial Hospital. “As a result, patience, compassion, and concern can quickly be thrown to the wind.”

There is a trend of hospital administrators implementing customer service programs based on corporate strategies, but this approach isn’t always successful in the ED, notes **Diana Meyer**, RN, MSN, CCNS, CCRN, CEN, clinical nurse specialist for emergency services at St. Joseph Hospital in Bellingham, WA.

“As nurses, we intuitively know that patient satisfaction scores have not gone up because we are using the wrong strategy,” Meyer argues. “Patients do not come to the ED expecting a business relationship. They expect a caring relationship.”

Show patients that you care

Patients have a basic expectation that your technical abilities are good, but that’s not how they measure satisfaction, says Meyer. To be satisfied, the patient needs to feel “truly cared for,” she says.

“Achieving that is the No. 1 thing nurses can do to turn the tide of patient satisfaction,” she adds.

Try these simple yet effective ways to increase patient satisfaction:

- **Introduce yourself with a smile.**

This is an easy way to make a patient feel they are being well-cared for, says Paunan. “The patient will remember that friendly, *smiling* nurse who helped them,” he says. “This is an effortless and effective technique of alleviating fear and tension.”

- **Sit down at eye level with the patient.**

When drawing blood, doing assessments, or obtaining a patient’s history, Paunan recommends sitting on a chair at eye level with the patient. “The patients’ perception of time with the nurse is seemingly longer when the nurse sits down,” he says. “This also saves your feet and back.”

Sitting down doesn’t take any longer and gives the perception that you are truly physically present, says Meyer. “You should not be standing at the bedside, looking like you have one foot out the door and are ready to bolt at any moment,” she says.

- **Keep the patient informed.**

Delays are a major source of complaints in the ED, especially when patients don’t know what they are waiting for, says Paunan. “By simply telling the patient what labs have come back and which lab tests are still outstanding, you can greatly alleviate their anxiety and impatience,” he says.

- **Provide a telephone.**

When the patient first arrives in the ED, they are in “crisis mode,” says Paunan. “They may forget things that are normally second nature to them,” he explains.

Offer the patient a telephone or ask if you can call

SOURCES

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someone for them, Paunan recommends. "This will bring a feeling of comfort and trust and also allow the patient to establish a relationship with you," he says.

- **Treat the patient's belongings with care.**

The way a patient responds to the care you give may be impacted by how you handle the patient's disrobed clothes, says Paunan. "The patient will unconsciously react negatively if you simply stuff all the clothes into a garment bag," he says.

Update patients every 30 minutes

- **Return to the patient voluntarily.**

Don't wait until the family or patient seeks you out for something, says Meyer. "You have completely lost the battle when patients come out from behind that curtain to find you," she explains. "Don't go in only because the patient rang the bell or you had another task to perform, such as an IV to give or dressing to change," she says.

Instead, try to go to the patient every 30 minutes to deliver an update, says Meyer. "It's difficult sometimes to have to keep saying, 'We still don't have anything,' or 'We are still waiting for the consultant to call,' but the patient will really appreciate it," she says.

- **Ask what you can do.**

When you're with a patient, "close the encounter" by asking what else you can do for them, says Meyer. "That tells the patient that you are focusing only on their needs at that moment," she says.

Surprisingly, Meyer has found that patients usually don't ask for anything. "Take the risk and offer. Most patients and families simply say, 'No thank you, I have everything I need,'" she reports. "Most of them don't take you up on it. But if a few do, you should do what you can to meet their needs." ■

Here's how to 'sell' your ED to nurses

Are you finding that even with hefty sign-on bonuses, you are losing nurses to competitors? The way you interview can mean the difference between a nurse choosing your facility or another, says **Patti R. Zuzelo**, EdD, RN, CS, assistant professor at La Salle University School of Nursing in Philadelphia, and per diem nurse in the emergency trauma care department at Abington (PA) Memorial Hospital.

"Effective interviewing skills are critical for successfully recruiting desirable nurse applicants," she stresses. "Nurses may participate in multiple interviews and have several job offers from which to choose."

Given the highly competitive workplace, declining numbers of available nurses, and the aging of the nursing work force, you must put your "best foot forward" during interviews, says Zuzelo. "Treat each interview as a critically important event in the process of attracting qualified nurses to the ED," she urges.

Tell them you help nurses grow

Here are ways to use the interview process to recruit nurses:

- **Make it clear that you value nurses.**

Nurses want to know that if hired, they will be seen as a critical contributor to quality patient care, says Zuzelo.

Experienced nurses are interested in professional opportunities that include support for certification and trauma education, says Zuzelo. "They want to participate in multidisciplinary working groups, engage in

EXECUTIVE SUMMARY

How you handle the interview process can give you leverage with nurse candidates who might receive offers from other EDs.

- Encourage inexperienced nurses to work in the ED by pointing to mentoring relationships and a gradual increase in patient responsibilities.
- Find out the nurse's individual priorities, such as work flexibility, performance bonuses, or tuition reimbursement, and focus on those opportunities.
- Introduce prospective nurses to other ED nurses, and have nurses give the applicant follow-up phone calls.

research, and contribute to decision making within the context of their practice environment,” she adds.

Ask applicants about their interests in those areas, and be prepared to candidly discuss professional growth opportunities, says Zuzelo.

- **Demonstrate support for inexperienced nurses.**

Newly licensed nurses and nurses without acute-care experience often are interested in ED nursing, but believe that they first need a generalist medical-surgical practice experience, says Zuzelo.

“You should be aware of this ambivalence and discuss the support systems available in the ED for new nurses,” she says.

She points to mentoring relationships, classroom and clinical orientation time, and a gradual increase in patient responsibilities, but warns that these supports must actually be in place.

“Otherwise, the organization will spend significant dollars recruiting and orienting a new nurse, only to lose him or her due to overwhelming clinical situations, clinician disappointment, and discouragement,” she says.

- **Send thank-you notes.**

Immediately after an interview, send letters to applicants thanking them for their time and interest, says Zuzelo. “The letters should be personalized and should mention the mutual benefits of an employment arrangement,” she explains.

- **Keep unique needs in mind.**

For some nurses, work flexibility and scheduling control are more important than salary, says Zuzelo. “For others, compensation issues, performance bonuses, tuition reimbursement, and educational opportunities are key variables when considering employment opportunities,” she says.

Focus on the applicant’s individual priorities and interests, says **Susan Conn**, RN, MS, director of clinics/emergency services for Denton (TX) Regional Medical Center. “When I am interviewing a prospective nurse, I try to determine exactly what he or she is seeking in the new position,” she says.

Conn asks nurses what they liked about their previous job and what they would have changed. “Then I try to offer them information regarding those issues rather than bombard them with generic information that they are not interested in,” she says.

- **Have the applicant speak to other nurses.**

Conn suggests having prospective nurses speak with nurses working in your ED. “I introduce them to the nurses and doctors who are available at the time,” she says. “Often, that introduction leads into other discussion.”

Recently, a nurse Conn was interviewing mentioned that she was homesick. “I asked her where she was

SOURCES

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from, and it turned out to be a small town in East Texas,” she says. Coincidentally, three ED staff members also were from that area, so Conn introduced the nurse to those individuals.

“She was very excited to meet people who were very familiar with the area that she was from and even knew some of the same families,” she says.

Conn acknowledges that this was an unusual experience, but ED nurses often will engage the applicant in conversation. “If nothing else, it lets the prospective employee see folks other than the director and get a feel for how it might be to work here,” she says.

Zuzelo suggests having an ED nurse contact potential hires and establish preliminary relationships. “Naturally, this should be a positive employee who is sincerely interested in this activity,” she cautions.

Nurses who have been with your ED for years are the best people to “sell” it to the prospective applicant, says Conn. “Additionally, it sends a message to the applicant that something must be OK here for all of these people to stay for such a long time,” she says. ■

Report: Parents don’t use booster seats

You might assume that most parents know about booster seats, but a new survey tells a different story. According to a report from the Washington, DC-based National Highway Traffic Safety Administration (NHTSA), booster seat use is currently below 10%.¹

The survey was done with approximately 4,000 parents and caregivers with children younger than age 6, during 1998 and 1999.

SOURCES

For more information about educating parents on booster seat use, contact:

- **Laurie Flaherty**, RN, MS, Traffic Safety Consultant Office of Communications and Outreach, US DOT/NHTSA, 400 Seventh St. S.W., NTS-22, Room 5119, Washington, DC 20590. Telephone: (202) 366-2705. Fax: (202) 366-6916. E-mail: lflaherty@nhtsa.dot.gov.
- **Janet Lassman**, EN CARE, 205 S. Whiting St., Suite 403, Alexandria, VA 22304. Telephone: (703) 370-4050. Fax: (703) 370-4005. E-mail: encare@aol.com.

Although almost all parents use car safety seats for infants, most are unaware of booster seats, says **Janet Lassman**, RN, BS, director of program development and training for Emergency Nurses CARE, the Alexandria, VA-based injury prevention arm of the Emergency Nurses Association.

“They need to hear about booster seats, and understand how they work to improve the fit of safety belts,” she stresses. “The use of age-appropriate restraints, such as booster seats, reduce the risk of injury by 70%-80% compared to the child being unrestrained.”

Address parents' misconceptions

Here are ways to educate parents:

- **Tell them not to be guided by state laws.**

Many parents equate state laws regarding child passenger safety with what is safest for their child, says **Laurie Flaherty**, RN, MS, an emergency nurse at Suburban Hospital in Bethesda, MD, and traffic safety consultant with NHTSA.

“In most states, laws only cover children through age 4,” she notes. “At this point, many well-meaning and well-educated parents move their children to adult seat belts.”

According to Lassman, many misconceptions are caused by state occupant restraint laws. “The laws vary from state to state, but most have gaps that need to be closed,” she says.

In a few states, laws have been passed requiring a booster seat for older children, but in some cases, children as young as 2 to 4 years old can be placed in an adult seat belt, she adds.

- **Explain that adult belts might not be the safest option.**

Parents might assume they are doing the right thing

by buckling up their children in an adult belt, says Lassman. “Although better than nothing, adult seat belts alone may not be the best option,” she adds. “Most of the time, after hearing the safety issues involved, parents soon realize the benefits of booster seats.”

Most parents who place their children in seat belts assume this will adequately restrain a small child in a crash, says Flaherty. “Research does not bear this out,” she warns.

She points to a study which found that children between 2 and 5 years old who rode in seat belts alone were 3.5 times more likely to suffer significant injury than children in car seats or booster seats.²

Until children are about 4 feet 7 inches tall and weigh about 80 pounds, they really don't fit properly in an adult seat belt, says Lassman. “As a result, in an effort to be comfortable in the car, they either move forward or slide down in the seat until they are out of position for the seat belt to work properly in a crash,” she explains.

Although some cars have a device that allows you to adjust an adult seat belt for children, most children older than 4 years and 40 pounds still do not fit well in an adult seat belt, says Lassman. “It is not only the issue of the shoulder belt hitting the neck, but also because the child's legs are too short for his/her knees to bend over the edge of the vehicle seat and for the feet to rest on the floor,” she explains.

This causes the child to move forward on the seat to get more comfortable and then they are out of position in the event of a crash, says Lassman. “A belt-positioning booster seat solves this problem and helps the shoulder belt fit more correctly,” she says.

Lassman notes that children generally like to sit in booster seats because they are more comfortable and “can see out the window.” “It's also important to “graduate” a child to a booster seat with no lapse between seats, so the child will understand that this is the norm and accept sitting in the booster seat,” says Lassman.

When you weigh a child

- **Take advantage of “teachable moments” to discuss booster seat use.**

For example, if you weigh a child between 40 and 80 pounds, Flaherty suggests asking if they use a child safety seat at all, and if so, what kind they use. “More than half of the kids killed in car crashes aren't restrained at all. We want to change that,” says Flaherty. “Also, you want to find out if they are using the correct seat for the age/size of their child.

Recommendations could then be made to use

RESOURCES

A complete copy of the *1998 Motor Vehicle Occupant Safety: Child Safety Seat Report — Volume 3* can be accessed at no charge from the National Highway Traffic Safety Administration (NHTSA) web site at www.nhtsa.dot.gov/people/injury/research. Click on “Occupant Protection.” NHTSA offers a variety of materials on child passenger safety, including *Buckle Up America — Boost ’Em Before You Buckle ’Em: Don’t Skip a Step* (Item No. 1P1123), *Child Passenger Safety Training Programs* (Item No. 1P1050), *Are You Using it Right?* (Item No. 1P0040) and *Child Transportation Safety Tips* (Item No. 1P1045). Single copies of these materials can be ordered at no cost on the NHTSA web site: www.nhtsa.dot.gov. (Click on “Safety Materials Catalog” and under topic, select “Child Passenger Safety.”) Or you can contact NHTSA to order copies of the materials or the report:

- **National Highway Traffic Safety Administration**, 400 Seventh St. S.W., Washington, DC 20590. Telephone: (800) 424-9393 or (202) 366-0123. Fax: (301) 386-2194. E-mail: custservice@nhtsa.dot.gov.

The NHTSA Standardized Child Passenger Safety Training Program is a four-day course with lectures, role-playing, and hands-on practice. Certification is available for the Technician and Technician Instructor

levels. For more information, click on “Child Passenger Safety” on the NHTSA home page, then click on “Child Passenger Safety Programs.” Next, click on “Summary Chart Showing Available NHTSA Training Programs.” Or contact the NHTSA Regional Office in your area.

The American Academy of Pediatrics (AAP) has resources pertaining to car safety that can be ordered from the web site (www.aap.org). A checklist for users of infant, convertible, or booster car seats, *One-Minute Car Seat Safety Check-up* is sold in pads of 100. The cost is \$19.95 or \$14.95 for AAP members. To order, under “BookStore” heading, click on “AAP BookStore,” then under “Parenting & Health Education,” click on “Safety & Injury Prevention.” The AAP’s *Car Seat Shopping Guide for Children with Special Needs* addresses various conditions including premature infants and children with tracheostomies. The guide costs \$34.95 or \$29.95 for AAP members. To order, under “Parenting & Health Education, click on “New & Most Requested Topics.” Or to order either publication by mail, contact:

- **American Academy of Pediatrics**, 141 N.W. Point Blvd., Elk Grove Village, IL 60009-1098. Telephone: (888) 227-1770 or (847) 434-4000. Fax: (847) 228-1281. E-mail: pubs@aap.org.

booster seats if they are not already being used, she says. “The parents of smaller children could receive anticipatory guidance from ED nurses about the need for booster seats once the child’s weight surpasses 40 pounds,” she adds.

Look for opportunities

- **Start when children are very young.**

Talk to new parents about the continuum of child restraints that they will need to keep their child safe through the years, says Lassman. “It takes only a few minutes to discuss this with parents,” she notes. (See chart on proper child safety seat use, enclosed in this issue.)

Discharge information also can provide guidelines to reinforce the discussion, Lassman adds. She recommends displaying free materials in ED waiting rooms and clinical areas. (See resource box for

ordering information, above.)

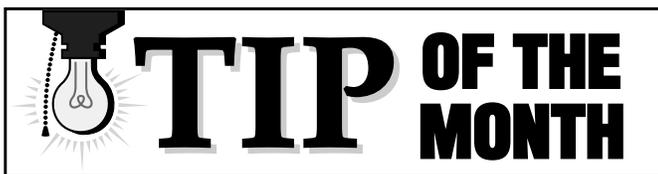
- **Volunteer as a guest speaker.**

Lassman recommends becoming a certified technician in child passenger safety and speaking to community groups. (For more information about certification courses, see resource box, above.)

As an ED nurse, you are a credible spokesperson because you see the sad, often preventable results of noncompliance, she says. “Nurses can get out in the community and speak to parenting, school, and church groups to provide the latest information available,” she recommends.

References

1. National Highway Traffic Safety Administration. Children in car seats and in the backseat. *Ann Emerg Med* 2001; 37:406-407.
2. Berg MD, Cook L, Corneli HM, et al. Effect of seating position and restraint use on injuries to children in motor vehicle crashes. *Pediatrics* 2000; 105:831-835. ■



618-5432. Fax: (847) 618-5419. E-mail: bweintraub@nch.org.] ■



Perform vagal maneuvers for children with SVT

New guidelines recommend vagal maneuvers for children with supraventricular tachycardia (SVT), so you'll need to be familiar with this technique, reports **Barbara Weintraub**, RN, MPH, MSN, pediatric critical care nurse practitioner at Northwest Community Hospital in Arlington Heights, IL.

Although vagal maneuvers never were formally recommended for pediatric SVT previously, they have been used in pediatric ED for years with success, Weintraub notes. However, new guidelines from the Dallas-based American Heart Association for pediatric advanced life support (PALS) include the option for initial treatment of stable SVT with vagal maneuvers, she explains. **(For more information on the new PALS guidelines, see *ED Nursing*, February 2001, p. 45 and p. 50.)**

Vagal maneuvers can be performed in a variety of ways, depending on the age, developmental level, and ability to cooperate of the child, Weintraub says. Here are three:

- having the child hold his or her breath and visualize blowing up a balloon;
- having a child take a deep breath and cough;
- suddenly plunging the child's hands and face into ice water.

All these methods are acceptable, says Weintraub. "The child should be on a cardiac monitor when this is done, and nurses should watch for a slowing of the rhythm with a return to a normal rate," she adds. "If acute or prolonged bradycardia develops, alert the physician and stop the vagal maneuvers."

Vagal maneuvers are only indicated in patients who are stable with normal level of consciousness and blood pressure within normal limits, Weintraub cautions. "Patients who are unstable with decreased level of consciousness, low blood pressure, extreme pallor, cyanosis, or diaphoresis should receive immediate synchronized cardioversion," she says.

[Editor's note: For more information about vagal maneuvers, contact Barbara Weintraub, RN, MPH, MSN, Northwest Community Hospital, 800 W. Central Road, Arlington Heights, IL 60005. Telephone: (847)

McCusker J, Bellavance F, Cardin S. **Prediction of hospital utilization among elderly patients during the six months after an ED visit.** *Ann Emerg Med* 2000; 36:438-445.

A brief self-report questionnaire can identify elderly patients who will experience high utilization of acute-care hospitalization, says this study from St. Mary's Hospital, McGill University, and University of Montreal Hospital Center, all based in Montreal.

The study gave a screening tool, Identification of Seniors at Risk (ISAR) to 1,620 patients 65 years and older who visited the EDs of Montreal hospitals. The tool consisted of six questions to gauge the risk of hospitalization. **(See ISAR screening tool enclosed in this issue.)**

More than half of the patients had a score of 2 or higher, indicating an increased risk of adverse health outcomes. The number of acute-care hospital days were reviewed for the patients during the next six months.

The screening tool can help you target interventions to reduce the chances of adverse outcomes and hospital admission, say the researchers. They note that it can be self-administered by patients in the waiting room or given by the caregiver. "As with all screening methods, the screening tool must be linked with effective interventions," they caution. They recommend doing the following for elderly patients who are at high risk for hospitalization:

- flagging the chart of admitted patients who are at increased risk;
- alerting staff to the need for early comprehensive assessment by the geriatric team;
- conducting a short clinical assessment to determine whether the patient can be safely discharged;
- determining whether home care services are needed;
- giving individualized referrals to a family physician or geriatric outpatient clinic. ▼

Gordon JA. **Cost-benefit analysis of social work services in the ED: A conceptual model.** *Acad Emerg Med* 2001; 8:54-60.

Although the cost of providing dedicated social

workers in the ED is often a deterrent, this practice might actually result in financial benefits, according to this study from Massachusetts General Hospital in Boston.

The study evaluated costs and benefits of providing full-time social work services at three levels of ED volume. The researcher used a model to approximate projected costs and benefits of social work services at hypothetical EDs, based on data from previous research. He estimated variables including the percentage of ED patients who would see a social worker and the number of return visits to the ED that could be prevented by social work intervention.

The researcher found that large urban EDs probably would have a net benefit from operating full-time social work services, moderate-size EDs may almost "break even" financially or incur moderate cost, and that small EDs may realize a net loss.

However, in any of these scenarios, the cost of social services can be significantly offset by decreased use of hospitalization and ED services and more efficient use of medical staff time, he writes.

The study only took economic benefits into account and did not look at "invaluable" measures such as improved patient quality of life, avoiding psychological crises, and alleviation of suffering, notes the researcher. "Dedicated 24-hour social work staffing of EDs may yield net economic benefits to a hospital system, especially in large urban centers," he concludes. ▼

Tanabe P, Thomas R, Paice J, et al. **The effect of standard care, ibuprofen, and music on pain relief and patient satisfaction in adults with musculoskeletal trauma.** *J Emerg Nurs* 2001; 27:124-131.

Patient satisfaction scores might be positive, even when pain is not relieved, as long as pain is addressed, says this study from Northwestern Memorial Hospital in Chicago. The study looked at 77 patients with minor musculoskeletal trauma from sprains and fractures who reported moderate pain with a rating of 4 or greater. The patients were separated into three groups receiving the following interventions: standard care (ice, elevation, and immobilization), standard care and ibuprofen, and standard care plus music distraction. Patients in the music distraction group were given a cassette tape player with headphones and their choice of multiple music tapes or the radio.

The patients were monitored for pain ratings for an hour, and two patient satisfaction questions about pain management were asked upon discharge. Although none of the therapies provided significant pain relief, the patient satisfaction scores were still sometimes positive.

Although distracting patients with music did not provide reductions in pain any more than standard therapy, it did have an impact on patient satisfaction. "Patients enjoyed the opportunity to listen to music of their choice and clearly expressed the desire to listen to music in future visits to the emergency department," the researchers write. They recommend the following:

- considering stronger analgesics for this population;
- including distraction opportunities in triage protocols;
- making follow-up phone calls to determine the effectiveness of discharge prescriptions;
- obtaining pain ratings for patients with all injuries;
- providing interventions based on the patient's subjective rating, instead of the final diagnosis or how severe the injury appears.

"The attention to pain relief, whether or not it was adequate, and distraction with music appear to increase patient satisfaction," the researchers conclude. ■

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Kathryn Wharton Ross, RN, MS, CNAA, BC, is president of KWR Consulting in Durango, CO. She consults with hospitals and corporate hospital systems regarding compliance with standards from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other topics. She has conducted JCAHO mock surveys and served as clinical faculty for JCAHO national seminars.

Patrice Spaff, RHIT, is a health information management professional with over 20 years of extensive experience in performance improvement activities. During the past 20 years, she has presented more than 350 educational programs and has authored more than 150 books. She is the consulting editor of *Hospital Peer Review* newsletter.

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CE objectives

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After reading this issue of *ED Nursing*, the CE participant should be able to:

1. Identify clinical, regulatory, or social issues relating to ED nursing. (See *New guidelines warn: You may not be prepared to take care of sick children; Journal Reviews; and Perform vagal maneuvers for children with SVT* in this issue.)
2. Describe how those issues affect nursing service delivery.
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. ■

Guidelines for Equipment and Supplies for Use in Pediatric Patients in the ED (Excerpt)

Monitoring Equipment

- Cardiorespiratory monitor with strip recorder
- Defibrillator with pediatric and adult paddles (4.5 cm and 8 cm) or corresponding adhesive pads
- Pediatric and adult monitor electrodes
- Pulse oximeter with sensors and probe sizes for children
- Thermometer or rectal probe*
- Sphygmomanometer
- Doppler blood pressure device
- Blood pressure cuffs (neonatal, infant, child, and adult arm and thigh cuffs)
- Method to monitor endotracheal tube and placement +
- Stethoscope

Airway Management

- Portable oxygen regulators and canisters
- Clear oxygen masks (standard and nonrebreathing — neonatal, infant, child, and adult)
- Oropharyngeal airways (sizes 0-5)
- Nasopharyngeal airways (12F through 30F)
- Bag-valve-mask resuscitator, self-inflating (450- and 1,000 mL sizes)
- Nasal cannulae (child and adult)
- Endotracheal tubes: uncuffed (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, and 6.0 mm) and cuffed (6.5, 7.0, 7.5, 8.0, and 9.0 mm)
- Stylets (infant, pediatric, and adult)
- Laryngoscope handle (pediatric and adult)
- Laryngoscope blades: straight or Miller (0, 1, 2, and 3) and Macintosh (2 and 3)
- Magill forceps (pediatric and adult)
- Nasogastric/feeding tubes (5F through 18F)
- Suction catheters — flexible (6F, 8F, 10F, 12F, 14F, and 16F)
- Yankauer suction tip
- Bulb syringe
- Chest tubes (8F through 40F)**
- Laryngeal mask airway (sizes 1, 1.5, 2, 2.5, 3, 4, and 5) ‡

Vascular Access

- Butterfly needles (19-25 gauge)
- Catheter-over-needle devices (14-24 gauge)
- Rate limiting infusion device and tubing ** %
- Intraosseous needles (may be satisfied by standard bone needle aspiration needles)
- Arm boards‡
- Intravenous fluid and blood warmers**
- Umbilical vein catheters** # (size 5F feeding tube may be used)
- Seldinger technique vascular access kit**

Miscellaneous

- Infant and standard scales
- Infant formula and oral rehydration solutions**
- Heating source (may be met by infrared lamps or overhead warmer**)
- Towel rolls, blanket rolls, or equivalent
- Pediatric restraining devices
- Resuscitation board
- Sterile linen ++
- Length-based resuscitation tape or precalculated drug or equipment list based on weight

Specialized Pediatric Trays

- Tube thoracotomy with water seal drainage capability**
- Lumbar puncture
- Pediatric urinary catheters
- Obstetric pack
- Newborn kit**
- Umbilical vessel cannulation supplies**
- Venous cutdown**
- Needle cricothyrotomy tray
- Surgical airway kit (may include a tracheostomy tray or a surgical cricothyrotomy tray)**

Fracture Management

- Cervical immobilization equipment**###
- Extremity splints**
- Femur splints**

Medical Photography Capability

Adapted from Committee on Pediatric Equipment and Supplies for Emergency Departments, National Emergency Medical Services for Children Resource Alliance.

* Suitable for hypothermic and hyperthermic measurements with temperature capability from 25°C to 44°C.

+ May be satisfied by a disposable CO₂ detector of appropriate size for infants and children. For children 5 years or older who are (greater than/equal to sign) 20 kg in body weight, and esophageal detection bulb or syringe may be used additionally.

** Equipment that is essential but may be shared with the nursery, pediatric ward, or other inpatient service and is readily available to the ED.

‡ Equipment or supplies that are desirable but not essential.

% To regulate rate and volume.

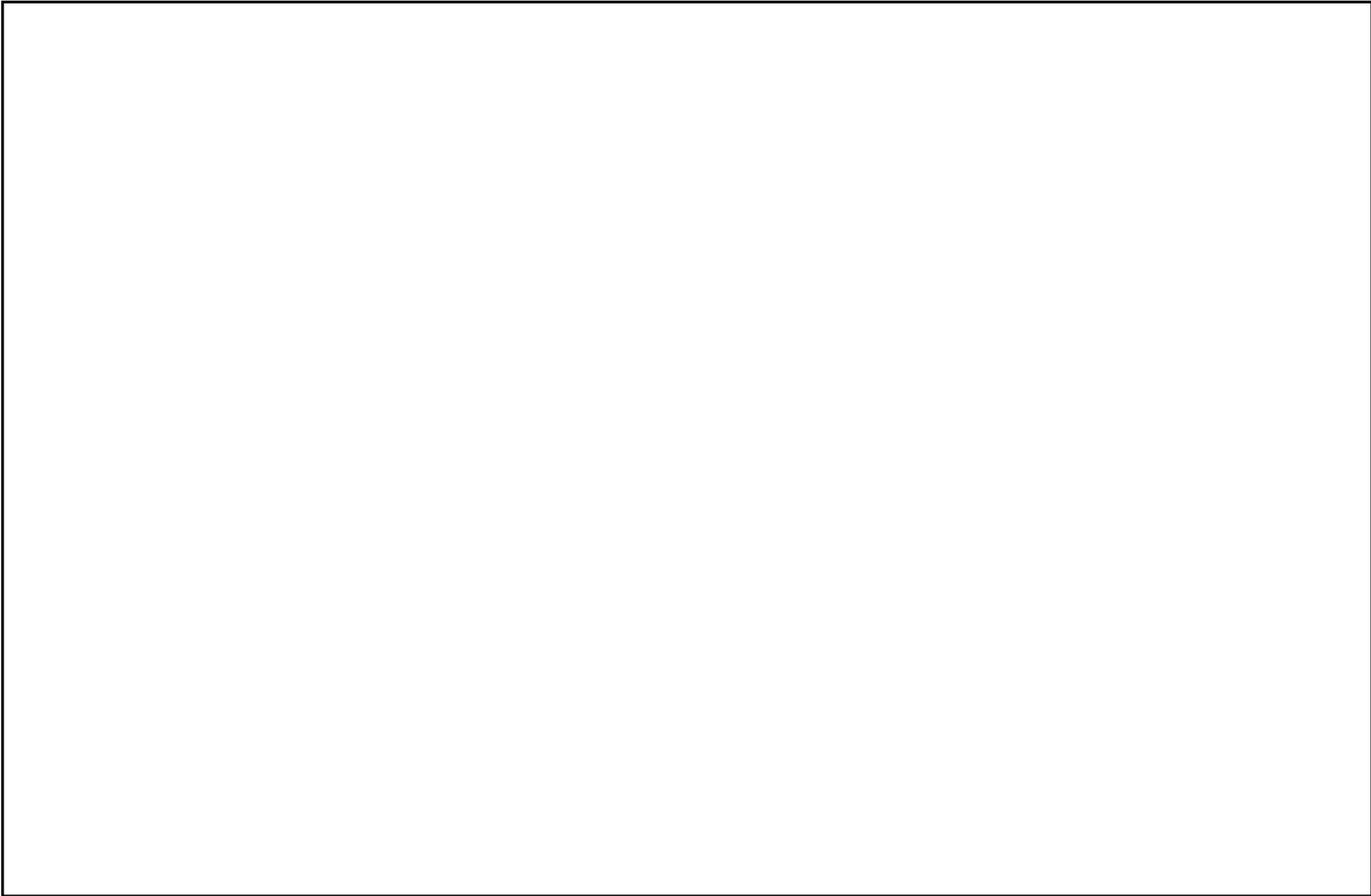
Ensure availability of pediatric sizes within the hospital.

++ Available within hospital for burn care.

Many types of cervical immobilization devices are available, including wedges and collars. The type of device chosen depends on local preferences and policies and procedures. Chosen device should be stocked in sizes to fit infants, children, adolescents, and adults. Use of sandbags to meet this requirement is discouraged, because they might cause injury if the patient has to be turned.

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

Source: American College of Emergency Physicians, Dallas, and the American Academy of Pediatrics, Elk Grove Village, IL. Used with permission. Excerpt from *Care of Children in the Emergency Department: Guidelines for Preparedness*; 2001.



Source: Illinois Emergency Medical Services for Children, a collaborative program between the Illinois Department of Public Health and Loyola University Medical Center, Maywood, IL.

Illinois Emergency Medical Services for Children (EMSC)

Facility Recognition Criteria For The Emergency Department Approved for Pediatrics (EDAP)

1. Professional Staff: Physicians

1.1 Qualifications

1. 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 as evidenced by **one** of the following:
 - 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;
 - B. certification in Pediatric Emergency Medicine by the American Board of Pediatrics/ABEM (ABP/ABEM) **or** residency-trained/board-eligible in pediatric emergency medicine and in the first cycle of the board certification process;
 - C. certification in one of the following boards **and current** American Heart Association (AHA)/American Academy of Pediatrics (AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians (ACEP)/AAP Advanced Pediatric Life Support (APLS) or equivalent course:
 - family practice by the American Board of Family Practice (ABFP) or American Osteopathic Board of Family Practice (AOBFP);
 - certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP);
 - residency-trained/board-eligible in either family practice or pediatrics and in the first cycle of the board-certification process;
 - D. a physician who has received a waiver from the Illinois Department of Public Health based on meeting one of the criteria below:
 - an emergency department physician who already has received a waiver per the *Trauma Center Rules & Regulations* (Section 515.2030, e 1 B; Section 515.2040, f 1 B);
 - completion of 12 months of internship followed by at least 7,000 hours of hospital-based emergency medicine that includes pediatric patients over the last 60-month period (including 2,800 hours within one 24-month period), verified in writing by the hospital(s) at which the internship and subsequent hours were completed and current AHA-AAP PALS or ACEP-AAP APLS recognition;
 - completion of professional activities spent in the practice of pediatric emergency medicine (PEM), over the last 60-month period and totaling a minimum of 6,000 hours, clearly focused in the care of patients in the pediatric age group (≤ 21 years of age) in the emergency department and demonstrated by the following:
 - 1) Of the 6,000 hours, 2,800 hours must have been accrued in a 24-month (maximum) consecutive period of time;
 - 2) A minimum of 4,000 of the 6,000 hours must have been spent in the clinical practice of PEM. (If practiced in a general ED, only time spent exclusively in pediatric practice can be used for credit);
 - 3) The remaining 2,000 hours may be spent in either clinical care or a mixture of related nonclinical activities clearly focused on PEM including administration, teaching, pre-hospital care, quality improvement, research, or other academic activities.

1.2 Continuing Medical Education

All full- or part-time emergency physicians shall have documentation of a minimum of 16 hours of continuing medical education (American Medical Association [AMA] Category I or II) in pediatric emergency topics within a two-year period.

1.3 Coverage

At least one physician satisfying 1.1 shall be on duty in the emergency department 24 hours a day.

(Continued)

1.4 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 the Illinois EMSC *Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline*.

1.5 Physician Backup

A "backup" physician whose qualifications and training are equivalent to that of 1.1 shall be available to the EDAP within one hour to assist with critical situations or disasters.

1.6 On-Call Physicians

Protocols shall be available that address maximum response time for on-call physicians.

2. Professional Staff: Mid-Level Providers. (Mid-level provider is defined as a nurse practitioner or physician assistant who works under the supervision of a licensed physician who satisfies criteria 1.1a and 1.1b.)

2.1 Qualifications

- A. Nurse practitioners shall have:
 - 1. completed a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program;
 - 2. an Illinois advanced practice license within one year of hire;
 - 3. credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient.
- B. Physician assistants shall have:
 - 1. current Illinois licensure (permanent or temporary);
 - 2. 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 PALS Course, the ACEP-AAP APLS Course, or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC).

2.2 Continuing Medical Education

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

3. Professional Staff: Nursing

3.1 Qualifications

- A. At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care.
 - AHA-AAP PALS provider course;
 - ACEP-AAP APLS provider course;
 - ENA ENPC.
- B. All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months of employment.

(Continued)

Proper Child Safety Seat Use Chart

Buckle Everyone. Children Age 12 and Under in Back!

	INFANTS	TODDLER	PRESCHOOLERS
WEIGHT	Birth to 1 year up to 20-22 lbs.	Over 1 year and over 20 lbs.-40 lbs.	Over 40 lbs. up to 80 lbs.
TYPE of SEAT	Infant only on rear-facing convertible	Convertible/forward facing	Belt positioning booster seat
SEAT POSITION	Rear-facing only	Forward-facing	Forward-facing
ALWAYS MAKE SURE:	<p>Children to one year and at least 20 lbs. rear-facing seats</p> <p>Harness straps at or below shoulder level</p>	<p>Harness straps should be at or above shoulders.</p> <p>Most seats require top slot for forward-facing.</p>	<p>Belt positioning booster seats must be used with both lap and shoulder belt.</p> <p>Make sure the lap belt fits low and tight across the lap/upper thigh area and the shoulder belt fits snug crossing the chest and shoulder to avoid abdominal injuries.</p>
WARNING	All children age 12 and under should ride in the back seat.	All children age 12 and under should ride in the back seat.	All children age 12 and under should ride in the back seat.

Source: National Highway Traffic Safety Administration, Washington, DC.

3.2 Continuing Education

All nurses assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education 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. **These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric-specific.**

4. Policies and Procedures

4.1 Interfacility Transfer

Transfer agreement(s) with emergency pediatric centers (EPCs) and policies/procedures concerning transfer of critically ill and injured patients to EPCs. Incorporating the components of the Illinois EMSC *Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline* into the emergency department transfer policy/procedure will meet this requirement.

4.2 Suspected Child Abuse

Policies/procedures addressing the identification, evaluation, treatment, and referral of victims of suspected child abuse in accordance with state mandates.

4.3 Treatment Protocols

Protocols addressing appropriate stabilization measures in response to critically ill or injured pediatric patients (i.e., trauma, respiratory distress, seizures).

4.4 Latex-Free Policy

Policy addressing availability of latex-free equipment and supplies.

5. Quality Improvement

5.1 Multidisciplinary Committee

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

Multidisciplinary continuous QI (CQI) activities shall be established with documented CQI monitors addressing pediatric care within the emergency department with identified clinical indicators and/or outcomes for care. These activities shall include children from birth up to and including 16 years of age and shall consist of, but are not limited to, all pediatric emergency department deaths, resuscitations, and interfacility transfers.

5.2 Pediatric CQI Liaison

A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated and supported by the hospital as the pediatric liaison. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience.

The responsibilities of the pediatric liaison shall include:

5.2.1 — ensure and document pediatric continuing education of all emergency department professional staff (Criteria 1.1, 1.2, 2.1, 2.2, 3.1 and 3.2);

5.2.2 — maintain a data summary and work in conjunction with the multidisciplinary CQI committee to coordinate criteria-based review and follow-up of sample pediatric emergency department visits (Criteria 5.1);

5.2.3 — coordinate review of pre-hospital provider transported pediatric cases and provide feedback to the emergency medical services (EMS) system coordinator and the EMS Regional Advisory Board.

5.2.4 — a written CQI report and attendance at the EMS Regional CQI subcommittee shall be supported by the hospital. One representative from the CQI subcommittee shall report to the EMS Regional Advisory Board.

5.2.5 — CQI information shall be made available to the Illinois Department of Public Health upon request.

Source: Illinois Department of Public Health, Springfield, IL. Excerpt from Facility Recognition Application Packet.