What is a Pediatric Readiness Center?

The Pediatric Readiness Center (PRC) Program is voluntary three-tiered designation program with a focus of improving pediatric care in emergency departments across the state of Georgia. The Pediatric Readiness Program will recognize facilities who are meeting best practice standards for their excellence in pediatric care. Other than organizational pride and community recognition what is the importance of Pediatric Facility Recognition?

Why become a Pediatric Readiness Center?

More than 80% of children who require emergency care first seek care in a community emergency department. However, 70% of emergency departments in Georgia see less than 15 pediatric patients daily. This means most hospitals lack the resources, training, and protocols required for the seamless management of the wide array of pediatric emergencies that may present to their facilities. This gap is felt most strongly in rural communities, where medical centers are few and far between. Although hospitals recognize they have areas of pediatric care that could be improved upon, they are unsure where to start or what the pediatric needs truly are.

How does a facility become a Pediatric Readiness Center?

The Pediatric Readiness Program will help facilities identify the steps needed to become a Pediatric Readiness Center. After reviewing the criteria at the desired level of designation and completing the virtual application, a site visit will confirm the presence of all required components before conferring recognition as a Level I, II, or III Pediatric Readiness Center. Not only will these emergency departments stand out among the crowd, they will be better prepared to provide high quality emergency care to pediatric patients.

Though it may be daunting to take these first steps, the Georgia Emergency Medical Services for Children Program is here to offer assistance and support throughout the process. Reach out to us with any questions or concerns you may have, and we can work together to help ensure that all hospitals within Georgia rise to meet the challenge of Pediatric Readiness.

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Clarification/ FAQ for PRC Criteria

1. Definition of a Pediatric Champion or Peds CHAMP
    a. Peds CHAMP (Children Have A Major Priority) is what we call Pediatric Emergency Care Coordinators (PECC) here in Georgia.
    b. An individual responsible for coordinating the emergency care for pediatric patients and provides pediatric leadership to their facility or organization.
    c. The nursing Peds CHAMP must be an ED nurse with interest, knowledge and skills relating to emergency care of children. They may hold other roles in the ED aside from being the Peds CHAMP, but they must maintain competency in pediatric emergency care.
        i. Examples of courses included in addition to PALS; CPN, ENPC or CPEN.
        ii. Four hours of pediatric CEU annually
    d. The physician Peds CHAMP (Level I and II only) must be board certified in emergency medicine or pediatric emergency medicine. This physician may have other role in the ED or throughout other facilities per their contracts and credentialing.
    e. Duties of a Peds CHAMP may include (but are not limited to) promotion of pediatric education and competencies, active participation in pediatric quality improvement initiatives, review of ED policies and procedures for pediatric inclusion, collaboration both within the facility and with external stakeholders to promote the determinants of pediatric outcomes and wellbeing, and ongoing communication about pediatric needs within the ED.
2. Pediatric Certifications
    a. PALS- Pediatric Advanced Life Support
    b. CPN- Certified Pediatric Nurse
    c. CPEN- Certified Pediatric Emergency Nurse
    d. ENPC- Emergency Nursing Pediatric Course
    e. PEARS- Pediatric Emergency Assessment, Recognition and Stabilization
    f. EPC- Emergency Pediatric Care
    g. PEPP- Pediatric Education for Prehospital Professionals
3. Pediatric Competencies and Education
    a. Areas of professional ongoing pediatric competency may include (but are not limited to)
        i. Assessment and triage
        ii. Medication administration and dosing
        iii. Device and/or equipment safety
        iv. Trauma care and resuscitation
        v. Disaster drills
        vi. Family centered care

vii. Procedures/ monitoring (for example airway management or monitoring of sedation and analgesia)

4. Medication safety process/ procedures
    a. Polices or protocols in place that promote safe medication prescription, administration, and disposal, including but not limited to
        i. Distraction free zones for medication preparation and administration
        ii. Alert system for high risk and/or look alike/sound alike medications or allergy risks
    b. Pre-calculated dosing guidelines
        i. Availability of tools that include the milligrams or milliliters per kilogram body weight.
        ii. Standardized concentrations/ formularies for high-risk medications.
5. Weight- based radiation dosing
    a. Guidance available for the recommended administered, minimum, and maximum radiation dosing by weight for children and adolescents.
6. ED staff educated on location of pediatric supplies and a daily check is completed to ensure location and functionality
    a. Staff training (such as new hire orientation) includes education on the location of pediatric specific supplies so that they may be easily retrieved in the event of an emergency. Check to ensure supplies are in stock and in the appropriate location this should be checked daily and there should be supporting documentation available.
7. Interfacility transfer plan
    a. Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and the referral center (including responsibilities for requesting transfer and communication).
    b. Roles and responsibilities as an accepting facility (Level I and II).
8. Immunizations
    a. A process in place for assessment/ screening of immunization status with the ability to recognize and manage under immunized children.
9. Assessment and Re-assessment
    a. Policies or protocols in place for assessment and reassessment, including vital signs and actions to be taken for abnormal vital signs.
10. Sedation and analgesia
    a. Policies and protocols in place to address the management of sedation and analgesia, including non-pharmacological interventions for comfort during procedures.
11. All hazard disaster plan including pediatric specific needs
    a. An existing disaster plan which would include pediatric specific components. Please see PRC criteria for level specific guidelines.
        i. Triage of pediatric victims
        ii. Tracking and identification for unaccompanied children

iii. Family reunification
iv. Availability of vaccines, medications, supplies, and trained providers.
v. Decontamination, isolation and quarantine for families and patients of all ages
vi. Determination of pediatric surge capacity (such as ability to care for pediatric patients, location of assessment/ rooming)
vii. Care of children with special healthcare needs
viii. Disaster drills, including a pediatric mass casualty incident every 2 years.
ix. Access to behavioral health and social services for children during a disaster.

12. Consent guidelines, including when a parent or legal guardian is not immediately available
    a. A policy or protocol addressing attaining informed consent or process to follow when parent/ guardian is not available for medical screening examination and determination/ treatment/ transport of an emergent medical condition.
13. Physical or chemical restraint of pediatric patients
    a. Are policies in place to address the process for determining needed for, applying, assessing, and removing both chemical and physical restraints specific to the pediatric patient.
14. Child maltreatment, including domestic violence and suspected trafficking reporting criteria and requirements
    a. Policies and protocols in place to address screening and identification, assessment, and mandated reporting of child maltreatment, includes physical and sexual abuse, sexual assault, human trafficking, and neglect.
15. Death of a pediatric patient in the ED
    a. Pre-existing policies and protocols in the event of a pediatric death in the ED. To include the following.
        i. Education of staff to act as resources to assist the family.
        ii. Process or protocol in place to manage cases in which medical examiner identifies child maltreatment.
        iii. Coordination with other individuals or organizations that may assist families, communities, and staff.
        iv. Critical incident stress assistance for ED staff, out of hospital providers and others
        v. Facilitation of organ procurement and consent for postmortem exams with appropriate.
16. Inclusion of family centered care
    a. Policies or protocols in place that address family centered care, including:
        i. Involving families/ guardians in patient care decision making and medication safety processes.

ii. Family/ guardian presence during all aspects of emergency care, including resuscitation.
iii. Education of the patient, family/guardian, and caregivers
iv. Discharge planning and education
v. Bereavement counseling

17. Medical home and primary healthcare provider communication
    a. Policies and protocols in place that address method of communication with the patient's medical home or primary healthcare provider at the time of the ED visit.