

1 TITLE 77: PUBLIC HEALTH
2 CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
3 SUBCHAPTER g: EMERGENCY SERVICES AND HIGHWAY SAFETY
4

5 PART 515
6 EMERGENCY MEDICAL SERVICES, TRAUMA CENTERS,
7 PEDIATRIC EMERGENCY AND CRITICAL CARE CENTERS, STROKE CENTERS, AND
8 HOSPITALS~~HOSPITAL~~ CODE
9

10 SUBPART A: GENERAL PROVISIONS
11

12	Section	
13	515.100	Definitions
14	515.125	Incorporated and Referenced Materials
15	515.150	Waiver Provisions
16	515.160	Facility, System and Equipment Violations, Hearings and Fines
17	515.165	Suspension, Revocation and Denial of Licensure
18	515.170	Employer Responsibility
19	515.180	Administrative Hearings
20	515.190	Felony Convictions

21
22 SUBPART B: EMS REGIONS
23

24	Section	
25	515.200	Emergency Medical Services Regions
26	515.210	EMS Regional Plan Development
27	515.220	EMS Regional Plan Content
28	515.230	Resolution of Disputes Concerning the EMS Regional Plan
29	515.240	Hospital Preparedness Program
30	515.250	Hospital Stroke Care Fund
31	515.255	Stroke Data Collection Fund

32
33 SUBPART C: EMS SYSTEMS
34

35	Section	
36	515.300	Approval of New EMS Systems
37	515.310	Approval and Renewal of EMS Systems
38	515.315	Bypass or Resource Limitation Status Review
39	515.320	Scope of EMS Service
40	515.330	EMS System Program Plan
41	515.340	EMS Medical Director's Course
42	515.350	Data Collection and Submission
43	515.360	Approval of Additional Pilot Programs, Medications, and Equipment

- 44 515.361 Mobile Integrated Health Care Program (MIHP)
- 45 515.370 Automated Defibrillation (Repealed)
- 46 515.380 Do Not Resuscitate (DNR) and Practitioner Orders for Life-Sustaining Treatment
- 47 (POLST) Policy
- 48 515.390 Minimum Standards for Continuing Operation
- 49 515.400 General Communications
- 50 515.410 EMS System Communications
- 51 515.420 System Participation Suspensions
- 52 515.430 Suspension, Revocation and Denial of Licensure of EMTs (Repealed)
- 53 515.440 State Emergency Medical Services Disciplinary Review Board
- 54 515.445 Pediatric Care
- 55 515.450 Complaints
- 56 515.455 Intra- and Inter-System Dispute Resolution
- 57 515.460 Fees
- 58 515.470 Participation by Veterans Health Administration Facilities

59
60 **SUBPART D: EDUCATION OF EMERGENCY MEDICAL TECHNICIANS, ADVANCED**
61 **EMERGENCY MEDICAL TECHNICIANS, EMERGENCY MEDICAL TECHNICIANS-**
62 **INTERMEDIATE, PARAMEDICS AND EMS PERSONNEL**

- 63
64 **Section**
- 65 515.500 EMS System Education Program-Emergency Medical Technician
 - 66 515.510 Advanced Emergency Medical Technician Education
 - 67 515.520 Paramedic Education
 - 68 515.530 EMT, A-EMT, and Paramedic Testing
 - 69 515.540 EMT, A-EMT, EMT-I and Paramedic Licensure
 - 70 515.550 Scope of Practice – Licensed EMR, EMT, EMT-I, A-EMT, and Paramedic
 - 71 515.560 EMT Continuing Education
 - 72 515.570 A-EMT and EMT-I Continuing Education
 - 73 515.580 Paramedic Continuing Education
 - 74 515.590 EMS Personnel License Renewals
 - 75 515.600 EMS Personnel Inactive Status
 - 76 515.610 EMD, EMR, EMT, A-EMT and Paramedic Reciprocity
 - 77 515.620 Felony Convictions (Renumbered)
 - 78 515.630 Evaluation and Recognition of Military Experience and Education
 - 79 515.640 Reinstatement

80
81 **SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER,**
82 **EMERGENCY MEDICAL RESPONDER, PRE-HOSPITAL REGISTERED NURSE,**
83 **EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND**
84 **TRAUMA NURSE SPECIALIST**

- 85
86 **Section**

- 87 515.700 EMS Lead Instructor
- 88 515.710 Emergency Medical Dispatcher
- 89 515.715 Provisional Licensure for Emergency Medical Responders
- 90 515.720 First Responder (Repealed)
- 91 515.725 Emergency Medical Responder
- 92 515.730 Pre-Hospital Registered Nurse, Pre-Hospital Physician Assistant, and Pre-Hospital Advanced Practice Registered Nurse
- 93
- 94 515.740 Emergency Communications Registered Nurse
- 95 515.750 Trauma Nurse Specialist Education Program and Licensing
- 96 515.760 Trauma Nurse Specialist Program Plan
- 97

SUBPART F: VEHICLE SERVICE PROVIDERS

- 98
- 99
- 100 Section
- 101 515.800 Vehicle Service Provider Licensure
- 102 515.810 EMS Vehicle System Participation
- 103 515.820 Denial, Nonrenewal, Suspension and Revocation of a Vehicle Service Provider License
- 104
- 105 515.825 Alternate Response Vehicle
- 106 515.827 Ambulance Assistance Vehicle Provider Upgrades
- 107 515.830 Ambulance Licensing Requirements
- 108 515.833 In-Field Service Level Upgrade – Rural Population
- 109 515.835 Stretcher Van Provider Licensing Requirements
- 110 515.840 Stretcher Van Requirements
- 111 515.845 Operation of Stretcher Vans
- 112 515.850 Reserve Ambulances
- 113 515.860 ALS Expanded Scope and Critical Care Transport
- 114

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

- 115
- 116
- 117
- 118 Section
- 119 515.900 Licensure of SEMSV Programs – General
- 120 515.910 Denial, Nonrenewal, Suspension or Revocation of SEMSV Licensure
- 121 515.920 SEMSV Program Licensure Requirements for Air Medical Transport Programs
- 122 515.930 Helicopter and Fixed-Wing Aircraft Requirements
- 123 515.935 EMS Pilot Specifications
- 124 515.940 Aeromedical Crew Member Education Requirements
- 125 515.945 Aircraft Vehicle Specifications and Operation
- 126 515.950 Aircraft Medical Equipment and Medications
- 127 515.955 Vehicle Maintenance for Helicopter and Fixed-wing Aircraft Programs
- 128 515.960 Aircraft Communications and Dispatch Center
- 129 515.963 Flight Program Safety Standards

- 130 515.965 Watercraft Requirements
- 131 515.970 Watercraft Vehicle Specifications and Operation
- 132 515.975 Watercraft Medical Equipment and Medications
- 133 515.980 Watercraft Communications and Dispatch Center
- 134 515.985 Off-Road SEMSV Requirements
- 135 515.990 Off-Road Vehicle Specifications and Operation
- 136 515.995 Off-Road Medical Equipment and Medications
- 137 515.1000 Off-Road Communications and Dispatch Center

138

139

SUBPART H: TRAUMA CENTERS

140

141 Section

- 142 515.2000 Trauma Center Designation
- 143 515.2010 Denial of Application for Designation or Request for Renewal
- 144 515.2020 Inspection and Revocation of Designation
- 145 515.2030 Level I Trauma Center Designation Criteria
- 146 515.2035 Level I Pediatric Trauma Center
- 147 515.2040 Level II Trauma Center Designation Criteria
- 148 515.2045 Level II Pediatric Trauma Center
- 149 515.2050 Trauma Center Uniform Reporting Requirements
- 150 515.2060 Trauma Patient Evaluation and Transfer
- 151 515.2070 Trauma Center Designation Delegation to Local Health Departments
- 152 515.2080 Trauma Center Confidentiality and Immunity
- 153 515.2090 Trauma Center Fund
- 154 515.2100 Pediatric Care (Renumbered)
- 155 515.2200 Suspension Policy for Trauma Nurse Specialist Certification

156

157

SUBPART I: EMS ASSISTANCE FUND

158

159 Section

- 160 515.3000 EMS Assistance Fund Administration

161

162

SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

163

164 Section

- 165 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient Critical Care Services
- 166
- 167 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)
- 168
- 169 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)
- 170
- 171 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center (PCCC)

172

173		SUBPART K: COMPREHENSIVE STROKE CENTERS,
174		PRIMARY STROKE CENTERS AND ACUTE STROKE-READY HOSPITALS
175		
176	515.5000	Definitions
177	515.5002	State Stroke Advisory Subcommittee
178	515.5004	Regional Stroke Advisory Subcommittee
179	515.5010	Stroke Care – Restricted Practices
180	515.5015	Comprehensive Stroke Center (CSC) Designation
181	515.5016	Request for Comprehensive Stroke Center Designation
182	515.5017	Suspension and Revocation of Comprehensive Stroke Center Designation
183	515.5020	Primary Stroke Center (PSC) Designation
184	515.5030	Request for Primary Stroke Center Designation
185	515.5040	Suspension and Revocation of Primary Stroke Center Designation
186	515.5050	Acute Stroke-Ready Hospital (ASRH) Designation without National Certification
187	515.5060	Acute Stroke-Ready Hospital Designation Criteria without National Certification
188	515.5070	Request for Acute Stroke-Ready Hospital Designation without National
189		Certification
190	515.5080	Suspension and Revocation of Acute Stroke-Ready Hospital Designation without
191		National Certification
192	515.5083	Acute Stroke-Ready Hospital Designation with National Certification
193	515.5085	Request for Acute Stroke-Ready Hospital Designation with National Certification
194	515.5087	Suspension and Revocation of Acute Stroke-Ready Hospital Designation with
195		National Certification
196	515.5090	Data Collection and Submission
197	515.5100	Statewide Stroke Assessment Tool
198		
199	515.APPENDIX A	A Request for Designation (RFD) Trauma Center
200	515.APPENDIX B	A Request for Renewal of Trauma Center Designation
201	515.APPENDIX C	Minimum Trauma Field Triage Criteria
202	515.APPENDIX D	Administrative, Legal and EMS Protocols and Guidelines
203	515.APPENDIX E	Minimum Prescribed Data Elements
204	515.APPENDIX F	Template for In-House Triage for Trauma Centers
205	515.APPENDIX G	Credentials of General/Trauma Surgeons Level I and Level II
206	515.APPENDIX H	Credentials of Emergency Department Physicians Level I and Level II
207	515.APPENDIX I	Credentials of General/Trauma Surgeons Level I and Level II Pediatric
208		Trauma Centers
209	515.APPENDIX J	Credentials of Emergency Department Physicians Level I and Level II
210		Pediatric Trauma Centers
211	515.APPENDIX K	Application for Facility Recognition for Emergency Department with
212		Pediatrics Capabilities
213	515.APPENDIX L	Pediatric Equipment Requirements for Emergency Departments
214	515.APPENDIX M	Inter-facility Pediatric Trauma and Critical Care Consultation and/or
215		Transfer Guideline

- 216 515.APPENDIX N Pediatric Critical Care Center (PCCC)/Emergency Department Approved
- 217 for Pediatrics (EDAP) Recognition Application
- 218 515.APPENDIX O Pediatric Critical Care Center Plan
- 219 515.APPENDIX P Pediatric Critical Care Center (PCCC) Pediatric
- 220 Equipment/Supplies/Medications Requirements
- 221

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

224

225 SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a
 226 maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203,
 227 effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31,
 228 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997;
 229 amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective
 230 September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill.
 231 Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000;
 232 amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367,
 233 effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended
 234 at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25,
 235 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill.
 236 Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December
 237 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255,
 238 effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended
 239 at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective
 240 September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35
 241 Ill. Reg. 20609, effective December 9, 2011; amended at 36 Ill. Reg. 880, effective January 6,
 242 2012; amended at 36 Ill. Reg. 2296, effective January 25, 2012; amended at 36 Ill. Reg. 3208,
 243 effective February 15, 2012; amended at 36 Ill. Reg. 11196, effective July 3, 2012; amended at
 244 36 Ill. Reg. 17490, effective December 3, 2012; amended at 37 Ill. Reg. 5714, effective April 15,
 245 2013; amended at 37 Ill. Reg. 7128, effective May 13, 2013; amended at 37 Ill. Reg. 10683,
 246 effective June 25, 2013; amended at 37 Ill. Reg. 18883, effective November 12, 2013; amended
 247 at 37 Ill. Reg. 19610, effective November 20, 2013; amended at 38 Ill. Reg. 9053, effective April
 248 9, 2014; amended at 38 Ill. Reg. 16304, effective July 18, 2014; amended at 39 Ill. Reg. 13075,
 249 effective September 8, 2015; amended at 40 Ill. Reg. 8274, effective June 3, 2016; amended at
 250 40 Ill. Reg. 10006, effective July 11, 2016; recodified at 42 Ill. Reg. 10700; amended at 42 Ill.
 251 Reg. 17632, effective September 20, 2018; amended at 43 Ill. Reg. 4145, effective March 19,
 252 2019; emergency amendment at 44 Ill. Reg. 6463, effective April 10, 2020, for a maximum of
 253 150 days; amended at 44 Ill. Reg. 15619, effective September 1, 2020; emergency amendment at
 254 45 Ill. Reg. 12108, effective September 17, 2021, for a maximum of 150 days; emergency
 255 expired February 13, 2022; emergency amendment at 46 Ill. Reg. 1173, effective December 27,
 256 2021, for a maximum of 150 days; emergency amendment to emergency rule at 46 Ill. Reg.
 257 7899, effective April 26, 2022, for the remainder of the 150 days; emergency rule as amended
 258 expired May 25, 2022; emergency amendment at 46 Ill. Reg. 3419, effective February 14, 2022,

259 for a maximum of 150 days; emergency expired July 13, 2022; emergency amendment at 46 Ill.
260 Reg. 10000, effective May 26, 2022, for a maximum of 150 days; emergency expired October
261 22, 2022; emergency amendment at 46 Ill. Reg. 17682, effective October 23, 2022, for a
262 maximum of 150 days; amended at 46 Ill. Reg. 20898, effective December 16, 2022; amended at
263 48 Ill. Reg. 16159, effective November 1, 2024; Subchapter f recodified at 49 Ill. Reg. 4112;
264 amended at 50 Ill. Reg. _____, effective _____.

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266 **SUBPART C: EMS SYSTEMS**

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268 **Section 515.445 Pediatric Care**

- 269
270 a) Upon the availability of federal funds for development of an emergency medical
271 services for children (EMSC) program, the Department shall appoint an Advisory
272 Board to advise the Department on all matters concerning emergency medical
273 service for children and to develop and implement a plan to address identified
274 pediatric areas of need. The Advisory Board shall advise the Department in the
275 formulation of policy that reflects the purposes of the Act and this Part. The
276 Advisory Board shall consist of 25 members to be appointed by the Director for a
277 term of three years. Membership of the Advisory Board shall include:
- 278
279 1) One practicing pediatrician, one pediatric critical care physician and one
280 board certified pediatric emergency physician, to be recommended by the
281 Illinois Chapter of the American Academy of Pediatrics;
282
 - 283 2) One pediatric surgeon, to be recommended by the Illinois Chapter of the
284 American College of Surgeons, or a trauma nurse manager/coordinator
285 recommended by the Illinois Trauma Advisory Council~~Coordinators~~
286 ~~Coalition~~;
 - 287
288 3) Two emergency physicians, one to be recommended by the Illinois
289 Chapter of the American College of Emergency Physicians and one to be
290 recommended by the National Association of EMS Physicians;
291
 - 292 4) One family medicine physician, to be recommended by the Illinois
293 Chapter of the American Academy of Family Physicians;
294
 - 295 5) Two RNs, one to be appointed upon recommendation of the American
296 Nurses Association-Illinois (ANA-Illinois) and one to be appointed upon
297 recommendation of the Illinois State Council, Emergency Nurses
298 Association (ENA);
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- 6) Two EMS Personnel of differing levels, to be appointed, one each, upon recommendation of the Illinois EMS Association and ~~Associated Illinois~~ Fire Fighters ~~of Illinois Association~~;
 - 7) An EMS Coordinator;
 - 8) A representative from each of the following: Division of Specialized Care for Children; Illinois Fire Chiefs Association; Illinois State Ambulance Association; Illinois State Medical Society; SAFEKIDS Coalition; Illinois Health and Hospital Association; Illinois Critical Access Hospital Network; Illinois Department of Children and Family Services; Illinois Poison Center; 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 and Highway Safety and the Office of Women's Health; ~~Division of Maternal, Child~~ and Family ~~Health~~ Services. EMS Regional representation shall be through board members who serve as representatives of other designated constituencies. The members shall have dual representation status in advising the Department, but shall retain one vote. The Department shall consider 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 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.
 - d) The Advisory Board shall act pursuant to bylaws that it adopts, which shall include the annual election of a Chair and Vice-Chair.

- 342 e) The Department, with the advice of the Advisory Board, shall address and
343 establish through the EMSC program at least the following:
344
- 345 1) Initial and continuing education programs for emergency medical services
346 personnel, which shall include training in the emergency care of infants
347 and children;
348
 - 349 2) Guidelines for referring children to the appropriate emergency or critical
350 care medical facilities;
351
 - 352 3) Guidelines for pre-hospital, hospital and other pediatric emergency or
353 critical care medical service equipment;
354
 - 355 4) Guidelines and protocols for pre-hospital and hospital facilities
356 encompassing all levels of pediatric emergency medical services, hospital
357 and pediatric critical care services, including, but not limited to, triage,
358 stabilization, treatment, transfers and referrals;
359
 - 360 5) Guidelines for hospital-based emergency departments appropriate for
361 pediatric care to assess, stabilize, and treat critically ill infants and
362 children and if necessary to prepare the child for transfer to a pediatric
363 intensive care unit or pediatric trauma center;
364
 - 365 6) Guidelines for pediatric intensive care units, pediatric trauma centers and
366 intermediate care units fully equipped and staffed by appropriately trained
367 critical care pediatric physicians, surgeons, nurses and therapists;
368
 - 369 7) An inter-facility transfer system for critically ill or injured children;
370
 - 371 8) Guidelines for pediatric rehabilitation units to ensure staffing by
372 rehabilitation specialists and capabilities to provide any service required to
373 assure maximum recovery from the physical, emotional and cognitive
374 effects of critical illness and severe trauma;
375
 - 376 9) Guidelines for the implementation of public education and injury
377 prevention programs throughout the State in conjunction with local fire,
378 public safety and school personnel;
379
 - 380 10) Guidelines for the collection, analysis and dissemination of pediatric
381 quality improvement information regarding ongoing improvements in the
382 EMSC program;
383

- 384 11) Guidelines and protocols for pre-hospital providers and hospital facilities
385 for the treatment, documentation, reporting and professional interactions
386 with family members, and for referrals to social, psychological and
387 rehabilitation services in suspected cases of child maltreatment; and
388
- 389 12) Guidelines addressing pediatric disaster/all-hazards preparedness.

390
391 (Source: Amended at 50 Ill. Reg. _____, effective _____)
392

393 **SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN**
394

395 **Section 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient**
396 **Critical Care Services**
397

- 398 a) Any hospital seeking recognition as a Standby Emergency Department Approved
399 for Pediatrics (SEDP), Emergency Department Approved for Pediatrics (EDAP)
400 or Pediatric Critical Care Center (PCCC) shall submit an application as outlined
401 by the Department in Section 515.Appendix K ~~or~~ and Section 515.Appendix N.
402
- 403 b) All EMS Resource Hospitals are required to receive recognition as a SEDP,
404 EDAP or PCCC. All Illinois hospitals are encouraged to obtain and maintain
405 SEDP or EDAP status.
406
- 407 c) All trauma centers are required to obtain and maintain recognition as an EDAP or
408 PCCC as outlined in this Part. Out-of-state trauma centers can meet this
409 requirement by meeting their own respective state defined pediatric criteria.
410
- 411 d) The Department shall recognize applicant hospitals as an SEDP, EDAP or PCCC
412 if they meet all of the requirements established by this Part.
413
- 414 e) Hospitals applying for PCCC recognition shall also meet all of the EDAP
415 requirements.
416
- 417 f) Recognition as a SEDP, EDAP or PCCC shall be for four years.
418
- 419 g) All requests for renewal of SEDP, EDAP or PCCC recognition shall be filed in
420 writing with the Department before the recognition expiration date, along with
421 submission of a Department-approved renewal application.
422
- 423 h) The Department shall deny an application for recognition or a request for renewal
424 of recognition when its findings show failure to comply with this Part.
425

- 426 i) The Department shall provide written notice, via certified mail, of its decision to
427 deny an application for recognition or request for renewal of recognition.
428 Hospitals may appeal the denial by submitting a written request to the Illinois
429 Department of Public Health, Division of EMS & Highway Safety.
430
- 431 j) Any SEDP, EDAP or PCCC that does not meet the requirements in subsection (b)
432 or (c), may voluntarily terminate recognition prior to the expiration date by
433 notifying the Department in writing. The hospital shall notify the Illinois
434 Department of Public Health, Division of EMS & Highway Safety a minimum of
435 60 days prior to termination and shall submit a plan that outlines the reason for
436 the termination notice, the date of termination, and a copy of the memo
437 notification being sent to the following entities to ensure their awareness of this
438 change in status: area pre-hospital provider agencies and area hospitals.
439
- 440 k) The Department shall inspect recognized hospitals to assure compliance with this
441 Part.
442
- 443 l) The Department shall take the following action, as appropriate, after determining
444 that an SEDP, EDAP or PCCC is in violation of this Part.
445
 - 446 1) If the Director determines that the violation presents an immediate threat
447 of death or serious physical harm to a patient, and if the SEDP, EDAP or
448 PCCC fails to eliminate the violation immediately or within a fixed period
449 of time, not exceeding 10 days, as determined by the Director, the Director
450 shall immediately revoke the recognition.
451
 - 452 2) If the Department determines that the violation does not present an
453 immediate threat of death or serious physical harm to a patient, the
454 Director shall issue a notice of violation and request a plan of correction,
455 which shall be subject to the Department's approval.
456
- 457 m) No hospital shall use the recognition levels of SEDP, EDAP or PCCC in relation
458 to itself or hold itself out as an SEDP, EDAP or PCCC without first obtaining
459 recognition pursuant to this Part.
460

461 (Source: Amended at 50 Ill. Reg. _____, effective _____)
462

463 **Section 515.4010 Facility Recognition Criteria for the Standby Emergency Department**
464 **Approved for Pediatrics (SEDP)**
465

- 466 a) Professional Staff: Physicians
467
 - 468 1) Qualifications

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

 - B) All physicians shall successfully complete and maintain current recognition in the AHA-AAP or American Red Cross PALS ~~or the ACEP-AAP-APLS~~. Physicians who are board certified or eligible in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine (ABP/ABEM) are excluded from this requirement. PALS ~~and APLS~~ shall include both cognitive and practical skills evaluation.
- 2) Continuing Medical Education
All full and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.
- 3) Coverage
At least one physician meeting the requirements of subsection (a)(1), or a nurse practitioner, clinical nurse specialist, or PA meeting the requirements of subsection (b)(1), shall be on duty in the emergency department 24 hours a day or immediately available in person. A policy shall define when a physician is to be consulted or called in at times when the emergency department is covered by one of these clinicians.
- 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.

511 5) Physician, Nurse Practitioner, Clinical Nurse Specialist, Physician
512 Assistant Backup
513 A backup physician, nurse practitioner, clinical nurse specialist, or PA
514 whose qualifications and training are equivalent to that required by
515 subsections (a) and (b) shall be available in person to the SEDP, within
516 one hour after notification, to assist with critical situations, increased surge
517 capacity or disasters.

518
519 6) On-Call Physicians
520 Guidelines shall address response time for on-call physicians.
521

522 b) Professional Staff: Nurse Practitioner, Clinical Nurse Specialist and Physician
523 Assistant
524 This subsection (b) pertains to nurse practitioners, clinical nurse specialists, and
525 PAs working within their scope of practice, and credentialed as defined by the
526 hospital.
527

528 1) Qualifications
529

530 A) Nurse practitioners shall:
531

532 i) Either
533

534 •i) Successfully Complete a Nurse Practitioner
535 Program with a Focus on the Pediatric Patient. The
536 following are programs that qualify as focused on
537 pediatric patients: acute care pediatric nurse
538 practitioner program, primary care pediatric nurse
539 practitioner program, pediatric critical care nurse
540 practitioner program, emergency nurse practitioner
541 program, or family practice nurse practitioner
542 program; or
543

544 •ii) Alternate Criteria: The nurse practitioner worked in
545 the emergency department prior to January 1, 2018
546 and has completed at least 2000 hours of hospital-
547 based emergency department experience or acute
548 care experience as a nurse practitioner over the last
549 24-month period that includes the care of pediatric
550 patients. This must be certified in writing by the
551 hospitals at which the hours were completed.
552

553 iiiii) Hold a current~~Current~~ Illinois APRN license. For out-of-
554 state facilities with Illinois recognition under the EMS,
555 trauma, or pediatric program, the nurse practitioner shall
556 have an unencumbered license in the state in which he or
557 she practices.
558

559 iiiv) Provide credentialing~~Credentialing~~ that reflects orientation,
560 ongoing training and specific competencies in the care of
561 the pediatric emergency patient, as defined by the hospital
562 credentialing process.
563

564 B) Clinical nurse specialists shall:
565

566 i) Complete a clinical nurse specialist program that includes
567 pediatrics;
568

569 ii) Maintain pediatric clinical nurse specialist certification
570 through a nationally recognized organization (American
571 Association of Critical Care Nurses (AACN), American
572 Nurses Credentialing Center (ANCC), or an equivalent
573 national organization);
574

575 iii) Hold a current Illinois APRN license. For out-of-state
576 facilities with Illinois recognition under the EMS, trauma,
577 or pediatric program, the clinical nurse specialist shall have
578 an unencumbered license in the state in which he or she
579 practices; and
580

581 iv) Provide credentialing that reflects orientation, ongoing
582 training, and specific competencies in the care of the
583 pediatric emergency patient, as defined by the hospital
584 credentialing process.
585

586 C) Physician Assistants shall:
587

588 i) Hold a current Illinois Physician Assistant License. For
589 out-of-state facilities with Illinois recognition under the
590 EMS, trauma, or pediatric program, the professional shall
591 have an unencumbered license in the state in which he or
592 she practices.
593

594 ii) Provide credentialing that reflects orientation, ongoing
595 training and specific competencies in the care of the

596 pediatric emergency patient as defined by the hospital
597 credentialing process.

- 598
599 2) Continuing Education
600
601 A) All full- and part-time nurse practitioners, clinical nurse specialists,
602 and PAs caring for children in the emergency department shall
603 successfully complete and maintain current recognition in one of
604 the following courses: the AHA-AAP or American Red Cross
605 PALS, ~~the ACEP-AAP-APLS~~ or the Emergency Nurses
606 Association (ENA) Emergency Nursing Pediatric Course (ENPC).
607 PALS, ~~APLS~~ and ENPC shall include both cognitive and practical
608 skills evaluation.
609
610 B) All full- and part-time nurse practitioners, clinical nurse specialists,
611 and PAs caring for children in the emergency department and fast
612 track/urgent care area shall have documentation of a minimum of
613 16 hours of continuing education in pediatric emergency topics
614 every two years that are approved by an accrediting agency.

615
616 c) Professional Staff: Nursing

- 617
618 1) Qualifications
619 At least one RN on duty each shift who is responsible for the direct care of
620 the child in the emergency department shall successfully complete and
621 maintain current recognition in one of the following courses in pediatric
622 emergency care:
623
624 A) AHA-AAP or American Red Cross PALS; or
625
626 ~~B) ACEP-AAP-APLS; or~~
627
628 B) ENA ENPC.
629
630 2) Continuing Education
631
632 A) At least one RN on duty on each shift who is responsible for the
633 direct care of the child in the emergency department shall have
634 documentation of a minimum of eight hours of pediatric
635 emergency or critical care continuing education every two years.
636 Continuing education may include, but is not limited to, PALS;
637 ~~APLS~~ or ENPC; CEU offerings; case presentations; competency
638 testing; teaching courses related to pediatrics; and publications.

639 The continuing education hours may be integrated with other
640 existing continuing education requirements, provided that the
641 content is pediatric specific. PALS, ~~APLS~~ and ENPC shall include
642 both cognitive and practical skills evaluation.
643

644 B) All emergency department nurses (RNs and LPNs) shall complete
645 a yearly competency review of high-risk, low-frequency
646 procedures based on their pediatric population.
647

648 d) Policies and Procedures
649

650 1) Inter-facility Transfer
651

652 A) The hospital shall have current written transfer agreements that
653 cover pediatric patients. The transfer agreements shall include a
654 provision that addresses communication and quality improvement
655 measures between the sending and receiving hospitals, as related to
656 patient stabilization, treatment prior to and subsequent to transfer,
657 and patient outcome.
658

659 B) The hospital shall have written pediatric inter-facility transfer
660 guidelines, policies, or procedures concerning transfer of critically
661 ill and injured patients, which include a defined process for
662 initiation of transfer, including the roles and responsibilities of the
663 sending hospital and receiving hospital; a process for selecting the
664 appropriate care facility; a process for selecting the appropriately
665 staffed transport service to match the patient's acuity level; a
666 process for patient transfer (including obtaining informed consent);
667 a plan for transfer of patient medical record information, signed
668 transport consent, and belongings; and a plan for provision of
669 directions and receiving hospital information to the family.
670 Incorporating the components of Appendix M into the emergency
671 department transfer policy/procedure will meet this requirement.
672

673 2) Suspected Child Abuse and Neglect

674 The hospital shall have policies/procedures addressing child abuse and
675 neglect. These policies/procedures shall include, but not be limited to: the
676 identification (including the screening process and screening questions
677 within the electronic medical record), evaluation, treatment and referral to
678 DCFS of victims of suspected child abuse and neglect in accordance with
679 State law.
680

681 3) Emergency Department Treatment Guidelines

682 The hospital shall have interprofessional emergency department pediatric
683 specific treatment guidelines, clinical pathways, or protocols addressing
684 initial assessment and management, including decision points, for the care
685 of the high-volume and high-risk pediatric population (i.e., fever, trauma,
686 respiratory distress, seizures).

687
688 4) Latex-Allergy Policy

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

691
692 5) Disaster Preparedness

693 The hospital shall integrate pediatric components into its Disaster Plan or
694 Emergency Operations Plan, based on the EMSC Hospital Pediatric
695 Preparedness Checklist.

696
697 e) Quality Improvement

698
699 1) Interprofessional Quality Activities Policy

700
701 A) Pediatric emergency medical care shall be included in the SEDP's
702 emergency department or section QI program and reported to the
703 hospital Quality Committee.

704
705 B) Interprofessional quality improvement processes/ activities shall be
706 established (e.g., committee).

707
708 C) Quality monitors shall be documented that address pediatric care
709 within the emergency department, with identified clinical
710 indicators, monitor tools, defined outcomes for care, feedback loop
711 processes and target timeframes for closure of issues. These
712 activities shall include children from birth up to and including 15
713 years of age and shall consist of, but are not limited to, all
714 emergency department:

715
716 i) Pediatric deaths;

717
718 ii) Pediatric inter-facility transfers;

719
720 iii) Child abuse and neglect cases;

721
722 iv) Critically ill or injured children in need of stabilization
723 (e.g., respiratory failure, sepsis, shock, altered level of
724 consciousness, cardio/pulmonary failure; and

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- v) Pediatric quality and safety priorities of the institution.
 - D) Interprofessional pediatric mock codes and debriefings shall be conducted and documented including follow-up on identified opportunities for improvement.
 - E) *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 activities (i.e. quality/performance improvement, clinical pathways, education/training). The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.
- 3) Pediatric Quality Coordinator
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department provided he or she has a minimum of 3600 hours of pediatric critical care experience or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:
- A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department professional staff in accordance with subsections (a), (b) and (c).
 - B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).
 - C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

- 768 D) Participating in regional QI activities, including preparing a written
769 QI report and attending the Regional Pediatric QI subcommittee
770 meetings. These activities shall be supported by the hospital. One
771 representative from the Regional QI subcommittee shall report to
772 the EMS Regional Advisory Board.
- 773
- 774 E) Providing QI information to the Department upon request. (See
775 Section 3.110(a) of the Act.)
- 776
- 777 f) Equipment, Trays, and Supplies
778 See Section 515.Appendix L.
- 779

780 (Source: Amended at 50 Ill. Reg. _____, effective _____)

781
782 **Section 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center**
783 **(PCCC)**

784
785 Any facility seeking PCCC level recognition shall meet requirements for both the EDAP and
786 PCCC levels.

- 787
- 788 a) Facility Requirements
789 A facility recognized as a PCCC Center shall provide the following:
790
- 791 1) An EDAP-recognized emergency department;
- 792
- 793 2) A distinct Pediatric Intensive Care Unit (PICU);
- 794
- 795 3) A Pediatric Committee established as a standing interprofessional
796 committee within the hospital with membership that includes, at a
797 minimum, one physician, one RN, one respiratory therapist, and other
798 specialties as determined by the hospital;
- 799
- 800 4) An interprofessional Pediatric Quality Improvement/Performance
801 Improvement Committee;
- 802
- 803 5) Helicopter landing capabilities approved by State and federal authorities;
- 804
- 805 6) Computerized axial tomography (CAT) scan availability 24 hours a day;
- 806
- 807 7) Laboratory 24 hours a day in-house, providing:
808
- 809 A) Standard analysis of blood, urine and body fluids;
- 810

- 811 B) Blood typing and cross-matching;
- 812
- 813 C) Coagulation studies;
- 814
- 815 D) Comprehensive blood bank or an agreement with a community
- 816 central blood bank;
- 817
- 818 E) Blood gases and pH determinations;
- 819
- 820 F) Microbiology, including the ability to initiate aerobic and
- 821 anaerobic cultures on site; and
- 822
- 823 G) Drug and alcohol screening;
- 824
- 825 8) Hemodialysis capabilities or a transfer agreement;
- 826
- 827 9) Staff, including a child life specialist, occupational therapy, speech
- 828 therapy, physical therapy, social work, dietary, psychiatry and child
- 829 protective services;
- 830
- 831 10) Hospital support staff to act as a resource and participate in
- 832 interprofessional regional pediatric critical care education;
- 833
- 834 11) A plan for implementing a program of public information/education
- 835 concerning emergency care services for pediatrics; and
- 836
- 837 12) Support for active institutional and collaborative regional research.
- 838
- 839 b) PICU Medical Director Requirements
- 840 A Medical Director shall be appointed, and a record of appointment and
- 841 acceptance shall be in writing.
- 842
- 843 1) Qualifications
- 844 The PICU shall have a dedicated Medical Director who is:
- 845
- 846 A) Board certified in Pediatrics by the ABP or the AOBP, and Board
- 847 certified or in the process of certification in Pediatric Critical Care
- 848 Medicine by ABP, or Pediatric Intensive Care by AOBP;
- 849
- 850 B) Board certified in Pediatrics by the ABP or the AOBP, and Board
- 851 certified in a pediatric subspecialty with at least 50% practice in
- 852 pediatric critical care. In this situation, a physician who meets the
- 853 criteria in subsection (b)(1)(A) shall be appointed as Co-director;

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- 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 or Co-Director shall achieve certification within seven years after his/her initial acceptance into the certification process for pediatric critical care or intensive care medicine, and shall maintain certification.
- 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 ~~one of~~ the following courses: the AHA-AAP or American Red Cross PALS ~~or ACEP~~

897 ~~AAP-APLS~~. PALS ~~and APLS~~ shall include both cognitive and
898 practical skills evaluation.
899

900 2) Physician Specialist Availability

901 If the applying hospital is a Pediatric Trauma Center, the applicable
902 requirements for physician response times that meet Sections 515.2035
903 and 515.2045 shall be followed.
904

905 A) Attending level physician specialists shall be on staff and are
906 required to have the following:
907

908 i) Pediatric proficiency as defined by the hospital
909 credentialing process;
910

911 ii) Board/sub-board certification in their specialty. If
912 residency trained/board prepared in their specialty,
913 physicians shall achieve certification within seven years
914 after initial acceptance into the board/sub-board
915 certification process, and maintain certification; and
916

917 iii) 20 hours every two years of pediatric CME (category I or
918 II) in their specialty.
919

920 B) The following on-call surgeons with pediatric proficiency shall be
921 available in-house within 60 minutes after the determination is
922 made that they are needed:
923

924 i) Surgeon; and
925

926 ii) Neurosurgeon, or transfer agreement with another facility.
927

928 C) On-call attending anesthesiologists with pediatric proficiency shall
929 be available in-house within 60 minutes after the determination is
930 made that they are needed. CRNAs with pediatric proficiency may
931 initiate appropriate procedures as identified in hospital by-laws.
932

933 D) On-staff subspecialists with the following pediatric proficiency
934 shall be available to the institution or by phone for consultation
935 within 60 minutes after the determination is made that they are
936 needed:
937

938 i) Cardiologist;
939

- 940 ii) Neonatologist;
- 941
- 942 iii) Nephrologist;
- 943
- 944 iv) Neurologist;
- 945
- 946 v) Orthopedic surgeon;
- 947
- 948 vi) Otolaryngologist; and
- 949
- 950 vii) Radiologist.
- 951
- 952 E) The following physician specialists shall be available in the
- 953 hospital or by consultation or transfer agreement with another
- 954 hospital:
- 955
- 956 i) Allergist or immunologist;
- 957
- 958 ii) Cardiothoracic surgeon;
- 959
- 960 iii) Craniofacial (plastic) surgeon;
- 961
- 962 iv) Endocrinologist;
- 963
- 964 v) Gastroenterologist;
- 965
- 966 vi) Hand surgeon;
- 967
- 968 vii) Hematologist-oncologist;
- 969
- 970 viii) Infectious disease;
- 971
- 972 ix) Micro-vascular surgeon;
- 973
- 974 x) Obstetrics/gynecology;
- 975
- 976 xi) Ophthalmologist;
- 977
- 978 xii) Oral surgeon;
- 979
- 980 xiii) Psychiatrist (physical medicine & rehabilitation);
- 981
- 982 xiv) Psychiatrist/psychologist;

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- xv) Pulmonologist; and
 - xvi) Urologist.
- d) PICU Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant Qualifications
- 1) Nurse practitioners shall:
 - A) Successfully complete a Pediatric Nurse Practitioner program or Pediatric Critical Care Nurse Practitioner Program and certification as an acute care pediatric nurse practitioner.
 - B) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the nurse practitioner shall have an unencumbered license in the state in which he or she practices.
 - C) Provide credentialing that reflects orientation, ongoing training, and specific demonstrated competencies in the care of the critically ill and injured pediatric patient, as defined by the hospital credentialing process.
 - 2) Clinical nurse specialists shall:
 - A) Successfully complete a clinical nurse specialist program that includes pediatrics.
 - B) Maintain pediatric clinical nurse specialist certification through a nationally recognized organization (AACN, ANCC or an equivalent national organization).
 - C) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the clinical nurse specialist shall have an unencumbered license in the state in which he or she practices.
 - D) Provide credentialing that reflects orientation, ongoing training, and specific demonstrated competencies in the care of the critically ill and injured pediatric patient, as defined by the hospital credentialing process.

- 1026 3) PA shall:
1027
1028 A) Hold a current Illinois Physician Assistant License. For out-of-
1029 state facilities that have Illinois recognition under the EMS,
1030 trauma, or pediatric program, the professional shall have an
1031 unencumbered license in the state in which the professional
1032 practices.
1033
1034 B) Provide credentialing that reflects orientation, ongoing training and
1035 specific demonstrated competencies in the care of the critically ill
1036 and injured pediatric patient as defined by the hospital
1037 credentialing process.
1038
1039 4) All full- and part-time nurse practitioners, clinical nurse specialists, and
1040 PAs shall successfully complete and maintain current recognition in ~~one of~~
1041 the following ~~course~~courses: the AHA-AAP or American Red Cross
1042 PALS ~~or ACEP-AAP-APLS~~. PALS ~~and APLS~~ shall include both
1043 cognitive and practical skills evaluation.
1044
1045 5) All full- and part-time nurse practitioners, clinical nurse specialists, and
1046 PAs shall have documentation of a minimum of 50 hours of continuing
1047 education in pediatric topics every two years that included a minimum of
1048 25 hours in pediatric critical care, and that are approved by an accrediting
1049 agency.
1050
1051 e) PICU Nursing Staff Requirements
1052
1053 1) Nurse manager. The PICU shall have a designated nurse manager who
1054 shall:
1055
1056 A) Be licensed as an RN;
1057
1058 B) Have the equivalent of three years full-time clinical critical care
1059 experience, with a minimum of one year in clinical pediatric care;
1060 and
1061
1062 C) Successfully complete and maintain current recognition in ~~one of~~
1063 the following ~~course~~courses: the AHA-AAP or American Red
1064 Cross PALS ~~or ACEP-AAP-APLS~~. PALS and ~~APLS~~ shall include
1065 both cognitive and practical skills evaluation.
1066
1067 2) Pediatric Clinical Nurse Expert. The PICU shall have a designated
1068 pediatric clinical nurse expert who is a member of the unit leadership and

1069 who facilitates the development, provision and conduction of clinical
1070 education, quality improvement, and policy development aimed at
1071 promoting pediatric evidence-based best practices. This nurse shall:
1072

- 1073 A) Successfully complete:
- 1074
 - 1075 i) An acute Care or Primary Care Pediatric Nurse Practitioner
1076 Program and hold certification as an acute care or primary
1077 care pediatric nurse practitioner;
 - 1078
 - 1079 ii) A Pediatric Clinical Nurse Specialist Program and hold
1080 certification as a pediatric clinical nurse specialist; or
 - 1081
 - 1082 iii) A masters or doctorate and hold certification as a certified
1083 pediatric nurse (CPN), certified critical care registered
1084 nurse in pediatrics (CCRN-P), or certified critical care
1085 registered nurse in pediatrics – knowledge professional
1086 (CCRN-K).
 - 1087
 - 1088 B) Hold a current Illinois RN license. For out-of-state facilities with
1089 Illinois recognition under the EMS, trauma, or pediatric program,
1090 the RN shall have an unencumbered license in the state in which he
1091 or she practices;
 - 1092
 - 1093 C) Successfully complete and maintain current recognition in ~~one of~~
1094 the following ~~course~~courses: the AHA-AAP or American Red
1095 Cross PALS ~~or ACEP-AAP-APLS~~. PALS, ~~and APLS~~ shall include
1096 both cognitive and practical skills evaluation; and
 - 1097
 - 1098 D) Provide documentation of a minimum of 50 hours of continuing
1099 education in pediatric topics every two years that include a
1100 minimum of 25 hours in pediatric critical care and that are
1101 approved by an accrediting agency.
 - 1102

1103 3) Nursing Patient Care Services

1104 All RNs engaged in direct patient care activities shall:

- 1105
- 1106 A) Successfully complete a documented hospital and unit orientation
1107 according to hospital guidelines before assuming full responsibility
1108 for patient care;
 - 1109
 - 1110 B) Complete a yearly competency review of high-risk, low-frequency
1111 procedures;

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- C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP or American Red Cross PALS, ~~the ACEP-AAP-APLS~~ or the ENA ENPC. PALS, ~~APLS~~ and ENPC shall include both cognitive and practical skills evaluation; and
- D) Complete a minimum of 16 hours of pediatric emergency/critical care continuing education hours every two years. 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 policies/protocols in place:

- 1) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;
- 2) A policy for managing the behavioral health/psychiatric needs of the PICU patient; and
- 3) Interprofessional treatment guidelines, clinical pathways, or protocols addressing ongoing assessment and management of high-risk 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.
- 4) Ensure current written transfer agreements are in place with those hospitals that transfer pediatric patients to your facility, and that each

1155 transfer agreement includes a provision that addresses communication and
1156 quality improvement measures between the sending and receiving
1157 hospitals, as related to patient stabilization, treatment prior to and
1158 subsequent to transfer, and patient outcome.

1159
1160 h) Quality Improvement Requirements

- 1161
- 1162 1) Each PCCC shall have members from the PICU, including the Medical
1163 Director, and from the Pediatric Department who serve on the
1164 Interprofessional Pediatric Quality Improvement Committee, which will
1165 include, but not be limited to: emergency department, pediatric
1166 department, respiratory, laboratory, social service and radiology staff.
1167
 - 1168 2) The Interprofessional Pediatric Quality Improvement Committee shall
1169 perform focused outcome analyses of its PICU and other pediatric
1170 inpatient unit services on a quarterly basis that consist of a review of at
1171 least the following:
 - 1172 A) All pediatric deaths;
 - 1173 B) All pediatric inter-facility transfers;
 - 1174 C) All pediatric morbidities or negative outcomes that are a result of
1175 treatment rendered or omitted;
 - 1176 D) Pediatric quality metrics that examine the process of care and
1177 identify potential patient care and internal resource problems;
 - 1178 E) Child abuse and neglect cases unless review is performed by
1179 another committee in the hospital;
 - 1180 F) All unplanned re-admissions within 48 hours after discharge from
1181 the emergency department or inpatient care that result in admission
1182 to the PICU (excluding patients scheduled for follow-up
1183 admission); and
 - 1184 G) Review of all potential and unanticipated adverse outcomes.

1185
1186 i) PICU Equipment (See Appendix [PΘ](#))
1187 The PCCC shall meet all equipment requirements as outlined in Appendix [PΘ](#). In
1188 addition, a specialized pediatric resuscitation cart shall be readily available on
1189 each pediatric unit, containing the required equipment.
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- 1198 j) Pediatric Inpatient Care Service Requirements
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1200 1) Physician Requirements
1201
1202 A) The Chair of Pediatrics or the Pediatric Inpatient Director shall
1203 have certification in pediatrics by the ABP or the AOBP.
1204
1205 B) All hospitalists, credentialed by their hospital to provide pediatric
1206 unit care, shall successfully complete and maintain current
1207 recognition in ~~one of~~ the following ~~course~~courses: the AHA-AAP
1208 or American Red Cross PALS ~~or the ACEP AAP APLS~~. PALS
1209 ~~and APLS~~ shall include both cognitive and practical skills
1210 evaluation.
1211
1212 C) The Medical Director of the PICU, or his/her designee, shall be
1213 available on call and for consultation for all pediatric in-house
1214 patients who may require critical care.
1215
1216 2) Nurse Manager Requirements
1217 The nurse manager shall:
1218
1219 A) Be licensed as an RN. For out-of-state facilities that have Illinois
1220 recognition under the EMS, trauma, or pediatric program, the RN
1221 shall have an unencumbered license in the state in which he or she
1222 practices;
1223
1224 B) Have the equivalent of three years full-time pediatric experience;
1225 and
1226
1227 C) Complete and maintain current recognition in one of the following
1228 courses: AHA-AAP or American Red Cross PALS, ~~the ACEP~~
1229 ~~AAP APLS~~ or the ENA ENPC. PALS, ~~APLS~~ and ENPC shall
1230 include both cognitive and practical skills evaluation.
1231
1232 3) Nursing Patient Care Services
1233 All nurses engaged in direct patient care activities shall:
1234
1235 A) Be licensed as an RN. For out-of-state facilities with Illinois
1236 recognition under the EMS, trauma, or pediatric program, the RN
1237 shall have an unencumbered license in the state in which he or she
1238 practices;
1239

- 1240 B) Complete a documented hospital and unit orientation according to
1241 hospital guidelines before assuming full responsibility for patient
1242 care;
1243
- 1244 C) Complete a yearly competency review of high-risk, low-frequency
1245 procedures based on patient population;
1246
- 1247 D) Complete and maintain current recognition in one of the following
1248 courses: AHA-AAP or American Red Cross PALS, ~~the ACEP-~~
1249 ~~AAP-APLS~~ or the ENA ENPC. PALS, ~~APLS~~ and ENPC shall
1250 include both cognitive and practical skills evaluation; and
1251
- 1252 E) Complete a minimum of 16 hours of pediatric continuing
1253 education hours every two years. Continuing education may
1254 include, but is not limited to, CEU offerings, case presentations,
1255 competency testing, teaching courses related to pediatrics, or
1256 publications.
1257
- 1258 k) Hospital General Pediatric Department Policies, Procedures and Treatment
1259 Protocols. The pediatric department shall have, but not be limited to:
1260
- 1261 1) A staffing policy that addresses nursing shift staffing patterns based on
1262 patient acuity;
1263
- 1264 2) A safety and security policy for the patient in the unit;
1265
- 1266 3) An intra-facility transport policy that addresses safety and acuity;
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- 1268 4) Interprofessional treatment guidelines, clinical pathways, or protocols
1269 addressing ongoing assessment and management of high-risk and low-
1270 frequency diagnoses;
1271
- 1272 5) A pediatric policy that addresses the resources available to meet the
1273 psychosocial needs of patients and family and appropriate social work
1274 referral for the following indicators:
1275
- 1276 A) Child death;
1277
- 1278 B) Child has been a victim of or witness to violence;
1279
- 1280 C) Family needs assistance in obtaining resources to take the child
1281 home;
1282

- 1283 D) Family needs a payment resource for their child's health needs;
- 1284
- 1285 E) Family needs to be linked back to their primary health, social
- 1286 service or educational system;
- 1287
- 1288 F) Family needs support services to adjust to their child's health
- 1289 condition or the increased demands related to changes in their
- 1290 child's health conditions; and
- 1291
- 1292 G) Family needs additional education related to the child's care needs
- 1293 to care for the child at home.
- 1294
- 1295 6) A discharge planning policy or protocol that includes the following:
- 1296
- 1297 A) Documentation of appropriate primary care/specialty follow-up
- 1298 provisions;
- 1299
- 1300 B) Mechanism to access a primary care resource for children who do
- 1301 not have a provider;
- 1302
- 1303 C) Discharge summary provision to appropriate medical care
- 1304 provider, parent/guardian, which includes the following:
- 1305
- 1306 i) Information on the child's hospital course;
- 1307
- 1308 ii) Discharge instructions and education; and
- 1309
- 1310 iii) Follow-up arrangements;
- 1311
- 1312 D) Appropriate referral of patients to rehabilitation or specialty
- 1313 services for children who may have any of the following problems:
- 1314
- 1315 i) Require the assistance of medical technology;
- 1316
- 1317 ii) Do not exhibit age-appropriate activity in cognitive,
- 1318 communication or motor skills, behavioral, or
- 1319 social/emotional realms;
- 1320
- 1321 iii) Additional medical or rehabilitation needs that may require
- 1322 specialized care, such as medication, hospice care, physical
- 1323 therapy, home health, or speech/language services;
- 1324
- 1325 iv) Brain injury – mild, moderate or severe;

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- 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 Interprofessional Pediatric Quality Improvement Committee (see subsection (h)).
- m) Equipment Requirements (See Section 515.Appendix ~~P~~Θ)
The PCCC shall meet all equipment requirements as outlined in Section 515.Appendix ~~P~~Θ. In addition, a specialized pediatric resuscitation cart shall be readily available on each pediatric unit, containing the required equipment.

(Source: Amended at 50 Ill. Reg. _____, effective _____)

1357 **Section 515.APPENDIX D Administrative, Legal and EMS Protocols and Guidelines**
1358

1359 Administrative, Legal and EMS Protocols and Guidelines shall include, but not be limited to the
1360 following:

1361 1) Administrative and Legal:

- 1362 • Patient disposition/selection of receiving facility
- 1363 • Patient choice and refusal regarding treatment, transport or destination
- 1364 • Patient abandonment
- 1365 • Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment
- 1366 (POLST)/Advance Directives/Health Care Power of Attorney (POA) status
- 1367 • When and how to notify a coroner or medical examiner
- 1368 • Appropriate interaction with law enforcement on the scene
- 1369 • The duty to perform all services without unlawful discrimination
- 1370 • Patient confidentiality and release of information/Health Insurance Portability
- 1371 and Accountability Act (HIPAA)
- 1372 • Appropriate interaction with an independent physician/nurse on the scene
- 1373 • Offering immediate and adequate information regarding services available to
- 1374 victims of abuse, for any person suspected to be a victim of domestic abuse
- 1375 • Mandated reporting policy
- 1376 • Relinquished newborn
- 1377 • Consent for treatment of minors
- 1378 • A policy that addresses the EMS System Participant safety, disinfection of
- 1379 EMS vehicles and equipment, and assessment, treatment, transport and
- 1380 follow-up of patients with suspected or diagnosed infectious diseases
- 1381 • Significant or high risk occupational exposure of EMS System Participants to
- 1382 an infectious disease, including notification to the designated infection control
- 1383 officer of the EMS provider agency following exposure
- 1384 • A policy concerning the use of latex-free supplies
- 1385 • Medical records documentation, retention, and reporting policy
- 1386 • Incident reporting/equipment malfunction/sentinel event reporting
- 1387 • Crisis response and medical surge/[multiple patient incidents](#) policy [that](#)
- 1388 [addresses both the adult and pediatric population](#)/~~multiple patient incidents~~
- 1389 • Professional ethical standards and behavioral expectations
- 1390 • Any procedures regarding disciplinary or suspension decisions and the review
- 1391 of those decisions that the System has elected to follow in addition to those
- 1392 required by the Act
- 1393 • A policy for notifying another EMS System of an EMT, EMT-I, AEMT,
- 1394 Paramedic, PHRN, PHAPRN, PHPA system suspension when that EMT,
- 1395 AEMT, EMT-I, Paramedic, PHRN, PHAPRN, PHPA is known to have dual
- 1396 participation with another EMS System.
- 1397
- 1398

- 1399 • Resource Hospital overrides (situations in which Associate Hospital orders are
- 1400 overruled by the Resource Hospital)
- 1401 • Protocols for ILS/AEMT and ALS personnel to assess the condition of a
- 1402 patient being initially treated in the field by BLS personnel, for the purpose of
- 1403 determining whether a higher level of care is warranted and transfer of care of
- 1404 the patient to the ILS or ALS personnel is appropriate; the protocols shall
- 1405 include a requirement that neither the assessment nor the transfer of care can
- 1406 be initiated if it appears to jeopardize the patient's condition, and shall require
- 1407 that the activities of the System personnel be under the immediate direction of
- 1408 the EMS MD or designee
- 1409 • A policy on treatment and transport of law enforcement animals
- 1410 • A policy on transport of a service/support animal
- 1411 • Any System policies regarding abuse of controlled substances or conviction of
- 1412 a felony crime by EMS Personnel, whether on or off duty
- 1413 • A Medication and Equipment Exchange Policy for System Participants
- 1414 • A policy for use of PPE during patient encounters
- 1415 • A policy on securing a weapon prior to transport of a patient
- 1416 • A policy on waste of controlled substance
- 1417 • Procedure/policy for provider notification when leaving the state for an
- 1418 EMAC or NAC response
- 1419 • A policy on additional healthcare personnel assisting in the transport of a
- 1420 patient in an ambulance, including but not limited to an RN, Physician or C.T.
- 1421 tech.
- 1422 • Requirements for EMS personnel who have identified an EMS system as
- 1423 secondary
- 1424 • Crisis response and medical surge policy
- 1425 • Complaint investigation including suspension
- 1426 • Storage and security of medication
- 1427 • A policy on identification of type of EMS patient care reports and crew
- 1428 member responsible for filling out patient care report for transport and non-
- 1429 transport EMS calls and submission of data
- 1430 • Policy for in system and out of system types of continuing education programs
- 1431 allowed
- 1432 • Replacement of medications and equipment for inter and intra facility
- 1433 transports
- 1434 • Notification of IDPH Division of EMS when an EMS crew member is killed
- 1435 in the line of duty
- 1436 • Policy on patient transport to a licensed mental health care facility
- 1437 • Policy on patient transport to a licensed urgent or immediate care facility
- 1438 • Policy requiring all licensed EMS personnel to participate in a process to
- 1439 physically demonstrate the correct use of defined pediatric-specific equipment
- 1440 minimally every recertification period
- 1441

- 1442 2) EMS Standing Medical Orders/Standard Operating Guidelines/Procedures
1443
1444
- **Cardiovascular:**
 - Adult and Pediatric Syncope and Pre-syncope
 - Chest Pain/Acute Coronary Syndrome (ACS)/ST-segment Elevation Myocardial Infarction (STEMI)
 - Tachycardia with a Pulse
 - Bradycardia with a Pulse
 - Heart Failure/Pulmonary Edema/Cardiogenic Shock
 - **Resuscitation:**
 - Cardiac Arrest (VF/VT/Asystole/PEA)
 - Adult Post-ROSC (Return of Spontaneous Circulation) Care
 - Determination of Death/Withholding or Termination of Resuscitative Efforts
 - **Respiratory:**
 - Airway/Ventilatory Management
 - Acute Respiratory Conditions
 - Chronic Respiratory Conditions
 - **Medical:**
 - Agitated or Violent Patient/Behavioral Emergency; Use of Restraints
 - Anaphylaxis and Allergic Reaction
 - Altered Mental Status
 - Hypoglycemia/Hyperglycemia
 - Pain Management
 - Seizures
 - Shock
 - Suspected Stroke/Transient Ischemic Attack
 - Nausea/Vomiting
 - Functional Needs/Special Needs Populations
 - **Pediatric Prehospital Protocols (BLS, ILS, AEMT and ALS):**
 - Initial Medical Care/Assessment
 - Initial Trauma Care/Assessment
 - Neonatal Resuscitation
 - Pediatric AED
 - Pediatric Allergic Reaction/Anaphylaxis
 - Pediatric Altered Mental Status
 - Pediatric Brief Resolved Unexplained Event (BRUE)
 - Pediatric Bradycardia
 - Pediatric Burns
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- 1485 ○ Pediatric Drowning
- 1486 ○ Pediatric Environmental Hyperthermia
- 1487 ○ Pediatric Hypothermia
- 1488 ○ Pediatric Nerve Agent/Organophosphate Antidote Guidelines
- 1489 ○ Pediatric Pulseless Arrest
- 1490 ○ BLS Pediatric Pulseless Arrest
- 1491 ○ ALS/ILS Asystole/PEA Pathway
- 1492 ○ ALS/ILS VF/VT Pathway
- 1493 ○ Pediatric Respiratory Distress
- 1494 ○ Pediatric Respiratory Distress with a Tracheostomy Tube/[Ventilator](#)
- 1495 ○ ~~Pediatric Respiratory Distress with a Ventilator~~
- 1496 ○ Pediatric Respiratory Failure
- 1497 ○ Pediatric Seizures
- 1498 ○ Pediatric Shock
- 1499 ○ Pediatric Tachycardia
- 1500 ○ BLS Pediatric Tachycardia
- 1501 ○ ALS/ILS Narrow QRS Pathway
- 1502 ○ ALS/ILS Wide QRS Pathway
- 1503 ○ Pediatric Toxic Exposures/Ingestions
- 1504 ○ Pediatric Trauma (~~with Head Trauma Addendum~~)
- 1505 ○ Suspected Child Abuse and Neglect
- 1506
- 1507 • **GI/GU/Gyne:**
- 1508 ○ Childbirth/Complicated and Uncomplicated Delivery
- 1509 ○ Newborn Care
- 1510 ○ OB Complications/All Trimesters
- 1511 ○ Obstetrical/Gynecological Conditions
- 1512
- 1513 • **Trauma:**
- 1514 ○ General Trauma Assessment/Management
- 1515 ○ Blast Injuries
- 1516 ○ Head/Facial/Neck Injury
- 1517 ○ Thoracic
- 1518 ○ Abdominal/Pelvic
- 1519 ○ Musculoskeletal Trauma/External Hemorrhage Management
- 1520 ○ Acute Spine Trauma and Selective Spine Precautions
- 1521 ○ Conducted Electrical Weapon (e.g., TASER)
- 1522 ○ Blunt, Penetrating and Perforating Injuries
- 1523
- 1524 • **Environmental:**
- 1525 ○ Hyperthermia/Heat Exposure
- 1526 ○ Hypothermia/Cold Exposure
- 1527 ○ Submersion Incidents

- 1528 ○ SCUBA Injury/Accidents
- 1529
- 1530 • **Burns:**
- 1531 ○ Electrical
- 1532 ○ Lightning/Lightening Strike Injury
- 1533 ○ Radiation Exposure
- 1534 ○ Thermal
- 1535 ○ Chemical
- 1536 ○ Inhalation
- 1537
- 1538 • **Toxins:**
- 1539 ○ Bites and Envenomation
- 1540 ○ Poisoning/Overdose Universal Care
- 1541 ○ Acetylcholinesterase Inhibitors (Carbamates, Nerve Agents,
- 1542 Organophosphates) Exposure
- 1543 ○ Stimulant Poisoning/Overdose
- 1544 ○ Central Nervous System Depressant Poisoning/Overdose
- 1545 ○ Cyanide Exposure
- 1546 ○ Hallucinogenic
- 1547 ○ Beta Blocker Poisoning
- 1548 ○ Calcium Channel Blocker Poisoning/Overdose
- 1549 ○ Carbon Monoxide/Smoke Inhalation
- 1550 ○ Biological Agents
- 1551
- 1552 (Source: Amended at 50 Ill. Reg. _____, effective _____)
- 1553

1554 **Section 515.APPENDIX K Application for Facility Recognition for Emergency**
1555 **Department with Pediatrics Capabilities**

1556
1557 FACILITY RECOGNITION
1558 Emergency Department with Pediatric Capabilities

1559
1560 Application Instructions

1561
1562 Follow these instructions to initiate the process to obtain recognition as an Emergency
1563 Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics
1564 (SEDP):

- 1565
1566 1) Complete the application form and obtain the appropriate signatures.
1567
1568 2) Using the Emergency Department Pediatric Plan Guideline and the EDAP or SEDP
1569 requirements, complete an Emergency Department Pediatric Plan. Attach all requested
1570 supporting documentation (credentialing forms, schedules, policies, procedures,
1571 protocols, guidelines, plans, etc.).
1572
1573 3) The Emergency Department Pediatric Plan shall follow the format outlined in the
1574 Emergency Department Pediatric Plan Guideline in this Appendix K and include all
1575 required documentation. The plan shall also address how each of the EDAP/SEDP
1576 requirements is currently being or will be met. The Pediatric Plan shall be developed
1577 through interaction and collaboration with the hospital disciplines as defined by the
1578 hospital.
1579
1580 4) The Pediatric Plan shall be submitted electronically as outlined by the EMSC Program
1581 using the electronic forms on the Department's Division of EMS website.~~The Emergency~~
1582 ~~Department Pediatric Plan shall follow the format outlined in the Emergency Department~~
1583 ~~Pediatric Plan Guideline in this Appendix K and include all required documentation. The~~
1584 ~~plan shall also address how each of the EDAP/SEDP requirements is currently being or~~
1585 ~~will be met. The Pediatric Plan shall be developed through interaction and collaboration~~
1586 ~~with all other appropriate disciplines.~~
1587
1588 5) Submit the original signed application form and one paper copy of the Emergency
1589 Department Pediatric Plan (including supporting documentation) using the tabbed
1590 dividers provided by the EMSC program to:

1591
1592 EMSC Coordinator, Division of EMS & Highway Safety
1593 Illinois Department of Public Health
1594 422 S. 5th Street
1595 Springfield IL 62701
1596 DPH.EMSCProgram@illinois.gov

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In addition, submit a digital application as outlined by the EMSC program using the electronic application forms on the Department's Division of EMS website. ~~(See Sections 515.4000 and 515.4010)~~

6) Maintain one paper copy, using tabbed dividers, for your files. ~~The application should be submitted in a single-sided format and unstapled.~~

75) Any submitted requests for equipment waivers 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.

87) Appendix M provides additional resource information related to pediatric inter-facility transfer and consultation and can be used in the development of the Emergency Department Pediatrics Plan.

98) For questions regarding the application process, specific requirements, or supporting documentation, please contact the Division of EMS & Highway Safety at 217-785-2080 or DPH.EMSCProgram@illinois.gov.

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 certifies that each requirement in this Request for Recognition is met and will be in operation by the date of recognition.

Typed name and title – CEO/Administrator

Email address – 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

Contact person – Phone number, fax number and email address

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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 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

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2. In addition, provide a separate Emergency Department Organizational Structure 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 he/she reports).

B. Emergency Department Services

1. Description of the emergency department services
 - a. 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.
 - b. Identify the age range that the hospital uses to define the pediatric patient, i.e., 0-15.
 - c. Provide information on participation/status in EMS system and trauma system as appropriate.
2. Description of the emergency department patient flow
 - a. Provide a narrative description or algorithm of patient path/flow from point of entry through disposition.
 - b. Provide any policies/guidelines that identify triaging/urgency categorization of patients.
 - c. Identify whether pediatric patients are seen in the general emergency department or in a separate area/bed space allocated for the pediatric patient.
 - d. 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
 - a. Provide a policy or narrative description of the emergency services dedicated phone/telemetry radio communication capabilities.

- 1693 b. Provide a policy outlining staffing qualifications to access and use such
1694 equipment.
1695
1696 4. Description of social service availability and capabilities
1697
1698 a. Provide a scope of services or policy that defines the services, capabilities
1699 and availability of social service department/personnel to the emergency
1700 department.
1701
1702 b. Describe typical mechanism and response by social worker to emergency
1703 department requests (i.e., handle over the phone, respond directly to the
1704 emergency department, follow-up consult/appointment made).
1705
1706 C. Pediatric Department Services
1707
1708 1. Description of the pediatric department services
1709
1710 a. Identify whether there is a dedicated pediatric inpatient unit, dedicated
1711 pediatric inpatient beds and pediatric intensive care unit.
1712
1713 b. Provide a scope of services/policy outlining pediatric department services.
1714
1715 2. Description of the pediatric staffing and availability
1716
1717 a. Provide policy or scope of services outlining pediatric unit shift nursing
1718 staffing patterns based on patient acuity and any pediatric continuing
1719 education requirements/competencies verification.
1720
1721 b. If pediatric patients are admitted for care to an adult inpatient unit, provide
1722 documentation that identifies unit pediatrician staffing/coverage for such
1723 patients and how RNs are assigned to the inpatient pediatric patient, i.e.,
1724 only RNs who have completed the PALS course.
1725
1726 3. Documented description of pediatric inpatient capabilities with identification of
1727 PICU and/or pediatric general floor bed availability and unit resources
1728
1729 a. Provide policy or scope of services that identifies what types of pediatric
1730 patients are typically admitted, i.e., types of conditions/diagnoses. Are
1731 there guidelines in place that define pediatric patients specifically by age
1732 parameters or diagnoses?
1733
1734 b. If a PICU is present, then a description of services, unit resources, and
1735 capabilities is needed. If a PICU is not present, then a description of

1736 where patients requiring such care are transferred, established
1737 relationships with pediatric tertiary care center, etc., is needed.
1738

1739 D. Professional Staff

1740
1741 1. Emergency Department Director

1742
1743 a. Submit a copy of the curriculum vitae or biosketch
1744

1745 b. Submit confirmation of Board Certification, as identified in the Facility
1746 Recognition Criteria (Sections 515.4000 ~~or~~ 515.4010), on the
1747 Emergency Department Physician Credentialing Form.
1748

1749 2. Emergency Department Physicians

1750 Documentation of the ability to meet recognition requirements in Section
1751 515.4000 or Section 515.4010.
1752

1753 Hospital Recognition Requirement – Section 515.4000(a)(1) or 515.4010(a)(1)

1754
1755 a. Provide a policy or description of emergency department physician
1756 staffing, coverage and availability (including fast track/urgent care area).
1757

1758 b. Provide a completed Department approved credentialing form for
1759 emergency department physician staff and a credentialing form for fast
1760 track/urgent care physicians.
1761

1762 c. Provide a one-month staffing schedule/calendar, including fast
1763 track/urgent care area (schedule should be from within the three month
1764 time period previous to the application submission).
1765

1766 d. Provide documentation of a plan to maintain PALS ~~or APLS~~-recognition.
1767

1768 e. Provide a policy that incorporates Section 515.4000(a)(1) or
1769 515.4010(a)(1).
1770

1771 Hospital Recognition Requirement – Section 515.4000(a)(2) or 515.4010(a)(2)

1772
1773 f. Provide a copy of the emergency department physician continuing
1774 education policy.
1775

1776 g. Provide a description of how physician continuing education is currently
1777 tracked.
1778

1779 h. Provide documentation of an implementation plan for attaining and
1780 tracking of pediatric specific continuing education hours (these hours can
1781 be integrated into the overall CME tracking process).
1782

1783 i. Provide a policy that incorporates Section 515.4000(a)(2) or
1784 515.4010(a)(2).
1785

1786 Hospital Recognition Requirement – Section 515.4000(a)(3) or 515.4010(a)(3)
1787

1788 j. EDAP applicants: Provide a staffing policy ~~for EDAP applicants~~ that
1789 incorporates Section 515.4000(a)(3) regarding physician coverage in the
1790 emergency department.
1791

1792 k. SEDP applicants: Provide a staffing policy ~~for SEDP applicants~~ that
1793 incorporates Section 515.4010(a)(3) regarding physician, nurse
1794 practitioner, clinical nurse specialist or physician assistant coverage. The
1795 policy shall define when a physician is consulted or called in at times
1796 when the emergency department is covered by one of these clinicians.
1797

1798 Hospital Recognition Requirement – Section 515.4000(a)(4) or 515.4010(a)(4)
1799

1800 l. Provide a one-month on-call schedule that identifies availability of a board
1801 certified/prepared pediatrician or pediatric emergency medicine physician
1802 for telephone consultation (schedule should be from within the three
1803 month time period previous to the application submission).
1804

1805 Hospital Recognition Requirement – Section 515.4000(a)(5) or 515.4010(a)(5)
1806

1807 m. EDAP applicants: Provide a copy of a policy that identifies physician
1808 backup availability (~~per Section 515.4000(a)(5) or physician, nurse~~
1809 ~~practitioner, clinical nurse specialist or physician assistant (per Section~~
1810 ~~515.4010(a)(5))~~ back-up availability to assist with critical situations,
1811 increased surge capacity or disasters.
1812

1813 SEDP applicants: Provide a copy of a policy that addresses physician,
1814 nurse practitioner, clinical nurse specialist or physician assistant backup
1815 availability (Section 515.4010(a)(5)) to assist with critical situations,
1816 increased surge capacity or disasters.
1817

1818 Hospital Recognition Requirement – Section 515.4000(a)(6) or 515.4010(a)(6)
1819

1820 n. Provide a protocol/policy/bylaws that identifies maximum response time
1821 for all specialty on-call physicians.

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3. Emergency department nurse practitioner, clinical nurse specialist, and PA
Note – Complete this section only if nurse practitioners, clinical nurse specialists,
or PAs practice in the emergency department and participate in the care of
pediatric patients.

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

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

- a. Provide a policy of emergency department nurse practitioner, clinical nurse specialist, and PA staffing, coverage, availability, responsibilities and credentialing process.
- b. Provide a completed Department approved credentialing form for all emergency department fast track nurse practitioner, clinical nurse specialist, and PA staff.
- c. Provide a copy of a one-month staffing schedule/calendar (schedule should be from within the three month time period previous to the application submission).
- d. Provide documentation of a plan to maintain PALS, ~~APLS~~ or ENPC recognition.
- e. Provide a policy that incorporates Section 515.4000(b)(1) or 515.4010(b)(1).

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

- f. Provide a copy of the emergency department and fast track nurse practitioner, clinical nurse specialist, and PA continuing education policy.
- g. Provide a description of how nurse practitioner, clinical nurse specialist, and PA continuing education is currently tracked.
- h. 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).
- i. Provide a policy that incorporates Section 515.4000(b)(2) or 515.4010(b)(2).

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4. Emergency Department Registered Nurses
Provide documentation of the ability to meet hospital recognition requirements in Section 515.4000(c) or 515.4010(c).

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

- a. Provide a policy/documentation outlining current nursing shift staffing plan/patterns.
- b. Provide a Department approved credentialing form for all emergency department nursing staff.
- c. Provide a copy of a one-month nursing staffing schedule/calendar (schedule should be from within the three month time period previous to the application submission).
- d. Provide documentation of a plan to maintain PALS, ~~APLS~~ or ENPC recognition.
- e. Provide a policy that incorporates Section 515.4000(c)(1) or 515.4010(c)(1).
- f. Provide a policy that describes annual competency review requirements for the pediatric population per Section 515.4000(c)(2) or 515.4010(c)(2).

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

- g. Provide a policy identifying continuing education requirements and competency testing for emergency department nursing staff.
- h. Provide a description of how continuing education is currently tracked.
- i. Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours.
- j. Provide a policy that incorporates Section 515.4000(c)(2) or 515.4010(c)(2).

E. Policies and Procedures

1. Policy/procedure for inter-facility transfer as identified in Section 515.4000(d)(1) or 515.4010(d)(1).

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- a. Provide a written transfer agreement with a Pediatric Critical Care Center and identification of facilities to which the hospital typically transfers pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the sending and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.
 - b. Provide a transfer policy that incorporates the physiologic/other criteria identified in Appendix M: EMSC Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline. The policy should also include a defined process for initiation of transfer, including the roles and responsibilities of the sending hospital and receiving hospital; a process for selecting the appropriate care facility; a process for selecting the appropriate 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 directions and receiving hospital information to the family.
2. Policy/procedure for suspected child abuse and neglect as identified in Section 515.4000(d)(2) or 515.4010(d)(2).
- a. Provide a policy that includes age-specific identification, assessment, evaluation and management measures for the suspected child abuse and neglect patient.
 - b. Provide an overview of your child abuse/neglect screening process, including screening questions within the electronic medical record (EMR).
3. Pediatric treatment guidelines as identified in Section 515.4000(d)(3) or 515.4010(d)(3).
- a. Provide copies of pediatric specific treatment guidelines as described.
 - b. The hospital shall have emergency department pediatric specific treatment guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).
4. Policy for latex allergy as identified in Section 515.4000(d)(4) or 515.4010(d)(4).
- Provide a policy that addresses assessment of latex allergies and the

- 1951 availability of latex-free equipment and supplies.
- 1952
- 1953 5. [Plan/policy for pediatric](#)~~Pediatric~~ disaster preparedness as identified in Section
- 1954 515.4000(d)(5) or 515.4010(d)(5).
- 1955
- 1956 a. Provide a copy of the Hospital Pediatric Disaster Preparedness Checklist
- 1957 that has been completed by the disaster/emergency management
- 1958 coordinator.
- 1959
- 1960 b. Provide a decontamination plan or policy that incorporates pediatric
- 1961 components.
- 1962
- 1963 c. Provide an evacuation plan or policy that incorporates pediatric
- 1964 components, including unit specific plans, policies, or considerations for
- 1965 the pediatric unit, pediatric intensive care unit, newborn nursery, and/or
- 1966 NICU (as applicable).
- 1967
- 1968 d. Provide a reunification plan or policy that incorporates pediatric
- 1969 components.
- 1970
- 1971 e) Provide a surge plan or policy that incorporates pediatric components.
- 1972
- 1973 fe. Provide a Multi-Year Training and Exercise Plan (MYTEP), Integrated
- 1974 Preparedness Plan (IPP) training and exercise plan, or equivalent that
- 1975 minimally addresses a three-year timeframe (and preferably begins with
- 1976 the current year).
- 1977
- 1978 F. Quality Improvement
- 1979
- 1980 1. Describe and document the ongoing emergency department program for
- 1981 conducting outcome analysis or quality improvement and how pediatrics is
- 1982 integrated into the process.
- 1983
- 1984 a. Provide a policy/guideline that outlines the emergency department quality
- 1985 improvement program, i.e., describe the quality improvement process,
- 1986 required clinical indicators, "loop closure" and target time frames for
- 1987 closure of issues.
- 1988
- 1989 b. Provide documentation outlining current and planned pediatric monitoring
- 1990 activities.
- 1991
- 1992 2. Document the ability to meet facility recognition requirements in Section
- 1993 515.4000(e) or 515.4010(e).

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

- a. Define the composition of the interprofessional QI 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.
- b. 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. If implementation of pediatric monitoring activities is pending, define implementation plan and time frame.
- c. Provide a plan for the conduction of interprofessional pediatric mock codes and debriefings.

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

- d. Provide a curriculum vitae or biosketch for the physician who will assume the pediatric physician champion role.
- e. Provide the curriculum vitae or resume of the individual who will assume the pediatric quality coordinator role.
- f. Provide a job description 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.

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 be identified, i.e., submission of a purchase order to assure that the item is on order, or equipment waiver shall be submitted for each item.

Requests for equipment waivers 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.

H. Outline of Site Survey Process
Site Survey Procedure

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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
 - h. The administrator of pediatric services, if applicable
 - i. [The pediatric physician champion](#)
 - ji. The pediatric quality coordinator
 - kj. The hospital quality improvement director or designee
 - lk. The hospital emergency management/disaster preparedness coordinator
 - ml. Nurse practitioner, clinical nurse specialist, or PA, for those hospitals that use these clinicians in their emergency department
 - nm. For EMS Resource or Associate Hospitals only: the EMS Medical Director and EMS Coordinator ([optional](#))

2079 3. In preparation for the site visit, hospital personnel shall prepare evidence to verify
2080 adherence to the hospital recognition requirements.

2081
2082 I. Hospital Professionals to Assist with Site Survey
2083 Site Survey Team

2084
2085 The EMSC program within the Division of EMS & Highway Safety will appoint the
2086 survey team. Site survey teams will be composed of a physician/nurse (or two nurse)
2087 team along with a representative from the Illinois Department of Public Health. All team
2088 members shall have attended formal training in the responsibilities, expectations, process
2089 and assessment of facility recognition.

2090
2091 J. Following the Site Survey

2092
2093 1. Within four to six weeks following the site visit, the Department will provide the
2094 hospital with the results of the survey. Those hospitals meeting all requirements
2095 will receive a formal "recognition" for their emergency department pediatric
2096 capabilities.

2097
2098 2. Hospitals may appeal the results of the survey by submitting a written request to
2099 the Illinois Department of Public Health, Division of EMS & Highway Safety.

2100
2101 3. Re-recognition shall occur every four years, with site visits scheduled as
2102 necessary.

2103
2104 (Source: Amended at 50 Ill. Reg. _____, effective _____)
2105

2106 **Section 515.APPENDIX L Pediatric Equipment Requirements for Emergency**
 2107 **Departments**

2108
 2109 The following list identifies pediatric equipment items that are required for the two emergency
 2110 department facility recognition levels. Equipment items are classified as "essential" (E) and
 2111 "need to be stocked in the emergency department" (ED).
 2112

	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/cardioverter with pediatric and adult sized paddles, or pads, with pediatric dosage settings and pediatric and adult pacing 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)
Otoscope/ophthalmoscope/stethoscope	E (ED)	E (ED)
Pulse oximeter with pediatric and adult probes	E (ED)	E (ED)
Sphygmomanometer with cuffs (neonatal-adult thigh)	E (ED)	E (ED)
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, syringe pumps, or devices with microinfusion capability using 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 medication transfer devices (i.e., T-connectors)	E (ED)	E (ED)
IV fluid/blood warmer	E (ED)	E (ED)
Syringes (1 mL through 20 mL)	E (ED)	E (ED)
Umbilical vein catheters (3.5 and 5 Fr; the same size feeding tube may be used for 5 Fr)*	E (ED)	E (ED)

Respiratory Equipment and Supplies

Bag-valve-mask device, self-inflating infant/child and adult (1000 ml) with O ₂ reservoir and clear masks (neonatal through large adult sizes)*; PEEP valve	E (ED)	E (ED)
Bulb syringe	E (ED)	E (ED)
Endotracheal tubes:*		
Cuffed or Uncuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5 and 8.0)	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)
Nasopharyngeal airways (sizes 14, 16, 20, 24, 28, 30 Fr)*	E (ED)	E (ED)

Nebulized medication, administration set with pediatric and adult masks	E (ED)	E (ED)
Oral airways (sizes 0, 1, 2, 3, 4, 5 or size 50 mm, 60 mm, 70 mm, 80 mm, 90 mm, 100 mm)*	E (ED)	E (ED)
Oxygen delivery device with flow meter and tubing	E (ED)	E (ED)
Oxygen delivery adjuncts:		
Tracheostomy collar	E (ED)	E (ED)
Standard masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Partial-non-rebreather or non-rebreather masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Nasal cannula (infant, pediatric and adult)	E (ED)	E (ED)
Peak flow meter	E (ED)	E (ED)
Supplies/kit for patients with difficult air way conditions (must have one of the following):	E (ED)	E (ED)
• Supraglottic airway devices (sizes 1.0, 1.5, 2.0, 2.5, 3.0, 4.0 and 5.0; or sizes appropriate for a neonate through adult);		
• Cricothyrotomy kit (pediatric size); or		
• Cricothyrotomy capabilities (i.e., 10 g needle and 3.5 mm ET tube adapter or 14 g needle and 3.0 mm ET tube adapter); or		
• Video laryngoscopy		
Suction capability (wall)	E (ED)	E (ED)
Suction capability (portable)	E (ED)	E (ED)
Suction catheters (sizes 5/6, 8, 10, 12, 14, 16, 18 Fr and Yankauer-tip catheter)*	E (ED)	E (ED)
Tracheostomy tubes (pediatric sizes 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 that 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 Fr)*	E (ED)	---

Medications (unit dose, prepackaged)

Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number at the nursing station or pre-programmed on unit phones	E (ED)	E (ED)
Activated charcoal (without Sorbitol)	E (ED)	E (ED)
Adenosine	E (ED)	E (ED)
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	E (ED)	E (ED)
Benzodiazepines, 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% or 50%)	E (ED)	E (ED)
Diphenhydramine	E (ED)	E (ED)
Dobutamine	E (ED)	---
Dopamine	E (ED)	---
Epinephrine (1 mg/mL and 0.1mg/mL)	E (ED)	E (ED)
Epinephrine (Racemic)	E (ED)	E (ED)

Fosphenytoin or Phenytoin	E (ED)	E (ED)
Furosemide	E (ED)	E (ED)
Glucagon or Glucose Paste	E (ED)	E (ED)
Insulin, regular	E (ED)	E (ED)
IV solutions: standard crystalloid solutions (D10W, D5/2 NS , D5/45 NS, D5/9 NS and 0.9 NS)	E (ED)	E (ED)
Lidocaine	E (ED)	E (ED)
Magnesium Sulfate	E (ED)	E (ED)
Mannitol or 3% Hypertonic Saline	E (ED)	E (ED)
Narcotics	E (ED)	E (ED)
Neuromuscular blocking agents (i.e., succinylcholine, rocuronium, vecuronium)	E (ED)	E (ED)
Ocular anesthetics	E (ED)	E (ED)
Poison Specific Antidotes		
Acetylcysteine	E (ED)	E (ED)
Cyanide antidote (Sodium Thiosulfate with or without Sodium Nitrite therapy; or Hydroxocobalamin single agent therapy)	E (ED)	E (ED)
Flumazenil	E (ED)	E (ED)
Naloxone	E (ED)	E (ED)
Sodium bicarbonate – 8.4% and 4.2%	E (ED)	E (ED)
Sedative/Hypnotic (e.g., Ketamine, Etomidate)	E (ED)	E (ED)
Tetanus Immune Globulin (Human)	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

Atomizer for intranasal administration of medication	E (ED)	E (ED)
Fluorescein (eye strips or eye drops) and blue light	E (ED)	E (ED)
Infant formulas and dextrose in water	E (ED)	E (ED)
<u>Medication and Equipment Resources</u>		
<u>Length or weight-based system for dosing and equipment</u>	<u>E (ED)</u>	<u>E (ED)</u>
<u>Resuscitation medication dosing guide based on kilogram weight</u>	<u>E (ED)</u>	<u>E (ED)</u>
Medication and Equipment Resources	E (ED)	E (ED)
• Length or weight-based system for dosing and equipment		
• Resuscitation medication dosing guide based on kilogram weight		
Nasogastric tubes 8 through-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 <u>various ages</u> age and languages	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/methods (e.g., papoose, distraction devices, comfort hold, swaddling)	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 (<u>locked</u> in kilograms only) for infants and children	E (ED)	E (ED)

Specialized Pediatric Trays

Lumbar puncture tray, including a selection of needle sizes (size 18-22 g, 1½-3 inch needle)	E (ED)	E (ED)
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Minor surgical instruments and sutures E (ED) E (ED)

Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel). Maintain each of the following newborn resuscitation equipment/supplies together for easy access (manometer, warming device, feeding tubes, neonatal mask, meconium aspirator). E (ED) E (ED)

Fracture Management Devices

Extremity splints 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 E (ED) E (ED)

2113

2114 * Shall minimally stock a range of small, medium and large sizes.

2115

2116 (Source: Amended at 50 Ill. Reg. _____, effective _____)

2117

2118 **Section 515.APPENDIX N Pediatric Critical Care Center (PCCC)/Emergency**
2119 **Department Approved for Pediatrics (EDAP) Recognition Application**

2120
2121 Application Instructions

2122
2123 Follow these instructions to initiate the process to request recognition as a Pediatric Critical Care
2124 Center (PCCC) and Emergency Department Approved for Pediatrics (EDAP). The Pediatric
2125 Plan shall be developed through interaction and collaboration with all appropriate disciplines:

- 2126
- 2127 1. Complete the Request for Recognition of Pediatric Critical Care Center and Emergency
2128 Department Approved for Pediatrics Status Application Form and obtain the appropriate
2129 signatures.
 - 2130
 - 2131 2. Using the Pediatric Critical Care Center Plan Application Guideline and the
2132 PCCC/EDAP requirements, complete a PCCC and EDAP Pediatric Plan. The Pediatric
2133 Plan should follow the Pediatric Critical Care Center Plan Application Guideline
2134 checklist format provided in this application and include all requested supporting
2135 documentation, including, but not limited to, scope of services/care, credentialing forms,
2136 policies (both administrative and department specific), procedures, protocols, guidelines,
2137 flow charts, rosters, calendars, schedules, etc.
 - 2138
 - 2139 3. Complete and obtain signatures on the Department-approved physician, nurse
2140 practitioner, clinical nurse specialist, physician assistant, and nursing credentialing forms.
 - 2141
 - 2142 4. Complete the EDAP, PICU and Pediatric Unit Equipment Checklists.
 - 2143
 - 2144 5. Submit the original signed application form and one paper copy of the hospital's Pediatric
2145 Plan ([including supporting documentation](#)) per the application instructions, [using tabbed](#)
2146 [dividers](#). In addition, submit a digital application using the electronic application forms
2147 on the Department's Division of EMS website. Both the paper copy and digital copy shall
2148 each contain the following:
2149
 - 2150 a. Signed Request for Recognition of Pediatric Critical Care Center ([PCCC](#)) and
2151 Emergency Department Approved for Pediatrics ([EDAP](#)) Status Application
2152 Form;
 - 2153
 - 2154 b. Completed PCCC Plan and EDAP Plan (including supporting documentation);
 - 2155
 - 2156 c. Completed physician, nurse practitioner, clinical nurse specialist, physician
2157 assistant, and nursing credentialing forms;
 - 2158
 - 2159 d. Completed EDAP, PICU and Pediatric Inpatient Unit Equipment Checklists.
 - 2160

- 2161 6. Submit these documents (including all supporting documentation) in the order listed in
2162 this application to: EMSC Coordinator, Division of EMS & Highway Safety, Illinois
2163 Department of Public Health, 422 S. 5th Street, Springfield IL 62701;
2164 DPH.EMSCProgram@illinois.gov.
2165
- 2166 7. Maintain one paper copy, using tabbed dividers, for your files~~The Pediatric Plan shall be~~
2167 ~~submitted in a single-sided format and unstapled.~~
2168
- 2169 8. Any submitted requests to waive any of the EDAP or PCCC equipment requirements
2170 shall include the criteria by which compliance is considered to be a hardship and shall
2171 demonstrate that there will be no reduction in the provision of medical care.
2172
- 2173 9. For questions regarding the application process, specific requirements, or supporting
2174 documentation, please contact the Division of EMS & Highway Safety at 217-785-2080
2175 or DPH.EMSCProgram@illinois.gov.
2176

2177 Site Survey Procedure
2178

- 2179 1. Within four to six weeks following the Department's receipt of the PCCC Pediatric Plan
2180 and supporting documents, the hospital will be informed as to the status of the
2181 application. If all documentation is in order, a site visit will be scheduled.
2182
- 2183 2. In preparation for the site visit, hospital personnel shall prepare evidence to verify
2184 adherence to the facility recognition requirements.
2185
- 2186 3. The site visit will include a survey of the Emergency Department, Pediatric Intensive
2187 Care Unit, Pediatric Units and a meeting with the following individuals:
2188
- 2189 a. chief administrative/executive officer or designee
2190
 - 2191 b. chief of pediatrics
2192
 - 2193 c. medical director of the pediatric intensive care services
2194
 - 2195 d. medical directors of the pediatric units
2196
 - 2197 e. medical director of pediatric ambulatory care
2198
 - 2199 f. nursing director or nurse manager of the pediatric intensive care services
2200
 - 2201 g. nursing director or nurse manager of the pediatric units
2202
 - 2203 h. pediatric clinical nurse expert

- 2204
- 2205 ih. administrator of pediatric services
- 2206
- 2207 ji. administrator of emergency services
- 2208
- 2209 kl. pediatric physician champion
- 2210
- 2211 lj. pediatric quality coordinator
- 2212
- 2213 mk. hospital quality improvement department director or designee
- 2214
- 2215 nl. emergency department medical director and the pediatric emergency department
- 2216 medical director
- 2217
- 2218 om. emergency department nurse manager and the pediatric emergency department
- 2219 nurse manager
- 2220
- 2221 pn. hospital emergency management/disaster preparedness coordinator
- 2222
- 2223 qe. transport team medical director
- 2224
- 2225 rp. transport team nurse coordinator
- 2226
- 2227 sq. Clinical nurse specialist, nurse practitioner or physician assistant for those
- 2228 facilities that use these clinicians
- 2229
- 2230 tf. For EMS Resource or Associate Hospitals: The EMS MD and EMS coordinator
- 2231

2232 Site Survey Team

2233

2234 The EMSC program within the Division of EMS & Highway Safety will appoint the site survey

2235 team. Site survey teams will be composed of a physician/nurse team along with a representative

2236 from the Illinois Department of Public Health. All team members will attend formal training in

2237 the site survey responsibilities, expectations and process.

2238

2239 Following the Site Survey

- 2240
- 2241 1. Within four to six weeks following the site visit, the hospital shall receive the results of
 - 2242 the survey from the Department. Those hospitals meeting all requirements will receive a
 - 2243 formal recognition of their Pediatric Critical Care capabilities.
 - 2244
 - 2245 2. Hospitals that do not meet the requirements will receive a letter from the Illinois
 - 2246 Department of Public Health outlining the areas of non-compliance. The Department

2247 shall deny a request for recognition if findings show failure to substantially comply with
2248 the EDAP and PCCC requirements. Hospitals may appeal the denial by submitting a
2249 written request to the Illinois Department of Public Health, Division of EMS & Highway
2250 Safety.

2251
2252 3. Re-recognition shall occur every ~~four~~^{three} years, with site visits scheduled as necessary.

2253
2254 ILLINOIS EMSC
2255 FACILITY RECOGNITION

2256 Request for Recognition of Pediatric Critical Care Center (PCCC) and
2257 Emergency Department Approved for Pediatrics (EDAP) Status

2258
2259 Application Form

2260 Name of hospital and address (typed)
2261
2262
2263

2264
2265 **The above-named hospital is requesting PCCC and EDAP recognition. In addition, the**
2266 **above-named hospital certifies that each requirement in this Request for Recognition is**
2267 **met.**

2268
2269 _____
Typed name and title – CEO/Administrator

Email address – 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

Signature – Medical Director of Emergency Services

Date

Emergency Department Contact Person – Typed name, credentials and title

Emergency Department Contact Person – Phone number, fax number and email address

Pediatric Inpatient Contact Person – Typed name, credentials and title

Pediatric Inpatient Contact Person – Phone number, fax number and email address

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(Source: Amended at 50 Ill. Reg. _____, effective _____)

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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)

EDAP Checklist

2316 Review the criteria in Section 515.4000(a)(1) and (2) for the physician staff qualifications and
2317 continuing medical education and submit each of the following:

- 2318
- 2319 A policy or medical staff bylaws that incorporate the physician qualifications and
 - 2320 CME requirements
 - 2321 A completed Credentials of Emergency Department Physicians form
 - 2322 A completed Credentials of Fast Track Physicians form
 - 2323 The curriculum vitae or biosketch for the ED medical director (that states their
 - 2324 role as the ED medical director)
 - 2325 A current one-month physician schedule for the ED
 - 2326 For physicians who meet alternate criteria as set out in Section 515.4000(a)(1)(D),
 - 2327 enclose the following: 1) a letter verifying hours worked by this physician, 2) a
 - 2328 copy of current AHA or American Red Cross PALS ~~or ACEP AAP APLS~~
 - 2329 certification, and 3) copies of 16 hours of pediatric CME completion over the past
 - 2330 two years

2331

2332 Review the criteria in Section 515.4000(a)(3) for the ED physician coverage and submit a policy
2333 that addresses this requirement.

2334

2335 Review the criteria in Section 515.4000(a)(4) for ED consultation and submit a one-month on-
2336 call schedule identifying availability of board certified/board prepared pediatricians or pediatric
2337 emergency medicine physicians.

2338

2339 Review the criteria in Section 515.4000(a)(5) for ED physician back-up and submit a policy that
2340 addresses this requirement.

2341

2342 Review the criteria in Section 515.4000(a)(6) for all on-call specialty physician response time
2343 and submit a policy that addresses this requirement.

2344

2345 Review the criteria in Section 515.4000(b)(1) and (2) for nurse practitioner, clinical nurse
2346 specialist and physician assistant qualifications and continuing medical education and submit the
2347 following (as applicable):

- 2348
- 2349 A policy(s) that incorporates the qualifications and continuing education
 - 2350 requirements of these practitioners
 - 2351 A completed Credentials of Emergency Department and Fast Track Nurse
 - 2352 Practitioner, Clinical Nurse Specialist, and Physician Assistant form
 - 2353 A current one-month schedule for the nurse practitioners/clinical nurse
 - 2354 specialists/physician assistants
 - 2355 For nurse practitioners who meet alternate criteria as set out in Section
 - 2356 515.4000(b)(1)(A)(i), enclose the following: 1) letter(s) verifying hours worked
 - 2357 by this nurse practitioner, 2) a copy of current AHA or American Red Cross

2358 PALS ~~or ACEP AAP APLS~~ certification, and 3) copies of 16 hours of pediatric
2359 CE completion over the past two years

2360

2361 Review the criteria in Section 515.4000(c)(1) and (2) for nursing qualifications and continuing
2362 education and submit the following:

2363

2364 A policy that incorporates the nursing qualifications and CE requirements

2365 A completed Credentials of Emergency Department Nursing Staff form

2366 A one-month nurse staffing schedule for the emergency department

2367 A policy(s) that describes annual pediatric competency review requirements per
2368 Section 515.4000(c)(2)

2369

2370 Review the criteria in Section 515.4000(d)(1) for inter-facility transfer and submit the following:

2371

2372 An inter-facility transfer policy that addresses pediatric transfers and includes all
2373 of the components defined in Section 515.4000(d)(1).

2374 A copy of all current pediatric-specific transfer agreements with hospitals that
2375 provide pediatric specialty services, pediatric intensive care and burn care not
2376 available at your facility

2377

2378 Review the criteria in Section 515.4000(d)(2) for suspected child abuse and neglect and submit a
2379 policy that addresses this requirement. Also submit an overview of the hospital's child
2380 abuse/neglect screening process, including screening questions within the electronic medical
2381 record (EMR).

2382

2383 Review the criteria in Section 515.4000(d)(3) for treatment protocols and submit all pediatric
2384 treatment protocols.

2385

2386 Review the criteria in Section 515.4000(d)(4) for the hospital latex allergy policy and submit a
2387 policy that addresses latex allergies and the availability of latex-free equipment and supplies.

2388

2389 Review the criteria in Section 515.4000(d)(5) for disaster preparedness and submit a completed
2390 hospital pediatric disaster preparedness checklist. In addition, submit the following:

2391

2392 A decontamination plan or policy that incorporates pediatric components

2393 An evacuation plan or policy that incorporates pediatric components, including
2394 unit specific plans, policies, or considerations for the pediatric unit, pediatric
2395 intensive care unit, newborn nursery, and/or NICU (as applicable)

2396 A reunification plan or policy that incorporates pediatric components

2397 A pediatric surge plan

2398 A Multi-Year Training and Exercise Plan (MYTEP) , Integrated Preparedness
2399 Plan (IPP) training and exercise plan, or equivalent that minimally addresses a
2400 three-year timeframe (preferably beginning with the current year)

2401

2402 Review the criteria in Section 515.4000(e)(1) for quality improvement activities and the
2403 interprofessional quality improvement committee and submit the following:

2404

2405 A quality improvement plan, including a QI policy, pediatric indicators, feedback
2406 loop and target time frames for closure of issues

2407 The composition of the interprofessional QI committee

2408 A plan for the conduction of interprofessional pediatric mock codes and
2409 debriefings

2410

2411 Review the criteria in Section 515.4000(e)(2) and (3) for the pediatric physician champion and
2412 the pediatric quality coordinator responsibilities and submit the following:

2413

2414 A curriculum vitae or biosketch for the pediatric physician champion that states
2415 their role as the Pediatric Physician Champion

2416 A curriculum vitae (or biosketch) and job description for the pediatric quality
2417 coordinator (that states their role as the PQC), and includes allocation of
2418 appropriate time and resources by the hospital to fulfill the PQC responsibilities;
2419 and outlines the responsibilities of the PQC as identified in 515.4000(e)(3)(A)
2420 through (E)

2421 Documentation detailing the participation of the pediatric quality coordinator in
2422 regional QI activities and how that has affected pediatric quality care in the ED

2423

2424 Review the criteria in Section 515.4000(f) for the list of emergency department equipment
2425 requirements and submit a completed checklist indicating the availability of all equipment.

2426

2427 Indicate in the pediatric plan whether each item is currently available. If equipment/supply items
2428 are not available, a plan for securing the items shall be identified (e.g., submission of a purchase
2429 order to assure that the item is on order) or an equipment waiver request shall be submitted for
2430 each item. Requests for waiver shall include the criteria by which compliance is considered to be
2431 a hardship and demonstrate that there will be no reduction in the provision of medical care.

2432

2433 B. PCCC Checklist

2434

2435 1. Hospital Requirements

2436

2437 Review the criteria in Section 515.4020(a) of the PCCC requirements as related to hospital
2438 resources and submit documentation identifying the ability to meet each of the following:

2439

2440 A scope of services/policy outlining PICU and Pediatric Inpatient resources and
2441 capabilities. Include any guidelines that outline pediatric admission criteria based
2442 on age parameters and diagnoses, and discharge criteria

- 2443 A list of the members of the Pediatric Interprofessional Committee, as well as
- 2444 their disciplines, to meet subsection (a)(3)
- 2445 A list of the members of the Pediatric Interprofessional Quality Improvement
- 2446 Committee, as well as their disciplines
- 2447 Documentation to substantiate that Section 515.4020(a)(4) (Helicopter landing
- 2448 capabilities) is met
- 2449 A statement regarding 24-hour availability to meet Section 515.4020(a)(5) (CAT
- 2450 scan)
- 2451 A statement regarding the ability to meet Section 515.4020(a)(6) (Laboratory)
- 2452 A statement of availability or transfer agreement to meet Section 515.4020(a)(7)
- 2453 (Hemodialysis capabilities)
- 2454 A statement or scope of service from each program identifying the availability of
- 2455 staff as required in Section 515.4020(a)(8) (Other staffing/services)
- 2456 A list of professional pediatric critical care educational trainings that staff have
- 2457 provided in the past year to meet Section 515.4020(a)(9) (include information on
- 2458 trainings held within the facility, within the region or surrounding geographic
- 2459 area)
- 2460 A list of pediatric emergency care classes that staff have provided in the past year
- 2461 to meet Section 515.4020(a)(10) (i.e., CPR, first aid, health fairs, etc., conducted
- 2462 for the patient population and the community, region or surrounding geographic
- 2463 area)
- 2464 Documentation of any pediatric research the facility has been engaged in during
- 2465 the past year to meet Section 515.4020(a)(11) (include the research project
- 2466 abstract, summary of projects or listing of research activities)
- 2467

II. PICU SERVICE REQUIREMENTS

A. Professional Staff

1. PICU Medical Director

2474 Review the criteria in Section 515.4020(b) for the Medical Director and Co-Director
2475 requirements and submit each of the following:

- 2476 A curriculum vitae or biosketch for the appointed PICU medical director
- 2477 A copy of board certification or verification of board certification
- 2478 A curriculum vitae or biosketch, and board certification for the co-director (as
- 2479 applicable – see Section 515.4020(b)(1)
- 2480

2. PICU Medical Staff Requirements

2484 Review the criteria in Section 515.4020(c) and submit each of the following:

2485

2486 PICU Medical Staff

- 2487 A policy outlining PICU physician staffing, coverage, availability, and CME
- 2488 requirements that incorporates Section 515.4020(c)(1)(A) and (B)
- 2489 A completed Credentials of PICU Physicians form that includes the medical
- 2490 director (and co-director as applicable)
- 2491 A one-month staffing schedule/calendar (schedule should be from within the
- 2492 three-month time period previous to the application submission)

2493

2494 Physician Specialist Availability (Section 515.4020(c)(2))

- 2495 A policy or by-laws that address the response time and on-call scheduling of
- 2496 pediatric surgeons
- 2497 A policy/process outlining board or sub-board certification or board preparedness
- 2498 for all specialist physicians
- 2499 A policy/process outlining how pediatric proficiency is defined and assuring that
- 2500 all specialist physicians maintain 20 hours of pediatric CME every two years
- 2501 A policy/process outlining anesthesiologist on-call staffing and response time, and
- 2502 subspecialty training in pediatric anesthesiology or pediatric proficiency as
- 2503 defined by institution. For Certified Registered Nurse Anesthetists, provide a copy
- 2504 of the by-laws that address their responsibilities and back up
- 2505 On-call schedules from the last month that list physician availability to meet
- 2506 Section 515.4020(c)(2)(~~DE~~) and (~~ED~~)

2507

2508 3. PICU Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant

2509 Requirements

2510

2511 NOTE – Complete this section only if physician assistants, clinical nurse

2512 specialists, or nurse practitioners practice in the PICU.

2513

2514 Review the criteria in Section 515.4020(d) and submit each of the following:

2515

2516 Nurse Practitioner, Clinical Nurse Specialist and Physician Assistant (Section 515.4020(d)(1),

2517 (2) and (3))

2518

- 2519 A policy outlining PICU nurse practitioner, clinical nurse specialist, and physician
- 2520 assistant staffing, coverage, availability, responsibilities and credentialing process
- 2521 A copy of a one-month staffing schedule/calendar (schedule should be from
- 2522 within the three-month time period previous to the application submission)
- 2523 A completed Credentials of PICU Nurse Practitioner, Clinical Nurse Specialist,
- 2524 and Physician Assistant form

2525

2526 Education (Section 515.4020(d)(4) and (5))

- 2527 A policy that incorporates ~~APLS~~, PALS or ENPC (Section 515.4020(d)(3))

- 2528 A copy of the PICU nurse practitioner, clinical nurse specialist, and physician
2529 assistant continuing education policy that incorporates Section 515.4020(d)(4)
2530 [and \(5\)](#)
2531

2532 4. PICU Nursing Staff Requirements
2533

2534 Review the criteria in Section 515.4020(e) and submit each of the following:
2535

2536 PICU Nurse Manager

- 2537 A curriculum vitae or resume for the PICU manager
2538 A policy or job description that incorporates Section 515.4020(e)(1)(C)
2539

2540 PICU Pediatric Clinical Nurse Expert

- 2541 A policy or job description of the role and responsibilities of the pediatric clinical
2542 nurse expert in the PICU
2543 A resume of the PICU pediatric clinical nurse expert
2544 A policy that incorporates Section 515.4020(e)(2)(C) and (D)
2545

2546 Nursing Patient Care Services

- 2547 A staffing policy that addresses nursing shift staffing patterns based on patient
2548 acuity
2549 A completed Credentials of PICU Nursing Staff form that includes the PICU
2550 nurse manager and PICU pediatric clinical nurse expert
2551 A policy or job description for the PICU nurse that outlines the orientation
2552 process to the unit responsibilities and the pediatric continuing education
2553 requirements that address Section 515.4020(e)(3)(C) and (D)
2554 A copy of a one-month nurse staffing schedule/calendar (schedule shall be from
2555 within the three-month time period previous to the application submission)
2556 A policy reflecting yearly competency review requirements for the PICU staff
2557

2558 B. PICU Policies, Procedures and Treatment Guidelines
2559

2560 Review the criteria in Section 515.4020(f) and submit each of the following:
2561

- 2562 A policy for managing the behavioral health/psychiatric needs of the PICU patient
2563 Interprofessional treatment guidelines, clinical pathways, or protocols addressing
2564 ongoing assessment and management of high-risk and low-frequency diagnoses
2565

2566 C. Inter-facility Transfer/Transport Requirements
2567

2568 Review the criteria in Section 515.4020(g) and submit each of the following:
2569

- 2570 A copy of the last annual report containing the number of annual transfers to the
- 2571 facility from transferring institutions
- 2572 A policy outlining the feedback process to transferring hospitals on the status of
- 2573 the referral patient and the methods for quality review of the transfer process that
- 2574 addresses requirements outlined in Section 515.4020(g)(1 and 4)
- 2575 Documentation outlining the pediatric inter-facility transport system capabilities
- 2576 and resources
- 2577

2578 D. Quality Improvement Requirements

2579 Review the criteria in Section 515.4020(h) and submit each of the following:

- 2580 [A list of the members of the Interprofessional Pediatric Quality Improvement](#)
- 2581 [Committee and their respective positions/disciplines](#)
- 2582
- 2583 An institutional Quality Improvement Organizational Chart
- 2584 The PICU outcome analysis plan and pediatric monitoring activities that meet
- 2585 Section 515.4020(h)(2) (minutes from the past year that reflect the activities of
- 2586 the Interprofessional Pediatric Quality Improvement Committee will be requested
- 2587 at the time of site survey)
- 2588
- 2589

2590 E. Equipment

2591 Review the criteria in Section 515.4020(i) and [the required equipment/supply items listed in](#)

2592 [Appendix P, and](#) submit the following:

2593

2594 Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply

2595 items are not available, a plan for securing the items shall be identified (e.g., submission of a

2596 purchase order to assure that the item is on order); if the item is not on order, an equipment

2597 waiver request shall be submitted for each item. Requests for an equipment waiver shall include

2598 the criteria by which compliance is considered to be a hardship and shall demonstrate that there

2599 will be no reduction in the provision of medical care.

2600

2601

2602 III. PEDIATRIC INPATIENT CARE SERVICE REQUIREMENTS

2603

2604 A. Professional Staff

2605

2606 1. Pediatric Unit Physician Requirements

2607

2608 Review the criteria in Section 515.4020(j) and submit each of the following:

- 2609 A curriculum vitae or biosketch and a copy of board certification for the pediatric
- 2610 inpatient director
- 2611

- 2612 [A roster of physician coverage of the pediatric units and identify any hospitalists](#)
- 2613 If pediatric hospitalists are used, [define their](#) ~~documentation that defines their~~
- 2614 scope of service, including their responsibilities to other attending physicians
- 2615 A completed Credentials of Pediatric Unit Hospitalists form
- 2616 A policy that incorporates Section 515.4020(j)(1)(B)
- 2617 A policy or scope of services outlining the responsibility of the PICU medical
- 2618 director or his/her designee as being available on call and for consultation on all
- 2619 pediatric in-house patients who may require critical care
- 2620

2621 2. Pediatric Unit Nurse Manager Requirements

2622

2623 Review the criteria in Section 515.4020(j)(2) and submit each of the following:

- 2624
- 2625 A curriculum vitae or biosketch for the pediatric unit manager
- 2626 A job description or policy incorporating Section 515.4020(j)(2)(C)
- 2627

2628 3. Pediatric Unit Nursing Care Services

2629

2630 Review the criteria in Section 515.4020(j)(3) and submit each of the following:

- 2631
- 2632 A staffing policy that addresses nursing shift staffing patterns based on patient
- 2633 acuity
- 2634 A policy describing annual competency review requirements for the pediatric
- 2635 nursing staff [based on high-risk, low-frequency procedures](#) (Section
- 2636 515.4020(j)(3)(B))
- 2637 A policy or job description for the pediatric unit nurse that outlines the orientation
- 2638 process to the unit responsibilities and continuing education requirements that
- 2639 address Section 515.4020(j)(3)(A) through (D)
- 2640 A copy of a one-month nursing staffing schedule/calendar (schedule shall be from
- 2641 within the three-month time period previous to the application submission)
- 2642 A completed Credentials for the Pediatric Unit Nursing Staff form that includes
- 2643 the Pediatric Unit Nurse Manager
- 2644

2645 B. Policies, Procedures and Treatment Protocols

2646

2647 Review the criteria in Section 515.4020(k) and submit each of the following:

- 2648
- 2649 A safety and security policy for the patient in the unit
- 2650 An intra-facility transport policy that addresses safety and acuity
- 2651 Interprofessional treatment guidelines, clinical pathways, or protocols addressing
- 2652 ongoing assessment and management of high-risk and low-frequency diagnoses

- 2653 A pediatric policy that addresses the resources available to meet the psychosocial
2654 needs of patients and family, and appropriate social work referral for the
2655 following indicators:
2656 1. Child death
2657 2. Child has been a victim of or witness to violence
2658 Family needs assistance in obtaining resources to take the child home
2659 3. Family needs a payment resource for their child's health needs
2660 Family needs to be linked back to their primary health, social service or
2661 educational system
2662 4. Family needs support services to adjust to their child's health condition or
2663 the increased demands related to changes in their child's health condition
2664 5. Family needs additional education related to the child's care needs to care
2665 for the child at home
2666 A discharge planning policy or protocol that includes the following:
2667 1. Documentation of appropriate primary care/specialty follow-up provisions
2668 2. Mechanism to access a primary care resource for children who do not have
2669 a provider
2670 3. Discharge summary provision to appropriate medical care provider,
2671 parent/guardian, that includes:
2672 • Information on the child's hospital course
2673 • Discharge instructions and education
2674 • Follow-up arrangements
2675 4. Appropriate referral of patients to rehabilitation or specialty services for
2676 children who may have any of the following problems:
2677 • Require the assistance of medical technology
2678 • Do not exhibit age-appropriate activity in cognitive,
2679 communication or motor skills, behavioral or social/emotional
2680 realms
2681 • Have additional medical or rehabilitation needs that may require
2682 specialized care, such as medication, hospice care, physical
2683 therapy, home health or speech/language services
2684 • Have a brain injury – mild, moderate or severe
2685 • Have a spinal cord injury
2686 • Exhibit seizure behavior during an acute care episode or have a
2687 history of seizure disorder and are not currently linked with
2688 specialty follow-up
2689 • Have a submersion injury, such as a near drowning
2690 • Have a burn (other than a superficial burn)
2691 • Have a pre-existing condition that experiences a change in health
2692 or functional status
2693 • Have a neurological, musculoskeletal or developmental disability
2694 • Have a sudden onset of behavioral change, for example, in
2695 cognition, language or affect

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C. Quality Improvement Requirements

Review the criteria in Section 515.4020(h) and (l) and assure appropriate documentation is submitted that address those sections of the checklist.

D. Equipment Requirements

Review the criteria in Section 515.4020(m) and [the required equipment/supply items listed in Appendix P, 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, an equipment waiver request shall be submitted for each item. Requests for an equipment 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.

(Source: Amended at 50 Ill. Reg. _____, effective _____)

2716 **Section 515.APPENDIX P Pediatric Critical Care Center (PCCC) Pediatric**
2717 **Equipment/Supplies/Medications Requirements**

2718
2719 All of the following equipment/supplies/medications shall be immediately available within the
2720 PICU and pediatric unit:
2721

AIRWAY

Cricothyrotomy capabilities (i.e., 10 g needle and 3.5 mm ET tube adapter or 14 g needle and 3.0 mm ET tube adapter)

Endotracheal tubes:

_____Uncuffed or Cuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 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)

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 0, 1, 2, 3, 4, 5)

Tracheostomy collar

Tracheostomy tubes (pediatric sizes 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 or ET may be substituted);

BREATHING

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

C-PAP or BiPAP device

End-tidal PCO2 monitor and/or pediatric CO2 detector (disposable units may be substituted)

Flow meter

Heated, humidified high flow oxygen

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 14, 16, 20, 24, 28, 30 Fr)

O2 Tank

O2 Blender

O2 connectors and spare O2 tubing

Partial non-rebreather O2 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

Arterial line monitoring capabilities (range of pediatric arterial catheter sizes; and transducers)
Blood collection tubes, culture bottles, arterial blood gas syringe
Butterfly needles (sizes 19, 21, 23, 25 g)
Cardiac resuscitation board
Catheter over needle IV access (sizes 16, 18, 20, 22, 24 g)
Central venous catheters (sizes 3 – 7 Fr)*
CVP monitoring capabilities
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 tubing and extension tubing
Infusion pumps, syringe pumps, or devices with microinfusion capability utilizing appropriate tubing and connectors
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 and medication transfer devices, i.e. T-connectors
Syringes (TB, insulin U100, 1 mL-20 mL and catheter tip)
Warming devices, age appropriate

MEDICATIONS

Access to the Illinois Poison Center 1-800-222-1222 through posting of the phone number at the nursing station or pre-programmed on unit phones
List of resuscitation medication dosages at patient bedside (based on child's kilogram weight)
Reference guide for appropriate sizing of equipment/supplies
Activated Charcoal
Adenosine
Albumin 5% and 25%
Amiodarone
AquaMEPHYTON
Atropine
Beta-agonist for inhalation
Beta Blockers, e.g. propranolol
Benzodiazepines, e.g., Lorazepam, Midazolam, Diazepam
Calcium Chloride 10%
Calcium Gluconate 10%
Dextrose 10%, 25% and 50%
Digitalis antibody

Digoxin
Diphenhydramine
Dobutamine
Dopamine
Epinephrine (1 mg/mL and 0.1 mg/mL)
Factor VIII, IX concentrate (pharmacy or blood bank)
Flumazenil
Furosemide
Glucagon
Insulin
IV solutions, standard crystalloid (D5W, D10W, D5/0.2 NS, D5/0.45 NS and 0.9 NS)
Kayexalate
Ketamine
Lidocaine
Magnesium sulfate
Mannitol or 3% Hypertonic Saline
Methylene blue
N-acetyl cysteine
Naloxone
Narcotics
Norepinephrine
Neuromuscular blocking agents (i.e., succinylcholine, pancuronium, vecuronium)
Oral rehydrating solution
Phenobarbital
Phenytoin and/or fosphenytoin
Potassium
Prostaglandin E1
Sodium Bicarbonate, 8.4% and 4.2%
Steroids – parenteral, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone
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
[Pain scale assessment tools appropriate for various ages and languages](#)
Weighing scales ([locked](#) in kilograms only) for infants and children

2722

2723

(Source: Amended at 50 Ill. Reg. _____, effective _____)