County ____________________________________

Date of Survey ______________________________

PRIMARY

Designated Level ____________________________

Type of Survey ______________________________

Name of Facility ____________________________________ Hospital License # ______________________

Address ____

Telephone (____) ____________________________________ Fax (_____) ___________________________

Manager / Director __________________________________ License / Certificate # ___________________

# of Bays ____

Surveyor's Signature _______________________________ Date _________________________________

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
ALL	1200-8-30-.01	100	PERSONNEL	DEFINITIONS		
ALL	1200-8-30-.01	101-136	PERSONNEL	1. ACLS. Advanced Cardiac Life Support 2. APLS. Advanced Pediatric Life Support 4. Board. Board for Licensing Health Care Facilities. 6. CPR. Cardiopulmonary Resuscitation 7. E. Essential 8. ECG. Electrocardiogram 9. ED. Emergency Department 10. EED. Essential in Emergency Department 11. EED&EPI. Essential in Emergency Department and Pediatric Intensive Care Unit 12. EH. Essential in Hospital 13. EMS. Emergency Medical Service 14. EMSC. Emergency Medical Service for Children 15. ENPC. Emergency Nursing Pediatric Course 16. EP. Promptly available 17. EPI. Essential in Pediatric Intensive Care Unit only 18. ES. Essential Service 20. ICP. Intracranial Pressure 21. IM. Intramuscular 22. IV. Intravenous 23. OR. Operating Room 24. PA. Physician's Assistant 25. PALS. Pediatric Advanced Life Support 27. PICU/PI. Pediatric Intensive Care Unit 29. QA. Quality Assurance 30. QI. Quality Intervention 31. RN. Registered Nurse	1) Pediatric patients: up to the 18th birthday 2) Pediatric Emergency Care Facility (PECF): All hospitals in Tennessee that have emergency care capability are Pediatric Emergency Care Facilities. These regulations are designed to assist health care facilities in Tennessee meet the emergency care needs of children. 3) Pediatric Facility Notebook (PFN): Each facility will maintain a Pediatric Facility Notebook containing key elements for documentation of pediatric care in the facility. Sections in the PFN include: Summary, Personnel, QI, Transfer and Transport, Education, and Data. All referenced Bylaws, Policies and procedures, and Report documents should be maintained in the PFN. An annual report for each level of facility of pediatric admissions including age, diagnosis, length of stay, and outcomes, such as transfers and deaths should be kept in the PFN. This report should also include pediatric ED visits and disposition. 4) Regional Participating Institution:	PFN tabs set up for: 1) Summary 2) Personnel 3) QI 4) Transfer & Transport 5) Education 6) Data Regulations designated as DATA/QI may be found in either section of the PFN. Some documentation may be kept in different places as noted in this interpretive guideline. Evidence of competency for staff such as listing of all patient care staff, their certifications and competency/skills evaluations with expiration dates. See Tags 301 and 501-510.

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				32. RRT. Registered Respiratory Therapist 33. SE. Strongly Encouraged if such services are not available within a reasonable distance. 34. Trauma. A physical injury or wound caused by external force or violence. 36. TRACS. Trauma Registry of American College of Surgeons	Lower level facilities networking with a Comprehensive Regional Pediatric Center. 5) Stabilized patient: The stabilized pediatric patient will have medical treatment of the emergency condition provided to minimize material deterioration during transfer. This includes having the airway managed, breathing established and circulatory support rendered when appropriate. The facility should provide evidence of competency using pertinent pediatric equipment and evidence of pediatric emergency training/competency. 6) Family Centered Care (FCC): Family centered care is an approach to health care that focuses on the relationships between families and health care providers. Family centered care emphasizes the vital role that families play in ensuring the health and well-being of infants, children, and adolescents.	Family Centered Care: examples of how facility incorporates FCC principles into its patient care processes.
PRIMARY	1200-8-30-.01(28)	128	SUMMARY	DEFINITIONS 28. Primary Pediatric Emergency Facility. The facility shall provide the same services as a Basic Pediatric Emergency Facility and shall have limited capabilities for the management of minor pediatric inpatient problems and may accept appropriate transfers of pediatric patients when there is no facility with more comprehensive capabilities available within a region.	The Primary Facility is the lowest level with physician coverage in the ED 24h/day, and access to general surgery/anesthesia coverage. This level may take transfers if appropriate services are available.	

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
ALL	1200-8-30-.02	200		LICENSING PROCEDURES		
ALL	1200-8-30-.02 (1)	201	SUMMARY	The hospital shall designate the classification of Pediatric Emergency Care Facility it will maintain and the level of care it will provide and submit this information to the Department of Health on the joint annual report.	Signage prominently placed in the Emergency Department should indicate the designation for each facility. Documentation of designation is included in the joint annual report to the Department of Health.	Copy of facility's joint annual report.
ALL	1200-8-30-.03	300		ADMINISTRATION		
ALL	1200-8-30-.03 (1)		SUMMARY	ADMINISTRATION. The hospital administration shall provide the following: (See below)	Hospital mission statement explicitly makes commitment to pediatric patients in accordance with requirements for the level of designation.	Copy of hospital mission statement.
ALL	1200-8-30-.03 (1) (a)	301	PERSONNEL	Adequate and properly trained personnel to provide the services expected at the designated Pediatric Emergency Care Facility classification.	Required medical, nursing staff roster including name, appropriate certification and training for each title as outlined in regulations. (See Tag 510). 1. Primary: ☐ ED Physicians, ☐ ED Nurses, ☐ Respiratory Therapists	Staff roster listing staff certifications, orientation outline for each position, and continuing education.
ALL	1200-8-30-.03 (1) (a)	301	PERSONNEL		On-Call lists to be maintained and available in PFN (Personnel section) for previous 12 months: Primary: ☐ Pediatrician or Family Practitioner, ☐ General Surgery, ☐ Radiology/Teleradiology, ☐ Anesthesiologist/Anesthetist	Copies of call lists for current & previous 12 months in PFN (Personnel Section).
ALL	1200-8-30-.03 (1) (b)	302	SUMMARY	The financial resources to provide the emergency department or the pediatric emergency department with the equipment necessary to provide the level of services of the designated PECF classification.	Corrective plan for any equipment not present or budgeted for.	

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ALL	1200-8-30-.03 (1) (c)	303	SUMMARY	Facilities designed for easy access and appropriate for the care of pediatric patients at the designated PECF classification.	Tour of ED and other patient care areas to assess: easy access for patients and emergency vehicles, clear signage, handicap access, and readily available parking. Sites of pediatric inpatient care in primary and general facilities should be visited, as well as the PICU in the CRPC. Appropriate for the care of pediatric patients means that some ability of physically isolating the pediatric patient from non-pediatric patients in the ED exists. It should be evident that FCC is a priority for the institution in its planning for pediatric patients. This should include sharing of medical information with parents, facilitation of parent/professional collaboration, recognition of families' method of coping, and the provision of direct emotional support to families. This includes provision for the ability to communicate with patients and primary caregivers who are deaf and special communication situations such as need for interpreter access if the facility regularly provides to non-English speaking families. Separation of child and parent for emergency care should be minimized by policy of the ED and, if applicable, the PICU.	1. Tour to demonstrate: o Easy access o Clear signage o Handicapped access o Readily available parking o Ability to physically isolate pediatric patients from non-pediatric patients in ED. 2. Refer also to Tag 100: Demonstrate how Family Centered Care principles are incorporated into patient care. 3. Demonstrate how staff members communicate with parents who are hearing impaired or non-English speaking. 4. Policy(s) minimizing separation of child and parent for emergency care.
ALL	1200-8-30-.03 (1) (d)	304	SUMMARY	Access to emergency care for all urgent and emergent pediatric patients regardless of financial status.	Bylaws or policies in the ED should assure no delays occur while checking on insurance status. The total number and percent of pediatric patients who leave the ED without being seen or without medical screening exam should be reviewed at least quarterly by the medical executive committee and/or quality improvement committee and be	1. Policy: no delays while checking insurance status. 2. Report: total number and percent of pediatric patients who leave the ED without being seen or without a medical screening exam. 3. Meeting minutes reflecting at least quarterly review by the

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					reflected in the minutes.	medical executive committee and/or QI committee.
ALL	1200-8-30-.03 (1) (e)		SUMMARY	Participation in a network of pediatric emergency care within the region where it is located by linking the facility with a regional referral center to: (See below)	A summary paragraph outlining the institution's role in a network of regional care and within the EMSC system in TN to address: o capability for caring for ED, ICU, medical and surgical pediatric patients, o plans for types of transport available for selected patients, with the relationship to other facilities in the region specified, o scope of professional training, o any institutional problems within the network along with plans of action to rectify, and o any problems regarding inaccessibility to pediatric courses, transfer/transport issues, and interfacility issues with a summary of steps taken to assure improvement. General/Primary/Basic Facilities: Demonstrate means of access to 24hrs/day consultation with a CRPC from the ED and other patient care areas treating pediatric patients.	
BASIC, PRIMARY and GENERAL	1200-8-30-.03 (1) (e) 1	305	TRANSFER & TRANSPORT	guarantee transfer and transport agreements;	All Basic, Primary, and General pediatric emergency care facilities shall have a transfer agreement in place with at least one CRPC. Basic and primary facilities may also have an agreement with a general pediatric emergency care facility in the region.	Copy of transfer agreement(s) with CRPC(s). Basic / Primary: Copy of transfer agreement with general facility if no CRPC transfer agreement is in place.
ALL	1200-8-30-.03 (1) (e) 2	306	TRANSFER & TRANSPORT	refer seriously and critically ill patients and special needs patients to an appropriate facility; and	Transfer agreements should be in place which specifically list seriously and critically ill and special needs patients. A log of referrals to a CRPC should be	Copy of transfer log that lists: o All pediatric patients referred/transferred. o Includes patients transferred

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					maintained, including transfers from patient floor, ICU, and ED. Patient transfer policy for the facility specifically requires documentation of consultation with the family prior to transfer including discussion of risks of transfer vs. benefit.	from ED, floor, and ICU. Copy of facility's transfer policy with required elements
ALL	1200-8-30-.03 (1) (e) 3	307	TRANSFER & TRANSPORT	assure the support of agreements to receive or transfer appropriate patients.	A record of all transfer and transport agreements should be maintained by hospital administration to assure the ability to promptly transfer or receive emergent pediatric patients. Transfer agreements should specifically reference seriously and critically ill and special needs pediatric patients.	1. List of facilities that your facility has transfer agreements with. 2. Copy of agreement demonstrating specific reference to seriously and critically ill and special needs pediatric patients.
ALL	1200-8-30-.03 (1) (f)	308	EDUCATION	A collaborative environment with the Emergency Medical Services and Emergency Medical Services for Children systems to educate pre-hospital personnel, nurses and physicians.	1. An education summary that includes records of participation by an institution's staff in education and outreach to area pre-hospital personnel, nurses, and physicians should be maintained in the PFN (Education section) as well as identifying personnel at the institution participating in this training. o Examples of training: PALS, PBTLS, BTLS, assessment classes, monthly case conferences, and child death reviews (pathology, police dept, MSSW, nursing, physician) which include the following groups: local fire departments, ambulance services, and community college paramedic/EMT programs. 2. Demonstration of how FCC principles are integrated in programs and how family representatives, which are not hospital employees, participate as	

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					faculty or advisors for training. 3. Basic / Primary / General Facilities: Demonstration of collaboration with CRPC: o Continuing education o Regional and state research and data collection o Quality indicators	
ALL	1200-8-30-.03 (1) (g)	309	DATA/QI	Participation in data collection to assure that the quality indicators established by the regional resource center are monitored, and make data available to the regional resource center or a central data monitoring agency.	As monitors are developed by the Committee for Pediatric Emergency Care or regional CRPCs, documentation of participation in data collection and submitted data must be available for review in the PFN (Data/QI Section). Documentation of annual collaboration with a CRPC shall be present.	
ALL	1200-8-30-.03 (1) (h)	310	TRANSFER & TRANSPORT DATAQI	Linkage with pre-hospital care and transport.	1 Summary of local destination guidelines in PFN (Transfer and Transport Section). 2 Pediatric pre-hospital protocols and the facility's involvement in development and review of these protocols in PFN (Transfer and Transport section). 3 Documentation of follow-up on variances from local guidelines or protocols in PFN (Data/QI section).	
ALL	1200-8-30-.03 (1) (i)	311	EDUCATION	Public education regarding access to pediatric emergency care, injury prevention, first aid and cardiopulmonary resuscitation.	1 Documentation of annual collaboration with a CRPC containing education planning and participation for the region. 2 Statement of support for public education and an institutional plan for local and regional involvement. 3 Records of participation in regional media, school, parent, or medical	Examples of documentation of collaboration with CRPC may include but is not limited to meeting minutes, site visits with summaries, and maintaining files with interactions of the various facilities.

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
					provider education. 4 Documentation of public education such as health fairs, PBLS & other public classes, newspaper articles, hospital publications, school visits, community talks, and infant CPR. 5 Public education includes the roles and responsibilities of families in response to pediatric emergencies and promotes FCC principles as best practice. 6 Policies concerning parents seeking telephone advice. 7 For programs offering ED advice to the public, appropriate training, clear protocols, careful documentation & routine monitoring should be in place. 8 All facilities shall have a pediatric liaison who is responsible for communicating with the hospital's designated CRPC Coordinator. Should this designated pediatric liaison change, notification to the CRPC Coordinator must be made.	Examples of promotion of FCC principles must be present among the documentation of public education, including considerations of age appropriateness, literacy, cultural and language issues for the population served.
ALL	1200-8-30-.03 (1) (j)		DATA/QI	Incorporation into the hospital existing quality assessment and improvement program, a review of the following pediatric issues and indicators: (See below)	These items should be specifically included in the written QI plan. The pertinent sections of the plan, along with a summary report of these indicators, should be available in the PFN with quarterly breakdown by indicator and QI or medical executive committee recommendations based on data review.	1 Written QI plan that addresses these items specifically. 2 Summary report of indicators with quarterly breakdown and committee recommendations based on QI or medical executive committee data review.
ALL	1200-8-30-.03 (1) (j) 1	312	DATA/QI	deaths;	Hospital bylaws should assure that all pediatric deaths are reviewed and this review is reported to QI Committee and/or Medical Executive Committee	Copy of Hospital bylaws assuring all pediatric deaths are reviewed & review reported to appropriate committee(s).

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
ALL	1200-8-30-.03 (1) (j) 2	313	DATA/QI	incident reports;	Review for trends and plan of action.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
ALL	1200-8-30-.03 (1) (j) 3	314	DATA/QI	child abuse cases;	Review for appropriate follow-up.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
ALL	1200-8-30-.03 (1) (j) 4	315	DATA/QI	cardiopulmonary or respiratory arrests;	Outcome of arrests subcategorized as cardiopulmonary or respiratory should be included in QI data.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
ALL	1200-8-30-.03 (1) (j) 5	316	DATA/QI	admissions within 48 hours after being discharged from the emergency department;	Hospital QI reports or QI plan should include documentation that these admissions are reviewed by a medical staff committee and reported to medical executive committee.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
ALL	1200-8-30-.03 (1) (j) 6	317	DATA/QI	surgery within 48 hours after being discharged from an emergency department;	Hospital QI reports or QI plan should include documentation that these admissions are reviewed by a medical staff committee and reported to medical executive committee.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review.
ALL	1200-8-30-.03 (1) (j) 7	318	DATA/QI	quality indicators requested by the Comprehensive Regional Pediatric Center or state/local Emergency Medical Services for Children authority regarding nursing care, physician care, pre-hospital care and the medical direction for pre-hospital providers of Emergency Medical Services systems;	Documentation of collaboration with a CRPC is required by Basic, Primary and General facilities to assure regional and state quality indicators are monitored and data shared. A quality indicator for physician care and nursing care should include patient/family survey data regarding pediatric ED visits at the institution.	Summary report of indicators with quarterly breakdown and committee recommendations based on data review: o Patient/family survey data regarding physician and nursing care delivered during pediatric ED visits.

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
ALL	1200-8-30-.03 (1) (j) 8	319	TRANSFER & TRANSPORT	pediatric transfers; and	Log of pediatric transfers listing: o department of the hospital transferred from (ED vs. patient floor vs. ICU), o mode of transport/transfer, o length of stay prior to transport, and o patient outcomes after transport. CRPC: o List of transferred patients (received and transferred). o Demonstrate how outcome data is made available to referring hospitals (transfers received). o Summary Report included in PFN (Transfer & Transport section).	
ALL	1200-8-30-.03 (1) (j) 9	320	DATA/QI	pediatric inpatient illness and injury outcome data.	Specific monitors as defined for TN EMSC by the Committee for Pediatric Emergency Care (or other designated Tennessee EMSC entity) or regional CRPCs shall be maintained by each pediatric facility.	
ALL	1200-8-30-.04	400		**Admissions, Discharges and Transfers**		
BASIC, PRIMARY and GENERAL	1200-8-30-.04 (1)	401	TRANSFER & TRANSPORT	A Basic, Primary, or General Facility shall be capable of providing resuscitation, stabilization and timely triage for all pediatric patients and, when appropriate, transfer of patients to a higher-level facility. A Basic, Primary, or General Pediatric Emergency Facility is responsible for having appropriate transfer agreements to assure that all pediatric patients receive timely emergency care at the most appropriate pediatric facility available to a specific region. Each facility shall be linked with a Comprehensive Regional Pediatric Center for pediatric consultation.	See Tags 101, 102, 103, 305, 306, and 307. The QI program should include monitoring of the timeliness of transfers. Adverse outcomes review should include evaluation of the timeliness of care and any needed transfers.	

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PRIMARY	1200-8-30-.04 (2)	402	TRANSFER & TRANSPORT	A Primary Emergency Care Facility shall support Basic Facilities within a region when necessary by having prearranged triage and transfer agreements to receive appropriate patients as a part of a regional pediatric care network.	See Tags 101, 102, 306, and 308. Review summary paragraph in PFN (Transfer and Transport section) to define facilities role in region. Primary facilities shall support Basic facilities with transfer agreements in regions without close proximity to a General facility or CRPC when appropriate. Assess the physical location in the hospital for pediatric admissions in Primary facilities.	
ALL	1200-8-30-.05	500		BASIC FUNCTIONS		
ALL	1200-8-30-.05 (1)			Medical Services. (See below)		

PRIMARY and GENERAL	1200-8-30-.05 (1) (b)	502	PERSONNEL	A Primary or General Pediatric Emergency Facility shall have an emergency physician in-house 24 hours per day, 7 days per week. The emergency department physician shall be competent in the care of pediatric emergencies including the recognition and management of shock and respiratory failure, the stabilization of pediatric trauma patients, advanced airway skills (intubation, needle thoracostomy), vascular access skills (including intraosseous needle insertion), and be able to perform a thorough screening neurologic assessment and to interpret physical signs and laboratory values in an age-appropriate manner. For physicians not board-certified board prepared by the American Board of Emergency Medicine, successful completion of courses such as Pediatric Advanced Life Support (PALS) or the American Academy of Pediatrics and American College of Emergency Physician's Advanced Pediatric Life Support (APLS) can be utilized to demonstrate this clinical capability. A pediatrician or family practitioner, general surgeon with trauma	See Tag 301.
					An ED physician roster shall be available for review. Credentials Committee documents shall be available for review of institutional credentialing in required skills: the recognition and management of shock and respiratory failure, the stabilization of pediatric trauma patients, advanced airway skills (intubation, needle thoracostomy), vascular access skills (including intraosseous needle insertion), and the ability to perform a thorough screening neurologic assessment and to interpret physical signs and laboratory values in an age-appropriate manner, training, CME course work (PALS, APLS, or other), and medical specialty Board status must be provided. The on-call general surgeon should be credentialed in trauma care. All physicians on the physician roster shall be able to demonstrate competency through PALS, APLS, ABEM, or ABOEM certification, or other (CME/letters from training/medical directors) means for the skills listed for caring for pediatric emergencies. In
						o ED physician roster
						o ED physicians competency demonstrated by:
						  o Board certified / admissible by American Board of Emergency medicine, or
						  o PALS, APLS, ABEM, or ABOEM certification, or CME / letters from training /medical directors can be used to demonstrate clinical competency (copy of valid cards).
						o Available for review: Credentials committee documentation of institutional credentialing in required skills.
						o On-call rosters for:
						  o pediatrician, or family practitioner,
						  o general surgeon with trauma experience,

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
				experience, anesthetist/anesthesiologist, and radiologist shall be promptly available 24 hours per day.	addition, on-call rosters for pediatrics or family practice, general surgery, anesthetist / anesthesiology, and radiology shall be available in the PFN (Personnel section). Medical executive committee minutes should reflect periodic review of response time issues for on-call physicians with plans for the correction of any deficiencies. Family practitioner is defined as an MD or DO licensed under Title 63, Chapter 6 or 9. Teleradiology services are acceptable at primary facilities as equivalent to radiologist available 24 hours per day.	o anesthetist / anesthesiologist, o radiologist (tele-radiology services acceptable at Primary facilities). o Medical Executive Committee periodic review of on-call physician response times & plans for correction of any deficiencies.
ALL	1200-8-30-.05 (1) (j)	510	PERSONNEL	Specialist consultants shall be board certified or board prepared and actively seeking certification in disciplines in which a specialty exists. A Comprehensive Regional Pediatric Center shall be staffed with specialist consultants with pediatric subspecialty training.	See Table 1 for medical and surgical specialty lists. All professional staff listed shall be either board certified by the appropriate American Board or be an active candidate, as defined by their respective board or sub-board. Documentation of Board status should be maintained by summary roster in PFN (Personnel section). See Tag 301.	Physician roster. See Tag 301.
ALL	1200-8-30-.05 (2)			Nursing Services (See below)		
ALL	1200-8-30-.05 (2) (a)	511	SUMMARY	Emergency staff in all facilities shall be able to provide information on patient encounters to the patient's medical home through telephone contact with the primary care provider at the time of encounter, by faxing or mailing the medical record to the primary care provider, or by providing the patient with a copy of the medical record to take to the physician. Follow-up visits shall be arranged or recommended with the primary care provider whenever necessary.	The ED should be capable of providing phone, fax, copy, mail or electronic availability of information about a patient visit. Policy should be in place stating indications for notification of a patient's physician at time of visit and for reporting of test results to patients in a timely manner.	o Methods of providing information regarding patient visit to primary care provider, and/or patient. o Policy stating indications for notification of PCP at time of visit and for reporting of test results to a patient's physician in a timely manner.

Pediatric Emergency Care Facilities (Primary) Licensure Survey

Applicable EMSC Designation	Regulation Number	Tag Number	PFN SECTION	Regulation	Surveyor Guidance	Suggested Documents / Evidence of Compliance
PRIMARY and GENERAL	1200-8-30-.05 (2) (c)	513	SUMMARY	In Primary or General Pediatric Emergency Facilities at least one RN shall be physically present 24 hours per day, 7 days per week, and capable of recognizing and managing shock and respiratory failure and stabilizing pediatric trauma patients, including early recognition and stabilization of problems that may lead to shock and respiratory failure. At least one emergency room nurse per shift shall have successfully completed courses such as the PALS or ENPC and can demonstrate this clinical capability.	The Primary and General facilities shall maintain in the PFN (Personnel section) a list of all nurses staffing the emergency department and training records documenting completion of PALS, ENPC, or similar courses. Alternatives to PALS, or the ENPC course should clearly document in the course content that the skills of recognizing and managing pediatric emergencies such as respiratory failure and shock are included. Prior work experience in a PICU or pediatric ED may be utilized. Staffing schedule should reflect that an RN that has completed supplemental pediatric training listed above is always on duty. Exceptions should be recorded for review, with plans for correction and prevention.	○ Roster of nurses staffing ED with training records (PALS, ENPC, if alternatives used, course content documented) Work experience in PICU or pediatric ED may be utilized. ○ Staffing schedule reflecting that RN with pediatric training (listed above) is always on duty. ○ Exceptions recorded for review with plans for correction and prevention.
ALL	1200-8-30-.05 (4)			Facility Structure and Equipment. (See below)		
ALL	1200-8-30-.05 (4) (e)	526	SUMMARY	An emergency cart or other systems to organize supplies including resuscitation equipment, drugs, printed pediatric drug doses and pediatric reference materials must be readily available. Equipment, supplies, trays, and medications shall be easily accessible, labeled and logically organized. Antidotes necessary for a specific geographic area should be determined through consultation with a poison control center. If the listed medications are not kept in the emergency department, they should be kept well organized and together in a location easily accessible and proximate to the emergency department.	See Table 1. There should be in place a system to rapidly and accurately determine emergency medication dosages and equipment requirements based on the child's weight/size while minimizing the opportunity for human error. Options for weight/size estimation include emergency bed scales to weigh a critical patient or length-based measuring tapes (Broselow or similar) to estimate weight.	