**Pediatric Care Guidelines for the Emergency Department**

1. **Definition of a Pediatric Patient**

Emergency Department Pediatric Patients are defined aspatients up to the age of 18 (up until the patient’s 18th birthday, or age 17 years, 364 days) in most circumstances, with the following factors considered:

For children presenting with a traumatic injury, the American College of Surgeons (ACS) guideline of under 15 years of age may be used to determine which trauma service (pediatric or adult) will be activated, taking into consideration the age-appropriate developmental and physiologic needs of each patient.

For children who are pregnant or have pregnancy related complaints, care may be transitioned to an adult care setting, taking into consideration age-appropriate developmental and physiologic needs of each patient.

Children with existing co-morbidities such as Cystic Fibrosis, Cerebral Palsy, childhood Cancer, etc. may be treated in either Pediatric or Adult care settings as appropriate, based on the recommendations of the attending/admitting specialist in collaboration with nursing team members. In either of these circumstances, consideration will be provided for the developmental and physiologic needs of each patient.

1. **Pediatric Weight Measurement**

A pediatric patient’s weight is important information because it is often used to calculate the appropriate medication dose. When medication errors arise due to inaccurate or unknown patient weights, the dose of a prescribed medication could be significantly different from what is appropriate. Strategies to address these problems include: all Emergency Departments will: 1) have the necessary equipment, both scales that weigh pediatric patients ONLY in kilograms AND a method of length-based calculation of weight ONLY in kilograms when the child is too critically ill to allow for an exact weight measurement, 2) a policy that states and enforces MEASURED (actual via scale or Tape) weight as a mandatory vital sign for every patient during triage or admission to the facilities, and weighing patients and documenting and reporting patient weights only in kilograms.

Source and Reference: Medication Errors: Significance of Accurate   
Patient Weights Pa Patient Saf Advis 2009 Mar;6(1):10-5.

1. **Providing Age and Developmentally Appropriate Care**

Demonstration of high standards of professional **competence while working with pediatric patients in the Emergency Department includes:**

1. Providing pediatric patient care that is family centered, safe and effective, for the treatment of illness and injury and the promotion of health.
2. Using a logical, evidence based and standardized clinical approach to the care of pediatric patients, applying principles of evidence-based decision-making and problem solving.
3. Demonstrating a commitment to acquiring the knowledge base expected of emergency department healthcare providers caring for ill and injured children.
4. Demonstrate standardized, evidence based teamwork and communication skills that result in information exchange, partnering and advocating with patients, their families and professional associates.
5. Standardize and maintain accurate, age and developmentally appropriate, timely and legally appropriate medical records for pediatric emergency care.
6. Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity of staff and patients in the emergency department.
7. Recognize the limits of one’s own knowledge and expertise and take steps to avoid medical errors. This includes being willing to ask for help from members of the team, both internal and external and across traditional professional divides.
8. **Immunizations and the Pediatric Patient in the Emergency Department**

Many families with children use the emergency department (ED) as their primary source of health care. Many of these children are at risk for preventable diseases and are not properly immunized. In addition, children present to the ED with diseases that may have been prevented by vaccines.

To promote the health and well-being of children and their families:

* All health care personnel should be encouraged to receive yearly influenza and other immunizations as recommended by the CDC.
* EDs should establish relationships with public health clinics, managed health care organizations, and private physicians to ensure the rapid referral of undervaccinated patients.
* In cases of outbreaks or epidemics of vaccine-preventable diseases (including emerging infections and biothreats), emergency healthcare providers should assist health care facilities in partnering with public health agencies to develop and implement mass vaccination strategies.
* At an appropriate time during the child’s visit in the ED, questions should be asked about immunizations previously received by that child and a comparison made with current recommendations of immunizations for their age group. Vaccination guidelines should be reviewed and updated frequently and posted in a location that is easily accessible to front line clinical staff.
* If immunizations are delivered, all health care professionals are required by federal law to give vaccine information statements (VIS) to vaccine participants or their parents or guardians. A VIS statement should be supplemented with oral explanation by the health care professional as necessary.

Adapted from The American College of Emergency Physicians (ACEP) regarding the immunization of pediatric patients in the emergency department.

1. **Measurement of Vital Signs in the Pediatric Patient in the Emergency Department**

**Triage**

Vital signs are measurements of physiological parameters (See Pediatric Vital Signs Poster for details and age appropriate pediatric vital signs). Heart rate, respiratory rate, oxygen saturation, blood pressure and pain assessment are the traditional measures obtained from patients in the ED setting. However, evidence suggests:

* Initial vital signs are not a mandatory component of the Triage Acuity Level-1 or 2 patient, however:
* The clinical presentation of the child can and should be, at a minimum, accurately determined by the assessment of all pediatric patients using the Pediatric Assessment Triangle (PAT). The PAT consists of the observation, documentation and reporting of the child’s Appearance, Work of Breathing and Circulation/skin signs (see reference chart).
* When triaging a stable patient, it is never wrong to obtain a set of vital signs. All Level 3 patients shall have a full set of vital signs to include: heart rate, respiratory rate, oxygen saturation, blood pressure and pain assessment.
* Trauma patients should be assessed for: PAT, Neurological status using an appropriate GCS scale, pain assessment and determination if Trauma System Activation is necessary.

Because of the inability of many children to report signs and symptoms directly, the waiting area of an ED can be one of great vulnerability. Vital signs are variable and dynamic indicators of physiological status thus there is a need to re-assess children who are waiting for care. As changes in physiological status may be exhibited by subtle changes in very young children, heart rate, respiratory rate, oxygen saturation and temperature are required points of initial vital signs measurement in ***all*** children under age 3.

Reassessment can be performed and documented by the use of the PAT at regular intervals prior to the Medical Screening Exam (MSE). Once the MSE is complete, reassessment should be performed according to facility policy:

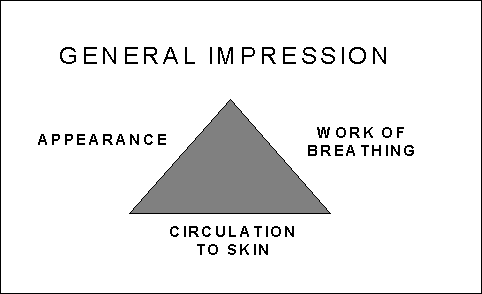
**Level I Patients are immediately placed in the treatment area**

**Level II Pediatric Patients**: Every 15 minutes

**Level III/IV/V Pediatric Patients**: Every hour

During hand-off of triage duties, a verbal briefing regarding the PAT status of waiting children should be discussed and documented between the off-going and on-coming triage nurse.

**Pediatric Assessment Triangle (Source: AAP Pediatric Education for Prehospital Professionals)**

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**Reassessment of Pediatric Vital Signs in the ED**

Best practice methodology for obtaining vital signs in pediatric patients includes tactile and auscultatory methods, especially to determine heart and respiratory rates. Manual blood pressure measurement should be attempted to verify electronic recording, however use caution not to distract from clinical care to obtain blood pressures. The physician or Licensed Independent Practitioner (LIP) is to be alerted to the presence of abnormal vital signs, or changes in vital signs that may indicate deterioration of patient condition.

**Level I Pediatric Patients:** Vital signs and PAT assessment should be obtained as soon as possible to admission to the treatment area and reassessed every 5-15 minutes until trended at levels indicating physiological stability (see Vital Signs Poster reference) Blood pressure shall be obtained and trended using correct sized equipment as soon as possible without compromising care of the patient.

**Level II Pediatric Patients**: PAT assessment and vital signs every 15-30 minutes until trended at physiological stability.

**Level III Pediatric Patients**: PAT assessment every hour, complete vital signs at discretion of clinical staff

**Level IV & V Pediatric Patients**: PAT assessment every hour, complete vital signs on admission and discharge.

**NOTES:** Triage ACUITY categorization shall NOT be changed once determined by the initial triage nurse. Reduction in the frequency of vital signs is determined by the presence of trends indicating physiological stability. All children shall be assessed at a minimum using the PAT at least once every hour.

**Sources:**

Hohenhaus S. “Someone Watching Over Me: Observations in Pediatric Triage” Journal of Emergency Nursing. Volume 32, Issue 5, pp.398-403.

American Academy of Pediatrics Pediatric Education for Prehospital Professionals (PEPP)

Emergency Severity Index (ESI) Version IV Implementation Handbook

Canadian Triage and Acuity Scale (CTAS) Implementation Guidelines

1. **Child Maltreatment**

When there is reasonable suspicion or concern that a child presenting to the emergency department (ED) has been abused or assaulted, the priorities of the clinician are:

1. Identify injuries and provide appropriate stabilization and diagnostic work-up
2. Accurately document the history described by child and/or caretaker
3. Initiate the investigative process by reporting to child protective services (CPS) and/or law enforcement agencies
4. Collect forensic evidence when appropriate, maintaining the chain of custody work with child protective services to provide a safety plan for the child victim and their siblings
5. Assist in the arrangements for follow-up medical care and counseling.

The clinician caring for the abused child whenever possible should limit repeated interviewing and examination of the child that may hinder the investigative process and traumatize or stress the patient.

For those children with severe injuries, multisystem injuries, or those who require pediatric subspecialty or inpatient care, rapid assessment and transfer to the closest tertiary-care pediatric hospital is essential.

For additional procedural recommendations for caring for children who are victims of maltreatment, see Appendix I, Care of Children in the Emergency Department; Child Maltreatment.