**Section 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)**

a) Professional Staff: Physicians

1) Qualifications

Twenty-four hour coverage of the emergency department (excluding designated areas utilized to care for minor illnesses or injuries, i.e., fast track, urgent care) shall be provided by one or more physicians responsible for the care of all children. Each physician shall hold one of the following qualifications:

A) Certification in emergency medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in emergency medicine and in the first cycle of the board certification process; or

B) Sub-board Certification in pediatric emergency medicine by the American Board of Pediatrics or the ABEM or residency trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or

C) Certification by one of the following boards and current American Heart Association – American Academy of Pediatrics (AHA-AAP) or American Red Cross Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation.

i) Certification in family medicine by the American Board of Family Medicine (ABFM) or American Osteopathic Board of Family Medicine (AOBFM); or

ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or

iii) Residency trained/board eligible in either family medicine or pediatrics and in the first cycle of the board certification process; or

D) Alternate Criteria. The physician has worked in the emergency department prior to January 1, 2018 and has completed 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including at least 2800 hours within one continuous 24-month period), certified in writing by the hospitals at which the internship and subsequent hours were completed. The physician shall have current AHA-AAP or American Red Cross PALS or ACEP-AAP APLS recognition and have completed at least 16 hours of pediatric CME within the past two years.

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 completion 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) Physician Coverage

At least one physician meeting the requirements of subsection (a)(1) shall be on duty in the emergency department 24 hours a day.

4) Consultation

Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation can be with an on-staff physician or in accordance with Appendix M.

5) Physician Backup

A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available in person to the EDAP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians

Guidelines shall be established that address on-site response time for all on-call specialty physicians.

b) Professional Staff: Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant

This subsection (b) pertains to nurse practitioners, clinical nurse specialists, and PAs working within their scope of practice, and credentialed as defined by the hospital.

1) Qualifications

A) Nurse practitioners shall:

i) Either:

• Successfully complete a nurse practitioner program with a focus on the pediatric patient. The following are programs that qualify as focused on pediatric patients: acute care pediatric nurse practitioner program, primary care pediatric nurse practitioner program, pediatric critical care nurse practitioner program, emergency nurse practitioner program, or family practice nurse practitioner program; or

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

ii) 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.

iii) Provide credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient, as defined by the hospital credentialing process.

B) Clinical nurse specialists shall:

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

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

iii) 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; and

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

C) Physician Assistants shall:

i) Hold a current Illinois Physician Assistant License. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the PA shall have an unencumbered license in the state in which he or she practices; and

ii) Provide credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient, as defined by the hospital credentialing process.

2) Continuing Education

A) All full- or part-time nurse practitioners, clinical nurse specialists, and PAs caring for children in the emergency department shall 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 Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

B) All full- or part-time nurse practitioners, clinical nurse specialists, and PAs caring for children in the emergency department and fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.

c) Professional Staff: Nursing

1) Qualifications

A) At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:

i) AHA-AAP or American Red Cross PALS;

ii) ACEP-AAP APLS; or

iii) ENA ENPC.

B) All emergency department registered nurses shall successfully complete and maintain the current recognition required in subsection (c)(1)(A) within 24 months after employment. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

2) Continuing Education

A) All nurses (RNs and LPNs) assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency or critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; or publications. These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric specific.

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

d) Guidelines, Policies and Procedures

1) Inter-facility Transfer

A) The hospital shall have current written transfer agreements that cover 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) The hospital shall have written pediatric inter-facility transfer guidelines, policies or procedures concerning transfer of critically ill and injured patients, which 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 appropriately 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. Incorporating the components of Appendix M into the emergency department transfer policy/procedure will meet this requirement.

2) Suspected Child Abuse and Neglect

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

3) Emergency Department Treatment Guidelines

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

4) Latex-Allergy Policy

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

5) Disaster Preparedness

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

e) Quality Improvement

1) Interprofessional Quality Activities Policy

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

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

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

i) Pediatric deaths;

ii) Pediatric inter-facility transfers;

iii) Child abuse and neglect cases;

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

v) Pediatric quality and safety priorities of the institution.

D) Interprofessional pediatric mock codes with associated 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 the individual 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 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.

D) Participating in regional QI activities, including preparing a written QI report and attending the Regional Pediatric QI subcommittee. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.

E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)

f) Equipment, Trays and Supplies

See Section 515.Appendix L.

(Source: Amended at 48 Ill. Reg. 16159, effective November 1, 2024)