EMERGENCY NURSES ASSOCIATION

Position Statement

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The Emergency Nurse's Role in Supporting Pediatric Readiness in the Emergency Department

Description

Emergency nurses care for patients of all ages, and the need to be prepared for any patient at any time is crucial. In 2015 the National Ambulatory Medical Care Survey reported that approximately 20% (27 million) of the more than 136 million U.S. emergency department (ED) visits were by children under 15 years of age.[1] Most children who seek emergency care are treated in community hospital EDs that see fewer than 15 children per day.[2] Being prepared for pediatric emergencies can be very challenging when there is such limited exposure to pediatric patients. Nevertheless, all emergency nurses must have access to the appropriate resources and demonstrate critical competencies to provide safe, effective care and emergency stabilization for pediatric patients in the ED setting, regardless of the volume of pediatric visits to an ED. Much of the responsibility for ED preparedness in terms of staff competency assessment; policy and procedure development; equipment and supply procurement; quality improvement planning; and implementation, documentation, disaster planning, and staff education lies firmly under the auspices of the emergency nurse leader.[3] There is a need for specific attention to assure that all EDs that treat pediatric patients are "pediatric-ready."[2,4-6]

The lack of a universal definition for "pediatric patients", which encompass infants, children, and adolescents, is reflective of a fundamental pediatric concept: while children may reach adult size in adolescence, they continue to have unique psychosocial and developmental needs well into young adulthood. These needs must be understood by those providing care for these vulnerable populations. While most EDs define pediatric patients according to age based on the legal definition of a minor (which is age 0–17 in most U.S. states), the American Academy of Pediatrics defines pediatric patients as those from birth to age 21.[7] The Centers for Disease Control and Prevention (CDC) reports patient data by several age categories that include under 1 year, under 15 years, 1–4 years, 5–14 years and 5–24 years.[1]

The Emergency Nurses Association (ENA) responded to a need for pediatric emergency nursing education when it launched the first Emergency Nursing Pediatric Course (ENPC) in 1993 and established ENPC as the minimum standard for emergency nursing education for nurses caring for children in the ED.[8] In its fifth edition, published in 2018, ENPC continues to prepare ED nurses to recognize that children have physiologic and anatomical differences that put them at risk for rapid deterioration when ill or injured.[9]

ENA Position

It is the position of the Emergency Nurses Association that:

1. All EDs have a professional and ethical responsibility to be prepared to deliver life- and limb-saving care and stabilization to pediatric patients just as they do for adult patients.

2. Identification of a nurse pediatric emergency care coordinator (PECC) is central to the readiness of any emergency department that cares for pediatric patients.

3. A nurse PECC be designated in the ED, or the duties and responsibilities of the PECC be incorporated into an existing nursing job description in the ED, depending on pediatric volume.

4. All EDs (hospital-based and free-standing) maintain appropriately sized equipment and supplies to provide quality care for children of all ages.

5. Continuing ED nursing education and competencies address the care of infants, children, and adolescents.

6. ED performance improvement plans include pediatric specific indicators.

7. ED disaster plans include children and ED practice drills include pediatric patients at least once every two years.

8. EDs have policies and procedures that address the care of children as specified in the joint ENA, American Academy of Pediatrics (AAP), and American College of Emergency Physicians' (ACEP) policy statement, *Pediatric Readiness in the Emergency Department*.

Background

The American Academy of Pediatrics (AAP) and the American College of Emergency Physicians (ACEP) began efforts to improve emergency care of children in 2001 when they published a joint policy statement titled *Care of Children in the Emergency Department: Guidelines for Preparedness*.[10] These guidelines were intended to stimulate interest and provide resources for improving ED preparedness to care for critically injured or ill infants and children in U.S. EDs. Those guidelines were subsequently updated in 2009 and 2018.[11,12]

In 2003 the Department of Health and Human Services' Health Resources and Services Administration, through its Emergency Medical Services for Children program, funded an AAP and ACEP project to conduct a baseline assessment of the pediatric readiness of U.S. EDs[13] and subsequently develop a toolkit[14] that would help U.S. EDs address gaps in their pediatric readiness. The pediatric readiness of U.S. EDs was assessed through a voluntary survey that assigned a confidential "pediatric readiness score" to each ED that completed the assessment. The pediatric readiness score was a weighted score based on the ED's compliance with the *Joint policy statement – Guidelines for Care of Children in the Emergency Department*. An important outcome of this baseline nationwide assessment was the demonstration that the single most important factor influencing an ED's readiness to care for children is the presence of a PECC.[13]

Following the 2003 assessment, work began on revision of the joint policy statement, which ENA was invited to contribute. The joint policy statement, *Guidelines for Care of Children in the Emergency Department,* was published in 2009.[11] A checklist was developed and co-branded by the AAP, ACEP, ENA, and the EMS for Children program to enable ED leaders to evaluate their EDs.[15] The checklist was incorporated into the 4th edition of ENA's ENPC and is currently under revision based on the 2018 guidelines.

The 2007 Institute of Medicine (IOM) report, *Hospital-based Emergency Care: At the Breaking Point,* concluded that a decrease in the number of EDs and an increase in ED volume led to frequent diversion of ambulances, crowding, and boarding of patients awaiting inpatient bed availability, which affected access to emergency care, especially for children.[16] The accompanying IOM report, *Emergency Care for Children: Growing Pains,* called the state of pediatric emergency care in the U.S. in 2006 "uneven," with some hospitals well prepared to care for children but many others challenged by the lack of resources or personnel.[17] The report further recommended that hospitals appoint two pediatric emergency coordinators – one a physician – to provide collaborative leadership for the organization. While the IOM didn't specifically recommend that a *nurse* fill the additional PECC role, the ENA, AAP, and ACEP Joint Policy Statement *Pediatric Readiness in the Emergency Department* recommends that "identification of a physician [PECC] and nurse PECC is central to the readiness of any ED that cares for children".[12] Guidance for the qualifications and responsibilities of the PECCs are included in each of the Joint Policy Statements that have been published to date.

Identifying a PECC who serves as a pediatric champion in each and every ED in the country would meet the intent of the IOM recommendation. This responsibility may not demonstrate the need for a full-time equivalent, depending on the pediatric patient volume of the ED. The PECC may be concurrently assigned other roles in the ED (e.g., frontline staff, nursing director, stroke coordinator). The PECC may also be shared through formal agreements such as when there is another ED capable of providing definitive pediatric care.[12]

In 2016, ENA joined the EMS for Children Innovation and Improvement Center (EIIC) to continue the partnership with AAP and ACEP to improve pediatric readiness by championing pediatric facility recognition. Using quality improvement science, the EIIC worked with state teams to identify opportunities and barriers to implementing a facility recognition program. A pilot assessment was conducted in the state of California with 90% of hospitals participating; 93% of the assessments were completed by nurse leaders.[4] Remick et al. demonstrated that pediatric readiness scores improved in California in those hospitals recognized as Emergency Departments Approved for Pediatrics.[4] In November 2018, ENA, AAP, and ACEP simultaneously published a revision of the 2009 joint policy statement, titled *Pediatric Readiness in the Emergency Department.*[12] This guideline revision continues to refine the standard for pediatric readiness in U.S. EDs.

All EDs that care for children must be continually prepared for pediatric emergencies and at minimum, be prepared to safely stabilize and transfer these children. Higher pediatric readiness scores have already

been associated with improved patient outcomes such as improved pain management and decreased exposure to radiation use for fractures,[18] better management of sepsis in a simulated environment,[6] and decreased pediatric mortality rates in verified centers.[5]

Resources:

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