

***Pediatric Receiving Center Designation Policy (4004.00)***

**I. PURPOSE:**

This policy defines the requirements for designation as a Pediatric Receiving Center (PedRC) in Kern County and establishes that pediatric patients are transported to the most appropriate facility, which is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of pediatric patients.

**II. AUTHORITY:**

- A. California Health and Safety Code, Division 2.5, Section 1797.103, 1797.204, 1797.220, 1797.250, 1797.252, 1798.150, 1798.170, 1799.204, 1799.205.
- B. California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100147 and Chapter 14 (Draft).

**III. DEFINITIONS:**

- A. California Children Services (CCS): A State of California program for children with certain illnesses or health problems. Through this program, children up to twenty one (21) years old can obtain necessary health care and required services.
- B. Continuous Quality Improvement (CQI): A method of evaluation composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care.
- C. Emergency Medical Services (EMS) Authority (EMSA or Authority): A department in California that is responsible for the coordination and integration of all state activities concerning EMS.
- D. Emergency Medical Services for Children (EMSC): The prevention, pre-hospital, emergency department (ED), in-patient and rehabilitation services specific for the care of children within an EMS system.

- E. Emergency Medical Services for Children Technical Advisory Committee (EMSC-TAC or TAC): A multidisciplinary committee, as appointed by the Authority. The TAC is advisory to the Authority on EMSC related issues.
- F. Emergency Medical Services Division (Division): The Kern County Public Health Services Department, Emergency Medical Services Division. The Division is the Local Emergency Medical Services Agency or LEMSA for Kern County.
- G. Interfacility Transfer: The transfer of an admitted or non-admitted pediatric patient from one licensed health care facility to another.
- H. Neonatal Intensive Care Unit (NICU): A designated area of the hospital that specializes in the care of critically ill or injured newborn infants.
- I. Neonatologist: A physician who is board certified or board eligible in neonatology.
- J. Neonatology Fellow: A post residency trained physician who is a board certified or board eligible physician currently enrolled in a subspecialty fellowship program in neonatology.
- K. On-Call: Agreeing to be available to respond to a Pediatric Receiving Center (PedRC) in order to provide a defined service.
- L. Pediatric Critical Care Fellow: A pediatric board certified or board eligible residency trained physician currently enrolled in a subspecialty fellowship program in pediatric critical care medicine.
- M. Pediatric Critical Care Service: A clinical service within a hospital that has oversight and responsibility for the care of pediatric critically-ill or injured patients in a licensed pediatric intensive care unit (PICU).
- N. Pediatric Intensivist: A physician who is board certified or board eligible in pediatric critical care medicine, or pediatrics and anesthesia and anesthesia critical care.
- O. Pediatric Intensive Care Unit (PICU): A designated area with licensed pediatric intensive care beds within the hospital that specializes in the care of critically ill or injured infant, children, and teenagers.
- P. Pediatric patient: Children 14 years of age or younger.

- Q. Pediatric Receiving Center (PedRC): The licensed general acute care hospital with, at a minimum, a permit for basic or standby emergency services that has been formally designated by the Division. The PedRC Levels are Level I Pediatric Receiving Center (Level I PedRC), Level II Pediatric Receiving Center (Level II PedRC), Level III Pediatric Receiving Center (Level III PedRC), and Level IV Pediatric Receiving Center (Level IV PedRC).
- R. Promptly Available: Responding without delay when notified and requested to respond to the hospital, and being physically available to the specified area of the PedRC within a fifteen (15) minute period of time in accordance with Division policies and procedures. When there are limited resources, telemedicine or video consultation is an acceptable alternative.
- S. Qualified Emergency Specialist: A qualified specialist who is board certified or board eligible in emergency medicine or pediatric emergency medicine, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- T. Qualified Pediatric Specialist: A qualified specialist who is board certified or board eligible in a pediatric specialty, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- U. Qualified Specialist: A physician licensed in California who has 1) taken special postgraduate medical training, or has met other specified requirements, and 2) has become board certified or is board eligible in the corresponding specialty, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty. A non-board certified physician may be recognized as a “qualified specialist” by the Division upon substantiation of need by the PedRC if: a) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada; b) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial

education, training, and experience in treating and managing pediatric critically-ill or injured patients, which shall be tracked by a pediatric performance improvement program; and c) the physician has successfully completed a residency program.

- V. Trauma Center: A licensed hospital, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the Division, in accordance with CCR Title 22, Division 9, Chapter 7.

#### IV. GENERAL PROVISIONS:

- A. No healthcare facility shall advertise in any manner or otherwise hold itself out to be a PedRC unless it has been designated by the Division.
- B. No provider of pre-hospital care shall advertise in any manner, or otherwise hold itself out, as affiliated with EMSC or a PedRC unless they have been so designated by the Division.
- C. PedRCs are designated by the Division in accordance with state regulations and local policies. PedRC designation and re-designation shall be on three (3) year cycles and include written agreements between the PedRC and the County of Kern.
- D. Every PedRC within the County shall be aligned with at least one (1) Level I PedRC for the purposes of outreach and education. Where geography precludes designation of a Level I PedRC within the County, the PedRC may align with a Level I PedRC within the State of California.
- E. All PedRCs shall participate in the Division's Pediatric Advisory Committee.
- F. All PedRCs shall be an approved pre-hospital continuing education provider and provide training and education relating to pediatrics for EMS personnel and MICNs. Continuing education programs shall be conducted in compliance with Division *Pre-Hospital Continuing Education Provider Policies and Procedures*. A sample of *Pediatric Education Guidelines for Paramedics EMSA # 187* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa187.pdf>.
- G. Level I PedRC and Level II PedRCs shall be designated Base Hospitals. These facilities shall provide on-line medical direction in pediatric care to pre-hospital

personnel regardless of patient destination either in County or transports out of County.

- H. All PedRCs shall participate in community education activities relating to pediatric illness and injury prevention efforts. A sample of *EMSC Recommendation For Illness and Injury Prevention EMSA # 190* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa190.pdf>
- I. Air transport for pediatric patients within Kern County shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*.
- J. The Division shall approve marketing and advertising of EMSC capabilities by PedRCs consistent with the designation process by the Division.
- K. The Division will charge for regulatory costs incurred as a result of pediatric receiving center application review, designation, and re-designation. The specific fees are based upon Division costs. Fee amounts shall be as specified in the County Fee Ordinance Chapter 8.13, if applicable.

**V. PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

- A. **A Pediatric Receiving Center (PedRC)** is a licensed general acute care hospital with, at a minimum, a permit for basic emergency services or, in a rural area, licensed standby emergency services, that has been designated by the Division as a Level I PedRC, Level II PedRC, Level III PedRC, or Level IV PedRC. *EMSA #182: Administration, Personnel and Policy Guidelines for the Care of Pediatric Patients in the Emergency Department* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa182.pdf>
- B. **CQI Program-** All PedRCs shall have a CQI Program which addresses the needs of children, to include structure, process, and outcome evaluations. The CQI Program at a minimum shall provide for:
  - 1. A process which integrates the ED CQI activities with the pre-hospital, trauma, inpatient pediatrics, pediatric critical care, and hospital-wide CQI activities, as applicable.
  - 2. A mechanism to provide for integration of findings from CQI audits and reviews into education and clinical competency evaluations of staff.
  - 3. A review of pre-hospital, ED, and inpatient pediatric patient care to include the following pediatric indicators:
    - a. Deaths

- b. Transfers
  - c. Child maltreatment cases
  - d. Cardiopulmonary or respiratory arrests
  - e. Trauma admissions
  - f. Operating room admissions
  - g. ICU admissions
  - h. Selected return visits to the ED
  - i. Patient safety including adverse events
4. Compliance with all federal and state laws protecting and governing patient safety, quality and confidentiality including compliance with applicable provisions of Evidence Code 1157.7 to ensure confidentiality with CQI activities.

**C. Policies, procedures, or protocols** for care of children in emergency settings, that are not limited to, but shall include, the following:

- 1. Illness and injury triage
- 2. Pediatric assessment
- 3. Physical or chemical restraint of patients
- 4. Child maltreatment
- 5. Consent
- 6. Death of a child
- 7. Procedural sedation
- 8. Immunization status and delivery
- 9. Mental health emergencies
- 10. Family centered care
- 11. Communication with patient's primary health care provider
- 12. Pain assessment and treatment
- 13. A disaster preparedness plan that addresses pediatric issues
- 14. Medication safety, including:
  - a. A process to weigh children on scales in kilograms only
  - b. A process to solicit feedback from staff including reporting of medical errors
  - c. Involvement of families in the medication safety process
  - d. Medication orders that are clear and unambiguous
  - e. Mental health and behavioral emergencies including drug and alcohol abuse

**D. Data Requirements-** The PedRC shall submit, at a minimum, the following data to the Division on a quarterly basis. This data will facilitate system management and allow for evaluation of system performance. Data will be collected by each

PedRC on the Division approved data reporting tool. Data will be aggregated and reported as numerical measurements for Countywide PedRC evaluation. Aggregated reports, with facility names removed, may be shared with the Pediatric Advisory Committee, the EMS System Collaborative, the Emergency Medical Care Advisory Board, Kern County Board of Supervisors, or posted for public viewing, if applicable. If mandated by regulation, aggregated data may be reported to the Authority by the Division as a representation of EMSC in Kern County. The following data elements shall be included:

1. Baseline data, including ambulance transports, to describe the system, including, but not limited to:
  - a. Arrival time/date to ED
  - b. Date of Birth
  - c. Gender
  - d. Ethnicity
  - e. Mode of arrival
2. Cause of illness and injury, and basic outcomes for CQI to include but not limited to the following:
  - a. Discharge or transfer diagnoses
  - b. External cause of injury (E codes)
  - c. Injury location
  - d. Disposition
  - e. Principal procedures
  - f. Other procedures
  - g. Discharge or transfer time and date from ED
  - h. Admitting facility name if applicable
  - i. Residence zip code

E. Each PedRC shall have written guidelines in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and primary caretakers of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child.

F. **ED Requirements:** All designated PedRCs shall comply with the following emergency department (ED) requirements:

1. ED administrative personnel including:
  - a. A Medical Director for the ED; and
  - b. A Physician Coordinator for pediatric emergency care (may be met by staff currently assigned to other roles in the department, and may be shared between EDs). The Physician Coordinator shall:

- i. Be a qualified emergency specialist *or* a physician who is a qualified specialist in Pediatrics or Family Medicine *and* shall demonstrate competency in resuscitation of children of all ages from neonates to adolescents.
- ii. Assume administrative responsibilities that may include, but not be limited to:
  - Oversight of ED pediatric CQI process
  - Liaison with appropriate hospital-based pediatric care committees
  - Liaison with PedRCs, Trauma Centers, the Division, base hospitals, pre-hospital care providers, and community hospitals
  - Facilitation of pediatric emergency education for ED staff
  - Ensuring pediatric disaster preparedness (*EMSA # 198: EMSC Pediatric Disaster Preparedness Guidelines for Hospitals* can be found at <http://www.emsa.ca.gov/pubs/docs/EMSA198.pdf>)
- c. A Nursing Coordinator for pediatric emergency care (may be met by staff currently assigned other roles in the emergency department, or in-house departments, and may be shared between EDs). The Nursing Coordinator shall:
  - i. Be a registered nurse (RN) with at least two (2) years' experience in pediatrics or emergency nursing within the previous five (5) years
  - ii. Demonstrate competency in resuscitation of children of all ages from neonates to adolescents
  - iii. Assume administrative responsibilities that may include but not be limited to:
    - Coordinate with the pediatric Physician Coordinator for pediatric CQI activities
    - Facilitate ED nursing continuing education and competency evaluations in pediatrics
    - Liaison with pediatric critical care centers, trauma centers, the Division, base hospitals, pre-hospital care providers, and community hospitals
    - Liaison with appropriate hospital-based pediatric care committees
    - Coordination with the Physician Coordinator to ensure emergency pediatric disaster preparedness



2. Personnel staffing the ED shall include, but not limited to:
  - a. Physicians that are qualified emergency specialists , *or* qualified specialists who demonstrate competency in resuscitation of children of all ages from neonates to adolescents
  - b. Registered Nurses (RNs) with at least one (1) ED RN per shift with current completion of PALS, APLS, ENPC, or other equivalent pediatric emergency care nursing course
  - c. Midlevel practitioners that may include Nurse Practitioners and/or Physician Assistants, as applicable, regularly assigned to the ED who care for pediatric patients and demonstrate competency in resuscitation of children of all ages from neonates to adolescents
  - d. Other services/personnel: Back-up personnel to the ED including, but not limited to:
    - i. A qualified pediatric specialist available for in-house consultation, *or* through real time consultation (e.g. phone telemedicine) or via agreed upon process within transfer agreements
    - ii. Pediatric qualified subspecialists (as a minimum pediatric Intensivist) available for in-house consultation, *or* through phone consultation and transfer agreements
    - iii. Support services including respiratory care, laboratory, radiology, and pharmacy to include qualified staff and necessary equipment
3. Pediatric equipment and supplies. Use of pediatric equipment and supplies requires:
  - a. A pediatric chart, length-based resuscitation tape, medical software, or other system available to assure ready access to proper sizing of resuscitation equipment and proper dosing of medications
  - b. Pediatric equipment, supplies, and medications easily accessible, labeled, and logically organized, including, but not limited to. the following:
    - i. Portable resuscitation supplies (crash cart) with a method of verification of contents on a regular basis
    - ii. General equipment for patient and fluid warming, patient restraint, weight scale (in kilograms), and pain scale tools for all age children

- iii. Monitoring equipment appropriate for children in all pediatric sizes including blood pressure cuffs, Doppler device, ECG monitor/defibrillator, hypothermia thermometer, pulse oximeter, and end tidal CO<sub>2</sub> monitor
- iv. Respiratory equipment and supplies appropriate for pediatric patients including clear oxygen masks, bag-mask devices, intubation equipment, tracheostomy equipment, oral and nasal airways, nasogastric tubes, and suction equipment
- v. Vascular access supplies and equipment appropriate for pediatric patients including intravenous catheters, intraosseous needles, umbilical and central venous catheters, infusion devices, and IV solutions
- vi. Fracture management devices appropriate for pediatric patients including extremity and femur splints, and spinal stabilization devices
- vii. Specialized pediatric trays or kits including lumbar puncture tray, difficult airway kit to include laryngeal mask airways and other devices to provide assisted ventilation if bag-mask ventilation or intubation are unsuccessful, tube thoracostomy tray to include chest tubes sizes for children of all ages, newborn delivery and resuscitation kit to include supplies for immediate delivery and resuscitation of the newborn, and urinary catheter trays to include urinary catheters for children of all ages

G. **Medications** for the care of children requiring resuscitation shall be consistent with the most current evidence-based recommendations (e.g. American Heart Association Pediatric Advanced Life Support). These shall be available in the ED.

## VI. LEVEL I PEDIATRIC RECEIVING CENTER REQUIREMENTS:

In addition to the requirements in Section V of this policy, a Level I PedRC shall:

- A. Be a CCS Approved Tertiary Hospital with specialized in-patient intensive care and diagnostic, operative, therapeutic services and equipment, and with in-house and/or promptly available physician specialists in pediatric subspecialties. A facility may be designated by the Division if the facility has full, provisional, or conditional CCS approval. Documentation of CCS eligibility must be on file at CCS.

- B. Be capable of providing comprehensive specialized pediatric medical and surgical care to any acutely ill and injured child.
- C. Provide ED services which include a separate pediatric ED or designated area for emergency care of children within an ED, and includes physician staff who are qualified emergency specialists in emergency medicine or pediatric emergency medicine.
- D. Have in-patient resources including at a minimum:
  - 1. Twenty five (25) licensed pediatric beds (exclusive of licensed intensive care neonatal nursery or intensive care beds)
  - 2. A NICU
  - 3. A PICU
- E. Plan and implement ongoing outreach to PedRCs (Level II, Level III, and Level IV) including:
  - 1. Collaborate for education in emergency care of pediatric patients
  - 2. Consultation via phone, telemedicine or onsite regarding:
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport
- F. Accept patients from Kern County who require specialized care not available at lower-level hospitals within the county through:
  - 1. Level I PedRC shall accept any patient that meets “emergent medical pediatric” criteria (see section X.A for description) for inter-emergency department transfer originating within the county
  - 2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Level I PedRC (such as burn centers, spinal cord injury centers, rehabilitation facilities)
  - 3. *EMSA # 183: Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa183.pdf>
  - 4. *EMSA #186: Model Pediatric Interfacility Transfer Agreement* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa186.pdf>
- G. Serve as a county referral center for the specialized care of pediatric patients or in special circumstances provide safe and timely transfer of children to other resources for specialized care.

## VII. LEVEL II PEDIATRIC RECEIVING CENTER REQUIREMENTS:

In addition to the requirements in Section V of this policy, a Level II PedRC shall:

- A. Be a CCS approved Pediatric Community Hospital which has most specialized diagnostic, operative, therapeutic services and equipment, and with promptly available pediatric subspecialists. A facility may be designated by the Division if the facility has full, provisional, or conditional CCS approval. Documentation of CCS eligibility must be on file at CCS.
- B. Have inpatient resources including at a minimum:
  - 1. Eight (8) licensed pediatric beds (exclusive of licensed intensive care neonatal nursery)
  - 2. A NICU or a PICU
- C. Include ED services with physician staff who are qualified emergency specialists.
- D. Have a department of pediatrics within the medical staff structure.
- E. Establish formal written agreements with a minimum of one (1) Level I PedRC as approved by the Division, for education, consultation, and transfer of pediatric patients for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- F. Collaborate with Level I PedRC for education in emergency care of pediatric patients and consultation including, but not limited to:
  - 1. Emergency care and stabilization
  - 2. Transfer
  - 3. Transport
- G. Accept patients from Kern County who require specialized care not available at lower-level hospitals within the county through:
  - 1. Level II PedRC shall accept any patient that meets “emergent medical pediatric” criteria (see section X.A. for description) for inter-emergency department transfer originating within the county
  - 2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Level I PedRC (such as trauma centers, burn centers, spinal cord injury centers, rehabilitation facilities)
  - 3. *EMSA # 183: Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa183.pdf>

4. *EMSA #186: Model Pediatric Interfacility Transfer Agreement* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa186.pdf>

### **VIII. LEVEL III PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

A hospital with basic emergency services staffed with a qualified specialist twenty four hours a day, seven days a week (24/7), which may have limited inpatient services. The Level III PedRC is a general community hospital that has adult in-patient specialty care and has no dedicated inpatient pediatric services; however diagnostic, operative, therapeutic services and equipment, and selected pediatric physician specialists are available for consultation.

In addition to the requirements in section V of this policy, a Level III PedRC shall:

- A. Establish formal agreements with a minimum of one Level I PedRC as approved by the Division, for education, consultation, and transfer of pediatric patients.
- B. Collaborate with Level I and/or Level II PedRC for:
  1. Education in emergency care of pediatric patients
  2. Consultation regarding
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport
- C. Develop written agreements with Level I and/or Level II PedRCs to transfer pediatric patients for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- D. Develop transfer agreements for pediatric patients needing specialized care (such as trauma center, burn center, spinal cord injury center, rehabilitation facilities).
  1. *EMSA # 183: Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa183.pdf>
  2. *EMSA #186: Model Pediatric Interfacility Transfer Agreement* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa186.pdf>

### **IX. LEVEL IV PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

A small and/or rural hospital, as defined by state rural criteria, with limited or no inpatient care capability and limited physician specialists available for consultation.

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Effective Date: 05/09/2014

Revision Date: 11/11/2016

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ED services may include physician staffing twenty four hours and day, seven days a week (24/7), or a physician available for consultation (e.g. stand-by or critical access hospital).

In addition to the requirements in Section V. of this policy a Level IV PedRC shall:

- A. Establish formal agreements with a minimum of one (1) Level I PedRC as approved by the Division, for education, consultation, and transfer of pediatric patients.
- B. Develop written agreements with Level I and/or Level II PedRCs to transfer all pediatrics for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- C. Collaborate with a Level I and/or Level II PedRC for:
  1. Education in emergency care of pediatric patients
  2. Consultation regarding:
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport
- D. Develop transfer agreements for pediatric patients needing specialized care (such as trauma centers, burn centers, spinal cord injury centers, rehabilitation facilities).
  1. *EMSA # 183: Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa183.pdf>
  2. *EMSA #186: Model Pediatric Interfacility Transfer Agreement* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa186.pdf>

#### **X. PREHOSPITAL DESTINATION DECISION:**

Pre-hospital personnel shall transport pediatric patients to a pediatric receiving facility that is capable of providing the most appropriate care. Pediatric trauma patients shall be transported in accordance with Prehospital Trauma policies and procedures. Pediatric patients who meet extremis criteria shall be transported in accordance with Destination Decision policies and procedures. The following criteria apply to medical non-extremis pediatric patients only:

- A. Emergent Medical Pediatric: Patients that are fourteen (14) years and younger with an emergent medical complaint shall be transported to a Level I or Level II

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PedRC if ground transport time is thirty (30) minutes or less. Ground transport times that are greater than thirty (30) minutes may be transported to the closest, most appropriate receiving hospital. The use of air ambulance transport shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*.

Emergent medical complaints are defined as:

1. Cardiac dysrhythmia
2. Evidence of poor perfusion
3. Severe respiratory distress
4. Cyanosis
5. Persistent altered mental status
6. Status epilepticus
7. Any apparent life threatening event in less than one (1) year of age

- B. Non-Emergent Medical Pediatric: Patients that are fourteen (14) years and younger with a medical complaint who do not meet trauma, medical extremis or emergent medical criteria shall be transported to any level PedRC.
- C. Pre-hospital personnel may consider base contact with the highest level of PedRC available to assist in destination decision.

## **XI. TRANSFER OF PEDIATRIC PATIENTS:**

Each PedRC shall have an Interfacility Transfer Plan for pediatric patients. Patients may be transferred between and from PedRCs providing that:

- A. Interfacility transfer process that is streamlined to include rapid acceptance and transfer of pediatric patients with evaluation and communication with one or more of the following:
1. A qualified pediatric specialist
  2. A qualified emergency medicine physician
  3. A pediatric intensivist
  4. A neonatologist
  5. A pediatric critical care fellow
  6. A neonatology fellow
- B. The process for transfers of pediatric patients between PedRCs shall be in accordance with Title 22 and EMTALA requirements.
- C. Any transfer which is determined by the ED physician of record, or pediatric inpatient service, medically prudent, and in accordance with Division interfacility transfer policies. *EMSA #186: Model Pediatric Interfacility Transfer Agreement* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa186.pdf>

- D. The PedRC has written criteria for consultation and transfer of patients needing a higher level of care. *EMSA # 183: Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines* can be found at <http://www.emsa.ca.gov/pubs/pdf/emsa183.pdf>
- E. Hospitals receiving pediatric emergency patients participate in EMSC and CQI activities for those pediatric emergency patients who have been transferred.

## **XII. APPLICATION PROCESS FOR PEDIATRIC RECEIVING CENTER (PedRC):**

- A. The following milestones outline the application process for a hospital to become designated as a Pediatric Receiving Center.
  - 1. Submit letter of application to the Division, the letter shall:
    - a. Specify intent to obtain PedRC designation and level
    - b. Identify names and contact information, including email addresses, for key pediatric personnel: Emergency Department Medical Director, Pediatric Physician Coordinator, Pediatric Nursing Coordinator, and administrative contact
    - c. Identify the anticipated target date for PedRC designation
    - d. List supporting documents being submitted with the letter to fulfill the designation requirements
  - 2. Compile and submit to the Division all information and documents requested in Appendix B, Column 2, "Objective Measurement" of the *Pediatric Receiving Center Designation Self Evaluation Tool*.
  - 3. All application materials will be reviewed for completeness. Additional information may be requested, if needed. Upon determination that the application is complete, the applicant and the Division will work towards execution of the designation agreement.
  - 4. Pediatric Receiving Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.
- B. The process for re-designation will be the same as stated above. Re-designation of PedRCs shall be every three (3) years with the exception of the letter of intent. Re-designation materials must be submitted to the Division ninety (90) days in advance of the expiration date of the designation.

## **XIII. LOSS OF DESIGNATION:**



- A. Any designated PedRC which is unable to meet the following requirements shall be subject to termination or loss of PedRC designation:
  - 1. Inability to maintain designation criteria as stated in this policy.
  - 2. Failure to comply with any policy, procedure, or regulation mandate by Local, State, or Federal Government.
  
- B. If the Division finds a PedRC to be deficient in meeting the above criteria, the Division will issue the PedRC a written notice, return receipt requested, setting forth with reasonable specificity the nature of the apparent deficiency.
  
- C. Within ten (10) calendar days of receipt of such notice, the PedRC must deliver to the Division, in writing, a plan to cure the deficiency, or a statement of reasons why the PedRC disagrees with the Division notice.
  
- D. The PedRC shall cure the deficiency within thirty (30) calendar days of receipt of notice of violation.
  
- E. If the PedRC fails to cure the deficiency within the allowed period or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication. EMCAB may make a recommendation to the Division for resolving the issue.

Revision Log:

01/10/13: Creation of Policy  
10/25/13: Comments received. Policy amended.  
01/07/14: Comments received. Policy amended.  
03/04/14: Comments received via Pediatric Designation meeting. Policy amended with agreement from all in attendance.  
05/08/14: EMCAB Approval- Implementation Date set 05/09/2014  
08/14/15: EMCAB Approval- Remove requirement for transfer agreements for Level I&II, add acceptance of patients meeting emergent medical criteria.  
11/11/2016 EMCAB Approval- Addition of PAC as Appendix C.

## APPENDIX A: PEDIATRIC RECEIVING CENTER DATA ELEMENTS

At a minimum, each PedRC shall collect and submit the following mandatory data elements to the Division on a quarterly basis.

Baseline Data	Cause of Illness or Injury
Arrival time/date to ED	Discharge or transfer diagnosis
Date of Birth	External Cause of Injury (E Codes)
Gender	Injury location
Ethnicity	Disposition
Mode of Arrival	Principal Procedures
	Other Procedures
	Discharge or transfer time and date from ED
	Admitting facility name
	Residence Zip Code

## **APPENDIX B: PEDIATRIC RECEIVING CENTER DESIGNATION SELF-EVALUATION TOOL**

The Following pages need completion by applicant for Pediatric Receiving Center designation and re-designation (every three (3) years). “Pediatric Designation Contract Standard” and “Objective Measurement” refers to all standards required. The “PedRC Level” section is what level of PedRC requires the standard of the preceding section, circle “Yes” or “No” as applicable. A completed copy of the Pediatric Receiving Center Designation Criteria Application and Evaluation Tool and copies of any agreements and licensing that are requested are to be placed in the front of the application binder.

## Pediatric Receiving Center Designation Self Evaluation Tool

Pediatric Designation Contract Standard	Objective Measurement	PedRC Level	Meets Standard		Comments
<b>GENERAL PROVISIONS</b>					
Current license as a general acute care hospital	Copy of license	I II III IV	Y	N	Required for designation
Permit for basic emergency services in Kern County (rural standby emergency services)	Copy of permit	I II III IV	Y	N	Required for designation
Current designation as a Paramedic base station in Kern County	Hospital Contracts	I II	Y	N	Required for designation
Participation in Pediatric Advisory Committee	Provide name, position for person designated to attend	I II III IV	Y	N	Required for designation
Approved pre-hospital continuing education provider	Copy of schedule of courses available for prehospital personnel  Copy of CE certificate to be issued for continuing education courses with all required information	I II III IV	Y	N	Required for designation
Alignment with Level I PedRC  Alignment for outreach and education.	Provide evidence of alignment or copy of contract with Level I	II III IV	Y	N	Required for designation
Community Education Participation	Provide evidence of community education program relating to pediatric illness and injury prevention efforts	I II III IV	Y	N	Required for designation
<b>PEDIATRIC RECEIVING CENTER REQUIREMENTS</b>					
California Children Service approved at appropriate level	Documentation on file at CCS	I II	Y	N	Required for designation

Continuous availability of PedRC resources 24 hours a day 7 days a week 365 days a year.	On-Call Schedules for 3 months. On-Call Policy/Procedure	I II	Y	N	Required for designation
Pediatric in-patient services	Verification of appropriate number of licensed pediatric beds	I II	Y	N	Required for designation
Separate Department of Pediatrics within the medical staff structure	Verification of a Department of Pediatrics	I II	Y	N	Required for designation
Neonatal Intensive Care Unit and/or Pediatric Intensive Care Unit	Verification of a NICU and/or PICU	I II	Y	N	Required for designation. Level II at a minimum must have one.
CQI Program to include structure, process, and outcome evaluations	Written quality improvement plan or program description.  <input type="checkbox"/> Integrate ED, Pre-hospital, trauma, inpatient, critical care <input type="checkbox"/> Integrate findings into education and clinical competency evaluation for staff	I II III IV	Y	N	CQI plan or policy only required for initial designation Ongoing expectation  Data Collection and Management based on Pediatric EMS data elements
CQI Program Pediatric Indicators	Review protocol/program description to deal with:  <input type="checkbox"/> Deaths <input type="checkbox"/> Transfers <input type="checkbox"/> Child Maltreatment Cases <input type="checkbox"/> Cardiopulmonary/Respiratory Arrest <input type="checkbox"/> Trauma Admission <input type="checkbox"/> Operating Room Admissions <input type="checkbox"/> ICU Admissions <input type="checkbox"/> Selected Return Visits to the ED <input type="checkbox"/> Patient Safety	I II III IV	Y	N	Policy and procedure or program description only required for initial designation Ongoing expectation

	including adverse events				
Pediatric Emergency Care Policies, Procedures, or Protocols	<p>Review policies/ procedures/protocols</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Illness and injury triage</li> <li><input type="checkbox"/> Pediatric assessment</li> <li><input type="checkbox"/> Physical and chemical restraint</li> <li><input type="checkbox"/> Child maltreatment</li> <li><input type="checkbox"/> Consent</li> <li><input type="checkbox"/> Death of a child</li> <li><input type="checkbox"/> Procedural sedation</li> <li><input type="checkbox"/> Immunization status and delivery</li> <li><input type="checkbox"/> Mental health emergencies</li> <li><input type="checkbox"/> Family centered care</li> <li><input type="checkbox"/> Communication with primary care provider of patient</li> <li><input type="checkbox"/> Pain assessment and treatment</li> <li><input type="checkbox"/> Disaster Preparedness Plan for Pediatrics</li> </ul>	I II III IV	Y	N	Required for designation
Medication Safety policy, procedure or protocol	<p>Review policies/ procedures/protocols for medication safety to address the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kilogram only scale</li> <li><input type="checkbox"/> A Process to solicit feedback from staff including medication errors</li> <li><input type="checkbox"/> Involvement of families in the</li> </ul>	I II III IV	Y	N	Required for designation

	<p>medication safety</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Orders that are clear and unambiguous</li> <li><input type="checkbox"/> Mental health and behavioral emergencies including drug and alcohol abuse</li> </ul>				
Participation in Kern County EMS data collection	Document agreeing to provide data elements deemed mandatory by Kern County EMS Division	I II III IV	Y	N	Name and contact information of responsible personnel required for designation
Written Guidelines for patients, parents/guardians of patients to provide input and feedback regarding care of the patient	Guidelines for Patients, Review documentation of guideline or feedback policy	I II III IV	Y	N	Designation Ongoing Expectation
<b>ED PERSONNEL REQUIREMENTS</b>					
ED Medical Director	Copy of medical license or contract	I II III IV	Y	N	Required for designation
Physician Coordinator for pediatric emergency care	Copy of current Board Certifications	I II III IV	Y	N	Required for designation
Responsibilities: Oversight of ED pediatric CQI process  Liaison with appropriate hospital-based pediatric care committees  Liaison with PedRCs, trauma centers, Division, base hospitals, pre-hospital care providers, community	Copy of Job description  Verification of competency in resuscitation of children of all ages  May be met by staff currently assigned other roles in the department, and may be shared between ED				



<p>hospitals</p> <p>Participates in protocol development</p> <p>Facilitate pediatric emergency education for ED staff</p> <p>Coordinate with RN Coordinator to ensure pediatric disaster preparedness.</p>				
<p>RN Coordinator for pediatric emergency care</p> <p>Responsibilities: Coordinate with pediatric Physician Coordinator for CQI</p> <p>Facilitate ED nursing continuing education and competency evaluations in pediatrics</p> <p>Liaison with ped critical care centers, trauma centers, Division, base hospitals, pre-hospital care providers, community hospitals</p> <p>Liaison with appropriate hospital-based pediatric care committees</p> <p>Coordinate with Physician Coordinator in</p>	<p>Copy of RN License</p> <p>Evidence of experience in pediatrics or emergency nursing</p> <p>Verification of competency in resuscitation of children of all ages</p> <p>Copy of Job description</p> <p>May be met by staff currently assigned other roles in the department, and may be shared between ED</p>	<p>I II III IV</p>	<p>Y    N</p>	<p>Required for designation</p>

ensure pediatric disaster preparedness					
Emergency Department Staffing:  Physicians	Copy of current Board Certifications  Verification of competency in resuscitation of children of all ages  Evidence of ED physician coverage by at a minimum one physician with appropriate qualifications for 3 months	I II III IV	Y	N	Required for designation  Ongoing expectation
Emergency Department Staffing:  Registered Nurses	Evidence of at least one ED RN per shift with qualifications for 3 months  Copy of RN license  Copy of course completion/card with current PALS, APLS, ENPC, or equivalent	I II III IV	Y	N	Required for designation  Ongoing expectation
Emergency Department Staffing:  Midlevel practitioners if regularly assigned to ED and who care for pediatric patients	Copy of license  Verification of competency in resuscitation of children of all ages	I II III IV	Y	N	Required for designation  Ongoing expectation
Qualified pediatric specialist  Available for in-house consultation, or telemedicine, or transfer	Copy of Board Certifications  Verification of process, policy, procedure, job description or work schedule for 3 months	I II III IV	Y	N	Required for designation  Ongoing expectation

process					
Pediatric qualified subspecialist (as a minimum pediatric Intensivist)  Available for in-house consultation, or telemedicine and transfer process	Copy of Board Certifications  Verification of process, policy, procedure, job description or work schedule for 3 months	I II III IV	Y	N	Required for designation  Ongoing expectation
Support Services:  a. Respiratory Care b. Laboratory c. Radiology d. Pharmacy	Evidence of availability of services with qualified staff	I II III IV	Y	N	Required for designation

**ED SUPPLIES AND EQUIPMENT**

Pediatric General Supplies and Equipment (easily accessible and labeled)	<input type="checkbox"/> Pediatric chart; length based resuscitation tape, medical software, or other system equivalent <input type="checkbox"/> Portable resuscitation supplies “Crash Cart” <input type="checkbox"/> Patient and fluid warming device <input type="checkbox"/> Patient restraint <input type="checkbox"/> Kilogram only scale <input type="checkbox"/> Pain scale appropriate for children  Pediatric size monitoring equipment: <input type="checkbox"/> Blood pressure cuff <input type="checkbox"/> Doppler Device <input type="checkbox"/> Electrocardiography Monitor/Defibrillator <input type="checkbox"/> Hypothermia thermometer	I II III IV	Y	N	Required for designation
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	<input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> End Tidal CO2 monitoring device  Fracture management: <input type="checkbox"/> Splints <input type="checkbox"/> Traction splints <input type="checkbox"/> Spinal stabilization devices  Specialized Pediatric Trays/Kits: <input type="checkbox"/> Lumbar puncture <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Difficult airway <input type="checkbox"/> Supraglottic <input type="checkbox"/> Needle/Surgical Cricothyrotomy <input type="checkbox"/> Tube thorachostomy tray <input type="checkbox"/> 12-36F <input type="checkbox"/> Newborn Delivery Kit <input type="checkbox"/> Newborn Resuscitation equipment <input type="checkbox"/> Umbilical clamp <input type="checkbox"/> Scissors <input type="checkbox"/> Bulb syringe <input type="checkbox"/> towel <input type="checkbox"/> Urinary Catheterization <input type="checkbox"/> 6F-22F				
Respiratory Equipment and Supplies	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Non Rebreather Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Simple Mask	I II III IV	Y	N	Required for designation

	<input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Nebulizer Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Bag-Mask Device with appropriate size mask <input type="checkbox"/> Neonatal <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Endotracheal Tubes <input type="checkbox"/> Uncuffed/cuffed 2.5mm-5.5 mm <input type="checkbox"/> Cuffed 6.0mm-8.0 mm <input type="checkbox"/> Stylets for ET Tubes <input type="checkbox"/> Pediatric <input type="checkbox"/> Oropharyngeal Airways <input type="checkbox"/> Size 0-5 <input type="checkbox"/> Nasopharyngeal Airway <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Laryngoscope Blades <input type="checkbox"/> Straight 0-3 <input type="checkbox"/> Curved 2-3 <input type="checkbox"/> Laryngoscope handle <input type="checkbox"/> Magill Forceps <input type="checkbox"/> Pediatric <input type="checkbox"/> Suction Catheter <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Yankauer Suction Tip <input type="checkbox"/> Tracheostomy Tubes (0-6) <input type="checkbox"/> Neonatal <input type="checkbox"/> pediatric <input type="checkbox"/> Nasogastric Tubes <input type="checkbox"/> Infant 8F			
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	<input type="checkbox"/> Child 10F <input type="checkbox"/> Laryngeal Mask Airway <input type="checkbox"/> Size 1-5 <input type="checkbox"/> Feeding tubes <input type="checkbox"/> 5F <input type="checkbox"/> 8F				
Intravenous Equipment and Supplies	<input type="checkbox"/> Arm Boards <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Catheter-Over-Needle <input type="checkbox"/> 14-24 gauge <input type="checkbox"/> Intraosseous Needles/Devices <input type="checkbox"/> Pediatric <input type="checkbox"/> Umbilical Vein Catheter <input type="checkbox"/> Central Venous Catheter <input type="checkbox"/> 4.0-7.0F double lumen <input type="checkbox"/> Intravenous solutions <input type="checkbox"/> Normal Saline <input type="checkbox"/> Dextrose 5%in Normal Saline <input type="checkbox"/> Dextrose 10% in water <input type="checkbox"/> Fluid warmer <input type="checkbox"/> IV administration sets with calibrated chambers and extension tubing <input type="checkbox"/> Infusion devices with ability to regulate rate and volume of infusion.	I II III IV	Y	N	Required for designation

**MEDICATIONS**

Medications (easily accessible and labeled)	Medications Requirements: <input type="checkbox"/> Alprostadil (PGE1)	I II III IV	Y	N	Required for designation  Approved Medications by The American Heart
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	<input type="checkbox"/> Albumin <input type="checkbox"/> Albuterol <input type="checkbox"/> Atropine <input type="checkbox"/> Adenosine <input type="checkbox"/> Amiodarone <input type="checkbox"/> Antiemetic <input type="checkbox"/> Calcium Chloride 10% <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Dextrose (D <sub>10</sub> W, D <sub>25</sub> W, D <sub>50</sub> W) <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Dopamine <input type="checkbox"/> Epinephrine (1:1000; 1:10,000 Solution) <input type="checkbox"/> Furosemide <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Ipratropium bromide <input type="checkbox"/> Lidocaine <input type="checkbox"/> Magnesium Sulfate <input type="checkbox"/> Methylprednisone <input type="checkbox"/> Milrinone <input type="checkbox"/> Naloxone Hydrochloride <input type="checkbox"/> Nitroglycerin <input type="checkbox"/> Norepinephrine <input type="checkbox"/> Oxygen <input type="checkbox"/> Procainamide <input type="checkbox"/> Sodium Bicarbonate (4.2%, 8.4%) <input type="checkbox"/> Sodium nitroprusside <input type="checkbox"/> Terbutaline <input type="checkbox"/> Topical, Oral, and Parenteral Analgesics <input type="checkbox"/> Antimicrobial Agents (Parenteral and Oral) <input type="checkbox"/> Anticonvulsants Medications <input type="checkbox"/> Antidotes should be accessible to the ED			Association Pediatric Advanced Life Support
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	<input type="checkbox"/> Antipyretic drugs <input type="checkbox"/> Bronchodilators <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Inotropic Agents <input type="checkbox"/> Neuromuscular Blockers <input type="checkbox"/> Sedatives <input type="checkbox"/> Vaccines <input type="checkbox"/> Vasopressors				
<b>TRANSFER INFORMATION</b>					
Accept in county "emergent medical pediatric" criteria for inter emergency department transfer	Statement verifying acknowledgement	I II	Y	N	Required for designation Shall accept patients meeting "emergent medical pediatric criteria"
Inter-Facility Transfer Guidelines or Cooperative Arrangement	Description of current cooperative practice or copy of supporting policies, procedures or guidelines. List all hospitals collaborating with and for what type services	I II III IV	Y	N	Required for designation List of facilities and description of cooperative arrangements (PedRC's and Non Pediatric Receiving centers)
Copy of transfer agreement: Trauma, spinal cord injury, rehabilitation, or burn patient	Plan, Policy, Procedure with estimated travel time	I II III IV	Y	N	Required for designation. Hospitals without trauma or burn unit. Written guidelines or description of current processes for rapid transfer of patients requiring additional care. Including elective or emergency Trauma and/or Burns.
Copy of written transfer agreements with higher level PedRC and Level I PedRC	Transfer policies and procedures.	II III IV	Y	N	Required for stabilization and post-stabilization



## Appendix C- Pediatric Advisory Committee (PAC)

- A. The Division shall be responsible to maintain policy compliance within the EMS system, and reserves the right to revise or modify this policy when necessary to protect public health and safety.
- B. Pediatric Advisory Committee (PAC) is an ad hoc subcommittee of the EMS System Collaborative.
- C. Pediatric Advisory Committee (PAC) shall be established to review certain potential problem cases and system trends identified through the submission of data (as described in the (*Pediatric Receiving Center Designation Policy*)).
  1. The Committee shall be composed of the following members:
    - a. Pediatric Emergency Care Coordinator
    - b. EMS Division Coordinator
    - c. Pediatric Program Director
    - d. Emergency Dept. MICN
    - e. EMS Dept. Medical Director
    - f. School Representative/ Consumer Representative
    - g. Community Based Pediatrician and Pediatric Intensivist
    - h. Metro Hospital Emergency Department Representative
    - i. Rural Hospital Emergency Department Representative
    - j. Rural Paramedic Representative
    - k. Metro Paramedic Representative
    - l. Air Ambulance/Critical Care Transport Representative
    - m. Communications Center Representative Ad Hoc
    - n. Law Enforcement Representative
    - o. Child Protective Services Representative

- p. Fire Department Representative
  - q. California Children's Services Representative Ad Hoc
  - r. Social Services Representative
  - s. Respiratory Therapist Ad Hoc
2. This Committee shall respond to the EMS Medical Director and EMCAB's inquiries and requests.
  3. The Committee shall consider and monitor identified issues and advise the Director on policy level recommendations and systemic or process issues as follows:
    - a. Create and monitor quality core measures
    - b. Conduct evidence based studies relevant to the unique needs and trends of pediatric care county wide.
      - i. The Committee will be responsible for establishing the criteria for cases to be brought to the committee.
      - ii. Each case reviewed by the committee will have a finding of appropriateness of care rendered and will, where appropriate, make recommendations for change.
    - c. Recommend revisions to policies and procedures based on study findings
    - d. Additional review of transfers or major complicated Pediatric patients as requested by a Pediatric receiving center.
    - e. Organize and administer pediatric specific programs as needed.
    - f. Review all cases of prehospital pediatric cardiac arrest.
  4. Meetings will be conducted in accordance with §1040, §1157.5, and 1157.7 of the California Evidence Code, and the California Business and Professions Code 805, 809 and be compliant with HIPAA and HCFA requirements.
  5. All members and invitees of the Committee will be required to maintain confidentiality of patient specific information.

- D. All pediatric organizational providers will submit to the Division the required documentation, as specified by the Division, to verify ongoing compliance with pediatric triage, treatment, and transport protocols.
- E. The Division, in conjunction with organizational providers, will collect data on a regular basis for system evaluation and continued quality improvement.
- F. Any deviations, specific problems, or deficiencies from policies, procedures and protocols shall be documented.
  - 1. This information will be subject to review by the Division and/or the Pediatric Advisory Committee (PAC).