



NPRP 2026: National Pediatric Readiness Assessment



WI EMSC – Pediatric Readiness Webinar Series

National Pediatric Readiness Project Overview
January 7th 2:00 p.m. – 2:45 p.m.

Role of the PECC
January 27th 4:00 p.m. – 4:45 p.m.

Quality Improvement
February 24th 11:00 a.m. – 11:45 a.m.

Policies, Procedures and Disaster Planning
March 18th 9:30 a.m. – 10:30 a.m.



Policy & Procedures

From the NPRP assessment:

What are the policies your ED has to address the needs of children?

The term 'policy' could also mean a procedure, protocol, plan, clinical guideline, or decision support tool.

These may be integrated into the overall ED policy manual or listed separately.

They should also be available to all staff in the ED, either in written or electronic format.



Triage, Assessment & Reassessment
Immunizations
Child Maltreatment
Death of a Child in the ED
Radiation
Behavioral Health
Social Issues
Clinical Care Pathways
Family Centered Care
Disaster Planning





Triage, Assessment & Reassessment

- Triage Policy
- Triage Tool
- Assessment and Reassessment Frequency





EMERGENCY DEPARTMENT POLICY AND PROCEDURE FOR SCREENING AND TRIAGE

POLICY TITLE

Emergency Department Screening and Triage

POLICY NUMBER

ED-TRI-001

EFFECTIVE DATE

[Insert Date]

REVIEW DATE

[Insert Date]

APPROVED BY

- Emergency Department Medical Director
- Chief Nursing Officer
- Quality and Patient Safety Committee
- Hospital Administration

I. PURPOSE

To establish standardized procedures for screening and triage of all patients presenting to the Emergency Department (ED) in order to:

- Ensure timely identification of life-threatening conditions
- Prioritize care based on acuity using the Emergency Severity Index (ESI)
- Promote safe patient flow
- Maintain compliance with EMTALA and regulatory standards



II. SCOPE

This policy applies to all ill or injured patients presenting to the ED, including:

- Pediatric patients (as defined by hospital policy)
- Adult patients
- All ED clinical and support staff involved in screening and triage

III. POLICY STATEMENT

All patients presenting to the ED shall receive a Medical Screening Examination (MSE) in accordance with EMTALA requirements. Screening and triage will be performed by qualified nursing personnel using standardized assessment criteria and the ESI to determine acuity and resource needs.

All patients presenting to the ED shall be triaged using the ESI, version 5, a validated five-level triage algorithm. The ESI tool shall be used without modification. No alterations, adaptations, or substitutions of the ESI decision algorithm are permitted.

IV. DEFINITIONS

Emergency Severity Index (ESIv5):

A validated five-level triage algorithm categorizing patients by severity and anticipated resource utilization. The triage or bedside RN shall assign acuity using the standardized ESI v5 algorithm without modification.

Emergency Medical Treatment and Labor Act (EMTALA): A federal law requiring EDs to provide a medical screening examination to anyone seeking care, regardless of ability to pay, and to stabilize or appropriately transfer patients with emergency medical conditions.

Medical Screening Examination (MSE): An exam performed by a qualified provider, as defined by the hospital's medical staff bylaws and approved by the governing body, to determine whether an emergency medical condition exists. Triage alone does not meet this requirement.

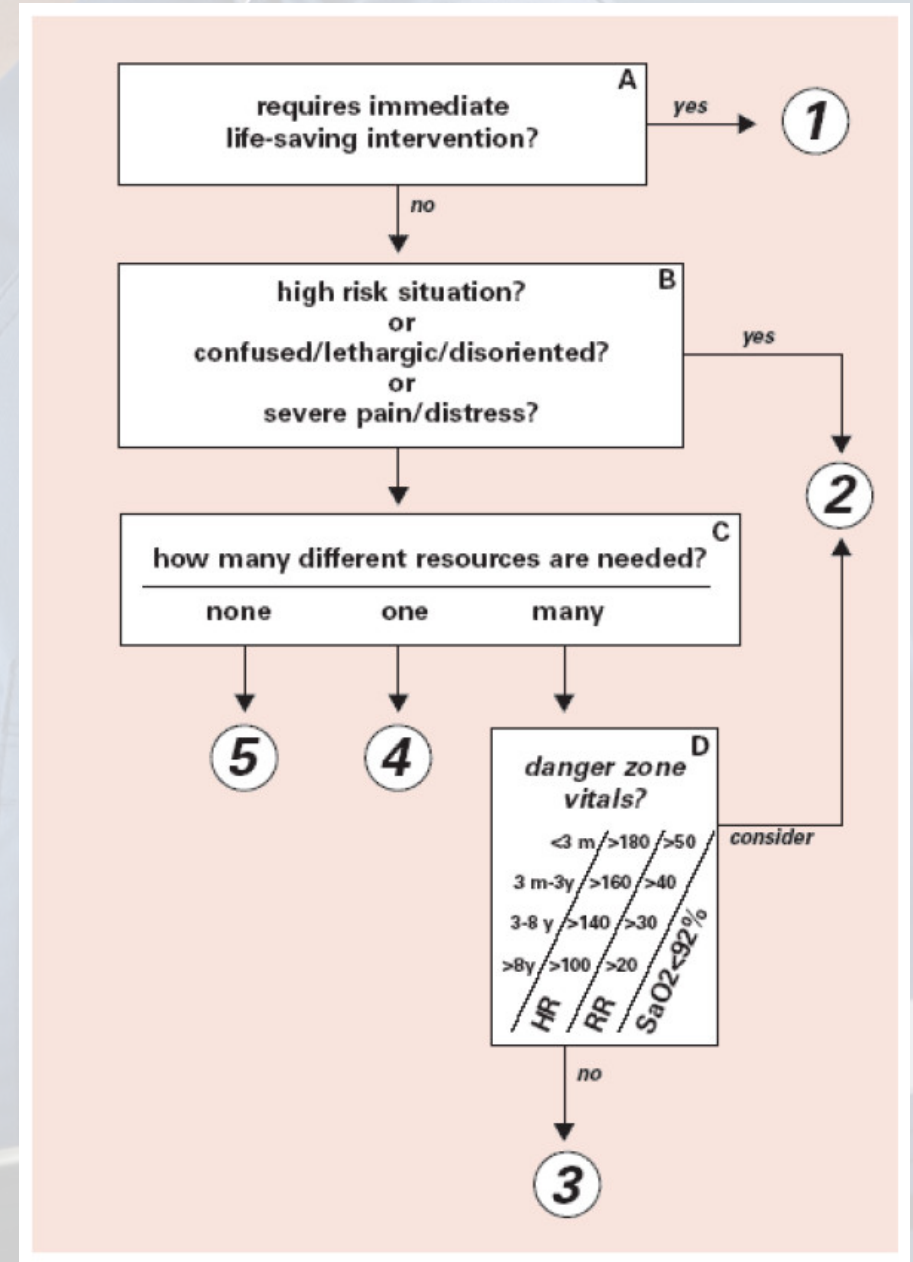
Pediatric Assessment Triangle (PAT):

A rapid, hands-off visual and auditory assessment tool used to identify physiologic instability in infants and children. The PAT allows providers to form a general impression within seconds of patient contact and consists of three components:

1. Appearance – Assesses neurologic status and overall condition using tone, interactiveness, consolability, look/gaze, and speech/cry.

Triage Tools

- ESI (Emergency Severity Index)
 - ES1
 - ES2
 - ES3
 - ES4
 - ES5



Triage Tools

- ESI (Emergency Severity Index)
 - ES1
 - ES2
 - ES3
 - ES4
 - ES5
- Paediatric CTAS (Canadian Triage and Acuity Scale)

The Canadian Paediatric E.D. Triage and Acuity Scale

Patients should have an initial triage assessment within 10 minutes of arrival.

First Impression of EMS Assessment → **Presenting Condition Assessment** (see below PAEDIATRIC PRESENTING CONDITIONS) → **Physiologic Assessment** (Appearance - Neurologic, Respiratory Rate + Effort, Heart Rate + Perfusion)

	TRIAS LEVEL I RESUSCITATION	TRIAS LEVEL II EMERGENT	TRIAS LEVEL III URGENT	TRIAS LEVEL IV LESS URGENT	TRIAS LEVEL V NON URGENT																																							
TIME TO REASSESSMENT OR MEDICAL CARE	0	15 MINUTES*	30 MINUTES*	60 MINUTES*	120 MINUTES*																																							
PHYSIOLOGIC ASSESSMENT	unresponsive	altered consciousness lethargic	infant - unconsolable not feeding atypical behaviour	infant - consolable history of atypical behaviour	no history of recent behaviour or vital sign change																																							
Respiratory Symptoms	RR <- 2 SD inadequate breathing severe distress	RR <- NR +/- 1 SD marked stridor moderate distress	RR outside NR for age stridor mild distress	RR - normal for age	RR - normal for age																																							
Cardiovascular	HR <- 2 SD cardiac arrest shock cyanosis (NR = Normal Range)	HR <- NR +/- 1 SD capillary refill > 4 sec	HR outside NR for age capillary refill > 2 sec	HR - normal for age	HR - normal for age																																							
	<table border="1"> <thead> <tr> <th rowspan="2">Age</th> <th colspan="2">RESPIRATORY RATE (RR)</th> <th colspan="2">HEART RATE (HR)</th> </tr> <tr> <th>+/- 2 SD</th> <th>+/- 1 SD</th> <th>Normal Range (NR)</th> <th>+/- 1 SD</th> </tr> </thead> <tbody> <tr> <td>Birth - 3 months</td> <td>10 - 80</td> <td>20 - 70</td> <td>30 - 50</td> <td>40 - 230</td> </tr> <tr> <td>3 months - 6 months</td> <td>10 - 80</td> <td>20 - 70</td> <td>30 - 60</td> <td>63 - 190</td> </tr> <tr> <td>6 months - 1 year</td> <td>10 - 60</td> <td>17 - 55</td> <td>25 - 45</td> <td>60 - 160</td> </tr> <tr> <td>1 year - 3 years</td> <td>10 - 40</td> <td>15 - 35</td> <td>20 - 30</td> <td>58 - 145</td> </tr> <tr> <td>3 - 5 years</td> <td>8 - 32</td> <td>12 - 28</td> <td>16 - 24</td> <td>55 - 125</td> </tr> <tr> <td>5 - 10 years</td> <td>8 - 26</td> <td>10 - 24</td> <td>14 - 20</td> <td>45 - 105</td> </tr> </tbody> </table>					Age	RESPIRATORY RATE (RR)		HEART RATE (HR)		+/- 2 SD	+/- 1 SD	Normal Range (NR)	+/- 1 SD	Birth - 3 months	10 - 80	20 - 70	30 - 50	40 - 230	3 months - 6 months	10 - 80	20 - 70	30 - 60	63 - 190	6 months - 1 year	10 - 60	17 - 55	25 - 45	60 - 160	1 year - 3 years	10 - 40	15 - 35	20 - 30	58 - 145	3 - 5 years	8 - 32	12 - 28	16 - 24	55 - 125	5 - 10 years	8 - 26	10 - 24	14 - 20	45 - 105
Age	RESPIRATORY RATE (RR)		HEART RATE (HR)																																									
	+/- 2 SD	+/- 1 SD	Normal Range (NR)	+/- 1 SD																																								
Birth - 3 months	10 - 80	20 - 70	30 - 50	40 - 230																																								
3 months - 6 months	10 - 80	20 - 70	30 - 60	63 - 190																																								
6 months - 1 year	10 - 60	17 - 55	25 - 45	60 - 160																																								
1 year - 3 years	10 - 40	15 - 35	20 - 30	58 - 145																																								
3 - 5 years	8 - 32	12 - 28	16 - 24	55 - 125																																								
5 - 10 years	8 - 26	10 - 24	14 - 20	45 - 105																																								
PAEDIATRIC PRESENTING CONDITIONS	Respiratory airway compromise severe distress critical asthma chest trauma with respiratory distress	marked stridor moderate distress severe asthma FB aspiration with respiratory distress inhalation of toxic substance	stridor mild distress moderate asthma FB aspiration with no respiratory distress constant cough - distressed	mild asthma possible FB aspiration with no distress minor chest injury no shortness of breath																																								
Neurological major head injury GCS < 10 unresponsive actively seizing	moderate head injury GCS < 13 altered consciousness headache severe sudden onset III - shunt dysfunction new neurologic findings	minor head injury GCS < 15 history of altered consciousness headache possible shunt dysfunction previous seizure	no vomiting or altered consciousness chronic headache																																									
Cardiovascular cardiac arrest shock hypotension exsanguinating haemorrhage	tachycardia ++ bradycardia severe dehydration uncontrollable minor haemorrhage	tachycardia signs of dehydration uncontrollable minor haemorrhage	normal heart rate chest pain	well hydrated																																								
Musculo-skeletal major trauma traumatic amputation - extremity hypothermia	traumatic amputation - digit open fracture fracture with neuro-vascular deficit back pain with neurologic symptom avulsed 2' tooth	fracture no neuro-vascular deficit joint pain with fever dental trauma	greenstick fracture extremely swelling sprain strain																																									
Skin burn > 25% BSA or airway involved	burn > 10% BSA burn - face, hand, foot chemical electrical	burn < 10% BSA frostbite cellulitis - III / fever	minor burn minor cold injury local cellulitis	superficial burn abrasion, contusion, local rash																																								

Assessment Tools

- PAT

PEDIATRIC ASSESSMENT TRIANGLE (PAT)

APPEARANCE
TONE
INTERACTIVENESS
CONSOLABILITY
LOOK/GAZE
SPEECH

WORK OF BREATHING
BREATH SOUNDS
POSITIONING
RETRACTIONS
FLARING
APNEA/GASPING



CIRCULATION

**PALLOR
MOTTLING
CYANOSIS**

ABNORMAL FINDINGS IN ANY OF THE THREE COMPONENTS MAY INDICATE RESPIRATORY DISTRESS, RESPIRATORY FAILURE, SHOCK, OR CENTRAL NERVOUS SYSTEM/METABOLIC COMPROMISE AND REQUIRE IMMEDIATE ESCALATION OF CARE.

Assessment Tools

- PAT

Reassessment

- How often are vital signs being taken?
- Does it matter how high acuity the patient is?

PEDIATRIC ASSESSMENT TRIANGLE (PAT)

APPEARANCE
TONE
INTERACTIVENESS
CONSOLABILITY
LOOK/GAZE
SPEECH

WORK OF BREATHING
BREATH SOUNDS
POSITIONING
RETRACTIONS
FLARING
APNEA/GASPING



CIRCULATION

**PALLOR
MOTTLING
CYANOSIS**

ABNORMAL FINDINGS IN ANY OF THE THREE COMPONENTS MAY INDICATE RESPIRATORY DISTRESS, RESPIRATORY FAILURE, SHOCK, OR CENTRAL NERVOUS SYSTEM/METABOLIC COMPROMISE AND REQUIRE IMMEDIATE ESCALATION OF CARE.

The background of the slide is a light blue gradient with faint, semi-transparent images of medical equipment: a stethoscope on the right, two syringes in the center, and an alarm clock on the left. In the top-left corner, there is a small orange square icon containing a white speech bubble.

Immunization Assessment





Immunization Assessment and Management of Pediatric Patients in the Emergency Department

I. PURPOSE

To define a standardized process for immunization assessment, shared decision-making, counseling, documentation, and vaccine administration for pediatric patients presenting to the Emergency Department (ED), consistent with nationally recognized immunization guidelines and Pediatric Readiness standards.

II. DEFINITIONS

- **Pediatric Patient:** Individuals 0–18 years of age, or as defined by facility policy.
- **Immunization Status Assessment:** Review of vaccination history via caregiver report, electronic health record (EHR), and/or state.
 - **Catch-Up Immunization Schedule:** Nationally recognized schedule for children and adolescents who are delayed in vaccination.
 - **Shared Decision-Making (SDM):** A collaborative process in which clinicians and caregivers review risks, benefits, alternatives, and patient values to make informed decisions regarding care.
 - **Vaccine Information Statement (VIS):** Federally required vaccine information document provided prior to vaccine administration.
- **Immunization Information System (IIS):** A confidential, population-based registry that consolidates vaccination records, supports clinical decision-making, and facilitates reporting to public health authorities.

III. POLICY

- All pediatric patients presenting to the ED shall have immunization status assessed as part of routine clinical evaluation.
- Immunization screening and counseling shall not delay the medical screening examination or emergency treatment.
- When clinically appropriate and operationally feasible, indicated immunizations may be administered in the ED in accordance with current nationally recognized immunization schedules and best practice guidelines.



- The ED supports opportunistic vaccination, particularly for under-immunized children, high-risk populations, and those with limited access to primary care.
- Vaccine-related discussions shall incorporate shared decision-making principles, particularly in circumstances where:
 - Vaccines are recommended but not emergently required
 - Caregivers and/or patient express hesitancy or concerns
 - Clinical discretion is appropriate (e.g., moderate illness, catch-up timing questions)
- Vaccines shall be stored, handled, and administered in accordance with manufacturer recommendations and institutional pharmacy policies.

IV. PROCEDURE

A. Immunization Screening

1. Immunization status will be assessed during triage or nursing intake and confirmed during the medical screening exam.
2. Screening shall include:
 - Caregiver- or patient-reported vaccine history
 - Review of EHR documentation
 - Query of state IIS when available
3. Immunization status will be categorized as:
 - Up-to-date
 - Delayed
 - Unknown
 - Documented exemption

B. Shared Decision-Making & Counseling

1. Clinicians shall use a clear, evidence-based recommendation when vaccines are indicated.
2. Counseling shall include discussion of:
 - Disease risk and potential severity
 - Vaccine effectiveness
 - Known risks and common side effects
 - Consequences of delayed or declined vaccination
3. Patient and caregiver questions and concerns shall be addressed respectfully and without coercion.
4. In cases of hesitancy or refusal:
 - Provide a clear medical recommendation
 - Offer written educational materials
 - Document refusal and counseling provided

Immunizations

- Tetanus:
 - DTap → 7 years and younger
 - Tdap → 8 years and older

TETANUS PROPHYLAXIS GUIDELINE (1)

Previous Dose of Tetanus Toxoid	Clean and Minor Wounds		All other Wounds	
	Tetanus Toxoid Vaccine (DTaP or Tdap)	Human Tetanus Immune Globulin (TIG)	Tetanus Toxoid Vaccine (DTaP or Tdap)	Human Tetanus Immune Globulin (TIG)
< 3 doses or unknown	Yes	No	Yes	Yes
3 or more doses	Yes, if last dose > 10 years	No	Yes, if last dose > 5 years	No*

EXAMPLES OF DIRTY OR MAJOR WOUNDS:

- PENETRATING OR PUNCTURE WOUNDS
- WOUNDS CONTAINING DIRT, SOIL, FECES, OR SALIVA (E.G., ANIMAL OR HUMAN BITES)
- PHYSICIAN DISCRETION
- WOUNDS CONTAINING DEVITALIZED TISSUE:
 - BURNS
 - COMPOUND FRACTURES
 - CRUSH INJURIES
 - FROSTBITE
 - NECROTIC OR GANGRENOUS WOUNDS

*TIG SHOULD ALSO BE CONSIDERED FOR PATIENTS WITH DIRTY OR MAJOR WOUNDS, WHO HAVE A SEVERE IMMUNODEFICIENCY DISORDER OR HIV

Immunizations

- Tetanus
- Rabies

10 M+
HAPPY CLIENT

ED DISCHARGE INSTRUCTIONS: RABIES FOLLOW UP

Rabies Vaccine Follow-up

- The first rabies vaccine was given today (day zero). You will need three more vaccines, which will only be 1 shot each time.
- [Delete after you read this.] These vaccines do not have to be scheduled on the exact day and can be scheduled +2/3 days. Most patients should not have to come back to the ED for the repeat vaccine.
- **You will need to call the infusion clinic at 414-266-2549** to schedule appointments for the following days:
 - Day 3: []
 - Day 7: []
 - Day 14: []

Accept Cancel

WI DHS – Rabies Algorithm

Immunizations

- Tetanus
- Rabies
- Open Fracture

EDTC Open Fracture Guideline

1. RN removes splint & dressing
2. RN assess for possible open fracture*
3. **ESI Level 2** & Provider Notified
(Consider CIA for fast-tracking patient and to get antibiotic ordered quickly)
4. Provider to **order antibiotic**, according to the table below
5. Order x-ray of injury site

Determine if IV is needed for:

- Sedation and reduction
- Ongoing IV antibiotics
- Hospitalization or procedural admission

Antibiotics given within 60min decreases the risk of infection

Type of Injury:	IV Abx:	Oral Abx:**
❖ Open Fracture of most bones	Cefazolin 30mg/kg/dose (Max: 2g per dose)	Cephalexin 30mg/kg/dose (Max: 500mg per dose)
❖ Facial/Oral Open Fx ❖ Bite with Open Fx (Human or animal)	Ampicillin-sulbactam 50mg/kg/dose of Ampicillin (Max: 2g Ampicillin/dose)	Amoxicillin-clavulanate (7:1) 22.5mg/kg/dose of Amoxicillin (Max: 875mg Amox/dose)

Type III Gustilo fractures and contaminated injuries (fresh water or farm injury) may need further antibiotic coverage.

*** (The definition of open fracture is a fractured bone with a disruption of the skin overlying the fracture site (any wound, abrasion or break in the skin).)**

*The American College of Surgeons recommends IV antibiotics within 60 minutes of patient presentation with concern for an **open fracture**¹

* Early IV antibiotic administration has been shown to decrease infection rates in **open long bone fractures**².

** There is insufficient evidence for prophylactic antibiotics and infection rates for pediatric open fractures, outside of long bone fractures.³⁻⁷ Current practice is to give a dose of IV or PO antibiotics. This guideline will be updated as new evidence becomes available.



Child Maltreatment





SAMPLE Policy: Management of Child Maltreatment

I. PURPOSE

To describe and outline the evaluation and treatment of the child or adolescent who presents to the ED and for whom there is a concern for abuse/neglect, thus ensuring consistent and thorough medical care of patients, appropriate reporting practices, and initiation of follow-up services.

II. TARGET GROUP

The target group for these guidelines include the emergency physician, nurse, nurse practitioner, physician assistant, and sexual assault nurse examiner (SANE), who all serve to care children and adolescents in the ED, ensuring appropriate initial and follow-up care.

III. INTRODUCTION

A. Outline of Priorities

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

- Identify injuries
- Provide appropriate stabilization and diagnostic work-up
- Consult child maltreatment medical subspecialists early, if available and appropriate
- Accurately document the history provided by child and/or parent/caregiver
- Report to child protective services (CPS) and/or law enforcement agencies when appropriate (refer to your state's laws and facility policies on reporting)
- Collect forensic evidence when appropriate (refer to your state's laws, state evidence collection procedures and national standards):
<https://www.justice.gov/ovw/file/846856/download>
- Maintain chain of custody
- Communicate with CPS and/or law enforcement agencies as necessary (in most states, CPS and/or law enforcement will determine a safety plan for the patient and their siblings if they deem it necessary)
- Assist in the arrangements for follow-up medical care and counseling



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

When obtaining a history from children who may have been abused/neglected, if possible, limit repeated history takings and examinations to reduce the potential for psychological trauma to the patient.

IV. DEFINITIONS

A. Child Maltreatment

There are varied definitions both medically and legally for child maltreatment and its types which include physical abuse, sexual abuse, neglect, psychological maltreatment, and medical child abuse. The varied definitions tend to have commonalities as represented in the definition here. Child maltreatment is an act of omission or commission that harms or threatens to harm a child or adolescent, typically by a parent or caregiver. 1

B. Physical Abuse

An act of commission to a child or adolescent which results in physical injury such as fractures, burns, bruises, welts, cuts and/or internal injuries (i.e., solid organ injury, hollow viscus organ injury, internal bleeding, ischemia), not caused by accidental mechanisms or solely the result of underlying medical condition(s), regardless of intent. Determining intent is not within the scope of medical practice. 1-4

C. Sexual Abuse

The involvement of a child/adolescent in sexual acts or the simulation of sexual acts that they do not understand, for which they cannot give informed consent, and/or that violates societal norms. These acts can be through various possible means (e.g., use, persuasion, coercion, inducement, enticement), can include exploitation (e.g., sexual acts with the minor child for financial or other gain, pornography), penetrative contact and/or non-penetrative contact. The penetrative contact may include penetration of the patient's genitals, oral cavity or anus or include penetration to the alleged abuser's genitals, oral cavity, or anus. Non-penetrative contact may include contact of the genitals, buttocks, breasts or other body part by hands, genitals, other body parts, or objects either to or by the alleged abuser. 4-7

Sexual assault and commercial sexual exploitation of children/youth, a subgroup of human trafficking, would fall into this category of maltreatment. 4,6

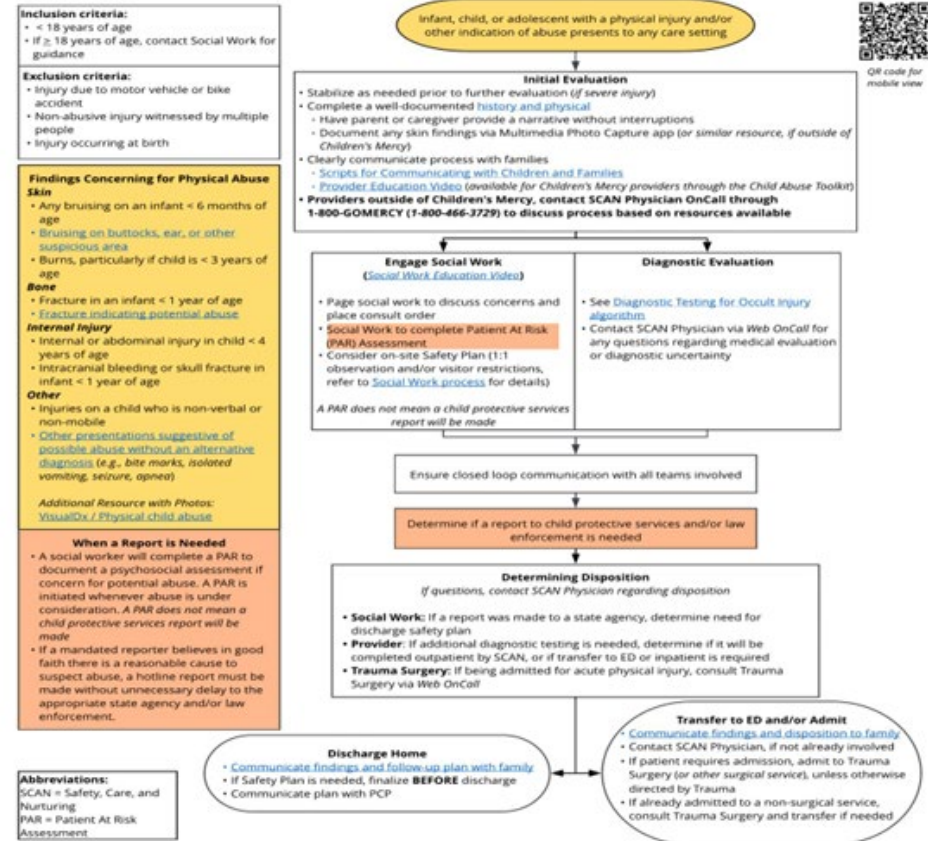
Human trafficking: The act of recruiting, harboring, transporting, providing or obtaining a person for compelled labor or commercial sex acts using force, fraud, or coercion.

Physical Abuse Guidelines

- Children's Mercy Hospital

Child Physical Abuse Clinical Pathway Synopsis

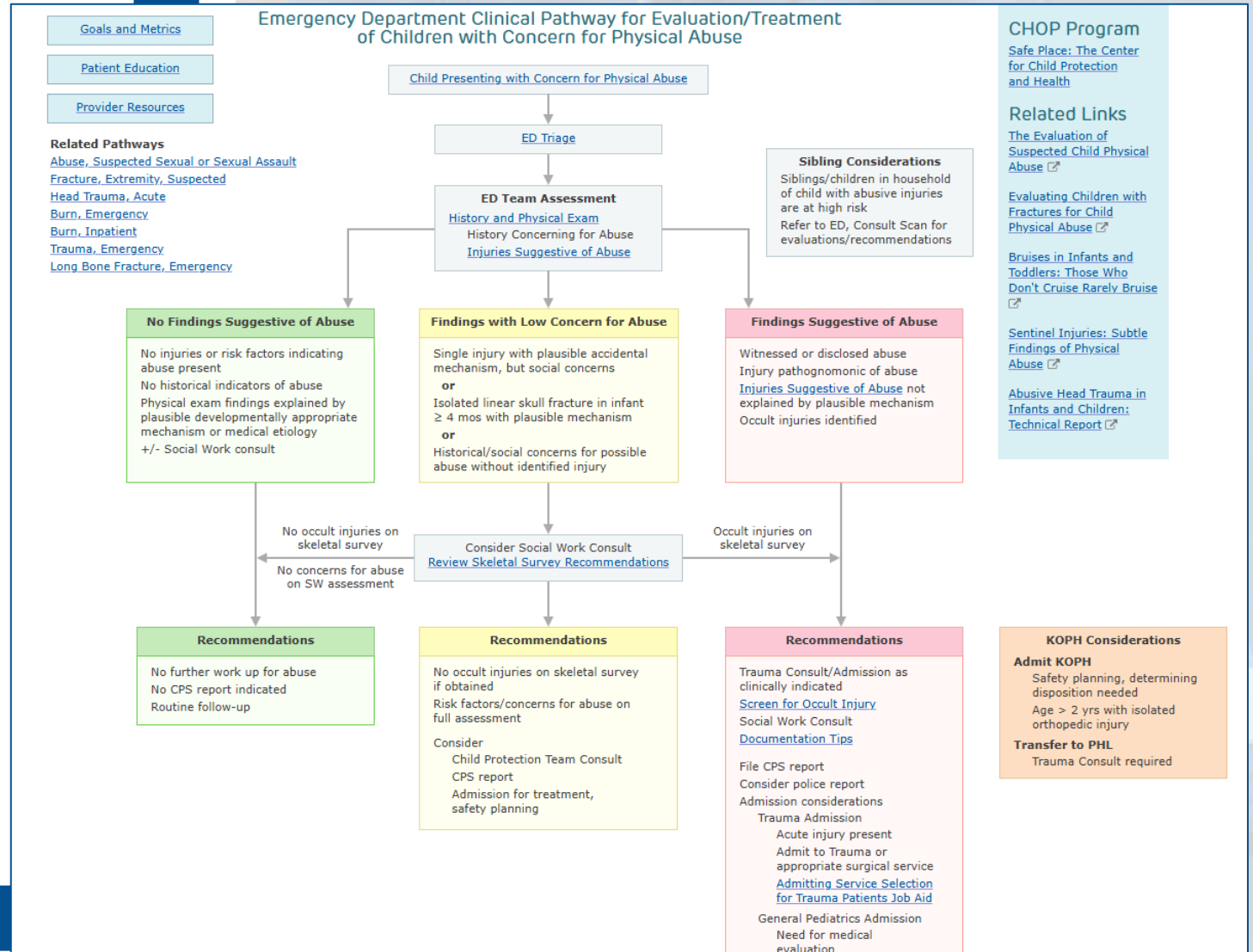
Child Physical Abuse Algorithm



* These clinical pathways do not establish a standard of care to be followed in every case. It is recognized that each case is different, and those individuals involved in providing health care are expected to use their judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. It is impossible to anticipate all possible situations that may exist and to prepare a clinical pathway for each. Accordingly, these clinical pathways should guide care with the understanding that departures from them may be required at times.

Physical Abuse Guidelines

- [Children's Mercy Hospital](#)
- [Children's Hospital of Philadelphia \(CHOP\)](#)






Physical Abuse Guidelines

- Children's Mercy Hospital
- Children's Hospital of Philadelphia (CHOP)
- Children's Hospital of Chicago

TEN-4-FACESp

Bruising Clinical Decision Rule for Children < 4 Years of Age


When is bruising concerning for abuse in children < 4 years of age?
If bruising in any of the three components (Regions, Infants, Patterns) is present without a reasonable explanation, strongly consider evaluating for child abuse and/or consulting with an expert in child abuse.

<p>TEN</p> <p>Torso Ears Neck</p>  <p>FACES</p> <p>Frenulum Angle of Jaw Cheeks (<i>fleshy part</i>) Eyelids Subconjunctivae</p> <p>REGIONS</p>	<p>4 months and younger</p>  <p>Any bruise, anywhere</p> <p>INFANTS</p>	<p>Patterned bruising</p>  <p>Bruises in specific patterns like slap, grab or loop marks</p> <p>PATTERNS</p>
---	---	--

See the signs Unexplained bruises in these areas most often result from physical assault. TEN-4-FACESp is not to diagnose abuse but to function as a screening tool to improve the recognition of potentially abused children with bruising who require further evaluation.

TEN-4-FACESp was developed and validated by Dr. Mary Clyde Pierce and colleagues. It is published and available for FREE download at luriechildrens.org/ten-4-facesp.

Ann & Robert H. Lurie Children's Hospital of Chicago
© Ann & Robert H. Lurie Children's Hospital of Chicago



The background of the slide features a light blue gradient with faint, semi-transparent images of medical equipment: a stethoscope on the right, a syringe in the center, and an alarm clock on the left. In the top-left corner, there is a small orange icon of a speech bubble.

Death of a Child in the ED

- ☑ Policy, Procedure or Plan
- ☑ Bereavement Counseling





Death of a Child in the Emergency Department and Family-Centered Management Sample Policy

I. PURPOSE

To establish a standardized, compassionate, legally compliant process for management of the death of a child in the Emergency Department (ED), consistent with family-centered bereavement principles and applicable state regulations.

This policy aligns with guidance from the American Academy of Pediatrics regarding trauma-informed, culturally sensitive bereavement care.

II. SCOPE

This policy applies to all ED physicians, advanced practice providers, nurses, social workers, chaplains, child life specialists, technicians, and ancillary staff involved in the care of pediatric patients.

III. DEFINITIONS

- **Pediatric Patient:** Defined per hospital policy.
- **Pronouncement of Death:** Official determination of death by a licensed provider authorized under state law.
- **Medical Examiner/Coroner Case:** A death meeting criteria for mandatory reporting under state statute.
- **Organ Procurement Organization (OPO):** Federally designated organization responsible for evaluating organ and tissue donation.

IV. POLICY STATEMENT

The Emergency Department will:

- Provide compassionate, culturally responsive, trauma-informed bereavement care.
- Support family presence during resuscitation when appropriate and feasible.
- Offer memory-making opportunities when desired by the family.
- Ensure timely notification of the Medical Examiner/Coroner when required.
- Notify the designated Organ Procurement Organization within the required timeframes.



- Complete all required documentation and reporting.
- Conduct a structured quality review of all pediatric deaths.

V. PROCEDURE

A. Immediate Actions Following Pronouncement

- Death shall be pronounced by a licensed provider.
- Time of death shall be documented in the medical record.
- Social Work shall be notified.
- Chaplain/Spiritual Care shall be offered.
- Child Life services shall be offered when available.
- The family shall be provided a private space whenever feasible.

B. Family-Centered Bereavement Care

1. Communication

- Deliver news in a private setting.
- Use clear, compassionate language.
- Avoid medical jargon.
- Allow silence and emotional expression.
- Encourage questions and provide repeated explanations as needed.

2. Family Presence and Viewing

- Offer family presence during resuscitation when appropriate and safe.
- Offer time to hold, touch, or remain with the child after death.
- Do not rush the family.

3. Memory-Making (When Desired)

- Offer handprints and/or footprints.
- Offer lock of hair when appropriate.
- Offer photographs.
- Provide memory items if available.
- Facilitate religious or cultural rituals when possible.

4. Cultural and Spiritual Considerations

- Ask about religious or cultural practices.
- Accommodate rituals within safety and legal parameters.

5. Staff Debrief

- Conduct a brief team debrief following the event.
- Provide access to employee assistance and wellness resources.

C. Medical Examiner / Coroner Determination

The attending provider shall determine whether the death meets state criteria for Medical Examiner/Coroner notification.

- If Medical Examiner/Coroner Case

Pediatric Death in the ED: Communicating News, Administrative Duties, Care Initiatives

v. 2020-06-17

1. Communicating news
 - Preparation
 - Delivering news
 - General guidelines
2. Administrative Duties
 - Notifications
 - Coroner
 - Organ Procurement Organization
 - Primary Care Physician
 - Funeral Home
 - Documentation
 - Report of Death
 - Electronic Medical Record
3. Care Initiatives
 - In Hospital
 - Viewing
 - Memory Making
 - Resources
 - Staff Support
 - Follow-up
 - Bereavement intervention program

COMMUNICATING NEWS

The unexpected death of a child is always hard and painful to the family and to the ED staff (albeit in a much different and less intense way). Caregivers must be prepared to ensure the child's family gets the care they need despite the emotional demands the situation places on caregivers.

1. Preparation
 - A. Prepare the family by providing information during the treatment/resuscitation process. If death seems likely, ideally a chaplain, social worker, or nurse will become the family's link to the treatment process. As the situation deteriorates, that person needs to be able to say to the family, "The team needs you to know that..."
 - "...they are working very hard to keep his heart beating."
 - "...they've started CPR because the heart is not beating on its own."
 - "...the injuries are severe and may be life-threatening."
 - "...there may be no way to control the severe bleeding. The bleeding is life-threatening."
 - B. Before meeting the family
 - Ensure there is no blood on the clothes of anyone who will meet the family.
 - Ensure there is privacy for the conversation.
 - Know the child's name.
 - Know with whom you will be talking and the emotional state of parents and their supporters; support services will assist.
 - Children in attendance will likely remain with the family. Work with support services to determine a course of action. Children should not be automatically excluded from the notification, but they should not stay if witnessing the emotional outburst, hearing the description of what happened, and/or being present for questions and answers would likely be traumatic.
 - Focus your attention on the parents rather than the calmest or most distressed person(s).
 - Relate with caring voice tones and mannerisms.
 - Use understandable language. Avoid medical jargon and acronyms.
 - Give your name and describe your area of medical expertise (e.g., orthopedics, neurosurgery, surgery, etc.).
 - The patient and family's memory of you and the hospital will be formed by both your competency and your compassion.
2. Delivering the death notification
 - A. Speak with the family as soon as possible.
 - B. Identify the parents.
 - C. If the parents are seated, when possible sit near them. Don't tell them to sit down, but instead ask, "Can we sit down?"



- D. Assume the parents have only one thing on their mind: Is their child alive? Given this, be prepared to deliver the news compassionately and quickly.
- E. Communicating the news:
 - a. Be calm and paced.
 - b. Identify yourself and your role in the treatment and convey the outcome
 - c. Example: "I'm Dr. Smith. I have been taking care of (name of child) since she/he arrived. I have hard news to share. I am so very sorry to tell you that (child's name) has died."
- F. When a death notification is given, expect an emotional expression. Use support services to assist at this time.
- G. Immediately after the notification is given, typically the parents/family will be so emotionally overwhelmed that it is impossible for them to ask their questions are. Do not press them for their questions at the time of the death notification or to seek information you may need about what happened. Return later for these.
- H. Convey condolences, avoid any statement that is trite or patronizing. Resist the urge to try and "fix" their pain with platitudes. Say, "Again, I am so sorry. I will come back in a little while to answer questions and talk with you about what will happen next."

Pediatric Death in the ED

How To Help

- Let your concern and caring show.
- Be available to do whatever is needed, including just listen. Being avoided by others only adds to the grieving parent's pain.
- Tell parents you are sorry about what happened to their child and about their pain, but don't say you know how they feel. Only other parents who have had a child die really know what that is like.
- Let parents grieve in their own way and at their own pace. It is not helpful to tell them what they should feel or do.
- Encourage parents to be patient with themselves and not expect too much. This is not the time for "shoulds" or "ought to's."
- Don't try to fix parent's pain. Reminding them that they still have other children or that they can have another child suggests the child who died is replaceable and not unique.
- Use the child's name and share your special memories of the child with his or her parents. Allow them to talk about their child as much and as often as they want to. They may cry but they also will tell you that it makes them happy to talk about their child.
- Remember birthdays, anniversaries and other special days. Grieving parents want to know their child has not been forgotten.
- Give special attention to the child's brothers and sisters, not only immediately following the death, but also in the months to come. They are also grieving and need support and understanding.



A RESOURCE
FROM
NACG
MEMBERS


NATIONAL ALLIANCE FOR
CHILDREN'S GRIEF

Grief Talk: Talking to Children About Death and Dying





Imaging Needs



State of Wisconsin Pediatric Imaging Guidelines for Blunt Trauma

(This guideline is not meant for Child Abuse Investigation)

Consider Head CT

(PECARN Data)

Less than 2 yrs:

- Altered mental status, GCS 14
- Loss of consciousness > 5 sec.
- Non-frontal scalp hematoma
- Palpable skull fracture
- Non-normal behavior according to family
- Severe mechanism of injury*

2 yrs and older:

- Altered mental status, GCS 14
- History of loss of consciousness
- Vomiting
- Signs of basilar skull fracture
- Severe headache
- Severe mechanism of injury*

*Severe mechanism of injury defined as:

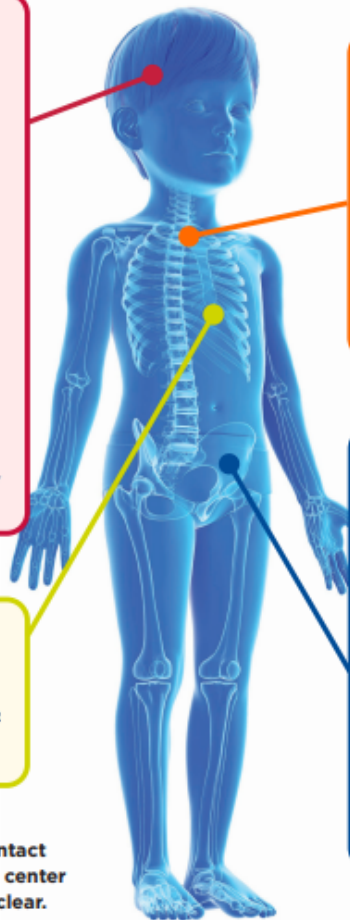
- MVC with rollover or passenger ejection
- Pedestrian or bicyclist without helmet struck by motor vehicle
- Fall greater than 3 feet for less than 2 yrs old, greater than 5 feet for 2 yrs and older
- Head struck by high-impact object (e.g., baseball, golf club)

Consider Chest X-ray

- Obtain a chest X-ray

If concern for cardiothoracic trauma and/or an abnormal chest radiograph, contact your closest pediatric trauma center.

Please avoid the pan scan, contact your nearest pediatric trauma center prior to imaging if transfer is clear.



Consider Cervical Spine

Less than 3 yrs:

- Obtain plain cervical spine X-rays (anterior/posterior and lateral views)

3 yrs and older:

- Obtain plain cervical spine X-rays (anterior/posterior, lateral and odontoid views)

If concerns, keep in cervical collar and contact your closest pediatric trauma center.

Consider Abdomen/Pelvis CT

If unable to obtain IV access for contrast, please contact closest pediatric trauma center.

Imaging: Positive FAST in hemodynamic stable patients

Labs: Increased AST/ALT > 200/125

Physical Findings:

- Abdominal wall bruising/seat belt sign
- Abdominal tenderness/pain/concern for peritonitis
- Thoracic wall trauma
- Vomiting
- Hematuria

If there is concern for a collecting system injury, please obtain a 5-min. delay images.

ctor

State of Wisconsin Pediatric Imaging Guidelines for Blunt Trauma

(This guideline is not meant for Child Abuse Investigation)

Consider Head CT (PECARN Data)

Less than 2 yrs:

- Altered mental status, GCS 14
- Loss of consciousness > 5 sec.
- Non-frontal scalp hematoma
- Palpable skull fracture
- Non-normal behavior according to family
- Severe mechanism of injury*

2 yrs and older:

- Altered mental status, GCS 14
- History of loss of consciousness
- Vomiting
- Signs of basilar skull fracture
- Severe headache
- Severe mechanism of injury*

*Severe mechanism of injury defined as:

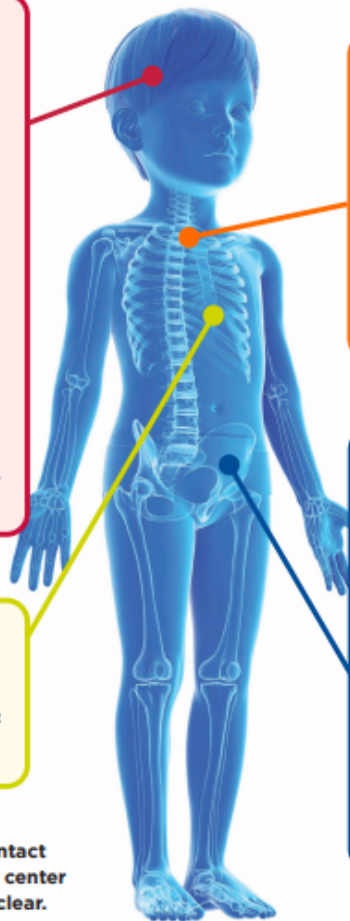
- MVC with rollover or passenger ejection
- Pedestrian or bicyclist without helmet struck by motor vehicle
- Fall greater than 3 feet for less than 2 yrs old, greater than 5 feet for 2 yrs and older
- Head struck by high-impact object (e.g., baseball, golf club)

Consider Chest X-ray

- Obtain a chest X-ray

If concern for cardiothoracic trauma and/or an abnormal chest radiograph, contact your closest pediatric trauma center.

Please avoid the pan scan, contact your nearest pediatric trauma center prior to imaging if transfer is clear.



Consider Cervical Spine

Less than 3 yrs:

- Obtain plain cervical spine X-rays (anterior/posterior and lateral views)

3 yrs and older:

- Obtain plain cervical spine X-rays (anterior/posterior, lateral and odontoid views)

If concerns, keep in cervical collar and contact your closest pediatric trauma center.

Consider Abdomen/Pelvis CT

If unable to obtain IV access for contrast, please contact closest pediatric trauma center.

Imaging: Positive FAST in hemodynamic stable patients

Labs: Increased AST/ALT > 200/125

Physical Findings:

- Abdominal wall bruising/seat belt sign
- Abdominal tenderness/pain/concern for peritonitis
- Thoracic wall trauma
- Vomiting
- Hematuria

If there is concern for a collecting system injury, please obtain a 5-min. delay images.

ctor

PECARN Pediatric Head CT Rule

younger
than 2 years

AMS
or
GCS < 15
or
Palpable skull fx

NONE

LOC > 5 sec
or
Non-frontal hematoma
or
Not acting normally
or
Severe mechanism*

NONE

No CT Required!

CT Head Recommended

Observation vs. CT Head

Discharge

*SEVERE MECHANISMS



PECARN + ALiEM *canadians*

PECARN Pediatric Head CT Rule

2 years
or older

AMS
or
GCS < 15
or
Signs of basilar skull fx

NONE

History of LOC
or
History of vomiting
or
Severe headache
or
Severe mechanism*

NONE

No CT Required!

CT Head Recommended

Observation vs. CT Head

Discharge

*SEVERE MECHANISMS



PECARN + ALiEM *canadians*

State of Wisconsin Pediatric Imaging Guidelines for Blunt Trauma

(This guideline is not meant for Child Abuse Investigation)

Consider Head CT (PECARN Data)

Less than 2 yrs:

- Altered mental status, GCS 14
- Loss of consciousness > 5 sec.
- Non-frontal scalp hematoma
- Palpable skull fracture
- Non-normal behavior according to family
- Severe mechanism of injury*

2 yrs and older:

- Altered mental status, GCS 14
- History of loss of consciousness
- Vomiting
- Signs of basilar skull fracture
- Severe headache
- Severe mechanism of injury*

*Severe mechanism of injury defined as:

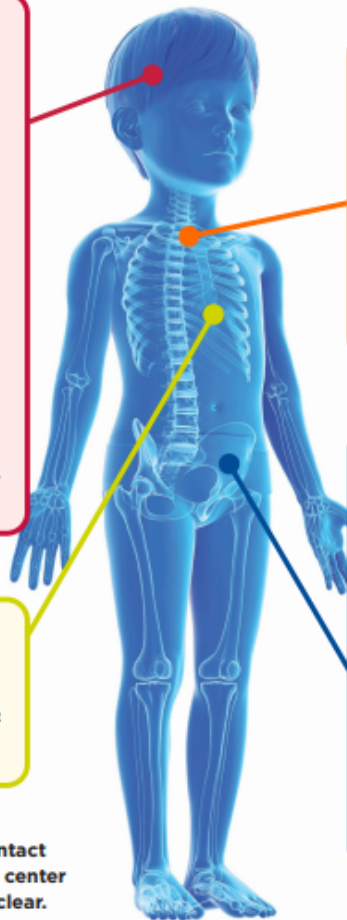
- MVC with rollover or passenger ejection
- Pedestrian or bicyclist without helmet struck by motor vehicle
- Fall greater than 3 feet for less than 2 yrs old, greater than 5 feet for 2 yrs and older
- Head struck by high-impact object (e.g., baseball, golf club)

Consider Chest X-ray

- Obtain a chest X-ray

If concern for cardiothoracic trauma and/or an abnormal chest radiograph, contact your closest pediatric trauma center.

Please avoid the pan scan, contact your nearest pediatric trauma center prior to imaging if transfer is clear.



Consider Cervical Spine

Less than 3 yrs:

- Obtain plain cervical spine X-rays (anterior/posterior and lateral views)

3 yrs and older:

- Obtain plain cervical spine X-rays (anterior/posterior, lateral and odontoid views)

If concerns, keep in cervical collar and contact your closest pediatric trauma center.

Consider Abdomen/Pelvis CT

If unable to obtain IV access for contrast, please contact closest pediatric trauma center.

Imaging: Positive FAST in hemodynamic stable patients

Labs: Increased AST/ALT > 200/125

Physical Findings:

- Abdominal wall bruising/seat belt sign
- Abdominal tenderness/pain/concern for peritonitis
- Thoracic wall trauma
- Vomiting
- Hematuria

If there is concern for a collecting system injury, please obtain a 5-min. delay images.

ctor

PECARN C-Spine Imaging Rule

for evaluation of children
after blunt trauma

- GCS 3-8 or AVPU = U
- Abnormal airway, breathing, or circulation
- Focal neurologic deficits

Consider
CT

NO

- GCS 9-14, AVPU = V or P or other signs of AMS
- Self-reported neck pain or neck tenderness on examination
- Substantial* head or torso injury

Consider
X-Rays

NO

- No risk factors

Consider
Clinical
Clearance

*Substantial injuries defined as warranting inpatient observation or surgical intervention. (Examples of substantial injuries for each body region: skull fracture; pneumothorax; signs of solid organ injury; thoracic, lumbar, or sacral spine fracture; pelvic fracture)

State of Wisconsin Pediatric Imaging Guidelines for Blunt Trauma

(This guideline is not meant for Child Abuse Investigation)

Consider Head CT (PECARN Data)

Less than 2 yrs:

- Altered mental status, GCS 14
- Loss of consciousness > 5 sec.
- Non-frontal scalp hematoma
- Palpable skull fracture
- Non-normal behavior according to family
- Severe mechanism of injury*

2 yrs and older:

- Altered mental status, GCS 14
- History of loss of consciousness
- Vomiting
- Signs of basilar skull fracture
- Severe headache
- Severe mechanism of injury*

*Severe mechanism of injury defined as:

- MVC with rollover or passenger ejection
- Pedestrian or bicyclist without helmet struck by motor vehicle
- Fall greater than 3 feet for less than 2 yrs old, greater than 5 feet for 2 yrs and older
- Head struck by high-impact object (e.g., baseball, golf club)

Consider Chest X-ray

- Obtain a chest X-ray

If concern for cardiothoracic trauma and/or an abnormal chest radiograph, contact your closest pediatric trauma center.

Consider Cervical Spine

Less than 3 yrs:

- Obtain plain cervical spine X-rays (anterior/posterior and lateral views)

3 yrs and older:

- Obtain plain cervical spine X-rays (anterior/posterior, lateral and odontoid views)

If concerns, keep in cervical collar and contact your closest pediatric trauma center.

Consider Abdomen/Pelvis CT

If unable to obtain IV access for contrast, please contact closest pediatric trauma center.

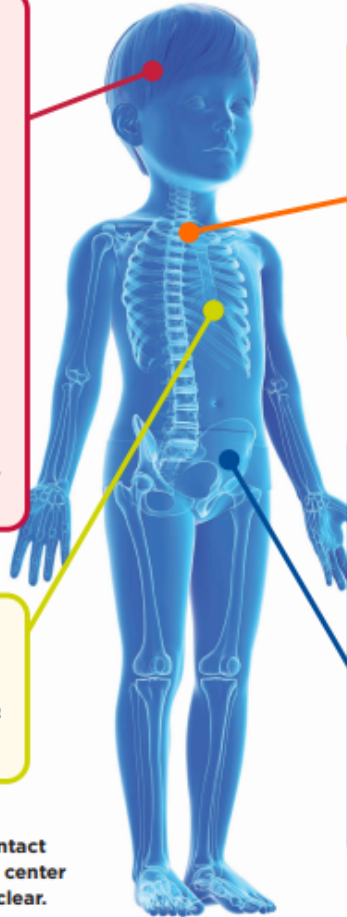
Imaging: Positive FAST in hemodynamic stable patients

Labs: Increased AST/ALT > 200/125

Physical Findings:

- Abdominal wall bruising/seat belt sign
- Abdominal tenderness/pain/concern for peritonitis
- Thoracic wall trauma
- Vomiting
- Hematuria

If there is concern for a collecting system injury, please obtain a 5-min. delay images.



Please avoid the pan scan, contact your nearest pediatric trauma center prior to imaging if transfer is clear.



American Family
Children's Hospital

Blunt Abdominal Trauma in hemodynamically normal children (Developed 2010, Updated 2019, Updated 2025)

Not applicable for NAT. Please refer to NAT guidelines for management of suspected NAT.

Evidence of abdominal wall trauma or seat belt sign^{1,2}
GCS < 14^{1,2}
AST > 200^{2,3} (ALT > 125⁴)
Elevated lipase^{2,3}
Abdominal wall tenderness^{1,2,3}
Evidence of thoracic wall trauma^{1,3}
Absent/Decr breath sounds^{1,3} or abnormal CXR²
Complaint of abdominal pain^{1,2,3}

Yes

Consider CT abdomen and pelvis with IV contrast*
(delayed images obtained automatically on all trauma CTAP)

No

Very low risk for injury
(0.1-0.6% risk of IAI)

Yes

Consider forgoing cross sectional imaging

*Additional comments:

- The risk of IAI is increased with increasing number of variables present.
- Increase clinical suspicion:
 - Altered mental status [Sensitivity of "complaint of abdominal pain" for IAI is 79% for pts with GCS 15, 51% for pts with GCS 14, 32% for pts with GCS 13. This is similar for abdominal tenderness on exam.]
 - Distracting injury [ie; femur fracture]
 - High-Risk Mechanisms [ie; handlebar injury] – PO contrast not required

¹Holmes et al, Ann Em Med 2013

²Streck et al, JACS 2017

²Abra, J Trauma 2018

³Karam et al, J Pediatr 2009

⁴Holmes et al, Ann Em Med 2002

State of Wisconsin Pediatric Imaging Guidelines for Blunt Trauma

(This guideline is not meant for Child Abuse Investigation)

Consider Head CT (PECARN Data)

Less than 2 yrs:

- Altered mental status, GCS 14
- Loss of consciousness > 5 sec.
- Non-frontal scalp hematoma
- Palpable skull fracture
- Non-normal behavior according to family
- Severe mechanism of injury*

2 yrs and older:

- Altered mental status, GCS 14
- History of loss of consciousness
- Vomiting
- Signs of basilar skull fracture
- Severe headache
- Severe mechanism of injury*

*Severe mechanism of injury defined as:

- MVC with rollover or passenger ejection
- Pedestrian or bicyclist without helmet struck by motor vehicle
- Fall greater than 3 feet for less than 2 yrs old, greater than 5 feet for 2 yrs and older
- Head struck by high-impact object (e.g., baseball, golf club)

Consider Chest X-ray

- Obtain a chest X-ray

If concern for cardiothoracic trauma and/or an abnormal chest radiograph, contact your closest pediatric trauma center.

Consider Cervical Spine

Less than 3 yrs:

- Obtain plain cervical spine X-rays (anterior/posterior and lateral views)

3 yrs and older:

- Obtain plain cervical spine X-rays (anterior/posterior, lateral and odontoid views)

If concerns, keep in cervical collar and contact your closest pediatric trauma center.

Consider Abdomen/Pelvis CT

If unable to obtain IV access for contrast, please contact closest pediatric trauma center.

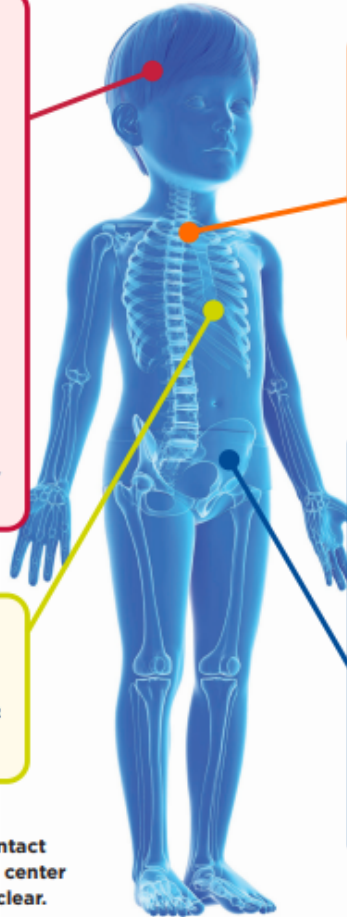
Imaging: Positive FAST in hemodynamic stable patients

Labs: Increased AST/ALT > 200/125

Physical Findings:

- Abdominal wall bruising/seat belt sign
- Abdominal tenderness/pain/concern for peritonitis
- Thoracic wall trauma
- Vomiting
- Hematuria

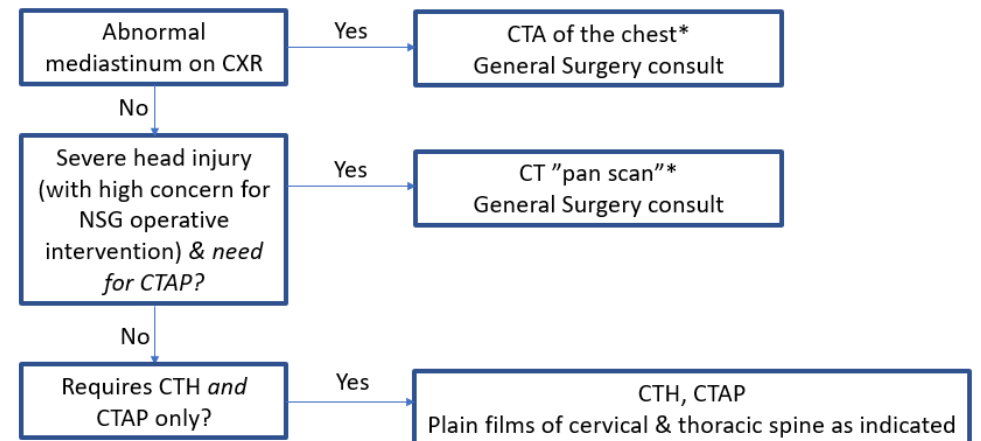
If there is concern for a collecting system injury, please obtain a 5-min. delay images.



Please avoid the pan scan, contact your nearest pediatric trauma center prior to imaging if transfer is clear.



Blunt Chest Trauma (Developed 2010, Updated 2019, Updated 2025)



*Additional comments:

- Mediastinal contour is assessed to look for blunt aortic injury (BAI). It can be normal in the setting of BAI and if there is clinical concern and a high-risk mechanism (ie: significant deceleration injury), decision is at the discretion of attending surgeon.
- CTA of the chest is to image the GREAT VESSELS. Management of rib fractures, pneumothorax, hemothorax, contusions, etc. rarely change with chest imaging. Spine imaging can *generally* be completed with plain films (see additional slides)
- CT "pan scan" includes non-con CTH, CTCS, CTA chest, CT abdomen/pelvis + Delays; T and L spine films can be reformatted
- Other Consideration: MCI or Surge in which multiple patients are concerning and all need imaging, consider pan scan to expedite ED work up and efficiency of imaging

Gunnink et al, Ped Em Care, 2024
Holl et al, Ped Em Care, 2020
Rodriguez et al, AJEM 2017
Golden et al, J of Trauma 2016
Rodriguez et al, AEM 2014
Holscher et al, JSR 2013
Yanchar et al, J of Trauma 2013
Markel et al, J of Trauma 2009
Renton et al, JPS 2003

The background of the slide features a light blue gradient with faint, semi-transparent images of medical equipment: a stethoscope on the right, a syringe in the center, and an alarm clock on the left. In the top-left corner, there is a small orange icon of a speech bubble.

Behavioral Health

- ☑ Policy, Procedure or Plan
- ☑ Suicide Screening
- ☑ Acute Agitation Management



SAFE-T Protocol with C-SSRS (Columbia Risk and

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity	
1) Wish to be dead <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>	
2) Current suicidal thoughts <i>Have you actually had any thoughts of killing yourself?</i>	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) <i>Have you been thinking about how you might do this?</i>	
4) Suicidal Intent without Specific Plan <i>Have you had these thoughts and had some intention of acting on them?</i>	
5) Intent with Plan <i>Have you started to work out or worked out the details of how to kill yourself? Did you actually do anything?</i>	
C-SSRS Suicidal Behavior: "Have you ever done anything, started to do anything, or tried to do anything?"	
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	
If "YES" Was it within the past 3 months?	
Activating Events:	Clinical Status:
<input type="checkbox"/> Recent losses or other significant negative event(s) (legal, financial, relationship, etc.) <input type="checkbox"/> Pending incarceration or homelessness <input type="checkbox"/> Current or pending isolation or feeling alone	<input type="checkbox"/> Hopelessne <input type="checkbox"/> Major depre <input type="checkbox"/> Mixed affec <input type="checkbox"/> Command H <input type="checkbox"/> Chronic phy disorders)
Treatment History:	<input type="checkbox"/> Highly impu <input type="checkbox"/> Substance a <input type="checkbox"/> Agitation or <input type="checkbox"/> Perceived b <input type="checkbox"/> Homicidal I <input type="checkbox"/> Aggressive <input type="checkbox"/> Refuses or f <input type="checkbox"/> Sexual abus <input type="checkbox"/> Family histo
<input type="checkbox"/> Previous psychiatric diagnosis and treatments <input type="checkbox"/> Hopeless or dissatisfied with treatment <input type="checkbox"/> Non-compliant with treatment <input type="checkbox"/> Not receiving treatment <input type="checkbox"/> Insomnia	
Other:	
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
<input type="checkbox"/> Access to lethal methods: Ask <u>specifically</u> about presence or absence of a firearm	
Step 2: Identify Protective Factors (Protective factors may not counteract risk)	
Internal:	External:
<input type="checkbox"/> Fear of death or dying due to pain and suffering <input type="checkbox"/> Identifies reasons for living <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Belief that sui <input type="checkbox"/> Responsibility <input type="checkbox"/> Supportive so <input type="checkbox"/> Engaged in wo



Suicide Risk Screening

Ask Suicide-Screening Questions

Ask the patient:

- In the past few weeks, have you wished you were dead?
- In the past few weeks, have you felt that you or your family would be better off if you were dead?
- In the past week, have you been having thoughts about killing yourself?
- Have you ever tried to kill yourself?

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity questions:

- Are you having thoughts of killing yourself right now?

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - "Yes"** to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation.
 - Patient **cannot leave until evaluated for safety**.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or responsible for patient's care.
 - "No"** to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. Patient **cannot leave until evaluated for safety**.
 - Alert physician or clinician responsible for patient's care.

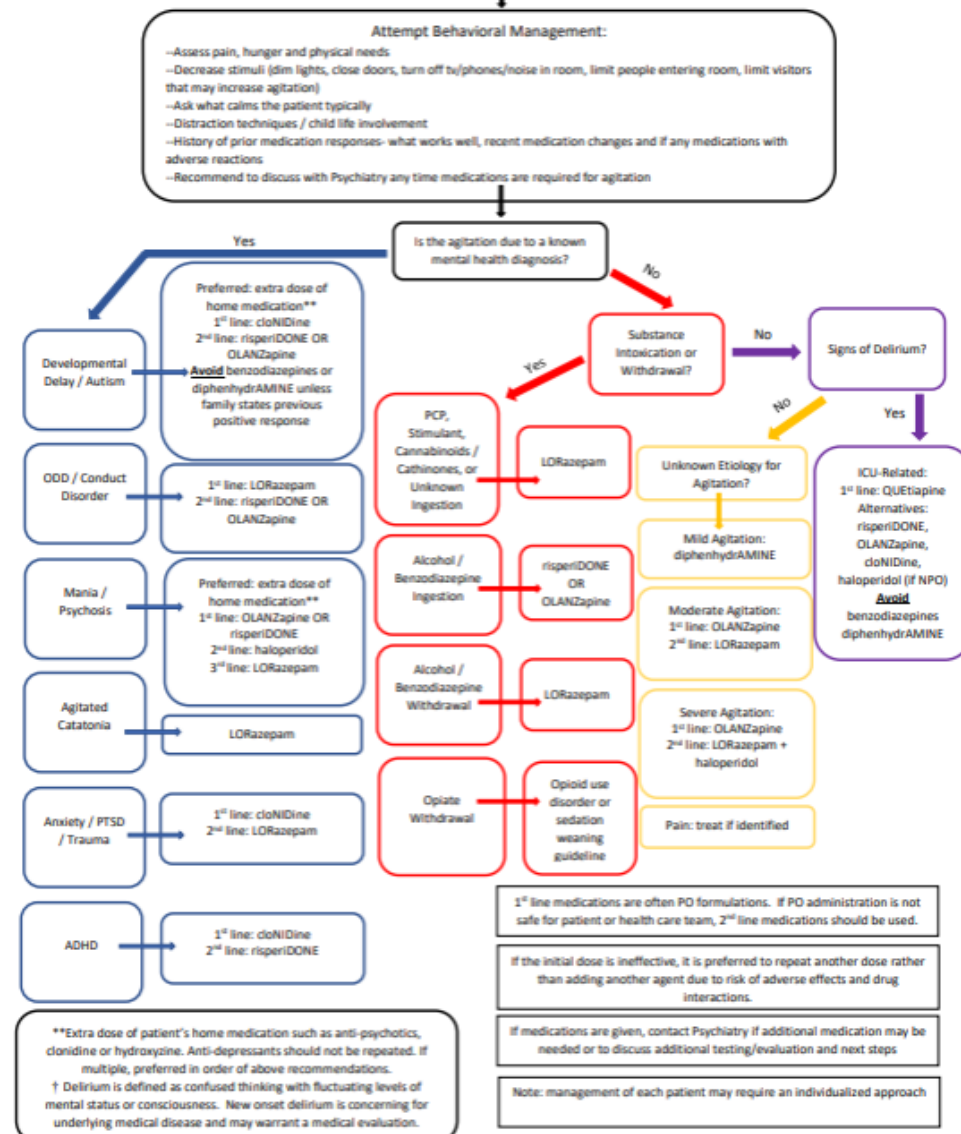
Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español
- 24/7 Crisis Text Line: Text "HOME" to 741-741



Patient presents with or develops agitation

--Detailed history of current symptoms, medical conditions, pmh, current and recent medications, personal and family hx of psychiatric illnesses.



The background of the slide is a light blue gradient with faint, semi-transparent images of medical and household items. On the left, there is a silver alarm clock. In the center, a white syringe is oriented vertically. On the right, a silver stethoscope is visible. The overall aesthetic is clean and professional, with a focus on health and safety.

Social Issues

- Home Safety
- Food Security





Home safety checklist

Children's Wisconsin Safety Center has many resources to help keep kids safe and healthy. This home safety checklist is a place to get started with things to think about to keep kids safe at home. Many additional resources are provided in links. Visit childrenswi.org/safetycenter for more information.

- Overall emergency planning** Create emergency action plans, and make sure everyone in your family knows how to respond to different types of emergencies. Get our family safety planning sheet.
- Home fire safety** Have working smoke alarms and carbon monoxide detectors on every level of your home, and check them monthly. Get our room-by-room fire prevention checklist. Also, home heating safety.
- Home cooking safety** Cooking is the No. 1 cause of home fires. Teach kitchen and cooking safety to kids and teens.
- Fall safety** Falls are the No.1 reason for injury in the home. Keep doors and stairs clear to avoid trips and falls. Keep cords and other tripping hazards out of sight.
- Medication safety** Place medications, vitamins, cleaning products and other poisons in a locked, high cabinet. Visit the Wisconsin Poison Center for more poison prevention information.
- Water safety** Supervise children at all times around water, including buckets, bathtubs and pools. Learn more about swimming and water safety.
- Toy safety** Check toys and other electronics for button batteries and magnets, and keep them out of reach of young children and pets.
- Furniture safety** Secure dressers, TVs and other furniture to the wall to avoid tipping over.
- Firearm safety** Make sure firearms are stored in a locked gun safe and separate from ammunition.

childrenswi.org/safetycenter
safetycenter@childrenswi.org

© 2022 Children's Wisconsin. All rights reserved. CS_SAF_224_702

SAFE
KIDS
 WISCONSIN

led by
 **Children's**
 Wisconsin

doctor



What is the Hunger Vital Sign™?

In 2010, Drs. Erin Hager and Anna Quigg and the Children's HealthWatch team developed the Hunger Vital Sign™, a validated 2-question food insecurity screening tool based on the [U.S. Household Food Security Survey Module](#) to identify households at risk of food insecurity.

The Hunger Vital Sign™ identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

“ Within the past 12 months we worried whether our food would run out before we got money to buy more.”

“ Within the past 12 months the food we bought just didn't last and we didn't have money to get more.”

Children's Health Watch – Hunger Vital Sign

The background of the slide features a light blue gradient with faint, semi-transparent images of medical equipment: a stethoscope on the right, a syringe in the center, and an alarm clock on the left. In the top-left corner, there is a small orange icon of a speech bubble.

Clinical Care Algorithms

- Asthma
- Croup
- Bronchiolitis
- DKA
- Abdominal Pain
- UTI
- Febrile Neonate





Family-Centered Care

- ✓ Policy to promote family-centered care
- ✓ Involvement in patient care decision-making
- ✓ Involvement in medication safety processes
- ✓ Family presence during all aspects of emergency care and resuscitation
- ✓ Bereavement Counseling





Patient- and Family-Centered Care in the Emergency Department

I. PURPOSE

To establish standardized practices that promote Patient- and Family-Centered Care (PFCC) in the Emergency Department (ED) for both pediatric and adult patients. This includes meaningful involvement of families and caregivers in care decision-making, medication safety processes, family presence during procedures and resuscitation when appropriate, education regarding treatment plans and disposition, and provision of compassionate bereavement support.

II. SCOPE

This policy applies to all ED clinical and support personnel involved in the care of pediatric and adult patients.

III. DEFINITIONS

Patient- and Family-Centered Care (PFCC): An approach to healthcare that is respectful of and responsive to individual patient and family preferences, needs, and values, ensuring that patient values guide clinical decisions.

Family/Caregiver: Individuals identified by the patient (or legal guardian for minors or incapacitated adults) as playing a significant role in the patient's life and care.

Shared Decision-Making (SDM): A collaborative process in which clinicians and patients/families make healthcare decisions together based on clinical evidence and patient/family values.

Family Presence During Resuscitation (FPDR): The practice of allowing family members to be present during resuscitative efforts or invasive procedures when appropriate.

Bereavement Support: Emotional, informational, and psychosocial support provided to families following a death or life-threatening event.



IV. POLICY

- The ED shall integrate PFCC principles into all aspects of care delivery for pediatric and adult patients.
- Patients and families shall be treated with dignity, respect, and cultural sensitivity and actively engaged in care planning and decision-making consistent with patient preferences, decision-making capacity, and legal authority.
- Families and caregivers shall be included in medication safety processes to reduce preventable harm.
- Family presence during procedures and resuscitation shall be supported when clinically appropriate and when resources allow.
- Clear, timely communication regarding diagnosis, treatment plan, risks, benefits, and disposition shall be provided in language understandable to the patient and family.
- The ED shall provide compassionate bereavement support following the death of a patient (adult or pediatric) or during life-threatening events.

V. PROCEDURE

A. Involving Families in Care and Decision-Making

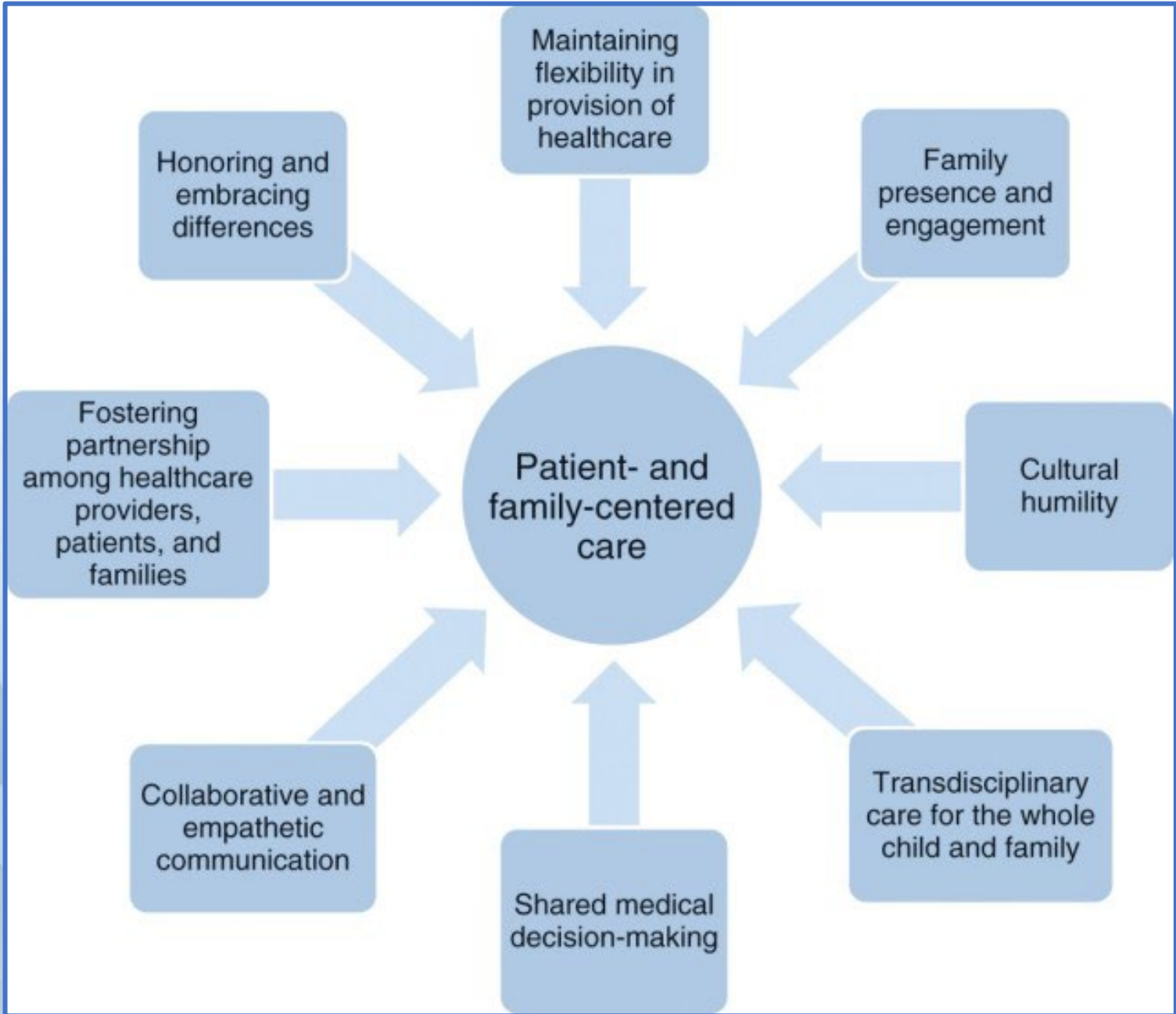
1. Patients shall be asked to identify individuals they wish to involve in care discussions.
2. For pediatric patients, parents or legal guardians shall be included in decision-making consistent with legal requirements.
3. For adult patients, involvement of family shall occur with patient consent or when legally authorized representatives are required due to incapacity.
4. Clinicians shall use shared decision-making when discussing diagnostic testing, treatment options, and disposition planning.
5. Cultural, linguistic, and health literacy needs shall be addressed through interpreter services and appropriate educational materials.

B. Medication Safety and Family Engagement

1. Medication reconciliation shall include input from the patient and/or caregiver whenever possible.
2. Patients and families shall be encouraged to confirm medication names, doses, purposes, and allergies.
3. Pediatric medication dosing shall utilize weight-based verification and standardized safety processes.
4. Discharge medication instructions shall include clear written and verbal education using teach-back methods when feasible.

C. Family Presence During Procedures and Resuscitation

1. Family presence during invasive procedures or resuscitation shall be offered when:



Disaster Planning

- ✓ Disaster plan addresses issues specific to children
- ✓ Includes plan for medications, vaccines, equipment, supplies, and appropriately trained providers for children
- ✓ Addresses decontamination, isolation and quarantine of families together, when possible
- ✓ All disaster drills include pediatric patients
- ✓ Includes pediatric surge capacity
- ✓ Includes access to behavioral health resources in the event of a disaster
- ✓ Includes access to social services for children in the event of a disaster
- ✓ Includes the care of children with special health care needs



Hospital Pediatric Disaster Plan

PLANNING TEMPLATE

BASIC Level

September 2022

Contents

- Introduction 3
 - Background & Purpose 3
 - Assumptions..... 3
- Emergency Operations Plan & Emergency Management Program 3
 - Risk Assessment/Hazard Vulnerability Assessment (HVA)..... 4
 - Drills, Exercises and Education 4
- Regional Healthcare Coalition (HCC) Engagement..... 5
- Surge Capacity and Capabilities 5
 - Medical 5
 - Equipment, Supplies 5
 - Space 6
 - Staff 6
 - Non-Medical..... 6
 - Equipment, Supplies 6
 - Space 7
 - Staff 7
- Transfer Protocols and Procedures 7
- Special Pediatric Planning Considerations 8
 - Decontamination Procedures 8
 - Infectious Disease 8
 - Children with unique healthcare needs 9
 - Behavioral and Mental health..... 10
 - Patient Tracking/Reunification 10
 - Evacuation & Sheltering-In-Place..... 10
 - Security 11
- Authorities and References..... 12

Hospital Pediatric Disaster Plan Template – Implementation Checklist

Blue color indicates the hospital may wish to tailor plan, inserting facility name or abbreviation
Purple color indicates an action – to insert, list, supply a sample, outline, etc. processes/locations/activities unique to the facility or its plan

Bold indicates the hospital will need to define its jurisdiction (LDH/HCC regions)

p. 3	<input type="checkbox"/> Identify plan type – stand-alone vs. incorporated into or appendix of EOP <input type="checkbox"/> Insert incident command system (HICS) organization chart or other response chart delineating roles with responsibilities during disasters <input type="checkbox"/> Outline pediatric champion as medical technical specialist
p. 4	<input type="checkbox"/> Hospital selects from list and/or outlines way pediatric HVA or Risk Assessment is conducted – multiple options of ideas are presented in template <input type="checkbox"/> Insert or attaches HVA and/or summary of findings as they pertain to pediatrics <input type="checkbox"/> Define HCC region
p. 5	<input type="checkbox"/> Indicate frequency of participation in HCC planning and engagement meetings <input type="checkbox"/> Indicates locations of pediatric supplies and equipment used in medical surge
p. 6	<input type="checkbox"/> Hospital identifies and lists departments and service areas included in planning for obtaining additional pediatric surge supplies/equipment <input type="checkbox"/> Outline surge strategies for pharmaceutical interventions for pediatrics <input type="checkbox"/> List out spaces used for medical surge <input type="checkbox"/> Lists staff - roles and responsibilities along with training and education programs inclusive pediatric medical and disaster response <input type="checkbox"/> Indicates location of non-clinical supplies and equipment needed during surge of uninjured/ill pediatric patients; identifies methods of obtaining additional supplies not maintained within hospital
p. 7	<input type="checkbox"/> Identifies space used for non-medical surge of pediatric patients <input type="checkbox"/> Identifies staff to support the management of non-medical pediatric surge <input type="checkbox"/> Outlines or direct/reference procedures to transfer patients out; identify nearest children’s hospital or facility with most advanced pediatric capability <input type="checkbox"/> List routine transfer protocols or mechanisms for obtaining medical transport
p. 8	<input type="checkbox"/> Does hospital have decontamination plan? If yes, reference that plan in this section <input type="checkbox"/> Outline areas/locations to be used for decontamination of pediatrics and locations pediatric decontamination supplies are stored <input type="checkbox"/> Include procedures for carrying out pediatric decontamination of age groups <input type="checkbox"/> Identify staff member(s) to provide oversight or guidance for pediatric decontamination <input type="checkbox"/> Does hospital infectious disease plan or policies address peds? If yes, refer <input type="checkbox"/> List areas used for pediatric isolation
p. 9	<input type="checkbox"/> List areas of pediatric PPE <input type="checkbox"/> Identify the role/staff to assist with planning and response for children with unique healthcare needs - Outline policies and procedures for unique pediatric patient populations <input type="checkbox"/> Indicate other providers or special groups to help with response to unique pediatric patient populations
p. 10	<input type="checkbox"/> Identify the role/staff to assist with planning and response for pediatric behavioral or mental health – reference any relevant protocols around mental or behavioral health <input type="checkbox"/> Indicate patient tracking coordinator roles/staff – use HICS org chart if necessary <input type="checkbox"/> Outline reunification procedures for pediatric patients <input type="checkbox"/> Identify locations to receive pediatric patients evacuated into facility and estimated bed or surge counts, including staff to help manage surged/receiving patients
p. 11	<input type="checkbox"/> Does hospital have evacuation plan inclusive of moving pediatrics? If yes, reference that plan <input type="checkbox"/> Identify primary and secondary sites to evacuate patients – for external evacuation <input type="checkbox"/> Identify scenarios to prompt Sheltering-In-Place and any special planning considerations for pediatrics not previously addressed in plan <input type="checkbox"/> List various staff members, locations and strategies related to security

EMSC: Pediatric Disaster Plan Implementation Checklist





Checklist of Essential Pediatric Considerations for Every Hospital's Disaster Policies

[EMSC:](#)
[Checklist Link](#)



Revised, September 2024

PROGRESSIVE CATEGORIES OF RECOMMENDATIONS: A KEY MODIFICATION

For each domain in this document, considerations are organized into a three-category progressive system: Foundation, Intermediate, and Advanced. It is intended that institutions start by focusing on the more fundamental activities in the Foundation column, then move to the other columns as their level of planning increases. The considerations in each category are meant to build on the capabilities and preparedness of the prior category. The goal is to enable the tailoring of recommendations based on approximate hospital pediatric volume and inpatient pediatric capabilities and capacity.

Foundation: These are the basic building blocks of pediatric disaster preparedness that every hospital should be prepared to provide. Hospitals without dedicated pediatric inpatient services will likely focus primarily on this column, though they may take on planning activities from other columns depending on their resources and level of engagement. They are meant as the foundational disaster preparedness considerations necessary to meet the needs of children.

Intermediate: Hospitals with inpatient pediatric services may need to build upon foundation-level planning activities to provide higher levels of support and expertise for pediatric disaster patients. These considerations may require establishing partnerships with pediatric tertiary care centers in your region.

Advanced: In addition to completing foundation- and intermediate-level planning activities, specialty children's hospitals, and comprehensive pediatric inpatient services within general hospitals, will often have the resources to provide a higher level of preparedness in their hospital as well as provide support and leadership within the region and state. Therefore, in addition to strengthening an individual institution's disaster response, these recommendations promote the assumption of a leadership role in the community.



Medications

Pain & Fever	
	Acetaminophen
	Ibuprofen
	Fentanyl
	Morphine
	Oxycodone
Antibiotics	
	Amoxicillin
	Ampicillin
	Cefazolin
	Ceftriaxone
	Cefotaxime
	Cefuroxime
	Clindamycin
	Gentamicin
	Metronidazole
	Vancomycin
Respiratory	
	Albuterol MDI
	Albuterol Nebulizer
	Ipratropium
	Racemic Epinephrine
	Epinephrine
	Magnesium Sulfate
	Methylprednisone
	Prednisone/Prednisolone

Cardiac	
	Furosemide
	Amiodarone
	Dobutamine
	Dopamine
	Epinephrine
	Norepinephrine
	Milrinone
	Nicardipine
Neurological	
	Diazepam
	Fosphenytoin
	Lorazepam
	Mannitol
	Midazolam
	Hypertonic Saline (3%)
	Phenobarbitol
	Levetiracetam
Resuscitation	
	Adenosine
	Calcium Chloride
	Epinephrine
	Glucose
	Sodium Bicarbonate
	Amiodarone
	Atropine

Reversal Agents	
	Flumazenil
	Naloxone
RSI:	
--Premedication	
	Atropine
	Lidocaine
--Induction	
	Etomidate
	Midazolam
	Ketamine
--Paralyzation	
	Rocuronium
	Succinylcholine
Procedural Sedation	
	Ketamine
	Propofol
	Nitrous Oxide
Anti-Toxins	
	Atropine (Nerve Agent Tx)
	Hydroxocobalamin (Cyanide Tx)
	Sodium Nitrite + Sodium Thiosulfate (Cyanide Tx)
Vaccinations	
	DTaP (7 and under)

Non-Medical Needs

Staff	
	Infant Childcare
	Child Life
	Interpretors
	Chaplain
	Social Work
	Mental Health Counselors

Supplies	
	Beds
	Cribs
	Linens
	Diapers
	Wipes
	Baby Bottles
	Sippy Cups
	Formula
	Food

Space	
	Separate room from medical care
	Safe, with no dangers to small children
	Play space
	Television, activities

9 Done!

¡Listo!

امت!

洗完啦!

완료!

완료!



RECOMMENDATIONS

Child is finished with decon and receives a blanket or gown to cover themselves. Pediatric patients are particularly vulnerable to hypothermia. They should be wet and exposed for as little time as possible. Distance between decon location and triage/hospital entrance should be as short as possible.

Dry off with a towel and provide gowns or blankets to cover themselves with.

Point to where the child should go and to the person who will continue their care. Introduce them to the child by name when possible.

SAY

"All done! Here is a blanket/towel for you to dry off with. I can help you if you need it. When you're ready, let's go that way with (name) so the doctors can check you out."

"Good job! You did great!"





Pediatric Decontamination Plan Template



The Pediatric Disaster Care Centers of Excellence CFDA # 93.889 funding opportunity announcement (FOA) requires Gulf 7 Pediatric Disaster Network to address known gaps in pediatric disaster care of all pediatric patient populations by augmenting the existing clinical capabilities within states and across multi-state regions. G7 developed multiple healthcare-level plan templates that are inclusive of pediatric population. This plan aims to assist healthcare entities build or strengthen response plans and health care system coordination related to pediatric medical surge in disasters. Specific focus will be given to the management of pediatric care related to burn care, decontamination, family reunification, highly infectious disease (HID), mass casualty incidents (MCI), patient evacuation, and behavioral health. These disaster plan templates should be developed to complement the hospital's current emergency operation plan (EOP). It is intended to be a high-level, incident-specific response plan that identifies the experts and specialized resources that exist within the hospital and within their region. Hospitals have obligations under the Occupational Safety and Health Administration (OSHA), and Joint Commission/CMS, to maintain detailed policies and procedures that support their individual operations.

This document is organized as such:

- Sample plan headings/sub-headings;
- Description and considerations (where appropriate, language from the FOA and Health Care Preparedness and Response Capabilities are used; refer to the full text of the capabilities for additional detail/information); and
- Sample resources/plans that may provide guidance or a template for hospitals to assist in their planning efforts. There is no guarantee the resource(s) listed will fully comply with the capability. A sample plan outline is provided in Appendix A of this document.

According to the Pediatric Disaster Care Centers of Excellence CFDA # 93.889 funding opportunity announcement (FOA), Gulf 7 Pediatric Disaster Network must develop a series of pediatric plan templates and resources to address emergencies that include a need for; decontamination, burn treatment, high consequence infectious disease, mass casualty incidents, family reunification, and evacuation. It is important to consider trauma, illness, surgical, and behavioral health topics inclusively since those caring for patients will likely be working on these situations simultaneously.

The FOA states, on page 7, "In Activity B: Strengthen pediatric disaster preparedness plans and health care system coordination related to pediatric medical surge in disaster, strategy 1: Review and update existing disaster preparedness plans and annexes to ensure they incorporate pediatric considerations":

- Convene relevant partners to collectively inventory existing disaster preparedness plans and identify gaps related to statewide and regional

PLACE LOGO HERE

Pediatric Surge Plan Template

Use this template to create a Facility plan for a Pediatric Surge Incident.

Policy/Reference Number: Click or tap here to enter text.

Purpose

Click or tap here to enter text.

Scope

This plan is a supplement to, not a replacement for, the response actions and resources described in the facility Emergency Operations Plan and provides additional details relevant to an incident that involves significant numbers of pediatric victims.

This annex is limited to no-notice incidents. Pediatric issues during *evacuation* and *infectious disease* incidents involve different considerations and are not included here.

Planning Assumptions¹

1. Our facility will utilize the Hospital Incident Command System (HICS) to respond
2. Non-pediatric facilities will receive children from mass casualty events
3. Families should be kept together during all phases of care whenever possible
4. In large incidents, or when access to the facility is an issue, we may have to provide ongoing care pending arrival of sufficient transportation or treatment resources
5. If the event involves more than one facility regional coordination will be required with the health care coalition (HCC)
6. Priority is to transfer the most critical and then youngest patients (<8 years old) as early as possible to an appropriate referral center
7. Our facility has stabilization supplies for:²
 - a. Click or tap here to enter text. critical patients less than 8 years old and Click or tap here to enter text. critical infants

¹ This plan template is NOT intended to be used at pediatric hospitals, where the Emergency Operations Plan should reflect pediatric content.

² See Pediatric Primer for additional information:

- b. Yellow (serious) and Green (minor) patients under age 18 are also considered under this plan

Concept of Operations

1. Patients will be triaged and receive initial treatment in the Emergency Department
2. Designated pediatric disaster supplies should be brought to the ED resuscitation area from: Click or tap here to enter text.
3. Hospital Command Center should quantify transportation and referral needs early in the incident and communicate these to EMS, jurisdictional EOC, or HCC depending on the current state of activation and role of these entities.
 - a. **EMS Dispatch phone:** Click or tap here to enter text.
 - b. **Local EOC phone:** Click or tap here to enter text.
 - c. **HCC/RHPC phone:** Click or tap here to enter text.
4. Pediatric Technical Specialist should be appointed by Incident Commander (See Appendix A for Job Action Sheet)
5. If multiple patients require transportation and some will have to stay temporarily at the hospital, the **Pediatric Services Supervisor**³ and **Pediatric Technical Specialist**⁴ should work with the **Incident Commander, Operations, and Planning section chiefs** to determine the priority for transport and what additional staffing and resources will be required. An emphasis will be placed on transferring the most critical victims and those <8 years of age to pediatric referral centers (see pediatric triage card in MDH Patient Care Strategies for Scarce Resources Situations).
6. The Regional Health Care Preparedness Coordinator (RHPC) should be notified at Click or tap here to enter text. when:
 - More than one regional facility receives victims
 - Transportation or referral resources cannot rapidly meet the incident demands
 - Click or tap here to enter text.

Organization - Responsibilities/Roles

Activation

The Pediatric Emergency Team (PET)

- a. Is activated by: Click or tap here to enter text.
- b. And consists of:⁵ Click or tap here to enter text.

³ See Appendix B for Job Action Sheet

⁴ See Appendix A for job Action Sheet

⁵ Note at least one physician that can perform triage/transport prioritization as the Pediatric Technical Specialist



Mitigating Trauma for Children in Disasters



Children have unique coping needs in disasters.

The CLDR Trauma Mitigation Model was developed utilizing current evidence and expert first-hand experience to attend to the specific needs of children in disasters and crises. The following summarizes the practical application of this model.

TRAUMA MITIGATION MODEL

CO-REGULATION



Recognize your own emotional state.

Intentionally use your body language, tone, and other nonverbal communication to regulate yourself while engaging the child.

Remain intentionally aware that the child may begin to copy or join you as you regulate yourself.

..... ACTION

- Identify how you are feeling and what actions you can take to regulate yourself
- Begin to regulate yourself while saying out loud what you are doing in simple terms, "deep breath"

CONNECTION



Be mentally and emotionally present for the child, in the current moment with your whole being, your whole attention, and whole awareness.

Connection with a safe, stable adult is a strong predictor of a child's ability to be resilient in a challenge.

..... ACTION

- Get on the child's level
- Communicate through your body language and facial expressions that you are attentive, you understand, and you are here with them in this challenge

COGNITION



Once the brain is in a regulated state and connection has been established, a child can more effectively enter into cognitive engagement.

Be intentional with your words. Use simple instructions that are honest yet supportive and use words that are understandable for the child.

..... ACTION

- Use honest words that build connection and emotional safety and decrease confusion

Examples:
 "I don't know the answer to that right now, but I will do my best to find out and tell you."
 "We are safe right now. If that changes, I will tell you, and you and I will move together"

CONTROL



Find ways to allow the child to have control.

This can be accomplished by creating predictability or routine and encouraging opportunities to engage in play.

..... ACTION

- Let the child know what they can expect
- Allow the child choices when possible
- Provide play opportunities, following the child's lead in the play

**Just In Time Handbook:
A Quick Pediatric Reference Guide for Adult
Healthcare Providers**

Final Draft October 2021



**WRAP-EM:
Pediatric Disaster
Handbook**

Key Planning Steps

Complete an Emergency Information Form (EIF) for your child

- An EIF is a list of your child's medical conditions, needs, medications, equipment, and care providers. Visit [this resource page](#) for examples of an EIF.
- Ask your doctor to help you fill out your EIF and update it each year.
- Keep a paper copy with your child's supplies and take a photo of the EIF on your phone.



Gather supplies your family will need in an emergency

- Consider items your family needs to survive for several days at home (e.g. food, water, equipment).
- Gather items you will need if you are forced to leave your home and keep them in an easy to carry container or "go bag." Include items your child needs if you are not going to a hospital (e.g. extra inhaler, tracheostomy supplies, insulated bag to keep medications cold).
- Review these items with your child's care team. For more information, visit [this resource page](#).



Create a family communication plan

- Plan and practice how your family will communicate if you are separated during an emergency (e.g. your child is at school during a severe storm).
- Write down contact information for your family and important people (e.g. doctors, care team, schools, service providers). Keep with your important documents and as a photo on your phone.
- Send your child to school with a "[backpack emergency card](#)" that includes this information.



Planning for Equipment that Needs Power

- Train a family member, neighbor, or friend in how to use your child's equipment.** Attach simple instructions to the equipment to help others use it.
- Notify your electric company and fire department** that your child has a medical device that needs power. Ask your electric company if they keep a "Priority Reconnection" list.
- Take a photo on your phone of any equipment settings** (e.g. ventilator). Losing power may cause the settings to reset.
- Get back-up power supplies and batteries and test them often.** Keep all equipment charged.
- Keep extra batteries for phones and tablets and keep them charged.** If you have a car, get a car charger to help you power your devices.
- Know how to contact your child's equipment provider.** Ask your child's doctor or care team if you are unsure who your equipment provider is.



Questions About Equipment? Ask Your Medical Equipment Provider



- How long can my child's equipment last without power?
- Is there a manual option for my child's equipment?
- What if my child's device is damaged during the emergency?
- How would temperature changes (like heat) or water damage affect the device?

Evacuating a Child with Physical Disabilities

Leaving your home quickly can be challenging, especially when you have a child with disabilities.

Make a "go-bag" of supplies, medications, and important documents you can leave with quickly.

If you need help carrying your child's equipment, identify people who can help (like a neighbor or nearby family member).

Keep the "go bag" in a place that is easy to access, ideally near equipment you would take with you. Check supplies monthly.

Contact your local first responders and let them know if you need help evacuating your child.

If your child cannot walk without help, figure out who is responsible for helping him/her evacuate. Identify a back-up person as well.

Know your evacuation routes and practice your evacuation plan with your family at least once every six months.



Helping Your Child Cope

Before

- Review and practice your emergency plan with your child. This will help increase confidence and give your child a sense of control.
- If your child has any communication challenges, think about other methods of communication that could help your child convey his/her needs during a disaster.

During

- Plan for activities that can keep your child occupied and help his/her routine from being disrupted. Items such as favorite blankets or toys, or a tablet or phone can help.
- Keep foods on hand that your child enjoys – comfort foods can help calm your child.

After

- Encourage your child to share concerns, ask questions, and talk about what he/she went through.
- Look out for any changes in behavior and discuss any changes with your child's doctors.



Questions About Planning for Your Child's Unique Needs?

Your child's doctors and care team know your child and can help you plan for his/her unique needs during a disaster. Here are some good questions to discuss with them:

- How can I keep refrigerated medications cool during a power loss?
- Can I get an emergency supply of medications for my child?
- In a power outage, how do I feed my child who requires mechanical feeding?
- In a power outage, how long does my child's oxygen or ventilator last?
- Where is the [best place to go](#) if our back-up power plan fails?



Additional Resources Available

- Local information resource guide
- Checklists for other special medical needs
- Emergency Evacuation Shelter FAQ

Key Planning Steps

Complete an Emergency Information Form (EIF) for your child

- An EIF is a list of your child's medical conditions, needs, communication difficulties, medications, and care providers. Visit [this resource page](#) for examples of an EIF.
- Ask your doctor to help you fill out your EIF and update it each year.
- Keep a paper copy with your child's supplies and take a photo of the EIF on your phone if you can.



Gather supplies your family will need in an emergency

- Consider items your family needs to survive for several days at home (e.g. food, water, supplies).
- Gather items you will need if you are forced to leave your home (e.g. medicine, headphones, tablet to keep your child calm) and keep them in an easy to carry container or "go bag."
- Review these items with your child's care team. For more information, visit [this resource page](#).



Create a family communication plan

- Plan and practice how your family will communicate if you are separated during an emergency.
- Write down contact information for your family and important people (e.g. doctors, care team, schools, service providers). Keep this information with your important documents and as a photo on your phone if you can.



Communicating During Emergencies



- Have your child wear some form of identification** (medical ID bracelet or necklace, or place a tag on your child's phone or shoe) with your child's name, medical conditions, and important contact information.

- Have your child carry a [Communication Card](#)** if they are non-verbal or has trouble communicating, to help others understand their needs.



- Teach your child simple statements** to use when communicating with first responders. Introduce your child to local first responders before a disaster.

- Alert neighbors and first responders if your child has a tendency to wander.** Review this [Autism Safety Kit](#) to help prevent wandering.

- If your child uses a device to communicate, **keep batteries or back-up chargers** in the event of a power outage.

- Talk with your child's school or daycare** about the plan for caring for your child if an emergency occurs while they are at school. Plan how you will connect with your child.



- Ask your child's specialists or speech therapists to help **build your child's vocabulary** for emergencies. [Social stories](#) can help your child learn what to expect in an emergency.

Be Ready for a Power Outage or an Evacuation



Keep these things handy in case you have to stay at home for several days without power:

- Things that help calm your child, such as favorite foods, clothing, blankets, games, and music
- Toys that can serve as a distraction
- Extra batteries for hand-held electronics and portable chargers (keep them charged)
- A car charger in case you can't power your devices at home

In case you have to leave your home in an emergency:

- **Keep a "go bag" ready** with things your child may need:
 - Your child's EIF, Communication Card, and copies of medical insurance cards
 - Your child's medications
 - Items to help with sensory sensitivities (e.g., headphones, ear plugs, sunglasses, hoodies)
 - Favorite toys, activities, and food
 - Tablet or hand-held gaming device with batteries
 - Other items that help comfort your child
- **Plan for where you will go** – ask family or friends in advance if you can stay with them, or plan to go to a hotel or shelter. Ideally, evacuate somewhere familiar to your child to help keep things as normal as possible.
- **Practice your evacuation plan** with your family often – at least once every six months.



Helping Your Child Cope

Before

- Review and practice your plan with your child. This will increase your child's confidence and sense of control.
- Introduce your child to local first responders at community events or a station visit to help your child get more comfortable and help responders communicate with your child.

During

- Plan for activities that can keep your child occupied and help their routine from getting disrupted.
- Consider comfort foods, toys, or other items that help keep them calm or reduce sensory overload.
- Your child may be frightened and may need help understanding what is happening. Check out [these resources](#) that help you talk with your child about disasters.



After

- Give your child a chance to talk about what they went through and were feeling as they are able.
- Look out for any changing behaviors and discuss any changes with your child's doctors/therapists.

Questions About Planning for Your Child's Unique Needs?



Your child's doctors and care team know your child and can help you plan for their unique needs during a disaster. Here are some good questions to discuss with them:

- How do I get an emergency supply of medications for my child?
- How can I help my child stay calm and accommodate their sensory needs?
- How might disruption of services and therapies affect my child?
- What steps should my family take to ensure consistent support for my child?
- What are some behavior changes I could expect to see?
- How can I connect with other parents who have children with similar needs?

Additional Resources Available

- Local information resource guide
- Checklists for other special medical needs
- What to expect at an emergency shelter

QUESTIONS?

Michael Kim, MD
American Family Children's Hospital
mkkim@medicine.wisc.edu

Maureen Luetje, DO
Children's Wisconsin
mluetje@mcw.edu

Carissa Brunner, MPH, CLC
Program Leader – WI EMSC
cbrunner@childrenswi.org

Anna VerKuilen, MPH
Program Manager – WI EMSC
averkuilen@childrenswi.org



National Pediatric Readiness Assessment: Open Now!



EDs

Do You Have 30 Minutes for Kids?

National
PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

Take the 2026 Assessment: pedsready.org

2025



Scan the QR code or go to pedsready.org to get started. National Assessment will run from **March 3-May 31, 2026.**

