

• • • Pediatric • • • READINESS IMPLEMENTATION GUIDE

Version 4 - July 2026



WISCONSIN
Emergency Medical
Services for Children
★ Children's Health
Alliance of Wisconsin

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Wisconsin Emergency Medical Services for Children

Children are not just small adults! They are anatomically and physiologically different, requiring specialized equipment and training for their emergency care. The National Emergency Medical Services for Children (EMSC) program is the only federal program focused on improving the quality of emergency care for children. It focuses on reducing child and youth mortality and morbidity resulting from severe illness or trauma. In 2013, the Wisconsin Department of Health Services called upon Children's Health Alliance of Wisconsin to lead the EMSC state partnership program in Wisconsin (WI). We work to meet the national EMSC performance measures related to improving emergency care for kids.

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Pediatric Readiness

What is the National Pediatric Readiness Program?

Most sick and injured children (82.7% of children in 2016)¹ seek initial emergency care at the community emergency department (ED) closest proximity to where they live. Because of this, it is critical that all EDs have the appropriate resources, capacity and trained staff to provide effective emergency care for children. Is your department pediatric ready?

The [National Pediatric Readiness Program \(NPRP\) assessment](#) is a tool your ED can use to measure your level of pediatric readiness and to aid in identifying gaps that may exist in your preparation to provide pediatric emergency care. The assessment addresses essential domains of readiness identified by the [2026 American Academy of Pediatrics Policy Statement – Pediatric Readiness in the Emergency Department](#). These domains include:

- Administration and Coordination
- Physicians, Nurses and Other ED Staff
- Quality Improvement
- Pediatric Patient Safety in the ED
- Policies and Procedures
- Equipment and Supplies Management

While a total of 100 points is available on the assessment, the questions are not weighted equally; readiness factors felt by expert consensus to be more impactful in a facility were assigned a larger point value.

From March 3, 2026 – May 31, 2026, the EMSC Data Center conducted a nationwide effort to assess EDs against the elements identified in the 2026 Policy Statement. ED nurse managers, or alternative ED staff person, received an invitation to complete an online version of the NPRP assessment. Following assessment completion, your ED received a Weighted Pediatric Readiness Score (Pediatric Readiness Score) and a Gap Report. These reports provide an understanding of the ways in which your department aligns with nationally recommended guidelines for the care of injured and ill children, while also identifying gaps and the opportunities for continued improvement.

How do we take the NPRP assessment?

The assessment can currently be taken at any time online. All respondents will immediately receive a Gap Report with their organization's Pediatric Readiness Score. The EMSC Innovation and Improvement Center (EIIC) states, the NPRP assessment, available at [PedsReady.org](https://www.pedsready.org), offers EDs the opportunity to:

- Benchmark against updated national standards
- Identify new gaps and opportunities for improvement
- Track progress over time

How is our score determined?

An individual ED's Pediatric Readiness Score is determined by the total score achieved on the assessment across all domains. The total possible score is 100. The relative contribution of each domain to the total score is described in Figure 1.

What does our score mean?

Your ED's Pediatric Readiness Score is a raw value representing the total score achieved out of 100 points possible based on your responses to the NPRP assessment questions. This provides an objective and measurable snapshot of your department's state of readiness to provide emergency care for children.

You will receive a Gap Report detailing your raw score, the national average of departments with similar pediatric volumes, the overall national average score and an analysis of all questions by section. Table 1 shows an example of Pediatric Readiness Scores for EDs who responded to the NPRP assessment.

FIGURE 1: BREAKDOWN OF NPRP SCORE TOTAL BY SECTION

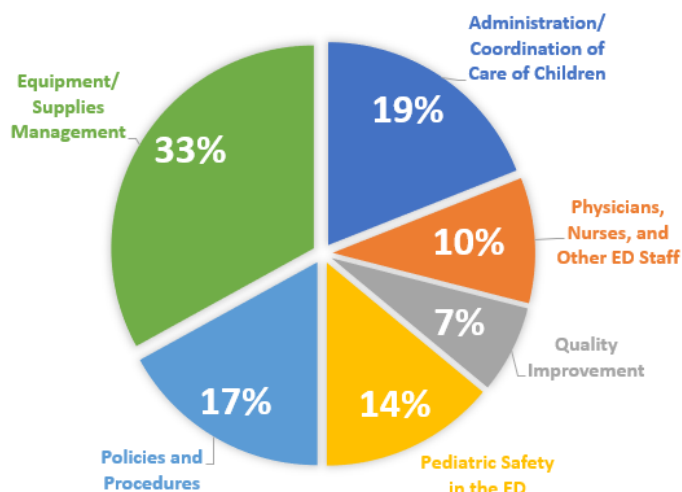


TABLE 1: Example of Pediatric Readiness Scores: Overall and by Pediatric Volume (2026 data)

	OVERALL (N=118)	LOW PEDS VOLUME (N=56)	MEDIUM PEDS VOLUME (N=46)	MEDIUM-HIGH PEDS VOLUME (N=13)	HIGH PEDS VOLUME (N=3)
MEAN	80	76	46	88	99
MEDIAN	80	76	80	91	100

Outcomes from Improved Pediatric Readiness

Since 2020, there have been multiple publications that have demonstrated the benefits of improved pediatric readiness in many areas including medical, trauma and even disparity. Some of the most recent publications are linked below:

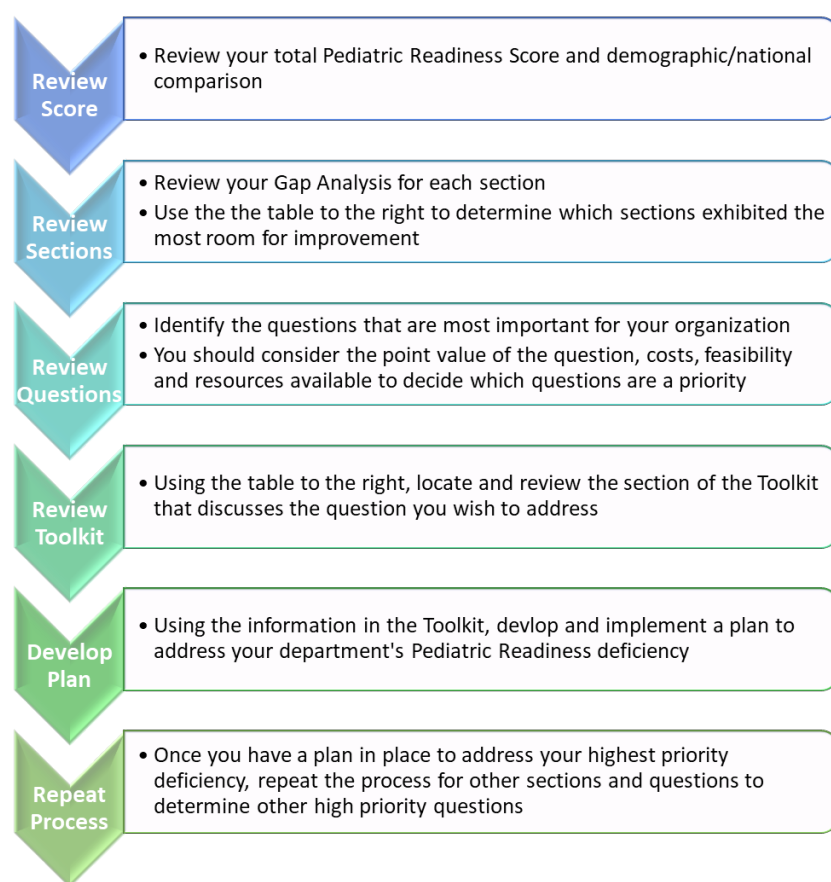
- [National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic](#)
- [Emergency Department Pediatric Readiness and Disparities in Mortality Based on Race and Ethnicity](#)
- [The Association Between Pediatric Readiness and Mortality for Injured Children Treated at US Trauma Centers](#)
- [Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care](#)
- [Association of Emergency Department Pediatric Readiness with Mortality to 1 Year Among Injured Children Treated at Trauma Centers](#)
- [Evaluation of Emergency Department Pediatric Readiness and Outcomes Among US Trauma Centers](#)
- [Emergency Department Pediatric Readiness and Mortality in Critically Ill Children](#)

How do we use the Implementation Guide?

The Implementation Guide is intended to be a question-by-question reference, organized in the same manner as the NPRP assessment. It is not meant to be read from beginning to end. Instead, it is organized so that you may review the sections and questions that are most important for you and your department, to address and focus on specific gaps related to your NPRP score and pediatric readiness.

For each NPRP question, there is a corresponding description in the Implementation Guide. Each page provides the rationale behind the question and indicates essential and supplemental activities that will satisfy the question's requirements. Additional resources such as policy statements, sample policies and procedure descriptions, along with evidence-based research, are included at the conclusion of each section.

To use the Implementation Guide, please follow these instructions.



Citation

1. Gausche-Hill M, Ely M, Schmuhl P, et al. A national assessment of pediatric readiness of emergency departments. *JAMA Pediatr.* 2015;169(6):527-534. doi:10.1001/jamapediatrics.2015.138

Administration and Coordination of Care

This section contains resources about the roles and requirements for the physician and nurse Pediatric Emergency Care Coordinator staffing your emergency department.

19

This section is worth a total of 19 points	
Identified Physician Pediatric Emergency Care Coordinator	9.5 points
Identified Nurse Pediatric Emergency Care Coordinator	9.5 points
Total:	19 points

Physician Pediatric Emergency Care Coordinator - NPRP Questions 28-30 (9.5 points)

Rationale: Importance of the ED Physician Pediatric Emergency Care Coordinator

Institute of Medicine (IOM) recommends hospitals appoint qualified coordinators for pediatric emergency care.¹ An analysis of the 2013 NPRP assessment found that EDs with a designated physician pediatric emergency care coordinator (PECC) were more 'ready' than those that did not. Based on the 2013 assessment, 47.5% of all EDs have a physician PECC and 59.3% have a nurse PECC. The presence of both nurse and physician PECCs is linked to better pediatric readiness, even when other factors are considered.² This physician PECC can take on this role alongside other duties. While establishing this role within a department requires time and effort, it can return strong results for both readiness scores and clinical outcomes

Essential Requirements

To meet this requirement, your department must have an identified physician PECC. The physician PECC may be shared with an advanced practice provider (APP) who works in the ED. A sample description of a physician PECC can be found in the Resources section below. These responsibilities were taken from the 2026 Joint Policy Statement – pediatric readiness in the ED.³

Supplemental Information (NPRP Questions 29 and 30)

While not scored on the NPRP assessment, questions 29 and 30 cover the time set aside for PECCs and the scope of their role. Physician PECCs may supervise the pediatric efforts of a single ED, or several within a health system or region. Physician PECCs given dedicated time to lead pediatric efforts will be more effective. We recommend this approach. If a physician PECC oversees more than one ED, they must understand the specific challenges, patient volume and provider skills at each site.

Resources

- [Emergency Medical Services for Children Innovation and Improvement Center NPRP Toolkit](#)
- [How to Initiate the Conversation on Acquiring a Pediatric Champion](#)
- [Emergency Department PECC Module Series](#)
- [Physician PECC roles and responsibilities](#)
- [Sample Physician PECC role description](#)
- [Sample Physician PECC job description](#)

Citations

1. Institute of Medicine Committee on the Future of Emergency Care in the US Health System. Emergency Care for Children: Growing Pains. National Academies Press; 2006.
2. Gausche-Hill M, Ely M, Schmuhl P, et al. A national assessment of pediatric readiness of emergency departments. JAMA Pediatr. 2015;169(6):527-534. doi:10.1001/jamapediatrics.2015.138
3. Remick KE, Foster AA, Jensen AR, et al. Pediatric readiness in the emergency department: policy statement. Ann Emerg Med. 2026;87(2):e11-e24. doi:10.1016/j.annemergmed.2025.11.016

Nurse Pediatric Emergency Care Coordinator - NPRP Questions 31-33 (9.5 points)

Rationale: Importance of the ED Nurse Pediatric Emergency Care Coordinator

IOM recommends hospitals appoint qualified coordinators for pediatric emergency care.¹ An analysis of the 2013 NPRP assessment found 47.5% of all EDs have a physician PECC and 59.3% have a nurse PECC. The presence of both nurse and physician PECCs is linked to better pediatric readiness, even when other factors are considered.² The 2019 Emergency Nurses Association (ENA) position statement, “*The Emergency Nurse’s Role in Supporting pediatric readiness in the ED,*” remains a foundational reference, identifying the nurse PECC as central to pediatric readiness. More recently, ENA reinforced this position through Resolution GA25-02 (2025), passed with a 95% vote from ENA delegates, which calls for a nurse PECC in every ED. Together, these statements reflect a strong and evolving consensus that formalized nurse PECC roles are essential to pediatric readiness.³ The nurse PECC can take on this role alongside other duties. While establishing this role within a department requires time and effort, it can return strong results for both readiness scores and clinical outcomes.

Essential Requirements

To meet this requirement, your department must have an identified nurse PECC. A sample description of a pediatric nurse coordinator can be found below in the Resources section. These responsibilities were taken from the 2026 Joint Policy Statement – pediatric readiness in the ED.⁴

Supplemental Information (NPRP Questions 32-33)

While not scored on the NPRP assessment, questions 32 and 33 cover the time set aside for nurse PECCs and the scope of their role. Nurse PECCs may supervise the pediatric efforts of a single ED, or several within a health system or region. Nurse PECCs given dedicated time to lead pediatric efforts will be more effective. We recommend this approach. If a nurse PECC oversees more than one ED, they must understand the specific challenges, patient volume and provider skills at each site.

Resources

- [Emergency Medical Services for Children Innovation and Improvement Center NPRP Toolkit](#)
- [How to Initiate the Conversation on Acquiring a Pediatric Champion](#)
- [Emergency Department PECC Module Series](#)
- [Nurse PECC roles and responsibilities](#)
- [Sample Nurse PECC role description](#)
- [Sample Nurse PECC job description](#)

Citations

1. Institute of Medicine Committee on the Future of Emergency Care in the US Health System. Emergency Care for Children: Growing Pains. National Academies Press; 2006.
2. Gausche-Hill M, Ely M, Schmuhl P, Telford R, Remick K, Edgerton E, Olson L. National assessment of pediatric readiness of emergency departments. JAMA Pediatr. 2015;169(6):527-534.
3. Emergency Nurses Association. The Emergency Nurse's Role in Supporting Pediatric Readiness in the Emergency Department. Position Statement. Emergency Nurses Association; 2019.
4. Remick KE, Foster AA, Jensen AR, Williams RF, Stone E, Joseph M, et al. Pediatric readiness in the emergency department: policy statement. Pediatrics. 2026;157(2):e2025075318. doi:10.1542/peds.2025-075318

Physicians, Advanced Practice Providers, Nurses and Other Emergency Department Health Care Providers

This section contains resources regarding the necessary skills, knowledge and training in emergency evaluation and treatment of children of all ages among staff in your emergency department.

10

This section is worth a total of 10 points	
Physician pediatric competency evaluations	2.5 points
Physician participation in continuing certification	2.5 points
Nurse pediatric competency evaluations	2.5 points
Nurse pediatric continuing education requirements	2.5 points
Total:	10 points

Physicians - NPRP Questions 34-40 (5 points)

Rationale: Importance of the Pediatric-Specific Competencies in Physician Credentialing

As team leaders, ED physicians play a critical role in ED team performance and patient care. While it may be unrealistic to staff your ED 24/7 with physicians who are board certified in Pediatric Emergency Medicine, there are optional approaches to ensure the highest level of pediatric emergency care with available resources. Alternative to board certification in pediatric emergency medicine, physicians in your ED should be participating in continuing certification with an American Board of Medical Specialties (ABMS) board. Another critical element is presence of a policy for physician credentialing which requires pediatric-specific competencies for working in the ED – specifically continuing education requirements, maintenance of board certification and hospital-specific competency evaluations, such as those required for sedation and analgesia privileges.

Essential Requirements

To fulfill both these requirements, your department must incorporate pediatric-specific competencies into your hospital credentialing for physicians who work in the ED **and** require maintenance of a certification with a ABMS board. Specific pediatric competencies are not stipulated. You may decide which to include in your credentialing process.

Supplemental Information (NPRP Questions 34-38, 40, 45-49)

Although not scored on the NPRP assessment, an ED staffed 24/7 by board-certified physicians who maintain pediatric competencies (regardless of primary specialty) will have improved pediatric readiness and capability to care for ill and injured children. If 24/7 physician coverage is not practical for your department, we recommend physician coverage that aligns with days and times in which pediatric visits are concentrated based on your department's census patterns.

Additionally, while the NPRP assessment does not specify which pediatric competencies hospitals are to include as part of their ED physician credentialing, you may consider the pediatric-specific training certifications in the following resource section that are recommended for ED physicians without primary certification in emergency medicine.

Finally, although unscored elements on the NPRP assessment, APPs are critical members of the care team for many EDs and must possess current knowledge in pediatric emergency care. A critical element in preparing APPs to care for children is the presence of a policy for credentialing that requires pediatric-specific competencies for working in the ED - specifically continuing education requirements, maintenance of specialty certification and hospital-specific competency evaluations.

Resources

- a. [Maintenance of a certification with a ABMS board](#)
- b. Pediatric-Specific Training Certifications
 - a. [Pediatric Advanced Life Support \(PALS\)](#)
 - b. [Neonatal Resuscitation Program \(NRP\)](#)
 - c. [International Trauma Life Support \(ITLS\)](#) (formerly Basic Trauma Life Support)
 - d. [Advanced Trauma Life Support \(ATLS\)](#)
- c. Examples of Hospital-Specific Competency Evaluations
 - a. Pediatric triage
 - b. Pediatric assessment
 - c. Medication administration and delivery

- d. Device/equipment safety
- e. Procedures
- f. Resuscitation
- g. Trauma
- h. Disaster drills with pediatric patients
- i. Patient and family centered care
- j. Team training and effective communication
- k. Pediatric Sedation
- l. Radiation safety
- m. Pain management

Registered Nurses - NPRP Questions 41-44 (5 points)

Rationale: Importance of the Pediatric-Specific Competencies in Nurse Credentialing

Nurses are critical members of the ED team and must have current knowledge in pediatric emergency care to respond to emergencies in children. A critical element in preparing nurses to care for children is a policy for nurse credentialing that requires pediatric-specific competencies for working in the ED, specifically continuing education requirements and hospital-specific competency evaluations. Incorporating those trainings and/or continuing education into your hospital credentialing requirements will ensure that essential nurses maintain the knowledge and skills required for pediatric emergency care.

Essential Requirements

To fulfill both these requirements, your department must incorporate pediatric-specific competencies into your hospital credentialing for nurses who work in the ED **and** require maintenance of pediatric continuing education requirements (ENPC, PALS, NRP). Specific pediatric competencies are not stipulated, and you may decide which to include in your credentialing process.

Supplemental Information (NPRP Questions 43 and 44)

Although not scored on the NPRP assessment, maintenance of specialty certification and competency evaluations are important elements in your credentialing process. Specific certifications are not stated on the NPRP assessment. You may consider the following:

- a. Maintenance of Specialty Certification
 - a. [Certification of Emergency Nursing \(CEN\)](#)
 - b. [Certification of Pediatric Emergency Nursing \(CPEN\)](#)
- b. Pediatric-Specific Training Certifications
 - a. [Emergency Nurses Pediatric Course \(ENPC\)](#)
 - b. [Pediatric Advanced Life Support \(PALS\)](#)
 - c. [Neonatal Resuscitation Program \(NRP\)](#)
 - d. [International Trauma Life Support \(ITLS\)](#) (formerly Basic Trauma Life Support)
 - e. [Advanced Trauma Life Support \(ATLS\)](#)
 - f. Pediatric-specific continuing medical education
- c. Examples of Hospital-Specific Competency Evaluations
 - a. Pediatric triage
 - b. Pediatric assessment
 - c. Medication administration and delivery
 - d. Device/equipment safety
 - e. Procedures
 - f. Resuscitation
 - g. Trauma
 - h. Disaster drills with pediatric patients
 - i. Patient and family centered care
 - j. Team training and effective communication
 - k. Pediatric Sedations
 - l. Radiation safety
 - m. Pain management

Quality Improvement

This section contains resources regarding the integration of pediatric patient care-review processes into the Quality Improvement and Performance Improvement plan of your emergency department.



This section is worth a total of 7 points	
Pediatric patient care review process (chart review)	1.4 points
Identification of quality indicators for children	1.4 points
Collection of pediatric emergency care data	1.4 points
Improvement plans for pediatric emergency care	1.4 points
Re-evaluation of performance using outcomes-based measures	1.4 points
Total:	7 points

Quality Improvement - NPRP Questions 50-55 (7 points)

Rationale: Importance of Quality Improvement in Pediatric Emergency Care

Basic quality improvement (QI) methodology and practices can dramatically improve pediatric emergency care. QI is a systematic and continuous process in which healthcare teams identify opportunities, implement changes, and measure outcomes to improve health care processes and patient outcomes.¹ In pediatric emergency care, PECCs and emergency department leadership play a key roles in leading pediatric readiness initiatives, QI activities, and sustained improvements in care delivery.² Employing QI methods to address necessary improvements in pediatric care within your ED and documenting its impact, are essential in developing pediatric readiness.

Essential Requirements

For the NPRP, the first requirement is to have a QI plan in place. While there are no points awarded for this question, it is a prerequisite to the follow-up questions that constitute all the points for this section. To be awarded all possible points, your QI plan must include:

1. A pediatric patient care review process (chart review)
2. Identified pediatric-specific quality indicators
3. Ongoing collection and analysis of pediatric emergency care data
4. Improvement plans for pediatric emergency care
5. Ongoing re-evaluation based on outcome-based measures

Supplemental Information

Initiating QI processes may seem daunting, however, it is possible to begin quality work with a small amount of effort. At the heart of QI methods, is the Plan-Do-Study-Act (PDSA) cycle (Figure 2).

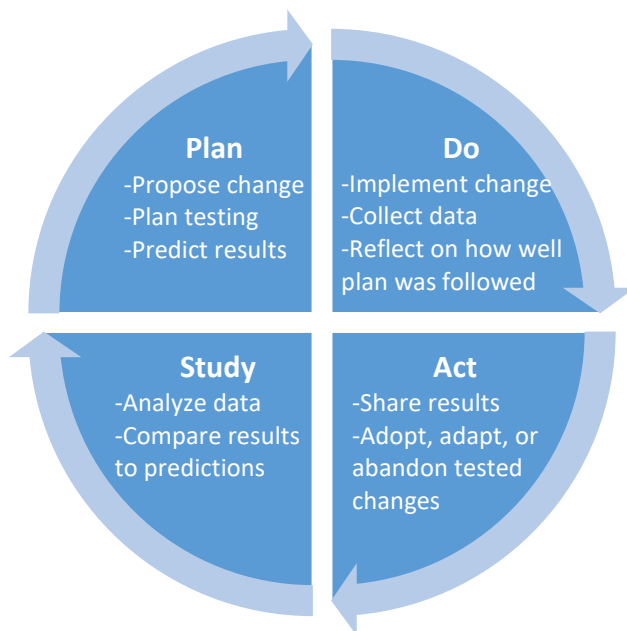


Figure 2: The PDSA Cycle

Plan: Identify an aspect of pediatric emergency care that you would like to improve and select a single change in your department's processes that plausibly will improve the selected aspect of care.

Do: Implement the change and track your desired outcomes.

Study: Next you analyze the data collected to determine if your change had the desired impact.

Act: Decide to permanently adopt, adapt or abandon the change altogether.

Once a PDSA cycle is complete, you may make another change to improve your selected outcome or choose a different outcome.

High-yield, pediatric-specific, quality improvement plans that you may consider implementing in your department include:

- Percentage of patients weighed in kilograms for patients < 18 years of age
- Percentage of patients identify using age-based abnormal pediatric vital signs
- Percentage of days when pediatric equipment is stocked and maintained
- Percentage of parent/caregiver understanding of discharge instructions
- Decreasing total length of stay
- Percentage of children with minor head trauma who receive a head CT
- Percentage of patients who followed protocol for suspected child maltreatment
- Percentage of patients who followed evidence-based management plan for bronchiolitis
- Percentage of patients receiving antibiotics for viral illnesses
- Percentage of patients who return within 48 hours resulting in admission
- Medication error rates

Resources

- [Webinar: Pediatric Readiness Data: An Opportunity to Improve Quality of Care in Your Emergency Department](#)
- [White Paper: Quality Improvement in Emergency Medical Services for Children](#)
- [Emergency Department Pediatric Performance Measures Toolkit](#)
- [National Pediatric Readiness Quality Initiative \(NPRQI\)](#)

Citations

1. Batalden PB, Davidoff F. Quality improvement research: the need for new concepts and methods for studying the challenges to improving quality. *Int J Qual Health Care*. 2007;19(1):2-6
2. Remick KE, Foster AA, Jensen AR, et al. Pediatric readiness in the emergency department: policy statement. *Pediatrics*. 2026;157(2):e2025075318. doi:10.1542/peds.2025-075318

Pediatric Patient Safety in the Emergency Department

This section contains resources for processes needed to maintain pediatric patient safety in your emergency department.

14

This section is worth a total of 14 points	
Weighing all children only in kilograms	1.5 points
Recording all weights in kilograms	1.5 points
Temperature, heart rate, and respiratory rate recorded	1 point
Blood pressure monitoring obtained on children of all ages	1 point
Pulse oximetry monitoring obtained on children of all ages	1 point
End tidal CO2 monitoring available based on severity of illness and/or need for sedation	.5 points
Process to notify abnormal vital signs to physicians	3 points
Process for the use of pre-calculated drug dosing	3 points
24/7 access to interpreter service	.5 points
The level of consciousness assessed in all children	1 point
Total:	14 points

Weighing in Kilograms - NPRP Questions 56 and 57 (3 points)

Rationale: Importance of Weighing all Pediatric Patients in Kilograms

The transition to kilograms (kg) is the single most evidence-based change your ED can make to enhance medication safety for pediatric patients. All pediatric medication dosing begins with the weight of the patient in kg. Accurate weight measurement and recording in kg is the most critical step in the reduction of medication dosing errors in pediatric patients. Due to errors associated with conversion from pounds to kg, pediatric medication errors may be as high as ten-fold,¹ and this is the most common type of prescribing error in pediatric care.² Resuscitation of critical patients is a significant risk factor for medication errors in the pediatric population. The highest risks for medication errors occur during pediatric resuscitations.³ Data suggest 25% of errors are due to “confusion between pounds and Kgs; and simply having the option to weigh in either unit contributed to wrong weight entries.”⁴ A single incorrect weight or conversion error may lead to multiple medication dosing errors. Therefore, weighing and documenting only in Kg be the standard method.

Essential Requirements

To fulfill this requirement, your ED must have a process to ensure that all pediatric patient weights are **measured** and **recorded** in Kgs only. The requirement is direct measurement in Kgs only, not to measure in pounds and convert to Kg.

Supplemental Information

There are a handful of approaches to address this challenge. Recommended interventions and strategies, shared by summit presenters, include:

- Make Kgs the institutional standard (policy level changes)
- Change all scales’ default settings to kgs; disable pounds/ounces
- Replace scales that do not weigh in kgs
- Maintain scales and make sure they are calibrated correctly
- Post laminate conversion charts for sharing weight in pounds to patient
- Collect and track weight-based errors via an incident reporting system
- Develop and post standardized statement for staff to explain to families regarding kg only policy

During critical situations when weighing patients may be difficult, a weight estimate system may be utilized. There are a handful of available methods including length-based measurements such as Broselow tape, but patient and parental estimates can be very accurate.

Beyond only using kgs as the standard measurement, there are other interventions recommended to ensure medication safety in children. They include optimization of Computerized Physician Order Entry by using clinical decision support, electronic processes to check dose, dosage schedule, drug interactions, allergies and duplicate therapies, along with embedding templates or clinical pathway order sets with alert systems.

Resources

- [American Academy of Pediatrics Statement of Endorsement: Weighing All Patients in Kilograms](#)
- [National Pediatric Readiness Project Key Points on Medication Errors](#)
- [Emergency Nurses Association Position Statement: Weighing All Patients in Kilograms](#)
- [Wells M, Goldstein LN, Bentley A. The accuracy of emergency weight estimation systems in children-a systematic review and meta-analysis. *Int J Emerg Med.* 2017;10\(1\):29.](#)
- [EMSC Innovation and Improvement Center fireside chat on weighing in kilograms](#)

Citations

1. Joseph MM, Mahajan P, Snow SK, Ku BC, Saidinejad M. Optimizing pediatric patient safety in the emergency care setting. *Pediatrics*. 2022.
2. Hannibal GD, Vithanage N, Madhushika MT, et al. A systematic review of prescription errors in paediatric care. *BMC Health Serv Res*. 2025.
3. Alsabri M, Eapen D, Sabesan V, et al. Medication errors in pediatric emergency departments: a systematic review and recommendations for enhancing medication safety. *Pediatr Emerg Care*. 2024.SR
4. Bailey B, Gaunt M, Grissinger M; Pennsylvania Patient Safety Authority. Update on medication errors associated with incorrect patient weights. *Pa Patient Saf Advis*. 2016;13(2):50-57.

Vital Signs - NPRP Questions 58-61 (3.5 points)

Rationale: Importance of Obtaining Complete Vital Signs in All Children

Obtaining, interpreting and acting on pediatric vital signs (VS) present challenges to care teams tending to pediatric patients. As a result, accurate measure and effective use of VS in children may be lacking in certain care settings.

Essential Requirement

To fulfill these requirements, your ED must have a documented policy or guidelines on the following,

- Obtaining and recording a full set of VS including heart rate, respiratory rate and temperature
- Guidelines on blood pressure monitoring on children of all ages
- Guidelines on pulse oximetry monitoring on children of all ages
- Guidelines on end tidal CO₂ measurements as clinically indicated

Supplemental Information

In addition to obtaining full vital signs, knowing the normal range of vitals for different sizes and ages of children is crucial. [This vital signs table](#) shows normal pediatric vital sign ranges based on age, adapted from the PALS 2025 course resources. Your ED should have established normal VS ranges for children.

While not required by NPRP, utilization of the Emergency Severity Intervention (ESI) score is recommended in addition to a patient's chief complaint, which incorporates VS in a patient's triage level. This score both predicts the level of intervention a patient may require and has shown to predict the ultimate disposition of the patient.

Obtaining, interpreting and acting on pediatric VS may present challenges. As a result, accurate measure and effective use of VS in children may be lacking in certain care settings. In order to obtain accurate VS from a child, your ED staff should be familiar with the selection of appropriately sized blood pressure cuffs. They should also possess knowledge and skill to obtain an accurate respiratory rate for an infant's periodic breathing tendency. They should also be skilled in soothing irritable or frightened children. In addition, they should understand the developmental limitations of patients – making both core vital signs and key triage data points such as mental status and pain assessment.

Resources

- [Validity of Different Pediatric Early Warning Scores in the Emergency Department](#)
- [Sample Template for Measurement of Vital Signs in the Emergency Department](#)
- [Emergency Nurses Association Non-Invasive Blood Pressure Measurement](#)
- [Emergency Nurses Association Non-Invasive Temperature Measurement](#)
- [Emergency Nurses Association Synopsis of Non-Invasive Blood Pressure Measurement: Description of Decision Options/Interventions and the Level of Recommendation](#)

Notification of Abnormal Vital Signs - NPRP Question 62 (3 points)

Rationale: Awareness of Abnormal Pediatric Vital Signs

Even when abnormal vital signs (VS) are recognized, delays in intervention may occur due to several factors.¹ For example, provider knowledge gaps in the importance of tachycardia in predicting a child's decompensation from septic shock, the difficulty in obtaining IV access in sick children, the lack of a patient's cooperation, or the need to provide family centered care. A process that consistently and reliably informs abnormal VS to the providers is critical². A child's state can change rapidly, underscoring the importance of a prompt reassessment of this challenge. As such, recognition, notification and intervention of abnormal VS are a crucial element of emergency care of children in the ED setting.

Essential Requirements

To fulfill this requirement, your ED must have set normal parameters for all VS based on age. When abnormal VS are obtained, there must be a documented, consistent and reliable notification process for the providers in a timely fashion for immediate interventions.

Supplemental Information

Although not specified by NPRP, once abnormal VS are recognized, there are a handful of methods that can be utilized to notify providers. Manual notification of the physician by the ED tech or nurse may be used, or the process can be automated using electronic medical records software to notify the physician as soon as the VS are deemed abnormal. A prime example is an electronic sepsis alert which monitors for tachycardia, hypotension, fever and hypothermia – it then triggers a Best Practice Advisory (BPA) for providers to intervene.

Resources

- [Emergency Department Triage of Patients](#)
- [Validity of Different Pediatric Early Warning Scores](#)

Citations

1. Valentino K, Campos GJ, Acker KA, Dolan P. Abnormal vital sign recognition and provider notification in the pediatric emergency department. J Pediatr Health Care. 2020;34(6):522-534.
2. Balamuth F, Alpern ER, Abbadessa MK, Hayes K, Schast A, Lavelle J, Fitzgerald JC, Weiss SL, Zorc JJ. Improving recognition of pediatric severe sepsis in the emergency department: contributions of a vital sign-based electronic alert and bedside clinician identification. Ann Emerg Med. 2017;70(6):759-768.e2. doi:10.1016/j.annemergmed.2017.03.019

Pre-calculated Medication Dosing - NPRP Question 63 (3 points)

Rationale: Safety of Pre-Calculated Medication Dosing for Children

As mentioned above in previous sections, reducing medication errors in children starts with weighing and documenting in Kg, but it requires much more. Medication dosing for children varies greatly between medications, and it requires calculation for each medication to be administered. This calculation is a great source of potential errors, especially in critical clinical situations in the ED setting. Therefore, development and utilization of pre-calculated dosing of medication based on weight, not only is simple and reduces stress, but significantly reduces dosing errors.

Essential Requirements

To fulfill this requirement, your ED must have a documented process for weight based or color based pre-calculated medication dosing guidelines/references, especially when caring for critically ill pediatric patients.

Supplemental Information

A common method used to estimate weight of a child and dosing medication is Broselow Pediatric Resuscitation system that utilizes color-coded assigned weight categories to simplify dosing calculations. In addition, adding a pharmacist with pediatric competency to the ED team (especially in large EDs), during times of higher volume, is a great measure in reducing medication errors in children.

Comprehensive measures should include:

- Identifying the administration phase as a high-risk practice (e.g., the simple misplacement of a decimal point can result in a 10-fold medication error)
- Promote distraction-free zones for medication preparation
- Implement computerized physician order entry and clinical decision support
- Kg-only dosing rules
- Including upper dosing limits within ED information systems
- Automated allergy alerts for all prescribed medications
- Development of standardized order sets for high-risk medications (opioids and antibiotics)
- Implement an independent 2-provider, cross-check process for high-alert medications
- Create a standard formulary for pediatric high-risk and commonly used medications
- Standardize concentrations of high-risk medications
- Reduce the number of available concentrations to the smallest possible number

Resources

- [Sample Pediatric Quick Dosing Reference](#)
- [SafeDose Tool for Eliminating Errors in Medication Administration](#)
- [Pediatric medication safety in the Emergency Department](#)
- [Michigan Medication Emergency Dosing and intervention Cards](#)
- [Sample Pediatric Quick Dosing Reference Colorado](#)
- [Key points in Medication Errors](#)
- [The pharmaco-epidemiology of medication errors for children treated in the emergency department](#)
- [Reported medication events in a paediatric emergency research network: sharing to improve patient safety](#)

Citations

1. Shaw KN, Lillis KA, Ruddy RM, et al; Pediatric Emergency Care Applied Research Network. Reported medication events in a pediatric emergency research network: sharing to improve patient safety. *Emerg Med J.* 2013;30(10):815-819
2. Gausche-Hill M, et al. Pediatric medication safety in the emergency department. *Pediatrics.*

24/7 Interpreter Service - NPRP Question 64 (0.5 points)

Rationale: The Need for Interpreter Services in Pediatric Care

All healthcare services should integrate health literacy concepts and skills, including the use of plain language, the teach-back method, pictograms and lower-literacy instructions. During acute care or life-threatening situations in the ED, the need for clear communication between the patient/family and providers is critical in providing basic lifesaving interventions. This requires 24/7 resource availability for language interpreter services, in-person or virtually. In addition, all services provided should be culturally and linguistically appropriate and the ED should provide an environment that is safe for children and supports patient- and family-centered care. Navigating health care events with linguistic and literacy limitations is very stressful. With this resource in place, families can be informed of patients' rights and responsibilities from the perspective of safety. The utilization of bilingual relatives or friends as interpreters is not recommended.

Essential Requirements

To fulfill this requirement, your ED should have 24/7 interpreter services available, utilizing in-person or telehealth options.

Supplemental Information

Although not required by NPRP, your ED should have a policy or guideline that integrates health literacy concepts and skills, including the use of plain language, the teach-back method, pictograms and lower-literacy instructions. This clear communication between patient, family and providers is not only necessary for appropriate medical care, but it fosters a safe environment that supports patient- and family-centered care – allowing a shared decision-making process for those who have linguistic and literacy limitations.

Resources

- [Medical Language Access Solutions for Care Delivery, EMSC Innovation and Improvement Center](#)
- [Improving Identification of Interpreter Need in the Pediatric Emergency Department](#)
- [Improving Interpreter Access in the Pediatric Emergency Department: A Quality Improvement Initiative](#)
- [Professional Interpreter Use and Discharge Communication in the Pediatric Emergency Department](#)
- [Patterns and Predictors of Professional Interpreter Use in the Pediatric Emergency Department](#)
- [Improving and Sustaining Interpreter Use Over 5 Years in a Pediatric Emergency Department](#)

Other Vital Information - NPRP Questions 65 and 66 (1 point)

Rationale: Assessment of Pediatric Mental Status

Evaluation of mental status is the first of the three components in the pediatric assessment triangle and is the first step in initial evaluation of any critically ill or injured patients in emergency settings.^{1,2} This assessment is recognized in every emergency training including BLS, PALS, NRP and ATLS. However, mental status assessment and documentation are often not required elements of standardized initial assessment such as vital signs. Recognition of altered mental status can have a profound impact on the timing of interventions in the ED and outcome of the patient.

Additionally, pediatric pain assessment has been a challenge due to its difficulties and lack of priority. Despite recent onslaught of evidence, the barrier to appropriate pediatric pain assessment and management remains. Pain assessment is a recommended element of initial assessment of all patients and should be included in the initial assessment of all children seen in emergency settings.

Essential Requirements

To fulfill these requirements, your ED must have a documented policy or guidelines on the following:

- Assessment of mental status in all children as initial assessment during triage
- Level of pain assessed in all children as initial assessment during triage

Supplemental Information

Common triage systems have mental status or level consciousness components within their criteria. However, they do not specifically require documentation of mental status assessment. Specific documentation of mental status should be in place using the Glasgow Coma Scale (GCS) or Alert, Voice Pain, Unresponsive (AVPU) system in every patient. The GCS score is used to assess mental status for all pediatric patients and is useful for giving an objective number and monitoring changes in. However, it has only been validated for patients presenting with traumatic injuries, and not for non-injury related altered mental status patients.

Pain is a subjective experience, making the clinical standard for a pain assessment a self-report scale. Simple numerical scales, such as verbally grading pain from 0 to 10 may be accurate in older children with moderate to severe pain. Children as young as 3 years are able to report their own pain level and the revised FACES pain scale, the Wong-Baker Faces scale and the 10-cm Visual Analog Scale can be used. For those who are unable to use self-report scales, behavioral scales such as Face, Legs, Activity, Cry and Consolability (FLACC) or Neonatal Infant Pain Scale (NIPS) are recommended.

Resources

- [Behavioral Scale for Scoring Postoperative Pain in Young Children](#)
- [FACES Pain Rating Scale](#)

Citations

1. Tørisen TAG, Glanville JM, Loaiza AF, Bidonde J. Emergency pediatric patients and use of the pediatric assessment triangle tool (PAT): a scoping review. BMC Emerg Med. 2024;24(1):158. doi:10.1186/s12873-024-01068-w
2. Fernandez A, Benito J, Mintegi S. Is this child sick? Usefulness of the Pediatric Assessment Triangle in emergency settings. J Pediatr (Rio J). 2017;93(suppl 1):60-67. doi:10.1016/j.jped.2017.07.002

Policies and Procedures

This section contains resources necessary to establish pediatric-specific policies and procedures in your emergency department.

17

This section is worth a total of 17 points	
Pediatric Triage Policy	1 point
Use of a Validated Triage tool	1 point
Pediatric Patient Assessment and Reassessment	2 points
Immunization Assessment and Management	1 point
Child maltreatment	1 point
Death of a Child in the ED	1 point
Reduced-dose Radiation Policy	1 point
Universal suicide screening policy for children	1 point
Policy for management of acute agitation	1 point
Clinical Pediatric Protocols or Algorithms	1 point
Family-Centered Care Policy	2 points
Pediatric Disaster Preparedness	2 points
Written Transfer Guidelines for Children	2 points
Total:	17 points

Pediatric Triage Policies and use of a Validated Tool - NPRP Questions 67 and 68 (2 points)

Rationale: Importance of Pediatric-specific Triage Policies and a Validated Tool

Triage is a critical process in the ED. Pediatric patients will present to your ED with chief complaints, pathophysiology and normal vital sign ranges that distinctly differ from adult patients. Being prepared to appropriately triage children of all ages ensures that the severity of a child upon presentation to the ED will be accurately assessed and allows for prioritization of care to the sickest children first.

Essential Requirements

To fulfill these requirements, your ED must have a triage policy that specifically addresses children of all ages and utilizes a standard, valid and reliable system to identify patients at high risk, which is based on severity of illness and injury, physiologic state and the risk or suspicion of critical illness and injury. This policy must include the use of a validated pediatric triage tool.

Supplemental Information

Once a specific pediatric triage policy is established, it is important to train and maintain competencies in application of the policy. A valuable tool in the rapid assessment of children in the ED is the Pediatric Assessment Triangle (PAT) (Figure 3). This tool, developed by the American Academy of Pediatrics, relies on three easily observable physical exam elements that can assist in rapid identification of critically ill and injured children. The three components of the PAT are appearance, work of breathing and circulation. Signs of critical illness discernible on this rapid assessment may include: irritability, listlessness, or lethargy (appearance); tachypnea, retractions, or grunting respirations (work of breathing); or mottling, pallor, or cyanosis (circulation). Children with one or more of these physical findings should be triaged as higher acuity, regardless of their presenting chief complaint.

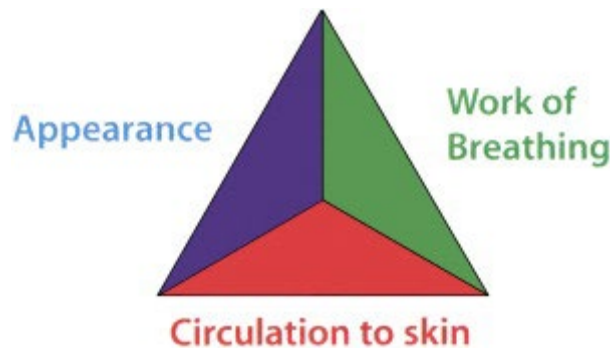


Figure 3: The Pediatric Assessment Triangle (PAT)

Resources

- [Emergency Nurses Association Position Statement: Triage Qualifications and Competency](#)
- [Emergency Severity Index \(ESI\) Triage](#)
- [Paediatric Canadian Triage and Acuity Scale \(Paediatric CTAS\)](#)
- [Pediatric Vital Sign Chart](#)

Citation

1. Tørisen TAG, Glanville JM, Loaiza AF, Bidonde J. Emergency pediatric patients and use of the pediatric assessment triangle tool (PAT): a scoping review. BMC Emerg Med. 2024;24(1):158. doi:10.1186/s12873-024-01068-w

Pediatric Assessment and Reassessment - NPRP Question 69 (2 points)

Rationale: The Importance of Policies to Guide Assessment of Children in the ED

In the United States, millions of children require emergency care annually. Most patients are seen in EDs not specialized in pediatric care and there is variability in the skill, competency and comfort of medical professionals assessing and managing pediatric complaints in the general ED. Children present a unique assessment challenge. Their development of verbal skills, dependency on caregivers and their developmental capacity often make it difficult for emergency professionals to accurately assess the severity of a child's illness or injury. Established policies, procedures and plans will assist EDs in maintaining competencies in pediatric patient assessment.

Essential Requirements

To fulfill this requirement, your ED must have established written policies, procedures and plans that specifically address pediatric patient assessment and reassessment. These may be inclusive of your policies that guide assessment of adults, but should specifically address pediatric VS ranges, presence of caregivers and rapid physical assessment of a child. The need for frequent reassessments of children in the ED should also be included in your department's policies, procedures and plans and may have different reassessment frequencies, depending on the presenting complaint or concerning exam finding.

Supplemental Information

To further improve your ED's pediatric preparedness and competency, you may also include policies on measurement of VS, pediatric pain assessment, accurate determination of patient weight with the use of tools such as length-based tools and implementation of clinical scores such as the Pediatric Early Warning Score (PEWS) that can detect physiologic deterioration in pediatric patients. Well established policies in these areas will improve accuracy of pediatric assessment and may improve patient safety by reducing the likelihood for medical errors.

Resources

- [Validity of Different Pediatric Early Warning Scores in the Emergency Department](#)
- [Pediatric Vital Sign Chart](#)

Immunizations - NPRP Question 70 (1 point)

Rationale: The Importance of Understanding and Responding to Immunization Status

Routine childhood immunizations have proven to significantly reduce or eliminate both common and life-threatening diseases. However, vaccine hesitancy is common, as is incomplete vaccination for variable reasons. Children presenting to the ED may be unvaccinated or partially vaccinated against vaccine-preventable infections. In children, under-immunization increases the risk of less common infectious such as invasive *Haemophiles influenza*, *Streptococcal pneumoniae*, *Clostridium tetani*, and *Varicella zoster*. Understanding the vaccine status of children in the ED is essential to enable the appropriate medical evaluation of children at higher risk for these diseases. Professional emergency organizations encourage emergency providers to be current in their understanding of recommended routine vaccines across all ages and to advocate the importance of vaccines to patients and families.

Essential Requirements

To fulfill this requirement, your ED must have policy, procedures and plans to obtain and update the immunization status on all pediatric patients. This policy must include universal screening for vaccine deficiencies and clear documentation of vaccine status that are easily accessible by the medical provider. The Wisconsin Immunization Registry is an excellent and quick resource for obtaining baseline vaccine information for patients who are unsure of vaccination status.

Supplemental Information

Childhood immunizations decrease morbidity and mortality from infectious diseases. Instituting policies to advocate for childhood immunizations in the ED are beneficial. Additionally, programs that encourage and provide influenza vaccination in the ED, have been successful across all ages. Tetanus vaccination status should always be considered for injured children, with consideration to the type of injury, wound contamination and most recent tetanus vaccination.

Resources

- [American Academy of Pediatrics – Recommended Child and Adolescent Immunization Schedule – January 2026](#)
- [American Academy of Pediatrics – Shared Decision-Making Guidelines](#)
- [Immunizations and Responsibility of the Emergency Nurse](#)
- [Vaccine Information Sheets](#)
- [Flowchart to Assess Pediatric Vaccination Status – American College of Emergency Physicians](#)
- [American Academy of Pediatrics Policy Statement – Increasing Immunization Coverage](#)
- [Wisconsin Immunization Registry](#)

Child Maltreatment - NPRP Question 71 (1 point)

Rationale: Need for Child Maltreatment Policies

Child maltreatment refers to physical, emotional, or sexual harm inflicted on a child and covers overt actions (such as a physical assault), but also includes the harm caused by neglect, or the failure of an individual to provide for a dependent's basic needs. Infants, children and adolescents represent a vulnerable population in that they lack the physical, developmental and emotional ability to adequately protect themselves from abusive actions of others. Child physical abuse is an important cause of morbidity and mortality, contributing to significant physical and mental sequelae in survivors. Physical abuse should be considered in all children with signs of physical injury that are developmentally inappropriate (e.g., bruising in a non-mobile child), are inconsistent with the mechanism of injury provided, or when a history consistent with abuse is given by the patient or a witness.

The World Health Organization defines child sexual abuse as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, and for which the child is not developmentally prepared and cannot give consent.” All sexual acts between an adult and an underage child – even with assent of the child – are, by definition, child sexual abuse. The responsibility of ED providers in identifying and managing child sexual abuse, include management of injuries including the empiric or prophylactic management of potential sexually transmitted infections, victim support, mandated reporting, partnering with law enforcement and providing court testimony.

Essential Requirements

To fulfill this requirement, your department must have a written policy that addresses how potential child maltreatment cases are identified and managed in your department.

Supplemental Information

While the content of this policy is not prescribed by this pediatric readiness requirement, such a policy may include guidance on clinical clues that should increase the suspicion of child maltreatment, common physical findings of abuse, key points on documenting physical findings observed, how to report to county social services or law enforcement, and how to provide resources to support victims and their families. This policy should contain guidance on behavior and findings that are concerning for human trafficking.

Resources

- [Sample Policy – Child Maltreatment](#)
- [Evaluation of Suspected Child Physical Abuse](#)
- [Child Sexual Abuse](#)
- [TEN –4-FACEsp Child Abuse Screening Tool](#)
- [EIIC/TREKK Bottom Line Recommendations: Child Abuse](#)
- [Wisconsin Child Protective Services \(CPS\) Process](#)

Death of a Child - NPRP Question 72 (1 point)

Rationale: Importance of Policies and Procedures that Address Activities Following the Death of a Child in the ED

The death of a child in the ED is an event with emotional, cultural, procedural and legal challenges. The infrequency of child death in the ED and the enormity of the tragedy magnify the challenges, while simultaneously providing clinical care, holistic support for families and emotional support to the medical team, while attending to significant operational, legal, ethical and spiritual issues.

Essential Requirements

To fulfill this requirement, your ED must have a policy or guideline for the ED team following a death of a child.

Supplemental Information

The American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and ENA support the following principles:

- The ED health care team uses a patient-centered, family-focused and team-oriented approach when a child dies in the ED.
- The ED health care team provides personal, compassionate and individualized support to families while respecting social, spiritual and cultural diversity.
- The ED health care team provides effective, timely, attentive and sensitive palliative care to patients with life span-limiting conditions and anticipated death presenting to the ED for end-of-life care.
- The ED health care team clarifies with the family the child's medical home and promptly notifies the child's primary care provider and appropriate subspecialty providers of the death and, as appropriate, coordinates with the medical home and primary care provider in follow-up of any postmortem examination.
- ED procedures provide a coordinated response to a child's death include written protocols for documentation of all necessary administrative information.

Resources

- [Guidelines for Supporting the Family After the Death of a Child](#)
- [Death of a child in the ED sample policy](#)

Radiation Dosing - NPRP Question 73 (1 point)

Rationale: Reducing Diagnostic Radiation Through Pediatric Dosing Policies

Utilization of imaging is an important element of assessment and care of an acutely ill child. However, the risks from ionizing radiation often used in imaging studies must be recognized and addressed at the organization level. Younger and small children are much more susceptible to ionizing radiation that is harmful to their growth and development. This detrimental effect can potentially lead to significant morbidity and mortality that we must make every attempt to reduce or avoid. The concept of “as low as reasonably achievable” (ALARA) has been accepted and implemented by many of the health care organizations and must be utilized consistently, especially in non-pediatric facilities. Especially in trauma setting, the use of Whole Body Computed Tomography or also known as ‘Pan scan’ has increased substantially but did not result in reduced mortality.¹ The radiology capability of hospitals may vary from one institution to another; however, every ED should promote various on-site radiology capabilities to meet the needs of children in the community.

Essential Requirements

To fulfill this requirement, your ED must have a policy or guideline establishing age- or weight-appropriate dose reductions for children consistent with “as low as reasonably achievable” principles.

Supplemental Information

Not specifically required, however, your policy or guideline should include referral of children to appropriate facilities for radiologic procedures that exceed the capability of the hospital. A process should be in place for timely review and interpretation reporting by a qualified radiologist for medical imaging studies in children. When a patient is transferred from one facility to another, to avoid unnecessary radiation exposure, all efforts should be made to transfer completed images. New technology (e.g., Cloud file sharing or Health Insurance Portability and Accountability Act protection) may facilitate image sharing between facilities. WI State Trauma Advisory Council, in cooperation with pediatric trauma centers, have published ‘State of Wisconsin Pediatric Trauma Imaging Guideline for Blunt Trauma.’

Resources

- [Sample Policy – Imaging and Radiology](#)
- [Radiation Risk to Children from Computed Tomography](#)
- [Optimal Emergency Department Management of Children with Minor Blunt Head Trauma](#)
- [State of Wisconsin Pediatric Imaging Guidelines for Blunt Trauma](#)
- [Pediatric Trauma imaging](#)

Citation

1. Meltzer JA, Stone ME, Reddy SH, Silver EJ. Association of whole-body computed tomography with mortality risk in children with blunt trauma. JAMA Pediatr. 2018;172(6):542-549. doi:10.1001/jamapediatrics.2018.0109

Behavioral and Social Health - NPRP Question 74-77 (2 points)

Rationale: Importance of Pediatric Behavioral Health Policies

Nationally, there has been a dramatic increase in the number of ED visits by children seeking help with mental health disorders. These concerns may include self-harm, anxiety disorder, impulse disorder and substance use. Reports indicate that behavioral health visits increased significantly in all types of EDs, both metropolitan and non-metropolitan, but particularly in rural areas and those with low pediatric volumes (less than 4,000 children per year) and these EDs are significantly less prepared to treat children with mental disorders than larger, urban EDs.¹

The 2021 NPRP survey found that only 47.2% of hospital EDs reported having a children's mental health policy and in rural areas, this drops to 33%. While over half of all EDs report having designated transfer guidelines for children with mental health issues, only 38% of rural EDs have such guidelines. The NPRP has also found that EDs seeing small numbers of children are less likely to be prepared to treat children resulting in worse outcomes, including mortality.

Pediatric mental health emergencies ideally are managed by a skilled, multidisciplinary team approach, including specialized screening tools, pediatric-trained mental health consultants, the availability of pediatric psychiatric facilities when hospitalization is necessary and an outpatient infrastructure that supports pediatric mental health care. This includes communication back to the primary care physician in addition to timely and appropriate ED referrals to mental health professionals.

Essential Requirements

To fulfill this requirement, your ED must have,

- A policy for universal suicide screening for children
- A policy for management of acute agitation

Supplemental Information (NPRP Questions 74, 77 and 79)

We recommend your policy addresses any behavioral health concerns for children of all ages. It is also recommended to include standardized patient search procedures ensuring an appropriate level of observation, enhanced environment and room safety and guidance for appropriate use of distraction, redirection, medication and physical restraints. Question 77 is unscored but addresses social issues that can significantly impact behavioral and physical health, including home safety education and food insecurity inquiry. Question #79 is unscored and related to telehealth capabilities for children of all ages. Telehealth and telemedicine can expand the availability of care within an ED.

Resources

- [Pediatric Suicide Risk Screening & Assessment](#)
- [Care of the Agitated Patient](#)
- [De-escalation Tips for the Agitated Pediatric Patient](#)
- [Pediatric Mental Health Care in the Emergency Department Toolkit](#)
- [Elements of the National Alliance on Mental Illness's Compassionate Care in the Emergency Room](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\) Practitioner Training and Virtual Learning Labs for Mental Health](#)
- [Guidance for Emergency Department Preparedness for Children Seeking Mental Health Care](#)
- [American Psychological Association Guidance on Setting up Telepsychology Services](#)

- [American Academy of Pediatrics and American College of Emergency Physicians Policy Statement – Pediatric Mental Health Emergencies in the Emergency Medical Services System](#)
- [Technical Report – Pediatric and Adolescent Mental Health Emergencies in the Emergency Medical Services System](#)
- [Executive Summary: Evaluation and Management of Children with Acute Mental Health or Behavioral Problems – Recognition of Clinically Challenging Mental Health Related Conditions Presenting with Medical or Uncertain Symptoms](#)
- [Ask Suicide-Screening Questions \(ASQ\)](#)
- [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)

Citation

1. Lo CB, Bridge JA, Shi J, Ludwig L, Stanley RM. Children's mental health emergency department visits: 2007-2016. *Pediatrics*. 2020;145(6):e20191536. doi:10.1542/peds.2019-1536

Clinical Care Protocols - NPRP Question 78 (1 points)

Rationale: Importance of Clinical Care Protocols

Pediatric clinical care protocols are an important component in ensuring that every child receives timely, consistent, equitable, and evidence-based care regardless of where they seek emergency treatment. Since most children receive emergency care in community hospitals and pediatric cases represent a relatively small portion of the overall patient volume, using clinical care protocols can reduce variability and support clinicians when pediatric emergencies do occur. Protocols can improve preparedness, identification and evidence-based management of common pediatric conditions, therefore contributing to better outcomes for sick and injured children.

Essential Requirements

To fulfill this requirement, your ED must have,

- Clinical pediatric protocols or clinical care algorithms for common conditions (e.g., asthma, seizure, anaphylaxis)

Supplemental Information

There are no specific number of protocols or types of protocols that are required by the NPRP, but the intent is to build a resource of commonly seen pediatric conditions and use evidence-based guidelines to ensure children are receiving consistent and effective medical care. There are many online resources, specifically many children's hospitals, which have shared their protocols publicly and are easy to access and adapt to a specific emergency department's capacity and capability.

The following are some pediatric conditions that may be commonly seen in an emergency department setting. While this is not an exhaustive list, it has some of the most common pediatric concerns that are seen and a good starting place in building resources for your Emergency Department:

- Abdominal Pain
- Anaphylaxis
- Asthma
- Bronchiolitis
- Concussion
- Croup
- Diabetes
- Febrile Neonate
- Migraine
- Pneumonia
- Seizures (febrile, first-time seizure, seizure disorder)
- Sepsis
- Urinary Tract Infection

Resources

- [Children's Hospital of Philadelphia Clinical Pathways](#)
- [Seattle Children's Hospital – Community Provider Resources: Clinical Standard Work Pathways](#)
- [Nationwide Children's Clinical Pathways](#)
- [Children's Hospital Colorado Clinical Pathways](#)
- [Children's Minnesota Clinical Guidelines and Decision Support](#)

Family-Centered Care - NPRP Questions 80-85 (2 points)

Rationale: Importance of Patient- and Family-Centered Care

Accompanying a child to the ED for medical care is always a stressful event for parents and families. This is most evident when stabilizing or resuscitative care is necessary. While the primary focus of the emergency provider is the medical care of the child, there is mutual benefit to both medical team and family members in establishing and maintaining patient and family-centered care (PFCC) even during ongoing resuscitations. PFCC is an “approach to the planning, delivery, and evaluation of health care that is grounded in a mutually beneficial partnership among patients, family, and health care professionals.”¹ While challenging in the emergency setting, PFCC improves health and well-being through a respectful partnership that honors strengths, cultures, traditions and expertise of both family and providers. PFCC supports concepts such as providing care for an individual, not a condition, while understanding a patient in the context of his/her values and those of his/her family. These concepts will lead to better health care, improved patient safety and heightened patient satisfaction.

Essential Requirements

To fulfill this requirement, you must first have a written policy that addresses family-centered care in your ED **and** have essential elements of PFCC included in that policy. You will receive partial points (.4 for each) for each of the elements that are addressed in your policy. These include,

- Involving families and caregivers in care decisions and
- Involving families and caregivers in medication safety processes
- Family presence during all aspects of emergency care
- Education of the patient, family and caregivers on treatment plan and disposition
- Bereavement counseling

Supplemental Information

All staff, nurses and emergency providers should be trained to involve family in decisions, comfortable with family presence during resuscitations and competent in comforting families following tragic outcomes.

Resources

- [Sample Policy – Family Presence during Invasive Procedure and Resuscitation](#)
- [Sample Family-Centered Care Guidelines](#)
- [Sample Family Presence Program in the ED](#)

Citation

1. *Patient and Family-Centered Care*. Institute for Patient- and Family-Centered Care. <https://www.ipfcc.org/about/pfcc.html>. Accessed July 15, 2026.

Disaster Planning - NPRP Questions 86-94 (2 points)

Rationale: The Need to Include Children in Disaster Planning

Children have unique, often complex physiological, psychosocial and psychological needs that differ from adults, especially during disaster situations; and unfortunately, children are often involved when disasters occur. Approximately half of hospitals reported lacking disaster plans (53.2%) that include specific care needs for children.¹ Disaster preparedness is built on, and dependent upon, pediatric emergency systems of care that operate effectively day-to-day. Emergency care providers in both prehospital and ED settings must have appropriate pediatric equipment and supplies, medical oversight, protocols and guidelines, and training in the care of children. Pediatric capabilities of EDs should be known and verified to facilitate initial transport or timely transfer to appropriate levels of care when needed along with presence of transfer guidelines and agreements.

Essential Requirements

To fulfill this requirement, your hospital's disaster plan must address issues specific to the care of children. The following elements of the disaster plan are all scored independently to meet the disaster planning element:

- Availability of medications, vaccines, equipment, supplies and appropriately trained providers for children in disasters
- Decontamination, isolation, quarantine of families and children of all ages along
- Minimization of parent-child separation and methods for reuniting children with their families
- Specify that **all** disaster drills should include pediatric patients
- A plan for pediatric surge capacity for both injured and non-injured children
- Access to behavioral health resources for children in the event of a disaster
- Include the care of children with special health care needs, including children with developmental disabilities.

Supplemental Information

Although not required, access to social services for children in the event of a disaster is a necessary element in navigating the challenges in supporting children who are not self-sufficient.

Resources

- [Pediatric Disaster Checklist for Every Hospital](#)
- [Pediatric Disaster Champion Resource](#)
- [Pediatric Tabletop Disaster Exercises Resource Kit](#)
- [ENA Topic Brief – Disaster Planning: Preparing for Pediatric Surges](#)
- [ASPR Exercise Program](#)
- [CDC Public Health Emergency Exercise Toolkit](#)
- [Pediatric Emergency Medicine Disaster Simulation Curriculum: The 5-Minute Trauma Assessment for Pediatric Residents \(TRAP-5\)](#) - See Appendices at the end of the article
- [Emergency Information Forms and Emergency Preparedness for Children with Special Health Care Needs](#)
- [Homeland Security Exercise and Evaluation Program \(HSEEP\)](#)

Citations

1. Remick K, Gausche-Hill M, et al. National assessment of pediatric readiness of emergency departments. JAMA Pediatr. 2015;169(6):527-534. doi:10.1001/jamapediatrics.2015.138

Interfacility Transfer Guidelines - NPRP Questions 95-97 (2 points)

Rationale: Need for Guidelines to Direct Interfacility Transfers for Children

To ensure the best possible health outcomes, critically ill and injured children should be treated at the facilities most prepared to address their needs. Often, however, children are treated at local community EDs where pediatric specialty services are not available (i.e., pediatric burn care, pediatric surgical services). Therefore, healthcare facilities should have written arrangements available to formalize their procedures for transferring pediatric patients to specialized centers quickly and safely.

Interfacility transfer guidelines are arranged between hospitals – including out of state/territory facilities and serve to outline procedural and administrative policies for transferring critically ill pediatric patients to facilities providing specialized pediatric care.

Essential Requirements

To fulfill this requirement, your hospital must have an interfacility transfer guideline that outlines procedural and administrative policies with other hospitals for the transfer of patients of all ages, including children in need of care not available at your hospital. Compliance with the Emergency Medical Treatment and Labor Act (EMTALA) does not constitute having interfacility transfer guidelines. The guidelines may be a separate document or part of an interfacility transfer agreement document.

Supplemental Information

Although not specifically scored, your interfacility transfer guideline should include:

- Standardized criteria for transfer of children of any age to another facility for care
- Defined process for initiation of transfer including outline of the roles and responsibilities of the referring facility and referral center
- Process for selecting the appropriate care facility
- Process for selecting the appropriately staffed transport service to match the patient's acuity level (e.g., level of care required by patient or equipment needed in transport)
- Process for patient transfer (including obtaining informed consent)
- Plan for transfer of copy of patient medical record
- Plan for transfer of a copy of the signed transport consent
- Plan for transfer of personal belongings of the patient
- Plan for provision of directions and referral institution information to family

Written interfacility transfer agreements are not required to meet this requirement, but it is recommended that your hospital have an interfacility transfer agreement with tertiary pediatric facilities.

Resources

- [SAMPLE – Interfacility Transfer Agreement Template](#)
- [Steps to Create a Transfer Agreement - EIIIC](#)
- [Pediatric Interfacility Transfer Guideline, EMSC Innovation and Improvement Center](#)

Equipment and Supplies Management

This section contains the list of equipment and supplies, and the associated pediatric sizes necessary to be pediatric ready.

33

This section is worth a total of 33 points	
Staff trained on the location of equipment and medications	2 points
Daily method to verify equipment and supplies	2 points
Portable Pediatric Resuscitation Cart or Bag	3 points
Standardized chart or tool to estimate weight	2 points
Monitoring equipment	3 points
Resuscitation equipment	2 points
Airway equipment	19 points
Total:	33 points

Equipment and Supplies Management - NPRP Questions 98-101 (9 points)

Rationale: Importance of Pediatric-sized Equipment and Supplies

Emergency management of children requires appropriately trained emergency providers with current and competent clinical skills, but even providers who are adequately prepared can struggle to provide appropriate care if pediatric-sized equipment and supplies are not stocked or maintained in the ED. To be available during emergency care, pediatric equipment, supplies and medications should be easily accessible, clearly labeled and organized.

Essential Requirements

To fulfill these requirements, your department will need,

- A process and documentation to train ED staff are trained in the location of all pediatric equipment and medications,
- Documentation of a daily process to verify the proper location and function of all pediatric equipment and supplies
- A standardized tool (i.e., pre-made chart, length-based measuring system, etc.) for estimating weights in children is used.
- A portable pediatric resuscitation cart or bag with equipment organized by age or weight

Supplemental Information

The importance of having a readily available and accurate standardized tool to estimate weights in children during resuscitation and other emergency care events is crucial to the safe care of children. Drug dosing errors comprise the majority of medical errors in children and standardized age-weight charts or systems that estimate weight based on the length of the child, do reduce medical errors and increase the safety of care children receive.

Resources

- [Remick K, Gausche-Hill M, Joseph MM, et al; American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Section on Surgery, American College of Emergency Physicians Pediatric Emergency Medicine Committee, Emergency Nurses Association Pediatric Committee. Pediatric Readiness in the Emergency Department. *Peds*. 2019;143\(3\): e20183894.](#)
- [Rappaport LD, Brou L, Givens T, Mandt M, Balakas A, Roswell K, Kotas J, Adalgais KM. Comparison of Errors Using Two Length-Based Tape Systems for Prehospital Care in Children. *Prehosp Emerg Care*. 2016 Jul-Aug;20\(4\):508-17.](#)
- [Emergency Medical Services for Children Innovation and Improvement Center – Pediatric Emergency Crash Cart Essential Equipment and Medications](#)

Monitoring (3 points), Resuscitation (2 points) and Airway Equipment (19 points) - NPRP Questions 102-149 (24 points)

The remainder of the questions in this section all address specific equipment required to provide care to children. We present this section as list on the opposite page rather than addressing each question individually.

Rationale: Importance of Appropriately Sized Equipment and Supplies

Nowhere is the difference between adults and children felt greater than in the need for the variety of sizes of resuscitative equipment and supplies. Children not only require smaller sizes of equipment compared to adult patients, but a larger variety of sizes is essential to care for children of all ages. Competent and successful pediatric resuscitations simply cannot be accomplished without equipment that is sized appropriately to the child.

Essential Requirements

To fulfill this requirement, you must maintain a stock of the proscribed sizes for all equipment items listed. While each individual item is worth 0.5 points each, this number of essential items makes the total of this section the largest point value. If not already done, maintaining a stock of all items listed can boost your readiness score considerably. This will also ensure that your department is prepared to provide necessary emergency interventions for children of all sizes.

Supplemental Information

While it is extremely important to maintain equipment appropriate for children of all ages, it is difficult to ignore the capital costs associated with maintaining current stocks of infrequently used equipment. This, unfortunately, is a reality faced by general EDs who must be prepared for pediatric emergencies but see children relatively infrequently. We encourage you to look for creative ways to maintain your necessary pediatric supplies in as cost-conscious manner as possible. Perhaps you may partner with a pediatric subspecialty center to exchange equipment that is within a year of expiration date and unlikely to be used in your department for equipment with a longer shelf life.

Monitoring Equipment	Resuscitation Equipment
(0.5 points each) ☐ Neonatal blood pressure cuff ☐ Infant blood pressure cuff ☐ Child blood pressure cuff ☐ Defibrillator with pediatric and adult capabilities including pads and/or paddles ☐ Pulse oximeter with pediatric and adult probes ☐ Continuous end-tidal CO₂ monitoring device	(0.5 points each) ☐ 22-gauge catheter-over-the-needle ☐ 24-gauge catheter-over-the-needle ☐ Pediatric intra-osseous needle ☐ IV administration sets with calibrated chambers or an infusion pump with the ability to regulate rate and volume of infusate
Airway Equipment	
(0.5 points each) ☐ Endotracheal tubes: uncuffed, 2.5mm ☐ Endotracheal tubes: uncuffed, 3.0mm ☐ Endotracheal tubes: cuffed and uncuffed, 3.5mm ☐ Endotracheal tubes: cuffed 4.0mm ☐ Endotracheal tubes: cuffed 4.5mm ☐ Endotracheal tubes: cuffed 5.0mm ☐ Endotracheal tubes: cuffed 5.5mm ☐ Endotracheal tubes: cuffed 6.0mm ☐ Stylets for pediatric/infant-sized endotracheal tubes ☐ Pediatric-sized Magill forceps ☐ Laryngoscope blades: straight, size 0 ☐ Laryngoscope blades: straight, size 1 ☐ Laryngoscope blades: straight, size 2 ☐ Laryngoscope blades: curved, size 2 ☐ Video Laryngoscopy for children ☐ Supraglottic airway: size 1 ☐ Supraglottic airway: size 1.5 ☐ Supraglottic airway: size 2 ☐ Supraglottic airway: size 2.5	☐ Nasopharyngeal airways: infant-sized ☐ Nasopharyngeal airways: child-sized ☐ Oropharyngeal airways: size 0 (50mm) ☐ Oropharyngeal airways: size 1 (60mm) ☐ Oropharyngeal airways: size 2 (70mm) ☐ Oropharyngeal airways: size 3 (80mm) ☐ Bag-mask device, self-inflating infant/child (500mL) ☐ Masks pre-term (size 0) to fit bag-mask device ☐ Masks neonatal (size 0 or 1) to fit bag-mask device ☐ Masks infant (size 0-1) to fit bag-mask device ☐ Masks child (size 1 2 or 3) to fit bag-mask device ☐ Simple oxygen face masks: infant ☐ Simple oxygen face masks: child ☐ Non-rebreather masks: infant-sized ☐ Non-rebreather masks: child-sized ☐ Nasal cannulas: infant ☐ Nasal cannulas: child ☐ Suction catheters: at least one in range 6-8F ☐ Suction catheters: at least one in range 10-12F

Appendix A

Additional Educational Resources

1. Simulation cases
 - <https://www.mededportal.org/action/doSearch?AllField=pediatric+simulation>
2. IV placement resources
 - Peripheral Intravenous Line Placement video (OPENPediatrics)
https://www.youtube.com/watch?v=W4_9louZ4OU
 - Infant IV (EMSC Innovation & Improvement Center)
 - <https://emscimprovement.center/education-and-resources/peak/peak-pediatric-pain/infant-iv-placement/> and
 - <https://www.ems1.com/ems-products/neonatal-pediatric/articles/4-steps-to-owning-the-infant-iv-YUi0wm598YIO4wvV/>
 - Pediatric IV/IO (EMSC Innovation & Improvement Center)
https://www.youtube.com/watch?v=-L6cX73P_R4
 - DIY: How to Create an IV/IO Training Model (EMSC Innovation & Improvement Center) – some easy models that could be made so staff can practice
<https://www.youtube.com/watch?v=GP43Qc15iIM>
 - Tips for Parent/Caregiver when a Child needs a Needle Poke (EMSC Innovation & Improvement Center) https://www.youtube.com/watch?v=8_tz94-fOcg