Australasian College
for Emergency Medicine

Hospital emergency department services for children and young persons

Policy P11

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Document Review

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Related documents

- Australian College of Paediatrics. *Delineation of Hospital Roles in Providing Paediatric Care.* Policy Statement. Aust. Paediatr. J 1985; 21: 151-154.
- Hill MK, Pawsey M, Cutler A, Holt JL, Goldfield SR. *Consensus Standards for the Care of Children and Adolescents in Australian Health Services.* MJA 2011; 194 (2): 78-82.
- Royal Australian College of Physicians. Standards for the Care of Children and Adolescents in Health Services. RACP, Sydney, 2008.
- Australasian College for Emergency Medicine. G15 Emergency Department Design Guidelines. ACEM, Melbourne.
- International Federation for Emergency Medicine. Standards of Care for Children in Emergency Departments. IEMC, Melbourne, 2019.
- Australasian Health Infrastructure Alliance. *Australasian Health Facility Guidelines. Part B – Health Facility Briefing and Planning. HPU 300 Emergency Unit.* Revision 7.0. AIHA, Sydney, 2019.
- Australasian College for Emergency Medicine. S12 ACEM Statement on Delineation of EDs. ACEM, Melbourne.

1. Introduction

This document aims to establish minimum standards in the provision of services to children and young persons who attend emergency departments (EDs) within Australia and New Zealand.

These standards relate primarily to the structure, function and services provided by EDs situated within hospitals which have a separate paediatric ward with dedicated paediatric resident staff and paediatricians on staff.

Clearly, in large paediatric tertiary hospitals these standards should be exceeded, whilst in smaller hospitals without any paediatric facilities they may only be partially met.

These guidelines do not imply the necessity for separate free standing and administratively distinct paediatric EDs, but stress the need for distinct areas which are appropriately designed, staffed and equipped for the treatment of children and young persons.

Note 1: The legal definition of each varies between jurisdictions across Australia and New Zealand but 'child' is considered under the age of 14–16, and 'young person' is considered under the ages of 17–18.

Note 2: Please see P35 Policy on Child at Risk for ACEM advice on children and adolescents at risk of abuse and neglect attending the ED.

2. Design and environment

The design of the department should pay particular attention to the specific physical, emotional and social needs of children and young persons. In the design of services EDs must consider the needs of adolescent patients as distinct from those of young children and of adults.

- Children and young persons should be kept separate (both acoustically and visibly) from the other patients in the department, ideally by the creation of a dedicated paediatric waiting area. Where this is not possible the use of various visual and auditory screening devices should be employed to provide separation. The paediatric area must be easily observed at all times by registered nursing staff
- The areas dedicated for use by children and young persons should be clearly designated and furnished and decorated in a manner that is colourful, comfortable and reassuring for both patients and their parents. Suitable play areas and play facilities should also be provided.
- The design of consulting and treatment areas should permit and encourage parents to remain with their child. The option of family-member presence must be encouraged for all aspects of ED care.
- Treatment rooms should be accessible from the paediatric waiting area, and should protect children from disturbing sights and sounds, including those emanating from the Short Stay Unit (SSU). If children and adults are managed in the SSU, ideally children will be physically, visually and acoustically separated from adult patients.
- A paediatric zone will require a greater proportion of standard isolation rooms compared with an acute adult ED zone.
- The resuscitation area must be fully equipped to manage all types of paediatric emergencies. Mobile paediatric resuscitation trolleys should be immediately accessible in any location in which a child could deteriorate. A camera in the paediatric resuscitation zone is required to communicate with neonatal emergency transport services.
- Younger children must have access to nutrition (this includes provision for breastfeeding).
- Dedicated space for the assessment of paediatric patients with mental health conditions is desirable.
- Adequate space should be available for children/families in crisis, and should include a private room with suitable supervision by emergency staff.

Please refer to the Australian Health Facility Guidelines (HPU 300 Emergency Unit) for the schedule of accommodation with respect to dedicated paediatric zones (AX.01 Schedule of Accommodation).

3. Staffing

3.1 Staffing

A registered nurse with appropriate training and experience (minimum of 12 months) in the emergency management of children and young persons must be rostered on duty at all times. This person should be deemed responsible, either directly or in a supervisory role, for the nursing care of all children and young persons presenting to the ED.

3.2 Triage

All triage nurses must be trained and competent in triaging children and young persons.

3.3 Medical staff

The Director of Emergency Medicine is ultimately responsible for the provision of services to children and young persons. All emergency physicians should maintain adequate CPD in paediatric emergency medicine.

There must be no barriers to accessing immediate initial assessment by a qualified staff member trained in the recognition of acute illness in children. A paediatric registrar or paediatrician should be available (not necessarily on-site) for immediate consultation regarding acutely ill children.

In addition to round the clock access to emergency medicine specialists, the following consultant staff should be available to give advice for department patients on a 24-hour basis as part of local emergency care network service arrangements:

- paediatrician;
- paediatric surgeon; and
- anaesthetist with paediatric skills.

Other specialists may be involved in consulting roles, depending on the level of service provided by the hospital (see ACEM Statement on Delineation of EDs (S12)). Junior medical staff must be involved in an ongoing teaching program in paediatric emergency medicine.

4. Equipment

Every ED must be supplied, equipped and organised to enable easy access to the equipment, supplies and medications needed for the investigation and treatment of acutely ill or injured children of all ages on a 24-hour basis.

4.1 Essential Equipment

In addition to the standard equipment of the ED, essential equipment for the treatment of children and young persons includes the following:

- Paediatric airway and ventilation equipment including:
  - Appropriate oxygen delivery devices
  - Paediatric masks and oropharyngeal airways
  - Endotracheal tubes of appropriate sizes
  - Paediatric nasogastric tubes
  - Paediatric laryngoscopes with straight and curved blades
- Ventilation equipment suitable for use in children

- Oximeter with paediatric probes
- End-Tidal Cardon Dioxide ETCO2 Monitor
- Paediatric intercostal catheters
- Paediatric infusion sets and catheters
- Infusion pumps capable of delivering low volumes
- Cardiac monitor/defibrillator with paediatric pads
- Blood pressure cuffs of appropriate sizes for children
- Paediatric stethoscopes
- Intraosseous access devices
- Lumbar puncture needles of sizes suitable for children
- Scales suitable for children of all ages
- Appropriate vascular access devices

4.2 Desirable Additional Equipment

Desirable additional equipment would include:

- Overhead heater for neonates
- Paediatric urinary catheters
- Paediatric humidified circuit nasal cannula and high flow devices
- Continuous nitrous oxide equipment with scavenger capabilities

5. Paediatric guidelines

Paediatric guidelines regarding the assessment and treatment of specific paediatric conditions must be available in the ED at all times. These guidelines should have the agreement of both the ED and the paediatric department and ideally be continuous from the ED to the wards. Staff in EDs should also have access to decision support tools which assist in correct medication dosing, equipment sizing, and in clinical pathways for paediatric illness and injury.

A minimum set of guidelines must include:

- abdominal pain
- acutely raised intracranial pressure
- acute upper airways obstruction
- adrenal crises
- anaphylaxis
- asthma
- brief resolved unexplained event (BRUE)
- bronchiolitis
- burns
- common fracture
- diabetic ketoacidosis
- cardio-respiratory arrest
- croup
- envenomation
- febrile convulsions
- gastroenteritis
- haemorrhagic and other hypovolemic shock
- head injury
- immersion
- intussusception
- major trauma
- meningitis
- pain management
- non-accidental injury
- poisonings
- pyloric stenosis
- recognition of a sick child
- septic shock
- status epilepticus
- sudden unexpected death in infant (SUDI)
- suspected child abuse and neglect
- urinary tract infections

Whilst paediatric drug doses should be included in the guidelines, access to a paediatric pharmacopeia must also be provided. Should in-house guidelines not be available, then guidelines from major paediatric teaching centres or authoritative recent texts must be available.

A set of patient handouts on major paediatric conditions should be available. Information should be written in simple language and cover languages relevant for the patient population, using diagrams where appropriate to aid understanding.

At discharge, carers must have advice which they understand for managing their child's condition and recognising deterioration.

6. Ancillary services

In addition to the usual services available to the ED, the following should be available:

- Pharmacy. Stocks of drugs likely to be needed by acutely ill children to be available for after-hours dispensing.

7. Other emergency services

All EDs that treat children but do not have in house paediatric and neonatal intensive care facilities must have the ability to consult with and utilise appropriate retrieval services. Clear, written guidelines for transfer criteria to specialist paediatric centres must exist, and mechanisms for swift and expert transfer agreed.

8. Summary

Children and young people attending EDs have special requirements and it is the responsibility of hospitals to provide suitable facilities so that these patients receive a high standard of care in an appropriate setting. Services should also reflect the cultural context of the family, and encourage families to be involved in patient care decisions.

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