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Pediatric Acute Care: A Systematic Approach to Error Reduction

Pediatric occurrences constitute an especially regrettable form of medical malpractice. According to a recent study, many harm-inducing errors in the pediatric setting may be preventable.[1] Associated claims also tend to be quite costly, especially with respect to cases involving lifelong mental or physical injury. One study notes that the average mean indemnity payment is greatest for cases involving newborns ($925,380), followed by children older than 1 year ($518,887) and infants between 1 and 12 months of age ($313,514).[2]

To protect the youngest and most vulnerable of patients from injury, healthcare organizations must institute a pediatric safety program that encompasses both prevention and response. This edition of *Vantage Point*® offers strategies to help pediatricians, hospitalists, nurses and other healthcare providers and administrators identify major sources of harm, prevent common pediatric safety lapses and recognize critical situations. Also presented are a variety of resources to help measure core competency levels among pediatric caregivers, streamline documentation in high-risk settings, promote family-centered communication, and facilitate safe and efficient handoffs between providers. The issue concludes with a gap analysis tool intended to help organizations assess their readiness to refer and transfer critically ill pediatric patients for consultation and additional treatment.

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1 Walker, M. "Nearly Half of Pediatric Medical Errors Deemed Preventable." *MedPage Today*, May 18, 2015. The article examines the most common sources of harm to babies and children – i.e., intravenous catheter infiltrations/burns, respiratory distress, constipation, pain and surgical complications – and finds that 45 percent of these events are potentially or definitely preventable.

2 Jena, A. et al. "Malpractice Risk Among US Pediatricians." *Pediatrics*, June 2013, volume 131:6, pages 1148-1154.

1. IDENTIFY POTENTIAL SOURCES OF PEDIATRIC HARM.

The first step in reducing risk is to measure the incidence of adverse pediatric events, using specialized tools designed to streamline the process of reviewing patient healthcare information records. The perinatal and pediatric trigger tools listed in the box below can help identify potential vulnerabilities and analyze error patterns in a range of high-risk clinical situations, including medication and fluid administration, surgery, treatment of infections, pediatric and neonatal intensive care, and patient transfers.

Formal record reviews should be complemented by a broad-based pediatric error reporting program. Together, these measures can help organizations collect and analyze data on real and potential sources of pediatric harm, while also focusing attention on flawed clinical processes in need of remedial action. Once underlying hazards have been detected, they can be minimized by various interventions, including adoption of electronic diagnostic and patient management tools, redesign of hospital systems and processes, development and implementation of sound handoff and drug safety protocols, and upgraded staff training.

PERINATAL AND PEDIATRIC TRIGGER TOOLS:

- Global Assessment of Pediatric Patient Safety (GAPPS) Trigger Tool, from Boston Children's Hospital.
- Pediatric All-Cause Harm Measurement Tool (PACHMT). (Available for download.)
- Perinatal Trigger Tool, from the Institute for Healthcare Improvement (IHI).
- Trigger Tool for Measuring Adverse Events in the Neonatal Intensive Care Unit, from the IHI.

2. PROACTIVELY ADDRESS COMMON PEDIATRIC SAFETY PROBLEMS.

Common sources of harm for pediatric patients include hospital-acquired infections, sepsis, sedation mismanagement and neonatal abstinence syndrome (i.e., newborn drug/alcohol withdrawal). Adoption and consistent utilization of clinical pathways, screening tools, documentation formats and other standardized guidelines can help minimize the risk associated with these injurious and often costly occurrences.

Hospital-associated infections. Central line-associated bloodstream infections (CLA-BSIs) are among the most frequent infections acquired in a pediatric intensive care setting. While consistent hand hygiene remains the most effective means of preventing the spread of CLA-BSIs, other precautions also should be implemented, such as utilization of practice bundles. These structured guides – which may take the form of clinical pathways, algorithms and/or checklists – are designed to help improve patient outcomes by automatically reminding providers of baseline clinical standards. By incorporating evidence-based practice bundles into electronic health record (EHR) systems, organizations can significantly improve pediatric outcomes associated with routine central venous catheter care.

The Joint Commission's Central Venous Catheter (CVC) Insertion Bundles and CVC Maintenance Bundles help reinforce compliance with infection control protocols by consistently reminding staff members and providers to …

- **Scrub/sanitize hands thoroughly** before and after catheter insertion or manipulation.
- **Apply antiseptic solution to the patient's skin** before inserting catheter.
- **Adhere to full barrier precautions,** such as wearing gloves, gowns and masks, as well as using physical barriers during catheter insertion.
- **Perform catheter tubing hub care** before administering fluids.
- **Review and comply with organizational protocols regarding catheter placement**, including site selection and insertion requirements.
- **Assess the need for continued catheter placement on a daily basis**, documenting the decision-making process.

Sepsis. Undetected infection in a newborn baby or child may spread to the bloodstream, causing hemodynamic changes, organ dysfunction, and potentially severe or even fatal sepsis. By adopting a sepsis identification pathway, hospitals can respond more swiftly to infections and improve septic shock outcomes in pediatric patients. A structured pathway potentially offers a number of clinical and risk management benefits, including, but not limited to, prompt recognition of early symptoms, timely evaluation, comprehensive treatment and thorough documentation of interventions. (See Bradshaw, C. "Implementation of an Inpatient Pediatric Sepsis Identification Pathway." *Pediatrics*, March 2016, volume 137:3.)

Increasingly, emergency departments and pediatric care units are working to enhance staff compliance with core safety measures by embedding sepsis identification pathways into their EHR documentation formats. The following list of basic pathway elements includes links to sample documentation tools:

- "ENA Topic Brief: Early Recognition of Sepsis in the Pediatric Patient," from the Emergency Nurses Association, July 2016.
- Larsen, G., Mecham, N., Greenberg, R. "An Emergency Department Septic Shock Protocol and Care Guideline for Children Initiated at Triage." *Pediatrics*, June 2011, volume 127:6, pages e1585-e1592.
- Pediatric Acute Sepsis: Physician's Orders, from Stony Brook University Medical Center.
- Sepsis Alert Checklist, from Wesley Healthcare.
- Sepsis Screening Tool Scoring Criteria, from Wesley Children's Hospital.
- Sepsis Shock Algorithm, from the University of North Carolina School of Medicine. (Scroll down to last page.)
- Severe Sepsis/Septic Shock Progress Note, from Cookeville Regional Medical Center.
- Transferring Facility Sepsis Recommendations, from Wesley Children's Hospital.

For additional information and resources, visit the website of the Society of Critical Care Medicine's Surviving Sepsis Campaign, as well as the organization's Special Considerations in Pediatrics recommendations list.

Mismanaged sedation. Apnea, airway obstruction or other life-threatening conditions may occur if healthcare providers fail to sufficiently monitor and manage pediatric patients during and after medical or dental procedures involving sedation. (See "Common Causes of Sedation Mishaps," below.) The American Academy of Pediatrics and American Academy of Pediatric Dentistry have issued updated clinical guidelines designed to help clinicians safely deliver sedation to pediatric patients, reducing the potential for mishaps and consequent liability. (See Coté, C. and Wilson, S. "Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016." *Pediatrics*, July 2016, volume 138:1, pages e1-e32.)

Requirements for sedation monitoring have evolved and are now nearly identical to those for general anesthesia, especially with respect to monitoring expired carbon dioxide as a means of ensuring airway patency and gas exchange. Sedation guidelines also require a second provider who is solely responsible for monitoring the patient and assisting the lead practitioner in any supportive or resuscitation measures, if required.

COMMON CAUSES OF SEDATION MISHAPS:

- Failure to follow dosing guidelines.
- Insufficient chart review, resulting in dangerous drug interactions.
- Lack of knowledge of drug pharmacokinetics and dynamics, potentially leading to hemodynamic instability, allergic reaction and other dangerous outcomes.
- High-risk conditions, e.g., croup, bronchiolitis or other serious respiratory ailments.
- Inadequate monitoring before, during or after the procedure.
- Excessively early discharge home.
- Deficient CPR skills, hindering rescue attempts.

As with any high-risk procedure, administration of sedative agents requires scrupulous documentation of interventions performed and assessment findings before, during and after the procedure. At a minimum, the following aspects of sedation and surgery should be noted in the patient healthcare information record:

- Pre-procedure patient evaluation.
- Discussion about risks, benefits and alternatives.
- Informed consent acknowledgment.
- Patient monitoring during the procedure.
- Post-procedure care.
- Discharge readiness.

Newborn withdrawal. Urban-based medical centers are rapidly expanding neonatal intensive care units to accommodate the rising number of opioid-exposed babies arriving from outlying facilities. These infants are at increased risk of neonatal abstinence syndrome (NAS) due to the long half-life of opiates and maintenance therapy drugs, such as methadone and buprenorphine. Withdrawal symptoms are usually but not always noticeable 24 to 72 hours after birth.

Successful treatment of infants born with an addiction requires prompt identification of signs and symptoms. The Modified Finnegan Neonatal Abstinence Score Sheet is a useful resource for detecting newborns with NAS and documenting the diagnosis.

Once NAS has been diagnosed, the infant's healthcare provider must be notified immediately, as NAS symptoms can mimic infections and serious metabolic disorders.

3. UTILIZE SAFETY CHECKLISTS IN HIGH-RISK SETTINGS.

Organizations can significantly enhance pediatric decision-making and patient outcomes by embedding effective, evidence-based safety measures – such as time-out procedures, redundancy checks and forced functions – into routine clinical tasks. In addition to reducing errors and promoting consistent practice in pediatric and neonatal intensive care units, built-in electronic checklists can help improve documentation and legal defense in the event a claim arises.

The following established checklist formats are intended for use in high-risk pediatric care settings:

- Critical Events Checklists, from the Society for Pediatric Anesthesia.
- CUSP Tool: Daily Goals Checklist, from the Armstrong Institute of Patient Safety and Quality at Johns Hopkins University. (Designed for use in the NICU.)
- Reese, C. "Implementation of a Daily Checklist to Improve Patient Safety and Quality of Care in a Pediatric Intensive Care Unit." Dissertation, University of Missouri-St. Louis, 2017. (For the PICU safety checklist, scroll down to Appendix B on page 38.)
- Ullman, A. et al. "The KIDS SAFE Checklist for Pediatric Intensive Care Units." *American Journal of Critical Care*, January 2013, volume 22:1, pages 61-69.

4. IMPLEMENT A PEDIATRIC DRUG SAFETY PROGRAM.

Pediatric inpatients experience up to three times more medication errors than do their adult counterparts.[3] These errors – such as incorrectly dosed antibiotics and intravenous medications – occur most often during the drug-ordering process. Computerized prescription order-entry systems, standardized order forms and dosing safety alerts can help prevent drug-related safety lapses, especially when supplemented by the following procedural safeguards:

- **Establish and maintain a pediatric formulary** that reflects written policies governing drug evaluation, selection and therapeutic use.
- **Standardize order sheets to include spaces for patient weight,** as well as old and new allergies, prescriber name, signature and contact number.
- **Develop and implement a pediatric drug educational program for all medical and hospital staff** that covers calculating, prescribing, preparing and administering medications for children.
- **Require legible, clear and unambiguous prescriptions and drug orders,** and monitor provider performance in this area.
- **Compile a list of high-risk pediatric drugs that must be approved for use by a pharmacist** or that require cross-checking with other hospital and/or medical staff.
- **Involve pharmacists in developing pediatric drug safety protocols** and reviewing medication errors.
- **Adopt specialized tools to facilitate tracking and analysis of pediatric medication errors,** such as the Pediatric Trigger Toolkit: Measuring Adverse Drug Events, from the Institute for Healthcare Improvement.

For additional strategies, see "Medication Error: A Risk Assessment Questionnaire" on page 7.

3 Rinke. M. et al. "Interventions to Reduce Pediatric Medication Errors: A Systematic Review." *Pediatrics*, August 2014, volume 134:2, pages 338-360.

5. DRAFT AND ENFORCE PROTOCOLS FOR SMOOTH PEDIATRIC TRANSITIONS.

Structured communication between providers during patient handoffs can significantly decrease the likelihood of misunderstanding and subsequent errors. Handoff protocols should include documentation requirements for different types of transitional situations, including provider shift changes and patient transfers. (For a more complete listing, see "Critical Handoff Points" to the right.)

At a minimum, handoffs should involve summarizing current medical status, recent lab values, allergies, medication orders and problems noted, as well as providing a to-do list for the covering provider. (The Children's Hospital of Pittsburgh has prepared a set of sample pediatric handoff formats for various scenarios. In addition, see Popovich, D. "30-Second Head-to-Toe Tool in Pediatric Nursing: Cultivating Safety in Handoff Communication." *Pediatric Nursing*, March-April 2011, volume 37:2, pages 55-59.)

6. TRAIN AND EVALUATE STAFF ON AN ONGOING BASIS.

Effective, well-documented staff education and skills training programs are integral to addressing identified safety issues and improving pediatric outcomes. To ensure organization-wide consistency of knowledge and practice, educational efforts should be directed to all healthcare professionals, including staff physicians, hospitalists, physician assistants, nurse practitioners, physical and respiratory therapists, dietary specialists, and other clinical and support personnel.

Training sessions should focus on critical aspects of pediatric care delivery, including working with parents in taking medical histories, lower-dosage medication administration, bedside assessment of preverbal patients, patient monitoring, medical device operation, and emergency and intensive care procedures. To measure and improve retention of information, consider conducting and documenting post-session skills assessments for all participants.

Training initiatives should be complemented by ongoing staff evaluation. Core competencies should be measured and documented upon hire, and at least annually thereafter, as part of the staff performance review process. (The "Pediatric Core Competencies" listing at right includes numerous resources intended to aid administrators in reviewing the competency levels of different types of hospital-based pediatric providers.)

CRITICAL HANDOFF POINTS:

- Nursing change of shift.
- Temporary relief or coverage breaks.
- Initiation of respiratory or physical therapy.
- Transfer from one provider to another.
- Transfer from the emergency department to an inpatient setting.
- Transfer from specialty units, e.g., pediatric and neonatal intensive care units, diagnostic imaging suites, the operating room, post-operative anesthesia care unit.
- Transfer to another hospital or care facility.
- Discharge home or to community-based care.

PEDIATRIC CORE COMPETENCIES

For RNs:

- Neonatal, NICU Skills Checklist, from SurgiStaff.
- Pediatric Competency Self Assessment, from Cross Country Healthcare, Inc.®
- Pediatric Skills Checklist, from Freedom Healthcare Staffing.

For nurse practitioners:

- Acute Care Pediatric Nurse Practitioner Competencies, from Vanderbilt University School of Nursing.
- Population-focused Nurse Practitioner Competencies, from the National Organization of Nurse Practitioner Faculties.

For hospitalists:

- *Caring for the Hospitalized Child: A Handbook of Inpatient Pediatrics,* second edition. American Academy of Pediatrics (AAP), 2017. Gershel, J. and Rauch, D., editors.
- Hospitalist Pediatric Medicine, from the University of California Davis Medical Center.
- Resource Link for Hospital Medicine, from the AAP.

7. COMMUNICATE CLEARLY AND OFTEN WITH FAMILIES. When providing acute care for infants or children, clear, straightforward and frequent communication is essential to reducing risk and enhancing family trust and satisfaction. Pediatric and neonatal communication protocols should serve to bolster transparency, consistency and engagement throughout the care process.

To minimize the risk of interpersonal conflict and misunderstanding, clinicians, social workers, chaplains and other members of the pediatric interdisciplinary team should be instructed to communicate with parents soon after admission and on a daily basis thereafter. The following strategies can help promote productive and supportive parental encounters:

- **Ask open-ended questions,** in order to prompt discussion and elicit parental concerns. (For example, "In your opinion, what would it take to make your child better?")
- **Assess parents' or legal guardians' level of medical literacy,** and use drawings, models, written materials and/or electronic tools to effectively convey information.
- **Explain in lay terms the clinical implications of key assessment findings,** honestly acknowledging any diagnostic or prognostic uncertainty.
- **Describe probabilities numerically,** whenever possible. (For example, "There is a 75 percent likelihood that the condition will resolve within a week.")
- **Provide specific time frames when describing expected improvements in condition** or planning future patient-related actions or discussions. (For example, "Let us meet again tomorrow at this time to reassess the situation.")
- **Invite parents to participate in clinical bedside rounds** or to remain with their child during invasive procedures, if practical.
- **Promptly inform parents of care transitions,** such as changes in the patient's bed location, condition or treatment plan, as well as shifts in medical or nursing staff.
- **Support family coping mechanisms,** including possibly unfamiliar religious and cultural practices.
- **Adopt a formal, legally reviewed medical error disclosure program,** which encourages providers to communicate swiftly and openly with parents about clinical errors and near-misses.
- **Document family or guardian involvement in care,** and note in the records everyone present at discussions.

Lapses in pediatric care are both a human tragedy for families and a disaster for hospitals and providers, in terms of potential litigation, financial loss and reputational harm. For these reasons, preventing pediatric errors and claims should be a top risk management priority for all healthcare settings. By systematically collecting and analyzing occurrence and outcomes data, reviewing pediatric policies and procedures, providing ongoing staff training, and emphasizing timely and sensitive communication, organizational leadership can significantly enhance quality of care and family satisfaction, while simultaneously strengthening defensibility in the event of a lawsuit.

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Medication Error: A Risk Assessment Questionnaire

Any drug-related occurrence – including overdose, allergic reaction and negative interaction – is likely to have serious consequences for highly vulnerable pediatric patients. The following questions are intended to spark facility-wide discussion about medication prescription and administration practices, encourage adoption of effective safeguards and promote the quality improvement process:

- **Are pediatric doses calculated using a computer algorithm,** as part of an integrated medication ordering system?
- **Are pediatric patients' age, weight and other dose indicators conspicuously displayed** on the medication profile?
- **Are known drug allergies prominently noted in electronic records,** on patient identifiers in the room and on the patient's person?
- **Prior to administration, are all pediatric medication orders reviewed by a registered nurse for appropriateness and dosage accuracy,** and are the patient's weight and other key indicators always taken into account?
- **Does a pharmacist process certain types of dosage forms and/or preparations,** including medications that are compounded or that require serial dilutions or other manipulation?
- **Are all calculations, whether made electronically or manually, independently double-checked by a pharmacist** and signed by another licensed provider to confirm accuracy?
- **Does policy stipulate that certain pediatric medications be prepared and dispensed in single-dose containers,** in order to prevent possible overdose?
- **If a machine is used to dispense pediatric medications, are appropriate safety rules and measures in place,** including double independent verification of medications loaded into the machine and safeguards against system overrides?
- **Does written policy address risks associated with "sound-alike" and "look-alike" drugs** – i.e., potential confusion between drugs of similar name or appearance?
- **Is an up-to-date list of authorized drug-related abbreviations, acronyms and symbols distributed to staff,** and are unauthorized abbreviations expressly prohibited?
- **Does written policy require that a leading zero precede any fractional figure smaller than one** (e.g., "0.5 mg"), in order to prevent misreading and consequent dosage mistakes?
- **Does a pharmacist participate in morning rounds** and interpret serum drug concentrations if necessary?
- **Does a team of physicians, residents, nurses, pharmacists and risk management professionals meet on a routine basis to review pediatric medication errors** and design processes and practices that reduce the likelihood and potential consequences of drug-related mistakes?

Pediatric inpatients experience up to three times more medication errors than do their adult counterparts. These errors – such as incorrectly dosed antibiotics and intravenous medications – occur most often during the drug-ordering process.

Gap Analysis Tool: Assessing Pediatric Transfer and Referral Readiness

Critically ill pediatric patients often require transport to another hospital or other referral center for consultation with specialists. The following tool is designed to help healthcare organizations evaluate their ability to transfer potentially unstable newborns or children in a safe, timely and efficient fashion.

GAP ANALYSIS QUESTIONS	YES OR NO?	COMMENTS
REFERRAL TEAM		
1. **Is a dedicated team in place to arrange inter-hospital referrals of critically ill children,** and are team members specially trained in pediatric transport?		
2. **Does the team comprise all relevant specialities,** minimally including a pediatric intensivist, an airway specialist and an advanced practice pediatric intensive care nurse?		
3. **Do members of the referral team receive continuing education** to keep them current regarding national standards governing care and management of pediatric transfer patients?		
4. **Are team members also provided with the educational resources and training programs they need** to safely resuscitate and stabilize critically ill children?		
TRANSFER INITIATION		
1. **Are there clear and unambiguous criteria to determine when pediatric patients are to be considered for inter-hospital transfer,** including, but not limited to, the following conditions and injuries:		
- Depressed or deteriorating neurological status, including status epilepticus?		
- Spinal cord or column injury?		
- Open head injury or depressed skull fracture?		
- Respiratory distress or failure?		
- Cardiac rhythm disturbance, arrest or failure?		
- Serious dehydration or electrolyte disturbance?		
- Renal or hepatic failure?		
- Neurovascular injury or compartment syndrome?		
- Amputation of an extremity?		
- Life-threatening infection, sepsis or shock?		
- Penetrating wounds to thoracic cavity, abdomen or pelvis?		
- Significant blood loss?		
- Severe hypothermia or hyperthermia?		
- Near-drowning?		
- Toxic substance ingestion?		
- Second- or third-degree burns and/or inhalation injury?		
2. **Is there a defined process for initiating a pediatric patient transfer,** and does it delineate the roles and responsibilities of both the referring facility and the referral destination?		

TRANSFER INITIATION (CONTINUED)		
3. **Are transfer consultation criteria and protocols relayed to clinicians and department heads,** as well as to relevant ancillary services staff, such as respiratory care, pharmacy and laboratory professionals?		
4. **Are all relevant diagnostic images transmitted to the receiving facility,** including chest X-rays, cervical spine and pelvic radiographs, ECGs and/or CT scans?		
5. **Are there written protocols to guide pre-transfer care for children with severe injuries and conditions,** such as single- or multi-organ trauma, severe burns, severe respiratory distress, intractable seizures, cardiac disease and sepsis/septic shock?		
TRANSFER AGREEMENTS		
1. **Are written transfer agreements entered into in advance** with designated trauma and referral centers?		
2. **Are these agreements reviewed periodically** to ensure that they reflect state trauma hospital criteria?		
3. **Do agreements clearly state that the referring physician/provider and facility are medically and legally responsible for patients** until their arrival at the receiving hospital?		
4. **Do agreements state the clinical criteria for utilizing different modes of patient transport,** including private automobile, ambulance, helicopter and fixed-wing aircraft?		
5. **Do agreements state required training and credentials for transport crews** (e.g., EMT, EMT-advanced, EMT-paramedic or pediatric transport team), in order to ensure that the team is suited to the patient's acuity level?		
6. **Do transport program partners agree in writing to assigned responsibilities during inter-hospital transfer,** including safety measures and documentation requirements?		
TRANSPORT TEAM		
1. **Does the organization carefully select pediatric transport program partners,** ensuring that all personnel are experienced and highly trained professionals with intermediate or advanced life-support credentials?		
2. **Is contact information for each transport program partner readily accessible** to pediatric care staff and providers?		
3. **Is there a system in place to alert team members of an imminent patient transport,** giving them sufficient time to marshal necessary information and resources?		
4. **Are transport team members trained to rapidly identify and stabilize pediatric physiological disturbances,** including:		
- Airway blockage?		
- Cervical spine injury?		
- Breathing problems?		
- Circulatory impairment?		
- Neurological deficits?		
- Wound, fracture and burn complications?		

SUPPORTING DOCUMENTATION		
1. **Does written policy require documentation of all communication between referring and receiving institutions,** including discussions regarding …		
- Whether the referral is necessary and advisable?		
- Whether a work-up is required prior to transport?		
- Whether the patient is sufficiently stabilized for transport?		
2. **Is the attending physician at the referring hospital consulted on how the patient should be transferred,** and is this input documented in the healthcare information record?		
3. **Is there a process for documenting patient arrival at the receiving institution,** as well as patient health status updates and referral outcome reports?		
4. **Is the informed consent of the patient's parent or guardian obtained in writing prior to transfer,** and is a copy of the signed consent form transmitted to the receiving facility?		
5. **Is a complete copy of the patient healthcare information record transmitted to the receiving facility,** and is receipt of this information confirmed?		
6. **Do referring and receiving hospital staff utilize an inter-hospital facility checklist to confirm successful transmittal of key documents,** such as the following:		
- Copies of lab work and diagnostic images?		
- EMS run sheet, if applicable?		
- Radiologist report, if applicable?		
- Copy of medication administration record?		
- Record of vital signs for the past 24 hours?		
- Copy of signed transport/transfer consent?		
- Discharge dictation from the emergency department, if applicable?		
7. **Are parents/guardians given clear written directions to the receiving institution,** as well as a contact name and telephone number?		
8. **Is the receiving facility given the name of a parent or guardian** and a corresponding telephone number?		

QUICK LINKS

- "Checklist: Guidelines for Care of Children in the Emergency Department," a joint policy statement of the American Academy of Pediatrics, the American College of Emergency Physicians and the Emergency Nurses Association.
- Children's Hospital Association (CHA) and CHA – Patient Safety.
- National Institute for Children's Health Quality.
- Vermont Oxford Network, Newborn Improvement Collaborative for Quality.

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