**Hospital Pediatric Disaster Plan**

**PLANNING TEMPLATE**

**BASIC Level**

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Contents

[Introduction 3](#_Toc113538791)

[Background & Purpose 3](#_Toc113538792)

[Assumptions 3](#_Toc113538793)

[Emergency Operations Plan & Emergency Management Program 3](#_Toc113538794)

[Risk Assessment/Hazard Vulnerability Assessment (HVA) 4](#_Toc113538795)

[Drills, Exercises and Education 4](#_Toc113538796)

[Regional Healthcare Coalition (HCC) Engagement 5](#_Toc113538797)

[Surge Capacity and Capabilities 5](#_Toc113538798)

[Medical 5](#_Toc113538799)

[Equipment, Supplies 5](#_Toc113538800)

[Space 6](#_Toc113538801)

[Staff 6](#_Toc113538802)

[Non-Medical 6](#_Toc113538803)

[Equipment, Supplies 6](#_Toc113538804)

[Space 7](#_Toc113538805)

[Staff 7](#_Toc113538806)

[Transfer Protocols and Procedures 7](#_Toc113538807)

[Special Pediatric Planning Considerations 8](#_Toc113538808)

[Decontamination Procedures 8](#_Toc113538809)

[Infectious Disease 8](#_Toc113538810)

[Children with unique healthcare needs 9](#_Toc113538811)

[Behavioral and Mental health 10](#_Toc113538812)

[Patient Tracking/Reunification 10](#_Toc113538813)

[Evacuation & Sheltering-In-Place 10](#_Toc113538814)

[Security 11](#_Toc113538815)

[Authorities and References 12](#_Toc113538816)

# Introduction

This plan is - intended to serve as an {Appendix} to {HOSPITAL NAME} Emergency Operations Plan (EOP) **OR** stand-alone plan to address {HOSPITAL NAME} - readiness and response to a disaster involving an influx of pediatric patients into the Emergency Department (ED). Other plans, policies and procedures may be referenced within this document that outline specific normal operating procedures which may be followed in a disaster scenario.

## Background & Purpose

Children account for approximately 25% of the nation’s population. Regulatory entities require that emergency plans account for at-risk populations. It is recognized that pediatric patients, due to their anatomical and cognitive differences between age ranges, should be factored as an at-risk population.

## Assumptions

* Pediatric or children’s hospitals utilized as referral centers may be overwhelmed during a disaster receiving high volumes of pediatric patients or more critically ill/injured pediatric patients.
* EMS agencies prefer to not separate family members, presenting pediatric and adult patients to single receiving facilities when possible.
* Pediatric patients often are not transported to the hospital by way of EMS, rather arrive in the ED by family or caregivers. (Source: National Hospital Ambulatory Medical Care Survey)
* EMTALA rules require hospitals who receive patients within their EDs provide appropriate assessment, triage, and treatment.
* The public is unable to distinguish a hospital with pediatric capabilities.
* Pediatric patients are anatomically different from adult patients and clinical considerations should be given to each age group as the needs and treatment modalities differ greatly with this population.

# Emergency Operations Plan & Emergency Management Program

{HOSPITAL NAME} maintains a comprehensive emergency operations plan (EOP) developed, reviewed, and tested by a team of individuals representing various departments across the facility who are essential for continued business, functional and clinical operations of the hospitals during disasters. Plans are reviewed {frequency} including supplemental plans/annexes and policies and exercised {frequency}. The EOP and EM program also is developed based on the patient population, including identified at-risk populations. Pediatrics due to their prevalence (25% of the population) and their unique physiological needs across the spectrum of the population, are identified within the EOP as an at-risk population.

The program includes utilization of a pre-established incident command structure based upon roles, including redundancies in roles and positions. {HOSPITAL NAME} utilizes the Hospital Incident Command Systems (HICS).

Essential to this pediatric plan is the identification of a pediatric medical technical specialist.

[Insert: HICS org chart sample]

{Hospitals lists out the role of persons who would be most appropriate – samples below}

The following roles may already be organic to the organization and IC structure or developed as a part of an Emergency Management program or other program focused around responding to the care or pediatric patients. These positions are supported by hospital administration and designation on committees to represent the care of children in disasters.

* Pediatric Emergency Care Coordinator
* ED Medical Director or another advanced practitioner
* Lead nurse or nurse with training or pediatric certifications

This team of pediatric champions should work to identify service lines throughout the hospitals to routinely participate in surge planning and exercising. This may include but is not limited to

* Medical services: including critical care, emergency department, surgical and anesthesia, nursing, respiratory and therapeutic care
* Support services: including phlebotomy, pharmacy, radiology, central supply, environmental services and communications
* Identify a staff member to champion pediatric disaster care. This person may serve in the role of the pediatric emergency care coordinator (PECC)
* Pediatric Champion, any other clinician with credentials or specialized training for pediatric treatment and care

## Risk Assessment/Hazard Vulnerability Assessment (HVA)

Risk assessments or hazard vulnerability assessments are required by TJC and CMS to focus planning efforts. In addition to incorporating pediatrics into the EOP and EMP as an at-risk population, {HOSPITAL NAME} conducts annual risk assessments. These assessments are carried out internal to the hospital as well as in conjunction with a community wide HVA in coordination with the HCC.

{HOSPITAL} carries out the pediatric risk assessment by – {facility to list the HOW - select one OR all methods in which they already are and plan to conduct a pediatric focused risk assessment}

* Facility-based HVA summarizing top hazards and reviewed by EM with input or engagement by a pediatric champion(s) to correlate direct pediatric impacts, clinical and non-clinical.
* Facility OR HCC conducts pediatric specific HVA or risk assessment, designed to address the risks to the pediatric population. (ex. [HVA\_Pediatric\_Template\_v8\_protected.xlsx (live.com)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fmedia.emscimprovement.center%2Fdocuments%2FHVA_Pediatric_Template_v8_protected.xlsx&wdOrigin=BROWSELINK))
* Community-based HVA which is summarized collectively at the HCC level and correlates top risks and impacts to the pediatric population.
* Participates in external risk assessment or HVA with relevant partners and stakeholders such as nearby schools/school systems, daycares, emergency management agencies or other clinical pediatric partners.
* LIST ANY OTHER METHODS

{Hospital – INSERTS Pediatric risk summary here; Any supplemental information/reports can be included as an Attachment. An attachment may list out schools, daycare centers, libraries and other places in which children congregate.}

The State’s Pediatric Surge Annex which is also adopted by the **[Region X HCC],** identifies the top risks in Louisiana for pediatric medical surge are the following events:

* Mass Casualty Incident
* Infectious disease outbreak
* Hurricane – prompting an evacuation scenario

## Drills, Exercises and Education

As a part of {HOSPITAL} EM program, a necessary step includes conducting drills based on probable scenarios outlined within the facility HVA. Drills and scenarios exercised are inclusive of children of varying ages when possible – including infants (< 1yrs), Toddlers (1-3 yrs), school-aged children (4-12 yrs), Adolescents ( > 13 yrs) and children with special health care or functional access needs. During drills, exercises and education opportunities, the use of the pediatric equipment and any mock or simulation equipment may be used.

The following criteria are considered when planning drills, exercises, and education:

* Coordination between departments and service lines for exercise planning and the role each plays in response to pediatric patients.
* Facilitate disaster-related learning activities (FEMA, ICS courses, lectures, etc) that include pediatric considerations and priorities for all staff.
* Collaborate with hospital emergency management and pediatric champion/PECC to ensure pediatric needs are addressed in the exercise planning process.

# Regional Healthcare Coalition (HCC) Engagement

{HOSPITAL} participates in the **[Region X]** healthcare coalition (HCC) by attending {quarterly/monthly/bi-annual} HCC meetings. Engagement with this group enables the hospitals to understand regional response concepts of operations, access to resources external to the facility and a single point of contact through a Designated Regional Coordinator (DRC).

The HCC meetings organized by the DRC allow for collective planning by various hospital partners within the region along with other EMS and Emergency Management officials. Specific planning and training topics are addressed during HCC meetings allowing opportunities to engage with other essential partners necessary for pediatric planning such as – school system officials, EMS for Children program, American Academy for Pediatrics. Outlined below are other partners the hospital will engage with during drills/exercises, education, or real event response.

Develop relationships with key state and regional partners to aid in pediatric disaster response such as:

* EMS Agencies / Fire Departments (Local)
* State Emergency Management Agency (GOHSEP DRC)
* EMSC State partnership program
* Public health authorities (RMD)
* Department of Public Health liaison (PHERC)
* Trauma Program (LERN)
* Children Services (Foster parent associations)
* Burn Programs
* Law Enforcement (local/Parish)

# Surge Capacity and Capabilities

## Medical

This section outlines the clinical aspects of key function areas that will support pediatric surge.

{HOSPITAL}has identified the following supplies, equipment, space and staff that will be essential to supporting pediatric **clinical care** during a surge incident.

###  Equipment, Supplies

* [Location of] pediatric monitoring equipment, resuscitation equipment, and respiratory and airway management equipment.
* Location of or access to other supplies not in ED but that may be used in a surge, such as adult equipment that can be converted or used to support a pediatric surge [hospital to list what departments/service areas]
* Pharmaceutical supplies and medications, including conversion procedures for administration of drugs [hospital to list how this is done]
* During extreme emergencies or large-scale events, the hospital may request additional pediatric clinical supplies within the region from neighboring hospitals with more advanced pediatric capabilities. This may also be conducted through the HCC by way of the DRC.

### Space

 [Hospital lists]

* Identified space(s) that can be used for pediatric surge within the ED
* Space external or adjacent to the ED that may be used for pediatric surge
* Other spaces may be used as an alternate triage and treatment site – hospital has a plan to activate the use of this space and has carefully considered its feasibility for the pediatric population
* Conversion of adult beds/units into pediatric capable areas [hospital lists what unit/area]

###  Staff

[hospital lists]

* Roles and positions in facility that may be essential to providing pediatric care – in the ED as well as other departments/services to ensure safe clinical care and treatment is provided - such as phlebotomy, radiology, social work, housekeeping, etc. [hospital to list]
* Staff are trained in pediatric disaster response through – hospital identifies avenues in which staff are trained in peds – this includes FEMA courses, clinical courses such as PALS, [hospital to list others as relevant]. A roster of the staff with pediatric training is maintained [where] and can be pulled by [who]
* Pediatric Medical Technical Specialist within HICS – [provide primary and backup role(s)]
* Hospital outlines avenues to obtain additional pediatric staff, external to hospital – (is this covered in the EOP regarding emergency credentialling procedures?)
* Hospital surging as a receiving site for pediatric patients in an evacuation may request staff of evacuating site accompany patients to receiving location
* Hospital defines methods and procedure to utilize telemedicine in a disaster or emergency surge event, if possible

## Non-Medical

###  Equipment, Supplies

Staff designated to support the uninjured or sheltering pediatrics during a surge event should know where to access non-medical supplies maintained on site. The following items are maintained [where], in what quantity (hours), or may be obtained through [what channels – local non-profits/groups].

* + Age-appropriate foods and infant formula
	+ Diapers and clothing
	+ Cribs, beds and blankets
	+ Toys, games

###  Space

The spaces outlined below are identified and used for holding non-injured pediatric patients or visitors. The intent of this space is to house the non-injured patients arriving at the ED as green patients for assessment or triage from the scene of an incident or are accompanying inured adults or caregivers. Additionally, this pre-identified space may be used to house non-injured patients or visitors who are sheltering-in-place (SIP) during an event, including children of staff members (may be covered within other part of EOP addressing Staff and SIP policies).

[Hospital lists]

1. Primary space
2. Secondary space
3. Additional planned space(s) considered (i.e. conference rooms, cafeterias, office areas, etc.)

The safety and security of this space has been evaluated to ascertain that it is sufficient for the needs of the non-injured pediatric patient. Spaces selected have been evaluated using the following criteria {hospital lists all that apply, includes others}

* + Cords, wires and other strangulation or electrical hazards have been identified or a plan to eliminate
	+ Furniture and equipment that could topple over has been identified and/or there’s a plan to eliminate
	+ Access to chemical or cleaners has been identified and a plan exists to eliminate
	+ Proximity to non-clinical pediatric supplies and resources such as sustenance, hygiene, comfort items and toys/games.
	+ Security measures have been identified (see the Security section)

###  Staff

Since this space is for the non-injured pediatrics within the facility, a non-clinical team of staff can be assigned to provide oversight and management of these areas. The following services or departments may be called upon to identify staff to support this space

* + [hospital lists departments/services internal. If external partners are considered and planned for, hospital outlines the process to solicit, the legal/liability and references any existing policies for the recruitment and rapid credentialing/onboarding procedures of such staff or volunteers]

## Transfer Protocols and Procedures

* Hospital maintains policies and procedures for transferring pediatric patients to hospitals with more robust pediatric capabilities when patient triage and assessment warrants a higher level of care is needed. [Hospital outlines or directs to existing procedures]. The pediatric facilities that within nearest proximity to {HOSITAL} in which providers routinely transfer pediatric patients to are {Children’s Hospital name} and/or will send to {Acute Care Hospital with advance pediatric services and in-patient capabilities}.
* Arrangement for transport of pediatric patients will occur through – [list routine transfer mechanisms or protocols for requesting transport services].
* When routine transfer mechanisms cannot be utilized, alternate methods may be used.
	+ Contacting LERN call center
	+ Contacting the Designated Regional Coordinator – ADRC, HDRC or EMS DRC

During large scale activations, such as evacuations before or after Hurricanes, LERN by way of the EMS Tactical Operations Center (TOC) or the EMS DRC may assign surge ambulances to support pediatric patient transports.

# Special Pediatric Planning Considerations

## Decontamination Procedures

{Does hospital decontamination plan address Pediatrics? If so, direct reader to that plan here – crosswalk elements listed below to make sure that plan covers essential procedures and processes to consider}. Establish a basic decontamination process if no decontamination procedure or area is pre-identified.

* + Area established for decontamination is {Hospital identifies here – the area(s) considered is within proximity to ED, access to water, areas for tentage to protect from the elements (children at higher risk for hypothermia) and for privacy}.
	+ Decontamination equipment is stored {where} and is inclusive of supplies that are best used for pediatrics – i.e. soft brushes and various sized gowns/clothing, etc.
	+ Process should include at minimum, the following steps. {Hospital to outline procedure for carrying out this process for the varying ages/sizes of children}
		- Infants – not mobile, not verbal
		- Toddler – mobile, not verbal
		- Children – mobile and verbal, may not be able to express themselves without parent/guardian present
		- Teenagers – mobile and verbal, may be able to express themselves without parent/guardian present
			1. Disrobe patient
			2. Wipe down skin
			3. Irrigate eyes
			4. Provide clean patient gowns / blankets
	+ Procedures allow for keeping families together when possible and include allowing parents to wash children if feasible and with direct guidance. {Staff member/role to provide guidance listed}.
	+ Hospital should consider the following when developing plans and building out process listed above for each pediatric patient age group:
		- Plan to move small / immobile children through showers as they are a fall risk. Consider using a laundry basket or other safe way to move child through shower instead of holding.
		- Aim for a 3–6-minute shower with a water temp of between 98-110 degrees (avoids hypothermia) and max water pressure of 60psi (avoid damage to skin)
		- Provide same sex staff member to help when family not available

## Infectious Disease

{Hospital Infectious disease plan – does it already exist and does it address Peds?

Infectious disease outbreaks which may impact the pediatric population, including but not limited to measles, influenza and other diseases requiring negative pressure and/or isolation, {HOSPITAL} has identified the following measures to consider for response to this type of surge.

* Protocols for parents/guardians accompanying children in isolation areas and negative pressure rooms. [Hospital lists areas]
* [List location] of pediatric personal protective equipment (PPE) and other supplies needed to provide care to a potentially infectious pediatric patient. PPE should also be supplied to parents/guardians isolating with patient.
* Staff are trained and aware of the challenges with the application of some infection control measures on younger patients, such as effectively and properly keeping PPE on the patient.
* Hospital POD plan is inclusive of dispensing to pediatric patients or pediatric family members of staff.
* Hospital infectious disease staff member or other ED clinician understands the steps to isolate and inform public health and epidemiology officials of pediatric patient with suspected ID.
* Hospital will monitor Office of Public Health (OPH), Health Alert Network (HAN) messaging along with other communicated guidance from the HCC and regional partners – including OPH Regional Medical Director (RMD), Public Health Emergency Response Coordinator (PHERC), and administrative or hospital DRC for notification and updates pertaining to ongoing ID outbreaks.
* When the hospitals experiences shortages in supplies such as pediatric PPE or clinical supplies, the hospital will work to coordinate directly with nearby pediatric capable hospitals or clinics. When large scale capacities are limited, the Hospital will coordinate with the HCC and regional network to obtain supplies or get on a list to be prioritized for an allocation of supplies. (This includes federally sourced supplies such as medical counter measures (MCM) and strategic national stockpile (SNS) supplies).

## Children with unique healthcare needs

Policies within the hospital address resources or procedures for how to accommodate for some of these unique needs. The [Pediatric Champion(s)/PECC/Social Worker] helps ensure appropriate staff and departments are aware of how policies apply to pediatrics. Additionally, hospitals should understand the risks of their community and probability that they will need to serve pediatric patients with healthcare needs during disasters.

{Hospital outlines policies or procedure for providing care to the following pediatric patient groups}

* Non-English-speaking children or their parents/guardians
* Children who are hearing and seeing impaired
* Children who are oxygen and/or electrically dependent
* Children who are non-verbal or cognitively impaired

{HOSPITAL} connects with various external partners to assist with planning for these populations as well as may solicit their aid during response to emergencies, such as hurricanes. [Hospital to select any of the following or include additions….}

* Pediatric primary care or therapy centers
* Pediatric day health centers that may be able to provide a site for power during large scale power loss events
* Non-government organizations who represent children with functional and access needs
* Local schools and education centers with programs for children with unique needs
* [Others]

The regional Healthcare Coalition and DRC network may also be able to provide guidance to hospitals to assist with linking parents/guardians to sites and special interest groups for resources. Some sites plan to assist with providing the needed support to families with children who have unique healthcare needs – such as locations of pediatric day health centers in the community and neighboring communities, medical needs shelters or other sites to access power, non-government organizations or collaborative groups to support with supplies such as Trach Moms, and staged sites to exchange oxygen tanks.

## Behavioral and Mental health

* {PECC/Pediatric Champion, behavioral health specialist or social worker} has will help identify and connect patients with referral resources in the community for children experiencing trauma (e.g., behavioral health specialists with expertise in trauma treatment of children) and/or loss (e.g., children’s bereavement centers/camps or hospice programs).
* {Hospital} has a protocol created for behavioral health professionals to be available on-call to provide services onsite during disasters **OR** if no mental or behavioral health professional is on staff, {Hospital} has signed agreements or MOUs with qualified behavioral health professionals.
* Qualified behavioral health professionals, with expertise to provide services to children, are members of hospital staff and provide coverage 24/7/365 with ability to surge during a disaster.
* Working through the HCC, hospital may gain access to community, local or state-run programs that can provide pediatric behavioral health services on-site, in the community or through tele-health capabilities.

## Patient Tracking/Reunification

{HOSPITAL} is aware that pediatric patients presenting to the facility from the scene of an incident may not be accompanied by a parent or guardian, may not be verbal to identify themselves, and may or may not be injured. This pediatric patient will need to be identified and family notification will be a priority of the hospital as care and assessment is provided.

The hospital lists patient tracking methods used at facility:

* {Role(s) serves as patient tracking coordinator/manage} – Reference HICS position, patient tracking manager and job action sheet)
* Systems used will be – spreadsheet, patient tracking log, etc.
* For large-scale events spanning across multiple facilities and regions, such as hurricane evacuations or MCIs, the state’s At-Risk Registry patient tracking system may be used.

Hospital outlines methods to assist with reunification including – {Hospital to list}

* Location of secured, private area to make contact with families of potentially injured/ill children at hospital
* Access to translators for non-English speaking and visually/hearing impaired families
* Involves communications staff for providing public or outward facing guidance through messaging

## Evacuation & Sheltering-In-Place

In this section, {HOSPITAL} outlines the response role to support during a multi-facility or regional evacuation event. Some events prompting evacuation may allow for advanced warning and execution of plans. However, it is recognized that there may be events in which no-notice or advanced warning will be provided. {HOSPITAL} plans for and is ready to accept pediatric patients if necessary, during either scenario.

Receiving Facility

Many of the considerations for receiving evacuated patients are outlined in the surge section of this plan. Depending on the severity of illness of the patient, {HOSPITAL} can support by providing space for [medical surge patients in XXXX area of the facility; may provide ICU beds within XXX area of the hospital]. Staff can be expanded from [Areas/Depts] to assist with appropriate surge levels and care. A request will be made to the sending/evacuating hospital to send staff, if possible.

Evacuating Facility

{HOSPITAL} maintains a facility evacuation plan (does it outline pediatrics?) If not…proceed to include within that plan the following elements or keep within this section of the stand-alone pediatric plan.

{HOSPITAL} has carefully considered the following criteria for evacuating pediatric patient population.

* Triggers for horizontal vs. vertical evacuation within the facility
* Adequate supplies for evacuation – include clinical supplies, sustenance, and hygiene
* Plan accounts for specialized equipment to support evacuation such as sleds or stair chairs, portable vents, emergency bags with portable equipment
* Patient tracking for planned or unplanned scenario – refer to Patient Tracking and Reunification section
* Staff understand role in evacuating patients, including evacuating with patient to receiving facility to continue to provide care
* Pre-designated evacuation sites include (consider within and outside of region)
	+ Primary Site {List Hospital}
	+ Secondary Site(s) {List Hospitals}
	+ Other sites
* Activation of plans to obtain transport resources, internal and external to facility – includes facility transport teams or staff assigned to transport patients, includes EMS agencies and request through HCC or DRC network to obtain surge ambulances.

Sheltering-In-Place (SIP)

[Hospital to list scenarios in which they would SIP – this may include a plant explosion, chemical release, weather event or other community disturbance such as an active shooter event external, but nearby]. Many of the considerations for routine SIP events remain applicable for the pediatric patient or visitor population. Reference the Surge sections for medical and non-medical spaces, supplies and staff to manage pediatric sheltering of pediatric patient population.

## Security

During events with pediatric patients, the hospital’s security plan and procedures will be activated. The following section outlines additional considerations for pediatric patients and visitors during a surge event.

[Hospital lists – where applicable]

* Person(s) or role(s) responsible for assessing if the current situation or event activation involves pediatrics or the potential to involve pediatrics and the need for these established security measures
* Secured areas for use to stage non-injured children from surge
* Secured area to conduct reunification of both injured and non-injured patients.
* Staff assigned to assist in identification, notification, protection, location, and reunification of children and their parents / legal guardians.
* Staff may work with communications department to receive and direct inquiries regarding reunification efforts.
* Considerations for security procedures during sheltering-in-place or evacuation scenario with pediatrics, both patients and visitors
* Implementation of missing child protocol activation (Code Pink) and any other protocols during events in which routine procedure may be interrupted
* Staff are pre-identified to serve as physical security to monitor safe areas for both injured and non-injured children along with the ingress/egress routes to these areas.

# Authorities and References

1. Pediatric Patients Brought by Emergency Medical Services to the Emergency Department: An Analysis From the National Hospital Ambulatory Medical Care Survey (NHAMCS). <https://pubmed.ncbi.nlm.nih.gov/35100778/>
2. Health Standards: Emergency Preparedness for Providers <http://ldh.la.gov/index.cfm/page/297>
3. [CMS Rule - Emergency Preparedness for Medicare and Medicaid Providers](http://ldh.la.gov/index.cfm/page/2621)
4. Developing an All-Hazards Risk Assessment and Emergency Plan  - Pediatric focused HVA tool - [HVA\_Pediatric\_Template\_v8\_protected.xlsx (live.com)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fmedia.emscimprovement.center%2Fdocuments%2FHVA_Pediatric_Template_v8_protected.xlsx&wdOrigin=BROWSELINK)
5. HCC Regional Coalition Preparedness and Response Plan – current copies can be obtained; distributed by Administrative Designated Regional Coordinator (ADRC) on an annual basis or upon request by Hospital or HCC member.
6. Hospital: Laws and Regulations
* EMTALA--Medicare participating hospitals must meet the Emergency Medical Treatment and Labor Act (EMTALA) statute codified at *§1867* of the Social Security Act, (the Act) the accompanying regulations in *42 CFR §489.24* and the related requirements at *42 CFR 489.20(l), (m), (q),*and *(r)*.
* HIPAA
* Telehealth: Louisiana RS 40: 1223.1-1223.5. Part VII. Louisiana Telehealth Access ACT
* LAC (Louisiana Administrative Code) Title 48, Subchapter B, §9327 Emergency Services
1. Personnel
* LA Administrative Code, Title 48 Part 1 Subpart 3 Subchapter B Hospital Organization and Services §9327 Emergency Services- outlines requirements and qualifications of professionals providing hospital emergency services
1. Emergency Medical Services for Children (EMS-C), Louisiana chapter - [LA Rev Stat § 40:1075.4 (2018)](https://law.justia.com/citations.html)
2. EMS-C Innovation and Improvement Center (EEIC) – National Pediatric Readiness Project: <https://emscimprovement.center/domains/pediatric-readiness-project/>