

3.32 STANDARDS FOR PEDIATRIC INTENSIVE CARE UNITS (PICUs)

A. PICU -- Definition

For the purpose of the California Children's Services (CCS) program, a Pediatric Intensive Care Unit (PICU) shall be defined as follows:

A PICU is a unit within a CCS-approved Tertiary or Pediatric Community Hospital that has the capability of providing definitive care for a wide range of complex, progressive, rapidly changing, medical, surgical and traumatic disorders, requiring a multidisciplinary approach to care for patients between 37 weeks gestation and/or two kilograms (kg) and those under 21 years of age who meet CCS medical eligibility criteria, as per California Code of Regulations (CCR), Title 22, Division 2, Subdivision 7, Chapter 4, Section 41800 et seq.

B. PICU -- General Requirements and Procedure for CCS Program Approval

1. A hospital with a PICU wishing to participate in the CCS program for the purpose of providing care to sick and injured infants, children, and adolescents shall be licensed by the Department of Health Services (DHS), Licensing and Certification Division, under California Code of Regulations (CCR), Title 22, Division 5, Chapter 1, for the following:
 - a. acute general hospital, Article 1, Sections 70003, 70005; and
 - b. intensive care service, Article 6, Section 70491 et seq.
2. The PICU:
 - a. shall be located in a hospital approved by CCS as a Tertiary Hospital, as per Chapter 3.3.1; or
 - b. shall be located in a hospital approved by CCS as a Pediatric Community Hospital, as per Chapter 3.3.2. (A PICU located in a Pediatric Community Hospital is exempt from the 21 day length of stay limitation.)
3. A PICU shall meet and maintain all CCS Standards for PICUs, as contained within this Chapter.
4. A hospital which meets the above prerequisites and wishes to participate in the CCS program for the purpose of providing care to critically ill infants, children, and adolescents and meets PICU requirements, as per Chapter 3.32, shall complete a CCS PICU application in duplicate and submit both copies to: Department of Health Services; Chief, Children's Medical Services (CMS) Branch; California Children's Services Program; 714 P Street, Room 350; P.O. Box 942732; Sacramento, CA 94234-7320. Questions concerning the standards and the application process should be directed to the appropriate CMS Regional Office.

5. Review Process
 - a. Upon receipt, the PICU application will be reviewed by the appropriate CMS Regional Office. A site visit will be scheduled if the documentation submitted by the hospital appears to meet the CCS Standards for PICUs.
 - b. The site review shall be conducted by a state CCS review team in accordance with established CCS procedures for site visits. The team shall consist of State staff augmented by consultant experts in the fields of pediatric critical care medicine and pediatric critical care nursing and, as indicated, by other medical specialists.
 - c. Approval shall be based on compliance with CCS Standards for PICUs and upon site review of PICU procedures, services provided, patient chart review, the demonstration of community need and PICU patient outcome data.
 - d. Approval may be withheld if there is not a community need based on geographic considerations and a lack of sufficient caseload that is necessary to maintain proficiency in the care of critically ill infants, children, and adolescents. The CCS program may consult with other divisions or branches within the DHS, such as the Maternal and Child Health Branch and/or Licensing and Certification Division and with other state and federal agencies to determine community need.
6. After the site visit, the following types of approval actions may be taken by the CCS program:
 - a. Full approval is granted when all CCS Standards for PICUs are met.
 - b. Provisional approval may be granted when all CCS Standards for PICUs appear to be met, however, additional documentation is required by the CCS program. This type of approval may not exceed one year.
 - c. Conditional approval, for a period not to exceed six months, may be granted when there are readily remediable discrepancies with program standards. The hospital must present a written plan for achieving compliance with program standards, and the plan must be approved by the CCS program. If the discrepancies are not corrected within the time frame specified by the CCS program, approval shall be terminated.
 - d. Denial is based upon failure of the hospital to meet CCS program standards.
7. A hospital shall be notified in writing of the decision regarding approval status within 90 days after the site visit. A hospital whose application has been denied may appeal the decision by submitting a letter in writing to the Chief, Children's Medical Services Branch, within 30 days of receipt of the notification of denial.

8. Annually, as determined by CMS, the hospital shall submit a list of staff who meet the qualifications as specified in the CCS Standards for PICUs to : Department of Health Services; Children's Medical Services Branch; Attention: Center Desk; 714 P Street, Room 398; P.O. Box 942732; Sacramento, CA 94234-7320. This list shall be accompanied by a copy of the most current hospital license. Any changes in the professional staff or facility requirements mandated by these standards shall be reported to the State CMS Branch at the address in Section 3.32/B.4. above within 30 days of occurrence.
9. Periodic reviews of CCS-approved PICUs shall be conducted no less than every three years or as deemed necessary by the CCS program. If a PICU does not meet CCS program requirements, the PICU may be subject to losing CCS approval.

C. PICU -- CCS Program Participation Requirements

1. Facilities providing services to CCS-eligible clients shall agree to abide by the laws, regulations, and policies of the CCS and Medi-Cal programs. Specifically, facilities shall agree to:
 - a. Refer all infants, children, and adolescents with potentially eligible CCS conditions to the CCS program for review of CCS program eligibility.
 - b. Assist families with the CCS referral and enrollment process by providing CCS application forms, phone numbers, and office locations.
 - c. Request prior authorization from the CCS program, as per Title 22, Section 42180.
 - d. Notify the local CCS program office, in a timely manner, of specialized patient transport methods for potentially eligible infants, children, or adolescents to and from the facility.
 - e. Accept referral of CCS-eligible clients, including Medi-Cal patients, whose services are authorized by CCS.
 - f. Serve CCS-eligible clients regardless of race, color, religion, national origin, or ancestry.
 - g. Bill client's private insurance, Medi-Cal or Medicare within six months of service in accordance with Medi-Cal and Medicare regulations regarding claims submission time frames or within 12 months for private insurance prior to billing CCS, including Medi-Cal or Medicare, if the client is eligible for such coverage.

- h** Bill CCS within:
 - 1) six months from the date of service if the client does not have third party insurance coverage; or
 - 2) six months from the date of receipt of insurance payment/denial, including an explanation of benefits from the insurance carrier; or
 - 3) twelve months from the date of service if insurance carrier fails to respond.

Utilize electronic claims submission when available, upon CCS request.

- j.** Accept CCS payment for authorized services in accordance with state regulations as payment in full.
 - k.** Provide copies of medical records, discharge summaries, and other information as requested by the CCS program within ten working days of request.
 - l.** Provide annual reports as requested by the CCS program.
 - m.** Provide services in a manner that is family centered and culturally competent, including the provision of translators and written materials.
 - n.** Permit CCS staff to visit and monitor facilities to assure ongoing compliance with CCS standards.
 - o.** Assist and cooperate with CCS staff in the on-site utilization review by CCS staff of services provided to CCS-eligible clients.
2. Failure to abide by the regulations and procedures governing the CCS program may result in removal of the hospital from the list of CCS-approved facilities.

D. PICU -- Exclusions

- 1. Hospitals that are formally and involuntarily excluded from participation in programs of federal and state agencies shall automatically be excluded from participation in the CCS program.
- 2. A hospital may also be excluded by the CCS program because of, but not limited to, the following:
 - a. Failure to successfully complete the CCS approval process;
 - b. Inadequate and/or untimely addressing of deficiencies identified during a CCS site visit;

- c. Loss of Joint Commission on Accreditation of Healthcare Organizations accreditation; or
- d. Failure to abide by the laws, regulations, standards, and procedures governing the CCS program.

E. PICU -- Organization

1. There shall be a separate and identifiable administrative unit for the PICU.
2. Medical care of the PICU shall be under the direction of a medical director:
 - a. Who shall meet the qualifications contained in Section 3.32/F.;
 - b. Whose primary responsibility shall be the organization and supervision of the PICU; and
 - c. Who shall not be the medical director of more than one PICU.
3. There shall be a PICU nurse manager:
 - a. Who shall have the responsibility on a 24-hour basis for the organization, management, supervision, and quality of nursing practice and nursing care in the PICU; and
 - b. Who shall meet the requirements contained in Section 3.32/F.
4. The PICU medical director and the PICU nurse manager shall have joint responsibility for the development and review of an ongoing quality improvement program.
5. The PICU medical director and the PICU nurse manager shall have joint responsibility for development and review of a Policies and Procedures Manual for the PICU which addresses, at a minimum, patient admission, patient care, discharge and transfer criteria.
6. There shall be an identified PICU multidisciplinary team:
 - a. Which shall be responsible for the coordination of all aspects of patient care; and
 - b. Which shall consist of, at a minimum, a CCS-paneled pediatric intensivist, a clinical nurse specialist, a respiratory care practitioner and a medical social worker whose professional requirements are defined in Section 3.32/F. Optional members of the PICU multidisciplinary team may include, but are not limited to, the following CCS-paneled providers: clinical registered dietitian, occupational therapist and physical therapist.

F. PICU -- Professional Resources and Requirements

1. PICU Physician Staff

1.1 PICU Medical Director

- a. There shall be a full-time CCS-paneled pediatric intensivist as the medical director:
 - 1) Who shall have overall responsibility for the quality of medical care for infants, children, and adolescents admitted to the PICU; and
 - 2) Who shall:
 - a) Be certified by the American Board of Pediatrics and certified by the American Board of Pediatrics in the subspecialty of Pediatric Critical Care Medicine, or
 - b) Be certified by both the American Board of Pediatrics and the American Board of Anesthesiology and also be certified by the American Board of Anesthesiology in the subspecialty of Critical Care Medicine.
- b. The facility shall maintain written documentation of the responsibilities of the PICU medical director which shall include, but not be limited to, the following:
 - 1) Participation in development, review and implementation of PICU policies and procedures as specified in Section 3.32/1.;
 - 2) Approval of patient admission and discharge criteria;
 - 3) Supervision of quality control and quality assessment activities (including morbidity and mortality reviews);
 - 4) Responsibility for assuring PICU staff competency in resuscitation techniques;
 - 5) Responsibility for assuring ongoing PICU staff education;
 - 6) Participation in PICU budget preparation;
 - 7) Oversight of patient transport to and from the PICU; and
 - 8) Responsibility for assuring the maintenance of PICU database and/or vital statistics.

1.2 PICU Pediatric Intensivist Staff

The PICU medical director shall have one or more full-time equivalent associate pediatric intensivist(s) on staff:

- a. Who shall be a CCS-paneled pediatric intensivist;
- b. Who shall share the clinical care responsibilities of the PICU, and
- c. Who shall:
 - a) Be certified by the American Board of Pediatrics and certified or eligible for subspecialty certification by the American Board of Pediatrics in the subspecialty of Pediatric Critical Care Medicine; or
 - b) Be certified by both the American Board of Pediatrics and the American Board of Anesthesiology and also be certified or eligible for subspecialty certification by the American Board of Anesthesiology in the subspecialty of Critical Care Medicine; and
- d. An associate pediatric intensivist who does not have the subspecialty certification at the time of application, shall pass the subspecialty board examination within six years of becoming eligible to sit for the examination.

1.3 PICU Additional Physician Staff

- a. A CCS-paneled pediatric surgeon, a CCS-paneled neurosurgeon with proficiency in the care of pediatric patients and an anesthesiologist with proficiency in the care of pediatric patients shall be on hospital staff, and available to be in the PICU in less than 30 minutes .
- b. At a minimum, the following CCS-paneled pediatric subspecialists shall be on hospital staff and available on-site for consultation to the PICU in less than one hour: cardiologist, neonatologist, gastroenterologist, hematologist/oncologist, infectious disease specialist, and neurologist. In addition, a radiologist meeting requirements contained in Chapter 3.3.1 of the CCS Standards for Tertiary Hospitals shall be available for consultation to the PICU.
- c. The following CCS-paneled surgical specialists with expertise in pediatrics shall be available for consultation to the PICU in less than one hour: otolaryngologist, ophthalmologist, orthopedic surgeon, plastic surgeon and/or maxillofacial surgeon, urologist and cardiovascular surgeon.

- d. The following CCS-paneled specialists with expertise in pediatrics shall be available for on-site consultation to the PICU: pulmonologist, endocrinologist, nephrologist, allergist/immunologist, physiatrist, obstetrician/gynecologist and psychiatrist.

2. PICU Nurse Staff

Nurse staff titles or positions listed in CCS Standards may differ from those used in a facility. For the purpose of CCS Standards for PICUs, the facility is allowed to have an individual whose staff title is not the same as that used in the CCS standards. However, the individual shall meet the requirements described below.

2.1 PICU Nurse Manager

- a. The nurse manager for the PICU shall direct the nursing administrative operation of the PICU, as per Section 3.32/E.3. and shall:
 - 1) be a registered nurse (R.N.) licensed by the State of California holding a master's degree in nursing, or
 - 2) be a R.N. holding a bachelor's of science degree in nursing (BSN) and either a master's degree in a related field or certification in health care administration from a nationally recognized accrediting organization; and
 - 3) have at least three years of clinical nursing experience of which at least one year shall be in pediatric critical care nursing.
- b. The responsibilities of the PICU nurse manager shall include, at a minimum, personnel, fiscal and materiel management, and coordination of the quality improvement program for the PICU.
- c. The PICU nurse manager shall directly supervise the nurse supervisor for the PICU.
- d. The facility shall maintain written documentation of the qualifications and responsibilities of the PICU nurse manager.
- e. The PICU nurse manager shall have direct responsibility to the hospital administrative director of nursing or individual holding an equivalent position.

2.2 PICU Nurse Supervisor

- a. The PICU nurse supervisor shall directly supervise personnel and assure the quality of clinical nursing care of patients in the PICU at all times.

- b. The PICU nurse supervisor shall:
 - 1) be a R.N. licensed by the State of California, with a BSN; and
 - 2) have at least three years of clinical experience one year of which shall have been in pediatric critical care nursing; and
 - 3) have evidence of current successful completion of the American Heart Association (AHA) approved Pediatric Advanced Life Support (PALS) or equivalent course.
- c. The PICU nurse supervisor shall have 24-hour responsibility for:
 - 1) the direct supervision of all clinical personnel who provide patient care; and
 - 2) the day-to-day coordination of and quality of clinical nursing care of patients in the PICU.
- d. The facility shall maintain written documentation of the qualifications and responsibilities of the PICU nurse supervisor.
- e. The PICU nurse supervisor shall not be assigned direct patient care responsibilities.

2.3 PICU Clinical Nurse Specialist

- a. There shall be a clinical nurse specialist (CNS) for the PICU.
- b. The CNS shall:
 - 1) be a R.N. licensed by the State of California with experience in a clinical specialty related to pediatrics;
 - 2) be certified by the State Board of Registered Nursing as a CNS, as per the California Business and Professions Code, Chapter 6, Section 2838 of the Nursing Practice Act;
 - 3) have at least three years of clinical nursing experience at least one year of which shall have been in pediatric critical care nursing; and
 - 4) have evidence of current successful completion the AHA approved PALS or equivalent course.

- c. The CNS shall be responsible for:
 - 1) directing the clinical nursing practice in the PICU;
 - 2) coordination and assessment of critical care educational development and clinical competency of the nursing staff in the PICU; and for ensuring continued critical care nursing competency through educational programs for both the newly-hired and experienced nursing staff;
 - 3) consultation with staff on complex critical care nursing issues;
 - 4) oversight of comprehensive parent and or primary caretaker education activities; and
 - 5) ensuring the implementation of a coordinated and effective discharge planning program.
- d. The facility shall maintain written documentation of the qualifications and responsibilities of the CNS.

2.4 PICU Charge Nurse

- a. There shall be at least one charge nurse for each shift in the PICU who shall:
 - 1) be a R.N. licensed by the State of California;
 - 2) have education, training and demonstrated competency in pediatric critical care nursing;
 - 3) demonstrate competency in the role of a charge nurse; and
 - 4) have evidence of current successful completion of the AHA approved PALS or equivalent course.
- b. The responsibilities of the charge nurse during each shift shall include the following:
 - 1) coordinating the patient care activities in the PICU; and
 - 2) ensuring the delivery of quality patient care.
- c. The facility shall maintain written documentation of the qualifications and responsibilities of the PICU charge nurse.

2.5 PICU Registered Nurses

- a. R.N.s who are assigned direct patient care responsibilities in the PICU shall:
 - 1) be licensed in the State of California;
 - 2) have education, training and demonstrated competency in pediatric critical care nursing; and
 - 3) have evidence of current successful completion of the AHA approved PALS or equivalent course.
- b. R.N.s functioning in an expanded role shall do so in accordance with standardized procedures as per CCR, Title 16, Division 14, Article 7, Sections 1470 through 1464.
- c. The facility shall maintain written documentation of the qualifications and responsibilities of the R.N. staff which shall include at a minimum, the standards of competent performance of the R.N. staff providing care in the PICU.

2.6 PICU Licensed Vocational Nurses

- a. Licensed vocational nurses (LVNs) who provide nursing care in a PICU shall:
 - 1) be licensed by the State of California;
 - 2) have demonstrated competency in pediatric critical care nursing;
 - 3) have evidence of current successful completion of the AHA Basic Life Support (BLS) or equivalent course; and
 - 4) be limited to those responsibilities within their scope of practice, as per CCR, Title 16, Division 25, Chapter 1.
- b. LVNs providing care in the PICU shall be under the direction of a R.N.
- c. The facility shall maintain written documentation of the qualifications and responsibilities of the LVN, which shall include only those responsibilities in accordance with their scope of practice, as per CCR, Title 16, Division 25, Chapter 1.

2.6 PICU Unlicensed Assistive Personnel

- a. Unlicensed Assistive Personnel, as defined by the State Board of Registered Nursing Position Statement, Unlicensed Assistive Personnel (September 1994),

shall function in accordance with written policies and procedures which delineate the non-nursing task(s) the unlicensed assistive personnel is allowed to perform in the PICU under the direction of a R.N. These non-nursing tasks shall require no scientific knowledge and/or technical skill.

- b. The unlicensed assistive personnel may be utilized only as assistive to licensed nursing personnel under the direction of a R.N.
- c. Unlicensed assistive personnel shall not be assigned tasks associated with the care of the medically fragile patient and shall only be assigned non-nursing tasks as defined in Section 3.32/H.

3. PICU Respiratory Care Practitioner Staff

- a. Respiratory care services shall be provided by respiratory care practitioners (RCPs) who are licensed by the State of California and who have additional training and experience in pediatric respiratory care. Additional training in pediatric respiratory care shall be demonstrated by the following:
 - 1) Completion of a formal pediatric respiratory therapy course at an approved school of respiratory therapy that includes didactic and clinical course work; or
 - 2) Completion of a minimum of 20 hours of didactic and four weeks of preceptored pediatric clinical experience in a hospital-based course.
- b. The facility shall maintain a written job description delineating the qualifications and duties of the RCP in the PICU which reflects the provision of practice in accordance with Business and Professions Code, Respiratory Care Practice Act, Chapter 8.3, Article 1, Section 3702 and CCR, Title 16, Division 13.6, Articles 1 through 8.
- c. The RCP shall be responsible, at a minimum, for the monitoring and application of respiratory equipment of all sizes for pediatric patients.
- d. There shall be an identified RCP with expertise in pediatric respiratory care practice available as a resource for consultation to the PICU.
- e. A RCP shall be assigned solely to the PICU when supportive ventilation is being provided and the staffing level shall be such that immediate availability of the RCP to the PICU is assured at all times.
- f. There shall be a system in place for ensuring continuing clinical respiratory care competency through education programs both for the newly-hired and experienced RCP staff in accordance with CCR, Title 16, Division 13.6, Article 5.

8. PICU Physical Therapy Staff

There shall be a CCS-paneled physical therapist available to the PICU who meets the requirements contained in Chapter 3.3.1 of the CCS Standards for Tertiary Hospitals.

9. PICU Child Life Specialist Staff

There shall be a child life specialist available to the PICU who meets the requirements contained in Chapter 3.3.1 of the CCS Standards for Tertiary Hospitals.

10. PICU Unit Clerk

There shall be at least one unit clerk present in the PICU 24 hours a day with a written job description delineating the administrative duties pertaining to patient care and traffic control.

G. PICU -- Facilities and Equipment

1. The PICU shall be a distinct, separate physical area within the hospital and shall demonstrate the following:

- a. There shall be at least eight licensed intensive care beds, as per CCR, Title 22, Division 5, Section 70499, dedicated to pediatric patients, located in one contiguous area;
- b. There shall be a minimum of 350 admissions to the PICU per year of infants, children and adolescents who require care for complex, progressive, rapidly changing medical, surgical and traumatic disorders and require a multidisciplinary approach.

2. If a facility has stepdown or intermediate care-unit beds within the PICU, these beds shall not count towards the requirement of licensed intensive care beds dedicated to pediatric patients within the PICU.

3. Bed space within the PICU shall:

- a. Have a minimum of 150 square feet for each bed;
- b. Have a minimum of 100 square feet per bed for storage; and
- c. Meet the construction requirements of the State of California Uniform Building Code requirements, Section 420A.35 and the requirements of CCR, Division 5, Title 22, Section 70497.

4. The PICU shall have the following space/rooms available within, adjacent to, or in close proximity to the PICU:
 - a. An on-call physicians' room/sleeping quarter;
 - b. A separate nursing station;
 - c. A staff lounge;
 - d. A family waiting room and accommodations shall be provided or arranged for parents staying overnight;
 - e. A separate room available for parent and physician/staff counseling/conferences;
 - f. A separate room for staff meetings, nursing reports, teaching/in-service education, multidisciplinary team conferences and case presentations; and
 - g. A clean area for formula preparation and dilutions by trained personnel.
5. There shall be one isolation room in the PICU for every eight to twelve intensive care beds.
6. The PICU shall meet the requirements contained in CCR, Title 22, Division 5, Section 70497, and in addition:
 - a. The following shall be present for each PICU bed:
 - 1) Sixteen electrical outlets (There shall be a common ground. Adapters, extension cords and junction boxes shall not be used.);
 - 2) Four oxygen outlets;
 - 3) Three compressed air outlets; and
 - 4) Three suction outlets.
 - b. There shall be equipment available in the PICU, for all pediatric-sized patients including, but not limited to, the following:
 - 1) Emergency ("code" or "crash") cart with emergency drugs in a range of unit doses appropriate for patients of varying sizes;
 - 2) Patient defibrillator/cardioverter capable of delivering energy at low doses and synchronized cardioversion;
 - 3) Electrocardiogram (ECG) machine;
 - 4) Automated/noninvasive blood pressure apparatus;

- 5) Laryngoscopes with endotracheal tubes (cuffed and uncuffed);
 - 6) Oral and nasal airways;
 - 7) Vascular access equipment including central catheters;
 - 8) Surgical cut-down trays;
 - 9) Tracheostomy trays;
 - 10) Emergency thoracotomy trays;
 - 11) Equipment for the placement of chest and pericardial tubes;
 - 12) Intracranial pressure monitoring trays;
 - 13) Peritoneal dialysis equipment;
 - 14) Oscopes and ophthalmoscopes;
 - 15) Patient scale/device for accurate measuring of body weight;
 - 16) Bag-valve-mask resuscitation devices; and
 - 17) Chest physiotherapy and suctioning equipment.
- c. Equipment available to the PICU shall include, but not be limited to, the following:
- 1) Procedure lamp;
 - 2) Doppler ultrasonography device;
 - 3) Infusion pumps (with microinfusion capability/transport capability);
 - 4) Suction device/machine for transport and backup (in addition to bedside);
 - 5) Expanded scale electronic thermometer with range sufficient to identify extremes of hyperthermia and hypothermia;
 - 6) Cribs and beds (with head access);
 - 7) Infant warmers, incubators;
 - 8) Heating and cooling blankets;
 - 9) Phototherapy lights;
 - 10) Transport equipment with provision for temperature control, ventilation and cardiopulmonary monitoring (Transport equipment shall also be available for in-house transport of infants);

- 11) Electroencephalogram (EEG) machine;
 - 12) Isolation cart;
 - 13) Blood warming apparatus; and
 - 14) Electric breast pump.
- d. Respiratory equipment available to the PICU for all pediatric-sized patients shall include, but not be limited to, the following:
- 1) Oxygen tanks for transport and backup of the central oxygen supply;
 - 2) Respired gas humidifiers;
 - 3) Air compressor;
 - 4) Air-oxygen blenders;
 - 5) Mechanical ventilators;
 - 6) Aerosol medication administration equipment;
 - 7) Spirometers; and
 - 8) Continuous oxygen analyzers with alarms.
- e. There shall be monitoring equipment at each bedside in the PICU for all pediatric-sized patients with the capability to continuously monitor the following:
- 1) Heart rate with dysrhythmia monitoring capability;
 - 2) Respiration;
 - 3) Temperature;
 - 4) Systemic arterial pressure;
 - 5) Central venous pressure;
 - 6) Pulmonary arterial pressure;
 - 7) Intracranial pressure;
 - 8) Oxygen saturation and /or transcutaneous PaO₂; and
 - 9) End-tidal carbon dioxide.

Bedside monitoring equipment features shall include, but not be limited to, the following:

- 1) Visible and audible high/low alarms for heart rate, respiratory rate, and all pressures (at least systemic arterial, central venous, pulmonary arterial and intracranial pressures);
 - 2) Four simultaneous pressure capability (systemic arterial, central venous, pulmonary arterial and intracranial pressures);
 - 3) Hard-copy capability for the rhythm strip and wave forms; and
 - 4) Capability for routine testing and maintenance of all monitors.
7. Oxygen and compressed air, supplied from a central source, must supply 50 pounds per square inch (psi) with an alarm system to warn of a critical reduction in line pressure. Reduction valves and blenders shall produce concentrations of oxygen from 21 percent to 100 percent at atmospheric pressure for head hoods and 50 psi for mechanical ventilators. Oxygen monitoring for inspired concentrations shall be available in the PICU.
8. Diagnostic imaging procedures and consultation services necessary for the level of care provided shall be available on a 24-hour basis as specified in Chapter 3.3.1 of the CCS Standards for Tertiary Hospitals.
9. Laboratory services and consultation services necessary for the level of care provided shall be available on a 24-hour basis. There shall be capability for a ten minute turnaround time for pH and blood gas determinations.
10. There shall be an operating room available within 30 minutes, 24-hours a day that meets the requirements contained in Chapter 3.3.1 of the CCS Standards for Tertiary Hospitals.
11. There shall be a fully staffed and equipped Emergency Department open 24-hours a day which shall be accessible to ground and air transportation. Within the Emergency Department, there shall be a distinct intake/resuscitation area with equipment and supplies appropriate for infants and children.

H. PICU -- Patient Care

1. The care of CCS-eligible clients in the PICU shall be under the direct supervision of the PICU medical director or CCS-paneled pediatric intensivist designee and/or the CCS-paneled attending physician in consultation with the pediatric intensivist.
2. A CCS-paneled pediatric intensivist or CCS-paneled physician shall review, evaluate, and document the clinical management of each patient, on site, at least on a daily basis.

3. It shall be the responsibility of the pediatric intensivist to ensure that information is provided, on an on-going basis, to referring physicians regarding their patients.
4. There shall be a CCS-paneled pediatric intensivist who shall be on-call to the PICU on a 24-hour basis and:
 - a. shall either be in the hospital or shall be no more than 30 minutes away from the PICU at any time;
 - b. shall not be on-call for more than one hospital at the same time; and
 - c. shall be notified of new admissions and adverse changes in the status of patients in a timely manner, as described in Section 3.32/H.
5. There shall be 24-hour in-house coverage provided by a physician(s) who is skilled in the management of emergencies in the PICU, skilled in pediatric airway management, including endotracheal intubation. This requirement shall be met by a physician(s) who is either:
 - a. A CCS-paneled pediatric intensivist; or
 - b. An anesthesiologist with expertise in pediatric critical care; or
 - c. A CCS-paneled pediatric subspecialist with expertise in pediatric critical care; or
 - d. An in-house physician at the post-graduate residency year three level or above who is specializing in pediatrics, anesthesiology or emergency medicine and who has successfully completed the AHA approved PALS or equivalent course within the past two years.
6. If the in-house physician is not the on-call pediatric intensivist, the on-call pediatric intensivist shall be notified of all potential and actual admissions to the PICU in a timely manner.
7. Nurse staffing in the PICU shall include the following:
 - a. There shall be a nurse manager assigned to the PICU who has 24-hour responsibility for the management of patient care.
 - b. There shall be a nurse supervisor assigned to the PICU who has 24-hour responsibility for the supervision of patient care personnel.
 - 1) The nurse supervisor or designee shall be present in the PICU at all times.
 - 2) There shall be at least one nurse supervisor assigned to the PICU for every 30 full-time equivalent PICU positions.

- c. If the nurse manager is dedicated solely to the PICU and does not oversee more than 30 full-time equivalent positions, the position and responsibilities of the nurse manager and the nurse supervisor may be combined under the nurse manager.
 - d. There shall be a designated charge nurse for each shift.
 - e. There shall be a R.N. assigned to each patient in the PICU.
 - f. There shall be no less than two R.N.s physically present in the PICU at all times when a patient is present.
 - g. There shall be no more than one LVN for every three R.N.s assigned to provide direct nursing care in the PICU.
 - h. LVNs may provide nursing care for patients in the PICU under the direction of the assigned R.N.
8. Unlicensed assistive personnel in the PICU may only be assigned non-nursing tasks which require no scientific knowledge and/or technical skill.
9. RCP staffing shall be based on the level of patient care required as determined by the attending physician or physician designee, and shall consider the acuity of, and numbers of, patients in the PICU.
10. There shall be a MSW assigned to all patients upon admission to the PICU; and:
- a. A social work assessment shall be completed on suspected child abuse/neglect patients within 24-hours of identification or suspicion or prior to discharge, whichever comes first.
 - b. A social work assessment shall be completed within two working days of admission or prior to discharge, whichever comes first.
 - c. The social work assessment shall include an interview of at least one of the patient's parents or primary caretaker(s). The parent(s) or primary caretaker(s) shall be included as early as possible in the decision-making process(es) relating to the care of their child.
 - d. A preliminary case service plan shall be developed with the parent(s) or primary caretaker(s) within three working days of admission to the PICU which shall include, but not be limited to, assessment of the following: significant family stress factors, environmental factors, mental health factors, and any other psychosocial factors, and how these factors in the family will be addressed.

- e. Social work progress notes shall be completed at least on a weekly basis, or more often as indicated, and shall include psychosocial data, significant changes in the patient's family, updates and results of the implementation of a service plan and plans to continue contact with the family for ongoing support.
 - f. MSW reports and notes shall be recorded in the patient's chart and be readily available to other PICU team members.
 - g. The authorizing CCS program shall have access to social work reports in order to coordinate services.
11. The PICU shall provide physician, nursing and social work consultation on a 24-hour basis to community practitioners and facilities who refer patients to the PICU.
12. There shall be, at a minimum, weekly multidisciplinary team conferences.
- a. The PICU multidisciplinary team conference shall include representation from the PICU's medical, nursing, medical social service, RCP staff and other specialists, i.e., the clinical registered dietitian, occupational therapist and physical therapist, when appropriate.
 - b. Minutes of these weekly team conferences which document attendance and discussion of plan(s) of care for individual patients shall be included either in the patient's chart or in a binder that shall be available for review by CCS program staff.
13. The PICU medical director shall ensure, either directly or through written agreements with other hospital departments or facilities, that an established mechanism for transport exists.
14. The medical director of the transport services shall be responsible for:
- a. Selecting the method of transport to be used;
 - b. Designating team members for the transport of unstable or potentially unstable patients. The transport team shall include an R.N., and at least one other professional who has also successfully completed the AHA approved PALS or equivalent course within the last two years, and is competent in the following:
 - 1) Pediatric airway management (including endotracheal intubation);
 - 2) Needle aspiration of the chest; and
 - 3) Establishment and maintenance of vascular access.

- c. Designating the team member(s) for the transport of a stable patient, which may be a R.N. who has nursing experience in pediatric critical care and who has successfully completed the AHA approved PALS course within the last two years.

PICU -- Policies and Procedures

1. There shall be a PICU Policies and Procedures Manual which shall be:
 - a. Updated, reviewed and signed at least every three years, or more frequently as necessary, by the medical director and nurse manager of the PICU; and
 - b. Readily available in the PICU for PICU staff.
2. The written Policies and Procedures Manual for the PICU shall address/include, but not be limited to, the following:
 - a. Criteria delineating the clinical privileges granted to attending CCS-paneled physicians other than the pediatric intensivists;
 - b. Criteria for admission of infants, children, and adolescents to the PICU;
 - c. Criteria for discharge of infants, children, and adolescents from the PICU;
 - d. Patient care including nursing management for infants, children, and adolescents admitted to the PICU;
 - e. Respiratory care management for infants, children, and adolescents admitted to the PICU;
 - f. Criteria for monitoring of patients in the PICU including the use of appropriate equipment;
 - g. Administration of medication, blood and blood products in the PICU;
 - h. Mechanism for bioethical review, when indicated, of patients admitted to the PICU;
 - i. Mechanism for infection surveillance, prevention and control in the PICU;
 - j. Parent visitation in the PICU;
 - k. Transport of patients (in-house, to the PICU from other facilities and from the PICU to other facilities) and describe, at a minimum, the following:
 - 1) Staff assigned to the transport team and the equipment to be used; and

- 2) Assurance of a review by the PICU medical director of the transports performed, at least on a monthly basis.
 - l. Discharge planning process which includes the roles of the designated coordinator for discharge planning and the PICU multidisciplinary team members with the parent or caretaker and the referring physician, primary care physician and any specialized follow-up agency;
 - m. Routine testing and maintenance of equipment in the PICU;
 - n. Responsibilities and functions for social work services in the PICU;
 - o. Mechanism for referral to the hospital's suspected child abuse and neglect team on a 24-hour basis;
 - p. Mechanism to inform a family regarding potential organ/tissue donation;
 - q. Use of life support and the techniques for resuscitation in the PICU;
Determination of brain death;
 - s. Pain management and conscious sedation for operative/medical procedures and for trauma; and
 - t. Consent for treatment and procedures.
3. The PICU shall maintain written agreements, approved by the CCS program, with hospitals requiring services relative to pediatric critical care education, consultation, transfer and transportation; and there shall be at least an annual mutual review of outcome data and modifications of agreements to reflect evaluation of outcome.

J. PICU -- Discharge Planning Program

Discharge of patients from the PICU shall be the responsibility of the CCS-paneled physician responsible for the care of the patient. At a minimum, discharge planning shall include, but not be limited to, the following:

- 1 Designation of a coordinator for discharge planning who shall be responsible for:
 - a. Ensuring collaboration between the PICU multidisciplinary team members and communication with the primary care physician, community agencies, CCS programs, CCS Special Care Centers, Medical Therapy Units (MTUs), Medi-Cal In-Home Operations Unit, and Regional Centers whose services may be required and/or related to the care needs of the infant, child, or adolescent after hospital discharge; and

- b. Ensuring that each patient discharged from the PICU shall have follow-up by a primary care physician and a specialized program of care, as applicable, in the follow-up care of the patient, i.e., rehabilitation services.
- 2. Identification of the responsibilities and involvement of the PICU multidisciplinary team members in discharge planning activities on an ongoing basis.
- 3. Ensuring that culturally and linguistically appropriate written discharge information shall be given to the parent(s) or primary caretaker(s) participating in the patient's care at the time of discharge and shall include but is not limited to the patient's diagnosis, medications, injury and illness prevention education, and follow-up appointments, including community agencies and instructions on any medical treatment(s) that will be given by the parent(s) or primary caretaker(s). A copy of this written discharge information shall be sent to the primary care physician and/or agency involved in providing follow-up care.

K. PICU – Quality Assurance and Quality Improvement

- 1. There shall be an ongoing quality assurance program specific to patient care activities in the PICU that is coordinated with the hospital's overall quality assurance program.
 - a. Documentation shall be maintained of the quality assurance and quality assessment activities provided.
 - b. Documentation shall include utilization review and medical records review which shall be available for on-site review by CCS program staff.
- 2. There shall be a morbidity and mortality review process held at least once a month to discuss pediatric critical care issues.
 - a. CCS encourages multidisciplinary participation, including primary care physicians, as well as participation by outside consultants on a regular basis.
 - b. Meeting agendas, lists of attendees, and minutes of such conferences shall be maintained and available for on-site review by CCS program staff.
- 3. There shall be a written plan that facilitates a family-centered and culturally-competent approach to PICU care by the professional staff which includes, but is not limited to, the following:
 - a. A system that will encourage and provide for inclusion of the parent(s) or primary caretaker(s) in the decision-making process relating to the care and interventions of their child as early as possible; and

- b. A method shall be in place for the parent(s) or primary caretaker(s) to provide input and feedback to the PICU multidisciplinary team members regarding their child's care and experiences in the PICU. This may be in the form of a patient/family satisfaction questionnaire to provide a mechanism to appraise the services in the PICU.
4. There shall be a formalized method for reviewing and documenting on an annual basis the skills of physicians responsible for 24-hour in-house coverage of the following:
 - a. Pediatric airway management, including endotracheal intubation;
 - b. Needle aspiration of the chest; and
 - c. Establishment and maintenance of vascular access.
5. A transport program shall have an ongoing continuous quality improvement process and evaluation of such shall be made available to the PICU medical director.
6. The PICU shall maintain a database and/or vital statistics which shall include, but not be limited to:
 - a. The number of PICU beds;
 - b. The number of children admitted to the PICU, with a breakdown by disease categories, length of stay, and age;
 - c. The number and origin of patient transports to the PICU, the mode of transport; and
 - d. An annual report of mortality and numbers of patients admitted to the PICU, stratified according to Pediatric Risk of Mortality (PRISM) III scores, or the most recent version of PRISM scores, shall be maintained by the PICU.
7. The PICU medical director shall submit the annual PICU outcome data described above to the Department of Health Services; Chief, Children's Medical Services (CMS) Branch; California Children's Services Program; 714 P Street, Room 350; P.O. Box 942732; Sacramento, CA 94234-7320, by July 1 of each year for the patient database of the preceding calendar year.
8. Assurance of continuing education for staff providing services in the PICU shall include, at a minimum, the following:
 - a. There shall be a written plan for orientation of all newly-hired professionals who will be providing care in the PICU and an ongoing evaluation of the program. This written plan shall include the competencies required of the professional and documentation of successful demonstration of these competencies.

- b. There shall be written plans for the continuing education of professionals involved in pediatric critical care.
9. At a minimum the latest editions of the following texts and documents shall be kept in the PICU:
- a. Red Book: Report of the Committee on Infectious Diseases, Committee on Infectious Diseases, American Academy of Pediatrics;
 - b. Pediatric Advanced Life Support, American Heart Association;
 - c. Standards for Nursing Care of the Critically Ill, American Association of Critical Care Nurses (AACCN);
 - d. Standards of Nursing Practice, American Nurses' Association (ANA);
 - e. At least one current reference book pertaining to pediatric critical care;
 - f. At least one current reference book pertaining to pediatric critical care nursing;
 - g. At least one current reference book pertaining to pharmacology and therapeutics;
 - h. CCS Manual of Procedures, Chapter 3.32, CCS Standards for Pediatric Intensive Care Units;
 - i. CCS Manual of Procedures, Chapter 3.3, CCS Standards for Hospitals;
 - j. Current listing of CCS medically-eligible conditions; and
 - k. A current Policies and Procedures Manual of the PICU.