

Checklist of Required Items for COPPER Recognition

Resources to help your emergency department address gaps in pediatric readiness:

COPPER Toolkit

NPRP National Toolkit

PEDIATRIC EMERGENCY CARE COORDINATORS/CHAMPION	Completed	In progress
Physician champion or pediatric emergency care coordinator (PECC)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse/Paramedic champion or pediatric emergency care coordinator (PECC)	<input type="checkbox"/>	<input type="checkbox"/>
PECC/Pediatric Committee (can be multiple people identified to support PECC's)	<input type="checkbox"/>	<input type="checkbox"/>
COMPETENCIES FOR ED HEALTH CARE PROVIDERS	Completed	In progress
ED physicians should have completed training in a certified pediatric resuscitation course such as Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), or Pediatric Emergency Assessment, Recognition and Stabilization (PEARS). *Maintenance of course certification not required for physicians boarded in Pediatric Emergency Medicine or Emergency Medicine *Physicians boarded in Family Medicine require current certification	<input type="checkbox"/>	<input type="checkbox"/>
All ED physicians are board certified and/or eligible specialists in emergency medicine or pediatric emergency medicine	<input type="checkbox"/>	<input type="checkbox"/>
At least one nurse on staff in the ED who is trained in the emergency evaluation and treatment of children of all ages at all times (e.g., PALS, APLS, ENPC certified)	<input type="checkbox"/>	<input type="checkbox"/>
There is a comprehensive pediatric training program ensuring all ED nurses participate in regularly scheduled pediatric training such as PALS, ENPC, APLS, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Baseline and ongoing competency evaluations for all ED clinical staff are population specific and include a review of clinical skills unique to children of all ages -see resource page for formal/informal examples. All staff are regularly oriented Q6 months on the location of pediatric equipment.	<input type="checkbox"/>	<input type="checkbox"/>
ED QUALITY IMPROVEMENT AND/OR PERFORMANCE IMPROVEMENT	Completed	In progress
QI/PI plan includes the following pediatric specific indicators for which data are collected and analyzed, system performance is monitored over time, and system changes are implemented based on performance: <ul style="list-style-type: none"> • Weighing in kilograms • Recording weight in kilograms • Weight-based medication doses 	<input type="checkbox"/>	<input type="checkbox"/>

<p>QI/PI plan also includes at least one of the following pediatric specific indicators for which data are collected and analyzed, system performance is monitored over time, and system changes are implemented based on performance:</p> <ul style="list-style-type: none"> • Avoiding antibiotics for viral illnesses • Readmission rates (within 3 days) • CXR for patients discharged with bronchiolitis diagnosis 	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric specific indicators are reviewed at a minimum quarterly and action item follow-up is integrated into the ED QI/PI plan	<input type="checkbox"/>	<input type="checkbox"/>
<p>*There is a quarterly pediatric case review process for:</p> <ul style="list-style-type: none"> • All pediatric deaths • All critical care transfers out • 10 patients/month or 25% of overall pediatric admissions, or 100% of pediatric census, if less than 10/month 	<input type="checkbox"/>	<input type="checkbox"/>
PEDIATRIC PATIENT AND MEDICATION SAFETY IN THE ED	Completed	In progress
*Children are weighed in kilograms	<input type="checkbox"/>	<input type="checkbox"/>
Weights are recorded in a prominent place on medical record	<input type="checkbox"/>	<input type="checkbox"/>
For children not weighed, a standard method for estimating weight in kilograms is used (e.g., a length-based system)	<input type="checkbox"/>	<input type="checkbox"/>
A full set of vital signs is recorded and reassessed for all children, including temperature, heart rate, respiratory rate, pulse oximetry, blood pressure, pain, and mental status/LOC (as indicated) <i>(if unable to obtain BP in triage, attempt in the secondary assessment of patient)</i>	<input type="checkbox"/>	<input type="checkbox"/>
*Processes are in place for safe, weight-based medication administration, such as pre-calculated drug dosing and formulation guides; consider identifying a pediatric pharmacist resource and ensure that a pediatric dosing reference is available at all times	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric emergency services are culturally and linguistically appropriate; this includes 24/7 access to interpreter services in the ED	<input type="checkbox"/>	<input type="checkbox"/>
Timely tracking and reporting of patient safety events; consider celebrating near misses/good catch events to encourage submission of possible safety events	<input type="checkbox"/>	<input type="checkbox"/>
Immunization status documentation and management of the under immunized patient	<input type="checkbox"/>	<input type="checkbox"/>
POLICIES, PROCEDURES, AND PROTOCOLS FOR THE ED	Completed	In progress
Intake and triage assessment of the pediatric patient: <ul style="list-style-type: none"> • Documentation of a full set of vital signs including blood pressure on all pediatric patients • Identification of abnormal pediatric vital signs and notification to the responsible provider 	<input type="checkbox"/>	<input type="checkbox"/>
Radiology: Must have guidelines to reduce radiation risk that are age and size specific consistent with ALARA (as low as reasonably achievable) should be in place and utilization of shielding techniques. The radiology capability of a facility must meet the needs of the children in the community it serves.	<input type="checkbox"/>	<input type="checkbox"/>

Pediatric patient assessment and reassessment including vital signs <ul style="list-style-type: none"> • Identification of abnormal pediatric vital signs and notification to the responsible provider • Continuous Monitoring of the pediatric patient (e.g., O2 saturations should be monitored during an infant lumbar puncture (LP), patients with DKA/new onset diabetes should be placed on an ECG monitor, asthmatic patients who are receiving a continuous nebulizer should be on an ECG monitor) 	<input type="checkbox"/>	<input type="checkbox"/>
Sedation and analgesia of the pediatric patient (CO2 should be monitored on children during sedation or intubation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Consent, including when parent or legal guardian is not immediately available	<input type="checkbox"/>	<input type="checkbox"/>
**Social and behavioral health issues	<input type="checkbox"/>	<input type="checkbox"/>
Use of physical or chemical restraint of patients	<input type="checkbox"/>	<input type="checkbox"/>
*Procedures for recognizing, assessing, and reporting suspected child maltreatment (hospital policy should specify where patients will be transferred if full assessment is not completed in house; if maltreatment is suspected, even if patients are transferred out, reporting is mandated and should be specified in hospital policy)	<input type="checkbox"/>	<input type="checkbox"/>
Management of family presence and family centered care during the death of the child in the ED	<input type="checkbox"/>	<input type="checkbox"/>
Family-centered care (examples include: counseling, treatment, resuscitation, medications, decisions)	<input type="checkbox"/>	<input type="checkbox"/>
Communication with the patient's medical home or primary care provider as needed	<input type="checkbox"/>	<input type="checkbox"/>
All-hazard disaster preparedness / emergency operations plan addresses pediatric issues including: <ul style="list-style-type: none"> • Availability of medications, vaccinations, equipment, supplies • Decontamination, isolation, quarantine of children and families • Minimization of parent-child separation and reunification • Training drills include children • Plan includes pediatric surge capacity • Behavioral health resources for children • Children with special health care needs 	<input type="checkbox"/>	<input type="checkbox"/>
Written pediatric interfacility transfer procedures and/or agreements that include pediatric components	<input type="checkbox"/>	<input type="checkbox"/>
EQUIPMENT AND SUPPLIES	Completed	In progress
Pediatric appropriate resuscitation equipment and supplies shall be kept in the ED; other pediatric appropriate items may be housed elsewhere, ensuring accessibility by the ED team when needed	<input type="checkbox"/>	<input type="checkbox"/>
ED staff must be able to verbalize the location of all pediatric equipment and supplies listed in the sections below	<input type="checkbox"/>	<input type="checkbox"/>
There is a daily method in place to verify the proper location and function of pediatric equipment and supplies	<input type="checkbox"/>	<input type="checkbox"/>

General Equipment	Completed	In progress
Weight scale, in kilograms only, for infants and children or a process in place to ensure weight is recorded in kilograms (it is highly recommended that scales are locked in kilograms mode)	<input type="checkbox"/>	<input type="checkbox"/>
Weight- and length-based tool or chart for resuscitation medication dosing and airway management	<input type="checkbox"/>	<input type="checkbox"/>
Rigid boards for use in CPR	<input type="checkbox"/>	<input type="checkbox"/>
Monitoring Equipment	Completed	In progress
Blood pressure cuffs (neonatal, infant, child)	<input type="checkbox"/>	<input type="checkbox"/>
ECG monitor and/or defibrillator with pediatric and adult capabilities, including pediatric-sized pads and/or paddles	<input type="checkbox"/>	<input type="checkbox"/>
Pulse oximeter with pediatric and adult probes	<input type="checkbox"/>	<input type="checkbox"/>
Continuous end-tidal CO2 monitoring; End-tidal CO2 monitoring is considered the optimal method of assessing for and monitoring of endotracheal tube placement in the trachea; however, for low-volume hospitals, adult and pediatric CO2 colorimetric detector devices can be substituted. Clinical assessment alone is not appropriate.	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Equipment	Completed	In progress
*Endotracheal tubes (uncuffed: 2.5mm, 3.0mm; cuffed (recommended) or uncuffed: 3.5mm, 4.0mm, 4.5mm, 5mm, 5.5mm, cuffed 6.0)	<input type="checkbox"/>	<input type="checkbox"/>
*Laryngoscope blades (curved: 2; straight: 00, 0, 1, 2) (curved: 3; straight: 3)	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Magill forceps	<input type="checkbox"/>	<input type="checkbox"/>
Difficult airway supplies and/or kit (contents to be based on pediatric patients served at the hospital and may include some or all of the following: supraglottic airways of all sizes, such as the laryngeal mask airway, i-gels, needle cricothyrotomy supplies, the surgical cricothyrotomy kit, or video laryngoscopy) Laryngeal mask airways can be shared with anesthesia but must be immediately accessible to the ED.	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric and infant sized stylets for endotracheal tubes	<input type="checkbox"/>	<input type="checkbox"/>
Suction catheters (infant and child: 6F, 8F, 10F, 12F)	<input type="checkbox"/>	<input type="checkbox"/>
Bag-valve-mask (manual resuscitator) infant, child, and adult sizes)- May substitute anesthesia bag if appropriately trained.	<input type="checkbox"/>	<input type="checkbox"/>
Simple oxygen masks (standard infant, standard child)	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen masks (non-rebreather) appropriate for use with infant patients and children	<input type="checkbox"/>	<input type="checkbox"/>
Masks to fit bag-mask device adaptor (neonatal, infant, child, adult)	<input type="checkbox"/>	<input type="checkbox"/>
Nasal cannula and securement device (infant and children, adult)	<input type="checkbox"/>	<input type="checkbox"/>
Nasogastric (Salem Sump) tubes: infant (8F catheter) and child (10F catheter) *Alternatively, this can be replaced with a tube that can be used for gastronomy decompression of the pediatric stomach (e.g., the average foley tube)	<input type="checkbox"/>	<input type="checkbox"/>
Nasal aspirator (recommend using something like the aspirators with the olive/mushroom tip)	<input type="checkbox"/>	<input type="checkbox"/>

Oropharyngeal airways (infant and child, sizes 0–5) (0-3 on readiness survey-consider moving – yes move to above)	<input type="checkbox"/>	<input type="checkbox"/>
Supraglottic device (e.g., LMA) (infant, child)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Equipment	Completed	In progress
Angio catheter (14–24 gauge)	<input type="checkbox"/>	<input type="checkbox"/>
Intraosseous needles or device (pediatric/ adult)	<input type="checkbox"/>	<input type="checkbox"/>
IV administration sets with calibrated chambers and/or infusion devices with the ability to regulate the rate and volume of infusion (including low volumes)	<input type="checkbox"/>	<input type="checkbox"/>
Manual rapid infusion device, rated for pediatrics, for easy push-pull fluid administration	<input type="checkbox"/>	<input type="checkbox"/>
Syringe pumps that can administer inotropic agents (e.g., epinephrine, norepinephrine, dopamine, and milrinone) at an appropriate pediatric drip rate	<input type="checkbox"/>	<input type="checkbox"/>
Atomizer for intranasal administration of medication *ensure dose is based off of route	<input type="checkbox"/>	<input type="checkbox"/>
Central venous catheters (4.0–7.0F) Required for High-Volume EDs (>10,000 Pediatric Patient Visits per Year)	<input type="checkbox"/>	<input type="checkbox"/>
MEDICATIONS	Completed	In progress
Alprostadil (prostaglandin E1)-Ensure there is a defined procedure for administering and monitoring.	<input type="checkbox"/>	<input type="checkbox"/>
Analgesics (oral, intranasal, and parenteral and topical anesthetics) <ul style="list-style-type: none"> • IN fentanyl with mucosal atomizer (see equipment list and weight-based dosing) • EMLA (Eutectic Mixture Local Anesthetics): lidocaine 2.5% and prilocaine • LET (Lidocaine, epinephrine, tetracaine), LMX 4 (4% lidocaine) 	<input type="checkbox"/>	<input type="checkbox"/>
Anticonvulsant: Valproate	<input type="checkbox"/>	<input type="checkbox"/>
Antidotes including lipids, naloxone hydrochloride (common antidotes should be accessible to the ED)-charcoal; 2-PAM,	<input type="checkbox"/>	<input type="checkbox"/>
Antihypertensives: nicardipine, and sodium nitroprusside	<input type="checkbox"/>	<input type="checkbox"/>
Suspension ibuprofen and suspension and rectal Tylenol: Antipyretic/Analgesics	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines (midazolam IN and lorazepam)	<input type="checkbox"/>	<input type="checkbox"/>
Dextrose (D ₁₀ W)	<input type="checkbox"/>	<input type="checkbox"/>
Sucrose solutions for pain control in infants	<input type="checkbox"/>	<input type="checkbox"/>
Vaccines: tetanus and rabies immunoglobulin		
Resuscitation Medications	Completed	In progress
Sodium bicarbonate (4.2%)- If only sodium bicarbonate 8.4% is available, may dilute 1:1 with normal saline before administration in children <2 y of age.	<input type="checkbox"/>	<input type="checkbox"/>