3.32.1 STANDARDS FOR COMMUNITY PEDIATRIC INTENSIVE CARE UNITS (PICUs)

A. Community PICU -- Definition

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

A Community PICU is a unit within a CCS-approved Pediatric Community Hospital that has the capability of providing care for critically ill infants, children, and adolescents with a wide range of medical, surgical, and traumatic disorders of moderate severity. These patients require a multidisciplinary approach to care. The Community PICU is for patients between 37 weeks gestation and/or two kilograms (kg) and who are under 21 years of age and who meet CCS medical eligibility criteria, as per California Code of Regulations (CCR), Title 22, Division 2, Subdivision 7, Chapter 4, Section 41515.1 et seq.

Community PICUs provide care of critically ill infants, children, and adolescents to avoid long-distance transfers for conditions of less complexity or lower acuity than what should be managed at a Regional PICU. A Community PICU must have a well-established communications system with a CCS-approved Regional PICU to allow for timely consultation and referral of patients who need care that is not available in the Community PICU. This shall be in the form of a Regional Cooperation Agreement (RCA) (see Section 3.32.1/B.4. below).

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

1. A CCS approved Pediatric Community hospital with a PICU wishing to participate in the CCS Program for the purpose of providing care to critically sick and injured infants, children and adolescents, shall be licensed by the California Department of Public Health, Licensing and Certification Division, under the California Code of Regulations (CCR), Title 22, Division 5, Chapter 1, as an acute general hospital, as per Section 70101 et seq, with supplemental services for intensive care service, as per Section 70491 et seq.

2. The Community PICU:

   Shall be located in a hospital approved by the CCS Program as a Pediatric Community Hospital, as per CCS Standards for Pediatric Community Hospitals; CCS Manual of Procedures, Chapter 3.3.2., and shall be accredited by the Joint Commission and demonstrate compliance with all standards.

3. A Community PICU shall meet and maintain all CCS Standards for a Community PICU, as contained within this Chapter.

4. PICU Regional Cooperation Agreement

   a. A Community PICU shall enter into a written PICU Regional Cooperation Agreement (RCA), with at least one CCS-approved PICU located at a CCS-approved Tertiary Hospital (and shall be referenced in these Standards as a
Regional PICU. An RCA shall specify mutual responsibility for at least the following:

1) Joint education and training of pediatric critical care health professionals (i.e. physician, nursing, and respiratory care practitioner staff);

2) Joint development of guidelines for PICU telephone and/or live interactive telehealth consultation by pediatric intensivists, and other specialty disciplines, including, but not limited to pediatric subspecialists, pediatric critical care nurse, social worker, clinical registered dietitian, and pharmacy staff.

   a) The PICU must meet all Centers for Medicare and Medicaid Services (CMS) and Joint Commission Standards for telehealth.

   b) There shall be available a copy of a signed and dated contract or agreement between the Community PICU and the CCS-approved Tertiary Hospital for the provision of live interactive telehealth that includes the names of the involved CCS-approved subspecialists.

3) Joint development of guidelines for infant, children, and adolescent patient referral and transport to and from each PICU;

4) Joint identification, development, and review of protocols, policies, and procedures related to the care of critically ill infants, children, and adolescents at least every three years; and

5) Joint review of the annual report from the Virtual PICU Performance System (VPS) California Data Set providing numbers of patients, diagnostic data, demographic data, mortality and length of stay admitted to the Community PICU, using risk adjustment mortality reported annually.

6) Joint review of transport data to and from the Regional and Community PICU, based on CCS requirements, at least annually.

b. A Regional Cooperation Agreement shall be developed, negotiated, signed and dated prior to CCS approval by at least the following persons from each hospital:

1) Hospital Administrator; and

2) Medical Director of the PICU; and

3) Nurse Administrator (i.e. the hospital’s Director of Nursing)

c. It shall be the mutual responsibility of the Regional PICU and Community PICU to review the PICU RCA annually (i.e., during the annual review the annual report from the VPS California Data Set) and recommend any modifications of said agreement to reflect the evaluation of outcomes.

d. The Community PICU medical director shall assure that a written policy is present which addresses implementation of the specific terms of the RCA.
5. 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 Community PICU requirements, as per Chapter 3.32.1, shall complete a CCS Community PICU application and submit one original via secure mail and/or one electronic copy to: Department of Health Care Services; Chief Medical Officer, Systems of Care Division, Children’s Medical Services (CMS); California Children’s Services Program: 1515 K Street, Room 400; Provider Services Unit; Sacramento, CA 95814-4040 or Facility Site Review Team, Phone # (916) 327-2119, Fax # (916) 440-5317. Questions concerning the standards and the application process should be directed to the following email address: ccsfacilityreview@dhcs.ca.gov

Sacramento Regional Office
Children’s Medical Services
1515 K Street, Room 400
Sacramento, CA 95814-4040
Telephone: (916) 322-3100

6. Review Process

a. Upon receipt, the Community PICU application will be reviewed by staff at the CMS Office. A site visit will be scheduled if the documentation submitted by the hospital appears to meet the CCS Standards for Community 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 health care professional staff, and may be augmented by consultant experts in the fields of pediatric critical care medicine and pediatric critical care nursing and, as indicated, by other medical and allied health care specialists.

c. Approval shall be based on compliance with CCS Standards for Community PICUs and upon review on-site of the PICU’s policies and procedures, services provided, patient charts, 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 organizations within the California Department of Public Health (DPH), such as the Maternal, Child and Adolescent Health Program and/or the Center for Health Care Quality and with other State and Federal agencies to determine community need.

7. 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 Community PICUs are met.

b. Provisional approval may be granted when all CCS Standards for Community 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, and the plan must be approved by the CCS Program. If 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.

8. 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 Medical Officer, Children’s Medical Services, within 30 days of receipt of the notification of denial.

9. Staffing changes involving professionals whose qualifications are incorporated into any portion of these standards shall be reported to the CCS Program whenever they occur. Yearly updates of Community PICU personnel shall be submitted to the CCS Program accompanied by a copy of the most current hospital license. This information shall be submitted to the CMS address in Section 3.32.1/A.5. with a copy to the Regional Office.

10. Periodic reviews of CCS-approved Community PICUs may be conducted on an annual basis or as deemed necessary by the CCS Program. If a Community PICU does not meet CCS Program requirements, a Community PICU may be subject to losing its CCS approval.

C. **Community PICU -- CCS Program Participation Requirements**

1. Facilities providing services to CCS patients shall 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, telephone numbers, and office locations.

   c. Request prior authorization from the CCS Program, as per CCR, Title 22, Section 41770.

   d. Notify the local CCS Program office, in a timely manner, of specialized patient transport methods for potentially eligible infant, 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 an insurance carrier fails to respond.

i. 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 language appropriate written materials.

n. Permit CCS staff to visit and monitor facilities to assure ongoing compliance with CCS Standards. Cooperate fully with local and State CCS staff who solicit information relevant to the assurance of such compliance, including but not limited to patient records.

o. Assist and cooperate with the on-site utilization review by CCS staff of services provided to CCS-eligible children.

p. Ensure all hospitals, physicians and surgeons and allied staff, as required in these standards, meet the CCS requirement for CCS-paneling and approval.

q. Establish criterion for privileging which differentiates a physician’s expertise in pediatrics and adults. (See Section 3.32.1/F.1.3.a. below)

2. Failure to abide by the regulations and procedures governing the CCS Program may justify the removal of the hospital from the list of CCS-approved facilities.

D. Community 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 or
   b. Deficiencies identified by CCS staff or
c. Loss of accreditation by the Joint Commission (or equivalent accreditation or organization; i.e. National Integrated Accreditation for Healthcare Organizations) or
d. Failure to abide by the laws, regulations, standards, and procedures governing the CCS Program.

E. Community PICU -- Organization

1. There shall be a separate and identifiable administrative unit for the Community PICU.

2. Medical care of the Community PICU shall be under the direction of a medical director:
   a. Who shall meet qualifications contained in Section 3.32.1/F.;
   b. Whose primary responsibility shall be the organization and supervision of the Community PICU; and
   c. Who shall be full time at the facility and shall not be a medical director of more than one critical care unit

3. There shall be a Community 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 Community PICU; and
   b. Who shall meet the requirements contained in Section 3.32.1/F.

4. The Community PICU medical director and the Community PICU nurse manager shall have joint responsibility for the development and review of an ongoing quality improvement program.

5. The Community PICU medical director and the Community PICU nurse manager shall have joint responsibility for development and review of a Policies and Procedures Manual for the Community PICU which addresses, at a minimum, patient admission criteria, patient care, procedure and criteria for patient discharge, transfer, and transport. The policy and procedure manual shall be reviewed and approved every year by the Community PICU medical director and nurse manager.

6. There shall be an identified Community 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-approved pediatric intensivist, a clinical nurse specialist or designee i.e. Pediatric Nurse Practitioner (PNP), a clinical registered dietitian (nutritionist), a respiratory care practitioner and a medical social worker, all of whose professional requirements are defined in Section 3.32.1/F. Other members of the Community PICU multidisciplinary team may include, but are not limited to, the following CCS-approved providers: clinical pharmacist, occupational therapist, physical therapist, and child life specialist.
F. Community PICU -- Professional Resources and Requirements

1. Community PICU Physician Staff

1.1 Community PICU -- Medical Director

a. There shall be a full-time CCS-approved pediatric intensivist as the medical director, and:

1) Who shall have overall responsibility for the quality of medical care for infants, children, and adolescents admitted to the Community PICU; and

2) Who shall:

   a) Be 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 in General Pediatrics and the American Board of Anesthesiology with certification 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 Community PICU medical director which shall include, but not be limited to, the following:

1) Participation in the development, review and implementation of Community PICU polices and procedures as specified in Section 3.32.1/I.;

2) Approval of patient admission, discharge, transfer, and transport criteria;

3) Has overall responsibility for quality of medical care and supervision of quality control and quality assessment activities (including morbidity and mortality reviews);

4) Responsibility for assuring Community PICU staff competency in resuscitation techniques;

5) Responsibility for assuring ongoing Community PICU staff education in pediatric critical care medicine;

6) Participation in Community PICU budget preparation;

7) Oversight of patient transport to and from the Community PICU; and

8) Responsibility for assuring the maintenance of Community PICU database and/or vital statistics, including transport data to and from the Community PICU.

9) Assurance that the joint responsibilities of the RCA are met, as per Section 3.32.1/B.4.
1.2 Community PICU -- Other Pediatric Intensivist Staff

The Community PICU medical director shall have at least one other full-time equivalent (FTE) associate pediatric intensivist(s) on staff who attends in the PICU. If the FTE for an associate intensivist is to be met by more than one individual, at least one of the pediatric intensivists must be a 0.5 FTE. The associate pediatric intensivist shall:

a. Be a CCS-approved pediatric intensivist;

b. Be certified by the American Board of Pediatrics in General Pediatrics and certified or is an active candidate for certification in the subspecialty of Pediatric Critical Care Medicine. For the intensivist who does not have subspecialty certification in Pediatric Critical Care Medicine at the time of application, the subspecialty board examination shall be passed within six years of becoming eligible to sit for the examination; or

c. Be certified by both the American Board of Pediatrics in General Pediatrics and the American Board of Anesthesiology with certification or active candidacy for subspecialty certification by the American Board of Anesthesiology in the subspecialty of Critical Care Medicine;

d. Shall share the clinical care responsibilities of the PICU, and

e. Be the designee of the Medical Director and make decisions when the Medical Director is not present to provide care.

f. The associate pediatric intensivist who does not have 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 Community PICU Additional Physician Staff

a. A CCS-approved pediatric surgeon, a CCS-approved neurosurgeon with proficiency in the care of pediatric patients and an anesthesiologist, (meeting requirements contained in Chapter 3.3.1 of CCS Standards for Tertiary Hospitals and as defined in Section H.7.), with proficiency in the care of pediatric patients shall be on hospital staff, and available to be on site in the PICU in less than 30 minutes. The proficiency must document that the neurosurgeon(s) and anesthesiologist(s) have experience in the care and management of the infant, child and adolescent patient. These subspecialists must also meet hospital medical staff credentialing for granting privileges for the care of pediatric patients in their subspecialty.

b. The following CCS-approved pediatric subspecialists shall be on hospital staff and available on-site for consultation to the PICU in less than one hour: cardiologist, and otolaryngologist. In addition, a radiologist (meeting pediatric education and training requirements contained in Chapter 3.3.1 of the CCS Standards for Tertiary Hospitals and as described in Section H.8., shall be available for consultation on-site to the PICU in less than one hour. A CCS-approved pediatric gastroenterologist, hematologist/oncologist, infectious disease specialist, and neurologist must be available in less than one hour, either on-site, by telephone or live interactive telehealth and have the capability to provide
consultation related to the stabilization and transfer of an infant, child and adolescent to a CCS–approved PICU at a CCS-approved Tertiary Hospital.

c. The following CCS-approved surgical specialists with expertise in pediatrics shall be on staff and available in less than one hour, for on-site, telephone and/or telehealth consultation to the PICU: ophthalmologist, orthopedic surgeon, and urologist.

d. The following CCS-approved pediatric subspecialists shall be available on a 24-hour basis for on-site and/or live interactive telehealth consultation to the PICU: neonatologist, pulmonologist, endocrinologist, nephrologist, and allergist/immunologist.

e. The following CCS-approved specialists with expertise in pediatrics shall be available on a 24-hour basis for on-site and/or live interactive telehealth consultation to the PICU: plastic surgeon and/or maxillofacial surgeon, cardiovascular surgeon, physiatrist, obstetrician/gynecologist and psychiatrist and/or CCS-approved psychologist.

2. Community 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 Community 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 education, training and job requirements described below.

2.1 Community PICU Nurse Manager

a. The nurse manager, for the Community PICU shall direct the nursing administrative operation of the PICU, as per Section 3.32.1/E.3., have 24- hour responsibility for the unit and its operation and shall:

1) Be a registered nurse (R.N.) holding a bachelor’s of science degree in nursing (BSN); and

2) Have at least three years of clinical nursing experience in pediatrics of which at least one year shall be in pediatric critical care nursing; and

3) Have national certification from a nationally recognized accrediting organization in either nursing or health care administration.

b. The responsibilities of the Community PICU nurse manager shall include, at a minimum, personnel, fiscal and materiel management, and coordination of the quality improvement program for the Community PICU.

c. The Community PICU nurse manager shall directly supervise the nurse supervisor for the Community PICU.

d. The facility shall maintain written documentation of the qualifications and responsibilities of the Community PICU nurse manager.
The Community PICU nurse manager shall have direct responsibility to report to the hospital administrative director of nursing or Division Head of Maternal/Child or Pediatric Care.

2.2 Community PICU Nurse Supervisor

a. The Community 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 Community 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;

3) Have completed a program in the clinical management of critically ill infants, children and adolescents; and be certified by a national certification organization as a critical care registered nurse (CCRN) in pediatric critical care or critical care nurse specialist (CCNS); and

4) Have evidence of current successful completion of the American Heart Association (AHA) approved Pediatric Advanced Life Support (PALS) or equivalent course as determined by another national organization such as the AHA and the Society of Critical Care Medicine (SCCM).

c. The Community PICU nurse supervisor shall have 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 Community PICU nurse supervisor.

e. The Community PICU nurse supervisor shall not be assigned direct patient care responsibilities.

2.3 Community PICU Clinical Nurse Specialist

a. There shall be a clinical nurse specialist (CNS), on staff who is at least 0.5 FTE, dedicated and available to the Community PICU. If the Community PICU does not have a CNS, the roles and responsibilities of the CNS may be met by a Pediatric Nurse Practitioner (PNP) who meets the qualifications in Section 3.32.1/F.2.4.

b. The Community PICU CNS shall:

1) be a R.N. licensed by the State of California and have a master's degree in a field related to nursing and have 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;

4) Have completed a program in the clinical management of critically ill infants, children and adolescents; and be certified by a national certification organization as a CCRN and/or CCNS; and

5) have evidence of current successful completion of the AHA approved PALS or equivalent course.

c. The CNS shall be responsible for:

1) Directing the clinical nursing practice in the Community PICU;

2) Collaborating with the nurse manager and nurse supervisor for the coordination and assessment of critical care educational development and clinical competency of the nursing staff in the Community 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) Collaborating with PICU management for the presence of comprehensive parent and or primary caretaker education activities; and

5) Collaborating with PICU management to ensure 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 available to the Community PICU.

2.4. Community PICU, Pediatric Nurse Practitioner (if a 0.5 FTE CNS is not on staff, dedicated and available to the Community PICU, a Pediatric Nurse Practitioner may fill the roles and requirements of the 0.5 FTE CNS). If a PNP fills the role of the CNS, she/he must have at least 0.5 FTE dedicated hours assigned to the CNS role separate from work assignments as a PICU PNP or PICU RN.

a. Pediatric Nurse Practitioners (PNPs) who provide care for infants, children and adolescents in the PICU may fill the roles and responsibilities of the CNS. The PNP functioning in the role of the CNS shall:

1) be a R.N. licensed by the State of California, holding a master’s degree in nursing; and

2) hold California licensure as a PNP and hold national certification as a PNP through the Pediatric Nursing Certification Board (PNCB) and the American Nurses Credentialing Center (ANCC); and
3) have completed a program in the clinical management of critically ill infants, children and adolescents; and be certified by a national certification organization as a CCRN; and

4) have evidence of current successful completion of the AHA approved PALS or equivalent course as determined by a national organization such as the AHA and the SCCM.

b. The facility shall maintain written documentation of the qualifications and responsibilities of the PNP available to the Community PICU

2.5 Community PICU Charge Nurse

a. There shall be at least one dedicated charge nurse for each shift in the Community 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 as determined by a national organization such as the AHA and the SCCM.

b. The responsibilities of the charge nurse during each shift shall include the following:

1) coordinating the patient care activities in the Community PICU; and

2) ensuring the delivery of quality patient care.

c. The facility shall maintain written documentation of the qualifications and responsibilities of the Community PICU charge nurse.

2.6 Community PICU Registered Nurses

a. R.N.s who are assigned direct patient care responsibilities in the Community 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 as determined by a national organization such as the AHA and the SCCM.
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 1474.

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 critical care nursing in the Community PICU.

2.7 Community PICU Licensed Vocational Nurses

a. Licensed vocational nurses (LVNs) who provide nursing care in the Community 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 have evidence of current successful completion of the AHA approved PALS or equivalent course as determined by a national organization such as the AHA and the SCCM; 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 Community 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.

2.8 Community PICU Unlicensed Assistive Personnel

a. Unlicensed Assistive Personnel (UAP), as defined by the State Business and Professions (B & P) Code, Chapter 6, Article 2, Section 2725.3, shall function in accordance with written policies and procedures which delineate the non-nursing task(s) the UAP is allowed to perform in the Community PICU under the direction of a R.N. These non-nursing tasks shall require no scientific knowledge and/or technical skill.

b. The UAP may be utilized only as assistive to licensed nursing personnel under the direction of a R.N.

c. The UAP shall not be assigned tasks and nursing functions in lieu of a R.N. and shall only be assigned non-nursing tasks as defined in Section 3.32.1/H. and in accordance with B & P Code, Chapter 6, Article 2, Section 2725.3.

3. Community 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, or

3) Have certification in pediatric respiratory care from a recognized national organization, (i.e. the Neonatal/Pediatric Respiratory Care Specialty Examination of the National Board for Respiratory Care).

b. The facility shall maintain a written job description delineating the qualifications and duties of the RCP with expertise in pediatric respiratory care in the Community 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 at all times to the Community PICU.

e. A RCP shall be assigned primary coverage to the Community PICU when supportive ventilation is being provided and the staffing level written in RCP policy shall be such that immediate availability of the RCP to the Community PICU is assured at all times.

f. There shall be a system in place for ensuring annual 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.

g. The Respiratory Therapy Services shall have a collaborative agreement with the Medical Director in the PICU regarding policies and procedures for respiratory care in PICU, and all such policies and procedures must be approved by the PICU Medical Director.

h. All RCPs providing services in the Community PICU shall have evidence of current successful completion of the AHA approved PALS or equivalent course.

4. Community PICU Medical Social Worker Staff

a. Social work services shall be provided in the Community PICU by a CCS-paneled medical social worker (MSW) holding a master’s degree in social work and who has expertise in psychosocial issues affecting the families of seriously ill infants, children, and adolescents.
b. The caseload per one full-time equivalent MSW shall not exceed twenty patients.

c. The MSW shall conform to requirements contained in Section 3.32.1/H.10.

5. Community PICU Pharmaceutical Services Staff

a. There shall be at least one licensed pharmacist, on staff, holding a doctoral degree in pharmacy (Pharm D) with documentation of pediatric expertise available for consultation, education, and interfacing with pediatric intensivists and other team members on PICU rounds and in team conferences in the Community PICU.

b. The facility shall maintain a written job description delineating the qualifications and duties of the pharmacist with pediatric expertise in the Community PICU.

c. Pharmacy staff and pharmaceutical services shall be available on-site on a 24-hour basis to the Community PICU. There shall be a pharmacist available at all times for consultation.

d. Pharmaceutical staff shall provide pediatric and neonatal unit doses in clearly marked containers, intravenous and parenteral nutrition solutions, nutritional products, and continuous drug surveillance.

e. The pharmacy shall be staffed with adequate personnel to ensure that medications are dispensed efficiently on a routine basis and are available immediately for use in emergencies.

6. Community PICU Clinical Registered Dietitian Staff

a. Nutrition consultation in the Community PICU shall be provided by a CCS-paneled clinical registered dietitian who has clinical experience in pediatric and neonatal nutritional services.

b. The clinical registered dietitian shall meet the following requirements.

1) There shall be a CCS-approved clinical registered dietitian who is registered by the Commission on Dietetic Registration, American Dietetic Association, on staff and available for consultation to the PICU.

2) The clinical registered dietitian shall provide consultation on medical nutrition therapy issues to medical professionals providing care in the PICU and to the patients and their families.

3) The facility shall maintain a written job description delineating the duties of the clinical registered dietitian who works within the PICU and provides nutrition therapy, but not be limited to:

a) Nutritional assessment, diet calculation and the provision of medical nutrition therapy.

b) Coordination of nutritional services with community agencies.
7. Community PICU Occupational Therapy Staff

There shall be a CCS-approved occupational therapist available to the Community PICU who meets the following requirements.

a. Inpatient occupational therapy services provided to CCS-eligible infants, children, and adolescents shall be performed by a registered Occupational Therapists (OT) who are licensed to practice occupational therapy in the State of California, as per the California Business and Professions (B & P) Code, Chapter 5.6 Occupational Therapy Practice Act, Section 2570-2571, et seq. and are certified by the National Board for Certification in Occupational Therapy and have a minimum of one year of pediatric experience.

b. The facility shall maintain a written job description delineating the duties of the OT staff responsible for the provision of inpatient occupational therapy for infants, children, and adolescents. The duties shall include, but not be limited to the following:

1) Participation in case conferences and discharge planning activities, and

2) Coordination with a CCS case manager for referral to a CCS-paneled provider or CCS Medical Therapy Unit (MTU) for the patient who may continue to require occupational therapy services after hospital discharge.

c. There shall be at least one OT who is CCS-paneled on hospital staff. Occupational therapy services provided to CCS-eligible clients by nonpaneled therapists shall be under the supervision of a CCS-paneled OT.

d. Services provided by a Certified Occupational Therapy Assistant shall be supervised by a CCS-approved OT, as per the California B & P Code, Section 2570 et seq.

8. Community PICU Physical Therapy Staff

There shall be a CCS-approved physical therapist available to the Community PICU who meets the following requirements.

a. Inpatient physical therapy services provided to infants, children, and adolescents shall be performed by a registered Physical Therapists (PT) who are licensed to practice Physical Therapy in the State of California, as per the California B & P Code, Chapter 5.7, Physical Therapy Practice Act, Article 3, Section 2630 et seq. and have a minimum of one year of pediatric experience.

b. The facility shall maintain a written job description delineating the duties of the PT staff responsible for the provision of inpatient physical therapy for infants, children, and adolescents. The duties shall include, but not be limited to, the following:
1) Participation in case conferences and discharge planning, and
2) Coordination with a CCS case manager for referral to a CCS-paneled provider or CCS MTU for the patient who may continue to require physical therapy services after hospital discharge.

c. There shall be at least one PT who is CCS-paneled on the hospital staff. Physical therapy services provided to CCS-eligible clients by non-approved therapists shall be under the supervision of a CCS-approved PT.

d. Services provided by a physical therapist assistant shall be supervised by a CCS-paneled PT, as per the California B & P Code, Chapter 5.7, Physical Therapy Practice Act, Article 4.5. Section 2655 et seq.

9. Community PICU Child Life Specialist

There shall be a child life specialist (CLS) available to the Community PICU who meets the following requirements.

a. There shall be at least one CLS available to the PICU to provide therapeutic activities, including participation in the preparation of children and their families for hospitalization, surgery, and medical treatment; liaison with local educational programs; organization in play activity programs; and the provision of developmentally appropriate toys for children restricted to bed.

b. The facility shall maintain a written job description delineating the duties of the CLS which shall include, but not be limited to, activities described above.

c. The CLS shall participate in case conferences and discharge planning activities when appropriate.

10. Community PICU Unit Clerk

There shall be at least one unit clerk present in the Community PICU, at a minimum, during the day shift, seven days a week, with a written job description delineating the administrative duties pertaining to patient care and traffic control.

G. Community PICU – Facilities and Equipment

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

a. There shall be at least six 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 250 admissions to the Community PICU per year of infants, children and adolescents who require critical care with a multidisciplinary approach. At least 100 of the 250 admissions shall require invasive mechanical ventilation and/or BIPAP, vasoactive/inotropic support and/or invasive arterial pressure or intracranial pressure monitoring.

c. Patients requiring more advanced techniques such as high frequency oscillatory ventilation, renal replacement therapy, (including but not limited to acute
peritoneal dialysis or new peritoneal dialysis, continuous renal replacement therapy (CRRT), inhaled nitric oxide, extracorporeal membrane oxygenation (ECMO), congenital heart surgery etc., shall be transferred to a CCS-approved Regional PICU located at a CCS-approved Tertiary Hospital as per 3.3.1/H.1.

2. Bed space within the Community 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.

3. The Community PICU shall have the following space/rooms available within, adjacent to, or in close proximity to the Community 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.

4. There shall be one isolation room capable of negative and positive pressure in the Community PICU for every six to twelve intensive care beds.

5. The Community 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 Community PICU bed:
      1) Twelve electrical outlets (There shall be a common ground. Adapters, extension cords and junction boxes shall not be used.);
      2) Two oxygen outlets;
      3) Two compressed air outlets; and
      4) Two suction outlets.
   b. There shall be equipment available in the Community 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) Emergency pediatric airway cart;

3) A written guide for emergency drug dosage and equipment appropriate for a patient’s age, weight, length and/or height;

4) Patient defibrillator/cardioverter capable of delivering energy at low doses and synchronized cardioversion;

5) Electrocardiogram (ECG) machine;

6) Automated/noninvasive blood pressure apparatus;

7) Laryngoscopes (with monitor visualization capability), oral and nasal airways, laryngeal mask airways and endotracheal tubes (cuffed and uncuffed);

8) Oral and nasal airways;

9) Vascular access equipment including central catheters;

10) Emergency tracheostomy and thoracotomy trays;

11) Equipment for the placement of chest and pericardial tubes;

12) Intracranial pressure monitoring trays;

13) Otoscopes and ophthalmoscopes;

14) Patient scale/device for accurate measuring of body weight, length and/or height;

15) Bag-valve-mask resuscitation devices; and

16) Chest physiotherapy and suctioning equipment.

c. Equipment available to the Community PICU shall include, but not be limited to, the following:

1) Surgical cut-down trays;

2) Procedure lamp;

3) Ultrasonography device appropriate for vascular access use;

4) Infusion pumps (with microfusion capability/transport capability);

5) Suction device/machine for transport and backup (in addition to bedside);
6) Expanded scale electronic thermometer with range sufficient to identify extremes of hyperthermia and hypothermia;

7) Cribs and beds (with head access);

8) Infant warmers, incubators;

9) Heating and cooling blankets;

10) Phototherapy lights;

11) Transport equipment with provision for temperature control, ventilation and cardiopulmonary monitoring (Transport equipment shall also be available for in-house transport of infants);

12) Electroencephalogram (EEG) machine;

13) Isolation cart;

14) Blood warming apparatus; and

15) Electric breast pump.

d. Respiratory equipment available to the Community 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 Community PICU for all pediatric-sized patients with the capability to continuously monitor, and have print, interrogation and storage capacity for a minimum 24 hour period for the following:

1) Heart rate with dysrhythmia monitoring capability;

2) Respiration;

3) Temperature;
4) Systemic arterial, central venous, and intracranial pressure;
5) Oxygen saturation; and
6) End-tidal carbon dioxide.

f. 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 three invasive pressures: systematic arterial, central venous, and intracranial pressures);
2) Three simultaneous invasive pressure measurements (systemic arterial, central venous, 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.

6. 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 Community PICU.

7. 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 3.3.2/G.12. of the CCS Standards for Pediatric Community Hospital.

8. 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 electrolyte, blood glucose, hematocrit, pH and blood gas determinations.

9. There shall be an operating room available within 30 minutes, 24-hours a day that meets the requirements contained in Chapter 3.3.2 of the CCS Standards for Pediatric Community Hospitals.

10. 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 equipment and supplies appropriate for infants, children, and adolescents.

H. Community PICU - Patient Care

1. The care of CCS-eligible clients in the Community PICU shall be under direct supervision of the Community PICU medical director or CCS-approved associate pediatric intensivist designee.

2. A CCS-approved pediatric intensivist shall review, evaluate, and document the clinical management of each patient, on site, on a daily basis.
3. There shall be a policy to ensure that information is provided, on an on-going basis, to referring physicians regarding their patients.

4. There shall be a CCS-approved 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 Community 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 all new admissions and significant adverse changes in the status of patients in less than 30 minutes, as described in section 3.32.1/H. 6.

5. There shall be 24 hour in-house coverage provided by a physician(s) who is skilled in the management of emergencies in the Community PICU, skilled in pediatric airway management, including endotracheal intubation. This requirement shall be met by a physician(s) who is either:
   a. A CCS-approved pediatric intensivist; or
   b. An anesthesiologist with expertise in pediatric critical care; or
   c. A CCS-approved 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, or a physician Board Certified in anesthesiology or emergency medicine, capable of managing a pediatric airway and who has successfully completed the AHA approved PALS or equivalent course as determined by a national organization such as the AHA and the SCCM 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 Community PICU in less than 30 minutes, with documentation in the chart.

7. All anesthesia for children from birth to two years of age shall be administered by board-certified anesthesiologists who have completed at least six months training in pediatric/neonatal anesthesia at a hospital with an anesthesia training program approved by the American Board of Anesthesiology or who meet two or more of the following criteria:
   a. One year of experience in providing anesthesia to infants with documentation of at least ten major cases proctored by an anesthesiologist who meets the qualifications described above and/or
   b. Documented proficiency in anesthesia provided to infants, 25 cases within the last three years which have been reviewed by an anesthesiologist who meeting the qualifications described above, and/or
   c. Documentation of at least one year of training in pediatrics.
8. Pediatric diagnostic imaging studies shall be interpreted, performed and read by at least one board-certified radiologist who has completed at least six months training in pediatric diagnostic radiology at a hospital approved for training by the American Board of Radiology and who has devoted at least 50 percent of his/her time to pediatric diagnostic radiology.

9. Nurse staffing in the Community PICU shall include the following:
   a. There shall be a nurse manager assigned to the Community PICU who has 24-hour responsibility for the management of patient care.
   b. There shall be a nurse supervisor assigned to the Community PICU who has responsibility for the supervision of patient care personnel
      1) The nurse supervisor or designee shall be present in the Community PICU at all times.
      2) There shall be at least one nurse supervisor assigned to the Community PICU for every 30.0 FTE Community PICU positions.
   c. If the nurse manager is dedicated solely to the Community PICU and does not oversee more than 30.0 FTE positions, the position and responsibilities of the nurse manager and the nurse supervisor may be combined under the nurse manager. The nurse manager, nurse supervisor and CNS/PNP cannot be combined into one FTE position.
   d. There shall be a designated charge nurse for each shift.
   e. There shall be a R.N. assigned to each patient in the Community PICU, (nurse to patient ratio of 1:2 or fewer at all times), as per CCR, Title 22, Section 70217.
   f. A comprehensive nursing assessment shall be completed within 8 hours of admission.
   g. There shall be no less than two R.N.s physically present in the Community PICU at all times when a patient is present.
   h. There shall be no more than one LVN for every three R.N.s assigned to provide direct nursing care in the Community PICU.
   i. LVNs may provide nursing care for patients in the Community PICU under the direction of the assigned R.N.

10. Unlicensed assistive personnel in the Community PICU may only be assigned non-nursing tasks which require no scientific knowledge and/or technical skill.

11. RCP staffing shall be based on the level of patient care required, as determined by the Community PICU medical director, and shall consider the acuity of, and numbers of, patients in the Community PICU. There shall be an identified RCP with expertise in pediatric respiratory care practice immediately available at all times to the PICU. A RCP shall be in the unit or immediately available at all times if a patient requires ventilator support.
12. There shall be a MSW assigned to all patients upon admission to the Community PICU; and:

a. A social work assessment shall be completed within two working days of admission or prior to discharge, whichever comes first.

b. 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.

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 Community 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 and at discharge, or more often as indicated, and shall include psychosocial data, significant changes in the patient’s family, updates and results of the implementation of 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 Community PICU team members.

g. The authorizing CCS Program shall have access to social work reports in order to coordinate services.

13. The Community PICU shall have available physician, nursing, and MSW consultation on a 24-hour basis from the CCS-approved Regional PICU with which the Community PICU has a Regional Cooperation Agreement.

14. There shall be, at a minimum, weekly multidisciplinary team conferences.

a. The Community PICU multidisciplinary team conference shall include representation from the Community PICU’s pediatric intensivist physician staff, nursing, medical social service, RCP staff, the clinical registered dietitian and other specialists, i.e., 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 and held for at least one year to be available for review by CCS Program staff.

15. The Community PICU medical director shall be responsible for an established mechanism of transport.
a. The Community PICU medical director or designee shall be responsible for:

1) Selecting the method of transport to be used;

2) The medical care of the infant, child, or adolescent during transport;

3) Designating team members for the transport of unstable or potentially unstable patients.

b. The written transport agreement for the provision of transport services of patients by another PICU or agency shall be subject to CCS Program approval. The pediatric transport agreement shall be updated and signed annually by the medical directors of the PICUs involved in the agreement.

c. The Community PICU medical director or designee shall be responsible for a written transport plan or policy. Maintenance of written records of each pediatric transport completed shall be available for review by CCS Program staff.

d. The Community PICU shall agree to accept, on a space and staff available basis, any infant, child, or adolescent requiring a level of care beyond that which can be provided by a hospital with which the PICU has transport agreements.

I. Community PICU – Policies and Procedures

1. There shall be a Community PICU Policies and Procedure Manual which shall be:

   a. Updated, reviewed and approved at least every year, or more frequently as necessary, by the medical director and nurse manager of the Community PICU; and

   b. Readily available in the Community PICU for Community PICU staff.

2. The written Policies and Procedures Manual for the Community PICU shall address/include, but not be limited to, the following:

   a. Criteria delineating the clinical privileges granted to attending CCS-approved pediatric intensivists, i.e., procedural sedation;

   b. Criteria delineating the clinical privileges granted to attending CCS-approved physicians other than the pediatric intensivists, i.e., procedural sedation;

   c. Criteria for admission of infants, children, and adolescents to the Community PICU;

   d. Criteria for discharge of infants, children, and adolescents from the Community PICU;

   e. Criteria for transfer of infants, children, and adolescents, in-house, to the Community PICU, and from the Community PICU to other facilities (see 2.o. below);
f. Patient care including nursing assessment, print out code sheets at each bedside, care and management of infants, children, and adolescents admitted to the Community PICU;

g. Respiratory care management for infants, children, and adolescents admitted to the Community PICU;

h. Criteria for monitoring of patients in the Community PICU including the use of appropriate equipment;

i. Administration of medication, blood, and blood products in the Community PICU;

j. Medication safety including high alert medications;

k. Mechanism for bioethical review, when indicated, of patients admitted to the Community PICU, including how parents/caretakers/patients are notified of their rights to request this;

l. Mechanism for infection surveillance, prevention and control in the Community PICU;

m. Parent visitation in the Community PICU;

n. Patient and parent/caretaker’s rights and responsibilities;

o. Transport of patients (in-house, to the Community PICU from other facilities and from the Community PICU to other facilities) and describe, at a minimum, the following:

1) Staff assigned to the transport team and the patient monitoring equipment to be used; and

2) Assurance of a review by the Community PICU medical director of the transports performed, at least on a monthly basis.

3) The qualifications and training required initially for each discipline to become a member of the transport team, and include defined annual competencies/requirements to maintain assignment to the transport team.

p. Discharge planning process which includes the roles of the designated coordinator for discharge planning and the Community PICU multidisciplinary team members (pediatric intensivist, MSW, R.N., and clinical registered dietitian at a minimum) with the parent or caretaker and the referring physician, primary care physician and any specialized follow-up agency;

q. Routine testing and maintenance of equipment in the Community PICU;

r. Responsibilities and functions for social work services in the Community PICU;

s. Responsibilities and functions for dietitian services in the Community PICU;

t. Mechanism for referral to the hospital’s suspected child abuse and neglect team on a 24-hour basis;
u. Mechanism to inform a family regarding potential organ/tissue donation;

v. Use of life support and the techniques for resuscitation in the Community PICU, including documentation of the performance of mock codes;

w. Determination of brain death; and do not resuscitate policy in the PICU;

x. Pain assessment and management and procedural sedation for operative/medical procedures and for trauma;

y. Consent for treatment and procedures;

z. Admission and shift R.N. assessment process for the PICU; and

aa. Provision of family-centered and culturally competent care.

bb. Telehealth, if used, policies and procedures shall be in accordance with regulatory issues and requirements of CMS and the Joint Commission.

3. The Community PICU shall maintain written agreements; (i.e. RCA and transport 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, including transport data, and modifications of agreements to reflect evaluation of outcome.

J. Community PICU – Discharge Planning Program

Discharge of patients from the Community PICU shall be the responsibility of the CCS-approved 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 Community PICU multidisciplinary team members and communication with the primary care physician, CCS-approved providers, community agencies, county CCS Programs, CCS Special Care Centers, Medical Therapy Units (MTUs), Medi-Cal In-Home Operations Branch, 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 Community 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., CCS Special Care Centers, CCS-approved providers, rehabilitation services.

2. Identification of the responsibilities and involvement of the Community PICU multidisciplinary team members (CCS-approved pediatric intensivist, R.N., MSW, and clinical registered dietitian, at a minimum) 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. Community PICU – Quality Assurance and Quality Improvement

1. There shall be an ongoing quality assurance program specific to patient care activities in the Community PICU that is coordinated with the hospital’s overall quality assurance and quality assessment activities provided.

   a. Documentation shall be maintained of the quality assurance and quality assessment activities.

   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 multidisciplinary morbidity and mortality review process held at least once a month to discuss pediatric critical care issues.

3. There shall be a quarterly meeting to address issues identified in the monthly morbidity and mortality review process to address quality improvement indicators in the PICU.

   a. Meeting agendas, lists of attendees, and minutes of such meetings/conferences shall be maintained and available for on-site review by CCS Program staff.

   b. The morbidity and mortality review process and indicators that define the cases or incidents to be discussed should be described in a written policy.

4. There shall be a written policy that facilitates a family-centered and culturally-competent approach to Community 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 related to the care and interventions provided to 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 Community PICU multidisciplinary team members regarding their child’s care and experiences in the Community PICU. This may be in the form of a patient/family satisfaction questionnaire to provide a mechanism to appraise the services in the Community PICU.

   c. Provision of translation services as indicated.

5. There shall be a policy that defines the 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.

6. A transport program shall have an ongoing continuous quality improvement process and policy that defines the evaluation of the process by the Community PICU medical director and is a part of the RCA.

7. The Community PICU shall maintain a database and/or vital statistics which shall include, but not be limited to:

   a. The number of Community PICU beds;

   b. The number of children admitted to the Community PICU, with a breakdown by disease categories, length of stay, and age;

   c. The number and origin of patient transports to and from the Community PICU, the mode of transport; and

   d. An annual report from California Data Set/Virtual PICU Performance System (VPS) providing numbers of patients, diagnostic data, demographic data, mortality and length of stay admitted to the Community PICU, using risk adjustment mortality with the Pediatric Risk Mortality (PRISM) III scores or VPS, shall be maintained by the PICU, or other CCS-approved reporting systems shall be maintained.

8. The Community PICU medical director shall submit the annual Community PICU report from the California Data Set/VPS reflecting severity adjusted mortality and length of stay described above to the Department of Health Care Services; Chief Medical Officer, Systems of Care Division, Children's Medical Services (CMS); 1515 K Street, Room 400, Sacramento, CA 95814-4040, by July 1 of each year for the patient database of the preceding calendar year.

9. Assurance of orientation and continuing education for staff providing services in the Community PICU shall include in policy, at a minimum, the following:

   a. There shall be policy describing the process for orientation of all newly-hired professionals who will be providing care in the Community PICU. The policy shall include the competencies required of the professional staff providing clinical services in the PICU and documentation of successful demonstration of these competencies.

   b. There shall be policy that defines the process for the continuing education of all professional staff providing care in the pediatric critical care unit.

10. At a minimum, the latest editions of the following texts and documents and/or capability for access by PICU staff to the most current on-line and/or hard copy texts, documents or their equivalent, which are less than five years old, shall be kept in the Community PICU:

   a. Red Book: Report of the Committee on Infectious Disease, Committee on Infectious Diseases, American Academy of Pediatrics}
b. Pediatric Advance Life Support, American Heart Association;

c. Nursing of the critically ill pediatric patient (i.e., Standards for Nursing Care of the Critically Ill, American Association of Critical Care Nurses [ACCN])

d. At least one current reference book pertaining to pediatric critical care (i.e., PEMSoft online, a software system for critical pediatric care);

e. At least one current reference book pertaining to pediatric critical care nursing;

f. At least one current reference book pertaining to pediatric pharmacology and therapeutics;

g. CCS Manual of Procedures, Chapter 3.32.1, CCS Standards for Community Pediatric Intensive Care Units; (http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx)

h. CCS Manual of Procedures, Chapter 3.3, CCS Standards for Hospitals; (http://www.dhcs.ca.gov/services/ccs/Documents/ccsni271298.pdf)

i. Current listing of CCS medically-eligible conditions; and (http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx)