National PRP

Pediatric Readiness Project

Ensuring Emergency Care for All Children

2026 OFFICIAL NATIONAL PEDIATRIC READINESS ASSESSMENT GAP REPORT IMPORTANT STATEMENTS

A companion guide to the NPRP Assessment Gap Report

Contact

PedsReady Support Team at PedsReady@hsc.utah.edu

The National Pediatric Readiness Project (NPRP) Assessment and Gap Report Important Statements are based on the 2026 Joint Policy Statement: Pediatric Readiness in the Emergency Department and were developed in collaboration with professional societies representing emergency physicians, emergency nurses, pediatricians, and trauma surgeons. This information is intended to be used to evaluate overall Pediatric Readiness in emergency departments. Users agree they will not adapt, alter, amend, abridge, modify, condense, make derivative works, or translate the assessment or Gap Report Importance Statements.

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2026 NPRP ASSESSMENT GAP REPORT IMPORTANCE STATEMENTS

This document provides context for the Pediatric Readiness domains included in the 2026 NPRP Assessment, as outlined in the 2026 Joint Policy Statement: Pediatric Readiness in the Emergency Department (ED).

When a Pediatric Readiness item is not met, an accompanying Importance Statement appears in the gap report to explain the item's relevance and highlight opportunities for quality improvement (QI). Items that are met do not generate an Importance Statement. This compilation includes all Importance Statements from the 2026 NPRP Assessment and is intended to support general QI efforts.

For additional resources, visit PedsReady.org to access the ED Checklist and ED Toolkit.

Each domain heading in the tables below is followed by its related items and a brief explanation of their importance to Pediatric Readiness:

Guidelines for Administration and Coordination of the ED for the Care of Children	
Physician Coordinator	The physician coordinator provides administrative oversight for pediatric emergency care. This person plays an important role to ensure ED staff have ongoing education and skills in pediatric emergency care, that policies and procedures for the care of children are in place, and that there is a quality improvement program for pediatric patients. The physician coordinator works closely with the nurse coordinator to enhance the overall care of children in the ED. Additionally, the physician coordinator serves as the designated contact for both hospital and community-based entities regarding pediatric issues. Assigning both a physician and a nurse coordinator is the most important step in improving pediatric readiness.
Nurse Coordinator	The nurse coordinator oversees pediatric emergency care, working alongside the physician coordinator, to ensure staff receive ongoing education, pediatric care policies and procedures are in place, and a quality improvement program is established for pediatric patients. The coordinator also ensures the ED is stocked with appropriate equipment and medications for children and that pediatric considerations are included in staff orientation and evaluations. Additionally, the nurse coordinator collaborates with hospital committees that impact pediatric care. Assigning both a physician and a nurse coordinator is the most important step in improving pediatric readiness.

Physicians, Nurses, and Other Health Care Providers Who Staff the ED	
Physician pediatric competency evaluations	A physician credentialing policy establishes requirements that include maintaining board certification, continuing education, and/or hospital-specific competencies like sedation and analgesia. This ensures that physicians have and maintain the knowledge and skills to provide optimal clinical care for children.
Physician participation in continuing certification	Maintaining certification from the American Board of Medical Specialties helps ensure that medical providers stay up-to-date with current treatment guidelines, evidence-based protocols, and best practices necessary to provide optimal care for this patient population.
Nurse pediatric competency evaluations	Competency evaluations, such as for triage, sedation, and patient resuscitation, ensure that nursing staff have the knowledge and skills to provide optimal clinical care for children. These evaluations may be required by accrediting organizations such as the Joint Commission or local hospital credentialing.
Nurse maintenance of pediatric continuing education requirements	Obtaining and maintaining continuing education in pediatric emergency nursing equips nurses with essential knowledge to recognize and treat life-threatening pediatric conditions and ensures the maintenance of critical psychomotor skills using pediatric equipment.

Guidelines QI/PI in the ED	
Patient care review process (chart review)	Chart review is essential for identifying system-level gaps in pediatric patient care delivery, tracking and monitoring trends and variations, providing feedback, reviewing sentinel events, and identifying interventions to enhance the patient care process.
Identification of quality indicators for children	Quality indicators for children enable the review of processes needed to influence outcomes, such as adherence to clinical care guidelines and prompt reporting of vital sign abnormalities. These quality indicators can be collected, analyzed, and used to assist in quality improvement plans.
Collection and analysis of pediatric emergency care data	Data collection and analysis are crucial to any quality improvement (QI) plan. Outcome metrics should be selected based on identified areas for improvement, and a plan should be developed for collecting, analyzing, and reviewing relevant data. This data should then be shared with staff and administration to guide further changes.
Development of a plan for improvement in pediatric emergency care	Quality improvement for pediatric patients in the ED ensures that processes are in place to review clinical cases and that data is gathered to assess for deviation from best practices or errors in care. The outcomes of children can be evaluated and improved by using appropriate metrics. Integration with other QI committees ensures coordination of care throughout the medical continuum.
Re-evaluation of performance using outcomes-based measures	Your ED's QI/PI plan should address patient-centered and evidence-based outcomes to improve care. These outcomes must be re-evaluated over time to assess change/improvement. Examples of metrics important to clinical outcomes include receipt of antibiotics within an hour in a potentially septic patient, early administration of steroids in a child with an asthma exacerbation, and timely pain treatment.

Guidelines for Improving Pediatric Patient Safety in the ED	
Children seen in the ED weighed in kilograms (without conversion from pounds)	One of the most important safety initiatives for children, as determined by several national medical professional organizations, is weighing and recording weight in kg only. Measuring in kg ensures that dosing is based on accurate weight and is not subject to calculation error, which can lead to serious adverse events and medication errors.
Children's weights recorded in the ED medical record in kilograms only	One of the most important safety initiatives for children, as determined by several national medical professional organizations, is weighing and recording weight in kg only. Measuring in kg ensures that dosing is based on accurate weight and is not subject to calculation error, which can lead to serious adverse events and medication errors.

Temperature, heart rate, and respiratory rate recorded	Recording all vital signs is critical for assessing children and enables early recognition of disease processes such as septic shock.
Blood pressure monitoring obtained on children of all ages	Recording blood pressure enables the detection of serious diseases such as renal failure and septic shock. It helps to identify children at risk for long-term complications from essential hypertension. It is important for emergency departments to measure blood pressure on every child, regardless of age or patient condition.
Pulse oximetry monitoring obtained on children of all ages	Pulse oximetry monitoring has been called the sixth vital sign and is important to measure in every child, regardless of condition. Hypoxemia may be difficult to assess clinically in children without pulse oximetry measurement, and it can clue the health care team to potentially serious underlying conditions like congenital heart disease. ESI triage requires a full set of vital signs including pulse oximetry.
End tidal CO_2 monitoring available based on severity of illness and/or need for sedation	End-tidal CO2 monitoring is vital for assessing the adequacy of ventilation, especially in critically ill children undergoing sedation or requiring advanced airway management, such as noninvasive ventilation (BiPAP, CPAP) or mechanical ventilation. It should be available for children of all sizes and ages and be compatible with the department's respiratory equipment.
Process in place for notification (manual or automated) of physicians when abnormal vital signs are found	Prompt provider notification of abnormal vital signs in children has been shown to significantly reduce time to treatment in cases of septic shock or clinical decompensation. This is a critical quality improvement measure that can save lives.
Process in place for the use of pre-calculated drug dosing in all children	Using a length-based resuscitation tape or other method to pre-calculate drug doses in children reduces errors and helps prevent adverse medication events.
Process in place that allows for 24/7 access to interpreter services in the ED	An accurate history is essential to understanding a child's symptoms and to providing an accurate diagnosis and treatment. It also helps to ensure the family’s understanding of their child’s condition, treatment, and discharge instructions. For non-English-speaking families, access to qualified interpreters is critical to ensure accurate communication.
The level of consciousness (e.g. AVPU or GCS) assessed in all children	A pediatric-specific neurologic assessment is essential for accurately evaluating the mental status of critically ill or dynamic patients. It also provides a consistent way to communicate findings during transfers. This evaluation should be included in the assessment of both medical and trauma patients.
The level of pain assessed in all children	Pediatric pain is often under-recognized and undertreated, especially in non-verbal children. Using a validated pediatric pain scale is essential for early recognition, effective intervention, and evaluating treatment outcomes.

Guidelines for Policies, Procedures, and Protocols for the ED	
Triage policy that specifically addresses ill and injured children	Triage schemes, such as the Emergency Severity Index (ESI), that address the unique needs of children are vital for appropriately prioritizing pediatric patients for care and recognizing critically ill children.
Use of validated pediatric triage tool	Validated triage tools have demonstrated the ability to improve early recognition of critical illnesses, such as sepsis. Tools validated for pediatric patients are essential, as they account for age-appropriate vital signs and can better predict the need for interventions and resources.
Policy for pediatric patient assessment and reassessment	Regular assessment and reassessment are crucial, as disease and injury are dynamic. Since patients may require prolonged treatment or have long wait times in the ED, reassessment helps identify any progressive or life-threatening conditions as their status evolves.
Policy that includes immunization assessment and management of children	Immunizations have significantly altered the epidemiology of pediatric infectious diseases in the United States. Assessing immunization status is a key part of evaluating children, helping to identify those at increased risk for certain diseases or those needing clinically indicated vaccinations, such as tetanus or rabies, after an acute injury.
Policy for child maltreatment	Identifying child maltreatment during an ED visit can save lives. Failure to identify these cases increases the risk of further injury and death. Having a policy in place that outlines proper evaluation, documentation, reporting, and testing is crucial.
Policy for death of the child in the ED	A child's death profoundly affects families. Having a policy in place to address the needs of family members is essential for supporting families and guiding them through the beginning of the grieving and healing process.
Policy for reduced-dose radiation for CT and x-ray imaging based on pediatric age or weight	Adult imaging protocols expose children to excessive radiation. Weight- or age-based adjustments can ensure proper imaging while minimizing radiation and reducing cancer risk.
Universal suicide screening policy for children	Universal suicide screening helps identify at-risk individuals equitably across racial and ethnic groups and ensures timely referrals to treatment. The ED, often the first point of access for vulnerable youth, is a critical setting for identifying and managing those at risk for suicide.
Policy for management of acute agitation	Children can become agitated for various reasons, which can disrupt care, cause distress to families, and pose risks to patients and staff. Children with limited verbal ability or autism may also become agitated in the ED. Managing pediatric agitation differs from adult care and requires addressing age-specific causes and using treatments like de-escalation, sometimes without using physical or chemical restraints.

Policy for clinical pediatric protocols or clinical care algorithms	Rapid identification and evidence-based management of common pediatric conditions ensures adherence to best practices, promotes equitable care, and improves outcomes. Several open-access clinical algorithms for pediatric conditions are available online.
Involving families and caregivers in patient care decision-making	A shared decision-making model with caregivers helps achieve agreed-upon outcomes, ensures families feel their concerns are addressed, supports the transition of care back to them, and decreases medical errors. Families, especially those with children with special healthcare needs, often know what works best for their child better than a provider seeing them for the first time.
Involving families and caregivers in medication safety processes	Family-centered care is essential throughout the healthcare visit, not just during treatment decisions and resuscitations. Since children are at higher risk for medication errors than adults, involving families in the medication administration process helps ensure correct medication and dosage, reducing errors.
Family and guardian presence during all aspects of emergency care, including resuscitation	Caregivers are often the best source of a child's medical/surgical history, and their presence ensures that treatment aligns with family values. Family involvement also reduces anxiety for both patient and caregiver and is crucial for healing from loss when a resuscitation ends in the child's death.
Education of the patient, family, and caregivers on treatment plan and disposition	Involving patients and caregivers in medical decision-making promotes transparency, reduces medical errors, and provides opportunities for clarification and questions.
Bereavement counseling	The loss or critical illness of a child is deeply traumatic for families. Trained personnel should be designated to address trauma and loss with families and caregivers in a developmentally appropriate way and provide long-term support resources.
Disaster plan includes availability of medications, vaccines, equipment, supplies, and appropriately trained providers for children	Trained personnel who understand pediatric medication dosing and equipment needs are essential to ensure children receive the best care during a disaster. Critical supplies include medical equipment and items like cribs, diapers, and formula for pediatric patients and their families. Vaccines also play a key role in the post-disaster setting, addressing issues like contaminated wounds, disease outbreaks, and exposures to biologic agents.
Disaster plan addresses decontamination, isolation, and quarantine of families and children	The decontamination and isolation process can be stressful for children of any age. Efforts should be made to keep caregivers nearby and allow families to stay together to reduce the stress of separation. Additionally, special considerations, such as using warmer water to prevent hypothermia in young children, are crucial in planning.
Disaster plan includes minimization of parent-child separation and methods for	During a disaster, children are often separated or displaced from their families or caregivers. Keeping parents and children together as much as possible during the care process can help reduce emotional stress and decrease the number of unaccompanied minors. It is crucial to track

reuniting separated children with their families	all children entering the healthcare system to aid future reunification efforts. Tracking should include specific details, such as clothing worn, especially if photographs are unavailable.
All disaster drills include pediatric patients	Nearly 25% of disaster victims are children, making it essential for simulation exercises to include all age groups. These drills help ensure care sites are prepared to manage pediatric-specific needs. Hospitals should also have tested procedures in place for handling unaccompanied minors and family reunification.
Disaster plan includes pediatric surge capacity for both injured and non-injured children	In any large-scale incident, it is essential to assemble a larger team of healthcare providers and secure adequate space to treat and manage pediatric patients. Equally important is having the resources and staff to care for non-injured children by keeping them safe and occupied when their families are unavailable. This is a vital component of addressing the social dimensions of disaster response.
Disaster plan includes access to behavioral health resources for children	Children are disproportionately affected during disasters due to their reliance on adults, varied developmental stages, and limited understanding of the circumstances in a disaster situation. Behavioral health specialists are crucial in addressing both the immediate physical and emotional trauma, as well as potential family loss or morbidity. Early intervention can help mitigate long-term behavioral issues, including post-traumatic stress disorder (PTSD).
Disaster plan includes specifics for care of children with special health care needs	Children with complex healthcare needs may require specialized equipment, formula, medications, and experience caring for their complex conditions. While it can be challenging to plan for every situation, including during a disaster, a systematic approach is important when caring for these patients. This includes staff training, access to specialized equipment, and a focus on family-centered care. In developing such a policy, involving community pediatricians and other specialists can be valuable.
Written interfacility transfer guidelines	When emergency departments receive children who are too ill or have needs too complex for their hospital's capabilities, they must transfer them to tertiary pediatric centers for critical or specialized care. Clear written guidelines and procedures are essential to support timely and efficient transfers.

Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED

Having appropriate equipment of ALL sizes is key to managing critical illness and injury in neonates, infants, children, and adolescents. In addition, educating staff about the location of equipment and a daily process for ensuring that equipment functions optimally is key to preventing delays in care and possible morbidity for critically ill children of all ages.

- All staff trained on the location of all pediatric equipment and medications
- Daily method used to verify the proper location and function of pediatric equipment and supplies
- Portable pediatric resuscitation cart or bag available to facilitate rapid identification of age- or weight-based appropriately sized equipment
- Standardized chart or tool to estimate weight if resuscitation prevents the use of a weight scale (e.g., length-based tape)
- Neonatal blood pressure cuff
- Infant blood pressure cuff
- Child blood pressure cuff
- Defibrillator with pediatric and adult capabilities including pads and/or paddles
- Pulse oximeter with pediatric and adult probes
- Continuous end-tidal CO2 monitoring device
- 22 gauge catheter over the needle
- 24 gauge catheter over the needle
- Pediatric intraosseous needles
- IV administration sets with calibrated chambers or an infusion pump
- Endotracheal tubes: uncuffed 2.5 mm
- Endotracheal tubes: uncuffed 3.0 mm
- Endotracheal tubes: cuffed and uncuffed 3.5 mm
- Endotracheal tubes: cuffed 4.0 mm
- Endotracheal tubes: cuffed 4.5 mm
- Endotracheal tubes: cuffed 5.0 mm
- Endotracheal tubes: cuffed 5.5 mm
- Endotracheal tubes: cuffed 6.0 mm
- Stylets for pediatric/infant-sized endotracheal tubes
- Laryngoscope blades: straight, size 0
- Laryngoscope blades: straight, size 1
- Laryngoscope blades: straight, size 2
- Laryngoscope blades: curved, size 2
- Video laryngoscopy
- Supraglottic airways: size 1
- Supraglottic airways: size 1.5
- Supraglottic airways: size 2
- Supraglottic airways: size 2.5
- Nasopharyngeal airways: infant-size
- Nasopharyngeal airways: child-size
- Oropharyngeal airways: size 0 (50mm)
- Oropharyngeal airways: size 1 (60mm)
- Oropharyngeal airways: size 2 (70mm)
- Oropharyngeal airways: size 3 (80mm)

- Pediatric-sized Magill forceps
- Bag-mask device, self-inflating (infant/child)
- Masks (pre-term size) to fit bag-mask device
- Masks (neonatal size) to fit bag-mask device
- Masks (infant size) to fit bag-mask device
- Masks (child size) to fit bag-mask device
- Simple oxygen face masks: infant
- Simple oxygen face masks: child
- Non-rebreather masks: infant-sized
- Non-rebreather masks: child-size
- Nasal cannulas: infant
- Nasal cannulas: child
- Suction catheters: at least one in range 6-8F
- Suction catheters: at least one in range 10-12F