AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Pediatric Emergency Medicine

Pediatric Care Recommendations for Freestanding Urgent Care Facilities

ABSTRACT. Freestanding urgent care centers are not emergency departments or medical homes, yet they are sometimes used as a source of pediatric care. The purpose of this policy statement is to provide updated and expanded recommendations for ensuring appropriate stabilization in pediatric emergency situations and timely and appropriate transfer to a hospital for definitive care when necessary. ***Pediatrics*** **2005;116:258–260;** ***urgent care, equipment standards, emergency preparedness, pediatric preparedness.***

Freestanding urgent care facilities remain a fixture in the provision of health services for children in some communities. Although the American Academy of Pediatrics does not encourage the routine use of urgent care facilities because it may undermine the provision of coordinated, comprehensive, family-centered care consistent with the medical home concept,[1] the use of these facilities as part of urgent and emergent care systems is not uncommon. The term "urgent care" may imply to the public that a facility is capable of managing critical or life-threatening emergencies. This was the case for the youngest victim of the sniper in the Washington, DC, area on October 7, 2002. After being shot in the abdomen, despite the advice of the 911 operator to stay and wait for help, this 13-year-old child was driven to a local freestanding urgent care center.[2] He survived because this freestanding urgent care center was properly equipped and staffed to handle this child's initial stabilization and transfer to a level I pediatric trauma center.

Freestanding urgent care centers are not emergency departments. However, they must have the capability to identify patients with emergency conditions, stabilize them, and coordinate timely access to definitive care. These facilities must have appropriate pediatric equipment and experienced staff trained to provide critical support for ill and injured children until transferred for definitive care. It is necessary for freestanding urgent care facilities to have prearranged access to comprehensive pediatric emergency services through transfer and transport agreements. Available modes of transport should be identified in advance and be appropriate for the acuity of illness of the child.

If freestanding urgent care facilities are to be used as a resource for pediatric urgent care, they should first solicit help from the pediatric professional community to define expectations and levels of plans for pediatric consultation. Pediatricians who are prepared to assist in the stabilization and management of critically ill and injured children should be accessible. Pediatricians should be certain that freestanding urgent care centers are prepared to stabilize and transfer critically ill and injured children before they are recommended to their patients and families for after-hours use.

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RECOMMENDATIONS

Freestanding Urgent Care Facility Emergency Preparedness

1. Administrators at freestanding urgent care facilities should ensure that their staff is capable of providing resuscitation, stabilization, timely triage, and appropriate transfer of all pediatric patients.
2. Although the minimum standards for drugs, equipment, and supplies are listed in Tables 1 and 2, freestanding urgent care facilities with emergency medical systems response times of >10 minutes and transport times of >20 minutes to an emergency department need to have all suggested equipment, resuscitation drugs, and supplies as detailed in "Care of Children in the Emergency Department: Guidelines for Preparedness," issued jointly by the American Academy of Pediatrics and American College of Emergency Physicians.[3]
3. Freestanding urgent care facilities that provide care for children must be staffed by physicians, nurses, and ancillary health care professionals with the certification, experience, and skills necessary for pediatric basic and advanced life support during all hours of operation.
4. Triage, transfer, and transport agreements should be prearranged with definitive care facilities that are capable of providing the appropriate level of care based on the acuity of illness or injury of the child.[4]
5. Mechanisms for notifying the primary care physician or another on-call health care professional about the treatment given to ensure appropriate follow-up with the child's medical home should be in place and should be compliant with the regulations of the Health Insurance Portability and Accountability Act (HIPAA) (Pub L No. 101-

TABLE 1. Office Emergency Equipment and Supplies

	Priority*
Airway management	
Oxygen-delivery system	E
Bag-valve-mask (450 and 1000 mL)	E
Clear oxygen masks, breather and nonrebreather, with reservoirs (infant, child, adult)	E
Suction device, tonsil tip, bulb syringe	E
Nebulizer (or metered-dose inhaler with spacer/mask)	E
Oropharyngeal airways (sizes 00–5)	E
Pulse oximeter	E
Nasopharyngeal airways (sizes 12–30F)	S
Magill forceps (pediatric, adult)	S
Suction catheters (sizes 5–16F) and Yankauer suction tip	S
Nasogastric tubes (sizes 6–14F)	S
Laryngoscope handle (pediatric, adult) with extra batteries, bulbs	S
Laryngoscope blades (straight 0–4; curved 2–3)	S
Endotracheal tubes (uncuffed 2.5–5.5; cuffed 6.0–8.0)	S
Stylets (pediatric, adult)	S
Esophageal intubation detector or end-tidal carbon dioxide detector	S
Vascular access and fluid management	
Butterfly needles (19–25 gauge)	S
Catheter-over-needle device (14–24 gauge)	S
Arm boards, tape, tourniquet	S
Intraosseous needles (16, 18 gauge)	S
Intravenous tubing, microdrip	S
Miscellaneous equipment and supplies	
Color-coded tape or preprinted drug doses	E
Cardiac arrest board/backboard	E
Sphygmomanometer (infant, child, adult, thigh cuffs)	E
Splints, sterile dressings	E
Automated external defibrillator with pediatric capabilities	E
Spot glucose test	S
Stiff neck collars (small/large)	S
Heating source (overhead warmer/infrared lamp)	S

* E indicates essential; S, strongly suggested (essential if emergency medical services response time is >10 minutes).
Adapted from: American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. *Emergency Medical Services for Children: The Role of the Primary Care Provider*. Singer J, Ludwig S, eds. Elk Grove Village, IL: American Academy of Pediatrics; 1992.

TABLE 2. Office Emergency Drugs

	Priority*
Drugs	
Oxygen	E
Albuterol for inhalation†	E
Epinephrine (1:1000)	E
Activated charcoal	S
Antibiotics	S
Anticonvulsants (diazepam, lorazepam)	S
Corticosteroids (parenteral/oral)	S
Dextrose (25%)	S
Diphenhydramine (parenteral, 50 mg/mL)	S
Epinephrine (1:10 00)	S
Atropine sulfate (0.1 mg/mL)	S
Naloxone (0.4 mg/mL)	S
Sodium bicarbonate (4.2%)	S
Fluids	
Normal saline solution or lactated Ringer's solution (500-mL bags)	S
5% Dextrose, 0.45 normal saline (500-mL bags)	S

* E indicates essential; S, strongly suggested (essential if emergency medical services response time is >10 minutes).
† Metered-dose inhaler with spacer or mask may be substituted.
Adapted from: American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. *Emergency Medical Services for Children: The Role of the Primary Care Provider*. Singer J, Ludwig S, eds. Elk Grove Village, IL: American Academy of Pediatrics; 1992.

191 [1996]). If a primary care physician is not identified, efforts should be made to refer the patient to a pediatrician able to promote a medical home environment.

6. Administrators at freestanding urgent care facilities must ensure that there is an organized and structured quality-improvement program to monitor and improve care for ill or injured children.
7. Freestanding urgent care facilities should have in place and should monitor compliance with policies, procedures, and protocols for emergency care of children consistent with those listed in "Care of Children in the Emergency Department: Guidelines for Preparedness."[3]
8. Freestanding urgent care facilities should have a policy for disaster preparedness and participate in their community disaster plan.[5]

Pediatrician's Role in Freestanding Urgent Care Facilities

1. Pediatricians should refer patients for after-hours care only to freestanding urgent care facilities that have the capability to identify patients with emergency conditions, stabilize them, and arrange transfer for definitive care.
2. When referring a patient, the pediatrician should provide to the freestanding urgent care facility necessary clinical information and be available to provide consultation.

If freestanding urgent care centers are staffed and equipped properly and have appropriate triage, transfer, and transport guidelines, the safety of children using these services for emergencies can be protected.[6]

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NEW BUREAUCRATIC JOBS WOULD PAY FOR 2,000 MORE DOCTORS AND 6,000 NURSES

"The NHS was accused . . . of wasting millions of pounds of taxpayers' cash on 'unnecessary' jobs and hospital bureaucracy. Figures released by the Conservative Party show that in the last nine months a staggering 3,300 non-clinical jobs have been advertised in one health magazine alone. The salaries for these jobs amount to more than £133 million, enough for 6,000 more nurses, 2,000 more doctors or 29,000 hip replacements."

Fletcher V. *Daily Express.* April 23, 2005

Noted by JFL, MD