# Children in the Emergency Department


Authors

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## Introduction

**About 20-25% of all attendances to an "average" Emergency Department will be children**

Children may be treated in specific 'paediatric only' emergency departments (PED) or as part of a 'mixed' adult and children emergency department. The standards and recommendations which follow are applicable to for all emergency departments which treat children. The legal definition of a child is a person below the age of 18 years, however many departments have an operational definition of 16 years. Adolescence is between 12 and 25 years, however in terms of specifically addressing the needs of the adolescent age group most would consider the target audience as aged 16-17. All children and young people attending an emergency department must receive the same access to high quality care as adults. To achieve this, it is necessary to acknowledge the differences in patterns of illness, injury, physiology and psychology in children and young people attending our departments. It is also necessary to acknowledge the different practicalities. Set out below are standards and recommendations to meet the varied needs of neonatal to adolescent patients.

## Standards

1. Paediatric waiting and assessment areas must be separate from adult areas and the environment within the children's area should be designed to reflect the needs of children and their parents/carers. [1]
2. An initial assessment of the patient needs to take place within 15 minutes of arrival and should be tailored to the individual needs of the patient, including the assessment and treatment of pain. [2], [3]
3. EDs treating children must have at least
    a. One consultant with Paediatric Emergency Medicine (PEM) dual accreditation, and with allocated sessions to paediatrics and
    b. At least two registered children's nurses on duty in the children's area at all times. [4]

# Standards

1. Emergency departments must use a specific paediatric early warning score and ensure appropriate triggers and actions are in place. [5]
2. Departments should implement the relevant RCEM “Sign-of” standards with regard to children.
3. All departments must have clear safeguarding policies in place for children and young people including child sexual exploitation as well as ensuring appropriate staff competencies. [1],[10]
4. For patients presenting with mental health related issues, the assessment process must start at triage and include a capacity assessment. [1]
5. Psychosocial assessments must be undertaken in a timely fashion by appropriately trained staff for patients in the adolescent age group. Admission must not be the default option. [6]
6. When children require admission there must be clear policies in place with regards which in-patient team will take the lead role, compliance with national standards (eg. 4-hr emergency access standard) and transition arrangements between paediatric and adult services. [6],[7]
7. Major Incident planning must take into account the needs of children and this should also be reflected in training exercises. [1]

# Recommendations

1. Service design and delivery should be built around achieving the standards described in “Facing the Future: Standards for children in emergency care settings.” .[1]. This document is currently in revision

2. Emergency Departments should have a clinical leadership team for PEM within their departments. This should include a PEM consultant, and a lead nurse for the Paediatric Emergency Department.

3. Departments should, as part of workforce planning, seek to employ sub-specialist PEM qualified consultants in proportion to their department’s ratio of paediatric attendances.

4. Departments should have clear guidance for staff with regards consent and the refusal of treatment in children. [6], [8]

5. Departments should take part in violence reduction initiatives. [9]

# Background

Paediatric Emergency Medicine (PEM) is increasingly recognised as a sub-speciality of Emergency Medicine.

Paediatric Emergency Departments should be specifically designed and staffed to meet the needs of children and young people, and the needs of their families / carers. In addition, their design and staffing should be based around demand-capacity modelling, and the specific functional and operational requirements. They should not simply be regarded as “bolt-ons” to adult departments.

Children need to be kept safe when they visit the ED. This means physical safety, so that security is paramount, and safety from sights and sounds that they might find distressing. It also means that safeguarding considerations need to be built into every interaction and process which occurs.

# Design

The needs of children and young people vary across different ages, and design of such areas is becoming increasingly complicated. This isn’t just about small chairs, toys, and decoration. For instance, spaces need to accommodate the needs of children not only of different ages, but also different needs (for instance children with mental health problems, learning disabilities, or with sensory processing difficulties). Waiting areas needs to be cater for the fact that children come with their families, whilst provision of facilities for play, breast feeding, nappy changing, and for the preparation of bottles or food are all important. Equipment needs to cover the full range of potential presentations in children of all sizes. A large number of presentations in children relate to infectious diseases, whilst the pastoral needs of families, along with the complex procedures involved around the death of a child, mean that bereavement facilities need to have special attention.

The needs of adolescents, however defined, are becoming increasingly important to address. This is partly the consequence of the changing pattern of presentations, particularly around mental health, and partly the consequence of overcrowding in EDs meaning that adult areas are even more unsuitable for both adolescents and young adults than they have been in the past.

# Workforce

PEM is evolving as a field and is complicated by overlaps with paediatrics, and by the fact that for doctors there are two routes into the field (Emergency Medicine and Paediatrics). Within the nursing profession there are separately trained Children's Nurses, along with nurses who work in the ED and who come from a general nursing background.

From an Emergency Medicine perspective Emergency Medicine clinicians are not "adult" clinicians, they are generalists. Expertise in the assessment and management of paediatric patients is a core requirement for all doctors training through the RCEM curriculum. ACPs may choose to credential in adult emergency medicine, paediatric emergency medicine, or both. Other clinicians, such as ENPs, will commonly see patients across the age range as part of their practice. Children's Nurses bring additional skills to the care of children in Emergency Departments, but it should be remembered that general Emergency Department nurses also possess a range of skills, and many are highly experienced in the management of children.

The workforce in Paediatric Emergency Departments may be provided by the ED alone, by Paediatric departments, or more likely as part of blended solutions involving clinicians, nurses, and other professionals from different backgrounds. This can be challenging in terms of managerial structure, provision of operational and clinical leadership, clinical governance, education and training. There is no "one-size-fits-all" model but there is a requirement for a clearly identified leadership structure and team, along with clarity of responsibility for quality management and improvement. Education and training should be integrated with major programs within both the ED and paediatrics.

# References


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