
— PEDIATRIC EMERGENCY CARE LITIGATION

Not Small Adults

Pediatric Readiness and the Child in a General Emergency Department

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Most American children who need emergency care aren't seen at children's hospitals. They're seen at community hospitals, many of which see only a few kids a day. That's geography, not a criticism. But it means the team caring for a critically ill child may not do it often, and the equipment, drugs, and protocols they need may or may not be ready.

The National Pediatric Readiness Project has measured this for over a decade, scoring emergency departments on a 100-point scale: Is there a pediatric emergency care coordinator? Are staff trained and tested on pediatric skills? Are children weighed in kilograms? Are the right sizes of equipment and the right medications on hand? Are there pediatric policies and transfer agreements? The last national assessment, in 2021, found a median score around 70, with many departments well below.

Readiness is linked to survival. Studies published in 2023 found lower mortality among children treated in the highest-readiness EDs, and researchers estimated that well over a thousand child deaths a year might be prevented if every ED reached that level. Research published in 2026 linked declining readiness, along with closures of pediatric inpatient units, to excess child deaths.

The national guidance is a joint policy statement from the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association. It's guidance, not federal regulation, although some states run their own pediatric readiness recognition programs or requirements.

WHY CHILDREN ARE DIFFERENT

Normal vital signs change with age; a heart rate that's fine for a toddler would alarm you in a teenager. Children hold their blood pressure up until late in serious illness and then fall fast. Drug and fluid doses depend on weight, and a pounds-for-kilograms mix-up can more than double a dose. Equipment has to fit. And young children can't tell you what's wrong, so staff depend on parents and close observation. Skilled, caring staff can still miss things in a department that isn't set up for kids.

A FICTIONAL CASE

A 2-year-old arrives at a small community ED at 11 p.m. with fever, vomiting, and unusual sleepiness. He's triaged as mid-acuity. His weight is recorded as "26," and the nurse enters it as kilograms when it was actually pounds. His heart rate is fast and his hands and feet are cool, but his blood pressure is normal. He gets fluids and a fever reducer, and the physician, who sees children only occasionally, plans a recheck. Ninety minutes later he's much worse. The right-sized airway equipment isn't easy to find, and reaching the regional children's hospital takes time. He's ultimately diagnosed with septic shock.

READING THE RECORD

Start with triage. Pediatric acuity should rest on age-specific vital signs and perfusion, such as cool extremities and slow capillary refill, not blood pressure. A fast heart rate, cool extremities, and unusual sleepiness together suggest possible shock even with a normal pressure.

Then the weight. Readiness guidance calls for weighing and recording in kilograms only, precisely to prevent this error. What was his real weight? Were fluid and drug doses based on the wrong number?

Then recognition. Did the ED use a pediatric sepsis screen or early warning score? Was it applied, and what did it show? Then reassessment: when was he rechecked, how did his vitals change, and when did anyone recognize the decline?

LISTENING TO PARENTS

Parents are often the earliest warning system. "He's not himself" means something in a toddler. What did the parents say, and when? Did they tell a nurse he seemed worse, and is it documented? Their timeline of the fever, fluids, wet diapers, and sleepiness helps show how sick he was on arrival. Some hospitals let families trigger a rapid evaluation when they're worried; did this one?

THE CHILD WHO COMES BACK

Many pediatric cases involve a child sent home who returns sicker. That first visit needs its own review: vital signs at discharge, whether abnormal values were addressed, whether the child was drinking, and what parents were told to watch for and in what language. Return visits within a day or two are a quality signal many hospitals track.

BEFORE THE HOSPITAL

If he came by ambulance, the prehospital care matters too. Pediatric readiness work now extends to EMS equipment, training, and protocols. The run sheet shows his condition en route and where the crew chose to go.

WAS THE DEPARTMENT READY?

Beyond the individual clinicians, was the department prepared? Was there a pediatric emergency care coordinator? Was pediatric equipment stocked in every size and organized for fast retrieval, often color-coded by length or weight? Were pediatric drug concentrations and dosing references available? Had staff trained and run pediatric simulations? Was there a transfer agreement with a pediatric center and a clear way to reach them at night? Many EDs have completed the NPRP assessment and have their own score and improvement plan; if discoverable, it may show what they knew about their gaps.

TRANSFER

How long did it take to reach the pediatric center and arrange transport? Was a specialized pediatric team used? What happened during the wait? Many children's hospitals offer telemedicine consults; was one available and used, and was the advice followed? Transfer agreements and call logs show where the time went.

CAUSATION

In pediatric sepsis, earlier recognition and treatment are generally associated with better outcomes, but what a specific delay meant for a specific child is a question for a pediatric emergency medicine or pediatric critical care expert. Dosing errors need their own analysis: what was given, what should have been, and whether the difference caused harm.

RECORDS WORTH REQUESTING

- Complete ED records from every visit, including triage
- Weight entry and all dosing calculations; the MAR
- Pediatric sepsis screening or early warning results
- Parents' account of the timeline and concerns raised

- EMS run sheet, if applicable
- Pediatric policies, equipment and medication lists, and staff pediatric training records
- Any NPRP assessment or pediatric readiness improvement plan
- Transfer agreements, call logs, telemedicine consult records, and transport records

SOURCES

- National Pediatric Readiness Project, 2021 national assessment (EMSC Innovation and Improvement Center)
- Studies of ED pediatric readiness and child mortality (2023), including in *JAMA Network Open*
- Study of changes in ED pediatric readiness, inpatient services, and excess child deaths (2026); Medscape coverage
- AAP, ACEP, and ENA joint policy statement on pediatric readiness in the emergency department

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case involving a child in a general ED and want both the bedside care and the department's readiness examined, we'd welcome the conversation.

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