“I still remember every child who has died under my care. It is something that stays in your mind forever,” said Isabel A. Barata, M.D., member of the Committee on Pediatric Emergency Medicine, American College of Emergency Physicians (ACEP). “You can never forget it or shake it.”

Regardless of the cause, a child dying in an emergency department (ED) is challenging. To update guidance on this emotional and complicated event, the Academy collaborated with ACEP and the Emergency Nurses Association (ENA) on *Death of a Child in the Emergency Department*, a policy statement and technical report. The documents, published in the July issue of *Pediatrics* (2014;134:198-201 and e313-e330) and released online June 23, are endorsed by all three organizations.

The goal of the revised policy and technical report, expanded to include emergency nursing, is to help ED staff care for the patient, family members and each other following a child’s death. When resuscitation fails, the care team should strive to achieve a “good death,” said Dr. Barata, a lead author. “It sounds like something that is not possible, but the concept is to take care of the patient, take care of the family and take care of the providers who did the resuscitation.”

### Have procedures in place

To achieve this, the statement recommends a patient-centered, family-focused, team-oriented approach to care. EDs should have procedures in place to provide a coordinated response to an impending death. Written policies should be created on family presence during and after resuscitation, said Patricia J. O'Malley, M.D., FAAP, lead author from the Academy.

“The idea of family presence makes clinicians anxious, but what we’ve learned is that it’s possible and a positive experience not only for the potentially bereaved family, but also for providers,” Dr. O’Malley said.

Local policies should consider when family presence can be accommodated safely and when not, Dr. O’Malley said.

The evidence fully supports giving families the opportunity to begin the bereavement process during resuscitation, said Sally Snow, R.N., B.S.N., C.P.E.N., FAEN, a lead author and member of the ENA Pediatric Committee. “It helps them to understand the length of time the resuscitation took place. They are often the ones to say, ‘It’s time to stop,’” she said. Care should be taken to ensure someone is present, such as a nurse, to support the family, Snow said.

Dr. O’Malley recalls a time when a child’s pediatrician was present during a resuscitation. The child was transferred from the pediatrician’s office to the ED on the same campus, Dr. O’Malley said. “The resuscitation was not successful, and the child died in the emergency department, but — even though he didn’t put a tube in or a line in — the pediatrician was able to be present with the family, which was so grounding to everyone there. That kind of collaboration can’t happen very often, but when it does, it makes this difficult situation more bearable,” she said.

In addition to family presence, EDs also should have written policies on:

- preterm delivery resuscitation;
- end-of-life care for a child with a lifespan-limiting condition;
- collaborating with law enforcement to address forensic concerns while still providing compassionate care;
- conducting procedures on the newly deceased; and
- procedures that should take place after the death of a child, including death certificates and discussions about organ donation.

Additionally, processes should be in place to notify primary care providers of the death. The emergency team should provide child death reviews and know what resources are available to help bereaved families.

### Communication skills, self-care vital

Careful attention should be paid to communication following a death, Dr. O’Malley said.

While difficult, she said, “It can be taught and simulated and learned very much the same way other procedures can be.” The policy recommends that providers and nurses receive training on communicating the death of a child to parents. Appendix 1 of the technical report includes guidelines useful to physicians breaking bad news, Dr. O’Malley noted.

After the news is shared, nurses should provide additional support to the family, Snow said.

Finally, all members of the care team need to practice self-care. “There’s evidence to support that people who do this job day in and day out suffer compassion fatigue,” Snow added. Debriefing and support programs can help providers deal with their own emotions and grief.