National PRQC

Pediatric Readiness Quality Collaborative

Ensuring Emergency Care for All Children

Learning Session
19-November 2019

Hosts:

Kate Remick, MD
Diana Fendya, MSN (R), RN
Meredith Rodriguez, PhD
Krystle Bartley, MA

ACKNOWLEDGEMENTS

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HRSA Maternal & Child Health

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National PRQC
Pediatric Readiness Quality Collaborative
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LEARNING SESSION DISCLOSURES

Note Faculty/Speakers and Planners for this learning session:

Kate Remick, MD

Diana Fendya, MSN (R), RN

Meredith Rodriguez, PhD

Krystle Bartley, MA

have no conflicts of interest. Additionally, no commercial support has been received for this activity.

Should participants detect any bias in this presentation please note such on the evaluation or reach out to Diana Fendya, nurse planner for continuing education.

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TO OBTAIN NURSING CEs

- Sign into the webinar: name, email address and name of your facility.
- At the completion of the presentation a link will be provided which will take you to a short evaluation form which you will need to complete.
- The evaluation must be completed within 2 weeks:
  https://tch-redcap.texaschildrens.org/REDCap/surveys/?s=C3CHENDRY8
- Within 48 hours of receiving your evaluation, your certificate will be sent to you electronically.

AGENDA

19-November 2019 LEARNING SESSION

Team Presentations– 80”

The Longhorn Kids
Eight is Enough
ETCH
Fight or Flight Response Team
LifesavERs
Lone Star Kids
New England EMSC
Oregon Pediatric Readiness Program

Aggregate Performance – 5”

PRQC Admin Team

Housekeeping – 5”

Meredith Rodriguez

The Longhorn Kids- Central Texas – November 2019 Update

- Sujit Iyer, MD, Pediatric ED Outreach
- Denita Lyons, Education Manager

The Longhorn Kids Team

- Members include:
- Sujit Iyer, ED Physician
  - Associate Professor, UT Dell Medical School, Department of Pediatrics
  - Associate Fellowship Director, Pediatric Emergency Medicine Fellowship, UT Dell Medical School
  - Director, Pediatric ED Outreach, Dell Children's Medical Center
  - Assistant Medical Director, Dell Children’s Emergency Department
- Denita Lyons, Clinical Education Manager
- Nurse trainers- Jennifer Heineman & Karleigh Johnson
- Training Team Organization –team based at a teaching hospital, the only pediatric hospital in our local network of 11 hospitals in Austin area and Waco.

Longhorn Kids

- 11 Affiliates
  - Geographic area – size of Ohio
- Pediatric Center – 78K visits
- Other centers combined – 70K
  - Lowest Volume: 300/yr
  - Highest Volume: 9000/yr

Prior Mean Pediatric Readiness Score: 65

Hospital	Characteristics	Total ED Visits	Pediatric ED Visits	PR Scores	Number of Beds/Designated Pedi Beds
Dell Seton Medical Center	Level 1 Trauma, Teaching hospital	71,257	1,950	81	41/0
Providence	General	72,052	13,117	?	50/6
Seton Edgar B Davis	Critical Access	9,658	2,257	99	4/0
Seton Hays	General	37,528	7,627	100	31/3
Seton Highland Lakes	Critical Access	11,779	2,149	74	13/0
Seton Main	General	32,064	946	100	31/0
Seton Northwest	General	29,434	2,724	86	29/6
Seton Southwest	General	14,233	2,761	89	9/2
Seton Smithville	Rural			?	6/0
Seton Williamson	General	28,549	4,587	100	26/5

Bundles selected- Weighing children in metric units
Recognition of Abnormal vital signs and notification plan

Team Philosophy and Goal(s)

Team Philosophy -

Don’t recreate the wheel!

Utilize the existing knowledge and experience at each site and offer specialized education to meet the needs.

Specific team PRQC goal(s)

By July 2019, a process will be established and >90% of all audited charts will have children measured in the proper method and documented in kilograms only

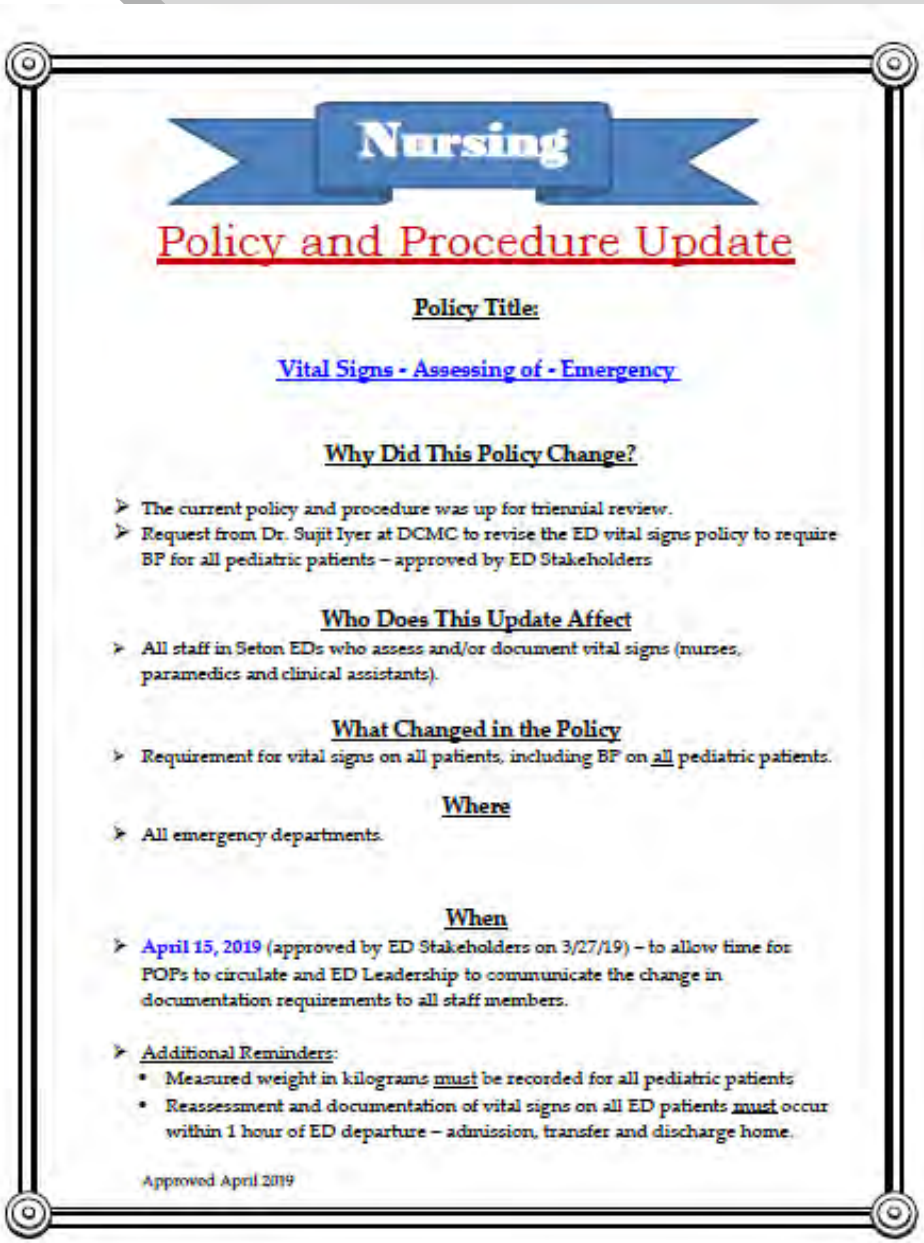
By July 2019, >90% of all children will obtain a full set of vital signs and those with abnormal vital signs will be identified and addressed by healthcare providers in the ED

Barriers and Enablers to PRQC Success Identified

- Barriers
  - Lack of unit educators
  - Lack of pediatric champions
  - Conflicting priorities- stroke center, trauma center
  - Lack of pediatric specialists in department
  - Inability to pay for staff time to participate in project
  - Different EHRs
- Enablers
  - Leadership support of staff at sites
  - DCMC Leadership agreed support nurse time (financial)
  - Use of Nursing portfolio to recruit champions

Work Done

- On Site education and trouble shooting
  - Laminate Cards
  - 100% scales locked
  - Address supply gaps
- Review of nursing policy
  - Myths and controversies
  - CNO adoption



Nursing

Policy and Procedure Update

Policy Title:

Vital Signs - Assessing of - Emergency

Why Did This Policy Change?

- The current policy and procedure was up for triennial review.
- Request from Dr. Sujit Iyer at DCMC to revise the ED vital signs policy to require BP for all pediatric patients – approved by ED Stakeholders

Who Does This Update Affect

- All staff in Seton EDs who assess and/or document vital signs (nurses, paramedics and clinical assistants).

What Changed in the Policy

- Requirement for vital signs on all patients, including BP on all pediatric patients.

Where

- All emergency departments.

When

- April 15, 2019 (approved by ED Stakeholders on 3/27/19) – to allow time for POPs to circulate and ED Leadership to communicate the change in documentation requirements to all staff members.
- Additional Reminders:
  - Measured weight in kilograms must be recorded for all pediatric patients
  - Reassessment and documentation of vital signs on all ED patients must occur within 1 hour of ED departure – admission, transfer and discharge home.

Approved April 2019

Over two-year span

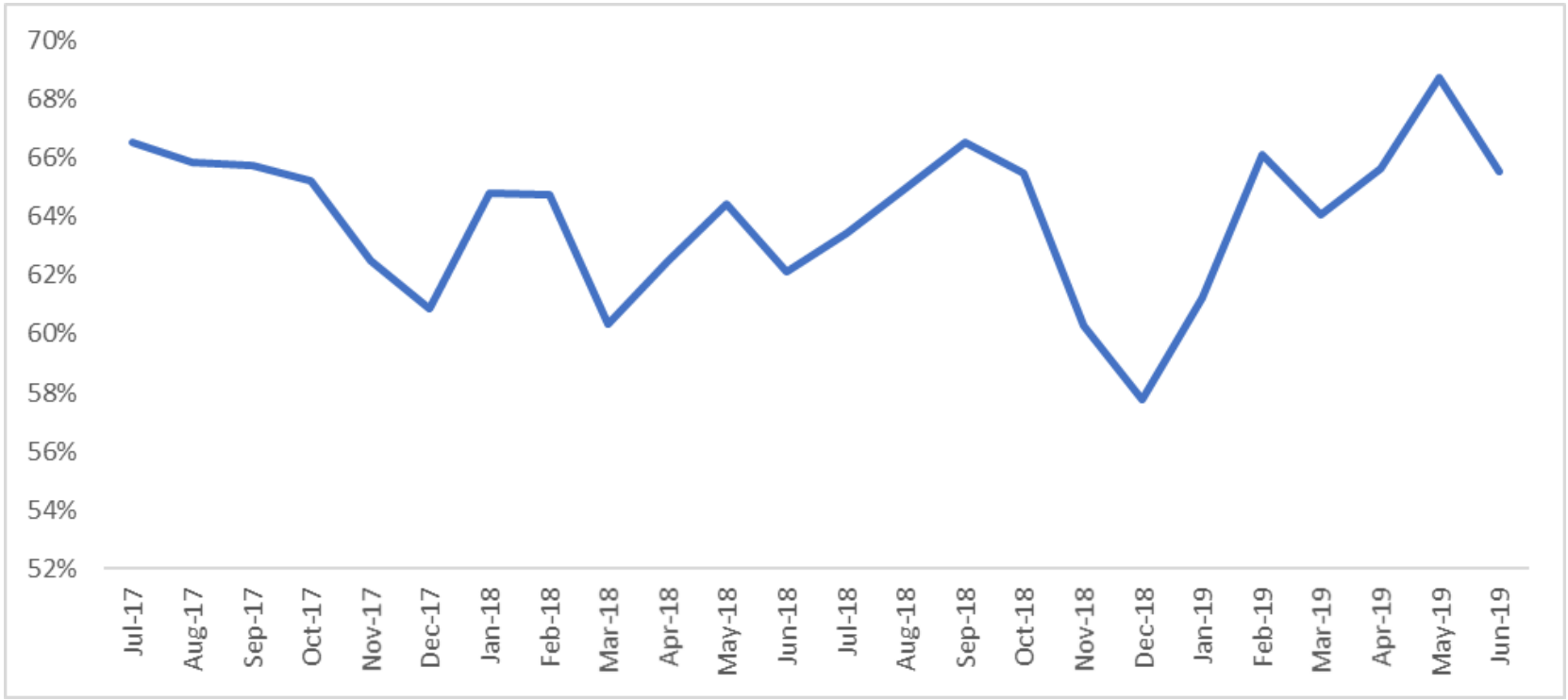
	total	patients weighed	Percent of Total	patients with vitals	Percent of Total	with weight and vitals	Percent with Wt and VS
Dell Children's	138674	134955	97%	105020	76%	102200	74%
Dell Seton Med Cntr UT	2715	949	35%	2088	77%	647	24%
Edgar B Davis	4720	4496	95%	3222	68%	3068	65%
Hays	19770	17333	88%	7759	39%	6568	33%
Highland Lakes	3898	3592	92%	1393	36%	1297	33%
Medical Center	1989	1351	68%	1066	54%	609	31%
Northwest	6670	5355	80%	3688	55%	2731	41%
Southwest	5694	5002	88%	4060	71%	3535	62%
Williamson	9356	7383	79%	3988	43%	2899	31%

Thse data represent the population of pediatrics (i.e., < 18 yo) ED visits during the period 7/1/2017 - 6/30/2019. This list includes peditric patients from all Ascension Seton sites.

Please note that patients who were "auto-discharged", i.e., patients who were unable to locate and were discharged via the automated function rather than being formally discharged by a physician, were excluded.

The indicators here are yes/no indicators for whether the data was recorded in the correct field in Compass. Any vitals/weights that were recorded in free text or in scanned PDF documents are not accounted for here.

All 5 Vital signs and Weight in KG (Network)



Next Steps

- Create a dashboard with slicers to filer by site over time
  - Emphasize the good – Weight in KG
  - Acknowledge challenge
    - Comfort with BP in small kids
    - Understanding expectations and policy
- New Tools
  - Creation of youtube video on tip/tricks to VS in kids
  - ? Suggestions
- Put in front of executives without being punitive to staff

Alexander C. Arroyo MD Director Pediatric Emergency Medicine

Maimonides Medical Center

(Eight is Enough)

PRQC

Disaster Bundle

Pediatric Readiness Survey

- MMC is **99%** prepared for pediatric emergencies

NYC PDP

The New York City
Pediatric Disaster Plan

Moving the Right Child, at the Right Time, to the Right Place.

Date May 15, 2015
FDNY Version Updated

FIRE DEPARTMENT CITY OF NEW YORK

N Y P D C

NYC Health

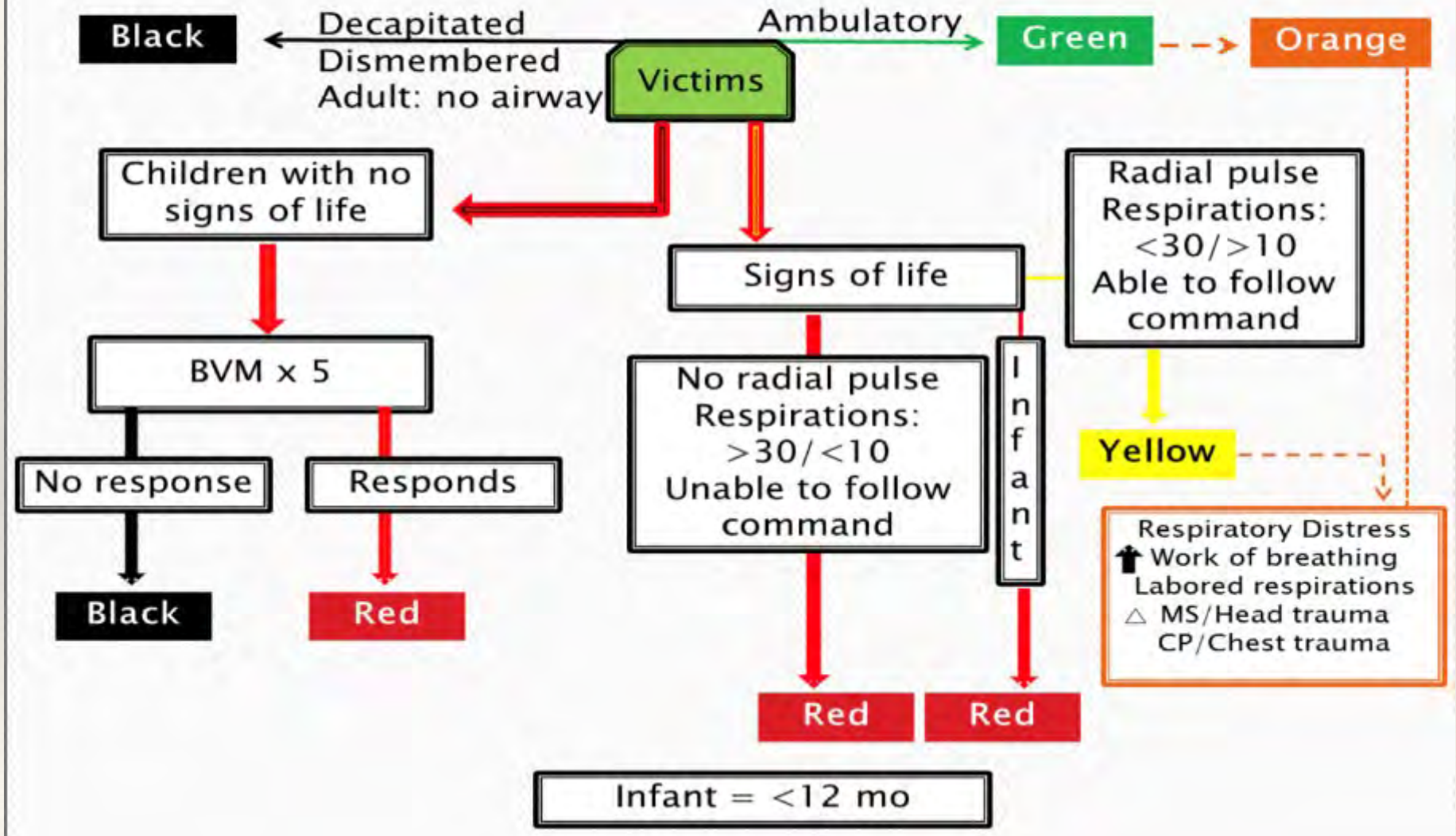
New York City medical reserve corps

NYC Emergency Management

Pediatric Disaster Ambulance Destination (PDAD)

- Tier 1: Designated hospital staffed with specialists and resources necessary to manage treatment and facilitate recovery required for pediatric patients
  - Pediatric surgical service
  - Pediatric emergency service (separate unit or capable)
  - Pediatric intensive care unit
  - Pediatric inpatient unit
  - Minimum of level III nursery
  - Comprehensive pediatric subspecialty support
  - Anesthesiology, neurosurgery, orthopedic surgery w/ experience in mgt of children
  - Disaster plan including pediatric surge capability
  - Tier One Hospitals: Receive ***Red***, ***Orange***, *Yellow* triaged children

Triage Modification



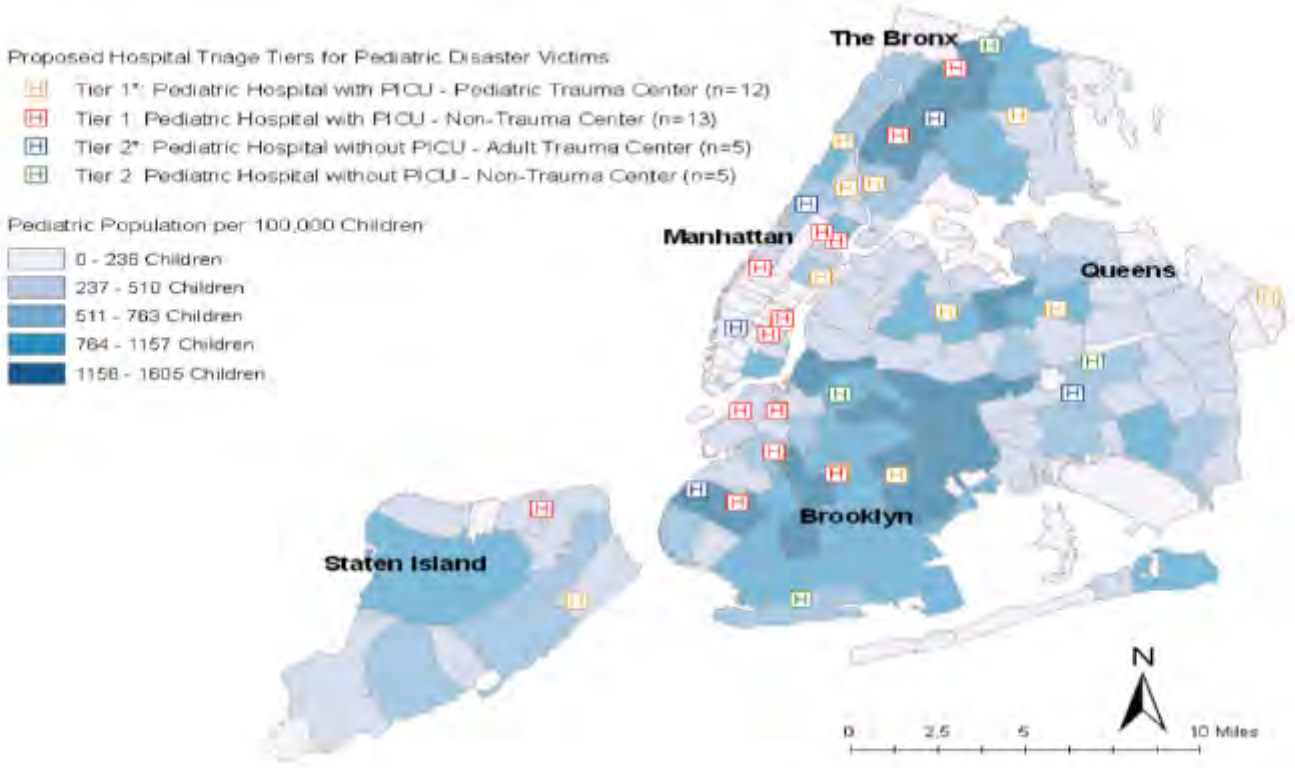
NYC PDP

Qualifying Tier One Institutions By Borough Of Location (Total = 19)	
Bronx	Bronx Lebanon Hospital Center-Concourse Pavilion Children's Hospital at Montefiore Jacobi Medical Center*
Brooklyn:	Brooklyn Hospital Center Kings County Hospital Center* Maimonides Medical Center* New York Methodist Hospital University Hospital of Brooklyn - SUNY Downstate Medical Center
Manhattan:	Bellevue Hospital Center* Harlem Hospital Center* Morgan Stanley Children's Hospital of New York-Presbyterian* Mount Sinai Hospital Mount Sinai Beth Israel New York-Presbyterian Hospital / Weill Cornell Medical Center* NYU Langone Medical Center
Queens:	Elmhurst Hospital Center* Steven & Alexandra Cohen Children's Medical Center of New York*
Staten Island:	Richmond University Medical Center* Staten Island University Hospital (North)*

* *Designated Trauma Center with Pediatric Capabilities*

NYC PDP

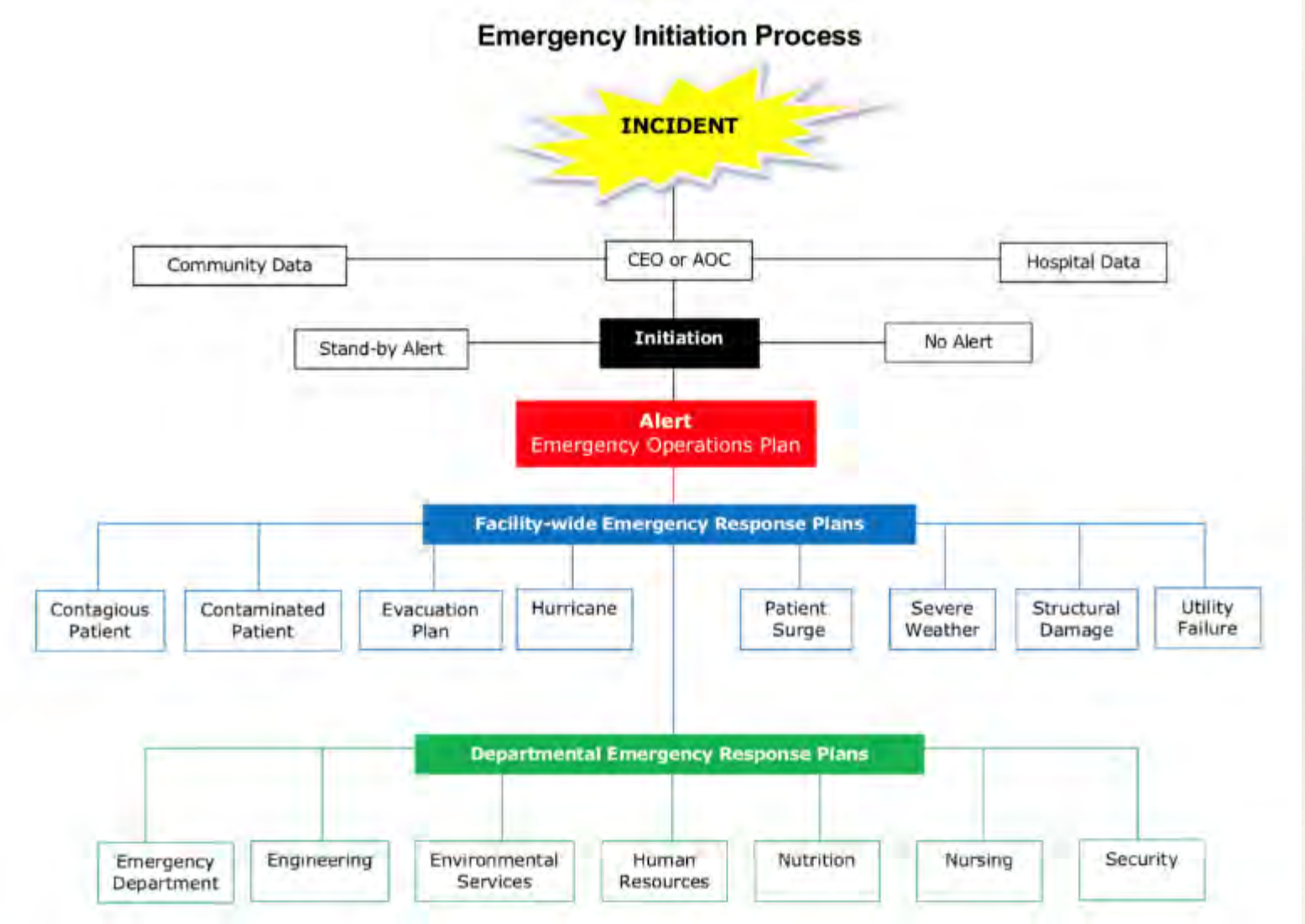
Proposed hospital triage tiers for pediatric disaster victims mapped against pediatric population density



MMC Emergency Management Leadership

- Karen Kobus: Incident Commander
- Alex D'Atri: Director of Security
- Bill Howe: Assistant Vice President EMS and Emergency Management
- Jeffrey Avner : Chairman of Pediatrics
- George Foltin: Vice Chair of Pediatrics
- Kelly Riley: Chief Pediatric Nursing Officer
- Alexander Arroyo: Pediatric Emergency Medicine Director
- Mohammed Gaffor: Pediatric Intensive Care Director
- Alok Bhutada: Neonatal Intensive Care Director
- Angel Lora: Director Respiratory Therapy
- Edwin Feliciano: Facilities Engineering Manager
- Linoba Howard: Director of Safety
- Marline Laurent: Senior Social Worker

EMERGENCY INITIATION PROCESS



MMC Rapid Discharge Protocol:ED

MMC ED RAPID DISCHARGE FORM

Patient Name	MR	Location	Attending MD

Working Diagnosis:

Disposition Status (Please check one):

___ Admitted
___ Admitted but possible discharge
___ ED patient definite admission
___ ED patient possible discharge
___ ED patient definite discharge
___ Discharged

For admitted patients who cannot be discharged complete this box:

1. Bed type required
   ___ ICU ___ Floor ___ Vent
   ___ Telemetry ___ Psych ___ Contact isolation ___ Airborne isolation
2. Is patient awaiting test results? ___ Y ___ N ___ Unknown
   a. If yes, can patient go to bed prior to test results? ___ Y ___ N
3. Has report been given? ___ Y ___ N ___ Unknown
4. Is patient awaiting transport? ___ Y ___ N ___ Unknown

For all other patients, complete this box:

1. Are test results required prior to discharge? ___ Y ___ N
   a. If yes, what _____
2. Does patient require treatment/medications prior to discharge? ___ Y ___ N
   b. If yes, what _____
3. Does patient require social services? ___ Y ___ N
   c. If yes, what _____
4. Does patient require interpreter services prior to discharge ___ Y ___ N
   a. If yes, what language _____
5. Is patient ventilator dependent? ___ Y ___ N
6. What is the discharge or transfer destination?
   ___ Home ___ SNF/group home ___ Other _____
7. What is the mode of discharge transport?
   ___ Patient can leave alone and has transport
   ___ Patient can leave alone but requires transport
   ___ Patient needs assistance of family/friend
   ___ Patient needs ambulance/ambulette

In the event of a disaster, I have assessed this patient and consider the patient medically stable for discharge either to home or to a care facility. Attending Provider's Initials: _____

MMC Rapid Discharge Protocol:PICU/PEDS

MMC PEDS/PICU RAPID DISPO FORM

Patient Name	MRN	Location (Bed)	Service
			__PHM __ PICU __ Ped Surg __Trauma __Ped HemeOnc Other:

Primary Diagnosis/Issue:

Other Relevant Diagnoses/Issues:

Resp Status: __RA ___ NC/mask ___ HFNC ___ NIPPV ___ intubated ___ trach ___ trach+vent
Bronchodilators: [ ] none [ ] q ___ hours [ ] continuous
IV Drips (medications): [ ] none [ ] _____
Other special care: __ chemo __chest tube Misc:_____
At baseline? ___ Yes __ No

Disposition Status:

___ dischargeable (may require modified discharge criteria in an emergency)
___ transfer to floor service (PICU only)
___ downgrade to intermediate status/surge on Ped6 (PICU only)
___ must remain at current level of care
___ Other (move to adult unit, to go to OR then PACU, etc.):
_____

If you checked "must remain at current level of care":

ESTIMATED time until dispo may change: ___ < 12 hours ___ 12 - 24 hours __ > 24 hours
Briefly note criteria to reevaluate dispo if < 24h (results, resp status, PO intake, etc.):

MMC PEDS/PICU RAPID DISPO FORM

If patient is dischargeable:

___ Parents/Guardians present, patient can be discharged immediately to home, lobby, etc.
___ Patient can be discharged to "holding area" (e.g., no parent/guardian present)
___ Patient can be discharged but cannot leave room. Reason: _____
___ Discharge soon, but after: _____ [Check when this is DONE: [ ]]

Are there special follow-up plans required to permit emergency discharge?
___ No ___ Yes (briefly describe):

Special discharge barriers/needs:
___ medical transport ___home care ___ ACS/Foster care ___ medical equipment/supplies
___Other: _____

Please check the following as tasks are completed (note that (*) tasks may be done after pt has left):
___ parents notified ___ Hospital Course completed*
___ prescriptions sent (or none needed) ___ follow-up scheduled*
___ Discharge Instructions completed ___ PMD contacted* (send Discharge Summary)
___ All special discharge needs resolved (see above)

Completed By: _____ Date/Time: _____

PEDS/PICU Rapid Intake Form

PED6/PICU Rapid Intake Tracking Form

Date: _____ **Unit:** **PED6** **PICU** **Other:**_____

Patient Name & MRN	Age/ Gender	Diagnosis & Key Info (intubated, e.g.)	From:	Arrived (Bed)	MD Assessed	Admit Orders	Notes
			[ ] ED [ ] PICU [ ]_____ [ ] ED [ ] PICU [ ]_____				
			[ ] ED [ ] PICU [ ]_____ [ ] ED [ ] PICU [ ]_____				
			[ ] ED [ ] PICU [ ]_____				
			[ ] ED [ ] PICU [ ]_____				
			[ ] ED [ ] PICU [ ]_____				

Form is intendend for use in emergency situations when a large number of patients will need to be moved quickly from one area to another. Left half is for the individual receiving hand off to get basic info on the patients. Right half is a checklist to ensure the BARE MINIMUM tasks are completed for successful transfer of care.

PICU SURGE PLAN

A Plan for Increasing Pediatric Critical Care Surge Capacity (PCCSP) at Maimonides Medical Center, Brooklyn, New York

December 2011

Medical Center Task Force

- Addresses multiple disaster level scenarios
- Detailed surge plan for PICU admits

Additional PICU Space:

Initially the some rooms in the PICU can be "doubled-up" to provide three additional beds. (Minor equipment additions can be made just in time to accommodate the surge)

Epilepsy rooms B612 (612 is a negative pressure room) & B613 (2 patients) in pediatrics and B611 (611 is also negative pressure able to accommodate 1 patient) the isolation room

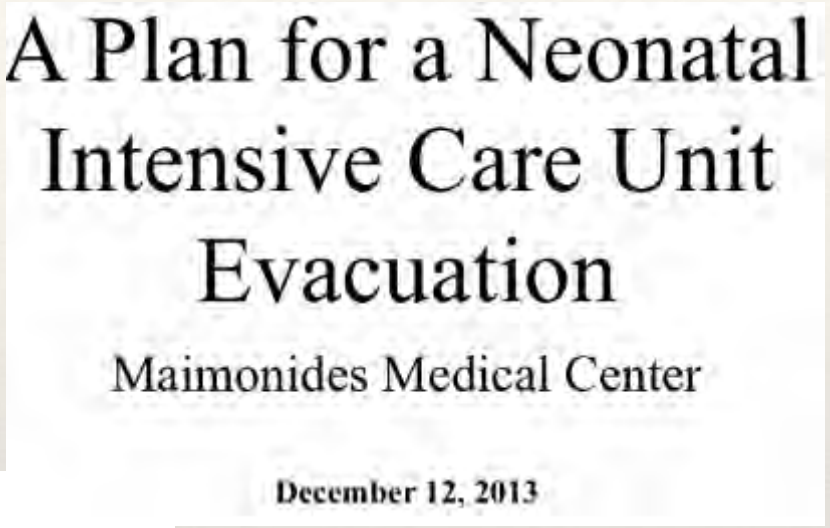
PICU rooms 2-10 could each accommodate 1 additional patient

Neonatology: Potential to shift babies <28 days and <44 weeks to NICU if there is a PICU surge

Adult units: Teenaged patients >12 yo can also be housed in medical ICU beds if need arises and the current disaster doesn't affect adult patient capacity.

NICU DISASTER/EVACUATION PLAN

- Addresses multiple disaster level scenarios
- Detailed evacuation plan for NICU pts



A Plan for a Neonatal Intensive Care Unit Evacuation

Maimonides Medical Center

December 12, 2013

V. Open Alternate NICU Sites (NICU, ext.: 7640; NICU Annex, ext.: 7327):

Fill NICU (28 beds, leave 3 open as admission beds); then,

Fill 9 beds in Room 4; then,

Fill 4 beds in Room 3 NICU Annex; then,

Put 2-3 patients in Breastfeeding Room/Isolation Room in NICU Annex.

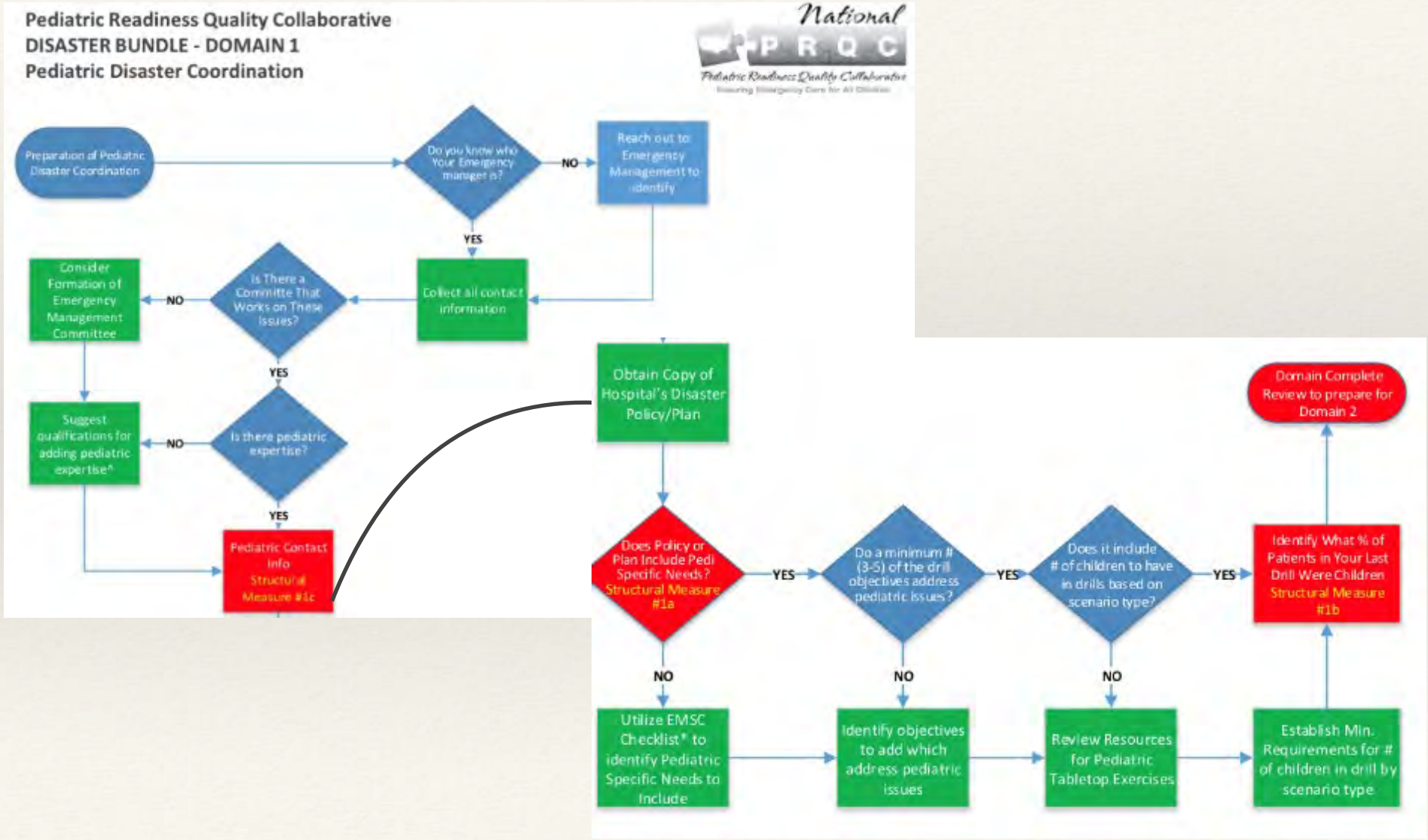
Put 3 patient in room A; then,

Put 3 patients in transition room.

Maximum total: 50 beds not including the 3 admission beds

If additional space is required after the above 50 beds are full the next step is to look to other space in the institution to add another 12 beds.

Domain 1


Pediatric Readiness Quality Collaborative
DISASTER BUNDLE - DOMAIN 1
Pediatric Disaster Coordination
National PRQC
Pediatric Readiness Quality Collaborative
Preparation of Pediatric Disaster Coordination
Do you know who Your Emergency manager is?
NO
Reach out to Emergency Management to identify
YES
Collect all contact information
Is There a Committe That Works on These Issues?
NO
Consider Formation of Emergency Management Committee
YES
Is there pediatric expertise?
NO
Suggest qualifications for adding pediatric expertise*
YES
Pediatric Contact Info
Structural Measure #1c
Obtain Copy of Hospital's Disaster Policy/Plan
Does Policy or Plan Include Pedi Specific Needs?
Structural Measure #1a
YES
Do a minimum # (3-5) of the drill objectives address pediatric issues?
YES
Does it include # of children to have in drills based on scenario type?
YES
Identify What % of Patients in Your Last Drill Were Children
Structural Measure #1b
Domain Complete Review to prepare for Domain 2
NO
Utilize EMSC Checklist* to identify Pediatric Specific Needs to Include
NO
Identify objectives to add which address pediatric issues
NO
Review Resources for Pediatric Tabletop Exercises
Establish Min. Requirements for # of children in drill by scenario type

Domain 1

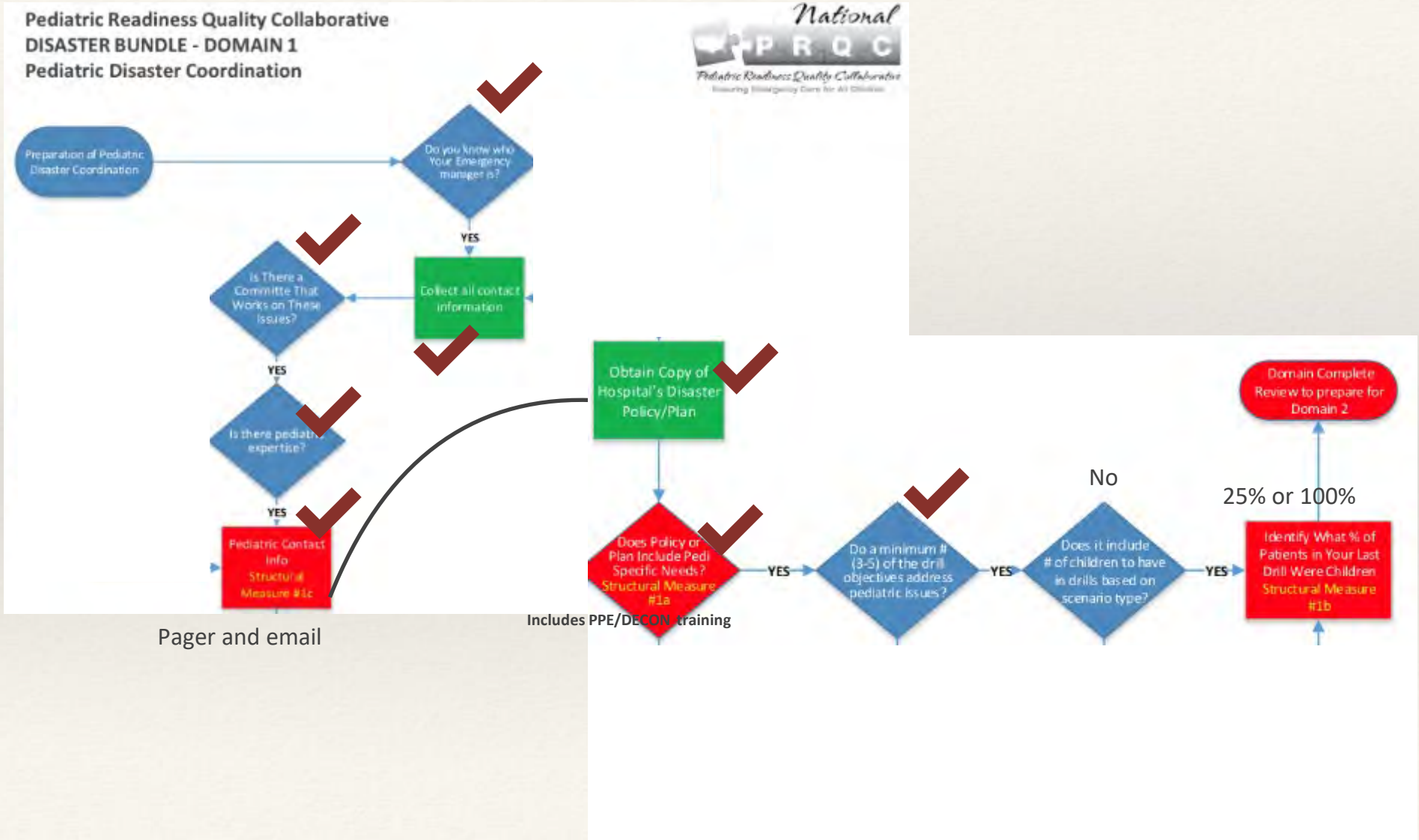
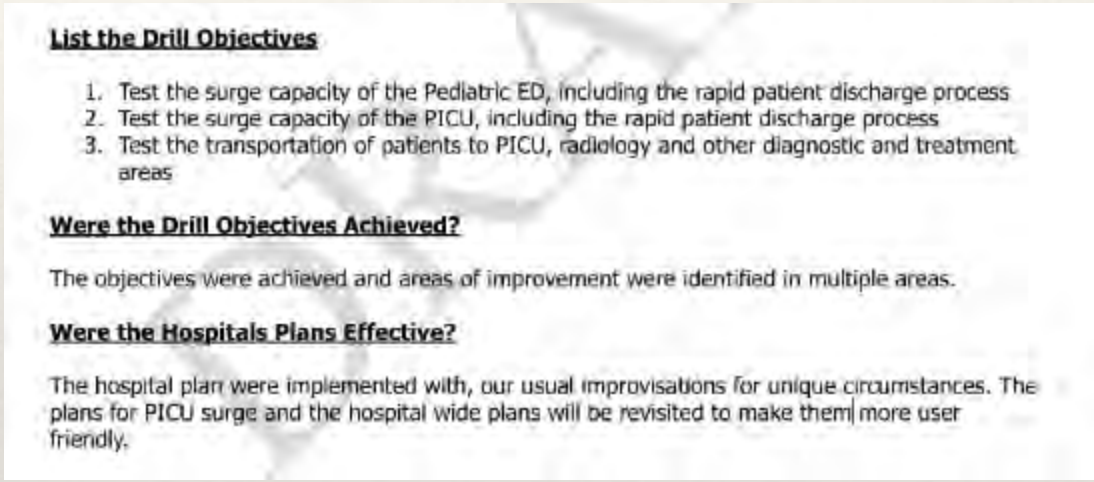

Pediatric Readiness Quality Collaborative
DISASTER BUNDLE - DOMAIN 1
Pediatric Disaster Coordination
National
PRQC
Pediatric Readiness Quality Collaborative
Preparation of Pediatric Disaster Coordination
Do you know who Your Emergency manager is?
YES
Collect all contact information
Is There a Committe That Works on These Issues?
YES
Is there pediatric expertise?
YES
Pediatric Contact Info
Structural Measure #1c
Pager and email
Obtain Copy of Hospital's Disaster Policy/Plan
Does Policy or Plan Include Pedi Specific Needs?
Structural Measure #1a
YES
Includes PPE/DECON training
Do a minimum # (3-5) of the drill objectives address pediatric issues?
YES
Does it include # of children to have in drills based on scenario type?
No
YES
Identify What % of Patients in Your Last Drill Were Children
Structural Measure #1b
25% or 100%
Domain Complete
Review to prepare for Domain 2

TABLE TOP DRILL: DOMAIN 2

- 5/2017
  - Multiple school busses bombed in Queens
  - ~ 300 injured children
  - 69 arrived at MMC
  - Incident command activated
  - Vents borrowed from adult unit/nursing homes
  - Rapid DC



List the Drill Objectives

1. Test the surge capacity of the Pediatric ED, including the rapid patient discharge process
2. Test the surge capacity of the PICU, including the rapid patient discharge process
3. Test the transportation of patients to PICU, radiology and other diagnostic and treatment areas

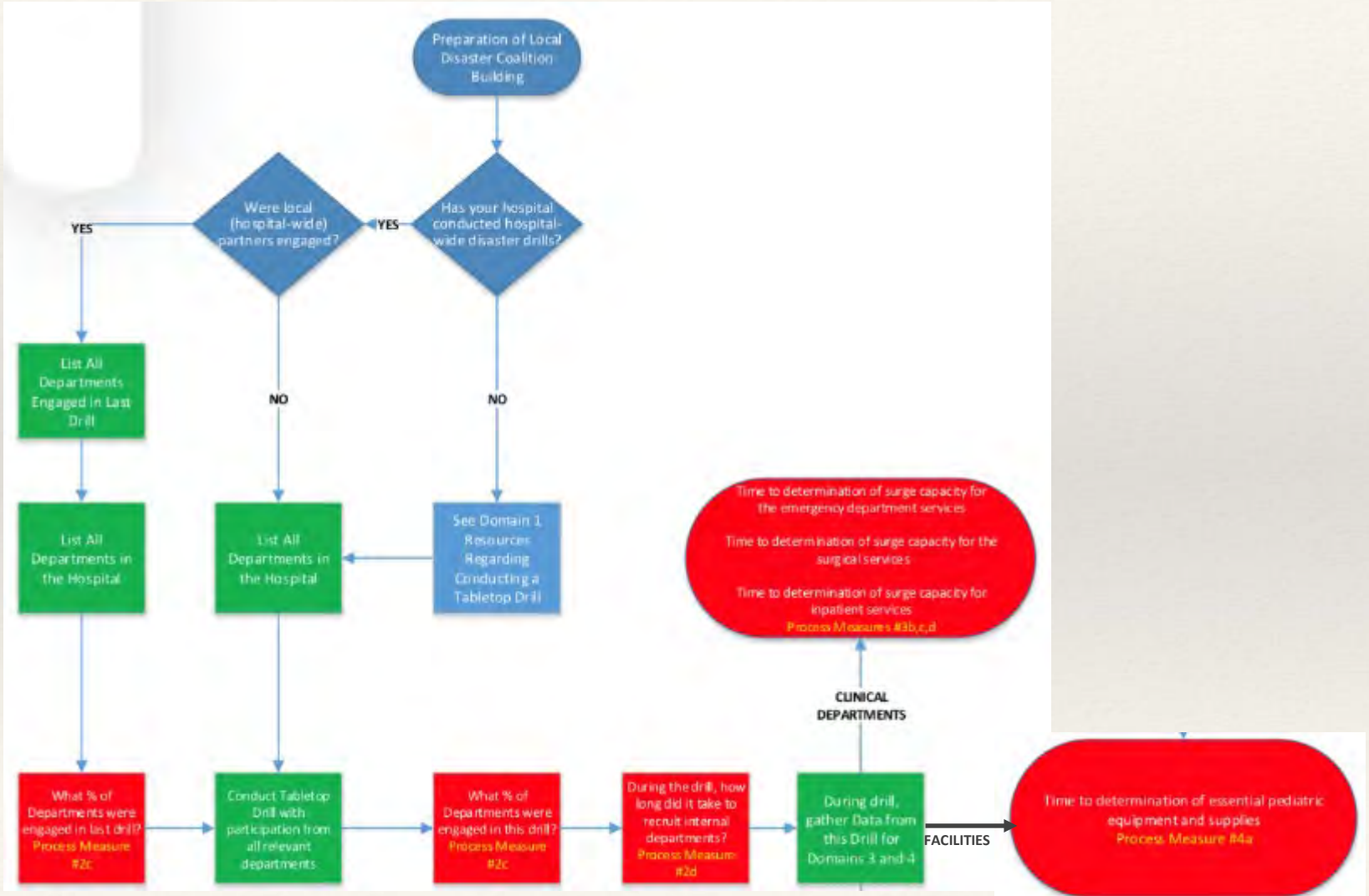
Were the Drill Objectives Achieved?

The objectives were achieved and areas of improvement were identified in multiple areas.

Were the Hospitals Plans Effective?

The hospital plan were implemented with, our usual improvisations for unique circumstances. The plans for PICU surge and the hospital wide plans will be revisited to make them more user friendly.

DOMAIN 2


Preparation of Local Disaster Coalition Building
Has your hospital conducted hospital-wide disaster drills?
YES
Were local (hospital-wide) partners engaged?
YES
NO
NO
List All Departments Engaged in Last Drill
List All Departments in the Hospital
List All Departments in the Hospital
See Domain 1 Resources Regarding Conducting a Tabletop Drill
Time to determination of surge capacity for the emergency department services
Time to determination of surge capacity for the surgical services
Time to determination of surge capacity for inpatient services
Process Measures #3b,c,d
CLINICAL DEPARTMENTS
What % of Departments were engaged in last drill? Process Measure #2c
Conduct Tabletop Drill with participation from all relevant departments
What % of Departments were engaged in this drill? Process Measure #2c
During the drill, how long did it take to recruit internal departments? Process Measure #2d
During drill, gather Data from this Drill for Domains 3 and 4
FACILITIES
Time to determination of essential pediatric equipment and supplies
Process Measure #4a

DOMAIN 2

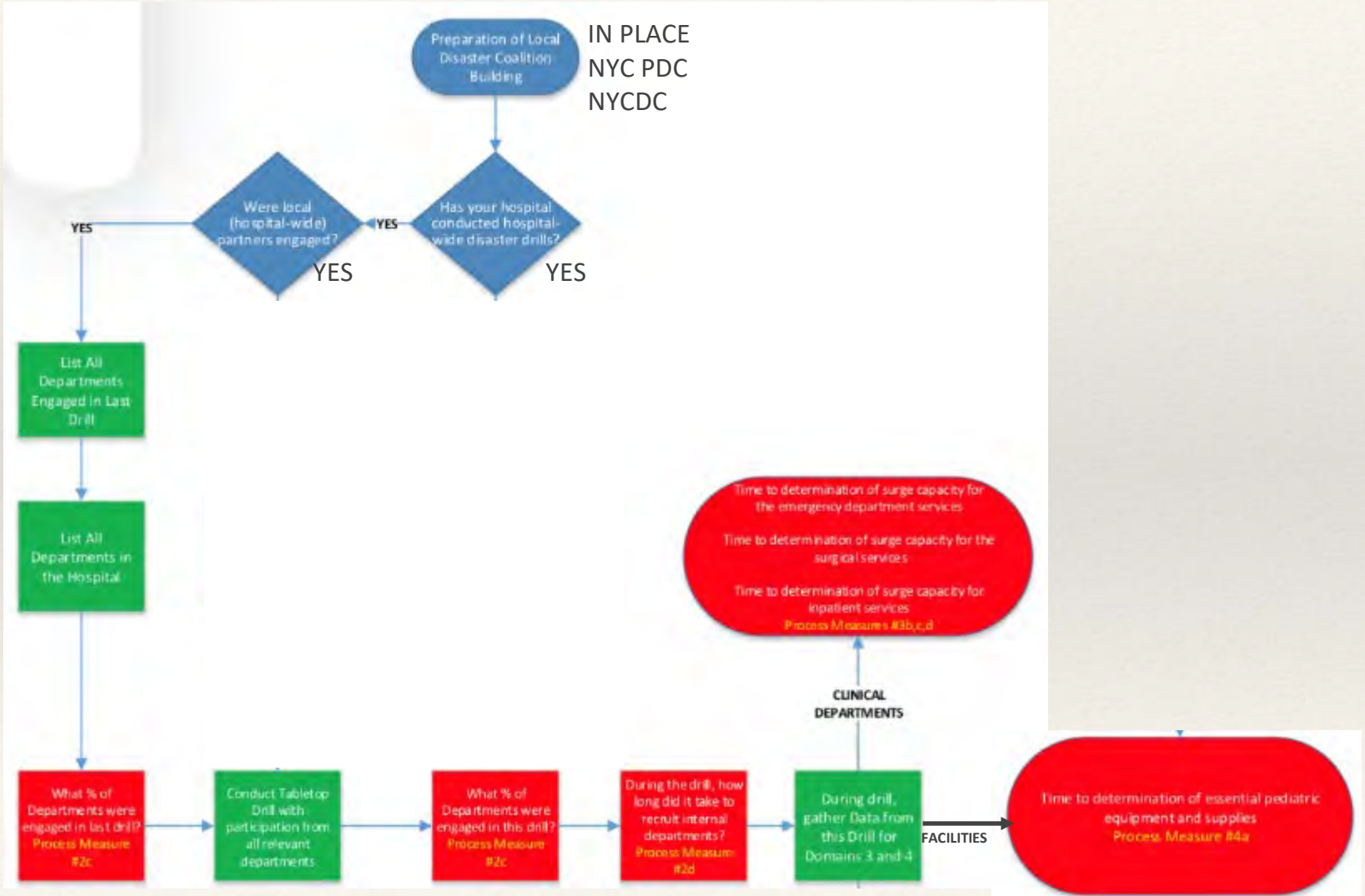
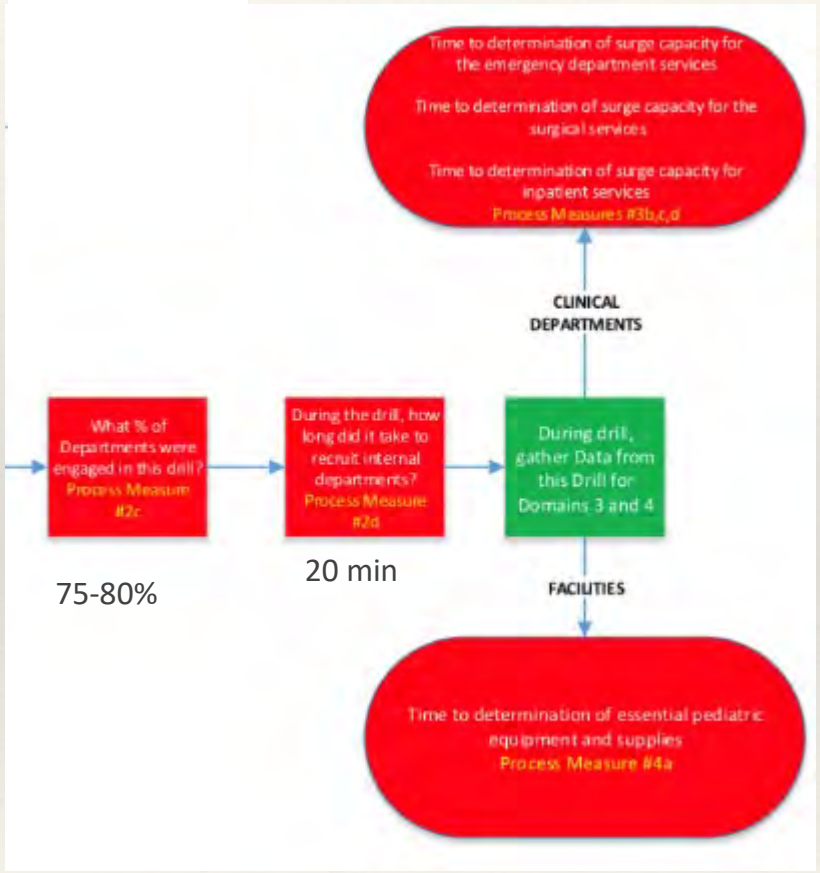

Preparation of Local Disaster Coalition Building
IN PLACE
NYC PDC
NYCDC
Has your hospital conducted hospital-wide disaster drills?
YES
YES
Were local (hospital-wide) partners engaged?
YES
YES
List All Departments Engaged in Last Drill
List All Departments in the Hospital
Time to determination of surge capacity for the emergency department services
Time to determination of surge capacity for the surgical services
Time to determination of surge capacity for inpatient services
Process Measures #3b,c,d
CLINICAL DEPARTMENTS
What % of Departments were engaged in last drill?
Process Measure #2c
Conduct Tabletop Drill with participation from all relevant departments
What % of Departments were engaged in this drill?
Process Measure #2c
During the drill, how long did it take to recruit internal departments?
Process Measure #2d
During drill, gather Data from this Drill for Domains 3 and 4
FACILITIES
Time to determination of essential pediatric equipment and supplies
Process Measure #4a

TABLE TOP DRILL: DOMAIN 2

- Pediatrics (ED/Peds/PICU/NICU/Outpt)
- Surgery (Peds/Trauma/Vascular/Ortho/SICU)
- Medicine (ED/General/MICU)
- Radiology (Gen/IR)
- Psychiatry
- Nursing/Emergency mgt
- Ancillary services (Security/Nutrition/Environmental/Engineering

75%

TABLE TOP DRILL: DOMAIN 2



- 15 mins all
- 20 mins

HOT WASH

- Over all score **86%** goal 90%

ICC

- Disaster plan was not used as a reference
- Good communication between staff in the ICC
- When families arrived was the family support center set up as per plan?
- What about the media?
- The IC left the room; there was no handoff of command
- Is there a hospital policy about keeping parents with their children?
- Organizational structure of command in the ICC not easily recognized. Where were logistics, planning and operations?
- Information sharing with the staff outside f the ICC
- Psychiatric support should have responded immediately
- Staffing officer should be activated
- Pre-scripted messages needed
- Email may not be the most efficient means of communications during a incident
- Plan - Check list and critical telephone numbers
- We rise to the occasion
- Focus on staff was not evident

HOT WASH

- Over all score **86%** goal 90%

PICU

- Overhead page was not heard
- The team leaders (MD and Charge Nurse) worked well
- RNs communicated "up-line" for needs
- There was a real world event during the drill
- Unit could use a white board for patient status
- One patient transferred to pediatrics without report
- PICU Staff could have gone down to the ED to assist and take patients up
- Joint plan for adult, pediatric and neonatal patients
- Job Action Sheets
- Sign out sheets

Pediatrics

- Nursing leadership and medical staff were duplicating efforts, not communicating
- Immediate dedicated support staff
- Discharge rounds were done earlier
- Where could the discharged children go?
- Also need just in time training for hazmat and Decontamination in PICU.

HOT WASH

- Over all score **86%** goal 90%

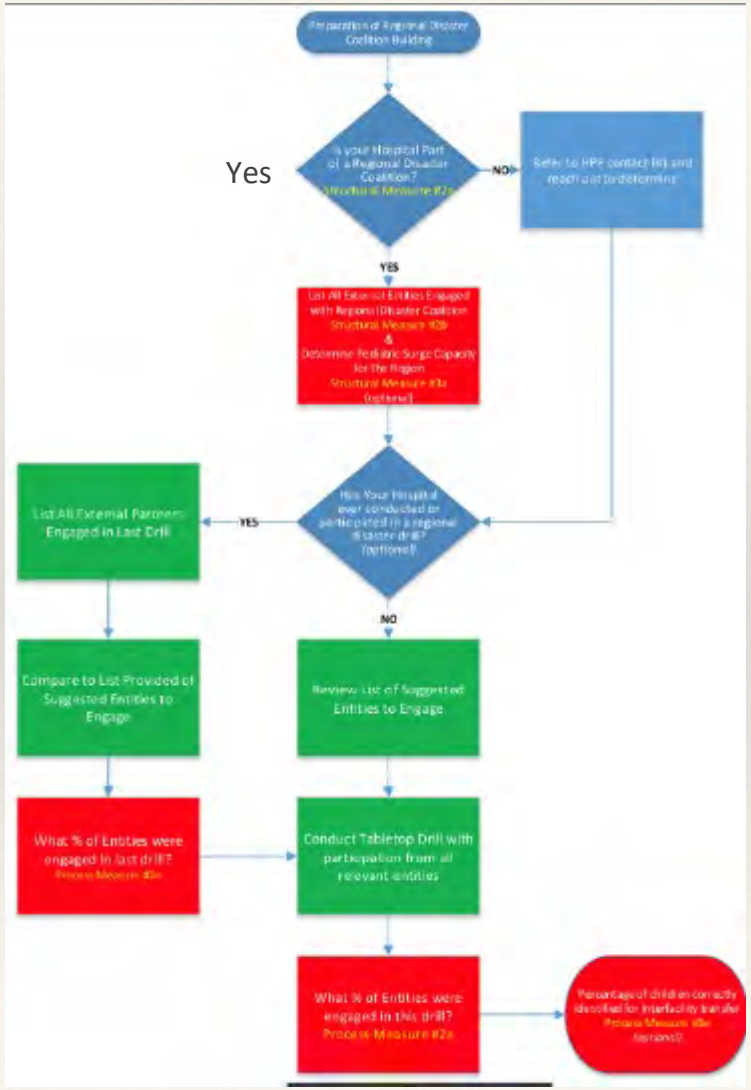
ED

- Crowd control needed to prevent the bottlenecks that occurred
- Recorders for charge nurse
- Runners for the ED
- Patient tracking system
- Cohort critical Patients
- Involvement of the Department of Surgery
- Support Staff
- PPE not used
- Need multiple disaster carts
- Separate command section for the ED
- RPD done well
- ED IC was overwhelmed
- Need 2 way radios
- Need more ICs
- Triage went very well
- Job action sheets
- Needed more controllers, observers and evaluators
- Having a doctor and nurse team at triage was excellent
- No coordination of personnel doing treatment in the different areas in the ED
- EMS needs to be kept out of the EDs during disasters the forward triage idea works
- Just in time training sheets for the treatment of injuries related to specific incidents. Example: blast injuries, organophosphate poisoning and radiation exposure
- Process for the "trauma team"
- Overhead page hard to hear
- EOC telephone number was not available

ED - Radiology

- Residents were available but underutilized
- Overhead speaker system not functioning properly

DOMAIN 3

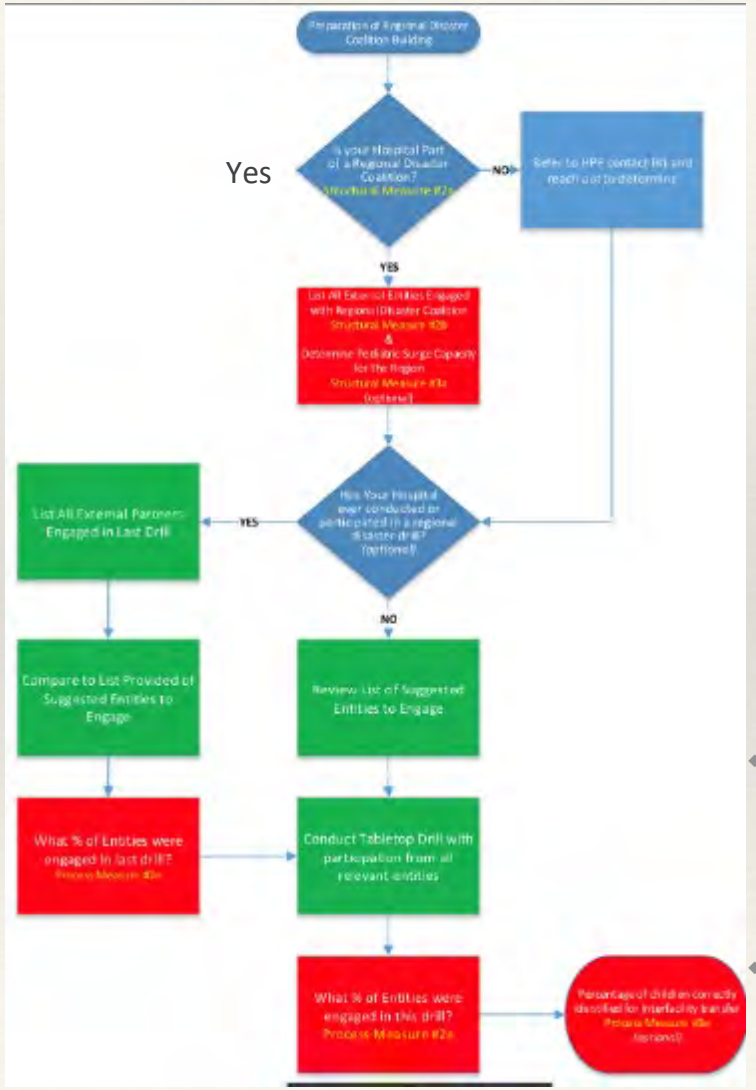


- Tier 1 & 2 hospitals
- FDNY/EMS
- Emergency Mgt
- GNYHA
- HHC

Rapid Discharge Drill

- 4/4/18
- Internal Surge Drill
  - City wide (receiving facility for other hospitals if needed)
  - Hurricane prep drill
  - Identified 15 of 20 RD PED pts, 1 rapid admit
  - Identified 4 of 8 PICU downgrades
  - Identified 8 of 20 RD Peds floor pts
  - NICU notified and evacuation plan activated

DOMAIN 4



- Pediatric equipment/supplies drill needed (Domain 4)
- Need to repeat major drill

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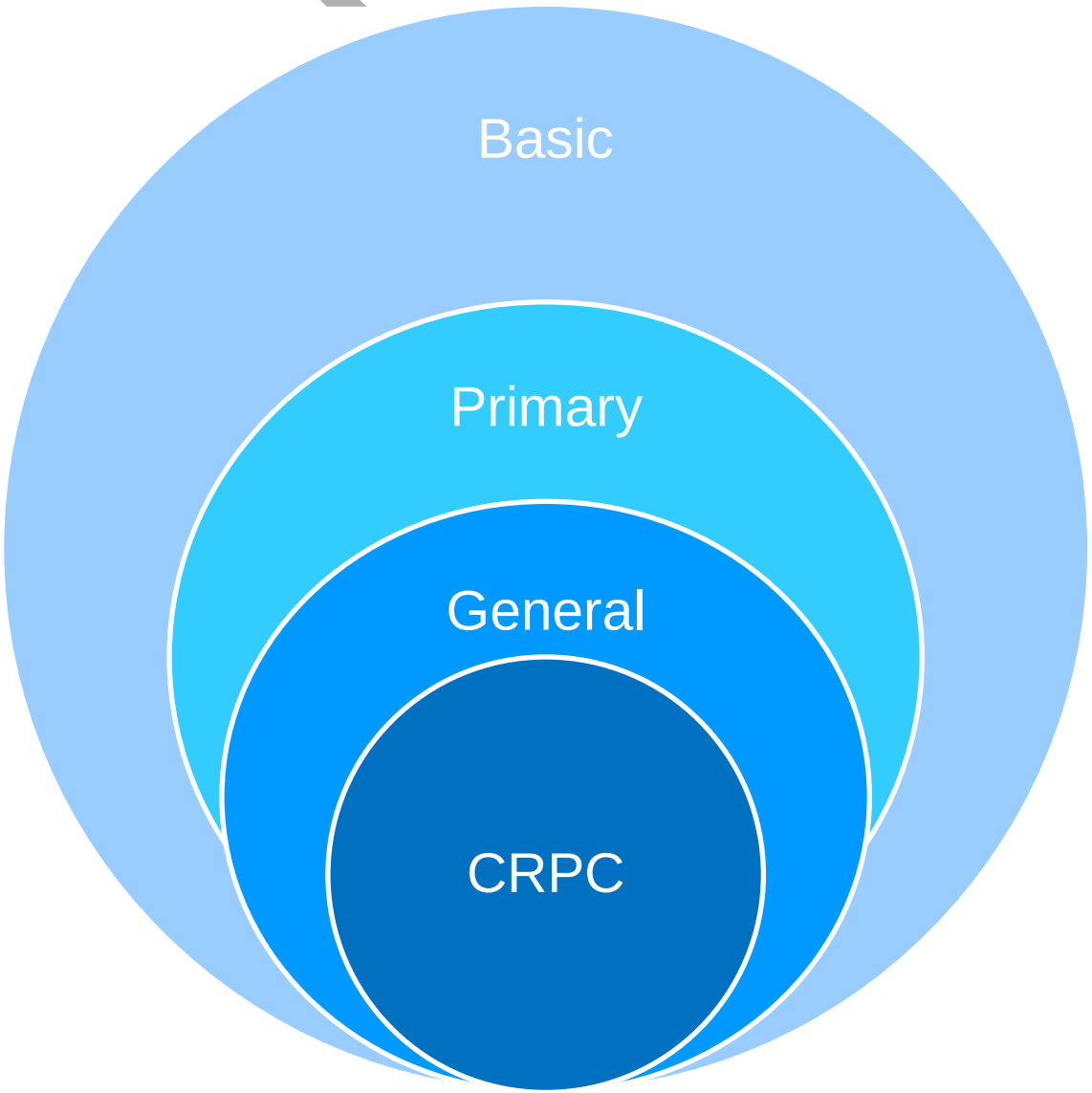
Ensuring Emergency Care for All Children

Vols for Kids!

Oseana Bratton BSN, RN, CPEN, CHEP
East Tennessee Children's Hospital
Pediatric Outreach Coordinator

Vols for Kids!

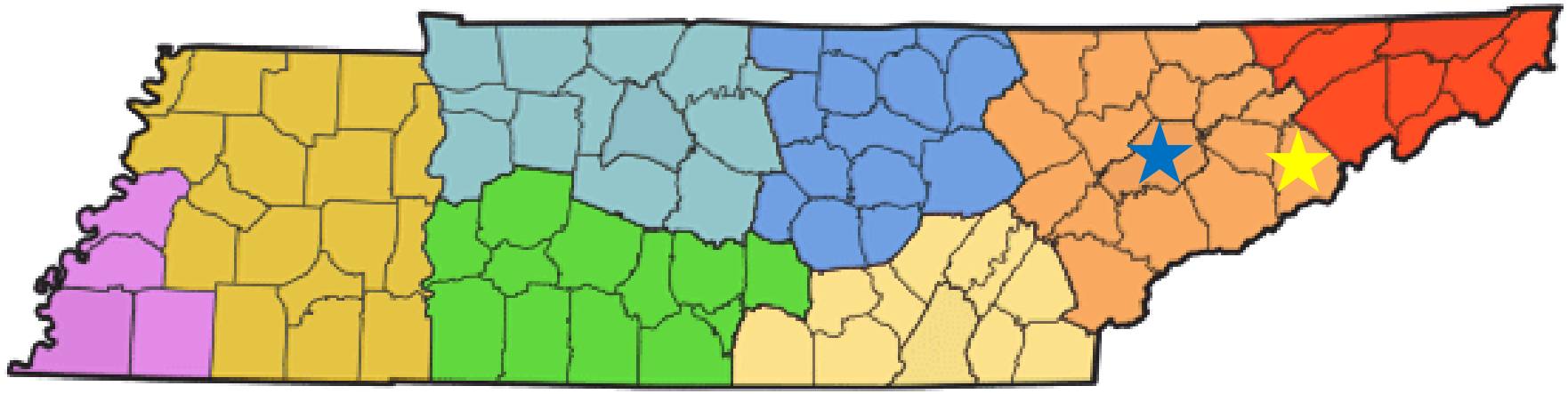
- Members include:
  - Oseana Bratton
  - Stephanie Guymon
- Team Organization
  - TN State Pediatric Emergency Care Facility partners



Vols for Kids!

- General facts about your team
  - 3 → 1 affiliates
    - **Stephanie Sneed & Lisa Boggs**
      (Newport Medical Center)

- Affiliate Characteristics
  - General Emergency Care Facilities (Basic)
  - Suburban Hospital (ETCH)
    - County Population: 460,000
  - Rural Hospitals (Affiliates)
    - County Population : 35,000
    - Ground Transport: 1 hour



Vols for Kids!

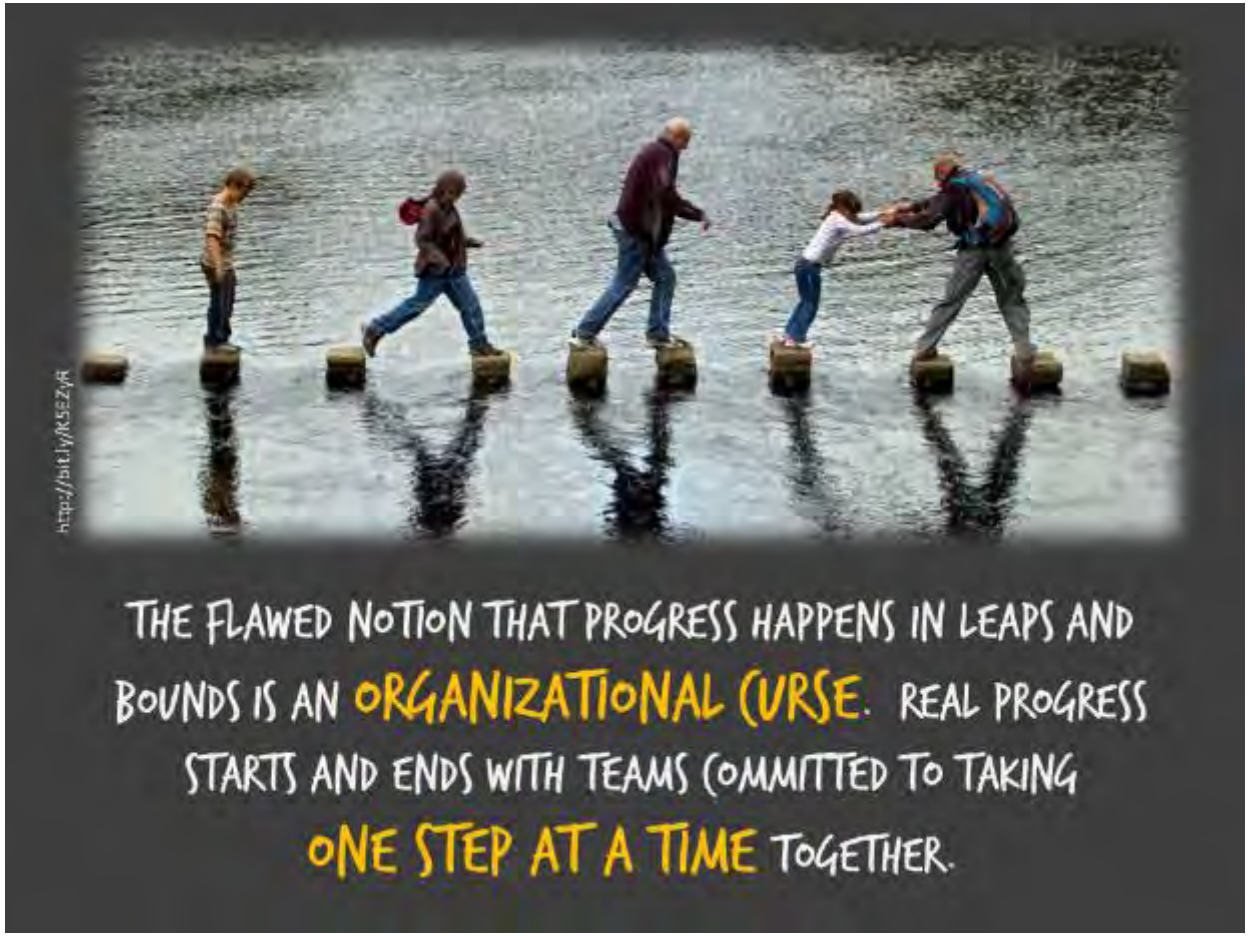
- General facts about your team
  - 12-16 beds (affiliate), 34 pediatric specific beds (training)
  - % Pediatric Patients:10-20% (affiliate), 99.9% (training)
  - 89 – Tennessee Overall Readiness Score
  - Common Gaps
    - Weights in kilos
    - Transfer guidelines
    - General pediatric knowledge
  - Intervention bundle selections being considered by facilities
    - Weights in kilos (Affiliate)
    - Escalation of vital signs (Training Site)

Preparing for Launch

Complete the launch grid below with your team's progress

Hospital Name	Site Type – Training/ Affiliate	NPRP Assessment Completed	Environmental Scan Completed	QI & Data Stewards Identified	Data Use Agreement in Place
East Tennessee Children's Hospital	Training	Yes	No	Oseana Bratton Stephanie Guymon	Yes
Newport Medical Center	Affiliate	Yes	Yes	No	Yes

Team Philosophy and Goal(s)



Barriers and Enablers to PRQC Success Identified

- Barriers
  - Time/Scheduling
    - Scheduling conflicts with learning sessions
    - Competing priorities
  - Resources (People & Equipment)
    - Manual chart reviews
    - Scales
      - Detecto Brand Model 750 & 758c
  - Communication

Barriers and Enablers to PRQC Success Identified

- Enablers
  - Mentor phone calls
  - Persistence
  - Celebrating small successes

UC DAVIS HEALTH

Pediatric Readiness Quality Collaborative Fight or Flight Response Team

MEDICAL CENTER

Sarah Haynes, PhD MPH, Project Manager

Julia Magaña, MD, Trainer

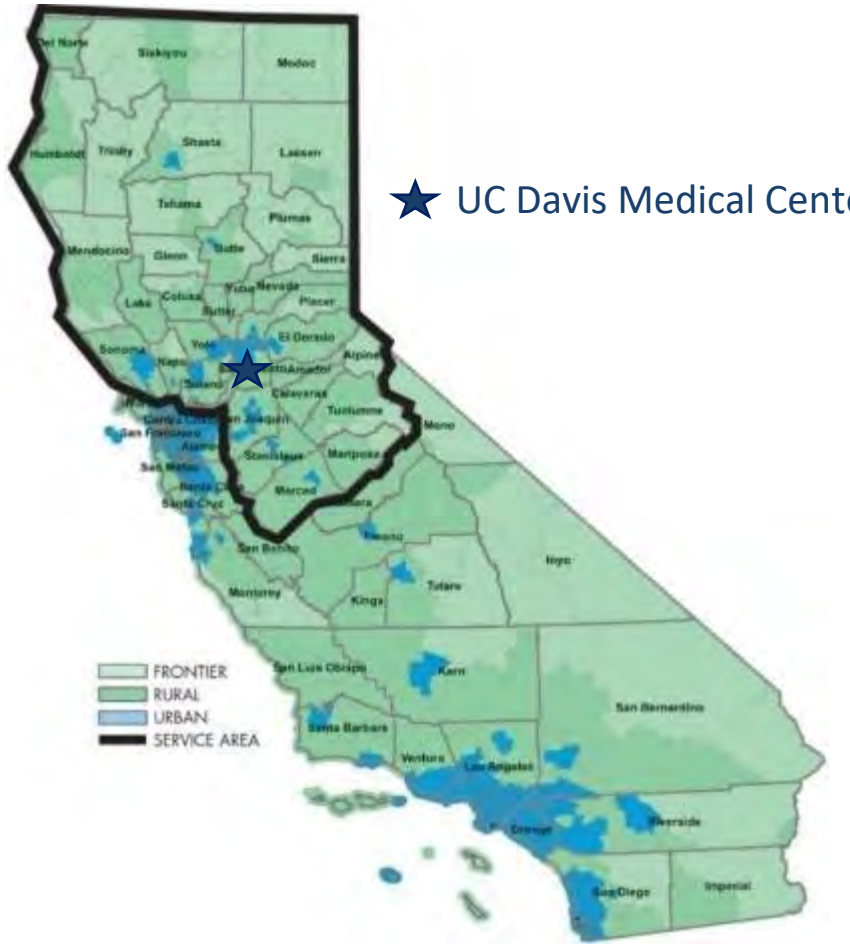
Jacqueline Burgard, RN, Trainer

The Fight or Flight Response Team – Training Team

- **UC Davis Medical Center**
  - 625-bed academic medical center
  - Serves 33 counties, 6 million residents, across 65,000 square miles
  - ~80,000 ED visits annually

    ~18,000 pediatric ED visits

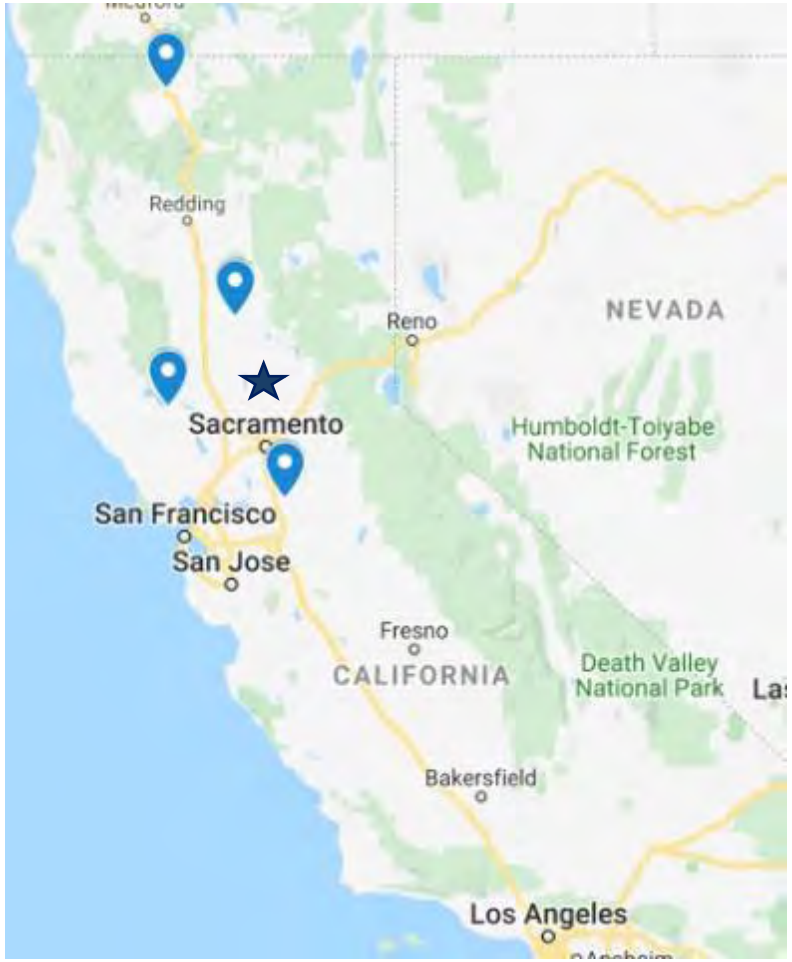
- **UC Davis Children's Hospital**
  - 129-bed children's hospital
  - Not a stand alone
  - Level I pediatric trauma center



The Fight or Flight Response Team

- **Training Team - UC Davis Medical Center:**
  - Jacqueline Burgard, RN, Trainer
  - Julia Magana, MD, Trainer
  - Sarah Haynes, PhD MPH, Project manager

- **Affiliate Sites (N=4):**
  - Adventist Health Clear Lake
  - Adventist Health Lodi Memorial
  - Enloe Medical Center
  - Fairchild Medical Center



The Fight or Flight Response Team

Affiliate Hospital Characteristics	
Rural Status, N	
Urban	2
Rural	2
Facility Type	
General	2
Critical Access Hospital	2
Licensed Beds, Median (Range)	
Hospital Beds	111 (28, 228)
ED Beds	18 (8, 41)
ED Volume, Median (Range)	
Annual ED Visits	36,169 (11,787, 71,000)
Annual ED Peds Visits	7,328 (2,282, 12,632)

Preparing for Launch –

Hospital Name	Site Type	PR Survey (NPRP Assessment)	Environ. Scan	QI & Data Stewards	DUA
UC Davis Medical Center	Training	Yes	N/A	N/A	N/A
Adventist Health Clear Lake	Affiliate	Yes	Yes	Wendy Bisaccio Jennifer Buller	Yes
Adventist Health Lodi Memorial	Affiliate	No	Yes	Kristy Reed Megan Bayrouty	Yes
Enloe Medical Center	Affiliate	Yes	No	Jennifer Morabito Jade Vernau	Yes
Fairchild Medical Center	Affiliate	No	No	Kristy von Saltza Ann Marie Moser	Yes

Sampling and data submission

- Sampling strategies
  - 2 sites using random sampling strategy
  - 2 sites reviewing all pediatric charts

- Approach to data submission
  - Data submission occurring in increments
  - Chart review scheduled between interventions to allow for change between data submissions

Selected change strategies

- Vital signs policy
  - Full set of vitals
  - Abnormal vital signs
  - All sites
- Education
  - Monthly newsletters posted in bathrooms and nurses stations
  - Education at staff meetings and during huddles
  - Emails notifying/reminding staff about policies and changes
- Improving capacity
  - Badge buddies: all sites
  - Developing or better utilizing notification systems

Challenges

- ONE single (very busy) person per site
- EMR thresholds and notifications
- IT resources to assist with notification systems
- Lack of documentation
- Ownership over vital signs
  - Example: If unable to get a vital sign in triage, who eventually takes responsibility for getting the vital sign documented later?

Thank you!

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Team #2

LifesavERsTeam

SSM Health Cardinal Glennon Children's Hospital St Louis Missouri

Timothy Staed, MD Physician Champion EMSC PRQC
Mary Bixby, RN Nurse Champion EMSC PRQC
Terry Cueller, RN Nurse Champion EMSC PRQC

LifesavERsTeam

LifesavERs Update 11/2019

Lessons Learned

LifesavERsTeam

Persistence Pays Off

1. Stay in contact with your hospitals
2. Ask questions of collaborative and group leader (Diana Fendya is the BEST!)
3. Participate in national meetings

LifesavERsTeam

This is a marathon – and a sprint

1. Sprint to the end of each goal – finish each ASAP (DUA's, PDSA cycles, Change strategies, etc)
2. Keep in mind the BIG picture – long term goals and agendas of each group

LifesavERsTeam

Be Supportive

1. Offer help guidance encouragement to each group.
2. Each hospital is like one of your children. Each one needs different support and guidance

LifesavERsTeam

Celebrate the victories

1. Each hospital has its own victories - this takes LOTS of hard work by people who do not necessarily have extra time for more hard work.
2. Celebrate the victories – because each one is a win for pediatric patients across the country

Heartland Regional Medical Center
Marion, Illinois

Patient Tracking, Information, Reunification and Notification Plan

Information and Notification Center

- Location ¼ mile off campus with transport available. (golf carts & hospital vehicles)
- On campus.
- MOU’s with local health department and a state funded mental health resource center for mental health professionals to be present and assist with notification.
- 2-way radio & AT&T FirstNet communication capabilities
- Staffed using non-essential admitting/registration/case management personnel. No longer considered as part of the labor pool to ensure operability.

Heartland Regional Medical Center

Family Information and Reunification Center
Information log

Name: _____ Patient name: _____

Relationship: _____ Verify Identification?_____

Emergency Contact Information_____

*Include time stamps on **all** notes.

Notes.:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name:

Date:

Facility:

Identification

- Cannot rely on all pediatric patients to be verbal, reliable, capable or conscious.
- Digital camera with designated SD card and photo printer.
- Photo of face or identifiers including scars, birthmarks, etc. Photo must also include triage number.
- Place photo on wall in Information and Notification Center.
- Ask attendees if they recognize the photo as their loved one take the picture and bring it to the information desk.
- Use the triage number in the photo to request information.
- Transport to hospital is available.

Tracking

- ER Physician, ER Charge & Patient Tracking at ER entrance. (additional physician or mid-level, RN & patient tracking sent to ER waiting room entrance, if needed)
- Patient Tracking notes all information available without interfering in the assessment/triage process. Photo taken at that time, if needed.
- Patient Tracking staff, not at triage entrances, will periodically collect forms from triage area. Those are referred to as ‘Tracking Floaters’.
- Tracking Floaters are trained to walk around with their forms and update the information on the patient so it is as current as possible. **THAT IS THEIR ONLY JOB**.
- Each department moved to paper charting, temporarily. We did that not only to make tracking more efficient, it isn’t reality that clinical staff will be able to chart electronically.

Patient Tracking

- The Triage Tag number can be found on the top right corner **OR** the last 4 digits of any barcode on the tag.
- If the patient is unconscious and you have no name use any identifier(s) you can to distinguish the person.
- If you do not have a DOB and the patient is unconscious estimate the age with " ~"
- If someone reaches out to the Emergency Contact put down **WHEN** that was done in the narrative and if they were contacted.
- Complete narratives in order of events.
- If the patient is transferred we need to know **WHERE, WHEN** and **BY WHOM**!
- If the patient went for testing/treatment/surgery in the hospital we need to know **WHEN** and what type of testing or treatment (CT/MRI, etc.).
- If you are receiving information from an individual instead of looking at a paper chart we need to know **WHO** gave you the information.
- All times are to be noted in 24-hour, commonly known as 'military time'.

Name/Identifier: _____ Sex: _____ (M/F) Age/DOB: _____

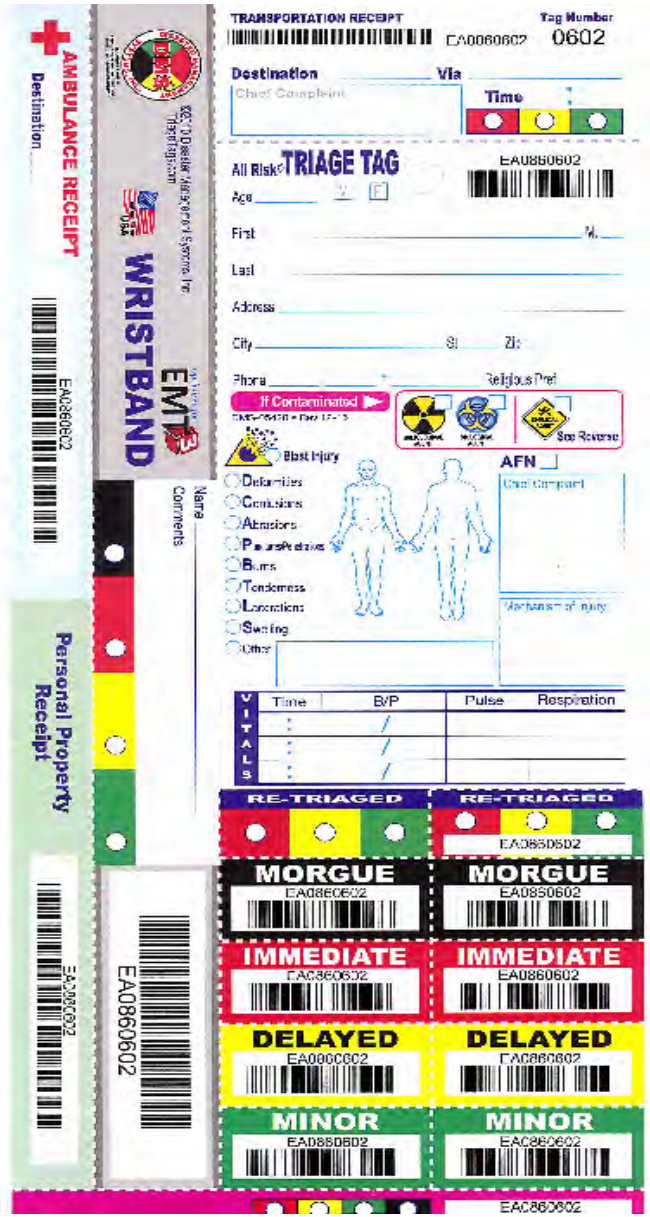
Arrival Time/Date: _____ (HH:MM) Triaged to where? _____ (ER, SDS, RR, etc.)

Initial Triage Color/Category: _____ (Green, Yellow, Red, Black)

Emergency Contact Information: _____

Time: HH:MM	Note:
___:___	_____
___:___	_____
___:___	_____
___:___	_____
___:___	_____
___:___	_____
___:___	_____
___:___	_____
___:___	_____

Tag #; top right/last 4 digits of bar codes
Transportation receipt
Wristband
Personal Property
Ambulance
Status
Bar Codes



Process

- Identified as a challenge in a small, functional exercise.
- Critical needs identified (Information Center, designated trackers, resources/forms)
- Designed using input from stakeholders (Information Center staff & Patient Trackers)
- Drilled & redesigned, as needed. Total of 3 drills and redesigns were done to meet the needs and requests of staff. Important that the process is user friendly and the users are comfortable.
- Exercised. City-wide, full-scale, active-shooter exercise. Shooter at the Jr. High. Used nursing students from local community college as victims.
- Successful

Contact

Nikolas Fort

Emergency Manager

Heartland Regional Medical Center

3333 West DeYoung Street, Marion, IL 62959

Phone: 618-998-7366

Cell: 618-922-2921

Email: Nikolas_fort@quorumhealth.com

National PRQC
Pediatric Readiness Quality Collaborative
Ensuring Emergency Care for All Children

- Team 5 Lone Star Kids
- Presenter- Ashley Yount MSN, RN, CPN
- Team Trainer and HCA Pediatric Network Coordinator

Lone Star Kids

- Medical City Children's Hospital is the training facility for team.
  - Ashley Yount, Pediatric Network Coordinator, Team Trainer, Pediatric Champion and Data Steward.
  - Collaborates with all units within the Children's Hospital to ensure that the patient is getting the best care.
  - Works with pediatric educator and pediatric quality coordinator to enhance pediatric education and measure pediatric metrics for better outcomes.

Lone Star Kids

- Facts about Lone Star Kids
  - 22 Affiliates- 13 General Hospitals, 9 Free Standing Eds. Medical City Children's Hospital only facility with in-patient pediatric unit and pediatric intensive care unit. Level 2 Pediatric Trauma Center - New Heart and Spine Hospital in Dallas, 2 new FSED.
  - Cogdell Memorial Hospital only facility not within HCA North Texas Division. Rural hospital in Snyder, Tx. Average pediatric volume per year averages at most 1800. Rural community hospital.

Barriers and Enablers to PRQC Success Identified

- The common challenges identified by affiliates have been related to pediatric supplies, pediatric education and clinical competencies, child life resources for pediatric population, nurse and leadership turnover in the ED.
- Successful strategies- development of child life resource book for all facilities, development of core pediatric nurse internship at MCCH (classes open to all employees in network), standardizing all policies for all facilities to have same care for pediatrics. Division new hire pediatric lecture and skills day during new nurse internship orientation.

Pearls of Wisdom or Best Practices

Best Practices-

Co-Branding all training and policies for the division

Collaboration with Pediatric Medical Director on each bundle and outliers identified immediately and resolved

Team focus on strengthening pediatric healthcare and comfort while visiting the emergency department

Take-Away

- Base-line data from Free-Standing EDs is usually a 30 patient pool varying between 1-3 months due to low pediatric volume.
- Missing 5-6 pediatric champions for the division. Team trainer has absorbed the load and works with ED directors for interventions for improvement for each bundle.
- Project is successful with a strong trainer and support from leadership team.
- Bundle 3 baseline and start date for December 1, 2019.

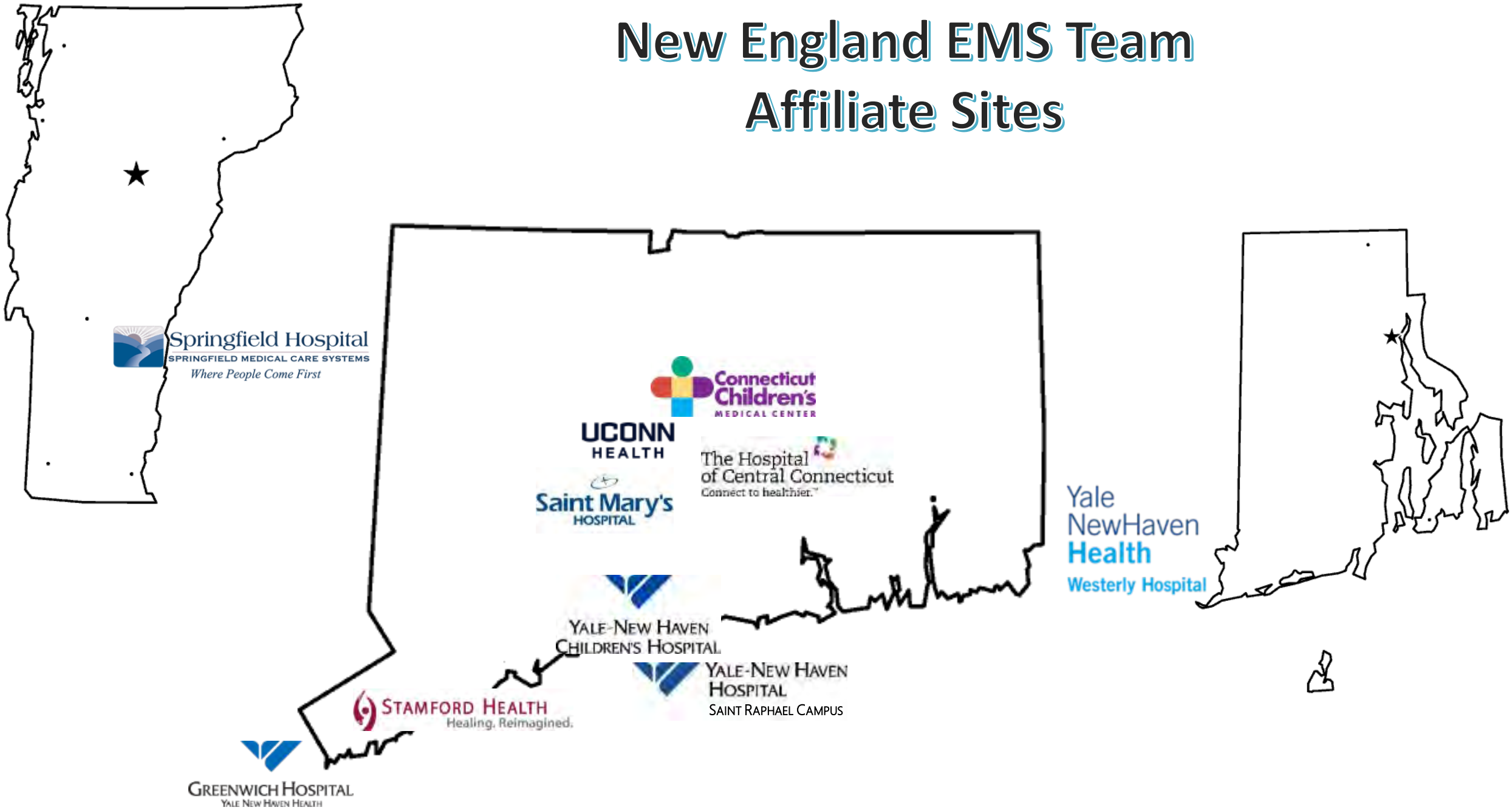
National PRQC
Pediatric Readiness Quality Collaborative
Ensuring Emergency Care for All Children

The New England EMS Team

Victoria Barnes, RN
Cristina Carusone-Biceglia
Michael Goldman, MD
Mariann Kelley, MD
Marc Auerbach, MD
Thomas Martin, MSN

Training Team Organization:
Yale-New Haven Children's Hospital
Connecticut Children's Medical Center

New England EMS Team
Affiliate Sites



Enablers and Barriers to PRQC Success

Enablers

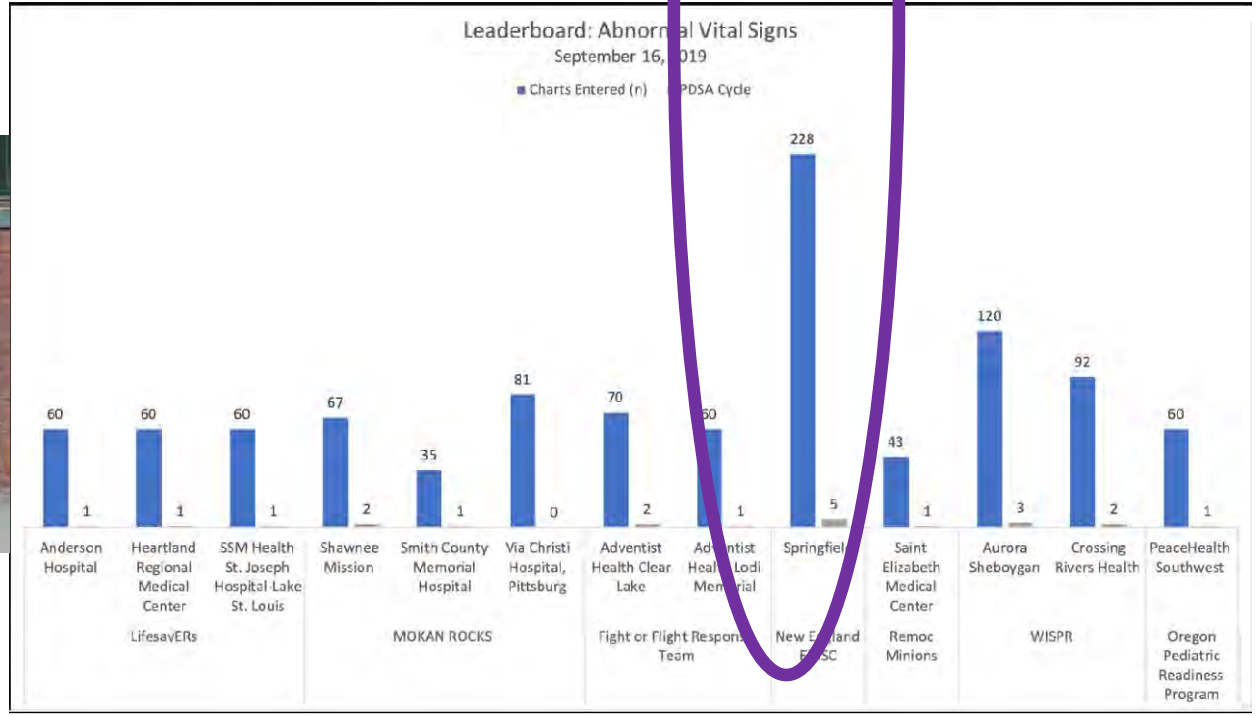
- EMSC-CT Rocks
- Victoria and Cristina
- Individual check-ins (video, email or in-person)
- QI via individual AIMs
- Real deal Peds champs!

Barriers

- Team personnel turn-over!!!
  - Mergers, new roles, etc…
- Data entry website saga
- Meeting participation
- Maintaining momentum
- QI intimidation / overload

3 Che
NPQRC

Springfield Hospital



SPRINGFIELD HOSPITAL

Peds Champs!

Pediatric Emergency Care Coordinator: Laura Sichling, BSN, RN

ED Nurse Manager: Catherine Howland, BSN, RN

Special Recognition: Springfield Hospital

Laura Sichling, BSN, RN takes on role of *Pediatric Emergency Care Coordinator* in 2018 under direction of ED Manager, C. Howland, MD

Goal –

To improve overall capacity and comfort with caring for pediatric patients in the ED.

Challenges to our Medical System –

- Last 12 months, 40+ positions were removed for budget cuts
- Emergency provider staffing group changed
- Childbirth center closed
- Filed for bankruptcy

Perseverance –

- Springfield is a rural, critical access facility.
- This collaborative has been incredibly useful for us, with our institutional changes we have endured.

TIMELINE OF PROGRESS – ADDRESSING BUNDLES 1 AND 2 AND 3!!!

FALL 2018 - *Staff Skills Day Session*

SPRING 2019 - *Baseline Data Entry Guiding Initial Interventions*

Baseline data entered into PRQC data system using 30 randomized charts from 2018—

- **AREAS OF IMPROVEMENT IDENTIFIED:** pain scales/assessment, notification procedures for abnormal VS, *no* minimum transfer criteria existing, weight measurements (both lbs and kg)

SUMMER 2019

- ***Policies drafted:*** *EMR Optimization, Inter-Facility Transfers, Red Flag VS & Notification Procedures*
- ***Staff Education:*** *weight policy, pediatric documentation, pain scales & implementation into practice*

FALL 2019 *(Current)*

- ***Policy Drafting:*** *Glasgow Coma Scale*
- ***Staff Education:*** *pain scales, medication calculation, febrile seizure pathway, SIMBOX enrollment and introduction*

Winter / Spring (Next Steps)

- **Multiple neonatal resuscitation trainings (ACEP SIMBOX)**
- **"Direct bedding' initiative with *bedside triage of all patients***
  - *Focused reminders for pediatric triage*
- **A clipboard back was created and placed on the backs of all individual treatment room clipboards;**
  - *Pain assessments (FLACC, FACES), weight conversions, and normal VS and parameters*
- **Resource sharing and local adaptation in partnership with the VT Dept. of Health, EMS Program Manager for Children**

Springfield Hospital—Weight in Kilograms

- **Initial AIM(s)/Goal(s)** –

  By December 2019, *85%* of pediatric patients presenting to the Emergency Department will have a weight documented in kilograms only upon arrival.

- **Baseline Data** –30 randomized charts from the year 2018 with sample including all *current staff members* at that time; *one ED campus only.*

  – **0% total compliance**—(all weights obtained in *BOTH* lbs and kg)

- **Interventions** – PDSA Cycles #1-#6
  - Equipment availability;
  - Staff education;
  - Policy drafting/review;
  - Compliance auditing & follow up

- **Post-Intervention Data –**

  – **72% compliance!!!**

Springfield Hospital—Abnormal Vital Signs

- **Initial AIM(s)/Goal(s)** –
  I. By December 2019, *80%* of pediatric patients presenting to the Emergency Department will have a pain assessment performed at triage.
  II. By December 2019, *75%* of abnormal VS obtained on pediatric patients upon triage will be reported to providers.
- **Baseline Data** –30 randomized charts from the year 2018 with sample including all *current staff members* at that time; *one ED campus only.*
  - **35% total compliance**
- **Interventions** – PDSA Cycles #1-#6
  - Equipment availability;
  - Staff education;
  - Policy drafting/review;
  - Compliance auditing & follow up
- **Post-Intervention Data –**
  - **61% compliance!!!**

Local Lessons Learned - Springfield

- **PROS –**
  - Providers and RNs **all** willing to participate
  - Development of regional & pre-hospital relationships
  - Opportunity to educate
  - Pediatric specific focus in lieu of our Childbirth Center closing and on call Pediatricians no longer available

- **DELTAS –**
  - Staff turnover
  - Subjective interpretation of pain scales—do we all interpret them the same?
  - VS obtained—accurate/inaccurate?
  - Mid-day team meetings
  - Lengthy data entry process

HOSPITAL OF CENTRAL CT

Peds Champs!

Ewelina Ledas, BSN, RN

Michelle McDade, MD

Allison Fangiullo, BSN, RN

Hospital of Central CT – Vitals Signs

- **Initial AIM/Goal** – By December 2019, 90% of pediatric patients with ESI level 1,2, or 3, will have all five vital signs documented in the triage note

- **Baseline Data** – 2 hospital campuses, sampled based on weighted pediatric volume at each location
  - 43% total compliance
- **Interventions** – PDSA #1
  - Equipment availability;
  - Staff education;
  - Compliance auditing & follow up

- **Post-Intervention Data –** 2 hospital campuses, sampled based on pediatric volume at each location
  - **93% compliance!!!**

Local Lessons Learned - HOCC

- **PROS –**
  - Providers all in!
  - Identified patient safety concerns
  - Patient Handoff Improved
  - Opportunity to mentor
  - Development of regional relationships

- **DELTAS –**
  - BPs accurate / needed?
  - Cumbersome data entry process
  - LOTS of calls…

ROLL CALL – NE EMSC, TEAM7

Progress

Site	Pediatric Champions	Bundle	Update
Greenwich Hospital	Seth Woolf, MD Jennifer Burns, RN Carly Giacomo, RN	Vital signs	• ***AIM – increase provider awareness and notification of abnormal VS*** • Chart selection used: picked a month of the year and the search criteria was to select every 5th patient out of the patient list for patients 20 years old and below • Interventions – VS cards, EPIC utilization, Staff meetings / education • Challenge – Staffing changes, EPIC documentation in 3 ways to say same thing • Baseline = 3% documented communication re abnormal vs
Hospital of Central Connecticut	Michelle McDade, MD Ewelina Ledas, RN Allison Fangiullo, RN	Vital signs	Superstars
St. Mary's Hospital	Karl Hellstrand, MD Lisa Roy, RN	Vital signs	• Completed the first PDSA cycle • ***Shows great improvement in entering weights in KG*** • Changed policy for obtaining weights which will hopefully increase our % in kg even further. • Dr. Hellstrand, nurse educator and nurse manger are entering the data • There continue to be changes in ED staffing so he is the most consistent presence
St. Raphael's Campus	Thomas Balga, PA Emily Scarpetti, RN	Disaster Preparedness	***The team has been compiling disaster resources and sharing across the Health System:*** • http://intranet.ynhh.org/hsc/disasterpreparedness/Pages/default.aspx • http://intranet.ynhh.org/hsc/disasterpreparedness/Pages/Vulnerable-Populations.aspx • https://ynhh.ellucid.com/documents/view/32992/88330/ • Actively working on vital signs by reviewing reports generated regarding pediatric vital signs and getting all children under the age of six into pediatric gowns and weights in kilograms.

Site	Pediatric Champions	Bundle	Update
Stamford Hospital	Heather Machen, MD Magda Bayoneta, RN	Disaster Preparedness	• Roles / responsibilities of a pediatric disaster coordinator have been approved • Policy updates awaiting final approval • ***Coalition building with regional EMS crews, expanding RN capabilities, role of security*** • Surge capacity plans have been written, awaiting approval • Essential pediatric resources – food, vents, have been tabulated • Disaster triage process and decontamination procedure has been written • Family reunification plans also in the works
Springfield Hospital	Cathy Howland, ED Nurse Manager Laura Sichling, RN	Disaster Preparedness, Interfacility Transfer, Weight in Kilograms	NPQRC Superstars!!!
UCONN Health	Khalilah Hunter-Anderson, MD Shannon Curtis, RN	Interfacility Transfer	• ***Direct feedback for pediatric transfers to Connecticut Children's Medical Center*** • Infrequent transfers slows data collection process. • On average they transfer only about 3 to 5 patients per month. • Common transfer indications discovered - orthopedic injuries, abdominal pain/diseases, & respiratory illnesses. • On point with assessments with regards to the need for transfer, consultation and/or admission.
Yale New Haven Westerly Hospital	Emily Pelletier, RN Bethany Gingerella, RN	Vital Signs & Weight in kilograms	• ***Met goals as it relates to the Weights in Kilograms*** • Noted a deficit in escalation of vital signs • Currently working on continued recognition of abnormal vital signs and documenting escalation to a provider within the EMR. • Had some technical issues with logging into data system. • Now that it has been resolved, they are entering in data and are very interested in drilling down where the 35% medication errors exists so they can work to fix that.

Final Steps for Team NE-EMSC

- Ensure work is being documented in the data entry system
- Ensure colleagues are recognized at their institutions for their efforts locally, regionally and nationally
- Completion of NPRQC ☺
- MOC & CEU Process Clarified

- Continue w/ partnerships built through this initiative












November 19, 2019

Team Update

Oregon Pediatric Readiness Program

WHO ARE WE?

2 Training Sites and EMSC

- OHSU Doernbecher Children's Hospital
- Randall Children's Hospital
- Oregon Emergency Medical Services for Children Program

9 Affiliate Sites

- Adventist Health Portland
- Blue Mountain Hospital District
- CHI Mercy Health – Mercy Medical
- Kaiser Sunnyside Medical Center
- Legacy Silverton Medical Center
- PeaceHealth Peace Harbor Medical Center
- PeaceHealth Southwest Medical Center
- Sky Lakes Medical Center
- Tuality Healthcare

WHO'S DOING WHAT

Site	Bundle
Adventist Health Portland	Abnormal Vitals
Blue Mountain Hospital District	Abnormal Vitals, Weight in Kilograms
CHI Mercy Health – Mercy Medical	Abnormal Vitals, Weight in Kilograms, Interfacility Transfers
Kaiser Sunnyside Medical Center	Abnormal Vitals, Weight in Kilograms
Legacy Silverton Medical Center	Abnormal Vitals
PeaceHealth Peace Harbor Medical Center	Abnormal Vitals
PeaceHealth Southwest Medical Center	Abnormal Vitals
Sky Lakes Medical Center	Interfacility Transfers
Tuality Healthcare	Abnormal Vitals

WHERE WE'RE AT

- Yet to enter data
  - Sky Lakes MC
- Completed baseline data
  - Adventist MC
  - CHI Mercy Health
  - Legacy Silverton
  - Tuality Healthcare
  - Peace Harbor
- Initiated or completed first intervention
  - PeaceHealth Southwest MC
  - Blue Mountain Hospital
- Initiated or beyond second intervention
  - Kaiser Sunnyside MC

PROCESS APPROACHES

Sampling strategy:

Adventist – All visits Jan 2018-Dec 2018. Then random number generator!

PeaceHealth SW- Pulled all pediatric patients for several months, then a randomization app to get 30 charts

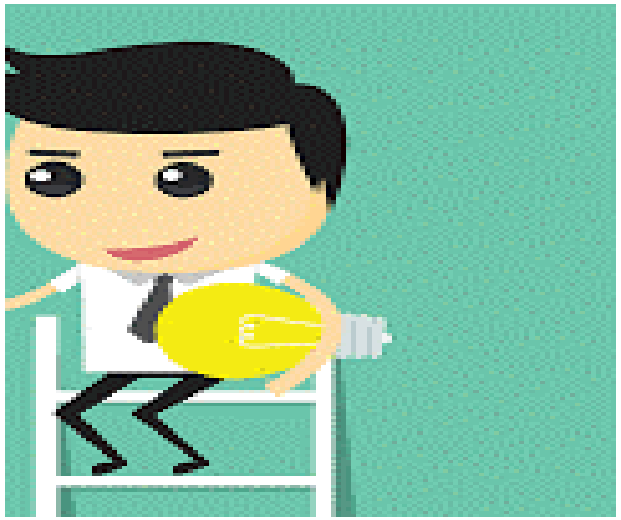
Kaiser Sunnyside – Monthly report of all peds patients, then randomization of a sample. ***Vital sign report for each patient!***

Time per chart :

Adventist - Data entry in a few sessions, ~10 minutes per chart

PeaceHealth SW – Marathon sessions (between other work)

Kaiser Sunnyside – 1-2 sessions per month/cycle



PROCESS APPROACHES

Baseline data takeaways:

Adventist – No specific existing pediatric policies, so not sure what to expect. Possibly deficits in pain, BP, and full sets of vitals?

Kaiser Sunnyside – Surprising number of medication errors flagged in older kids

Change Strategies:

PeaceHealth SW – Reviewing existing policies at skills day. Project spurred formation of a Peds Improvement Group

Kaiser Sunnyside – Regional Pediatric Critical Response Council, sharing baseline data, individual performance data

WHAT'S BEEN GOOD, WHAT'S BEEN HARD

What's worked well

- Teams and Delegation – KPS, PHSW

Challenges

- Team turnover – AH
- Absence of policies
- Knowing existing policies

AGGREGATE PERFORMANCE

Data deep dives are coming!

Over 5,000 charts entered

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Process and Outcome Measures

Team Name
All

SiteAcronym
All

Intervention Bundle
All

Overall Process/Outcome Measures Information

Intervention Bundle	Sum of Sites Participating	Max Current Cycle	Total # of Charts Entered	Measure Name	Average Measure Value
Weight in Kilograms	39	6	1,915	OM1 - % of Dosing Errors	42%
				PM1 - % with Weights Documented in Kilos Only	84%
Abnormal Vital Signs	57	6	2,944	PM1 - % of Patients with standard vitals	60%
				PM2 - % of Patients with abnormal vitals included in notification process	43%
				PM3 - % of Patients with pain assessed	75%
				PM4 - Median time from recognition of abnormal vital signs/pain to first intervention	34.8 min
Interfacility Transfer	11	1	268	PM1 - Median time from arrival to transport	235.5 min
				OM1 - % of Transferred patients who were discharged from ED at receiving center	0%
				PM2 - % of Transfers met minimum criteria	84%
				PM3 - % of Families that received transfer packet	0%

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PDSA Metrics for All in All

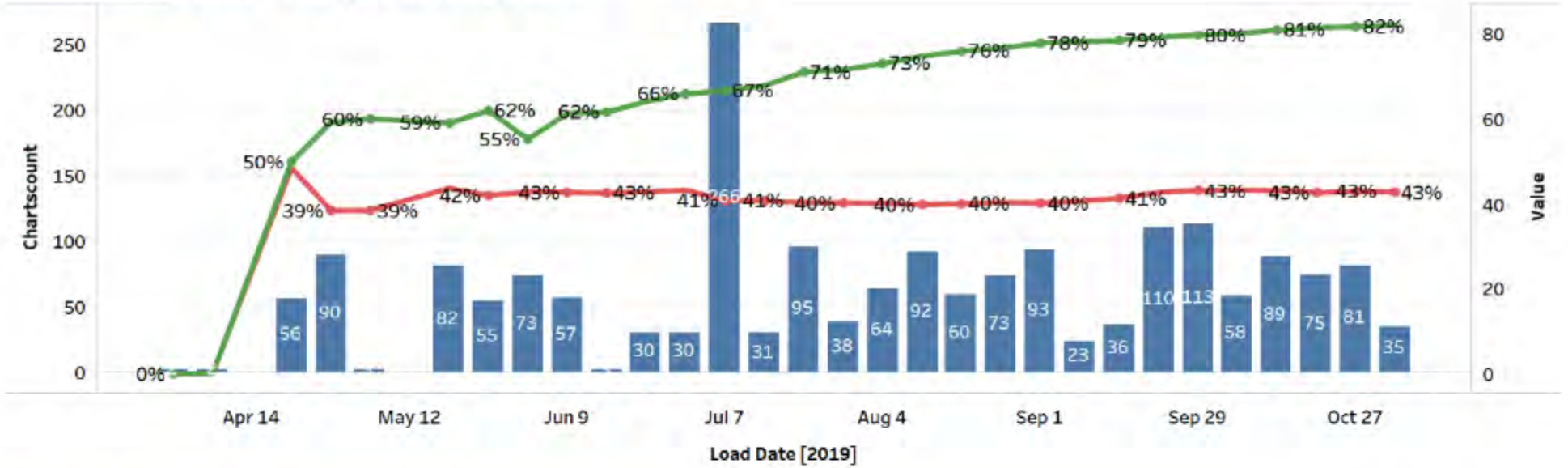
Team Name
All

Site Acronym
All

Intervention Bundle
Weight in Kilograms

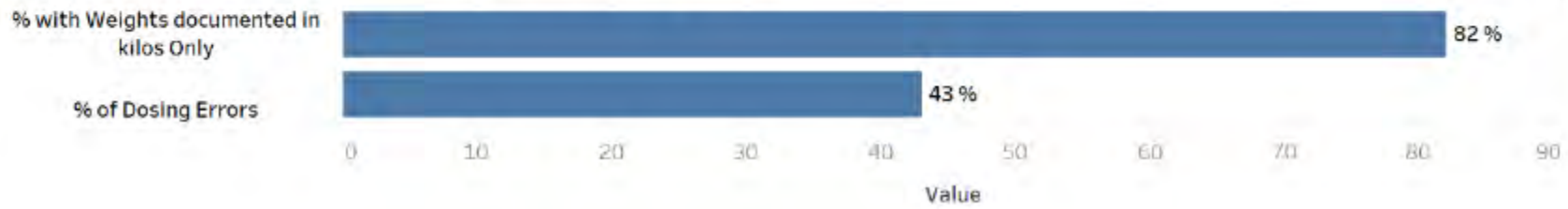
Chartscount
Cumulative % of Dosing Errors
Cumulative % of Weights Documented in Kil..

PDSA Metrics for : Weight in Kilograms



Current Quality Metrics : Weight in Kilograms

Cycle Counter
All



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PDSA Metrics for All in All

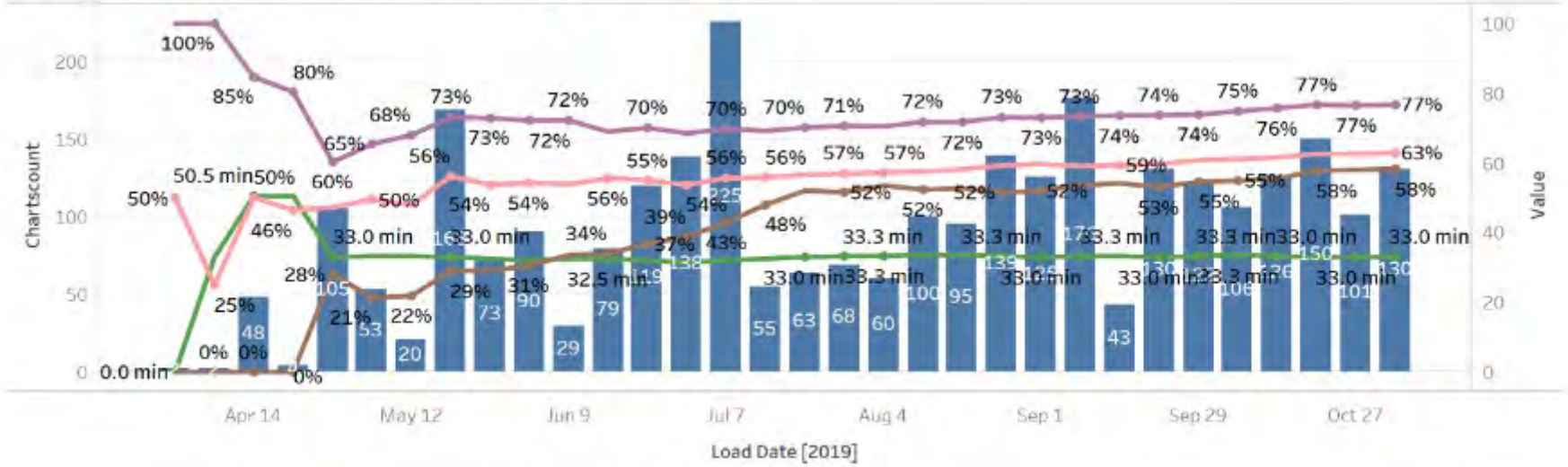
Team Name
All

Site Acronym
All

Intervention Bundle
Abnormal Vital Signs

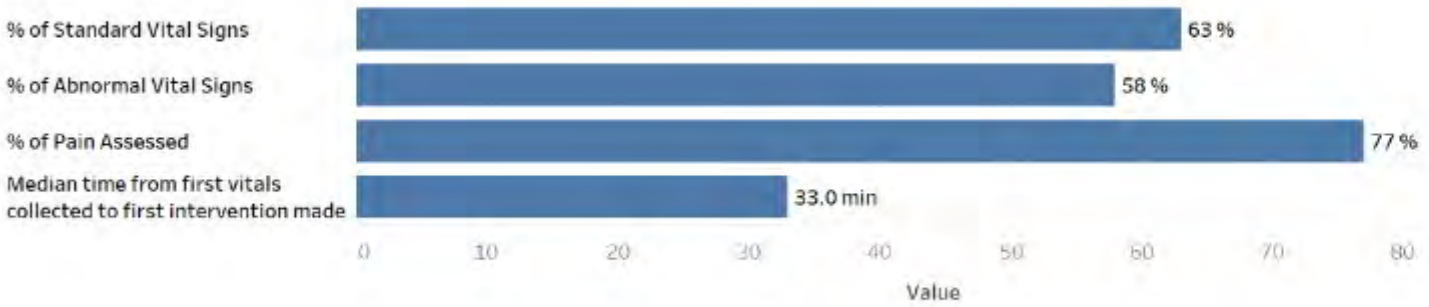
Cumulative % of patients with pain assessed
Cumulative % of patients with standard vitals
Cumulative % of patients with abnormal vitals includ..
Chartscount
Cumulative Median time from first vitals collected to ..

PDSA Metrics for : Abnormal Vital Signs



Current Quality Metrics : Abnormal Vital Signs

Cycle Counter
All



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PDSA Metrics for All in All

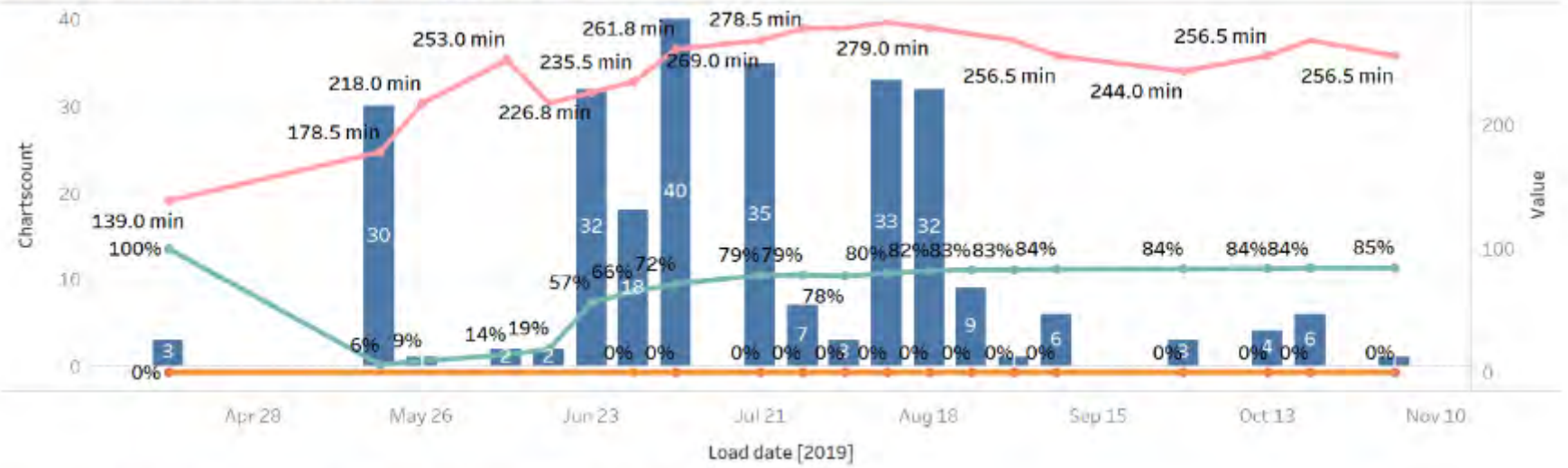
Team Name
All

Site Acronym
All

Intervention Bundle
Interfacility Transfer

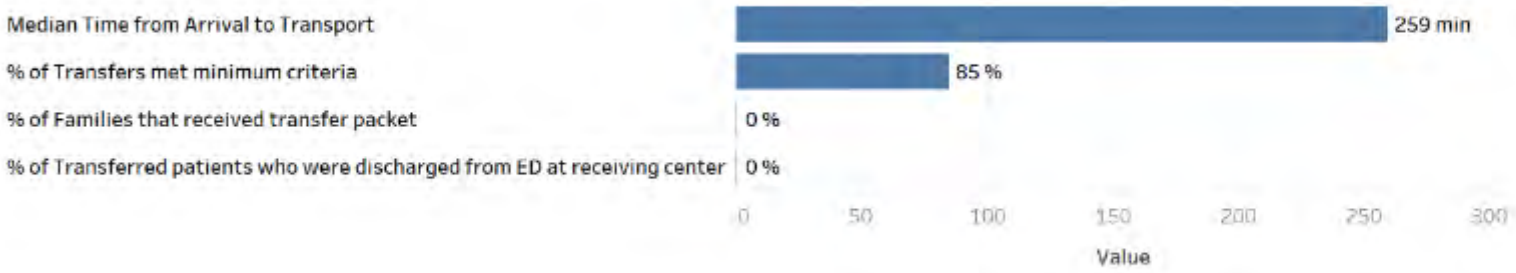
Cumulative median time from arrival to transport
Chartscount
Cumulative % of transfers met minimum criteria
Cumulative % of families that received transfer packet
Cumulative % of transferred patients who were discharged ..

PDSA Metrics for : Interfacility Transfer



Current Quality Metrics : Interfacility Transfer

Cycle Counter
All



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Structural and Process Measures

Team Name
All

SiteAcronym
All

Drill Domain
All

Overall Structural & Process Measures Information

Drill Domain	Sum of Sites Participating	Total # of Records Entered	Measure Name	Measure Value (My Site/Median All Sites)
Pediatric Disaster Coordination	5	0	SM1 - A disaster plan that includes pediatric-specific needs	2.0
			SM2 - A disaster plan that outlines the number of pediatric patients that must be involved in a disaster drill	0.0
			SM3 - Hospital disaster committee with pediatric representation	5.0
Domain 2 - Coalition Building (Internal)	3	9	PM1 - % of internal departments that are mobilized during a disaster drill	
Domain 2 - Coalition Building (Regional)	1	1	PM2 - Median time to recruitment of internal departments during a disaster drill	
			PM3 - % of external entities involved in a disaster drill	
			SM1 - Emergency department participation in a regional disaster coalition	
			SM2 - A catalog of entities that participate in a regional disaster coalition1	
Domain 3 - Pediatric Surge Capacity (External)	2	2	SM1 - Determination of external pediatric surge capacity for region	
Domain 3 - Pediatric Surge Capacity (Internal)	1	1	PM1 - Median time to determination of emergency department surge capacity services	
			PM2 - Median time to determination of surgical services surge capacity	
			PM3 - Median time to determination of inpatient services surge capacity	
Domain 4 - Essential Pediatric Resources	1	1	PM1 - Median time to determination of essential pediatric equipment and supplies	

HOUSEKEEPING

Housekeeping

- November newsletter: share with your ED and hospital leadership
- Site visits:
  - Celebrate successes
  - Sustainability planning
- MOC extended until the end of April
- CE credit available for nurses
  - (you must submit your feedback within 2 weeks of the session to get credit)

Upcoming Learning Sessions

- Dec 3, 2019
  - MOKAN Rocks
  - Pediatric Peaches
  - Pediatric Pit Crew
  - Remoc's Minions
  - ReTEE for Kids
  - The Last Frontier Kids
  - WISPR
  - WranglERs for Kids
- January 28, 2019
  - Brief team updates from ALL teams
  - Deep dive into the data
- March 3, 2019
  - Brief team updates from ALL teams
  - Sustainability planning
- April 7, 2019
- April 28, 2019

Key Information

CNE Link: https://tch-redcap.texaschildrens.org/REDCap/surveys/?s=C3CHENDRY8

Google: EMSC PRQC (Password also)

Email: qeca@texaschildrens.org | dcc_prqcsupport@hsc.utah.edu