



Learning Session 28-January 2020

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ACKNOWLEDGEMENTS

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ACKNOWLEDGEMENTS

This continuing nursing education activity was approved by the Emergency Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation for 1.5 contact hours.

LEARNING SESSION DISCLOSURES

Note Faculty/Speakers and Planners for this learning session:

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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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<https://tch-redcap.texaschildrens.org/REDCap/surveys/?s=C3CHENDRY8>
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AGENDA

28-JANUARY-2020 LEARNING SESSION



Creating Sustainability– 15”

Sujit Iyer, MD
The Longhorn Kids
Dell Children’s Hospital, Austin TX



Aggregate Performance – 5”

PRQC Admin Team



Team Presentations– 30”

WISPR
LifesavERs



Housekeeping – 5”

Meredith Rodriguez



Investing in Community Pediatric Champions to Drive Improvement

Sujit Iyer, MD. FAAP, FACEP

Director, Pediatric ED Outreach, Seton Family of Hospitals

Assistant Medical Director, Dell Children's Medical Center Emergency Department

Associate Fellowship Director, UT Austin Dell Medical School, Pediatric Emergency Medicine Fellowship



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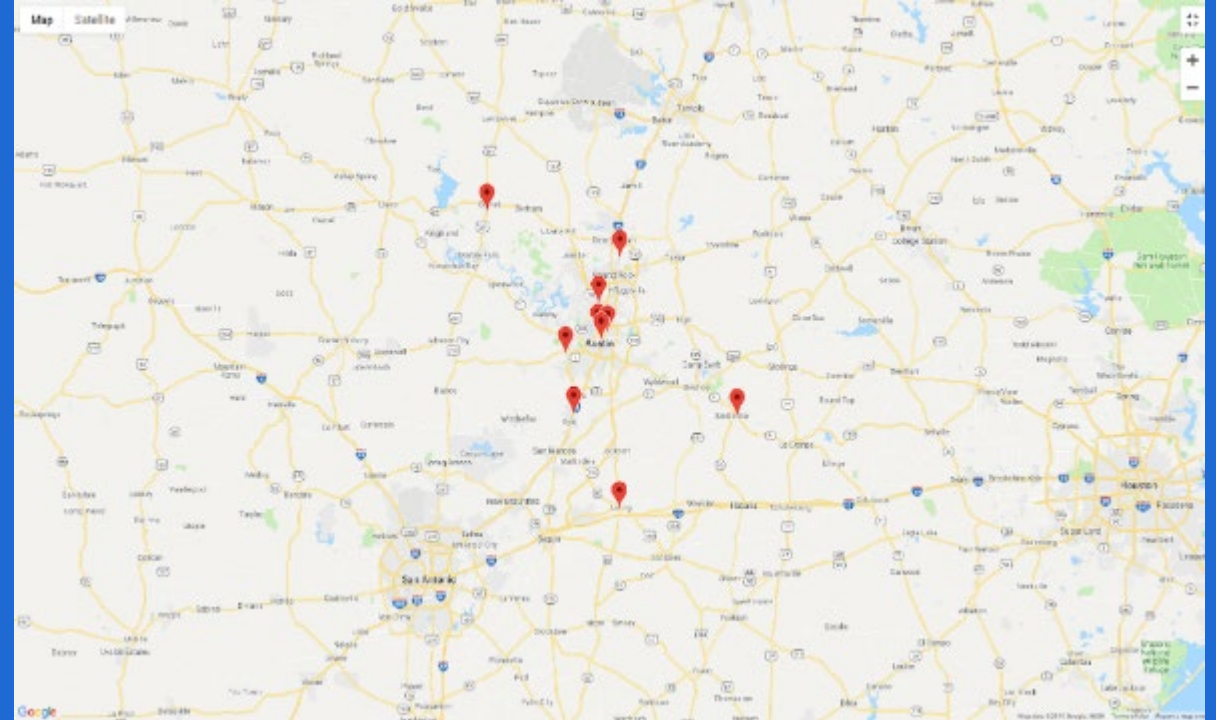
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Background

- Level 1 Pediatric Trauma Center (79K ED Visits)
- “Adult” Hospital Network
 - 10 community hospitals
 - Market: 149K Pediatric Visits
 - Community hospitals total
 - 70K Pediatric ED Visits
 - Small community hospital
 - 9,000 ED visits per year
 - Large Community Hospital
 - 300 Peds ED visits per year



Different Drivers

C-Suite

- Public Reputation
- Market Share
- ROI

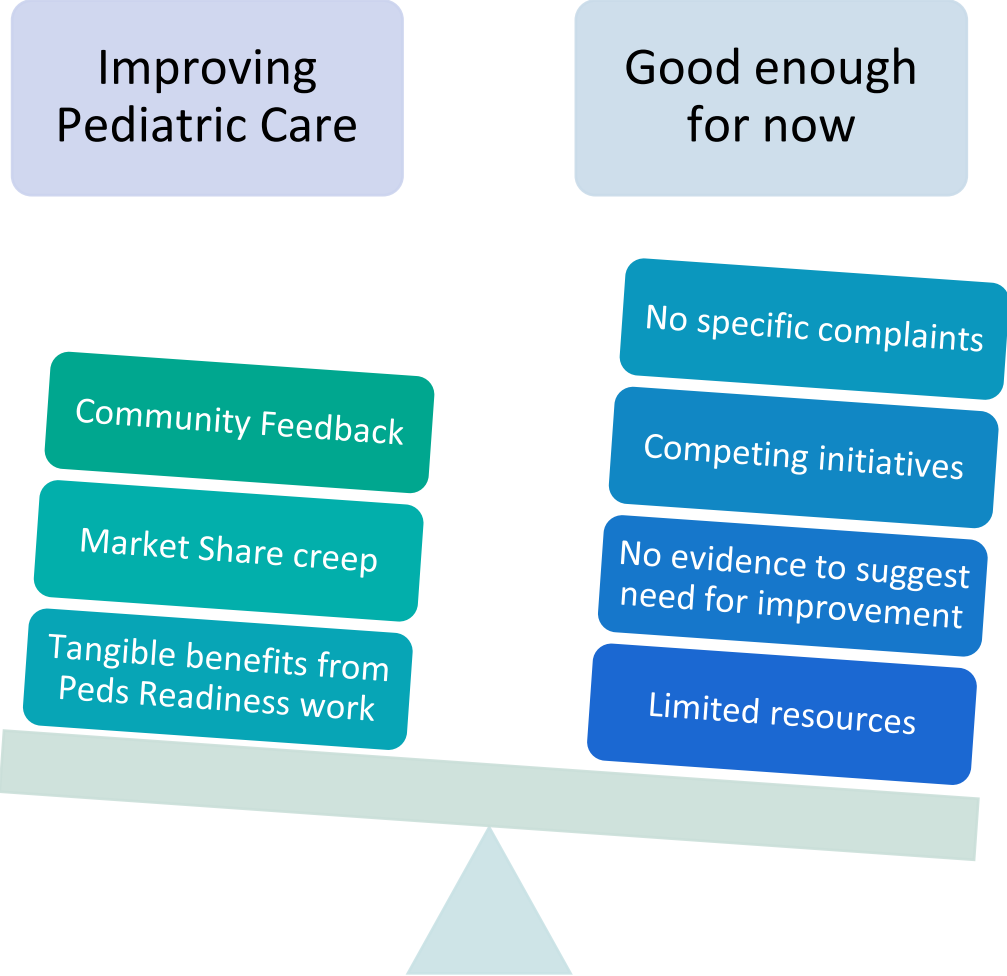
ED Leaders

- Competing interests
- Staff training vs patient need (bang for the buck)
- Patient safety
- Staff resources

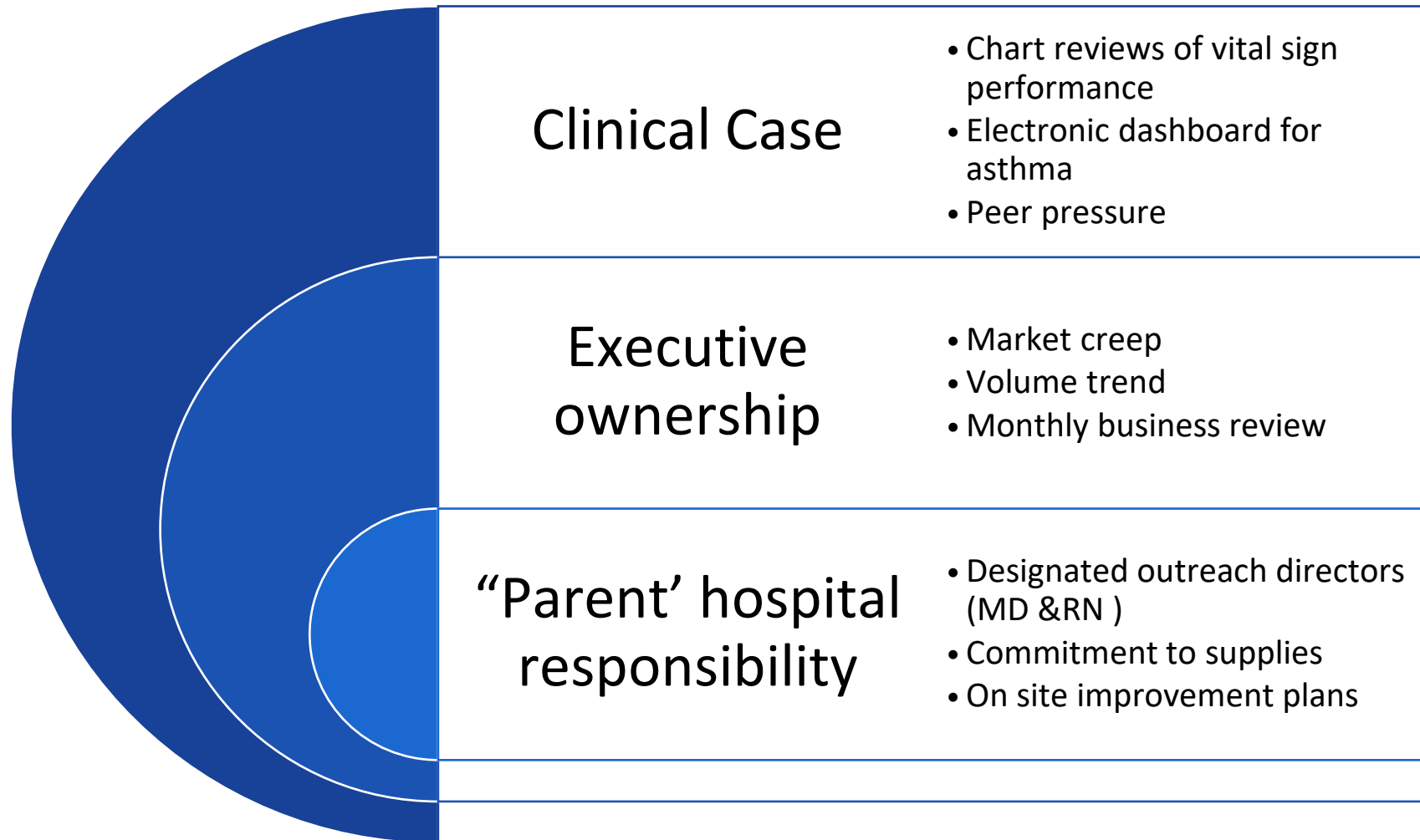
Bedside Staff

- Initiative of the month
- Perceived need for improvements
- Who are the local experts they trust

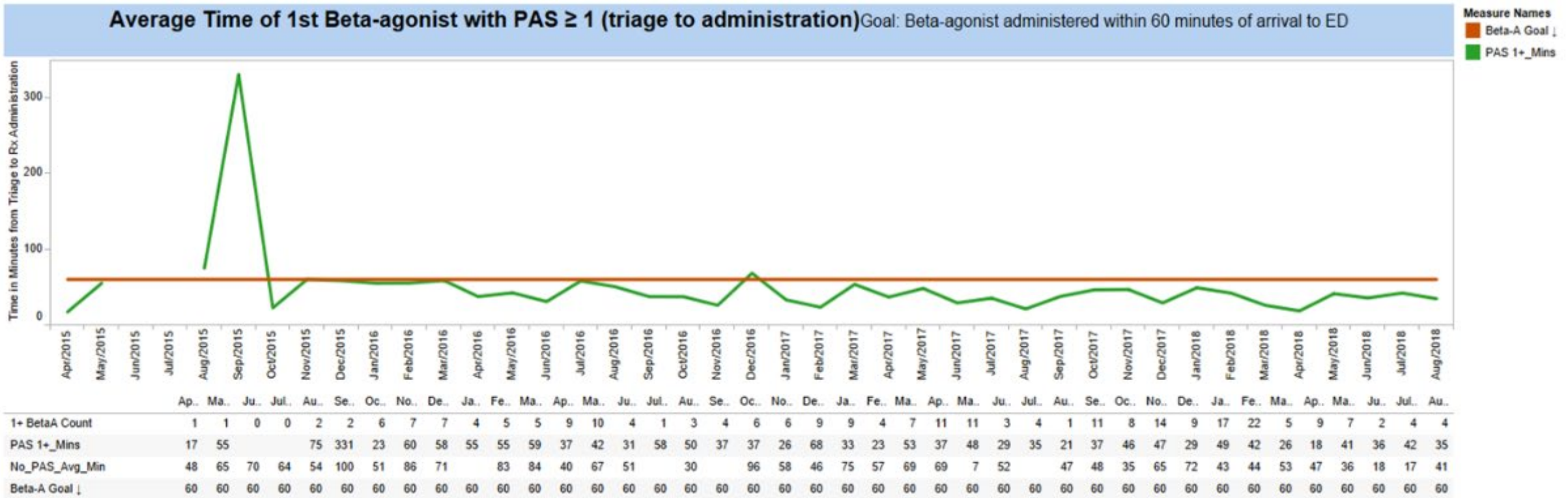
Why should we work on this?



Prove the case for improvement



“Peer” pressure



Data Source: Compass

Albuterol metric met, beat DCMC many months

More than “pushing information”

Supplies

- Review checklist and fill in gaps
- Expired supply process
- On site training

Clinical training

- Cross trained personnel
- On site training
- Video training series

Data

- “Home” site reviews charts
- Develop monthly operational review
- Keep it simple

Advocate

- Present needs to c-suites
- Aim for success (not the stars)
- Praise the wins

Always help with the “easy”

Supplies

- “Free” infant scale
- Take expired supplies
- “Pediatric cart:

Training

- “Hosting” at children’s hospital
- Directed by sites - multimodal

Access

- Back line office numbers
- Centralized protocols and information
- Case management

Keeping pediatrics on the radar

SSW, Pediatric ED Volume

SSW	2015	2016	2017	2018	2019
2015	293	267	278	381	248
2016	267	274	268	304	270
2017	257	278	245	288	271
2018	381	304	288	253	228
2019	248	270	271	228	209

8/27/2019 For additional information contact jgrantham@seton.org Dell Children's Medical Center of Central Texas Proprietary and Confidential

- Slight increase in last two months pediatric volumes to last year (193 v 173)
- Similar percent of total ED patients as pediatrics, 16% (range is usually 15-25%)
- LWBS rate of < 2%
- Top 4 diagnosis groups:
 - Traumatic injuries
 - Wounds of head/neck
 - Lacerations/wounds
 - GI complaints



Metrics: Clinical Quality Review, July-August 2019

Metric	Goal	Jan-Mar 2019	April 2019	July-Aug 2019
% of children receiving LET gel (if needed)	> 95%	50%	85%	100%
% of children (<5 yo) receiving at least one intranasal medication	> 90%	12%	14%	75%
% of children receiving injectable lidocaine	< 5%	25%	28%	0%
"Appropriate" management	100%			100%

- Pain Management/ Laceration Care – Chart Audit Themes
 - 20 cases meet review criteria, 16 charts audited (4 with no lac repair)
 - Great adoption of the use of LET gel**
 - No one with inappropriate injectable lidocaine!**
 - KUDOS: Duncan & Jackson (high adoption), Flores (complicated case)**
 - 4 kids on the border to consider intranasal. *Ideas in 5-6 year old category?*

Momentum is hard

Site Name	2013-14 Score	2015-16 Score	Last Listed Champion
Seton Hays	60	100	Jennifer Valencia
Seton Edgar B Davis	N/A	99	David Indorf
Seton Main	71	100	Jan Duich
Seton Williamson	N/A	100	Anita Moran and Laura Pittman
Seton Highland Lakes	60	74	Vickie Spaw and Sherry Brown
Seton Northwest	60	86	Sue Phillips and Jessi Ray
Seton Southwest	60	89	Rebecca Mull
Dell Seton Med Center at UT	97	81	Bryony Anderson
Seton Smithville			Melinda DeLong
Providence Health Center	N/A	N/A	
Dell Children's Medical Center	100	100	Denita Lyons/Kate Remick



Metrics: Clinical Quality Review, April 2019

Metric	Goal	Jan-Mar 2019	April 2019
% of children receiving LET gel	> 95%	86%	80%
% of children receiving at least one intranasal medication	> 90%	7%	15%
% of children receiving injectable lidocaine	< 5%	20%	15%

- Pain Management/ Laceration Care – Chart Audit Themes
 - 22 cases meet review criteria, 20 screened (2 had no lac repair done)
 - Paucity of intranasal use, even in very young patients. Some documentation in provider notes alluding to the fact the IN medication is sedation – not the case per Seton policy
 - All 3 children who had injectable lidocaine were very young (17 months and 3 year old). Good intranasal candidates and likely didn't need injectable lidocaine



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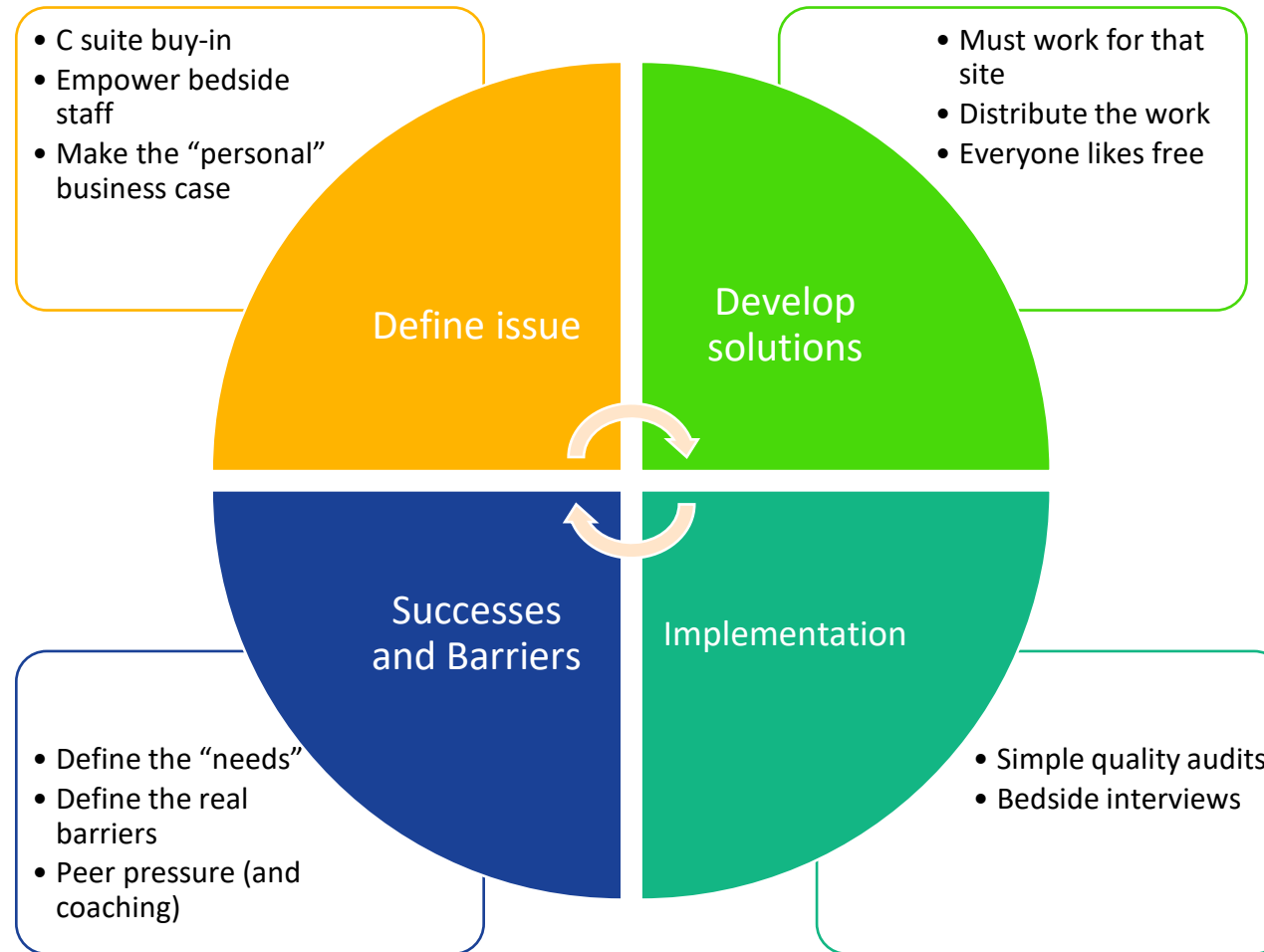
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Different strategies for different places?

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17

Pushing the right buttons



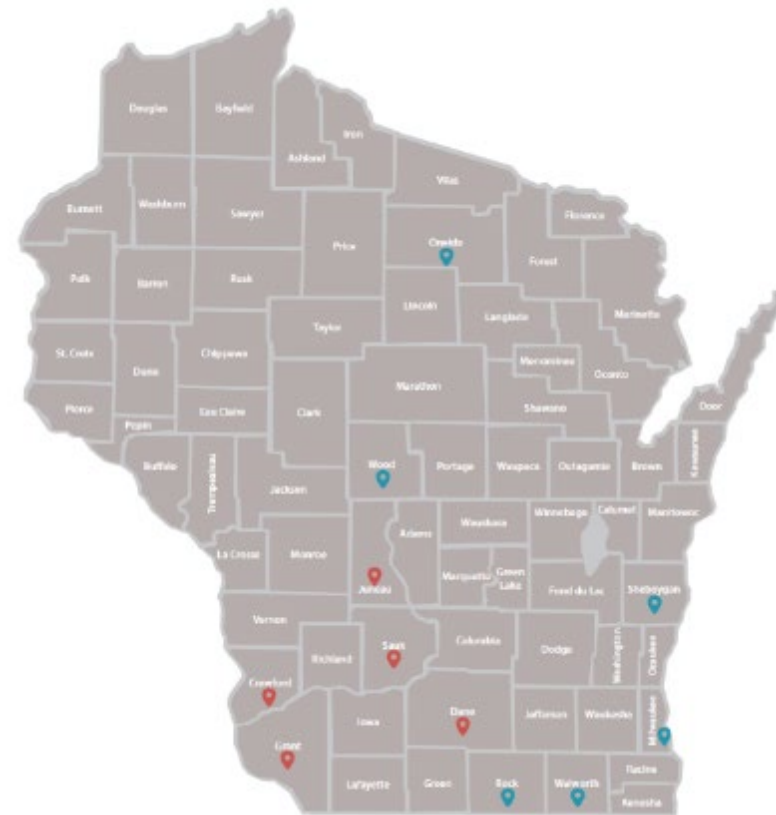




TEAM PRESENTATIONS

Team 12 – WISPR

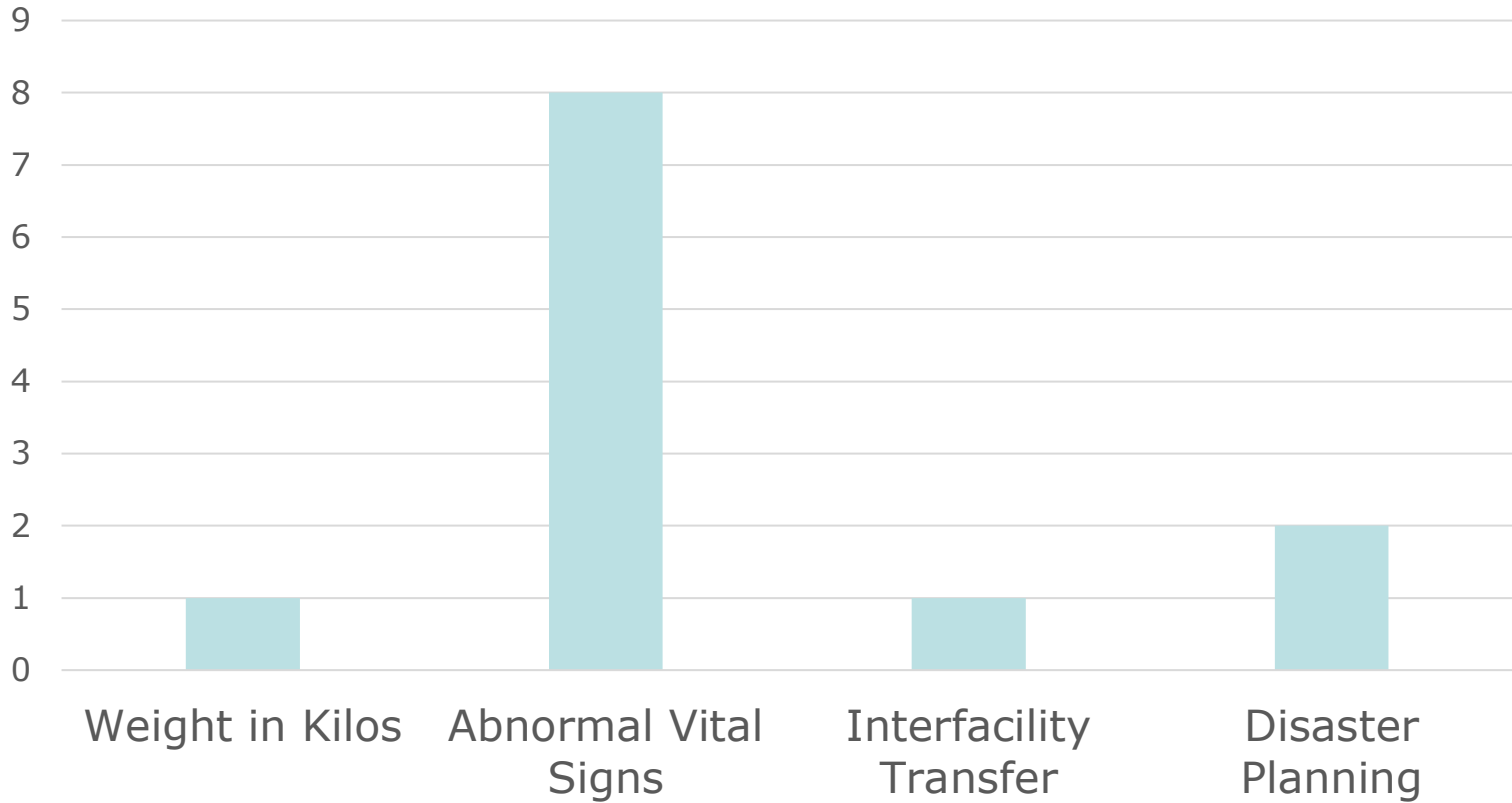
- 14 original affiliate hospitals
- 11 active affiliate hospitals
- Mix of rural and urban
- 25 – 505 beds
- Peds volume: Low (<1,800), medium, (1,800-4,999) and medium high (5,000-9,999)



Team 12 - WISPR

- Crossing Rivers Health
- Sauk Prairie Healthcare
- Southwest Health Center
- Mile Bluff Medical Center
- UnityPoint Health - Meriter
- Howard Young Medical Center
- Ascension - Franklin
- Mercy Health Hospital and Medical Center - Walworth
- Mercy Health System and Trauma Center - Janesville
- Aurora Sheboygan Memorial Medical Center
- Marshfield Medical Center
- Training team
 - Lorin Browne, DO
 - Matt Pinsoneault, NRP
 - Michael K. Kim, MD
 - Ben Eithun, MSN, CRNP, RN, CPNP-AC, CCRN

Bundle Selection



WISPR Data Entry and PDSA Cycles

- 7 affiliate hospitals entering data
 - Total of **824** pediatric charts entered
 - 2 disaster planning drill completed
- 16 PDSA cycles completed
 - Crossing Rivers Health (4 cycles)
 - Ascension Franklin (2 cycles)
 - Aurora Sheboygan Memorial (6 cycles)
 - Mile Bluff Medical Center (3 cycles)
 - Sauk Prairie Hospital (1 cycle)

Challenges

- Delays in completing DUA
- Pediatric champion turnover
- Competing priorities at affiliate hospitals
- Current focus
 - Encourage hospitals to move from baseline data entry to PDSA cycles

Best Practices

- Monthly team meetings
- Regular communication between pediatric champions and training teams
- Utilize WI EMSC State Partnership Program Manager
- Monthly pulse-checks with team at EIIC

Ascension Franklin Emergency Department



Ascension

Pediatric Readiness

Marybeth Heise, RN, CEN, CPEN
Drinka Marinkovic, BSN, RN

All abnormal vital signs on pediatric patients will be recognized and communicated to the ED provider (MD or APP) and documented using the provider communication tab.

Aim Statement

Pediatric Readiness

Process

- Needed to establish a standardized method for notifying the ED provider of abnormal vital signs in pediatric patients (pediatric being classified as anyone <18 years old).
- Use the provider communication tab in EPIC to document action of “notifying provider.”
- Nursing judgement will determine if you have that face to face conversation or indicate the abnormality in comments section on the tracking board.
- Sampling strategy – every 5th patient up to 30-35 charts.
- 21,000 visits annually, 3,000 pediatric visits annually.

Pediatric Readiness



Pediatric Vital Signs Reference Chart

This table, along with our detailed references can be found online at <http://www.peds-cases.com/pediatric-vital-signs-reference-chart>. For a more detailed approach to this topic, see our podcast on "Pediatric Vital Signs."

Heart Rate			Respiratory Rate	
Normal Heart Rate by Age (beats/minute) Reference: PALS Guidelines, 2015			Normal Respiratory Rate by Age (breaths/minute) Reference: PALS Guidelines, 2015	
Age	Awake Rate	Sleeping Rate	Age	Normal Respiratory Rate
Neonate (<28 d)	100-205	90-160	Infants (<1 y)	30-53
Infant (1 mo-1 y)	100-190	90-160	Toddler (1-2 y)	22-37
Toddler (1-2 y)	98-140	80-120	Preschool (3-5 y)	20-28
Preschool (3-5 y)	80-120	65-100	School-age (6-11 y)	18-25
School-age (6-11 y)	75-118	58-90	Adolescent (12-15 y)	12-20
Adolescent (12-15 y)	60-100	50-90		

Blood Pressure			
Normal Blood Pressure by Age (mm Hg) Reference: PALS Guidelines, 2015			
Age	Systolic Pressure	Diastolic Pressure	Systolic Hypotension
Birth (12 h, <1000 g)	39-59	16-36	<40-50
Birth (12 h, 3 kg)	60-76	31-45	<50
Neonate (96 h)	67-84	35-53	<60
Infant (1-12 mo)	72-104	37-56	<70
Toddler (1-2 y)	86-106	42-63	<70 + (age in years x 2)
Preschooler (3-5 y)	89-112	46-72	<70 + (age in years x 2)
School-age (6-9 y)	97-115	57-76	<70 + (age in years x 2)
Preadolescent (10-11 y)	102-120	61-80	<90
Adolescent (12-15 y)	110-131	64-83	<90

For diagnosis of hypertension refer to the 2017 AAP guidelines Table 4 and 5:
<http://pediatrics.aappublications.org/content/early/2017/08/21/peds.2017-1904>.

Temperature		Oxygen Saturation
Normal Temperature Range by Method Reference: CPS Position Statement on Temperature Measurement in Pediatrics, 2015		Normal pediatric pulse oximetry (SPO2) values have not yet been firmly established. SPO2 is lower in the immediate newborn period. Beyond this period, a SPO2 of <92% should be a cause of concern and may suggest a respiratory disease or cyanotic heart disease.
Method	Temperature (°C)	
Rectal	36.6-38	
Ear	35.8-38	
Oral	35.5-37.5	
Axillary	36.5-37.5	

Temperature ranges do not vary with age. Axillary, tympanic and temporal temps for screening (less accurate). Rectal and oral temps for definitive measurement (unless contraindication).

Thresholds

Blood Pressure	Heartrate	Respiratory Rate	Temperature	SPO2
≥ 20 over DBP ≥ 10 over OR < $70 + (\text{age in years} \times 2)$	≥ 20 over (in the absence of crying) ≤ 10 under	≥ 10 over OR ≥ 4 under	$\geq 40^\circ\text{C}$ (104) OR $\leq 36^\circ\text{C}$ (96.8) PR or TA and ≤ 35.5 (95.9) PO $>38^\circ\text{C}$ (100.4) in an infant under 3 mo	<94%

Developed by Dr. Chris Novak and Dr. Peter Gill for PedsCases.com. July 10, 2018.

Pediatric Readiness

Barriers

- Late data user agreement
- Entering data: 1. time format 2. no place in IV intervention for pre-hospital or undocumented in chart (time isn't accurate).
- Scheduling conflicts with learning sessions.
- Competing with other initiatives that require staff buy-in (sepsis and stroke protocol).
- EMR optimization: cannot change build in EPIC.

Pediatric Readiness

Best Practices

- Adapted new vital sign parameters which are more age-specific, to avoid “lumping” broad ranges.
- Will be including an expected timeframe for 1st set of vitals into triage policy.
- EDTs should make sure they are entering the time of vitals as the time actually taken.
- Staff reinforcement: vital signs including blood pressure on age 3 and up, and as appropriate for other ages.
- Revisiting ESCAPE screen with staff and discussing better strategies for assessing mental health/suicide on the pediatric population.



Ascension Franklin

Pediatric Readiness

PEDIATRIC READINESS QUALITY COLLABORATIVE DATA



Ensuring Emergency Care for All Children
Ashley Vossekuil, RN BSN

PDSA Cycle # 1- Obtain Full set of Vital signs on every pediatric patient in the month of November

Summary after our chart audits:

- 80% of chart did obtain a full set of vital signs.
- Blood pressure and Pain scale were the two missed documented vital signs.

Barriers

-Staff expressed it was difficulty to obtain a blood pressure on the younger pediatric patients and to assess pain.

Workflow change after doing chart audits:

- Education on abnormal vitals signs
- Implemented abnormal vital signs worksheet that are easy assessable for staff
- -Positive feedback from patients and clinics



PSDA cycle #2

Recognition of abnormal vital signs on any pediatric patient and informing the provider.

After the triage nurse recognizes any abnormal vitals, they will need to inform the provider and document that in a new query we made in our computer database.

2 PDSA cycle= Recognition of abnormal vital signs/
informing the provider

What do we need our staff to do?

Still need staff to obtain a full set of vitals on every pediatric patient that is 3- 17 years of age, during the triage assessment.

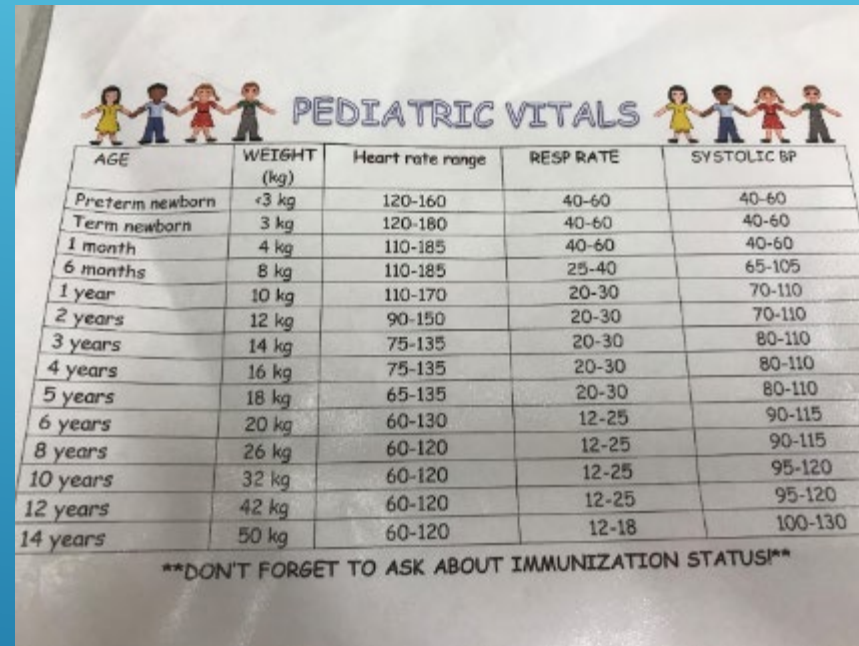
This still includes doing vital signs on pediatric patient regardless if they are ER, URC, or fast-track.

Standard set of vital signs include:

**Temperature
Heart Rate
Respiratory Rate
Pulse Oximetry
Blood Pressure
Pain**



These are guidelines that our nurses use when recognize any abnormal vital signs:



AGE	WEIGHT (kg)	Heart rate range	RESP RATE	SYSTOLIC BP
Preterm newborn	<3 kg	120-160	40-60	40-60
Term newborn	3 kg	120-180	40-60	40-60
1 month	4 kg	110-185	40-60	40-60
6 months	8 kg	110-185	25-40	65-105
1 year	10 kg	110-170	20-30	70-110
2 years	12 kg	90-150	20-30	70-110
3 years	14 kg	75-135	20-30	80-110
4 years	16 kg	75-135	20-30	80-110
5 years	18 kg	65-135	20-30	80-110
6 years	20 kg	60-130	12-25	90-115
8 years	26 kg	60-120	12-25	90-115
10 years	32 kg	60-120	12-25	95-120
12 years	42 kg	60-120	12-25	95-120
14 years	50 kg	60-120	12-18	100-130

****DON'T FORGET TO ASK ABOUT IMMUNIZATION STATUS!****

Temperature: Contact MD if the following
3 year and under and is greater than 100.4
3 years and older and is greater than 101

Contact MD if Pulse oxygen sat is lower than 94%.

Documentation that the Provider was notified of abnormal vital signs

TEST, HARVEY M000864 - PCS Flowsheet - HIM Dept: HIM (SPM/SPM.TEST6.08F/SPM.TEST6.08F) - (TEST 6.08) - Arneson, Kathleen J [CST]

Test, Harvey 97 M 02/22/1922 PRE ER E Allergy/Adv: Not Recorded V0003449 M000864 E00000871

Tue Jan 7 08:31 by KJA

At Baseline Nasal Flaring
 Accessory Muscle Use Pursed Lip
 Agonal Retracting
 Crying Shortness of Breath
 Gasping Snoring
 Grunting Splinting
 Labored Stridor

Normal Deep Shallow Retractive

None Substernal Supraclavicular
 Subcostal Intercostal Sternal

Room Air CPAP Tent
 Nasal Cannula High Flow T-piece
 Oxymask Mask Trach Collar
 Ambu-Bag Non-Rebreather Venturi Mask
 Bi-pap Mechanical Ventilator
 Blow By RAM Cannula

Numeric (0-10) Face (1-5) FLACC (0-10)
 Descriptive Face (0-10)
 Other:

Mild Moderate Severe
 Yes No

Respiratory Depth
Respiratory Retraction Type
O2 Sat by Pulse Oximetry
Oxygen Delivery Method
Oxygen Flow Rate (L/min)
Pain Score
Maximum Pain Score
Pain Scale Used
Descriptive Score
Provider notified of abnormal vital signs

Measurements

This new query was added to our computer database, for our staff to have an easy and fast way to document that they notified the provider. They will only check this box if there is an abnormal vital sign and have notified the provider.

Sauk Prairie Healthcare

Starting January 9th, 2020 staff will continue documenting a full set of vitals on any pediatric patients that are between the ages 3-17 years old. Regardless of their registration status- (ER or Urgent Care). After obtaining triage vitals, the nurse should recognize any abnormal vitals and document that they informed the Provider.

After January, chart audits will be done to recognize any barriers or areas for improvements.





Updates as of 01/09/2020



**PRQC-PEDIATRIC READINESS QUALITY
COLLABORATIVE**



Pediatric 0-14 General: intervention


- Chief complaint of all pediatric patients should be “Pediatric 0-14 General”
 - This will prompt a pediatric vital sign intervention that is required documentation-within documentation is the question “do these vitals fall WNL for age of the pt”, also a place to state provider was notified if the answer is no.
 - Has been live in Meditech since 9/29/2019
 - Laminated normal pediatric vital signs can be found throughout the ER-also linked into Meditech by clicking on the globe.
- 



Chart audits

- 63 charts audited from 12/9/19-01/09/2020
- All peds visits with ESI levels 1, 2, 3 audited
- All visits that were ER with Peds general complaint audited (including ESI 4 and 5)
- There were a total of 97 pediatric ER visits from 12/9-01/9 :36 of the 97 visits used the appropriate intervention (37%)
- 48.3% is an improvement from 29.6% from the last audit!!!!!!!
- 37% is a significant decline from the 48.3% of the charts that were correct in the last cycle.
- 20 of the 36 visits that used the appropriate complaint were used correctly (all documentation complete)-which is down from the 24 that were correct last audit



So what's next?

- 1st cycle of audits was looking for the documentation (completion of the appropriate interventions) **Still improving!!**
- 2nd cycle of audits will address if nursing staff is appropriately recognizing when pediatric vital signs are not within normal limits **All vitals that were outside of normal limits except 2 were documented as outside of normal limits!**
- 3rd cycle of audits will address proper physician notification **Notification is still not being done even though nurses are recognizing the abnormal vitals.**
- Feel free to find me/email me with any questions, comments, concerns!

Graphs



PDSA Metrics for Mile Bluff Medical Center

Site Acronym (For multiple sites)
Mile Bluff Medical Center

Intervention Bundle
Abnormal Vital Signs

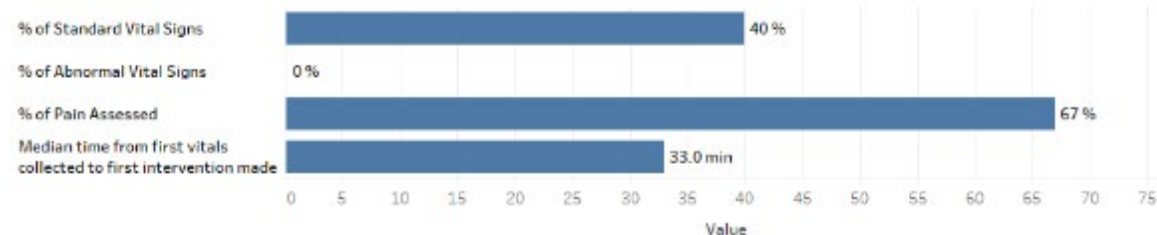
- Chartscount
- Cumulative % of patients with pain assessed
- Cumulative Median time from first vitals collected to ..
- Cumulative % of patients with standard vitals
- Cumulative % of patients with abnormal vitals includ.

PDSA Metrics for : Abnormal Vital Signs



Current Quality Metrics : Abnormal Vital Signs

Cycle Counter
0





And the graphs mean??

- Our average time from first vitals being taken to intervention (meaning IV start etc) is 33 minutes. (keep in mind that a majority of our peds patients don't get IVs and when they do its right before they transfer or are admitted)
- What we really need to be working on is the pink line. This shows in essence if the process was completed or not. (recognition → appropriately documented provider notification). We are at 36%--this number should ideally be 100%
- We have some work to do, improvements to be made. Although this project is nearing an end, I do intend on following these trends and educating appropriately.



SSMHealth Cardinal
Glennon

Glennon Transport Team
at SJ LSL



SSMHealth St. Joseph
Hospital Lake St. Louis



LifesavERsTeam

SSM Health **St. Joseph Hospital, Lake St. Louis** St Charles Missouri

Timothy Staed, MD SJ LSL Physician Lead EMSC PRQC

MJ Irwin, RN SJ LSL Nurse Champion EMSC PRQC

Cherie Coletta, PNP SJ LSL Nurse Champion EMSC PRQC

LifesavERsTeam

SSMHealth St. Joseph Lake St. Louis

Update 1/28/2020

Lessons Learned

LifesavERsTeam

SSM Health St. Joseph Lake St. Louis

It takes a Team

1. Involve as many people as you can on your team
2. Not everyone is available all the time – so encourage many people to participate
3. More participants = more buy-in from the hospital

LifesavERsTeam

SSM Health St. Joseph Lake St. Louis

Drive fast AND Look at your Dashboard

1. Your Dashboard is your friend to assess how well you are meeting your goals
2. Getting data in quickly to increase number of PDSA cycles improves chances of seeing significant improvement

LifesavERsTeam

SSM Health St. Joseph Lake St. Louis

REPORT to Administrators

1. Tell the people who are NOT part of the project what progress you are making
2. They will more likely support changes you want to make

LifesavERsTeam

SSM Health St. Joseph Lake St. Louis

Celebrate victories and say Thank You

1. Each step forward is a victory that takes hard work and someone's time
2. Participants are giving up their most valuable resource – their TIME. And not necessarily being reimbursed. Tell them how much you appreciate their contribution.

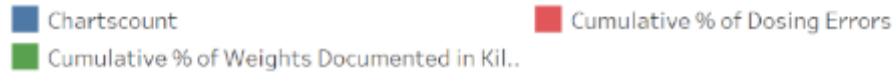


AGGREGATE PERFORMANCE

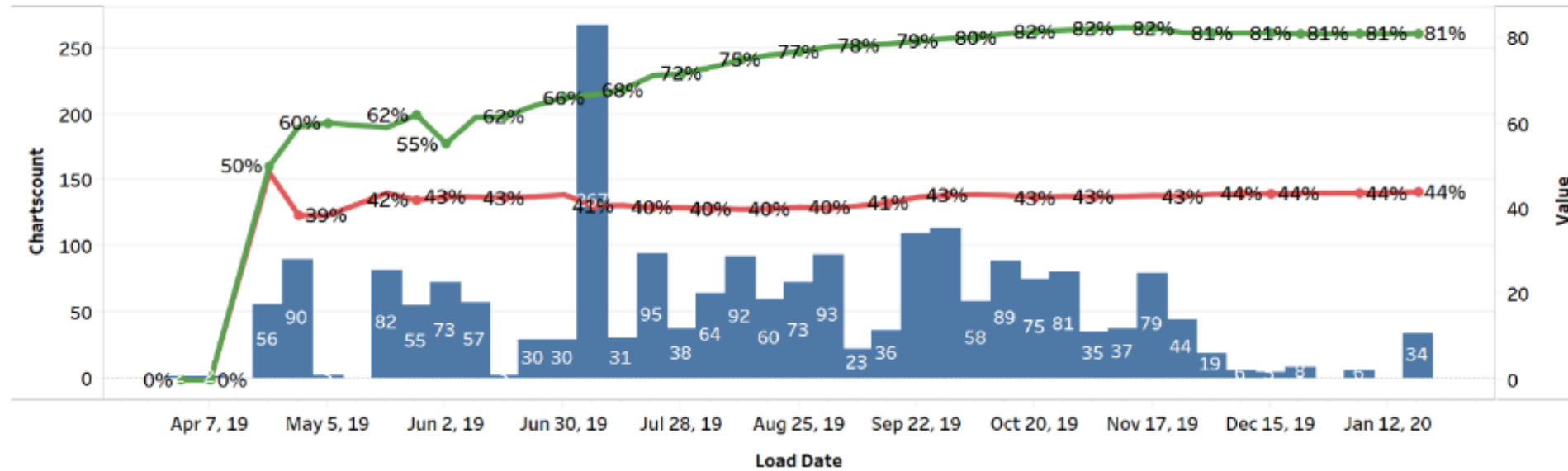
Data deep dives are coming
Over 6,200 charts entered

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	40	7	2,154	OM1 - % of Dosing Errors	43%
				PM1 - % with Weights Documented in Kilos Only	83%
Abnormal Vital Signs	62	7	3,781	PM1 - % of Patients with standard vitals	60%
				PM2 - % of Patients with abnormal vitals included in notification process	45%
				PM3 - % of Patients with pain assessed	76%
				PM4 - Median time from recognition of abnormal vital signs/pain to first intervention	34.5 min
Interfacility Transfer	11	1	283	PM1 - Median time from arrival to transport	235.5 min
				OM1 - % of Transferred patients who were discharged from ED at receiving center	2%
				PM2 - % of Transfers met minimum criteria	85%
				PM3 - % of Families that received transfer packet	0%

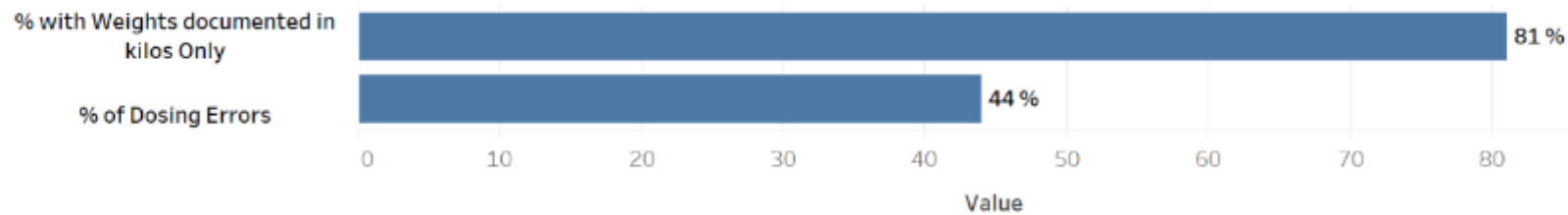


PDSA Metrics for : Weight in Kilograms

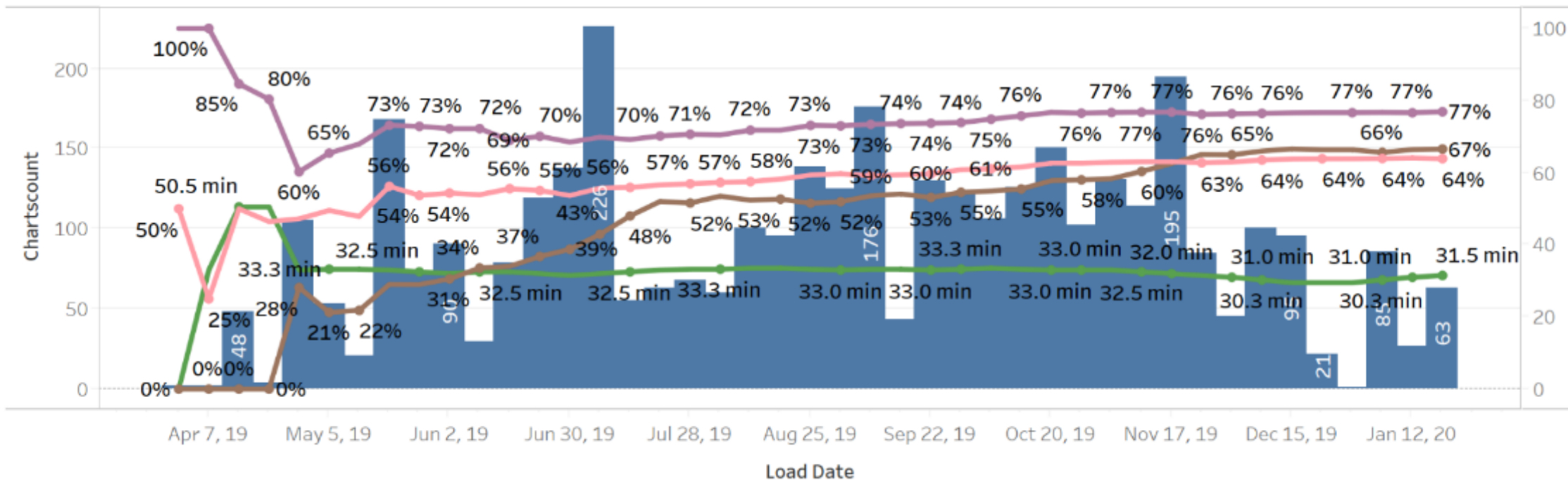


Current Quality Metrics : Weight in Kilograms

Cycle Counter
All

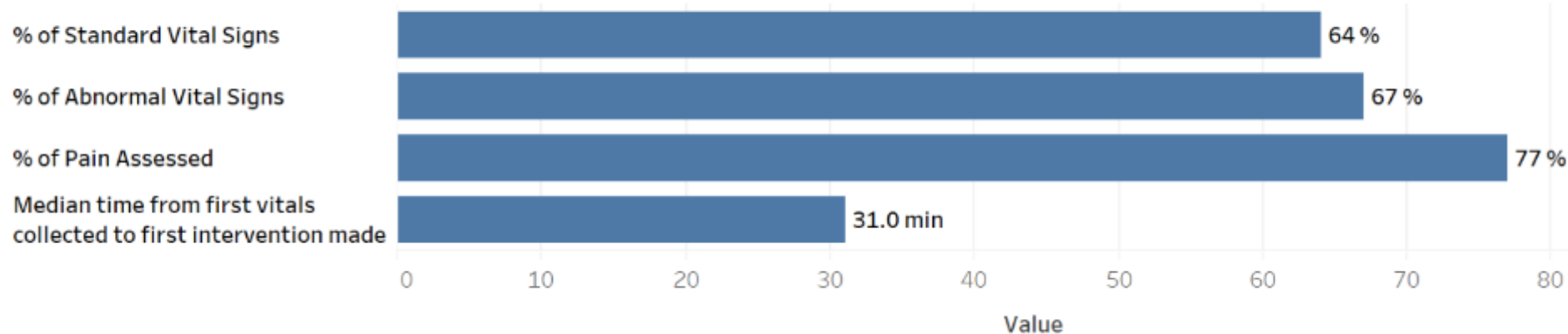


PDSA Metrics for : Abnormal Vital Signs



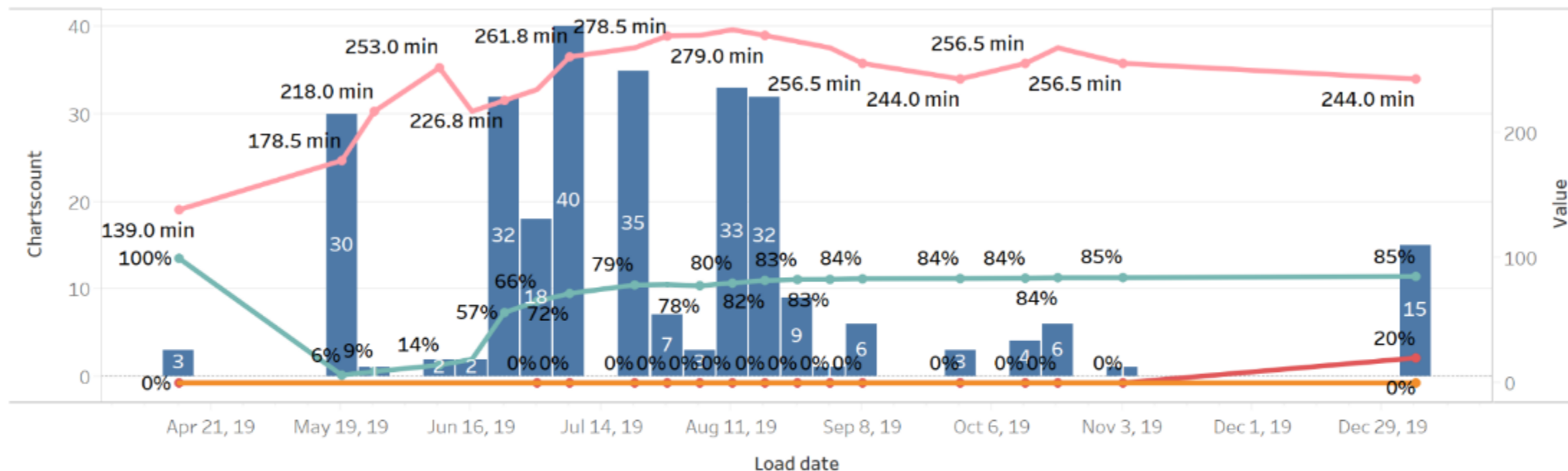
Current Quality Metrics : Abnormal Vital Signs

Cycle Counter
All





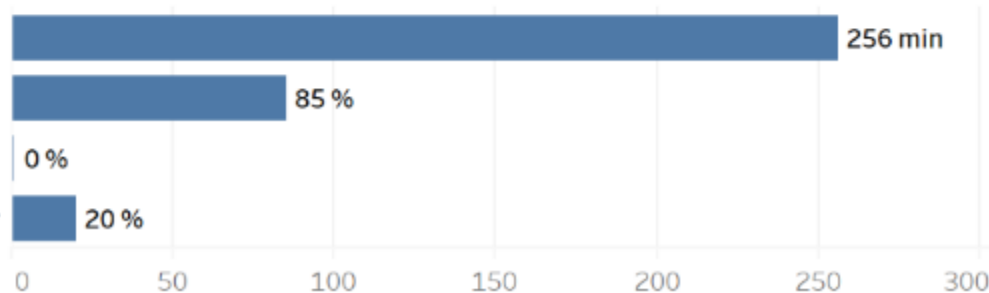
PDSA Metrics for : Interfacility Transfer



Current Quality Metrics : Interfacility Transfer

Cycle Counter
All

Median Time from Arrival to Transport



% of Transfers met minimum criteria

% of Families that received transfer packet

% of Transferred patients who were discharged from ED at receiving center

Value

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	
Domain 3 - Pediatric Surge Capacity (External)	2	2	SM2 - A catalog of entities that participate in a regional disaster coalition1	
			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	



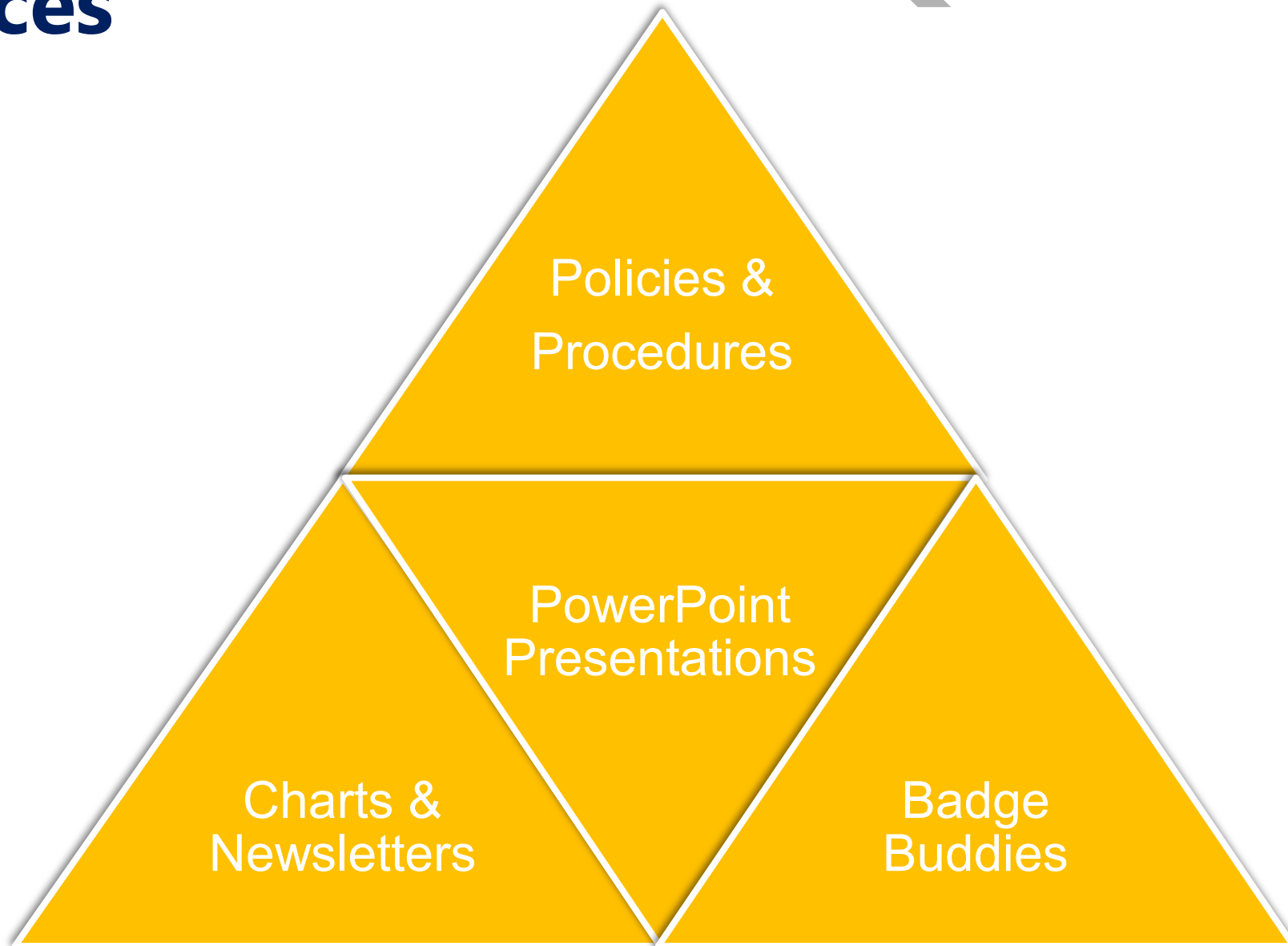
HOUSEKEEPING

All Teach, All Learn Culture



- All working together
- Share what works!
- Get help and advice from others

Consider Sharing Resources



Close of Collaborative: NPRP Assessment



- April 1-30th
- PRQC-specific website
- Issues: email Meredith (mrodrqu@bcm.edu)

2020 Peds Ready Assessment



- Assessment opens June 1st
- www.PedsReady.org

Close of Collaborative

- Final site visits:
 - Redcap Survey to be sent soon
 - Reflect on progress
- Final team presentations-April
- Certificate of Appreciation signed by HRSA
- **Poll: Would you continue to use the DES?**
- PRQC V2 will be coming



2020 Learning Sessions

- March 3, 2019
 - Team updates
 - Sustainability planning
- April 7, 2019 & April 28, 2019
 - Final presentations
 - Invite hospital leadership!

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

