ACS VRC Verification Review Consultation
American College of Surgeons

ACS VRC
Pediatric Readiness Standard

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Professor of Surgery-Department of Surgery, Dell Medical School
ACS VRC Chair-American College of Surgeons

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I attest that clinical recommendations are evidence-based and free of commercial bias.

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Objectives

- Review steps involved in adding Peds Ready to ACS Standard
- Review the Peds Ready ACS Standard and how to comply with Standard
- Review examples of Peds Ready Gap analysis

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Resources for optimal care of the injured patient: 1976-2014

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An Inclusive Process

Stakeholder surveys

- Surveys available on COT website
- Over 2,000 responses across chapters
- Comments provided the basis for review and revision

Work groups

- 14 work groups
- Members included specialty representatives, TPMs, COT members across the Quality Programs, and staff.

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- Solicited input from TMDs, TPMs, medical staff, hospital leadership, medical associations, state trauma leadership, and surgical specialties
- Surveys for each chapter available on COT website
- Over 2,000 responses across chapters
- Comments provided the basis for review and revision

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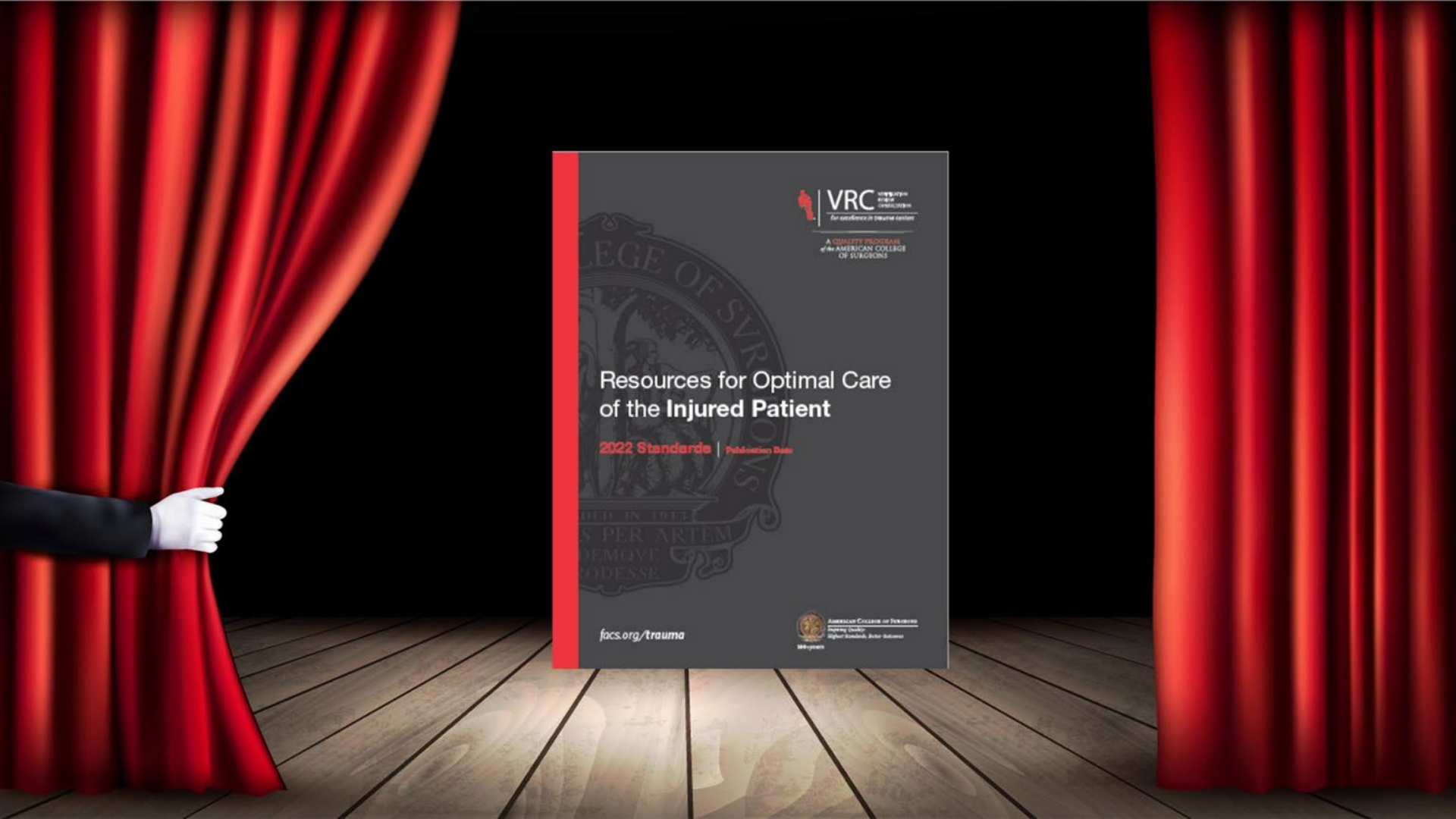
Key Considerations

WHAT'S BEST FOR OUR PATIENTS?

WHAT IS THE IMPACT ON CENTERS?

CAN THEY BE MEASURED?


VRC
A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS
Resources for Optimal Care of the Injured Patient
2022 Standards | Publication Date
facs.org/trauma

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Research has shown high pediatric readiness in emergency departments (EDs)–or scoring > 87 points on the National Pediatric Readiness Project Assessment–improves outcomes for children. While prehospital research is ongoing, a similar impact is anticipated in EMS settings.

High pediatric readiness in EDs is associated with:

76% lower mortality rate in ill children[1,2]

60% lower mortality rate in injured children[2]

AT LEAST 1,400 children's lives saved across the U.S. each year[2]

1. "Emergency Department Pediatric Readiness and Mortality in Critically Ill Children" *Pediatrics*, 2019, Ames et al.
2. "Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care" *JAMA Network Open*, 2023, Newgard et al.

The Power of PECCs:
Designating an individual to serve as a pediatric champion at an ED or EMS agency (also known as a pediatric emergency care coordinator or PECC) is one of the best ways to increase readiness for children.

Research on the impact of prehospital pediatric readiness will be supported by the launch of the *Prehospital* Pediatric Readiness Project Assessment in 2024.

You can help save children's lives.
www.pediatricreadiness.org

The EMSC Innovation and Improvement Center is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award [UA7MC37471] totaling $3M with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. government. For more information, visit HRSA.gov. 230511

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5.10 Pediatric Readiness-Type II

Applicable Levels
LI, LII, LIII, PTCI, PTCII

Definition Requirements
In all trauma centers, the emergency department must evaluate is pediatric readiness and have a plan to address any deficiencies

Additional Information
"Pediatric readiness" refers to infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the center is prepared to provide care to n injured child. The components that define readiness are available in the Resources section below

Measures of Compliance
Gap analysis with plan to address deficiencies in pediatric readiness

Resources
Pediatric readiness assessment:
https://emscimprovement.center/domains/pediatric-readiness-project/assessment/

Other resources to address deficiencies:
https://emscimprovement.center/domains/pediatric-readiness-project/readiness-toolkit/

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Resources for Optimal Care of the Injured Patient (2022 Standards)

- Will be effective for visits starting in September 2023
- Standard 5.10 - Pediatric Readiness
  - The NPRP assessment must be conducted once during the verification cycle.
  - One cycle is defined as the thirty-six (36) month period preceding the expiration date of the current verification status.

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Components of Pediatric Readiness

- Guidelines for Administration and Coordination of the ED for the Care of Children
- Physicians, Nurses, and Other Health Care Providers Who Staff the ED
- Guidelines for QI/PI in the ED
- Guidelines for Improving Pediatric Patient Safety in the ED
- Guidelines for Policies, Procedures, and Protocols for the ED
- Guidelines for Equipment, Supplies, and Medications for the Care of
- Pediatric Patients in the ED

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What does compliance look like

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Gap Analysis

PEDIATRIC READINESS GAP ANALYSIS

	CURRENT STATUS	TARGET	GAP ANALYSIS	PLAN
People	Nursing competencies are being completed, with pediatric considerations. Pediatric focused competency not developed, especially related to triage and age specific assessments.	Complete annual Pediatric only competency. Highlighting needs assessment from EM Physicians and ED Nursing leadership & PI/QA Audits.	Pediatric specific cases no regularly brought to ED PI. Charts being reviewed are looking at systems based PI. Need a clinical analysis of care.	Working with ED PI Committee & ED Nursing Educators develop a needs assessment for annual Pediatric competencies.
Disaster Preparedness	Internal Disaster plan for hospital is comprehensive to the adult population. It does not address "vulnerable" populations, including pediatrics, but does not have an included yet separate plan or subject matter experts related to pediatrics in the EOCC. [redacted] is part of the District 5 Emergency preparedness district and has developed a HEALTHCARE COALITION PEDIATRIC SURGE ANNEX plan. Gaps noted between D5 pediatric plan and internal plans to address D5 needs. Disaster drills do not include pediatric patients in every drill.	Align with D5 Pediatric Surge Annex. Have Pediatric Specific Disaster plans. Pediatric considerations/objective within each disaster drill.	D5 Pediatric surge plan outlines agreed upon needs from all trauma centers. Gaps in current Emergency Mgmt plans internally are noted. No Pediatric specific disaster plan in place Pediatric considerations (triage and rapid sorting of patients) are no on every drill. Although there have been Pediatric specific drills throughout the year.	Emergency Management committee to review and develop a subgroup to review D5 Pediatric surge Annex plan. Identify gaps and align workgroup to address [redacted] specific needs. Emergency Mgmt team to convene a subgroup of subject matter experts to develop and test a pediatric disaster plan. Emergency Mgmt team to add a pediatric objective to disaster drills at [redacted].
PI/QA	PI on all trauma transfers out being reviewed monthly. Timeliness of transfers and patient outcomes at receiving facility being reviewed. Clinical reviews are not routinely being completed at this time as it relates to quality of pediatric care giving	Have a process that allows for MD & RN review of a set number of Pediatric related cases, reviewing appropriateness of clinical care and system issues.	Pediatric specific cases not regularly brought to ED PI. Charts being reviewed are looking at systems based PI. Need a clinical analysis of care.	ED PI have dedicated time for Pediatric audit review. Review of 5 charts per month plus all Pediatric ED deaths. Specific Audit filters to be developed that address triage, interventions, outcomes and timeliness of care.
Reports	Emergency Medical Services for Children (EMSC) report completed in 2021.	Complete the report with zero errors noted.	Emergency Nursing leadership completed survey with noted documentation errors, specifically Physician Maintenance of Board Certification & Nurse Maintenance of Specialty Certification	Resubmit report and review adjusted report findings. Pediatric Nursing Liaison and EM Pediatric Champion.

Pediatric readiness survey results were formally reviewed by EM/ED Leadership , Trauma, and an EMSC Pediatric Readiness Physician Liaison. Review of findings led to the development of this plan.

Disaster Preparedness

CURRENT STATUS

Internal Disaster plan for hospital is comprehensive to the adult population. It does not address "vulnerable" populations, including pediatrics, but does not have an included yet separate plan or subject matter experts related to pediatrics in the EOCC. [redacted] is part of the District 5 Emergency preparedness district and has developed a HEALTHCARE COALITION PEDIATRIC SURGE ANNEX plan. Gaps noted between D5 pediatric plan and internal plans to address D5 needs.

Disaster drills do not include pediatric patients in every drill.

Disaster
Preparedness

TARGET

Align with D5 Pediatric Surge Annex.

Have Pediatric Specific Disaster plans.

Pediatric considerations/objective within each disaster drill.

Disaster Preparedness

GAP ANALYSIS

D5 Pediatric surge plan outlines agreed upon needs from all trauma centers. Gaps in current Emergency Mgmt plans internally are noted.

No Pediatric specific disaster plan in place

Pediatric considerations (triage and rapid sorting of patients) are no on every drill. Although there have been Pediatric specific drills throughout the year.

Disaster Preparedness

PLAN

Emergency Management committee to review and develop a subgroup to review D5 Pediatric surge Annex plan. Identify gaps and align workgroup to address [redacted] specific needs.

Emergency Mgmt team to convene a subgroup of subject matter experts to develop and test a pediatric disaster plan.

Emergency Mgmt team to add a pediatric objective to disaster drills at [redacted]

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Guidelines for Administration and Coordination of the ED for the Care of Children (19 points possible)

Question	Your Answer	Possible Score
Physician Coordinator	Our ED does NOT HAVE a physician coordinator at this time	9.5
Nurse Coordinator	Our ED does NOT HAVE a nurse coordinator at this time	9.5

Our ED does NOT HAVE a physician coordinator

Gap analysis- physician coordinator is being recruited

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Is the Standard Awesome?
Is the Standard Weak?

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Thank you!

Pediatric Readiness at US Trauma Centers:
Background, Access for Kids, and Impact

Aaron Jensen, MD, MEd, MS, FACS, FAAP

Trauma Domain Co-Lead, EMSC Innovation and Improvement Center

Trauma Medical Director, UCSF Benioff Children's Hospital Oakland

September 13, 2023

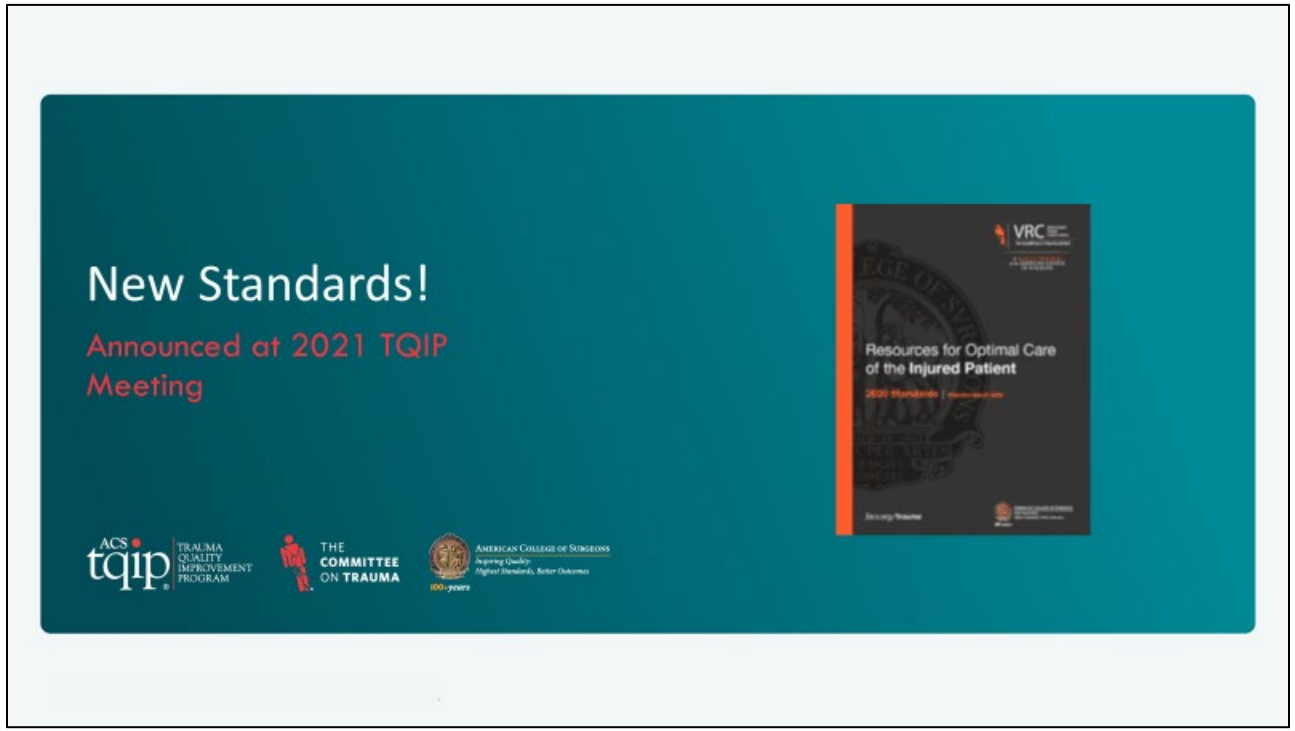
EIIC
EMSC Innovation and Improvement Center

Disclosures and Funding Acknowledgements

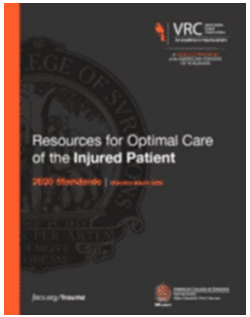
- I have no personal or financial disclosures

- Salary support:
  - The **EMSC Innovation and Improvement Center** is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award (U07MC37471) totaling $2.5M with 0 percent financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. government. For more information, visit HRSA.gov.
  - The **Pediatric Pandemic Network** is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of cooperative agreements U1IMC43532 and U1IMC45814 with 0 percent financed with nongovernmental sources. The content presented here is that of the authors and does not necessarily represent the official views of, nor an endorsement by HRSA, HHS, or the U.S. Government.

2022 ACS Standards



New ACS Pediatric Readiness Standard for All Trauma Centers



Standard 5.10—Pediatric Readiness—Type II

Applicable Levels

LI, LII, LIII, PTCI, PTCII

Definition and Requirements

In all trauma centers, the emergency department must **evaluate** its pediatric readiness and **have a plan** to address any deficiencies.

Additional Information

"Pediatric readiness" refers to infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the center is prepared to provide care to an injured child.

Measures of Compliance

Gap analysis with plan to address deficiencies in pediatric readiness

Objectives for Today

- Access to trauma care for kids
- Impact of pediatric readiness on outcomes
- Current State of pediatric readiness at US trauma centers
- EIIC Trauma Domain efforts to support pediatric readiness in adult trauma centers

Why Does This Matter?

Access to PTCs is Limited

By Air

30min	<20%
45min	~55%
60min	~70%

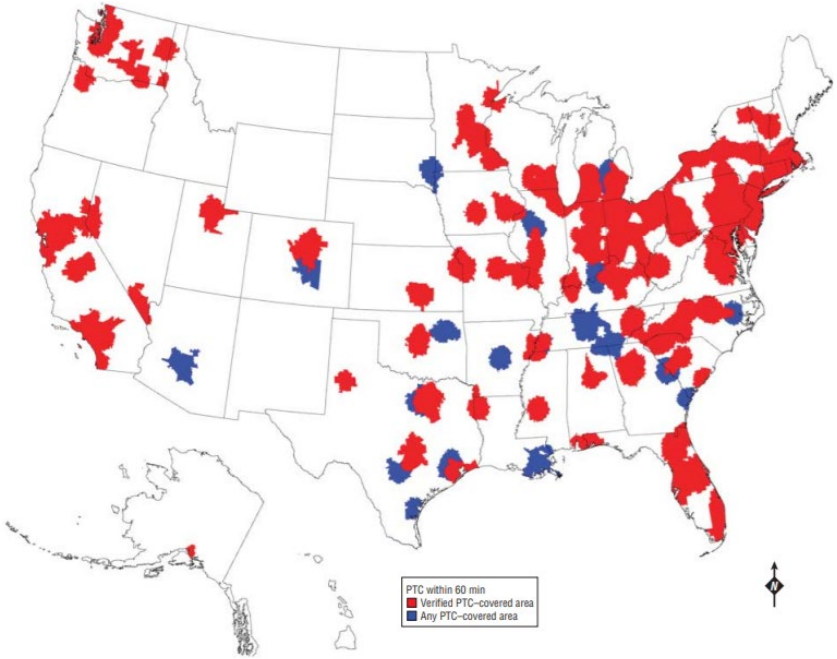
By Ground

30min	<20%
45min	~30%
60min	~40%

ARTICLE

Access to Pediatric Trauma Care in the United States

Michael L. Nance, MD; Brendan G. Carr, MD, MA, MS; Charles C. Branas, PhD



Nance ML, Carr BG, and Branas CC.
Arch Pediatr Adolesc Med. 2009;163(6):512-518

Why Does This Matter?

Pediatric Trauma Centers

57% of Children within 30 miles

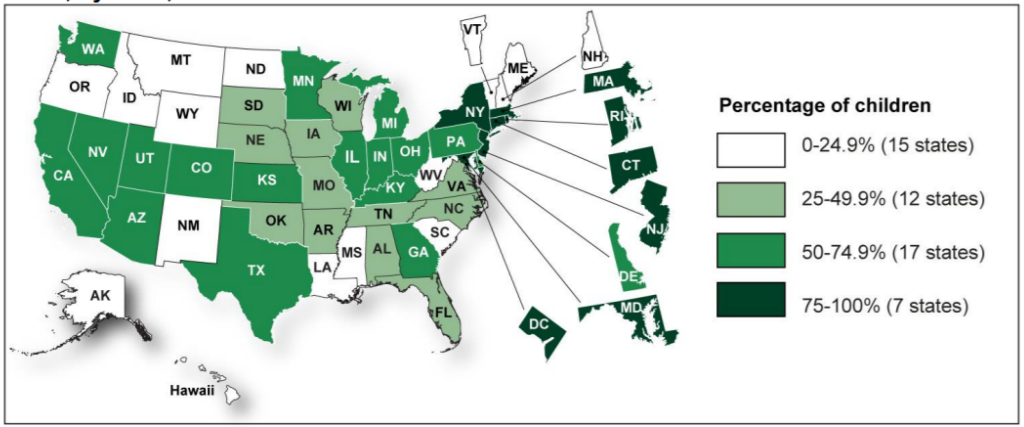
100% coverage only in Northeast

United States Government Accountability Office

GAO

Report to Congressional Requesters

Estimated Percentage of Children Who Lived within 30 Miles of a High-Level Pediatric Trauma Center, by State, 2011-2015



Sources: GAO analysis of American Trauma Society and U.S. Census Bureau data (data); Map Resources (map). | GAO-17-334

Why Does This Matter?

Pediatric Trauma Centers

57% of Children within 30 miles

100% coverage only in Northeast

Any L1-L3 Trauma Center

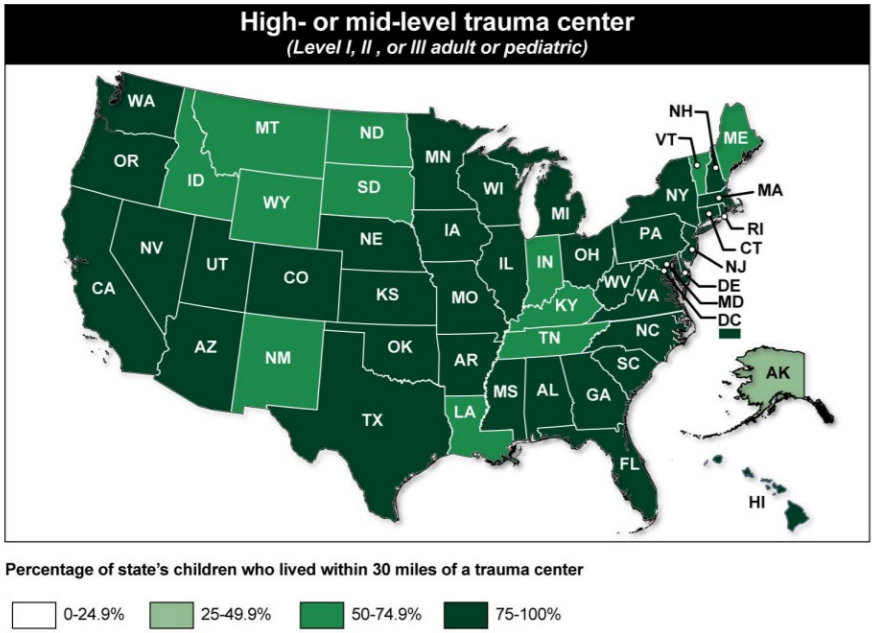
88% of Children within 30 miles

100% coverage in 37 states

United States Government Accountability Office

GAO

Report to Congressional Requesters



Why Does This Matter?

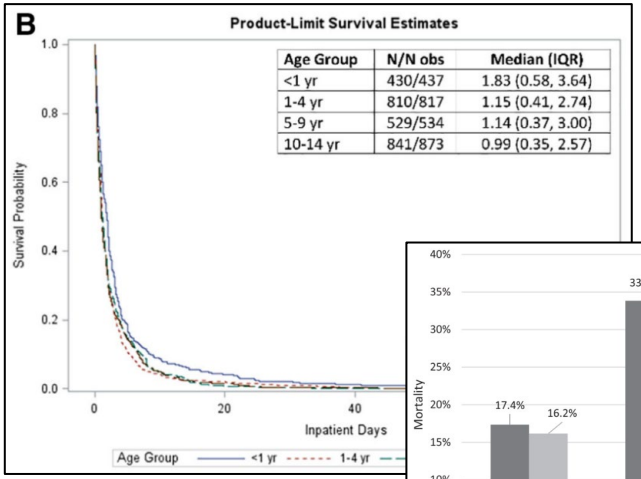
Children Die Early After Injury

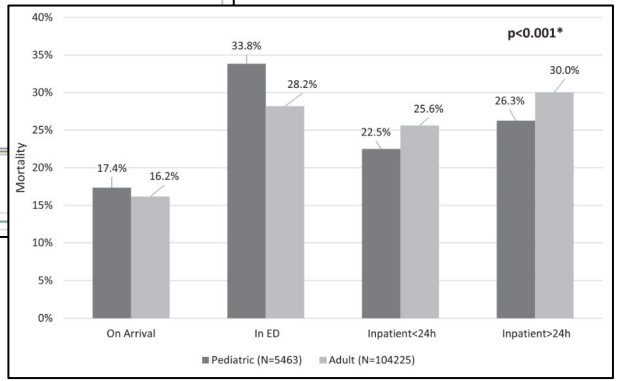
- Earlier than adults
- 51% on arrival or in ED
- 74% within first 24h

Suggests greatest impact on outcomes is during early resuscitative care!

Timing of mortality in pediatric trauma patients: A National Trauma Data Bank analysis☆,☆☆,★,★★

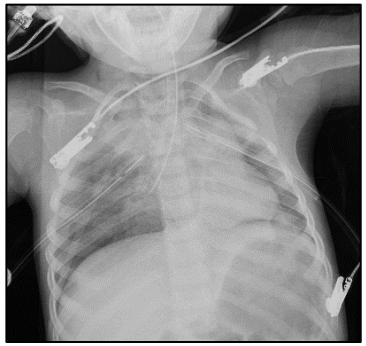
Cory McLaughlin [a], Jessica A. Zagory [a], Michael Fenlon [a,b], Caron Park [c,d], Christianne J Lane [c,d], Daniella Meeker [c,d], Randall S. Burd [e], Henri R. Ford [a,b], Jeffrey S. Upperman [a,b], Aaron R. Jensen

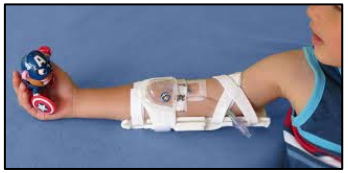


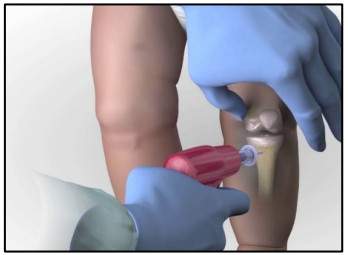


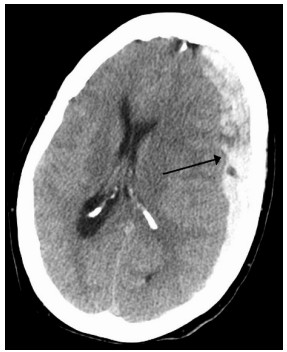
McLaughlin C, Zagory JA, Fenlon M et al.
J Pediatr Surg. 2018 Feb;53(2):344-351

Early Resuscitative Care?



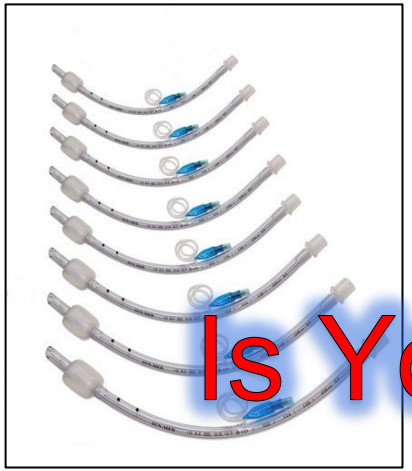




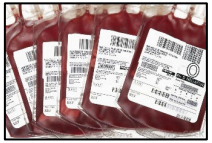


Normal:
Perfusion
EtCO2
SaO2
Temp
Glucose

Early Resuscitative Care…*is Complex for Kids*



Is Your Center Ready?



2 'Units': 10cc/kg
MTP Volumes?
Ratios?

Pediatric Readiness Matters!

832 Eds / 372,000 Kids:

- Analyzed outcomes by Peds Readiness Score of INITIAL RECEIVING HOSPITAL
- Risk-adjusted mortality 58% lower for kids treated at EDs with highest Peds Readiness Scores.
- “If all children cared for in the lowest-readiness quartiles were treated in an ED in the highest quartile of readiness, an additional 126 lives might be saved each year in these trauma centers”.

JAMA Pediatrics | Original Investigation

Evaluation of Emergency Department Pediatric Readiness and Outcomes Among US Trauma Centers

Craig D. Newgard, MD, MPH; Amber Lin, MS; Lenora M. Olson, PhD; Jennifer N. B. Cook, GCPH; Marianne Gausche-Hill, MD; Nathan Kuppermann, MD, MPH; Jeremy D. Goldhaber-Fiebert, PhD; Susan Malveau, MS; McKenna Smith, BS; Mengtao Dai, MS; Avery B. Nathens, MD, PhD; Nina E. Glass, MD; Peter C. Jenkins, MD, MSc; K. John McConnell, PhD; Katherine E. Remick, MD; Hilary Hewes, MD; N. Clay Mann, PhD, MS; for the Pediatric Readiness Study Group

Variable	OR (95% CI)	In-hospital mortality	*P* value
All patients (n = 372 004)			
4th Quartile	0.58 (0.45-0.75)		<.001
3rd Quartile	0.90 (0.70-1.17)		.44
2nd Quartile	1.16 (0.87-1.54)		.32
ISS ≥16 (n = 50 440)			
4th Quartile	0.61 (0.49-0.76)		<.001
3rd Quartile	0.90 (0.72-1.12)		.34
2nd Quartile	1.11 (0.87-1.43)		.39
Head AIS ≥3 (n = 57 368)			
4th Quartile	0.56 (0.44-0.71)		<.001
3rd Quartile	0.86 (0.68-1.10)		.24
2nd Quartile	1.03 (0.78-1.36)		.82
Any AIS ≥3 (n = 124 507)			
4th Quartile	0.57 (0.45-0.71)		<.001
3rd Quartile	0.88 (0.70-1.11)		.30
2nd Quartile	1.05 (0.80-1.37)		.44

Newgard CD, et al. JAMA Pediatr. 2021 Sep 1;175(9):947-956

Pediatric Readiness at US Trauma Centers

1247 Trauma Hospitals:

- Children's Hospitals are Peds Ready (99/100, duh!)
- EDAP Hospitals are Peds Ready (91/100)
- Trauma Hospitals are no better than national average (Median 68 v. 72)
- We have OFI…as a trauma system (57% ->88% access)

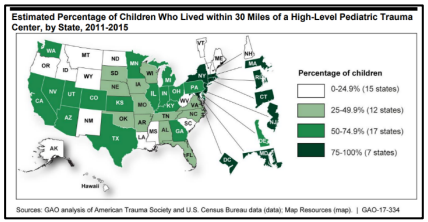
Pediatric emergency department readiness among US trauma hospitals

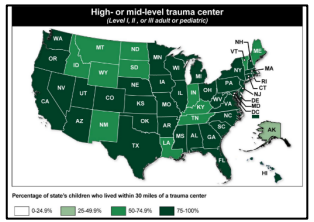
Katherine Remick, MD, Barbara Gaines, MD, Michael Ely, Rachel Richards, MStat, Diana Fendya, MSN, *and* **Elizabeth A. Edgerton, MD**, *Austin, Texas*

TABLE 1. Trauma Hospital Type

	Children (n = 49)	EDAP (n = 110)	Trauma (n = 1088)	Overall (N = 1247)	*p*
Score					<0.001*
Mean (SD)	96.7 (4.8)	87.0 (12.4)	69.1 (16.8)	71.8 (17.6)	
Median (Q1, Q3)	98.6 (95.1, 100.0)	90.7 (82.7, 95.8)	68.4 (56.6, 81.9)	71.7 (58.1, 87.0)	
Min, max	74.4, 100.0	47.1, 100.0	27.3, 100.0	27.3, 100.0	

* Kruskal-Wallis test.





Remick K, et al. J Trauma Acute Care Surg. 2019 May;86(5):803-809.

So how are we working to get there?

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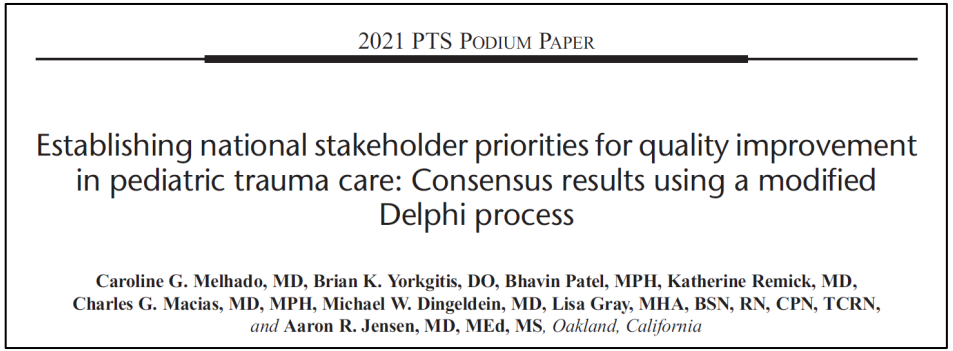
Defining Quality Improvement Needs at Trauma Centers

Consensus Priorities:

- Facilitate PECC development
- Disseminate best practice guidelines for imaging
- Implement toolkit and standardized provider training for pediatric trauma triage, hemorrhagic shock, and neurotrauma resuscitation
- Develop minimum standards for pediatric trauma care to optimize the adult system.



2021 PTS Podium Paper

Establishing national stakeholder priorities for quality improvement in pediatric trauma care: Consensus results using a modified Delphi process

Caroline G. Melhado, MD, Brian K. Yorkgitis, DO, Bhavin Patel, MPH, Katherine Remick, MD, Charles G. Macias, MD, MPH, Michael W. Dingeldein, MD, Lisa Gray, MHA, BSN, RN, CPN, TCRN, *and* Aaron R. Jensen, MD, MEd, MS, *Oakland, California*

EIIC EMSC Innovation and Improvement Center

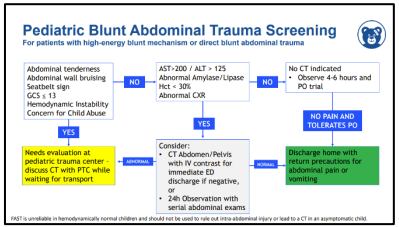
J Trauma Acute Care Surg. 2022;93: 467–473

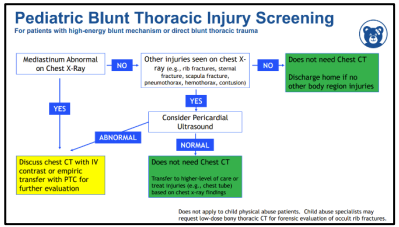
Improving Pediatric Care Coordination

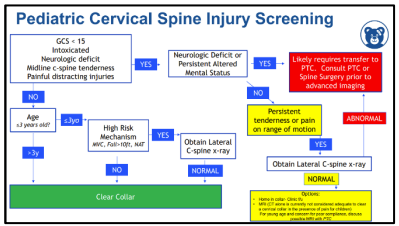
- **Trauma Center PECC Development:**
  - Leveraged ACS TQIP Communication Channels
  - Collaborated with EMSC PWDC
  - **300 PECCs** trained from trauma centers in Spring 2022
  - *Anticipating more to come with new ACS Standard…*

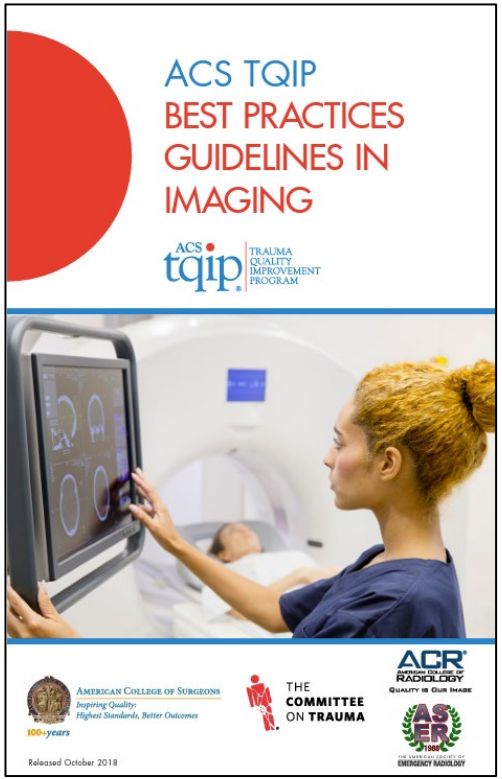
Best Practice Guidelines for Imaging

- **Problem:**
  - 83% of Pan-Scans done prior to transfer to a pediatric trauma center are unindicated
  - Guidelines are hard to access…







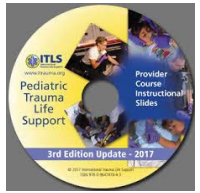


116 Pages

EMSC Innovation and Improvement Center

Trauma Quickguides / JIT Support

- **Problem:**
  - Lots of courses (minimal aids)
  - People take them once (maybe)
- **Ongoing Work:**
  - National needs assessment survey (complete)
  - Toolkits being developed followed by training
    - Pediatric Trauma Triage
    - Recognition and Management of Moderate and Severe TBI
    - Recognition and Management of Hemorrhagic Shock (including pediatric MTP)



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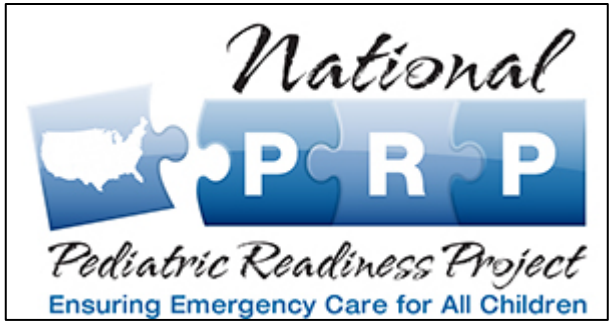
Ongoing Development of Minimum Standards for Trauma Centers

Data Driven (2021 NPRP Assessment):

- Updated assessment of pediatric readiness at trauma centers
- Updated geospatial analysis of access to pediatric trauma centers and to ‘pediatric ready’ adult trauma centers
- Updated analysis of associations between wPRS and mortality
- Engagement with facility recognition quality improvement collaborative – how to integrate with trauma systems



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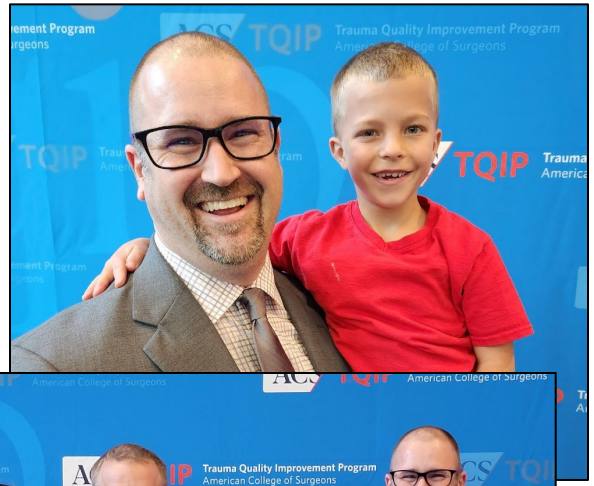
Partnership with ACS



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Pediatric Readiness
In
Texas Trauma Centers

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September 13, 2023

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Speaker Disclosure

I have no financial interests or relationships to disclose.

Why Pediatric Readiness in Texas Trauma Center?

- ACS new recommendation to include aspects of Pediatric Readiness
- Texas Trauma Rules Revision to include Pediatric Readiness
- 303 Texas Trauma Centers need help to comply
- It's the RIGHT thing to do for Texas children

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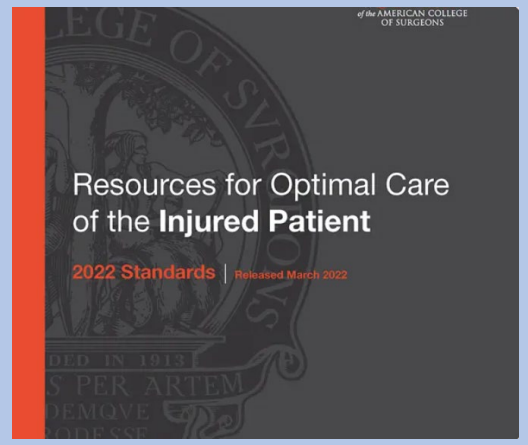
What Got Us Here?

TEXAS Department of State Health Services

EMSC Emergency Medical Services for Children



ENA EMERGENCY NURSES ASSOCIATION

THE COMMITTEE ON TRAUMA

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American Academy of Pediatrics

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American College of Emergency Physicians

ADVANCING EMERGENCY CARE

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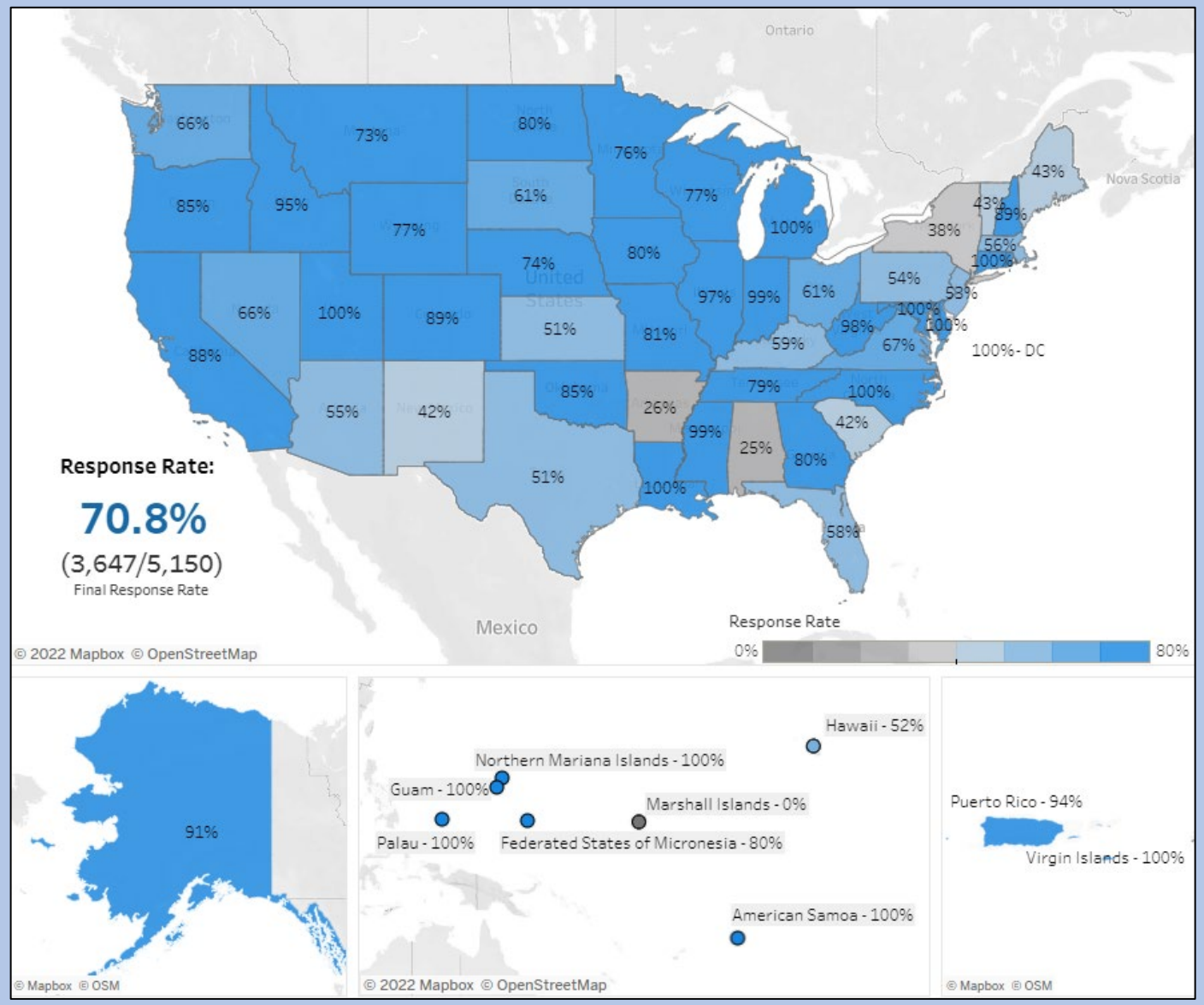
National PRP Pediatric Readiness Project
Ensuring Emergency Care for All Children



TEXAS

NUMERATOR: 267

DENOMINATOR: 525

RESPONSE RATE: 50.9%

Supported by:

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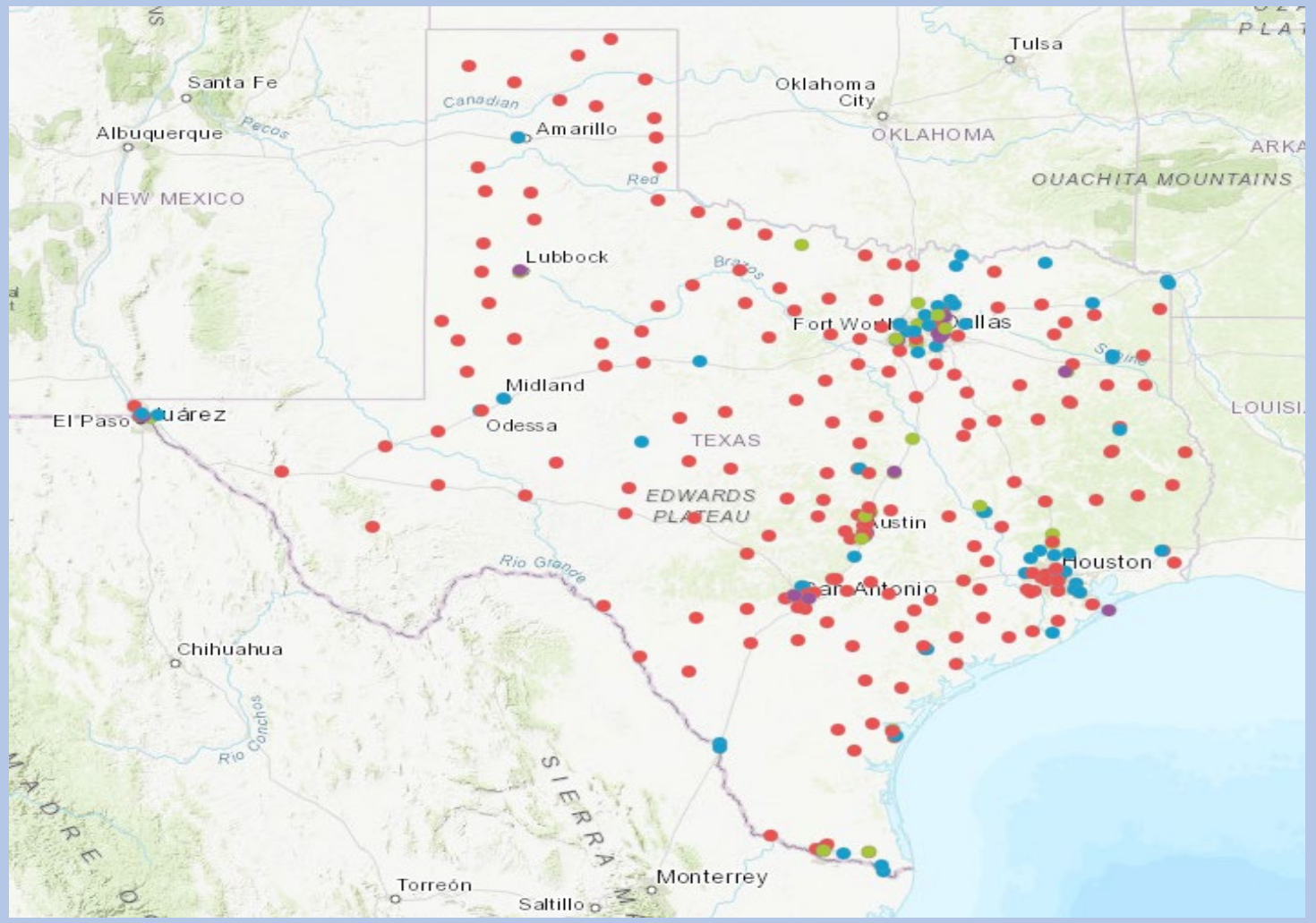
Texas Designated Trauma Centers (303)

- **Level I: 22**
- **Level II: 27**
- **Level III: 60**
- **Level IV: 194**

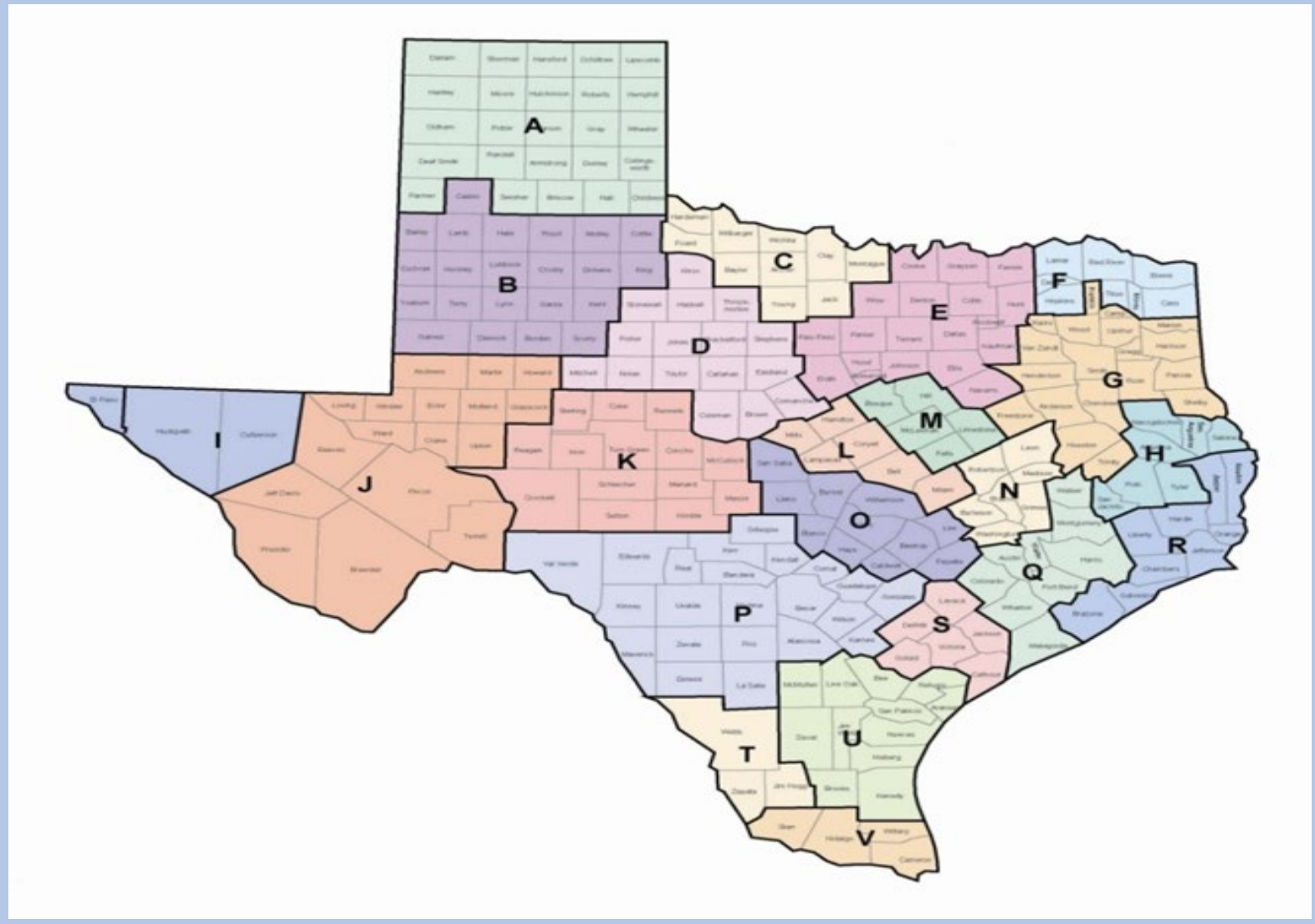
- **Peds Level I: 3**
- **Peds Level II: 3**
- **Peds Level III: 2**
- **Peds Level IV: 3**



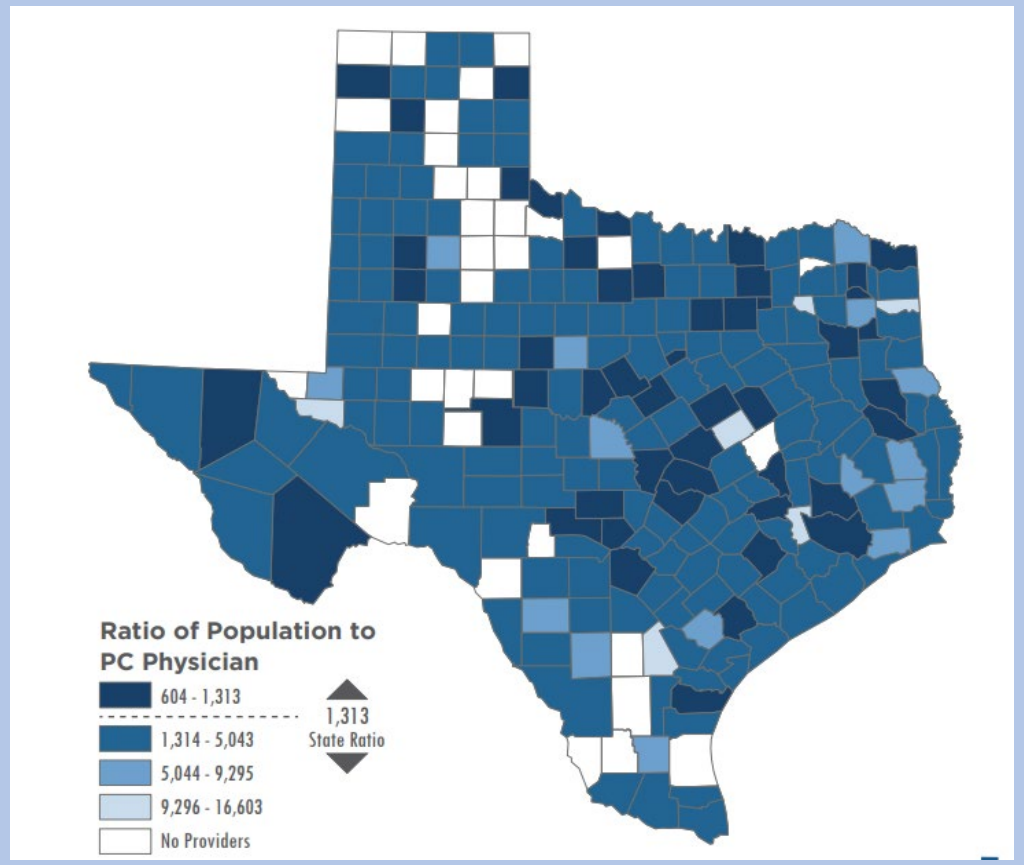
Texas' Regional Approach to Trauma

- Geographical trauma regions established around existing patient referral patterns
  - Each TSA is governed by a Regional Advisory Council (RAC)
- RACs vary in size, resources, and capacity
  - Composed of health organizations, providers, and interested stakeholders
  - Goal is to minimize the time from onset of injury or illness to appropriate definitive quality care

Texas is Divided into 22 Trauma Service Areas



Things to remember about Texas' Access to Care



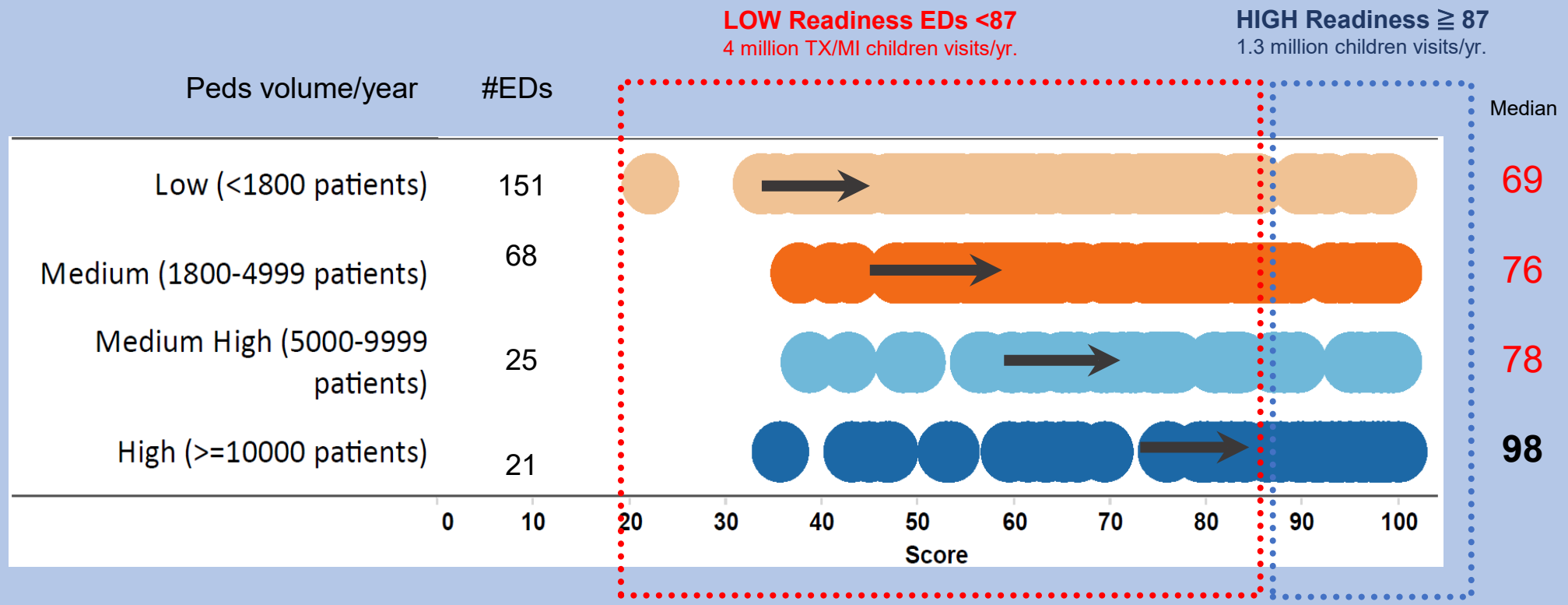
2020 data

- 77 counties have NO hospital
- Some are more than 75 miles from the nearest hospital
- 28 counties have no active patient care physician
- 147 have no obstetrician
- 11 counties have no EMS station

N=254 counties

Where Did Texas Stand in 2021?

71% median
(267/525 EDs)

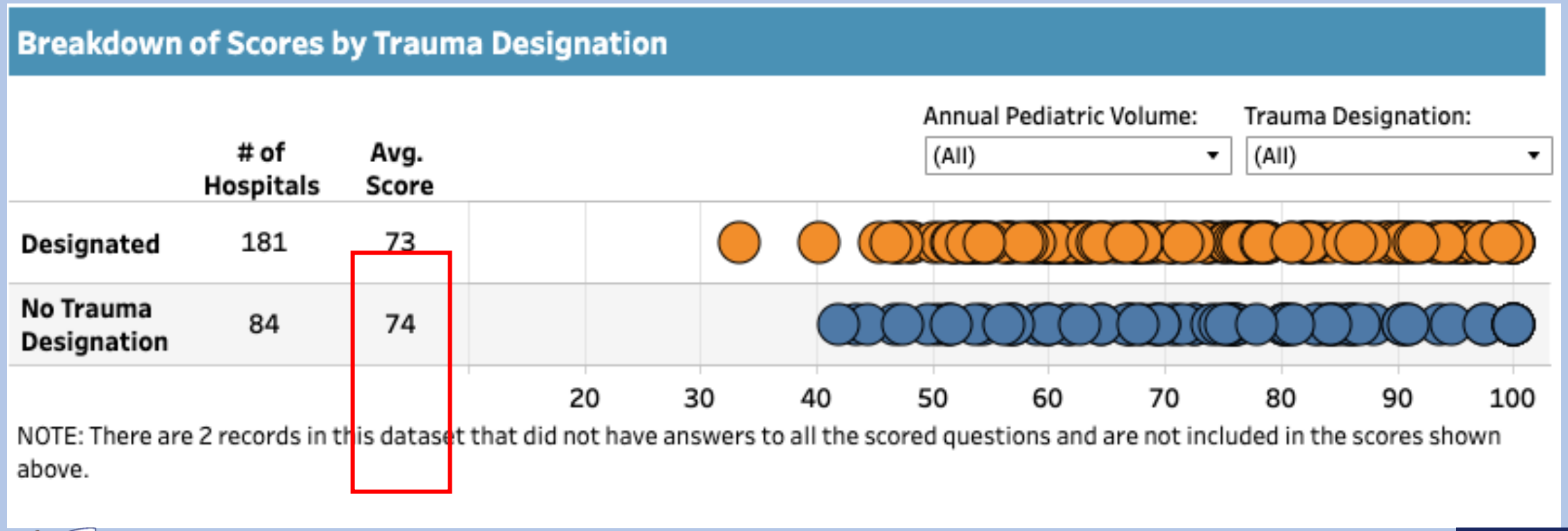


60% higher survival for severely injured children visiting HIGH Readiness EDs
Unfortunately, most rural/underserved children visit LOW Readiness EDs

Pediatric Emergency Care Coordinators *(PECCs) are the strongest driver of HIGH Readiness across all domains*

>60% EDs have no PECC, reported barriers: insufficient training, limited time/resources

Trauma Facility vs Non-Trauma (State)



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New Resources “Hot off the Press”

- Impact of individual components of emergency department pediatric readiness on pediatric mortality in US trauma centers.

  Remick K, Smith M, Newgard CD, Lin A, Hewes H, Jensen AR, Glass N, Ford R, Ames S, Cook J, Malveau S, Dai M, Auerbach M, Jenkins P, Gausche-Hill M, Fallat M, Kuppermann N, Mann NC.J Trauma Acute Care Surg. 2023 Mar 1;94(3):417-424. doi: 10.1097/TA.0000000000003779. Epub 2022 Sep 1.PMID: 36045493

- Emergency Department Pediatric Readiness Among US Trauma Centers: A Machine Learning Analysis of Components Associated With Survival.

  Newgard CD, Babcock SR, Song X, Remick KE, Gausche-Hill M, Lin A, Malveau S, Mann NC, Nathens AB, Cook JNB, Jenkins PC, Burd RS, Hewes HA, Glass NE, Jensen AR, Fallat ME, Ames SG, Salvi A, McConnell KJ, Ford R, Auerbach M, Bailey J, Riddick TA, Xin H, Kuppermann N; Pediatric Readiness Study Group.Ann Surg. 2023 Sep 1;278(3):e580-e588. doi: 10.1097/SLA.0000000000005741. Epub 2022 Nov 1.PMID: 36538639

Texas Proposed Trauma Rules

- Participation in the National Pediatric Readiness Project (NPRP) Assessment (https://pedsready.org/) Annually
- Ensure pediatric equipment and resources are immediately available at the facility (staff have competencies on that equipment)
- Education requirements for ENPC or PALS is compliant for nurses
- The facility conducts one pediatric trauma simulation quarterly that has documentation of medical staff participation

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Texas Quality Measures for Trauma Designation

- Adult trauma centers conduct simulated pediatric trauma resuscitation with physician leadership quarterly.
- Children are weighed in kilograms only and weights are recorded in kilograms only
- Pediatric vital signs include T, HR, RR, BP and include pain assessment. Vital signs are recorded serially
- Pediatric equipment is available for resuscitation in diagnostic areas, Operating Room and IP setting
- Management guidelines for pediatric imaging and initial resuscitation are present and compliance is monitored.
- Child abuse screening is completed and documented on every pediatric patients.
- Pediatric Psychosocial support services are available.

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How Can We Possibly Manage This Task???

- The Texas Office of Trauma and EMS
- The Governor's EMS and Trauma Advisory Council
  - Pediatric Committee
  - Simulation Task Force
- Texas Emergency Nurses Association
- Texas Trauma Coordinators Forum
- Texas Regional Advisory Council Leaders

National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

Texas ENA

Texas Trauma Coordinators Forum

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TOYOTA way forward FUND

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Ongoing Efforts to Implement Peds Ready

- Identify Nurse Super PECC's in each Region of our State and Physician SMEs to support system education efforts.
- Educate the Super PECC's in a train-the-trainer model to
  - disseminate pediatric protocol/guidelines education,
  - facilitate simulation and
  - coach trauma program and ED leaders on QI/PI initiatives through the National Pediatric Quality Improvement Initiative.
- Assist hospital PECC's with simulation and QI/PI planning
- Promote the Texas EMSC Voluntary Pediatric Recognition Program across the State

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Here are my reasons to get up in the morning!