Pediatric Readiness Recognition Programs Collaborative

Session 6
March 21, 2024

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Funding Acknowledgement

The Pediatric Pandemic Network and the EMSC Innovation and Improvement Center are 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, U1IMC45814, and U07MC37471 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.

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Thank you for joining!

Session is being recorded

Raise your hand or come off mute

Today's session is interactive

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

PRRPC Session Agenda

- Discuss minimum criteria for prehospital pediatric readiness recognition programs, review round two results, and prepare for round 3 – **30 minutes**

- Effectively Communicating Peds Ready Recognition **- 20 minutes**

- Discuss minimum criteria for emergency department pediatric readiness recognition programs, review round three results – **30 minutes**

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Prehospital Recognition Programs

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Proposed Ranking for Round 3

- Scores averaging 4.4 or higher:
  - Recommended minimum criteria to be included in a recognition program
- Scores averaging 3.01 - 4.3:
  - Stretch criteria for recognition programs
- Scores averaging below 3.0:
  - Optional criteria- states can use these at their discretion

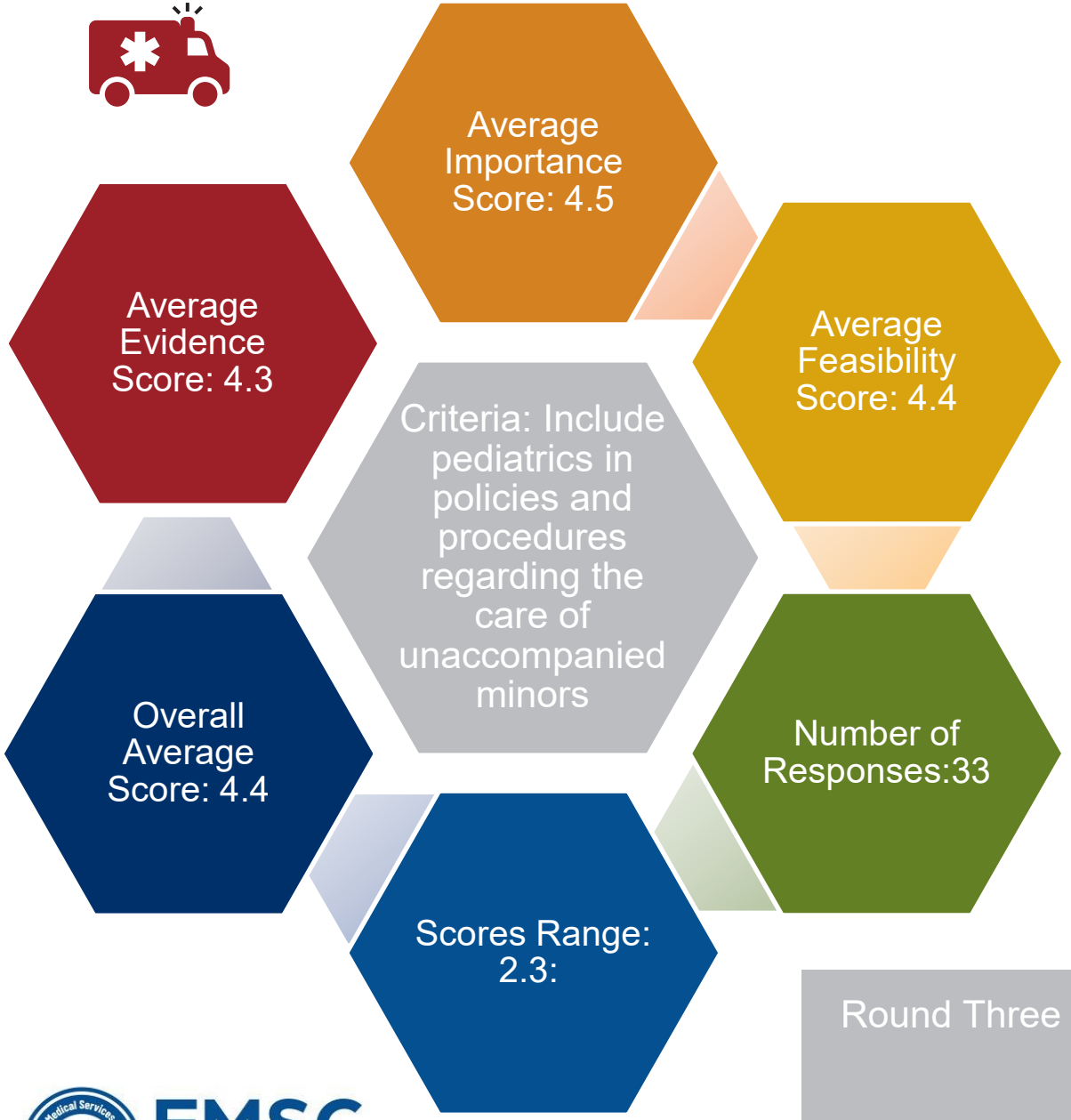
EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Prehospital Round 2 Results

PH- Criteria	Overall Average	Average Max	Average Min	Range
Requires training on medication dosing for children	4.6	5	3	2
Uses weight estimation system	4.6	5	2.7	2.3
Include pediatrics in policies and procedures regarding the reporting of child maltreatment	4.6	5	2.3	2.7
Prehospital personnel can locate pediatric specific equipment	4.5	5	1	4
Include pediatrics in policies and procedures regarding the use of trauma triage destination protocols	4.4	5	1	4
Prehospital personnel physically demonstrate correct use of pediatric specific equipment	4.4	5	2.7	2.3
Include pediatrics in policies and procedures regarding the care of unaccompanied minors	4.4	5	2.7	2.3
A designated PECC	4.4	5	2.3	2.7
Established process for the regular verification of pediatric equipment and supplies	4.3	5	2.3	2.7
Include pediatric in policies and procedures regarding refusals involving children	4.3	5	2.7	2.3
Policies, procedures, and training integrates elements of patient and family centered care	4.3	5	2.7	2.3
All recommended equipment and supplies readily available	4.3	5	2.3	2.7
Participates in disaster drills that include children	4.2	5	1.7	3.3
Has a prehospital disaster triage algorithm that includes children	4.2	5	1.7	3.3
QI plan includes pediatric considerations	4.1	5	1	4
Utilizes national consensus recommendations to guide availability of equipment and supplies to treat all ages	3.98	5	1.3	3.7
Has a mass transport policy or protocol that includes children	3.8	5	1	4

EMSC Quality Improvement Collaboratives



Pros:

- Policies typically seem an easier life in terms of feasibility.
- This can be easily addressed through individual company policies.
- Guidance needs to be developed in conjunction with this requirement to address unique situations, such as when an adult is accompanying the child but it may be questionable as to their custodial rights.

Cons:

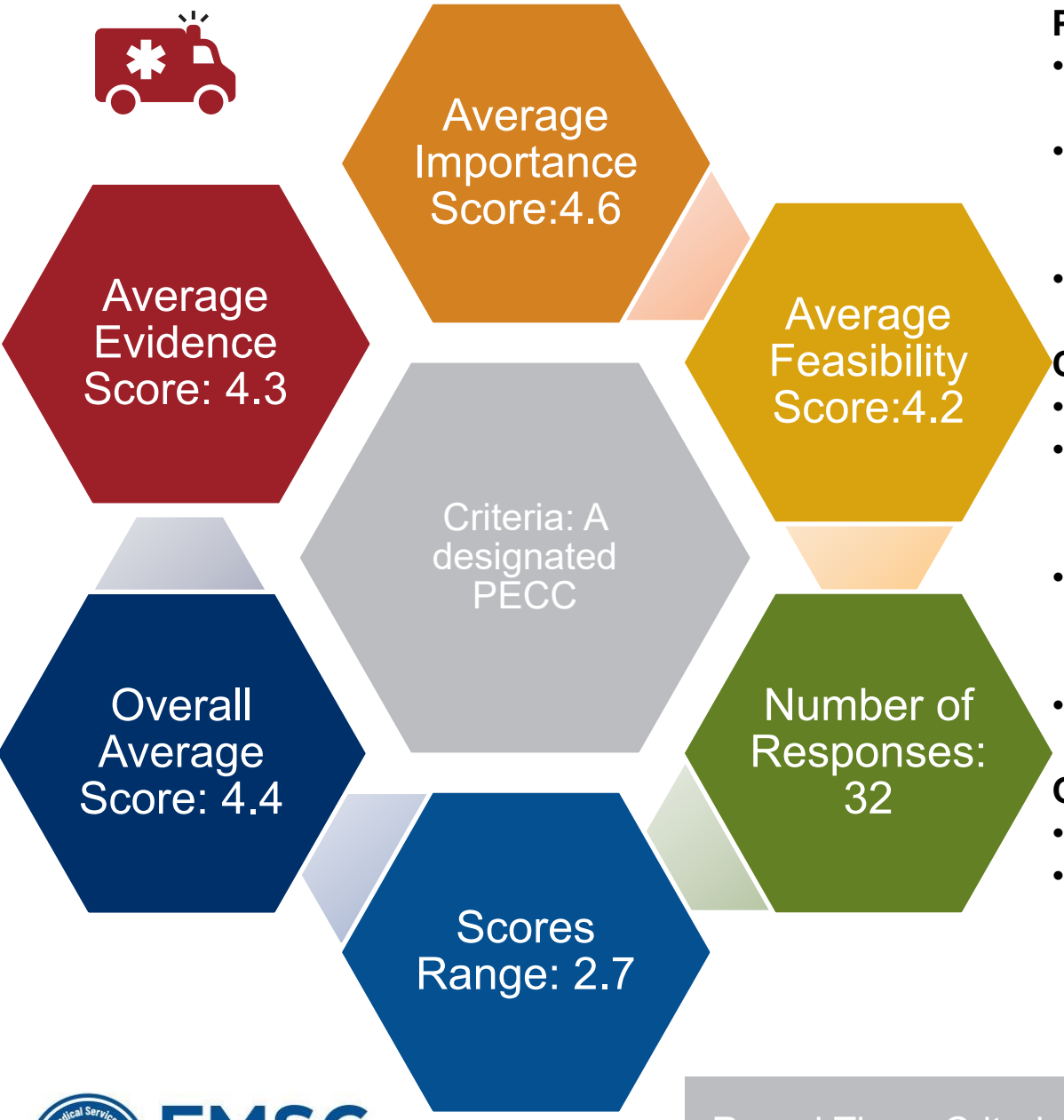
General Comments:

- State level legislation has several of these policies
- Aren't unaccompanied minors by nature pediatric? How could you not include them? How could you not include peds in child maltreatment policies? Not sure what we are debating here.

Round Three Criteria:

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK



PROS:

- PECC is needed in the Prehospital Agencies to assist us with what their needs are to help provide skill checks
- This is an absolute must and the easiest to achieve by ALL locations. Having a qualified provider can bring a focus to pediatric care and improve provider confidence on pediatric transports.
- Having a qualified provider can bring a focus to pediatric care and improve provider confidence on pediatric transports.

CONS:

- Not feasible for agencies that are staffed by volunteers.
- The common argument is that they are unable to add additional staff and that having PECC responsibilities would overwhelm their personnel's workload.
- Very difficult to have a PECC for non-transport first responder agencies, makes more sense to be within the contracted 911 provider and/or the LEMSA
- It will be difficult for some of the smaller EMS agencies to attain this requirement, particularly volunteer EMS agencies

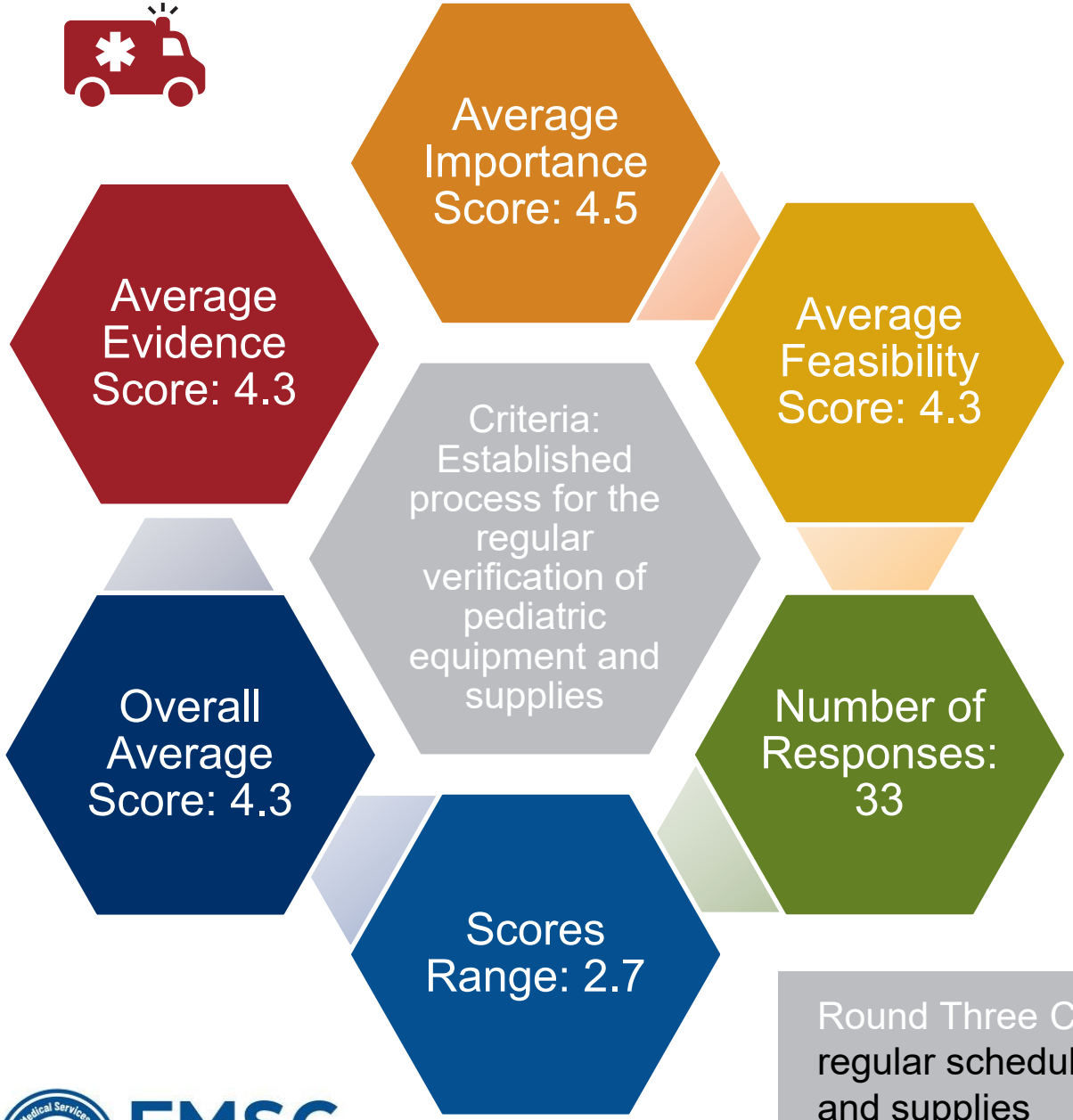
GENERAL:

- This is much more feasible if the kind of PECC is not designated
- Does this position need to be full time
  - A regional PECC would suffice - could cover a few agencies at once
  - Is this per agency, per LEMSA??? Very difficult to have a PECC for non-transport first responder agencies, makes more sense to be within the contracted 911 provider and/or the LEMSA

Round Three Criteria: A designated PECC who may support one or more agencies

EMSC Quality Improvement Collaboratives

Pediatric Pandemic Network



Pros:

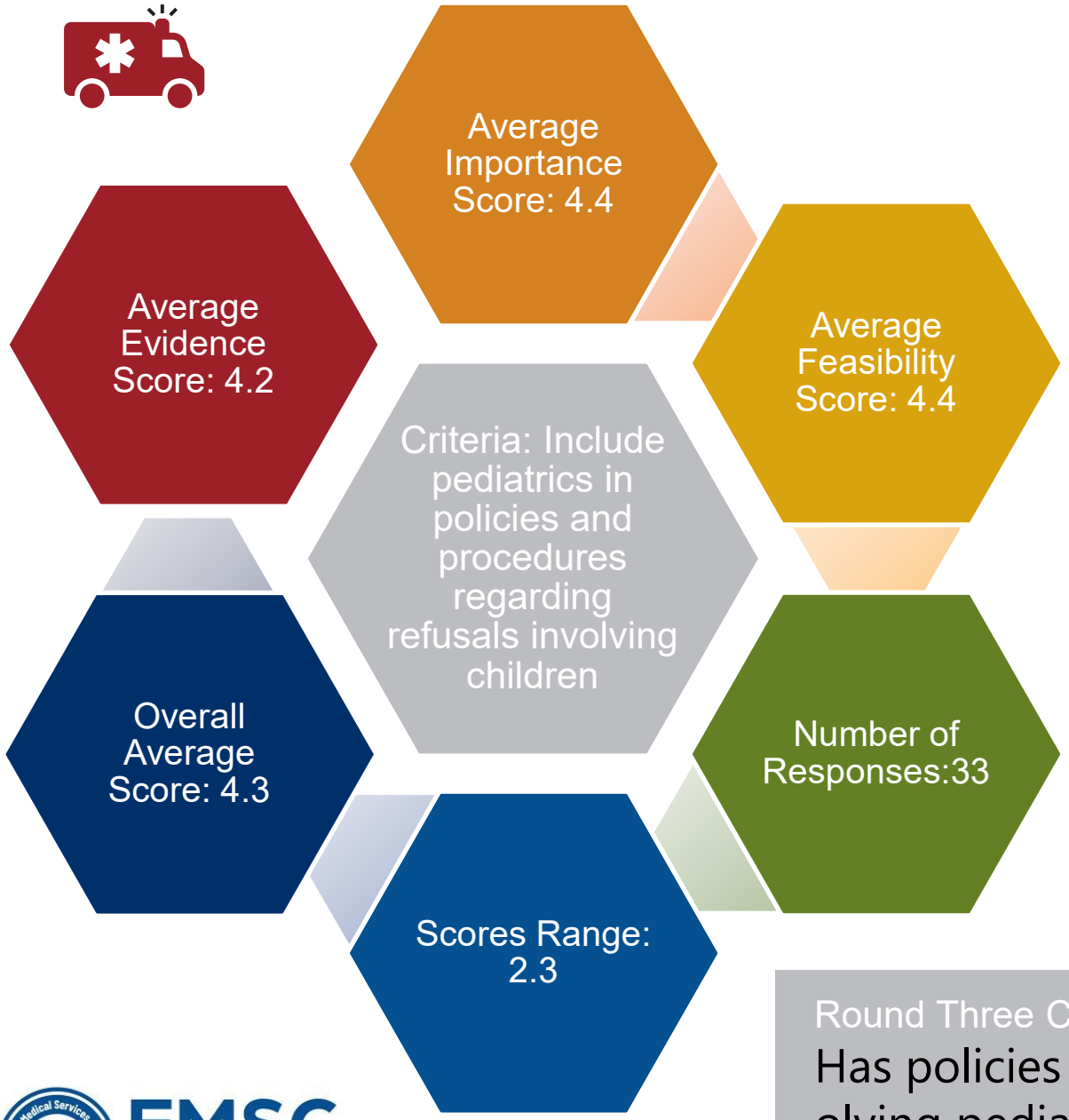
Cons:

General Comments:

- Define regular verification

Round Three Criteria: Established process for the regular scheduled verification of pediatric equipment and supplies

weekly- regularly scheduled/ monthly-



Pros:

- Policies typically seem an easier life in terms of feasibility.
- This can be easily addressed through individual company policies.

Cons:

General Comments:

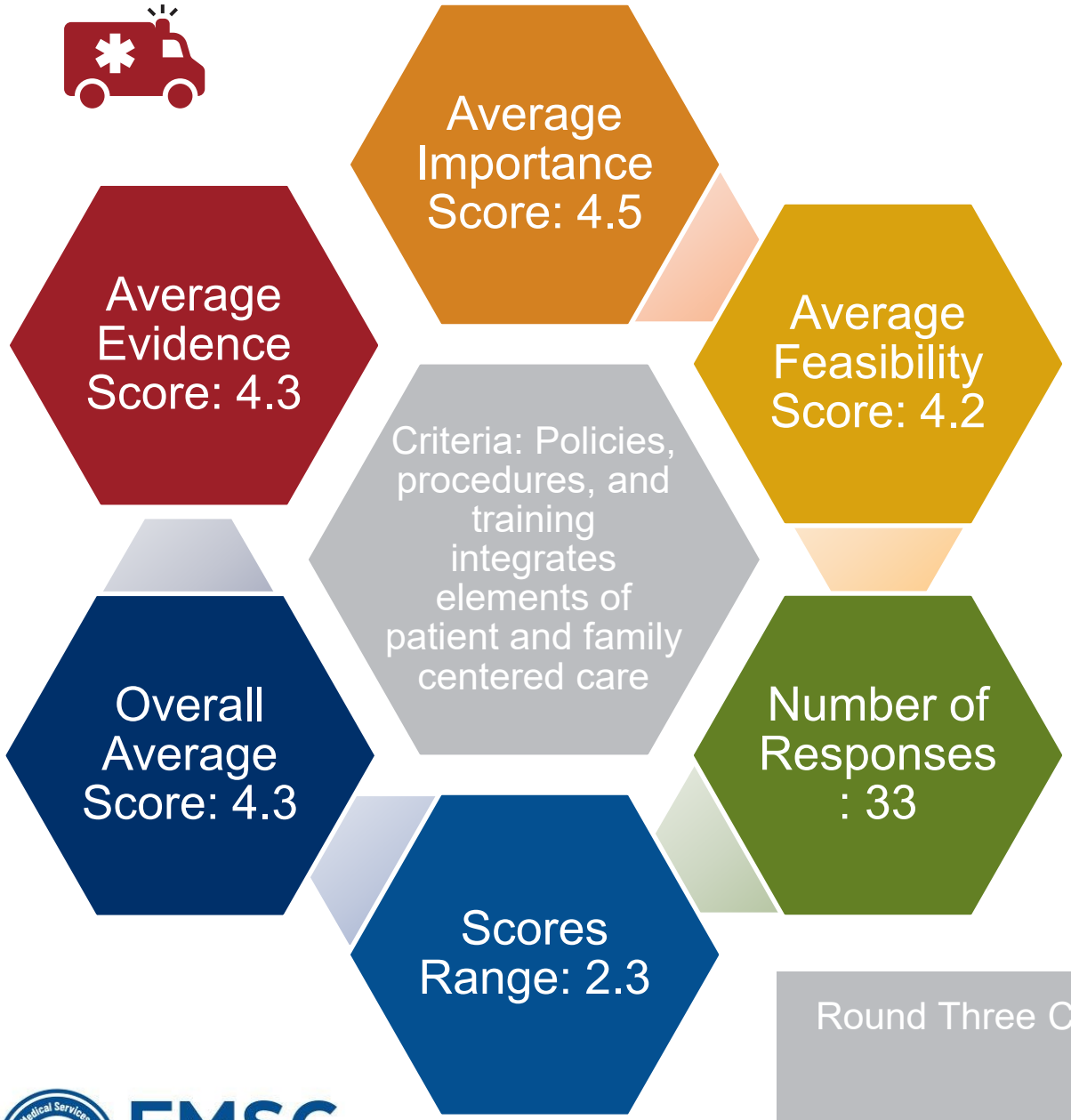
- State level legislation has several of these policies.

Round Three Criteria:

Has policies and procedures for refusals inv olving pediatric patients

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK



Pros:

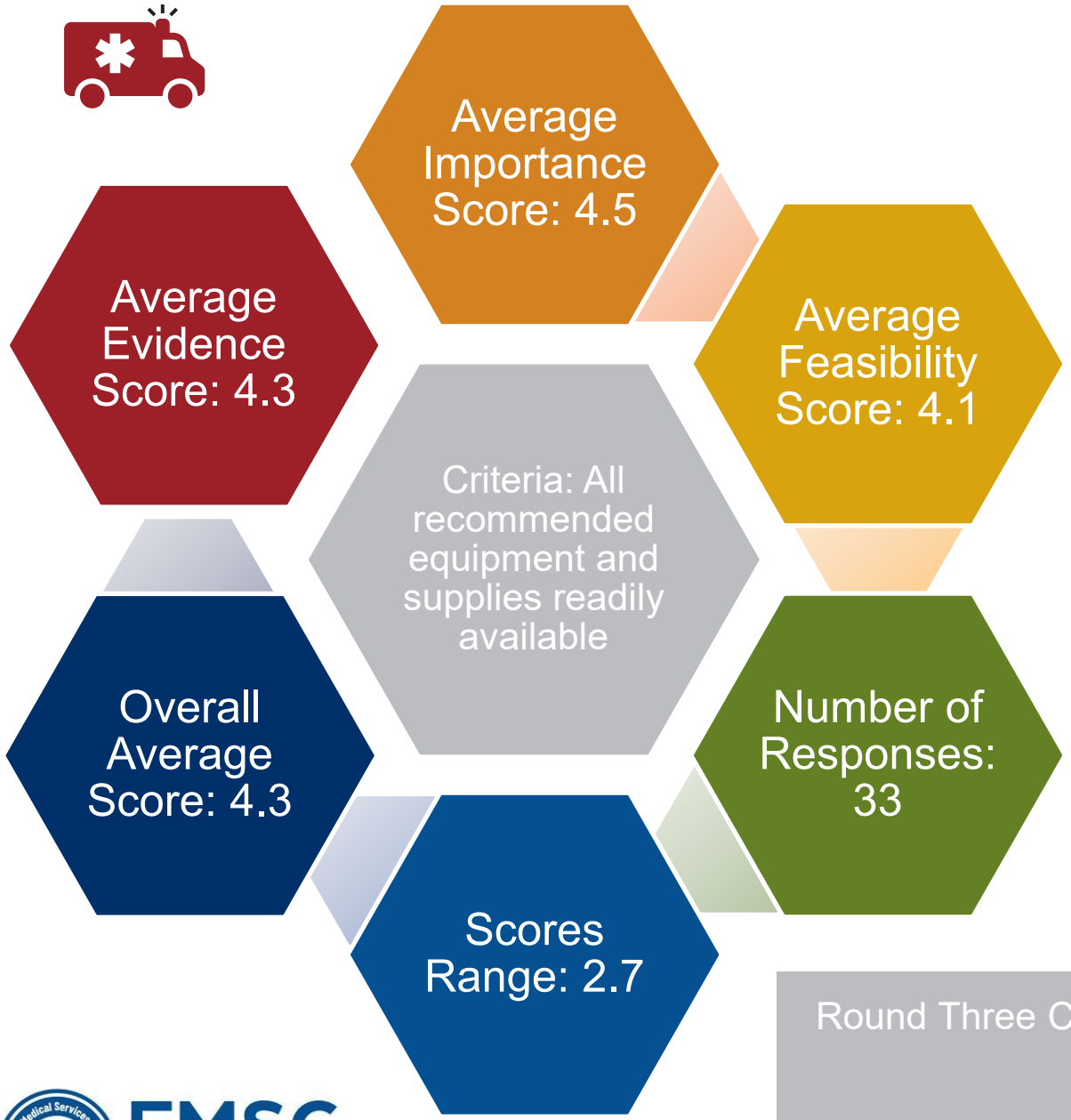
- Policies typically seem an easier life in terms of feasibility.
- This can be easily addressed through individual company policies.

Cons:

General Comments:

- State level legislation has several of these policies.

Round Three Criteria:



Pros:

Cons:

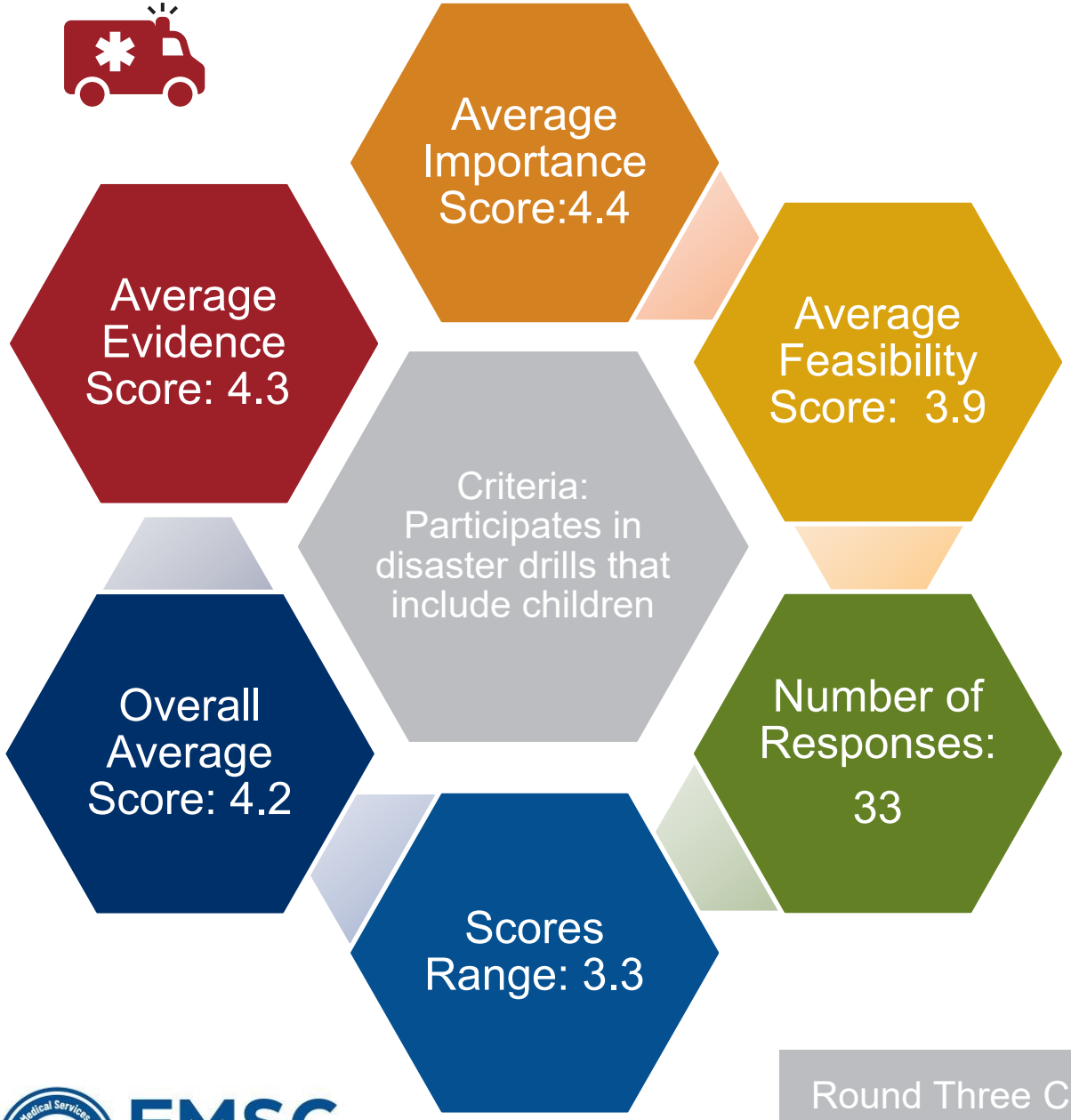
General Comments:

- Define "readily available" more clearly. Is this on each rig? In each bag, this should be clear as some agencies may scratch the grey area. Smaller agencies may struggle obtaining storing and having certain supplies if they do not encounter pediatrics often must ensure list is verified for minimally necessary yet appropriate.

Round Three Criteria: as appropriate

EMSC Quality Improvement Collaboratives

Pediatric Pandemic Network



Pros:

- Disaster drills must include working with a Ped receiving hospital on some set basis.
- Disaster drills must include working with a Ped receiving hospital on some set basis. for example every 3 years full-scale disaster drill with ED and has pediatric component
- Disaster drill that account for and include pediatric patients are extremely useful to providers. These scenarios and drills can have lasting impressions on providers boosting their confident in real situations

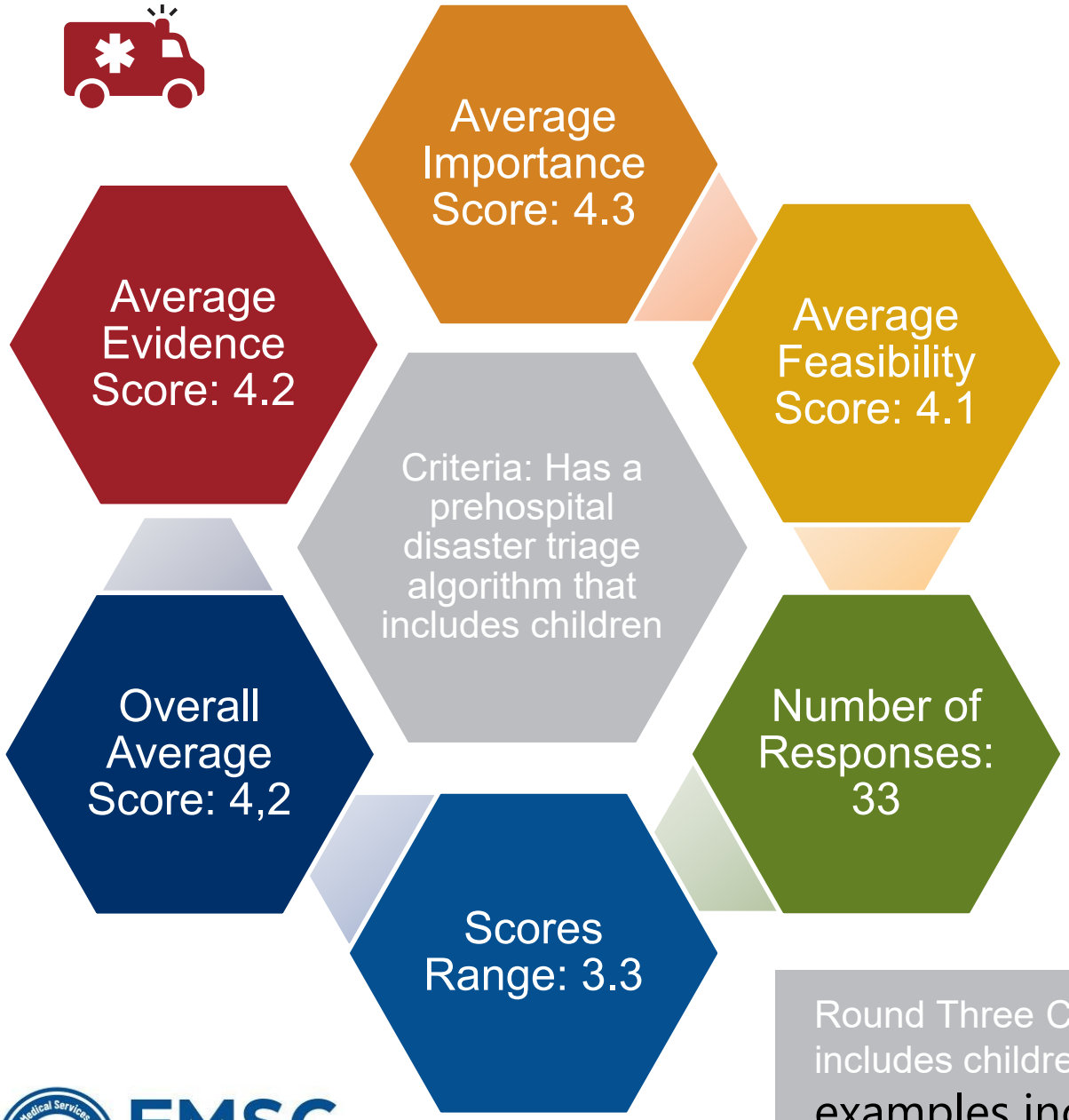
Cons:

- It is anticipated this will be difficult to define to some degree in rural areas due to hospital/tertiary care center distances.

General Comments:

- Functional and table-top are more feasible.
- Participate in regional/ state plans, drills and follow practices that include children and families-

Round Three Criteria:



Pros:

- Every EMS agency should have a disaster plan, and thus children should be in it.

Cons:

- The vast majority of the content (like the items above) are covered in the statewide plan and would not be mentioned at the service level.

General Comments:

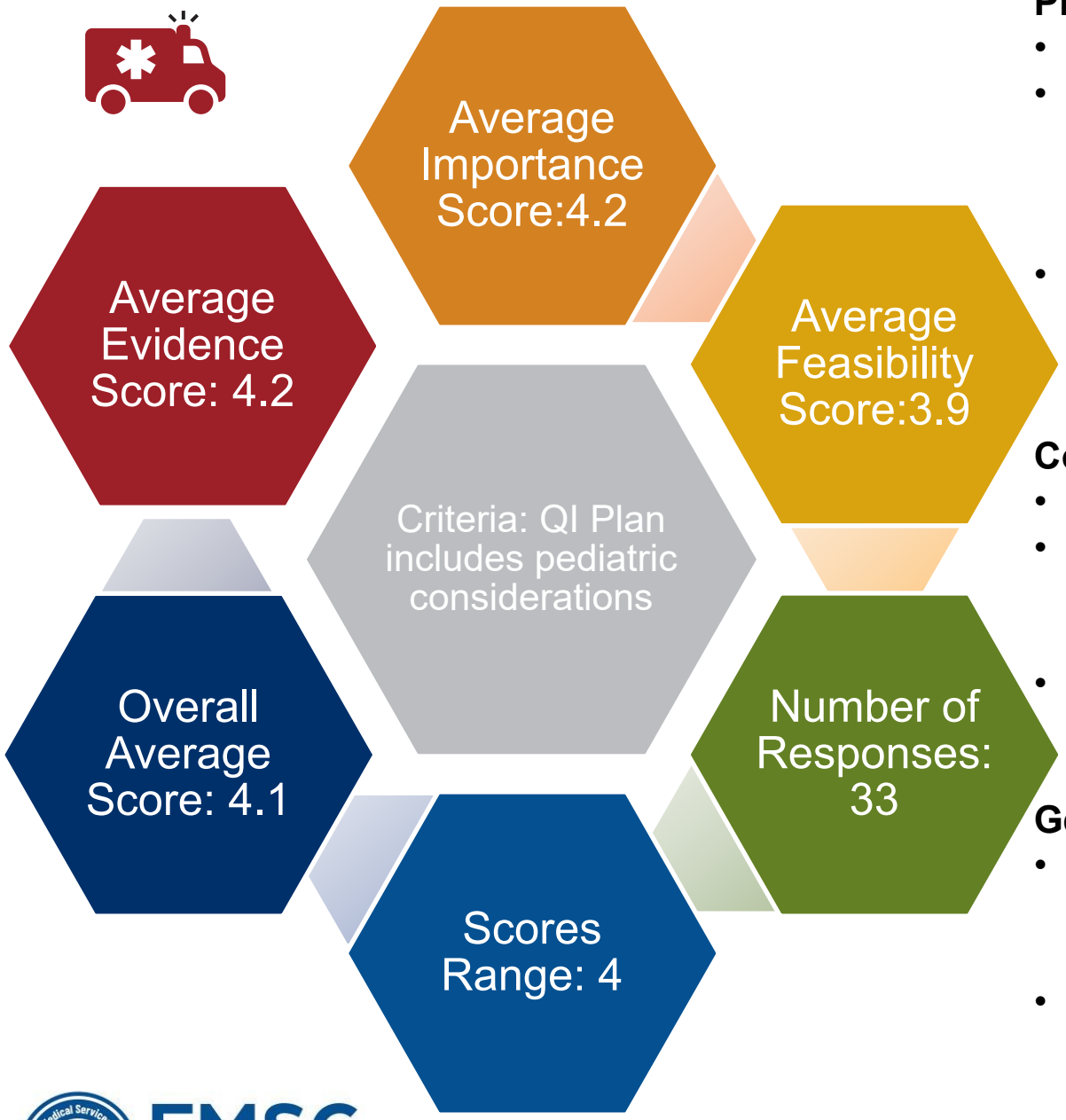
- Include participation in their local HCC
- An EMS agency is part of (by MOU or other document) with an agency or regional disaster plan. County wide plans can include agency participation and meet the requirement

Round Three Criteria: utilize a field triage algorithm that includes children-

examples include: SALT or JumpSTART Triage Algorithm

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK



Pros:

- QI every pediatric chart to see where training is needed.
- QI and case review that is relayed back to prehospital providers can help guide their treatment in the future. Utilizing QI to review treatment and outcomes can help improve protocols and treatments recommended by LEMSAs also
- QI and case review that is relayed back to prehospital providers can help guide their treatment in the future. Utilizing QI to review treatment and outcomes can help improve protocols and treatments recommended by LEMSAs also

Cons:

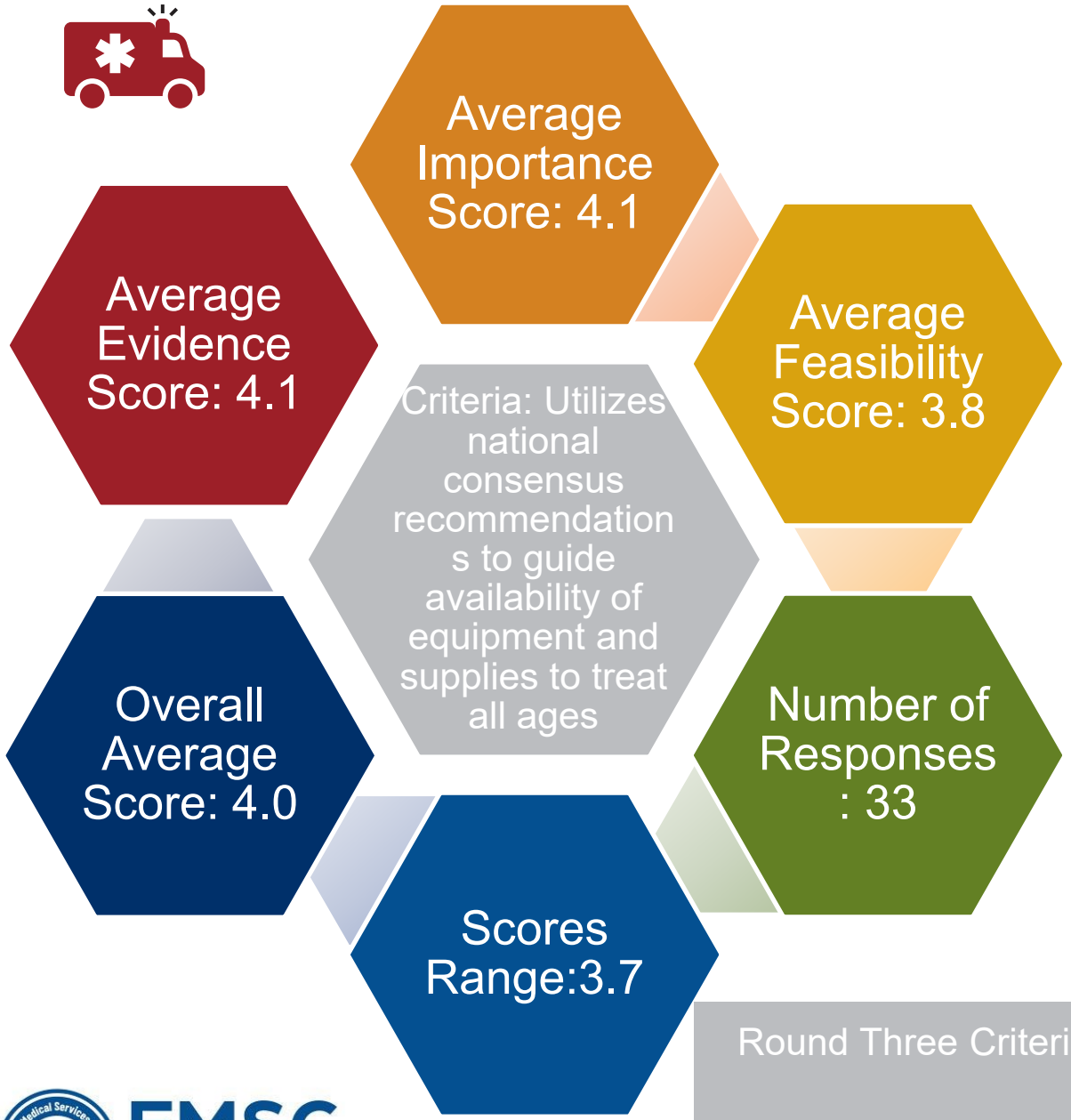
- Very vague and a high-level criteria.
- Difficult for small, rural EMS agencies (particularly volunteer agencies). There may be a need to network with the hospitals/pediatric tertiary care centers to assist with this.
- The feasibility of having a QI system that is pediatric specific will rely on the charting software the providers use. Some will be easily utilized to query based on age while others are more cumbersome.

General Comments:

- Is this per Agency, LEMSA, etc.? For lowest level or smaller entities would having addendum or section of QI plan include pediatric indicators be sufficient.
- NESMQA has pediatric specific measures to refer to as a starting place. And one QI consideration to review all Cardiac arrests would meet this criteria as stated-

EMSC Quality Improvement Collaboratives

Round Three Criteria:



Pros:

- There should be some standardization of equipment so providers from all areas can have access to beneficial pediatric specific equipment.
- Pediatric specialty equipment varies from state to state and even county to county. There should be some standardization of equipment so providers from all areas can have access to beneficial pediatric specific equipment. Pediatric emergency care is often stressful and equipment needs to be readily/easily available for use.

Cons:

- Several states: state policies direct the equipment in every ambulance and it is based upon statute and state rules and not national consensus.
- Our state does not mandate which equipment and supplies services use--that is the job of the individual medical director

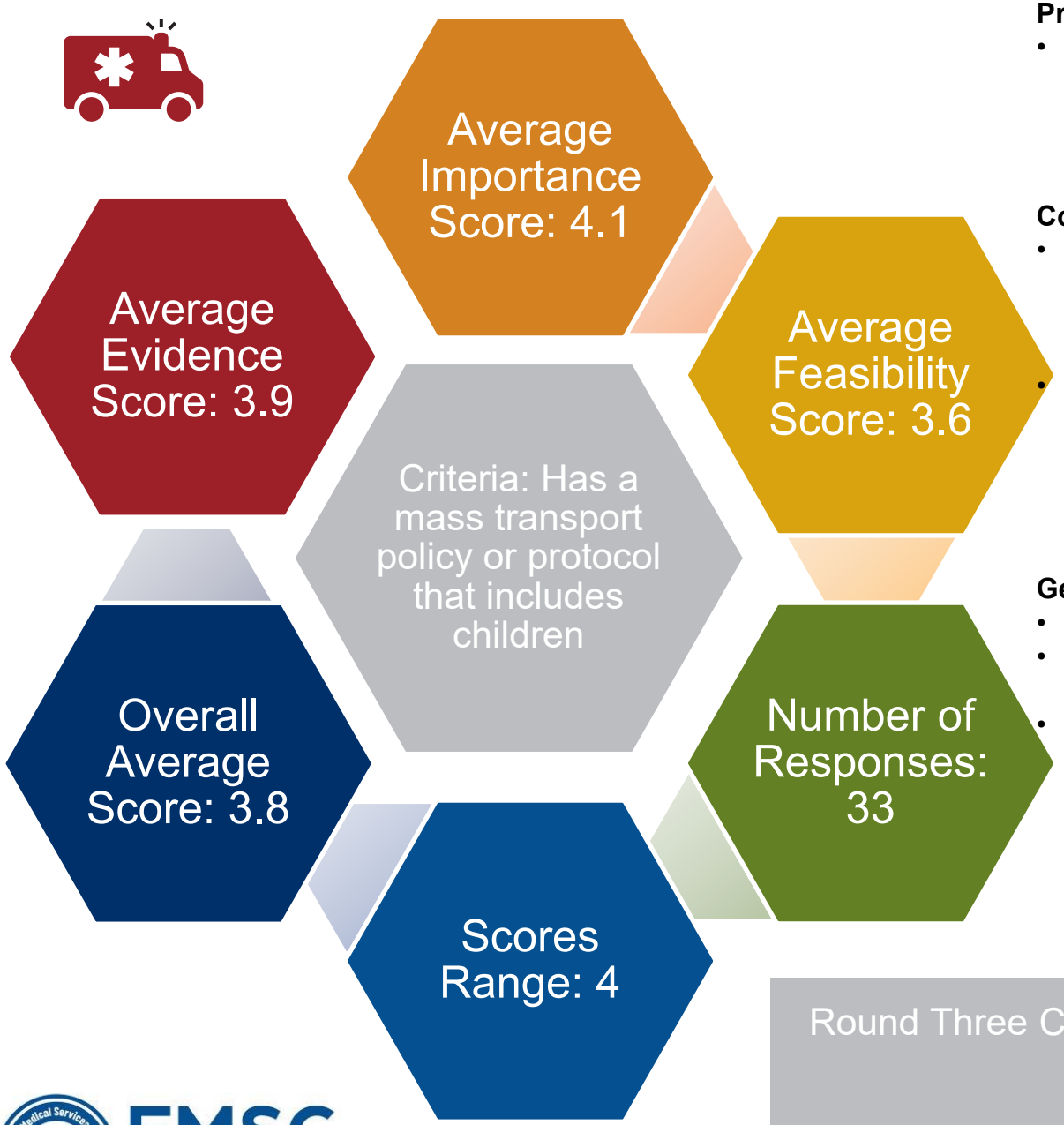
General Comments:

- Smaller agencies may struggle obtaining storing and having certain supplies if they do not encounter pediatrics often must ensure list is verified for minimally necessary yet appropriate.
- again define "readily available" more clearly. Is this on each rig? In each bag, this should be clear as some agencies may stretch the grey area. Smaller agencies may struggle obtaining storing and having certain supplies if they do not encounter pediatrics often must ensure list is verified for minimally necessary yet appropriate.
- state specific pediatric equipment requirements, by license level for the agency. So national consensus may be confusing to our agencies. State regulated pediatric specific equipment would be clearer for us
- does this include car seats? Our state department has a list of EMS equipment and supplies that they need to have but car seats aren't one of them- but laws that deem them necessary.

Round Three Criteria:

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK



Pros:

- Pediatric patients are much less independent during disasters and need focused plans to help provide for their needs. Mass transport of pediatric patients can be complicated due to the need for specialty transport devices and other issues. Having a policy/protocol that includes provisions for pediatric mass transport is necessary

Cons:

- Private EMS not having access to certain resources in the community. The private companies will not be willing to invest funds into creating their own MCI transport unit and staffing it. They also would have a difficult time including various non-emergency agencies into their plan. This would have to be a coordinated effort through a
- The feasibility of having a mass transport policy is decreased due to private EMS not having access to certain resources in the community. The private companies will not be willing to invest funds into creating their own MCI transport unit and staffing it. They also would have a difficult time including various non-emergency agencies into their plan. This would have to be a coordinated effort through a statewide centralized office.

General Comments:

- Having a Mass Transport Policy would depend on the size of the EMS service
- It is anticipated this will be difficult to define to some degree in rural areas due to hospital/tertiary care center distances.
- I think there should be wiggle room that these criteria fall under the state. For example, in MA, all EMS must follow our statewide EMS MCI Disaster Plan. While services may choose to include area specific details in their service level plans, the vast majority of the content (like the items above) are covered in the statewide plan and would not be mentioned at the service level.

Round Three Criteria:

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Next Steps

Round 3 survey will be sent today— **3/21/24**

- No evidence ranking- Ranking based on importance and feasibility
- Average score per state will be considered
  - Share this survey with your team/key players if needed
- Handout with consensus process outline provided
- Due date: **April 12****
  - Is 3 weeks enough time to complete PH minimum criteria re-ranking?

Next PRRPC Session: **April 18, 2024, 1:30-3:00 pm CT**

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Effectively Communicating Peds Ready Recognition

Importance, challenges & strategies

EMSC Quality Improvement Collaboratives

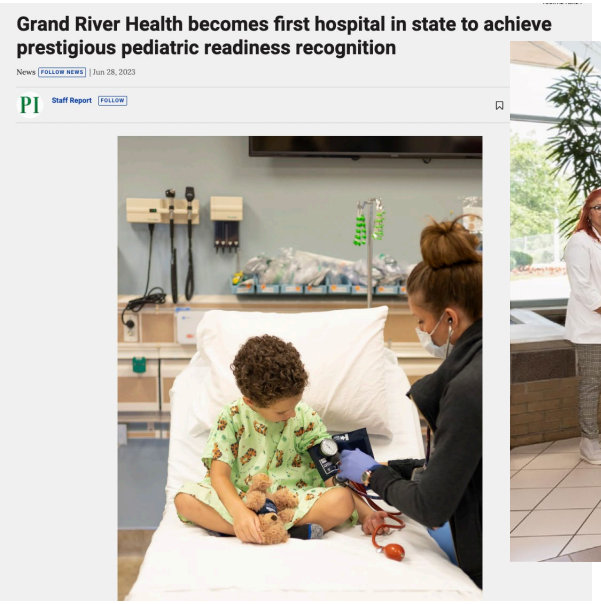
Agenda

- Challenges & strategies – Emily (10)
- Your experiences & needs – Amy (10)

EMSC Quality Improvement Collaboratives

Why care about communications?

Recognition programs are, in many ways, a marketing strategy for encouraging pediatric readiness



EMSC Quality Improvement Collaboratives

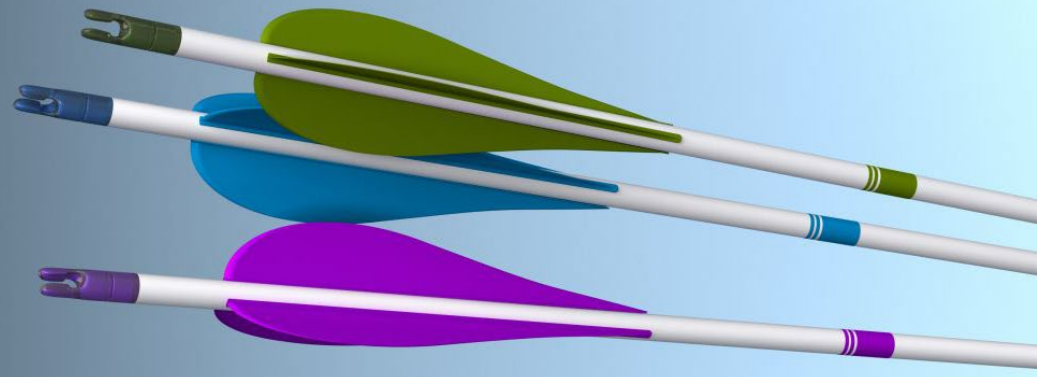
The challenges

1. Complex
2. Sensitive
3. Niche

EMSC Quality Improvement Collaboratives

Problem 1: Complexity
Strategy: Consistency

- Consensus process
- Consistent messaging & visuals
  - Messaging
  - Branding



EMSC Quality Improvement Collaboratives

Problem 2: Sensitivity Strategy: Balance

- Target messaging by audience
- Lean on stories
- When in doubt, skew positive
  - But remember: discomfort → change

EMSC Quality Improvement Collaboratives

Problem 3: Niche Strategy: Be Clear & Compelling

- Focus on ”WIIFM”
- Explain it to me like I’m 5 (use plain language)
- Consistent branding & messaging (again)

EMSC Quality Improvement Collaboratives

Your experiences & needs

EMSC Quality Improvement Collaboratives

Menti survey

EMSC
Quality Improvement
Collaboratives

Questions? Need help?

communications@emscimprovement.center

EMSC Quality Improvement Collaboratives

ED Round Three

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Proposed Ranking for Round 3

- Scores averaging 4.4 or higher:
  - Recommended minimum criteria to be included in a recognition program
- Scores averaging 3.01 - 4.3:
  - Stretch criteria for recognition programs
- Scores averaging below 3.0:
  - Optional criteria- states can use these at their discretion

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Criteria- Round 3	Round 3- Mean	Round 2- Criteria	Round 2- Mean
Pediatric Equipment and Supplies Criteria: Access to pediatric emergency equipment (crash cart/bag) in ED	4.7	Access to pediatric crash cart in ED	4.6
PECC Specific Criteria: At Least 1 PECC	4.6	At least 1 PECC	4.5
Weight in Kilograms Criteria: Weighing children in kg only	4.5	Weighing children in kg only	4.7
Pediatric Equipment and Supplies Criteria: All recommended equipment and supplies are readily available within the ED	4.5	All recommended equipment and supplies immediately available	4.4
Weight in kilograms criteria: Weighing and recording children in kg only	4.4	Weighing and recording children in kg only	4.7
Pediatric Policies and Protocols Criteria : Include pediatrics in policies and procedures	4.4	Include pediatrics in policies and procedures	4.4
Disaster-Specific Criteria: ED disaster plan must include pediatric considerations	4.4	ED Disaster plan must include pediatric considerations	4.3
Interfacility Transfer Criteria: Interfacility transfer guidelines	4.3	Interfacility transfer guidelines	4.2
Pediatric Equipment and Supplies Criteria: Daily method to verify the proper location of pediatric equipment and supplies	4.3	Daily method to verify the proper location of pediatric equipment and supplies	4.3
Pediatric Policies and Protocols Criteria: Pediatric-specific triage	4.3	Pediatric-specific triage policy	4.4
Pediatric Policies and Protocols Criteria: Family centered care	4.3	Family centered care policy	4.3
Pediatric Competency Evaluations Criteria: Pediatric annual training opportunities for key staff	4.3		#N/A
Pediatric Competency Evaluations Criteria: Pediatric competency evaluations for nurses	4.1	Pediatric Competency evaluations for nurses	4.3
Pediatric Competency Evaluations Criteria: Pediatric Competency evaluations for key staff	4.1	Pediatric Competency evaluations for all staff	4.0
QI Criteria: Pediatric QI plan	4.1	Pediatric QI Plan	4.2
Pediatric Equipment and Supplies Criteria: Require critical/commonly missing pediatric equipment items	4.1	Require critical/commonly missing pediatric equipment items	4.2
Pediatric Policies and Protocols Criteria: Pediatric evidence-based pathways and/or decision support	4.0	Pediatric evidence-based pathways and/or decision support	4.3
Pediatric Competency Evaluations Criteria: Pediatric competency evaluations require pediatric skills practice	4.0	Pediatric Competency evaluations require pediatric skills practice	4.2
Pediatric Policies and Protocols Criteria: Pediatric reduced dose radiation policy	4.0	Pediatric reduced dose radiation policy	4.2
Pediatric Policies and Protocols Criteria: Pediatric Mental Health policy	4.0	Pediatric Mental Health policy	4.2
QI Criteria: Pediatric QI plan that includes pediatric-specific indicators and tracking performance	3.9	Pediatric QI Plan that includes pediatric specific indicators and tracking performance	4.0
Interfacility Transfer Criteria: Interfacility transfer agreements	3.7	Interfacility transfer agreements	3.9
Disaster Plan Specific Criteria: ED Disaster plan must include pediatric considerations and highlight critical domains from the EIIC's Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Policies	3.6	ED Disaster plan must include pediatric considerations and highlight critical domains from the EIIC's Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Policies	3.6

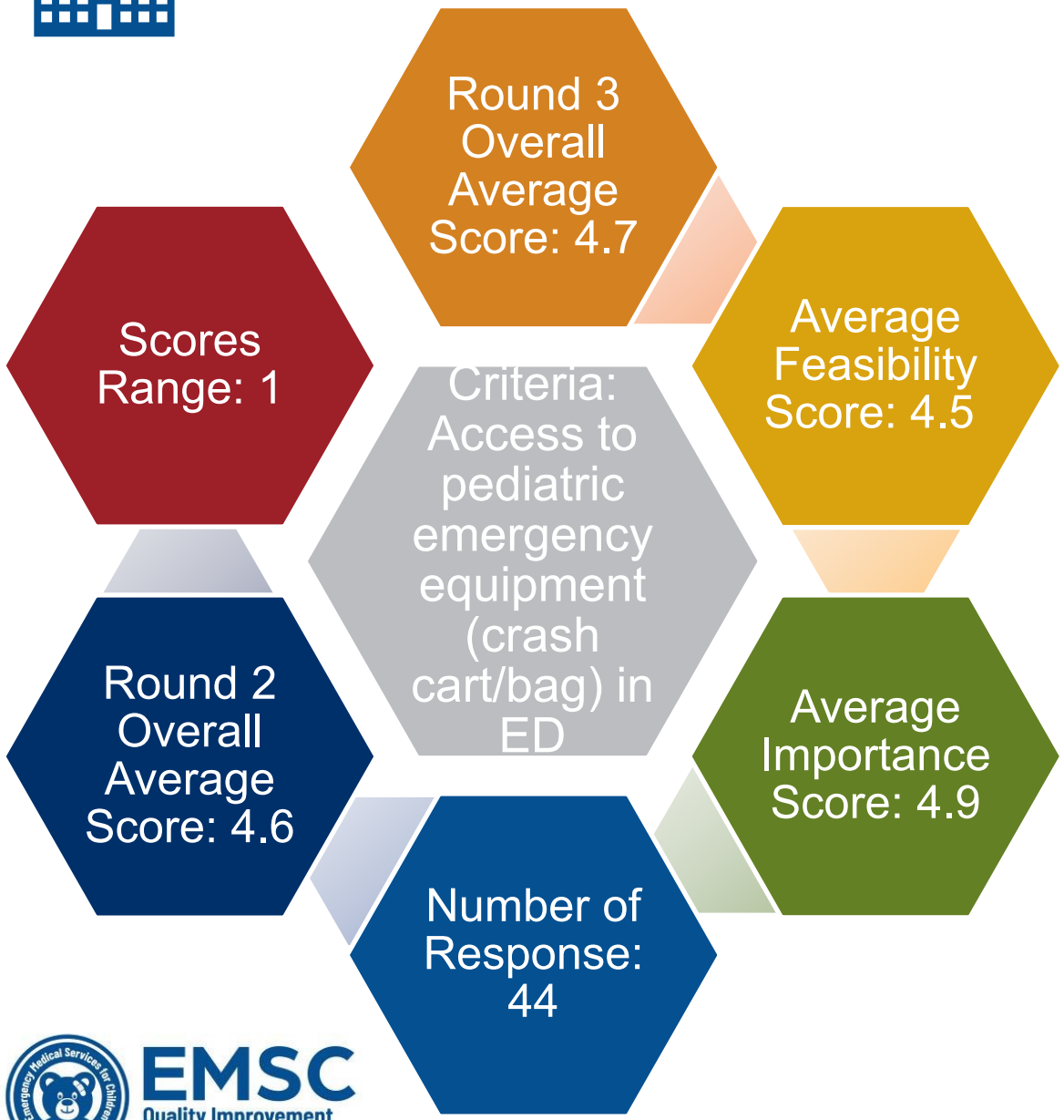
Round 3 Results

Criteria	Mean	Min	Max	Range
Pediatric Equipment and Supplies Criteria: Access to pediatric emergency equipment (crash cart/bag) in ED	4.7	4	5	1
PECC Specific Criteria: At Least 1 PECC	4.6	3	5	2
Weight in Kilograms Criteria: Weighing children in kg only	4.5	1	5	4
Pediatric Equipment and Supplies Criteria: All recommended equipment and supplies are readily available within the ED	4.5	2.75	5	2.25
Weight in kilograms criteria: Weighing and recording children in kg only	4.4	2	5	3
Pediatric Policies and Protocols Criteria : Include pediatrics in policies and procedures	4.4	2.5	5	2.5
Disaster-Specific Criteria: ED disaster plan must include pediatric considerations	4.4	3	5	2
Interfacility Transfer Criteria: Interfacility transfer guidelines	4.3	2.5	5	2.5
Pediatric Equipment and Supplies Criteria: Daily method to verify the proper location of pediatric equipment and supplies	4.3	2.5	5	2.5
Pediatric Policies and Protocols Criteria: Pediatric-specific triage	4.3	2.5	5	2.5
Pediatric Policies and Protocols Criteria: Family centered care	4.3	3	5	2
Pediatric Competency Evaluations Criteria: Pediatric annual training opportunities for key staff	4.3	2.5	5	2.5
Pediatric Competency Evaluations Criteria: Pediatric competency evaluations for nurses	4.1	1	5	4
Pediatric Competency Evaluations Criteria: Pediatric Competency evaluations for key staff	4.1	2	5	3
QI Criteria: Pediatric QI plan	4.1	2	5	3
Pediatric Equipment and Supplies Criteria: Require critical/commonly missing pediatric equipment items	4.1	2.5	5	2.5
Pediatric Policies and Protocols Criteria: Pediatric evidence-based pathways and/or decision support	4.0	2.5	5	2.5
Pediatric Competency Evaluations Criteria: Pediatric competency evaluations require pediatric skills practice	4.0	2	5	3
Pediatric Policies and Protocols Criteria: Pediatric reduced dose radiation policy	4.0	2	5	3
Pediatric Policies and Protocols Criteria: Pediatric Mental Health policy	4.0	2.5	5	2.5
QI Criteria: Pediatric QI plan that includes pediatric-specific indicators and tracking performance	3.9	2	5	3
Interfacility Transfer Criteria: Interfacility transfer agreements	3.7	1	5	4
Disaster Plan Specific Criteria: ED Disaster plan must include pediatric considerations and highlight critical domains from the EIIC's Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Policies	3.6	1	5	4

Round 2 Results

ED Criteria	Overall Average	Average Max	Average Min	Range
Weighing children in kg only	4.7	5	2	3
Weighing and recording children in kg only	4.7	5	1.7	3.3
Access to pediatric crash cart in ED	4.6	5	2	3
At least 1 PECC	4.5	5	1	4
Include pediatrics in policies and procedures	4.4	5	1.8	3.2
Pediatric-specific triage policy	4.4	5	2	3
All recommended equipment and supplies immediately available	4.4	5	2	3
Daily method to verify the proper location of pediatric equipment and supplies	4.3	5	1.7	3.3
ED Disaster plan must include pediatric considerations	4.3	5	2	3
Pediatric Competency evaluations for nurses	4.3	5	2	3
Family centered care policy	4.3	5	1.7	3.3
Pediatric evidence-based pathways and/or decision support	4.3	5	1.7	3.3
Pediatric reduced dose radiation policy	4.2	5	1.3	3.7
Pediatric Competency evaluations require pediatric skills practice	4.2	5	1.8	3.2
Require critical/commonly missing pediatric equipment items	4.2	5	1	4
Interfacility transfer guidelines	4.2	5	1	4
Pediatric Mental Health policy	4.2	5	2	3
Pediatric QI Plan	4.2	5	1.7	3.3
Pediatric Competency evaluations for all staff	4.0	5	1.7	3.3
Pediatric QI Plan that includes pediatric specific indicators and tracking performance	4.0	5	1	4
Interfacility transfer agreements	3.9	5	1	4
ED Disaster plan must include pediatric considerations and highlight critical domains from the EIIC's Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Policies	3.6	5	1	4

EMSC Quality Improvement Collaboratives



Adopt

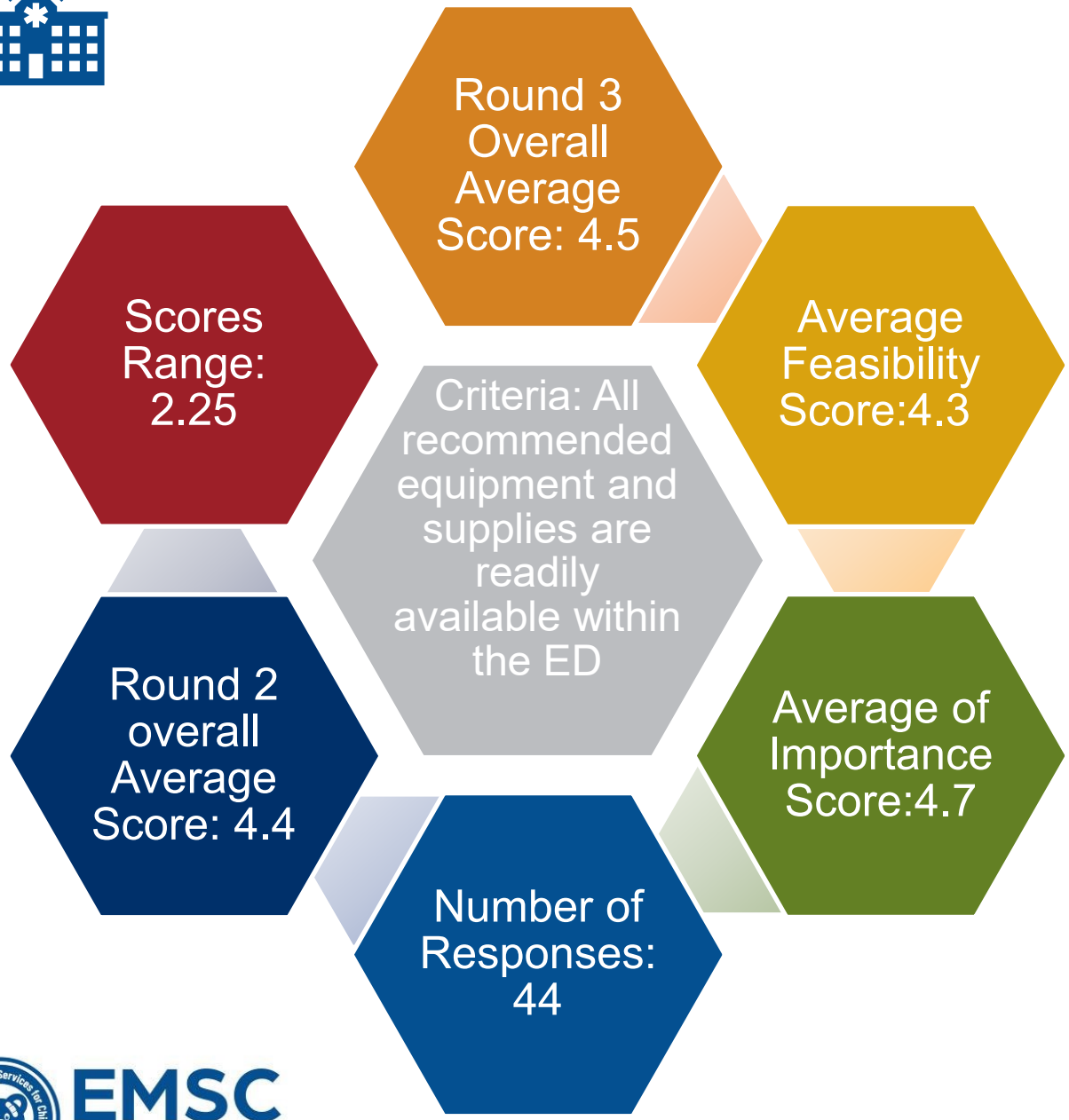
- A must along with at least one PECC
- Having quick access to this equipment along with being more familiar with the equipment seeing it each day is important to providing that care when needed.
- Sometimes purchasing and maintaining this type of equipment can be expensive for smaller departments that don't often see pediatric patients. There should be a reasonable effort made to purchase and maintain this equipment even in those remote departments that don't often see pediatric patients.
- This is imperative for acute care of critically ill children.

Adjust

- I think we should take the "crash cart/bag" term out and let EDs decide what is best method for access to the emergency equipment. Would also support change to "such as a crash cart/bag“
- I would suggest we just say something like "immediate access to critical pediatric equipment and supplies needed for resuscitation in the ED" instead of going down the bag/cart rabbit hole.
- We should define access somewhere. Is it required to be in a crash cart or bag?

Abandon

- A crash cart/bag should not be required. Having equipment in a designated area within a treatment area should meet the requirement.
- Resistance to spend the money and to keep supplies current due to expiration dates.



Adopt

- A must
- An extremely sick pediatric patient can be carried through the doors no matter the ambulance destination designation, specialty offered, or typical patient population. Having quick access to this equipment along with being more familiar with the equipment seeing it each day is important to providing that care when needed.

Adjust

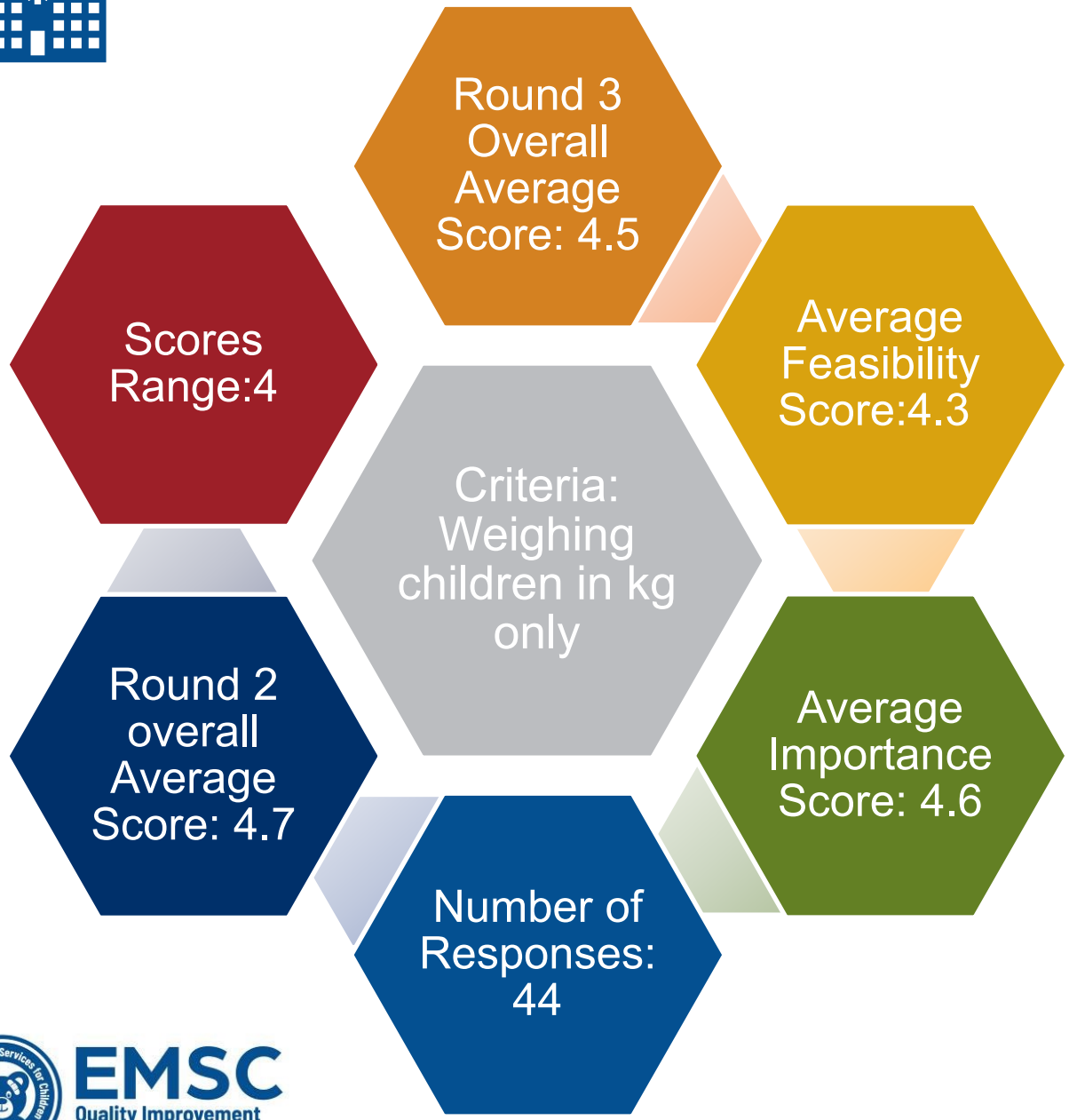
- Depends on what the "recommended equipment and supplies" are. difficult to define "readily available" and "all"
- Most items should be in ED, but we allow some limited use meds/items to be kept in other locations as long as there is 24/7 access in moments-minutes.
- Need to specify what ALL means to evaluate
- Some equipment could be available near ED, like PICU and OR.
- Would like clarity if "recommended equipment" would be further defined (reference to published list etc.).

Abandon

- There are recognized barriers particularly related to cost and expiration dates. For example, some items have to be purchased in quantity and are seldom utilized by smaller hospitals and therefore feel that is a wasteful expense when the item expires before used.

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK



Adopt

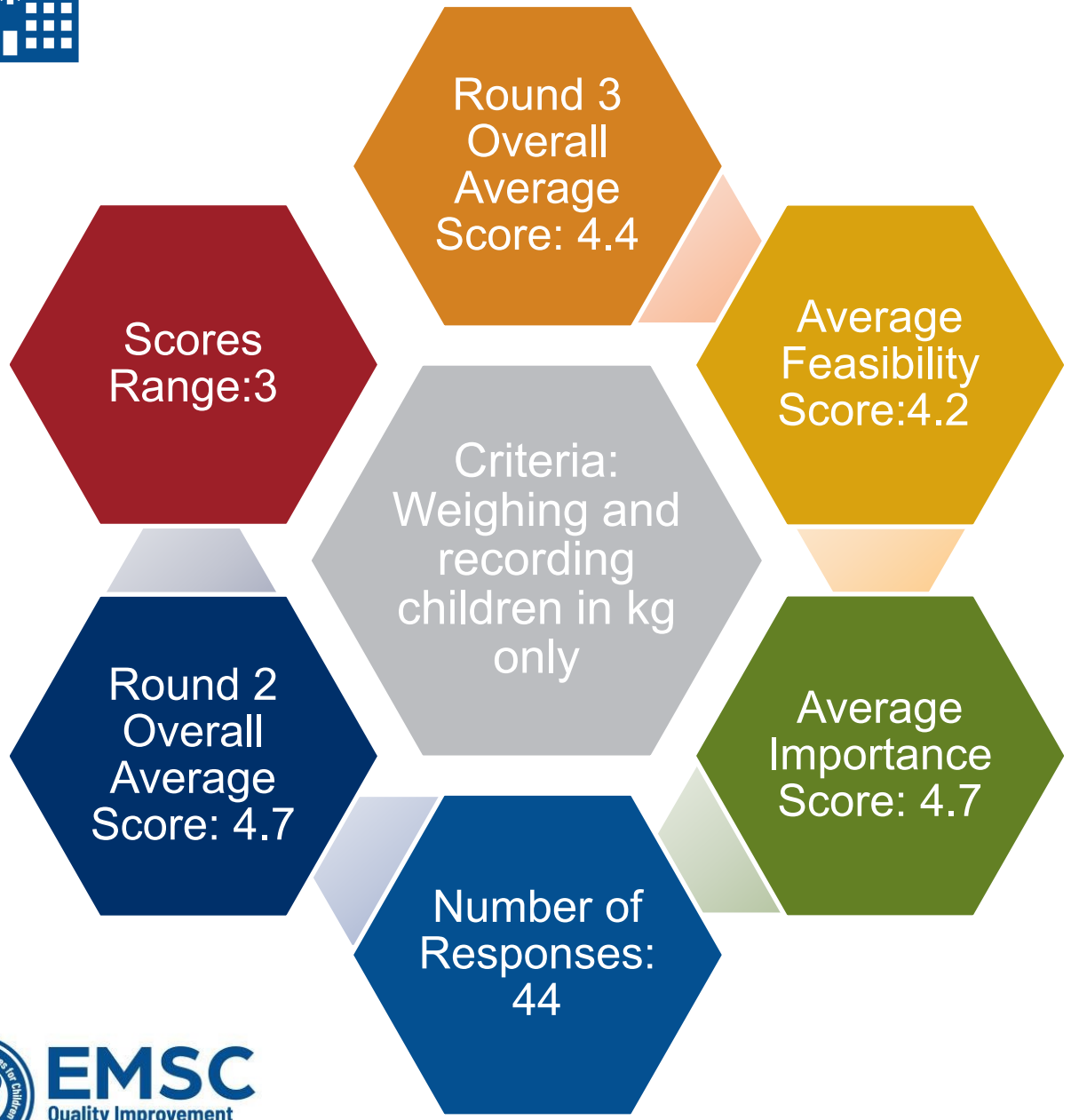
- Converting the weight of children from pounds to kilograms during a stressful situation can lead to errors. If all pediatric weight is measured in kilograms this could reduce that chance for conversion error. Almost all pediatric medication is dosed based on weight in kilograms, measuring weight in kilograms only would be one less step to accurately calculating the dose. This would be easy to implement with policy change and staff education.
- Scales come with option of lbs/kgs. We've had EDs that wanted to buy scales that only had kgs but could not find them.
- Scales have settings to be in either kg/lbs to accomplish this deliverable.
- some charting systems software would need to be changed.

Adjust

- Allowing weight in either, but requiring recording in kg only
- I think we still see challenges of EDs with scales that can switch between pounds and kilograms - is there a joint commission standard?
- Parents consistently ask for their child's weight and we typically have to reconvert to pounds to answer their question. Weighing in kgs isn't as important as DOCUMENTING in kgs

Abandon

- This criteria can be excluded, as the next criteria includes weighing and recording
- Prefer the wording below which notes both weighing AND recording.
- Prefer the statement below - weight and document



Adopt

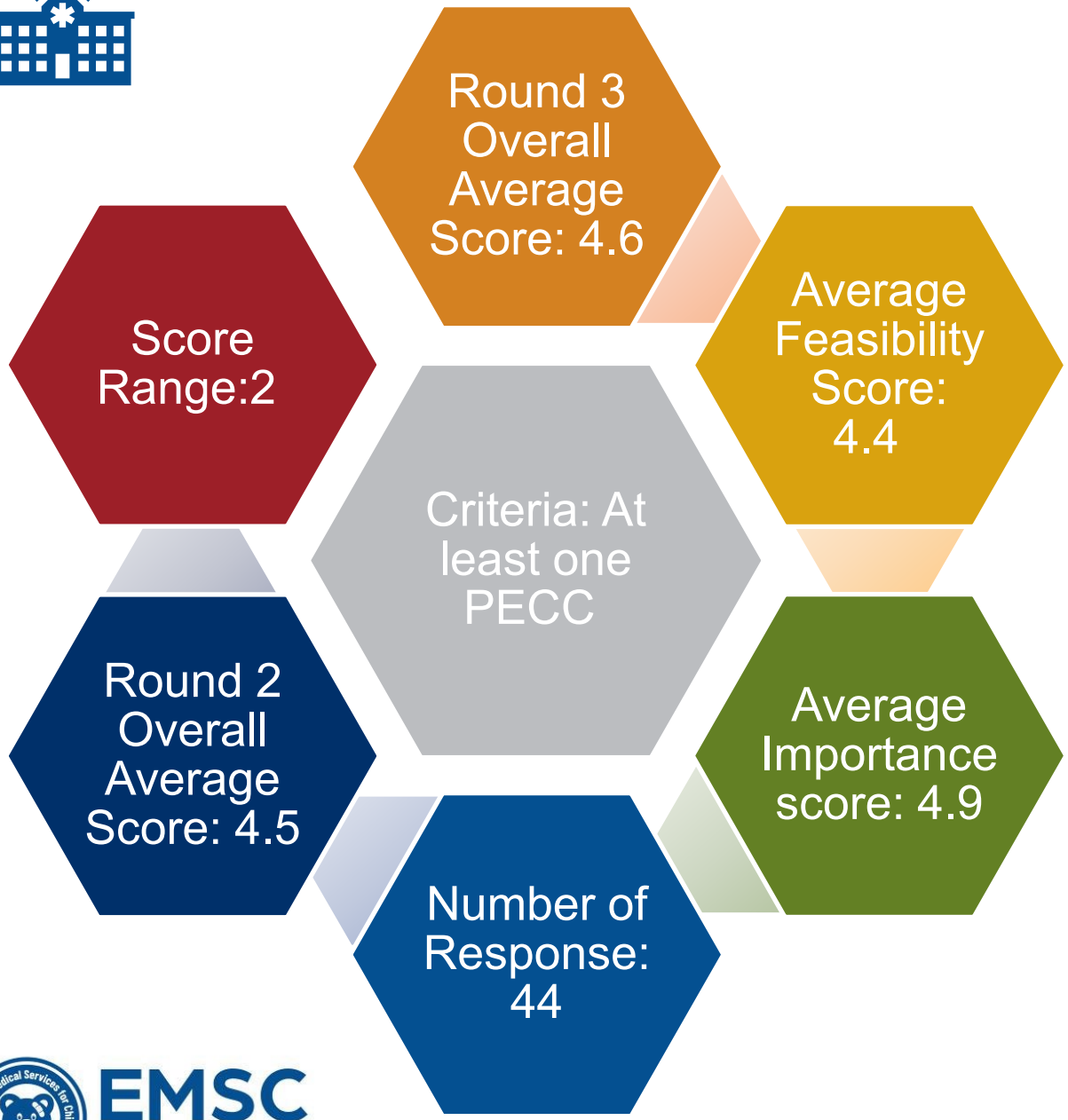
- Converting the weight of children from pounds to kilograms during a stressful situation can lead to errors. If all pediatric weight is measured in kilograms this could reduce that chance for conversion error. Almost all pediatric medication is dosed based on weight in kilograms, measuring weight in kilograms only would be one less step to accurately calculating the dose. This would be easy to implement with policy change and staff education.
- Need to lock scales AND the EMR, hence minus one on the feasibility.

Adjust

- Allowing weight in either, but requiring recording in kg only
- EMR programs (EPIC) convert lbs to kg. Thinking about would you accept, if they weighed in lbs then it converts to kg in the computer. EPIC does this automatically and gives you both numbers (lbs and kg)
- Need to include the electronic patient care records developers to only allow this to happen.
- This gets complicated around EMR platform capabilities.
- We need to help EDs troubleshoot this if they are running into barriers with administration/EMR/Scales/ETC
- Why can we not get this done at the national level? Pressure EMR companies to make this the standard option for all patients under 18 yo. The biggest hurdle I face is EDs that don't know how to get their EMR system changed to stop showing pounds for kids.

Abandon

- Are we selecting either weight in KG criteria? There are two back to back which are slightly different. Weigh and record children's weight in KG only would be a way to make this one.



Adopt

- A designated PECC is crucial in providing feedback from families and the communities they serve.
- Having at least 1 PECC is important to maintain pediatric preparedness and allows someone to focus on pediatric care. It seems reasonably feasible for most any dept or agency.
- Hospitals do not value pediatric patients or the impact a pediatric disaster could have on them. There is little support for the PECC. Having a PECC is vital to the improvement of readiness and the appropriate responses in a disaster.
- I still believe that for second and third level (or more depending upon the state) pediatric hospitals (in patient and PICU) they need to have both RN and Doc Champions. But for entry level Peds Ready ED - one is essential.

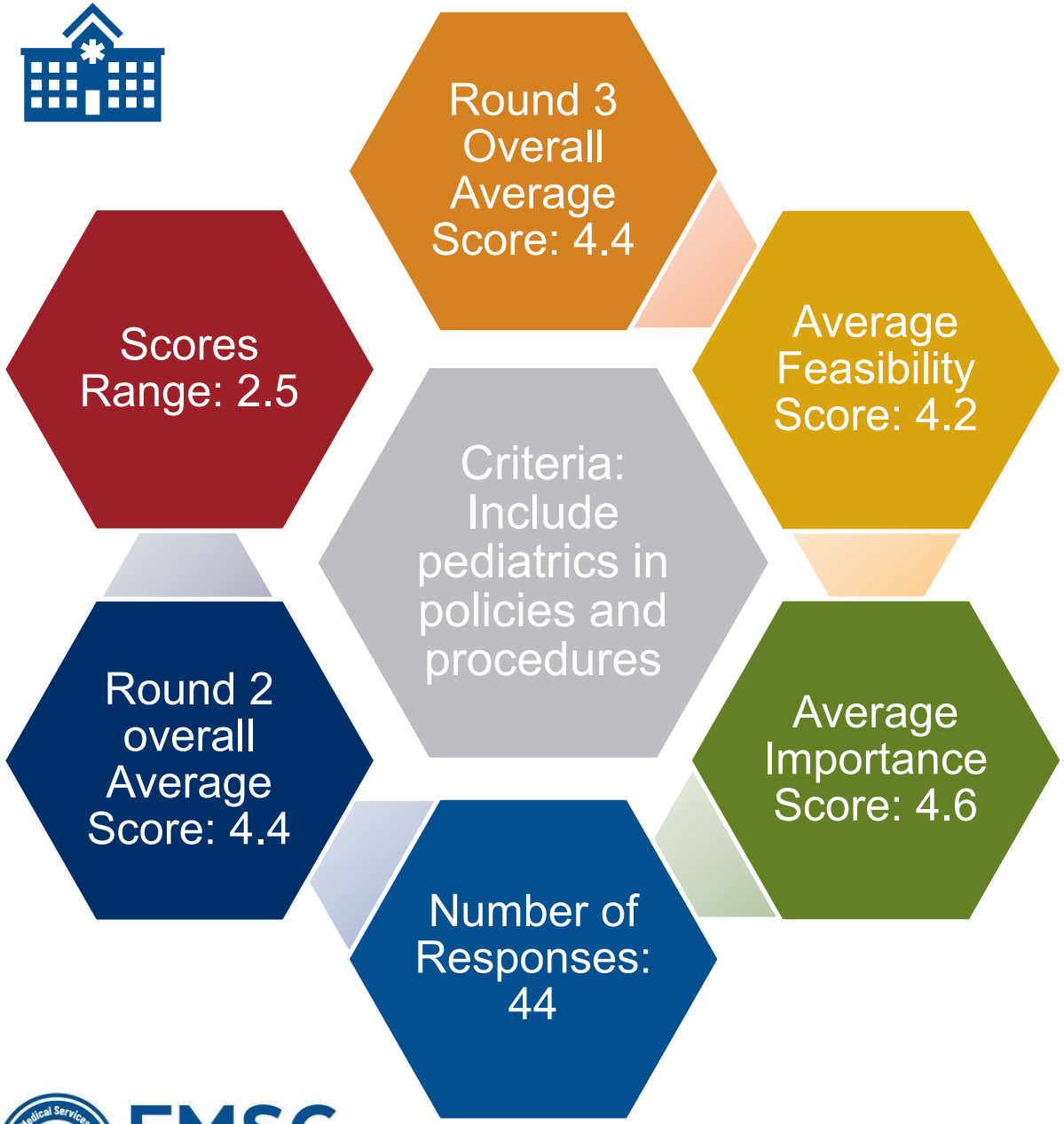
Adjust

- Although there is agreement for having a PECC is important, stakeholders feel that feasibility of a dedicated PECC can be a hardship. It would be helpful if the following minimums were defined: % FTE/time allotment and requirements to serve as a PECC, and resources for financial support to do this work
- Does this mean 1 per location or can it be shared (we have freestanding 24/7 EDs that are part of larger hospitals with EDs - they would likely use the same PECC)
- Highly encourage that this measure includes the phrase, "who works clinically at that facility."
- It should be 2 PECCs - one nurse and one physician
- Language to let folks know who the PECC "could" be. Can this be a nurse OR physician OR advance practice provider? Open this up so any facility can participate
- PECC must serve as a connector to the EMS community.
- This position should be available as a shared role.
- Appreciate the language that supports a PECC can be shared with other facilities, but a Nurse and/or MD PECC should be considered for all except comprehensives.

Abandon

- Difficult due to reduced workforce, recruitment and funding.
- Dramatically variable funding and staffing will impact the ability to achieve this.
- Research has shown the value of having at least one PECC, however, facilities and services have had some complaints about being able to provide this. They tend to site staffing and workload as the reasoning.
- smaller hospitals may struggle with staffing this person or keeping them in the role.

EMSC Quality Improvement Collaboratives



Adopt

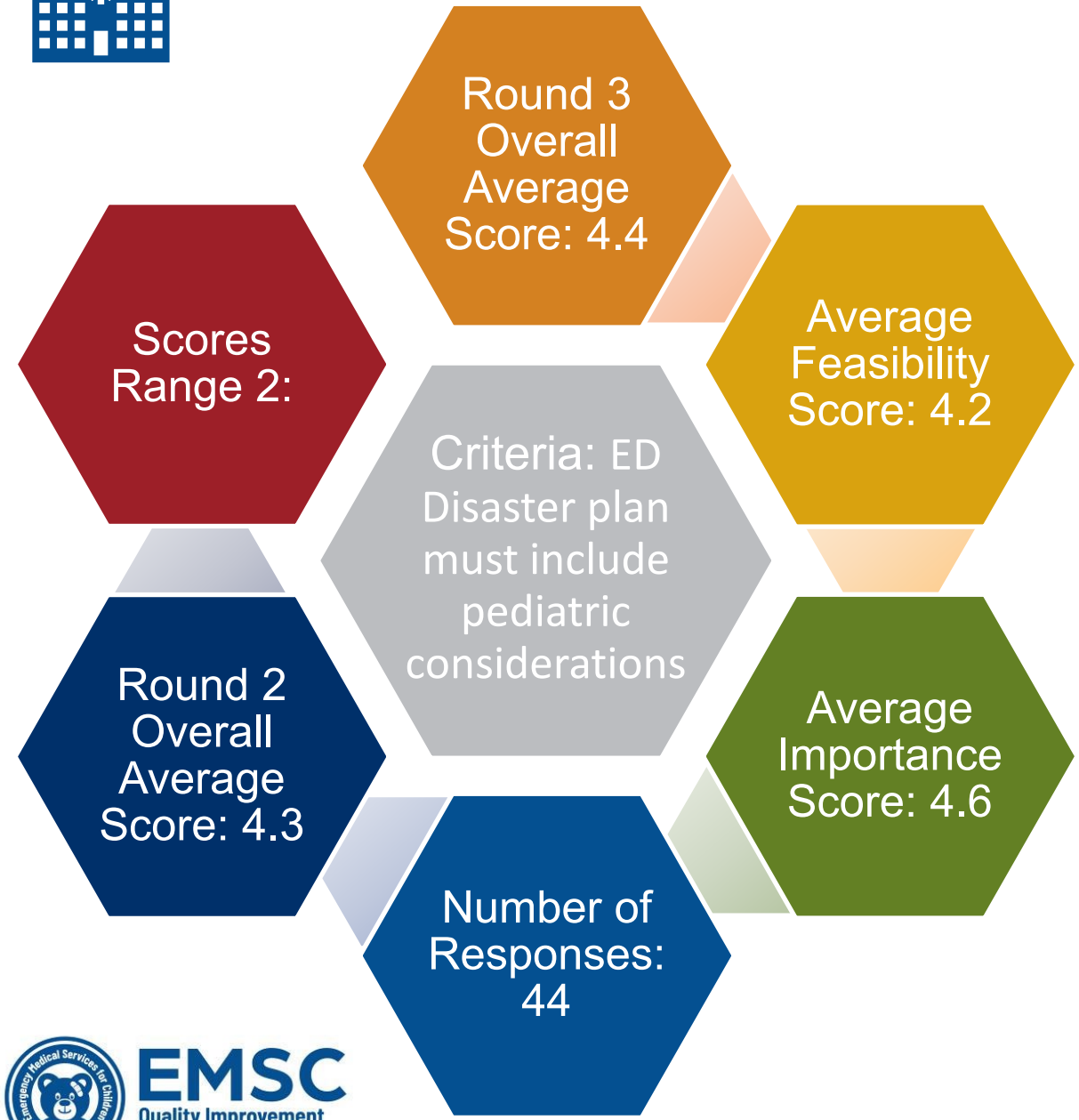
- There should always be pediatric considerations in policies and procedures. Providers and staff need guidance on dealing with pediatric specific situations.

Adjust

- Depends on the policy and the procedure
- When relevant. Some general organizational policies and procedures would not be relevant to pediatrics

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK



Adopt

- An ED disaster plan absolutely needs to include pediatric considerations, there are multiple examples of recent pediatric MCIs. It would be easy to incorporate pediatric specific disaster plan and refresh with yearly training.
- If you are talking critical access hospitals and all that rarely care for kids, requiring disaster plan specific to children seems like a waste of time/effort. I assume ALL hospitals have disaster plans already that would be inclusive of children.
- Pediatric census of 20-25% of the population supports the need to include pediatric considerations in disaster plans.
- The needs of children should be included in facility disaster plans. A stand-alone plan or annex is not required.

Adjust

- A listing of these considerations would be helpful, i.e. suggested considerations to include:
- Define considerations?
- It might be more helpful to include examples, as many EDs may believe a strict list of specifics is required when it could be something as simple as having an area set aside to supervise unattended (uninjured) children
- Need specific recommendations and templates from subject matter experts
- What are joint commission requirements and can that verbiage be incorporated for more embracing of the concepts?

Abandon

- A lot of disaster plans are at regional or state levels

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

Next Steps

- **ED Minimum criteria**
- PH Minimum Criteria Consensus Activity Third Round
- Next PRRPC Session: **April 18, 2024, 1:30-3:00 pm CT**
- Future Topics?

Pexels.com

EMSC Quality Improvement Collaboratives

Thank you!

For additional questions, contact us:

collaboratives@emscimprovement.center