Pediatric Readiness Recognition Programs Collaborative

Session 7
April 18, 2024

EMSC Quality Improvement Collaboratives

PEDIATRIC PANDEMIC NETWORK

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Thank you for joining!

Session is being recorded

Raise your hand or come off mute

Today's session is interactive

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PRRPC Session Agenda

Pediatric Readiness Recognition Programs

- **Minimum Criteria for Prehospital and Emergency Department Programs- 45 minutes**
- **Discuss Schedule/Future Topics- 5 minutes**
- **Application Process for Programs- 40 minutes**

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Prehospital Recognition Programs

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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

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PH Criteria Being Considered- Round 3	Round 3 Mean	PH Criteria Being Considered- Round 2	Round 2 Mean
Requires training on medication dosing for children	4.4	Requires training on medication dosing for children	4.6
Uses weight estimation system	4.5	Uses weight estimation system	4.6
Prehospital personnel physically demonstrate correct use of pediatric-specific equipment	4.4	Prehospital personnel physically demonstrate correct use of pediatric specific equipment	4.4
Policies and procedures regarding the care of unaccompanied minors	4.0	Include pediatrics in policies and procedures regarding the care of unaccompanied minors	4.4
Has policies and procedures for refusals involving children	4.1	Include pediatric in policies and procedures regarding refusals involving children	4.3
Policies, procedures, and training integrates elements of patient and family centered care	3.8	Policies, procedures, and training integrates elements of patient and family centered care	4.3
Policies and procedures regarding the reporting of child maltreatment	4.7	Include pediatrics in policies and procedures regarding the reporting of child maltreatment	4.6
A designated PECC who may support one or more agencies	4.5	A designated PECC	4.4
Established process for a regularly scheduled verification of pediatric equipment and supplies	4.4	Established process for the regular verification of pediatric equipment and supplies	4.3
All recommended equipment and supplies readily available as appropriate	4.4	All recommended equipment and supplies readily available	4.3
Participates in disaster drills that include children	4.0	Participates in disaster drills that include children	4.2
Utilizes a field triage algorithm that includes children (e.g., SALT or JumpSTART Triage Algorithm)	3.7	Has a prehospital disaster triage algorithm that includes children	4.2
Utilizes national consensus recommendations to guide availability of equipment and supplies to treat all ages	3.8	Utilizes national consensus recommendations to guide availability of equipment and supplies to treat all ages	4
Prehospital personnel can locate pediatric specific equipment	4.6	Prehospital personnel can locate pediatric specific equipment	4.5
Include pediatrics in policies and procedures regarding the use of trauma triage destination protocols for transporting services	4.2	Include pediatrics in policies and procedures regarding the use of trauma triage destination protocols	4.4
QI plan includes pediatric considerations	3.9	QI plan includes pediatric considerations	4.1
Mass transport policy or protocol that includes children	3.9	Has a mass transport policy or protocol that includes children	3.8

Prehospital Round 3 Results

PH- Criteria	Average	Min	Max	Range
Policies and procedures regarding the reporting of child maltreatment	4.7	1	5	4
Prehospital personnel can locate pediatric specific equipment	4.6	3	5	2
Uses weight estimation system	4.5	3	5	2
A designated PECC who may support one or more agencies	4.5	3	5	2
Established process for a regularly scheduled verification of pediatric equipment and supplies	4.4	3	5	2
Requires training on medication dosing for children	4.4	3	5	2
Prehospital personnel physically demonstrate correct use of pediatric-specific equipment	4.4	3	5	2
All recommended equipment and supplies readily available as appropriate	4.4	2	5	3
Include pediatrics in policies and procedures regarding the use of trauma triage destination protocols for transporting services	4.2	1	5	4
Has policies and procedures for refusals involving children	4.1	1	5	4
Participates in disaster drills that include children	4.0	2.5	5	2.5
Policies and procedures regarding the care of unaccompanied minors	4.0	1	5	4
QI plan includes pediatric considerations	3.9	1	5	4
Mass transport policy or protocol that includes children	3.9	1	5	4
Policies, procedures, and training integrates elements of patient and family centered care	3.8	1	5	4
Utilizes national consensus recommendations to guide availability of equipment and supplies to treat all ages	3.8	1	5	4
Utilizes a field triage algorithm that includes children (e.g., SALT or JumpSTART Triage Algorithm)	3.7	2.5	4	1.5

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

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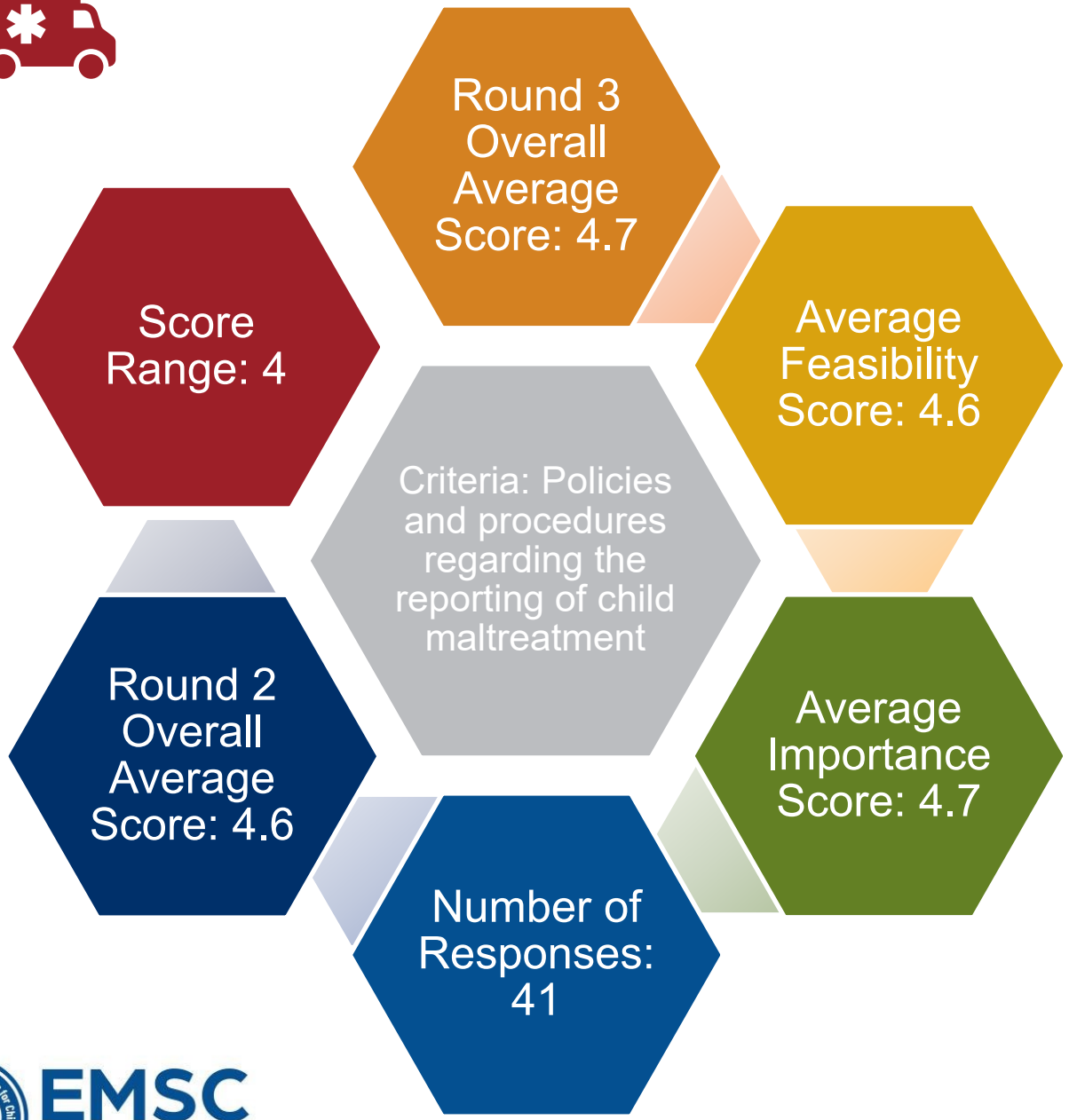

Adopt

- Statewide protocols address this as EMS providers are identified in the state as mandated reports and the protocols clearly outlines the steps for reporting (multiple answers included similar statement).

Abandon

- This is the responsibility of the medical director and cannot be dictated from the agency-level.
- Can be on hold for an hour with abuse hotline and online reporting not always reviewed in timely manner so EMS often delegates to ED.

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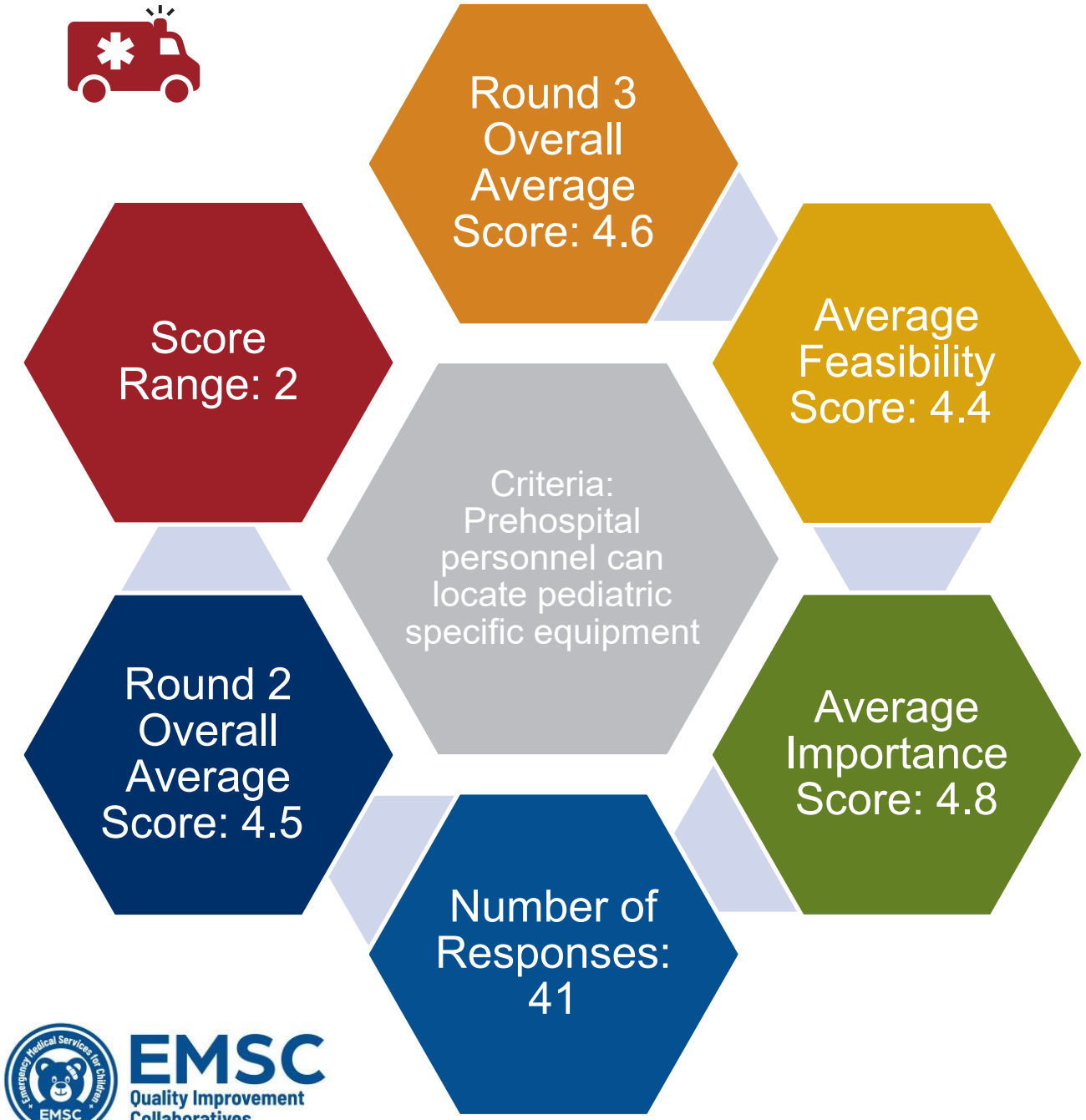

Adopt

- Probably the single most important criterion in the list. This is where we should be spending our energy - it may be difficult to have every EMS clinician in the agency demonstrate this -- but this is what matters for the pediatric patients they will be treating and transporting.
- Some states have skills competencies - both adult and pediatric, as part of their statutes, regulations, or rules. Even if they do not, it should not be cumbersome for any agency, including volunteers, to perform skills competencies at least once per year.
- The equipment is located on the ambulance or in their equipment travel bags. Should not be super difficult to locate if stocked equipment.

Adjust

- Locate pediatric equipment relative to their scope of practice is the key
- Prehospital transport providers are required to perform periodic equipment checks which, by nature, requires them to locate the equipment. This, however, is not well monitored and would have to be established in company policy which could be daunting.
- Would recommend applying a frequency, such as an annual /quarterly competencies and new hire training

Abandon

- Cannot mandate. This is outside of state and national requirements for license renewal/continuing education.
- Regular rig checks and knowledge of equipment location is a daily expectations that should not require a defined process.
- Not feasible to have it observed in the patient - EMS clinical care delivery.

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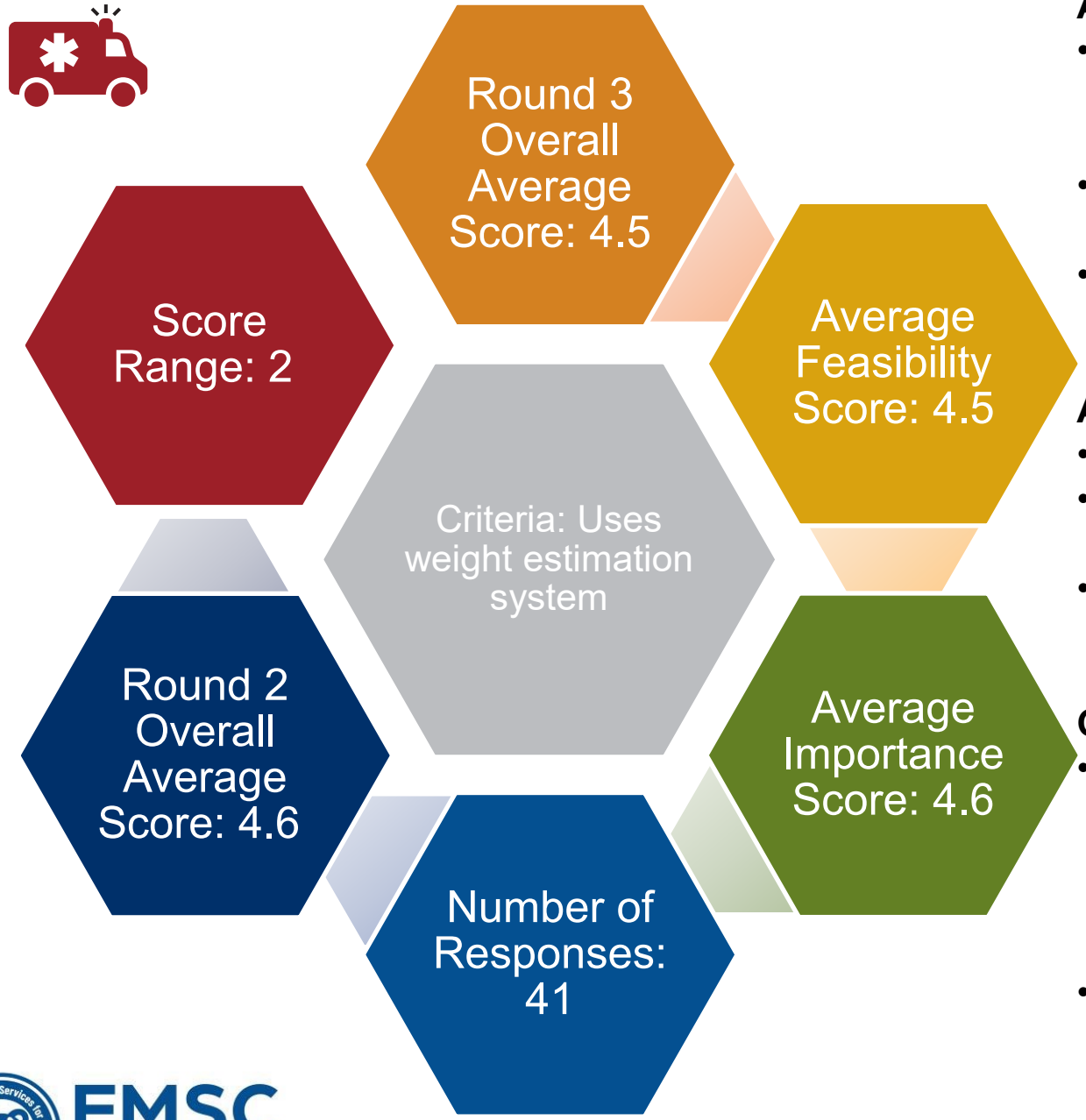

Adopt

- Use of a length/weight-based system to reduce pediatric medication and dosing errors should be a minimum requirement.
- Already required as well- Included in state rule for ground ambulances.
- Required by protocol and equipment list as part of licensure. required in the State

Adjust

- Add in kg
- Could be worded "Policies, procedures, and training to use weight estimation system.“
- Use of Broslow tape or measuring device of their own creation.

General

- I agree with the tools and cognitive offloading to address medication errors- but providers are notoriously bad at estimating pediatric weights and even PECARN is working on research related to age based dosing. Yes too tool, wary on the weight requirement.
- Provide evidence-based methods and examples for agencies to consider. Many of the products become prohibitively expensive.
- Provide example (e.g., length based)

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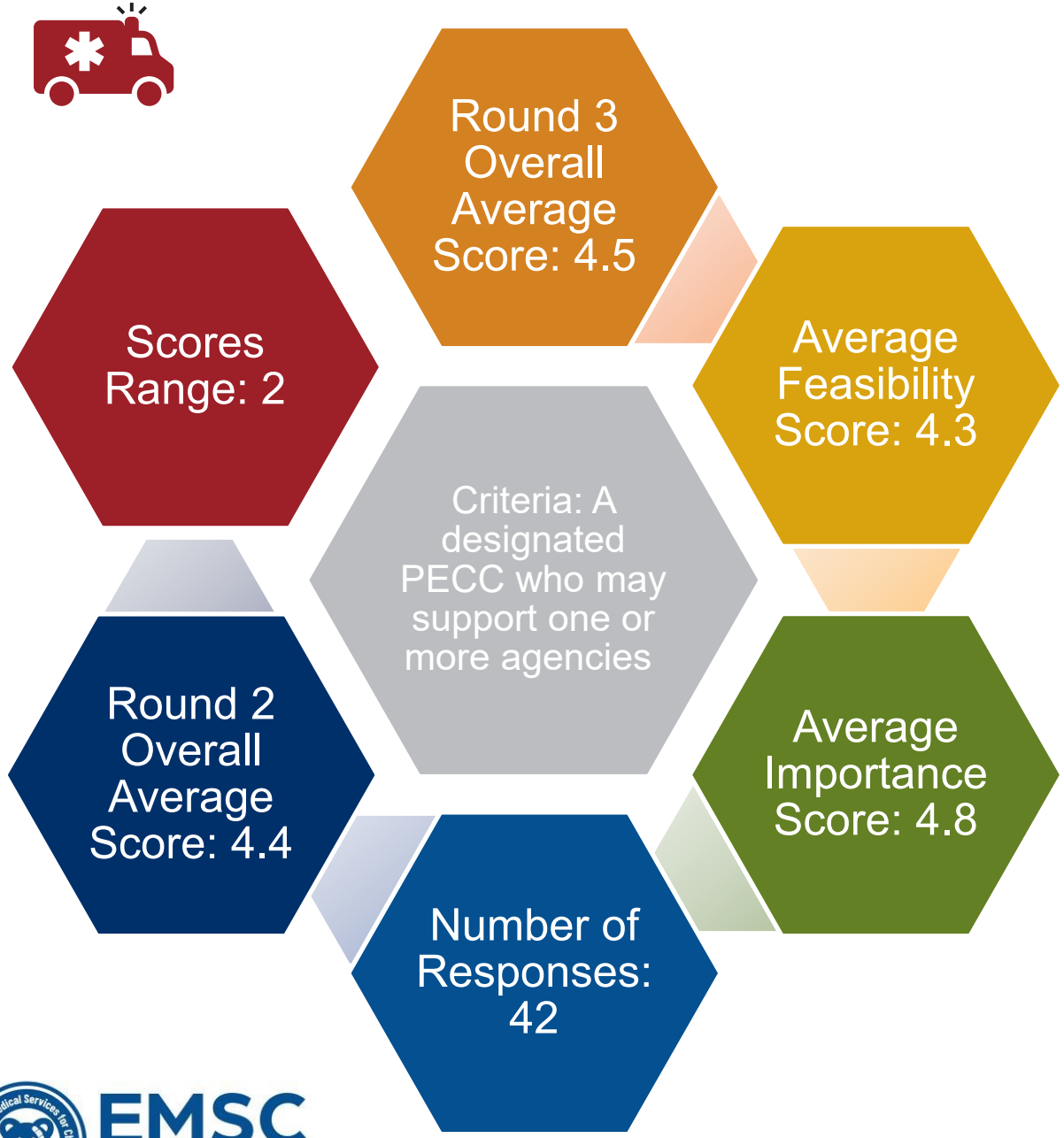

Adopt

- Allowing same PECC to support multiple agencies allows for leveraging highly invested PECCs across smaller agencies and allows bigger jurisdictions to support smaller ones
- Depending on the population, I believe it may be doable. It may help with processes and standardization
- Our hospital recognition program requires a PECC at all levels- the prehospital recognition program should as well. A champion is needed to ensure the preparedness work is continuous and included in agency priorities.
- The most important minimal criteria. Doable for even the smallest locations - can share PECCs between other agencies.
- This is critical because data shows that those with a PECC are better prepared to care for the pediatric population.

Adjust

- Shift PECCs should be considered as most agencies do not have the funds or resources for a full-time solely designated PECC
- Would this only apply to the primary agency for 911 transports? Or to all agencies including fire first responder (non-transport) agencies as well. What would be the "or more agencies" definition. Could 1 person represent 3 smaller city fire departments?
- I believe that this should be established as a "district PECC" which could be contracted to service either ER or PH services. I believe that the state systems should define a criteria for utilizing a district PECC so that one PECC could provide the necessary services without a serious risk of an overwhelming workload.

Abandon

- Challenges to obtain/maintain PECCS , especially at smaller volunteer agencies
- Smaller agencies will struggle with this as they compete for volunteers time in simply staffing ambulances/response vehicles.

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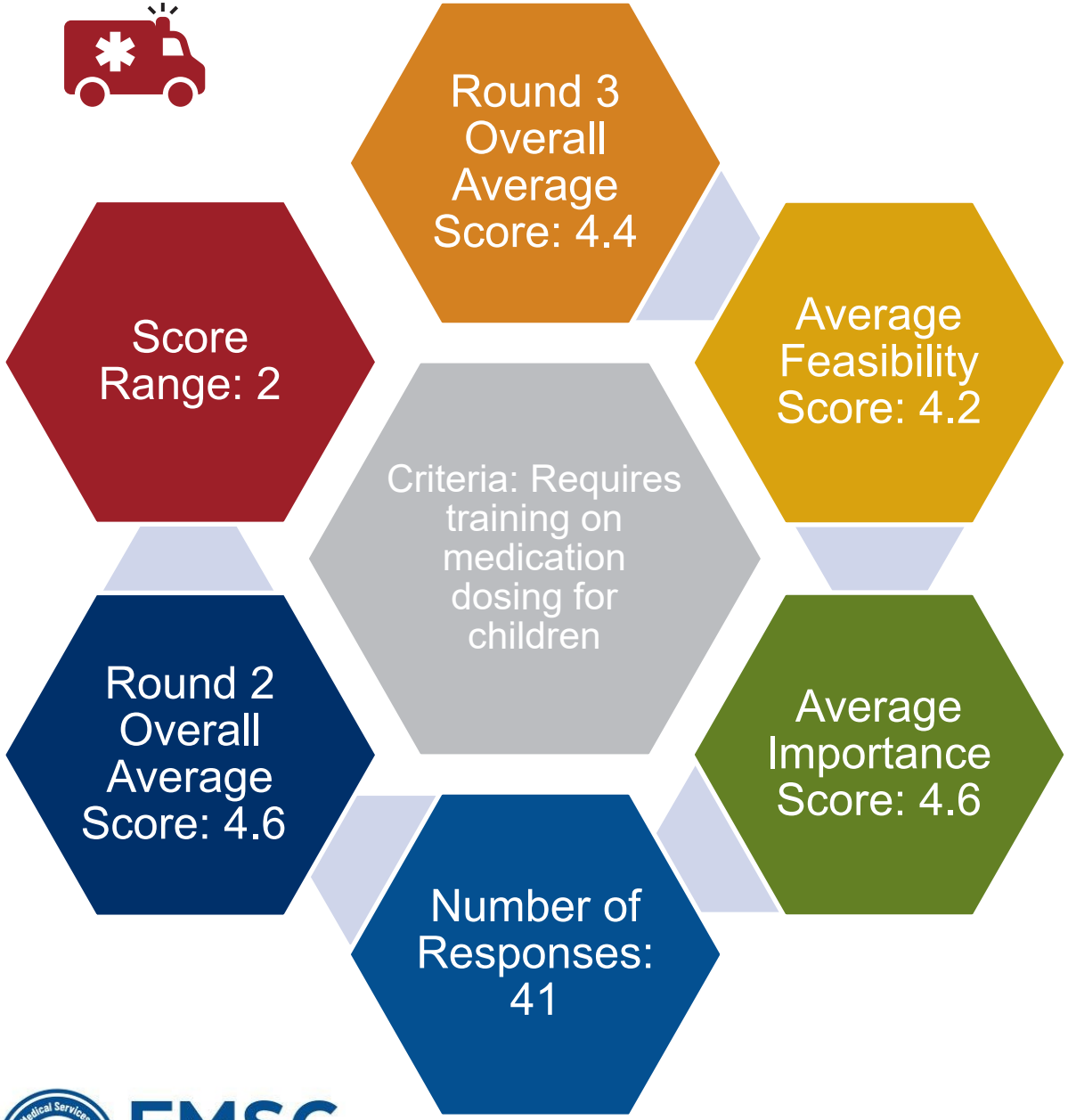

Adjust

- Annual/quarterly? Adding language of how often is more helpful.
- Ideally should be hands on drawing up simulated meds.
- Part of education from Bureau of EMS.
- This is so vague that I have a hard time imagining what the actual content of such training would be (could range from a short mention of weight-based dosing to one or more hours of content on specific drugs).

Abandon

- Less likely in smaller agencies similar to the QI plan response however has a higher frequency of activity when packaged with adult care.
- Required in the State - however only for paramedics. So, if an agency is MFR non-transporting for example - there would not be a provider there who is administering medications, and is not eligible for the pediatric medication administration training. This should not prohibit them from being minimally peds ready - since they do not administer medications, does not apply to them. This should be a higher level of pediatric readiness consideration.
- State does not require provider training on medication dosing for children.

General

- Provide examples or courses to reduce costs for agencies to deliver - perhaps a national math class freely available for EMS
- This could be part of an agency's annual staff training.
- The tools are required; however, training would require a systematic approach by the services to train their respective personnel. We could also see the above-mentioned problem of a service utilizing a distant hub for training which would cause increased workload for off duty personnel.

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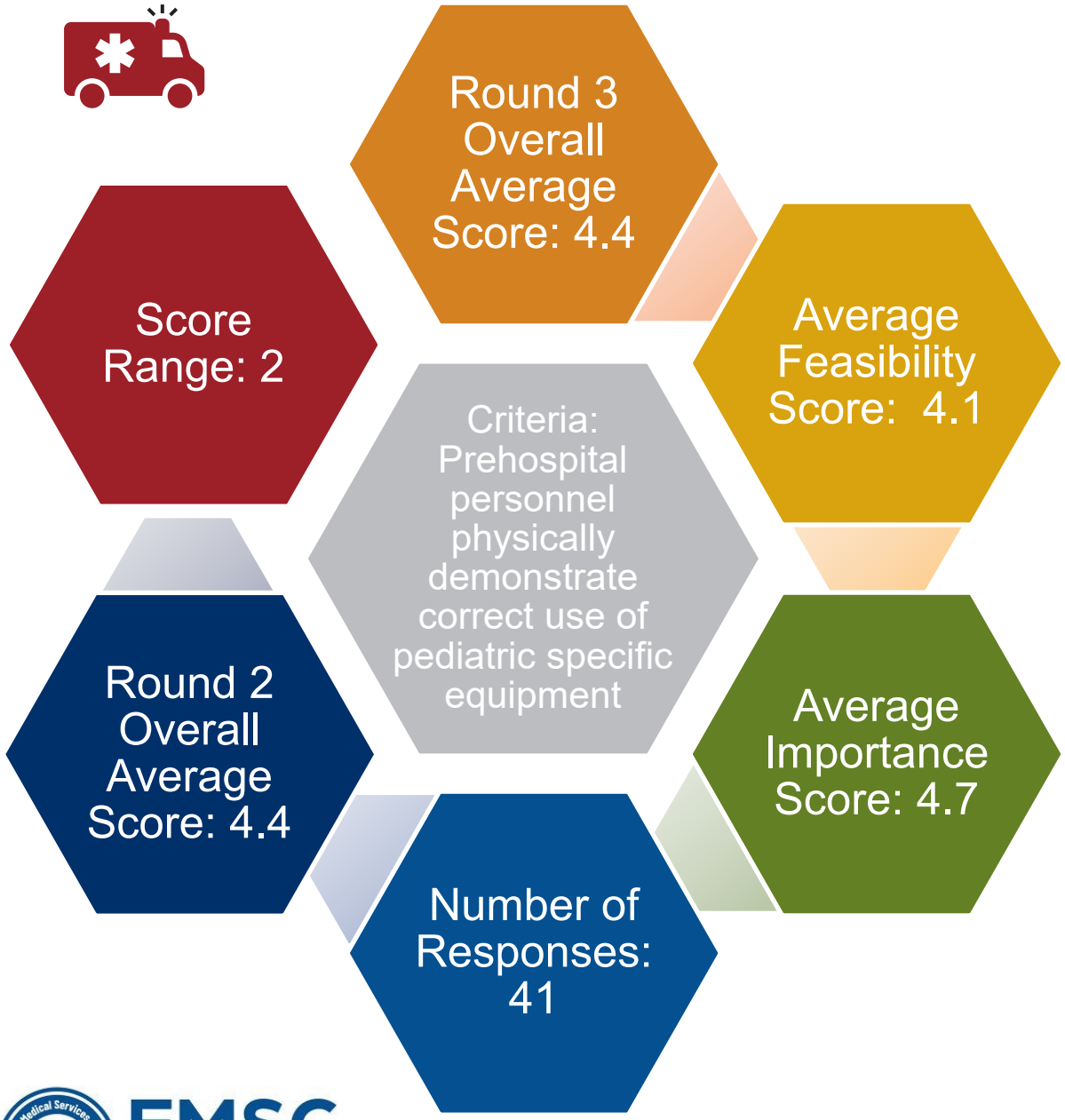

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Adopt

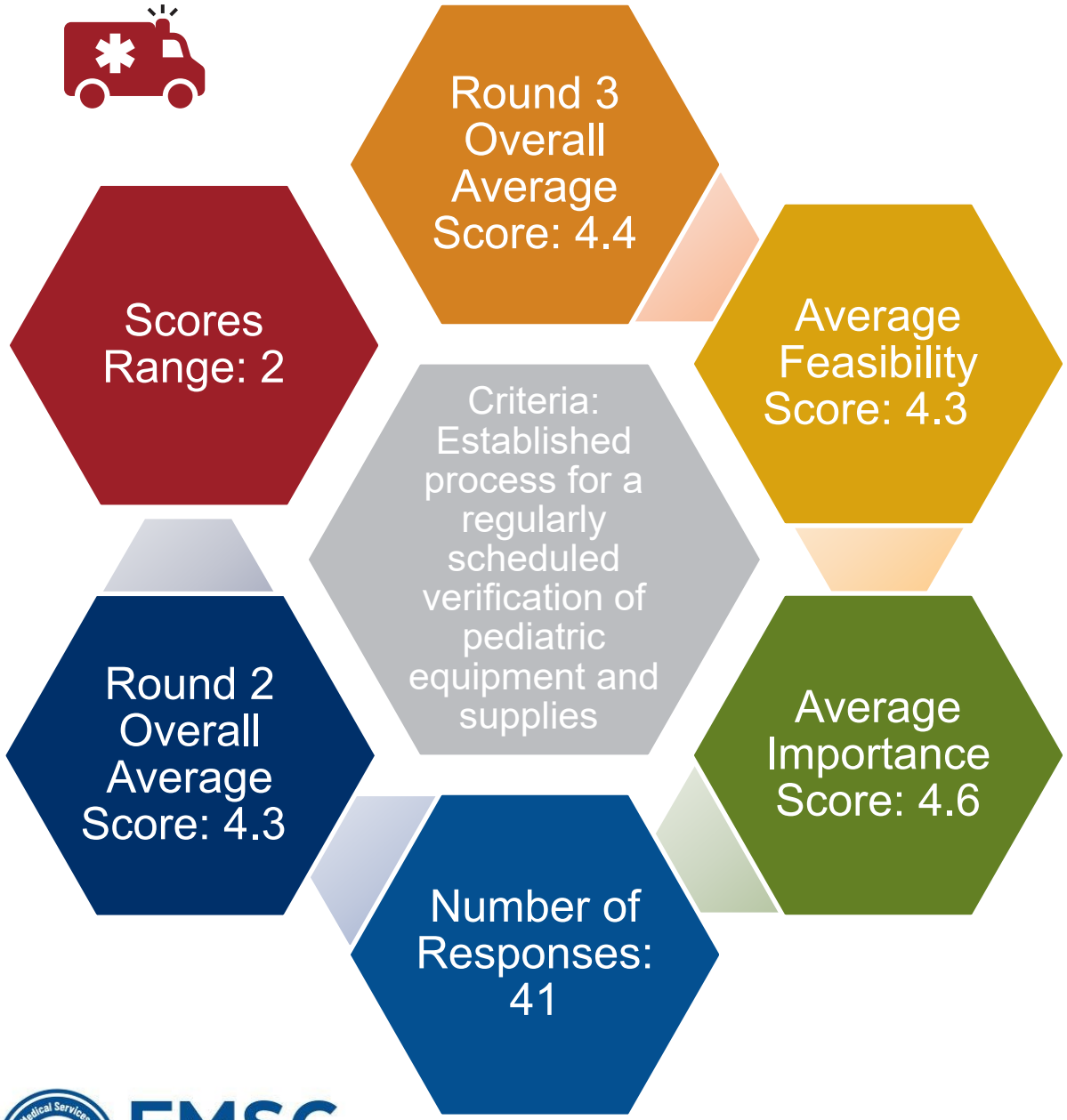
- EMS agencies should be encouraged to provide a pediatric training component into their agency continuing education program.
- This might be "hard" but for me this is the heart of this project. Some states have skills competencies - both adult and pediatric, as part of their statutes, regulations, or rules. Even if they do not, it should not be cumbersome for any agency, including volunteers, to perform skills competencies at least once per year.

Adjust

- The issue here is frequency if all that is done is a once-a-year check that is useless. Recommend changing to has a scheduled established a process to physically demonstrate correct use to pedi-specific equipment.
- There should be a specific number. Example - demonstrate the correct use of one piece of equipment each year or something similar to that / Would recommend applying a frequency, such as annual /quarterly competencies and new hire training
- Which equipment? All? Most common used? high risk/low frequency? Need further definitions and also needs to be relative to each individual's scope of practice. Additionally, the cost is high for disposables and mannikins to support this. The even bigger challenge is finding the person who KNOWS the correct use.
- Who is going to check providers in a department using equipment?

Abandon

- Cannot mandate. This is outside of state and national requirements for license renewal/continuing education.
- Many smaller agencies do not have training officers/ educators. This is typically ensured during recertification skills checks every 2 to 3 years. This could be used as a higher level in a multi-level recognition program.
- Logistics of this will be the most difficult due to call volume and understaffing. I do not believe that this could be regulated effectively at the state level but could be incorporated into the PECC duties. With that being said, this would demonstrate an opportunity for a PECC to service multiple agencies or districts.



Adopt

- All known ambulance licensing requires periodic inspection of the units. (multiple comments)
- Currently required for agency licensure (multiple comments)
- These inspections include pediatric equipment and supplies. For non-state agency partners, they can easily collaborate with the respective licensing firm to ensure pediatric specific equipment is on the "required equipment" manifest.
- There should be a process for regularly scheduled verification of pediatric equipment and supplies that should apply to all EMS agencies - paid or volunteer. Whether that schedule is daily or monthly, or is regulated by statute, rule, regulation does not matter. What matters is that they have a process to regularly check the equipment and supplies.
- This can easily be integrated into the current standards for periodic equipment checks. The functionality will need to be left to the agencies/services due to the differences of systems. As an entity, we should make a recommended checklist with suggestions for frequency

Adjust

- Define regularly scheduled
- Definition would be important...
- This should be combined with the other metric on equipment location and checking
- Verification of what? Presence/inventory? Knowledge/use? Not expired? This will also vary greatly based on state, scope of practice, license level, type of service (transporting vs not), etc.

Abandon

- Cannot mandate. This is outside of state requirements for agencies

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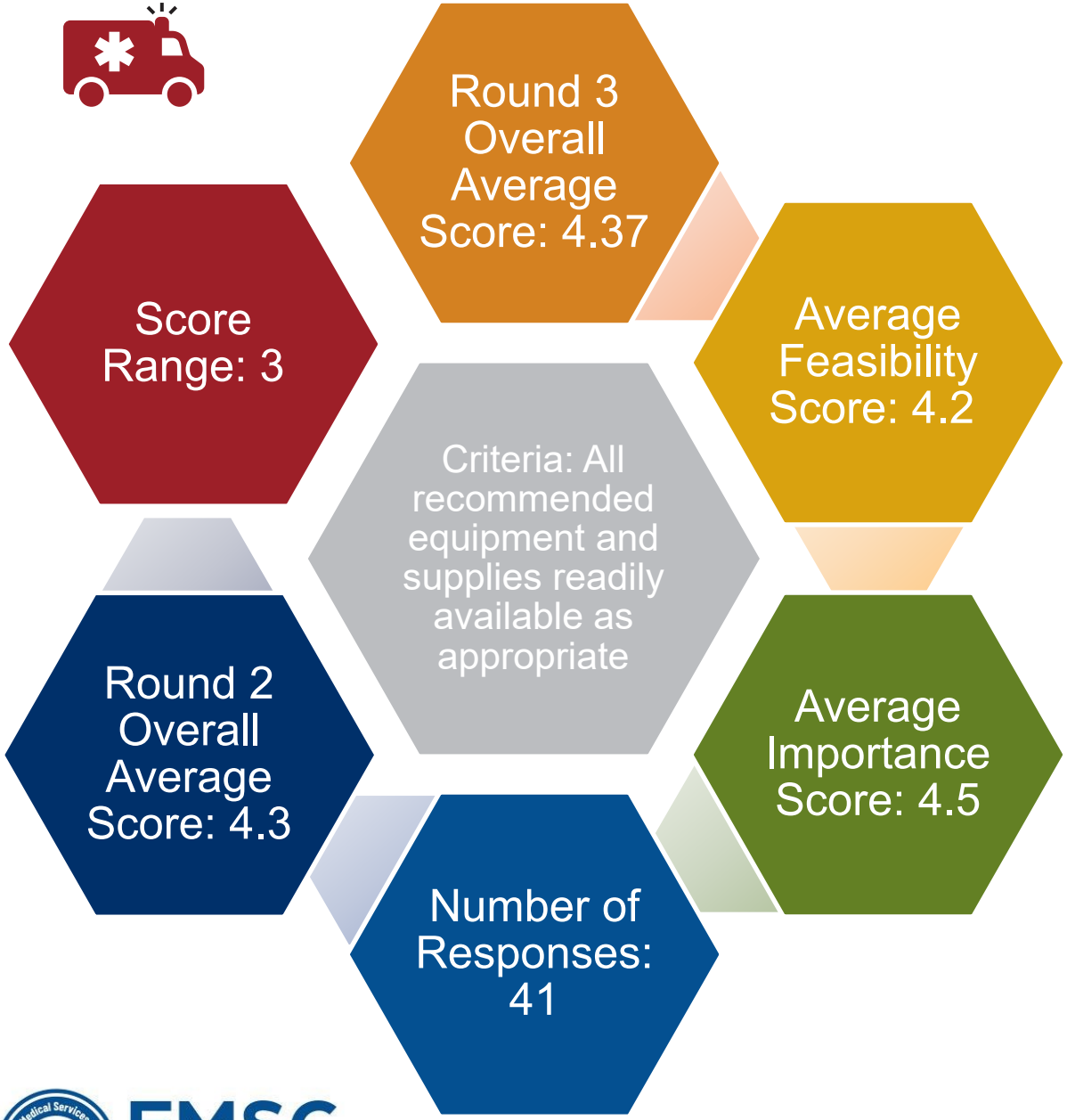

Adopt

- If not already existing, the agency could make this part of the rig check performed by EMS staff when coming on duty.
- This is also addressed in the trauma designation guidelines.

Adjust

- "as appropriate" makes this statement swiss cheese - may ways to only have one of something or put it on a supervisor vehicle that may or may not get there....
- Combine with the other metric on equipment. Seems just a different way to say a similar thing/not sure you need this plus question above
- Recommended? As appropriate? Odd wording

Abandon

- Checked upon re-licensure inspections of the vehicle
- Not for minimum
- Many states have specific rules and just because something is recommended and an agency is willing to purchase it,
- doesn't mean they can. They cannot be held or "punished" for not having it

General

- "The recommended equipment and supplies are based on the Recommended Essential Equipment for Basic Life Support and Advanced Life Support Ground Ambulances 2020: A Joint Position Statement. This document is intended to represent minimum essential equipment recommendations and should not be used to limit the addition of items to a services repertoire. Carriage of items that supplement those listed should be based on local clinical and operational needs and should be left to the discretion of the physician medical director and other agency administrative personnel. Equipment should always be appropriate for the size/age of patients. Availability and use of appropriate pediatric sized equipment is necessary, not discretionary."
- What is ALL??? Who dictates this equipment list - CEMS or EMSC?
- Whose recommendation?

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ED Round Three

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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

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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

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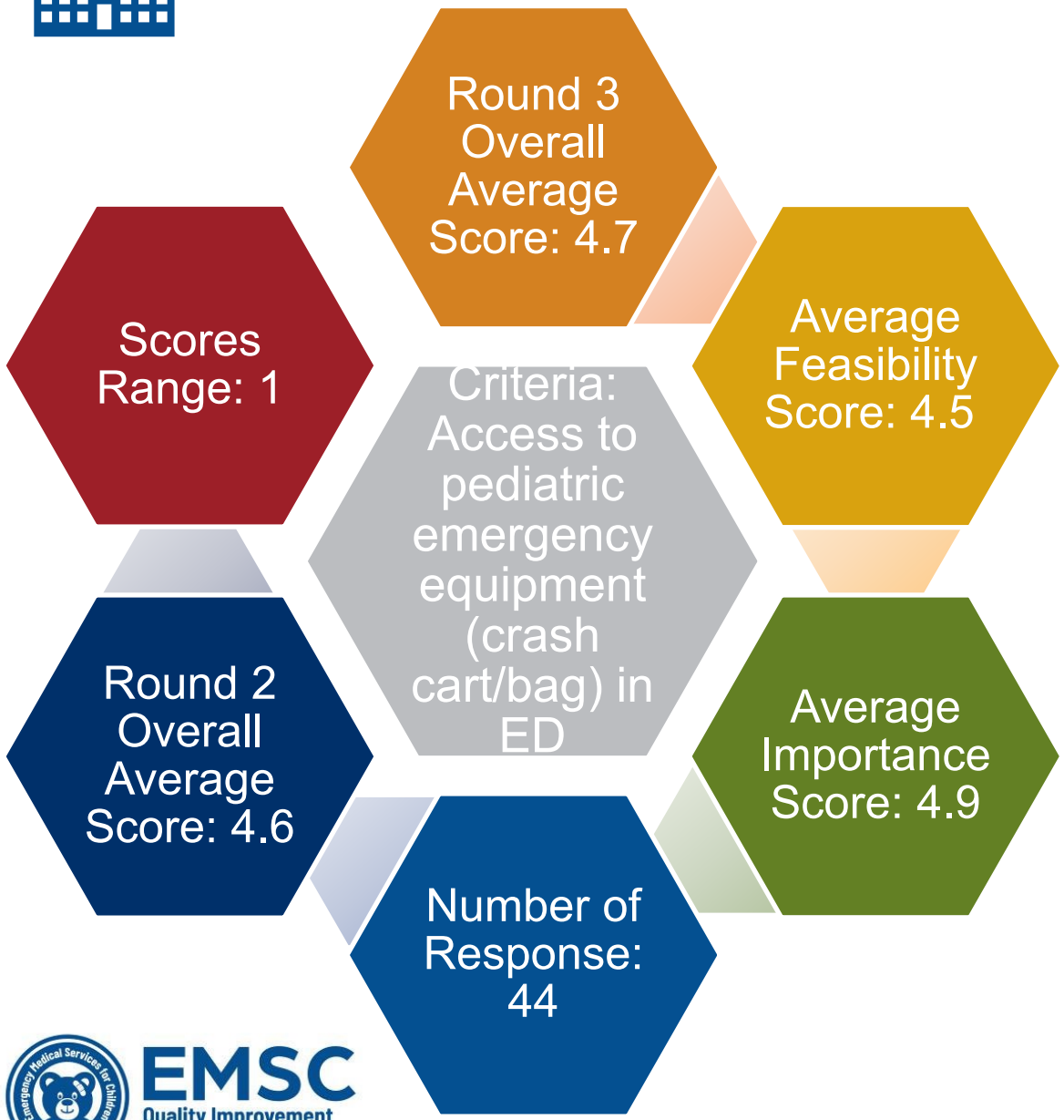


Adopt

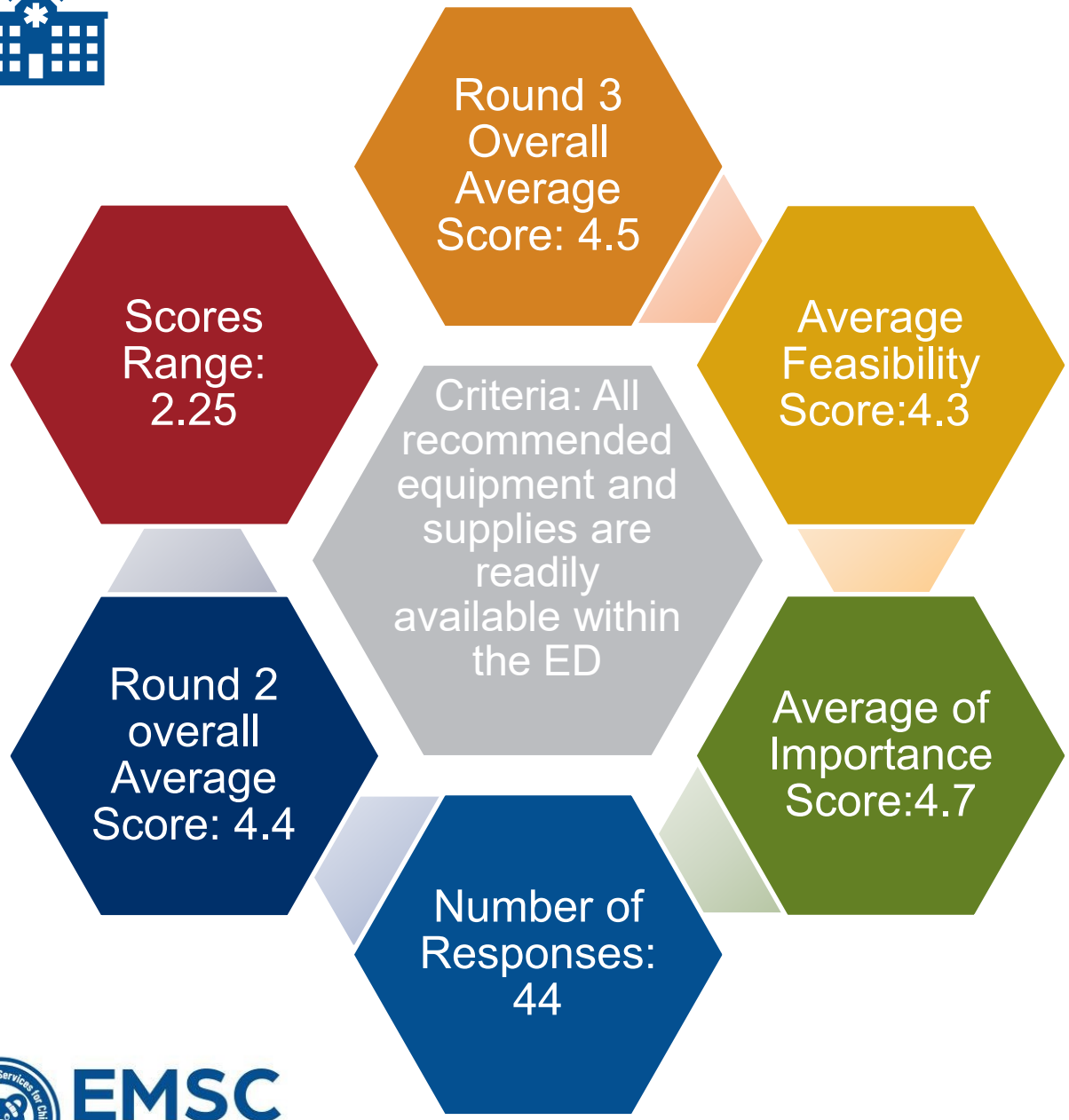
- Having quick access to this equipment along with being more familiar with the equipment seeing it each day is important to providing that care when needed.
- Sometimes purchasing and maintaining this type of equipment can be expensive for smaller departments that don't often see pediatric patients. 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.

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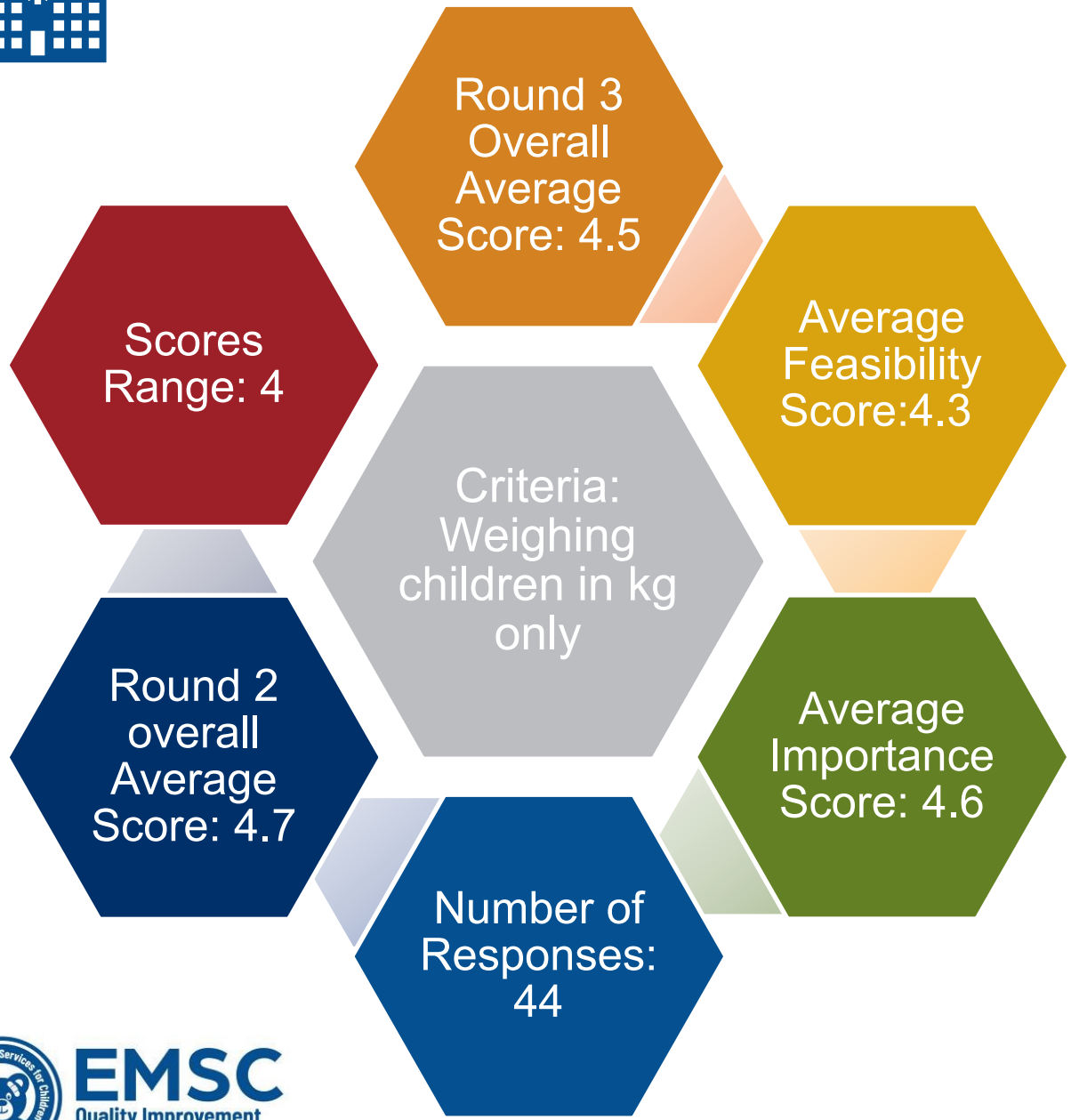


Adopt

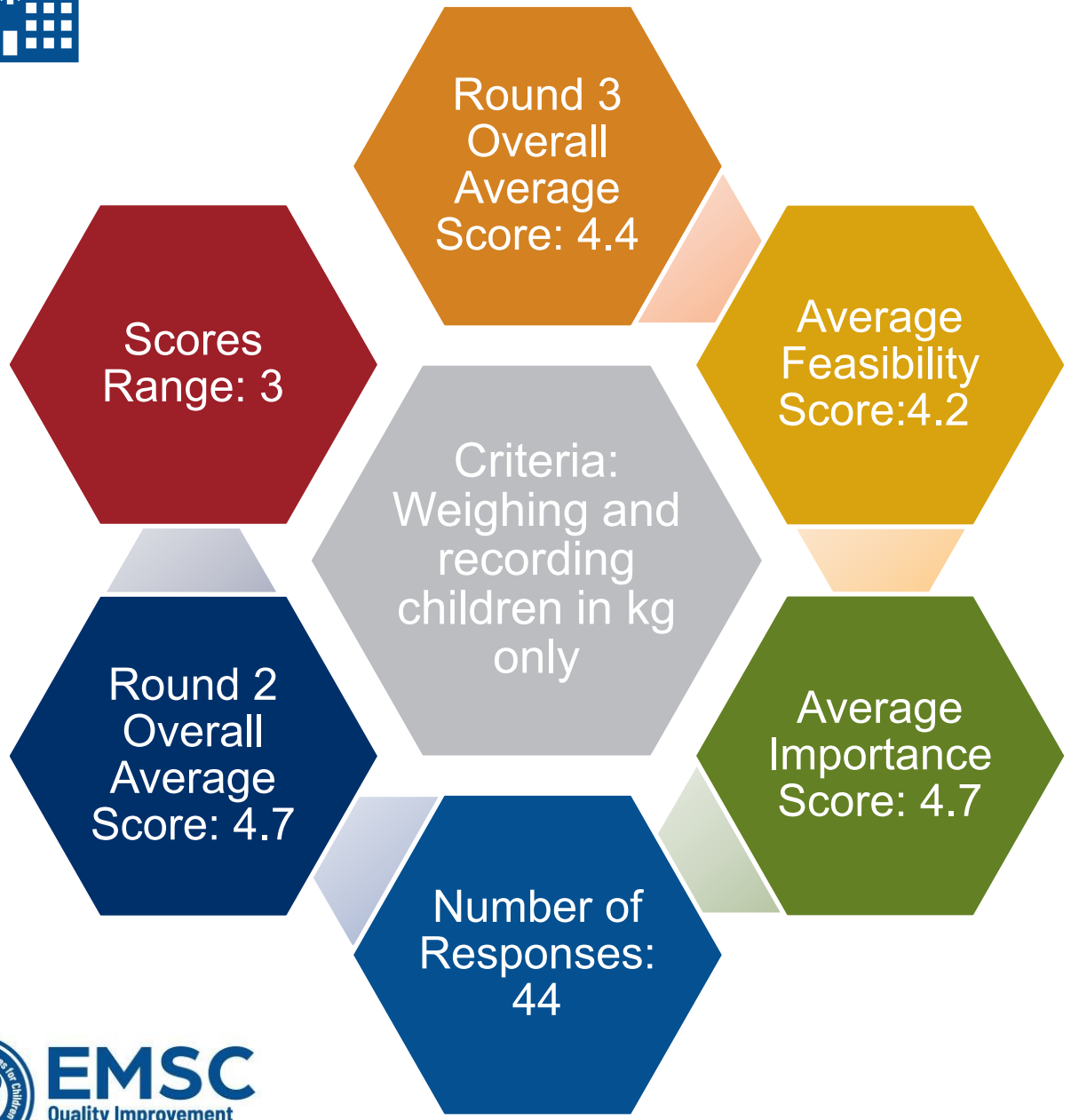
- Converting the weight of children from pounds to kilograms during a stressful situation can lead to errors. If all pediatric weight is measured in kilograms this could reduce that chance for conversion error. Almost all pediatric medication is dosed based on weight in kilograms, measuring weight in 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

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- 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.

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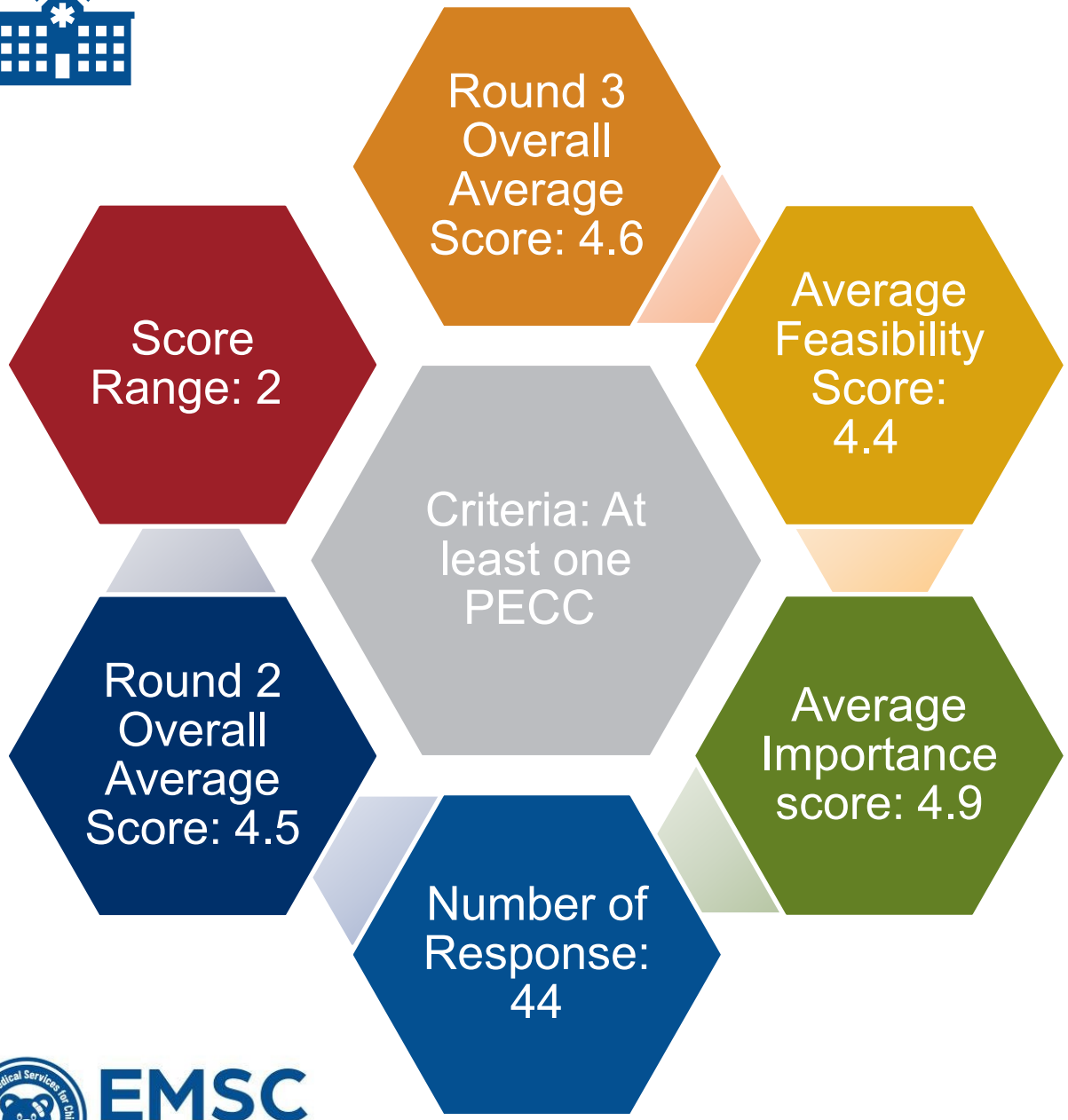


Adopt

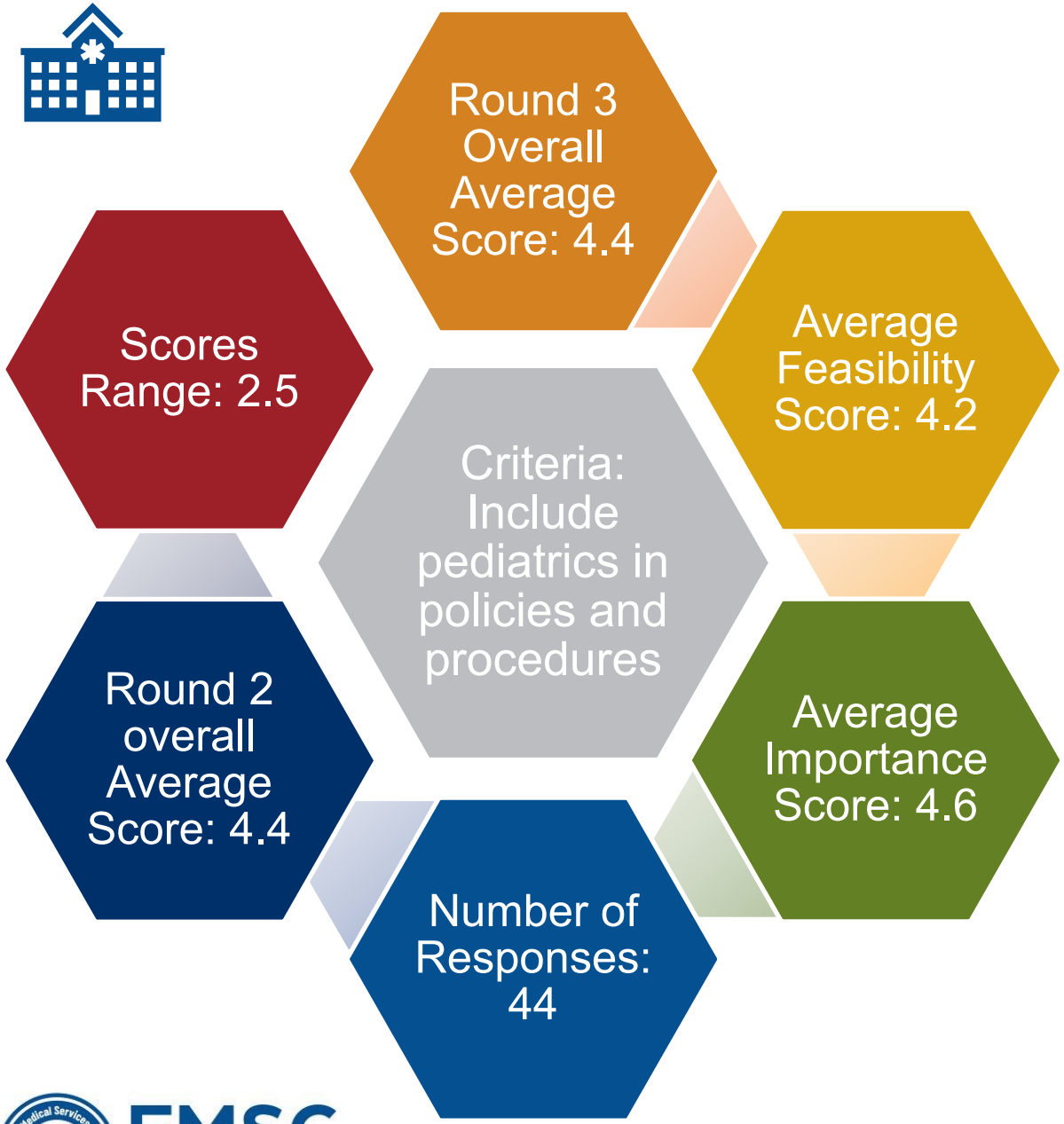
- A designated PECC is crucial in providing feedback from families and the communities they serve.
- Having at least 1 PECC is important to maintain pediatric preparedness and allows someone to focus on pediatric care. It seems reasonably feasible for most any dept or agency.
- Hospitals do not value 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



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

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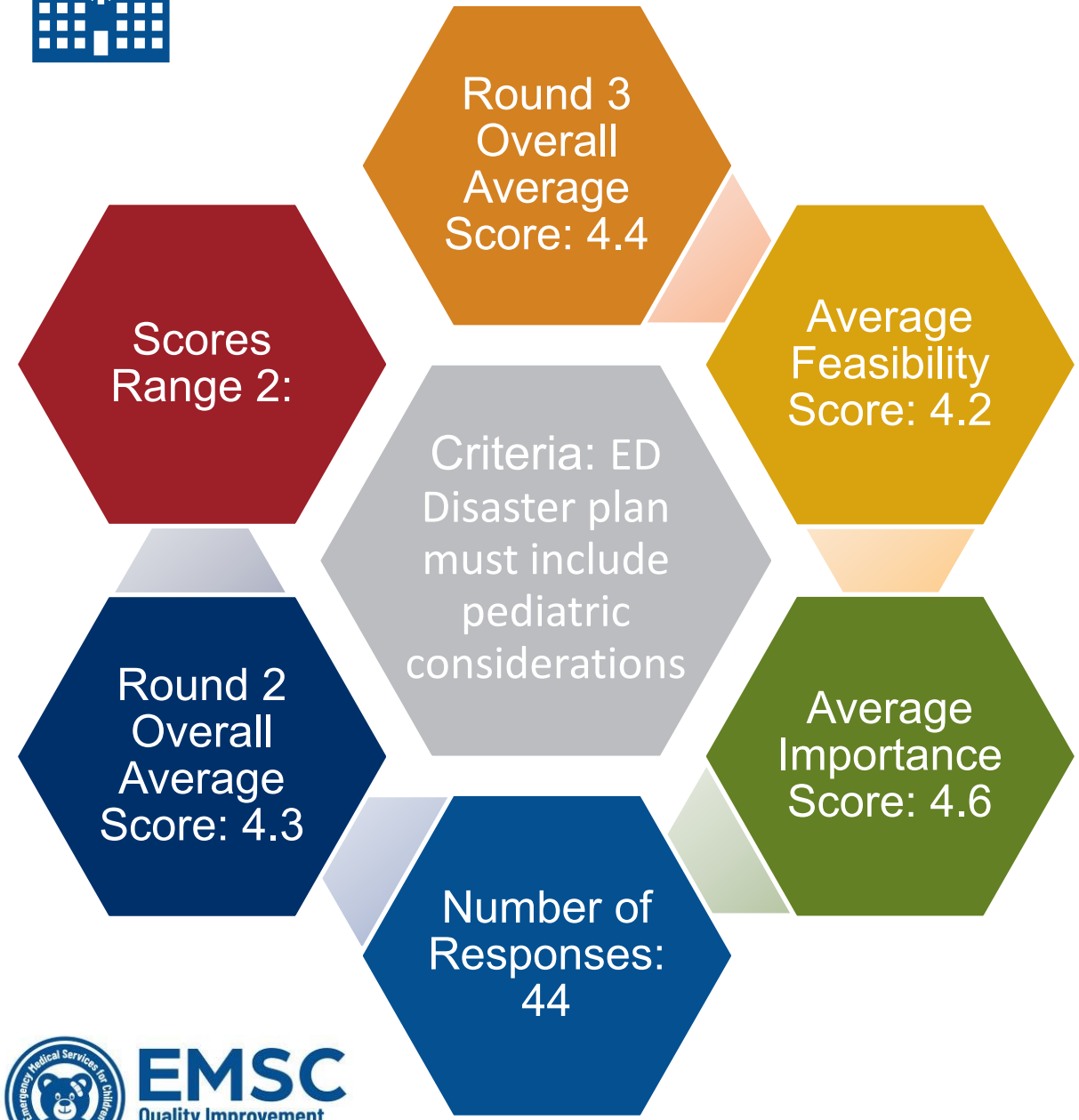

Adopt

- 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

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PEDIATRIC PANDEMIC NETWORK

Pediatric Readiness Recognition Programs

The Application Process

EMSC Quality Improvement Collaboratives

Thank you!

For additional questions, contact us:

collaboratives@emscimprovement.center