TEXAS EMS FOR CHILDREN VOLUNTARY PEDIATRIC READINESS PROGRAM (VPRP)

APPLICANT MANUAL

2019

TEXAS EMSC STATE PARTNERSHIP

1102 Bates Ave, Suite 1850
Houston, TX 77030
Phone: 832-824-3672
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Email: emsctexas@bcm.edu
www.bcm.edu/pediatrics/emsc

September 2019,

Dear Hospital Administrator:

Congratulations on your decision to participate in the Texas EMS for Children Voluntary Pediatric Readiness Program!

Enclosed is information on our program as well as documents that will need to be submitted to our office for review and consideration. The readiness program is an excellent opportunity for your Division or Department of Emergency Medicine to prepare and be ready to manage pediatric emergencies within your community. By preparing your facility to become pediatric ready, you will receive acknowledgement from your community and local media outlets that you are voluntarily choosing to go "above and beyond in your care of children."

It is important to note that your decision to participate in this readiness program will in no way impact your licensure by the Texas Department of State Health Services Office of EMS and Trauma Systems.

Please review this packet and complete and return the attached application along with the supporting documents for review by our office. Organizations who successfully meet the requirements will receive a Certificate of Readiness to acknowledge their accomplishment and commitment to the infants and children of Texas.

Please do not hesitate to contact me or our Texas EMSC Program Manager with any questions at 832-824-EMSC (3672) emsctexas@bcm.edu .

Sincerely,

Brian Bassham, MD, FAAP
Program Director, Texas State Partnership
Emergency Medical Services for Children

1

Table of Contents

VPRP BACKGROUND

I.   Introduction

1. Goal

The VPRP will prepare EDs to provide higher quality care for infants, children, and adolescents for the evaluation, treatment, and/or stabilization of children with medical and traumatic emergencies. One of the primary goals of pediatric readiness programs for EDs is to bolster pediatric readiness within communities and critical access hospitals such that children and families can benefit from the availability of at least one ED in their own community that is equipped to stabilize and/or manage common emergencies for children.

2. Program Overview

The VPRP will prepare EDs to provide higher quality care for infants, children, and adolescents for the evaluation, treatment, and/or stabilization of children with medical and traumatic emergencies. One of the primary goals of pediatric readiness programs for EDs is to bolster pediatric readiness within communities and critical access hospitals such that children and families can benefit from the availability of at least one ED in their own community that is equipped to stabilize and/or manage common emergencies for children.

3. Program Description

On a national level in 2005, the federally-funded EMS for Children (EMSC) program established performance measures to assure the existence of a standardized statewide, territorial, or regional system that acknowledges hospitals capable of stabilizing and/or managing pediatric medical emergencies and traumatic injuries. The goal previously set by EMSC was for each state/territory to have a system in place by 2017.

Similar to trauma center designation, a pediatric readiness program aids facilities in self-identifying areas in which they can optimize care. Unlike trauma center designation, however, the purpose of the VPRP is **NOT** to differentiate EDs based on the level of care they can provide for children. Rather, the purpose is to promote basic readiness for **ALL** EDs to be able to provide initial stabilization of children with emergency conditions given that nationally, 30% of ED patients are children. Additionally, greater than 90% of children are seen in general EDs when they have an emergency, not at a children's hospital. The intent of the VPRP is to equip all EDs with the ability to safely treat and manage children in their own communities when appropriate, not to bypass these facilities.

At its core, pediatric readiness provides the foundation to ensure high quality pediatric emergency care. Successful pediatric readiness programs share many common traits:

- Enhance awareness of pediatric emergency care gaps
- Recognize hospital and EMS infrastructures within the state
- Establish and maintain strong partnerships between hospitals and EMS agencies
- Define minimum criteria to promote pediatric readiness in the following areas:
    - Staff qualifications
    - Quality improvement
    - Policies/procedures

- o Continuing education
- o Equipment/supplies
- Adaptable to refine the process on an ongoing basis

4. Justification for Texas

In 2013, 305 of 504 hospitals in Texas participated in the National Pediatric Readiness Project (NPRP) assessment. These 305 hospitals cumulatively treat 1,572,835 children annually in their EDs. Of these children, 799,959 (51%) were treated in a pediatric ED in either a children's hospital or general hospital ED, while the remainder were treated in general EDs without a separate area for pediatric patients. In addition, 75% of these hospitals have the capability to admit a child to an inpatient unit, while 38% have a Neonatal Intensive Care Unit (NICU), and 9% have a pediatric intensive care unit (PICU). While not every hospital may have a pediatric ED or the capability to admit a child, every ED must be equipped for the basic evaluation, management, and/or stabilization of a child with an emergency.

Based on NPRP data from Texas, it is clear that variability exists among EDs in their ability to provide basic care to children. This variability does not necessarily correlate with geography or annual pediatric ED volume. There are some EDs with low pediatric volumes that scored high on the NPRP assessment, while there are some EDs that see more children that scored lower. Also, there are some rural EDs that scored higher on the NPRP assessment than urban EDs.

Some feedback that has been provided to the EMSC State Partnership from some EDs that see a low volume of children is that it is not necessary to invest the resources required to have the components assessed by the NPRP, since these children can be transferred to other EDs that are more equipped, such as children's hospitals. Though children's hospitals play a vital role in providing a higher level of care to children when medically necessary, the unnecessary transfer of children to children's hospitals, which are often located in urban areas, has negative consequences for patients, families, and local hospitals. If not covered by insurance, families must pay for the cost of the inter-facility transport. Also, being far from home can create social hardships for families by interfering with the ability for caregivers to go to work or safely return home after being discharged. Over time, such practices may also weaken the abilities of community EDs to be prepared to stabilize critically ill and/or injured children. Thus, critical access and/or community EDs may glean the greatest benefit from participating in a VPRP.

Texas Summary: In Texas, there are 504 emergency departments (EDs) that met the inclusion criteria for the pediatric readiness assessment (see Appendix C). Of the 504 EDs, 305 responded to the assessment, which is 60.5% of all EDs in the state. On a national level, Texas represents 7% of the national data. Overall, Texas performed similar to other states. Data shown in Appendix C are also summarized below.

Overall Readiness Scores: As the pediatric volume of an ED increases, its average pediatric readiness score is also higher.

Texas Emergency Department Demographics: Only 7% of the hospitals in Texas have a pediatric ED. In Texas, most EDs are general EDs. Only 4% of EDs are based in children's hospitals whereas another 3% of EDs have a separate pediatric section in a general hospital ED.

Every ED should be equipped to care for children at a basic level. When children require a higher level of care, it is helpful for EMS agencies and other hospitals to know the capabilities of other facilities, so that transfers to the appropriate facility can occur. In the event of a disaster or mass casualty incident, it is also important for

hospitals and EMS agencies to know the EDs in their area that have the resources available to meet the needs of children.

Texas Emergency Department Age Cut-Off: Most hospitals in Texas use an age cut-off of 17-18 years to distinguish between a child and adult, both for medical and traumatic conditions. This varies from region to region and between hospitals within a region. For the purposes of the VPRP, the intent is to focus on ages 0-17 years, since this is the age range used by most hospitals to define a "pediatric" patient. The American College of Surgeons Committee on Trauma defines a child as under 15 years old.

Texas Pediatric Inpatient Capabilities: Of the hospitals in Texas, 36% have an inpatient unit, and 28% have a Neonatal Intensive Care Unit (NICU); only 9% of hospitals in Texas have a Pediatric Intensive Care Unit (PICU). Though inpatient pediatric services are not available in all hospitals in Texas, every ED must be equipped to stabilize children and be able to identify the hospitals that can provide a higher level of care, if required.

Presence of a Physician or Nurse Coordinator in the Emergency Department: Another factor that was assessed from each ED was the presence of a nurse or physician coordinator to focus on pediatric emergency care. Having at least one pediatric emergency care coordinator (PECC) ensures that someone is tasked with identifying and meeting the needs of children in the ED. The PECC may be a full or part-time position and it may be part of the job description of an existing ED role, such as a trauma coordinator, ED director, or a quality improvement coordinator, to name a few examples. The PECC can focus on some or all of the following: ongoing education and skills competencies in pediatric ED care, ensuring that policies and procedures are in place for children, creating a quality improvement plan for pediatric patients, ensuring that appropriate medications and supplies are stocked, and that pediatric care is included in staff orientation. National data from the NPRP shows that having a PECC is associated with having a higher pediatric readiness score

Physician Staffing: Physician staffing was also assessed. Emergency medicine (EM) and pediatric emergency medicine (PEM) training equips physicians to care for children in emergencies. General pediatrics and family medicine training may do this as well, if the skills are maintained. Specific training in handling pediatric emergencies is often lacking for other specialties.

Physician Board Certification: In Texas, 36% of hospital emergency departments have all of their physicians board-certified in either emergency medicine or pediatric emergency medicine. Of the EDs in Texas, 16% require neither board certification in EM or PEM for the entire medical staff.

Pediatric Patient Care Review Process: In Texas, 47% of EDs have a pediatric patient care review process in place. Having a patient care review process is also essential to identify system issues that may impact safety and quality of care.

Weighing and Recording in Kilograms: In Texas EDs, only 51% of pediatric patients have their weight both measured and recorded in kilograms. Weighing a pediatric patient in kilograms is important to ensure pediatric patient safety with respect to medication dosing. Since pediatric medication doses are calculated based on weight in kilograms, this is one of the most important areas for improvement in pediatric care.

Hospital Pediatric Disaster Plan: Only 41% of the hospitals in Texas include pediatrics in their disaster planning process. On a regional level, there is a variation in the presence of a disaster plan that addresses the needs of children. Planning for pediatric needs in disasters requires coordination between EMS and hospitals and it requires coordination between hospitals. This can often be overlooked.

Equipment Availability: Greater than 90% of the emergency departments in Texas have the recommended pediatric equipment available. For a list of items that are present less than 90% of the time, please refer to Appendix C (C12 – Equipment Availability).

II.   General Cost to Hospitals

Depending on the readiness level, there are two site assessment options available to hospitals a) virtual for the first two levels of recognition and b) on-site for the highest level of recognition. Some additional considerations are:

a) Time/labor costs of possibly more than one ED and administration staff member to coordinate the assessment with the EMSC program.
b) QI Multidisciplinary committee - each hospital will probably require a committee/process to discuss ED pediatric QI issues, which require staff time and commitment. Some hospitals meet monthly, some meet quarterly however, there is no mandated number of meetings per year.
c) Equipment/supply costs (cost varies by hospital based on their level of readiness prior to being a pediatric ready facility).
d) Required certifications – depending upon the readiness level, this ranges from all staff being required to have specialized certifications/competencies, to only one staff member on duty.
e) Pediatric-specific continuing education (some hospitals cover this cost, others do not reimburse for CE).

III.   Benefits to Hospitals

Becoming a VPRP recognized facility is a positive occurrence for both the hospital and the its staff. Benefits include:

- Creating a culture driven to continue improvement of pediatric patient outcomes, availability of equipment, services, and up to date treatment policies and protocols.
- Increasing the public's confidence in overall quality of a hospital's ability to address medical needs of children.
- Recognizing physicians, nurses, specialists, and other clinical staff for their knowledge, abilities, and commitment through their employment in an ARK recognized facility; therefore demonstrating a solid hospital wide commitment to excellent health care of Texas' pediatric population through their support of the VPRP program.
- Increasing exposure in local communities as a facility prepared for addressing critical pediatric needs during a medical or trauma emergency. This is visible in the form of a plaque displayed in the facility's emergency department and through listing the facility on the Texas EMSC State Partnership's website, and, additionally through self-promoting this accomplishment through local and/or statewide media outlets.
- Utilizing it as a recruiting and marketing tool to attract high quality physicians, nurses and other healthcare specialists.
- Enhancing potential educational and grant funding opportunities developed for rural hospitals and staff

FACILITY RECOGNITION APPLICATION
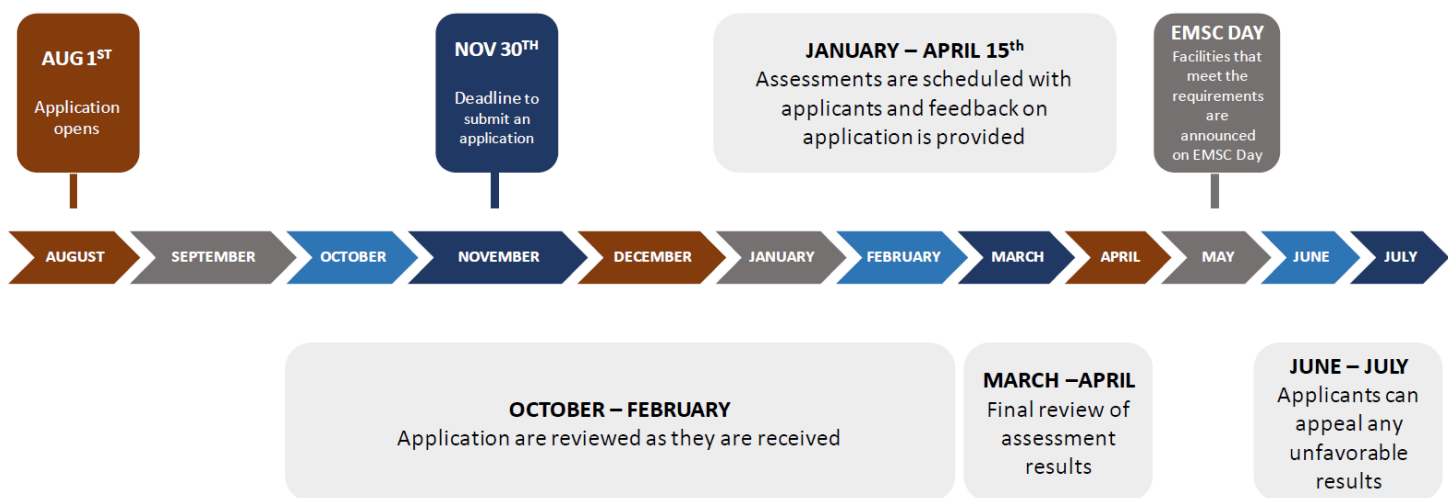
I.   **Process**

A process map of the application can be found in APPENDIX A.

1. All applicants are required to submit the VPRP Assessment Request form online in order to receive the application package from the program manager. The form can be found on this link https://orit.research.bcm.edu/redcap/surveys/?s=PYMKHEL9JK

2. The application is to be returned to the manager with all required documents attached. The application will then be reviewed for completeness after which a team of facilitator will be selected to conduct a site assessment.

3. The program manager will work with the team and the facility to schedule the assessment and notify both parties of the assessment date and details.

4. Prior to the assessment, the program manager will provide the facility and the team of facilitators with an Application Summary Form that highlights any areas of the application that requires additional information or clarification. The facilitators will be responsible for ensuring that the additionally requested information within that document is provided during the assessment.

5. The facility can also reach out to the program at any point during the application process to seek clarifications, or to request for resources that can help with meeting the criteria for recognition.

6. The assessment will take place either virtually, or physically depending on the level of recognition the facility is seeking.

7. Following the assessment, the facilitators will convene and complete a Final Consultation Report that will be shared with the EMSC program and its advisory committee (EAC).

8. Once the committee reviews the results of the assessment, it will provide the facility with a feedback on the overall performance of their application in a TBD format

9. The EAC will then proceed with a decision on whether or not the facility will be recognized through the program, or if a focused assessment will need to ensue in order to address any critical deficiencies identified.

10. The applicant is notified of the EAC's decision, and if recognition will be given, it will be announced on EMSC day of that year.

II.   **Timeline**

1. The VPRP Assessment Request Form will become available when the application period opens on August 1st and will remain so through the deadline to submit applications on November 30th.

2. Assessments are scheduled with the facilities from January to mid-April.

3. Recognition will be awarded to the facilities that meet the requirements for the program on EMSC Day, which falls on the Wednesday of the 3rd week of May.

4. Applicants whose applications require additional information to gain recognition can submit the necessary documentation between June and July, or wait until the next application period to re-submit their applications.

AUG 1ST
Application opens

NOV 30TH
Deadline to submit an application

JANUARY – APRIL 15th
Assessments are scheduled with applicants and feedback on application is provided

EMSC DAY
Facilities that meet the requirements are announced on EMSC Day

AUGUST ▸ SEPTEMBER ▸ OCTOBER ▸ NOVEMBER ▸ DECEMBER ▸ JANUARY ▸ FEBRUARY ▸ MARCH ▸ APRIL ▸ MAY ▸ JUNE ▸ JULY

OCTOBER – FEBRUARY
Application are reviewed as they are received

MARCH –APRIL
Final review of assessment results

JUNE – JULY
Applicants can appeal any unfavorable results

III. **Recognition as a VPRP Facility**

1. Upon achieving recognition as a VPRP facility in the State of Texas, an official letter from the Director of the EMSC Program and a Certificate of Recognition will be issued to the facility.

2. If the application is incomplete, or if pediatric emergency care standards are not met to the level required for recognition, a letter will be sent to the facility with deficiencies identified. Subsequently, the facility will be given the opportunity to work on those deficiencies and can request a focused assessment to be conducted in order for the program to verify the improved upon measures.

3. A facility may also choose to submit applications multiple times until the program issues a Certificate of Recognition.

4. Recognition may be renewed by submitting a renewal application every three years. A separate application will be available for facilities renewing their recognized pediatric emergency care status.

5. If due to extenuating circumstance a facility recognized through the program is unable to maintain their recognition status, they may withdraw their recognition status or downgrade to the next attainable level. In this situation, the hospital will notify the EMSC Program through a written notice at least 60 days prior to withdrawal or the status change, if possible. In the notification, please include information on the rationale for the decision.

1. **Appeals Process**

Every effort will be made by the program to assist a facility/hospital meet the requirement of the readiness program both prior to the site assessment and after. However, If a facility/hospital has any question or concerns regarding an unfavorable result of their assessment, they are welcome to submit a written explanation of why they disagree with the decision and to request for a new panel of facilitators to conduct a second assessment. The overall aim of the VPRP is to help every emergency department in the state be better prepared to treat and manage pediatric trauma/medical emergencies within their communities and so every effort will be made by the program to help each facility reach that goal.

2. **Performance Monitoring**

In an effort to evaluate the effectiveness of the VPRP, data will be requested from each facility and for the data to be reported directly to the EMSC program office on a periodic basis. The method of gathering the data will be determined at a later date and the frequency of reporting will also be determined through consultation with participating facilities. We intend to ensure that data is seamlessly shared between EMSC and each participating facility. At a minimum, the metrics described and listed in APPENDIX B are being suggested as starting points in terms of the type of data that will need to be captured and reported.

FACILITY ASSESSMENT PROCESS

I.   **Assessment Overview**

Time	Item	Presenter
15 mins	Introductions	All
45 mins	Opening Statements	All
15 mins	BREAK	
60 mins	Review of Checklist Items	All
60 mins	Pediatric Scenarios	All
30 mins	BREAK	
30 mins	Exit Meeting	Facilitators

II.   **Specifics of the assessment**

A. **Participants**
   1. Facility representatives. The following are encouraged to represent the hospital
      - ED Nurse Manager/Director
      - Physician ED Medical Director
      - Hospital Administrator (VP or CEO)
      - Staff ED nurse
      - Staff ED physician
      - Nurse PECC
      - Physician PECC

   2. Team of facilitators

   <mark>NOTE: The names of the facilitators will be submitted ahead of the assessment</mark>

B. **Duration**
   1. Approximately 4 hours and a half (240 minutes) or as otherwise determined by the facilitator team

C. **Format**
   1. Virtual Conference with the use of a pre-selected videoconferencing software installed on a portable-device.

D. **Additional considerations**
   1. Hospital staff should reserve a room with strong internet connection that is available for the duration of the assessment. The room should be located away from patient care areas with traffic and noise at a minimum.
   2. Hospital staff and facilitator team should have contact information on hand for the troubleshooting team of the video-conferencing software for any urgent technical assistance.

III. **Process**

A. **Introductions – 15 mins**
1. Introductions of the facilitators and the hospital staff with their roles and the organizations they represent.

B. **Opening Statements – 45 mins**
1. EMSC overview (presented by facilitators)
2. Outline of assessment agenda (presented by facilitators)
3. Facility representatives should be prepared to do the following:
   a. Provide an overview of ED units
   b. Present baseline pediatric data
       i. Annual number of emergency department visits (including a pediatric breakdown)
       ii. Age range of pediatric patient population;
       iii. Transfer out rates;
       iv. Return visits within 48 hours rates;
   c. Identify the facilities where they normally transfer pediatric trauma and medical patients.
   d. Provide a brief description of their **S**trengths, **W**eaknesses, **O**pportunities, and **Threats** as related to their pediatric emergency care capabilities, services and resources as a general ED facility or Pediatric Emergency Department/Center.

C. **Review of checklist items – 60 mins**
1. Opportunity to provide additional clarifications on documents submitted in advance, as requested by the facilitator team
2. Facility representatives should be ready to discuss ED Staffing and personnel competencies:
   a. Provide details on how the providers are credentialed;
   b. Discuss how the provider's competencies to care for pediatric patients are assessed, how often, and how do they decide which competencies to assess.
   c. Detail what types of CE is required of their providers (e.g. EMPC, APLS, PALS etc.);
   d. Discuss the roles of the Pediatric Physician Coordinator and the Pediatric Nurse Coordinators if they are not available to speak with the facilitators;
   e. Provide a pre-selected personnel file by the facilitators from the list of staff. The file should contain documentation of competency evaluations.
3. The facilitators will then visualize a set of pre-selected equipment and supplies.

   ==**NOTE: The pre-selected list of equipment and medication to be visualized over VC will not be divulged to the hospital staff prior to the assessment.**==

4. Facility representatives should be ready to provide a description of the process of safe storage, prescribing, and delivery of pre-selected medication. The process should then be demonstrated via VC.

5. Assessment of patient safety elements:
   a. The scale that is used to record weight in Kilograms (kgs) will be visualized over VC.

b. The facilitators will then conduct a brief interview with the staff responsible for taking vitals (PCA or RN) to discuss what the hospital's reference for normal vital signs is, the staff's plan of action to address abnormal vital signs, and what system is used to notify the providers.

c. The hospital staff will provide a demonstration of the process used to access the interpreter via VC.

D. Pediatric Scenarios – 60 mins

1. The hospital staff should be prepared to respond to questions related to scenarios presented by facilitators

E. Exit meeting – 30 mins

1. The facilitators and the facility representatives will take this opportunity to address any unanswered question.

2. To conclude the assessment, the facilitators will provide the hospital staff a general timeline for when a feedback will be provided to them.

APPLICATION GUIDELINES

I.   Points of Contact

Three key staff members should be designated to assist and act as the points of contact for this application:

1. Primary Contact Person: This individual will be assuming responsibility for completion and submission of this application packet and will be the main point of contact for the coordination of the site assessment.

2. Physician Pediatric Emergency Care Coordinator: This individual assures that the medical providers are compliant with pediatric educational components, assists in pediatric medical performance improvement and assists in the development and oversight of all pediatric protocols.

3. Nurse Pediatric Emergency Care Coordinator: This individual assures that all ED nurses are compliant with pediatric educational components and works with emergency room Quality Improvement staff in implementing pediatric quality improvement.

II.   Submission Instructions

1. Before you begin the application, please take a moment to carefully review all requirements in this application. Below are the items required at the time of application submission.

    a. Application Form: This will be your application cover page.

    b. Checklist Section: this is the list of required equipment, supplies, personnel and policies in a table format with columns for initials of those who verify items that are present in the facility. Both the application form and the checklist can be found in APPENDIX D.

    c. Please organize in an appendix any appropriate supporting documentation (schedules, policies, procedures, protocols, guidelines, plans, etc.). Also remember to clearly label any supporting documentation provided.

    d. You are encouraged to use the Supporting Document Checklist provided (APPENDIX C) to ensure the completeness of your application.

    e. You can submit your application to the EMSC Program via the following ways:

    > **Mail:** 6621 Fannin Street, Suite A2210, Houston, TX 77030
    > **Fax:**   832-824-1182
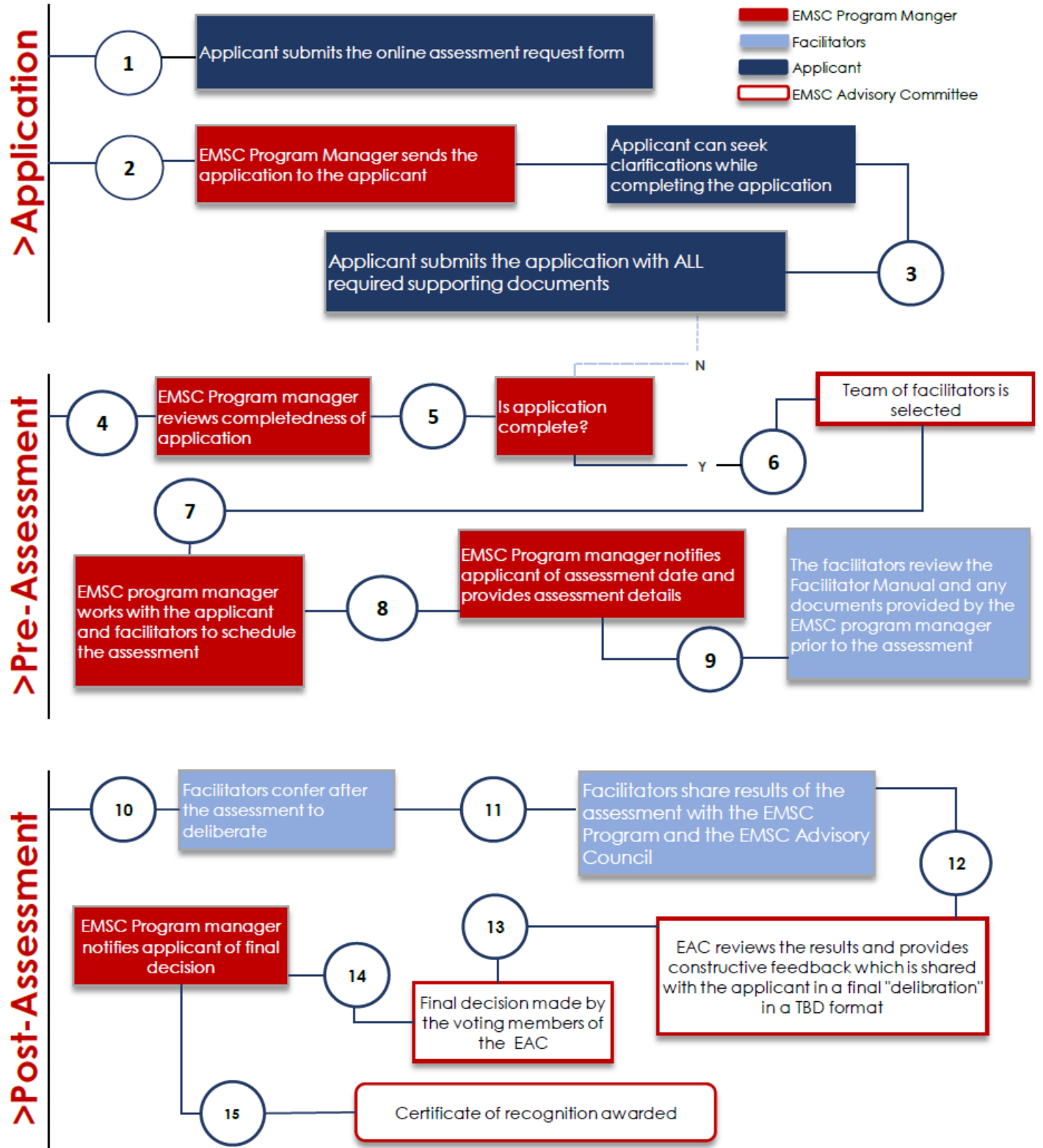   > **Email**: emsctexas@bcm.edu

For questions regarding the application process, specific criteria items, and/or supporting documentation, please contact the EMSC Program Manager at (832) 824-3672.

APPENDIX

I.   APPENDIX A – Application Process Map

VOLUNTARY PEDIATRIC READINESS PROGRAM

Application Process

>Application

1. Applicant submits the online assessment request form

2. EMSC Program Manager sends the application to the applicant

Applicant can seek clarifications while completing the application

Applicant submits the application with ALL required supporting documents

3

>Pre-Assessment

4. EMSC Program manager reviews completedness of application

5. Is application complete?

N

Y

6. Team of facilitators is selected

7. EMSC program manager works with the applicant and facilitators to schedule the assessment

8. EMSC Program manager notifies applicant of assessment date and provides assessment details

9. The facilitators review the Facilitator Manual and any documents provided by the EMSC program manager prior to the assessment

>Post-Assessment

10. Facilitators confer after the assessment to deliberate

11. Facilitators share results of the assessment with the EMSC Program and the EMSC Advisory Council

12

13. EAC reviews the results and provides constructive feedback which is shared with the applicant in a final "delibration" in a TBD format

14. EMSC Program manager notifies applicant of final decision

Final decision made by the voting members of the EAC

15. Certificate of recognition awarded

II.   APPENDIX B: Performance Monitoring Data

Facility Information		
NPI#		
Tx DOH #		
RAC		
Name		
Address (Full)		
Facility Phone Number		
ER Phone Number		
CEO		
CEO email address		
CNO		
CNO email address		
Adminstration Phone Number		
ER Total Bed Capacity		
ER Pediatric Bed Capacity		
Pediatric Bed Capacity		
IMU (if separate) Bed Capapacity		
PICU Bed Capacity		
Subspecialty Capabilities	Y/N Value List	Pediatrics, PEM, Gastro, Ortho, Gen Sur, Trauma Surg, Neuro, NS, Cards, CTS, ICU
Program Submission		
Total Patients (Adult & Pediatric) Seen in ER		Pediatric is < 17
Total Pediatric Seen in ER	Calculated from Data	
Total Pediatric Transfers Out	Calculated from Data	
Total Pediatric Transfers In	Calculated from Data	
Total Pediatric Deaths	Calculated from Data	
Chart Review	**Data Type**	
Pediatric Record ID	Text	YYYY-ID#, Serial Increment
Mode of Transport	Text	POV, EMS-Ground, EMS-Air
Facility Point of Entry	Value List	ER, Floor, IMU, ICU
Admission Type	Value List	ER, Direct Admission, Transfer
Admission Status	Value List	Inpatient, Observation
Date & Time of Arrival	Date/Time	
Date & Time of Discharge	Date/Time	
ICD10 Diagnosis Codes	Text	
ICD10 Procedure Codes	Text	
Transferred From	Value List	
Transferred To	Value List	
Chief Complaint / Admitting Diagnosis	Text	
Initial Height (cm)		Number 1 decimal
Initial Weight (kg)		number 3 decimal
PCP	Y/N	
Discharge / Final Diagnosis	Text	
Discharge Type	Value List	Home, Transfer HLOC, Transfer LTAC, Death
Highest Level of Care		
Suspected Appendecitis		
CT Type	w/o Cont, w/w/o Cont, w/Cont	
CT Result		
US Result		
Asthmatic	Y/N	
Steroids w/in 1h arrival to administration	Y/N	
Continuous Albuterol		
Magnesium Sulfate Admin		
PASS Initial Score		
PASS Final Score		
TBI		
CT		
MRI		
Highest GCS		
Lowest GCS		
Behavioral		
CPS Report Filed	Y/N	
Susptected Abuse/Neglect Screening Result	Y/N	
Suicide Risk Assessment Completed	Y/N	

III.　　APPENDIX C: Supporting Document Checklist

SUPPORTING DOCUMENT CHECKLIST

For the Pediatric Ready Level of Recognition

<u>Use this checklist to ensure the submission of all required supporting documents</u>

Equipment, Supplies and Medication

List of the medications in the ED. If a national shortage is in effect, submit documentation that the facility attempted to acquire the medication

Official equipment list for unit with hospital logo on the document from central supply/biomed department OR a picture of the equipment.

Staff

List of de-identified medical staff and their board certification

List of de-identified current nursing and ED health care providers and the expiration date of their APLS/PALS or ENPC provider verification

Name of Pediatric physician coordinator and copy of official position description

Name of pediatric nurse coordinator and copy of official position description listing their duties as described in the guidelines.

Policies

Copy of written policy for vital signs

Copy of written policy regarding scope and frequency of evaluations for staff

Copy of written policy mandating that all children seen in the ED be weighed in kilograms (kgs) and that weight recorded in the ED medical record in kg only

☐ Copy of the triage policy that addresses ill and injured children, specifies which validated triage tool used in the ED, and details how the staff are trained is to use it.

☐ Copy of ED's written policy which addresses how frequently children should be reassessed

Copy of the ED's policy for the initial identification/evaluation and management of suspected child neglect and/or abuse

Copy of the ED's policy on how to handle the death of a child in the ED.

Copy of the ED's policy of medical imaging that addresses pediatric age- or weight-based appropriate dosing for studies that impart radiation consistent with the ALARA (as low as reasonably achievable) principle, if a computed tomography (CT) scanner is available at the facility.

Copy of the ED's or hospital all-hazard disaster-preparedness plan that addresses issues specific to the care of children.

☐ Copy of the ED's inter-facility transfer policy defining the roles and responsibilities of the referring facility and referral center.

Processes

A written description of the facility's process that promotes family-centered care (e.g. family presence at the bedside, family involvement in clinical decision making, caregiver education, etc.).

A description of the processes that are in place for safe medication storage, prescribing, and delivery that includes pre-calculated dosing guidelines for children of all ages.

A description of the process the ED has for assessing immunization/ vaccination status and risk stratifying the under/ un-immunized patient.

A description of the hospital's written guideline for the initial management and transfer of children with behavioral and mental health issues out of the facility to an appropriate facility.

A description of the medication chart, length-based tape, medical software, or other systems that are readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications.

Data

Submission of the following data: number of pediatric patients seen in the ED, admission rate, incoming and outgoing transfer %, mortality, and return visit rate.

IV.	APPENDIX D: Application Form & Checklist

APPLICATION FORM

In order to process your application, please complete the following form and forward this application to the Texas EMS for Children State Partnership office.

Name of Facility/Organization:	
Mailing Address:	

LEVEL OF RECOGNITION APPLYING FOR:		
☐ Pediatric Ready	☐ Pediatric Champion	☐ Pediatric Innovator

Physician Pediatric Emergency Care Coordinator	Name:
	Title:
	Email address:
	Telephone:

Nurse Pediatric Emergency Care Coordinator	Name:
	Title:
	Email address:
	Telephone:

Official Completing The Form	Name:
	Title:
	Email address:
	Telephone:

By signing this document, the applicant understands that: The program is voluntary, the decision to participate will in no way impact licensure by the Texas Department of State Health services Office of EMS and Trauma Systems, and that the facility's recognition status will be determined by the EMSC Advisory Committee

Signature: _____   Date: _____