

Florida EMS-C Advisory Committee Meeting
Wednesday, September 14, 2022
1300 - 1500 EST
Orlando, FL





Welcome and Call to Order

- Welcome committee members, liaisons, visitors and PECCs
- Sign roster or email attendance confirmation with name/title/contact info to pedready@jax.ufl.edu or via chat box
- For online participants, please mute your phones and do not put on hold; *6 to mute or unmute
- June meeting summary and documents emailed and posted on PEDReady website, email corrections to pedready@jax.ufl.edu

EMSC Advisory Committee and Liaisons



- New committee appointments and liaison updates
- Thank you to all who applied!

FL EMSC and PEDReady Contact Information

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FL EMSC Program Director: Christina Parmer

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FL EMSC/PEDReady Education/Outreach Coordinator

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Group email:

pedready@jax.ufl.edu

Key Websites:

<https://www.emlrc/flpedready>

<https://emscimprovement.center>

<http://www.floridahealth.gov/provider-and-partner-resources/emsc-program/index.html>

Appointed FL EMSC Advisory Committee Members

Term ends: 08/25/2024

- Tricia Swan, MD, M.ED, FAAP, FACEP

- Physician with Pediatric Experience
- Associate Professor of Emergency Medicine, UF COM (Gainesville)
- Program Director, Pediatric Emergency Medicine Fellowship
- Chair, ACEP Pediatric Emergency Medicine Section

- Barbara Tripp RN, EMT-P

- Emergency Medical Technician/Paramedic
- Fire Chief, City of Tampa Fire Rescue

- Marshall Frank DO, MPH, FACEP, FAEMS

- Emergency Physician
- Medical Director, Sarasota County Fire Department
- Officer FAEMSMD

- Sandra Nasca, RN

- FAN Representative
- Former ED Nurse, Forensic Medical Investigator

- Nichole Shimko, RN, MSN, CCRN, CPN, C-NPT

- Nurse with Emergency Pediatric Experience
- Transport Team Manager, Golisano Children's Hospital of Southwest Florida

Florida EMSC Advisory Committee Liaisons

- Michael Rushing, NRP, RN, BSN, CEN....
 - FL ENA
 - AHA Coordinator, Baptist Healthcare
- Tracey D. Vause, MPA, CPM, EMT-P
 - Rural EMS
 - EMS Chief, Walton County Fire Rescue
- Ernest (Sonny) Weishaupt EMT-P
 - PECC (EMS/ED)
 - EMS Liaison, Arnold Palmer Hospital for Children
- Julie Downey
 - Disaster
 - Chair, Disaster Committee
 - Fire Chief, Davie Fire Rescue
- Lauren Young, LCSW
 - Mental health
 - Medical Social Work & MIH Coordinator, Palm Beach County Fire Rescue

- Jeremiah Rabish, PMD
 - PECC (EMS)
 - Operations Captain and PECC, Sarasota County Fire Department
- Sarah Weed
 - PECC (EMS)
 - Rescue Lieutenant /FF/CCP-FPC, Alachua County Fire Rescue
- Lisa Nichols, MBA, BSN, RN, CCRN-K
 - Trauma program manager
 - Pediatric Trauma Program Manager at Wolfson Children's Hospital
- Jennifer N. Fishe, MD
 - Research and Data
 - Associate Professor of Emergency Medicine and Director, Center for Data Solutions, UF College of Medicine-Jacksonville
 - PECARN's WPEMR node- Affiliate Researcher

PECARN's WPEMR node advances mentorship, data linkages, enrollment

Published August 31, 2022

The West/Southwest Pediatric Emergency Medicine Research (WPEMR) node – one of the seven nodes within the first federally funded emergency research network in the United States, [the Pediatric Emergency Care Applied Research Network \(PECARN\)](#) – continues to focus on mentorship and development of rising young talent.

The principal investigator (PI) for the node is Eileen Klein, MD, MPH, at Seattle Children's Hospital. Site leaders are Michael Sayre, MD, at Seattle Fire/Medic One; Mohamed Badawy, MD, Children's Medical Center Dallas (University of Texas-Southwestern), and Todd P. Chang, MD, MACM, Children's Hospital Los Angeles.



New Affiliate Researchers

While the four sites within the WPEMR have actively grown and mentored rising researchers, WPEMR has also taken on three affiliate faculty from sites outside of its three primary hospital-based emergency department affiliates (HEDAs):

- **Jennifer Fishe, MD**, had joined in 2020 for her work in exploring oral steroids for asthma in a prehospital setting. She is an Associate Professor of Emergency Medicine at the University of Florida (UF)-Jacksonville and serves as the Associate Medical Director of the UF Health Jacksonville Pediatric Emergency Department and Associate Medical Director for Pediatrics for two local fire departments. She has always been interested in prehospital and EMS research and was PI for a HRSA grant (H34MC30232) on the implementation of a pediatric destination decision-making tool. She is also the Director for the UF Center for Data Solutions, further providing local infrastructure for biostatistical support.
- **Colleen Gutman, MD**, joined WPEMR in 2021 and is currently Assistant Professor of Emergency Medicine at UF-Gainesville. Gutman has had a rising research career focused on access to care and issues related to diversity, equity, and inclusion. These include differences in management such as for [diagnostic imaging](#) and [language or communication facilitation](#). She is currently focused on her KL2 and preparing for her K-award support, focused on examining health equity in febrile infant management.

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National Preparedness Month: Ensuring children are part of the equation

August 31, 2022

PEAK: Agitation resource now available!

August 31, 2022

New data on the power of ED facility recognition programs

August 31, 2022

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EMSC/DOH BEMO Advisory Staff

- Steve McCoy

- Bureau Chief, Bureau of Emergency Medical Oversight at Florida Health

- Jane Bedford

- Community paramedicine/MIH/HART

- Kate Kocevar

- Trauma Administrator

- Jennifer McManus

- Rural EMS

- Michael Hall

- EMS Administrator, Florida DOH
Bureau of Emergency Medical Oversight

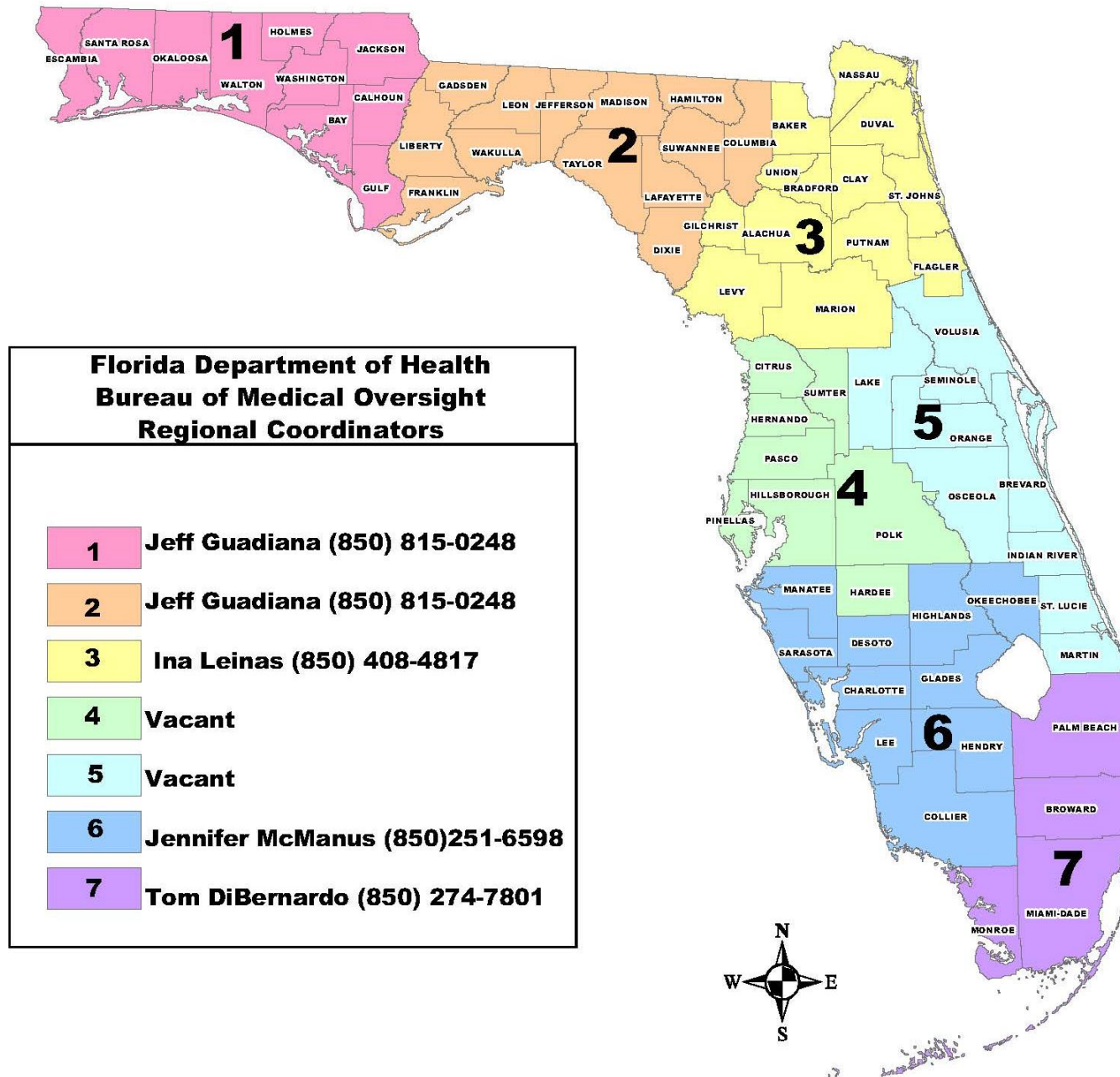
- Angus Jameson, M.D.

- FL EMS Medical Director

- And many more: Data, CARES, Region Coordinators, etc.

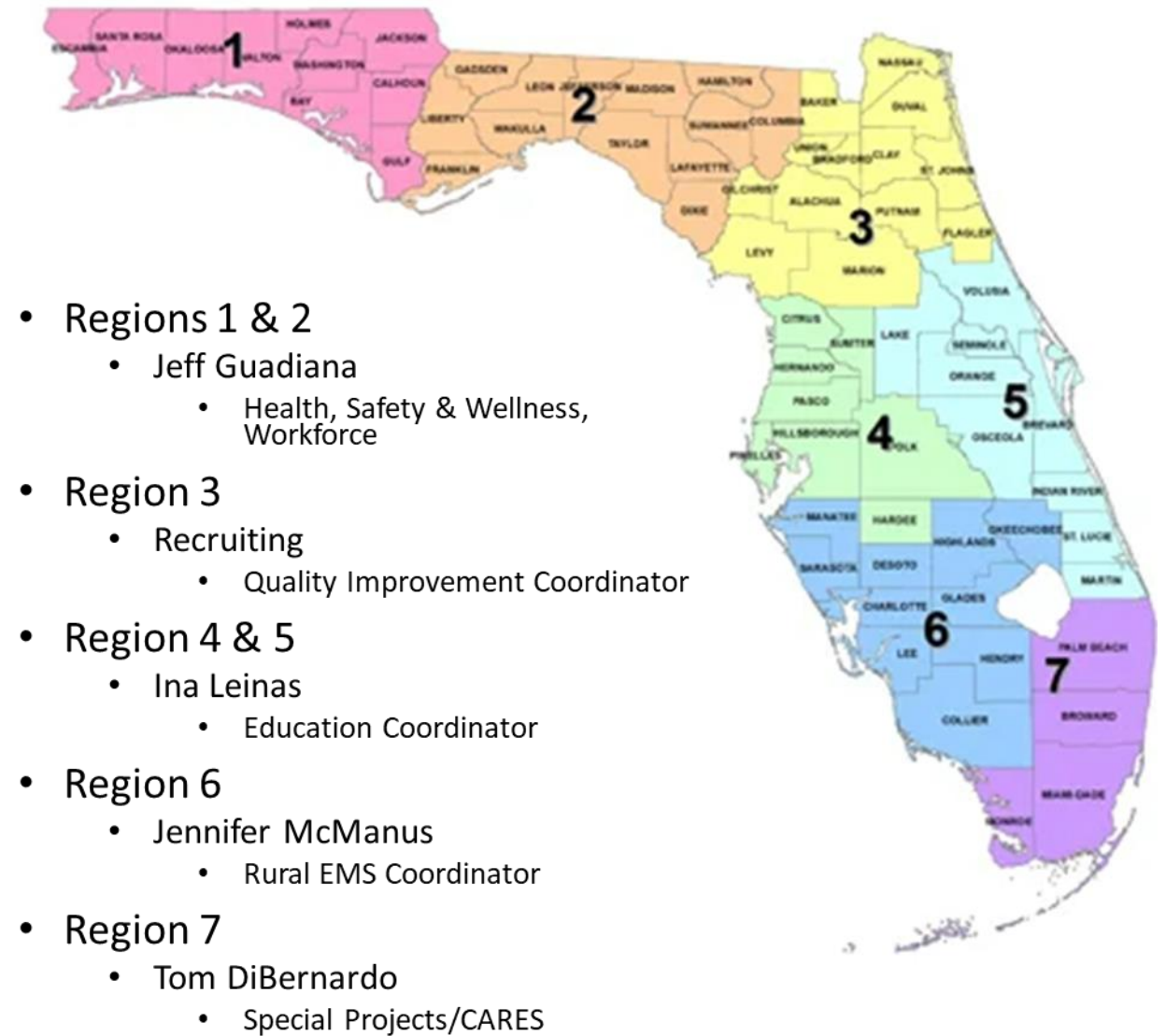
Opening Announcements and Key Updates

- Bureau update and regional coordinators
 - Bobby Bailey - Preparedness
 - Jeff Guadiana - Workforce, Health Safety & Wellness, Regions 1 & 2
 - Ty Carhart - EMS Operations Manager
 - Working on EMSAC Meeting Enhancements
- In last year of current HRSA EMSC State Partnership Grant
- Focus on new HRSA EMSC Performance measures



Agency Site Visit ideas:

1. Ask about agency PECC, pediatric equipment and training, pediatric transport restraint devices, and pediatric protocols
2. Share national and state EMSC/PEDReady resources and websites
3. Ask about pediatric challenges
4. Recognize pediatric champions
5.



National EMSC Related Updates



2021 NPRP Assessment (ED pediatric readiness):

FL 58% response rate

Average FL score 75/100, median 76.

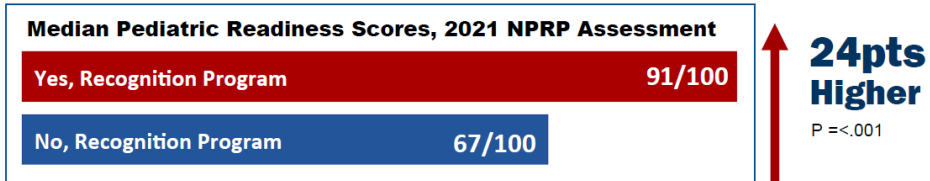
Pending national score due to publication

<https://pedsready.org/>

EMSC Data Center (NEDARC) new factsheet describing link between pediatric readiness facility recognition on NPRP assessment scores:

https://media.emscimprovement.center/documents/EMSC_NPRP_Hospital_Recognition_Factsheet_072622.pdf

Emergency Departments that Participate in a Pediatric Readiness Recognition Program Score Significantly Higher on the National Pediatric Readiness Project (NPRP) Assessment*



What is an Emergency Department (ED) Pediatric Readiness Recognition Program?

A recognition program designates and verifies a hospital ED's capacity to provide care to children. The recognition program incorporates standards previously defined as essential capabilities and resources to meet the needs of children: presence of pediatric emergency care coordinators; required pediatric staff competencies and training; availability of pediatric equipment, supplies, and medications; and the inclusion of pediatric-specific guidelines and agreements or other processes to ensure the quality of care rendered. Examples of guidelines and policies include pediatric quality improvement processes, pediatric patient safety considerations such as a pediatric triage policy, and pediatric specific disaster plans. Recognition programs are designed by each state and territory and include establishing specific recognition criteria that are necessary to provide effective care; implementing a verification process to assess pediatric capabilities; partnering with key stakeholders to assist with verification efforts; and a well-defined plan to assure sustainability of the program, which may include the development of formal state regulations addressing the recognition program.



*The NPRP Assessment was conducted in 2021 to evaluate readiness to care for children based on nationally published guidelines for pediatric care in the ED. At the time of the Assessment, seventeen states had a recognition program to stabilize/manage pediatric emergencies:

Alaska, Arizona, California, Connecticut, Delaware, Illinois, Indiana, Kentucky, Montana, New Jersey, New Mexico, South Carolina, Tennessee, Texas, Utah, West Virginia, and Wyoming.

Why is it Important to Assess and Formally Recognize the Readiness of Facilities to Care for Children?

Approximately 90% of children needing emergency care are first treated at a local community emergency department¹. Higher NPRP Assessment scores have been linked to improved clinical outcomes, and critically ill and injured children treated in EDs with high pediatric readiness scores have lower mortality than those treated in EDs with lower pediatric readiness scores²⁻⁴. As shown in the graphic on page 1, EDs that participate in a recognition program scored a median of 24 points higher than EDs not involved in a formal recognition program.

What Makes Pediatric Ready EDs DIFFERENT?

Hospital EDs verified as pediatric ready more frequently include pediatric emergency care coordinators and have established pediatric specific quality improvement indicators and initiatives to support pediatric care. Participation in a recognition program and verification processes affirms an emergency department's commitment to children, and can help to improve clinical outcomes for this important population.



Pediatric Readiness in the Emergency Department

This checklist is based on the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and Emergency Nurses Association (ENA) 2018 joint policy statement "Pediatric Readiness in the Emergency Department," which can be found online at: <https://pediatrics.aappublications.org/content/pediatrics/142/5/e20182459.full.pdf>. Use this tool to check if your hospital emergency department (ED) has the most critical components listed in this joint policy statement.

Administration and Coordination of the ED for the Care of Children

- ☐ Physician Coordinator for Pediatric Emergency Care (PECC)*
 - Board certified/eligible in EM or PEM (preferred but not required for resource limited hospitals)
 - The Physician PECC is not board certified in EM or PEM but meets the qualifications for credentialing by the hospital as an emergency clinician specialist with special training and experience in the evaluation and management of the critically ill child.
- ☐ Nurse Coordinator for Pediatric Emergency Care (PECC)*
 - CPEN/CEN (*preferred*)
 - Other credentials (e.g. CPN, CCRN)

**An Advanced Practice Provider may serve in either of these roles. Please see the guidelines/ toolkit for further definition of the role(s).*

Physicians, Advanced Practice Providers (APPs), Nurses, and Other ED Healthcare Providers

- ☐ Healthcare providers who staff the ED have periodic pediatric-specific competency evaluations for children of all ages. Areas of pediatric competencies include any/all of the following:
 - Assessment and treatment (e.g. triage)
 - Medication administration
 - Device/equipment safety
 - Critical procedures
 - Resuscitation
 - Trauma resuscitation and stabilization
 - Disaster drills that include children
 - Patient and family-centered care
 - Team training and effective communication

Guidelines for QI/PI in the ED

- ☐ The QI/PI plan includes pediatric-specific indicators
 - Data are collected and analyzed
 - System changes are implemented based on performance

ED Policies, Procedures, and Protocols

Policies, procedures, and protocols for the emergency care of children. (*These policies may be integrated into overall ED policies as long as pediatric-specific issues are addressed*)

- ☐ Illness and injury triage
- ☐ Pediatric patient assessment and reassessment
- ☐ Identification and notification of the responsible provider of abnormal pediatric vital signs
- ☐ Immunization assessment and management of the under-immunized patient
- ☐ Sedation and analgesia, for procedures including medical imaging
- ☐ Consent, including when parent or legal guardian is not immediately available
- ☐ Social and behavioral health issues
- ☐ Physical or chemical restraint of patients
- ☐ Child maltreatment reporting and assessment
- ☐ Death of the child in the ED
- ☐ Do not resuscitate (DNR) orders
- ☐ Children with special health care needs
- ☐ Family and guardian presence during all aspects of emergency care, including resuscitation
- ☐ Patient, family, guardian, and caregiver education
- ☐ Discharge planning and instruction
- ☐ Bereavement counseling
- ☐ Communication with the patient's medical home or primary care provider as needed.
- ☐ Telehealth and telecommunications

All-Hazard Disaster Preparedness

The written all-hazard disaster-preparedness plan addresses pediatric-specific needs within the core domains including:

- ☐ Medications, vaccines, equipment, supplies and trained providers for children in disasters
- ☐ Pediatric surge capacity for injured and non-injured children
- ☐ Decontamination, isolation, and quarantine of families and children of all ages
- ☐ Minimization of parent-child separation
- ☐ Tracking and reunification for children and families

- ☐ Evidence-based clinical pathways, order sets or decision support available to providers in real time

Inter-facility Transfers

- ☐ Written pediatric inter-facility transfer agreements
- ☐ Written pediatric inter-facility transfer guidelines. These may include:
 - Criteria for transfers (e.g. specialty services)
 - Criteria for selection of appropriate transport service
 - Process for initiation of transfer
 - Plan for transfer of patient information
 - Integration of family-centered care
 - Integration of telehealth/telecommunications

Guidelines for Improving Pediatric Patient Safety

Pediatric patient and medication safety needs are addressed in the following ways:

- ☐ Children are weighed in kilograms only
- ☐ Weights are recorded in kilograms only
- ☐ For children who require emergency stabilization, a standard method for estimating weight in kilograms is used (e.g., a length-based system)
- ☐ Infants and children have a full set of vital signs recorded
 - A full set of vital signs includes temperature, heart rate, respiratory rate, pulse oximetry, blood pressure, pain, and mental status when indicated in the medical record.
- ☐ CO2 monitoring for children of all ages
- ☐ Process for safe medication delivery that includes:
 - Prescribing
 - Administration
 - Disposal
- ☐ Pre-calculated drug dosing and formulation guides
- ☐ 24/7 access to interpreter services in the ED
- ☐ Timely tracking and reporting of patient safety events

Guidelines for ED Support Services

- ☐ Medical imaging capabilities and protocols address age- or weight-appropriate dose reductions for children.
- ☐ All efforts made to transfer completed images when a patient is transferred from one facility to another.
- ☐ Collaboration with radiology, laboratory and other ED support services to ensure the needs of children in the

Pediatric equipment, supplies, and medications are appropriate for children of all ages and sizes (see list below), and are easily accessible, clearly labeled, and logically organized.

- ☐ ED staff is educated on the location of all items.
- ☐ Daily method in place to verify the proper location and function of pediatric equipment and supplies
- ☐ Medication chart, length-based tape, medical software, or other systems is readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications.
- ☐ Standardized chart or tool used to estimate weight in kilograms if resuscitation precludes the use of a weight scale (eg, length-based tape)

Medications

- ☐ Analgesics (oral, intranasal, and parenteral)
- ☐ Anesthetics (eutectic mixture of local anesthetics; lidocaine 2.5% and prilocaine 2.5%; lidocaine, epinephrine, and tetracaine; and LMX 4 [4% lidocaine])
- ☐ Anticonvulsants (benzodiazepines, levetiracetam, valproate, carbamazepine, fosphenytoin, and phenobarbital)
- ☐ Antidotes (common antidotes should be accessible to the ED e.g. naloxone)
- ☐ Antipyretics (acetaminophen and ibuprofen)
- ☐ Antiemetics (ondansetron and prochlorperazine)
- ☐ Antihypertensives (labetalol, nicardipine, and sodium nitroprusside)
- ☐ Antimicrobials (parenteral and oral)
- ☐ Antipsychotics (olanzapine and haloperidol)
- ☐ Benzodiazepines (midazolam and lorazepam)
- ☐ Bronchodilators
- ☐ Calcium chloride and/or calcium gluconate
- ☐ Corticosteroids (dexamethasone, methylprednisolone, and hydrocortisone)
- ☐ Cardiac medications (adenosine, amiodarone, atropine, procainamide, and lidocaine)
- ☐ Hypoglycemic interventions (dextrose, oral glucose)
- ☐ Diphenhydramine
- ☐ Epinephrine (1mg/mL [1M] and 0.1 mg/mL [IV] solutions)
- ☐ Furosemide
- ☐ Glucagon
- ☐ Insulin
- ☐ Magnesium sulfate
- ☐ Intracranial hypertension medications (mannitol, 3% hypertonic saline)
- ☐ Neuromuscular blockers (rocuronium and succinylcholine)
- ☐ Sucrose solutions for pain control in infants
- ☐ Sedation medications (midazolam, etomidate and ketamine)
- ☐ Sodium bicarbonate (4.2%)
- ☐ Vasopressor agents (dopamine, epinephrine and



Prehospital Pediatric Readiness EMS AGENCY CHECKLIST

This checklist is based on the 2020 joint policy statement “[Pediatric Readiness in Emergency Medical Services Systems](#)”, co-authored by the Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), National Association of EMS Physicians (NAEMSP), and National Association of EMTs (NAEMT). Additional details can be found in the AAP Technical Report “[Pediatric Readiness in Emergency Medical Services Systems](#)”.

Use this tool to check if your EMS agency is ready to care for children as recommended in the Policy Statement.

Consider using resources compiled by the Health Resources & Services Administration’s Emergency Medical Services for Children (EMSC) Program when implementing the recommendations noted here, to include the [Prehospital Pediatric Readiness Toolkit](#).



EDUCATION & COMPETENCIES FOR PROVIDERS

- ☐ Process(es) for ongoing pediatric specific education using one or more of the following modalities:
 - Classroom/in-person didactic sessions
 - Online/distributive education
 - Skills stations with practice using pediatric equipment, medication and protocols
 - Simulated events

Process for evaluating pediatric-specific competencies for the following types of skills:

- ☐ Psychomotor skills, such as, but not limited to:
 - Airway management
 - Fluid therapy
 - Medication administration
 - Vital signs assessment
 - Weight assessment for medication dosing and equipment sizing
 - Specialized medical equipment
- ☐ Cognitive skills, such as, but not limited to:
 - Patient growth and development
 - Scene assessment
 - Pediatric Assessment Triangle (PAT) to perform assessment
 - Recognition of physical findings in children associated with serious illness
- ☐ Behavioral skills, such as, but not limited to:
 - Communication with children of various ages and with special health care needs
 - Patient and family centered care
 - Cultural awareness
 - Health care disparities
 - Team communication

EQUIPMENT AND SUPPLIES

- ☐ Utilize national consensus recommendations to guide availability of equipment and supplies to treat all ages
- ☐ Process for determining competency on available equipment and supplies

PATIENT AND MEDICATION SAFETY

- ☐ Utilization of tools to reduce pediatric medication dosing and administration errors, such as, but not limited to:
 - Length based tape
 - Volumetric dosing guide
- ☐ Policy for the safe transport of children
- ☐ Equipment necessary for the safe transport of children

PATIENT- AND FAMILY-CENTERED CARE IN EMS

Partner with families to integrate elements of patient- and family-centered care in policies, protocols, and training, including:

- ☐ Using lay terms to communicate with patients and families
- ☐ Having methods for accessing language services to communicate with non-English speaking /non-verbal patients and family members
- ☐ Narrating actions, and alerting patients and caregivers before interventions are performed

Policies and procedures that facilitate:

- ☐ Family presence during resuscitation
- ☐ The practice of cultural or religious customs
- ☐ A family member or guardian to accompany a pediatric patient during transport

POLICIES, PROCEDURES, AND PROTOCOLS (TO INCLUDE MEDICAL OVERSIGHT)

- ☐ Prearrival instructions identified in EMS dispatch protocols include pediatric considerations, when relevant, such as, but not limited to:
 - Respiratory distress
 - Cardiac arrest
 - Choking
 - Seizure
 - Altered consciousness
- ☐ Policies, procedures, and protocols include pediatric considerations, such as, but not limited to:
 - Policy on pediatric refusals
 - Pediatric assessment
 - Consent and treatment of minors
 - Recognition and reporting of child maltreatment
 - Trauma triage
 - Children with special health care needs
- ☐ Direct medical oversight integrates pediatric-specific knowledge
- ☐ Protocols (indirect medical oversight) include pediatric evidence when available
- ☐ Destination policy that integrates pediatric-specific resources

QUALITY IMPROVEMENT (QI)/ PERFORMANCE IMPROVEMENT (PI)

- ☐ PI process includes pediatric encounters
- ☐ Pediatric-specific measures are included in the PI process
- ☐ Submission of EMS agency data to the state’s prehospital patient care database
- ☐ Submitted data is compliant with the current version of NEMSIS (version 3.x or higher)
- ☐ Process to track pediatric patient centered outcomes across the continuum of care, such as, but not limited to:
 - Transport destination
 - Secondary transport destination
 - ED and hospital disposition
 - ED and hospital diagnoses
 - Survival to hospital admission
 - Survival to hospital discharge

INTERACTION WITH SYSTEMS OF CARE

Policies, procedures, protocols, and performance improvement initiatives involve ongoing collaboration with:

- ☐ Pediatric emergency care
- ☐ Public health
- ☐ Family advocates

Plans and exercises for disasters or mass casualty incidents include:

- ☐ Care of pediatric patients, such as, but not limited to:
 - Pediatric mental health first aid
 - Pediatric disaster triage
 - Pediatric dosing of medications used as antidotes
 - Pediatric mass transport
- ☐ Tracking of unaccompanied children
- ☐ Family reunification
- ☐ Collaborate with external personnel or have internal staff focused on enhancing pediatric care, such as, but not limited to:
 - Pediatric emergency care coordinator (PECC)
 - Regional PECC
 - Pediatric advisory council(s)
 - Medical director with pediatric knowledge and experience

- ☐ Understand pediatric capabilities at local and/or regional emergency departments for children with the following types of conditions:
 - Medical emergency
 - Traumatic injury
 - Behavioral health emergency
- ☐ Policies and/or procedures for transfer of responsibility of patient care at destination

Revised May 20, 2021

To provide feedback on this checklist, please email pprp@emscimprovement.center

For additional information on the Prehospital Pediatric Readiness Project (PPRP), visit:
<https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness>



National EMSC Related Updates

NEDARC EMSC 2022 EMS Agency Survey closed March 31, 2022

FL response rate 81% !

- Focus on Performance Measures 2 and 3 (PECC and pediatric equipment)
- First year survey was *not* part of the FL annual EMS survey
- Feedback to NEDARC and HRSA

<https://www.emscsurveys.org/>

- National score PECC: 35.6%; **Florida score: 44.7%**
- National score use of pediatric equipment: 26.1%;
Florida score 32.6%

Florida EMS for Children Program

2022 EMS Agency Survey Results

Florida Data Collection Numbers:

Number of Respondents: **142**

Number Surveyed: **176**

Response Rate: **80.7%**

Number of Records in Dataset (after data cleaning)*: **142**

*Data cleaning includes removing agencies that do not respond to 911, duplicates, etc.

Performance Measures EMSC 02 and EMSC 03:

Number of Records Used in Performance Measure Calculation (see below): **141**

Performance Measure Exclusions*:

Indian Health Services or Tribal Agencies Participating: **0**, Military Facilities

Participating: **1**, Air-Only Agencies: **0**, or Water-Only Agencies: **0**.

* The agencies listed above are excluded from any final calculations related to the Performance Measures (see below). However, all states and/or territories were given the opportunity to survey these agencies for additional reporting based on state interest and need. Therefore, information from these agencies is included in all other data points.

Pediatric Emergency Care Coordinator (EMSC 02):

44.7%
(63/141)

(Exclusions See Above)

Use of Pediatric-Specific Equipment (EMSC 03):

32.6%
(46/141)

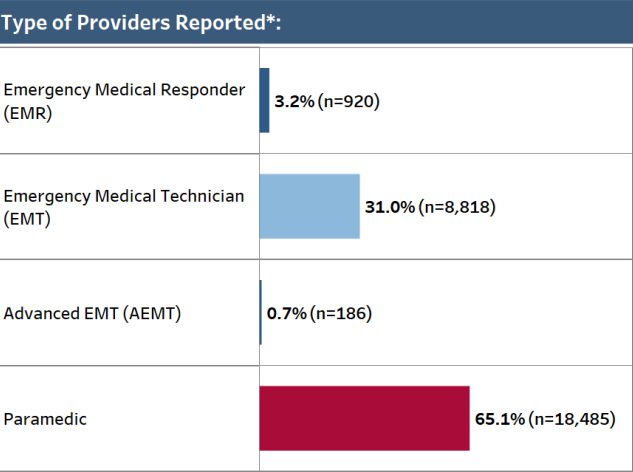
(Exclusions See Above)

A respondent needed to answer **YES** to "Having a designated individual who coordinates pediatric emergency care" in the survey to meet this measure.

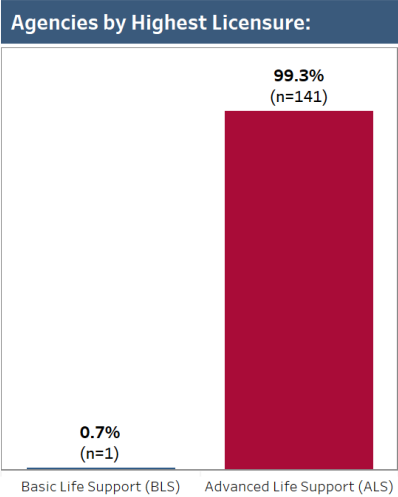
See pg. 35 in the "EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017" for an explanation of the scoring.

Florida Agency Demographics for ALL 2022 Agencies

Survey Year: 2022 County: All Agency Type*: All *Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).



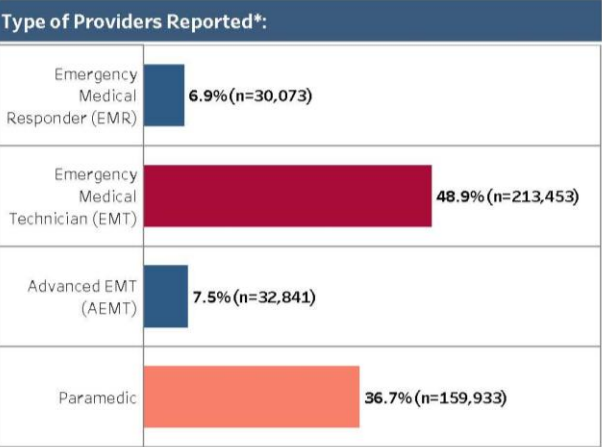
* Number of Responding Agencies Not Reporting: 0



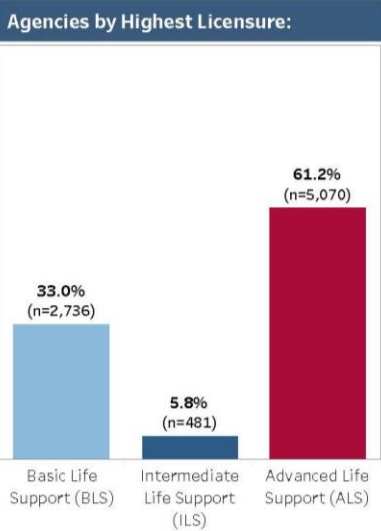
Pediatric Call Volume by Number of Agencies and Association with PECCs:			
	Num of Agencies	Num of PECCs	% of those Agencies with a PECC
HIGH: More than 600 pediatric calls in the last year (more than 50 pediatric calls per month)	34	14	41.2%
MEDIUM HIGH: Between 101-600 pediatric calls in the last year (8 - 50 pediatric calls per month)	56	30	53.6%
MEDIUM: Between 13-100 pediatric calls in the last year (1 - 8 pediatric calls per month)	40	14	35.0%
LOW: Twelve (12) or fewer pediatric calls in the last year (1 or fewer pediatric calls per month)	9	3	33.3%
None	1	1	100.0%
Did Not Respond to Question	2	2	100.0%
Grand Total	142	64	45.1%

Agency Demographics for ALL 2022 Agencies

Survey Year: 2022 Agency Type*: All *Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).

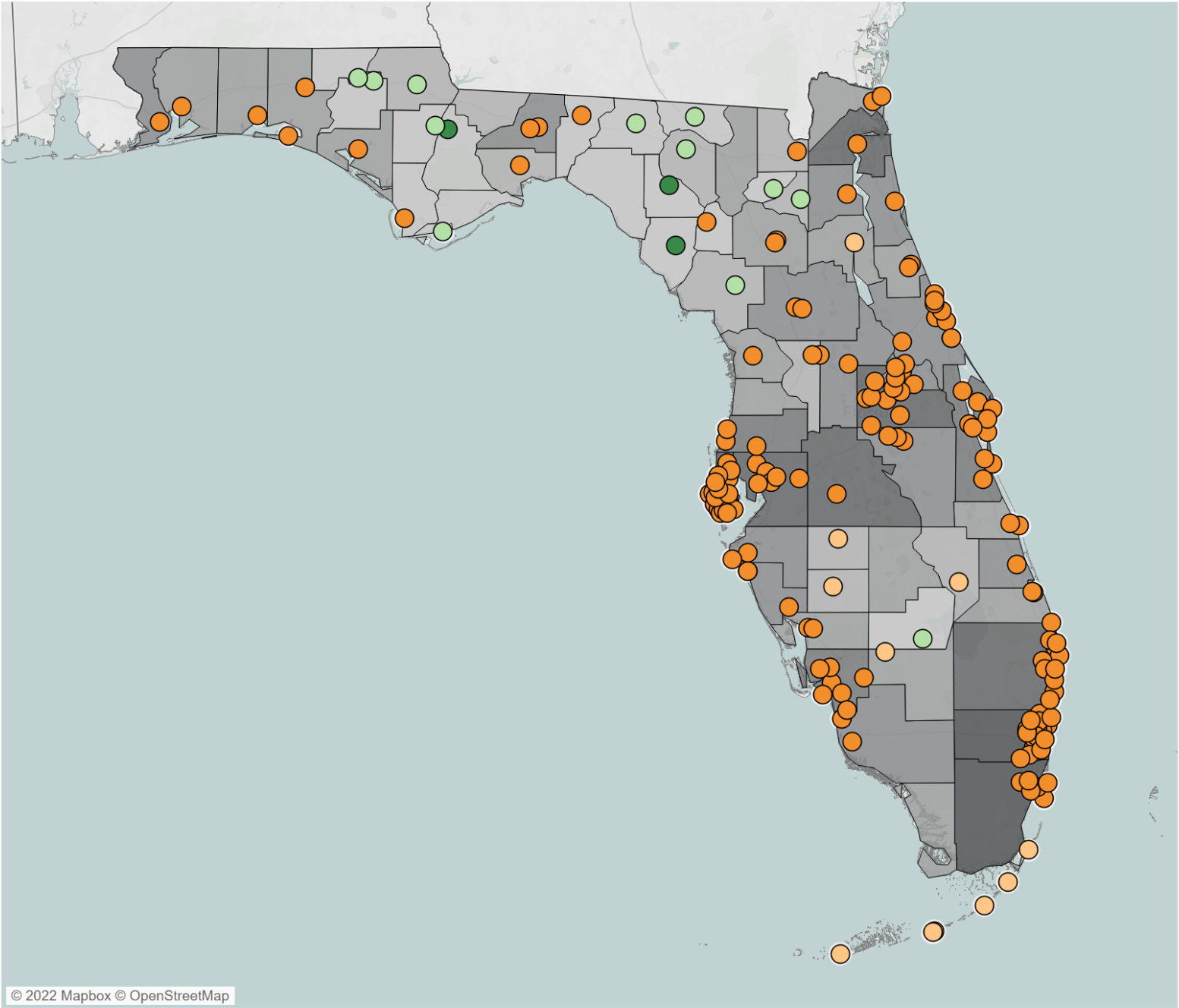


* Number of Responding Agencies Not Reporting: 36

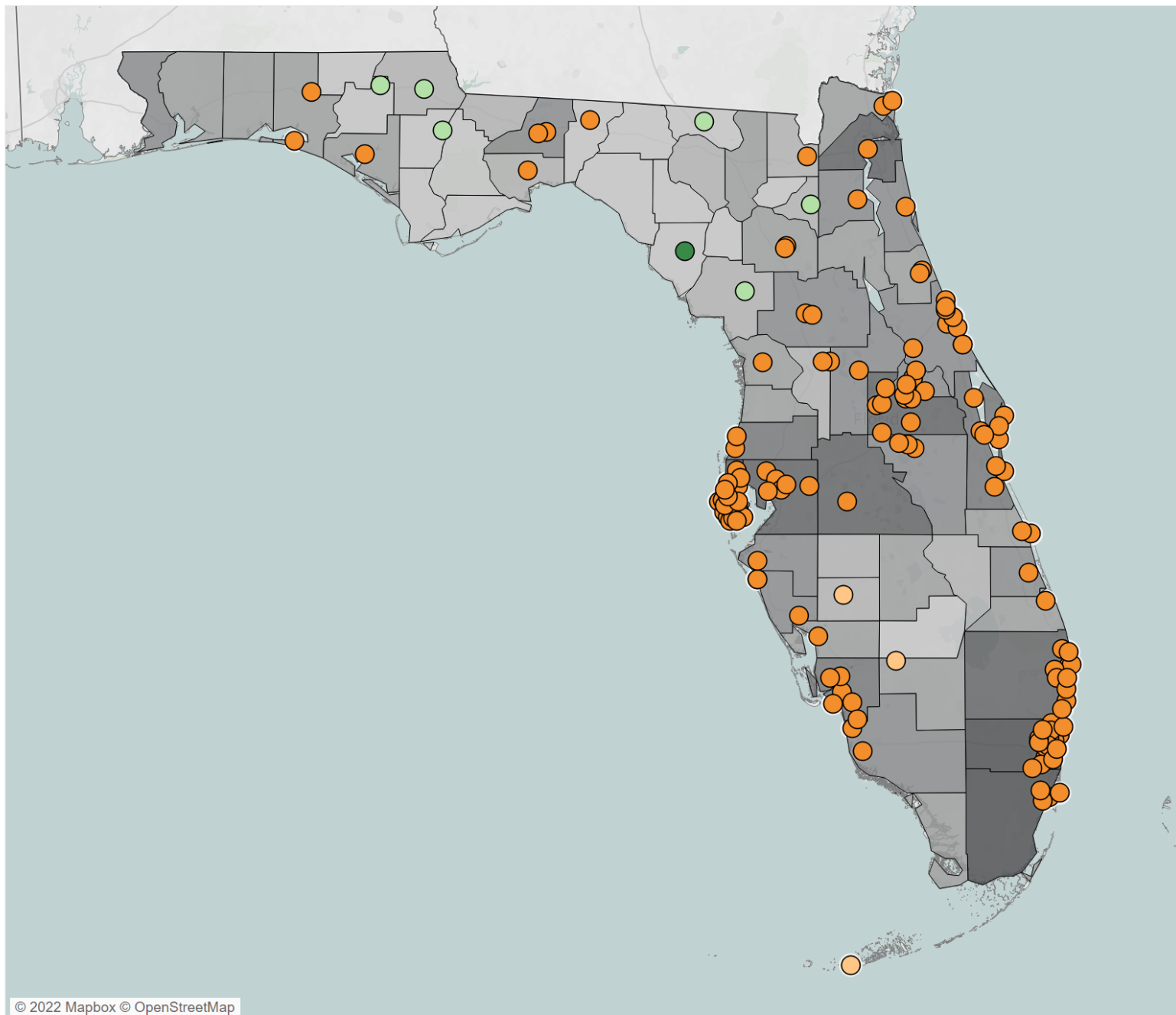


Pediatric Call Volume by Number of Agencies and Association with PECCs:			
	Num of Agencies	Num of PECCs	% of those Agencies with a PECC
HIGH: More than 600 pediatric calls in the last year (more than 50 pediatric calls per month)	352	190	54.0%
MEDIUM HIGH: Between 101-600 pediatric calls in the last year (8 - 50 pediatric calls per month)	1,165	564	48.4%
MEDIUM: Between 13-100 pediatric calls in the last year (1 - 8 pediatric calls per month)	3,265	1,222	37.4%
LOW: Twelve (12) or fewer pediatric calls in the last year (1 or fewer pediatric calls per month)	3,238	927	28.6%
None	240	50	20.8%
Did Not Respond to Question	27	10	37.0%
Grand Total	8,287	2,963	35.8%

Florida 2022 Map of ALL Agencies in the NEDARC Contact List Management System (CLMS)



Florida 2022 Map of ALL Agencies in the NEDARC Contact List Management System (CLMS)



Took Survey?

Yes

EMS Licensure:

All

Pediatric Volume:

All

Urbanicity:

Urban

Suburban

Rural

Remote

18 and Under Population*:

1,001 to 5,000

5,001 to 10,000

10,001 to 50,000

50,001 to 100,000

100,001 to 150,000

150,001 to 350,000

Over 350,000

*Population Data from
the U.S. Census Bureau,
2016-2020 American
Community Survey
5-Year Estimates

Florida EMSC 02 - Pediatric Emergency Care Coordinator (PECC) Performance Measure Trending:

Trending Over Time:

There are many ways to measure improvement over time. On this page, you can see how your state performed for EMSC 02:

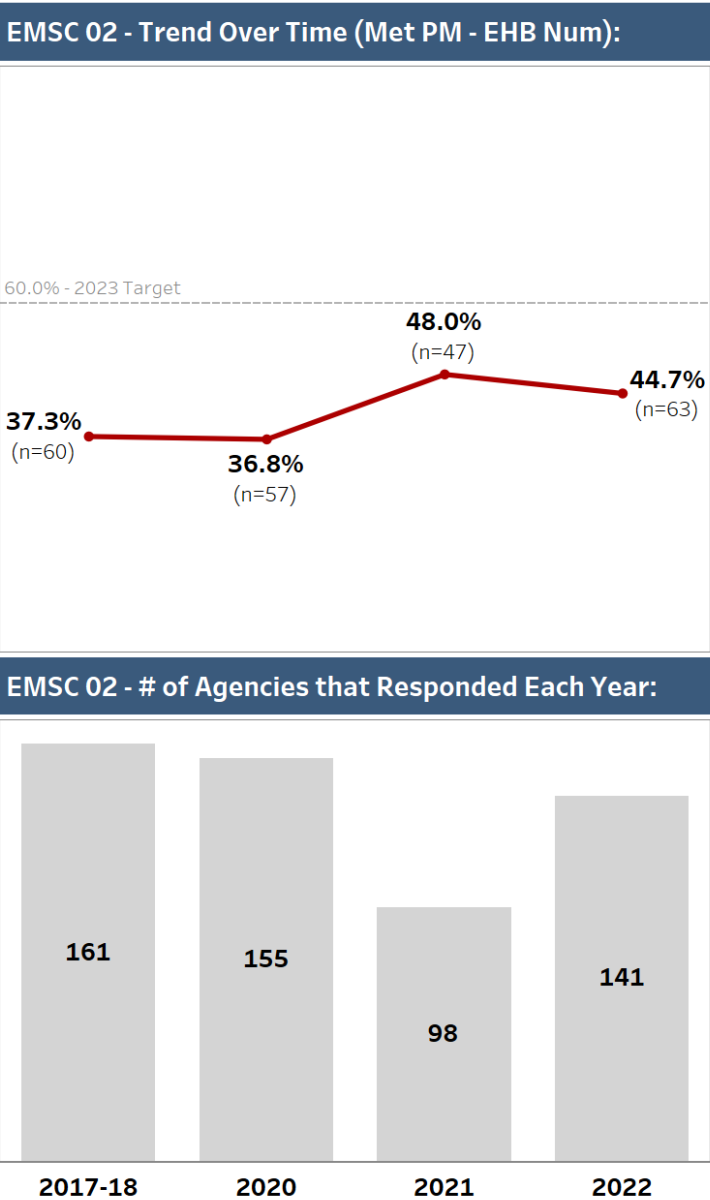
1) **Trend Over Time** - This looks at all respondents from all four survey years to see how your state's performance measure numbers are changing. The number of respondents may not be the same because response rates often change and the same agencies do not always participate.

2) **Trend Over Time (One to One Analysis)** - This looks at only those agencies who participated in all four years of the survey. This type of analysis illustrates collective upward or downward movement with EMSC 02 over time for those agencies who completed the survey in all four years.

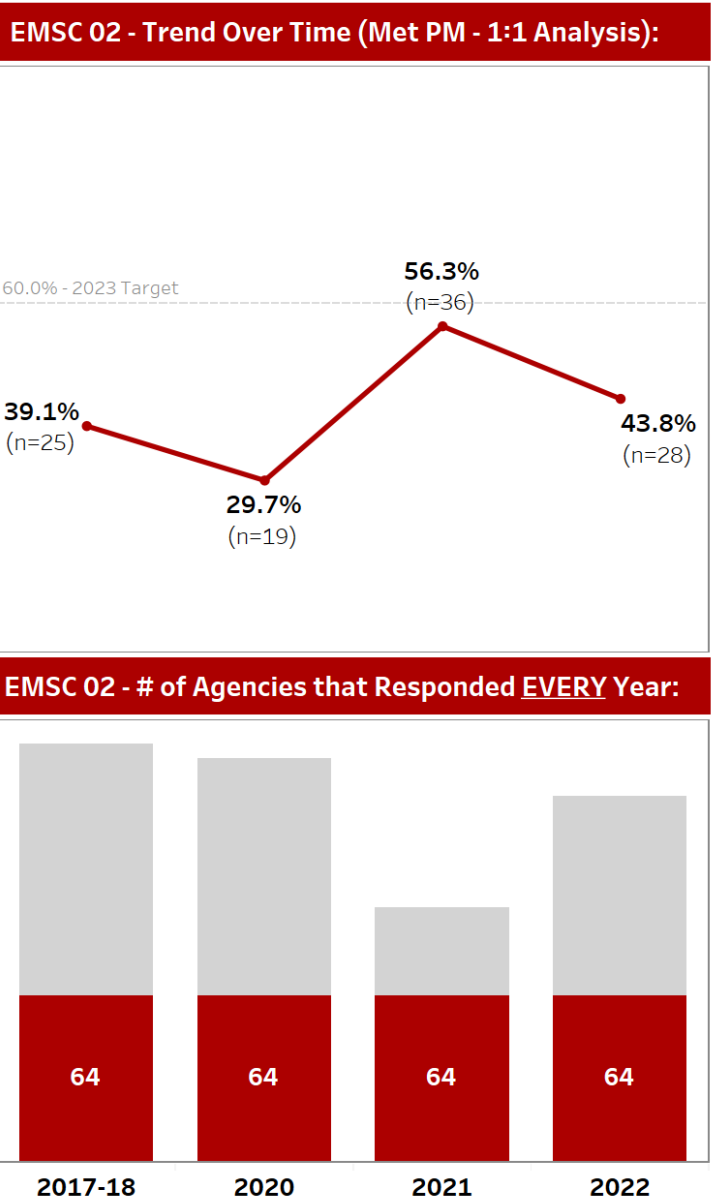
NOTE: EHB = Electronic Handbook. These are the official numbers that are reported to the EMSC Program.

The horizontal dashed gray line in the graphs indicates the EMSC National Target for 2023 which is 60%.

BELOW: Percent and Number of Florida Agencies that Reported Meeting EMSC 02 by Survey Year.

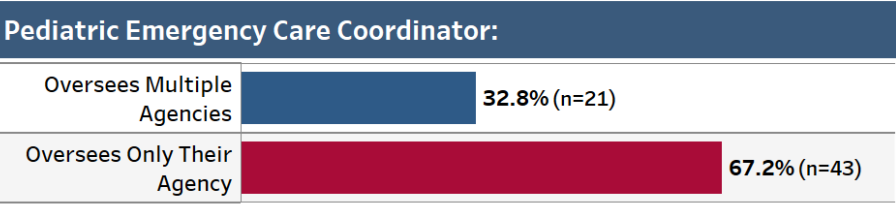
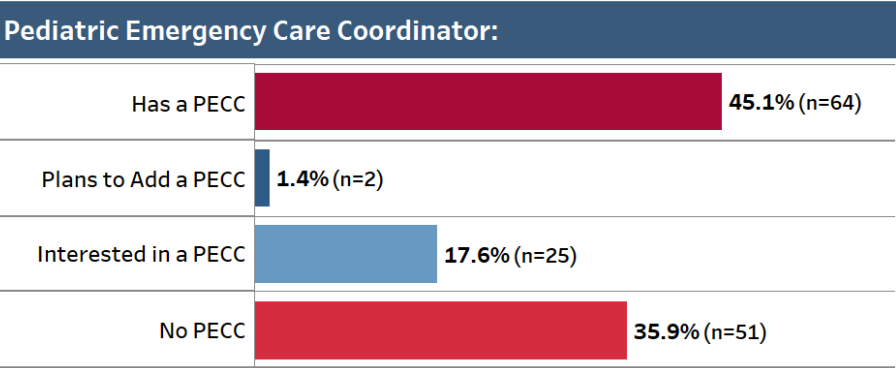


BELOW: Percentage and Number of Florida Agencies Participating in ALL FOUR Survey Years that Reported Meeting EMSC 02.



Florida Pediatric Emergency Care Coordinator (PECC) Overview for ALL 2022 Agencies

Survey Year: 2022 County: All Agency Type*: All *Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).



Other Reported PECC Activities (shared by respondents):

Agency	
	We stay current with Handtevy and PALS
Bonita Springs Fire Control and Rescue District	
	Our Medical Director and sub-committee develop progressive pediatric protocols and CME for all PCEMS clinicians.
City of Safety Harbor	

Agencies who Have a PECC - Reported PECC Duties:	
Ensures that the pediatric perspective is included in the development of EMS protocols	96.9% (62/64)
Ensures that fellow providers follow pediatric clinical practice guidelines and/or protocols	96.9% (62/64)
Promotes pediatric continuing education opportunities	95.3% (61/64)
Oversees pediatric process improvement initiatives	95.3% (61/64)
Ensures the availability of pediatric medications, equipment, and supplies	95.3% (61/64)
Promotes agency participation in pediatric prevention programs	76.6% (49/64)
Coordinates with the emergency department pediatric emergency care coordinator	68.8% (44/64)
Promotes agency participation in pediatric research efforts	54.7% (35/64)
Promotes family-centered care	53.1% (34/64)
Other Activities	23.4% (15/64)

Feedback from regional coordinator regarding PECCs ?

Florida EMSC 03 - Use of Pediatric-Specific Equipment Performance Measure Trending:

Trending Over Time:

There are many ways to measure improvement over time. On this page, you can see how your state performed for EMSC 03:

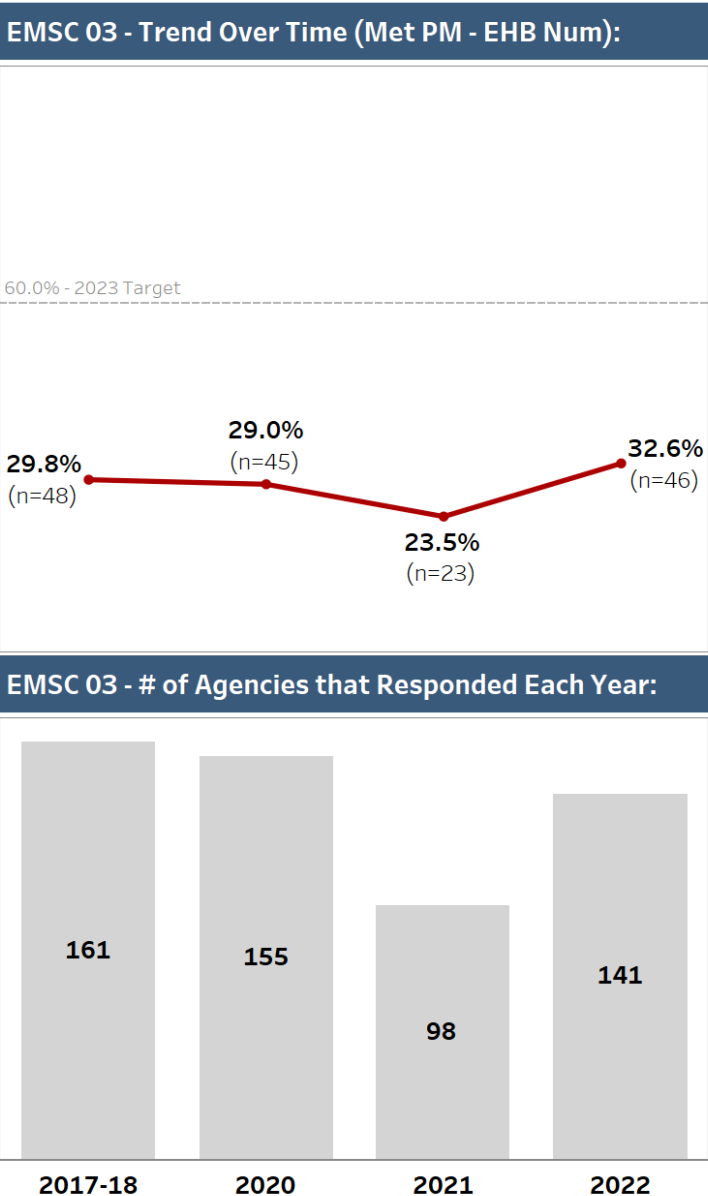
1) **Trend Over Time** - This looks at all respondents from all four survey years to see how your state's performance measure numbers are changing. The number of respondents may not be the same because response rates often change and the same agencies do not always participate.

2) **Trend Over Time (One to One Analysis)** - This looks at only those agencies who participated in all four years of the survey. This type of analysis illustrates collective upward or downward movement with EMSC 03 over time for those agencies who completed the survey in all four years.

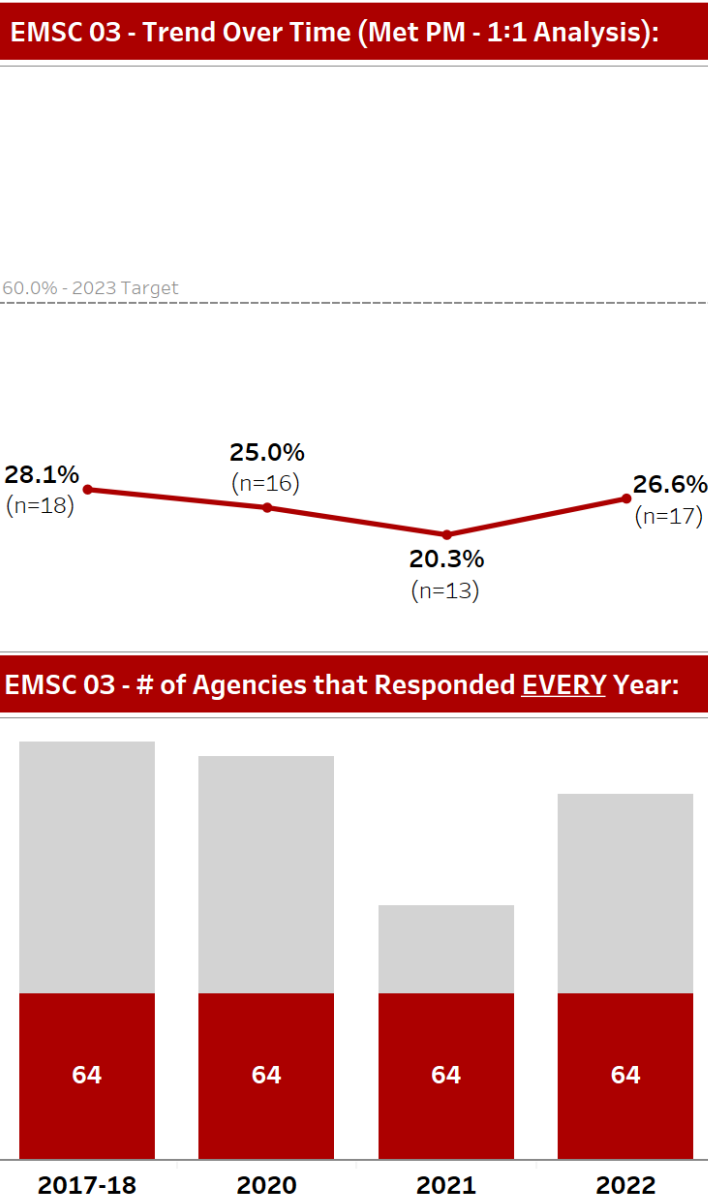
NOTE: EHB = Electronic Handbook. These are the official numbers that are reported to the EMSC Program.

The horizontal dashed gray line in the graphs indicates the EMSC National Target for 2023 which is 60%.

BELOW: Percent and Number of Florida Agencies that Reported Meeting EMSC 03 by Survey Year.



BELOW: Percent and Number of Florida Agencies Participating in ALL FOUR Survey Years that Reported Meeting EMSC 03.



Florida Use of Pediatric-Specific Equipment Overview for ALL 2022 Agencies

Pediatric-Specific Equipment Score by Percentage of Agencies and Percentage of PECCs		
	% of Agencies	% of Agencies with a PECC
Scored 6 pts or Higher	32.4% (n=46)	54.3% (n=25)
Scored Less than 6 pts	67.6% (n=96)	40.6% (n=39)

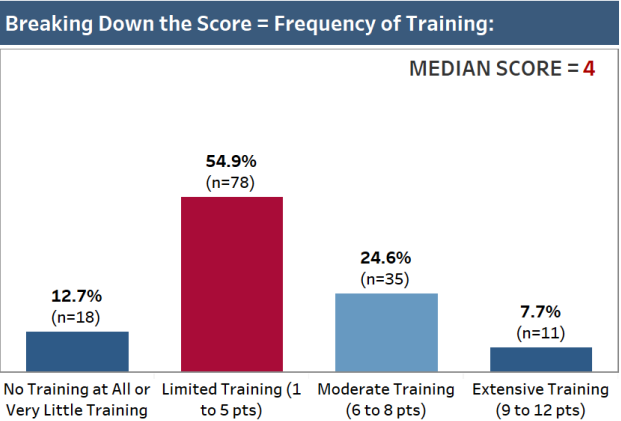
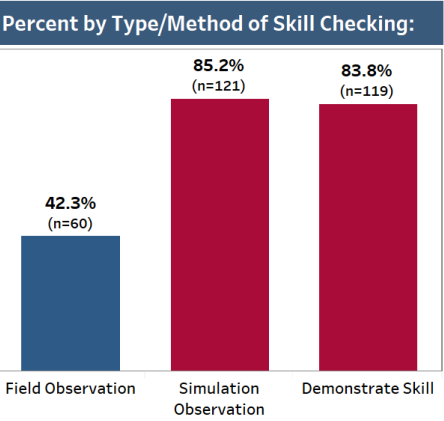
Survey Year:
2022

PECC/No PECC:
All

County:
All

Agency Type*:
All

*Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).



Use of Pediatric-Specific Equipment Matrix:

% of Agencies 3.5%70.7%	Two or more times per year (4pts)	At least once per year (2pts)	At least once every two years (1pt)	Less frequency than once every two years (0 pts)	None
How often are your providers required to demonstrate skills via a SKILL STATION?	16.2% (n=23)	38.7% (n=55)	25.4% (n=36)	3.5% (n=5)	16.2% (n=23)
How often are your providers required to demonstrate skills via a SIMULATED EVENT?	15.5% (n=22)	38.7% (n=55)	27.5% (n=39)	3.5% (n=5)	14.8% (n=21)
How often are your providers required to demonstrate skills via a FIELD ENCOUNTER?	11.3% (n=16)	16.9% (n=24)	4.9% (n=7)	9.2% (n=13)	57.7% (n=82)

This matrix was used to score the type of skill demonstration/simulation and the frequency of **occurrence**. A score of 6 pts or higher “met” the measure. The darker the box the higher the percentage of agencies in that group. See pg. 35 in the “EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017” for additional information about this matrix.

Use of Pediatric-Specific Equipment Overview for ALL 2022 Agencies

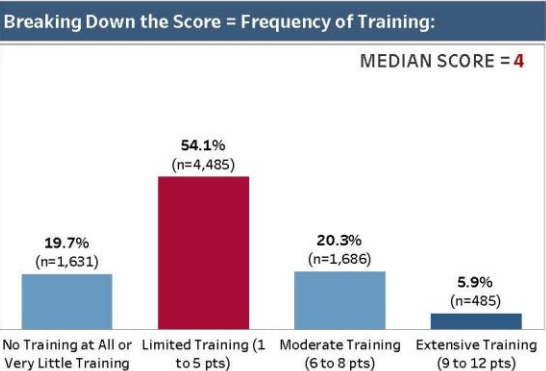
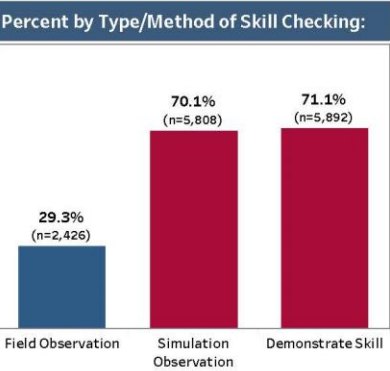
Pediatric-Specific Equipment Score by Percentage of Agencies and Percentage of PECCs		
	% of Agencies	% of Agencies with a PECC
Scored 6 pts or Higher	26.2% (n=2,171)	53.2% (n=1,154)
Scored Less than 6 pts	73.8% (n=6,116)	29.6% (n=1,809)

Survey Year:
2022

PECC/No PECC:
All

Agency Type*:
All

*Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).



Use of Pediatric-Specific Equipment Matrix:

% of Agencies

2.1%

70.7%

	Two or more times per year (4pts)	At least once per year (2pts)	At least once every two years (1pt)	Less frequency than once every two years (0 pts)	None
How often are your providers required to demonstrate skills via a SKILL STATION?	15.0% (n=1,243)	42.1% (n=3,488)	11.9% (n=987)	2.1% (n=174)	28.9% (n=2,395)
How often are your providers required to demonstrate skills via a SIMULATED EVENT?	12.1% (n=1,000)	41.0% (n=3,395)	14.2% (n=1,175)	2.9% (n=238)	29.9% (n=2,479)
How often are your providers required to demonstrate skills via a FIELD ENCOUNTER?	6.9% (n=570)	15.1% (n=1,252)	4.0% (n=333)	3.3% (n=271)	70.7% (n=5,861)

This matrix was used to score the type of skill demonstration/simulation and the frequency of **occurrence**. A score of 6 pts or higher “met” the measure. The darker the box the higher the percentage of agencies in that group. See pg. 35 in the “EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017” for additional information about this matrix.

National EMSC Related Updates: PEAKs

New EIIC PEAKs (Pediatric Education and Advocacy Kit) on *Pain and Agitation/de-escalation*

<https://emscimprovement.center/education-and-resources/peak/peak-pediatric-pain/>

<https://emscimprovement.center/education-and-resources/peak/pediatric-agitation/>

are related to pain." Untreated pain has short-term (pain, distress, prolonged procedure time; slower healing) and long-term consequences (increased sensitivity to pain; avoidance of healthcare settings; needle phobia; higher for multi-modal pain care improves procedure success rate, patient flow, and improves patient and caregiver satisfaction). Before initiating any procedure, consider whether it is necessary to minimize pain management, and engage caregivers in planning/decisions.

TO MINIMIZE PAIN

AINES IN CHILDREN
 their pain. If unable (e.g., cognitive issues, non-verbal), or children 4-12 years of age.
 eg - For children over 4 years of age:
 re 0 is no pain and 10 is the worst pain
 t number your pain is 5".

EIIC/TREKK BOTTOM LINE RECOMMENDATIONS: PAIN TREATMENT

Key facts and recommendations for treating pain in children.

res used to assess and treat children can cause significant pain and distress for the child, caregivers, and healthcare providers. Long-term consequences (increased sensitivity to pain; avoidance of healthcare settings; needle phobia; higher for multi-modal pain care improves procedure success rate, patient flow, and improves patient and caregiver satisfaction). Before initiating any procedure, consider whether it is necessary to minimize pain management, and engage caregivers in planning/decisions.

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 eg - For children over 4 years of age:
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 t number your pain is 5".

EIIC/TREKK BOTTOM LINE RECOMMENDATIONS: PROCEDURAL PAIN

Key facts and recommendations for procedural pain management in children.



PEAK: PAIN PODCAST SERIES

Five-part series on assessing, managing, & supporting the pediatric patient in pain

AUDIENCE

- Clinicians 14
- Nurses 15
- Patients & Families 13
- Prehospital Practitioners 8

SORT ORDER

- Pinned
- Most Recent
- Alphabetical

Spread the word

Suggest content here

19 Results

Document
 Pinned

EIIC/TREKK: Bottom Line Recommendations: Pain Treatment

7 minutes Details

Document
 Pinned

EIIC/TREKK: Bottom Line Recommendations: Procedural Pain

7 minutes Details

5 Resources
 Pinned

PEAK: Pain Podcast Series

Details

Document

Alberta Health Service: Comfort Care Plan

5 minutes Details

Video

CHEO: Reduce Your Infant's Pain During Newborn Blood Tests

4 minutes Details

Video

EIIC: Administering Intranasal Pain Medications - prehospital

6 minutes Details

Video

PACES Just-in-Time: No More Ouchies

5 minutes [Details](#)

Document

PAMI®: Communication Cards

5 minutes [Details](#)

2 Resources

PAMI®: Virtual Reality for Pain Management

[Details](#)

Video

SKIP: Mom Hack: What You Can Do When Kids Are Afraid of Needles

2 minutes [Details](#)



Infographic

SKIP: Psychological Therapies & Headache Pain

2 minutes [Details](#)

Video

SKIP: Needle Pain & Phobia. How to Avoid Fear of Needles & Vaccines by Andrea Furlan, MD, PhD

9 minutes [Details](#)

Document

SKIP: Opioids Can Be Safe When Used Properly

3 minutes [Details](#)

Video

TREKK: How to Help When Your Child Needs a Needle Poke

3 minutes [Details](#)



Document

TREKK: How to Help When Your Child Needs to Get a Needle Poke

3 minutes [Details](#)

Pediatric Education and Advocacy Kit (PEAK): Agitation



Children in emergency settings may become agitated for a variety of reasons, including psychiatric disorders, delirium, withdrawal or intoxication. Agitation can lead to disrupted care, distress for the family, and risk to staff, making it vital to manage effectively (Gerson et al., 2018). For the agitated pediatric patient, the approach must be safe, proactive, and begin with least restrictive options possible.

PEAK: Agitation resources were created to assist hospital teams, in partnership with patients and families, to support the agitated pediatric patient—including identifying the etiology and initiating management strategies.

Last updated August 2022

Infographic Pinned

ElIC: De-escalation Tips for Pediatric Agitation Infographic

3 minutes Details

Toolkit

New England EMSC: New England Regional Behavioral Health Toolkit

7 Resources

ElIC: Safe Control of the Agitated Patient Webinar Series

Details

Featured Content



ElIC/TREKK: CARE OF THE AGITATED PATIENT
Care algorithm co-created by ElIC & TREKK on identifying & caring for the agitated pediatric patient

Medications for the Agitated Pediatric Patient			
Medication	Dose	Frequency	Notes
1. Lorazepam	0.1 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
2. Propofol	0.5-1 mg/kg	Every 10-15 minutes	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
3. Ketamine	0.5-2 mg/kg	Every 10-15 minutes	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
4. Haloperidol	0.05-0.1 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
5. Risperidone	0.25-0.5 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
6. Meprobamate	0.5-1 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
7. Valproic Acid	10-20 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
8. Carbamazepine	10-20 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
9. Phenytoin	10-20 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.
10. Levetiracetam	10-20 mg/kg	Every 6-8 hours	Consider oral or IV administration. Monitor for respiratory depression. Avoid use in patients with severe liver or kidney disease.

ElIC: AGITATION MEDICATION DOSING RECOMMENDATION TABLE
Medication dosing recommendation table for the agitated pediatric patient

AUDIENCE

- Clinicians 5
- Nurses 5
- Patients & Families 2
- Prehospital Practitioners 3

SORT ORDER

- Pinned
- Most Recent

Search... Search

5 Results

Practice Guideline Pinned

ElIC/TREKK: Care of the Agitated Patient Algorithm

5 minutes Details

Practice Guideline Pinned

ElIC: Agitation Medication Dosing Recommendation Table

5 minutes Details

De-escalation Tips for Pediatric Agitation



PEAK
Pediatric Education
and Advocacy Kits



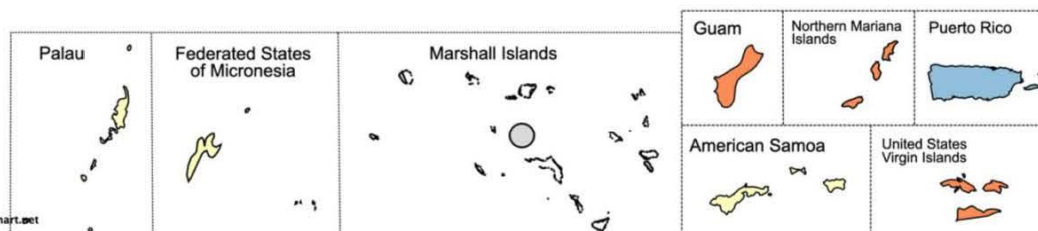
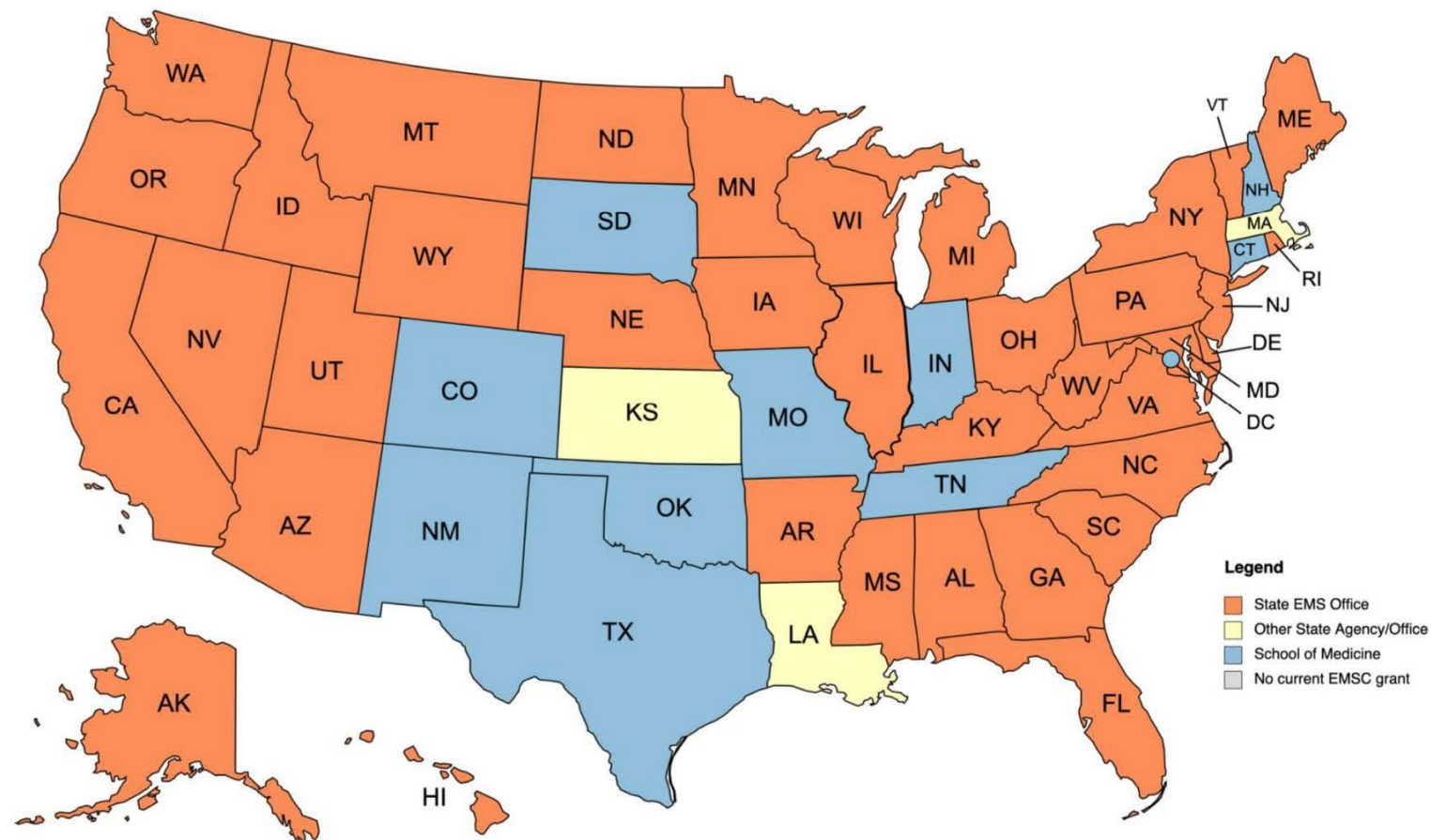
Manage the Environment	Use Behavior De-escalation Techniques	Use Calming Interventions
• Remove dangerous objects and equipment • Monitor patient in a safe space with dimmed lights, minimize noise • Decrease sources of stress, stimulation, including family or caregivers as required to reduce patient triggers • Avoid overuse of medications, physical restraints, and security personnel	• Respect personal space • Listen to patient and caregiver • Keep neutral tone and body language • Establish concise verbal contact • Avoid provocative actions and words • Identify wants and feelings • Offer choices and optimism • Reward cooperation	• Listen to patient, validate distress • Address needs (e.g., food or drink) • Use distraction (e.g., safe activity, food, warm blanket) • Explain what to expect in ED, next steps, provide updates • Debrief patient and care team



Remember that long hair, jewelry, necklaces, stethoscopes, and ID badges hanging around your neck can be a potential safety risk when interacting with an agitated patient.

New HRSA EMSC State Partnership Performance Measures: Announcement on August 9th

- Grant application due Nov 7th, \$130,000-205,000/yr to include full time program manager plus benefits, travel, etc.
- UF COM Jacksonville writing grant application in collaboration with DOH BEMO
- Must be DOH or University School of Medicine
 - Many states shifting to University model in new grant cycle
 - https://media.emscimprovement.center/documents/SP_Program_Location.pdf



Column 1 National Performance Measure and Program Objective	Column 2 Data Source	Column 3 Frequency of Data Collection	Column 4 Baseline Data	Column 5 Target
States/jurisdictions have a standardized pediatric readiness recognition program for EDs	Grantee Performance Report	Annual	2020 national baseline: 29% (n=17/58)	59%
States/jurisdictions have a standardized pediatric readiness recognition program for prehospital EMS agencies	Grantee Performance Report	Annual	2021 national baseline: 7% (n=4/58)	21%
States/jurisdictions have a family representative on their EMSC state advisory committee who represents the emergency needs of children in their community	Grantee Performance Report	Annual	Maintain 98% (n=57/58)	100%
Prehospital EMS agencies have a designated PECC	EMSC Data Center Survey and National Prehospital Pediatric Readiness Assessment	Annual	2022 national baseline: 36% (n=2934/8234)	50%
Prehospital EMS agencies have a process for pediatric skills-check on the use of pediatric equipment	EMSC Data Center Survey and National Prehospital Pediatric Readiness Assessment	Annual	2022 national baseline: 26% (n=2,145/8,234)	46%
Prehospital EMS agencies have disaster plans that address the needs of children	EMSC Data Center National Prehospital Pediatric Readiness Assessment	2024 (national survey every 5 years)	Baseline: 0% (developmental)	75%
Hospital EDs have a designated PECC	EMSC Data Center National Pediatric Readiness Assessment	2026 (national survey every 5 years)	2021 national baseline: 46% (n=1,666/3645)	75%
Hospital EDs weigh and record children's weight in kilograms	EMSC Data Center National Pediatric Readiness Assessment	2026 (national survey every 5 years)	2021 national baseline: 74% (n=2713/3645)	84%
Hospital EDs have disaster plans that address the needs of children	EMSC Data Center National Pediatric Readiness Assessment	2026 (national survey every 5 years)	2021 national baseline: 47% (n=1724/3639)	75%

Program Requirements and Expectations

EMSC SP Program recipients are required to:

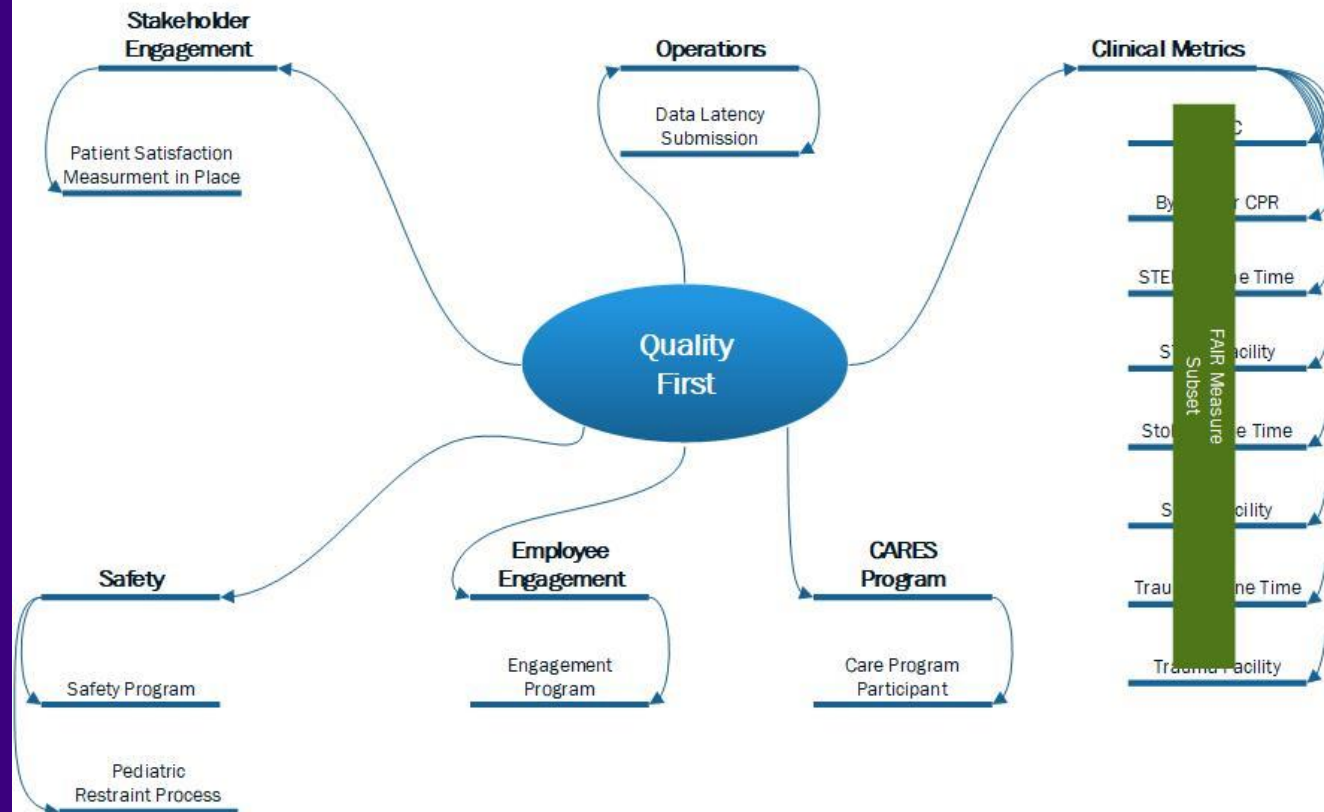
1. **Establish an EMSC Advisory Committee** with the required core members, convening at least four times each grant year.
2. **Ensure sufficient oversight of the EMSC grant program** by maintaining one full-time SP program manager that is dedicated solely to the EMSC SP Program.
3. **Support data collection, analysis, and continuous quality improvement.** Monitoring and oversight of the EMSC SP grant program activities include the collection of data from hospital EDs and prehospital EMS agencies. Sufficient personnel support will be necessary to ensure that data are collected and submitted consistent with program reporting deadlines of this program. Some examples of data collection activities include collaborating with the EMSC Data Center to manage and maintain the Program's Contact List Management System for your state/jurisdiction; disseminating information to hospital EDs and prehospital EMS agencies regarding data collection activities; and providing technical assistance for EMSC surveys and national pediatric readiness assessments of hospital EDs and prehospital EMS agencies.
4. **Expand the uptake of Pediatric Readiness in Emergency Departments** where not already done, by establishing a state, territorial, or regional Pediatric Readiness Recognition Program for hospital EDs; designating PECCs in EDs; and ensuring hospital EDs weigh and record children's weight in kilograms.
5. **Improve Pediatric Readiness in EMS Systems** where not already done, by establishing a state, territorial, or regional standardized Prehospital Pediatric Readiness Recognition Program for prehospital EMS agencies; increasing PECCs in prehospital EMS agencies; and increasing the number of prehospital EMS agencies that have a process for pediatric skills-check on the use of pediatric equipment.
6. **Increase pediatric disaster readiness in hospital EDs and prehospital EMS agencies** by ensuring that disaster plans address the needs of children.
7. **Prioritize and advance family partnership and leadership** in efforts to improve EMSC systems of care. Within 6 months of the start of funding cycle, create a strategic plan (including all 4 years) for your Family Advisory Network (FAN) representative that engages them as an indispensable and equal partner in your work by centering and integrating the patient and family perspective in your efforts. The minimum requirement for the strategic plan is the inclusion of the FAN representative on Advisory Committee meetings and quarterly meetings. Include the frequency and details that explain how the FAN representative will be involved in developing and/or implementing the strategic plan and the goals and objectives of this NOFO. Examples of activities include contributing to educational content, reviewing fliers/handouts/websites, and presenting at events or trainings
8. **Attend HRSA EMSC Grantee Meetings in FY2023 and FY2025.**

Quality First



Florida EMS Advisory Council

Concept Document For Discussion Purposes



Presentations and Special Topics



Sensory Comfort Kits by Lauren Young Work, LCSW

- Medical Social Work Coordinator
- Mobile Integrated Health Program,
Medical Services Division
- Palm Beach County Fire Rescue
- Ldyoung@pbcgov.gov
- Sensory Sensitivity Comfort Kit
Informational Video

<https://www.youtube.com/watch?v=mz3KGTjKUEI>

Sensory Comfort Kits

A **Sensory Comfort Kit** may assist a patient or bystander exhibiting signs of physical or emotional stress (sensory sensitivity) and should be offered as deemed appropriate on scene (ex. child or adult with Autism)

Possible Observations: Ear covering, ear or clothes tugging, fingers in ears, head or body shaking, repetitive/rocking movements, pacing, agitation, crying, yelling, fearful behavior, head banging, frozen/lack of movement, any sign of physical or emotional discomfort.

Two kits stocked on every Rescue, and distributed via par levels. Two kits available for Engines at every station.



Kit Items & Guidance:

- **Clear Backpack**
- **Sound Reducing Adjustable Ear Muffs:** *Reduces discomfort with scene sounds.*
- **Communication Cards:** *Non-verbal communication tool for use any time the individual is not speaking/responding to words or having difficulty communicating (English, Creole & Spanish Available).*
- **Fidget Spinner:** *Use for distraction and stress reduction.*
- **Fire Helmet Squeeze Toy:** *Use for distraction and stress reduction.*
- **211 Special Needs Brochure and Drowning Prevention Brochure:** *Resources for parent/guardian/caregiver post incident.*

Florida EMSC/PEDReady Updates

Safe transport working group report (Dr. Marshall Frank and team)

Develop a position statement ✓

Develop a sample policy/SOP ✓

Develop an educational tool ✓ (Slide set, recording, resources)

Cost issue? Think of as a piece of equipment needed to manage a child

NASEMSO updating product document:

<https://nasemso.org/wp-content/uploads/Pediatric-Transport-Products-for-Ground-Ambulances.pdf>



Prehospital Pediatric Readiness EMS AGENCY CHECKLIST

This checklist is based on the 2020 joint policy statement “[Pediatric Readiness in Emergency Medical Services Systems](#)”, co-authored by the Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), National Association of EMS Physicians (NAEMSP), and National Association of EMTs (NAEMT). Additional details can be found in the AAP Technical Report “[Pediatric Readiness in Emergency Medical Services Systems](#)”.

Use this tool to check if your EMS agency is ready to care for children as recommended in the Policy Statement.

Consider using resources compiled by the Health Resources & Services Administration’s Emergency Medical Services for Children (EMSC) Program when implementing the recommendations noted here, to include the [Prehospital Pediatric Readiness Toolkit](#).



EDUCATION & COMPETENCIES FOR PROVIDERS

- ☐ Process(es) for ongoing pediatric specific education using one or more of the following modalities:
 - Classroom/in-person didactic sessions
 - Online/distributive education
 - Skills stations with practice using pediatric equipment, medication and protocols
 - Simulated events

Process for evaluating pediatric-specific competencies for the following types of skills:

- ☐ Psychomotor skills, such as, but not limited to:
 - Airway management
 - Fluid therapy
 - Medication administration
 - Vital signs assessment
 - Weight assessment for medication dosing and equipment sizing
 - Specialized medical equipment
- ☐ Cognitive skills, such as, but not limited to:
 - Patient growth and development
 - Scene assessment
 - Pediatric Assessment Triangle (PAT) to perform assessment
 - Recognition of physical findings in children associated with serious illness
- ☐ Behavioral skills, such as, but not limited to:
 - Communication with children of various ages and with special health care needs
 - Patient and family centered care
 - Cultural awareness
 - Health care disparities
 - Team communication

EQUIPMENT AND SUPPLIES

- ☐ Utilize national consensus recommendations to guide availability of equipment and supplies to treat all ages
- ☐ Process for determining competency on available equipment and supplies

PATIENT AND MEDICATION SAFETY

- ☐ Utilization of tools to reduce pediatric medication dosing and administration errors, such as, but not limited to:
 - Length based tape
 - **Volumetric dosing guide**
- ☐ **Policy for the safe transport of children**
- ☐ Equipment necessary for the safe transport of children

PATIENT- AND FAMILY-CENTERED CARE IN EMS

Partner with families to integrate elements of patient- and family-centered care in policies, protocols, and training, including:

- ☐ Using lay terms to communicate with patients and families
- ☐ Having methods for accessing language services to communicate with non-English speaking /non-verbal patients and family members
- ☐ Narrating actions, and alerting patients and caregivers before interventions are performed

Policies and procedures that facilitate:

- ☐ Family presence during resuscitation
- ☐ The practice of cultural or religious customs
- ☐ A family member or guardian to accompany a pediatric patient during transport

POLICIES, PROCEDURES, AND PROTOCOLS (TO INCLUDE MEDICAL OVERSIGHT)

- ☐ Prearrival instructions identified in EMS dispatch protocols include pediatric considerations, when relevant, such as, but not limited to:
 - Respiratory distress
 - Cardiac arrest
 - Choking
 - Seizure
 - Altered consciousness
- ☐ Policies, procedures, and protocols include pediatric considerations, such as, but not limited to:
 - Policy on pediatric refusals
 - Pediatric assessment
 - Consent and treatment of minors
 - Recognition and reporting of child maltreatment
 - Trauma triage
 - Children with special health care needs
- ☐ Direct medical oversight integrates pediatric-specific knowledge
- ☐ Protocols (indirect medical oversight) include pediatric evidence when available
- ☐ Destination policy that integrates pediatric-specific resources

QUALITY IMPROVEMENT (QI)/ PERFORMANCE IMPROVEMENT (PI)

- ☐ PI process includes pediatric encounters
- ☐ Pediatric-specific measures are included in the PI process
- ☐ Submission of EMS agency data to the state’s prehospital patient care database
- ☐ Submitted data is compliant with the current version of NEMSIS (version 3.x or higher)
- ☐ Process to track pediatric patient centered outcomes across the continuum of care, such as, but not limited to:
 - Transport destination
 - Secondary transport destination
 - ED and hospital disposition
 - ED and hospital diagnoses
 - Survival to hospital admission
 - Survival to hospital discharge

INTERACTION WITH SYSTEMS OF CARE

Policies, procedures, protocols, and performance improvement initiatives involve ongoing collaboration with:

- ☐ Pediatric emergency care
- ☐ Public health
- ☐ Family advocates

Plans and exercises for disasters or mass casualty incidents include:

- ☐ Care of pediatric patients, such as, but not limited to:
 - Pediatric mental health first aid
 - Pediatric disaster triage
 - Pediatric dosing of medications used as antidotes
 - Pediatric mass transport
- ☐ Tracking of unaccompanied children
- ☐ Family reunification
- ☐ Collaborate with external personnel or have internal staff focused on enhancing pediatric care, such as, but not limited to:
 - Pediatric emergency care coordinator (PECC)
 - Regional PECC
 - Pediatric advisory council(s)
 - Medical director with pediatric knowledge and experience

- ☐ Understand pediatric capabilities at local and/or regional emergency departments for children with the following types of conditions:
 - Medical emergency
 - Traumatic injury
 - Behavioral health emergency
- ☐ Policies and/or procedures for transfer of responsibility of patient care at destination

Revised May 20, 2021

To provide feedback on this checklist, please email pprp@emscimprovement.center

For additional information on the Prehospital Pediatric Readiness Project (PPRP), visit:
<https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness>



The NASEMSO released interim guidance in 2017 on the safe transport of children by EMS, and this organization specifically highlighted the need for further research to establish a Society of Automotive Engineers standard for pediatric restraint recommendations through crash testing of different types of equipment. The interim guidance emphasized that **safe transport for children should be considered standard of care equivalent to EMS airway, breathing, and circulation maintenance**. The guidance strongly states that all EMS agencies should have pediatric safe transport policies and procedures for evidence-based and appropriately sized and positioned child-restraint systems. Children should not be transported in ambulances unrestrained (eg, held in laps and/or arms).

<https://publications.aap.org/pediatrics/article/145/1/e20193308/36984/Pediatric-Readiness-in-Emergency-Medical-Services>



Safe Transport

Keeping our pediatric patients safe

Florida EMS for Children Advisory Committee, Safe Transport Working Group

Developed by: Marshall Frank, DO; Niki Shimko, MSN; Tracey Vause, EMT-P; Kevin Meade, EMT-P; David Summers, RN; Amy Kennedy, Elijah Virgin, BSN; Sandra Nasca, RN; Nathan McManus, EMT-P; Penny Blake, MSN and others





Safe Transport Course and Resources

Draft under review by the Florida EMS for Children
Advisory Committee with support of a HRSA/MCHB
EMS for Children State Partnership Grant



DISCLAIMER:

The information in this presentation is offered as general guidance and is not meant as a substitute for EMS medical direction, agency protocols or approved standard operating procedures. Patient care must be individualized. As new research and clinical experience becomes available, patient safety and transport standards may change. Healthcare professionals should remain current on medical literature and national standards of care and structure their protocols and treatment accordingly.



Objectives

1

Identify risks involved with transporting pediatric patients

2

Identify resources available for restraint of the pediatric patient

3

Learn about National Highway and Transportation Safety Administration's (NHTSA) efforts to improve child safety and their specific guidelines for ambulances

4

Identify developmental age distractions for separation and securement of the pediatric patient

Florida EMS for Children

Safe Transport Position Statement

The Florida EMS for Children Advisory Committee is comprised of state pediatric, emergency, trauma, and EMS professionals; in addition to family advocates with a mission to enhance pediatric readiness in EMS agencies, emergency departments, inter-facility transports, and prevention programs.



FL EMS-C and Florida PEDReady Goals for Pediatric Transportation

- All infant and pediatric patients should be transported using a commercially manufactured, appropriate sized, pediatric restraint device
- EMS and Fire personnel education regarding safe transport should be conducted through a variety of educational methods in order to understand restraint guidance and select devices
 - FL EMSC *Safe Transportation of Pediatric Patients* online training resource
 - Hands-on Training
 - Community Education
- Agencies are encouraged to implement a safe pediatric transport Standard Operating Procedure (SOP) or protocol

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Endorsed by:



Florida Association of Critical Care Transport Specialists



Other Florida EMS Committees and Organizations: PIER Committee, FAREMS, etc.

Florida EMSC/PEDReady Updates



PEDReady website: <https://emlrc.org/flpedready/>

Weekly PEDReady and FL EMSC news in *weekly FCEP news briefs* and monthly FAEMSMD newsletter:

- pediatric related announcements, resources, literature, news from national, state and local organizations, PECC updates, champions
- email pedready@jax.ufl.edu to sign up for news briefs

Florida EMSC/PEDReady Updates



- Communication Cards: New supply, binder ring size
- JumpSTART badge buddies
<https://emlrc.org/wp-content/uploads/JumpSTART-badge-buddy-2021-v2.pdf>
 - Shout out to Michael Ung, Captain, EMS Training and Education OIC, Miami-Dade Fire Rescue who used badge buddies to train > 1500 operations personnel over a month including a new recruit class! And sent a thank you note and photos😊
- EMSC Day May 24, 2023

START Modified ADULT

(size, + 2° sex characteristics)

Move the Walking Wounded

MINOR

No Respirations after Head Tilt

EXPECTANT

CONTROL BLEEDING

Respiratory Distress (> 30/min)

IMMEDIATE

Perfusion (No Radial Pulse)

IMMEDIATE

Mental Status

IMMEDIATE

(Unable to Follow Commands)

Normal RPM, Follows Commands

DELAYED

CONDUCT SECONDARY TRIAGE IN THE TREATMENT PHASE

FL MCI LEVELS

MCI Level 1: 5-10 victims

MCI Level 2: 11-20 victims

MCI Level 3: 21-100 victims

MCI Level 4: 100 -1000 victims

MCI Level 5: Over 1000 victims

July 2021

On PEDReady website

IMMEDIATE

Red

DELAYED

Yellow

MINOR

Green

EXPECTANT

Black

JumpSTART Modified

(Newborn to Young Adult*)

Move the Walking Wounded

MINOR

No Respirations and No Peripheral Pulse

EXPECTANT

Respiratory Rate: > 45/min, < 15/min
or †Work of Breathing, obvious distress

IMMEDIATE

No Respirations with Peripheral Pulse
Give 5 Ventilations via Barrier Device
Spontaneous Respirations Resume
after 5 Ventilations

IMMEDIATE

No Spontaneous Respirations Resume
after 5 Ventilations

EXPECTANT

CONTROL BLEEDING

Perfusion (No Palpable Pulse)

IMMEDIATE

Mental Status**

Unresponsive or not localizing pain

IMMEDIATE

Alert, responds to voice, localizes pain

DELAYED

*Presence of 2° sex characteristics; **Consider developmental level
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CONDUCT SECONDARY TRIAGE IN THE TREATMENT PHASE

New Katrina documentary “Katrina Babies” focuses on the disparities and numerous mental health and other disaster impacts on the black population who lived through the experience as children. This documentary is available on HBO (pay for view) and has a discussion guide and other resources to inform communities about what happens to children in disaster.

Katrina Babies Official Website and preview:

<https://www.hbo.com/movies/katrina-babies>

<https://www.youtube.com/watch?v=NjteP4qBqn4>

Katrina Babies Discussion Guide

https://static.hbo.com/2022-08/Katrina%20Babies%20-%20Discussion%20Guide%20-%20Designed_08232022SGJ_0.pdf



Liaison and Constituency Group Reports

- a. Rural update (Vause and McManus)
- b. Florida FAN Report (Nasca)
- c. Trauma: Program managers (Nichols), FTSAC, FCOT
- d. Disaster
- e. Mental Health
- f. Data Committee, Biospatial (EMSC dashboard)
- g. Community Paramedicine/MIH/H.A.R.T. (Health-Access-Resiliency and Telehealth) Section (Bedford)
- h. FL ENA (Rushing)
- i. EMS Educators
- j. PECCs (Rabish, Weed, Weishaupt)
- k. Pediatric and neonatal transport
- l. Injury prevention (Summers)
- m. Other

New Business

- Request from EDs and families

Acetaminophen and Ibuprofen pediatric dosing tables and magnet for parents



Pediatric Pain and Fever Dosing Guide

Acetaminophen (Tylenol®) Dosing Table – every 4-6 hours as needed									
Child's Age	0-3 m	4-11 m	12-23 m	2-3 y	4-5 y	6-8 y	9-10 y	11-12 y	12+ y
Weight (pounds)	6-11 lbs	12-17 lbs	18-23 lbs	24-35 lbs	36-47 lbs	48-59 lbs	60-71 lbs	72-95 lbs	96+ lbs
Weight (kilograms)	3-5 kg	6-7 kg	8-10 kg	11-15 kg	16-21 kg	22-26 kg	27-32 kg	33-43 kg	44+ kg
Liquid 160mg/5mL (mL)	1.25 mL	2.5 mL	3.75 mL	5 mL	7.5 mL	10 mL	12.5 mL	15 mL	20 mL
Liquid 160mg/5mL (tsp)	--	½ tsp	¾ tsp	1 tsp	1 ½ tsp	2 tsp	2 ½ tsp	3 tsp	4 tsp

Ibuprofen (Advil®/Motrin®) Dosing Table – every 6-8 hours as needed									
Child's Age	0-6 m	6-11 m	12-23 m	2-3 y	4-5 y	6-8 y	9-10 y	11-12 y	12+ y
Weight (pounds)	0-11 lbs	12-17 lbs	18-23 lbs	24-35 lbs	36-47 lbs	48-59 lbs	60-71 lbs	72-95 lbs	96+ lbs
Weight (kilograms)	0-5 kg	6-7 kg	8-10 kg	11-15 kg	16-21 kg	22-26 kg	27-32 kg	33-43 kg	44+ kg
Drops 50mg/1.25mL (mL)	--	1.25 mL	1.875 mL	2.5 mL	3.75 mL	5 mL	--	--	--
Liquid 100mg/5mL (mL)	--	2.5 mL	4 mL	5 mL	7.5 mL	10 mL	12.5 mL	15 mL	20 mL
Liquid 100mg/5mL (tsp)	--	--	--	1 tsp	1 ½ tsp	2 tsp	2 ½ tsp	3 tsp	4 tsp

* Ideal dosing is based on **weight**, not age. Use a dosing syringe if possible. 1 teaspoon = 5 mL

New Business

- BLS Pediatric training courses
- Rural newborn deliveries: closure of OB units in US rural hospitals increasing number of newborns cared for by EMS and general EDs
- NRP vs. PALS guidelines for newborns and neonates-national discussion
 - Controversy on PEM related social media
 - <https://aacnjournals.org/ccnonline/article/41/6/22/31618/NRP-Versus-PALS-for-Infants-Outside-the-Delivery>

NRP Versus PALS for Infants Outside the Delivery Room: Not If, but When?

Jaime Esbensen Doroba, MSN, CRNP-AC

BACKGROUND: Both the Neonatal Resuscitation Program and Pediatric Advanced Life Support guidelines can be used for infants requiring cardiopulmonary resuscitation outside the delivery room. Each set of guidelines has supporting algorithms for resuscitation; however, there are no current recommendations for transitioning older infants outside the delivery room.

OBJECTIVE: To provide background information on the algorithms in the Neonatal Resuscitation Program and Pediatric Advanced Life Support guidelines and to discuss the role that nurses and advanced practice nurses play in advancing scientific research on resuscitation.

CONTENT COVERED: Summaries of both sets of guidelines, differences in practices, and recommendations for practice changes will be discussed.

DISCUSSION: Provider preference and unit practice determine which guidelines are used for infants outside the delivery room. Providers in pediatric intensive care units and pediatric cardiac intensive care units often use the Pediatric Advanced Life Support guidelines, whereas providers in neonatal intensive care units use the Neonatal Resuscitation Program guidelines for infants of the same age. The variation in resuscitation practices for infants outside the delivery room can negatively affect resuscitation outcomes. (*Critical Care Nurse*. 2021;41(6):22-28)

About 10% to 20% of neonates require respiratory support after birth, and less than 1% of neonates require extensive resuscitation, such as medications and chest compressions.¹ Mortality and neurological morbidity remain high among neonates who receive chest compressions (either alone or with medications), and these patients have a poor prognosis.² Such findings indicate the need to improve methods of cardiopulmonary resuscitation (CPR) for neonates outside the delivery room.² The resuscitation needs of newborns are difficult to predict, and neonates in the delivery room do not often require resuscitation. According to Garcia-Hidalgo and Schmölzer,² these factors limit the ability of providers to research high-quality resuscitation practices for neonates. Barriers to researching the resuscitation of neonates can affect long-term outcomes, including morbidity and mortality.

Objective

The purpose of this paper is to discuss the resuscitation of neonates and infants by providing background information about the Neonatal Resuscitation Program (NRP) and Pediatric Advanced Life Support (PALS) guidelines, comparing both sets of guidelines, and describing the role nurses and advanced practice nurses (APNs) play in advancing scientific research on resuscitation.

NRP Versus PALS for Infants Outside the Delivery Room: Not If, but When?

Both the Neonatal Resuscitation Program (NRP) and Pediatric Advanced Life Support (PALS) guidelines can be used for infants requiring cardiopulmonary resuscitation outside the delivery room. In this article, the author provides background information on the algorithms in the NRP and PALS and discusses the role nurses play in advancing scientific research on resuscitation.

Neonatal Resuscitation Program

- According to the American Heart Association, the NRP guidelines apply to resuscitation efforts for newborns transitioning from intrauterine to extra-uterine life, transitioned neonates during the first weeks after birth, and infants during their initial hospitalization.
- The NRP algorithm follows the sequence of A-B-C (airway, breathing, and circulation), prioritizing ventilation efforts as the most important step for successful resuscitation of newborns because of their transitional physiology.
- If bag-valve-mask ventilation is ineffective or prolonged, an advanced airway should be inserted or chest compressions should be initiated. Advanced airways include endotracheal intubation or a laryngeal mask for neonates born at more than 34 weeks' gestation when tracheal intubation is not feasible.
- Chest compressions are started if a neonate's heart rate remains less than 60 beats per minute even with adequate ventilation; chest compressions should begin after the establishment of an advanced airway, if it is possible to establish one. Chest compressions

are delivered with a 2-thumb or 2-finger technique to the lower third of the sternum at a depth of one-third the anterior-posterior diameter of the chest.

Pediatric Advanced Life Support

- For infants and children, CPR is often needed in response to a primary respiratory cause, such as respiratory shock. Respiratory shock usually begins with acidosis, hypoxemia, and hypercapnia, then progresses to bradycardia and hypotension, and finally results in cardiac arrest.
- Compressions are started for patients whose heart rate is less than 60 beats per minute with signs of poor perfusion or for patients who have no pulse. The American Heart Association guidelines state that the rates for infants and children must be 100 to 120 compressions per minute and that the chest should be compressed to at least one-third of the anterior-posterior diameter.
- While receiving compressions, the patient should be attached to a monitor to assess for shockable rhythms, such as ventricular fibrillation or pulseless ventricular tachycardia, and should undergo defibrillation accordingly.
- The PALS guidelines outline the use of medications during cardiac arrest in pediatric patients. An epinephrine dose of 0.01 mg/kg drawn from a concentration of 1:10 000 should be given every 3 to 5 minutes via intravenous or intraosseous catheters. If such a catheter is not established, an epinephrine dose of 0.1 mg/kg drawn from a concentration of 1:1000 should be given via an endotracheal tube. **CCN**

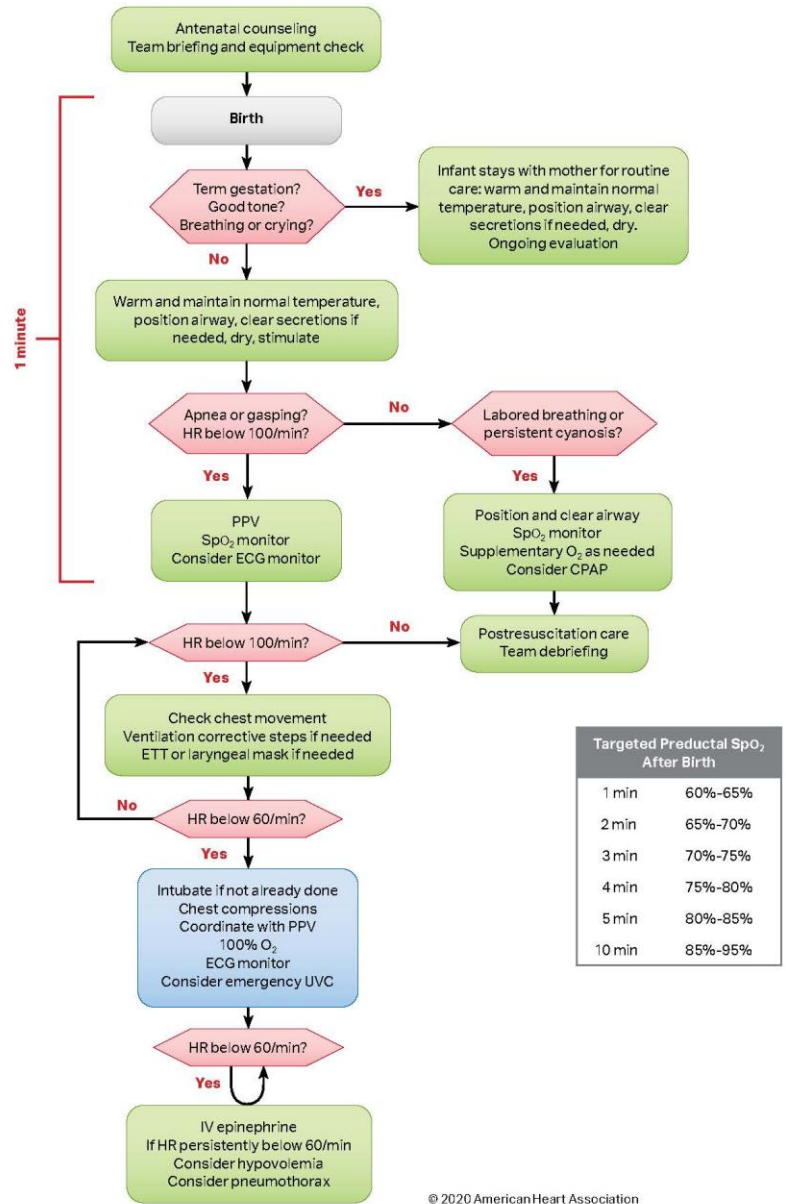
NRP

Intervention	Specification
Chest compression rate, compressions per minute	90
Depth	One-third anterior posterior diameter of the chest
No advanced airway, compression to ventilation ratio	3:1 coordinated
Advanced airway, compression to ventilation ratio	3:1 coordinated

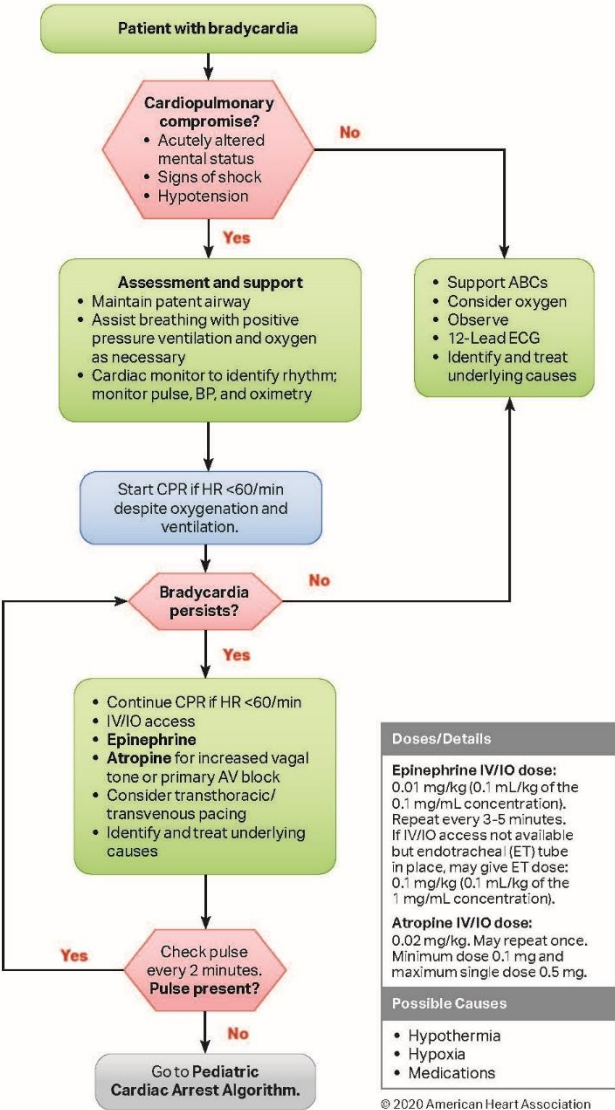
PALS

Intervention	Infant	Child	Adolescent
Chest compression rate, compressions per minute	100-120	100-120	100-120
Depth, in	1.5	2	2
No advanced airway, compression to ventilation ratio	15:2	15:2	30:2
Advanced airway, compression to ventilation ratio	1 breath every 6-8 s Asynchronous with chest compressions		

Neonatal Resuscitation Algorithm



Pediatric Bradycardia With a Pulse Algorithm



Although most of us work in Children's Hospitals on this list we need to be aware that nationally with the closure of OB units in many rural hospitals across the US an increasing number of delivering mothers/fresh newborns are being cared for in these general EDs. EDs without ready access to neonatologists should be prepared for this and have a warmer/precip kit available.

For extramural deliveries (born within minutes of arrival to ED) or births in the ED I would strongly suggest using NRP resuscitation strategies and/or calling your NICU colleagues as the baby is likely transitioning.

These babies need time to transition and efforts must focus on warm/dry/stimulate AND ventilation/MRSOPA to open up the alveoli (not on intubation/compressions). I am always surprised when I look at the NRP card and see a normal Pox at 2 min is 65% and at 10 min is 85%. We do not want to be intubating and/or moving to aggressive measures based on those sats/blue color. Additionally, looking at neo data < 5% of term deliveries should need PPV, 1-2% need additional measures such as intubation/meds and < 1% need CPR.

I try to remember the words Axl Rose of GNR when I have an ED delivery -- Said woman take it slow, and it'll work itself out fine, All we need is just a little patience"

If the newborn/infant has been out for > 10 minutes and/or is presenting after days at home I would agree that PALS is the way to go.

Finally- practice makes perfect-- there are some great resources out there to practice newborn delivery using sim in your PED or regional community EDs <https://www.emergencysimbox.com/>

From PED EM listserve Dr. Auerbach

New Business

- November meeting online to include Pediatric Battery Related Injuries and Ingestions (disc/button batteries) and Biospatial EMSC dashboard and data. Date TBD
- Fire-Rescue EAST dates are January 17-20, 2023, Daytona Beach

Thank You PEDReady Champions!

- Questions, Comments and Announcements
- Send your photos, resources, stories!

pedready@jax.ufl.edu

904-244-4986

<https://emlrc.org/flpedready/>

