Pediatric Readiness in Indian Health Service and Tribal Emergency Departments: Results from the National Pediatric Readiness Project

Authors: Juliana Sadovich, PhD, RN, Terry Adirim, MD, MPH, Russell Telford, MAS, Lenora M. Olson, PhD, MA, Marianne Gausche-Hill, MD, and Elizabeth A. Edgerton, MD, MPH, Rockville, MD, Philadelphia, PA, Salt Lake City, UT, and Torrance, CA

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Introduction: In 2014, 45 Indian Health Service (IHS)/Tribal emergency departments serving American Indian and Alaskan Native communities treated approximately 650,000 patients of which, 185,000 (28%) were children and youth younger than 19 years. This study presents the results of the National Pediatric Readiness Project (NPRP) assessment of the 45 IHS/Tribal emergency departments.

Methods: Data were obtained from the 2013 NPRP national assessment, which is a 55-question Web-based questionnaire based on previously published 2009 national consensus guidelines. The main measure of readiness is the weighted pediatric readiness score (WPRS), with the highest score being 100.

Results: The overall mean WPRS for all emergency departments is 60.9. Of the IHS/Tribal emergency departments that had pediatric emergency care coordinators, scores across all domains were higher than those of emergency departments without pediatric emergency care coordinators. All 45 emergency departments have readily available a pediatric medication dosing chart, length-based tape, medical software, or other system to ensure proper sizing of resuscitation equipment and proper dosing of medication. Of the 45 IHS/Tribal 37% report having 100% of the equipment items, and 78% report having at least 80% of these items.

Discussion: This article reports the results of the NPRP assessment in IHS/Tribal emergency departments that, despite serving a historically vulnerable population, scored favorably when compared with national data. The survey identified areas for improvement, including implementation of QI processes, stocking of pediatric specific equipment, implementation of policies and procedures on interfacility transport, and maintaining staff pediatric competencies.

Key words: Pediatric readiness; Pediatric emergency care; Quality improvement; American Indian/Alaskan Native

Juliana Sadovich is Nurse Consultant for EMSC, Indian Health Service, U.S. Department of Health and Human Services, Rockville, MD.

Terry Adirim is Professor, Pediatrics and Emergency Medicine, Section of Emergency Medicine, Department of Pediatrics, Drexel University College of Medicine, Philadelphia, PA.

Russell Telford is Biostatistician II, National EMS for Children Data Analysis Resource Center, University of Utah, Salt Lake City, UT.

Lenora M. Olson is Principle Investigator, National EMS for Children Data Analysis Resource Center, University of Utah, Salt Lake City, UT.

Marianne Gausche-Hill is Director of Emergency Medical Services, Department of Emergency Medicine and Pediatrics, Harbor-UCLA Medical Center, Torrance, CA.

Elizabeth A. Edgerton is Director, Division of Child, Adolescent, and Family Health, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, Rockville, MD.

The National Pediatric Readiness Project is supported by grant U03MC00008 for Emergency Medical Service (EMS) for Children network development and by grant U07MC09174 for EMS for Children National Resource Center from the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS).

This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, the Indian Health Service, the HHS, or the US government.

For correspondence, write: Juliana Sadovich, PhD, RN, Department of Health and Human Services, Indian Health Service, 801 Thompson Ave, Rockville, MD 20154; E-mail: Julie.sadovich@gmail.com.

J Emerg Nurs 2017;43:49-56.
Available online 31 October 2015
0099-1767

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http://dx.doi.org/10.1016/j.jen.2015.09.004

Forty-five Indian Health Service (IHS)/Tribal emergency departments serve American Indian and Alaskan Native communities in 11 states throughout the United States. Wide variation exists in the structure, sites, and capabilities of the 45 emergency departments. For example, 2 of the IHS/Tribal emergency departments are stand-alone emergency departments in health centers with no inpatient services, and 5 are within hospitals designated critical access hospitals. Eight of the hospitals' emergency departments are designated trauma centers, with 6 designated as level IV, one designated as level III, and one designated as level II. No dedicated pediatric emergency departments exist within the IHS/Tribal health care system. Furthermore, within the IHS/Tribal system, unintentional injuries are the leading cause of morbidity and mortality in the pediatric age group. The leading causes of hospitalizations include respiratory diseases, injuries, and poisonings.[1]

Although investigators have reported on pediatric readiness in emergency departments in general, little information has been published regarding the emergency care of American Indian and Alaska Native children in Tribal areas.[2] However, information has been published regarding pediatric readiness in emergency departments in general. In 2006 the Institute of Medicine released a 3-volume report on emergency care in the US, including "Emergency Care for Children: Growing Pains."[3] This report noted the many issues in providing emergency care to children and elucidated challenges to readiness of general emergency departments to care for children.[3] Gausche-Hill et al[4] examined the readiness of emergency departments to provide care for children and found that issues cited as barriers to preparedness of care for children include the lack of available pediatric-specific equipment, lack of implementation of published guidelines for care of children, and lack of pediatric experience and training of nurses and physicians. In 2009, Cichon et al[5] identified similar issues relating to the implementation of a statewide program to improve ED readiness for pediatric care. A 2009 study from the United Kingdom echoed the previous reports on ED care of children. This study by Prentiss and Vinci[6] stated that "The minimal requirements as outlined in these documents of pre-hospital care services and in-hospital needs, such as staffing, medication, equipment and supply requisites, must be met by any system that cares at any time for children in order to effectively evaluate, stabilize and, when necessary, transfer acutely ill children."

In 2001, the American Academy of Pediatrics (AAP) and the American College of Emergency Physicians (ACEP) developed the first joint guidelines on care for children in the emergency department to address gaps in readiness to care for children in general emergency departments. In 2009, ENA and the federal Emergency Medical Services for Children program joined with AAP and ACEP to update the guidelines and established the National Pediatric Readiness Project (NPRP). Emergency nurses have had a key role in the execution of this project as co-investigators and as participants in the project, representing their emergency departments. The purpose of the NPRP is 3-fold: (1) to establish a composite baseline of the nation's capacity to provide care to children in the emergency department, (2) to create a foundation for emergency departments to engage in an ongoing quality improvement (QI) process that includes implementing the *Guidelines for the Care of Children in the Emergency Department* (2009 national guidelines), and (3) to establish a benchmark that measures an emergency department's improvement over time.[7,8] The first phase of this initiative was completed in 2013. In 2015, Gausche-Hill et al[7] published a report on the results of the NPRP assessment, finding general improvement in readiness for pediatric care in emergency departments. To date, readiness of emergency departments within the IHS/Tribal health care system has not been specifically evaluated. This study presents the results of the NPRP assessment of the 45 IHS/Tribal emergency departments that serve a vulnerable population in largely rural geographic areas.

Methods

Data were obtained from the 2013 NPRP national assessment, for which the detailed implementation methods have been previously described.[7] Briefly, the NPRP assessment is a 55-question Web-based questionnaire (pediatricreadiness.org) based on the 2009 national guidelines, a joint consensus-based policy statement by AAP, ACEP, and ENA.[7] The assessment was completed online via a Web page link that was sent by E-mail to each of the ED nurse managers. The assessment addresses the coordination of pediatric patient care, including physician/nurse staffing and training, QI activities, patient safety initiatives, policies and procedures, and availability of pediatric equipment. Data regarding hospital demographics, including ED configuration and annual overall and pediatric patient volume, were also collected, and rural and urban location was designated using geocoding.[9] The main measure of readiness is the weighted pediatric readiness score (WPRS). The WPRS was based on the results of an expert panel modified Delphi process that resulted in 24 of the 55 questions being weighted to generate a score that was normalized to a 100-point scale.[7]

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