

Nicklaus Children's Leveling Guide for Pediatric Urgent Care Centers Hospital David Diaz, BSN, RN; Sheree Mundy, DNP, BSc, ARNP, PPCNP-BC, NE-BC; Nicole Quinlan, MSN, RN, NE-BC

Background

- > Pediatric urgent care centers (UCCs) rapidly expanding within the Nicklaus Children's Hospital system
- \geq 9 UCCs currently
- ➤ 1 more UCC to open before the end of 2017
- In 2016, over 118,000 Urgent Care Visits
- Services to the tri-county area Miami-Dade, Broward, Palm Beach
- > In November 2014 it was discovered that the Emergency Medical Treatment and Active Labor Act (EMTALA) law applied to these UCCs
- > Transfer guidelines needed 8 components for compliance
- > Patients needed to be prioritized in terms of severity of illness instead of order of arrival
- > 100% compliance needed as soon as possible after gaps identified
- > Multi- disciplinary task force (nurses, medical providers, quality and regulatory department personnel) organized to address and correct gaps

Leveling

- \succ Live system wide in 10/2015

- > Nursing team at the UCCs previously recognized higher acuity illnesses based on relatively subjective criteria > New policy streamlined a process to improve the quality of care provided to our patients by using a primarily objective leveling system to identify higher acuity patients and ensure they are seen quicker
- practices
- > Level assigned in intake by the nurse
- \succ Guides medical provider as to the order in which to see patients \succ Guide comprises of:
- > Diagnoses
- > Parameters
- > Symptoms
- > Definition of resources
- > Normal vital signs

Purpose

> To describe metrics and methods used to:

> Develop an innovative leveling process to categorize, treat and expedite transfers of the critically ill pediatric patient population to a higher level of care (as needed) from a pediatric urgent care center in the outpatient setting.

Practice Change

- > Acuity of patients seen in the UCCs are similar to those seen in the Emergency Department, however, complexity is not as high and they typically require less resources.
- > Developed a simplified leveling system based on current Emergency Severity Index (ESI) guidelines and information from a literature search of best practices (Marx, et al, 2013).
- > Further research was conducted and 3 levels of severity to categorize patients was created.
- > 3 levels: RED, YELLOW, and GREEN with Red being most severe and Green low severity.
- \succ Guides the physician to the order by which to complete the Medical Screening Exam (MSE).
- > The use of mostly objective information gathered upon initial intake of the patient is used.
- > When initial intake is performed by a nurse, a standard process is used to level the presenting severity and thus noted in the medical record documentation.

S Ð \mathbf{n}

RED level: Patient needs immediate medical attention. These patients may be presenting to the intake nurse with compromise in one or more areas. EMS 911 transfer to a higher level of care may be a depart disposition by the physician once the MSE is performed.

YELLOW level: Patient presents with a serious illness/ injury yet stabilization status is not expected to deteriorate.

GREEN Level: Patient presents with relatively minor complaint (s) or injury. Patient's status is unlikely to deteriorate.

Nicklaus Children's Hospital, Miami, Florida

 \rightarrow Current practice was to see patients in order of arrival rather than by acuity.

> Simplified leveling system based on Emergency Severity Index (ESI) guidelines and literature review of best

> Based on symptoms, severity of illness or history and potential number of resources to be used for treatment

Leveling

- > Detailed guide developed and updated
- \succ Intense staff education
- > Colors embedded in electronic health record (EHR) and visible on tracking board for all (especially medical providers) to see







Leveling Guide

| Active Sei | zures |
|-------------|--|
| Anaphyla | tic Reaction (onset in minutes to hours) |
| ÷ | Resignatory Compromise (dyspnea, wheeze, stridor, hypoxemia) Reduced systolic blood pressure Hypopentiasin (e.g. Synope, incontinenea, hypotonia) Skin and/or muccasi Involvement (hives, tich-flush, swollen lips, tongue or uvula) Presistent astrictinetimal symptoms |
| | Il thickness. Partial thickness burns in the face over more than portion of the body |
| Cardiopul | monary Arrest |
| Comorbid | ty history with exacerbation and/ ill looking presentation |
| Drowning | or near drowning |
| Fractures | of long bones (suspected or verified) |
| Febrile inf | ant <28 days of age with fever >100.4 F (38.0 C) rectal temperature |
| Hemophili | a patients with possible acute bleeds |
| : | Joint pain or swelling History of fall or injury Vital aigns and/or mental status outside of baseline |
| Hypotherr | nic infants <90 days of age with temperature <97.7 F (36.5 C) rectal temperature |
| Immunoco | ompromised patients with fever |
| Ingestion | f toxic items |
| Mental sta | itus changes or abnormalities / suicidality / homicidality/ overdoses |
| | Id Trauma with hypoventilation and / loss of consciousness and/ or vomiting and / or signs of increased ICF nequal pupils |
| Moderate | to severe croup |
| Motor veh | icle accident victim |
| Open frac | tures |
| Ocular em | ergencies eg. Chemical splashes, significant trauma |
| Pain level | of >8 on a 10 point scale with 10 being the most severe (with signs of distress) |
| Petechial | Rash in a patient with Altered Mental Status (regardless of age) |
| Respirato | y Arrest |
| | ry Distress (Tachypnea, Tachycardia, Increased Respiratory Effort, Abnormal sounds such as grunting, <mark>abs</mark> utered Mental Status) |
| sounds, A | |

Examples of YELLOW Level Conditions LLOW Level patients will usually need two reso ources in the UCC's are defined as Labs (CBC, Strep Antigen, RSV/Flu, etc. IV Fluids or Meds

| Complex Facial/ Intraoral Lacerations |
|--|
| Lacerations across the Vermillion Border |
| Lacerations requiring a multilayered closure |
| Extremely dirty or contaminated wounds |
| ysuria |
| lank Pain |
| oreign Body in Ear, Nose, or Eye that does not impede vision, airway or hearing. |
| eneralized Abdominal Pain |
| igestion of non-toxic items |
| ain level of >4 but <8 on a 10 point scale with 10 being the most severe with clinical evidence such |
| S. |
| Tachycardia |
| Elevated BP |
| Diaphoresis |
| artial thickness burns over one section of the body |
| - |
| trains/Sprains with swelling and/or needs assist to ambulate or move the affected limb |
| ncomplicated Fracture/Dislocation stabilization |
| pper Respiratory Infection with mild labored breathing, vital signs stable |
| omiting/Diarrhea with no noted signs of dehydration such as: |
| Technologia |
| Tachycardia Pallor |
| Panor Dry cracked lips |
| Dry cracked lips |

Outcomes: continued

| | Nicklaus Children's Hospital UCC Acuity Census 2017 Running Totals | | | | | | | | | | | |
|--------|--|-------|-------|-------|-------|-------|--------|-------|--------------|--------|--|--|
| | PB | DO | WK | MIR | PBG | MID | ML | MAIN | West Bird | TOTALS | | |
| GREEN | 10,358 | 6,560 | 6,695 | 4,107 | 2,823 | 6,626 | 11,685 | 5,870 | 4,200 | 58,924 | | |
| RED | 120 | 43 | 23 | 13 | 8 | 46 | 120 | 25 | 29 | 427 | | |
| YELLOW | 1,745 | 803 | 776 | 342 | 720 | 990 | 1,300 | 356 | 469 | 7,501 | | |
| None | 48 | 16 | 27 | 6 | 9 | 12 | 59 | 61 | 17 | 255 | | |

Red- immediate medical attention needed. Anticipate transfer to higher level of care

llow- serious illness / injury bu is stable and not expected to deteriorate

Green- relatively minor illness / injury





Results



Conclusions / Significance

- \geq 35.9% decrease in LOS for 2016
- > Critical patients being seen and transferred to higher levels of care such as Emergency Rooms more quickly
- > Monthly evaluations of length of stay and amount of critical patients being seen at the UCCs are evaluated and increased staffing correlates to these patterns.
- > UCCs maintaining their 90 minute target for average length of stay for each patient visit.

Reference

Marx, J., et al. (2013). Rosen's Emergency Medicine: Concepts and Clinical Practice. 8th ed. Philadelphia: Saunders.

