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# **Fireside Chat Abnormal Vital Signs Bundle**

**August 1, 2023**

# Acknowledgments

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Thank you for  
joining!



Session is  
being recorded  
and posted  
online along  
with slides



Utilize the Q&A  
feature to ask  
questions



Place your  
name in the  
chat for  
nursing and  
social work  
credit



Discussion will  
follow  
presentation

# Objectives

After participating in this session, attendees will be able to:

- Describe how quality measures impact a site's pediatric readiness
- Be familiar with resources that are available to you as you embark on your QI Journey
- Explain the importance of early identification of abnormal vital signs in pediatric patients

# Speakers

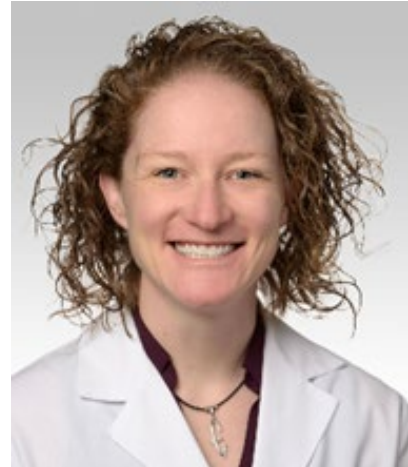
## Sheryl Yanger, MD, FAAP

- EIC Collaboratives Domain Co-lead
- Assistant Professor of Medicine, Department of Pediatrics
- Quality Director, Pediatric Emergency Medicine, Dell Children's Medical Center of Central Texas
- The University of Texas at Austin, Dell Medical School



## Emily Roben, MD, MS

- Pediatric Emergency Medicine Physician
- Director for Quality Improvement and Patient Safety
- UCSF Benioff Children's Hospital, Division of Pediatric Emergency Medicine
- Associate Professor, UCSF School of Medicine



# Background

This intervention bundle is designed to help guide PRQC teams that want to implement change strategies specific to the clinical care processes for assessment and reassessment of vital signs.



# Background



The early identification of patients at risk of clinical deterioration and matching the severity of illness to the appropriate level of care and resources needed are integral components of high-quality emergency medical care.

Abnormal vital signs are key in the early identification of critically ill and injured patients.

# Background

Goal: Early identification of abnormal vital signs to ensure timely recognition of patients with potential or established critical illness and to ensure a timely and appropriate response from skilled staff.

Vital sign measurements include:  
(using appropriately sized tools)

- Temperature
- Heart rate
- Respiratory rate
- Blood pressure
- Pulse oximetry
- \*Pain





# Vital Sign Assessment and Reassessment

Arrival

Triage

Intervention  
Workup

Reassessment

Interventions

Disposition



Obtain full vital signs,  
including pain score and  
weight in kilograms

Reassess  
vital signs

Intervene when vital  
signs are abnormal

# Obtaining and Detecting Abnormal Vital Signs:



- At triage: Recognition of potentially sick patients
- Reassessment: Detection of clinical deterioration
- Appropriate and timely responses at each phase

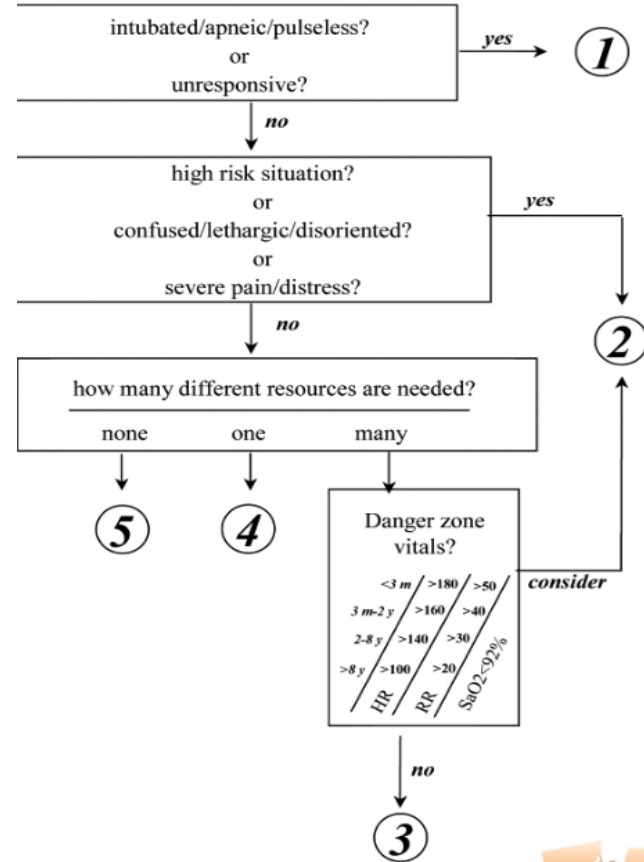
# Triage

## ESI TRIAGE



- 1** Requires immediate life saving intervention. Many resources required. Must be seen immediately.
- 2** Situation could progress to severe without intervention. Requires many resources. Seen within 10 minutes.
- 3** Has the potential to increase in severity if not treated. Requires 3 or more resources. Seen within 30 minutes.
- 4** Not severe or life threatening. Requires 1-2 resources. Seen within 60 minutes.
- 5** Not life threatening in any way. No resources required. Can wait for treatment.

## ESI Triage Algorithm



**EMSC**  
Quality Improvement  
Collaboratives

# Correct Equipment and Techniques

- Pediatric pulse ox probes
- Appropriate BP cuff sizes
- Rectal temps in infants, small children (<2y), critically ill patients
- Comfort holds



# MORE COMFORT, Less Pain MÁS COMODIDAD, Menos Dolor

These techniques reduce pain during procedures. Make a plan with your nurse before every procedure. Estas técnicas reducen el dolor durante los procedimientos. Haga un plan con su enfermera antes de cada procedimiento.



| Pain Management<br>Control del dolor   | Comfort positions<br>Posiciones de comodidad | Distraction for every age<br>Distracción para todas las edades   |
|--|--|--|
| <b>Infant   (0-12 months)</b><br><b>Bebés   (de 0 a 12 meses)</b>  |  | <p>Singing or listening to music<br/>Cantar o escuchar música</p>         |
|     |  | <p>Blowing bubbles or a pinwheel<br/>Soplando burbujas o un molinete</p>  |
| <b>Toddler &amp; Preschool   1-5 years</b><br><b>Niños pequeños y en edad preescolar / de 1 a 5 años</b>   |  | <p>Toys and games<br/>Juguetes y juegos</p>                               |
|     |  | <p>Reading or activity books<br/>Libros de lectura o de actividades</p>  |
| <b>Schoolage   6-11 year</b><br><b>Niños en edad escolar / de 6 a 11 años</b>  |  |  |
|     |  |  |
| <b>Adolescent   12-18 year</b><br><b>Adolescente / de 12 a 18 años</b>   |  |  |
|   |  |  |



# Standards for Normal

In order to recognize what is abnormal, must first have age based standards for normal VS ranges

**PALS**  
Vital Signs in Children

These 3 tables are reproduced or modified from *Textbook of Pediatric Nursing*, 6th Edition, by Nancy Grace of the City of Chicago, 3rd ed. © 2003, Mosby, 2013, 1-16, copyright Elsevier.

**Normal Heart Rates\***

| Age              | Awake rate | Sleeping rate (beats/min) | Age              | Rate (beats/min) |
|------------------|------------|---------------------------|------------------|------------------|
| Neonate          | 100-200    | 90-160                    | Infant           | 90-153           |
| Infant           | 100-160    | 90-160                    | Toddler          | 93-157           |
| Toddler          | 98-140     | 80-120                    | Preschooler      | 80-128           |
| Preschooler      | 80-120     | 65-100                    | School-age child | 65-105           |
| School-age child | 75-118     | 58-90                     | Adolescent       | 60-100           |
| Adolescent       | 60-100     | 50-90                     |                  |                  |

**Normal Respiratory Rates\***

| Age              | Rate (breaths/min) |
|------------------|--------------------|
| Neonate          | 30-53              |
| Infant           | 22-37              |
| Toddler          | 20-28              |
| Preschooler      | 18-25              |
| School-age child | 12-20              |
| Adolescent       | 12-20              |

**Normal Blood Pressures**

| Age                      | Systolic pressure (mm Hg) | Diastolic pressure (mm Hg) | Mean arterial pressure (mm Hg) |
|--------------------------|---------------------------|----------------------------|--------------------------------|
| Birth (12 h, <1000-g)    | 39-59                     | 16-36                      | 28-42†                         |
| Birth (12 h, 3 kg)       | 60-76                     | 31-45                      | 40-57                          |
| Neonate (60 h)           | 67-94                     | 35-53                      | 45-60                          |
| Infant (1-12 mo)         | 72-104                    | 37-56                      | 50-62                          |
| Toddler (1-2 y)          | 86-106                    | 42-63                      | 60-62                          |
| Preschooler (3-5 y)      | 89-112                    | 46-72                      | 59-69                          |
| School-age child (6-9 y) | 97-115                    | 57-76                      | 66-72                          |
| Preschooler (10-12 y)    | 102-120                   | 61-80                      | 71-79                          |
| Adolescent (12-15 y)     | 110-131                   | 64-83                      | 73-84                          |

\*Systolic and diastolic blood pressure ranges assume 50th percentile for height for children 1 year and older. †Mean arterial pressure (diastolic pressure + 1/3 difference between systolic and diastolic pressures) - 10 for 1 year and older, assuming 50th percentile for height. ‡Approximate normal pulse oximetry age in weeks (top) and 5 mmHg (bottom). Data from Daniels et al. *Eur J Pediatr*. 1990;145(2):138-320; Vermeulen et al. *Pediatrics*. 1981;67(5):670-673; and Daniels et al. *Eur J Pediatr*. 1990;145(2):138-320; Vermeulen et al. *Pediatrics*. 1981;67(5):670-673; and Daniels et al. *Eur J Pediatr*. 1990;145(2):138-320. Reprinted with permission from Elsevier. The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents. Publication No. 016-5063. NLM, Bethesda, MD, 2005.

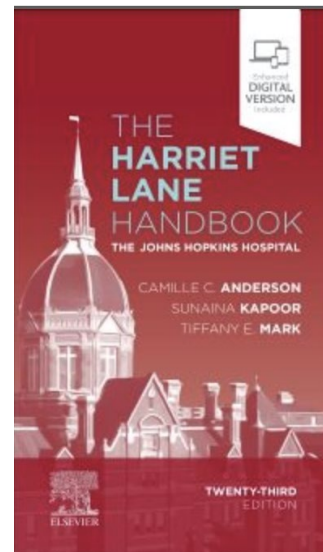
**Pediatric Early Warning Score (PEWS)**

| Behavior       | 0  | 1   | 2   | 3  | Score |
|----------------|--|---|---|--|-------|
| Behavior       | Playing/ Appropriate                     | Sleeping  | Irritable   | • Lethargic/confused OR<br>• Reduced response to pain  |       |
| Cardiovascular | Pink OR<br>capillary refill 1-2 seconds  | Pale or dusky OR<br>capillary refill 3 seconds  | • Grey or cyanotic OR<br>• Capillary refill 4 seconds OR<br>• Tachycardia of 20 above normal rate | • Grey or cyanotic AND mottled OR<br>• Capillary refill 5 seconds or above OR<br>• Tachycardia of 30 above normal rate OR<br>• Bradycardia |       |
| Respiratory    | Within normal parameters, no retractions | • >10 above normal parameters OR<br>• using accessory muscles OR<br>• retractions OR<br>• >30+%/FIO2 or 3+liters/min. | • >20 above normal parameters OR<br>• retractions OR<br>• >40+%/FIO2 or 6+liters/min.             | • ≥5 below normal parameters with retractions or grunting OR<br>• SO <sub>2</sub> +%/FIO2 or 8+liters/min.                                 |       |

\*Score by starting with the most severe parameters first.  
\*Score 2 extra for every 15-minute nbs (includes continuous nbs) or persistent post-op vomiting.  
\*Use "liters/minute" to score regular nasal cannula.  
\*Use "FIO2" to score a high flow nasal cannula.

Monaghan, A. (2005) Detecting and managing deterioration in children. *Paediatric Nursing*, 17, 32-35. Adapted for use at Children's of Minnesota.

|                               | Heart Rate at rest | Respiratory Rate at rest |
|-------------------------------|--------------------|--------------------------|
| Newborn (birth – 1 month)     | 100-180            | 40-60                    |
| Infant (1 – 12 months)        | 100-180            | 35-40                    |
| Toddler (13 months – 3 years) | 70-110             | 25-30                    |
| Preschool (4 – 6 years)       | 70-110             | 21-23                    |
| School Age (7 – 12 years)     | 70-110             | 19-21                    |
| Adolescent (13 – 19 years)    | 55-90              | 16-18                    |



**EMSC**  
Quality Improvement  
Collaboratives

National  
**PRQC**  
Pediatric Readiness Quality Collaborative  
Ensuring Emergency Care for All Children

# Notification System

- Notify providers of abnormal VS
- Trigger reassessments

BestPractice Advisory - TeeSystem, MaryJo

**Your patient has tachycardia and/or hypotension documented.**

Filed Sepsis-Related Vitals:  
03/24/15 1221

Pulse: 200

Additional assessments are needed to determine further interventions.

**Is there a fever (home or ED  $\geq 38$ ), hypothermia or signs/symptoms of infection for this patient?**

Do one of the following:

If **No**, click the **no concern for infection** button below.

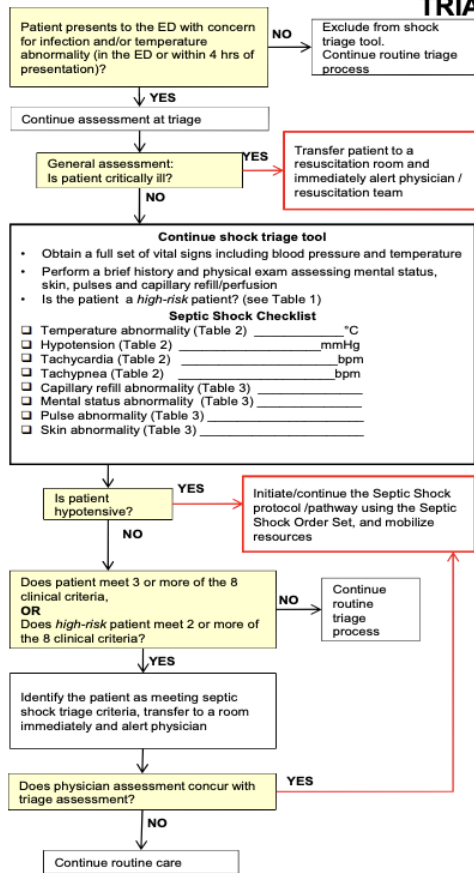
If **Yes**, click the **hyperlink** below to document additional assessments.

Acknowledge reason:

[CLICK HERE TO DOCUMENT ADDITIONAL ASSESSMENTS](#)

|                                |   |
|--------------------------------|---|
| 02,01/VB02<br>Possible SIRS Pe | 3 |
| 04,01                          | 3 |
| 15,01                          | 3 |
| 17,01<br>Sepsis Screen         | 2 |

## PEDIATRIC SEPTIC SHOCK COLLABORATIVE TRIAGE TRIGGER TOOL



**Table 1. High Risk Conditions**

- Malignancy
- Asplenia (including SCD)
- Bone marrow transplant
- Central or indwelling line/catheter
- Solid organ transplant
- Severe MR/CP
- Immunodeficiency, immunocompromise or immunosuppression

**Table 2. Vital Signs (PALS)**

| Age           | Heart Rate | Resp Rate | Systolic BP            | Temp (°C)    |
|---------------|------------|-----------|------------------------|--------------|
| 0 d – 1 m     | > 205      | > 60      | < 60                   | <36 or >38   |
| ≥ 1 m - 3 m   | > 205      | > 60      | < 70                   | <36 or >38   |
| ≥ 3 m - 1 r   | > 190      | > 60      | < 70                   | <36 or >38.5 |
| ≥ 1 y - 2 y   | > 190      | > 40      | < 70 + (age in yr × 2) | <36 or >38.5 |
| ≥ 2 y - 4 y   | > 140      | > 40      | < 70 + (age in yr × 2) | <36 or >38.5 |
| ≥ 4 y - 6 y   | > 140      | > 34      | < 70 + (age in yr × 2) | <36 or >38.5 |
| ≥ 6 y - 10 y  | > 140      | > 30      | < 70 + (age in yr × 2) | <36 or >38.5 |
| ≥ 10 y - 13 y | > 100      | > 30      | < 90                   | <36 or >38.5 |
| > 13 y        | > 100      | > 16      | < 90                   | <36 or >38.5 |

**Table 3. Exam Abnormalities**

|  | Cold Shock        | Warm Shock                                     | Non-specific   |
|--|-------------------|--|--|
| <b>Pulses (central vs. peripheral)</b>           | Decreased or weak | Bounding                                       |  |
| <b>Capillary refill (central vs. peripheral)</b> | ≥ 3 sec           | Flash (< 1 sec)                                |  |
| <b>Skin</b>                                      | Mottled, cool     | Flushed, ruddy, erythroderma (other than face) | Petechiae below the nipple, any purpura  |
| <b>Mental status</b>                             |                   |  | Decreased, irritability, confusion, inappropriate crying or drowsiness, poor interaction with parents, lethargy, diminished arousability, obtunded |



# Why is this important?



Tachycardia can be sign of:

- Fever
- Anxiety
- Pain
- Dehydration
- *Early indication of shock:*
  - *Sepsis*
  - *Myocarditis*
  - *Hypovolemia*

# Challenges

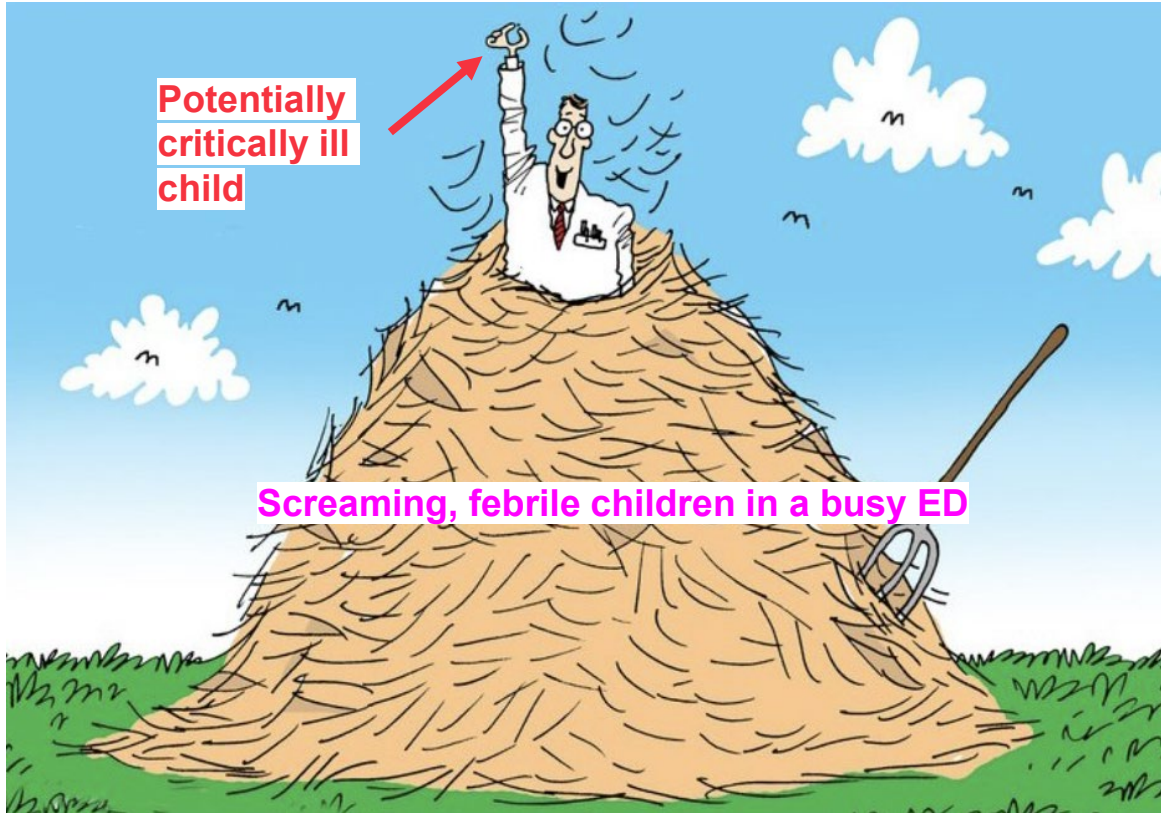
- Early, accurate recognition of pediatric severe sepsis is challenging
- Many children present initially with compensated shock and no apparent hypotension
- Difficult to differentiate rare severe sepsis/septic shock from many non-septic patients with fever and tachycardia

# Sepsis Screening

From: [Pediatric sepsis screening in US hospitals](#)

| Author                         | Year | Framework          | Form                                      | Population screened          | Reference standard   | Sens (%) | PPV (%) |
|--------------------------------|------|--------------------|---|------------------------------|--|----------|---------|
| Cruz et al. <sup>13</sup>      | 2012 | Internally derived | Automated alert followed by manual screen | All ED patients              | Shock diagnosed by ED attending  | 81       | 4       |
| Sepanski et al. <sup>12</sup>  | 2014 | Modified SIRS      | Automated                                 | All ED patients              | Presence of SIRS with organ dysfunction among patients with specific diagnosis codes or who met alert criteria             | 97       | 49      |
| Lane et al. <sup>22</sup>      | 2016 | PSSC               | Manual                                    | Fever or suspected infection | Internal criteria derived from ACCM guidelines <sup>20</sup>   | 99       | 20      |
| Balamuth et al. <sup>31</sup>  | 2017 | PSSC               | Automated alert followed by manual screen | All ED patients              | Use of ED sepsis protocol or ICU admission meeting Goldstein <sup>25</sup> severe sepsis/septic shock criteria within 24 h | 86       | 25      |
| Lloyd et al. <sup>27</sup>     | 2018 | PSSC               | Automated                                 | All ED patients              | Use of ED sepsis protocol  | NR       | NR      |
| Eisenberg et al. <sup>32</sup> | 2021 | Modified SIRS      | Automated                                 | All ED patients              | Goldstein <sup>25</sup> severe sepsis/septic shock criteria or ICD code for severe sepsis/septic shock within 24 h         | 85       | 4       |

ED emergency department, ICU intensive care unit, NR not reported, PPV positive predictive value, PSSC Pediatric Septic Shock Collaborative, Sens sensitivity, SIRS systemic inflammatory response syndrome.



# Pediatric Sepsis

**Sepsis is the leading cause of morbidity and mortality worldwide**

- Annual healthcare costs in US >\$15 billion
- Mortality in children < adults, up to 10%
- 80% increase in pediatric severe sepsis 1995 to 2005\*
- Septic shock >50% of shock presenting to peds ED<sup>^</sup>

# Systemic Inflammatory Response Syndrome (SIRS)

At least two criteria:

- **Core temperature  $<36$  or  $>38.5^{\circ}\text{C}$**   
And/or
- **WBC elevated or depressed for age**  
plus
- Tachycardia (or bradycardia in infants)
- Tachypnea
- $>10\%$  immature neutrophils

# Surviving Sepsis

- International initiative, consensus guidelines
- Decrease mortality from severe sepsis/septic shock
- Early goal-directed therapy



# Guided Interventions

0 min  
 5 min  
 15 min  
 60 min  
 Department  
 Emergency  
 Unit

Recognize decreased mental status and perfusion.  
 Begin high flow O<sub>2</sub>. Establish IV/IO access.

**Initial resuscitation:** Push boluses of 20 cc/kg isotonic saline or colloid up to & over 60 cc/kg until perfusion improves or unless rales or hepatomegaly develop.  
 Correct hypoglycemia & hypocalcemia. Begin antibiotics.

If 2nd PIV start inotrope.

*shock not reversed?*

**Fluid refractory shock:** Begin inotrope IV/IO. use atropine/ketamine IV/IO/IM to obtain central access & airway if needed.  
*Reverse cold shock* by titrating central dopamine or, if resistant, titrate central epinephrine  
*Reverse warm shock* by titrating central norepinephrine.

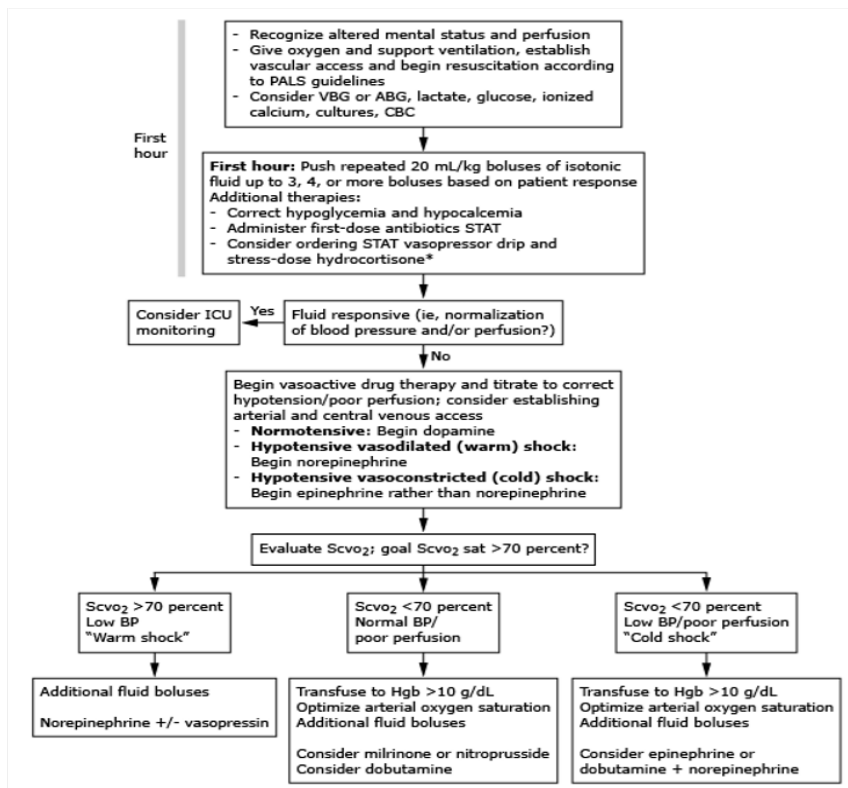
dose range:  
 dopamine up to 10 mcg/kg/min,  
 epinephrine 0.05 to 0.3 mcg/kg/min.

*shock not reversed?*

**Catecholamine resistant shock:** Begin hydrocortisone if at risk for absolute adrenal insufficiency



# PALS Septic Shock Algorithm



# Early Recognition = Improved Outcomes

- Decreased organ dysfunction
- Decreased hospital and ICU LOS
- Decreased mortality

# Quality Measures

| Phase of Care | Quality Measures  |
|---------------|---|
| Assessment    | Percentage of pediatric patients with their weight documented in kilograms only |
|               | Percentage of pediatric patients with pain assessed                             |
|               | Percentage of pediatric patients with vital signs re-assessed                   |
| Intervention  | Median time from collection of first set of vital signs to first intervention   |

# Choosing Measures for Your Site

Arrival

Triage

Intervention  
Workup

Reassessment

Interventions

Disposition

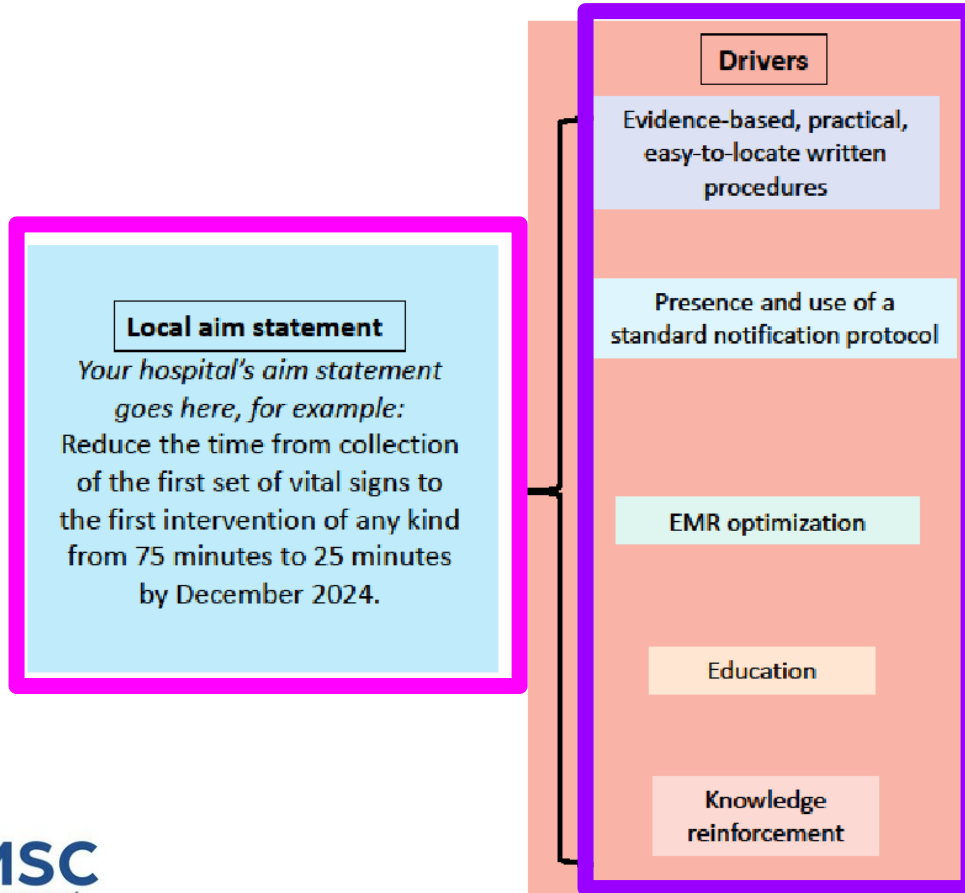


Obtain full vital signs,  
including pain score and  
weight in kilograms

Reassess  
vital signs

Intervene when vital  
signs are abnormal

# Key Driver Diagram



# Key Driver Diagram

## Local aim statement

*Your hospital's aim statement goes here, for example:*  
Reduce the time from collection of the first set of vital signs to the first intervention of any kind from 75 minutes to 25 minutes by December 2024.

## Drivers

Evidence-based, practical, easy-to-locate written procedures

Presence and use of a standard notification protocol

EMR optimization

Education

Knowledge reinforcement

## Intervention strategies

- Create a written procedure guideline for vital signs in pediatric patients
- Length-based tape available in triage



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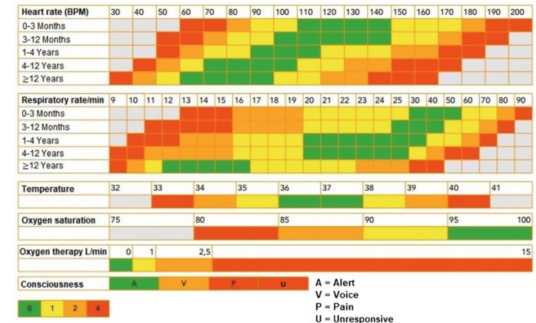
Education

Knowledge reinforcement

Chief Complaint: Juan has a cold  
Reason for Visit: Lingering cough, fever, possible nasal infection  
Weight: 145 Lbs, Height: 66 In, Temp: 102, Pulse: , Resp: , Vision: , BP: 127 / 75  
Systolic: 124, Diastolic: 77  
Location: arm

- Adopt a validated triage tool
- Establish criteria for activating a notification system
- Establish the process and components of notification system
- Implement standing orders in triage

## MPEWS



# Key Driver Diagram

## Local aim statement

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## Drivers

Evidence-based, practical, easy-to-locate written procedures

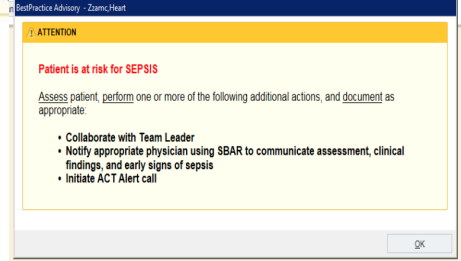
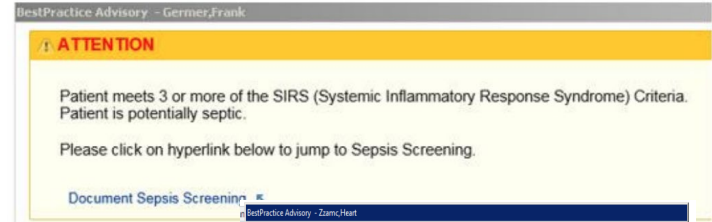
Presence and use of a standard notification protocol

EMR optimization

Education

Knowledge reinforcement

- EMR alerts for vital signs out of range
- Integrate clinical decision support tool to combine patient factors into alerts
- Color coding system for patient charts



| Bed  | Patient                         | Lang         | CC           | ESI    | TT | RN | MD | New Fl | Lab | Shel | Prod | Shel | Crigo | EIO | POC | Utens | Pains | Sitter |
|------|---------------------------------|--------------|--------------|--------|----|----|----|--------|-----|------|------|------|-------|-----|-----|-------|-------|--------|
| A    | Zemk, McLean (88 year old)      | Eng          | MedTech Peds | 194.29 |    | ZB |    |        |     |      |      |      |       |     |     |       |       |        |
| A    | Zemk, Clark (72 year old)       | Eng          | MedTech Peds | 194.17 |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| A    | Zepoths, Orders (23 year old)   | MedTech Peds | 459.39       |        |    | FT | 11 | 14     | 14  | 14   |      |      |       |     |     |       |       |        |
| A    | Zemk, J (20 year old F)         | MedTech Peds | 123.47       |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| B    | Zemk, C (12 year old F)         | MedTech Peds | 91.49        |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| B    | Zemk, Gogo (88 year old)        | Eng          | MedTech Peds | 239.41 |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| B    | Zemk, White (28 year old)       | MedTech Peds | 191.17       |        |    | RM |    |        |     |      |      |      |       |     |     |       |       |        |
| C    | Zemk, J (20 year old F)         | MedTech Peds | 91.59        |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| C    | Zemk, Preliminary (28 year old) | Sp. Sp.      | MedTech Peds | 75.19  |    | E  | 1  | 12     |     |      |      |      |       |     |     |       |       |        |
| D    | Zemk, J (20 year old F)         | MedTech Peds | 91.59        |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| D    | Zemk, Haskins (28 year old)     | Sp. Sp.      | MedTech Peds | 75.12  |    | E  | 1  | 12     |     |      |      |      |       |     |     |       |       |        |
| D    | Zemk, J (13 year old F)         | MedTech Peds | 91.49        |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| HALL | Zemk, J (20 year old F)         | MedTech Peds | 123.46       |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |
| HALL | Zemk, Clark (72 year old)       | MedTech Peds | 124.43       |        |    | E  |    |        |     |      |      |      |       |     |     |       |       |        |





# Key Driver Diagram

## Local aim statement

*Your hospital's aim statement goes here, for example:*  
Reduce the time from collection of the first set of vital signs to the first intervention of any kind from 75 minutes to 25 minutes by December 2024.

## Drivers

Evidence-based, practical, easy-to-locate written procedures

Presence and use of a standard notification protocol

EMR optimization

Education

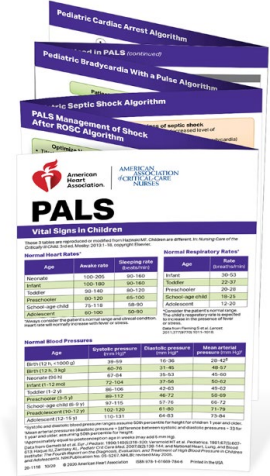
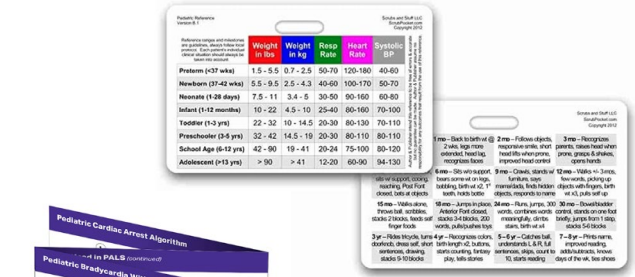
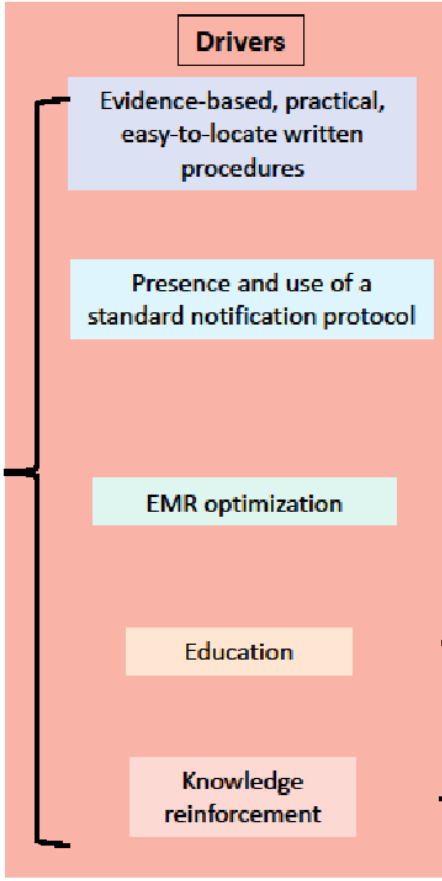
Knowledge reinforcement



- Develop training education for care team
- Identify training modality
- Present new information at staff meetings

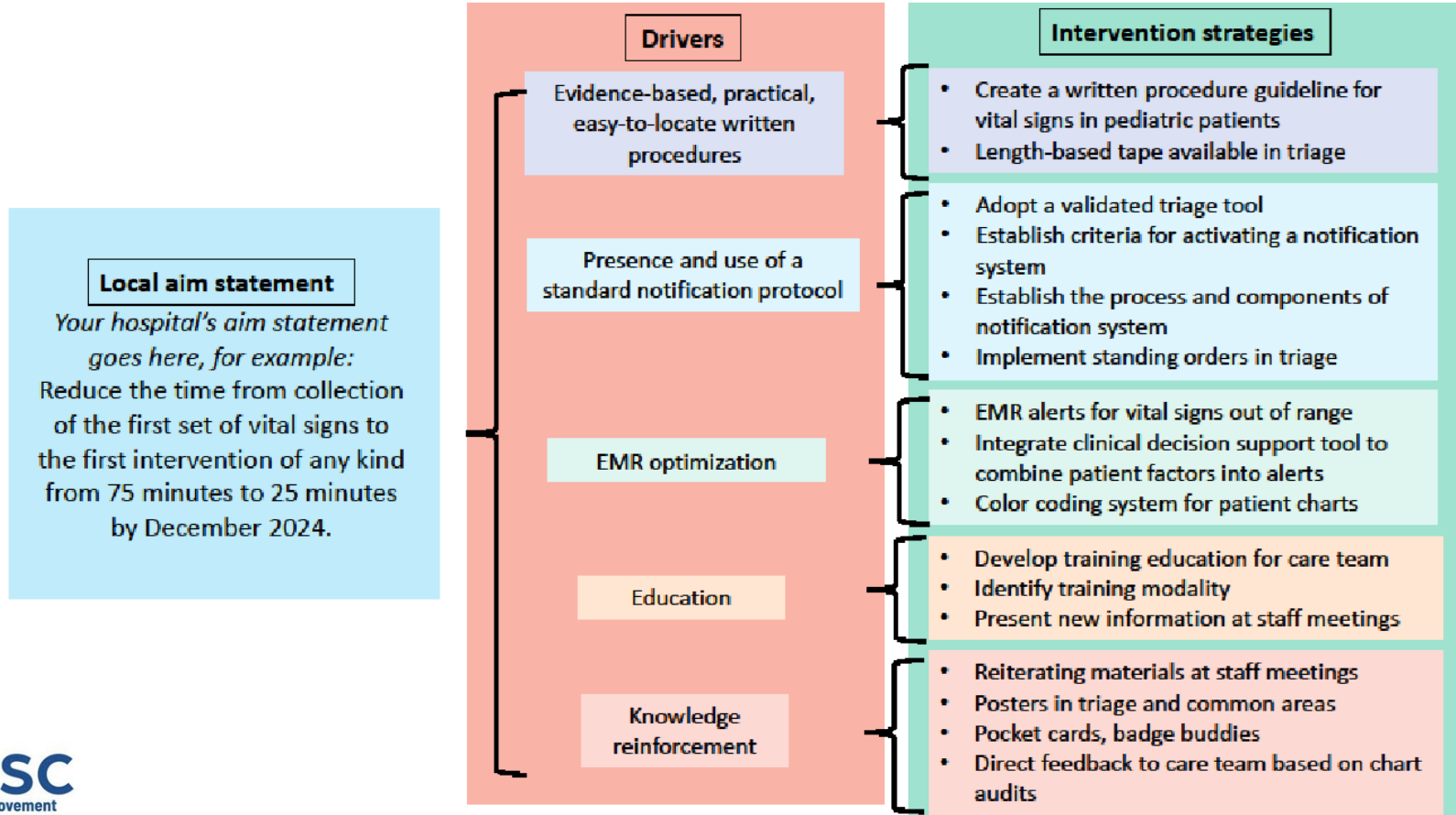
# Key Driver Diagram

**Local aim statement**  
*Your hospital's aim statement goes here, for example:*  
 Reduce the time from collection of the first set of vital signs to the first intervention of any kind from 75 minutes to 25 minutes by December 2024.



- Reiterating materials at staff meetings
- Posters in triage and common areas
- Pocket cards, badge buddies
- Direct feedback to care team based on chart audits

# Key Driver Diagram



# Summary

Background on the importance of pediatric vital sign assessment and reassessment

Quality measures for pediatric readiness

Basic structure of determining your site's aims, drivers, and interventions

# Things to Consider

Why is this bundle right for your site?

- Vital sign assessment and reassessment is a great place to **START**
- Vital signs are at the core of how we evaluate and begin our management of **ALL** patients
- This bundle will employ some **SIMPLE** and **STRAIGHTFORWARD** tools that you can implement
- The data analysis is likely to be manageable and we anticipate that **YOU WILL SEE RESULTS!**

# Q&A Session



## Complete Registration for the Data Platform

- Share demographics
- Provide data platform users
- *Include name, email, phone # of POA signatory*
- *Upload signed POA to data portal registration*



## Register for the Next Fireside Chat

- August 8, 2023
- 1-2 pm CT
- Topic: Weight in Kilograms



## Patient Safety



August 8, 2023

## QI and Data Sampling



August 15, 2023

## Data Literacy in a QI Project



September 5, 2023

# Join us for upcoming sessions



# Nursing - CE contact hours

## Fireside Chat #4 August 1, 2023

1. Enter your first and last name in the **chat** if you have not done so already
2. Scan the QR code/use link to access session evaluation
3. Submit completed evaluation by 1700 (Pacific) on **8/03/2023** to be eligible for CE hours



<https://bit.ly/PRQCFireside4>

If you have any questions, please contact Robin Goodman at

[robin.goodmannrn@gmail.com](mailto:robin.goodmannrn@gmail.com)

BRN CE Provider: Pediatric Liaison Nurses Los Angeles County. Provider approved by the California Board of Registered Nursing, Provider # 15456, for 1 Contact Hours

# Social Work Professionals – CEU's Fireside Chat #4 August 1, 2023

1. Enter your first and last name in the **chat** if you have not done so already
2. Scan the QR code/use link to access session evaluation



[https://utexas.qualtrics.com/jfe/form/SV\\_5gopiw6YInB4TWe](https://utexas.qualtrics.com/jfe/form/SV_5gopiw6YInB4TWe)

# Please Complete Session Evaluation

*Thank you!*

