Welcome to the 43rd Annual School Health Conference

Friday July 30th, 2021
Attendance Tracking

• Use your camera app and hold up over the QR code to have access to the attendance form OR click on link in Chat

• Your information will be used to send a Survey Monkey Survey for:
  • Feedback
  • CNE credit

https://cmhredcap.cmh.edu/surveys/?s=NYAP47MCHL
43rd Annual School Health Conference
Disclosures

Requirements for Successful Completion (to receive the ___ contact hour(s) for this activity):

The participant will:
• Complete REDCap attendance form
• Attend the entire conference
• Complete the conference evaluation by August 6

Provider Approval Statement:
Children’s Mercy Kansas City is approved with distinction as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

Conflict of Interest:
No conflicts of interest have been identified for the planners or presenters of this activity.
Important Details

• All mics are muted during the conference
• Submit your questions in the chat box
• We will have two Q & A sessions to address questions in the chat box
COVID-19 School Assistance


Have a question about COVID-19?
Submit it through the COVID-19 School Assistance Form

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15 AM</td>
<td>Today’s Agenda</td>
<td></td>
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<tr>
<td>8:15 AM –</td>
<td>Diabetes Management and Technologies</td>
<td>Ryan McDonough, DO</td>
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<tr>
<td>9:00 AM</td>
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<tr>
<td>9:15 AM –</td>
<td>Urgent vs. Emergent Injuries/Illnesses</td>
<td>Heather Jones, MSN, RN, CPNP, AC/PC</td>
</tr>
<tr>
<td>9:45 AM –</td>
<td>Q &amp; A Session</td>
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<td>10:00 AM</td>
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<tr>
<td>10:10 AM</td>
<td>What Every School Nurse Wants to Know: Mental Health Pearls</td>
<td>Becky Austin-Morris, DNP, PMHNP-BC</td>
</tr>
<tr>
<td>10:55 AM</td>
<td>Q &amp; A Session</td>
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<tr>
<td>11:10 AM</td>
<td>Mental Health: We’re in This Together</td>
<td>Children’s Mercy Parent Advisory Council Panel</td>
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<td>11:40 AM</td>
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<tr>
<td>11:55 AM</td>
<td>Prepped and Ready</td>
<td>Shayla Sullivant, MD</td>
</tr>
<tr>
<td>12:10 PM</td>
<td>Still in a Pandemic: Return-to-School Considerations</td>
<td>Atenas Mena, MSN, RN, CPN</td>
</tr>
<tr>
<td>12:25 PM</td>
<td>Q &amp; A Session</td>
<td></td>
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<tr>
<td>12:30 PM</td>
<td>Closing and NCPD/CNE instructions</td>
<td>Angie Knackstedt, BSN, RN, CPN</td>
</tr>
</tbody>
</table>
The Highs and Lows of Living with Diabetes at School

Laughter is the best medicine…
Well, unless you have Type 1 Diabetes. Then, insulin is probably better…

Ryan McDonough, DO, FAAP
Pediatric Endocrinologist & Diabetologist
Co-Medical Director, Pediatric Diabetes
Associate Professor of Pediatrics, UMKC
Children’s Mercy – Kansas City
Disclosures

- **Financial**
  - No financial disclosures

- **Academic**
  - TrialNet (Type 1 Diabetes research collaborative) has funded travel to research meetings
  - Type 1 Diabetes Exchange (Type 1 Diabetes QI collaborative) has funded travel to learning sessions

- **Brand Name/Off-Label**
  - Presentation will use proprietary names and images of specific diabetes technologies and insulins. No preference or support of any particular device or brand is implied
  - “Off-Label” use of technologies will be discussed throughout the lecture as most devices are only approved in subsets of pediatric patients
Learning Objectives

• Review the diagnostic criteria, incidence, prevalence and natural history of diabetes mellitus

• Explore the use of advanced technologies, including Continuous Glucose Monitors (CGM) and Insulin Pumps in the management of pediatric diabetes

• Discuss the use of “artificial pancreas” technology

• Understand the rare, but potentially serious, diabetes emergencies at school
Diagnostic Criteria

• ADA sets standards for dx
• Presence of symptoms is key
• Labs cannot be run on POC for dx
• Thresholds set based on development of retinopathy
• OGTTs are rarely needed for dx

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Threshold</th>
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</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Present</td>
</tr>
<tr>
<td>Fasting BG</td>
<td>≥ 126 mg/dL</td>
</tr>
<tr>
<td>Random</td>
<td>≥ 200 mg/dL</td>
</tr>
<tr>
<td>OGTT 2hPP</td>
<td>≥ 200 mg/dL</td>
</tr>
<tr>
<td>Hemoglobin A1c</td>
<td>≥ 6.5%</td>
</tr>
</tbody>
</table>
Diagnosis & Classification

- Diabetes is a complex metabolic disorder characterized by chronic hyperglycemia.
- Results from inadequate insulin secretion, action, or both.
- Lack of insulin action results in:
  - Decreased glucose disposal
  - Increased hepatic glucose output
  - Increased lipolysis (protective & dangerous)
  - Osmotic diuresis leads to dehydration/lactic acidosis
Type 1 vs Type 2

• Type 1 Diabetes
  • Autoimmune Disease
  • Beta-Cell Destruction
  • Insulin deficiency
  • Any Age, but typically < 45 years old
  • More common in children

• Type 2 Diabetes
  • Diet/Lifestyle driven
  • Ineffective use of insulin
  • Overweight/Obese
  • After puberty
  • More common in adult
Pathophysiology – Type 1

- Beta cell death caused by autoimmune destruction
- 80-90% of the pancreatic cells destroyed before symptoms develop
- Genetic predisposition contributes
Inheritance

- Familial aggregation accounts for ~10% of T1D
- No recognizable Mendelian pattern of inheritance

<table>
<thead>
<tr>
<th>Family Member w/ T1D</th>
<th>Risk of Developing T1D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>1.3 – 3.6%</td>
</tr>
<tr>
<td>Father</td>
<td>3.6 – 8.5%</td>
</tr>
<tr>
<td>Sibling</td>
<td>4%</td>
</tr>
<tr>
<td>Identical Twin</td>
<td>40%</td>
</tr>
</tbody>
</table>
T1D Epidemiology

• 1.54 cases per 1,000 youth
  ▪ Incidence is rising (JDRF)

• Prevalence by Race/Ethnicity
  ▪ 2 per 1,000 in non-Hispanic children
  ▪ 1.34 per 1,000 in Black children
  ▪ 1 per 1,000 in Hispanic children
COVID & New Onset Diabetes
INSULIN TREATMENT
Insulin Treatment, eh?

FUN TRIVIA!

- When was insulin discovered?
- What is the dog’s name?
- Where was insulin discovered?
Normal Insulin Secretion

Plasma insulin

Time

0:00 8:00 12:00 16:00 20:00 24:00

Breakfast  Lunch  Dinner
Insulin Treatment

- Insulin Action Times

- Novolog, Humalog, Apidra, Fiasp, Admelog
- Regular
- NPH
- Lantus, Basaglar, Tresiba, Levemir
Insulin: Injections

Breakfast  Lunch  Dinner

Basal Insulin  Bolus Insulin

Time

Plasma insulin

0:00  8:00  12:00  18:00  20:00  24:00

LOVE WILL.
Dosing Vocabulary

- **Basal Insulin**: long-acting insulin given typically once per day to provide some insulin in the “background” all the time.
- **Bolus Insulin**: short/rapid-acting insulin given several times per day to account for carbohydrate intake and to lower high glucose.
Bolusing Vocabulary

- **Carb Dosing**
  - **Carb Ratio**: amount of short/rapid-acting insulin given per # of grams of carbohydrate

- **Correction Dosing**
  - **Insulin Sensitivity Factor** (ISF or “correction factor”): how much someone’s blood glucose would drop if given 1 unit of short/rapid-acting insulin
  - **Target Blood Glucose**: blood glucose patient is “aiming” for when giving corrections for high blood glucose
  - **Threshold**: blood glucose level above which extra insulin is given to correct hyperglycemia
  - **Insulin On Board/IOB/Active Insulin**: amount of insulin that is still working in the body
Example Insulin Dosing

Pre-Meal Values

- Pre-Meal BG: 250
- Target Glucose: 150
- BG above Target: 100
- ISF: 50

Meal Values

- 1/2 cup Mac & Cheese: 23g
- 1 cup green beans: 4g
- 1 cup milk (8oz): 13g
- 2 Double Stuff Oreos: 21g
- Total Carbs: 61g
- Insulin: Carb Ratio 1:15

Final Dose

- Correction Dose: 2
- Meal Dose: 4
- Rapid acting insulin dose: 6
Treatment Goals

- American Diabetes Association Recommendations
  - A1c < 7.5% until 18 years
  - Tighter control (lower A1c) is encouraged provided avoidance of hypoglycemia
  - A1c < 7% in adulthood
  - A1c < 6% (normal) for people with T2D has been recommended
  - Few patients are meeting the goal (at CMH ~23%)
  - > 70% of time “in range (70 – 180 mg/dL)
Treatment Goals

*≤2 years old and ≥80 years old are pooled
INSULIN PUMPS
The First Pump: 1978
Insulin Pumps
MDI vs Pump

- Continuous Subcutaneous Insulin Infusion (CSII) is more physiologic
- CSII has increased treatment satisfaction, but does not show difference in glycemic control
- DKA rate is variable between studies, but generally higher in “pumpers”
- Artificial Pancreas Technology
Normal Insulin Secretion

Plasma insulin

4:00  8:00  12:00  16:00  20:00  24:00

Breakfast  Lunch  Dinner

Time
Insulin: Pump Regimen

Only rapid acting insulin is taken (before meals or for high BG), basal rates are set by family and healthcare team and run in the background.
No more basal injections!

- Patient must always remain attached to pump at all times (even while sleeping), in order to receive basal insulin
  - 30–60-minute breaks are acceptable for bathing and some exercise.
Tubed Pumps

- Reservoir filled with enough insulin to last 2-3 days
- Insulin travels into body through flexible tubing
- Plastic (or steel) cannula is inserted under the skin and is changed every 2-3 days

- The cannula is held in place by an infusion set (to secure the cannula to the skin)
Tubeless Pumps

- “Pod” is filled with enough insulin to last 2-3 days
- Insulin travels into body through SQ cannula
- Controlled by handheld device, thus no tubing
- If controller is lost, no bolus insulin can be given

- Often denied by state insurances
- No need to disconnect for activities or bathing
Where Might You Find a Pump?

- Can be placed anywhere an insulin injection can be given
  - Outer arm
  - Abdomen
  - Hip area
  - Thigh
  - Buttocks
- Site rotation mandatory for insulin absorption and to avoid lipohypertrophy
Problems w/ Pumps

- Pumps ONLY delivery fast acting insulin
- Pumps sometimes break!
- Sites can “go bad” (see picture)
- Pumps DO NOT take away diabetes, or allow someone to “set it and forget it”
- Not all patients are good candidates for pumps
- Pumps will not fix non-adherence or prevent DKA/hospitalization
- Pumps have been shown to improve quality of life
CONTINUOUS GLUCOSE MONITORS (CGM)
CGM

Smart devices sold separately.
How do sensors work?

- Bio-filament (wire-like probe) placed subcutaneously
- Continuously measures interstitial glucose
- Algorithm converts reading to “blood sugar”
- Displayed with directional arrows and able to alarm when BG is high, low, rising, or falling
- Contains 3 parts: sensor, transmitter, and receiver
- FDA approved to wear for 7-10 days
CGM Gives More Data

• Calibration: most recently approved devices do not require calibration
• CGM gives directional context to a BG that a finger stick cannot
• CGM can observe effects of exercise, food choices, etc. on blood glucose

If you saw this number, what would you do?

If you saw this instead, would you do something differently?
What do those arrows mean?

<table>
<thead>
<tr>
<th></th>
<th>Dexcom G5/G6*</th>
<th>Guardian Connect</th>
<th>FreeStyle Libre</th>
<th>Eversense</th>
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<tbody>
<tr>
<td>Arrow</td>
<td>Glucose slowly falling 1-2 mg/dL/min 0.06-0.1 mmol/L/min</td>
<td>Glucose slowly falling 1-2 mg/dL/min 0.06-0.1 mmol/L/min</td>
<td>Glucose rapidly falling &gt;3 mg/dL/min &gt;0.2 mmol/L/min</td>
<td>Glucose rapidly falling &gt;2 mg/dL/min &gt;0.1 mmol/L/min</td>
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<td>Glucose rapidly falling &gt;2 mg/dL/min &gt;0.1 mmol/L/min</td>
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<tr>
<td></td>
<td>Glucose is rising 2-3 mg/dL/min 0.1-0.2 mmol/L/min</td>
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<td>Glucose is rising 2-3 mg/dL/min 0.1-0.2 mmol/L/min</td>
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<td>Glucose slowly rising 1-2 mg/dL/min 0.06-0.1 mmol/L/min</td>
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<td>Glucose slowly rising 1-2 mg/dL/min 0.06-0.1 mmol/L/min</td>
</tr>
<tr>
<td>Glucose steady</td>
<td>Increasing/decreasing &lt;1 mg/dL/min &lt;0.06 mmol/L/min</td>
<td>Glucose steady Increasing/decreasing &lt;1 mg/dL/min &lt;0.06 mmol/L/min</td>
<td>Glucose steady Increasing/decreasing &lt;1 mg/dL/min &lt;0.06 mmol/L/min</td>
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INTEGRATED TECHNOLOGIES
“Artificial Pancreas”

- “Artificial pancreas” options (in ascending order of automation)
  - Sensor augmented pumping
  - Low glucose suspend
  - Predicted low glucose suspend
  - Hybrid Closed Loop
  - Full Closed Loop “aka “artificial pancreas”
  - Dual Hormone pumps
Normal Insulin Secretion

The graph illustrates the plasma insulin levels over time, with peaks corresponding to meals:
- **Breakfast** at 8:00
- **Lunch** at 12:00
- **Dinner** at 20:00
Insulin: “Artificial Pancreas”
Choices Choices!

A) A pump alone

B) A CGM alone (to use with shots or with any of the pumps)

C) A pump w/ augmented CGM

D) A pump that has integrated or controlling CGM

E) Multiple Daily Injections
DIABETES EMERGENCIES
Hyperglycemia

- **Symptoms**
  - Abdominal pain, vomiting, breathing quickly, fruity odor to breath

- **Blood Glucose > 200 mg/dL (or outside target)**
  - Need a correction dose to bring BG down

- **Blood Glucose > 240 mg/dL**
  - Check for ketones

- **Treatment**
  - Ketone dosing (Need to know TDD of insulin)
  - Drink water!!!
  - Pumpers: Change pump site!

- **Emergency Treatment**
  - If ketones are not clearing after 2 correction doses, call parent/Diabetes Team
  - If vomiting, needs to be evaluated in ED to rule out DKA
Hyperglycemia

- No acute harm for BG > 200 mg/dL without ketones
- Can continue to participate in school activities/testing
- If ketones present, then delay testing and avoid intense physical activity
- Some kids have poor control, and they may “live” in the 200’s or higher
  - Only about 25% of kids at CM are meeting glycemic targets
  - Sometimes the only insulin they reliably get is at school!
Hypoglycemia

- Blood Glucose < 70 mg/dL
- Symptoms
  - Dizzy, lightheaded, hungry, irritable, aggressive, sweaty, shaky
  - Do not send to RN Office unaccompanied!
- Treatment
  - 15/15 Rule: 15 grams rapid acting carbs, repeat BG check in 15 minutes
  - Caveat: some kids, particularly those on HCL systems, do not always need a full 15 grams
- Emergency Treatment
  - Seizures/Unconscious: Give glucagon, THEN call 911
  - Glucagon comes in multiple forms now!!!
Thank you!

Mom: “Her a1c was what?!”

Pediatric Illness & Injury
Urgent vs. Emergent

Heather L. Jones, MSN, RN, CPNP-AC/PC
Disclosure

• I have no disclosures.
Objectives

• Discuss the indications for recommending Urgent vs Emergent Care
• Categorize injury into Urgent or Emergent conditions
• Categorize illness into Urgent or Emergent conditions
• Identify local resources for care
Urgent Conditions

• Urgent conditions do not involve compromise or failure of systems.
• Symptoms in the system (i.e., wheezing, dehydration, headache, etc.) may be present but the patient's body system is able to compensate.
• Urgent conditions may evolve into emergent conditions if left untreated.
Emergent Conditions

• Compromise or failure of the Respiratory

• Cardiovascular or Neurologic Systems
Respiratory Compromise

- Increased work of breathing
- Altered rate of breathing
- Diminished breath sounds
- Inability to speak in full sentences
- Grunting or Stridor
- Circum-oral cyanosis
- Altered LOC
Circulatory Compromise

- Infrequent except in case of congenital heart disease
- Altered Heart Rate
- Hypotension
- Altered LOC
- Syncope
Neurological Compromise

- Altered LOC
- Seizure
- Weakness/numbness in arms or legs
- Slurred speech
- Change in behavior
- Headache
Injuries
Head Injuries: Common Symptoms

- Headache
- Nausea/Vomiting
- Dizziness
- Sleepiness
- Scalp Hematoma (goose-egg)
Head Injuries: Abnormal Findings

- Child acts confused or unusual
- Seizures/convulsions
- Weakness in extremities
- Eye or pupil abnormalities
- Emesis > 3 times in 12 hours
- Difficulty walking or talking
- Worsening headache
Head Injuries: Treatment

- • Emergent-Call 911
  - Any loss of consciousness
  - Fall from height or high-impact injury
    - • Protect airway
    - • Protect C-spine
    - • Control bleeding
Head injuries: Treatment

• Initial
  – Cold pack
  – Treat lacerations or abrasions
  – Tylenol for pain (avoid ibuprofen)
  – Sips of fluids
  – Rest
Head Injuries: Treatment

• Initial
  – Monitor for abnormal or worsening findings
  
  If worsening symptoms occur

  – Urgent referral to a facility with CT capabilities, most likely an ER, is indicated
Head injuries: Concussion

• A concussion is a brain injury causing a temporary disturbance of brain function. Caused by a bump, blow, or jolt to the head or body

• If a concussion is suspected, seek care

• Concussion is common with head injury
Head injuries: Concussion

- Headache
- Vomiting
- Dizziness
- Blurred vision
- Balance problems
- Sensitivity to light and noise
- Confusion
- Drowsiness
- Difficulty concentrating or remembering
- Fatigue
- Irritability
- Emotional issues: nervous, anxious
Head injuries: Concussion

• Symptoms of a concussion can last up to 3 weeks!

• Treatment may include restricted schoolwork, shortened school days and decreased physical activity

• Initial evaluation and follow up care needed
Head injuries: Concussion

• Seek immediate care in this period for:
  – Worsening headache
  – Increased drowsiness
  – Difficulty recognizing people or places
  – Repeated vomiting
  – Unusual/irritable behavior
  – Seizures
  – Weakness/numbness in arms/legs
  – Slurred speech
Common Injuries
Bone and Joint Injuries

- Soft tissue injury, such as a sprain or strain of a joint space or muscle
- Torn ligament or tendon
- Fracture or broken bone
Assessment

- Deformity
- Swelling
- Sensation
- Perfusion (pulses, cap refill)
- Range of motion
Soft Tissue Injury

- Usually without point tenderness
- + Swelling, tenderness with ROM, normal sensation
- Neurovascularily intact, no deformity
- Treat with (RICE) Rest, Ice, Compression (splint or wrap), Elevation and anti-inflammatory medication (Ibuprofen)
Ligament or Tendon Injury

• Can be mild or severe

• Mild may only require RICE (rest, ice, compression (splint or wrap), elevation) and anti-inflammatories

• Severe may require surgery – will have loss of ROM if ligament or tendon is severed
Fractures: Most common

- Finger
- Distal radius (Buckle Fracture)
- Nursemaid's elbow common in < 5-year-olds
- Supracondylar (humerus)
- Clavicle
- Lateral malleolus (ankle)
Fractures: Emergent

- Open fracture
  - Think Basketball.....Kevin Ware...
- Surgical emergency
- Cover with sterile gauze and send to ED
- Deformity, compromised pulses or cap refill also indicate need for emergent evaluation
Fractures: Urgent

• Injuries with point tenderness may indicate a fracture and should have an x-ray

• + Fracture may require splinting or casting or a combination of both

• Return to regular activity is determined by the provider
Eye Injuries

• Corneal abrasion
  • Symptoms:
    – Tearing
    – Pain
    – Feeling as if something is in the eye
    – Sensitivity to light
Corneal Abrasion

• Needs evaluation, including exam of the eye with fluorescent stain.

• Good candidate for Urgent Care or Primary Care visit.

• Treatment depends on location of the abrasion on the cornea, may need to see ophthalmologist for follow up
Ruptured Globe of the Eye

- Caused by blunt or penetrating trauma to the eye
- Medical Emergency to the ER
- Do not attempt to remove any foreign body from the eye (i.e., tree branch, BB)
- Do not apply any pressure to the eye
Nose Injury / Nose Bleeds

• Nose injury:
  – check for septal deviation; treatment may be deferred until edema subsides

• Nosebleeds:
  – Pressure to nose x 10 minutes, reassess
  – Apply pressure for 10 more minutes as necessary
  – Further evaluation if bleeding does not subside after 20 minutes of direct pressure
Lacerations / Abrasions

- Hold pressure to stop bleeding
- Assess severity
- Clean with soap and water
- Apply non-stick dressing
- Evaluate at an urgent care for sutures if wound is gaping open or bleeding does not stop
Lacerations

• Lacerations to lips, tongue, inside of mouth, generally do not require sutures

• If laceration crosses the Vermillion Boarder of the lip, sutures are necessary
Lacerations: Home Care

• Keep area clean and dry
• Monitor for signs of infection
• Scar care as needed (massage, sunscreen)
Common Acute Illness: Urgent or Primary Provider Bound
Common Respiratory Conditions

- Asthma
- Croup
- Allergy
- URI
Asthma: Clinical Practice Guideline

- Childrensmercy.org
- Search under “for health care professionals”
- Evidenced Based Practice
- Clinical practice guidelines (CPG)
- Asthma ED/UC CPG
ENT Conditions

- Ear FB
- Ear drainage
- Nosebleeds
- Sore throat
Eye Conditions

- Conjunctivitis
- Stye
Conjunctivitis: New Recommendations

• Recommendation for a delayed treatment option

• Pink Eye often self-limiting condition
  • If symptoms remain for 3 days, then evaluate and treat.
Skin Conditions

• Poison Ivy
• Eczema
• Scabies
• Viral Exanthem
Neurological Condition

- Headache
- Seizure
Urgent Care vs Emergent Care

- Conditions requiring prescriptions
- Injuries self-limited care
  - Simple fractures
  - Simple lacerations
- Common acute illness

- Resuscitation
  - Cardiopulmonary failure
  - Anaphylaxis
- Acute change in LOC or behavior
- Conditions requiring sedation
- Cervical spine injuries
Our Locations

Broadway

South

Hospital Hill

East

Northland

West
Bibliography


• Ukwuoma, O. (2021, July). Trends in Head Computed Tomography Utilization in Children Presenting to Emergency Departments After Traumatic Head Injury, Allareddy, J., Allareddy, V., Rampa, S., Rose, J.A., Rhein, W., A.T. Pediatric Emergency Care,
Q & A
Use Chat Box to submit your questions