# A Quality Improvement Initiative to Improve the Pediatric Surgical Pathway at an Academic Medical Center

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## About Pennsylvania Hospital

- 475 Bed Urban Teaching Hospital in Center City Philadelphia
- One of five Magnet ® designated acute-care hospitals in the Penn Medicine system
- Nation's first hospital founded by Benjamin Franklin and Dr. Thomas Bond
- Over 29,000 inpatient admissions and 115,000 outpatient visits each year, including over 5,300 births

## Purpose

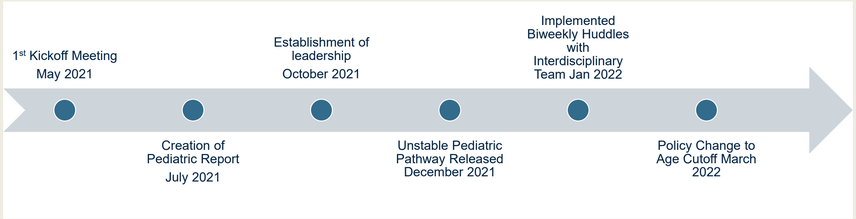
The goal of this group was to analyze the current state surrounding adolescent surgery at an academic medical center, improve the processes and close the gaps in scope.

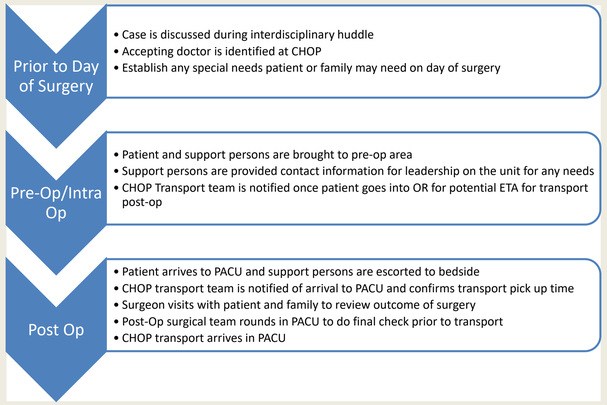
## Background

It was discovered that approval and oversight of adolescent surgical cases in our adult hospital setting was being performed inconsistently and lacked standardization. In order to optimize our processes, and ensure consistent and safe pediatric patient care that aligned with hospital policies, a formal hospital-based interdisciplinary workgroup was formed. After review, the main gaps that existed were around lack of communication amongst multi-disciplinary teams in preparation for a pediatric patient admission, need for updated hospital policies around care of the pediatric patient, and lack of clear guidance on how to manage an acutely decompensating pediatric patient in the adult hospital setting.

## Process of Implementation

The team first developed a emergent transfer pathway for clinician use in the event that a pediatric patient should acutely decompensate at any point in their stay at Pennsylvania Hospital; this was published to Dorsata for ease of accessibility by staff. Next, recurrent "huddles" were established with the workgroup to clinically review upcoming pediatric cases with the multidisciplinary team. The team included a representative from each of the following disciplines: nursing, therapy services, social work/case management, pharmacy and APPs/physicians, including members from both the inpatient and outpatient teams in order to better facilitate safe transitions in care. Lastly, , the team revised the adolescent surgery policy in order to define the scope of care for patients at Pennsylvania Hospital.




## Statement of Successful Practice

Since implementation of the multi-disciplinary "huddle", approximately 50 inpatient pediatric surgical cases have been reviewed with the group to date, with 5 of those patients safely transferred to CHOP in the post-operative period. No major safety events occurred in this cohort of patients. Examples of changes made to the patient's clinical course as a result of these huddles include: improved pre-op expectation setting with patient and family, adjustments to medications as needed based patient age and size, improvements in the discharge planning process, and changes in the patient's post-op level of care.

## Implications for Advancing the Practice of Perianestheisa Nursing

These meetings gave each stakeholder the opportunity to weigh in on any potential implications related to their discipline, and talk through strategies to avoid potential patient safety issues. The efforts of this work have helped to circumvent any potential patient progression/safety issues and facilitated a better overall experience for the pediatric patient and their family/support persons.

## Conclusion

Safe facilitation of pediatric surgical patients at an adult academic medical center is possible; keys to success include proactively engaging with stakeholders, involving all disciplines with an impact on patient care, and creating sustainable processes that are process-dependent and not person-dependent.