

Descriptive Assessment of the Pediatric Emergency Team System: The Memorial Health University Medical Center Experience

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Disclosures

None





Background

- At Memorial Health University Medical Center (MHUMC), the rapid response team is known as the Pediatric Emergency Team (PET)
- Composed of multidisciplinary health professionals
- PET purpose: bring critical care expertise to bedside and help before clinical deterioration
- Study aim: Assess the current PET process at MHUMC and identify potential areas of performance and process improvement
- Hypothesis: Improvement needed in communication, leadership, and documentation





Study Design/Methods

- Prospective observational study, single-center children's hospital
- Inclusion criteria: children (age 0-18 years) admitted to MHUMC during the pre- and post- intervention phase (i.e. 2/1-5/1/22 & 9/1/22-12/1/22 respectively) who experienced a PET call
- Exclusion criteria: patients >18 years of age, non-admitted children, code blue, or staff assist cases
- Physicians completed observation sheets regarding team dynamics, communication, documentation, and patient care
- Developed multiple educational interventions based on findings
- Post-intervention analysis





Study Interventions

- Formed multidisciplinary PET process committee
- Created PET call template for standardized documentation
- Clearly defined PET team member roles and duty responsibilities
- Provided education refresher
- Conducted multidisciplinary PET simulation session





PRE-INTERVENTION

- 14 total PET calls
- 7% standardized documentation
- 50% no clear leader
- 64% initial SBAR
- 64% occurred at night
- 50% respiratory complaints

POST-INTERVENTION

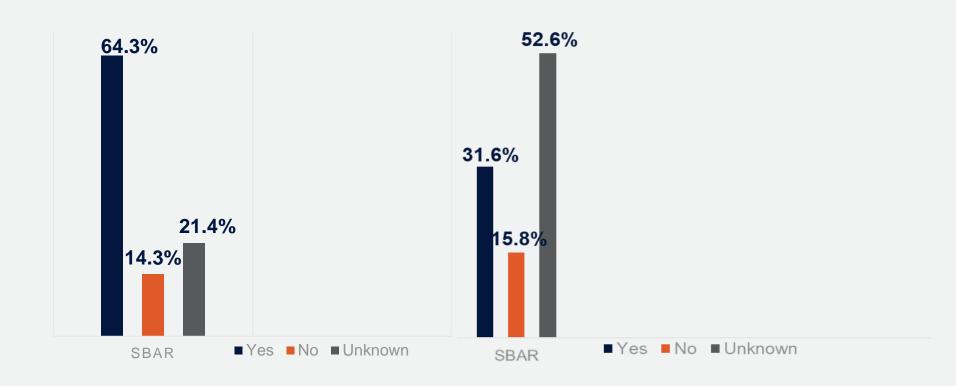
- 19 total PET calls
- 64% standardized documentation
- 64% no clear leader
- 32% initial SBAR
- 58% occurred at night
- 79% respiratory complaints





SBAR USE PRE-INTERVENTION

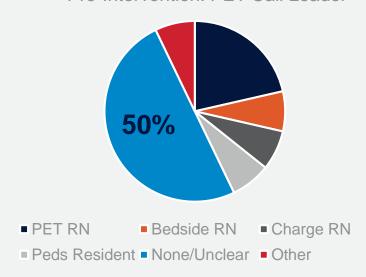
SBAR USE POST-INTERVENTION



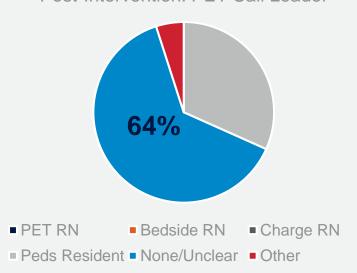








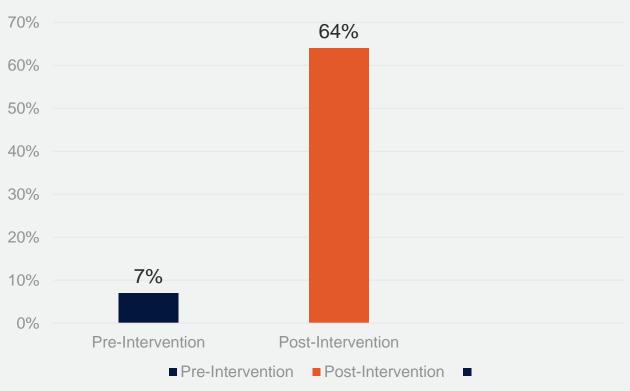
Post-Intervention: PET Call Leader







Occurrence of Standardized Documentation







Conclusions

- Inconsistent documentation, team dynamics, and communication practices exist with current PET call process
- Standardization of documentation improved recorded information
- PET leader identification and SBAR communication use remained low despite educational intervention
- Team dynamics and communication continue to be ongoing QI growth opportunities





Limitations

- Single-center study
- Reporter bias
- Lack of third-party observer data collection
- Missing data (inconsistent data reporting)





Next Steps

- Continued leadership reinforcement of standardized template use, assumption of team member roles and duties, and SBAR communication
- Repeat post-intervention phase with use of third-party observer
- Continued and more frequent multidisciplinary PET simulations (biannual or quarterly basis)





Acknowledgements

- Many thanks to the CHOS RNs, RTs, and staff who also recognized the need for improvement and helped support this project
- Special thanks to Drs. Lee, Hebert, and Keshwah for their support
- Final thanks to our patients the little ones who keep us searching for process improvement

