PICU Faculty Quality Improvement Involvement

Andrew Ausmus, MD
1. Reducing Alarm Fatigue
3. Decreasing Line-Associated VTE in Pediatric Cardiac Patients

Paul Bauer, MD
1. Line Entry and Rounding Checklist Utilization
2. PICU CLABSI group
3. High Acuity PICU Transfer Working Group (Code Prevention Framework on Medical Wards)
4. Human Factors Engineering working group for CLABSI

Tara Benton, MD
1. Pediatric Severe TBI Guideline Implementation
2. Severe Pediatric Burn Management Guideline Implementation
3. Line Entry and Rounding Checklist Utilization
4. Reduction of Pressure Ulcers Related to NIV by Standardizing Equipment
5. Reduction of Pressure Ulcers Related to Nasal ETTs
6. Fluid Goals in Cardiac Surgery Patients in the Post-Operative Time Period
7. Implementation of Bedside Huddle to Improve Communication When Coordinating Care for PICU Patients with Newly Diagnosed Anterior Mediastinal Masses

Jennifer Flint, MD
1. Passport to the PICU: A Quality Improvement Project for Resident Critical Care Education
2. Implementation of an Evaluation and Treatment Algorithm for Single Ventricle Patients with Concerns for NEC
3. PICC Line Insertion Checklist for the PICU
4. Severe Pediatric Burn Management Guideline Implementation
5. The Effects of Protocol Implementation on Fluid Resuscitation in Severely Burned Pediatric Patients
6. Improving and Describing Initiation of Nutrition in Severely Burned Pediatric Patients through Protocol Implementation
7. Direct admissions to general pediatrics via local EMS: Improving resident communication with referring providers and handoff standardization.
8. Multidisciplinary approach to decreasing high acuity Floor to PICU transfers within 24 hours of hospital admission

Yong Han, MD
1. Quality Improvement Analysis of the Global Pediatric Sepsis Initiative Registry
Jenna Miller, MD

1. Severe Pediatric Burn Management Guideline Implementation
   a. The Effects of Protocol Implementation on Fluid Resuscitation in Severely Burned Pediatric Patients
   b. Improving and Describing Initiation of Nutrition in Severely Burned Pediatric Patients through Protocol Implementation
2. Testing Preparedness for Extracorporeal Membrane Oxygenation Cannulation in Pediatric COVID-19 Patients via Multi-Disciplinary In-Situ Simulation

Brian Olsen, MD

1. CMH Pediatric Critical Care Transport Quality Improvement Program
2. Ground and Air Medical Quality Transport (GAMUT) Database
3. AAP-Increasing Use of Waveform Capnography in Pediatric Patients with Advanced Airways During Interfacility Transport

Jay Rilinger, MD

1. CHA Sepsis collaborative: Improving Pediatric Sepsis Outcomes
2. Neurocritical Care workgroup
3. Pediatric Stroke workgroup
4. Pediatric Severe TBI Guidelines workgroup
5. ABCDEF / PICU Liberation Workgroup

Alyssa Stoner, DO

1. Testing Preparedness for Extracorporeal Membrane Oxygenation Cannulation in Pediatric COVID-19 Patients via Multi-Disciplinary In-Situ Simulation

Kelly Tieves, DO

1. Pediatric Severe TBI Guideline Implementation
2. Cardiac Arrest Prevention in the Intensive Care Unit, a PC4 Collaborative Project
3. Continuous EEG monitoring s/p congenital heart surgery
4. Code LITE, low tech internal training experience
5. Clinical champion, Pediatric Cardiac Critical Care Consortium, PC4

Marita Thompson, MD

1. Development of CRRT Protocol for Children with Underlying Metabolic Disease
2. Severe Pediatric Burn Management Guideline Implementation
3. Implementation of Bedside Huddle to Improve Communication When Coordinating Care for PICU Patients with Newly Diagnosed Anterior Mediastinal Masses

Jessica Wallisch, MD

1. Children’s Mercy Pediatric Neurocritical Care workgroup
2. Pediatric Severe TBI Guideline update
4. Stroke Committee