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Improving Thromboprophylaxis In Hospitalized Pediatric Inflammatory Bowel Disease Patients- A Quality Improvement Project

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IMPROVING THROMBOPROPHYLAXIS IN HOSPITALIZED PEDIATRIC INFLAMMATORY BOWEL DISEASE PATIENTS- A QUALITY IMPROVEMENT PROJECT

Submitting/Presenting Author (must be a trainee): Amy Issa, DO and Panam Kaur, MD

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Fellow

Primary Mentor (one name only): Mukta Sharma, MD

Other authors/contributors involved in project: Alka Goyal, MD and Julia Harris, MD

IRB Number (if applicable): N/A

Describe role of Submitting/Presenting Trainee in this project (limit 150 words):

Dr. Issa and Dr. Kaur are co-primary investigators. We have collected pre-interventional data, developed the algorithm, and will collect post-interventional data. We have also educated residents on the GI service and distributed the algorithm to the residents as well as the entire GI section.

Problem Statement/Question, Background/Project Intent (Aim Statement), Methods (include PDSA cycles), Results, Conclusions limited to 500 words

Problem Statement/Question:

There is a lack of standardization/pediatric guidelines regarding thromboprophylaxis in pediatric inflammatory bowel disease patients admitted for acute flare.

Background/Project Intent (Aim Statement):

Pediatric inflammatory bowel disease (IBD) patients in acute flare have 1.5 to 3-fold higher risk of thromboembolism compared to the general population. Anticoagulation therapy is recommended for pediatric IBD patients who have ≥ 1 risk factors for venous thromboembolic events. At Children's Mercy Hospital (CMH), approximately 80 patients/year are admitted for acute flare, of which, roughly 30% receive appropriate thromboprophylaxis. Lack of standardization of thromboprophylaxis and an educational gap amongst providers are significant barriers. Our goal is to standardize and improve the rates of thromboprophylaxis in IBD patients admitted at CMH from 30% to 60% by 12/2020. The development of a protocol will be associated with more consistent clinical care and lead to successful patient related outcomes in terms of prevention of complications like venous thromboembolism.

Methods (include PDSA cycles):

A retrospective chart review was done for IBD patients admitted from 06/2019-12/2019. For those with acute flare, we assessed different variables including risk factors, duration of hospitalization, and thromboprophylaxis measures. A thromboprophylaxis protocol was created with our Hematology colleagues and will be initiated for IBD patients upon admission. Elements include ambulation, adequate hydration, placing sequential compression devices, and anti-coagulants for patients with history of thrombosis, family history of thrombotic disorder <40 years of age, and those with a central line. The team will document which thromboprophylaxis measures were implemented. Monthly emails will be sent regarding implementation of the protocol. The protocol will be posted in the workrooms and discussed at the monthly department IBD meeting.

Results:

Pre-intervention data: Out of 30 IBD patients admitted for acute flare at CMH, approximately 33% received thromboprophylaxis. Patients who were not admitted with acute flare were excluded. Post-intervention data will be obtained and analyzed through 12/2020. Feedback will be obtained from attendings and fellows during the monthly meeting.

Conclusions:

Potential hurdles in implementation include difficulty achieving full participation of the team members and convincing providers of the clinical impact of the protocol. We will monitor our data on a monthly basis to ensure sustainability and perform additional interventions as necessary. Once post-interventional data is obtained, we plan to publish the findings as our thromboprophylaxis protocol and implementation process could benefit CMH and other institutions.