



Trauma Program Performance Improvement Plan

2014

OVERVIEW:

The Trauma Program PI Plan is a definitive plan to provide the optimal care and treatment of traumatically injured patients across the entire spectrum of necessary services, starting with the pre-hospital provider's care and ending with post-injury rehabilitative services/discharge/death. The Trauma PI Plan supports the HCA and RMC Mission:

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve.

PURPOSE:

- ◆ To identify and facilitate quality improvement activities for trauma patients working in conjunction with RMC hospital-wide QM Programs.
- ◆ To establish standards of quality care through frequent audits of data collection, compliance monitoring, evaluation and analysis, and corrective actions.
- ◆ To educate physicians and staff about Trauma PI principles, methodology, and regulatory compliance.
- ◆ To promote a multidisciplinary team approach to performance improvement activities throughout the hospital and within the community.
- ◆ To continually refine, streamline, and reprioritize PI processes based on the most current available knowledge and research.

TRAUMA PROGRAM PI PLAN KEY FUNCTIONS/SERVICES:

- ◆ Provides clinical and non-clinical education to key personnel involved in the care of traumatically injured patients and facilitates a multidisciplinary team approach to optimal patient care and safety.
- ◆ Serves as a resource for performance improvement activities, data collection and management. Uses appropriate methodology for the capture and documentation of data used in performance improvement activities and for credentialing processes
- ◆ Coordinates and conducts monthly PI meetings to conduct peer review, identify program areas of strength and weakness, and determine plans for corrective actions as deemed necessary by the committee (or any sub-committees).
- ◆ Works in conjunction with other facility committees (to include but is not limited to the Critical Care Committee) to maintain communication and consistency within the facility.
- ◆ Creates, maintains and updates all program policies and procedures in compliance with all national, state and local regulatory agency standards.
- ◆ Actively participates in all required Colorado Department of Public Health and Environment (CDPHE), State Emergency Medical and Trauma Services Advisory Council (SEMTAC) and Mile High Regional Emergency Medical and Trauma Advisory Council (MHRETAC) activities/committees to make sure all national, state and local regulatory requirements are met.
- ◆ Facilitates outreach programs such as community injury prevention activities through the use of public education and offers professional continuing education to local EMS partners.

- ◆ Coordinates timely and appropriate reporting of data to the State's Trauma Data Registry Program.

AUTHORITY:

- ◆ The Trauma Medical Director (TMD) has the authority and responsibility for overseeing all aspects of the Trauma Program PI Program.
- ◆ The Trauma Nurse Coordinator (TNC) is responsible for the maintenance of the hospital Trauma Registry and entry of data into the State Trauma Registry, coordinating all activities associated the Trauma PI program (including data entry, written audits, continuing education requirements, policy manuals and any other necessary records), attendance at CDPHE, SEMTAC/RETAC activities and coordinating educational activities for hospital staff and pre-hospital providers plus overseeing outreach for community partners (in the form of injury prevention education).

STANDARDS OF CARE:

- ◆ The patients that will be identified for performance improvement and quality assurance review and who will be included in the Rose Medical Center (RMC) Trauma Registry are consistent with the CDPHE "*Trauma Service Statistical Information: Inclusion/Exclusion Criteria*" (see attached).
- ◆ All evaluation and monitoring of trauma care delivery at RMC will be based on current CDPHE, SEMTAC and MHRETAC standards and guidelines.

PI/CQA PROCESS:

1. Data Collection

- 1.1. Data and referrals for trauma process improvement reviews will be collected concurrently and retrospectively. Sources of data/referrals include but are not limited to:

- 1.1.1. Hospital Trauma Registry
- 1.1.2. Daily Admissions Log
- 1.1.3. Referrals From Staff at Facilities Receiving Transferred Patients
- 1.1.4. Referrals From RMC Staff Involved in Care of Trauma Patients
- 1.1.5. Referrals From Pre-hospital Staff Involved in Care of Trauma Patients
- 1.1.6. Hospital Information System/Hospital QM Department
- 1.1.7. Referrals from Hospital Risk Management

2. Monitoring Compliance

- 2.1. Any patient that meets criteria for entry into trauma registry will be monitored for compliance with and/or adherence to standards of care established in the RMC Trauma Program policies and procedures.
- 2.2. All deaths, complications and hospital system process issues related to trauma will be reviewed to look for preventable factors.

- 2.2.1. Complications that occur in trauma patient care are recorded in the Trauma Registry. The Trauma Multidisciplinary Committee will review complications as a result of injuries or treatment that significantly affect patient outcome (sentinel events). The Trauma

Multidisciplinary Committee will make referrals and recommendations based on complications that do not significantly affect patient outcome will be tracked. Major complications will be reported quarterly and monitored for trend analysis.

2.2.2. Special Audit for trauma deaths will be initiated by the TMD for any patient that meets audit filter criteria established by the Committee on Trauma of American College of Surgeons and CDPHE. Issues will be placed into the following categories:

- 2.2.2.1. Preventable
- 2.2.2.2. Potentially preventable
- 2.2.2.3. Non-preventable

2.2.3. Comparison of data to national outcome norms will be done by using the Injury Severity Score (ISS), Revised Trauma Score (RTS) and Probability of Survival Matrix.

2.2.4. Comparison of data to state/regional outcomes occur through SEMTAC /Mile High RETAC programs

EVALUATION AND ANALYSIS

1. Trauma Multidisciplinary Committee

1.1. The Trauma Multidisciplinary Committee will consist of two meetings. The monthly meeting will focus on trauma patient case review, formal peer review and process/quality improvement trends and resolutions. This meeting's membership includes but is not limited to the following representatives:

- Trauma Medical Director
- Trauma Nurse Coordinator
- Emergency Medicine Physician
- Emergency Nursing Director
- Chief Medical Officer
- Orthopedic Physician/Liaison
- Hospitalist
- EMS Coordinator
- CAD-Nursing Supervisor
- Quality Management/Risk Management Liaison

1.1.1 The second meeting will meet quarterly to give updates and review process/quality improvement trends and resolutions with ancillary staff involved with trauma patient care. Nurse Managers and educators from floors that commonly receive trauma patients (i.e. ortho) will be invited to attend this meeting as well to discuss nursing care topics, trends and updates. This meeting's membership includes but is not limited to the following representatives:

- Laboratory services
- Respiratory Therapy
- Radiology

- Nursing Educators/Managers
- Case Management

- 1.2. Attendance requirements are 50% of meetings annually. Attendance is monitored and reported by the TNC.
- 1.3. Committee members are responsible for disseminating information to their respective departments along with leading any corrective actions deemed necessary.
- 1.4. The TMD and TNC may invite guest physicians, nursing and ancillary staff if they would contribute to case review and discussion.
- 1.5. The monthly meetings will include trauma patient case presentations of all complications, causes of death and interesting patient presentations for educational purposes with the goal of improving overall care of trauma patients at RMC. Cases shall include all aspects of care from pre-hospital treatment (if applicable) through discharge or death. Documentation of case reviews will include date, reason for review, problem identifications (if any), corrective action (if applicable), resolution and any changes that result from the review. These records shall reside in the office of the TNC along with minute meetings from all Trauma Multidisciplinary Committee meetings.
- 1.6. External Agency PI/QI issues related to the pre-hospital care of trauma patients received at RMC will be reviewed on a case-by-case basis by the EMS Coordinator in cooperation the Trauma Multidisciplinary Committee. If necessary, a referral to the appropriate agency will be made with the EMS Coordinator attempting to work with the system for problem resolution. The EMS Coordinator will file a report with the committee for final recommendation of action needed (i.e. education, policy review, etc...)
- 1.7. The Trauma Program upholds a multi-disciplinary, multi-departmental approach to the review of patient care issues across all departments and divisions of RMC by working in collaboration with and attending meetings (when necessary) of all performance improvement committees in the hospital, including but not limited to the Critical Care Committee.

DOCUMENTATION OF ISSUES:

1. Identified PI issues will be documented on the ***“Trauma Program Quality Improvement Tracking Report and may be reported to the hospitals occurrence reporting system.*** This Trauma QI Tracking form includes all aspects of case review for both adult and pediatric patients, including summary of clinical care, discussion/minutes from Trauma Multidisciplinary Committee meetings, committee judgment and recommendations, actions and resolutions. This form assures that issues are pursued and documented to closure. These forms will reside in the office of the TNC.
2. Levels of Review
 - 2.1. First Level Review
 - 2.1.1. After the TNC completes his/her initial review of a case, if no clinical or system issues are identified then no further review is necessary. Examples of these types of cases include:
 - 2.1.2. Transfers to another acute care center of a stable patient, usually for insurance purposes.
 - 2.1.3. Admission of a trauma patient to a non-trauma service after the patient is found to have no trauma-related issues.
 - 2.1.4. Other identified audit filters where care is identified as appropriate.

2.2. Second Level Review

2.2.1. This review is completed by the TMD and TNC and is required when issues with clinical care or system issues may or may not be evident. These cases may be resolved with the clinical judgment and expertise of the TMD or sent on for peer review at the TMD's discretion.

2.3. Third Level Review

2.3.1. The TMD and TNC do the initial case review in preparation for the Trauma Committee meeting. These are formal reviews by the committee and consist of:

2.3.1.1. All trauma deaths

2.3.1.2. Readmission to RMC for trauma-related issues

2.3.1.3. Major complications

2.3.1.4. Audit filter fall-outs with evidence of clinical care or system issues

2.3.1.5. Any case deemed appropriate by the TNC, TMD or at the request of any committee member.

3. Referrals

3.1. Cases determined to be preventable or potentially preventable will be referred to departmental committees or department medical Chairs as deemed appropriate. The TMD reviews all responses to referral.

4. Review of Hospital Trauma Registry Reports

4.1. PI reports are generated from the Trauma Registry. These reports are reviewed by the Trauma Multidisciplinary Committee to provide an overview of the health of Trauma Program and to identify areas in need of action or discussion. These reports include monthly reports, ad-hoc reports and an annual report. A complete list and tracking system for reports is housed in the office of the TNC.

5. Recommendations for Improvement

The Trauma Multidisciplinary Committee will determine any recommendations for improvement needed to address identified problems with the TMD having ultimate decision-making capacity.

5.1.1. Recommendations for improvement may consist of one of more of the following:

5.1.1.1. No action needed

5.1.1.2. Education conducted within the hospital

5.1.1.3. Education conducted to external agency:

5.1.1.3.1. Pre-hospital continuing education offerings

5.1.1.3.2. Meetings with the pre-hospital providers QA/QI coordinator to discuss individual cases

5.1.1.4. Written trending or formal study

5.1.1.5. Policy review or revision

5.1.1.6. Other

6. Trauma Program Policy and Procedures/Practice Guidelines

- 6.1. Ongoing assessment of P&Ps/Guidelines should occur at regular intervals, and at determined by the TMD and Trauma Multidisciplinary Committee or at least every three years.
7. Reevaluation
 - 7.1. Continuous monitoring will occur to evaluate the effectiveness of recommendations for improvement. For focus audits, the appropriate time period will be determined by the Trauma Multidisciplinary Committee.