

Trauma Center Performance Improvement

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Performance Improvement

- Evaluation of **ALL** aspects of the patients' care
 - ◆ Pre-hospital to Rehab and Home
- Identification of **ALL** opportunities to improve the care provided
 - ◆ System or Provider
- Action plan form improvement
 - ◆ Documented Loop closure

Components of PI

- Identify all “trauma” patients
 - ◆ State – inclusion criteria
 - ◆ Hospital’s may differ
- Abstraction of the chart
 - ◆ Best done concurrently
 - ◆ Identify all injuries and injury related complications

Chart Abstraction

- Standard form should be used
 - ◆ Injuries
 - ◆ AIS and ISS
 - ◆ All the ADH filters
 - ◆ Other hospital or program filters
- ◆ Should identify any OTHER opportunities to improve

The dog that caught the truck

- Complications , opportunities to improve, filter fall-outs, general questions
 - ◆ Document discussion between TPM and TMD
 - ◆ Decide the action – and document

Options for “Action”

- Discuss with TMD and trend
 - ◆ Be able to show trend and track progress
- Discussion “one on one”
 - ◆ Come back and document
 - ◆ Note, e-mail, etc.

Options for “Action”

- Discuss a “system” issue with the trauma steering committee
- Discuss a “provider” issue with the multi-disciplinary peer review group

Trauma Steering Committee

- System issues
 - ◆ Activation criteria, OR availability, statistics
 - ◆ Pathways, protocols and treatment guidelines
 - ◆ Broad attendance - nursing, ancillary services, & Administration

Trauma Steering Committee

- Not protected from discoverability
- Should not be about specific patients but rather issues (although may come from a patient care issue)
- Document minutes – Hospital Steering Committee

Multi-disciplinary peer review

- Provider issues – physician, nursing, pre-hospital
- Attendance is mandatory (50%)
 - ◆ Recommend monthly or q.o.m
 - ◆ All general surgeons,
 - ◆ Liaisons from Ortho, Anesth, Neuro, EM, Radiology, Rehab

Multi-disciplinary peer review

- Closed meeting, protected from discoverability
- Cases are identified by TPM and TMD – multiple paths (all deaths and significant complications)
- All providers involved should be present
- Issues to be discussed should be identified and made clear to the parties ahead of the meeting

Multi-disciplinary peer review

- Cases should be summarized and points in question discussed in a non-punitive, evidence based manner
- Care should be judged against “best practice”

Multi-disciplinary peer review

- Determinations should be made as to the care – were there opportunities to improve?
- Document discussion and adjudication
- Documentation kept with patient's abstract and in the provider's file
- Minutes go to Med. Staff

Multi-disciplinary peer review

- Output
 - ◆ Trend provider care
 - ◆ New PI filter established – take to trauma committee
 - ◆ New process – Pathway, guidelines – take to trauma committee

Using the Data

- If you track it – trend it
 - ◆ Compare periodic results of tracked item against:
 - ★ Historic data
 - ★ Benchmark data – similar centers
 - ★ National data – NTDB
- Share this with the hospital, region and State

Let's do some cases

- Listen carefully
- Identify All opportunities to improve
- Tell me what you would do with each
- How would you document and close the loop?

Case #1

- Scene time > 20 min.
- No C-collar
- Failure to secure and airway for a patient with a GCS < 8
- Surgeon arrival time > 30 min.
- Failure to identify a pneumothorax in ED
- Unstable patient not taken to the OR
- Time to decision to transfer > 30 min.
- Time to transfer > 2 hours
- EMS arrival for the transport of an urgent trauma patient > 15 min.
- Death (outside facility)
- Missed pelvic fracture
- Trouble loading the CT at outside facility
- Lack of documentation

Outcome

- Identify all issues
- Discussion with TMD
- Case should be presented at multi-disciplinary peer review for provider issues
 - ◆ EMS, surgeons, nursing
- Issues should be discussed at trauma committee
- Action plan should be documented and followed until achieved

Case # 2

- Lack of appropriate C-collar
- Lack of definitive airway for patient with GCS < 8
- Size of ETT
- IV fluid management
- PaCO₂ 68, re-intubation
- Death

Outcome

- Identify all issues
 - Discuss with TMD
 - Present at peer review and trauma committee
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- No c-collar - TRAC initiative
 - Airway management in children – lecture by ped EM, surgeon
 - Intubation with wrong sized ETT – Policy for Braslow use, ATLS

Summary

- PI is the tool to use to be sure that the “next patient” receives optimal care
- Identification of patient, injuries,
 - ◆ Discussion with TMD
 - ◆ Decision to escalate
 - ◆ System discussion – Hospital
 - ◆ Provider discussion - MEC

Summary

- Documentation of all work done and action taken
- Follow the action plan through to completion and document
- Track, trend and USE all PI filters