GUIDELINES AND PROTOCOLS

Lyndon B. Johnson General Hospital Trauma Services Department
Guideline/Protocol Number: T65

Guidelines and Protocols

TITLE: TRAUMA PERFORMANCE IMPROVEMENT PROGRAM

PURPOSE:

To ensure that the injured trauma patient receives timely quality care that meets or exceeds the standards established by the Texas Department of State Health Services, the American College of Surgeons, and the Southeast Texas Regional Advisory Council.

PROCESS:

I. MISSION
   A. Lyndon B. Johnson General Hospital of Harris County, Texas, is a Level III Trauma Center dedicated to providing the highest quality of trauma care in a cost effective manner to victims of trauma. The Trauma Program is committed to provide comprehensive quality health care for victims of trauma, community service through education and public awareness of trauma prevention and regional trauma networking to improve trauma outcomes.

II. SCOPE
   A. The Trauma Performance Improvement Committee is an interdepartmental multidisciplinary committee with representation from medical, nursing, and allied health professionals who participate in the care of the trauma patient. This committee is responsible for monitoring and evaluating trauma care and all activities across the care continuum that relate to the trauma patient.
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III. GOALS

A. To facilitate continuous quality improvement in patient care provided by the Trauma Service by establishing mechanisms to improve clinical processes which may affect clinical outcomes and monitoring aspects of care or service which are key departmental activities.

B. To provide the framework for a planned, systematic, ongoing approach for the objective monitoring and evaluation of the quality, appropriateness, and effectiveness of emergency patient services provided.

C. To pursue opportunities for improving patient care by evaluating the systems and processes associated with patient care.

D. To cooperate and work with other hospital departments and services to identify and improve processes which have direct and indirect effects on patient outcomes, including those that cross departmental/service/facility boundaries.

IV. OBJECTIVES

A. Assure the delivery of trauma care at an optimally achievable level of quality in a safe environment.

B. Utilize externally, as well as internally, designed standards to measure trauma care.

C. Design effective mechanisms for problem focused identification, assessment, resolution, and evaluation of trauma care within the hospital system.

D. Assure that the nursing staff practice professional competency and are routinely evaluated.

E. Develop effective systems for the documentation and dissemination of quality assurance activity findings to appropriate persons and/or committees.
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F. Provide mechanisms, including educational opportunities, by which all staff may become knowledgeable and participate in the quality management process

V. AUTHORITY
A. The Trauma Medical Director in conjunction with the Trauma Program Manager has the ultimate responsibility and authority for the administration of the Trauma Service Performance Improvement Program. Together they are responsible for:
   1. Recommending and designing monitoring activities.
   2. Reviewing and approving summaries of monitoring activities.
   3. Approving changes in activities, functions, and/or standards emanating from monitoring activities.
   4. Submitting monthly/quarterly/annual reports of monitoring activities to the hospital wide committees or regulatory bodies. Reports shall include:
      a. Quality management activities
      b. Problem assessment priorities
      c. Corrective action and desired outcome
      d. Follow up review for loop closure

VI. ROLES
A. TRAUMA MEDICAL DIRECTOR
   1. Responsible for primary review of cases with Trauma Program Manager.
   2. Triages cases for closure or presentation/referral at another performance improvement forum.
   3. Supervises the preparation of trended data reports along with the Trauma Program Manager and/or the Trauma Coordinator(s).
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4. Monitors the divisional performance improvement forums: Trauma Performance Improvement Committee, Morbidity and Mortality Committee, Surgical Performance Improvement Committee.

5. Assists with the development of practice management guidelines.

6. Assists with the over-site of the Performance Improvement Program.

7. Directs loop closure with the Trauma Performance Improvement staff.

8. Leads educational/counseling sessions regarding provider issues

B. TRAUMA PROGRAM MANAGER

1. Responsible for issue identification and issue validation, as part of concurrent review/rounds.

2. Maintains the Trauma Performance Improvement database.

3. Maintains individual trauma patient performance improvement files.


5. Oversees maintenance of case review summaries and updates concurrently.

6. Produces and analyzes trended data and provider specific profiles in collaboration with Trauma Medical Director.

7. Clinical practice management guideline surveillance, variance analysis and reporting.

8. Coordinates follow-up back to facilities that transfer patients to Lyndon B. Johnson General Hospital and to facilities to which we transfer.
9. Reports trauma performance improvement data at hospital forums (i.e. Quality Review Council, EC Performance Improvement Committee).

C. TRAUMA COORDINATOR
1. Interfaces directly with the Trauma Program Manager during concurrent review to identify/validate registry audit filters.
2. Ensures/monitors performance improvement processes for the Registry database.
3. Coordinates/ensures accuracy of the Registry database for transmission to Texas Department of Health.
4. Participates in the Trauma Performance Improvement Committee and Trauma Morbidity and Mortality Committee and captures autopsy findings for entry into Registry database.
5. Assists with report compilation for performance improvement purposes.
6. Assists with retrospective chart review for performance improvement purposes

VII. COLLECTION AND ORGANIZATION
A. Data is collected and organized for review by the Trauma Program Manager under the direction of the Trauma Medical Director. Data is collected from a multitude of sources including, but not limited to:
1. Daily Patient Rounds
2. Trauma Registry Inclusion Criteria
   a. Deaths
   b. Transfers
   c. Admissions
   d. ICD 9 Codes 800 – 959.9
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e. All trauma activation and patients meeting activation criteria

3. Surgery/Trauma and Emergency Medicine Morbidity/Mortality Conferences

4. Medical Records

5. Trauma Medical Record Review Form

6. Trauma Case Referral

B. Data is collected both concurrently and retrospectively by the Trauma Program Manager and Trauma Coordinator(s) and other trauma team members. Consideration for collection will be given to:

1. Who will collect data

2. What data is to be collected

3. Frequency of data collection

4. How data should be collected and displayed

5. Sources for data collection

VIII. INDICATORS / AUDIT FILTERS

A. Indicators are objective, measurable, based on current knowledge and clinical experience, and related to the quality and appropriateness of trauma care. The indicators reflect structure of care (i.e. Resources), process of care (i.e. Procedures, systems, and techniques), or outcomes of care (i.e. Complication rates).

Indicator Descriptions are:

1. Rate Based

   a. Definitions (frequency of occurrence/denominator of total cases)

   b. Trend monitoring (i.e. Complication rate)

2. Sentinel event – an event that results in an unanticipated death or major permanent loss of function not related to the patient’s care course.
B. Indicators are:
1. Non-Discretionary – (ACS, Institution, JCAHO, TDH)
2. Discretionary – (User Defined)
3. Peer Specific
4. Outcome Related
5. Process Related
6. Financial Related
7. Clinical Related

C. Clinical Outcome Indicators include, but are not limited to:
1. Mortality
2. Morbidity
3. Length of stay
4. Cost
5. Errors in judgment, communication, technique, treatment
6. Missed Injuries

D. The Trauma Service will establish a threshold for each indicator/audit filter. The threshold value can be from 0 – 100%. All deviations from criteria will be reviewed.

IX. LEVELS OF REVIEW
A. Primary Review: The purpose of primary review is concurrent/retrospective issue identification/validation for immediate resolution and feedback. The case summary is initiated from this data. It consists of daily review of the following phases of care:
1. Pre-hospital
2. Resuscitation
3. Inpatient Care Review
4. Outpatient/Rehabilitation Care Review
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B. Secondary Review: The purpose of secondary review is to investigate issues and determine what goes to committee (tertiary review). The secondary review is conducted on a regular basis by the Trauma Medical Director and the Trauma Program Manager. Potentially preventable/preventable issues and non-preventable issues with educational value are identified. An issue may be closed at this level. Cases/issues may be referred to the following for review, response and loop closure:
1. EC Medical Director
2. Specialty PI Committee (i.e. Radiology)
3. Nursing PI Committee
4. Specialty Surgeon
5. Specialty Focus Group (i.e. Transfer)

C. Tertiary Review: The purpose of tertiary review is to identify issues for peer review/accountability determination, loop closure plan, and/or trended data review. Cases/issues may be referred to Trauma Performance Improvement Committee, Morbidity and Mortality Committee, Organizational PI/safety Committee or regional and systems PI meeting.

X. CASE REVIEW
A. Cases are generally brought forward for review by the Trauma Medical Director and Trauma Program Manager, but may be brought by any member of the Medical and Nursing staffs who participate in trauma care. Cases that are forwarded to a PI meeting consist of the following:
1. Unexpected outcomes
2. Systems issues
3. Sentinel Events
4. Practice management guideline non-compliance
5. Policy/protocol not followed
6. Special populations
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7. DSHS Audit filter fallouts
8. All Deaths
9. All Transfers
10. Selected Complications

B. Actions to be taken are based on the recommendation of the Trauma Medical Director and Trauma Performance Improvement Committee. Actions plans may consist of any of the following:
1. Educational session
2. Trauma center strategic plan
3. Trend – monitor/report
4. Practice management guideline/policy development
5. Hospital/system PI project
6. Change in privilege or credentials
7. External review

C. The Trauma Program Manager and the Trauma Medical Director will analyze the data collected and determine if further investigation is needed. When areas of improvement are identified, the root causes will be established. Root causes are described as one of the following:
1. Systems problems
2. Knowledge problems
3. Behavioral problems

D. The results of monitoring and evaluation activities of service will be reviewed monthly by the Trauma Performance Improvement Committee. Communication of relevant information is made to the organization wide Quality Review Council quarterly.

E. Indicators to be reported are determined by the Texas Department of State Health Services Survey report from the Level III Trauma Re-Designation Survey.
F. The effectiveness of the Trauma Performance Improvement Program will be evaluated on an annual basis and revised as deemed appropriate.

REFERENCE / BIBLIOGRAPHY:

OFFICE OF PRIMARY RESPONSIBILITY:

LYNDON B. JOHNSON HOSPITAL TRAUMA SERVICES

REVIEW / REVISION HISTORY

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