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Deaconess REGIONAL TRAUMA CENTER

Performance Improvement and Patient Safety Plan

Purpose: Deaconess Midtown Hospital's Trauma Performance Improvement and Patient Safety (PIPS) plan is designed to measure, evaluate, and improve the process and effectiveness of care rendered to the injured patient, including medical oversight of pre-hospital providers, resuscitation, inpatient care, and inter-hospital transfer. This includes a multidisciplinary effort to monitor, assess, and improve both the processes and outcomes of care to the injured.

Goals: To decrease death and disability by reducing inappropriate variation in care through progressive cycles of performance review.

To establish and manage a healthcare delivery system that provides optimal care for injured patients in our region. This system encompasses injury prevention, emergency medical services and transportation, acute care, transitional care, and the return of the individual to a productive life.

Deaconess Trauma Services will strive to lead Deaconess Midtown Hospital and our community in improving its performance through following the Deaconess mission, including values and goals already established, development of a regional trauma system, creating and providing an effective learning environment and ongoing educational opportunities, encouraging discovery and fulfillment of group and individual potential, modeling effective behavior and practices and providing high-quality care in a fiscally responsible fashion.

Canons:

A. Authority and Scope
   a. Trauma (PIPS) reviews all patients with traumatic injuries through the continuum of care
      i. This includes pre-hospital, resuscitation, operative intervention, critical care, stabilization, and general care, through transition to rehabilitation
      ii. Each trauma admission is screened for compliance with trauma guidelines and variation in care
   b. The Trauma Medical Director (TMD) in conjunction with the Trauma Program Manager (TPM) has the ultimate responsibility and authority for the administration of the PIPS as granted and empowered by the Hospital governing body
      i. This authority does transcend service lines

B. Credentialing
    a. All clinicians who participate in the care of the injured patient will be credentialed according to the Medical Staff Bylaws
        i. In addition, surgeons and surgical specialists taking trauma call will meet additional credentialing criteria as set forth by the American College of Surgeons (ACS) relating to specific trauma verification level
        ii. Refer to the Trauma Team Attending Requirements guideline
    b. TMD has the authority to determine provider's ability to participate in trauma call and remove providers from trauma call if deemed necessary
        i. TMD will complete annual Ongoing Professional Practice Evaluation (OPPE) on trauma surgeons, trauma APPs, orthopedic liaison, and neurosurgical liaison
            1. The Surgical ICU Medical Director will complete OPPE on TMD
        ii. TMD may complete a Focused Professional Practice Evaluation (FPPE) if there is a specific issue with a physician/advanced practice provider (APP)

C. Organizational Structure
    a. Performance improvement (PI) consists of internal and external monitoring and evaluation of care provided by EMS, medical, nursing, and ancillary personnel, as well as hospital departments, services, and programs
    b. Monitoring is ongoing and systematic
        i. Opportunities to reduce inappropriate variation in care are sought, and strategies to improve care are documented in the registry
        ii. The effectiveness of corrective action is evaluated through continuous reassessment and monitoring utilizing ongoing performance improvement processes
    c. Trauma Services collaborates with Deaconess Hospital's Quality Improvement Liaison in screening mortalities, variances in care, and at-risk cases
        i. A representative from the Quality Improvement Department attends the monthly Trauma Mortality and Morbidity Committee ("Trauma Peer") meetings and reports to the Medical Staff Quality Council if necessary
    d. Trauma Services reports as requested to Quality Improvement Committee (QIC)

D. Roles in the Trauma (PIPS)
    a. See Appendix A

E. All trauma guidelines will be reviewed every 3 years in accordance with ACS standards.

F. Trauma Patient Population Criteria: See Data Quality Plan Guideline

G. Data Collection and Analysis: See Data Quality Plan Guideline
    a. The trauma program evaluates data through a structured peer review process and continuous monitoring of key performance metrics. These metrics include those required by the ACS as well as additional indicators defined by the trauma program to identify opportunities for improvement in patient care.
    b. Data is collected and organized for review under the direction of the TMD and TPM
        i. The primary source of trauma data is the trauma registry.
            1. Information is entered into the trauma registry by the Trauma Services department

H. PI Indicators
    a. Outcome Indicators
        i. Deaconess Trauma Services measures the outcome of trauma care
            1. Complications and injury-related deaths are identified and evaluated for appropriateness of care
            2. Outcome measures are reported at Trauma Peer (Trauma Peer) and Trauma Operational Committee (Trauma Op)
            3. Outcome measures related to specific physician groups are presented at their departmental meetings and in OPPE reviewed by the TMD
            4. Outcome measures are reviewed and discussed during annual evaluations of trauma panel members completed by the TMD
    b. Process Indicators
        i. These are used to measure, evaluate, and improve the delivery of trauma care. These indicators identify opportunities for improvement and support loop closure within the trauma PIPS program.
            1. Performance expectations are established through multidisciplinary committee consensus, hospital policies and procedures, clinical practice guidelines, protocols, requirements of the ACS Resource for Optimal Care of the Injured Patient (2022 et seq), and Indiana and Illinois rules and regulations.
            2. Indicators may include but are not limited to:
                a. Appropriate triage and patient destination, including minimizing undertriage and overtriage and ensuring patients are transported to the appropriate level trauma center.
                b. Timely access to definitive care (e.g., transfer times, time to operating room, time to interventional radiology, and emergency department throughput.)
                c. Documentation and communication throughout the continuum of trauma care
                d. Trauma team activation performance, including adherence to activation criteria and timely team response.
                e. Availability and utilization of trauma system resources, including operating room, blood products, imaging, ICU beds, and specialty consultants.

f. Performance of multidisciplinary trauma care, including communication and coordination among emergency medicine, surgery, anesthesia, radiology, nursing, rehabilitation, and other services.
g. Compliance with trauma resuscitation protocols, clinical practice guidelines, and massive transfusion protocols.
h. Timely completion of diagnostic imaging and specialty consultations.

c. System Indicators
    i. These indicators ensure that the trauma program continuously evaluates and improves the quality, safety, and efficiency of care throughout the continuum of trauma care. System level indicators include:
        1. Interfacility transfer performance, such as transfer appropriateness, communication between facilities via Trauma Outreach Physician coordinator, and delays in transfer. Communication with EMS is done through the EMS coordinator.
        2. Compliance with evidence-based protocols and clinical practice guidelines across the institution.
        3. Loop closure and corrective actions, ensuring identified system issues are analyzed, interventions are implemented, and improvements are monitored for effectiveness involving Emergency, ICU, OR, Floor, and other departmental leadership including the Medical Staff Quality Committee (MSCQ.)
        4. Participation in trauma registry review and benchmarking, using registry data to identify trends and compare performance with regional and national standards as outlined by the ACS.

I. Event Identification
a. Events will be identified through a variety of mechanisms including but not limited to multidisciplinary rounds, trauma registry data and reports, Trauma Peer, Trauma Ops, EMR, autopsy findings, referring facilities, incident reporting, audit filters, and referrals from staff and departments involved in the care of the patient
    i. Issue identification can be concurrent or retrospective

J. Nonsurgical Admissions
a. Trauma Services will review all nonsurgical admissions and report findings periodically at the Trauma Peer and the Trauma Ops meetings
b. PI and complications will be entered on those patients who are admitted for treatment of traumatic injuries
c. If there is no identified opportunity for improvement, the following non-surgical admission may be closed during the primary review
    i. Admissions that have had a surgical or trauma consultation; or
    ii. ISS ≤ 9
    iii. Nelson score ≥ 6
d. A secondary review performed by the Trauma Medical Director is required for non-surgical admissions that meet any of the following criteria

i. No trauma or surgical consultation
ii. ISS > 9
iii. Nelson score ≥ 5
iv. Cases with an opportunity for improvement identified during primary review

K. Levels of Review
a. Trauma Services utilizes a four-level review process for trauma patient performance improvement.
b. Every trauma patient chart is screened using a standardized review tool and database to ensure timely, appropriate patient care and identify opportunities for improvement.
c. Primary review (Level 1)
i. Initial screening completed by Trauma Analysts, Trauma PI RN, and/or the TPM
ii. All events that are identified and resolved in the Level 1 review will be documented and tracked for ongoing trending and analysis
iii. Events that require additional investigation will be referred for Level 2 review
d. Secondary review (Level 2)
i. Level 2 review evaluates variations in care that were not resolved during the Level 1 review.
ii. The TMD conducts the review to determine whether the identified variances or complications were preventable or resulted in a negative impact on patient outcomes.
1. If the TMD is closely involved in the patient's care related to the identified variance or complication, the Surgical ICU Medical Director will conduct the review.
iii. Events resolved during the Level 2 review will be documented and traced for ongoing trending and analysis.
iv. If the TMD determines that an opportunity for improvement cannot be adequately addressed through a Level 2 review, a detailed event timeline will be developed, and the case will be referred for a Level 3 review.
v. TMD may also select cases for educational review.
vi. The TMD will perform a Level 2 review for the following patient populations
1. All trauma-related mortalities
2. All trauma patient transfers
3. Patients discharged with hospice services
4. Cases identified during Level 1 review as having an opportunity for improvement
5. Nonsurgical admissions as outlined above
e. Tertiary review (Level 3)
i. All Level 3 reviews will be presented at the Trauma Peer meeting for multidisciplinary discussion. An action plan will be developed, as appropriate, to address identified opportunities for improvement.
ii. All mortalities and transfers are reviewed at Trauma Peer meeting

1. If the TMD is unable to determine the classification of a mortality or the appropriateness of a transfer, then committee will review the case and determine the appropriate classification. If the committee is unable to reach a consensus, the case will be referred to Medical Staff Quality Committee (MSCQ) for final review and resolution.

f. Quaternary review (Level 4)
    i. All Level 4 reviews will be presented to the Medical Staff Quality Committee (MSQC) for discussion, recommendations, and final resolution, as appropriate.

L. Trauma Committees
a. Trauma Peer (“Trauma Peer Review”)
    i. The purpose of the Trauma Peer Review Committee is to improve the quality of trauma care through multidisciplinary physician-led review of trauma cases.
    ii. The committee reviews provider-related morbidity and mortality, significant complications, adverse events, process variances, unusual or complex cases, trends, and unanticipated outcomes to identify opportunities for performance improvement.
    iii. Committee membership includes, but is not limited to
        1. Trauma Surgeons
        2. Trauma Advanced Practice Providers
        3. Vascular Surgeons
        4. Pediatric Intensivists (ad hoc)
        5. Emergency Medicine Physicians
        6. Pulmonary/Critical Care Physicians
        7. Anesthesiologists
        8. Radiologists
        9. Neurosurgeons
        10. Orthopedic Surgeons
        11. Geriatric Liaison representatives
    iv. The Trauma Program Manager, Trauma PI Nurses, and Trauma Services staff also attend the Peer meeting.
    v. The committee determines the preventability classification and physician judgment for cases reviewed.
    vi. The meetings are physician led, confidential, and protected under applicable peer review statuses.
    vii. Meetings are conducted monthly and maybe canceled at the discretion of the TMD.
    viii. Continuing medical education (CME) may be available for physicians who attend and complete the required evaluation related to educational content, case review, and evidence-based practice.
    ix. Attendance requirements:
        1. Trauma Medical Director will maintain a minimum 60% attendance rate over any rolling 12-month period.

2. Trauma surgeons participating in the trauma call panel must maintain a minimum 50% attendance rate over any rolling 12-month period.
3. Physician Liaisons from Anesthesiology, Critical Care Medicine, Emergency Medicine, Neurosurgery, Orthopedic Surgery, Radiology and Geriatric will maintain a minimum 50% attendance rate over any rolling 12-month period. Each liaison is allowed to have one (1) predetermined alternate whose attendance may be applied toward the required 50% attendance rate.
4. Attendance requirements may be waived by the TMD for approved military deployment, medical leave, and missionary service. Documentation in support of absences will be provided to the ACS as outlined in Resources for Optimal Care of the Injured Patient (2022 et seq.)

x. Case Review Requests
1. Requests are typically initiated by the TMD, TPM or PI RN.
2. Any member of the multidisciplinary trauma team directly involved in the patient's care may request a case review
3. Cases appropriate for review include, but are not limited to:
    a. Unexpected outcome
    b. System issues
    c. Sentinel events
    d. Trauma guideline noncompliance
    e. Audit filter events
    f. Deaths
    g. Transfers
    h. Selected complications
    i. Other cases identified as opportunities for improvement
4. Case review evaluates clinical decision-making, technical performance, treatment, and systems of care to determine opportunities for improvement and assess preventability.

xi. Morbidity and Mortality Review
1. Morbidity and mortality cases will be evaluated to determine whether the occurrence is:
    a. Disease-related
    b. Provider-related
    c. System-related
2. A disease related morbidity or mortality is defined as an anticipated consequence of the patient's disease process, medical condition, or injury.
3. Provider-related morbidity or mortality is associated with delays, omissions, or errors in treatment provided by pre-hospital personnel, nursing staff, physicians, and/or other healthcare professionals.
4. Mortality classifications will be assigned by the TMD using terminology and definitions outlined in the ACS Resources for Optimal Care of the Injured Patient (2022 et seq).

a. Mortality without opportunity for improvement
b. Mortality with opportunity for improvement
c. Anticipated mortality
d. Unanticipated mortality (Include all classifications required by our trauma policy.)

5. Cases requiring additional follow-up, corrective action or referral will be forwarded to the Deaconess Medical Staff Quality Committee and/or other departmental committees for further review and resolution.

b. Trauma Operational Committee
   i. The purpose of the Trauma Operational Committee is to optimize trauma patient care performance through monitoring trauma-related hospital operations
   ii. Operational committee meetings are chaired by the TPM and co-chaired by the TMD
   iii. Committee meetings are held monthly and may be cancelled at the discretion of the TMD.
   iv. The Committee consists of a multidisciplinary team representing all phases of care provided to the injured patient, including but not limited to:
      1. Pre-hospital/EMS
      2. ICU, Medical Surgical, Orthopedic and Neurological Floors
      3. Administration
      4. Emergency physicians
      5. Operating Room staff
      6. Blood Bank,
      7. Trauma Services staff members
   v. The Committee will review identified issues, analyze performance, and propose corrective action plans to reduce variations in care, improve overall patient care, and correct identified problems
   vi. All trauma-related diversions will be reviewed for opportunities for improvement

M. Corrective Action
   a. The TMD and TPM oversee corrective action planning and event resolution
   b. The Trauma Ops and/or the Trauma Peer determine an action plan to reduce variation in care, improve care, and/or correct identified problems
   c. Corrective strategies include but are not limited to:
      i. Revising hospital policies, trauma guidelines, or protocols
      ii. Professional education for staff
      iii. Counseling of involved personnel
      iv. Credentialing, delineation of privileges
      v. Ongoing review until event resolution occurs
      vi. Periodic reviews are conducted over time to ensure data trends show improvement
         1. Once event resolution has occurred, the period review is completed.

2. Periodic review provides a method for assuring the effectiveness of corrective actions.
3. Verifies sustained improvement and successful resolution of identified issues.

N. Documentation
   a. The PI program emphasizes thorough documentation, continuous tracking of issues and corrective actions, strict confidentiality, secure handling of records, and appropriate communication to support quality improvement while protecting patient and provider information.
   b. Trauma Services follows hospital confidentiality policies and agreements. This is addressed in Hospital orientation for all Hospital personnel.
   c. Identified issues and resolutions are recorded in Trauma Peer and Trauma Operational minutes, which are peer-protected and are not distributed to maintain patient confidentiality
   d. Identified events are referred to the appropriate medical service or hospital leadership for management and improvement.
   e. Confidentiality is maintained via a confidential letter or e-mail, or direct communication with the providers involved
   f. Adherence to the hospital confidentiality agreement is maintained while summaries are distributed to department chiefs and/or nursing directors for further resolution
   g. The essential aspects of control to protect patient information include
      i. Storage of protected information in locked files
      ii. Shredding of paper copies of PI documentation
   h. Computer generated PI documentation (i.e. medical minutes and case reviews) may only be accessed via user ID and are password protected
   i. Peer review documentation is collected and shredded after each meeting

O. Benchmarking
   a. Deaconess Regional Trauma Center submits data to the Trauma Quality Improvement Program (TQIP) on a quarterly basis
      i. Reports are reviewed by the TPM and TMD
      ii. TQIP reports may be used to
         1. Identify trends and focus on outliers within our facility
         2. Develop and implement processes or practice improvements
         3. Evaluate the effectiveness of corrective action plans.

P. Annual Process for Identification of Priority Areas for PI
   a. Trauma Services will run reports on audit filter elements to identify those metrics that do not meet the trauma program goals. Once identified, metrics will be presented to the appropriate Committee(s) for evaluation.
   b. TQIP reports are reviewed to identify priority improvement areas.
   c. Audit filters and reports are generated on new guideline metrics
   d. Reports on top two mechanisms of injury are used to guide injury prevention educational opportunities in the community.

References:

- Resource for Optimal Care of the Injured Patient: 2022
- Trauma guideline: Trauma Team Attending Credentials
- Trauma guideline: Trauma Team Resuscitation Role Assignments
- Hospital Quality Improvement Plan and Organizational Charts
- Trauma guideline: Trauma Registry
- Trauma Outcomes and Performance Improvements Course, 2015 edition
- Society of Trauma Nurses, Optimal Course, 2015 edition

Appendix A

Roles in the Trauma Performance Improvement Program

The Trauma Medical Director, Trauma Program Manager, Trauma Outreach Medical Director, Trauma Performance Improvement Medical Director, Director of Patient Care Services, Trauma Data Quality Coding Coordinator(s) (Trauma Registrars), Trauma Performance Improvement Nurses (PI RN), and EMS Coordinator(s) address performance issues, which involve multiple services and departments.

Trauma Medical Director:

1. Oversee the structure and process of the trauma PIPs program (ACS)
    a. Overall institutional responsibility and authority for trauma PI.
    b. Oversight and authority of the trauma center's care, credentialing of trauma surgeons and participating liaisons.
    c. Authority and oversight for the trauma center through all phases of trauma care and all components of the trauma center
2. Develop and enforce policies, procedures, guidelines relevant to the care of the trauma patient. (ACS)
3. Ensure that all providers meet requirements and adhere to institutional standards of practice (ACS)
4. Work across departments and/or other administrative units to address deficiencies in care (ACS)
5. Determine, with the assistance of the liaisons, provider participation in trauma care. This may be guided by the findings from the PIPS process or an Ongoing Professional Practice Evaluation (ACS)
6. Develop, coordinate and provide input in the development and maintenance of practice guidelines, policies, and methodologies for the care of the trauma patient

Trauma Program Manager:

1. Oversee the trauma program in conjunction with the TMD and Administration (ACS)
2. Assist with the budgetary process for the trauma program (ACS)
3. Develop and implement clinical protocols and practice management guidelines in conjunction with the TMD. (ACS)
4. Provide educational opportunities for staff development. (ACS)
5. Monitor performance improvement activities in conjunction with Trauma PI RN. (ACS)
6. Serve as a liaison to administration and represent the trauma program on hospital and regional committees to enhance trauma care. (ACS)
7. Oversee the trauma registry, responsible for the management, review, validation, and documentation of events that are processed through the levels of review. (ACS)
8. Coordinate action planning and documentation between the trauma program and the hospital-wide PI program.
9. Spend 0.5 FTE of the 1.0 FTE on Trauma Program Manager related activities. The other 0.5 FTE may be dedicated to other roles within the trauma program.

Trauma Performance Improvement RN (PI RN):

1. Collaboration with Leadership: Trauma PI RNs Work in collaboration with the TMD and TPM to enhance the quality of trauma care across the continuum of care, from pre-hospital settings through hospitalization to discharge and recovery.
2. Conduct Chart Reviews: Perform comprehensive, concurrent chart reviews to identify adverse events, variances in clinical management, patient outcomes, complaints, and systemic or process issues that negatively affect the care of the trauma patient from time of injury (EMS Care) through rehabilitation.
3. Report Critical Issues: The PI RN escalates identified issues to the TMD, TPM, and Trauma Services Team to ensure concurrent follow-up and resolution.
4. Screening Cases for Review: Patient cases are thoroughly screened to identify those cases requiring physician review in collaboration with the TPM.
5. Documenting PI in Registry: The PI RN enters all performance improvement issues into the trauma registry, ensuring all variances in care are addressed and resolved in a timely fashion.
6. Support Peer Review: Prepare selected cases for Trauma Peer Review Committee.

Trauma Registry Analyst(s) (Trauma Registrar)

1. Ensure Accurate Data Entry: Trauma Data Analysts record accurate, timely data into the trauma program registry software following guidelines outlined by the American College of Surgeons Committee on Trauma, the states of Indiana and Illinois, and the Trauma Quality Improvement Program (TQIP).
2. Maintain Registry: Create, update, and maintain patient data in the trauma registry, State of Illinois registry, and State of Indiana registry.
3. Code Clinical Data: Analysts will accurately abstract and input clinical, statistical, and abstract data elements; including AIS coding, ICD-10-CM/ICD-10-PCS codes, as required by ACS, the State of Illinois, the State of Indiana, and national registry for TQIP.
4. Code Validation: Analysts are responsible for entering and validating E-codes for all injured patients who meet National Trauma Database Standards (NTDS) inclusion criteria as defined by the NTDS Data Dictionary.
5. Meet Strict Deadlines: Data Analysts must ensure that 80% of all patient data is finalized in the trauma registry software within 60 days of patient's discharge.
6. Validate Data Accuracy: Verify that 100% of all trauma entries in the trauma registry software are validated by cross-referencing the data in the trauma registry with patient information in the EMR, EMS run reports, and referring hospital record.
7. Screen for Complications: Analysts review patient care documentation at discharge to screen for complications or performance improvement issues.
8. Utilize Reporting Tools: Generate comprehensive reports utilizing the trauma registry as the core source of program data.
9. Maintain Data Integrity: Accountable for the collection, completion, and verification of the accuracy of all patient data collected from Deaconess Midtown Hospital and the trauma registry data collection system.

Trauma Injury Prevention Coordinator:

1. Manage Injury Prevention Program: Coordinator is responsible for overall planning, development, and oversight for the Injury Prevention Program.
2. Implementing Community Education: The coordinator procures, develops, and implements educational offerings on injury prevention and trauma projects involving

pediatric, adolescent, adult, and geriatrics in the community based on mechanism of injuries identified in the trauma registry and other statistical sources.
3. Networking: Injury Prevention coordinator collaborates at the local, state, and national level to offer the most appropriate community outreach programs.
4. Create Lasting Impacts: Establish and implement strategies for continuous improvement for injury prevention.

Trauma Outreach Medical Director:
1. Networking: The outreach medical director will pursue the development and enhancement of relationships with pre-hospital, referring hospital and in-hospital providers to ensure high quality trauma patient care is being provided.
2. Loop Closure: Provide feedback regarding clinical care in the trauma region.
3. Educational Opportunities: Provide Education and Outreach presentations/events (i.e. Audit and Review, in-hospital education, grand rounds, etc.).
4. Follow Up with Outside Hospitals: Make telephone calls and/or visits to referring providers for performance improvement purposes and to foster collaborative relationships with area hospitals.

Trauma Neurosurgical Medical Director:
1. Provide medical supervision of neurosurgical trauma services, as Medical Director, including directing the development and review of proposed policies and procedures relating to the provision of Neurosurgical Trauma Services.

Orthopedic Medical Director
1. Provide medical supervision of orthopedic trauma services, as Medical Director, including directing the development and review of proposed policies and procedures relating to the provision of Orthopedic Trauma Services.

Surgical ICU Medical Director
1. Participates in the development of protocols/guidelines for the care of trauma patients.
2. Demonstrate and oversee medical practices are consistent, efficient, cost-effective, and in compliance with trauma protocols and guidelines. Participates in the care of the trauma patients in the ICU where the majority of trauma patients are located.
3. Participates in unit-based PI activities and provides review and recommendations for education and skill development of the nursing staff facilitates a collaborative relationship with ICU management and all disciplines associated with trauma Consults with appropriate medical staff, unit staff, and unit administration to identify and resolve quality of care issues and adverse outcomes; and identify opportunities and pathways to improve patient care
4. Keeps ICU manager informed of equipment/supplies needed for medical practice related to trauma patients.

EMS Coordinator:
1. Participate in trauma case review.
2. Work with the TPM and TMD to assist in development and implementation of educational offerings on trauma related projects.
3. Promote trauma standards of care as it pertains to pre-hospital providers according to nationally accepted American College of Surgeons guidelines
4. Complete monthly audits on all Category 1 activations as well as those requested by the trauma team.

5. Send opportunities for improvement documentation to the trauma program.

Trauma Liaison:

1. Representative from subspecialty services such as emergency medicine, orthopedics, neurosurgery, anesthesia, critical care, radiology, and geriatrics who actively participate in the Trauma PIPS program.
2. Must attend 50% of the committee's meetings in any 12-month rolling calendar year.

Other PI Committee Members:

1. Representatives from nursing, emergency medicine, ICU, Medical/Surgical Unit, Blood Bank, EMS, Anesthesia, Radiology, Surgery, Spiritual Care, Trauma Registrars, will be invited to participate as determined by TMD and TPM.

Audit Filters, Event, or Report Reviews

Pre-Hospital
- Compliance with pre-hospital triage criteria as dictated by regional protocols
- Delays or adverse events associated with pre-hospital trauma care

Emergency Department
- Surgeon arrival time for the highest level of activation
- Accuracy of trauma team activation protocols
- Compliance of trauma team activation, as dictated by program guideline

Blood Bank
- Massive Transfusion Protocol (MTP) activations
- Inadequate or delayed blood product availability

Operating Room
- Unanticipated return to the OR
- Compliance with policies related to timely access to the OR for urgent surgical intervention

Radiology
- Interpretation errors or discrepancies between preliminary and final report

ICU
- Unanticipated transfer to the ICU or Intermediate Care (“Stepdown”) Unit
- Delay in response to the ICU for patients with critical needs

Admissions
- All nonsurgical admissions excluding isolated hip fractures
- Pediatric admission to non-pediatric trauma center

Timeliness
- Delay in response to call for urgent assessment by the neurosurgeon and/or orthopedic specialist
- Delay in recognition of injury, or missed injury
- Delay in access to time-sensitive diagnostic or therapeutic interventions
- Delay in providing rehab services

Patient Population
- Transfer out of facility
- Discharge to hospice
- All deaths
- Those with significant complications and/or adverse events
- Referrals to Indiana Donor Network (IDN) and organ procurement rates

Equipment

- Lack of availability of essential equipment for resuscitation or monitoring

Screening

- Screening of eligible patients for psychological sequelae
- Screening of eligible patients for alcohol misuse

Diversion

- Review of Trauma and Neuro diversion

Reports

- Benchmarking Reports