PIPS Committee Members

The peer review committee must be chaired by the trauma medical director (CD 5–25). All liaisons to the PIPS committee must participate actively in the trauma PIPS program with at least 50 percent attendance at multidisciplinary trauma peer review committee meetings. In Level I, II, and III trauma centers representation from:

General Surgery (CD 6-8) – You are be regularly involved in the care of injured patients. You participate in the organization of:

- Trauma protocols
- Trauma teams
- Trauma call rosters
- Trauma rounds

It is important for trauma surgeons to maintain their surgical skills. You must have privileges in general surgery (CD 6–4). To maintain operative skills, general surgeons you should participate in elective and emergency general surgery. Your participation at the multidisciplinary trauma peer review committee is essential because the general surgeon is the foundation for trauma care in the trauma program.

Emergency Medicine (CD 7–11) - Emergency physicians on the call panel must be regularly involved in the care of injured patients (CD 7–7). You should be an active participant in the organization of:

- Trauma protocols
- Peer review meetings
- Trauma resuscitations

As part of the trauma PIPS program, you are responsible for **all emergency department audits, critiques, and mortality reviews of patients who are treated in the emergency department**. You should also be included when trauma patients are reviewed by the surgical staff.

Orthopedics (CD 9–16) -In conjunction with the trauma team leader, the orthopedic surgeon on call is responsible for the development and coordination of the management strategy for:

- All axial and appendicular musculoskeletal injuries
- The determination of patient weight bearing and activity status
- Making sure the overall goals of patient care are not forgotten.

After the acute treatment phase, you frequently are delegated the responsibilities of: Rehabilitation

- Co-coordinating transfers
- Referral to rehabilitation services
- Providing long-term follow-up care for fracture-related problems.

Your team should have regular meetings (at least quarterly), which may include an orthopedic-specific PIPS process under the guidance of the multidisciplinary trauma PIPS program. In conjunction with the trauma team, **you should develop, distribute, and regularly update written treatment protocols for the care of patients with severe musculoskeletal injuries**, particularly patients requiring multiple specialty care. Examples would include patients with open fractures, patients with fractures with neurologic and vascular injury, and multisystem trauma patients with unstable pelvic ring and/or long bone fractures.

Anesthesiology (CD 11–13) - Although anesthesia services may be based primarily in the operating room, your responsibilities may extend into other areas of the hospital. Examples include:

- Establishing airway control
- Assisting with resuscitation
- Providing preoperative and postoperative cardiorespiratory support
- Assisting with pain control.

The **availability of anesthesia services** and **delays in airway control** or **operations** must be documented by the hospital PIPS process.

Critical Care (CD 11–62) - In Level III trauma centers, physician coverage of the ICU must be available within 30 minutes, with a formal plan in place for emergency coverage (CD 11–56). The coverage for emergencies is not intended to replace the primary surgeon in caring for the patient in the ICU; it is to ensure that the patient's immediate needs are met while the primary surgeon is being contacted.

In Level III trauma centers, the PIPS program must review **all ICU admissions** and **transfers of ICU** patients **to ensure that appropriate patients are being selected to remain at the Level III center vs. being transferred to a higher level of care** (CD 11–57).

Neurosurgery (CD 8–13) - Qualified neurosurgeons should be regularly involved in the care of patients with head and spinal cord injuries and you must be credentialed by the hospital with general neurosurgical privileges (CD 8–11). In a hospital committed to trauma care, neurosurgeons with special expertise in trauma should be identified. Participation in the organization of:

- Trauma protocols
- Trauma teams
- Trauma call rosters
- Trauma systems
- Trauma rounds

In conjunction with the trauma team, your team should develop, distribute, and regularly update written treatment protocols for the care of patients with neurotrauma injuries, particularly patients requiring multiple specialty care. Examples of this include timeliness of placement of intracranial pressure monitors, management of increased intracranial pressure, timeliness of operative intervention, and compliance with current Brain Trauma Foundation guidelines.

Radiology (CD 11–39) - The trauma center must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department (CD 11–28).

The radiologist liaison must attend at least 50 percent of peer review meetings and **should educate and guide the entire trauma team in the appropriate use of radiologic services** (CD 11–39).**Changes in interpretation between preliminary and final reports**, as well as **missed injuries**, must be monitored through the PIPS program.

PIPS Meeting

Once an event is identified, the trauma PIPS program must be able to verify and validate that event (CD 16–11).The tertiary review is a multidisciplinary review. The goals of multidisciplinary review are as follows:

(1) Review the **efficacy, efficiency, and safety** of the care provided by the trauma center
(2) Provide focused education
(3) Provide peer review

The multidisciplinary trauma peer review committee must systematically review mortalities, significant complications, and process variances associated with unanticipated outcomes and determine opportunities for improvement (CD 16–17). Moreover, **the committee should determine the definition and classification of these events** in a manner consistent with the trauma center's institution-wide performance improvement program.

Based on this review process:

- Both the **appropriateness** and **timeliness** of care should be reviewed
- **Opportunities for improvement** (for example, errors in judgment, technique, treatment, or communication, along with delays in assessment, diagnosis, technique, or treatment) should be determined and documented.
- When an error can be attributed to a single credentialed provider, use of the departmental or institutional formal medical peer review process should be considered.

Corrective Action

When an opportunity for improvement is identified, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented, and clearly documented by the trauma PIPS program (CD 16–18). Examples of corrective actions include the following:

- Guideline, protocol, or pathway development or revision.
- Targeted education (for example, rounds, conferences, or journal clubs).
- Additional and/or enhanced resources.
- Counseling.
- Peer review presentation.
- External review or consultation.
- Ongoing professional practice evaluation.
- Change in provider privileges.