2018 PI BOOTCAMP REGION 8 TRAUMA

AUGUST 17, 2018 ~ MARQUETTE, MICHIGAN

PRESENTED BY:
CHRIS BALLARD, MINNESOTA TRAUMA SYSTEM COORDINATOR

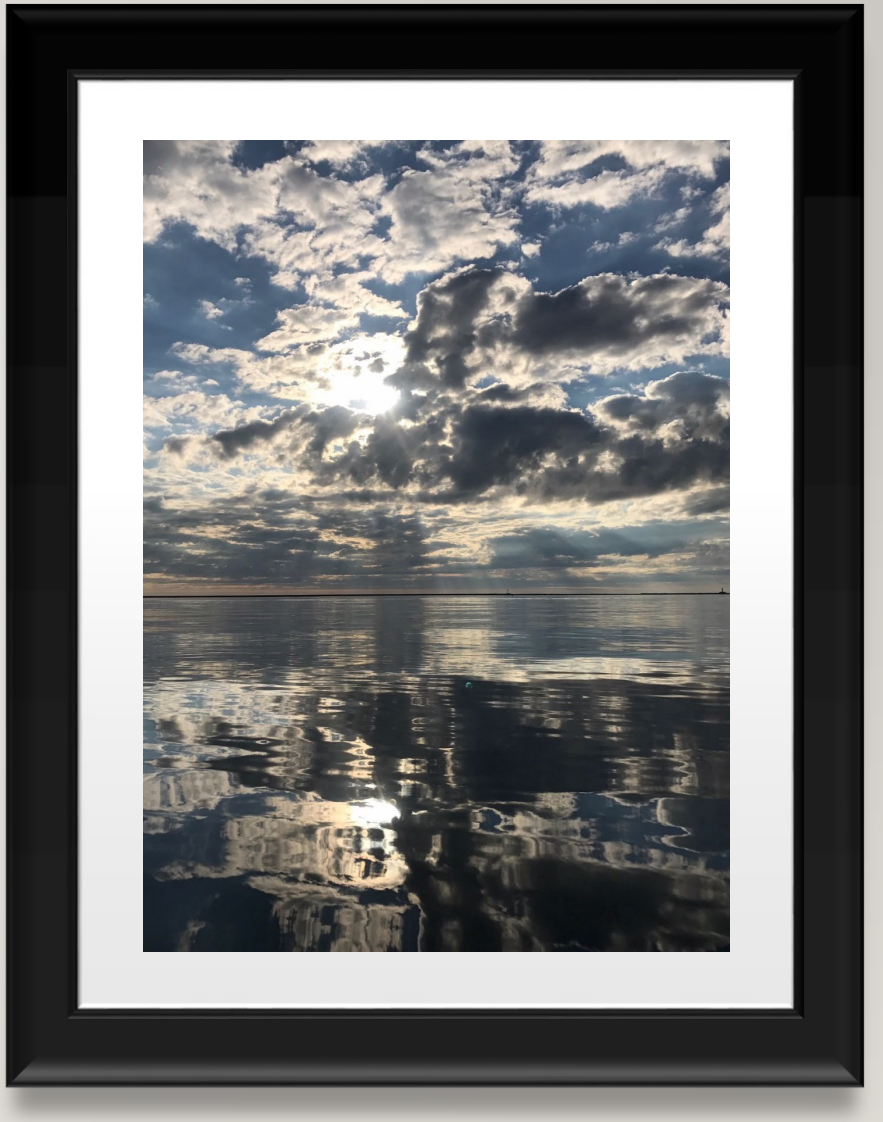
BOOTCAMP OBJECTIVES

Receive ORIENTATION and leave with a system understanding

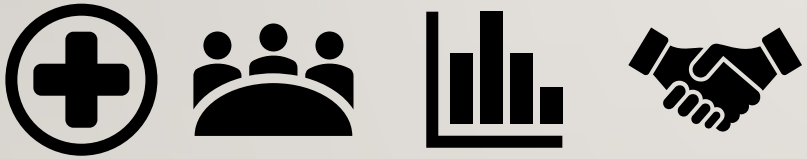
Have the GEAR to describe event identification, levels of review, and loop closure

Be able to TRANSFORM existing practices

Complete a CONFIDENCE COURSE of scenarios

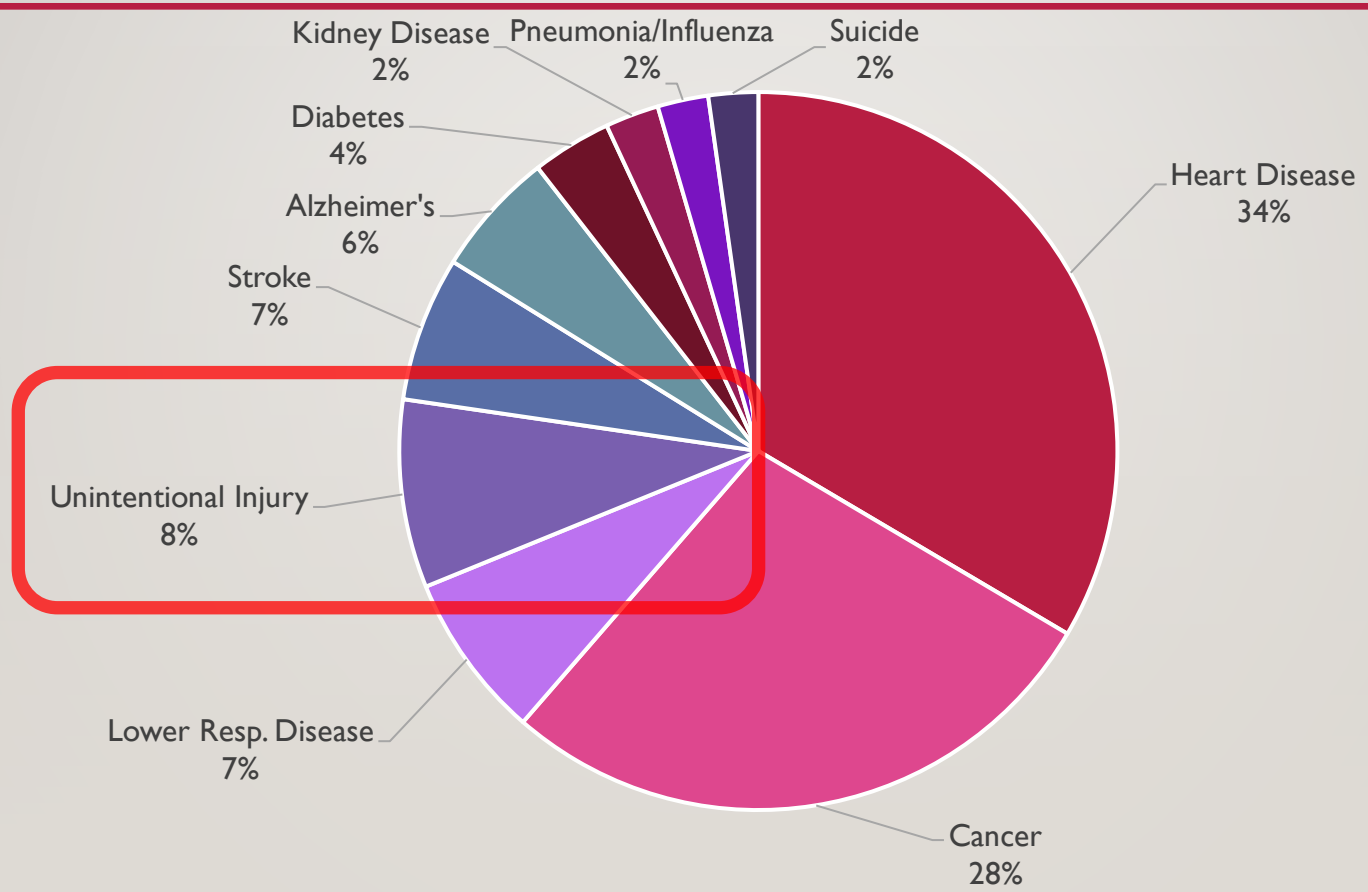


ORIENTATION



TEN LEADING CAUSES OF DEATH

AGE-ADJUSTED MORTALITY RATE



10 Leading Causes of Death by Age Group, United States – 2016

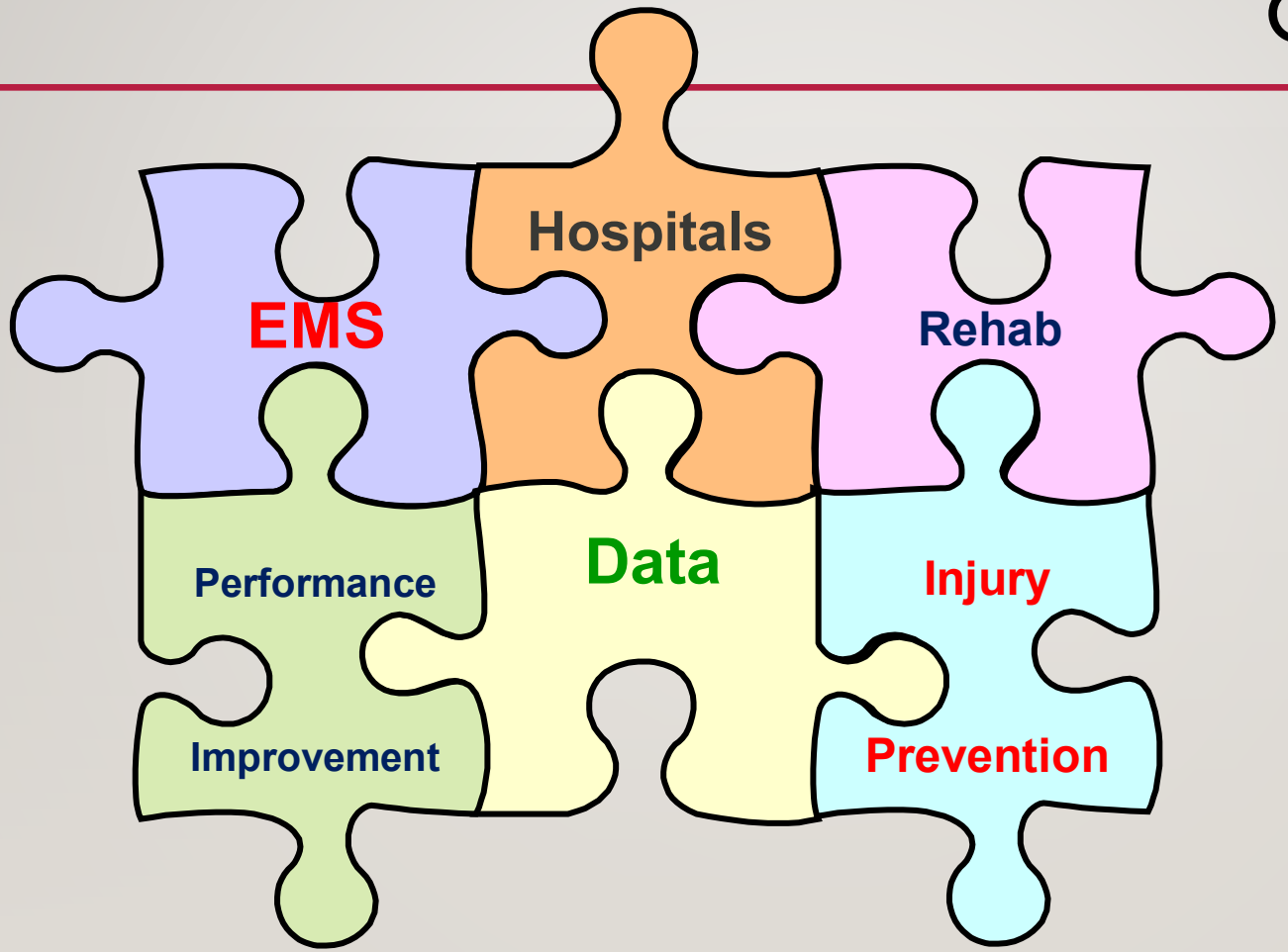
	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,816	Unintentional Injury 1,261	Unintentional Injury 787	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	Short Gestation 3,927	Congenital Anomalies 433	Malignant Neoplasms 449	Suicide 436	Suicide 5,723	Suicide 7,366	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	SIDS 1,500	Malignant Neoplasms 377	Congenital Anomalies 203	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	Chronic Low. Respiratory Disease 131,002	Unintentional Injury 161,374
4	Maternal Pregnancy Comp. 1.402	Homicide 339	Homicide 139	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	Suicide 7,030	Suicide 8,437	Chronic Low. Respiratory Disease 17.810	Cerebro-vascular 121,630	Chronic Low. Respiratory Disease 154.596
5	Unintentional Injury 1,219	Heart Disease 118	Heart Disease 77	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Placenta Cord. Membranes 841	Influenza & Pneumonia 103	Chronic Low. Respiratory Disease 68	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	Bacterial Sepsis 583	Septicemia 70	Influenza & Pneumonia 48	Chronic Low Respiratory Disease 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Respiratory Distress 488	Perinatal Period 60	Septicemia 40	Cerebro-vascular 50	Chronic Low Respiratory Disease 206	Cerebro-vascular 575	Cerebro-vascular 1,851	Chronic Low. Respiratory Disease 4.307	Suicide 7,759	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
9	Circulatory System Disease 460	Cerebro-vascular 55	Cerebro-vascular 38	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095	Nephritis 50,046
10	Neonatal Hemorrhage 398	Chronic Low Respiratory Disease 51	Benign Neoplasms 31	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405	Suicide 44,965

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

GOALS

- Shorten time to definitive care
- Standardized response
- Lengthen "Golden Hour"
- Data-driven improvement

TRAUMA SYSTEM COMPONENTS



ROLE DISTINCTIONS

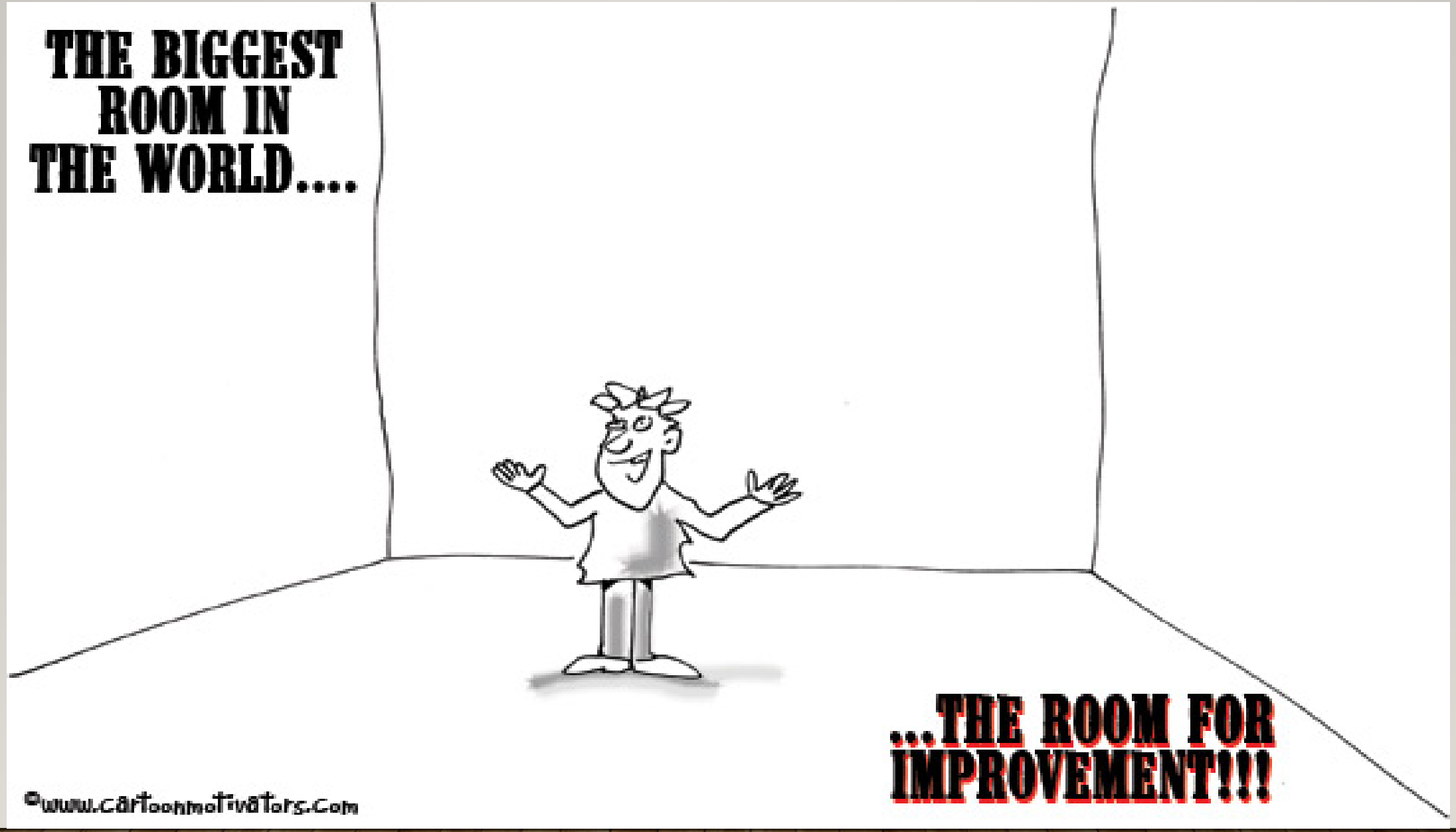
LEVEL I & II

- Identify all injuries
- Definitively manage all injuries
- Admit most trauma patients

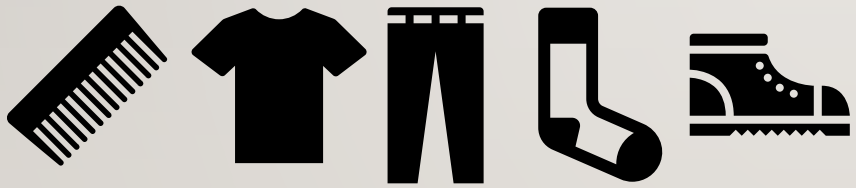
LEVEL III & IV

- Recognize injury severity
- Identify immediate life threats
- Intervene with life threats
- Transfer most trauma patients

EARLY TRANSFER DECISION!


THE BIGGEST ROOM IN THE WORLD....
...THE ROOM FOR IMPROVEMENT!!!
©www.cartoonmotivators.com

GEAR ISSUING



WHAT IS PERFORMANCE IMPROVEMENT (PI)?

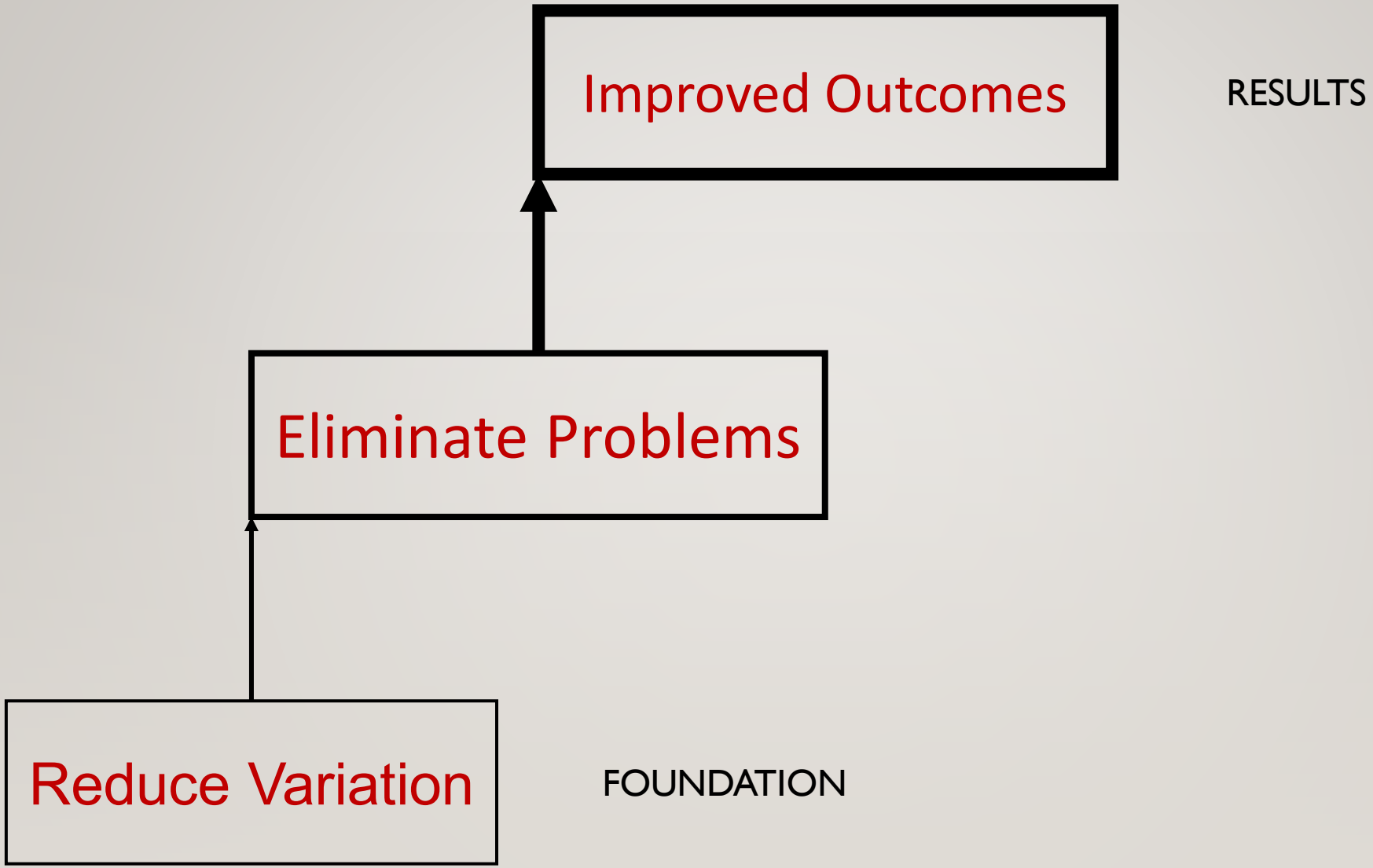
There is no precise prescription for trauma performance improvement…

but a structured process by a trauma program

to demonstrate a continuous process for improving care

for injured patients is required.

–Adapted from American College of Surgeons statement


Improved Outcomes
RESULTS
Eliminate Problems
Reduce Variation
FOUNDATION

TRAUMA PI

PHILOSOPHICAL CHANGE

- Continuous improvement
- Review and thoughtful analysis
- Fix problems before they're problems

FOCUS ON

- Process improvements
- Clinical standards
- Problem recurrence
- Patient Safety

Culture of Safety

PI COMPONENTS

- Evaluate care, provider response, system performance
- Identify opportunities for improvement

Foster competency among clinicians all levels

Measure performance and validate care

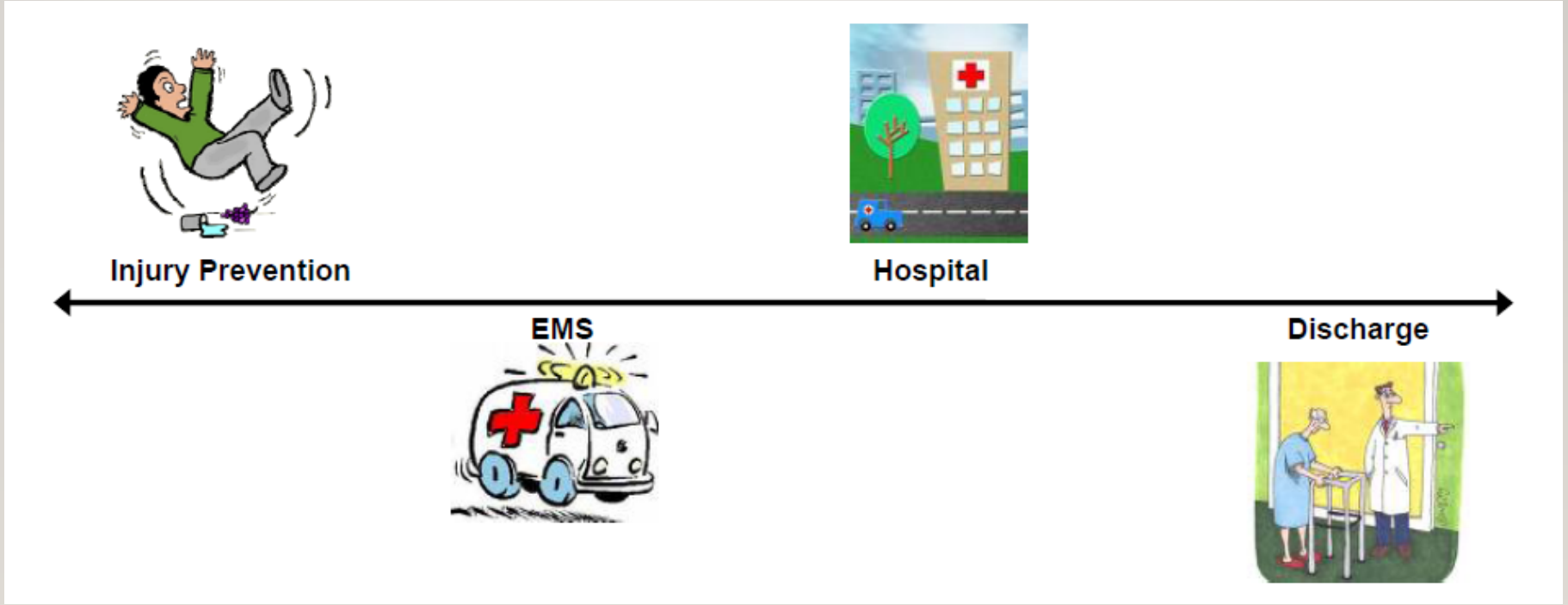
PI CHARACTERISTCS

- Data-driven
- Systematic
- Measurable

Improves care at the bedside

PI CHARACTERISTCS

Spans the continuum of care



MICHIGAN STATES A STRONG PI PROGRAM:

- Contains a detailed audit
- A multi-disciplinary trauma peer review committee that includes all members of the trauma team
- Participation in the trauma system data management system
- The ability to follow up on corrective actions
- Regional performance improvement activities
- Practice guidelines, protocols, algorithms, derived from evidenced validated resources are used to stratify benchmarking and measure performance improvement

STANDARDS OF CARE

- Local, regional, state or national
- Filters (population & performance standards)
  - Non-Discretionary (handout)
  - Discretionary
    - Hospital specific – such as definitive airway within 10 minutes of arrival

Level III Audit Filters (handout)

Emergency Department

Anesthesia

General Surgeons

Operating Room

Transfers

Pediatrics

Radiology

ICU

Miscellaneous

Level IV Audit Filters (handout)

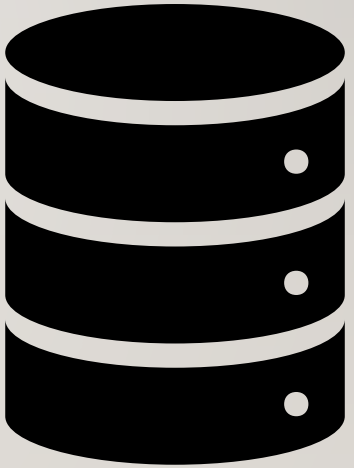
Emergency Departments

Transfers

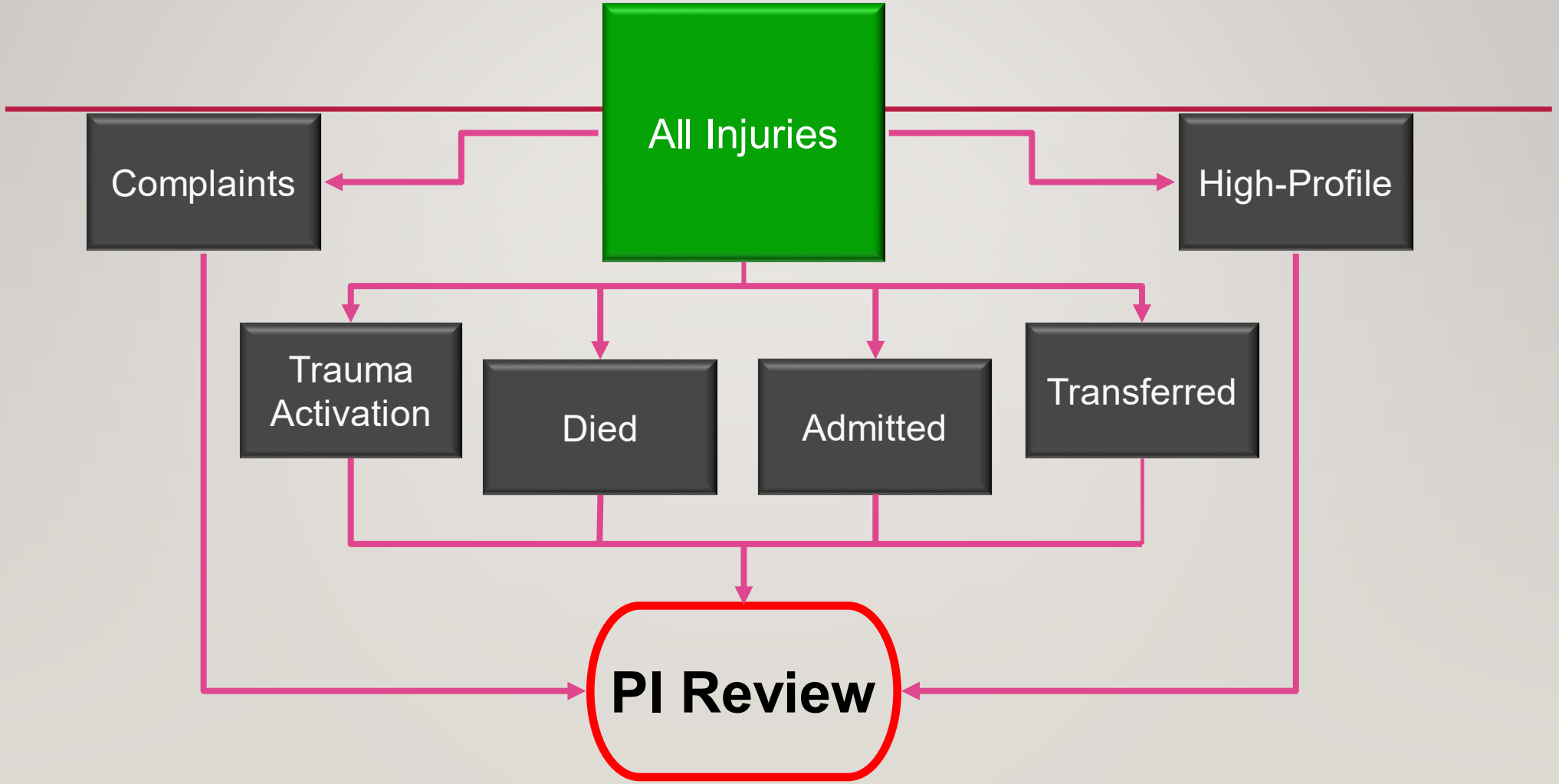
Miscellaneous

BUILDING BLOCKS

1. Define a trauma patient
2. Locate the patients in your hospital
3. Establish standards (PI Filters)
4. Work the process



DEFINE A TRAUMA PATIENT



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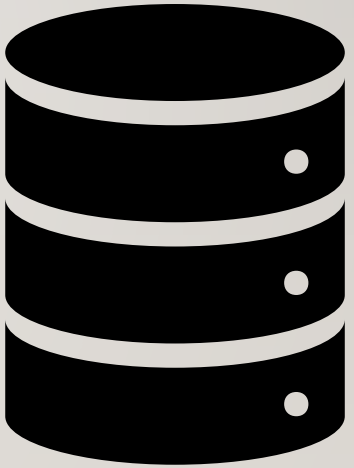

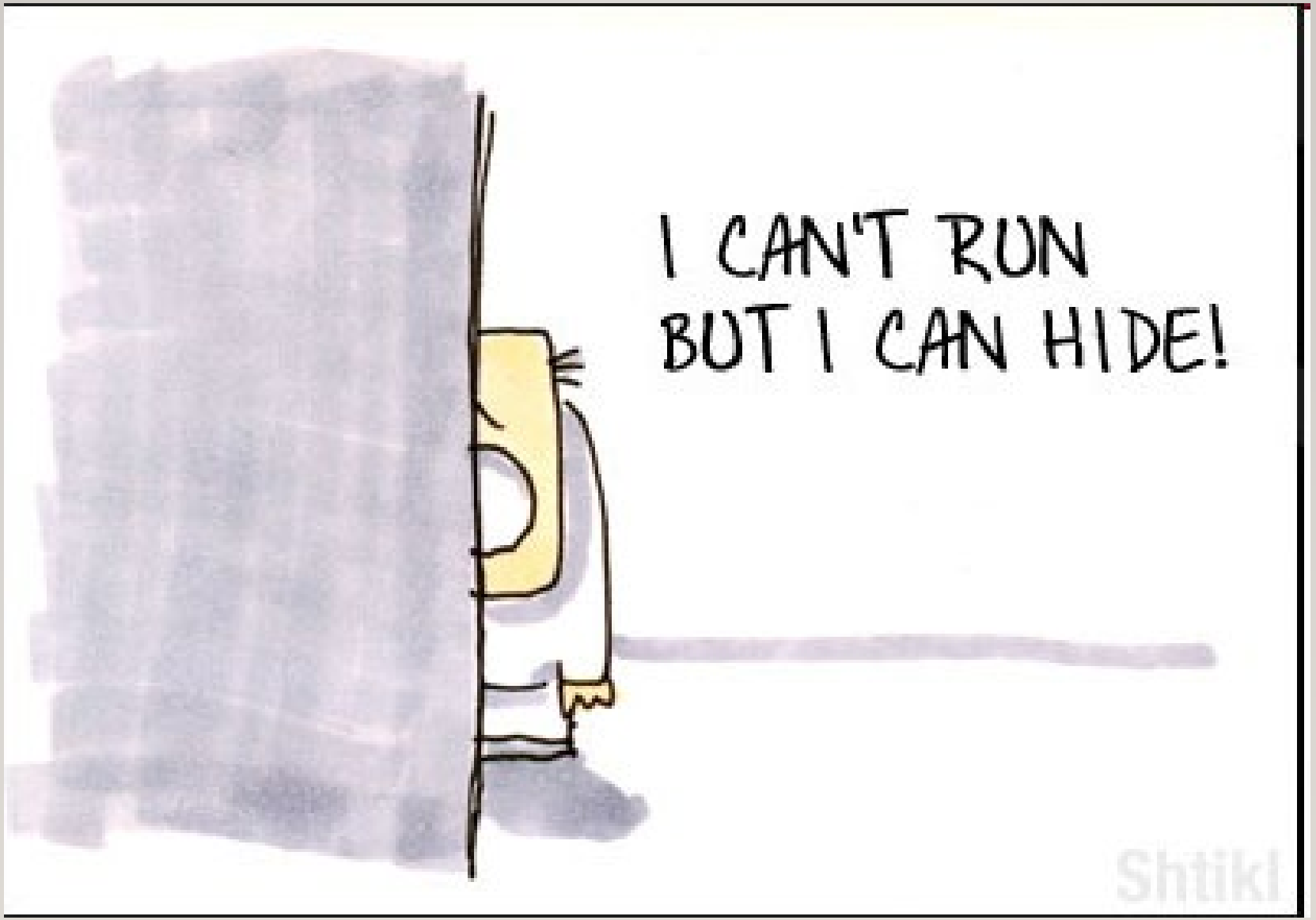
I CAN'T RUN
BUT I CAN HIDE!
Shtikl

BUILDING BLOCKS

1. Define a trauma patient
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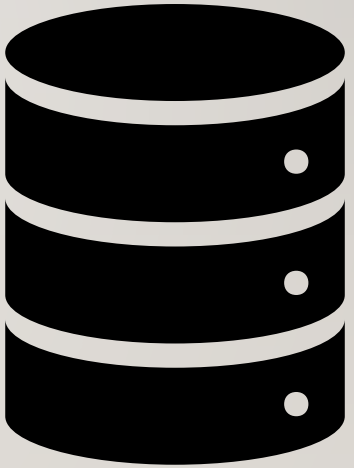

PI FILTERS

- Length of stay in ED >120 minutes
- Under-triaged/trauma team not activated when criteria met
- Emergency department provider arrival >15 minutes
- Trauma death
- Admitted by non-surgeon
- GCS ≤10 & no intubation or surgical airway
- EMS scene time >20 minutes
- C spine injury missed on initial evaluation
- GCS <14 and head CT >2 hours after admission
- EMS report not in patient chart
- Fewer than two IV lines
- Absent hourly charting

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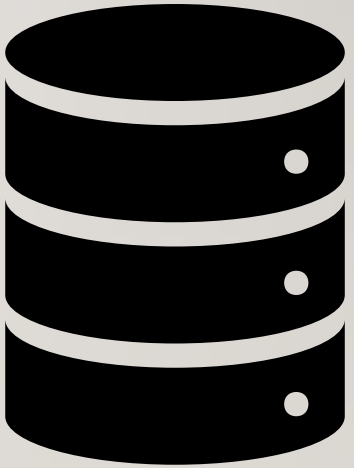

THE PROCESS

1. Case Finding
2. Review
   - Thoughtful analysis
   - Issue Identification
   - Investigation
3. Action Plan
4. Measure Effectiveness of Action Plan

   Evaluation, Re-evaluation, Re-re-evaluation…

   Re-action Plan
5. Loop Closure

INFORMATION SOURCES

ED & In-patient Log

Medical Record & EMS Run Sheet

Daily Rounds

PI Committee Meetings

Autopsy Reports

Risk Management Variance Reports

Trauma Registry

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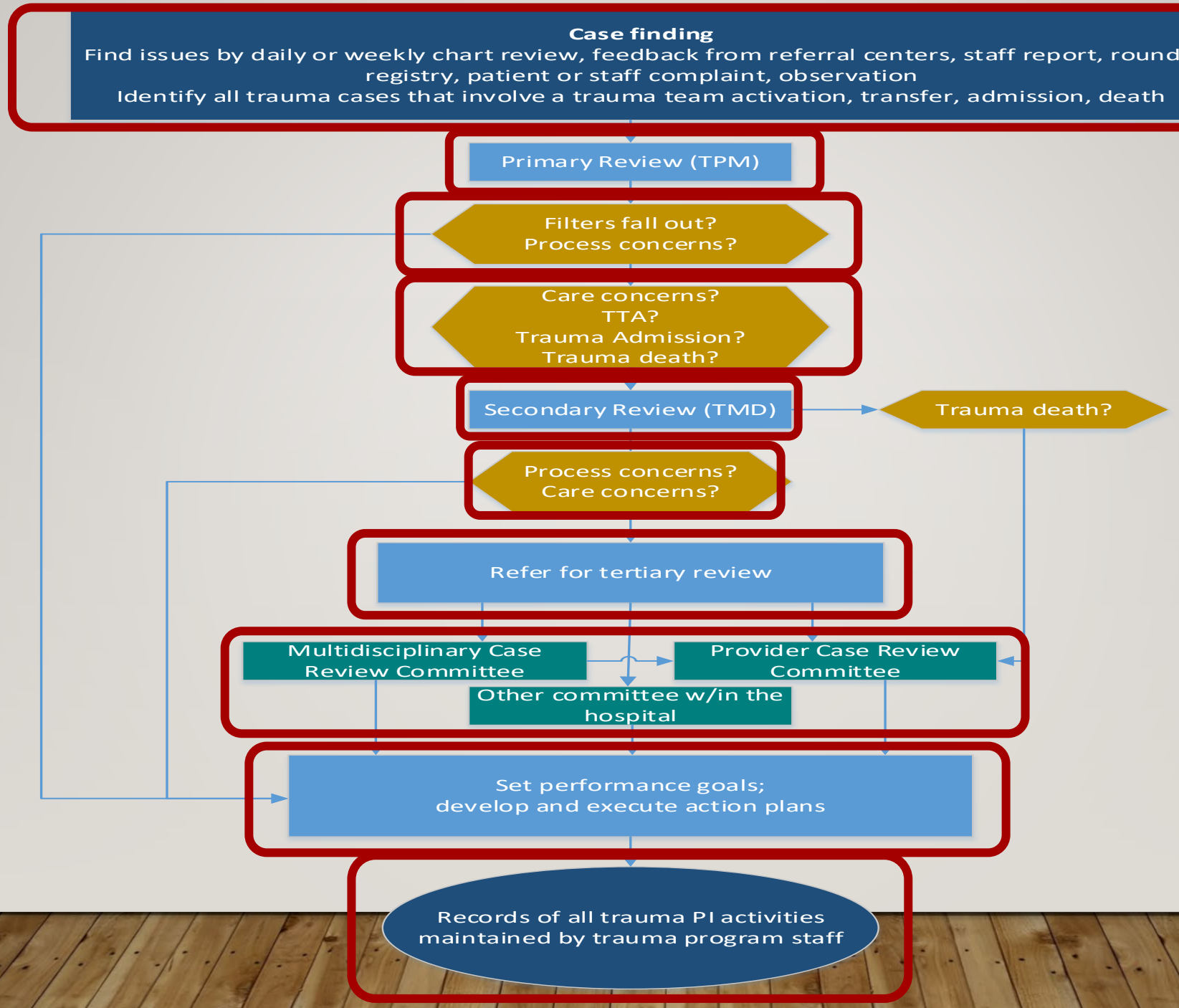
MULTI-LEVEL REVIEW DESCRIBED IN PLAN

Trauma Program Manager

Trauma Program Manager and Trauma Medical Director

Trauma Committee

Hospital Medical Review and/or Regional Review


Case finding
Find issues by daily or weekly chart review, feedback from referral centers, staff report, rounds, registry, patient or staff complaint, observation
Identify all trauma cases that involve a trauma team activation, transfer, admission, death
Primary Review (TPM)
Filters fall out?
Process concerns?
Care concerns?
TTA?
Trauma Admission?
Trauma death?
Secondary Review (TMD)
Trauma death?
Process concerns?
Care concerns?
Refer for tertiary review
Multidisciplinary Case Review Committee
Provider Case Review Committee
Other committee w/in the hospital
Set performance goals;
develop and execute action plans
Records of all trauma PI activities maintained by trauma program staff

REVIEW

- Objective
- Subjective
- Thoughtful

Critical (krĭt´ĭ-kəl) adj.

Characterized by careful, exact evaluation and judgment.

INVESTIGATING

Read

Interview

Research

Follow Up

Reach Out

ISSUE IDENTIFICATION

Was standard of care followed (e.g. ATLS, TNCC, RTTDC)?

Were practice management guidelines and protocols followed?

Were policies followed?

What circumstances existed at the time (multiple, simultaneous patients)?

Were there system failures?

Was supervision adequate?

What were the pre-existing conditions?

What was the outcome?

DISCERNING ISSUES

Consistent with…

1. Industry guidelines
2. Acceptable practice
3. Regional/state standards
4. Local/hospital treatment guidelines
5. ~~Status quo~~

BUCKETS

- Process or System-related
- Disease-related
- Provider-related

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ACTION PLANNING

- Measurable
- Many types
  - Education
  - Resource enhancement (supplies, equipment, forms)
  - Protocol revision/Practice management guideline
  - Remediation/counseling
  - Root cause analysis
- Set a Goal

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MEASURING EFFECTIVENESS

Using Data

- Trauma Registry
- Hand-Collected
  - Long-term e.g., tracking filters
  - Short-term e.g., custom study

LOS >60 minutes before transfer from ED

Medical Record Num	ED/Acute Care Admission Date	ED/Acute Care Admission Time	ED/Acute Care Discharge Time	ED/Acute Care LOS Minutes	Hospital Transferred To	Trauma Team Activation Level	ISS Calculated
[redacted]	9/20/14	11:03 AM	3:55 PM	292	[redacted]	Not Activated	1
[redacted]	9/23/14	8:02 AM	9:59 AM	117	[redacted]	Not Activated	5
[redacted]	9/25/14	8:13 PM	2:09 AM	356	[redacted]	Not Activated	4
[redacted]	9/27/14	9:22 AM	2:30 PM	308	[redacted]	Not Activated	10
[redacted]	9/28/14	4:56 AM	8:03 AM	187	[redacted]	Not Activated	1
[redacted]	10/1/14	3:40 AM	5:29 AM	109	[redacted]	Tier 1	5
[redacted]	10/1/14	8:20 PM	12:07 AM	227	[redacted]	Not Activated	9
[redacted]	10/2/14	5:48 PM	8:09 PM	141	[redacted]	Not Activated	1
[redacted]	10/6/14	6:19 AM	9:29 AM	190	[redacted]	Not Activated	5
[redacted]	10/8/14	6:31 AM	9:27 AM	176	[redacted]	Not Activated	5
[redacted]	10/11/14	1:11 PM	6:28 PM	317	[redacted]	Not Activated	9
[redacted]	10/17/14	10:20 AM	1:50 PM	210	[redacted]	Not Activated	4
[redacted]	10/19/14	4:14 AM	6:48 AM	154	[redacted]	Not Activated	4
[redacted]	10/19/14	1:44 PM	5:26 PM	222	[redacted]	Tier 2	5

Filter	Quarter 1 %	Quarter 2 %	Quarter 3 %	Quarter 4 %
LOS > 60 min= transfer	20	18	35	12
Hip fx and no DVT prophylaxis	0	0	3	0
IV smaller than 16 Ga.	80	76	86	45
IV fluid volumes not documented	35	16	22	30
No warming measures	67	62	44	12
> 65 y.o., head inj. & no collar	33	19	5	8

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"Effective PI demonstrates that a corrective action has had the desired effect as determined by continuous monitoring and evaluation" (ACS, 2014)

The action plan is NOT loop closure

Action Plan = what you intend to do about it

Loop Closure = evidence of the effectiveness of the action plan

LOOP CLOSURE

Demonstrate loop closure

- High frequency opportunities:
  - Execute the action plan
  - Measure effectiveness/monitor for recurrence
  - Attain a goal
- Low frequency opportunities:
  - Execute the action plan

TPM & TMD REVIEWS (SECOND TIER)

- Admits
- Trauma team activations
- Direct to OR
- Care by advance practice providers

TRAUMA COMMITTEE REVIEWS (THIRD TIER)

- Complications
  - e.g.: DVT, hospital acquired-pneumonia, missed injury
- Unexpected outcomes
- Sentinel events
- Deaths

DOCUMENTATION

CONFIDENTIAL PURSUANT TO [INSERT CITATION]
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Trauma PI Filter Tracking Worksheet

Patient name: _____ Admit date: _____

Medical record #: _____

Population Filter	Yes	No	N/A
*TTA and/or patient met TTA Criteria			
*Death (ED or in-house)			
*Transferred to level of higher care within hospital			
*Transferred			
Performance Standard Filter			
*Emergency department provider arrival >30 minutes			
High acuity or high energy mechanism and patient's length of stay in ED >60 minutes before transfer			
Low acuity or low energy mechanism and patient's length of stay in ED >120 minutes before transfer			
GCS ≤8 and no endotracheal tube or surgical airway			
No chest tube placed for pneumothorax or hemothorax before transfer			
Spine board removal >30 minutes after arrival			
Initial temperature not recorded			
EMS report not in patient chart			
Pain level persistently >5			

Any chart that generated a "Yes" must be reviewed by trauma PI team.

☐ No improvement opportunities identified

Comments:

Signature:	Date:

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Trauma PI Tracking Form

Demographics	Source of Information	Location of Issue
Date of report: Date(s) of occurrence: Medical record #:	☐ Trauma program coordinator ☐ Nurse manager ☐ Staff nurse ☐ Physician ☐ Patient relations ☐ Rounds ☐ Multi-disciplinary conference ☐ Registry ☐ PI chart audit ☐	☐ EMS ☐ ED ☐ OR ☐ ICU/PACU ☐ Floor ☐ Radiology ☐ Lab ☐ Rehab ☐

Complication, problem or complaint:

Date of review:	Reviewed by:

Determination	Outcome	Preventability
☐ system-related ☐ disease-related ☐ provider-related ☐ unable to determine	☐ expected outcome ☐ unexpected outcome	☐ without opportunity for improvement ☐ with opportunity for improvement

Corrective action

☐ not necessary	☐ guideline/protocol	☐ resource enhancement
☐ trend/track similar occurrences	☐ individual counseling	☐ privilege/credentialing review
☐ education	☐ provider case review	☐ _____

Action Plan(s) & Effect(s):

Signature:	Date:

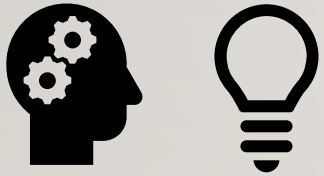
Trauma Patient Safety Peer Review Committee
MINUTES

DATE: DATE, LOCATION
DEPARTMENT/COMMITTEE: Trauma Patient Safety Peer Review Committee
ATTENDANCE: See Attachment A

AGENDA ITEM	PHYSICIANS/ MEDICAL STAFF	DISCUSSION/CONCLUSION	ACTION	PROCESS
1.CALL TO ORDER		Called to order by at	The meeting was called to order.	-------
2.APPROVAL OF MINUTES FROM		On a motion by second by . Members approved the DATE Trauma Patient Safety Peer Review Committee minutes.	The minutes were approved	Closed
3.PEER REVIEW A. Patient Cases Log #	All in Attendance	Committee Reviewed for: _____ Location of issue: Principle Diagnosis: Principle Procedure: Case presented by: Discussion: Needs:	**Note here if any memos sent, letters, policy changes, sent to committee for X, etc.**	**Document closed, awaiting feedback from X, etc.**
ISS > XX				
B.AUDIT FILTERS				
i.ADMIT TO NONSURGEON				
ii.MISSED INJURIES				
iii.TRAUMA TRANSFERS				
iv.DIRECT ADMITS		MONTH had X cases of direct admits. Committee reviewed and found all acceptable or whatever there findings are.		
v.PEDIATRIC TRANSFERS		MONTH had X cases of pediatric admits. YEAR admitted for ___ hours then transferred to _____. Committee reviewed and asked for a letter to be sent to Dr. X addressing delay in transfer.	**Letter sent to Dr. X on DATE. Continue to monitor**	**ongoing**
vi.MONTHLY PI				
vii.COMPLICATION				
viii.REGISTRY STATS		Attached - Trauma Registry Stats report for MONTH. NAME presented report to committee members.		
4.EDUCATION		Trauma handout article on _____.		
5.NEW BUSINESS				

Include your legal peer review statement

TRANSFORMATION



SYSTEM TRANSFORMATION EXAMPLE
CASE FINDING

- *Reviewed emergency department log; found a high acuity trauma patient who was transferred*

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SYSTEM TRANSFORMATION EXAMPLE
REVIEW

- *Pulled up record and reviewed case; completed PI Tracking Form*
- *Length-of-stay before transfer was 90”*
  - *Performance standard: Length of stay <60” before transfer, 80% of the time*

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*Death (ED or in-house)		√	
*Transferred to level of higher care within hospital		√	
*Transferred		√	
Performance Standard Filter			
*Emergency department provider arrival >30 minutes		√	
Length of stay in ED >60 minutes before transfer	√		
GCS ≤8 and no endotracheal tube or surgical airway		√	
No chest tube placed for pneumothorax or hemothorax before transfer		√	
Spine board removal >30 minutes after arrival		√	
Initial temperature not recorded		√	
EMS report not in patient chart		√	
Pain level persistently >5		√	

Any chart that generated a "Yes" must be reviewed by trauma PI team.

SYSTEM TRANSFORMATION EXAMPLE
INVESTIGATION/INQUIRY

- *Were imaging studies needed to aid in disposition determination?*
- *Was transportation delayed?*
- *When was need to transfer identified?*
- *Make inquiries of staff involved*

1. Case Finding
2. Review
   - Thoughtful analysis
   - Issue Identification
   - Investigation
3. Action Plan
4. Measure Effectiveness of Action Plan
   Evaluation, Re-evaluation, Re-re-evaluation…
   Re-action Plan
5. Loop Closure

SYSTEM TRANSFORMATION EXAMPLE
INVESTIGATION/INQUIRY

Delayed transfer appears to involve imaging studies performed before transfer

- *Provider related?*
- *System related?*
- *Disease related?*

1. Case Finding
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CONFIDENTIAL PURSUANT TO [INSERT CITATION]
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Trauma PI Filter Tracking Worksheet

Patient name: _____ Admit date: _____

Medical record #: _____

Population Filter	Yes	No	
*TTA and/or patient met TTA Criteria		√	
*Death (ED or in-house)		√	
*Transferred to level of higher care within hospital		√	
*Transferred		√	
Performance Standard Filter			
*Emergency department provider arrival >30 minutes		√	
Length of stay in ED >60 minutes before transfer	√		
GCS ≤8 and no endotracheal tube or surgical airway		√	
No chest tube placed for pneumothorax or hemothorax before transfer		√	
Spine board removal >30 minutes after arrival		√	
Initial temperature not recorded		√	
EMS report not in patient chart		√	
Pain level persistently >5		√	

Any chart that generated a "Yes" must be reviewed by trauma PI team.

☐ No improvement opportunities identified

Comments:

LOS 90"; EMS response time 20"; many imaging studies
Imaging needed to make transfer decision?

Signature: *TPM*	Date:

Need to transfer appeared clear upon patient presentation

Review case w/ providers

Signature: *TMD*	Date:

SYSTEM TRANSFORMATION EXAMPLE
ACTION PLANNING

- *Send case to committee for review*
- *Review transfer indicators in policy*
- *Discuss need to refrain from obtaining studies that do not impact the resuscitation*

1. Case Finding
2. Review
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SYSTEM TRANSFORMATION EXAMPLE
MEASURING EFFECTIVENESS

Did it work?

- *Analysis with data (when available)*
- *Track, trend & report*
  - *Add new filter*
  - *Measure performance*
- *Strategize new solutions*

1. Case Finding
2. Review
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   Re-action Plan
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SYSTEM TRANSFORMATION EXAMPLE
LOOP CLOSURE

Did it work?

Yes!

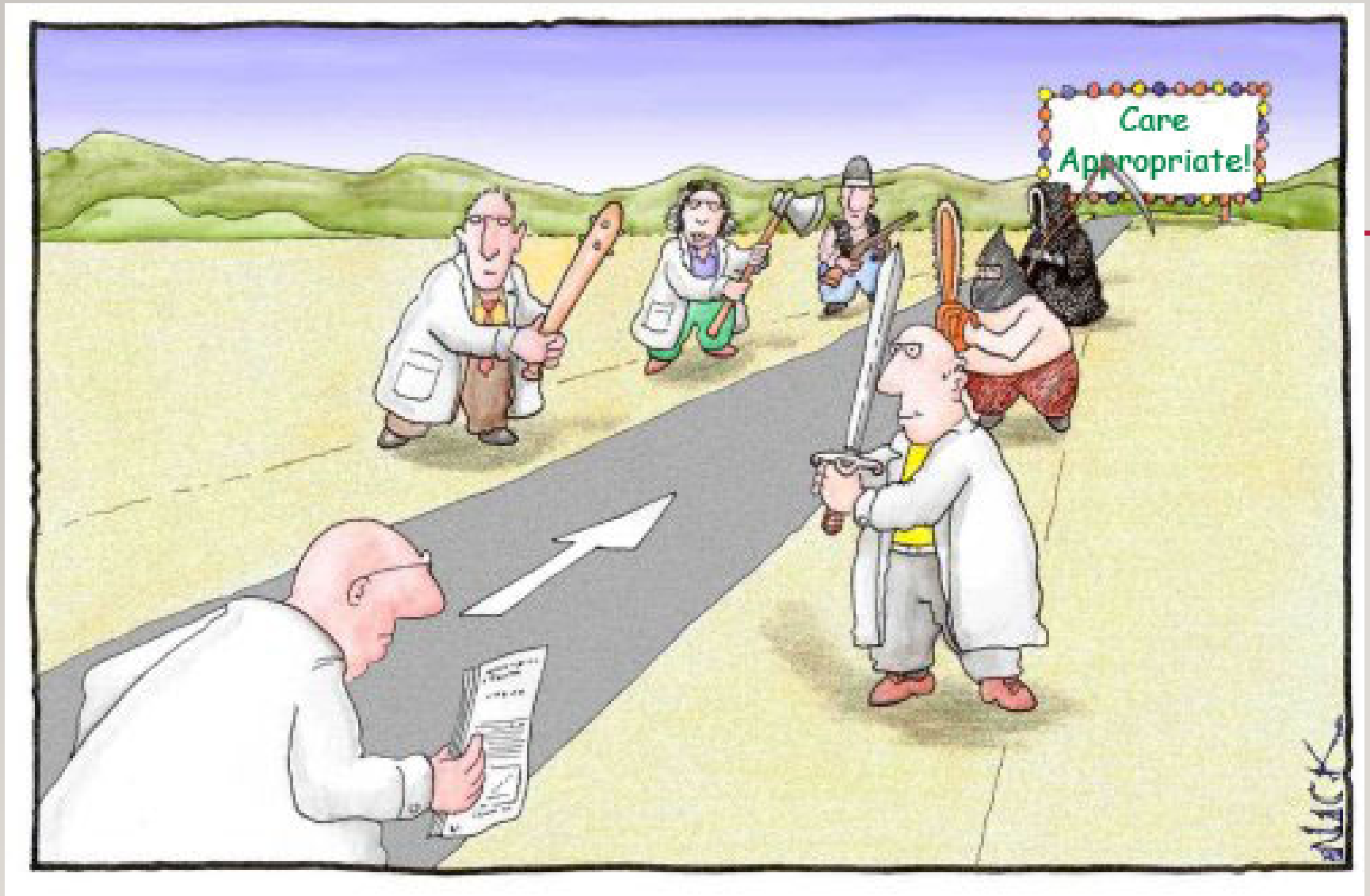
Goal Attained

1. Case Finding
2. Review
   - Thoughtful analysis
   - Issue Identification
   - Investigation
3. Action Plan
4. Measure Effectiveness of Action Plan

   Evaluation, Re-evaluation, Re-re-evaluation…

   Re-action Plan
5. Loop Closure

CASE REVIEW



"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement

CASE REVIEW MEETINGS

OLD

- Who did it?
- Punishment
- Errors are rare
- Medical staff doesn't participate

NEW

- How did the system allow it to happen?
- Collaborative learning
- Errors are everywhere!
- Everyone must participate

CASE REVIEW MEETINGS

- Regularly scheduled
- Attended by all providers
- Environment
  - Constructive
  - Educational
  - Not punitive
  - Non-accusatory

Goal is to improve everyone's and everything's performance!

ACTIONS

- Evaluate for acceptable practice
- Education or training
- Practice management guideline
- Individual counseling
- Additional peer review

ENGAGING LOCUMS

Videoconferencing

Agency Partnership

Individual Counseling

Review Minutes

ADMINISTRATIVE RULES

Michigan Criteria for Trauma Facility Designation

at www.Michigan.gov/traumasystem

CONFIDENCE COURSE

CONFIDENCE COURSE

Small group exercise

Report outs at the end

ADMINISTRATIVE RULES

- R 325.127

"Quality improvement program" means actions taken by a life support agency, medical control authority, trauma facility, or jointly between a life support agency, medical control authority, or trauma facility with a goal of continuous improvement of medical care in accordance with the code. Actions shall take place under a professional standards review organization, as provided in MCL 331.531 to 331.533.

ADMINISTRATIVE RULES

- R 325.127

"Regional Professional Standards Review Organization or RPSRO" means a committee established by the regional trauma network for the purpose of improving the quality of trauma care within a recognized trauma region as provided in MCL 331.531 to 331.533.

CONFIDENTIALITY TIPS

- Do not discuss/disclose for any purpose other than review
- Disclaimer on ALL PI documents
  - Ex:"Confidential Pursuant to MI Statute…"
- Lock the file cabinet
- Avoid email and fax mediums
- Do not reference PI documents/activities in medical record

CASE REVIEW MEETING TIPS

- Attendees must have legitimate purpose
- Regularly review confidentiality procedures
- Sign in
- Lock the door
- De-identify documents
- Number copies, collect and inventory
- Consult with legal/risk management

BUILDING AND REMODELING

CONCLUSION

- Receive ORIENTATION and leave with a system understanding
- Have the GEAR to describe event identification, levels of review, and loop closure
- Be able to TRANSFORM existing practices
- Complete a CONFIDENCE COURSE of scenarios