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TRAUMA PROGRAM PERFORMANCE IMPROVEMENT PLAN

I. Purpose

The Trauma Performance Improvement Plan is designed to ensure efficient, cost effective, high quality patient care. Patient care is facilitated by continuous, systematic and objective data analysis, along with multidisciplinary peer review in order to identify opportunities to improve patient safety through all phases of trauma care.

II. Authority/Scope of Trauma Performance Improvement

A. The trauma performance improvement program crosses many specialty lines, and must be empowered to address events that involve multiple disciplines. The PI Program is endorsed by the hospital governing body as part of its commitment to optimal care of injured patients.

B. The PI program is integrated with the hospital quality and patient safety effort and have a clearly defined reporting structure and method for provision of feedback.

C. The hospital's trauma program is integrated into the hospital's organizational structure with sufficient authority to effect change across several departments.

D. The Trauma Program has a formal performance improvement process that allows for a multidisciplinary approach to problem identification, data driven analysis and resolution of issues.

1. Patient care will be monitored utilizing guidance from the American College of Surgeons Committee on Trauma, guidance from the State of Michigan and the facility's Trauma Performance Improvement Committee.
2. All cases or systems issues identified will be reviewed by the TPM/TPC and elevated to the Trauma Medical Director as directed in the Trauma Program PI Plan. within the Trauma Department meeting.

3. Levels of Review:

First Level of Review:

- Identification, Validation, Documentation
- Trauma Program Manager, Department Issue

Second Level of Review:

- Trauma Program Manager
- Trauma Medical Director

Third Level Review:

- Trauma Peer Review

D. Documentation of Identified Trauma Issues
E. Referral Process for Investigation or Review

III. Multidisciplinary Trauma Committee

A. The trauma facility's PI program must have a multidisciplinary trauma peer review committee chaired by the TMD with representatives from general surgery (group of general surgeons on the call panel), orthopedic surgery, emergency medicine, ICU, and anesthesia, and neurosurgery (if applicable). (CD 6–8, CD 5-25)

The following trauma team members must attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings. (CD 16-15)

1. Trauma Medical Director (CD 5-10)
2. General Surgeons on the call panel (CD 6-8)
3. Emergency Medicine Representative or designee (CD 7-11)
4. Orthopedic Liaison (CD 9-16)
5. Anesthesiology Representative (CD 11-13)
6. ICU Liaison (CD 11-62)
7. Neurosurgical Representative (CD 8-13)

B. The multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured. (CD 2–18)

C. There must be documentation (minutes) reflecting the review of operational events and, when appropriate, the analysis and proposed corrective actions. (CD 16-13)

IV. Trauma Program Staff

A. Trauma Performance Improvement is a hospital-wide effort. All departments, employees, services, committees, medical staff, all levels of management, and the Board of Trustees are involved.

1. **Trauma Medical Director** - responsible for chairing the Trauma Operational and Multidisciplinary PI meetings and for the initial review of all physician related issues including deaths and identified complications utilizing data support from the trauma registry. They are also responsible for developing/facilitating trauma protocols and guidelines, performance improvement initiatives and physician FPPE/OPPE.
2. **Trauma Program Manager/Coordinator** - responsible for identification of issues and their initial validation, the maintenance of the trauma PI data, facilitating data trends and analysis, and for coordinating surveillance of protocols and guidelines to assure standard of care is being met. They are also responsible for developing/facilitating trauma protocols and guidelines, maintaining the Trauma PI process with data support from the trauma registry and development of PI initiatives based on data trends.
3. **Trauma Registrar** - assists the Trauma Coordinator in activities, using registry indicators and compilation of reports to support the PI program.

V. Review Process

A. **Medical Staff:** The Trauma Registrar will enter data into the Statewide Trauma Registry. The Trauma Medical Director and Trauma Coordinator will review charts against established criteria. Those charts determined to need a 2nd level review will be taken to the Trauma Services Committee. Evaluation of care, processes and systems will be made.

B. **Hospital Staff or System Issues:** Trauma issues identified that involve nursing and/or ancillary department staff will be taken to the Trauma Operations Committee. Timely feedback will be given to staff and physicians involved. Areas for improvement and education will be identified. Changes will be made and monitored for improvement.

VI. Loop Closure and Re-evaluation

A. 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 PI program. (CD 16-18)

B. Examples of corrective actions include the following:

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

C. All loop closure must be documented, included when the corrective action is completed.