Trauma Nurse Coordinator Connect

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Quality is a journey, not a destination…………….

if you don't have a road map, how do you know where you need to go??????

Cindy Blankenship, RN
Trauma Nurse Coordinator
CHI Health Good Samaritan Hospital
Advanced State Designation

Jane O'Connor, RN
Trauma Performance Improvement Coordinator
CHI Health CUMC-Bergan Mercy
Level 1 ACS Verified

A Trauma Process Improvement Program is our road map for Trauma PI

- A continuous process of monitoring, assessing, and management, directed at improving care
- A clearly defined and written plan the incorporates recognition of issues, corrective actions, and **loop closure!!**
- What PI ISN'T…..blaming, punitive, or retaliatory…..
- Our GOAL, 'to make tomorrow's trauma care better'. A quote from Renae!!

A Trauma Process Improvement Program is our road map for Trauma PI

- Elements of PI Plan
  - Mission and Goals
  - Administrative Structure and Scope
  - Data Collection and Management
    - Methods of Identifying PI Issues
    - Permanent Audit Filters
    - Types of PI Quality Indicators
  - Levels of PI Review
    - Primary Review
    - Secondary Review
    - Tertiary Review
  - Corrective Action Plan and Implementation
- Committee Structure
  - Performance Improvement and Patient Safety (PIPS) Committee
  - Multidisciplinary Peer Review
  - Mission and Goals
- Integration into Hospital Quality Program
- Review of PIPS Plan
- Attachments (e.g.)
  - PIPS Flow Chart
  - Indicators and Complications
  - Trauma Mortality and Morbidity Classifications

How am I going to create that road???

Levels of review: ***(additional algorithms)***

Defined steps in order to reach an event resolution……

- Primary Review
- Secondary Review
- Tertiary Review
- External review

Primary Review….

- How are you identifying your patients??? Do you have an ED log, in patient census???
- Primary review is often done by the Trauma Nurse Coordinator or PI nurse
- It is a process to look at every patient in an organized fashion
- Utilization of audit filters will help facilitate ‘your binoculars’ for issues and/or trends
- Review may be concurrent, often retrospective, but you want it to be timely
- Events may be closed at this level. REMEMBER you WANT loop closure!!

What’s an audit filter????

- Audit filters are a way to look at patient care and process and system issues. Can include, but are not limited to pre-hospital, nursing, physician, and inpatient filters. Theses filters can trigger a review if the standard is not followed.
- Audit filters are continuously monitored, evaluated and adjusted. When you find your consistently meeting a care data point, think about moving on to another care issue.
- Audit filter examples:

  Potential EMS filters: How was documentation, was it complete? Did you have a full set of VS to include GCS? Were they appropriately immobilized? Were there any airway issues?

  Potential Trauma Activation filters: Did team members arrive in a timely fashion? Was it an appropriate level of activation? How was the nursing documentation, did they use a trauma flow sheet?? What was the ED LOS.

  Did they document **decision to transfer times and did you meet your goal??**

  Potential In-patient filters: Did they receive antibiotics in a timely fashion for open fractures. Did the patient have appropriate DVT prophylaxis?

  Don’t forget to Include pediatric audit!!

- **MAKE THEM YOUR OWN AND MEANINGFUL TO ISSUES YOU MAY BE HAVING OR SUSPECT YOU ARE HAVING…….REMEMBER, THEY CAN BE ADJUSTED BASED ON CURRENT HAPPENINGS…**

If the loop isn't closed with the primary review, issues may be sent for a **Secondary Review…**

- Secondary Review may be sent to a Department Leader for Loop Closure
- Secondary Review may be sent to your Trauma Medical Director for Loop closure
- OR, you may need to send it for Committee review:
  - Multidisciplinary committee
  - Physician Peer Review
  - May have other Committees in your facility

Multidisciplinary Committee:

- Often looks at process issues. Make sure to include ALL players!!
- Meet regularly
- Often chaired by Trauma Medical Director (TMD) or Trauma Program Manager (TPM)
- System and process focused
- Can often result in PI projects
- Minutes
  - Actions
  - Responsible person(s)

Trauma Peer Review Committee:

- Can be a part of your Quality Committee, but MAKE SURE Trauma is separate agenda item with clear documentation of Trauma related issues
- Usually chaired by Trauma Medical Director
- TPM can be a part of this Committee OR needs to have communication for the TMD about classifications / actions / levels
- PEER protected (Privileged Communication Not Subject to Disclosure per Nebraska 25-12, 123; 28-435.01; 126; 38-1, 127; 71-6736; 71-7460.02 and Iowa Code 147.135)
- Review of selected cases, mortalities, adverse events, and selected cases
- Mortality classifications: Mortality without opportunity, Mortality with opportunity, and unanticipated mortality with opportunity
- Minimum of 50% attendance requirement
- ALL MINUTES MUST INCLUDE FRANK AND OPEN DISCUSSION WITH DEMONSTRATION OF LOOP CLOSURE…..

Tertiary Review:

- External Review of a mortality with opportunity

Loop closure: It’s HARD!!!!

What is loop closure??

How do I know when I’m done??

- Most cases are done quickly
- Not every case needs an action plan
- Sometimes closure is tracked and trend, but make sure you have a way to track and trend!!
- If death is a mortality without opportunity…. You’re done
  - Autopsy

Morbidity & Morality Classifications

- **ACS: Mortality w/o OFI**
  - Death or morbidity results from an event or complication that is a sequela of a procedure, disease, illness, or injury for which reasonable and appropriate preventable steps have been taken
- **ACS: Mortality w OFI**
  - Death or morbidity results from an event or complication that is a sequela of a procedure, disease, illness, or injury that has the potential to be prevented or substantially ameliorated
- **ACS: Unanticipated Mortality w OFI**
  - Death or morbidity results from an event or complication that is an expected or unexpected sequela of a procedure, disease, illness, or injury that could have been prevented or substantially ameliorated

Taxonomy: Classification System

- Contributing Factors
  - System Related
  - Disease Related or Condition
  - Provider Related
  - Unable to Determine

Taxonomy: Classification System

- **Contributing Factors** *(continue)*
  - **System Related** (not specifically related to provider or disease)
    - Resources
    - Staffing, training, budget
    - Communication verbal and or documented
    - Protocols / Policies / Patient Safety
    - Equipment
    - Pre-hospital care
  - **Disease Related or Condition** (an expected sequela of a disease or injury / failures related to patient characteristics)
    - Non-compliant or refusal
    - Survival Probability and or DOA
    - Co-morbidities
    - DNR / withdrawal of life support

Taxonomy: Classification System

- **Contributing Factors** *(continue)*
  - **Provider Related**
    - Diagnosis Error
    - Technique Error
    - Judgement Error
    - Other
  - **Unable to Determine**

Last thought…..

- MAKE SURE YOU'RE USING YOUR TRAUMA REGISTRY TO DRIVE YOU PI AND/OR PREVENTION PROJECTS!!
  - Reports
  - Scorecards / Dashboards

Resources

Cindy Blankenship, RN

Email: CindyBlankenship@catholichealth.net

Office: 308.865.7684

Jane O'Connor, RN

Email: jane.oconnor@Alegent.org

Office: 402.639.5283

State of Nebraska: QA/Data Committee / State Data Dictionary review in progress

National Trauma Data Standard (NTDS) Data Dictionary: 2019

https://www.facs.org/~/media/files/quality%20programs/trauma/ntdb/ntds/data%20dictionaries/ntdb_data_dictionary_2019_revision.ashx

American College of Surgeons Trauma Quality Improvement Program (TQIP)

www.facs.org/quality-programs/trauma/tqp/center-programs/tqip

Quarterly Registrar Webinars

Monthly Verification Webinars

"Orange Book" Optimal Care of the Injured Patient

Society of Trauma Nurses www.traumanurses.org

Trauma Outcomes and Performance Improvement Course (TOPIC)

The END….
Questions????????