

# **Taxonomy Trivia**

## **A Panel Presentation**

*Transitioning to a common language:  
Together - Identifying avoidable errors in the management of the injured*

# 2013-2014

- December 2013, ACS COT Endorsed The Joint Commission Taxonomy as:
  - Recommended as best practice
  - ACS COT PIPS committee
  - ACS VRC leadership
  - Inclusion next Optimal Resource book.
- 2014, The ACS Resources For Optimal Care Of The Injured Patient, brought focus & attention to Performance Improvement Process and expectations.

# Not only appearance changes...

Pennsylvania Trauma Systems Foundation  
2015-2016 Standards for Trauma Center Accreditation  
Adult Trauma Centers—Levels I, II & III

General Standards	Level I	Level II	Level III
<b>Standard XXXIII—Trauma Performance Improvement and Patient Safety Programs</b>			
<ul style="list-style-type: none"> <li>c. Analysis (i.e. Performance Improvement forums and meetings)</li> <li>d. Preventability classification</li> <li>e. Action plan development / implementation / reevaluation</li> </ul>			
5. Development of and use of patient management guidelines to guide and assess appropriateness of care			
D. A multidisciplinary forum(s) for (PIPS) review is necessary. The Trauma Program Medical Director, in collaboration with the Trauma Program Coordinator, will have a leadership role in all forums. Minutes must be maintained for all meetings. The goals of multidisciplinary review include:	E	E	E
1. Review of the performance of the trauma program. This can be accomplished by a multidisciplinary committee, which should include representatives from all phases of care. The following elements will be addressed: all disciplines, all trauma facilities	E	E	E

## STANDARD 6

### Performance Improvement & Patient Safety (PIPS) Program

3. There must be a comprehensive written Performance Improvement Plan that includes:
  - A. Authority and empowerment by the hospital governing body for the TPMD and TPM to lead the PI program and transcend service lines.
  - B. Trauma credentialing requirements.
  - C. Roles and responsibilities for PI.
  - D. Issue identification encompassing all phases of care.
    - i. Process for verification and validation of events:
      - a. Process for retrospective review.
      - b. Process for concurrent review.
  - E. Process for data collection, use of indicators, opportunities for improvement (OFI), occurrences, and audit filters.
  - F. Levels of review as defined by the PIPS plan, such as:
    - i. Primary: Typically TPM, Trauma PI Coordinator, Registry or designee
    - ii. Secondary: Typically TPM, PI Coordinator and TPMD
    - iii. Tertiary: Typically multidisciplinary forum
    - iv. Quaternary: Typically hospital (high-level) committee, system level or external review

# PTSF Standard PIPS Updates

## 2015-2016

- PIPS Plan
- POPIMS utilization (Including Level IV centers)
- POPIMS Central Site Submission
- FT/ 1.0 FTE Performance Improvement Coordinator (PIC) role
  - Education requirement of 8 hours annually
  - TOPIC completion
  - 75% PI meeting attendance
- Multidisciplinary PIPS committee : Peer Review
- Multidisciplinary Operational PIPS committee
- Utilization of Practice Management Guidelines
- PIPS Core Measures
- Updated PTSF PIPS Committee Structure

# PA PIPS Updates & Implementation 2016-2017

- POPIMS software updated to support discretionary use of taxonomy classification
- POPIMS Central Site Submission required with taxonomy classification of death issue only
- TQIP participation required
- PA TQIP Collaborative started
- ACS – further defining & traumatizing “The National Quality Forum Taxonomy”

# PA PIPS Updates & Implementation 2018

- 1879 PTOS Deaths/1541 POPIMS Central Site Submissions
  - **113 (P)/(OFI-UE)**
  - **293 (PP/OFI-AE)**
  - **406 (Identified with OFI)**
  - **1134 (NP/(NO-OFI))**
- Transitioned to PA V5 Outcomes
- Development of PA V5 RDE Report Package
- Development of Core Measures & AFS Report

# Lessons Learned to Date

- Taxonomy is used to classify “events” (issues, opportunities) Death classification without events caused confusion ? value
- Taxonomy language isn’t intuitive and does not align with common trauma event definitions
- Thank you to the following panel participants sharing PI processes with incorporation of taxonomy to date
- ACSCOT Taxonomy update to follow panel presentation & 2019 next steps
- Please hold questions until end of the presentation

## Panel Participants:

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Trauma Program Manager,

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Trauma PI Coordinator,

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Susan Lampariello, BSN, RN

Trauma PI Coordinator

Patricia Palubinsky, BSN, RN, CCRN

Trauma PI Coordinator

Penn State Health

Milton S. Hershey Medical Center



# Value & Future of Trauma Taxonomy

- This information is based on the work of Donald Jenkins, MD, Carol Immermann, RN & Kathie Martin RN
- Link to access the LMS directly:  
<https://secure.icohere.com/PTSF>
- Implementing Trauma PIPS Classification (webinar)

# Limitations with “the old way”

- Traditional trauma PI programs have employed: “preventable”, “possibly preventable”, or “non-preventable”.
- Does this ensure that performance is improved?
- Tends to focus on the attribution of blame.
- Unfortunately - determining that a death was “non-preventable” often led to no further evaluation of the case
- Many opportunities for improvement (OFIs) are not investigated.

# A Familiar Comparison

## Registry

Data Quality



Poor interrater reliability

## PI Program

Preventable

Pot preventable

Non preventable



Poor interrater reliability

# Taxonomy Enables Data Sharing & Analysis

- **Building blocks**
  - Common definitions
  - Clear terminology
- **Scope**
  - Comprehensive tool
  - Applicable to all settings
  - Includes multiple levels of
  - patient harm
- **Addresses:**
  - Sentinel events
  - Adverse events
  - No harm events
  - Near misses
  - Close calls
  - Potential events

# ACSCOT Update

- Connect PIPS with NTDS, NTDB, VRC and TQIP
- Definitions of NQF taxonomy are being ‘traumafied’
- NTDB and TQIP input (worked on at EAST)
- Many NTDB and TQIP adverse events have elements that are not defined in the NQF taxonomy (Worked on at EAST)
- Evaluate best practices
- Advise low performing centers on these

# Primary Classifications Further Defined

1. **Impact**: the outcomes or effects of medical error and systems failure, commonly referred to as harm to the patient.
2. **Type**: the implied or visible processes that were faulty or failed.
3. **Domain**: the characteristics of the setting in which an incident occurred and the type of individuals involved.
4. **Cause**: the factors and agents that led to an incident.
5. **Prevention and Mitigation**: the measures taken or proposed to reduce the incidence and effects of adverse occurrences.

# PA PIPS Updates Implementation 2019

- Moving forward
- PTSF Outcomes Central Site will include taxonomy data
- Taxonomy classification utilized for all issues/events associated with death case submission
- Utilizing ACS “traumafication” of the “National Quality Forum Taxonomy”

## Differentiating Levels of Harm

1. No Harm - Sufficient information determines no harm occurred
2. No Detected Harm - patient outcome is not symptomatic or no symptoms detected and no treatment is required. Insufficient information or unable to determine any harm
3. Minimal Temporary - patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review or minor treatment) is required
4. Minimal Permanent - requires initial but not prolonged intervention
5. Moderate Temporary - patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure; additional therapeutic treatment), an increased length of stay, or causing permanent or long term harm or loss of function
6. Moderate Permanent - Requires intensive but not prolonged hospitalization (not resolved at time of hospital discharge)
7. Severe Temporary - Requires intervention necessary to sustain life but not prolonged hospitalization (resolved at time of hospital discharge)
8. Severe Permanent - patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing major permanent or long term harm or loss of function (not resolved at time of hospital discharge)
9. Death - on balance of probabilities, death was caused or brought forward in the short term by the incident



# Examples of Impact & Harm

## Determinations

- **No harm**: Wrong patient got an AM chest x-ray. Similar names on different floors. No harm, a patient safety event.
- **Minimal**: Wrong antibiotic to wrong patient. Potential temporary harm slight reaction with treatment for reaction and monitoring.
- **Moderate**: Pneumothorax cause by subclavian central line placement; requiring a chest tube and extended ICU LOS.
- **Severe**: A previous active elder female with a history of Coumadin is admitted for hip fracture. She is taken to OR post ED with elevated INR unnoticed. Suffers bleeding complications and needs MTF protocol to stabilize with multiple clotting factors.
- **Death**: Frequent doses of Ativan administered over a 24 hour period to a geriatric patient causing respiratory depression and respiratory arrest. Required intubation and transferred to ICU. Course of events was extended ICU with the patient remaining unresponsive and family withdrawing care.

# Degree of Harm

- **No Harm** – Standard of care provided with some deviations with no impact to the patient
- **Potential for Harm** – Event occurred but did not reach or impact patient; no treatment
- **Death** – death was caused or brought forward by the event
- **Temporary Harm** - Resolved by hospital discharge
- **Permanent Harm** - Does not resolve