PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN
FY 2013-2014
BACKGROUND:

The Trauma Performance Improvement Plan has been developed to describe the quality management processes utilized to review care of injured patients at the Robert Packer Hospital Regional Trauma Center. This plan outlines how the Division of Trauma performance improvement activities relate to the Pennsylvania Trauma System Foundation (PTSF) Standards for Trauma Center Accreditation; the Joint Commission standards for the Accreditation of Hospitals (JCAHO); and the Robert Packer Hospital Clinical Effectiveness and Quality Improvement (CEQI) plan.

This plan was developed utilizing nationally recognized trauma literature such as Resources for Optimal Care of the Injured Patient, The Society of Trauma Nurses Trauma Outcomes Performance Improvement Course, American College of Surgeons-Committee on Trauma, as well as, materials developed by JCAHO and other agencies.

DEFINITIONS:

**Trauma Program Staff** – Trauma Program Medical Director (MD), Trauma Program Manager (RN); Trauma Performance Improvement Coordinator (RN); Trauma Resource Nurse & Injury Prevention Coordinator(RN),Trauma Registrars.

**Major Unisystem/Multisystem Trauma Patient**
The patient with severe multisystem or major unisystem injury the extent of which may be difficult to ascertain, but which has the potential of producing mortality or major disability. This may result in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical, or chemical energy, or by the absence of heat or oxygen” (ICD9-CM codes 800-959.9); (ACS, 2006 p. 18 – Reference #1); (PTSF Standards glossary, pg. 65- Reference #2)

**PTSF** – Pennsylvania Trauma Systems Foundation – The private Pennsylvania foundation with legislated authority to designate hospitals as trauma centers

**PTOS** – Pennsylvania Trauma Outcome Study – The statewide Pennsylvania trauma database.
I. PHILOSOPHY:

At Robert Packer Hospital, our core values, patient centeredness, teamwork, and excellence, are the foundation of quality. These values shape us as we strive to fulfill our purpose “Making a meaningful difference in the lives of those we serve through compassion and excellence in healthcare....Every person, every time”. Excellence is defined as the delivery of care and services which are safe, effective, patient centered, timely, efficient, and equitable. Our aim is to achieve service and clinical excellence through the application of practices based on scientific evidence, published research, demonstrated best practices and performance standards.

The philosophy and mission of the Trauma Program is to sustain a center of excellence in trauma clinical care for every patient presenting to Robert Packer Hospital, lead the development of a comprehensive rural trauma system to serve the communities in this region, contribute to innovative evidenced-based clinical practice through education, research and publication, and to reduce the incidence of trauma through community education and injury prevention programs.

The Trauma Program seeks to maintain the trauma standards, both administratively and clinically, through the promotion and implementation of a continuous quality improvement system to monitor all aspects of the Trauma Program’s activities.

II. PLAN PURPOSE:

The purpose of this plan is to describe the framework and processes utilized in identifying, intervening, assessing and measuring activities designed to improve all aspects of care and services for injured patients and their families/significant others. This document outlines the steps of the performance improvement process from issue identification to intervention and resolution (loop closure).

Trauma care involves a systematic, collaborative approach. The Trauma Team encompasses a network of personnel from multiple hospital departments and disciplines, both at the staff and administrative levels. This multidisciplinary trauma team consists of professionals who work together to effect positive patient outcomes.

The Trauma Program Medical Director has the responsibility of monitoring the provision of injury care from the point of access through initial assessment, diagnosis, management, recovery and discharge. The Trauma Program with the help of the Associate Trauma Medical Directors, Trauma Liaisons and other trauma team members seek to continuously improve the processes and patient outcomes across this continuum.

All Trauma Program Performance Improvement initiatives are focused on a process-oriented systematic approach. The concepts and methods of Performance Improvement and Systems models are integrated throughout this plan.
III. MISSION:

The Trauma Center at Robert Packer Hospital (RPH) is committed to providing state of the art, quality injury care. In keeping with Guthrie Healthcare System values, the trauma center’s mission is to provide excellent care and the best possible service in a manner that is efficient and cost effective. The guiding principle is to assure Access, Service, Quality, and Value at all levels for every patient, every visit. (Also see Philosophy above)

IV. OVERALL GOALS:

The overall goals of the Trauma Performance Improvement Program at RPH are:

A. To provide a consistent, optimal level of care and service to all injured patients in the most effective, appropriate and resource efficient manner that is consistent with state and national standards of trauma care.
B. To assure the provision of integrated, refined levels of care and service for patients, families and significant others across the continuum of care.
C. To improve outcomes related to the quality of care for injured patients.
D. To provide leadership in the field of Trauma quality management through the development and implementation of best practices at Robert Packer Hospital and across the Guthrie Healthcare system.

V. SPECIFIC OBJECTIVES:

The core objectives of the Trauma Program Performance Improvement and Patient Safety Plan are “to monitor the process and outcomes of patient care, to ensure the quality and timely provision of such care, to improve the knowledge and skills of trauma care providers, and to provide the institutional structure and organization to promote quality improvement.” (Pennsylvania Trauma System Foundation, 2012 Standards for Accreditation: Standard XXXIII, pg. 54)

By integrating all appropriate hospital areas and considering national standards for trauma care and quality improvement, the RPH Trauma Program Performance Improvement and Patient Safety (PIPS) Plan strive to do the following:

A. Establish processes to identify, measure, assess, and improve clinical and system performance; thereby improving patient outcomes. Based on the principle areas of Access, Service, Quality and Value, the following process steps guide trauma performance improvement activities and are consistent with the JCAHO approach to performance activities: (See Attachment D)

B. 
   - PLAN
   - DO
   - CHECK
   - ACT

C. Utilize national and state standards in developing performance measures.
D. Encompasses PTSF Standard XXXIII elements:
   1. Concurrent and retrospective review
   2. Pediatric patient review
3. Documentation of performance review to include adult, elder, and pediatric sections.
4. Development and compliance monitoring of practice management guidelines (PMG’s). (aka: CMG’s clinical management guidelines)
5. Routine assessment of resources (staff) to manage Performance Improvement Program.
6. Assure that resource utilization and cost effectiveness features of performance improvement initiatives are monitored continuously

E. Utilize PTSF audit filters, Opportunities for Improvement and User Defined (Institution Specific) issues to review the care of the trauma patient and trauma systems processes and show measureable improvements based on issues identified. (See Attachments E & F for Calendar showing schedule of audit filter/PMG reviews)

F. In various multidisciplinary forums (See Attachment B): Peer review clinical care and program issues including: mortalities, transfers, and morbidities. Minutes will be maintained. Documentation will reflect: problem identification, analysis, preventability, action plan, implementation and re-evaluation. The Trauma Program Medical Director or designee will be responsible for the leadership of this forum.

G. Once an opportunity for improvement has been identified, the PI process will analyze, determine preventability, develop an action plan, implement the plan and re-evaluate the effectiveness of process.

H. Completed EMS trip forms, to be included in medical record, when available.
I. Post-mortem examination information will be sought in all trauma-related deaths (when available).

J. Written performance improvement plan will be maintained and reviewed annually.
K. Embrace a philosophy, which encourages and facilitates the discussion of trauma performance improvement activities.

L. Minimize clinical variations through the adoption and surveillance of Practice Management Guidelines for injured patients.

M. Assure that trauma performance improvement processes encompass clinicians from across the continuum of care and are focused on systematically resolving identified opportunities for improvement.

N. Develop, implement, and evaluate action plans for select clinical and system performance issues.

O. Provide reports on trauma performance improvement activities at appropriate Divisional, Institutional and State forums that are for the purpose of promoting the highest quality of care and efficient utilization of services.

P. Maintain confidentiality of Trauma Performance Improvement data, reports, and discussions as per the guidelines of the Pennsylvania Peer Review Act and the Health Information Portability and Protection Act (HIPPA).

Q. Communicate, through the various councils, pertinent information related to opportunities for improvement that are interdisciplinary in nature and reports (via balanced scorecards) to the RPH Performance Improvement structure (Hospital CEQI) on measures encompassing Access, Service, Quality and Value.
VI. AUTHORITY/SCOPE

The Trauma Program Medical Director in cooperation with the Trauma Program Manager along with RPH and Guthrie Healthcare Leadership has the ultimate responsibility for ensuring the delivery of quality injury care at Robert Packer Hospital. Summary findings, including variance reports, and trended data reports, are submitted to the appropriate RPH performance committees as per the RPH Quality Management Strategic Plan.

-Trauma performance improvement is under the direction of the Trauma Program Medical Director as delegated by the Medical Staff and hospital bylaws. Refer to RPH reporting structure. The trauma service has the authority to monitor all events that occur during a trauma-related episode of care when admitted to the institution.

-The Trauma Program Medical Director is empowered by the Medical Executive Committee to direct the Trauma Performance Improvement Program. The Trauma Program reports all PI activity to the Trauma Executive Committee & the Medical Executive Committee.

VII. CREDENTIALING

All surgical staff will be credentialed according to the Medical Staff Bylaws and the Department of Surgery Policy and Procedures before being scheduled for trauma call. The Trauma Program Medical Director will do initial and annual review of credentials for the trauma call panel. Neurosurgery, Orthopedic surgery, and Emergency Medicine will also undergo annual review of privileges for participation on the Trauma call panel. The Trauma Director in cooperation with the trauma liaisons, and department chairs will complete this process.

VIII. PERFORMANCE IMPROVEMENT TEAM MEMBERS:

A. Trauma Program Medical Director Position (1.0 FTE)
B. Trauma Program Manager Position Description (1.0 FTE)
C. Trauma Performance Improvement Coordinator Position Description (1.0FTE)
D. Trauma Resource Nurse & Injury Prevention Coordinator (1.0FTE)
E. Trauma Registry Staff Position Description (2.0 FTE)

Role of the Trauma Program Staff in the Trauma Performance Improvement Program

Trauma Program Medical Director (TPMD)

- Responsible for primary review of cases with Performance Improvement Coordinator.
- Triages cases for closure or presentation/referral at another Performance Improvement Forum.
- Analyzes trended data reports along with Trauma Performance Improvement Coordinator and Trauma Program Manager.
- Moderates/leads discussion at the Trauma Performance Improvement Tertiary Review forums: Trauma Morbidity and Mortality Conference, Trauma Team Leader Conference, Trauma Service Performance Improvement Conference.
- Oversees development of Clinical Management Guidelines.
- Assists with over-site of the Performance Improvement Program / Plan.
- Responsible for direct feedback (meeting/letters) of PI issues to provider and subspecialty coordinators
- Directs loop closure, where appropriate, with Trauma Performance Improvement staff.
- Leads educational/counseling sessions regarding provider issues.
- Oversees the Trauma Interdisciplinary Trauma Team physician liaisons and Associate Trauma Medical Directors.
- Reports (with Trauma Program Manager) trauma performance improvement data at hospital forums including: 1) Critical Care Committee, 2) Trauma Executive Committee 3) Hospital Performance Improvement Committee.
Trauma Performance Improvement Coordinator (TPIC)
- Responsible for issue identification, issue validation, as part of concurrent review/rounds.
- Maintains Trauma Performance Improvement database (POPIMS).
- Maintains individual trauma patient performance improvement files.
- Coordinates and participates in case selection for trauma performance improvement forums.
- Oversees maintenance of case review summaries and updates concurrently.
- Produces and analyzes trended data and provider specific profiles in collaboration with Trauma Program Manager & Trauma Program Medical Director.
- Oversees Practice Management Guideline surveillance, variance analysis, real time intervention and reporting.
- Coordinates follow-up back to facilities that transfer patients to Robert Packer Hospital and to institutions to which we transfer.
- Serves on the hospital-wide Performance Improvement Committee – working on hospital PI/Patient Safety initiatives.
- Coordinates loop closure strategies with in the hospital as it relates to the care of the trauma patient or system and re-evaluates the effectiveness of the implementation.
- Moderates Trauma Operations Committee: Multidisciplinary Trauma Performance Improvement peer review committee (non-physician).

Trauma Program Manager (TPM)
- Directs and Assures loop closure with Trauma Program Medical Director and Trauma Performance Improvement Coordinator.
- Participates routinely in weekly PI triage meetings with PI Coordinator and Trauma Program Medical Director
- Analyzes and reports Trauma Performance Improvement data up through the following RPH hospital level performance improvement forums: 1) Critical Care Committee, 2) Trauma Executive Committee 3) Hospital Performance Improvement Committee.
- Responsible for action plan development, implementation, re-evaluation of systems PI issues.
- Serves as back-up for Trauma Performance Improvement Coordinator.
- Assist with linking educational programs to performance improvement data.
- Assures re-evaluation and loop closure is documented in the Trauma Performance Improvement database (POPIMS).

Trauma Resource Nurse (TRN)
- Participates in weekly PI triage meetings with PI Coordinator and Trauma Program Medical Director
- Daily review and validation of performance improvement issues
- Attends Morning Report and bedside clinical rounds daily and collects information on any performance improvement concerns.
- Responsible for daily input of PI related issues and pertinent case summary events into the Trauma Performance Improvement database (POPIMS).
- Assist with linking educational programs to performance improvement data.

Trauma Registry Staff (TR)
- Interface directly with Trauma Performance Improvement Coordinator & Trauma Program Manager during concurrent review to identify and validate registry audit filters and occurrences
- Participates in the Trauma PI meetings.
- Participates in the Trauma Mortality conference and captures autopsy findings for entry into Registry database.
- Assists with report compilation for performance improvement purposes.
- Track documentation completeness including medical record forms, EMS run sheets, autopsy reports, etc.
- Provides monthly standing reports for performance improvement, administration, education and research.
- Lead Registrar directs inter-rater reliability monitoring is completed and any issues are addressed.
IX. **Process for Monitoring Compliance & Trauma Performance Improvement:**
(Refer to Attachment B- Trauma PI Process Flow Diagram)

**A. PA Trauma Outcome Study Submission Criteria**
Information for submission to the Pennsylvania Trauma Systems Foundation/ Pennsylvania Trauma Outcome (PTOS) database includes the following:

- All ICU admissions
- All patients declared dead on arrival (DOA)
- All trauma deaths
- All trauma admissions over 48 hours, beginning from time of ED arrival
- All trauma admissions remaining at your facility between 36-48 hours with an ISS of nine or greater.
- All transfers out
- All admitted transfers in
- Select burn cases
- All Step-down admissions

Excluding

- solitary fractured hip, ICD-9CM code 820 – 820.9 with no other injuries
- asphyxiation with no other injuries
- drowning
- poisonings
- Admitted patients injured while in a trauma center
- hypothermia or hyperthermia with no other injuries

**B. Issue Identification/Issue Triage & Levels of PI Review** – (See Attachment B for PI process flow diagram) Trauma Daily Clinical Report/ Concurrent Review by Performance Improvement Coordinator/ PI Hotline/Email, Filters/PI issues Identification via multidisciplinary bedside rounds. (See attachment C)

Trauma Performance Improvement issues are identified in a variety of ways. A Trauma Morning Report Meeting is conducted daily. The Trauma Performance Improvement Coordinator, Trauma Resource Nurse and/or the Trauma Program Manager attend and capture issues that are discussed during the presentation of the cases. Issues are then validated by the Trauma Performance Improvement Coordinator through review of the medical record. Additionally, any new issues may also be identified during this concurrent medical record review. Specific criteria for identification of issues are multifaceted and includes the Pennsylvania Trauma Systems Foundation audit filters and occurrences, JCAHO filters, PTSF Opportunities for Improvement and RPH specific filters. All validated issues are entered into the PTSF required Pennsylvania Outcomes Performance Improvement Monitoring System (POPIMS) database, which interfaces with Collector, a program used by the Trauma Registry. Once the initial focused review and issue validation is performed, the issue can then be addressed by the PIPS nurse through action oriented loop closure or forwarded for further review by the PI process.
**Primary Review process:** Initial focused review performed by the Trauma Performance Improvement Coordinator along with the Trauma Resource Nurse:

- Review, investigation and validation that clinical care, provider performance, system and processes were acceptable, acceptable with reservations or unacceptable
- Initiation of corrective action(s) for identified issues.
- Assignment of preventability and source.
- Issue resolution and loop closure
- Discussion of case with Trauma Program Medical Director with focused review if clinical care or physician provider issue identified
- Case referral to a Secondary or Tertiary Review as appropriate

**Secondary Review process:** decisions regarding whether further review/follow-up (referral to tertiary review) is warranted or whether a case can be closed or finalized with corrective action planning as appropriate. Secondary Review may occur through various ways as defined below:

- Focused review by Trauma Program Medical Director with:
  - Confirmation or validation that clinical care, provider performance, system and processes were acceptable, acceptable with reservations or unacceptable.
  - Initiation of corrective action(s) for identified issues.
  - Assignment and/or confirmation of preventability and source
  - Issue resolution and loop closure or case referral to a Tertiary review as appropriate.

- Presentation to and/or discussion with an Associate Trauma Medical Director, Trauma Liaison, Department Chair or Manager, or other appropriate clinical or administrative leader by the Trauma Program Medical Director or Trauma Program Manager regarding identified clinical care, provider performance, system or process issue with:
  - Confirmation or validation that clinical care, provider performance, system and processes were acceptable, acceptable with reservations or unacceptable.
  - Initiation of corrective action(s) for identified issues.
  - Assignment and/or confirmation of preventability and source
  - Issue resolution and loop closure or case referral to a Tertiary review as appropriate.

- Focused review by an Associate Trauma Medical Director, Trauma Liaison, Department Chair or Manager, or other appropriate clinical or administrative leader with:
  - Confirmation or validation that clinical care, provider performance, system and processes were acceptable, acceptable with reservations or unacceptable.
  - Initiation of corrective action(s) for identified issues.
  - Assignment and/or confirmation of preventability and source
  - Issue resolution and loop closure or case referral to a Tertiary review as appropriate.
Tertiary Review Process: Cases that are particularly complex and have multiple issues identified (audit filters, occurrences, sentinel events, unexpected outcomes) are presented at the following peer review forums for mitigation/loop closure actions:

- **Trauma Service PI**: Multidisciplinary Physician Peer Review
- **Trauma Team Leader**: Trauma Surgeon Peer Review
- **Trauma Morbidity & Mortality**: Multidisciplinary Peer Review of Deaths
- **Trauma Operations**: Multidisciplinary Non-physician Peer Review

Trended data reports are presented routinely at Trauma Peer Review Meetings.

External Peer Review may also be requested when clinical care, provider, system or process issues are evident or ambiguous and expert opinion is deemed necessary for confirmation or validation of issue and assistance with appropriate mitigation and/or loop closure of issue.

The cases determined to need tertiary review will be subject to Corrective Action Planning as delineated at the tertiary review meeting (see Corrective Action Planning below as well as attachment B for these action options).

All levels of review will be documented in the Trauma Performance Improvement Database (POPIMS).

X. **Trauma Performance Improvement Patient Safety Forums**
(See Attachment A)

XI. **PI Case Review Format**: Review of specific cases will encompass the following components:

1. **Demographics/Data** – In general the format follows the Performance Improvement database (POPIMS) files, but includes the following: background information/data surrounding the case inclusive of various trauma scores, cause of injury, patient demographics (age, sex, MR #, Trauma #) – Abstracted data from the Trauma Registry database (Collector) will be integrated into case review to assist in review of cases and to assess accuracy of registry abstraction.

2. **Description** – Summary of events surrounding injury from pre-injury events through hospital course. Includes mechanism of injury details, extenuating circumstances and relevant past medical history/medications.

3. **Deficiencies** – Identification of issues as screened utilizing trauma performance indicators master list. Includes identification of clinical and system problems/issues, as well as, presence of specific occurrences, audit filters and opportunities for improvement.

4. **Discussions** – At appropriate performance improvement forums, guided discussions with relevant team members present will occur and be documented under the correlating meeting or issue section in the Performance Improvement Database (POPIMS).

5. **Decisions** – Consensus peer review judgments will be assigned to specific aspects of case and documented as part of the patient’s performance improvement file. These decisions will consider: acuity of care, system issues, clinical appropriateness/timelines of care, adequacy of documentation to objectively review and provider comments regarding the case. Definitions related to preventability are
based on those described by the American College of Surgeons in “Resources for Optimal Care of the Injured Patient – 2006”. Additionally, the grid below is utilized to help guide the team to appropriate decisions on preventability.

**Categorization of Mortality**

<table>
<thead>
<tr>
<th>Injuries &amp; Sequelae</th>
<th>Event without opportunity for improvement</th>
<th>Anticipated Event with opportunity for improvement</th>
<th>Unanticipated Event with opportunity for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-survivable</td>
<td>Potentially survivable or Survivable</td>
<td>Survivable</td>
<td></td>
</tr>
<tr>
<td>Standard Protocols</td>
<td>Followed</td>
<td>Not followed (potential impact)</td>
<td>Not followed (impact)</td>
</tr>
<tr>
<td>Provider Care</td>
<td>Appropriate</td>
<td>Inappropriate (potential impact)</td>
<td>Inappropriate (impact)</td>
</tr>
<tr>
<td>TRISS</td>
<td>&lt;0.25</td>
<td>0.25 – 0.50</td>
<td>&gt;0.50</td>
</tr>
</tbody>
</table>

6. **Delineation:** WHO – This includes provider specific and team specific judgments regarding clinical decisions, management, and outcomes.

7. **Do:** Action Steps – (Can include any/all of the following) Written requests for review/follow-up, educational sessions, counseling, policy development/modification, focused audit.

8. **Documentation** – Individual performance improvement files will be maintained. All conversations, summary of discussions and judgments will be considered Confidential for Peer Review only and are protected by the PA Peer Review Act. Documentation will occur on the approved Trauma Performance Improvement Case Review Form. Information maintained via computer will be password protected and access limited.

**XII. Trauma Performance Improvement Case Files**

A typical performance improvement file will include:

1. POPIMS case summary
2. PI Case Referral form
3. All correspondence sent and received
4. Supporting documents related to follow-up and closure
5. Autopsy reports, if applicable

Hard copy PI files are maintained in a secure area and are peer review protected/non-discoverable. An archive of hard copy PI information is kept for five years.

**XIII. CORRECTIVE ACTION PLANNING:**

The Trauma Program Medical Director oversees all corrective action planning. Structured plans may be created by any of the Trauma PI team members or committees in an effort to improve sub-optimal performance identified (root cause analysis) through the PI process. Our goal is to create forward momentum to effect demonstrable outcome change leading to subsequent loop closure. An evaluation and re-evaluation process will be part of the plan according to institutions
action plan methodology of plan, do, check, act (PDCA). Examples of potential corrective action categories are:

- Organization of Improvement PI Teams
- Education
- Referral to peer group
- Trending
- Focus Audit
- Protocols
- Provider/Team Counseling
- Provider/Team Education
- Proctoring/Change in Privileges or credentials
- Enhanced resources or methods of communication
- PMG or Policy revision or development

XIV. Data Maintenance: Performance Improvement Program Data will be maintained in an accepted computer application. This program will include features to track provider specific data on morbidity and mortality. In addition, this data program will interface with other necessary hospital/program information systems to ensure efficiency and cost-effectiveness. The approved Performance Improvement computer database will be capable of generating necessary trended reports, including provider specific profiles. Access to computerized patient data will be restricted and be considered Confidential and for Peer review purposes only.

Specific Interfaces: Trauma Registry system (Collector)

XV. Additional Attachments:
- Attachment A- Descriptions of Trauma Meetings/Committees
- Attachment B- Trauma PI Issue Review Process Flow
- Attachment C-Trauma PI Issue Report Poster
- Attachment D- Plan, Do, Check, Act PI system
- Attachment E-Trauma PI Issue Review Grid
- Attachment F-Practice Management Guideline Monitoring Schedule
- Attachment G-Trauma Morning Report Agenda
- Attachment H- Sample PI Review Referral Form
- Attachment I- Robert Packer Hospital Organizational Chart
- Attachment J- Robert Packer Hospital PI Reporting Structure
- Attachment K- Trauma Center Calendar

References:
A. ACS Optimal Resource Guide
B. Pennsylvania Trauma System Foundation Standards for Trauma Center Accreditation
C. RPH CEQI Plan
D. Joint Commission for the Accreditation of Health Care Organizations
E. ACS: Trauma Performance Improvement Manual (Rhoads 1/2009)
F. STN: Trauma Outcomes & Performance Improvement Course manual (2013 edition)
### NAME OF FORUM: Morning Report

**FORUM DESCRIPTION:**
The daily morning report exists so that on-coming and off-going teams can exchange pertinent information about all trauma patients on the Trauma Service or for whom Trauma is consulting. All new admissions are presented for education of team and all current Trauma Service patients are reviewed in detail for plan of care management. All performance improvement events (within the last 24 hours) are discussed with preliminary review and data collection from primary source of information.

**FREQUENCY OF MEETINGS:** Daily

**HOW PROBLEMS ARE IDENTIFIED:**
Quality of care issues and system issues are identified through review of case presentations.

**HOW PROBLEMS ARE RESOLVED:**
Counseling and education

**CRITERIA USED TO ID CASES FOR REVIEW:**
All new admissions are presented for education of team and all current Trauma Service patients are reviewed in detail for plan of care management.

**TITLES OF PARTICIPANTS:**
- Attending of the Day, Trauma faculty, residents, medical students, Trauma Program Manager, Trauma PI Coordinator RN, Trauma Resource Nurse, Trauma Registry Staff

**TITLES OF THOSE RESPONSIBLE FOR FOLLOW-UP ACTIONS:**
- Trauma Program Medical Director, Trauma attending of the day, Trauma Program Performance Coordinator RN, Trauma Program Manager

**MINUTES/ DOCUMENTATION MAINTAINED (YES/NO):**
Specific opportunities for improvement and any counseling and education that occurs is recorded by the Performance Improvement Coordinator and entered into the Trauma Performance Improvement database, concurrently.

**ITEMS REVIEWED/DISCUSSED/ADDRESSED:**
- daily patient events
- trends
- deaths
- transfers in
- transfers out
- morbidities
- issues identified by the PI process
- systems issues

December 2013
### Weekly Trauma PI Chart Review Meetings

<table>
<thead>
<tr>
<th>NAME OF FORUM</th>
<th>PURPOSE OF FORUM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To review clinical/system quality of care with Trauma Program Medical Director, Trauma Program Manager and Trauma Performance Improvement Coordinator. Determination is made regarding which cases can be closed and which cases require follow-up or presentation at the Monthly Trauma Performance Improvement Meeting(s).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FREQUENCY OF MEETINGS</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW PROBLEMS ARE IDENTIFIED</td>
<td>Chart review, PI Issue Identification Forms, PI Hotline Audit filter review, concurrent registry abstraction, direct verbal report of issue.</td>
</tr>
<tr>
<td>HOW PROBLEMS ARE RESOLVED</td>
<td>Cases may be closed, or referred for further review at other meetings</td>
</tr>
</tbody>
</table>

| CRITERIA USED TO ID CASES FOR REVIEW | Any PTOS case with potential opportunities for improvement that warrants further discussion                                                                                                                                  |

| TITLES OF PARTICIPANTS | Trauma Program Medical Director (TPMD) or his designee Performance Improvement Coordinator (PIC) Trauma Registry Staff Trauma Program Manager Trauma Resource Nurse |

| TITLES OF THOSE RESPONSIBLE FOR FOLLOW-UP ACTIONS | Trauma Program Medical Director Trauma Program Manager Performance Improvement Coordinator |

| TRAUMA PROGRAM MEDICAL DIRECTOR’S ROLE | Moderates/Facilitates discussions. Directs follow-up action plan development. |

| Minutes / DOCUMENTATION MAINTAINED (YES/NO) | Discussion/actions are recorded directly into POPIMS by case. |

| ITEMS REVIEWED/DISCussed/ADDRESSED: | trends deaths transfers in transfers out morbidities issues identified by the PI process systems issues |
## Attachment A - RPH Trauma PI Plan: Description of Trauma PI Meetings

<table>
<thead>
<tr>
<th>Name of Forum</th>
<th>Trauma Team Leader Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose of Forum</strong></td>
<td>Monthly Divisional Trauma Performance Improvement Meeting. To review clinical/system quality of care among trauma attending physician faculty and resident trauma liaisons.</td>
</tr>
<tr>
<td><strong>Frequency of Meetings</strong></td>
<td>Monthly (Fourth Thursday of each month at 12:00pm-1:30pm)</td>
</tr>
<tr>
<td><strong>How Problems are Identified</strong></td>
<td>Chart review, PI Issue Identification Forms, PI Hotline Audit Filter review</td>
</tr>
<tr>
<td><strong>How Problems are Resolved</strong></td>
<td>Provider/team specific decisions regarding appropriateness of clinical decisions, management and outcomes are discussed</td>
</tr>
<tr>
<td><strong>Criteria Used to ID Cases for Review</strong></td>
<td>Issues identified through weekly chart review</td>
</tr>
<tr>
<td><strong>Titles of Participants</strong></td>
<td>Trauma Program Medical Director, Trauma Program Manager, Trauma PI Coordinator, Trauma Surgeon Faculty, Trauma Resident Liaisons</td>
</tr>
<tr>
<td><strong>Titles of Those Responsible for Follow-Up Actions</strong></td>
<td>Trauma Program Medical Director, Trauma Program Manager, PI Coordinator</td>
</tr>
<tr>
<td><strong>Trauma Program Medical Director's Role</strong></td>
<td>Moderates/Facilitates discussions. Directs follow-up action plan development.</td>
</tr>
<tr>
<td><strong>Minutes/Documentation Maintained (Yes/No)</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Items Reviewed/Discussed/Addressed:</strong></td>
<td>trends deaths transfers in transfers out morbidities issues identified by the PI process systems issues</td>
</tr>
<tr>
<td>NAME OF FORUM</td>
<td>Trauma Service Performance Improvement (TSPI)</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>PURPOSE OF FORUM</td>
<td>To review clinical/system quality of care with trauma attending physician faculty and subspecialists.</td>
</tr>
<tr>
<td>FREQUENCY OF MEETINGS</td>
<td>Monthly (First Wednesday of each month at 7am)</td>
</tr>
<tr>
<td>HOW PROBLEMS ARE IDENTIFIED</td>
<td>Chart review, PI Issue Identification Forms, PI Hotline Audit filter review</td>
</tr>
<tr>
<td>HOW PROBLEMS ARE RESOLVED</td>
<td>Provider/team specific decisions regarding appropriateness of clinical decisions, management and outcomes are discussed</td>
</tr>
<tr>
<td>CRITERIA USED TO ID CASES FOR REVIEW</td>
<td>Cases involving subspecialties with potential of identified opportunities for improvement that warrants tertiary peer review.</td>
</tr>
<tr>
<td>TITLES OF PARTICIPANTS</td>
<td>Trauma Program Medical Director, Trauma Program Manager, Trauma PI Coordinator, Trauma Faculty, resident trauma liaisons, Registry staff, Subspecialists liaisons including: Neurosurgery Orthopedics Critical Care Radiology Physical Medicine and Rehabilitation Anesthesia Emergency Medicine Perioperative Services EMS/Prehospital</td>
</tr>
<tr>
<td>TITLES OF THOSE RESPONSIBLE FOR FOLLOW-UP ACTIONS</td>
<td>Trauma Program Medical Director, Performance Improvement Medical Director, PI Coordinator, Clinical Program Administrator</td>
</tr>
<tr>
<td>TRAUMA PROGRAM MEDICAL DIRECTOR'S ROLE</td>
<td>Moderates/Facilitates discussions. Directs follow-up action plan development.</td>
</tr>
<tr>
<td>J) MINUTES/ DOCUMENTATION MAINTAINED (YES/NO)</td>
<td>Yes</td>
</tr>
<tr>
<td>ITEMS REVIEWED/DISCUSSED/ ADDRESSED:</td>
<td>trends deaths transfers in transfers out morbidities issues identified by the PI process systems issues</td>
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<tr>
<td>NAME OF FORUM</td>
<td>Trauma Morbidity and Mortality</td>
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<tr>
<td>PURPOSE OF FORUM</td>
<td>To review all aspects of care in trauma death cases</td>
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<tr>
<td>FREQUENCY OF MEETINGS</td>
<td>Monthly</td>
</tr>
<tr>
<td>HOW PROBLEMS ARE IDENTIFIED</td>
<td>Chart review, PI Issue Identification Forms, PI Hotline Audit filter review, Review of autopsies</td>
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<tr>
<td>HOW PROBLEMS ARE RESOLVED</td>
<td>Provider/team specific decisions regarding appropriateness of clinical decisions, management and outcome are discussed</td>
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<tr>
<td>CRITERIA USED TO ID CASES FOR REVIEW</td>
<td>All deaths, All DOA's</td>
</tr>
<tr>
<td>TITLES OF PARTICIPANTS</td>
<td>Trauma Program Medical Director, Trauma Program Manager, Trauma PI Coordinator, Trauma Surgeon Faculty, Trauma Resident Liaisons. Other Surgeon and Mid-levels providers from Acute Care Surgery and other surgical services. Ad hoc guests are invited related to specific opportunities in education and review.</td>
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<tr>
<td>TITLES OF THOSE RESPONSIBLE FOR FOLLOW-UP ACTIONS</td>
<td>Trauma Program Medical Director, PI Coordinator RN, Trauma Program Manager</td>
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<tr>
<td>TRAUMA PROGRAM MEDICAL DIRECTOR'S ROLE</td>
<td>Moderates/Facilitates discussions. Directs follow-up action plan development.</td>
</tr>
<tr>
<td>J) MINUTES/ DOCUMENTATION MAINTAINED (YES/NO)</td>
<td>Yes</td>
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<td>ITEMS REVIEWED/DISCUSSED/ ADDRESSED:</td>
<td>trends deaths morbidities issues identified by the PI process systems issues</td>
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December 2013
<table>
<thead>
<tr>
<th>NAME OF FORUM</th>
<th>Trauma Operations Committee</th>
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<tbody>
<tr>
<td>PURPOSE OF FORUM</td>
<td>To review clinical/system quality of care with the multidisciplinary non-physician providers of trauma care within the institution.</td>
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<tr>
<td>FREQUENCY OF MEETINGS</td>
<td>Monthly (Second Wednesday of each month 3:00-4:00pm)</td>
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<tr>
<td>HOW PROBLEMS ARE IDENTIFIED</td>
<td>Chart review, PI Issue Identification Forms, PI Hotline Audit filter review</td>
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<tr>
<td>HOW PROBLEMS ARE RESOLVED</td>
<td>Team specific decisions regarding appropriateness of clinical decisions, management and outcomes are discussed</td>
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<tr>
<td>CRITERIA USED TO ID CASES FOR REVIEW</td>
<td>All trauma cases with related opportunities for improvement. Review program trends &amp; opportunities for improvement (Non-physician groups)</td>
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<tr>
<td>TITLES OF PARTICIPANTS</td>
<td>Trauma Program Manager, Trauma PI Coordinator, Trauma Faculty, Nursing unit trauma liaisons, other liaisons from the following services: Rehabilitation, Nursing, Emergency Department, Pastoral Care, Nutrition, Pain Services, Administration (Nursing and Clinical Coordinators), Social work and Case Management, Lab Services/Blood Bank, Department of Nursing Education &amp; Research</td>
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<tr>
<td>TITLES OF THOSE RESPONSIBLE FOR FOLLOW-UP ACTIONS</td>
<td>PI Coordinator RN, Trauma Program Manager</td>
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<tr>
<td>TRAUMA PROGRAM MANAGER’S ROLE</td>
<td>Moderates/Facilitates discussions. Directs follow-up action plan development.</td>
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<tr>
<td>J) MINUTES/DOCUMENTATION MAINTAINED (YES/NO)</td>
<td>Yes</td>
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<tr>
<td>ITEMS REVIEWED/DISCUSSED/ADDRESSED:</td>
<td>trends deaths transfers in transfers out mortalities issues identified by the PI process systems issues</td>
</tr>
</tbody>
</table>

December 2013
GUTHRIE
Robert Packer Hospital

Report Trauma Performance Improvement concerns via Lotus notes or Trauma "STAT" Line 24/7/365

Quality

Lotus Notes: "Trauma PI"
or
Phone: "STAT" (x7828)

The Trauma "STAT" Line (a 24 hour, 7 day a week dedicated phone line with voicemail) and the Trauma Lotus notes address (which goes directly to the Trauma PI Team) are used to report any concern or issues regarding a trauma patient's clinical care or any process, program or system issue with assured confidentially and anonymously without fear of recrimination.

Both communication avenues offer concurrent reporting which allows for immediate review, prompt corrective action and timely follow up. Calls and emails are reviewed daily by the Trauma Program staff and communicated to the appropriate trauma review forum.

Confidentiality is strictly maintained!

Please contact the Trauma Program Manager @ 4640 or pager # 883 if you have any questions.
System Performance Improvement Model

The philosophy of performance improvement at Robert Packer Hospital supports a culture of continuously measuring, assessing and initiating changes in order to improve outcomes. Performance improvement is customer-focused; safety centered, and is integral to overall medical management. Improving outcome measures are the ultimate indicators of the value provided to the communities in which we serve. Robert Packer Hospital strives to provide a coordinated, consistent and high level of care and service to all patients in the most effective, appropriate and efficient manner.

Performance improvement projects at Robert Packer Hospital follow several frameworks selected to meet the needs of the clinical teams and the patient.

The Plan-Do-Check-Act model is a four-step process that incorporates the following components:

1. **Plan** - Define the process improvement initiative (problem statement) and utilize data to identify improvement opportunities in a selected process. Identify the why, what, who and how to design the improvement. Collect baseline data.
2. **Do** - Utilize methods and tools of quality improvement to intervene in the process. What changes are you implementing and how are you implementing them?
3. **Check** - Assess the impact of the intervention that was tested on the overall process and outcomes. Collect data and analyze the results of the data.
4. **Act** - Based on the results of the tested intervention, change the process to reflect the intervention’s success. The next steps are to continue to monitor in order to maintain the benefits gained from the change and to diffuse the results to other processes. Interventions that did not achieve desired results must be noted and another intervention must then be tested.

The model for performance improvement requires that interventions are tested efficiently and effectively to ensure that changes are made *as quickly as possible* for the ultimate benefit of our customers. The short time period for testing interventions is critical to the success of building a continuous quality improvement culture.

**Failure Mode and Effects Analysis (FMEA)** provides a framework for a detailed cause and effect study of a process/product that may lend itself to a performance improvement initiative. RPH has embraced the methods utilized by the aerospace and engineering industries to prospectively analyze, identify and correct potential failure modes in our care processes before they reach the patient. FMEA and PDCA are complementary structures that may be utilized for a single process. The key challenge is to promote a culture that insures the highest level of quality of care and rewards risk reduction at all levels of the organization by setting expectations for all staff to participate in the organizational change that encourages reporting and proactive analysis of real/potential risk.

**Practice Management Guidelines**

Practice Management guidelines are developed and utilized for high volume, high risk, and problem prone patient populations at RPH. These guidelines form the basis of a standardized plan of care which provides a process for consistent clinical management of an identified patient group. The clinical outcomes are measured, analyzed and standardized practice is readjusted as necessary to support best practice and procedures.
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<tr>
<th>Peds/Rehab</th>
<th>PI Indicator</th>
<th>Phase of care</th>
<th>Start Date</th>
<th>End Date</th>
<th>Current status</th>
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<td>P</td>
<td>Decubitus ulcers</td>
<td>All phases of care</td>
<td>Jan 13</td>
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<td>Pediatrics, Age &lt; 14</td>
<td>All phases of care</td>
<td>Jan 13</td>
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<td>UTI</td>
<td>All phases of care</td>
<td>Jan 13</td>
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<td>ongoing</td>
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<td></td>
<td>DVT prophylaxis</td>
<td>Critical Care/post resuscitative phase</td>
<td>Feb 13</td>
<td>June 13, Oct 13</td>
<td>ongoing</td>
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<td></td>
<td>VAP</td>
<td>Critical Care</td>
<td>Jan 13</td>
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<td>Ongoing monitoring in ICU</td>
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<td>Central Line Infection</td>
<td>Critical Care</td>
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<td>Corvical Spine Clearance PMG</td>
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<td>Jan 13, May 13, Sept 13</td>
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<td>Self extubation</td>
<td>Critical Care/Post anesthesia care</td>
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<td></td>
<td>Filter 18: Any patient requiring reintubation within 48 hours of extubation</td>
<td>Critical Care/Post anesthesia care</td>
<td>Jan 13</td>
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<td>Filter 9: Pts requiring laparotomy, which is not performed within 2 hours of ED arrival</td>
<td>Perioperative</td>
<td>Jan 13</td>
<td></td>
<td>ongoing</td>
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<td>Unexpected deaths and survivors</td>
<td>Post DC</td>
<td>Jan 13</td>
<td></td>
<td>ongoing</td>
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<td></td>
<td>Return to ICU</td>
<td>Unplanned upgrade in care</td>
<td>Post resuscitative phase</td>
<td>Jan 13</td>
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<td></td>
<td>Delayed/missed injuries</td>
<td>Post resuscitative phase/rehabilitative care</td>
<td>Jan 13</td>
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<td>ongoing</td>
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<td>Incidental Findings</td>
<td>Post resuscitative phase/rehabilitative care</td>
<td>Jan 13</td>
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<td>SW alcohol abuse counseling</td>
<td>Post resuscitative phase/rehabilitative care</td>
<td>Feb 13, June 13, Oct 13</td>
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<td></td>
<td>Transfers In</td>
<td>Prehospital</td>
<td>Jan 13</td>
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<td>Filter 15: Trauma patient admitted to the hospital under the care of admitting or attending physician who is not a surgeon</td>
<td>Resuscitation</td>
<td>Jan 13</td>
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<td></td>
<td>MTP Protocol</td>
<td>Resuscitation</td>
<td>Jan 13</td>
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<td>ongoing</td>
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<td>ED Documentation/RTS</td>
<td>Resuscitation</td>
<td>Jan 13</td>
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<td></td>
<td>Filter 11b: Pt transferred OUT to another health care facility after spending &gt; 3 hours in initial hospital</td>
<td>Resuscitative/Critical Care/post resuscitative</td>
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<td></td>
<td>Filter 10: Pts with epidural or subdural hematoma receiving craniotomy &gt; 4 hours after arrival at ED, excluding those performed for ICP monitoring</td>
<td>Resuscitative/Critical Care/post resuscitative</td>
<td>Jan 13</td>
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<td>Tertiary Survey Completion</td>
<td>Post Resuscitative</td>
<td>Jan 13, May 13, Sept 13</td>
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<td></td>
<td>Traumatic Brain Injury PMG</td>
<td>All phases of care</td>
<td>March 13, July 13, Nov 13</td>
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<td>Pelvic Fracture PMG</td>
<td>Resuscitative/Critical Care/post resuscitative</td>
<td>March 13, July 13, Nov 13</td>
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<td>Blunt Head Trauma on anticoagulation PMGs</td>
<td>Resuscitative/Critical Care/post resuscitative</td>
<td>April 13, Aug 13, Dec 13</td>
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<tr>
<td>Month</td>
<td>PMG</td>
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<tr>
<td>January</td>
<td>Cspine, Tertiary survey</td>
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<tr>
<td>February</td>
<td>DVTP, Substance Abuse</td>
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<tr>
<td>March</td>
<td>Traumatic Brain Injury, Pelvic Fracture</td>
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<td>April</td>
<td>Blunt Head: Anticoag reversal, coumadin, AC therapy</td>
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<td>Quarterly Reports</td>
<td>Tx in, Tx out, Peds, Exlap &gt;2, Crani &gt;4, Open tibia &gt;8, Compartment Syndrome, PTSF reports</td>
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<tr>
<td>May</td>
<td>Cspine, Tertiary survey</td>
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<td>June</td>
<td>DVTP, Substance Abuse</td>
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<td>July</td>
<td>Traumatic Brain Injury, Pelvic Fracture</td>
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<td>August</td>
<td>Blunt Head: Anticoag reversal, coumadin, AC therapy</td>
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<td>Quarterly Reports</td>
<td>Tx in, Tx out, Peds, Exlap &gt;2, Crani &gt;4, Open tibia &gt;8, Compartment Syndrome, PTSF Reports</td>
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<td>September</td>
<td>Cspine, Tertiary survey</td>
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<td>October</td>
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<td>November</td>
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<tr>
<td>December</td>
<td>Blunt Head: Anticoag reversal, coumadin, AC therapy</td>
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<td>Quarterly Reports</td>
<td>Tx in, Tx out, Peds, Exlap &gt;2, Crani &gt;4, Open tibia &gt;8, Compartment Syndrome, PTSF Reports</td>
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</table>
Morning Report Agenda

1. Assign Response Teams
2. Issues requiring immediate attention
3. New Patient Review: Admissions/Transfers/ED Discharges
   a. Night Team
   b. Day Team
4. Review ICU list (with sign out if change in provider)
5. Review of Radiology Reads & Films
   a. Notify Radiology with any discrepancies
6. Inbound transfers
7. Announcements/Education
8. Assign ICU rounding time for Multidisciplinary Team
   (TRN pages team with time for start of ICU rounds)
9. Previous days procedures (Info to Coder)
10. Adjourn

REMINDER: Interdisciplinary Barriers to Discharge Meeting:
    Thursdays @ noon in 4 Blue Conference Room

TRAUMA ON-BOARDING:
First weekday of each month this will be conducted
immediately following Morning Report.
Patient is a 37 year old male who was admitted on 12/8/13 to trauma service. The patient was transported by ambulance to our facility. Trauma alert - lowest level was called for this patient on 12/8/2013. The cause of injury for this patient was 880.9 - P: was drinking at a friends, fell down a flight of stairs, he awoke approx. 5-6 hours later. Patient diagnosis include:
- Mild TBI, concussion
- Fx L L.rib (5)
- Small L pneumothorax
The patient has not been discharged at this time.

**IDENTIFIED ISSUE 1 / DATA FROM THIS CASE:**

Delayed Diagnosis: Patient complained of pain in L ankle when he was able to ambulate. Xray of ankle completed and pt found to have bimalleolar fracture.

**REASON FOR VARIANCE PER DISCUSSION WITH ATTENDING STAFF INVOLVED:**

- [ ] Error in Management
- [ ] Delayed/Missed Diagnosis
- [ ] No Factors
- [ ] Error in Technique
- [ ] Other
- [ ] Communication/Documentation

I recommend / have assigned this outcome as:

- [ ] Preventability
  - [ ] Unanticipated Event with Opportunity for Improvement
  - [ ] Anticipated Event with Opportunity for Improvement
- [ ] Event without opportunity for Improvement

**REVIEWER COMMENTS:**

**RECOMMENDATIONS FOR PI FOLLOW-UP:**

- [ ] Refer to __________________ for concurrent review.
- [ ] Adjust this process if deemed appropriate after Lean Six Sigma project. (Begin / complete project and follow-up this case when system distribution known, avoid type 1 and type 2 error.)
- [ ] Examine case in context of already completed (or soon to be completed) Lean Six Sigma project at future PI meeting & report out at PI conference.
- [ ] Discuss case at Trauma PI / Trauma M&M Conference.
- [ ] Close case. Reviewed in context of appropriate endpoints and relevant providers counseled.

**LOOP CLOSURE:**

- [ ] Reviewer and relevant provider(s) have discussed this case review, findings, and plan for follow-up as above.
Attachment H - Robert Packer Hospital Regional Trauma Center Performance Improvement Plan

REVIEWER COMMENTS:

PREVENTABILITY KEY:

Preventable:
- Unanticipated event with opportunity for improvement

Potentially Preventable:
- Anticipated event with opportunity for improvement.

Non-Preventable:
- Event without opportunities for improvement.
Robert Packer Hospital Performance Improvement Reporting Structure

Attachment J- RPH Trauma PI Plan: RPH Reporting Structure
## Trauma Center Schedule

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
</table>
| 8:00 a.m. – 9:00 a.m. | 8:00 a.m. – 9:00 a.m. | 7:00 a.m. – 8:00 a.m.  
Trauma AM Report  
Trauma Conference Room | 8:00 a.m. – 9:00 a.m. | 8:00 a.m. – 9:00 a.m.  
Trauma AM Report  
Trauma Conference Room |
| 12:00-1:00pm  
Trauma Executive Meeting  
Quarterly-4th Tuesday  
(Advisory to Senior Leadership Team) | 1:00pm-2:00pm  
Trauma PI Chart Review  
Trauma Conference Room  
Weekly Secondary Review with  
TPMD, TPM, TPIC, TRN | 8:00 a.m. – 9:00 a.m.  
M & M Meeting  
(Trauma M & M rotating every 4th Thursday)(Tertiary Review) | 8:00 a.m. – 9:00 a.m.  
Trauma AM Report  
(4 Blue Conference Room) | 1:00-2:00pm  
Trauma Leadership Meeting  
Chairman of Surgery, VP of surgical services, TPMD, TPM (Advisory) |
| 1:00 p.m.-5:00pm  
Trauma Outpatient Clinic  
4th level clinic | 3:00 – 3:30  
TRAUMA OPERATIONS  
2nd Wednesday  
GHS Boardroom  
(Tertiary Review) | 1:00 p.m.-5:00pm  
Trauma Outpatient Clinic  
4th level clinic |