

Trauma Performance Improvement Form Dictionary

PI forms shall be completed by Community and Trauma Receiving Hospitals and worksheet data should be submitted to the state quarterly.

Performance improvement documentation is considered “Privileged Peer Review Information. Confidential and Not Subject to Discovery.” Therefore, as a trauma coordinator, it is your responsibility to ensure all PI documentation is secured under lock and key within your institution. PI information should not be filed within patient charts.

This dictionary should be used as a reference to the trauma PI tracking form and worksheet. Remember, all trauma cases involving trauma registry inclusion criteria, trauma team activation, admissions, transfers, or deaths should have at least primary PI review.

Levels of Involvement (LOI)

System Related (SR)—SR LOI correlate to issues affecting the trauma system overall and that are not isolated to a particular disease or provider. Examples include performance improvement cases that reveal insufficient chest tube sizes, RSI medications located outside the ER and not immediately available or temperatures not being recorded resulting in unwanted hypothermia.

Disease Related (DR)—DR LOI correlate to co-morbidities a patient has that ultimately affect patients outcome. Examples include performance improvement cases that reveal trauma patients with underlying COPD, cancer, or patients on Coumadin, just to name a few.

Provider Related (PR)—PR LOI correlate to issues specific to providers, this can include both pre-hospital and hospital providers. Examples include performance improvement cases that reveal a provider who orders film studies on a critical patient delaying transport.

Preventability of Mortality (POM) with/without Opportunity for Improvement (OFI)

Unanticipated Mortality with OFI (UM)—UM POM correlates to cases where a patient’s death was unanticipated. Examples include performance improvement cases that reveal mortality due to isolated thoracic injury with tension pneumothorax that was not appropriately and expeditiously decompressed via chest tube insertion. In essence, this patient should have survived with proper treatment.

Anticipated Mortality with OFI (AM)—AM POM correlates to cases where a patient’s death was anticipated. Examples include performance improvement cases that reveal multisystem trauma such an open vault injury with associated crush injuries to the thoracic, abdominal, and pelvic regions. Even though mortality is anticipated, an opportunity for improvement in this case would be rapid transport to tertiary facility instead of delays for a head CT.

Mortality without OFI (M)—M POM correlates to cases where a patient dies and there is no opportunity for improvement. Examples include performance improvement cases that reveal penetrating injuries to the chest with no palpable pulses and no cardiac rhythm.

Contributing Factors/Determination (CF/D)

There is opportunity for each case to have a (CF/D). Many of these statements are objective in nature; although, some subjectivity can exist.

Performance Improvement Actions (PIA)

Any case review that results in performance improvement opportunities must have an associated action.

None Required—an example for this selection would be scene time of 35 minutes due to weather delay.

Guideline or Protocol—an example for this selection would be a revision or addition to current standards i.e. policy for Emergency Release of Uncross-matched Blood (ERUB) where the provider can request blood without having to stop treatment and sign a consent. Obtaining ERUB policy would be considered loop closure with effective education and monitoring.

Education-Specify—an example for this selection would be educating all ER staff on trauma team activations. Used if pre-hospital staff report requests trauma team activation, but ER staff did not activate.

Morbidity and Mortality Peer Review (M&M Peer Review)—an example for this selection would be a provider related level of involvement where the trauma medical director sits down and discusses a case with another provider. This can be multidisciplinary, but is most commonly one on one.

Process Improvement—an example for this section would be ensuring all chest tube supplies are grouped together or all RSI medications are in or just outside the ER and that all ER personnel have ready access with dosages and procedure steps written out.

Trend—Trending would be when any performance improvement action needs continued review. An example would be monitoring temps are recorded for six months until satisfactory percentages are obtained i.e. obtain temps on admission 96% of the time within the first 30 minutes.

Letter with F/U Required—an example for this section would be the trauma medical director requesting a colleague review a case involving a transfer delay due to CT studies. This letter would require a follow up meeting ensuring the issue was addressed and an action plan was instituted.

Counseling—an example for this section would be either the trauma nurse coordinator or the trauma medical director provide direction, guidance, or instruction to colleagues on applicable protocols or standards.

Resource Enhancement—an example for this selection would be the purchase of a rapid fluid infuser, a glide scope, or any other therapeutic device to add in patient care.

Pre-Hospital Performance Improvement Filters—should only be valued if patient was transferred via ambulance. If Personally Owned Vehicle (POV), do not complete this section.

(Pre-hospital Patient Care Reports, PCR, lacking sufficient documentation should be flagged for PI)

- EMS Trip Ticket in Patient's chart
 - Mark Yes, if at the time of trauma registry entry, an electronic or paper PCR is available
 - Mark No, if at the time of trauma registry entry, an electronic or paper PCR is unavailable
- Scene Time < 20 minutes
 - Value calculated by "Arrival at Patient" and "Depart Scene" in PCR. If scene delay is marked, use (CF/D) "Scene Delay"
- Appropriate Airway Maintenance
 - Mark Yes if airway was maintained appropriately upon arrival to ED
 - Mark No if airway was not maintained appropriately upon arrival to ED
 - Value should consider level of service: Basic Life Support (BLS) or Advanced Life Support (ALS)
- Appropriate Spinal Immobilization (Backboard and Collar)
 - Mark Yes if appropriate spinal immobilization was maintained upon arrival to ED
 - Mark No if appropriate spinal immobilization was not maintained upon arrival to ED
- Patient Met Physiological and/or Anatomical Absolute Criteria—Yes/No only
 - Mark Yes if Absolute Criteria was met (This does not include high degree of suspicion or co-morbidities)
 - Mark No if Absolute Criteria was not met
- Trauma Team Requested by EMS—Yes/No

Hospital Performance Improvement Filters

- Patient Met Physiological and/or Anatomical Absolute Criteria—Yes/No only
 - Mark Yes if Absolute Criteria was met (This does not include high degree of suspicion or co-morbidities)
 - Mark No if Absolute Criteria was not met
- Trauma Team Activated by ER Staff—Yes/No
- Trauma Team response times < defined criteria (30 minutes)
 - This is only applicable to trauma team activations yet involves all respondents (providers, radiology, laboratory)
- Patient Transferred with ER LOS < 2 hours
 - Calculated by ER Departure minus ER Arrival (Does not evaluate "Call to transfer" but patients physical presence in ER)
- GCS < 8 and airway established
- Complete VS documentation including GCS (x2 minimum)
- Required/appropriately sized equipment immediately available
- Appropriate warming measures (blankets, warmed IV Fluids)
 - Mark Yes if temp was below 96 degrees and warming measures were initiated and documented
 - Mark No if temp was below 96 degrees and warming measures were not initiated or documented

Definition of a Trauma Team Alert patient:
South Dakota Trauma System

Physiological Absolutes:

Adult:

GCS < 10

BP < 90

Pulse > 120

Respirations < 10 or > 29, or airway obstruction or respiratory compromise requiring use of advanced airway

Child:

The Pediatric Assessment Triangle should be the basis for all pediatric emergencies

Anatomic Absolutes:

- Penetrating injury to chest, abdomen, head, neck
- Limb Paralysis (associated with Trauma)
- Flail Chest
- Amputation proximal to wrist or ankle