

Scottsdale Healthcare Osborn Medical Center – ACS Verified Level I Trauma Center



Scottsdale Healthcare Osborn Medical Center Trauma Program

Corrective Action: Tools for Success

July 18, 2014

**Frank (Tres) L. Mitchell, III, MD, MHA
Medical Director, Trauma & Surgical
Critical Care**



Scottsdale Healthcare Osborn Medical Center – ACS Level I Trauma Center

Performance Improvement and Patient Safety (PIPS)

- Patient care
- PIPS
- Challenging

Performance Improvement and Patient Safety (PIPS)

- Problems
- Deaths
- Adverse events

- Trauma Registry

History of Committee on Trauma Verification/Consultation Program

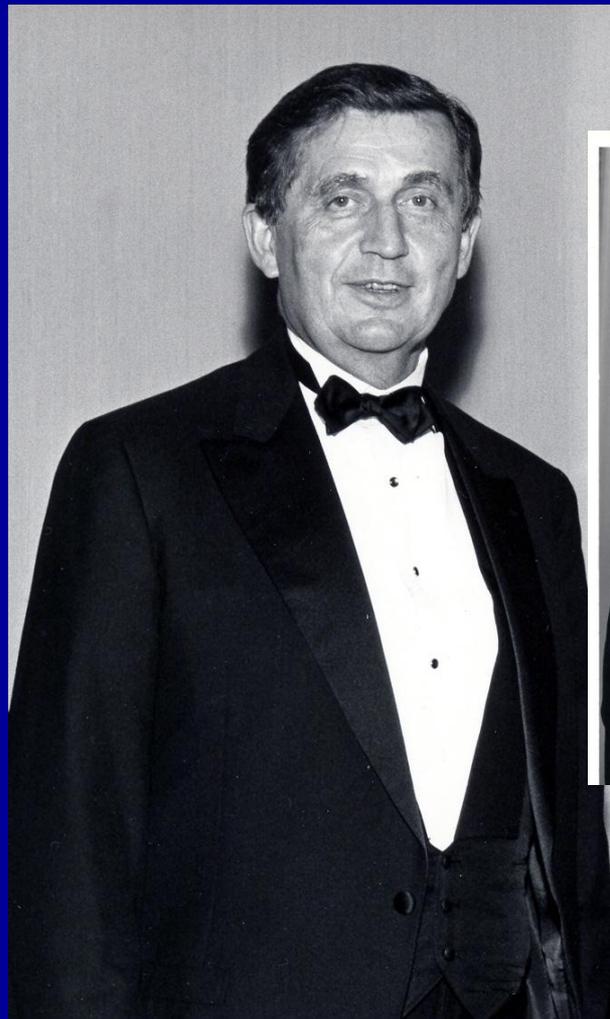
- 1986 – Approval of Verification Program
- American College of Surgeons

- **Verification Review
Committee**

COT Chairmen – Development of Verification/Consultation Program



1978-1982

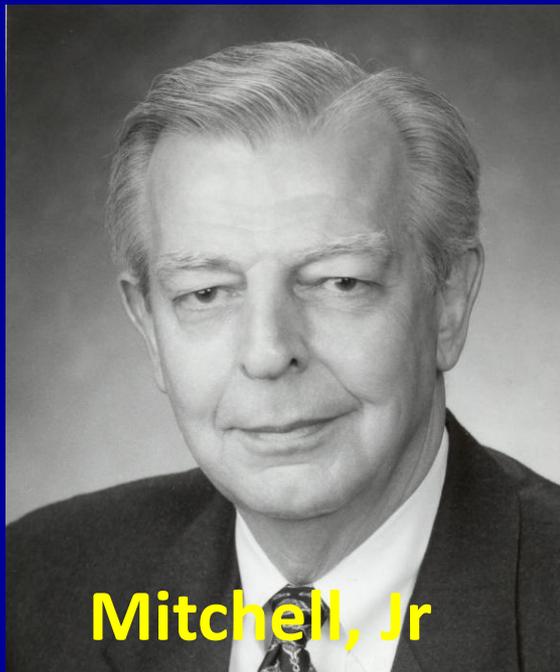


1982-1986

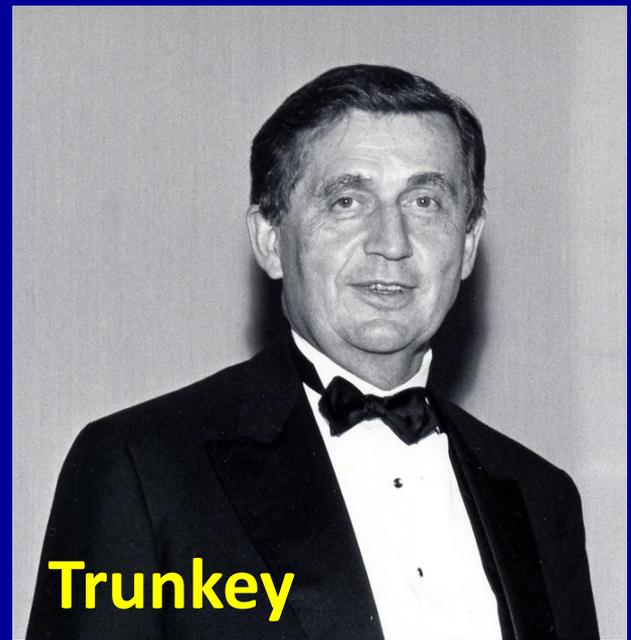


1986-1990

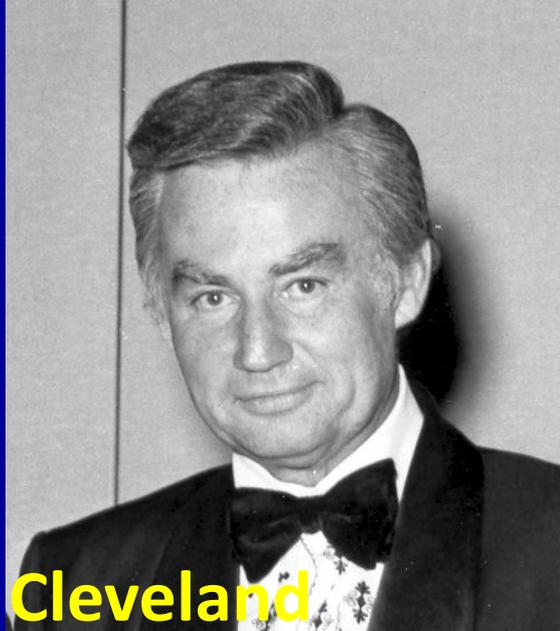
**The First
Verification
Review
Committee
1986**



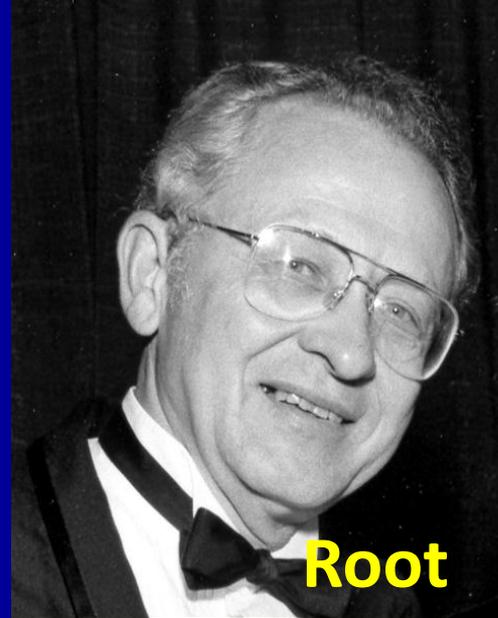
Mitchell, Jr



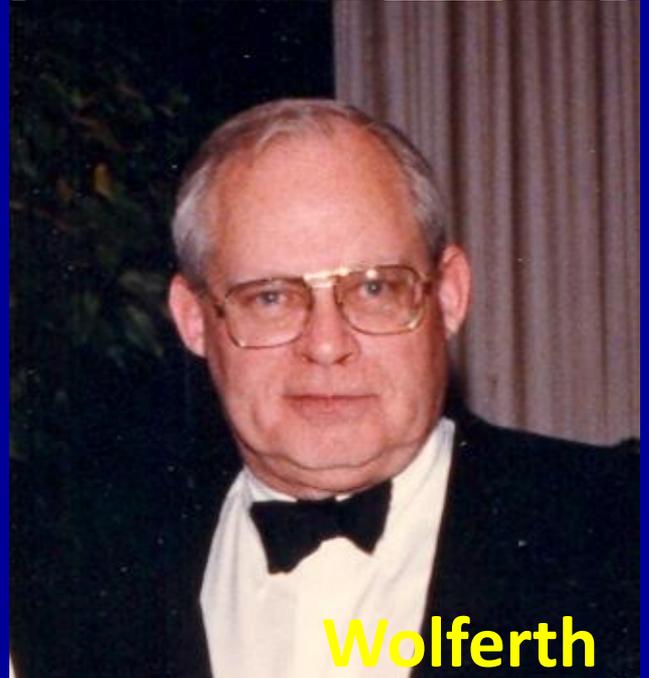
Trunkey



Cleveland



Root



Wolferth

Verification/Consultation Committee – 1986

- **Frank L. Mitchell, Jr., Chairman**
- **Henry C. Cleveland**
- **Harlan D. Root**
- **Donald D. Trunkey**
- **Charles C. Wolfert**



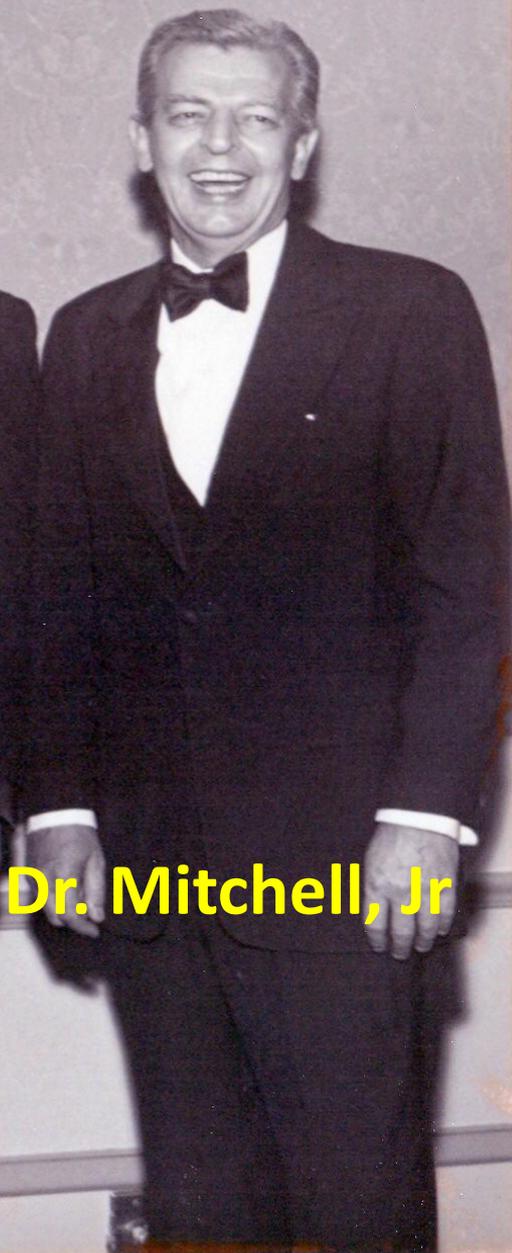
Dr. Thal



Dr. Thompson



Dr. McSwain



Dr. Mitchell, Jr

Resources for Optimal Care of the Injured Patient



Optimal hospital resources for care of the seriously injured

The feasibility for providing optimal hospital resources for the care of the seriously injured (and possibly other high-risk patients) is dependent upon a number of factors: patient, injury, hospital, and community resources. The report identifies key areas for improvement and provides a framework for the development of a comprehensive plan for the care of the seriously injured patient.

In brief:

Optimal hospital resources for care of the seriously injured is a report of the Task Force on the Committee on Trauma of the American College of Surgeons in response to a request by the Society for Trauma Medicine of the American College of Surgeons. The report was released and distributed by the American College of Surgeons on June 1, 1993. The report is available in print and on the American College of Surgeons website.

Hospital and Prehospital Resources for Optimal Care of the Injured Patient and Appendices A through J

AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT

COMMITTEE ON TRAUMA AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 1993

COMMITTEE ON TRAUMA AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 1999

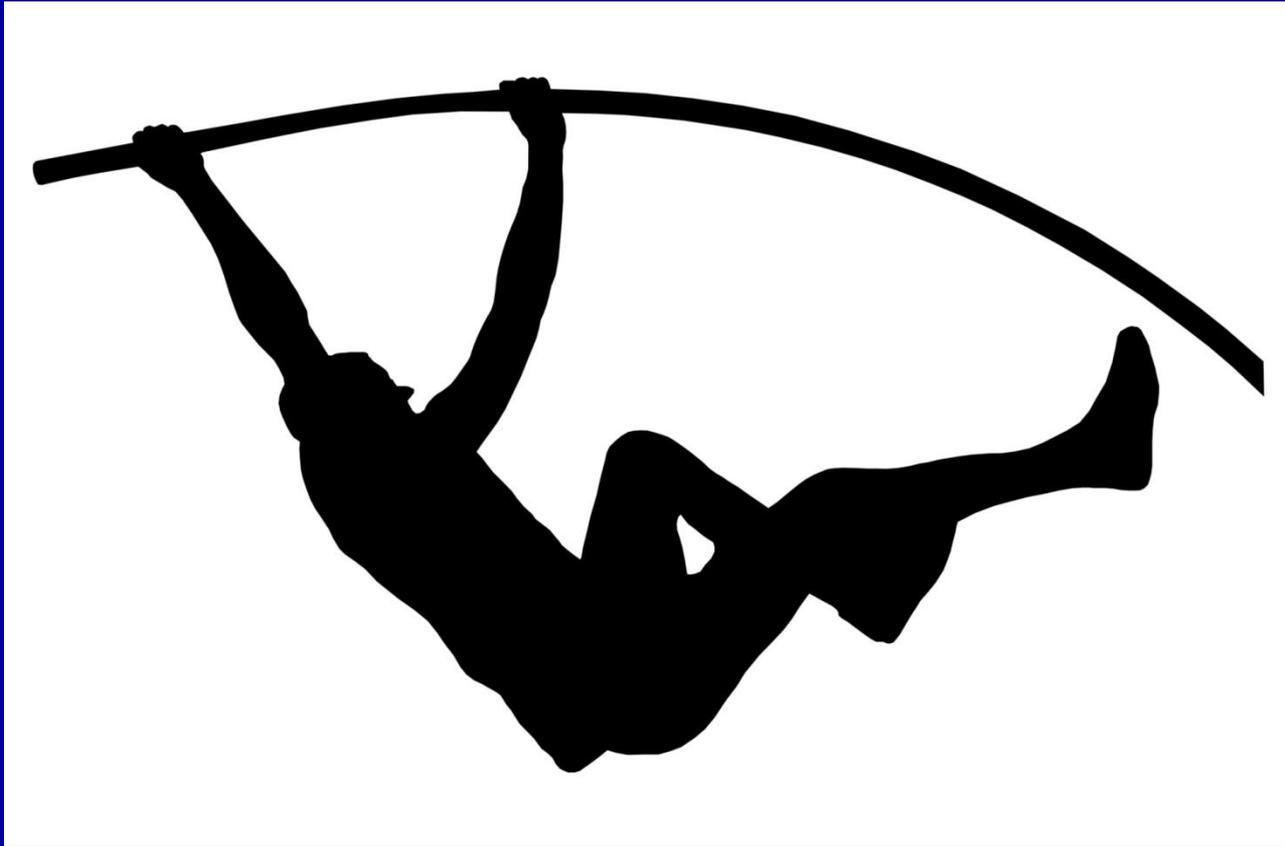
COMMITTEE ON TRAUMA AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT 2006

COMMITTEE ON TRAUMA AMERICAN COLLEGE OF SURGEONS

ACS-COT Requirements for Trauma Centers

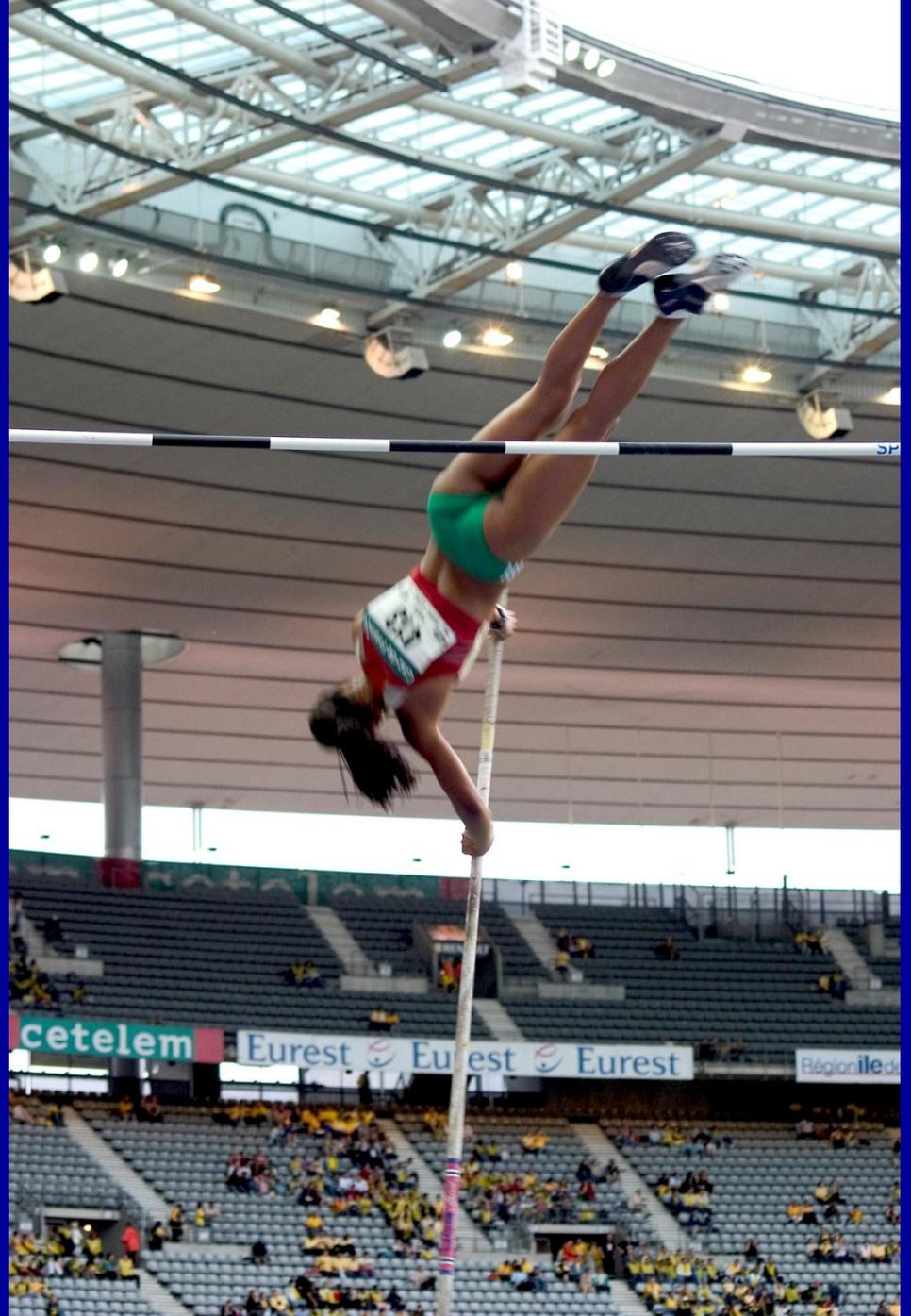
Continue to Raise the Bar



Trauma Surgeons

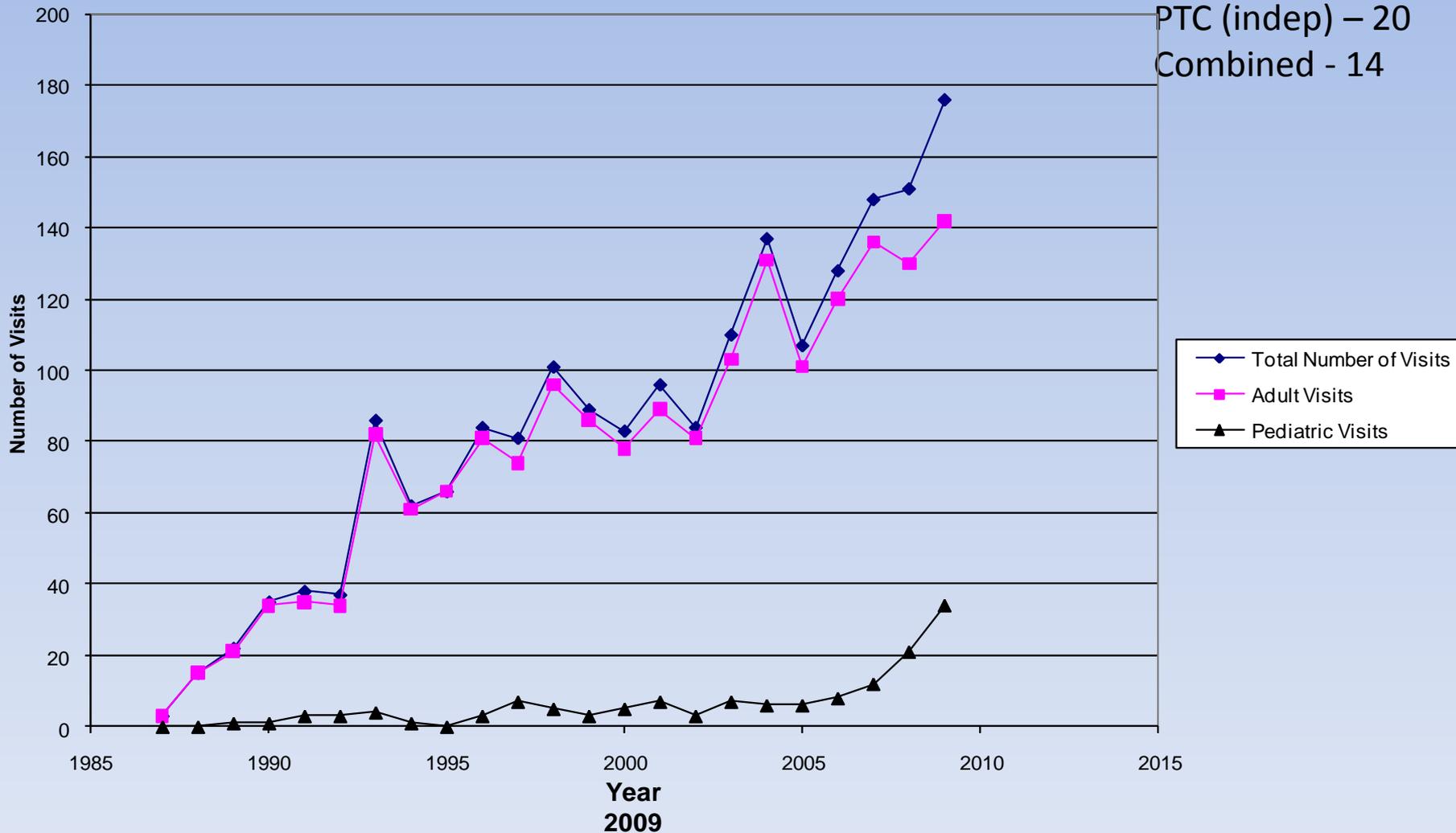


- Trauma Nurses



**ACS Verification Visits 1987-2009
(Including consults and on-site focus visits)**

2009
 Total – 176
 TC – 142
 PTC (indep) – 20
 Combined - 14



Raising the Bar

- **Requirements** to be a Verified Trauma Center
- **Accountability** – verify that these requirements are in place
- **Outcomes are Improved** – publications and from site visits

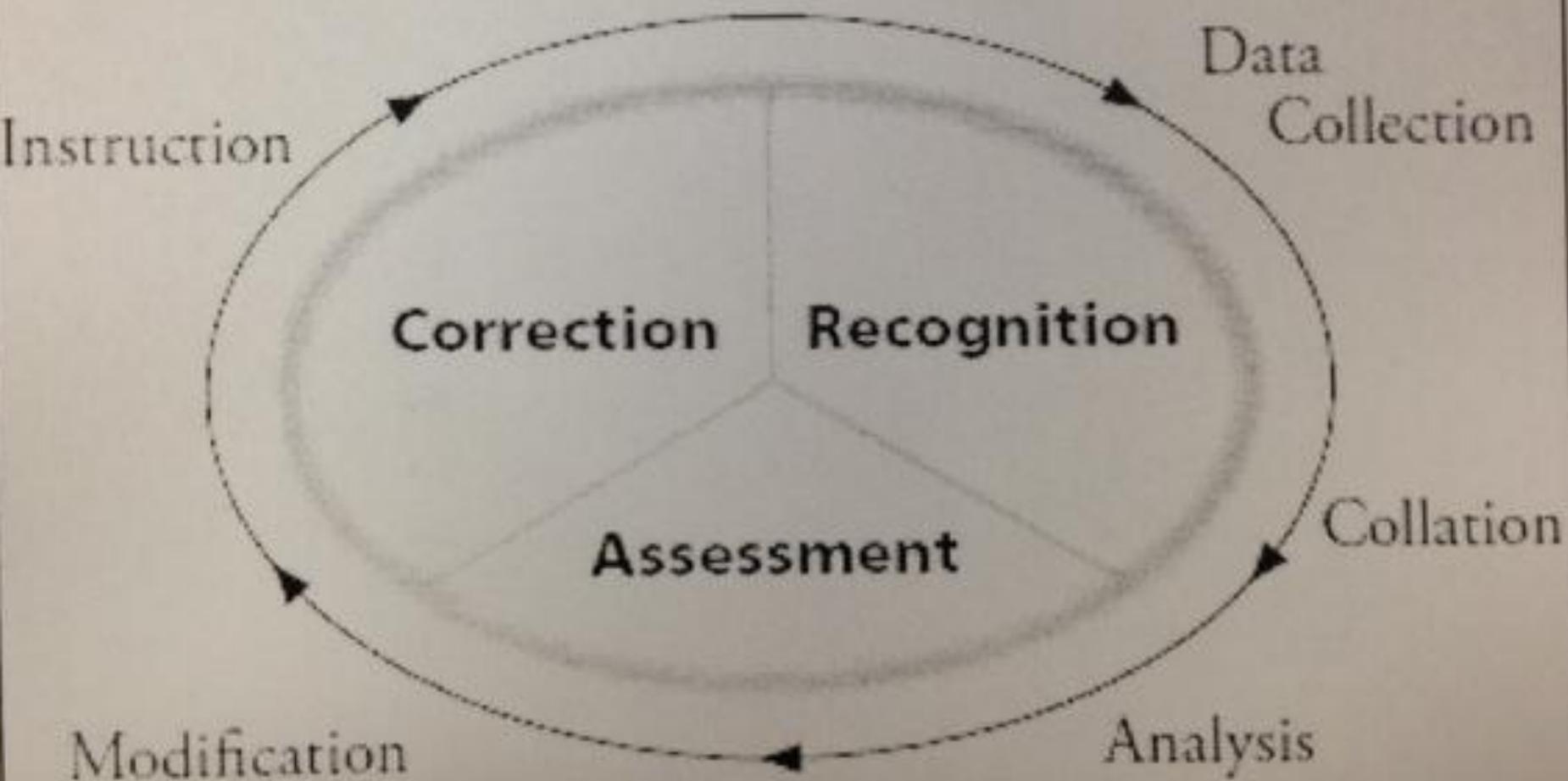
Performance Improvement and Patient Safety Program - Concepts

1. Trauma Center – should provide **safe, efficient, and effective care** to the injured patient
2. Requires – the **authority and accountability** to **continuously measure, evaluate, and improve care** (performance improvement)
3. This effort – should routinely **reduce unnecessary variation** in care and **prevent adverse events** (patient safety)

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Figure 1. The Continuous Process of Performance Improvement



Opportunities for Improvement

- Not an accusatory environment
 - Constructive
 - Educational
-
- Goal – improve patient care

Resources for Optimal Care of the Injured Patient



Optimal hospital resources for care of the seriously injured

The responsibility for providing optimal hospital resources for the care of the seriously injured rests inevitably with hospitals. Efficient administrative organization and sound financial policies with specialty related personnel and a wide range of other related personnel are essential. In particular, optimal resources emphasize trauma centers and specialty surgical and non-surgical staff, immediate resuscitation and critical care facilities, and sophisticated laboratory and radiologic services. Personnel must be available on all times, and equipment ready for use on short notice. Funding requirements for maintaining adequate staff, physical plant, services, and administrative personnel, as well as specialty related non-surgical related programs for emergency physicians and emergency radiologists remain constant, as do hospitalists. Hospitalists should consider various media, and involve and critique all professional and non-professional services, such as nurses, radiologists, hospitalists, and other staff. Hospital resources for the care of the seriously injured, however, are not limited to these key areas. A study of the relationship and personnel in these areas with existing hospitals and education, staff, and investigative research programs designed to improve the care of trauma patients. Various models of these requirements are listed in Table 2.

In brief:

Optimal hospital resources for care of the seriously injured is a report of a Task Force of the Committee on Trauma of the American College of Surgeons in response to a request by the Committee of the ACS Board of Trustees. The report was released and copyrighted by the American College of Surgeons on June 1, 1993. The report approved the report in its original form, and authorized its publication in the JOURNAL OF TRAUMA as an online College document.

The Board of Trustees and the Task Force recognize that the development of a set of guidelines representing current thinking, practices that be adopted as new or improved equipment become available and the design of special facilities is important. ACS is looking for facilities, staff, and medical staff, as well as hospital, staff, and financial health planning agencies, to meet their requirements with the published of these guidelines.

Resources from ACS-COT 1993 1993 and 1993 1993

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ACS-COT Requirements for Trauma Centers

Corrective Action

- **(CD 16-18)** 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 PIPS program.

Levels of Review

- 1. Primary Review** (first level) – Trauma Program Manager or designee
- 2. Secondary Review** – further evaluation with the Trauma Medical Director
- 3. Tertiary Review** (Multidisciplinary Review)

Tertiary Review (Multidisciplinary Review)

1. Prehospital Trauma PIPS Committee
2. Mortality and Morbidity Review
3. Multidisciplinary Trauma
Systems/Operations Committee
4. Multidisciplinary Peer Review

(CD 16-10)

- Sufficient mechanisms must be available to **identify events for review** by the trauma PIPS program.
- Events identified – **Concurrently and Retrospectively**.
- **Mechanisms** – Individual personnel reporting, morning report (sign-outs), case abstraction, registry surveillance, pathway and protocol variances, and patient-relations (or risk management).

(CD 16-11)

- Once an event is identified, the trauma PIPS program must be able to verify and validate that event.
- Level of Review – **Primary Review**

(CD 16-12)

- There must be a process to address trauma program operational events.
- **Multidisciplinary Trauma Systems/Operations Committee**
- **(CD 16-13)** – Documentation (minutes) reflects the review of operational events and, when appropriate, the analysis and proposed corrective actions.

(CD 16-14)

- Mortality data, adverse events and problem trends, and selected cases involving **multiple specialties** must undergo multidisciplinary trauma peer review.

(CD 16-17)

- Determination
- The multidisciplinary trauma peer review committee must systematically review mortalities, significant complications, and process variances associated with unanticipated outcomes and determine **opportunities for improvement.**

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Examples of Corrective Actions

1. Guideline, protocol, or pathway development or revision
2. Targeted education (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

Closing the Loop

- “Effective performance improvement demonstrates that a corrective action has had the desired effect as determined by continuous monitoring and evaluation.”
- **(CD 16-19)** An effective performance improvement program demonstrates through clear documentation that identified **opportunities for improvement** lead to specific interventions that result in an alteration in conditions such that similar adverse events are less likely to occur.

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Clinical Practice Guidelines, Protocols, and Algorithms

1. Use of Massive Transfusion Protocols
 2. Assessment & clearance of C-spine
 3. Severe Traumatic Brain Injury
 4. Reversal of oral anticoagulants
 5. Open Fractures – timing of antibiotics and time to OR
 6. Venous thromboembolism prophylaxis
- Monitor Compliance

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Education

- Rounds
- Conferences
- Hospital departments
- Journal Club
- One-on-One

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Questions???

