Southern Minnesota Regional Trauma Advisory Committee

Performance Improvement Patient Safety Plan

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Southern Minnesota Regional Trauma Advisory Committee (SMRTAC)

SMRTAC Performance Improvement and Patient Safety (PIPS) Plan

Purpose

The purpose of this plan is to assure the PIPS activities in the SMRTAC region support the primary mission of the organization, to decrease morbidity and mortality of trauma patients in the region through collaborative practice, education, and research to ensure quality and timely care to injured citizens. The overarching concept directing all PIPS activities is the culture of safety; trauma PIPS embraces an environment that supports activities to drive safe care practices and improved patient outcomes through a process that evaluates real and possible events in an objective and blameless methodology.

Scope

The PIPS plan applies to all stakeholders that impact the care for injured patients across the region. This includes hospitals, EMS agencies, law enforcement, physicians, nurses, and aeromedical.

Authority

The SMRTAC PIPS process is fully supported by the regional and state trauma system organizations. The following groups grant authority to the SMRTAC PIPS subcommittee to conduct PIPS activities:

A. MN State Trauma Advisory Council (STAC):
STAC was established by legislation to advise, consult with and make recommendations to the Commissioner of the Minnesota Department of Health regarding the development, maintenance and improvement of the statewide trauma system. The SMRTAC Chair and/or coordinator provide as needed regional updates to this council.

B. SMRTAC Executive Board:
The SMRTAC Executive Board has authority for the administrative operation of SMRTAC, including all subcommittee work up to and including the PIPS Subcommittee. This board answers to the SMRTAC membership and STAC leadership. The SMRTAC Chair is a standing member of SMRTAC Executive Board.

C. SMRTAC Board:
The SMRTAC Board consists of multidisciplinary members from the region, considered voting members, who are appointed by the Commission of Health. Executive Board members are members of the board.

D. SMRTAC General Membership:
The SMRTAC general membership consists of all stakeholders interested in trauma including by not limited to the general public, hospitals, EMS services, law enforcement,

and trauma program personnel. All members of these entities are welcome to all meetings and educational opportunities.

Committee Structure

A. SMRTAC PIPS Subcommittee:

The SMRTAC PIPS Subcommittee is a multidisciplinary peer review subcommittee functioning under the auspices of the SMRTAC Board. The charge of the committee is to provide a tertiary or quaternary level review for events identified through the PIPS process. Members provide critical review of all aspects of the case/event involved further identifying prevention and/or mitigation strategies to facilitate event resolution.

1. Roles and Responsibilities
    a. SMRTAC PIPS MD co-chair has overall responsibility and leadership for the regional PIPS process and provides secondary reviews when needed.
    b. SMRTAC PIPS RN co-chair provides operational support for the PIPS process including intake of events from regional stakeholders, providing primary reviews and documentation of all SMRTAC PIPS activities.
2. In addition to the co-chairs noted above, other SMRTAC PIPS Subcommittee membership may include multi-disciplinary representation as follows:
    a. SMRTAC Chair
    b. Level 1 Trauma Center representative (if chair not from Level 1)
    c. Pediatric Trauma Center representative
    d. Level III representative
    e. Level IV critical access representative
    f. Level IV representative
    g. EMS provider BLS service
    h. EMS provider ALS service
    i. EMS provider aeromedical service
    j. Advanced Practice Provider (APP) from critical access site
    k. Level IV Trauma Medical Director
    l. Law enforcement representative
3. Attendance at SMRTAC PI Subcommittee is required to be 50% annually at a minimum for all committee members. This attendance is tracked as part of the PI activities of SMRTAC.

SMRTAC PIPS Process

A. Event Identification

1. Information for PIPS purposes is collected concurrently and retrospectively. Sources of events and data, include but are not limited to the following:
    - SMRTAC PI Subcommittee Case Review Request (attachment #1)
    - Regional Database

2. The following quality indicators are used for event identification

- Standards of quality care: All regional trauma patients that meet activation criteria for entry into the trauma registry are monitored for compliance with or adherence to the standards of quality trauma care as established by the Statewide Trauma System and SMRTAC. Adherence to current practice management guidelines will be monitored on an on-going basis through a variety of methods including but not limited to; discussion at SMRTAC meetings, focused reviews when specific complications are identified as problematic, and when national standards of care demonstrate a need for change. In addition, practice management guidelines will be reviewed on a2-3 year basis assuring they are in keeping with current accepted standards.
- Death Reviews: Trauma patient deaths within the SMRTAC region are reviewed as they relate to trauma care and trauma system issues when referred by local hospital or other agency. All trauma deaths include a judgement as to presence or lack of an opportunity for improvement.
- Audit Filters: Audit Filters as defined by the American College of Surgeons (ACS) and/or the Minnesota State Trauma Plan and/or SMRTAC PI Subcommittee are monitored as part of the PI process.
    1. PI Filters: Trauma specific indicators that relate to generally accepted standards of care. The SMRTAC PIPS Committee will determine the audit filters to be monitored and this data will be reviewed to determine any opportunities for improvement.
    2. Measures to be captured and evaluated will be reviewed on an annual basis by the SMRTAC PIPS subcommittee and general membership

B. Review Process

A. Levels of Review: algorithm attachment #2

1. Primary Review: Primary review is defined as finding and validating the event. The SMRTAC PIPS RN co-chair will do the initial case review. This review includes confirmation and validation that an event actually occurred and determination of level of harm. If the primary review affirms the clinical care was appropriate based on current standards and policies; that no provider or systems events were identified; and there was no harm or potential harm to the patient, the case requires no further review. Events that require more investigation will be referred for secondary review.

2. Secondary Review: The secondary review can be conducted by the SMRTAC PIPS MD Co-chair or SMRTAC chair. A secondary level review is required when there is a question regarding clinical care, provider or systems factors and physician expertise and judgement is necessary. This may begin further

analysis, implementation of action without formal referral to SMRTAC PI Subcommittee.

3. Tertiary Review: Tertiary review occurs within the multi-disciplinary SMRTAC PI Committee structure. The "goals of this tertiary review include but are not limited to: review the efficacy, efficiency, and safety of the trauma care provided, provide focused education, and provide peer review" (Optimal Care ACS 2014). Based upon the SMRTAC PI Subcommittee review decision, the committee may communicate with individual providers or request a quaternary review. Recommendations related to systems events might include process changes/improvements and/or guideline, protocol development. Event determination will be made by the committee using the criteria to follow.

4. Quaternary Review: Quaternary review is defined as an additional review by an outside agency. The conclusions and results of these reviews should be documented and available to the SMRTAC PI Subcommittee leadership.

5. All levels of review require documentation that includes the following:
    - Analysis of event
    - Action plan for resolution
    - Date of event resolution

Determinations
The SMRTAC PI Subcommittee uses the following judgment designations:

Mortality Determinations
Mortality with opportunity for improvement
Mortality without opportunity for improvement

Event Determinations (Factors)	
System Factors	An event or complication not specifically related to a provider or a disease, such as operating room availability, blood availability, and diagnostic testing availability; an event or complication whose correction usually goes beyond a single provider or department. System-related issues usually involve multiple individuals or departments.
Human Factors – Patient	An event or complication that is an expected sequela of a disease, illness or injury
Human Factors - Provider	An event or complication largely due to provider-related provision of care by a credentialed or non-credentialed provider functioning in a supportive and otherwise well-functioning system.

C. Action Planning

a. When an opportunity for improvement is identified through the PIPS process, appropriate actions plans to mitigate or prevent similar future adverse events must be developed and implemented. Though not all inclusive, the majority of events are addressed through the following means:
    i. Guideline, protocol, or policy development or revision
    ii. Targeted education
    iii. Additional and/or enhanced resources
    iv. Counseling
    v. Focused workgroup
    vi. Periodic reporting, tabulation and tracking for further reporting
    vii. External review or consultation

D. Event Resolution

a. An event is considered resolved when the actions taken prove successful in the mitigation or prevention of similar future cases. This requires a demonstrated measurement of improvement or change over time.

E. Documentation of Analysis and Evaluation

A. Analysis of an event will include:
    1. Documentation of all case related events, including meeting minutes, all levels of review, and action plans will be kept in a secure environment.
    2. Documentation of all operational process performance events will be included in SMRTAC PI Subcommittee minutes.
    3. The SMRTAC PI Subcommittee chair(s) is responsible for assuring all events are brought to event resolution and that documentation of such is complete.

F. Confidentiality Protection

1. All performance improvement activities at the local, regional and state must follow:

MN State Statute 145.61-145.67 provides discovery protection for review organizations

145.64 CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION.

Subdivision 1. **Data and information.**

(a) Except as provided in subdivision 4, data and information acquired by a review organization, in the exercise of its duties and functions, or by an individual or other entity acting at the direction of a review organization, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of

the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings.

Pursuant to **Section 160.007** of the Minnesota Occupations Code, the following information relating to trauma performance improvement review is confidential and privileged.

The EMS/Trauma System Performance Improvement initiative consists of ongoing and systematic monitoring, evaluation, management and documentation of performance. This system PI process is supported by a valid and objective method of data collection and collation. The development of standard guidelines from evidence based practice, protocols, consensus of aspects of care and regulatory statutes are components of the review process. Defined outcome measures and quality care indicators are tracked and monitored through this process.

4. Whenever possible, generic identifiers for patients and care providers will be utilized. No PI information will be part of the patient medical record. All PI paper documents and electronic information will be kept in a secure location with limited, controlled access.

Attachments:

#1 SMRTAC PI Subcommittee Case Review Request – When completed please forward to : admin@smrtac.org

Southern Minnesota Regional Trauma Advisory Committee

Performance Improvement Subcommittee Case Review Request

Date of Request	
Person referring case (please print)	Name _____ Title _____ Agency _____ Contact Information _____
Date of occurrence	
Please describe the problem and information from the initial case review.	Location of incident (check all that apply): ☐ Scene First Responder/Law Enforcement ☐ EMS ☐ Air ☐ Enroute ☐ ED ☐ Hospital (Inpatient status) ☐ Dispatch Communication: Describe your concerns and your reason for requesting a regional review:

What actions have you taken to address the problem? (Example: Contacted agency PI person and requested run sheet/chart; talked with PI person and informed them of issue, etc.)	

Initial Review by PI Co-Chair	
Date Reviewed	
Regional System Issue Determination	☐ This is a regional issue, appropriate for PI Subcommittee ☐ This is a non-regional issue between involved entities ☐ This is a trend that should be reviewed by PI Subcommittee
Recommendations (check all that apply)	☐ Refer to PI Subcommittee ☐ More in-depth information is required ☐ Do not refer to PI Subcommittee
Chair (or designee) will discuss with referring agency to obtain names/specifics	Hospital/Facility: _____ EMS Agency: _____ Other: _____

Signature of PI Chair_____ **Date**_____

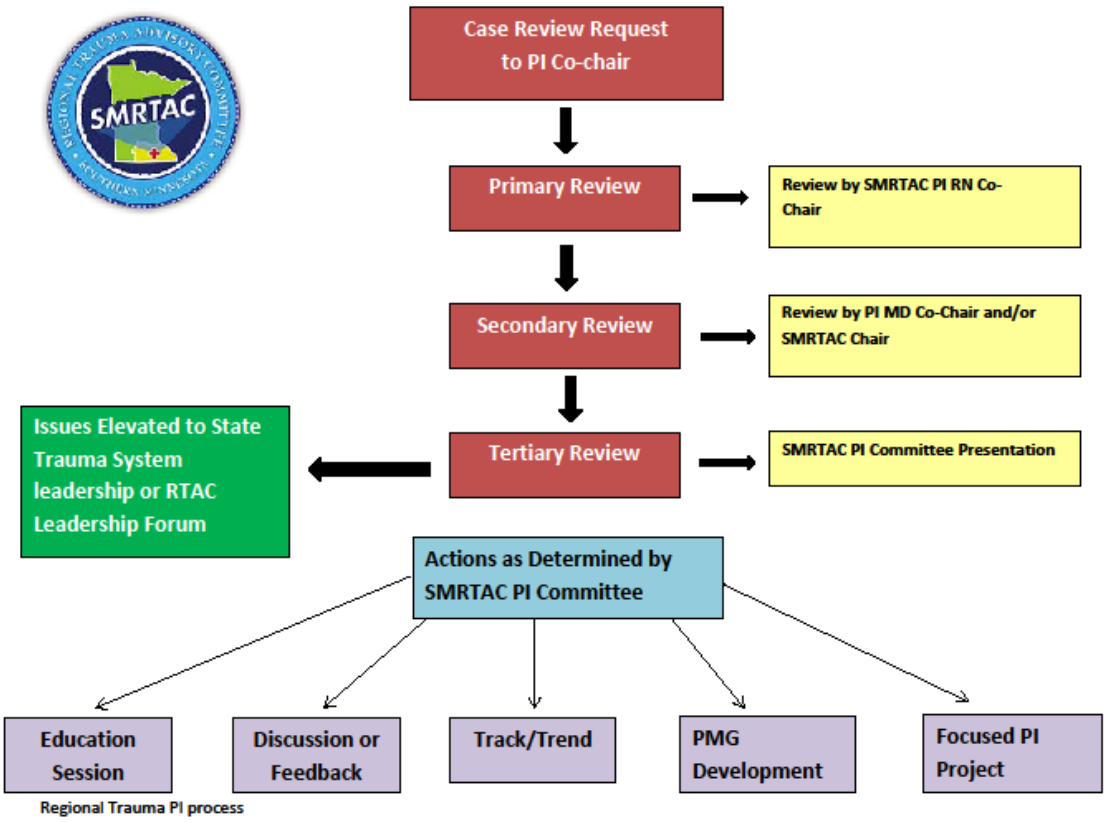
This page to be completed by SMRTAC PI Subcommittee

PI Subcommittee Review	
Date referred to PI Subcommittee	
Summary of discussion	
Mortality Determinations	☐ Mortality with opportunity for improvement ☐ Mortality without opportunity for improvement
Event Determinations (Factors)	☐ System Factors ☐ Human Factors-Patient ☐ Human Factors-Provider
Action Plan Determination	☐ Unnecessary ☐ Trend ☐ Education ☐ Guideline/Protocol ☐ Counseling ☐ Peer-review presentation ☐ Resource enhancement ☐ Other
Action Plan(s)	☐ Requires written communication from the SMRTAC in the form of: ☐ Recommendations for improvement 1.

	2. 3. ☐ Education on _____ _____ ☐ One-on-one discussion between _____ & _____ ☐ Referral to home RTAC (if outside SMRTAC) ☐ Requires verbal communication ☐ Communication is unnecessary ☐ Communication is inappropriate
Person(s) responsible for taking corrective actions	
Date to be completed	
Date loop closed	

Signature of PI Chair_____
Date_____

Regional Trauma PI Levels of Review



Regional Trauma PI process