Trauma Quality Improvement Program

The purpose of this section is to demonstrate the trauma facility's approach to the rigorous and continuous improvement of its system of trauma care in WAC 246-976-700. Quality Improvement (QI) includes documentation of the evaluation of care quality, the identification of areas for improvement, and efficient correction to achieve the best possible outcomes for patients.

A multidisciplinary trauma quality improvement program that must:

Level: All

Section Item 1: ☐ Be led by the multidisciplinary trauma service committee with the trauma medical director(s) as chair of the committee.

Section Item 2: ☐ Demonstrate a continuous quality improvement process supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement.

Section Item 3: ☐ Have membership representation and participation that reflects the facility's trauma scope of service.

Section Item 4: ☐ Have an organizational structure that facilitates the process of quality improvement, with a reporting relationship to the hospital's administrative team and medical executive committee that ensures adequate evaluation of all aspects of trauma care.

Section Item 5: ☐ Have authority to establish trauma care standards and implement patient care policies, procedures, guidelines, and protocols throughout the hospital and the trauma service must use clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources.

Section Item 6: ☐ Have a process to monitor and track compliance with the trauma care standards using audit filters and benchmarks.

Section Item 7: ☐ Have a process in which outcome measures are documented within the trauma quality improvement programs written plan which must be reviewed and updated at least annually. Outcome measures will include, at a minimum:

- ☐ Mortality (with and without opportunities for improvement)
- ☐ Trauma surgeon response time (If general surgery services are provided)
- ☐ Undertriage rate
- ☐ Emergency department length of stay greater than three hours for patients transferred out.
- ☐ Missed injuries
- ☐ Complications

Section Item 8: ☐ Have a process to evaluate the care provided to trauma patients and to resolve identified pre-hospital, physician, nursing, or system issues.

Section Item 9: ☐ Have a process for correcting problems or deficiencies.

Section Item 10: ☐ Have a process to analyze, evaluate, and measure the effect of corrective actions to determine whether issue resolution was achieved.

Section Item 11: ☐ Have a process to continuously evaluate compliance with full and modified (if used) trauma team activation criteria.

Section Item 12: ☐ Have assurance from other hospital quality improvement committees, including peer review if conducted separately from the trauma committee, that resolution was achieved on trauma related issues. The following requirements must also be satisfied:

- ☐ Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion;
- ☐ A process must be in place to ensure that the trauma program manager receives feedback from peer review for trauma-related issues;
- ☐ All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review;
- ☐ This effort must involve the participation and leadership of the trauma medical director and any departments, such as: General surgery, emergency medicine, orthopedics, neurosurgery, anesthesia, critical care, lab and radiology;
- ☐ The multidisciplinary trauma peer review committee must systematically review significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement.

Section Item 13: ☐ Have a process to ensure the confidentiality of patient and provider information, in accordance with RCW 42.56 and RCW 70.168.090.

Section Item 14: ☐ Have a process to communicate with, and provide feedback to, referring trauma services and trauma care providers.

Section Item 15: ☐ Have a current trauma quality improvement plan that outlines the trauma service's quality improvement process, as defined in this subsection.

Section Item 16: ☐ Participation in the regional quality improvement program as defined in WAC 246-976-910.

Section Item 17: ☐ Use risk-adjusted data for the purposes of benchmarking and performance improvement. For level I and II trauma services, the risk-adjusted benchmarking system must be the American College of Surgeons Trauma Quality Improvement Program (TQIP).

Level: III, IV, V

Section Item 18: ☐ Trauma services with a total annual trauma volume of fewer than 100 patients may integrate trauma quality improvement into the hospital's quality improvement program; however, trauma care must be formally addressed in accordance with the quality improvement requirements above. In this case, the trauma medical director is not required to serve as chair.

Level: All

Section Item 19: ☐ Have a pediatric-specific trauma quality improvement program for a trauma service admitting at least one hundred pediatric trauma patients annually. For a trauma service admitting less than one hundred pediatric trauma patients annually, **or**

☐ Trauma services that are transferring pediatric trauma patients, the trauma service must review each case for timeliness and appropriateness of care.

Respond to the following items:

Insert required documents in the following pages. Label each with the corresponding Section number and Item number.

Response Item 1: Include an organizational chart or diagram that shows the Multidisciplinary Trauma Quality Improvement Committee's (MTQIC) reporting structure within the facility. The chart should show the facility's governing entity and how each MTQIC reports to that entity—along with the relationship to the Medical Executive Committee, the departmental committees of Surgery, Emergency Medicine, Critical Care, and other major departments or service line committees.

Response Item 2: Submit the most recent Trauma QI Program Plan with date of MTQIC approval. The plan must demonstrate process and flow, and can be easily applied to issue, action, and resolution. See Exhibits for an example.

Response Item 3: Provide MTQIC attendance records for the most recent two-year period, with legible names, and each representative's title and department or service (See Exhibits for a table example). For level I-III services, the requirement is that there are Identified medical staff representatives or their designees from departments of general surgery, emergency medicine, orthopedics, neurosurgery, anesthesiology, critical care, and radiology who must participate actively in the multidisciplinary trauma quality improvement program with at least fifty percent attendance.

Response Item 4: ☐ Yes ☐ No Has lack of attendance at MTQIC been an issue? If No, skip to Item 7.

Response Item 5: ☐ Yes ☐No If Item 4 is Yes, has lack of attendance at MTQIC been addressed?

Response Item 6: ☐ Yes ☐No Has improvement in MTQIC attendance been noted?

Response Item 7: ☐ Yes ☑ No ☐N/A If trauma peer review is conducted separately from MTQIC, provide attendance records from the most recent two-year period, with legible names or each representative's title and department or service. For level I and II trauma services, the program must be able to demonstrate a minimum of 50% attendance from all the general surgeons who participate on the trauma panel. For level III trauma services, If at least fifty percent of the general surgeons did not attend the peer review committee meetings, then the trauma service must be able to demonstrate that there is a formal process for communicating information from the committee meetings to the group of general surgeons.

Response Item 8: Process and outcome measures, referred to as audit filters, require defined criteria and metrics. In the following pages, insert a clearly labeled summary of results for each adult and/or pediatric audit filter (outcome measures) used to review trauma care during the current designation cycle. This summary should include, at a minimum, the results for the WAC required outcome measures prescribed in WAC 246-976-700(4)(i)(i-vi) (Section Item 7). Dashboard summaries require a bulleted explanation of results. See Exhibits for an example.

Response Item 9: Insert clearly labeled case summaries, from the current designation cycle:

- Level IV and V: 1 completed trauma QI issue review from the categories below.
- Level I-III: 3 completed trauma QI issue reviews for adult trauma patients.
- Dual designated facilities should have a total of six completed case summaries; three adult and three pediatric.
- Pediatric-only designated facilities should submit three pediatric case summaries.

These summaries should include:

☐ A system issue affecting trauma care in the facility.
☐ A physician or nursing trauma practice issue in the facility.
☐ A trauma patient death in the facility. This should be an unexpected or preventable death, or a non-preventable death with opportunities for improvement.

For Item 9, mark submitted documents as confidential. Include all auditing and tracking documents used.

Each QI review in Item 9 must include the following (check the boxes below to indicate each is included in both Item responses):

☐ Issue identification
☐ Discussion and conclusions
☐ Action plans: Goals, audit filter or quality indicator developed, steps to goal
☐ Implementation details of action plan
☐ Evaluation and measurement results
☐ Adjustments or re-evaluation
☐ Issue resolution (loop closure, the positive outcome of QI efforts from MTQIC minutes).

Response Item 10: For level III-V trauma services, submit a summary that demonstrates how the trauma program is using the state provided risk-adjusted data reports to improve outcomes. For level I and II trauma services, submit the most recent TQIP reports available.

Response Item 11: List all Washington state regional QI meetings for the past two years of your current designation—indicate the TMDs and TPMs attendance. Attendance is required in accordance with WAC 246-976-910.

Response Item 12: List how the trauma service participates in regional QI meetings (check all that apply):

☐ Share findings from the facility trauma program's QI processes to benefit regional partners.
☐ Contribute to problem-solving of regional system issues.
☐ Maintain currency of the facility's specialty physician availability on a state- or region-wide website (e.g., WaTRAC, RAMSES, etc.)
☐ Maintain currency of the facility's bed availability on a state- or region-wide website (e.g., WaTRAC, RAMSES, etc.)
☐ Use state or regional trauma data to drive regional QI priorities.
☐ Other: Explain; limit response to 750 characters. _____

Response Item 13: ☐ Yes ☐ No Does the trauma service have a process to receive feedback from receiving facilities on a trauma patient transferred-out to an acute care facility?

Response Item 14: ☐ Yes ☐ No Does the trauma service use that feedback information in the trauma QI program? Check all that apply:

☐ Review data accuracy
☐ Determine loop closure
☐ Identify missed diagnoses
☐ Check compliance with facility's clinical guidelines, standards, protocols, or procedures
☐ Evaluate appropriateness of transfer
☐ In QI case review
☐ Review patient outcomes
☐ Other. Explain; limit response to 500 characters. _____

Response Item 15: ☐ Yes ☐No ☐ N/A Does the trauma service provide feedback to referring (sending) facilities?

Response Item 16: ☐ Yes ☐No If received or obtained, is the receiving facility's injury severity scores (ISS) entered into the patient record in the collector trauma registry software?

Response Item 17: ☐ Yes ☐No Does the receiving facility's ISS information trigger a re-review in the trauma QI program?

Response Item 18: Check all that apply. The trauma QI Plan includes:

- ☐ A process to continuously evaluate compliance with full trauma team activation criteria.
- ☐ Measurement of compliance to FTTA criteria
- ☐ FTTA issue identification
- ☐ FTTA action plans
- ☐ Implementation of FTTA action plan
- ☐ Re-evaluation of FTTA compliance measurement
- ☐ MTQIC's conclusion of the outcome's effectiveness for loop closure

Response Item 19: ☐ Yes ☐ No Is under-triage measured for full TTAs?

Response Item 20: ☐ Yes ☐ No Is over-triage measured for all TTAs? If over-triage is not currently measured for all TTAs, the trauma program will demonstrate over-triage in the next trauma designation application.

Response Item 21: ☐ Yes ☐ No Does the trauma service use modified TTAs?

Response Item 22: ☐ Yes ☐ No Is under-triage measured for modified TTAs?

Response Item 23: In the response field provided, detail the methodology used to determine undertriage: