In Trauma Center Verification

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The Trauma Professional's Blog

No financial disclosures

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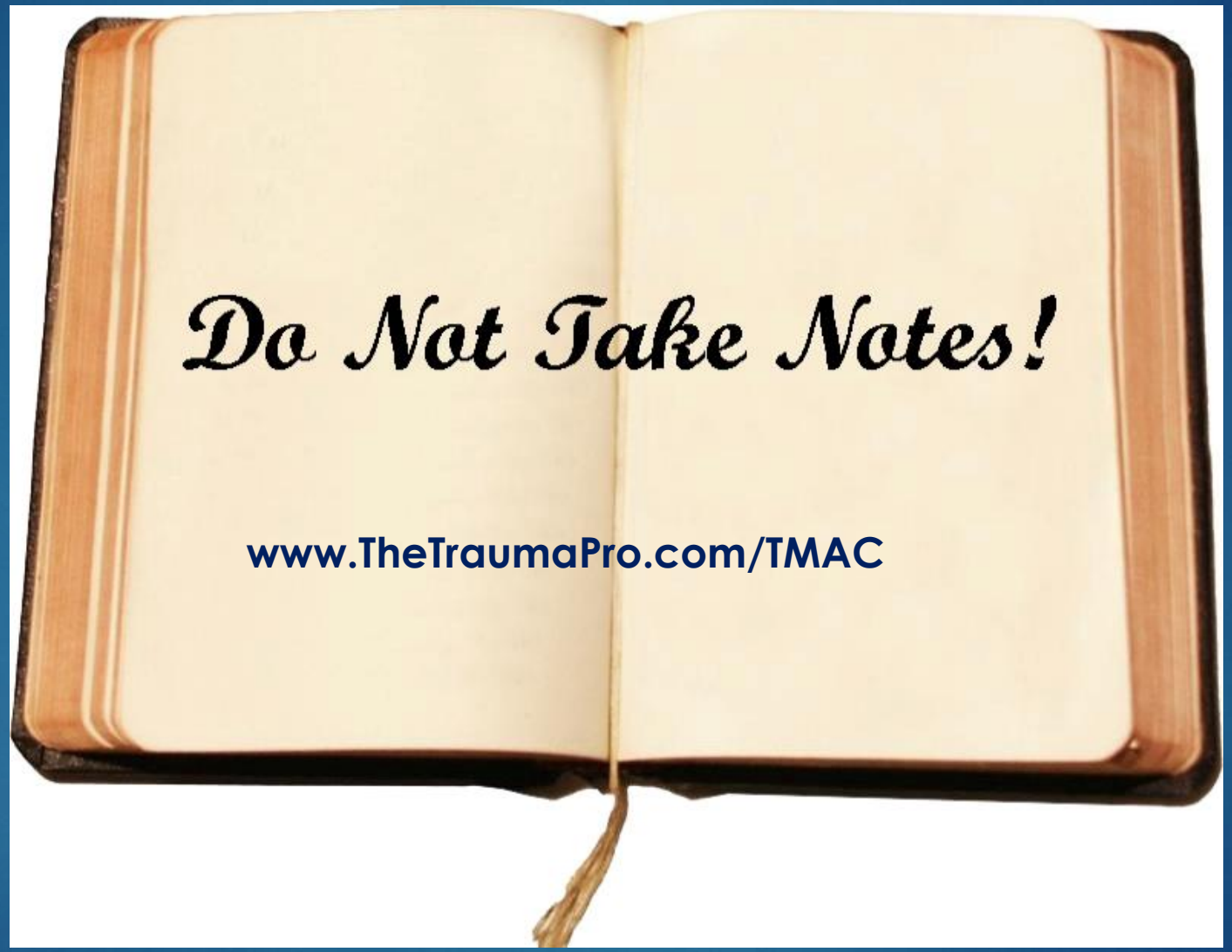
"DISCLAIMER"
....RIGHT

Objectives

- Review new concepts in the verification process
- Describe common pitfalls encountered
- Provide some valuable pearls for your center


Do Not Take Notes!
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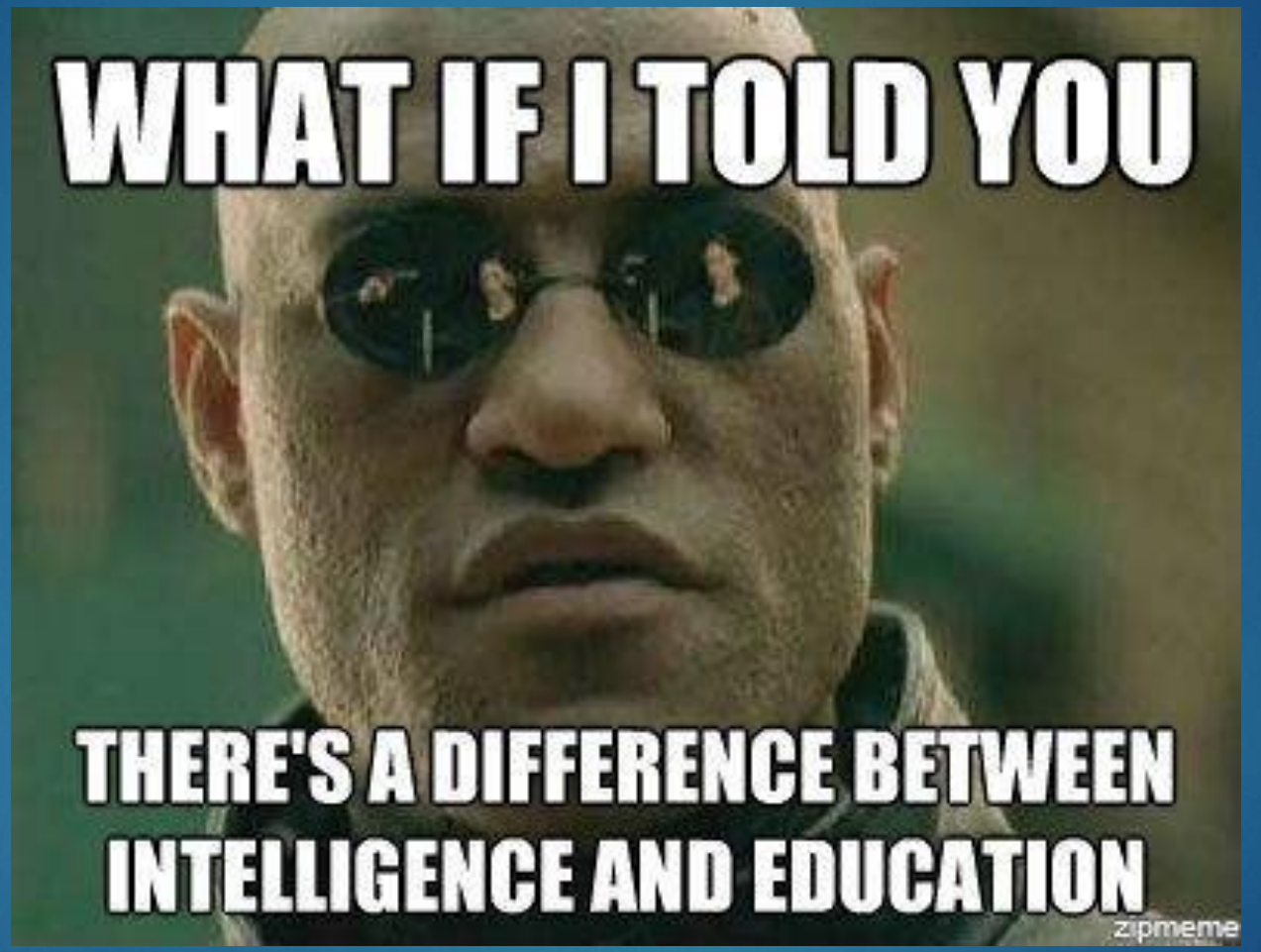
LIONS CLUB

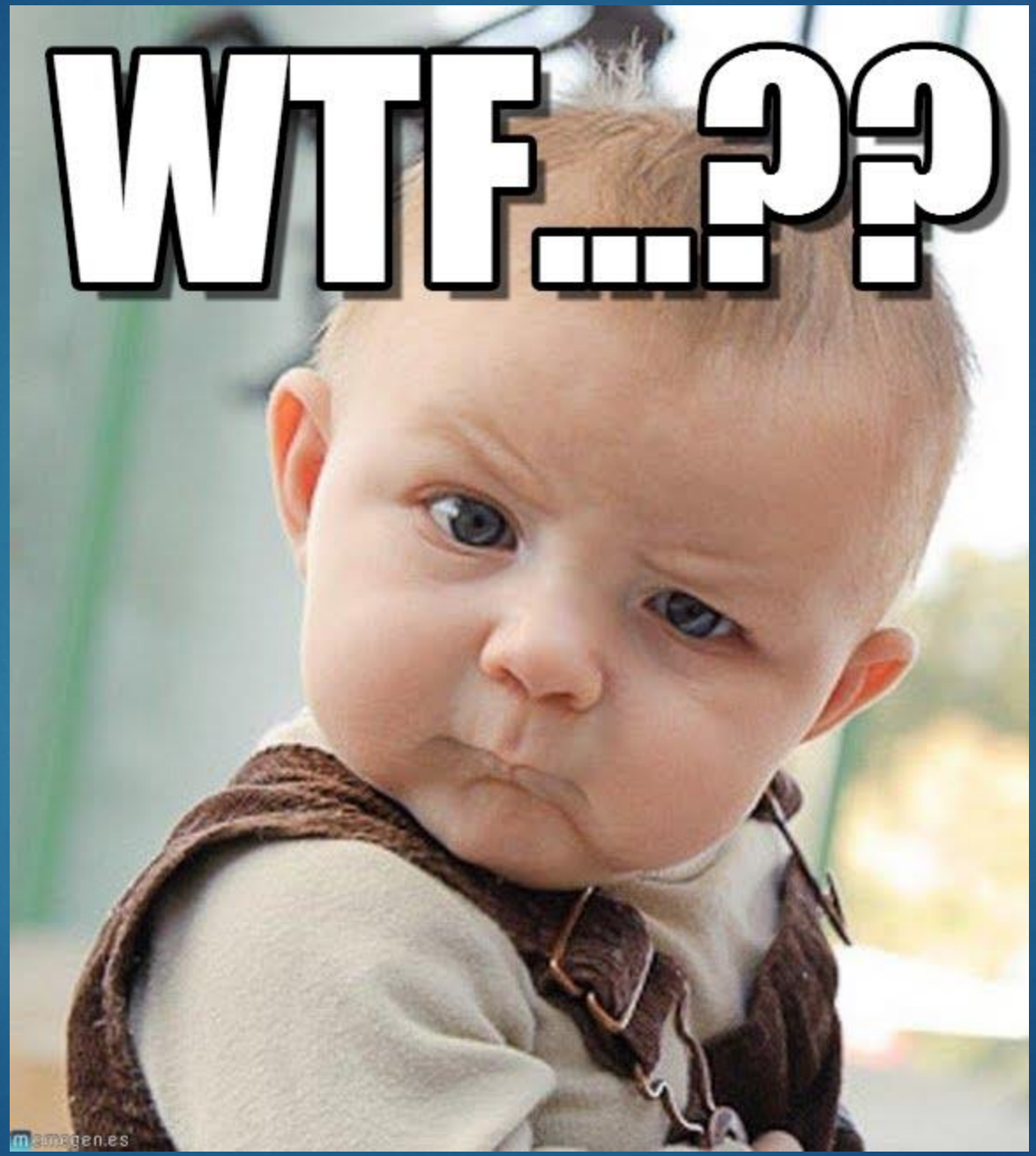

WHAT IF I TOLD YOU
THERE'S A DIFFERENCE BETWEEN INTELLIGENCE AND EDUCATION
zipmeme

The CME Change

- 48 -> 36 -> 0 ?!
- Only the TMD still required

The CME Change

- 48 -> 36 -> 0 ?!
- Only the TMD still required and…
- Alt Pathway physicians

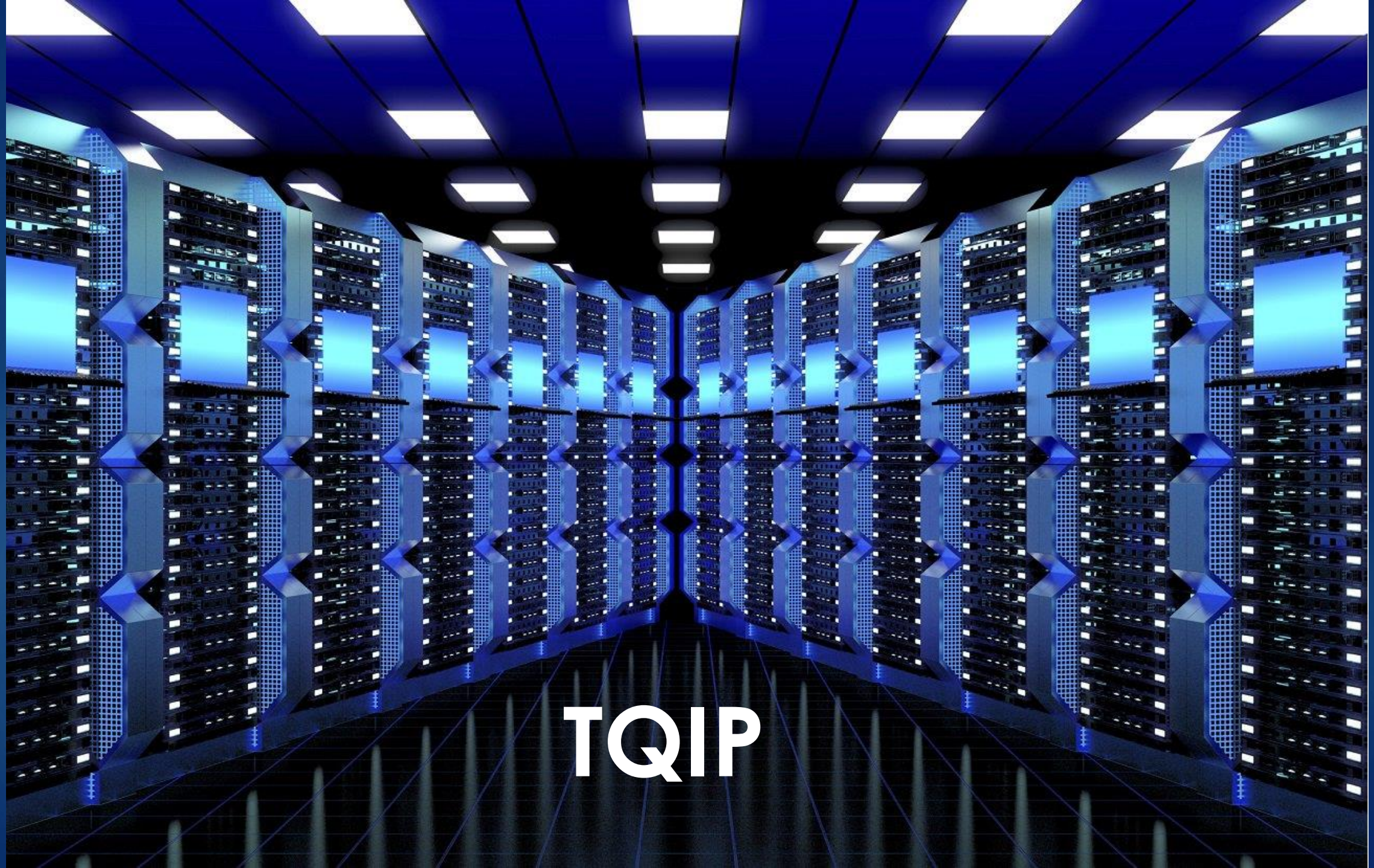

WTF...??


WTF...??
WORLD TAEKWONDO FEDERATION

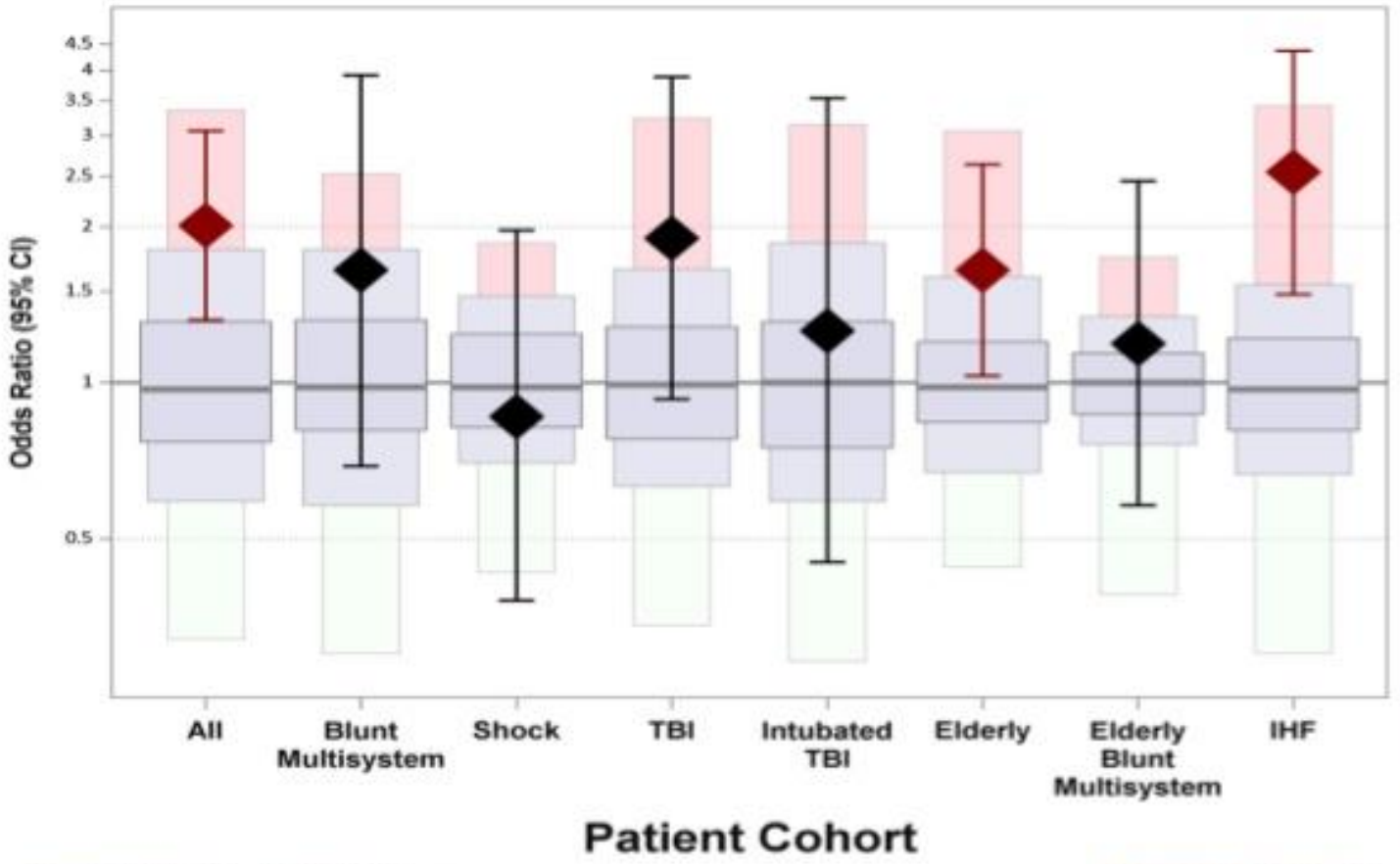
My Recommendation

- Require <u>something!</u>

- CME?
- IEP?
- Hybrid?


TQIP

TQIP Benchmarking report



Highest Standards, Better Outcomes

100 years

PROGRAM

TQIP

- All Level I-III centers must now participate
- Develop a plan for everything in the red

TQIP

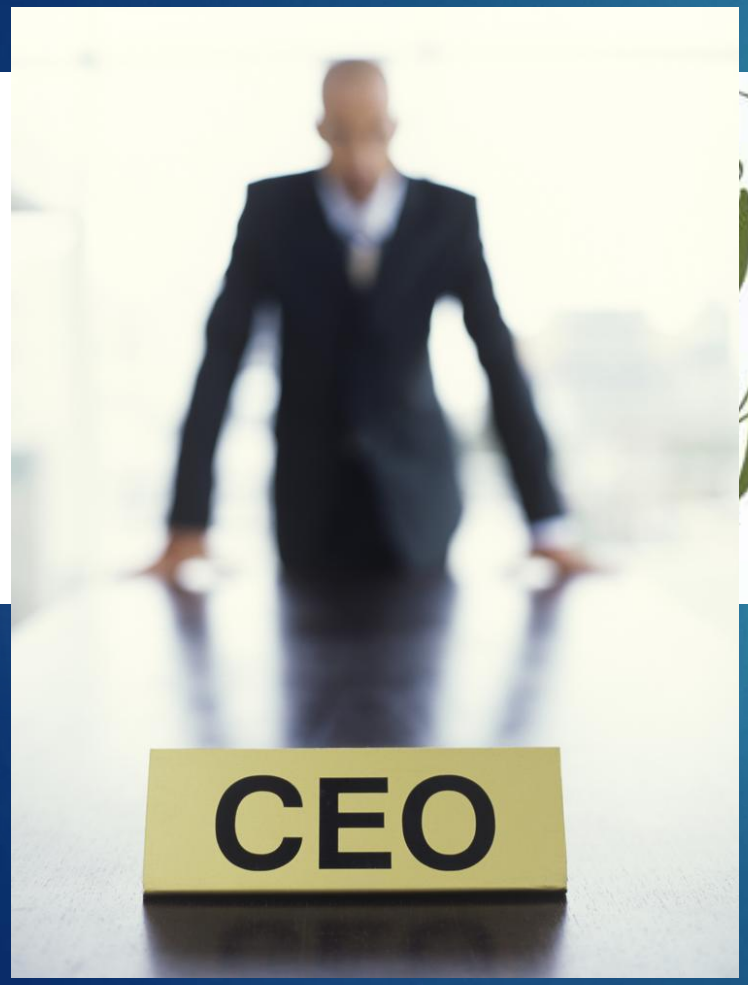
- Is TQIP used effectively in your PI process?
- Evolution from PI process to outcome and quality
- Integration of best practices

Wedding Registry!

Trauma Registry!

Trauma Registry!

500 – 750 admissions / registrar



750 admissions / registrar

Trauma Registry?!

Trauma / Burn / State / Corporate / ???

Trauma Registry!

600 admissions / registrar


SBIRT

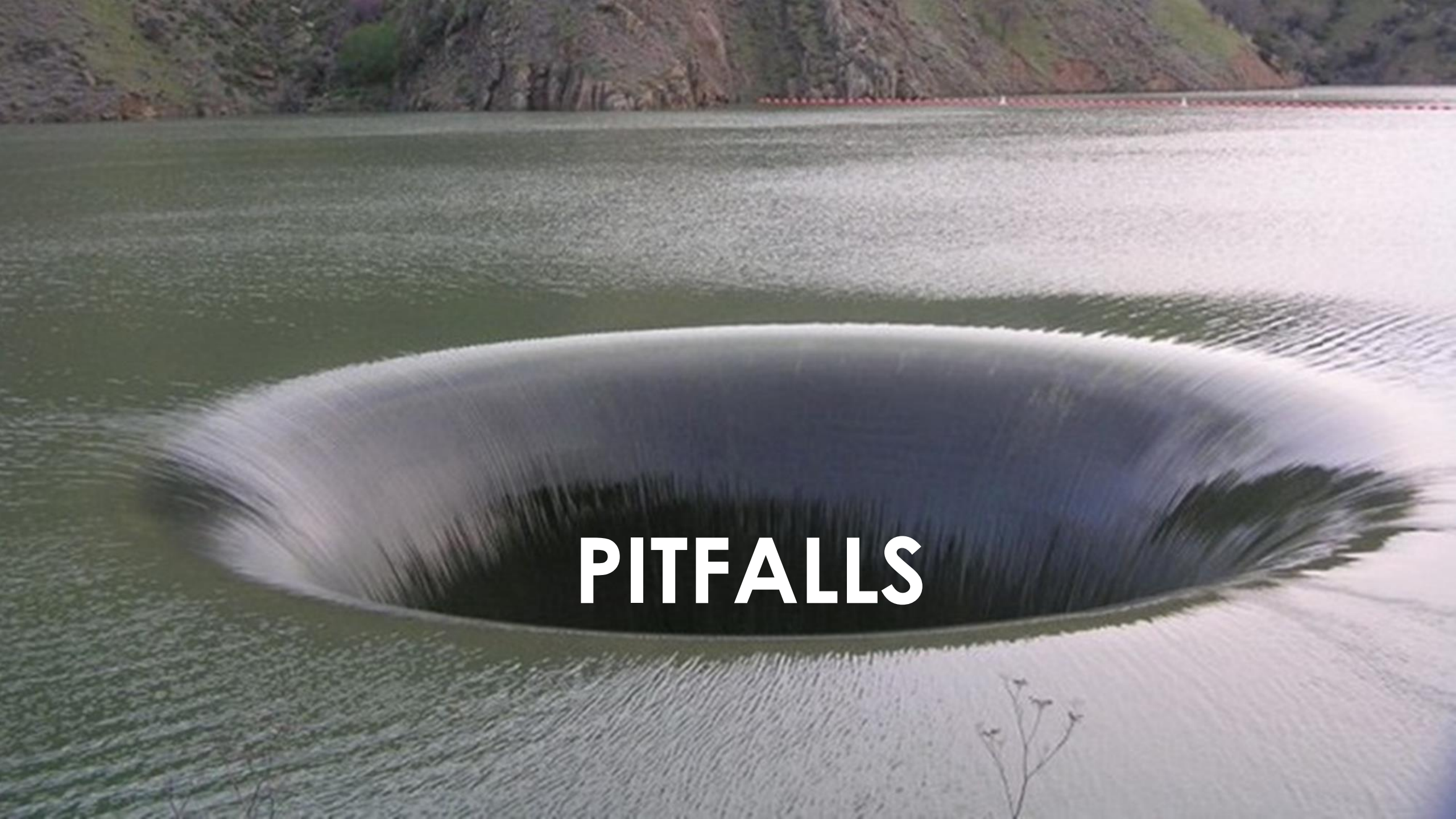
SBIRT

- All patients
  - Activated vs non-activated
  - Meet your registry inclusion criteria
  - Hospital stay > 24 hours

SBIRT

- All patients
  - Activated vs non-activated
  - Meet your registry inclusion criteria
  - Hospital stay > 24 hours
  - Includes ortho and neurosurgery!

- 80% must be screened

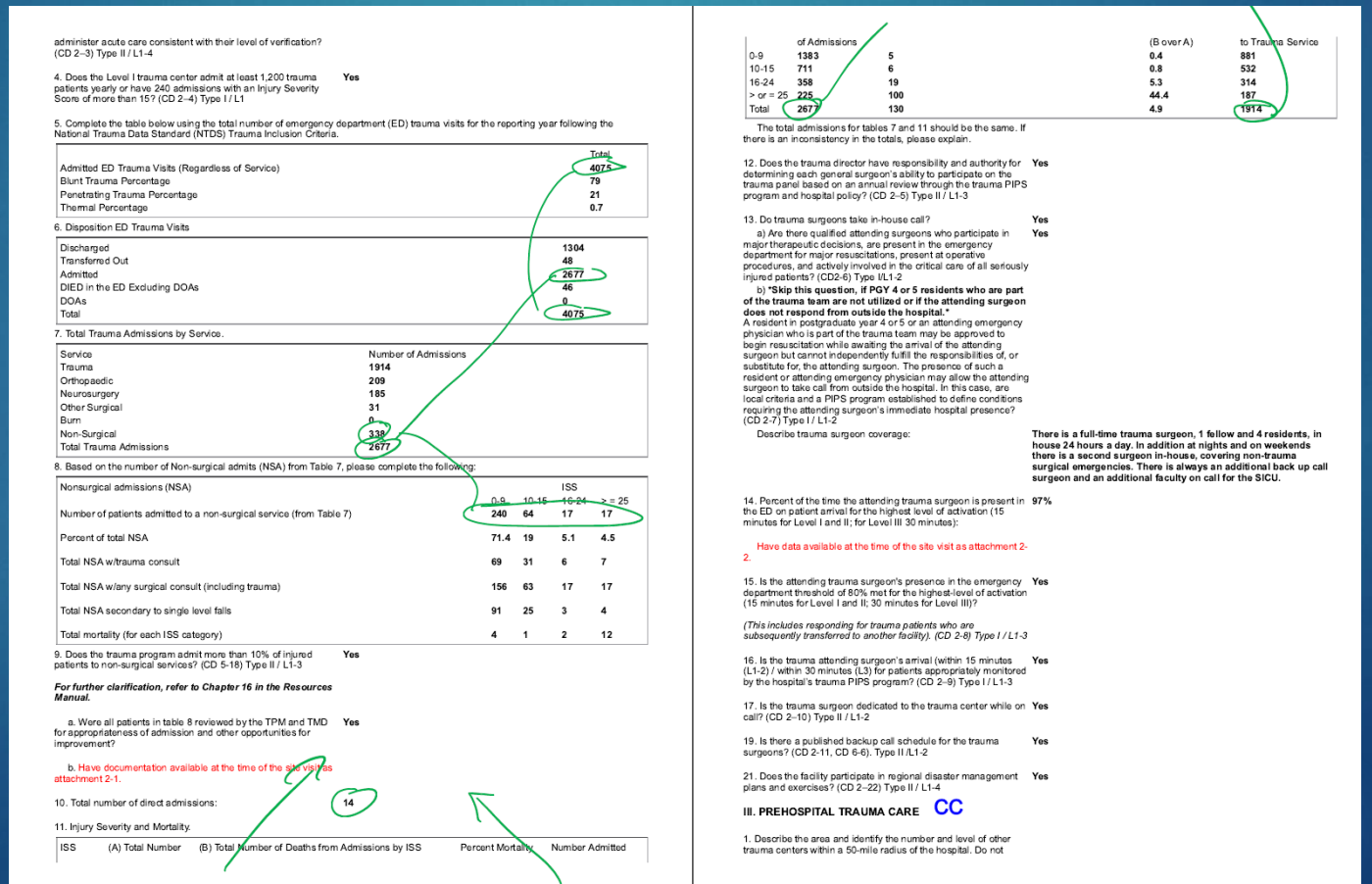

PITFALLS

Chapters 1 & 3

- System involvement is expected!
- EMS training and good PI interface are, too!

Chapter 2

- The numbers don't match!



administer acute care consistent with their level of verification? (CD 2–3) Type II / L1-4

4. Does the Level I trauma center admit at least 1,200 trauma patients yearly or have 240 admissions with an Injury Severity Score of more than 15? (CD 2–4) Type I / L1 — **Yes**

5. Complete the table below using the total number of emergency department (ED) trauma visits for the reporting year following the National Trauma Data Standard (NTDS) Trauma Inclusion Criteria.

	Total
Admitted ED Trauma Visits (Regardless of Service)	4075
Blunt Trauma Percentage	79
Penetrating Trauma Percentage	21
Thermal Percentage	0.7

6. Disposition ED Trauma Visits

Discharged	1304
Transferred Out	48
Admitted	2677
DIED in the ED Excluding DOAs	46
DOAs	0
Total	4075

7. Total Trauma Admissions by Service.

Service	Number of Admissions
Trauma	1914
Orthopaedic	209
Neurosurgery	185
Other Surgical	31
Burn	0
Non-Surgical	338
Total Trauma Admissions	2677

8. Based on the number of Non-surgical admits (NSA) from Table 7, please complete the following:

Nonsurgical admissions (NSA)	ISS 0-9	10-15	16-24	> = 25
Number of patients admitted to a non-surgical service (from Table 7)	240	64	17	17
Percent of total NSA	71.4	19	5.1	4.5
Total NSA w/trauma consult	69	31	6	7
Total NSA w/any surgical consult (including trauma)	156	63	17	17
Total NSA secondary to single level falls	91	25	3	4
Total mortality (for each ISS category)	4	1	2	12

9. Does the trauma program admit more than 10% of injured patients to non-surgical services? (CD 5-18) Type II / L1-3 — **Yes**

For further clarification, refer to Chapter 16 in the Resources Manual.

a. Were all patients in table 8 reviewed by the TPM and TMD for appropriateness of admission and other opportunities for improvement? — **Yes**

b. Have documentation available at the time of the site visit as attachment 2-1.

10. Total number of direct admissions: **14**

11. Injury Severity and Mortality.

ISS	(A) Total Number	(B) Total Number of Deaths from Admissions by ISS	Percent Mortality	Number Admitted
0-9	1383	5	0.4	881
10-15	711	6	0.8	532
16-24	358	19	5.3	314
> or = 25	225	100	44.4	187
Total	2677	130	4.9	1914

The total admissions for tables 7 and 11 should be the same. If there is an inconsistency in the totals, please explain.

12. Does the trauma director have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review through the trauma PIPS program and hospital policy? (CD 2-5) Type II / L1-3 — **Yes**

13. Do trauma surgeons take in-house call? — **Yes**

a) Are there qualified attending surgeons who participate in major therapeutic decisions, are present in the emergency department for major resuscitations, present at operative procedures, and actively involved in the critical care of all seriously injured patients? (CD2-6) Type I/L1-2 — **Yes**

b) ***Skip this question, if PGY 4 or 5 residents who are part of the trauma team are not utilized or if the attending surgeon does not respond from outside the hospital.***
A resident in postgraduate year 4 or 5 or an attending emergency physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon. The presence of such a resident or attending emergency physician may allow the attending surgeon to take call from outside the hospital. In this case, are local criteria and a PIPS program established to define conditions requiring the attending surgeon's immediate hospital presence? (CD 2-7) Type I / L1-2

Describe trauma surgeon coverage: **There is a full-time trauma surgeon, 1 fellow and 4 residents, in house 24 hours a day. In addition at nights and on weekends there is a second surgeon in-house, covering non-trauma surgical emergencies. There is always an additional back up call surgeon and an additional faculty on call for the SICU.**

14. Percent of the time the attending trauma surgeon is present in the ED on patient arrival for the highest level of activation (15 minutes for Level I and II; for Level III 30 minutes): — **97%**

Have data available at the time of the site visit as attachment 2-2.

15. Is the attending trauma surgeon's presence in the emergency department threshold of 80% met for the highest-level of activation (15 minutes for Level I and II; 30 minutes for Level III)? — **Yes**

(This includes responding for trauma patients who are subsequently transferred to another facility). (CD 2-8) Type I / L1-3

16. Is the trauma attending surgeon's arrival (within 15 minutes (L1-2) / within 30 minutes (L3) for patients appropriately monitored by the hospital's trauma PIPS program? (CD 2–9) Type I / L1-3 — **Yes**

17. Is the trauma surgeon dedicated to the trauma center while on call? (CD 2–10) Type II / L1-2 — **Yes**

19. Is there a published backup call schedule for the trauma surgeons? (CD 2-11, CD 6-6). Type II /L1-2 — **Yes**

21. Does the facility participate in regional disaster management plans and exercises? (CD 2–22) Type II / L1-4 — **Yes**

III. PREHOSPITAL TRAUMA CARE CC

1. Describe the area and identify the number and level of other trauma centers within a 50-mile radius of the hospital. Do not

Chapter 2

- **The numbers don't match!**

	Total
Admitted ED Trauma Visits (Regardless of Service)	**2441**
Blunt Trauma Percentage	**89**
Penetrating Trauma Percentage	**11**
Thermal Percentage	**0.8**

(Table 5)

Discharged	**214**
Transferred Out	**8**
Admitted	**2441**
DIED in the ED Excluding DOAs	**12**
DOAs	**4**
Total	**2679**

(Table 6)

Chapter 2

10. Total number of direct admissions:	**410**

2441 +

Service	Number of Admissions
Trauma	**1756**
Orthopaedic	**482**
Neurosurgery	**22**
Other Surgical	**176**
Burn	**25**
Non-Surgical	**390**
Total Trauma Admissions	**2851**

(Table 7)

Nonsurgical admissions (NSA)

(Table 8)

	ISS			
	0-9	10-15	16-24	> = 25
Number of patients admitted to a non-surgical service (from Table 7)	**342**	**31**	**5**	**12**

Chapter 2

(Table 7)

Service	Number of Admissions
Trauma	**1756**
Orthopaedic	**482**
Neurosurgery	**22**
Other Surgical	**176**
Burn	**25**
Non-Surgical	**390**
Total Trauma Admissions	**2851**

(Table 11)

ISS	(A) Total Number of Admissions	(B) Total Number of Deaths from Admissions by ISS	Percent Mortality (B over A)	Number Admitted to Trauma Service
0-9	**1859**	**12**	**0.65**	**894**
10-15	**516**	**8**	**1.5**	**422**
16-24	**273**	**11**	**4**	**262**
> or = 25	**203**	**50**	**24.6**	**178**
Total	**2851**	**81**	**3**	**1756**

Chapter 4

- **Know every transfer out, cold**

5. Total number of transfers:

Please complete the table below. The total of transfers in column 2 + column 3 in the table should = the total number of transfers out.

Transfer Category	Number of transfers out < 24 hrs	Number of transfers out > 24 hrs
Pediatrics	0	
Hand	0	
Spine	0	
Orthopaedics*		
Pelvic ring/acetabular fxs	0	
Soft tissue coverage	0	
Other orthopaedics	0	
Neurosurgery*	0	
Replantation	0	
Vascular/aortic injuries	0	
Cardiac (Bypass)	0	
Facial trauma	1	
Health Plan Repatriation	5	1
Burns	0	
Other-Specify	1	1
Total		

what were these?

Chapter 7

- Make sure your disaster specialist is present for the walk-around!

Chapters 8 & 9

- Pick good 30-minute criteria
- Develop a good monitoring system

Chapter 11

- 30-minute response for IR (radiologist)

Chapter 16

- Guidelines, guidelines, guidelines
- Make sure they can be monitored!

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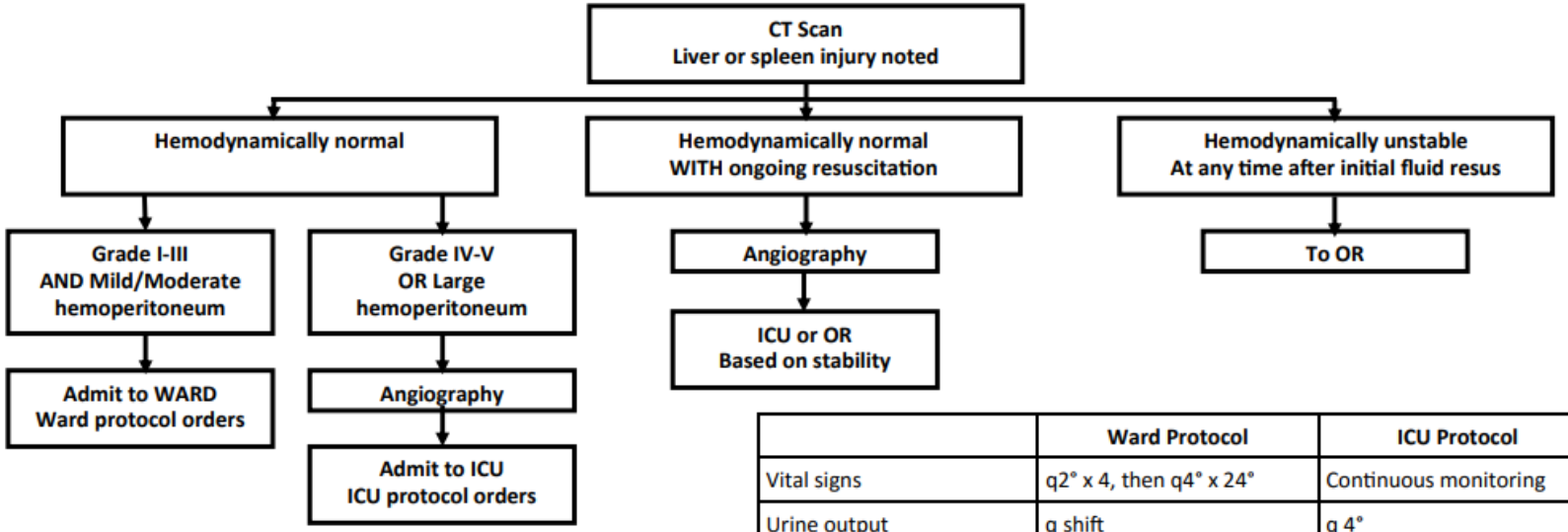
Clinical Practice Guideline
Blunt Liver And Spleen Injury



Notes:

- **No** NPO
- **No** activity restriction
- **No** serial Hgb
- **No** repeat CT scan

Discharge Instructions

Activity:

- **Nonvigorous, normal activity weeks 0-6**
- **Vigorous activity weeks 7-12**
- **High impact activity / sports after 12 weeks**

Expect mild increase in abdominal pain 7-10 days after injury. Should return to baseline after 1-2 days.

Call if:

- **New, unrelenting pain**
- **Frequent light-headedness**
- **Persistent pain after 2 weeks**

	Ward Protocol	ICU Protocol
Vital signs	q2° x 4, then q4° x 24°	Continuous monitoring
Urine output	q shift	q 4°
IV access	16 Ga or better	16Ga or better
IV fluid	Maintenance rate	Maintenance rate
Diet	Regular	Regular
Lab	Hgb on admission, and following day	Hgb on admission, 8 hrs after admission, then daily only at physician discretion
Abdominal exam	q4° x 3, and prior to discharge	q4°
Activity	Up ad lib	Up ad lib
Thresholds	Call MD for SBP<90, HR>120, significant change in abdominal exam	Call MD for SBP<90, HR>120, significant change in abdominal exam
Discharge criteria	To home: Hemodynamically normal x36°, no change in abdominal exam x36°	To ward: Normotensive with no tachycardia x24°, average fluid requirements

Chapter 18

- Prevention coordinator
- SBIRT

Appendices

- Fill out all:
  - Residency
  - Board certs
  - ATLS
  - Meeting attendance


Esso
FOR SALE
PARACHUTE
ONLY USED
ONCE
NEVER
OPENED


PEARLS

Submit A Clean PRQ

- Looks like it was written by one person
- All data complete and correct
- Grammar and spelling

Organize Your Charts!

- Paper vs electronic?
- Patient list for each “box”
- Basic info for each chart
- Mark sections
- Flag good PI

Organize Your PI

- Place copies of worksheets, minutes, and supporting documentation in each chart
- Make sure you aren't the only one who understands your PI system
- Be able to explain your relationship with Hospital Quality

Pre-Visit PI Review

- Applies to TPM **AND TMD!**
- Review every death
- Review every chart with significant PI

The Secret Folder

The Secret Folder

9. Does the trauma program admit more than 10% of injured patients to non-surgical services? (CD 5-18) Type II / L1-3 ***For further clarification, refer to Chapter 16 in the Resources Manual.***	**Yes**
a. Were all patients in table 8 reviewed by the TPM and TMD for appropriateness of admission and other opportunities for improvement?	**Yes**

- 14% MPM

Note: Do not include hip fractures or injures that result from a trip/fall.

19. Percent of femoral shaft fractures (defined as intramedullary rod, external fixation or ORIF) stabilized within 24 hours of admission.	**81**
20. Does the orthopaedic service participate actively with the overall trauma PIPS program and the multidisciplinary trauma peer review committee? (CD 9–15) Type II / L1-3	**Yes**

report on these

CDs For Free!

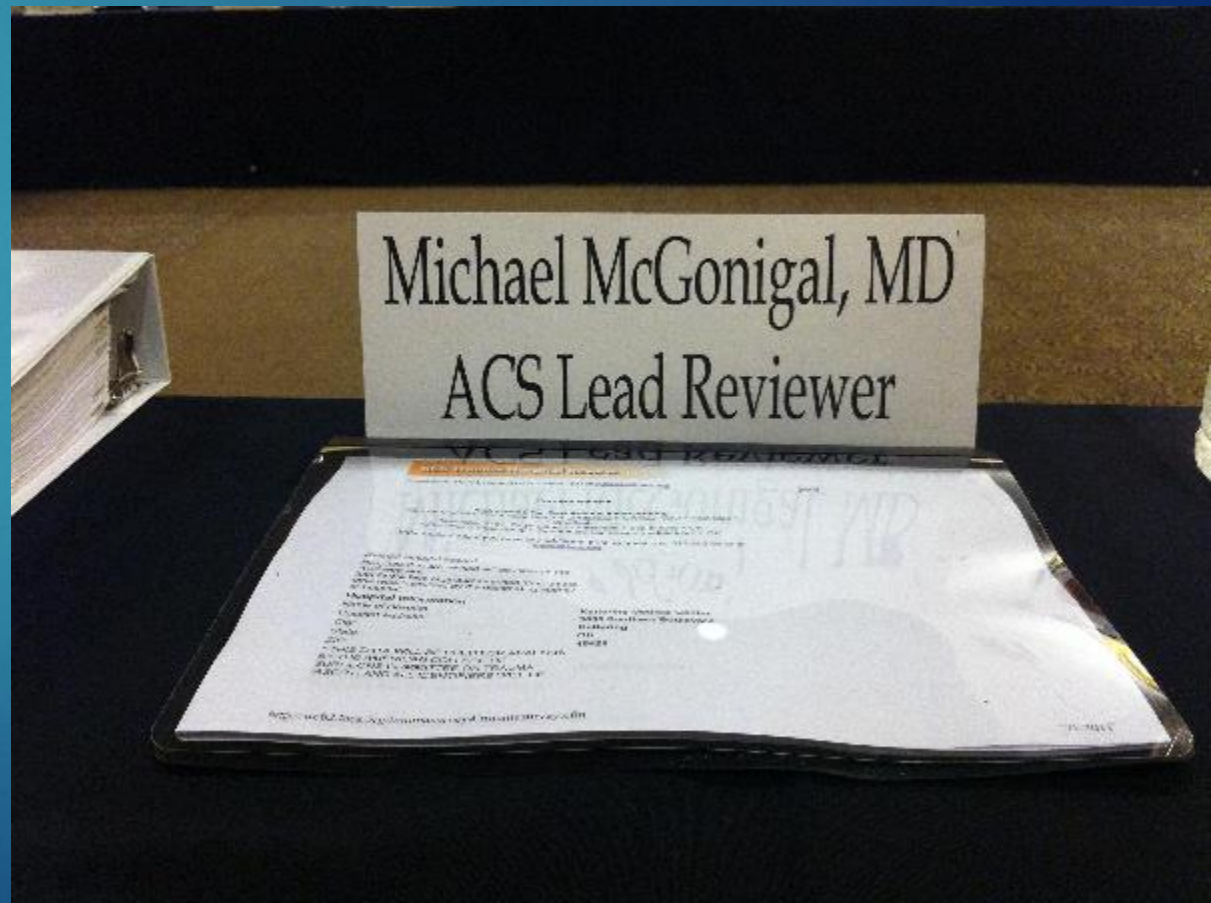
XVI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS)	
A. Performance Improvement PI Program.	
1. Are the TMD and TPM knowledgeable and involved in trauma care collaboratively with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking? (CD 2-17) Type II / L1-4	**Yes**

Set Up The Conference Room

- One workstation per reviewer
- One EMR expert per workstation
  - Not the TMD, TPM, or a resident
- Hardware: power outlets, WiFi
- Test everything that is not made of paper!

Set Up The Dinner

- Make sure it's quiet and well-lit
- Collect dinner orders in advance
- Ensure adequate space and good signage
- Don't believe anything the venue tells you!

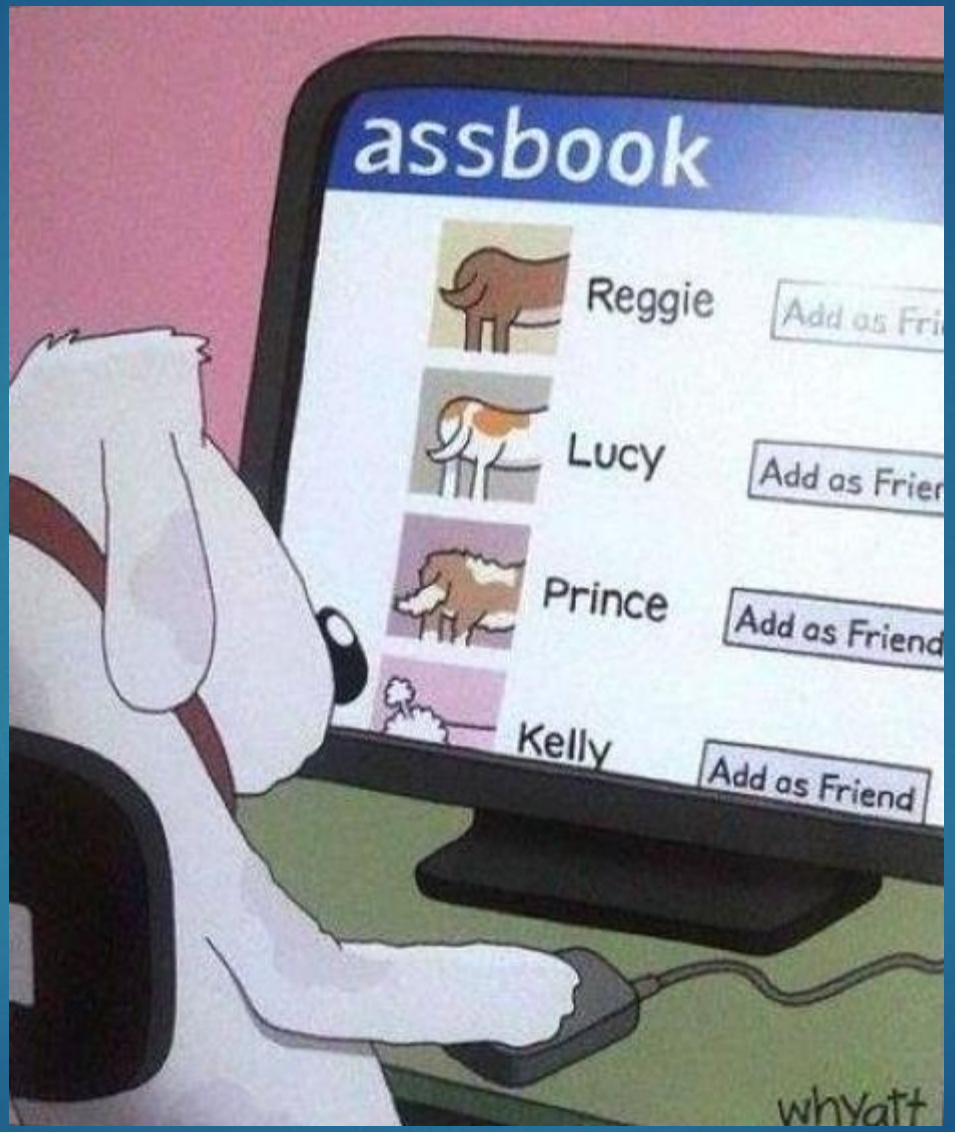


Arrange The Transportation

- Assign someone or some service
- Questions may be asked!

Nail It!

- Make sure your team knows what to expect
- Visits are educational, not punitive
- Show off your stuff!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Reggie
Add as Fri
Lucy
Add as Frie
Prince
Add as Friend
Kelly
Add as Friend
whyatt

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The End

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