9 Tips for Running an Effective Trauma PIPS Program

A trauma leadership ebook from *Trauma System News*

Introduction: From "Shoulds and Musts" to Nuts and Bolts

How do you run a trauma performance improvement and patient safety (PIPS) program? *Resources for the Optimal Care of the Injured Patient* spells out detailed program requirements, and other resources provide a good theoretical framework for managing the PIPS process. But according to Michael McGonigal, MD, bridging the gap between theory and practice can be a challenge.

"Trauma PI is pretty complicated," Dr. McGonigal said. "You can go to Chapter 16 in the *Orange Book* and it will lay out all the 'shoulds' and 'musts,' but there are still a lot of practical nuts and bolts that you need to know about PI if you are going to do it well."

Dr. McGonigal is the director of trauma services at Regions Hospital in St. Paul, Minn. He is also the author of The Trauma Professional's Blog, which provides injury care education to thousands of trauma providers worldwide.

As a site reviewer for the American College of Surgeons, Dr. McGonigal has evaluated PIPS programs across the U.S. He recently shared nine practical ideas for running an effective trauma performance improvement program.

1. Watch for system issues masquerading as peer issues

“System problems are actually among the most common issues that trauma centers face,” Dr. McGonigal said. “But many people don’t recognize them because it is just so easy to say that a problem is a peer issue.”

Then a few months later the same error happened again with a different physician.

“That’s when we recognized that this was not a peer problem at all, but a system issue,” Dr. McGonigal said. “DPL was once common, but now we perform this technique so infrequently that it is a simple matter for someone to not remember how to do it.”

Dr. McGonigal encourages PI coordinators and trauma program managers to be on the lookout for system issues, especially if they see the same “peer issue” occurring to different practitioners.

“You have to be really sensitized to looking for this,” he said. “You always have to step back, take it a level higher and say, Could this be a system problem?”

2. Push for timely resolution

While complex system problems can take a long time to fix, most PI issues can and should be resolved promptly.

“I have visited trauma programs where it has taken six or seven months to close the loop on a particular PI issue,” Dr. McGonigal said. “The problem is that after a few months nobody is going to remember anything about the case, so it will be hard to get accurate information about it and make a good determination. And at that point the clinical issue may be moot.”

The key is to identify and address issues while they are still fresh in people’s minds. Dr. McGonigal suggests a window of about 4 to 5 weeks. “This is basically the time it takes for an item to get to your multidisciplinary peer review committee.”

How do you keep the PI process moving forward? Establish expectations and follow up. “When an issue is sent to the neurosurgery M&M conference, for example, everybody needs to know that there is an expectation that they will have the determination back to us within 10 days to 2 weeks,” Dr. McGonigal said. “And you need to put some teeth into that. People should know that if the determination doesn’t come back quickly enough, they are going to get annoying phone calls and emails and people standing outside their door.”

3. Make documentation a priority

“One of the more common problems I see as a reviewer is lack of documentation,” Dr. McGonigal said. “A program will identify an issue, send it to the multidisciplinary PI meeting, and then close the loop with provider education or a new form or a new policy, etc. But then there is nothing on paper that essentially shows what happened.”

Documentation is the only way the ACS can verify the effectiveness of a PIPS program. But Dr. McGonigal emphasizes that documentation is not just for the benefit of reviewers. Good documentation memorializes your program’s PI work.

“Let’s say you have taken care of a problem within your PI process, then two or three years later the same issue comes up again,” Dr. McGonigal said. “If there is no good documentation about what was done, then you may not be able to see that the problem is a recurring issue, or that your previous solution was not effective, or that what you thought was a peer issue is really a system problem.”

How much documentation is enough? “I always tell the programs I review that any *verb* in the resolution section of your PI document really needs to have some kind of piece of paper attached to it.” For example, if loop closure involved staff education, documentation could include a set of PowerPoint slides and an attendance list. If a PI issue led to the development of a new policy, attach a copy of the policy to the issue file.

4. Develop a system for capturing every patient

Under the *Orange Book*, trauma centers must be able to demonstrate that all trauma patients can be identified for review. But capturing trauma patients can be tricky.

“You have to make sure every possible way trauma patients can get into your hospital is covered,” Dr. McGonigal said. “It’s easy to identify trauma patients who come in through the emergency room. But if you are a hospital that gets a lot of patients referred in from outside, there is an opportunity for people to slip through the cracks—especially if they are direct admits to, for example, orthopedic surgery.”

Trauma programs need to establish systems to identify all injured patients by the day following admission. Many programs have arranged to receive a daily admission log of every patient that comes into the hospital, whether through the ED or as a direct admit.

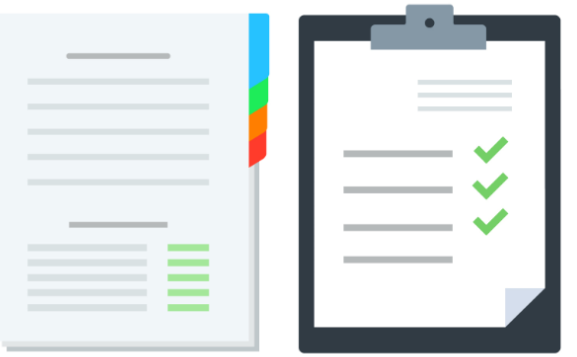
“The log typically includes a name and location and, importantly, a diagnosis.” Dr. McGonigal said. “The PI coordinator or another person will go through that report manually and look for trauma-related diagnoses.”For every injured patient identified, program staff will investigate further by either checking the medical record or visiting the patient. “The point is to make sure the patient did not meet trauma activation criteria, to see if a trauma consult is in order, and to make sure that appropriate care is being delivered.”

5. Keep your ducks in a row

“I always tell staff at the programs I visit that they really need to make sure all their PI information is organized,” Dr. McGonigal said. Every PI issue should have a unique folder for collecting records and documentation.

“It is also important to maintain a to-do list that shows all your open items,” he said. The list allows program leaders to keep track of outstanding review items, monitor delays, and verify adequate loop closure and documentation. The to-do list is also useful for tracking complex PI issues that cannot be closed within a short timeframe.

“Most programs I visit use an electronic spreadsheet to track open items,” Dr. McGonigal said, “but in others programs they use a paper list or even a grease board on the wall of the trauma program manager’s office.”



6. Carefully monitor PI meeting attendance

“One of the easiest ways for any trauma program to get a deficiency is to have insufficient attendance at multidisciplinary trauma peer review committee meetings,” Dr. McGonigal said.

Under the *Orange Book*, trauma surgeons and specialty liaisons must attend at least 50% of all multidisciplinary peer review meetings. “So if you have one surgeon, your EM liaison and one other liaison under the 50% attendance mark, then you have three deficiencies and you’re very quickly in jeopardy of not being verified,” Dr. McGonigal said.

He recommends careful monitoring. “One thing you can do is calculate attendance percentages after every meeting, and put that on a dashboard report that you circulate to the committee. Making sure everyone knows their attendance rate can help keep everyone above the 50% mark.”

What do you do when a key player is cutting it close? “If a liaison’s attendance is getting close to that 50% mark, then the trauma program has to start pushing,” Dr. McGonigal said. “Reemphasize that they need to either attend the meeting or get a designee to go in their place. And at a certain point you have to question how committed the person is to the process. Perhaps they need to be replaced.”

7. Steer between a punitive and an exonerative environment

Addressing peer issues can be a challenge. For trauma medical directors, the key is keeping the focus on what is best for patients.

“From the very start, you have to develop the reputation that there will be an open and fair discussion about issues,” Dr. McGonigal said. “The trauma medical director has to gain the trust of all the clinicians he or she deals with, so that they understand you are not trying to be punitive but you also can’t sweep issues under the rug.”

While peer discussions need to be documented, Dr. McGonigal advises discretion. “I recommend that any peer discussions or counseling *not* be documented at the hospital level, but be maintained internally in the trauma program’s records.”

“A lot of times the hospital hierarchy tends to be in a more punitive mode. So if they get their hands on trauma PI discussions, it just makes everybody feel bad,” he said. “I think that’s where the inclination to cover things up gets started.”

8. Right-size your PI program to your trauma center

Some trauma programs make the mistake of trying to implement processes and activities that are not appropriate for their situation. “One thing I typically say to trauma program leaders is that your PI activities need to make sense for your program,” Dr. McGonigal said.

For example, how do you refer issues for resolution?

“If you are a small Level III hospital, pretty much everything will be taken care of by your multidisciplinary PI committee,” Dr. McGonigal said. “But if you are a busy Level I center, you may choose to farm out specific issues to various committees and groups—and save your multidisciplinary committee for more complex issues.”

9. Don’t try to run before you can walk

A trauma team’s problems may be legion, but PI resources are always limited. So how do you decide which issues to focus on?

“It’s easy to get overwhelmed,” Dr. McGonigal said. “The thing is to realize there is a whole spectrum of issues in terms of clinical significance and clinical insignificance.”

“On one end of the spectrum, you have major issues like a surgeon who didn’t take a patient to the OR in time,” he said. “On the other end, there are minor issues like an ED nurse who didn’t record a patient’s temperature in the trauma flow sheet.”

Consider your program’s stage of development. “I always recommend to newer trauma programs that they triage their PI issues based on the potential patient impact,” Dr. McGonigal said. He defines newer programs as trauma centers that have been verified about 5 years or less. “They are still building their PI process. They are learning the ropes, trying to figure things out, and they really have their hands full just trying to do a good job.”

By the time a trauma program has gone through three verification cycles, it is ready to tackle PI issues more aggressively. “At that point, you have the resources and expertise to identify pretty much everything,” Dr. McGonigal said. “Then you are ready to deal with PI issues down to the level of, for instance, a missing set of vital signs.”

Thank You

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Thank you as well to the trauma professionals who have downloaded this ebook.

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