

Peer Review and Opportunities for Performance Improvement: Experience of an Urban Trauma Centre.

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Scope

- Setting
- Peer review process
- Methods
- Results
- Discussion

The specialist's crede

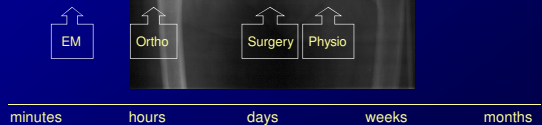
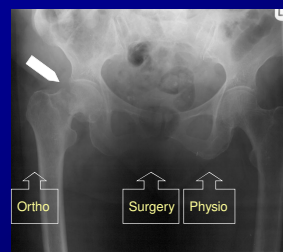
My disease is important

My specialty is special

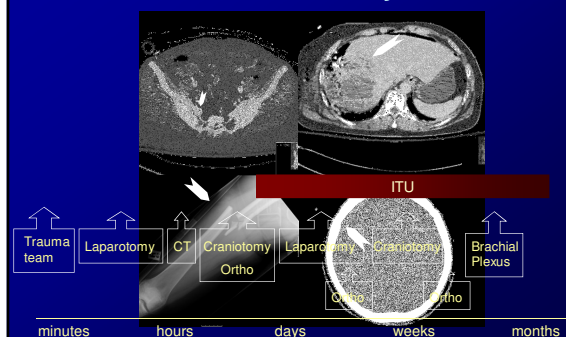
My interest is specially important

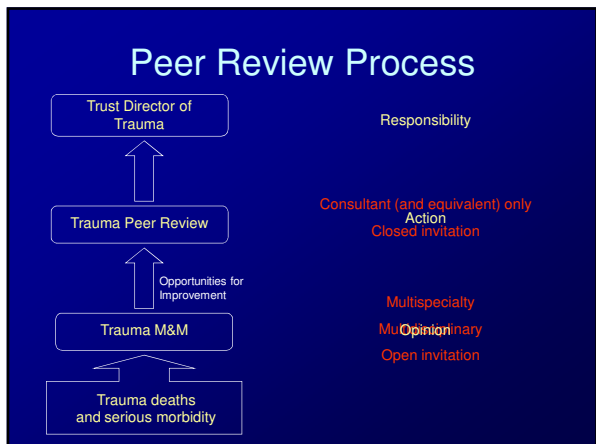
Trauma is importantly special

Trauma - Minor



Trauma - Major





- ### Methods
- First 12 monthly meetings of Peer Review Committee reviewed
 - Assessment of
 - Workload
 - Preventability of deaths
 - Category of errors
 - Action taken
 - Audit loop closure

- ### Results
- 1451 trauma team activations
 - 383 cases with an Injury Severity Score >15
 - 64 deaths were reviewed by the Trauma M&M

- ### Results
- Preventability
 - Preventable 4
 - Probably preventable 3
 - Possibly preventable 13
 - Non-Preventable 44
 - Opportunities for improvement
 - 28 cases
 - Includes 8 non-preventable deaths

Results

- Error Category

Category	No of incidents
Delayed diagnosis	4
Missed injury	1
Delay to CT	3
Inappropriate imaging	4
Delay to OR / angio	7
Procedural error	6
Delay to spinal clearance	1
Inappropriate treatment	13
Personnel unavailable	9
Other	12

Results

- Action taken

Action	Number of cases
Staff education	7
Peer counselling	5
External communication	4
New and altered protocols	3
Enhanced internal communications	3
Improved resource availability	2
Initiation of audit	1
Altered supervision	1

Results

- Audit loop closure
 - Within first year 16
 - Now 28

Results

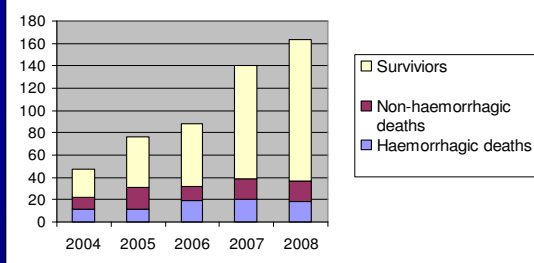
- Audit loop closure
 - Within first year 16
 - Now 28

Discussion

- Assurance of effective action
- Credible judgement
- Practical authority

- Pre-hospital governance
- Regional governance
- Who guards the guardians?

RLH Outcomes in shocked patients



2008 v 2004 – statistically significant fall in rate of haemorrhagic deaths ($p=0.0174$, Fisher's exact test) and total deaths ($p=0.003$)