Government of **Western Australia**
Department of **Health**

State Trauma Registry Database Outputs Initiative 43

Initiative 43 – State Trauma Registry Database Outputs

The Clinical Leads of the Injury and Trauma Health Network will determine agreed outputs for the State Trauma Registry Database in collaboration with the Directors of the Adult Major Trauma Service and Paediatric Major Trauma Service, and the Trauma Clinical Evaluation Committee. The Director of the Major Trauma Service will ensure these outputs are delivered.

State Trauma Registry Database Outputs – Mandatory

Each hospital's Trauma Registry would be expected to produce or contribute towards the timely delivery of the following activities:

- measuring outcomes, including safety and quality improvement activities
- improving clinical management by supporting multidisciplinary clinical audit
- providing summative information to health managers about the trauma workload and its management
- providing confidential comparative statistics to clinicians about institutional performance
- benchmarking performance against other Trauma Centres
- providing population based statistics on the epidemiology of trauma to aid in the development of injury prevention strategies
- assisting in the planning of future trauma service development.

When implementing a new trauma system, it is critical to know how the trauma services are performing according to set measures and outputs.

This performance monitoring is aimed at reducing preventable deaths and permanent disability from major trauma.

Hospitals are encouraged to provide reasons for not meeting these outputs.

State Trauma Registry Database Outputs – Optional

There are a range of other roles that the Registry *could fulfil*, including:

- Annual report – produced within twelve months (minimum) after the end of the calendar year and to include all major and non-major trauma admissions. Some may be compiled every two years.
- Contribute towards an annual State Trauma Registry Report.
- Provide required information for each hospital to conduct a Trauma Death Audit of all trauma related deaths.
- Provide information for each hospital to conduct an audit and analysis of "missed injuries".
- Data collection must be in real time and up to date with no more than three months in arrears.
- Scientific Research – State Trauma Registries to list their contribution towards research, injury prevention and injury treatment, including rehabilitation. A copy of the final research paper/report demonstrating how the trauma registry data was used will be provided by the data requestors.\

History of Action

1. 20/10/11: WA Trauma Directors Committee accepted original list of outputs as per the Trauma Report[1].
2. 20/10/11: WA Trauma Directors Committee agreed that the WA Trauma Inter-registry subcommittee should discuss the proposed outputs and provide feedback at the next WA Trauma Directors Committee meeting in January 2012.
3. 3/11/11: WA Trauma System and Services Implementation Committee recommended swapping the list of outputs whereby the optional outputs are classed as mandatory.
4. 3/11/11: WA Trauma System and Services Implementation Committee requested the amended outputs list be circulated to members before presenting to the WA Trauma Directors Committee.
5. 29/3/12: WA Trauma System and Services Implementation Committee approved this document. Table at the next WA Trauma Directors Committee.
6. 26/4/12: WA Trauma Directors Committee approved this document. Present at the next WA Trauma Inter-Registry Sub-Committee for implementation. Publish on the State Trauma Services internet site.

References

[1] Trauma system and services: Report of the Trauma Working Group, DoH, 2007