

**REVIEW AGENDA**

The purpose of the trauma center designation review process is to verify a hospital’s compliance with American College of Surgeons (ACS) standards for a Level IV trauma facility as outlined in 7AAC 26.720(d). Site surveyors are responsible for obtaining an accurate assessment of the hospital’s capabilities in a very short period of time. For this reason, we ask that the personnel responsible for overseeing the trauma care of patients at the hospital carefully prepare for the visit by having all documents and medical records organized and accessible to the surveyors. Please use the attached checklist to assure that you have included all documents needed for the questionnaire. Please be aware that surveyors will look beyond the requested documents and medical records if they need additional verification of compliance with the standards. This questionnaire gives surveyors an overview of the trauma program and serves as a guide for the review process.

For planning purposes, the review will last approximately eight hours. Please note that, in general, the review team will set the schedule for the day. The schedule may vary according to surveyor preference. Please have one staff member available to accompany the surveyors on the tour of the facility. It is helpful for the Clinical Director, Nurse Director, and Medical Records Director to be readily available to the survey team for the entire review. The surveyors will visit each department listed below, not necessarily in the order stated.

1. **Ambulance Bay -15 minutes**
	1. Inspect facility
	2. Determine process for notification and arrival of ambulances

1. **Emergency Department - 45 minutes**
	1. Review emergency department facility, resuscitation area, equipment, protocols, flow sheet(s), staffing, physician call
	2. Interview emergency department physician(s) and emergency department nurse(s)
	3. Review the pre-hospital interaction and QI/PI feedback mechanism

III. **Radiology Department - 15 minutes**

* 1. Inspect facility
	2. Interview technicians
	3. Determine process for changes between preliminary and final interpretations of radiographs

IV. **Blood Bank/Laboratory - 15 minutes**

1. Inspect facility
2. Interview technicians
3. Determine availability of protocols for blood products
4. **Working Lunch - 60 minutes**

The review team will conduct a presentation on the Alaska Trauma System and discuss the facility’s role in the system. Potential invitees include Hospital Administration and Board members, QI Coordinator, Medevac Medical Director, Injury Prevention Coordinator/Director, local EMS representatives. Other invitees welcome at the hosting facility’s discretion.

1. **Chart Review/QI - 4 hours**
	1. Review Quality Improvement documents
	2. Review medical records
2. **Site Surveyors preparation for Exit Interview - 45 minutes** (Closed meeting - site survey team only)
3. **Exit Interview - 45 minutes**

Hospital Administration, Clinical Director, Nursing Director, QI Coordinator and others as desired by hospital administration

**Available at Time of Review**

All materials listed below and requested in the application must be available *in the room where the chart review will take place*. A room with conference-style table and adequate space for surveyors to comfortably complete the review of the medical records should be available.

*Note: For the purposes of the review, the* ***reporting year*** *is 12 continuous months with the start date no earlier than 14 months prior to the review date.*

1. Listing of hospital’s trauma activity for one year:
	1. Intramural education - physicians, nurses, paramedics/EMTs
	2. Extramural education - physicians, nurses, paramedics/EMTs
	3. Community outreach/Injury prevention programs
	4. Copy of schedule for three months prior to review:
		1. Emergency department physicians
2. Quality Improvement:
	1. Minutes of all QI meetings for one year
	2. Attendance records for all QI meetings for one year
	3. Documentation of all quality improvement programs relating to trauma for one year (provide evidence of loop closure)
	4. Trauma registry information/statistics
3. Medical Record Review:
	1. Specific trauma patient medical records will be requested either before the review or from the trauma registry at the time of the review. Those records requested prior to the review should be in the review room and organized in stacks by type of injury to make them easily accessible to the surveyor. Please label all stacks by type of injury. See the “Preparing for Trauma Site Review” for categories of records to prepare.
	2. All deaths should be placed together by category – unanticipated, anticipated with opportunity for improvement, anticipated without opportunity for improvement- in separate stacks. Label all stacks so the surveyors can access the appropriate charts easily.



# PRE-REVIEW QUESTIONNAIRE

# (Please feel free to use additional pages for your response, if necessary)

# PURPOSE OF SITE REVIEW

* 1. **Type of review: Level IV Trauma Facility** (circle one) consultation verificationreverification
	2. **This review is at the request of**
	3. **Previously designated and/or reviewed?** (circle one) Yes No
		1. If yes, type of review and date?
		2. If yes, describe in detail, any changes regarding the issues defined in the previous summary as strengths:
		3. If yes, describe in detail, the improvements directed toward the previously defined institutional weaknesses:

### Dates used to define reporting year (12 continuous months of data) for the purposes of this questionnaire: \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\*The earliest month of data should be no older than 14 months prior to the review date

* 1. **Have there been any administrative changes at your facility that have influenced the care of trauma patients?** (circle one) Yes No If yes, please explain:
	2. **Discuss any recent local or regional trauma system improvement activities and your facility’s involvement in these activities:**

### Trauma Program personnel:

* + 1. Trauma Program Manager/Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		2. Trauma Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		3. Trauma Registry Abstractor(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		4. Emergency Department Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		5. EMS Medical Director(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PREHOSPITAL SYSTEM

* 1. **Prehospital system description**

# Describe your EMS process to get patients to your facility for trauma care and evaluation:

* + 1. **Are EMS personnel in the field able to call for a trauma activation? \_\_\_\_\_**
		2. **What modes of prehospital transportation are available in your area?**
			1. **Ground EMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* + - 1. **Air Ambulance/Medevac (Please list services, nearest bases, and types of aircraft): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* + - 1. **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
		1. **Briefly describe the EMS governing body, include descriptions of medical leadership:**
			1. **Is a 911 system present in your community? (circle one) Yes No**
			2. **Is a 911 enhanced system present in your community?**

 **(circle one) Yes No**

* + 1. **How are EMS personnel dispatched to the scene of an injury?**
		2. **EMS providers are: (circle correct response)**

# paid volunteer part paid/part volunteer

* + 1. **What is the highest level of EMS response in your community?** \_\_\_\_\_\_\_
		2. **Describe in detail your hospital’s participation in QI activities of prehospital personnel:**
		3. **Describe any participation at your facility in state or regional EMS boards:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* + 1. **Describe your hospital’s participation in a regional disaster plan:**

# FACILITY INFORMATION

* 1. **Attach:**
		1. **Signed Medical Staff Resolution**
		2. **Signed Hospital Board Resolution (templates can be provided for use with your facility’s letterhead)**
	2. **Describe your hospital, including the governance and affiliations, and its role in the community, including regional trauma activities. (Include applicable organizational charts.)**
	3. **Facility beds**
		1. **Total number of licensed acute care beds:**
		2. **Number of beds staffed and operational:**
			1. **Adult beds:**
			2. **Pediatric beds:**
		3. **Average daily census for past year:**
			1. **Adult:**
			2. **Pediatric:**

## Facility commitment

1. **How is facility commitment evidenced by support in the following areas?**
	1. **Injury prevention:** What community injury prevention activities does your facility support? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* 1. **Acute trauma care:** How does your facility provide support for acute trauma care?
	2. **Long-term and/or rehab care:** How is long-term and/or rehab care for the trauma patient at your facility provided?

**Which of the following are available at your facility (circle all that apply): PT OT SLP Case Management Counseling/Behavioral Health**

* 1. **Staff education: Does your facility support trauma education for employees? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# TRAUMA CARE

* 1. **Describe your personnel response to trauma team activations in your facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have tiered trauma activation criteria (i.e. full, partial, consult)? \_\_\_\_\_\_\_\_\_\_**

**If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\***Please have Trauma Team Activation Criteria available for viewing at the site visit.

* 1. **How do you obtain additional needed personnel during emergencies?**
	2. **What is your procedure for handling more than one injured patient arriving simultaneously?**
	3. **Trauma/Statistical Data** (obtain from State Trauma Registry**)**
		1. **Total number of ED visits for reporting year:**
		2. **Total number of trauma-related ED visits for reporting year:**
		3. **Number of hospital trauma admissions for one year:**
		4. **Number of hospital trauma transfers for one year:**
		5. **Number of trauma registry patients admitted or transferred by ISS:**

####  Admitted Transferred Mortality

* + - 1. **ISS <= 8:**
			2. **ISS 9-15:**
			3. **ISS 16-24:**
			4. **ISS >= 25:**

**Note:** The totals in (3) and (4) above should equal the totals in the corresponding columns in (5). Describe any discrepancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. **Trauma Transfers**
		1. **Are there any formal transfer agreements for transfer of trauma patients into the hospital?** (circle one) Yes No
		2. **Were there any formal transfer agreements for transfer out of facility in last reporting year?** (circle one) Yes No If yes, indicate number:
* Please have any transfer agreements available for viewing at the time of the site visit.

# HOSPITAL FACILITIES

* 1. **List emergency department physicians on Chart A and attach.**
		1. **Attach ED medical director’s curriculum vitae**
		2. **Include trauma-related CME course names for all ED physicians**
	2. **Attach a copy of Emergency Department Trauma flow sheet(s) and any trauma care protocols/guidelines.**
	3. **Define the experience, certification, and education requirements, as well as the credentialing process for the nurses providing care to the trauma patient in the emergency department.**
	4. **Is there resuscitation and monitoring equipment available within the emergency department?** (circle one) Yes No
	5. **Is there a blood transfusion protocol?** (circle one) Yes No
		1. **Blood Bank inventory:**

|  |  |
| --- | --- |
| **Product** | **Units** |
| O Positive |  |
| O negative |  |
| All PRBC |  |
| Fresh Frozen Plasma |  |
| Liquid Plasma |  |
| Pooled Cryoprecipitate |  |
| Platelets |  |

* **If applicable, attach your Massive Transfusion Protocol**
	1. **Is there a lab tech available 24 hours?** (circle one) Yes No

### What is the estimated ED stat lab order response time?

### Are radiologists promptly available for interpretation of radiographs?

###  (Circle one) Yes No

* + 1. **In person (days/hours):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
		2. **Teleradiology (days/hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	1. **Do you have a CT Scanner?** (circle one) Yes No
	2. **Do you have MRI?** (circle one) Yes No
	3. **Describe your process for reviewing and communicating changes in radiography interpretation.**
	4. **Number of burn patients treated during last reporting year:**
	5. **Number of burn patients admitted during last reporting year:**
	6. **Number of burn patients transferred to another facility last reporting year:**
	7. **Describe your transfer policy/procedure for burn patients:**
	8. **Do you have transfer protocols for burn patients? (circle one) Yes No**
	9. **Number of spinal cord patients treated during last reporting year:**
	10. **Number of spinal cord patients transferred to another facility last reporting year:**
	11. **Describe your transfer policy/procedure for spinal cord patients:**
	12. **Describe your transfer policy/procedure for pediatric trauma patients:**
	13. **Who discusses organ procurement and donation with the family of terminally injured patients at your facility?**

# SOCIAL SERVICE

* 1. **Do you have social services within your facility?** (circle one) Yes No
	2. **Do you have crisis intervention programs in the community?** (circle one) Yes No
	3. **Do you have counseling available for the family?** (circle one) Yes No
	4. **Does your facility have an SBIRT process**? (circle one) Yes No

If Yes, briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Describe how you screen and follow up on suspected non-accidental trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# QUALITY IMPROVEMENT

#  (Be prepared to have examples of QI reviews and loop closure of issues available on site)

* 1. **Describe how trauma care issues are identified and tracked in the QI program at your facility:**
	2. **Do the nursing units participate in the review of trauma cases?** (circle one) Yes No
	3. **Does your QI process review appropriateness or care?** (circle one) Yes No
	4. **Does your QI process review provider responsiveness?** (circle one) Yes No
	5. **List your QI filters related to trauma care:**
	6. **Has the QI Process and trauma case reviews affected the way trauma patient care is provided?** (circle one) Yes No

If yes, please describe or give example(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. **List all QI committees at your facility who review trauma care as well as the membership of those committees:**

### Is attendance required at these committee meetings? (circle one) Yes No

* + 1. **To whom do the committees report findings?**
		2. **How often do the committees meet?**
		3. **How is information disseminated to the medical and nursing staffs?**
	1. **Who abstracts data for the trauma registry?**

### Is the trauma registry data obtained concurrently during the patient’s admission? (circle one) Yes No

* 1. **Describe your process for data abstraction and entry into the trauma registry at your facility:**
	2. **What is the most recent date (month/year) for which trauma data submission is complete?**
	3. **Who reviews deaths in your emergency department?**

# EDUCATIONAL ACTIVITIES/OUTREACH PROGRAMS

* 1. **Are your ED physicians required to take ATLS?** (circle one) Yes No

**Percentage of ED physicians that have current ATLS certification:**

* 1. **Are your nurses who provide trauma care to patients required to take TNCC?**

(circle one) Yes No

* 1. **What is the percentage of nurses providing trauma care who have current TNCC certification?**
	2. **Is there funding for trauma education for physicians, nurses, and/or prehospital personnel at your facility?** (circle one) Yes No
	3. **List all trauma educational programs funded by your facility and the location of those courses:**
	4. **Describe any public trauma educational activities sponsored by your facility:**
	5. **Describe any trauma education programs for prehospital providers at your facility:**

* 1. **Do you have injury prevention programs?** (circle one) Yes No

* 1. **List all injury prevention programs and briefly describe:**

* 1. **Do you do alcohol screening/ brief interventions in your ED?** (circle one) Yes No

If yes, who does the screening and/or brief intervention? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there days/times when SBIRT is unavailable? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. **Is there any other information you would like to share about your facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name/Title of Person Completing Application**

**Chart A**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Physician Name | ResidencyWhere and When completed | Board Certified? If yes, list place and date. | ATLS status: (provider or instructor)Date of expiration | Attach a list of trauma related CME taken during the last three years by each physician listed. | Frequency of ED rotation(all regularly scheduled shifts)Attach list of all ED schedules for previous three months. |
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