

REVIEW AGENDA

The purpose of the ACS review process is to verify a hospital's compliance with ACS standards for a trauma center. Site surveyors are charged with the responsibility of obtaining a detailed and accurate assessment of a hospital's capabilities in a very short period of time. For this reason, we ask that the trauma program personnel at the hospital carefully prepare for the visit by having all documents and medical records carefully organized and accessible to the surveyors. Please be aware that surveyors will look beyond the requested documents and medical records if they need additional validation of compliance with the standards. The Pre-Review Questionnaire (PRQ) 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 six to eight hours. Do not prepare your own agenda or presentation. In preferred situations, the surveyors will begin with the review of patient charts before the pre-review dinner meeting. However, due to flight scheduling and arrival times, the surveyors may not be able to review charts prior to the pre-review dinner meeting and will begin chart review the morning of the second day. The lead reviewer will coordinate the format with the hospital and the survey team.

Ideally available for the Pre-Review Dinner/Meeting (other essential personnel may also attend).

- Hospital administrator for the trauma program
- Trauma medical director
- Emergency medical director
- Trauma neurosurgeon
- Trauma orthopaedic surgeon
- Trauma program manager
- Trauma anesthesiologist
- Trauma physiatrist
- Chief of surgery
- Surgical director of the critical care unit
- Radiologist

Please have one staff member (trauma program manager, trauma medical director, or trauma surgeon) available to accompany each of the surveyors on the tour of the facility. It is helpful for the trauma program manager, trauma registrar, and trauma medical director to be readily available to the survey team for the entire review. One of the reviewers will visit each department listed below, not necessarily in the order stated.

A. Emergency Department

1. Review emergency department facility, resuscitation area, equipment, protocols, flow sheet, staffing, trauma call
2. Interview emergency physician, and emergency nurse.
3. Review the prehospital interaction and performance improvement and patient safety feedback mechanism.
4. The emergency department log book should also be available for the reviewers to view during the hospital visit. There may be additional records requested on-site based on this review

B. Radiology

1. Inspect facility
2. Interview radiologist and technician
3. Discuss patient triage
4. Determine patient monitoring policy
5. CT log (if applicable)

C. Operating Room/PACU

1. Interview operating room nurse manager and anesthesiologist/CRNA
2. Check operating room schedule
3. Determine how a trauma OR suite is opened STAT
4. Review equipment availability

D. ICU

1. Inspect facility/review equipment
2. Review flow sheets
3. Interview medical director/nurse manager/staff nurse
4. Discuss patient triage and bed availability

E. Blood Bank

1. Inspect facility
2. Interview technicians
3. Determine availability of blood products and massive transfusion protocols

F. Rehabilitation

1. Inspect facility
2. Interview staff
3. Determine where rehabilitation is initiated

G. Interviews – if not accomplished during Pre-Review Dinner

Potential interviews include:

1. Hospital administration
2. Trauma medical director
3. Neurosurgeon
4. Orthopaedic surgeon
5. Trauma program manager
6. Chief of staff

H. Chart Review/PIPS

1. Review performance improvement documents
2. Review medical records
3. Review Peer Review Committee attendance/minutes

I. Site Surveyors preparation for exit interview. Closed meeting – site survey team only.

J. Exit Interview

1. Hospital administration
2. Trauma medical director
3. Trauma program manager
4. Others as desired by hospital administration
5. The Verification Review Committee would also like to make the following statement with regard to the Exit Interview:

While the ACS COT does not have any specific guidelines regarding attendees at the Exit Interview, the Exit Interview is considered to be confidential and the hospital may wish to construct its attendance list carefully.

This voluntary site visit has been made by surveyors approved by the American College of Surgeons Committee on Trauma. The surveyors' findings will be presented in an executive summary at the beginning of the report and are divided into four major headings:

- 1) Deficiencies
- 2) Strengths
- 3) Weaknesses
- 4) Recommendations

Deficiencies are determined by the guidelines found in the current edition of the document "*Resources for Optimal Care of the Injured Patient*".

The confidential report will be sent to the VRC office in Chicago and then forwarded to the members of the Verification Review Committee. The final decisions regarding deficiencies will be made by the Verification Review Committee, and may differ from the surveyors' findings that were reported.

MATERIALS AVAILABLE AT TIME OF REVIEW

All materials requested are to be available on site in a 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.

A. Documentation of the hospital's trauma activity for one year

1. Intramural Education – physicians, nurses, paramedics
2. Extramural Education – physicians, nurses, paramedics
3. Community Outreach/Injury Prevention
4. Research – protocols, IRB submissions, committee minutes, and attendance
5. Trauma related manuscripts – published or in press within the last 3 years.

B. Copy of call/backup schedule for 3 months prior to review

1. Trauma, neurosurgery, orthopaedic attendings/primary and back-up
2. Residents (include PGY level) for trauma, neurosurgery, and orthopaedics

C. Documentation of CME (for past 3 years)

1. The trauma medical director must have 16 hours per year and 48 hours for 3 years of verifiable external CME. The surveyors may spot check certificates to verify this. The same is true for the liaisons from neurosurgery, orthopaedic surgery, and emergency medicine. Visiting professors, invited speakers and teaching ATLS are all considered external CME.
2. Other members of the trauma team including the above specialties need to be knowledgeable and current in the care of trauma patients. This requirement must be met by acquisition of 16 hours of CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program. In preparation for the site review, the hospital should demonstrate how the physicians received CME. This can be done by attendance sheets from trauma related conferences, meetings, certificates from computer based programs, documentation of articles that were read etc.

D. Performance Improvement and Patient Safety (PIPS)

1. Minutes of all trauma PI for one year, including multidisciplinary peer review and trauma system committees
2. Attendance records for all trauma service PI meetings
3. Documentation of all PI initiatives
4. Specific evidence of loop closure

E. Specific trauma patient medical records will be requested before the review.

Charts should be pulled from the reporting year (should not be older than 14 months prior to the scheduled survey date) as identified in the hospital's Pre-Review Questionnaire (PRQ).

With regard to the trauma PI program, pull all of the trauma deaths. Based on your Mortality Conference, separate the charts into the categories listed below. Each stack should be labeled accordingly. If it is a busy trauma center, please pull the last fifty deaths.

- 1) Preventable;
- 2) Possibly Preventable;
- 3) Non-preventable;

In addition, pull the last 10 charts for each of the following categories:

- 1) ISS >25 W/SURVIVAL;
- 2) Pediatric patient <15 years of age;
- 3) Epidural/subdural hematoma;
- 4) Thoracic/cardiac injuries (include aortic injuries);
- 5) Spleen and liver injuries;
- 6) Pelvis/femur fractures (include unstable pelvic fractures with hypotension);
- 7) Transfer out for the management of acute injury;
- 8) Adverse event/Death in the PICU/SICU

Pull the last 12 charts for trauma patients admitted to non-surgical services. Examples of non-surgical services include internal medicine, neurology, pediatric, family practice, hospitalist and geriatric medicine.

If the non-surgical admissions are more than 10% of the total admissions, in addition to pulling the last 12 admits to non-surgical services we would also like to see a breakdown of how many of those patients that meet the following criteria:

- 1) Due to same height falls;
- 2) Drownings, poisonings, or hangings;
- 3) ISS less than or equal to 4 **and** who do NOT meet the criteria defined in #1 and #2 above.

If the medical records are electronic, there must be computers available for each of the site surveyors. At the time of the review, there must be one person available for each of the surveyors that are proficient and knowledgeable in the electronic medical record system. Also, be prepared to extract data from the trauma registry upon the site surveyors' request.