REVIEW AGENDA AND LOGISTICS

The purpose of the American College of Surgeons Verification, Review, & Consultation (VRC) Program is to verify a hospital's compliance with the ACS standards for a trauma center.

The trauma program personnel at the hospital must carefully prepare for a site visit, as Reviewers must obtain a detailed and accurate assessment of a hospital's capabilities, within a short period of time. Thus, all documents and medical records must be carefully organized and easily accessible, and Wi-Fi/ Internet access should be available, as Reviewers will be working on the VRC Site Visit Report at the time of the site visit.

Additionally, Reviewers may request additional information, clarification and supportive content, besides the indicated documents, before validating compliance with ACS standards.

It would be helpful for the hospital to have the trauma program manager (TPM), trauma registrar, and trauma medical director (TMD) available on-site, during the entire site visit.

The hospital and/or trauma program personnel are responsible for Reviewers' hotel and ground transportation; however, if a Reviewer prefers a rental car, they will arrange that through the ACS Travel Agent, for which ACS will cover the cost. This will occasionally happen when there is a tandem visit scheduled (back-to-back) and the two hospitals are far away from each other, or if the airport is significantly far from the hospital. For the most part, the Reviewers prefer to be picked up at the airport since they are not familiar with the area. In such a case, the hospital and/or trauma program personnel would be responsible for receiving the Reviewers and arranging their pick-up/ drop-off to/from the airport.

It is recommended that once the hotel arrangements are made, the TPM forward the hotel confirmations directly to the Reviewers. At this time, the TPM may inquire about their travel plans, arrangements, and dietary restrictions.

Review Agenda

The review process will last approximately six to eight hours, over the two-day site visit period.

Please do not create your own agenda or presentation. We ask that you follow the agenda provided below:

Sample Agenda		
Day #1	11:00 am – 5:00 pm	Chart review and evaluation of Performance Improvement and Patient Safety (PIPS)
	6:00 pm – 8:30 pm	Review dinner
Day #2	7:00 am – 8:00 am	Hospital tour
	8:00 am – 9:00 am	Additional assessments, examples could be: - Injury prevention documents - Review of other documentation
	9:00 am – 10:00 am	Review Team Closed Meeting (30-60) minutes
	10:00 am – 12:00 pm	Exit Interview (30-60) minutes
Note: -Depending on the Reviewer's flights, they typically arrive anytime between 11am-1pm the day of the visit or occasionally the night before. -The Lead Reviewer will coordinate the format of the site visit or the hospital tour with the trauma program manager and the Review Team.		

Chart Review/ PI Review
Refer to the list beginning on page 6 (specify which list)

1. Review performance improvement documents
2. Medical case review

Review Dinner

A working review dinner is required. The dinner can be on or offsite.

Recommended attendees at the review dinner

- Hospital Administrator for the trauma program
- Chief of Surgery
- Trauma Medical Director
- Trauma Program Manager
- Emergency Medical Director
- Trauma Neurosurgeon
- Trauma Orthopaedic surgeon
- Trauma Anesthesiologist
- Trauma Physiatrist
- Surgical Director of the Critical Care Unit
- Radiologist
- Trauma Registrar
- Other essential personnel: PI Clinician, Advance Practice Providers, CRNA

Hospital Tour

Reviewers will determine the specifics of the hospital tour, including the start time. Please arrange a group of trauma team members, who will guide each Reviewer during the tour. Additionally, please ensure that the appropriate department staff will be available to meet with Reviewers during the tour.

The hospital tour will include the following departments:

A. Ambulance Bay
Evaluated by all Reviewers

B. Helipad (if onsite)
Evaluated by all Reviewers

C. Decontamination/Mass Casualty (DO NOT setup decontamination or mass casualty equipment)
Evaluated by all Reviewers

D. Emergency Department
Evaluated by all Reviewers
1. Review Emergency Department resuscitation area, equipment, protocols, trauma flow sheet, staffing, and trauma call schedule
2. Interview Emergency Physician, and Emergency Nurse

Evaluated by assigned Reviewer
3. Review the pre-hospital interaction and PIPS feedback mechanism
4. The Emergency Department Physician schedule should be available for review.
5. There may be additional documentation requested on-site by the Reviewers.

E. Radiology
Evaluated by assigned Reviewer
1. Inspect department
2. Interview Radiologist and Technician
3. Discuss patient triage
4. Determine patient monitoring policy
5. CT log or report

F. Operating Room/PACU
Evaluated by assigned Reviewer
1. Interview Operating Room Nurse Manager and Anesthesiologist/CRNA
2. Review Operating Room schedule
3. Determine how a trauma Operating Room suite is opened STAT
4. Review equipment availability

G. ICU / PICU
Evaluated by assigned Reviewer
1. Inspect department
2. Review equipment
3. Review flow sheets
4. Interview Medical Director/Nurse Manager/Staff Nurse
5. Discuss patient triage and bed availability

H. Blood Bank

Evaluated by assigned Reviewer

1. Inspect department
2. Interview Technicians
3. Determine availability of blood products and Massive Transfusion Protocols

I. Rehabilitation (if on-site location)

Evaluated by assigned Reviewer

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

Additional Assessments

J. Interviews/Questions for a specific department

Evaluated by assigned Reviewer

May be conducted during the Review Dinner, or any time during the site review

Interviews include; however, are not limited to, the following hospital personnel:

1. Hospital Administrator
2. Trauma Medical Director
3. Trauma Program Manager
4. Neurosurgeon
5. Orthopaedic surgeon
6. Chief of Staff

Review Team Closed Meeting

The Reviewers will have a closed meeting in preparation for the Exit Interview. No hospital and/or trauma program personnel will be permitted to attend. However, if the designating agency representative is present and available, they may be invited to attend.

Shortly after the Closed Meeting, the Reviewers may have a debriefing session with the TMD and TPM to present a summary of their findings. This is an opportunity to address or clarify any deficiencies with the Reviewers.

Exit Interview

The purpose of the Exit Interview is to share the preliminary findings of the Reviewers with the Trauma Center Leadership team. In the exit interview, the Reviewers will communicate the critical Deficiencies, Strengths, Opportunities for Improvement, and Recommendations.

Attendees for the Exit Interview may include; however, are not limited to, the following:

1. Hospital Administrator
2. Trauma Medical Director
3. Trauma Program Manager
4. Others as desired by the Trauma Center Leadership Team

Materials Required at the Time of the Onsite Review

All indicated materials must be available and organized systematically, as noted below, where the medical case review assessment will be conducted. Please note that this room must have adequate space for Reviewers to be comfortable while conducting the medical case reviews.

Please provide a power source and internet access for Reviewer's computers.

The required documentation must be organized systematically and labeled in binders (excludes medical case reviews).

A. Documentation of the hospital's trauma activity during the review period (the timeframe used to complete the online PRQ)
    1. Research protocols, IRB submissions, trauma related manuscripts must be published or in press within the last 3 years. *Applicable to Level I adult and/or pediatric trauma centers*.
        a. The *Research Form Template* for articles must be completed for each article being considered to meet the requirement, http://www.facs.org/quality-programs/trauma/vrc/resources
    2. Community Outreach/Injury Prevention

B. Copies of the attending's and resident's call/backup call schedules for 3 months during the reporting year for the following services:
    - Trauma
    - Neurosurgery
    - Orthopaedic

C. Performance Improvement and Patient Safety (PIPS)
    1. Minutes of all trauma PIPS for medical case reviews during the review period, including Multidisciplinary Peer Review and Trauma System Committees
    2. Attendance records for the Peer Review meetings during the review period
    3. Documentation of all PIPS initiatives during the review period
    4. Specific evidence of loop closure during the review period
    5. Trauma Program Performance Improvement Plan

D. Medical records must be available at the time of the review

    For programs seeking separate pediatric verification, separate medical records must be available onsite for the pediatric population (less than 15 years of age) for the same categories as the adult.

    For the Electronic Medical Records (EMR), each Reviewer must have an assigned computer and staff member who is proficient and able to navigate the EMR software. The EMR software must be easily tabulated to display the contents listed below. If the EMR is not able to be tabulated, then the following contents must be printed for each trauma case.

    1. Prehospital
        a) EMS run sheet
        b) Transferring facility ED info
    2. Trauma Flow Sheet
    3. H&P
    4. Consult Notes
    5. Operative Report/ Notes

6. Discharge Summary
7. Autopsy Report, if available
8. Copies of PIPS documentation and other related information, if applicable

The Trauma Registrar may be asked to extract data from the Trauma Registry upon the Reviewers' request.

For any of the following medical record categories, if the minimum requested is not available, pull what is available at the time of the onsite visit. You may also, include medical records outside the reporting period that impacted the center's PIPS to demonstrate improvements.

Trauma deaths based on the trauma center's Mortality review for the types of patients the center admits:

- Adults only - minimum of 30 medical records, if available
- Pediatric only – minimum of 20 medical records, if available
- Adults & pediatric combined programs (verification) - minimum of 30 adult & 20 pediatric medical records, if available
- Adult trauma center that admits children - minimum of 30 medical records (pull mixture of both), if available

Tabulate or label the medical records into the following categories:

- Mortality Without Opportunity for Improvement
- Mortality With Opportunity for Improvement
- Unanticipated Mortality With Opportunity for Improvement

Adult Population Medical Charts

At minimum, the last 10 medical records for each of the categories listed below should be available at the time of the site visit. If there are not 10 medical records in each category, pull what is available at the time of the onsite visit. You can also, include patients from the year before that underwent PIPS review and had an impact on your process.

It is possible that some medical records overlap into other categories. Do not copy the medical record; however, place the medical record in the category deemed most appropriate.

1. ISS > 25 With Survival
2. Pediatric patients < 15 years (for adult centers that admit children regardless if seeking separate verification)
3. Epidural/Subdural Hematoma admitted to the ICU
4. Thoracic/Cardiac injuries with an AIS code of 3 or greater (include aortic injuries)
5. Severe TBI (GCS < or = 8 in the ED and admitted to the ICU)
6. Spleen and Liver injuries: Grade III or higher and requiring surgery, embolization, or transfusion.
7. Pelvis/Femur fractures;
    a. Include unstable pelvic fractures with hypotension requiring embolization, surgery, Resuscitative endovascular balloon occlusion of the aorta (REBOA), or transfusion
    b. Open femur fractures
8. Transfer Out for the management of acute injury;
9. Adverse Event/Death in the SICU or unexpected return to the SICU -or- Operating Room
10. Trauma patients admitted to Non-Surgical Services with an ISS > 9
11. At least one patient transferred to hospice should be included, if applicable.

Pediatric Population Medical Records <15 years of age

At minimum, the last 10 medical records for each of the categories listed below should be available at the time of the site visit. If there are not 10 medical records in each category, pull what is available at the time of the onsite visit. You can also, include patients from the year before that underwent PIPS review and had an impact on your process.

It is possible that some medical records overlap into other categories. Do not copy the medical record; however, place the medical record in the category deemed most appropriate.

1. ISS > 25 With Survival
2. Epidural/Subdural Hematoma admitted to PICU;
3. Severe TBI (GCS < or = 8 in the ED or admitted to PICU/ICU)
4. Thoracic/Cardiac injuries with an AIS code of 3 or greater (include aortic injuries);
5. Pelvis/Femur fractures:
   a. Unstable pelvic fractures/pelvic fractures that go to OR, embolization, or transfusion
   b. Open femur fractures
6. Spleen and Liver injuries; (grade III or higher) or with intervention
7. Unexpected Return to the OR or PICU
8. Non-Accidental Trauma (suspected and/or confirmed) with an ISS > 9
9. Trauma patients admitted to Non-Surgical Services with an ISS > 9
10. Transfer Out for the management of acute injury

E. Risk-Adjusted Benchmarking Program
If you have your most recent TQIP benchmark report, please have that available at the time of the site visit.

FINAL REPORT STRUCTURE

The report process is the same for all types of visits.

Stage	Phase I	Phase II	Phase II	Phase IV	Phase V	Final
Process	Report submitted by Review Team	Office Receipt	Editorial Review	VRC Vetting	Chair Ruling	Letter/Report Release to Hospital
Anticipated Times	10 working days after initial site visit	Times may vary				8 weeks after initial site visit